CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

INSIDE



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# Health System's Transitional Care Program Includes Out-of-area Patients

*Case managers communicate across the continuum*

Some of the biggest challenges in care transition involve bridging patient care between the hospital and the community — especially when the community is hundreds of miles away.

Communication always is the key, says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, senior director of care management for the Cleveland Clinic Health System. Davis also is the immediate past president of the Case Management Society of America in Little Rock, AR.

Electronic medical records can help transitions — even across the miles. But these only work if the two healthcare organizations use compatible electronic systems.

"One of our other major hospitals is a county hospital that uses [the same system], and if our patients go back and forth, we can see what's going on with them and communicate with their care coordinators," Davis says. "We always communicate. If they go to another hospital, we will call that care coordinator."

> "WE SHOW CONCERN FOR THE PATIENT AND SHOW CONCERN FOR COLLEAGUES BECAUSE WE'RE ALL IN THIS TOGETHER."

With an electronic referral system, the health system can refer patients to skilled nursing facilities and home care easily. "But we also encourage people to pick up the phone, especially for complex patients," Davis says.

Cleveland Clinic is on the frontier of another transition in case management



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**AUTHOR:** Melinda Young
**EDITOR:** Jill Drachenberg
**EDITOR:** Jesse Saffron
**EDITORIAL GROUP MANAGER:** Terrey L. Hatcher
**SENIOR ACCREDITATIONS OFFICER:** Lee Landenberger



and health systems, says **Stefani Daniels**, MSNA, ACM, CMAC, president and managing partner of Phoenix Medical Management of Pompano Beach, FL.

The health system changed its case managers into transitional care coordinators, and they work with social workers to ensure patients receive optimal care coordination throughout their hospital stay and beyond.

This newer model is something that hospitals increasingly will need to implement. They will have to redefine case managers' roles to focus on care transition and coordination, separating out the utilization management role. Instead of focusing primarily on length of stay, they are looking more at care continuum and quality, Daniels explains.

"There still are hospitals I visit where length of stay is be-all, end-all, and that's what case managers have to do," Daniels says. "But it's not by coincidence that the fee for value-based purchasing that Medicare put in place has as its indicator for efficiency Medicare spending-per-beneficiary and not length of stay."

Spending-per-beneficiary is a key that ties together case management in the hospital and in the community. With the goal of lowering overall healthcare spending, case managers work collaboratively with patients and community case managers as they move between healthcare settings. For those within the same organization, the transition could be a face-to-face handoff, Daniels says.

For example, Daniels describes a health system that has four small critical care hospitals that feed into one flagship hospital. Care coordination activities include formal, structured handoffs so information from flagship case managers would be shared with satellite case managers, she says.

In a small hospital, case managers can do it all, Daniels notes. "One person may follow that patient through inpatient care and spend time in the community, visiting the patient at home or at a nursing home, or meet with home care staff, making sure everyone agrees on the treatment plan."

Cleveland Clinic's case managers, called transitional care coordinators, have departmental roles in the hospital, but they work with community managers at handoffs, Davis says.

## EXECUTIVE SUMMARY

Care transitions can be challenging whether they involve patients transitioning across the street or across the country. It is the job of case managers or transitional care coordinators to make the process work smoothly for patients.

- Electronic medical records can help with communication during the care transition process.
- Working with social workers, transitional care coordinators focus on care continuum and quality.
- The transitional care process also helps out-of-town patients find home care agencies, skilled nursing facilities, or other healthcare services in their hometowns.

This can be challenging. For example, one recent patient had several challenges, including being undocumented, unable to speak English, and uninsured. The patient also suffered a neurological problem that suggested a transition to a freestanding acute care rehabilitation hospital, she recalls.

"But that hospital was nervous because in acute rehab, you have to have a good home plan, and there are rules around that, too," Davis says.

Acute rehab was the best option for the patient, so the hospital agreed to take the patient. "What happened was the patient ended up in another one of our hospitals, and the first hospital that originally received the patient was called and was in communication with the others," she says. "They called the care manager at the second acute care hospital, saying, 'This is what's going on. Here's a story of family, and this is what they need; this is what we're recommending.'"

