ANA’s Belief

Quality, affordable health care is not a privilege, but a basic human right.

ANA’s Four Pillars of Health Care Reform
ANA Health System Reform Agenda

Access – health care services must be:
- Affordable
- Available
- Acceptable.

ANA Health System Reform Agenda

Quality Aims – health care must be:
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

ANA Health System Reform Agenda

Cost of care – strike a balance between:
- High-technology treatments and
- Community-based and preventive services.
ANA Health System Reform Agenda

- Workforce – there must be an adequate supply of:
  - Well-educated
  - Well-distributed
  - Well-utilized
  - REGISTERED NURSES

“We in America do not have government by the majority. We have government by the majority who participate.”

Thomas Jefferson
The Affordable Care Act

The Patient
Protection and
Affordable Care Act
was signed into law

ACA - What’s Already in Effect

Children with Pre-Existing Conditions
- Cannot be denied coverage
  - New Plans
  - Grandfathered group plans
  - Up to age 19

Adults with Pre-Existing Conditions
- No discrimination, beginning 2014

ACA - What’s Already in Effect

Coverage for Young Adults
- All parent health plans which cover children
  must make available until age 26.
  - Includes married adult children.

Tax Credit For Small Businesses/Nonprofits
- 35/25 percent of employers’ contribution to
  coverage for employees
ACA - What’s Already in Effect

Ending “rescission” of insurance coverage
• Insurers can no longer end health insurance when someone gets sick.

No more Lifetime or Annual limits to insurance coverage
• Health plans can no longer impose lifetime or annual limits on benefits.

ACA-What’s Already in Effect

Help with the Medicare “Donut Hole”
• $250 rebate checks for Part D beneficiaries
• Donut hole currently $2,830 to $6,440
• 50 percent discount - brand-name drugs
• Increasing discounts - generic drugs
• “Donut hole” closes completely by 2020

ACA - What’s Already in Effect

Wellness Visits
• Medicare now offers one annual wellness visit, at no charge.

Preventive Health Services
• All new health plans & all Medicare plans must cover certain preventive services at no charge.
ACA – Major Changes to Come

2014: State Health Insurance Exchanges
- State, regional, federally run
  - 2014: Individuals & Employers of 50-100 workers
  - 2017: Employers of over 100 workers
- Certify & offer private, cooperative plans
- Inform consumers & Medicaid/CHIP eligible
- $6 Billion-Consumer Operated & Oriented Plans

ACA – Major Changes to Come

2014: Expanding Medicaid Eligibility
- To 133% of poverty level (non-elderly).
- Cover 40% of uninsured / 12 million people.
- Projected cost to States: $20 billion / 10 years.
- 2014-2019 costs:
  - MD: $338 Million
  - PA: $468 Million
  - WV: $118 Million

ACA – Major Changes to Come

2014: “Individual Mandate”
- US citizens must have health insurance coverage or pay a fine:
  - $95 in 2014
  - $325 in 2015
  - $695 in 2016
- Caps: Individuals-2.5% of AGI; Families-$2,250
- Fine is ½ for children
ACA – Major Changes to Come

2014: Fines for Businesses
• Not offering health insurance for employees
• $2,000 or $3,000 per employee

2018: Taxes on “Cadillac Plans”
• Taxes on employer plans costing over $27,500/family or $10,200/individual

ACA & Nursing Practice

The Affordable Care Act supports a larger role for RNs & APRNs in our health care delivery system, through
- Education
- Reimbursement
- New Models of Care
- New Patient Services
- Quality Assurance

ACA & Nursing Education

ACA Supports Title VIII Nursing Workforce Development Programs:
• Loan repayment and scholarship programs
• Nurse faculty programs
ACA & Nursing Education

ACA Supports:
• Nursing Student Loan Program
• Nurse Loan Repayment and Scholarship Programs
• Advanced Education Nursing-Midwifery Programs

ACA & Nursing Education

ACA Supports:
• Nurse Education, Practice, & Quality Grants
  – HHS grants for nursing career advancement
  – HHS awards for enhanced collaboration & communication

ACA & Nursing Education

ACA Supports:
• Nurse Faculty Loan Program
  – Increase from $30,000 to $35,000/year
  – $10,000-$20,000/year for MSN/PhD faculty members
• Nursing Workforce Diversity Grants
  – Expanded to include RN to BSN, accelerated programs
ACA & Nursing Education

1. Graduate Nursing Education (GNE) for APRNs
   - $50 Million/year – for FY 2012 – 2015
   - Medicare GNE Demonstration Program
   - NPs, CNSs, CRNAs, CNMs
   - Hospitals partner with nursing schools, community health

