What the World Needs now . . .

Margaret E. Reidy M.D.
November 2015

...IS MORE REHAB!
What the World Needs Now...Our Role in the Changing Healthcare Environment
Margaret Reidy, MD

CFAR 1979
FIM 1984
UDSMR 1987
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The get my life back Institute.

Read Brittany’s Story
Health Care in 2015: Themes

• **Moving from volume to value**
  – Value Based Purchasing
• Better science
  – Evidence Based Pathways
• Measurement of outcomes
  – Development of measures
• Avoidance of complications of care
  – Never events, HACs and PSIs
• Shared decision making
  – Informed consent
  – Family/ support system involvement
• Patient responsibility
  – Health literacy
  – Directing own care

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Scenario : The volume story

• Mrs. B is a 72 yo female who has been seen by her PCP for COPD. She goes to a family picnic and has an episode of wheezing. She is taken to the ED and needs to be admitted. The hospital is full, but a patient on a med surg unit is awaiting discharge. Mrs. B waits on a gurney in the ED for 4.5 hours until the room is ready in the evening. Upon arrival to the unit, no one asks Mrs. B about meals. There is a nurse-to-nurse report from the ED but no bedside report, as patient is new to unit and arrives after shift change. She remains in bed the rest of the night. Nursing is awaiting SCD sleeves to come from Central.
  • The next day Mrs. B complains of severe leg pain, and is diagnosed with DVT.
Case Review – What went wrong?

The patient waited too long in the ED. What was the hold up with the room?

The patient did not receive a meal.

There was no handoff involving the patient.

SCDs were not applied. Who checked to see why the SCDs weren’t on? Did anyone assess the patient throughout the night? Where’s the documentation?

Patient was never mobilized. Did the patient get to the bathroom or have a catheter?

The patient’s basic needs were not met. We must provide exceptional safe, quality care along with a more caring, personal touch.

We are uniquely trained to assist hospitals in this move from volume to value.

• Rehabilitation physicians are medical doctors who have completed training in the medical specialty of physical medicine and rehabilitation (PM&R). Specifically, rehabilitation physicians:
  – **Restore maximum function** lost through injury, illness or disabling conditions
  – **Treat the whole person**, not just the problem area
  – **Lead a team** of medical professionals
  – Provide **non-surgical** treatments
  – **Explain** your medical problems and treatment/prevention plan
  – **FIM**

» AAPMR
Why do these things sound familiar? Explain Care

• **Doctors need to work on their people skills.** It's something patients have grumbled about for a long time. Doctors are rude. Doctors don't listen. Doctors have no time. **Doctors don't explain things in terms patients can understand.** It's a familiar litany. But here's what is new: The medical community is paying attention. **That lack of communication, after all, isn't just frustrating for patients. It can hurt the quality of care, drive up costs and increase the risk of lawsuits.** And under new Medicare rules, providers won't get as much money if they rack up poor patient-satisfaction scores or too many preventable readmissions. So, medical schools, health systems, malpractice insurers and hospitals are trying to help doctors improve their bedside manner.

Why do these things sound familiar? Non-surgical care

• **Comparative Effectiveness**
  – Comparative effectiveness research, when utilized by medical decision makers, has the potential to reduce overutilization of procedures and services and avoid use of unnecessary or unproven medical services. When there are no alternatives, studies should determine if a procedure is clinically effective. **Savings result if the research prompts use of less costly services that achieve comparable outcomes. Cost savings are also possible by preventing avoidable adverse outcomes.**
The incorporation of multiple perspectives in health care offers the benefit of diverse knowledge and experience; however, in practice, shared responsibility without high-quality teamwork can be fraught with peril. For example, “handoffs,” in which one clinician gives over to another the primary responsibility for care of a hospitalized patient, are associated with both avoidable adverse events and “near misses,” due in part to inadequacy of communication among clinicians.

In addition to the immediate risks for patients, lack of purposeful team care can also lead to unnecessary waste and cost.

Given the frequently uncoordinated state of care by groups of people who have not developed team skills, it is not surprising that some clinicians report that team care can be cumbersome and may increase medical errors.

