

Redesigning the Role of the RN in Case Management: Impact on HCAHPS and Readmission Rates Session C093

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Debra Potempa MSN, RN, NEA-BC
Kara Sankey MSN, RN, CNL, CMSRN
Mercy Health System, Janesville Wisconsin

MERCY
HEALTH SYSTEM
With all our heart. With all our mind.

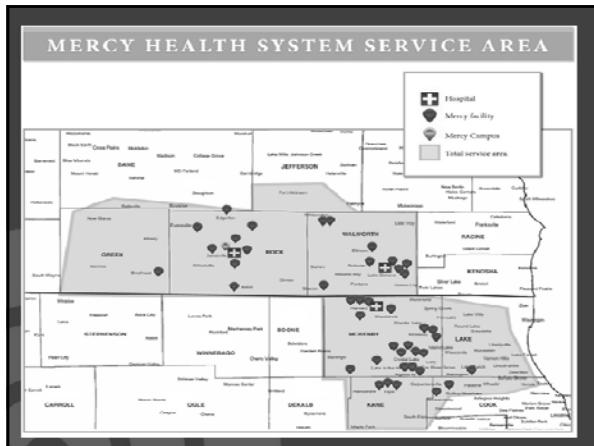
Mercy Health System



A black and white photograph showing the exterior of a modern hospital building. The building has a curved glass entrance and a stone facade. In front of the building is a circular driveway with a sign that reads "MERCY CAMPUS".

Mercy Health System

- Mercy is a comprehensive vertically integrated health care system consisting of 70 facilities in 24 communities throughout Wisconsin, and Illinois.
- Mercy Hospital and Trauma Center, Janesville, Wisconsin, is a 240-bed acute care facility
- Mercy Harvard Hospital, Harvard, Illinois, is a 15 bed Critical Access Hospital combined with a 45 bed skilled nursing facility
- Mercy Walworth Hospital and Medical Center, Lake Geneva, Wisconsin, is a 25-bed critical access hospital
- 43 Outpatient Clinics
- Four core service areas: hospital-based services, clinic-based services, post-acute care and retail services, and insurance products.



Mercy Health System

Recognized for Excellence

- Magnet® Recognition (2014)
- Awarded bronze recognition through the Workplace Partnership for Life Hospital Campaign for organ donation enrollment efforts (2014)
- Received the Get With The Guidelines Stroke Gold-Plus Quality Achievement Award from the American Heart Association/American Stroke Association (2014)
- Malcolm Baldrige National Quality Award (2007)
- The Joint Commission's Top Performer for Key Quality Measures for Mercy Harvard Hospital (2014)
- US Department of Health and Human Service's Silver Medal of Honor for providing exemplary commitment to organ donation (2009, 2014)
- Named to Hospitals & Health Networks magazine's 25 Most Wired/Most Improved for enhancements made between 2012-2013

Centers of Excellence

- Advanced Certification in Heart Failure by the American Heart Association and The Joint Commission
- Level II Trauma Center by the American College of Surgeons
- Advanced Certification for Primary Stroke Centers by The Joint Commission
- Chest Pain Center Accreditation from the Society of Cardiovascular Patient Care
- Total Hip Replacement Certification by The Joint Commission
- Total Knee Replacement Certification by The Joint Commission

Assessed Need for Change

- Mercy Health System was becoming an Accountable Care Organization
- Transition of care questions were being added to the HCAHPS
- Identified that patients needed continuous support throughout their acute admission and beyond the acute stay

Goals for Program

- Coordinate care in the acute episodes
- Monitor progress along an expected pathway, and address deviations quickly
- Efficiently transition patient to next level of care
- Improve access to care
- Provide knowledge and skill and create patient engagement around improving the patients health

Goals Continued

- Provide bedside education to patients around care and disease processes
- Identify potential risk for readmission using an evidence based tool
- Reduce avoidable admissions
- Reduce avoidable days
- Identify opportunities for enhanced communication between inpatient and outpatient nurses

Initial Focus for RN

- Screen all patients admitted to the hospital within the first 24 hours.
- Educate patients on illness management around our top five readmissions
- Enhance care coordination focus on all services within our integrated system and build a mechanism for communication of the patients plan and special needs

