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INSIDE

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Program Targeting Serious Illnesses Helps Reduce ED Visits, Hospital Readmissions

Study highlights positive outcomes

A healthcare provider's case management-style program produced a 43% reduction in hospital visits and a 24% reduction in ED visits within an 18-month period, according to authors of a new study.[1]

The program, Reaching Out to Enhance the Health of Adults in Their Communities and Homes (REACH), involved a care model that integrated palliative care with primary care for seriously ill, elderly patients.

This case management model can be an alternative to the traditional trajectory of seriously ill, older patients moving from inpatient hospitalization into long-term care, says **Timothy P. Daaleman**, DO, MPH, professor of family medicine at the University of North Carolina (UNC) at Chapel Hill. Daaleman also is a professor in the department of social medicine and a research fellow at the Cecil G. Sheps Center for Health Services Research.

> "OUR GOAL WAS TO SEE IF WE COULD PREVENT THEIR CHRONIC ILLNESSES FROM GETTING OUT OF CONTROL AND LANDING THEM IN THE HOSPITAL IF WE VISITED THEM EVERY THREE MONTHS AT HOME."

Patients with diabetes, chronic obstructive pulmonary disease, and congestive heart failure are good matches with the program as they are the same patients

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who frequently use hospital services, says **Robin Motley**, MSN, FNP, a home-based palliative care nurse practitioner at UNC Palliative Care at Home.

"Our goal was to see if we could prevent their chronic illnesses from getting out of control and landing them in the hospital if we visited them every three months at home," Motley says. "With REACH, we were doing primary care in the home."

Until population health and value-based care models received demonstration project funding through the Affordable Care Act (ACA), healthcare organizations did not attempt programs like REACH because they were not cost-effective, Daaleman says.

"A decade ago, it was too costly to have physicians visit patients. It would not generate enough income to sustain the program," he says.

When ACA demonstration project funding became available, alternative models were financially feasible.

The program's funding source changed, and the program changed from REACH to a palliative home care model with the same goals of providing patients with in-home symptom management and disease management to prevent readmissions, Motley explains. *(See story on how the home-based palliative care program works, page 76.)*

"We really try to get ahead on the process that can quickly spiral out of control and land people in the emergency room," she adds.

The program's team includes two nurse practitioners, two physicians, two registered nurses, and one social worker, Motley says.

The palliative care model is a natural fit for a home-based primary care program.

"We developed a home-based primary care hybrid of two different models," Daaleman says. "One was home-based primary care, and the other was home-based palliative care."

The challenge was coordinating patients within those two models and serving both populations.

"We built infrastructure in the electronic medical record and came up with ways to communicate across different providers," Daaleman says. "We had a nurse manager [and] social worker, and had the physician go out to do assessments."

Case managers helped handle communication, manage caseloads, and assess patients' care needs based on comorbidities and the seriousness of their illness.

The program hired two nurse practitioners and one part-time physician, but finding people with

EXECUTIVE SUMMARY

The Reaching Out to Enhance the Health of Adults in Their Communities and Homes (REACH) program helped seriously ill, elderly patients reduce hospital visits.

- The program included patients with diabetes, chronic obstructive pulmonary disease, and congestive heart failure.
- The goal was to help patients become medically stable and keep them out of the hospital.
- REACH evolved into a palliative care program with similar goals.

the right skill sets was a challenge, Daaleman notes.

"To work with this population was fairly unique," he explains. "You needed people with clinical skills and who could help patients manage what was going on in their homes."

The necessary skills include being unafraid of handling complex patients with messy situations and being creative in finding solutions. Also, the individual needs to be a team player.

For example, a patient could be clinically unstable but unwilling to go to the hospital. For many providers, the easiest course of action would be to call 911 and have the patient transported to the hospital. But the program encouraged providers to manage patients in their home environment, Daaleman says.

"These are people who have chronic, serious illness, and having an extra layer of support in the home would be beneficial in managing their symptoms," Motley says.

"Many times, it is difficult for people with serious illnesses to leave their homes."

For instance, an elderly patient with dementia might become disturbed when visiting new places. Breaking out of this patient's daily routine could be disruptive, she says.

"We don't see the people who are healthy and able to get out to their doctor's appointments. We don't do this as a convenience," Motley says.

