Redesign the System: Reducing Length of Stay for Patients with Medical Needs through a strategic direction in:

Case Management
Care Across the Continuum
Population Health
- Identify successful strategies for engaging clinical leaders across disciplines and units to improve flow for patients with medical needs

- Consolidating Case Management across the continuum to manage patients and reduce hospital stays

- Leveraging the disciplines with case management to assure professionals are working as teams and at the top of their license

- Learn 10 strategies that involve case management in reducing LOS and improving capacity
What are complex needs?

- Patient’s that do not have the resources to facilitate a timely and safe discharge plan
  - Family or Personal Resources
  - Financial Resources (benefits, personal income)
  - Emotional Resources (depression, substance abuse, mental health)
- Patient’s who come into the emergency room and are admitted because there is no safe plan for them
- Patient’s who are readmitted because the discharge plan failed
- Patient’s who did not understand their health care recovery plan and failed because the system did not identify and intervene
- Goals for discharge are undefined
Why Do we Care About the Care Continuum in attempting to manage patient flow?

- **Readmissions**
  > 16% of patients in beds were due to a readmissions

- **Social Admissions**
  > 5-10% of patients in beds were due to the lack of a safe plan in the community rather then medical necessity needs

- **Frequent ED visits**
  > Frequent fliers often gridlock 3-5 ED beds up at a time, causing delays in ED flow and admission process

On a typical hospital day, it is not unusual for 10%-20% of the patient beds to be occupied with patients who do not have medical needs.
Table 3.17
Number of Hospital Discharges and Average Length of Stay, 1980-2004

Hospital discharges and length of stay have generally declined over the last two decades.

Note: Non-Federal short-stay hospitals.
Source: Center for Disease Control and Prevention, National Center for Health Statistics.

Centers for Medicare & Medicaid Services
Office of the Assistant Secretary for Planning and Evaluation
Contemporary Approach

Healthcare Case Management Across the Care Continuum

Most Critical CM Responsibilities
- Patient advocate: 17%
- Complex patient care: 15%
- Care transition management: 13%
- Health coaching/disease management: 9%

5 Conditions That Get a Case Manager’s Attention
- Diabetes: 59%
- CHF: 37%
- CVD: 36%
- COPD: 31%
- Heart disease: 38%

29% Diabetes is the condition most responsive to case management

CM-Patient Connections
- 87% Telephonic
- 67% Face to Face
- 42% E-mail
- 34% U.S. mail
- 32% Home visits

11 Keys to Successful Case Management
1. Flexibility and Inexpediency
2. Patient satisfaction with coordination of care
3. Metrics and accountability
4. Interagency cooperation and coordination
5. Assignment of case managers
6. Effective intervention and evaluation
7. Patient advocacy
8. Care coordination
9. Patient engagement and education
10. Care transition management
11. Medical errors

CM Challenges for 2013
1. Home care senior care
2. Skilled facility
3. U.S. economy
4. Reimbursement
5. Cost trends in workers compensation
6. Healthcare reform
7. Pay for performance
8. Embedded care management

Average Monthly Caseloads
- 1-49: 31%
- 50-99: 42%
- 100-169: 16%

CASE MANAGER CASE MANAGEMENT NETWORK
Infographic Editor: Patricia Donovan
Infographic Designer: Marble Chess

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10 Key Strategies

- Consolidating Leadership/Attention to the Continuum
- Disease Management
- Positioning the Team/Models
- Leveraging Skills
- Embedding/Enhancing Practices
- Targeted Discharges
- Patient Placement
- Using Data & Prediction
- Developing a Discharge Cycle
- Choosing Networks
VP or Senior Director of Case Management/Social Work
- Oversees both inpatient and outpatient practices
- Ensures a clear, shared vision
- Connects the dots and the outcomes
- Subject matter expert for all things case management and social work
- Provides a comprehensive roadmap for the organization that addresses cost per case, maximizing reimbursement, and avoiding penalties and managing capacity by ensuring the patient is in the right place at the right time
Case In Point

- Director of Case Management oversees both IP and Ambulatory Practices
- Decreasing avoidable admissions through bi-directional communications and identifying risk
- Inviting ambulatory Case Managers to Complex Care Meetings and carrying the patient across the continuum of care
- Developing focused populations that care for patients longitudinally by both case managers and social workers (Oncology)

More patient’s were managed in the ambulatory settings
#2 Disease Management

- Care Across the Continuum for Targeted Diagnosis
- Using Evidence Based practice guidelines
- Critical Skills that understand the trajectory of care
- Supporting Patient Self-Management/Health Literacy

Service Line

| People with Chronic Conditions Account for the Majority of Health Care Expenditures |
|---------------------------------|---------|---------|---------|
| ONE OR MORE CHRONIC CONDITION | SHARE OF HEALTH CARE EXPENDITURES |
| UNINSURED                      | 27%     | 63%     |
| MEDICAID                       | 37%     | 77%     |
| MEDICARE                       | 39%     | 85%     |
| PRIVATE                        | 61%     | 68%     |

**SOURCE:** Partnership for Solutions (2002). Chronic Conditions: Making the Case for Coordinating Care (Baltimore, MD: Johns Hopkins University)

Case Management Functions
- Warm Handovers
- Bi Directional Communications
- Predicting Needs & Patient Outcomes
Case In Point

- Developed clinical pathways across the continuum of care
- **Preferred Provider Networks** who were ready and prepared as choices were made prior to surgical admissions (increasing home health over SNF’s)
- Dedicated case managers who understood the disease trajectory and evaluated for risk
- Case Managers fundamentally changed the choice conversation from geography to quality
#3 Positioning the team

