HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

JUNE 2019 Vol. 27, No. 6; p. 61-72

Health System's Integrated Care Program Is a People-Centered Strategy

Approach can reduce readmissions

By Melinda Young, Author

Health system leaders nationwide are beginning to break down care silos and coordinate integrated care systems. In some models, hospital case managers work with their community and payer case management peers, and everyone participates in a care team with a targeted care coordination plan.

For example, a Michigan healthcare system has spent more than a year integrating all care coordination activities across its region with the goal of aligning with a strategic, integrated plan. An Ohio health system also is coordinating care to reduce ED and hospital readmissions.

> "OUR PATIENT PHILOSOPHY IS PUT PATIENTS FIRST AND HELP THEM STAY OUT OF THE HOSPITAL, STAY HEALTHY, AND MANAGE THEIR CHRONIC DISEASES IN THE BEST SETTING."

Hospitals, ambulatory sites, physician offices, skilled nursing facilities (SNFs), and home health are all part of the Trinity Health strategic plan, says **Mary Beth Pace**, RN, BSN, MBA, vice president of care management at Trinity Health in Livonia, MI.

"Integrated care coordination means we're wrapping our arms around our patients," Pace says. "We're

Financial Disclosure: Author **Melinda Young**, Author **Jeanie Davis**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Leslie Coplin,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™, **ISSN 1087-0652, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**
GST Registration Number: R128870672.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
ReliasMediaSupport@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $469.

Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers.

This activity is valid 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

integrating with organizations where we have them and creating relationships with SNFs and home health when we don't own that."

Breaking Down Silos

Taking a patient-focused approach, an Ohio health system is identifying patients at risk of frequent readmissions to manage them with a coordinated care team. The team helps patients improve their health by using comprehensive, individualized care plans.

"We have individual cases where we've improved patients' readmissions and connected them to ambulatory resources," says **Colleen Royer**, RN, MSN, CCM, senior director for care management at Cleveland Clinic Health Systems Eastern Region Hospitals.

"Our patient philosophy is put patients first and help them stay out of the hospital, stay healthy, and manage their chronic diseases in the best setting," Royer says. "This breaks down barriers between silos and inpatient and outpatient and the community hospital. It improves dialogue among all of those resources in the community, keeping patients in the right setting for their needs."

The three pillars of the Trinity Health strategic plan are community health, well-being, and episodic care.

"We make sure all care coordinators in all of those buckets are reporting to a single clinical executive," Pace says.

There can be case management handoffs. Providers share case information via an electronic medical record, when this is possible. Not all electronic records can be shared between different health organizations, but technology is improving and making interoperability possible, Pace says.

The goal is for acute care coordinators to be able to read notes from community providers. When all providers are within one accountable care organization (ACO), sharing data is simpler, she notes.

"The patients we have more difficulty with are those patients that show up on our doorstep and are assigned to another ACO in our area," Pace explains.

Focus on Optimal Communication

Optimal care requires communication between healthcare

EXECUTIVE SUMMARY

Two Midwestern health systems exemplify the emerging new strategy of coordinating integrated care systems to improve patient care and reduce hospital and ED readmissions.

- Hospital case managers collaborate with other hospital providers, as well as with community case managers and providers, to develop care plans.
- Hospitals develop relationships with skilled nursing facilities, home health agencies, and primary care providers.
- In one strategy, a health system identifies patients at risk of frequent readmissions for a coordinated care team to target them with comprehensive, individualized care plans.

organizations, patients and families, and payers about patients' care plans.

The Cleveland Clinic Health Systems case managers reach out to insurance company case managers to share their patient care plans and make sure everyone is working toward the same goal, Royer says. *(See story on Cleveland Clinic's care coordination, below.)*

"We're trying to negotiate for the patient, collect resources, and navigate throughout the healthcare system," she says.

Care coordination works best when there is optimal communication.

"The ultimate goal is for care coordinators to communicate with each other and keep the plan," Pace says.

The process can start in the hospital or ED. Hospital case managers do everything they can to make sure patients transition to the appropriate level of care, says **Colleen Fitzgerald**, MSN, CCM, ACM-RN, director, system care management, Trinity Health.

"Patients in acute care facilities are managed by acute care coordinators, and they follow patients in the hospital," she says.

"We do interprofessional rounds daily, on all nursing units, to discuss patient care," Fitzgerald adds. "Physicians, nurses, case managers, therapists, and social workers attend the rounds and discuss the patients for one to two minutes each, discussing care transition plans for each patient."

Making sure the entire team is involved with the patient's care takes a lot of work, she notes.

Care Coordinators Help With Handoffs

Transition handovers help patients in the next site of care. The integrated care coordination system can provide a good handoff process to the community, Fitzgerald says.

"We make sure we're handing over patients to the next site of care, even for those not in the model," she says. "We make sure we're doing good communication to ensure the patient's care is in place for any patient that goes out of our hospital to the next level of care."

In the acute care environment, the care coordinator is responsible for all admitted patients, Pace says.

"If a patient in the emergency department is stabilized and needs medical follow-up, the emergency room knows they are followed by a care coordinator in the community, which helps with transitioning them back to the community," she explains. "If there is no care coordinator, then the emergency department might keep them in the hospital if they are not comfortable with medical follow-up."

Patients are handed off to community care coordinators using handover tools, including one that Fitzgerald helped create, called the Handover Process SBAR. *(See overview of Trinity Health's integrated care coordination tool, page 64.)*

Each piece of the tool represents a part of what the handover should include. SBAR stands for situation, background, assessment, and recommendation/request. ■

Plan of Care Collaboration Can Reduce Readmissions

Focus on care team approach

Hospital case managers are part of a care team collaboration that spans healthcare settings and disciplines, focusing on improving patient care and preventing high-risk patients from being readmitted to the hospital.

