Four Tactics to Tune Up a Safe Patient Mobility Program

An Aon White Paper

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Understanding the Issue

Safe Patient or Resident Mobility initiatives are often undertaken with a significant management commitment in terms of financial resource support for the project, which typically cost from $500,000 to several million over the life of the program for multi-facility locations. Aon clients typically experience 40% to 50% reductions in their workers compensation injury rates once the program is fully implemented. The challenge is that after the initial rollout, programs can lose steam and experience constraints which can lead to flattened results.

Improving a flat or declining safe patient or resident mobility program can be a daunting task. With rapid changes in the way health care is delivered, accessed and financed, quantifying the program's return on investment is essential. Programs that fail to check in, assess, refine and re-evaluate the core elements may find flat or declining results in the future. This is particularly the case as internal stakeholders and program champions experience turnover, safety directors change, financial climates fluctuate and mergers present additional challenges.

This paper explores four key tactics to power up a safe patient or resident mobility program. Applying these four tactics can help to keep the program on the path of continuous improvement and greater long-term success.

Tactic 1: Power Up Your Lagging Indicators

Many safe patient mobility programs rely on lagging indicators to baseline success metrics. Lagging indicators such as OSHA DART rates (*D*ays *A*way from work, job *R*estrictions and/or job *T*ransfer), which measure injuries per 100 workers, only tell part of the story; they confirm past trends but do not predict them. When looking at accident frequency and severity, many third party and insurance carrier loss runs do not provide sufficient loss causes relevant to patient mobility. For example, one long-term care client posted "strain from lifting" as the leading loss driver, accounting for 222 claims. Lacking a clear claim report, there was no way to discern whether claims were incurred from lifting a resident or caused by a different lifting task.

By working with the carrier or third-party administrator, health care-specific cause codes can be developed that are more meaningful to the Patient/Resident Mobility Program (Table 1). Working to establish patient or resident mobility cause codes can allow easier trending of lagging indicators and, more importantly, a timelier response to the clearly identified trends. Good data also provides a platform for predictive modeling and a platform for more effective continuous improvement strategies. As an advocate for the client, the TPA or carrier should be willing to sit at the table and develop and structure custom coding for improved data mining and stratification.

Table 1: Example of custom coding for a Safe Patient or Resident Movement Program. Codes can be as specific or general as needed.

EXAMPLE 1: Nursing Home	EXAMPLE 2: Home Health
• Strain or Injury by Transferring Resident • Strain or Injury by Toileting Resident • Strain or Injury while Bathing Resident • Strain or Injury from Combative Resident • Strain or Injury from Dressing/Undressing Resident	• MSD from Patient Mobility • MSD from Patient -Repositioning • MSD from Patient -Transfer • MSD from Patient- Ambulating • MSD from Patient -Stair Assist

• Strain or Injury from Falling Resident • Strain or Injury from Repositioning Resident	• MSD from Patient- Outside Home • MSD from Patient - Assist with Equipment
EXAMPLE 3: Hospital	**Example 4: Assisted Living**
• Strain or Injury-Lifting Body Part During Wound Care • Strain or Injury-Lifting Patient • Strain or Injury –Patient Ambulating • Strain or injury – Lateral Transfer of Patient • Strain or Injury- Moving/Lifting Patient During Ambulance/EMT Response • Strain or Injury-Repositioning Patient • Strain or Injury-Pushing or Transporting	• MSD-Transferring Resident to Bed • MSD-Transferring Resident to Chair or Commode • MSD-Bed Repositioning • MSD-Walking with Resident • MSD-Lifting a Resident • MSD-Weighing a Resident • MSD-Bathing a Resident • MSD-Undressing or Dressing Resident • MSD-Transferring a Resident to stand from bed or chair to walker • MSD-Repositioning a Resident • Assisting Resident to or from a Vehicle

Another red flag issue regarding health care loss runs is the cause category: “Not Otherwise Classified (NOC)” or “Miscellaneous”. A recent review of a health care client’s loss run revealed 118 claims, or about 15% of the total claims, were coded as *Miscellaneous Strain* in the most recent policy year. Beyond giving insufficient detail for near-term claims support, these “miscellaneous” labels are limiting, e.g., these 118 claims can’t be analyzed further without going through each claim description for clarification. This ambiguity adds more time to the process and reduces the effectiveness of lagging indicator reports. When these nebulous classifications appear on a loss run, it is essential that the claims manager or coordinator work with the insurance carrier or adjuster to get NOC and miscellaneous coded appropriately so that accurate trending can be realized.

Many safe patient or resident mobility programs fail to analyze the deeper lagging indicators, such as total disability days, medical to indemnity conversion rates, injury frequency stratified by age, etc., to see if the results are at, above or below industry average. To measure and compare a company’s core lagging indicators against industry best practices, Aon clients can leverage one of two metric-driven diagnostic tools: Laser and Illuminate, The data derived from these casualty diagnostic tools enables the program champion to understand where current performance may be best-in-class or in need of improvement. By benchmarking lagging indicators against industry best practices, organizations can get a high level, comparative view of your program, relative to peers. Remember, reporting a number or result is important but *understanding that number in context of industry best practices* will help fine tune the lagging indicators and provide specific, actionable items for areas that are performing below expectation.

Hint: Be sure to capture both patient and employee injury data. Also, capture absenteeism on the non-occupational side for trends of musculoskeletal disorders that are resulting in casual absences.

Tactic 2: Introduce Leading Indicators

Many safe patient or resident mobility programs only track lagging indicators and are therefore missing important opportunities to capture leading, proactive activities that are contributing to the success of the program. Lagging indicators measure the failure modes (an accident occurred) while leading indicators measure what employees are doing on a regular basis to prevent a patient or resident mobility injury. Leading indicators help to predict future success and continuous improvement. Identifying and tracking

leading indicators is crucial to providing evidenced based data that activities are effective and creating the desired outcomes.

Table 2: Leading indicators for a patient or resident mobility program

LEADING INDICATORS PREDICT FUTURE RESULTS
• Percentage of employees trained versus expected in safe patient or resident movement program • Number of hazards corrected versus hazards identified for safe patient or resident mobility • Number of new or enhanced safety controls implemented • Results of accident investigations • Results of employee perception surveys related to safety patient or resident mobility program • Available equipment per census need, unit or department • Bariatric equipment per census need, unit or department • Safe Patient or Resident Mobility Champions per unit , department, floor or shift • Maintenance turnaround time on equipment repairs • Preventive maintenance completed on equipment • Vendor response time for parts, new equipment requests • Number of directors, managers or supervisors participating in program • Percentage of monthly SPH equipment skills demonstrations completed and documented • Percentage of monthly SPH Coach observations completed and documented • Annual vendor review using score card process (reputation, customer service, consultants) • Number of Certified Safe Patient Handling Professionals • Reviews equipment assessment tool and newly available equipment • Number of resident assessment completed • Scenario planning sessions

Hint: Identify leading indicators that will drive the desired outcomes for your program.

Tactic 3: Manage Patient Mobility Claims Effectively

A study by Dockrell, et al (2007) revealed that manual mobility incidents were not managed satisfactorily when they occurred and that the management of the injured worker was generally poor in the health care sector. (1) Another report by Hanson et al (2006) identified that programs for managing employees with musculoskeletal disorders in the health care sector, using case management and rehabilitation principles, can be an effective intervention. Key components of successful programs include providing early access to appropriate advice, remaining at work or returning early, and staying in touch with the individual during absence. (2) Health care organizations use various strategies for return to work and claims management. The key is to have a defined process for safe patient or resident mobility claims and clearly assigned responsibilities for the management of that process.

A good percentage of patient and resident mobility claims result in lost time. These cases tend to result in temporary, total disability days (TTD). One claim management strategy is to directly assign any employee claim from patient or resident mobility activities to an indemnity adjuster up front. This ensures that an experienced adjuster will be identified to effectively manage the claim. Further, if the claim converts from medical only to indemnity (which many do) the indemnity adjuster has all the data necessary and can actively pursue return to work strategies when appropriate.

The overall strategy is predicated on having *a defined plan in place*. This plan should include incident reporting, investigation and managing the claim from start to finish. A return to work process with didactic learning and return demonstration for accident reoccurrence prevention is also essential. Didactic methods follow a specific scientific model that focuses learning on three to five key points, with visuals and interactive sessions. (4) Using this type of learning will enable users to learn how to prevent a similar injury and demonstrate the core competencies to avert an injury in the future.