By acknowledging the aspects of collaboration inherent in health care and striving to improve systems and skills, identification of best practices in interdisciplinary team-based care holds the potential to address some of these dangers, and might help to control costs.

Why do these things sound familiar? Team Based Care

• Take a broader perspective than illness. Instead of solely focusing on illness and activity-based services, the health care system should focus on wellness and outcomes, placing a greater emphasis on preventative or public health services that primary care physicians can provide at the community level. This also requires a shift away from a disease based paradigm to a holistic health paradigm that values social and behavioral care. To accomplish this objective, policy makers can: realign funding streams, establish outcomes relevant for all stakeholders, foster data transparency and interoperability, create team-based care, increase competitiveness and define treatment protocols.

» Brookings Institute

Why do these things sound familiar? Holistic Care
Why do these things sound familiar?  
Focus on Function

- You know, the idea that just because you can't walk anymore or you can't eat the food you used to eat, that therefore you don't have a contribution to make or you can't be the leader of your own life? That *is* depressing. And I think the existence of places and people who are showing you how it's possible to be otherwise is incredibly helpful. But it's still only a minority of what's available. It doesn't cost more. It's mostly about changing what our goals are. It's focusing on helping people achieve the priorities that are most important in their lives. And that's what I want when I'm older.

  » Gawande

What do health systems need?
### Major Milestones in Health Care Reform Implementation

<table>
<thead>
<tr>
<th>Year</th>
<th>Coverage Expansion</th>
<th>Financing</th>
<th>Delivery System Reform</th>
</tr>
</thead>
</table>
| 2010 | • Coverage for non-dependent children through age 26  
• Prohibition on denying coverage for children with pre-existing conditions  
• Small business subsidies to provide coverage to employees  
• High-risk pools for those denied coverage  
| • Tanning salon tax takes effect  
• Productivity and market basket adjustments to DRG updates  
| • Patient-centered outcomes research  
• Community transformation grants  
• Gainsharing, global payment demos  
• Hospital Value-Based Purchasing  |
| 2011 | • Five-year opt-in long-term care program begins  
| • Medicare Advantage payments restructured  
| • Center for Medicare and Medicaid Innovation launched  |
| 2012 | • Payments to primary care physicians takes effect  
| • First industry fees take effect  
• Medicare Advantage bonuses take effect  
| • Medicaid Shared Savings Program (A50s)  
• Hospital Readmission Reduction Program  
• Independence at Home demo  |
| 2013 | • Health Benefit Exchanges created  
• Individual, employer mandates take effect  
• Medicaid expanded to 133% of FPL  
| • New Medicare tax takes effect  
• Passive income tax takes effect  
• Excise tax on medical devices takes effect  
| Bundled Payment pilot begins  |
| 2014 | • Individual, employer penalties take effect  
• DSH payment adjustments take effect  
| Independent Payment Advisory Board begins submitting recommendations  |
| 2015 | • Payment adjustment for hospital-acquired conditions takes effect  
| 2016 | • Individual, employer penalties rise  |
| 2018 | • Excise tax on “Cadillac” health plans  

**Reduce Readmissions**  
**Hospital Acquired Conditions**
### We Are All Accountable Now

**Future Hospital Reimbursement More Closely Tied to Performance**

<table>
<thead>
<tr>
<th>Payment Driver</th>
<th>Description</th>
<th>Payment Reduction Timeline</th>
</tr>
</thead>
</table>
| Value-based Purchasing Program  | • Mandatory pay-for-performance program assessing 20 quality, satisfaction metrics  
                                 | • Percentage of hospital inpatient payments withheld, earned back based on quality performance | • Withholds begin at 1% in 2013, grow to 2% by 2017                                         |
| Hospital Readmissions Reduction Program | • Hospitals with greater than expected readmission rate subject to financial penalty  
                                          | • Performance based on 30-day readmission metrics for 3 conditions in 2013, expanding in 2015 to include 4 others | • Penalties capped at 1% of total DRG payments in 2013, 2% in 2014, and not to exceed 3% in 2015 and beyond |
| Hospital-Acquired Condition (HAC) Penalty | • Hospitals in bottom quartile of performance relative to national risk adjusted average are subject to financial penalty | • 1% penalty deducted from DRG payment starting in 2015                                     |

