

VOICE of nursing leadership

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> JULY 2015 Focus on Nursing and Successful Collaboration

Voice of the President



Linda Burnes Bolton,
DrPH, RN, FAAN,
2015 president, AONE
Board of Directors

This edition of Voice of Nursing Leadership provides excellent examples of our behaviors as partners, innovators, conveners and synthesizers. The authors in this issue address four critical areas for nurse leaders to consider in their quest to engage consumers and health professional partners to shape health care. The key is purposeful collaboration.

Purposeful collaboration is an essential strategy to achieve institutional and societal goals. It begins by engaging individuals and organizations that hold different perspectives to imagine the possibilities of achieving defined outcomes. Leaders seek out those

who provide and consume services to promote creation of shared objectives.

As pointed out in Rita Linnenkamp's article, author Antonie Hiemer describes collaboration as occurring when both sides continue problem solving until they produce solutions that are mutually beneficial and satisfactory to all. Nurse leaders often assume the role of convener, inviting diverse voices to the table with the purpose of co-creating solutions that will benefit the patient. We use our knowledge and ability to make room for others to participate in the design of systems to achieve the Triple Aim: excellence in clinical outcomes, engaged consumers with whom we work to improve their health care experience and the creation of a system of care that provides the right amount of services, at the right time, in an efficient and effective manner.

The implementation of patient- and family-centered care (PFCC) has long proven to be an excellent example of collaboration between health professionals and consumers of health care services. The goal is to create a

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²14 Attributes that exemplify nursing excellence, identified by the American Nurses Credentialing Center, a subsidiary of the American Nurse Association (ANA).



Nursing and Finance: Collaborating for Better Operations

Finance and nursing are often pitted against each other; the two disciplines speak different languages with unique terminology, and are often foreign to each other. Common ground becomes difficult to discover. Julie Holt, RN, MSN, CENP, former vice president of patient services, nursing, and Alma Helpling, vice president of patient services, finance, at Cincinnati Children's Hospital Medical Center chose to bridge this gap by forging a relationship born out of intention. Both began new roles in the organization in January 2014 and spent every day together for two months learning and better understanding each other's worlds. Together, they arranged for sessions partnering clinical department leaders with business directors. Conversations were directed toward patient needs, available fiscal resources and the role of the budget in financial and operational planning. Eventually, the group figured out what it really takes to safely and appropriately care for patients and both Holt and Helpling participated in the dialogue. Together, this group re-examined established direct care hour targets, modifying these targets in light of the care and services that patients actually require (incorporating consideration of patient population and acuity).

Both disciplines used these assumptions:

- The worked-hours standard (nursing hours per patient day) can be fundamentally determined by time motion studies.
- Most organizations have historically determined the worked-hours standard mathematically and then adjusted accordingly, based on historical experience, using an assumed patient census.
- On paper, the patient volume multiplied by direct care hour targets is equal to the full-time equivalent (FTE) required.

Consequently, much time was spent working with clinical, administrative and physician leaders to understand historical census patterns, population trends, medical practice changes, technology advances, etc. to refine the prediction of an average daily census (ADC) by unit. Both of these "deep dive" reviews into the worked hours and ADC predictions allowed the group to more thoroughly validate key budget and staff planning assumptions, a process that is essential to financial and operational planning, particularly in light of the trajectory of change in the health care today.

National trends call for collaboration

America's health care system, which accounted for approximately 17 percent of GDP in 2012, is operating at a cost that is widely perceived as unsustainable (Mangan, 2014).

As an industry, health care is under intense pressure from private and government payers, patients and families, all of whom are

seeking options that provide higher quality care and better patient experiences at less cost. In short, all are demanding more value. One way to reduce the cost of health care is to reduce the utilization of services or modify the mix of service utilization to a less expensive model of care (i.e., trend toward outpatient surgeries). Another way to reduce the cost of health care is to reduce the cost of providing care—permitting the pass-through of efficiencies realized back to patients and payers via the pricing of services. Nursing and financial managers, working collaboratively, can impact the cost of providing care by applying both operational and financial awareness to daily decision-making. Leaders at Cincinnati Children's recognize it is difficult to purposefully influence that which is not understood. Understanding the cost of care on a unit level is an important foundational element to delivering the highest quality of care in a sustainable and cost effective way. Assigning nursing and financial managers the task of preparing a zero-based budget may facilitate that joint understanding.

Role of budgeting in nursing

A budget is an organization's financial roadmap, linking the organization's long-term strategy and shorter-term operational goals to a detailed financial plan. Budgets may be prepared annually or with some other (rolling) frequency; they lay out the expected financial results (revenues, expenses, cash flow, etc.), given a set of operational goals and industry, environmental and market assumptions.

Zero-based budgeting refers to the level of granularity in the budget build. In zero-based budgeting, every item in the budget is substantiated and re-evaluated from a baseline of zero dollars. Zero-based budgeting is designed to ensure a more efficient allocation of resources, as funding of budgeted line items is based on vetted needs rather than history. The discipline and thoroughness of zero-based budgeting techniques generally increases communication, coordination and understanding of budgets, particularly by clinical managers. When zero-based budgeting techniques are used, for example, the budgeted patient census (volume, mix and acuity) for a particular unit is modeled and clearly articulated. Below are the activities clinical managers completed using a zero-based budgeting approach for inpatient units:

- With the assumed census levels, mix and acuity, clinical managers were asked to evaluate the level and complement of resources needed each day and each shift.
- Clinical managers completed staffing grids laying out the resources, at an assumed census compliment, by shift.

