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Understand patients' lives, follow up after discharge

Slow down the hospital revolving door

For some patients, particularly senior citizens, the hospital can be like a revolving door. They're in and out of the hospital frequently, despite the best efforts of clinicians to keep them healthy in the community.

It may be that they don't understand their treatment plan, but in many cases, it's because the case managers who are coordinating their care don't understand their life situation and the obstacles they face in trying to stay healthy at home.

"The main factor that causes patients to come back to the hospital time and time again is lack of understanding on the part of the clinical staff about how patients take care of themselves once they leave the hospital. We have to take the time to find out what is going on in patients' lives and encourage them to be active participants in their own healthcare rather than passive ones," says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, consulting firm specializing in hospital case management.

Catherine M. Mullahy, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm, adds that it's essential for case managers to conduct an in-depth assessment of patients, especially seniors. "While some seniors truly do have complex medical conditions that might result in frequent hospitalizations and readmissions, some of the reasons for these occurrences are actually related

EXECUTIVE SUMMARY

Some senior citizens are in and out of the hospital frequently, in part because the staff don't come up with a treatment plan that works or thoroughly educate patients on what they need to do after discharge.
- CMs should take the time to conduct an in-depth assessment that includes psychosocial issues as well as medical ones.
- CMs should involve the patient and the family/caregiver in the plan of care.
- Look at cultural issues, transportation problems, financial issues, and other issues that could affect adherence with the discharge plan.
- Support patients after discharge with follow-up phone calls and home visits.

to non-medical issues. Case managers often spend time on the obvious medical/clinical/nursing issues, but unfortunately don't always spend sufficient time assessing the psychosocial, financial, and other issues that can have a great impact on a senior's ability to remain at home," Mullahy says.

Even if patients don't qualify for or need skilled nursing services, that doesn't mean they don't need some kind of care and support services at home. Many seniors are socially isolated and may not have friends and family to help with care, assist with meal preparation or pick up medication at the pharmacy.

Kizziar points out that a variety of factors can affect a patient's recovery at home.

Cultural practices, particularly involving diet, often can interfere with the recommendations for keeping a chronic condition under control, Kizziar says. For instance, heart failure patients should restrict their intake of sodium, but this may be difficult for someone whose cultural practices include eating starchy and high-sodium foods once a day. "They get home and they're going to eat what the rest of the family is eating," she says.

Polypharmacy issues are common, and many people with chronic conditions are on multiple medications. For instance, many times patients are discharged with different medications from the ones they were taking before hospitalization. "They don't know if they should take the new medications, the old ones, or all of them," she says.

Mullahy adds that seniors may have stopped driving and are hesitant about asking a neighbor to drive them to and from doctor visits or don't have access to public transportation. Vision and cognitive problems also can affect their ability to manage their care at home.

Case managers should explore support services, some of which may be funded by Medicare, supplemental insurance, long-term care insurance or a community program, Mullahy suggests. "As case managers we need to be vigilant in keeping ourselves updated on what is available and successful in the communities where our patients are located," she says.

Kizziar emphasizes that patients who are frequently hospitalized need more than just a follow-up phone call to ensure that they are recovering at home and adhering to their discharge plan. Some hospitals are creating specialty clinics for patients with heart failure, pulmonary conditions, diabetes, and other chronic illnesses. These clinics see patients within three or four days of discharge to follow up on their condition and review their medication, Kizziar says. "One of the drawbacks is that this requires patients to make the effort to come to the clinic and to find their own transportation," she says.

"We're encouraging hospitals to become more involved in seeing people in the home environment. They can see what is in the refrigerators, look for any safety problems in the home, and make sure what the patients are supposed to do to manage their own care realistically can be incorporated into their everyday life," she says.

Home visits can help clinicians identify issues that clinicians could never find out during an office visit, points out **Kathleen Mylotte**, MD, director for quality and disease management at Independent Health Association in Buffalo, NY. Her organization's Care

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Partners for Frail Elders provides home visits for eligible Medicare Advantage members with chronic conditions to help them avoid preventable complications and medical emergencies. *(For details, see related article, this page.)*

Nurses and social workers visit eligible seniors in their homes to check their health status, support them in following their care plan, and coordinate care with their primary care physician. They link patients with community resources such as transportation services, support groups, and financial assistance and arrange for home health care when needed.

"This program is unique in terms of putting eyes and ears in the home. Someone in an office setting who is talking with a patient may miss key pieces of the patient's situation. When our staff visits the home, they can see issues around safety, medication duplication, evidence of abuse or other social issues, transportation problems, and nutritional issues that never could be uncovered in the office setting," Mylotte says. For instance, a patient may tell the physician or nurse that he is eating well, but a look at the refrigerator and cupboards will indicate that he is subsisting on tea and toast.

