Realizing the Future of Nursing: VA Nurses Tell Their Story
Dedication

This book is dedicated to the Veterans who serve our country and the nurses who care for them.
Contributing Authors

Editors
Cathy Rick
Phyllis Beck Kritek

LaDonna Adkins, RN, MSN, CNL
Clinical Nurse Leader
Central Texas Veterans Health Care System
Temple, TX

Anna C. Alt-White, PhD, RN, FAAN (Retired)
Director, Research and Evidence Based Practice
Office of Nursing Services
Washington, DC

Gwen Anderson, PhD, RN
Professor, School of Nursing
Azusa Pacific University
Nurse Scientist VA San Diego Healthcare System
Former VA Nursing Academy Co-Director
San Diego State University
VA San Diego Healthcare System
San Diego, CA
Jacqueline Andersen, RN, BSN (Retired)
Nurse Manager: Same Day Surgery/Procedure,
Same Day Testing, Outpatient Infusion, Dialysis
VA Medical Center, Syracuse, NY
Syracuse, NY

Alice Avolio, MS, RN, NE-BC
Consultant, Office of Nursing Services
CNL Implementation and Evaluation Service
Portland VA Medical Center
Portland, OR

Jemma Ayvazian, DNP, ANP-BC
Oncology Nurse Practitioner
Washington DC VA Medical Center
Washington DC

Julie Azar, RN, BSN, CCRN, CSC, VHA-CM
RN Co-Chair Nursing Practice Council
Charles George VA Medical Center
Asheville, NC

Sylvia M. Barchue, RN, MS, VHA CM
Patient Care Center Director
James J. Peters VA Medical Center
Bronx, NY

Murielle Beene, DNP, MBA, MPH, MS, RN-BC, PMP
Department of Veterans Affairs
Chief Nursing Informatics Officer
Washington, DC

Michael Bethel, MSN, RN-BC, NE-BC, CCM
Program Manager, Primary Care Service
VA Central California Health Care System
Fresno, CA
Contributing Authors

Alan Bernstein, RN, MS
Associate Director for Patient Care Services
VA North Texas Health Care System
Dallas, TX

Mary Susan Biggins, MBA, BSN, RN, CRRN
Polytrauma Rehabilitation Clinical Nurse Advisor
Polytrauma Clinical Nurse Educator
Edward Hines Jr VA Hospital
Hines, IL

Rose Birkmeier, DNP, MSN, FNP-C
Certified Family Nurse Practitioner
Clinical Programs Manager
Veterans Integrated Service Network (VISN) 11
Ann Arbor, MI

Mary G. Boland, DrPH, RN, FAAN
Dean and Professor
School of Nursing & Dental Hygiene
University of Hawaii at Manoa
Honolulu, HI

Linda Lake Boyle, DM, RN
Associate Director, Patient/Nursing Services
Alaska VA Healthcare System
Anchorage, AK

Wanda G. Bradshaw, MSN, RN-BC
Performance Improvement Facilitator, Mental Health Nursing
VA St. Louis Health Care System
St. Louis, MO

Rebecca S. Brienza, MD, MPH
Co-Director, VACHS Center of Excellence in Primary Care Education
Assistant Professor, Yale School of Medicine
VA Connecticut Healthcare System
West Haven, CT
Kameka Brown, MBA, PhD, FNP
Nurse Practitioner Co-Director
Seattle Center of Excellence in Primary Care Education
VA Puget Sound Health Care System
Seattle, WA

Janet Cameron, RN, MSN, CNS Oncology
CNS Oncology
Providence VA Medical Center
Providence, RI

Cynthia Caroselli, RN, PhD
Associate Health Care System Director
Chief Nurse Executive
VA New York Harbor Health Care System
New York, NY

Kathleen Chapman, MSN, RN, NEA-BC, FACHE
Deputy Director – Patient Care Services
Portland VA Medical Center
Portland, OR

Kay Clutter, PhD, RN
Operations Director, VISN 23 Tele-ICU
Minneapolis VA Health Care System
Minneapolis, MN

Alesia A. Coe, DNP, RN, NEA-BC, VHA-CM
Associate Director Patient Care/Nurse Executive
VA Illiana Health Care System
Danville, IL

Jamie Connelly, MS, RN, CNL, CMSRN
Clinical Manager
VA Portland Health Care System
Portland, OR
Janet Cogswell, RN MSN AOCN
Nurse Manager and Advanced Practice Nurse
VA New Jersey Healthcare System
East Orange, NJ

Rosa M. Colon, RN, BSN
Nurse Manager
Central Texas Veterans Health Care System
Temple, TX

Nancy Crandall, MSN, NP
Surgical Service
Providence VA Medical Center
Providence, RI

Amy Daly, MSN, RN-BC
ONS Chair National Nursing Practice Council
Nurse Manager, Critical Resource Teams
Minneapolis VA Health Care System
Minneapolis, MN

Mary Ellen Dellefield, PhD, RN
Research Nurse Scientist
VA San Diego Healthcare System
San Diego, CA

Bruce Delphia, MAEd, EMT-P
Department of Defense
DeCA HQ/Workforce Development Division
Leadership Development Branch (COHW)
Fort Lee, VA

Previously
Instructional Systems Specialist/Education Project Manager
ICT Pilot Program Coordinator
VHA/Employee Education System
Washington EERC
Arlington, VA
Contributing Authors

Vilma Cong Divinagracia, MSN, RN-BC, PHCNS-BC
Clinical Nurse Specialist
VA San Diego Healthcare System
San Diego, CA

Mary A. Dolansky, RN, PhD
Co-director Center of Excellence in Primary Care
Louis Stokes Cleveland VA Medical Center
Cleveland, OH

Mary B. Dougherty, DNSc, MBA
Director, Nursing Education
Office of Academic Affiliations
Veterans Health Administration
Washington, DC

Lyn Dubbs, MSN, RN
VA Nursing Academy Program Director
VA Pacific Islands Health Care System
Honolulu, HI

Natina Dudley, MSN, RN
Clinical Educator - Surgery Nursing
VA Puget Sound Health Care System
Seattle, WA

Greg Eagerton, DNP, RN, NEA-BC
Associate Director / Patient Care Service
Durham VA Medical Center
Durham, NC

Jill Edwards, MSN, APRN B.C.
Nursing Director, Specialty Care
VA Connecticut Healthcare System
West Haven, CT

Janette E Elliott, RN-BC, MSN, AOCN, CNS
Pain Management Clinical Nurse Specialist
VA Palo Alto Health Care System
Palo Alto, CA
Teresa L. England, PhD, RN  
Associate Director for Patient/Nursing Service  
Salem VA Medical Center  
Salem, VA

Christine Engstrom, PhD CRNP AOCN  
Director Clinical Practice  
Office of Nursing Services  
Washington, DC

Ellen C. Fagan-Pryor, PMHCNS-RN, CPRP  
mMental Health Case Manager-Clinical Nurse Specialist  
VA Northern Indiana Health Care System  
Fort Wayne, IN

Amber K. Fisher, PharmD, BCPS, BCACP  
Associate Chief of Pharmacy  
Co-Director, Center of Excellence in Primary Care Education  
Ambulatory Care Pharmacy Residency Director  
Boise VA Medical Center  
Boise, ID

Marquetta Flaugher, PhD, ARNP-BC, RN-BC  
ARNP-BC in Sleep Medicine Services  
C.W. Bill Young VA Medical Center  
Bay Pines, FL

Maura Flynn, MSN, NP  
GI Service  
Providence VA Medical Center  
Providence, RI

Sheila Ford, RN MSN CNL  
Clinical Nurse Leader/Care Manager RN  
VA Oakland Outpatient Clinic  
Oakland, CA
Amanda Fore, RN, MS
Nurse Coordinator/Program Analyst
National Center for Patient Safety
Office of Quality, Safety, and Value
Ann Arbor, MI

Brenda Rushing French, MSN, CRRN, CBIS, VHA-CM, RN-BC
Polytrauma Staff Educator
Hunter Homes McGuire VA Medical Center
Richmond, VA

Barbara Galbraith, RN, MBA
Chief of Quality Management
Roseburg VA Healthcare System
Roseburg, OR

Gayla Gift, BSN, RN, CCPRP
Staff Nurse Mental Health Outpatient
VA Northern Indiana Health Care System
Marion, IN

Jamie H. Gilliam, MSN, RN, CNL, CCRN
Surgical Intensive Care Unit/Cardiothoracic Intensive Care Unit
Clinical Nurse Leader
Malcolm Randall VA Medical Center
Gainesville, FL

Stuart Gilman, MD, MPH
Director, Advanced Fellowships and Professional Development
Office of Academic Affiliations
Veterans Health Administration
Washington, DC

Margaret Gound, DNP, APRN-NP, BC
Nurse Researcher
VA Nebraska-Western Iowa Health Care System
Omaha, NB
Mimi Haberfelde, RN-BC, MSN (Retired)
Nursing Informatics Specialist
VHA Health Informatics, Applied Informatics Services
San Francisco, CA

Carole Hair, PhD, RN, GNP-BC
Coach/Mentor Nursing Academic Partnerships
VA Office of Academic Affiliations
Former Associate Nurse Executive/Education and
   VA Nursing Academy Director
VA San Diego Healthcare System
San Diego, CA

James L Harris, DSN, APRN-BC, MBA, CNL, FAAN
Professor of Nursing
University of South Alabama College of Nursing
Community Mental Health
Mobile, AL

Janet L. Henderson, MD, FACEP
Chief of Medicine, Director of the Emergency Department
VA Medical Center Hampton
Hampton, VA

Lou Etta Hicks, MSN, ARNP, GNP-BC
Post Hospital Transitional Care Nurse Practitioner
C.W. Bill Young VA Medical Center
Bay Pines, FL

Bree Holtz, PhD, MSc
Adjunct Research Professor
Department of Telecommunications, Information Studies, & Media
Michigan State University
East Lansing, MI

Lori Hoffman Högg, MS RN CNS AOCN®
National Oncology Clinical Advisor for Office of Nursing Services
Cancer Program Director
Stratton VA Medical Center
Albany, NY
Melissa L Hutchinson, MN, RN, CCNS, CCRN  
Clinical Nurse Specialist, MICU/CCU  
VA Puget Sound Health Care System  
Seattle, WA

Penny Kaye Jensen, DNP, FNP-C, FAAN, FAANP  
Liaison for VHA National APRN Policy  
Office of Nursing Services  
Washington, DC

Ellen Jones, RN, BSN  
Nurse Educator  
500 W. Fort Street  
Boise VA Medical Center  
Boise, ID

Lorraine R. Kaack, MS, RN-BC, CNL  
Clinical Nurse Leader  
C.W. Bill Young VA Medical Center  
Bay Pines, FL

Terry Keene, DNP, FNP-BC, ARNP  
NP Co-director, Center of Excellence in Primary Care Education  
San Francisco VA Health Care System  
San Francisco, CA

Kimberly Kirkpatrick, MS, RN, CNL  
Clinical Nurse Leader  
VA Portland Health Care System  
Portland, OR

Rebecca Kordahl, RN, MBA, NEA-BC  
Associate Director for Patient Care Services and Nurse Executive  
William S. Middleton Memorial Veterans Hospital and Clinics  
Madison, WI

Phyllis Beck Kritek, RN, PhD, FAAN  
Consultant and Editor  
Sole Proprietor, courage  
Half Moon Bay, CA
Merry Kuyper-Carson RN, MSN, ACNS-BC
Associate Chief Nursing Service-Education
Boise VA Medical Center
Boise, ID

Jennifer S. Lee, MD
Deputy Secretary of Health and Human Resources,
Commonwealth of Virginia
Richmond, VA
Previously
Special Assistant for Community Engagement
Veterans Health Administration

Narda A. Ligotti, MSN, CNS, FNP, RN
NNEI, VALOR & Nursing Education Coordinator
VA Central California Health Care System
Fresno, CA

Maxine E. Lindsay-Shillingford, RN, MSN, MSM
Administrative Care Team Manager, Emergency Department
James. J. Peters. VA Medical Center
Bronx, NY

Patricia Hryzak Lind, RN, MS, VHA-CM
Associate Director for Patient Nursing Services
VA Western New York Healthcare System
Buffalo, NY

Michelle A. Lucatorto, DNP, RN, FNP-BC
Clinical Program Manager – Specialty Care Nursing
Office of Nursing Services
Washington DC

Kelly R. Machuca, DNP, RN, ACNP-BC, CNS, VHA-CM
Deputy Nurse Executive
VA Roseburg Healthcare System
Roseburg, OR
Linda L. Madaris, DNP, ARNP-BC, CRRN, NEA-BC
Assistant Chief Nurse, SCI/Rehab
James A. Haley Veterans Hospital & Clinics
Tampa, FL

Nancy L. Martin, BSN, RN, CWOCN, CFCN
Foot Care Nurse/Wound Care Nurse
Northern Arizona VA Healthcare System
Prescott, AZ

Gloria N. Martinez, MS, RN, NEA-BC, VHA-CM
Associate Director Patient Care Service/Nursing Services
VA Palo Alto Health Care System
Palo Alto, CA

Linda McConnell, RN, MSN, NEA-BC, FACHE
Associate Medical Center Director for Patient Care/Nursing
James H. Quillen VA Medical Center
Mountain Home, TN

John McIntosh, BS Finance, BSN
Board Certified Gerontological Nursing
Case Manager Post Hospital Transitional Care
C.W. Bill Young VA Medical Center
Bay Pines, FL

Pam McNutt, RN, BSN
Psychosocial Rehabilitation and Recovery Center Coordinator
VA Northern Indiana Health Care System
Marion, IN

Andrea Millman, MSN, RN NEA-BC
Chief Nurse Geriatrics and Extended Care
Orlando VA Medical Center
Orlando, FL

Anna Jones Monnett, MS RN
Associate Director, Patient Care Services
VA Medical Center Dayton
Dayton, OH
Contributing Authors

Storm Morgan, MSN, RN, MBA
Patient Aligned Care Team Program Manager
Office of Nursing Services
Washington, DC

Wendy S. Morrish, MSN, RN, CNL
Navigator Coordinator
VA Ann Arbor Healthcare System
Ann Arbor, MI

Darcy L. Mortimer, RN, MSN, CCRN
Associate Chief Nurse
Veterans Health Care System of the Ozarks
Fayetteville, AR

Marthe J. Moseley, PhD, RN, CCRN-K, CCNS, VHA-CM
Associate Director Clinical Practice
Office of Nursing Services
Washington, DC

Melanie Nash, DNP-c, FNP, NP-C
Co-director Boise VA Center of Excellence in Primary Care Education
Boise VA Medical Center
Boise, ID

David G. Newman, RN
Facility Telehealth Coordinator
Cheyenne VA Medical Center
Cheyenne, WY

Bridget C. O’Brien, PhD
Associate Professor, Dept of Medicine, UCSF
Director of Evaluation
San Francisco VA Center of Excellence for Primary Care Education
San Francisco VA Health Care System
San Francisco, CA
Contributing Authors

Grace Oligario, DNP, FNP-BC, ACHPN
Oncology and Palliative Care Nurse Practitioner
John D Dingell VA Medical Center
Detroit, MI

Bruce D. Oran, D.O., FACEP
Assistant Clinical Professor of Medicine, Columbia University
College of Physicians and Surgeons
Clinical Assistant Professor of Emergency Medicine,
Touro College of Osteopathic Medicine
Chief, Department of Emergency Medicine
James J. Peters VA Medical Center
Bronx, NY

Karen M. Ott, DNP, RN
Director for Policy, Education and Legislation
Office of Nursing Services
Washington, DC

Jennifer Ouelette MSN, NP
GI Service
Providence VA Medical Center
Providence, RI

Karyn R Overturf, MSN, ANP, OCN
Oncology Nurse Case Manager
Alaska VA Healthcare System
Anchorage, AK

MaryLee Pakieser, MSN, RN, BC-FNP
Primary Care NP, Integrated Primary Care Clinic
Northern Lakes Community Mental Health
Traverse Health Clinic
Previously
Nurse Practitioner
Traverse City VA Community Based Outpatient Clinic
Traverse City, MI
Contributing Authors

Natalie Parce, MSN, RN
Clinical Nurse Specialist- Shared Governance Coordinator
Charles George VA Medical Center
Asheville, NC

Kattie Payne, RN, MSN, PhD
Nursing Research/Evidence Based Practice Coordinator
Boise VA Medical Center
Boise, ID

Janice Morey Pedersen, RN, MS, NP
National Certification: Adult Nurse Practitioner
Nursing Professional Development, Ambulatory Care Nursing
Adjunct Professor of Nursing
Crouse Hospital College of Nursing
Nurse Practitioner
Syracuse VA Medical Center
Syracuse, NY

Yvette Marie Petti, PhD, APRN-BC
Certified Adult Nurse Practitioner
The Department of Primary Care and Women’s Wellness Services
Battle Creek VA Medical Center
Battle Creek, MI

Toni Phillips, RN, MSN
Nursing Informaticist
North Florida/South Georgia Veterans Health System
Gainesville, FL

Pamela Pickett, RN-BC, MS (Retired)
Nursing Informatics Specialist
VHA Health Informatics, Applied Informatics Services
South Pomfret, VT

Beverly Priefer, PhD, RN
Associate Director, Research and Evidence Based Practice
Office of Nursing Services
Washington, DC
Contributing Authors

David Przestrzelski, MS, RN
Associate Director, Patient Care Services/Chief Nurse Executive
Charles George VA Medical Center
Asheville, NC

Kimberly L. Radant, RN, MS (Retired)
Associate Medical Center Director
Richard L. Roudebush VA Medical Center
Indianapolis, IN

Susan Resti, MSN, MS, RN-BC, CNL
Clinical Nurse Leader
C.W. Bill Young VA Medical Center
Bay Pines, FL

Michelle Rhoney, MS, RN, CNL, CMSRN
Clinical Nurse Leader
VA Portland Health Care System
Portland, OR

Jeannette Richardson, DNP, RN, CNS
Education Division Director
VA Portland Health Care System
Portland, OR

Cathy Rick, RN FAAN NEA-BC
Former Chief Nursing Officer (2000-2014)
Department of Veterans Affairs
Washington, DC

Larry W. Rivers, Jr., MPA
Executive Assistant
Office of Nursing Services
Washington, DC

Nancy Robinson, MSN, CCRN, VHA-CM
Nurse Manager Emergency Department
Valor Coordinator
Cincinnati VA Medical Center
Cincinnati, OH
Kathryn Rugen, PhD, FNP-BC  
Nurse Practitioner Consultant, Centers of Excellence in Primary Care Education  
Office of Academic Affiliations  
Veterans Health Administration  
Washington, DC

Michiele Schrieber, RN, MSN, CCM  
Associate Chief Nurse  
Veterans Health Care System of the Ozarks  
Fayetteville, AR

Joanne M. Shear, MS, FNP-BC  
National Clinical Program Manager, Primary Care  
Veterans Health Administration  
VA Central Office  
Washington, DC

Rebecca Shunk, MD  
HS Clinical Professor of Medicine  
University of California, San Francisco  
Physician Co-Director, Center of Excellence in Primary Care Education  
San Francisco VA Health Care System  
San Francisco, CA

David M. Sine, DrBE, CSP, ARM, CPHRM  
Chief Risk Officer, Quality, Safety, and Value  
Department of Veterans Affairs, National Center for Patient Safety  
Ann Arbor, MI

Mamta K. Singh, MD, MS, FACP  
Physician Director, Center of Excellence in Primary Care Education  
Louis Stokes Cleveland VA Medical Center  
Cleveland, OH

Amy W. Smith, RN, DNP, FNP-BC, FAANP  
Deputy Chief Medical Officer/VISN Nurse Executive, VISN 16  
South Central VA Health Care Network  
Ridgeland, MS
Contributing Authors

Evelyn Sommers, MHSA
Health Systems Specialist
Office of Nursing Services
Washington, DC

Jason Sork, RN
CLC Staff Nurse
Community Living Center
Marion VA Medical Center
Marion, IL

Karen Landers Spada, MSN, MHP, MHA, FNP, DNP (Retired)
Associate Director for Patient and Nursing Services
Central Texas Veterans Health Care System
Temple, TX

Linley Stanger, RN, MSN
Associate Nurse Executive
Boise VA Medical Center
Boise, ID

Sheila Cox Sullivan, PhD, RN
Associate Director, Associated Health Education and Evaluation
Geriatric Research Education and Clinical Center, VISN 16
Central Arkansas Veterans Healthcare System
North Little Rock, AR

Beth Ann Taylor, DHA, RN, NEA-BC
Director, Workforce and Leadership
Office of Nursing Services
Washington, DC

Kathleen L. Taylor, MSN, MS, BSN, RN
Nurse Informaticist
Captain James A. Lovell Federal Health Care Center
North Chicago, IL
Contributing Authors

Melissa V. Taylor, PhD, RN
Associate Chief Nurse for Research
VA Pittsburgh Healthcare System
Pittsburgh, PA

Mary L. Thomas, MS, CNS, AOCN
Hematology Clinical Nurse Specialist
VA Palo Alto Health Care System
Palo Alto, CA

Sabrina Thomas, RN, BSN
Veteran Centered Care Coordinator
Charles George VA Medical Center
Asheville, NC

Sheila Thompson, RN-BC, MSN, FACHE
VANOD Coordinator
Southern Arizona VA Health Care System
Tucson, AZ

Suzanne Thorne-Odem, DNP, RN
Acting Director, Clinical Practice
Office of Nursing Services
Washington, DC

Laural Traylor, MSW
Centers of Excellence in Primary Care Education
Academic PACT/Patient Aligned Care Team
Office of Academic Affiliations
Veterans Health Administration
Washington, DC
Donna C. Vogel, MSN, CCM
Director, Case Management & Telehealth
VA Connecticut Healthcare System
West Haven, CT

Colleen Walsh-Irwin, DNP, RN, CCRN, ANP
Cardiovascular Clinical Nurse Advisor,
Office of Nursing Services
Nurse Practitioner, Cardiology Division
Northport VA Medical Center
Northport, NY

Jessica Watkins MSN, RN, CNL
Clinical Nurse Leader
Community Living Center
Marion VA Medical Center
Marion, IL

Sharon A. Watts, DNP, FNP-BC, CDE
Chair Office of Nursing Services Metabolic Syndrome &
Diabetes Field Advisory Committee
Louis Stokes Cleveland VA Medical Center
Cleveland, OH

Tracy L. Weistreich, PhD, MSN, RN, NEA-BC
Associate Director Patient Care Services/Nurse Executive
VA Roseburg Healthcare System
Roseburg, OR

Jane A Wellman, MS, CNP, ANP-BC
Associate Director Patient Care Services/Nurse Executive
VA Pacific Islands Health Care System
Honolulu, HI

Kathy Wieneke, RN, BSN
Nurse Manager
Sioux Falls VA Healthcare System
Sioux Falls, SD
Marjory D. Williams, PhD, RN, NEA-BC
CNL Implementation & Evaluation Service
VHA Office of Nursing Services
Central Texas Veterans Health Care System
Temple, TX

Kristina Willin, Aeromedical Evacuation Technician (AET)
Intermediate Care Technician (ICT)
Emergency Department
Louis Stokes Cleveland VA Medical Center
Cleveland, OH

Richard V. Wing, RN, BSN, MS-HCA, VHA-CM
Nurse Manager Western Blind Rehabilitation Center
VA Palo Alto Health Care System
Menlo Park, CA

Joyce E. Wipf, MD
Professor of Medicine
University of Washington
Section Head of General Internal Medicine
Physician Co-Director, Seattle Center of Excellence in Primary Care Education
VA Puget Sound Health Care System
Seattle, WA

Salena Wright-Brown, APRN, MNSc, RN
Associate Director Patient Care Services
G. V. (Sonny) Montgomery Medical Center
Jackson, MS

Susan A. Zapatka, APRN –BC, MSN
NP Co-Director
Center of Excellence in Primary Care Education
VA Connecticut Healthcare System
West Haven, CT
Frances Zarella, MS, RN, CNL  
Clinical Nurse Leader  
James A. Haley VA Medical Center  
Tampa, FL

Kristen Zimbardi, FNP-BC, MSN, RN  
Certified Family Nurse Practitioner  
Deputy Co-Director, Nurse Practitioner Residency Program  
Louis Stokes Cleveland VA Medical Center  
Cleveland, OH
Table of Contents

iii Dedication

v Contributing Authors

xxxvii Tables and Figures

xliv Acknowledgements

xlix Foreword: Donna Shalala, PhD, President, University of Miami

1 Part 1: Strategic Innovation, Creating the Future of Nursing

3 Introduction: VA Nurses and Their Stories in Context

5 Introduction Part 1: The Why and How of This Book
   Phyllis Beck Kritek
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Part 2</td>
<td>Introduction Part 2: Creating Context: Where the Story of VA Nursing Emerged</td>
<td>Larry Rivers and Cathy Rick</td>
</tr>
<tr>
<td>37</td>
<td>Chapter 1</td>
<td>Strategic Approaches and Robust Communication: Key Ingredients for the Future of Nursing to Advance Health and Lead Change</td>
<td>Cathy Rick</td>
</tr>
<tr>
<td>49</td>
<td>Chapter 2</td>
<td>Structure, Form, and Process within a Shared Governance Framework</td>
<td>James L. Harris</td>
</tr>
<tr>
<td>57</td>
<td>Chapter 3</td>
<td>Transformational Leadership: The VA Nurse Leaders’ Journey</td>
<td>Kathleen Chapman, Gregory Eagerton and Kimberly Radant</td>
</tr>
<tr>
<td>75</td>
<td>Part 2</td>
<td>Part 2: Acting Strategically to Innovate, Demonstrating the Future of Nursing</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Key Message 1</td>
<td>Key Message 1: Nurses should practice to the full extent of their education and training</td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>Chapter 4</td>
<td>Transforming the Advanced Practice Registered Nurse Role and Policy in the Veterans Health Administration</td>
<td>Marthe Moseley</td>
</tr>
<tr>
<td>99</td>
<td>4.1</td>
<td>4.1: From RN to NP: How the VA Helped Me to Achieve My Dreams</td>
<td>Colleen Walsh-Irwin</td>
</tr>
<tr>
<td>107</td>
<td>4.2</td>
<td>4.2: Knocking Down the Barriers and Letting the Sunshine In</td>
<td>Mary Lee Pakieser, Yvette Marie Petti, and Rose Birkmeier</td>
</tr>
<tr>
<td>113</td>
<td>4.3</td>
<td>4.3: Full Practice Authority for Advanced Practice Registered Nurses throughout Veterans Health Administration</td>
<td>Penny Kaye Jensen and Suzanne Thorne-Odem</td>
</tr>
<tr>
<td>126</td>
<td>Chapter 5</td>
<td>Chapter 5: Integrating the Clinical Nurse Leader Role in the VA System</td>
<td>Marjory Williams, Alice Avolio and Karen M. Ott</td>
</tr>
<tr>
<td>Page</td>
<td>Section</td>
<td>Title</td>
<td>Authors</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>133</td>
<td>5.1:</td>
<td>The VA CNL as a Transformational Leader</td>
<td>Susan Resti</td>
</tr>
<tr>
<td>138</td>
<td>5.2:</td>
<td>The Amazing Role of the Clinical Nurse Leader: Champion of Versatility in a Veteran's Hospital</td>
<td>Frances Zarella</td>
</tr>
<tr>
<td>142</td>
<td>5.3:</td>
<td>VA CNL Leadership – Journey from Novice to Expert</td>
<td>Lorraine R. Kaack</td>
</tr>
<tr>
<td>148</td>
<td>5.4:</td>
<td>AIM Collaborative: Clinical Nurse Leaders and Clinical Nurse Managers Working Together</td>
<td>Kimberly Kirkpatrick, Michelle Rhoney, Jamie Connelly and Alice Avolio</td>
</tr>
<tr>
<td>153</td>
<td>5.5:</td>
<td>CNL Partnership for Improvement: Rapid Recovery Ambulation Program</td>
<td>LaDonna Adkins &amp; Rosa Colon</td>
</tr>
<tr>
<td>158</td>
<td>5.6:</td>
<td>The CNL: A Lean Practitioner</td>
<td>Jamie Gilliam</td>
</tr>
<tr>
<td>165</td>
<td>6.1:</td>
<td>Creating a Culture of Team-Based, Patient-Centered Primary Care: Expanding RN Roles</td>
<td>Michael Bethel</td>
</tr>
<tr>
<td>191</td>
<td>6.2:</td>
<td>Developing a New Position: Creating Your Own Path</td>
<td>Janice Morey Pedersen and Jacqueline Andersen</td>
</tr>
<tr>
<td>200</td>
<td>6.3:</td>
<td>Mentoring Mid-Career RNs</td>
<td>Janice Morey Pedersen</td>
</tr>
<tr>
<td>206</td>
<td>6.4:</td>
<td>Increasing the Number of Baccalaureate Prepared Registered Nurses</td>
<td>Darcy Mortimer, Michiele Schrieber, and Salena Wright-Brown</td>
</tr>
<tr>
<td>212</td>
<td>7.1:</td>
<td>&quot;Nurses Own Pain&quot;</td>
<td>Janette Elliott</td>
</tr>
</tbody>
</table>
Table of Contents

234 7.2: Development and Implementation of a Multidisciplinary APRN Managed Colorectal Cancer Surveillance Program
Janet Cameron, Nancy Crandall, Maura Flynn, and Jennifer Ouellette

240 Chapter 8: The Intermediate Care Technician
Bruce Delphia, Jennifer Lee, and Karen M. Ott

256 8.1: Intermediate Care Technicians in the Emergency Department: A Transition to Civilian Care
Nancy Robinson

261 8.2: The Intermediate Care Technician Pilot: A Home for Military Medics
Janet L. Henderson

265 8.3: Just One More
Kristina Willin

272 8.4: Battlefield Experience Comes Full Circle
Maxine E. Lindsay-Shillingford, Bruce D. Oran and Sylvia M. Barchue

