PPMC LOS
contextual inquiry/bkgd info

Katherine Choi, July 7-14, 2015
Penn Medicine Health Care Innovation Center

Interviews/Shadowing with:

5: ANM maureen and vibette and case manager/SW, neurosurg NP

3E: ANM jen nelson, unit clerk, NP (kathleen higgins)

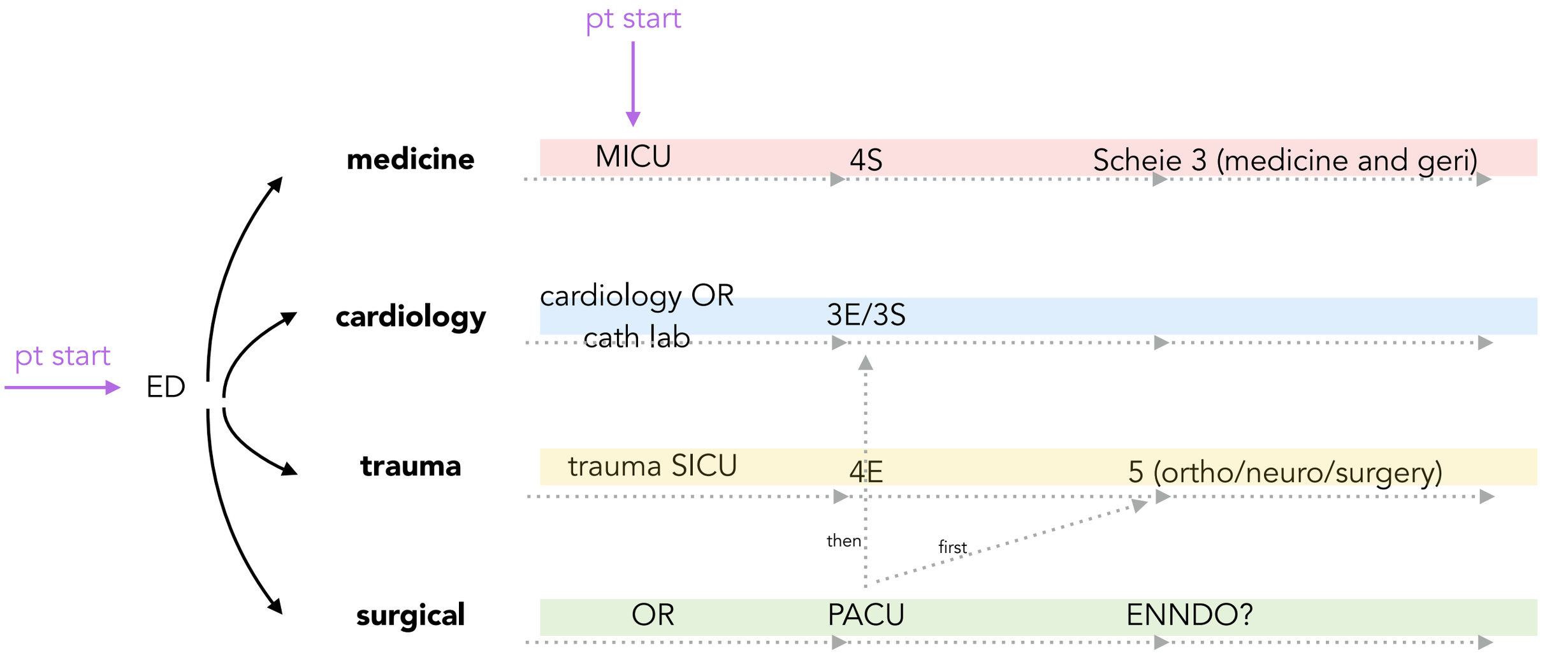
3S: unit clerk, becky charge nurse

4S: Annie McGowan

Bed management - nurse administrative coordinator

CDI - Barbara Schrader and Larry Berthold

Service lines:

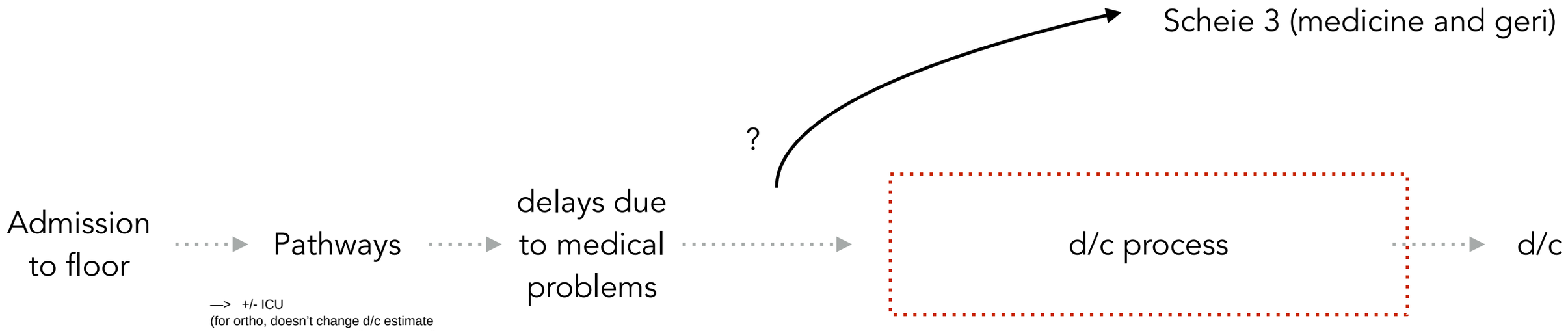


bed management

greenlight project = 4S

d/c process

10,000 foot view



—> +/- ICU
(for ortho, doesn't change d/c estimate because continues along "post op day" whether on ICU or floor and keeps count running)
(surgery it does add 1-2+ days)

D/c process

Timeline

[case manager]

[MD]

[Patient readiness]

[Documentation in: navicare SCM canopy

** see bed management section

d/c rounds (daily on each patient)

submits clinical summary to insurance

submits clinical reports (updates) if patient stays beyond "last day covered"

studies/procedures, dialysis, cx results needed

insurance gives "last day covered"

PT rec

estimated LOS based on admission DRG and working DRG

?

sees/hears PT rec

discussions re: code status, family meetings

calls insurance to get authorizn

pt medically ready

notified about d/c today

secures available bed at facility

ride available

discharge day

d/c summary, med rec

transport order

d/c order

patient literally leaves bed

bed cleaned -> next patient reaches bed = 2+hrs!

Greenlight Project

10:30am d/c rounds (daily on ALL patients)

MD identifies patients who are going to be **medically ready to be d/c'd tomorrow**

Med A and Med B teams

2pm d/c "huddle"

charge RN

Family med

Pharm

CRC/SW

Hospitalist

Calls resident and gets answers to checklist via phone
(paper checklist)

charge RN

Pharm

CRC/SW

Delegates to staff (CRC, SW, PT, Pharm) with tasks needed via phone

Proposed new task flow

10:30am d/c rounds (daily on ALL patients)

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charge RN
Pharm
CRC/SW

Med A and Med B teams
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Delegates to staff (CRC, SW, PT, Pharm) with tasks needed via phone

MD alerted to fill out checklist asynchronously

Staff can access answers to checklist

Patient transfer - timeline w landmarks

events

documentation in navicare

MD puts in bed order in sunrise and ?MD or unit clerk puts time into navicare

auto

- requested bed and time seen in floor view

can find "time entered" log @ patient right click -> view info -> events -> "confirmation required - time change"

IMG 1

? MD or unit clerk places transfer order

floor view

Bed hub or Nurse admin coord assigns bed

IMG 2

auto

- assigned bed and time seen in floor view

again, can find "time entered" log @ patient right click -> view info -> events -> "confirmation required - time change"

doc to doc, nurse to nurse occurs

manual

Unit clerk (MICU) or charge nurse (HVICU) changes 1-2-3 icons to reflect transfer order, d2d, n2n

patient literally ready to move

manual

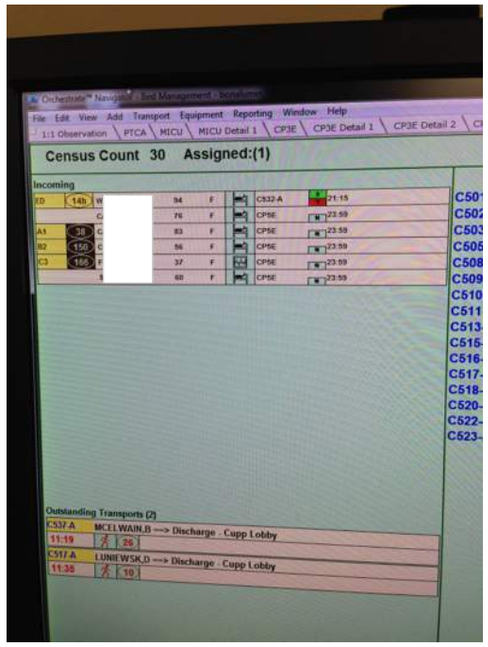
PACU - ?nurse makes "yes" icon
ED - nurse admin coord changes to "yes"
others - variable

= green light initiative on navicare

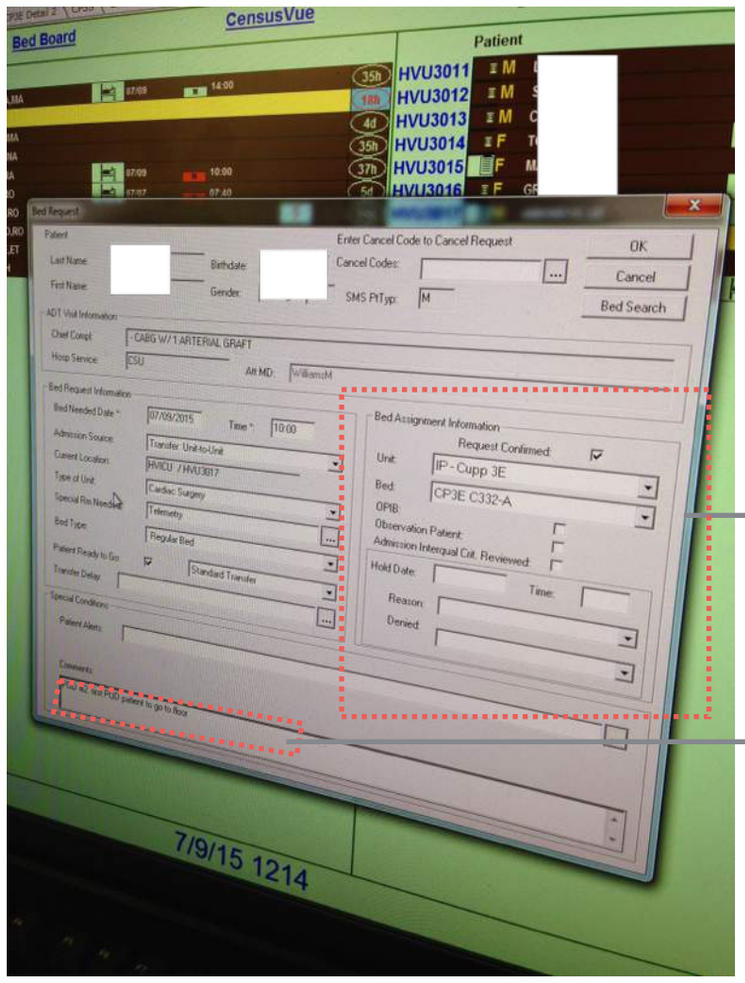
patient actually transferred

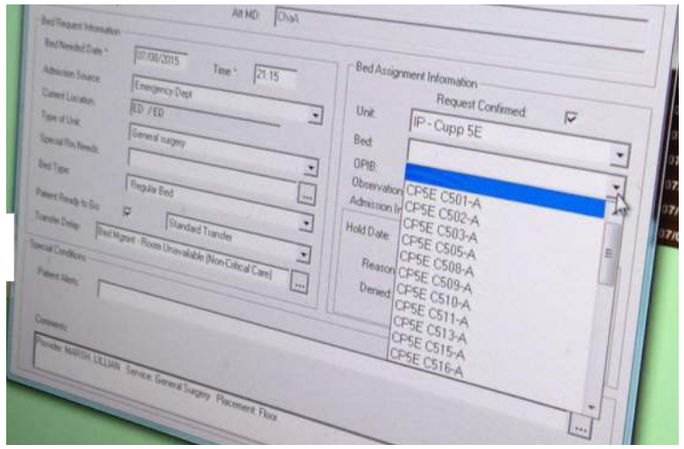
Note: this "green light" time is monitored by a QI team, but is different from the "green light" project on cupp4s. Both have to do with earlier discharge but do not measure the same time intervals (this navicare one measures time elapsed from patient literally ready to move to actually transferred. cupp4s identifies patients who will be d/c'd the next day and does separate rounds to talk about their needs.

