
2024 VIZIENT CONNECTIONS SUMMIT
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Revolutionizing Care Transitions: How Strategic Partnerships Can Increase Capacity

Kelly Pigott, MSW, LCSW, ACM, Director of Ambulatory Care Coordination and Post-Acute Network, Population Health, Northwestern Medicine

Valmira Sylejmani, MHA, Manager Post-Acute Network, Population Health, Northwestern Medicine

Anna Blackburn, MSW, LCSW, ACM-SW, Manager of Post-Acute Network, Population Health, Northwestern Medicine

Joleen Lonigan, DNP, RN, NE-BC, FACHE, Associate Chief Nursing Officer & Executive Director, UC Davis Health

Eddie Eabisa, MBA, CSSGB, Manager, Transitions of Care, UC Davis Health

Vanessa McElroy, MSN, ACM-RN PHN,IQCI, Director, Care Transition Management, UC Davis Health

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Learning Objectives

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- **Describe** positive outcomes of utilizing the LTAC level of care to reduce length of stay and transition patients to the right level of care at the right time.

- **Discuss** strategies from a bed lease program to enhance patient care transitions and manage hospital capacity effectively.

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Background and Goal

- Our Academic Medical Center (Northwestern Memorial Hospital) encountered long length of stays, caused in part, by under utilization of LTAC placement and patients unnecessarily transferring from ICU to medicine units rather than discharging to LTAC.
- We identified an opportunity for optimization of service line specific post-discharge care pathways
- **Goal:**
  - Increase and optimize LTAC referrals and placements from target ICU and medicine units, reducing length of stay and excess days.
  - Early identification of LTAC appropriate patients to reduce insurance or clinical denials from LTAC, contributing to longer length of stay.
  - Improve the patient experience.

NMH LTAC Discharges from LTAC Pathway Pilots Sep 1, 2021- Mar 31, 2022			
Excess Days	**Discharges**	**Avg Excess Days per Patient**	**LOS O/E**
190.34	11	17.3	1.67

Strategy (Interventions)

A Two-Pronged Approach for Better Care

Process Model: Northwestern Medicine Hospitals

- Target 2 LTAC Groups (all locations within our post-acute network)
- Pathway: Direct Discharge from ICU to LTAC when possible
- Northwestern Memorial Hospital (NMH) Pilot Population: Medical ICUs + step down unit
- Central DuPage Hospital (CDH) Pilot Population: Medical ICU + step down unit

Physician Rounding– Strategic Plan

- Target 1 LTAC Partner
- Embed Northwestern Medicine (NM) physicians rounding on NM patients at LTAC Hospital to strengthen partnership, build trust with patients and physicians, and provide *better* care
- Population: pulmonary physicians

Critical Success Factors for Pathway: On-site dedicated clinical liaison, weekly huddle, prioritization of NM patients, weekend coverage/escalation path, direct access to LTAC physicians for enhanced communication.

Outcomes

Patient Impact:

- Successfully screened over 600 patients between May 2023-Nov 2023 at two pilot NM hospitals
- Earlier identification of medically stable patients for transfer to LTAC
- Increased identification of patients appropriate for LTAC
- Discharged 80 patients to LTAC level of care during the pilot phase

LOS:

- **Average LOS O/E at NMH decreased by 2.69 days** on all pilot units from prior year to pilot year.
- Proactive screenings prevented extended stays and identified opportunities for LTAC level of care.

Hospital Throughput:

- Increased bed capacity on ICU pilot units.

NMH LTAC Discharges from LTAC Pathway Pilots

	Excess Days	Discharges	Avg Excess Days per Patient	LOS O/E
Pre-Pilot (May-Nov 2022)	727.40	22	33.06	2.15
Pilot (May-Nov 2023)	324.33	30	10.81	1.33
Current State (Dec 2023-June 2024)	481.44	30	16.04	1.44

Lessons Learned

- The pathway reinforced the importance of NM Post-Acute Network support and LTAC partnerships.
- Collaboration with NM clinical teams was a key to success.
- Early identification of LTAC appropriate patients and earlier referrals led to an increase in placements and a decrease in denials to due insurance or clinical criteria.

Key Takeaways

- Increasing clinical teams' understanding of LTAC criteria was crucial in the LTAC pathway success.

- NM Physician presence in LTAC facilities provided coordinated continuity of care and an improved patient experience.

Background and Goal

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- Our hospital **faced significant bed shortages**, impacting patient care and leading to delays in discharges.
- In 2021, identified **3,436 avoidable days** directly related to delays in short-term SNF placements.
- These avoidable days resulted in annual **financial losses** ranging from $9-12 million.
- Complexity of patient cases often led to **SNF denials,** exacerbating the problem.
  - Underfunded | insurance auth delays | complex medical needs | etc.
- **Goal**: Optimize hospital capacity by reducing unnecessary SNF discharge delays.

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Interventions

- **Established** an agreement with a local SNF in January 2022, initially securing 15 beds and expanding to 24 by July 2022 and 30 by Jan 2024.
- **Developed** a real-time bed tracker to monitor SNF bed occupancy and forecast discharge dates, and conducted regular multidisciplinary meetings between SNF and hospital to resolve issues.
- **Appointed** a dedicated supervisor to review and approve bed lease placements and empowered discharge planners to escalate placement delays.
- **Capped** length of stay for leased beds at 40 days; after 40 days, patients transitioned to SNF's standard beds.
- **Integrated** MD/NP, UC Davis Health care coordinator, and clinical pharmacist within the SNF to ensure high-quality care and timely rehabilitation.

