Educating the multi-disciplinary team to optimize acute PT utilization

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Henry Ford Hospital, Detroit, MI

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

Disclosures
- None

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

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/ subacute facilities
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**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
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

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

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

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

AROT 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.

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, NA 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

**“Teachable moments”**

- Pt had not been out of bed with nsg yet
- “Hi Betty, I’m Krissy from PT. I just worked with Mr. Smith in B515. He reports that he hasn’t been out of bed since admission, but we worked and now he’s up in the chair. I made sure to place the chair so when he’s ready to go back to bed, it is to his strong side. He shouldn’t be up more than an hour or two this first time, but to build his strength and endurance, getting up for all meals is important. I posted a sign in his room reviewing his precautions and what equipment he needs as well as how much assist you can expect to provide him”

**Scripting of key phrases**

- Increased comfort for shy or newer staff
- Provides words or framework
- Common situations

**Empowering therapists**

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

**“Teachable moments”**

- 88 y/o lady from assisted living uses walker to get to meals, is walking around the halls with SBA from nsg. & IV pole
- “Ms. Smith is at her baseline, you can have the RN order a walker, but she does not require skilled intervention to return home, this order was not the best use of PT resources, it’s ok to not call us for pts like this”.

**Scripting of key phrases**

- General Script Example:

- Patient/Family Member requesting more frequent visits
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**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

**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
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.”

**Strategies for Success**

- Energy Audit
- Refocus your energy
- Create mutual purpose and respect
- Understand some people are resistant to change
- Practice

**Impact Effort Matrix**

<table>
<thead>
<tr>
<th>Situation</th>
<th>No Control</th>
<th>Influence</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Co-Worker</td>
<td>Their attitude and behavior</td>
<td>Amount of time you spend around them</td>
<td>Your attitude and behavior</td>
</tr>
<tr>
<td>Electronic Medical Record</td>
<td>Choosing the system</td>
<td>Suggestions for revisions</td>
<td>Seeking advise &amp; best practices</td>
</tr>
<tr>
<td>Physicians orders</td>
<td>Actual order placement</td>
<td>Education</td>
<td>Initiate or provide PT</td>
</tr>
</tbody>
</table>

http://www.sixsigmadaily.com/tag/impact-matrix/
Considerations

- 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

- 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

STRETCH BREAK

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
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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
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**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**
- 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**

**PowerPoint Content**
- Scope of Practice
- How to Consult
  - Include any orders for weight bearing status, ROM or other precautions
- Insurance considerations
- Discharge planning
- Discharge pending process

**PowerPoint Examples – actual slides used**
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Objectives
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

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, 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

<table>
<thead>
<tr>
<th></th>
<th>PT</th>
<th>OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average DAILY total pts in queue</td>
<td>200 patients</td>
<td>180 patients</td>
</tr>
<tr>
<td>Average FTE M-F</td>
<td>18.5</td>
<td>17.5</td>
</tr>
<tr>
<td>Average FTE Sa-Su</td>
<td>2.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

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.
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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 patient’s functional status improves to independent while inpatient, please CANCEL 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

The New Yorker

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 postsurgical patient? ie: Joint Replacement, Spine Surgery, Stroke Unit, Cardiac Rehab, Vascular, Transplant, etc

Professional Collaboration

- Clinical practice issues
- Post op protocols
- Common lab value or medical stability guidelines
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**Success**
- Improved collaboration
- We are on the same team
- Hospitalist example
- Resident monthly training example

**Nursing**
- **Nursing model of education**
  - Breadth of knowledge vs depth of knowledge
- **Objective** is to increase basic patient mobilization
  - Provide safe assistance
  - Advocate for PT involvement when needed
- **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
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Train the Trainer
Train the Trainer
C3/C6 Mobility project

- Gait Belt Use
  - Purpose: Given something to hold onto instead of a hospital gown.
  - Place snugly around waist (even if your fingers fit between the patient and the belt); secure belt is tied through “teeth” of buckle to allow proper tightening.
  - May need to readjust or tighten again when patient stands if belt becomes too loose (patient may 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 stopped or out of way
    - Lithotomy or chair can be used to lift patient off of chair if necessary
    - Sturdy chair when in doubt

Nurse Examples

- Train the Trainer
  - For slide transfers, use slide board or orange slide sheet
  - Can also stand patient up to a standing position (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 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 (“knee” 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 “pusher” or “pusher,” 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

PowerPoint Examples – actual slides used

HFHS NURSE DRIVEN MOBILITY PROTOCOL

- 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 CE, 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 Improves Outcomes

- ↓ ICU LOS by 1.5 days
- ↓ Hospital LOS by 3.4 days-WOW!
- 59% of mobilized patients returned to independent functioning while only 35% of non-mobilized patients did
- ↓ length of ICU delirium from 4 to 2 days

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.