281 Chapter 9: Making Technology Work for Our Patients: Telehealth Nursing in the VA
David Newman

291 9.1: Developing Tele-ICU Competencies for VA Nurses to Ensure Optimal Patient Outcomes
Toni Phillips and Kay Clutter

297 Key Message 2: Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression

299 Chapter 10: VA Nursing Academy: Lessons Learned from Successful Academic Partnerships
Mary Dougherty, Gwen Anderson and Anna C. Alt-White

312 10.1: VA Nursing Academy: Providing the Bridge to Connect Nursing Education with the Health Care of Our Veterans
Jane Wellman, Lyn Dubbs, and Mary Boland

319 10.2: Building a Successful Academic Service Partnership: The San Diego VA Nursing Academy Experience
Carole Hair and Gwen Anderson
<table>
<thead>
<tr>
<th>Page</th>
<th>Chapter Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>330</td>
<td>Chapter 11: Creating Transitions to Ensure Successful Movement from Education</td>
<td>Karen M. Ott, Beth Taylor, and Mary Dougherty</td>
</tr>
<tr>
<td></td>
<td>to Practice</td>
<td></td>
</tr>
<tr>
<td>338</td>
<td>11.1: One Voice….for VA: A Personal Story of Transformational Leadership</td>
<td>Karen Spada</td>
</tr>
<tr>
<td>346</td>
<td>11.2: Moving Forward</td>
<td>Kathleen L. Taylor</td>
</tr>
<tr>
<td>351</td>
<td>11.3: The Dream: An RN Residency Distance Program for VA</td>
<td>Ellen Jones, Merry Kuyper-Carson and Kattie Payne</td>
</tr>
<tr>
<td>357</td>
<td>11.4: Creating Transitions to Ensure Successful Movement from Education to</td>
<td>Brenda Rushing French and Mary Susan Biggins</td>
</tr>
<tr>
<td></td>
<td>Practice</td>
<td></td>
</tr>
<tr>
<td>366</td>
<td>Chapter 12: Expanding the Cadre of VA Nurses with Earned Doctorates</td>
<td>Cathy Rick</td>
</tr>
<tr>
<td>376</td>
<td>12.1: Recognizing Ongoing Research Needs in Nursing and Patient Safety</td>
<td>Amanda Fore</td>
</tr>
<tr>
<td>381</td>
<td>12.2: The Meaning of Life</td>
<td>Jemma Ayvazian</td>
</tr>
<tr>
<td>388</td>
<td>12.3: Springing from the Shoulders of Giants</td>
<td>Narda A. Ligotti</td>
</tr>
<tr>
<td>394</td>
<td>Chapter 13: Building a Business Savvy Community of Nurse Leaders</td>
<td>Cynthia Caroselli</td>
</tr>
<tr>
<td>405</td>
<td>13.1: Working Smarter</td>
<td>Andrea Millman</td>
</tr>
<tr>
<td>410</td>
<td>Chapter 14: Creating a Culture of Inquiry and Evidence Based Practice</td>
<td>Beverly Priefer, Anna C. Alt-White, Wanda Bradshaw, Kathryn Rugen,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sheila Cox Sullivan, Melissa Taylor, and Mary Thomas</td>
</tr>
<tr>
<td>427</td>
<td>14.1: Nurses Making Change with Evidence Based Practice</td>
<td>Marquetta Flaugher</td>
</tr>
</tbody>
</table>
434 Chapter 15: VA Centers of Excellence in Primary Care Education: Interprofessional Education as the Future of Nursing
   Kathryn Rugen, Stuart Gilman, and Laural Traylor

445 15.1: Development and Implementation of an Adult Interprofessional Nurse Practitioner Fellowship: The West Haven VA Prototype
   Susan Zapatka, Rebecca Brienza and Jill Edwards

456 15.2: Nurse Practitioner Residency Development in VHA: The Experience of the Louis Stokes Cleveland Department of Veterans Affairs Medical Center
   Sharon A. Watts, Kristen Zimbardi, Mary A. Dolansky and Mamta K. Singh

464 15.3: Interprofessional Education: Pressing for Sustainable Change and Growth
   Melanie Nash and Amber Fisher

470 15.4: Academic PACT: The San Francisco VA Experience
   Terry Keene, Bridget C. O’Brien, and Rebecca Shunk

477 15.5: VA Puget Sound Center of Excellence in Primary Care Education DNP Residency Evolution: Leveraging Established Best Practices for Transition to Practice
   Kameka Brown and Joyce Wipf

487 Key Message 3: Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States

489 Chapter 16: Reframing Nursing's Leadership Role in Crafting New Partnerships
   Anna Monnett and Linda Lake Boyle

505 16.1: Collaborative Partnerships: The Key to Innovation and Increasing Standards of Care through New Models of Cooperation and Coordination
   Lori Hoffman Høgg and Christine Engstrom

512 16.2: Research and Evidence Based Practice for the Professional Nurse: Advancing Healthcare through Rigor and Partnerships
   Margaret Gound
Chapter 16: Sharing Governance: Decentralization of Nursing Decision-Making and Nurse Satisfaction

David Przestrzelski

Chapter 17: Creating Innovative Models of Nursing Care

Suzanne Thorne-Odem, Christine Engstrom, Evelyn Sommers and Amy Daly

Chapter 18: Building Collaborative Interdisciplinary Partnerships That Promote Best Practice for Patient-Centered Care

Richard Wing
621 18.4: Building Interprofessional Partnerships: VHA's Pressure Ulcer Prevention Initiative  
Mary Ellen Dellefield and Storm Morgan

628 18.5: Collaborative Partnerships Promote Improved Veteran-Centered Outcomes in the Field of Spinal Cord Injury and Disease  
Mary Susan Biggins and Linda Madaris

640 Chapter 19: Organizing Change and Innovation Using an Integrated Enterprise-wide Quality Framework  
David Sine and Karen M. Ott

649 19.1: Patient Emergency Response System: Improving Resuscitation Care to the Veteran  
Natina Dudley and Melissa L Hutchinson

659 Chapter 20: Managing Diversity: A Blueprint for a Successful Workforce  
Cathy Rick

665 20.1: Diversity and Cultural Competency in Patient Care  
Vilma Cong Divinagracia

670 20.2: My Personal Experience with Diversity in the VA  
Gloria Martinez

672 20.3: Diversity and Inclusion  
Alesia Coe

675 Chapter 21: Optimal Impact through Innovative Projects with New Partners  
Lori Hoffman Högg, Janet Cogswell and Christine Engstrom

687 21.1: Nursing Collaborative Approach Leading to the Transformation of Day Treatment to a Psychosocial Rehabilitation Recovery Center  
Pam McNutt, Gayla Gift and Ellen C. Fagan-Pryor

696 21.2: Integration of Palliative Care in Oncology  
Grace Oligario

702 21.3: Pioneering Cancer Care in the Last Frontier for Veterans in Alaska  
Karyn Overturf
<table>
<thead>
<tr>
<th>Page</th>
<th>Chapter</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>710</td>
<td>Chapter 22: Magnet Status as Transformational Nursing Leadership</td>
<td>Becky Kordahl</td>
<td></td>
</tr>
<tr>
<td>724</td>
<td>22.1: Transformative Nursing Leadership in the Journey Toward Excellence</td>
<td>Kathleen Chapman</td>
<td></td>
</tr>
<tr>
<td>737</td>
<td>Key Message 4: Effective workforce planning and policy making require better data collection and an improved information structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>739</td>
<td>Chapter 23: Using Data and Evidence to Manage Change and Add Value</td>
<td>Murielle Beene, Mimi Haberfelde, Pamela Pickett and Toni Phillips</td>
<td></td>
</tr>
<tr>
<td>753</td>
<td>23.1: A Nurse Executive’s Perspective on Using Data and Evidence to Manage Change and Add Value</td>
<td>Linda McConnell</td>
<td></td>
</tr>
<tr>
<td>759</td>
<td>23.2: A Team Approach to Pressure Ulcer Identification</td>
<td>Kelly Machuca and Tracy Weistreich</td>
<td></td>
</tr>
<tr>
<td>766</td>
<td>23.3: Electronic Resuscitation Documentation: Improving Documentation at the Point of Resuscitation</td>
<td>Melissa Hutchinson</td>
<td></td>
</tr>
<tr>
<td>776</td>
<td>23.4: Wound Prevention and Management from Staff Nurses in the Community Living Center</td>
<td>Jessica Watkins and Jason Sork</td>
<td></td>
</tr>
<tr>
<td>784</td>
<td>23.5: Clinical Roles in Barcode Medication Administration: Overcoming Resistance to Changing Practices</td>
<td>Kimberly Radant</td>
<td></td>
</tr>
<tr>
<td>788</td>
<td>Chapter 24: Creating Essential Electronic Patient Assessment Systems</td>
<td>Pamela Pickett, Storm Morgan, Amy Smith and Donna C. Vogel</td>
<td></td>
</tr>
<tr>
<td>798</td>
<td>24.1: Developing an Outpatient RN Assessment Tool to Facilitate Delivery of Patient-Centered Care</td>
<td>Wendy Morrish and Bree Holtz</td>
<td></td>
</tr>
<tr>
<td>807</td>
<td>24.2: Using Patient Assessment Data to Drive Improvements in Care</td>
<td>Sheila Ford</td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Section</td>
<td>Title</td>
<td>Author(s)</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>815</td>
<td>24.3</td>
<td>Nursing-Sensitive Indicator Data: A Pathway to Better Patient Outcomes</td>
<td>Sheila Thompson</td>
</tr>
<tr>
<td>820</td>
<td>Chapter 25: Enhancing Staffing Methodologies to Improve Workforce Management</td>
<td>Alan Bernstein and David Przestrzelski</td>
<td></td>
</tr>
<tr>
<td>829</td>
<td>25.1</td>
<td>Creating a Staffing Methodology: A Personal Search for Excellence</td>
<td>Teresa England</td>
</tr>
<tr>
<td>833</td>
<td>25.2</td>
<td>A Nurse Executive's Perspective on Using Data to Determine Nurse Staffing Requirements</td>
<td>Linda McConnell</td>
</tr>
<tr>
<td>837</td>
<td>Part 3</td>
<td>Conclusions</td>
<td></td>
</tr>
<tr>
<td>839</td>
<td>Chapter 26: Summarizing the Process of Transformation</td>
<td>Phyllis Beck Kritek</td>
<td></td>
</tr>
<tr>
<td>850</td>
<td>Chapter 27: Looking Forward</td>
<td>Cathy Rick</td>
<td></td>
</tr>
</tbody>
</table>
Tables and Figures

Tables

1.2.1 VHA Nursing Skill Mix Employee Count – FY12, 26

1.1 Veterans Health Administration Clinical Organizations, 41

4.1 Additional Potential APRN Privileges for Specified VA Subspecialties, 86

4.2 Frequently Asked Question Categories Developed by the VA APRN Implementation Advisory Group to Provide Web Based Guidance for VHA Facilities, 91

4.3 Survey Questions Developed by the VA APRN Implementation Advisory Group to Survey Nurse Executive (ADPCS/NE) Information about APRNs in their VHA Facility, 92
22.1  Sample Page from Current Nursing Action Plan of Madison, Wisconsin Veterans Hospital, 713

22.1.1  Cross-walk between Magnet and Baldrige Criteria, 734

25.1  Workload Factors for Projecting VA Nursing Personnel Requirements, 826

Figures

I.2.1  Department of Veterans Affairs Three Administrations, 16
I.2.2  Federal Oversight, 17
I.2.3  Veterans Health Administration Organizational Structure, 19
I.2.4  Veterans Integrated Service Networks (VISNs), 20
I.2.5  Office of Nursing Services Organizational Chart, 24
I.2.6  Office of Nursing Services Functional Model, 25
4.1  Representation of the Bidirectional Flow of Communication from the VA Practice Community in Office of Nursing Services and the Executive Leadership in VHA Medical Centers  Subspecialties, 82
6.1  Current and Future Health System Areas of Focus, 169
6.2  Veterans Health Administration Principles of the Patient Centered Medical Home (PCMH), 173
6.3  Personnel Composition of the Teamlet within the Patient-Aligned Care Team, 175
6.4  The Central Role of the RN and Expanded Team Members in the PACT Model, 176

6.5  Aspects of Care Management and Case Management, 180

8.1  Screen Shot of VA for VETS Website Homepage Featuring Recruitment for Intermediate Care Technicians, 247

8.2  Intermediate Care Technician Applicants by Branch of Service Including Reserve Components, 248

8.3  Samples of Feedback on ICTs by ED Staff Members at Pilot Sites, 250

8.4  Samples of Feedback from ICTs on their New Role, 250

8.5  Samples of Local Media Coverage of the ICT Pilot Programs, 251

8.4.1  VHA Online News Story Describing the JJP VAMC ICT Program, 278

8.4.2  VHA Internal Educational Story Describing the JJP VAMC ICT Program, 279

10.1  Visual Image of the 4 D Cycle of Appreciative Inquiry Guiding Leadership Practices in Implementing the Veterans Affairs Nursing Academy (Adapted from Keefe & Pesut, 2004), 304

12.1  Total Number of Doctorally Prepared Nurses in VA (FY 09-13) by Type of Doctorate, 370

12.2  Doctorally Prepared Nurses in VA (FY 09-13) by Role, 370

14.1  Face Page of the VA Nursing Evidence Based Practice Resource Center Website, 421

15.2.1  Conceptual Unified Framework of Components of the Nurse Practitioner Program at Louis Stokes Cleveland Department of Veterans Affairs Medical Center, 461

16.2.1  VA Nebraska-Western Iowa Health Care System Professional Practice Model, 514

16.4.1  Charles George VA Medical Center Nursing Pledge to Our Veterans, 529

17.1.1  The Nursing Practice Model Development Research Team, 548
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.1.2</td>
<td>Boise VA Medical Center Nursing Practice Model Lapel Pin</td>
<td>554</td>
</tr>
<tr>
<td>17.1.3</td>
<td>Boise VA Medical Center Nursing Philosophy</td>
<td>555</td>
</tr>
<tr>
<td>17.5.1</td>
<td>Monthly Comparison of Bed Days of Care 6 Months Pre PHTC (Gold Bars) with 6 Months Post PHTC Interventions (Purple Bars) January 2012 through August 2012</td>
<td>578</td>
</tr>
<tr>
<td>17.5.2</td>
<td>Re-Admission Rates for Post Hospital Transitional Care (PHTC) From April 1, 2012 - October 31, 2012</td>
<td>579</td>
</tr>
<tr>
<td>19.1</td>
<td>Relationship between Quality Improvement and Patient Safety</td>
<td>645</td>
</tr>
<tr>
<td>19.1.1</td>
<td>VA Puget Sound Health Care System Emergency Systems Brand Logo</td>
<td>654</td>
</tr>
<tr>
<td>19.1.3</td>
<td>VA Puget Sound Health Care System Emergency Systems Brand Logo on Crash Cart Books</td>
<td>655</td>
</tr>
<tr>
<td>19.1.4</td>
<td>VA Puget Sound Health Care System Code Blue Team Member Lanyard Image</td>
<td>656</td>
</tr>
<tr>
<td>20.1</td>
<td>VA Initiative for Civility, Respect and Engagement in the Workplace</td>
<td>661</td>
</tr>
<tr>
<td>22.1</td>
<td>Madison, Wisconsin Veterans Hospital Professional Nursing Practice Model</td>
<td>716</td>
</tr>
<tr>
<td>22.2</td>
<td>Madison, Wisconsin Veterans Hospital Nursing Council Structure</td>
<td>717</td>
</tr>
<tr>
<td>22.1.1</td>
<td>Keeping the PROMISE, Our Statement of “Stand Fors” Portland, Oregon VA Health System</td>
<td>730</td>
</tr>
<tr>
<td>23.1</td>
<td>Conceptual Model of the Vision of the VA Office of Nursing Services Informatics</td>
<td>745</td>
</tr>
<tr>
<td>23.2</td>
<td>Example of Targeted Nursing Hours per Patient Day (NHPPD) Report by Unit in VA Nursing Unit Mapping Application (NUMA)</td>
<td>747</td>
</tr>
<tr>
<td>23.2.1</td>
<td>One Year Comparison of Three Months of Data on Completion of Daily Skin Inspection by Nursing Personnel</td>
<td>763</td>
</tr>
<tr>
<td>23.2.2</td>
<td>One Year Comparison of Pressure Ulcer Prevalence Survey Error Rate (Consistency of Staging)</td>
<td>764</td>
</tr>
</tbody>
</table>
23.2.3 One Year Comparison of Three Months of Data on Documented Plan of Care, 764

23.3.1 Example of Handwritten Paper Documentation of Resuscitation Event Data, 767

23.3.2 Example of Handwritten Paper Documentation of Resuscitation Event Data Using Template Categories, 768

23.3.3 Code Net Device Screen Designed to Record Defibrillation Events Using the American Heart Association Advanced Cardiovascular Life Support Guidelines, 770

23.3.4 Example of Record of Defibrillation Events Aggregate Data Generated by Combining Defibrillator Electronic Records with Electronic Log Events, 771
The editors wish to first thank the individual nurse authors who generously shared their stories in this book, and shared with the reader their insights and the personal time required to craft a way to share them. Their partners who helped create the stories and then tell them are also acknowledged, validating the power of partnerships. We wish in particular to acknowledge Chris Engstrom, Karen Ott, Larry Rivers and Austin Moore who generously lent their personal support to this project.

The accomplishments described in this book would not have come to life without the thoughtful leadership of many great nurses who paved the way in years past. We are grateful for their trailblazing efforts and we are confident that future VA nurse leaders will carry on the tradition of innovation and continuous improvement.

Maryetta Lancaster and her team of designers, Ellen Ogu, Monica Person, Gloria Roman and Kenneth Smith, were competent, engaged and persistent in creating the book design and ushering it through to completion. We thank her, and the members of her team for their creativity and dedication. We also want to acknowledge Donna Shalala for her thoughtful foreword and the Tri-Council nurse leaders, Polly Bednash, Beverly Malone, Pamela Thompson and Marla Weston who provided perspectives beyond the walls of the VA. We also acknowledge Sue Hassmiller and all who created and are building
on the Institute of Medicine report on the future of nursing, a report that provided both structure and context for our stories.

It is perhaps apparent, but we wish to honor and acknowledge the Veterans who served for all of us, and who created the motive for our stories. It is their service to our country that catalyzes VA nurses and makes their stories worth telling.

Cathy Rick wishes to extend recognition and gratitude to Phyllis Kritek, co-editor. This book would never have happened without Phyllis. Her expertise, colleagueship and support got us started and kept us going. She is one of a kind!

I am forever grateful to the talented VA nursing community. I acknowledge their expertise and commitment to the mission of caring for Veterans in the most thoughtful and professional manner possible. I appreciate their dedication to an interprofessional interdependence as they have and will continue to shape healthcare strategies for Veterans across VA and the healthcare industry. I have been privileged to have countless important colleagues across the professional nursing and healthcare communities; so, I say THANK YOU to all … there are just too many to mention here.

My personal thanks goes to my family for their constant support, inspiration and encouragement: Ken (husband), Eric, Adam, and Amy (adult children), Michelle (daughter-in-law), Olivia and Chase (grandchildren), Elizabeth and Jeanne (sisters) and Scott (brother). A very special acknowledgement to my close Veteran friends and family: Chuck Hareng, Bob Mayer, Dennis Radler, Darol Kubacz, Rick Wenzel, Ed Rick, Keith Jasinski, Kurt Jasinski, John Horvath, Roy Healthcoat, Ken Wolff, Alan Lewis, Aaron Mathews, Noah Currier, Audrey Drake, Karen Ott, Carmen Kestner, Bill Bester, Patti Horoho, Jeff Peters, and Jose Llamas. I am forever grateful for the executive leadership and support of Secretary Principi, Deputy Secretary Mansfield and Secretary Shinseki. I’ll close my statement of acknowledgements by recognizing and noting how very important and influential my parents have been throughout my life and professional career…Betty (mother, passed at the young age of 47), Marcy (step-mother) and Frank Marshall (father and proud Marine).

Phyllis Kritek wishes to acknowledge first her co-editor, Cathy Rick, who created the conditions for the stories in this book, told some of them, and ushered through the rest of them with doggedness and imagination in equal measure. Cathy showed a unique resilience in her hope to ensure that those who created the stories garner well-earned recognition for their work benefitting both Veterans and nursing.
I also wish to thank the book authors with whom I created a complex network of digital relationships, people who have never met me face to face and yet shaped a relational process through their creative dedication. I enjoyed meeting each of them, sometimes sharing hardships and challenges, more often sharing humor and good will. Without fail, they forgave me my limitations and acknowledged my good faith efforts to serve them well. They sustained me.

From a personal perspective, I wish to acknowledge with gratitude my network of friendships, the people who invest in my visions through support, encouragement and a faith in my possibilities. These include Sara Looney, Sue Pinkerton, Janet Krejci, Shelly Malin, Mike Bleich, Barbara Nichols, Phyllis Waters, Poldi Tschirch, Dan Pesut, Deb Gerardi, and John Godon. They were often my sustenance during a process that expanded well beyond my expectations.

My daughters, Patricia (Trish) Kritek and Rebecca (Becky) Kritek evoke both love and pride. They continue to be my best teachers and my touchstone for truthfulness and hope. I am grateful to their partners, Andy Luks and Karl Behringer, for the gift of their friendship. My grandchildren, Alex Mormon, Grady Mormon and Riley Mormon, keep me in equal measure honest and committed to my capacity for joy. They also created a complex sports schedule that provided essential diversion while working on this book.

Finally, I want to acknowledge the power and pleasure of living where the Pacific Ocean, stands of redwood trees and the Santa Cruz mountains remind me daily that there are forces greater, more mysterious, and more compelling than those I am able to imagine.
Foreword

Dr. Donna Shalala
November 18, 2013

VA Leads the Way
on a Nurse-led
Health Care
Transformation
Why We Should Listen to Nurses

The American health care system is undergoing a challenging but necessary recalibration. It is vitally important that we get it right for everyone—patients, providers, employers, and private, state, and federal insurance programs. There is a lot of distracting noise out there about how best to provide and pay for quality health care for all Americans, and no one has all the answers.

We can, however, look to some large scale success stories, like the Veterans Health Administration (VA), the largest health care system in the United States. One impressive way the VA is leading the way through the difficult maze of health care delivery options and obstacles is by listening to its nurses.

We haven’t always listened to our nurses, and the VA’s system-wide paradigm shift is indeed revolutionary and replicable. Why put nurses at the center of the patient-provider experience? Nurses traditionally spend more time at the patient’s bedside than any other clinician, and they typically play the role of patient advocate. Nurses are actively engaged with patients far beyond the constraints of the hospital bed; they are practicing in community health centers, physicians’ offices, long-term care centers, rehab, and schools. Nurses provide more than care; they are health educators-in-chief.

If we are to change our health care system from one that focuses on sickness to one that promotes wellness, we need to value the role of the patient educator. If we are determined to make good on our promise to provide quality care to all Americans, then we must ensure that every clinician is working to the top of his or her health care training – and not restricting well-qualified nurses from doing the job we need them to do. This is in large part what the Institute of Medicine’s Report on the Future of Nursing (which I chaired) is all about: giving nurses a voice and making sure they play a central role in reshaping our health care system.

This is also what this book does – it provides nurses who have led the drive for care and policy changes with a platform for sharing their best practices and the ways these can help to transform health care. We can all learn from their expertise, creativity, and fearlessness. It is now our task to use their knowledge and insight to truly make a difference in patients’ lives.
The Challenge

In 2013, the VA ran 152 medical centers, 972 primary and specialty care clinics, 180 long-term care facilities, 98 residential rehabilitation programs, 288 vet centers, and nine mobile vans. This massive network serves more than 8 million Veterans, more than half of whom are 60 or older. The VA is also one of the largest health care employers in the world with 80,000 nursing staff – more than any other single health care entity.

It is the way in which the VA utilizes these nurses that deserves serious consideration by other health care systems.

In 1996, Congress significantly expanded the number of Veterans eligible to receive care in VA facilities. This meant that the system had to find ways to operate more efficiently and effectively (VHA, 2003). Not only was there a need to care for those wounded in the wars in Afghanistan and Iraq, but the Veteran population as a whole had aged, so that the VA was now hard pressed to care for a large percentage of older patients.

One of the VA’s main strategies to meet the needs of this larger – and more medically complex – patient population was to use nurses strategically and effectively.

The VA encourages nurse leadership, relies on nurse scientists, and expects all health care providers – including nurses – to practice to the top of their education and training. This has enabled the VA to successfully tackle challenges that many other systems and providers are still grappling with, such as how to:

- Provide care for more patients while containing costs;
- Improve the quality of care;
- Care more efficiently for increasing numbers of older patients with more chronic health conditions;
- Reduce medical errors;
- Meet the needs of patients who live far from a medical center or health care provider;
- Improve care coordination, especially for patients whose conditions require multiple providers and treatments; and
- Simplify bureaucratic systems to meet the needs of patients.

Sound familiar?
The VA Leading the Way

Today’s VA is very different from the VA of 30 years ago. The same can be said of our Veterans. Many of our recent Veterans face unprecedented health and medical challenges that simply did not exist during previous wars. Advances in treatment, triage, and care are enabling soldiers to survive injuries that were once highly fatal, such as severe head trauma and spinal cord damage. So as the VA finds ways to meet the unique medical needs of Veterans, it can provide valuable lessons for all of us in health care.

For example, a critical point in health care is successfully managing care transitions – when a patient is moved from one unit or entity to another. Care transitions have historically been a hot bed for medical errors – rife with opportunities for mistakes. The VA manages more care transitions – and probably more complex transitions – than any other health care entity. They must transition every patient from the Department of Defense, where they receive their medical care while in service, to the VA, which manages and provides their care once they have left service. That includes transitioning active duty soldiers whose injuries no longer allow them to serve. These transitions are often medically complex, and they are always emotionally complex.

Improving and streamlining these care transitions was one of the issues raised by the Commission on Wounded Warriors, which I co-chaired with former U.S. Senator Bob Dole, who is himself a wounded World War II Veteran. The VA heard us loud and clear. Each patient is now assigned an RN nurse manager who is responsible for overseeing their transition and the development of a care plan. This strategy has worked exceptionally well. The VA has not only reduced medical errors during transitions, it has provided each patient with one point of contact – an advocate – who can guide them through the changes.

This is just one of many nurse-led innovations and practices implemented by the VA that our general health care system can learn from.

IOM Future of Nursing Recommendations

The 2010 Institute of Medicine Committee on the Future of Nursing looked to the VA as a model for nurse-led care. This committee was convened to examine how nurses could best be utilized to meet the current and future demands on our health system. With significantly more patients in need of care, the answer became clear. Nurses who are fully trained, educated, and licensed to provide care should not be made to sit on the sidelines. We simply can’t afford it. And neither can patients.
The report states:

“Over the past 20 years, the U.S. Department of Veterans Affairs (VA) has expanded and reconceived the roles played by its nurses as part of a major restructuring of its health care system. The results with respect to quality, access, and value have been impressive.”

Not only did the VA improve access to and the quality of care, it also managed to contain costs. Again, to cite the IOM Nursing report, a Congressional Budget Office analysis found that VA spending per patient increased 30 percent from 1999 to 2007 compared to an 80 percent increase for Medicare patients over the same period.

So, how can we meet the needs of more patients, while improving care and containing costs? The IOM’s Future of Nursing report recommends the following:

1. **Listen** to the unique perspective of nurses and encourage them to lead change and practice innovations.
2. **Utilize** advanced practice nurses to the full extent of their education and training to expand access to quality care.
3. **Promote** interprofessional collaboration and team-based care models to improve the quality and coordination of care.
4. **Strengthen** nurse education and training to better prepare nurses for more complex systems and different care settings.
5. **Improve** our understanding of workforce requirements and expand cultural and ethnic diversity to better meet the needs of patients.

The report provides a blueprint for anyone who wants to reduce medical errors and re-hospitalizations, increase patient satisfaction, and give health care providers more time with patients. Three years after the report’s release, it remains the most widely read report in IOM history and the number one reason people visit the IOM website. This says volumes for an organization that has issued some of the most groundbreaking and game-changing reports in modern medical history.

Immediately following the release of the report, which was funded by the Robert Wood Johnson Foundation, RWJF joined with AARP® Real Possibilities (formerly known as the American Association of Retired Persons), to launch the Future of Nursing. Campaign for Action, which is working to implement the report’s recommendations. The Campaign’s vision is for:
Everyone in America to live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health. You need look no further than the VA for this vision made reality.

Nurse-led Health Care Transformation

As the largest segment of the health care workforce, improving quality and promoting patient-centeredness won't happen without nurses. We need their support, but more importantly, we need their leadership. The benefits of that leadership are recounted in this book in the form of what one nurse calls “talk stories.”

In their own words, these nurses explain the challenge they faced and how they developed a program or process to overcome that challenge. The results in some cases are quite extraordinary. They include:

- A tele-health program that helps providers meet the needs of patients when and where they need it;
- Expanding access to care and reducing wait times by utilizing advanced practice nurses to the full extent of their education and training;
- Transforming nurse residency programs to help providers better understand and meet the needs of their patients;
- Establishing an interprofessional team to improve the coordination of care for Veterans who must see multiple providers for their injuries; and, as previously mentioned,
- A nurse (or RN) care manager assigned to every patient to navigate care transitions and develop and direct care plans.

What do these ideas have in common? They are evidence based and patient-centered. This practice approach empowers everyone on the medical team to speak up about changes and improvements. And the VA listens.

A Commitment to Evidence Based, Patient-Centered Care

When pursuing meaningful innovation, how many times have we heard, “This is the way we’ve always done it”? The VA has a different approach.