When visiting in the home, the Care Partners staff have the ability to talk to family members, friends, and neighbors that they wouldn't see during an office visit. In addition, seeing people in their homes over long periods of times makes them aware of when the member is failing or needs more assistance.

Kristy Duffey, MS, BNP-BC, vice president of clinical operations for Baltimore-based XLHealth, adds that by integrating a spectrum of care management services, the company's Care Improvement Plus, XLHealth's Medicare health plan, has reduced hospitalizations and emergency department visits among chronically ill members. The Chronic Conditions Special Needs Plan includes in-home visits, telephonic nurse care management, pharmacist assistance, social services, a transitions-in-care component, and an advanced illness program for members in the final stages of life. *(For more details, see related article on page 64.)*

"Far too many seniors with chronic conditions have repeat hospitalizations and emergency department visits. By offering a collection of population-based and individualized patient outreach programs that all are interrelated, we hope to break this cycle and help our members stay healthy at home," she says.

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Program aims for early interventions

Home visits keep elderly away from the hospital

To help frail Medicare Advantage members with multiple medical problems live independently at home, Independent Health Association in Buffalo, NY, works with Family Choice, a care management provider, to arrange home visits. During visits, they educate members about their healthcare conditions and treatment options, discuss medication, and arrange for needed services.

Participants in the Care Partners for Frail Elders program are the frailest of the frail and tend to be among the highest utilizers of healthcare resources, says **Kathleen Mylotte**, MD, director for quality and disease management at Independent Health Association. "It's hard to get a good comparison group, but the trends seem to indicate a slight reduction in emergency department and hospital visits. This program is not a money-maker, but it has not proven to be a cost burden to the plan," Mylotte says.

The service, begun in 2008, is provided at no cost to the patient and is open-ended. The nurse or social worker will visit the patient as often as needed and for as long as needed. The staff are available 24 hours a day, seven days a week and can make a home visit at a moment's notice. "We have found extra value in this in-depth case management program." Mylotte says.

EXECUTIVE SUMMARY:

Case managers and social workers from Independent Health Association in Buffalo, NY, visit frail Medicare Advantage members at home in a program that aims to reduce emergency department visits and hospitalizations.
• Program is open-ended and provides social support as well as medical care.
• Home visits help identify issues that may not show up during an office visit and facilitate early interventions.
• The Care Transitions program provides in-home visits for patients after hospitalization.

Most members in the program are referred by health plan case managers, health coaches, and community physicians, reports **Jo Ann Calandra**, RN, BSN, BCM, clinical manager for Medicare at Independent Health. "When we started the program, we used a predictive modeling tool to identify participants. This wasn't as helpful as having clinicians refer patients, either following a hospitalization or if they knew from working with the member that the caregiver was overwhelmed or the member was not thriving at home."

Suzanne Ruiz, RN, BSN, director of the Care Partners program, says that when members are referred to the program, a nurse or social worker from the Care Partners program contacts the member and talks to the family member if possible, and sets an appointment to visit the patient in the home. During the visit, the nurse conducts a thorough assessment — looking at psychological issues, safety, the home situation, and medication as well as the member's medical condition.

"We want to keep members as functional as possible in the setting in which they live with an increased quality of life, even though many of them have lost a lot of independence. The nurses, social workers, and other staff at Independent Health work to identify resources that will allow members to live at home as long as they possibly can," Ruiz says.

As long as a member is in the program, his or her care is coordinated by one case manager and one social worker, unless there is a dire emergency. "If you have been seeing somebody for many months, you can tell in a few seconds if something is wrong. "The continuity in providers helps with building relationships as we work with members and talk about advance care planning," she adds.

During the regular visits, the nurses can spot exacerbations, such as ankle edema and increased problems with minor exertion among heart failure patients. They contact the physician and either get orders to make medication changes or get the patient a same-day or next-day appointment. "This helps get the patient's condition stabilized and an emergency department visit avoided," Ruiz says.

If a member is not feeling well, a nurse is available 24-7 to troubleshoot over the telephone or make a home visit.

Mylotte adds that the nurse can identify life changes that could become major changes and intervene to prevent a hospitalization. For instance, if a member has a history of cardiopulmonary disease and tells the nurse he's feeling short of breath, the nurse can visit, assess the member, and notify the physician about changes in the member's condition. In many cases, the physician can intervene over the telephone or the nurse can facilitate a same-day physician appointment. "By providing earlier interventions, we can prevent patients from experiencing a medical crisis and being hospitalized," Mylotte says.

