Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

October 2012: Vol. 23, No. 10
Pages 109-120

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Financial disclosure:
Editor **Mary Booth Thomas**, Executive Editor **Russ Underwood**, Senior Vice President/Group Publisher **Don Johnston** and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

Ensuring good transitions is just the right thing to do

CMs can help patients avoid readmissions, ED visits

Providers and payers alike are recognizing that ensuring smooth transitions when patients move between levels of care — and implementing projects to help transitioning patients avoid an emergency room visit or a hospital readmission — is the right thing to do.

"There's a great interest in how all of us in the healthcare industry can do a better job for patients. Payers and providers are developing case management programs and are making an impact on transitions in care. Not only do they improve outcomes and save money, but they improve patient and family satisfaction as well," says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY, case management consulting firm.

Case managers are the key to successful transitions because they can work closely with patients and family members, often identifying barriers to care and psychosocial needs that, in the past, providers never knew about, Mullahy says.

Avoidable readmissions have a variety of causes, including unclear discharge instructions; patients' lack of knowledge or resources to get their

EXECUTIVE SUMMARY

Ensuring smooth transitions when patients move from one level of care to another improves outcomes, saves money, and improves patient and family satisfaction.

- Reasons for readmissions include unclear discharge instructions, lack of knowledge about the disease and treatment plan, lack of follow-up appointments, and the need for community resources.
- Problems occur when case managers and other providers work in silos, rather than extending care coordination beyond their setting of care.
- Case managers should collaborate with their colleagues in other settings of care to share information and ensure that patients and the receiving providers have everything they need for a smooth transition.

medication, manage their diet, or receive follow-up care; and lack of medical follow-up, adds **Randall Krakauer**, MD, national medical director for Aetna. "Many readmissions are the result of a breakdown in processes after patients are discharged. Case management has demonstrated the potential to reduce avoidable readmissions by ensuring that patients have a smooth transition," he says.

Aetna adapted the University of Pennsylvania's Transitional Care Model for a pilot project in which advanced practice nurses visited at-risk Medicare patients in their home after discharge. The nurses conduct an extensive assessment of patient needs and the home situation, connect patients to whatever post-acute services and community resources they need, and educate patients and family members on the treatment plan, the need to follow it, and signs and symptoms that indicate the patient's condition is worsening. The pilot produced a savings of $439 per member per month and is being expanded to communities where there are sufficient numbers of Aetna Medicare members. *(For details on the program, see related article on page 113.)*

"We know from experience that good transitional care can provide a positive impact on quality and cost for home discharges and discharges to skilled nursing facilities. An admission that doesn't happen is not just a cost saving. It's also a matter of providing good quality care for the patient," Krakauer says.

Coordination of care shouldn't be limited to what happens in the hospital or the clinic but should extend across settings, adds **Carol Barnes**, MS, PT, GCS, executive consultant for strategic programs, CARE Management Institute, Kaiser Permanente, Oakland, CA.

Part of the problem in the past has been that clinicians typically worked in silos with little communication with their colleagues in other levels of care, Barnes says.

"When we began a project to improve transitions in care and interviewed patients, family members, and providers, we learned that care was happening in what we call 'individual towers of excellence.' The hospital was doing great work, the clinics were doing great work, and the home health nurses were doing great work, but the transitions were broken between them," Barnes says.

Some patients who were interviewed told Kaiser representatives that they were confused about their treatment plan and medication regimen, that they didn't know who to call with questions and concerns after discharge, that they didn't remember that they should make a follow-up appointment with their primary care provider, and that often their primary care provider didn't know they had been in the hospital. The organization's process improvement team developed a set of six key initiatives to improve the transition process. After a successful pilot, the program is being rolled out in Kaiser regions throughout the country. *(For details on the program, see page 112).*

"People go home from the hospital confused about what they should do. Some don't even know their basic diagnosis. They don't follow their treatment plan and end up back in the emergency department or the hospital," Mullahy says.

Regardless of where they work, case managers

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Case Management Advisor™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $67 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours. This activity has been approved by the Commission for Case Manager Certification for 18 clock hours. This activity is valid 24 months from the date of publication.

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need to look backward before they go forward and determine what caused the patients' problems in the past, and then determine what can be done to remove the barriers to keeping the patient healthy, she adds.

Everyone needs to know who the at-risk patients are. Medicare and Medicaid beneficiaries represent a good portion of high-risk patients, but they aren't the only patients who may need extra help after discharge, she says.

