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INSIDE

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ACO Improves Population Health by Using Case Management, Data

A doctor's phone call can help

Collecting population data and creating targeted case management strategies can help a healthcare organization improve patient health and reduce medical costs.

Case management often is geared toward achieving population health quality targets, but sometimes the best solution is to help a patient manage his or her minor medical complaints.

"There were many times when I'd get a call on a Sunday morning from a patient who had a little abdominal pain, and it didn't sound too serious — just some acid reflux and heartburn," says **Rick Ludwig**, MD, chief medical officer of value-based care at Providence St. Joseph Health in Renton, WA. "I'd suggest their spouse go to the drugstore and get some antacids and have them crush it up and take them. I'd call back in an hour or two and the pain was gone."

PHYSICIANS CAN BE PART OF THE CASE MANAGEMENT SOLUTION TO OVERUTILIZATION OF HOSPITALS AND THE ED WHEN THEY MAKE THEMSELVES AVAILABLE TO PATIENTS AFTER HOURS.

Physicians can be part of the case management solution to overutilization of hospitals and EDs when they make themselves available to patients after hours.

In another example, Ludwig tells of speaking with patients in the evening about their skin rashes, bladder infections, and similarly minor concerns. "I suggest they see me the next day in the clinic, and I'll see them at 8 a.m.," he explains. "They know they can

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call me at 2 a.m. if their problem gets worse, so it's not like they're abandoned."

Without that kind of telephone interaction, the patients might have headed to the ED worried that their problems were serious.

A population health strategy also addresses routine screenings, vaccinations, and chronic illnesses. "We have an electronic medical record that allows us to drill down to [data on] individual patients," he says.

The population health approach helps patients, including employees, manage their chronic illnesses and ensures they receive appropriate health screenings.

"We talk with patients about the importance of quality care, and we want to keep our employees healthy, too," says **Linda Marzano**, senior vice president of value-based care at Providence St. Joseph Health.

This is one aspect of how an accountable care organization (ACO) uses data and case management strategies to improve the health of its population.

"We have our own ACO, started in 2014," says **Barbara Fetty-Solders**, RN, MN, CCM, manager of care management at Providence St. Joseph Health.

"We initially started with some direct contracting with employers in our area, and we have continued to expand our risk-based contracts, mostly with payers," Fetty-Solders says. "We have almost 800,000 lives that are in some sort of risk contract."

The organization collects Healthcare Effectiveness Data and Information Set (HEDIS) measures and sets targets to improve population health over time, she says.

"Each year, our regions are expected to improve their existing quality measures by a certain percentage," she adds.

Hospital utilization is improved, but work on the quality measures continues, she says. "We're not quite where the goal is yet."

An ambulatory quality council (AQC), which consists of medical leaders and other stakeholders, decides what to measure and sets goals, Ludwig says.

"That group looks at where we are for each measure and sets goals for each year," he explains. "The ultimate goal is to hit the 75th percentile for national benchmarks by 2020."

This goal already has been achieved for some measures. "In others, we're far behind," Ludwig says. "We look at 2020 and do the math to see what [data point] we have to hit each year in order to get there."

EXECUTIVE SUMMARY

A population health program uses quality metrics, case management, and other strategies to reduce healthcare costs and improve patients' health outcomes.

- Patients are encouraged to call their primary care physicians during evening and weekend hours if they're concerned about a health issue.
- The strategy addresses routine screenings, vaccinations, and chronic illnesses.
- An ambulatory quality council decides what to measure and sets goals.

Anecdotal evidence and data suggest the program is working. For instance, a pilot program titled "Call Us First" advertised the importance of calling an after-hours number before heading to the ED, Ludwig says.

"We engage patients in the clinic to call us before they make a decision to go into the ED," he says. "They've reduced ED use by more than 5% in the pilot study, and we're spreading this program this year to the rest of the organization."

The program has cost-savings potential. "There's no cost associated with the program," Marzano says. "Our physicians take the after-hours calls for patients who call in with some kind of problem and want to talk with a doctor."

The program didn't result in more calls than physicians were able to handle, Ludwig notes. "It wasn't an avalanche of need after hours by our patients."

Physicians worry about taking more calls, but the pilot project showed that there wasn't that much demand after normal clinic hours, he adds.

But those who do make the after-hours call need help or else they might head to the ED as their default. "It's striking how many patients think when the clinic is closed, they're on their own," Ludwig says. "They just didn't know that the point of getting a doctor is you have coverage. They're surprised and delighted they have the ability to call someone."

The program's model is mixed. Some case managers are embedded in the clinic, and some provide phone support. Some are RNs, and still others are social workers, Marzano says.

Nurse case managers also call patients who have overutilized the ED and help them find a community primary care provider, Fetty-Solders says.

"We see what kinds of needs they have and why they keep returning to the emergency department," she says. "We use community resources for referrals, and in our clinic, we have embedded, licensed social workers who can do counseling and we have psychiatrists who can help with diagnoses."

The idea is to address any issues that affect their health and ED visits.

"The success of this program is teamwork and having good relationships with clinics and staff," Marzano says. "It takes a team to manage these patients." ■

Strategies to Tie Case Management to Population Health Data

Start with quality measures

Case management is an integral part of population health programs that work to improve overall patient health and reduce hospital and ED use by people with chronic conditions and behavioral-mental health issues.

To serve a large population of patients, it's important to gather health data and quality measures, and to develop goals.

Here is how one data-driven population health and case management program works:

• **Select quality measures.** It's important to select quality measures that are evidence-based and related directly to patient health improvements, says **Rick Ludwig**, MD, chief medical officer of value-based care at Providence St. Joseph Health in Renton, WA.

For example, colon cancer screening can save lives. One quality measure could be that people for whom colon cancer screening is recommended undergo a colonoscopy.

Another quality measure might be to reduce ED usage among high utilizers, including people who visit the ED five or more times a month.

Quality measures could include a target blood glucose or blood pressure level and meeting kidney disease screening goals.

• **Case management focuses on quality targets.** Quarterly joint operating committees report on risk-based contract outcomes. These are based on claims data, says **Barbara Fetty-Solders**, RN, MN, CCM, manager of care management at Providence St. Joseph Health.

Some contracts have downside risk and others are upside, meaning the organization receives a bonus for meeting quality targets. "Others are capitated," she notes.

Downside risk can lead to significant losses, and all risk must be managed well.

"These ACO [accountable care organization] contracts typically have incentives built around how well you do against a cost target for the total population," Ludwig says. "If you

beat a target, you may share in some of the savings, but you don't get the savings unless you also deliver on quality measures."

"We learned over time that it takes clinical transformation and cultural change to manage these contracts well," Fetty-Solders adds. "It takes time to make these changes from fee-for-service to value-based care and quality outcomes, where you're focusing payment methodology on value."

Case management is just one of the tools for shifting healthcare to value-based care.

"It's not just case management, but also focusing on quality targets and defining quality," Fetty-Solders says. "With these outcomes of risk-based plans, we routinely report on utilization, emergency department use, and inpatient care."

Case managers contact patients after ED visits and help patients find primary care providers.

• Provide case management help for various patient needs. "I think it's important to get across to people that the work the case managers do is very creative work and complex work," Ludwig says. "They're looking at the whole patient and how they can improve the health of the whole patient. It might have to do with chronic disease, but also behavioral health issues and family issues," he explains.

For instance, if an elderly patient is falling at home, then case managers can help the patient transition to an assisted living facility, Ludwig says.

"Or maybe the patient's spouse has a little dementia, and they both live at home but are becoming frail," he adds.

Case managers also assist with behavioral health issues. "That's a big issue in a Medicaid population and in the commercially insured population — particularly for those patients who go to the emergency department a lot," Ludwig says.

"It's a broad topic, but you do the best you can to engage patients and refer them to appropriate services, whether that's substance abuse treatment or seeing a psychologist," he adds.

• Medical assistants can lend help. One model has a nurse case manager and a medical assistant focus on disease management.

Medical assistants check patients' records to make sure they are up to date on all screenings.

"If the patient hasn't had a mammogram, then they're told they are behind on that," Fetty-Solders says.

Medical assistants help with focusing on quality targets, she adds.

• Use alternatives to helping patients in traditional medical settings. One alternative setting is in pharmacies. Chain pharmacies can provide quick, low-cost medical care to patients with low-acuity conditions.

"Recently, I took my 85-year-old neighbor, who is legally blind, to a Walgreens on a Sunday because he couldn't hear and thought it was ear wax," Fetty-Solders says. "It was his ear wax, and he was so pleased to get the ear wax out, and the nurse practitioner showed him which products to buy to keep ear wax out of his ears."

Another option is to have dietitians take patients to grocery stores to teach them how to read labels and make healthier food choices, says **Linda Marzano**, senior vice president of value-based care at Providence St. Joseph Health.

• Target high utilizers. "We have good stories about what care managers have done for patients, including engaging patients who would go to the ED every week," Ludwig says.

Case managers helped to stop patients from using the ED as their primary care provider.

"We have engagement with the entire patient population to help them understand that we're here for them, and we encourage them to call us before they go to the ED," he says. "That's more than care management."

Nurse care managers focus on the patients with a history of frequent inpatient stays and ED visits, and they try to get these patients' chronic conditions under control, Fetty-Solders says.

"We encourage the implementation of a care model where they reach out to patients with diabetes and invite them to ongoing case management," she explains. "The nurse takes their case to a committee or case review, where they go over

EXECUTIVE SUMMARY

Organizations can employ a number of strategies to improve health outcomes and reduce medical spending when engaged in a population health program.

- A first strategy is to select quality measures that are evidence-based and related directly to patient health improvements.
- Case managers focus on quality targets, including screening targets, and chronic disease management goals.
- Changing the organization's culture from fee-based to value-based care is a crucial part of success in population health efforts.

what medications the patient is on and what the patient's goals are."

• **Change the culture.** The healthcare industry is undergoing a big shift from fee-based to value-based care. It's a cultural change from being fully focused on production to focusing on the quality outcome, Fetty-Solders says.

Capitated health plans, population health, and a focus on utilization and quality measures are helping organizations make this shift, but it take continual reinforcement, she notes.

"It's about not jumping to the high-cost imaging tests first, but trying other things that help a patient improve, like physical therapy [or other] non-opioid pain treatment," Fetty-Solders says.

"Sometimes it takes focusing on advance directives," she adds. "With an elderly population, make sure advance directives are in place, asking patients what they would want done if they're hospitalized with a serious illness."

Every patient should have this conversation about decisions they would like to make, and should discuss these issues with their families.

"I'm passionate about care management and where we can go with this in the United States," Fetty-Solders says. "Let's make good decisions around care for our patients." ■

Case Managers Help Total Joint Surgery Program Reach Goals

Outcomes show no infections or hospitalizations

Case managers are integral to two North Carolina bundled payment for total joint surgery programs, one of which is an outpatient program and another that is Medicare-based.

The outpatient bundled program established in August 2017 by Delta Joint Management of Greensboro, NC, has case managers coordinating care for patients with physical therapy and other appointments up to 90 days after surgery in an ambulatory surgery center. Its financial and health outcomes success is tied, in part, to case managers assisting with criteria assessment, communication, and coordination.

The organization's case managers handle a Medicare bundled total joint program, so when the outpatient bundled program was launched, case managers were trained to work with this private insurance population, says **Donna Garvey**, CMPE, practice administrator of Sports Medicine and Joint Replacement in Greensboro and executive director of Delta Joint Management.

The program has worked very well for bundled ambulatory surgery total joint patients, with outcomes better than the national average: There were zero infections and deep vein thrombosis issues in the bundled program's first nine months, and a 1.6% reoperation rate — less than half of the national rate. Hospital readmissions are zero, compared with 3.5 to 6.5% nationally, says **Steve Lucey**, MD, co-founder of Delta Joint Management.

Because of the positive health outcomes, the bundled payment strategy is financially feasible. The physician owners of Delta Joint Management pay for patients' care from the day of surgery to 90 days after surgery. One negotiated payment per patient with a private payer covers everything required to ensure a successful surgery. If a patient's surgical site became infected or some other problem arose, the physicians' company would be responsible for covering those costs, up to a cap.

Patients pay 10 to 20% of the total amount in co-insurance. Their out-of-pocket costs are much less in the outpatient setting, Lucey says.

For the program to work financially, case managers must ensure patients and families are aware of their responsibilities.

"Our outpatient patients have done very well," says **Lisa Thornton**, case manager at Sports Medicine and Joint Replacement. "We make sure patients have everything they need when they get home. They have prescriptions filled, any equipment they might need, outpatient physical therapy appointments scheduled, and we make sure a caregiver is there with them."

This type of focused case management gives case managers more time to focus on what patients need and what the outcomes should be, says **Renee Angiulli**, RN, BSN, MHA, CCM, case manager at

Southeastern Orthopaedic Specialists in Greensboro, NC.

"I think there's more consistency when you focus on a population than when you work across the spectrum of patients," Angiulli says. "You learn the nuances and tricks to keep those patients successful."

Case management for the inpatient total joint Medicare population requires a little more creativity because they often have less household support, Angiulli says. *(See story on case management with Medicare total joint program, page 79.)*

Here's how the program works:

• Case managers assess patients for inclusion in the outpatient total joint program. Patients must meet specific criteria to enter the program. Case managers use an assessment tool to ask patients about their health. Questions target risk behaviors, such as whether the patient has any of the following red flag issues:

- Does the patient take more than 10 mg of oxycodone a day?
- Is the patient's A1c (blood glucose level) over 7.5?
- Is the patient morbidly obese?
- Does the patient experience serious psychiatric issues?

A "yes" answer to any of those questions could suggest it would be safer for the patient to undergo surgery in the hospital, where he or she could be monitored for a few days post-surgery.

"I do the risk assessment to make sure they're truly healthy enough to do outpatient surgery at the center," says **Jill Lauer**, registered nurse/case manager at Delta Joint Management.

After performing the risk assessment, case managers check the patients' medical records for respiratory, cardiac, liver, and other conditions to see if anything stands out as a potential surgery risk. Checking the medical records can verify or correct patients' recollections of their medical history, Lauer notes.

"It's a lot of communication between schedulers and physicians and case managers," Angiulli says. "I call the patient and go through the check-off questions, and then I put it in and say 'This is a good candidate for outpatient surgery.'"

• Physicians conduct pre-surgery physical. Patients who meet criteria are scheduled for surgery. A few weeks before surgery, patients visit the surgeon for a physical and medical history.

"They are potentially diving even deeper than I do," Lauer says. "They go over medications and make sure any health conditions are controlled. They discuss the surgery in detail and answer any questions patients might have."

Then a case manager meets with patients to make sure they have someone who can be with them for at least three days after surgery.

"We ask how many steps they have at the house and how many stories. What kind of equipment do they need? What kind of therapy will they have after surgery?" Lauer explains. "Then I set them up for the therapy appointment and coordinate that."

• Develop a care plan. "As case managers with Dr. Lucey's practice, we started several years ago treating total joints and partial knee replacements," Thornton says. "As a case manager, I speak with a patient prior to surgery, and we design the patient's care plan."

Case managers determine whether the patient needs home health or outpatient physical therapy.

"We make sure they have a caregiver to stay with them for at least 72 hours when they're discharged from the surgical facility," Thornton says. "We make sure they have transportation lined up, and we're the first contact point for our patients."

Case managers also tell patients how to keep their legs elevated properly after surgery. "We tell them to keep their toes above their noses and go over icing protocols, giving them a folder of frequently asked questions," Lauer says.

• Contact patients one day post-surgery. "We talk to patients the day they're discharged from the facility," Thornton says.

Case managers call patients to ensure they have filled their prescriptions. "We call to make sure the pain meds are controlling their pain," she says.

"If they will be using a CPM [continuous passive motion] machine, we make arrangements for

EXECUTIVE SUMMARY

For an outpatient bundled total joint surgery program, case managers play an important role in helping patients stay healthy post-surgery.

- Case managers were trained to work with a private insurance population that undergo total joint surgery in an outpatient setting where they are sent home instead of to a hospital bed after surgery.
- Outcomes show no infections or deep vein thrombosis issues, and a lower percentage of reoperations than the national average.
- Case managers start by assessing patients for inclusion in the outpatient surgery program.

it to be delivered," Thornton adds. "We also make sure they know when the home health physical therapist is scheduled to come in for the first visit."

Case managers encourage patients to ask questions. Some common patient questions include:

- When do I take my medications?
- When can I take a shower?
- What do I do about drainage from the bandage?
- How should I take muscle relaxers?

Patients have a lot of questions about pain, Thornton notes.

"Our physician assistant is good about explaining prior to surgery that they're going to feel pain," she explains.

"Often, they've had a nerve block in the hospital and it hasn't worn off, so when they leave the hospital they haven't been feeling the pain, but they'll start to feel it once they are at home," she adds.

Case managers should prepare knee replacement patients for the pain they'll experience, Lauer says.

"We have a protocol in place for pain management, but a lot of people get concerned that the pain isn't normal," she says. "We reassure them that the pain is normal."

• Call at one week and 30 days post-discharge. At one week after surgery, case managers call to make sure patients have attended their outpatient physical therapy.

This phone call is proactive, helping to reduce the volume of phone calls patients make to the physician's front office, Thornton says.

The calls also might prevent a hospitalization. For example, one patient developed a significant hematoma. Instead of going to the ED, he called Lauer and texted a picture of his knee.

"I sent that photo to Dr. Lucey, and we got the patient on antibiotics and had him see the doctor the next business day," Lauer recalls. "He had to have a wash-out procedure, but otherwise he would have ended up in the ER."

At two weeks post-discharge, patients visit the doctor's office. Case managers usually do not call patients between one and four weeks post-surgery unless patients are experiencing considerable pain, Lauer notes.

At 30 days post-surgery, case managers check in on patients to

Case Managers Assist With Total Joint Care Transition

A Medicare bundled total joint program has case managers help patients transition from the hospital to a post-acute care or home setting.

"We follow patients long-term — up to 90 days, or longer if they need to reach out to me," says **Renee Angiulli**, RN, BSN, MHA, CCM, case manager at Southeastern Orthopaedic Specialists in Greensboro, NC.

Case management starts a few days before the surgery. The case manager visits the nursing home to make sure it's an appropriate plan for when the patient leaves the hospital, she says.

"For 90 days after the hospital discharge, I call the patient weekly, tapering off to bi-weekly for up to 12 weeks," Angiulli says. "Then I call at six months and a year. We really follow up to make sure they don't fall through the cracks."

With the Medicare population, case managers must be creative. There sometimes are difficult situations, such as cases where the patient's family lives in another state and the patient has no one to care for him or her after the surgery, she says.

Even when a caregiver is available for the first few days post-discharge, the caregiver might have difficulty handling the job.

"Sometimes I have to call these patients every day, including weekends," she says. "Maybe the patient is confused or had a bad reaction to medication, and they can't handle it."

Help at home is essential for elderly patients, and it's important that caregivers stay with the patient as outlined in the care plan, says **Lisa Thornton**, case manager at Sports Medicine and Joint Replacement in Greensboro.

"We had an incident with an inpatient Medicare patient where the patient had a family member lined up to stay with them," Thornton recalls. "After the patient was discharged, the family member got up the next day and went to work."

The elderly patient was left alone on pain medications. The woman took her medications incorrectly, which placed her at risk of a fall. In situations like this, a case manager might move the patient to a skilled nursing facility for a week, she adds. ■

see how they're doing with their pain and physical therapy sessions. Patients experiencing excessive pain or other issues are called more frequently. Those who have had this surgery before might not need much guidance, Lauer says.

Total joint surgery requires a well-trained team, and case managers are the contact people between the team's surgeon, physician assistant, patients, physical therapists, and others, Thornton notes. "I think our roles are very important in the successful outcomes of our patients." ■

Hospitals Leverage Safety Huddles to Reduce Patient Harm, Drive Culture Change

The Joint Commission says daily safety briefings, or huddles, as they often are called, are a hallmark of a high-reliability organization. But how does one keep such sessions from devolving into just another task that must be checked off every day as opposed to a vehicle for reducing harm?

While hospitals design safety huddles in several formats, most organizations that have enjoyed success with the process say these huddles must be driven and supported by executive leadership. However, just as important are filtering mechanisms that bring frontline clinicians into the process and foster a culture of reporting and transparency that penetrates deep into the many layers of a modern healthcare system. In fact, when executed effectively, safety huddles can be a primary tool for driving effective organizational change, experts note.

Focus on Communication

Certainly, a revamp of the safety huddle process was a top priority at Providence Little Company of Mary Medical Center in San Pedro, CA, and it was one of the first steps hospital leaders took in their quest to improve safety and high reliability.

Steven Brass, MD, MPH, MBA, director of medical affairs at the hospital, says the organization's focus on this issue was all about communication.

"The way our day begins at the hospital is with everyone getting together. It's where communication happens," he says. "We know that 70% of errors relate to communication problems. The huddle is the perfect way to improve communication and, therefore, to reduce these errors."

WHEN EXECUTED EFFECTIVELY, SAFETY HUDDLES CAN BE A PRIMARY TOOL FOR DRIVING EFFECTIVE ORGANIZATIONAL CHANGE, EXPERTS NOTE.

In designing a new process, developers were not starting from scratch. There already was a morning meeting that took place every day during which nursing leaders would report on key metrics, such as bed occupancy and staffing issues, to the house supervisor.

"It would take less than five minutes, and then quickly disband," Brass notes. "There was no structure; it was not used to do quality metrics or to review data, and it was solely limited to the nurses."

However, a sister hospital that already was well into its journey toward high reliability had recently revamped its safety huddle process, and Brass took full advantage of the organization's experience.

"I attended their safety huddle and observed how they did it," he says. "We put together an agenda based on what they had done and then added a couple of areas we thought were very relevant to our hospital."

However, that was just a starting point, as the agenda and the process went through several iterations — even after the new safety huddle process went live in April 2015. For example, since that starting date, the length of the huddle has been trimmed by more than half to 20 minutes and 20 specific agenda items, beginning with reflection and safety messages, but then quickly moving on to concrete safety issues such as:

- ED boarding;
- psychiatric holds;
- excessive lengths of stay (LOS);
- readmissions within 30 days;
- medication errors;

• falls;
• hospital-acquired infections (HAIs);
• use of restraints and Foley catheters;
• unexpected deaths;
• codes;
• skin ulcers;
• electronic medical record (EMR)-related problems;
• delays of service;
• any physician or caregiver safety concerns;
• equipment-related issues.

To go along with the agenda items, developers designed documentation tools to facilitate the tracking of various HAIs, the use of Foley catheters and restraints, skin ulcers, 30-day readmissions, and excessive LOS.[1] Further, certain topics or themes are covered in more depth on specific days.

"On Monday, we review our finances and how we are doing. Tuesday, we quickly review our recruitment and open positions, and on Wednesday we look at readmissions over the past 30 days," Brass explains. He adds that Thursday is set aside for a discussion of HAIs and falls, and on Friday the huddle attendees discuss issues pertaining to the patient experience. "We have leaders on each of these areas come into the huddle and provide information on the [specific] topic area," Brass adds.

Exercise Discipline

With such a lengthy list of agenda items, it can be challenging to control the duration of the huddles. However, Brass says it is a matter of setting expectations.

"We start at 9:30, whether everyone is in the room or not, and we close the door. The expectation is that everyone will arrive on time. That is crucial," he says.

Further, Brass explains that when an issue comes up that clearly will require much more discussion, huddle leaders direct participants to take the matter offline, perhaps in a smaller group following the safety huddle.

"THEY ARE SUPPOSED TO BE HUDDLING EVERY DAY ON THEIR UNITS AT THE HUDDLE BOARD. THAT IS A SOURCE OF THEIR DATA AND HOW THEY ARE DOING ON THE INDIVIDUAL UNITS."

"We manage time throughout the huddle," Brass notes. "If there are 10 minutes left, we make people aware that the goal is to get out of there at [10:00] at the latest."

When the leader of a particular unit cannot make it to the huddle, he or she is expected to send a representative in his or her place.

"We actually monitor attendance, so when people stop showing up, the executives will start sending emails to the people involved, saying that they would really like their participation in the huddle; that it is vital for the safety of the hospital," Brass says. "It is not something that is optional. We calendar it into a no-meeting zone from 9:30 to 10. That is on everyone's calendar in the hospital."

Given that clinical unit leaders, department leaders, executives, and physicians are expected to attend the safety huddles, how does the safety culture exemplified during the huddles filter down to frontline caregivers and staff? Brass explains that individual, frontline caregivers are, on occasion, asked to observe the huddles.

"That is one way of having them there at the table so that they can see what is going on safety-wise at the hospital," he says. "Also, we ask that the information shared during the huddle be reported back on the individual units."

Highlight Metrics

Further, each unit has a patient safety huddle board where the hospital's goals or pillars are posted. "Under each pillar is a metric, and the whole hospital has the same strategic goals, but each unit has a metric [that unit staff] are trying to attain," Brass explains. "What they do is update the huddle boards either weekly or monthly."

For example, regarding falls, the huddle boards will show the number of falls that have occurred every year and how the unit is doing, Brass says.

"They are supposed to be huddling every day on their units at the huddle board. That is a source of their data and how they are doing on the individual units," he explains. "The best way to change a metric is to have it visible. That way, you can see where you are and where you are going."

While it is hard to draw a direct line between the safety huddles and specific outcomes, Brass notes that the hospital has made good progress on several key metrics since the new huddle process was implemented.

For instance, physician hand hygiene compliance has increased from 76% in 2014 to 94% in 2017. There also have been improvements in patient experience scores, the incidence of some HAIs, and overall mortality.

Further, Brass notes that the organization has been able to maintain the effectiveness of the huddle process. In fact, he believes people actually look forward to the daily sessions, and that is by design as well.

"We make them fun. We make announcements about what is going on in the hospital, and we recognize people at the end of the huddle for their hard work," he says. "We start the huddles with educational safety stories and regulation updates. That keeps people engaged."

Establish a Vision

The huddle process has worked so well that in January 2017, the hospital started conducting an additional safety huddle for its behavioral health campus immediately following the general safety huddle.

"We have a 24-bed inpatient unit, 25 chemical dependency beds, and a psych ED," Brass explains. "There are so many behavioral health issues with boarding patients and risk matters that come up that trying to cover all of those issues in the main hospital huddle is impossible, so even though those issues are relevant to safety and operations, we need to have a separate focus."

Participants in the behavioral health huddle include Brass, the director of the inpatient behavioral health unit, the director of the main ED, the chief nursing officer, hospital administrators, and representatives from risk management and security.

"It has worked out amazingly well," Brass reports. "A lot of the things that come to the surface create situational awareness among staff ... and improve operational issues."

Brass's advice to other hospitals interested in designing a new safety huddle process is to establish a vision of what one wants to accomplish and how it will benefit patients and the hospital specifically. Then, solicit input from leaders in each department to determine what should be on the huddle agenda. This will help with buy-in as well.

"Make sure that hospital executives are involved to show support for the process," he adds.

It can be helpful to start the process with a baseline agenda, so feel free to borrow one from the literature, and then personalize it, depending on the needs and characteristics of your hospital, Brass offers. Further, make sure that accountability is built into the process.

"If you are going to have metrics that you display at the huddles, which we do on our hospital-wide huddle board, you need to assign responsibility for who is going to take care of that every week," he says. "Also, who is going to be the notetaker? You need to [determine] that up front."

Other keys to an effective process include consistency, punctuality, and respect for everyone's time, Brass says. "Also, be open to change. After a month, if things aren't working or there is something that is going wrong, be adaptable to altering the agenda," he says. "Assess the temperature of the room, and get feedback on how you can make things better."

Drive Culture Change

Charlene Sanders, CPHQ, MHA, the vice president of quality at Mary Lanning Healthcare, a community hospital in Hastings, NE, also methodically implemented a safety huddle process, and has come away from the experience thoroughly impressed with what can be accomplished when such a mechanism is used effectively.

"I think it is one of the most significant and effective tools for enhancing the culture of safety in an organization," she says.

After the hospital's safety huddle

process started four years ago, there was a significant upward trend in the perception by staff that safety is a hospital priority as measured by a culture-of-safety survey tool.

"We are also seeing faster turnaround times on occurrence reporting and notification on events that happen," Sanders explains.