IMG 1



IMG 2





only bed hub/mgt and nursing admin coordinator sees this box and can fill this out

comments can be used by charge nurse on receiving floor end to communicate specific room preferences nurse admin coordinator

pain points

<u>need better measurement of opportunity space/metrics</u>
time elapsed from d/c order placed —> patient has left
~2 hrs elapsed (Meghan Maini)

<u>need better reliability of data already in navicare</u>
non-manual updates (variability based on floor) of:
1. who is ready for d/c.
2. time of estimated d/c.
3. (+ 3. how long d/c order was put in, for medicine floor)

<u>need new data that doesn't exist</u>
when transfer order placed (automatic)

<u>who doesn't see this information</u>
EVS/environmental doesn't see "yes" (so can't anticipate cleaning soon)
transport doesn't see navicare

<u>would a predicted (not manual) estimate of LOS, or more accurate information change how you effectively do your job?</u>
"yeah, that would be great! yeah, using the board more robustly would change patient progression. we could know who would be going first, by noon (HVICU uses prioritized list at bed report)….

knowing 2-3 days out would help with nursing coordination to gauge where we need to put patients. "
- susan chonko

Where DRG estimates exist:

	1	2	3	4	5
clinical chart review	**CRC aka case manager**	**CDI** **Remedy bundled payments - Rose (ask Larry for more info)**	**Physician**	**Pathways**	**Coder**
DRG estimate	Insurance company sends back: actual DRG or just "DRG approved"	CDI	Physician	# days	Coder, post-discharge
Where documented?	Canopy note	Canopy/ECIN	"Navicare" via unit clerk	trained	?
When updated?	day after "last covered day" if patient is still here	some patients maybe once-few times, esp if had procedure or OR	daily at d/c rounds		
Who sees?	CRC	No one… CRC could but the insurance estimate is more relevant	nurse staffing coordinator, bed management	everyone knows	
What response?	Insurance "last covered day" and need for clinical reports to justify extended stay		structures discussion of "medically ready"	discussed in terms of "POD" and NP documents deviations*	Reimbursement
For how many patients?	everyone	only some…	everyone, but typically granularity up to 2-3 days….	ones that have a relevant pathway (specific procedures)	everyone

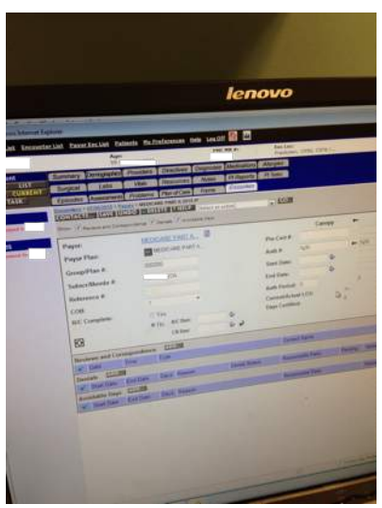
Note:

@HUP….. case managers put DRG into canopy…. and they don't have 3M tool

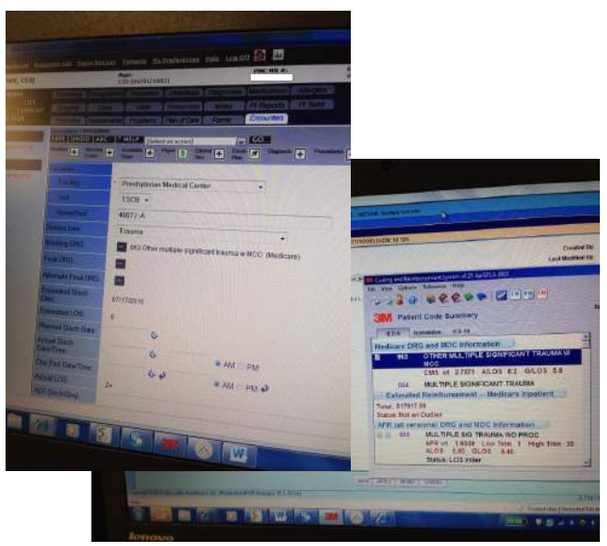
Note:

Brian Morely, physician advisor to the CRC's on 5th floor - says there the denial days from insurance companies (aka denied extensions beyond the original 'last covered day') has doubled this month compared to 4 months ago.

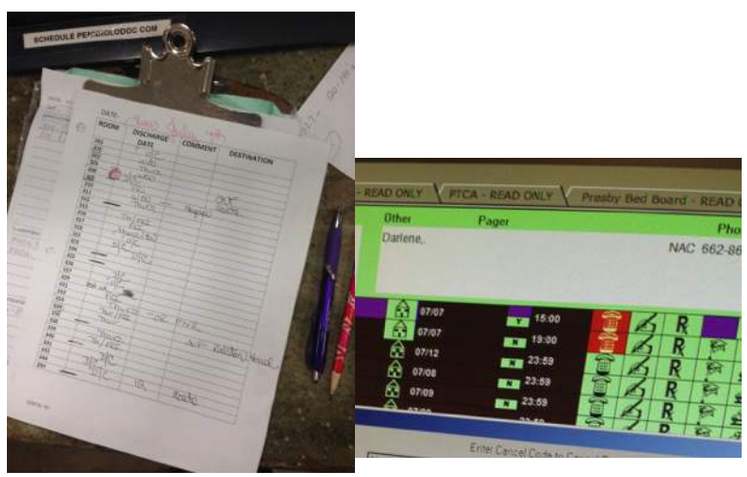
IMG 1



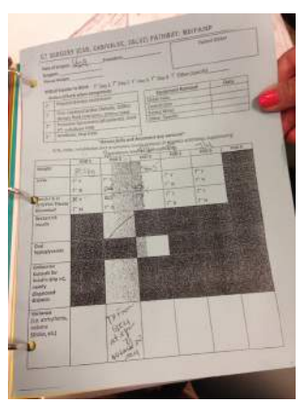
IMG 2



IMG 3



IMG 4



quotes re: utility of LOS estimate:

Would it change your care if you could see an estimated average LOS for your patient?

Charge nurse 3S (becky) -

- no — heart failure LOS changes based on baseline — iv diurese — which is pt specific
- cath pts - stent and go home, barring complications (ex: coumadin dosing)

NP 3E (Kathleen Higgins) -

- "we do this day in day out, we all know it [the day of discharge] intuitively. the number/date doesn't matter. what we DO need for discharge is….I would rather be goal oriented. to have us all know *what needs to happen for this patient to get towards discharge*
  - suggested solutions: rather than estimated LOS, have goal oriented plan per patient.
  - have prompts in work flow to suggest action items ("this patient is diabetic, consider ACE?. this patient had a cabg, do they need IV lasix? [there are times where this is forgotten]")

Case manager 5E (Eileen) -

- "most of us have many years of clinical experience, we have a sense, and we pretty much know what LOS is. But I think it'd be really helpful for interns and residents."

Case manager 5S (Lynette) -

- No, it doesn't really matter what estimate the physician gives me. I already have an estimate from the insurance company, and from the clinical info I've been following.

Neurosurg NP (Nya) -

- No. For elective cases and mild traumatic brain injury patients (which are straightforward and easier to predict when ready for d/c), wouldn't help since it's predictable already. For severe traumatic brain injury patients (example DRGs: intracranial bleeds nonsurgical intervention, intracranial bleeds surgical intervention needed…) doesn't think it'd change management bc it's complicated.

RN/Clinical nurse education staff (Vibette Robles) -

- basically the pathways give you that sense of estimated time of d/c. When the patient stay exceeds the pathway # of days, then d/c time is estimated based on the to-do items that remain to be done (mostly problem-based)