Leaning Care Management Documentation To Reflect The CMS Conditions Of Participation And Enhance Multidisciplinary Communication Of The Discharge Plan

Stacey Willis Jr. MBA
Emily Teesdale MSN RN
Spectrum Health System

- Spectrum Health Grand Rapids, 1040 inpatient beds
- 11 Spectrum Health Hospitals
- 1,080 Physicians
- 21,400 Staff
- Not for profit
- Spectrum Health Continuing Care
- 170 Outpatient Centers
- Priority Health
Health Care Environment Today

- Quality Improvement
- Informed public
- Decreasing reimbursements
- Economic climate
- Health Care Reform
- Technology
- Rapid pace of change
Purpose

- Create leaner documentation
- Improve efficiency of workflow
- Provide structured documentation to assist meeting the increasing regulations for discharge planning.
Rationale

1. Lean and standardize work
2. Support role as coordinators and drivers of care
3. Support role delineation
4. Provide structure for best practices
5. Assure compliance
6. Increase staff satisfaction
Project Phases

**Phase I:**
- Map current state
- Review regulations and best practices (TJC, CMS, ACMA)
- Select FIE team
- Conducted initial internal process improvement steps.

**Phase II:**
- Conduct FIE
- Build future state model of Cerner Documentation
- Identify immediate Lean opportunities
- continued steps of internal process improvement
Phases continued

**Phase III:**
- Establish timeline and IS resources
- Build new Initial Assessment, new Progress Note and new SW Consult Note
- Test new documentation with end-users
- Communicate and obtain approval from Legal and Risk
- Continued steps of internal process improvement

**Phase IV**
- Educate users on new documentation tools and processes
- Implement new documentation
- Create sustainability plan
Current Document- lesson learned

Structure changes were needed:

■ Current documentation tools were not meeting the health care team’s needs in an efficient or effective manner
  ■ Documentation was not delineated out for roles
  ■ Documentation was buried in the electronic chart

■ Social Work & Nurse Case Manager Practice Councils – developed best practice standards that required changes to documentation
Spectrum Health Performance Improvement System

- Safety & Quality
- Patient Experience
- Strategic Growth
- Financial Stewardship
- Talent Development and Performance

True North
Gears of Success

People

Process

Structure
Key points to inform our documentation standards

- Medicare & Medicaid Regulations (CoP)
- Joint Commission Best Practice Standards
- *False Claim Act*
- Standardized Documentation for both
  - Adults & Pediatrics
  - NCM, SW and care management team
- ACMA – Preeminent organization for Hospital Case Management
ACMA Guidelines

It is incumbent on case managers along with the health care team, to describe in detail the circumstances driving the plan of care to ensure that the care is individualized and properly reflects the true care needs of the patient.

- If you didn’t document it – you didn’t do it!
- Document all activities related to care coordination, transition planning, and communication with patient/family.
Hospital must have in effect a discharge planning process that applies to all patients.

Policies & procedures must be specified in writing.

Hospital discharge planning process includes:
- Determining appropriate post-hospital discharge destination
- Identification of patient needs for a smooth and safe transition
- Initiation of the process of meeting the patient’s identified post-discharge needs
CMS CoP

- Reducing the number of preventable hospital readmissions is a major priority for patient safety.
- Holding hospitals accountable for complying with discharging planning CoP is one key element of an overall strategy for reducing readmissions.
- Multiple factors contribute to readmission:
CMS CoP

- CoP applies to all patients, not just Medicare
- CoP applies to inpatients only, not observation or outpatient
- 4 Step Process:
  1) Screening all patients to determine risk of adverse health consequences post-discharge if they lack discharge planning
  2) Evaluation of the post-discharge needs of inpatients identified in 1st step, or of inpatient’s or physicians who request evaluations
  3) Development of a discharge plan if indicated by the evaluation or at the request of the patient’s physician
  4) Initiation of the implementation of the discharge plan prior to the discharge of an inpatient
Hospitals must actively involve patients or their representatives throughout the discharge planning process.

