A glimpse inside the incubator: Creating new CM outcomes tool

**Goal is usefulness across populations**

Case management (CM) work increasingly is under measurement. Often, the tools used to indicate CM outcomes look at healthcare utilization and costs. But are these really the best ways to measure outcomes? That’s the question researchers and a mobile case management services company asked before embarking on a mission to create a better case management measurement tool.

“We wanted something that was really congruent with and a measure of how well we were fulfilling our mission of helping people improve self-sufficiency and improve community integration,” says Jeffrey Marks, MA, director of clinical services, Service Access and Management, Inc. of Reading, PA.

Using hospitalization rates as a measurement is not ideal because it indirectly measures a negative outcome, Marks says.

“Hospitalization can represent the failure of the consumer to be independent and self-sufficient,” he says.

**EXECUTIVE SUMMARY**

Case management work increasingly is being measured, but the big issue is finding tools for effective measurement of CM outcomes.

- Hospitalization rates are an indirect way to measure a negative outcome.
- A measurement tool should address the case management consumer’s progress from using professional support to less restrictive, more natural support.
- One tool under development measures domains and living situations, activities of daily living, financial, educational, vocational, and other factors.

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explains. “We were looking for something more direct, more sensitive.”

The new measurement would be evidence-based and more directly applicable to case management service planning. It would be useful in measuring case management across all populations, Marks says.

“It was our desire to find an effectiveness tool with some sort of analysis behind it,” says Lori Hartman, MA, deputy director of operations at SAM.

SAM needed a partner to help develop the new tool. Through connections on an advisory board, two researchers from Clarion University in Clarion, PA, became collaborators, Hartman notes.

“That’s how the collaboration began,” she adds.

The collaborators, Rick Sabousky, PhD, chair of the Department of Special Education at Clarion University, and Ray Feroz, PhD, CRC, LPC, professor and chair of the Department of Human Services, Rehabilitation, Health, and Sports Sciences at Clarion University, looked closely at case management consumers’ sources of support. Sabousky, Feroz, Marks, and Patrick Sanphy presented the tool at the National Association of Case Management Conference, Sept. 21-23, 2015, in New Orleans.

“If case management is making a difference, we should see people move from professional support to less restrictive, more natural support,” Sabousky says. “As we looked at [the issue], I realized it’s very difficult to measure program effectiveness.”

Sabousky asked this basic question: “If people aren’t making progress, how would I know?”

Sabousky and Feroz brought to the task the perspective of program evaluation, individual descriptive planning, and measurable objectives, Feroz says.

“We’ve worked with SAM to take a look at measuring success in terms of what they’re doing with their case managers and their clients,” Feroz adds. “There’s a huge desire in the field for evidence-based practice and efficiency.”

Ideally, the tool would keep CMs focused on looking at a client’s different services and the frequency of those services, he adds.

“We felt it was a good time — during service planning — to get data for these measures, and it also would help reinforce and support case managers’ and consumers’ consideration of all domains of consumer functioning,” Marks says. “It’s designed to reinforce, facilitate, and keep case managers’ heads into the service planning process.”

The collaboration has resulted in a data collection tool that can be used for any population, no matter what an individual’s primary service need, Feroz says.

“We know clients come to us with differing needs; every individual is different. That’s the hallmark of good treatment in case management,” he explains. “What Rick and I wanted to do was develop some sort of measurement in case management that could work across all types of goals and clients and objectives.”

The instrument measures domains and living situations such as housing, family support, cultural, spiritual, social, and recreational issues. It also looks at activities of daily living (ADLs), financial, educational, vocational, legal, drug treatment, mental health, safety, crisis management, mobility, transportation, and other systems involvement and natural support, Feroz says.

“Some clients have a priority in
one domain, but no goals in another,” he explains. “We listed everything that contributes to a common service coordination plan, and we measure whether they can do this, they’re adept at it, and whether they have a need for professional services.”