With patient mobility claims, note that aging workforce are becoming more common concerns in the health care sector, thus effective claims management is a core strategy for improving the SP/RHP program. In addition, communicating "lessons learned" to other employees is essential in preventing future claims of the same type and should be part of the process.

Hint: Include didactic re-education learning modules with return demonstration for an employee returning to work following a patient or resident mobility injury.

Tactic 4: Develop a Continuous Improvement Platform

Establishing a continuous improvement platform is essential in driving *sustainable excellence* in the safe patient or resident movement program. Many safe patient or resident mobility programs stall because they fail to realize the importance of following a continuous improvement platform and drive greater results for all aspects of the program. Whether Six Sigma or Lean tools are used or an in-house model, the program should follow a defined process and strive to continually improve. Table 1 details a continuous improvement platform that could be followed annually.

EVALUATE STAKEHOLDER ALIGMENT
• Have a process in place that understands stakeholder's wants and needs. In a safe patient or resident mobility program the stakeholders include employees, lift teams, vendors, managers and the senior leadership. Each stakeholder's responsibilities, performance and technical proficiency should be evaluated annually to gauge program effectiveness and ensure employee and patient safety needs and wants are being met. Affected Employees can range from end-users to staff performing preventative maintenance tasks. These needs and wants should be aligned with the capabilities of the champion and the overall goals of the program.
ASSESS THE WRITTEN PROGRAM
• Review all written program documentation annually to determine if the program material is 1) easy to understand and follow, 2) accurately reflects the program elements and 3) is missing any essential elements. Many programs fail to review program documentation annually causing the material to become stale and outdated. Use a non-program peer reviewer to see if the documentation is meeting the needs of the reader in a clear, concise and professional manner. Training material should be evaluated for content and the delivery platforms assessed. Slide decks should be reviewed and cleaned up for content using minimal number of slides. Be sure to simplify and limit the number of words on a slide, use good quality images, embed video clips, and be sure that the mission and current metrics are included where applicable.
REVIEW METRICS AND MILESTONES
• It is important to measure what really matters in a program. If metrics are too limiting (e.g. only reporting lagging indicators) it will be difficult to understand what is lacking in terms of activities to drive improved program performance. If metrics are too extensive, they can bog down the program and devote valuable resources to data collection versus program administration. As a best practice, pick three to four leaning indicators and then three to four lagging indicators.

The point of establishing metrics is to gauge program success while also defining which activities are effective or need to be enhanced. Many programs stick with failing activities versus trying to understand why they are failing and either fixing the issue or replacing it with a better program or process. Ensure the program is defining its return on investment using direct and indirect savings to demonstrate the desired outcomes (patient fall reduction, employee injury reduction, higher employee satisfaction).

REFINE THE STRATEGIC PLAN

- Strategic plans fail for a variety of reasons. Forbes Magazine identified 10 reasons why strategic plans fail which include unrealistic goal setting, lack of focus, lack of resources and no accountability or follow-through. (3) The strategic plan should be reviewed annually and assessed every quarter to ensure the program is on target. Consider defining a 1-3-5 year plan and continue to tweak the strategy, time and resources as organizational structures change.

EVALUATE THE ADMINISTRATIVE PROCESS

- Many programs fail to assess the administrative side of the program which can be clunky, slow or inefficient. If a piece of equipment takes six weeks to repair, can it be reduced to one week over time? If the initial risk assessment takes weeks to complete to determine equipment needs, can this be reduced to days or hours? If there are multiple touch points to obtain capital expense approval for equipment purchases, can this be minimized? If the vendor takes six weeks to deliver the products after a purchase order is received can this be reduced to one week? If the accident investigation process is delayed can this be sped up to the same day? Reviewing the administrative processes on at least an annual basis is essential to keeping the program robust, nimble and efficient. Can this be made a priority in the program?

ONBOARDING ANALYSIS

- Does Human Resources support the onboading process? The hiring and training of new safe patient or resident mobility program users, coaches, coordinators and new facilities are brought up to speed is critical to an effective process. This should be evaluated at least annually to ensure the onboarding process is fast, efficient and effective. Slow onboarding processes, particularly when a new hospital or facility is purchased, can be detrimental to a standardized, enterprise-wide program. Develop an onboarding matrix and review to ensure there are no holes in the onboarding process.