As Cathy Rick, the VA’s Chief Nursing Officer and one of the editors of this book explains:
“We are constantly looking for ways to improve what we do. We have nurse scientists who uncover and review medical evidence and create strategies to translate that evidence into practice. And we don’t let habit or tradition block change. We ask ourselves, ‘What is going to work best for patients?’ That drives everything we do.”

As one example, the VA has led the way in relying on advanced practice nurses (APRNs) for primary care. (Studies have found that advanced nurse practitioners – APRNs – can safely and effectively provide more than 90 percent of pediatric primary care services and 75 percent of general primary care services.) This approach – one of the key recommendations of the IOM nursing report – has enabled the VA to serve more Veterans and reduce wait times. It also enables physicians to spend more time with the patients who need them most. This is what I call a win-win-win.

The VA made a bold move when it chose to leverage its status as a federal entity and not be hampered by the widely varied state laws and regulations that tie the hands of some nurse practitioners. Depending on the area of the country, VA clinicians are needed to provide care in different states. A fully trained and licensed APRN does not become less competent because she moves from one state to another. And the VA needed to be able to send nurses to care for patients in different communities, and sometimes across state borders.

The bottom line is that the VA has led the way on this issue – and proved that it works. By following this approach, providers win, the system wins, but most importantly, patients win.

A Road Map for Improvement

The IOM Future of Nursing report and the VA case studies in this book serve as a road map for anyone who wants to expand access to quality care, reduce medical errors, improve patient safety and satisfaction, and also improve the satisfaction of providers.

When we follow evidence based practices and listen to those on the frontlines, we can achieve great things. We can learn by listening. That is the motto three nurses followed as they tried to improve a nurse residency program. They wanted to help their trainees better understand their unique patients – Veterans who had been through horrific injuries and faced monumental rehabilitation challenges. Nurse residents were encouraged to ask patients to talk about what they had been through and what they were worried about. The Veterans talked and the nurses
listened. The nurse residents gained a new-found respect for and deeper insights into how to care for and support their patients. And the Veterans benefited by releasing some of the burdens they were carrying.

Another win-win.

There are many moving success stories in this book. I encourage you to read it, listen and learn. Then take what you learn and lead. One way you can lead is by joining the Future of Nursing: Campaign for Action.

I am not a nurse. I have, however, had the honor and privilege to spend my professional life dedicated to improving health and health care. I have learned many hard-won lessons, and I am convinced that utilizing nurses – and all health care providers for that matter – to the full extent of their education and training is essential to improving both access to and quality of care.

And the VA is leading the way.

For more information about the Future of Nursing Campaign for Action, please visit www.campaignforaction.org
Part 1
Strategic Innovation
Creating the Future of Nursing
Introduction: VA Nurses and Their Stories in Context
Introduction
Part 1

The Why and How of This Book

Phyllis Beck Kritek
The Why of This Book

This book emerged, for me, from a convergence of forces, each compelling in its own right. The Institute of Medicine (IOM), in collaboration with the Robert Wood Johnson Foundation, sponsored a two year study about the future of nursing in the United States, concluding in a comprehensive report released electronically in 2010, available in print in 2011 (Institute of Medicine, 2010; Institute of Medicine, 2011). Operating on the margins of this process, testifying once myself, reading burgeoning publications indicating the direction of the report, I watched the presence of the Veterans Administration (VA) Office of Nursing Services (ONS) influencing pieces of the process, contributions that were eventually reflected in the report. I was pleased that VA nurses were present, proactive, leading.

This positive response was based on the second compelling force, my personal observations about VA nursing under the leadership of my coeditor, Cathy Rick. During over 30 years as a nurse educator, I had been involved, several times, in one or another VA facility, usually as a visiting nurse educator making observations. My early experiences shaped my first impressions: a system in need of resources and innovation. My work on conflict engagement, particularly during the last fifteen years, gave me additional opportunities to make observations, both in training some groups of VA nurses and participating in some national VA nursing meetings. I could watch, from the outside, noting that through Cathy’s vision and leadership, innovative changes were emerging that in time became national phenomena, influencing both nursing and health care practices. The nurses in the largest health care system in the United States were already field testing and refining what many other nurses would only begin to ponder as possible by reading the IOM report.

Concurrent with the emergence of the IOM report, the United States Congress was engaged in a tortuous process of crafting legislation designed to reform United States health care. This complex and often fractious process resulted, eventually, in the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), which was signed into law on March 23, 2010 by President Obama. I followed the process closely, dismayed by the media’s fascination with the political process, thus failing for the most part to report on the actual content of the legislation. I became a tenacious student of the PPACA content, frustrated that the words “Patient Protection” were inappropriately rendered invisible. It really was being crafted to protect patients in many ways, nudging us collectively to a substantively different model of health care.
This was the third compelling force. This law was the most extensive overhaul of United States health care since 1965 when Medicare and Medicaid were legislated. While some provisions of the law are common knowledge, many seemed to me to presage the exact role for nurses that the IOM was recommending, one of influence, leadership in redesigning health care, expanding nurses’ roles, increasing emphasis on health promotion and disease prevention, shifting our focus from providers to patients, financing based on ensuring wellness over time. These emphases on healthier Americans with improved access to quality patient care reflected fundamental nursing values, as did the law’s insistence on justice, integrity and expanded educational opportunities. These changes seemed to ensure a seat at the table for the vision and voice of nurse leaders.

Voice, shaped by an underlying vision, is important. Since 1990 Gallup has surveyed Americans, asking them to rate the “honesty and ethical standards” of several professions. As Gallup noted in their 2013 survey report, 82% of respondents said that nurses had “very high or high” honesty and ethical standards. As Gallup notes in this report,

Since 2005, more than 80% of Americans have rated nurses as having “high” or “very high” honesty and ethical standards. Nurses have topped the list since 1999, the first year Gallup asked about them — with the exception of 2001. That year, Gallup included firefighters on a one-time basis, given their prominent role in 9/11 rescue efforts” (Swift, 2013, para. 2).

I have been following this survey for years, noting that Gallup didn’t even include nurses until 1999. I have been convinced that if any other profession had achieved this acknowledgement with such persistence, it would have made the front page of the New York Times, above the fold. I think people trust nurses because of how we behave, how we are. I think they are less informed about what we actually do. We do not, in the main, tell our story often or well. Although we are deeply grounded in our vision of what nursing is, we seem to have trouble finding voice, stating simply, in our own words, our story, articulating clearly the profound work we are privileged to do. We meet total strangers, often under conditions of extreme duress, and ask simply: “How can we help you with this health experience? How can we alleviate your suffering and return you to a sense of personal wholeness and well being?” We bring a science, an art, and a moral conviction to those questions, and stand ready to respond. And we always respond. Our work is intellectually challenging, grounded in research, complex,
demanding, compassionate, and difficult. We work hard to do all this ethically and honestly. Yet we often struggle to explain ourselves.

So I have spent most of my career coaching, cajoling, urging nurses to write their stories, to develop the fine art of first person, active voice narration. I have struggled with the commitment we have made to third person passive voice reporting, where the actual actors are unacknowledged: things happen, and who does what is a mystery. I have edited two previous collections of nurses’ stories. I consider myself increasingly an expert in the project of nursing’s voice. And this was the fourth compelling force. Here in the VA was an amazing panoply of nurses’ stories, and they needed to be told.

Though two of my four brothers are Vietnam Veterans, I am not a Veteran. I have cared for Veterans though, and taught returning Vietnam Veterans, medics hoping to become nurses, many troubled, struggling, discounted by their countrymen. Their suffering was palpable, and in time, some committed suicide. This has haunted me; what more might I have done; what more might we have done?

So I was paying attention to the Veterans returning from Iraq and Afghanistan, and I was again troubled. Their suffering seemed equally palpable. We had improved our capacity to ensure their survival, despite desperate odds. We had concurrently created an enormous demand for complex care for a huge surge in Veterans. Much as the wars morphed well beyond the planning first promoted, the care of these Veterans seemed at risk, escalating Veteran demand dramatically exceeding resources the nation would demand on their behalf. VA was absorbing the impact of this failure to ensure a robust response, and the ease with which we as a nation wanted to critique the VA, yet failed to step up to ensure care, was unsettling. I wanted the work VA nurses were doing to meet this challenge to be known; I wanted that story told. And this was the fifth compelling force.

The final compelling force, coming full circle, was my personal response to the messages of the IOM report itself, the urgent insistence that nursing should proactively shape health care systems, take a leadership role in transforming health care, act. As the report itself indicated, VA nurses were a critical mass of frontrunners in not merely responding to the recommendations of the report, but in having actually implemented many of recommendations embedded in the report, many before the report emerged. I knew this; I was not sure if anyone else did, including some VA nurses.
It seemed that VA nurses, in telling their stories, could provide templates for change, could serve as role models and catalysts, could accelerate the rate of change our discipline might achieve in its transformation. There are many stunning projects throughout the United States, creative and courageous ventures responsive to the IOM report. This book joins their ranks as one group’s contribution to the challenge.

The How of This Book

Cathy Rick was one of the nurses subjected repeatedly to my urging to get the story out. She wanted to do so, in part to share the VA story, to provide exemplars and motivate other nurses. She also wanted the nurses who had engaged in so much innovative change, persistence and hard work to be recognized for their contributions. She, and her many nurse colleagues, are driven first by a deep commitment to our nation’s heroes; they do take action to pay our Veterans back for their service.

These nurses could find an easier job. They could find one with better hours or pay or benefits. They could avoid the heart-wrenching impact of complex suffering, the challenge to Veterans’ families and the moral distress that is sometimes inevitable. They could escape the complexity of a government health care system, the Gordian knot of bureaucracy, a resource base controlled by a sometimes fractious Congress, the persistent scrutiny sometimes ballooning to harsh critiques. But they chose not to do so. That alone is a story worth telling. As I have watched the surges in criticism of the VA, I wanted to differentiate the work of these nurses from troublesome choices made by some in the VA that in no way could or should diminish the work of these nurses.

So we sent out invitations, and many responded. The early plan was more modest, limited, contained. The final product is larger, more complex, and more compelling. The range of stories begins to reflect the actual complexity of the system, but also the stunning reality that despite the challenge, innovations mushroomed, spread, and flourished. Veterans benefitted, as did the nurses, as did health care in the United States. Because the VA is a government health system, ideologies grounded in views of such systems often shape the national dialog about the VA and the scrutiny of its practices. Having worked, as a consultant, with a myriad of health systems throughout the United States, I knew that few could endure unharmed the scrutiny we direct at the VA. That reality creates an imbalance and can distort the story of nursing in the VA. This book serves as antidote.
The stories in this book tend to focus primarily on the achievements of VA nurses during the tenure of Cathy Rick as the VA’s Chief Nursing Officer, a role she brought to a close as the book neared completion, a summary of the journey she shared with a wonderful group of dedicated nurses. We elected to organize the stories around the key messages of the IOM report because there was a natural fit, and the links between the VA nurses’ journey and the IOM urgings were evident. Most of the nearly 150 authors are nurses; those who are not join us to tell a story of interprofessional collaboration, one of the key innovations discussed in the book.

As the organic nature of the book began to reveal itself, we discovered that there were two types of stories that might serve our readers. The first were the stories of leadership and initiative emergent from the vision of the Office of Nursing Services, the central office for the system. These stories focus on specific national innovations, how they were catalyzed, realized, evaluated and refined. Each was a project intended to permeate the entire system over time, with a commitment to extend creative change. Nurse executives and health care systems can find here imaginative ways to address current health care system challenges.

The second set of stories was from “the field”, how individuals and groups made the national initiative happen in their specific unique environments. Nurse managers, doctoral and graduate students in nursing, and staff nurses can find here potential projects to pursue to improve patient care.

With these two levels of innovation implementation as guide, we structured the book with lead chapters that described the national initiative and exemplar stories that provide some selected field descriptions of how this was made manifest in real work situations. Structurally, what emerged over time, was a collection of stories responsive to one of the four key messages of the IOM report, narratives about national leadership creating an innovation and stories about how nurses in real world situations made those innovations real for Veterans and their families. Happily, this fit my understanding of the compelling forces that stimulated this book and motivated me to persevere.

Some authors are experienced; many however, are publishing for the first time. Many authors struggled with using first person voice, having been schooled in the use of third person, where the actor is invisible, further obscured by passive voice. The challenge of simply saying “I did this” or “We did this” was sizable, affirming the need for strengthening nurses’ voices. Passion for the care of Veterans was always apparent, always there as a moral anchor. The possibilities of what VA
was modeling for the nation’s health care systems were apparent; VA nurses were the PPACA and IOM report precursors with a story to tell.

Leadership counts. What Cathy Rick’s vision made possible, through her leadership and a sobering amount of hard work, is a shared journey full of wonderful stories that can transform nursing. In the book both the parts and the whole honor our readers by giving them ideas, acknowledging challenges, cheering them on to innovate, discover, give the best care possible. Nurses can and will transform nursing and with our professional colleagues and partners, redesign health care. This book is one expression of VA nurses’ contribution to this transformation.

REFERENCES


Introduction Part 2

Creating Context: Where the Story of VA Nursing Emerged

Larry Rivers and Cathy Rick
The stories told in this book have emerged from the work of VA nurses who provide care to a community of heroes, service with a proud history. It has been our experience that the systems of healthcare and other Veterans’ services are not well understood by many, including health care communities, across the United States. This chapter will outline important features of the Department of Veterans Affairs (DVA, VA) and the Veterans Health Administration (VHA).

History

Comprehensive services for Veterans have been available dating back to 1636 when the pilgrims granted support to soldiers who were disabled as a result of their service in the war with the Pequot Indians. Congressional action of 1776 led to providing pensions for disabled soldiers as an incentive to enlist during the Revolutionary war. The first long term housing (domiciliary) and medical facility was authorized in 1811 and soon after that Veterans’ programs were extended to their widows and dependents. Each State developed a system of care for indigent and disabled Veterans of the Civil War, Indian Wars, Spanish-American War and Mexican Border conflicts.

With the involvement of the United States in World War I in 1917, Congress authorized a new system of benefits. By 1920, these benefits were administered by three distinct federal entities: the Veterans Bureau, the Bureau of Pensions of the Interior Department and the National Home for Disabled Volunteer Soldiers. These bureaus were consolidated with the establishment of Veterans Administration in 1930. Brigadier General Frank T. Hines had been the head of the Veterans Bureau for seven years; he was named the first head of the newly integrated federal office of Veterans Administration. Administrator Hines held that position until 1945.

Federally directed services for Veterans expanded significantly with the United States engagement in an increasing number of foreign conflicts. The numbers of Veterans grew to large numbers and new benefits were authorized by Congress in recognition of their service to our country. The World War II GI Bill was enacted in 1944, expanding Veteran benefits even further (Department of Veterans Affairs, n.d.). By 1973 the Veterans Administration grew to include the federal national cemetery system with the exception of the Arlington National Cemetery, which is maintained by the Department of Defense (DoD). With the expanding scope of services and national interest in Veterans services, the Veterans Administration was elevated to a cabinet-level position in 1989 under President George Herbert
Bush, which shifted the programs to the executive branch of government and was renamed as the Department of Veterans Affairs (DVA or VA).

**VA and Other Veteran Services**

One way to begin to understand the VA is to recognize that there are many services offered to Veterans, both within the government and in the private sectors. We who work in the VA often hear questions about the differences between these services.

**The Department of Defense**

The Department of Defense (DoD) is a cabinet-level federal agency that is authorized to focus on active duty military and their families. In contrast to this, the Department of Veterans Affairs is authorized to provide services to Veterans. These two federal departments work closely together on transition needs when active duty Service members separate from armed forces but their medical and other services are managed separately by each department. For example, the DoD has military treatment facilities, such as Walter Reed Hospital, that provide healthcare to active duty Service members. The VA has a national system of care (described later in this chapter) that is separate and distinct from the DoD medical treatment facilities.

There are state and county level government entities that are authorized and funded to provide Veterans services, like any other program by those local governments. The interface between these many government services is challenging since the structures, management, and communication channels are distinct from one another. The VA, and more specifically, we who work in the VHA, make every effort to provide smooth transitions, responses, and when possible partnerships with these varied government services.

**Veteran Service Organizations and Other Private Sector Veteran Services**

Veteran service organizations (VSOs) are member organizations that have local, regional and national programs to support Veterans. They advocate for Veterans and represent Veterans’ interests to Congress as well as government and private sector entities. You may be familiar with some of these organizations since they typically have a high profile in local communities. Examples of these organizations include the American Legion, Disabled American Veterans, Vietnam Veterans of America, and Paralyzed Veterans of America. We have found these
organizations to be significant partners for us, having mutually beneficial approaches to address the diverse needs of our Veteran population.

There are currently approximately 22 million Veterans in the United States, and of these, eight million Veterans are enrolled to receive healthcare services from the VA. Private sector services are provided to Veterans across the U.S. healthcare industry and employment markets. Healthcare systems and community organizations across the country provide services to Veterans in their hospitals, clinics, home care programs and other supportive services and settings. Thus, from our vantage point, it is important for our readers to recognize the unique needs and attributes of our nation’s Veterans knowing that many of the patients you come in contact with have served our country in the military. The stories told in this book will highlight many key aspects that are not necessarily unique to Veterans or VA, but are presented to readers as a springboard for discussion and collaboration among all segments of the healthcare industry.

**Department of Veterans Affairs**

The Secretary of the Department of Veterans Affairs is the highest ranking VA official. This position is a cabinet level position reporting to the President of the United States, similar to the Secretary of Defense, Secretary of State, Secretary of Health and Human Services etc. Guiding principles for VA are stated as: People-Centric, Results-Driven and Forward-Looking. VA core values are defined by the acronym I-CARE: Integrity, Commitment, Advocacy, Respect, and Excellence. VA programs and our workforce are charged to ensure characteristics of being trustworthy, accessible, quality-oriented, innovative, agile and focused on integration.

**VA Organizational Structure**

VA has three organizational administrations: Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA). The top official in each of the administrations is referred to as the Under Secretary (Figure I.2.1). The Under Secretaries are responsible for setting the department’s strategic priorities and carrying out operations across the national enterprise that covers Veterans services provided throughout the entire United States and its territories. The Under Secretaries collaborate and coordinate programmatic approaches across the three administrations using frequently held executive meetings and departmental committee structures.
VA Funding, Personnel and Oversight

Congressionally appropriated tax dollars are the funding source for VA operations and services. These funds are under the category of discretionary spending rather than mandated spending. The President’s proposed budget goes through congressional review and approval in order to set levels of funds available for VA during annual budget planning processes. This is a lengthy back and forth process that readers often hear about via public media. VA healthcare services are currently under a two-year cycle in order to avoid delayed services to Veterans when the federal budget is under a continuing resolution which freezes spending authority for federal agencies for lengthy periods of time until consensus and congressional approval is reached each year (the federal fiscal year runs from October through September).

As you may recall from your early studies in governmental affairs that our democratic federal government has three branches that are designed to balance political powers: the Judicial Branch, the Executive Branch and the Congressional Branch. We mention this here in order to shine a light on the unique levels of oversight that the VA experiences. Like all corporate or bureaucratic structures, there are many internal oversight functions to ensure efficient and effective operations. VA has an Office of the Inspector General that serves as the main internal oversight arm. External oversight for VA comes from both the Executive and Congressional branches. The Executive branch conducts oversight across all federal departments for functions such as budget (Office of Management and Budget-OMB) and
personnel (Office of Personnel Management-OPM). You can imagine the complexities of having federal policies that need to have standardized approaches that govern budget and personnel issues for departments with such distinctly different responsibilities like the Department of Veterans Affairs and the Department of Transportation. Dedicated congressional committees (on both the Senate and House sides of Congress) provide oversight to the Executive Branch. The House Veterans Affairs Committee and Senate Veterans Affairs Committee are charged with primary congressional oversight functions for VA. These committees also call upon the Government Accountability Office (GAO) to review and evaluate VA functions when issues or concerns arise from congressional members. These structures are the mechanism by which statutory authority is set for the VA. VA must comply with and seek approval via these avenues when setting internal policies and strategies. We ask the reader to consider this brief description as a comparative snapshot to private sector governance and oversight that is provided by Boards of Directors and/or Boards of Trustees or Advisory Boards which is visually presented in Figure I.2.2.

**Figure I.2.2 Federal Oversight**

<table>
<thead>
<tr>
<th>Dynamics of a Federal Healthcare System</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Executive Branch Oversight</td>
</tr>
<tr>
<td>■ Office of Management &amp; Budget (OMB)</td>
</tr>
<tr>
<td>■ Office of Personnel Management (OPM)</td>
</tr>
<tr>
<td>■ Government Accountability Office (GAO)</td>
</tr>
<tr>
<td>■ Office of Inspector General (OIG)</td>
</tr>
<tr>
<td>□ Congressional Oversight</td>
</tr>
<tr>
<td>□ Budget Process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Congressional Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="House Committee on Veterans' Affairs" /></td>
</tr>
<tr>
<td><img src="image" alt="Subcommittee on Health Oversight and Investigations" /></td>
</tr>
</tbody>
</table>
Veterans Health Administration

VHA’s stated mission is to honor America’s Veterans by providing exceptional health care that improves their health and well-being. The stated VHA vision is to continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence based. This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement. It will emphasize prevention and population health and contribute to the nation’s well-being through education, research and service in national emergencies.

VHA’s goals and objectives are the benchmarks used to determine if VHA is accomplishing its mission and vision. Our stated VHA goals are to provide Veterans with personalized, proactive, patient-driven health care based on objectives that have measurable improvements in health outcomes and resources aligned to deliver sustained value to Veterans.

VHA System of Care

VHA began with 54 hospitals in 1930 and currently has 152 hospitals, 825 community based outpatient clinics (CBOCs), 135 nursing homes (now referred to as community living centers-CLCs) and 35 domiciliaries. VHA healthcare services span the continuum of primary care, acute care, home care, telehealth, long term/extended care and rehabilitation with facilities in frontier, rural, and urban settings. This is an integrated model/ system of care with primary, secondary, tertiary and quaternary facilities that have typical referral options within the system and standardized approaches for best known practices. Many facilities are academic centers with structured university affiliations, often times having shared space, faculty and staff.

VHA Organizational Structure

VHA has national program offices with responsibility for key elements of administrative, clinical, academic, research and emergency management functions. Program offices are led by Chief Officers who report through Deputy Under Secretaries to the Under Secretary for Health (Figure I.2.3). For example, the Chief Nursing Officer (CNO) reports to the Principle Deputy Under Secretary for Health. Later in this chapter, we will describe the functions and structure of the Office of Nursing Services. VACO program officials set policy and direction for all services delivered across the VHA enterprise. VHA policies are labeled as Directives or Handbooks. We work to have communication channels and committees that support an integrated
approach to the understandably complex nature of the many moving parts of this large organization. A National Leadership Council, chaired by the Under Secretary for Health, provides the highest level governance platform for VACO officials and field-based officials to address strategic approaches.

**Figure I.2.3 Veterans Health Administration Organizational Structure**
The VHA field-based system of care is organized into 21 regional networks referred to as Veterans Integrated Service Networks (VISNs). You’ll note in Figure I.2.4 that there are 23 VISNs depicted. In the mid-nineties VISNs 13 and 14 were integrated into one VISN which was renamed as VISN 23. This renaming allowed for continuity of record keeping for all other VISNs rather than renaming all VISNs for the sake of maintaining a numerical sequence. The top official for each network is the VISN or Network Director (ND). Facility Directors (comparable to Chief Executive Officers in private sector facilities) within each VISN report up through the ND to a VHA Deputy Under Secretary in VA central office (VACO or Headquarters). Operationally, all key officials at local facilities report to the facility Director and follow the VISN chain of command to the VACO Deputy Under Secretary. For example, facility-based chief nurse executives (most common VHA title used is Associate Director for Nursing and Patient Care Services) have a local accountability reporting relationship rather than a direct report to the CNO in VACO. Facility level executive teams typically consist of the Director, Associate Director, Chief of Staff (physician) and Associate Director for Nursing/Patient Care Services (nurse). Our facility executive team is often referred to as the Quadrad. For information about VISNs and specific VAMCs, go to http://www2.va.gov/directory/guide/division_flsh.asp?dnum=1.

**Figure I.2.4 Veterans Integrated Service Networks (VISNs)**

The VHA established a regional network system in 1995 to decentralize clinical management that resulted in 21 regional networks called Veterans Integrated Service Networks or VISNs. These 21 VISNs are the fundamental units for managing funding and ensuring accountability for outcomes. Each VISN is responsible for coordination and oversight of the administrative and clinical activities within a geographic area of the country. A map is included above that shows the location of the VISNs. Note: VISN 23 is a consolidation of the previous VISNs 13 and 14.
Veteran Eligibility for VHA Care

As mentioned earlier in this chapter, approximately eight million of the 22 million Veterans in the U.S. are enrolled with VHA to receive healthcare. The Secretary of Veterans Affairs sets the eligibility criteria for enrollment based upon the priority needs of Veterans and the capacity/funding available to provide best available care. Priority currently goes to those Veterans who have service-connected disabilities or are in a low income category. Eligibility criteria are highly complex. VSOs are a common avenue for Veterans to receive well-advised assistance when seeking eligibility for VA healthcare services. For more detailed information on eligibility go to http://www.va.gov/healthbenefits/apply/Veterans.asp.

VHA Funding and Personnel

We described the funding and personnel management approaches of the federal government in the prior section of this chapter. It’s important to mention some unique VHA features related to oversight, budget and personnel. In addition to the oversight functions mentioned earlier, VHA has many other internal and external checks and balances. The Under Secretary has designated a VHA Office of Medical Inspector to review adherence to clinical and administrative functions across VHA. Each program office conducts a level of oversight related to their areas of responsibility and evidence based standardized performance metrics (comparable to industry standards) for program offices as well as field based facilities are in place. External oversight is mostly provided via accreditation bodies such as The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

In addition to the tax dollar appropriated funds for VHA (allocated at the departmental VA level to all three administrations: VHA, VBA and NCA), funding comes from third-party insurers and minimal co-payments from Veterans. VHA is not authorized to receive funds from Medicare or Medicaid. Third party insurers are billed (if the Veteran has coverage) for services that Veterans are not eligible to receive based on their level of service-connected disability. VHA provides funding to local healthcare providers on a fee basis when VA doesn’t have the availability or capacity for required, eligible services in a timely basis.

VHA employs 277,000 people. All VHA services, including physician services, are provided by employed personnel. Employment may be in the nature of a full or part-time employment, contract, memorandum of understanding or in an uncompensated employment status. All federal employees fall under the policies and governance of the Office
of Personnel which supersedes any State of local governance statues or policies (federal supremacy). Federal Supremacy means that licensure requirements for the employment of VA nursing and health care providers are established by Federal law, not State law. Under the Supremacy Clause of the U.S. Constitution, VA has the authority to establish qualifications for, and regulate the professional conduct of its health care practitioners.

Federal employees can move from one federal job to another and maintain their seniority for the purpose of calculating employee benefits. VHA licensed clinicians are authorized to practice in any State across the Nation with a single, unrestricted license from any one State. This portability of licensure is a distinct advantage to clinicians who have an interest in transferring within the VHA system of care. Another advantage to the licensure portability is that it supports our capacity to respond to national medical emergencies such as major hurricane crises or interruptions in private sector community services due to terrorists acts against the country.

Workforce Diversity

VHA personnel are a talented, diverse cadre of individuals who are mission-driven, grounded in our commitment to care for the nation’s heroes who have served our country to preserve our freedom. We’d like to note that there are many approaches and initiatives that ensure diversity among our workforce. Workforce databases track personnel characteristics such as gender, ethnicity, and race for the purpose of developing best known strategies to retain and recruit a diverse workforce. Advisory groups, committees and other forums for employee input are purposefully comprised of appropriately designated diverse members. National and local strategic plans encompass required elements to attend to attracting, maintaining and advancing personnel with diverse characteristics. One example of a specialized national program that targeted approaches to support a diverse nursing workforce was our 2004 Office of Nursing Services Innovation Award. The theme for our 2004 award was “Enhancing the Diversity of the VA Nursing Workforce and/or Addressing Culturally Sensitive Patient Care” which focused on our strategic priority of attending to retention, recruitment and advancement of underrepresented nursing employee groups. Ten nurse-led interdisciplinary teams were recognized with a $10,000 cash award for programs and initiatives that enhanced the diversity of the VA nursing workforce and/or addressed culturally sensitive patient care.
Clinical Programs

Lastly, we’d like to highlight some key elements of our VHA system of care since the stories told by VA nursing staff in this book will relate to features and priorities that we’ll describe here. VHA has an envisioned future state that is wrapped around patient engagement with a team-based approach that is data driven. The cornerstone of the VHA vision is our primary care program that embraces the Medical Home principles [AHRQ, 2011]. This primary care model is referred to as our “Patient Aligned Care Team” (PACT). The acronym aptly describes our intent to have a pact with our Veterans to provide patient-driven care which respects and incorporates patient preferences. Our PACT is reliant on patient engagement and transparency of care options, informed choices and mutually understandable consequences of choices. Specialty care is considered to be an essential companion to primary care. Specialized services are provided along the continuum of ambulatory, acute, telehealth, rehabilitation, long term/extended care and home care programs. Strategic initiatives focusing on prevention and population health are in place to move the system of care to a shared decision-making approach which requires a healthy dose of innovation. You will read about our nursing innovation on this journey to achieve the desired future state through the stories told from the vantage point of representative VHA nurses in the lead and exemplar chapters of this book. Our stories will highlight aspects of clinical care, administrative practices, academic initiatives, nursing research, technology and emergency management.

Office of Nursing Services

ONS is the national VHA program office responsible for all matters related to nursing practice, education, research and emergency management. Our strategic initiatives are aligned with organizational priorities. The strategic initiatives are developed with a shared decision-making approach using our national shared governance structure. We have a lean, dedicated, extremely talented group of key ONS officials who work under the direction of the VHA Chief Nursing Officer (Figure I.2.5). ONS program directors coordinate efforts to set national policy, action plans, initiatives support and oversight for field-based nursing services. Our organizational structure is designed to support defined functions and action plans described.
in the national nursing strategic plan. We update the plan and action items periodically as VA and VHA priorities are modified.