- Financial managers, working side by side, then “priced out” the staffing grids and calculated the worked hours per patient days (WHPPD) represented by the completed grids.
- Calculated WHPPD was then compared to national benchmarks, on a unit-by-unit basis. Variances were investigated and assessed by clinical leaders.
- In some cases, purposeful, intentional rationale existed for our WHPPD variance from the benchmark data. In other cases, the variances pointed to opportunities to re-examine and tweak our budgeted staffing complement.

Following the conclusion of this budget process, clinical and financial managers:

- created/verified the budgeted WHPPD by unit from zero;
- understood how the budgeted WHPPD compared to national benchmarks;
- understood and could visualize how the budgeted WHPPD correlated into a unit staffing schedule (at an assumed census point);
- had confidence that the WHPPD they had agreed to would be fully budgeted.

Monitoring actual vs. budgeted plans

When the new fiscal year opened July 1, 2014, the focus switched from budgeted to actual WHPPD run rates. Six-week staff schedules were prepared and entered into our scheduling system on the basis of the budgeted WHPPD; automated “soft” messaging (as opposed to a hard stop) was triggered if scheduled WHPPD exceeded budget at identified census points. Each pay period, reports compared actual WHPPD by unit to budgeted WHPPD. Financial and clinical managers partnered to analyze, understand and document underlying causes and action plans for variances. Results were monitored and communicated monthly to the chief nursing officer and chief financial officer. Within a few pay periods, some trends in WHPPD run rates began to emerge. Two Rapid Cycle Improvement Teams, which included both clinical and financial managers, were formed to pursue targeted opportunities on a granular (unit) level and a systemic level. Improvement initiatives implemented included:

- educating clinical managers on a new WHPPD calculator tool to use in shift/shift staffing decisions
- revisions to a 1:1 direct observation policy and strategies to safely accomplish patient surveillance in alternative ways, in specified circumstances

The results of these initiatives produced positive financial results—meeting productivity targets—on four pilot units and are in the process of being spread to other inpatient units.

To ensure the implications to patient safety risk that might be presented by the staffing decisions that are being made on a shift-by-shift basis using the WHPPD calculator tool and the revised

direct observation policy, staff developed a tool to monitor unit/system stress indicators. This tool, which creates a microsystem stress indicator report, allows staff to initiate early intervention and risk mitigation, based on targeted measurements correlated to unit/system stress.

Ensuring safety when census varies

It is important to talk openly at all levels of an organization about the role of budgeting in efficient health care. In order to best implement and meet a budget, the budget process needs to be tied to actual scheduling and staffing practice. Using staffing grids is a safety net which assures there is adequate, safe staffing because clinicians often visually verify they have enough nurses to deliver care. When clinical managers worked together to learn how to create staffing grids, they were asked this question: Knowing your unit’s average daily census, how many nurses do you need to adequately staff it? Many clinical managers had a moment of enlightenment when they realized they had a lot of nurses on their units. It became incredibly clear to them that scheduling and staffing are the operationalization of the budget, and the staffing grid became the double check that the correct resources were allocated on each unit.

It is also important to be able to accommodate for variation in patient volume and nursing hours per patient days. One of the greatest challenges faced by clinical and finance partners is dealing with volume fluctuation. Average Daily Census (ADC) can change by 50 or more patients in a large hospital in a 24-hour period. To accommodate, a float pool was enhanced so that worked-hour standards could be maintained. Helping and Holt worked closely with the RN float pool leader to determine the appropriate way to right-size the Cincinnati Children’s float pool. Float pools and resource teams allow organizations to deal with fluctuations without paying expensive overtime to exhausted staff, decrease the need for expensive agency nurses not integrated into organizational cultures and policy, and allow for flexibility in the distribution or location of skilled nurses (Mendez de Leon & Stroot, 2013). The 2003 Institute of Medicine report *Keeping Patients Safe: Transforming the Work Environment of Nurses* recommended the use of internal resource teams, as did a 2006 Advisory Board report.

Collaborative benefits

Clinical managers now have a deeper understanding of their budgeted FTE complement, as well as their projected/budgeted patient census. They can speak with more knowledge and confidence about their budgeted nursing hours and how their budgets compare to national counterparts. These clinical managers have a greater understanding of the impact that daily decisions have on productivity results. On a shift-by-shift basis, they can increase the allocation of resources when the patient population demands it, but also are able to rebalance and

reduce resource allocation when the opportunity presents itself. The financial managers involved have a deeper understanding of how operating needs correlate with FTEs and budgeted salary dollars. With zero-based budgeting, they can more thoughtfully address where true cost reduction opportunities exist and where they do not. Working more broadly in the system budgets, financial managers can be instrumental in identifying areas where resource reallocation may be appropriate. When unit-based initiatives are considered or patient populations change, nurse managers can readily estimate the impact on the FTE complement.

In addition, a deeper relationship and trust was created between financial and clinical leaders, with both understanding how decision-making impacts operational and financial results. Goals are shared between clinical and financial managers to ensure continuing balance and foster the organization's success. Working together, finance and nursing have created a collaborative model of excellence that has not only bridged a gap in knowledge, but has ventured into uncharted territory. Counterparts from both disciplines are learning each other's language to partner in improved staffing, efficiency and experience to the organization. Ultimately though, the true benefactors are patients and their families who experience improved care, delivered as a result of the combined insight from nursing and financial managers.

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Nurse Leader Organizations Begin New Affiliate Agreements with AONE

Congratulations to the following affiliate organizations that have aligned with AONE under a new affiliation agreement. Each state/regional affiliate will continue to operate independently of AONE, although it will be aligned to support nurse leaders from both a national and local level. Leaders from the affiliates meet twice a year with the leaders of AONE to share best practices, discuss critical nursing issues and learn about key AONE priorities.