The population Daaleman and co-investigators studied was particularly fragile. Of the 159 people enrolled, 50 died while in the program, he says.

"A number of these patients were dying at home," he adds.

Since the demonstration project ended, the program has continued as a home-based palliative care program. "The infrastructure is all the same, and we haven't had much staff turnover," Daaleman says.

"THESE ARE PEOPLE WHO HAVE CHRONIC, SERIOUS ILLNESS, AND HAVING AN EXTRA LAYER OF SUPPORT IN THE HOME WOULD BE BENEFICIAL IN MANAGING THEIR SYMPTOMS."

"It's a fairly flexible program where we're trying to find the sweet spot between home-based primary care and home-based palliative care," he adds. "There's a little space in between, consisting of patients who are probably on that trajectory for palliative care, but they or their caregivers are not ready for it."

One patient with dementia was in the program for six months before the patient and his wife started to talk about advance care planning, laying the foundation for accepting palliative care, Daaleman says.

"Technically, the patient is not eligible for hospice, but he has progressive, terminal disease — dementia," he explains. "We were concerned about his functional status and comorbidities."

It helped the couple to have providers visit them at home and to have people the patient and caregiver trusted introduce the concept of palliative care. One of the program's key features is having the team start advance care planning conversations with patients and their families, Daaleman says.

It might take three or more visits before the patient is ready to hear about advance care planning, palliative care, or hospice, largely because of the stigma associated with hospice and palliative care, he notes.

"We provide a continuum of care for patients, between primary care and palliative care," Daaleman says. "This can take months or years, preparing patients and coming up with a serious primary care approach." ■

REFERENCE

1. Daaleman TP, Ernecoff NC, Kistler CE, et al. The impact of a community-based serious illness care program on healthcare utilization and patient care experience. *J Am Geriatr Soc.* 2019;27:Epub ahead of print.

Home-Based Palliative Care Program Keeps Patients Out of the Hospital

Technology improves communication

A North Carolina palliative care program employs doctors and other members of a healthcare team to help keep patients out of the hospital through in-home, quality care.

The following is how the program works:

• Identify patients through referrals. "We are a specialty service, where providers can put in a referral for palliative care at home," says **Robin Motley**, MSN, FNP, a home-based palliative care nurse practitioner at University of North Carolina (UNC) Palliative Care at Home.

"If a primary care provider [PCP] or specialist thought their patient had palliative care needs and would benefit from us making routine visits in the home or a one-time visit, we could go out, take a look, and do an in-home assessment," she explains. "Typically, what we tell providers is if you have someone with multiple chronic illnesses and symptoms that are not well-managed and they have difficulty getting in to see you, or high utilization, it would be appropriate to refer us, and we could augment their care with an added layer of support in the home."

• Use technology to improve communication. The program uses an electronic medical record (EMR) to engage everyone in the patient's care.

"At the end of my visit, I can send a copy of my visit notes to every member of the care team," Motley says. "Additionally, through the EMR, I can send a direct message to a particular provider if I have a specific question or concern and want to let them know something."

For example, if Motley were seeing a patient with chronic obstructive pulmonary disease (COPD) and she were worried about the patient's coughing and congestion signifying a flare-up, she could send the patient's doctor a quick message about the symptoms.

"I could let the doctor know that I will treat the patient for COPD with steroids and will follow up in X period of time," Motley says. "The patient would know to call me if the symptoms got worse."

• Work as a team with PCP. "We work as a team with patients' primary care providers, but we do not replace the PCP," Motley says. "We also work very closely with patient specialists."

For example, Motley might have a patient with painful arthritis of the knees, and the patient has been seeing a sports medicine provider for steroid injections.

"During visits, I might find that her pain is flaring up and the things I've recommended are not as helpful as I'd like them to be," she says. "So I might reach out to her sports medicine physician."

In another example, Motley might contact a patient's cardiologist if the patient is experiencing cardiac symptoms and fluid overload.

"I might say, 'Here's what I'm thinking about changing [in] the medication regimen. What are your thoughts?'" she says. "We are highly collaborative, and our goal is to work with patients and their providers to manage symptoms so they are well controlled and patients can avoid going to the hospital and being uncomfortable."

• Nurses triage patients for home visits. "We have two RNs at our office who triage and are very familiar with all of our patients," Motley says. "If a patient calls us with a problem or symptom, a nurse will triage that and, if needed, talk with one of the providers."

The nurses decide whether a patient needs to be seen at home, she adds.

When patients visit a clinic, the environment is conducive to a physical exam, blood draws, and other diagnostic tests. In-home visits might have poor lighting and less space, and

EXECUTIVE SUMMARY

A team of professionals provides palliative care patients with in-home, quality care to prevent readmissions.

- The program's electronic medical record (EMR) makes it easy for case managers and others to share notes with all providers involved in a patient's care.
- Case managers team up with primary care providers and other physicians to optimize patient care decisions.
- Nurses provide triage for which patients can be seen at home and which should return to the clinic for a physical exam.

examining patients might require creativity, Motley notes.

"On the flip side, you get so much more information when you get into a patient's home," she says. "We can see gathered rugs or clutter that might be a fall risk. We know what medications they have, and we can see whether they have heat, running water, food, and security."

Providers who see patients in a clinic might not get the full perspective.

• **Visits depend on the patient's acuity and symptoms.** After the initial visit, the nurse will schedule follow-up visits in one or more months, depending on the patient's acuity level and symptoms, Motley says.

"We might start someone on an antidepressant, for example, and follow up with the patient," she explains. "Then when things are stable, we try to see patients every one to three months."

When patients are doing well and do not need symptom management, they still are high-risk, so the team will keep in touch, she adds.

Most of the patients have serious chronic illnesses, and many of them will transition to hospice care or go into the hospital, where they will die from complications of their diseases, she says.

"Some patients do have symptoms that are adequately controlled, and they no longer need us," Motley says. "So we discharge those patients for now — and if they need us in the future, we're happy to come back." ■

Medical Roundtables Helpful in Workers' Compensation Cases

MDs, RNs, and psychologists can help

Medical expenses are the chief drivers of expenses in workers' compensation claims, fueled in part by patients with multiple medications and comorbidities.

"We recognize more and more that medical complexity drives activities and outcomes on a claim," says **J.J. Schmidt**, MBA, PhD, senior vice president and head of analytics and innovations at York Risk in Jersey City, NJ.

"When someone has a workers' compensation injury, we want to get that person back to the state they were in before they had their injury," he says.

This is why it is important to seek guidance from medical professionals, he adds.

"We need to pull in medical experts to advise and guide the direction of those claims," Schmidt says. "What we've seen is that pulling in medical experts serves a couple of purposes."

Physicians, nurses, psychologists, and others can educate and share information on cases. Workers' comp claim adjusters can use the medical roundtable model to access their expertise.

> "WHEN SOMEONE HAS A WORKERS' COMPENSATION INJURY, WE WANT TO GET THAT PERSON BACK TO THE STATE THEY WERE IN BEFORE THEY HAD THEIR INJURY."

"When you're doing rounds in a hospital, the physician and residents will go around and talk about what's going on with patients and what we need to do and what are the challenges," Schmidt says. "We can borrow those same concepts and deploy the grand rounds into a claim or administrative setting."

The typical claim review might involve adjusters and their clients meeting remotely to go through dozens of open claims. They would look at claims that had been open for six months or a year and talk about why it was still open and what kind of progress is being made in resolving the claim, Schmidt explains.

"What we started to recognize is that so many things that were obstacles or challenges on a claim were medical issues," he says.

For example, a patient may be unable to undergo surgery due to diabetes, hypertension, and medication.

"Or, this person has been on opioids for nine months or a year, and it's stalling the progress of getting this person back to work, or they can't do surgery because of obesity issues," Schmidt says.

These kinds of medical issues were driving claim complications.

The solution was to meet with a medical team that could include a physician, psychologist, pharmacist, and clinical program manager.

"An adjuster will present this claim, and then we talk about it, and a medical team is able to give some advice," he says.

Case managers also can be involved in claim review. "For many case managers or case management companies, this is something they could be doing," Schmidt adds.

Case managers can help with social determinants of health barriers and provide an all-encompassing perspective on what it might take to get a patient back to work, he says.