**Figure I.2.5 Office of Nursing Services Organizational Chart**
National Shared Governance

As mentioned earlier in this chapter, there is no direct reporting/supervisory relationship between ONS and field-based nursing services. In order to ensure appropriate input, engagement and communication, we developed a national shared governance model in 2000. The committees of the national shared governance structure are charged with developing realistic, visionary strategic nursing initiatives that support VHA priorities. Chairs and members of the national shared governance councils, committees and advisory groups are representatives that come from field-based facilities. ONS officials facilitate the work of the councils etc. The shared governance structure and its relationship to ONS and organizational priorities is depicted in Figure I.2.6. Through this structure, field-based representatives have substantial impact on shaping the future for VA nursing and facilitating innovations in nursing practice, informatics and technology, and business processes that enhance quality and patient safety. Our experience has shown us that this structure and a strong commitment to bidirectional communication have been the foundation for achievement of major accomplishments. Our nursing stories told in this book often refer to this integrated structure of national and field-based efforts that have been an essential ingredient for innovation and advancement of VA nursing services (clinical, academic, research and emergency management).

**Figure I.2.6 Office of Nursing Services Functional Model**
Nursing Workforce

Just a few words about our VA nursing workforce. Nursing staff make up the largest component of the VHA healthcare workforce (Table I.2.1).

**Table I.2.1 VHA Nursing Skill Mix Employee Count – FY12**

<table>
<thead>
<tr>
<th>Nursing Skill Mix</th>
<th>Number by Skill</th>
<th>Mix Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>56,305</td>
<td>59.60%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>5,415</td>
<td>5.74%</td>
</tr>
<tr>
<td>Clinical Nurse Specialists</td>
<td>539</td>
<td>0.76%</td>
</tr>
<tr>
<td>LPNs and LVNs</td>
<td>15,890</td>
<td>16.80%</td>
</tr>
<tr>
<td>Nursing Assistants</td>
<td>13,027</td>
<td>13.80%</td>
</tr>
<tr>
<td>Other Health Technicians</td>
<td>3,194</td>
<td>3.40%</td>
</tr>
<tr>
<td><strong>Total Nursing Employees</strong></td>
<td><strong>94,370</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

*Source: 10/9/14, VANOD Demographic & Financial Cube, includes all Facilities*

Appointments and advancements for nursing personnel are governed by national policy that sets forth nurse qualification standards which outline requirements that include VHA defined dimensions of nursing practice, education, years of experience, and the criteria for consideration for advancement. We use peer review via professional standards boards that follow the qualification standards. Under the Federal Supremacy clause mentioned earlier in this chapter, VA has the authority to determine the elements of practice of its nurses, without regard to individual State Practice Acts, for clinical nursing practice other than the prescribing of controlled substances. Qualifications for employment and elements of practice are guided by the Dimensions of Practice outlined in the Nursing Qualifications Standards.

**Summary**

We have outlined some key features of our federal healthcare system in order to provide a starting point for our readers as you delve into the rich stories told by representative VA nurses in this book. This introductory chapter should be a reference point for readers to use as background information that is important to understand the context of our nursing stories. We intended to help readers realize
the many similarities and few differences between the Veterans Health Administration and other public and private sector healthcare systems.

REFERENCES


Creating Context: VA Nursing as a National Resource

Phyllis Beck Kritek
Larry Rivers and Cathy Rick have described the national health system that serves as the site for the stories in this book, the Veterans Health Administration (VHA), part of the Department of Veterans Affairs (VA). The stories also are embedded in a larger context, the United States’ unique relationship with the VA. We believed some key nurse leaders could provide a perspective that would create an enriching backdrop to our collection of VA nurses’ stories. The larger health care community and the larger nursing community provide a context for nursing in the VA.

We turned quite naturally to the nurse executives of our discipline’s four major nursing organizations, viewing them as optimal informants about our discipline and its relationships with VA nursing. These nurse leaders convene as the “Tri-Council” and collaborate to pursue shared goals that benefit nurses, nursing and those we serve. We realized that they had a shared history, and would create a lively discussion. And so I issued an invitation, and they graciously consented. We agreed to meet for a shared luncheon during the annual meeting of the American Academy of Nursing.

On October 18, 2013 I met with these four extraordinary nurse leaders for a group interview. Geraldine Polly Bednash, PhD, RN, FAAN was at the time of our interview the Chief Executive Officer of the American Association of Colleges of Nursing (AACN). Beverly Malone, PhD, RN, FAAN is the Chief Executive Officer of the National League for Nursing (NLN). Pamela Thompson, MS, RN, CENP, FAAN is the Chief Executive Officer of the American Organization of Nurse Executives (AONE) and Senior Vice President for Nursing of the American Hospital Association (AHA). Marla J. Weston, PhD, RN, FAAN is the Chief Executive Officer of the American Nurses Association (ANA).

The interview was ultimately a conversation, with each participant offering unique perspectives. In many ways, the group reflected high concurrence; in others, a distinct viewpoint was evident, often shaped by the experiences of the respective organization of the nurse leader or the personal and professional experiences of the individual nurse leader. My hope was to elicit their perceptions of the VA and VA nursing, guided by a series of open-ended questions, largely asking the same question from a variety of perspectives: What are your perceptions of VA nursing? While my questions were not rigorously pursued as a checklist, they guided me in exploring this same question from a number of vantage points, and served as a catalyst to start the conversation.

The group quickly described the ways they viewed the VA as unique, identifying a range of factors. VA is the largest health care provider system in the country, the only publicly financed system of this size and scope, complex and extensive enough that most people know of it but few understand it.
The VA is a value-driven national resource, serving only those Veterans who meet criteria of service rendered and/or need. Veterans have earned the healthcare they receive and those who provide it do so with that conviction. The group also noted that the VA provides Veterans access to care at all levels, in all environments, serving a very diverse patient population of all ages, noting that although at one time this was primarily a World War II and Vietnam Veteran population, the “new wars” had created a whole new community of Veterans in need of care. It was agreed that this new group of Veterans required care that was complex, demanding, and challenging. The group also noted that services have expanded to include new venues such as care for Veterans who are homeless or living in wilderness areas.

The group spent some time reflecting on this new generation of Veterans, more diverse, with more women, and with physical and mental injuries that exceeded our prior experiences. They also observed that this new generation of Veterans took the initiative to include in their understanding of their role as Veterans care for one another, that participation in their own care included caring for their Veteran peers, watching out for fellow patients. They wondered if this perhaps was a trait of millennials, or perhaps a function of the VA more successfully involving families and friends in the healing process and emphasizing the importance of Veterans as partners in their own care. It might also be a function of learning about caring for one another from those who went before them, Veterans from previous generations.

All agreed that VA nurses were very mission focused with a clear philosophy about care, making patient-centric care a system wide focus before the rest of the nation moved in that direction. Nurses have always been patient-centric; VA integrated this perspective into system structures and practices. More specifically, VA translated this fundamental nursing value into a care emphasis that was Veteran-centric. The nurses, in part because of the VA’s relationship with the Department of Defense (DoD), share in the culture of a community of warriors, VA nurses as warriors at the bedside, in the community, and in every setting where healing is required. Hence, VA has a unique language system reflecting their connection to the military, a language system that sometimes confounds others in health care. Perhaps of much greater significance, this link to the military means that they assume that they should bring everyone along, leave no one behind. They have a family focus, a culture of leadership, a commitment to innovation. The group agreed that our decision to link the VA nurses’ stories to the key messages of the Institute of Medicine’s (IOM) report *The Future of Nursing: Leading Change, Advancing Health* was a sound decision, and fit the VA nursing community’s history, practices and commitments. (IOM, 2010). They noted that VA nurses
were fulfilling the IOM recommendations that many in nursing were still trying to figure out, transforming care ahead of the curve of change.

One potential explanation for this emphasis on innovation, the belief that VA nurses were frontrunners, involved the actual structures of the VA. The VHA is centralized in terms of policy and practices, but decentralized in implementation and leadership, so innovations are easily disseminated, yet applied locally in ways that fit a specific site, region, or Veteran group. Thus the VA is uniquely structured to be a frontrunner, given the leadership to make it happen. In addition, the centralized capacity to disseminate innovations rapidly, largely through available technologies, speeds up the adaptation process. Federal Supremacy also helps, since the constraints on practice, particularly with the advanced practice registered nurse (APRN), are controlled by variances in state legislation. The VA has been able to invoke Federal Supremacy to ensure that more VA APRNS are able to work to the full extent of their education and competencies as recommended in the IOM report. There are no regulatory state boundaries so that a nurse in Iowa, through technology, can give care to a Veteran in Alaska. This has also enabled them to create new service provider roles, such as the Intermediate Care Technician, capitalizing on the skills of medics and corpsmen after they have completed their tour of duty.

As noted earlier, each nurse leader at our luncheon conversation brought some unique insights to the conversation. Polly Bednash was at that time completing her 28th year providing executive leadership for AACN and brought a rich sense of history to the conversation. Her sense of history of the VA itself informed, as she chronicled changes she had observed and participated in during her tenure, with particular emphasis on the role of the former Under Secretary for Health, Department of Veterans Affairs, Kenneth W. Kizer, MD, MPH. His leadership during the 1990s set the stage for many of the stories told in this book, and emphasized interprofessional communication, partnerships as a way of doing business, and teamwork as an optimal model for effective care. He recognized that strong nurses would be essential to the "revolution" he hoped to create in the VA, to transform care of our Veterans, and encouraged nurses to lead and drive the changes he sought. Nurses recognized that they had a partner in Ken Kizer and capitalized on it. This also set the stage for strong partnerships between VA physicians and nurses, a theme that often emerges in the stories told in this book.

Thus he was invested in VA leaders, and in his belief in the need for strong nurses and strong nurse leaders. Although he predated the tenure of Cathy Rick, as Polly noted, in many ways he created the conditions for
the innovations Cathy was able to spearhead, supporting a culture of risk taking among VA leaders. Polly also noted that the capacity of the VA to sustain innovations augured well for the future strength of nurses. Of particular note in recounting the impact Ken Kizer had on VA nurses was his focus on research, which created a culture where this nursing responsibility became part of the culture. As Polly noted, he moved us “to do the things nursing should do” and provided a partner for us to work with.

Polly also was able to speak to specific initiatives where VA nurse leaders and AACN nurse leaders collaborated to achieve shared goals. One was the pursuit of service/academic partnerships and interprofessional education, where VA nurses played a critical role in operationalizing these practices at several VA sites. Another was the AACN’s efforts to create the Clinical Nurse Leader (CNL) role, where VA partnered to co-create this role and implement it in a more comprehensive manner than any other health care system, demonstrating the impact CNLs could have on patient care outcomes. She noted that Cathy Rick “championed” this role and made it vital and impactful in the VA. Polly was pleased to learn nurses, in telling their stories about the CNL role and the creation of numerous academic partnerships, including nurse residencies and interprofessional education programs through the VA Centers of Excellence in Primary Care Education, would describe these shared agendas in greater detail in this book.

Beverly Malone framed many of her observations grounded in her expertise as a psychiatric/mental health nurse, and more specifically one conscious of the unique role the VA plays in the mental health care services in the United States. Bev had the added perspective of having provided nursing leadership in a large public system. Prior to assuming her executive role at the NLN in 2007, she served as general secretary of the Royal College of Nursing in the United Kingdom for six years. This was reflected in her awareness of the impact of leadership in a large public system, one with a clear mission dedicated to service, and her observation that nursing leadership at all levels of the VA was essential, something Cathy Rick made a priority by providing nursing leadership learning experiences for her nurse leaders and those who were in the pipeline. Succession planning with mentoring systems built in was essential to sustainability of VA nursing leadership.

Bev spoke reflectively of the deep sense of mission she has observed in VA nurses, noting that many of them see their work as an expression of their commitment to their country. She observed that this depth of investment was reminiscent of our nursing roots in religious orders and in the military, and thus VA nurses bring together these historical heritages in a single enterprise. She also noted that many VA nurses are
themselves Veterans, further strengthening this sense of commitment to country, sharing with their patients a personal history of serving.

Bev also spoke about the patients themselves, noting that “Social determinants are important in the story of the VA.” Looking at the patient population served by the VA, she noted that for many, if they did not have the VA, they would simply not have care. Because the United States has scaled back its mental health care services so severely, especially for the indigent or disadvantaged, mental health services are often not available, and thus the VA meets a critical need. It also provides unique services; there really are few available services for post traumatic stress disorder (PTSD), a disorder that the VA has uniquely prepared itself to address. Many Veterans have a limited education about mental health care, so creating this service becomes even more important, further reinforced by the inclusiveness that is a VA value.

Bev spoke in more depth about mental health services, indicating that VA has provided powerful leadership in mental health care practices, in recognizing mental illnesses, in diagnosing them accurately and promptly, and in initiating interventions appropriate to these illnesses. It is, for her, an excellent example of VA nurses as frontrunners, and wondered if VA nurses electing employment elsewhere might serve as catalysts in other healthcare environments. VA nurses have shaped best practices in mental health, a good example being the initiation of telehealth services for mental health care, rendered more powerful because of the reach of the VA in spreading innovations throughout the nation. These new templates for mental health care are a contribution not often known to be a contribution made by the VA and its nurses.

Pamela Thompson offered a perspective that framed the VA as “a parallel universe” to private health care in the United States. As the Vice-President for the Children’s Hospital, Obstetrics and Perinatal Care, Psychiatry and Strategic Planning for an academic medical center before assuming the executive role at AONE, she brings to her observations an awareness of the challenge of nursing leadership in complex healthcare environments. This has been further expanded through her work with nurse executives throughout the United States. After several years as the AONE executive, her role was expanded to include that of AHA Senior Vice President for Nursing. This was a new role she not only assumed, but also helped create. Thus she sits at a table and observes the healthcare services and policies in the United States from a position few nurses experience, and more importantly, she is a decision-maker at that table.

Pam’s first observation focused on establishing best practices, noting that the VA has standardized practice more than any other care
entity. As such, VA and its nurses become templates of national health policy, setting an example for other entities. As she observed, when the VA does something, everyone else pays attention. In some ways they serve as our laboratory, testing possible innovations in care, as they did, for instance, with electronic health records (EHR) and their potential to alter and improve patient care and patient safety. VA not only introduces innovations but also conducts research on them and publishes their outcomes. They set an example others can then imagine and follow.

Pam particularly admired the mission clarity that is evident in VA nurses. She included in this not only the clarity, however, but also the widespread commitment of VA nurses. As she observed: “Most nurse executives would give their eye teeth for this kind of clarity and commitment.” She complemented this observation with a suggestion for VA nurses in the future. She encouraged them to expand their partnerships with other health systems in a deliberate fashion, making it possible for other health systems to learn from them. She also encouraged VA nurses themselves to more proactively integrate with the larger nursing community, sharing their successes and providing more opportunities for cross fertilization. A good example, she noted, was planning VA nurse leader gatherings so they occurred before or after AONE national meetings where VA nurses could attend both. We collectively agreed with Pam’s urgings for expanded cross-fertilization, and noted that we hoped this book would play a role in dissemination and perhaps invite more extensive partnership building.

Marla Weston echoed Pam’s observations about the VA as a “parallel universe”, doing so from the unique perspective based not only of her role as executive of the ANA, but also informed by her prior role as Deputy Chief Officer in the VHA Workforce Management Office. This national position gave her a bird’s eye view of the VA and VA nurses in action, shaping her perceptions. Marla described VA as a “frontrunner laboratory for all other health systems”, urging that we do not have to wait ten years to implement what VA has already achieved. An easy example is the VA information systems. A more nuanced one is the Accountable Care Organization proposed as the structure of the future that many health care entities are trying to create, but one that is already a reality in the VA. Throughout this book references are made to the primary care model implemented by VA, the Patient Aligned Care Team (PACT). This is the VA version of the medical home, now being field tested in various sites in the United States, though it is already in place in the VA.

Marla summarizes this as VA already having in existence what private sector healthcare systems have as emergent or desired. While we recognize
the need for a national health policy, the reality is that the VA already has one, and provides a template we could simply replicate as a nation. In that sense, VA gives us a choice that we can make. Marla speaks with the certitude that comes from being part of the innovation process, having participated in the implementation and evaluation of these creative initiatives, knowing both their challenges and their potential. She is particularly articulate about the depth of expertise the VA has about patient-centered care, having participated in the design of the system-wide change processes. Lessons have been learned and they can be shared and replicated.

One unusual topic that was discussed was the partnerships between medicine and nursing, where the mission overrides the historic disconnections or competitions these two disciplines at times become mired in. Some thought that this was perhaps because the physicians are employees rather than external to the system. Marla observed this is particularly evident in the role of APRNs in the VA where their physician colleagues say, “We love our nurse practitioners; what’s the problem?”

Nursing research as intrinsic to the mission of VA nurses was also discussed, in part because it predated the research investments made by other healthcare systems. Of particular import is the fact that the EHR not only helps manage and document nursing care. Perhaps of greater interest to nurse researchers and scientists, there is an enormous database that can be mined, revealing important nursing information and shaping decision making and best practices. A good example of this is the patient safety research that VA has led in, shaping decisions made by nurses elsewhere.

As our conversation was drawing to a close, I asked the four nurse leaders what they thought were the key achievements of VA nurses. They answered quickly and precisely: patient safety measures, use and evaluation of electronic medical records, continuity of care and models to ensure it, implementation and research on evidence based practice, and implicit in all these achievements, nursing leadership. This list opened up a discussion about VA nurses’ partnerships with their physician colleagues and other health care colleagues. It was the group’s consensus that these partnerships served as proof that these collaborative approaches work and make a significant difference in the quality of care for patients. In revisiting the partnerships, the group returned to the CNL role and partnerships with academic centers and nursing schools, urging the VA to do even more partnering. The PACT was also discussed as a template for other systems, modeling how to co-create the best possible patient-centered primary care.

Further discussion led to a chronicling of the achievements less known. VA nursing has a very robust and extensive research initiative with many
nurses with a major body of work and nursing research as their central career trajectory. Models for accountable care organizations are a related “less known” achievement that, much like nursing research, is having an impact on health care in the United States. Operationalized academic partnerships that are not always publicly known were also discussed. The group noted that many of these achievements are now deeply embedded in the various VA organizations and are thus not likely to be readily reversed.

All members of the group showed an interest in this book, sometimes inquiring if we had included one or another topic of interest to the person asking. In all cases, I was happy to indicate that we indeed had included this content. We agreed that the book served as a report on progress made to date, pointing to next steps to take in the committed effort to create the desired future of nursing. We also explored the value of the book for educating student nurses, for giving nurse leaders ideas on solutions to real work challenges, and perhaps a resource for telling others the story of nursing. We concluded with a final request to encourage even more partnering and cross-fertilization, a suggestion all endorsed.

I am grateful for the generosity of spirit and time these nurse leaders gave to us and this book, providing a more compelling context for the VA nurses stories told in this book. The backdrop of their wisdom and life experiences, their knowledge of nurses, nurse leaders and nursing, their affirmation of VA nurses’ and nursing, enriched our conversation, and in sharing it, enriched our readers.

In reviewing this summary of our conversation, our nurse leaders reflected on some of the political challenges faced by VA nurses since our conversation, particularly focused on access to care issues in some VA medical centers and national discord about APRN scope of practice. This too exemplifies the unique role VA nurses find themselves in as they present nursing practice stories to large and complex audiences, supporting the utility of this book.

REFERENCE

Chapter 1

Strategic Approaches and Robust Communication: Key Ingredients for the Future of Nursing to Advance Health and Lead Change

Cathy Rick
The work of nursing is essential to the transformation of healthcare. Nurse leaders are in a position to take that truism from an abstraction to a lived reality, one they ensure by their choices. My role as a nurse leader has taught me that, and a good deal more. The Institute of Medicine (IOM) report on the Future of Nursing (2010) was evolving as I was eight years into my role as the Chief Nursing Officer (CNO) of the Department of Veterans Affairs. The report provides a perfect backdrop for describing the necessary characteristics, systematic approaches and guided processes that we have developed for the Department of Veterans Affairs (VA) nursing initiatives as we have moved the needle to advance health and lead change.

The Future of Nursing Report describes four key messages and eight recommendations. I will describe, later in this chapter, how pivotal our VA nursing journey was in influencing the development of that report and how the report was clear confirmation of what we describe in this book as overarching approaches and exemplars for each of the four key messages:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and an improved information structure. (IOM, 2010, pp. 29-33).

In this book we, VA nurses from throughout the United States and its territories, describe our progress as we journeyed from 2000 to 2013. Our stories will shed light on the endless opportunities for transforming healthcare that are available to nursing at every point of care and at the broadest intersections of nursing on the national scene. In sharing these experiences, we express our pride of ownership through descriptions of meaningful contributions that demonstrate a connection to organizational stewardship and professional identity.

Excitement about our achievements has created a rapid pulse that we believe will grab the readers’ attention to consider how they too
have and will pave the way toward an improved future for nursing. It has become clear to us that the report’s described future of nursing is a depiction of what U.S. healthcare should and can expect to hold nursing accountable for. Nursing plays an unmistakably pivotal role in making the right things happen and creating the conditions for optimal care. The voices of this book demonstrate the simple yet expert caring nature of the VA nursing community, a cadre of extremely talented individuals who collectively focus on always delivering on the promise of continuous improvement as we care for those who have borne the battle; those who have served to preserve our country’s freedom. The chapter authors were both invited and volunteered to write their perspectives and to highlight and showcase stories of the strategic initiatives that they have personally led. The authors’ contributions to this book provide a solid demonstration of the talent and ability that VA nurses bring to the healthcare industry. The chapter exemplars provide individual stories that demonstrate the impact of these strategic initiatives, and highlight the opportunities to enhance VA linkages with public and private sector individuals, communities, and professional organizations for healthcare transformation efforts.

It is understood that chapters and exemplars presented here are not the full story and certainly not the complete or final story for VA or for nursing at large. Let this just be the beginning of catalyzing more to come within VA and beyond, a snapshot in time designed to further nursing’s collective commitment to creating its desired future.

I began my VA career in 1992, following a twenty-one year career of progressive assignments in the private sector. My experience from 1971-1992 was in community hospitals with a range of roles spanning clinical practice in critical care, shift supervision, hospital-based nursing education, and executive leadership. I had the opportunity to incorporate functions of responsibility related to staffing methodology, quality improvement initiatives and fiscal acumen along that path. Over that time, I became convinced of the power of inclusion and the vital nature of nursing’s work in the context of the whole.

As I entered the VA system of care at a local VA academic medical center, I encountered many similarities with and distinctions between my private sector experience and VA. I was first struck by the very special nature of the VA mission: to serve those who have served us. I immediately felt this mission to be the cornerstone of staff commitment and prioritization of quality, safety and value features embedded in the work of Veterans Health Administration (VHA).
The similarities to my private sector experience were those aspects that shaped clinical practice, the nature of hierarchical decision-making, and the importance of interprofessional interdependence. Some factors created prominent distinctions for me. The VA funding source was Congressional appropriations rather than Medicare, Medicaid and third party payers. VA policies were governed by federal legislation rather than corporate boards. These policies required compliance with oversight entities of the executive branch of the federal government such as the Office of Personnel Management (OPM) and Office of Management and Budget (OMB) in addition to industry standards for accreditation. To my surprise, one additional important distinction that had significant impact on operations and decision-making was that physicians are employed by VA. Physicians as employed co-workers had proven to be motivated by the same incentives and priorities as all other clinical and administrative staff rather than approaches that I believed often motivated independent physicians. VA physicians are engaged and committed to organizational goals, objectives and strategies. I found this to be a key factor in how I would approach my work by using a true partnership approach in shaping relationships and accomplishing shared goals.

I transitioned from a chief nurse executive role (CNE) of one of 172 VA medical centers to the chief nursing officer (CNO) at the enterprise level. During my tenure as CNE at the local medical center, I had not experienced a direct linkage between my field-based responsibilities and the national program office of nursing. Therefore, I took the time to learn the structures, connections and culture of the overall system. I now held the highest ranking position which was advisory to senior executives of the Department of Veterans Affairs on all matters related to nursing. This position originally reported to a program official two layers down from the top official within VHA but was reorganized during my tenure to have a direct reporting relationship to the top VHA official.

I found that the Office of Nursing Services (ONS) was among many national program offices having responsibility for national level strategic planning, policy setting and advisory to the principal officials within the Department of Veterans Affairs. I was pleasantly surprised every day to learn about the expansive scope of programs and services that VA offered. I have included a description of our organizational structure in Table 1.1.
### Table 1.1 Veterans Health Administration Clinical Organizations

The Veterans Health Administration is on the forefront of providing excellent health care to America's Veterans. The following organizations oversee, innovate, and enhance the quality of that care, improving health for Veterans across the entire nation. This is not a complete list of VHA clinical organizations; the following have Internet websites www.va.gov/health

<table>
<thead>
<tr>
<th>Specialty Programs</th>
<th>Clinical Services</th>
<th>National Offices</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Caregiver Support Program</td>
<td>• Anesthesia Service</td>
<td>• Disease Prevention &amp; Health Promotion, National Center for</td>
</tr>
<tr>
<td>• Chaplain, National Center</td>
<td>• Blind Rehabilitation Services</td>
<td>• Geriatrics and Extended Care, Office of</td>
</tr>
<tr>
<td>• Compensated Work Therapy</td>
<td>• Dental Service</td>
<td>• Medical Inspector, Office of the</td>
</tr>
<tr>
<td>• Diagnostic Electron Microscopy Program</td>
<td>• Nursing Service</td>
<td>• Mental Health, Office of</td>
</tr>
<tr>
<td>• Hepatitis Program</td>
<td>• Nutrition and Food Service</td>
<td>• Patient Safety, National Center for (NCPS)</td>
</tr>
<tr>
<td>• HIV Program</td>
<td>• Optometry Service</td>
<td>• Pharmacy Benefits Management</td>
</tr>
<tr>
<td>• Imaging Program</td>
<td>• Prosthetic and Sensory Aids Service</td>
<td>• PTSD, National Center for</td>
</tr>
<tr>
<td>• National Center for Ethics in Health Care</td>
<td>• Rehabilitation Services</td>
<td>• Public Health, Office of Quality and Safety, Office of</td>
</tr>
<tr>
<td>• Pain Management Program</td>
<td>• Social Work Service</td>
<td>• Research &amp; Development, Office of</td>
</tr>
<tr>
<td>• Patient Aligned Care Teams</td>
<td></td>
<td>• Rural Health, Office of</td>
</tr>
<tr>
<td>• Polytrauma/TBI System of Care</td>
<td></td>
<td>• Women’s Health, Office of</td>
</tr>
<tr>
<td>• Primary Care Program</td>
<td></td>
<td>• Centers for Excellence</td>
</tr>
<tr>
<td>• Quality of Care Program</td>
<td></td>
<td>• Epilepsy Center of Excellence</td>
</tr>
<tr>
<td>• Spinal Cord Injury &amp; Disorders System of Care</td>
<td></td>
<td>• Multiple-Sclerosis (MS) Center for Excellence</td>
</tr>
<tr>
<td>• Telehealth Program</td>
<td></td>
<td>• Parkinsons Disease Research, Education and Clinical Center (PADRECC)</td>
</tr>
<tr>
<td>• Transplant Program</td>
<td></td>
<td>• War Related Illnesses and Injury Support Center (WRIIISC)</td>
</tr>
<tr>
<td>• Vet Centers (Readjustment Counseling Service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Weight Management (MOVE!)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The challenge became clear. I would need to quickly understand how nursing services (clinical, academic, research and emergency response) had been or would need to be interconnected to these many programs serving our Veteran population. I was aware of publicly known issues regarding Veteran’s access to care and understood that this was not directly attributed to nursing but I would need to be involved in organizational problem solving at the highest levels as a key member of the executive team.

As the Chief Nursing Officer (CNO) for the largest integrated healthcare system in the United States, I came to this role with a sense of humility and privilege. I was awestruck as I began my work in the summer of 2000. I asked myself how I would translate my work of executive leadership at a single medical center to a national multi-hospital system with a workforce that spanned a nation. I had seen little evidence of how the complex elements of the system made connections with and for the then 50,000 nursing staff members across the enterprise. I had learned a great deal throughout my progressively complex clinical, supervisory and executive positions across my 29 years of experience. I knew that the key factors for addressing today’s challenges while keeping an eye on shaping the future required well developed communication channels and a clearly defined strategic plan.

It’s difficult to describe the tension between excitement and fear that I faced as I launched into the early years of my tenure as the CNO. The organization had embarked on a path of significant transformation described as the Journey of Change (Kizer, 1998). It was the VA era of implementing computerized patient records and bar code medication systems which were seen to be trail blazing efforts in the healthcare industry. The level of anxiety over impact on roles and care delivery was palpable. Yet, there was a keen sense of wonder and curiosity that sparked the imagination of those who were geared up to be innovative and committed to undoing any barriers or hurdles that they faced. I needed to attend to both those who were anxious and those who were excited about the change.

I decided to focus on the two key ingredients of robust communication and strategic planning that had ensured my previous successes. Fortunately, VA has a solid system of support functions that enhance our ability to manage complex initiatives across such a large entity. I relied heavily on direct communication through one-on-one introductory meetings, email using targeted groups of subject matter experts and communities of practice (Wegner 1998) along with the technical support of the national employee education center and VA online learning management system to support these connections.
First things first. Since I had only worked at one site within the very large VA system, I needed to gain a sound understanding of the full enterprise. I wanted to discover where nursing was at the time and how VA nursing saw itself in the context of the whole. I quickly learned that there was unbelievable talent across the system. This talent ran the gamut of clinical, administrative, academic and research expertise. I also realized that I needed to be sensitive to how others within VA and within the broader nursing profession viewed VA nursing.

