Discharging the Impossible: Proven Strategies to Safely Transition the Most Difficult Patients Through the Continuum of Care

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Who is Denver Health Medical Center?

Denver Health Vision:

“To be the healthiest community in the United States”
Who is Denver Health Medical Center?
(Cont’d)

525 Bed Safety Net Academic Hospital serving a diverse metropolitan population
Who is Denver Health Medical Center?
(Cont’d)

Level I Trauma Center for Adults

Level II Trauma Center for Pediatrics

911 for Denver County
Ambulatory Care Services

16 School Based Clinics

20 Community Health Clinics, FQHC's

17 Specialty Care Clinics

Outpatient Behavioral Health Clinic
Inpatient Services

Correctional Care Medical Facility

Acute Rehabilitation Unit

Inpatient Behavioral Health

Acute/Medical Eating Disorder Unit
Denver Health in the Community

- Denver Health Managed Care
- Denver Cares Detoxification Facility
- Regional Poison Control Center
- Denver County Public Health Department
Components of Complex Discharge Strategies

- Hospitalist Complex Discharge Team
- Executive Level Complex Discharge Committee
- Community Partnership with SNF Provider
- Post-Acute Care Coordinator
- Co-located unit that transitions patients with extreme discharge barriers
Hospitalist Complex Discharge Team
Who is Appropriate for Transfer to this Team?

- Legal issues
- Patient/family challenging behaviors
- Pay source issues
CRITERIA FOR REFERRAL

- Capacity has been determined and a guardianship letter has been written, if needed.
- Attempts have been made to locate family.
- Not expected to discharge within 5-7 days.
- Patient has had at least 3 next level of care denials.
- Recommendations discussed with patient/family.
HOW DOES IT WORK?

* WEEKLY ROUNDS

* ADDITIONAL SUPERVISION

* LCSW “DETECTIVE” WORK
Executive Level Complex Discharge Committee
<table>
<thead>
<tr>
<th>Position</th>
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<tr>
<td>Chief Nursing Officer</td>
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<td>Associate Chief Nursing Officer</td>
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<tr>
<td>Safety &amp; Chief Quality Officer</td>
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<tr>
<td>M.D. Hospitalist for Complex Discharge Team</td>
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<tr>
<td>Legal</td>
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<tr>
<td>Post Acute Care Coordinator</td>
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<tr>
<td>Director of Enrollment Services</td>
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<tr>
<td>PT Supervisor</td>
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<tr>
<td>Palliative Medicine Chief MD</td>
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<tr>
<td>Risk Management</td>
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<tr>
<td>M.D. Director of Behavioral Health</td>
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<tr>
<td>Director of Clinical Social Work/Care Management</td>
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Data Base with Categorized Barriers

Clinical Social Worker

RN Care Coordinator

Hospitalist Complex Discharge Team

Enrollment
Examples of Legal Barriers:

- Incomplete court documents required for guardianship
- Inability to expedite guardianship hearings
- Neuropsychiatric testing required by Adult Protective Services
- Patient/family refusal to sign documents to qualify for medical benefit
Examples of Financial Barriers:

- Placement in long-term care required for patients without insurance
- Lack of long-term acute care hospital beds for Medicaid patients
- Lack of skilled nursing facilities to transport patients to and from dialysis
- Time required to reinstate expired Medicaid benefits
- Delay at county level in processing Medicaid application for long-term care Length of application process for home and community-based services
Examples of Behavior Management Issues:

- History of sex offense or sexually inappropriate behavior to staff
- History of mental illness or alcohol/substance abuse
- History of incarceration for violent crimes
- History of assaultive or inappropriate behavior combined with need for dialysis chair
- Lack of secure long-term care beds for at-risk patients, including those with traumatic brain injury
Capacity for medical management at the next level of care:

- Complex wounds and associated wound care
- Complex staffing, transportation or equipment needs for morbidly obese patients and those requiring outpatient dialysis
- Ventilator dependence or complex tracheostomy care
- Prolonged intravenous antibiotic therapy for patients who do not qualify for long-term care
Interhospital and International Transfers:

- Lack of funding source for transportation of patients to city of residence or country of origin
- Refusal of referring facilities to accept patients back when they are stable for transfer
- Lack of documentation for patients who do not qualify for long-term care in the United States
Accelerating guardianship - Video Conferencing
SNF placement with community partners
Rural facilities - Teleconferencing
Specialized equipment provided
Consulate
Internal barriers/access
Relationships with outside stakeholders
Mean Length-Of-Stay For Adult Patients At Denver Health Medical Center, January 2007-August 2011

Complex Discharge Subcommittee started

**Source:** Authors’ analysis of Denver Health data. **Notes:** Includes inpatient and observation status patients who occupied a hospital bed. Excludes obstetrics patients and those whose length-of-stay exceeds 365 days.
Community Partnership with SNF Provider
Agreed to develop an integrated health care system
A) Care Coordination

• Establish single point of contact for each
• Development of a post-acute care committee
• Reduction of facility acquired conditions
• Development of SNF admission criteria for Denver Health patients
B) **Assessment of:**

- Feasibility and efficacy of Denver Health providers rounding
- Clinic access
- Call center use
C) Development of standardized transfer documents

D) Manage the care of patients assigned to the Denver Health Medicaid Choice program
E) Strategic Planning & Business Development

- Joint planning to improve access
- Quality improvement
- Partner in funding applications, grants
- Partner in creating ACO
- Development of joint ventures to address the discharge barriers encountered by patients.
F) Jointly develop other post-acute care continuum providers according to community need

G) Bed Lease agreement
Role Developed of Post-Acute Transitional Care Coordinator
The Role of the Post-Acute Transitional Care Coordinator

- Liaison and point of contact
- Oversees affiliation agreement
- Pro-active troubleshooting
- Key leadership for the development of the Co-Located Unit
Co-located Unit That Transitions Patients with Extreme Discharge Barriers

Joint Project
OASIS Transitional Unit Proposal

Co-locate OASIS (long stay) patients onto a closed unit; increasing patient FLOW and to assist in providing a daily program that includes:

- Life enrichment
- Meaningful engagement
- Training for Denver Health staff
- Creation of a therapeutic environment that assists patients towards a safe and appropriate transition to the community or skilled nursing level of care
Unit Leadership

- Nurse Manager
- Oasis Medical Director
- Post-Acute Care Coordinator
- Vivage Unit Coordinator

Development of clinical care guidelines
Patient Population

- Been at Denver Health for extensive & atypical period of time
- Have unique/challenging care or payer needs creating a delay
- Need programmatic focus to prepare them for community based long-term care placement
Denver Health:
- Nurses hired specifically for this unit
- DH Oasis Clinical Social Worker
- C.N.A’s

Vivage:
- Psychosocial Team Manager
- Activity Specialist
- Program Manager for Behavioral Health
- Psychosocial Assistant
### Goals

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<th>Increase patient flow from the ED</th>
<th>Improve patient satisfaction</th>
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<td>Improve workforce engagement</td>
<td>Work with the State on future plans/reimbursement for unit</td>
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<td>Financial Vitality &amp; Growth</td>
<td>Reduce length of stay for patients with barriers</td>
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Unit’s Success Metrics

- Decrease ED boarding
- Decrease average length of stay for long stay patients
- Increase in patients with a payer source
Successes

- Employee engagement
- Strengthened community relationships
- Quality of life for patients
- Other facilities are looking at our model

* A LOS for patients with complex discharge needs as of August 2014 = 94 Days

* A LOS for patients with complex discharge needs as of March 2015 = 79.7 Days
It is not the “Denver Health SNF”
Hospital staff think it is someone else's responsibility to handle difficult patients
Community sees this unit as a respite opportunity
Guard against “too much one-on-one care”
Thought we would need more staff than we actually did
(Assumption was: patients would display an increase in behavioral acuity)
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Questions?
References & Acknowledgments


- **Amanda Thompson, LCSW**
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- **Joe Gerardi, BSN, MHA**
  Associate Chief Nursing Officer Acute Care

- **Peg Burnett**
  Chief Financial Officer

- **Tami Kendall**
  Vivage Director of Behavioral Health Services