Meeting Patient Flow Demands with Creative Case Management

It's a familiar story. A hospital has to put its emergency department on "divert" status. Patients are stacking up in hallways waiting for inpatient beds to become available. The operating suites are running behind schedule, delayed because of overcrowding in the recovery room.

The American health system is in the grip of a chronic shortage: there are not enough beds… or are there?

Bridging the "capacity gap" is the current imperative that underscores the call for throughput reform. The challenge is to do as much as possible with the beds you have. At its heart, that challenge involves faster patient throughput: treating more volume with the same level of capacity. Even hospitals that have already shortened length of stay can realize substantial gains from an aggressive focus on operational performance. Many of these gains can be orchestrated by case management. Best estimates from the Health Care Advisory Board indicate that hospitals could create about 25 percent more "virtual beds" from faster throughput.[1]

This white paper provides a framework for case management excellence, with six strategies to better align operations with your organization's bed capacity goals for effective occupancy.

[1]Urgent Matters Poster Abstract, "Perfecting Patient Flow" George Washington University, October 2007

Create Virtual Beds with Aggressive Throughput Management

A QHR White Paper

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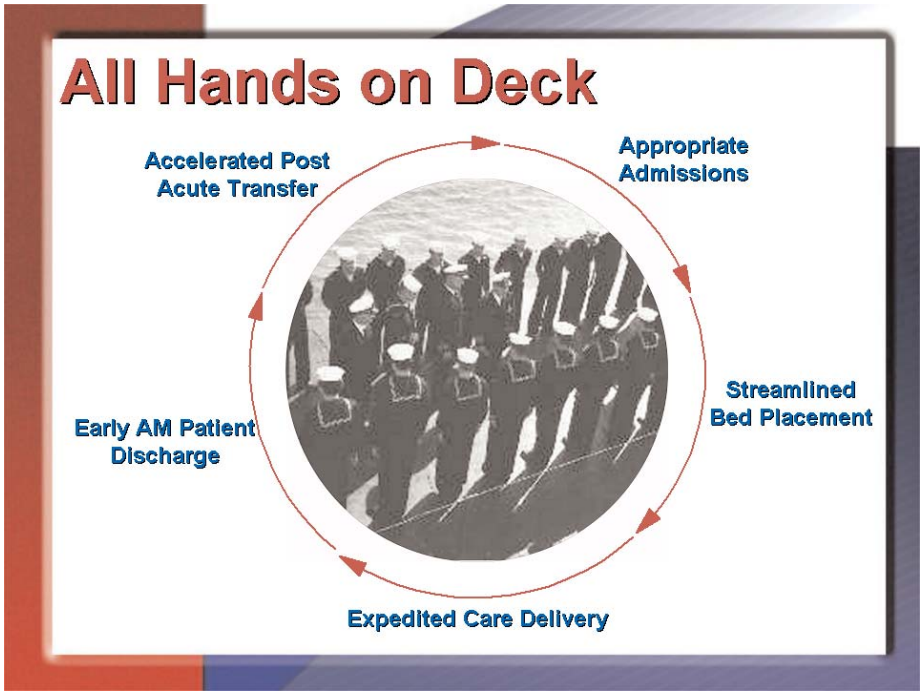
Responding to the Capacity Challenge

There is no one tactic that will lessen the stress of bed demand, but the mantra of "the right patient in the right bed at the right time" could drive a combination of solutions.

Ensuring appropriate inpatient admissions, pushing harder on length of stay, minimizing the use of inpatient beds for outpatient services and accelerating placement in post acute settings are the most immediate, straightforward sources of new capacity.



The most promising – and most difficult – opportunity to manage a capacity shortage is through expediting each patient's course of care. These gains require the most careful attention to physician enfranchisement. ***"All hands on deck"*** has been a common thread in the most successful throughput improvement efforts. What makes them work is the broad participation of the staff best positioned to identify barriers and develop solutions; what makes them keep working is ongoing monitoring and ongoing teamwork.

Engaging Case Management in Throughput Reform

The QHR Model for Engaging Case Management in Throughput Reform has assisted multiple facilities in reinforcing specific tools and techniques at the core of patient flow. The following case management initiatives support practices that will result in additional bed capacity and organize the effort for faster throughput.

Strategy #1: Make the right call: inpatient, outpatient or observation.

Overcrowding results when inpatient beds are filled with outpatients or observation patients. Some 10% of admissions nationally are "avoidable" – most are elderly patients with chronic diseases.[2] Aggressively treating patients in an outpatient or ED setting can prevent unnecessary admissions.

Many throughput improvement strategies engineered by case management result in incremental gains – measured in length of stay reductions of hours, not days. Research has shown that shaving hours off LOS is a worthwhile endeavor for multiple reasons. These hours taken off of patient stays are likely to be the most frustrating and least satisfying for the patient. That is certain to improve both patient satisfaction and quality of care. Most importantly, the mathematical reality of hours saved can turn into days. Very often three or four hours saved could mean the difference between admitting another patient or not.

