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AHC Media

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Palliative care services create need for case management

Services increased nearly 150% in the last decade

Case managers likely are going to hear a great deal more about palliative care in coming years. Case management's team-based approach to improving quality of care increasingly is being used for patients with life-threatening illnesses.

Within the past decade, palliative care services have multiplied by 148%, studies show.[1,2]

"The evolution of palliative care in the last five years has been tremendous," says **Ellen Wild**, RN, CHPN, palliative care nurse coordinator for the Mayo Clinic in Rochester, MN.

"A lot of this is because of the complexity of medical care and people's medical issues," Wild says. "Fifteen to 20 years ago, when people got sick from advanced cancer, heart disease, and lung disease, there often were limits in treatment and people didn't live long

EXECUTIVE SUMMARY

Palliative care services have been on the rise in the past decade as an increasingly aging population is in need of these services. Palliative care and case management can work well together.

- Both case management and palliative care have a team-based approach to improving quality of care.
- There is greater need for both palliative care and case management due to the increasing complexity of medical care and medical challenges.
- People with advanced diseases are living longer and are in need of services that provide the benefits of hospice without the prognosis of having less than six months to live.

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with the diseases they had."

Now, people with advanced diseases are living longer and often are not eligible for hospice care under Medicare, for which patients qualify with a prognosis of less than six months to live. "People have more complex diseases now and it's often not just one medical event, but a combination of things, that lends itself to palliative care," Wild says.

Palliative care is both a philosophy of care and expert, holistic, interdisciplinary care for people with serious, life-limiting illness, says **Lynn Borkenhagen**, DNP, CNP, ACHPN, assistant professor of medicine at the Mayo Clinic College of Medicine. Borkenhagen also is a hospice and palliative care nurse practitioner who works with the Mayo Care Transitions/Palliative Care Homebound Program.

"What we do is add a layer of support to the care teams already involved with the patient, so patients do not have to give up their long-time physicians or nurse practitioners," Borkenhagen says. "We come on board and augment the care they're receiving now."

Worldwide, only 14% of people who need palliative care receive it, and a growing number of people are in need of palliative services as populations age and chronic illnesses are on the rise, according to the World Health Organization (WHO).

"The evolution of case management in nursing and primary care has taken place for similar reasons: People have more comorbidities, complex illnesses, and care has become more complex," Wild explains.

"In order to keep people from being in the hospital and to give them the best care, they've instituted care teams and case-managing nurses to fill that gap," She adds. "This also is true in primary care and palliative care."

Including palliative care services is absolutely critical in care coordination, says **Walter Rosenberg**, MSW, LCSW, manager of transitional care, health, and aging, at Rush University Medical Center in Chicago.

"Goals of care discussions are something we integrate in our program," Rosenberg says. "In our care continuity calls, we've recently mandated that somebody from the Rush palliative care team be on those calls, whether the person is heading to palliative or hospice care or not."

Four out of five adults needing palliative care have cardiovascular diseases, cancer, and chronic respiratory diseases, a WHO 2015 fact sheet reports.

"Palliative services are, for the most part, concentrated in acute care," says **Diane E. Holland**, PhD, RN, clinical nurse researcher in the department of nursing and an associate professor in nursing at the Mayo Clinic College of Medicine. Holland has focused on palliative care in her research.

"Yet, there is an understanding now of the benefit of palliative care services further upstream when a patient has a known condition that can be life-limiting," Holland adds. "There is very much a growing interest in establishing palliative care as part of primary care."

Holland's research has shown that most palliative care services are in hospitals, limiting their availability to rural patients. Also, discharge plans that fail to coordinate transitions from hospitals to home often result in poorly managed care and costly medical errors.[1]

Case or care management, using technology, can help bridge the

palliative care gap. "When a patient is introduced to acute care palliative care resources and then sent home, the primary care provider might not have any education about palliative care," Holland explains. "Palliative care is different from end-of-life services."

Since case managers focus on improving patients' quality of life, palliative care services are a good fit, Holland says.

"There is some evidence that connections to palliative care actually prolong people's lives," she adds.

Palliative care is an undervalued service, Rosenberg notes.

"These are tough conversations to have, and we see a lot of families who are struggling with [end of life] terms," he says. "We have conversations about what it feels like for patients and their caregivers to have discussions about end of life care, and it's critical to include this in all transitional care programs."

Case managers can continue conversations with patients, their families, acute care, and primary care providers about palliative care, Holland says.