Care Partners does more than just provide medical care, Mylotte says. "We are trying to keep the member stable and help elderly people who are struggling to stay at home," she says. The nurses and social workers can arrange services such as Meals on Wheels, counsel patients and families on advance care planning, and help with placement for people who no longer can live independently.

All the staff members are in the field on a daily basis and see patients a minimum of once a month. Many see members more frequently and follow them by telephone between visits. "They have a small enough caseload so they can see patients as often as needed," Ruiz says.

When members who are at risk for readmission within 30 days are discharged from the hospital, they are enrolled in the Care Transitions program, which provides in-home visits, medication reconciliation, and education. A nurse visits appropriate patients in their homes within 72 hours of discharge and conducts an in-depth medication reconciliation, reviewing pre-hospital and post-hospital medications. If necessary, the nurse refers patients to a pharmacist for medication counseling. The nurse then follows up with the patients by telephone once a week for four weeks at a time that is convenient for the patient.

Ruiz adds that when a patient in the Care Partners program is hospitalized, the Care Partners nurse waits to visit the patient until the Care Transitions program is completed. The Care Partners team continues to pull together all the resources the patient needs to live at home while the Care Transitions nurse is looking at the medical piece and keeping the patient medically stable, she adds. "We want to avoid confusing members by getting too many people involved in the care," Ruiz says. ■

High-risk Medicare members targeted

Integrated CM cuts hospitalization, ED visits

An integrated approach to managing the care of Medicare Advantage members with special needs has paid off for Baltimore-based XLHealth, resulting in increased primary care interventions and reduced

rates of hospitalization and emergency department visits.

Members in the Medicare Advantage Chronic Condition Special Needs Plan experienced increased primary care interventions by 7%, decreased hospitalizations by 9%, cuts in hospital days by 19%, and reductions in readmissions by 28% when compared to a sample of members in fee-for-service Medicare, according to **Kristy Duffey**, MS, BNP-BC, vice president of clinical operations.

The program aims to reduce unnecessary and costly readmissions among the high-risk members of Care Improvement Plus, XLHealth's Medicare Advantage plan, Duffey says.

When members enroll, a nurse practitioner visits them at home, completes a comprehensive assessment, and enters it into the health plan's XLCare database. The health plan's predictive modeling system uses information gathered by the nurse practitioner during the home visit, historical and real-time claims data, and laboratory data to stratify members based on severity of illness, gaps in care, and psychosocial needs.

"We have the ability to look at the members' chronic conditions and acute conditions and predict future events. This enables us to get members into appropriate programs earlier and stop or slow the progress of the disease," she says. Members who are at high risk receive intensive case management services. Those with advanced illnesses are enrolled in Connected Care, which provides a palliative care team and telephonic case management to help prevent unnecessary hospitalizations. About 12% of members in the special needs program are in the high-risk case management program. About 3% of those in the high-risk program are enrolled in Connected Care.

The program includes telephonic nurse case management, pharmacy management, social services, access to a nurse hotline 24 hours a day, seven days a week, and a Transitions of Care program that bridges the gap as members move from one level of care to another.

A key component of the model is the health plan's HouseCalls program, which sends nurse practitioners and physicians to at-risk patients' homes to conduct assessments, provide education, and coordinate care with the patients' primary care physicians. Approximately 85% of special needs enrollees receive a HouseCalls visit. *(For details on the HouseCalls program, see* Case Management Advisor*, March 2011, page 30.)*

A health plan pharmacist contacts members who are taking multiple medications, reviews the medications and follows up with each member's primary care provider.

Nurse care managers call high-risk members at regular intervals to make sure they are following their treatment plan. In 2011, the health plan's nurse care managers conducted more than 455,000 counseling sessions over the telephone.

When members are hospitalized, XLHealth care managers collaborate with the hospital case managers on the discharge plan. A health plan nurse works at one hospital where a large number of health plan members are admitted, visits the members while they are in the hospital and works with the discharge planning staff. When members are admitted to other hospitals, the health plan case manager contacts the hospital case manager by telephone.

"We know that when health plans and hospitals work together on discharge planning and transitions of care, we can reduce readmissions. Since we started the program, readmission rates have gone down in the hospital where we have an on-site nurse," Duffey says.

When members are hospitalized, a case manager calls them within 24 to 48 hours of discharge. In addition, a HouseCalls practitioner makes a post-discharge visit and a health plan pharmacist calls the member and conducts medication reconciliation and counseling. "We have a strong transitions-of-care program because we know that patients are most vulnerable when they transition from one level of care to another," she says.

