Transformational Leadership

Opera singer and patient, Charity Tillemann-Dick performs an aria from “La Bòheme” for caregivers at Cleveland Clinic’s Patient Experience Empathy and Innovation Summit, held in May 2010.

Six months earlier, Ms. Tillemann-Dick underwent a lung transplant at Cleveland Clinic.

From left: Patricia Benner, PhD, RN, Professor Emerita, University of California, San Francisco; Kera Medoff Barnett, Director, Executive Strategy and Business, Lincoln Center for the Performing Arts; and Jean Watson, PhD, RN, Distinguished Professor of Nursing, Endowed Chair in Caring Science, University of Colorado Denver.

Cleveland Clinic CEO and President Delos M. Cosgrove, MD, and Beth Mooney, KeyCorp Chairman and CEO, engaged in a panel discussion during the Patient Experience Summit.
Cleveland Clinic nurses have been collaborating with Cleveland Clinic’s Office of Patient Experience and redesigning the treatment path for patients in the Emergency Department. They have been taking a central role in acute care during transport and strengthening interdependent, mutually respectful relationships between themselves and physicians. Cleveland Clinic nurses are leading change to positively affect both the patient experience and their own nursing profession.

**Improving Patient Experiences:**

**Cleveland Clinic’s Office of Patient Experience Collaborates with the Zielony Institute**

A good patient experience requires a supportive, healing and patient-centered care environment. Putting patients first requires more than world-class clinical care; it requires care that addresses every aspect of a patient’s encounter with Cleveland Clinic, including the patient’s physical comfort, as well as his or hers educational, emotional and spiritual needs.

**Nurses’ Impact on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

Patient experience is measured by the inpatient HCAHPS survey.

Understanding the impact nurses have on HCAHPS is important. HCAHPS:

- Provides the patient’s view of his or her experience. Improving scores is the right thing to do.
- Reflects Cleveland Clinic’s reputation. Scores are publicly reported. Our goal is to rank in the national 90th percentile.
- Scores will impact reimbursement in the near future.

**Patient Experience Advisory Resource**

The Office of Patient Experience team serves as an advisory resource to the Zielony Institute personnel. Advisors provide patient experience expertise for critical initiatives to ensure consistent delivery of patient-centered care.

The Office of Patient Experience advisors attend monthly Zielony Institute Council meetings to provide updates about the Office of Patient Experience and identify areas for continued collaboration.

**Patient Experience Empathy and Innovation Summit**

Nursing leaders participated in a collaborative multidisciplinary team with physicians and key patient experience stakeholders to plan a unique Patient Experience Empathy and Innovation Summit, which was held in May 2010. Of the more than 600 attendees, there were nearly 150 nurses, and about half of those were from Cleveland Clinic.
Nursing leaders Patricia Benner, PhD, RN, Professor Emerita, University of California, San Francisco, and Jean Watson, PhD, RN, Distinguished Professor of Nursing, Endowed Chair in Caring Science, University of Colorado, Denver, engaged in a lively discussion with James B. Young, MD, Executive Dean, Cleveland Clinic Lerner College of Medicine, during the panel session “Empathy as a Differentiator.” The session highlighted the importance of relationship-centered care.

Dr. Young stressed the need to bring the nurse and physician professions closer together in practice. As a result, a Physician-Nurse Communication Task Force was formed to improve communication between physicians and nurses.

**HUSH: Quiet at Night Initiative**

In an effort to improve Quiet at Night HCAHPS scores and in response to patient complaints about noise during the hospital stay, Cleveland Clinic took a proactive approach to reducing nighttime noise. A multidisciplinary Quiet at Night improvement team, with representatives from each community hospital, developed consistent HUSH (Help Us Support Healing) guidelines and assisted with local implementation efforts to reduce nighttime noise. Nursing played an integral part in the Quiet at Night improvement initiative. Comprehensive nighttime guidelines were implemented in every Cleveland Clinic hospital to help ensure a quiet, healing environment between 9 p.m. and 7 a.m. A standard 9 p.m. overhead announcement was created to provide a consistent message to notify patients, visitors and employees about the start of the nighttime quiet (or HUSH) hours. An online tool was provided in a “Read and Validate” format to educate employees about the HUSH protocol and to gain their commitment to providing a quiet, restful, healing environment.

