Managing Resources in the Changing Healthcare Environment
Components included in this module

1. Centers for Medicare and Medicaid Service (CMS) Measures and Value-Based Purchasing (VBP)
2. Change Management and Tolerance
3. Elimination of Wasteful Process and the Assumption of Fiscal Responsibility into Clinical Practice
Objectives

- Achieve Value-Based Purchasing metrics in clinical practice
- Exhibit approaches to change management/change tolerance that are conducive to individual and unit success
- Advocate for patient access to care and for judicious use of patient resources
- Incorporate the elimination of wasteful process and the assumption of fiscal responsibility into clinical practice
1. Quality and safety are integral to providing care to patients in the hospital setting. Barcode medication administration is an example of innovation improving patient safety.
   a) True
   b) False

2. Traditional nursing practice is based on multi-settings, outcome driven, best practice oriented, emphasized by technology and minimally invasive interventions, user driven, health based, geared for early intervention.
   a) True
   b) False

3. Resistance is recognized as a natural and expected response to change.
   a) True
   b) False

1. Quality and safety are integral to providing care to patients in the hospital setting. Barcode medication administration is an example of innovation improving patient safety. (T or F), this is a true statement TRUE

2. The traditional nursing practice is based on multi-settings, outcome driven, best practice oriented, emphasized by technology and minimally invasive interventions, user driven, health based, geared for early intervention. (T or F)

   FALSE, traditional nursing is institutionally based care, process orientated, procedurally driven, based on mechanical and manual intervention, provider driven, reflective of late stage intervention, based on vertical relationships.

3. Resistance is recognized as a natural and expected response to change. TRUE
4. True: 20% to 30% of health spending is waste that yields no benefit to patients
   a) True
   b) False

5. Learning Kaizen is a methodology to
   a) Look at waste
   b) Learn Japanese
   c) Make employees understand their work better

4. True: 20% to 30% of health spending is waste that yields no benefit to patients

5. a
Centers For Medicare and Medicaid Service (CMS) Measures and Value-Based Purchasing (VBP)
How Nursing Impacts CMS Measures

Jo May, MSN, CNS, RN, RN-BC
Leah Scalf RN, MSN, NE-BC
Objectives

The new graduate nurse will

- Understand the history behind CMS and quality measures
- Understand the definition of Value-Based Purchasing in relation to hospital reimbursement
- Identify how quality measures impact nursing care
- Understand what measures nursing can directly impact
- Synthesize learning into everyday practice
CMS stands for the Centers for Medicare and Medicaid Services. It is housed in the Department of Health and Human Services and is the provider for both the nation’s Medicare and Medicaid programs. These programs were created in 1965 by the Johnson administration as part of the Social Security Act. The first program I will discuss is Medicare. This program was designed to provide lifelong coverage for the elderly population (those 65 or older). At the time that the program was created, 35% of this population had no health insurance. The Medicare program was designed to provide lifelong healthcare coverage for this population. Eventually it was expanded to younger persons diagnosed with permanent disabilities. This distinction is important as I will explain, but it is also important to remember that Medicare was designed to be lifelong coverage.
Medicare

- Provides coverage for elderly
- 35% did not have any health insurance prior to Medicare
- Expanded to younger persons with permanent disabilities
- Coverage intended for duration of person’s life

