Integrated Care Coordination Leads to Positive ROI at Riverside University Health System

By Whitney Fishburn

By implementing patient-centered care coordination across its large countywide public health system, Riverside University Health System dramatically improved cash flow, cut average length of stay, and improved multiple facets of the patient experience.

Care at RUHS was growing increasingly fragmented, in part because of a high rate of executive turnover and silos among county services, according to the system's executive director for business development and service lines, Donna Bennett, RN, who spoke during a webinar presented by Press Ganey.

"We really needed some stability, some grounding," Bennett said. "We were looking to reduce variation, and to avoid missed revenues and lapses in patient care."

"There are clear connections between care transitions management and patient experience," Adam Higman, Press Ganey partner in Transformational Advisory Services, said during the webinar. "Care transitions is not discharging patients from care. It's moving them to the next setting of care. It implies continuity, and it is very patient-centric, meeting their health care needs at that point in time."

Once senior leadership were aligned around the concept of leveraging the county's many resources to improve patient expectations and deliver better service, they assessed what barriers existed to providing seamless care across the safety net system's network, which includes two teaching hospital campuses, a Level 2 trauma center, 77 specialty clinics, and 11 federally qualified health clinics, as well as RUHS's other acute and ambulatory care facilities. In all, the system collectively serves 2 million visitors annually, including a large prison population, undocumented workers, and Medicaid beneficiaries. The average age of patients treated at RUHS is just under 32 years, according to Bennett.

AT A GLANCE

- California-based Riverside University Health System (RUHS) redesigned its case management model to optimize care coordination and transition practices.
- Following a six-week assessment to identify barriers in coordination and transition processes, the system revitalized its case management leadership structure, reconfigured staff models to meet patient and service line needs, and trained care team members on patient-centered care across the continuum.
- Since beginning its integrated care coordination journey, RUHS has achieved a 0.7-day decrease in length of stay, from a high of 5.5 days in 2018 to 4.8 days in June 2019; reduced uncollected reimbursements by more than 75% at any given time; reduced ED and inpatient admission wait times; and improved its HCAHPS scores.

In addition to the high executive churn rate, there had also been a change in payer incentives around value-based purchasing and population health incentives, reallocation of nursing staff due to medical necessity reviews leaving some departments understaffed, and unclear job descriptions across a number of departments that also had high turnover rates. Additionally, only one nurse in the entire system had certification in case management, Bennett explained. Leadership also found that although there were multiple data streams, they were uncoordinated. Meanwhile, coding and patient tracking were inconsistent, leading to millions of dollars in lost revenues annually, she said.

Overhauling Resource Allocation

The root of the problem was the perpetual leadership void in the case management department, Bennett said, noting that in a six-year period, there had been 21 different department leaders.

To fill the leadership void, the system hired an interim manager to fulfill the director of case management role—the only position in the department that was not unionized—and began working with a team of Press Ganey transformational advisors to identify specific steps RUHS could take to reverse course.

After a six-week assessment, a strategy for integrating care coordination systemwide took shape, beginning with a complete restructuring of the case management model to comprehensively include care across the continuum, leading to the creation of a patient-centered culture systemwide.

Because a significant portion of the RUHS patient population is insured through public programs, particular attention was paid to ensuring regulatory compliance and to standardizing documentation and patient tracking. This helped stanch the flow of lost reimbursement revenues in the department. Clearly stated compliance metrics also helped improve resource allocation and shape performance metrics. Dashboards subsequently were created to track performance improvement, and discussions about data-driven patient outcomes and performance metrics were included in nurse huddles.

Before the department's resource allocation overhaul, there typically was one nurse for every 45 to 60 patients. Now, as part of a stepped recruitment plan, more than two dozen new full-time positions have been created, lowering the ratio to around 27 patients per nurse. Bennett said the goal is for nurses to have no more than 20 patient cases each.

More social workers have also been added to team with the nurses. Job descriptions for the new hires were written according to the new care model so that having a patient-centered focus was top of mind from day one, according to Bennett.

Additionally, all staff were given preparation for case management certification. After only one year, Bennett said nine nurses, with support from the organization, have become case manager-certified through one of two certifying bodies: the Commission for Case Manager Certification or the American Case Management Association.

Leadership staffing across the two hospitals was also restructured, creating a greater balance between union and non-union staff and providing more direct oversight of the case management functions. Since 2017, four new managerial leadership positions have been created and filled.

A three-tiered approach to care was standardized to include discharge planning, care coordination, and patient management and engagement, with case management workers placed at all points of patient access.

"The earlier you get eyes on a patient, the easier it is to plan for their needs," Higman explained. For example, in the emergency department, RUHS case managers now work alongside physicians, determining a patient's ultimate needs. This helps ensure bed capacity and patient access to other care such as psychosocial services. It also ensures outpatient care coordination such as the correct follow-up with primary care and specialty physicians, ultimately helping to lower hospital readmissions, according to Higman.

At all points of a patient's stay, case managers repeat their assessments according to a risk stratification system to help maintain the appropriate resource intensity.

"Risk stratification is essential," said Higman, adding that the simpler it is, the better. "Three to five categories should be enough. If it's too complicated, it's hard to implement and maintain over time."

Adopting an "All In" Mindset

Medical staff systemwide were continuously brought in to review the evolving integrated care model. "We were fortunate to have a strong and active physician advisor," Bennett said. This person worked with the program's executive sponsor on the utilization review committee, helping facilitate regular communication from key medical personnel across the system, including primary care physicians, hospitalists, specialists, and others.

"I cannot stress enough the importance of strong communication. That had been one of our weak points," Bennett said, adding that beyond the regular medical staff, there also was a need to operationalize communication with the more than 1,000 medical students, residents, and interns in the system so they would understand the implications of the patient-centric culture taking shape. "Medical leadership needs to be involved from the beginning," she said.

Getting buy-in from the nursing staff by working with the chief nursing officer is also important, according to Bennett, as is collaboration with the human resources department and union leadership.

To set the new culture in place, training modules were developed for all stakeholders according to their specific job functions, emphasizing that care coordination was everyone's responsibility. A preceptor model, role playing, practice modules, and peer education were used to develop sound patient assessment and risk stratification skills. New process reviews were also regularly included in huddles.

Since beginning its integrated care coordination journey, RUHS has achieved a 0.7-day decrease in length of stay, from a high of 5.5 days in 2018 to 4.8 days in June 2019. The system also has reduced uncollected reimbursements by more than 75% at any given time. Additionally, it has seen reductions in ED and inpatient admission wait times, and improved HCAHPS scores, Bennett said, noting that the specific improvements are still being quantified.

Lessons learned, according to Bennett, include the importance of standardizing documentation and data collection to ensure accuracy. "We were data-rich but information-poor," she said. This contributed to compliance issues and lost revenues.

Bennett said that future goals include implementing an autoreview feature in the record management system to streamline data navigation and work queues.

Overall, RUHS discovered that by designing a care coordination system to engage patients at the right stage in their care, plan for their needs accordingly, and address common organizational problems around adequate resource allocation and utilization, it is easier to reach common organizational goals such as improving throughput, reducing length of stay, preventing readmissions, and engaging with community resources such as psychosocial facilities to provide care to specific populations, according to Higman.

"It's a wholesale realignment of the inpatient care model," Higman said. "Having a good care management system in place is essential to making all of these things come together."