Cover Story

Radical Redesign

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It takes guts to question one of the basic tenets of healthcare: doctors give orders; nurses carry them out. But that's exactly what Maribeth Hetherington and her team at Appleton Medical Center did, and the results are astounding.

In 2005, Hetherington had been with ThedaCare for six years and was being considered for the role of chief nursing officer. Kathryn Correia, president of Wisconsin-based Appleton Medical Center and Theda Clark Memorial Hospital and senior vice president of parent company ThedaCare, was looking for someone with a new vision for patient care.

With a long background in nursing, combined with many years in managed care and insurance, Hetherington knew one thing for certain: the role of care management in the hospital made no sense.

"We have care managers, who are nurses, come to the unit and say to the bedside nurse, 'I'm here to manage length of stay, so how are you progressing care? Why does this patient still have a catheter in? Are you advancing the diet appropriately so we can get them ready for discharge?'" said Hetherington.

"I looked at that and thought, 'Why would we send an RN who is not knowledgeable about that patient to talk to another RN and physician about how to manage care?' That should be managed at the bedside by the physician and nurse who are caring for the patient."

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Two years later, in February 2007, the first collaborative care unit opened at Appleton Medical Center. The unit was physically designed to accommodate a new system of care in which a clinical trio (a physician, an RN, and a pharmacist) act in concert to treat patients. Rather than acting as task-oriented order takers, nurses are a critical part of the care team, rounding with the other members of the trio and playing an expanded role in decisionmaking.

Less than a year later, the data overwhelmingly shows the success of the new model, including a 20% reduction in length of stay, a 21% reduction of cost per case, zero defects per patient for mediation reconciliation, and 98% use of the CMS best-practice bundle for pneumonia (up from 38%). Not surprisingly, 95% of patients say they would recommend the unit to others, and nursing turnover is almost nil.

Addressing frustration

It was nursing turnover that led Kristine Vosters, RN and clinical lead, to become involved with the collaborative care project. As someone who taught and mentored new nurses, Vosters was puzzled by the high turnover rate of med/surg nurses in the region.

At first, she questioned the quality of orientation and training, but eventually, as nurses she had mentored returned to her expressing frustration, she realized it was something else. “I knew these nurses were fully trained,” she said. “I had spent 12 weeks with them; they were more than ready to go out on their own and be responsible for patient care.”

Nurses told Vosters they were having problems keeping up with the workload, did not feel they could effectively deal with questions from patient family members, and were frustrated at the variety of protocols used by physicians for the same conditions. Vosters didn’t know it when she joined the project in 2006, but the collaborative care model (combined with lean management principles), would solve all those problems.

Both Vosters and Meg Lauterbach, an RN who was a cardiac care staff nurse until she joined the project, spent about a year serving as clinical advisors in the design of the new unit, development of the processes, and the creation of an EMR designed to support the new model.

Lean processes (eliminating waste to improve productivity) were the foundation of the project, and the team conducted 14 rapid improvement events between October 2005 and the February 2007 unit launch. For example, research conducted for the project on the daily movement of nurses confirmed national research that nurses spend about three hours of each shift looking for or gathering supplies.

The new unit has 14 private rooms, each with a supply cabinet on a track. The cabinet can be pulled into the hallway for restocking and accessed from within the room by nurses. The cabinet contains not only the supplies needed to treat each patient, but also the patient’s medications (excluding controlled substances).

Each room is equipped with an IV pole, a walker, and a commode. “It’s more expensive to put those in each room, but the productivity improvement more than pays for it,” said Hetherington. An in-room ceiling lift capable of holding a patient up to 400 pounds eliminates the need for nurses to find staff members to move large patients while reducing nurse injuries and improving patient safety.

There is no central nursing station in the unit, having been replaced by one collaborative alcove for every two rooms. The clinical trio, accompanied by

a care manager who now focuses on planning for post-hospital care, meets there for a pre-huddle before doing rounds with the patient, conducts the patient round together, and returns to that area to discuss the care plan before moving to another patient. Computers are located in patient rooms, in the alcoves, and around the unit on computer carts.

