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INSIDE

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Mental Health Crises and Suicide Rates on the Rise

Intervention strategies, tools can help

Case managers throughout the care continuum increasingly are focusing on sociobehavioral health issues, helping patients prevent problems. But more Americans are dying from mental health crises than ever before.

The suicide rate in the United States rose by nearly one-third between 1999 and 2015. The total suicide rate for 2016 was about 45,000, according to CDC data. *(Read more at: http://bit.ly/2SUPVUY.)*

In some states, suicide rates have increased even more. Pennsylvania's suicide rate increased by 34.3% between 1999 and 2016. *(Read more at: http://bit.ly/2Bpm67Q.)*

In response to the growing crisis, one organization created a crisis intervention strategy that supplements behavioral health services and a call-in crisis line.

"We're the third- or fourth-largest behavioral health system in Pennsylvania; we respond to over 12,000 crisis intervention calls a year," says **Edward B. Michalik**, PsyD, mental health/developmental disabilities program administrator for Berks County in Reading, PA.

"We have a very active suicide prevention effort, and as the rest of the country is experiencing it, we have a crisis in suicides with a peak of 72 suicides several years back," he says.

> THE SUICIDE RATE IN THE UNITED STATES ROSE BY NEARLY ONE-THIRD BETWEEN 1999 AND 2015. THE TOTAL SUICIDE RATE FOR 2016 WAS ABOUT 45,000, ACCORDING TO CDC DATA.

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"The key to reducing the amount of completed suicides is persistently and constantly getting the message out," he adds.

Call-in interventions work, but more needed to be done. Michalik met with a crisis intervention director from Services Access & Management in Reading to brainstorm for ideas on how to reach more people.

"We have a large Latino population, and we needed to find a way to reach out to everyone," Michalik says.

The idea came to him when he was at a conference and trying to reach his daughter. She didn't take his call, but when he texted her, she got right back to him. The new crisis intervention strategy uses texting, and it works: "Adults are using it. Kids are using it. Parents are using it," he says.

Berks County subcontracts with Service Access & Management to provide crisis intervention, and Michalik's liaison is **Amy Groh**, MA, director of crisis intervention services.

"We provide mobile, telephone, and walk-in services," Groh says. "Texting is a fourth way for people to access crisis intervention services."

Texting is a strategy to help start a conversation with people who might be experiencing a crisis and are afraid to call for help or to seek out mental health services.

"Our goal is always face-to-face contact," Groh notes. "Let's talk with or see someone so we can best assess how the person's doing."

But texting is an easy way for someone to ask questions or seek help. They could be standing in line or sitting in class and send a quick text.

"It removes so many barriers to access to service," Groh says.

The county carved out existing funds to pay for the texting program. Since it began two years ago, there have been 12,000 individual texts from close to 400 unique users.

The people who texted likely were not comfortable making a phone call, and many of them had not been served previously by crisis intervention staff, Groh says.

"We've published this texting line by purchasing billboards and electronic ones where the messages change. We've gone on radio talk shows and TV and been in newspapers," Michalik says. "We have disseminated the texting line and information line all over the place. It's designed to serve residents from Berks County, but sometimes

EXECUTIVE SUMMARY

The United States is experiencing a suicide and mental health crisis that national data show is worsening. At least one county in Pennsylvania developed a crisis intervention strategy that attracts people who might not call into a hotline.

- About 45,000 Americans took their own lives in 2016 — a suicide rate that has increased by nearly one-third since 1999.
- Berks County in Pennsylvania responds to 12,000 crisis intervention calls each year.
- A new text message crisis intervention program has attracted 12,000 texts from about 400 people.

we snag other people and hook them up with the proper place for help where they live."

Full-time, trained crisis staff members respond to the walk-ins, calls, and text messages. Berks County requires face-to-face crisis intervention to be the goal, while phone discussions can be used for informational and referral purposes, Michalik says.

"It's hard to assess people over the phone," he explains. "You can't tell what they're doing or thinking."

Crisis intervention professionals are trained to use phone calls and text messages as a tool to set up a meeting with the caller or person who sent the text.

"Texting is anonymous," Groh notes.

Through this anonymous encounter, a crisis interventionist can ask if the person would like to meet in person and talk further about what's going on.

"If they refuse to meet with us, they don't have to, but we've had good results with this," Michalik says.