I delved into the ONS recent past and quickly found that I would be standing on the shoulders of “nursing giants”. Two luminaries stood out: Vernice Ferguson and Audrey Drake. These two individuals are to be recognized and congratulated for their visionary leadership and for paving a solid path for those of us who followed in their footsteps.

I spent a great deal of time learning from various VA leaders (nursing and others) and sharing my views as to how I would attend to my responsibilities as CNO. This activity had to be a deliberative process that would engage front line staff and nursing leaders (formal and informal) as well as organizational officials and labor partners. I came to understand that this process had to evolve over time to allow for the development of trusted relationships and collaborative approaches.

As I reflect back on that time, I am glad that I didn’t let my typical bent toward impatience overtake the process. I made frequent site visits to VA medical centers across the country, including US territories. During these site visits, I learned to stay focused on what was best for patient care and what nursing’s role needed to be in order to achieve our desired future state. What emerged for me was a high degree of insight into the organization and myself. I came to this insight by asking tough questions, soliciting nursing perspectives from all levels across decision-making bodies and varied nursing roles (clinical, academic, research, administrative), encouraging debate, listening carefully and making bold statements. I reached out to internal and external stakeholders to gain a broader understanding of perceptions and expectations.

These concentrated activities created a solid foundation for moving forward with a servant leadership style; that is to say, how our national program office leaders and I would position ourselves to ensure bidirectional communication and shared decision-making for strategic initiatives. It wasn’t enough to set an expectation or vision for this communication and decision-making approach. I had to model it by not jumping in and making unilateral decisions or setting policy from “on high”. It was
important to take the necessary time and be truly transparent about sharing background information as well as context for what needed to be attended to with input and consensus across field advisory groups which were a part of our national shared governance structure that evolved over the early years of my tenure as CNO. It was important to build trust and partnership for the servant leadership approach.

The importance and impact of the initiatives described in this book are a result of making the right things happen in a collective engagement process that has been translated up and down the VA nursing organization. I began by convening a group of VA nursing thought leaders early in the journey. I invited these preeminent leaders to work with me on crafting a path forward that would be inclusive of national VA nursing officials and local VA nursing leadership. My idea was to create structures and processes that would provide robust channels for bidirectional communication and engagement. I believed this would ensure a realistic yet bold road map for VA nursing to advance health and lead change.

Over the initial three years of my tenure in the CNO position, our ongoing conversations evolved into a national shared governance structure. This structure created the conditions for us to develop a meaningful national nursing strategic plan that guided national and local strategic initiatives aligned with enterprise priorities. We purposefully designed the membership of a national nursing executive council that would be endorsed by regional officials in order to gain understanding and endorsement beyond nursing at the highest levels. Our governance model included the voice of advanced practice nurses and nurse researchers. More recently, we have expanded it to include a national nursing practice council comprised of staff nurse representatives from each of the 152 healthcare facilities across the system. Our nursing workgroups within this structure are chaired by members representing local nursing leadership and facilitated by national nursing program office officials. This intentional structure has ensured the continuous interaction between two essential perspectives. Local nurse leaders provide realistic approaches to address challenges of today that fit the real world of the VA nurse. National program office officials provide integration of our visionary way forward.

As CNO I have felt that it is of vital importance to ensure that the nursing initiatives and vision are on solid footing within the context of the VA organization and nursing profession as well as the broader healthcare industry. I embarked on specific actions in order to provide guidance and leadership along these lines. I had always kept pace with nursing literature and activities of professional organizations through
membership and review of communication avenues such as newsletters, online announcements and policy proposals. However, I realized I had to expand my efforts to the broad horizon of the healthcare industry with special attention to public and private sector transformation strategies. Ideas found in one sector of the professional communities (clinical and administrative) were often at cross-purposes or on parallel tracks. When leading across a continuum of care and medical centers as well as ambulatory and telehealth services that have varied levels of complexity, it took a high degree of critical thinking and consideration of various scenarios to arrive at concepts that would provide appropriate direction for nursing while being an organizational steward. Staying well informed and offering to be involved in multiple internal and external activities were key ingredients for me to execute meaningful approaches.

Over the years, it became clear to me that the VA nursing community is mission-driven. This fine group of professionals is open to the possibilities of advancing health and leading change and committed through tireless efforts to address today’s challenges while shaping the future. The community’s focus on meeting the needs of our nation's heroes brings meaning to our work and a sense of ownership through the local and national structures and processes that we have developed, implemented and sustained. I am convinced that having paved the way for opening channels of engagement for all VA nurses has unleashed the talent of an extraordinary workforce that deserves recognition as a national treasure for nursing and healthcare.

I have encouraged nurse leaders across VA to think big and act small in order to open doors and unlock pathways. When asked about what it means to “act small”, I describe how important it is to be inclusive, share the credit and remember that good things come from the collection of efforts from many individuals…not any one individual. This has taught me to be open to questions, to clearly articulate rationale and justification for planned efforts and strategies, and to realize that diverse opinions are a force multiplier on the journey toward innovation and improvement.

As we collectively pursued specific initiatives, we attended to trends within our VA system of care but always in the context of external forces and visionary perspectives across the industry. This approach meant that we became participants in and often front runners in national nursing initiatives such as the emerging role of the Clinical Nurse Leader, the need for increasing the capacity for nurse researchers, the value of creating a healthy work environment, the impact of data driven staffing methodologies, the evolving opportunities of and reliance on nursing informatics, elements of independent practice for advanced practice nurses
and the understanding of the linchpin of nursing leadership skill sets. The stories told in this book substantiate this frontrunner role we often assumed.

It was my conviction that the role of the CNO was to scan the landscape and engage in partnership with internal and external nursing leaders in order to inform our VA nursing approaches. This commitment led to numerous opportunities for me to be at several tables to learn from others and contribute to the national dialog...definitely a win-win for VA and nursing. Through strategic approaches to engage with national efforts targeted at transforming healthcare, I sought involvement at many internal and external tables to be an active participant in shaping this journey.

Offering to join workgroups and taskforces that were charged with developing recommendations and options to pave the way for a desired future state gave me the opportunity to learn from others and offer solid examples of realistic, effective strategies underway in VA. This turned out to be one of the most important approaches that facilitated my ability to scan the horizon and bring innovative suggestions to the national nursing shared governance structure as well as the national leadership bodies of VA. I treated the involvement on these workgroups and taskforces as a key responsibility and adopted it with respect and high regard. I made a conscious effort to be objective and not focus on "what's in it for me". Rather, I focused on what I saw as my responsibility, having been given the privilege of being positioned in the awesome role of Chief Nursing Officer of this incredible organization. An example of this approach is described later in this chapter when I share how VA nursing contributed to the work of the IOM committee that authored the Future of Nursing report.

Bottom line, my focus has been to create a true north for the work of VA nursing: putting patients first and defining what nursing can and should be held responsible and accountable for to advance health and lead change. Since my earlier experience in a single VA facility was shaped by a lack of understanding about how nursing at the local level was or should be aligned with national efforts, I was bound and determined to create a real connection for and presence of nursing across our entire system. I believe this approach has resulted in elevating the VA healthcare community’s understanding of nursing’s role in the context of the whole. This in turn has resulted in VA nursing’s impact on the nursing profession at large and created endless opportunities for VA nursing to be relied upon as a national treasure for advancing health and leading change in the healthcare industry.

There have been some bumps in the road along the way and there were those among the VA nursing community that didn’t embrace change as is to be expected when you take bold action on a broad scale. Most significantly,
we have dealt with the perception of some that nursing appears to believe that our work stands above others and deserves special attention and credit. This response has created unique challenges, requiring me to emphasize clarity of messaging focused on organizational stewardship. It has been my responsibility to shoulder these challenges and not deflect any negative reactions on others. This is not easy and has taught me to develop a keen sense of timing and humility, bringing the adage of "don't take things personally" to the forefront. This is not done as a behind the scenes sense of having things magically happen. The transparency of actions and inclusion across all necessary elements is a leadership characteristic I have attempted to permeate across what is now over 80,000 nursing staff members of the VA.

Aligning actions with stated goals and staying on track with faith in our history and today’s talent we rallied collective efforts to make our way through any hurdles that were encountered. I found that prayer helps too. What sustained me in leading this work was knowing that everything we do matters to Veterans and it feels good to be a part of such significant progress. Unsolicited positive feedback from all directions sustained our momentum and was personally very rewarding.

A very specific example of how my broad-scoped engagement and structured approaches to ensure VA subject matter nursing experts’ involvement resulted in a far-reaching impact related to the Institute of Medicine (IOM) Future of Nursing report. I ensured comprehensive communication across multiple VA nursing communities of practice early and often about this IOM work. As the Committee preparing the report sought expert input, we prepared verbal and written testimony as well as written exemplars on several topics that the IOM committee were evaluating as they deliberated on key aspects for the future of nursing. The various options to provide input to the IOM committee made it possible to include key VA nursing leaders across the enterprise as they contributed to written submissions and helped shape verbal testimony. It became crystal clear that VA nursing had taken the lead on implementing constructive strategies that were informative to the IOM committee. This also confirmed the usefulness of our national shared governance structure, our strategic planning process and positive impact of sincere bidirectional communication to support shared decision-making between national, regional and local levels. The powerful congruence between the work of VA nursing and the key messages of the Future of Nursing report has been recognized throughout the VA nursing community and by high-ranking VA officials. This book is a collection of VA nursing examples of how we have lived the experience envisioned as described
in the report’s key messages. We encourage our nursing colleagues to critique, adopt, adapt as appropriate to their own situations.

In summary, I take great pride in offering the perspective of VA nursing and I am thrilled to know that this work can influence others. I expect that my VA nursing colleagues will take shared pride in the contagious positive journey described in this book knowing that their work is well represented by the stories chosen to showcase collective efforts across our system of care. I hope that the book will be a catalyst for all to envision how their work has or could make an impact. I can only imagine the possibilities that will arise when readers find applications of improvement science and examples of initiatives and processes to focus on as we collectively move toward a desired future state. It should be clearly evident that the stories provide data-driven, evidence based means to consider how nursing has and should speak up and be a part of big picture solutions.

VA nursing has inspired me to continue on the rewarding journey of making connections, taking pride of ownership and embracing the rigor and energy of past, current and future generations of nurses. Imagine yourself in the shoes of a chief nursing officer, advanced practice nurse, nurse scientist, clinical nurse leader, staff nurse, licensed practical/vocational nurse, unlicensed assistive role, educator, policy maker, or the profession at large and decide how you would make the right things happen for healthcare transformation. The future of VA nursing is without boundaries to realize a system that is patient-driven with an emphasis on value added actions that provide the best patient experience possible.

REFERENCES


Chapter 2

Structure, Form, and Process within a Shared Governance Framework

James L. Harris
Strong nursing leadership is an inspiring and powerful tool that is foundational to an engaged workforce. A workforce with a voice in shared decision-making affects practice, standards, and quality of care. Similarly, shared governance within organizations fosters growth and development of staff, and reflects the high professional stature of nurses. Shared governance is designed to integrate values and beliefs that enhance, direct, and sustain professional practice (Anthony, 2004). It allows nurses to network with teams and collaborate among nursing units and other departments.

As discussed in Chapter One, the opportunities to share how Department of Veterans Affairs (VA) nurses shape their professional destiny within the context of a shared governance model requires organizational structure, form, and processes designed at the corporate level. This facilitates the spread of shared governance throughout a multi-site health care system. This offers individual medical centers the context and tools in which to tailor the governance model to specific facility characteristics and services provided, and ultimately the engagement of staff in the process.

In 2009, I accepted a promotion to Deputy Chief Nursing Officer for the Department of Veterans Affairs, where I had an opportunity to observe, and often shape, the impact of our shared governance model. I also served as Acting CNO for a year, which further strengthened my understanding of shared governance. By accepting these leadership positions, I also had the opportunity to ensure its success by maintaining, sustaining, and continuously strengthening our collective potential for creative innovation ensured by the structure, form and processes of this model. In this chapter I describe the impact of that model for all nurses and for nursing in the VA.

Structure, Form, and Process

More than ever, the words of Tim Porter-O'Grady written over two decades ago, “reorganization in health care institutions is currently the rule rather than the exception” still resonates today (Porter-O'Grady, 1987, p. 281). While meeting the challenges inherent in reorganization and the daily operations of a health care facility are not easy, they require bidirectional communication and active involvement by all staff. This further reinforces the argument to develop and implement a shared governance model.

Consider a blank canvas before an artist. The artist has a vision and masterfully creates beauty using imagination, drive, and creativity that transform into a visual image that engenders thought and often action by others. Such was true of VA nurses as the journey over a decade and half ago began to form a governance model that has spread nationally across 152
health care facilities. As we together integrated our mission, vision, and core beliefs into the visionary ideas and thoughts of VA leaders, the governance model took form. From the inception of thought to implementation of the model, we ensured that positive Veteran, nurse, and organizational outcomes remained at the forefront of actions, which were then recognized across the national enterprise. Our efforts have remained constant on how to best meet the unique needs of Veterans and their families, the changing landscape of health care, engagement of field-based advisors and experts across the VA system, and the unique contributions of VA nurses aimed at sustaining and mobilizing others involvement in the shared governance model.

The mission of the VA Office of Nursing Services (ONS) is to provide leadership, guidance, and strategic direction on all issues related to nursing practice and workforce for clinical programs across the continuum of care and the spectrum of care delivery sites that impact Veterans. Our vision’s focus is on VA nursing as a dynamic, diverse group of honored, respected, and compassionate professionals. VA is the leader in the creation of an organizational culture where excellence in nursing is valued as an essential element for ensuring quality health care for those who served America.

Guided by this one mission and vision, we structured our shared governance model to include a national nurse executive council, four work streams, and six functional groups that serve in an advisory role to the VA Chief Nursing Officer and design systems and processes that support field–based operation, sites where nurses deliver health care to Veterans. Our national nursing strategic plan, aligned with the VHA Strategic Plan establishes the structure, form and processes germane to the executive council, work streams, and functional advisory groups. The guiding principles of VA nursing, focused on our services being people-centric, results-driven, and forward-looking, are the key drivers of our shared governance model. Likewise, the Veterans Health Administration (VHA) goals to provide proactive, personalized, patient-driven care; achieve measurable improvements and outcomes; and, align resources complement the model and ensure that VA nursing initiatives are in alignment with those of VHA. I have described below, in more detail, the executive council, work streams, and functional groups. This national governance model serves as the blueprint that shapes how nurses in individual VA medical centers structure and operationalize processes based on the shared governance model. Many of the chapters in this book tell stories emerging from the processes of our governance structure that created new health care initiatives and improved many already in place.
The national nurse executive council includes program director, members of the corporate office, a nurse executive from each of the 21 integrated health care networks across the VA system, and chairs from the six advisory groups. This council serves in an advisory capacity to the VA Chief Nursing Officer on practice, academic, and research issues and trends as well as identified nursing and health care needs across the system. As with many system-wide governance bodies within the VA, using our well-developed technology for meetings facilitates the work of this group and all other governance groups. This also makes it possible to meet conveniently and to respond rapidly when appropriate or necessary.

The four work stream groups each have strategic governance functions. They include 1. workforce and leadership; 2. clinical practice; 3. academics, policy, and legislative affairs; and 4. research and evidence based practice. We identified these as focal areas that in the composite would address the most compelling opportunities for excellence in nursing practice and outcomes. The work streams are facilitated by staff at the corporate level and include members selected from the 152 medical centers. This exemplifies the bidirectional communication identified earlier, where the national leadership collaborates with representative nurses from throughout the system to create meaningful initiatives, changes, and solutions to vexing challenges.

The workforce and leadership work stream is tasked with enhancing the competent, dedicated, compassionate, and high-performing nursing workforce through retention, recruitment, and organizational initiatives. Additionally, the work stream supports the development of leadership for existing executives and aspiring leaders for the future. The clinical practice work stream establishes systematic approaches to support efficient and effective Veteran-driven care in all settings and programs. The academics, policy, and legislative affairs work stream group are directed at a skilled and competent workforce of life-long learners and the development of national policy and legislative proposals to guide quality, safe, and value-driven care. The research and evidence based practice work stream group focuses on creating an environment of scholarly inquiry and use of the best available evidence to improve health care delivery and outcomes across the continuum of care. As is perhaps apparent, the content of this book mirrors the focal emphases of these four work streams. The achievements reported in this book provide validation of the powerful impact of the governance structure, form and processes I am describing.

The six advisory groups are just that in nature, advisory to the Chief Nursing Officer and national ONS Program Directors on issues specific to the group that impact practice, education, research, and related areas confronting health care delivery. The advisory groups include:
1. nursing research advisory group, 2. advanced practice nursing advisory group, 3. nursing clinical practice program, 4. national nursing practice council, 5. national nursing informatics council, and 6. emergency management advisory council. Many accomplishments are credited to these group members in the advancement of nursing and care delivery. While exemplars are highlighted throughout this book, select group accomplishments that align with the Institute of Medicine (IOM) *Future of Nursing: Leading Change, Advancing Health* recommendations are noteworthy and I have described them here in more detail (IOM, 2010). The accomplishments are guideposts for charting the course for continued excellence and engagement of VA nurses as they engage in activities that contribute to advancing nursing and meeting the IOM recommendations throughout the health care system. I believe they also provide valuable templates others might replicate in other care environments.

**Shared Governance Accomplishments**

The Advanced Practice Nursing Advisory Group continues to advance VA nursing by removing scope of practice barriers, as proposed in the IOM report in Recommendation One (IOM, 2010, p. 9). They accomplished this through some very specific initiatives. These included: 1) the development and revision of a VA-specific advanced practice registered nurse (APRN) definition, role, and practice statement; 2) the establishment of a VHA policy on establishing medication prescribing authority for APRNs; 3) the ongoing review of the focused professional practice evaluation (FPPE) and the ongoing professional practice evaluation (OPPE) processes for all APRNS; and 4) the posting of best practices for reference throughout the VA health care system.

The National Clinical Practice group has expanded opportunities for nurses to lead and diffuse collaborative improvement efforts, responsive to Recommendation Two in the IOM report (IOM, 2010, p. 11). Some examples demonstrate the variance in these initiatives. The mental health advisory group contributed guidance on ways to capture the mental health workload of providers. The cardiology advisory group provided input into a Veteran Implant Tracking and Alert System and developed system-wide competency tools for nurses assigned to critical care and telemetry areas. The metabolic syndromes group developed and offered five modules for Patient Aligned Care Team (PACT) registered nurse care managers that address seven self-care behaviors for individuals diagnosed with chronic diseases, including diabetes. The oncology group completed Phase I of breast cancer measures in collaboration with The Joint Commission and
Oncology Nursing Society. The polytrauma/rehabilitation group authored clinical practice guidelines and guides for patient/family education for traumatic brain injury. As is apparent, each of these initiatives, lead by VA nurses in collaborative relationships with their health care colleagues, made substantive improvements in care of Veterans throughout the entire system.

The National Nursing Practice Committee assisted in the development and implementation activities for a Clinical Nurse Leader (CNL) residency program, one of the most well developed CNL programs in the country. They also developed a RN transition to practice residency to enhance this transition for VA nurses. These activities supported meeting Recommendation Three of the IOM report, implementing nurse residency programs (IOM, 2010, p. 11).

Engaging nurses in lifelong learning, described in IOM’s Recommendation Six, (IOM, 2010, p. 13), included VA nurses activities to make contributions to the IOM report using VA’s innovations, contributions to the revision of the American Association of Colleges of Nursing Essentials of Master’s Education in Nursing, the ongoing spread of CNLs to be employed in all VA facilities by year 2016, and an evidence based tool (EBP)/resource center aimed at enhancing the nursing staff’s understanding of EBP and assisting them in applying evidence in daily practice.

The IOM’s Recommendation Eight, urging nurses to build an infrastructure for the collection and analysis of interpersonal health care workforce data, (IOM, 2010, p. 14) has included a myriad of actions within the VA nursing governance initiatives. These have included: 1) clinical application teams directed at developing simulation training and product testing; 2) initiatives that ensured interdisciplinary care planning; and 3) enhanced employee satisfaction surveys.

The preceding examples only spotlight a few of the IOM recommendations and multiple activities that VA nurses engage in daily as excellent practice, education, inquiry, and service remain at the forefront of advancing VA nursing and engagement in shared decision-making and action. The vitality of our governance structures ensures that each of these initiatives supports our bidirectional communication and the inclusion of all nurses in the possibilities of creative change. Grounding in this bidirectional communication makes the implementation of change more realistic and possible for all VA services.

**Engagement through the Governance Model**

In the preceding text I provided an overview of the shared governance model at the corporate level. The following is how I used this model to engage myself and other VA nurses while assigned as
a Deputy Chief Nursing Officer (DCNO), as an Acting CNO, and as an employee at the corporate level in shared decision-making.

As a registered nurse for 34 years with multiple clinical, education, research, administrative, and consultant experiences, I had the privilege to use each of my past opportunities as I transitioned from a field-based VA CNO to the corporate level. As a corporate program director, a Deputy Chief Nursing Officer, and an Acting Chief Nursing Officer, I often reflected on my early VA experience. I not only had the power to change practice, but could also engage in multiple activities that changed the lives of VA nurses and the care of Veterans. A constant inner voice of the value of nursing input into decisions guided my travels as I worked with many nurses across VA facilities.

But let me regress to my beginning in the VA in order to provide perspective on the value of shared governance and decision-making. As an educator in my early nursing career, I had students assigned to a local VA facility for their mental health clinical experiences. I was there only a short time observing the “voice of nursing” at the facility. Nursing students often commented on how nurses had real authority and engagement in decisions made about treatment and policy development. I thought, “Oh, we are on to something”. While I had read much literature about shared governance, a first hand experience was what I needed. So needless to say, I began my VA journey as a part-time clinical nurse there and experienced having a voice. Yes, as a junior nurse! What a revelation! As I continued my VA journey, I transitioned to other facilities in the health care system that spanned clinical, education, and research positions, culminating in CNO positions at several medical centers across the US.

As a CNO, I encouraged staff involvement in decisions. I had always believed that was the hallmark of any profession and the VA more than any of my previous affiliations promoted this notion. I am convinced that self-regulation of professional practice is essential for successes and assures staff nurses that they can and will influence their practice environment and clinical decisions. As a CNO, it was my role to ensure nursing staff members were provided opportunities to change practice and clinical processes at the point of care, as well as discipline-wide changes through interaction across all nursing specialties and at all organizational levels. And the blueprint to ensure this was provided from the ONS shared governance model.

Engagement at the point of care level was an essential first step. The development of unit-based councils that mirrored and interfaced with the standing nursing committees was required for shared decision-making and bidirectional communication and sharing of ideas. The councils were tailored using those from the ONS and included nurses who represented advanced practice nursing, nursing education and staff development,
professional practice, nursing research and evidence, quality care, and clinical practice. Charters for each were developed and approved to include purpose, duties, and membership. Over a period of time, nurse engagement flourished and the value of nursing was recognized throughout the organization and satisfaction scores both from Veterans and staff soared. In addition, the groundwork was in place to begin the Magnet journey and continuously more toward meeting the IOM recommendations.

In summary, I believe that shared governance and decision-making are cornerstones for the advancement of nursing and the delivery of quality, safe, and value-based care. Having a corporate blueprint for shared governance that is operationalized and sustained provides the map for field-base facilities to transform care at the bedside and across the continuum of care. I attribute the success of VA nursing today and in the future to the shared governance model currently in place.

REFERENCES


Chapter 3

Transformational Leadership: The VA Nurse Leaders’ Journey

Kathleen Chapman, Gregory Eagerton and Kimberly Radant
We pose what is possibly an unanswerable question: which came first, ideas from the field that were given support and structure by the VA Office of Nursing Service (ONS) or ideas from ONS that were developed and given life by the nurses in the field? As we composed this chapter, we struggled to identify the starting point for most of the initiatives we will discuss. We eventually came to the conclusion that it is not important where the ideas originated, but rather, that they did. What follows is our lived and collective memory of VA nursing transformation during the past two decades from our three unique perspectives.

Kimberly Radant, who is a Desert Storm Veteran, became a VA nurse executive in 1991 at a two division medical center in Mississippi. She later served for seventeen years as the nurse executive at a large academic tertiary VA medical center in Indiana. Greg Eagerton became a nurse executive in 2001 at a tertiary VA academic medical center in Alabama where he served for 12 years before moving to the nurse executive position at another VA tertiary academic medical center in North Carolina. Both Kim and Greg began their VA nursing careers as staff nurses and pursued their executive leadership positions through the traditional VA trajectory by geographically moving around the system into increasingly more complex nursing leadership roles. Both have been integrally involved in developing and orienting new nurse executives and executive managers in VA.

Kathleen Chapman left her 23-year career in private sector healthcare settings in 1996 to join a large tertiary academic VA medical center in Oregon as the nurse executive, a position she has held for 18 years. Kathy, a nurse executive since 1988, had worked in eight private sector medical centers and was experienced in leading decentralized nursing departments while also serving as the leader for other clinical and administrative departments. Kathy was one of the few nurse executives in the 1990s that was hired as a VA nurse executive without prior VA nursing experience. In 1996, it was very unusual for any VA leadership role to be filled from “external” applicants; typically, executive leadership roles were filled through internal promotion.
Transformational Leadership

The term “transformational leadership” implies significant change: creating anew, innovation, forward movement, upward movement and quite simply, everything as far away from “status quo” as things can move. Not only does “transformational leadership” imply improvement in outcomes or processes, it also refers to qualities of the individuals or groups that lead, and the process of leadership itself. Transformational leadership extends beyond a single outcome, but is instead, a journey of many small and large actions, successes and failures, as well as passions and persistence. It involves creating vision, building consensus, execution, and sustainability.

Transformational leadership is complicated. Transformational leadership in healthcare may present itself as being more complex and at times, personally and professionally overwhelming. Factors such as population variance; disease status of patient groups; practice patterns; local, state, and regional politics; geography; staff education levels; staff availability; and local culture impact every hospital. When considering all of these factors and how they differ across the country, it gets thorny. An additional complication for VA is our public sector bureaucratic environment with its national rules, regulations, requirements, and layers of approval. Achieving transformational leadership within and across the VA healthcare system is not for the faint of heart. Despite the challenges, this chapter will examine how VA nurse leaders have not only met the challenge, but have excelled in both large and small scale transformation, often setting the pace for the profession, at large.

A Little VA History…..

All organizations undergo cycles of restructuring to maintain a competitive edge. For those that are highly bureaucratic, reorganization can be slow, but also necessary. Since the 1980s, the 172 VA medical centers have gone through several major organizational shifts. Some facilities were consolidated or closed resulting in the 152 medical centers today. The VA structure evolved from medical centers grouped into 27 districts, to seven regions, and then to four regions. Every time these groupings were reconfigured, each medical center director (comparable to private sector chief executive officer or president positions in the private sector) continued to report to VA central office (VACO) in Washington, DC.

The VA system remained heavily centralized until mid-1990 when the current structure was created. After that reorganization, medical
center directors reported to one of 22 network directors who, in turn, reported to VACO. Staffing in Washington DC was reduced and many VACO employees were reassigned to serve as consultants to the administrative and clinical services in the VA medical centers across the nation. These consultants were now in positions of little to no line authority.

In 1994, a new Undersecretary for Health, Dr. Kenneth Kizer, began an organizational transformation, the scope of which the VA had not experienced in its history. Some of his goals were to inspire creativity by decentralizing leadership, establishing evidence based performance measures, and highlighting best practices from medical centers for deployment across the system. Direct, controlling line authority practices were discouraged and facility leadership teams were charged with the authority and freedom to organize their medical centers according to their preferences as long as they met established performance metrics.

This change in philosophy was nothing short of controlled, and in some cases uncontrolled, chaos! No longer bound by a prescribed organizational structure, field-based medical center leadership teams across the country engaged in a flurry of reorganizations of their own. In some cases, medical centers that were separated geographically by many miles were now consolidating under one executive management umbrella while others were creating new reporting structures within their own walls. The Portland Oregon VA Medical Center, for instance, created a decentralized structure of service lines based on clinical specialty. We decentralized some services completely, such as medical administrative services (MAS), embedding all of the clerical roles within the respective service lines. Other services were a mix, maintaining a smaller centralized core with the majority of staff realigned. By way of example, the housekeepers cleaning the operating room suites and inpatient units now reported to the respective nurse manager, rather than Environmental Services. On the clinical side, a core of nursing professional services, Pharmacy, Social Work, and Nutrition Service remained intact, while many nurses, pharmacists, social workers, and dietitians were realigned and embedded in the matrixes of the service lines. Other medical centers realigned clinical services under physician leaders and the other clinical leaders for the respective professions assumed a consultative role.

Under Dr. Kizer’s leadership evidence based standards for safe medical practices were established. Medical centers became focused on nationally prescribed performance metrics tied to clinical outcome. During this time, media coverage frequently presented negative perceptions of VA at large, often influenced by singular events taken out of context. This
negative perception inspired the development of the VA National Center for Patient Safety (NCPS). VA, in partnership with other leading stakeholders, began to influence the development of patient safety standards across the healthcare industry. Articles began to appear that called out the VA as a leader in keeping patients safe. Published literature examining patient outcomes revealed that our results surpassed those of the private sector. Transparency to the public and to the taxpayer at-large about our sea-change improvements was a critical aspect of re-gaining the public trust. Quality and safety are foundational to clinical excellence. We remain mindful of that each day as we strive to fulfill our incredible mission.

A Little VA Nursing History....

