HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Case Managers Can Guide Patients with COVID-19 to Rehab Services

By Melinda Young

After days, weeks, or even months of hospitalization with COVID-19, patients often need considerable help with their post-discharge recovery. This is especially true for people who need pulmonary, brain injury, or cardiac rehabilitation.

Hospital case managers can help patients recover by educating them about various rehabilitation services, says **Gerard Francisco**, MD, chair of physical medicine and rehabilitation at The University of Texas Health Science Center at Houston (UTHealth), and chief medical officer of The Institute for Rehabilitation and Research Memorial Hermann.

"COVID-19 patients' rehab needs are varied. Many people who have this virus have a more protracted recovery," he says. "Once patients are transferred out of the intensive care unit, some are sent out to the floors and others are discharged home. But many end up being at home for a long time, still convalescing, and they do not benefit from rehab — either because they don't know about it, or are afraid to leave the house again."

> UNLIKE PATIENTS WHO RECOVER FROM THE FLU, MANY PEOPLE WHO RECOVER FROM COVID-19 WILL EXPERIENCE DEBILITATING SYMPTOMS FOR WEEKS OR MONTHS.

Most COVID-19 patients recover well, but others have symptoms that cannot be explained by anything else, he adds.

The SARS-CoV-2 virus or the person's immune system reaction to the virus can cause symptoms ranging from

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signs of traumatic brain injury to heart disease, pulmonary disease, and musculoskeletal problems.

"Practically every organ system is involved," Francisco says.

Traumatic brain injury units have seen fewer car accident injuries since the COVID-19 pandemic shut down the nation. But they have seen something new: COVID-19 patients with delirium, dizziness, memory problems, and strokes. *(See story on COVID-19's effects on the brain in this issue.)*

"We're seeing higher incidences of stroke in patients we wouldn't normally think of being at high risk for a stroke," he says.

There are many possible discharge plans that could work for COVID-19 patients. Case managers should ensure patients are aware of the rehabilitation options, says **Katharine Seagly**, PhD, director of the traumatic brain injury rehabilitation program, clinical neuropsychologist, and assistant professor at Michigan Medicine.

The first transition might be from acute care to inpatient rehab services. This is for patients with severe debilitation. It provides them with the most hours of physical therapy and other rehab services, Seagly notes.

"A neuropsychologist or psychologist on staff could help them manage the anxiety and depression or post-traumatic response that can arise when someone has been in the hospital for weeks or months and had to face their own mortality," she says.

Emotional health issues are common, especially during the pandemic when patients were not permitted to have family members with them on the intensive care unit.

"That can be a very traumatic time," Seagly says. "Being in the hospital facility for rehab makes sense, at least for the first few weeks, and it gives families time to plan."

COVID-19 patients exhibit a wide range of physical symptoms. One of the most common post-discharge problems is physical weakness from prolonged immobilization, Francisco says.

"There appear to be some effects on the musculoskeletal system as well," he adds. "Some people have a loss of balance that may require an expert, skilled physical therapist, or occupational therapist to work with them."

Unlike patients who recover from the flu, many people who recover from COVID-19 will experience debilitating symptoms for weeks or months. For instance, a COVID-19 Survivors group on Facebook includes posts from survivors who list long-term issues with chest pain and abnormal ECG

EXECUTIVE SUMMARY

As many COVID-19 patients struggle with long, slow recovery, case managers can refer them to inpatient and outpatient rehabilitation services.

- COVID-19 patients have varied rehab needs, including pulmonary, brain injury, and cardiac rehabilitation.
- A first transition could be from acute care to inpatient rehab services, especially if patients are severely debilitated.
- Loss of balance might require help from a physical therapist or occupational therapist.

results, hair loss, leg pain, bloating, difficulty breathing, fatigue, heart problems, anemia, brain fog, and confusion. *(View the posts at: https://bit.ly/3iBDjik.)*

Inpatient and outpatient hospital rehabilitation departments can offer COVID-19 patients programs geared to assisting their recovery. For instance, patients with ongoing pulmonary issues could benefit from a program designed to help them improve their lung function.

