

Abstract:

The applications of quality improvement in health care are many, as efforts are undertaken to achieve the Institute for Healthcare Improvement's triple aim. Varying institutional infrastructure models exist based on leadership philosophies, organizational charts, and/or resource availability. Successes are dependent on tactics that yield execution, engagement, and sustainability. In the following piece, we review the strategy and tactics taken by the Lurie Children's Emergency Department leadership team to maximize our operational and quality improvement impact, offering perspective for the development of quality improvement structural components at the local department level.

Keywords:

transformation; quality improvement; emergency services; emergency department; lean; infrastructure; operations; committee

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Change in Healthcare: The “How” to Make the “What” More Successful

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The term *change efforts* in health care continues to permeate the landscape. New technology; new equipment; and new medical management practices, clinical guidelines, and quality initiatives, among others, have contributed toward quality and process improvement in emergency care. This list of advances is long, growing, and expected to be mainstream for the foreseeable future. We all recognize the necessity of improving our health care system to deliver better patient care. What we sometimes fail to see, however, is the manner by which we do so. Can we plan better, be more inclusive, implement more effectively, or have better mechanisms for follow-up? Better yet, are we promoting better outcomes for our patients? Are we truly assessing our own needs to be successful with an honest and objective perspective?

BACKGROUND

Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago's largest pediatric provider, handles 58 000 patient visits per year in its emergency department (ED). The ED has been open since 2012 when the hospital (formerly Children's Memorial Hospital) moved from the Chicago northside neighborhood of Lincoln Park to a more central downtown location in Streeterville, a less residential area adjacent to Northwestern Memorial Hospital and the Feinberg School of Medicine. Prior to the move, the Children's Memorial Hospital ED had grown to nearly 65 000 annual visits in

an outdated facility that had been built decades earlier to accommodate less than half that volume. This environment, with routine overcrowding and throughput concerns, provided the compelling need for vigorous process improvement. Driven by these concerns, with a steadily expanding patient volume, and a limited ability to enhance the ED footprint, the ED team achieved significant improvement in key operational metrics (eg, waiting times, length of stay, patients leaving prior to being seen) as well as top-tier patient satisfaction scores. Looking back, although these improvements were informed by throughput data, they were not created or evaluated using rigorous quality/process improvement principles; instead, it was change by consensus. In hindsight, although there was excellent support from hospital administration and strong collaboration among clinical leaders and frontline staff in these efforts, functional silos remained between the participating disciplines. Because of these and other factors, change and improvement achieved were not fully imbedded into care processes (or culture) as we transitioned to a new facility in June 2012.

Despite substantial new facility planning¹ and a much larger and more functional work space, plus additional staffing and enhanced capacity, by December 2016, the ED's pace of operations had slowed and the length of stay had increased by 20% for reasons which were initially unclear until analyzing patient flow. The ED team launched an effort that pushed the department in the right direction, reducing length of stay by 11%, boosting patient satisfaction scores, and improving employee engagement. Although these types of change efforts are not novel, what was unique was the manner by which the change was enacted, the “how”. Amidst these changes, the department had also begun undertaking a dozen or more clinical quality initiatives. Unfortunately, these clinical guidelines were implemented during a period of time with significant ED staff turnover and the orientation of new hires and new graduate nurses.

PLANNING AND COMMUNICATION

Like most institutions, Lurie Children's Hospital still faced the frustrating construct of siloed efforts. The ED structure includes the Division of Emergency Medicine, composed of academic and clinical faculty, fellow trainees, and advanced practice providers. On the hospital side, the department encompasses nursing and other clinical and non-clinical support staff. The division has a clinical leadership (medical director) team, as does nursing. These 2 bodies, although working in parallel and

collaborating in decision making, were not functioning as a unit, often preventing timely resolution when problems arose. The “why” revealed many barriers to cohesion. Beyond these constructs was also the challenge of dedicated time. With so many busy individuals whose needs and voices required representation, how could we find time to meet during a single window and with great enough frequency to have an impact? The leadership team decided that there was no perfect format and instead developed a standing infrastructure formally known as the *Operations Committee*². Meetings occurred on a weekly basis on a standing day and time, making scheduling easier. A set agenda was organized to evaluate operating metrics, joint staffing statuses, operational planning and updates, clinical pathways, and quality initiatives and left room open on the agenda for new business items to review. The leadership team did not stop there². The invitation to participate was extended to frontline ED staff, division faculty and trainees, and the department for involvement. The expectation of leadership serving as the departmental experts was relinquished in favor of supporting and elevating those closest to day-to-day care delivery to help with decision making³. All with an equal voice, the Operations Committee is composed of medical directors, senior nursing directors, directors, nurse managers, and frontline staff (Figure 1). Each is expected to offer their expertise in decision making while also supporting the work in their respective capacities. Included is representation from the Division of Emergency Medicine, emergency department, patient registration and access, and key ancillary services.

