Red Plan, White Boards, Blue Huddles, & Clear Pathways: Synopsis of a Length of Stay Reduction Strategy

By Yisrael M. Safeek, MD, MBA, CPE, and Gina S. Padaco

In this article…

Discover several ways to reduce length of stay through coordinated processes and various techniques that promote teamwork and strong communication.

Today's lean economic times require lean strategies to drive hospital net incomes. One of the ways hospitals can stay healthy is by saving costs from cutbacks in resources consumed during the episode of care relative to the diagnosis-related group (DRG).

This is precisely why a length of stay (LOS) reduction strategy is important. Even though there are no additional revenues generated through LOS reductions, increases in the operating margin are realized through resource management and cost reductions. Savings yielded through cost containment are the primary reason why decreasing LOS has become a hospital priority.

Getting the most of LOS is at best a collaborative process of diligent care assessment, planning, and facilitation. The process involves advocacy for services to provide the most appropriate, cost-effective level of care based on the patient's needs. This process begins from the time of patient access, extends via throughput, and terminates when the complex discharge planner (CDP) places the patient at the most appropriate (lowest) level of care.

An auxiliary result of this function is to identify opportunities for cost reduction of services by utilizing hospital resources as efficiently as possible. Indeed, cutting length of stay requires a fully coordinated, concurrent, and robust process that encompasses various leverage points (Fig 1).

Priorities of transformation

Attempts to reduce hospital LOS require a coordinated, multipronged approach. Called a transformational care coordination process (TCCP), it aims for improved patient safety, increased staff collaboration, and reduction of waste.

Figure 1. Tools and Tactics of a Length of Stay Reduction Strategy

Leverage Point	Tactic
Utilization Management	**Whiteboards:** Determining initial patient status, performing concurrent stay reviews, managing denials.
Care Facilitation	**BLUE (Better Lean & Utilization Exchange) Huddles:** Coordinates care at each level across the continuum and avoids duplication of services.
Discharge Planning	**RED (Readiness Early Disposition) Plan:** Promotes patient clinical and emotional readiness for progression to appropriate level of care.
Clinical Integration	**Clear Pathways:** Care pathways are communicated with the physician and care team to ensure services are provided at the right time and at the right level of care.

Figure 2. Example of a Whiteboard

Rm	Pt	Doctor	Admit Dx	Safety Risks	Barriers to DC	Audit (A/D)	Pendinglab tests	DRG days	Est. DC
306	Smith, Y	Jones, X	HTN	Falls	homecare	Accept	K, Na	3	Today, PM
307	Evans, T	Jones, X	Diabetes	Skin ulcers	oxygen	Deny-reason	EKG	5	10/31

TCCP means having the right people, in the right place, doing the right things, in the right order, at the right time, and with the right outcomes. It involves leveraging various tools to track and trend various metrics (LOS per DRG, LOS per physician, and one and two days inpatient vs. observation status stays).

The TCCP consists of four overlapping components all aimed at providing effective and efficient patient care. It uses utilization management, care facilitation, discharge planning, and clinical integration to effectively manage costs, and optimize patient care services.

By virtue of providing a common framework that standardizes the continuum of care, the process also reduces LOS.

Utilization management (UM)

This aspect of the care coordination process centers on determining initial patient status (observation versus inpatient care), and involves the CDP making proactive decisions in three key areas to reduce LOS.

These are appropriateness, medical need, and efficiency of services based upon the right patient, the right bed, and the right time. The right patient refers to the patient who actually needs an acute medical bed. The right bed refers to the acute care setting that can best accommodate the condition (critical care, respite beds, rehab beds). The right time refers to avoiding delays in care, treatment, and services.

UM also focuses on reviewing if the patient meets medical necessity, and managing any denials. Medical necessity involves managing patient cases efficiently and cost-effectively before and during care administration by capturing objective and quantifiable patient information.

This information is used to devise strategies to drive down LOS, improve patient flow within the acute care setting, and obtain pre-certification. Managing denials includes any clinical case appeals introduced by the provider, payer, or patient.

Getting the most out of UM requires a consistent, standardized approach like a whiteboard. Whiteboards are interactive, dry-erase boards, which are strategically placed at the nurses' stations. They allow documentation of initial patient status, updates of concurrent stay, inherent safety risks, and barriers to attaining the DRG (Fig 2).