- Not just Medicare mandate
- Private payers are accelerating payment innovation

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### CMS Hospital P4P – VBP Patient Care Domain Weight Shift

**FY 2013**

- HCAHPS 30%
- Process Measures 70%

**FY 2014**

- Outcomes 25%
- Process Measures 45%
- HCAHPS 30%

**FY 2015**

- Efficiency 20%
- Process Measures 20%
- HCAHPS 30%
- Outcomes 30%

**FY 2016**

- Process Measures 10%
- Efficiency 25%
- Outcomes 40%
- Patient Experience of Care 25%

**FY 2017**

- Safety 20%
- Efficiency and Cost Reduction 25%
- Clinical Care 30%
- Patient Experience & Care Coordination 25%

Reimbursement Impact:
- FY13 – 1%
- FY14 – 1.25%
- FY15 – 1.50%
- FY16 – 1.75%
- FY17 – 2%
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CMS Hospital P4P – VBP FY17 (Performance Period NOW!)

1 AMI:
- Fibrinolytic therapy w/in 30 minutes of arrival
1 IMMUNIZATION:
- Influenza vaccine
1 Perinatal*:
- Elective delivery

Performance Period: 01/01/15 – 12/31/15

3 Mortality:
- 30-Day AMI
- 30-Day HF
- 30-Day PN

Performance Period: 10/01/13 – 06/30/15

An asterisk (*) indicates a newly adopted measure or domain for the Hospital VBP Program

Emphasis on the patient experience of care
Where should hospitals focus attention?
The science of suffering.

<table>
<thead>
<tr>
<th>Sources of Suffering</th>
<th>Unavoidable (Providers’ goal: mitigate)</th>
<th>Avoidable (Providers’ goal: eliminate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asssociated with diagnosis</td>
<td>Associated with treatment</td>
<td>Associated with health care delivery system dysfunction</td>
</tr>
<tr>
<td>Symptoms of disease (including pain)</td>
<td>Post-operative pain</td>
<td>Unnecessary pain resulting from failure to identify and treat the source.</td>
</tr>
<tr>
<td>Loss of functioning (temporary or permanent)</td>
<td>Loss of functioning (temporary or permanent)</td>
<td>Hospital-acquired conditions</td>
</tr>
<tr>
<td>Fear or anxiety arising from the implications of the diagnosis for health and functioning</td>
<td>Fear or anxiety regarding outcomes of treatment</td>
<td>Fear or anxiety resulting from lack of coordination and teamwork, lack of respect shown to patient, and loss of trust in providers.</td>
</tr>
<tr>
<td>Fear or anxiety due to unfamiliar processes, disruption in daily life, and loss of control.</td>
<td>Side effects</td>
<td>Unnecessary visits</td>
</tr>
</tbody>
</table>

Thoughtful attention to Pain Management
Mobility
Expectation Management
Pharmacy and Dietary Interventions
Hand Hygiene and Infection Control
Care Coordination
Capacity Management
The basics: underpinning evidence with great care

Common Metrics: Unit-based Score Cards
- What you can measure you can manage

Care coordination
- Ideally avoids hospitalization but for elective hospitalization, starts in the prehospital space
- Involves patient, OP office nurse or IP bedside nurse, IP or OP CM and provider in conversation
- Needs to be tailored to surgical, procedural and independent practitioners’ needs
- Needs to consider arc of an episode of care overlying continuity of ongoing chronic management.
• Mobility
  – All patients screened and triaged
  – How do we assure patients are being moved as directed?
  – How do we maintain training in mobilizing patients?
  – Same measure IP, HHC, HP (NOT IPR!)
  – How can we involve families and patients themselves?
• Nutrition (Aspiration Prevention)
  – Same design as mobility
  – Move into pre-operative/pre-procedural space
  – Same measure for all settings
• Sleep (Delirium Avoidance)
  – Rest Assured
  – Timing of Lab draws
  – Engage and involve family

