A “Real-Life” Guide to Integrate SPHM into Ambulatory Settings

A Panel Discussion

Objectives

- Recognize how SPHM practices can impact regulatory compliance for equal access to healthcare services for people with mobility disabilities.
- Verbalize key design guidelines and assessment for the design of ambulatory environments, to facilitate SPHM practices.
- Review two case scenarios illustrating how SPHM practices impacted accessibility, fall prevention, quality care, satisfaction and safety for both patients and healthcare workers.
- Understand strategies for making a business case to administration on expanding and sustaining a SPHM program in ambulatory settings.

Overview

Why Include SPHM in Ambulatory Settings and in Future Design?

Guy Fragala

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Patient Safety Center of Inquiry
Healthcare of the Future is Moving to Ambulatory Care Settings

- Ambulatory care accounts for more than one-third of healthcare spending in the United States
- Factors such as new care protocols, reimbursement models and the consumerization of healthcare are driving further growth.
- From 2005 to 2015, hospital inpatient stays declined by 6.6% while visits to outpatient facilities increased by 14%.

Designing Ambulatory Clinical Space for the Future

- A more thoughtful design of the exam room layout with respect to the placement and physical design of the computing set-up
- May reduce provider cognitive effort and enhance aspects of patient centeredness by viewing the computer and EMR it displays as an important aspect of the provider and patient interaction

Transitioning from Fixed Height to Adjustable Examination Tables

- Reduces risk to the caregiver
- Improves access, safety and comfort for the patient
- Other SPHM considerations now, and for the future
Design and Assessment

- Compliance with FGI Guidelines, PHAMA (2010) and SRA (2014, 2018)
  - Hospital, Outpatient, and Residential (LTC settings)
  - Distinguishing 'Persons of Size' from Bariatric, Obese, etc.
- Cost-Influence: Retrofits are cost prohibitive as compared to proactively thinking through issues first
- More than equipment types
  - What are the interactions and relationships for the model of care?
  - How does facility design best support safe care for patients and staff?
- Guidance through the free, on-line Safety Risk Assessment toolkit
  - Six topic areas, including patient handling & mobility

The views and opinions expressed in this presentation are the opinion of the speaker and may not be the official position of FGI or the Health Guidelines Revision Committee.
The Facility Guidelines Institute

Guidelines for Design and Construction

• Hospital
• Outpatient Facilities
• Residential Health Care
  and Support Facilities

The Facility Guidelines Institute

KEY

2018
2014
2010
2006
2001
1996–97

Equivalency*
HVAC only

*Guidelines may be applied as an equivalency to state rules.

2018: From ‘Bariatric’ to ‘Persons of Size’

Obesity Trends Among U.S. Adults

*Pleaseweighsexclusiveofclothing(weightlost)
1.2-3.1.1 SRA Requirement

All health care facility projects shall be designed and constructed to facilitate the safe delivery of care.

To support this goal, an interdisciplinary team shall develop a safety risk assessment.

*A1.2-3 Safety Risk Assessment (SRA)*

The SRA is intended to proactively identify hazards and risks and mitigate underlying conditions of the environment that contribute to adverse safety events.

The process includes:

• Evaluation of the population at risk, and
• The nature and scope of the project.
Why a Safety Risk Assessment (SRA) for healthcare facility design?

Current Practice Fails to Deliver Safety

Moving Safety Upstream in the Healthcare Facility Design Process

You thinking what I’m thinking?
Orange is the new black?
Out is the new in.

FGI Bariatric Accommodations Topic Group (2015-16)

Growth in outpatient care
The role of quality and value incentives

Medical procedures are moving into outpatient facilities, mostly due to technological advances such as minimally invasive surgical procedures. Real value-based care incentives are also playing a role in this trend.

Executive summary
GROWTH incentives, patient preferences, and financial incentives stretching far outside fear of complications at hospitals to successful surgery. Aggregate hospital-specific experience indicates that great value can be placed on the cost and effectiveness of procedures, as well as the use of readmissions and other hospitalization savings with a relatively lower surgical procedure and more favorable techniques in outpatient complications and other patient outcomes.
Moody's Investor Service Hospital Report

Estimates show:

45% of joint replacement procedures could be outpatient by 2025.

