Educating the multi-disciplinary team to optimize acute PT utilization

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Disclosures

- None

Objectives:

- Identify and discuss tools to empower therapists to advocate for appropriate utilization of PT services
- Compare educational needs of referral sources and individual members of multi-disciplinary team
- Explore various methods for delivery of education including specific examples
- Define data collection methods and tracking of success rates & barriers

Henry Ford Health System

Core Services:

- 4 acute care hospitals
- 3 behavioral health hospitals
- 40 Medical Centers
- Health Alliance Plan insurance company
- 1200 group practice physicians & scientists (3rd largest in US)
- 2200 private physicians
- 1500 MD & DO residents

Henry Ford Hospital

- Level 1 Trauma center
- 802 beds (168 ICU beds)
- 16th largest teaching hospital in US
- One of largest non-university research programs in the US
- Largest number of ICU beds in Michigan, one of the largest in the nation
- Founded in 1915

Henry Ford Hospital

- Founded by innovator Henry Ford
- Recruited from Hopkins School of Medicine; focus on clinical discovery
- Dr. Mayo advised model of medical practice
- Focus of service and quality continues
- Rehab competencies have been shared with over 150 hospitals in 27 states

Henry Ford

The Henry Ford Hospital, 1923

Southeast Michigan

- Utilization of PT and OT can be highly driven or affected by insurance, regulatory requirements
- Very competitive health care environment
  - Third party payers
  - Skilled nursing facilities; Subacute rehab facilities

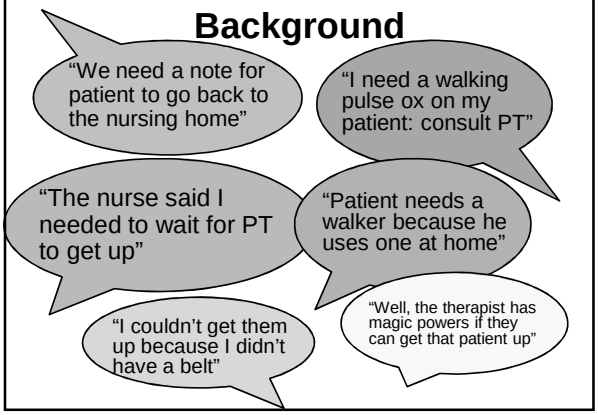
Background

- Large volume of "inappropriate" consults
- Consulted for completely dependent or independent patients
- Decreased time and resources from patients requiring skilled PT services
- Therapists providing basic mobility or discharge recommendations only

Background

- Timely and appropriate utilization of PT services:
  - optimizes patient care
  - reduces cost by delivering care that is efficient and patient-centered
  - Reduces discharge delays
  - Allows PTs to be more productive, effective, have the most impact on a patients life
  - "I get to do what I do best every day"

Background



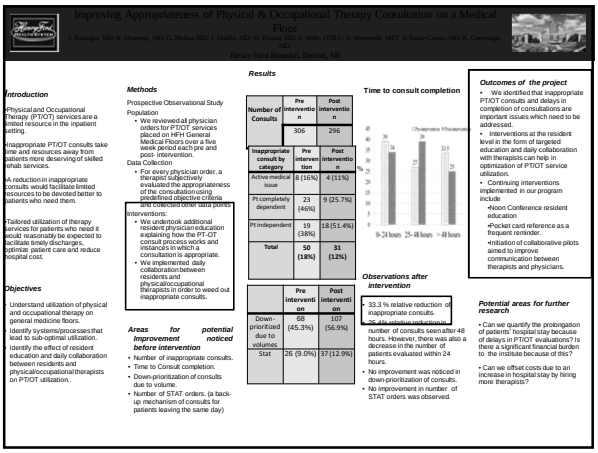
Introduction

- Started informally
- Structured approach needed
- Collaborated with our #1 source of "inappropriate orders"
- Teamed up for QI project

House Officer QI Project

- Data collection by therapists
  - For every physician order, a therapist subjectively evaluated the appropriateness of the consultation using predefined objective criteria and collected other data points

Days After Admission/Transfer to GPU that Order Placed	Date Consult Initiated	Date Consult Completed	Time Consult Completed	Reason not seen within 24 hours	Order is Routine or STAT	Appropriate Consult	Inappropriate Consult
Ordered in ICU or other floor			0-12 hours	24 hour mark was overnight	Routine order	Frequent Falls	Patient independent currently
On Admission/Transfer to GPU			13-24 hours	24 hour mark was over weekend	Duplicate routine order	Admit from Rehab	Patient completely dependent at baseline
1day			25-36 hours	Downprioritized due to volumes	STAT order	Suspected Need for Rehab	Active medical issue - present at time of consult
2 days			36-48 hours	Patient Unavailable / Off floor	Duplicate STAT order	Specific Question	Active medical issue - not present at time of consult
3-4 days			>48 hours	Patient not appropriate due to medical issue	Other	Requested by Case Manager	Inappropriate STAT consult - not ready D/C in 24 hrs
5-6 days				Other		Functional Decline from Baseline	Inappropriate STAT consult - consult indicated sooner
7 or greater days						Other	Other



Outcomes of Project

- 33.3% reduction in “inappropriate” consults (From 18% to 12%)
- Identified need for more targeted education – what do MDs really want to know?
  - Noon conference education – Physician to physician training
  - Pocket Card Reference
  - Various trials for collaboration

Introduction

- Educating the multidisciplinary team is key
- Consider each discipline and team members’ roles
  - Referral sources
  - Approach to patient care
  - Level of education
  - How they learn best

Introduction

- Therapists need to advocate for their profession
- Education is constant and ongoing
- Change habits
- Don’t quit!