Appropriate heart failure patients use telemonitoring equipment that measures their weight on a daily basis and feeds the information back to the case management team. The case manager is alerted if a member has weight gain or weight loss. He or she calls the

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EXECUTIVE SUMMARY:

Baltimore-based XLHealth's integrated approach to managing the care of high-risk Medicare Advantage members has resulted in a 7% increase in primary care visits, a 9% cut in hospitalization, a 19% reduction in hospital days, and 28% fewer readmissions.

- A nurse practitioner visits enrolled members at home and enters the results of a comprehensive assessment into a database that also includes claims data and laboratory data.
- Members are stratified according to risk and may receive in-home visits, telephonic nurse care management, pharmacist assistance, or social services, depending on their needs.
- The program includes a transitions-in-care component, and an advanced illness program for members in the final stages of life.

member immediately and doesn't wait to get a call from the emergency department, she says.

When members are discharged from the hospital to a lower level of care, such as a skilled nursing facility, the case manager conducts telephonic concurrent review with the facility to ensure the member's progress. If the member has been stratified as high-risk, a HouseCalls clinician visits the member in the facility.

Care for members who qualify for a new program, Connected Care, is coordinated by a nurse practitioner who works with the member, the family, and the primary care physician. The program takes a holistic approach to care and provides social, psychosocial, and spiritual support and education on treatment options in order to help the patient avoid unnecessary hospitalization and get advance directives in place.

The program includes telephonic case management by nurse practitioners and social workers, in-home visits by HouseCalls practitioners, and palliative care services. "Members are in this program in their last 12 to 18 months of life. We help them with quality-of-life issues and work with physicians on managing the disease progress," she says. The team educates the family about what is likely to happen with the patient so their choices are documented and plans are in place when the patient takes a turn for the worse. "We don't want the family to wait until the patient's weight drops dramatically to decide if they want a feeding tube. We want to get everything in place before the decision is critical," she says. ■

CMs help HIV patients get care, other support

Holistic approach improves outcomes

At the Open Door Medical Center, a community health center in Ossining, NY, embedded case managers work with patients infected with HIV, helping them navigate the healthcare system and get the medical care and other assistance they need to keep their condition under control.

"The case management program provides all the support these patients need in dealing with their diagnosis. They look at the patients 'holistically' and help them with all of their needs, whether it's family issues, mental health assistance, or help with issues such as housing and meals," says **Andrea Beltran Ruggiero**, HIV director. The case management program is funded by the Ryan White HIV/AIDS program.

The health center is staffed by three HIV specialists, in addition to family practitioners and other practitioners who can provide much of the care patients need in one setting; including optometry, nutrition, and mental health services. Since the center provides care for patients with a variety of ailments, HIV patients feel their confidentiality is protected when they see their practitioner.

The biggest barrier that case managers face in ensuring that patients with HIV get the care they need is overcoming the stigma associated with the condition, Ruggiero says. "This is a small, tight-knit community, and being infected with HIV can affect patients' relationships with their families and friends and they fear having people know about their condition," she says.

The HIV case managers are trained as test counselors and see all patients at high risk for HIV. If a provider suspects domestic abuse, or substance abuse, a sexually transmitted disease, or other red flags, they refer the patient to the HIV test counselor. New York state law recommends HIV testing to anyone over the age of 13, which helps eliminate the stigma barrier to being tested, Ruggiero says.

If the results are positive, the case managers meet the patients when they come back to the clinic for post-test counseling with a provider. They talk to them about enrolling in case management and other programs at the clinic.

The case managers help patients enroll in assistance programs such as the AIDS Drug Assistance Program (ADAP), administered through the New York State Department of Public Health. "Most patients are eligible for some kind of assistance," Ruggiero says.

The case managers are trained to talk about treatment options, making sure the patients understand the process and the importance of getting proper medical care. "We have an intricate and very crucial process in place to help these patients come to terms with a very difficult diagnosis," she says. The case managers educate the patients about HIV and assure them that

EXECUTIVE SUMMARY

Embedded case managers at Open Door Medical Center in Ossining, NY, help HIV patients navigate the health system and get the medical care and community support they need.

- CMs are trained as test counselors and see all patients at risk for HIV.
- Patients who test positive are enrolled in case management and receive help in enrolling in assistance programs.
- CMs educate them about the disease and help them identify treatment options that will work best for them.

it's a chronic disease and that they aren't likely to die in a few months as long as they receive treatment and adhere to their care plan.

"Most patients end up becoming knowledgeable about HIV and controlling it. If they are committed to care, they can have long and prosperous lives. We have one patient with HIV who has been with us 27 years and is doing great," she says.