Alabama Organization of Nurse Executives
Association of California Nurse Leaders
Colorado Organization of Nurse Leaders
Delaware Organization of Nurse Leaders
Illinois Organization of Nurse Leaders
Indiana Organization of Nurse Executives
Iowa Organization of Nurse Leaders
Kentucky Organization of Nurse Leaders
Louisiana Organization of Nurse Executives
Michigan Organization of Nurse Executives
Minnesota Organization of Leaders in Nursing
Missouri Organization of Nurse Leaders
New York Organization of Nurse Executives and Leaders

North Carolina Organization of Nurse Leaders
Nurse Leaders of Idaho
NWone (serving Oregon and Washington)
Ohio Organization of Nurse Executives
OMNE: Nurse Leaders of Maine
Organization of Nurse Executives New Jersey
Organization of Nurse Leaders of Massachusetts & Rhode Island
Pennsylvania Organization of Nurse Leaders
South Carolina Organization of Nurse Leaders
Texas Organization of Nurse Leaders
Utah Organization of Nurse Leaders
Virginia Organization of Nurse Executives and Leaders
Wisconsin Organization of Nurse Executives

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Creating New Tools Through Collaboration: Using Informatics to Improve Nurse Leader Rounding

Increased focus on patient experience in the acute care setting, coupled with growing demand for outcomes data, creates both opportunity and challenges for a nurse leader. Information technology offers enormous options to track the results of care processes initiated at the bedside. The challenge is to find systems that work for professionals who are rarely seated at a computer. These systems should enhance rather than inhibit patient interaction and give nurse leaders real-time information to support both patients and bedside nurses. Looking at systems through the lens of another discipline can result in a unique perspective and novel approaches. One such approach is a collaborative effort with a physician informaticist that improved nurse leader rounding by leveraging the technology of an iPad application.

Implementing evidence-based strategies to enhance inpatient hospital experience is a priority for acute care organizations. Two measures noted to improve inpatient satisfaction include discharge phone calls and nurse leader rounding (Setia & Meade, 2009). Both of these tactics were adopted at my organization, Medstar Washington Hospital Center; bedside nurses learned to contact and converse with patients following their hospital discharge and nurse leaders received education on conducting inpatient rounds. These rounds included manually recording patient responses in a spiral notebook or pad of paper and entering these responses into a Microsoft Excel workbook. This workbook was then used to track and trend patient issues and resolutions to these issues, as well as share this information with bedside nurses and senior nurse leaders.

As a nursing director of a 21-bed advanced heart failure unit, the benefits associated with nurse leader rounding were evident to me. As many of our patients' care was complex and required a hospital stay approaching five or six days, our patients became familiar to our nursing team and in turn, our team was able to anticipate and accommodate many personal preferences. Conducting nurse leader rounding and keeping diligent notes was generally straightforward and uncomplicated.

When promoted to a senior nursing director position with oversight for 12 medical-surgical units, it became clear to me that my nurse leader rounding experience as a unit director was dissimilar from that of other nurse leaders. A vast array of diagnoses and clinical regimens were prescribed for patients on these 12 units; their clinical and emotional needs were diverse and complicated, and they were discharged from the hospital following shorter hospital stays. Nurse leader rounding was challenging, as manually recording and entering notes into an Excel spreadsheet was cumbersome and inefficient. Managing

this process became a task in itself and there was little opportunity to review the data. Discovering an electronic solution to nurse leader rounding became of paramount importance.

While serving on our hospital's interdisciplinary patient experience committee, I had the great fortune of working with an extraordinary colleague who was both an attending physician in our active emergency department, as well as a clinical informaticist and software developer in our health system's institute for innovation. My physician colleague, who collaborates with clinicians to create novel software, had previously consulted with our nursing leadership team to create a software program that enhanced our discharge telephone call practices. After reviewing our current means of documenting nurse leader rounding in a spreadsheet, he readily agreed to pursue an electronic solution with us.

We determined that the most promising system would include a portable, handheld device that nurse leaders could use during rounding. The Apple iPad was well known and liked by many nurse leaders; my colleague believed he could create a program that would use this device to capture key data elements of nurse leader rounding. With the support of our chief nursing executive, five iPads were purchased, the software application created was downloaded on the devices and five nurse leaders from medical-surgical inpatient units were selected for a pilot.

The collaboration among the nurse leaders on the pilot units and our physician developer was ongoing and intensive. During weekly meetings which began in October 2012, the group discussed elements of the project that were working well and what components needed adjustment. The involved nursing directors posed numerous questions, asked for additional data options and suggested revisions, such as adding drop-down menus to accommodate multiple patient responses instead of free text data entry. The pilot team reviewed results, described the most desirable formatting, reflected on emerging possibilities and hurdles, and made recommendations for reporting and other enhancements. As the enhancements were incorporated into the software, it was clear the nurse leaders were more than ready to adopt the iPad technology, particularly as the process became more intuitive and streamlined. This readiness also sprung from the fact that nurses had contributed to the software's development and they had a stake in its success.

After the four-month trial of modifying and enhancing the application, the benefits of using iPads to conduct nurse leader rounding became well-recognized and universally appealing. Again with the support of our chief nurse executive and our

physician developer, eRounding, as it became known, was extended to inpatient nursing leaders throughout our hospital. The wider use of eRounding by the full complement of nurse leaders engendered more questions and more refinements. One refinement included a messaging system to other departments. For example, if a patient informed a rounding nurse leader that a meal did not contain the anticipated food items, when the nurse leader recorded this event in the eRounding tool, an immediate message could be dispatched to nutrition services for resolution.

