THE PULSE OF NURSING AT CONE HEALTH

nursingbeat

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More than Just a Phone Call

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CONE HEALTH®
The Network for Exceptional Care

Happy Summer!

MAGNET
TRANSFORMATIONAL LEADERSHIP

We serve our communities by preventing illness, restoring health and providing comfort, through exceptional people delivering exceptional care.

During this time of new growth, our nursing community is also experiencing a fresh start with the creation of a new site -- the downtown Union Square campus.

In early April, I was privileged to join a group of community leaders, Cone Health nurses and our CEO Terry Akin at the groundbreaking of the campus's first building. Dedicated to nursing, this building will feature significant classroom space and state-of-the-art simulation labs needed to train, develop and retain nurses in our community.

This site is possible because of the collaboration of Greensboro's three nursing schools - the University of North Carolina at Greensboro, NC A&T State University and Guilford Technical Community College. Nursing leaders from these campuses have worked together with Cone Health for the good of students and our entire community. There has been no competition, no barriers and no hurdles. Instead, this project truly has been all about nursing.

INSIDE THIS ISSUE

We all know that health care and nursing are fast growing employment sectors, and this downtown campus is critical to Greensboro's creation of these jobs. It will provide more space for these schools' growing nursing programs and easy access for all students and professors.

For Cone Health, this building will offer access to a state-of-the-art nursing simulation lab to teach all aspects of patient care. This lab will simulate everything from hospital care and intensive care to surgery and physician office visits. As we anticipate the future of health care, this is especially important. We will be able to train our students to provide the right nursing care at the right time and in the right place!

In addition, we will have incredible new conference space. This will help with the national nursing conferences we host right here in Greensboro. Of course, all of this generates more commerce downtown, which is so significant for this community.

As Terry Akin said, the groundbreaking was a great day for health care, a great day for nursing and a great day for the city of Greensboro!

Thank you for all you do, every day, to care for our patients and advance the cause of nursing in our community. It has been an honor to represent you on this project, and I look forward to sharing more with you as it develops. ❖

Theresa

Theresa Brodrick, PhD, RN, CNS, CNA

More than Just a Phone Call

By Sarah Lackey, RN MSN CCNS

The new Cone Health Strategic Plan, *Creating Our Bold New Future*, has "Healthy Communities" as one of its Strategic Priorities. Caring for Our Communities is one of our health system values, and patients and families are at the heart of everything we do. This story recognizes how one group of nurses addressed that value by using creative thinking, and by tapping their own resources and those outside their usual purview.

Discharge phone calls

The Office of Patient Experience (OPE) makes discharge phone calls to some of the Emergency Department patients and many discharged inpatients. The conversation is driven by the patient, with no scripted questions, except to ask the patient how they are doing after their hospital visit. Nurses may respond to clinical needs, make referrals, field complaints, encourage a call to a doctor or consultant, and generally converse about what patients need. They ask patients about both positive and negative experiences, to acknowledge any outstanding personnel, and encourage them to complete the patient survey should they receive one. These nurses are also empowered to make decisions about service recovery in a way that resolves any issues that surface during the conversation.

Laine McKinney Tousey, RN, BSN, CCRN, (alumnus), Patient Experience Lead Nurse Specialist, says this is the best nursing job she has ever had because of the difference she can make in someone's life in just a single phone call. In one month the department may make up to 10,000 phone calls.

One of the trends nurse callers identified was that many patients could not afford their medications, particularly antibiotics, insulin and steroids. These medications are urgently needed to recover from and/or prevent illness. They also noticed that the same names kept showing up on the discharge call back records, many from frequent admission to the Emergency Departments.

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On front cover: Patient Experience Nurse Discharge Call Team (L) to (R) Tonie Bryant, Marjorie Marcelo-Selom, Patricia Williams, Beth Passmore, Laine Tousey, Jill Wine, Barbara Holzimmer, Donna Trotter, Robin Bridges, Christina Woods contributes significant initiative to the Cone Health Strategic Plan.

Above: From (L) to (R) Med Assist staff provides access to lifesaving prescription medications, patient support, advocacy, and related services to the poor, vulnerable, and uninsured North Carolina residents. : From left to right: Barbara Holzimmer, RN; Beth Passmore, RN; Jill Wine RN; Lori Giang, Executive Director of NC Med Assist; Brenda Vass, Chief development Officer, NC Med Assist; Christina Woods, RN

More than Just a Phone Call, *Continued*

Following up on an identified need

Initially thinking the problem was a financial one, the nurses in OPE created a structure to collect donations that would help patients pay for needed medication. They initiated fundraising activities, and met with nurses at the Community Health and Wellness Center (CHWC) (see page 10) so the funds could be dispersed to patients who needed them. They explored existing medication assistance programs run by the county, the state, the local United Way, and other agencies and organizations, and learned about the function and the protocols that exist in the CHWC. They raised more than $600 for their cause.

An expanded solution

By talking to one another, nurses in both facilities figured out a method to get medication assistance for patients identified by OPE, as well as a way to get patients referred to the Center. This may sound like a small thing. In fact, for the patient, it is a significant shift in their access to health care.

Patients who use the Emergency Department as their first-line care provider do not get the best care for their chronic conditions. This is also costly to the patient and the system, and it uses resources that are better allotted to take care of emergency patients. With a CHWC referral, these patients have a primary care provider in the CHWC staff, as well as a medical office that schedules appointments and follow-up visits, and the help needed to guide their care. This means medication is supplied, care is coordinated, and patients can go to a doctor at the CHWC instead of the Emergency Department.

The OPE initiative, and the cooperative effort with the CHWC, has contributed to a healthy community by ensuring patients are receiving appropriate care for their conditions. As the nurses rolled out the initiative, one more process had to be added. To make sure patient-to-patient communication did not result in misuse of the system, they developed an official referral template so CHWC nurses know the referral is coming from OPE nurses.

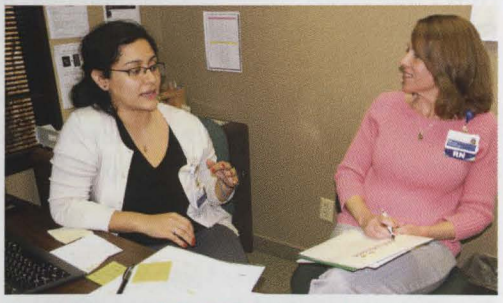
Listening with intention

By identifying trends in the information from phone interactions with patients, acting on that information, and contributing to a strategic priority in the organization, this group of nurses is true to their name: the Office of Patient Experience. These nurses have made a significant contribution to improving the health care experience and potential outcomes for the members of our community. ❖

MAGNET
STRUCTURAL EMPOWERMENT

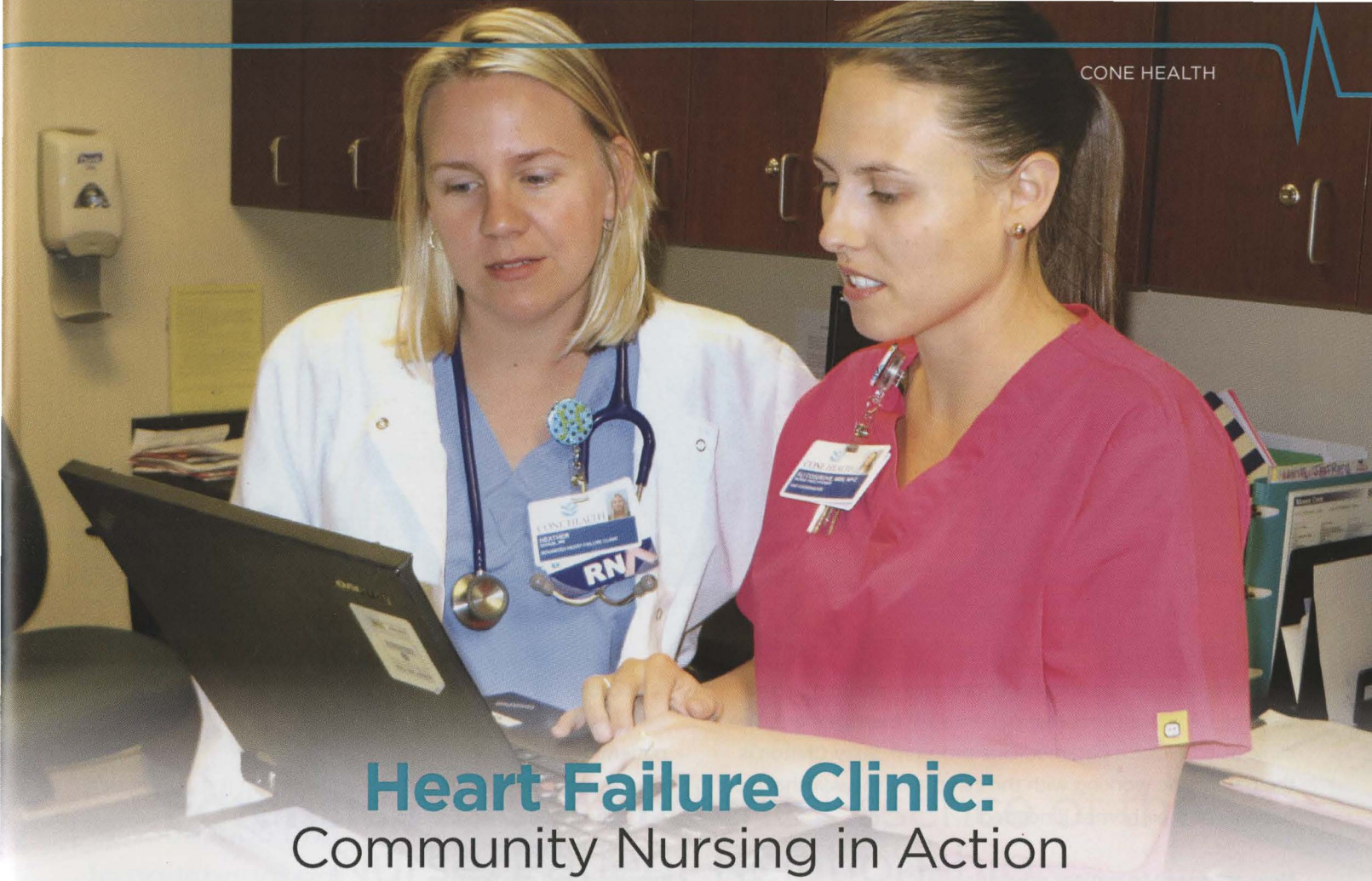
In a typical month the nurses in the Office of Patient Experience can make up to 10,000 calls. Calls begin with a simple question: "How are you doing after your hospital visit?"

