Managing Outlier LOS:
A Partnership to Reduce Barriers to Discharge for the Chronically-Acute Patient

Brenda Ohta, PhD

UHC Annual Conference
September 2011
Greetings From…
NYU Langone Medical Center

- A world-class, patient-centered, integrated academic medical center located in the heart of Manhattan.

- 3 Hospitals:
  - Tisch: 705 acute care beds
  - Hospital for Joint Diseases: 190 orthopedic beds
  - Rusk Institute: 174 rehabilitation beds

- 8 Outpatient Clinics
NYULMC by the numbers

<table>
<thead>
<tr>
<th>FY 2010 Annual Utilization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>41,526</td>
</tr>
<tr>
<td>ER Visits</td>
<td>42,819</td>
</tr>
<tr>
<td>Deliveries</td>
<td>4,389</td>
</tr>
<tr>
<td>Ambulatory Surgeries</td>
<td>28,009</td>
</tr>
<tr>
<td>Cancer Center Visits</td>
<td>108,824</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>1,040,000</td>
</tr>
<tr>
<td>Case Mix Indicator</td>
<td>2.00</td>
</tr>
</tbody>
</table>
Objectives

- To describe a highly structured meeting format that has dramatically reduced outlier cases
- To identify innovative approaches and proactive planning to minimize individual barriers to discharge
- To articulate the role of hospital leadership in addressing barriers and processes which impede efficient patient movement through the system
Background

- Patients with LOS ≥30 Days: 20-25 per week
  - Large variability in LOS among MDs
  - Inconsistent/inefficient Care Management processes/structure
  - Unattended end-of-life decision-making needs
  - Health beliefs of patient population
  - Extended stays – increased risk of hospital acquired conditions

- 35% Medicare = 62% of long stay cases

- High LOS relative to UHC
Improvement Effort

- Process and structure redesign
  - Physicians/Hospitalist Service
  - Care Management Service
  - Approach to End-of-Life Care
Aim

- Improve timeliness/appropriateness of acute care transitions
  - Decrease 30+ day stay patients; Reduce to 10/week
  - Decrease average Medicine LOS
  - Increase communication regarding patient health care decisions
  - Generate cost savings
  - Ensure no negative impact on readmission or mortality rates
Interventions

Physician Level

- Development of Hospitalist Service
- Daily Interdisciplinary Team Rounds
- Education for Physicians on End-of-life Care (EPEC)
- Meetings and chart reviews for MD outliers
Interventions

Care Management Level

- Integrated Care Management Model
  - Implement use of evidence-based criteria
  - RN Care Manager – MSW Teams
  - Coaching on identification of clinical/other barriers

- Redesign subacute referral process

- Expanded Use of Post-Hospital Services

- 7-day hospital/weekend CM staffing
Interventions

Approach to End-of-Life Care

- Utilization of inpatient hospice beds
- Development of Advance Directives/Goals of Care interdisciplinary ‘wiki’ note/education
- Introduction of “Cultural Navigator” to enhance cross-cultural communication
Health beliefs of our patients

Ten zip codes have 25% of discharges but 40% of excess stay
Intended to advance discussion of directives/care goals on all services

- by making the information available in all areas of the chart
- by making the information easy to record in a shared format
- by empowering different care givers to engage the patients and families on these issues
Pulling it all together...

- Twice-weekly extended stay rounds
- All cases 12+ day LOS
- Physician advisor, CM/SW, ancillary depts, administration, finance
- Focus on clinical progression/barriers; discharge target/options
- Physician Advisor places immediate call to attending
Administrative Involvement

- Required
- Removes system barriers
- Realistic view of issues
- Reinforces initiative
Reporting Format for Mon & Thurs Long Stay Rounds

• Patient name _______________ Age _______ Sex _______ Rm#/SD/RCU
• LOS ____ Princ/Working DX _______________ Attending of record ________________
• Advance Dir Discussion _______ Date________ Code Status ________________

• Current **next geographical goal** (ex. stepdown, floor, AR, SAR, SNF, home) for this patient *and expected date* of transition?

• **Medical endpoints** and **medical / social barriers** that have to be achieved for that next step and/or goal to occur?
  
  *Endpoint:*
  *Barrier:*
  *Endpoint:*
  *Barrier:*

• What steps must be taken for ultimate transition to occur? *Time frame?*
Key Concepts for Care Managers

- End Points
- Barriers
Outcomes: Medicine Service
30+ Day Cases

Weekly Volume 30+ Days LOS Medicine Patients

Cases/Week

March 2008

June 2011

Initial Long Stay Rounds 30+ Days
CM/Hospitalist Process/Rounds Intensify

We thank J. Porrovecchio's Inhouse 30+ Days for Medicine
Outcomes: Medicine Service
30+ Day Cases

Weekly Volume 30+ Days LOS Medicine Patients

- Initial Long Stay Rounds 30+ Days
- CM/Hospitalist Process/Rounds Intensify

Cases/Week

March 2008 - June 2011

Source: J. Porrovecchio's Inhouse 30+ Days for Medicine
Outcomes: Medicine Service 30+ Day Cases

Weekly Volume 30+ Days LOS Medicine Patients

Cases/Week

March 2008

June 2011

Initial Long Stay Rounds 30+ Days

CM/Hospitalist Process/Rounds Intensity

30+ Day Cases
% of All Pt Days: 30+ Day LOS Cases

- 2008: 23% (15375)
- 2009: 18% (10509)
- 2010: 16% (846)
- 2011 FYTD: 8% (363)
Shift in Payer Mix & Cost Savings

Medicare shift from 62% of cases to 45% of cases
Observed to Expected LOS

LOS Index (Obs/Exp)

1.0

1.1

All Payers

Medicare

2009-01 to 2011-05

2009-02 to 2011-05

2009-03 to 2011-05

2009-04 to 2011-05

2009-05 to 2011-05

2009-06 to 2011-05

2009-07 to 2011-05

2009-08 to 2011-05

2009-09 to 2011-05

2009-10 to 2011-05

2009-11 to 2011-05

2009-12 to 2011-05

2010-01 to 2011-05

2010-02 to 2011-05

2010-03 to 2011-05

2010-04 to 2011-05

2010-05 to 2011-05

2010-06 to 2011-05

2010-07 to 2011-05

2010-08 to 2011-05

2010-09 to 2011-05

2010-10 to 2011-05

2010-11 to 2011-05

2010-12 to 2011-05

2011-01 to 2011-05

2011-02 to 2011-05

2011-03 to 2011-05

2011-04 to 2011-05

2011-05 to 2011-05

All Payers

Medicare
Discussion

- Improvement: requires strong and enduring collaboration between physicians, care management, and administration

- Patient plan of care: alignment with patient preferences/cultural and spiritual beliefs

- Positive patient outcomes (e.g., low readmission rates) can be sustained even with a more aggressive approach to LOS management
Thank You!

Time for a Few Questions