The case managers see their patients every time they come back to the clinic. They assist with booking appointments and enter the patient appointments on the case management calendar to be sure they see the patients. In some cases, they accompany the patients into the examination room. "They help them navigate the system and learn how to access the care and assistance they need," she says.

Helping patients adhere to their medication regimen is a big part of the case manager's job. "Every patient is different. The medication that works for one person might not work for another. When patients experience side effects, the case managers work with providers to find alternatives," she says. Some patients who work at night need a different medication regimen from those who work during the day, she points out. "The case managers work closely with the patients and the providers to make sure each patient's medication regimen meets his or her needs," she says.

Unemployment is a problem for some HIV patients. "Many patients want to work but are limited as to what they can do because of their illness. These patients need a lot of assistance from case managers and social services to meet their needs," she says. The case managers work with social workers at the clinic to arrange housing assistance, meal deliveries or access to food banks, and other community programs that provide support. "When patients' social problems are addressed, treatment adherence is easier," Ruggiero says.

They help appropriate patients enroll in substance abuse programs and, if they are eligible for funding, help them find a treatment facility that offers a sliding fee scale.

All of the clinic's mental health practitioners are given HIV training. "We have a strong mental health component at Open Door. We try to get all patients infected with HIV to have at least one mental health evaluation a year," she says.

The patients stay in case management as long as they are being treated at Open Door. If they move away, the case managers help them find a provider in their new community.

SOURCE

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Root out under-triage in the ED

Train nurses to think beyond triage tools

Under-triage, or assessing patients as being less ill than they actually are, can lead to treatment delays and adverse outcomes, including serious injury and even death. Despite such dire consequences, however, **Lisa Wolf,** PhD, RN, CEN, FAEN, a clinical assistant professor nursing at the University of Massachusetts in Amherst, MA, believes that under-triage is occurring in ED environments across the country. Why? Wolf believes that part of the problem is that triage decisions are not always based strictly on a patient's condition.

"A lot of clinical decision-making is affected by the people around you — the nurses, the volume, the lengths of time that patients wait in the waiting room, and the presentation of the patient," she says. Further, Wolf suggests that the people charged with making triage decisions are not always equipped with the high-level capabilities needed to be able to differentiate between Emergency Severity Index (ESI) level 2 patients, who are typically seen right away, and ESI level 3 patients, who are deemed stable enough to wait.

An under-triage problem is not always obvious, but routine chart reviews can give ED leaders clues as to whether their triage process is working effectively and whether the right clinicians are handling triage. Then it is up to ED leaders to devise appropriate corrective steps to improve triage accuracy.

Consider implications of triage designation

Wolf has been observing clinical decision-making in EDs across different regions for years, but recently participated in a study to identify what factors most impact transfer times between the ED and the intensive care unit (ICU.)[1] In the study, which was conducted at a 142-bed community hospital, data was collected on 75 patients who were transferred from the ED to the ICU. The researchers found that more than half of these patients (58.7%) spent more than four hours in the ED before being transferred, and that the strongest factor impacting transfer times in these cases was the initial ESI triage assignment.

Perhaps not surprisingly, patients designated as

ESI 3 were well-represented in the delayed group. In fact, 19 of the 25 patients designated as ESI 3 had delayed transfers, making up more than 40% of all the patients who had delayed transfers. This highlights the difficulty many triage nurses can face, trying to discern whether a patient is potentially unstable, which would match the ESI 2 assignment, or urgent but stable, which is in line with ESI 3. However, Wolf stresses that the difference between these two triage designations has important implications for how these patients will be cared for in the ED.

"The triage designation sets the tone and the trajectory for the entire visit. When a patient is triaged as urgent but stable, the nurse is less likely to go to that patient first if she is busy because the patient is stable. That is what ESI 3 tells you. This patient can wait a half hour," she explains. "However, when somebody gets triaged as potentially unstable or unstable, the nurse will go to see that patient first, so things will be picked up faster with a higher triage."

In Wolf's study, cases of sepsis were the most likely to be under-triaged, but she observes that there are many conditions that require higher-level skills to assign accurately. "There is a whole category of well-appearing ill people out there who get ignored, and their treatment gets delayed. It is really problematic," says Wolf.

Further, in a tricky case, a triage nurse may be reluctant to follow her instincts in an environment that she senses will not be supportive of her decision. "We ignore the fact that clinical decision-making takes place within a social context rather than on a piece of paper," says Wolf. "It is really hard for people to put forward their clinical decisions in the face of resistance."

