A New Look at Length of Stay: Substantial Benefits Emerge through Focus on Care Transitions

By Brian K. Pisarsky, RN, ACM, Senior Vice President of Kaufman, Hall & Associates, LLC and Tina M. Pike, M.S.N., HCM, RN, Vice President of Kaufman, Hall & Associates, LLC

Proactive hospital leaders are hard at work redesigning and implementing processes and systems to ensure the right care is delivered, in the right setting, at the right time, with the right workforce—every time, for every patient.

Length-of-stay (LOS) reduction is an initial and important component of operational transformation work that focuses on sustainable change and overall redesign. A leadership focus on LOS-related issues arising during care transitions can shed light on improvement opportunities for enhanced patient experience, satisfaction, and safety; greater efficiency; and real savings from both reduced excess patient days in the acute care setting and better throughput across the continuum of care.

The article begins with the description of a leading assessment process that identifies improvement opportunities at a high level. This is followed by practical recommendations to achieve LOS-related operating and financial benefits as the patient enters, receives, and exits acute care, and as foundational work occurs across these interconnected stages. Recommendations stem from initiatives that currently are taking place in many hospitals and health systems nationwide.

**Assessment**

Assessment of an organization’s care management model provides the starting point for identification of LOS improvement opportunities—particularly, how people, processes, and technology currently are involved in every step of a patient’s care coordination throughout the care continuum.

These elements should work synergistically to coordinate the patient care journey effectively from portal of entry through discharge to the appropriate level of care. A high-level comparison of a hospital’s current performance with leading practices in hospitals around the country enables identification of promising improvement opportunities in each domain.

Figure 1 illustrates people, process, and technology improvement opportunities compared to leading practice. Items in red indicate the components with the greatest opportunity to achieve an efficient care management process—i.e., those items furthest from leading practice.
Care Transitions

The patient’s overall acute care experience includes transitions at the following points: entry into the system of care through one of the portals of entry; initiation of, and changes within, acute care provision; and discharge to home with appropriate services or to other post-acute settings. An organization’s denial prevention and management function works across these three phases to ensure continuity of care and payment for that care (Figure 2).

Recommendations to achieve LOS-related, denial prevention, and operating and financial benefits at each phase follow.

FIGURE 2. PHASES OF CARE TRANSITIONS
Source: Kaufman, Hall & Associates, LLC.
Portals of Entry Recommendations

1. Develop a patient flow process that encompasses all portals of entry (ED, surgery, direct admit, transfer, or other), including the role of the command center or bed control. This is a crucial first step of the care redesign process. To reduce unnecessary acute care days, staff must manage the patient appropriately, assuring the right status and prompt initiation of discharge planning wherever and however the patient encounters a point of entry.

2. Develop a process for multidisciplinary communication at least every three hours in the Emergency Department (ED) between nursing, physicians, and case managers to discuss accurate patient status assignment and appropriate, timely discharge intervention. The patient's status assignment and discharge readiness must be communicated to, and understood by, the command center, physicians, nursing staff, and ancillary providers.

3. Ensure thorough evaluation and mapping of precertification processes and requirements. Requirements must be documented and clear to all relevant staff—most importantly, the staff members who are placing the precertification call(s) to the insurer to obtain authorization for admission and surgery, as appropriate.

4. Collaborate with the Finance team to implement necessary process changes. Frequent communication with the central or hospital business office can signal where and when problems such as insurance denials are occurring, thereby spurring process improvements around preventing these denials in the future.

Expected results, all of which reduce LOS and prevent denials, include seamless patient admission and accurate patient status assignment; appropriate management of patients from all portals of entry, whether the ED, surgery department, direct admits from a physician's office, transfers from other facilities, or others; and system-wide understanding of precertification requirements and the ramifications of noncompliance. Additionally, consistent identification and implementation of needed changes, denial prevention, and the early identification and resolution of any payer eligibility issues and gaps in coverage set the stage for the next phase of the redesign process.

Acute Care/Post-Acute Management Recommendations

1. Establish “long-LOS or high-risk LOS” meetings. For patients at risk for an extended stay either in inpatient care or outpatient observation, these meetings include the following people: the physician advisor; hospitalist leadership; utilization managers; case managers; social workers; ancillary staff; nursing staff; and business office/revenue cycle leadership. The goal of these meetings is to ensure the patient’s timely progression through the acute stay and the execution of an appropriate, well-timed discharge plan.

2. Implement multidisciplinary rounds (MDRs), with a focus on interdisciplinary collaboration for all patients on all units. Daily MDRs with participation from the entire team improve collaboration among disciplines, resulting in increased patient throughput and earlier discharge times. This is key in decanting the emergency room, assuring optimal surgical flow, and placing the right patient in the right location at the right time. Many organizations include only nursing and physicians in rounds, but a truly multidisciplinary team meeting for a few minutes each day for each patient, with a set agenda and staff scripts, is much more effective.

