Care Coordination: Realizing the Potential of the Interdisciplinary Team

Holly L. Lorenz, MSN, RN
Margaret E. Reidy, M.D.
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Introduction and Baseline States
Baseline state: Nursing

- Nursing Shift Report
- Nursing Transfer Report
- Nurse to PCT communication
- Nurse to HUC communication
- Nurse to charge nurse communication
- Nurse to APP, Clinician communication
- Nurse to UD communication
- Nurse to physician communication?
- Nurse to Care Manager Communication
- Nurse to patient communication
- Nurse to family
- Nurse to procedural nurse
- Nursing “responsible” to communicate to all other disciplines
Baseline state: Physician

- Morning report
- Pre-rounds: trainees and students, APPs
- Teaching rounds
- Rounds
- “Noon” Conference
- Clinic
- Speak with nurse, hope she’s spoken with everyone else
- Speak with CM, hope he’s spoken with everyone else
- Make decisions and review with trainee APP
- Speak with patient and family
So much communication, so little time!
And more devices!
Baseline state: Patient

- Has a PCP, but sometimes sees an APP or partner in office vs. has traditional relationship with PCP
- Utilizes e-tools to communicate vs. face to face appointments and phone calls
- If hospitalized, may come in through ED and see new providers
- When hospitalized, may be admitted to a hospitalist service with unfamiliar providers
- If hospitalized for surgery, will transition from pre to operative to post operative teams before being formally admitted
- Hospital based providers rotate on and off at intervals that may bisect the stay
- May see multiple consultants
- Nursing may include admission team, primary nurse, specialty nurses, PCTs, IV team, ET nurse, discharge team
- If discharged to SNF, LTAC, IPR, new set of providers at new setting
"Next, I will use a medium-point roller-ball pen with black ink and, on the anterior side of the upper-left quadrant, two centimetres below the binding staple, begin detailing in bold print the patient's previous medications and treatments relating to present indications for procedure and treatment, as required on this particular health-insurance form."
Where is the “voice” of the nurse in the midst of this din?

- We have slowly drifted from focusing on the patient and one another to focusing on:
  - Documents we must author
  - Tasks we must complete
    - Medications!!!!
      - Reconciliation
      - Administration
  - Managing alarms
  - Dealing with interruptions
  - And this is just not just nursing!
Care Coordination
Care Coordination

- Observations of the process, people, and roles
- Rapid Improvement Event
- Multiple disciplines involved
- Reviewed current states
- Listened to patient feedback
- Identified a change package to be piloted

- Relational communication & equity of voice
Day in the Usual Life of a Provider

Multiple caregivers, sometimes multiple floors

CM 8
CM 3
CM 5
CM 7
CM 8
RN 15
RN 14
RN 13
RN 12
RN 11
RN 10
RN 9
RN 8
RN 7
RN 6
RN 5
CM 1
CM 2
CM 3
CM 4
CM 5
CM 6
CM 7
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
Day in the Usual Life of a Bedside Nurse
<table>
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<tr>
<th>Role</th>
<th>Discharge Work Observed By Role</th>
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<tr>
<td>CM</td>
<td>• Talk to patient/family&lt;br&gt;  • Admission/continued stay reviews&lt;br&gt;  • Freedom of choice form&lt;br&gt;  • Initiates referrals&lt;br&gt;  • Arrange transportation&lt;br&gt;  • PASS-R form&lt;br&gt;  • IMM form&lt;br&gt;  • Get phone/fax numbers for receiving facilities</td>
</tr>
<tr>
<td>PCL</td>
<td>• Admission Med Rec&lt;br&gt;  • Determining PCP and where fill scripts&lt;br&gt;  • DC order/depart&lt;br&gt;  • Order entry&lt;br&gt;  • Arrange f/u appts&lt;br&gt;  • HC orders&lt;br&gt;  • Progress notes&lt;br&gt;  • Prior auths for meds&lt;br&gt;  • Connects w patients and families</td>
</tr>
<tr>
<td>PNCC</td>
<td>• DC instructions w pts&lt;br&gt;  • Puts in HC orders and updates HC&lt;br&gt;  • Gets prescriptions filled at Falk&lt;br&gt;  • Documentation: IPOC’s&lt;br&gt;  • POLST&lt;br&gt;  • Coordinate PT “priority visits”&lt;br&gt;  • Pulls IV’s&lt;br&gt;  • Communicates with MD’s&lt;br&gt;  • Faxes report to post acutes&lt;br&gt;  • Tells HUC to copy chart&lt;br&gt;  • Connects w patients and families&lt;br&gt;  • Checks on status of other services/consults, etc.</td>
</tr>
<tr>
<td>SW</td>
<td>• Talk to patient/family&lt;br&gt;  • Initiates referrals&lt;br&gt;  • Arrange transportation&lt;br&gt;  • IMM form&lt;br&gt;  • PASS-R form&lt;br&gt;  • Connects w patients and families</td>
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<tr>
<td>Bedside Nurse</td>
<td>• Gives medications&lt;br&gt;  • Documentation, incl IPOC’s&lt;br&gt;  • Gets updates from MD, PNCC, and UD about patients&lt;br&gt;  • DC instructions w pts&lt;br&gt;  • Pulls IV’s&lt;br&gt;  • Calls report&lt;br&gt;  • Connects w patients and families</td>
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<tr>
<td>MD</td>
<td>• Discharge med rec.&lt;br&gt;  • DC Order/depart&lt;br&gt;  • Order entry&lt;br&gt;  • Scripts&lt;br&gt;  • HC orders&lt;br&gt;  • Progress notes&lt;br&gt;  • Connects w patients and families</td>
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*purple indicates a task that can be done by multiple people*
Patient Centered Observations

