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INSIDE

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Patient Activation Measure Guides Education and Realistic Goal-Setting

Building patient confidence in self-care

By Melinda Young

As case managers work harder to meet their organizations' patient engagement goals — particularly in the value-based care model — evidence-based tools can help them succeed.

One such tool is the Patient Activation Measure (PAM), a scale that describes four stages of activation. Research showed the tool to be a valid and reliable instrument to measure activation and to help patients individualize care plans.[1]

"It's important to have a tool to measure patient engagement," says **Heidi Steinhebel**, RN, BSN, CCM, CCP, senior associate director of care management at IHA in Ann Arbor, MI. "It's not just how much the patient will interact with you, but also how well the patient has confidence in managing their own healthcare. It's important to not make assumptions."

> "IT'S NOT JUST HOW MUCH THE PATIENT WILL INTERACT WITH YOU, BUT ALSO HOW WELL THE PATIENT HAS CONFIDENCE IN MANAGING THEIR OWN HEALTHCARE."

With PAM, case managers might discover their patients are more engaged than they expected, or less so. "The tool looks at their confidence, their ability to engage, and their ability to make behavior change," Steinhebel says.

Value-based care is about providing patients with all the care they need for

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their chronic conditions, explains **Martha M. Walsh**, MD, MHSA, FACOG, chief quality and population health officer at IHA. It also is about keeping patients healthy and preventing new chronic conditions or exacerbating existing ones.

"Patient engagement in their own health is at the heart of value-based care," Walsh says. "If patients are engaged, they are more likely to get their quality metrics met, such as breast cancer screening and colorectal cancer screening."

Patients also are more likely to take their medications for better control of their chronic conditions, and more likely to exercise, lose weight, and engage in other healthy behaviors. "Patient activation is associated with certain self-management behaviors," says **Richard Ginnetti**, DHA, director of performance improvement at IHA. "Having pre-treatment measures of the patient's activation level may provide additional information to providers, allowing for more robust tailoring of care plans, while maximizing the patient's ability to self-manage their care."

Through care management, patients become more engaged, more knowledgeable, and confident in making decisions and implementing routines and healthy practices. "It can be a simple as getting a scale and weighing themselves daily to changing their eating behaviors to lose weight," Steinhebel says.

Case managers could help patients with engagement through motivational interviewing and talking with them about their goals and what is important to them. "We use [PAM] because it's a good tool for care managers," she says. "It allows us to personalize the interventions we do with patients, based on that level."

The most significant benefit of using PAM is its ability to risk-stratify a patient population by adding the activation level component lacking in traditional medical risk calculation. "The combined information provides a wealth of patient information, allowing the care management group the ability to manage their patient population through panel management effectively," Ginnetti says. "One area that needs focus is ensuring patients can sustain their improvements and continue self-managing their health."

IHA uses a couple of tools to stratify patients for care management, including PRISM, which is used to stratify discharged patients based on predictor of mortality and readmission at the time of their emergency department visit. "An additional stratification is built into our electronic medical record. It utilizes patient factors, such as patient diagnosis, to assign a score,"

EXECUTIVE SUMMARY

Case managers can use the Patient Activation Measure (PAM) to assess patient populations and guide case management goals and tactics.

- The goal of value-based care is to keep patients healthy and prevent new chronic conditions.
- Activation involves helping patients improve self-management and create better habits.
- PAM can risk-stratify a patient population.

Steinhebel says. "IHA risk-stratifies their patients in order to effectively manage their patient populations and to improve patient outcomes. "Traditional risk stratification lacks a key component of patient activation, as well as social, behavioral, and environmental factors, to fully understand a patient's total active risk."

Care management eligibility includes patients who are hospitalized, diagnosed with multiple comorbidities, and are not successfully self-managing. Also, patients with a new diagnosis that requires education, need coordination of services and resources, and are not able to handle these independently are eligible for case management, Steinhebel adds.

"At IHA, we evaluate patients' medical risks, their social determinants of health risks, and their engagement risk," Walsh says. "Depending on the patient, certain aspects put them at higher risk for unnecessary healthcare utilization and disease progression."

