Acute Care Model Redesign: Clinical Nurse Leaders Partnering within the Care Team

2015 ANCC National Magnet Conference: Session C931
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Texas Health Resources
Arlington, TX

Why was it so important for THR to redesign its care delivery system?

The SAME reasons it is so important for you to redesign your care delivery system.

Texas Health Resources

- Total of 25 acute-care and short-stay hospitals that are owned, operated, joint-ventured or affiliated with the System.
- 14 Hospitals are wholly owned
- 18 Outpatient Facilities
- 250 Community access points
- 3,800 Licensed hospital beds
- 22,500 Employees
- 6700 Registered Nurses
- 5500 Physicians
### Triple Aim

#### Goals
- Population Health
- Member Experience
- Total Cost of Care

#### Tools
- Prevention
- Disease Management
- Access
- Care Coordination
- Resource Stewardship
- High Value Network

#### Outcomes
- **Clinical Outcomes**
  - Disease specific (Diabetes, Cardio, Resp)
  - Preventive care
  - Care coordination
  - High value network
  - Member experience

- **Financial Outcomes**
  - Total medical PMPM
  - Revenue
  - Growth
  - Revenue
  - Revenue

### Business Model

#### Expense reduction
- Decrease unit cost
- Decrease utilization

#### Revenue
- Expensive reduction
- Robust reporting
- Dashboards
- Clinical Review
- Financial Outcomes
  - Total medical PMPM
  - Care Providers
  - Care Transition Mgmt
  - Robust reporting
  - Dashboards
  - Clinical Review

### Care Delivery System

- Delineates nurses’ authority / accountability for decision-making and outcomes
- Integrated with the professional practice model
- Promotes continuous, consistent, efficient, and accountable nursing care
- Regulatory requirements, context of care, skill set required and expected outcomes
- Related Sources of Evidence (e.g. OO 8, TL7, EP5, EP7EO)
Point of Care Accountability

- Need a standard role to assume accountability for patient-care outcomes
- Someone to OWN the patient’s experience
- Need a provider and coordinator of care at the point of care
- A provider who is consistent, reliable, and available across the patient’s stay
- Needed POC application of EBP and PI to design, implement, evaluate, and improve patient-care processes
- Additional issues:
  - Not meeting the desired mark
  - Lack of innovation for new roles / CDMs
  - Move to 12 hour shift
  - Hospitalists

Care Management Redesign Initiative: The Case for Change

- The need for change:
  - Over the next few years, we expect health care costs to rise, reimbursements to decrease and a large growth in the number of patients we will serve. To succeed in this new environment, THR has to deliver care differently. One of the ways THR will do this is in care management.
  - There is a great variety in how THR cares for patients from hospital to hospital, making it difficult to consistently deliver evidence-based care system wide and across the continuum.

- The vision:
  - Over the next few years, we will create a new care management model, adopt new technologies, workflows and processes.
The New Definition of Care Management

- Acute Care Coordinator
- Nurse Manager
- Charge Nurse
- Advanced Practice Nurses
- CTO/POC
- Direct Care Nurse

Orlando & Approach Management
- Clinical Review Orlando & Appeals RNs
- Clinical Review Specialists

Care Transition Management
- CTH RN
- CTH SV
- Post-acute Care Managers

Utilization Management
- Clinical Review Utilization Management RNs
- Clinical Review Specialists

- Coordinates EBP collaboration
- Collaborates with physicians to assure that a quality plan for each POC is in place
- Collaborates with other disciplines to ensure a flow of communication between disciplines:
- Demarcates priority and workflow
- Assures effective use of resources
- Assures effective use of resources

The New Definition of Care Management

- Improves outcomes by reliably applying medical science to each patient.
- Acts as consistent figure for patient in the hospital to offset fragmentation.
- Acts in the role of 'traffic control' or "quarterback" or "attending nurse" in coordinating rollout of the plan for care.
- Acts as the primary liaison for physicians, other disciplines, and families.
- Monitors competency and mentors team members.
- "Advanced Generalist" role needed.
- Responsible 24/7.

Patient Care Facilitator / Clinical Nurse Leader™ Roles and Collaboration

- Coordinates and facilitates the discharge plan between the patient, families, and discharge planners.
- Monitors discharge planning for quality, safety, and efficiency.
- Coordinates interdisciplinary conferences with the patient, families, and referring physician.
- Oversees the discharge process.
- Directs the implementation of the various service programs for patient safety, unit development, case reduction, and quality improvement.

