Leveraging Infrastructure and Staff Engagement to Achieve and Maintain Stroke Accreditation

Being recognized with an Advanced Certification for Comprehensive Stroke Centers from The Joint Commission demonstrates that a hospital or health system has achieved exceptional stroke treatment quality. There are over 800 accredited organizations in the United States, but the process of gaining advanced Comprehensive Stroke Center certification—a nod only 15 hospitals in the U.S. have earned so far—from The Joint Commission is an extremely involved process. However, healthcare organizations may find that accreditation is easier to achieve with well-defined protocols and strong administrative organizational policies surrounding stroke treatment education and execution. Those elements, combined with strong technology and talented staff members, form the foundation of delivering best practice stroke care.

Ahead of the Curve
Mercy Hospital of Oklahoma City (MHOKC) began its journey to accreditation in 2001 when Dr. Vance McCollom joined its staff. Dr. McCollom, an interventional radiologist, had experience with intravenous and intra-arterial treatment of acute ischemic strokes, treatments that were state-of-the-art at the time. “Dr. McCollom’s experience suggested for the first time in the entire history of medicine that there was meaningful treatment of acute ischemic stroke,” says Dr. Richard V. Smith, the Medical Director of the NeuroScience Institute at MHOKC. Based on these early techniques, the hospital decided to implement a large-scale stroke treatment program that same year, although The Joint Commission did not establish its Primary Stroke Center certification process until December of 2003. “Once [Joint Commission] requirements were published, we were already aware of them, “we found we had many of the Primary Stroke Center requirements already in place,” Smith points out.

Staff Engagement
MHOKC’s Comprehensive Stroke Center transition began by preparing all involved staff members. After establishing a 16-member core stroke team to oversee the process, Smith recalls that MHOKC’s neurology department was far from the only area of the hospital that was affected. “It affected all of our hospital departments. In addition to our stroke team, we estimated that there were probably 500 other individuals in the hospital that had either direct or indirect involvement in acute stroke patient care. It required a tremendous effort to keep our vision in front of everyone.” Kay Oglesby RN, MHOKC NeuroScience Institute’s Clinical Coordinator, says that the vision they attempted to put forth

Breaking Down Communication Barriers to Enhance Case Management Effectiveness

Case management is a key component of both patient care and a healthcare organization’s revenue cycle. When successfully executed, case management can help patients move through their hospital stays more smoothly and can help them effectively transition out of their stays in a way that decreases the likelihood for readmission. From a workforce perspective, case management involves participation from multiple individuals, including specialty physicians, hospitalists, nurses, and case management representatives. As a result, clear, well-organized communication between all involved employees may greatly enhance the efficiency and effectiveness of case management.

Creating Communication Plans
Chandler Regional Medical Center—a 243-bed hospital located in Chandler, Arizona—has developed a thorough process for case management that involves RN case managers and non-licensed discharge coordinators. The department instituted high-risk assessment processes for readmission that require case managers to individually visit each patient and score him or her based on a list of twelve questions, including questions regarding patient readmission, family support, and living arrangements. “Each question is given a score from 0–3 points. At the end of the assessment tool there is a scoring mechanism: if a patient’s
FROM STROKE ON PAGE 1

revolved around how to make a difference in the lives of stroke patients. “We needed to make it clear that effective treatment could mean the difference between having stroke patients transferred to a nursing home and or having them walk out of the hospital,” explains Oglesby. Because there had never been meaningful treatment of acute ischemic stroke there was some initial resistance from staff members, so MHOKC began to devise ways to obtain staff engagement in the process. “We formed a committee composed of representatives from our physician staff, neurologists, nurses, EMS, and administration,” describes Oglesby. “The committee was the first to come to the table and talk about where we wanted to go with our stroke program. Our goal from the very first meeting was to build the most comprehensive stroke program we could for our patients.”

“Applying for the Joint Commission’s advanced certification is a meticulous and exhaustive process. But thanks to the relentless passion of the team, we have the staff, technology and experience to improve stroke outcomes in our state.”

– Jim Gebhart
President of Mercy Hospital
Oklahoma City

Education Techniques

MHOKC also instituted concrete instruction methods to ensure all in-scope staff members knew their role in stroke care. The hospital created a custom electronic education module to teach foundational knowledge to staff members, and all incoming members of the stroke program are required to complete additional trainings at a much higher expertise level. Additionally, each department develops stroke-related courses for its area “As staff members grow in their departments, they have their own education path,” says Kelli Dutton RN APN, MHOKC’s Stroke Treatment Program Manager, “Everyone is very different.” MHOKC also conducts peer instruction and in-services. “Our nurses bring back information to their peers when they return from any kind of stroke conference,” Dutton says. Smith also explains that MHOKC provides education to the community and first responders so that they can recognize stroke symptoms and what kind of initial treatment can be done for them. “They don’t always understand what strokes mean or how critical the time element is;” Smith explains. The hospital reaches out to urban and rural organizations as well, and it holds neurological conferences in order to provide stroke information to them.