Communication during transitions is the right way to handle such patients, she says.

"It's not just 'close your eyes and hope for the best,'" Davis says. "We show concern for the patient and show concern for colleagues because we're all in this together."

When transitional care coordinators work with patients whose homes are miles and states away, they help the patients find community resources in their hometowns.

"We use a software system and do a search and see facilities, CMS ratings, and five-star ratings for facilities in their area," Davis says. "We give the list to the family."

When out-of-town patients have a primary care provider at home, care coordinators and social workers will reach out to that doctor's office or to the home care agency that will be caring for the patient. If they do not have a primary care provider, the care coordinators work hard to find one, she says.

"Getting them set up with an appointment prior to leaving the hospital is a lot of work," Davis says. "Everyone is committed to it."

For instance, social workers research patients' communities, often calling their local hospitals to ask them for referral contact information, she says.

"For some patients, home care services are not enough. Some have behavioral health components and need a behavioral health nurse," Davis says. "Or if there is a diabetic patient with amputation and schizophrenia, the goal is to find home care that will integrate the behavioral health elements with him."

Cleveland Clinic also has an ambulatory care management piece in which social workers take care of patients' social work needs via phone. "We saw a need for that," Davis says. "They're tied to primary care practices locally."

Sometimes the transitional care coordinator's work depends on the insurance company and the insurer's care manager.

"We connect with the payer's care manager and ask who they recommend and how we can help this patient," Davis says. "If there's workers' compensation involved, we definitely work with those case managers."

Each case is different, with its own set of challenges. One patient might be difficult to transition from the hospital because of lack of insurance and other barriers. When this happens, the transitional care coordinator will need to set up a care conference to discuss the patient's struggles and how using the hospital for this person's care is not the most appropriate way to handle the case, she adds.

"As a group, across our system, we discuss it and really think outside the box," Davis says. "We even have a global care conference for patients in our system when we are stymied and don't know what else we can do for them to get them into a more appropriate level of care."

The group discusses the case, thinking outside the box and using all internal and external expertise, she says.

"If any of us have a concern, we can always pick up the phone," she says. ■

# Diabetes Prevention Program Shows Positive Outcomes for Patients

*Strive for better engagement*

Better engagement with patients is the key to success in chronic illness case management, according to a dietitian and care manager of patients with diabetes.

The Diabetes Care Program has successfully improved diabetic patients' A1c testing rate, nephropathy monitoring, blood pressure control, and other self-management measures, says **Rachel Brown**, RD, MBA, IBCLC, dietitian and care manager for Lifetime Family Care in Warren, MI.

Lifetime Family Care, a small family practice, has helped diabetes patients improve their health and care management for several years, earning the practice a best overall diabetes practice award in 2016 by the Michigan Care Management Resource Center in Ann Arbor.

As part of its patient-focused approach, Lifetime Family Care sends patients surveys and reviews the results monthly, using the feedback to improve care. Also, employees participate in monthly training sessions about how to improve patient and practice team relationships.

Brown describes how the program works:

• **Referrals and first call**. Lifetime Family Care refers patients who might benefit from nutritional consulting to Brown.

"I contact patients via telephone and work with them to get any questions answered regarding nutrition and lowering their carbohydrate intake to lower their blood sugar," Brown says.

Most calls range from 15 to 30 minutes and include a basic assessment of the patient's nutrition, current medication, and lab results.

"I ask what they're struggling with and then we develop a good plan for them with the ultimate goal of teaching them how to manage their own care," she says.

For this first call, Brown helps patients come up with a simple goal for the near term. Although patients often say their goal is to lower their blood sugar, she helps them make sure it is a SMART goal: specific, measurable, achievable, relevant, and time-bound.

"One of my jobs is to get those goals more SMART, so they can set out to achieve what they want to do," she says.