ACA & Nursing Education

2. Other Educational Support:
   - Pediatric Health Care Workforce
   - Public Health Workforce Loan Repayment
   - Allied Health Loan Forgiveness
   - Mid-career public & allied health scholarships
   - Direct (Chronic/Long-Term)Care Workers
   - Geriatric Nursing Career Incentives

ACA & Nursing Education

3. For More Information
   - Visit HRSA Website
   - www.hrsa.gov
   - www.rnaction.org/healthcare
Nurse-Midwife Reimbursement
Certified Nurse-Midwives
• Enrolled as Medicare providers/bill directly
  • Were reimbursed at 65% of physician rate
  • Beginning January 2011, receive 100% of physician rate
• CRNAs receive 100% - no change
• NPs & CNSs still receive 85% - no change

Primary Care Bonuses
Primary Care Practitioners
• In Health Professional Shortage Areas
• Including Nurse Practitioners & Clinical Nurse Specialists
• Receive 10 percent bonus
  • Added to Medicare reimbursement
  • FY 2011-2016

Nurse-Managed Health Centers
• $50 million in grants for NMHCs that:
  • Provide primary care or wellness services
  • Care for underserved or vulnerable populations
  • Are associated with:
    • Academic department of nursing
    • Qualified health center
    • Independent nonprofit health/social services agency
School-Based Health Centers

Two new grant programs:
• $50 million/year (FY 2010-13) to construct & equip new Centers
  • Priority – many Medicaid-eligible children
• Funding for existing Centers
  • Priority – Primary care shortage areas, many uninsured children

Nurse Home Visitation Services

“Evidence-based nurse home visitation programs”
• Established by states after needs assessment
• Serve maternal, infant, early childhood
• Priority to supporting high-risk populations
• Federal grant support

Independence at Home

Supports “home-based primary care teams”
• Led by Nurse Practitioners and/or Physicians
• Serve chronically ill Medicare patients
• Incentives for lowering costs
• Priority for:
  • High cost locales
  • Experience with home health
  • HIT & Individual care plans
National Health & Public Health Service Corps

- Several ACA provisions enhance primary care provided under the National Health Service Corps
- Includes APRNs who participate

ACA Panels & Nurse Members

Almost 150 new national advisory panels, including
- Medicare Independent Payment Advisory Board

Patient Centered Outcomes Research Institute
- Debra Barksdale, PhD, RN – PCORI member
- Robin Newhouse, PhD, RN – Member, Methodology Committee

National Health Workforce Committee
- Peter Buerhaus, PhD, RN - Chairperson

New Models of Care

Accountable Care Organizations
- Medicare “shared savings” program
- Hospitals, providers form ACO to manage $ coordinate care for Medicare patients
  - Must meet quality performance standards, financial benchmark
  - Payments based on cost savings
  - Must include primary care professionals – including Nurse Practitioners & CNSs
**New Models of Care**

**Medicaid/CHIP Pediatric ACOs**
- Demonstration project
- State Medicaid/CHIP beneficiaries
- Incentive payments for
  - Achieving savings target
  - Meeting performance standards

**Medicare Medical Homes**
- HHS grant program to States
- Establish community-based, interdisciplinary “health teams”
- Support primary care practices
- Nurses & Nurse Practitioners specifically included in “health teams”

**Center for Medicare and Medicaid Innovation**
- Newly created, to examine & develop innovative ways to improve care & cut costs

**Community-Based Care Transitions Program**
- To reduce recidivism, readmissions
- Based on research of Nursing Interventions that manage transition from hospital, etc. to home
New Models of Care

Health Care Innovation Zones
Planning grants for teaching hospitals, etc.
- To address increasing costs
- Provider collaboration to offer full spectrum of care, share data

ACA & Quality of Care

Decreasing Hospital Readmissions
- Hospital readmissions reduction program – decrease payments to hospitals with readmissions and requires public reporting of readmission rates.
- Community based care transition – development of transition programs to decrease readmissions.

ACA & Quality of Care

Patient-Centered Outcomes Research Institute
- Comparative Effectiveness Research (CER)
- Prevention, diagnosis, treatment, monitoring & management of health conditions
- AHRQ issues findings, relate to coverage decisions

Center for Quality Improvement & Patient Safety
- "Best practices" identification & assistance
- Quality Improvement Network Research Program
Divided Government
2010 Elections

Executive Branch –
– White House, Federal Agencies, Etc.
Legislative Branch – SPLIT!

Political Landscape in Washington, DC

MAJOR SHAKE UP!!