The tool evaluates the following factors on a 0-5 scale:

• 0: The person might receive medication management, but otherwise can receive all natural support and will do fine without professional case management.
• 1: The client might need occasional or quarterly services.
• 2: Intermittent — monthly or less frequently, but more than quarterly — professional services are necessary.
• 3: The client needs intensive professional services of between monthly and weekly support.
• 4: The intensity of services requires ongoing professional support in a community setting of more than weekly.
• 5: The client needs continuous professional services in a clinical setting.

The tool is useful in evaluating an individual person’s independence and need for case management services, as well as the person’s improvement or decline over time. But it also can be used to evaluate how well a case management program or case manager is doing across a CM population, Feroz notes.

“What this scale allows us to do is in a single area like in ADLs, we can keep moving toward improved independence on the part of the client,” he explains. “So if the client is at a 2 in ADLs, we might want to move the client to a 0 — with total natural activities and no need for professional oversight.”

The tool can be an idea-generator for case managers, giving them clues on where they can focus their energy to help clients improve independence.

“In a world of evidence-based practice, you can’t be dead in the water,” Feroz says. “You have to show continuous improvement.”

The tool allows case managers to look at modest improvements that still are reasonable goals for individuals in primary interest areas, he adds.

For example, a patient with congestive heart failure (CHF) at onset might need a high level of professionally provided support, including hospitalization and Lasix treatment, Sabousky says.

“I don’t look at hospitalization as a failure,” Sabousky says. “I look at what happens between hospitalizations for someone with chronic health conditions: Maybe the person made some progress and then relapsed.”

For instance, a person with CHF might have reached an improved level of support and could manage self-maintenance with assistance from a spouse, but still calls for help from professionals because the spouse has suddenly taken ill or is less able to help due to other issues. Case management dives into these kinds of nuanced issues, he adds.

In two initial tests of the new tool, case managers appeared to do well with the measurement once they understood the scale and its domains of Living Situation/Housing; Family/Natural Supports; Cultural/Spiritual; Social/Recreational/Leisure; Living Skills; Medical/Health Care; Financial/Insurance; Educational/Learning; Vocational; Legal; Crisis/Safety; Mobility/Transportation, Marks says.

“Case managers already are looking at all domains of a consumer’s life, so it’s really just the nomenclature that we put on to the frequency of services,” Marks says. “We look at every consumer holistically — in all areas of their life, including mental healthcare.”

Case managers use their own electronic equipment to complete the assessment form. So if they carry laptops, they have the tool’s application on the laptop, Hartman says.

The next steps will include training case managers to use the tool as studies of the tool gear up.

“We have to show first that the tool has validity and reliability,” Hartman says. “It’s about bettering case management for everyone; we don’t have a marketing plan or strategic plan around the tool.”

Goals will include better coordination between case management and service providers and a greater focus in case management on quality of life issues for chronically ill clients, Sabousky says.

“Put people in a position to be supported at a level that doesn’t include hospitalization and also have a good quality of life,” he explains. “Say you have someone in a supportive environment who uses professional transportation, and we’d like to see the person begin to use the bus; the person might be more willing to use bus transportation because of the gains from case management.”

The tool’s usefulness hopefully will work on various levels — both in individual case management practice and across populations, Marks says.

“One of the cool aspects of this is we could look at data from the smallest point in time across time,” he adds. “Once the tool is perfected and in place, that flexibility and breadth of view is something we believe could be a really powerful tool.”
Motivating clients to make changes for health improvement is one of the challenges in case management. Increasingly, evidence suggests fear tactics — i.e., telling them of the dire consequences of non-action — do not work. So what does?

Motivation is one of the most important factors in patients’ ability to stay healthy, notes Robert Drapkin, MD, FACP, an internist and author in St. Petersburg, FL. In the U.S., many people will maintain their automobiles more meticulously than they’ll maintain their bodies, so it takes a concerted effort to improve their motivation, he adds.