Key for the flows on next slides

- Work OUTSIDE a patient’s room
- Work INSIDE a patient’s room
RY (day 2)

7:50 RN confirms d/c with PNCC

8:45 RN visit confirms D/C w pt

9:06 MDR

9:45 CM reviews case

9:48-9:53 CM to room to get IMM and ask about ride home

10:07-10:12 MD and PCL rounds, rev meds, offer to set up appts, informs pt of dc

10:51 PNCC Who is your pharmacy (for po vanco)

11:29-11:33 PNCC called for Vanco script and PCL got it and brought to her

11:58 PNCC faxed scripts to Falk

12:00 PNCC tells pt getting meds at Falk

12:40 PNCC tells pt getting meds at Falk

12:55-12:58 RN gives Vanco, offers d/c instructions, pt wants to wait for daughter

1:08-1:15 IV nurse arrives, learns of discharge and deactivates port

1:50 Falk calls PNCC – need prior auth for vanco

1:51-2:13 PCL calls insurance and gets prior auth

2:15 PCL calls PNCC with auth

3:07 Meds delivered to pt

3:32 RN to HUC: Order WC

4:04 Daughter arrives

4:09 RN prints d/c instructions

4:14-4:18 Reviews with daughter

1:50 PNCC calls PCL re this

11:59-12:01 PCL and MD do dc orders and depart

12:55-12:58 RN gives Vanco, offers d/c instructions, pt wants to wait for daughter

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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

And others...
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
• We ignored the expert in the room
• Importance of geographics
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
Day in the Life of a Provider in Care Coordination

MD  Care Manager

RN 1  RN 2  RN 3

Others as appropriate (SW, Pharmacist, etc)
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
“We’d like to start out being very involved with you but eventually be drawn away to much more interesting cases down the hall.”
# HCAHPS

**Combined Data ALL Medicine Care Coordination Units, 7ST, MICU**

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Updated 5/8/14
### HCAHPS ALL Presbyterian Data

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Updated 5/8/14
Nursing Unit Scorecard Update: Comprehensive Single Source of Data

• New format: ICU version and Non-ICU version
  – Unit LOS for both versions rather than discharging LOS
  – Impact is to the ICU version
• CMI adjusted LOS removed
  – As it has been causing some confusion among nursing departments (Especially the ones with a high CMI, as their LOS looked like it was half or a third of what they typically see).
• Changed the source of the data in our reporting system
  – Allowed for the capture of the HCAHPS data
  – Will also assist with future enhancements
• Forthcoming:
  – Option to run report including CMI adjusted LOS
  – Hospital wide version
  – Exploring methods to add Care Coordination implementation dates to the scorecards
  – Ability to change time stamps for reports
## UPMC Presbyterian - (7ST) Non ICU Scorecard

