Developing Change Agents in an Ever Evolving Health Care Delivery System

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Chief Nursing Officer / VP Patient Care Service

July 20, 2018

No Conflict of Interest to Declare

OBJECTIVES

- The learner will be able to articulate the DNP essentials.

- The learner will be able to demonstrate the understanding of the synergies and differences of the DNP and PhD prepared nurses.

- The learner will be able to understand the role of the DNP in quality improvement, system redesign, and translational research.

- The learner will be able to identify how the DNP prepared nurse is positioned to improve the professional practice environment and achieved desired patient outcomes.

ROLE OF THE CHIEF NURSING OFFICER IN THE UNITED STATES

Regulations: Medicare and Medicaid Services (CMS)

§482.23   Condition of participation: Nursing services.

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

(a) *Standard: Organization.* The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.

CHIEF NURSING OFFICER ROLE – POSITIONS STATEMENT

Provide executive-level leadership advancing, developing, refining, and innovating nursing operations throughout Hospital and Health System; lead nursing operations through efficiency in care delivery, emphasis on quality outcomes, and attention to high-value care through new and established clinical service lines, clinical programs of excellence, and culturally aware, patient-centered care delivery.

ACADEMIC PREPARATION OF MAGNET CNOS AMERICAN NURSES CREDENTIALING CENTER

- The CNO must be a participant of the hospital's governing body as well as the body responsible for strategic planning.

- The CNO must have at least a master's degree. If this degree is not in nursing, the officer must have either a bachelor's or a doctorate that is in nursing.

- There must be a single Chief Nursing Officer. This officer must be responsible for maintaining the standards of the hospital's nursing program.

HISTORICAL PERSPECTIVE ON US DOCTORATE EDUCATION

In the US, Nursing is the nation's largest health care profession, with more than 3.1 million registered nurses.

In 2004 in the USA the landmark decision was arrived at through a vote of membership of the American Association of Colleges of Nursing (AACN) to rationalize doctoral education in the USA and streamline the educational products offered to two types of doctorates:

- Doctor of Nursing Practice (DNP)

- Doctor of Philosophy in Nursing (PhD)

Source: US Department of Labor retrieved 5.2018 from https://www.bls.gov/oes/current/oes291141.htm

DEVELOPING CHANGE AGENTS

The changing demands of this nation's complex healthcare environment require the highest level of scientific knowledge and practice expertise to assure quality patient outcomes.

The Institute of Medicine, Joint Commission, Robert Wood Johnson Foundation, and other authorities have called for re-conceptualizing educational programs that prepare today's health professionals.

In the landmark document The Future of Nursing: Leading Change, Advancing Health (Institute of Medicine [IOM], 2010), the IOM recommended increased education for nurses, specifically increasing the number of nurses with baccalaureate degrees, but also doubling the number of nurses with doctoral education to "add to the cadre of nurse faculty and researchers, with attention to increasing diversity" (p. 4).

ANCC DNP ESSENTIALS

The Essentials of Doctoral Education for Advanced Nursing Practice

1. Scientific Underpinnings for Practice

2. Organizational and Systems Leadership for Quality Improvement and Systems Thinking

3. Clinical Scholarship and Analytical Methods for Evidence-Based Practice

4. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

5. Health Care Policy for Advocacy in Health Care

6. Inter-professional Collaboration for Improving Patient and Population Health Outcomes

7. Clinical Prevention and Population Health for Improving the Nation's Health

8. Advanced Nursing Practice

WHY MOVE TO THE DNP

Some of the many factors building momentum for change in nursing education at the graduate level Include:

- The rapid expansion of knowledge underlying practice
- Increased complexity of patient care
- National concerns about the quality of care and patient safety
- Shortages of nursing personnel which demands a higher level of preparation for leaders who can design and assess care
- Shortages of doctorly prepared nursing faculty
- Increasing educational expectations for the preparation of other members of the healthcare team

Source: American Association of Colleges of Nursing
http://www.aacnnursing.org/Portals/42/News/Factsheets/DNP-Factsheet-2017.pdf

WHY MOVE TO THE DNP

The DNP is designed for nurses seeking a terminal degree in nursing practice and offers an alternative to research-focused doctoral programs.

DNP-prepared nurses are well-equipped to fully implement the science developed by nurse researchers prepared in PhD, DNS, and other research-focused nursing doctorates.

Nursing is moving in the direction of other health professions in the transition to the DNP:

- Medicine (MD)
- Dentistry (DDS)
- Pharmacy (PharmD)
- Psychology (PsyD)
- Physical Therapy (DPT)
- Audiology (AudD)

CURRENT DNP PROGRAM STATISTICS

- In the United States 303 DNP programs are currently enrolling students at schools of nursing nationwide, and an additional 124 new DNP programs are in the planning stages

- DNP programs are now available in all 50 states plus the District of Columbia.

- States with the most programs include California, Florida, Illinois, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, and Texas.

- From **2015 to 2016**, the number of students enrolled in DNP programs increased from 21,995 to 25,289
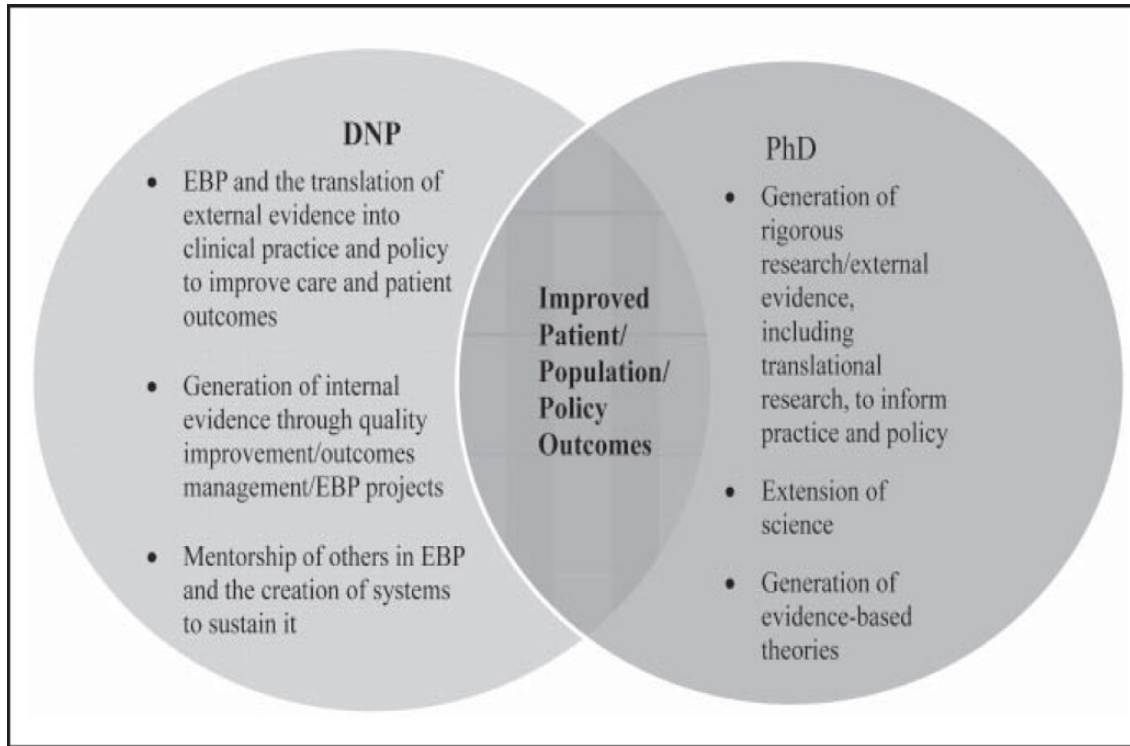