One strategy is to find out what is important to the patient.

“Before I get started with patients, I ask them what their goals are, what they would like to accomplish,” Drapkin says. So if the person’s goal is to improve his or her appearance and lose weight, then the daily measurement activity would be to record weight daily.

“I tell them that in order to achieve their goals, they’ll need to measure their activities on a daily basis so they can see that they are getting closer to their goals,” Drapkin adds. “This helps people control their behavior better.”

Case managers can improve client motivation through strategies that include learning what is important to them and breaking up their overall goal into bite-sized steps.

- Focus on what’s important to the client.
- Encourage clients to measure their small steps in the right direction to both reinforce the positive behaviors and to provide an incentive through recognition of small successes.
- “Trick” clients into improving motivation and positive behaviors through small actions that affect their attitude and self-awareness.

EXECUTIVE SUMMARY

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is a small action that has a higher likelihood of success, and when the patient does this, the activity is reinforcing and can lead to another, bigger activity, such as taking a walk once a week in the evening, Hibbard says.

“What the care manager does is not prescribe the activity so much as bite-size the activity according to the person’s motivation,” she adds.

There are case management programs that can help with bite-sizing activities, or a case manager could develop an approach that is based on heading in that direction, Hibbard suggests.

“One way to change a person’s mindset is to think in terms of increases of activation, on a zero to 100 scale, as one of the outcomes,” she adds. “Think of zero to five as a success and look for intermediate outcomes.”

Ultimately, that’s how case management should work: providing reward based on patients’ activation scores, Hibbard says.

Starting with easy activities will work with any patient, Drapkin says. “If walking is painful, then have the person try swimming or walking in a pool, where it’s less stress on the joints and muscles,” he suggests. “The person’s body will adapt, and the patient can increase the amount of time in the activity.”

Another strategy is to teach patients to trick themselves into improving their willpower. For instance, a patient who would like to lose weight can take a cell phone photo of his or her body once a month and also record waist measurements at that time, Drapkin suggests.

“These are objective measurements that help people stay on their diet and routine,” he says.

As their willpower improves and they lose weight, they’ll see improvements in their appearance via the photos, and also see smaller waist sizes in their measurements. At the same time, their behavior change will be reinforcing in how they feel as their energy levels and health also will begin to improve, Drapkin explains.

“I tell patients that it’s a race won by the turtle, not the hare,” he says. “It’s a lifelong process of having a healthy lifestyle, so I have them write down their goals, keep journals, and record their daily weight.”

Drapkin also asks patients to record the food they eat and note the proportions of protein and carbohydrates. If a patient shows no improvement, he might say, “What you’re currently doing isn’t working, so we have to change something. What would you like to change? What can you change? Can you quit drinking alcohol or stop smoking? Can you eat smaller, more frequent meals?”

Drapkin also motivates through encouragement: “I tell them they have the body of an athlete whether or not they know it.”

The human species has succeeded, in part, because of its athleticism, he says.

“We can outrun most other animal species — not running faster, but we can outlast them,” he says. “I convince patients that they are becoming athletes because they’re exercising a little bit each week.” ■

Case managers need to connect across continuum

No more communication silos

Once a patient is hospitalized, the patient and family often become lost in the maze of healthcare, feeling a loss of control and unable to understand what’s going on with their medical treatment and insurance. Case managers working together from the hospital and community can help them navigate this maze more efficiently and with less stress.

“It’s very important for case managers in hospitals to not only do discharge planning, but to also get involved in the patient’s community so they can help that community provide the patient with the necessary support,” says Susan Rogers, RN-BC, MSN, CCM, a board-certified nurse case manager and chief executive officer of Rogers Professional Guidance Nurses in Overland Park, KS. Rogers speaks at national conferences about how case managers can build care management across the care continuum.

