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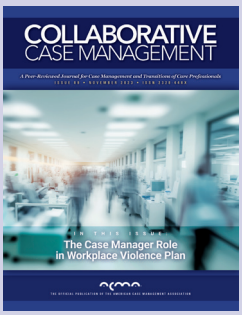
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The Case Manager Role in Workplace Violence Plan

Marcy M. Morrison, BSN, RN, CCMC; Anna C. Squillace, BSN, RN

LEARNING OBJECTIVES:

1. Define workplace violence and the case management role in a workplace violence plan.
2. Discuss the case manager's role in the identification of disruptive violent patients and the formulation of the care plan.
3. Assess the case manager's role in driving consistency with the multidisciplinary team to improve staff and patient safety.
4. Review outcome data and a plan for sustainability to progress care and balance staff/patient safety.

ABSTRACT

Workplace violence in health care is rising on a national scale and organizations have been tasked to find solutions to keep staff and patients safe. A literature review, including the September 2022 issue of Workplace and Health Safety (Wells, 2018) showed a significant number of hospital nurses reported facing increased verbal abuse and physical violence from patients, visitors, and loved ones compared with pre-COVID-19 pandemic levels. In 2021, Monument Health in South Dakota saw a 22% increase in incidents of workplace violence as compared to 2020.

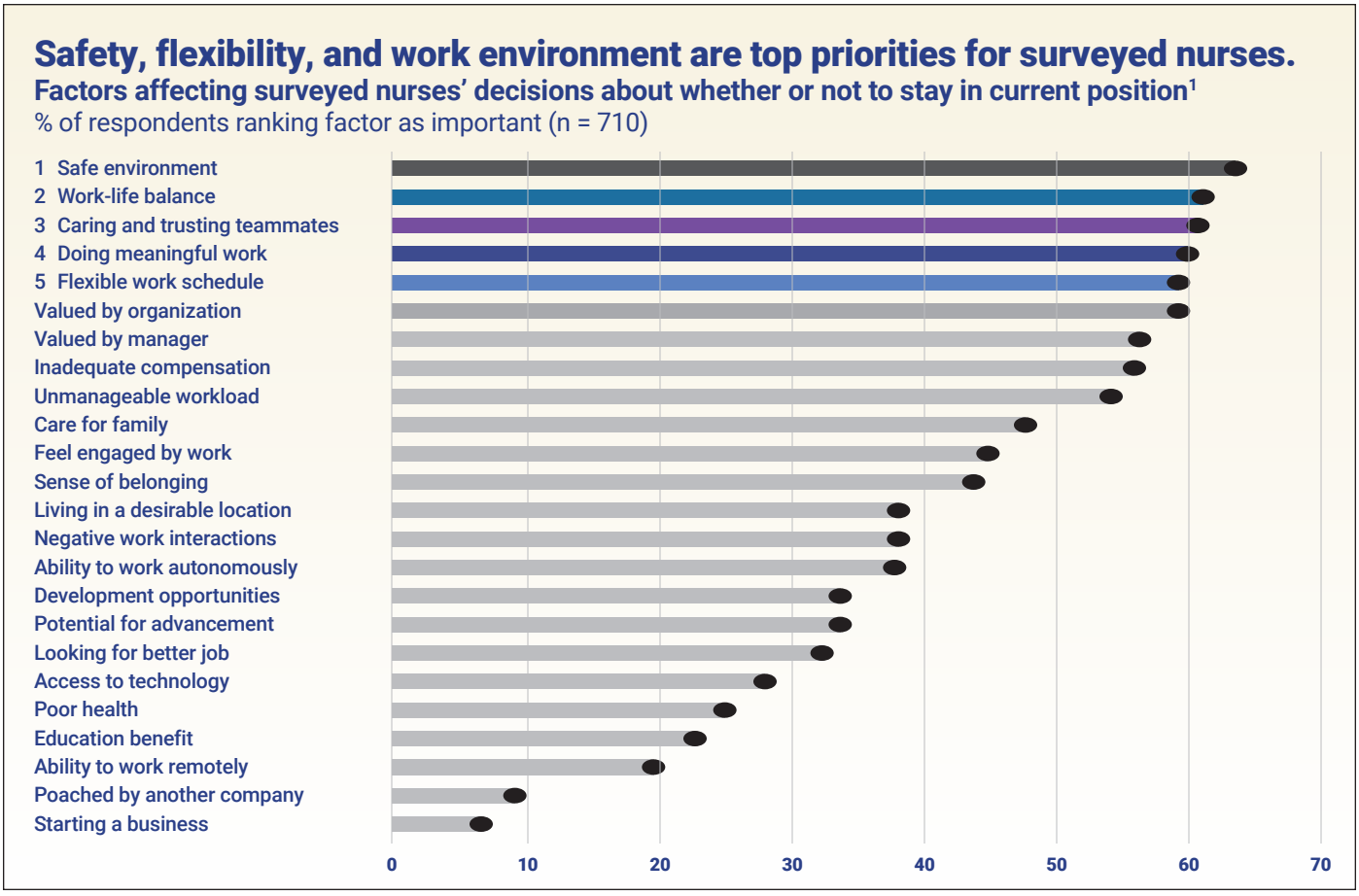
This article will review the process of the organization's Workplace Violence Team, the role that case managers play in creating consistency with the plan of care and bridging the gap for the multidisciplinary team. The strategies implemented range from the development of a transparent identification process that leverages technology and staff education to promote awareness and consistent behavioral expectations that can be followed by everyone on the care team. As a result of these efforts, the data shows a 36% reduction in the incidents of workplace violence at this organization.

HISTORY/BACKGROUND

Workplace violence as defined by The Joint Commission (Workplace Violence Prevention, 2022) is an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assault; or other behaviors of concern involving caregivers, licensed practitioners, patients, or visitors.

Monument Health implemented a Workplace Violence Team in 2017 to include a multidisciplinary team, including Case Management representation. They began collecting data in 2018, evolving from manual data entries into electronic spreadsheets in 2019 and directly from reporting software in 2020. A charter was established with goals, objectives, and toolkit development. One of the main goals was to improve staff retention. A McKinsey & Company study done in 2022 (Berlin et al., 2022) shows that nurses' number one priority in the workplace is to have a safe working environment (see Figure 1).

FIGURE 1 – NURSE DECISION FACTORS



Also in 2018, South Dakota enacted a law that made violence against a health care worker a felony (Simple Assault, 2018):

> 22-18-1.05. Simple or aggravated assault against law enforcement officer, firefighter, ambulance personnel, Department of Corrections employee or contractor, health care personnel, or other public officer.
>
> Simple assault, as provided in § 22-18-1, if committed against a law enforcement officer, firefighter, ambulance service personnel, Department of Corrections employee or person under contract assigned to the Department of Corrections, or other public officer, which assault occurred while the officer or employee was engaged in the performance of the officer's or employee's duties, is a Class 6 felony.
>
> Aggravated assault, as provided in § 22-18-1.1, if committed against a law enforcement officer, firefighter, ambulance service personnel, Department of Corrections employee or person under contract assigned to the Department of Corrections, or other public officer, which assault occurred while the officer or employee was engaged in the performance of the officer's or employee's duties, is a Class 2 felony (Simple Assault, 2018).

The penalties in this section also apply to a simple assault or aggravated assault if committed against any health care facility personnel while engaged in patient care.

Beginning in 2018 and through 2021, there were three strategies to guide the Workplace Violence Team: Workplace Violence Toolkit, De-Escalation Training, and Dr. BERT (Behavior Emotional Response Team). The Workplace Violence Toolkit included safety tips for caregivers, suggested room modification for patients, scripted responses for staff, improved documentation on any event, safety plans for both patients and staff, and a quick reference checklist. The De-Escalation Training was developed by Monument Health, utilized tactical communications by Rapid City Police Department, and taught in person as well as via e-learning. Dr. BERT included members of Hospital Security, Hospital Coordinator, and Floor Charge Nurse who responded to incidents of violence comparable to a Code Blue or a Code Red.

"The Safety Care Team can be requested by any employee, attempts to convene within 24 hours of the request, and recognizes that care plans are best developed by listening to the front-line employees."

In May 2021, Monument Health expanded strategies to include Hospital Security rounding on each floor based on Lavender Banners, Active Killer Training to all facilities within the hospital system, Safety Care Team consult upon request and/or committee recommendation, creating a Lavender Banner notification within the electronic medical record (EMR) and weekly review of banner content by committee.

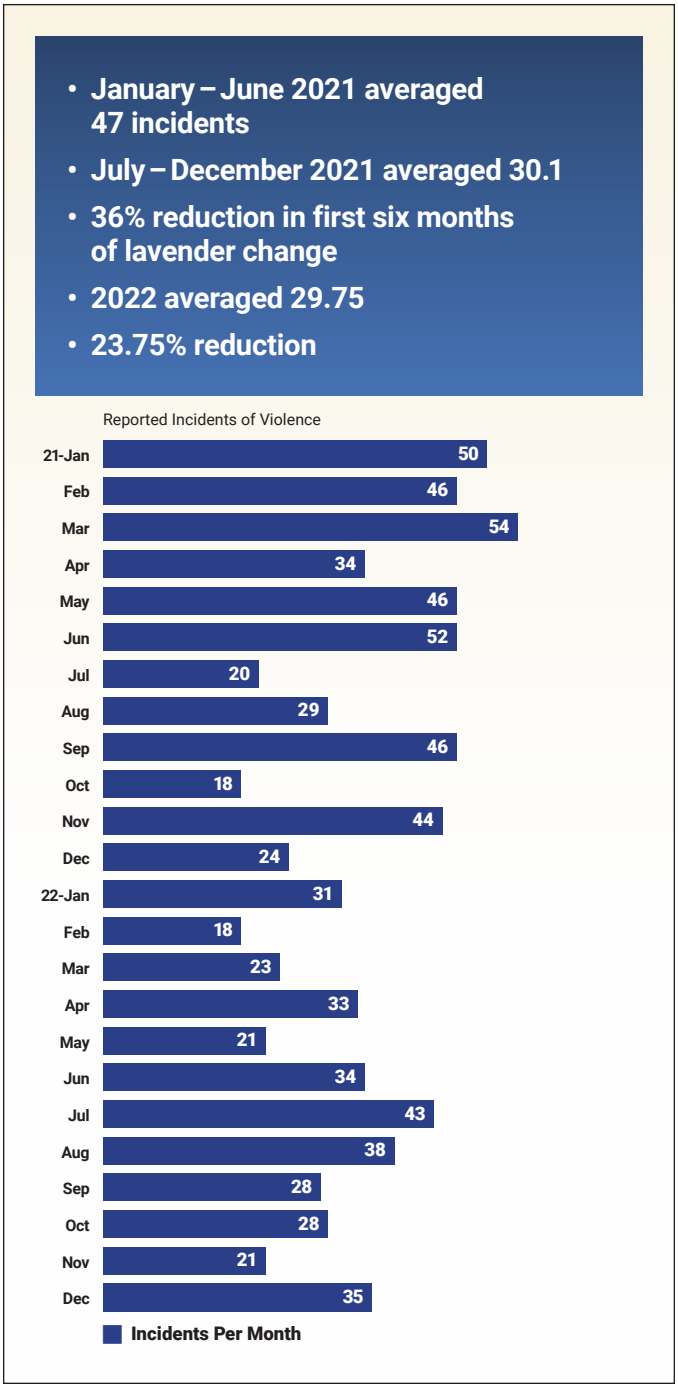
The Safety Care Team is a multidisciplinary group and includes representatives from the affected unit (ICU, ED, medical floor, etc.), Legal Department, Patient Experience Coach, Case Management, and anyone else deemed to be necessary for the specific issue (i.e. if triggers are food, include Dietary). The Safety Care Team can be requested by any employee, attempts to convene within 24 hours of the request, and recognizes that care plans are best developed by listening to the front-line employees.