Republicans now control
House of Representatives
(R- 242, D, 192 1 vac.OR
(Wu)

Democrats still control
Senate D–51, R- 47, I-2
Lieberman (D) Sanders (I)

Political Landscape in Washington, DC

MOC Different
Priorities
Passing legislation will be ????? in the 112th Congress.
Double the Nurses in the House

- Karen Bass (D-CA)
- Diane Black (R-TN)
- Ann Marie Buerkle (R-NY)
- Renee Ellmers (R-NC)
- Returning nurses: Reps. Capps (D-CA), Johnson (D-TX), McCarthy (D-NY)

112th Congress & ACA

- Efforts to repeal ACA
- Hearings on ACA
- Defunding parts of ACA

State Responses

- Introduction of state laws reversing the insurance coverage mandate (more than 45 states; limit, alter or oppose selected state or Federal actions.) 17 passed binding leg.
- Opposing elements HCR.
- State AG Filed lawsuits challenging the constitutionality.
- Ballot questions during November elections
State Challenges to ACA

26 State lawsuits challenge ACA constitutionality – mostly “individual mandate”

– Most States simultaneously following ACA provisions, receiving ACA funding

– Upheld in all but 2 federal court decisions

– Supreme Court will have to decide

What Health Care Reform Means for the States...

We need an infusion of nurses at the table!

2011 Nursing’s Next Steps

With HHS Secretary Kathleen Sebellius (center), November 2010
The Regulatory Process – an Uphill Battle

We must be **vigilant** about how the law is implemented.

ACA Regulations

- Agencies implement & interpret laws through formal rule-making, other actions.
- Proposed & final rules are published in Federal Register, with opportunity for comments.
- Final rules become part of the Code of Federal Regulations & have the force of law.

ACA Regulations

- Many provisions in ACA are not effective until regulations are prepared & adopted.
- Many notices of proposed rulemaking have been issued since ACA signed into law.
- Process is moving quickly.
- Main agencies: HHS, CMS, IRS.
ACA Resources

  - A federal government Website managed by the U.S. Department of Health & Human Services.

www.healthcareandyou.org

The Power of Grassroots:

Share Your Story!

www.rnaction.org/healthcarestory.
When Nurses Talk, Washington Listens

www.rnaction.org

✓ Educate consumers and patients about how the new law will impact them.

✓ Get involved. Serve on a state task force or committee that will shape reform at the state level.

✓ Keep the pressure on legislators when there are attempts to de-fund health care reform.

Nurses Make a Difference...

“Never doubt that a group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.” -- Margaret Mead

When Nurses Talk, Washington Listens
The Cost of Nursing: The Dollars and Sense of Caring

PA State Nurses Association Annual Summit

October 28, 2011

Handout/ Note Pages

Spanning the Continuum of How Nurses Matter: Nurse Staffing and Inpatient Mortality, and Nurse Practitioners Providing Primary Care for Medicare Beneficiaries - Peter Buerhaus, PhD, RN, FAAN

1. Discuss the association of hospital nurse staffing and inpatient mortality.

2. Describe RNs views of issues affecting the nursing workforce.

3. Describe the American public’s attitude, knowledge, and behavior toward nurses; and of how health policy thought leaders view the nursing and health workforce.

4. Describe at least 5 implications for nursing regulatory policy.
BULLYING:
EVERYONE HAS THE POWER
TO MAKE A DIFFERENCE

Presenters:
Denise Lucas, RN, MSN, NEA-BC
Vice President Patient Services/Chief Nursing Officer
DuBois Regional Medical Center
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Program Objectives:

At the conclusion of this program, participants will be able to:

1. Describe factors in the current healthcare environment that foster bullying and identify the behaviors in the current culture
2. Define Bullying and its ten most frequent forms
3. Explain the leadership role in building a culture of respect and costs of Bullying culture
4. Explain three strategies to stop Bullying
5. Describe a practical application of "No Bullying" strategy in a clinical department
6. Identify practical tips for a "No Bullying" implementation strategy
BULLYING:
Everyone has the power to make a Difference

A. Environmental Factors
   1. Value based purchasing/ quality, safety, and service mandates
   2. Economic forces
   3. Workforce supply/ diversity
   4. Leadership effectiveness to manage within current scope of responsibility

B. No Bullying Definition and Common Forms
   1. Nonverbal innuendo
   2. Verbal affront
   3. Undermining activities
   4. Withholding information
   5. Sabotage
   6. Infighting
   7. Scope quality
   8. Backstabbing
   9. Failure to respect privacy
  10. Broken confidences