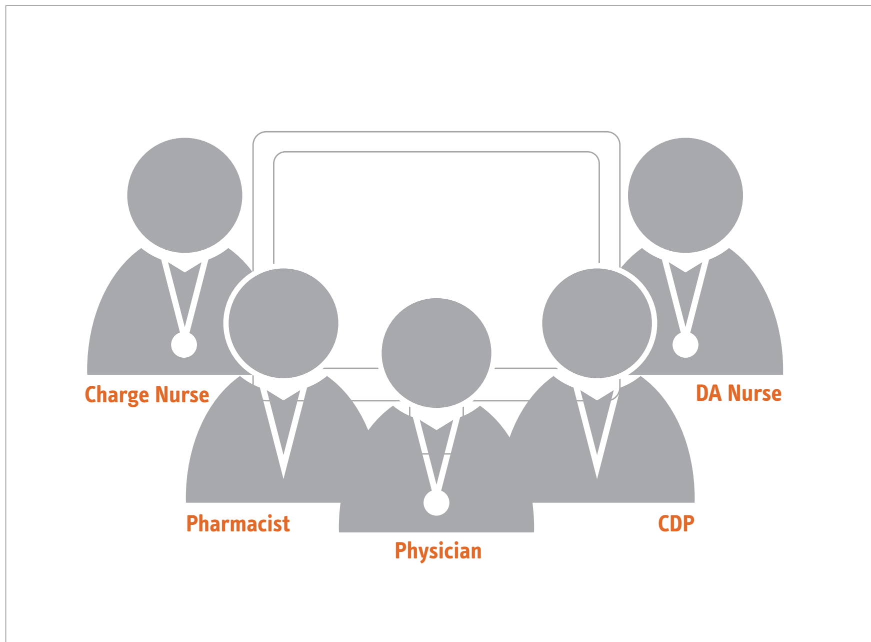
By facilitating improved communication between the medical, nursing, and care management staffs, the whiteboard serves as a dynamic summary of care. It is updated by care staff as patient status, care plans, and treatment options change.

For effective UM, the whiteboard is especially useful for focusing the attention on potential barriers to meeting the DRG. Delays of care, treatment and therapy are identified by the care team and documented on the board by assigned staff.

For example, if the hurdle to discharge is failure to wean the patient from oxygen, the CDP takes ownership of the process, tracks and communicates pending blood gases to the physician. Safety risks scores like the Morse Scale for falls and the Braden Scale for skin breakdown can also be documented on the whiteboard for discussion.

Another UM function of the whiteboard is management of payer denials that prevent the hospital from receiving the appropriate reimbursements for services offered. Through a streamlined process, the CDP care managers can identify, quantify, and sort denials by carrier, provider, location, current procedural terminology code, date of service, type of denial, or any other reportable field. Denials

Figure 3. Example of a BLUE Huddle



are appealed when appropriate, and progress in the revenue recovery process is tracked on the whiteboard. LOS is adjusted accordingly.

A rarely utilized technique to decrease LOS is to convert from afternoon admissions and morning discharges (PM/AM) to morning admissions and evening discharges (AM/PM). This tradition of afternoon admissions and morning discharges has its roots in the hotel industry, and leads to filled beds at night.

By doing the switch, hospitals would have more available beds overnight. The whiteboard is an excellent tool to track for morning admissions and evening discharges by identifying patients no longer requiring acute care beds in a timelier manner.

Care facilitation

This area can be exploited to rein in high LOS by utilizing clearly defined roles for everyone on the care team. Care teams that include discharge advocate (DA) nurses, CDP care managers, physicians, pharmacists, therapists, as well as other health care professionals can provide individual care, education and efficient discharge planning.

Furthermore, care coordinated by multidisciplinary teams through special rounding known as BLUE (better lean & utilization exchange) huddles have been shown to improve patient outcomes (Fig 3).

Through daily reports, these BLUE huddles are a patient-driven approach for improving clinical engagement and the patient experience. These informal 10-15 minute meetings, ideally in front of the whiteboard, can facilitate better management of patient care. BLUE huddles highlight hot issues and hurdles to discharge, increase staff awareness of urgent conditions, and identify avoidable days.

Much of the evidence supporting the role of BLUE huddles in reducing LOS concentrates on the role of effective and timely communication. BLUE huddles close the information gap by allowing interaction between DA nurse, physicians, resource coordinators, clinical documentation specialists, and CDP.

Permitting everyone on the multidisciplinary team to participate leads to better understanding of the plan of care and management of the patient. Collaboration between the various sectors also leads to effective throughput and the ability to shorten LOS.