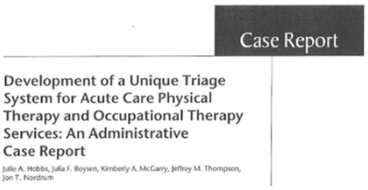
Empowering therapists as our own advocates

Empowering therapists

- Knowledge of scope of practice
- If therapists feel comfortable defining their role, they can communicate with other staff to prevent misuse of time and services.

Empowering therapists

- In 2013, clinicians from the Mayo Clinic presented at CSM and published a unique system for triaging acute care patients


Case Report

Development of a Unique Triage System for Acute Care Physical Therapy and Occupational Therapy Services: An Administrative Case Report

Julie A. Hobbs, Julia F. Boysen, Kimberly A. McGarry, Jeffrey M. Thompson, Jon T. Nordrum

Getting it Right – Staff Resource

ARIOT 2

Acute Rehabilitation Innovation and Optimization Team – Part 2

"Getting it Right" in Acute Care

Staff Resource

Communication—Talking Points

Use these talking points to communicate your clinical decisions to other colleagues.

This is not the **RIGHT PATIENT** because:
- No acute functional loss
- Loss is transient and will improve without therapy
- Patient does not need skills of a therapist
- Patient does not have the capacity to learn

Therapy is not the **RIGHT PROVIDER** because:
- Nursing or family members can provide service
- The clinical condition does not require specialized skills

This is not the **RIGHT SETTING** because:
- Therapy will not change the length of stay or discharge disposition
- It is most appropriate to address the condition in an outpatient setting
- The patient has met all acute goals

This is not the **RIGHT TIME** because:
- The patient is not making functional gains
- The patient has met all acute care goals
- The patient's medical condition prohibits them from participating meaningfully in therapy

Getting it Right

- In acute care, to determine ongoing therapy needs, we need to answer several questions:
  - Who is the **right patient**?
  - Who is the **right provider**?
  - Where is the **right setting** for providing therapy services?
  - What is the **right amount, frequency and duration** of services?
  - When is the **right time** to start and discontinue therapy services?

Who is the Right Patient?

- Does the patient have **unmet goals** which need to be achieved in acute care setting?
- Is intervention focused on an **acute medical change** versus a chronic condition?
- Is the patient functioning **below baseline**?

NOT the Right patient:

- No acute functional loss
- Patient does not need skills of a therapist
- Patient does not have the capacity to learn.
- Loss is transient and will improve without therapy or patient is independent

Is PT or OT the right PROVIDER?

- Is the therapy **complexity**/sophistication such that only a qualified therapist could do?
- Is the care too complex to be transferred to another provider such as nurse, PMA or family member?

Empowering therapists

- Confidence in clinical skills
  - New hire orientation
  - Department competencies
  - Mentoring
  - Team huddles
  - Evidence-based article review
  - Acute Care listserv
  - Collaboration with outside facilities

Empowering therapists

- Scripting of key phrases
- Embracing “teachable moments”
- Regular communication with members of team
- Support from management
- Training for crucial conversations

Crucial Conversations

Scripting


Crucial Conversations

BY KELLY BROOKS, PREVIOUS EDITOR ON APRIL 13, 2011 HOPKINS NURSE, PAST ISSUES, SIBLEY, SPRING 2011

Nurses Learn Communications Strategies That Improve Patient Safety

“Staff also learn to recognize the feelings they bring to the conversation and to listen to other sides of the story, all while staying focused on — and quickly resolving — the central issue at hand. “In healthcare you have to be able to speak to somebody spontaneously,” says Haresign. “If you can state facts and not worry about the emotions, you can really get to the point of what you need.”

Silence Kills

The Seven Crucial Conversations in Healthcare

David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson, and Al Switzler

Why Don't People Speak Up and Share Their Full Concerns?

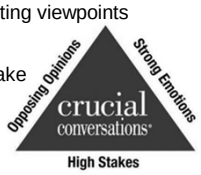
The obvious reason is that confronting people is difficult. In fact, most respondents to the survey indicated it was between difficult and impossible to confront people in these crucial situations. People's lack of ability, belief that it is "not their job," and low confidence that it will do any good to have

Lack of Support: 53 percent of nurses and other clinical-care providers report that 10 percent or more of their colleagues are reluctant to help, impatient, or refuse to answer their questions. 83 percent have a teammate who complains when asked to pitch in and help. On the

"Some people here are burnt out. They've lost the excitement or have some personal issue in their life .

Crucial Conversations

- What makes a conversation "crucial" vs. typical?
  - Opinions differ
    - what is best for patient; conflicting viewpoints
  - Strong emotions
    - Professional credibility is at stake
  - High Stakes
    - Patient care can be impacted



"Common" Crucial Conversations

- Critiquing a colleague's work
- Talking to a team member who isn't keeping commitments
- Talking to a nurse about patient's lack of mobility
- Talking to a physician about referral patterns
- Talking to a case manager who refers a patient to SNF even though you recommend IPR

Crucial Conversations

- How do we typically handle crucial conversations?
  - We can avoid them
  - We can face them and handle them poorly
    - Emotions tend to rule; your body physically reacts
    - We are under pressure or we are stumped
    - We act in self defeating ways
  - We can face them and handle them well

Crucial Conversations

- Mutual Purpose:
  - When others believe you are genuinely committed to their best interests, they stop resisting you and become more open to your interests
- Show mutual respect

Considerations

- Am I pretending not to notice my role in the problem?
- What should I do right now to move toward what I really want?
- Be concise

Strategies for Success

- "One of the best ways to persuade others is with your ears - by listening" - Dean Rusk
  - Interrupts defensiveness

Strategies for Success

- Don't begin a conversation telling someone what they are doing wrong
- Begin a conversation with facts not assumptions
- Remember to ask yourself why would a decent, reasonable and rational human being behave this way