Collaborative efforts between OPE nurses and Med Assist staff. From (L) to (R) Christina Woods, Barbara Holzimmer, Patricia Williams, Jill Wine, Beth Passmore, of CHWC. Seated: Brenda Vass, and Lori Giang, of NC Med Assist



Karen Rivera of CHWC (left) and Jill Wine, Office of Patient Experience (right)) work out the details of the protocol.

From (L) to (R) Courtney Isom, and Kathryn Foster of Community Health and Wellness Center HWC; Jill Wine, of the Office of Patient Experience; Jill Smith, CWHC; and Patricia Williams, OPE, collaborate on the new initiative.



Heart Failure Clinic:
Community Nursing in Action

By Rebecca Albertson, RN, BSN

Nurses and other health care professionals understand that heart failure (HF) is a delicate and often frustrating balancing act. A patient's status can dramatically change within hours, based on missed medications, hydration status, eating certain foods, or a host of other factors. The American Heart Association states that 6 million Americans have HF, with HF symptoms listed as a common cause for hospital admission in people over age 65.

A productive strategy

According to **Anita Sherer, RN, MSN, CSN, PCCN**, Cone Health had a HF patient readmission rate of almost 25 percent in May 2011. From a hospital reimbursement standpoint, Cone Health wanted to focus on strategies to reduce HF readmissions. More importantly, Cone Health wanted to improve quality of life for their HF patients. Researchers focused on studying predictors of HF readmissions. Sherer states, "We identified that patients were struggling with disease management and that our patient education strategies were not effective."

Because of their research findings, Anita and her team, including **Daniel Bensimhon, MD**, created a Heart Failure Clinic. They saw the clinic as a productive strategy to help lower readmission rates and better care for individuals on an outpatient basis. They developed a team to provide inpatient services and to identify patients in need of ongoing, outpatient services.

A team of providers

The provider team consists of **Dr. Bensimhon** (cardiologist), **Dr. McLean** (cardiologist), **Amy Clegg, RN, NP-C**, and **Ali Cosgrove, RN, NP-C**. **Daphne Wood, RN**, is the HF navigator, tasked with identifying inpatient individuals who need to be connected with the clinic. Two clinic nurses, **Heather Schubb, RN**, and **Megan Bradley, RN**, monitor each patient closely, with the support of **Chantal Jefferies, CMA**, and Ventricular Assist Device Coordinator **Molly Reese, RN**. Clinic Social Worker **Jackie Brennan, CSW**, helps each patient determine personal goals of care. A simple conversation about how involved

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Above: Heather Schubb and Ali Cosgrove, nurses who work with the Left Ventricular Assist Device (LVAD) program.

Heart Failure Clinic, *Continued*

Amy Clegg, one of the nurse practitioners for the Heart Failure Clinic.

The Heart Failure Clinic is located in the Heart and Vascular center on the Moses H. Cone Memorial Hospital campus.

a patient wants to be with his or her care can change the way the Clinic supports that patient's HF management. The clinic also utilizes a paramedicine program. **Suzy Chilton** is the paramedic working with the clinic, and she will check on patients at their homes if needed.

New approach to patient education

The Clinic organizers developed a new approach to patient education, using five key take-home messages. These include:

1) Weigh myself daily.
2) Know how I feel today.
3) Take my medicines.
4. Eat low salt foods.
5) Get moving.

Patients are given the Heart Failure Zone tool for self-assessment and instructions about when to seek care. The team follows up with each patient seven days after their inpatient discharge to tightly monitor medication dosages and assess for HF symptoms. A patient is assessed every two to three weeks, then every month and a half. During each visit patients receive valuable education about signs and symptoms to watch for on a daily basis, using the five key messages printed in each patient's heart failure zone tool. Patients always have a goal of "green" on their zone tool. If they land in "yellow," they are instructed to call the clinic. If they land in "red" the tool instructs them to call 911, as this is an emergency.

Breaking down barriers

"The Clinic breaks down barriers to how patients receive care," says Clegg. Just last week a patient confessed illiteracy. Although the patient had the right medications with her, she did not know how to take them. Because of the close relationship nurses in the Clinic had formed with the patient, they were able to identify gaps in this patient's education about her disease. This led to more effective teaching and medication adherence. Clegg described another patient's struggle with fluid overload, and how the Clinic titrated his medications to keep him balanced. The patient reported feeling much better, and is now back to walking, housework, and his woodworking hobby. With the efforts of the Clinic staff, this fine-tuning of medications led to major improvement in the patient's quality of life.

> Empowering patients through good nursing care and education is the foundation of the HF clinic.

Giving patients power in their condition

Empowering patients through good nursing care and education are the foundation of the HF Clinic. Patients who are properly educated about their disease management, socially supported in managing their care, and have their medications closely titrated achieve better outcomes. According to follow-up statistics, the efforts of the Clinic have led to a significant reduction in hospital readmissions, which dipped as low as 13 percent in October 2013. The numbers fluctuate, but readmission rates at Cone Health have trended downward since 2011.

The interdisciplinary approach of the HF Clinic has redesigned how patients are cared for. Nursing plays a key role, keeping patients active in the community and able to live satisfying lives for as long as possible. ❖

Forensic Nurses and the Essence of the Nurse/Patient Relationship

By Sarah Lackey, RN, MSN, CCNS

For the past 17 years, **Cathy Rossi, FNP-BC, RN, MSN, SANE-A, SANE-P**, has led a unique group of nurses who provide care to a highly delicate and specialized patient population. She is the Manager of the Cone Health Forensic Nursing Program, a team of specialized nurses trained to care for sexual assault and domestic violence patients. Requiring special skills, a delicate touch and a mix of medical knowledge, nursing wisdom and compassion, these nurses care for members in our community who are often in the shadows.

Before

Here was the typical scenario, pre-forensic nursing program and before Cathy Rossi joined our team: victims entered the Emergency Department and may or may not have been tested for sexually transmitted diseases, or received other standard care or comprehensive treatment. The patient returned to the community with little to no education, support or guidance. A follow-up medical appointment, needed in 10-14 days after the assault, may or may not be kept because the victim would not want to tell her story again.

Many victims do not have primary care providers to go to for a follow-up appointment. Even with medical options, these individuals often have no ability to pay for appointments, and no insurance. They tell themselves they are fine, and go back to their lives. Often the cycle repeats itself over and over again. Although victims of this kind of violence may have had access to a number of community resources, the medical and nursing care available to them was sorely lacking. Without valuable evidence from the time of the assault, the legal system has very little to offer to stop the cycle.

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The Family Justice Center is a collaborative project funded by the City of Greensboro and Guilford County. Its existence is a major step forward in breaking the cycle of domestic violence in our community.

Above: Cone Health's team of forensic nurses: Lechia Davis, Lindsey Strickland (back row), Amy Coyne, Cheryl Anderson, Sherie Mahan (back row), Brooke Michael, Jennifer Oxendine, Jacque Perkins (back row), Cathy Rossi

Forensic Nurses, *Continued*

SANE nursing draws on the essence of the nurse/ patient relationship. Consistent and accessible nursing support and guidance softens the legal process and creates opportunities for victims to enact real solutions for their safety and the safety of their families.

