



Sigma Theta Tau International
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INTERPROFESSIONAL COLLABORATION: A LEADERSHIP IMPERATIVE

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Faculty Disclosure

Faculty Name:	Susan Thurman, DNP, RN
Conflicts of Interest:	None
Employer:	WellStar Health System
Sponsorship/Commercial Support:	None

Goals and Objectives

- Session Goal:
 - Discuss the impact of interprofessional collaboration on value-based care
- Session Objectives:
 - Describe key historical events that affect quality and patient centered care
 - Discuss Affordable Care Act and Value Based Care
 - Explain Interprofessional Rounds
 - Review the role of leadership in change management



Transparency

- Patient safety and Quality are in question
 - Highlighted by Institute of Medicine Landmark Reports To Err Is Human
- Preventable Errors in health care
 - 100,000 deaths per year
 - \$17 billion to \$29 billion per year in hospitals nationwide
 - Mistrust of healthcare system

(IOM, 1999; IOM, 2001)

**HOW SAFE
IS YOUR
HOSPITAL**



Call to Action

- Crossing the Quality Chasm
 - Total redesign of Health Care system
 - Need for leadership to facilitate change
 - Six aims for improvement
 - Safe
 - Timely
 - Effective
 - Efficient
 - Equitable
 - Patient Centered



(IOM, 1999; IOM, 2001)

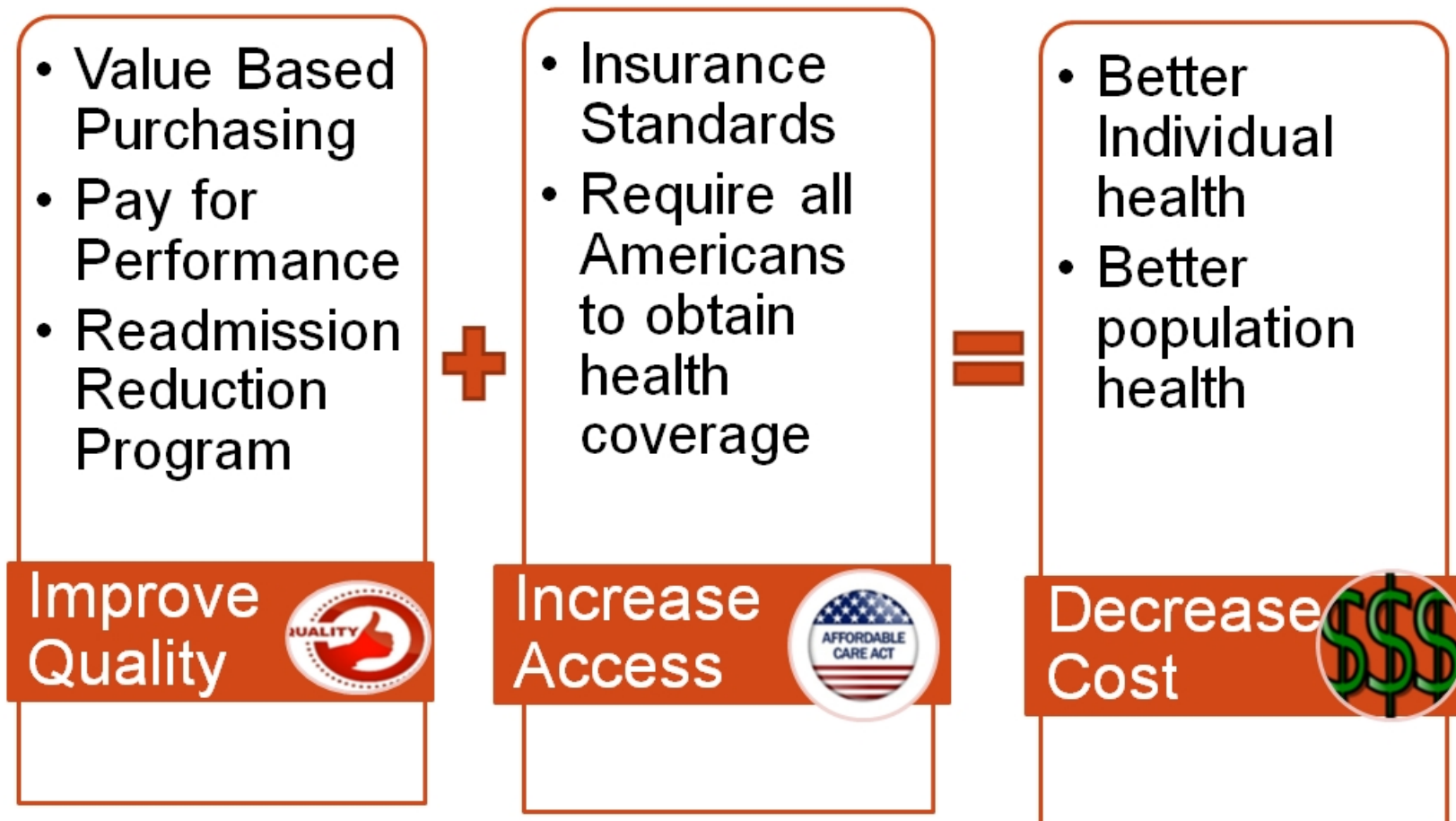
Triple Aim

- Better care for individuals
- Better health for populations
- Reducing per-capita costs



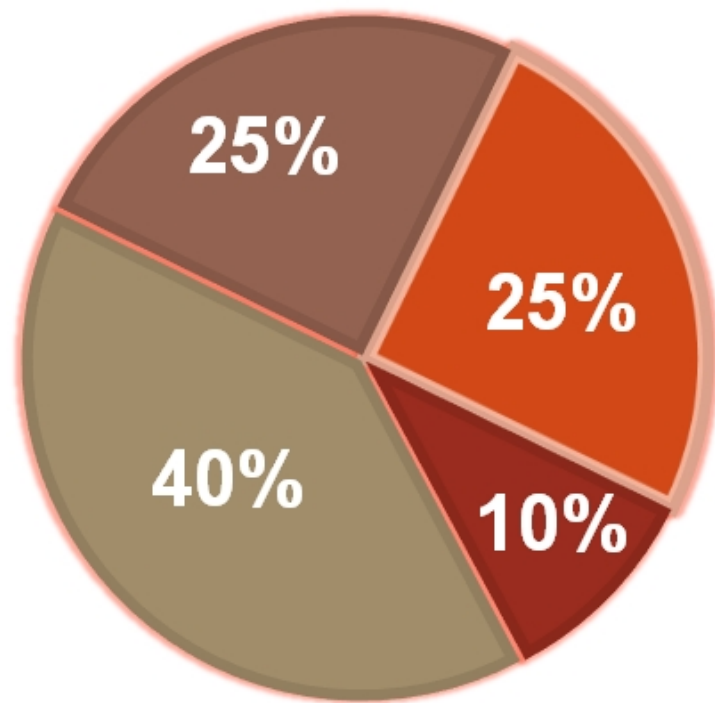
(IHI, 2010)

Affordable Care Act: 2010



(Kaiser Family Foundation, 2015)

Value Based Purchasing



- Patient Experience
- Process of Care
- Outcomes
- Efficiency

(CMS, 2014)

Value Based Care

- New Paradigm
- Moving away from Fee for Service
 - Higher volumes = more money
- Moving To Value
 - Quality care = more money



(CMS, 2014)

Interprofessional Collaboration

- Key Driver in Value Based Care
 - **Interprofessional Collaboration**
 - Key to improving quality (IOM,2001)
 - Significant driver to improving quality (TJC,2014)
 - Vital to improving patient satisfaction (Press Ganey, 2014)
 - Fundamental in improving quality and health (WHO, 2008)
 - Healthy Work Environments Standards focus on true collaboration (AACN, 2008)

Review of Literature

- Studies done on Rounds at Bedside
 - Medical units; Critical care
 - Cardiac units; Pediatric units
- Measure patient satisfaction and communication
 - Improves communication between caregivers (Rosen et al., 2009; Maxson et al., 2012)
 - Improves communication between health care providers and patients (Maxson et al., 2012; Jacobowski, Mulder, & Ely, 2010)
 - Increases patient satisfaction (Reinbeck & Fitzsimons 2013; Radtke, 2013; Rosen et al., 2009)

Review of Literature

- Literature supports Interprofessional Rounds improvement of quality
 - Decrease Length of Stay
 - Decreases Hospital Acquired Infections
 - Decreases Falls
 - Decreases Readmissions
 - Increases Patient and Family Satisfaction

(Zwarenstein, Goldman, & Reeves, 2009)

Unit Project

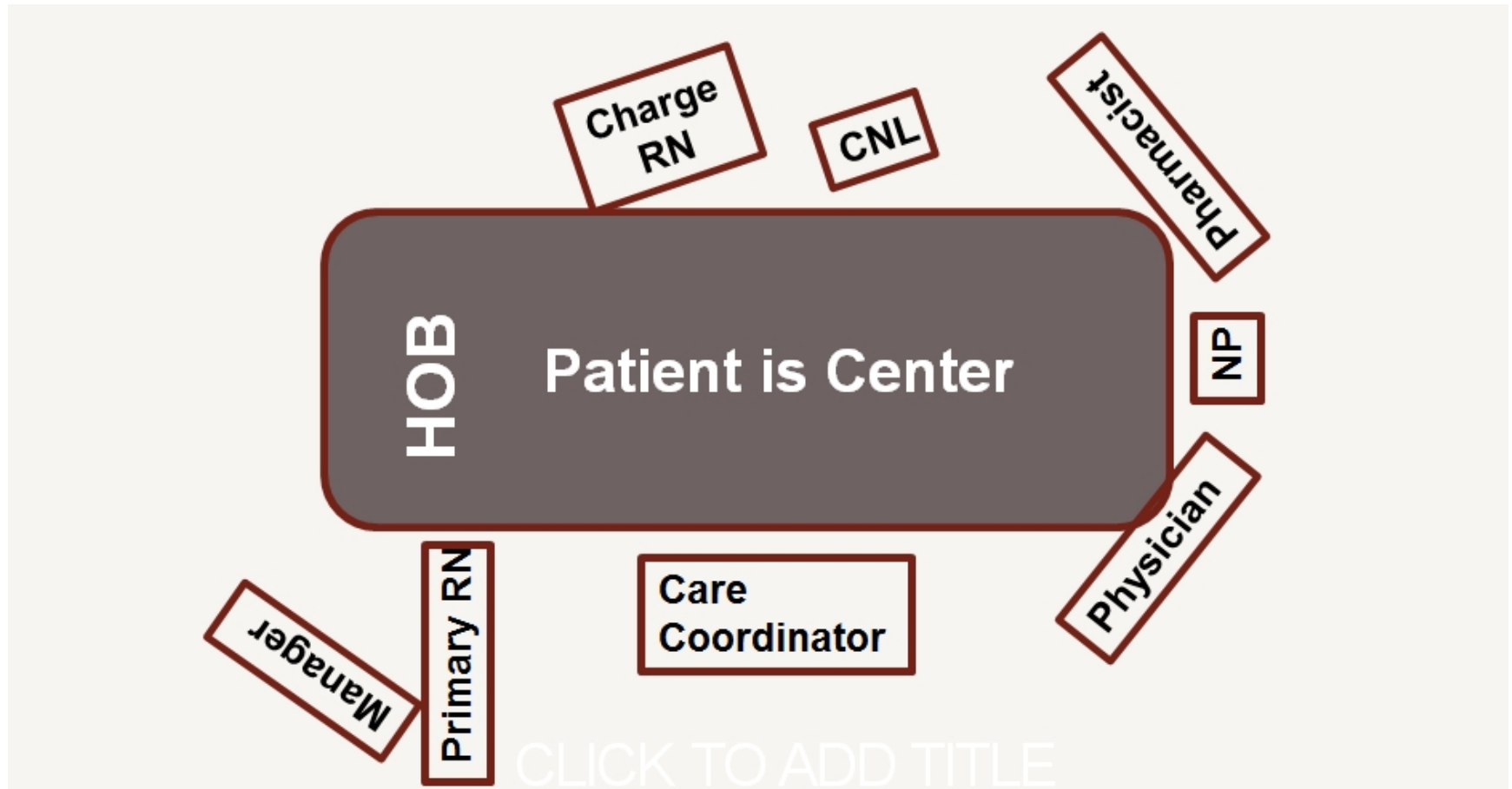
- Implement interprofessional rounds at the bedside
- Evaluate the effect on HCAHPS data
 - Nurse Communication
 - Doctor Communication
 - Discharge Data