Strategies for Success

- Scripting examples
- Practice responses:
  - Doctor consulted on a patient that walked to the gift shop
  - Nursing asking when you are coming back to get the patient back to bed

Educational needs of referral sources & Methods for delivery of education

Know your Audience

- Providers:
  - Senior staff physicians
  - Hospitalists
  - Residents, medical students
  - Mid-level providers – Nurse Practitioner, Physicians Assistant
- Nursing staff
- Case management/Social Work

Providers

Senior staff physicians

- Academic
- In some cases, not front line
- High level of experience
- Could be resistant to change
- Can be champions for process improvement due to position

Hospitalists

- Staff Physician
- Primary Care provider in acute care
- Front Line
- Could be resistant to change especially if private practice
- Can be champions due to position

Residents & Medical Students

- Focus on immediate medical needs, not ancillary staff or bigger picture
- Lack of training & experience with rehab in medical school
- Receive delegated tasks; report back to senior staff
- Look for path of least resistance

Mid-level providers

- Non-rotating staff
- Varied education level, PA (medical model) vs NP (nursing model)
- Education is specific to service line

Delivery of Education

- PowerPoint presentations
  - – Senior Staff may receive only via email
    - Only more pertinent facts, statistics & evidence
  - – For residents: provide at initial orientation
    - Include Case Studies with Learning points
      - – Created by chief resident

Delivery of Education

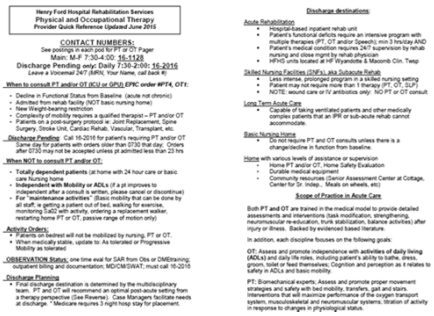
- Refresher talks - Rotation to new service
  - Brief, to-the-point descriptions: role of PT, discharge destinations, checklists
- Pocket cards
- One-on-one training

Provider Considerations

- Short attention spans! Need to be concise.
  - High demands, long hours
- Don't go into unnecessary details
- Describe in medical model definitions – speaks to physicians
- Want to build trust and respect

Provider Examples

Pocket Card



Henry Ford Hospital Rehabilitation Services
Physical and Occupational Therapy
Provider Quick Reference Updated June 2015

CONTACT NUMBERS:
See postings in each pod for PT or OT Pager
Main: M-F 7:30-4:00: 16-1128
Discharge Pending only: Daily 7:30-2:00: 16-2016
Leave a Voicemail 24/7 (MRN, Your Name, call back #)

When to consult PT and/or OT (ICU or GPU) EPIC order #PT4, OT1:
- Decline in Functional Status from Baseline (acute not chronic)
- Admitted from rehab facility (NOT basic nursing home)
- Activity/Weight-bearing status
- Complexity of mobility requires a qualified therapist – PT and/or OT
- Patients on a post-surgery protocol ie: Joint Replacement, Spine Surgery, Stroke Unit, Cardiac Rehab, Vascular, Transplant, etc.

Discharge Pending: Call 16-2016 for patient's requiring PT and/or OT Same day for patients with orders older than 0730 that day; Orders after 0730 may not be accepted unless pt admitted less than 23 hrs

When NOT to consult PT and/or OT:
- Totally dependent patients (at home with 24 hour care or basic care Nursing home
- Independent with Mobility or ADLs (if a pt improves to independent after a consult is written, please cancel or discontinue)
- For "maintenance activities" (Basic mobility that can be done by all staff; ie getting a patient out of bed, walking for exercise, monitoring SaO2 with activity, ordering a replacement walker, restarting home PT or OT, passive range of motion only)

Activity Orders:
- If patients on bedrest will not be mobilized by nursing, PT or OT.
- When medically stable, update to: As tolerated or Progressive Mobility as tolerated

OBSERVATION Status: one time eval for SAR from Obs or DMEtraning; outpatient billing and documentation; MD/CM/SWAT; must call 16-2016

Discharge Planning
- Final discharge destination is determined by the multidisciplinary team. PT and OT will recommend an optimal post-acute setting from a therapy perspective (See Reverse). Case Managers facilitate needs at discharge. * Medicare requires 3 night hosp stay for placement.

Discharge destinations:

Acute Rehabilitation
- Hospital-based inpatient rehab unit
- Patient's functional deficits require an intensive program with multiple therapies (PT, OT and/or Speech); min 3 hrs/day AND
- Patient's medical condition requires 24/7 supervision by rehab nursing and close mgmt by rehab physician
- HFHS units located at HF Wyandotte & Macomb Clin. Twsp

Skilled Nursing Facilities (SNFs), aka Subacute Rehab
- Less intense, prolonged program in a skilled nursing setting
- Patient may not require more than 1 therapy (PT, OT, SLP)
- NOTE: wound care or IV antibiotics only: NO PT or OT consult

Long Term Acute Care
- Capable of taking ventilated patients and other medically complex patients that an IPR or sub-acute rehab cannot accommodate.

Basic Nursing Home
- Do not require PT and OT consults unless there is a change/decline in function from baseline.

Home with various levels of assistance or supervision
- Home Health Aid, Home Safety Evaluation
- Durable medical equipment
- Community resources (Senior Assessment Center at Cottage, Center for Sr. Indep., Meals on wheels, etc)

Scope of Practice in Acute Care

Both PT and OT are trained in the medical model to provide detailed assessments and interventions (task modification, strengthening, neuromuscular re-education, trunk stabilization, balance activities) after injury or illness. Backed by evidenced based literature.

