Title:
Interprofessional Collaboration: A Leadership Imperative to Value-Based Care

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Session Title:
Interprofessional Collaboration

Keywords:
HCAHPS , bedside rounding and patient experience

References:
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Abstract Summary:
Top priorities in all healthcare organizations are improving patient safety and the patient experience. Nationally, The IOM published concerns with fragmented processes causing harm. The Joint Commission highlighted ineffective communication as a factor in medical errors. It is crucial for leaders to promote evidence based practices to improve patient outcomes.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to demonstrate an understanding of how key historical events affect quality and patient/family centered care	Review and Explain the following IOM reports: To Err is Human, Crossing the Quality Chasm, The Future of Nursing Report.
The learner will be able to verbalize the impact the Affordable Care Act and how the Triple Aim has changed hospital practices	Describe key elements of Affordable Care Act (ACA). Discuss the Triple Aim Initiative. Review changes in hospital processes due to the passage of the ACA.
The learner will be able to discuss Value Based Care and how pay for performance is guiding decisions by hospital leaders.	Review Value Based Care. Explain Value Based Care Concepts. Describe Pay for Performance Measures. Explain Pay for Performance Impact.

The learner will be able to identify Interprofessional Collaboration as a key element in interprofessional rounds at the bedside	Discuss the importance of interprofessional collaboration. Review the literature related to interprofessional rounding practices and the impact on quality and the patient experience.
The learner will be able to examine the role of leadership in change management and impact on implementing new processes at the bedside	Discuss the importance of change management in new process development. Examine barriers to implementing rounding processes. Review the importance of leadership during new process implementation.

Abstract: Top priorities in all healthcare organizations are improving patient safety and improving the patient experience. Nationally, The Institute of Medicine (IOM) highlighted many concerns with broken systems and fragmented processes causing harm in the hospital setting (IOM, 2001). The Centers for Medicare and Medicaid Services (CMS) approved the Value Based Purchasing (VBP) program with a goal of improving quality care in the inpatient setting (CMS, 2014; Raso, 2013). Many healthcare organizations are focusing on the patient experience as part of their quality performance measures. Our hospital wanted to focus on interprofessional collaboration as a key strategy in improving patient safety. Therefore, the inpatient units implemented interprofessinal rounds at the bedside. Our organization needed to improve the patient experience based on current HCAHPS scores at the start of this project. Achieving HCAHPS benchmarks are a goal from the bedside clinicians to senior leadership. A high importance to achieve top scores is part of the culture within the hospital. Monthly HCAHPS data are analyzed and discussed at unit meetings, shared governance, amongst leadership, and with patients and families. Our hospital had knowledge of rounding processes and had tried several different ways to implement to improve outcomes previously. The team continued to use data, evidence, and collaboration to implement this project. The team focused on interprofessional rounds at the bedside as a process to communicate the patient's plan of care, discuss any changes in a patient's condition, allow patient and family involvement, and focus on discharge needs. There is clear evidence that interprofessional rounds at the bedside improve quality including decreasing medical errors, decreasing mortality rates, and fewer hospital admissions (VanderWielen et al., 2014). There is a lack of evidence on how interprofessional rounds at the bedside affect the patient experience or HCAHPS data. Our team wanted to implement this project and determine the impact on HCAHPS data.

It is crucial for hospitals leaders to stay current with the best evidence and relay the information to their teams. For example, the Joint Commission has highlighted the need to improve communication in the hospital setting to improve safety. In fact, ineffective communication is recognized as a contributing factor in medical errors and patient harm (AHRQ, 2014). The Joint Commission reports that approximately eighty percent of errors are related to miscommunication (Kitch et al., 2008). Communication failures are reported as the root cause of seventy percent of sentinel events (AHRQ, 2014). The Joint Commission supports process improvement focused on structured communication to ensure high quality care is provided (Kitch et al., 2008). This is another key reason this project was selected from hospital leaders to improve collaboration and communication to ensure all patients receive the highest level of care.

Methods: This project examined the effects of interprofessional rounds (IPR) at the bedside on three key areas: nurse communication, doctor communication, and discharge information. Interprofessional rounds at the bedside was implemented on a 28 bed medical surgical unit. Process data was collected using an observational format. Outcome data was examined by comparing Hospital Consumer Assessment of Health Care Provider Systems (HCAHPS) data both before implementation of rounds and three months post implementation.

Discussion: Effective communication with patients and families is important in increasing quality of care. There is clear evidence that IPR (interprofessional rounds) at the bedside improves quality including decreasing medical errors, decreasing mortality rates, and fewer hospital admissions (VanderWielen et

al., 2014). There is a lack of evidence on how IPR at the bedside affects the patient experience or HCAHPS data. This study focused on the impact of IPR at the bedside on the patient experience by using data collected from a validated tool. This project suggests that IPR at the bedside increases three areas on the HCAHPS survey: nurse communication, physician communication, and discharge information. Barriers exist in implementation of IPR at the bedside including the workload of the unit and the hospital. Hospitalists also have difficulty with patients being admitted on several different units. These hospitals decided the hospitalist would be assigned to a specific unit and oversee the patients on their assigned unit. Barriers still exist with this model; however, much effort is placed on geographic localization of patients without impacting hospital flow of patients. This unit also experienced barriers related the hospitalist first shift for the week. The rotation of hospitalist on this unit started on Monday. The team decided to continue interprofessional rounds but occurring in a conference room on Mondays.

Conclusion: According to the literature, evidence suggests that interprofessional rounds at the bedside are a way to increase communication and collaboration between the health care team and patients and their families. Improving communication and collaboration improve quality of care and patient safety. This project suggests a positive linkage between interprofessional rounds at the bedside and the patient experience metrics (nurse communication, physician communication, and discharge information). This project can be implemented on any unit in the hospital setting with the support from leadership and physician involvement. With the right team and the desire to improve patient care, any hospital unit can implement this process.

Results: Process data: Three to eight patients were rounded on with every session with an average of six patients per rounding session. Time spent per patient (n=311) ranged from two minutes to eight minutes with an average time per patient of 3.94 minutes. Outcome data: HCAHPS data increased in all three areas identified for this study. HCAHPS data in nurse communication increased from 69.4% in January to 82.4% in June. Physician communication increased from 77.3 % in January to 82.0% in June. Discharge information increased from 77.9% in January to 86.8% in June

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