"Nurses and case managers have a unique perspective on these medical issues, and I think that these issues are forgotten, sometimes, on the claims side of things because adjusters are trained to be adjusters — not medical professionals," Schmidt explains.

Here is how the medical roundtable can work:

• **Assess caseload.** Medical roundtables can be held via conference or video call.

"We have claims in different states and offices, so we usually do it virtually," Schmidt says.

A first step is to identify 10 to 15 medically complex claims.

"We tell clients we're going to do this medical roundtable, and we ask, 'Which are the files you want us to include based on medical complexity factors?'" Schmidt says. "We put those files together."

The roundtables also could be used for cases involving certain types of injuries or when workers experience medication issues, such as opioid use.

When injured workers use opioids and exceed a high threshold of morphine equivalent dosages (MEDs), then the claim adjuster might ask for solutions from a medical roundtable. People taking high dosages of opioids might forget they have already taken their pills and take more, or they might think it is OK to drink a glass of wine and not realize that it could increase their risk of complications.

Case managers can call these patients to make sure they know the risks of taking high dosages of opioids and to reinforce that they should not drive or drink alcohol, he says.

Ideally, physicians tell patients of opioid risks, but some injured workers might not have been to a doctor in four or five years or they have not become comfortable with their doctor.

"When you have that situation, often there is not a level of trust between the injured worker and the physician," Schmidt says. "In discussing these claims in roundtables, we might say, 'You know, this might be an opportunity to hire a nurse to provide patient education.'"

• **Review, summarize, discuss, and take action.** The medical roundtables include the claims adjuster, sometimes a unit manager, and the medical team. A case management company and pharmacist also can be involved, and the employer might weigh in on the discussion.

Before the meeting, the adjuster writes a short summary that is sent to everyone on the medical team, so they are prepared when the discussion begins. The summary includes the case challenges, demographics, and other issues, Schmidt says.

"When our medical director looks at the file, she looks at challenges, notes, claims files, virtual table, and physical table, and is ready to discuss everything," he adds.

Each person reviews the cases that will be discussed over the course of the one- to 1.5-hour meeting, Schmidt says.

"We talk about settling the claim and see if we can close it," he says. "We want an action plan when we're finished."

The adjuster makes the action plan part of the claim strategy and executes the plan.

• **Include case management expertise.** Case managers help adjusters understand the solutions they can provide, Schmidt notes.

For instance, case managers can

EXECUTIVE SUMMARY

One strategy for resolving workers' compensation claims as quickly and optimally as possible is to assemble a medical roundtable of professional experts to review claims.

- The roundtable experts can discuss the types of medical issues that drive claim complications and require multifaceted solutions.
- Case managers can be involved in claim review, helping with social determinants of health barriers and providing practical guidance on getting patients back to work.
- The roundtables can take place over conference calls, covering 10 to 15 medically-complex claims, including cases that have certain types of injuries or medication issues, such as opioid addiction.

talk about patients' medications and complications. They can talk about social determinants of health solutions, he says.

"Case managers are more in tune with translating those things to help the adjuster understand how those factors can complicate a claim or add to the challenges on a claim," Schmidt says.

For many people, the medical process is very complex. They do not interact with healthcare systems very often, nor do they have someone who can advocate for them, he says.

When the adjuster wonders why the patient did not follow their medical instructions, the case manager might be able to explain how the patient didn't graduate from high school and doesn't understand the medical terminology, he adds.

Case managers bring value to the table. They can be advocates who help patients and guide them through the healthcare system, Schmidt says.

"We need to adapt to the changing nature of claims administration and recognize that it's the medical components driving it," he says. "We need medical resources, like nurse case managers, available and able to assist and move these claims along and be part of the team." ■

'Purposeful Rounding' Mixes Security, Clinical Teams to Help De-Escalate Tense Situations

Early data show this tighter relationship has reduced "disruptive patient" calls to security

Concerned about the rise in workplace violence across the United States, administrators at St. Louis-based SSM Health decided they needed to look for new solutions to the problem in their network of hospitals. What they came up with was a cultural shift of sorts that they refer to as "purposeful rounding," a concept based on the idea that if security personnel are more integrated into the care team, there is a better chance of de-escalating behaviors so situations do not turn into major disruptions or violent acts.