"Although victims of this kind of violence may have access to a number of community resources, the medical and nursing care available to them was sorely missing."

– Cathy Rossi

After

Enter Cathy Rossi and her team of nurses. They are dedicated and passionate about serving this population. Realizing that a comprehensive option was essential - one that included prevention, prophylaxis and follow-up care - they developed a program that offers hope and possibility to its patients.

In the Emergency Department forensic nurses meet and establish relationships with their patients. By offering a mix of medical, nursing and legal knowledge, the nurse becomes a consistent advocate and source of support during an otherwise chaotic process. Because they know what to collect for evidence, how to document it, and how to empower their clients, the necessary ground work for legal action is laid right from the beginning.

As the 14-day, follow-up appointment for the sexual assault patient looms, patients are more likely to return for needed care because of the relationship with the forensic nurse. Having a forensic nurse who is familiar with their story means it does not have to be told over and over again. They do not have to revisit the event in their minds. If the patient is a victim of domestic violence, the patient gains courage to take the steps needed to affect the situation at home. Because forensic nurses have collected appropriate evidence from initial visits, options are available for making the situation in the home safer through the appropriate legal channels. The presence of the nurse/patient relationship, and the nature of the work of the forensic nurses, softens the difficult legal battle for victims and has the potential to impact real change in the cycle of domestic violence.

Physical and psychological needs

These complex patients suffer not only psychological but real physical injury. They need education about potential physical complications; they may need tests to determine integrity of airways, hemorraghic events, strokes, and a myriad of other complications that can occur directly or latently as a result of assault. The lack of attention to medical and nursing care for victims of sexual assault is the gap that Rossi and her team fill.

Her work with this population motivated Rossi to complete a Nurse Practitioner (NP) program. Recently graduated, she now has the skills to directly impact the medical/nursing gap that existed in the care of these fragile patients. She can take comprehensive health histories, can prescribe needed medication, is available as an expert to answer any questions/concerns, can order appropriate testing, and provides the much needed follow-up care in a safe and supportive environment. Her Nurse Practitioner skills are available to the entire forensic nursing team, and any patient the team cares for.

Community collaboration

The team works consistently with professionals across the community: law

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Forensic Nurses, *Continued*

enforcement officers, patient advocates, social workers, representatives from the district attorney's office, and any others who work with victims of sexual assault. An important community initiative is now in process for the residents of Guilford County: the Family Justice Center. Based on a model from San Diego, and following closely on the heels of a similar center that recently opened in Alamance County, the Center will contribute significantly to breaking the cycle of domestic violence in our community. The building is in downtown Greensboro, and will function as a "One-Stop Shop," housing offices for law enforcements' Special Victims Unit, the Major Case Squad--the Sheriff's Department's unit dealing with domestic violence--representatives from Family Services of the Piedmont, the Child Abuse Center. It will also provide office hours for the Legal Aid Society. Rossi and her teammates will be there too, as dedicated space has been allocated for Cone Health's forensic nurses to see patients and document injury. The office hours will be 8 a.m. to 5 p.m., Monday through Friday; some patients will still be processed through the Emergency Departments. The existence of the facility, with all the key advocates and services under one roof, is a concerted effort to address the situation of domestic violence in our community.

As health care moves to an increased focus on preventative and community health care, Cone Health's Cathy Rossi and the team of forensic nurses are actively involved in creating the vision and framework for an innovative approach to collaborative nursing care in our community. ❖

MAGNET
EXEMPLARY PROFESSIONAL PRACTICE

Students Support the **Cone Health Community**

By Connie Lewter, MSN, RN-BC, CNE and Sarah Clark, MSN, RN, CCRN, CHSE

In the past, nurses traditionally worked in the hospital setting. With the recent trends in health care, more non-traditional opportunities have opened up for nurses. Nursing school curricula are being revised to reflect this change in practice. Facilitating learning opportunities for students in the community is one way Cone Health supports nursing education at all levels. Cone Health provides clinical space and resources for learners to achieve their objectives, from entry level practice to advanced practice nursing. These include community clinical placement opportunities for nursing students, nurse practitioner students, doctoral candidates and allied health students who are attending programs for certified medical assisting or phlebotomy.

One such clinical site is the Child Health Center, which provides health care and wellness care for children from indigent or underserved populations. The Center offers a wide variety of programs for their clients, including help with school work for children who have English as a second language, and to education and access to birth control for adolescents. In the fall of 2014, area nursing students began having clinical experiences at this valuable community clinic. Students assist with wellness visits, health education, and seeking resources for patients and families. The concepts of holistic nursing, health promotion and education are role modeled for the students. One student wrote in an anonymous evaluation of her clinical experience, "It's so important to speak up and advocate for these patients and families to improve their care. I really learned that in this clinic and will use it in my own nursing practice."

There are other examples of helping nurses and allied health care personnel grow in practice and education through Cone Health's strong presence in the community. Nurse practitioner students are required to log many hours of patient care in the community. Many Cone Health clinics and providers' offices provide clinical space for these nurses to learn patient assessment, diagnosis and treatment that will allow patients to stay home, rather than be admitted to the hospital. **Dawn Whitmire, RN - BC, MSN, CNOR,** NP student, stated, "I have had so many great opportunities to learn this semester. I really appreciate Cone Health providing me with the clinical experience I need to learn to provide exceptional patient care." As a result of these rich clinical experiences, many nurses choose to practice within the Cone Health system after graduation and licensure.

Cone Health values education at all levels. Its commitment to the community it serves is strong. The partnership between academia and caring for our community exemplifies this Cone Health value. ❖

MAGNET
EXEMPLARY PROFESSIONAL PRACTICE

Nurses Lauren Ducatte and Denise Juarez confer with Dr. Lee Chambliss at the CHWC.

Community Nursing on the Moses Cone Campus

By Sarah Lackey, RN MSN CCNS

One of the challenges in our current healthcare climate is helping the patient who has chronic disease and no primary provider. Often these patients use Emergency Departments as their healthcare agency, and while Emergency Departments across the network are designed for dealing with all kinds of emergency situations, this is not the place for the patient who needs follow-up, guidance and help in managing their chronic condition.

Health care safety nets

To answer the need to serve these patients in the community there are a number of agencies, services and funding sources available. These are called Health Care 'Safety Nets', defined by the Institute of Medicine as "Those providers that organize and deliver significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients." (Lewin & Altman, 2000).

Cone Health contributes to the Health Care Safety Net in Guilford County through the Community Health and Wellness Center (CHWC), located in a small office building that borders the campus of the Moses H. Cone Memorial Hospital (MCH). Opened in November 2013, the Center transitioned to the current location in 2014. It serves as a bridge between the free-floating, unmanaged patients who frequently visit Urgent Care and Emergency Departments, and access to regular, consistent, guided care. This means the patient has the opportunity to move into a more stable existence rather than living from crisis to crisis in their chronic disease process.

Nurses driving care

Typically community care clinics are staffed primarily with Certified Medical Assistants. At the Center, nurses drive much of the care provided. RNs function as Team Leaders and a Family Nurse Practitioner started at the Center this spring. More positions are being made available as the Center grows. The Center holds about 60 appointments per day.

Nursing care at the Center involves every skill a nurse has. Critical thinking is a must. Patients are complex, both clinically and socially. They have more social issues, less resources, and a greater need for continuous, clear and individualized education. RNs at the Center must triage patients, establish trusting relationships, function as case managers, and engage creative thinking to get the needs of their patients met.

Partnering with acute care

The Center partners with nurses across the Cone Heath network in various ways. **Patricia Williams, RN**, originally from 5W MCH, was instrumental in helping to establish the

Continued on page 11

Community Nursing, *Continued*

As a Hospital based clinic, the Center must follow Joint Commission regulations. They are managed by the Cone Health Medical Group.

Jill Smith, RN.,Supervisor for Community Health and Wellness Center

strong link between the Center with the hospital. **Wanda Lynn Rogers, RN**, a nurse in the Emergency Department (ED), does case management at the Center three days per week. Her experience brings a unique perspective and base of experience for the Center. **Camille Woods, RN, BSN**, the Heart Failure Case manager, works with the Center to identify uninsured atrial fibrillation and heart failure patients to arrange for visits to the CWHC cardiac clinic and to arrange hospital follow-ups. The Congregational Health Nurses program works very closely with CHWC to identify patients in need, particularly in the homeless and immigrant population. The Cone Health Wise Woman Program, coordinated by **Christine Brannock, RN, BS, OCN**, identifies cancer patients without insurance and partners with CHWC to help fund medications. **Jill Wine, RN, BSN**, and Patricia Williams, now from the Office of Patient Experience, recently coordinated an initiative with the Center to provide a new patient referral mechanism, a need identified from discharge patient phone calls (see page 3).