CMS Survey Procedures:

- Determine if hospital has written policies and procedures for discharge planning.
- Evaluate compliance with each CoP standard…following standard practice, depending on needs related to specific discharge planning standards.
- Determine if noncompliance.
## Subjective/Objective

### Mut/Spoke With:
- Patient
- Spouse
- Brother
- Cousin
- Niece
- Daughter
- Foster Father
- Foster Son
- Significant other
- Stepfather
- Grandmother
- Host mother
- Nephew
- Son
- Grandfather
- Host father
- Niece
- Stepfather
- Granddaughter
- Host father
- Niece
- Stepfather
- Significant other
- Stepfather

### Language Spoken:
- English
- Spanish
- Sign Language
- Other
- Vietnamese
- Unable to assess
- Sign Language
- Other

### Interpretation Services Used:
- Yes
- No

### Readmission Within 30 Days?
- Yes
- No

### Patient Type:
- Inpatient
- Outpatient (ED, SICU)
- Outpatient (Ambulatory)
- Emergency Department

### Admitted From:
- Aeromed
- Ambulance
- Clinic
- Home
- Emergency Department
- Other
- Post Anesthesia Care Unit (PACU)
- Unable to assess
- Other

### 8P's

#### 1) Problem Medications
- Yes

#### 2) Psychological
- Yes

**Depression screen positive or depression diagnosis**

#### 3) Principal Diagnosis
- Yes

**Any of the following: cancer, diabetes, glycemic complications, COPD, heart failure**

### Taking Problem Medications
- Warfarin
- Oral hypoglycemic agents
- Insulin
- Digoxin
- Aspirin combo (with Plavix/Clapitideg)

### Data Review

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Designate specific sections for SW and NCM

Re-label as: Psychological/Substance abuse

Any of the following: cancer, diabetes, glycemic complications, COFD, heart failure.
It’s only the beginning…

<table>
<thead>
<tr>
<th>Subjective/Objective</th>
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<tbody>
<tr>
<td>Met/Spoke With:</td>
</tr>
<tr>
<td>Patient □</td>
</tr>
<tr>
<td>Spouse □</td>
</tr>
<tr>
<td>Father □</td>
</tr>
<tr>
<td>Mother □</td>
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</tr>
</tbody>
</table>

Interpretation Services Used:
- □ Yes
- □ No
- □ Other:

Problem Medications:
- □ Yes

Psychological/Substance Abuse
- □ Yes

Principal Diagnosis
- □ Yes

- Any of the following: cancer, diabetes, glycemic complications, COPD, heart failure, ESRF, suicide, asthma

Polypharmacy
- □ Yes

Patient’s Perceived Length of Stay

Readmission within 30 Days?
- □ Yes
- □ No
# Assessment

Re title as: Current issues

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## Multidisciplinary Recommendations/Communications

<table>
<thead>
<tr>
<th>Multidisciplinary Recommendations/Communications</th>
<th>Provider/Staff Member</th>
<th>Comment</th>
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<tbody>
<tr>
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## Care Management Recommendations

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## Care Management Action Plan Recommendation

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## Multidisciplinary Communications

<table>
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<td>&lt;Alpha&gt;</td>
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</tbody>
</table>

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# Build to look like IA
Leaning out Documentation

Sections eliminated due to duplication

- Cognitive/Perceptual
- Emotional/ Psychological
- Tobacco/Alcohol/and Drug use

Improvements

- Reduced DTAs
- Standardization
- SW Consult
- Structure of workflow
- Some sections re-labeled for clarity
### Initial Evaluation Redesign DTA Analysis

<table>
<thead>
<tr>
<th>IE Sections Before</th>
<th>Questions</th>
<th>IE Sections After</th>
<th>Questions</th>
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<td>Subjective/Objective</td>
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<td>Contact Information</td>
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<td>Factors for Readmission</td>
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<td>1</td>
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<tr>
<td>Home Assessment</td>
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<td>Patient and Family</td>
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<td>-2</td>
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<td>Communication</td>
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<tr>
<td>Current Resources</td>
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<td>Multi-Displinary Communication</td>
<td>4</td>
<td>0</td>
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<tr>
<td>Plan</td>
<td>2</td>
<td>Contact Information</td>
<td>2</td>
<td>-15</td>
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<tr>
<td>Emotional/Psychological</td>
<td>5</td>
<td>Role Relationship</td>
<td>11</td>
<td>9</td>
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<tr>
<td>Tobacco/Alcohol/Drug</td>
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<td>Home Assessment</td>
<td>9</td>
<td>4</td>
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<tr>
<td>Obstetrical</td>
<td>7</td>
<td>Current Resources</td>
<td>6</td>
<td>-22</td>
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<tr>
<td>Diabetes</td>
<td>8</td>
<td>Discharge Planning</td>
<td>2</td>
<td>-5</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>6</td>
<td>Plan</td>
<td>16</td>
<td>8</td>
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<tr>
<td>CM Rehabilitation Goals</td>
<td>3</td>
<td>Obstetrical</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Role Relationship</td>
<td>8</td>
<td>Diabetes</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>IRU-Care Manageant</td>
<td></td>
<td>Rehabilitation Goals</td>
<td>2</td>
<td>-6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
<td><strong>-45</strong></td>
</tr>
</tbody>
</table>
Calculate Waste for NCMs