"It's also helpful for case managers to have knowledge about a patient's [advance care planning] preferences and why the person wants to move forward with treatment," she adds.

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Integrating palliative care in case management can work

Here are some ideas

Palliative care's recent growth has been partly fueled by the Affordable Care Act's (ACA's) focus on improving healthcare quality.

"It's a very important topic," says **Walter Rosenberg**, MSW, LCSW, manager of transitional care, health and aging at Rush University Medical Center in Chicago.

"I really hope the new payment models and structure under ACA will by necessity include palliative care more," Rosenberg says. "So many people are struggling for a long time when they really should have been in hospice or palliative care."

The ACA focuses on improved quality of care, and the health industry is collecting data that shows how expensive end-of-life care is when patients spend their last days in and out of hospitals. These efforts likely will result in more transitional care programs integrating hospice and palliative care, Rosenberg says.

"Palliative care is different because we try to look at people's preferences and find value in determining what is the best care for them," says **Ellen Wild**, RN, CHPN, palliative care nurse coordinator for the Mayo Clinic in Rochester, MN.

Integrating palliative care into case management is the next step in improving healthcare quality. "We have the ability to be in a role to have different conversations to elucidate people's goals and wishes and preferences and to develop a care plan that meets their wishes," Wild says.

Palliative care is a skill set that requires some attention, notes **Diane E. Holland**, PhD, RN, clinical nurse researcher in the Department of Nursing and an associate professor in nursing at the Mayo Clinic College of Medicine.

Case managers should consider palliative care for very ill patients, and it's never too early to bring up

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) helped fuel the growth of palliative care, creating opportunities for case management to improve.

- The healthcare industry's data collection has highlighted how expensive end-of-life medical treatment can be and will likely result in more integration of traditional care management with palliative care.
- It's never too early to bring up palliative care when patients have chronic and life-limiting conditions.
- Palliative care providers have had training in pain and symptom management.

advance care planning, especially if a person has a chronic and life-limiting condition, Holland says.

Holland and Wild offer the following suggestions for integrating palliative care into case management or educating patients and others about palliative services:

• **Care coordination.** Palliative care nurses can provide care coordination with patients, similar to case management services.

"Oftentimes, I'm doing care coordination with patients via the phone," Wild says.

"When palliative care patients are in the hospital there are multiple teams managing everything, but when they leave the hospital to go home, things kind of fall apart; people don't know which medications to take, they let their symptoms go on longer," she explains. "Palliative care outside of the hospital becomes more important."

Wild calls patients and has visits in clinics, but she does not visit patients' homes. That's handled by a palliative care nurse practitioner, she says.

"We visit with new patients, providing education and care coordination, and then we triage all the phone calls and talk with patients as they call in with their concerns," Wild says. "We coordinate with clinic providers."

Eventually, the palliative care coordination services will expand to include inpatient and additional medical teams. "Then, we'll do some follow-up discharge phone calling to make sure patients' transition home is what it should be."

For palliative care patients who typically are very sick, the transition home presents problems with symptom management and accessing resources, Wild explains.

"With palliative care, we have the ability to develop relationships with people over time, allowing nurses to have discussions of their goals of care," she says.

• **Pain and symptom management.** One of the most important reasons why case management might add a palliative care component is because nurses and others trained in palliative care know a great deal about pain and symptom management, Wild suggests.

Primary care providers generally have a brief window to discuss symptoms with patients, she says.

> "I OFTEN TELL PATIENTS AND PEOPLE WHEN I SPEAK ABOUT THE DIFFERENCE BETWEEN HOSPICE AND PALLIATIVE CARE THAT HOSPICE IS ALWAYS PALLIATIVE CARE, BUT PALLIATIVE CARE IS NOT ALWAYS HOSPICE."

"You will need someone with expertise in pain and symptom management who also is an expert in having difficult conversations with patients and helping them elucidate goals."

Palliative care providers look at patients' health from a whole person perspective and are better able to pull together all of the pieces, Wild says.

• **Discussing palliative care in case management.** When case managers talk with patients who might benefit from palliative care or end-of-life care, it's important to learn about the patient as a person and assess his or her own understanding of the illness, Wild says.

"You can find out what they are most hoping for and try to have those conversations in a way that reflects what they value and what's important to them and their family," she explains. "I try to approach each patient that way."