For example, a patient with diabetes may not have access to healthy food due to cost and other barriers, she says. This social determinant of health risk puts the person at a disadvantage for disease control, and case managers need to address it.

"Engagement risk really means that a patient is not engaged in their own healthcare, so they are at risk of not having disease control or not staying healthy," Walsh explains. "An example of this may be a diabetic who eats whatever they want and does not check their blood sugar."

If case managers can set a goal based on the patient's engagement, then help the person control their blood glucose levels, the patient will be less likely to experience complications, she adds.

IHA uses PAM to guide patient care and improve engagement and education through studying results among patients in the program.

"The primary focus of the program assessment, which was a retrospective study, was to assess the effectiveness of the coaching for activation [CFA] tools, coupled with our homegrown risk prediction algorithm, PRISM, to better care for our patient population," Ginnetti says. "The study also looked at the use of CFA and its impact on clinical outcomes, i.e., A1c, blood pressure, HDL, LDL, compared to the care management, care-as-usual program."

They collected data from a multipractice, cluster-randomized control study of patients in case management. All patients in the program had taken PAM's 10-statement questionnaire, starting April 12, 2018, and continuing with analysis and assessment through Dec. 31, 2019. The resulting sample included 2,024 patients.

"The assessment showed the impact that a care management program has on patient's health and utilization," Ginnetti says. ■

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How the Patient Activation Measure Works

By Melinda Young

The Patient Activation Measure (PAM) can help case managers discover how engaged patients are with their care and what types of services and assistance they may need.

Here is how it works:

• Train staff and administer survey. "Our team of nurses, social workers, and medical assistants are trained in administering the survey," says **Heidi Steinhebel**, RN, BSN, CCM, CCP, senior associate director of care management at IHA in Ann Arbor, MI. "All patients who are engaged into the care management program have a PAM completed within the first one to two touches," she says. "This can be during a phone call or a face-to-face visit in the clinic."

Patients complete subsequent PAM surveys every three months or at the time of closure. "If the patient refuses to complete the PAM assessment, it is offered again during the time the patient is in care management," she says.

"The initial assessment is considered the patient's baseline measure," Steinhebel adds. "The case managers follow up with their patients as frequently as a couple of times a week to monthly. This depends on the patient's PAM level and the goals they are working on."

• Determine patient's engagement level. "When a patient's PAM score is determined, this becomes their baseline PAM score, which allows the care manager to understand the patient's engagement

level," Steinhebel explains. "The care manager is then able to select the appropriate CFA [coaching for activation] tools that correspond with the patient's activation level, coupled with any chronic conditions the patient may have."

The care manager helps the patient set goals, develop action steps, and provide any supporting resources needed. "They provide patient-centered education and goal-setting to meet the patient where they currently are in their healthcare journey," she adds.

• Understand the four levels of activation. Each level in the PAM tool pertains to a point score:

- Level 1: "The individual is less engaged; they lack confidence, their knowledge is low, and they are less likely to adhere to change," Steinhebel says. "Interventions are typically weekly, or more frequently. They are short conversations of five to seven minutes, focused on small steps, encouragement, overcoming barriers, and next steps."

- Level 2: At this level, the person is struggling and becoming aware. The patient may have some knowledge, but large gaps remain.

"They are willing to set some simple goals, as they recognize they can do more," Steinhebel explains. "Interventions are typically every one to two weeks and last a bit longer, say seven to 10 minutes. Focus on the status of change and addressing barriers; as simple goals are met, set new ones."

- Level 3: "These patients are taking action, building self-management skills, are goal-oriented, and strive for best practice behaviors," Steinhebel says.

The interventions are every two to three weeks, and last about 10 to 15 minutes.

"Focus on what is or is not working, overcome barriers, take next steps, and set new goals," she adds.

- Level 4: "The patient is maintaining behaviors and pushing forward," Steinhebel says. "They may struggle in times of stress, but they are likely to seek out knowledge and support."