Interprofessional Rounds

- Implement Interprofessional Rounds at the Bedside
- Monday through Friday at 11am
- Rounding team: physician, nursing, pharmacist, care coordination, clinical nurse leader
- Involvement of patient and family
- Time keeper

Standard Positions

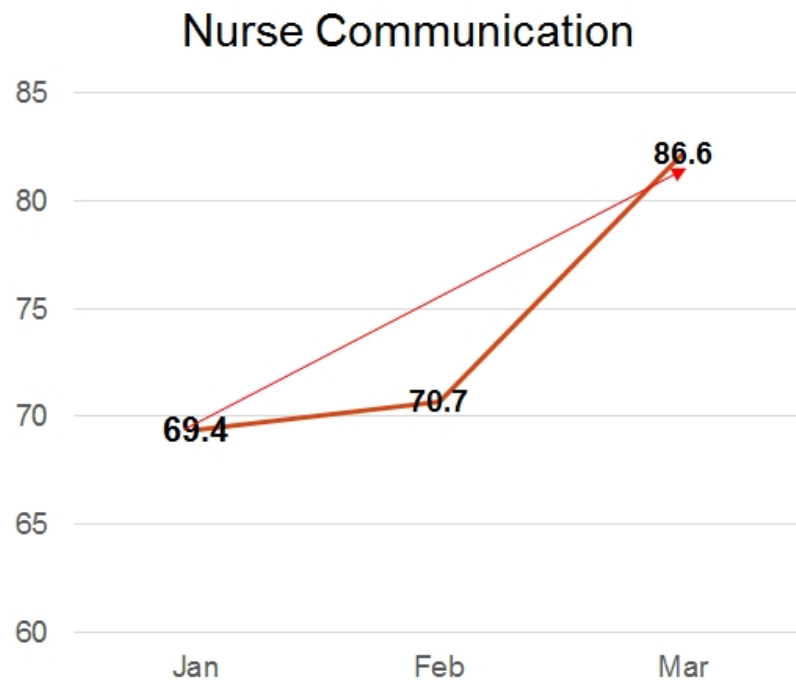


Process Results

- 53 Rounding Sessions observed
- 12-9-2014 to 3-9-2015

Length of time to round	Time spent per patient	Rounding team present
Goal: 30 mins (51/53) 96% of time	Between 2 – 8 mins per patient (n=311)	Goal: 100% team present (37/53) 69% of the time
	Average time per patient 3.94 mins	

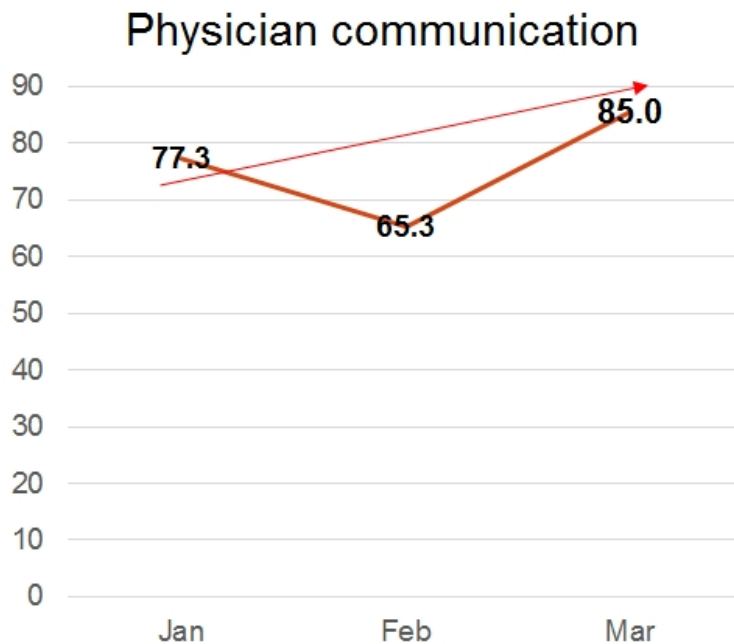
Outcome Results



- Nurse communication increased from 69.4% in January to 86.6% in March
 - Nurses treat with courtesy/respect
 - Nurses listen carefully to you
 - Nurses explain in way you understand

(Press Ganey, 2014)

