TRANSFORMING PATIENT CARE AND EXPERIENCE

Key points from chief nursing executives at the 2018 HealthLeaders CNO Exchange

An independent HealthLeaders report supported by perfectserve.
Discussion

5 Factors That Influence Patient Care Delivery

Multiple factors must be considered when striving to evolve patient care

The healthcare landscape is changing, requiring nurse leaders to forge new paths to achieve high-quality, cost-effective, patient-centered care. Embarking on this journey to transform nursing and patient care delivery involves multiple considerations.

For instance, nurses are connecting with patients in more settings than ever before through new and changing roles. This calls for different types of knowledge, skills, and competencies than in the past. Additionally, patients now expect care to be delivered in a seamless, timely, and efficient manner that accounts for their personal needs and preferences.

To help resolve these complex issues, leaders are seeking peers to learn best practices in redesigning care delivery. A dialogue of ideas and strategies took place during the 2018 HealthLeaders CNO Exchange in Charleston, South Carolina, when 35 nursing and patient experience executives gathered in roundtable sessions that addressed key concerns.

1. CARE MUST EXTEND ACROSS THE CONTINUUM.

Population health and value-based care are pushing for preventive care in non-acute settings, and outcome-based reimbursement is requiring better care coordination across all settings and levels of care. Nurses

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ON THE COVER • From left: Katie Boston-Leary, CNO, University of Maryland Prince George’s Hospital Center, Cheverly, Maryland; Cathleen Wheatley, chief nurse executive and senior vice president, clinical operations, Wake Forest Baptist Health, Winston-Salem, North Carolina; and Tammy Daniel, senior vice president and CNO, Baptist Health, Jacksonville, Florida, share the personal side of their careers at the executive gathering.

TAKEAWAYS:

1. CARE MUST EXTEND ACROSS THE CONTINUUM.
2. TECHNOLOGY SHOULD HELP NURSES WORK SMARTER, NOT HARDER.
3. SHARED GOALS PROMOTE PATIENT FLOW.
4. INTERPROFESSIONAL COLLABORATION IMPROVES OUTCOMES.
5. BOOST PATIENT EXPERIENCE WITH PERSONAL CONNECTIONS.
DISCUSSION 5 FACTORS THAT INFLUENCE PATIENT CARE DELIVERY

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have an opportunity to drive patient care across the continuum, but organizations need to support them in developing the necessary skills to provide optimal patient care in these settings.

“The biggest opportunity for us will be figuring out how we take the strength of nurse residency programs for acute care and bridge that over into the full care continuum. With the emphasis on population health, we really need to do a better job at getting nurses into non-acute settings so that they can help lead the clinical care team in the community setting.”

Beverly Bokovitz, CNO and vice president, patient care services, University of Cincinnati Medical Center, Cincinnati, shares the value of a dyad model leadership during a roundtable discussion. Pictured at right is Meg Scheaffel, vice president and CNO, Carilion Clinic, Roanoke, Virginia.

“We’ve also added nurse educators to the off-shifts and weekends to act as a resource to the novice nurses on the night shift. That’s been a big help for us. And we have transitions-of-care nurse practitioners. They work with a pharmacist and perform inpatient care coordination, and follow a subgroup of high-risk patients from discharge to home.”

Jennifer O’Neill, CNO, Vice President of Patient Care Services, Saint Barnabas Medical Center, Livingston, New Jersey

“We’re developing a nurse residency in home health and hospice. I served as the CEO of the VNA for eight years, and saw a huge gap between inpatient and outpatient, and patients were going into a dark hole. That’s where most of the...
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frustration came from, and the frustration was [expressed in] our inpatient survey as, ‘You guys didn’t prepare us for a transition to that next level of care.’ So, the inpatient satisfaction results suffered. The residency in home healthcare and hospice will include the traditional approach as well as some community care because we have a center for inclusion health that focuses on homeless and marginalized patients.

“Some nurses come out of nursing school and don’t want to work in a hospital. They want to work in ambulatory but [traditionally, nursing says] you’ve got to have two to three years of hospital experience. Well, no, you really don’t, and we want to help with that. We expect great success with this initiative.”

Claire M. Zangerle, Chief Nursing Executive, Allegheny Health Network, Pittsburgh

2. TECHNOLOGY SHOULD HELP NURSES WORK SMARTER, NOT HARDER.

In healthcare, the word technology is often synonymous with electronic health records. And in the minds of frontline caregivers, EHRs are often synonymous with increased workload. But there is much more to technology, which can decrease workload and improve patient care by providing nurses with decision support.