These interventions are monthly and last 10 to 15 minutes. They are focused on the areas in which the patient is struggling or seeking information, she explains.

• Choose interventions. Interventions might include:

- changing talk to elicit expectations or goals;

- educating patient about their disease or symptom management;

- discussing lifestyle modifications to improve their health;

- addressing barriers to meeting goals;

- assessing confidence.

It also is important to set appropriate goals based on diagnosis and PAM levels. "For example, a patient who is a Level 1 may need something as simple as setting a goal to buy a glucometer, and a Level 2 may be just to test their blood sugar once a day," Steinhebel says.

"At IHA, we want to focus our work on patients who are Level 1 and Level 2, as these groups are more likely to struggle with making change," she adds. "They require knowledge and support to identify their goals and to start to set small, incremental goals, leading to behavioral change."

This also is the population for which case managers can make the biggest impact, Steinhebel adds. ■

Case Managers, Nurses, Staff Need Help to Overcome Occupational Trauma

By Melinda Young

Research shows healthcare workers are suffering from extremely high levels of stress, burnout, post-traumatic stress disorder (PTSD), and occupational trauma. These existed before the COVID-19 pandemic, but have worsened over the past year and a half of the world in crisis.

"We have a workforce in a dysfunctional dance with patients — no one can escape the stressors of what they're going through," says **Ellen Fink-Samnick**, LCSW, CCM, CRP, DBH-C, principal of EFS Supervision Strategies, LLC in Burke, VA. She spoke about resilience, occupational trauma, and social determinants of health at the Case Management Society of America's 2021 Virtual Conference, June 7-10.

Collective, infused trauma has created a toxic work situation for many healthcare professionals. "It hits the workforce head-on; they feel it, whether they are case managers, utilization management, or reviews," she adds.

In normal times, when case managers are stressed or experiencing burnout, they can take a day off or go on vacation. Even when these time-outs were available during the pandemic, they were not enough to help people regain their energy and emotional equilibrium.

"The pandemic was not a one-and-done thing," Fink-Samnick says. "We have now been living with this for [18] months, and it's still going on with people unsure about these latest waves. We've never stopped."

Collective occupational trauma can create an all-encompassing cycle in which the workforce has no way to escape professional and personal stressors.[1] "People are tired and burned out," Fink-Samnick says. "When you look at collective occupational trauma, think of it in the context of PTSD. You have got a little stress, and that contributes to trauma and the shared experience of what's going on."

In a survey assessing the effect of COVID-19 after one year of the pandemic, 51% of nurses said they experienced exhaustion within the past 14 days. Another 43% said they felt overwhelmed, 37% felt irritable, and 36% said they were anxious or unable to relax. One in seven nurses said they felt numb.[2]

The survey, conducted by the American Nurses Foundation, also revealed one-third of nurses said their work has no meaning, and 30% were sad. Nearly as many also said they wanted to quit their jobs.

"Folks hit the breaking point where they can't work," Fink-Samnick says. "Across every discipline, substance use is up, suicidal ideation is up, PTSD is up."

The traditional priority in healthcare organizations is the patient. Nurses and other staff are expected to keep going — no matter how tired they are, no matter how challenging the circumstances.

But, the big lesson from the pandemic's relentless assault on healthcare workers is that organizations will need to shift their focus to their staff, truly supporting them, nurturing them, and taking care of them, Fink-Samnick says.

One study of New York City clinicians, conducted during April 2020, revealed high rates of psychological symptoms. Nearly half of the physicians, nurses, and others screened positive for psychological symptoms, including 57% for acute stress, 48% for depressive symptoms, and 33% for anxiety symptoms. Researchers concluded these healthcare workers, especially nurses and advanced practice providers, experienced COVID-19-related psychological distress.[3]

"Mental health issues of the workforce have escalated," Fink-Samnick says.

EXECUTIVE SUMMARY

Since the COVID-19 pandemic forced a shutdown in the United States, nurses, case managers, and other healthcare professionals have faced high levels of stress, burnout, and occupational trauma.