Growth in Doctoral Nursing Programs: 2006-2016
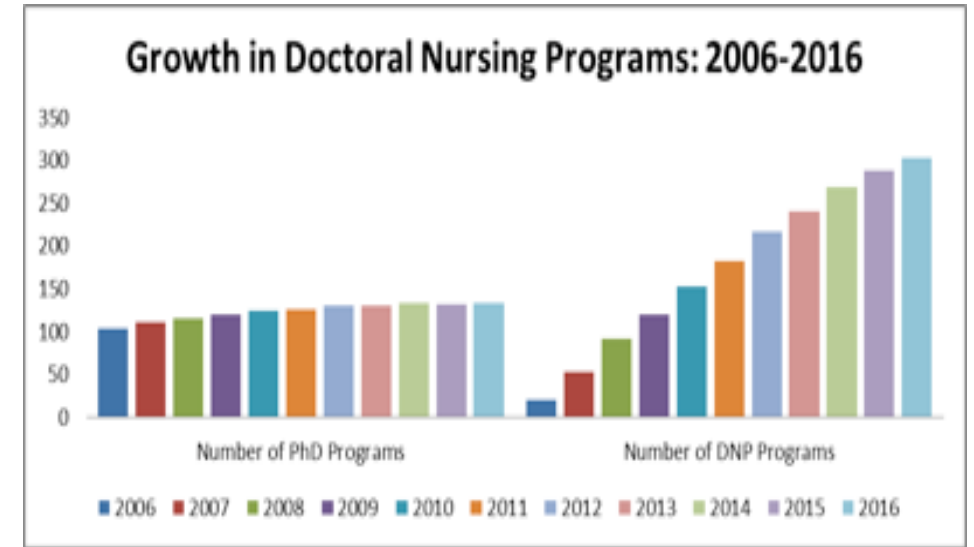
DNP AND PHD GRADUATE STATISTICS IN UNITED STATES
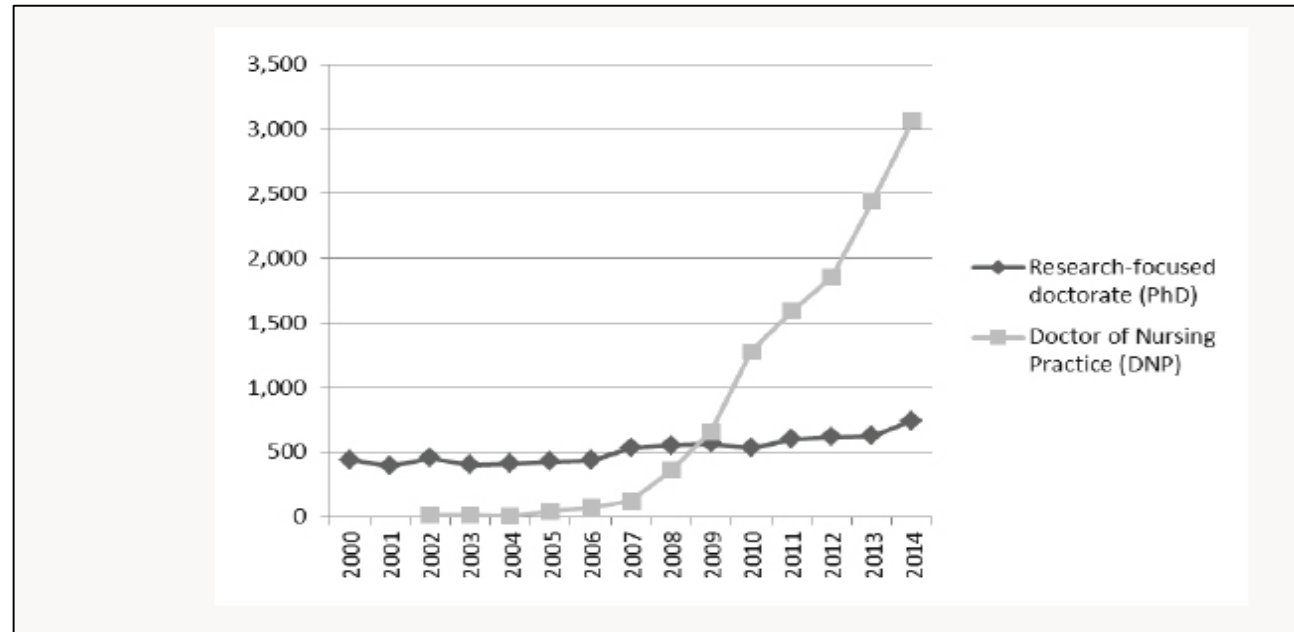
Numbers of Nursing PhD and DNP graduates, 2000 - 2014

Stanford Nursing / Patient Care Services

IMPROVING PATIENT/ POPULATION/ POLICY OUTCOMES

DNP
- EBP and the translation of external evidence into clinical practice and policy to improve care and patient outcomes
- Generation of internal evidence through quality improvement/outcomes management/EBP projects
- Mentorship of others in EBP and the creation of systems to sustain it

Improved Patient/ Population/ Policy Outcomes

PhD
- Generation of rigorous research/external evidence, including translational research, to inform practice and policy
- Extension of science
- Generation of evidence-based theories

Source: Melnyk. (2013) Journal of Nursing Education

Although much confusion in the academic preparation and roles of the PhD versus DNP still exists throughout the United States, PhD and DNP programs have two clearly distinct end points: (a) the PhD degree prepares researchers and scholars to generate external evidence (i.e., evidence generated through rigorous research) to extend science and theory and guide practice, and (b) the DNP prepares expert clinicians to generate internal evidence (i.e., evidence generated through outcomes management, quality improvement, and EBP projects) and to **translate evidence produced through rigorous research into practice to improve health care quality, patient outcomes, and organizational or health policy**

DNP CASE STUDY:

Improving Patient Outcomes and System Redesign / Translational Research

CLINICAL ISSUE/PRACTICE PROBLEM

- Emergency Department is overcrowded limiting access for emergency department patients and creating potential quality and safety issues

- The aim of this project is to increase inpatient bed availability by implementing standardized interprofessional inpatient discharge huddles in all inpatient units thus decreasing ED boardering time

- The key stakeholders are emergency department inpatient boarders are patients, families, nurses, clinicians, physicians, health system.

EVIDENCE

Emergency Department (ED) overcrowding is a nationally recognized problem.
(Asarso, Lewis, & Bowerman, 2007)

Inpatient boarding is a root cause of overcrowding in a majority of emergency departments.
(Baker & Esbenshade, 2015).

Inpatient boarders are an important and unacceptable consequence of emergency department overcrowding. (IOM, 2006).

SUMMARY OF THE SUPPORTING LITERATURE

- Emergency Department length of stay of 2.8 hours, the length of 11.6 hours was associated with a relative risk of 3.5 (95% CI 3.3 to 3.7) of admission. (Gabayan et al., 2015).

- The use of "HUDDLES" improves communication between the multidisciplinary team members resulting in improved quality, safety, and the patient experience. (Glymph et al., 2015).

- Patients who received coordinated care at discharge were more likely to report satisfaction with services (odds ratio 1.6, 95% CI 1.1 to 2.4) (5 RCTs). (Stevenson, 2005).

SUMMARY OF THE SUPPORTING LITERATURE

ProQuest /Medline and CINAHL search:

Key words: *ED overcrowding, patient boarders, huddles, communication, discharge, bed occupancy and patient flow.*

Articles from January 1, 2000 to June 1, 2016.

931 articles initially identified.

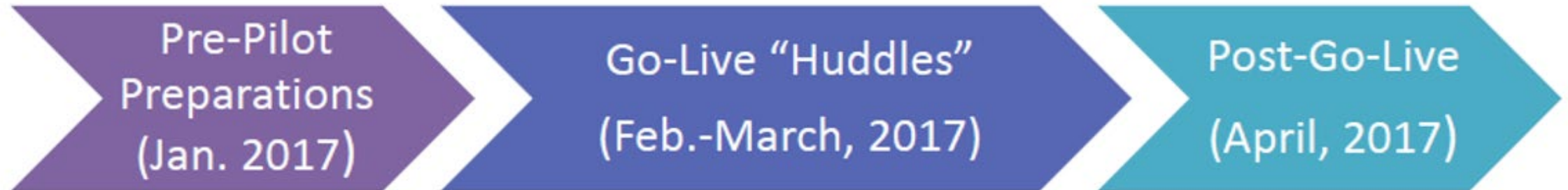| Studies Included	Cochrane Specialized Register		Individual Randomized Control Trials (RCTs)	Retrospective Cohort Studies	Case-Controlled Study
	11 RCTs	11 Studies	2 RCTs	4	1

PROJECT IMPLEMENTATION

- Applied the Donabedian Quality Framework.