C. Leadership Role and Organization Costs of Bullying
   1. Leader Responsibilities
      a. Daily practice
      b. Vigilant oversight
      c. Zero tolerance
   2. Costs
      a. Quality, Safety, and Service
      b. Work environment
      c. Financial

D. Strategies to stop Bullying
   1. "I" message
   2. "OUCH"
   3. Crucial conversations

E. Clinical Department Implementation

F. Practical Implementation Tips
   1. Executive Role
   2. Training
   3. Organization wide approach
   4. Committed core team
1. Examine the elements associated with the definition of a Medication Error.
2. Discuss the elements associated with a “Near Miss”
3. Develop a listing of prevention strategy including process of the Medication User System
4. Describe the development of a measuring and monitoring Medication Use System
5. Identify the safety components of Safety Reports Events System related to medication safety for trending and prevention purposes.
6. Incorporate the principles of “Just Culture” in the evaluation of Medication Error Reduction efforts.
1. Discuss the health care reform debate from nursing's perspective.
2. Describe why nurses are at the health care reform table and how nursing can continue to influence the debate.

See attachment entitled Healthcare Reform
Improving Outcomes with Compassion - Karen Carman, RN, MSN

1. Identify at least four elements of compassion.
2. Describe three strategies for providing compassionate care to all patients.
3. Describe at least two benefits to both nurse and patient that compassionate care provides.
State of the Nursing Workforce: Intersection of Demographic Trends, Economic Recession and New Public Policy Initiatives - Peter Buerhaus, PhD, RN, FAAN

1. Identify how the recession has impacted hospital RN employment and earnings.
2. Describe strategies to prepare for the impact of a recovery in economic growth and overall employment in the national economy.
3. Identify the latest forecasts of the future age and size of the RN workforce.
4. Describe the current status of the National Health Care Workforce Commission and implications to the nursing workforce.
5. Describe 5 actions that can be taken to strengthen the nursing workforce
PA State Nurses Association
Practice Showcase
Abstract Compilation
October 28, 2011
Abstract 1 - Developing an Educational Clinical Practicum to Assist in Translating Evidence-Based Research into Practice to Improve Patient Care in a Tertiary-Care Magnet Hospital.

Vera C. Brancato, Ed.D., MSN, RN

Objective: Describe the process of (i) developing and implementing an educational practicum to facilitate application of evidence-based theory by nursing students to actual clinical problems and (ii) assessing the effectiveness of the practicum on student learning.

Abstract: The Institute of Medicine’s report Health Professions Education: A Bridge to Quality (2003) proposed that health care professionals be educated on the use of evidence-based practice (EBP). As applied to nursing, EBP incorporates the most current and best knowledge to enhance the likelihood that patients will receive the most effective nursing care possible. This is accomplished through an integration of clinical expertise with external research. Moreover, the October 2010 Robert Wood Johnson Foundation Initiative on the Future of Nursing exhorted nursing educators to employ educational initiatives to improve nursing competencies in decision-making skills, clinical judgment, critical reasoning and evidence-based practice.

The call for use of EBP in nursing has been heeded in a number of ways. For example, regulatory agencies such as JCAHO have standards requiring health care providers to utilize best practices based on research, and EBP has become an essential component of Magnet hospitals. However, because RNs in practice report that their educational preparation in EBP is lacking, it is evident that more needs to be done by nursing educators to effectively teach EBP and how to apply it in clinical practice settings.

A nursing educator in an RN to BSN program developed an innovative clinical practicum to help nursing students translate EBP theory taught in the classroom into the reality of the practice environment. The presentation will describe how the educator overcame potential barriers to the use of EBP and how she set up the clinical practicum to successfully achieve the practicum’s goals and objectives and assess the effectiveness of the practicum on student learning. Necessary resources such as tutorials and websites to access the best available external research will be outlined. This presentation also will focus on how to combine active learning strategies to educate nursing students on how EBP can be used to make decisions that can improve patient care delivery. Qualitative research findings will be described that indicate the progress which nursing students made in their skill/knowledge development, their comfort level with EBP, and their capacity to value a lifelong learning approach to EBP. Benefits to the hospital and patient care delivery also will be included.