Department Growth

- Needed to grow
 - Increased Staff adding 3.8 FTE
 - Extend services to 7 days a week
- Added ER coverage 7am to 10pm
 - Primary focus is correct status and preventing unnecessary admissions,
- Social workers work on consult basis
 - All self pay patients and patients 85 years and older
 - Primary responsibility for OB department

Department Roles

- Nursing has two core functions (12.15 FTE)
 - Utilization Management Staff
 - Based out of Emergency Department
 - 630 AM to 1000 PM – 7 days a week
 - Holiday / Evening coverage for CAH
 - Complete all initial, continuing stay, and retro reviews
 - Functions as case manager for ED

RN Patient Navigators

- Assess and complete care coordination for all patients admitted to the hospital
- Complete all discharge planning
- Focus on patient education around core measures
- Work to decrease length of stay and minimize avoidable days for Mercy Health System
- Schedule follow up phone call at discharge

Social Workers

- Assess all self pay patients
- Advanced Directives
- Patient and Family Counseling
- Complex Discharge Planning

Changing Job Description

- Changed name from Case Manager to Patient Navigator
- Extended hours
 - RN to ER
- BSN Requirement – Previous staff had to establish education plan
- Certification Requirement – Any Specialty
 - Many came in with certifications

Case Manager Role (2012)

- Completed all utilization review and patient status review for case load
- Discharge planning on less complex patients
- Did initial assessments on given case load
- Any patient over 65 went to social workers and less than 65 went to RN case managers.

Patient Navigator Role (current)

- Meet and assess every patient admitted to hospital.
- Promotes customer satisfaction and intervenes at critical moments of service
- Identifies and intervenes in situations that pose financial risk to the patient and the organization. Monitors patient length of stay and facilitates efficient completion of hospital services.
- Separated UM function from role

Other Improvement Activities

- Increased community partnership with skilled nursing facilities
 - Lack of appropriate beds available in area
- Reaching out to county services
 - ADRC, County Case Managers, Mental Health
- Executive level complex discharge committee meets biweekly
 - (CNO, Vice Presidents, Finance and Legal, Home Health and Hospice, SNF Administrator)

Measuring the Programs Success



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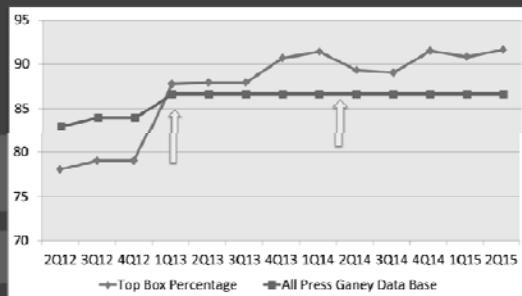
Outcome Measures

- Discharge and Transition of Care outcomes on PG and HCAHPS
- Readmission rates
- Core measure outcomes

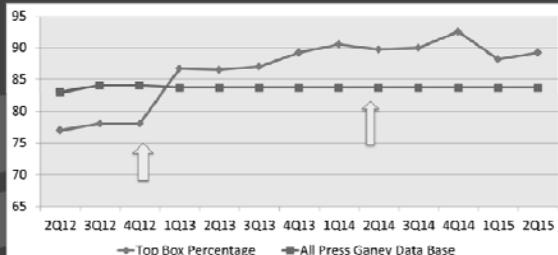


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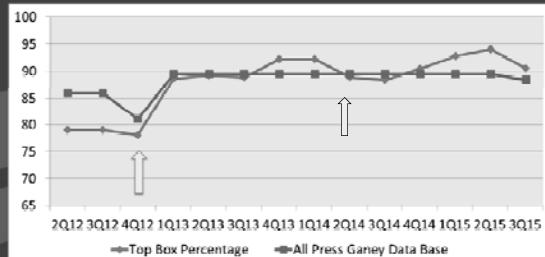
Global Domain : Discharge Information



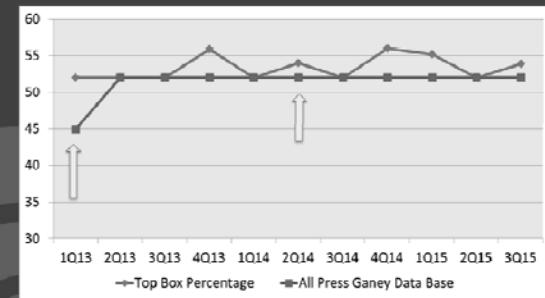
During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?