- Developed an interprofessional inpatient "HUDDLE" as an intervention with patient care executive team
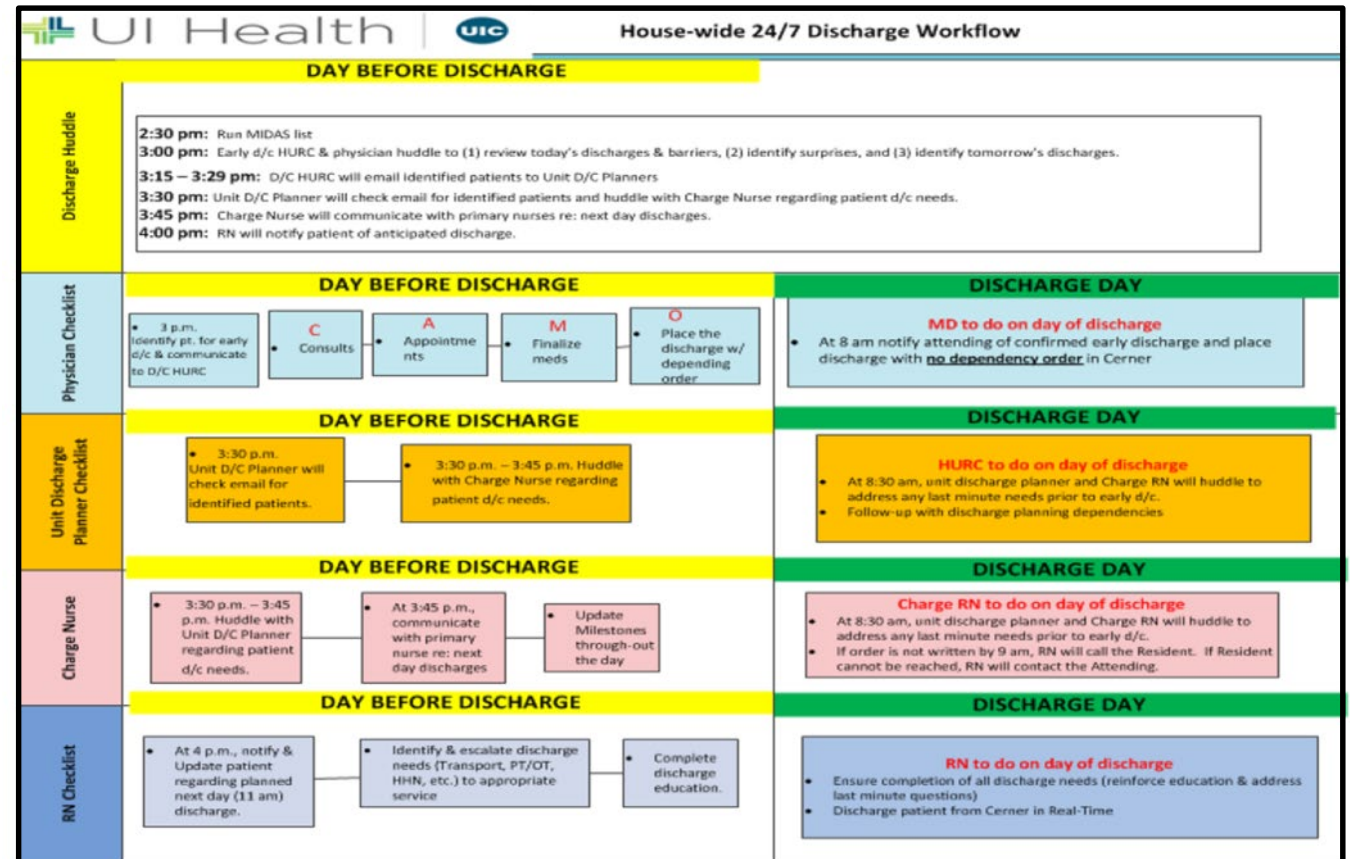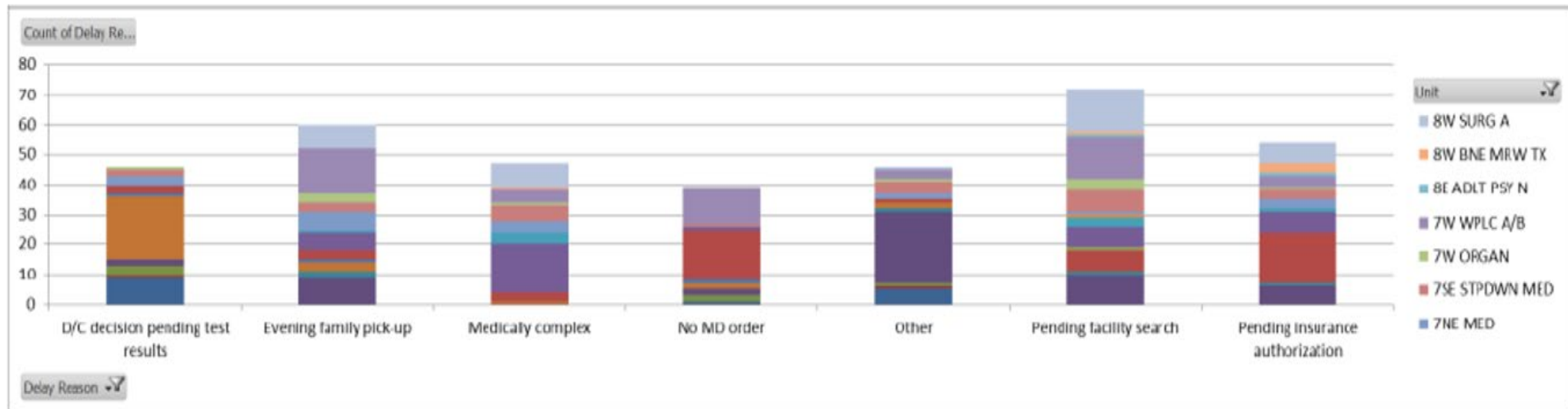
PROJECT IMPLEMENTATION

- Scope of project included all inpatient units.
- Big Bang implementation methodology for deployment on February 1, 2017.

| Pre-Pilot Preparations (Jan. 2017) | Go-Live "Huddles" (Feb.-March, 2017) | Post-Go-Live (April, 2017) |

PROJECT IMPLEMENTATION

- Inpatient data analyzed and opportunities were identified for improvement. (Top 7 Milestone Report developed for reasons for delays).

PROJECT IMPLEMENTATION

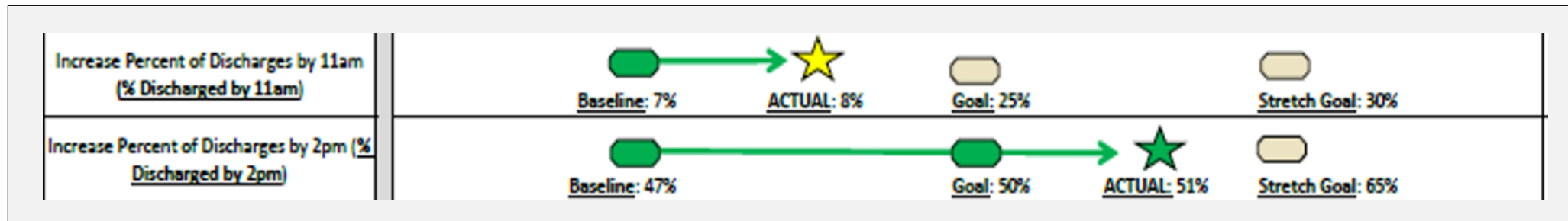- Quality improvement study that was exempt from the IRB.
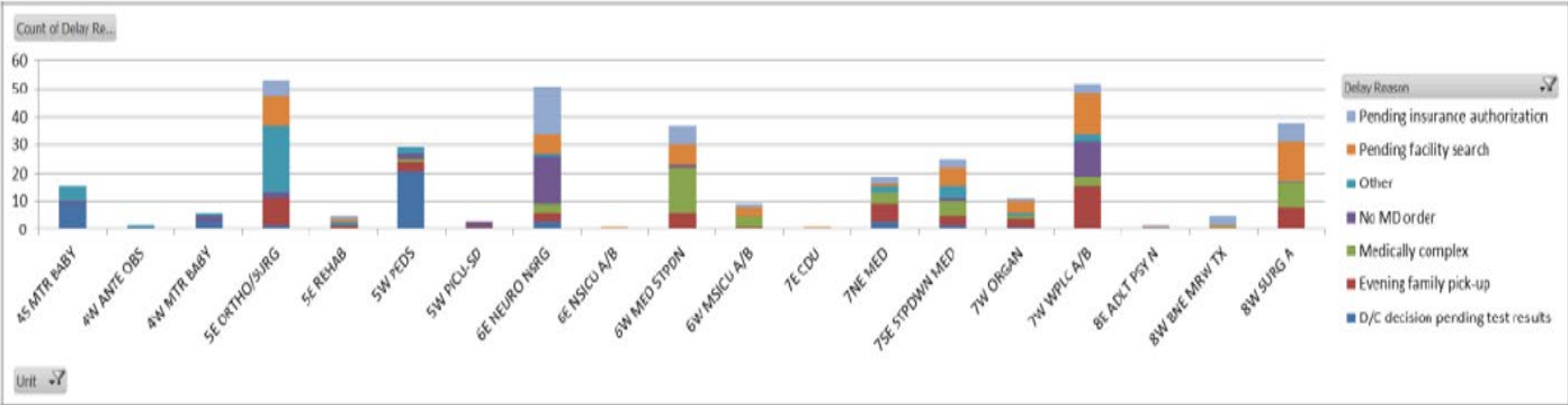
OUTCOMES