VACO Nursing Service had always been responsible for overseeing the placement of nurse executives (NE) and strongly influenced local decisions pertaining to nursing practice. At times, this created problems for nursing both at VACO and at the medical centers. The lines of authority for placement of nurse executives were sometimes unclear, yet collaboration between medical center leadership and VACO Office Of Nursing Services was essential. In medical center organizational structures, the chief nurse (nurse executive), reported to the physician chief of staff (COS) who in turn reported to the medical center director, as stated earlier, the private sector equivalent of the chief executive officer. The chief nurse was not considered a member of the executive leadership team for the medical center. The executive team consisted of the medical center director, the chief of staff, and the associate director, the private sector equivalent of the chief operating officer.

It is difficult to establish a specific timeline when it seemed so many things were changing at once, but we believe that the first “glimpses” of transformation in VA nursing services began when VA’s chief nursing officer position was elevated to report directly to the Undersecretary for Health (highest ranking position in VA healthcare administration). This was followed by a succession of events whereby the role of the nurse executive in medical centers was also redefined and elevated. The change occurred over a number of years, with some medical center leadership teams embracing this change, and others being more reticent.

Along with the realignment of the Nurse Executive, the appropriate “title” for the role was addressed. Until this time, the NE’s title had typically been Chief Nurse or Associate Chief of Staff for Nursing. With the new realignment of the NE, and the scope of
responsibility having organizational parity with that of the Associate Director and Chief of Staff, other titles evolved. In some facilities the accepted title became “Associate Director - Patient Care Services” and in others, such as multi-campus facilities, the title for the Nurse Executive became “Deputy Director – Patient Care Services.”

With any change, there are early adopters, late adopters, and resisters. Medical centers reacted with various levels of acceptance. In some medical centers, the path was rough and steep, while others readily welcomed the additional executive leader. As you can imagine, this was a significant historical departure that shook the collective political sensibility. The transformation of the role of the Nurse Executive within the VA had begun. This transformation made it possible for nurses to be strategically positioned to effectively influence executive stakeholders and impact change at the organizational level.

In addition to overseeing nurses and nursing practice, the role of the NE expanded in some medical centers to include oversight of other clinical and administrative services. In some medical centers, nurses remained centralized reporting directly to the NE; in others, nurses were completely realigned to clinical service lines and did not report to the NE. In those organizational structures, the NE had ultimate accountability via a consultant role for nursing practice with few direct reports.

The changes did not impact nursing only at the local medical center level; VACO Nursing Service was experiencing change as well. In this new era, VACO Nursing now had little input into the selection of the nurse executives in the field. Nurse executives were hired into the system from the private sector as well from within the system, creating a diversity of NEs with varied backgrounds, histories, and experiences. Some VA nurse executives who had been in the VA for a long time, as well as some who were new, were struggling to develop their changing roles. This new environment created many emotions. Excitement was mixed with the stress of change, hope about the potential was mixed with apprehension, and optimism about opportunities for success was mixed with concerns about failure.

We quickly realized there was a glaring need for a shared governance model that would organize the national nursing workforce and capitalize on its potential. The model needed to build a network that would support VA nurse executives across the enterprise, compel VA nursing to partner with local, state, and national professional nursing organizations, and impact the nursing profession through its own initiatives.
VA Nursing Transformational Leadership Initiatives

With the turnover of nurse executives at the medical centers, nurses were being hired into these new complex roles, many with little or no executive experience. Positions were filled with VA nurses who were promoted, as well as with those new to VA. It became clear to us that we needed to provide standardized training and support for them as they came into these new executive level positions.

Audrey Drake, Deputy Chief Consultant for Nursing Programs, worked with nurse executives from the field and created a New Nurse Executive Orientation Program. The program included introductions to the various program offices and department leaders in VACO, and provided opportunities to learn more in-depth information about nurse pay, nursing policies, nurse qualification standards, various VA organizational structures, and the overall VA political environment. In recognition of the unique and important role of the nurse executive, the new nurse executives were given an opportunity to meet with the Secretary of the VA and the Undersecretary for Health. These informal meetings frequently led to open and enlightening conversations for the VACO leaders as well as the new nurse executives. We (Greg and Kim) were two experienced NEs who were appointed to facilitate the program and provide coaching and mentoring both during and following the program.

In addition to the orientation program, we believed that new nurse executives needed more than a one week orientation. They needed ongoing support long after they began these complex roles. Realizing this, VA nursing leadership developed a Nurse Executive Mentoring Program that matched new nurse executives with those more experienced. During these one-year mentoring assignments, the pairs were expected to have a minimum of monthly coaching conversations. Additionally, the mentor was expected to be an available resource any time the new nurse executive encountered a new situation or just needed a peer to talk with for personal and/or professional support. A steering committee of experienced nurse executives from across the VA system and VACO nursing provided oversight of the program.

In 2009 leaders from the VA Employee Education System (EES), the Healthcare Talent Management (HTM) office, and other stakeholders asked VA nursing leaders to share the success factors of the New Nurse Executive Orientation Program. After a series of discussions among the stakeholders and nursing leadership, they decided that new Chiefs of Staff, Associate
Directors, Assistant Directors, and Deputy Network Directors would benefit from a program similar to the new NE program. The national Succession and Workforce Development Management Subcommittee approved the proposal. The first New Executive Training (NExT) Program was held in 2011. An interprofessional planning committee, consisting of experienced executive leadership team members, developed the core curriculum and continued to provide ongoing curriculum updates to ensure that new executives received an appropriate, timely orientation. Planned biannually, the NExT is offered to all new executive leadership team members. We take a great deal of pride in the role that nurse executives played in the development and implementation of the NExT program. We believe it is indicative of the transformative influence nursing has had in the VA system.

Amidst a time of considerable turbulence, Cathy Rick was appointed to the role of Chief Consultant for Nursing Programs in 2000. (The title has since changed to VA Chief Nursing Officer). The flurry of reorganizations that preceded her appointment had left a void in structured communication between the VACO Nursing Service and field-based nursing. With the centralized structure shifting, VACO’s centralized priorities for nursing were, at times, in direct competition with the priorities for nursing identified at the medical centers.

In addition, though Ms. Rick was a VA nurse at the time of her appointment, her primary nursing experience had been as a nurse executive in private sector healthcare settings. This fact did not settle well with some VA nurse leaders, especially some of the more experienced VA nurse executives. Many voiced concerns and made comments like, “She isn’t really a VA nurse!”

Ms. Rick walked into her office with many challenges facing her but jumped right in by attending the new nurse executive orientation program soon after she arrived at VACO. She later used this program as a vehicle for personally meeting all new nurse executives. She always scheduled herself an hour out of the week where she could meet with the new nurse executives, spend time getting to know them and enabling them to get to know her.

**VA Nursing Leadership and the IOM Initiative on the Future of Nursing**

In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess the role of nursing for healthcare transformation. The IOM appointed the Committee on the RWJF Initiative on the
Future of Nursing, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing. Their completed work was published online in 2010, followed by print distribution of the report in 2011. (IOM, 2011).

We are struck by the similarities in VA nursing’s history and the recommendations of the IOM’s report on the Future of Nursing. Travelling a somewhat separate path years earlier, VA nursing leadership had come to similar conclusions about what was needed to create a vibrant nursing service at both a national level and within each medical center, and what was needed to create a structure where nursing, on a national scale, could thrive and drive necessary innovative initiatives. Several VA initiatives are described as exemplars in the IOM report.

**IOM Report: Key Message #1: “Nurses Should Practice to the Full Extent of Their Education and Training.”** (IOM, 2011, p. 4)

Within a year of Ms. Rick’s appointment as Chief Nursing Officer, with input from multiple nursing leaders and the support of the 22 Network Directors, ONS unveiled an organizational shared governance structure that would enhance communication, streamline the sharing of best practices, encourage input into policy affecting nursing practice, facilitate feedback to ONS from the field and from the field to ONS, and drive new practices in nursing practice and legislation. The structure reflected the 22 Networks by appointing one nurse executive representative from each. They met monthly by conference call and held face-to-face meetings on a quarterly basis.

This group of nurse executive representatives would formally become the National Nurse Executive Council (NNEC). Their initial work was to develop a strategic plan for VA nursing that complemented the goals of the Network Directors and the national VA strategic plan. Many goals have been accomplished and continue to evolve through the development and implementation of national nursing strategic plans. These plans have become the compass for the Office of Nursing Service (ONS), as well as for nursing at the local VA medical centers.

The NNEC became the formal organizational structure representing ONS’s shared governance model for VA’s nursing organization, and a template for future governance structures within the ONS. Each member of the NNEC was challenged to be actively involved and was encouraged to offer input into decisions. They were also expected to communicate
with the other nurse executives in their Networks and engage them, capitalizing on the full extent of their collective education and experience.

In a national healthcare system, communication among leaders is essential to shape and convey a consistent vision. Cathy convened monthly national conference calls, which she personally facilitated. Nurse executives at all medical centers were encouraged to participate and use these calls to share information, clarify policy, facilitate formal and informal conversations, and raise issues for future agendas. During calls, a variety of informational topics were explored, including legislative issues, changes in clinical standards, reports from committees, noteworthy accomplishments of nurses from across the country, and presentations from other VACO program offices about topics relevant to our roles and responsibilities. Talking points were often provided about specific topics so that messages that we were to convey to our staff were communicated in a manner that was consistent with the corporate nursing vision.

Strategic plans continued to be developed through the NNEC and passed back and forth among the nurse execs in the field and the NNEC through the NNEC representative. One of our goals for developing the strategic plan is to identify transformational direction for nursing throughout the system, to identify key goals, and establish expectations. An additional goal for the nursing strategic plan is to facilitate communication between ONS and the field. Goals and strategic direction are clearly articulated. Through the process of implementing the plan, expert nurses from across the country are asked to join national committees and workgroups, furthering nursing practice and patient care in a way not possible if acting alone. The synergy divides the work and multiplies the outcomes. Tools and other resources developed nationally are shared via the ONS website or through frequent informative emails to the field. The resources facilitate nursing autonomy and enable nurses to achieve full practice.

Having established the NNEC, we then had a mechanism for creating additional shared governance structures to further nursing goals. A national Nursing Practice Transformation Committee was charged by the NNEC to address the topic of nurses working to the full extent of their education and competence. One product of this committee was establishing the role of the registered nurse (RN) Care Manager in the Patient Aligned Care Team (PACT), the VA’s branding of the Medical Home model for primary care. The role emphasizes the RN’s critical thinking skills, necessary for assessing complex outpatients health care needs, facilitating patient engagement, providing effective patient education, and care coordination and chronic disease management for populations
of patients. The role also requires RNs to utilize their leadership skills as they provide direction to the other members of their teams, which typically consist of a licensed practical nurse (LPN) and a medical clerk. The VA was transforming the RN role, as well as nursing leadership at the point of care.

As early as 1994, ONS developed an Expert Panel Nurse Staffing and Resource Methodology Program to replace an outdated acuity-based staffing system. Staff nurses serve as members of these expert panel teams, along with their manager representatives, and are responsible for reviewing data that include quality metrics, changes in types of patients, changes in patient care, and make recommendations for their staffing plans. The Expert Panel approach is yet another example of respecting the knowledge and experiences of the direct care VA nurse in a shared governance structure.

In an effort to support clinical nursing practice in the field, the ONS began to formally provide clinical consulting services through its office by developing a Clinical Practice Program. The program was developed to support nursing clinical practice, develop policies in coordination with other VHA program offices and to disseminate communication on clinical practice issues to the field. The program was phased in over several years. It currently consists of seven field advisory committees (FACs) in the following specialties: Cardiovascular, Geriatrics and Extended Care, Mental Health, Metabolic Syndrome/Diabetes, Oncology, Perioperative and most recently, Polytrauma Rehabilitation. Nurses from the field who are clinical experts in these areas of nursing practice chair the FACs. The committees are composed of VA nurses at all organizational levels, once again supporting the IOM recommendation of encouraging and supporting nurses to practice to the full extent of their license and education. In addition to supporting the IOM recommendation, these FACs further our overall goal of fully implementing and supporting a shared governance model.

While the NNEC was working on national nursing issues pertaining to our strategic goals, at the facility level the role of the advance practice registered nurse (APRN), which includes nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified nurse anesthetists was expanding. It became clear to all involved that APRNs were going to significantly influence VA’s ability to meet ambitious clinical performance metrics. The emergence of the APRN as an independent provider in the VA was not without consternation; in fact, at times, it seemed to be surrounded by controversy.

APRNs were often licensed in one state but practicing in another under the federal supremacy guidelines that allow nurses to practice in a federal facility outside of the state in which they are licensed. There were several legal and statutory issues to sort out across the country due
to the variances in state regulations and the responsibilities of the state Boards of Nursing to regulate nursing practice in their states. Additionally, independent practice for NPs and CNSs was controversial with many medical staffs, who expressed legitimate concerns about differentiating practice. Questions swirled about the need to include NPs on medical staff credentialing and privileging Boards. Suffice it to say that differentiating the practice of these caregivers and the service they could provide within the VA system was a joint collaboration among multiple nurse executives, chiefs of staff, clinical providers, and leaders in VACO. The APRN group, formally structured as the Advanced Practice Nursing Advisory Group (APNAG), advised the NNEC on issues across the states, and worked with their counterparts in facilities across the country to clarify and sort through the issues confronting their practice. This collaboration set an example for the nation on the utilization of nurses to the full extent of their education and training. APRNs have emerged as key providers in VA medical centers across the country.

The clinical practice groups established by VACO nursing leadership continue to provide guidance to facilities as questions arise. They are the national shared leadership vehicles for sorting out clinical and professional issues and creating innovations in practice.


VA has a five level nursing career ladder based on specific qualification standards that identify requirements for education, practice, professional development, collaboration, and scientific inquiry for each level. In 1999, an updated set of nurse qualification standards was established that required a four year bachelor’s degree (BSN) to advance to Level II. RNs employed at that time were given six years to obtain a BSN so they would be eligible for promotion. Several educational initiatives were launched to support these changes in degree requirements including tuition support, scholarships, and debt reduction programs. ONS initiated a distance learning education program with the Department of Defense (DoD). The VA/DoD distance learning program provides a post-masters certificate for nurse practitioners and educates clinical nurse specialists across the country through programs taught
by the faculty of the Uniformed Services University of the Health Sciences (USUHS). The VA continues each year to sponsor several students, through tuition support, in the USUHS programs of Doctor of Philosophy in Nursing Sciences or Doctor of Nursing Practice.

In 2008, ONS began a national initiative called the “Let’s Get Certified” campaign to promote specialty certification among VA nurses. The aim of this initiative was to enhance RN knowledge and to promote life-long learning, thus ensuring and improving quality patient care outcomes. Annual awards are given to medical centers achieving milestones along the journey to increase the percentage of nurses attaining specialty certifications.

ONS has partnered not only with the medical centers to enhance nursing education, but has also worked collaboratively with other government and private sector agencies to fully engage in the effort to enhance nursing practice through education and training. For example, ONS has a long history of working closely with the Office of Academic Affiliations (OAA), another office within the Department of Veterans Affairs. One of the most notable programs resulting from the combined efforts of ONS and OAA is the Veterans Affairs Nursing Academy (VANA) that, in its second round of funding, was called the Veterans Affairs Nursing Academic Partnership (VANAP). The initial program funded faculty for 14 VA medical centers that established academic partnerships with schools who offered baccalaureate nursing programs. Funding for six additional partnerships was offered through the 2013-2014 VANAP request for proposals. Goals of the initiative are the following:

1. Expanding faculty and professional development
2. Increasing nursing student enrollment, primarily in baccalaureate programs although some increases in graduate programs may also occur
3. Providing opportunities for educational and practice innovations, and
4. Increasing recruitment and retention of VA nurses as a result of enhanced roles in nursing education.

An example of ONS working with a non-governmental professional organization is the collaboration with the American Association of Colleges of Nursing (AACN). Under the leadership of VA Chief Nursing Officer, Cathy Rick and AACN Chief Executive Officer, Polly Bednash, a group of leaders from each organization as well as leaders from OAA met twice each year, and virtually as needed, to partner on new initiatives and address national nursing education issues that could be improved by working together.
These discussions frequently focused on the clinical nurse leader (CNL) role, the Doctor of Nursing Practice (DNP) degree, tuition support and reimbursement for nursing education for VA nurses, the accelerated bachelor’s and master’s degree programs, and other academic/practice trending issues. The creation and evolution of the CNL role is often attributed to the vision and leadership of Chief Nursing Officer, Cathy Rick. Together with VA’s Deputy Chief Nursing Officer, James Harris and ONS Program Director, Karen Ott, Cathy led the nation in determining how this role would be developed, educated, and implemented at the bedside. Without the collaborative partnership between the VA and AACN, this role may never have been brought to life.

IOM Report: Key Message #3: “Nurses should be Full Partners, with Physicians and Other Health Professionals, in Redesigning Health Care in the United States.” (IOM, 2011, p. 7)

This section cannot be adequately addressed without reference to an earlier section of this chapter about the inclusion of the nurse executive within the executive leadership team. Prior to nurse executive elevation, the nurse executive was the chief of staff’s subordinate, and afterwards was aligned as his/her peer with expectations that this relationship would become a partnership at the highest level of the organization.

After this reorganization, there were VA initiatives to support partnership and to enhance relationships between the chief of staff and the nurse executive. One specific initiative was the planning of a joint chief of staff and nurse executive national conference. This initiative spoke volumes, by specifically modeling on a national basis the vision that nurses and physicians were equal partners in directing and managing clinical work. Our Chief Nursing Officer, Cathy Rick, often said, “When nurses and physicians are at the table together, patients win.” We can’t agree more.

The joint conference was recommended by two workforce subcommittees of the NNEC; one addressed the nurse executive/chief of staff relationship and the other addressed the recruitment and retention of nursing staff. A review of the literature described the important role of the physician in adding to or detracting from nurse satisfaction. The two day conference was structured to include joint nurse executive/chief of staff sessions on day one and breakout groups for the separate disciplines on day two. Feedback from participants after the conference revealed that the second day’s breakout sessions by discipline had offered content that both
disciplines considered important to them! This led to subsequent combined conferences that planned for combined sessions with no discipline specific breakout sessions. This was one of many clear indicators that true partnerships between nurse executives and chiefs of staff were beginning to form.

A more recent example of physician/nurse partnership at the staff nurse and staff provider level is the development and implementation of the Patient Aligned Care Teams (PACT) in primary care. This model of delivering primary care to our Veteran patients began taking shape in 2009. The PACT model, similar to what is known as the medical home in the private sector, requires that a team of caregivers provides primary care for a panel of identified Veterans. The team consists of a provider (physician, nurse practitioner or physician assistant), an RN, LPN, and medical clerk. This team is equally responsible, within the scope of practice of each role, for the care of the Veterans in their panel. This model requires a close partnership among all of the members of the team. PACT, with its empowered RN role, represents nursing at its finest. As a model that has been rolled out throughout the entire VA system of hospitals and clinics, it is a visible exemplar for RN role potentiation.


Through the leadership within the ONS, we developed a VA Nursing Outcomes Database (VANOD), recognizing the need to collect data on nursing outcomes that could drive changes in nursing practice. The purpose of the program was to develop a national database of standardized clinically relevant, nurse-sensitive quality indicators that support strategic decision-making and benchmarking for patient care across the continuum. The VANOD became a database that was constantly under “design” as new data were gathered and new ways to present data became available, a pattern that continues providing invaluable information for VA nurses.

Recognizing the need for organized data to assist nurse executives with decision-making, ONS developed a nurse executive dashboard. Several nurse executives worked with the ONS informatics team to develop the dashboard. Prior to deployment, we convened a face-to-face meeting to review and refine the product with the representative nurse executives. The purpose of the product was to combine data
from multiple sources into one report to provide key nursing leaders the administrative (e.g. nursing hours per patient day), clinical (e.g. VANOD), and satisfaction information needed for operations and management. The report enabled nurse executives to monitor their key administrative and clinical indicators important to evaluating, validating, and, when necessary, guiding changes in nursing practice.

Through NNEC and feedback from various workgroups, it became evident that VA's electronic record was data rich but information poor. A "Structured Language for Documentation" transformation initiative was launched to provide a standardized vocabulary to describe nursing assessment, intervention, and outcomes. Our intent was to enhance more precise communication, standardize vocabulary so that the ability to sort documentation data by topic was possible, and to have the ability to compare and contrast outcomes based on nursing interventions. This all sounded grand, but the question that quickly surfaced was what language scheme should be adopted.

Unprecedented questions can lead to unprecedented solutions. A member of the workgroup suggested that there should be a wide net cast to seek solutions to this issue. She advocated for direct care nurses throughout the organization having direct involvement in finding the right answer. The suggestion was that each medical center would identify two staff nurses who could attend a national face-to-face meeting with presentations on selected languages. The desired outcome of the meeting would be a decision about which language to pursue. With slight modifications, the suggestion was embraced as yet another way to demonstrate the commitment to shared governance.

Prior to the face-to-face meeting, we created a series of video presentations to provide background information on each of the various language options. After these virtual presentations, each medical center had the opportunity to have one person represent them at a face-to-face meeting and to have the other attend virtually via conference call. The agenda involved detailed discussions of the pros and cons of each language, including the perceived ease of incorporating it into our electronic medical record platform. Nurses physically present, as well as those back home, voted. By the end of the summit, we were able, together, to make a decision.

These staff nurses involved in the summit were asked to continue to serve as inaugural members of the VA's National Nurse Professional Council, the next progression of the national shared governance model. This once again demonstrated ONS' commitment to give voice to staff at all levels of the organization concerning issues that directly impact their own practice.
Transformational Leadership: The Magnet Journey

An attribute of VA as a system is not only how its facilities are similar, but also how they differ. Facilities individually make decisions in the pursuit of excellence, from striving for Baldrige or Carey awards, to other forms of accreditation and recognition. Each individual facility accomplishment serves as a best practice for other facilities to emulate. The discussion about transformational leadership and VA nursing would not be complete without recognition of VA facilities who have achieved Magnet designation, or Pathway to Excellence designation, and those who are on the journey.

Developed by the American Nursing Credentialing Center (ANCC), the Magnet Recognition Program® is the international gold standard for quality nursing care. The designation is based on standards related to leadership, nursing and organizational structure, professional practice, patient care outcomes, and innovation and new knowledge. Consumers and payers rely on Magnet designation as the ultimate nursing credential. The literature validates an association between Magnet hospitals and lower patient mortality rates, lower complication rates of nurse sensitive conditions, and greater nurse retention.

The VA Medical Center in Tampa, Florida was the first VA to achieve Magnet designation. Other VA medical centers that have since achieved this prestigious award are those in Houston, Texas, Portland, Oregon, Atlanta, Georgia and Madison, Wisconsin. In addition, the VA Medical Centers in Martinsburg, West Virginia and Providence, Rhode Island have achieved the ANCC Pathway to Excellence designation which recognizes quality nursing in smaller facilities. There are several VA medical centers currently in the process of seeking Magnet recognition. ONS has served as a support system and a central clearing house for resources, networking, and consultation to assist medical centers as they work toward designation.

The Voyage Continues

In this chapter, we have highlighted some of the key issues, resolutions, leaders, and relationships that have been instrumental in our development. Ours is a story of transformational leadership at both the national and local levels. VA nurse executives in medical centers and the staff of ONS have a hard-wired and synergistic relationship. The reciprocal nature of the work and the vastness of the system provide many opportunities. Collectively, we are surely “greater than the sum…”
Nursing does not and cannot operate in a vacuum. Throughout this book you will see examples of admirable, transformative interprofessional collaboration. Our successes do not belong exclusively to nursing. Without the help, support, and guidance of colleagues from other professional disciplines, our opportunities for impact are not nearly as bright. We believe that inherent in our transformational leadership role is the responsibility to be the unifying force in bridging disciplines and creating opportunities for interdisciplinary collaboration.

As we go about our daily work striving to ensure that each and every decision contributes to our Veteran mission, we realize that it is the Veterans who transform us. VA nurse leaders choose to spend their careers in the VA system for many reasons, but without fail, the most common response to the question about their career choice is their commitment to our nation’s heroes.

To the transformational leaders who came before, we are indebted to you for your legacy. To those who will come behind, we hope that we have instilled in you a passionate desire for the sea!

REFERENCE

Part 2
Acting Strategically to Innovate
Demonstrating the Future of Nursing
Nurses should practice to the full extent of their education and training
Chapter 4

Transforming the Advanced Practice Registered Nurse Role and Policy in the Veterans Health Administration

Marthe Moseley
Imagine a community based outpatient clinic (CBOC) located across state lines from its main Veterans Health Administration (VHA) hospital. Imagine being a Veteran patient, seeking access to care and not being able to get access to a provider in this clinic when you should be able to do so. Or, imagine yourself as an advanced practice registered nurse (APRN) whose license is restricted based on one state licensing board working side-by side with another APRN who is licensed in another state without the same restrictions.

We believe unexpected, unwarranted variations prevent optimal outcomes in care and should not exist because of the state in which an APRN is licensed or certified. VHA has been working diligently on a national level to make changes across all state lines by invoking Federal Supremacy for VHA APRNs. In this chapter I describe some of the strong proactive actions the VHA Office of Nursing Services (ONS) has taken to ensure the professional practice of VHA APRNs. I also provide some answers to the frequently asked questions (FAQs) about what is necessary to move forward with APRN full practice authority. I include the essential implementation processes we believe should be communicated across the nation to address the need for planned transition and implementation and the key national and regional meetings we believe must be convened. Finally, I provide our observations on focused professional practice evaluation and ongoing professional practice evaluation (FPPE/OPPE) processes as best practices for APRNs.

I am the Associate Director for Clinical Practice in the Office of Nursing Services in Washington, DC. In this role, one of my responsibilities is to facilitate the Advanced Practice Nurse Advisory Group (APNAG), which will be described later in this chapter. Meri Hauge, Associate Director Patient Care Services and Nurse Executive (ADPCS/NE) at the VHA Health Care System in St. Cloud, Minnesota had just completed her tenure as the ADPCS/NE representative to APNAG. I am a critical care clinical nurse specialist (CNS). Meri is board certified as an advanced nurse executive, has a master’s degree in nursing with a focus in public health, and previously held a credential as a CNS in community health. For both of us, the APRN role and future is an issue of personal and professional importance.

In addressing the complex issue of APRNs, VHA’s initial work focused on addressing the inappropriateness and elimination of the reference to APRNs as “physician extenders” or “mid-level providers”. This labeling, ascribed to APRNs, tended to position the vital APRN role...
under the authority of the physician, diminishing the importance of nursing licensure and the nursing competence that the APRN brings to patient care. As independent practice for APRNs began to move forward, the reference to APRNs as working to the top of their scope of practice and licensure warranted that the appropriate reference to and naming of the APRN role be accurately characterized. From here VHA’s vanguard leadership focused on the development of a national policy of full practice authority for APRNs in the VHA and the crafting of a briefing paper provided to the National Council of State Boards of Nursing (NCSBN). This briefing was used to guide dialogs with selected states in contrasting federal and state authority and practice.

Early in 2010, the VHA APRN leadership group, the Advanced Practice Nurse Advisory Group (APNAG) crafted a strategic plan at our annual meeting. The APNAG, had as its initial purpose enhancing excellence in advanced practice nursing through leadership, collaboration, communication, and the use of best available evidence. In addition APNAG continues to serve in an advisory capacity to the ONS and it’s National Nursing Executive Council (NNEC) regarding trends, issues, and activities related to advanced practice nursing both within and outside of the VHA.

The organizational structure of ONS is a model of shared governance promoting a two-way communication network from ONS through the NNEC to each of the strategic goal groups. The goal group that the APNAG reports to is the Nursing Practice Transformation (NPT) goal group. The NPT group membership includes ADPCS/NEs and ONS officials who work in the Clinical Practice program. NPT reports in both directions both to and from APNAG, which in turn communicates to all throughout the VHA system in an organized manner. At the regional level VHA regional groups are named the Veterans Integrated System Network (VISN). There are 21 VISNs within VHA. VISN-represented groups within the APRN structure are referred to as the APRN liaison group. The APRN liaison group communicates both to and from the APRN councils within the 21 VISNs and then through the medical centers located across the nation, which VHA refers to as field facilities. The VISN level APRN councils communicate to the field based APRN councils. Communication is promoted and encouraged bidirectionally between the ONS and the facility-level councils. There is cross representation of members on the goal groups, representing practice and the executive leadership level for nursing. See Figure 4.1 for an illustration of this cross representation.
APNAG is comprised of representative APRNs including both nurse practitioners (NPs) and clinical nurse specialists (CNSs) representing one or more VISNs. Additional members of APNAG include a nurse executive from the NNEC as well as a facilitator from ONS. Meri served as the NE from NNEC and I serve as the ONS facilitator. APNAG members are nominated by medical center nurse executives and endorsed by existing APNAG members through a formal application process and finally approved by the VA Chief Nursing Officer. The term of membership is three years, not to exceed two terms.

The APNAG published a statement of professional practice as a guiding document using known sources including the Institute of Medicine’s (IOM) report on the future of nursing (Institute of Medicine, 2010) and the Consensus Model for APRN Regulation published by the National Council of State Boards of Nursing (NCSBN) and endorsed by 48 professional nursing organizations (National Council of State Boards of Nursing, 2008).
Bold recommendations were created and endorsed by APNAG regarding APRN independent status and size of population to be cared for by an APRN provider specific to VHA primary care. In April of 2010, VHA had embarked on a transformative change in primary care delivery based on the patient-centered medical home model. This model was adopted throughout VHA and renamed, within VHA, Patient Aligned Care Teams (PACT). Essential team members for the PACT are referred to collectively as a teamlet and include the patient, provider (physician, physician assistant, or APRN), RN care manager, clinical associate (licensed practical/vocational nurse, nursing assistant, or medical assistant) and clerical associate. This development was significant because through the PACT model VHA became a front-runner in identifying APRNs as primary care providers in the teamlets, along with physicians and physician assistants.

