Goal-directed Achievements through Geographic Location (GAGL)


Background: The rising Medicare population, Value Based Purchasing models, and future implementation of Medicare Spending per Beneficiary modeling are forcing organizations to consider highly efficient quality methods for delivering inpatient appropriate care without complication. Co-locating same service line patients on the same unit can provide value to the organization through efficiencies gained related to teamwork, resource management and services provided in a consistent manner.

Objectives
1. Increase efficiency with staff resource allocation to geographically designated work areas seen through a variety of quality and financial measures.
2. Positively impact the patient experience given a multidisciplinary team-based model, providing consistent quality interventions, resulting in appropriate disposition of the patients.
3. Support institutional initiatives to drive down observed-to-expected mortality, lower the readmission rate, decrease the average length of stay for a defined population, and reduce the cost per case through mindful ordering of procedures and testing.

Planning and Research Methods: Hospital Internal Medicine service patients were targeted to occupy a newly opening unit, allowing this pilot with minimal overall impact to the hospital infrastructure. Planning a daily multidisciplinary rounding process required commitment from several key services to set up the process for success. This work was sponsored by the Readmissions Subcommittee where multiple stakeholders had input on designing the pilot. Daily rounds would be hosted by the inpatient Case Manager, last between 15-20 minutes, and focus on discharge planning, specifically addressing individual patient needs that were preventing discharge. A rounding program was developed using Microsoft Access for use in the process. Additional data points were collected through EHR interfacing using a data warehouse. To assess impact, the team planned on conducting monthly assessment to determine effectiveness by comparing patients geographically located on the selected inpatient unit compared to Hospital Internal Medicine patients on other units with respect to primary diagnosis, length of stay, 30-day readmission rate and adverse events such as cardiac/respiratory arrests (code blue) events and inpatient mortality.

Implementation Methods: The project was executed over a six month period beginning in January 2017. The multidisciplinary GAGL rounds were hardwired to begin at 10 AM daily Monday – Friday including a case manager, nursing team leader, hospitalist physicians and nurse practitioners, pharmacist, physical therapist or occupational therapy and dietician. The case manager lead rounds daily in a standardized pre-defined fashion discussing patient needs, discharge barriers, home health needs, and post discharge support. Findings were documented in the created database and priority action items communicated to the members of the team and nursing staff using internal communication methods, most often within 15-30 minutes of completion of the rounding process, allowing for focused work to facilitate patient discharge.

Results: Six-hundred and twenty patients met inclusion criteria. 213 (34%) patients were admitted to the selected unit while 407 (66%) patients were admitted to other hospital units. Patients in both groups were similar with respect to age [68 (55, 80) vs 69 (55, 79), p=0.891], female gender [116 (54.5), p=0.272].

Patients admitted to the selected hospital unit had a shorter LOS [3.17 days vs. 4.18 days, p=0.01] fewer RRT/Code blue events [2 (0.9%) vs. 15 (3.7%), p=0.047] and fewer risk events [20 (9.4%) vs. 70 (17.2%), p=0.009]. Lower 30-day readmissions occurred in the cohort admitted to the selected hospital unit; however the difference did not reach statistical significance [20(9.4%) vs 50(12.3%), p=0.28]. A significant difference in the number of avoidable days between the two groups studies (p=0.92) was not appreciated. Plans for further dissemination of this rounding technique are planned for implementation following development of a more robust rounding data management tool.

Next Steps: The Access Database was converted in MIDAS (Mayo Clinic’s quality database) and plans are in place to implement this on additional units in the first half of 2019. With Mayo Clinic’s transition to Epic, an enterprise workgroup has formed to identify how to build a similar tool within Epic.

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