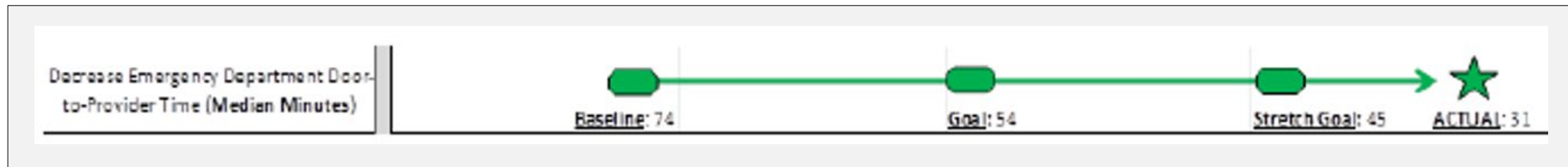- Inpatient discharge performance by unit for both 11 AM- 2PM

Units	Total Discharge	MD Order by 9AM	% of MD Order by 9AM	Patient left by 11AM	% left by 11AM	MD Order by Noon	% of MD Order by Noon	Discharge by 2PM	% discharge by 2PM	Average Time to Process Discharge (hh:mm)
Medical Surgical units										
5E Surgery & Rehab	142	18	13%	10	7%	68	48%	59	42%	0:37
7NE MEDICINE	62	1	2%	2	3%	18	29%	22	35%	15:49
7SE SD MED	141	7	5%	7	5%	42	30%	43	30%	6:59
8W BONE MRW TX	38	2	5%	3	8%	11	29%	11	29%	10:13
8W SURG A	158	12	8%	11	7%	50	32%	55	35%	1:40
	541	40	7%	33	6%	189	35%	190	35%	5:00
Critical Care										
6E NEURO/NSURG	128	7	5%	6	5%	45	35%	44	34%	3:56
NSICU	26	1	4%	1	4%	11	42%	10	38%	0:18
6W MED STPDN	113	7	6%	7	6%	32	28%	32	28%	1:36
MICU	9	0	0%	2	22%	4	44%	4	44%	0:23
7E CDU	93	5	5%	8	9%	27	29%	37	40%	0:02
7W ORGAN TX	41	0	0%	1	2%	20	49%	9	22%	0:41
7W WP	88	7	8%	8	9%	39	44%	34	39%	0:54
	498	27	5%	33	7%	178	36%	170	34%	1:38
Women, Children and Psychiatric Services										
4W MB/APSD	299	72	24%	30	10%	228	76%	209	70%	1:35
5W PEDS	79	3	4%	14	18%	37	47%	41	52%	12:28
NICU	35	0	0%	6	17%	26	74%	25	71%	1:46
5W PICU-StepDown	48	6	13%	11	23%	26	54%	26	54%	0:42
Psychiatry Adult	44	9	20%	10	23%	24	55%	28	64%	0:29
8EAP ADOL PSYCH	0	0	0%	0	0%	0	0%	0	0%	0:00
	505	90	18%	71	14%	341	68%	329	65%	3:07
Total	1544	157	10%	137	9%	708	46%	689	45%	3:18

OUTCOMES

- The desired outcome for this DNP project is to reduce ED inpatient boarding time by discharging 25% all appropriate daily inpatients by 11 A.M. and an additional 25% by 2 P.M. *Overall goal achieved with 51% of DC by 2 PM.*

Increase Percent of Discharges by 11am (% Discharged by 11am)	Baseline: 7%	ACTUAL: 8%	Goal: 25%	Stretch Goal: 30%
Increase Percent of Discharges by 2pm (% Discharged by 2pm)	Baseline: 47%	Goal: 50%	ACTUAL: 51%	Stretch Goal: 65%

- Door to Provider goal was exceeded with only 31 minutes.

Decrease Emergency Department Door-to-Provider Time (Median Minutes)	Baseline: 74	Goal: 54	Stretch Goal: 45	ACTUAL: 31

OUTCOMES

- A reduction of the emergency department inpatient boarder time below the University Health Consortium's (UHC) average performance.

  - *Average boarder time did decrease to 78 min compared to the UHC average of 150 minutes* (UHC, 2017) *for February month end.*

CLINICAL IMPLICATIONS FOR PRACTICE AND NEXT STEPS

- The outcome is a reduction of emergency department inpatient boarding time by improving inpatient discharge care coordination.

- Improvement in inpatient care coordination via the "HUDDLES" increased bed capacity and patient flow. As a result, a reduction in inpatient emergency boarders was realized.

- As cited in the literature, reducing emergency department boarders improves the quality, safety, and service excellence for patients seeking care.

- Further evaluation is needed to assess physician service-line performance, seasonal and volume variation, and the effectiveness of the interprofessional team huddle.

- System Case Study of a Development of Professional Nursing Practice in an Academic Medical Center:

  - Dr. Jean Watson's Caring Science
  - Dr. Patricia Benner's "From Novice to Expert"
  - ANCC Magnet Model

NURSING THEORIES AND CONCEPTS

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PROFESSIONAL PRACTICE MODEL
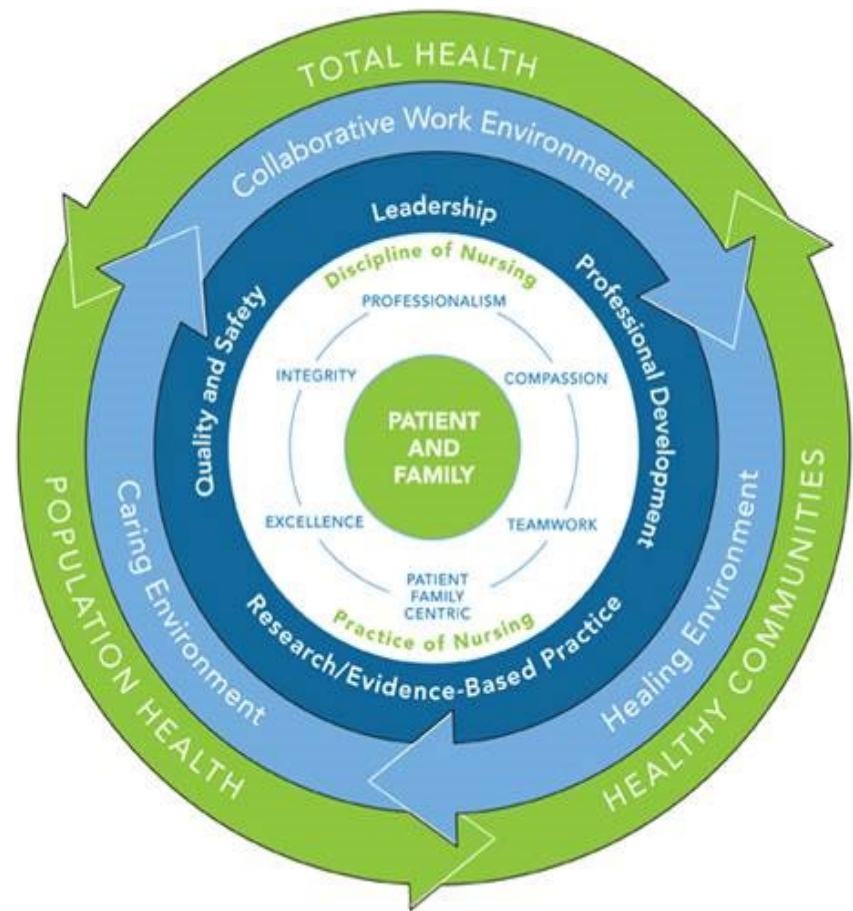
CORE ASPECTS OF CARING SCIENCE THEORY – SACRED SCIENCE

- **Heart/Soul** – Relational Caring as ethical-moral-philosophical values guided foundation (Source of Compassion; Philosophy, Ethics, Love, Values & Human Spirit Connection)

- **Voice** – Caring core: Ten Caritas Processes (Language & Structure)

- **Hearth** – Transpersonal Caring Moment-Caring Filed (Where Theory Lives)

- **Mind** - Caring as Consciousness-energy-intentionality- human presence (Informed Moral Action)

- **Hands/Praxis** – Caritas-Healing modalities (Artistry: All Ways of Knowing/Being/Becoming/Doing)

BENNER'S DOMAINS OF PRACTICE

- The "Helping Role"