We crafted bold assumption statements agreed upon by consensus throughout VHA. The 2010 statements included the following elements:

- All licensed teamlet clinical members are required to function at the top of their education, licensure, certification, and competency to produce optimal patient outcomes that maximize health and wellness.
- Non-clinical teamlet members are also required to function at the top of their competency.
- Fully functional and optimized teamlets support comparable workloads across all providers.
- Patient complexity and acuity are to be considered.

In August 2011 at our strategic planning committee meeting, APNAG then forth recommendations on how to strategically implement the VHA vision:

- All teamlet members acknowledge their own as well as each other’s skills, competencies, and strengths.
- All teamlet members’ duties reflect their level of competence by taking ownership of their own practice and/or position.
- Providers stay abreast of evidence based practices, conduct clinical inquiries, and consult based on levels of expertise; all team members supplement their level of knowledge on an ongoing basis.
- Communication is critical among the teamlet, teams, and local leadership.
• National communication is essential from the APNAG with the APRN Implementation Advisory Group (described later in this chapter).

• Partnerships should exist with the PACT evaluation processes. Possible areas of focus include testing models of care delivery considering patient complexity/acuity in terms of recidivistic patterns, frequency, and intensity of patient visits.

APNAG’s summary vision statement is that fully functional optimized teamlets will support comparable workloads across all providers.

Under federal law and supported by the VA Office of General Council, VHA rendered a formal opinion that VHA has the authority to establish qualifications for, and regulate the professional conduct of its health care practitioners (Office of General Council, 2011). In addition, VHA may determine elements of practice for nursing, without regard to individual State Practice Acts, with the exception of prescribing controlled substances. The single most crucial element is that nurse practitioners and clinical nurse specialists would function to the full scope of their license and training and thus be designated as independent providers of healthcare in the VHA system.

We then formed other APNAG work groups to assist with the planned implementation of the Nursing Handbook, which is the national policy document declaring the invocation of Federal Supremacy for APRNs. These workgroups include ones focused on: privileges and specialty privileges, credentialing and privileging, FPPE and OPPE, medical staff bylaws, controlled versus non-controlled medication ordering, and an APRN transition to practice program.

The chairpersons for the workgroups are members of APNAG as well as other workgroup committee members. Sample documents were provided to each chairperson to support implementation of the APRN changes in the VHA Nursing Handbook as they related to the five workgroup topics. We included in the sample documents information about: 1) ensuring that the key steps in the process of credentialing and privileging are the same in each field facility, 2) the OPPE/FPPE process and how to move toward incorporating APRNs into that process, 3) procedural steps to include APRNs on the medical bylaws committee at the field facility level, 4) policy on the administration guidelines for narcotic and non-narcotic medications by APRNs, and finally 5) how to optimize APRN transitions to practice for new graduates of APRN programs, APRNs new to a VHA field facility, and APRNs new to a role within the same VHA field facility.
Each of the workgroups was comprised of approximately four to five committee members from APNAG, with each workgroup having a designated chair. The first workgroup focused their efforts on credentialing and privileging at the VHA medical center level. At a number of VHA medical centers, the APRNs were already completing the credentialing and privileging process as all other providers did. Other facilities were somewhere along the journey of making this a practice and policy at the facility level. Thus a guidance document was produced. This document provided details of example elements for privileges for APRNs. A listing of generic privileges was written into this document to consider when requesting privileges at the local medical center facility. These examples included the following privileges:

1. Provide ongoing care for a panel/population of patients taking into consideration gender, and physical, psychosocial and cultural needs
2. Conduct health history and physical examinations
3. Assess, diagnose, and manage common health problems
4. Order diagnostic studies and interpret results to include (but not limited to) radiology and lab studies
5. Prescribe medications, adhering to institution’s formulary re: restrictions to specific medications/services
6. Order/request consults and referrals as appropriate
7. Develop a comprehensive plan of care, revising as appropriate
8. Document care in progress notes

Some VHA medical center facilities were not accustomed to APRNs applying for privileges because they have been adhering to their state’s Practice Act to determine the APRN scope of practice. Thus, the APNAG workgroup drafted the examples listed above to address basic elements. Furthermore, it is proposed that additional privileges, e.g. suturing simple lacerations, incision and drainage, performing pap smears, could also be requested based on the individual APRN’s practice setting, e.g. surgical services, women’s health. It is understood that additional privileges are only requested for what the APRN will actually do. If additional privileges are needed in the future, those privileges would be requested at that time and are specific to the procedure for which the APRN is requesting privileges. Some examples of additional privileges that VHA APRNs might request are included in Table 4.1. Each individual APRN practices within the privileges that are granted at the local level by the Professional Standards Board of the local VHA medical center.
### Table 4.1 Additional Potential APRN Privileges for Specified VA Subspecialties

<table>
<thead>
<tr>
<th>Additional Privileges:</th>
<th>Subspecialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical APRN's</td>
<td>Perform suturing, incision and drainage, minor lesion removal, wound care including diabetic ulcers, insertion of PICC lines</td>
</tr>
<tr>
<td>Allergy &amp; Immunology</td>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the immune system. Procedures may be performed on inpatients or outpatients. Privileges may include skin testing and interpretation of the skin tests and allergic desensitization.</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the heart and blood vessels. Procedures may be performed on inpatients or outpatients. Privileges may include interpretation of EKG’s, treadmill testing, Holter scan interpretation, cardioversion</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the integumentary system. Procedures may be performed on inpatients or outpatients. Privileges may include excision of benign and malignant lesions; curettage; electrosurgery; liquid nitrogen cryosurgery; dermabrasion; laser treatments.</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the GI system. Procedures may be performed on inpatients or outpatients. Privileges may include upper endoscopy; colonoscopy with polypectomy; management of treatment protocol for hepatitis B and C.</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the blood and blood-forming tissues and malignancies. Procedures may be performed on inpatients or outpatients. Privileges may include bone marrow aspiration; PICC line insertion and maintenance; administration of chemotherapeutic agents; phlebotomy.</td>
</tr>
</tbody>
</table>
### Table 4.1 Additional Potential APRN Privileges for Specified VA Subspecialties (continued)

<table>
<thead>
<tr>
<th>Additional Privileges: Subspecialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephrology</td>
</tr>
<tr>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the kidneys. Procedures may be performed on inpatients or outpatients. Privileges may include management of acute and chronic hemodialysis; management of chronic peritoneal dialysis; treatment of catheter infections; dressing changes for temporary vascular access devices.</td>
</tr>
<tr>
<td>Pulmonary</td>
</tr>
<tr>
<td>Provide consultation and treatment of adult patients who present with diseases and disorders affecting the pulmonary system. Procedures may be performed on inpatients or outpatients. Privileges may include pulmonary function testing and interpretation; management of mechanical ventilation; management of noninvasive ventilation; ordering of oxygen for outpatients; ordering of equipment for sleep apnea patients.</td>
</tr>
<tr>
<td>Rheumatology</td>
</tr>
<tr>
<td>Provide consultation and treatment of adult patients who present with rheumatological disorders. Procedures may be performed on inpatients or outpatients. Privileges may include joint aspirations, joint, bursae, and tenosynovial injections.</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Provide consultation and treatment of adult patients who present with psychiatric disorders. Privileges may include conducting individual or group therapy, prescribing and monitoring effects of psychiatric medication.</td>
</tr>
</tbody>
</table>

**APNAG then set out to address the important issue of professional practice evaluation of VHA APRNs. In 2011 APNAG developed and distributed a sample policy for the Focused Professional Practice Evaluation (FPPE) and the Ongoing Professional Practice Evaluation (OPPE) process to provide guidance for local implementation. The sample policy contained a purpose statement, the policy steps, definitions, responsibilities, procedure steps, and references. It also included the following definitions for FPPE and OPPE:**

- The FPPE occurs at the time of initial appointment and prior to granting new or additional privileges. An FPPE may also be used when a question arises regarding a currently privileged provider’s ability to provide safe, high-quality patient care.
The OPPE provides ongoing monitoring and includes activities such as direct observation, clinical discussions, and documented clinical reviews. Information and data considered must be provider specific, and could become a part of the practitioner’s provider profile which is analyzed in the facility’s ongoing provider monitoring.

As we developed and implemented these policy changes, we recognized that a number of facility policies, including medical staff bylaws, might need modification in order to grant privileges to APRNs. The bylaws committee would need to be required to open membership to APRNs. We recommended that local facility leadership staff meet with local APRN councils. Each VISN in VHA would be responsible to ensure full implementation of changes that facilitate the full practice of APRNs. The medical staff bylaws at each facility would need to be reviewed to determine if APRNs are designated as full practice providers.

Our guidance documents noted that all privileged providers must go through the same medical staff process, going through the same committees, not parallel committees. This meant that APRNs would need to have their privilege requests and credentials reviewed by the same committee(s) that review(s) the physicians, dentists, and any other providers who are privileged at the facility. Preliminary validation of these documents is ongoing across VHA facilities. The documents are “living” documents as they provide guidance. If a point of clarification is made at the national level, the guidance document will be changed to provide clarity or updates for field facilities.

We have ensured that consultation is available from APNAG and ONS to individual VHA medical centers requesting assistance in the implementation of the changes necessary for APRNs to become full practice providers. From a national perspective, a number of initiatives were planned to enhance communication to the VHA medical centers. First of all, a series of national telephone conference calls was planned based on the output of each of the workgroups. These national calls are lead by the workgroup leader and are supported by the group membership. Other dissemination strategies have included: 1) individual conference calls with facility level APRN leadership teams, 2) individual conference calls with VISN level APRN leadership teams, 3) national announcements through the existing communication structure of ONS through the National Nurse Executive Council (NNEC) and ONS monthly nursing services conference calls, 4) individual calls with Associate Director of Patient Care Services/Nurse Executive (ADPCS/
NE) on an as needed basis. The calls are scheduled based on email communications where the ADPCS/NE asks for clarification on some APRN issue. ONS provides direct communication to answer those email queries, as often one question catalyzes a discussion on related issues.

In addition to the work being done to assist with credentialing and privileging, FPPE/OPPE, and changing medical bylaws at local VHA medical centers, another workgroup formed within APNAG to address the need for residency type programs for APRNs. State Boards of Nursing, accrediting bodies, the federal government, and health care organizations are all taking action to support nurses’ completion of a nurse residency program after they have completed an advanced practice degree program. VHA refers to our nurse residency program for APRNs as the APRN transition to practice program.

Whenever a VHA APRN transfers from one clinical area to another, for example a primary care clinic located in the medical center hospital to a primary care clinic at a community based outpatient clinic, the APRN needs an orientation to the new primary care area. We are not referring to this type of transition into practice. The transition to practice program focuses on new APRNs who come into VHA having graduated from a master’s degree program ready to begin their APRN role at VHA. These are the nurses who participate in our transition to practice program, “fellowship” model we had adopted.

VHA has centers of excellence in primary care education where nurse practitioner (NP) post-masters fellowships are being piloted. The five pilot sites have fulltime positions for a one-year residency. Competency tools to assess NP fellow needs and progress at baseline, six months and one year are developed to track outcome measures. Further validation of the tool is currently being tested by comparing new post-masters NPs working in VHA PACT teams and experienced VHA NPs working in PACT teams. The purpose of the use of this tool is to track progress of the NP’s skill acquisition over time and look at trends for the purpose of program evaluation.

Our ongoing work for implementation continues to be disseminated to key external and internal stakeholder groups. Support from external stakeholders includes the National Council of State Boards of Nursing (NCSBN), The Joint Commission, and the National Partnership Council, a VHA national labor-management leadership body. The NCSBN provided positive support for the VHA initiatives towards full APRN practice provider status and posted and distributed a letter of support for the VHA policy. The Joint Commission also offered positive support for the move toward full practice provider status for APRNs. Internal
stakeholders include the Under Secretary for Health and the Principal Deputy for the Under Secretary for Health; the National Leadership Board (comprised of VHA National leaders); and the Chief Medical Officer/Quality Management Officer for the VISNs. Each of the persons in these positions represents critically important internal stakeholders essential for implementing transformation of the APRN role within VHA.

An additional APNAG strategy designed to integrate our internal stakeholders was to form an APRN Implementation Advisory Group to provide direction regarding implementing APRN requirements from the proposed VHA Nursing Handbook. The group membership consists of approximately fifteen members representing ONS, APNAG, Chief Medical Officers for the VISNs, Quality Management Officers of the VISNs, field-basic Chief of Staff representation, and Primary and Specialty Care Office representatives from VHA Central Office. The members are responsible to ensure communication through their respective program offices and field advisory committees, including VISN leadership and leadership at the local medical centers.

During the first year of this advisory group, we were able to publish two products. The first was a nationally accessed electronic web site that included answers to frequently asked questions (FAQs). The questions and answers were formulated based on the most common questions posed from VHA medical center officials related to planned APRN practice changes with the implementation of the VHA Nursing Handbook. We asked the APRN Implementation Advisory Group to provide a final evaluation of our answers to ensure clarity among all stakeholder groups. In our national calls we highlighted access to the FAQs, encouraging our stakeholders to use this resource. We continue to track inquiries to this site. We clustered the questions posed on the FAQ website into common categories shown in Table 4.2. The categories under each theme have been hyperlinked to detailed content containing a more complete answer.

The second product the advisory group published was a survey distributed to the VHA facility ADPCS/NEs. Twenty questions were posed to the nurse executives of the 152 VHA medical centers. A listing of the questions is found in Table 4.3. The questions are enumerated under the question column and the answer options are placed under the answer column, providing for significant variance and open-ended options for responses under each of the questions, the direction of the scaling for the answer is placed in parenthesis to show the direction of the scaling of each item.
### Table 4.2  Frequently Asked Question Categories Developed by the VA APRN Implementation Advisory Group to Provide Web Based Guidance for VHA Facilities

<table>
<thead>
<tr>
<th>Institute of Medicine (IOM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why now?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office of General Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>What authority does the VHA have to determine APRN Independent Practice?</td>
</tr>
<tr>
<td>Does a State Licensing Board have the authority to take action or revoke license of an APRN who practices beyond the respective State Practice Act?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the position of the National Council of State Boards of Nursing (NCSBN) and The Joint Commission (TJC)?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Independent Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>What kind of training does an APRN receive that prepares them to function as an independent provider/practitioner?</td>
</tr>
<tr>
<td>What would happen if a current APRN does not want to attain independent status?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescriptive Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is prescriptive authority impacted?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>What actions are required at the VISN and facility level?</td>
</tr>
<tr>
<td>Do Medical Staff Bylaws need to be revised?</td>
</tr>
<tr>
<td>Will qualification standards change?</td>
</tr>
<tr>
<td>Who will determine appointment grades/steps?</td>
</tr>
<tr>
<td>What is the Credentialing process?</td>
</tr>
<tr>
<td>Will reporting relationships for APRNs need to change?</td>
</tr>
<tr>
<td>Can local policies restrict privileges for APRNs?</td>
</tr>
<tr>
<td>What are core privileges?</td>
</tr>
<tr>
<td>What is the timeline for implementing this handbook?</td>
</tr>
<tr>
<td>How will this affect part-time APRN's?</td>
</tr>
<tr>
<td>Are there recommendations for panel size based on the independent practice status?</td>
</tr>
<tr>
<td>What will happen to the current Scopes of Practice?</td>
</tr>
<tr>
<td>What will be the role of the Associate Director Patient Care Services/Nurse Executive (ADPCS/NE) in working with APRNs in an independent practice status?</td>
</tr>
<tr>
<td>Could an example of the application hiring process be given to illustrate sequence?</td>
</tr>
<tr>
<td>Could descriptions be given for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)?</td>
</tr>
<tr>
<td>What is the process for proficiency completion?</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Indicate your level of support for the change to independent practitioner status: (scale of 1 to 5 - five is high support)</td>
</tr>
<tr>
<td>2. Indicate your level of knowledge about the current State Board of Nursing requirements for your facility APRN's: (scale of 1 to 5 - five is high knowledge)</td>
</tr>
<tr>
<td>3. Do you understand the Federal Supremacy clause that allows VHA to determine the scope of practice for APRNs? (scale of 1 to 5 - five is high understanding)</td>
</tr>
<tr>
<td>4. Do you understand the requirements for prescriptive authority for both controlled and non-controlled substances? (scale of 1 to 5 - five is high understanding)</td>
</tr>
</tbody>
</table>
| 5. At your medical center, have you been successful in avoiding the reference to APRNs as “mid-level providers and/or “extenders”? | Yes, very successful
No, still referred to in “mid-level” terms
Somewhat successful |
| 6. How many APRNs are employed at your medical center/health care system? | (actual number)                       |
| 7. Do APRNs report to: | Nursing or Medicine                  |
| 8. In how many States are your facility APRNs licensed? | (actual number)                       |
| 9. Has your facility leadership been in conversation regarding independent practitioner status of APRNs? | Yes
No |
### Table 4.3 Survey Questions Developed by the VA APRN Implementation Advisory Group to Survey Nurse Executive (ADPCS/NE) Information about APRNs in their VHA Facility (CONTINUED)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Indicate which of the following you have discussed with your Chief of Staff: (please check all that apply)</td>
<td>• The use of privileges as opposed to a scope of practice.</td>
</tr>
<tr>
<td></td>
<td>• Incorporating APRNs and their practice into Professional Staff Bylaws.</td>
</tr>
<tr>
<td></td>
<td>• The role of the ADPCS/NE and COS interface regarding APRN practice.</td>
</tr>
<tr>
<td></td>
<td>• Involvement of the Chief Nurse Executive and NPSB in credentialing and privileging processes.</td>
</tr>
<tr>
<td></td>
<td>• None of the Above</td>
</tr>
<tr>
<td>11. Indicate facility leadership support for these changes: (choose any that apply)</td>
<td>• Chief of Staff</td>
</tr>
<tr>
<td></td>
<td>• Medical Center Director</td>
</tr>
<tr>
<td></td>
<td>• APRNs</td>
</tr>
<tr>
<td></td>
<td>• ACNSs</td>
</tr>
<tr>
<td></td>
<td>• NMs</td>
</tr>
<tr>
<td></td>
<td>• Service Chiefs</td>
</tr>
<tr>
<td>12. Have you been in communication directly with the APRNs at your facility regarding the proposed change to independent practice as applicable?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>13. If you answered &quot;Yes&quot; in question 12, please indicate mode: (please choose any that apply)</td>
<td>• E-mail communication</td>
</tr>
<tr>
<td></td>
<td>• Meetings with APRNs</td>
</tr>
<tr>
<td></td>
<td>• Other, please specify</td>
</tr>
<tr>
<td>14. Is independent practitioner status for APRNs generally viewed as a positive change at your site?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
### Table 4.3 Survey Questions Developed by the VA APRN Implementation Advisory Group to Survey Nurse Executive (ADPCS/NE) Information about APRNs in their VHA Facility (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. What concerns are coming forward from APRNs in your facility regarding independent practitioner status?</td>
<td></td>
</tr>
<tr>
<td>16. Indicate your level of confidence that this will be a relatively smooth transition: (scale of 1 to 10 - ten is high confidence)</td>
<td>1 2 3 4 5 6 7 8 9 10 If you rated your confidence level in item 16 as 7 or higher, please skip to question 19. If you rated your confidence level as 6 or less, please answer 17, then 18, if appropriate. You may then skip to item 20.</td>
</tr>
<tr>
<td>17. If your response was 6 or less on item 16, do you think you will need support to make a smoother transition? (if you select “Yes” you will get contact information on the screen that appears after submitting your response)</td>
<td>Yes No</td>
</tr>
<tr>
<td>18. If you answered &quot;Yes&quot; in item 17, please indicate what would be helpful:</td>
<td>(narrative response)</td>
</tr>
<tr>
<td>19. The Implementation Group is considering how best to assist sites who identify a need for assistance in implementing these changes. If you score high on the confidence scale (item 16 above), would you be willing to be a mentor to another facility? (if you select “Yes” you will get contact information on the screen that appears after submitting your response)</td>
<td>Yes No</td>
</tr>
<tr>
<td>20. Please share any thoughts/questions/concerns about these changes from your facility leadership with the Implementation Group.</td>
<td>(narrative response)</td>
</tr>
</tbody>
</table>
We used the results of this survey as discussion points at VHA leadership meetings to enhance the action plan for full implementation of the changes in APRN practice. The results informed the Implementation Advisory Group about viewpoints of the nursing leadership in the individual VHA medical centers. The trends of the responses have become the platform for further discussion points at monthly NNEC teleconferences as well as the monthly NE teleconference calls.

Concurrent with our VHA work on APRN practice, APNAG achieved another milestone. ONS leadership requested that APNAG develop a Clinical Nurse Specialist (CNS) Workgroup. CNSs are employed in VHA and are a subset of the APRN group. Based on specific questions from VHA medical centers regarding the best clinical areas for placement of CNSs, this workgroup developed a position paper on CNS practice in primary care. This CNS position paper complimented the newly developed APRN (NP/CNS) checklist, guiding the consideration for specific CNS candidates when applying for a position in a VHA facility. Table 4.4 details the APRN (NP/CNS) checklist.

<table>
<thead>
<tr>
<th>Table 4.4 VHA APRN (NP/CNS) New Graduate Employment Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place a ✓ if met</strong></td>
</tr>
<tr>
<td><strong>New graduate – APRN (NP/CNS)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Once again internal and external stakeholders were participants in the CNS workgroup initiated by APNAG. The CNS workgroup was asked by ONS leadership to provide a recommendation on the assignment of certified CNSs as full practice providers in primary care. Workgroup membership included the chair appointed by the Chief Nursing Officer, the Office of Nursing Services and Primary Care Chief of the VHA Central Office;

<table>
<thead>
<tr>
<th>Place a √ if met</th>
<th>√ Item to be verified</th>
<th>Sub-element or Example/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>New graduate – APRN (NP/CNS)</td>
<td>√ Ensure credentials are current, consistent with clinical practice, privileges, competencies, and complexity of the assignment</td>
<td></td>
</tr>
<tr>
<td>Experienced APRN (NP/CNS)</td>
<td>√ Master's degree or above from an accredited school</td>
<td>NLN, AACN (American Association of Colleges of Nursing)</td>
</tr>
<tr>
<td></td>
<td>√ APRN Status</td>
<td>From any state</td>
</tr>
<tr>
<td></td>
<td>√ RN Licensure</td>
<td>From any state</td>
</tr>
</tbody>
</table>
| | √ Clinical while in school in the area where applying for the job OR | Minimum of 500 hours of clinical documented experience
| | √ Current documented experience in the area where applying | From school
| | | From work experience |
| | √ Full and current certification from nationally recognized certifying body | Certification must fit the role and population focus to that which the APRN is being appointed or selected |
| | √ State of License has approved APRN to have prescriptive authority | Needed if prescriptive authority has been granted by the State where licensed |
| | √ Ensure credentials are current, consistent with clinical practice, privileges, competencies, and complexity of the assignment | |
a CNS and NP representative assigned to primary care, a physician practicing in primary care, a nurse executive, a chief of staff, a quality management officer, a Primary Care office representative, and a representative from the VHA/American Association of Colleges of Nursing liaison committee. The group reviewed existing literature which became the basis for their dialogue regarding knowledge of curriculum and clinical and curriculum requirements.

Based on the current variations across master’s degree CNS programs in the nation, e.g. specific focus, and completion of clinical hours for the certification exams, this workgroup recommended that each VHA facility determine on an individual basis if the CNS meets the criteria for a specific specialty area of practice. They recommended that this be in accordance with the individual’s professional knowledge and skills acquired through the academic program where degree completion was attained. The workgroup further recommended that APNAG provide a template for VHA facilities to use when determining if a CNS meets the criteria for placement into a position. Thus, there was a dual focus and need for the APRN (NP/CNS) checklist. This checklist is used by VHA nursing in the medical centers as well as in recruiting departments within VHA to assist in obtaining critical information to process APRNs into VHA when they are seeking employment.

At the beginning of this chapter, I asked you as the reader to imagine a community based outpatient clinic located across state lines from a main VHA hospital. I asked you to imagine being a Veteran patient, seeking access to care and wondering if you would be able to get access to a provider in the clinic where you wanted to go and receive the same level of care in the clinic that you received at the main hospital. Invoking Federal Supremacy for all APRNs working in the VHA ensures that each APRN, as a full practice provider, is functioning at the top of his/her training and education to enhance the care delivered to Veteran patients at VHA medical centers.

At the beginning of this chapter you were also asked to imagine yourself as an APRN whose license might be restricted based on the state licensing board working side-by side with another APRN who was licensed in another state without the same restrictions. Invoking Federal Supremacy for all APRNs working in VHA reduces this unexpected, unwarranted variation that may prevent optimal outcomes in care and should not exist because of the state in which the APRN is licensed or certified.

VHA has been working diligently on a national level to make changes across all state lines by invoking Federal Supremacy for VHA APRNs. In this chapter I have described the strong proactive actions the VHA ONS has taken to ensure the professional practice of APRNs in VHA. I also provided some answers to the frequently asked questions about what is necessary to move forward with APRN
full practice authority. I included in this chapter the essential implementation processes VHA ONS believes should be communicated across the nation to address the need for planned transition and implementation and the essential national and regional meetings we believe must be convened. Finally, I provided observations on FPPE/OPPE processes as best practices for APRNs.

Transforming the APRN role within VHA has been the work of many dedicated professionals. APNAG, supported by ONS, provided the leadership needed for this massive undertaking. Identified workgroups provided the bench strength and knowledge for sample documents to be written, published, and presented nationally to stakeholders in order to move toward a better understanding of requirements to invoke Federal Supremacy within VHA.

There are several reasons why “now” is the time for this initiative: (1) reducing variability in APRN practice across the VHA is consistent with the Institute of Medicine (IOM) Future of Nursing recommendations and the Consensus Model for APRN Practice, (2) many VHA facilities span more than one State, and (3) all VHA care models require team members to support personal, proactive, Veteran-driven health care.

REFERENCES


Chapter 4.1

From RN to NP: How the VA Helped Me to Achieve My Dreams

Colleen Walsh-Irwin
As a senior in high school, I had no idea what I wanted to do with the rest of my life. I didn't have a great desire to go to college and no burning desire to become a nurse. My parents were afraid that I would choose not to go to college and asked my aunt, who was a nurse, to convince me to go to our local community college for nursing. It was 1984, during one of the many nursing shortages. My aunt opened the New York Times to the “Help Wanted” ads. There were pages of nursing jobs. She pointed out that with a degree in nursing, I could do anything! Work in a school, a hospital, doctor’s office, and a cruise ship! I could travel around the world as a visiting nurse if I wanted. It sounded so glamorous, and after all Bobbie Spencer on the television daytime drama show General Hospital could do it! I figured two years in college wouldn’t kill me; I applied and got accepted. Nursing school, I learned, was anything but glamorous.

After graduation, I started working in one of the local community hospitals. Actually, it was where I did my last clinical rotation and I figured that at least I knew where the parking lot and the cafeteria were. I interviewed and got hired the same day. I started working on the 11pm-7am night shift and I will never forget my first night after orientation. I had a patient with complications from a transurethral resection of the prostate (TURP) and the urologist was screaming at me. Luckily a nurse who was a few months my senior was working with me that night and quickly became one of my closest friends, eventually one of my bridesmaids and is still a good friend 25 years later. Not only did she save me that night, but also encouraged me to quickly go back to school part time for my bachelor’s degree. Within a year or two we both took positions in the intensive care unit (ICU) where we both worked together for the next seven years while we finished our baccalaureate academic studies, which then somehow, for me, turned into a master’s degree. Somewhat ironic for someone who never wanted to go to college! It was during my studies for my master’s degree that my life in VA began.

Much as I had never had a burning desire to become a nurse, I never had any desire to be a nurse practitioner (NP). It was very easy to move effortlessly from the bachelor’s degree program into the master’s degree program at the state university I was attending. Working 12-hour nights enabled me to go to school and although I got married during this time, I decided I might as well just keep going and finish my master’s degree before we had children. My thought process was that maybe I would like to teach eventually. I became less sure I could ever really teach when, during a mandated preceptorship at the university hospital where I went to school, I had no patience explaining to undergraduate nurses how
exactly you opened an alcohol swab, opened the medication vial, took the syringe out of packaging, took off the cap of the needle, injected air into the bottle and drew up the medication. For me at that point, it was one fluid step, not six different steps to be agonized over by first year nursing students. So maybe, teaching wasn’t going to be for me after all.

My master’s program was an advanced practice nurse program, with the emphasis on becoming a NP. For me, it was just a convenient way to finish a master’s degree. There was no way I was going to become an NP. If that were what I wanted to do, I would have gone to medical school and become a physician! But here I was in an NP program and next thing I knew I was doing my clinical rotations at the Northport Veterans Affairs hospital.

It was my third clinical rotations semester when I was assigned to work with an NP in Pre-Admission Testing (PAT). One of the most wonderful things about being a VA student is that the patients are not only accustomed to having students see them, but many of them love it. Right off the bat, I loved it here. The staff had time to teach and actually seemed to enjoy it. After a few weeks of PAT, I was craving something else. My search for a new challenge created my first realization that VA was really an amazing place for students. It is no wonder that VA is the nation’s largest provider of graduate education. It is affiliated with more than 152 medical and dental schools, training more than 80,000 students in health care related fields and 90,000 physician residents each year. More than half of U.S. physicians and nurses have received at least part of their training at VA hospitals and clinics.

Being a student at VA made it possible to spend a lot of my clinical hours in many different practice settings. I spent time in gastroenterology and saw procedures such as colonoscopies, sigmoidoscopies, endoscopic retrograde cholangiopancreatographies. While I was in radiology the radiologists sat and explained every x-ray imaginable, as well as magnetic resonance imaging (MRI) and computed tomography (CT) scans. My first day in ophthalmology, the chief of ophthalmology explained the difference between ophthalmologists and optometrists, and I later also spent time in optometry. I observed a variety of cardiac diagnostic testing procedures such as stress testing, echocardiograms and cardiac catheterizations. I even saw an autopsy in the morgue, which was a once in a lifetime experience (at least for me)! There seemed to be no experience that was off limits when I was a VA student and I have to say everyone I met embraced me as a student and was eager to teach. There wasn’t a better learning environment for an eager NP student.