In addition, each discipline focuses on the following goals:

OT: Assess and promote independence with activities of daily living (ADLs) and daily life roles, including patient's ability to bathe, dress, groom, toilet or feed themselves; Cognition and perception as it relates to safety in ADLs and basic mobility.

PT: Biomechanical experts. Assess and promote proper movement strategies and safety with bed mobility, transfers, gait and stairs. Interventions that will maximize performance of the oxygen transport system, musculoskeletal and neuromuscular systems; titration of activity in response to changes in physiological status.

PowerPoint Examples

Objectives for Provider education

1. Review scope and skills of Physical Therapy and Occupational Therapists in the acute care setting
2. Discuss when a consult for PT and/or OT is appropriate and when one is not the best use of hospital resources; How to consult
3. Provide updates, statistics and processes for consults, Pathways, Obs unit and QI Initiatives

PowerPoint Examples

- How to Consult
  - Include any orders for weight bearing status, ROM or other precautions
- Insurance considerations
- Discharge planning
- Discharge Pending process

Introduction

- Consults to PT or OT Provide:
  - A detailed functional assessment
  - Individualized treatment plan for functional and self care deficits
  - Discharge recommendations for next level of care
- Entry level requirements: DPT, MPT State board licensure
- Right patient, Right provider, Right timing for acute care

Scope of PT and OT in acute care

- Detailed assessments
  - thorough chart review PMH/PSH, present medical history, lab values, radiology exams, consult reports, physician daily notes, vital signs trends, functional assessment, etc)
- Interventions
  - task modification, strengthening, neuromuscular re-education, trunk stabilization, balance activities) after injury or illness in ICU and GPU
- Recommendations for optimal post-acute setting

Scope of the Physical Therapist

- Assess and promote proper movement strategies and safety with bed mobility, transfers, gait and stairs; Training with assistive devices for mobility (walkers, crutches, canes)
- Interventions that will maximize performance of the oxygen transport system, musculoskeletal and neuromuscular systems
- Titration of activity in response to changes in physiological status.

Scope of the Occupational Therapist

- Assess and promote independence with **activities of daily living (ADLs)** and daily life roles, including patient's ability to bathe, dress, groom, toilet or feed themselves
- Cognition and perception as it relates to safety in ADLs and basic mobility
- Treatment to overcome deficits contributing to decreased independence with ADLs
- Post-op, includes adapting ADL's to maintain restrictions and/or precautions

Statistics (example)

	PT	OT
Average DAILY total pts in queue	200 patients	210 patients
Average FTE M-F	13.5	10.6
Average FTE Sa-Su	3.0	2.0

- Order time to evaluation completion is 24-48 hours. Follow up care is typically 2-3 times per week unless patient has no medical reason for continued admission and requires PT or OT to clear to go home.

What You Can Do

- Consider the patient's functional level and/or home situation in addition to medical when examining the patient
- Ensure that activity orders ("Progressive Mobility") are appropriate so that patient is mobilized by nursing staff
- Improve timeliness of discharge planning

When NOT to consult PT and OT

- Patient's baseline level of functioning is totally dependent (at home with 24 hour care or basic care Nursing home)
- Patient is already independent with mobility or activities of daily living
  - If a patient's functional status improves to independent while inpatient, please CANCEL a previously placed PT or OT consult
- Solely for maintenance activities (Basic mobility can be done by nursing)
  - Getting a patient out of bed
  - Walking a patient in the hallway for exercise
  - Monitoring Sa02 with activity
  - Ordering a replacement walker
  - Passive Range of motion only (to prevent contractures)

Checklists


2/3/13 Peter Pronovost : The New Yorker

THE NEW YORKER

ANNALS OF MEDICINE

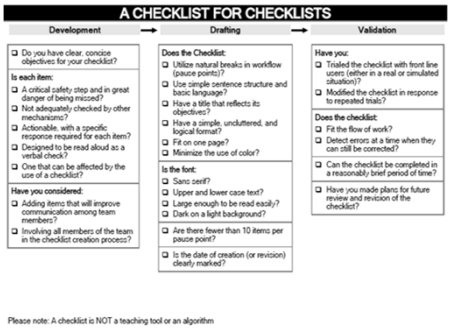
THE CHECKLIST

If something so simple can transform intensive care, what else can it do?

BY ATUL GAWANDE

DECEMBER 10, 2007

Checklists


A CHECKLIST FOR CHECKLISTS

Development → Drafting → Validation

Development:
- ❑ Do you have clear, concise objectives for your checklist?

Is each item:
- ❑ A critical safety step and in great danger of being missed?
- ❑ Not adequately checked by other mechanisms?
- ❑ Actionable, with a specific response required for each item?
- ❑ Designed to be read aloud as a verbal check?
- ❑ One that can be affected by the use of a checklist?

Have you considered:
- ❑ Adding items that will improve communication among team members?
- ❑ Involving all members of the team in the checklist creation process?

Drafting:

Does the Checklist:
- ❑ Utilize natural breaks in workflow (pause points)?
- ❑ Use simple sentence structure and basic language?
- ❑ Have a title that reflects its objectives?
- ❑ Have a simple, uncluttered, and logical format?
- ❑ Fit on one page?
- ❑ Minimize the use of color?

Is the font:
- ❑ Sans serif?
- ❑ Upper and lower case text?
- ❑ Large enough to be read easily?
- ❑ Dark on a light background?

- ❑ Are there fewer than 10 items per pause point?
- ❑ Is the date of creation (or revision) clearly marked?

Validation:

Have you:
- ❑ Trialed the checklist with front line users (either in a real or simulated situation)?
- ❑ Modified the checklist in response to repeated trials?