One of its kind

"The Center is the only place in the area for patients to get primary needs met without insurance," says **Jamilla Pinder**, the Center's Practice Administrator. Other centers care for specific patient populations, but there is a lack of comprehensive management for the complex comorbidities seen in the CWHC patient population. She is continually looking for programs that will meet patient needs. For example, the Medication Assistance Program helps patients get their meds at no cost or low cost. Patients are asked to pay based on their ability, and the staff evaluates their eligibility for various funding programs in the County.

There are varying options to subsidize the cost of patient care. The Center also retains an Affordable Care Navigator who helps to access benefits from the Affordable Care Act for the benefit of patients.

Pharmacy presence unique

The presence of a pharmacy at the Center is a drawing card for the patient population. Pinder feels strongly that this service is part of treating the whole patient. Medication is an integral part of a care plan for a patient with chronic conditions. More than 100 people were on the new patient waiting list at the time of this writing, many of whom were there because of the ability to get medications at the Center. Patients who currently live in Greensboro or Guilford, Alamance, or Rockingham counties and seek treatment within their local health systems are often referred to CHWC for care..

Challenges to the work

Challenges to the Center's work exist primarily because they must follow a non-traditional structure for healthcare. Most of the care delivered must be "right now care," with little put off to a potential next visit. There are a lot of 'no-shows' to appointments because of transportation issues, family obligations and job prospects. Inability to attend follow-up appointments interrupts the continuity of care and affects the ability to manage chronic conditions effectively. With the key therapies being chronic disease management and medication management and compliance, these obstacles create continual challenges to the health of these community members.

The bottom line for the Center? Treat as many people as we can; save as much money as we can save; treat the whole person. At the end of the day it's about the relationship we have with our community. Nursing makes a big difference in that delivery of care. ❖

Lewin, M.E. & Altman, S. (2000) America's Health Care Safety-Net: Intact but Endangered. Institute of Medicine. Washington, DC. National Academy Press

MAGNET
STRUCTURAL EMPOWERMENT

Triad HealthCare Network: **Reducing COPD Readmissions**

By Thresa Isley, DNP, RN, APRN-BC

The COPD Gold card, given upon enrollment in the program, designates to patients and their providers that they are a COPD Gold patient, which entitles them to earlier appointments and follow ups when issues are identified.

Imagine what chronic disease management education, medication delivery, appropriate vaccines, bus passes to help patients make their appointments, and 24-hour phone access to a nurse, all at no cost, could do for the quality of life for a Chronic Obstructive Pulmonary Disease (COPD) patient. That's what a new and highly successful program, called the COPD Gold card, is doing for these patients in our community. The program also provides same-day office visits and low-cost pulmonary rehabilitation.

The idea is born

The program is the brain child of Elvin Perkins III, MBA, chronic disease project manager for Triad HealthCare Network (THN), Cone Health's nationally acclaimed accountable care organization. The COPD Gold card program was designed to reduce readmissions among patients with COPD who have at least three all-cause admissions (not just COPD) in a six-month period. THN identified that the COPD population often accounts for a startlingly large percentage of our readmissions.

Using statistical analysis, the quality team identified a target list of 65 patients with COPD who had three or more admissions to the largest facility, the Moses H. Cone Memorial Hospital. The team also focused improvement strategies, education, and care coordination in the Emergency Department, where two-thirds of COPD patient admissions begin.

Partnership: Inpatient identification and preparation/outpatient follow up and management

The inpatient arm of the program involves identification of target patients by inpatient nurses. **Lyndsey Currin, RN-BC, BSN**, assistant director for 4th floors at Wesley Long Hospital, manages the program for her unit. She identifies patients and ensures the program process is complete. Lyndsey states, "This is a project I am very proud to have been involved with. It is very rewarding to see a project that truly benefits COPD patients and benefits Cone Health as well."

The launch of the COPD Gold project at Annie Penn Hospital included all levels of nursing personnel: the Clinical Nurse Specialist, Department Director, Assistant Director, charge nurses, weekend administrative coordinator and clinical nurses. Every day in progression rounds, each patient is screened for COPD Gold status.

The electronic medical record helps identify and track potential COPD Gold patients. A banner in the electronic health record alerts providers and nurses about how many ED visits and hospital admissions the patient has had in the past six months. This then triggers follow-up appointment planning, vaccination, and the engagement of a multidisciplinary COPD care team that includes pulmonology, respiratory therapy, case management and social work. Patients receive tools and education to help them manage their condition more effectively at home.

Results

COPD Gold improvement strategies have now been implemented across the health system: in physician offices, in the EDs and in the hospitals.

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Elvin Perkins, reviewing education of the COPD Gold program.

To date, the program has led to a reduction in admissions in the highest risk group by 21 percent, preventing 1,244 admissions in the first year. Admissions for pneumonia in patients with COPD decreased from 7 percent to 4 percent. All-cause, all-payer 30-day readmissions decreased by 2.3 percent, and average length of stay declined by 1.8 days

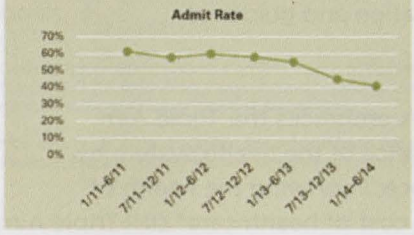
Success in collaboration

Cone Health nursing, in partnership with THN, is dramatically improving the lives of patients who live with chronic obstructive pulmonary disease (COPD). Population health is melding with the acute inpatient care setting, requiring a patient-centered plan of attack to keep patients at their best state of well-being and reduce hospital visits. Why do we want to keep them out of the hospital? Because it is the right thing to do. We have a commitment and opportunity to impact the health and well-being of our patients, helping them to create better lives for themselves. ❖

ACO CUTS COPD READMISSIONS AND REDUCES LENGTH OF STAY

Triad Healthcare Network used claims data to identify COPD patients with the highest risk of readmission. Through better population health management, the ACO was able to avoid $9.1 million in healthcare costs from July 2013 through June 2014. For these and other efforts, the ACO earned a $10 million shared-savings check from the Centers for Medicare & Medicaid Services in 2014.

Decline in Admissions



- Reduced admission rate by 18%
- 1,244 "avoided" admissions (P-value = 0.000)
- Value per admission: $7,000

Reduced LOS

Time Period	LOS Wesley Long Hospital
Jan – June 2011	6.0
July – Dec 2011	5.7
Jan – June 2012	5.7
July – Dec 2012	6.0
Jan – June 2013	5.8
July – Dec 2013	4.8
Jan – June 2014	4.2

- November 2013–June 2014: 701 admissions
- 970 days avoided
- Valued at $275/day
- Saving in nine months: $266,750

Source: Cone Health and Triad Healthcare Network. Used with permission.

MAGNET
EXEMPLARY PROFESSIONAL PRACTICE

Cone Health and TriadHealthcare Network: Partners Caring for Our Community

By Angela Thomas, RN MSN-L, CCM, AND Sarah Clark, RN, MSN, CCRN, CHSE

Hospital Value-Based Purchasing is part of the Centers for Medicare & Medicaid Services' long-standing effort to link Medicare's payment system to a value-based system to improve health care quality, including the quality of care provided in the inpatient hospital setting. (Reference CMS.gov)

When patients transition from an inpatient setting to home, gaps in care may exist that result in readmissions, complications or less than optimal management of chronic medical conditions. The CNS role was created to proactively manage this process.

Triad Healthcare Network (THN) was one of eleven Accountable Care Organizations in the country to meet the Centers for Medicare Service's quality metrics and achieve savings. The bar has been set very high with the Medicare Shared Savings Program. Through its collaborative efforts, THN achieved a cost savings of $21,510,000 while reducing admissions per 1,000 patient days, readmissions per 1,000 patient days and emergency room visits per 1,000 patient days.

Angela Thomas, RN, MSN-L, CCM

Progressive thinking

The THN Care Management team is made up of forward-thinking individuals who demonstrate positive outcomes daily. That team now has a new nursing member: a clinical nurse specialist (CNS). **Angela Thomas, RN, MSN-L, CCM**, brings a wealth of nursing and case management experience with patients across the continuum of health care to her new role. Angela will enhance the already impressive outcomes by fostering change within the organization, moving it toward a value-based care model. The organization will grow in many areas to include research, education and program enhancements. Creating a seamless transition from inpatient to outpatient care will continue to improve outcomes for patients served by Cone Health and THN.

THN patient populations

THN Care Management targets high-risk Medicare recipients who have chronic illnesses such as heart failure, COPD, and diabetes and are managed on an outpatient basis. THN Care Management strives to decrease the readmission rate within this population while improving patients' quality of life through education and guidance.