Design for the highest threat?

Consider the consequence

• Minor: first aid
• Catastrophic/serious: death, permanent injury

Consider the likelihood

• Unlikely: Not expected, but possible
• Almost Certain: Undoubtedly will happen/frequent event

What is “acceptable” risk to the organization

The Safety Risk Assessment Toolkit

A Proactive Process for Design of Health Care Facilities Mitigates Risk
The SRA Toolkit was developed through grants from the Agency for Healthcare Research and Quality (AHRQ).

The content is solely the responsibility of the author and does not necessarily represent the official views of AHRQ.

www.healthdesign.org/sra
Design Considerations

For an risk assessment, identify potential harms and areas within the proposed project associated with those potential harms. Review and discuss the following design considerations for each of the components. Consider the

realistic, the expected, those group, all of the potential harms, risk, and the potential outcomes.

This process may help identify the likelihood of events specific to your organization. Consider circumstances,

before, after, and during construction.

Patient Handling

www.ada.gov

ADA is required, and...
Building Layout

- Locate departments and units that patients are frequently transported from/to as close to each other as possible (e.g., ED and imaging if ED-imaging is a frequent patient transport route).
- Minimize the time, physical effort, and risks associated with transporting patients between departments and units through building design (e.g., ample corridor width, minimal turns, wide doorways without thresholds, open layout, elevators with ample space to accommodate bariatric beds etc.)

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Building Layout

- Provide patient elevators to accommodate patient beds/stretchers for the transport of special patients (such as bariatric patients).

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Unit & Room Layout

- Consider flexibility and adaptability of patient room design (e.g., bariatric patient room, universal room, spaces for portable CT scanners) in order to reduce the needs of patient transport.
- Provide adequate clearance (width and ceiling height) in corridors and patient rooms to accommodate use of patient handling / movement assistive equipment.
Unit & Room Layout
• Design room and bathroom layouts to facilitate safe and effective use of patient handling and movement equipment (e.g., patient rooms as well as diagnostic / operating / holding area / rehabilitation rooms).
• Designate enough conveniently located storage spaces for patient handling equipment and accessory supplies in the rooms where PH will occur (e.g., slings, lateral transfer devices, slide boards).

Equipment
Select patient handling and movement devices based on:
• Patient dependency
• Patient weight and size
• Projected patient populations
• Patient handling tasks
• Transfer time
• Risk of injury
• Ease of use
• Space/structural/other requirements

Other Considerations
Structural Design
• Support the current and anticipated requirements for using ceiling- and/or wall-mounted overhead patient lifts.
Lighting
• Provide enough illumination in ambient and task lighting for patient handling and movement tasks.
• Position lighting fixtures appropriately to accommodate clinical needs, as well as requirements of using patient handling and movement tasks.
Other Considerations

Interior design/finishes
• Design the ceiling and floor (including ceiling track systems, ceiling height, flooring materials, thresholds, and ramps) to support the use of ceiling-mounted or floor-based patient handling and movement equipment as needed.

Electrical design
• Optimize locations of electrical supply for charging and/or using patient handling equipment so they are easily accessible to the users.

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Case Study
Number 1

The Cyclical Impact of a Pre-Op Appointment

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The Cyclical Impact of a Pre-Op Appointment

A wheelchair bound patient needed eye surgery
- Safe transfers between wheelchair & OR table
- Current lift: 500 lb. capacity
- Patient’s weight: 552 lbs

Needs
- A lift with a higher capacity
- Current and accurate weight
- Weight capacity of specialty OR tables

704 lbs. capacity

Specialty OR Tables & Stretcher-chair

396 lbs. capacity

496 lbs. capacity
Specialty OR Tables & Stretcher-chair

- 500 lbs. capacity
- 600 lbs. capacity

Other Potential Options

- 650 lbs. capacity
- Removable Wrist Rests

Outcomes

- Team work
- Satisfaction
- Safety
- Quality of care
- SPHM practices as a continuum care package
Accommodating a Patient with Complex Diagnoses

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Accommodating a patient with complex diagnoses

• 56 year-old male; on bedrest for 1.5 years; weight = 306 lbs.
• Entered ambulatory clinic on a stretcher and must receive all services on the stretcher
• Medical services needed in Neurology, Neuro-Surgery, I.D., Family Medicine, Behavioral Health, Podiatry, Cardiology and Interventional Radiology
• Equipment used: Hospital bed, walker, wheelchair, gait belt, slider sheet, scooter ramp (donated), and multiple carts

Challenges

• Bedrest since 9-17-2017; ambulance arrival
• Came to large clinic sites via drivable “Stryker” cart
• Staff cart competency
• Ambulance transport team moving him on their cart
• Large room for cart to fit in any clinic
• Five + appointments in one day and laboratory services
• Staff communication – communication - communication
What would your clinic do for Mike?