“We’ve always talked about healthcare having silos, including the silo of the hospital and primary care, and we as case managers have perpetuated that silo — even amongst ourselves,” Rogers says. “When you talk about hospitals and accountable care organizations [ACOs] and health plans, we are all the same regardless of where we practice.”
Increasingly, case managers are embedded in primary care sites, a trend that further emphasizes the need for the care continuum, she notes.

If every case manager — no matter where he or she works — advocated for patients, there should be no silos, Rogers says.

Rogers offers the following suggestions on building a continuum of care between case managers in various settings:

- **Educate providers about the care continuum.** When working with hospitals and primary care providers, Rogers begins with education about case management. Case managers in primary care settings are in a good position to prevent health crises among at-risk populations, she notes.

  They might identify trends in patients, such as elevated blood sugar levels that indicate pre-diabetes.

  “The case manager in the primary care office is looking to find records and results to help people through health issues,” Rogers says.

  Case managers also can help make sure that when patients are sent to a specialist or hospitalized that information from those handoffs returns to the primary care practice, she adds.

  “Often, the primary care physician doesn’t know they’ve been in the hospital and there’s no communication until discharge,” Rogers says.

  Continuous communication between case managers and care settings is a critical step in individuals’ wellness, she adds.

- **Risk stratify and assess patient issues.** “If we look at the community as a whole, we might say we have 100 people with a [particular] diagnosis, and 20 might need to see a specialist,” Rogers says. “So where do we need to divide our time?”

  The answer might be to identify the higher-risk cases to pay more attention to them and prevent some of those people from returning to the hospital. Also, case managers can work with other community resources to find solutions to problems that result in patients’ worsening health and need for referrals beyond primary care.

  “We need to figure out how to get back to the sense of community in healthcare,” Rogers says. “It’s very important that case managers keep in mind who they’re working for and that they identify their community.”

  For instance, a case manager who works in a community that has a significant population of Vietnamese-speaking individuals might need to identify interpreters to work with primary care providers, Rogers says.

  Case managers working with this sort of population might also need to think about the various factors, including cultural differences, that affect clients’ needs, she notes.

  “Case managers need to be in the same thinking mode as their clients, or they’ll be ineffective in motivating them to make changes,” Rogers says.

  For instance, Rogers’ own experience included working with a population of clients who lived in homes with dirt floors and outhouses. Helping someone with a mobility issue improve their independence under such circumstances is challenging, but the situation is made worse if the case manager doesn’t even know that’s how the client lives, she explains.

  “If you know your population, then you can anticipate their needs,” Rogers adds.

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**EXECUTIVE SUMMARY**

Case managers working together across the care continuum can improve the problem of healthcare silos.

- Providers, as well as patients, need to learn more about the care continuum and case management’s role in it.
- Case managers in primary care settings can help identify patient trends that might prevent a health crisis.
- Case managers should keep in mind who they’re working with, including being aware of their client population’s cultural issues, and address needs through that filter.
"Warm handoffs" can reduce hospitals’ readmission rates

Collect data discharges, handoffs

Newton-Wellesley Hospital in Newton, MA, improved its readmission rates through a quality improvement process that included measurements of “warm handoff” rates.

As a result, readmission rates fell and patient experience rates improved, says Bert Thurlo-Walsh, RN, MM, CPHQ, vice president of quality and patient safety at Newton-Wellesley Hospital. Thurlo-Walsh recently received the Rising Quality Star Award from the National Association for Healthcare Quality (NAHQ).

“We’ve been collecting warm handoff rates, including how many patients are discharged, whether the warm handoff was conducted and documented, the rate of completion by unit, and an overall aggregate,” Thurlo-Walsh says.

“We look at the overall readmission rate in 30 days for all causes, all payers, and we don’t drill down into individual areas,” he adds.

Unit-by-unit data is more challenging to measure because patients can be transferred from one unit to another, and it’s difficult to track them, he explains.

