Interview With Debra Albert, MSN, MBA, RN, NEA-BC

Roxane Spitzer, PhD, RN, MBA, MA, FAAN

Debra Albert, MSN, MBA, RN, NEA-BC, is senior vice president and CNO at the University of Chicago Medical Center.

RS: Debra, thanks so much for agreeing to share your experience and knowledge with our readers. Would you share the highlights of your background with us?

DA: I took a very traditional path in nursing leadership. I started in a summer extern program at the Cleveland Clinic, transitioning to a nursing assistant once the summer program was over. Before I knew I wanted to pursue nursing leadership, my nurse manager tapped me to consider being her assistant. She saw something in me and encouraged me before I recognized the desire and my potential. After that, I was fortunate to have been given many opportunities to learn and grow, progressing my responsibilities. In my current role, I am honored to be able to lead our therapies, pharmacy, and clinical laboratories. Working with this interdisciplinary team of clinical professionals serves as a daily reminder than no one profession practices on an island. Our patients need each clinical discipline to bring their skills and expertise to bear, ensuring we work collaboratively, always focused on the patients needs. When we do this, it is remarkable at what we can accomplish!

RS: You are working in a very distinguished institution known for its scholarly research and commitment to those from challenged socioeconomic backgrounds? How would you describe your demographics?

DA: The University of Chicago Medical Center is located on the Southside of Chicago. As such, our community reflects all that we have come to understand about the impact of social determinants of health. From a health needs perspective, our community's highest needs are around diabetes, asthma, and violence prevention and resiliency.

However, as you mention, we are an academic medical center (AMC), thus one of our strengths is our ability to bring cutting edge research to the bedside. Indeed, we run several hundred active clinical protocols, which attract patients regionally, nationally, and internationally as patients seek a highly specialized level of care. Given both of these dynamics, our patient demographics are as diverse as our city.

RS: What is your number 1 challenge today?

DA: Our number 1 challenge today is capacity and access to care. Specifically, our inpatient capacity at the AMC is presently severely constrained. This constraint to inpatient care puts pressure on our emergency department (ED) and hospital transfers. Both of these are important points of access for our local and regional community as the ED remains the point of access for our immediate community. Hospital transfers is a point of access for a wider section of our community and how we support smaller hospitals by providing a higher level of care found in tertiary or quaternary AMCs. While we currently have some capacity in our community hospital and some of our outpatient settings, patient flow through our system remains a constant focus.

RS: Why do you think this is happening at this time?

DA: No doubt our capacity constraints are happening for a myriad of reasons. Over the past several years, we have worked to partner with our community to provide open access, to include opening a new and larger emergency department, a level one trauma center, and about 200 inpatient acute care beds. Our physicians have focused on creating referral pathways with community providers to ease access to our comprehensive specialty care. Changes in health care reimbursement and narrowing provider networks are beginning to drive how and where patients receive care. Finally, reflecting back to our community demographics, the prevalence of chronic care unfortunately drives a constant demand for care.

RS: What is your plan or actions related to solving this issue?

DA: Addressing this issue requires us to take a multipronged approach. This ranges from focusing on ambulatory sensitive conditions, reducing excessive inpatient days, reducing readmissions from chronic conditions, and opening convenient immediate access to outpatient care. Longer-term actions include a focus on the system of care in our community and ways we can participate in strengthening that system. That means working with other hospitals and care providers to create a system such that each provider plays a role in which they are uniquely positioned, given their mission and capabilities.

RS: What stakeholders are involved?

DA: Given the complexity of the issue, we really have a wide range of stakeholders. On the day-to-day management of addressing patient flow, we rely on our clinical teams of nurses, physicians, advanced practice providers, case managers, social workers, and therapy teams. We have created a network of preferred post-acute providers who are key to this work, as is our bed access and transfer center team. We have our clinical leadership team very focused on our midrange actions such as increasing specialty outpatient care access and leveraging our health system resources effectively. Finally, our strategic planning and senior leaders are engaged with community representatives and Southside care providers to look for ways we can work together to strengthen our system of care and increase the health of our community.

RS: How do the changes in the health care sector impact your work, this challenge, and how does your work impact nurse leaders?

DA: Changes in health care continue to focus me on addressing the model of care and ensure we are creating roles in which our employees work to the top of their license and support a collaborative approach to care. This means looking at current processes and continually asking which is the best role to fill the patient care need and eliminating non–value-added work. A role that we have been very focused on for this work is our advanced practice providers (APPs). Given changes in residency work rules and the increased complexity and chronicity of care needs, this role is an often identified solution. However, ensuring that we are using this valuable group of providers effectively and creating care models that allow for meaningful APP work requires focus to ensure APPs are adding to access to care rather than performing work other team members can provide. As such, we are currently focused on creating an APP operating model to drive consistency in the role and ensure top of license work.

RS: What can you share with other nurse executives that will help them in problem solving?

DA: When problem solving, I suggest first turning to those closest to the work to understand the problem. We use a lean process improvement system that incorporates an evidence-based approach to identify best practices we can implement. Ensuring that decisions are based in evidence and supported with relevant data most often results in the best possible problem resolution. However, identifying and then monitoring success metrics can provide early warning signs of the need for course correction that might be needed. Know that you will likely have to continue to evolve the solution to the problem until you get the desired outcomes. In short, forward progress is better than taking prolonged time to analyze a problem and create the perfect solution. Finally, including key stakeholders in the process will help increase buy-in and sustainability of the identified resolution to the problem.

RS: Thanks so much for your time, Debra. You certainly have your work cut out for you and your team. This problem has plagued nursing for a long time, and your insights and plans will help others addressing this issue.

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