Working out the kinks

Despite six weeks of training conducted by Vosters, Lauterbach, and others for both nurses and the hospitalists who would be working on the unit, there were some kinks to be worked out when the unit opened.

Interestingly, the cultural issues Lauterbach expected to encounter turned out to be minor, eclipsed by logistical glitches that were easily fixed. “We thought it would be difficult to change to the culture of nurses working as a team with physicians and pharmacists. But people were okay with it,” she said.

Of course, it took some time for everyone to get fully up to speed. “It took about six months before the teams understood that they needed to speak their thoughts out loud as opposed to internally processing everything,” said Vosters. “It was a little roadblock, but we got through it.”

One reason the transition went well, said Hetherington, was that the hospitalists who would work on the unit were involved in its development. “We were looking for our hospitalist service to become more involved in the organization as leaders, so it was a perfect opportunity for them to be the champions for this,” she said.

In terms of logistics, because there is only one pharmacist assigned to the unit, when two physicians wanted to round on patients at the same time, there was an immediate conflict. The unit teams decided to move to a rounding schedule, with physicians given an estimated time to start their rounds and a page sent 10 minutes before the round prior to theirs is completed.

Having hospitalists as the only physicians to work on the pilot collaborative care unit made it easier, of course, but Hetherington and her team are prepared to roll out the model throughout the four-hospital ThedaCare group. The next pilot will be a medical floor with 19 beds at Theda Clark Memorial Hospital and will include both hospitalists and independent internal medicine physicians.

Hetherington said accommodations will be made for the fact that these physicians are not in the hospital full time. “For example, how will we admit a patient coming directly from their office? It will look a little different than it does for the hospitalist,” she said. “The next unit after that will probably be surgical specialty, which will require more tweaks in the admission process.”

The model in action

Both Vosters and Lauterbach say they can’t imagine going back to the old way of patient care. The biggest impact for nurses, they say, is not the fact that they are no longer order takers spending large amounts of time hunting and gathering, although this is certainly important. The transformational thing is the collaboration with physicians that leads to meaningful interactions with patient families.

“In the old world, as a nurse, I never had an answer for the family. Now, as part of the team, I hear what the physician is thinking and planning,” said Vosters, adding that she knows what the next step will be—for example, upon receiving a positive test result.

Indeed, Vosters says the collaborative care model has completely changed the way she thinks about her professional role. “I grow every day that I work because I’m learning something,” she said. “I’m able to come up with the answers to the questions that patients and their families have, so now—finally—I’m growing as an individual. I’m using the critical thinking skills I was taught in school that were stifled after I graduated because of the focus on tasks.”

Hetherington agrees that the collaborative model is extremely powerful. “When I see the model in action, it’s amazing to see nurses having those kinds of conversations with physicians. And the physicians act as mentors and teachers, especially for the less experienced nurses,” she said. “The physician listens to the patient’s lungs, then the nurse does, and they talk about what they’re hearing. The physician doesn’t get those calls in the middle of the night saying, ‘I’m not sure if this is what you heard’—they know; they did the assessment together.”

When Vosters conducted patient discharge interviews during the first few months of the unit’s operation, she wanted to uncover the reasons for the high patient satisfaction levels. The feedback was clear—a different level of communication with caregivers.

“Many of the patients had stayed at our hospital in the past, and they said they had never been treated like this. They said they used to have to go to the doctor with all their questions, but now they could ask the nurse, and she knew what was going on,” she explained.

With the tremendous success of the new care model, the only fly in the ointment would seem to be the amount of cultural change needed to implement it. But Hetherington doesn’t see it that way. “It is a big change, but I don’t think incremental change will get us where we need to go,” she said, referring to the US’s high number of medical errors and rising healthcare costs.

“We have the perfect storm developing: the public is demanding improved clinical quality and reduced costs, and we have declining reimbursement, a shortage of nurses, and an aging population. Developing innovative care delivery models is critical as people seek more value for the dollars they spend. Value equals highest quality at the lowest cost—that’s what people are going to be looking for, and this model delivers it.”

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