- The Teaching Coaching Function

- The Diagnostic and Patient-Monitoring Function

- Effective Management of Rapidly Changing Situations

- Administering and Monitoring Therapeutic Interventions and Regimens

- Monitoring and Ensuring the Quality of Health Care Practices

- Organizational and Work-Role Practices

PRENTICE HALL HEALTH

From Novice to Expert

Excellence and Power in Clinical Nursing Practice

Commemorative Edition

Patricia Benner
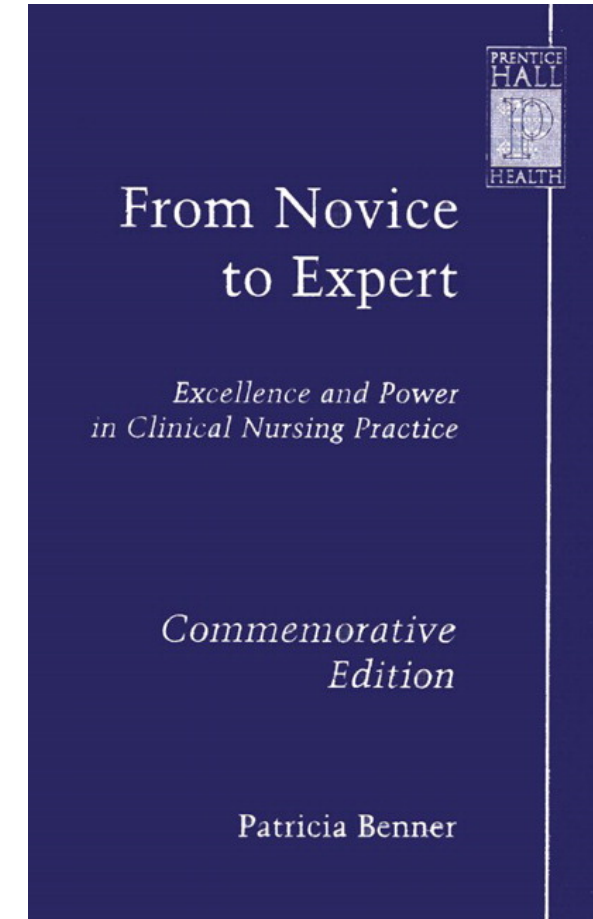
Benner (1984) : p.46

THE 5 LEVELS OF SKILLS ACQUISITION

Benner	PNDP Equivalent	APP Equivalent	Example
Novice	None	None	A student nurse; learns rules, but can't adjust to change in condition. Context-free rules-can't see the big picture
Advanced Beginner	CN I	APP I	A new graduate; learn to apply rules to different situations, learning pt population, tasks, priority setting. Min capacity w/ changing situations
Competent	CN II	APP I	**Most nurses at SHC, (2-3yrs);** increased understanding of clinical situations. Aware of normal course, and expected complications, knows tasks, sets goals/plan of care based on pt readiness
Proficient	CN III	APP II	Increased perceptual acuity; *Hallmark of this stage; self-reflection, self-correction.* Alter POC to meet pt needs, better idea of whole picture; still need to think about what to do
Expert	CN IV	APP III	Perform under pressure; see what is **Salient**: see through confusion and get to the point; stands out among peers, 'go with the flow', gut feeling, hunches…act upon them. Goal oriented

UNIVERSITY HEALTH SYSTEM CONSORTIUM/AACN

UCH Background: UHC/AACN has built the curriculum around supporting the increase of expertise of the nursing workforce and positively influencing patient outcomes focusing on three critical areas: leadership, patient outcomes and professional role (UHC, 2015).

PROGRAM GOALS

- Transition the beginner nurse to a competent professional

- Develop effective decision-making skills related to clinical judgement

- Provide clinical nursing leadership to the resident

- Strengthen the commitment to the nursing profession

- Evolve the formation of an individual professional development plan

- Incorporate research-based evidence linked to practice outcomes

CURRENT DESIGN

- Partnership between SHC and UHC/AACN began in 2006

- Hire into 2 cohorts per year
    - May and September to match the times nurses graduate from nursing schools

- Accept around 25 residents per cohort

- Residents are hired into service lines

Medicine → Surgery → Oncology → Psychiatry

INTERVIEW PROCESS

- Nurses with BSN or MSN without prior RN experience are encouraged to apply

- Receive upwards 300 applications

- Top 20% are invited to interview

  o First interview is with a panel of all hiring mangers for that service line

  o Second interview is with a team from a hiring unit

- Nurses offered a position are hired into 0.9FTE positions and are SHC employees with full benefits

Nurse Residency Program:

✓ One year commitment

✓ Series of 12 classroom sessions

✓ Complete participation in the Fundamentals in Acute and Critical Care (FACC) series

✓ Supported by multiple faculty who are content experts

✓ Faculty work in conjunction with unit leadership

✓ Unit rounding to support the residents in clinical area

Competent - Experts:

Quality Improvement / Evidence – Based Practice

DONABEDIAN'S MODEL

Supported by a model for assessing health care quality developed by Dr. Avedis Donabedian based on Structure, Processes and Desired Outcomes

Outcomes

Consequence of the healthcare provided

Method by which healthcare provided

Environment in which healthcare provided

Processes

Structures
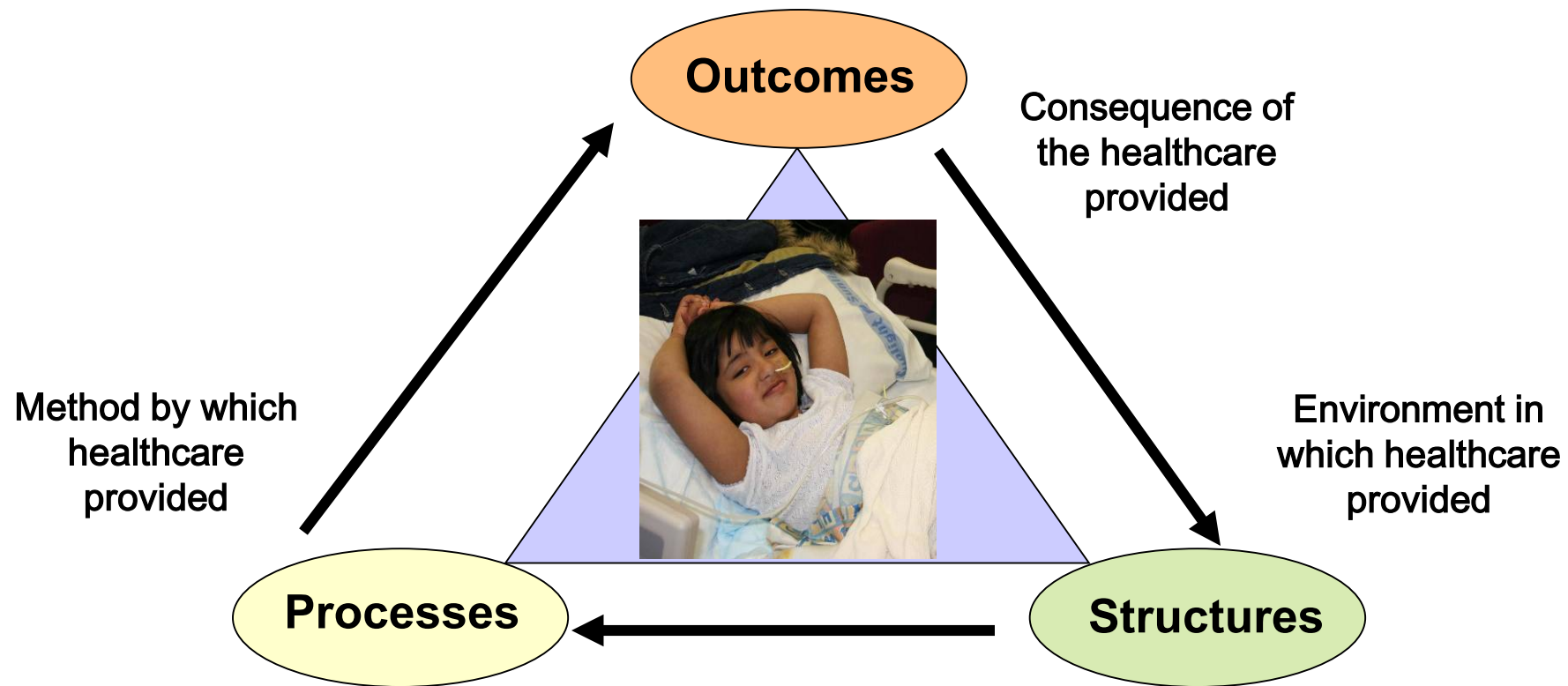
STRUCTURES
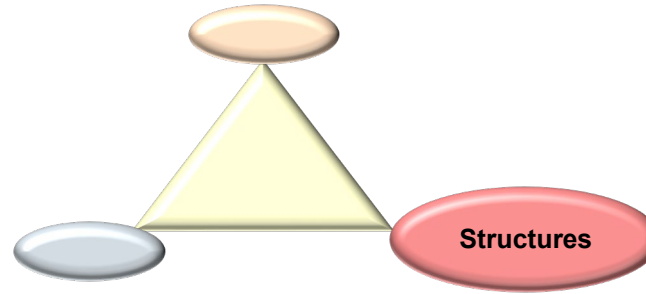
Structures