Does the checklist:
- ❑ Fit the flow of work?
- ❑ Detect errors at a time when they can still be corrected?
- ❑ Can the checklist be completed in a reasonably brief period of time?
- ❑ Have you made plans for future review and revision of the checklist?

Please note: A checklist is NOT a teaching tool or an algorithm

Checklist / Red Flags

If answer is YES to any, a PT and/or OT consult may be appropriate:

- Has the patient had a decline in Functional Status from Baseline?
- Was patient admitted from a subacute (NOT basic nursing home) or acute rehab facility?
- Has the patient had a Fall at home in the last 6 months?
- Does patient have a weight-bearing restriction or specific precautions related to mobility?
- Is PT and/or OT on pathway or protocol for post-surgical patient? ie: Joint Replacement, Spine Surgery, Stroke Unit, Cardiac Rehab, Vascular, Transplant, etc

Professional Collaboration

- Clinical practice issues
- Post op protocols
- Hemoglobin guidelines
- Examples
  - PEG tubes for digestive disorders
  - High Risk Pregnancy
  - ENT
  - Specialties

Nursing

Nursing

- Nursing model of education
  - Breadth of knowledge vs depth of knowledge
- Objective is to increase basic patient mobilization
- How can mobility be a part of their tasks?

Nursing

- Delivery of education
  - Inservices
    - Train the trainer
  - Nursing mobility champions
  - Grand Rounds
    - Review patient cases
  - Online courses
    - Initial training
    - Remediation

Nursing

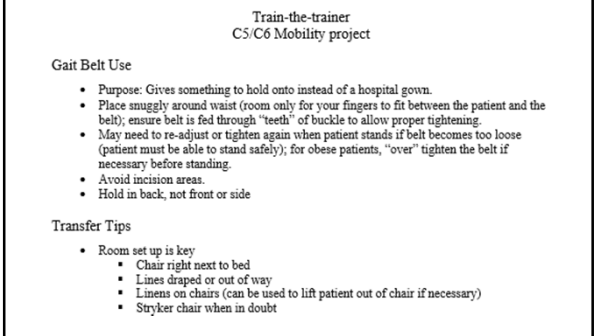
- Delivery of education
  - Tools that increase confidence, patient safety
    - Transfer training
    - Body mechanics
    - Effective use of gait belts
    - Appropriate equipment, furniture/chair usage
  - One-on-one training as needs arise

Nurses

- How they will incorporate into daily practice
- Examples:
  - UE ROM can be completed WHILE the patient is turning for peri-care in bed
  - Have patient do self-care with set-up and assist for thoroughness – save staff work, too

Nurse Examples

Train the Trainer



Train-the-trainer
C5/C6 Mobility project

Gait Belt Use

- Purpose: Gives something to hold onto instead of a hospital gown.
- Place snuggly around waist (room only for your fingers to fit between the patient and the belt); ensure belt is fed through "teeth" of buckle to allow proper tightening.
- May need to re-adjust or tighten again when patient stands if belt becomes too loose (patient must be able to stand safely); for obese patients, "over" tighten the belt if necessary before standing.
- Avoid incision areas.
- Hold in back, not front or side

Transfer Tips

- Room set up is key
  - Chair right next to bed
  - Lines draped or out of way
  - Linens on chairs (can be used to lift patient out of chair if necessary)
  - Stryker chair when in doubt

Train the Trainer

- For Slide transfers, use slide board or orange slide sheets
- Can also stand pivot to a stryker (in case patient fatigues after sitting, can be slid back to bed)

- Stand close to patient
  - Easier to lift from center of gravity
  - Example: easier to hold a gallon of milk close to body than at arm's length away
  - May also want to support knees/feet (avoid bone-on-bone contact between care provider and patient)
- Patient should be positioned with feet flat, knees lower than hips and slightly forward relative to feet; lean trunk forward ("hinge" at hips) with 'nose over toes' prior to attempting stand
- Maximize patient participation: have patient push up from bed, if possible. If patient is a "grabber" or "pusher" have them put their arms around your waist or the back of your arms/elbows (DO NOT have them hold around your shoulders or neck); OR ask for assistance from a colleague

Nurse Education

- PowerPoint
  - Delivered as Healthstream module required for all nursing
  - Grand rounds

HFHS NURSE DRIVEN MOBILITY PROTOCOL
The 6th Vital Sign

- Henry Ford Health System Nursing Development (OH 312, 11/1/2015) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- To receive 1.0 CEs, the participant must complete the program in its entirety and submit a program evaluation .

Objectives

1. Identify the effects of immobility on the human body
2. Understand the concepts of the new HFHS Nurse Driven Mobility Protocol
3. Identify small changes in practice that will enhance the culture of mobility
4. Learn 1 tip for success to use mobilizing your patient population.

Do No Harm!

- Nurses can prevent the complications of immobility that take away patients ability to have a meaningful life after hospitalization.
- Mobility is a Nursing standard of care!
- The Nurse Driven Mobility Protocol will guide effective and safe mobility for all patients.

Effects of Immobility…

- ↑ hospital LOS
- ↑ risk for pneumonia
- ↑ risk for pressure ulcers
- ↑ risk for delirium
- ↑ recovery time
- ↑discharges to skilled nursing facilities as opposed to home.
- The effects of immobility affect every body system

Effects of Immobility…

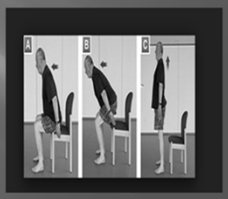
- Skin
  - The GREATEST RISK FACTOR for pressure ulcer development is immobility

Immobility Increases Pressure Ulcer risk by

87%

Mobility Level 3 Tips for Success

- Patient needs to scoot to the edge of the bed or chair to be able to stand.
- (Try it! It is very difficult to get out of the chair when sitting all the way to the back of it.)