The Medicaid program was initially designed to help individual states offer medical coverage for families that had fallen on hard times financially. It was designed to provide a temporary help to cover urgent procedures until an individual or family could get to a place where they could cover their own medical expenses or were covered under a different program or plan. A key factor to remember about Medicaid is that the program was originally designed for short term help and was not intended for long term coverage. Because Medicaid is state run, eligibility is based on individual state requirements and may vary from state to state. Although Medicaid was designed to be a temporary help for families and individuals, by the year 2032 we will see the possibility of the first generation of persons born under Medicaid to age into eligibility for Medicare. This population would have had their healthcare during their entire life provided by the government. There have been changes to Medicaid in recent years and the program is beginning to provide coverage for items and procedures that were not originally covered. That said, there are still things that are covered for a Medicare patient that are not covered for a Medicaid patient even though CMS runs both programs. This would include items that are not deemed to be an urgent need for a Medicaid patient. As I said earlier, we are beginning to see this change as the government considers the growing population that is relying solely on Medicaid for their healthcare reimbursement over long term periods. This is especially true as the Obama administration is asking states to expand their Medicaid roles as part of the affordable care act.
According to the most recent census data, CMS currently covers approximately 92.9 million patients between its Medicare and Medicaid programs. Census data for 2011 listed CMS reimbursements for care of patients under these programs at 47.2 percent or about 182.7 billion of the total aggregate inpatient hospital costs in the United States. Additionally, the Affordable Care Act is asking states to expand their coverage for patients already enrolled in Medicaid programs as well as increase the number of overall participants. When you look at all of these factors, you can begin to see that the amount of money required for Medicaid programs will increase dramatically over the next few years. Some states have elected not to expand their Medicaid program eligibility - Indiana is one of these states. This is due to the fact that while the Affordable Care Act will provide help to states electing to expand coverage, this help is only temporary. Some states such as Indiana feel that they might not be able to sustain an expanded Medicaid population once the government help is gone and are looking at alternatives to expanding coverage.

As we have discussed, the changes brought by the Affordable Care Act will increase the total Medicaid population. In addition, the overall age of our population is increasing. The estimate is that by the year 2030, the number of Medicare eligible patients will increase from 48 to 80 million. It is also known that this generation is sicker than previous generations: it is estimated that 20% of Baby Boomers have five or more chronic conditions.

When you take all of these factors into consideration it is evident that CMS not only is but will continue to be the largest consumer of healthcare services in the U.S.
The goal of the Affordable Care Act is to provide quality care for all Americans with an emphasis on accountability among healthcare providers and public disclosure. This is part of the administration’s commitment to transparency in the provision of healthcare. Accountable and transparent healthcare was also the goal of CMS when in 2001 it looked to create quality measures. These measures placed the responsibility on hospitals to provide an expectation of quality care for patients being admitted with the top diagnoses that CMS was receiving claims for at that time: pneumonia, heart failure, heart attack and surgical procedures. To help in creating quality measures for these “Core Conditions”, CMS turned to agencies that were already monitoring best practice and creating evidence-based care recommendations. Among them were the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF). With the help of these and other agencies, CMS released the first set of quality measures for the four core conditions previously mentioned. Again, these quality measures looked at what would entail quality care for a patient presenting to a hospital with one of these conditions. An example of this would be the expectation that a patient being admitted to the ED for PN would have appropriate antibiotics administered within an appropriate time frame. This is based on research into best practice guidelines. It was these guidelines that CMS used to reimburse hospitals for care. Based on a hospital’s performance in relation to other hospitals, hospitals could have reimbursement withheld or earn more money. As you will see, the bar was set pretty high to meet or exceed measures due to the fact that some hospitals were and continue in meeting measures at 100%.
From the CORE quality measures has branched a new parameter that CMS is using to gauge performance in healthcare: Value-Based Purchasing. VBP was started in fourth quarter of 2012 so it is a fairly new program. Under Value-Based Purchasing, CMS no longer pays a fee for simply caring for a patient with a certain diagnosis or performing a certain procedure, but bases reimbursement on how well we cared for the patient or did the procedure. Value-Based Purchasing also looks at the outcomes of that care as we will see. Hospitals are rewarded for meeting benchmarks or targets for delivery of care. This grading is not only on a hospital’s performance but also, the efficiency with which they provided that care. CMS is starting VBP with hospitals, but eventually will be expanding this grading system to physician offices and other healthcare providers such as Extended Care Facilities (ECFs). In addition to incentives for meeting targets of care, VBP also has and disincentives for negative consequences of care such as hospital acquired conditions (HACs). VBP started within hospitals because hospital systems generally have more resources and personnel to implement larger programs such as VBP. It is also the expectation of CMS that hospitals will reach out to other healthcare providers within the community to provide support services and education to help these providers meet the VBP benchmarks.