For instance, patients may not qualify for post-acute services but they may not have anyone to make their meals. "There may not be food in the refrigerator, and someone who has just been discharged from the hospital isn't going to feel like going shopping right away. In addition, many people with chronic conditions are on modified diets and don't know how to shop. Case managers need to spend more time finding out specific patients' needs and connecting them with needed resources," Mullahy says.

Case managers bear a sizeable responsibility to ensure that patients are safe in the next place they go, whether it's back home, to an assisted living center, or skilled nursing facility, and to make sure that the hand-off to the next level of care goes smoothly, she adds. "Case managers should never treat the hand-off like a hot potato. They should continue to be accountable for what they did to get patients ready for the transition," she says.

This means that providers at all levels of care should work together to make sure that patients don't fall through the cracks when the transition happens, Mullahy says. As consumers become more savvy about healthcare choices, providers and payers both risk losing clients if they don't facilitate good transitions, she adds.

"As case managers, we've got to stop being so insulated in our own silos and learn what other organizations are doing," she says. By meeting face to face with their peers in other settings, case managers get to know each other and know who to call when there are questions about the transitions, she says.

When a patient is receiving care in any part of the healthcare system, all case managers involved with the patient should know about it, she says. Providers and payers are starting to partner with each other to improve transitions, she says.

"Hospitals are starting to establish true partnerships with medical group practices, and case managers in both settings are starting to have active conversations," Mullahy says. Insurers are embedding their case managers in group medical practices, and in some cases, in hospital settings. "This is real partnering and can only benefit the patients," she says.

Case managers at different settings should also collaborate on follow-up calls after patients are discharged from the hospital. "Follow-up calls are important because many times patients don't know what medication to take or have other questions. But it will be confusing if they get a call from the insurance case manager and the hospital case manager," she says. ■

Redesigning the transition process cuts readmissions

Patients, providers gave input on new practices

Kaiser Permanente's six-step process to improve transitions of care has resulted in reduced preventive hospital readmissions, an increase in the percentage of patients with physician appointments within five days of discharge, and raised patient satisfaction scores.

"Our 30-day readmission rates were better than average, but we knew some patients were experiencing fragmented care during transitions. We began the program as a pilot project in Portland, OR, and are rolling it out nationwide," says **Carol Barnes**, MS, PT, GCS, executive consultant for strategic programs, CARE Management Institute, Kaiser Permanente, Oakland, CA, who facilitated the transition improvement project.

Results vary among regions and medical centers, but every facility that has implemented the process has shown improvements, Barnes says.

The transition process includes a bundle of six

EXECUTIVE SUMMARY

Kaiser Permanente's new initiative to reduce avoidable hospital readmissions has reduced readmissions, increased follow-up visits, and raised patient protection scores.

- The organization interviewed hundreds of patients, family members, and providers to get their views on where there were glitches in the process.
- The team came up with a six-step process that includes better discharge information, follow-up phone calls, and standardized medication reconciliation.
- Based on input from providers, the team revised the way it communicates to post-acute providers.

critical elements for successful care transitions, Barnes says. They include making sure patients know who to call if they encounter problems after discharge; ensuring that patients have timely follow-up appointments with their primary care physician; making follow-up calls to patients after discharge; improving the medication management process; creating standardized assessments to determine patients' risk for readmission and post-discharge needs; and improving communication with post-acute providers. *(For details on the six initiatives, see related article, below.)*

Before Kaiser Permanente embarked on the project, the organization conducted hundreds of interviews with patients, family members, doctors, nurses, and other staff in hospitals and skilled nursing facilities.

"We started out thinking we knew a lot about what was wrong in the transition process, but the patients and family members gave us a lot of new insight into what was happening in the transition process and where the glitches were," Barnes says.

The team interviewed members by phone and in person and videotaped some interviews, producing a series of short video clips called "The Voices of Our Members" for the medical centers' staffs to view. "It makes a big impression when people can see members and hear about their experiences, rather than just reading a document," Barnes says.

They asked patients and caregivers what part of the transition process worked for them, what wasn't working well, what they needed at home, how they were managing their conditions, and what Kaiser could do to improve the transition process.

After all of the feedback had been collected, the organization assembled a team of front-line clinical and administrative staff, physicians, health plan leaders, and 10 patients and family members to come up with a plan to redesign transitions. A patient also served on the leadership team when the pilot project was implemented.