CNS role

THN, in partnership with Cone Health, embraces the Triple Aim framework to maximize the performance of the health system by "improving the patient care experience, improving the health of populations and reducing per capita cost of health care" (IHI Triple Aim Initiative, 2012). When patients transition from an inpatient setting to home, gaps in care may exist that result in readmissions, complications or less than optimal management of chronic medical conditions. The CNS role was created in order to proactively manage this process.

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Partners Caring for Our Community, *Continued*

The CNS role has three spheres of influence as outlined by the North Carolina Board of Nursing, "1) patient, 2) nurse, 3) system." THN Care Management goals within the Triple Aim framework and CNS spheres of influence will be to improve patient outcomes through educating nursing and ancillary staff, implementing evidence-based practice and collaboration with physicians throughout the health system.

Positive outcomes

Health care reform has spotlighted the need for quality metrics and positive patient outcomes. Nola Pender's health promotion model, which blends nursing and the study of behavior to effect change in patients' health, is the framework utilized by THN Care Management to gain positive patient outcomes (McEwen & Willis, 2011). The application of this model has proven to reduce hospital readmissions through education of positive health behaviors, daily weights for heart failure patients; recognizing symptoms of respiratory distress for COPD patients; and medication adherence for chronic conditions.

The bar must be continuously raised to promote positive outcomes for patients. Case managers are the catalyst that will help move patients to their next level, THN Care Management, in collaboration with the health system and physicians, has a goal to improve the health and wellness of the patient. In doing this, the CNS role is to facilitate meeting and exceeding these goals. ❖

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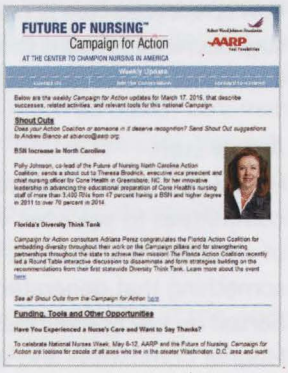
Community Networks Transform Healthcare Through Nursing


FUTURE OF NURSING™
Campaign for Action
AT THE CENTER TO CHAMPION NURSING IN AMERICA
AARP
Weekly Update
Below are the weekly Campaign for Action updates for March 17, 2015, that describe successes, related activities, and relevant tools for this national Campaign.
Shout Outs
Does your Action Coalition or someone in it deserve recognition? Send Shout Out suggestions to Andrew Bianco at abianco@aarp.org.
BSN Increase in North Carolina
Polly Johnson, co-lead of the Future of Nursing North Carolina Action Coalition, sends a shout out to Theresa Brodrick, executive vice president and chief nursing officer for Cone Health in Greensboro, NC, for her innovative leadership in advancing the educational preparation of Cone Health's nursing staff of more than 3,400 RNs from 47 percent having a BSN and higher degree in 2011 to over 70 percent in 2014.
Florida's Diversity Think Tank
Campaign for Action consultant Adriana Perez congratulates the Florida Action Coalition for embedding diversity throughout their work on the Campaign pillars and for strengthening partnerships throughout the state to achieve their mission! The Florida Action Coalition recently led a Round Table interactive discussion to disseminate and form strategies building on the recommendations from their first statewide Diversity Think Tank. Learn more about the event here.
See all Shout Outs from the Campaign for Action here
Funding, Tools and Other Opportunities
Have You Experienced a Nurse's Care and Want to Say Thanks?
To celebrate National Nurses Week, May 6-12, AARP and the Future of Nursing: Campaign for Action are looking for people of all ages who live in the greater Washington, D.C. area and want

Theresa Brodrick PhD, RN, CNA, executive vice president and CNO for Cone Health, recently addressed a joint meeting of the North Carolina Area Health Education Center (AHEC) Nurse Council and RN to BSN/MSN directors. As part of her presentation, "The Journey to Reaching the IOM's 80% BSN Recommendation by 2020: Cone Health's Story," Brodrick pointed out that Cone Health's BSN nursing numbers have risen from 59 percent in 2012 to 70.3 percent in 2014.

Polly Johnson, co-lead of the Future of Nursing North Carolina Action Coalition, was so impressed with Dr. Brodrick's presentation and strategies for success that she submitted a report of her work to the national weekly update of the Campaign for Action.

The Campaign for Action is a national organization that includes Action Coalitions in 50 states. These Coalitions are grassroots networks populated by a diverse group of community, business, academic, health care and consumer members. The mission of the Campaign is to promote the implementation of the Institute of Medicine's 2010 report, "*The Future of Nursing*." ❖

Above: Polly Johnson, co-lead of the Future of Nursing North Carolina Action Coalition, chats with Theresa Brodrick, executive vice president and chief nursing officer, Cone Health, at the AHEC sponsored Joint Meeting.

MAGNET
TRANSFORMATIONAL LEADERSHIP

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Walking the Talk
with the Ambulatory Shared Governance Council

By Sarah Lackey, RN, MSN, CCNS

Some of the areas represented in the Ambulatory Shared Governance Council include:

- Multiple Cancer Center locations
- Radiation Oncology
- Medical Oncology
- Regional Center for Infectious Disease
- Sickle Cell Clinic
- Wound Center
- Triad Healthcare Network case management (system-wide)
- Cone Health Medical Group main offices representing all their practices
- Vein and Vascular Surgeons
- Pain Center
- Family Practice
- Sports Medicine
- Internal Medicine
- Lebauer GI
- Lebauer Cardiology
- Greensboro Neurological Associates
- Clinical Intelligence
- Ambulatory Cone HealthLink team
- Accreditation

How many times do you keep trying to initiate something you believe in? As many times as it takes! At least, that's what **Sharon Powers, RN-BC, BSN**, Assistant Director for the Internal Medicine Clinic, learned when she had the vision to establish an Ambulatory Shared Governance Council in the Cone Health network.

Sharon Powers, RN-BC, BSN

We are all aware that health care is changing, with the emphasis moving away from acute inpatient care and more toward care in the community, with a focus on keeping people healthier. With the expansion of our facilities to include medical groups, affordable care organizations, services for high-risk and indigent populations, and others, the need for everyone to talk to each other, and have a role in making patient-centered decisions, was clear. Nurses at ambulatory sites were struggling to adapt to Cone Health network initiatives and policies because of how specialized care is in their areas. With a national trend toward shorter lengths of stay, decreased readmissions, the focus on funding is in ambulatory and operative care. It was vital to strengthen the ambulatory arm of the network.

A slow start

How was it done? It started small. Powers reached out to existing departments and committees to see what was being done already and what was needed in terms of ambulatory areas. She became a champion for ambulatory nursing advocacy, something that generated interest only after years of networking. She placed herself on key committees, including the manager-supervisor forum and the Magnet committee, and spent time looking proactively for other areas where she could represent ambulatory nursing.

When the network faced Joint Commission surveys, the Director of Nursing Practice, Education and Research asked Powers to assist with ambulatory areas in readiness for the site visit. Awareness of ambulatory need was increasing. Approaching the Chief Nursing Officer to request an executive champion to help with the ambulatory council initiative helped boost momentum for the project. Slowly, awareness was raised, barriers were overcome, and the Council got its start.

Turning the corner

The Ambulatory Shared Governance Council started small, with three to five members, as a subgroup of the Joint Service Practice Quality Council (comprised of the chairs of all unit-based Shared Governance Councils in Nursing). Quickly the group decided a larger council, with more inclusive membership, was needed. The group established a regular and predictable meeting time, and soon grew from the original five members to more than 20. Consistent membership was being logged at regular meetings in 2013. More members are being identified and added all the time.

With momentum going, the Council has accomplished some key initiatives. Council members have ensured that ambulatory areas are in line with practices across

Continued on page 17

Walking the Talk, *Continued*

the network, such as fall prevention measures, allergy identification, use of arm bands as identifiers and signals for risk in patients. They have successfully bridged the electronic medical record for the system, Cone HealthLink, so that ambulatory areas can see inpatient information, resulting in more complete and comprehensive care for patients. The Council also ensures that ambulatory areas are part of the whole process in the continuum of care, as in Emergency Department throughput.

The Council's voice and influence continue to be refined. It now has standing representatives for major initiatives, seen in the Ambulatory Quality Coordinator and an ambulatory clinical documentation committee. It has contributed directly to solutions related to patient care, health care communication, interdisciplinary collaboration and communication, and improvements in throughput. Through the creative use of technology, the Council maintains consistent attendance at meetings. There are now Ambulatory Council representatives on the Professional Development Council (Nursing), and the Policy and Procedures committee, by invitation.

Inclusive and broad

The Ambulatory Shared Governance Council, an example of a nurse-driven, interdisciplinary and collaborative effort, exists because of vision and perseverance. ❖

MAGNET
TRANSFORMATIONAL LEADERSHIP

Vice President of **Nursing Education, Practice** and **Community Integration**

By Belinda Hammond, RN, MSN, CEN, CCRN

The words 'Education' and 'Practice' in the title "Vice President of Nursing Education, Practice and Community Integration" are pretty self-explanatory. But what about "Community Integration"? We interviewed **Debbie Grant, RN, MSN, CENP,** who has been in the new position for a year, to find out just what she does.

