Optimizing Higher Levels of Care

Appropriate levels of care ensure patients have an available bed that matches their acuity. Without a clear set of criteria to determine a patient's level of care, health care facilities may opt to place a patient in a higher level of care than clinically necessary, complicating patient flow and placing undue financial burdens on the hospital and patient.

To optimize levels of care, organizations should have clear level of care criteria, unit structures, guidelines on clinical progression and clinical variation, metrics and governance structures for improved efficiency and quality.

Level of Care Criteria

There are three levels of care: critical, intermediate and medical/surgical (acute). Telemetry services, often confused for a level of care, can supplement critical, intermediate and acute care.

To develop level of care criteria, start by identifying the appropriate patient population for each level of care. Criteria should be established with nursing and physician input and aligned with the latest guidelines from professional societies, such as the Society of Critical Care Medicine, and medical necessity criteria, such as Milliman Care Guidelines (MCG) and InterQual.

The criteria for each level of care are determined by considering:

· Necessary interventions
· Degree of monitoring required
· Severity of illness

Level of care criteria are typically outlined in an admission, discharge or transfer policy for critical, intermediate and acute care. This policy should also describe the purpose, oversight and decision-making related to higher levels of care and receive approval from the appropriate governance structures (e.g., Critical Care Committee, Medical Executive Committee).

Unit Structure

An organization has many decisions to make in determining how to structure units designated for patients who need higher levels of care. Some of the important considerations include:

· The number of intermediate care beds needed and their locations. Should they be in a designated area within the critical care unit or on a separate unit? Should specialty-based units be established for higher levels of care, such as a neuroscience critical care/intermediate care unit?

· If the critical and intermediate care units should be closed (only intensivists and selected services such as trauma, cardiology or neurosurgery allowed to admit patients), open or hybrid.

- The makeup of the provider teams for each unit Will there be mid-level providers such as nurse practitioners? What will be their responsibilities?

Clinical Progression

Appropriate level of care management relies on clear discharge and transfer criteria from each unit. Transitions are appropriate when patients no longer need the services identified in the admission criteria and they meet the discharge or transfer criteria for their current level of care.

The appropriate level of care should be discussed daily for each patient in an interdisciplinary round structure in relation to medical milestones and the estimated discharge or transfer date. Typically, the case manager will call attention to patients who do not meet the level of care criteria for the patient's current unit. If the patient does not meet the level of care criteria, the care team should discuss the medical needs of the patient. Key areas to consider include:

- The documentation: Does it need to be updated to accurately reflect the patient's acuity?

- Medical milestones: Which milestones does the patient need to reach before they can transfer or discharge? What is the estimated date of discharge/transfer?

Inefficient processes often delay patient progression. Organizations can identify some common performance improvement opportunities by asking the following questions:

- Are there delays in transferring patients who do not meet criteria? Have analytics been conducted to determine the root causes (e.g., lack of availability of acute care beds, physician delays, nursing delays)? Is there an escalation process involving leadership to effectively address the delays?

- Are patients who do not meet criteria for higher levels of care placed in critical and intermediate care because physicians are not comfortable sending them to the acute care units? What training is needed on medical/surgical units to increase their ability to care for patients who are appropriate for an acute level of care but who may require interventions that the staff are not familiar with?

- Do triggers exist to prompt family meetings to discuss the patient's condition, treatment goals, treatment plan and available options including palliative care and hospice?

Clinical Variation

Standardization of care based on evidence-based protocols and guidelines is essential to optimize efficiency and quality within higher levels of care. Examples of leading practices include:

- Evidence-based protocols and procedures are consistently used for clinical management (e.g., ABCDE bundle to improve ventilator weaning, mobility, and delirium; trach insertion procedure and standardization of supplies; insulin protocol; hyper/hypotension protocol)

- Standard order sets for the critical, intermediate, and telemetry areas have been developed and approved

- Variations from the approved order sets and protocols without supporting documentation are concurrently managed through an escalation process involving the physician advisor and physician leadership

Dashboard and Metrics

Organizations should use a dashboard with key process metrics (such as protocol adherence) and outcome metrics (such as mortality and transfers to higher levels of care within 24 – 48 hours after initial admission to a lower level of care) to track progress towards achieving their goals for effective delivery and management of higher levels of care. Leaders should hold regular performance management meetings to review these metrics with staff, identifying challenges and discussing initiatives to overcome them.

Governance Structures

A well-structured Critical Care Committee should provide effective multi-disciplinary leadership and oversight for higher levels of care. The Critical Care Committee typically has delegated authority from the Medical Executive Committee for implementing policies and procedures to improve efficiency and outcomes on the critical and intermediate care units. It is chaired by a physician and generally includes roles such as the critical care nurse manager, physician representatives from all specialties practicing in the higher level-ofcare environments, case management, respiratory therapy, etc.

Examples of responsibilities of the Critical Care Committee include:

· Reviewing and updating the admission/ discharge/transfer policy

· Working on initiatives such as increasing intensivist staffing or outsourcing

· Developing and approving protocols

· Evaluating critical care outcomes using the dashboard and overseeing improvement initiatives

Bottom Line

Managing levels of care effectively leads to increased consistency of care aligned with evidence-based protocols and standards, reduced length of stay and increased revenues. To optimize higher levels of care, organizations need to adopt a comprehensive, multi-disciplinary approach.

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