"We've always talked about patient-centered care, but now that we better understand what patients go through as they transition, it feels like we're really doing it," Barnes says. ■

Six steps lead to better transitions

Facilities implement them the way that works best

After interviewing hundreds of patients and family members, a multi-disciplinary team at Kaiser Permanente redesigned the process for transitioning patients from the hospital to home and developed a list of six processes that should happen during every discharge for every patient.

"As each facility implements the transitions-in-care procedures, they do it in the way that works best for them, but all their transition plans include the same bundle of processes," says **Carol Barnes**, MS, PT, GCS, executive consultant for strategic programs, CARE Management Institute, Kaiser Permanente, Oakland, who facilitated the transition improvement project.

Based on the responses from patients and family members, the team identified six elements to improve the patient experience during the discharge process.

A dedicated phone line for discharged patients:

For instance, one patient told the team that shortly after he got home, he wasn't feeling well and wondered what he should do. He looked through the thick packet of discharge information and the only telephone number he could find was 911. Then he looked up the facility's number in the phone book and was routed through a long voicemail tree and never connected with a person. He tried finding the number online and finally gave up and called 911.

"Our team heard similar stories from other patients and realized that patients leaving the hospital are vulnerable and need a number where they can reach someone right away," she says.

The team recommended that discharge instructions include a dedicated phone number for newly discharged patients so they can get answers to their questions and concerns immediately. The line is answered by a nurse who has access to the patient's medical record and discharge information and who is backed up by the physician team.

Follow-up calls after discharge:

"Patients told us that having someone to check on them after discharge is important," Barnes says.

For instance, a patient reported that he gets a call from the veterinarian after his cat receives treatment and that the dentist follows up after all procedures, but nobody from the hospital called to check on him after open heart surgery.

With the new process, all patients leaving the hospital get a call from a nurse within 48 hours. If patients are high risk, a nurse creates a personalized plan of care and follows them by phone for 30 days at intervals that depend on patient needs. In the Northwest Region of Kaiser Permanente, complex care nurses in the primary care offices make the calls. In other regions, it may be the hospital nurse or the emergency department physician.

Follow-up primary care appointments:

Some patients told the interviewers that when they

got home, they didn't realize they needed to make a follow-up appointment with their primary care physician.

"I'm sure the nurses or doctors told me, but I was on a lot of medications in the hospital and I don't remember much about what they said," one patient reported.

Now, the hospital team makes a follow-up appointment while the patient is still in the hospital and includes the information in the discharge plan.

Since almost half of the patients who were readmitted came back within the first week, the team makes sure everybody gets an appointment within a week and that high-risk patients see their primary care doctor for follow up within two to three days.

Redesigned medication management:

"Some patients told us they often don't understand why their medications changed and what they were supposed to do when they got home," Barnes says. "Medication management is really important and the hospital may not be the best place for patients to learn."

The team developed a process for medication management across settings. A pharmacist reviews the medications for at-risk patients while they are in the hospital and calls the patients after discharge to go over the medications. The nurse who makes follow-up calls goes over the medication regimen. "Medication management is the number-one place where we find problems during the follow-up calls," she says.

In addition, the team recommended a system to ensure that medications are reconciled when patients come into the hospital. "The new system has reduced medication errors," she says.

Standardized discharge assessments:

Some patients reported that they didn't have confidence that the system knew what they needed at home. "One caregiver told us that the treatment team educated his wife on what she was supposed to do after discharge but that the wife has dementia and didn't understand," she says.

The redesign team recommended standardized assessments throughout the hospital. Physicians stratify all patients for risk of readmission based on their physical condition. The discharge planning nurses also stratify patients based on their home situation and psychosocial needs. The information is based on the discharge summary, alerting the primary care physician, the home health nurse, and post-acute facilities of the patient's risk.

Patients at high risk get tailored discharge planning and education and frequent follow up calls.

Improved communication with primary care physicians:

Some patients reported that sometimes their primary care physicians weren't aware that they had been hospitalized. The primary care physicians reported that often they didn't get discharge information and that when they did it was either a lengthy document or just one line.

The team developed a simple, standardized discharge summary that hospital physicians create and transmit the day the patient leaves the hospital. The document, which is integrated into the patient's medical record, has a place at the top where the physicians can write key information.

The nurses who answer the special post-discharge phone number can access the information. In addition, it's transmitted to home health nurses who use it to coordinate the patient's care. ■

Nurse visits result in fewer readmissions

Project targets high-risk patients

Aetna's pilot program sending advanced practice nurses into the home of at-risk Medicare patients within seven days of hospital discharge resulted in a 20% decrease in hospital readmissions, over and above the 23% readmission reductions already achieved by the health plan's case management program for Medicare Advantage patients.