The Safety Care Team was developed in response to an early 20s female patient in early 2021 with a history of mental health issues and highly unpredictable and impulsive behavior. Throughout

three different hospitalizations, there were a total of seven assaults on health care workers. The Safety Care Team convened, established strategies to prevent/reduce assaults, and implemented processes such as two caregivers present during tasks, staff remaining between patient and door, keeping the door open when possible, and explaining proposed treatment/procedure before initiating and alerting Security to manage behaviors if escalated beyond what staff could manage. Restraints are considered a last resort; however, in that case, a Posey bed was utilized with a positive effect as it allowed freedom of movement within a safe environment. Eventually, charges were pressed, and once medically stable, the patient was escorted to jail awaiting transfer to the only inpatient psychiatric hospital in South Dakota. After her psychiatric hospital admission, she had one subsequent visit to Monument Health where floor staff immediately implemented the previous strategies with her acknowledgment of previous behaviors. This collaboration between staff and patient resulted in no further violent behavior.

The Lavender Banner implemented into the EMR to identify high-risk patients capable of violent behavior is a purple highlight that surrounds the patient's name and is visible every time the EMR is accessed by any employee. It is a visual alert to employees; a click into the banner provides access to a template that describes the details of the initial event that triggered a Lavender Banner, ongoing behaviors, considerations when working with the patient, and the date of the last committee review. Any employee can initiate the banner and it can apply to a patient, a patient's family, or visitors and is visible for any facility within the health system, which helps all caregivers if patients seek care at multiple hospitals. Types of violence in the banner template are verbal, physical, threat, weapon, and sexual harassment. Daily Security rounds are focused on areas where patients with Lavender Banners are located. Lavender Banners are reviewed weekly by a multidisciplinary team for patients currently hospitalized. Case Management participates in active discussion to ensure that ongoing behaviors are recorded, considerations are updated, and to determine if the banner should remain or be removed. Case Management serves as a subject matter expert

FIGURE 2 – RISK DATA INCIDENTS PER MONTH

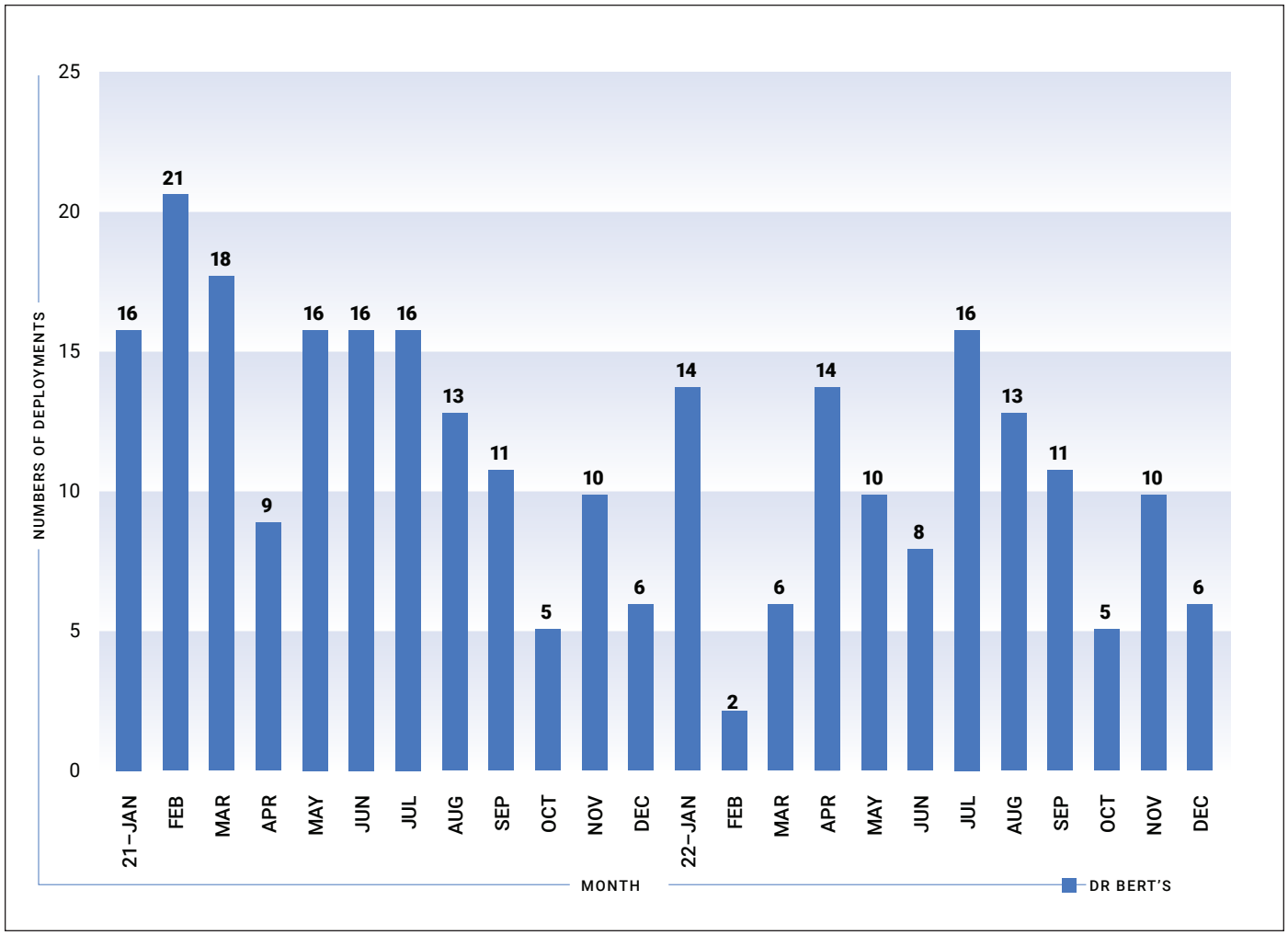


in navigating the EMR. Lavender Banners typically remain in place for one year and require a majority vote of the committee to remove the banner.

After initiating the Lavender Banner, the data indicates that there was a 36% reduction in reported violent behaviors (see Figure 2). Factors that influence reporting are staff biases as to whether dementia, alcohol withdrawal, psychiatric illness, and rude behaviors constitute violent behavior.

Case Managers are vital in helping to identify which patients have behaviors that make it unlikely to ever have a Lavender Banner removed and require the development of a behavior care plan. These patients require consistent care plan implementation at every touch within the health care system (e.g., clinic, ED, inpatient admission, lab). For example, a 65-year-old male with multiple admissions to several hospitals within the system and behaviors of stalking employees outside of the hospital, verbal, physical, and sexual assault of caregivers, needed assistance with managing his manipulative tendencies to help prepare him for a safe discharge plan. Case Management led the team in developing a vastly detailed care plan. It outlined which of his behaviors would be tolerated, listed behaviors that would not be tolerated with consequences, defined his goals, and included specific activities of daily living in which his participation was required. He was motivated by independence to select food

FIGURE 3 – BEHAVIORAL EMOTIONAL RESPONSE TEAM DEPLOYMENTS



for his meals and by watching TV; these served as his rewards. Case Management was crucial in helping his care plan evolve throughout his 144-day admission to eventually include daily multidisciplinary conferences as he progressed closer to discharge to prevent his actions from escalating into violent behaviors.

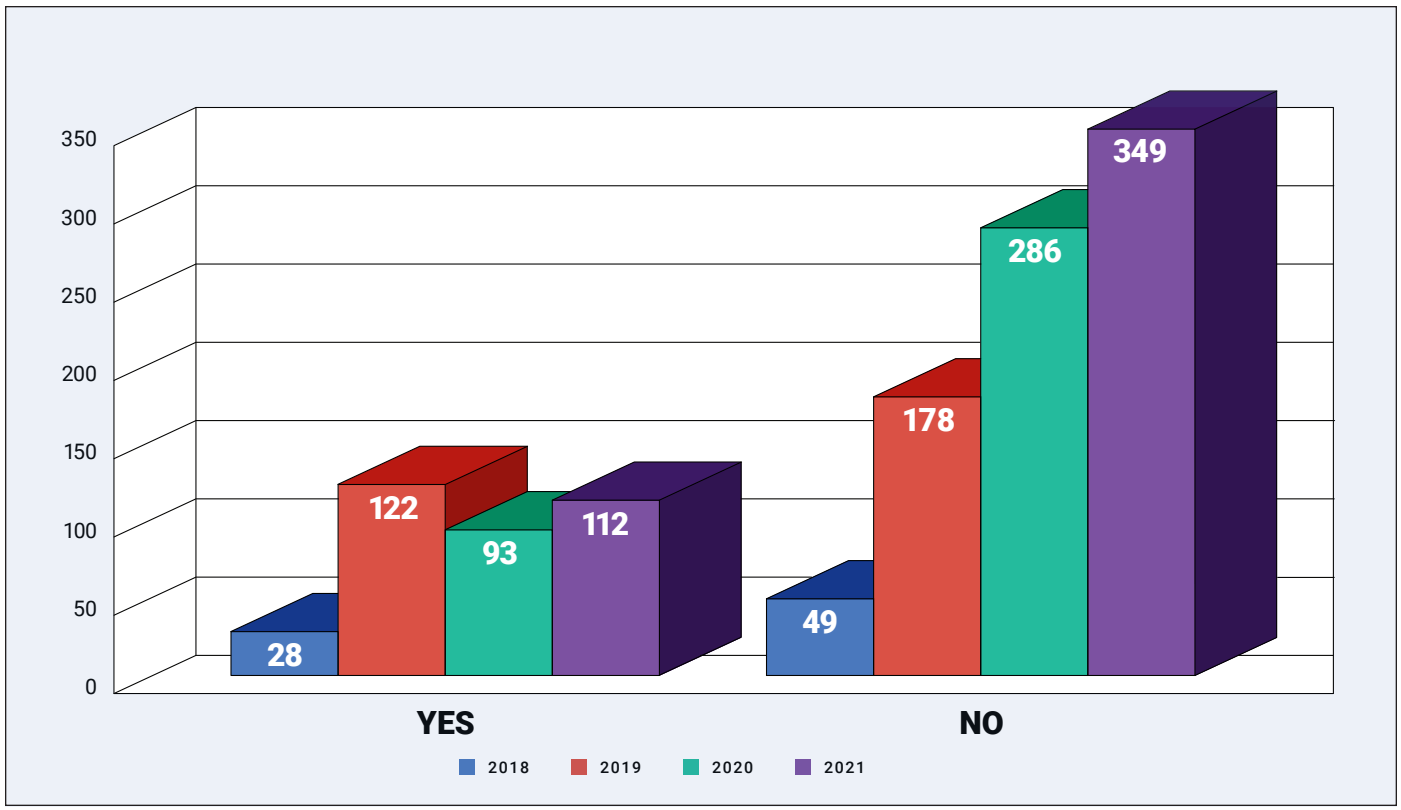
Lavender Banners helped to identify potentially violent patients, family, or visitors and provided staff with the tools they needed to remain safe while providing patient care. If situations still escalated despite the approaches taken, Dr. BERT was utilized for immediate assistance to ensure a safe environment for both the patient and staff. The data below indicates a significant reduction of Dr. BERT alerts called after the Lavender Banner was implemented (see Figure 3).