"We also know the virus affects the heart, causing inflammation. We thought chest pain was pneumonia-related, and now we think it's because of the heart," Francisco says.

Case managers can help COVID-19 patients prepare their homes for discharge, Seagly says. They can suggest ramps and moving a bed to the first floor if patients struggle to walk during their post-acute recovery period.

Transitions home also might include outpatient rehabilitation services. "That was a little tricky at first because nonemergent services were all closed, but, thankfully, things are opening back up. Many are using the hybrid model of some services virtually and some services in-person," Seagly says.

Case managers can help patients transition to the best post-acute care services, including rehabilitation services, by asking them what they hope to do when they return home. If a patient has been away from work, then rehabilitation services can help them improve their work readiness.

"Let's say the patient works in a factory. The physical therapist can help them go through the motions of the type of labor they were performing before," Seagly explains. "If they had an office job, the occupational therapist can sit them at a computer and have them practice movements with their upper extremities and strengthen the muscles required for that."

Rehab therapists also can help patients improve higher-level cognition and help them develop compensatory techniques like phone reminders and ensuring everything is well-organized, Seagly says.

"It's figuring out what they want to get back to and letting them know what might be a barrier," she adds. "We say, 'Here's what we can do with these services to get you back to the valued activities that make you feel better.'"

UTHealth offers a mini-program for rehabilitation care tailored to help patients with COVID-19 return to their new normal, Francisco says. Rehab professionals also can follow general principles for pulmonary rehabilitation, which is a common problem with COVID-19 patients.

"We have to pay more attention to the heart and lungs of a person as they may not tolerate one full hour of therapy," he adds. "We may have to split it to three 20-minute sessions or two 30-minute sessions so the person can participate fully." ■

COVID-19 Can Cause Neurological Symptoms and Strokes in Patients

By Melinda Young

Neurological symptoms and signs of brain injury have cropped up as one of the major health problems that people experience with COVID-19.

"We're seeing a lot of patients with delirium," says **Katharine Seagly**, PhD, director of the traumatic brain injury rehabilitation program, clinical neuropsychologist, and assistant professor at Michigan Medicine at the University of Michigan.

Patients with traumatic brain injury (TBI) often present with post-traumatic amnesia or confusion. Some patients with COVID-19 experience similar symptoms, Seagly says.

"Patients might not know where they are, what they're doing, and their attention is waxing and waning," Seagly says. "They can pay attention for a minute at a time, but are easily distractible."

Ventilators or sedating medication could have caused confusion, delirium, or memory issues. "There can be significant cognitive consequences of those types of procedures — decreased oxygen to the brain," she explains. "We call that acute period of confusion post-traumatic amnesia, which is due to prolonged ventilation, multiple infections, or sedating medications," she explains.[1]

Some patients with COVID-19 will be cleared of delirium by the time they are transitioned to rehabilitation care, but others experience lingering cognitive issues, Seagly says. The most frequent cognitive problems involve processing information. Patients might show improvement in maintaining attention, but could

struggle with complex attention, such as multitasking. Shifting attention from one item to the next can be challenging for these patients, and they might not be able to process information as quickly as they did before their illness.

"We're seeing that visual-spatial processing seems to be more impacted than verbal processing, but this is all anecdotal," Seagly says.

Many COVID-19 survivors are behaving like brain-injured patients, says **Gerard Francisco**, MD, chair of physical medicine and rehabilitation at The University of Texas Health Science Center at Houston (UTHealth), and chief medical officer of The Institute for Rehabilitation and Research (TIRR) Memorial Hermann. "They might be people who have permanent or long-lasting injury," he says.

