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“Case management in hospital and health care systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The case management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of case management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination.”

Approved by ACMA membership, November 2002
Mentorship in Case Management: Identifying Opportunities and Employing Practical Strategies

Paula Lenhart, RNC, MSN, CNS, ACM, FABC

The Memorial Hermann Health System includes 10 acute care facilities, two freestanding rehabilitation facilities, home health and Hospice services, and an independent living, skilled nursing facility and nursing home. Since many patients with widely varying needs, the efficiency and collaboration of case management professionals and all hospital professionals is critical. Case managers in all settings need to take a fresh look at mentoring and consider how they can use new strategies for teamwork and advising to provide better patient care.

LEARNING OBJECTIVES
1. Recognize the value and benefits of mentorship within case management practice.
2. Identify opportunities to both mentor and be mentored.
3. Implement practical and effective mentorship strategies

Case managers, by trade, have a wide variety of responsibilities. The system care management team at Memorial Hermann is no exception; they provide education to executive leaders, physicians and the case management teams, ensure program integrity, manage any necessary Medicare-related changes, and interface with payers and resource providers to address issues, among many other critical tasks. In many ways, case management professionals act as the liaisons between all of the elements to help facilitate patient care delivery resulting in efficient and timely patient discharges.

In this role there are many opportunities to mentor and be mentored. Case managers interact with staff members from every corner of the hospital system, who all have unique approaches to their work and to interpersonal relationships. Taking the time – both formally and informally – to learn from those relationships and to share best practices can ultimately make valuable differences in patient care and hospital efficiency. Mentoring can improve morale, increase
retention, help on-board new employees, and train the next generation of leaders.

The good news is case managers and social workers are extremely qualified to be mentors. In a profession based on creative and collaborative problem solving, case managers and social workers have the tools at their disposal for great mentoring relationships. In fact, many case managers may already consider mentoring part of their job responsibilities – just perhaps in relation to their patients, not their colleagues. Perhaps even better news is focusing on mentoring is a very low-cost or even free option.

INTENTIONAL AND UNINTENTIONAL MENTORSHIP

Mentorship in all forms can be useful, but it can primarily be broken down into two categories: intentional and unintentional. Intentional mentorship involves the formal construction of system supports, which encourages collaboration and communication. One example is the Medicare-mandated Utilization Management Committee. The Memorial Hermann system care management team is seeking to provide further systemic mentorship by improving the committee structure and making compliance easier for individual campuses. Case Management directors researched the regulations and drafted the charter document, making it generic enough campuses could customize it to their needs. The skeleton of the document would be consistent from hospital to hospital, with core elements present in every version, making the committee structure easier to maintain and coordinate among campuses.

This would also allow campuses to coordinate their goals and plans for the year, and for the system to provide broader education about the regulations and their implications. Additionally, it could ease the process for year-end evaluations. This kind of intentional mentorship – of which there

staffers are sharing new practices and innovations with their superiors. These advisory relationships can be hugely important to the individuals, to the hospitals where they work, and to the case management profession as a whole. A mentor may make employees feel more accountable for their progress and build enthusiasm for their ongoing career at the hospital and in the field.

The structure of a devoted mentorship program will vary from hospital to hospital, as the needs and culture of every workplace are different. It is important to be clear on the application process, the time commitment required, and the responsibilities of all parties from the beginning. Early buy-in from team members is important in order to begin the recruiting process and build enthusiasm for the program. Throughout the implementation, garnering feedback and performing routine evaluations of the mentoring program is critical. As with any initiative, it can be useful to refine expectations and processes.

However, unintentional mentorship, the day-to-day relationship building and sharing that occurs in our lives on and off the job, is just as important, if not more so for our professional growth. There is an opportunity in every conversation with a colleague to mentor that person and to be mentored. For case managers, that mentorship can facilitate real innovation and improvements in patient care.

Intentional mentorship also includes formal programs to link more experienced case managers with those newer to the profession, and to share knowledge and nurture the younger professionals. Some organizations are even undertaking “reverse mentoring,” where younger, lower-level
support each other, this individual came to challenge the facilitator on diabetes research he had done on the Internet. Although his research was important to him, it kept the group off track. When the facilitator was ready to tell the patient he could no longer attend the group meetings, a mentoring moment between the facilitator and the care management team revealed a better solution.