The pilot program demonstrated a cost saving of $175,000, or $439 per member per month.

"The other benefit to the program is that patients were able to stay healthier and experience a greater quality of life. Our goal is to develop programs that demonstrate impact on the intersection of quality and costs. The way to save costs is to provide better quality care for patients," says **Randall Krakauer**, MD, national medical director for Aetna.

For the pilot study, the health plan partnered with the University of Pennsylvania to adapt the Transitional Care Model for a population of 155 Medicare beneficiaries in the Philadelphia area. The Transitional Care Model was developed by Mary Naylor, PhD, RN, and colleagues at the University of Pennsylvania School of Nursing.

"We had a strong telephonic case management program that was identifying and managing our Medicare membership who were at-risk for readmissions or had special needs, such as coordination of end-of-life care. We conducted the pilot to see if it provided additional value to

our population that already was receiving case management," he says.

For the pilot, Aetna identified a population believed to be at risk for an unsuccessful transition to the community. Criteria included dementia, depression, a previous history of avoidable readmissions, and selected clinical conditions. Some members for the program were also identified by concurrent review.

After the successful pilot, Aetna is expanding the program to communities throughout the country wherever there is a sufficient concentration of members.

The health plan contracts with advanced practice nurses living in the patients' community because they are familiar with services and community resources in that specific area.

The nurses visit the patients within the first seven days of discharge because that's when most of the problems occur, Krakauer says. During the visits, the nurses complete an assessment to determine if patients have everything needed to follow their treatment plan and arrange for whatever the patients need to live safely at home. For instance, they may arrange for home health, housekeeping services, Meals on Wheels, physical therapy visits, or nutritional consults.

They educate patients and caregivers about the patients' care plans, why it's important for the patients to take their medication and follow their treatment plans, signs and symptoms that could indicate problems, and who to call if the symptoms get worse. They make sure patients understand what medications they are to take and how to take them.

"Very often patients have medication at home and get a new prescription when they leave the hospital and don't know which to take. By being in the home, the nurses can compare the medication list that patient got upon discharge with the medication the patient is taking and communicate with the doctor to make sure the patient takes the right medication," he says.

Since Medicare patients often are vulnerable to falls and other accidents, the nurses conduct an assessment of the home to make sure the patients' living situations are safe and arrange for equipment, such as grab bars in the shower, or advise patients or family members to make changes, such as removing throw rugs.

After the initial home visit, the nurses contact patients by telephone at intervals that depend on the patients' conditions, and may visit the patients in the homes again or accompany them to doctor visits. They contact the patients' primary care physicians to let them know what is going on with the patients and to alert them to any problems.

The pilot program resulted in significant improvements in functional status, depression symptoms, self-reported health, and quality of life, as well as saving money, Krakauer says.

For more information on the Transitional Care Model, visit: www.transitionalcare.info. ■

EXECUTIVE SUMMARY

Aetna's pilot project that includes home visits for at-risk patients has cut readmissions by 20% over and above the 23% already achieved by case management.

- Advanced practice nurses visit the homes of at-risk Medicare Advantage patients within seven days of discharge.
- The nurses complete an assessment to determine the patient's needs, set up needed community resources, and educate the patients on their treatment plan.
- They follow up by telephone and in person and communicate what's going on with the patients' primary care physicians.

Ensure a smooth transition to rehab

Patients must be stable, ready for therapy

To prevent readmissions when patients are transitioning from the acute care hospital to an inpatient rehabilitation center, case managers should make sure the patients are appropriate for acute rehab, that their medical conditions are stable, and that they can tolerate three hours of therapy every day.

There are a number of factors that may result in patients returning to the acute care hospital or being transferred to the emergency department for evaluation and treatment, says **Lori S. Aylor**, BSN, MSN, CRRN, chief nursing officer, at UVA-HealthSouth Rehabilitation Hospital, a 50-bed inpatient rehabilitation hospital in the University of Virginia Health System in Charlottesville.

Communication is a key component of successful transitions, and making sure that the receiving facility has a detailed and complete discharge summary can help avoid an emergency room visit or readmission, adds **Karion G. Waites**, DNP, RN, CRRN, BS-FNP, nurse practitioner at Spain Rehabilitation Center, a 47-bed inpatient rehabilitation hospital that is part

of the University of Alabama at Birmingham Health System.