"Some of the collaboration's achievements have been related to reducing the frequency of these individual patient readmissions to the hospital over time," says **Colleen Royer**, RN, MSN, CCM, senior director for care management at Cleveland Clinic Health Systems Eastern Region Hospitals.

"A few years ago, we noticed more and more similar patients returning to our hospital," Royer says. "We didn't have the ability to know if someone was at one hospital versus another hospital, and we were not sharing individual care plans."

The hospital's ED team and additional healthcare professionals began meeting to talk about individual cases and discover the root cause of why these patients returned repeatedly, she adds.

"The team developed comprehensive plans, individualized to the patients," Royer says.

The next step was to identify the patients who most needed this targeted intervention. The solution involved metrics collected

electronically. Data included claims data, lab values, multiple readmissions, frequent ED use, and two or more chronic diseases, she says.

The technological tool assigned each patient a score. A high score was considered high risk, and this patient could be included in the intervention, she adds.

The individual plan of care team consisted of ED physicians, case managers, a case management manager, social workers, ED nursing teams, and specialists including psychiatrists. Community providers, including primary care physicians, community case managers, and community mental health workers, also were included as team members.

"There is even pastoral care," Royer says.

The plan of care is written from an electronic template that one team member documents. The whole team contributes to the plan, addressing the primary reasons why the patient keeps returning to the hospital. The plans address the patient's chief issues, goals, and interventions, she adds.

The team follows patients over time and reassesses plans, as needed.

In one case, a patient had 37 hospital encounters over a one-year period — including eight encounters in the month before the plan was created. After the team implemented the plan of care, the woman's readmissions dropped to four for the remaining four months of the year, with no readmissions in 2019.

Success follows when the team coordinates its efforts. The team discovers and assesses patient barriers to better health, including transportation issues. If the patient is experiencing food insecurity, the team might connect the patient to food pantries. If the patient needs a wheelchair and insurance will not cover the expense, the team finds a funding solution, Royer says.

"We become creative when seeing what's available for patients in the community," she adds. "Maybe a church has a resource that we're not aware of, so we put all of our heads together to see what is available." ■

A Closer Look at Trinity Health's Integrated Care Coordination System

Care coordinators can help hospitals better manage care through an integrated system that provides best practices in the handover process.

For example, Trinity Health in Livonia, MI, created a care coordination tool to ensure the most effective care. It is adapted from the Agency for Healthcare Research and Quality (AHRQ) TeamSTEPPS 2.0. *(Find out more about TeamSTEPPS at: http://bit.ly/2GqG0mv.)*

The following are some sample items from Trinity Health's two-page handover process SBAR (situation, background, assessment, recommendation/request) guidance:

• Situation:

The guidance suggests questions to consider in one column, and their descriptions in an adjoining column. Here are a few examples:

- What are the current situation and overarching concerns? "Describe specific situation. Include code status. Be concise and concrete," according to the guidance.

- What are key, recent changes to the patient's health status? "Determine the current opportunities and/or challenges."

- What is the patient's level of risk for poor outcomes? "Utilize standard risk stratification methodology."

• Background:

- What are the relevant comorbid conditions? "Highlight the comorbid conditions that place patients at risk."

- How does the family history impact the plan of care? "Share applicable family history."

- Does the patient have a support network? "Include family and caregiver dynamics."

• Assessment:

- What are the pertinent biometrics — the pertinent, critical, and pending labs, diagnostics, or medications? "Communicate clinical information, as applicable."

- What are the safety concerns? "Highlight allergens, falls, isolation, socioeconomic factors."

- Is the patient able to self-manage? "Consider health literacy, cultural factors, social determinants (food insecurity, transportation, housing, medications)."

• Recommendation and Request:

- What is the recommended plan or the next steps? "Respect patients' preferences and goals of care."

- What actions will be taken to ensure a safe transition? "Clarify expectations. Ensure there is adequate time allowed in handover process to ask/answer questions."

- How will the next site of care connect with the previous site of care if further questions arise? "Communicate follow-up contact information." ■

Case Managers Can Drive Success in Hospitals

Proactive — not reactive — focus

Hospitals — some more slowly than others — are moving from the traditionally reactive to newer proactive model of providing quality healthcare. This puts case managers in the driver's seat when it comes to steering the organization to better outcomes.

"Healthcare costs are high, and we want to try to reduce costs for patients while maintaining quality care," says **Lisa Morrison**, MSN, RN, CCM, regional case manager of Signature Care Management with Signature Medical Group in St. Louis.

"Quality is incorporated into the whole process," she says. "I've been a nurse and case manager for more than 25 years — I've seen this whole shift from being more reactive to being more proactive in care, and it has changed healthcare costs. That's where value-based care really shines."

In Morrison's early nursing days, the focus was on fixing the patient's health problems. If a patient had heart disease, case management and nursing care helped the patient recover and return home. Now, under a preventive care model, nurses and case managers help patients stay healthy, follow heart-healthy diets, take medication, and do what they can to prevent heart disease, Morrison explains.

"It's nice to see that nurses and case managers have become more proactive in the way healthcare is delivered," she adds.

As hospitals make this shift to proactive care, here are some of the ways case managers can help organizations successfully navigate the new paradigm:

• Become the communication point person. "They can advocate for the patient and talk to all providers involved in the case," Morrison says. "Whether they're working with the physician, post-acute care facility, or home health agency, the case manager takes ownership as the point person."

This requires strong communication skills and the ability to speak in a way that everyone can understand, including patients, physicians, and post-acute providers.

"Case managers basically guide and assist in that post-acute care setting, adhering to physician orders," Morrison says.

Communication can include phone calls, face-to-face conversations, educational pamphlets, text messages, and emails, she notes.

"Case managers can be the communication hub," she says. "They now are being incorporated into physician practices, and those case managers work one-on-one with hospital case managers and discharge planners to streamline the patient's process of moving through the continuum of care."

• Set expectations for a value-based care environment. In today's value-based care world, case managers need to help patients set expectations as early in their hospital visit as is possible, Morrison suggests.