> As the focus for health care provision moves away from acute care facilities and is placed more on the health care needs across the life span, visionary leaders in the Cone Health network established a new nursing executive position: the Vice President for Nursing Practice, Education and Community Integration.

The primary focus of this Vice President for Nursing role is to ensure continuity across the care continuum. Grant is responsible for bringing all involved health care members together -- from acute care, through home care, and long-term care -- to talk to each other and to coordinate services to offer patients the best possible care.

Here are some examples of the work she has done in the past year:

BLS competency

Practice and education issues exist in all settings and basic patient safety skills are not always present in every patient care area. Basic life support (BLS) competency was not uniformly maintained in physician's offices. Thanks to a focus on our patients in the community setting, BLS classes are now offered so that this rescue skill can be immediately provided to patients who may need it. In addition, job descriptions, minimal levels of practice, and education are being evaluated for Cone Health Medical Group offices to ensure safe and competent practice by all staff.

Helping nursing homes improve

Cone Health patients could potentially be admitted to one of 45 nursing homes across three counties. Patient hand-off during this transition is often inadequate: the physician may not be aware that the patient has been admitted to the nursing home for rehabilitation until the facility contacts the physician's office with discharge information. The new clinical nurse specialist (CNS) for community health, **Angela Thomas, RN, MSN-L, CCM**, who reports to Debbie Grant, builds

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Vice President of Nursing Education, Practice and Community Integration, *Continued*

MAGNET
TRANSFORMATIONAL LEADERSHIP

relationships and case coordination structures with these nursing facilities. As education is provided and quality evaluated, Cone Health providers will be able to identify the best nursing home facilities for our patients' extended care.

Palliative care: expanding the discipline

Another new CNS reporting to Grant is **Sue Ellen Grounds, RN, MSN, CHPN**. As the CNS for Palliative Care, Grounds brings team members together to maximize the comfort and safety of many patients. Palliative care is not hospice care, but rather a specialty whose goal is to create a highly individualized plan of care focused on reducing stressful symptoms. The quality of physical, emotional, and spiritual experiences of patients suffering from chronic and/or life limiting illness is thus improved.

Refugee populations

Efforts to integrate Congregational Nurses and physicians caring for refugees in our community, particularly related to controlling communicable diseases, are underway. To help remove barriers to care for the refugee population, the congregational nurses established a regularly scheduled "refugee day" at the Cone Health Community Health and Wellness Clinic. Similar efforts are underway to coordinate medication prescriptions for this population.

Re-energizing physician involvement

One of the most sweeping changes made in the past year is the formation of a new group, the Clinical Program Committee (CPC). Designed to streamline communication and collaboration, the CPC intends to bring the joy of practicing medicine back to physicians by liberating them from attending so many meetings. There are currently 11 CPCs, organized along service lines such as Pediatrics, Surgical Oncology, Behavioral Health, Cardiology, and others. Each CPC is headed by a physician; additional members include inpatient physician and community physician representatives, nursing representation (usually a CNS), an executive champion, and other interdisciplinary team members.

Physician "shared governance"

Functioning as a shared governance council for physicians, the new Operations Coordination Council is modeled after a Mayo Clinic structure that has demonstrated how Affordable Care Organizations can change community health outcomes for the better. This group will focus on quality of care across the continuum of health care services.

As the focus of health care moves from acute care facilities to integrated community care, a leader with a clear vision for the future is necessary. Grant acknowledges this, saying, "This role allows me to touch clinical practice in so many arenas I had not thought possible."

Pamela Hamilton stands by a recent project done to benefit Victory Junction.

Caring for Our Community Built into the New Grad Nursing Academy at Cone Health

The newest nurses in our health network, also new in their careers as nurses, develop and implement group projects as part of their Academy attendance during the first year of employment at Cone Health. ❖

"These projects are group projects designed to help new nurses think about how to give back to the community."

– Pamela Hamilton, RN, MHA, New Grad RN Coordinator

Community, Cone and Congregations:
Making significant contribution to the health of our community through the Congregational Nurse Program

By Lelia Moore, RN BSN, and Sarah Lackey, RN MSN CCNS

Caring for Our Communities, as one of our organization's values, is more than evident in the work of the Congregational Nurse Program (CNP). The program is exemplary.

Begun in 1998, originally with a grant from the Duke Endowment and the Moses Cone/Wesley Long Community Health Foundation, this program has grown from affiliation with 10 congregations in the year 2000 to having established partnerships with 93 congregations or faith communities, including 15 religious affiliations, in 2015. The program serves more than 80,000 individuals in the Cone Health service area. One-third of the organizations represent underserved congregations and community groups, with a heavy concentration being the homeless, the working poor, people in public housing and refugees.

One of the sites through which congregational nurses can reach the community is the Interactive Resource Center, a community day center for the homeless. This center represents the integration of community and religious organizations. Board members are heavily involved in addressing the holistic needs of the homeless, with client-centered, wrap-around services (health assessments, case management, job skills training, GED preparation, housing, food, and mental health/substance abuse counseling). The CNP provides behavioral health nursing on-site, and was instrumental in developing a nurse practitioner clinic for the homeless housed there. CNP also provides nursing care at the Salvation Army Center of Hope in Greensboro, and the Salvation Army facilities in Eden and Reidsville.

The Congregational Nurse Program partners with everyone in the community:

- Within the acute care setting, congregational nurses work with many patient populations to avert readmissions. Congregational nurses are members of the Congestive Heart Failure Breakthrough Project and serve as a vital link to the community to decrease readmissions for heart failure. A similar liaison exists for the COPD patient population.
- Program nurses work with organizers of community events, such as the Women's Only 5K run, which raises awareness for breast cancer and funds mammography screenings.
- Congregational Nurses, in collaboration with Women's Hospital, helped to organize and staff successful refugee health fairs that include bone density screenings for women. The health fair provides interpreters for specified language dialects; this allows varying population groups in the Triad area to receive health care attention.
- The program also works closely with schools of nursing in the area, offering clinical experiences for students, precepting RN to BSN candidates, and working with masters' level and doctoral level students.

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Community, Cone and Congregations, *Continued*

- The CNP has a strong footprint with the homeless, refugees and immigrants—eight of the Cone Health nurses specialize in work with refuges across two counties.

Another community initiative by congregational nurses is a program developed by working collaboratively with multiple groups. The HOPES Initiative was developed to assist with homeless patients who have been discharged from Cone Health but are still medically compromised. This program was developed thanks to an anonymous donor who specified that it be used to care for the underserved. The initiative was implemented in 2012 with collaboration among four groups:

- The Cone Health Department of Social Work.
- The Congregational Nurse Program.
- University of North Carolina Greensboro Congregational Social Work Education Initiative.
- The Interactive Resource Center.

Assistance includes lodging, bus passes, gift cards for medications and food, case management and assistance in finding more permanent housing.

All the services of the Congregational Nurse Program are free to recipients. The program is supported by the Cone Health Foundation and Cone Health. The Office of Fund Development assists with community outreach to secure private gifts. This has enabled congregational nurses to do community screenings, give free flu vaccines, and provide medication and transportation assistance for clients in both Guilford and Rockingham counties.

Lelia Moore, RN, BSN, Coordinator for the Congregational Nurse Program, is a dynamic leader who refuses to be limited by traditional program definitions and boundaries. Having created collaborative partnerships in the community to provide new and expanded services for those in need, she describes herself as a 'bridge-builder." For her amazing work and its results, the Greensboro News and Record chose to honor her as the Woman of the Year in 2012.

The Cone Health Congregational Nurse Program celebrated 15 years of success in Guilford County at the 2014 Performance Excellence Awards on Feb. 3, 2015, at the new John A. Lusk III

Continued on page 21.

MD Caregiving Education Center at Hospice and Palliative Care of Greensboro. During the event, 31 congregational nurses (paid and volunteer) and faith leaders who met performance excellence standards for the year were honored. The guest speaker was **Tim Rice**, Cone Health CEO Emeritus.

The Congregational Nurse Program also recognizes an Outstanding Congregational Nurse of the Year for exemplary professional accomplishments within their faith community and the community at large.

The 2014 recipient is **Maureen Flak, RN,** who serves a dual role in the community. She has served as a Congregational Nurse at Holy Trinity Episcopal Church since 2006 and as a Congregational Nurse working with refugees through Church World Services and the Glen Haven Community since 2010. Maureen's many professional gifts enable her to work across the age continuum to help individuals find health and healing. She is a tireless advocate for refugees in helping them navigate a complex health care system in spite of the barriers of language and culture. Maureen is a former Cone Health employee with Behavioral Health.

Also honored during the event were the five congregational nurses who work with the HOPES initiative: **Wanda Martin, RN, MSN**; **Marietta Douglas, RN, MSN**; **Sharon Muckenfuss, RN, BSN**; **Christine Murdock, RN, BSN**; and **Felicia Reid, RN, MSN**.