When patients are being transferred, make sure your documentation is complete, legible, and, in addition to details on medical issues, includes information about the patient's behavior at different times of the day during the last few days in the hospital, Aylor and Waites suggest.

For instance, if the patient gets agitated and confused at night and the discharge summary doesn't mention any problems, the rehab staff are likely to send the patient back to the emergency department to rule out any additional medical issues, such as a stroke.

When you gather the hospital records to send to rehabilitation, include any information you have on family dynamics, particularly if the family members are anxious, if the patient doesn't have a good support system, or if a caregiver might do something harmful, such as wanting to do everything for the patient during rehab.

Here are some other tips for making sure patients will have a successful transition to rehabilitation:

• If patients have had an amputation, make sure they have an ultrasound to check for clots and remain in the hospital until they no longer need bed rest. "We can work with an anticoagulation regimen, but we don't want to keep patients in bed for several days. If bed rest is indicated, we send them back to the acute setting," she says.

• If the patient's Foley catheter is removed before the patient is transferred, make sure he or she has voided and that it is documented in the medical record.

• Make sure patients are up on their pain medications so they don't arrive in a lot of pain. If patients take medication that requires food, the hospital should either back off the medication before transfer or give them something to eat. "It takes time for the rehab hospital to get orders in place after the patient arrives," Aylor says.

• Transition patients from IV pain medication to oral medication before transferring them to rehab to make sure they can tolerate pain when they start moving around. Heavy doses of pain medication can make patients drowsy and increase the risk of falls or they may become constipated, experience bowel blockage or become nauseated and not able to participate in rehab.

• See to it that patients have gotten out of bed and built activity tolerance before the move to rehab. Otherwise, they may be completely fatigued by the transfer itself and the rehab facility may send them back.

• Keep patients in the acute care hospital until their bed sores or fractures of weight bearing limbs have time to heal. They won't be able to participate in rehab if they can't bear weight or sit up comfortably.

Patients who are experiencing atrial fibrillation, unstable vital signs, or elevated blood pressure may not tolerate a transfer well. Patients with infections or poorly healing wounds may have an underlying medical condition that will inhibit their ability to tolerate rehab. Patients who need long-term IV antibiotics or frequent blood draws are not suitable for rehab.

Patients on two liters of oxygen may be able to tolerate rehab, but it is cumbersome to drag an oxygen tank to therapy. "If patients still need three to four liters of oxygen at rest, they won't be able to maintain proper saturation when they exercise," Waites says.

Editor's note: Lori S. Aylor, BSN, MSN, CRRN and Karion G. Waites, DNP, RN, CRRN, BS-FNP are members of the Association of Rehabilitation Nurses. For more information, see www.rehabnurse.org. To read their article on improving the transition between acute care and rehab, visit http://www.rehabnurse.org/uploads/files/pdf/pr_readmissions_article.pdf. ■

EXECUTIVE SUMMARY

Patients who return to the acute care hospital after rehab often did not meet criteria for acute rehabilitation services.

- Provide detailed documentation in the discharge summary, including information on the patient's behavior and mental status at different times of the day.
- Make sure patients are medically stable and can tolerate three hours of rehab a day.
- Don't transfer patients until they have transitioned from IV to oral pain medication and make sure they are up on their meds before transferring.

ED flow facilitators make throughput center stage

Position frees nurses to oversee core measures

On any given day, the ED at Mercy Hospital in Springfield, MO, has two zone captains acting as mini-charge nurses, for the east and west sides of the department. There is also an

up-front triage nurse who is the first person most patients see when they walk in the door, and a lobby nurse who regularly rounds through the waiting room, taking vital signs and monitoring patients who have yet to see a provider.

These types of personnel are common to many busy EDs, but in the fall of 2010, ED staff decided the department needed someone who could focus all of his or her energy on throughput. Yearly volume at the time was 93,000, but it was rising rapidly along with the left-without-being-seen (LWBS) rate, which was hovering in 8% territory at the time.

Administrators decided to put the problem in the hands of front-line staff to resolve, believing they had the best understanding of the issues involved. Consequently, the staff created a new position with the formal title of "ED flow facilitator," although they often use different terminology, referring to person filling this position as the "bed wizard."

Look for good multi-taskers

"The role of the bed wizard or ED flow facilitator is to monitor the in-and-out throughput on each zone, and she also takes charge of ambulance calls," explains **Ted Shockley**, RN, CNRN, administrative director of the Emergency Trauma Center at Mercy Hospital Springfield. "We have anywhere from 60 to 80 ambulances that arrive between 11 a.m. and 11 p.m. every day."