Start by asking the patient and family permission to discuss advance care planning, and then find a certain comfort zone in bringing up difficult issues, Wild adds. *(See case studies on advance care planning discussions, page 41.)*

"I often tell patients and people when I speak about the difference between hospice and palliative care that hospice is always palliative care, but palliative care is not always hospice," Wild says. "Hospice is end-of-life care, the last six months of life, and palliative care falls into the continuum of the spectrum."

A chief difference is that palliative care patients can continue to receive treatment toward a potential cure at the same time they are receiving palliative services. Hospice patients do not receive treatment, and the chief focus is on symptom relief.

• **Education about palliative care and advance care planning.** "Hospice is about the end of life, but palliative care is living your life to the fullest," Holland says.

The World Health Organization calls palliative care an important public health issue that is concerned about patients' suffering, dignity, care needs, and quality of life.

Case managers can learn more about palliative care and discussing values and end-of-life preferences with patients on sites such as the National Hospice and Palliative Care

Organization's (NHPCO) website at www.nhpco.org.

Also, physicians need to be aware that CMS has included two Current Procedural Terminology codes for advance care planning. The codes are for physicians to document, and receive reimbursement, for having advance care planning conversations, including a first 30-minute conversation with a patient and a second add-on code for another 30-minute conversation.

"In conversations about palliative care, we discuss the individual's goals and values and help them think forward on what's most important," Holland says.

Patients will need to understand the risks of treatments, including side effects, she adds.

"I also think it helps to have conversations with the families," she says.

A provider can ask the following questions:

- Is the family in agreement with what the patient decides?

- What happens when the patient can't make decisions for him- or herself in a future episode of care?

- Does the family know what the patient wants, and is it in accordance with their sensibility?

- What would the patient's parent(s) do in this situation?

Advance care planning includes deciding on a person to make medical decisions when the patient is unable to do so, but it's important for family members to understand that they should base the decision on what the patient would want and would define as quality of life, Holland says. ■

Patient's last goal was to attend family reunion

Woman's ulcer wouldn't heal

A woman in her early 60s left the hospital with a stage 4 pressure ulcer about the size of a grapefruit on her sacrum.

"It was very deep, and they tried for two years to heal it," recalls **Lynn Borkenhagen**, DNP, CNP, ACHPN, a hospice and palliative care nurse practitioner who works with the Mayo Care Transitions/Palliative Care Homebound Program in Rochester, MN.

The woman had chronic obstructive pulmonary disease (COPD) and a mitral valve replacement that failed. She spent two months in the ICU and needed heart surgery again, Borkenhagen says.

"When she came out of the ICU, the goal was to heal her wound, so we followed her along for several months to optimize her heart functioning and promote wound healing," she says. "We got a plastic surgeon involved and put every effort we could into healing the wound."

But when they performed a CT scan to check the progress, they were surprised to see that the wound had gotten even larger and there likely was bone infection, Borkenhagen says.

The woman's treatment while in palliative care had reached an impasse. "We needed to sit down and talk," she says.

Borkenhagen first gathered together the cardiologist, plastic surgeon, and pulmonologist and asked them for honest feedback.

"We asked the plastic surgeon about any further treatments to heal her wound," she says. "He was very emotional and said, 'I have absolutely nothing more to offer her. There's nothing more we can do — this will not heal.'"

The cardiologist said that the woman would not be eligible for a heart valve replacement if her wound wouldn't heal, and without it she was facing certain death.

With this information, Borkenhagen had a difficult talk with the patient. She told her how the medical team had done everything they could to heal her wound, and nothing was working. Then she said, "I'm so sorry I don't have better news. Based on your CT scan, it would appear that your wound is getting worse."

Then Borkenhagen asked the patient what she understood about her heart condition and, also, what was most important to her once they stopped trying to treat the wound.

"She wanted to go to a family reunion on the East Coast and said, 'Please, make this happen,'" Borkenhagen says.

The woman had limited mobility, so it took considerable effort to make her comfortable for safe traveling on an airplane. But the team stabilized her wound and heart and had her travel with family to the reunion. The patient returned safely and died at home eight weeks later, she says.

The woman's death was the way she wanted it, and she was glad that she could make a decision — to travel to the reunion — about something that was important to her, Borkenhagen adds.

"She wore a cute red dress to the family reunion and looked great," she says. ■

Patient only needed someone to listen

Patient's pain an issue

A woman visited the clinic, seeking palliative care services and to see a provider about managing her pain and her goals for care.