Given the stakes involved with an incorrect triage assignment, Wolf is concerned about attempts to speed up or simplify the triage process in the interest of faster throughput. "The whole point of triage is to get people the resources they need as quickly as they need them rather than just to put bodies in chairs or in beds," she says. "It is an assessment decision, not a task."

Assign the right nurses to triage,

More than anything else, getting triage right boils down to making sure that the right people are doing the job, according to **Jeff Solheim**, RN, BRE, CEN, CFRN, a triage expert, consultant, and frequent speaker at emergency care conferences around the world. "There are a lot of ED leaders who look at triage as just another assignment, but it isn't. It is a very unique place that needs to be staffed by the right people," he says. "Not everybody is going to be a good charge nurse or manager, and if they don't have the skills they shouldn't be there. I think triage is the same. It requires a certain subset of skills that I am not convinced every emergency nurse has."

Some facilities use a staffing process that insures that everyone gets rotated through triage, but Solheim believes that ED leaders should put a lot more thought and effort into determining which personnel can do the job well. "Some EDs have clinical ladders, and one of the levels that a nurse can reach is triage," he says. "I think that is a very powerful way of making sure the right people — people who have met the requirements — climb the ladder."

It's an objective process, although it still allows for an educator or ED leadership to have some input on who handles triage and who doesn't, says Solheim. This is important because the best triage nurses can pick up on things that triage tools cannot.

"This is one of the reasons why I like the Emergency Severity Index. It allows the nurse a little bit more subjectivity in decision-making than some of the other triage systems that are out there," says Solheim. "Some of the tools are great. They make people think, but ultimately the tool always has to allow for nurse subjectivity, and that is why you want the right nurse out there."

Solheim adds that some people just have those great decision-making skills where they can think outside the box or outside the tool, and that is what makes a good triage nurse. "Those who don't have that same critical thinking process may stick too close to the tool," he says. "Tools can be good and bad, but if the right person is out there they can use a tool to reinforce their triage, and ultimately know that they are making the right decision."

Make nurse training a priority

In addition to selecting the right people to handle triage, Solheim says ED leaders should prioritize training so that personnel fully understand the basics of triage as well as the particular process that is being used in the facility. Too often, ED leaders will tell someone that it is their day to triage, and then they will take 10 minutes to show them how to do it, he says. "That does not establish a good triage nurse," adds Solheim.

Further, to reinforce training, Solheim advises nursing leaders to establish procedures for good quality control, where a certain percentage of each nurse's charts are regularly audited to determine whether she or he is triaging to the correct level, or under- or over-triaging. "When thresholds of a certain percentage fall out, then the nurse needs to be retrained or reevalu-

ated to determine whether [this individual] should even be doing triage," he says, noting that a triage nurse should be making accurate assessments about 95% of the time. "If this isn't happening, then it is a good opportunity to help the nurse go back and look at what she is doing."

"Sometimes we get into bad habits, even as triage nurses. Sometimes people forget the initial training. Quality control audits can help to keep the training in mind and keep triage at the right level," says Solheim.

There are different ways to conduct chart audits. Staff nurses can even conduct some of these audits themselves if department leaders want to increase the number of charts reviewed, says Solheim. However, he says an ED leader or an educator should complete some of these audits, or at least review them to bring some objectivity to the process.

Monitor nurse triage assignment

One other issue that ED leaders should consider is how the initial triage decision is being used. Why? Because like Wolf, Solheim has seen instances in which the triage assignment is used inappropriately throughout a patient's stay in the ED. "Whatever is initially assigned should be there, but you can assign a new level if the patient's condition changes," says Solheim. "A lot of times EDs are surprised to hear that."

Further, Solheim emphasizes that once a patient is in a bed, there should be no need to reassign a triage level. "Triage is all about who comes into the treatment area first, but once a patient is in the treatment area, the triage assignment should be put away," he says. "It really shouldn't be used in any further decision-making. Once a patient gets to the back, other tools should be used to determine urgency."

Solheim says that EDs that continue to rely on the triage priority as their assessment in the back are perverting what triage is meant to do. "It is not meant to continue throughout a patient's stay," he says. "Once a patient is in the back, there should be a new system defined for how urgent a patient is viewed."

REFERENCE

1. Yurkova I, Wolf L. Under-triage as a significant factor affecting transfer time between the emergency department and the intensive care unit. *Journal of Emergency Nursing* 2011; 37:491-496.

SOURCES

• **Jeff Solheim**, RN, BRE, CEN, CFRN, Solheim Enterprises, Keizer, OR. E-mail: jeff@solheimenterprises.com.

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Are your people too afraid to report errors?