An expanded team of nursing and corporate developers continues to refine aspects of the program, which has now been deployed to nine other acute care hospitals in our system, the first of which went live in May 2014. The challenge lies in building capabilities to visualize results and to better understand our patients' experiences. The collaboration involved in building new

technology tools is an important evolution for nursing leadership. In this example, collaborating with a discipline outside of nursing created the synergy needed to move us in new directions with useful patient- and nursing-centric tools.

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AONE Foundation Emerging Nurse Leader Institute – Sept. 9-11, Indianapolis

During the three-day interactive program, attendees will explore the basics of budgeting, quality and patient safety, conflict management and the tools necessary to make the transition to nursing leader. The ENLI program is intended for staff nurses, charge nurses and nurse coordinators looking to advance their careers. Visit the www.aone.org/enli and register today!

AONE Foundation Nurse Manager Institute – Nov. 3-5, Pittsburgh, Pa.

One of the core concepts of the NMI is appreciative inquiry. Participants explore their leadership potential while focusing on their strengths, and then learn to leverage these methods in their day-to-day practice. Skills such as understanding the basics of budgeting, conflict management, quality and patient safety, and their roles in the future of nursing are developed and are immediately applicable to daily work. Learn more at www.aone.org/nmi.

Managing Health Care Delivery at Harvard Business School

AONE is partnering with Harvard Business School for the 2015-2016 Managing Health Care Delivery (MHCD) program. This intensive learning experience is geared toward health care executives and deepens their understanding of organizational effectiveness. The strong international participation at MHCD offers a unique opportunity to understand health care and health care leadership through a global lens. The application deadline is Aug. 15. Learn more at www.aone.org/hbs.

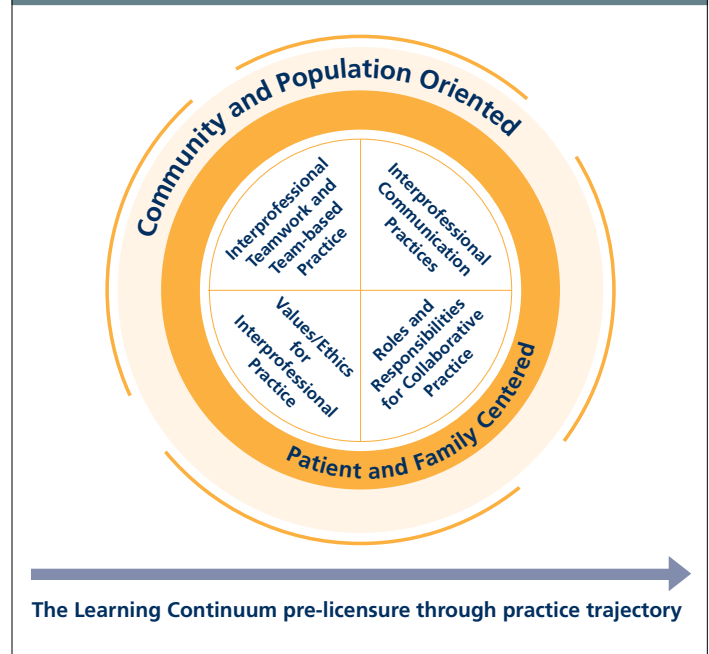
Collaboration in the Classroom: Nursing and Engineering Students Redesign Care Systems

This is an exciting time to be a nurse! The Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* highlighted the vital role nurses play in health care and recommended actions that are needed in order to effectively meet our nation's health care needs. As a clinical nurse specialist and nurse educator, I was especially pleased to see the recommendation that nurses should be full partners in redesigning health care in the United States. The authors recommend that nurses take responsibility for monitoring the quality of care provided in the care environment (microsystem), and lead teams charged with designing health care delivery systems. In order to do this, nurses need to know how to assess microsystems, diagnose problems, and plan, implement and evaluate any improvements. These are important leadership skills that should be taught in every professional nursing program, but that is often easier said than done. The Montana State University-Bozeman College of Nursing has approached this curricular challenge in an innovative way by developing a graduate course (Design of Healthcare Delivery Systems) with the College of Engineering.

Rationale for course development

The industrial systems engineer (ISE) has significant knowledge and expertise in improving quality and safety in complex, high-risk systems (e.g., aviation, nuclear power). They are eager to do the same in health care. This course appeals to both engineering and nursing students for similar but different reasons. The ISE graduate student wants to learn about the health care delivery system (structures, processes and outcomes) in order to use engineering tools to plan, implement and evaluate any improvements. The engineers are eager to work with the nurses because, in their words, the nurse is the “operator” of the health care delivery system. In the engineering world, the operators play a key role in ensuring quality and safety because they are actively engaged in the work being done in the system. They want to team up with nurses to plan improvements. The graduate nursing students (clinical nurse leader and doctorate of nursing practice candidates), know quite a bit about the role of nursing in the current health care delivery environment. But they want to learn how to work with an ISE and understand how to use engineering tools to assess the system to identify problems, plan and implement any improvements. In the process, both types of students also learn a little more about their own profession.

Figure 1: Interprofessional Competency Domains



Source: Core Competencies for Interprofessional Practice, May 2011.

Preparing for collaboration

It has been exciting to see these students interact and learn how to work together. They begin the course by examining current issues in health care that are driving the need for redesign. Then they explore the roles that each of them play in health care and the core competencies of interprofessional education (IPE). These competencies were developed by the Interprofessional Education Collaborative (IPEC) Expert Panel to inform IPE curricular development (IPEC Expert Panel, 2011). The intention of IPE is to ensure that graduates of health professions programs have the skills to engage in collaborative practice with the other professions. The IPE competencies have been categorized into four domains (see Figure 1). The first focuses on the development of trust and respect of each profession (values/ethics). The second is being able to understand other roles and how each contributes to safe, patient-centered care (roles/responsibilities). Interprofessional communication is the third domain, which includes the ability to indicate readiness to work together and communicate respectfully with each other. The last domain (teamwork/teams) describes the ability to be an effective team member.