The ambulances were getting to be too much to handle at the triage desk, so it made sense to couple this task with the overall responsibility of managing flow, adds Shockley. "The flow facilitator assigns patients, so her main job is to watch the flow of patients coming in through the waiting room to each zone, and to try to distribute the flow as equally as possible."

While the zone captains coordinate with the flow facilitator, they focus on managing their respective areas, facilitating tests, taking in new patients, and getting patients discharged or admitted. "On rare occasions, the flow facilitator will take in a new patient," says Shockley, but he stresses that the ED tries to avoid that because it takes the focus off of throughput. "As soon as she gets bogged down with patients, the whole team kind of slows down."

Meanwhile, the charge nurse is able to oversee the entire department, focusing on core measures, quality assurance, and staffing. "They look several shifts down the line and make sure we are not short somewhere because doing a schedule for 200 people is tough," says Shockley. "They concentrate on functional, departmental issues and the flow facilitator does throughput."

The most challenging aspect of the job is finding space for higher acuity patients when the ED or hospital is overwhelmed, according to **Gayla Reynolds**, RN, one of the ED's flow facilitators. This is the boarding issue that affects many EDs, and is associated with poor ED flow. "A typical bottleneck is when people have been seen and admitted, but the hospital has no beds or is waiting on discharges," says Reynolds. To resolve the problem, flow facilitators usually call a hospital supervisor, who can then take steps to speed up the discharge process, she says.

What type of person makes a good flow facilitator? "They have to have a deep understanding of throughput, and generally we use nurses who have been here a while," explains Shockley. Some of the flow facilitators would make good supervisors, but many prefer to stay involved with nursing care, he adds. "They may work as a flow facilitator two days a week, and then the other days of the week they will be a general nurse. They like that mix."

Reynolds adds that flow facilitators need to be able to multi-task, and to be "willing to get their hands dirty," if need be, cleaning beds, or whatever is necessary to keep the patients moving. "It can be highly stressful, so flow-facilitators must be able to remain professional and to keep things in perspective," adds Reynolds.

For solutions, listen to staff

The home-grown position has clearly delivered. Within months of implementing the flow facilitator position, the LWBS rate declined to the 3% to 5% range, and there were also slight declines in length-of-stay and door-to-bed placement times, says Shockley, but he notes that managing volume remains a challenge as the daily census continues to climb. "We treated 95,740 patients last year, and we are now on track to see 97,000 or maybe even 100,000 this year," he says. "We had one day not long ago when we had 31 walk-in patients in one hour, and I only have 45 rooms."

Other busy EDs could definitely benefit from the use of patient flow facilitators, says Shockley, but he emphasizes that each ED needs to fashion a solution that fits its own circumstances, and it is critical to stay on top of patient use patterns. "You can't do the same staffing pattern when your patient patterns change," he says. "We look at [our numbers] at least quarterly, if not more," he says.

Shockley also advises ED administrators to look to their front-line staff for solutions when trying to

improve a process. "Sitting back in this office from the 30,000 mile mark, I don't know all the details," he says. "The staff came up with the idea for a patient flow facilitator, and it is working quite well."

SOURCES

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Patient flow, boarding standards strengthened

Responsibility is pushed up chain of command

As demand for emergency care continues its upward climb, The Joint Commission is taking steps to strengthen its accreditation standards pertaining to patient throughput, and it is putting hospital leaders on notice that they will be held accountable for patient flow challenges that occur in the ED.

Under revisions to Standard LD.04.03.11, it will soon no longer suffice for hospitals to simply measure elements of patient flow. Hospital leaders will also have to use this data to set goals for improvement, explains **Jeannie Kelly**, RN, MHA, LHRM, an expert on risk management and quality assurance at Soyring Consulting in St. Petersburg, FL.

"This involves setting goals and reporting them up to leadership so that the CEO, COO, and CNO all know what is going on, and they are charged with making sure that [problems] get fixed," Kelly says. "In the past, [the requirements] never went up that high. Managers had to be aware of what was going on, but now The Joint Commission has really pushed it up the chain of command to hospital leadership, and I think that is very important because they are the ones with the power to make things happen."

Further, The Joint Commission has expanded the standard to include all areas where patients receive care, treatment, and services, including inpatient units, laboratory, operating rooms, telemetry, radiology and PACU, as well as support services such as housekeeping and patient transport, Kelly says. "This allows department managers and leadership to identify issues that impact patient throughput," she says. "Hospital leadership must take action to ensure that barriers, whether real or imagined, are removed so that patients are either admitted or transferred as appropriate."