References:


**Abstract 2 – Social Choice: THE COSTS OF CONVERSATONS OR CRITICAL CARE BEDS?**

Susan B. Dickey, PhD, RN

This poster seeks to enlighten nurses in the membership of the Pennsylvania State Nurses Association (PSNA) and possibly others about the recently published ANA Position Statement on end of life care. It is imminently practical in depicting many evidence-based ways in which professional nurses at any level of education can improve conversations among nurses, patients and their families, and members of all other disciplines, including health care providers, clergy, medicine, social work, law and more. An extensive literature review was conducted by members of the ANA sub-committee who wrote the document, followed by intense scrutiny at the subsequent levels of the ANA Advisory Committee on Ethics and Human Rights, the ANA Commission on Nursing Practice and the ANA Board of Directors. When nurses and other health care providers seek to educate and then find out what patients and their families really want for their end of life care, or when they care for persons with life-threatening or health-threatening illnesses, much pain (emotional and physical) can be averted and much aggravation, dashed expectations, frustration, anger and money can be saved. It takes a nurse!

**References**

American Nurses Association (2010). Position Statement: Registered Nurses’ Roles and Responsibilities in Providing Expert Care And Counseling at the End of Life – 6/14/10[PDF]


**Bibliography**

Abstract 3 - : Nurse Practitioners, High Quality and Cost Containing in the Hospital Setting

Theresa Eiser-Brown, MSN, CRNP, ANP-BC and Sandhra Thekkumthala, MSN, CRNP

In both the outpatient and in-patient environment time is money, the more a work product has faster turnaround time; the more work can be accomplished thus lowering costs and increasing revenue. When the work product is human lives in the hospital settings, quality must be maintained. Then the question becomes how can costs be streamlined while preserving the integrity of the work product? Nurse Practitioners have a long, rich history of providing quality, comparable healthcare while lowering the costs as well as increasing volume. In a 2005 study Barnett noted that the use of Nurse Practitioners in a pre-operative setting lowered costs by 79% for same day surgeries and by 44% for admitted patients. In the pre-procedure arena, preparing the patients for invasive cardiac procedures, state, regional and local standards of care must be met, all the while moving the patients through the process in an expedited fashion. Through the use of Nurse Practitioners to perform histories and physicals, the collaborative Attending physician is able to accommodate more patients, thus increasing volume and revenue. Cardiac outpatient office (attending notes) history and physicals from a variety of situations including private practices and a university setting practice, where compared to the history and physicals performed by the Nurse Practitioners by means of evaluating the comprehensiveness of the past medical and surgical histories, medication lists, and review of systems. It was revealed that not only were the Nurse Practitioner history and physicals more inclusive, the costs of this care were controlled.

References


Abstract 4 - Heart Failure: Reducing Readmissions Through Continued Education and Monitoring in Outpatient Cardiac Rehabilitation.

Susan Gills RN, BSN

Introduction: Heart Failure is the leading diagnosis for hospitalized patients over the age of 65 and more Medicare dollars are spent for diagnosis and treatment of heart failure than any other illness. It is the leading cause of morbidity and mortality and is associated with decreased quality of life. The American College of Cardiology and the American Heart Association guidelines refer to patient education, attention to monitoring for symptoms and provider follow-up as the most effective and underused practices in the treatment of heart failure.

Purpose: Patients participate in cardiac rehabilitation post hospital discharge for a period of six to twelve weeks creating an opportunity for continued education and monitoring and follow-up for symptoms. Participation will lead to increased compliance to prescribed regimens and decreased readmissions for heart failure as well as increased quality of life. Continued monitoring will lead to early intervention.

Methods: All patients in cardiac rehabilitation with a primary or secondary diagnosis of heart failure were educated on all of the following: medications, diet instructions, daily weight, activity guidelines, worsening signs and symptoms, heart failure zones and physician follow-up. Methods of education included Teachback Method, Brown Bag Medication Reconciliation, written educational materials including heart failure zones and critical thinking skills in a one-on-one setting. All charts were reviewed from January 2010 until June 2011 to see if any patients were readmitted for heart failure.

Results: Patients enrolled in cardiac rehabilitation with a diagnosis of heart failure charts were reviewed retrospectively from January 2010 through June 2011. Only one patient was readmitted during that 18 month period with a diagnosis of heart failure and anemia requiring transfusions.

Of note this 90 year old patient’s baseline BNP upon entering the program was 1623 (normal B-type natriuretic peptide < 100; measures heart failure) and had only attended three sessions before readmission to the hospital for “sudden onset of CHF”.

Conclusions: Heart failure is associated with high readmission rates to the hospital causing both an economic and emotional strain. Readmissions are often due to preventable complications, lack of knowledge and self-care abilities. Educating patients promotes self-care, early intervention for symptoms and reduces readmissions. Cardiac rehabilitation offers the perfect setting to continue post hospital discharge education. We need to encourage referrals to cardiac rehabilitation in the future.