First implemented in several hospitals in the summer of 2018, the health system has found that the approach has nurtured closer bonds and communications between security personnel and clinicians. In turn, this is making a difference in the number of incidents involving disruptive patient calls. Indeed, at one hospital, data show that the number of such calls to security was cut by half following implementation of the new approach.

Security personnel anticipate that there will be more fine-tuning in the months and years ahead. Still, they also believe they have hit on a winning solution that they can use without the need for big investments in added staff or technology.

The concept behind purposeful rounding grew out of a systemwide rapid improvement event, a tool SSM Health uses regularly to identify solutions to reduce waste, improve efficiency, and problem-solve, explains **Todd Miller**, CPP, regional public safety and security specialist for SSM Health.

"One of the more concerning issues that we have had for healthcare security nationwide is a rising trend for workplace violence, especially in high-risk departments [such as] the ED, behavioral health, and mother and baby units," he says.

Consequently, in June 2017, SSM Health focused the rapid improvement process on finding new ways to reduce incidents of workplace violence more effectively. "All four of our states [Illinois, Oklahoma, Missouri, Wisconsin] were represented [at the event]. We had ED directors, behavioral health directors, and security leadership involved, as well as executive leadership," Miller recalls. Purposeful rounding was one of the more promising ideas that emerged from this process.

Purposeful rounding is designed to identify troubling or potentially disruptive behaviors before they begin to escalate. This way, appropriate resources can align to prevent tempers or high emotions from potentially turning into something worse, Miller explains.

Considering security officers already round through high-risk areas to increase visibility and promote a law enforcement presence, purposeful rounding involves adding another layer to that process. Essentially, the role of the officer evolves so that he or she becomes another member of the care team, Miller observes.

"The expectation now is to work with the clinical staff and work with the team to communicate observations ... and even build a positive rapport with patients if it is appropriate," he says. "It really revolves around having a more

proactive approach and intervening before [a violent incident] occurs rather than traditionally being reactive where once someone is injured, security is called."

Begin With Education

Implementing purposeful rounding involves first providing a sound base of education about de-escalation and recognizing behavioral indicators before a physically violent act occurs. "This includes doing live, scenario-based education with nursing staff and actors to try to create a team environment that allows [security personnel and clinicians] to train together and work together naturally," Miller says. "The first time an officer and a nurse interact isn't in a crisis; it is in training and understanding how they work together and have a more natural communication."

Part of this educational phase involves learning how to use more facets of the rapport-building aspects of Crisis Prevention Institute training, a widely used methodology with which most healthcare personnel and security personnel are at least somewhat familiar. *(Learn more about this training online at: https://bit.ly/2kxm9bk.)*

This education and practice equips security personnel with the skills to effectively communicate with clinical staff as they are rounding, Miller explains. This is especially important when it comes to sharing observations about potentially troubling behaviors in patients or visitors.

"There is a constant stream of actionable information back to not only the department during a shift, but also for oncoming shifts so that they can align resources ahead of time, intervene if needed, build rapport if needed, and show an extra presence on the floor instead of being reactive once an incident occurs," Miller shares. "Having a constant feedback loop of communication between nursing and security is the biggest part of purposeful rounding."

In fact, Miller says that of all the units, security personnel are probably closest to the ED in terms of building a positive line of communication. While building a good rapport with clinicians is central to the concept of purposeful rounding, there are times when it is essential for security personnel to take an extra step with patients or visitors.

"Building a rapport with a high-risk patient before the patient escalates is a big deal," Miller offers. "It is an attempt, at the very least, to initiate a positive interaction with the patient ... so that should [the patient] escalate, it is not just a uniform coming in after a crisis has started; it is Officer Jones who the patient met earlier."

Another part of the cooperation between clinical and security leaders concerns determining when extra resources or more frequent security rounding is needed in a department. "It is based more on acuity [in a security sense, meaning higher risk] and is at the discretion of the clinical leaders," Miller notes.

"If the ED is high-acuity or there are a lot of behavioral health patients or the nursing staff has been feeling that a greater security presence is needed, it is up to that shift leader or that director to say what is appropriate for that shift."