3. Consistently apply criteria to all continued-stay patients, focusing on medical necessity and discharge planning criteria. Staff must apply evidence-based criteria correctly on admission and throughout the continued stay.

4. Track, trend, report, and take action on avoidable days to improve processes. Among other reasons, many avoidable days and/or delays can be the result of patient admissions on a Friday, with lack of available testing or ancillary services at the facility on the weekend. Additionally, bottlenecks frequently occur when discharge times coincide with admissions times. Figure 3 illustrates the occurrence of this issue between 1 p.m. and 7 p.m. at an example hospital. Care managers can minimize bottlenecks through collaborating with post-acute sites. For example,
nursing homes can be encouraged to admit patients earlier in the day (at 10 a.m.) rather than after 2:00 p.m. In addition, an inclusive family-centered approach facilitates the development of discharge plans with the patient’s family—for example, arranging pick-up of the patient up at a specific, agreed-upon time earlier in the day.

**FIGURE 3. SAMPLE ADMISSIONS AND DISCHARGE BY HOUR OF DAY**

*Source: Kaufman, Hall & Associates, LLC.*

Expected results also include improved safety and patient satisfaction, a comprehensive approach to discharge planning by all members of the care team, and better alignment of the organization’s average LOS to the Medicare geometric mean LOS (GMLOS). The proactive identification and resolution of throughput barriers prior to expected or anticipated date of discharge facilitate progress toward best-practice performance in all care management processes. The use of accurate and reliable software systems helps to drive throughput, reporting, trending, productivity, and the efficient use of resources.

**Utilization Review and Denial Management/Prevention Recommendations**

1. **Consider centralized utilization review and denial management/prevention.** These two functions support patient flow throughout an organization. The quality of their management also can make a critical difference in length of stay.

To address an increase in denials and multiple issues with payers, consider implementing centralized or “offsite” utilization review and denial management/prevention. Maintaining a common process with a common EMR across hospitals in a system eliminates the need for each hospital’s UR staff to keep abreast of CMS and other payer rules, and allows early identification of payer variation and fluctuations. Additional benefits of centralization include the ability for facility-to-facility comparisons, a common connection with the business office to provide one source of information for all hospitals, and consolidated reporting.

However, an integrated communication plan is vital to the success of a centralized process, as are defined roles and responsibilities. For example, the communication plan should identify the individual(s) who speak(s) to the patient’s physician, the patient, and the insurer’s physician or hospitalist when the treating doctor believes the patient needs one more day or when the payer denies additional days. The process should also identify

the escalation/governance processes to resolve these differences. Use of video with the offsite UR team, care management team, physician, and patient can be helpful to enhance communication.

2. Use denial information to identify and execute needed improvements across the portals of entry, acute care, and post-acute stages. Most denials reveal improvement opportunities. For example, if an insurer denies a patient claim following treatment, the insurer’s determination or a root cause analysis by the organization may point to a suboptimal pre-certification process or issues with pre-admission testing authorization.

What Benefits Are Achievable?

Length-of-stay reductions from improvement in care transitions produce impressive results.

Figure 4 provides a look at the benefits an example organization may be able to achieve with low (25%), medium (40%), or high (55%) targets for percent improvement. The “excess day opportunity” is calculated by subtracting the number of inpatient days an organization expected in a fiscal year based on the Medicare GMLOS (in this case 80,000 expected days) from the observed or actual number of inpatient days (126,000 days) in that same fiscal year. Thus the example organization has an “excess day opportunity” of 46,000 inpatient days (126,000 - 80,000 = 46,000 days).

The numbers in Figure 4 represent significant cost-reduction and revenue-improvement progress, even at the lower end of improvement achievement. In our experience, organizations with leading care management practices in place typically can achieve 35-40 percent reduction of excess days through targeted and facility-specific interventions.

**FIGURE 4. EXAMPLE IMPROVEMENT OPPORTUNITY FROM LOS REDUCTION**

*Source: Kaufman, Hall & Associates, LLC.*

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
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<tbody>
<tr>
<td>Percent improvement</td>
<td>25%</td>
<td>40%</td>
<td>55%</td>
</tr>
<tr>
<td>Excess day opportunity (total: 46,000 excess days)</td>
<td>11,500</td>
<td>18,400</td>
<td>25,300</td>
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<tr>
<td>Potential additional bed capacity per day (excess days/365)</td>
<td>32</td>
<td>50</td>
<td>69</td>
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<td>Cost of an additional day ($500 cost reduction per day x excess day opportunity)</td>
<td>$5,750,000</td>
<td>$9,200,000</td>
<td>$12,650,000</td>
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A collaborative approach and best-practice processes ensure that the patient gets the right care, in the right setting, at the right time—every time. Effective care transitions not only improve patient safety and experience, but reduce length of stay with the benefits quantified here. Is your organization ready to pursue these gains?

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