Educating the multi-disciplinary team to optimize acute PT utilization

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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

Disclosures
- None
Educating the multi-disciplinary team to optimize acute PT utilization.

**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 patient’s life
  - “I get to do what I do best every day”

**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

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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

Empowering therapists as our own advocates

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

Getting it Right – Staff Resource

ARIO2
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 intervention
- Patient does not need skills of a therapist
- Patient does not have the capacity to learn

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
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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

“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.”
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Silence Kills
The Seven Crucial Conversations in Healthcare

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: 63 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. 63 percent have a teammate who complains when asked to pitch in and help. On the

“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

- 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

“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

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
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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
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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

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

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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)

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- 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
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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 SaO2 with activity
  - Ordering a replacement walker
  - Passive Range of motion only (to prevent contractures)

Checklists

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**

- 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

**Train the Trainer**

- **Gait Belt Use**
  - Purpose: Given something to hold onto instead of a hospital gown.
  - Place snugly around waist, keep only your fingers to fit between the patient and the belt; ensure belt is tied through "loop" of buckle to allow proper tightening.
  - May need to re-adjust or tighten again when patient stands (belt becomes too loose, patient may be able to stand safely); for obese patients, "tourn" tighten the belt if necessary before standing.
  - Avoid incision areas.
  - Hold belt, not front or side

- **Transfer Tips**
  - Room setup is key
    - Chair right next to bed
    - Lass draped or out of way
    - Lass on chair (can be used to lift patient out of chair if necessary)
    - B elderly chair when in doubt
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Train the Trainer

- For side transfers, use slide board or orange slide sheet.
- Can also stand prior to a gaiter (in case patient fatigues after siting, can be slid back to feel)
- Stand close to patient
- Easier to lift from cause of gravity
- Example: easier to hold a pillow 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
- Minimize patient participation: have patient push up from bed, if possible. If patient is a ‘guide’ or ‘guide’ have them put their arms around your waist or the back of your arms/shoulders (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 (OM 311, 1/9/2015) is an approved provider of continuing nursing education by the Ohio Nurses Association (1700-0401-01), 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.
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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 occupational 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
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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

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

Nurse Assistant Orientation

Case managers
Social workers
Discharge Planners

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

Department initiatives beyond education
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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

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

Discharge Pending Check

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**Improved data collection**

<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>Data from EPIC and Daily Organization Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Data from Revenue and Productivity</td>
</tr>
<tr>
<td></td>
<td>Total Visits Billed</td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Morning Triaging**

**Floor Assignments**

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

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Success
- "PT and OT are awesome, they do a great job!"
- "The nurse helped me sit up in the chair for breakfast"
- "I already ordered the patient a walker because he uses one at home"
- "Did you see that vent patient walking in the hallway with PT?"
- "Can you stand by and observe me transferring this patient back to bed and give me tips?"

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

References

Questions?
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References for Online Discharge Pending TOT: Physician or mid-level provider must Call 26-2016 before 2:00pm** Holidays before 10:00am

Questions?
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