So the quality department looks at the overall readmission rate and disease-specific rates, such as rates for heart disease diagnoses, pneumonia, strokes, and chronic obstructive pulmonary disease (COPD), he says.

“If patients with those conditions are readmitted for any other reason, we look at that, as well,” Thurlo-Walsh says.

The following are some of the steps the quality department took to achieve positive outcomes:

• **Warm handoff.** “Our biggest focus has been nurse to nurse,” Thurlo-Walsh says.

Communication needs to be fluid between the inpatient care nurse at the hospital and the skilled nursing facility (SNF) nurse.

The hospital nurse should make sure the SNF nurse receives the patient’s paperwork before the handoff occurs. And they should speak, discussing interventions done in the hospital, antibiotics or other medications, and discharge instructions for the patient and family, he explains.

The hospital’s discharge process should include the teach-back method to improve patients’ understanding of what needs to be done, he adds.

“All of that information goes to the next provider of care,” Thurlo-Walsh says.

• **Making discharge phone calls.** “The discharge phone calls are when patients are discharged to their home with or without services,” he says.

“They receive a discharge phone call from one of our staff nurses within 24 to 48 hours with specific questions around their care and transition to home.”

Nurses also ask about opportunities for improvement: “How can we do better on our end, and would you like to recognize anyone for exceptional care?”

That last question is key, Thurlo-Walsh says.

“We believe in recognition and always want to do better,” he says.

“We have a great service excellence program and want to recognize our staff that’ve done a good job because recognizing staff is key to keeping them happy.”

• **Improve communication.**

“In relation to HCAHPS, nurse communication is the biggest driver of almost every other domain except physician communication and quality,” Thurlo-Walsh says. “If you do well with that, then almost all fall into place; in our service excellence program we link the two together now.”

For instance, if patient surveys demonstrate quality nurse communication, then patients also rate pain management and medication communication higher, he adds.

“We’ve run data on whether or not a patient received a post-discharge phone call, and we looked at the difference from overall domain scoring,” Thurlo-Walsh says. “In all domains, it was consistently higher if they received a call versus if they didn’t, and we follow that data ongoing.”

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**"WE LOOK AT THE OVERALL READMISSION RATE IN 30 DAYS FOR ALL CAUSES, ALL PAYERS, AND WE DON’T DRILL DOWN INTO INDIVIDUAL AREAS."**
Despite the fact that ED crowding is associated with a range of concerning outcomes, including higher mortality rates, higher rates of complications, and increased errors, there is new evidence many EDs are leaving proven strategies for improvement in this area on the table. In a study looking at crowding at U.S. hospitals from 2007-2010, researchers found that while the adoption of interventions to reduce crowding has increased, some of the most crowded EDs have failed to take advantage of approaches that have been shown to work.1

Leah Honigman Warner, MD, MPH, an attending physician in the Department of Emergency Medicine at Long Island Jewish Medical Center in New Hyde Park, NY, and the lead author of the study, notes that the data suggest ED crowding is still not a priority at many hospitals.

“ED crowding has become increasingly commonplace and I worry that a crowded ED is now the new status quo, which reduces the incentive to change,” she explains. “Additionally, since the influx of patients to the ED cannot be easily controlled, on first glance ED crowding might seem difficult to change. However, many interventions actually affect the efficiency by which patients are cared for in the ED or reduce the amount of time admitted patients are kept in the ED.”

Researchers evaluated the adoption of both ED-based and hospital-level interventions. The ED-level tactics reviewed included:

- bedside registration;
- use of an electronic tracking system or dashboard;
- computer-assisted triage, which involves using algorithms to improve the reliability of triage decisions;
- zone nursing, which ensures that all of a nurse’s patients are in one area;
- establishment of a fast-track area for patients with minor illnesses or injuries;
- increasing the number of ED beds;
- physically expanding ED space;
- establishment of an ED-based observation unit;
- radio frequency identification (RFID) tracking, in which patients receive tags so that their physical location can be tracked and monitored throughout their ED stay.