The patient was invited to attend biannual personal meetings with the facilitator, where he could ask all of his research questions outside of the regular sessions. This solved the problem with the patient and with the group, and actually made the patient feel more confident about his role in the group. This casual, collaborative mentorship opportunity between the facilitator and the care manager helped the patient get what he needed, kept the facilitator from burning out on the responsibilities of managing the group, and kept the group functioning well. In a situation where the success of the program depends on the reputation of the program and of the hospital, it was a huge success.

**IMPROVING MENTORSHIP**

This brand of mentorship happens every day at all levels of case management teams. Case management professionals (social workers and nurse case managers) are doing intentional and unintentional mentorship at every turn. However, this needs to become more systemic and more deliberate. Case management professionals have to think about the fact that, whenever they are in a dialogue with another person, it is an opportunity to mentor both positive and negative behaviors. For team leaders, this means being intentional about respectful behaviors and attitudes, as they set the tone for how the entire group of people will behave in their department.

Obviously, in a hospital setting, this has to be done with care. It is not a case manager’s responsibility to tell a physician how to practice medicine. Telling a physician how to administer antibiotics would be out of scope. However, it is decidedly in scope to help the physician determine whether a patient’s admission order should be an in-patient or out-patient, recommend discharge plans, and plan post-acute services based on the patient’s clinical presentation. When case managers can develop these working relationships, they can bring something to the physician and gain information about how the medical plan will be developed. Case managers can help the physician and healthcare team learn more about what possibilities exist in regards to care planning for challenging patients, as well as the impacts of government regulations. This symbiosis ultimately benefits the patients.

It would also be in-scope to teach employees the skill of mentoring in a formal way. It should be incorporated into formal education and encouraged throughout a case manager’s career. Although it can and does happen in the de facto manner described above, it will be much more prevalent and successful if done in a deliberate and thoughtful way. The best mentors are those who are working with their mentees in a committed and personal way, who take pride in sharing knowledge and wisdom. And mentors can certainly learn and improve from high-quality, accredited mentoring training programs.

Case managers and all professionals also should be open to being mentored throughout their workday. Many mentoring relationships are positive and productive, but there are critical skills that can be learned from even the harshest personalities. The workplace will not always be a positive environment, but every day can bring learning experiences if the employee is open to feedback and learning from others. Furthermore, the best mentors are those who recognize that lifelong learning moments exist and look to their relationships as opportunities to learn new techniques to improve their own practice.

**ABOUT THE AUTHOR**

**Paula Lenhart**, RNC, MSN, CNS, ACM, FABC, is the Senior Director of Care Management for Memorial Hermann Health System in Houston, Texas. In her current role, she is responsible for care management program development, education, and has oversight of clinical quality improvement. Ms. Lenhart also serves as coach and mentor to case management directors and case managers in skill development, and acts as a resource to hospital-based case management directors. She has more than 30 years of health care experience in the areas of nursing and case management. Ms. Lenhart earned an Associate’s Degree in Nursing from St. Mary’s School of Nursing in Minneapolis, Minn.; a Bachelor’s Degree in Nursing from the University of Minnesota School of Nursing; and a Master’s Degree in Nursing from the University of Texas Health Science Center at Houston, School of Nursing, in Houston, Texas.
Collaborative Case Study: Readmissions Reduction
Tackling All Cause Readmissions: One Integrated Health System’s Approach

Joan Brueggeman, RN, BSN; Michelle LaFleur, RN, BSN, MHA; and Lisa Sheldon, BS

In October 2012, the Centers for Medicare and Medicaid Services (CMS) introduced a separate penalty program, which stemmed from the Patient Protection and Affordable Care Act and reduced payments to hospitals with excess 30 day readmissions for heart attack, heart failure and pneumonia patients (COPD and total hip/knee replacements were added to the condition list for FY 2015).