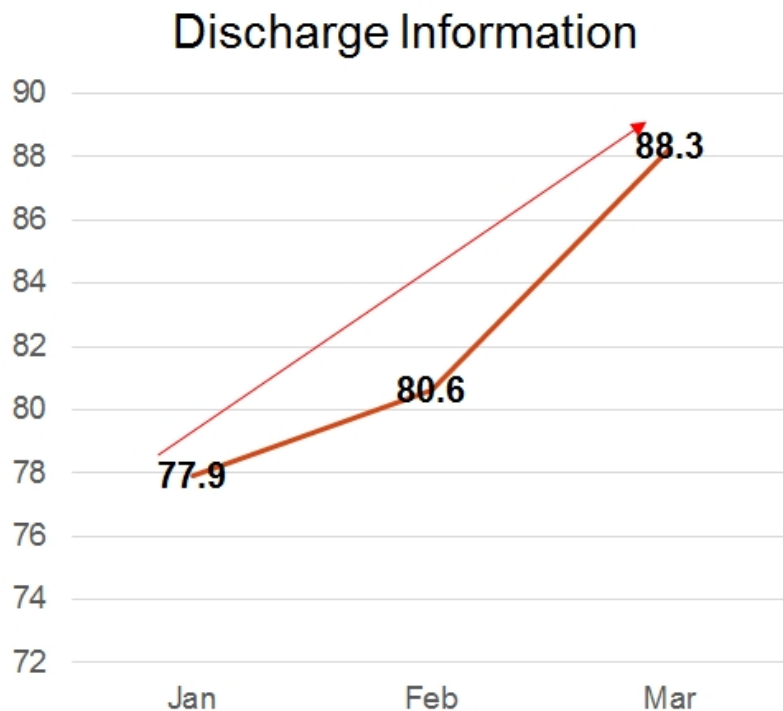
Outcome Results



- Physician communication increased from 77.3 % in January to 85.0% in March
 - Doctors treat with courtesy/respect
 - Doctors listen carefully to you
 - Doctors explain in way you understand

(Press Ganey, 2014)

Outcome Results



- Discharge information increased from 77.9% in January to 88.3% in March
 - Staff talk about help when you left
 - Information was given regarding symptoms or problems to look for

(Press Ganey, 2014)

Organizational Change

- Health care is in a state of dramatic change (Porter-O'Grady & Malloch, 2015)
 - Rapid changes in advancement of medical science and technology
 - Growing complexity of health care
 - The public's health care needs have changed (IOM, 2001)
- Changes are not easy to implement and sustain
 - 70% of change fails in organizations (Kotter, 1995)
 - 62% of change in health care fails (Ponti, 2011)

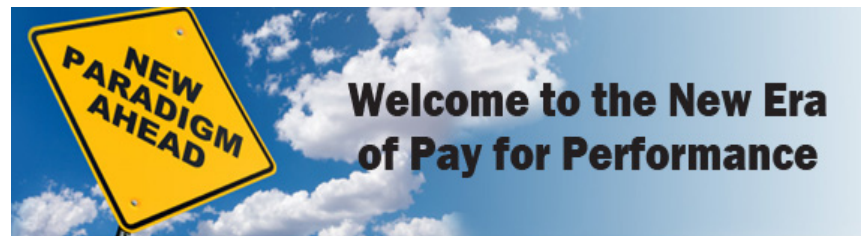
Leadership

- Strong leaders are crucial in providing safe, timely, effective, efficient, and patient centered care (IOM, 2001)
- Leaders should
 - Empower the team at the point of care to create better processes and outcomes (Porter-O'Grady & Malloch, 2015)
 - Create a culture of teamwork and innovation (Porter-O'Grady & Malloch, 2015)
 - Motivate team members (Porter-O'Grady & Malloch, 2015)
 - Create a sense of urgency (Kotter, 1995)



Future Opportunities

- Fully implement Population Health across settings
- Focused communication with all transitions
- Nurse's practicing at the fullest extent of their education
- Nurse's involvement in policy
- More resources for indigent population



(IOM, 1999; IOM, 2001; IOM, 2010)

Conclusion

- Clear evidence supports the need for improvements (IOM, 1999; IOM, 2001)
 - Quality and safe patient care top priority in health care organizations (IOM, 2001)
 - Practice changes and process improvement are beneficial in improving quality (TJC, 2014)
- Interprofessional collaboration and communication is key to improving patient outcomes (IOM, 2001; TJC, 2014, Radtke, 2013)



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