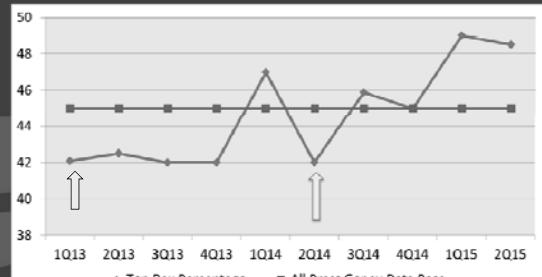
During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?



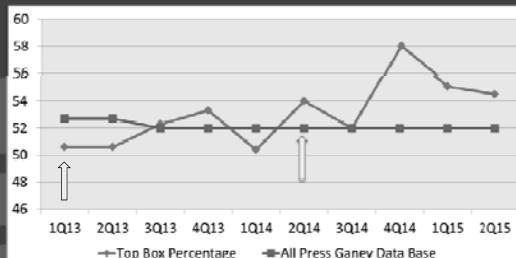
Global Question: Care Transitions



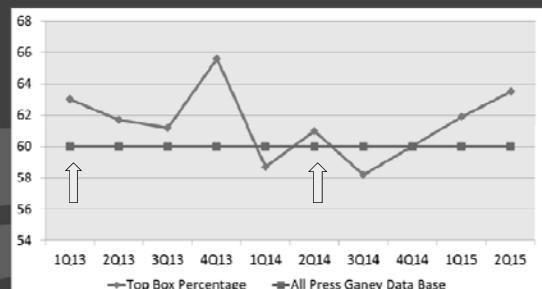
During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

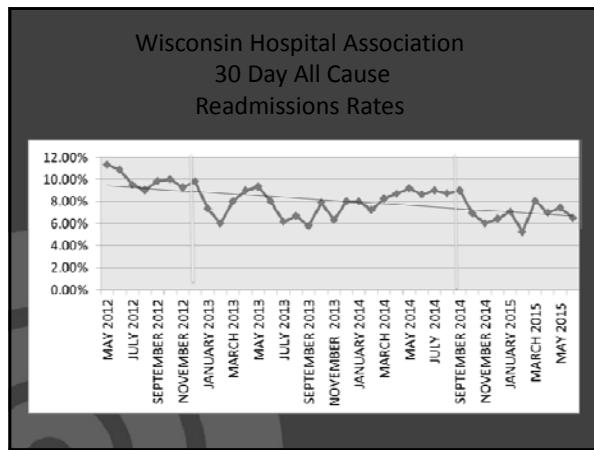


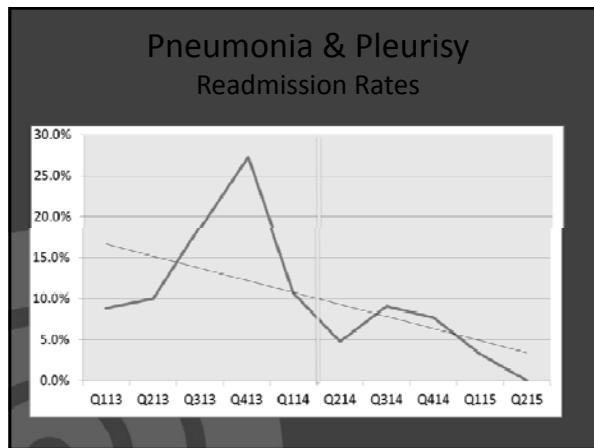
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