Care Delivery Infrastructure Enhancements

As the program expanded, the MHOKC built an additional catheterization lab, added a new Transcranial Doppler and obtained a 128 slice CT scanner. “With physiological data this specific, we can make very precise decisions on what kind of treatments we should be doing,” notes Smith. MHOKC is extending its technological solutions to other hospitals as well. Smith states that smaller hospitals hours away from MHOKC do not always have the capacity to adequately treat stroke patients. Telestroke is now utilized in many rural ERs in order to establish visual communication. “The neurohospitalists here at MHOKC can see the physician and the patient in the rural facility and can help that physician determine what kind of treatment the patient needs before they’re brought to Mercy,” says Smith.

MHOKC also expanded its staff, adding six stroke coordinators that are overseen by Dutton, two neurohospitalists, two advanced practice nurses, and have four interventional radiologists. This interventional team has rotations that ensure that it operates at full effectiveness 24/7. “When we get a stroke call either from an ambulance or the emergency room, one of those stroke nurses is right there at the door,” Smith explains. Combined with the stroke treatment education given to all clinical staff, MHOKC has broad stroke coverage across the entire hospital.

Leveraging Strong Leadership

Smith, Dutton, and Oglesby all stress that pursuing Comprehensive Stroke Center accreditation is a difficult process. “You need to have physician leadership,” Oglesby advises. “If we didn’t have the stroke team Dr. Smith, I don’t know if we could’ve done it. Also, you need a physician champion as part of the team someone in charge who believes in the program and that can move it forward all the time because you’re going to have bumps in the road.” Dutton explains that it was crucial for MHOKC to continually evaluate its stroke treatment standards and performance indicators since it began its stroke treatment improvements before the accreditation process was established.

Dutton believes that healthcare organizations should make use of the seminars and conferences The Joint Commission now offers. “We all worked together with the same goal. That brought all these pieces together like a Swiss watch, but that watch requires a lot of maintenance. We have to walk the talk literally on a day-by-day basis,” Dutton observes.

Although Advanced Certification for Comprehensive Stroke Centers is difficult to achieve, it proves that a healthcare organization has fully optimized its stroke treatment protocols in order to maximize the quality of patient care. However, by fully committing to educating all in-scope staff members on best practice stroke care and implementing the infrastructure to deliver that care, organizations are likely to put themselves on the road to accreditation.
The Three “D’s”
In order to benefit most from this assessment tool, however, Chandler Regional’s Case Management team implemented a check-in process with physicians to ensure clear communication between all those involved. The Director of Case Management notes that case managers are out on their units the entire day and that physicians or hospitalists see about 90% of their patients, so this practice was put into effect in order to create a system of constant communication. “Physicians have to check in with the case manager after they see their patients on the floor, and they discuss the three D’s: Discharges, Downgrades (e.g. Telemetry to Med/Surg, ICU to Telemetry) and Dialogue (i.e., looking into long-term care or any other concerns),” she explains.

In order to hold physicians accountable for the check-in process, Chandler Regional’s Case Management team has created a form for each physician to fill out each day that includes case management notes, a summary of the day, a census, and the three D’s for each patient. Through this system, Chandler Regional has seen great financial impact by tracking downgrades and discharges; the Director of Case Management notes that they have totaled millions of dollars in savings, particularly due to downgrades, since the implementation of this process.

Staff Education
In order to successfully escalate communication between all staff members involved in case management, Chandler Regional thoroughly educated case managers, physicians, and even charge nurses in the new process. That way, if a case manager is unavailable, the physician may communicate with the charge nurse. “If neither is available, the third option is for the physician to use the census sheet on the clipboard that we keep in the same place each day on every unit so they can jot down notes even if nobody’s available. This way, they don’t have to waste their time searching,” says the Director of Case Management.

Physician Participation
Physician compliance at Chandler Regional is over 90%, which the Director of Case Management attributes to successful planning and implementation of the process. “We put a couple of the physician-leaders from each hospital’s group on this team for the check-in process. We really made this a physician initiative rather than just a case management effort, so it went over a lot better,” she observes. “I think it’s the leadership that we have—our physician advisor works very closely with us. We include the physicians in everything. In case management, we go to the hospital’s committee meetings every month to build that relationship in the decision.”

Additionally, leadership throughout all departments of the hospital have enabled Chandler Regional to successfully enhance case management, and interdepartmental relationships have helped with physician compliance and refining case management processes in general.