A readmission generally refers to an admission to an acute care hospital within 30 days of a discharge from the same or another acute care hospital. Excess readmissions are measured by a ratio – dividing a hospital’s number of “predicted” 30 day readmissions for each condition by the number that would be expected, based on an average hospital with similar patients. A ratio greater than 1.00 indicates excess readmissions. This data is risk adjusted, meaning it takes into account how sick patients are based on their age, gender and co-morbid conditions. The CMS readmission maximum penalty is 2% of a hospital’s Medicare base operating diagnostic related groups (DRG) payments in 2014, and increases to 3% for 2015 and beyond. Results are publicly reported on the CMS Hospital Compare consumer website – www.Medicare.gov/HospitalCompare.

This article will examine one health system’s approach to decreasing hospital readmissions and avoiding CMS penalties.

LEARNING OBJECTIVES
1. Identify the components of a successful readmissions reduction program.
2. Understand the processes and personnel involved in decreasing readmissions and avoiding CMS penalties.
3. Discuss tracking methods, metrics and measures used to determine the effectiveness of Gundersen’s readmissions reduction strategies.

ABOUT GUNDERSEN HEALTH SYSTEM
Gundersen Health System is an integrated health system located in La Crosse, Wisconsin. A level II trauma teaching hospital with 325 beds, Gundersen Health System also includes outpatient clinics serving 19 counties in 3 states.
In 2013, approximately 6,000 employees and 700 providers provided support or health care services for over 1 million outpatient services and 16,000 inpatient hospital admissions.

Gundersen Health System was one of the few health care systems nationwide deemed by CMS to be exempt from readmission penalties due to its low readmission rates—below 1.00 for excess readmission ratios for each condition (see figure A.). The following examines the processes and programs Gundersen Health System utilizes to minimize readmissions and maintain low readmission ratios for conditions, including: acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD) and total hip/knee replacements (THA/TKA).

GUNDERSEN’S READMISSIONS REDUCTION STRATEGY

Gundersen’s readmissions reduction efforts are supported by a variety of departments, teams and practitioners, all of which contribute to a collaborative, effective strategy for efficient patient care. Gundersen’s philosophy centers on providing patient care and focused readmission projects or initiatives on all patients regardless of the payer or disease process. The focus is not simply preventing readmissions for the CMS diagnosis listed for penalties, but rather a focus on all patients who are at high risk for readmission. Gundersen has taken a multi-disciplinary approach to decreasing hospital readmissions, through which multiple projects, departments and practitioners contribute to the organization’s success. No one single department or program is solely responsible for successfully decreasing readmissions. Like spokes in a wheel, all of these areas have been critical in driving the organization’s overall decrease in readmissions.

TRANSITIONS OF CARE TASK FORCE

The focus of readmissions reduction efforts at Gundersen included the development of a task force consisting of interdisciplinary members of the health system. The Transitions of Care Task Force includes nurses, clinical managers, administration, quality specialists, physicians, social services and other key contributors. The focus of the task force is to improve systems and processes that ensure high quality care. This methodology has been beneficial as CMS focuses on penalties for certain conditions and possibly an all cause readmission penalty in the future.

The task force also focused on “foundational” concepts for patient care improvement, including daily interdisciplinary rounding at the bedside centered on the patient and family. Other improvement efforts were focused on ways to improve patient education packets at the hospital bedside, and included a patient “plan of the day,” teach back methodology, and medication reconciliation by pharmacy personnel upon hospital admission from the emergency department (ED).

The task force includes a readmissions review committee monthly meeting where a chart review occurs, examining three to five in-house patients who have readmitted within 0-7 days of their original discharge date. Almost 45% of Gundersen’s patients return within the first seven days, and thus this patient population is a specific focus for the organization. The meeting includes a chart review of the original admission and readmission, as well as a patient and family interview. A data collection tool is completed based on the findings from the review. Data is compiled and reported to the team monthly. The in-house reviews are performed by hospitalist providers, inpatient and outpatient nurses, pharmacists and social services.

Beyond the development of the readmissions task force, some of the other key departments and players that contribute to the organization’s readmissions reduction efforts are outlined in the following sections. These departments focus their efforts on high risk patients, transitions of care and enhancing the overall patient and provider relationship.