Since the texting crisis intervention strategy began, Groh has found that most people who text the crisis texting number do not say they are suicidal. Typically, the person sending the text acknowledges experiencing depression.

"The reasons most often given for reaching out through a text are anxiety, depression, and family problems," Groh says. "They just want to be heard. If they have anxiety, they want to be reminded of coping skills."

It helps people to know that someone is focusing attention on their own concerns and provides reassurance without judgment, she adds.

One sign of the texting intervention's success is that users overwhelmingly support it.

"Over 96% say they'd use the service again, which is huge," Groh says. "We can't always give people what they want or desire, but if they'll use it again, we've at least met some of their needs." ■

Care Managers Who Are Social Workers Make Magic Happen for Complex Patients

ED visits dropped by 46%

A prevention-focused care management program successfully reduced hospital admissions and ED visits among a vulnerable population.

"We're dealing with a very complex patient demographic," says **Mo'sha Myles**, MSW, LSW, a social work program manager at Oak Street Health in Indianapolis. Oak Street Health treats more than 50,000 patients at 42 centers in five states. Rhode Island will be the sixth state in 2019.

Oak Street Health's program has reduced hospital admissions by 44% and ED visits by 46% for its patient population. The organization also has a 94% patient retention rate, according to the organization's internal data.

The population mostly is older, low-income patients who suffer multiple physical and psychosocial-behavioral health issues. The program's underlying theme is for physicians, care managers/social workers, and others to spend time with patients, looking at their health from a holistic perspective, Myles says. *(See case study showing how the program works, page 17.)*

"We think about the challenges and complex needs these populations bring with them," she says. "We look at patients from a holistic perspective; we don't see them as just a medical concern or issue."

The care model includes assessing patients' mental health status, socioeconomic status, and access-to-care barriers.

Myles explains how care management works at Oak Street Health:

• **Create a team.** Centers can have one or more — up to six — care teams, depending on their patient population.

Each team includes care managers who are master's-level social workers. Also included are a physician, nurse practitioner, medical assistant, nurse, and scribe. Scribes are the people who take notes as physicians talk to patients. Each clinic also employs a phlebotomist.

"That team has a high level of focus on patients' needs," Myles says.

Care teams meet daily in morning huddles to talk about the patients who will be seen that day.

"We have a patient dashboard every morning that shows all the patients currently in the hospital and all who are coming through the door that day," Myles says.

The dashboard notes medical red flags and any needed health screenings.

Care teams also meet weekly to dive into their patients' needs.

"They look at patients' challenges and the support they need," Myles explains. "Everyone sitting in that room is collaborating and brainstorming and seeking out ways to help patients."

The weekly meeting focuses on finding out why certain patients are frequently hospitalized, and their new diagnoses or complex care needs. "We talk about priorities inside the patient's complex needs and determine where our focus needs to be right now," she says.

"Maybe the patient has two or three things going on, but one issue is very pertinent, and that's when our team is all-hands-on-deck to help the patient with that problem," she adds. "This meeting is carved out so there is no distraction and the time can be used specifically for patients and their needs."

• **Use scribes.** Scribes typically are students enrolling or planning to enroll in medical school or a physician assistant program, Myles says.

"They come to Oak Street to get clinical hours," she says. "They put in all the notes and anything a doctor is writing — outside of a prescription."

The scribe program at Oak Street Health has been very successful, she notes.

When someone applies to be a scribe, the person is paired with a doctor and stays with the doctor until the scribe begins medical school. Some stay with the program for six months, and others might be scribes for a couple of years. Some are local, and others come to Oak Street Health from other states because they value the clinical hours they obtain in the job, she says.

• **Coordinate and collaborate with other providers.** Social workers visit patients at skilled nursing facilities (SNFs). They share information with SNF staff and collaborate to discuss patients' issues and to bring more information back to the care team, Myles says.

Care managers/social workers stay connected to hospital transition nurses, sometimes meeting to discuss a patient's change in a living situation — for instance, a hospitalized patient who had been living independently before suffering a stroke cannot return to independent living, she explains.

> "WE LOOK AT PATIENTS FROM A HOLISTIC PERSPECTIVE; WE DON'T SEE THEM AS JUST A MEDICAL CONCERN OR ISSUE."

They also are involved in direct patient follow-up. Patients with the highest need return every three weeks. The social worker calls them weekly to check up on how they're doing and to follow up on scheduled visits. "The social worker might say, 'I know the doctor has scheduled you for this visit, are you still planning to go? Have you had any challenges since your last appointment?'" Myles says.