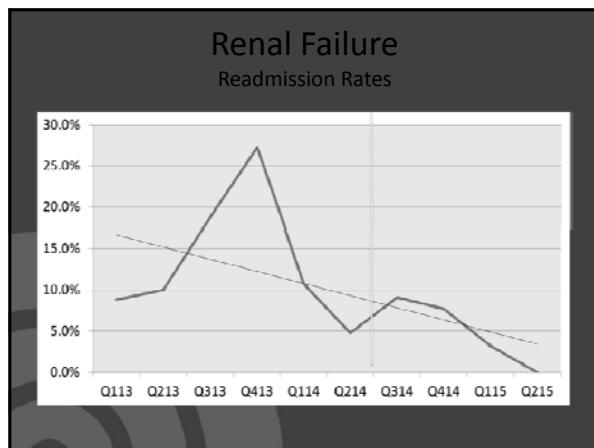


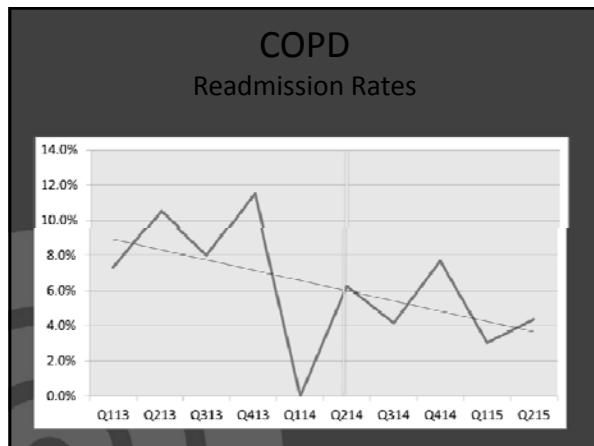
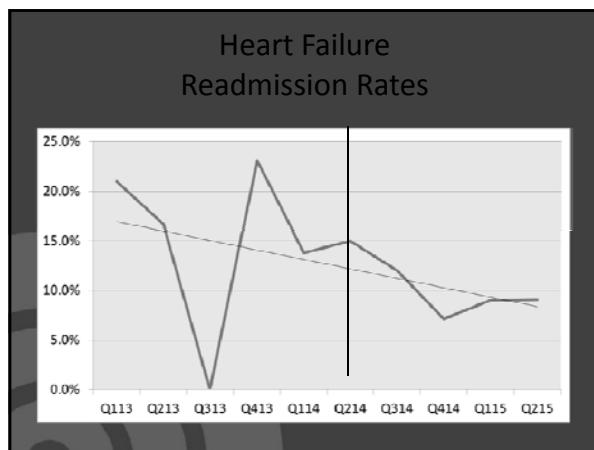
When I left the hospital, I clearly understood the purpose for taking each of my medications.











Partner Engagement Item	2013 % Favorable	2015 % Favorable
Overall, I am satisfied with my job.	22%	100%
I have [not] seriously considered resigning in the last six months.	30%	93%
My job gives me an opportunity to do the things I do best.	60%	93%
Mercy Health System provides me the opportunity to improve my professional knowledge and job skills	36%	100%
My supervisor encourages my career growth	22%	93%

Avatar Solutions HC Pro

Magnet Items	2015 % Favorable
I understand how my job contributes to the mission of this organization.	100%
Mercy Health System provides me the opportunity to improve my professional knowledge and job skills.	100%
I have enough authority to accomplish the nursing work that is expected of me.	91%
This organization's nursing policies and practices promote the most effective patient care.	91%
Employee innovation is encouraged at this organization	82%

Increased Engagement
<ul style="list-style-type: none"> • There was a steep learning curve <ul style="list-style-type: none"> – Needed to step out of comfort zone • Quickly identified gaps in care transitions <ul style="list-style-type: none"> – Collaborating with internal and external agencies to streamline care – DME Now arranging CPM prior to admission – Attending and working Joints class – Attending town hall meetings – More work around community involvement – More involvement in shared governance and system committees

Lessons Learned
<ul style="list-style-type: none"> • Social Work Role • Division of Work <ul style="list-style-type: none"> – Identify responsibilities • Establish Set Workflow <ul style="list-style-type: none"> – Standardize materials • Staff Education • Involvement of executive leadership is imperative to enhance understanding of role and decrease barriers to services

Questions?

Debra Potempa MSN, RN, NEA-BC
Vice President Chief Nursing Officer
dpotempa@mhsjvl.org

Kara Sankey MSN, RN, CNL, CMSRN
Manager Inpatient Case Management Social
Services
(608) 756 – 6798
[ksankey@mhsjvl.org](mailto:kasankey@mhsjvl.org)