For example, when case managers are working with patients undergoing surgery, the goal is to explain how they will be heading home after the surgery and not necessarily be admitted to inpatient rehabilitation services, she says.

"If there's a caregiver at home and the patient doesn't have many comorbid conditions and has stable health, then the discharge expectation destination could be going home instead of utilizing post-acute care, which can be very costly and drive up healthcare costs," Morrison says. "You might set that destination expectation on day one."

Tell patients what might happen. Emphasize that they will see better outcomes at home and could still receive home health services or outpatient therapy services as needed, she adds.

It is very important for case managers to help patients understand what to expect post-surgery and to help them prepare for all necessary self-care. Case managers also might ensure patients' social networks are stable and someone will be at home with them in the first few days post-surgery.

"Case managers look at all aspects of the patient to optimize them to the fullest potential and to set expectations for the patient going home," Morrison says.

The goal also is to discuss these expectations with patients' caregivers while educating them about how to help patients recover health and movement and avoid rehospitalization.

"Having educational training sessions with the family can be very helpful," she says.

• Align care across all provider areas. In a value-based world, case managers are team players. They might round with physicians. They meet with patients face-to-face early in the hospital stay, and they follow up near the end of the stay, Morrison says.

"They engage with physicians and align care, informing patients, families, and all other providers of what the care plan is and what the physician's expectations are," she explains.

"Case managers can help empower and educate physician staff about being part of the team," she adds. "It gives a certain credibility to your role as case manager; it helps build trust."

Aligning care entails having providers share a vision for the patient's care and goals and how to integrate their services into that care, she says.

• Learn more, continuously. "We can continually educate ourselves," Morrison says. "Knowledge doesn't stop when you get your degree or certification. Knowledge is continuous; continuous growth and continuous education is key."

Case managers might also learn best practices in educating patients. "It's vital you make sure you are consistent in your messaging to patients," Morrison says.

"Don't give patients mixed messages because that will set up the patient for failure," she explains. "Be genuine. I know it sounds cliché, but I think all nurses are very compassionate people, and we all want to make sure that patients are doing their best. When a nurse builds trust, it feeds into their credibility."

It also is important that case managers advocate for the shift to value-based, proactive care as a positive trend for all healthcare providers.

"I'm so passionate about case management because I've seen it from the very infancy to where it is now, and it's just phenomenal to be a part of it," Morrison says. "It makes me proud to be a nurse and case manager." ■

Study Targets Causes of 30-Day Rehospitalizations

Patient education is key

A new study has identified some of the most common physiological reasons for 30-day unplanned rehospitalizations among heart failure patients — making it possible for case managers and others to develop interventions and strategies to address this problem.[1]

To fix a problem, one first must understand what causes it. This is why investigators looked at the root physiological factors behind heart failure patients' rehospitalizations.

"The readmission rate was a little bit high," says **Omar Alzaghari**, PhD, MSN, RN, assistant professor in the school of nursing at the University of North Carolina at Wilmington.

Alzaghari began to identify factors that could increase readmission risk. His first study looked at physiological factors, like cardiovascular disease, lab values, and the presence or absence of chronic kidney disease and other conditions.

"We found some significant factors that predicted rehospitalization," Alzaghari says. "The main one was chronic kidney disease."

Other factors associated with rehospitalization were the patient's use of a continuous positive airway pressure (CPAP) machine and higher levels of the hormone B-type natriuretic peptide (BNP) — a heart failure hormone.

From a case management perspective, the study's findings suggest hospitals take the following actions to reduce the risk of unplanned readmissions among heart failure patients:

• Make sure patients have functioning CPAP machines, if needed. "We have to make sure the patient goes home with a CPAP machine and it's functioning," Alzaghari says. "The patient also needs to know how to contact the company that provides the CPAP machine."

Case managers can give patients the most current information about using a CPAP and ensure they are compliant with instructions for use. They can explain to patients that research shows that heart failure patients who use the CPAP properly are less likely to return to the hospital within 30 days.

Case managers can make sure patients follow up with their primary care providers after the initial discharge. "We like patients to follow up within five to seven business days, and we can make sure patients have a primary care doctor," Alzaghari says.

If there are barriers to the patient following through on a doctor's visit, case managers can identify and address these obstacles. They could involve the lack of funds, transportation, or other access barriers that case managers are skilled at resolving for patients.

• Focus on patient education.

"Make sure patients understand their instructions," Alzaghari says.

For example, case managers could use the teach-back method of delivering information to the patient and then asking the patient to explain the information to ensure he or she understands everything, he explains.

"I might say, 'Tell me how often you will weigh yourself. Tell me what kind of diet you will be using at home,'" he says.

• **Check medications.** Hospital case managers also can help reduce readmission rates by making sure patients have the correct medication at discharge and will have access to medications post-discharge, Alzaghari says.

"Maybe we could provide the patient with medication under an indigent fund, or give the patient one or two weeks or a month supply of medication and then refer the patient to a community program," he adds. "There also are some medication assistance programs — some run by the government and others privately run, so there are different ways you can help patients."

• **Reinforce daily behavioral changes.** "We emphasize that patients have to weigh themselves every day," Alzaghari says.

Home health staff could visit the patient's home post-discharge and catch any problems early on, communicating the issues with the primary care doctor and assisting with an intervention, he notes.

"If patients are not following the right diet, they are putting pressure on the heart and the release of BNP is increased, indicating the heart's function is getting worse," he explains. "When the heart is struggling for oxygen, it needs help, and the patient gets fluid build-up in the body."

When healthcare providers discover this problem early, they can intervene and give the patient more medication to help reduce the fluid build-up, he adds.

• **Create continuum of care with community providers.** Heart failure patients with kidney disease need to be very compliant with their medication regimens, and should follow up with nephrology or primary care physicians. Hospital case managers can help by making sure these provider appointments are scheduled and by calling to check whether the patient showed up to the appointments.