Since implementation of this consistent nighttime protocol in the third quarter 2010, Cleveland Clinic’s Quiet at Night HCAHPS scores are steadily improving.

**Support of Hourly Rounding Initiative**

The Zielony Institute implemented hourly rounding in spring 2010. When patients perceive that nurses are consistently rounding, they are more likely to respond with a positive response to the HCAHPS questions related to responsiveness, nurse communication, pain management and quiet at night. Similar to research reports, consistent hourly rounding with purpose by nurses was associated with improved Cleveland Clinic patient satisfaction scores and a decrease in patient falls and patient need to use the call light. Hourly rounding with purpose involves:

- Nurses introducing themselves to patients
- An explanation of the purpose of rounding (for the first visit)
- An assessment of the “Four Ps” (Pain: Evaluate pain level; Position: Help patient get comfortable; Potty: Ask about toileting needs; Personal items: “Is everything you need within your reach?”)
- Asking the patient, “Is there anything else I can do for you?”

An enterprise committee is targeting ways to reinforce purposeful hourly rounding, and educational tools will be available in 2011.
Critical Care Transport: Cleveland Clinic’s Front Door to the World

Through Cleveland Clinic’s Critical Care Transport, critically ill patients are being transported here more frequently from distant places to access our expert care.

Our critical care advanced practice nursing model provides the domains associated with the rapidly changing needs of critically ill or injured patients requiring treatment in tertiary care centers.

Our approach is driven by the dynamic changes of the patient and his or her environment, and an evaluation of the patient’s response to intervention. This results in initiating or changing prescribed therapy as identified by clinical evaluation, data interpretation and diagnostic reasoning. Since developing the academic program in 2003 at the Case Western Reserve University Frances Payne Bolton School of Nursing and implementing it at Cleveland Clinic in 2007, the critical care advanced practice nursing model has expanded to flight programs in Ohio, Illinois, Texas, Japan and Australia. It is under consideration in several other states and China.

At the center of our advanced practice model is an acute care nurse practitioner (ACNP). ACNPs are formally prepared as critical care interventionists who assess and treat for patients with complex physiologic compromise. During the stabilization phase and throughout the transport process, the ACNP formulates differential and evolving diagnoses based on real-time patient information. The ACNP then orders, performs and interprets diagnostic tests and, along with information derived from the physical exam, formulates a subsequent plan of care.

After initial interventions and stabilization, the ACNP reformulates and reprioritizes interventions based on continued patient surveillance and care needs.

The complex multi-model level of triage process services is provided by ACNPs through all modes of transport, including rotor-wing (helicopters), fixed-wing (jets) and mobile intensive care unit (MICU) surface vehicles. All missions are staffed by on-duty crew members, who may include physicians, nurse practitioners, registered nurses and paramedic-level emergency medical technicians.

The three rotorcraft are Sikorsky S-76 A++ dual-pilot, instrument flight rule compliant (IFR) aircraft with capacity to carry up to four medical crew members and service an area of about 250 nautical miles. Our four dedicated jet aircraft provide a global reach to ensure the highest level of care worldwide. Additionally, the pediatric team staffs one mobile intensive care unit 24 hours a day with the ability to transition to one of the rotor- or fixed-wing modes of transport as needed. Each pediatric crew consists of one RN and one EMT-P with the availability of either a neonatal or pediatric intensivist or nurse practitioner to supplement the team when needed.

The critical care transport service has placed the front door of Cleveland Clinic in 39 states and 26 international locations and transported 4,612 patients in 2010.
From Integration to Differentiation: Improving Cleveland Clinic Emergency Services

A challenge for Cleveland Clinic emergency services is providing care to two very different types of patients – those with an urgent need to be seen by a healthcare provider and those with less urgent needs.

As part of Cleveland Clinic’s integration of emergency services, our emergency departments (EDs) are moving to a single electronic medical record, standardized processes and equipment, and the implementation of “split-flow” treatment tracks tailored to each hospital and the communities and patients they serve.