SMART goals might include these:

- "I will check my blood glucose three times per week."
- "I will keep my doctor's appointment."
- "I will start exercising, walking for 10 minutes, four days a week."
- "I will cut down on my soda intake, and I'll drink more water every day, aiming for 60 ounces per day."
- "I will take my medication every day as prescribed, refill, and call the office as needed."

Brown covers as much information as she can on the first call. "If they're overwhelmed, I schedule a weekly follow-up."

• **One-stop diabetes check-up.** The primary care provider's office makes it convenient for patients to undergo their annual diabetes exams at one location. Lab work, foot exams, and retinal eye exams can be performed, Brown says.

"We assist patients in the office to get those gaps taken care of," she says.

• **Patient education**. Brown mails patients basic educational information regarding the do's and don'ts of diabetes, healthy eating plates, the importance of eating three meals a day, limiting sugar and sweets, maintaining a healthy weight, controlling intake of carbohydrates, reducing high-fat foods, filling up with fiber, and the importance of exercise as it pertains to blood glucose control, Brown says.

"I mail out literature that verbalizes all of these points, so when

## EXECUTIVE SUMMARY

Chronic illness case management works better with optimal patient engagement. In one primary care provider practice's experience, a diabetes care program has improved diabetic patients' self-management.

- Lifetime Family Care uses a patient-focused approach.
- A dietitian/care manager helps patients improve their goals, working to ensure they are SMART: specific, measurable, achievable, relevant, and time-bound.
- Care plans are individualized and take into consideration the patient's willingness to change.

I call back on the second visit, they have a paper in front of them and things make more sense," she adds.

• **Individualized plan.** "I assess their understanding and intent to comply," Brown says.

If patients' lab work shows that their overall glucose levels are improving and their A1c is improving, then she knows they have a good grasp of what they need to do to improve their health.

The individualized care plans take into consideration each patient's readiness to change.

"One of the hardest things is seeing where they're at in readiness to change, readiness to move forward, and we try to meet them where they're at," Brown says.

"Something I do with every patient before hanging up is set a goal, clear boundaries, and SMART goals so they'll know how to meet that goal."

During each call, Brown discusses with patients how to meet the goal and whether they met the last session's goal. If they have not met their goals, they look at what the barriers are and how to overcome them going forward.

If a patient is doing well with the last session's goals, then Brown will suggest he or she make the goal a little more challenging, maybe working toward 15 minutes of exercise, four times a day. "We see what they've accomplished with the current goal and then see if they're OK with that and then add more," Brown says.

• **Addressing barriers**. "Sometimes, patients' barriers may include transportation, funding, time management — and those are things I can help them with," she says. "We do what we can to get them in touch with programs that help with transportation to doctor's appointments and help with medication."

Brown helps patients make connections to community health information, as needed.

"I spend maybe half an hour per patient doing that," Brown says. "Some patients don't have any social determinants of health affecting their health outcome."

• **Measuring outcomes.** "We measure their A1c and blood pressure, and we're looking for improvement across the board in all those metrics," Brown says.

The case management program has shown the following improvements between 2016 scores and 2017 scores:

- A1c testing rate increased by 6.8 points;
- monitoring for nephropathy increased by 10.1 points;
- blood pressure control increased by 2.6 points;
- percent of days covered by statins increased by 8.1 points;
- percent of days covered by diabetic meds (all class) increased by 3.5 points.

A comparison of 2017 scores versus 2018 (through July 31, 2017) showed these results:

- retinal eye exams increased by 14.4 points;
- percent of days covered by statins increased by 27.4 points;
- percent of days covered by diabetic meds (all class) increased by 33.3 points. ■

# Study: Little Difference in Outcomes Between ACO and Non-ACO Patients

*Patient satisfaction also was the same*

The Affordable Care Act established accountable care organizations (ACOs) to reduce costs and improve quality of care, and some studies have shown positive outcomes. But new research examined the impact of hospitals' ACO participation on their performance on readmission rates for several conditions. The results are surprisingly limited.

"The ACO model seeks to save money by care coordination and case management, but is it showing the benefit we're looking for?" says **Mark Diana**, PhD, associate professor and chair of global health management and policy at the School of Public Health and Tropical Medicine at Tulane University in New Orleans.

Diana's research suggests, "not so much."

The study examined whether hospitals that participate in ACOs have lower readmission rates on average than those that did not participate — and what investigators found is mixed. "In general, they don't. But with heart failure, there was a lower readmission rate," Diana says.

The study found that ACO participation is significantly associated with a decrease in the heart failure readmission rate, but not in any change in readmissions among patients with acute myocardial

infarction or pneumonia. Its conclusion is that "Medicare ACO programs have limited effects on readmission rates."[1]

"There are a number of nuances. Fundamentally, the study we did was to look at hospitals participating in ACOs," Diana says. "If you're participating — even if it's only for a Medicare population — then those activities also will impact other patients in the hospital, and we should see a reduction or improvement in outcomes metrics across the hospital."

Research data did not separate the Medicare population from the general population with those same health conditions. "It could be if we examined just the Medicare population in each of those hospitals, we would see a difference," he says. "But data was not provided that way."

Also, future ACO programs might be set up with tracks that shift more downside risk to providers. It is possible that once hospitals stand to lose significant funds if their care management programs fail, they will put more resources into these programs and show better outcomes as a result, he adds.

"Maybe these ACOs don't bear enough risk to move in that direction," Diana says.

Another factor could be the type of patients helped in ACO programs. It is possible that benefits to a program are best when patients are most in need of help.

"What it shows depends on the severity of the illness of the patients in the population you're looking at," he says. "The more severely ill, the more likely they are to benefit from care coordination activities."

Investigators found a similar pattern in patient satisfaction scores. There was not much effect in ACO hospitals versus non-ACO hospitals.

"I would have expected satisfaction scores to be higher," Diana says.

The study does not suggest that case management and care coordination do not work: "When you have patients that are ill with comorbidities and complex health problems, they tend to benefit from care coordination/case management activities," he says.

Alternately, healthy patients who regularly see their doctors are a population that would not benefit as much from case management and care coordination, he adds.

When health organizations participate in an ACO, it is expected they will increase case management and care coordination, but the study did not collect data on how many of the hospitals had developed such programs specifically because of the ACO. "We didn't have the details on what kind of specific programs they were implementing," he says.

"My primary interest is around how these new models of care are influencing cost and quality of care," he adds. "What are these new care models, and do they have the potential to bend ... the cost curve and keep quality up?"

Diana also has researched how ACO participation influences hospitals' performance. Another recent study found that ACO participation improved some aspects of patient experience in hospitals with prior good experience but did not benefit hospitals with historically poor performance.[2]

Patient experience data came from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. HCAHPS scores are used for nearly one-third of incentive-based payments from Medicare's Value-Based Purchasing Program.[2]

The study found similar reported results between ACO hospitals and non-ACO hospitals on measures that include the following:

- communication with nurses;
- communication with doctors;
- responsiveness of hospital staff;
- pain management;
- communication about medications;
- cleanliness of hospital environment;
- discharge information;
- overall hospital rating;
- would recommend the hospital.[2]

One factor, quietness of hospital environment, had a higher rating among non-ACO hospitals than ACO hospitals — 61.70 vs. 57.76.[2]

The study concluded that hospital participation in ACOs does not lead to improvement in patient experience, but hospitals with a track

## EXECUTIVE SUMMARY

Accountable care organizations (ACOs) were established to reduce costs and improve quality of care, but do they achieve those goals?

- A new study found that hospitals that participate in ACOs generally do not have lower readmission rates.
- Only patients with heart failure had a decrease in readmission rate in the ACO group.
- One factor could be that ACOs do not confer enough downside risk to health systems. With more financial risk, their care coordination programs resulting from the ACO model might work better.

record in care coordination are more likely to benefit from participation in an integrated care delivery model like that of ACOs.[2]

Diana also has researched the characteristics of hospitals that decided to participate in an ACO. "An interesting question in my mind of hospitals doing this kind of work before the ACO model came along is how they fare in the ACO model versus those not doing this work," Diana says. "So I looked at hospital characteristics." ■

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# Ethics Involvement Needed With Complex Discharges

*Moral distress is issue*

Ethicists are seeing increasing numbers of consults involving concerns with discharge planning. "This is an even more common ethical issue than end-of-life issues. Those happen regularly but not hourly as with discharges," says **Bob Parke**, BA, BSW, MSW, RSW, MHSc, a former clinical ethicist at Humber River Hospital in Toronto.

Discharge planning encompasses multiple ethical issues, including consent, capacity, and autonomy. "The pressure for expedient discharges can risk less-than-thorough assessments and referrals for follow-up care," says Parke, who worked as a discharge planner in the hospital setting early in his career.

Moral distress stemming from discharge planning needs to be "on the radar screen of ethics," says Parke.

If patient preferences conflict with clinical recommendations or needed resources are unavailable, it can result in significant moral distress for clinicians. "Not uncommonly, patients would likely benefit from additional support — for example, a home health aide — but don't qualify for funding," says **Maralyssa Bann**, MD, director of hospital medicine at Seattle-based Harborview Medical Center.

Hospital policies regarding potentially unsafe discharges, says Bann, "should take into account an ethical framework for how to frame the discussion, as well as how to support the clinician and patient."

The following are common scenarios that trigger ethics consults:

**• Utilization managers are pressuring family to arrange nursing home admission prematurely.**

Because an elderly patient's cognitive function decreased during hospitalization, a utilization manager pressured the family to start the process of arranging nursing home admission. "Fortunately, there was a good history of the person's preadmission cognitive and physical function," says Parke. Clinicians advocated for more time to assess the patient. This included referrals to a geriatric specialist.

"This was met with anger for delaying a discharge plan," says Parke. A thorough assessment revealed that the patient was experiencing delirium, not dementia. After some additional time and treatment, the patient was discharged home. "If the healthcare team had yielded to expediency, the patient would have been wrongfully discharged to an inappropriate setting," says Parke.

A good social work assessment and collective advocacy on behalf of the patient contributed to a positive outcome. "Doing the ethically correct discharge required courage and knowledge of the patient," says Parke.

**• The patient wants to go home, but clinicians think it is unsafe.**

"While we accept that a capable person has the right to live at risk, we feel moral distress about whether we are doing the right thing discharging the person," says Parke. This is true for suicidal patients, persons living with substance abuse, frail seniors who live alone, or vulnerable people returning to possibly abusive situations.

A recent ethics consult involved an elderly woman who lived alone with minimal social support, who was hospitalized after a fall. The patient wanted to go home, but the physiotherapist and occupational therapist were concerned about fall risk. In such cases, says Parke, "there is tension between our desire to avoid harm and also respect our patient's autonomy."

The ethicist's first question was, "Is the patient competent to make decisions?" The staff acknowledged that the patient clearly understood that a fall could lead to a serious injury and limit her ability to care for herself. The patient was discharged home despite the staff's concerns about a serious injury that might be avoidable in a supervised care setting. The clinical team's ethical obligations included:

- performing a quality assessment, which revealed the patient's need to get home to care for pets who were unattended;

- making referrals to social workers who identified financial resources to supplement home care.

"We cannot always assume that the optimal discharge plan is being made," says Parke. Consequently, all team members — including the bioethicist — may need to recommend necessary follow-up care.

Patients do not always agree to the treatment plan. "In these situations, the clinician may be tasked with creating a plan in line with the patient's desire to maintain independence that feels unsafe," says Bann.

The ethical dilemma then becomes a debate between respect for autonomy and the principle of beneficence. "Clinicians have a duty to provide appropriate care and benefit to a patient, while the patient has the right to choose an alternative," Bann says.

**• The patient wants to go home and is cleared for discharge, but the family thinks it is unsafe.**

After a patient's recent displays of uncharacteristic anger and forgetfulness, the family requested admission to a long-term care facility. After treatment, both cognitive and physical function improved.