• Communication
  – Consents
    • What are we consenting to? Procedure or all options?
    • Education before elective admission
    • Age specific additions to consents
    • Periodic review of consent content by owners
  – Family meetings
    • IN all ICUs
    • Others? Age groups? Frequent readmissions?
  – Appropriate use of less aggressive interventions
    • Cardiology and CT surg in Heart and Vascular Care
    • Rehab and Ortho, Neurosurg in Spine
  – Appropriate use of Palliative and Supportive Care
  – Effort to move these conversations into the PCP office
Three stories

- Care Coordination
- Mobility
- LUHU

Care Coordination
“We’d like to start out being very involved with you but eventually be drawn away to much more interesting cases down the hall.”

Day in the Usual Life of a Provider

Multiple caregivers, sometimes multiple floors

The MD

CM 8
CM 3
CM 7
CM 5
CM 1
CM 4
CM 10
CM 11
CM 12
CM 13
CM 14
CM 15
RN 1
RN 2
RN 3
RN 4
RN 5
RN 6
RN 7
RN 8
RN 9
RN 10
RN 11
RN 12
RN 13
RN 14
RN 15
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Day in the Usual Life of a Bedside Nurse

Discharge Work Observed By Role

<table>
<thead>
<tr>
<th>CM</th>
<th>PCL</th>
<th>PNCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk to patient/family</td>
<td>Admission Med Rec</td>
<td>DC instructions w pts</td>
</tr>
<tr>
<td>Admission/continued stay reviews</td>
<td>Determining PCP and where fill scripts</td>
<td>Puts in HC orders and updates HC</td>
</tr>
<tr>
<td>Freedom of choice form</td>
<td>DC order/depart</td>
<td>Gets prescriptions filled at Falk</td>
</tr>
<tr>
<td>Initiates referrals</td>
<td>Order entry</td>
<td>Documentation: IPOC’s</td>
</tr>
<tr>
<td>Arrange transportation</td>
<td>Arrange t/u appts</td>
<td>POLST</td>
</tr>
<tr>
<td>PASS-R form</td>
<td>HC orders</td>
<td>Coordinate PT “priority visits”</td>
</tr>
<tr>
<td>iMM form</td>
<td>Progress notes</td>
<td>Pulls IV’s</td>
</tr>
<tr>
<td>Get phone/fax numbers for receiving facilities</td>
<td>Prior auths for meds</td>
<td>Communicates with MD’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SW</th>
<th>Bedside Nurse</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk to patient/family</td>
<td>Gives medications</td>
<td>Discharge med rec.</td>
</tr>
<tr>
<td>Initiates referrals</td>
<td>Documentation, incl IPOC’s</td>
<td>DC Order/depart</td>
</tr>
<tr>
<td>Arrange transportation</td>
<td>Gets updates from MD, PNCC, and UD about patients</td>
<td>Order entry</td>
</tr>
<tr>
<td>PASS-R form</td>
<td>DC instructions w pts</td>
<td>Scripts</td>
</tr>
<tr>
<td>iMM form</td>
<td>Pulls IV’s</td>
<td>HC orders</td>
</tr>
<tr>
<td>Connects w patients and families</td>
<td>Calls report</td>
<td>Progress notes</td>
</tr>
</tbody>
</table>

purple indicates a task that can be done by multiple people
Clown Car Discharge!

Patient Centered Observations

Key for the flows on next slides

Work OUTSIDE a patient’s room

Work INSIDE a patient’s room
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Ideal Design for Care

“Core Care Team”
- Lean care team the patient sees
- AM round together in pt room
- PM touch base huddle
- Continuity from day to day
- Gets help from consulting care team as needed

“Consulting Care Team”
- Involvement as requested by core care team
- May or may not interface with patient
- Clinical Resource Specialist expedites/facilitates clinical care and allows bedside RN to have uninterrupted time with patients

Clinical Resource Specialist

MD/CRNP/PA

Care Coordinator

Bedside RN

PharmD

MSW

HUC

PCTs/PSTs

And others...