BLUE huddles can also serve as an excellent time for handoffs between shifts, and ensure services are provided at the right time, thus preventing delays and avoidable days. The huddles assure care is offered at the right level across the continuum, prevent duplication of services, and assign services that could be performed on an outpatient basis. For example, inpatient PET scans can be rescheduled as outpatient. This would shorten LOS.

BLUE huddles also help to facilitate decreased LOS by empowering staff to take ownership of care plans. They minimize stalled care plans by facilitating collaboration and contributing to a heightened awareness of the care trajectory, which drives the care plan forward in the continuum of care.

Through daily review of patient status, the health care team can monitor the progress of every patient, every shift, and ensure that care is at the appropriate juncture, and tests are timely. By this fact alone, BLUE huddles help to identify delays in treatment, and impediments to throughput.

Clinical integration

At the heart of any successful effort to reduce LOS are clear and streamlined interventional care pathways. Clinical pathways are adapted from engineering where they are used to increase efficiency and provide timelines for job completion.

Evidence suggests that critical pathways and standard order sets improve quality of care by decreasing variation. Clear evidence-based guidelines shrink LOS as well. They do so by supporting clinical

management, resource management, clinical audit, and financial management. When physicians adhere to unambiguous care pathways, services are provided to the patient at the right time and at the right level of care.

Integrated clinical pathways also decrease LOS by improving the continuity and co-ordination of care across different clinical disciplines and sectors. Care pathways provide a roadmap for each stage in the management of a patient's condition over the continuum of care (diagnosis, interventions, and therapy).

In fact, each specific pathway offers a timeline, the categories of care, the needed interventions, and outcomes details. While acknowledging that clinical judgment overrides any pathway, tracking variations in care timelines through a computerized scorecard can highlight physicians with the longest LOS.

High LOS data can also help the care team optimize resources to get the most effective clinical integration. Benchmarked against data from care pathways, a targeted approach can be formulated that focuses on decreasing variation and increasing adherence to pathways. Through consensus, unbiased communication, a focus on teamwork and care planning, constructive discussions to shorten LOS can happen.