Long-Term Effects Unknown

The problem is no one knows what happens over the long term because COVID-19 cases have only been around since late 2019. As scientists and physicians learn more about the disease, their information can help case managers, rehabilitation professionals, and physicians prepare better treatment plans.

"Like with any other virus, there's a good chance we'll have another surge," Francisco says. "Should it happen again, we'll be better prepared and know better how to handle the needs for people with COVID-19."

For example, clinicians in Texas learned methods for treating patients with COVID-19 from their colleagues in New York, since the surge in Texas started after New York's surge was winding down.

Many COVID-19 patients are professionals, and there is a risk that neurological complications could impair their ability to return to work. "I'm concerned there are cognitive issues not addressed, and that they may fail when they return to work," Francisco says.

One way to address this is for patients to report personality changes and memory changes. These are sent to a neuropsychologist and speech pathologist for evaluation, Francisco says.

"Older age puts you at greater risk — as is the case with many health complications, in general — but younger people are not excluded," Seagly adds. "This notion that if you are young and you get the virus, you'll be OK is a misconception." Seagly has seen patients in their 20s with lingering cognitive impairment after they are transitioned from the intensive care unit to inpatient rehabilitation to home.

All Ages at Risk for Stroke

Younger people, as well as older populations, are at risk of strokes caused by COVID-19 — even if they lack other risk factors.[2,3]

People who have strokes typically also have underlying conditions, such as high blood pressure, high cholesterol, smoking habits, sleep apnea, and other things that affect their vascular system. "We're seeing patients who don't have these types of risk factors and are still having cerebral vascular incidents in the course of their COVID recovery trajectory," Seagly says.

One recent study revealed neurological complications from COVID-19 are becoming more common and present in the form of encephalitis, meningitis, Guillain-Barré syndrome, and seizures.[4] In another study, autopsies of COVID-19 patients revealed signs of mild-to-moderate hypoxia-associated changes, severe ischemic injury, and abundant microhemorrhages.[5]

Chinese researchers, studying 86 COVID-19 patients, reported 65% presented with at least one neurological symptom. Nearly one-quarter of patients had symptoms that included delirium, cerebrovascular diseases, or hypoxic-ischemic brain injury. Seven patients had a new stroke.[6]

"What people call the 'COVID brain' can manifest as overt neurological problems, similar to a

EXECUTIVE SUMMARY

One major health problem related to COVID-19 involves neurological symptoms and signs of brain injury.

- Patients with COVID-19 can experience acute periods of confusion, post-traumatic amnesia, and delirium.
- Physicians and researchers do not know what will happen to patients with COVID-19 over the long term and whether they will fully regain their prior cognitive status.
- Case managers and nurses could ask patients to report personality changes, memory changes, and other signs of neurological problems, and suggest referrals to a neuropsychologist or speech pathologist.

stroke," Francisco says. "One report I heard was they had patients who had COVID, but the symptoms were so mild they didn't require hospitalization," he says. "But, after a few weeks, they ended up in the emergency room with a stroke."

These patients often were in their 30s or 40s and not at high risk of experiencing a stroke, so their condition was attributed to an inflammatory response from COVID-19, he adds.

Other people might not have a stroke, but they experience changes in their memories and report they do not feel like the same person as pre-COVID-19.

"'It's like having a veil over my head,' one patient said," Francisco recalls.

"I'm hoping through our rehab interventions, we can facilitate recovery so loss from work will be minimized," he adds. "Imagine the psychological impact of a high performer who develops COVID and is not able to resume his or her prior activities. Imagine how devastating it is for that person." ■

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Look for Undocumented Social Determinants of Health in Patient Charts

By Melinda Young

One conundrum for hospital case managers involves identifying patients' social determinants of health needs when the hospital record does not list all these data.

"Typically, when people are using data, they look at the data they see," says **Sue Feldman**, PhD, RN, professor and director of graduate programs in health informatics at the University of Alabama at Birmingham.