CARE COORDINATION

Gundersen has a Care Coordination department which focuses on services for the most medically complex patients seen in the health system (the top 1-3%). The care coordination program includes nurses and social workers who work together to help high risk patients and families navigate the health care system – in both the inpatient and outpatient settings. The Care Coordination nurses and social workers work to ensure the patient receives the appropriate care for their disease(s) while avoiding unplanned or unnecessary health care services. Care Coordination nurses and social workers are already connected to many patients who are at high risk for readmission prior to their transition from the inpatient to the outpatient setting at time of hospital discharge. These pre-established relationships are valuable in assisting the patient and family as they move from a hospital setting to the home or lower level of care setting. Care Coordination staff partner with the patient and family promptly after hospital discharge to ensure discharge plans, medication adherence and follow-up visits are accurate and completed.

The Clinical Nurse Leaders (CNLs) are Master’s prepared nurses that work on the Medical-Surgical units in a separate role from the Care Coordination nurses. Unlike the Care Coordination nurses, the CNLs work only in the hospital setting. However, together the Care Coordination nurses along with the Clinical Nurse Leaders work to ensure successful transitions of care planning for high risk hospitalized patients.

Patients who are at high risk for readmission are identified by use of the LACE scoring tool during hospitalization, and then these patients receive a follow-up phone call from the CNLs or Care Coordination nurses within 48 hours of discharge. CNLs also chart review nursing home patients that return within 48 hours and document findings on a data collection tool.

Another program that Gundersen offers, which contributes to a decrease in readmissions from an organizational standpoint, is Gundersen’s end-of-life program, “Respecting Choices.” The Palliative Care department provides advanced directives and power of attorney for health care for patients with chronic medical conditions. Patients are identified as palliative, and end-of-life decisions are communicated to the care team and determined prior to hospitalization, thus avoiding unnecessary admissions or readmissions, dependent on what is outlined in the patient’s care plan.

One more “spoke in the wheel” at Gundersen in the organization’s efforts toward reducing readmissions is an interdisciplinary team that meets weekly to discuss hospitalized patients who have generated more than $125,000 in hospital costs, or who have been hospitalized for greater than 14 days with discharge barriers present. These meetings include representatives from Utilization Management, Social Services and Patient Financial Services – legal and other departments attend ad hoc. At these weekly
meetings, discharge and transition planning are discussed with a focus on providing the most cost-effective and successful transitions of care.

MEASURES AND OUTCOMES:

TRACKING

Several readmission metrics are tracked internally on a monthly basis for all payers and Medicare patients, such as:

- 0-30 days (posted on the organization’s Practice Management Dashboard)
- 0-7 days
- 0-30 days unplanned & planned readmissions separately
- 0-7 day unplanned & planned readmissions separately
- 0-30 days readmissions for AMI, HF, Pneumonia, COPD, Stroke, PCI and CABG patients
- 0-30 days unplanned readmissions that closely mimics the Hospital Wide Unplanned measure from CMS

OUTCOMES • See Figure A.

CONCLUSION

Being part of an integrated health system has been invaluable for Gundersen Health System in addressing readmissions from a holistic, systems perspective; allowing the organization to initiate and refine quality improvement projects. Gundersen remains hopeful that the processes in place will allow the organization to continue to minimize readmissions and avoid penalties for excess readmissions, while improving the quality of care for its patients and families for years to come.

ABOUT THE AUTHORS

Joan Brueggeman, RN, BSN, is Clinical Manager for the Utilization Management and Care Coordination departments at Gundersen Health System in La Crosse, Wisconsin. Ms. Brueggeman has been in her current role since 2007, and has managed the Care Coordination department since 2010. She recently served as President of the ACMA Wisconsin Chapter, and has been on the Wisconsin chapter board since 2008. She has held a variety of nursing positions throughout her 27-year nursing career, the last 20 of which have been dedicated to case management/care coordination and utilization management services.