STRUCTURES

- Organizational Structures
- Meetings, Committees, and Taskforces
- Shared Leadership / Governance

SHARED LEADERSHIP / GOVERNANCE MODELS
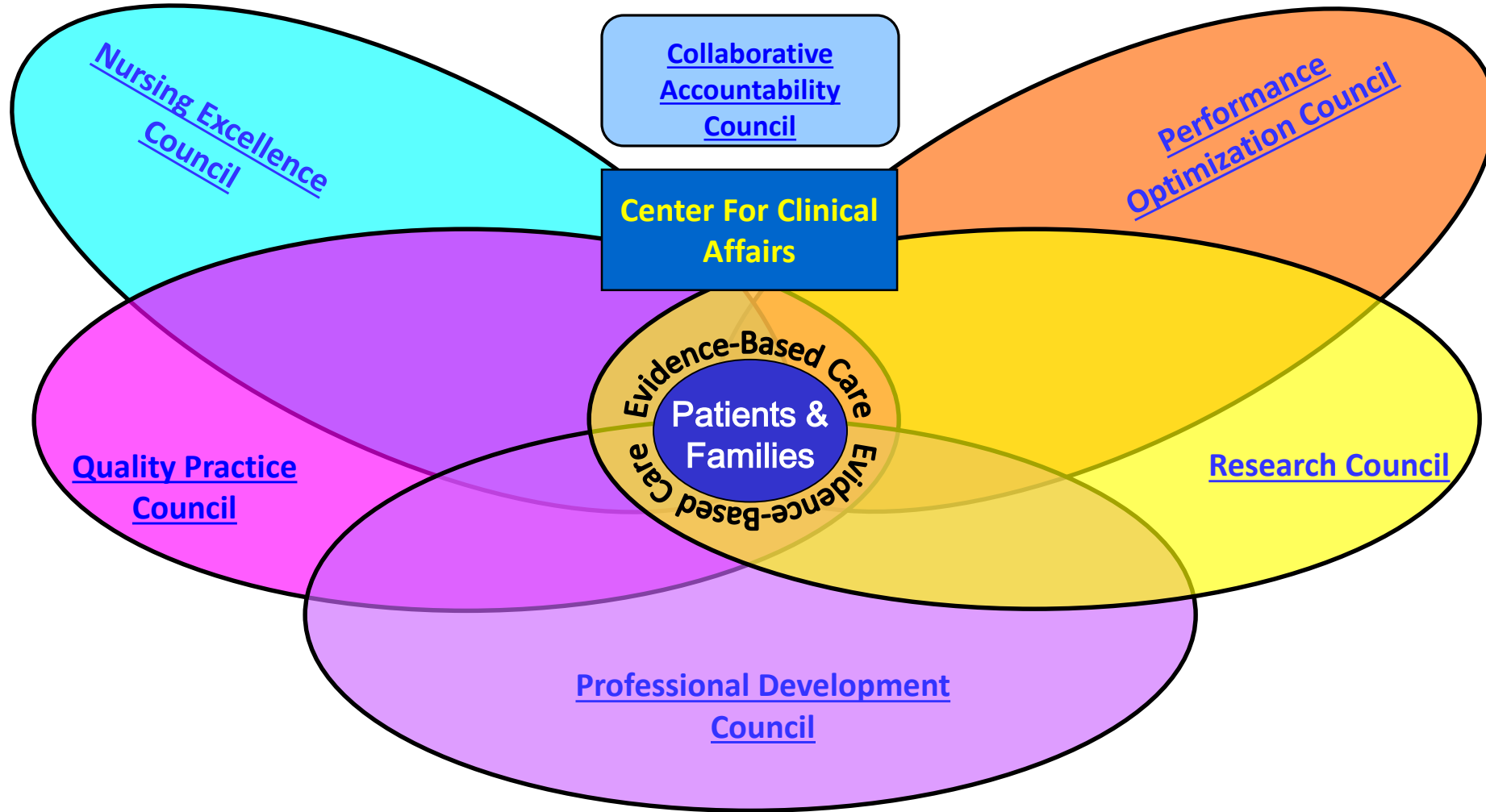
PROCESSES
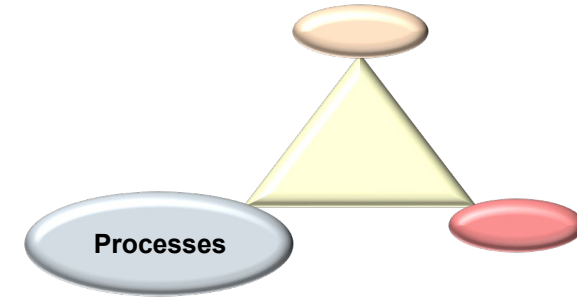
Processes that support patient care delivery
"Goal: services should be patient centered and should be pushed to the point of service." (TCAB)

- Caregiver workflow redesign
- Materials & supplies
- Medication delivery and administration
- Linens
- Clinical documentation

- Policies and Procedures
- Care Protocols
- Evidenced Based Order Sets
- Work Redesign
- RN Stacking – Cognitive Ordering
- Information

A day in the life …

Nurse Travel Patterns:
1st Shift (8:30 – 9:30am)
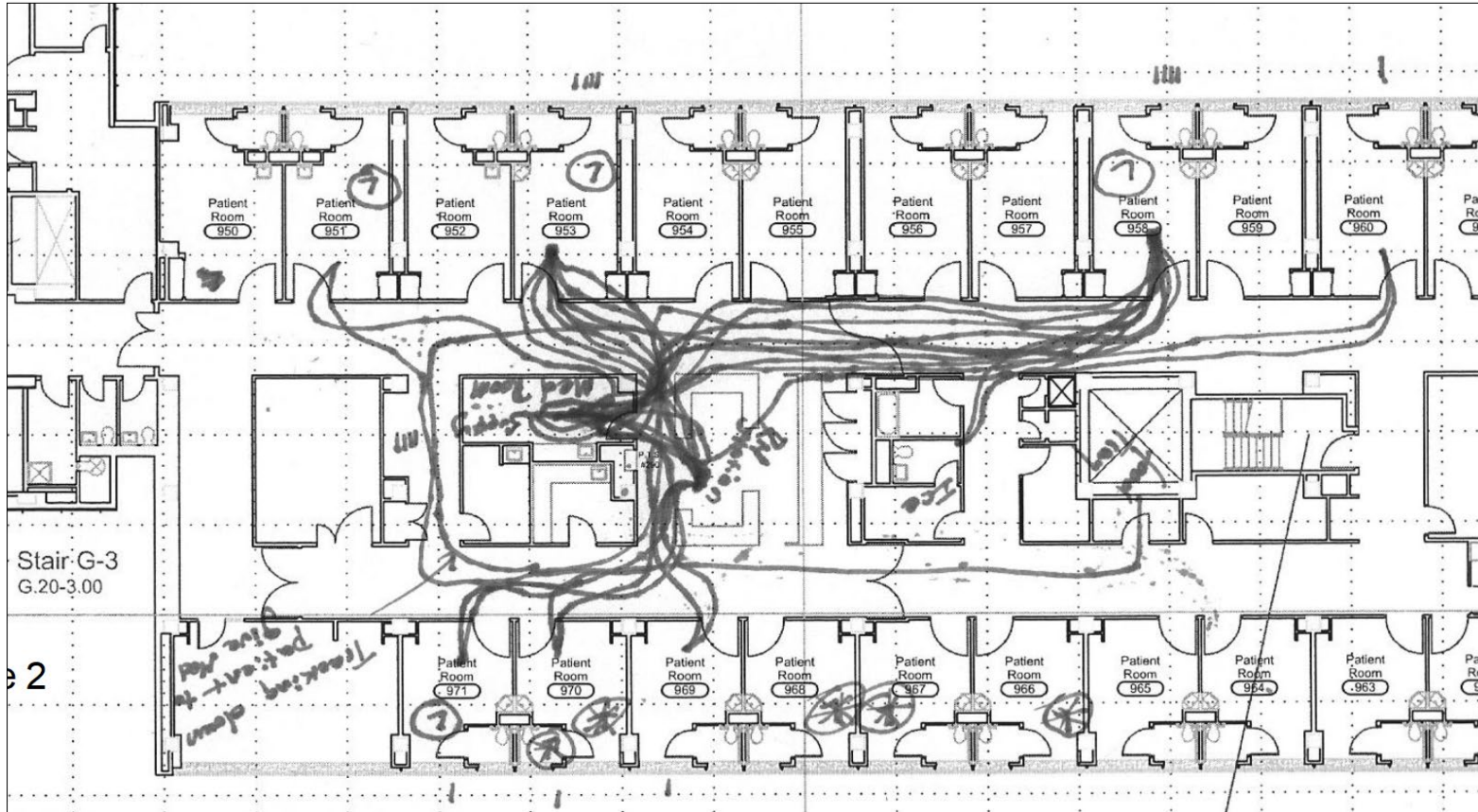
National Benchmark :
Medications located at bedside can save up to 2 hours of nurse's time walking back and forth to Med. Room.