The safety huddles are held at 8:30 every morning, giving unit leaders time to walk through their departments and find out what has happened in the last 24 hours and to anticipate whether there are any issues that are going to occur in the next 24 hours, Sanders says.

"We have been able to address IT issues, medication issues, and medical errors," she says. "It is just an effective tool for identifying risk to the organization ... and for getting people talking."

At Mary Lanning Healthcare, the safety huddle includes all nursing unit directors and department leaders.

"For us, that includes about 30 people," Sanders observes. "We always start out with patient safety success stories. After that, we go into how many days it has been since our last serious event and how many days it has been since the last employee injury, because that is an organizational focus."

Later, each leader has time to report what has happened in his or her department or unit, and how any specific issues are being addressed. "It is just very, very focused," notes Sanders, explaining that the safety huddles last, at most, 15 minutes.

Build in Accountability

The meetings take place in a boardroom, but often there is standing room only because physicians are invited to attend if they have a concern.

"We had one of our pathologists come because he had an issue that occurred between the lab and surgery, and he was there the next morning to discuss the issue," shares Sanders, noting that a meeting has been scheduled to delve into the issue further. "Many times after our safety huddle, you will see people who have brought up issues huddling even in the room because they are anxious to address an issue so that we don't see a repeat of the problem."

It is a priority to get all the leaders to the safety huddle. "They are then going to go back to their units after the meetings, and if there is something that has been identified as a house-wide risk, they are talking to their staff," she says. "There is that expectation."

However, after the safety huddle was in place for about three months, administrators saw the need to talk about matters relating to beds and the census, and coordination with social work and care management. "So, now we have a 15-minute leader/safety huddle, and then go directly into a bed huddle," Sanders explains. "Then, after that, there is a 9 a.m. ED huddle, so [we cover] all of our high-risk areas."

Accountability is built into the safety huddle process, in part, by recording all the issues discussed in writing, and then disseminating the report to all participants on a daily basis. With this approach, anyone who is out of the office for the day still can keep up with what is going on at the hospital. Also, these summaries include reminder flags to the directors of departments that have issues that need to be resolved, along with a deadline for completion.

One thing Sanders learned from benchmarking her safety huddle approach with the practices at other health systems is that the CEO must drive the process.

"That is first and foremost. If the CEO isn't present or part of the sessions, there is a lack of engagement and buy-in to the process," she says. "I was at an organization a couple of years ago where the leaders were derisively referring to their process as the 'safety muddle.'"

In that case, the chief nursing officer was present, but not the other members of the executive team, and the lack of buy-in was obvious, Sanders observes. "That is the biggest lesson ... it has to be driven by the CEO and supported by the executive team," she says. "Then, it is a matter of having follow-up to the discussion and building in an accountability structure. That is the other key to making this successful." ■

REFERENCE

1. Brass S, Olney G, Glimp R, et al. Using the patient safety huddle as a tool for high reliability. *Jt Comm J Qual Patient Saf* 2018;44:219-226.

COMING IN FUTURE MONTHS

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CE QUESTIONS

1. **In a population health program, where might an organization focus its efforts to make improvements?**

   a. Routine health screenings, vaccinations, chronic illnesses
   b. Exercise, diet, sleep
   c. Reducing MRI use, reducing opioid use, reducing physical therapy
   d. None of the above

2. **The healthcare industry is undergoing what type of transition?**

   a. From patient-centered care to population-centered care
   b. From value-for-service to fee-based healthcare
   c. From fee-based to value-based healthcare
   d. All of the above

3. **Case managers assist with an outpatient total joint surgery program, helping to ensure patients achieve optimal outcomes post-surgery. A health assessment tool determines whether patients are candidates for ambulatory surgery. Which of the following is a question on the assessment tool?**

   a. Does the patient take more than 10 mg of oxycodone a day?
   b. Is the patient's A1c level over 7.5?
   c. Is the patient morbidly obese?
   d. All of the above

4. **After an outpatient total joint surgery, what do patients often ask case managers?**

   a. When to see the occupational therapist
   b. What deep vein thrombosis looks like
   c. What to expect in terms of pain and pain medication
   d. None of the above

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.