Michelle La Fleur, RN, BSN, MHA, has been the Director of Quality and Patient Safety at Gundersen Health System since 2008. She earned her Bachelor’s of Nursing Degree from Viterbo University in LaCrosse, WI, and has a Masters in Healthcare Administration. During her career, Ms. La Fleur has 26 years of experience in health care with the last 14 years in quality and patient safety.

Lisa Sheldon, BS, is the Quality Improvement Specialist for Gundersen Health System. She has worked in Gundersen’s Quality & Patient Safety department since 2008, and has more than 15 years of experience in the health care industry. Her areas of expertise include quality improvement, patient experience, data design, analysis, reporting, survey design and methodology. Ms. Sheldon earned her Bachelor of Science degree in Marketing with an emphasis in Sales and Promotion from the University of Wisconsin at La Crosse.

Figure A.

Gundersen Health System 30-Day Unplanned All Cause Risk Standardized Readmission Results for the CMS Hospital Readmissions Reduction Program

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INDICATIONS AND USAGE

ZYVOX is indicated for the treatment of infections caused by susceptible strains of the designated organisms in the specific conditions listed below. It is contraindicated for the treatment of patients with a known history of idiosyncratic reactions caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus pneumoniae. The selection of ZYVOX for the initial therapy of Gram-negative infections is not indicated for the treatment of Gram-negative infections in patients with a history of prior treatment with aminoglycosides. ZYVOX is not indicated for the treatment of Gram-negative infections. It is associated with a higher rate of isolation of nonsusceptible isolates in adults with acute and chronic respiratory tract infections (including sinusitis, bronchitis, and pneumonia) caused by Streptococcus pneumoniae, and is generally not recommended for the treatment of these infections. It should be used only when the target microorganisms have been shown to be susceptible to ZYVOX by local or central laboratory methods.

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The use of ZYVOX for the treatment of skin and skin structure infections is not indicated for the treatment of patients with a history of prior treatment with aminoglycosides. The selection of ZYVOX for the initial therapy of Gram-negative infections is not indicated for the treatment of Gram-negative infections in patients with a history of prior treatment with aminoglycosides.

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Patients with a history of penicillin allergy are at increased risk of developing an allergic reaction to ZYVOX. If a patient experiences a skin rash or urticaria, ZYVOX should be discontinued and alternative antibiotic therapy should be started.
Patients should be counseled that antibacterial drugs including ZYVOX should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When ZYVOX is prescribed to treat a bacterial infection, patients should be told that it is very important to take the drug exactly as directed by their physician. Incomplete courses of antibiotic treatment may decrease the effectiveness of ZYVOX and increase the chance that bacteria will develop resistance and will not be treatable by ZYVOX or other antibacterial drugs in the future. Patients should be advised that ZYVOX may be taken with or without food. Patients should inform their physician if they have a history of hypoglycemia. Large quantities of foods or beverages with high tyramine content should be avoided while using ZYVOX. Patients should inform their physician if taking medications containing pseudoephedrine HCl or phenylpropanolamine HCl, as cold remedies and decongestants. They should inform their physician if taking serotonergic re-uptake inhibitors or other antidepressants. Phenylethanolamines: Each 5 mL of the 100 mg/5 mL ZYVOX for Oral Suspension contains 20 mg phenylethanolamine. The other ZYVOX formulations do not contain phenylethanolamine. Contact your physician or pharmacist. They should inform their physician if they experience changes in vision. They should inform their physician if they have a history of seizures. Diarrhea is a common problem after starting treatment with antibiotics, which usually ends when the antibiotic is discontinued. Sometimes after antibiotic treatment and for up to 2 months (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, patients should contact their physician as soon as possible. Inform patient, particularly those with diabetes mellitus that hypoglycemic reactions, such as diaphoresis and tremulousness, along with nausea and vomiting may occur when treated with linezolid. If such reactions occur, patients should either call their physician or other health professional for proper treatment.