Usually, such decisions are made in concert with a security shift supervisor and are the result of the strong bilateral communication that the purposeful rounding approach encourages, Miller adds. Such an approach helps to ensure that resources go where they are needed most. "What we didn't want to do is use up resources in areas where the acuity [or risk] is low or where there are only a few patients," Miller adds.

Nurture Relationships

Kate Madden, BSN, RN-C, team leader for the neonatal ICU at Cardinal Glennon Children's Hospital (part of SSM Health), notes that the implementation of purposeful rounding has been a welcome change for her staff.

"Our security team always had a great presence. They were immediately available, and we had a good relationship with them, but we were definitely in a reactive mode," she explains. "That was the biggest shift, going from a reactive mode with a problem focus to being proactive and developing relationships."

Prior to implementation, security staff provided Madden with information about purposeful rounding and what it would involve. She passed that information to staff during huddles and through a weekly newsletter. "Security officers then layered in what they were trying to do with the families [in the unit], but they also did that piece with the staff," she says. "Having [the security officers] speaking with families and making friends and building relationships — that was very welcome because people were interested in having them around a little bit more."

Now, rather than just rounding through the 65-bed unit, security officers will engage in conversation with staff nurses and ask them about any security concerns or anyone in the department who may need extra attention. For instance, it is not uncommon for parents under stress to pace or raise their voices. Sometimes, people will level accusations or start arguments with staff, Madden says.

She recalls one couple that was under great stress because of their sick baby. They started bickering. "They were in a good relationship, but they had financial woes and then a sick baby as well," Madden says. "They were missing work, they were worried about their jobs, and you can imagine how extremely stressed they felt."

A security officer who had observed the bickering made an effort to get to know the couple. "In speaking to them and in proactively building a relationship, he was able to help them tap into some support services," Madden recalls.

These were services that the nursing staff had told the couple about. However, because the security officer knew the couple and had been proactively supportive, he drew attention to the fact that they had been bickering. The officer indicated he was worried about them, Madden relates. Thus, she believes the information about the support services was received in a different way, helping defuse the tension and potentially preventing the couple's bickering from turning physical.

In other instances, the security officer has passed helpful observations on to the nursing staff so they can take steps to intervene. "In building a relationship with one mom, the officer noticed a change and felt like she was escalating," recalls Madden of one recent situation.

The officer told the staff nurse that he thought the woman was upset, so the nurse helped the woman talk through her feelings, Madden says.

"I think the mom was trying to put up too brave of a front and maybe let her guard down with the security officer instead of the nurse," she says.

Madden explains that one of the things that has to happen for a person to de-escalate is for a "break" to occur.

"The goal of de-escalation is to control that break, for it to be a relief instead of a traumatic break," she shares. "We want to give people a controlled break, a supported break."

It is helpful for both security and nursing personnel to receive training in de-escalation techniques so that everybody knows what escalated behavior looks like and what they can do to provide that break before the behavior becomes unpleasant, scary, or dangerous.

> "THAT WAS THE BIGGEST SHIFT, GOING FROM A REACTIVE MODE WITH A PROBLEM FOCUS TO BEING PROACTIVE AND DEVELOPING RELATIONSHIPS."

"Just 'unpleasant' is stressful for families, too," Madden adds. "No one wants to act like that, and we can really help people not to do that."

So far, hospital administrators are encouraged by the results of the purposeful rounding initiative. One of the first hospitals to implement the approach found that "disruptive patient" calls to security declined dramatically after the procedure change.

"They did a four-month average before we started the purposeful rounding process. They had an average of 34.16 calls per month before purposeful rounding," reports Miller, noting he is not permitted to reveal the specific hospital involved. Immediately following implementation of purposeful rounding, the average number of calls per month dropped to 15.75 for a similar four-month period.

"Something that dramatic shows that it wasn't a fluke," Miller says. "We're excited. We're positively encouraged that what we are doing has value or else we wouldn't be doing it."

Indeed, the implementation of purposeful rounding is now a systemwide initiative for SSM Health, including more than 20 hospitals in four states. Further, Miller notes that he is in the process of instituting a robust data collection process to understand the initiative's results going forward, along with any tweaks and refinements to the process.

"We are so new to it right now, and we are being very deliberate," he says. "I am looking forward to seeing the initiative evolve as we see what works and what can be improved upon, like any continuing process-improvement program."