**Value-Based Purchasing**

- Emerging movement in healthcare
- Traditional fee-for-service--how *many* did you do?
- Moving to pay-for-performance--how *well* did you do?
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Value-Based Purchasing

- Rewarded for meeting pre-established targets for delivery of healthcare services- performance measures of quality and efficiency
  - Hospitals
  - Physicians
  - Other healthcare providers
- Disincentives for negative consequences of care
- Penalty for HAC and readmissions
- Scope of responsibility is moving outside of hospital
Data is collected and reported to CMS in regards to quality measures and Value-Based Purchasing measures in several different ways: CMS collects data submitted by hospitals as well as claims sent to CMS for payment. An example would be many of the current CMS measures such as the global flu vaccination measure. This data is currently manually abstracted from charts and submitted to CMS via outside vendors such as Quantros and Indiana Hospital Association (IHA). Data is also collected when claims are sent to CMS for payment. An example of this would be 30-day readmission rates. When a claim for a patient is sent to CMS followed within 30 days by another claim for the same patient, the hospital submitting the first claim may be penalized for a readmit within 30 days. Note that the patient does not have to readmit to the same hospital. If the patient readmits to any hospital within 30 days, the hospital that discharged the patient initially may be penalized. While hospital readmissions is not part of VBP, it does impact a hospital’s revenue when penalties such as this are levied.
CMS and the government have committed to providing safe, effective and efficient care for all Americans. Part of this commitment is transparency via public reporting. One way this data is available is through the public website Hospital Compare. This website is available for anyone to quickly access data regarding a hospital’s performance on any measures collected by CMS as well as the ability to compare up to three hospital’s performance on these measures. Future state for this site is the expansion of this data to include other healthcare entities such as Extended Care Facilities (ECFs) and physician offices. To use the site, you go to the website address above and begin your comparison by entering data such as your zip code or search a specific hospital name. You can search up to three hospitals at a time.
Many other private payers and entities such as HealthGrades are utilizing the vast amount of data collected by CMS and are basing their reimbursement and awards on this data. This makes being familiar with and meeting CMS measures even more vital to the success of hospitals.
VBP domains--2017 weighting for payment

Clinical care outcomes
  • 25%

Efficiency and cost reduction
  • 25%

Patient and caregiver experience
  • 25%

Safety
  • 5%

Clinical care processes
  • 5%
How will hospitals be evaluated?

- Hospitals are given points for achievement and improvement for each measure
- Points are added across all measures to reach total performance score
  - Patient and caregiver centered experience of care
  - Care coordination experience of care
  - Clinical care outcomes
  - Efficiency and cost reduction
  - Safety
  - Clinical care processes

Hospitals have the ability to earn Achievement and Improvement points for each of the measures evaluated by CMS with the highest of the two being awarded. Achievement points are awarded by comparing an individual hospital’s rates with the threshold, which is the median, or 50th percentile of all hospitals’ performance during the baseline period, and the benchmark, which is the mean of the top decile, or approximately the 95th percentile during the baseline period. So achievement points are awarded by comparing hospital with other hospitals. Improvement points are awarded by comparing a hospital’s rates during the performance period to that same hospital’s rates from the baseline period. So improvement points are awarded by comparing hospital against benchmark and own baseline. It’s important to note that as hospitals get closer to benchmark without achieving it, the less improvement point opportunities, there is less significant difference between baseline and benchmark.
How will hospitals be evaluated?

**Achievement Points**-Hospital compared to other hospitals
- Hospital rate at or above benchmark = 10 points
- Hospital rate below threshold = 0 points
- Hospital between threshold and benchmark = 1-9 points

**Improvement Points**-Hospital compared to itself
- Hospital at or above benchmark = 9 points
- Hospital at or below baseline = 0 points
- Hospital between baseline and benchmark= 0-9 points