But the visible data could be missing critical factors related to why patients are returning to emergency departments (EDs) or are not taking their medications. For example, a recent study revealed comorbidity data were more likely to be omitted in patients with few comorbidities. One major social determinant of health omitted in data is whether a patient lives alone or with other people.[1]

"A data element that was missing and of statistical significance was this element called 'lived with…,'" Feldman explains. "If that information is not collected, then you don't know if they live by themselves or with others."

When it is time to safely transition patients to the community, this information can be crucial to understanding the patient's risks for returning to the ED or being rehospitalized.

Study results showed 12 social determinants were missing from a de-identified data set of 123,697 people who visited the University of Alabama at Birmingham Medical Center ED at least once in 2017. Among the 12 social determinants, the missing data pertaining to whether the patient lived alone was associated with higher odds of ED revisits.[1]

"The other thing that was surprising was when we looked at comorbidities, relative to data missing, we found that those with fewer comorbidities had more missing data. That was curious to us," she adds. "I can't help but think there was some unconscious bias going on there."

It is possible nurses, case managers, ED intake staff, and others did not ask about comorbidities from every patient, especially if the patient appeared to be healthy.

"What could be happening is 'Because I think you are healthy, I'm not going to go through and ask all of these questions because they might

not apply,'" Feldman says. "But we know from the opioid epidemic, for example, that this could not be further from the truth: Opioid abusers might not fit the typical drug user demographic, so there could be a whole lot of information we're missing."

Among the oft-missing social determinants of health data include:

- Activities of daily living;
- Living situation;
- History of abuse;
- Employment status;
- Problems at home.

"We found the things that were the most predictive of revisits to the ED were things like the pain score, activities of daily living, and living situation," Feldman says. "Living situation came up twice in the study. It's interesting how many times that was not collected."

The paper was written to encourage thinking about knowledge gaps in transitions of care from the hospital to home. "If we know more before we transition our patients out of the hospital, then we potentially could provide better and more targeted services for that person's needs," Feldman explains. "We could help patients avoid future trips to the emergency department, or readmissions."

A chief cause of readmission is when patients delay their health needs until the problem becomes a crisis or catastrophic, she says. Many health conditions should have been managed in the ambulatory environment through patients' health clinics or primary care providers. But case managers and others working with at-risk patients are not always armed with the best and most up-to-date information about the patient's health issues and social determinants of health.

"If patients received the right services, right attention, and everything focused on their needs, then I wonder if we could decrease the amount of catastrophic care," Feldman says.

This is tied to the process of transitioning patients from the hospital to their home. Often, case managers have too many patients to deal with and challenging discharge deadlines to meet. "There are all of these confounding factors," Feldman says. "But I am proposing that this is not just to focus on the right social determinants for that patient. It's not about requiring more time from case managers, but requiring the right focus of time."

For example, if a case manager is sending a patient home and does not know whether the patient lives alone, then this missing information could affect follow-up care. The patient who lives alone might need home care services and someone to ensure the person has enough food and is eating well, she explains. The key is for case managers, nurses, social workers, and hospital ED intake staff to collect all the social determinants of health listed in their electric health record every time they screen a patient.

"Don't assume that this information is not important for this patient," Feldman says. "I think the opioid epidemic has opened our eyes that issues like substance use cross all geographic and social barriers."

Case managers could anticipate missing social determinants of health information in patients' medical records and ask questions when they see information, such as their living status, is not listed.

"Sometimes, it's hard to get this information from patients; some people might be incoherent or unable to answer," Feldman says. "You'll need to get ahold of their family and friends or neighbors."

It also is important for case managers to think about expanded social determinants. For instance, access to the internet could be considered a social determinant of health in 2020, while it was not an issue in 2000.

"Now, internet access can impact someone's health outcomes because of their ability or inability to seek health information," Feldman says. "Then, there's the health literacy level to think about."