Clinical Nurse Leader

- Master’s prepared advance clinician who functions as a clinical leader for RNs and other staff, not as manager.
- Advances professional practice, accountability and reduces costs.
- Major partner to nursing supervisors/managers.
- Knows about each patient in their microsystem.
- Acts as consistent figure for patient in the hospital to offset fragmentation.
- Acts in the role of 'traffic control' or "quarterback" or "attending nurse" in coordinating rollout of the plan for care.
- Acts as the primary liaison for physicians, other disciplines, and families.
- Monitors competency and mentors team members.
- "Advanced Generalist" role needed.
- Responsible 24/7.
Texas Health PCFs & CNLs
“Fast Forward” approved for 2014

Denton – 9
Alliance - 2
Azle – 1
Plano - 10
Allen – 2
Dallas 22
Fort Worth – 31
THSH - 1
Southwest – 9
Cleburne – 2
Stephenville-1
Total = 112 positions

Our Purpose: Closing Gaps in Patient Care

The CNL Role

CNL Practice Model

Methods

Operational standards were created
- Purpose Statement
- Practice Model
- Orientation standardization
- Rounding Process
- Care Coordination Objectives
- Computer Charting
- Recruitment
Clinical Nurse Leader's Role Responsibilities are Beyond the Work of Care Management

**THR**

Leading the unit's care coordination efforts fits here (within the broader role of the CNL).

**CNLA Conference**

October 2014

**PATIENT ROUNDING**

The CNL PAVES the way to great patient outcomes:

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| Patient Education about the Role

- **Clinical Nurse Leader (CNL)**
- **About Me:** I am a registered nurse (RN) with special training in nursing (Master’s degree). I work with you, your family/friends, and your care team to coordinate your care. I will be checking in on your progress, and will be helping your care team create the right plan for your care.
- **My Goal For You:** My goal for you is for you to have the best outcome and be satisfied with your care.
- **What I Will Be Doing:** I will be communicating with you, your family/friends, and your health care team during your hospital stay. I will lead a daily meeting with your health care team to make sure that everyone is in contact with each other. I will also be checking your patient record to make sure that you receive very good care.
Care Management Redesign Initiative

Key Features

- Centralized Utilization Management and Clinical Denial activities
- Risk stratification criteria for assigning care coordination intervention
- 7 day a week care coordination and care transition management functions
- Daily interdisciplinary patient progression discussion (Daily Care Briefings)
- Active communication with pre / post-acute care providers
- Assignment of a Primary Care Physician
- Follow up appointments arranged prior to transition
- Use of Physician Advisors
- Health Decision Planning (i.e. Advance Directive) conversations with patients
- Literacy screening for all patients

Care Management Responsibilities

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Outcomes

Average Length of Stay: System-wide
Care Management Redesign Average LOS

Systemwide ALOS was calculated using all patients, all in-scope units, and all wholly-owned entities (excluding THSH and THHVH). ALOS analysis excludes patients under 18, psych, mother/baby, and expired patients.

Readmission Rate: System-wide
Care Management Redesign Readmission Rate

All-cause readmission rates were calculated using 1-30 day readmits as the numerator, and total all-cause, all-readmission cases as the denominator. Includes all wholly-owned entities, excluding THSH and THHVH.
Clinical Review Data Trend: Systemwide

Systemwide Clinical Review Performance

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Source: Executive Dashboard metrics; XNET PXPWC1AND PXPWC2
Includes clinical and technical denials.
Includes all wholly-owned entities.

HCAHPS – Nurse Communication: Systemwide

Care Management Redesign HCAHPS Nurse Communication

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R² = 0.813

HCAHPS: Discharge Information

Discharge Information – Press Ganey National Average – Goal: Top Decile – Texas Health Trend

Care Management Redesign

HCAHPS: Discharge Information
VTE Prophylaxis – Texas Health Fort Worth

Falls Reduction: Texas Health Kaufman

System Initiative:
Partner with Population Health to Address Readmission Rates

Let’s Get Moving
July 15th Implementation
Let's Get Moving

Walking for Wellness
Ambulation in the hallway at 10am, 2pm, 4pm, & 8pm
Aimed at patients who are ambulatory
Can be used in conjunction with Out to Eat (see below)
Contraindicated for patients with "strict bedrest" orders due to current diagnosis
Incorporate ambulation times in the daily routines on your unit

Out to Eat
To the chair for meals
Aimed at patients who are not ambulatory or exhibit weakness
Contraindicated for patients with "strict bedrest" orders due to current diagnosis
Patients are to be out of bed for all meals. This is an opportune time to check skin integrity, refresh linens, perform daily hygiene, etc.
Value Based Purchasing and Pay for Performance

- Retention of masters prepared generalists at the point of care and actively engaged in patient management
- Focus of the CNL role is on patient advocacy and continuity
- CNLs lead and improve interprofessional team coordination and communication
- CNLs directly intervene to prevent complications and assure appropriate documentation of care
- CNLs can impact quality and performance outcomes
- CNLs promote evidence based care at the point of care and directly with staff

QUESTIONS

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