**Non-teratogenic**

Zyvox is not teratogenic in mice, rats, or rabbits at exposure levels 6.5-fold (in mice), 1.4-fold (in rats), or 0.06-fold (in rabbits) the expected human exposure level based on AUCs. However, embryo and fetal toxicities were seen (see Non-teratogenic Effects). There are no adequate and well-controlled studies in pregnant women. Zyvox should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Non-teratogenic Effects in mice, rats, and rabbits: The effects consisted of decreased fetal body weight and reduced ossification of sterna. Effects were often seen in association with decreased fetal body weights. Slight sternebrae, a finding often seen in association with decreased fetal body weights. Some dosage levels of linezolid were not consistently achieved or maintained in the CSF. Therefore, the safety and effectiveness of ZYVOX for the treatment of pediatric patients with the following infection have been established in a comparator-controlled study in pediatric patients ranging in age from 3 through 17 years: uncomplicated skin and skin structure infections caused by *Staphylococcus aureus* methicillin-resistant strains only or *Enterococcus faecalis*. Pharmacokinetic information generated in pediatric patients with ventilator-associated pneumonia showed variable cerebral fluid (CSF) linezolid concentrations following single and multiple dosing of linezolid, therapeutic concentrations were not consistently achieved or maintained in the CSF. Therefore, the use of linezolid for the empirical treatment of pediatric patients with central nervous system infections were as follows: for CSF linezolid concentrations of 10 mg/L and at least 0.75 mg/L, linezolid was evaluated in pediatric patients from birth to 17 years of age, in general, weight-based clearance of linezolid gradually decreases with increasing age of pediatric patients. However, in premature infants and in neonates < 7 days of age, linezolid clearance is often lower than in full-term neonates < 7 days of age. Consequenty, premature infants and newborns of < 7 days of age may require a dose of 10 mg/kg every 12 hours. In limited clinical experience, 5 out of 6 (83%) patients with infections due to *Citrobacter freundii* had a clinical response, particularly with pathogens with MIC of 4 mcg/mL, lower systemic exposure, site and severity of infection, and the underlying medical condition should be considered when assessing clinical response. In one trial treated with ZYVOX comparator-controlled clinical trials, 58% (29%) were 65 years or older and 253 (12%) were 75 years or older. No overall differences in safety or effectiveness were observed between these patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater severity of some older individuals cannot be ruled out.
Progression of Care Innovations: Employment of Video Debriefing, Scripting, and Scoring to Improve Quality of Multidisciplinary Rounds

Megan Olman, LCSW, ACM

LEARNING OBJECTIVES
1. Identify strategies to enable staff to engage in “self reflection” (“hansei”) through video debriefing.
2. Employ specific process improvements to effect change in patient flow/throughput.
3. Identify key elements to successful progression of care.

This project was developed to reinforce and focus on pertinent patient information that would lead to a more comprehensive plan of care for the patient, more productive and timely rounds, and increased staff satisfaction.

Multidisciplinary rounding involves all of the care partners coming together to actively discuss the patient, identify needs, and attempt to expedite the patient’s healing. Groups proactively assess patients’ complete well-being and call in consults or referrals as needed. These groups generally involve a case manager, nurse manager, bedside nurse, and social worker, but can include others depending on the team. On seven units at Cedars-Sinai, the teams are led by a physician advisor.

As part of the nursing care delivered at Cedars-Sinai, nurses always participated in progression of care rounds. During these rounds, the nurses discussed the plan of care. However, over time, multidisciplinary rounds had become more of a discussion of tasks that needed to be performed for the patient than a discussion of the patient’s improvement and progression toward improved health and discharge.

Multidisciplinary roundings can be an efficient and effective method of addressing patients’ needs and coordinating services among hospital professionals. However, when performed ineffectively, rounds can waste time and effort while contributing to lengthy stays and miscommunications. At Cedars-Sinai Medical Center in Los Angeles, California, a new model has been implemented to examine the strengths and challenges of multidisciplinary rounding and improve upon the current system the hospital is utilizing. This article will discuss the circumstances that led to the development of this intervention and present early results from changes made to hospital unit rounds.
Team members described the existing rounds system as “Groundhog Day.” Much would be communicated throughout the day about patients’ health and readiness to be discharged or transferred, but by the next morning, a miscommunication or an issue initiated by the patient had prevented or complicated the necessary action. In general, there was incorrect information communicated during handoffs, critical developments were not reported as needed, and plans were not followed through.