This research into the missing social determinants of health is the tip of the iceberg. "I am hopeful it will get more people to look at what's missing and the value of what's missing," Feldman says. ■

EXECUTIVE SUMMARY

When case managers read charts that are missing some elements of social determinants of health, they might lack information important for a smooth transition.

- One common piece of missing data is whether a patient lives alone or with someone else.
- Missing data about who a patient lived with was associated with higher odds of revisiting the emergency department.
- Other data often missing include activities of daily living, employment status, and history of abuse.

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Medical Records in the COVID-19 Era: Renewing the Case for Interoperability

By Jeanie Davis

The problems of electronic medical records (EMRs) have been all too real during this pandemic.

Patients with life-threatening COVID-19 symptoms have gone to hospitals without family or friends. They may not recall critical details of their medical history, including medications.

"This is so common, and is especially problematic if the patient has chronic disease comorbidities that impact how well they do in treatment," says **Vivian Campagna**, MSN, RN-BC, CCM, the chief industry relations officer for The Commission for Case Manager Certification.

EMR System Flaws and Interoperability

At the crux of this crisis is the patient's EMR, which holds important details that help providers make treatment decisions. Too often in hospitals, healthcare providers cannot access all these records, which is frustrating for everyone.

When the Affordable Care Act became law in 2010, there were incentives to set up EMR systems to allow all providers across the country to access a patient's medical records, all within Health Insurance Portability and Accountability Act (HIPAA) privacy rules. The goal was to enhance patient care with this access.

"Interoperability" was the concept born during this time. It describes an optimal system in which patient records are easily accessed — a "patients first" goal of the Centers for Medicare & Medicaid Services (CMS). As the country faced the pandemic, CMS issued an updated rule to break down barriers and improve access to health information.

"Certainly, it is inherent in the pandemic that the situation is more complicated because we don't have true interoperability," says Campagna. "Case managers have been resourceful in using FaceTime to connect with families to retrieve essential information. Hearing the family's story and having that dialogue can be very helpful to the case manager. A video chat or a conference call is also valuable."

However, true interoperability is needed. "We need medical information that follows us so there is continuity of care wherever we are," she explains. "All the details the patient can't remember will be readily available to facilitate treatment, leading to better patient outcomes."

Major Concerns and Challenges

Turf battles among EMR vendors have proven to be the biggest challenge, industry experts say. As every EMR system is built to be unique, each system includes features that inherently prevent interaction with another vendor's system.

While using the same EMR vendor generally will mitigate interoperability issues, there often are many custom or add-on features that may be in place with the same vendors. These still may prevent interoperability and block the flow of important health information to the point of care. A variety of EMR vendors make achieving the goal of interoperability (and liberating data) that much more difficult, says Campagna.

Health Information Exchanges have blossomed over the past decade to improve the EMR dilemma. To assess the progress, eHealth Initiative conducted its annual survey to determine the biggest challenges. The survey went to 199 data exchange initiatives and revealed the huge task of building IT connections between dozens of disparate systems. A total of 142 groups reported interoperability as a major concern, as it is both difficult and expensive. *(More information is available at: https://bit.ly/35MeVHx.)*

Lack of Consistency a Problem

In the survey, health IT groups asked vendors for more standardized pricing and integration solutions. They also asked for more "plug-and-play" functions, as well as standards in data vocabulary and transport.

Inconsistency in identifying patients is a big issue, as EMRs may use patient name, date of birth, or Social Security number as their primary identifier. Without standardization, it creates havoc in sharing a patient's records.

Many patient advocacy groups

have asked for a national, unique patient identifier similar to Social Security number, which would be used throughout the person's lifetime and at every point of care.

HIPAA called for the creation of a unique patient identifier. However, Sen. Rand Paul, R-KY, introduced legislation in 2019 to repeal this requirement. *(More information is available at: https://bit.ly/3mBpWRW.)*

Without a unique patient identifier, there is no way to link any person's health data into a comprehensive picture of their healthcare experiences, says Campagna. "This must occur before industrywide interoperability can become a reality."