**Waste decreased**

- Minutes saved: 10 min
- Amount of IE: 5 IEs
- Total Per Day: 50 min
- Total Per Week: 250 min
- Total per Month: 1,000 min
- Total per Year: 52,000 min
- Times the of Care Managers (40): 2,080,000 min

34,667=Hours of waste  16.7 FTE
Structure of Documentation SBAR

**Situation:** Effective communication is essential to teamwork, efficiency, patient safety and the One Patient Experience

**Background:** Discharge Information is documented by multiple disciplines in various locations in the electronic health record

**Assessment:** A “one stop shop” for viewing discharge information is needed with “less clicks”

**Plan:** Pilot an M-page that pulls discharge information from various discipline’s documentation in Cerner to ONE VIEW – Interdisciplinary Discharge Planning Page = “IDP Page”
Interdisciplinary Discharge Planning Page

![IDP Summary Menu Item](image-url)

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### Interdisciplinary Discharge Planning Summary

#### Code Status
- **DO NOT Resuscitate** 06/17/13 06:23:00, Do Not Resuscitate - Patient - Aggressive Treatment

#### General Information
**Anticipated Discharge Date:** 06/15/13
**Anticipated LOS based on DRG:** Not Available
**Current Actual LOS:** 19.1 Days
**Primary Care Provider:** Kidd, Pamela G
**Care Manager:** Steven Tyler, RN CCRN-ICU; Joan Jett, RN-PS-2222 [GPS]
**Discharge Destination:** Home with home care

#### Discharge Team Talk
To地产 thoughts about the discharge, like data, goals, etc.

**Notes:** These notes are not stored as part of the permanent record and are removed if they have not been updated in 14 days.

**Current Team Talk:**
- ‘Plan 2 more days of IV antibiotics’
- ‘Daughter coming at 10AM tomorrow for discharge education’
- ‘Patient and Daughter speak Spanish’

**Notes:** These notes are not stored as part of the permanent record and are removed if they have not been updated in 14 days.

---

#### Guardian
- **Guardian Information:** No guardian information found for this patient.

#### Care Management (9)
- **Care Management Information:**

#### Rehab/PT and OT (2)
- **PT and OT Discharge Information:**

#### Speech Therapy (1)
- **Speech Therapy Information:**

#### Respiratory Care (1)
IDP Summary

No guardian information found for this patient.

Care Management (5)
Care Management Related Discharge Information

- Readmission Within 30 Days: Yes
- Prescription Coverage: VA benefit
- Care Management Clinical: Patient and son George and daughter Ally all in agreement for SH Home Health Care for deconditioning and basic needs.
- Opinion: Home with home care
- Current Discharge Plan: Home with home care
- Potential Barriers to Discharge Planning: Pol Barriers for PN
- Anticipated Discharge/Transfer Date: 06/12/2013
- Primary Issue: Care Management Primary Issue - Decision making
- Diagnosed Psychiatric Disorder: Yes

Rehab/PT and OT (2)
PT and OT Discharge Information

- Discharge Recommendations Rehab: Home health occupational therapy
- Discharge Readiness OT: Ready for discharge from therapy

Speech Therapy (1)
Changing culture: Step 1

Department Culture

Response: Consistency Inconsistency

Response motivates staff to do what is expected

Articulate Expectations Communicate Model Teach

Observation, Measurement, Feedback
Immediate Lean Opportunities

EPIC page

IA:
- Skips: Advanced Directive (nursing does)
- PCP (registration does – if no PCP per IDP – M2A process
- Reinforce the IDP charting tips
- Can skip emotional psych – skip unless you are doing a SW consult
- Delete tobacco questions – nusing does
- ETOH – SW do if consulted
- Acknowledgement – don’t have to put if you are SW or NCM don’t need credentials