Barbara Marksamer, who was a congregational nurse at St. Paul The Apostle Catholic Church for 12 years, died in December. Until a few years ago, Barbara was a nurse for many years at Cone Health Behavioral Health. Barbara was lovingly remembered for all her contributions to her church and the Congregational Nurse Program.

In addition to the accolades listed above, 31 congregational nurses achieved the performance excellence recognition for 2014.

Says **Lelia Moore, RN, BSN**, Coordinator for the Congregational Health Nurse Program, "In the last 15 years we have had 102 life-saving interventions. That's a pretty significant community service." ❖

MAGNET
STRUCTURAL EMPOWERMENT

Victory Junction Nursing: **A Cure for Nursing "Burn Out"**

By Denise Leone, DNP, RN, CPNP

No special pediatric training is needed to volunteer at Victory Junction. There is a full time staff of pediatric nurses on site at all times.

"Seeing the joy on the kids' faces makes this a worthwhile experience," says **Pierina Cangialosi,** a Cone Health nurse who works on the mother/baby unit at Women's Hospital. "This camp is unlike any other camp I have experienced. To see kids with various diseases and disorders have a chance to escape reality and just be kids is priceless."

Victory Junction, the unique vision of late race car driver Adam Petty, opened in 2004 with the goal to give every camper the opportunity to participate in year round activities in a medically safe environment. This one of a kind camp has provided life-changing experiences for children with serious illnesses and chronic medical conditions at no cost to the children or families. Victory Junction serves children with many different diagnoses (see text box). Children from all over the country come to Victory Junction to forget about their diagnosis for a while and just be a kid. They leave refreshed by new experience and rejuvenated to face their lives.

Nursing care in a camping environment

What helps make it possible for these children to have a camp option? Volunteer nurses, many from Cone Health facilities. Nurses offer the medical expertise and passion for children that is needed to make camp a reality. There is no need to have pediatric experience to volunteer, as the camp has a full-time, pediatric trained staff and nurses who are hired for the summer.

The goal of the Victory Junction healthcare team is to provide the same type of care at camp as the children receive at home with as few interruptions as possible to the flow of camping routine. Medication administration, urinary catheterization, glucose testing and other minor procedures are performed for children at the camping program areas to decrease time spent

Continued on page 23

away from camp activities. Counselors are trained to assist campers in activities of daily living, personal hygiene and elimination, allowing the medical team to focus on more acute needs.

Should a camper need it, the Body Shop—the medical facility at the camp—is available for more complicated procedures that cannot be taken to the program areas. Nearly all medical procedures can be performed there, including peritoneal dialysis, intravenous infusions, and central line access. The staff at Victory Junction try to keep campers out of the Body Shop as much as possible. "This camp has gone above and beyond to make accommodations for these children and you can tell the staff genuinely care," says Cangialosi.

Repeat volunteers

Victory Junction has become such a positive experience for nurse volunteers that many of them repeat their service year after year. Several Cone Health nurses have been regular volunteers in the 10 years the camp has been open, working during family weekend days, week-long summer camps, even during the one-day fund raising events like the annual Run-to-Victory held each fall. "My experience with Victory Junction was a heartwarming one," says Cangialosi. By early 2015 she had already signed up to volunteer for a neuro/genetic week in the summer.

Come to Victory Junction and remember why you became a nurse. The facility is always looking for nurses, nurse practitioners, physician assistants, and physicians to be a part of their medical team. Healthcare providers can volunteer for a family weekend in the spring or fall from Friday to Sunday. In the summer, volunteers are needed for the overnight camp from Sunday to Wednesday or Sunday to Thursday. Victory Junction covers all food and housing costs for their volunteers. "We are fortunate in the Triad to have Victory Junction in our backyard to offer opportunities to our local healthcare providers," says **Denise Leone, DNP, RN, CPNP**, the camp's nursing director. ❖

Selected diagnoses of children at Victory Junction:

bleeding disorders
cancer
cerebral palsy
craniofacial anomalies
diabetes
epilepsy
gastrointestinal disorders
genetic disorders
heart disease
lung disease
kidney disease
mitochondrial disorders
neurological disorders
rheumatologic disorders
sickle cell disease
skin disorders
spina bifida

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To apply to make a difference in a child's life, please visit https://victoryjunction.campmanagement.com/apply or contact Victory Junction's nursing director, Denise Leone, DNP, RN, CPNP at dleone@victoryjunction.org or 336-495-2015.

CONTRIBUTING TO
NURSING
SCIENCE

Development and Results of a Postpartum Hemorrhage Protocol in a Regional High-Risk Perinatal Care Center

Jenny Clapp, RNC-OB, MSN and
Sue Pedaline, DNP, RNC, MS

Our hospital is a teaching facility serving a diverse population of families. It is the only free-standing women's hospital in the state and averages 6,200 deliveries per year. Despite being a ground-breaker in many ways, our rate of postpartum hemorrhages (PPH) was almost equal to the state and national averages. There was no standardized approach to the management of PPH and with an increasing urgency to improve PPH outcomes, nurses made the decision to institute change.

The goals of our initiative were to develop a PPH protocol, decrease the rate of PPH-related blood product transfusions, and decrease the number of PPH-related adverse outcomes such as peripartum hysterectomies and maternal death. A team approach was needed to develop and utilize a standardized protocol. Education of all members of the health care team would be essential, and historically physicians and nurses did not participate in education together. Therefore the decision was made to change the culture of the hospital toward a culture of safety and to enhance interdepartmental teamwork.

A focused, multidisciplinary team representing every clinical department in the hospital formed a PPH committee and was facilitated by a nurse leader. Each member of the team took ownership of his/her part of the process using the Plan-Do-Check-Act Quality Improvement methodology. The protocol was developed, and didactic and simulation classes took place with over 83 percent of the entire nursing and physician staffs participating. Before participating in the simulations, the mean confidence level in identifying/managing PPH was 2.6 (n=307) on a Likert scale (1=not confident at all, 4= very confident). One month after the simulations, 90 percent of the participants felt either "confident" or "very confident". The PPH protocol was implemented in 2012. The rate of PPH-related transfusions decreased from 3.5 percent in 2009-2012 to 2.8 percent in fiscal year 2014. Unplanned hysterectomies due to PPH decreased from an average 4.6/year in 2009-2011 to 2.6/year in 2012-2014.

Nurses can be change agents in an environment that has not previously embraced a true team approach. A well-coordinated effort and physician champions were major factors in the success of our efforts. Nurses at the bedside can be empowered to initiate evidence-based practice approaches in order to improve outcomes, and the overall quality of life for our mothers and their families. ❖

CONTRIBUTING TO
NURSING
SCIENCE

Improving Quality Outcomes in Hip Fracture Patients through Development and Implementation of an Evidence-Based Protocol

Eva Hyde, RN, MSN CNS, ONC
Linda Bryson, RN
Nicole Baltazar-Holbert, RN, MSN

Hip fractures are a growing problem in the United States with more than 300,000 occurring annually. This number is expected to increase by approximately 500,000 each year by 2040, with an annual hospital cost of $4.5 billion. Ninety percent of hip fractures in the elderly are due to falls and mortality rates range from 10 - 35 percent within the first year post-fall.

The purpose of this protocol development was to create a consistent interdisciplinary approach to hip fracture patient care based on best practices, decrease variability, and improve patient outcomes including mortality rates. The IOWA model of evidence-based practice and the PDSA (Plan-Do-Study-Act) Quality Improvement Process were utilized for protocol development. Current literature was reviewed and hip fracture care at other facilities was investigated prior to protocol development. Baseline data was collected and retrospective patient chart reviews were conducted. An interdisciplinary Hip Fracture Committee was formed to lead in the development and implementation. The protocol was implemented in June 2013.

Before the protocol was implemented, hip fracture mortality was 5.15 percent. Post-protocol implementation mortality rates have ranged from zero to 4.76 percent (better than the expected national benchmark). Protocol utilization compliance outcomes showed 97 percent usage of the orthopedic order set, and 100 percent compliance with post-operative metrics and 87.6 percent of discharge metrics.

This protocol demonstrates a state-of-the-art approach to a common problem seen throughout the U.S. and internationally, and serves as a model for integrating best practices and a co-managed approach in providing standardized top-tier care to hip fracture patients. It also showcases an innovative strategy for engaging physicians from multiple practices to lead the implementation of clinical practice improvement. Outcomes within our hospital network continue to improve following implementation of this protocol.

