PATIENT FLOW OR PATIENT CARE: CAN WE ACHIEVE BALANCE THROUGH THE CASE MANAGEMENT APPROACH TO RAPID?

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Outline

- General Internal Medicine at St. Michael’s
- The Genesis of RAPID
- What is RAPID
- How RAPID works
- Implementation Strategies-break out
- Results
- Remaining challenges
General Internal Medicine

- 70 bed unit made up of 60 ward beds, 4 step up beds and a 6 bed ACE unit
- Approximately 4000 patients admitted/year
- Inner city population-vulnerable, complex cases
- Daily census averages around 80
ED Visits are increasing ...
GIM Admissions are increasing even faster

**ED Visits**

- 2008: 50,000
- 2010: 65,000
- Increase: 9%

**GIM Admissions**

- 2008: 2,500
- 2011: 4,000
- Increase: 24%

**SMH ER**

- 5,500 - 6,000 / month

**SMH Admissions**

- 800 - 850 / month

**GIM**

- 35 - 40%
Typical Day

Total Census = 81
- 14cc GIM = 60 + Step Up = 4
- Bed Spaced Patients = 10
  - 5 in medical cluster and 5 in surgical cluster

ED Waiting
- Total patients = 7
  - 1 female s/u RCP, 2 male s/u, 1 male sitter, 1 female RCP/tele, 1 female RCP, 1 male regular

Discharges
- Expected on 14cc = 8
  - Home = 5; Ambulance = 3
  - Discharges on other units = 3
  - Surgical cluster = 2; medical cluster = 1
Finding the Balance

Patient Flow
- ED wait times
- Increasing volumes
- BED
- Surgical cancellation
- LOS

Patient Care
- Right Bed First Time
- Efficient Care
- Smooth Transitions
- LOS
- ALC Partnerships
The Genesis of RAPID

Pre-RAPID
- Bed spacing
  - Care Expertise mismatch
  - Inefficient care
  - Surgical cancellations
  - Repatriation Request

TC LHIN Request
- Short Stay Unit
  - No space, no extra $$
  - for renos, continued inefficiencies with care
  - Repatriation Requests

RAPID
- Right Patient, Right Bed, First Time
  - Improved patient care,
  - Reconcile high ER volumes,
  - Intelligently distribute patients,
  - Timely access
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Pre-RAPID State - GIM Charge RN

Charge RN

Admitting

Surgical Unit

Medical Unit

Manager

ED

MSICU

Patient Flow
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How RAPID works

FRONT END: Dealing with the ER Volumes

RAPID = Rapid Assessment and Planning to Inform Disposition

1. 100% ER Admits to 14CC
2. ER Level Access to Labs, Imaging, Interventions x 24 h

ER Level Access x 24 h
What happens after 24 hours?

**RAPID**

1. 4 possible *dispositions* are identified
2. Labs and Imaging *priorities revert* back to standard levels

**Possible Dispositions at 24 hours**

- **GIM 14CC**
- **GIM Bedspaced**
- **Transfer Alternate Service**
- **Discharge Home / ALC**
How RAPID works

BACK END: Smart Bedspacing

RAPID Assessment
- "Right Match" Assessment
- Stability
- Plan +

Monitor Efficacy
- Infrastructure to monitor effect on:
  - Patient care
  - Throughput
  - Other Programs

ER Flow
- Anticipated
- Actual

Create Capacity on 14CC

Match patient
- Bedspacing decision makers
  - Right Patient
  - Right Bed
  - Fast

Receiving Service
GIM Partners

- Medical Cluster
- Surgical Cluster
- Critical Care Cluster
- ED

St. Michael's
Inspired Care. Inspiring Science.
Post RAPID state for Charge RN

- MSICU
- Charge RN and Case Manager
- ED
- Cluster Lead Patient Flow

St. Michael’s
Inspired Care.
Inspiring Science.
Break Out Session

Case Study: See Handout

1. As a Case Management Expert, what would be your next steps?
   
a) Identify which core competencies you would apply to this situation
   
b) With which services would you collaborate (internally/externally)?
   
c) Would either of these patients be appropriate for bed-spacing?
NCMN Case Management
Core Competencies

- Advocate
- Case Management Expert
- Manager
- Navigator
- Communicator
- Professional
- Collaborator
Case Management Roles – Pre-Implementation

- **Advocate**
  - Timely access
  - Appropriate environment

- **Manager**
  - Determination of Resource requirements (e.g. extra staff)

- **Navigator**
  - Created Smart Bed-spacing Criteria
  - Identified barriers to care for patients

- **Communicator**
  - Met with Unit staff to address changes in practice
  - Weekly meetings with internal and external partners

**Case Management Expert**
Case Management Roles – Post-Implementation

**Advocate**
- For clients in ED for timely care
- Identify patients who cannot be bed-spaced

**Navigator**
- CMs continue to follow pts once bedspaced
- Address barriers (e.g. delays in bed transfers)

**Communicator Collaborator**
- Daily Meetings with Medical cluster
- ED assessments for new pts

**Case Management Expert**

RAPID PHILOSOPHY = CASE MANAGEMENT
Results

- Decreased LOS by 1.4d (17% reduction)
- Bed spacing footprint decreased by 50%
- Readmission rate stayed the same
- Pt. satisfaction remained high at 92.68%
  - Went up to 100% in the ¼ immediately following RAPID implementation
Challenges

- Lack of Beds or patients for Smart Bed Spacing
  - Special needs (isolation, telemetry)
- Weekend admissions
- Patients don’t want to move
- CCAC notification with smart bed spacing
- Before Eleven Discharges
  - Many ambulance bookings are now smart bed spaced
Next Steps

Sustaining Rapid Program
- Addressing ongoing challenges
- Meeting with partners – "RAPID Refresh"
THANKS FOR YOUR ATTENTION

QUESTIONS?