In some cases, the social worker might call and find out the patient experienced problems such as headaches or nausea since seeing the doctor. The social worker will ask the patient to explain what's going on and then contact a nurse to talk about symptoms.

"A lot of case coordination happens like that," she says.

Care managers/social workers can connect patients to home health services and hospice care as needed, she says.

"If a patient falls a lot and needs physical therapy at home, the doctor would contact the social worker here and say, 'Mr. Jones is a fall risk, and I feel like his muscles are weak and he needs physical therapy,'" Myles says.

The social worker also can assist with a referral to a home health company.

Physicians can bring social workers into cases in which patients are deteriorating and will need hospice care. They can reinforce to the patient and family what hospice means and clear up any anxiety they might have, Myles says.

"When the patient is ready to connect with hospice, we're the first line of defense to make that connection," she adds.

• **Attend to social determinants of health and advance care planning.** Care managers/social workers handle any challenges providers have with patients. If patients say they do not have transportation to get to their specialist, a social worker can help them connect with a transportation organization.

"They can help the patient go online and fill out an application," Myles says.

Social workers also help patients complete applications for housing and help them obtain medication when they cannot afford it. If patients need clothing, housing, and food, the care team helps out.

Sometimes, patients need behavioral health services, which Oak Street Health can provide. The

centers offer individual therapy and telepsychiatry, Myles says.

But patients who need extensive behavioral health services, such as substance abuse treatment, are referred to external providers.

Care teams assist with advance care planning by helping patients understand the process, Myles says.

In 2018, Oak Street Health helped about 600 patients complete advance care planning documents. These were scanned into the medical records, shared with their loved ones, and seen by their specialists, she says.

"We think of all the challenges our families are going through, and we're being proactive," Myles says. ■

Case Study Illustrates How Care Team Works

Collaboration is best approach

A healthcare organization's care team model provides complex patients with holistic care, helping them stay out of the hospital and ED.

The care team includes master's-level social workers who fulfill a care management role for the team. They collaborate with other team members and with providers in the community and hospital, says **Mo'sha Myles**, MSW, LSW, a social work program manager at Oak Street Health in Indianapolis.

The following is a sample case study that demonstrates how the care team interacts with patients and collaborates to provide the best treatment and care coordination:

"Let's say we have a 50-year-old homeless female with a history of being a victim of domestic violence. She's been in and out of rehab for substance abuse and has uncontrolled high blood pressure and uncontrolled diabetes," Myles says.

The care team discusses the woman's case at a weekly meeting. The social worker might say, "I met with her yesterday, and there are cognitive issues displayed. She has not had cognitive screening or testing done yet," Myles says.

When the woman visited the clinic the previous week, her blood pressure was high. The care team provided education about her health issues, but the information was not connecting with her. She was unable to grasp her diagnoses or the importance of taking her insulin.

The care team's physician might speak up and ask the scribe, "Can you check that chart and say what her blood pressure was the last two times she was here?"

Then the social worker talks about run-ins the woman has had with a home health company.

The nurse practitioner says she is less concerned about the woman's blood pressure than she is about her insulin levels. So the social worker says, "I talked with her about that, and she told me she can't afford her insulin."

The goal of the care team meetings is to dig into the patient's problems to come up with pragmatic solutions. So the team begins to discuss whether the woman's nonadherence to taking her insulin is due to cognitive issues or something else. Maybe she doesn't understand the importance of taking the medication. Taking insulin may not be a priority because she is homeless and spends more time worrying about finding a place to sleep.

The social worker might mention how the patient said she couldn't afford her insulin, and the team then discusses how to eliminate the barrier.

"They'll describe her next appointment on Monday and say, 'When she comes in next Monday, this is what everyone is going to do,'" Myles says. "The nurse will take her blood pressure and glucose and provide her with diabetes information and see if the patient is connected to a diabetes resource."

The social worker will do some research to see whether the woman can be connected to adequate housing.

"We talk with the patient collaboratively," she explains. "The doctor may go in the room and say, 'I was talking about you to the team, and we're very concerned about you. Do you mind if the social worker comes in and talks to you about housing resources? We're concerned about your glucose level. Do you mind if I bring in my nurse to talk with you about these important issues?'"

At that visit or another one, the nurse might bring up the woman's history of domestic violence: "My understanding is that you were a victim of domestic violence. Have you been hit in the head recently?"