• Where is your cart in the clinic settings?
• Do you have consistent outpatient program and care coordinators to help?
• Care conference and safety huddle to ID who are the right people?
• Will providers change their care delivery?
• How many times do we ask the same things over and over and over?

Outcomes in 2018

• No bed sores and avoided nursing home, for 1.5 years
• Began therapy in October, 2018; no need for in-home hospital bed
• Transitioning to out-patient therapy; hope for pool therapy by spring 2019
• Came in via wheelchair for first time on October 30, 2018
• Pivoted to walker for the first time to get into car to enter clinic
• Care Coordinator wears “Green Bay Packer Hat”
This is why we do it after all...
The Big Rewards!
“Life is finally looking brighter on the other side.”

Making the Business Case & Implementing a Program

How do I Begin?

Patti Wawzyniecki
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SPHM Consultant

Implementing a Program

1st Identify high risk clinic
2nd Investigate an incident
3rd Perform assessment
4th Present recommendations and ROI
Implementing a Program

Accommodate key organizational differences

- Leadership
- Data recording
- Staffing of clinical functions
- Financial recording and reporting

Implementing a Program

Adjust program to unique ambulatory characteristics

- Leadership Structure: business managers and physicians have more influence, in general
  - For example: equipment trials, include in hands-on contact
- Education & Training: include managers & physicians
  - Scheduling Time: availability during vacation weeks or Grand Rounds
  - Anticipate more push-back; may be less understanding of risks and costs
- Environment: conducive to sharing of some resources

Adjust program to unique ambulatory characteristics

- Assessment
  - In-person observations of clinic activities
  - In-depth interviews with manager and front-line staff
  - Inventory equipment and evaluate environment
  - Collect data with a survey – design survey tool to gather information on patient characteristics
    - functional mobility level
    - use of mobility aides
    - was exam or treatment performed in wheelchair or patient moved to table
Building the Business Case

Return on Investment: when benefits are greater than costs, this is a value proposition for leadership = a worthwhile investment

How long will it take to pay off the initial investment?

Calculation:
- Basic: Use commonly available SPHM data
- More Complete: Include quality and satisfaction data

<table>
<thead>
<tr>
<th>Costs</th>
<th>Expected Savings (per year or month)</th>
<th>Years or months to recoup costs</th>
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</thead>
<tbody>
<tr>
<td>Direct Costs</td>
<td>$261,000</td>
<td>$28,333/month</td>
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<tr>
<td>Indirect Costs Estimated</td>
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<tr>
<td>3-Yr. Estimated Total Cost</td>
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<tr>
<td>Average Monthly Cost</td>
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<tr>
<td>Total Cost of Equipment</td>
<td>$363,000</td>
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</tbody>
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$261,000 = 9.2 months

Building the Business Case

Understand unique factors influencing ROI at your facilities
- Cost justification method(s) used at your facility
- Key measurements of success or failure
- Specific forms or investment policy guidelines
- Facility/Organization profit margin
- Expected return on investment (ROI)
- Capital expense policy and planning cycle
- Supervisor signature limit
Key Take-Aways

- Ambulatory SPHM programs are the RIGHT thing to do, and it’s the LAW
- Will ensure that ALL patients receive equal, quality care
- Tailor program to ambulatory organizational structure
- Follow FGI guidelines
- Partner with your design department proactively

Resources

- 2018 Edition - Guidelines for design and construction for outpatient facilities; The Facility Guidelines Institute (FGI)
- Access to Medical Care for Individuals with Mobility Disabilities
  www.ada.gov/medicare_ta
- American Nurses Association: Safe Patient Handling and Mobility

THANK YOU