The hospital-level tactics reviewed included:

- bed census availability or a system that lets staff know the number and type of beds that are available;
- avoiding elective admissions during ambulance diversion;
- pooled nursing or maintaining supplemental staff who work on a flexible schedule based on patient volume;
- use of a bed czar whose job is to manage beds hospital-wide and to ensure the efficient transfer of ED patients to inpatient beds;
- full-capacity protocol, in which admitted ED patients are moved to inpatient areas so that the burden of patient boarding is not borne entirely by ED staff;
- transfer of boarded patients to inpatient hallways, similar to full-capacity protocol;
- establishment of a separate operating room for ED patients;
- surgical schedule smoothing, which involves planning surgical procedures over six or seven days to match the availability of inpatient beds.

Take a multidisciplinary approach

Investigators found that the average number of interventions adopted increased during the four-year study period from 5.2% to 6.6%. However, while the most crowded EDs increased their implementation of crowding interventions, their adoption of interventions that have been shown to work was still lacking. For
instance, researchers found that 19% of the most crowded EDs did not use bedside registration and that 94% did not adopt surgical schedule smoothing.

Why wouldn’t hospitals take advantage of proven strategies? The reasons most likely vary, but investigators acknowledge that addressing a problem like crowding is not an easy process for a hospital.

“It involves putting together a multidisciplinary team that needs longitudinally to conduct quality improvement interventions. Sometimes it involves buying technology to try to facilitate some of the interventions, which can involve costs. It is not something that has an easy fix,” explains Jesse Pines, MD, MBA, director of the Office of Clinical Practice Innovation and a professor of emergency medicine and health policy at the George Washington University School of Medicine and Health Sciences and a co-author of the study. “It requires both considerable staff time and often trying to change the culture of how people operate within the hospital. The reason a lot of hospitals haven’t done it is because although there are evidence-based fixes out there, they are hard to achieve and they involve a lot of time and energy.”

However, Pines adds that it is clear some hospitals have prioritized crowding while others have not.

“What we found in the study is that many of the hospitals that were most crowded really had not implemented a lot of these interventions that are easier to do,” he says.

For example, Pines notes that bedside registration, in which registrars enter the ED so that they can register patients right from their beds, thereby eliminating a step from the process, is not particularly difficult to implement, but he notes that many hospitals have not moved to implement this intervention.

**Embrace systemic solutions**

Investigators note that some hospitals have failed to implement two proven interventions that can be implemented at little or no cost: surgical schedule smoothing and full capacity protocol. But Pines acknowledges that while these interventions require little in the way of resources, they are not necessarily easy fixes.

“With the full capacity protocol, [for example], you’ve got to work with both the ED and other departments at the hospital and come to an agreement of what the hospital is going to do when the ED is overrun with patients, and that is even harder than getting stakeholders in the ED to agree on making a change,” he explains. “There is still in many hospitals a silo mentality where everyone is trying to protect their own units — the ORs, the ED, the ICU, and the hospital floors — and there is not a great priority to improve flow throughout the hospital.”

However, while many of these units or floors have a fixed capacity, the ED has no top-off valve, Pines observes.

“People will continue to come to the ED regardless of whether there is space, so that tends to really disadvantage EDs because there is no right of refusal in the ED,” he says.

Another issue that can come into play is economics, according to Pines. That may, for example, be why hospitals may continue to perform elective procedures even while their ED is on diversion.

“Elective procedures tend to have higher margins than patients who are admitted through the ED, so despite losing the influx of low-margin patients, hospitals make the economic decision to maintain the inflow of high-margin patients because they are more profitable,” he explains.

Economics also may have something to do with the finding that the number of ED-based observation units actually declined during the study period, although Pines acknowledges that he was surprised by this decline.