The physician thought the patient's most pressing issue was physical pain, but that wasn't the problem she mentioned when asked what she most wanted, recalls **Ellen Wild**, RN, CHPN, palliative care nurse coordinator with the Mayo Clinic in Rochester, MN.

"She began to cry because these discussions were so difficult to have with her family," Wild says. "Patients want to be able to tell their story and have someone listen to them."

They also don't want to be a burden on their family. Wild helped the woman develop a plan of care that gave her some independence and helped relieve her of the feeling that she was a burden to her family.

"This woman was very appreciative that someone asked her why she was coming in, and she thanked me for asking," Wild says.

To learn more about the patient, Wild asked her what she understood about her medical treatment.

"Then I tried to discern from that how we could best help relieve her symptoms and improve her quality of life," Wild adds.

In cases like this, Wild also will provide patients with information about how to have these end-of-life discussions with their families, and she will meet with family members as needed. "I've had discussions with people about their loved one, whose condition is changing, and what their goals are and how they can achieve these goals — maybe transitioning to hospice care," Wild says. "Case management plays a role in developing those relationships." ■

Care coordination model works well with diabetes patients

Caseloads could range to 300 patients

As health systems are evolving to population health models seeking to keep chronically ill patients out of the hospital, they're using case management in the community setting as a tool to achieve this goal.

It's challenging work to improve the health of a population of people, particularly with people who have been sick — or at least not healthy — for a long time, such as a diabetic population. "We're working really hard on getting our patients where their disease is manageable," says **Nancy Loeffler**, MHA, BSN, RN, ACM, CCM, senior director of care coordination and clinical practice at Inova Medical Group in Falls Church, VA.

The program's outpatient case management and care coordination was initiated as part of a patient-centered medical home, Loeffler says.

"We started out with nurse navigators who are care coordinators," she says. "We did data analysis and found the low-hanging fruit, which was diabetic patients in critical care with neuropathies."

After reviewing charts, nurse navigators found there were opportunities to improve care and outcomes through education and follow-up, Loeffler says.

A typical caseload could range up to 300 patients, says **Elena Rushing**, RN, BSN, CNRN, nurse navigator for Signature Partners/Inova Medical Group.

"Most of the patients are diabetics who have A1c [glycated hemoglobin/blood sugar] tests of over 9," Rushing says.

About 30 patients she follows have other chronic illnesses, including congestive heart failure, asthma, and coronary artery disease. And she follows some high-cost patients who use the emergency department frequently.

"I work in five offices; two are family practices, and all are under the patient care medical home," Rushing says.

Anecdotally, case management appears to be working: Diabetic patients receiving case management have shown improvement on the chief measures of disease control, Loeffler says.

"In the first sixteen weeks, we saw that 80% of the 534 patients had dropped 5.5 points in their A1c test."

With those results, the organization expanded the program, hiring two more nurse navigators, she adds.

Loeffler and Rushing offer the following look at how the program works:

- **Obtaining physician buy-in.**

When the care coordination program began, it met with some physician resistance for the first few months, Loeffler notes.

But after Loeffler met with doctors and explained what the program would do, she began to build trust and a relationship. The true buy-in occurred when they saw case managers at work and learned of the positive outcomes, she adds.

Physicians and their staff now gladly welcome the care coordinators: "When they walk into the building, they hear, 'The angel is here!'" she says.

The physician office staff make care coordinators feel welcome, Rushing says.

"Everyone is very excited that we're there," she says. "I really feel like people want us in the offices and are grateful we're there."

• **Dedicated space and times.** When Rushing isn't meeting with patients, she has a space in each doctor's office where she can use a computer and make calls from her work phone.

"That way, I can work in the office and not keep moving around, and I appreciate that space," she says.

Case managers meet with patients in the physician office conference rooms, spending 15 to 30 minutes with patients, Loeffler says.

Rushing makes appointments with patients, going over their diabetes education packet, which covers basic information about their diet, symptoms of low and high blood sugar, and medications.

"I show them how their plates should look when planning meals," Rushing says. "I try to not overwhelm them in the first sitting, and I answer a lot of questions."

When Rushing doesn't have appointments scheduled, the doctor might give her an on-the-spot patient referral.

For instance, the physician might have a problem with a patient who needs to be on daily medications, but cannot afford them. Rushing would meet with the patient and discuss the problem, finding resources as needed, she says.