“We need to look at where we have opportunities for integration with IV pumps, beds, and other areas where nurses would typically be required to document themselves. And, also, where can nurses lead the design of some predictive analytics that we have in the EHR? We’ll be implementing a predictive model for sepsis and a falls predictive model. This will help with that decision support for our nurses, and we’ll have some protocol development associated with it. Then by the time they contact the physician, we have additional information for them to make good decisions.”

Erin LaCross, CNO, Parkview Regional Medical Center and Affiliates, Fort Wayne, Indiana

“It’s a highly collaborative group bound by a highly compelling shared vision.”

STEPHEN MAFFEI, VICE PRESIDENT, ORGANIZATION EFFECTIVENESS AND PATIENT EXPERIENCE, METHODIST HEALTH SYSTEM, DALLAS

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“Transparent patient classification [in the EHR] pulls the patient acuity from the nurse’s documentation. It recommends staffing based on patient need. Daily staffing is not based on pure hours per patient days (HPPD); it’s about workload. It took years of building up to using purely workload for staffing. We had to show accuracy in our patient classification. It was years of proving our case—probably about 10 years of classifying patients while using HPPD for staffing. Once we established accuracy and I got buy-in from the senior leadership team, we transitioned to using purely workload. We took away HPPD and committed to plus or minus 2% for actual to recommended staffing.”

Teresa Connolly, CNO & Chair, Department of Nursing, Mayo Clinic, Phoenix

3. SHARED GOALS PROMOTE PATIENT FLOW.
“When we redesigned bed placement services, multiple departments aligned goals with the outcome metric focused on moving patients from the emergency department to a clean-and-ready inpatient bed within 30 minutes. In the first month, we realized that we weren’t using standardized handoff procedures, which caused delays. By aligning the 30-minute goal across multiple departments, we created a team mindset for addressing and correcting issues quickly. We were able to do that by defining expectations and standardizing handoffs. Subsequently, we defined throughput with simple stoplight terminology. On green days, we have no bottlenecks.
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anywhere and patients are transitioning well throughout the organization. The focused efforts allowed us to achieve a 35% improvement in ED throughput.

“On yellow days, we are at risk of boarding in the ED, PACU, or in the region. At that point, we send out alerts through text messages to select nurse managers and other disciplines who need to be informed and have the ability to affect throughput through specific action. We conduct short conference calls to inform the organization that we’re at risk of holding and why, and then discuss barriers to meeting the supply and demand of ready inpatient beds, and eliminate the possibility of holding patients. We also send out communication to the hospitalists and the nursing staff to help prioritize units where discharges need to occur.

“The patient hears the term discharge at 6:30 in the morning, but it’s always ‘pending clinicals.’ That could be five consultants weighing in on the plan or trying to get medical equipment, or something like that. Then the family can’t come get them until 6 p.m. So here you have this absolutely frustrated patient sitting there. Standardizing language across the team—so that when you say discharge, everyone knows what it means—that helps.

Karen Grimley, chief nursing executive, UCLA Health, and vice dean, UCLA School of Nursing, Los Angeles, says patient satisfaction improved when they kept the discharge lounge open all the time and staffed by a nurse.

“On red days, additional text messages and conference calls are conducted. More disciplines are included in the calls, including representation from the executive level, EMS, and even postacute partners, who all have a role in helping us avoid going on diversion.

“What we found is we were able to break down the silos throughout the health system. We were able to align goals from admission to post-acute and remove barriers of throughput—including adding transport services to discharge. These procedures changed our culture, improved outcomes, and increased operational efficiency.”

Amy Susott, Chief Innovation Officer, Deaconess Health System, Evansville, Indiana

“The biggest opportunity for us will be figuring out how we take the strength of nurse residency programs for acute care and bridge that over into the full care continuum.”

Rebekah Couper-Noles, Associate CNO, Intermountain Healthcare, Salt Lake City

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"Every patient wants you to know they have a life outside this hospital and this hospital stay is just a small part of a much bigger life.”

BARBARA JACOBS, CNO, ANNE ARUNDEL MEDICAL CENTER, ANNAPOLIS, MARYLAND

“We have a discharge lounge, and nurses from there can go up to the floor and discharge the patient for the staff nurse. We have three nurses that staff it, and it’s made a huge difference with our patients.

“The discharge nurse who goes to the bedside and did all the paperwork physically escorts the patient to the lounge. We have recliners there and a nurse is there so someone can help the patient if they need anything. Then when the ride pulls up, that nurse will take them out.

“The success for us was when we left the discharge lounge open all the time. We have a core group of nurses from our float pool who are deployed there on a regular basis, and we’ve actually opened it to Saturdays now because we have that much volume moving on Saturdays.”