Then the social worker can help the patient find local resources, including a shelter where she can be out of harm's way if she currently is being abused.

Through the meeting's discussion and follow-up, the care team resolves the patient's pressing problems and eliminates care access barriers. ■

Basic Compliance Training Should Focus on Payer Service Standards

Fee-for-service programs most at risk for noncompliance

The Medicare Fraud Strike Force has charged more than 3,700 people for $14 billion in false billings in the Medicare program since 2007, and the current administration is aggressively targeting billing schemes that rob Medicare, Medicaid, and other insurance programs. *(http://bit.ly/2CjhnGA)*

Recent settlements between healthcare providers and the United States include a $5.86 million False Claims Act resolution with a hospice care provider that allegedly submitted claims to Medicare that either were for medically unnecessary treatment or lacked documentation. In another case, a healthcare organization paid $12.5 million to resolve False Claims Act liability for fraudulent billing. *(http://bit.ly/2rFY2ZU)*

Case management departments can prevent False Claims Act violations by training case managers to follow the rules set by their program funders and payers, including the Centers for Medicare & Medicaid Services (CMS).

"Case management programs reimbursed on a fee-for-service process are the most vulnerable to fraud, waste, and abuse issues," says **Chris Ambrose**, MBA, CHC, CHPC, healthcare compliance officer at Service Access & Management in Reading, PA.

The fee-for-service model sets definitive billing and reimbursement requirements, and case managers should know precisely what these are. *(See list of noncompliance red flags, right.)*

For example, some payers do not allow case managers to bill for the time it takes them to travel between visits with patients. Early intervention case management in Pennsylvania has an exception to this rule, and case managers can bill for travel between their appointments

Keep an Eye Out for Noncompliance Red Flags

Case management directors can train staff to log their hours, maintain accurate documentation, and follow all payer rules and requirements to maintain compliance with laws and regulations.

Directors also might keep in mind that certain actions or issues can be red flags to auditors and regulators.

"If case managers understand what the red flags are, they're more likely to be cognizant," says **Chris Ambrose**, MBA, CHC, CHPC, healthcare compliance officer at Service Access & Management in Reading, PA.

The following are some of the more common red flags:

- **Billing for services that are not reimbursable.** Case managers should know exactly which services are included in what payers will cover and document these accurately.
- **Overlapping services.** A case manager might bill for one patient from 3 p.m. to 3:30 p.m. and bill for a second patient from 3:25 p.m. to 4 p.m. That means there were five minutes of overlapping billing open to scrutiny, Ambrose says.
- **Billing for travel time.** If a patient's service does not reimburse for travel, case managers should be certain to document appropriate transition time between appointments. For instance, if the case manager documents that one patient's service ends at 4:20 p.m. and then documents that a second patient's service begins at 4:20 p.m., the payer will know that it is impossible for the case manager to have seen the two people in that span of time when they live 10 minutes apart, he explains.
- **Ensuring clients sign all necessary paperwork.** "Make sure clients have signed all information and appropriate documentation that you billed for," he says.
- **Report problems.** "Case managers also need to know they are expected to report clients' concerns and any potential compliance concerns," Ambrose says.

"Nonreporting has the worst outcome for the organization," he adds. "Putting your head in the sand, pretending you didn't see an issue, will have the worst outcome." ■

with very young patients, Ambrose says.

"This varies between states and programs," he adds. "The point is that case managers and case management directors need to have an absolute understanding of what their funders' service and reimbursement requirements are."

Without that understanding, they could inadvertently run afoul of fraud and abuse laws.

Ambrose offers these suggestions for how case management programs can prevent compliance problems:

• Train on service delivery requirements. "Training is the most effective way to prevent fraud, waste, and abuse issues," Ambrose says.

Case management directors should word explanations of fraud and abuse laws in clear, simple language, avoiding legalese, he suggests.

"I provide simplified versions of legal definitions and scenarios that are related to their work," Ambrose says.

For example, Ambrose might explain a billing scenario in which a case manager was providing services to the mother of a client. The service notes did not indicate that any service was provided to the client.

"As a case manager, often times you do need to help family members of clients, and our funders understand that," he explains. "But the note has to reflect that the service goes back to the client and the client is the one who benefits from the service."

If documentation does not show that the patient benefited from the service, the funder will not pay for that service.