- A year after the pandemic began, more than half of nurses said they have felt exhausted within the previous two weeks.
- In New York City, clinicians experienced high rates of psychological symptoms, including 57% reporting acute stress, according to a study.
- Too often, case managers and other leaders put on a strong front and do not share with their staff the uncertainty and challenges of a crisis, instead of talking about how everyone can work together to get through it.

What can healthcare organizations do about it?

"It is the elephant in the room," she says. "If you ask organizations if they're doing something, of course they say they are. Everyone is well-intended and wants to fix it and to stop employers from pushing staff to the max."

But there remains a healthcare work culture of doing everything possible for patients and putting employees' needs on the back burner.

From an individual case management director's perspective, the first step is to acknowledge their own fear and uncertainty. "Too often, leaders feel they must put a strong face forward and tell their staff it's going to be all right," Fink-Samnick says. "It's the little kid syndrome, where you're told everything is going to be all right, and you believe it until you're into adolescence."

Instead, leaders should acknowledge the challenges and uncertainty and promote the idea that "We're all in this together."

"Let's sit down and talk about what ideas we all have to get through this and see what it means to identify the physical manifestations of stress," Fink-Samnick suggests. "Go up to a staff member and say, 'You look exhausted; you look no good today, so why don't you go home?'"

But the first step is to build a workplace culture in which it is acceptable to acknowledge exhaustion and stress and to make it OK to take a break from it. "Until you build that culture and people can show they're a little vulnerable, feeling crispy around the edges, no one will do it," Fink-Samnick says.

Case management leaders also can work to build morale and resilience among their staff. "We hear everyone has to be resilient, but what do you do to get there?" she asks. "Organizations need to make sure they're coming across in a way that shows their staff they're prioritizing their health, safety, and well-being. Maybe do one-on-one checks with colleagues and have staff put reminder items on the calendar for self-care, and you — as a leader — can ask, 'Did you do it? I want to make sure you prioritize you.'"

Leaders also can consistently check on their teams, repeating this for more than just one or two weeks. *(See steps to save staff's mental health in this issue.)*

"When we put a new initiative in place, everyone looks at it, but over time the novelty wears off," Fink-Samnick says. "We need to provide ongoing, consistent support."

Case management directors also need their own support system to prevent burnout, and this also may take a culture change. "Too often, leaders do not accept support from other people," Fink-Samnick says. "They think, 'If I stop, I won't be able to start again.'"

What would help leaders is support and communication with other leaders, whether they are in case management or another area. "They can do cues with each other around things like sleep hygiene," Fink-Samnick says. "Organizations need to create a culture where people can talk about their mental health, and it's not a dirty word."

One tactic is to use the emotional personal protective equipment (PPE) model. This is shorthand for giving staff emotional/behavioral health equipment. Healthcare professionals affected emotionally by the pandemic can find information about therapists in their area at: emotionalppe.org. All services provided through the Emotional PPE Project are free of charge, the website states.

The new lesson for healthcare organizations is to learn how to support staff for the long haul and not just for the short-term. "This is a constant theme. If you want a sustainable case management workforce, then you need to support their health and mental health," Fink-Samnick explains. "The more stress they endure, the more exacerbation of chronic illnesses and autoimmune disorders — the more those ramp up."

Case managers' mental health should be assessed as part of the normal performance appraisal. "Some organizations are assessing staff burnout as part of their performance metrics," Fink-Samnick says. "How

burnt out is staff, and how is it impacting workforce performance and quality of care?"

The pandemic and its terrible mental health toll on healthcare providers is an opportunity for organizations, healthcare leadership, and professional disciplines to step up and acknowledge that good mental health of the workforce is a mandate, Fink-Samnick says.

"By addressing that, you'll better improve and inform healthcare quality," she adds. ■

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10 Simple Steps to Protect Staff's Mental Health

By Melinda Young

In the pandemic and post-pandemic times, case management leaders can take many steps to help their staff prevent mental health issues, like trauma, stress, burnout, post-traumatic stress disorder (PTSD), and others.