This evidence-based protocol won First Place in its category at the 3rd Annual Nursing Research Symposium Poster Presentations, Greensboro, NC, 2014. ❖

CONTRIBUTING TO
NURSING
SCIENCE

"Heavyweight" Champion Fights for a Cause: Best Practice in Daily Weight Monitoring for Heart Failure Patients

Laurie Freeman, RN, CHFN
Lanisha Hunter, RN-BC, BSN, MHA

Having a nurse tech as the project champion increased buy-in from staff, particularly the nurse techs. In addition this nurse tech exhibited transformational leadership as he modeled behaviors for his peers and kept them accountable to the standards.

An important prevention tool for managing the patient with heart failure (HF) is weight monitoring. Random audits by nurses on our inpatient heart failure unit revealed that only 30 percent of HF patients had consistent daily weights documented along with the type of scale used. In addition nurses were being notified of weight gain > 2 pounds only 15 percent of the time. These triggers prompted us to ask, "Would a dedicated weight champion assist with daily weight monitoring in HF patients?"

Using the IOWA model, we formed an evidence-based practice team. Our literature review yielded strong evidence to support weight monitoring as an essential component of HF care. We collected baseline data on weight documentation and examined our current practice. A practice change was clearly indicated.

We did find it necessary to reeducate the staff as to the importance of accurate daily weights and the purpose of the project. A nurse tech was appointed as our "heavyweight" champion to do weight audits on the department and notify the nurse of significant weight change, allowing immediate follow up with staff. Having a nurse tech as the project champion increased buy-in from staff, particularly the nurse techs. In addition this nurse tech exhibited transformational leadership as he modeled behaviors for his peers and kept them accountable to the standards.

Follow-up audits demonstrated an improvement in weight documentation regarding scale type from 30 to 90 percent. Appropriate nurse notification of weight gain increased from 15 to 100 percent. Although the importance of weight documentation had been addressed previously on our department, staff engagement in the evidence-based project made the difference. By improving daily weight accuracy and documentation, this project has positively impacted the care of our HF patients. Physicians can more adequately assess fluid status and our patients are benefiting from best practices in HF care. ❖

CONTRIBUTING TO
NURSING
SCIENCE

What's Going on Under the OR Drapes?

Melody Austin, RN, BSN, CWOCN
Dawn Engels, RN, MSN, CWOCN, CWCN-AP, CNS

Early identification of potential risk factors prior to the patient entering the OR is the first step toward implementing a preventive process to decrease the incidence of pressure ulcer development. Nurses across the continuum of care need to develop improved communication systems during hand-off to support these preventive measures.

Prevention of hospital-acquired pressure ulcers (HAPU) is an important quality measure since it is considered a "never event". Literature suggests pressure ulcer prevalence occurs at a rate of 8.5 percent or higher among patients who undergo surgical procedures lasting longer than three hours. The purpose of this study was to determine what factors contribute toward the development of pressure ulcers in patients who have been to the operating room (OR).

A retrospective chart review was conducted of all patients found to have a HAPU noted within one week of having a surgical procedure performed at our four acute care hospitals. A dedicated drill-down tool was created reflecting specific risk factors identified in the literature as contributing to perioperative pressure ulcer development. Fifteen patients who underwent surgical procedures developed a pressure ulcer that was noted during the post-operative stay. The study group was compared to a randomized control group of 45 patients who had surgical procedures performed during the same time frame and did not develop a perioperative pressure ulcer.

The findings revealed a statistically significant increased risk for pressure ulcer development when patients have incontinence, sepsis, decreased body temperature or increased length of surgery. Of the patients who developed perioperative pressure ulcers, 40 percent were incontinent of bowel or bladder and 53.3 percent were septic. Perioperative hypothermia was also a significant factor ($p = 0.039$) as was surgical time. The average length of surgery for those patients who developed pressure ulcers was 365 minutes; pressure ulcer risk increased by 48 percent with each additional hour of time in the OR ($p = 0.056$).

Early identification of potential risk factors prior to the patient entering the OR is the first step toward implementing a preventive process to decrease the incidence of pressure ulcer development. Nurses across the continuum of care need to develop improved communication systems during hand-off to support these preventive measures. Ongoing educational efforts regarding pressure ulcer staging and appearance, appropriate padding and positioning, and documentation is a multidisciplinary process and a critical component in decreasing pressure ulcers during the perioperative period. ❖

CONTRIBUTING TO NURSING SCIENCE

A Three-Tiered Bundle to **Prevent Falls**

Anne Brown, RN, MSN, NEA-BC; Kellie Capes, RN, BSN, PCCN; Thresa Isley, DNP, RN, ACNS-CS; Danyel Johnson, RN, MSN, CNN; Tammy Mebane, RN MSN, CNML; Brenda Murphy, RN, MSN, GNP-BC; Nancy Watson, RN, BSN; Jennifer Watkins, RN, BSN, CNML

Falls in hospitalized patients are considered "never events." Increased length of hospital stay and additional treatment needed after a fall contribute to a 61 percent increase in patient care costs. In an attempt to decrease our patient fall rates, the SAFE (Stop All Fall Events) team examined the literature to determine interventions to help prevent falls. These evidence-based interventions were categorized into three bundles: education, leadership and clinical. Key interventions for each bundle were determined and intensive education related to the bundles was done.

The education bundle consisted of assigning staff a computer-based learning module each quarter related to hourly patient and environmental rounds, developing and following a patient safety plan, and assessing the ABCs (age, bones, coagulopathy), and surgery for patients. As part of the leadership bundle, "never event fall huddles" were held at the patient's bedside, with patient and family input, immediately after a patient fall. A discussion of falls prevention was placed on the agenda for every department-level meeting. The clinical bundle interventions such as use of bed alarms, placement of yellow armbands and socks, and moving the patient to the room with best visual access, were based on the level of risk for falls (universal, moderate, high).

We were pleased with the results of this three-tiered falls prevention bundle. During fiscal year 2012, we recorded 541 inpatient falls. Following implementation of the bundles, falls were reduced to 305 during fiscal year 2014. By standardizing interventions and assigning accountability, we were able to impact lives saved and health care dollars spent. ❖

Meet a Wellness Nurse:
Debbie Kinney, RN, BS, RYT

By Nancy Summerell RN, MSN, CEN

In the summer of 2012, Cone Health and the Spears Family YMCA launched a partnership designed to improve the health of the "Y" members, placing a Wellness Nurse at the facility. As the Wellness Nurse, Debbie Kinney focuses on nursing care that improves the overall health, welfare and safety of the clients. During her open office hours three times a week, she offers wellness counseling, answers questions, checks blood pressure, does lab draws and certain point of care testing. At least twice yearly, Kinney organizes health fairs sponsored by Spears YMCA and Cone Health. The newest program to be launched soon is a provider referral Exercise and Wellness Program. As a health coach, Kinney will meet with each participant to create a very individualized, 12-week program focused on strategies to help clients make lifestyle changes and achieve their self-identified health goals. ❖

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Send graduation and certification notices to Settingthepace@conehealth.com in order to be recognized.

SETTING THE PACE

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From the **Editor**

Recently I had the experience of being a patient. Not a medical patient; a dental patient. But a patient nonetheless. Anyone in health care should be a patient at least once. Repeating the experience periodically is a good practice, too. I had forgotten just what it felt like.

I was scheduled to go to a specialty dental office I had used for the same kind of procedure about 10 years ago. I dreaded it. Last time they were impersonal, strictly business, explained little, and I felt like just another number on the schedule. I remember leaving thinking that all they cared about was making sure I paid before I left.

In the years that have passed since then they must have gotten the health care 'memo.' This time was totally different. I had a name. My comfort was attended to regularly. They included me in conversations. They took time to explain things, establish eye contact, and speak directly to my face. They had special little techniques that helped with distraction through some parts of the procedure. And at any time I was uncomfortable in any way I had a signal to use (since I could not talk) to let them know. It could not have been better.

I was relieved. Despite all this though, as I lay there listening to the drilling sounds, I was thinking about our patients. I knew that my procedure would end that afternoon. I would get up, walk out of the office, and go back to my life. But what if I were laying in an ICU bed? What if I had no idea when the discomfort would end, or when I could get up and go home?

The experience reminded me of two things: the scariest thing about needing health care is the unknown, and much of the dread comes from feeling like we are in it alone. It is desperately important that we see our patients as people, with preferences, needs and fears, and treat them accordingly.

This issue of Nursing Beat focusses on the way Cone Health nurses provide care for our ambulatory patients and patients in the community. Nurses in our network do so much that we were unable to include everyone's work with these patient populations. The Editorial Board hopes you enjoy the articles we have presented as a sample of the truly amazing things Cone Health nurses are doing for patients in these settings.

Thanks for all you do for our patients and for each other every day, in big ways and especially in little ways. ❖

Sarah

Sarah Lackey, RN, MSN, CCNS, Editor-in-Chief
Magnet Program Coordinator, NDNQI Site Coordinator

"The scariest thing about needing health care is the unknown, and much of the dread comes from feeling like we are in it alone. It is desperately important that we see our patients as people, with preferences, needs and fears, and treat them accordingly."

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Nursing Beat

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