"In all five offices I go to, the doctors know I am there on that day," Rushing says. "It helps everyone to know the nurse navigator will be there."

• **Clarify what case managers do.** It's possible that a busy doctor's office could begin to rely too heavily on nurse navigators, seeing them as an extra set of hands, Rushing notes.

"Nancy was very firm in making sure that we were not doing those things," she says. "The offices are very aware of that and they know that."

Nurse navigators are there to help patients with health education and to assist them with any social needs they have that act as barriers to their maintaining optimal health, Rushing says.

"A lot of patients want to be listened to, and if I were walking back and forth, trying to help the office's nurses with blood pressure, then I wouldn't be able to give patients 100% of my attention," she explains.

• **Access EMRs.** Through EMR access, Rushing could review patients' charts, hospital records, and outpatient charts.

"I can keep up with them and find out how they're doing when they're in the hospital and when they're discharged," Rushing says.

• **Fridays for staff meetings:** All nurse navigators cover five to six offices each day of the week except for Fridays, which is when they meet at the main office to discuss the week and agenda items, Rushing says.

"For example, one thing I brought up a month ago was that I needed some assistance with a patient I had," she says.

"I discussed a patient from where we were doing transitional care management calls, transitioning patients from the ER or hospital and discharging into the community," Rushing explains. "This patient was going to the ER frequently, two to three times a month, and one of my thoughts was that this patient is going to the ER a lot. Is there something I could do to help with that?"

Rushing's peers have her ideas of strategies to help keep the patient out of the ER. One idea was to have the patient visit the Inova infusion clinic for hydration services. "One of the reasons the patient was going to the emergency room frequently was because she had gastroparesis and needed to be hydrated."

Taking the advice, Rushing got the patient connected with the infusion clinic.

"The patient started going there, receiving services, and has not been back to the ER for the past three months," Rushing says. ■

EXECUTIVE SUMMARY

An outpatient case management and care coordination program targeted a population of people with diabetes to improve quality of life and medical care.

- After a chart review, nurse navigators identified problems that could be fixed and result in positive outcomes.
- After the first 16 weeks, the program had 80% of the 534 patients drop five points in their A1c tests.
- Nurse navigators provide health education and help patients with social needs.

High reliability organizations aim high, strive for zero

Hospitals and health systems are always striving to improve quality and become more reliable providers of healthcare, but some are setting even higher goals by striving to become high reliability organizations (HROs). With the HRO concept, these hospitals are aiming not to just improve and reduce errors, but to completely eliminate them.

That may sound like a recipe for failure, but hospitals are showing that it can be done as they achieve HRO status. Cincinnati Children's Hospital in Ohio and Memorial Hermann Health System in Houston are both HROs that have eliminated many risks entirely and are on the way to zero with others.

Memorial Hermann's mission to zero was prompted in part by two blood transfusion errors in 2006 that left one patient dead and another in critical condition. A new protocol was established that requires more thorough identification and cross-checking at each stage of the process, but reducing transfusion errors would not be enough. The goal was to eliminate them altogether, and from 2007 to today, more than 1.1 million transfusions were performed in Memorial Hermann facilities without a single transfusion adverse event. That first effort at reaching zero evolved into Memorial Hermann's crusade to become an HRO.

Memorial Hermann was among the earliest healthcare providers to strive for HRO status, but the industry is adopting the concept more readily now, says Chief Medical Officer **M. Michael Shabot**, MD, FACS, FCCM, FACMI, at Memorial Hermann.

"Applying the high reliability concept had a slow start, but it is picking up some momentum," Shabot says. "The usual hindrance is a cultural belief that accidents and errors can't be prevented, especially in healthcare, due to the non-perfectibility of man. While it is true that man is non-perfectible, high reliability organizations don't count on perfect employees and perfect users to achieve high reliability."

Cincinnati Children's Hospital has been striving for high reliability for 10 years and **Stephen E. Muething**, MD, vice president for safety and an attending physician, has come to realize that there is no end point for an HRO. The philosophy at Cincinnati Children's is that the good comes from always striving for more. "High reliability is not something you achieve," he says. "We believe the important thing is to relentlessly be on the journey to try to achieve high reliability. The more we improve, the more we feel that we have to improve."

Minimizing errors not enough

The HRO concept was first developed through studies of the air traffic control system, naval aircraft carriers, nuclear power operations, and other systems that must operate with zero defects where minimizing errors is just not enough. HROs have many feature in common, including risky and complex technologies that present the potential for error and complex processes. They also have highly trained personnel, ongoing training, process audits, and continuous improvement efforts. One of the main traits of an HRO is that they can't afford to learn through trial and error; the scale of the potential harm is too great.

In HROs, senior leaders are conducting frequent walk-rounds to reinforce safety behaviors and find and fix critical safety issues, Muething notes. Senior leaders also meet in daily operational briefs where they look back to learn from failures and look forward to predict and lessen risk or harm. At Cincinnati Children's, frontline leaders such as unit charge nurses round with staff every day, giving 5:1 positive to negative feedback, conduct daily huddles, and model the expected safety behaviors. HRO leaders also manage by anticipation and prediction rather than reaction, Muething notes. They focus on predicting events in the next 24 hours and making real-time adjustments.

Support from the highest levels of administration and the C-suite are crucial to achieving high reliability, Muething says. Transparency is a critical element in high reliability, he says, and that cannot happen without support from top leaders. "You can't be on this high reliability journey if you aren't willing to talk about what went wrong every single day," he says. "If you have a culture of fear and uncertainty, you can't do this."

Impressive results for HROs

Shabot emphasizes that HRO is about making a cultural change in the organization, which takes time. It is about establishing the belief that measurable adverse events can be

prevented for long periods of time, he says. Once that concept is accepted, the hospital can focus on developing systems to reach that goal. Three hospitals in the Memorial Hermann system have gone for more than five years without a retained foreign object, Shabot says, which he says is a testament to how an HRO achieves what previously would have been called an unrealistic goal.

"Is it because we found a whole crop of perfect surgeons and nurses? No, we have the same surgeons and nurses, but five years ago they developed new processes for what to do when a sponge count is off and the actions taken before the patient is closed," he says. One of the process improvements was the implementation of radio frequency identification (RFID) scanning of sponges in addition to the radiopaque marker.

"The healthcare organizations that are moving toward high reliability are seeing very dramatic results," Shabot says. Memorial Hermann worked with the Joint Commission Center for Transforming Healthcare to target hand hygiene and saw the average across all 12 hospitals in the system go from a baseline of 44% hand hygiene compliance to 92%. As a result, the rate of central line-associated bloodstream infections and ventilator-associated pneumonia decreased to essentially zero across the system, Shabot says.

Memorial Hermann also began a program called "Board to the Bedside," intended to engage all 21,500 health system employees in high reliability. To achieve that goal, the health system centralized its quality departments, trained all employees off-site in the principles of high reliability, and emphasized the use of evidence-based protocols. It also documented performance on quality measures with data dashboards.

Striving for high reliability also has led Cincinnati Children's to broaden its view on what constitutes patient harm, Muething says. What might previously have been regarded as a complication or just an inevitable part of the medical process can now be classified as patient harm.

"It might be slowness in making a diagnosis or managing a situation, or a complication that was considered just a risk that came with the treatment," Muething says. "Now we look at that and say, 'No, that is unacceptable harm.' We keep raising our standards about what we consider preventable. Instead of debating whether a harm was preventable or not, now we're moving toward thinking that all harm is preventable and we just don't know how to prevent some if it yet."

Muething notes that at Cincinnati Children's, little distinction is made between patient safety and employee safety. Metrics for both are intertwined, so any discussion of patient safety metrics will be accompanied by similar data on employee lost work time injuries and similar measures.

Shabot notes that while safety is the primary goal of high reliability, reaching zero risks in a particular area also has the added benefit of improving the work experience for many people in the system.

"No one gets in trouble. Our physicians and nurses don't get in trouble because a patient was harmed, and nobody goes to peer review," he says. "We don't have lawsuits. Everybody wins, and we're proving that hospitals can do it. It's not just airlines and nuclear power plants."

Memorial Hermann recognizes hospitals with a Certified Zero Award for eliminating risks. One hospital received a Certified Zero Award for having no central line-associated bloodstream infections for 12 months, for instance, and five hospitals eliminated ventilator-associated pneumonia. Others have received the award for eliminating retained foreign objects, serious pressure ulcers, hospital-associated injuries, deaths among surgical inpatients with serious treatable complications, birth traumas, accidental punctures and lacerations, deep vein thrombosis, and many other risks. Two hospitals have now gone longer than a year without a catheter-associated urinary tract infection, "something we thought was impossible as recently as two years ago," Shabot says.

Memorial Hermann recently assisted the Hospital Association of South Carolina with implementing the HRO concept for its member hospitals, and the association included the Certified Zero Award.

"They have now given out 188 Certified Zero Awards to hospitals in South Carolina," Shabot says. "That is remarkable because before they did this they had no hospitals going a year without these kinds of adverse events. It's not because they made people perfect, but because they put in processes and systems that catch errors before they ever get close to patients. That's how well it works."

Muething endorses a word of advice he was given years ago when first considering high reliability: Start before you're ready.

"Because you're never going to be ready," he says. "It's a journey you just have to get started on. There is so much to learn from other organizations that have taken this step, and I have been so impressed by how much people from other industries are willing to share their insights if you just ask." ■

Hospital culture must be measured, not just improved

Hospitals strive to have the right culture, particularly when it comes to patient safety, but measuring improvement can be challenging. It's not enough to strive for a health culture, one expert says. You also have to know if you're getting any closer to your goal.

The idea of a hospital's culture is challenging enough for many people, but the idea of measuring it can be even more difficult, says **Catherine Miller**, RN, JD, senior risk management and patient safety specialist for the Cooperative of American Physicians in Los Angeles.

"All of the major patient safety leaders really think that culture most significantly impacts patient safety, worker happiness, and patient outcomes," Miller says. "It's nebulous, it's hard to get your arms around it and define it, but you can see it and feel it. And you can measure it."

A working definition of hospital culture is the attitudes, behaviors, beliefs, and expectations of an organization, Miller says. A more folksy definition is "the way we do things around here," she adds. In hospitals with a good safety culture, people feel supported, that they have tools to do the job, that they are listened to, and they can escalate patient safety concerns without fears of retaliation, she says. A good safety culture correlates with fewer infections, fewer readmissions, and overall better patient outcomes.

A multi-pronged approach is best when measuring culture, Miller says. The Joint Commission requires that hospitals annually survey and assess their safety culture, and there are several tools available. One that Miller recommends is the Hospital Survey on Patient Safety, created by the Agency for Healthcare Research and Quality, available online at http://tinyurl.com/pzm62sn. The survey asks questions of hospital staff such as whether they have enough staff to handle the workload, whether people treat each other with respect, and if the respondent can escalate a patient safety concern without fear of reprisal.

"Surveying your folks is a good way to start improving your culture because you get a baseline," Miller says. "Another thing to consider doing is conducting patient safety rounds and interviewing staff. Maybe when you get the survey results, that is a good time to go out on the floor and try to drill down deeper into any issues that were identified there."

> A COMMON MISTAKE WHEN TRYING TO IMPROVE HOSPITAL CULTURE IS TO UNDERESTIMATE HOW LONG THE PROCESS WILL TAKE.

Interviewing patients and family members also can yield great insight, Miller says. The most useful information can come from long-term and frequent flyer patients because they have the most exposure to the hospital, she notes.

A common mistake when trying to improve hospital culture is to underestimate how long the process will take, Miller says. She likens it to a political campaign: long and arduous, but you should be able to tell if you're winning or not.

"It's easy to think that if you get out there and promote your mission statement, staff will align themselves with it. Then that's it and after a while you have a culture of safety," Miller says. "That's not enough. It's very much dependent on leadership guiding this from the top down, having a presence at new employee orientation, every chance they get to be seen advocating for a culture of safety."

Periodically, you should reassess the culture by surveying staff at least annually as required by The Joint Commission, but perhaps more often to explore specific areas that you are trying to improve. Also, don't underestimate the value of face-to-face discussions with managers and frontline staff, Miller says. Data from surveys and other tools is essential, but sometimes your best assessment of progress will come from the few minutes you spend chatting with a nurse who happened to be walking by. You may hear that he or she has noticed real improvements in the way staff feel about the culture of safety, and you may hear that there are still particular issues that need more attention.

"Leadership can get so bogged down with meetings and other distractions that they find it hard to get out on the unit and connect. Just getting out there and introducing themselves is one way they show their commitment to the culture of safety, so you can't downplay the importance of just walking onto a unit and saying hello," Miller says. ■

Malpractice can begin at the front desk with simple errors by admissions staff

Seemingly simple errors at the front desk can have devastating effects on patient safety and may expose the hospital to litigation that is more damaging than malpractice lawsuits, warns a lawyer who has studied the issue. The lawsuit resulting from a front-desk error may be viewed by the courts as ordinary negligence, which brings the possibility of larger jury awards.