Many employees think culture is too punitive

Perhaps the saddest thing about the Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report, released in February by the Agency for Healthcare Research and Quality (AHRQ) is not that so many people believe the culture in their hospitals is an impediment to error reporting, but that so many people who work in the patient safety arena are not surprised at the high number of people responding that way.

The survey included about four dozen questions about the safety culture, including queries about overall perceptions, staffing, communications, and transitions. For example, nearly two-thirds of respondents think it is pure luck that more errors do not happen and that there are safety issues on their unit; fewer than half those responding feel free to question those above them, even if they think they might be making a mistake, and 63% are afraid to ask questions if something seems off. Half the respondents think their mistakes are held against them, and nearly as many think the organization looks for a person to blame, rather than a problem to solve. In the last year, none of those numbers had moved in a positive way more than 2%, and most were unchanged from the previous year. *(The complete report is available online at http://www.ahrq.gov/qual/hospsurvey12/.)*

"If something is not obviously the result of a process breakdown, people like someone to blame if something goes wrong," says **Frances Montoya**, manager of the patient safety program for Presbyterian Healthcare Services in Albuquerque, NM.

Barbara Rebold, RN, MHA, CPHQ, director of operations at the ECRI Institute Patient Safety Organization in Plymouth Meeting, PA, agrees. "It is human nature to find someone to blame and make an example of them, rather than looking at the system and why the system might be an issue."

Often, Rebold says, management will object to creating an organization that has an open and nonpunitive culture, saying it lacks accountability. "But there is a difference between accountability and blame," she says. "It is a fine line, but there is a difference." Accountability means people feel responsible

for making things happen, bringing hazards to light, and stopping activity if necessary. "People have to be empowered to be accountable. It is easier to blame a person, or educate, train, or discipline him, than to create the systems that empower them. But despite the effort, it is better in the long run to help them be willing to report errors and near misses."

"Dr. [W. Edwards] Deming said that errors are usually the responsibility of the system, not the worker," explains **Cary Gutbezahl**, MD, president and CEO of Compass Clinical Consulting of Cincinnati, OH. Gutbezahl consults with many organizations about creating a non-punitive culture for error reporting. "But that does not fit well with healthcare. We do not have well-designed systems, but rather we rely on good people to implement processes. We have an operator-dependent system, and that does not create teamwork, transparency, or effective error-proofing."

The number of employees who feel they work in a punitive environment? It is not surprising, he says, in context of the kind of industry healthcare is and the place on the quality path where it is at this point.

That does not mean you can't create an environment where the survey numbers seem wrong, sad, or ridiculous. Montoya says Presbyterian Healthcare Services started working on rolling out a Just Culture program in 2009. Based in part on training from the Institute for Healthcare Improvement, it started with an in-depth look at the constraints that existed around not identifying potential places of harm. "You have to know first where you are harming people," she says. "Then you can determine how to prevent that harm."

The worry that many had was that you would end up with a system that had no accountability, but Montoya says they got around that by making the message clear. "We recognize that healthcare is complex, with a lot of changes and handoffs. There will be mistakes. But we will be transparent, share where there are areas where we are prone to mistakes and figure out how to fix them. If you speak up about an error or near miss, we will use that as a learning experience. This is not a blame-free culture, but we want you to speak up. If you do, you will not be punished."

The initial inquiry into errors focused on pressure ulcers, surgical-site infections and other problems that could be identified using existing coding to capture. "We did quarterly reviews," Montoya says. "We sent them to the boards, and while at first they wanted to know who was making mistakes, over time they stopped."

Next, Montoya says they put together a Significant Clinical Review Team. "Before, it was just one person who dealt with events. The team included risk management, nursing, pharmacy, and HR." They began to notice trends — things that happened more than once, providers who had the same problem repeatedly. They created Red Rules — the things for which providers are responsible 100% of the time and if not done result in some sort of remediation, punishment, perhaps even termination.

Gutbezahl spent some of his clinical life managing a blood bank. Red Rules there included following strict procedures for releasing blood from the bank to the nurses and up to a unit. If they were not followed every single time, it led to immediate termination.

One of the first Red Rules Montoya says they implemented in Albuquerque related to hand hygiene; another related to positive patient identification using name and date of birth. While things have improved in the year since the rules were rolled out, Montoya says they still struggle with the line between accountability and blame, even with the Red Rules. Who has to see you not washing your hands? If you have a verbal reminder, is that considered breaking the rule, even if you haven't touched a patient yet? What if it is a particularly frantic day and you miss something, but then come back and correct yourself, but your manager notices? A recent outbreak of norovirus allowed them to revisit the importance of hand hygiene. "If employees had been more accountable for this, maybe it wouldn't have spread so far," Montoya says.