Outcomes

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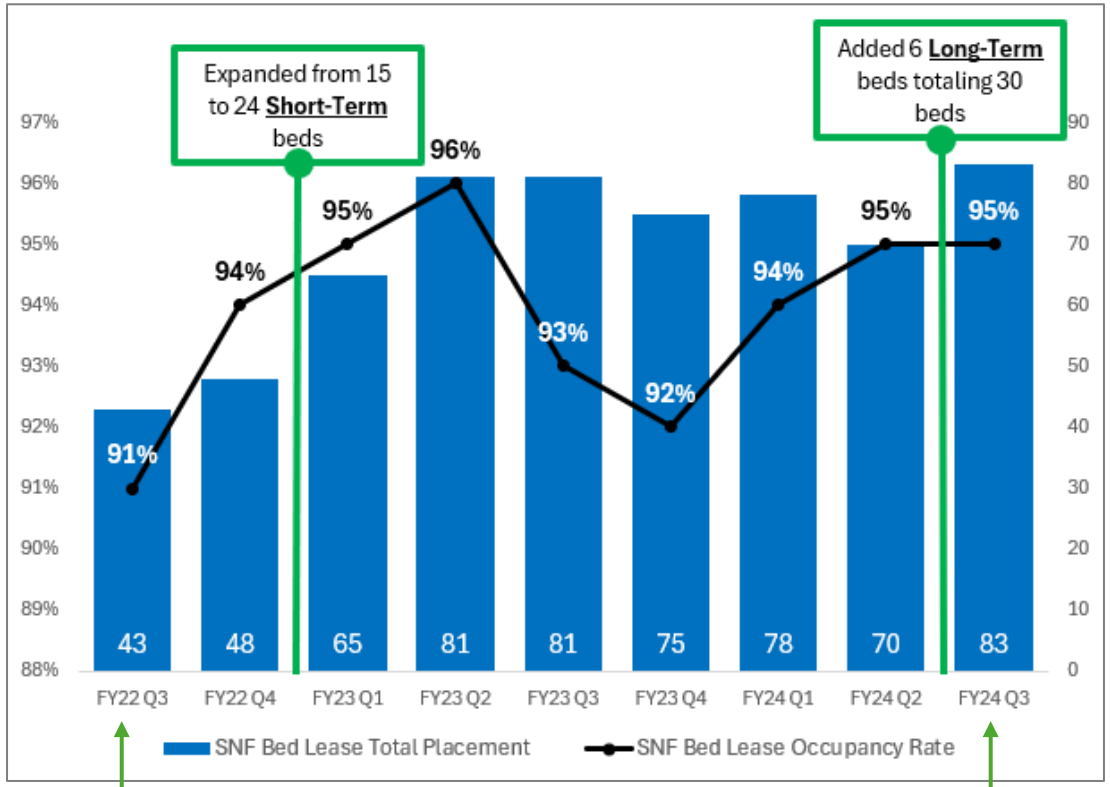
- **Patient Impact:** Successfully discharged over 778 patients between January 2022 and June 2024 (17,363 occupied days on leased beds)
- **Occupancy Rate:** Maintained a 94% bed day occupancy rate for the last three years, saving 5,400+ acute bed days (~7 days per patient).
- **Financial Success:** Achieved a positive contribution margin of about $1 million in FY23 after deducting the bed lease cost.
- **System Efficiency:** Mitigated financial strain on the healthcare system and streamlined transitions for challenging patient cases.
- **Enhanced Capacity:** The Bed Lease Program increased hospital capacity, reducing avoidable hospital days and improving throughput for higher acuity patients.
- **LOS Cap on SNF Bed Lease**: Proactive SNF discharge planning, prevent extended stays on leased beds as patients transition to SNF standard bed after 40-days
    - An average of 15-20 patients that are initially discharged through the bed lease are on the SNF's standard bed: Ave LOS: 252, [72, 655]



Source: Internal data tracker

Jan 2022

Mar 2024

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Lessons Learned

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- **Shared risk models** between healthcare organizations can support quality of care and patient transitions.
- **Development of cost-positive** programs to support transitions of care and reduce hospital length of stay.
- **Strong collaboration** and communication are crucial in shared workflows.
- Clear & Concise discussions with SNF leadership - **shared vision.**
- **Dedicated points of contact** and leadership from both organizations.

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Key Takeaways

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- **Effective Collaboration:** Strong hospital-SNF partnerships ensure seamless transitions and optimized care.
- **Proactive Planning:** Early identification and planning reduce avoidable bed days and improve capacity.
- **Dedicated Resources:** Empowered discharge planners and dedicated supervisors enhance efficiency.
- **Innovative Tools:** Real-time tracking and regular meetings maintain optimal SNF bed occupancy.
- **Embedded Clinical Support:** Integrating MD/NPs and care coordinators ensures high-quality, timely rehabilitation.
- **Positive Outcomes:** The program alleviates bed shortages, yields financial benefits, and improves patient satisfaction.

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Questions?

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Contact:

Kelly Pigott, Kepigott@nm.org

Val Sylejmani, Val.Sylejmani@nm.org

Anna Blackburn, Anna.blackburn@nm.org

Joleen Lonigan, jalonigan@ucdavis.edu

Vanessa McElroy, mcelroy@ucdavis.edu

Eddie Eabisa, eabisa@ucdavis.edu

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