Tips for Success

- When assisting a patient to sit at the edge of the bed, put their feet flat on the floor.
- It helps to re-orient them and prevent delirium.
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.)

Tips for Success

- Make sure patient has an assistive device of a cane or walker if used prior to admission.
- If patient is unsteady consult physical therapy if an assistive device is needed.

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.
- Dangling is a good starting point for staff and patient, start there and progress as patient tolerates!

Nurse Assistant Orientation

- Mandatory
- Monthly
- 30 minute PowerPoint
- Skills lab/practice
- Check off session

Nurse Assistant Orientation

- 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 IVs & 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
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**Case managers**

**Social workers**

**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, economic and psychological factors, MSW

**CM, SW, Discharge Planners**

- Can obtain information from patient/family and advocate with providers during rounds
- Thorough understanding of insurance requirements

**CM, SW, Discharge Planners**

- Delivery of education
  - PowerPoint presentation
    - Staff meetings, lectures
  - Use of technology for communication
    - Shared medical record information, census lists
  - Regular collaboration
    - 5-minute daily rounds
    - Build mutual trust & respect
    - 1:1 training, teachable moments

**CM, SW, Discharge Planners**

- Education content
  - Role of PT in acute care
  - Facilitation of discharge
  - Insurance requirements for PT documentation

**CM Examples**
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CM, SW, Discharge Planners
- Delivery of education
  - Use of technology

Triaging a STAT

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
- Questionnaires after training sessions
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**Physician Survey**

<table>
<thead>
<tr>
<th>Quality of Understanding of Acute Care PT and OT</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>Poor or No Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your current knowledge of acute care PT and OT</td>
<td>26.00%</td>
<td>15.00%</td>
<td>20.00%</td>
<td>20.00%</td>
<td>20.00%</td>
</tr>
<tr>
<td>Your current knowledge of acute care PT and OT</td>
<td>7.00%</td>
<td>9.00%</td>
<td>10.00%</td>
<td>7.00%</td>
<td>3.00%</td>
</tr>
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</table>

**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**

**Improved data collection**

<table>
<thead>
<tr>
<th>Month</th>
<th>2014</th>
<th>2015</th>
<th>Variance</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>January</td>
<td>4402</td>
<td>4297</td>
<td>105</td>
<td>2%</td>
</tr>
<tr>
<td>February</td>
<td>3550</td>
<td>3946</td>
<td>396</td>
<td>8%</td>
</tr>
<tr>
<td>March</td>
<td>3852</td>
<td>4208</td>
<td>356</td>
<td>8%</td>
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<tr>
<td>April</td>
<td>3999</td>
<td>4280</td>
<td>281</td>
<td>6%</td>
</tr>
<tr>
<td>May</td>
<td>3782</td>
<td>4038</td>
<td>256</td>
<td>6%</td>
</tr>
<tr>
<td>June</td>
<td>3579</td>
<td>4208</td>
<td>629</td>
<td>11%</td>
</tr>
<tr>
<td>July</td>
<td>3012</td>
<td>4543</td>
<td>1531</td>
<td>16%</td>
</tr>
<tr>
<td>August</td>
<td>3558</td>
<td>4200</td>
<td>642</td>
<td>15%</td>
</tr>
<tr>
<td>September</td>
<td>2965</td>
<td>5279</td>
<td>2314</td>
<td>8%</td>
</tr>
<tr>
<td>October</td>
<td>3994</td>
<td>4180</td>
<td>186</td>
<td>5%</td>
</tr>
<tr>
<td>November</td>
<td>4588</td>
<td>2117</td>
<td>2471</td>
<td>11%</td>
</tr>
</tbody>
</table>
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Floor Assignments

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

Morning Organization

P2 Rehabilitation Services

PHYSICAL THERAPIST (PT):
Jenny #0540
Assistant: Heather, PTA #1714

OCCUPATIONAL THERAPIST (OT):
Justine #0202
Assistant: Cindy, OTA #0857

"PT and OT are awesome, they do a great job!"

Resident to Medical Student: "The patient needs a walking pulse ox"

"The nurse helped me sit up in the chair for breakfast"

"Did you see that vent patient walking in the hallway with PT?"

"Can you stand by and watch me transferring this patient back to bed and give me tips?"