Or, in a worst-case scenario, the funder might have paid the bill but later audited it and discovered that the documentation did not justify payment — a potential compliance issue.

"We provide six different types of programs funded on a fee-for-service basis, and each of those six programs has a different service delivery requirement," Ambrose says.

Case management departments should provide definitive and detailed training about each service delivery requirement, he adds.

• Provide hands-on training. Compliance training might start in the classroom, but it also should include having staff follow a supervisor to learn how to bill appropriately, Ambrose suggests.

"Classroom training is good, but it's not enough," he says. "It's equally important to be in the field with the case manager."

New staff might need a week or longer of shadowing the supervisor and experienced case managers. "They need to see what it looks like to be an effective case manager who knows how to provide case management per the funders' requirements and when billing on fee for service," Ambrose says.

• Reinforce the importance of preventing fraud, waste, and abuse. Every unit of service that case managers bill has the potential to be billed incorrectly.

Case managers need tools to help them track their 15-minute units of service effectively.

"There are apps I've seen case managers use that will track their travel time, so they know not to bill during those times," Ambrose says. "They need to enter the exact start and end times in their Outlook calendar or an activity log or notebook."

Some type of log ensures accuracy. When it's time to write a case note about the service delivered, the case manager who uses a log will have an accurate record of when service started and ended, he explains.

"They're not putting themselves into a position to rely on their memory of what time the service ended," he adds.

• Document accurately, without fail. Many of the federal government's fraud cases include allegations of poor or missing documentation. For instance, if a case manager provides a billable service for a patient but fails to document it accurately, it could result in an allegation of fraud.

"Documentation has to reflect the exact requirements that a particular funder expects," Ambrose says. "For example, with the case management programs we provide, there has to be a purpose of case management involvement that is well documented."

It's not enough to write a service note. The documentation must reflect the client's service plan, goals, and how the case management visit fit into that plan, he says.

• Use audits to learn and correct. "Our programs are audited throughout the year by our funders, so we have an idea from those audit results where the funders are focused," he says. "We pass this information on to our staff during training."

For example, Ambrose has found that funders currently are focused on documentation that does not substantiate billed time. So if a case manager billed for eight units, which is two hours of service, the documentation must show a service that would take two hours to complete. This particular service must be in the client's service plan.

"If they chat with patients about what they had for dinner last week, then that likely will not relate to the patient's goal of obtaining employment, for example," he explains. ■

Innovative Staffing Model Reduces Handoffs, Boosts Provider Satisfaction

Patient handoffs are a point of risk for medical errors in the emergency setting. For example, during shift changes, an outgoing provider may be stressed and fatigued, heightening the potential that he or she may fail to highlight important information or miscommunicate clinical details about one or more patients. Further, errors of this sort can be compounded if incorrect information is documented and continues to follow a patient as he or she moves through the health system.

Recognizing the risks to patient safety, many investigators have focused on improving handoff processes to reduce the potential for errors when the care of patients is transferred to new providers. This is valuable work, but what if someone takes steps to address the number of handoffs that occur as well as the stress and fatigue that clinicians often experience toward the end of their shifts?

Investigators at Seattle Children's Hospital have found that by adjusting their staffing model, they can not only reduce the number of handoffs that take place in the ED without increasing attending provider hours, but also boost provider satisfaction. Further, while the staffing model takes work and patience to implement fully, researchers believe that with the proper support and commitment, the approach is flexible enough to work in many other EDs, both adult and pediatric.

The opportunity to make a change around the scheduling of providers presented itself to Seattle Children's leadership when the ED transitioned into new quarters in 2013, explains **Hiromi Yoshida**, MD, MBA, an emergency attending physician there and a clinical assistant professor of pediatric emergency medicine at the University of Washington School of Medicine. Yoshida was the lead author of an investigation into the development, deployment, and results of the new staffing model.[1]

"We wanted to improve patient care, but at the same time, we also wanted to make the experience better for the physicians that work here," she says.

Under the original staffing model, the ED consisted of three pods with seven shifts that each lasted seven to nine hours. "The idea was that at the end of your shift, you signed out to the next person who was coming in. Basically, you had to hand off everyone that you had to the next person ... when your shift ended," Yoshida explains.

It is a fairly traditional approach with which many emergency providers likely are familiar. However, this approach places considerable demands on clinicians at the very end of their shifts when they tend to be fatigued. It is at this point when they need to communicate important information about their patients to the next provider who will be taking over their care. In the ED at Seattle Children's, there were several concerns about this original staffing approach, Yoshida shares.

