



# Is Our DOS at “Risk?”

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# Defining the Opportunity for Improvement

- At times our DOS can be extended due to several discharge planning barriers, which if identified earlier can help us decrease our DOS.
- We were previously tracking discharge barriers but as we initiated our LMS board, the data proved that our Care Management team could move the needle on decreasing DOS by completing our first assessment within the first 24 hours.



# Defining the Opportunity for Improvement

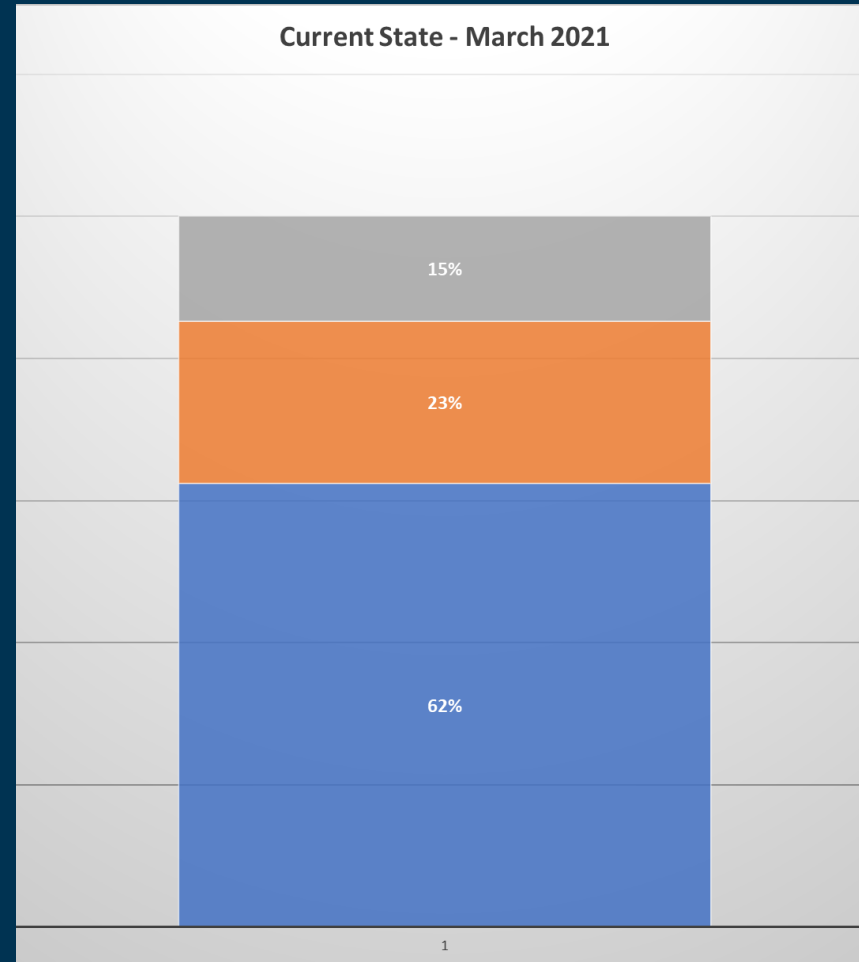
Why is this important?

- Early identification of previous services and new needs, such as preferred pharmacy, home health services, equipment needs, facility placement, and initiation of financial and social assistance can help expedite discharge.
- For example:
  - If the patient's insurance does not cover certain medications
  - Patient admitted without Home Oxygen and requires new setup at discharge



# Defining the Opportunity for Improvement

- We completed the current state analysis which showed only 62% of the first assessments were being completed within the first 24 hours of admission.
- Collected feedback from the team to determine the most common questions from the first assessment that would make the biggest impact.



# What Are We Trying To Accomplish?

- Design and implement a standardized process to complete the first assessment within 24 hours of admission in order to reduce DOS on med/tele units by January 1, 2022.
- The resulting decrease in DOS will increase throughput for the organization.



# What Changes Did We Make to Solve for the Problem?



We revised our first assessment (see right).

We developed a standard process throughout the entire Care Management team.

9/15/2020 visit with Joel A Turner, MD for Hospital Encounter

ON ADMISSION  
Facesheet

Risk / Interview

SDOH  
Family & Patient...  
Disch Planning

HOSPITAL STAY  
Care Teams  
Problem List  
Discharge Milest...

DISCHARGE  
Pharmacy  
Patient Instructions  
Appointments  
Follow-up Provid...  
Follow-up Misc  
Destination  
DME Coord  
Dial/Inf  
Home Care  
MyChart at GBM...