“ED observation units can be very effective, particularly at reducing admissions for patients who just need short-term hospital care,” he explains, noting that patients with such conditions as chest pain, cellulitis, or asthma are often treated in observation units. “The fact is that you can bill more for an inpatient bed than for an
observation bed in the ED, so in a world where you think you can fill beds with patients who will have a full admission to the hospital, it would make sense to focus on creating more inpatient beds.”

Warner observes that the hospitals that have been successful at addressing ED crowding are those that embrace systemic solutions.

“ED leaders should collaborate with hospital leadership to develop solutions to reduce crowding. There are many evidence-based interventions, both which we evaluated as well as others, that should be considered,” she says. “Some would simply require a change in protocol [inpatient boarding through a full capacity protocol], while others would require changes in staffing [pooled nursing and surgical schedule smoothing]. Other interventions require more capital investment, such as upgraded technology or the creation of new treatment space [observation units or fast tracks].”

Warner adds that once ED crowding is recognized as an issue that affects the entire hospital, it should be easier to find successful solutions.

Hold leaders accountable

Pines is calling for a national strategy to hold hospitals accountable for flow in the ED. He notes this has already begun with new measures for patient flow, and he hopes to see the issue gain more prominence in pay-for-performance initiatives.

Pines would also like to see the United States follow the lead of other countries in adopting limits for how long a patient can remain in the ED, with hospital leaders held accountable for their performance in adhering to such limits.

“The United Kingdom, back in 2003, implemented what is called the four-hour rule where patients could only be in the ED for up to four hours. Beyond that was unacceptable, and hospital leaders would be held responsible,” he explains. “Since then, the rule has been relaxed, but there are still major priorities for ED flow in the United Kingdom.”

Similarly, Pines notes that Australia’s rule does not allow patients to spend more than eight hours in an ED.

“Personally, I think that is a more reasonable target, given the complexity of patients that are seen in the ED, and the time it actually takes to sort out whether they need to be admitted,” Pines observes.

REFERENCE


Tampa hospital reduces falls 16% in facility’s common areas with simple changes

Determined to reduce slips, trips, and falls in common areas, a safety team at St. Joseph’s Hospital in Tampa, FL, studied incident reports to determine the most common causes and potential solutions. After implementing several mostly simple safety initiatives, the hospital saw a 16% reduction in falls from the previous year.

The project arose after hospital leaders realized that a significant number of slips, trips, and falls were occurring in common areas of the hospital campus such as lobbies, waiting rooms, stairwells, sidewalks, and parking garages. Past efforts to reduce falls in patient care areas had not specifically addressed these common areas, and in 2012 the risk management department contacted facilities manager David D. Miller to express concern that there recently had been a dozen falls in one of the hospital’s parking garages, including some that led to litigation.

Falls are costly, with the CDC estimating that costs tied to hospital falls average $35,000 per incident. (Information is available at http://tinyurl.com/mf3ua5j.)

An investigation found that about 60% of falls in the hospital’s parking garages were people tripping over the concrete car stops at each parking space. Miller researched the building code in Tampa and found that car stops were not required in parking garages except for the spaces on the perimeter of each floor. Miller had all the unnecessary car stops removed, eliminating that tripping hazard.

That change led to Miller thinking about what other changes might be needed on the 35-acre campus, which led to him working with risk management to hire a
consulting company for a pedestrian accommodation survey. The company produced a report with more than 50 recommendations, and St. Joseph’s implemented most of them. The following were some of the significant changes:

- At pedestrian crosswalks, the hospital prohibited cars from parking on either side. Cars parked close to the crosswalk might shield pedestrians from drivers’ view as they step into the street.
- The hospital removed shrubs and other vegetation from entrances and exits to the parking decks to avoid blocking drivers’ view of pedestrians.
- The hospital changed speed bumps to speed tables, which have a gradual incline and a flat plateau and then a gradual decline. Several falls at St. Joseph’s were attributed to people tripping over the speed bumps.
- The hospital installed a mid-block pedestrian crosswalk at a point where people were crossing a four-lane road instead of going to the corner crosswalk.