Karen Grimley, Chief Nursing Executive, UCLA Health, and Vice Dean, UCLA School of Nursing, Los Angeles

4. INTERPROFESSIONAL COLLABORATION IMPROVES OUTCOMES.

Shared vision and partnership among an organization’s various disciplines can help translate vision and goals into measurable outcomes.

“We’re in the process of implementing our Care Delivery Integration System (CDIS), and this is a model that’s being championed by our system chief medical officer. The model involves bringing together the medical directors of all our units—nine inpatient ICUs and 23 inpatient medical and surgical units—in a dyad model, which pairs the medical director with each unit’s nurse manager. We meet regularly and identify issues and discuss any quality or safety concerns. For instance, we recently focused on reducing CAUTI and CLABSI in the ICUs.

“Each dyad is joined into a larger group (i.e., ICU grouping) and includes representation from other team members such as performance improvement, supply chain, infection control, IS & T, etc. You’re bringing together all the key players in the organization to focus on a specific improvement and reduce barriers, but the major change is a more robust involvement from our physicians. It’s been a spectacular success based on our recent outcomes. We’ve gone 120 days in our neuroscience ICU with no instances of CAUTI. It’s been a physician champion model, and it’s coming together to partner with nursing and with all the other disciplines.”

Beverly Bokovitz, CNO & Vice President, Patient Care Services, University of Cincinnati Medical Center, Cincinnati

“I’ve noticed in many work areas how important solid change management has to be. You have to create a compelling vision, remove the barriers people perceive toward achieving the intended change, move some of the structural problems out of the way, and obtain the necessary stakeholder support. All those change management components are really important. Then, all of a sudden, things seem a lot more ‘possible.’ With change, you need to have both a sound plan and a clear and compelling vision in order to overcome resistance.

“For example, one of our hospitals has organically created a workgroup dedicated to maximizing patient experience in their ED that meets monthly. This group is functionally very diverse – management, physicians, nurses, other clinical staff, patient experience coaches, and hospital administration. It’s a highly collaborative group bound by a highly compelling shared vision. They always have a strong agenda, predictable
meeting cadence, and a well-vetted and sound plan of action. As a result, they’ve done some incredible work together. In a relatively short period of time, their ED began to achieve top-decile performance with consistency. Now they’re focusing on digging deeper, strategizing on how to maintain this performance during significant volume fluctuations and sustaining the gains already realized.”

Stephen Maffei, Vice President, Organization Effectiveness and Patient Experience, Methodist Health System, Dallas

5. BOOST PATIENT EXPERIENCE WITH PERSONAL CONNECTIONS.

Patients want to be seen as whole people, not just a disease or room number. By paying attention to what many consider to be small things, nurses can improve the patient experience.

“We started changing the way we talk to people in the ED, and it seems to be helping. When the leaders round and the nurses round, they’ll say, ‘Do you know what you’re waiting for?’ If the patients say no, then they’ll say, ‘OK, here’s what we’re waiting for.’ If patients say, ‘Yes, I know what I’m waiting for,’ then they’ll say, ‘Do you know how much longer you’re going to have to wait?’ Again, if patients say no, then they’ll fill them in. The physicians have started saying, ‘What questions can I answer?’ It’s made a big difference. It’s more welcoming. It makes patients feel like we have time for questions. It makes people feel like they’re being treated in a more special way. It’s the little things.”

Shawna Cunning, Assistant CNO, MacNeal Hospital, Berwyn, Illinois

“I had a bright, young nurse and we were working on making quick personal connections. I was rounding on her floor and said, ‘So tell me something personal about your patients.’ She said, ‘I don’t have anything. I can’t figure out how to do this.’ So, I said, ‘Let’s walk into this room. In one minute, we’re going to have a personal connection because all you’re trying to do is to let that patient know that you see them as a person, not just a disease. Every patient wants you to know they have a life outside this hospital and this hospital stay is just a small part of a much bigger life.’

“We went in and her husband was sitting at the patient’s bedside and was holding two cups of Starbucks coffee. I said, ‘Do you bring her Starbucks coffee?’ And he said, ‘Oh, yeah, I bring her Starbucks every single morning and every evening.’ I said, ‘You are the luckiest woman to have a husband that brings you Starbucks coffee like that!’ I took the nurse outside and I said, ‘See, that is it: She is the lucky woman with the husband who brings her Starbucks coffee every day. That’s all you have to pass on to the next nurse. When that nurse walks in and tells the patient how lucky she is to have a husband who brings her coffee, you have established a simple personal connection. You have let the patient know that you know there is more to her life than her illness.’

Barbara Jacobs, CNO, Anne Arundel Medical Center, Annapolis, Maryland

Claire Zangerle, chief nurse executive, Allegheny Health Network, Pittsburgh, is developing a nurse residency in home health and hospice.

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