Still, she counts the program as a success. "We have a safety culture now, not just a culture. And it is not about what just happened, but about the next patient. It is not about your role or relative position with the person you are questioning or correcting. It might sound like a no-brainer to call each other on hand-washing, but it does not always happen. So we have to give them better tools on how to approach their peers and co-workers. And we have to have the rules and hold every person accountable the same way — doctors and nurses."

Rebold says the key to implementing a non-punitive culture is making sure that from the very top down, everyone supports the idea that you aren't looking for the person whose head needs to roll. When people talk about errors — and they talk about them whether you have a punitive culture or not — the conversation will include whether someone was scape-goated. When you stop blaming

individuals and start looking at systemic reasons for errors, that word will spread. People will, over time, begin to feel more comfortable reporting mistakes. "Staff will begin to see there is no reason to keep secrets and hide reports," says Rebold. "They will understand that the risk is patient safety, not job or income security."

You also have to have good ways to determine if there was any intentional human error, Rebold notes. "And that's not as easy as you think." There are tools that come from other industries that can help. ECRI has one available through its website. Another important tool, she says, is something that evaluates the various corrective actions you can take. ECRI has one of those, too, which outlines low-, medium- and high-impact methods of effecting change. Most people stick to things such as education and remediation, which are on the low end. "You need to choose actions that have higher impact, like optimizing redundancy through second checks, minimizing choices, or standardization." Those fall into the medium category. Failsafe mechanisms like Red Rules, stopping the line or automation are high-level actions. "Do not do something on the low end alone. If you do those alone, you will not have improvement."

Gutbezahl recommends talking to employees first to get their opinion on your culture. Then create your message and disseminate it. It could be as simple as "We work as a team, and any member of the team can speak up." Ensure acceptance at the top and roll it out to management — not just senior management, but managers from every level of the organization — before expanding it to everyone. Buy-in is crucial, he says.

"Fear is the enemy of quality," he says. "If people are afraid, they cover up errors and you get under-reporting of problems." That can lead to poor mortality and readmission rates; quality improvement departments will not know what needs fixing, either at the system level or even at the individual patient level.

Expect the changes to take about a year to percolate through your organization, Gutbezahl concludes. Reassure your staff that you are committed to changing the culture and when events happen, encourage discussion. "Say you used to have surgeons come in and complain about nurses who raise questions. You do not fire the nurse though. You talk about teamwork with the doctor and the nurses and how to have constructive conversations in surgery. People will hear about that. They will know that the nurse raised a concern and nothing bad happened."

SOURCES/RESOURCES

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Further Internet Resources:

Just Culture website: http://www.justculture.org/default.aspx
ECRI Institute website: http://www.ECRI.org
California Hospital Patient Safety Organization website: http://www.chpso.org/index.php
Compass Clinical Consulting resource links: http://www.compass-clinical.com/resources/ ■

COMING IN FUTURE MONTHS

- Providers, health plans team up for better care
- What your peers are doing to reduce readmissions
- CM opportunities with the U.S. military
- Helping seniors stay healthy at home

CNE QUESTIONS

1. According to B.K. Kizziar, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, what is the main factor that causes patients to come back to the hospital time and time again?
   A. Poor sharing of information between the hospital and the post-acute providers.
   B. In-hospital patient education that is not geared to the patient's health literacy level.
   C. A lack of understanding on the part of the clinical staff about how patients take care of themselves once they leave the hospital.
   D. Financial issue that prohibit patients from filling their prescriptions.

2. How long do patients stay in Independent Health Association Care Partners for Frail Elders program?
   A. 30 days.
   B. Six months.
   C. One year.
   D. As long as needed.

3. What does the Care Improvement Plus Transitions of Care program do to bridge the gap as members move from one level of care to another?
   A. Health plan care managers collaborate with hospital case managers on the discharge plan.
   B. A case manager from the health plan calls patients within 24 to 48 hours of discharge.
   C. A HouseCalls practitioner makes a post-discharge visit to the patient's home and a health plan pharmacist calls the member and conducts medication reconciliation and counseling.
   D. All of the above.

4. According to Andrea Beltran Ruggiero, HIV director at the Open Door Medical Center in Ossining, NY, what is the biggest barrier case managers face in ensuring that people with HIV get the treatment they need?
   A. Overcoming the stigma associated with HIV.
   B. Signing patients up for medication assistance plans.
   C. Helping patients follow their treatment plan.
   D. Assisting patients in choosing the best treatment options.

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
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 last test of the semester, 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 emailed to you instantly. ■