Still seeing room for improvement, Miller formed the Non-Patient Care Slip and Fall Committee in late 2012 that included himself and representatives from risk management, safety and security, and environmental services. He obtained the hospital’s slip and fall data from non-patient care areas for the previous five years, and the committee studied them for evidence of preventable falls. The committee met monthly, reviewed any falls from the previous month, and visited the location of the fall to look for possible solutions.

Most of the remedies were fairly simple and inexpensive. Where people were walking off a sidewalk edge because they were busy looking at their phones, the committee installed a yellow chain on the sidewalk to get people’s attention. When there were falls in the cafeteria from ice melting on the floor, they installed mats in front of the ice machine. Falls also occurred in the cafeteria when people spilled their coffee or soft drinks, so the hospital provided lids at the cashier and instructed the cashiers to encourage people to use them.

One of the most influential changes at St. Joseph’s, Miller says, was the installation of pop-up safety cones and paper towel dispensers in elevator lobbies and many other common areas. Next to the paper towels and cones are signs that read, “If you see a spill, don’t pass it up. Wipe it up.” The slogan was promoted through in-house publications and other employee communications.

“The biggest concern we got was that our staff didn’t know what they were cleaning up, and so they didn’t want to touch it. We told them to just put a paper towel on it, put a cone on top of it, and call housekeeping,” Miller says. “Then we led by example. I do rounds weekly with the president of the hospital, and we use the supplies every time we see a spill.”

Other changes included the following:

- Improved lighting in parking lots and parking garages.
- Crosswalks with amber flashing lights were installed in parking decks.
- Walk-off mats and umbrella holders with plastic bags provided at all entrances.
- After several falls in parking deck stairwells, the hospital posted signs at each landing encouraging people to use the handrails.

A year after the committee’s changes, falls in non-patient care areas were down 16%, from 46 in 2012 to 35 in 2013.

“None of the changes were all that creative or groundbreaking, but we found that you can make a real difference with attention to the details,” Miller says. “The changes also were not costly in most cases, and the expenses were more than offset by the savings from the fall reduction.”

**CE OBJECTIVES**

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

**COMING IN FUTURE MONTHS**

- Make your CM team more effective
- Improve accountability, eliminate barriers to greater productivity
- Personalizing care through data in case management
- Creating best practices in team-based, collaborative models
To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.
2. Scan the QR code at right or log onto AHCMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

1. What is the difference between professional support and natural support in case management, according to Rick Sabousky, PhD?
   A. Professional support refers to case management in the hospital setting; natural support refers to case management in the community setting.
   B. They refer to the same type of client support with different terms.
   C. Professional support refers to case management and other healthcare services; natural support refers to the client’s family and non-healthcare community help.
   D. None of the above.

2. Which of the following are domains and living situations that can be part of a case management assessment of a client’s outcomes?
   A. Housing and cultural issues.
   B. Family support and recreational activities.
   C. Activities of daily living and financial support.
   D. All of the above.

3. Which of the following is a good example of a bite-sized step that can be employed to motivate a client to positive health changes, according to Judith Hibbard, DrPH?
   A. Require the client to walk for 30 minutes five times a week.
   B. Suggest the client begin an exercise routine by taking the stairs at work three times a week.
   C. Have the client train with a “coach potato to marathon running” program.
   D. All of the above.

4. According to Susan Rogers, RN-BC, MSN, CCM, why is it important for case managers to improve communication and collaboration across the care continuum?
   A. Case managers in the hospital setting see patients during a health crisis but have little control over prevention, so communication with primary care case managers can help with prevention efforts.
   B. It’s not really important because each case manager has his or her own information to work with.
   C. Communication can improve efficiency from a payer perspective.
   D. None of the above.