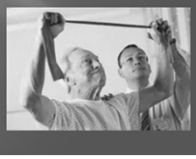


Small Changes

- Start getting patients in the chair for all meals.
- Marking distance on walls, and have patient keep track. (Another way to measure is that each ceiling tile is 2 feet)
- Put mobility level and goal on white boards.
- Dangle is a good starting point for staff and patient, start there and progress as patient tolerates!

Rehabilitation Services

- If the patient is not progressing as expected or not tolerating interventions collaborate with the physician to order physical and occupation therapy consults.



Other ppt examples

Helpful Tips

- If unable to stand from bed, may raise bed height up to make it easier
  - Consider if it's safe for patient to sit in a chair, or consider adding pillows to make it easier for patient to get out chair, or use a Stryker chair
- Lower bed height to help patient get back into bed
- If extra help is needed: one person on each side of patient
- Stand close to patient, easier when patient is closer to your center of gravity
  - Ex: lifting gallon of milk with outstretched arms vs close to body

Nurse Assistant Orientation

- Mandatory
- Monthly
- 30 minute PowerPoint
- Practice
- Check off session

Nurse Assistant Orientation

Moving Patients (special considerations)

- Always check with the RN regarding the patient's activity order
- Encourage the patient to help as much as possible
- Before moving the patient, place IV's & catheters so they won't be pulled
- Give more support to the heaviest parts of the patient's body
- Move with smooth and steady motions

Nurse Assistant Orientation

Clinical Competency Development and Evaluation Guide

Name:_____ **Unit:**_____

Title: Assisting With Ambulation: Gait Belt

KEY: 1=WITH ASSISTANCE 2=VERBAL CUES 3=INDEPENDENT

	Skills Lab	Practice 1			Practice 2			Practice 3		
Procedure:	*	1	2	3	1	2	3	1	2	3
1. Wash hands, using friction.										
2. Take patients vital signs and report vital signs and clarify ambulation orders with RN.										
3. Walk route planned to ensure no objects are in the way (ex: tray tables, chairs, trash cans, etc).										
4. Explain procedure to patient.										
5. Place bed in lowest position, lock bed elevate HOB.										
6. Assist patient to sit on side of bed. Allow patient to sit until she/he feels secure (1-2 minutes) and has no dizziness/faintness. Do not ambulate until symptoms go away.										
7. Help patient put on robe and non-skid footwear.										
8. Wrap transfer belt around patient's										

Nurse Assistant Orientation

Clinical Competency Development and Evaluation Guide

Name:_____ **Unit:**_____

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Case managers
Social workers
Discharge Planners

CM, SW, Discharge Planners

- RN case managers have nursing model background and in-depth education on medical needs of discharge, BSN
- Social Workers take into account social and psychological factors, MSW, economics

CM, SW, Discharge Planners

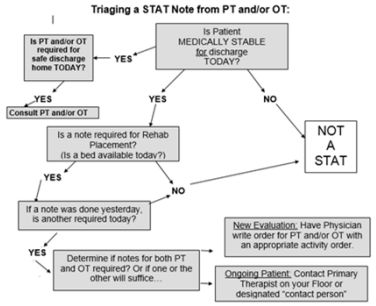
- Can obtain information from patient/family and advocate with providers during rounds, economics, social sciences
- Understanding of insurance requirements

CM, SW, Discharge Planners

- Delivery of education
  - Role of PT in acute care in discharge planning
  - Focus on end goal, facilitation of discharge
  - Use of technology for communication: shared medical record information, census lists
  - Regular collaboration to build mutual trust & respect
  - Teachable moments

CM Examples

Triaging a STAT



Role of Case Management:

Complete utilization reviews for inpatient admission and continued stay
Identify and assess psychosocial needs integral to safe discharge
Initiate, facilitate, and execute safe discharge plan including HHC/DME/SNF/IPR/AFC
Counseling
Community resource referrals

Insurance Placement Guidelines

Carrier	Authorization Required ?	PT	OT	Contracted SNF	Contracted IPR
Medicare	NO	24 hours	24 hours	No	No
Medicare Adv	Yes	24 hours	24 hours	Some	Some
HAP	Yes	24 hours	24 hours	Yes	Yes
BCBS	Yes	24 hours	24 hours	Some	Some
BCN	Yes	24 hours	24 hours	Yes	Yes
United Healthcare	Yes	24 hours	24 hours	Yes	Yes
Total Healthcare	Yes	24 hours	24 hours	Yes	Yes
Aetna	Yes	24 hours	24 hours	Yes	Yes
Cigna	Yes	24 hours	24 hours	Yes	Yes
Straight Medicaid	NO	24 hours	24 hours	Yes	Yes
Health Plan of MI	Yes	24 hours	24 hours	Yes	Yes
Great Lakes	Yes	24 hours	24 hours	Yes	Yes

Created by Jennifer Brooks, CM; Reviewed/Revised LEAN Rehab/CM group March 2011

Specific Carrier Tips:

Medicare Tips:

If patient admitted and discharged within 23 hrs, may return to SNF without PT/OT
If patient is long-term resident of SNF without skilled need, may return to SNF without PT/OT
Patient must have qualifying admission & hospital admit of 72 hrs & skilled need to discharge to SNF
If patient disagrees with discharge rec to lower level of care, patient may appeal with MPRO who may require updated PT/OT < 24 hrs

HAP Tips: (NOT HAP Sr +)

Auth line closed certain holidays	Auth valid for 24 hrs

When HAP closed, if PT/OT rec SNF within last 24 hrs and meets HAP criteria for SNF, may discharge to any Heartland, Lakeland or HFH SNF
If pt HAP HFH Network assigned will discharge to HFH facility, but still requires PT/OT within 24 hrs
May require auth of Medical Director who can request PT/OT less than 24 hrs