IPE occurs when students from two or more professions learn about, from and with each other to improve a patient's health (World Health Organization, 2010). The best way to develop the IPE competencies is for students to work collaboratively on a project. In this course, this is accomplished by having the students work together to assess a microsystem, identify problems and plan improvements. We have incorporated elements of the Dartmouth Microsystem Improvement Curriculum to guide the process that can lead to the development of an improvement proposal (Nelson, Batalden & Godfrey, 2007; Nelson, Batalden, Godfrey & Lazar, 2011).

Course assignments provide collaboration setting

The course assignments are designed to provide students with opportunities to practice nurse and engineer collaboration. For example, during the assessment of the microsystem, the students are expected to create high-level flowcharts depicting the flow of patients through the microsystem. The nurse teams up with an engineer and describes the patient flow. The engineer then creates the flow chart based on the nurse information. This exercise is a great ice-breaker, as it requires the nurse to communicate effectively so that the flowchart reflects the process accurately. The exercise also gives them both an opportunity to teach the other about their profession. Often the nurse will not know where to start, and the engineer takes the lead by explaining how and why a flow chart is developed and asking questions that can help the nurse identify the key steps in the selected process. When an engineer has difficulty with medical terminology or has questions about why things are done a certain way, the nurse takes the lead by explaining the terminology or the rationale for a process. The feedback from the students has always been very positive after this exercise; they note that they have learned a lot about each other and their own professions. Once the process is displayed in a flow chart, they both can begin to see ways that it could be improved.

The students also collaborate on the analysis and visualization of the assessment data. After a comprehensive review of the methods and metrics used to monitor the quality of care, they begin to see how they can work together. The engineers provide expertise in analyzing and displaying the data while the nurses provide expertise in interpreting the clinical implications of the data. These different and complementary types of expertise were revealed when we were teaching the students how to recognize common cause or special cause variation in a run chart (display of data over time). The example we used was a chart displaying a patient's daily blood sugar readings over a 30-day period. The engineering students, who know how to create run charts and recognize patterns of variation in data, had no trouble recognizing common cause variation in this particular data set. This meant

that there were no special causes creating the variation, that this variation was common for this patient. But the mean (average) blood sugar value that was also noted on the run chart was not meaningful to them. It was the nurses who expressed concern that the mean blood sugar (150mg/DL) was above normal, indicating the need for further assessment and possible treatment changes to bring the mean closer to the normal range. This was a powerful example of how important it is for nurses and engineers to collaborate when analyzing, visualizing and interpreting health care quality data.

If the course enrollment is small and there is the potential for 1:1 ratio of engineers to nurses, we have the students identify a theme for improvement (safety, timeliness, effectiveness, patient-centered care, efficacy, access), and develop aims (general and specific) that guide the improvement process. They collaborate closely on the development of the aims, which includes defining the beginning and end of the process targeted for improvement, rationale for targeting the process (why it is important to do this now) and the expected outcomes (measurable goals). Once the aims are developed, they engage in a root-cause analysis (RCA) of the problem. The RCA is an exercise that gives students an opportunity to apply this important engineering tool in a health care setting. Once the root causes are identified and displayed in a fishbone analysis, the students brainstorm potential solutions and select an improvement. The final phase of the activity is to develop an improvement proposal that includes implementation and evaluation plans.

Course projects bring improvement

The work that has been accomplished in this course is impressive. Here is a partial list of student projects:

- reducing operating room turnaround times in a community hospital;
- evaluating the effectiveness of a group prenatal education model in a primary care clinic;
- standardizing the renal transplant screening process in a health care system;
- enhancing workflow in a cancer treatment center;
- reducing risk of readmission for heart failure treatment in a community hospital;
- evaluating the effectiveness of group education of persons living with an implantable defibrillator device;
- standardizing the care management of diabetic patients in a primary care clinic;
- reducing bar code medication administration workarounds in a community hospital;
- reducing wait times in an outpatient laboratory;
- improving compliance with patient rounding policy.

Challenges remain

I would be remiss to not note the challenges in developing and implementing this course. The biggest one is that the nursing program is entirely online and the engineering program is delivered in a traditional classroom. This type of education would be even more effective if the students were in the same location allowing the engineering students to observe processes in the settings where nurses work. Despite the challenges, the feedback from the students has been positive. The following statements are typical comments from students reflecting on their experience:

When exposed to new ways of thinking, challenges will arise. One of the challenges that I faced was having to explain myself thoroughly to others. It is easy to be a nurse and explain nursing things to each other with limited detail. But, when asked “why that way?” or “what do you mean by that?” it really makes you step back and look at the whole situation and ask yourself questions you have never thought about. Often this reflection can reveal a problem or a solution that otherwise would have been missed. This challenge turned into a great lesson learned. Having the opportunity to look at the health care delivery system through the eyes of an engineer will change the way I practice for the rest of my career.
– nursing student

This semester has definitely been a learning experience, with a greater focus on an interdisciplinary teamwork than I have ever had before...several lessons were learned about interprofessional collaboration/teamwork...the importance of patience and clear explanation of terminology...a relationship where either of us felt comfortable asking questions—a respectful environment...to be overly clear in communication, both in expectations and in general discussion of topics.
– engineering student

It has been an honor to be able to work with these students and witness the development of interprofessional practice competencies in the classroom. It has also been very enjoyable to learn about systems engineering and work with engineering faculty to develop and implement this course. In many ways, the relationships that developed between the nursing and engineering faculty mirrored the ones developing between the students. In

closing, I encourage you to explore ways to promote nurse and engineer collaboration in your own setting—the insights gained are well worth the effort!