Risk managers should ensure that front-desk personnel are properly trained and follow strict protocols, says **Alex Stein**, JD, professor of law at the Cardozo Law School in New York City. It is easy to forget that front-desk staff can influence medical care and patient safety even though they are not clinicians, he notes.

These protocols should tell exactly what should be done at the registration process and at the front desk, but Stein cautions against developing your protocol from scratch. Even if you are eager to devise the perfect protocol, you are better off using one that is already available.

"The best strategy is to copycat. See exactly what the industry does, and then do exactly that," Stein says. "If those protocols reflect what is going on in the industry, and if you follow those protocols very closely, that will practically preclude liability for the hospital because negligence is defined as a deviation from what is going on in the industry."

The Georgia Court of Appeals recently addressed a malpractice allegation that illustrates how errors in the admissions process can threaten patient safety and lead to liability.

In that case, the court determined that a clinic staff member's failure to communicate a patient's complaints to a doctor is ordinary negligence rather than medical malpractice, as the plaintiff contended. *(The case is Wong v. Chappell, 773 S.E.2d 496 [Ga.App. 2015].)* Stein explains that an unlicensed medical assistant employed by the clinic took a phone call in which the patient said she was experiencing pain radiating from her flank and back, changes in her bowel movement, and was bleeding. Court records indicate that the assistant suspected the patient was having a urinary tract infection and inquired about the typical symptoms.

The assistant did not relay the patient's concerns to any doctor, nurse practitioner, or physician's assistant because, she stated, she did not think the symptoms were sufficiently serious. The patient developed a life-threatening complication and died.

"The lesson that jumps out at you is how this is such a crucial link in the system, that person who answers the phone or greets people at the door," Stein says. "If that person fails to act responsibly, especially if critical information about a patient is not conveyed to the clinician, it can be a disaster."

In addition to demonstrating how an insufficiently trained front-desk employee can jeopardize the safety of patients, the court's ruling has important lessons regarding how such cases are likely to be viewed by the legal system, Stein says. Treating the allegation as ordinary negligence rather than malpractice means that the plaintiff can file suit and go to trial without first obtaining a certificate of merit and expert testimony, he notes. Also, ordinary negligence can give plaintiffs an edge because many states have limitations and caps on damages for medical malpractice.

One of the most important differences is that the plaintiff can use a much broader jury instruction regarding ordinary negligence, instead of a jury instruction that speaks to the specific and narrow definition of medical malpractice, Stein explains.

"The big takeaway lesson from this case is that being sued for negligence in the registration process, or whatever happens at the front desk, is the worst-case scenario," Stein says. "You won't be entitled to all the protections that doctors and hospitals get when sued for medical malpractice rather than this negligence." ■

COMING IN FUTURE MONTHS

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- Ambulatory RN care management service reduces mortality, readmissions
- New CMS rules will tweak discharge planning and case management
- Strategies for handling dementia patients in ambulatory setting

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CE QUESTIONS

1. Which of the following best describes the purpose of palliative care, according to Lynn Borkenhagen, DNP, CNP, ACHPN?

A. Palliative care is both a philosophy of care and expert, holistic, interdisciplinary care for people with serious, life-limiting illness.
B. Palliative care is pain and symptom management solely for hospice patients.
C. Palliative care is a type of alternative medicine that is offered to cancer patients.
D. None of the above.

2. Under CMS, a palliative care referral requires which of the following?

A. A physician's prognosis that the patient has less than six months to live.
B. The patient has one of the diseases or conditions specified by CMS.
C. The patient is willing to stop all potentially curative treatment.
D. None of the above.

3. When having an advance care planning discussion with the family of a patient who is nearing the end of life, providers should ask several questions. Which of these is *not* correct, according to Diane E. Holland, PhD, RN?

A. Is the family in agreement with what the patient decides?
B. What happens when the patient can't make decisions for him- or herself in a future episode of care?
C. Would the family like to continue with treatment even though the patient has indicated a desire to stop?
D. Does the family know what the patient wants, and is it in accordance with their sensibility?

4. A care coordination program for diabetic patients resulted in which of the following results, according to Elena Rushing?

A. Within six months, their A1c tests showed a 50% drop.
B. Within a year, their blood sugar levels were stabilized to normal range.
C. Within 16 weeks, 80% of the patients had dropped 5.5 points in their A1c test.
D. Within 6 weeks, the average blood sugar level had dropped 15%.