In some cases, case managers might have to find primary care doctors for patients before discharge. They also might need to set up a medication assistance program and connect patients with the health department, if needed, Alzaghari says.

"Before discharge, we have a new model that helps with follow-up: A nurse with a case management background makes sure the patient is doing OK and has transportation," he says.

"This is becoming important because we can set up patients with a doctor's appointment — but if they don't have access to transportation to that doctor, it won't help them," he adds. ■

REFERENCE

1. Alzaghari O, Wallace DC. The impact of physiological factors on 30-day unplanned rehospitalization in adults with heart failure. *J Comm Health Nurs.* 2019;36(1):31-41.

Helping Human Trafficking Victims: Is Your Staff Prepared?

If a sex trafficking victim presented to your ED, would your staff recognize the signs? This victim might seem very much like an "ordinary" person. Most likely she (or he) has a sexually transmitted infection requiring medical attention.

The scenario is complicated by one critical fact: This victim is a source of income. The person who accompanies this victim will "do anything" to protect his or her victim.

Could your hospital's team handle the situation? Are they prepared to help that victim take first steps in exiting this nightmare?

Rosario V. Sanchez is a forensic nurse and PhD candidate at Rutgers School of Nursing who studies the trauma of sex trafficking. She is working to educate nurses and other hospital staff — including CEOs — on the traumas that these victims experience.

Sanchez wants to help hospital staff recognize trafficking victims and establish hospital protocols that protect and aid a victim's escape from the trafficking coercion. Safety of both the hospital staff and the victim is a critical concern that must be addressed, Sanchez says.

Human trafficking involves both forced labor and sex trade, with an estimated 40.3 million victims around the world. Seventy-five percent are said to be women and girls. *(More information is available online at: https://bit.ly/2kgJE72.)*

The population at highest risk is teens, and especially runaways and kids labeled as "troublemakers" who have been in juvenile court. While females are at greatest risk, so are young males — and they often are overlooked, says Sanchez.

Kids from suburban middle-income families also are at risk. "Both parents work, so kids are home alone," says Sanchez. "The kids are into social media, and that's where a trafficker can tap into them. These are good kids being lured."

Traffickers know psychology; they lure young college kids who don't quite fit in. They may promise great jobs with escort services and modeling agencies, with lots of flattery: "You look so beautiful, you could be a model."

Protect your own kids by talking to them about these risks, she says, "We think when they hit 18, they know everything. They don't. We teach them independence — a great thing. But we don't teach the safety factor."

Even more disturbing — young children are at risk via adoptions by traffickers, Sanchez adds.

How did our society get to this point? "We were blinded to it for a long time," she says. "Our eyes weren't open to the atrocities of this crime. Now that eyes are opening, we must decide, what are we doing as a society?"

Incidence is escalating because it's a "hidden, profitable crime," Sanchez says. "They can sell a drug once but can sell a body over and over for years. When they're done, they sell it to somebody else who will make a profit."

Most concerning is the complex trauma the victims endure, she says. One survivor she met was 30 years old and had been trafficked since age 8. She had gastrointestinal and heart problems, including a heart attack, all linked to the extensive trauma.

Victims typically enter the healthcare system via the ED. However, OB/GYN facilities and dental clinics also see victims, Sanchez explains. "They're coming with STIs, often multiple times, due to complications of the infections. Yet no one is asking why they're coming in that often."

Nurses have the best chance in rescuing these victims, says Sanchez. But nurses need training to handle the situation optimally and safely.

Congress recently passed a bill mandating that all hospital staff receive training in sex trafficking. The SOAR program has been established to provide training and technical assistance via the National Human Trafficking Training and Technical Assistance Center. This training is specifically for healthcare providers. *(The NHTTAC is available online at: https://bit.ly/2iYD8Ad.)*

Sanchez foresees one problem with the new federal mandate. "Michigan and Florida have mandated nurses training in human trafficking. But they haven't specified the type of training. Some hospitals only require reading one article — but how much can they learn?"

Hospitals should set up education programs, Sanchez advises. "If nurses are to respond effectively, the training needs to be standardized."

She is advocating for a form of trauma-informed care training. "These patients are victims of violence. But the trauma they have been exposed to is not equal to other types of trauma. Nurses must learn the special trauma associated with sex trafficking. They must also acknowledge that each patient is different."

Sex trafficking is not found in big cities only; it's everywhere, Sanchez adds. "Sex trafficking has no boundaries, and every nurse should know how to help these victims. It's a form of modern-day slavery, so damaging to any person who endures it. We are nurses. We must do what we can to help them."

The trafficker often is within the girl's immediate family, including her boyfriend or husband. Even if the trafficker was initially a stranger, he knows how to manipulate a young girl or boy, she explains. "He knows how to make them fall in love with him."

Social isolation, intermittent love and abuse, power control, and the victim's perceived inability to escape feed the coercion. The victim believes the trafficker will take care of him or her. No matter what happens, the victim will never give up that connection, says Sanchez.

Victims often view healthcare providers and law enforcement as "enemies," she adds. "It's frustrating for those who want to help. The victims don't want your help. Even if you get them into a shelter, they will return to the trafficker."

But it is important for nurses to make the effort to try to help, as some victims have successfully exited the relationship, she adds. "They have survived the trauma."

Sanchez believes the long-term trauma changes the young person's brain when it begins in adolescence, when the brain is still forming. The amygdala becomes triggered so often that there may be a pattern of addiction that forms.

Her research is now focused on adolescents who have exited the coercion. She wants their insights in order to help others. "We're just coming to understand the complex trauma of human trafficking," says Sanchez. "But the thing we know is we can reverse it with proper treatment." ■

First Steps to Help a Trafficking Victim

Nurse **Rosario Sanchez** has worked with trafficking victims who have escaped their captors. From their insights, she has developed specific steps to help nurses who encounter a potential victim.