Another issue is lack of standards for sending, receiving, and managing health information creates difficulties at every step. Even getting a simple copy of a health record — or sharing it with another institution — is foiled by mismatched type fonts, data fields, and formats, Campagna says.

All this is proprietary for the vendors and means data must be "manipulated and sanitized" before it can be imported by another system, she explains.

Why Interoperability Is Critical

Interoperability is focused on providing an overall picture of the person's medical condition. The goal is to reduce duplication of tests and treatments that increase medical costs, misuse resources, and can result in treatment delays.

The goal is also to improve continuity of care, giving every provider the same access to patient information, explains Campagna. This expedites patient care as the provider knows immediately what treatment is required at that point instead of having to backtrack.

One common issue: When a patient is traveling, they may not have medical information with them. If they are in another region of the United States or abroad, how quickly can a medical provider access their records? It should be automatically available, but we are not there yet, Campagna says.

THE GOAL IS ALSO TO IMPROVE CONTINUITY OF CARE, GIVING EVERY PROVIDER THE SAME ACCESS TO PATIENT INFORMATION.

Instead, a patient typically must undergo another test, but the doctor will have nothing to compare the results. Without a benchmark, it is not optimal medical care.

"If the EMR systems were interoperable, there would be continuity," says Campagna. "If I had an MRI five years ago, it would be in the record for comparison with my new MRI. If I can't remember where I had that previous MRI, we'll have to start all over again. We won't know if the problem is progressing or if I'm having complications from the original problem."

With current electronic systems, there should be no waiting three weeks for a copy to arrive from the previous facility, she adds. "Unfortunately, we haven't quite got to that point."

"With hospitals partnering and forming large health systems, we do see EMRs available to hospitals, clinics and physician offices within that system," Campagna says. "All these groups are able to talk to each other, but if you leave the system, you may be required to go 'old school' and bring a written report from your doctor's office that has to be scanned."

Interoperability will lead to improvements in healthcare, says Campagna, as it will encourage continuity of care. Any diagnosis or illness will be recorded so every doctor will know a patient's history. There will be increased efficiency as they will not have to repeat tests.

What Case Managers Can Do

To ensure patients do not undergo unnecessary tests, case managers can go the extra step to track down the records, she advises. "That gives us the ability to be much more efficient and effective as we work with patients and helps us formulate treatment and discharge plans. When working with patients, with families, or reaching out to providers in the community, case managers are very good at getting what they need, acting as detectives to track down the information."

Professional organizations and other healthcare organizations have consistently lobbied for interoperability.

"Case managers should be making their voices heard in their professional organizations to keep the momentum in pushing forward," Campagna adds. "We all recognize that with interoperability, we will have an optimal system for health records." ■

Kaizen Method Can Improve Case Management

By Jeanie Davis

Efficiency and cost savings are worthy goals. Satisfaction also is relevant, whether applied to patients, frontline staff, managers, or chief executive officers. If your hospital workday is inefficient, satisfaction suffers at all levels.

That is where the Kaizen method can help, explains **Karen Hooven**, RN, BSN, CRRN, CCM, manager of case management at Cleveland Clinic Medina Hospital.

Kaizen is a Lean manufacturing tool that improves quality, productivity, safety, and workplace culture. Kaizen focuses on applying small, daily changes for major improvements over time. Kaizen is derived from two Japanese words: Kai (improvement) and Zen (good), which translates to "continuous improvement."

Kaizen is relatively new to the healthcare industry, Hooven says. "Teamwork is a hallmark of Kaizen. We include everyone — not just the leaders and managers, but also frontline staff in making change."

In the Kaizen process, caregivers analyze their environment, identify barriers, and develop a plan to remove those barriers — executing that plan quickly, she explains.

Questions include:

• Do you have the right equipment and the right supplies, at the right place, right time, right quality, and right quantity to keep work flowing smoothly?