Hospitals have the ability to earn Achievement and Improvement points for each of the measures evaluated by CMS with the highest of the two being awarded. Achievement points are awarded by comparing an individual hospital’s rates with the threshold, which is the median, or 50th percentile of all hospitals’ performance during the baseline period, and the benchmark, which is the mean of the top decile, or approximately the 95th percentile during the baseline period. So achievement points are awarded by comparing hospital with other hospitals. Improvement points are awarded by comparing a hospital’s rates during the performance period to that same hospital’s rates from the baseline period. So improvement points are awarded by comparing hospital against benchmark and own baseline. It’s important to note that as hospitals get closer to benchmark with out achieving it, the less improvement point opportunities, there is less significant difference between baseline and benchmark.
You have heard me talk about hospitals receiving reimbursement or earning back money from CMS for performance on the measures. This illustration will help to explain this process. At the beginning of the Fiscal Year, CMS withholds a percentage of money payable to hospitals for treating their patients, currently this is 2% withheld. This money is illustrated by the green bag in the picture. From this money, hospitals have the ability to earn back incentive based on their performance on measures in Value-Based Purchasing. It is important to note that a hospital can earn back more than what was withheld by being one of the hospitals in the top decile for performance. The hospitals with the lowest scores earn back nothing. This is a “fee for performance” model whereas in the past CMS reimbursement was a “fee for service” model.
Nursing plays a central role in helping hospitals meet CMS measures. In the Patient Experience of Care Domain nurses can focus on meeting the patient’s needs in the hospital during their acute phase of illness such as providing pain management and ensuring that patients have adequate instruction and information to successfully take care of themselves after discharge. Nurses can ensure the safety of their patients by proper aseptic technique to prevent the spread of hospital acquired infections. Nursing can act as patient advocates by ensuring that antibiotics and indwelling urinary catheters are discontinued when indicated to decrease the incidence of CAUTIs and C-diff.

Nursing can also focus on preventative measures such as imparting to the patient the importance of maintaining immunizations such as annual flu vaccinations as a preventative measure to help keep the patient in their optimal state of health.

Finally nurses can partner with Advanced Practice nurses in utilizing evidence-based research to guide their practice.

<table>
<thead>
<tr>
<th>What measures can nursing focus on?</th>
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<tr>
<td>Patient experience of care dimensions</td>
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<tr>
<td>• Nurse communication</td>
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<td>• Hospital staff responsiveness</td>
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<td>• Pain management</td>
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<td>• Medicine communication</td>
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<td>• Discharge information</td>
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<td>Preventative measures</td>
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<td>• Influenza immunizations</td>
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<td>Safety, efficiency, and cost reduction measures</td>
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<td>• Preventing central line-associated blood stream infections (CLABSI)</td>
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<td>• Preventing catheter-associated urinary tract infections (CAUTI)</td>
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<tr>
<td>• Doing your part in preventing hospital-associated infections (HAI) such as C-diff and MRSA</td>
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By educating yourselves on the CMS measures including the process by which hospitals are evaluated and by following the practices that ensure that measures are successfully met, Nursing becomes a vital partner with CMS in the overall goal of providing the right care for every person every time.
References


References


Change Management and Tolerance

Kathleen Kleefisch, DNP, FNP-BC
change
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Objectives

1. Define change and innovation and what facilitates both
2. Identify changes in nursing practice
3. Discuss elements that make healthcare complex and promote a constantly changing environment
4. Define Complex Adaptive Systems Change Theory
5. Describe resistance to change
6. Identify actions that facilitate successful change
Change and Innovation

Change can be defined as:
The act or process of substitution, alteration, or variation.
(Webster’s New World Dictionary, 2000, p. 45)

Ask yourself:
- What is my attitude toward change?
- How do I define innovation?
- What ties at the heart of both innovation and change?

Introduction notes: Example that there are different types of change: Personal (a change for self improvement), Professional (a change made in one’s career), and Organizational change (one made in the workplace to achieve a goal).

As a new graduate nurse change is not new for you. I can confidently say that you are not the same person today as you were when you entered your nursing program. Today we are going to talk about the importance of understanding change. When you think about change remember what Henry Ford said:”…whether you think you can or whether you think you can’t, you’re right.” *Explain a few of the changes you have experienced during your career (uniforms, technology, staffing, etc..)

The answer to last question is learning, this short PowerPoint will help illustrate the changing environment of healthcare and the importance of being open to the changes.
Innovation is putting a process in place for the first time; think of it as the idea.

Change is a broader concept that deals with any modification in organization composition, structure of behavior to implement the innovation.

Innovation can be defined as the process of creating new services or products: Shortell and Kaluzny state that change and innovation are different. Change is a broader concept that deals with modification in organization composition structure of behavior. Innovation is more restricted to new modifications in ideas or practices.