UPMC Life Changing Medicine
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Highlights of Change Package

- Daily multidisciplinary rounds at the bedside
  - Patient-centric
  - Shared decision making
  - Critical concept: equity of voice among team
- Decisions made during rounds
- Orders entered during rounds
- Central role of bedside nurse
- Shifting of tasks to promote working to scope
- Clear delineation and accountability for work
- Design of a designated “help chain” for the team
- Strategic bedding of patients
- Linking patient/nursing assignments to care management and provider models

Surprises

- Nurses, trainees, attending and others uncomfortable speaking with one another, and in front of patients and families
- Reluctance to correct one another
- Lack of awareness of others’ roles
- Reluctance to be IN ROOM
- Resistance to change
- Lack of awareness of the importance of communication and planning
- Ignored the “expert” in the room
- Importance of geographics
- Importance of data
## Elements of MDR

- Introduce team members *every time* (Name and Role)
- Ask each team member if they have additional information (Nurse John: Any issues overnight?)
- Insure all of HCT on same page regarding care and discharge plan
- Verify patient/family understanding of care
- Engage patients in rounds
  - Stand around bed
  - Eye contact and conversation *with* patient
  - Assess patient understanding
- Address patient concerns
- Reassure patients we work as a team
- Patient hears same story
- End rounds asking patient if they have questions
6th Annual Current Concepts in Brain Injury Rehabilitation

*What the World Needs Now...Our Role in the Changing Healthcare Environment*

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**Day in the Life of a Provider in Care Coordination**

- MD
- Care Manager
- Others as appropriate (SW, Pharmacist, etc)
- RN 1
- RN 2
- RN 3

**Day in the Life of a Nurse in Care Coordination**

- RN
- MD/APP
- CM
- Others as appropriate (SW, Pharmacist, etc)
### Outcomes: Team views

- 70% staff believe team communication has been improved
- 62% staff believe patient communication has been improved
- RN comments: “I feel I am a better nurse because of the model. Everyone knows the plan and I have time to educate my patients.”
- Teams have had to script rounds to increase discussion. “Voice” needs to be nurtured.

### Outcomes: communication and efficiency

- Reduction in MD pages from 30 to <12
- 70% of orders entered by end of rounds
- More time for meaningful clinical dialogue
- More time for patient / family teaching
Outcomes: Cost

- Better resource utilization and time management
- 11 physician teams reduced to 9
- Redeployed 6 patient care liaisons to outpatient roles
- 2 RN’s redeployed as discharge nurses
  - Ability to focus on important aspects of the patient’s transition
- Increase in meds passed by 9a: from 52 to 85%
  - Reduction in non-valuable work

### Phased Implementation Units

<table>
<thead>
<tr>
<th>Units Live with Care Coordination Beginning 2013 to present</th>
<th>CY 2013 Q 1</th>
<th>CY 2013 Q 2</th>
<th>CY 2013 Q 3</th>
<th>CY 2013 Q 4</th>
<th>CY 2014 Q 1</th>
<th>CY 2014 Q 2</th>
<th>CY 2014 Q 3</th>
<th>CY 2014 Q 4</th>
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<tbody>
<tr>
<td>7G</td>
<td>62.0</td>
<td>67.1</td>
<td>63.3</td>
<td>64.6</td>
<td>61.9</td>
<td>69.3</td>
<td>64.5</td>
<td>62.6</td>
</tr>
<tr>
<td>8N 10E/W 10S 12S</td>
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<td>MICU</td>
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<tr>
<td>10D/G 7F 9G 12D</td>
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<td></td>
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<tr>
<td>3E 4D 5D</td>
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<tr>
<td>11N 12N 9N</td>
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</tbody>
</table>