"Trauma has become such a big deal, and all of the healthcare workforce is traumatized by what they see," says **Ellen Fink-Samnick**, LCSW, CCM, CRP, DBH-C, principal with EFS Supervision Strategies, LLC in Burke, VA.

Fink-Samnick offers these 10 steps leaders can take to save their staff from emotional overload:

• **Pay attention.** "Demonstrate attention to the health, safety, and well-being of your staff," she says.

• **Staff creatively.** Case management leaders should consider creative staffing, including providing flex time, remote work when feasible, and other alternative options to give employees more flexibility.

• **Create predictability.** "It's important to create predictability and stability where you can," Fink-Samnick says. "These are uncertain times."

Leaders can combat the unpredictability of a crisis period by creating consistent workflows, including holding huddles and communicating well with staff, she adds.

• **Explain.** "Make sure you have two-way communication that tells staff both what to do and why it's happening that way," Fink-Samnick says. "Staff gets very stressed out when they don't know why something has to happen in the way it does. It minimizes some of their stress when you tell them why."

• **Support PRN (pro re nata).** The term "support PRN" refers to checking in with staff as needed to ensure they are doing well emotionally. This might entail bringing employees a cup of coffee or rolling up one's sleeves and skipping a meeting to help case managers when they are overwhelmed with work. It also means showing the leader cares and shows compassion for what they are going through, she says.

• **Recognize limits.** "You need to know both your own limits as a leader and those of your staff," Fink-Samnick says. "Brainstorm together to figure out the next steps, how to fill the gap, and how to work through this together."

• **Express gratitude.** "Everyone gets stressed, and they forget to say 'Thank you' or let someone know they really appreciate them," she says.

• **Maintain visibility.** Case management directors should be visible to staff, and case management team members should be their neighbors' keeper.

"Make sure you see each other," Fink-Samnick says. "Team members can observe each other and know when folks are feeling burned out, tired, and they can reach out to them."

Most leaders take an active role in trying to support staff, she notes.

"Because it's so engrained in staff that they have to be tough, they often don't accept the help, or they feel like they would be penalized if they asked for help. We need to get rid of that culture because it's not helpful," Fink-Samnick adds.

• **Be mindful.** "Be mindful of the team's needs," she suggests. "Take time to stop and listen."

Organizations have tried asking for an anonymous wish list from staff, but they need to follow up and respond to these wishes.

• **Know hot buttons.** "People have to give themselves permission to stop, sleep, take time off, hydrate, or dance around to music to recharge," Fink-Samnick says. "What are the feel-good stories in the pandemic? How do employees celebrate successes? Do they actively talk about things that are not work related? Have they set up virtual happy hours, or do they share a meal?"

Talking about each person's daily lives, including pet adoptions, graduations, weddings, and more, can help improve morale, even if the conversation is five minutes or less, she adds. ■

COVID-19 Pandemic Put Pioneering Capacity Command Center to the Test

By Dorothy Brooks

No knew the world would be in the grips of COVID-19 in 2016. That is when Johns Hopkins Hospital unveiled a first-of-its-kind Capacity Command Center (CCC), a high-tech control room designed to apply all the latest analytical tools to bed management, patient transfers, and surge planning.

Built in collaboration with GE Healthcare, CCC leaders have spent the last five years working around the clock to optimize patient flow and anticipate any potential bottlenecks. But there is no question the concept has been put to the test by pandemic conditions. How did it fare?

By March 1, 2021, administrators reported the CCC managed the transfer of 659 patients with COVID-19 to and from hospitals in the Johns Hopkins Health System. Another 877 patients with the virus were transferred internally within Johns Hopkins Hospital. In each case, there were no reported patient-to-staff virus transmissions.

Safe transfers are a key responsibility of the more than two dozen staff members who work the CCC 24 hours a day, but this only represents a slice of what the CCC is all about.

The CCC is led by **Anna Ye**, MHA, assistant administrator of the office of capacity management, the leadership team of the CCC.