Porter-O’Grady and Malloch (2011), authors of Quantum Leadership: Advancing Innovation Transforming Health Care, discuss the role of leadership within nursing and healthcare relative to sustainability and success. They outline key factors needed of leaders to create a “healing environment” for both the health professionals as well as their patients. In particular, they stress the need for including courage, creativity, emotional competence, and transformative leadership in all levels of management and care. The next slide demonstrates some of the changes in the healthcare
environment.
Talk a few minutes about how these factors are having a big impact on the healthcare environment and how important it is to create a healing environment. Examples, can hospital administrators place new computers on the floors and assume nurses can instantly use them as part of patient care? Of course not. When considering information technology one needs to consider training of the healthcare worker, coordinating care across different sites, rapid change of pace due to rapid information transfer, which all need to be planned.

Other examples:
In an expanding world economy we meet the challenge of new and reemerging infectious disease.

We are in need of new treatment sites to accommodate new treatment options, compound this with our aging population and the need for the nurse to be cultural literate.

For the healthcare workers and managers strive for new ways to increase efficiency, productivity, and quality.

It becomes clear that “Organizations are preserved by change and constant renewal. Without change, the organization may stagnate and die”.

Changes in the healthcare environment

- Information technology
- An expanding world economy
- Advances in biological and clinical sciences
- Aging population
- Increased ethnic and cultural diversity
- Increased accountability for performance
- Globalization of the world economy
- Make the healthcare environment safe, efficient and promote quality
Organizations are preserved by change and constant renewal. Without change, the organization may stagnate and die.

(Marquis & Huston, 2009)
A good example of innovation within the context of quality of care and patient safety is Quality and Safety Education for Nurses project that evolved from several studies and initiatives by organizations such as the Institute of Medicine (IOM), the American Association of Colleges of Nursing (AACN), the National League for Nurses (NLN), and the Robert Wood Johnson Foundation. The QSEN project aimed to “meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of the health care systems within which they work (QSEN, 2011, p. 1).

On the slide you see the six core competencies that nurses should demonstrate with knowledge, skill, and attitude: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.
Can you describe the changes that have happened in nursing practice?

Porter-O’Grady (2003) posits that the profession must examine and adapt to the changing context of nursing practice. How would you describe traditional nursing?

Institutionally based care, process orientated, procedurally driven, based on mechanical and manual intervention, provider driven, reflective of late stage intervention, based on vertical relationships.

The new or emerging realities of nursing practice are mobility based on multisettings, outcome driven, best practice oriented, emphasized by technology and minimally invasive interventions, user driven, health based, geared for early intervention. Take a few minutes to describe how nursing practice is in today’s healthcare setting.
Historically, many of the changes that have occurred in nursing or have affected the profession are the results of change by drift. For the next slide looks at the healthcare environment and how this has affected nursing practice.
There are numerous theories and frameworks one can use to structure change, due to a time restraint we will explore one: **Complex Adaptive System Theory** works well with Healthcare, because it states that Change is unpredictable, occurs at random and is dependent upon rapidly changing relationships between agents and factors in the system. Even small changes can effect an entire organization.

Marquis & Huston text page 172

Complexity science is the latest generation of systems thinking that investigates patterns and has emerged from the exploration of the subatomic world and quantum physics (Holden, 2005, p. 651). Complexity science argues that the world is complex as are individuals who operate within it. Thus, control and order are emergent rather than predetermined, and mechanistic formulas do not provide the flexibility needed to predict what actions will result in what outcomes. Brown (2006) echoes a similar assertion in his statement that complexity theory “reiterates that many contemporary problems are a consequence of highly interactive contexts and agents and cannot be reduced to a single cause and effect analysis” (p. 595).

**In applying CAS theory to planned change, it becomes clear that the multidimensionality of health care organizations, and the individuals who work within them, results in significant challenges implementing change**

Next slide.
### Main features of Complex Adaptive Systems (CAS) approach

- Changes should be achieved through connections.
- Expect uncertainty during the change.
- Goals, plans, and structures should be allowed to emerge.
- Value differences should be amplified and explored.
- Change can start at different levels of the organization.
- Successful change fits with the current organizational environment instead of with an ideal.

(Marquis & Huston, 2009)

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Change should be achieved through connections among change agents instead of from the top down.

There should be adaptation to uncertainty during the change instead of trying to predict stages of development.

Goals, plans, and structures should be allowed to emerge instead of depending on clear, detailed plans and goals.

Value differences should be amplified and explored instead of focusing on consensus in change efforts.