**HCAHPS**

<table>
<thead>
<tr>
<th>Rate Hospital %</th>
<th>62.0</th>
<th>67.1</th>
<th>63.3</th>
<th>64.6</th>
<th>61.9</th>
<th>69.3</th>
<th>64.5</th>
<th>62.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend Hospital %</td>
<td>68.0</td>
<td>66.8</td>
<td>67.5</td>
<td>65.7</td>
<td>67.7</td>
<td>67.6</td>
<td>68.2</td>
<td>72.3</td>
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<tr>
<td>Comm w/Nurses %</td>
<td>71.2</td>
<td>74.7</td>
<td>76.1</td>
<td>74.1</td>
<td>72.6</td>
<td>78.9</td>
<td>75.8</td>
<td>79.1</td>
</tr>
<tr>
<td>Comm w/Doctors %</td>
<td>74.6</td>
<td>77.6</td>
<td>76.3</td>
<td>77.0</td>
<td>75.4</td>
<td>80.9</td>
<td>77.3</td>
<td>80.8</td>
</tr>
<tr>
<td>Discharge %</td>
<td>87.6</td>
<td>86.6</td>
<td>87.2</td>
<td>85.3</td>
<td>87.1</td>
<td>89.1</td>
<td>85.7</td>
<td>87.1</td>
</tr>
</tbody>
</table>
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NDNQI RN Survey: “Collegial Nurse-Physician Relations”

<table>
<thead>
<tr>
<th>Unit Type</th>
<th>Unit</th>
<th>RN-MD Relations</th>
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</thead>
<tbody>
<tr>
<td>Adult Medical</td>
<td>20075 - 3E</td>
<td>3.96</td>
</tr>
<tr>
<td></td>
<td>20085 - 4D</td>
<td>3.13</td>
</tr>
<tr>
<td></td>
<td>20090 - RN Medicine</td>
<td>2.80</td>
</tr>
<tr>
<td></td>
<td>20113 - 10E/W</td>
<td>3.09</td>
</tr>
<tr>
<td></td>
<td>20905 - 12D</td>
<td>3.08</td>
</tr>
<tr>
<td></td>
<td>33370 7G General Medical</td>
<td>3.14</td>
</tr>
<tr>
<td>Adult Moderate Acuity</td>
<td>20210 - 12N</td>
<td>3.10</td>
</tr>
<tr>
<td></td>
<td>20211 - 12N</td>
<td>2.76</td>
</tr>
<tr>
<td></td>
<td>20510 - 12S</td>
<td>2.80</td>
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<tr>
<td></td>
<td>20515 - 12E/W</td>
<td>3.05</td>
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<tr>
<td></td>
<td>20520 - 5G</td>
<td>2.88</td>
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<tr>
<td></td>
<td>20610 - 10S</td>
<td>2.80</td>
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<tr>
<td></td>
<td>20615 - 8D</td>
<td>2.71</td>
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<tr>
<td></td>
<td>20620 - 8G</td>
<td>2.89</td>
</tr>
<tr>
<td>Adult Rehab.</td>
<td>21125 (11E/W)</td>
<td>2.98</td>
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<tr>
<td>Adult Surgical</td>
<td>20055 - 7F</td>
<td>2.47</td>
</tr>
<tr>
<td></td>
<td>20060 - 5D CT Surgery/Cardiology</td>
<td>2.77</td>
</tr>
<tr>
<td></td>
<td>20220 - 9D</td>
<td>2.12</td>
</tr>
<tr>
<td></td>
<td>20230 - 8W</td>
<td>3.19</td>
</tr>
<tr>
<td></td>
<td>20517 - 10N</td>
<td>3.27</td>
</tr>
<tr>
<td></td>
<td>20705 - 7F</td>
<td>3.10</td>
</tr>
<tr>
<td></td>
<td>21115 - 9N</td>
<td>3.24</td>
</tr>
</tbody>
</table>

All highlighted units fully implemented CC

Nursing Unit Scorecard Update: Comprehensive Single Source of Data

- ICU version and Non-ICU version
  - Unit LOS for both versions rather than discharging LOS
  - Impact is to the ICU version
- Changed the source of the data in our reporting system
  - Allowed for the capture of the HCAHPS data
- Later improvements:
  - Option to run report including CMI adjusted LOS
  - Hospital wide version
  - Ability to change time stamps for reports
Next steps: Patient Engagement

- Can we help families participate in team based rounding?
  - Provide a notebook
  - Scripted questions by diagnosis
  - Encourage visiting during rounds
  - Expectation management before scheduled admissions
- Can we script ourselves?
  - Code among team for anxiety
  - Teaching outside of room/rounds
Mobility
Problem: Culture of Immobility