EQUIPMENT REVIEW

- Review equipment annually for usage, preventative maintenance, issues, and repair effectiveness. Continually seek out new equipment that may be of benefit to the program. Review the new equipment approval process for effectiveness and also review the process for removing equipment that is not performing as expected.

QUALITY REVIEW SESSION

- Having an open and honest dialogue around the program on an annual basis and identifying ways that the program can be further improved from a quality standpoint will help ensure activities and performance stay on target for continuous improvement. Remember, brainstorming and critiquing the program is a good way to address blind spots or areas not meeting all stakeholder's needs.

EVIDENCE REVIEW

- Successful programs continually review new studies and literature for information for new equipment, tools and evidence-based techniques, processes and procedures that are shown to be effective in reducing employee and patient injuries. New and relevant research should be incorporated into the program to continually improve content. Attending association webinars, like those put on by the Safe Patient Handling Association, are good to keep champions current on the latest topics and best practices. The program champion should be reviewing new research on an annual basis to refine the evidence-based practice of the safe patient mobility program. Attending association webinars, like those put on by the Safe Patient Handling Association, are recommended to keep champions current on the lasts topics and best practices.

ASSESS SUPPORT NETWORK

- Without continued support and succession planning of champions the program will lose momentum and eventually fail. Each year the program champion should meet with the executive sponsor to gauge support level, understand and discuss a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) to understand where support may be lacking (e.g. financially, resources, employee acceptance, etc.). Discuss where the executive sponsor can improve on reaching out for additional support and maintaining a strong network of advocates for the program. Develop a plan for what the lead champion can do day-to-day to create positive messaging around the program.

Conclusions

It is not uncommon for Safe Patient or Resident Mobility programs to fluctuate and lose steam. By performing an honest and accurate assessment of the core program elements annually and keeping the program focused on continuous and sustainable improvement, any lag issues will be mitigated before they become a drain on the program. While the elements of a patient mobility or resident movement program can be complex and exhaustive, applying these four tactics can help any program remain on the path of continuous improvement.

About the Author

Vicki Missar is an Associate Director at Aon Global Risk Consulting and has over 25 years of experience in the health care casualty arena. She is a Certified Safe Patient Mobility Professional, a Certified Health Care Safety Professional, a Six Sigma Black Belt and a Board Certified Professional Ergonomist. Vicki has authored many white papers on the impacts of aging, obesity and ergonomic issues as they relate to the health care industry. Vicki is part of the Aon Risk Solutions' Health Care Practice provides support for all lines of coverage, develops the analysis of current risk transfer programs, delivers insurance/reinsurance program structure planning and design, and prepares market submissions and renewal proposals. In addition, Aon provides managed care and medical/provider stop-loss broking to support medical excess loss insurance programs and offers clinical and enterprise risk management consulting to help enable strategic, long-term risk mitigation for health care organizations. Aon's services also address exposures in management liability, workers' compensation and property.

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AGRC's Casualty Risk Consulting team is dedicated to providing clients with innovative and sustainable solutions for their risk management needs. The differentiating factor is the *Strategic Improvement Platform*, a continuous improvement model leveraged to assess, plan, implement solutions, and measure success for our clients.

The Five Phases of the Aon Strategic Improvement Platform

- ***Calibrate:*** A critical understanding of our client's vision to ensure we deliver solutions that are consistent with long-term business plans.
- ***Diagnose:*** Establish baselines and benchmarks to identify strengths and prioritize opportunities for improvement. Then, by assessing the current state of the casualty program from a risk management, culture and prevention perspective, we help client build a program that drives measurable impact.
- ***Strategize:*** Team with clients to build a proactive, metric-driven plan to drive near-term milestones and long-term and sustainable successes. The objective is to help clients build SMART goals, so sustainable and replicable success for your organization can be managed.
- ***Execute:*** A hallmark of our consulting approach is "execution through client service". Planning with poor execution will not drive results, therefore, Aon's global resources are ready to support, compliment or directly manage portions of the strategic plan.
- ***Measure:*** The purpose of designing a strategy and then committing time and resources to its implementation is to drive results. Part of our planning sessions will be to identify how our clients will measure success.

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