"The patient and staff both started to ask about going home," says Parke. The family objected. In this case, the team's ethical obligation included conducting a thorough assessment to determine whether the patient needed assistance with basic activities of daily living.

It turned out that the patient had difficulty hearing. If this communication barrier went undetected, says Parke, "we might have created a discharge plan that did not engage the patient in the decision-making process."

The ethicist informed the patient's surrogate decision-maker, who was very reluctant to accept the discharge, that:

- the law allows only the capable person to make his or her own healthcare decisions;

- the role of the surrogate only comes into effect when an individual is found incapable.

The patient was ultimately discharged home over the surrogate's objections. The team's ethical obligation at that point, says Parke, was "to ensure that the optimal level of support was planned for when the patient was discharged home, where the patient wanted to be." ■

# Alarm Fatigue Still Serious, Solutions Slow to Come

Alarm fatigue still is a serious threat to patient safety, and years of effort have yielded minimal improvement, experts say. Some effective strategies have been identified, but the problem could worsen before a real solution is found.

Diminishing the cacophony of alarms is proving to be more difficult than first imagined, says **Paul Dexter**, MD, research scientist with the Regenstrief Institute, an informatics and healthcare research organization, and associate professor of clinical medicine at Indiana University School of Medicine, both in Indianapolis.

"It's a very active issue. There have been efforts to improve the situation, but it is likely, in many ways, to only get worse," Dexter says. "I don't think the rate of improvement is matching the influx of all the new alerts, reminders, and alarms coming our way. We have tried to improve the precision and specificity of the alarms, but so far, that is not enough."

Most efforts involve trying to make the alarms and reminders more patient-specific, Dexter says. The patient history also can be factored into the way alarms work, he notes, so that if a clinician has overridden an alert a number of times, that particular alert might be disabled or made less intrusive.

The adoption of such strategies is inconsistent across hospitals and health systems, Dexter says. Part of the problem is that device vendors tend to err on the side of safety, partly because of their own liability concerns, and encourage the widest use of their databases to detect allergy conflicts, for example, he says. It is up

to the healthcare providers to tailor the use of the machine to their own needs, he says.

"You should take the vendor's package of drug interactions and have clinicians assess what is right for your institution and your patients," Dexter says. "If you don't and you go with the vendor's default settings for everything, you can end up with an overwhelming number of alarms and reminders. That can prompt people to turn off the functionality entirely, which is the wrong solution."

Dexter urges hospitals to monitor and catalog alarms on particular units because you cannot effectively reduce the burden without knowing exactly what clinicians are subjected to on a daily basis.

"It's the only way to know what's really happening and to find a way to isolate those alarms that are most problematic," Dexter says. "You can find those alarms that are overridden on a regular basis, and then there should be a very good reason to keep that alarm as-is or else you need to stop that alarm from interfering with patient care."

## New Guidelines Can Help

The American Association of Critical-Care Nurses (AACN) in Aliso Viejo, CA, recently issued a Practice Alert on the issue, titled "Managing Alarms in Acute Care Across the Life Span: Electrocardiography and Pulse Oximetry," which outlines evidence-based protocols and clinical strategies related to alarm management.

Alarms can be detrimental to patient safety if they are not managed properly, says **Nancy Blake**, PhD, RN, NEA-BC, CCRN, FAAN, former nursing director at Children's Hospital in Los Angeles, former board member with AACN, and member of the Association for the Advancement of Medical Instrumentation Alarm Coalition.

"While clinical alarms are meant to alert the clinician to a potentially harmful event for the patient, they are not without problems. If any of the monitors with integrated alarms aren't used properly, they can become more of a hindrance to the clinician in performing their patient care duties," she says. "Over the years, the growing number of alarms have contributed to sensory overload, and the clinicians have become desensitized to the alarms because of alarm fatigue. This alarm fatigue has contributed to delayed response to the alarms, which is a patient safety issue as clinicians could be missing a potentially critical event that triggered the alarm."