• Is the process more difficult than it should be?

• Could the process be more efficient?

The overarching goal is creating a culture focused on improvement, Hooven adds. But an integral component is that "every caregiver feels capable, empowered, and expected to make improvements every day, and to sustain those improvements."

In one instance, nursing staff were not receiving information discussed in nursing huddles. A Kaizen project was focused on that problem. "A formal process was developed, and now everyone is on the same page — simple as that," Hooven explains. Assessing and reorganizing supplies among nursing units already has saved time and improved efficiency.

Overall, Hooven says, "we focus on making the job better so we're not working as hard but getting things done. All staff are expected to participate. Because we engage everyone, we help ensure everyone is satisfied in the end, not just the patient or the hospital system."

The Kaizen method promotes professional growth among staff, she adds. Project managers keep the teams focused, "but we want our staff to do the work so they can feel empowered and make the case for change."

Eight Forms of Waste

In analyzing factors that affect job efficiency, one problem-solving exercise is to analyze the eight forms of waste with the acronym TIMWOODU:

• **Travel:** Is there unnecessary patient or material movement? Do you have patient transfer paperwork?

• **Inventory:** Do you have too many supplies? Too few?

• **Motion:** Do you waste time looking for misplaced forms, equipment, or charts?

• **Waiting:** Are you always waiting for lab results? Or waiting for the doctor to write a discharge order?

• **Overproduction:** Are you printing reams of paper? Is there a better way to share the information?

• **Overprocessing:** Are you completing too many forms with the same information?

• **Defect:** Are you encountering too many entry errors?

• **Underuse of human talent:** Is the right person performing the job? Is this really a task for a nurse case manager, or can another staff person handle it?

A simple problem-solving technique helps get to root of problems is asking "why?" at every point. When those answers are mapped, your solution becomes clear, says Hooven.

Hooven suggests bringing the project team together every one or two weeks to review the progress. Illustrating the progress via a process map or sticky notes helps the team visualize where they are in the process.

"This process will show when you were able to complete part of project so you can celebrate it, and everyone feels good about it," she says. "This empowers the staff, keeps them engaged and motivated so they will keep working toward change. We're holding that carrot, giving them motivation."

The team also is encouraged to create an elevator speech about the project. "This helps them find their voice so they can make the case for change, and for sustaining change," she explains. "It's important that we emphasize the need to continue the change after reaching our goal."

Some projects can be completed in a couple weeks — the easy fixes, Hooven says. A larger project will take months. She advises working on a short-term goal while the larger project is in process. "This allows the team to see results, which provides motivation to keep with the bigger project."

One recent project: to reduce hours a patient is held in observation. "We don't want patients in observation status over 18 hours, or we lose money," explains Hooven. "In the end, we decreased observation by several hours in each case."

For this project, they implemented a few techniques to decrease observation patients' hours in the unit, says **Colleen Royer**, RN, MSN, CCN, senior director of care management nursing at Cleveland Clinic Foundation.

"We implemented a visual board, which showed actual hours in observation so that the team could all be alerted to the importance of time," Royer adds. Also, they developed a gatekeeper for the observation unit — a nurse practitioner to facilitate orders and results faster. To sustain their efforts, they posted data every three months for the team to see their progress and celebrate results.

Their next short-term project will be to reduce avoidable delays in patient discharge. What is holding up the discharge? The consulting physician? Precertification for admission to a skilled facility? These avoidable delays are costs that add up.

The team will document and evaluate these avoidable delays to determine a process for correcting the situation. Hooven expects the process to take just two weeks.

The next big hospitalwide project will focus on timely patient discharge. The team will work to ensure doctors, nurses, and case managers are communicating consistently to prepare patients for discharge.

It is all based on preparing discharge orders quickly. Putting in place all the key components for discharge is vital. "The nurse, case manager, and social worker must be proactive in getting all factors ready," says Hooven. "If the patient needs antibiotics to take home, we will make sure there's a prescription ready. Otherwise, discharge is not going to happen."