Recognized the need to focus on delivering basic patient needs including mobility to mitigate a multitude of hospital acquired issues:

- Decreased Quality of Life post D/C
- Falls
- VTEs
- Longer LOS
- Pressure Ulcers
- Ventilator Acquired Pneumonia
- Aspiration prevention
- Patient/Health Care Provider Satisfaction

Mobility Pre-Pilot Assessments - Support Need for Action

<table>
<thead>
<tr>
<th>Non-ICU Model (Baseline Mar 2013)</th>
<th>ICU Model (Baseline July 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of patients walked ≤ once/day</td>
<td>Majority of intubated patients remain sedated and on bed rest until extubated</td>
</tr>
<tr>
<td>50% of patients were out of bed only once/day</td>
<td>Approx only 5% of ventilated patients had OOB orders</td>
</tr>
<tr>
<td>No clear strategy for mobilizing patients</td>
<td>Less than 5% of ventilated patients actually were mobilized OOB</td>
</tr>
<tr>
<td>Only 5% of nurses act on results of current functional screen</td>
<td>Sedation interruption was inconsistent</td>
</tr>
<tr>
<td>No mobility component in daily rounding of patients</td>
<td>No mobility component in daily rounding of patients</td>
</tr>
</tbody>
</table>
Interdisciplinary Unit Based Approach to Improving Patient Mobility

**Two Models:**
1. Acute Care Model
2. Intensive Care Unit Model

**The Team:**
- Nurse
- Physical Therapist
- Occupational Therapist
- Case Manager
- PCT, PST, Rehab Aide
- Pre Pilot Survey
- Introduce the utilization of the AMPAC -“6- Clicks” Functional Screening Tool – Activity Measure Post Acute Care

Acute Care Model

All patients will be Functionally Screened utilizing the AMPAC Tool for Mobility and Daily Activity

**Admissions Team**
- Complete the AMPAC tool in eRecord. Based on individual scores the patient will be placed into one of the three mobility groups

**Mobility Groups:**
1. Skilled Therapy (PT)
2. Therapy Guided Mobility (PT guiding Rehab Aide, PCT)
3. Team Reinforced Mobility (Nurse, PCT)
What the World Needs Now...Our Role in the Changing Healthcare Environment
Margaret Reidy, MD

Group 1: Team Reinforced Mobility
Patients “walk” into hospital at base line.
OOB activity, ambulation and mobility will be responsibility of nursing team

Group 2: Therapy Guided Mobility
Patients admitted with significant risks for functional decline
OOB activity, mobility and therapeutic exercise performed by Rehab Aide

Group 3: Skilled Therapy Required
Patients admitted with functional deficits requiring skilled therapeutic intervention
Skilled therapeutic interventions delivered by PT/OT

Mobility Results – 2 units versus controls

- Unit A:
  - LOS reduction between 0.182 and 0.595 days per encounter
  - Estimated reduction of **266.25 and 867.70 total hospital encounter-days**

- Unit B:
  - LOS reduction between 0.368 and 2.276 days per encounter
  - Estimated reduction of **201.53 and 1,245.17 total hospital encounter-days**
What the World Needs Now... Our Role in the Changing Healthcare Environment
Margaret Reidy, MD

Detailed ICU Mobility Protocol

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Patient Count</th>
<th>MICU ALOS</th>
<th>Hospital ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-Sept 2012</td>
<td>1117</td>
<td>5.27</td>
<td>13.64</td>
</tr>
<tr>
<td>Jan-Sept 2013</td>
<td>1187</td>
<td>4.73</td>
<td>11.58</td>
</tr>
</tbody>
</table>

ALOS Decrease (0.54) (2.06)

<table>
<thead>
<tr>
<th>MICU</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
<th>HCAHP</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 day readmission rate</td>
<td>9.1%</td>
<td>7.5%</td>
<td>Staff Responsiveness</td>
<td>56%</td>
<td>88%</td>
</tr>
<tr>
<td>Falls Rate/1000 days</td>
<td>1.15</td>
<td>1.08</td>
<td>Nurse Communication</td>
<td>38%</td>
<td>58%</td>
</tr>
</tbody>
</table>
From Pilot to Program