COORDINATED CARE  
Post Discharge...  
CC Enrollment  
CC Documentation  
CC Self-Manage...  
CC Discharge

AFTER VISIT SUMMARY  
After Visit Summ...

Risk / Interview

Time taken: 10/20/2021 1622 Responsible Create Note

Show Last Filed Value  Show Details  Show All Choices

### Readmission Risk Assessment

Age

2-Age 85 Plus 1-Age 65-84 0-Age less than 65

Patient Admitted From

Acute Rehab  Assisted Living  Chronic Hospital  Detention Center  Group home  Homeless  Independent Retireme...  
 Inpatient Hospice  Long Term Care  Other Hospital  Private Residence wit...  Private Residence wit...  Psychiatric Hospital  Senior Apartment  
 Skilled Nursing Facility  Substance Abuse Rehab  Other (Comment)

Does Patient have a PCP?  
Yes No

Does the patient have a preferred pharmacy on file?  
Yes No

Diagnosis of

10-CHF  10-COPD  10-End-Stage Renal Disease  7-Cancer - Active within last 12 months  7-Confirmed Stroke  
 4-Diabetes  5-Mental Health Issues w/Hospitaliza...  5-Drug/Alcohol Abuse in Past Year  None of the above

Social Barriers to Medical Adherence

5-Yes 0-No

Examples: Homelessness, Limited Caregiver Support, Lives Alone

Medical Barriers to Medical Adherence

5-Yes 0-No

Examples: Medical Non-compliance, Cognitive Deficits

Economic Barriers to Medical Adherence

5-Yes 0-No

Examples: Transportation Access Issues, Challenges Affording Medications, Lack of Insurance

High Risk Meds Prior to Admission

5-High Risk Meds equal or > 4 3-High Risk Meds 2-3 2-High Risk Meds 1 0-No High Risk Meds

High Risk Meds Include:  
Anticoagulants (Coumadin, Eliquis, Lovenox, Plavix, Xarelto, Aspirin in combination with previously listed meds)  
Entresto



# Who Are We Collaborating With?

- Our stakeholders include, but are not limited to:

EPIC Analyst

Nursing

Physicians

Post-acute Providers

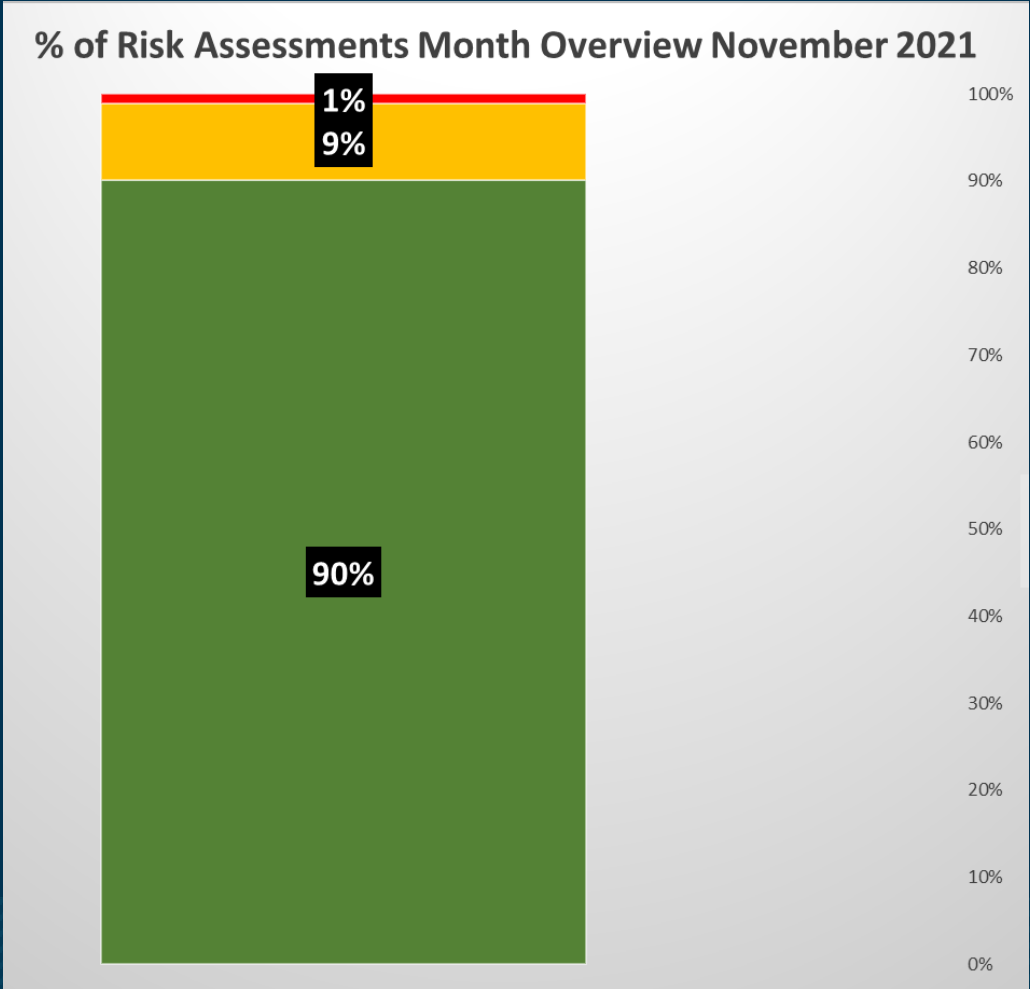
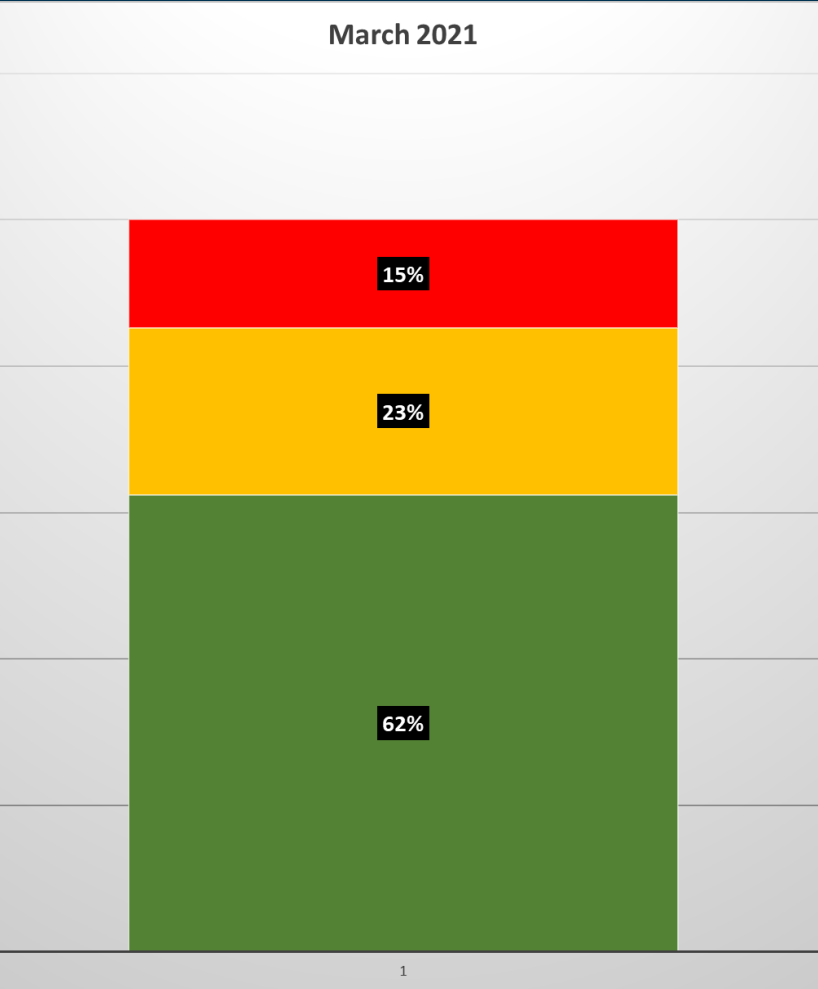
Transition Guides (through Johns Hopkins collaboration)





# Outcomes & Lessons Learned

## Before and After Data



# Outcomes & Lessons Learned

Baseline for DOS:  
3.02 days  
(median)

Our goal for DOS:  
2.92 days  
(median)

Currently YTD  
DOS:  
2.85 days  
(median)



- Input from the entire team on what changes to include in this project
- Updating and streamlining our first assessment allowed us to include pertinent information and knowledge surrounding patient's status pre-admission
- Learning LMS approach for future process re-designs within the department



## Next Steps

- Integrate this new standard work into Orientation of new employees (orientation manual, etc.)
- Develop future efficiencies by leveraging our EPIC system and utilizing the various roles within our team (Epic work queues, Care Coordinators, etc.)
- Expand improvement work from the first assessment to include the initial assessment as well.





**QUESTIONS?**

**COMMENTS?**