References

American Heart Association www.americanheart.org

Heart Failure Society of America www.hfsa.org

AACVPR www.aacvpr.org

Institute for Healthcare Improvement www.ihi.org

Health Literacy Council www.nchealthliteracy.org

Aligning Forces for Quality www.forces4quality.org
Abstract 5 - Chief Quality Officer Rounds: Charting A New Course for Performance Improvement

Nicole M. Hartman, MSN, RN

Reimbursement changes from the Centers for Medicare and Medicaid Services and value based purchasing systems have made performance improvement more crucial then ever. A voluminous amount of data collection is the norm within medical-surgical practice environments, however, robust analysis of and subsequent action plans that truly enhance quality outcomes is often lacking.

This presentation describes a successful performance improvement model on a 30-bed medical-surgical oncology unit in an academic, community Magnet hospital. Root cause analysis and an evidence review prompted development of a quality model inclusive of four key elements: prioritization and exclusivity; staff awareness of data; transparency of outcomes; and, ownership and accountability. One of the more unique aspects of this innovative model is the implementation of daily Chief Quality Officer Rounds (CQOR) by the unit educator to facilitate real-time learning to improve patient care focusing on one quality indicator at a time. The educator assesses each patient situation, assures appropriate interventions are implemented, and educates the staff regarding opportunities for improvement. The unit staff are held accountable for their ability to improve quality indicators via goals tied to their annual performance appraisal, which focus on the utilization of data transparency and quality rounds to improve outcomes.

Since initiating CQOR focusing on reducing falls, the unit has seen a reduction in fall rates from 4.14 to 2.97 in 10 months. Learners attending this session will gain pragmatic strategies to create a culture of inquiry and passion for quality improvement in any medical-surgical patient care setting.

Reference


Abstract 6 - The Academic Electronic Health Record and Multiple Clinical Information Systems; Price vs. Value in Nursing Education

Julie Greenawalt, PhD, RNC and Theresa Calderone, EdD, MEd, MSN, RN-BC

Introduction - The growth of emerging technologies in twenty first century health care has enabled nurses to apply information technology and communication tools to nursing care. Nursing schools and undergraduates may experience a gap in informatics skills needed in this environment due to the high cost of educating a new workforce ready graduate due to the high cost of technology, time and talent. Indiana University of Pennsylvania’s (IUP) Nursing and Allied Health Department will implement an Academic Electronic Health Record and Telehealth Information System in the Community Health curriculum. Our framework is based upon the national HIT agenda
that calls for an electronic health record for every American by 2014 and the Technology Informatics Guiding Education Reform (TIGER) Initiative. We will share with you the cost in terms of equipment, resources, time and talent that it has taken to initiate a workforce ready graduate.

Project Implementation - The purpose of our presentation is to present our project from conception to inception of how a simulated medical records documentation environment for undergraduate nursing students was developed. We’ll discuss the integration of our simulation rooms, academic electronic health record, and telehealth information system. A challenge is the creation of a “simulated” integration of two clinical information systems to give students an experience of a seamless real-world work environment. We will share our implementation project plan, funding for this project, partnerships with technology vendors, and faculty adoption strategies for this technology intensive environment that was established with variable funding mechanisms that were garnered in this tight economic era.

Conclusions/Next Steps - Our project is a work in progress and we plan to implement in the Fall of 2011. The ability to provide nursing students with cutting edge educational modalities in the practice environment is our goal. Our project team continues to develop a Simulated Medical Center for the prospective future nurse.

References


Abstract 7 - Huddle Up! Collective Responsibility to Positively Impact Workflow and Patient Safety

Christine Marakovits, BSN, RN and Jessica Beaver, BSN, RN

The workflow on a medical-surgical unit frequently changes within minutes and nurses can begin to fall behind and become stressed, leading to potentially negative outcomes. When this happens, a method to assure situational awareness among all staff members can turn the tide to assure delivery of safe and effective care.

This issue was identified and addressed by members of a shared governance nurse practice council on a 30 bed medical-surgical unit in an academic community Magnet hospital. Their search for best practice led them to discover concepts associated with Crew Resource Management, specifically Safety Huddles to improve patient safety and teamwork. The premise of Safety Huddles is designed to bring the entire team together to discuss the current and potential workflow of the entire unit and all patient safety issues. Each team member attends the brief check-in, and using an internally developed template gives a concise update on their assignment, identifying high risk patients and issues that could impact their planned workflow for which they may need assistance. Additional impromptu huddles may be initiated by any staff member at any time and, are also held following an untoward event as a debriefing.