Kelly suggests that data associated with the patient flow process could be part of the hospital's Quality Assurance and Performance Improvement (QAPI) plan. "This provides a ready-made platform for performance measurement and evaluation," she says.

Boarding: Safety needs to be the priority

The Joint Commission has also revised Standard PC.01.01.01, which covers the issue of behavioral health patients who present for care to the ED, and the common practice of boarding these patients in the department while other care arrangements are made.

The revisions state that hospitals that do not primarily provide psychiatric care or substance abuse services must have a written plan of care that "defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse." And the agency recommends that patients should not be boarded for longer than four hours.

Further, the revisions spell out specific standards that need to be met when behavioral health patients are boarded while awaiting care. "Patients with behavioral issues should be monitored in a safe area that is clear of items that the patient could use to harm himself or others," says Kelly. "Also, patients need to be medically stabilized before transfer. Psychiatric issues can be caused or exacerbated by medical conditions. Failure to properly medically assess patients can lead to negative outcomes, including EMTALA violations."

Kelly acknowledges that meeting these standards will be challenging, as most EDs are not physically set up to monitor patients with behavioral health or substance abuse issues for an extended amount of time. "[Hospital administrators] are going to have to start looking at where these behavioral health patients are going to be held while they are awaiting transfer," she says. "And they are going to have to look at it from the point of view of safety."

Revisions will assist over-burdened EDs

Sue Dill Calloway, RN, CPHRM, AD, BSN, MSN, JD, president, Patient Safety and Health Care Consulting, Dublin, OH, and chief learning officer, Emergency Medicine Patient Safety Foundation, based in Folsom, CA, believes the revised standards

will help to provide ED administrators with the kind of support they need to resolve patient throughput problems. "It is not an ED problem, it is a hospital problem," says Calloway. "So hospital leaders need to be doing studies and coming up with ways to mitigate problems with patient flow."

Calloway notes that the leaders of all the major emergency medicine organizations recognize hospital overcrowding and the practice of boarding patients in the ED as among their top challenges. However, she stresses that many of these problems require system-level solutions.

"I was visiting a hospital that had a six-bed ED hold that was staffed not by ED staff, but behavioral health staff," she says. "Leadership needs to do that. The ED can't do that alone."

In another instance, hospital leaders stepped in with a creative solution for an ED that had 20 boarded patients. "They decided that they would put one of these patients on every unit," she says. "It was a lot more manageable to have one additional patient on each unit than it was to have 20 sitting around the ED, so again, that was a leadership solution."

SOURCES

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How mobility can shorten stay, improve outcomes

Organization started by defining mobility

Every now and then at Sunnybrook Health Sciences in Toronto, Canada, there was talk about getting ventilated patients up and about even if they were still intubated. Some people thought that the patients should be weaned off the ventilator first, some thought after, says **Linda Nusdorfer**, RN, MSN, an advanced practice nurse for critical care and cardiovascular care at the facility. Still others wanted to work on weaning and mobility at the same time. But what did mobility mean? Is it passive range of motion exercises or walking?

"We would have these quality walkabouts every month, and once, we spent it asking nurses for the definition of mobility," she explains. "One of the answers was that it was using a lift to put a patient in the chair."

The idea of improving mobility — and the way caregivers thought of it — burbled along without resolution until 2011, when Nusdorfer and her colleague **Angie Jeffs**, RN, MSN, the patient care manager for critical and cardiac care, attended an Institute for Healthcare Improvement conference. "It was inspiring," Jeffs says. "When we were trained in the 1980s, we were taught to sedate ICU patients as much as possible. We were told they wouldn't want to remember they were here, and besides we should rest their lungs."

The IHI conference gave the women and the others from Sunnybrook added information and the confidence they needed to try to do something different — to get the patients up and moving as soon as possible. The potential benefits included less time being intubated, less delirium, reduced DVT risk, less potential for bed sores, and better patient and family satisfaction. "The families like to see the progress," Nusdorfer says. "The patients like to be up and around." Although there is not proof yet, she thinks they may even have a reduced rate of ventilator-associated pneumonia (VAP) because the patients spend less time horizontal, less time intubated, and have a greater degree of muscle strength that helps them clear their lungs.