Success

If answer is YES to any, a PT or OT consult may be appropriate:
- U/P or OB: re evaluation of progress or protocol for post-surgical patient
- Does patient have a weight-bearing restriction or specific prescriptions related to mobility?
- Has the patient had a change in Functional Status from baseline?
- Does patient attend a subacute or acute rehab facility?
- Does the patient have one or more Falls at home or in the last 6 months?

Range of Physical Therapists:
- Assessment and treatment of neuromusculoskeletal, musculo-skeletal, and other medical diagnoses and conditions
- Training in assistive devices for mobility (wheelchairs, gait trainers, etc.)

Range of Occupational Therapists:
- Assessment and treatment of physical, cognitive, and functional impairments or limitations that interfere with ADLs (activities of daily living), IADLs (instrumental activities of daily living), and community mobility

For referrals or general questions, call Secretary, 606-232-3005

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Conclusion

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

References


Questions?

- Contact Information:
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  – Third party payers
  – Skilled nursing/ subacute facilities
Educating the multi-disciplinary team to optimize acute PT utilization.

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”

Physical Therapist
- What my friends think I do
- What my patients think I do
- What society thinks I do
- What my co-workers think I do
- What I think I do
- What I really do

Background
- "We need a note for patient to go back to the nursing home"
- "I need a walking pulse ox on my patient: consult PT"
- "The nurse said I needed to wait for PT to get up"
- "Patient needs a walker because he uses one at home"
- "I couldn’t get them up because I didn’t have a belt"
- "Well, the therapist has magic powers if they can get that patient up"

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

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

AROT 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 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.

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?

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?

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, NA or family member?
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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
- Embracing “teachable moments”
- Scripting of key phrases
- Regular communication with members of team
- Support from management
- Training for crucial conversations

“Teachable moments”
- Pt had not been out of bed with nsg yet
  “Hi Betty, I’m Krissy from PT. I just worked with Mr. Smith in B515. He reports that he hasn’t been out of bed since admission, but we worked and now he’s up in the chair. I made sure to place the chair so when he’s ready to go back to bed, it is to his strong side. He shouldn’t be up more than an hour or two this first time, but to build his strength and endurance, getting up for all meals is important. I posted a sign in his room reviewing his precautions and what equipment he needs as well as how much assist you can expect to provide him”

“Teachable moments”
- 88 y/o lady from assisted living uses walker to get to meals, is walking around the halls with SBA from nsg. & IV pole
  “Ms. Smith is at her baseline, you can have the RN order a walker, but she does not require skilled intervention to return home, this order was not the best use of PT resources, it’s ok to not call us for pts like this”.

Scripting of key phrases
- Increased comfort for shy or newer staff
- Provides words or framework
- Common situations

Scripting of key phrases
- General Script Example:
  Patient/Family Member requesting more frequent visits
Educating the multi-disciplinary team to optimize acute PT utilization.

**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

**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
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Silence Kills
The Seven Crucial Conversations in Healthcare
David Marflett, Joseph Greer, Ron McMann, Barry Patterson, and Ait Switzer

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 led to the “not their job,” and low confidence that it will do any good to have.

Lack of Support: 83 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 other hand, 37 percent have a teammate who offers help when needed.

“Some people here are burnt out. They’ve lost the excitement or have some personal issues in their life.

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.”

Strategies for Success

- Energy Audit
- Refocus your energy
- Create mutual purpose and respect
- Understand some people are resistant to change
- Practice

Impact Effort Matrix

http://www.sixsigmadaily.com/tag/impact-matrix/
Considerations

- **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**

<table>
<thead>
<tr>
<th>Strategies for Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Don’t begin a conversation telling someone what they are doing wrong</strong></td>
</tr>
<tr>
<td><strong>Begin a conversation with facts not assumptions</strong></td>
</tr>
<tr>
<td><strong>Remember to ask yourself why would a decent, reasonable and rational human being behave this way</strong></td>
</tr>
</tbody>
</table>

**Knowledge your Audience**

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

**PowerPoint Content**
- Scope of Practice
- How to Consult
  - Include any orders for weight bearing status, ROM or other precautions
- Insurance considerations
- Discharge planning
- Discharge pending process

**PowerPoint Examples – actual slides used**
Objectives

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

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, 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

<table>
<thead>
<tr>
<th></th>
<th>PT</th>
<th>OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average DAILY total pts in queue</td>
<td>200 patients</td>
<td>180 patients</td>
</tr>
<tr>
<td>Average FTE M-F</td>
<td>18.5</td>
<td>17.5</td>
</tr>
<tr>
<td>Average FTE Sa-Su</td>
<td>3.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

- 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.

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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 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 postsurgical patient? ie: Joint Replacement, Spine Surgery, Stroke Unit, Cardiac Rehab, Vascular, Transplant, etc

Professional Collaboration

- Clinical practice issues
- Post op protocols
- Common lab value or medical stability guidelines
**Success**

- Improved collaboration
- We are on the same team
- Hospitalist example
- Resident monthly training example

**Nursing**

- Nursing model of education
  - Breadth of knowledge vs depth of knowledge
- Objective is to increase basic patient mobilization
  - Provide safe assistance
  - Advocate for PT involvement when needed
- How can mobility be a part of their tasks?

<table>
<thead>
<tr>
<th>Nursing</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of education</td>
<td></td>
</tr>
</tbody>
</table>
  - 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 |
| Delivery of education |
  - Inservices |
    - Train the trainer |
  - Nursing mobility champions |
  - Grand Rounds |
    - Review patient cases |
  - Online courses |
    - Initial training |
    - Remediation |
| 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 |
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Nurse Examples

Train the Trainer

Train-the-trainer
C3/C5 Mobility project

Gait Belt Use
- Purpose: Used to help patients get up instead of a hospital gown.
- Place snugly around waist (lace only for your fingers fit between the patient and the belt); ensure belt is tied through "hearts" of belt so that it does not easily loosen
- May need to re-adjust or tighten again when patient stands (belt becomes too loose)
- Patient must be able to stand unaided
- For obese patients, "screw" 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
  - Loom draped out of way
  - Linen on chair (can be used to lift patient out of chair if necessary)
  - Stryker chair when in doubt

PowerPoint Examples – actual slides used

HFHS NURSE DRIVEN MOBILITY PROTOCOL

- Henry Ford Health System Nursing Development (OH 312, 11/1/2015) is an approved provider of continuing nursing education by the Ohio Nursing Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

- To receive 1.0 CE, 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.
Educating the multi-disciplinary team to optimize acute PT utilization.

**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 Improves Outcomes**
- ↓ ICU LOS by 1.5 days
- ↓ Hospital LOS by 3.4 days-WOW!
- 59% of mobilized patients returned to independent functioning while only 35% of non-mobilized patients did
- ↓ length of ICU delirium from 4 to 2 days

**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.

**Tips for Success**
- When assisting a patient to sit at the edge of the bed, put their feet flat on the floor.
- It helps to re-orient them and prevent delirium.
Educating the multi-disciplinary team to optimize acute PT utilization.

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.)

Tips for Success

- Make sure patient has an assistive device of a cane or walker if used prior to admission.
- If patient is unsteady consult physical therapy if an assistive device is needed.

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.
- Dangling is a good starting point for staff and patient, start there and progress as patient tolerates!

Nurse Assistant Orientation

- Mandatory
- Monthly
- 30 minute PowerPoint
- Skills lab/practice
- Check off session

Nurse Assistant Orientation

- 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 IVs & 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:

<table>
<thead>
<tr>
<th>Task</th>
<th>Eval</th>
<th>Prob</th>
<th>Expe</th>
<th>Prog</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dangle feet, engage tissues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Stand patient in chair and ensure hand open and steady position before crouch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. With light pressure, assist patient to stand</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. Assist patient to sit</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>5. Make bulb to assist patient, hold hand</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Place patient in chair and secure</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. Provide continuous observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Move patient in chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Assist patient to sit</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

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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, economic and psychological factors, MSW

CM, SW, Discharge Planners
- Can obtain information from patient/family and advocate with providers during rounds
- Thorough understanding of insurance requirements

CM, SW, Discharge Planners
- Delivery of education
  - PowerPoint presentation
    - Staff meetings, lectures
  - Use of technology for communication
    - Shared medical record information, census lists
  - Regular collaboration
    - 5-minute daily rounds
    - Build mutual trust & respect
  - 1:1 training, teachable moments

CM, SW, Discharge Planners
- Education content
  - Role of PT in acute care
  - Facilitation of discharge
  - Insurance requirements for PT documentation

CM Examples
Educating the multi-disciplinary team to optimize acute PT utilization.

CM, SW, Discharge Planners
- Delivery of education
  - Use of technology

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
- Questionnaires after training sessions
Educating the multi-disciplinary team to optimize acute PT utilization.