Patterns in one part of the organization are often repeated in another part. Thus, change does not need to begin at the top of an organization to be successful. The goal instead is self-similarity rather than differences in how change is implemented in different parts of the organization.

Successful change fits with current organizational environment instead of with an ideal. This is what makes it sustainable. For example: In the USA, up to one quarter of nurses’ time is spent on administration and documentation. Researchers have explored the documentation of nursing care plans from a complex adaptive system perspective and made practical changes by adopting a standardized nursing language. Clancy, Delaney, Morrison, Gunn, (2006).

There are many more theories about change, I encourage you to learn about...
different theories and how to apply them.
The level of resistance generally depends on the type of change proposed. Technological change encounters less resistance than changes that are perceived as social or that are contrary to established customs or norms. Does anyone know why?

True or False: It is much easier to change a person’s behavior than it is to change an entire group’s behavior. Of course this is true, likewise, it is easier to change knowledge levels than attitudes. But all major change takes time.

In an effort to eliminate resistance to change in the workplace, managers historically used an autocratic leadership style with specific guidelines for work, an excessive number of rules, and a coercive approach to discipline. The resistance, which occurred anyway, was both covert (passive aggressive behavior) and overt. The result was wasted managerial energy and time and a high level of frustration.

In today’s environment resistance is recognized as a natural and expected response to change. Contemporary administration immerse themselves in identifying and implementing strategies to minimize or manage this resistance to change. One such strategy is to encourage subordinates to speak openly so that options can be identified to overcome objections.

Many times meetings are held for workers to talk about their perceptions of the forces driving the planned change so that the manager can accurately assess change support and resources. It benefits workers to celebrate progressive changes during the project completion.
What is greatest factor contributing to resistance?

- Lack of trust between the employee and the manager or the employee and the organization

- Employees want security and predictability

How do you typically respond to change? Do you embrace it? Seek it out? Accept it reluctantly? Avoid it at all cost? Is this behavioral pattern similar to your friends’ and that of your family? Has your behavior always fit this pattern, or has the pattern changed throughout your life?

What is the greatest factor contributing to resistance? Lack of trust between the employee and the manager or the employee and the organization. Employees want security and predictability.
This research study used a qualitative approach with phenomenological interviewing of 25 participants to investigate how administrators can increase their credibility during a planned change in the organization.

Three themes emerged: change, leaders, and communication
Suggested that leadership credibility in a planned change exists when: the leadership is perceived as a united team that communicates planned change in a meaningful way and in a consistent manner, using well-structured and well-planned multiple methods to communicate the planned change.
Understanding how you perceive change is key to you accepting changing in the work environment.
Key concepts for successful change

- Change should not be viewed as a threat but as a challenge and a chance to do something new and innovative
- Change should be implemented for good reason
- Resistance should be viewed as a natural part of change, but can be managed using appropriate measures
- It is much easier to change a person’s behavior than it is to change an entire group’s behavior. It also is easier to change knowledge levels than attitudes
- Most importantly, involve key members in the change process. The feeling of control is critical to thriving in a changing environment
References


References


References


References


Elimination of Wasteful Process and the Assumption of Fiscal Responsibility into Clinical Practice

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Matthew Pierce, RN, MSN, LSSBB
Factors in controlling costs & improving the efficiency of healthcare

- Spending on healthcare has generally grown faster than the economy as a whole
- The cost of healthcare imposes an increasing burden on the federal government, state governments, and the private sector
- Rapidly rising costs for healthcare have generated rapid increases in the price of health insurance
- The available evidence suggests that a substantial share of spending on healthcare contributes little if anything to the overall health of the nation

(Retrieved from: https://www.cbo.gov/publication/41167)
Healthcare spending facts

Spending on healthcare and related activities will account for nearly 18% of GDP in 2009—an expected total of $2.5 trillion. 20% to 30% of health spending is waste that yields no benefit to patients.

— Dr. Donald M. Berwick, former Administrator for CMS

The national numbers for waste in healthcare are between 30% and 40%, but the reality of what we've observed doing minute-by-minute observation over the last three years is closer to 60%.

— Cindy Jimmerson, RN National Science Foundation medical researcher
Eliminating waste

- Waste can be identified only after one understands what adds value in a process.

- Waste can be defined as any activity or action that does not add value to the customer or that negatively impacts the value the customer receives.