Everyone doing their job more efficiently is the goal, she explains. "The patient will be happy because they're ready to move on and won't be delayed. The hospital system will be happy because they're utilizing beds more efficiently and helping patients go home sooner," says Hooven.

Also important, "the staff will be happy because they get to go home on time," she adds. "In our analysis of the process, we had to recognize staff unhappiness with late discharges. No one wants to work late, not get home until 6 p.m., time after time, they get burned out. Our goal is to make the process more efficient to increase caregiver satisfaction as well." ■

Engage Staff When Training or Implementing New Programs

Quality improvement professionals often must train staff in new processes or initiatives, but the effectiveness of those sessions can depend on the approach. A simple meeting with a PowerPoint presentation may not be the best way to get good results.

The best results will come when the participants feel involved with the effort and want to help reach the desired goal, says **Camille Epps**, MM, director of learning for Vizient in Irving, TX.

"You have to engage them. You can still use PowerPoint presentations, but they need to include images that resonate and not just bullet points," she says. "You also need to incorporate activities, scenarios/storytelling, and group discussions to help participants better understand the concepts and the expected behaviors. Keeping the learner engaged is the key to effective training."

Epps endorses the Analysis, Design, Development, Implementation, and Evaluation (ADDIE) model, and says it helps ensure the efforts are relevant to what is needed.[1]

Vizient also has moved away from using the word "training" and emphasizes that these are "learning" events. Clear objectives help ensure the goal of the learning event is achieved.

"We also use 'chunk learning,' sometimes called microlearning, using adult learning principles, which show that they can only process information in short bursts. Another effective approach is to create YouTube-style videos and infographics to help emphasize the main points," Epps says. "Lastly, you can design the training around a story. Start the training session by telling a story and tie training concepts together at the end of the learning event."

Epps cautions against these common mistakes:

• A data dump with too much information in one learning event. Learners will not retain all the information.

• Vague content that does not flow together.

• Not allowing time for questions or breaks.

• Not allowing time for hands-on interaction, discussions, and activities.

• Insufficient time to summarize what was presented.

• Not discussing next steps.

Surveys Measure Effectiveness

Surveys help evaluate if the training session was effective. Send surveys immediately after the learning event. The suggested time frame for completing a survey is three days after the learning event, while the learning experience is still fresh on the learner's mind.

"Another way to evaluate training is to use the Kirkpatrick four levels of learning evaluation method [reaction, learning, behavior, and results].[2] Set the stage at the beginning of your learning event to ask what the learners' expectations are so that you can adjust if needed or make plans to address expectations that are presented," Epps says. "Set up a check-in/follow-up appointment with the participants a few weeks after the learning event. Use that time to analyze what learning has been applied or what may need to be reviewed at a later date." ■

REFERENCES

1. InstructionalDesign.org. The ADDIE Model. https://bit.ly/3bozzys
2. Training Industry. The Kirkpatrick Model. https://bit.ly/3lFCM1i

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CE QUESTIONS

1. **When compared with patients recovering from influenza, patients with COVID-19 might experience:**

   a. prolonged fever and/or coughing.
   b. a faster recovery to full function and activities of daily living.
   c. pneumonia.
   d. debilitating symptoms for weeks or months.

2. **In a recent study of social determinants of health in medical records, which missing piece was most highly associated with emergency department revisits?**

   a. Problems at home
   b. Living situation
   c. History of abuse
   d. Employment status

3. **Which is an issue with electronic medical records, according to survey results from eHealth Initiative?**

   a. Programs that crash
   b. Inconsistency in identifying patients
   c. Lack of intuitive controls
   d. Not enough options when filling in charts

4. **One of the eight forms of waste in the Kaizen method is:**

   a. time.
   b. communication.
   c. overprocessing.
   d. money.

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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.

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