Figure 4. Example of Clear, Care Pathway for Community-Acquired Pneumonia

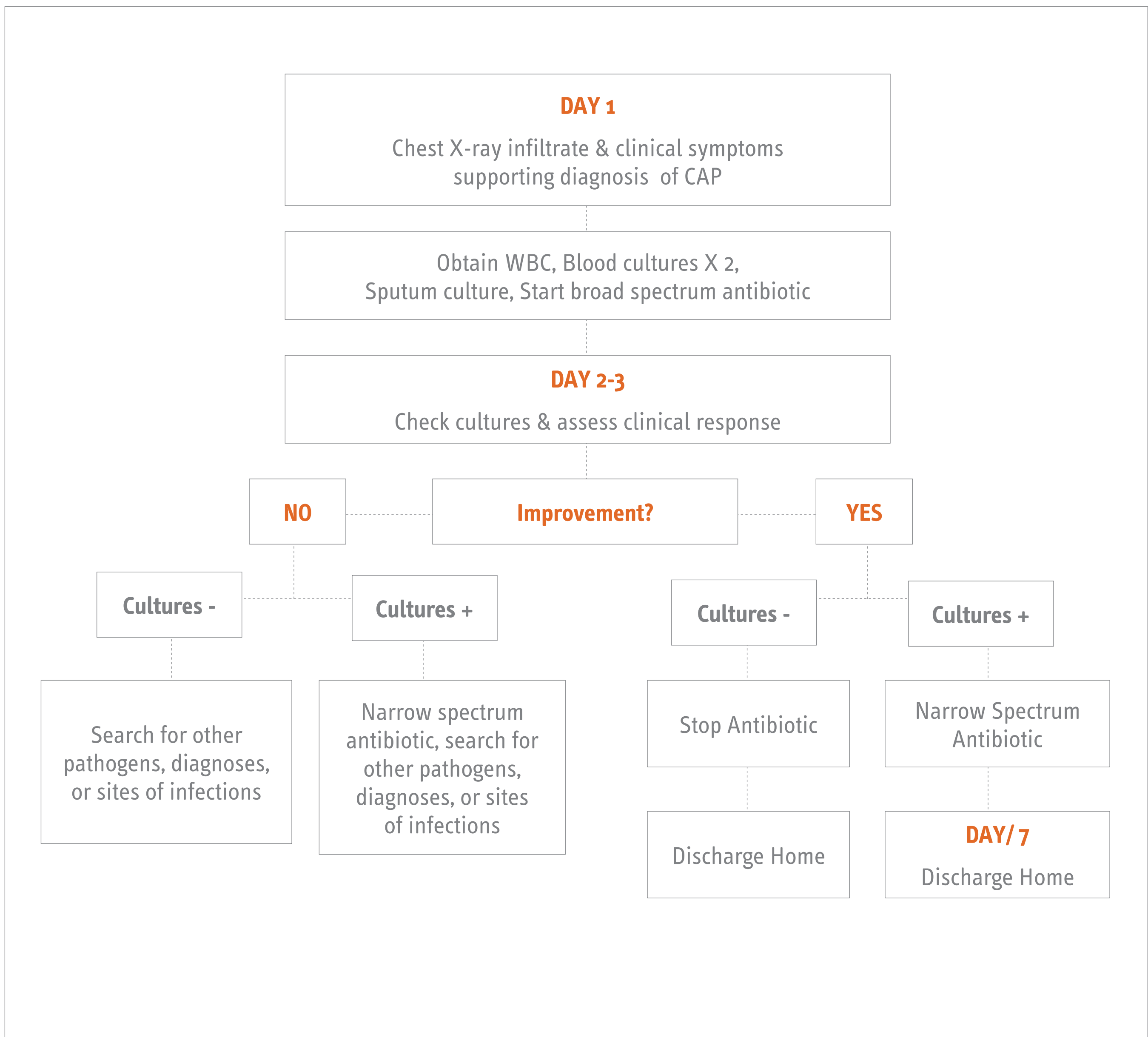


Figure 5: Example of a RED Plan

RED Plan							
Inpatient							
Name:			Age:		Date/time:		
Medical, Surgical, Mixed							
Main Diagnosis:							
Abnormal Labs:							
Treatment(s) Received:							
Discharge to:	Home	Nursing Home	Skilled Nursing	Rehab	LTAC	Assisted Living	Other
DME Need:		Transportation Arrangement (Y/N)					
Medications (list):							
Name	Dose	Route					
Main side effects:							
Follow-up							
Physician/Clinic	Date/time:						
Discharge Call w/i 72 hrs.)							
DA nurse signature							

Physician In Management

2010 Live Seminar – November 14–18, 2010 – Westin La Paloma, Tucson, Arizona

Opening the Doors of Possibility

For more than 30 years the Physician in Management Seminar (PIM) has opened new doors of possibility and perspective for physicians choosing to pursue management and leadership training and education. The PIM course teaches the key principles and concepts necessary to understand the disciplines required in managing and leading at all levels and organizations within health care.

Choose the full course or take individual modules

- **Finance in Health Care Organizations** (full-day)
  Hugh W. Long, MBA, PhD, JD
- **Marketing and Strategic Planning** (full-day)
  Eric Berkowitz, PhD
- **Increasing your Influence** (full-day)
  Charles E. Dwyer, PhD
- **Management Skills** (half-day)
  Michael B. Guthrie MD, MBA, FACPE
- **Valuable Communication Skills** (half-day)
  Timothy Keogh, PhD
- **Powerful Negotiation Skills** (full-day)
  Linda Babcock, PhD

Earn credit toward your Master of Medical Management or Online MBA degree—Each PIM module is approved for credit in ACPE's graduate degree programs. For more info on the degree program go to ACPE.org/Degrees.

Order the Physician in Management program at ACPE.org/PIM or call ACPE at

800-562-8088
813-287-2000 (outside US)

Can't make it to Tucson?

Complete this course from the comfort of your home on **InterAct** Distance Education

www.acpe.org/interact

American College of Physician Executives

Figure 6. Example of Avoidable Days Tally

Tool Involved	UNIT	CDP/DA Nurse/ Caregiver	CIRCUMTANCES • Failure to Anticipate • Failure to Activate • Failure to Communicate
Utilization Management			
Care Facilitation			
Discharge Planning			
Clinical Integration			

Discharge planning

When discharge planning is fragmented and haphazard, it increases the time that the patient spends in the hospital. Discharge planning to reduce LOS requires an individualized, written discharge plan to anticipate patient discharge placement needs as soon as possible after admission.