First, the nurse's focus should be on providing necessary medical care. In the intake phase, it is not necessary to get details of the whole history of trauma. Focus on diagnosing and treating the current medical condition.

Say, "Hi, how are you feeling? Would you like a cup of tea, or glass of water?" "When somebody treats [the victim] like a human being, they begin to trust," says Sanchez.

She describes a safe way to separate the perpetrator from his victim. Tell him the front desk needs insurance forms to be completed. Then, take the victim into an examining room. It is a simple transition that works very smoothly, she says.

It is important to spot the following red flags:

- burns, bruises, broken teeth, and signs of physical trauma;
- current/frequent STIs (gonorrhea, chlamydia, HIV);
- weight loss, malnutrition;
- broken teeth/bones;
- substance abuse;
- tattoos such as a bar code or "Daddy";
- confusing/contradictory details;
- inability to focus or concentrate;
- does not know his or her location/age/time.

If the victim presents with a sexually transmitted infection, a way to secure a safe place is to arrange an observational one-day admit to the hospital. That should be standard protocol, especially if the victim wants to escape, says Sanchez. This transition must be handled with utmost care to ensure safety for both hospital staff and the victim/patient. Hospital security should get involved.

To ensure patient and staff safety, each organization should develop a protocol for human trafficking that includes these elements: staff training; multidisciplinary approach; screening and identification; mandatory reporting; follow-through procedures.

> "IT IS CRITICAL TO REMAIN CALM, PROVIDE SUPPORT TO VICTIMS, AND REMAIN FOCUSED ON THE TASK AT HAND — THE MEDICAL EVENT THAT BROUGHT THEM TO THE ER."

"It's the same as domestic violence — once the perpetrator loses control, that's when victim is in the most danger," Sanchez says. "If the perpetrator fears they will go to jail or lose income, they are going to kill the victim."

By admitting the patient, you provide that safety. "This allows the victim a safe environment where the trafficker doesn't have access. This is the best way to gain her trust and rescue her."

After the patient has been admitted, the next step: "If the girl looks malnourished, you must provide food. Offer a warm meal. Does she need shelter?" Sanchez asks. "Focus on building trust slowly. Don't ask too many questions too quickly. They must feel rapport with you so they can tell you everything."

If the victim refuses to exit the trafficking relationship, says Sanchez, then provide the victim with community resources, along with the National Human Trafficking Hotline. Do not discharge a victim without any resources.

Sanchez reports that in the state of New Jersey, alerting the police department will be the first step. Then, the case will be referred to a detective and the county prosecutor's human trafficking liaison, who then will investigate the circumstances that prompted the investigation and the results of the investigation to date.

She advises that a forensic nurse needs to be part of the ED staff in every best practice organization. "The forensic nurse has been trained to deal with this sort of situation, he or she knows how to handle the perpetrator and maintain a safe environment not only for the victims but also for staff members, and is able to provide a medium of communication between law enforcement and the medical staff," Sanchez says.

If a forensic nurse is not available, the ED staff should receive comprehensive training on the organization's human trafficking protocol, Sanchez says. "It is critical to remain calm, provide support to victims, and remain focused on the task at hand — the medical event that brought them to the ER." ■

Making Progress to Reduce Overtreatment

The National Academy of Medicine (formerly the Institute of Medicine) opened the healthcare industry's eyes to the issue of overtreatment. Excess screenings, scans, and treatments that offered little or no benefit were being prescribed at an estimated $210 billion a year, according to a 2013 report. *(The report is available online at: https://bit.ly/2VrevSs.)*

In many cases, this practice stemmed from the physician's fear of malpractice, or to meet hospital performance measures. Many patients during that era felt that "more care is better care" and pushed for tests and scans to confirm earlier findings.

"We had so much technology, and put our confidence in it," says **Vivian Campagna**, MSN, RN-BC, CCM, chief industry relations officer for the Commission for Case Manager Certification. "We were double-checking to be absolutely sure, but along the way lost sight of the cost."

Today, hospitals continue to grapple with the issue of overtreatment, Campagna reports. Electronic health records have helped, but the industry is still working out the bugs of interoperability. Certain software products do not interface with other brands, so hospital systems are unable to share the patient records. "It's been very frustrating for all of us," she says.

However, there have been notable steps toward progress in hospitals, Campagna adds, and case managers are at the heart of that progress. "Communication has been key. In interacting with the physician, patient, social worker, and therapists, case managers facilitate that communication."

One primary example: Case managers have had an integral role in working with the utilization review process, and this has helped rein in the excess, says nurse advocate **Anne Llewellyn**, MS, BHSA, RN-BC, CCM, CRRN.

Utilization Review Helps

Each hospital's utilization review (UR) department is separate from nursing. UR receives day-to-day reports of the patient's progress and shares this status report with the insurance company for approval and precertification of scans, tests, and treatments, even the hospitalization itself.

During this UR process, the case manager acts as intermediary with the multidisciplinary team in working out details of the treatment plan, Llewellyn explains.

"Case managers work with physicians to inform them about the patient's progress," she says. "From that interaction, the team can implement the plan in the most effective, efficient, and timely manner to meet the patient's needs, [and to] ensure the plan is working and meets evidence-based guidelines. When these things line up, it ensures the plan is cost-effective."

"The case manager plays an essential and multifaceted role by supporting the patient as they transition throughout their hospital stay," says **Dana Deravin Carr**, RNC, CCM, DrPH, MPH, MS, care manager for high-risk transitions initiative at Jacobi Medical Center in New York City.

As patient advocates, care managers coordinate and support the patient-centered care delivery process. Working in collaboration with the physician-led interdisciplinary team, case managers conduct ongoing assessments of the patient's clinical status, clarify and monitor medical interventions and associated treatment, and evaluate clinical outcomes — all of which enhance patient safety.

By working collegially and collaboratively with their interdisciplinary peers, case managers assume the vital role of ensuring that patient-centered care delivery is appropriate, timely, and medically necessary, thus minimizing the occurrence of overtreatment, Carr explains.