- Waste can also be described as any motion, problem, or delay that interferes with the caregiver’s ability to provide the safest, most timely, high-quality patient care. 

(Graban and Swartz, 2012)

Eliminating waste is key to reducing cost and managing resources however one must identify what “waste” is in any given situation.
Nursing’s part in healthcare

- Nursing is the nation's largest healthcare profession, with more than 3.1 million registered nurses nationwide
- Nearly 58% of RNs worked in general medical and surgical hospitals
- Nurses comprise the largest single component of hospital staff, are the primary providers of hospital patient care, and deliver most of the nation's long-term care
- Nurses' roles range from direct patient care and case management to establishing nursing practice standards, developing quality assurance procedures, and directing complex nursing care systems

(Retrieved from: http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-fact-sheet )

Nurses know there is a lot of waste in what they do…even non-essential nursing tasks can be seen as waste
Nurses are uniquely positioned to aid in the elimination of waste in healthcare

The following slides detail different types of “WASTE” in terms of activities.
# Types of waste

1. Transportation  
2. Overproduction  
3. Motion  
4. Defects (errors and rework)  
5. Waiting  
6. Inventory  
7. Overprocessing  
8. Lost human potential, creativity and opportunities

The following slides detail different types of “WASTE” in terms of activities.
Transportation

- Includes patient, material, or information movement
- Also includes conveying, transferring, picking up or setting down, piling up, and otherwise unnecessary movement

Examples
- Moving patients from location to location
- Moving equipment to a patient location
- Moving a patient chart from its designated location

(Graban and Swartz, 2012)
Overproduction

- Includes producing more than what is really needed or producing faster (or earlier) than needed
- Examples
  - Preparing labels or packets of documents “just in case”
  - Delivering large batches of specimens to the lab faster than can be received
  - Making up IV fluids after a patient has been changed to oral medicines
  - Reports (lab, radiology, etc.) printed and/or mailed when not needed

(Graban and Swartz, 2012)
Motion

- Includes any unnecessary movement of people or machines
- Time and motion saved can be reapplied into patient care activities, especially in nursing settings
- Examples
  - Searching for things: supplies, equipment, patient charts, records, other care team members, etc.
  - Walking to get equipment and medications
  - Walking across the room to answer the phone
  - Walking to get charts (Graban and Swartz, 2012)
Defects (errors and rework)

- Related to errors, inspection, and rework, as well as handling and addressing customer complaints
- Cannot just inspect if we do not have a better way of error-proofing the process to ensure quality
- Examples
  - Relearning due to poor training or lack of knowledge sharing
  - Errors and harm to patients
  - Missing information, such as orders not being completed before a procedure
  - Complaints about service
  - Errors or mistakes caused by incorrect information or miscommunication

(Graban and Swartz, 2012)
Waiting

- Includes ideal time caused when people or equipment are waiting for one or the other
- Can affect patients or staff members
- When we see waiting, we should improve the system to eliminate the root causes of the problems that causes the delays

Examples

- Waiting to be seen or waiting in hallways to be admitted
- Waiting for missing instruments to start a procedure
- Waiting for callbacks
- Waiting for drug validation
- Waiting for a patient to be properly positioned on a CT scanner table

(Graban and Swartz, 2012)
## Inventory

- Includes any supply in excess of what is necessary to provide the right service and patient care.
- The lack of inventory often creates the waste of motion or the waste of waiting.

### Examples

- Stocks of printed forms
- Hidden and hoarded supplies and equipment
- Outdated supplies and expired medicines or specimen collection tubes
- Unnecessary proliferation of different variants of items that cannot be medically justified.