Accelerate the Pace

Not surprisingly, Ye says the hospital was fortunate the CCC had been running for several years before the pandemic hit.

"We maintained normal operations as we worked," she says. "We didn't have to alter much about how we were operating to manage the volume, understand the changes that were happening, and how to respond to them."

However, that does not mean there have not been challenges. For example, Ye notes the pace for decision-making had to accelerate, beginning with the initial patient surge in April 2020.

"The office of capacity management was heavily involved with the leadership team of the hospital to try to anticipate the creation of spaces needed to take care of our patients, especially those with COVID-19," Ye explains. "Having the [CCC] gave us the ability to use these systems engineering tools that we have at our disposal, tools like predictive modeling and real-time analytics, to help us make those quick strategic decisions."

During the rapid influx of patients in spring 2020, CCC staff members were devising ways to create new COVID-19 units every week.

"We used epidemiological modeling to try to anticipate what the demand [would be]. Based off of that, we created a surge plan of how many COVID-19 patients we might see in the coming weeks," Ye shares. "We tried to stay at least two weeks ahead, but we could plan even a little bit further ahead."

Such plans would include provisions for how the hospital would respond to various levels of demand. As soon as one hospital unit was turned into a strictly COVID-19 unit, CCC staff members were thinking about how they would flip the next unit.

Boost Communications

The CCC remained the center of gravity for all clinical operations within the hospital. But Ye notes that with COVID-19, it quickly became clear there was a need for new avenues of communications.

Not only was it vital to keep the hospital's leadership team connected and involved, it was important to maintain the transparency of

decisions made at the executive level. Thus, the CCC began to host daily leadership briefings. "At the beginning of the pandemic, we were actually having [these briefings] twice a day, but now we have gone to a daily cadence, [including] 50 to 100 leaders across the hospital," Ye explains. "This is where any new therapeutics or new guidance from the CDC can be brought up and discussed at a leadership level, and where quick decisions can be made."

The briefings have enabled the CCC to act faster and to stay on top of any changing needs or directives. For example, it became clear that long waits for COVID-19 test results for patients presenting to the ED were a significant drag on hospital throughput. CCC leadership seized on the opportunity to bring in the equipment necessary to provide point-of-care testing in the ED, a step several physicians had been pushing administrators to take before the pandemic.

"Once we put in the point-of-care testing and also put in some automatic orders to get the testing done from the nursing perspective, that really helped push our throughput and allowed us to deal with some of the isolation concerns [with respect to patients with suspected COVID-19] a little bit more easily within the ED," Ye says.

The approach has eliminated the time it used to take for specimens to be transported to the hospital's central lab for processing. Test results are expedited. "This was a big project. A lot of different people were involved, but it has been a huge success," Ye adds.

Beyond leadership briefings, the CCC stays in close contact with the ED all day, every day.

"We have our bed management staff in the CCC, and a lot of our admissions come through the ED. They are in constant communication about what operations look like in the ED and how they might affect the rest of the hospital," Ye says.

Typically, when the ED decides a patient needs to be admitted, the bed managers in the CCC will receive an alert to look for a bed for that patient.

"If there is a disagreement with the service line or the level of care, [the bed managers] will communicate with the clinicians in the ED to determine what the best placement for the patient might be," Ye says. "Often, this goes without a hitch, but if there is any escalation needed, that is when the attendings will come into play."

Leverage Protocols

Before the pandemic, the CCC was working to ensure patients who present to the ED with mental health concerns or substance use disorders received prompt, appropriate, and safe care, and that approach has continued. However, as a systemwide strategy, added provisions have been put in place for patients in this population who also have COVID-19.

"We created a special [psychiatric] unit at one of our hospitals where we would transfer any patients from across the entire health system if they became COVID-19-positive at any point," Ye explains. "That eased any isolation concerns while also making sure those patients receive the best care."

The CCC has a range of procedures and protocols in place for when the hospital hits high occupancy levels, all of which were employed during surges of COVID-19 patients. These included building new ICU-level care units, working with the hospital medicine team to discharge as many patients from the floor as possible to improve throughput, and helping the ED with extra beds and linens.