Utilization review is helpful, but without a informed comprehensive assessment and care coordination by the case manager, it will not reduce overutilization, Campagna says. Communication and coordination are critical.

The case manager also can educate patients who request extra tests to confirm results, adds Campagna. "If validity of the first test is high-caliber, why have unnecessary tests that may be expensive and uncomfortable for the patient? Why can't we trust the results of the primary test?"

The focus is on streamlining the process so patients get what they need when they need it, from the right provider, she explains. "Could they benefit from seeing a specialist or another service provider like occupational therapy or physical therapy? If you provide the right service, you get them to recovery quicker."

Elderly patients are particularly vulnerable to overtreatment, Campagna adds. They may not hear or understand what the doctor says, or it may be too technical.

Focus on Education, Understanding

"One thing the case manager can do when dealing with an elderly patient is to encourage at all times that they have a care partner with them," she explains. "The elderly person may not hear or fully understand what a doctor says, or they may be afraid to ask questions." Having a family member or friend with them allows another set of ears who can listen, take in information, and understand the plan of care.

That is where a care partner can help, Campagna says. Typically, the care partner is a family member, but a neighbor or friend is fine. Or, the hospital team can recommend an independent case manager to act as the patient's care partner/advocate, keeping long-distance family members apprised.

The care partner accompanies the patient in all health-related discussions, asking questions and recording responses. "When they leave the office, they have something tangible, they have notes — what was said and options that were presented," Campagna explains.

A case manager also can help patients understand their options, both the risks and benefits. How much mobility do they expect from a hip replacement? Do they want to work in the garden, get up the stairs in the house, or run a marathon? The case manager helps patients think about the outcomes they want so they understand the limitations of the procedure.

"Just because the procedure is an option doesn't mean it's effective in every case," says Campagna. "The case manager can help the patient understand the options realistically and make informed choices."

Transition from hospital to home is another critical juncture. "We do very well with hospital case management and setting up services at the home, making sure we have all of the necessary insurance approvals," Campagna says. "But 24 hours later, if the home care service hasn't arrived, the patient goes into a panic. They don't understand what is happening, who to turn to."

Case managers can easily circumvent that panic by giving the patient a number to call if he or she has questions. Also, they can reassure the patient with education about what to expect following the treatment or procedure.

Be sure to repeat patient discharge instructions multiple times, Campagna adds. Patients do not always remember the instructions they were given for self-care, or may misunderstand what they hear. Too often, that results in readmission.

"We need to prepare patients before they leave the hospital," she explains. "We need to repeat instructions and ask them to teach back what they've heard to ensure they understand. Then, we need to send them home with written instructions so they can share them with caregivers, so they understand, too."

For many patients, there also is need for education on lifestyle changes, adds Llewelyn. "We can't have them going to McDonald's instead of a balanced diet. We can't discharge them with all new medications if they have no money to buy the meds. We've got to ask questions and educate our patients on managing their condition appropriately so we reduce setbacks or complications."

If the patient needs help making lifestyle changes, the case manager must help that patient find what will motivate him or her to achieve better health. It is known as motivational interviewing, or "meeting the patient where they are," she explains.

For example, a heart failure patient may work toward attending a daughter's wedding as their motivator for weight loss. Or the case manager can develop an exercise and diet plan to help the patient lose a little weight so she can get into a nice dress. That motivation will help the patient reach her goal — and that helps the healthcare team reach the goal of helping the patient follow the plan to avoid a readmission.

Patient engagement is key, Llewelyn explains. "The patient has to do the work, they have to make the right choices. Or they can decide they don't want care. They've been battling this their entire lives, and they may choose to stop care and let natural events occur. We have to remember, patients have choices, but they need to be informed about their choices and the impact of those choices. Case managers work with each patient so they make the right choices for them."

Without patient and family engagement, readmissions will continue — another form of overtreatment. "We're getting patients out the door faster than before, but are we educating them? No, because we say we don't have the time," says Llewelyn. "So, it becomes a revolving door. We know how to fix that problem. It's in patient education."

Patient education should begin as early in the admission process as possible, adds Carr. "Patients are often overwhelmed and can only digest small bits of information at one time."

Referrals for skilled home care services and early physician follow-up are crucial to ensuring patient understanding and adherence to these very important care interventions, she says. ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CE QUESTIONS

1. **In creating a care coordination tool to improve patient handoffs between health settings, which of the following is a good question for care coordinators to ask, according to nurses at Trinity Health?**

   a. "What is the patient's current hospital length of stay?"
   b. "What are key, recent changes to the patient's health status?"
   c. "How quickly will the episode of care claim be processed by the payer?"
   d. "What are the patient's end-of-life plans?"

2. **What are the main physiological factors affecting heart failure patients' hospital readmissions, according to a 2019 study in the *Journal of Community Health Nursing*?**

   a. Chronic kidney disease, higher levels of B-type natriuretic peptide
   b. Liver disease, high blood pressure
   c. Homelessness, food insecurity, lack of access to transportation
   d. Lung cancer, diabetes, AIDS

3. **Which of the following is *not* a common red flag of human trafficking listed by Rosario Sanchez?**

   a. Burns and bruising
   b. Broken bones
   c. Signs of intoxication
   d. Does not know his or her location

4. **Overtreatment, such as excessive scans, screenings, and treatments, costs how much per year?**

   a. $100 billion
   b. $210 billion
   c. $150 billion
   d. $200 billion

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Interdisciplinary Care Rounds: A Key Strategy for Improving Case Management Outcomes, Part Three

By Toni Cesta, PhD, RN, FAAN

Introduction

In the last two editions of *Case Management Insider,* we discussed the notion of interdisciplinary walking/bedside rounds and strategies for developing and implementing these rounds in your organization. This month, we will continue our discussion with a review of how to script rounds and what role each team member plays.