Acknowledgements

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Creating the 'Power of 2': Collaborating with Patients and Families to Improve Care

The word collaboration conjures vision of smiles, satisfied nods, handshakes and back slaps. So I was recently surprised to read that collaboration is not the go-to problem solving style for nurses. In fact, according to a study by Valentine (2001), collaboration does not even make the top three. As I continued to study collaboration, I ran across an apt definition from Hiemer (2007), who describes collaboration as existing when both parties continue problem solving until they produce resolutions that are mutually beneficial and satisfactory. Time and commitment are the key ingredients.

Collaboration can be challenging to achieve in the health care setting with among professionals. Add the patient and family, and the challenge increases, but so do the benefits. No one argues with the concept that patient-centered care is best practice. We are just not always sure what it looks like.

One of the core concepts of patient- and family-centered care (PFCC) is collaboration, which is defined by the Institute for Patient- and Family-Centered Care as:

Patients, families, health care practitioners, and leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Other viewpoints needed

One way to collaborate with patients is by partnering with patient and family advisors across the organization, including the use of Patient and Family Advisory Councils (PFACs). Our work with advisors began with a need, a special project. We decided to create an advisor program, but we were having trouble getting started. We saw an opportunity to jumpstart our program when Sherry Perkins, PhD, RN, NEA-BC, chief operating officer and chief nursing officer previewed proposed signage for a new tower. With the help of the patient advocacy department, we assembled eight patient/family advisors and staff members. The first meeting of this Wayfinding Workgroup was energizing and inspiring. The advisors were engaged, excited and had ideas and perspectives that we had not considered. This group met four times during which we explored what they wanted from signage and the proposed sign for the new tower. For the last meeting, the advisors shared their recommendations with senior leadership. A few months later, we launched our PFAC from the success of the Wayfinding Workgroup. We used this core group of advisors as the founding members. Following are two examples from our organization of this partnership with patient and family advisors.



Sherry Perkins, PhD, RN, NEA-BC, chief operating officer and chief nursing officer, Anne Arundel Medical Center, with Chuck Roydhouse, a patient/family advisor.

Peer-to-peer support

One of the roles of our PFAC is to give input and recommendations on our annual PFCC goals. One advisor on the PFAC, Judy, is a stroke survivor and her passion was to develop a peer-to-peer support program. She was already part of the stroke support group but was passionate that the peer-to-peer support would be an additional benefit to stroke patients. Over the course of many months, every time we talked about the potential PFCC goals for the next year, Judy raised her hand, recommending peer-to-peer support. Based on her recommendation, this became one of the medical center's two PFCC 2014 goals.

After being approved by the Board of Trustees, a team of advisors and staff began making Judy's idea a reality. Working with an existing peer-based support program in our Breast Center, the team developed and implemented the Power of 2 Stroke Mentor Program. Mentors are identified by staff through observing the support group and rehabilitation. If a patient is interested in being a mentor, he or she completes an application, interview and orientation. Patients who would like to have a mentor are also identified by staff in the inpatient area, support group and rehabilitation programs. Mentors are introduced to their mentees at the end of a rehabilitation session; then the pair arranges further meetings that suit their schedules and needs. Follow-up is provided to make sure the match is appropriate.

Working out the details and the needed resources has taken some time. Most recently, using the Lean methodology, 12 staff and advisors are working to expand the existing program to patients with other diseases or conditions. Judy reported at a recent PFAC meeting how thrilled she is with this partnership. Staff members at the meeting thanked her for consistently bringing her idea forward, an idea that the staff had not originally considered.

The first mentee of the program shared that the emotional support she received through the Power of 2 program was just as valuable to her as the medical care. Collaboration with patients and families is truly a win-win. We are now providing a service that reaches the stroke patient in a way the health care team cannot. Currently, the program consists of 10 mentors and has supported 10 mentees.

Other initiatives

The small projects are as important as the large ones. In May of 2014, during National Nurses Week the PFAC set up a table to engage and educate staff on PFCC. At that time, our organization had a big emphasis on bedside shift reports, so the PFCC coordinator brought this subject to the advisors. The advisors came up with the theme “Include Me.” One of our advisors, Chuck, lay in a stretcher in a hospital gown during the Nurses Week Fair and stopped staff members as they passed him. “Don’t you think I should be included in shift report? I do. It is about me, right?” This message made an impact on the staff—and again, this was an idea that came from our patient and family advisors.

Working to get it right

Perhaps the biggest challenge lies in creating a good match between the advisor and the work group or committee. This requires a staff member who knows the advisors and understands the needs of the work group or committee. Our PFCC coordinator, Jeanne Morris, BSN, RN, reads each advisor application, then interviews and orients each advisor. She then has a good feel for how that individual will operate as an advisor. Some advisors work best reviewing material electronically from home, while others are a good fit on high-level organizational committees.

Another challenge is staff understanding the role of advisors and how to incorporate them into meetings. We have written resources to help staff members prepare their work group or committee. In addition, Jeanne is available to provide guidance. The advisors are there to give insight and perspective from the patient and family point of view and not to critique the health care team. When both the staff and advisors understand this, then there is a meaningful exchange of information and collaboration that produces positive results. An advisor in the critical care unit, Pat, helped the staff take an information packet and make it more welcoming, friendly and useful for patients and families. The content changed little but Pat worked with the staff on the tone of the message and the presentation.

We have committed ourselves to the hard work needed to build and develop the structures and processes for true collaboration with patients and families; the outcomes speak for themselves.