What to do

Screen admissions: Position a case manager to evaluate incoming patients' acuity levels, determine patient status appropriateness and provide guidance to the physician as he or she determines the right patient status and bed type.

Designate beds for outpatient recovery: Manage the short-stay patient without compromising inpatient beds by dedicating a separate pool of beds to the recovery of outpatient procedural patients. Patients experiencing complications from outpatient surgery might be admitted; having these beds gives you time to decide.

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Implement an observation unit: Patients who need to be aggressively managed but do not need to be admitted (such as those with head trauma, abdominal pains or complications from surgery) should be treated in an observation unit.

Use a clinical decision unit: Also a form of observation, this type of unit is primarily used for analysis of chest pain. It can help you avoid unnecessary admissions through rapid assessment and intervention for these critical cases. Most facilities locate it within the ER where appropriate resources are available.

Strategy #2: Set the game plan: daily bed briefings.

This strategy gives your team a good handle, early in the shift, on current occupancy, planned admissions and discharges, and what is soft – other potential discharges and admissions. The concept of daily bed briefings is frequently used to bridge the gap between admitting and floor staff. The benefit of the practice is that your team can be more efficient working the same plan: getting discharge orders, lining up skilled nursing beds, planning coverage for later shifts. But there are obstacles to the success of this strategy, such as spotty attendance and staff resistance to "policing" of beds since this has been somewhat of a territorial issue for quite some time.

[2] *Throughput Gap Analysis*, Healthcare Advisory Board, Washington, D.C., 2006

What to do

Form your team: Assemble representatives from all patient care areas, emergency room, operating room, nursing, admitting, bed control and case management daily to discuss current and expected census, anticipated discharges, final discharges and encourage coordination of resources between units. These meetings allow for a "best-guess" snapshot of day's capacity and projected bed needs.

Keep it brief: Meetings should take less than 30 minutes and be held twice daily.

Be accountable: Maintain executive oversight. Be clear about who's responsible for what. Unit representatives are expected to bring accurate information to these meetings and complete follow-up steps as agreed. Run effectively, the process resembles a game strategy session, with incredible teamwork. Leaving with assignments from the team, nurses and case managers negotiate between units to float staff as needed, with vendors to accept post-acute patients, or with payers to accept a rate or cover another day. The result is efficient operations for the hospital, a faster return home for the patient, and a more empowered staff.

Strategy #3: Fix processes: expedite care; reduce delays.

Hospitals realize house wide throughput gains by tightening care delivery processes and operational factors contributing to length of stay, with a particular focus on case management interventions and physician resource support. This strategy is highly effective for freeing inpatient beds by accommodating incremental admissions since the impact of each change is magnified house wide.

In recent years, ALOS measures have begun to level off, with many hospitals saying they've hit a floor on length of stay. A closer look reveals evidence to the contrary.[3] High variability around aggregate DRG-level measures suggests plenty of opportunity left for most hospitals. Research and pilot studies point to three real time tactics presenting the most potential improvement for reducing ALOS: physician based case management, access to a physician advisor and physician profiling.

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What to do

First, refocus case management on patients: We're under such time demands to get patients in and out that sometimes we overlook the obvious. We might evaluate how many steps are in the home, whether the patient can keep up with her medications, etc., without stopping to question why this is her fourth admission this year. Could she need education about her condition? Does she know what she can do to manage it, or prevent another crisis? We may need to improve our interview and assessment skills.

[3] *Key Tools and Techniques for Patient Flow Success,* Kirk Jensen, MD, MBA, 2006

Revisit physician rounding: Has your hospital done away with nursing rounding with physicians? If so, reconsider. This practice clarifies expectations. To make it happen, case managers often have to be assertive.

Leverage the physician advisor, your liaison: Often a semi retired physician, he or she has a real interest in quality and efficiency. This is your go-to doctor when you have a problem case or need direction. Reviewing the case, he/she will offer the attending physician an alternate plan, discuss and negotiate, acting as your advocate for the good of the patient and the hospital.

Profile physicians: This "score card" approach allows doctors to see how they compare to their colleagues regionally and nationally in terms of length of stay, cost per case and number and type of tests ordered. Scientists as well as caregivers and business people, physicians usually respond positively to solid information but reject less documented claims. Therefore the success of this initiative depends on beginning with reliable severity adjusted data and analyzing it with expertise. The best approach is to have the physician advisor present quarterly reports to the staff, and offer the option of further investigation.

Strategy #4: Take a team approach: all players on the field.

The most significant shortfalls of unit-based utilization review are its minimal contact with patients and its marginal impact on length of stay and resource consumption. In response to bed capacity demands, a supporting practice is to form multidisciplinary teams of physician, case manager and social worker. As a result, the case manager and social worker become integral components of patient care planning and are viewed as resources for physicians. The physician benefits by being treated as a partner in length of stay management and knowing which case manager to contact.