Research has indicated that a range of 89% to 99% of alarms are false or clinically insignificant, Blake says. There are alarm parameters that are unique to every patient population, so it is important to look at the issue across the lifespan of the patient, she notes. It is important to ensure that the alarm settings are appropriate for the patient population.

The Joint Commission developed a standard that requires the organization's leadership to work with clinicians to develop structures and processes to manage alarms, Blake notes. This standard reinforces that alarm management affects the entire organization and is not an individual clinician problem.

"The Joint Commission realized that without a comprehensive approach, bedside clinicians alone are unable to fix this issue in organizations. It also ensures that the key decision-makers, when it comes to equipment, policies, and procedures, fully understand and are actively involved in solving this issue together as part of the team," she says. "This has made alarm management an organization priority over the last few years, causing organizations to change the way they manage alarms from an organizational perspective and making it a high priority patient safety issue."

## Find Best Practices

By setting up teams to work on this issue and making this a joint problem to solve, an organization can truly examine its own issues and events and create a unique process based on evidence to help decrease or eliminate alarms that may be clinically insignificant or not actionable, Blake says.

The AACN Practice Alert also looks at best practices, from using the equipment correctly or as intended by the manufacturer to how the skin is prepped prior to placing the ECG electrodes, Blake notes. It suggests how often the electrodes must be changed daily to decrease the number of false alarms and technical alarms that are not due to a patient event.

"As hospitals strive to be high-reliability organizations and decrease patient harm while in the hospital, the AACN Practice Alert can assist in not only changing organization practice but also developing unit-specific practices, organizational policies and procedures, ongoing education, and safe bedside practices to check the alarms at patient handoff, which supports excellence in practice," Blake says. "Implementing the recommended practices and understanding the entire issue around managing clinical alarms will improve patient safety."

The very high rate of false or

clinically insignificant alarms is difficult to reduce, notes **Bette McNee**, RN, NHA, clinical risk management consultant at insurance broker Graham Company in Philadelphia. From the 89% to 99% found in research, even a concerted effort to address alarm fatigue typically reduces that number only about 50%, McNee says.

"Any nurse working in this area will still tell you that these alarms are still a diversion in their efforts to provide good patient care," McNee says. "They have to keep their sensitivity up and respond to these alarms even when a far majority of them are false. They have to step away from documentation and other patient care to check them out."

In terms of improvements, the low-hanging fruit includes things like setting parameters specific to each patient rather than having a machine default to a generic range of readings for all patients, she says. That kind of improvement is necessary but only gets you so far in tackling the problem, she says.

Real improvement will come with building algorithms that consider various vital sign readings before triggering an alarm, McNee says. The goal should be to get the technology to work for the healthcare staff, having the machine do some of the initial thinking to realize that the one abnormal reading does not actually require the nurse's intervention, she says.

"We've seen hospitals trying to go more toward wireless and silent alarms, and we're seeing hospitals involve IT more to address technical alarms," she says. "Some of these alarms are for technical issues like loss of Bluetooth connectivity or a low battery, so hospitals are diverting those nonclinical alarms to the IT department, which helps relieve some of the fatigue for nurses."

McNee says that hospitals must continue to seek solutions because otherwise nurses will be tempted to silence the alarms instead of responding to each one, which can be deadly.

"Unfortunately, when people don't know how to adjust them or nothing is done to reduce the alarms, nurses have been known to silence them. There have been deaths attributed to nurses silencing alarms because they just had so many alarms they didn't know what else to do," McNee says. "Unless hospitals put in some innovative solutions, the risk is still there to silence the alarm and move on." ■

# 'Dry Run' for Radiology Improves Patient Safety

Radiology can be a complex process using the latest technology, and the results can drive the course of a patient's care. Getting it right the first time is not always easy, so one health network has found that sending patients through a "dry run" simulation before the actual procedure can improve outcomes and patient safety.

**Steven Gresswell**, MD, and colleagues in the division of radiation oncology at Allegheny Health Network in Pittsburgh implemented a "verification simulation" across its 11 radiation oncology clinics in 2014.

