Redefining Care of the Seriously Ill in a Hospital Setting

Long Island Jewish Forest Hills

Topic: Strategic Quality Improvement

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Objectives

- Align the plan of care with the goals and wishes of seriously-ill patients.
- Improve the experience of patients with advancing chronic illnesses throughout the full spectrum of care
- Identify/risk-stratify patients with advancing chronic illnesses.
- Right-size ICU Utilization.
- Use an interdisciplinary approach to discharge planning.
- Close the communication loop by involving community providers.

Background

Long Island Jewish Forest Hills (LIJFH), a 235 bed community hospital in Queens, NY, serves an aging population facing advancing chronic illnesses for which traditional medical interventions are insufficient to meet their complex needs. In response, the LIJFH critical care and palliative care teams developed the Special Care Unit (SCU) under an existing Advanced Illness Management Program in 2015. The aim of the Special Care Unit is to provide a setting for patients who do not require intensive care, yet need care too specialized for medical/surgical units. The SCU team strives to align patients' wishes with the medical plan of care through ongoing goals of care discussions, psychosocial support, and continued medical care.

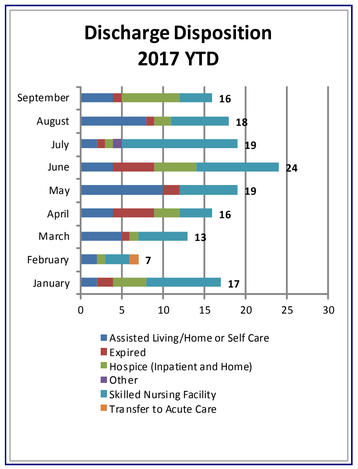
Patient Identification and Admission

SCU candidates are identified through a screening tool used by the ICU and ER teams when evaluating critically-ill and complex respiratory patients. The use of screening tool risk-stratifies patients based on advanced illness criteria consisting of readmissions, co-morbidities, functional status, emergency room utilization, and more. To qualify for SCU admission, patients must both meet these criteria and require a higher level of care for complex medical issues, as determined by the ICU team. Initially reserved for select ICU patients, the SCU, also accepts patients from the ER and medical/surgical floors.

Elevated Level of Care

The SCU has a 1:6 NP-patient ratio and a 1:5 nurse-patient ratio. Patients and families receive ongoing education, comprehensive, personalized care, and complex symptom management, including curative and palliative measures. The SCU provides ongoing psychosocial support including visits from respiratory therapy, physical therapy, registered dieticians, wound care specialists, chaplaincy, social work, and when necessary, medical ethicists. Patients have the benefit of being under the care of the ICU team in close partnership with the palliative care team.

In the SCU, communication is the foundation of comprehensive and collaborative care. Patients are given the time to comprehend their diagnosis through compassionate and thorough discussions with all team members. Disease-specific education, palliative care and symptom management, as well as goals of care discussions are all provided by the medical team and ELNEC trained nurses. The goal is for patients and caregivers to be able to make informed healthcare decisions necessary to achieve the best quality of life.



Transitions of Care

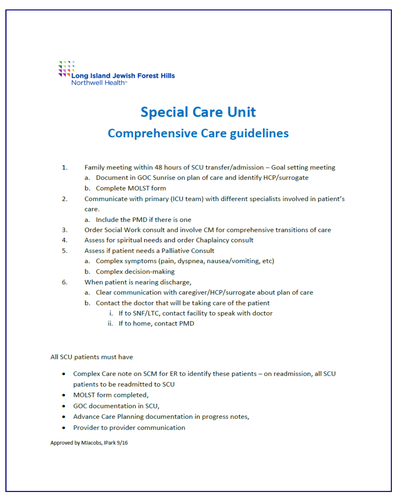
Planning for transitions of care is vital to achieving the best possible outcomes for seriously ill patients. Utilizing comprehensive care guidelines, the SCU team initiates conversations with the patient and their family to establish personal health goals and plans for the future, and align these with appropriate treatment and discharge disposition. The team coordinates for post-discharge resources such as house call programs, home-care programs, and the advanced illness program. Should patients require skilled nursing facilities, the SCU team ensures a good handoff via provider-to-provider communication.
Upon discharge, a note is placed in the ER electronic medical record to flag every SCU patient. If the patient is readmitted, the note will alert the ER that the patient should be assigned to the ICU team for admission back to the SCU for continuity of care.