As a result of the Workplace Violence Plan and focus on education, there was an increase in reporting (see Figure 4). The data also reveals an increase in utilization of interventions resulting in decreased injury.

Case Management is pivotal in arranging a safe discharge plan. Patients with violent behaviors pose additional barriers to placement. Monument Health's EMR has developed to allow for electronic referrals to be placed to post-acute rehab facilities and expanded the denial reasons for facilities to indicate why they are denying the patient(s) so the team can better determine how we can overcome barriers. In a discharge plan, it is crucial to question, "Is this a want or a need?" or a "have to have vs. nice to have."

Many barriers to placement, violent and nonviolent, are prevented by consistent Case Management collaboration with patients, families, nursing leadership, physicians, and support services by educating and facilitating the removal of 1:1 monitoring, video monitoring, and/or restraints that many patients with

FIGURE 4 – INJURY REPORTING



violent behaviors require. These efforts align with Center for Medicare and Medicaid Services (CMS) Condition of Participation (Conditions of Participation: Discharge Planning, 2023). To help guide care toward realistic, safe discharges, it is helpful to explore options for medication adjustments, Palliative Care consults, Psychiatric consults, mental holds, Masters Social Work involvement, behavior contracts, involvement with local law enforcement, Security physical presence with personal care, assisting employees in filing charges if victims of violence, and issuing trespassing notifications can help guide care toward realistic, safe discharges. At Monument Health, Security issued nine notifications in 2017-2018. Alternatively, the health system issued 35 notifications in 2020-2021.

SUMMARY

Workplace violence is present and ever-changing. All levels of health care must implement processes to ensure the safety of staff and patients. Case Management has a pivotal role on a Workplace Violence Team, can serve as subject matter experts in navigating EMR, and can facilitate active discussion with the team about when to remove banners. Identification and formulation of a plan to detect and prevent violence includes coaching and mentoring challenging conversations, coordinating care conferences, participating in multidiscipline rounds, formulating care plan/behavior contracts, identifying motivating factors for patients, encouraging adequate documentation, and coordinating safe discharge plan. Case Managers drive consistency by collaborating with the multidisciplinary team to improve staff and patient safety.

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AUTHOR BIOS

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A Collaborative Approach to Manage Hospital to Nursing Home Transitions

Anita Dunham, MS, BSN, CMAC, NE-BC; Emily Mills, RN BSN; Christy Gerdes, BS, Lean Green Belt

LEARNING OBJECTIVES

1 Review the processes for creating the Geriatric Forum Collaborative and integrating improvement strategies.

2 Discuss regulatory requirements that impact transitions in care, including a formalized Nursing Home Transfer Agreement.

3 Describe standardized workflows and the sustainability plan across all facilities for continued success.

ABSTRACT

Transitions of care can be challenging for organizations and for patients who meet the criteria for nursing home placement, whether the patient needs a short-term or long-term stay. The organization highlighted faced hospital capacity issues and patient flow challenges. A 19.3% readmission rate for this population necessitated a partnership between case management, the providers, the multidisciplinary team, and community facilities, under the direction of

Operational Performance Management to coordinate individualized patient plans with a focus on safe transitions.

In this article, you will learn key strategies to implement a community Geriatric Forum Collaborative which can be utilized in multiple health care settings, leveraging the electronic medical record and standardized expectations to achieve regulatory compliance for transitions to both hospitals and nursing homes. The outcomes included a 17% reduction in excess hospital days, a 36% reduction in the time between discharge order to discharge for nursing home patients, and an overall reduction in readmissions from 19.3% down to 14.6%.

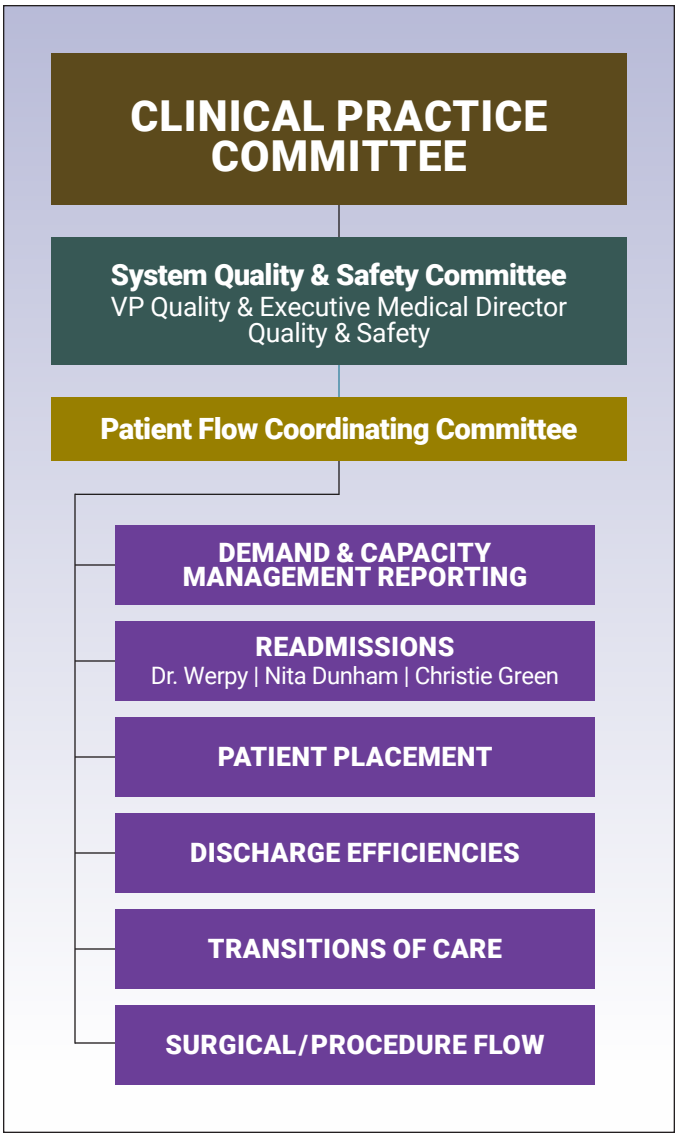
QUALITY INITIATIVE FOCUS

We all experienced heightened capacity challenges during the pandemic and our organization was no exception. As part of our initiative to maintain capacity and care for the patients in our service areas, we developed a focused approach to standardize and compartmentalize performance improvement opportunities in a meaningful way. The organization chose to integrate this work into our Quality Assurance Performance Improvement (QAPI) structure and used Lean Methodology as our approach to secure desired outcomes ("What is Lean Healthcare?," 2018).

The first step defined where this work fit into the overall QAPI structure (see Figure 1); it was determined that it fit best as a subgroup of the Patient Flow Coordinating Committee. This committee oversees various capacity management initiatives and Transitions of Care was one body of work in this category. Exploration of the data was the next step to ensure we made data-driven decisions which led us to the nursing home transitions population.

Under the direction of Performance Engineering, we focused on what was value added for the patient and/or the patient's family. We determined what the patient and/or family were willing to pay for while maintaining the guiding principle of Lean methodology, Respect for People (Womack & Jones, 1996).

FIGURE 1 – QAPI PATIENT FLOW STRUCTURE



PHASE 1

Monument Health has, for many years, led a Geriatric Forum Collaborative team which includes community nursing home partners and providers who review new regulations to ensure that everyone understands any changes. That team paused meeting in person during the pandemic and the focus shifted to topics related to COVID-19. In 2022, given the

outcomes from the pandemic that included longer hospitalizations, it was decided the team needed to restart their work with a more granular focus.

The stakeholder list was reviewed to ensure appropriate participants were identified who could implement the needed changes. This Black Hills Geriatric Collaborative Team included the following disciplines:

- Performance Management
- EMR Colleagues
- Nursing Leadership
- Case Management
- Geriatric Nursing Home Providers
- LTC Directors of Nursing
- Hospitalist Leadership
- Ad Hoc: Pharmacy, Wound Care, Therapy, Medical Equipment

In the QAPI structure, Transitions of Care was one area of focus. Data was reviewed with the team, and it was easy to see that this was an area that would be beneficial, especially with all the changes that happened through the pandemic. With Lean led structure (*Going Lean in Health Care,* 2005), the team started by defining the problem and created the following Problem Statement:

> Lack of consistent workflows, expectations, and understanding of regulatory requirements between hospitals and Nursing Homes, leads to inefficiencies, communication issues, safety concerns and delays in transitions in care.

Performance Engineering started with setting the expectations behind group consensus, defining consensus with the team, and understanding opportunities for improvements and standardization as potential value added for the patient, family, and facilities. Once the current state of Hospital to Nursing Home Transitions was successfully process mapped, inconsistencies and opportunities were identified to create standard work across all facilities. The large group divided the opportunities into small subprocesses such as COVID-19 testing, COVID-19 vaccination status, post-acute funding, specialty equipment such as wound care, sitters for challenging patients, and transportation, along with streamlining any EMR functionality. These subgroups met until each small process was developed into the current state of Hospital to Nursing Home Transitions.