OUTCOMES
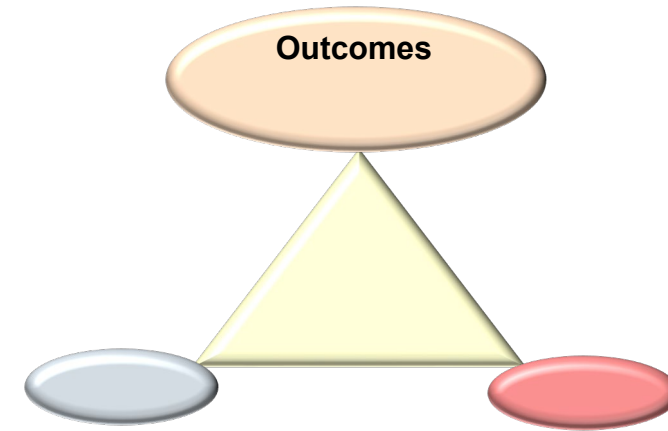
- RN Satisfaction

- Practice Environment

- Vacancy & Turnover

- Nursing Sensitive Indicators

- Workforce Development - IOM

Likelihood to Recommend

Patient Satisfaction w. Nursing Care

Pain Management

Falls w. Injury

Hosp. Acquired Pressure Ulcer Prevalence

Hours Per Patient Day

Medication Errors

Discharged w. Reconciled Medications

ED Admission Length of Stay

Clinical Trials / Research

Purpose is to perpetuate Stanford University School of Nursing's traditions of nursing: nursing excellence in clinical care, education, administration and research.

OFFICE OF RESEARCH
PATIENT CARE SERVICES

The Office of Research is building on the traditions of academic nursing established over 100 years ago at Stanford and that continue to be supported by our Nurse Alumnae. Stanford Nurse Alumnae are key supporters of nursing education and research-related activities at Stanford Health Care and contribute to the excellence of front-line clinical staff.

David Pickham
Exec. Director
(UCSF)

Mary Lough
Research Scientist
(UCSF)

Monique Bouvier
Research Scientist
(USD)

Maria Yefimova
VA-Research
Scientist (UCLA)

Sana Younas
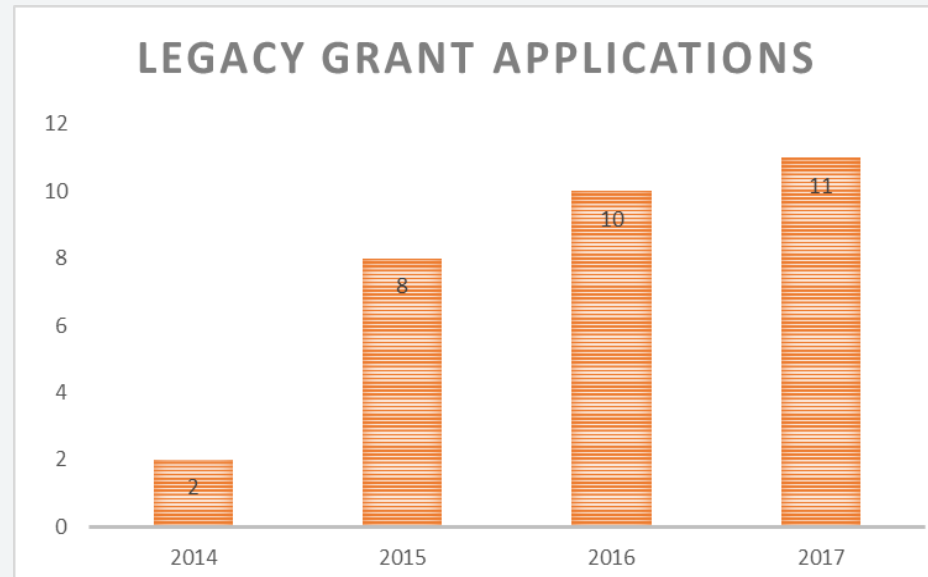Administrative
Assistant

Debbie Hsieh
Business Manager

Nic Berte
Research Project
Manager

OFFICE of RESEARCH
PATIENT CARE SERVICES

Revamped 2014

- Collaboration between Alumnae, SHC, SCH
- Two Cycles (April, October)
- $104,030/ 16 Projects (50% funding rate)

LEGACY GRANT APPLICATIONS

Year	Applications
2014	2
2015	8
2016	10
2017	11

Legacy Project Grants

alumni
Stanford
Nurse Alumnae

4 Weeks Left to Apply for Legacy!

The Stanford Nurse Alumnae Legacy Project Grants are awarded twice a year, and support innovative research and demonstration projects that improve health care outcomes, the patient experience, and health system efficiency. Up to **$10,000** may be awarded at each cycle.

Email **Research@stanfordhealthcare.org** to apply!

Application Deadline:

Monday, April 30th, 2018

Click **HERE** for more information.

2014

Kristine Taylor
Mahyar Jahanbakhsh

Lucile Packard Children's Hospital Stanford

Non-Pharmacological Pain Management in the Pediatric Setting

Taught staff non-pharmacological interventions to improve patient experience

2015

Kelly Bugos

Evaluation Symptom Change After Cancer Survival Care

Survivors with two or clinic visits reported reduced symptoms – currently working with Biomedical Data Science to understand symptom clusters.

2016

Truman Cowles

Stanford
HEALTH CARE
STANFORD MEDICINE
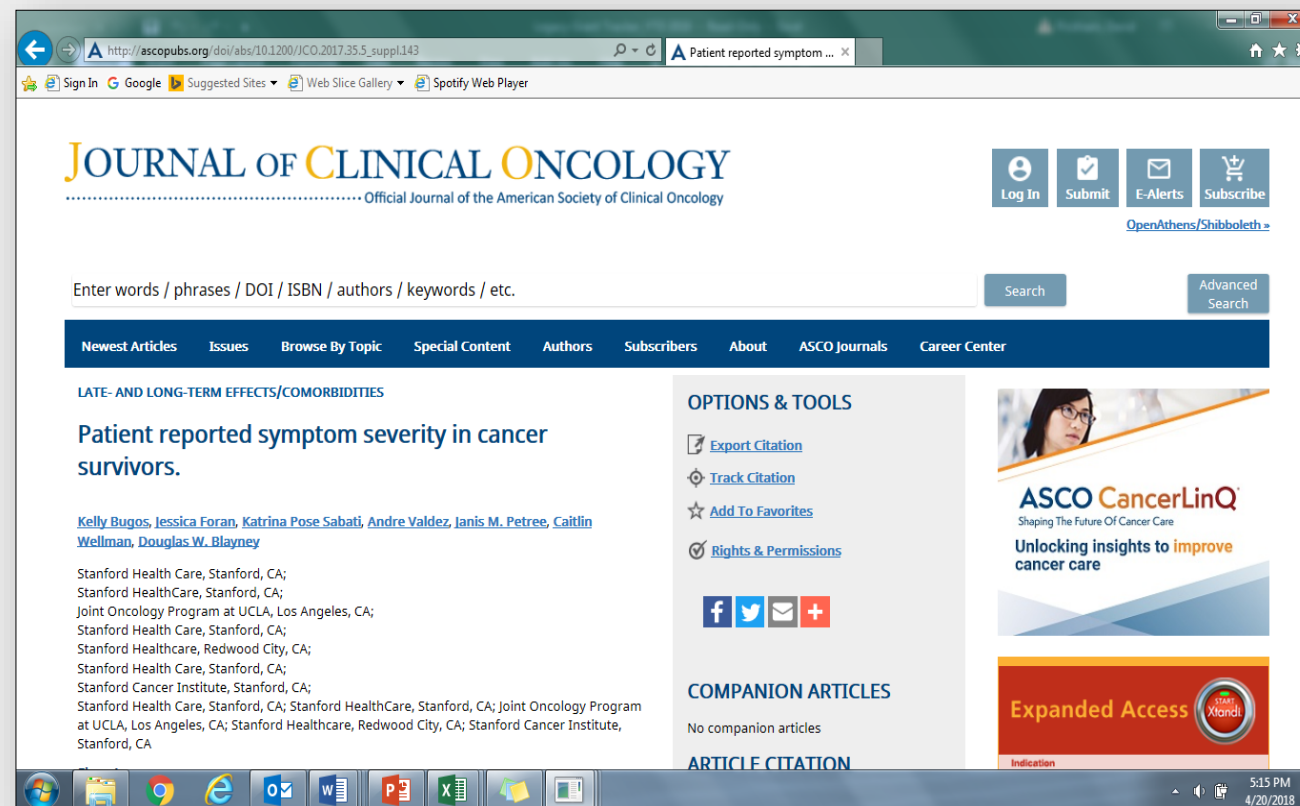
Effects of Aquatic Therapy in Multiple Sclerosis Patients

A 12 wk Ai Chi program reported improvements in General Health Scale, comparable to Chair Yoga.