Community Outreach
Case Management at Chandler Regional has also improved through unique community outreach. Department representatives visit all of the senior centers in the area to gather additional resources for the elderly population and to identify the many services that are available to them, such as transportation, social activities, and an organization that does meal deliveries, all of which can be a tremendous resource for a recently discharged patient.

Another outreach program at Chandler Regional entails working with an area skilled nursing facility to operate a transitional care unit. The unit has 30 beds for transitional care; it has a separate entrance from the nursing home, special contracts with the lab so they can obtain lab results more quickly, and contracts with the physicians if they need to see the patient daily. “They work with our physicians here in the hospital, and they have RNs instead of LPNs in this unit so they can take higher acuity patients. Two of our hospitalists head on the committee for this, and in the two hospitalist groups that we have here, a physician from each of their groups actually sees patients in the skilled nursing facilities,” the Director of Case Management notes.

Chandler Regional’s care coordination techniques have been successful in ensuring that each patient receives the right care at the right time. Effective case management is a vital component of both patient care and a hospital or health system’s revenue cycle, so it can be extremely important to ensure that all of the organization staff members who play a role in the case management process are aligned. This is most likely to be achieved by breaking down communication barriers and looking creatively at external resources that may improve the efficacy of the organization’s case management process to ultimately help patients avoid readmissions.

Tips for Improving Communication in Case Management
- Implement a check-in process for physicians that includes
  - The three D’s (Discharges, Downgrades, Dialogue)
  - Notes from and for case management
  - Summary of each day
  - Census
- Educate all staff members involved, including case managers, physicians/hospitalists, and charge nurses
- Include physician leaders
- Encourage strong interdepartmental relationships/teamwork

**Chandler Regional High-Risk Assessment Scoring**

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Chandler Regional has created a list of 12 questions that case managers use to assess patients’ needs, which in turn helps determine the patient’s plan of care.
Accounting for Bedded Outpatients in Nurse Productivity Measurement for Inpatient Units

It can be difficult for hospitals and health systems to track nurses’ productivity, especially when patient statuses change and patients move between units. This is particularly the case when faced with outpatients who are in beds but are not classified as being in observation status, like when a patient undergoes outpatient surgery and then needs a significant recovery period before being discharged.

At Baptist Health Louisville (BHL)—a 519 bed hospital that is part of a seven-bed hospital system—there is a specific patient status code in the hospital’s host system for bedded outpatients. They may require an extended period of recovery or something beyond the normal period of recovery, which is four to six hours. “It also could just be the type of procedure or the comfort level due to the patient’s age,” explains Gayle Dickerson, Director of Case Management at BHL.

Bedded outpatients do not typically cause a strain on nurse productivity, though, because good communication has enabled BHL to maintain efficient staffing. “In regards to the surgery schedule and the catheter lab schedule, there’s good communication going out to the leadership of those units knowing what the schedule looks like tomorrow,” notes Dickerson. “We anticipate how many beds we’re going to need for a lot of the patients, so we have a pretty good idea.”

At Trinity Regional Health System (TRHS)—a four-hospital system in the Quad Cities region of Iowa and Illinois that is part of Iowa Health System—nursing leadership emphasizes the importance of establishing the correct patient status as early as possible. “Our nurse managers get very involved with the particular and appropriate level of care as far as inpatient, outpatient, and observation status. If we have to put an outpatient or an observation patient in an inpatient unit, we don’t go much further than that: a patient is a patient. They usually require the same amount of care as—and in some cases more than—regular inpatients. We try to get a patient to the appropriate level and place of care the first time,” explains Rochelle Tinman, Director of Clinical Care Services at TRHS. “As an admitting nurse on the floor, I don’t necessarily know who’s which status.” Additionally, in the surgery unit, clear status determination allows nurses to remain focused on the patients’ needs. “We know ahead of time what to expect. Our OR scheduling department does a really nice job of marking patients that are going to be inpatients. Also, just from an experience level our nurses know which types of patients are going to potentially stay [for longer recovery periods],” notes Betsy Demarest, TRHS’s Surgery Director.

TRHS uses a technology solution based on both historical and current patient census patterns to project the need for nurses as well. “If you can predict your census and build your staffing plans around it, you can also predict salary expenses and operate more efficiently,” says Tinman. Beyond enhancing nurse productivity through appropriate staffing levels, TRHS was able to save $1.2 million in six months from what was originally budgeted for salary costs to what was actually spent after the implementation of the technology solution.

Bedded outpatients can potentially complicate nurse productivity, but that may be avoided by proactively monitoring outpatients who may end up in a bed, and that bed’s location.