Split-flow is not a new concept. It involves splitting patients into two tracks: those with urgent needs and those with nonacute needs. Adapting the concept to meet Cleveland Clinic’s “Patients First” philosophy in our EDs requires an empowered team committed to change. Splitting patients into two tracks allows ED staff to better meet the needs of both acute and nonacute patients. Acute patients experience little to no wait to be evaluated by an ED physician or mid-level provider prior to possible hospital admission. Those with less acute needs are taken through a series of steps that keep them moving in a caring, efficient manner toward discharge.

Using experiences with an early version of split-flow at Cleveland Clinic Hillcrest Hospital and working with a multidisciplinary team at Euclid Hospital, a new model was developed and tested at Euclid Hospital for implementation at other Cleveland Clinic EDs.

Euclid Hospital’s team scrutinized every phase of the split-flow process looking for defects. Ground rules were established. When obstacles were found, solutions were vetted by the team before implementation. In order to reduce variability and ensure the integrity of the process, the decision was made to have dedicated nurses assigned to key roles for the first two weeks of implementation. These staff members would provide consistent feedback and reduce variability in practice. Another key understanding was that suggestions and concerns would be addressed, but changes to the actual process would take place once a week to keep the team from responding to an isolated event or one-person perspective.

Our multidisciplinary team worked to redesign the treatment path for lower-acuity patients. From quick registration on arrival by an Emergency Severity Index (ESI) nurse, a new intake process for ESI Level 3 and lower patients, the creation of new results waiting, continuing care and discharge areas, the Euclid ED team developed its unique version of split-flow. Staff looked at the process from the patient point of view and how we could meet the needs of our patients and their families to create the best possible experience.

On the first day of implementation, no patients were in the waiting room even though we had chosen a holiday Monday to institute the change. Further, despite an increase in volume of 6 percent, average ED length of stay decreased 18 percent and patients
leaving without being seen fell to below 1 percent. Even with an increase in patient volume and acuity over the next month, patient satisfaction improved by 20 percent and financial collections increased by 10 percent. Length of stay and time to provider has continued to improve as the team works to refine and improve the split-flow process.

As we developed the program for Euclid Hospital, we made an effort to begin to develop tools to assist in future implementations. A readiness assessment was created and tools to map the process for each ED were made so they could be customized in the future. Guides were developed for each role including responsibilities, time limits and contingency plans for when things went wrong. All of these could be modified for each new launch.

Patient flow is an ongoing process extending beyond the ED. This nurse-led initiative is meant to not only meet the needs of patients and their families, but also improve staff engagement and pride. By engaging staff at the bedside and continuing to listen to their ideas and suggestions, we are building a model of care that adapts to changes in volume, acuity and innovations in emergency medicine while retaining compassion and caring.

Integration of emergency services and split-flow is allowing our EDs to positively impact patients and their families. More important, it allows us to connect in very meaningful ways as caregivers. Nurses who feel a part of this innovative process are helping to ensure that we always put patients first and that by working together we provide a unique Cleveland Clinic experience that differentiates our services from others.

**Nurse-Physician Committee Explores Best Practices**

A Nurse-Physician Committee, chaired by Executive Chief Nursing Officer Sarah Sinclair and James Young, MD, was convened in 2010 to explore nurse-physician dynamics. The committee is composed of physician and nurse leaders representing a wide array of clinical specialties and leadership positions. The specific intent of the committee is to identify the current nurse-physician culture at Cleveland Clinic and to examine examples of best practice as they relate to nurse-physician interactions.

Historically, the literature on nurse-physician relationships has concentrated on management of negative behaviors in the clinical setting. In contrast, this committee is exploring examples of excellent nurse-physician relationships that reflect interdependence, mutuality and respect. To date, the committee has looked at baseline perceptions of the professional practice environment at Cleveland Clinic’s main campus, highlighted examples of best communication practices and determined the need to enhance the positive professional practice environment at Cleveland Clinic.

Projects planned for the future include sharing information about this initiative with nurses and physicians at Cleveland Clinic, conducting a qualitative study to examine best practice data from nurse and physician interviews, and developing strategies to enhance mutual respect and collegiality.

“If there is one unifying theme in the IOM report on the Future of Nursing, it is one of collaboration between nurses and physicians,” says C. Martin Harris, MD, Chief Information Officer, Cleveland Clinic. Dr. Harris participated in the IOM committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing.