Title:
Interprofessional Collaborative Approaches to Reduce Risk, Decrease Financial Loss, and Improve Patient Care Outcomes in Acute Care and Skilled Nursing Facilities

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Session Title:
Rising Stars of Nursing Invited Posters - Group 1
Slot (superslotted):
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Interprofessional collaboration, Nursing care delivery model and Risk management

References:
Anticipated References Aon Risk Solutions. (nd). 2013 Long term care general liability and professional liability actuarial analysis. Retrieved from http://www.wrotenlaw.com/pdf/blog/2013-Liability-Analysis.pdf Barwell, J., Arnold, F., & Berry, H. (2013). How interprofessional learning improves care. Nursing Times, 109: 21, 14-16. Retrieved from http://www.nursingtimes.net/ nursing-practice/clinical-zones/educators/how-interprofessional-learning-improves-care/5059052.article ECRI Institute. (2009). Healthcare Risk Control, 2. Retrieved from https://www.ecri.org/documents/ secure/risk_quality_patient_safety.pdf Haney, C. (2010). New care delivery models in health system reform: opportunities for nurses & their patients. ANA Issue Brief, June, 2010. Retrieved from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Care-Delivery-Models.pdf Interprofessional Education Collaborative. (February, 2011). Core Competencies for Interprofessional Collaborative Practice. Washington, D.C.: Association of American Medical Colleges. Kiselev, M. (2010). Hospitals in distress. How the economy has affected the financing of healthcare. Illinois Business law Journal. Retrieved from http://www.law.illinois.edu/bljournal/post/ 2010/03/16/Hospitals-in-Distress-How-the-Economy-has-Affected-Financing-of-Health-Care.aspx Missen, K., Jacob, E., Barnett, T., Walker, L., & Cross, M. (2012). Interprofessional clinical education: Clinicians' views on the importance of leadership. Collegian, 19, 189-195. doi: 10.1016/j.colegn.2011.10.002 National Research Corporation. (2013). 2011-2012 National Survey of Customer and Employee Satisfaction in Assisted Living Communities. Retrieved from http://www.ahcancal.org/research_data/staffing/Documents/ALF_NationalReport2012.pdf Research Department of the American Health Care Association. (2014). Nursing Home Care Quality Measure Report: 2013Q3 Update. Retrieved from http://www.ahcancal.org/research_data/quality/Documents/NH_QUALITY_MEASURE_2013Q3_FINALREPORT.pdf Medical Liability Mutual Insurance Company. (nd). Risk Management Tips. Retrieved from http://www.mlmic.com/portal/pages/RM/tips.jsp Mello, M.M. (2006). Understanding medical malpractice insurance: A primer. Research Synthesis Report sponsored by the Robert Wood Johnson Foundation, 8. Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2006/rwjf17974 The American Health Care Association. (2014). 2013 Quality Report. Retrieved from http://www.ahcancal.org/qualityreport/Documents/AHCA_2013QR_ONLINE.pdf Sage, W. (2004) The forgotten third: Liability insurance and the medical malpractice crisis. Health Affairs, 23(4), 10-21 Retrieved from http://content.healthaffairs.org/content/ 23/4/10.full. doi: 10.1377/hlthaff.23.4.10 Stevenson, D.G. & Studdert, D.M. (2003). The rise of nursing home litigation: Findings from a national survey of attorneys. Health Affairs, 22(2), 219-229. doi: 10.1377/hlthaff.22.2.219 Westbrook, J.I., Duffield, C., Li, L. & Creswick, N.J. (2011). How much time do nurses have for patients? A longitudinal study quantifying hospital nurses' patterns of task time distribution and interactions with health professionals. BMC Health Services Research 11(319). Retrieved from http://www.biomedcentral.com/1472-

6963/11/319. doi: 10.1186/1472-6963-11-319 Anticipated Reference Sites - Unspecified (References will be properly sited as information in used) Advancing Excellence in America's Nursing Home Campaign. www.nhqualitycampaign.org AHCA/NCAL National Quality Award Program. http://www.ahcancal.org/quality_improvement/quality_award/Pages/default.aspx Interprofessional Education Collaborative. www.IPECollaborative.org National Association of Insurance Commissioners and The Center for Insurance Policy Research. http://www.naic.org/cipr_home.htm Reynolds, F. (2005). Communication and clinical effectiveness in rehabilitation. Oxford, UK: Elsevier, B.V. TeamSTEPPS approach. http://teamstepps.ahrq.gov/

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE	TIME ALLOTTED	FACULTY/SPEAKER	TEACHING/LEARNING METHOD	EVALUATION/FEEDBACK
Example Critique selected definition of the term, "curriculum"	**Example** Definitions of "curriculum" Course of study Arrangements of instructional materials The subject matter that is taught Cultural "training" Planned engagement of learners	**Example** 20 minutes	**Example** Name, Credentials	**Example** Lecture PowerPoint presentation Participant feedback	**Example** Group discussion: What does cultural training mean to you?
The learner will be able to state prevalent	Explanation of prevalent facility-acquired conditions	5 minutes	M. Shoi Parker, MBA, Rhode Island College BSN '15	Poster presentation; Participant feedback	Participant discussion: What are some of the facility-acquired conditions most prevalent in

	and costly facility-acquired conditions.	including but not limited to pressure ulcers, UTIs, falls, fractures, DVTs, medication errors and other conditions as listed by the CMS.				your units or facilities?
	The learner will be able to site rationale for non-performance of tasks required to prevent facility-acquired conditions.	Rationale for non-performance of tasks include nurse assignment overload, lack of accountability, unit/facility culture, and more.	5 minutes	M. Shoi Parker,MBA, Rhode Island College BSN '15	Poster presentation; Participant feedback	Participant discussion: What are some of the reasons you can think of as to why staff does not perform required tasks related to prevention of facility-acquired conditions? What are some methods you can think of to reduce risk of harm related to these conditions?
	The learner will be able to understand the proposed nursing care delivery model, and be able to offer criticisms	Criticisms include implementation or funding obstacles, staff dissatisfaction with new model, misalignment with staff	5 minutes	M. Shoi Parker, MBA, Rhode Island College BSN '15	Poster presentation; Participant feedback	Participant discussion: How would the proposed care delivery model work in your facility or experience?

	of such a model.	culture, and more.				

Abstract Text:

Background

The recent economic crisis has increased pressure on hospitals, subacute, and long-term care facilities to reduce operating expenditure such as labor, supply, capital, and litigation costs. Additionally, the shift from fee-for-service to outcome-based reimbursement models increases a facility's expectation to perform in order to maintain revenue streams and continued operations. Current efforts to improve quality care while maintaining cost efficiencies have been taken on throughout the wide spectrum of care delivery: from administrative measures such as risk sharing partnerships between hospitals and third party payers, to process improvement strategies such as integrated electronic health record systems, to direct care approaches such as interprofessional team-based models. When teams perform risk reduction and quality improvement activities patient care improves and financial loss, in part, is mitigated. This project will focus creating a care model based on workflow logistics, communication tactics, and customer service strategies at the unit level to help reduce risk and cost of care, and improve care performance and patient outcomes.

Problem

Common facility- and hospital-acquired conditions (HACs) are largely preventable if evidenced-based interventions are correctly implemented. However, studies on how nurses spend time indicate that interruptions or assignment overload often lead to medication or protocol error, and incompletion of preventative interventions. These deviations from the care plan can result in harm to the patient, which may lead to increased hospital stays, auxiliary administrative and care services, loss of opportunity to fill beds with new patients, denial of reimbursement, increased hospital and professional liability insurance, litigation costs and judgments, damaged reputation, loss of patients to competition, staff discipline, and patient dissatisfaction. Unfavorable care outcomes may not stem from staff “not knowing what to do.” Abundant research on HACs have resulted in proven evidence-based care strategies, and facilities have often integrated these interventions into policy, education, care, and documentation requirements. Nevertheless, staff may be unable to fully complete tasks known to prevent HACs due to heavy assignment loads and other competing demands. This problem poses the question: how can managers structure workflow operations that promotes efficiency and a culture of care, that also increases follow through on evidenced-based preventative interventions?

Objective

This project will attempt to offer interprofessional collaborative workflow logistics, communication tactics, and customer service strategies in a nursing care delivery model. The model will increase communication between nurses and their unit assistive personnel, assigns specific accountability to staff to perform preventative tasks, reduces risk of HACs, increases work performance, and ultimately increases staff and patient satisfaction.

Method

Via secondary analysis, the project identifies prevalent unintentional patient outcomes that affect facility/professional liability, can increase variant care costs, and negatively affect the patient experience. An examination of medical liability claims, current and emerging risk management reports, care delivery models, and evidenced-based care interventions are used to construct interprofessional workflow solutions that target these unintentional outcomes. The project will design a care delivery model based on the evidence-based interventions and incorporating workflow logistics, communication tactics,

and customer service strategies. The project will also attempt to propose a plan to test the model. Testing the model would involve measuring risk-reduction, cost efficiencies and indicators of improved care; quantitative and qualitative measures may include number of HAC-specific tasks (e.g. repositioning to prevent pressure ulcers, catheter care to prevent UTIs) completed in a given time frame, number of HACs in a given time period with implementation of the model, patient satisfaction survey results during implementation of the model, staff feelings on the model, etc.

Results, Findings and Conclusions

As part of a student nurse's senior honors project, the project is in the model development stage as of August 1, 2014. Upon completion of the project, results, findings and conclusions will be presented at an honors colloquium in spring of 2015 and can be found in the Rhode Island College School of Nursing archives.