2017

Linda Ottoboni

Mindfulness Meditation and Patient Education for Symptom Management in Individuals with Paroxysmal Atrial Fibrillation: Do they need to be offered together?

Compared to no intervention, is RN-delivered mindfulness meditation, AF education, and phone visits more effective in alone or in combination, effecting in overall symptoms & and improving QOL.

Presented by Stanford Children's Health and Stanford Health Care
6TH ANNUAL NATIONAL NURSING RESEARCH SYMPOSIUM:

An Interdisciplinary Exploration Of Transitions In Healthcare

May 4, 2015

2015

Stanford Children's Health and Stanford Health Care are proud to present THE 7TH ANNUAL NATIONAL NURSING RESEARCH SYMPOSIUM:

A Bridge to the Future: How innovative healthcare technologies drive successful transitions in the continuum of patient care

June 2, 2016

2016

Stanford Children's Health and Stanford Health Care are proud to present THE 8TH ANNUAL NATIONAL NURSING RESEARCH SYMPOSIUM:

Creating a Healing Environment: From Designing Space to Delivering Care

June 2, 2017

2017

Healthcare Research & Education Conference

HEALTHCARE Con
Inspire | Teach | Showcase

2018

Conferences

Stanford HEALTH CARE STANFORD MEDICINE | Stanford Children's Health | Lucile Packard Children's Hospital Stanford

UCDAVIS HEALTH | NorthBay HEALTHCARE | SANTA CLARA VALLEY | El Camino Hospital | Salinas Valley Memorial Healthcare System | Washington Hospital Healthcare System

NEAR FUTURE…

Nurse Alumnae (Janet Darrow, Pat Sparacino, Patti Fry, Julie Shinn)
Dean – UCSF/Johns Hopkins
Chief Nursing Officers – SHC/SCH
Physician Partners – Karl Lorenz, Stephanie Harmon
Development Office – Jill Stanley

Stanford HEALTH CARE STANFORD MEDICINE

Palliative Care
Postdoctoral Fellowship
For Nurse Scientists

HIGHLIGHTS:

- Exposure to health policy, regulatory, and financial issues relevant to advanced illness, aging, or frailty
- Rigorous methodological training and experience with design and implementation of health services research studies
- Professional and career development, networking and grant writing
- Novel academic/practice partnership in the heart of silicon Valley.

STIPEND INCLUDES:

- Full-Time Salary
- Housing & Relocation
- Research Stipend

PROGRAM LEADERSHIP:

- Garrett Chan, PhD, NP, CNS, FAEN, FPCN, FNAP, FAAN, Director
- Karl Lorenz, MD, Co-Director
- David Pickham, PhD, RN, FAHA, Associate Director

Information

Summary: Building on the ethos of creative innovation that best defines Silicon Valley and leveraging the best of Stanford's leading Schools of Medicine, Business, Engineering, and Education, join our world-class Palliative Care Team for a unique one- to three-year postdoctoral training program focused on nursing science within palliative care. Our program uniquely integrates Stanford Health Care with Stanford University to provide a rich applied research setting.

Description: Nurse Postdoctoral Fellows will participate in the academic and research activities of the new interdisciplinary Stanford Palliative Care Center of Excellence, as well as collaborate with the Palliative Care and Geriatric clinical services teams at Stanford Health Care. Stanford's program uniquely emphasizes implementation science, as well as potential applications of technology. The goals of the fellowship are for fellows to (a) establish their own program of research in palliative care; (b) learn how to promote integration of significant research findings into clinical practice; (c) develop skills to secure funding through grants; (d) foster dissemination of research through presentations and publications; and (e) build on the fellowship experience to achieve a sustainable career pathway as a leader in nursing scholarship and practice.

Qualifications: Candidates will be selected based on the following criteria: Completion of a research-focused doctorate prior to fellowship commencement; a track record of contributing to peer-reviewed publications; prior clinical and/or research expertise with palliative care; ability to articulate in a written statement the specific areas of interest that build on prior education and/or clinical experiences; and outline the relevant schools, centers, and institutes at Stanford University that will contribute to establishing your program of research. Applicants must be eligible for Registration with the California Board of Registered Nursing.

Applications are being received on a rolling basis. Please contact Sana Younus, Fellowship Administrative Lead at rsearch@stanfordhealthcare.org to receive further application details.

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What's Next for this Emerging Role?

- Need for academic-practice partnerships

- DNPs to increase the literature

- Timely translation of research into practice

Parting Thoughts: Personal Journey or Perspective

Stanford Nursing / Patient Care Services

Questions ?

Key References:

Assessing Progress on the Institute of Medicine Report The Future of Nursing (2016). The National Academies Press retrieved 5.2018 from https://www.nap.edu/read/21838/chapter/5#89

Association of Colleges of Nursing (AACN) (2015). The Doctor of Nursing Practice: Current Issues and Clarifying Recommendations. Retrieved from www.aacn.nche.edu

Association of Colleges of Nursing. (2017). DNP Fact Sheet. Retrieved from www.aacn.nche.edu

Baker, S. J., & Esbenshade, A. M. S. N. (2015). Partnering effectively with inpatient leaders for improved emergency department throughput. *Advanced Emergency Nursing Journal, 37*(1), 65-71. doi:10.1097/TME.0000000000000050

Bureau of Labor Statistics (2017). United States Department of Labor retrieved 5.2018 from https://www.bls.gov/oes/current/oes291141.htm

Key References:

Cashin, Andrew (2018). The debate on the knowledge product developed in nursing doctorates and the assignment of the PhD to a modernist endeavor in the creation of the contrasting position. *Nurse Education in Practice,* 31 p. 101 -103.

retrieved 5.2018 https://doi.org/10.1016/j.nepr.2018.05.012

Donabedian, A. (2005). Evaluating the quality of medical care.   *The Milbank Memorial Fund Q.* 1966; 44(3)(supl):166—206. Reprinted in Milbank Q.; 83(4):691-729.

Gabayan, G. Z., Derose, S. F., Chiu, V. Y., Yiu, S. C., Sarkisian, C. A., Jones, J. P., & Sun, B. C. (2015). Emergency department crowding and outcomes after emergency   department discharge. *Annals of Emergency Medicine, 66*(5), 483-492.e5 1p. doi:10.1016/j.annemergmed.2015.04.009

Glymph, D. C., Olenick, M., Barbera, S., Brown, E. L., Prestianni, L., & Miller, C. (2015). Healthcare utilizing deliberate discussion linking events (HUDDLE): A systematic   review. *AANA Journal, 83*(3), 183-188 6p. Retrieved from http://search.ebscohost.com.proxy.cc.uic.edu/login.aspx?direct=true&db=rzh&AN=109799869&site=ehos   t-live

Key References:

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health.* Washington, DC: National Academies Press.

Pencak Murphy, Marcia; Staffileno, Beth; Carlson, Elizabeth. (2015) Collaboration among DNP- and PhD-prepared nurses: Opportunity to drive positive change. *Journal of Professional Nursing*, 31(5) pp. 388 -394.

Pines, J. M., Iyer, S., Disbot, M., Hollander, J. E., Shofer, F. S., & Datner, E. M. (2008). The effect of emergency department crowding on patient satisfaction for admitted   patients. *Academic Emergency Medicine, 15*(9),   825-831 7p. Retrieved from
    http://search.ebscohost.com.proxy.cc.uic.edu/login.aspx?direct=true&db=rzh&AN=105422692&site=ehos_t-live

University HealthSystem Consortium. (2016). Emergency Department Throughput Benchmarking Study. Retrieved on March 28, 2017, from https://www.uhc.edu/pages/32378

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