Meanwhile, the team wanted to improve patients’ average length of stay and focus on being proactive with patient care. When discharge delays occurred due to orders or services like physical therapy or medications, the team wanted to take action and see if those could be followed through earlier. A theory emerged that strengthening progression of care conversations would lead to better communication, quicker follow-through, and ultimately better, more efficient patient care.

THE PLAN

The team implemented a Plan-Do-Study-Act (PDSA) cycle for qualitative improvement of multidisciplinary progression of care rounds. The “plan” phase involved scoring and sharing key processes among team members. The “do” phase included video debriefing of rounds, and the “study” phase examined those videos for best practices and areas for improvement. And in the “act” phase, key interventions were chosen and undertaken – based on information learned in the video debriefing process – to enhance quality, speed, and outcomes of rounds.

The team was looking for a new and innovative approach to solving their problem, and they eventually settled on video debriefing. The tool, which involved rounds being recorded in action and then played back for participants later, had been used extensively in emergency medicine. It is standard operating procedure in many emergency rooms, where treatment happens quickly and urgently, without time in the moment for self-reflection. The idea was to take that tool and apply it to an entirely different area of the hospital.

Leadership was advised to maintain current processes and to allow frontline staff to debrief prior to leadership participation. Viewing the tapes provided an opportunity for quick feedback and recognition of verbal and nonverbal miscommunications. The team found the video recordings very interesting, and viewing the recordings helped inform changes to their practice.

For example, rounds may be held promptly at 10:15 each day at the nurse’s station. Team members receive a text at 9:50 reminding them of the meeting, and everyone arrives ready to provide reports on their patients. Test results and charts are available and can be quickly referred to when needed.

The following criteria are used to keep rounds efficient; these functional best practices do not mandate a one-size-fits-all approach to rounds.

- Use a checklist focused on the plan for each patient’s day/stay.
- Display the checklist as a prompt during rounds.
- Encourage one-rounds to avoid handoff errors. For instance, in one Cedars-Sinai unit, rounds are now held once each morning.
- Have a “batter on deck” to reduce any wasted time. All nurses and staff members report to rounds at the same time, in the same place, with all ready to report on their patients one right after another.
- Have electronic health record open during rounds.
- Have clearly identified leadership of rounds. At Cedars-Sinai, one designated team member generally takes the lead and manages each session.
- Develop an action plan at the unit level following rounds.
- Hand off action plan to night shift leader. A second set of rounds is not done, but the night nurse is made aware of the plan and is responsible for seeing it through.
- Allow staff to set their own goals.
- Encourage engagement.
- Choose optimal rounds location.

The rounds were streamlined throughout the hospital by using hangtags (See Figure A), which contained valuable information and were attached to the backs of staff name badges. There are some differences in the script that are necessary and innate on different floors among different patient populations, but there are some universal elements in every progression of care discussion. The use of hangtags highlighted those, so that floating nurses could easily reference them and see what needed to be part of that patient’s progression of care conversation.

These questions utilized a Situation, Background, Assessment, Recommendation (SBAR) format. For Cedars’ 3SCCT (3 Saperstein Critical Care Tower) unit, the script included the following questions:

1. What is the patient’s last name and individual service plan?
2. Is the patient a direct admit, from the emergency department, or an in-house transfer?
3. Is the patient an inpatient or under observation status?
4. What was the patient’s admitting diagnosis? What brought the patient to the hospital?
5. Does the patient have a history of heart failure? Does the patient meet the frailty criteria?

6. Has the depression/suicide risk assessment been completed? Is it positive?

7. What diagnosis are we treating today? Are there any tests or procedures scheduled today?

8. What is the patient’s current functional status? Is this a change from his or her baseline?

9. What is the discharge plan? What needs to happen for the patient to be discharged?

10. When does the attending MD expect the patient to be discharged? What do we need to do to ensure discharge by 11:00 AM?

11. Does the bedside nurse have any questions or concerns with the patient’s progression of care?

The goals were to improve scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) and to discharge more patients by 11:00 AM.