COMMITTEE OBJECTIVES

- Discharge Orders
- Ancillary Services
- Case Management Workflows
- Medications
- Nursing Home Expectations
- Provider Expectations
- Nursing Contributions
- EMR Functionality

Each nursing home involved expressed specific wants and needs. By openly discussing this we were able to come to an agreement on the “nice to have” versus the “have to have.” By doing so each of the facilities agreed and expectations were set.

To streamline our process, we broke down each area of focus to ensure no stone was left unturned, starting with discharge orders. EMR partners built a nursing home-specific discharge order set. This provided a smoother discharge process for the physicians while maintaining consistency in our discharge orders amongst the nursing homes. With that, we were able to auto-populate the order set with real-time documentation (i.e., current diet, oxygen needs, and wound care orders). Doing so made for quicker and more concise orders.

Ancillary services, specifically pharmacy, played a large part in the standardization process, one example being Hospice orders. We found that as our physicians completed the discharge orders, the accepting facility then had a separate order set for

Hospice admissions. This resulted in the duplication of orders requiring several corrections to the discharge orders and caused interruptions to the physician's workflow, which led to dissatisfaction among the team. By identifying this gap, we developed a Hospice order set to help bridge patient transition from hospital to Skilled Nursing Facility.

Nursing home referrals were also cumbersome and often required multiple phone calls and interruptions throughout the day. An electronic referral process was developed to help standardize the information provided when a referral was made. This markedly decreased the back-and-forth communication and additional questions, thus improving the case management workflow.

PHASE TWO

The next phase of the work was to look at the regulatory guidelines for which each environment was accountable. The guidelines did not always line up seamlessly which contributed to confusion among the team, making it necessary to review the regulations. That review resulted in an increased ability to manage expectations and improved our global understanding of how each entity approached a referral for both a new admission and a returning resident.

The regulations reviewed in depth were related to Hospital Regulation and Nursing Home Regulations.

HOSPITAL REGULATION

§ 482.43 Condition of participation: Discharge planning (2019)

The hospital must have an effective discharge planning process that focuses on:

- Patient's goals and treatment preferences
- Includes the patient and caregivers/support person(s)



- Be consistent with the patient's goals for care
- Reduce the factors leading to preventable readmissions.

This regulation stimulated conversations around communication and the referral/response process when referrals are made to a patient or family's preferred nursing home. Reviewing this and emphasizing the desire to provide timely feedback to patients about their discharge plans, provided the rationale for a focus and consensus around the timeframe from referral to receiving a response from the nursing home. The determination was that if a referral was made in the afternoon, a response could be expected before noon the following day and if a referral was made in the morning, a response could be expected by the end of that calendar day. Furthermore, if no response was received; a denial was assumed.

NURSING HOME REGULATIONS

The following regulations were important to understand and were ultimately tied together to ensure compliance for the nursing home, hospital and existing nursing home residents who needed hospital services.

F843 Transfer Agreement requires that nursing homes have a written transfer agreement with one or more Medicare/Medicaid-certified hospitals in their geographic area (CMS Compliance Group, 2021). This agreement must have a reasonable assurance that the nursing home's residents will be transferred to the hospital and ensures timely admission.

Resident Rights & Protection protects residents against unfair transfer or discharge (Resident Rights, 1989). Except in emergencies, the nursing home must provide a written 30-day notice to discharge an individual that includes the plan, reason for discharge, anticipated date and location as well as an individual's appeal rights. This was important for the team to understand since there had been occasions where a patient was hospitalized, and the nursing home declined to readmit them once they were stable. This put the hospital care team and the patient or resident in a position that led to confusion and extended length of stay in the hospital while alternative placement could be identified.

Nursing Home Discharge Rights were then explored to build on the understanding of the regulations and were noted to have some protection for the individual if the 30-day notice process had not been followed. Individuals have the right to return to the nursing home following a hospitalization and being admitted to the hospital did not relieve the nursing home of the responsibility to follow the discharge requirements. Therefore, the team expanded their understanding of the Ombudsman Program and how to refer and educate the patient and their family should they be denied return admission to the nursing home.

Ultimately, the above regulations were embedded into an updated Monument Health Transfer Agreement that was completed with all nursing homes in the Black Hills Region. Along with the other required components of a Transfer Agreement, the team worked collaboratively to create a statement that was added to the agreement with the expectations around return admissions.

The additional statement was:

Nursing Home agrees to accept the return admission of the patient within 24 hours if/ when the hospital physician has deemed the patient no longer needs the specialized capabilities of the hospital, regardless of the status of bed hold, ability to pay and intended duration of stay.

This updated Transfer Agreement contributed to the reduction of return admission denials, and Ombudsman referrals and set a clear expectation between the hospital system and community nursing homes. It was updated with a plan to renew annually and compliance with the agreement is

closely monitored for real-time conversations when situations arise.

PHASE THREE

To build off the work of the team, communication had to be included in the plan. The team chose to primarily leverage existing technology to accomplish some components of this. In this phase of the work, there were multiple areas on which the team focused.

In the area of referrals and responses, it was identified that adding clarity to the rationale for denials was an important piece of communication. The prior denial reasons were broad and vague, which proved problematic for the hospital caregivers when they attempted to explain the denial reasons to patients and providers the denial reasons.

For example, Patient Complexity was a reason why we needed to drill down into what about the patient made them complex to better understand the rationale for the denial. Expanding the denial reasons and making the options multi-select, catalyzed additional conversations that would otherwise not have occurred and ultimately allowed the team to clarify and overcome some barriers to gain facility acceptance.

As the team solidified the placement destination for the patient, they were also aware that provider-to-provider communication was critical to ensure acceptance and discharge. The providers from the hospital and Geriatrics met as a subgroup and determined that they needed to be involved much earlier in the process. Historically, they communicated as the patient was discharged, however, they wanted that communication to occur before the discharge orders were written. This allowed them an opportunity to openly discuss the transition plan, clarify orders, and come to a consensus on medical stability for discharge. This was intended to have a positive impact on readmission risk and reduce order clarification questions after discharge (Centers for Medicare & Medicaid Services, 2015).

Once the logistical work was completed, the difficult sustainability plan began. The large group started with 30-60-90-day review meetings to discuss the process changes and barriers. Each month, the large group discussed subgroup updates and any feedback since going live with the new processes. After the initial 90-day post-go-live, the large group continues to meet monthly with a standard agenda including follow-ups from the previous month, data analysis updates and barriers since the last meeting. These barriers roll into follow-ups for the next meeting.

Discharges can be a very busy time for not only the case managers but also for floor nurses. A time-out checklist was developed to assist with communication among the team. This tool provided the floor staff with facility information, mode of transportation and time of discharge. Included were various requirements for a nursing home discharge. This communication improved patient outcomes to ensure orders were completed correctly and consistently.

We also created a patient transfer variance form for the nursing homes to ensure our patients received the best possible care during their transition. Items such as order clarification, pharmacy concerns, or other various discrepancies identified were documented on this form. This was then forwarded to the nurse manager of the Care Management department. With this feedback, we continue to improve processes and identify trends or barriers. Combined, these components contributed to improved efficiencies in the discharge process.

CONCLUSION

Outcomes and key performance indicators were an ongoing focus for this work. Some of the metrics monitored were related to efficiency and readmissions. By streamlining processes,

improvements have been noted in both areas monitored as well as in overall Provider, Case Manager, and Nursing Home satisfaction. Reducing readmissions in skilled nursing facilities is a focus for CMS for FY2024, as well. Based on the CMS data; the mean readmission rates in FY22 for individuals who discharged to a skilled nursing facility were 19.2%. Our organization continues to focus on this population and has reduced readmission rates to 14% thus far in 2023 (see Figures 2 and 3).

Through the efforts of the Geriatric Forum Collaborative over the years, there has been an ongoing focus on quality of care and readmissions. In 2020, the organization made strides to provide caregivers Lean training to establish a foundation for continued process improvements. In 2021, a formal request was completed for Performance Management support to provide the structure for this work, and the additional process improvements mentioned above were implemented over time in 2022-2023.

The team learned many lessons throughout this project with the cornerstone related to communication, mutual respect, and relationships.

FIGURE 2 – RCH AVERAGE TIME BETWEEN DISCHARGE ORDER AND DISCHARGE FOR PATIENTS DISCHARGED TO SNF

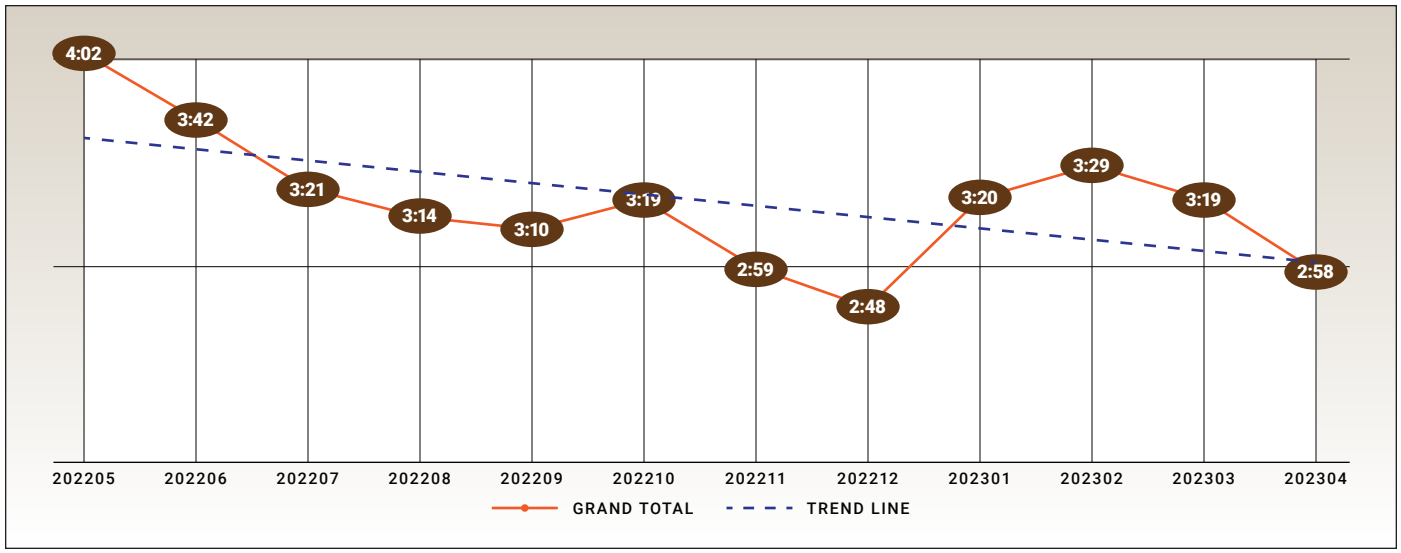
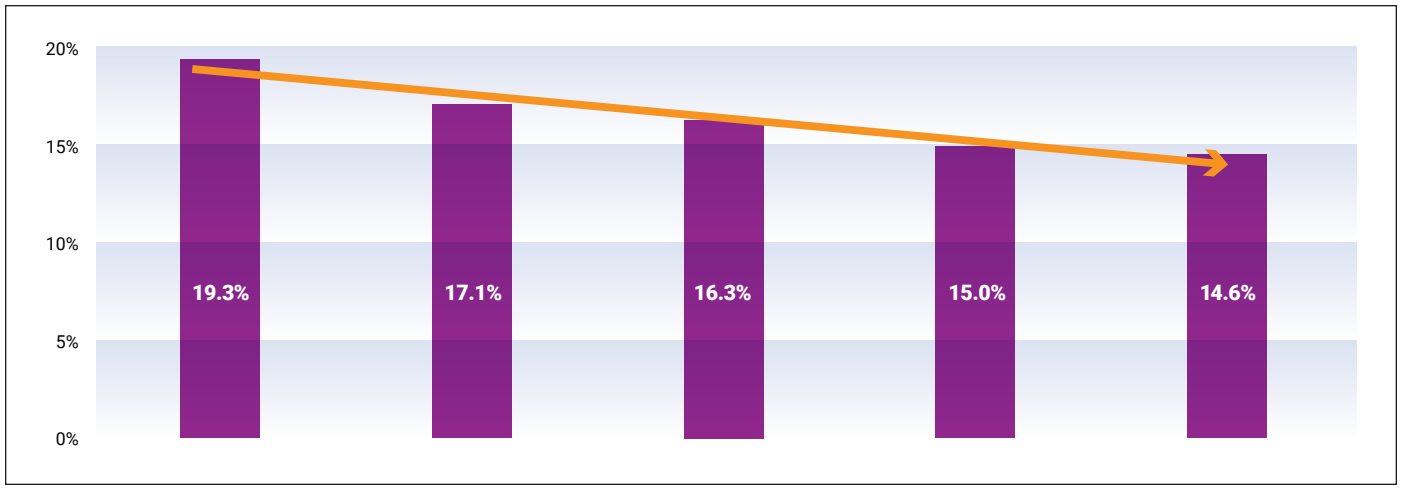