MAXIMIZING THE ROLE OF THE CLINICAL QUALITY COORDINATOR NURSE

Forward thinking by the leadership team identified the need to support the multitude of quality initiatives past, present, and future. Historically, quality improvement initiatives and projects landed on the shoulders of the unit educator and nurse managers, who with many competing priorities found quality projects difficult to implement and sustain. To maintain daily operations and advance quality initiatives, the role of a Nursing Clinical Quality Coordinator was created. The hospital's Chief Nurse Executive initially supported this need by partially removing a full-time equivalent (FTE) from staffing, whereby this individual spent one third of their time in clinical care with the remainder dedicated to quality initiatives. This

ED Multidisciplinary Operations and QI Structure

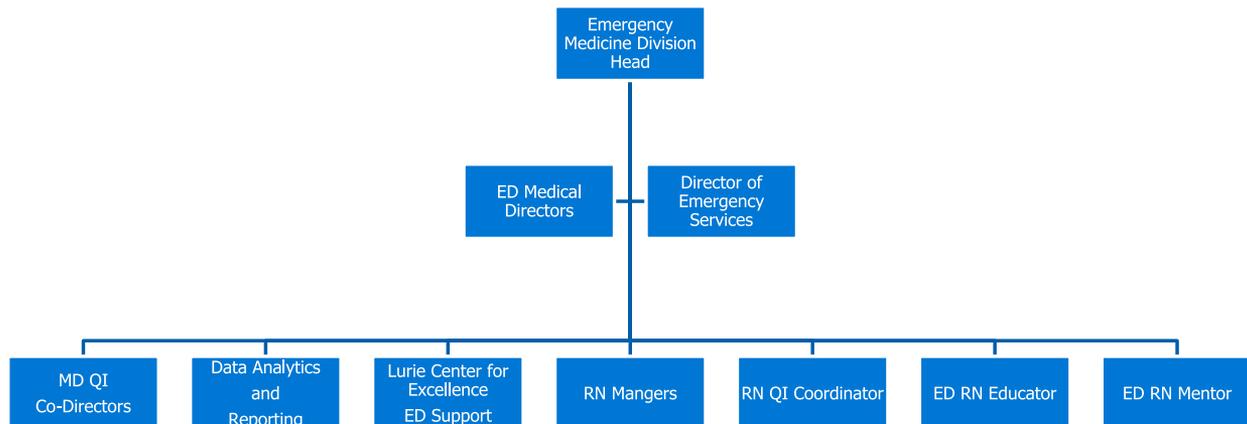


Figure 1. Emergency department operations committee structure.

concept was a novel approach that required validation of the positive impact within prioritized department initiatives. As the magnitude of the role has since expanded and the demonstrated value grown, this role has now become a dedicated FTE, whereby 100% of time is spent on clinical quality efforts. This individual serves as the central locus between the Division of Emergency Medicine and emergency department and is the representative for clinical quality in the weekly operations committee meeting as well as the partner to physician quality and process improvement leaders. The Nursing Clinical Quality Coordinator serves as a primary liaison to hospital-wide quality improvement initiatives. This role was developed not only in the essence of participating in shaping the changes but also for serving as the intermediary and voice for staff, assisting in implementation, and helping to monitor changes and progress through the use of metrics and individual feedback.

DEVELOPING THE MENTOR NURSE ROLE

With a central hub of planning, discussion, and decision making residing with the Operations Committee and the clinical quality nursing coordinator functioning as a catalyst for change, the department sought to close the loop on another key tenet to success—education rollout and sustainability. To achieve this, the leadership team faced

an objective reality, reiterated by the staff. Not all staff are as experienced, especially with the evolution of new graduate nurse hiring programs. Existing hiring practices of bringing new staff first onto nights created an environment where this experience mix was more concentrated on particular shifts. We also aspired to grow and develop our staff to matriculate to master's programs and onto management or into clinical specialist roles. How does one continue to cultivate an environment of expertise and excellence, especially in an academic medical center setting? Observing the impact of mentorship in physician academic development, the department created an expert or “mentor” role to provide this mentorship and to educate. This role did not exist in other patient care units within the hospital, thereby serving as a pilot for the organization. The mentor nurse is scheduled during times most needed, typically evenings and nights. Not everyone can serve in this role, as these mentors are experienced ED nurses who are removed from staffing numbers and do not deliver direct patient care. Rather, they are there to serve as mentors and to help with technical and critical thinking skills for newer and even some more experienced staff. A huge success, this role is now a dedicated budgeted FTE, much like the Clinical Quality Coordinator Nurse role, and has added to the resources in the department. With the creation of this position, we have established a foundation

for the development of our frontline staff to be as successful as they can be.

SUMMARY

As the ED continues to move forward in the era of change, we continue to ask ourselves not only the “what” of this change but the “how” in facilitating, managing, and executing. As we all peruse case studies, articles, and best practices across the country, we often find ourselves thinking “that makes sense” or “that seems like an obvious fix.” Find a problem, and frontline providers and staff are often already creating their own solutions. Instead of thinking of what the fix is, perhaps we ought to be reflecting upon how the team made it work and what

made them successful in taking idea and concept to reality. It might just live in the “how.” 🇪🇺

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