For other hospital or ED administrators intrigued by purposeful rounding and interested in pursuing a similar approach in their own settings, Miller advises them to clearly define the process they intend to put in place first and then track that process until it becomes standard practice. "Like any new process, you go through a period of fearing the unknown and fearing change," he says. "However, once the infrastructure is put in place and staff can see the value, it gets easier."

Further, Miller stresses that it is critical that both sides of the equation understand the importance of the purposeful rounding process.

"If one side is putting themselves out there to communicate more, it needs to be supported by the other side," he advises. "If security personnel are taking the time to reach out to ED leadership, they need to be supported and feel like what they are doing has value or the program will die on the vine." ■

Quick Wins: Blood Draws, Infection Rates, Sepsis

University of Pittsburgh Medical Center (UPMC) has had success with several quick wins through the kind of quality improvement effort that yields meaningful change without requiring a lot of time, money, or effort.

Quick wins are a favorite strategy for **Tamra Minnier**, BSN, MSN, chief quality officer at UPMC and executive director of the Beckwith Institute, a foundation that supports healthcare innovation. She says the following are some of her favorite quick wins at UPMC:

• **Blood draws.** Responding to concerns that certain patients were put at risk of needing blood transfusions when too much was taken for lab work, UPMC decreased the amount of blood taken in each draw.

"We changed our tube sizes so that we gathered 1 cc less of blood per patient, and that saved us 3,000 units of blood in one year," Minnier says. "All we did was buy tube A instead of tube B from the supplier, and that meant we gathered 1 cc less than before. Not having that 1 cc didn't change anything we did with labs or keep us from doing any tests."

Fewer patients needed blood transfusions, and so the hospital did not have to buy as much for its blood bank. With a unit of blood typically costing at least $200, that was a savings for UPMC of at least $600,000 in one year.

• **Infection rates.** One of the best ways to reduce surgical infections is to provide each individual surgeon his or her own infections rate, Minnier notes. That is a well-known strategy for reducing infections, yet it does not happen as much as many quality professionals assume, she says.

"Through the years of bigger data, bigger systems, and more reporting, we see a lot of aggregated data and we lose sight of the individual surgeon and their own number of surgical site infections," Minnier says. "People had gotten used to seeing CMS data at the hospital level, and maybe they thought it was too difficult to share individually or wouldn't work."

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The chairman of neurosurgery decided two years ago to start sending out those rates to all the surgeons, without making it a big deal and saying it was just interesting information and maybe there was room for improvement, Minnier explains.

Neurosurgery cut their infection rate in half just by sharing data, so Minnier expanded the data-sharing to all surgical departments and is about to take it systemwide. It is a very simple strategy, but it works because all physicians are scientists and like to see information — and they are competitive, she says.

"We have found this to be so easy and so effective. People could start doing this tomorrow. If you're not doing it, you should," she says. "In quality improvement, never underestimate the value of being transparent."

• **Blood platelets.** Because they last only a couple of hours before going bad, platelets can be a significant cost when they are ordered and not used. For years, the process at UPMC was that the doctor would order platelets and the lab would immediately start the defrosting process, get the platelets ready, and send them up to the unit for transfusion.

But when nurses are busy, the platelets may not be used right away, and they sit past their use-by time, Minnier explains. To avoid that kind of waste, UPMC changed from its old system — what the manufacturing industry calls a push system — to a pull system.

"When the nurse is ready for the platelets, that's when she calls down and tells them to go ahead and start defrosting. It doesn't take long for them to do that, so the turnaround is still pretty fast," Minnier says. "You can imagine how much waste there was in platelets that were defrosted and not administered in time because the nurse was tied up with another critical patient. It was just a procedure change that made the nurse happier and avoided the waste."

• **Sepsis education.** In the aftermath of the tragic death of a 12-year-old boy from sepsis after scraping his arm, concerns were raised that the parents had not been alerted

to the possibility of sepsis and missed warning signs. A foundation was established to raise awareness about sepsis, and leaders at UPMC wanted to improve its education of parents and others about this risk. *(More information about the Rory Staunton Foundation is available online at: https://bit.ly/1l3kgA3.)*

"We created small magnets that say 'Think Sepsis,' and now they're all over the place at the hospital, encouraging parents and others to become advocates for thinking about sepsis," Minnier says.

