Creating a New Model of Care: A Clinical Transformation

Key factors intersect to develop scenarios that meet organizational goals.

“To develop our new model of care, we looked for a way to test ideas without putting patients at risk or stressing staff with trial and error.”

Nancy L. Davis, RN
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Quality, cost and access continue to challenge healthcare organizations. Often at the root of these issues are embedded behaviors that result in institutionalized inefficiencies in the delivery of care. With fewer resources and dwindling budgets, many hospital leaders are overwhelmed at the prospect of overhauling their care delivery model processes so that all components—human resources, physical space, workflow and operational strategies—work together to enable higher quality, timelier care at a lower cost per patient, per day.

Ochsner Health System—southeast Louisiana’s largest nonprofit, academic, multispecialty healthcare delivery system—found itself in such a position. Specifically, the medical-surgical (med-surg) nursing units were performing below desired levels. Patient satisfaction and employee engagement levels were under target. Lengths of stay exceeded standards consistently, and costs were escalating rapidly.

One of the challenges facing Ochsner’s med-surg nursing units was staff utilization. Relationships between registered nurses (RNs), certified nursing assistants (CNAs) and patient care technicians (PCTs) were uneasy. Communication, misaligned support services, role clarity and accountability were ongoing issues. Confusion and uncertainty contributed to staff tension, and as a result, recruitment and retention were affected. Furthermore, nursing staff members were performing support services activities—including transport, linen, dietary, materials, etc.—at periods throughout their shift when dedicated staff members for those services were unavailable. In this all-too-common scenario, care is delivered in a way that compromises quality and drives up costs. “When we studied how our nurses spent their time, only 15 to 30 percent of their shift was dedicated to direct patient care,” says Nancy Davis, RN, Ochsner’s vice president and CNO.

Care delivery inefficiencies are not new. One reason they persist is that the methods for resolving them typically involve good ideas developed in departmental silos and well-intended, incremental trial-and-error endeavors. While temporary success often follows, the visible problem may be fixed but underlying, systemic issues remain. Time and resources have been wasted, frustration mounts and the problem does not go away. “Despite the fact that we tried many solutions over the years, we just couldn’t seem to fix our processes,” says Davis. “We wanted to re-create the med-surg model, but we didn’t know exactly how to do that or where to start.”

Resolving these issues requires compelling and robust data, a solid plan of action, a “good-to-great” model, committed leadership and a dedicated, persistent team. Passion for “making a difference” and active participation drive engagement. In search of a solution, Ochsner turned to its long-time strategic partner GE Healthcare, which had the clinical and workflow expertise to help. In addition, it had developed a proprietary software tool that creates dynamic simulation models for new care delivery scenarios.

After learning about the simulation tool, Davis and her team at Ochsner decided to use it to help determine what model of care would best suit the med-surg units and the organization as a whole. The first step was to analyze the problem from a clinical Lean perspective. The GE Healthcare team extracted secondary data from Ochsner’s systems and collected extensive primary data by observing care processes, measuring time spent on tasks and activities, and mapping travel patterns of staff through the units. The data helped

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Ochsner and GE Healthcare understand and identify the actual work taking place on each unit as defined by resource and patient specifics—not “averaged” data from macro sources.

More than 460,000 activities and 1.1 million tasks were identified in a one-month time frame. Interdependencies and competition for resources were determined based on frequency and distribution of tasks and activities—a critical feature that is not possible with most simulation models.

After intense brainstorming sessions and idea generation, the team designed seven solutions that presented the most desirable features. GE Healthcare simulated these concepts and worked with Ochsner clinical leaders to integrate several features of the more successful concepts, resulting in a hybrid of the seven that was selected as the new model. The objectives were:

- Achieve a savings target of 8 to 10 percent
- Increase nurse-patient interaction time by 15 to 20 percent
- Increase patient satisfaction
- Reduce falls, medication errors and pressure ulcers
- Increase employee satisfaction
- Eliminate nurse use in support service activity

“Our work provided Ochsner with information on the percentage of time nurses were spending in direct and indirect care delivery as well as how that time was being spent,” says Marcia Peterson, RN, director of Infrastructure, GEHC—Performance Solutions. “In the new design, we not only wanted to increase direct care time, we wanted that time to be value based and outcome focused.”

Ochsner’s new care model for its med-surg nursing units consists of one RN and one licensed practical nurse who partner in caring for seven to eight patients. Ochsner eliminated the CNA and PCT positions and placed those individuals within the health system. All frontline staff participated in a three-day training program that included a one-day didactic session followed by two days of experiential learning designed to provide feedback, problem-solving tips and on-the-spot coaching. The first med-surg unit completed training at the end of May 2010. Elements of relationship-based care were also incorporated to maximize patient experience.

Using measurements taken before implementation and then at three-week intervals, units implementing the model have realized:

- An 18 to 43 percent increase in outcome-focused direct care delivery time
- Support services improvements and minimal nursing use
- A 29 to 50 percent reduction in nurse travel times
- A 30 percent decrease in call-light activations immediately post-implementation

Additional objectives are expected to be met as the new model stabilizes. “Adding well over 150 new full-time employees is no small challenge, much less introducing a new model of care,” says Ochsner’s Davis. “We had to learn to let go and rethink patient care.”

Davis credits the success of the new nursing care model to the diligence of GE Healthcare’s guidance and the Ochsner clinical team working in tandem, problem solving together and making adjustments during the entire process. GE Healthcare’s simulation model was critical in providing a clearly defined blueprint for success. “We were able to consider and test a multitude of solutions to our problem so that we could then pilot a model that had been vetted clinically, operationally and financially,” says Davis.

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