Summary

The success of the SCU model is evidenced by improved ICU metrics, including length of stay, an increased number of patients being discharged home, and an increase in palliative and hospice referrals. Additionally, from 2015-2017, there has been a cost savings of more than $400,000 by avoiding unnecessary ICU utilization. The development of the Special Care Unit afforded a unique care environment for patients who ordinarily would have gone to or remained in the ICU. The SCU provides patients with advancing chronic illness an elevated level of care designed to meet their complex needs in a cost effective and supportive environment.

Next Steps:

- Strengthen education and SCU referral process for ED
- Expand ELNEC training to all nurses
- Modify data collection to demonstrate more meaningful metrics as to how the SCU is changing care delivery for the hospital.
- Expand the SCU capacity with more resources (nursing, nurse practitioners)



Long Island Jewish Forest Hills
Northwell Health℠

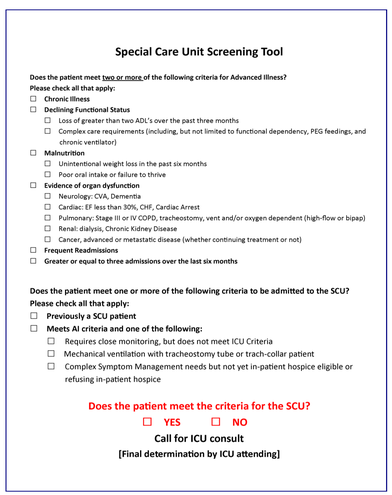
Special Care Unit
Comprehensive Care guidelines

1. Family meeting within 48 hours of SCU transfer/admission – Goal setting meeting
   a. Document in GOC Sunrise on plan of care and identify HCP/surrogate
   b. Complete MOLST form
2. Communicate with primary (ICU team) with different specialists involved in patient's care.
   a. Include the PMD if there is one
3. Order Social Work consult and involve CM for comprehensive transitions of care
4. Assess for spiritual needs and order Chaplaincy consult
5. Assess if patient needs a Palliative Consult
   a. Complex symptoms (pain, dyspnea, nausea/vomiting, etc)
   b. Complex decision-making
6. When patient is nearing discharge,
   a. Clear communication with caregiver/HCP/surrogate about plan of care
   b. Contact the doctor that will be taking care of the patient
      i. If to SNF/LTC, contact facility to speak with doctor
      ii. If to home, contact PMD

All SCU patients must have

- Complex Care note on SCM for ER to identify these patients – on readmission, all SCU patients to be readmitted to SCU
- MOLST form completed,
- GOC documentation in SCU,
- Advance Care Planning documentation in progress notes,
- Provider to provider communication

Approved by Mlacobs, IPark 9/16



Special Care Unit Screening Tool

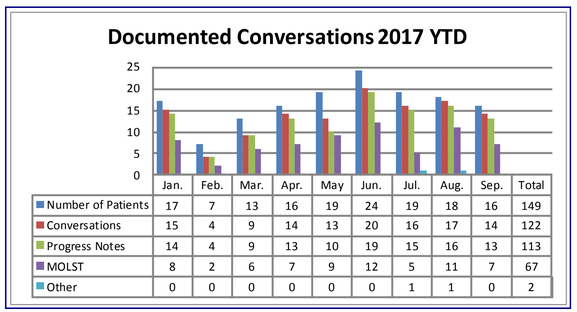
Does the patient meet two or more of the following criteria for Advanced Illness?
Please check all that apply:

- ☐ **Chronic Illness**
- ☐ **Declining Functional Status**
  - ☐ Loss of greater than two ADL's over the past three months
  - ☐ Complex care requirements (including, but not limited to functional dependency, PEG feedings, and chronic ventilator)
- ☐ **Malnutrition**
  - ☐ Unintentional weight loss in the past six months
  - ☐ Poor oral intake or failure to thrive
- ☐ **Evidence of organ dysfunction**
  - ☐ Neurology: CVA, Dementia
  - ☐ Cardiac: EF less than 30%, CHF, Cardiac Arrest
  - ☐ Pulmonary: Stage III or IV COPD, tracheostomy, vent and/or oxygen dependent (high-flow or bipap)
  - ☐ Renal: dialysis, Chronic Kidney Disease
  - ☐ Cancer, advanced or metastatic disease (whether continuing treatment or not)
- ☐ **Frequent Readmissions**
- ☐ **Greater or equal to three admissions over the last six months**

Does the patient meet one or more of the following criteria to be admitted to the SCU?
Please check all that apply:

- ☐ **Previously a SCU patient**
- ☐ **Meets AI criteria and one of the following:**
  - ☐ Requires close monitoring, but does not meet ICU Criteria
  - ☐ Mechanical ventilation with tracheostomy tube or trach-collar patient
  - ☐ Complex Symptom Management needs but not yet in-patient hospice eligible or refusing in-patient hospice

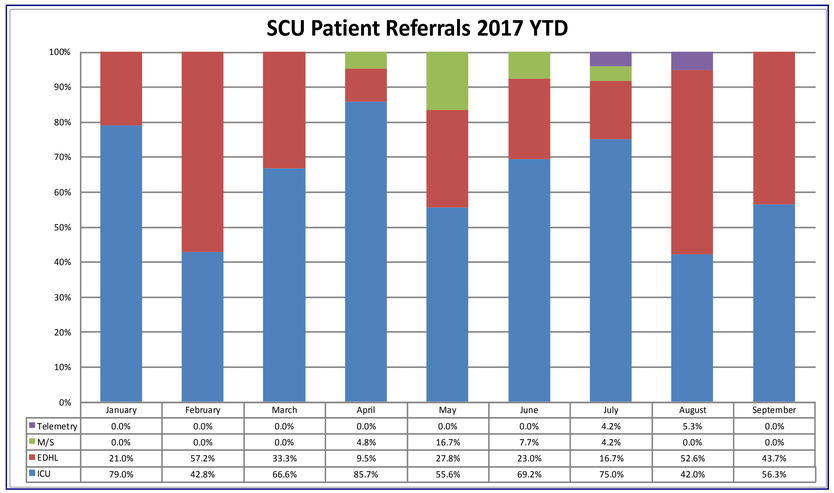
Does the patient meet the criteria for the SCU?
☐ **YES** ☐ **NO**
Call for ICU consult
[Final determination by ICU attending]



Documented Conversations 2017 YTD

	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Total
Number of Patients	17	7	13	16	19	24	19	18	16	149
Conversations	15	4	9	14	13	20	16	17	14	122
Progress Notes	14	4	9	13	10	19	15	16	13	113
MOLST	8	2	6	7	9	12	5	11	7	67
Other	0	0	0	0	0	0	1	1	0	2

	Baseline 2014					Measurement Period (June YTD 2017)								Supply Saving		Labor Saving					
		ICU		Med Surg			ICU		Med Surg		Variable Supply Cost		ALOS Variance		Supply Cost		Days		FTE		FTE Dollars	
Facility	Cases	Days	ALOS	Days	ALOS	Cases	Days	ALOS	Days	ALOS	ICU	Med/Surg	ICU	Med Surg	ICU	Med/Surg	ICU	Med/Surg	ICU	Med/Surg	ICU	Med/Surg	Total Saving
Forest Hills	365	3,429	9.4	2,851	7.8	88	475	5.4	685	7.8	307	167	(4.0)	(0.0)	(108,130)	(395)	(352)	(2.4)	(2.2)	(0.0)	(324,663)	(1,091)	(434,278)



	January	February	March	April	May	June	July	August	September
Telemetry	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	5.3%	0.0%
M/S	0.0%	0.0%	0.0%	4.8%	16.7%	7.7%	4.2%	0.0%	0.0%
EDHL	21.0%	57.2%	33.3%	9.5%	27.8%	23.0%	16.7%	52.6%	43.7%
ICU	79.0%	42.8%	66.6%	85.7%	55.6%	69.2%	75.0%	42.0%	56.3%