"It's an in-depth opportunity for the radiation therapist to own the plan. We bring the patient in a day beforehand and go through everything the radiation therapist does beforehand, all except actually delivering the radiation," he says. "This allows them to make sure the beam angles and other parameters are correct and that there's no potential collisions with the linear accelerator."

The team also verifies the prescription and double-checks all information related to the upcoming procedure.

"If there are any errors, this is an opportunity to fix them in an environment that allows the time to do it," Gresswell says. "We bring them in for 15-minute or 30-minute appointment slots depending on the complexity of the treatment plan. We saw this as a good opportunity to slow things down, look for any potential issues, and have the time to address them."

## Fewer Incidents With Simulation

The team reported the results in a recent study. They compared success and incident rates with 965 patients in an 18-month period prior to implementation of the verification simulation and 984 patients treated in the same time period with the addition of the dry run.

The dry run typically was scheduled the day before a patient's first fraction of radiotherapy. Clinicians walked the patient through setup, imaging, and

treatment, explaining the process without actual delivery of any radiation.

"The session is designed to allow staff time to verify that the parameters of treatment are accurate and troubleshoot problems in an organized team approach," Gresswell and his colleagues wrote in their report.

Twenty-eight incidents — errors or potential errors during the dry run or the actual radiography process — were reported in the nonsimulation group, and 18 incidents in the verification simulation cohort. In the simulation group, more incidents also were detected before the day of treatment, and fewer on the day of treatment. They concluded that a verification simulation can be an integral part of any radiation oncology QA program and a risk reduction strategy in the administration of radiotherapy.

## Less Anxiety for Patients

Though it was not the aim of the project, they found that 83% of patients reported decreased anxiety because of the dry run.

"Error identification in radiation therapy is critical to maintaining a safe and efficient therapeutic environment," the authors wrote. "A verification simulation for patient information provides a dedicated time prior to treatment to duplicate steps of patient setup, imaging, and treatment processes as a final quality assurance step."

*(An abstract of the report is available online at: https://bit.ly/2unjUKm.)*

Gresswell notes that the findings were not exactly what he expected. There were fewer incidents reported in the simulation group when he expected to see more just because there were two opportunities to spot errors — the dry run and the actual treatment.

"That might be because the errors were caught before they could lead to more errors down the road. They were caught in the simulation and addressed instead of going unseen and leading to other incidents on the day of treatment," he says. "When we have the dry run in place, that also gives the radiation therapists more time to do their jobs, and we found more of the incidents were detected by the radiation therapists. That was good to see." ■

### SOURCE


- **Steven Gresswell**, MD, Division of Radiation Oncology, Allegheny Health Network, Pittsburgh. Email: steven.gresswell@gmail.com.


## CE QUESTIONS

1. **In a new transitional care coordination model for case managers in hospitals, what has changed?**
   a. Transitional care coordinators are a skills-level step up from care managers.
   b. Case managers now work exclusively with patients' primary caregivers, and social workers are hands-on with daily patient care.
   c. Case managers' roles are redefined to focus on care transition and coordination, separating out the utilization management role.
   d. All of the above

2. **Case managers can help patients set SMART goals. What are these?**
   a. Selective, motivational, answerable, relatable, tough
   b. Specific, measurable, achievable, relevant, and time-bound
   c. Short, manageable, attainable, realistic, and tested
   d. None of the above

3. **Which of the following is an example of a SMART goal?**
   a. "I will check my blood glucose three times per week."
   b. "I will keep my doctor's appointment."
   c. "I will start exercising, walking for 10 minutes, four days a week."
   d. All of the above

4. **A new study that examines the impact of hospitals' accountable care organization (ACO) participation found which of the following outcomes?**
   a. ACO hospitals had significant improvement in their readmission rates on all measures.
   b. ACO hospitals had worse outcomes on all measures.
   c. ACO hospitals did not show better readmission rates, although one measure had a lower readmission rate.
   d. None of the above

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