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Circle of Life Award Applications Sought

Nomination forms for the 2016 Circle of Life Award are now available www.aha.org/circleoflife. The award, administered by the Health Research and Educational Trust, honors innovative programs in palliative and end-of-life care. Organizations that have submitted or previewed the application in the past are encouraged to review the newly revised application. Questions and data requests have been refined and significantly streamlined. For questions on the award or the application, please email circleoflife@aha.org. Applications are due Aug. 10, 2015.

Academic/Practice Partnership Exemplars Presented at Conference

Academic/practice partnerships are a vital component of successful health care reform, including implementation of the Institute of Medicine (IOM) recommendations outlined in *The Future of Nursing: Leading Change, Advancing Health*. Through these partnerships, nurses are positioned to ensure that an effective, efficient and accessible health care system is realized. According to the American Association of Colleges of Nursing (AACN)-AONE Academic/Practice Partnerships Guiding Principles, "...academic/practice partnership is a mechanism for advancing nursing practice to improve the health of the public. Such intentional and formalized relationships rely on mutual goals, respect and shared knowledge. An academic-practice partnership is developed between a nursing education program and a care setting. Such relationships are defined broadly and may include partnerships within nursing, and other professions, corporations, government entities, and foundations."

To demonstrate exemplars in academic/practice partnership, the Academic Progression in Nursing (APIN) National Program Office, APIN grantees and partners presented pre-conference and concurrent sessions at the Western Institutes of Nursing 48th Annual Conference in Albuquerque, N. M., April 22-25, 2015. The partnerships explored what academia and practice can do together to help achieve a greater baccalaureate-educated nursing workforce. A three-hour pre-conference entitled "Useful Models & Strategies to Promote Academic Progression in Nursing" was offered to conference attendees on the first evening of the event. Eight representatives from western APIN grantee states presented to a packed room on academic progression innovations and the academic/practice partnerships supporting this transformation.

New Mexico presenters showcased their partnership, which is grounded in statewide concept-based curriculum at both the associate degree in nursing (ADN) and BSN levels. With increasing pressure to fit more nursing content into curricula, coupled with regulatory pressure to reduce the number of credits required for a nursing degree, the New Mexico Nursing Education Consortium (NMNEC) embraced a concept-based framework to optimize student outcomes and experiences. NMNEC students are taught key exemplars from across the domains of nursing education, allowing them to think critically about patterns of health and illness in patients across the continuum of care. Exemplars (disease/disorders) of the concepts are selected for the curriculum based on prevalence, with particular attention paid to the disease prevalence and health needs of New Mexicans.

"Educators can't prepare the nurse of the future in a vacuum," said Judy Liesveld, PhD, PPCNP-BC, RN, associate professor of nursing and APIN project director at the University of New Mexico. "Employers and educators across New Mexico collectively identified the need for highly educated nurses prepared to meet the specific health and wellness needs of our state's citizens. Together we are now working in partnership to implement the concept-based curriculum to better meet this need."

"Employers across care settings in New Mexico are also asking for more baccalaureate-prepared nurses, to enhance quality and safety outcomes and fill important care roles in all care settings," added Diane Evans-Prior, DNP(c), RN, academic affairs director of nursing at Central New Mexico Community College. "To help meet this demand, NMNEC has implemented a BSN track that is available at many community colleges with nursing programs in the state. Students can take university courses within their home community and graduate with a BSN conferred by one of New Mexico's two public universities. Student demand for this option is high, and our practice partners are eager to have more BSNs without expecting people to relocate."

"New Mexico's approach represents what is being referred to nationally as the Emerging Model," noted Mary Dickow, MPA, FAAN, statewide director of the California Action Coalition. "Students in this model sit for the NCLEX after receiving their ADN and BSN degrees—which are conferred simultaneously." Dickow added, "This approach could have significant impact on the percentage of the workforce practicing with a baccalaureate degree or higher. A similar regional shared curriculum model in California sees up to 90 percent of students immediately progress through the BSN track and not opt out at the ADN to begin licensed practice. Students need more of these options across the nation in order to reach the IOM's recommendation of an 80 percent baccalaureate-prepared nursing workforce."

In another session, APIN partners from Washington state described the launch of a university-based RN-BSN program in the isolated community of Bellingham. Spearheading this partnership were presenters Casey Shillam, PhD, RN-BC, the program's director at Western Washington University (WWU), and Kelly Espinoza, MSN, RN, CNO for PeaceHealth St. Joseph Medical Center. Both the university and the medical center are in Bellingham.

"The Bellingham area was in urgent need of a BSN program," said Espinoza. "Recruiting BSN nurses from outside the community is very difficult, and it became clear that we needed to grow our

own baccalaureate nurses in order to ensure patients have access to the best care possible.” For that reason, PeaceHealth St. Joseph works with WWU to secure faculty and instructors for classes, as well as offering diverse and necessary opportunities for clinical components of the program. Espinoza’s staff RNs enrolled in the WWU program also have flexible scheduling options to ensure that they are available for class time and clinical experiences. Annual tuition support and a pay differential for staff nurses who have a BSN also are offered. “The Bellingham community understands the importance of having more baccalaureate-prepared nurses. Foundation and community donors are helping us to grow an endowment that will help fund nurses in pursuing BSN and higher degrees.” Espinoza adds. “We are very excited to be offering the first scholarships in fall 2015.”

“The partnership between our institutions ensures that we can continue to align academia and practice to meet the needs of our community,” says Shillam. “WWU students also benefit tremendously from the partnership with St. Joseph. Many of our students conduct research and hone their baccalaureate competencies at the facility, frequently going on to employment there. The students are empowered by the ability to see the outcomes of their research through evidence-based practice in their own community.”