FIGURE 3 – SNF READMISSION RATES 2018-2021 (SINGH, 2016)



Consensus doesn't just happen; a conscious effort must be made to drive towards it in a meaningful way. To do that, we must invest time to understand the regulations and what others face in various environments to gain the full picture of the transition process. Ultimately, relationships were built, and the key to continued success over time is a focus on sustainability with ongoing collaboration.

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AUTHOR BIOGRAPHIES

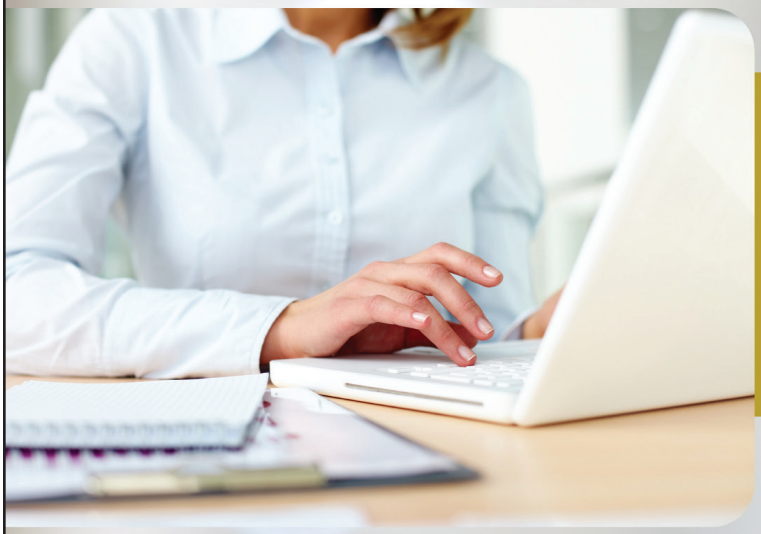
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Physician Advisor Role in Timely Discharge and Impactful Care Coordination Opportunity

Sweta Singh, MD; Shanda Willis, RN; Teresa Jacobs, MD

LEARNING OBJECTIVES

1. Assess workflow for Physician Advisors to work closely with case management for timely completion of the OBRA 3878 documents.
2. Review the volume of OBRA 3878 documentation workload in a large academic institution.
3. Demonstrate understanding of the Physician Advisor role in Care Management to assist with the timely discharge of patients.

INTRODUCTION

When the Omnibus Reconciliation Act (OBRA-87) was passed in 1987, the bill improved and enhanced the quality of life for patients in nursing homes. It also created additional paperwork to be completed by hospital providers for patients discharged to long-term care facilities. Recently, Michigan state moved the previous paper forms to an electronic format. As the new format was implemented, it became clear that while the electronic format was more

convenient and easier to track, the large nature of the institution with its many providers presented a barrier to swift completion. With a considerable number of additional logins required to support the electronic format, the medical center found an opportunity and innovation for Physician Advisors to work closely with Case Management to ensure timely completion of OBRA 3878 documents. The change resulted in timely completion of OBRA forms, decreased challenges for Information Technology, reduced disruption in clinical work, and encouraged collaboration between Physician Advisors and Case Managers.

> ***"Through careful communication and appropriate timing, PAs work closely with CMs to complete the required OBRA exemption documentation."***

BACKGROUND OF OBRA-1987

In 1986, the Institute of Medicine issued a report describing "deficient care" in nursing facilities and urged "more effective government regulation" to protect patients' rights, increase quality of care, staffing and training, as well as the process of certification ("Improving the Quality of Care in Nursing Homes," 1986). OBRA-1987 dictated "maximum possible functioning" for patients in long-term care facilities and the success of the reform is evident in the decline of hospitalization rate and the increase in the health of residents (Hawes, 1996; Wiener et al., 2007).

As a result of this legislation, at the practice level, patients who are discharged from a hospital to a long-term care facility must be reviewed by a provider through the Preadmission Screening and Annual Review (PASRR). The review process begins with the Level I DCH-3877 form (typically completed at the nursing or social work level) and where appropriate, the DCH-3878 form (completed by the provider). Depending on the initial assessment, the PASRR determination process can advance to Level II (Health & Human Services, 2021).

HISTORICAL ORGANIZATIONAL WORKFLOW

In the past, Case Managers (CMs) or Social Workers at the large academic medical center handled the paper forms. The process required them to locate a doctor and ask them to fill out the form by hand and then fax the document.

Recently, the DCH-3878 form went from a paper format to an electronic format in State of Michigan. Due to the complex nature of the electronic form completion process, the Michigan Department of Health and Human Services (MDHHS) created an in-depth OBRA 3877 and 3878 user manual *(3877-78 User Manual for Facility Users OBRA, Sep 2020).* The manual includes screenshots and step-by-step instructions for requesting access and permissions to the OBRA application as well as creating new 3877 and 3878 forms.

This innovation caused the Information Technology department an unexpected complication due to the sheer volume of provider logins required to support the new system.

CURRENT ORGANIZATIONAL WORKFLOW

As a response to the substantial amount of work involved with Information Technology creating and maintaining login information for large numbers of healthcare professionals who need to access the electronic 3877 and 3878 forms, the medical center chose to introduce a process change. Now, PAs serve as the main point of contact for OBRA-87 documentation.

The current Michigan Medicine (MM) organizational workflow for internal PAs is a five-step procedure. First, internal PAs review cases for level of care, and readmissions, and complete peer-to-peer discussions. Second, PAs intermittently review the built-in Epic system (Electronic Medical Record) list for pending OBRA exemption form 3878 which have been provided by the Case Management nurses. Then, the PAs review any pending cases for eligibility for OBRA exemption. Once cases are reviewed and found to be eligible/ineleigible for exemption, the PAs log in to the medical center's website at the state level to complete the electronic form/s. Finally, they complete the referral through the MM Epic system.

METHODS

Through careful communication and appropriate timing, PAs work closely with CMs to complete the required OBRA exemption documentation. This collaborative process includes a detailed communication and escalation pathway. The pathway provides questions with "yes" and "no" answers resulting in next steps. Beginning with an OBRA exemption form 3878 referral submitted to a PA and ending with a completed OBRA exemption form 3878 referral, the pathway ensures clear progression of the documentation process from PAs to Case Management Discharge Planning Nurse (DCP) or Social Worker (SW) and through to the CM Educational Nurse Coordinator (ENC).

Communication and Escalation

The communication and escalation pathway includes color codes for PA, DCP, and ENC steps and responsibilities. Practical questions such as "Does PA need additional info/documentation to complete the OBRA review" and "Is it a weekday or weekend/holiday" guide PAs through the necessary steps while pointing them toward the appropriate person to acquire the information they need to complete documentation.

The escalation pathway includes phone, paging, and secure chat communication channels and includes shift-specific guidance for PAs completing the referral process. The escalation pathways also includes clear method of communication for the Case Managers to be able to reach out to Physician Advisors if they have any questions. These collaborative communications have ensured a successful system for MM OBRA completions.

Timing

Timing is key for the different steps included in the escalation pathway. For instance, is the OBRA review occurs on a weekend or a holiday, a different communication process is set in motion. If it's a weekday, PAs send a secure chat to DCP or SW who is listed in the treatment team and includes the ENC. The specific timing intervals specified in the pathway are intended to ensure the quickest possible completion of the documentation. For instance, a different step is taken if a response is needed in less than 45 minutes or 30 minutes.

For more information on the OBRA communication escalation pathway see Appendix A.

DATA COLLECTION

Since the electronic OBRA 3877 and 3878 document format was introduced and PAs took over control of the referrals, data has been gathered on the number of exemptions completed as well as the volume of referrals, and the time to completion using

EMR. To clearly illustrate visual snapshots of the exemption amount and timing, the following tables and figures reflect the last six months of data.

Monthly OBRA Exemptions

For the last six months, between May 2023 and October 2023, 10 PAs completed OBRA exemptions and were tracked by color. The differing volume of PA completion reflects varying efforts invested in the role. The tracked data allows the PAs to see how are they doing compared to their peers on completing the exemptions (see Figure 1). The data is also collected for volume at different days of week and time of day to allow appropriate PA shift timing decision. It is discussed further below under Volume by Weekday.

Volume by Weekday

Due to common preparation for the weekend which typically happens on Fridays, the data gathered on the volume of OBRA completion by weekday revealed that Fridays are the busiest days. Saturdays and Sundays are typically lighter due to limited discharges to skilled nursing facilities over the weekend (see Figure 2).

FIGURE 1 – OBRA EXEMPTIONS COMPLETION BY MONTH, DIFFERENT COLOR REFLECTS VOLUME OF DIFFERENT PAS COMPLETING THE OBRA EXEMPTION FORM

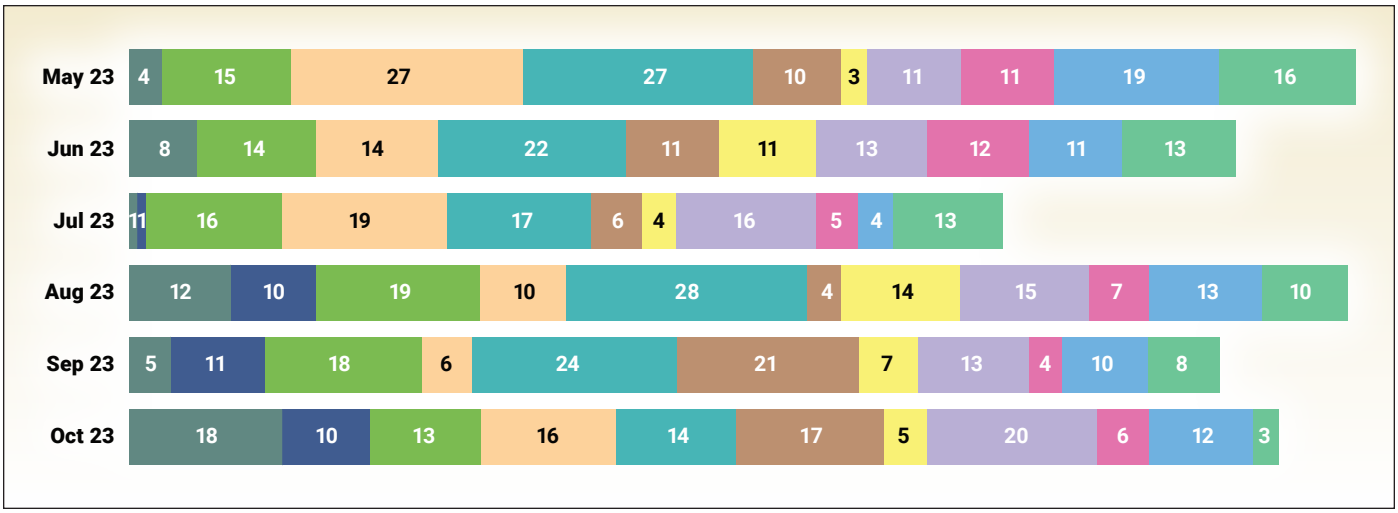
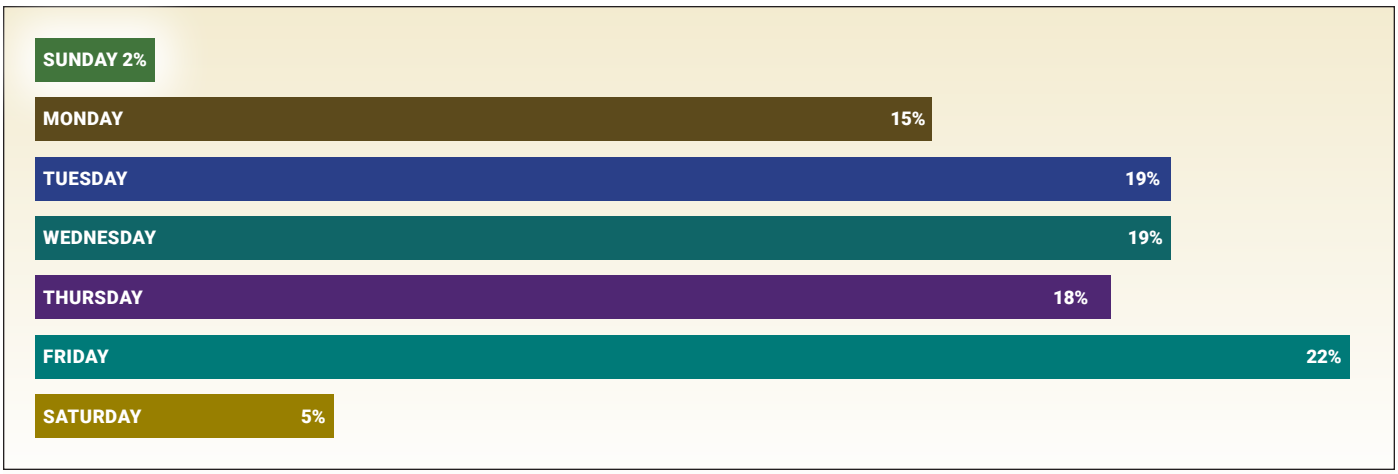


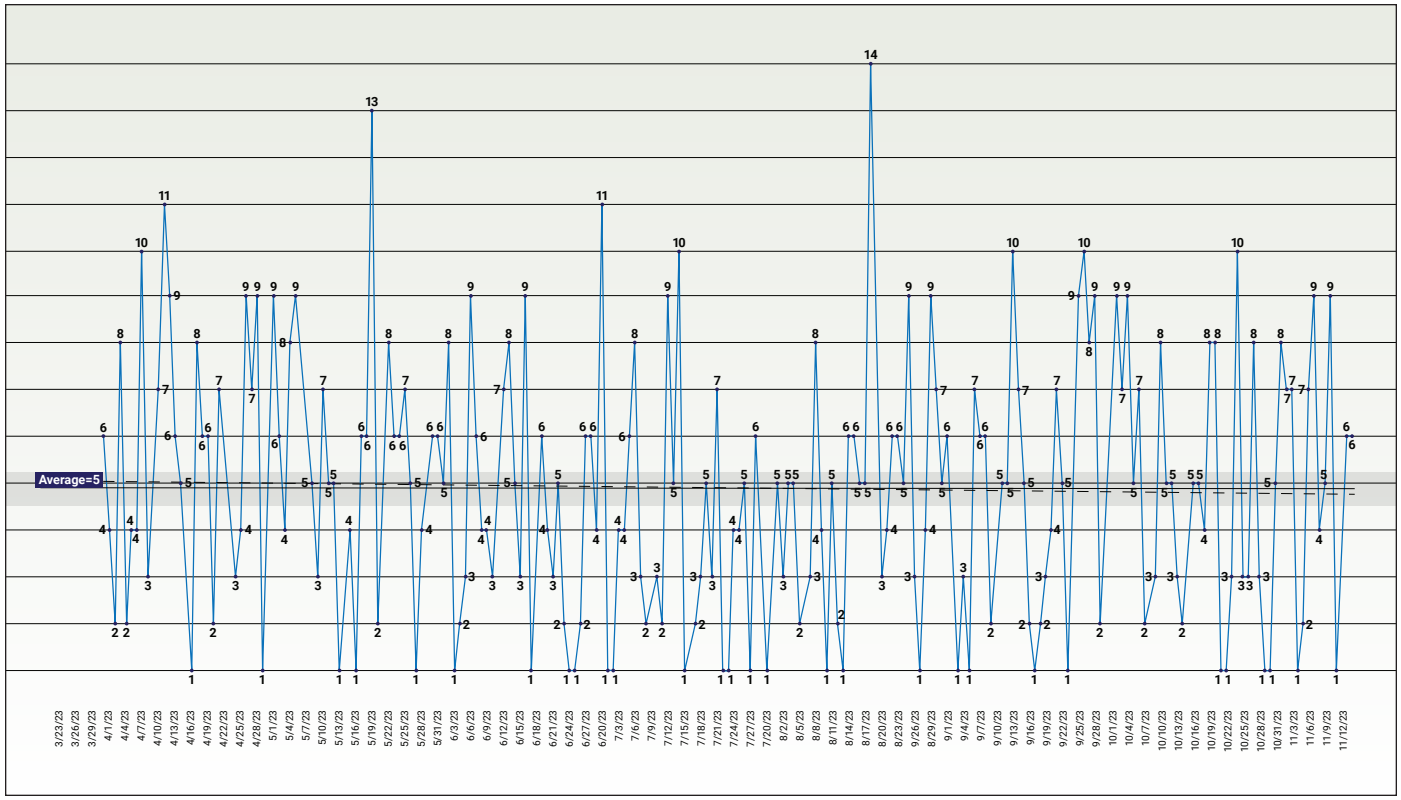
FIGURE 2 – OBRA EXEMPTIONS BY DAY OF WEEK



OBRA Exemptions by Daily Volume

The volume of OBRA exemptions varies day to day and the data shows an average daily volume of five for the past six months. The maximum daily exemption volume was 14 and the minimum was one (see Figure 3).

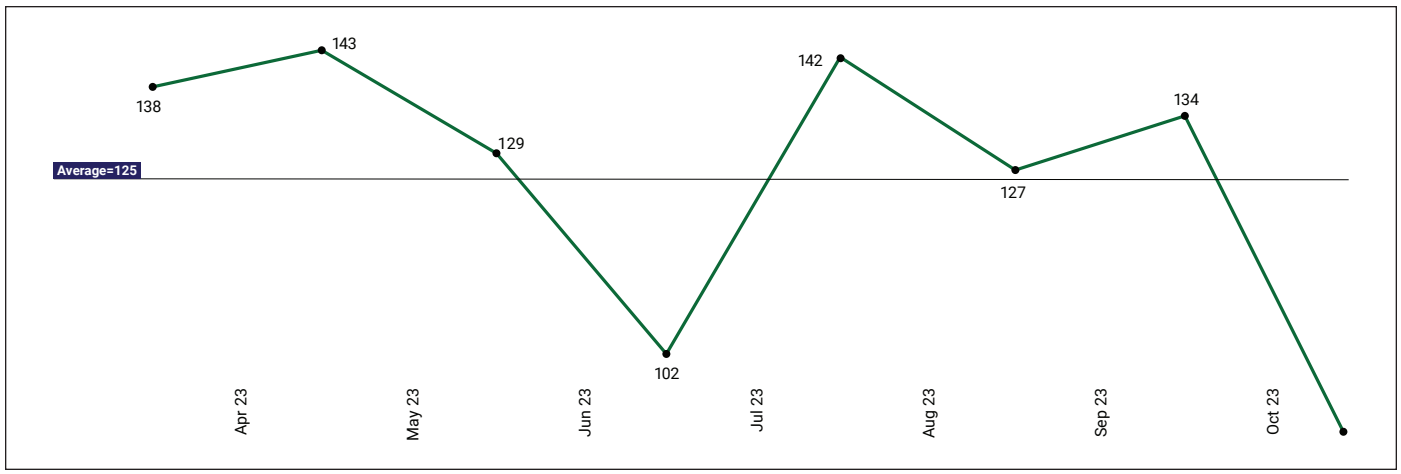
FIGURE 3 – DAILY OBRA EXEMPTIONS



OBRA Exemptions by Monthly Volume

The average monthly volume over the last six months was 125 with minimum 102 cases/month and maximum 143 cases/month (see Figure 4)

FIGURE 4 – MONTHLY OBRA EXEMPTIONS



OBRA Exemption by Hour of Day

Additional context was provided by data gathered on OBRA exemption by hours of the day and as expected majority are completed during 7AM to 6PM. There are fewer OBRA exemption requests between 7PM to 7AM as fewer discharge planning happens during that time to SNF. (see Figures 5 and 6).

FIGURE 5 – HOURLY OBRA EXEMPTIONS

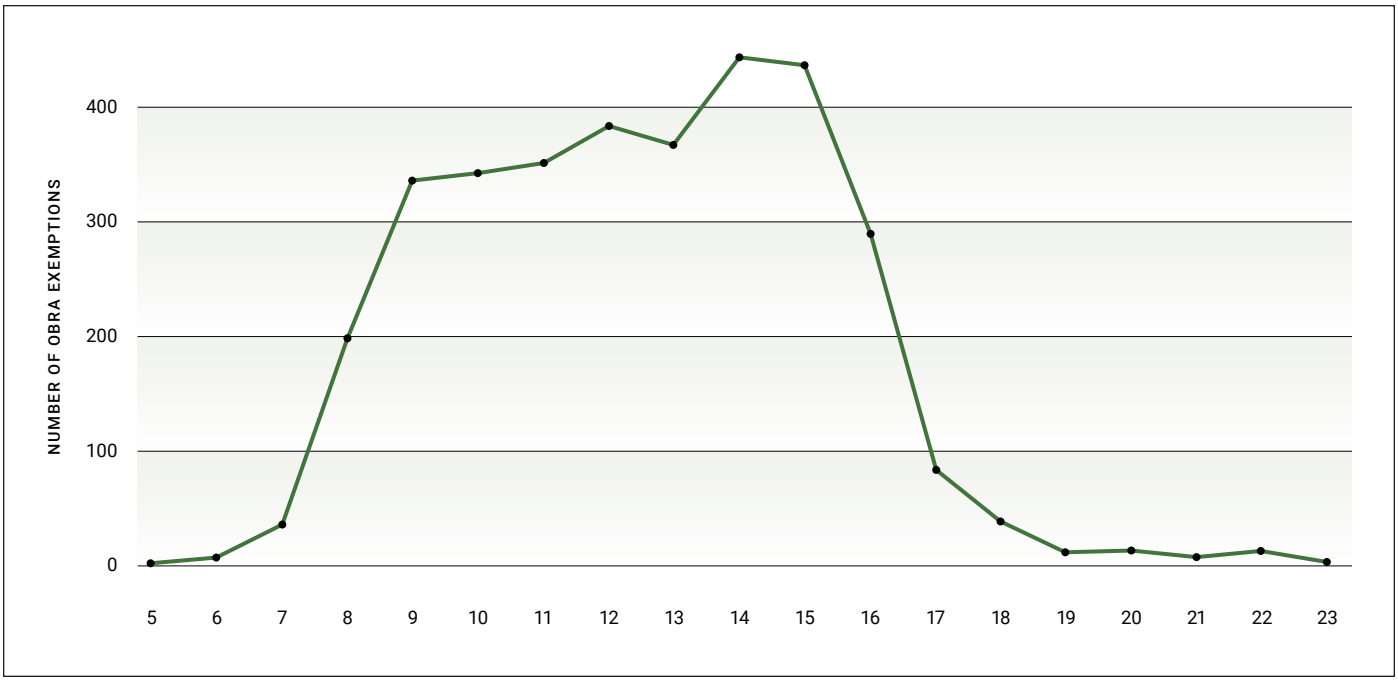
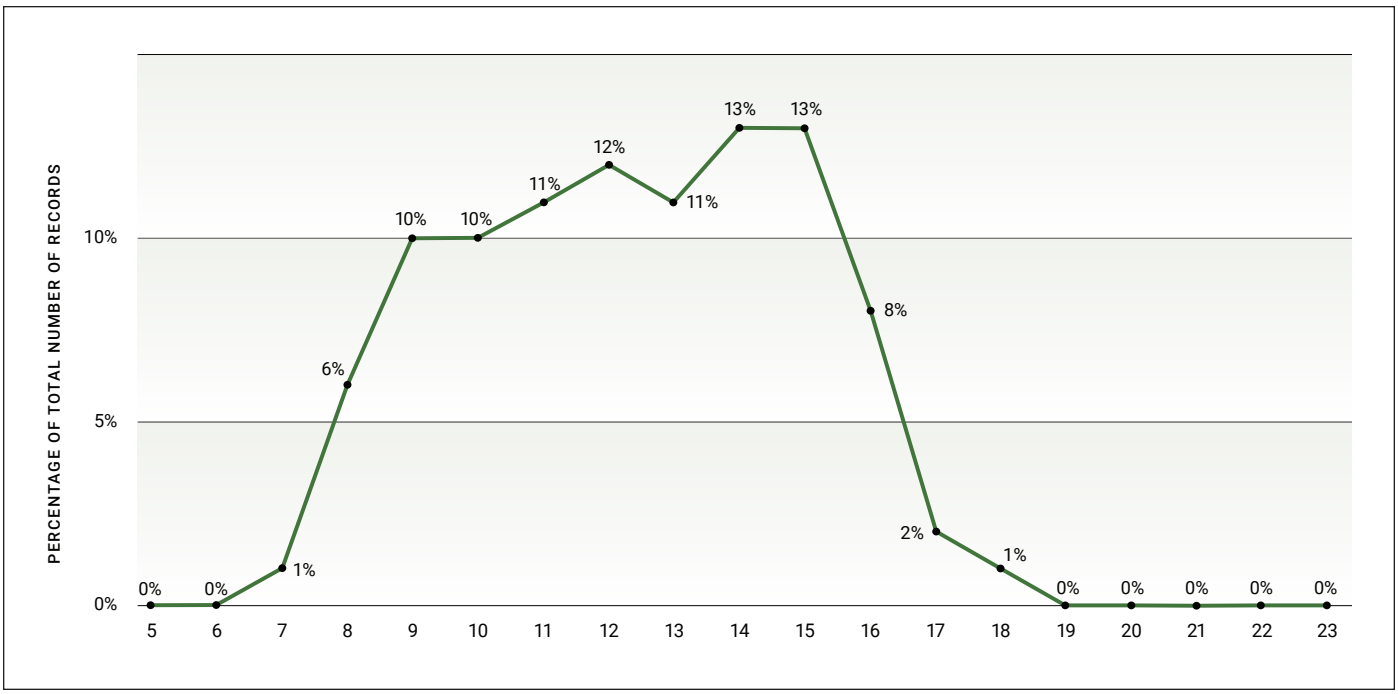


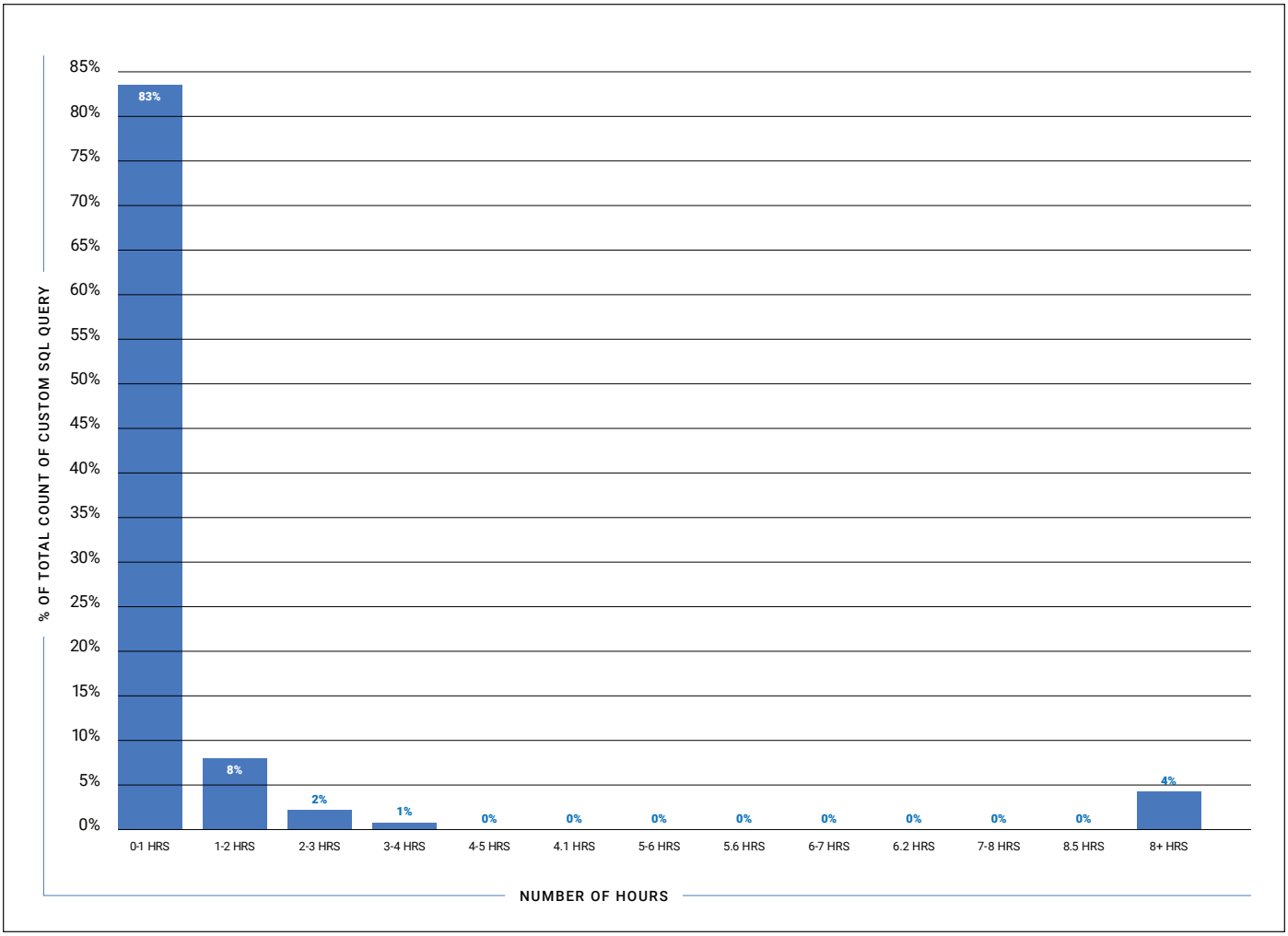
FIGURE 6 – HOURLY OBRA EXEMPTION PERCENTAGE



Time to Completion

After gathering data on the volume of exemptions completed by each PA, exemptions by day of the week, and daily/monthly/hourly volume, an analysis was conducted on time to completion. The data gathered on time to completion included average, median, and maximum of time to exemption in hours, time to exemption in minutes (see Figure 7).

FIGURE 7 – TIME TO COMPLETION BY HOUR



RESULTS

Due to the development of the PA role in OBRA at the medical center, the time to completion of forms 3877 and 3878 is dramatically low and allows rapid completion of this form. Over 90% of 3878 forms are completed in less than two hours with more than 80% in just one hour. The timely completion of documentation means that length of stay is minimized, and potential discharge delays are decreased.

At the time of initiation, the state had no previous electronic data. Prior to digitizing the work, only paper documentation existed and that was dependent on the manual coordination of Case Management with the Attending provider. This would be possible with hospitalists but not so when surgeons are in the OR outside of rounding times.

DISCUSSION

With PAs working collaboratively with CMs to communicate and escalate where needed the OBRA exemption forms, three main advantages were noted.

First, since the PAs already have a dedicated login for the system site, the process is streamlined, and Information Technology does not need to set up and monitor logins for additional providers. With over 3000 providers who are constantly in flux into and out of the system, this becomes a major organizational benefit. When internal PAs use the system, they log in the way they do daily. One potential concern with having all providers perform 3878 in a large academic center is the challenges of maintaining and remembering the login information for the state website and thus possible additional workload for Information Technology.

Second, PAs' timely completion of the forms means the primary attending doctor does not need to leave clinical work or be pulled from the bedside. There is no delay in discharge as this is actively being monitored, which ensures a reduction in the length of stay.

Third, working closely with CMs and clinicians results in a collaborative environment and breaks down silos. This program has enhanced the communications and relationships between the PAs and the CM staff which spills over into other aspects of CM work.

PAs already work many charts for both surgical and medicine departments. The PA program was built by hiring for OBRA efforts as part of the job description and PAs are fractional FTE appointments to Care Management. Of note, there are 12 PAs in the program, as evident in Figure 1, but all have majority of clinical efforts. Most of the PAs in the program have 20% effort for the PA role to keep the connection with the clinical team, as well.

Hospitalists (who, in this institution, care for medicine patients) would be pulled from work with their patients to do the OBRA review and paperwork for all patients, which would not be an effective strategy for this organization. Since PAs are positioned as a bridge between providers and Case Management, it is more cost-effective to use an existing, internal PA team to do this work, rather than form and assign this role to a new team.

While there is an upside to a provider who knows the patient best rapidly completing the forms, at this major academic and research center, a PA is the better option when a clinician may only cover a few weeks of the year and be unfamiliar with 3878 completions requiring re-training for each time on service. Also, with over 3000 providers, the administrative burden to the institution to keep track of an electronic username, password, and other accountability issues, is a very expensive proposition. Since changing the forms to electronic there was a need to centralize this work to allow smooth throughput.

Instituting the expanded role of PAs in OBRA exemptions and tracking the resulting efficiency in time to completion allowed the CM/PA program to take the data to leadership to gain support to support an increase in the number of PAs. The PA role reduced clinical disruption and challenges for CMs and providers thus ensuring timely completion of exemptions which help to assure appropriate length of stay.

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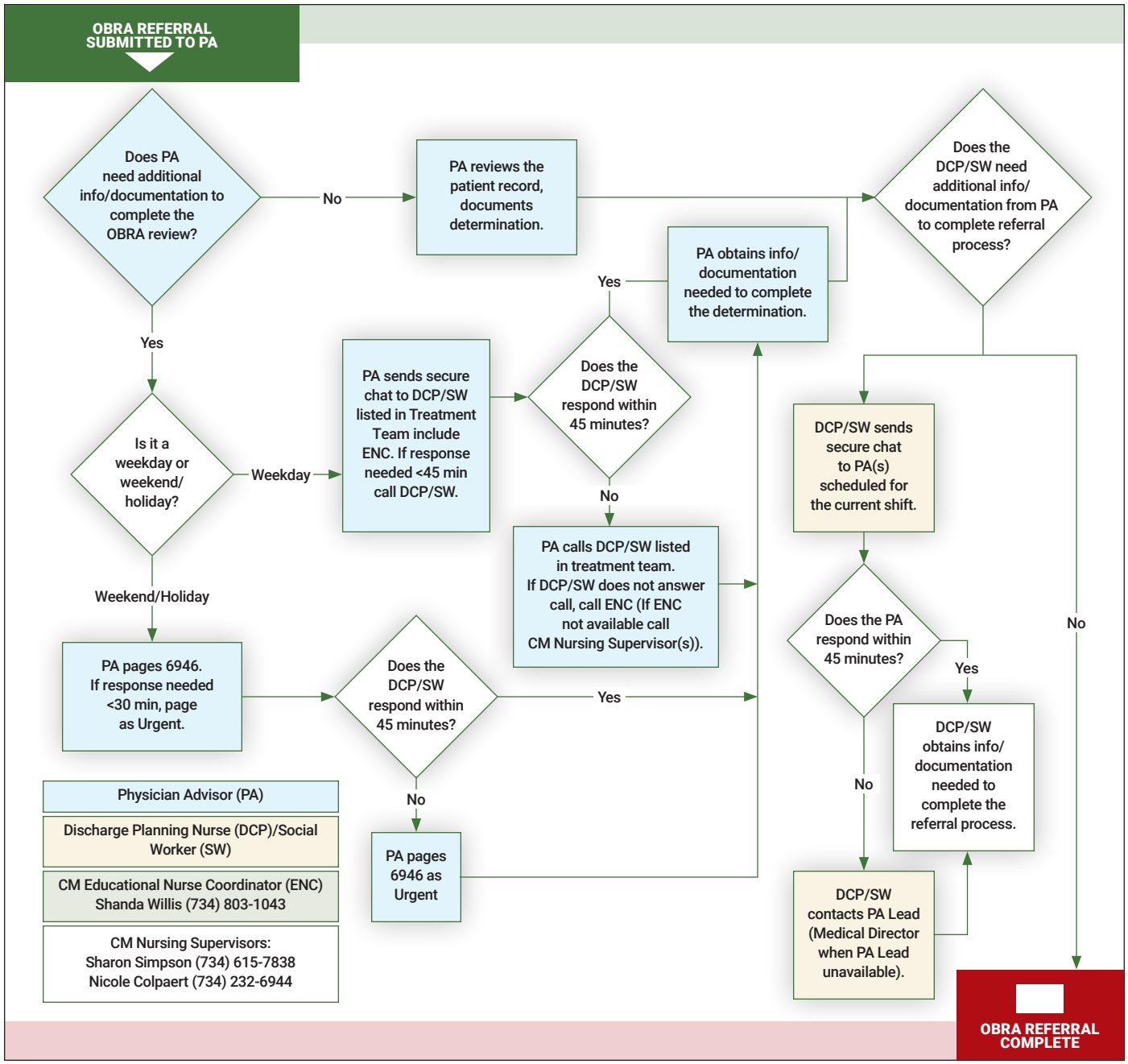
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APPENDIX A – OBRA COMMUNICATION / ESCALATION PATHWAY

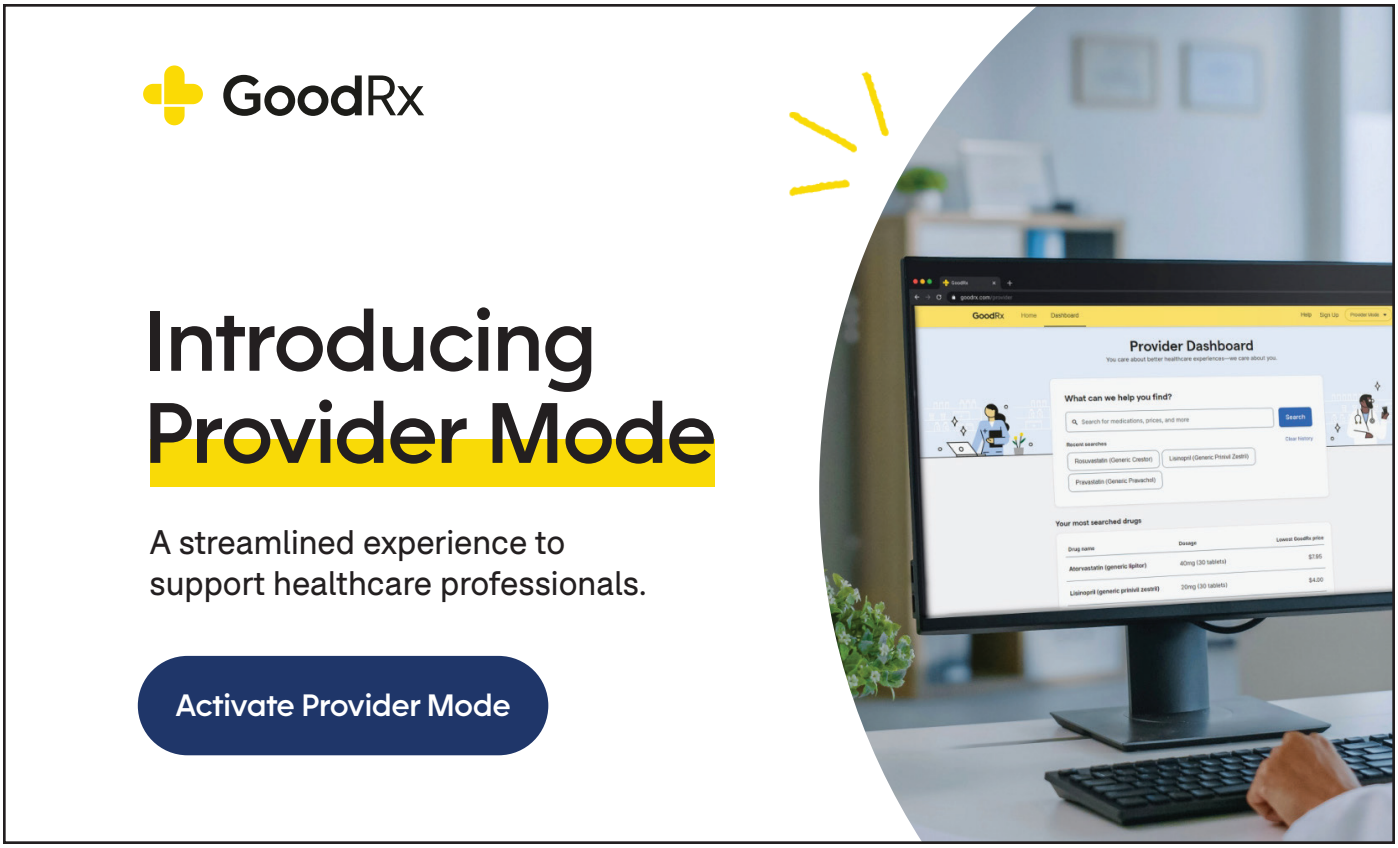


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