BCBS Tips:

Auth line closed daily 12:00-1:00pm and certain holidays, require PT/OT by 11:00am
May require PT/OT less than 24 hrs
May require PM&R consult
Auth valid 24 hrs

Department initiatives beyond education

Data collection, tracking success rates & barriers

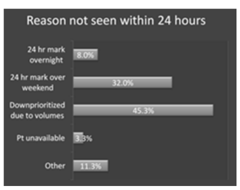
- Discharge pending orders vs number of patients actually discharged
- Inappropriate orders
- Office staff tracking
- Staff tracking forms and surveys

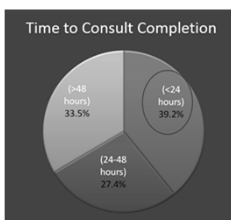
Physician Survey

- Needs to be brief

SurveyMonkey

	Excellent	Good	Average	Fair	Poor or no knowledge of	Total	Weighted Average
Your knowledge or understanding of acute care PT and/or OT PRIOR TO the presentation	25.00% 5	15.00% 3	20.00% 4	20.00% 4	20.00% 4	20	2.95
Your CURRENT knowledge or understanding of acute care PT and/or OT	35.00% 7	45.00% 9	15.00% 3	5.00% 1	0.00% 0	20	1.90
Content presented was relevant to my practice	50.00% 10	40.00% 8	10.00% 2	0.00% 0	0.00% 0	20	1.60
Quality of powerpoint presentation	45.00% 9	50.00% 10	5.00% 1	0.00% 0	0.00% 0	20	1.60
Length of presentation	40.00% 8	55.00% 11	5.00% 1	0.00% 0	0.00% 0	20	1.65
Usefulness of Pocket Card provided	50.00% 10	40.00% 8	10.00% 2	0.00% 0	0.00% 0	20	1.60





Date of Hospital Admission	Time Order Was Written	Time Order Entered into OE	Days After Admission/Transfer to GPU that Order Placed	Date Consult Initiated	Date Consult Completed	Time Consult Completed	Reason not seen within 24 hours	Order is Routine or STAT	Appropriate Consult	Inappropriate Consult
			Ordered in ICU or other floor			0-12 hours	24 hour mark was overnight	Routine order	Frequent Falls	Patient independent currently
			On Admission/Transfer to GPU			13-24 hours	24 hour mark was over weekend	Duplicate routine order	Admit from Rehab	Patient completely dependent at baseline
			1day			25-36 hours	Downprioritized due to volumes	STAT order	Suspected Need for Rehab	Active medical issue - present at time of consult
			2 days			36-48 hours	Patient Unavailable / Off floor	Duplicate STAT order	Specific Question	Active medical issue - not present at time of consult
			3-4 days			>48 hours	Patient not appropriate due to medical issue	Other	Requested by Case Manager	Inappropriate STAT consult - not ready D/C in 24 hrs
			5-6 days				Other		Functional Decline from Baseline	Inappropriate STAT consult - consult indicated sooner
			7 or greater days						Other	Other

Discharge Pending Process

- PLAN: Team formed to study current process
  - Stakeholders from Rehab, Case Management, Residents, mid-level providers
  - LEAN approach used to identify simplified process with higher stakeholder satisfaction
- DO: Changes Piloted on Medicine floors for 4 weeks
- CHECK: Feedback and Results of Pilot
  - Survey of physicians, rehab staff
  - Data from Pilot
- ACT: Final version
  - Modifications included to make the process more efficient – implemented use of Spectra-link phone to ensure coverage (16-2016)
  - On-going tracking to sustain the improvements
  - Permanent Process Change on Pilot Floors

SATURDAY SUNDAY Date:____________ TURN IN TO BARB PAUL PLEASE

COMPLETE ALL AREAS WHEN RECEIVING REQUEST | POST EVA

TIME call received	Patient Name and (MRN so we can audit when pt was discharged)	Room Number	Discharge Pending Today (seen within 2hrs)	Discharge Plan requires PT/OT assessment today (seen	Stat for PLACEMENT	INS: Medicare 3nights LOS All others notes within 24 hr	Have all procedures/tests been complete? Y/N	Reason for Consult?	What is the pts current mobility status? Has patient been mobilized by nursing?	Orders in chart?	Previous Orders? # of hours old	MD's name	Call back number	PT confirmed STAT	OT confirmed statSTAT	Comme
			☐ Home ☐ Placement ☐ Home vs Placement													
			☐ Home ☐ Placement ☐ Home vs Placement													
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16-2016 Voicemail Instructions:
From Spectralink phone: 1) Dial 534998 2) Press # 3) Enter password 204568 # 3) Press 3 to listen [6=delete; 7=replay]
From ANY phone: 1) Dial 534998 2) Enter 162016# 3) Enter password 204568 # 3) Press 3 to listen [6=delete; 7=replay]

Triaging or Prioritization Tips:
For Stats: 1. Verify Orders 2. Check CM Notes for indication patient is leaving 3. Check Insurance -->
-- Medicare: requires 3 night hosp stay and PT, OT rec in last 30 days
-- All other INS require PT, OT within 24-48 hours of disch (So on Satruday, patients with HAP, BCBS, etc who definitely need rehab and CM hasn't already arranged placement, tell caller that patient will be seen Sunday if time or first thing Monday