"Patient care just kind of stopped for a little bit of time [during the handoffs]. There were delays because people had to wait, and I think that led to frustration from the staff ... patient care wasn't moving forward. Potentially, that could lead to patient harm," she says. "Also, people were working at full capacity throughout their entire shift. We know that people make better decisions toward the beginning of their shifts because decision-fatigue kicks in toward the end."

The new staffing approach, designed by a multidisciplinary team, attempts to ease some of these end-of-shift burdens by collapsing the model into two pods and staggering the arrival of oncoming attending physicians in what creators of the approach describe as waterfall shifts. Under this structure, when a physician first arrives for work, he or she is considered the primary attending provider and begins seeing patients.

"The next attending physician arrives three to five hours later, depending on the shift. Then, [he or she] becomes the primary attending," Yoshida explains.

At this point, the provider who arrived first becomes the secondary attending. In this secondary attending role, Yoshida says, this physician can complete work on existing patients. Meanwhile, secondary attendings can work with other physicians on less complex cases, treating and discharging those patients before the end of the secondary attendings' shifts.

The thinking behind this approach is that by the time a provider's shift ends, there will at least be a plan in place for any patients still under the clinician's care. These patients are likely less complex because of the way the provider picked up patients. Also, there are likely to be fewer handoffs, Yoshida notes.

"For those patients who do need to be handed off, there will be fewer opportunities for miscommunication

because [the patients] will hopefully be less complex, less sick," she says.

Further, with a new provider coming on board every few hours, leaders hoped that the new waterfall-style shifts would provide relief and a morale booster to emergency clinicians, Yoshida says.

"When providers come in, they can just start seeing patients. No one has to wait to staff their patients. Everything just keeps moving forward," she says. "Sign-out happens at staggered times. It is not necessarily happening with the whole board [of patients]. You are signing out fewer patients, which is less stressful, I think, for the people doing it."

Following implementation of the new staffing model in April 2013, a retrospective study by Yoshida and colleagues found that the overlapping, waterfall-shift approach significantly reduced handoffs compared to the previous staffing model. An analysis of nearly 44,000 patient encounters that occurred under the new staffing model showed a 25% reduction in encounters that included patient handoffs from one provider to another.

Researchers also observed improvements on secondary metrics. For example, while there was a very slight increase in average length of stay under the new staffing model, the left-without-being-seen rate and the 72-hour return rate for patients both decreased slightly. Also, the percentage of charts signed within 72 hours increased from 90.4% to 95.7%.

Investigators noted that there was one serious safety event both before the change to the new staffing model and following implementation. However, when surveyed about the new model, physicians and charge nurses reported that, in their view, the new model improved patient safety. Twelve of 18 attending physicians surveyed reported that they "strongly agreed" that the model improved patient safety, and six attending physicians responded that they "agreed" with the statement.

Similarly, among 13 charge nurses who responded to the survey, eight indicated they "strongly agreed" that the model improved patient safety, and five charge nurses indicated they "agreed" with the statement. The surveyed charge nurses also indicated that the new model improved patient flow in the ED.

When given an opportunity to provide comments about the model on the survey, some physicians voiced strong approval of the waterfall-staffing approach.

"One physician commented that the staffing model is the single most important change we made in terms of contributing to job satisfaction. Someone else mentioned that it had definitely increased their longevity [in the job]," Yoshida reports. "I do think the way it is set up will keep experienced physicians here longer and also keep them happier ... having happy, healthy staff leads to better care."

While the waterfall shifts are firmly ingrained in the ED at Seattle Children's, the clinicians who championed the model note that others interested in adopting the method should not underestimate the challenges involved with implementing a new approach.

"The biggest challenge for us was that people are generally resistant to change, so we did a lot of talking to individuals and groups before the change to get their buy-in," explains **Susan Mazor**, MD, an emergency attending physician at Seattle Children's, an assistant professor in pediatric emergency medicine at the University of Washington School of Medicine, and one of Yoshida's colleagues on the study of the waterfall handoff structure.

Yoshida echoes these sentiments, noting that it is important to collect feedback from everyone about any proposal. "However, remember that sometimes you just have to try it and see how it goes in the spirit of quality improvement," she says. "Emergency medicine is a great place given that everyone is flexible and willing to pitch in ... for quality improvement work, the ED is a very willing place to do things like this."