(Graban and Swartz, 2012)
Overprocessing
Can be described as effort that adds no value to the product or service

Examples:
- Redundant capture of information upon admission
- Giving every patient with back pain a CT instead of first trying physical therapy
- Multiple recording and logging of data
- Producing paper hard copy when a computer file is sufficient
- Making hand copies of computer documents

(Graban and Swartz, 2012)
Lost human potential, creativity, opportunities

Examples

- Employees and staff not being engaged in process or quality improvement
- People consistently working below their education and skill level

(Graban and Swartz, 2012)
Tools to eliminate waste

- Kaizen
- 5S
- 5 Why
Kaizen

- Japanese—Kai(change) Zen(good)
- Kaizen benefits the patient, employee, and organization
- Creating a Kaizen
  - See and find waste/opportunity
  - Discuss
  - Implement
  - Surface (document)
  - Share (submit)
Benefits of Kaizen

Employee
- Empower
- Engage
- Job satisfaction/recognition
- Quality of work

Patient
- Satisfaction
- Safety
- Quality
- Cost of care

Organization
<table>
<thead>
<tr>
<th>Baby Triage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>It has always been awkward to take temperatures and do quick exams of infants in the triage rooms at the MV ED. Parents had to either lie the child over their lap or hold them as there was no good place to lie the child.</td>
</tr>
<tr>
<td><strong>After</strong></td>
</tr>
<tr>
<td>![Image of a hospital setting]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>The triage nurse now has a better place to lie the infant for temperature and exam making the flow of triage much smoother.</td>
</tr>
</tbody>
</table>
5S

- A simple method to achieve a change for the better by improving workspace layout for better process flow
- A lean tool for organizing workspace in order to be more efficient when performing a process

1. **Sort**—remove unneeded items
2. **Set in order**—find an appropriate place for everything
3. **Shine**—clean the area
4. **Standardize**—standard (visual) organization of the area
5. **Sustain**—maintain and improve the 5S design
The 5 Why’s

- A simple approach to drill down on the root cause of a problem by asking Why? 5 times (or more)

- A way to drill down on process issues, not people issues

- Once the root cause has been identified, a change (Kaizen) can be made to eliminate the root cause
5 Why example

**Problem Statement:** Inpatient satisfaction scores for meal quality have decreased

**5 Why?**
1 – Patients say the food does not taste good
2 – Because hot food is cold, cold food is hot
3 – Because of the time it takes to be delivered
4 – Because of the time it takes to leave the kitchen
5 – **Because there are several obstacles in the path used to exit for delivery—Root Cause!**
is this an original drawing?

Marian, 7/22/2015
## 5 Why example

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tray passers had a difficult time moving meal carts out for delivery. This was due to crates, boxes, carts, tables and other objects obstructing their path.</td>
<td>A path was cleared to the elevators. Any items that are used regularly were given standardized spaces marked by tape on the floor.</td>
</tr>
</tbody>
</table>

### The Effect

Meal carts now take less time to get out of the kitchen, the overall time to deliver food is quicker.
Summary

- Spending on healthcare has generally grown faster than the economy as a whole
- The cost of healthcare is imposing an increasing burden on the federal government, state governments, and the private sector
- Within healthcare, there is a considerable amount of waste which has been estimated to be as high as 60%
- Given their numbers and involvement in many aspects of healthcare, nurses are uniquely positioned to identify and assist in the elimination of waste
- Nurses have a responsibility to be a part of eliminating waste in healthcare
References


Nursing Fact Sheet, American Association of Colleges of Nursing, retrieved from: http://www.aacn.nche.edu/mediarelations/factsheets/nursing-fact-sheet
1. Quality and safety are integral to providing care to patient in the hospital setting. Barcode medication administration is an example of innovation improving patient safety.
   a) True
   b) False

2. Traditional nursing practice is based on multi-settings, outcome driven, best practice oriented, emphasized by technology and minimally invasive interventions, user driven, health based, geared for early intervention
   a) True
   b) False

3. Resistance is recognized as a natural and expected response to change
   a) True
   b) False
2. The traditional nursing practice is based on multisettings, outcome driven, best practice oriented, emphasized by technology and minimally invasive interventions, user driven, health based, geared for early intervention. (T or F) FALSE, traditional nursing is institutionally-based care, process orientated, procedurally driven, based on mechanical and manual intervention, provider driven, reflective of late stage intervention, based on vertical relationships.

3. Resistance is recognized as a natural and expected response to change. TRUE
4. True: 20% to 30% of health spending is waste that yields no benefit to patients
   a) True
   b) False

5. Learning Kaizen is a methodology to:
   a) Look at waste
   b) Learn Japanese
   c) Make employees understand their work better

4. True: 20% to 30% of health spending is waste that yields no benefit to patients

5. a
Pre & post-test answers

1. True
2. False
3. True
4. True
5. a