- Geography
  - UNIT BASED
- Service line
  - Patient Populations
- Physician Partnerships
  - MD Practices
### Points to Consider

#### PRO’s and CONS

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<thead>
<tr>
<th>Points to Consider</th>
<th>PRO</th>
<th>CON</th>
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<tbody>
<tr>
<td>Consider Your Facility</td>
<td>• Manage patent’s along the Disease Trajectory</td>
<td>• Limited providers, able to develop relationships</td>
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<th>Physician Partnerships</th>
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<tr>
<td></td>
<td>• Limited providers</td>
<td>• Less productive time</td>
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<th>Geography</th>
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<td>• Allows for team based management</td>
<td>• Unless the units are population based, harder to facilitate Disease Management concepts</td>
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<tr>
<td>• Increased availability</td>
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<td>• High Productive Time</td>
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<td>• Helps to manage the rhythm of the unit via relationships</td>
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**KEY: Time, Availability, Influence, Credibility**
Leveraging Skills

Emerging Role of Social Work
- Comprehensive Psychosocial Assessments
- Crisis Intervention
- IADL’s
- Practical Wisdom
- Psychosocial Discharge Planning

Evolving Role of RN Case Management
- Comprehensive Clinical Assessments
- Coordinating Care for 30-60-90 days
- Safe & Sustainable Discharges
- Incentive Alignment

Early Interventions – Timely Transitions – Maximizes recovery
Case In Point

Mercer Health

RN Utilization Review

SW Discharge Planner

LOS 6.5

LOS 4.8

Care Coordination
Utilization Management

Care Coordination
Psychosocial Support

INTEGRATED

INTEGRATED

SILOED

SILOED
#5 Embedding Enhancing Practices

- Rounds
- Complex Care Rounds
- Bi-Directional Communications
- Warm Handovers
- Patient/Family Conferences
Coordinated Interdisciplinary Rounds
All Disciplines are present
Run by a collaborative practice between Case Management and Hospitalists
Estimates discharge date during first discussion of patient
Develops “goals for discharge” that are then shared with the patient
#6
Targeted Discharge Dates

- Using DRG’s to predict discharge dates
- Guides the team towards managing outcomes
- Provides common goals for patient/family/team
- Helpful with Hospitalist “change days”
Case In Point

Omaha Children’s Hospital

- Using EPIC and help from CDI Case Managers are entering Estimated Discharge Dates into the system
- Team uses these dates to focus on goals for discharge and timing these goals with the EDD
- Families are provided this information at the beginning of the stay
- 60% of patients are hitting the discharge dates
- Opportunities now exist to research the following
  > Why didn’t the patients who didn’t meet the goals leave on time?
  > Why were there patients that left not on the EDD list
#7

Patient Placement

- Creating a 3 way call system that ensures appropriateness and speed of appropriate admissions
- Ensuring a clinical patient placement team
- Using criteria “light”
- Development of transfer policies and agreements
Clinical Nurses in Patient Placement

- Receives an electronic notification of an admission request
- Organizes a phone call between them, the provider requesting the bed and the admission physician
- Able to guide the conversation to ensure appropriate level of care, status, and patient bed placement
- In the case of cases that do not meet criteria for admission, can engage case management to find alternative solutions to an admission
Case Management “Vital Signs”
  Avoidable Days
  Length of Stay
  Cost Per Case
  Observation Care
  Boarder Days
  Daily Discharges by the numbers
Key Points

TRENDS....

- Avoidable Days (unnecessary patient days)
- Discharge days (guides coverage needs)
- Surgical Days (helps predicts bed demand)
- Length of Stay
Case In Point
Reacting To Trends

St. Francis Hospital, Tulsa, OK

- High number of ICU “boarder days”
- Data revealed that these patients had pulmonary diagnosis
- Met with pulmonology who claimed that their patients did not have appropriate pulmonary interventions coming out of ICU and onto Acute Care Units
- Validated with data related to ICU readmissions
- Pulmonologists felt an Intermediate Care Unit would keep patients out of the ICU
- 8 bed pulmonary intermediate unit built – “Thoracic Park”
- Pulmonary readmissions reduced from 30% to less then 5%
  > created better patient flow from ED through Acute Care Units
Case In Point

- Study the patterns of admissions – by day, by hour
- Study the types of bed demand
- Goal for capacity – 80%
- Recognize that most capacity data is at midnight, not connected to the actual

By doing this, Baystate Health realized that they needed 75 discharges per week day and 50 discharges per weekend day
The Discharge Cycle

Involving the Entire Team 24/7
• Night Shift Team has a lot of information
• Nutrition services can be very predictive!
• Identify next day discharges
• Study the patient’s that were discharged without predicting them rather then those that failed to discharge
• Get ahead of the physician, don’t be passive
#10

LEVERAGING THE NETWORK

- Create preferred provider networks based on quality not geography
- Fundamentally change the choice conversation
- Determine your needs and choose BUY, JOINT VENTURE, BROKER

- Reductions in Readmissions offers improved capacity
Case In Point

- Created a scorecard to choose their preferred provider networks
- Those facilities with quality outcomes, timely responses to referrals, and had good communications skills were selected
- Monthly quality reviews were held to discuss patients that were readmitted to the hospital
- Clinical pathways were created across the entire continuum of care and seamlessly moved the patient from hospital to post acute services

Outcomes:
- LOS went down during the inpatient stay
- Less patient’s were readmitted from the SNF, improving hospital capacity
FINAL POINTS

- Leverage your case management team, it will make a difference
- Connect case management to bed management activities
- Use prediction and trends