Once they got back to Sunnybrook, Jeffs says they were a little overwhelmed with how to convince their peers that this was a good idea. "We chose our first candidates carefully, to make sure that they were stable," she says. "But we saw at the conference that this could be done, so we moved forward."

Two nurses, a physical therapist, a respiratory therapist, and Jeffs and Nusdorfer met regularly and started to go out as a team to identify likely candidates. "We talked to the physicians on rounds about getting people up, as well as other nurses and therapists." While the physicians were all for it, there was resistance from some nurses and therapists. "They wanted to take it slowly," Nusdorfer says.

For instance, there might be a patient in a collar who a physicians says can tolerate mobility, but somehow, it would never get done, Nusdorfer says. "PT would have to take the bull by the horns and just get that patient up." Or a patient would be up in a chair, and the nurses would argue that they were mobile, but they were being lifted into the chair mechanically. They were not using their own muscle power to do anything.

Leading by example

Having a nurse manager there to help with education was key in convincing recalcitrant people to take this chance. "We led by example," Nusdorfer says. "And then, once they saw it could be done, and the benefits that accrued to the patients, they were much more interested in getting on board." They also noted successes in a very public way — taking pictures of walking patients, celebrating the first walk down the hall, or even sitting up in a chair for the first time. They take videos of patients, and every couple months when a new batch of residents cycles through the ICU, they do an in-service education module to dismiss the myth that ventilated patients can't be mobilized.

Whenever anyone suggested that they were willing, if only there was a team that could put the idea into place, Nusdorfer informed those staff members that they were the team. "They had the best knowledge of the patient, not some group of outsiders. They were best placed to coordinate this."

Not just any patient is pulled out of bed for a saunter through the ward. Nusdorfer says they use a safe mobility tool to assess the level of consciousness in a patient, which helps determine the level of activity appropriate for the patient. It might be that one patient can dangle but isn't ready to sit in a chair, while another one, who is so soon out of surgery you don't think he or she would want to do anything but moan in bed, is raring to get up and move.

There is a database collecting pertinent information, including when is the patient medically stable, whether the patient was mobilized within 24 hours of admission or of being deemed medically stable (the definition of early mobilization), intubation data, mode of ventilation, how much oxygen the patient was on at the time of early mobility, progression of mobility from passive range of motion to walking. They look at the resources used when walking — one nurse, two nurses, PT, RT, aide, family member, any tube losses during mobilization (to date there have been none). They are looking at whether there were any pressure ulcers at admission and on discharge, delirium rates, sedation, and restraint use.

Jeffs says a year ago, a delirious patient would have been restrained. Now, the first thing they do is get them up and moving. "The staff really sees the benefits of that." She also says they note how much more alert patients get just from sitting up. "All of a sudden their eyes get wide. It's almost like there is this synapse [that] wasn't connecting, and now it's on by helping them move." They notice, too, that the patients who are moving more are sleeping better and move more easily back into a regular routine.

Nusdorfer says they are doing a chart review now of a period from before they implemented the early mobilization program about 15 months ago so that they can compare things like pressure ulcer rates.

"Our slogan is 'Time is Muscle,'" she says. "You hear it as a cardiac phrase, but we should remember it's true for all muscle in the hospital."

RESOURCES

For more information on this topic, contact:

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COMING IN FUTURE MONTHS

- Helping heart failure patients stay out the hospital
- Managing the care of uninsured patients
- Opportunities for case managers in the military
- Providers, health plans collaborate on patient care

CNE QUESTIONS

1. According to Randall Krakauer, MD, national medical director for Aetna, many readmissions are the result of a breakdown in processes after patients are discharged from the hospital.
   A. True
   B. False

2. Kaiser Permanente came up with six steps to a successful transition between levels of care. Which was NOT a step in their process?
   A. Improving communication with post-acute providers.
   B. Follow-up appointments and phone calls.
   C. Home visits after patients are discharged.
   D. Standardized medication reconciliation process.

3. How soon after discharge does Aetna send advanced practice nurses into the homes of discharged patients?
   A. Within two days.
   B. Within seven days.
   C. Within 10 days.
   D. Within 30 days.

4. According to rehabilitation hospital nurses, why are patients returned to the acute care hospital shortly after they arrive at rehab?
   A. They act confused and there is nothing to indicate the cause in the discharge summary, so the rehab hospital wants to rule out a stroke or other complication.
   B. Bed rest is indicated for patients who have had an amputation.
   C. Patients have bed sores or fractures of weight bearing limbs that hinder their participation in rehab.
   D. All of the above.

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 e-mailed to you instantly. ■