PN
- Delete CM Information
## Communication Plan

<table>
<thead>
<tr>
<th>To WHOM (Stakeholders)</th>
<th>WHAT (Kind of Information)</th>
<th>DATE (When)</th>
<th>FREQUENCY (When)</th>
<th>HOW (Communication Method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMD Leadership</td>
<td>Project status updates. Will also work on workflow processes.</td>
<td>5/1/14 – go live</td>
<td>Weekly</td>
<td>In-person Meetings</td>
</tr>
<tr>
<td>All CMD Staff</td>
<td>Project status updates, purpose, reasoning's, etc.</td>
<td>5/28/14</td>
<td>Once</td>
<td>All staff Meeting</td>
</tr>
<tr>
<td>Nurse Case Managers and Medical Social Workers</td>
<td>Information regarding education sessions, sign-up, etc. All content regarding Discharge Planning Regs, Documentation Redesign, etc</td>
<td>5/23/14 (Multiple Class dates)</td>
<td>Multiple</td>
<td>Email, flier, formal class</td>
</tr>
<tr>
<td>IS Team (Marcia Poulis &amp; Mary Nader)</td>
<td>Obtain timeline information, go-live, testing time period, etc.</td>
<td>4/2/14 – go live</td>
<td>Bi-weekly</td>
<td>In-person Meetings</td>
</tr>
<tr>
<td>Nursing – Amy Majeski</td>
<td>Go-live information, documentation changes, purpose, IDP summary importance, etc.</td>
<td>6/4/14</td>
<td>Once</td>
<td>Informational Flier</td>
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<tr>
<td>Regional Hospitals</td>
<td>Go-live information, documentation changes, purpose, education sessions, etc.</td>
<td>5/27/14</td>
<td>Multiple</td>
<td>Conference Calls</td>
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<tr>
<td>Allscripts Administrators</td>
<td>Documentation changes and effects on Allscripts (interface fields)</td>
<td>3/19/14</td>
<td>Multiple</td>
<td>Email/ Allscripts Bi-Weekly touch bases</td>
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<tr>
<td>SHCC &amp; Core Health</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td>Once</td>
<td>Meeting</td>
</tr>
</tbody>
</table>
## Communication Plan.

<table>
<thead>
<tr>
<th><strong>Physician/Physician Leadership</strong></th>
<th><strong>Emily Teesdale</strong></th>
<th><strong>Go-live information, documentation changes, purpose, IDP summary importance, etc.</strong></th>
<th>6/4/14</th>
<th><strong>Once</strong></th>
<th><strong>Informational Flier</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NaviHealth</strong></td>
<td>Jeannine Nylaan</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td><strong>Once</strong></td>
<td>During the NaviHealth updates.</td>
</tr>
<tr>
<td><strong>Clinical Informatics Council</strong></td>
<td>Emily Teesdale</td>
<td>Documentation changes and brief explanations on regulations</td>
<td>4/17/14</td>
<td><strong>Once</strong></td>
<td><strong>Meeting</strong></td>
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<tr>
<td><strong>Coding – June VanKuiken</strong></td>
<td>Stacey Willis</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td><strong>Once</strong></td>
<td><strong>Informational Flier</strong></td>
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<tr>
<td><strong>Therapy Services</strong></td>
<td>Emily Teesdale</td>
<td>Go-live information, documentation changes, purpose, IDP summary importance, etc.</td>
<td>6/4/14</td>
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<td><strong>Informational Flier</strong></td>
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<td><strong>Pulmonary Rehabilitation</strong></td>
<td>Emily Teesdale</td>
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<td>6/4/14</td>
<td><strong>Once</strong></td>
<td><strong>Informational Flier</strong></td>
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<tr>
<td><strong>Denials Management – Karen Denko</strong></td>
<td>Stacey Willis</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td><strong>Once</strong></td>
<td><strong>Meeting</strong></td>
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<tr>
<td><strong>Patient Placement/ Clinical Call Center</strong></td>
<td>PEQ Team</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td><strong>Once</strong></td>
<td><strong>Informational Flier</strong></td>
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<td><strong>Quality Improvement – Julie Bonewell</strong></td>
<td>PEQ Team</td>
<td>Go-live information, documentation changes, purpose, etc.</td>
<td>6/4/14</td>
<td><strong>Once</strong></td>
<td><strong>Email/Information Flier</strong></td>
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<tr>
<td><strong>Executive Team???</strong></td>
<td>PEQ Team</td>
<td>Final Report-out</td>
<td>July</td>
<td><strong>Once</strong></td>
<td><strong>Presentation</strong></td>
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</table>
Let’s do this!

- Scheduled Mandatory Classes
- Discussion of the “Why”
- Leaner Documentation
- Go-Live
- Follow-up
Average LOS (Inpatients)

Average Length of Stay
Updated Millman Benchmark

February 2014
April 2014
June 2014
August 2014
October 2014
December 2014
30 Day Readmission Rates (Inpatients)

30 Day Readmission Rates

Percentage of Admissions

<table>
<thead>
<tr>
<th>Month</th>
<th>Blodgett</th>
<th>Butterworth</th>
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<tbody>
<tr>
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<td>11.00%</td>
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<td>December 2013</td>
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<tr>
<td>January 2014</td>
<td>10.50%</td>
<td>10.00%</td>
</tr>
<tr>
<td>February 2014</td>
<td>11.00%</td>
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<tr>
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<td>10.50%</td>
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</tr>
<tr>
<td>November 2014</td>
<td>10.00%</td>
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Wrap it up…

- Lessons Learned
- Sustainability
- Next steps
References