The scheduled huddles have been hard-wired into the daily unit operations. In addition, impromptu huddles are initiated on average twice per week. Qualitative evaluation demonstrates improved communication and a culture of collective responsibility. Quantitative evaluation demonstrates reduction in falls, catheter associated urinary tract infections, pressure ulcers, and length of stay.
References:


Abstract 8 - Enhancing Patient Care, in the Physician Office, through Utilization of Health Literacy Toolkit

Jane A. Oyler, MSN, RN

Introduction - As part of a Learning Collaborative, five physician practices, in two counties, were chosen to implement tools from the Health Literacy Universal Precautions Toolkit. Dr. Darren DeWalt, of the University of North Carolina, acted as consultant to the collaborative.

Background - The Agency for Healthcare Research and Quality (AHRQ) commissioned the University of North Carolina at Chapel Hill to develop and test the Health Literacy Universal Precautions Toolkit. The physician leading the project was Dr. Darren DeWalt.

The Aligning Forces for Quality (AF4Q), a Robert Wood Johnson Foundation grant and Highmark provided financial support to a project, in two central Pennsylvania counties, to assist physicians and their office staff to learn to communicate more effectively with their patients through the use of tools from the Toolkit.

Strategy - Through the use of the methodology of Plan-Do-Study-Act, the physician office practices were able to implement rapid cycles of change. These cycles were discussed on webinars that included Dr. DeWalt, his assistant, the practice coaches, the physicians, and practice leaders.

Outcomes - The physicians and their staff did realize the importance of speaking clearly and in plain language so their patients would be capable of understanding their role in their health and what to do when they got home. This realization was shared at a Physician-Clinical Learning Network meeting.

Several lessons were learned including change takes time and tremendous amounts of energy and reinforcement of automated messages is necessary to ensure patient understanding therefore compliance.

Implications for Nursing Practice - Two outpatient units, within the hospital, have begun using tools from the toolkit with focus on Teach-Back which has demonstrated positive impact on the transition of care.

References


**Abstract 9 - CSI: Critical Sepsis Identification...Earlier Recognition, Earlier Treatment**

Erin Sarsfield, RN, MSN and Cheri West, RN, MS

The 2008 Surviving Sepsis Campaign established evidence-based guidelines for the management of sepsis. At our Academic Medical Center, a review of over 800 patient charts estimated that at least 60 deaths might have been avoided if sepsis had been recognized earlier, and anchor antibiotic and fluid resuscitation administered earlier. From January 2009 until September 2010, septicemia was the top diagnosis on our University Healthcare Consortium (UHC) Excess Death report. A multiservice, interdisciplinary team was formed in 2010 and focused on admissions to our Emergency Department (ED) and adult Intensive Care Units (ICUs). A sepsis bundle protocol, antibiotic algorithm and electronic order sets were developed and implemented. Nursing and physician computer-learning modules with clinical vignettes were developed. The ED/Critical Care Nurses had 95% compliance with the education in just six weeks. Posters, reference pocket guides, antibiotic infusion and documentation tips were posted on our hospital Intranet. Nurses were empowered to initiate the sepsis protocol and notify Attending Physicians if Resident Physicians did not respond to nursing assessments of potential sepsis. Our rapid cycle team eliminated 25 sepsis-related deaths over the initial nine months of our implementation. Septicemia was eliminated from our Excess Death report for the first six months. One of our most significant results was demonstrated in the arrival-to-initial antibiotic infusion and fluid resuscitation time which was reduced from an average of 4-6 hours to 1-3 hours. We reduced our sepsis mortality from 18.77% to 13.64% and our sepsis observed-to-expected mortality from 1.3 % to 0.78%. We also accomplished substantial financial reductions by decreasing ICU length of stay slightly more than 0.5 days and average total costs by almost $2,000 per patient in the first six months. There were marginal setbacks observed initially this year, which were related to capacity issues. We continue to strive toward initial antibiotic and fluid resuscitation within the first hour of ED admission, and earlier identification of Systemic Inflammatory Response Syndrome (SIRS) criteria. Our focus on earlier identification and treatment of sepsis resulted in an annualized cost avoidance of over $700,000. We have significantly improved the care of these patients and saved many lives.