“Academic/practice partnerships build trust and efficiency between different institutions that are too often siloed,” says Mary Baroni, PhD, RN, of the University of Washington Bothell and co-director of the Washington state APIN grant. “This

model partnership between WWU and St. Joseph assures that academic progression will be sustainable in this community. Support for the APIN work will continue to grow in areas like this, where nurses are leading with one voice and putting the needs of their community first.”

For more information on academic/practice partnerships, please see the AACN-AONE Academic/Practice Partnerships Guiding Principles found on the AONE website at www.aone.org/resources/principles.shtml.

Academic Progression in Nursing (APIN) collaborates with state Action Coalitions and their partners to accelerate implementation of promising practices that will help states achieve our goals of seamless academic progression and increasing the number of nurses with a baccalaureate degree to 80 percent of the nursing workforce by 2020. Developing innovative strategies with community colleges, universities and practice partners will ensure that the nursing workforce is prepared to deliver high quality patient care across all practice settings. APIN is a grant initiative of the Robert Wood Johnson Foundation in partnership with the Tri-Council for Nursing and administered by the American Organization of Nurse Executives (AONE).

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Certified Nurse Manager and Leader (CNML) Essentials Review Course – Aug. 14, Marietta, Ga.

The CNML Essentials Review Course is a one-day course that assists participants in preparing for the CNML exam by delving into the four tested practice areas covered on the exam. Participants of the course will also have the opportunity to purchase the supplemental certification preparation Self-Assessment Exam at a discounted rate. Sign up today at www.aone.org/cnml.

Certified in Executive Nursing Practice (CENP) Essentials Review Course – Aug. 28, Marietta, Ga.

The CENP Essentials Review Course is a one-day course that assists participants in preparing for the CENP exam through a review of the AONE Nurse Executive Competencies and practical application of the competencies. This is intended to be an opportunity to integrate concepts with experience, honing your critical thinking abilities in preparation for the exam. View course information at www.aone.org/cenp.

forum where patients are equal partners with health professionals in the design and evaluation of health care services that meet the unique needs of different populations. PFCC builds on our core values of diversity and inclusivity to improve the likelihood that consumers will benefit from the services we provide.

Linda Torma describes an academic initiative to engage both nurses and industrial engineers. Similar to the way of working that emerged from the Technology Drill Down (TDD) and Transforming Care at the Bedside (TCAB) projects, the aim is to achieve co-created designs by nursing and engineering professionals that improve the ability of the health workforce to provide safe and efficient care. The launching of interprofessional collaborative expert panels as described by Torma expands the knowledge gained from the study of interprofessional collaboration from TDD and TCAB projects, following recommendations from two Institute of Medicine studies: *Improving Health Professional Continuing Education* and *The Future of Nursing: Leading Change, Advancing Health*. Both strongly endorsed the need for interprofessional collaboration to improve health and health care in the United States.

In another collaboration example, Ariam Yitbarek presents a compelling case for the engagement of a physician informaticist in efforts to improve the efficacy of leader rounding. Technology-enabled rounding as described in this article utilizes an iPad to capture real-time patient feedback for nurse leaders on rounds. The ability to send pertinent information to members of the team regarding the patient experience provides an opportunity to intervene, provide service recovery and positively influence the patient's experience.

Finally, Julie Holt, Lori Puthoff and Alma Helping describe an effective operational system to simultaneously provide resources to meet patient needs based on mutually agreed upon metrics between finance and nursing, while at the same time delivering value. Reaching consensus on the term "value" by the chief nursing and financial officers is a critical step in the quest to achieve the organization's mission.

An orchestra is a metaphor for purposeful collaboration. Each member of the ensemble plays their instrument while simultaneously listening and responding to the music emanating from other members of the orchestra. The conductor directs

individuals and sections of the team to achieve desired sounds, beats that become stronger or silent in response the conductor's movement of the baton. The members are keenly aware and work in unison to produce an outcome that they and the audience appreciate as beautiful music. Playing without direction is not as impactful as when the members of the orchestra perform in unison. The same is true in health care. The outcomes of purposeful collaboration are more beneficial for patients and the organization than the outcomes from a single discipline.

Nurse leaders often assume the role of conductor when they practice and promote the collaboration between members of the care team, patients and the communities they serve. The leader calls upon each member to do his or her very best as an individual contributor and as a member of the team. You have all used purposeful collaboration to improve quality and efficiency in your organization. Think about the number of lives we have saved by launching rapid response and cardiac arrest teams. We have deployed nurses in the community to improve influenza vaccinations and worked with social workers to assist placement of homeless individuals post hospital care. We have sought and must continue to seek out opportunities to collaborate as part of our commitment to human caring.

Collaboration requires nurse leaders to adopt the behaviors of stewardship, diversity, inclusivity and leadership in our efforts to bring other members of the team to the table. Engagement of consumers, the public, academicians, finance, technology experts are examples described in this edition. Many more opportunities exist for nurse leaders to reach out beyond the traditional partners to collaborate in ways that promote the provision of safe, effective, efficient, person-centered care. I'm sure you have many other examples and we look forward to learning about your collaborative efforts as you share them through our Leader2Leader Mentorship Program, AONE Foundation Nurse Manager Fellowship, AONE Foundation Nurse Director Fellowship, the Care Innovation and Transformation Program and our many educational programs. Such offerings are designed to enhance your ability to collaborate with others. Courageous leaders are always ready to work with others to achieve their goals. I invite you to be bold and to seek new partners to actively practice purposeful collaboration!

Certificate Program in Health Care Finance for Nurse Executives – Aug. 31-Sept. 1, Indianapolis

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