Discharge Pending Check

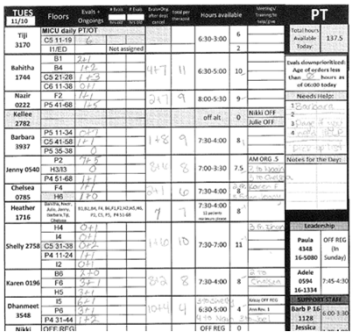
Data from Stat Sheet				Reason			
TOTAL # of STATS Received	Placement	Home vs Placement	Home	# OF PTS NOT DC'D ON DAY STAT CALLED	MRN # 1	Reason # 1	MRN

Improved data collection

	Occupational Therapy					Data from EPIC and Daily Organziation Sheet			
1									
2	Date	Day of Week	Active caseload	Dept cancel in hours	# evals last 24	Total EVALS patients to be scheduled	Total ONGOING patients to be scheduled	# Stats received not already scheduled	TOTAL Scheduled Patients (F+G+H)

Data from Revenue and Productivity			
Total Visits Billed	Total Hours Worked	Average Visits per Hour (J / K)	Total Missed Visits (I - J)

Morning Triaging



Floor Assignments

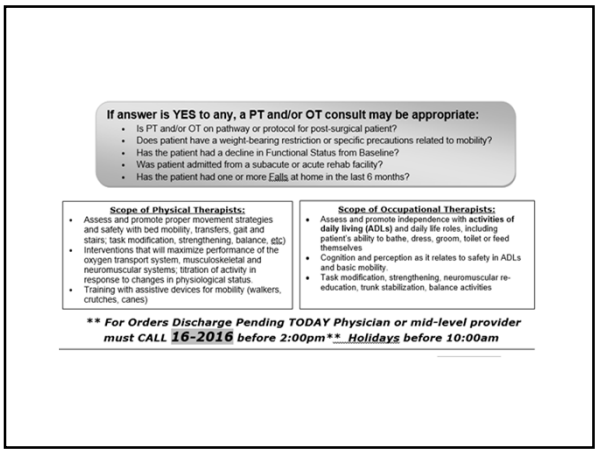
- Staff visibility on floors
- Improved relationships with staff
- Postings for contact info also include reminders regarding checklist and scope

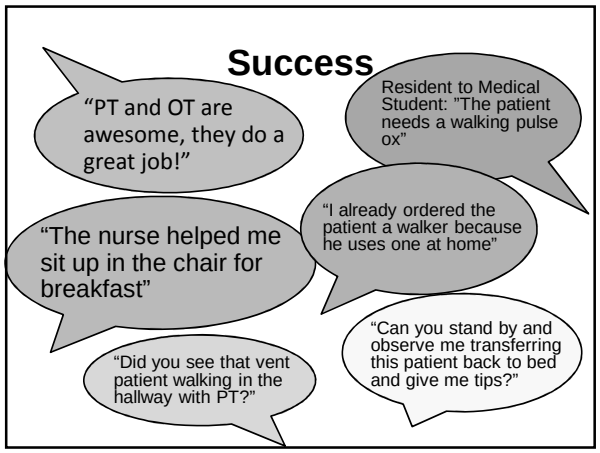
	Physical Therapy Monday through Friday			
Month	2014	2015	Variance	Percent
January	4405	4097	(308)	-8%
February	3555	3848	293	8%
March	3858	4335	477	11%
April	3996	4330	334	8%
May	3792	4308	516	12%
June	3379	4280	901	21%
July	3812	4543	731	16%
August	3505	4232	727	17%
September	3581	3909	328	8%
October	3952	4191	239	6%
November	3686	4137	451	11%

	Occupational Therapy Monday through Friday			
Month	2014	2015	Variance	Percent
January	4012	3886	(126)	-3%
February	3511	3288	(223)	-7%
March	3697	4288	591	14%
April	3770	4109	339	8%
May	3661	4024	363	9%
June	3227	4163	936	22%
July	3612	4248	636	15%
August	3327	3615	288	8%
September	3288	3690	402	11%
October	3692	3930	238	6%
November	3445	3832	387	10%

Floor assignments

Ortho	B3, F3	Chris #6483 - Nikki #1948	Nora #3669 Michele COTA #3268 Tu/Fr: Annette #3911
Neuro	B5, F5, I6, C6W	Karyn #3994 - Karen #0196 M: Laura #5084; T/Th: Kellee #2872	Lana #4334 Danielle #4183
Med/Surg	B1	Bahitha #1744 (Th: Leslie #3916)	Tricia #1784
	B2	Kathy #1284 (F: Romina# 0262)	Annette #3911
	B4	Bahitha #1744 (Th: Kathy #1284)	Nora #3669
	B6	Kathy #1284 (F: Adele# 0594)	Renee #6602 W: Justine0202
	F1	Tiji #3170	Beth# 5047
	F2	Nazir #0222 W/F: Romina# 0262	Hilary #4112
	F6	MTh: Kathy 1284 / Leslie #3916	Chad #7476 W/F: Tricia #1784
	H2	Laura #5084	Beth # 5047
	I2	Shelly #2758 W: Nikki 1948	Jen S #0188 (Th: Chad #7476)
	H3/I3	Jenny #0540	Renee #6602
	H4	Shelly #2758 W: Krissy 4689	Hilary #4112 (T/F: Kara #1680)
	I4		
	H5	Tiji #3170	Narmean #2542
	I5	Dhanmeet #3548 M: Krissy 4689	Jen S #0188 (Th: Chad #7476)
	H6	Romina 0262 (T/Th: Laura #5084)	Tricia #1784
	P2	Jenny #0540	Justine #0202 (Tu: Jen S #0188)
	P3	Adele #0594	Beth# 5047
	P4 rm 11-24	Shelly #2758 W: Krissy 4689	Renee #6602 (W:Justine #0202)





Conclusion

- Find champions
- Education is constant and ongoing
- Get to them early and often
- Globally and individually
- Don't quit!

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Questions?

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