Rounding With Hospitalists

The hospitalist plays a key role in the rounding process. Hospitalists have become an increasingly visible part of the majority of hospitals and health systems today. They should play an equally integral part in the rounding process. Without hospitalists, it is very difficult to ensure that a physician is present at rounds at the same time every day unless it is a resident or an intern.

Unfortunately, some hospitals do not employ house staff or hospitalists. While their numbers are few, this can create a true dilemma for them when implementing rounds. For the majority, either a hospitalist or a house staff member can fill in the role of physician on the interdisciplinary rounding team.

The greatest barrier to ensuring that the hospitalist is in attendance or leading rounds every day is the fact that many hospitals are not assigning hospitalists to designated geographic areas — specifically, nursing units. Attendance is particularly difficult if hospitalists are scattered throughout the hospital. It becomes an impossible task for them to be at all rounds every day. It also is a scheduling nightmare for the nursing units trying to arrange these rounds.

For our discussion, we will consider the hospitalist and case manager as unit-based. This is considered best practice and should be the template for implementing effective and efficient rounds.

HOSPITALISTS HAVE BECOME AN INCREASINGLY VISIBLE PART OF THE MAJORITY OF HOSPITALS AND HEALTH SYSTEMS TODAY. THEY SHOULD PLAY AN EQUALLY INTEGRAL PART IN THE ROUNDING PROCESS.

Scripting

Scripting is a way of organizing what each team member will be expected to say during rounds. It provides a structure for the dialogue so that team members do not spend too much time on one patient, do not veer off topic, and come prepared to present their clinical perspectives during rounds.

It also can ensure that key questions are standardized. They can be written on a goal sheet or other tool. Academic questions or discussions can be conducted in the hallway before the team enters the patient's room. If the discussion will be longer than anticipated, that deeper conversation can be held until rounds are completed. In this way, other team members are not held up, and rounds can continue in a timely manner.

The average amount of time per patient should be 60 seconds. There will be occasions when this time may be a bit longer or shorter depending on the situation. If the patient has a lot of questions that may require additional

time, the appropriate team member can return once rounds have been completed. Finally, should patients ask for non-emergent items such as tissues or water, a support staff member can bring those without disrupting the rounding process. By standardizing all of these elements, time is much more easily managed.

Scripting should include specific areas of discussion, including the following:

• Demographics

a. Name/medical record number;
b. Room number;
c. Admission date;
d. Primary team members;
e. Code status;
f. Family information;
g. Insurance information.

• Problem List

a. Pertinent medical history;
b. List of current problems;
c. Invasive tubes/devices, if any.

• Expected Tasks to be Completed

a. Labs/radiology results;
b. Order or follow up on tests.

• Diagnostic One-Liner

a. Includes age, sex, relevant medical history, and current chief reason for hospitalization.

• If/Then

a. Frequent issues to be expected with a plan to resolve in if/then format. Example: "If hypertensive, then please give hydralazine."

• Therapeutics

a. Medications;
b. Focus on when IV meds can be switched to oral;
c. Diet with any weaning orders;
d. Oxygen with weaning instructions;
e. Progressive ambulation.

• Results and Other Important Facts

a. Labs;
b. Cultures;
c. Radiology test results;
d. Consults.

• Care Coordination

a. Expected length of stay;
b. Day of stay. Example, day three of an expected five-day stay;
c. Any patient care barriers:
i. Social;
ii. Insurance;
iii. Adherence.

The development of daily goals is a critical tool for managing length of stay and patient care progression. It provides the team with a structured, interdisciplinary approach to patient management. The development of goals is part of the scripting process, and the team should understand how to develop daily goals and see this as a mandatory part of the rounding infrastructure.

The process should be as follows:

The team should determine the key goals for that day, providing feedback and reflection on the progress toward the goals every day. Reset the goals as needed. If goals have been met, then new, forward-moving goals may need to be written. If the patient is progressing toward discharge, this may not be necessary.

Once identified, the goals should be documented so that they are readily accessible to the entire care team, as well as the patient and family. They can be documented on the patient's white board in his or her room so that the patient and family are included in the process. By being aware of the goals, the patient and family are much more likely to be active participants in the care recovery process, rather than passive receivers of care.

The involvement of the patient and family in the rounding process is what differentiates walking rounds from other types of rounds. Including them in the discussion of daily goals will increase the likelihood of participation as active members in their care recovery. This process can be a very powerful tool in managing length of stay, reducing readmissions, and improving patient satisfaction.

It is important to orient the patient and family to rounds before inviting them to participate. A designated team member, either the staff nurse or case manager, should discuss the focus of rounds, the rounding routine, and what expectations the patient and family should have from the rounding process.

Other strategies for engaging the patient and family include posting the day and time of rounds both inside the patient's room and in the hallways and nursing station, if appropriate.

A team member should begin bedside rounds with a brief introduction to the patient and family. This should be repeated each time rounds are conducted. Include the purpose of rounds and the time the team will spend with the patient and family. Finally, the team member should encourage the patient and family members to participate.

Physician/Hospitalist

The process for each discipline should include three phases. These are the pre-rounds, rounds, and post-rounds phases. Each phase is unique to the professional and should be included as part of the scripting process.

We will begin with the physician provider who is attending rounds.

Pre-Rounds Phase

• Listen to last 24-hour patient update;
• Discuss diagnosis;
• Enter patient orders;
• Review preliminary plan for discharge, medications, and tests.

Rounds Phase

• Sit next to patient;

• Introduce team;
• Interview patient;
• Discuss plan of care, test results, next steps, other recommendations;
• Answer any questions.

Post-Rounds Phase

• Enter orders and clarify issues;
• Enter progress notes;
• Call consulting physicians and family regarding test results;
• Summarize expectations to team members.

Resident/Intern

House staff also must be prepared to attend rounds as they often are a support to the attending of record. Below are the phases that a house officer should include when preparing and attending rounds.