"While it was part of a multipronged strategy at UPMC, the magnets have played a big part in getting people to just know what sepsis is and consider it when they see an unexplained fever or other sign," she adds. "We've had several instances in just the past six months where a family member raised the possibility that it might be sepsis, and the caregivers said yes, maybe so, and initiated treatment." ■

Third-Party Social Determinants of Health Data Can Help Improve Quality of Care

Healthcare providers are increasingly focusing on social determinants of health (SDOH) to improve quality of care and outcomes, and many are finding that data from third parties can be key to the success of those programs.

Healthcare organizations often derive SDOH from their own resources, but a recent report from the Healthcare Information and Management Systems Society in Chicago and Acxiom, a data-based marketing company in New York City, found that two-thirds of survey respondents use or want to use third-party consumer data related to SDOH to improve patient experiences. *(The report is available online at: https://bit.ly/2Ug6dMy.)*

Sixty-one percent said they use or would use the data to improve community health needs assessments, while 56% said they see opportunities to use the data for improving chronic disease management. Another 47% said it could help them better understand what motivates patients.

SDOH will be central to any forward-looking healthcare strategy, says **Cameron Thompson**, managing director for healthcare with Acxiom.

"Hospitals that do not understand the social determinants and details of their individual patients will not be able to build new facilities, create outreach programs, or know who to build programs with," Thompson says. "They need to know where the pockets of opportunity are from a commercial perspective, and all of that can be supported with a holistic view of the patient."

The report lists the following five key takeaways from the research:

1. "Siloed data sources and difficulty measuring ROI are among the top challenges facing hospitals as they strive to deliver better patient-driven experiences and outcomes."

2. "One-third also cite the transition to value-based care as a key challenge to delivering better patient-driven experiences, a notable concern given six out of 10 report participation in ACOs and more than one-third participated in bundled payments or patient-centered medical homes."

3. "More than four out of 10 hospitals have access to and are actively using third-party consumer and lifestyle data on the social determinants of health with another quarter reporting interest in gaining access to this data. More than half would be interested in integrating this data into the EHR."

4. "Hospitals see a variety of opportunities to leverage consumer and third-party data on social determinants of health including improved community health needs assessments and better chronic disease management. Opportunities that are most often expected to improve patient satisfaction, reduce readmission rates, and drive patient engagement."

5. "There are some barriers hospitals need to overcome to realize the benefits from tapping into consumer and lifestyle data on social determinants of health. Among the top obstacles are budgets and limited funding, uncertainty about the best sources of data, and difficulty recognizing tangible ROI." ■

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CE QUESTIONS

1. **The Reaching Out to Enhance the Health of Adults in Their Communities and Homes (REACH) program, involving a care model that integrates palliative care with primary care for seriously ill, elderly patients, helped reduce hospital visits among its patient population. By how much did hospital visits decline?**

   a. 24%
   b. 38%
   c. 43%
   d. 61%

2. **Hospitals generally did not start programs like REACH before the Affordable Care Act (ACA) was passed. Why not?**

   a. Patients preferred to be treated in the hospital setting.
   b. It was too costly to have physicians visit patients, so a home visit program would not have been cost-effective.
   c. Physicians did not have home visit training until after the ACA was passed.
   d. Hospitals had physician and nursing shortages and could not spare staff for these visits.

3. **Which of the following is a reason why an in-home doctor's visit might work better than having the patient visit a clinic?**

   a. Clinicians can learn a lot more about a patient's household risks when visiting his or her home.
   b. Physicians can see patients at home more efficiently than in the clinic.
   c. Clinics have worse lighting and smaller spaces.
   d. The home visit works better for the physical exam and blood draw.

4. **In which ways could a case manager contribute to a medical roundtable discussion about workers' compensation cases?**

   a. Case managers can talk about patients' medications, complications, and social determinants of health.
   b. Case managers can give advice on the patients' medications and lab values.
   c. Case managers can provide a risk-benefit and cost analysis for various solutions.
   d. Case managers can review patients' medical notes and claims files and suggest medical goal targets.