Rolling 12 Months: May 01, 2013 - Apr 30, 2014

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<td>HA CAUTI Rate per 1000 days</td>
<td>0.00</td>
<td>11.63</td>
<td>6.99</td>
<td>0.00</td>
<td>7.19</td>
<td>7.14</td>
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<td>0.00</td>
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<td>0%</td>
<td></td>
<td>3.06</td>
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<td>-22%</td>
</tr>
<tr>
<td>HA CLAB Rate per 1000 days</td>
<td>0.00</td>
<td>1.49</td>
<td>0.00</td>
<td>1.63</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.60</td>
<td>1.83</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>0.60</td>
<td>0.90</td>
<td>-0.30</td>
<td>-34%</td>
</tr>
<tr>
<td>HCAHP Nurse Communication</td>
<td>91%</td>
<td>84%</td>
<td>91%</td>
<td>79%</td>
<td>81%</td>
<td>82%</td>
<td>100%</td>
<td>65%</td>
<td>82%</td>
<td>88%</td>
<td>76%</td>
<td>67%</td>
<td>72.5%</td>
<td>-6.9%</td>
<td>-8%</td>
<td></td>
<td>82.3%</td>
<td>76.5%</td>
<td>6.8%</td>
<td>9%</td>
</tr>
<tr>
<td>HCAHP Staff Responsiveness</td>
<td>67%</td>
<td>61%</td>
<td>56%</td>
<td>71%</td>
<td>43%</td>
<td>47%</td>
<td>33%</td>
<td>50%</td>
<td>55%</td>
<td>47%</td>
<td>20%</td>
<td>50%</td>
<td>33.3%</td>
<td>16.7%</td>
<td>50%</td>
<td></td>
<td>53.7%</td>
<td>45.5%</td>
<td>8.2%</td>
<td>10%</td>
</tr>
<tr>
<td>HCAHP Doctor Communication</td>
<td>97%</td>
<td>86%</td>
<td>92%</td>
<td>92%</td>
<td>74%</td>
<td>85%</td>
<td>67%</td>
<td>62%</td>
<td>72%</td>
<td>75%</td>
<td>81%</td>
<td>58%</td>
<td>72.5%</td>
<td>-14.2%</td>
<td>-20%</td>
<td></td>
<td>81.7%</td>
<td>77.7%</td>
<td>4.1%</td>
<td>5%</td>
</tr>
</tbody>
</table>
# MICU (Go Live: December 2013)

## UPMC Presbyterian - (MICU) ICU Only Scorecard

**Rolling 12 Months: May 01, 2013 - Apr 30, 2014**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Discharges (Unit)</td>
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<td>31</td>
<td>34</td>
<td>30</td>
<td>39</td>
<td>41</td>
<td>35</td>
<td>26</td>
<td>24</td>
<td>21</td>
<td>25</td>
<td>26</td>
<td>32</td>
<td>-6</td>
<td>-19%</td>
<td>31</td>
<td>30</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>ALOS (Unit)</td>
<td>5.9</td>
<td>6.3</td>
<td>6.4</td>
<td>5.5</td>
<td>5.8</td>
<td>6.1</td>
<td>6.7</td>
<td>6.2</td>
<td>4.9</td>
<td>5.4</td>
<td>5.0</td>
<td>4.4</td>
<td>7.0</td>
<td>-2.6</td>
<td>-13%</td>
<td>6.7</td>
<td>6.8</td>
<td>-1.1</td>
<td>-16%</td>
</tr>
<tr>
<td>CMI (Unit)</td>
<td>3.3</td>
<td>3.1</td>
<td>3.2</td>
<td>3.1</td>
<td>2.9</td>
<td>3.2</td>
<td>3.3</td>
<td>2.9</td>
<td>3.1</td>
<td>4.1</td>
<td>4.2</td>
<td>2.8</td>
<td>3.9</td>
<td>-1.1</td>
<td>-26%</td>
<td>3.3</td>
<td>3.3</td>
<td>0.0</td>
<td>-1%</td>
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<tr>
<td>ALOS Housewide</td>
<td>18.8</td>
<td>14.5</td>
<td>12.9</td>
<td>11.2</td>
<td>12.6</td>
<td>12.6</td>
<td>15.5</td>
<td>12.8</td>
<td>15.9</td>
<td>18.1</td>
<td>18.0</td>
<td>14.3</td>
<td>18.5</td>
<td>-4.2</td>
<td>-22%</td>
<td>14.9</td>
<td>15.5</td>
<td>-0.4</td>
<td>-4%</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>31</td>
<td>30</td>
<td>30</td>
<td>29</td>
<td>29</td>
<td>31</td>
<td>29</td>
<td>27</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>31</td>
<td>-5</td>
<td>-25%</td>
<td>27</td>
<td>31</td>
<td>-3</td>
<td>-11%</td>
</tr>
<tr>
<td>Turnover % (Terms Only)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.1%</td>
<td>2.2%</td>
<td>1.1%</td>
<td>1.1%</td>
<td>0.9%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>5%</td>
<td>69%</td>
</tr>
<tr>
<td>7 Day Readmission Rate</td>
<td>7.7%</td>
<td>8.3%</td>
<td>0.0%</td>
<td>7.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>6.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>6.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.5%</td>
<td>7.7%</td>
</tr>
<tr>
<td>30 Day Readmission Rate</td>
<td>15.4%</td>
<td>8.3%</td>
<td>0.0%</td>
<td>14.3%</td>
<td>16.7%</td>
<td>26.7%</td>
<td>6.7%</td>
<td>14.3%</td>
<td>0.0%</td>
<td>14.3%</td>
<td>25.0%</td>
<td>16.7%</td>
<td>5.9%</td>
<td>10.0%</td>
<td>16.3%</td>
<td>13.4%</td>
<td>21.2%</td>
<td>-7.8%</td>
<td>-37%</td>
</tr>
<tr>
<td>Falls Rate per 1,000 days</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>2.21</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.39</td>
<td>0.00</td>
<td>1.40</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.60</td>
<td>-0.83%</td>
</tr>
<tr>
<td>HAPU Rate per 100 Disch'd</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>2.94</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>2.86</td>
<td>3.45</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>HA CAUTI Rate per 1000 days</td>
<td>5.55</td>
<td>1.26</td>
<td>2.72</td>
<td>2.65</td>
<td>6.21</td>
<td>4.67</td>
<td>9.74</td>
<td>4.32</td>
<td>4.52</td>
<td>1.77</td>
<td>1.78</td>
<td>0.00</td>
<td>8.53</td>
<td>0.00</td>
<td>0.00</td>
<td>4.07</td>
<td>4.62</td>
<td>-0.55</td>
<td>-12%</td>
</tr>
<tr>
<td>HA CLAB Rate per 1000 days</td>
<td>0.00</td>
<td>2.49</td>
<td>0.00</td>
<td>2.61</td>
<td>1.30</td>
<td>1.22</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.62</td>
<td>0.00</td>
<td>0.00</td>
<td>2.40</td>
<td>0.00</td>
<td>0.00</td>
<td>0.03</td>
<td>0.78</td>
<td>0.04</td>
<td>6%</td>
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<tr>
<td>HA VAE Rate per 1000 days</td>
<td>0.23</td>
<td>0.25</td>
<td>0.00</td>
<td>0.29</td>
<td>0.00</td>
<td>0.23</td>
<td>0.25</td>
<td>0.73</td>
<td>0.54</td>
<td>0.09</td>
<td>0.00</td>
<td>0.00</td>
<td>0.21</td>
<td>0.00</td>
<td>0.00</td>
<td>0.31</td>
<td>0.06</td>
<td>0.25</td>
<td>442%</td>
</tr>
</tbody>
</table>
What comes from nurturing the voice of our nurses?

• Tale of two ideas:
  – Mobility
  – “Pack your parachute”
Mobility
• Early and effective team mobilization of the acute care patient improves and/or maintains higher levels of patient function, patient satisfaction and patient quality of life post discharge

• Mobilization, in conjunction with strong interdisciplinary communication and compliance with interdisciplinary discharge plans has also been suggested in the literature to potentially reduce LOS and Readmissions

• Reason to suspect that mobilization will favorably impact: falls, HAPUs, VTE and indirectly rate of urinary catheterization
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>
Acute Care ICU Mobility Pilot – MICU PUH

Inclusionary Criteria:
- 17 years of age
- Mechanically Ventilated
- Able to follow simple commands prior to MICU admission.

Exclusionary Criteria:
- Potential lethal arrhythmia
- Acute myocardial ischemia
- Spinal injury
- Tenuous airway
- Status Epilepticus
- Agitation, Active bleeding, CMO

Interdisciplinary Mobility Rounds – PMR presence

RN assesses patient’s LOC & command following

**LEVEL 1:** PROM/Positioning
(Sedated/No Command Following. Do not consult PT)

**LEVEL 2:** AROM

**LEVEL 3:** EOB - OOB

**LEVEL 4:** AMBULATION

Minimize Sedation and Consult PT
*Refer to mobility protocol*
# ICU Mobility Ongoing Outcomes: MICU PUH (Jun’13-May‘14)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>MICU ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun’12 – May’13</td>
<td>6.7</td>
</tr>
<tr>
<td>Jun’13 – May’14</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>ALOS Decrease</strong></td>
<td><strong>(1.1)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MICU</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>7day readmission rate</td>
<td>7.8%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Falls Rate/ 1000 days</td>
<td>.61</td>
<td>1.34</td>
</tr>
</tbody>
</table>
100% patients admitted/transferred to unit were Functionally Screened utilizing the **AM-PAC inpatient short forms** — *Tool for Mobility and Daily Activity. Accurate and meaningful*

PT/Nursing completed the AMPAC tool.

PT assigned patients based on clinical assessment into one of 3 Mobility Groups.

AM-PAC scores were then analyzed to determine predictive cut points into the 3 categories:

1. **Skilled Therapy Required**
   - Skilled therapeutic interventions will be delivered by PT and/or OT staff. Need for MD orders will be discussed in rounds with PCC. *Team to reinforce*

2. **Therapy Guided Mobility Required**
   - OOB activity, mobility, and therapeutic exercise performed by Rehab Aide as assigned by PT/OT. *Team to reinforce*

3. **Team Reinforcement of Mobility Required**
   - No current functional deficits. Nursing primary mobilizer. *Team to reinforce*

**Rapid Interdisciplinary Mobility Rounds – Daily**
## Non-ICU Mobility Ongoing Outcomes: 7ST PUH (Jun’13- May‘14)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>7ST ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>May’12-Apr’13</td>
<td>9.7</td>
</tr>
<tr>
<td>May’13-Apr’14</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>ALOS Decrease</strong></td>
<td><strong>(1.3)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7ST</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>7day readmission rate</td>
<td>5.5</td>
<td>5.3</td>
</tr>
<tr>
<td>HAPU Rate/1000 days</td>
<td>.88</td>
<td>.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCAHP</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Responsiveness</td>
<td>46.6</td>
<td>51.7</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>77.7</td>
<td>82.1</td>
</tr>
</tbody>
</table>
### Non-ICU Mobility Pilot Outcomes: 3E SHY (Jun-Oct 2013)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Patient Count</th>
<th>3E ALOS</th>
<th>Hospital ALOS</th>
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<tbody>
<tr>
<td>Jun-Oct 2012</td>
<td>724</td>
<td>4.76</td>
<td>6.22</td>
</tr>
<tr>
<td>Jun-Oct 2013</td>
<td>835</td>
<td>4.34</td>
<td>5.94</td>
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</tbody>
</table>

**ALOS Decrease**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(.42)</td>
</tr>
<tr>
<td>(.28)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3E SHY</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>7day readmission rate</td>
<td>6.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Falls rate per 1000 days</td>
<td>8.43</td>
<td>4.96</td>
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</table>

<table>
<thead>
<tr>
<th>HCAHP</th>
<th>Previous Rolling 12 months</th>
<th>Current Rolling 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Responsiveness</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>71%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Highlights of Change

- Meaningful Functional screen completed within 24 hours of admission
- Patient’s mobility needs identified early and objectively through categorization into groups
- Resources objectively allocated to perform the Right task, by the Right professional, at the Right time
  - PT responsible for managing patients in two of the 3 Mobility Groups: (category and the goal was written on the White Board in patient’s room)
  - NSG responsible for managing patients in one Mobility Group and assisting with others (Team Reinforced Mobility Required)
- Daily rapid mobility rounds
- Increased interdisciplinary communication of mobility group
- Team consensus and participation in patient’s mobility needs
- Accountability of staff roles/responsibilities to facilitate culture change
7ST Story: Mobility Meets Care Coordination

• 7ST: 40 beds, pulmonary patients, step down level of acuity
  – Mobility efforts solidly in place
  – Met with team re: Care Coordination
  – Duration of Med Pass SIGNIFICANT barrier to interdisciplinary team rounds

• Problem solving ensued
Parachutes
Summary of Initial Data/Observations

- Majority of meds administered between 08:00-10:00
- Average # of meds per patient = 21
- Average # of minutes for initial med pass = 93

- Pathway of one nurse’s footsteps during initial med pass for two patients
- This nurse walked ¼ of a mile during her initial med pass
- Nurse traveled to multiple locations to collect medications and supplies for initial med pass
## Volume of Meds by Nursing Assignment

<table>
<thead>
<tr>
<th></th>
<th>0800-0859</th>
<th>0900-0959</th>
<th>1000-1059</th>
<th>total 8-11a</th>
<th>total 7a-7p</th>
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</thead>
<tbody>
<tr>
<td>MARY (3 patients)</td>
<td>2</td>
<td>10</td>
<td>12</td>
<td>24</td>
<td>55</td>
</tr>
<tr>
<td>ROBIN (2 patients)</td>
<td>20</td>
<td>5</td>
<td>4</td>
<td>29</td>
<td>44</td>
</tr>
<tr>
<td>LIZ (3 patients)</td>
<td>11</td>
<td>16</td>
<td>2</td>
<td>29</td>
<td>57</td>
</tr>
<tr>
<td>CARMEN (4 patients)</td>
<td>13</td>
<td>28</td>
<td>14</td>
<td>55</td>
<td>105</td>
</tr>
<tr>
<td>KARLIE (3 patients)</td>
<td>21</td>
<td>1</td>
<td>22</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>MIKE (3 patients)</td>
<td>13</td>
<td>23</td>
<td>1</td>
<td>36</td>
<td>66</td>
</tr>
<tr>
<td>ASHLEY (3 patients)</td>
<td>21</td>
<td>11</td>
<td>2</td>
<td>34</td>
<td>51</td>
</tr>
<tr>
<td>SUSY (3 patients)</td>
<td>9</td>
<td>14</td>
<td>1</td>
<td>24</td>
<td>47</td>
</tr>
<tr>
<td>MICHELLE (3 patients)</td>
<td>18</td>
<td>15</td>
<td>2</td>
<td>35</td>
<td>64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128</strong></td>
<td><strong>122</strong></td>
<td><strong>38</strong></td>
<td><strong>288</strong></td>
<td><strong>520</strong></td>
</tr>
</tbody>
</table>

## 12/19 Volume of Meds Passed Over Time 7a-7p (Scheduled, PRN, and Respiratory)

- **Time 7ST Medications**
- **Baseline State**
- **Volume of Meds by Nursing Assignment**

![Graph showing volume of meds passed over time]
The medication dilemma
Learning to Pack a Parachute; learning to trust a team member to pack your parachute for you.
Our Intervention

Overarching Goal: The right med at the right time in the right location
Eliminate: RN sorting, hunting, and gathering of medications

- Intervention
  - Removed meds from AcuDose
  - Increased meds in Cart Fill
  - Created 2 envelopes per patient
    1. AM med pass 0700-1000
    2. All other medications
  - Unit-based pharmacy technician
    - “Packs the parachute” to ensure AM meds available in envelope
    - Coordinates med logistics
AcuDose* Dispensing

![Graph showing AcuDose Drugs and Transactions before and after intervention. The graphs indicate a 61% decrease in AcuDose Drugs and a 66% decrease in Transactions.]* Non-narcotic – Non respiratory
What This Means to the Bedside Nurse

- Fewer steps, with less hunting and searching for meds
- Frees the bedside nurse to participate in rounds
- Preliminary results:
  - 75% of am meds passed by 09:00
  - Average time of med pass decreased from 93 minutes to 62 minutes
What This Means to Pharmacy

• Increase in dispensed first doses and meds in the cartfill
  – Increase accuracy
  – Creation of “med passes”
    • Placed where nursing needs the medication
• Integration of unit-based technician into medication logistics
  – Ambassador to nursing
  – Reduce rework by pharmacy
    • “Missing” vs. “delayed” medications
  – Evaluate medication delivery
  – Help nursing find medications
  – Improved job satisfaction for technician
• Future evaluation: Improve Transition of Care
7ST Scorecard

LOS ↓ by 1.3 Days 14%

CMI ↑ by 7%

RN Turnover ↓ by 64%

HAPU’s ↓ by 36%

CLABS ↓ by 22%

Nurse Communication scores ↑ by 6 pts & above 50th percentile

7 day & 30 day readmissions ↓ by 2% & 6%

Staff responsiveness by 11%

Doctor Communication scores ↑ by 5 pts & above 50th percentile

HAPU’s by 36%

Nurse Communication scores ↑ by 6 pts & above 50th percentile
Conclusions
Industry pressures demand we become

- More effective (producing better outcomes)
- More efficient (at a lower cost)
  - Fewer unnecessary hospital days, treatments, meds
  - Fewer complications
  - Decrease turnover of staff
  - Improve training of staff
  - Improve interdisciplinary work
    - Increased engagement
    - Increased job satisfaction
  - More caring (with patients feeling satisfied with their 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 value the input of all members, encourage their contributions and see increased participation from all as they mature together

• As leaders, we need to be committed to patient and nurse focused models that seek nursing input, empower nursing accountability and promote the development of our nurses at every stage of their careers