Pre-Rounds Phase

• Present patient's case to attending physician/hospitalist/team;
• Update team on patient's condition;
• Give recommendation for the plan of care;
• Enter any orders, including medications.

Rounds Phase

• Support attending physician/hospitalist during discussion;
• Help answer any questions.

Post-Rounds Phase

• Enter patient orders as needed;
• Enter progress notes;
• Call consulting physicians as directed by attending;
• Discuss any medication reconciliation issues with clinical pharmacist.

Staff RN

The staff RN is a key player in the rounding process. During rounds, the bedside nurse can provide the interdisciplinary team with clinical updates and the patient's progress for the past 24 hours. Conversely, he or she can ask the attending or hospitalist what the next steps and goals of care are so that he or she does not have to seek the physician out later.

This real-time communication speeds up the process of care and reduces the opportunity for things to fall through the cracks. The staff nurse should consider the following as it relates to rounding:

Pre-Rounds Phase

• Review patient progress over past 24 hours;
• Focus on any abnormal findings;
• Review any patient/family concerns;
• Identify barriers to patient discharge or throughput;
• Review any issues such as activity, Foley catheter, IV, wound vac.

Rounds Phase

• Bring laptop or other device to room;
• Discuss any gaps or delays in care;
• Listen to conversation with patient/family;
• Ask/answer questions from patient/family/team as necessary;
• Take note of orders to be written later.

Post-Rounds Phase

• Verify orders;
• Discuss and implement medication monitoring;
• Identify who will correct any gaps or delays in care;
• Make decisions about any remaining concerns;
• Document outcomes of rounds.

Case Manager

Case managers are one of the three mandatory disciplines to attend rounds. The others are the physician and the staff nurse. Case managers are key players in the exchange of information. Through their role in care coordination, they also need to understand the plan for the day as well as the stay.

Through the rounds communication process, the case manager can better understand what services are needed as well as what services may have been delayed. This is a much more efficient method for managing patient flow and can result in shortened lengths of stay and lower cost of care.

Pre-Rounds Phase

• Review admission status;
• Review case management admission assessment;
• Review initial discharge plan and patient insurance;
• Review expected length of stay and discharge date.

Rounds Phase

• Discuss expected length of stay and discharge date;
• Discuss any barriers or delays in care;
• Discuss discharge plan with team;
• Discuss the discharge plan with patient and family;
• Identify any additional patient education needs;
• Identify any triggers for referral to social work;
• Answer any questions.

Post-Rounds Phase

• Clarify next steps based on patient's goals and progress toward expected outcomes;
• Correct any barriers or delays in care as needed;
• Document any changes to the discharge plan;
• Refer to social work as needed.

Social Worker

Depending on the case management model, the social worker may not be able to attend all rounds

every day. If the social worker is covering more than one unit, he or she may have to provide patient information and updates to the RN case manager prior to rounds and be represented by the case manager on rounds.

If the social worker needs to speak with the entire team about a particular patient, then he or she must plan to attend rounds on that unit on that day.

The social worker has unique information to share related to the patient's psychosocial, financial, and discharge planning issues that may be relevant to the entire team, and should attend accordingly.

The following action steps should be considered as the social worker prepares for rounds and/or attends rounds:

Pre-Rounds Phase

• Review case management admission assessment;

• Review reasons for referral;

• Determine patient's psychosocial needs;

• Review the discharge plan;

• Review expected length of stay and discharge date.

Rounds Phase

• Begin psychosocial assessment;

• Address any psychosocial barriers or issues;

• Discuss anticipated date of discharge and discharge destination;

• Offer assistance and support to patient and family.

Post-Rounds Phase

• Discuss next steps based on goals achieved by patient;

• Document any updates to the discharge plan;

• Complete in-depth psychosocial assessment.

Clinical Pharmacist

The clinical pharmacist can play a key role on the interdisciplinary care team, where pharmaceutical issues can create vulnerabilities for specific patients. Examples of patients who may experience these issues might include cancer, geriatrics, or hospice.

Patients also may experience polypharmacy issues combined with a change in mental status, such as delirium. These issues can affect the patient's outcomes, length of stay, and cost. Engaging the pharmacist as needed is a valuable aid in addressing any medication-related issues.

The rounding process for the pharmacist is as follows:

Pre-Rounds Phase

• Review daily documentation;

• Review medication profile, history, and medication reconciliation;

• Review PRN ("as needed") medication use;

• Discuss medication concerns and abnormal lab/culture findings;

• Discuss any patients experiencing a change in mental status.

Rounds Phase

• Listen to conversation;

• Ask/answer any patient questions;

• Note orders to be placed later.

Post-Rounds Phase

• Verify orders;

• Discuss and implement medication monitoring;

• Make decisions about any medication concerns;

• Document progress notes;

• Provide medication education to patient/family as needed.

Clinical Documentation Improvement Specialist

The clinical documentation specialist (CDS) is not often included in rounds. The CDS can perform his or her role more effectively if he or she is able to attend rounds and listen to the physician's plan of care and the patient's progress toward outcomes, then compare this information to the actual documentation in the medical record.

Here are the process steps for the CDS:

Pre-Rounds Phase

• Review patient information in medical record;

• Listen to overview of patient.

Rounds Phase

• Listen to patient status from each member of the clinical team;

• Consider any questions to ask the physician.

Post-Rounds Phase

• Identify and/or clarify any additional diagnoses/conditions and query if necessary;

• Review physician documentation for accuracy;

• Provide any needed physician education.

Summary

In Part Three of our series on interdisciplinary walking rounds, we reviewed the role of each team member. We also discussed the importance of scripting as a tool to keep each team member's communication timely, on-track, and relevant.

As you consider who to include on the walking rounds team, bear in mind the unique role each member can play, particularly as it relates to their contribution to the patient's care plan and care progression.

In the next edition of *Case Management Insider,* we will continue our discussion with a checklist for rounds and ways to measure the outcomes of interdisciplinary walking rounds. ■