One of the initial challenges was gaining buy-in from participants. The success of the initiative relied on changing the day-to-day operations of the hospital staff, encouraging everyone to think about each individual patient, their needs, and their anticipated discharge dates. Not everyone embraced the new system or felt comfortable with it immediately. It was a change in thinking for everyone and placed a great deal of additional responsibility on the team members. In progression of care rounds, the team began to identify action items to move the patient toward discharge, and everyone on the team became accountable for those action items. At the end of the day, if an item had not been completed, the team members had to own the reason why. At times, this was uncomfortable.

Nurses are busy but their understanding of why stopping their day for rounds was important. Their buy-in was crucial, since they spend the most time with patients and have great insight into their progress. Fortunately, the nurse manager saw the value in reforming the system and her support carried through to the unit nurses. Now there is significant buy-in from nursing staff at all levels and they are enthusiastic about the new system.

One important change occurred in sharing the anticipated discharge date with patients. Case managers always work to move the patient toward discharge, but discharge dates were not consistently discussed with the patient. In many cases, such discussions would make the patient anxious – if the date felt too soon, too far away, or if the anticipated date went by without release. Now, case managers, physicians, and nurses work together toward identifying anticipated discharge date on admission. This process encourages all members of the health care team to think about tests and the movement of patients along the health care continuum from inpatient to outpatient care.

**RESULTS**

Ultimately, rounds became much more effective and efficient. The number of best-practice items being covered during rounds increased, while the time spent in multidisciplinary rounds simultaneously decreased. Teams shared their innovations with some units leading in the development of checklists and hangtags, while others improved their scripts. These best practices were shared among teams and adopted in different units throughout the hospital.

Key factors for success and replication were identified, including a strong positive work culture supported by leadership. Effective rounds leaders showed strong interpersonal and organizational skills – and they came from a variety of job classifications. In different units, nurse managers, assistant nurse managers, charge nurses, case managers, and social workers played the role of rounds leader. In all cases, having engaged nursing staff, social workers and case managers helped the initiative gain traction and succeed.

The team was also successful in its goal to improve discharge times. They observed a sustained and differential increase in discharge by 11:00 AM compared to performance prior to the intervention, and also compared to other units that did not participate in the PDSA initiative. This effect continued beyond the initial observation period.

The ultimate conclusion is that progression of care rounds, performed in a structured and consistent manner, led to improved communication between multidisciplinary team members and patients and families related to plans of care and timely discharge planning. These improvements with the multidisciplinary rounds enhanced patient outcomes, patient satisfaction, and patient flow.

**ABOUT THE AUTHOR**

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Heart Failure Readmission Cuts May be a Phone Call Away

Bruce Jancin
THIS AUTHOR HAS NO FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS TO DISCLOSE.

A structured follow-up telephone call to heart failure patients made within 48 hours post discharge can reduce 30-day readmissions by fully one-half to two-thirds.

That’s been the experience at Stanford (Calif.) University Medical Center, where the 30-day heart failure readmission rate dropped from 20% in 524 patients at baseline to 10% among 341 patients discharged since the follow-up phone call practice was introduced, clinical nurse specialist Christine Thompson reported at the annual meeting of the Heart Failure Society of America.

In the first 14 months since the full readmission-reduction program was launched, 96% of patients reached via a postdischarge phone call demonstrated that they understood their discharge medications and how to take them.

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It was possible to determine the specific contribution that the early postdischarge phone call made to the observed sharp decrease in 30-day readmissions because 61 patients didn’t get the follow-up phone call but did receive the other interventions. Their 30-day readmission rate was 28%, compared with 10% in those who did get the phone call, which translates to a 66% relative risk reduction. In a multivariate logistic regression analysis adjusted for the other interventions as well as patient age, sex, marital status, length of stay, and discharge destination, the early postdischarge follow-up phone call was independently associated with a 72% reduction in the risk of readmission within 30 days, according to Ms. Thompson.

She reported having no financial conflicts regarding this study. This article reprinted with permission from Hospitalist News Digital Network, October 9, 2014. For more information, visit www.ehospitalistnews.com.
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