Ye acknowledges the demand for ICU beds proved particularly challenging. This prompted capacity management leadership to create a new role in the CCC called the Hopkins triage and integration physician, a position designed to help with triage, but especially regarding ICU-level care.

"Since the ICU was such a bottleneck for us, we needed to make sure that appropriate patients were placed in our ICU beds," Ye explains. "This was definitely a new lesson for us, and something we will continue using going forward. Having a physician in the CCC helping to triage patients has been really beneficial."

Medical Centers Jump on Board

Since the debut of the CCC, other medical centers have jumped into the space, creating command centers of their own, often with the guidance or assistance of the pioneers at Johns Hopkins. "Before the pandemic, we were doing one to two tours [of the CCC] every week," Ye observes. "We are happy to share everything we have learned ... with anyone who will listen."

Johns Hopkins is hoping to learn from the new entries into the space, too.

Adds Ye, "We have been able to create an ecosystem of others who share the same mindset and some of the same challenges that we have now." ■

Rapid Mortality Reviews Improve Quality and Patient Safety

By Greg Freeman

Staff at a California hospital found rapid mortality reviews conducted soon after a patient death resulted in the treatment team identifying opportunities to improve the patient's care in more than 40% of the cases.[1]

The team conducting the rapid mortality reviews concluded this technique can offer advantages over the standard retrospective case reviews, provider surveys, and structured morbidity and mortality conferences.

The authors studied data from five years of patient deaths that occurred in the 24-bed medical ICU at the UCLA Medical Center.

Expanding Through Hospital

What started as a quality improvement effort in the ICU has now expanded because of the good results, says **Kristin Schwab**, MD, study co-author, co-director of the Post-ICU Recovery Clinic at UCLA, and medical director of UCLA Pulmonary Rehabilitation.

"It came about as part of our continual process to continue the care we provide in the ICU. We wanted to create a concrete and standardized process by which we could review all deaths and figure out how to improve care for people in the future," Schwab says. "It's now gone from our ICUs to other units in the hospital as well. Oncology is doing it with their patients, and it's moving to every other area of the hospital."

The project began in 2013 with patients who had died in the medical ICU in one week. By 2017, Schwab and colleagues were holding weekly meetings with the intention of reviewing every death on the unit. Over five years, the team reviewed 542 deaths, more than 80% of all deaths on the unit.

The weekly meetings are led by a facilitator drawn from a pool of quality-trained nurses and physicians who work to standardize the process. The facilitator is not someone who was involved in caring for the patient but reviews the patient's chart before the meeting, held in a private conference room in the ICU.

The facilitator leads an interview with the care team. Questions include "Was the death potentially preventable?" and "Are there any aspects of care that could have been improved?"

Frank conversations are encouraged. These discussions begin broadly before narrowing to standard questions and then detailed queries specific to the case.

"We look at the deaths through the lens of process improvement. It's important that it's not meant to be punitive in any way," Schwab says. "It is a standardized but relatively informal conversation with the entire care team. That includes the doctors, the nurses, and any consulting teams who were involved in the care."

Action Items Identified

The facilitator enters a summary of the interview into a database the hospital quality leaders can review. They may identify action items and make recommendations.

Most other rapid mortality reviews last only 15 minutes, but Schwab

says they often reveal meaningful information.

The rapid mortality reviews are not intended to catch anyone acting inappropriately but rather to identify potential areas of improvement. Schwab and colleagues determined only 7% of deaths were potentially preventable. However, in 40% of the cases, the treatment team concluded the patient's care could have been better.

The facilitators saw room for improvement in a slightly higher percentage of cases, more than 50%. Action items were more likely to be identified when the patient received resuscitation after an in-hospital cardiac arrest or was not receiving comfort care.

Common quality improvement issues identified included medical errors, hospital-acquired infections, delays in care, communication, teamwork, advance care planning, and procedural complications. Lack of protocols, resource availability, and throughput also were cited at a system level.