The new staffing approach should be able to work in adult and pediatric EDs, but there does need to be enough staff to construct the waterfall shifts.

"The plan should be able to be scaled to an ED of any size with more than single coverage," Mazor offers.

As with any staffing model, changes in volume and other factors need to be addressed. The ED at Seattle Children's has continued to tweak its approach.

"Last winter was one of the busiest winters we have ever had. As our census grows, we are actually adding a shift during the winter months so we can see more patients," Yoshida explains, noting that adding more staff is not only for the health of patients but also to maintain the health of ED staff.

Further, while the model has been very well received, ED leadership continues to collect feedback and to make improvements as needed, although the approach has proven to be robust and flexible.

"There are more physicians during our peak hours. The waterfall starts with only one physician. As the day goes on, more physicians come more frequently ... we try to match the timing based on when we think

patients are coming," Yoshida notes. "Ninety percent of the time, the model works well because of the way the waterfall shifts are scheduled. We have the [highest] number of physicians when we know we are going to be the busiest." ■

REFERENCE

1. Yoshida H, Rutman LE, Chen J, et al. Waterfalls and handoffs: A novel physician staffing model to decrease handoffs in a pediatric emergency department. *Ann Emerg Med* 2018; Oct 1. pii: S0196-0644(18)31160-0. doi: 10.1016/j.annemergmed.2018.08.424. [Epub ahead of print]

Johns Hopkins' Intrahospital Patient Transfer Program Reduces Risk

Adult and pediatric patients moving from one area of Johns Hopkins Hospital in Baltimore to another face less risk than might be found in other institutions because of a program ensuring that they will receive the same quality of care during transfer as they do on a unit.

Modeled on similar teams that move patients via ambulance or helicopter, specially trained Lifeline Intrahospital Transport Teams provide transport of critically ill patients from ICUs to other areas for treatment or diagnostic services, as well as moving all cardiac-monitored patients.

The Lifeline program was initiated in 1992, when there were few designated intra- or interhospital transport teams. It has since grown to include more units in the Hopkins system. The Lifeline teams perform more than 12,000 intrahospital transports each year, with an adverse event rate of less than 1% with critically ill patients.

The intrahospital transfer program grew out of the benefits realized from Hopkins' early experience with improving interhospital transfers, explains **James Scheulen**, PA, chief administrative officer for emergency medicine and capacity management, and president of Johns Hopkins Emergency Medical Services in Baltimore. Hopkins leaders realized that patient care was suffering during transport from another hospital — particularly with severe cases like burns — because the referring hospital and ambulance service had little experience in treating those conditions.

"We started a retrieval system in which someone from the burn center would get on a helicopter and fly out to those hospitals and institute the appropriate care there, then bring the patient back," Scheulen says. "We saw a tremendous change in patient outcomes, so then we thought the same thing applies to cardiac patients, stroke patients, and every other patient who needs to be stabilized and who needs a treatment plan carried out during the transportation from point A to point B."

That was the general concept that led to Hopkins developing a program for critical care transport between hospitals and eventually applying the same idea in-house.

"We started to see that inside the hospital, moving patients from one side of our campus to another side for diagnostics or another service sometimes took as long as an ambulance ride from another hospital five or 10 miles away," Scheulen says. "In most hospitals, the people who do transfers within the hospital for critical care patients are an intern and a nurse from the floor. We saw in one year a couple of sentinel events in which people were mistakenly extubated or lost central lines, and they had bad outcomes."

High-Level Team Members

The hospital's risk management department went to Scheulen and the other Lifeline leaders to ask if they could improve quality of care for transports within the hospital the same way they had done for outside transfers. The result was the Lifeline Intrahospital Transfer Program.

"Having an interhospital transport team is no longer a revolutionary concept, but I think the number of hospitals who use that same concept for intrahospital transport is still a very small number," Scheulen says.

A Hopkins Lifeline Intrahospital Transport Team comprises these clinicians: an emergency medical technician-basic, an emergency medical technician-paramedic, and a registered nurse. A medical director oversees the team.

All team members are certified in Advanced Cardiac Life Support, Pediatric Advanced Life Support, Neonatal Resuscitation Program, and International Trauma Life Support, in addition to other advanced training. They can use and maintain

almost any monitor or other device needed for the patient.

Selecting and recruiting the most appropriate team members is crucial to success, says **Heidi Hubble**, director of operations for Johns Hopkins Lifeline.