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM-PAC Inpatient Short Form in Cerner as improved functional screen. Replaces current screen</td>
<td>Forms created in Cerner, Ulearn for nurses in development, Logic built to task to NSG once patient is bedded.</td>
</tr>
<tr>
<td>AM-PAC Score Drives Initial Resource Allocation</td>
<td>Cerner Internal logic: Mobility risk score from AM-PAC automatically identifies and places an order for the appropriate mobility group</td>
</tr>
<tr>
<td>Interdisciplinary communication</td>
<td>Cerner therapy documentation update: allows for change in mobility group during the patients LOS as determined by team. New Rehab Aide position and documentation forms were created in Cerner.</td>
</tr>
<tr>
<td>Protocol based therapy</td>
<td>Cerner developed “Mobility Protocol Order” (active for entire encounter) Automated for 100% of patients admitted to hospital. MEC to approve as parent order for therapy to evaluate and treat if score on AM-PAC&lt; risk cut points. Compliance signed off.</td>
</tr>
</tbody>
</table>

Potential Hospital Concerns

Staffing Model
- Built on ADC run rate
- Will be adjusted when budgets assigned
- Recommend positions report to Centers for Rehab Services

Needs assessment
- Chairs suitable to patient sitting
- Recliner chairs
- ICU recliner stretcher chairs
- Portable Pulse ox meters
- Walkers

Physician Champion
- Communicate need for new ordering paradigm to MEC and Medical Staff
- Support local team
Patient Engagement

- Can families participate in assuring patients are mobilized?
- Can families learn safe techniques and manage transfers and ambulation with their loved one?
- How do we ensure this from the start of an admission?
- How can these principles apply to other “basics” of care?

LUHU

- “Let us Help you”
- Identify patients with disabilities who are primary WC users
- In advance of scheduled admissions
- Ascertain needs and assure right room, equipment and
- JIT staff training rehab nurse to acute nursing team
- Identified MANY opportunities
- Being used as platform for other patient engagement strategies
Mrs. B is a 72 yo female who has been seen by her PCP for COPD. She goes to a family picnic and has an episode of wheezing. She is taken to the ED and needs to be admitted. Mrs. B is admitted within the hour. As Mrs. B’s nurse gets her settled, she completes the admission assessment including the AMPAC and is sure Mrs. B gets her dinner. The PCT walks her to the bathroom and encourages her to do ankle pumps. During bedside shift report, the on-coming nurse verifies that SCDs are properly applied to Mrs. B’s legs. Mrs. B is assessed throughout the night with an attention to her sleep needs. The next morning Mrs. B is starting to feel better and is discharged later that day.

Positive Outcomes: You have one take to get it right.

- Decreased VTEs
- Decreased LOS
- Decreased Readmissions
- Decreased Mortality
- Increased Patient Satisfaction
- Increased Staff Satisfaction
- Increased Revenue
Health Care in 2015: Themes

- **Moving from volume to value**
  - Value Based Purchasing
- Better science
  - BASICS OF GOOD CARE
  - Evidence Based Pathways
- Measurement of outcomes
  - Development of measures
  - Consistent deployment and use
- Avoidance of complications of care
  - Never events, HACs and PSIs
- Shared decision making
  - Informed consent
  - Family/ support system involvement
- Patient responsibility
  - Health literacy
  - Directing own care.

Evolution To Shared Decision Making

- Supporting the Best Patient Condition
- Patient Centered Team Based Care
Go Team

• “The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don’t play together, the club won't be worth a dime.” -Babe Ruth
• Truly functional teams have a common goal, value the input of all members, encourage their contributions and see increased participation from all as they mature together
• The patient and family are members of the team!
• As leaders, we need to be committed to patient and team member focused models that seek input, empower accountability and promote the development of our staff at every stage of their careers

Questions?
References

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• Controlling Health Care Costs While Promoting The Best Possible Health Outcomes: American College of Physicians White Paper 2009

• Atul Gawande: "We Have Medicalized Aging, and That Experiment Is Failing Us": Mechanic, motherjones.com 10/07/2014