More than 10% of the issues identified in the rapid mortality reviews led to changes within the unit, with 29 separate changes during the five years. In one case, the review led the hospital to create a standardized checklist for inbound patient transfers. In another, the hospital altered the electronic health record so that one-time orders were differentiated from continuing orders.

Different from M&M

The hospital's rapid mortality reviews differ from typical morbidity and mortality reviews in that they are held sooner after many patient deaths — every week, rather than monthly. The rapid mortality reviews also are conducted by the care team rather than an outside reviewer. "This is a discussion among the team that was on the ground actually providing care, and it's a face-to-face interview. Often, there are surveys or chart abstractions used for mortality reviews. That is a very different approach," Schwab says. "Without the face-to-face interview and the open-ended discussion, you end up missing a lot. This also benefits from including everyone who was involved — not just the doctors and nurses, but the ancillary staff as well."

The information revealed in the rapid mortality reviews can be more useful than what might be gleaned from a monthly review.

"The recall bias can be so great if you wait weeks thereafter. The immediacy of it helps people with their recall and minimizing issues of memory," Schwab says. During the COVID-19 pandemic, the rapid mortality reviews still are held in the ICU conference room, but they include a virtual option for team members who were not in the hospital that day.

Schwab encourages other hospitals to adopt the rapid mortality review, calling it a relatively easy process to implement that can significantly affect care quality.

"Finding a leader for this who can frame this from the quality improvement lens is really important. It also is important to establish a regular time when everyone involved knows this is going to happen every week," Schwab says. "If you don't have the capacity to review every death per week, we found that the most high-yield cases are those with a cardiac arrest and CPR, or patients not receiving comfort care. Focusing on those first and then expanding from that can be a good approach."

Six percent of the deaths reviewed in the rapid mortality reviews were referred for further analysis in the morbidity & mortality conference. There are multiple avenues for cases to be referred to morbidity & mortality, so the rapid review represents one route for referral, Schwab says.

For cases that are referred, Schwab says there is direct communication between the rapid mortality review and morbidity & mortality teams to confirm the reason for referral. Case details from the rapid mortality review are conveyed to the other reviewers. ■

REFERENCE

1. Schwab KE, Simon W, Yamamoto M, et al. Rapid mortality review in the intensive care unit: An in-person, multidisciplinary improvement initiative. *Am J Crit Care* 2021;30:e32-e38.

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CE QUESTIONS

1. **The Patient Activation Measure features four levels of patient engagement. Which best describes Level 1?**

   a. The patient is struggling, becoming aware, and may possess some knowledge, but there are some big gaps.
   b. The individual is less engaged, lacks confidence, possesses little knowledge, and is less likely to adhere to change.
   c. The patient is taking action, building self-management skills, creating goals, and striving for best practice behaviors.
   d. The patient maintains behaviors and pushes forward, sometimes struggling with stress, but is likely to seek knowledge and support.

2. **Stress, burnout, and collective trauma have increased among healthcare professionals during the COVID-19 pandemic. According to Ellen Fink-Samnick, LCSW, CCM, CRP, DBH-C, what lesson from the pandemic should healthcare organizations learn?**

   a. Healthcare leaders should offer every employee at least one mental health day a month.
   b. Organizations should offer employees opportunities for yoga, meditation, and tai chi.
   c. Organizations need to shift their focus to their staff and truly support and nurture them.
   d. Healthcare leaders need to screen job applicants for resilience and stress.

3. **Which is one of the 10 important steps leaders can take to help their staff prevent emotional overload?**

   a. Establish two-way communication that tells staff what to do and why.
   b. Offer staff a weekly drawing, and their entry is a handwritten positive thought.
   c. Promote a fit mind, fit body approach with weekly 15-minute dance-in-place sessions.
   d. Once per quarter, bring a mental health counselor on site for mini-counseling sessions to anyone in need.

4. **What is at the heart of value-based care, according to Martha M. Walsh, MD, MHSA, FACOG?**

   a. Quality metrics
   b. Communication
   c. Patient engagement
   d. Educational brochures