"An important lesson learned is the value of having the right people. We took the people who were already experts in transport from our interhospital program and had them apply those skills to the intrahospital program," she says. "There is a huge difference when one of our teams is transporting a patient versus when staff from an ICU or a unit is transferring a patient. The difference is in their approach, their philosophy, what they're looking for, and their comfort level."

Patients Needing Advanced Care

Intrahospital transfers at Hopkins are categorized in four levels. Level I and Level II patients are stable and need no medical intervention or monitoring during the transfer, so they can be transported by patient escort. Patients in Level III typically require cardiac monitoring and are transferred by a two-person team of a paramedic and an EMT-basic.

The Lifeline team steps in for Level IV patients, who need advanced medical care and monitoring during transfer. This could include ventilation and infusions. The transport team stays with the patient through the diagnostic study, ready to provide whatever care might be needed.

Before the Lifeline program, intrahospital transfers at Hopkins usually required a registered nurse and sometimes a physician to attend the patient. The Lifeline team allows nurses to stay on their units without risking any deviation in the quality of care the patient receives, Scheulen says.

"We think we have made an enormous difference in the safety profile of moving patients within the hospital," Scheulen says. "It's the combination of the right people, the right technology, and the right experience that has made people feel very secure about moving patients into the hospital and within the hospital once they are here."

Few Aborted Transfers

Scheulen co-authored a study showing the benefits of the Lifeline program, finding that in 3,383 intrahospital transports of adult patients in a six-month period, there were 59 clinically significant adverse events during transfer. *(The study is available at: https://bit.ly/2SAsKQp.)*

"Diagnostic radiology was the transport destination for 73% of those patients. With the inclusion of interventional radiology suites, 95% of those patients were ultimately transported to a location within the radiology department's study areas," the study authors wrote. "As for clinical needs, the transported patients who had a clinically significant adverse event all had a fairly high acuity level. At the time of transport, 71% of those patients were intubated (42/59), 41% had both an arterial and a central venous catheter (24/59), and 63% had at least one ongoing infusion of medication (37/59)."

According to the study, "The most common events (75%) were related to either hypoxia or hypotension." However, only one patient was extubated, and only one code team was activated during the study period. The authors also noted that "Only 20% of transports that had adverse events were aborted."

Start Small and Expand

The authors concluded that the benefit of an intrahospital transport team goes "beyond the reduction in the frequency of adverse events. It keeps nursing staff in their units to manage other patients; physician staff can focus on other duties while their patients are properly cared for in diagnostic areas; and diagnostic resources are better used because intended studies get completed."

The Lifeline Intrahospital Transport Program provides a huge morale boost to nurses, Scheulen says.

Nurses are relieved that they do not have to leave their other patients to transport and care for one patient during diagnostic studies, he says.

Hopkins also found that the reliable availability of Lifeline Transport Teams improved scheduling so much that radiology could perform one or two more CT studies per day.

Hospital leaders who want to emulate Hopkins' success with intrahospital transfers may want to start small and expand the program incrementally, Hubble suggests. That was the Hopkins strategy, and other hospitals might want to focus first on a subset of critically ill patients, such as those who are intubated or who require cardiac monitoring.

Once a process is established with those patients, the program could be expanded to include more, she suggests.

"We started with one of the ICUs to do proof of concept, worked out the kinks, and expanded from there," Hubble says. ■

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **How many people in the United States committed suicide in 2016, according to data from CDC?**

   a. 25,000
   b. 35,000
   c. 45,000
   d. 55,000

2. **How might a scribe be used in a multidisciplinary care team?**

   a. A scribe is the care team's secretary, taking minutes at morning huddles and weekly meetings.
   b. Scribes can be medical school students who earn clinic hours by working with a doctor and handling the notes.
   c. Scribes follow up on all suggestions made by the various members of the care teams.
   d. All of the above

3. **Which of the following is a common red flag for False Claims Act violations?**

   a. Billing for services that are not reimbursable
   b. Overlapping services
   c. Billing for travel time
   d. All of the above

4. **Which of the following is a way that a community clinic's care team can help its most vulnerable and at-risk patients with needs that are outside of medical care?**

   a. Care teams can assist with transportation, housing, filling out applications, and advance care planning.
   b. Care teams can provide massage therapy and acupuncture services.
   c. Care teams can enroll patients in clinical trials where their care services are provided free of charge.
   d. All 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.