**Physician Survey**

<table>
<thead>
<tr>
<th>SurveyMonkey</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor or no knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your knowledge of understanding of acute care PT and/or OT PRIOR TO the presentation</td>
<td>25.00%</td>
<td>15.00%</td>
<td>20.00%</td>
<td>20.00%</td>
<td>20.00%</td>
</tr>
<tr>
<td>Your CURRENT knowledge or understanding of acute care PT and/or OT</td>
<td>35.00%</td>
<td>45.00%</td>
<td>15.00%</td>
<td>5.00%</td>
<td>1.00%</td>
</tr>
</tbody>
</table>

**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
- 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**

<table>
<thead>
<tr>
<th>Reason</th>
<th># of PTs NOT ODD ON DAY STAT CALLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL # of STATS Received</td>
<td>Placement</td>
</tr>
<tr>
<td>Data from Stat Sheet</td>
<td></td>
</tr>
</tbody>
</table>

**Improved data collection**

<table>
<thead>
<tr>
<th>Date</th>
<th>Day of Week</th>
<th>Active</th>
<th>Active in Hours</th>
<th># Days Lost</th>
<th>Total # Days Lost</th>
<th>Total Ongoing Patients to Be Scheduled</th>
<th># Stats Received Not Already Scheduled</th>
<th>TOTAL Scheduled Patients (F=G+H)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Month</th>
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<th>2015</th>
<th>Variance</th>
<th>Percent</th>
</tr>
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<tbody>
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<td>4425</td>
<td>4097</td>
<td>328</td>
<td>-8%</td>
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<tr>
<td>February</td>
<td>3355</td>
<td>3046</td>
<td>309</td>
<td>8%</td>
</tr>
<tr>
<td>March</td>
<td>3900</td>
<td>4209</td>
<td>309</td>
<td>11%</td>
</tr>
<tr>
<td>April</td>
<td>3990</td>
<td>4230</td>
<td>240</td>
<td>6%</td>
</tr>
<tr>
<td>May</td>
<td>3792</td>
<td>4208</td>
<td>416</td>
<td>17%</td>
</tr>
<tr>
<td>June</td>
<td>3379</td>
<td>4208</td>
<td>829</td>
<td>21%</td>
</tr>
<tr>
<td>July</td>
<td>3812</td>
<td>4543</td>
<td>731</td>
<td>16%</td>
</tr>
<tr>
<td>August</td>
<td>3926</td>
<td>4122</td>
<td>294</td>
<td>7%</td>
</tr>
<tr>
<td>September</td>
<td>3561</td>
<td>3959</td>
<td>398</td>
<td>8%</td>
</tr>
<tr>
<td>October</td>
<td>3962</td>
<td>4191</td>
<td>229</td>
<td>6%</td>
</tr>
<tr>
<td>November</td>
<td>3668</td>
<td>4137</td>
<td>469</td>
<td>13%</td>
</tr>
</tbody>
</table>
Educating the multi-disciplinary team to optimize acute PT utilization.

Floor Assignments

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

Morning Organization

<table>
<thead>
<tr>
<th>Physical Therapist (PT):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny #0540</td>
</tr>
<tr>
<td>Assistant: Heather, PTA #176</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Therapist (OT):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justine #0202</td>
</tr>
<tr>
<td>Nurse: Cindy, COTA #6657</td>
</tr>
</tbody>
</table>

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

- Is the patient out of bed or mobile?
- Does the patient have an active/handicapped/handicap-related mobility challenge?
- Is the patient a patient in the hospital for a prolonged period?
- Does the patient have an active/handicap/handicap-related mobility challenge?

Scope of Physical Therapists:

- Assess and provide assessment, intervention and/or education, and evaluation for mobility, function and performance in the context of physical and functional limitations
- Task modification, strengthening, balance, gait
- Interventions that align with the performance of the musculoskeletal system, neurocognitive, and neuromuscular systems, strategies of activity in the context of physical and functional limitations
- Training with assistive devices for mobility, function, and performance

Scope of Occupational Therapists:

- Assist in the development of a comprehensive treatment plan
- Design and fabricate custom splints
- Adaptive equipment planning
- Assistive devices
- Range of motion exercises
- Training with assistive devices for mobility, function, and performance

*For Orders Discharge Pending TODAY Physician or mid-level provider must CALL 16-2016 before 2:00pm**. Holidays before 10:00am

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 watch me transferring this patient back to bed and give me tips?"

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Conclusion

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

References


References


References

Questions?

- Contact Information:
  - Adele Myszenski, PT
    - amyszen1@hfhs.org
  - Krissy Stein, PT
    - kstein1@hfhs.org
  - Jen Trimpe, PT
    - jtrimpe1@hfhs.org