What to do

Pick teams: Assign case managers and social workers to work individually with specific physicians. This arrangement allows the case management team to become accustomed to and complement the physician practice patterns.

Put your heads together: Have at least one member from each case management team round with physicians each morning. When the team meets as a group, discuss treatment, discharge plans and special needs.

Physician rounding and unit-based interdisciplinary team meetings create excellent venues for case review and update. This sharing of information solidifies the care plan framework and underscores accountabilities by all team members. The physician, nurse and case manager have a vested interest in each case. As professional care givers, they want to know they have provided benchmark care: that they achieved what was expected, in the appropriate time frame, and met expectations. The formality of forming a team aligns these stakeholders' objectives and creates shared expectations for outcomes. When the data comes in, the team celebrates successes and learns how to improve. It's a positive experience for all, including the patient.

Have a back up plan: In the event the team is unavailable, have the clinical care unit manager serve as a backstop for case management.

Document and study results: As case manager and physician review the aggregate physician performance data together, it becomes a much more meaningful experience. Working toward shared goals, they share a vested interest in the success of their work, as proven by patient outcomes and other performance indicators.

Strategy #5: Stay ahead of the game: morning discharges start the day right.

When patient admissions and discharges are misaligned, a bulk of patients requiring beds hit the hospital in advance of the discharge-ready patient pool. Jumpstarting patient disposition or placement planning within the first twenty-four hours of each stay will accommodate additional admissions by discharging patients earlier in the day. This strategy is very effective for maximizing the use of existing capacity and accommodating additional admissions if the facility is turning away patients at peak times of the day.

The patient who is deemed by the attending as "will discharge in AM if stable" can be discharged at 9AM or 7 PM depending on time of physician rounding, diagnostic results reporting promptness, transportation arrangements and a multitude of other controllable factors. Proactive planning and information transfer can make the difference.

What to do

Instill a "hotel checkout" mind-set: Patients and families must clearly understand the need to vacate the bed by a specified time. Operational refinements may be needed to ensure that the case manager and healthcare team confirm that the patient, family and physician are all ready for a morning discharge.

Mitigate the midday squeeze for beds: Case management should target two key facets of the patient discharge process: assembly of critical information for discharge ready patients and education of patients and families about the discharge process and expectations.

Be creative with the "late rounding" physician: Implement "tuck in rounds" where a physician designates patients for next day discharge on the prior evening. This strategy will help ensure discharge readiness and on-time checkout.

Dedicate staff to facilitate earlier discharges: Nurse practitioners can function as discharge expeditors with key responsibilities of rounding with physicians, writing and executing patient care orders in doctor's absence with sign off by attending within specified time frames.

Strategy #6: Know your end-game: refine post acute transfers.

Some patients stay a little too long because we're inefficient. A few end up staying way too long… because they don't have an ideal place to go. Both represent significant opportunities. Placement is often compromised by internal factors such as incomplete patient profiles, bulky and labor intensive processes and cumbersome communication between providers. The first correction, and one that will help you correct all the others, is to instill a sense of urgency in your team.

What to do

Dig into your avoidable delay data: Sort it by attributable cause and validate it. You'll have an eye-opening experience that will spur your team to action. This data helps you understand why patients who could have moved on stayed in your acute care beds. There is a system or human reason for the failure. Is it that their families refused to take them home? Their lab or radiology results weren't available? Nursing failed to prep them for a procedure? A physician failed to write the order? A bed was not available at the SNF? Study this data and you'll identify your best opportunities to improve. Once validated, diffusing this type of delay presents multiple obstacles and therefore should be approached by considering many options. Although local market availability of beds and patient funding can limit achievable gains, you can get creative with each individual case.

Stay positive: Some facilities have a concern about using avoidable delay data because it can come across as finger pointing. The answer is to keep the focus on improving. You may identify bottlenecks in a certain ancillary area; be careful to involve that department in the solutions you develop, and keep the process upbeat and the focus on the patient as you implement them.

Target difficult discharges: Long-stay cases are contributing heavily to your overall length of stay. Many have clinical and psycho-social needs requiring consistent dedicated resources. Use a SWAT team, comprised of physicians, case managers, social workers and executives, meeting twice weekly to discuss difficult to place patients. Work with the patients' families to select the best options and to prompt earlier SNF referrals, minimize evaluation delays and encourage faster responses from providers.

Summary

QHR's goal is to provide guidance in maximizing your hospital's capacity. We can provide creative solutions developed through relevant, hands-on experience to help your team expedite patient throughput by revamping some of the most basic case management strategies. The economics may be new, but the task for America's health system leaders remains unchanged – continuously driving operational performance improvement.

If you have any questions about this white paper, or would like to speak with QHR about your Case Management challenges, please call Donna Turtle at 1/800-233-1470, ext. 2033. To read more about how QHR has successfully helped clients address case management issues, go to www.qhr.com, and click on the Consulting Services tab.