The RED (readiness early disposition) plan (Fig 5) is such a tool that can help identify and resolve discharge delays, as well as assist in directing current management of the patient. The RED plan alerts the DA nurse to interact with front line staff as they seek to expedite the discharge process.

The RED plan requires ongoing collaboration and communication in alliance with the patient's physician, nurse, and ancillary services (durable medical equipment, transportation to and from outpatient hemodialysis etc).

It facilitates ownership of the discharge process to the DA nurse who coordinates disposition planning, patient education, medication reconciliation, and physician follow-up with other members of the care team (CDP, nurse, pharmacists, therapists, and physicians).

It is documented in a patient-centered, low-literacy format that includes information about the patient's condition, laboratory studies, treatments received, medications, and contact information follow-up appointments. Further, patients are grouped according to conditions (elderly medical patients, surgical patients, mix of conditions) in order to promote safe discharge.

The RED plan increases the care team's awareness of the patient's status on the continuum of care from day one. It also allows tracking and identification if the patient no longer requires an acute care bed, so timely discharge could be anticipated. By requiring alternate settings of care, consideration is given to the patient's behavioral (psycho/social/emotional) health.

The plan allows the DA nurse to coordinate and prepare the patient both clinically and emotionally for transition to an appropriate level of care. For example, it ensures pre-surgical planning to decide on transfer to a new lifestyle at a rehab, skilled nursing facility, or home care.

In order to empower patients, the RED plan is printed in duplicate and a copy is explained and distributed to the patient/family by the DA nurse. The DA nurse does a scripted telephone call within 72 hours after discharge inquiring about clinical condition, prescription use, adverse drug reactions, and possible complications.

Monitoring and managing

After these RED plans, whiteboards, BLUE huddles, and clear pathways are implemented, LOS should be monitored and measured to detect surfacing problems early.

Monitoring involves weekly LOS reports that should be distributed and displayed on each units' whiteboard. By doing so, it can influence and drive discussion of important aspects of care by the DA nurse, physicians, resource coordinators, clinical documentation specialists, and CDP during the huddles.

Following successful implementation of the strategy, all units LOS should be reviewed from a systems perspective using the "avoidable days tally." It should be performed as part of a root cause analysis to identify factors contributing to poor performance.

The review must focus on any of the causes ("failure to anticipate," "failure to activate," and "failure to communicate") that led to delayed, missed, or inappropriate discharges (Fig 6).

Examples of "failure to anticipate" would include failure by the CDP or DA nurse to engage the whiteboards, participate in the BLUE huddles, or complete the RED plan. It would also include caregivers who fail to apply clear pathways when those pathways exist.

Examples of "failure to activate" would involve system delays, discharge planning impediments, and lack of utilization of the tools.

Examples of "failure to communicate" would include lack of effective use of the tools to enhance throughput over the continuum. For LOS reduction to be sustainable, areas of noncompliance should be identified, rectified, and tracked as performance reports. Only then, the goal of zero avoidable days would become a reality.

Yisrael Safeek, MD, MBA, CPE, is president & CEO, Integrity Physician Solutions. He is also a Joint Commission surveyor and is appointed to the Board of Examiners for the Malcolm Baldrige National Quality Program.

ysafeek@mdintegrity.com

Gina S. Padaco, is a consultant to Integrity Physician Solutions.

gpadaco@mdintegrity.com"

Bibliography

1. Coffey RJ, Richards JS, Remmert CS, LeRoy SS, Schoville RR, Baldwin PJ. An introduction to critical paths. *Qual Manag Health Care* 1(1):45–54, FAll 1992.
2. Shukla RK, O'Hallaron RD. AM admissions/PM discharges can reduce length of stay. *Hospital & Health Services Administration*. 31(4):74-81, Jul-Aug 1986.
3. Heywood JT, Saltsberg MT, Strategies to reduce length of stay and costs associated with decompensated heart failure, *Congestive Heart Failure* Reports, 2 (3): 140-7, Sept 2005

"My classmates helped me understand the peculiar economics of healthcare and how they affect my patients' care."

Yale has created an MBA program that brings experienced professionals from all spheres of the industry into the classroom. On alternate weekends, students work closely with top business and clinical faculty, learning management and leadership skills and gaining valuable new perspectives to innovate and influence change in their workplaces and the world.

Learn what others already have.
www.mba.yale.edu/mba-e

Yale SCHOOL OF MANAGEMENT
MBA for Executives: Leadership in Healthcare

Natalie, MD
Class of 2010