**References**


Abstract 10 - Sepsis Protocol: The Nurse’s Role in Reducing Cost and Mortality

Adelle Lotinsky, RN, BSN and Shera Stack, RN, BA

In 2003, the Surviving Sepsis Campaign (SSC) was launched by the European Society of Intensive Care Medicine, the International Sepsis Forum, and the Society of Critical Care Medicine. The Surviving Sepsis Campaign is a global initiative to create an international effort to improve the treatment of sepsis and reduce sepsis mortality. According to the Surviving Sepsis Campaign, there are approximately 750,000 new cases of sepsis reported each year in the United States, resulting in a minimum of 210,000 fatalities. Purpose: To explore the effectiveness of a nurse driven sepsis protocol in reducing cost and patient mortality. Method: A preliminary thematic analysis of the literature was conducted. Results: The research suggests that patients experience a delay in the recognition and treatment of sepsis. This rapidly progresses to severe sepsis and septic shock and is associated with a cost of tens of billions of dollars annually. The timely implementation of an early goal-directed therapy protocol is critical in preventing the mortality of patients with septic shock and severe sepsis. This results in an average cost reduction of 25% per patient. Implications for practice: The research recommends involving the nurse to recognize the early signs and symptoms of sepsis via a standardized screening tool, implementing the Surviving Sepsis Campaign’s recommended early goal-directed therapy protocol, and monitoring compliance.

References


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**Abstract 11 - Enhancing Perioperative Teamwork to Improve Patient Safety**

Hope L. Johnson, RN, MSN, CNOR

Description: A “Culture of Patient Safety” survey conducted in 2008 revealed a lack of patient centered focus, teamwork, and positive communication amongst the majority of perioperative staff members at a Pennsylvania multi-campus health network. After reviewing the results of the survey which identified 53% of the staff were afraid to ask questions when something seemed amiss and 43% of the staff were unwilling to challenge authority, members from the Operating Room (OR), Anesthesia, and the Department of Surgery knew action needed to be taken. Key members from these departments joined forces with the Division of Education to develop a mandatory training program focusing on teamwork, open communication, and stressing the patient as the most important person in the OR. After incorporating various techniques and vignettes demonstrating beneficial methods of communication, comprehensive, mandatory patient safety training was created. This poster will focus on the development and implementation of the safety training program and how it positively transformed workplace culture.

**References**


Abstract 12 - Post Thoracotomy Pain Syndrome: The Patient Experience

2010 Nursing Foundation of Pennsylvania

Pauline Thompson Clinical Nursing Research Award Recipient

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and

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Introduction: Surgery is the first option for patients with early stage lung cancer. After surgery, regardless of the procedure (open thoracotomy, minimally invasive), pain may persist for a year or longer in as many as 50% of patients. This outcome, termed post thoracotomy pain syndrome (PTPS), is the focus of this study. PTPS is defined as pain that recurs or persists along a thoracotomy incision at least 2 months following the surgical procedure.

The purpose of this study was to compare the symptom experience of patients with and without PTPS.

Setting: University of Pittsburgh Medical Center (UPMC) Hillman Cancer Center

Inclusion criteria: 1) diagnosed with Stage 1, 2, or 3a lung cancer; 2) managed surgically; 3) between 2 and 12 months post-operative; 4) 40-85 years of age. Exclusion criteria: 1) diagnosed with metastatic lung cancer; 2) unable to read and write English.

Methods: Subjects completed a visual analog scale (VAS) that rated pain using the scale 0=none to 10=maximum, the Functional Assessment of Cancer Therapy-Lung (FACT-L) which measures participants’ well-being using five sub scales (physical, social/family, emotional, functional, and lung related concerns) and the McCorkle Symptom Distress Scale (SDS). FACT-L and SDS subscores were also used to rate frequency of pain and medication effectiveness. Demographic data were collected from the medical record. Data were analyzed using descriptive statistics and independent t-tests.

Results: Subjects were 32 patients, 47% women, aged 62.1 (±10.8) years. There were no statistically differences between PTPS (n=17) and non PTPS (n=15) patients for socio- or surgical demographics. The average VAS pain score was 3.41 ± 3.14 for PTPS patients (range 0-7, median=1). All non PTPS subjects rated pain as “0”. 8/17 PTPS patients rated their usual pain level as “0” by VAS. However, 4/8 rated pain intensity as moderate and not controlled by medications when pain did occur. 6/17 participants rated pain as moderate in response to questionnaire items and 3/6 participants rated their medications as ineffective. 3 PTPS participants had severe pain and were being seen at pain clinic with some pain control.

Conclusion: Post-surgical lung cancer participants’ diagnosed with PTPS experience pain on an intermittent basis that varies in severity from moderate to severe. Improved understanding of factors producing pain could improve functionality and reduce associated costs. The study is ongoing with the goal of further defining the symptoms, influencing factors and performance limitations associated with PTPS in a larger sample and with qualitative methodology.

References