When I entered my fourth semester, I knew there was nowhere else I wanted to go to do my clinical rotations. I’ll never forget my teacher
Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

explaining that the chief of surgery was willing to take an NP student for the first time. She was stressing that this was quite an honor, but I think that in some way that alone scared some people off. I have to admit as a 20 something year old nurse, I was a little intimidated myself, and it seemed like a lot of pressure if you were going to be the first one, but my hand went up and I jumped at the opportunity. I will never forget the first day I showed up at the surgery department and asked for the chief of surgery; he was on vacation for two weeks and the secretary knew nothing about an NP student. Feeling a little deflated, but unwilling to wait two weeks to start my clinical, I asked to speak to the chief resident. She informed me that he was rounding on the surgical floor, so I made my way up there, found him and introduced myself as the NP student on surgical service for the month. And that was when I realized that if I just acted like I belonged there, everyone else would assume I did!

I spent the next six weeks on surgical service. It was a crazy six weeks to say the least. The difference between the training of medical students and residents and the training for nurse practitioners is that the residents are there full-time. I, however, had a full time job as a registered nurse working nights in an intensive care unit. To be taken seriously, though, I knew I had to be part of the team relatively full time, so I scheduled myself to work my twelve-hour ICU shifts every Thursday, Friday and Saturday nights and I would be at VA on surgical service every Monday, Tuesday, Wednesday and Thursday. They were also twelve-hour days, with the exception of Thursdays because I had to leave around 4pm to get home and get to my real job. It was an incredible experience, rounding with the team early in the morning, going to the operating room, the clinic and then back to the inpatient units for afternoon/evening rounds. I learned so much and was really accepted and embraced as part of the team; running up to the floors to do consults on my own, scrubbing in during surgeries, assisting with procedures in between. There seemed to be nothing I wasn’t allowed to do if I was willing and able to do it.

At some point, I had decided I also wanted to do a concentrated rotation in cardiology. So, I walked over to the chief of cardiology, introduced myself and explained that I was finishing up my clinical rotation in surgery and asked if I could do my next rotation in cardiology. He had never had a nurse practitioner student and I could clearly tell he wasn’t quite sure what to do with me. But he agreed, asking me if all my paper work was in order with the education department. I assured him it was; VA has a strict vetting process for students. I showed up the following Monday morning and explained to the cardiology fellow that I was the nurse practitioner
student on service that month. Again, I just acted like I belonged there and he accepted it. I shadowed him the first day or two, became familiar with the routine and then would start the consults on my own, and then discuss them with the fellow and the attending. At that time, we had a coronary care unit and I would come in before the fellow and assess all eight patients and enter progress notes in the patient record. I would discuss the cases with the fellow when he came in. Then we would round with the attending. What a wonderful way to learn and such great first-hand experience. I was like a sponge: eager to learn anything they were willing to teach me.

Working in cardiology as a student was an incredible experience. I was able to help with stress tests, help out in the cardiac catheterization lab, assist in transesophageal echocardiograms and read the nuclear stress tests with the attendings in nuclear medicine and the cardiologists. Again, I attended clinicals Monday through Thursday, but at least in cardiology the days were only eight-nine hours long and I continued to work Thursday, Friday and Saturday nights at my ICU job. I graduated with many more clinical hours than I needed, but I knew that this was an amazing opportunity and I wasn’t about to pass it up. I finished my clinicals at the end of April and graduated in May, pregnant with my first child! I had no idea what lay ahead for me.

The one thing I noticed about VA was that everyone was so nice. I would say to my preceptors that they must be paid well because everyone seemed so happy to work there. When I left, I had no plans to pursue a job there. I had finished my master’s degree, which was my goal and was due to have a baby in November. My career goals were secondary at this point. Or so I thought. One Saturday night in September, I went into work and found a note tacked up on the bulletin board in the ICU conference room. It was a note from the day shift nursing supervisor. Dr. Paul Diggs, a cardiologist at the Northport VA called looking for me and left a message for me to call him. Apparently, he had a hard time tracking me down, because I had moved twice since I had initially started my VA clinical rotations. Someone remembered that I worked at Glen Cove Hospital so he took a chance that Saturday and called and asked for the nursing supervisor on duty. I called him back to find out that he wanted to offer me a job in the cardiology department. They had never had a nurse practitioner, but he needed someone to do stress tests and wanted to know if I would be interested. I explained to him that I was pregnant and he said he would wait, to which I replied “Thanks, but no thanks”.

To make a long story, short, I changed my mind, gave birth to my first son in November and started not just a new job, but my new career eight
weeks later. Remember, I never set out to be a nurse practitioner and here I was an NP in cardiology and my VA career began. The irony is that I was hired to do stress tests and I now no longer do these tests. I was the first NP hired in cardiology and only the second one hired by medical service; I was the first NP hired by a medical specialty at my facility. There are now four NPs in cardiology and many in the other medical subspecialties.

There weren't enough stress tests to do to fill my days. This didn’t seem to bother anybody but me. I did go to cardiology clinic once a week with the cardiology attendings and fellows and read the nuclear stress tests with the nuclear and cardiology attendings, but there was still a lot of down time. This was great in the beginning, because it gave me time to read, learn, study and continue to get involved in procedures. I took this opportunity to explore opportunities to develop and mold my career, something that I was able to do at VA.

Prior to the completion of the clinical trials testing internal cardiodefibrillators (ICDs) in heart failure patients, ICDs were only used in extreme situations, for patients with a history of sudden cardiac death or lethal arrhythmias. We had four such patients with ICDs when I started working in the cardiology department. While patients’ devices were to be systematically checked after insertion, a regular follow-up for a permanent pacemaker (PPM) or ICD, was done only when needed, often haphazardly, and by a representative from the device company. There was no clinic for these patients to be scheduled into and followed regularly.

I took an interest in device follow-ups and started to get the representatives from the various companies to show me how to work their programmers and interrogate the devices myself. I then started a device follow-up clinic with Dr. Diggs to follow these patients. Also, at that time the PPM patients were getting transtelephonic monitoring, but were not being interrogated unless there was a suspected problem. This was changed also. Dr. Diggs and I set up a clinic, became more and more educated on the different programmers, became proficient in device follow-up and I eventually took the North American Society for Pacing and Electrophysiology (NASPE) exam and became certified as an Allied Health Professional.

In the late 1990s, the idea of heart failure (HF) clinics was in its infancy. We had a cardiology fellow who was very interested in HF and I was able to work with her and help develop an educational brochure. We then hired a second NP to run a HF clinic and I also started seeing patients in HF clinic. This was just another expansion of my job. Our general cardiology clinic runs on Wednesday afternoons. We have a volunteer transportation system that is supported by the Disabled American Veterans (DAV)
organization. It runs vans in the mornings only, picking up patients and bringing them to their VA appointments. We had no means to see patients in cardiology if they used the volunteer transportation so I started a DAV clinic so these patients could be seen in the morning, since this was their only means of transportation. Gradually stress testing, the reason I was hired, became a smaller and smaller part of my daily routine.

The years went by and I became supervisor of the cardiology department. I also became involved in various nursing and medical service committees throughout the hospital. As device implants grew more prevalent and we were increasingly referring patients to one of the other facilities in our VA regional network for ICD implants, we decided to research the possibility of implanting devices at our own facility. We were able to recruit a per diem electrophysiologist. Our catheterization lab staff and I were trained on implants and we started doing this procedure one day a week. At this point, I think there was no longer any time left for me to do stress tests.

I have had a wonderful VA career and many happy years but at one point in my career, I was beginning to feel like there wasn’t a lot of room for me to grow anymore within my facility. While I loved my job, I began to think about leaving because I need to be challenged and I felt that wasn’t happening anymore. And then I came across an announcement the day I was leaving for vacation for a position on a new cardiovascular field advisory committee for the Office of Nursing Services. It sounded interesting, and although I had a hard time getting the application completed before I left for vacation (I had to have Paul Diggs mail it for me while I was away after some required signatures were obtained), I sent it off and happily gained a spot on the committee. Little did I know where that would lead!

This newly formed committee turned out to be my next big adventure in my VA career, one that has given me the most joy and satisfaction. While I love taking care of my patients at my facility, I really thrive on the excitement of getting in a room with some of the greatest VA minds and developing ideas that make things better, not just for one patient, but for many patients (and also for nurses)! After two years on the committee, I was asked to chair it, when Marthe Moseley left this position to start a new workgroup for ICU nurses. The past five years have been exceptional, as I have had opportunities to meet and work with brilliant people all over the country. I have developed relationships and real friendships with physicians and nurses that I admire and love to work with. I truly have the best job in the world.

VA has given me more opportunities as a nurse than I ever dreamed possible. I started here as a student, took a job as an NP and now work
for the Office of Nursing Services in the greatest healthcare system in the world. I never could have accomplished my goals without all of the opportunities that are only available at an organization like ours, and certainly not without all of the incredible mentors I have had since I started here 19 years ago. In addition, VA not only provides an opportunity for me to work to the full extent of my education and training, but also encourages it. Cathy Rick, Chief Nursing Officer for VA for the majority of my 19 years of service, is the most forward thinking nurse I know and an inspiration to all nurses. I am very proud to be a VA nurse. I don’t know of any healthcare organization that has the advantages of working at the VA.

In the VA if you dream it, you can achieve it.
Chapter 4.2

Knocking Down the Barriers and Letting the Sunshine In

Mary Lee Pakieser, Yvette Marie Petti, and Rose Birkmeier
“To speak up, to improve, to make positive suggestions—this is loyalty. Loyalty is for patients and patient care. Loyalty is to the profession and its advancement. Loyalty does not stand silent in the presence of persons or policies which diminish any of these…” Leah Curtin, 1993

This chapter was written in a collaborative effort and is dedicated to all advanced practice nurses and the communities that they serve.

— • —

The Department of Veterans Affairs (VA) Office of Analytics reported in 2013 that the VA Health Administration (VHA) employed 483 clinical nurse specialists and 4,782 nurse practitioners who were appointed to clinical positions. These nurses are referred to as advanced practice registered nurses (APRNs). Presently, over 52% of VHA nurse practitioners are primary care and women’s health providers. As health care continues to evolve it is prudent that nurses and the profession lead by example. We hold appointments as advanced practice nurses in VHA primary care services with areas of specialty in women’s wellness. Two of us practice in a medical center, and one of us practices in a rural community based outpatient clinic (CBOC). We are active in our state and local professional nurse practitioner association, the Michigan Council of Nurse Practitioners, and hold faculty positions in advanced practice nursing programs both Master’s of Science in Nursing (MSN) and Doctor of Nursing Practice (DNP) at our regional universities and colleges. Working full time, within a large health care delivery system such as VA, we feel we have the ultimate opportunity to lead others by example.

APRNs, during their graduate education and preparation, are often asked to adopt a theoretical paradigm from which to build their clinical practice and innovation in the delivery of care to patients and their communities. VA is a delivery system that has challenged itself to provide care to a diverse population of Veterans with the focus being Veteran centric care. In response to this changing population base, VA has and is undergoing systems redesign in an attempt to better meet the needs of Veterans (Klein, 2011). This further identifies a need for having an interdisciplinary care team which is inclusive of physicians, registered nurses, clinical pharmacists, physician assistants, clinical psychologists, and advanced practice nurses, and of course, ancillary service and clerical support personnel. The patient aligned care team model has been adopted by VA nationally and has been
accepted as a transformative model of practice for regional, state, and rural primary care practice in the delivery of Veteran centric care.

We believe that this model of care challenges APRNs to illuminate this transformation process and lead others by example in the delivery of primary care to Veterans. We have discovered that one successful strategy for leading and meeting this challenge is through an integrative model of clinical training which can serve as a template for the translation of best practice approaches across the VA healthcare system. APRNs serve as preceptors and have instructed students from varied disciplines (including medical students). APRNs who serve in this capacity introduce prospective healthcare providers to an integrative model of care delivery during formative clinical skills and training development. We have found that this can lead to an easier transition for all health professionals during their postgraduate professional development and integration. This, in turn, benefits Veterans, assuring them of seamless access to the care components that they need.

We have personally experienced some of the barriers that remain toward implementation of a collaborative relationship between APRNs and other health professionals, not only within the VA healthcare system but also in private sector health systems. This has been attributed to misunderstandings of the APRN role by administration, physicians, and other health professionals (Legault, et al., 2012, Guzman, Ciliska, & DiCenso, 2010).

This has led us to ask the compelling question: How do we transform the traditional medical model upon which the VA healthcare system was founded into a more adaptable, global, and interdisciplinary model lead by APRNs? One response to this question that has made sense to us is to regard system redesign as more than a physical process. We believe it should be an evolutionary process embracing the notion of APRNs as pivotal dynamic change agents. Traditionally, most APRNs within the VA healthcare system had stood as participant observers with others defining their role is in this system. One reason for this can be attributed to the fact that most APRNs in the community as well as in the VA healthcare system are not aligned directly with nursing administration and often work within a specialty or primary care department of medicine. From the APRN perspective, this has lead to a loss of administrative support from nursing leadership within the institution, often creating disengagement from and discordance between nursing administration and leadership and APRNs. We believe, however, that this situation offers an optimal opportunity for APRNs to lead by example.

One approach we have successfully pursued is to take the initiative, meeting face to face with the nurse executives, medical center directors,
and chiefs of staff to engage in dialogue clarifying the role of the APRNs within and external to their particular VA medical center. In this discussion, we have provided a concise analysis regarding current legislative practice, standards, and guidelines and reflected how these variables impact APRNs in practicing to the full extent of their education and clinical preparation. We have found that this discussion is most productive if presented within a framework of enhancing the delivery of seamless primary healthcare to Veteran populations, in particular to those Veterans residing in rural locations, remote from the main VA medical center location. We also emphasize that many VA APRNs hold adjunct faculty appointments at graduate and undergraduate nursing programs at colleges and universities external to their VA medical center. We note that these APRNs can lead by example, serving as a liaison between the two institutions and serving as mentors for retention and recruitment of nurses with varied academic preparation. Many APRNs within the VA medical center also work closely with nurse managers to plan educational and clinical simulation opportunities for the nursing staff and participate as content experts in grand round presentations for the medical center.

We have learned that another optimal opportunity for APRNs to lead by example is through autonomous persistent requests made to executives in their VA facility to be offered a seat at decision-making tables for program development, implementation, and evaluation, otherwise known as health systems redesign. We think that the most compelling rationale for this is the significant number of nurse practitioners working in primary care within the VA healthcare system. Often both within and beyond the VA healthcare system, APRNs, who are primary care providers are excluded from program design and implementation processes. APRNs find that although they are the direct care providers, others may determine the framework for that care, including those who may not be currently engaged in clinical practice. This disconnect can create a dissonance between needs of Veterans and needs of the institution. This can become a moral dilemma for those of us who work within large health systems. Poghosyan, Nannini, & Clarke (2013) describe the professional visibility of APRNs as very influential in identifying APRNs (nurse practitioners in particular) as stakeholders in patient care delivery and professional identity. These authors further discuss organizational climate and note that further research and exploration is needed to evaluate APRN leadership within health care systems.

Within many VA medical centers, APRNs have made great strides, gaining appointments to many committees where executive decisions are made such as the Nurse Professional Standards Board, the Medical Professional Standards Board, and the Nurse Education and Development Committee. APRNs are also encouraged to participate in grand rounding and be advocates for the Veteran population, particularly those who are underserved or underrepresented in primary care. These opportunities allow APRNs to lead by example, influence decision-making, and promote the delivery of high-quality care to Veterans.
Standards Board, and the Medical Service Executive Board. These decision-making bodies collectively direct scope of practice and influence practice policy at the local and regional level. We believe that it is up to APRNs assigned to the leadership committees to insure their voices are heard and to continue to be active change agents within their organizations. We recognize that the topic of limited or unsuccessful collaboration on the part of APRNs and physicians is not new; it is an area that members of both of these provider groups face in everyday working relationships. It has been our experience that knowledge and understanding of the barriers to collaboration and the consistent use of effective strategies to eliminate these barriers can help all practitioners develop effective, lasting interprofessional relationships that will ultimately positively affect patient outcomes. In the end, we all recognize that patients benefit from a team that accepts and respects each other’s professional expertise (Clarin, 2007).

We are committed to ensuring that where the invisibility of VA APRNs exists, within and external to nursing services, it must be addressed and remedied. An important indicator of this persisting invisibility exists in our organizational documents, which we believe must have inclusive and neutral language supporting inter-disciplinary practice. The word “physician”, casually accepted as the synonym for the professional healthcare provider, and which is sustained with an assertion that this implicitly assumes inclusion of APRNs, is an example of troublesome language contrary to our commitment to inclusiveness and neutrality. Gloria Smith is quoted by Hostutler, Kennedy, Mason, & Scorr (1999) in their discussion about nurse leaders. Smith stated that “Most nurses are proud of colleagues appointed to governing positions in the wider health care field, but nurse health care leaders do encounter some sentiment that they’ve abandoned nursing”, going on to observe that “one doesn’t see things only in relation to how they impact nursing, but must have a far-reaching perspective” (p. 37). It is this perspective that we advocate for as APRNs.

The call for health care transformation is now a reality for all of us. The need for health systems redesign is critical. In this chapter we have tried to illuminate the exemplar of how advanced practice nurses have and will continue to be stakeholders within the VA Health System. Advanced practice nurses bring their experience of system assessment and organizational skills into the interdisciplinary team contributing to the intentionality and direction of patient aligned care. It is through the underpinnings of the work and focus of advance practice nurses that systems such as the VA healthcare system can attain a best practice model for ensuring engagement for better patient outcomes and sustainability of care.
REFERENCES


Chapter 4.3

Full Practice Authority for Advanced Practice Registered Nurses throughout Veterans Health Administration

Penny Kaye Jensen and Suzanne Thorne-Odem
Our intent in this chapter is to describe a journey in health policy, and more specifically, a journey toward the destination of obtaining full practice authority (FPA) for advanced practice registered nursing (APRNs) working within Veterans Health Administration (VHA). This journey required that we, along with many of our colleagues both within VA Office of Nursing Services (ONS) and in other areas of VHA, take on the role of change agents. Becoming a change agent in health policy is not for the weak or sensitive. Endurance, passion, and patience were required to sustain us, while strategizing and negotiating political challenges on a daily basis. We quickly learned that embarking on this journey required a coordinated strategy, consistent messaging, and above all perseverance.

As authors of this story, we are providing our perspective on the events experienced during our journey. An unlikely pair, we began to work together as a team, facilitating approval of FPA for all APRNs within VHA. Suzy, a nursing administrator for clinical practice and Penny, a nurse practitioner and health policy expert, worked tirelessly together. We found that we complemented one another’s strengths and limitations.

Penny served as the public speaker and “face” for VHA FPA. She provided face-to-face briefings to VHA leadership and front-line staff, physician colleagues, and Congressional figures. Her experience in public speaking and networking capabilities were key in facilitating support. In addition, she created and nurtured alliances with professional organizations, the United States Health and Human Services staff, the Health Resources and Services Administration, and even the White House.

Suzy’s role required use of her administrative skills, as she worked behind the scenes. She maintained schedules, tracked deadlines for Congressional responses and coordinated travel and appointment schedules. She navigated VHA Program Offices and monitored responses, while ensuring required communication procedures were followed. She attended face-to-face meetings and many national presentations. Although Suzy dislikes public speaking, she did rise to the occasion in numerous situations to answer administration process and policy questions as they emerged. Suzy also developed a relationship with staff at the Federal Trade Commission (FTC). FTC leadership became very interested in VHA efforts, since they had recently cautioned several individual states regarding restraint of trade and state regulation of APRNs. In March 2014, the FTC released a policy brief focused on competition and regulation of APRN practice. FTC staff has consistently urged state legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns (FTC, 2014). Based on substantial evidence and experience, expert
bodies have concluded that ARPNs are safe and effective as independent providers of many health care services within the scope of their training, licensure, certification, and current practice (Institute of Medicine, 2010, pp. 98-99). Therefore, new or extended layers of mandatory physician supervision may not be justified. Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition (FTC, 2014).

The FTC was one of several resources that supported our efforts. Together, we spent many late hours, writing response letters and strategizing next steps to gain approval of FPA. Sixteen-hour work days became common. More importantly, we provided support to one another during the achievements and disappointments, throughout the progression of this journey. Our complementary collaboration and our strategy were instrumental in moving the VHA FPA initiative to where it is today.

Many VHA nurses have been involved in this FPA initiative throughout the years. However, this journey would not have begun without the vision of the Chief Nursing Officer, Cathy Rick. This journey is dedicated to her legendary leadership. We believe that her leadership will have historical impact on VA nursing and advanced practice nursing for many years to come. The process of working toward achieving FPA within VHA gained national attention as well as creating controversy. The proposed policy received both positive and negative attention from Congress, professional organizations, media, and even VHA staff. This is our story of that process and its relevance.

Setting the stage for our journey, in 2009 the VHA Office of Nursing Services (ONS) began the development of a nursing handbook to establish policy for the process of care delivery and the elements of nursing practice in VHA. The ONS staff and ONS national nurse executive council (NNEC) members began the arduous process of writing the first VHA ONS nursing handbook, which includes all aspects of nursing practice across the VA system. The ONS Advanced Practice Nurse Advisory Group (APNAG) was responsible for crafting initial APRN practice language and obtaining input from physician partners.

Within the draft of this nursing handbook, VHA is proposing the authorization of FPA for APRNs without regard to their individual State Practice Acts, except for the dispensing, prescribing and administration of controlled substances. This proposed change in nursing policy would standardize APRN practice throughout the VA system, increase access to healthcare services and decrease variability throughout the system. At
present, the proposed policy for APRN FPA is under review and will be
published in the Federal Register for notice and comment in 2015. Following
the public comment period, VA will render a decision on the policy.

Implementation of FPA would increase patient access to care by
alleviating the effects of national health care provider shortages on VA
staffing levels and enable VA to provide additional health care services
in medically underserved areas. The absolute number of APRNs this
would affect is in itself noteworthy. There are 5,724 APRNs working
within VHA: 4630 (81%) are nurse practitioners (NPs), 807 (14%) are
certified registered nurse anesthetists (CRNAs), and 284 (5%) are
clinical nurse specialists (CNSs) (VHA Support Service Center, 2014).

The 2010 Institute of Medicine (IOM) landmark report, The Future of
Nursing: Leading Change, Advancing Health, recommended removal of
scope-of-practice barriers, allowing APRNs to practice to the full extent
of their education and training (IOM, pp. 9-11). As this transformational
recommendation emerged during the IOM report development, it prompted
VHA to propose FPA for APRNs. The VHA’s proposed Nursing Handbook
is consistent with the IOM recommendation to remove barriers including
the variation in APRN scope of practice that exists across VHA as a result of
disparate state regulations. As an integrated federal health care system, the
proposed policy parallels current policies in the Department of Defense
(DoD), the Indian Health Service (IHS), and the Federal Prison System.

The passage of the Patient Protection and Affordable Care Act
(PPACA) has prompted a greater demand for national healthcare
services and providers. Many Americans have insufficient access to
primary care services. The Health Resources and Services Administration
(HRSA), the federal agency responsible for improving access to health
care services for people who are uninsured or medically vulnerable,
has identified roughly 5,700 geographic areas containing 55 million
residents as primary care health professional shortage areas (Cassidy,
2012). These areas would need more than 15,000 additional practitioners
to meet the target ratio of one primary care practitioner for every 2,000
residents (Cassidy, 2012). APRNs play a critical role in alleviating provider
shortages and expanding access to health care services for medically
underserved populations (National Governors Association, 2012).

The VA released an audit in early June 2014 showing that more
than 57,000 Veterans have had to wait at least three months for initial
appointments while many Veterans never received an appointment.
There has been a large influx of new enrollees in the VA Healthcare System
and VA statistics since 2000 demonstrate a consistent upward trend in
enrollment numbers. Much as the nation struggles with primary care provider shortages, so too does the VA struggle, competing for these providers. Over the past three years, primary care appointments have increased by 50% yet the staff of primary care physicians has increased by only 9% (VHA Office of Primary Care, 2013). Many NPs are working in these clinics but are not able to function to the full extent of their education and training due to barriers created by disparate state regulations.

The Office of Nursing Services supports the efficacious use of the nursing workforce, and is thus a driving force for the FPA initiative. Veterans seeking care should be evaluated in a timely manner. Referring patients to the private sector is not a new concept and is already in place throughout VHA. However, passage of the PPACA has prompted a greater demand for national health care services and providers. In the private sector, patients often wait between 30 to 60 days for appointments in primary care due to the shortage of primary care providers. An influx of Veterans into an already overburdened system cannot improve access for Veterans, particularly those living in dense urban or remote rural areas. Implementation of FPA would allow APRNs to function to the full extent of their education, training and certification resulting in patients’ increased access to primary care services in states where scope of practice barriers now limit an APRNs ability to practice. FPA would also result in cost savings to VA by decreasing the need to outsource care to community services.

In a 2013 VHA report, physicians were identified as the occupation most challenging to recruit and retain, with primary care providers (PCPs) identified among the top physician specialty recruitment challenges, a situation also descriptive of NPs and physician assistants (PAs) (VHA Office of Primary Care, 2013). These occupations also ranked high for attrition in VA during FY 12 and 13 (VHA Office of Primary Care, 2013). VHA data demonstrate primary care physician turnover rates of 12-13% annually. In addition, 45% of primary care providers report burnout as compared to an average of 28% among all VHA provider employees (VHA Office of Primary Care, 2013).

There is a growing body of evidence demonstrating that patients perceive that receiving primary care and having usual source of care is more important than who provided the services. Research studies comparing the quality of care provided by physicians and nurse practitioners have found that clinical outcomes are similar (Cassidy, 2012). The Newhouse systematic review conducted by Stanik-Hutt, et al. (2013) found that health status, prescribing behaviors and health outcomes were consistent between nurse practitioners and physicians. As part of the process to attain FPA for APRN, VHA Office of Quality and Safety also conducted a
robust literature review focused on the quality and safety of granting FPA to APRNs, providing validation for their decision. VHA believes that the future of health care depends on all health care providers practicing to the full extent of their education, training, and certification.

Currently, the state laws in which the APRN is licensed determine VHA APRN practice. The most influential of these are the state scope-of-practice laws, which legislate the functions a healthcare professional can perform and to what extent. Medical practice acts in every state grant all physicians full authority to diagnose and treat all health conditions. In contrast, nurse practitioner authority varies significantly, with some states allowing nurses to practice independently from physicians, while others require direct supervision. The majority of states fall somewhere in between, restricting practice and requiring APRNs to collaborate, often mandating a written agreement with physicians in order to maintain state licensure (Phillips, 2014). The 50 States and the District of Columbia have vastly different laws governing APRN practice (Phillips, 2014). The 51 nurse practice acts currently lack any clear consistent framework or shared congruence.

In 2013, two states achieved full practice authority for NPs, including prescriptive authority. In addition, for the first time, a state mandated third party reimbursement parity for nurse practitioners’ services, and controlled substance prescriptive authority was secured in one of the two states where this was not authorized. In 2014, two additional states achieved FPA for NPs. Nineteen states and the District of Columbia now allow NPs to practice to the full extent of their education, training and certification. Currently, because VA follows the practice act of the state of licensure of the APRN, if the state of licensure allows for independent practice then VA allows it. If the state of licensure does not allow for independent practice, then VA defines the practice of the APRN in a scope of practice agreement between the facility, the APRN, and the collaborating physician for the APRN’s practice.

The Federal requirement that CRNAs must be in a supervisory relationship with anesthesiologists creates barriers to adequate analysis of patient safety data, as the CRNA may not be identified as a distinctive provider group, providing anesthesia care. This policy also has a detrimental effect on rural states that are not able to staff small hospitals with anesthesiologists. Therefore, many States have opted out of the Federal requirement for CRNA supervision in order to increase access and meet patients’ needs (O’Grady, 2008).

VHA is a primary employer of clinical nurse specialists (CNSs). These APRNs have unique competencies focused on improving the quality of patient care and reducing healthcare costs (National Association of Clinical
Nurse Specialists, 2014). CNSs serve as leaders of change and developers of evidence based programs to improve patient outcomes. They also have a significant role in educating and mentoring nursing staff. CNSs fulfill a unique role in VHA that no one else can provide to Veterans.

Although VHA does not currently employ certified nurse midwives (CNMs), care of female Veterans by these APRNs is currently being considered. Since 1996, the VA healthcare benefits package has included maternity benefits. These benefits begin with the confirmation of pregnancy and continue through the postpartum visit or when the Veteran is medically released from obstetric care. On October 5, 2012, VHA issued the Maternity Health Care and Coordination Handbook 1330.03, which establishes procedures for providing and coordinating maternity care for pregnant women Veterans enrolled in the VA healthcare system. According to VHA Handbook 1330.03, Certified Nurse Midwives (CNMs) are qualified to provide routine obstetric care.

Thus FPA for APRNs employed by VHA would have an impact on all types of APRNS, and all are included in our initiatives. Model APRN regulation is aimed at public protection by ensuring uniformity across all jurisdictions. Uniformity of national standards and regulation not only allows for the mobility of nurses, it also serves the public by increasing access to care and clearly communicating to the public the accountabilities of the APRNs. Currently, each jurisdiction devises its own standards in regard to APRNs. This has resulted in a huge diversity of rules and regulations among jurisdictions. The lack of uniformity among jurisdictions leads to confusion on the part of the public, profession and related fields. Even APRN titles differ from one jurisdiction to the next. The need for standardization also affects the livelihood of practicing APRNs and their ability to relocate to areas experiencing health care shortages. An APRN may have extensive experience in one jurisdiction, but is limited in mobility because moving to another jurisdiction would mean being subject to different qualifications or standards of practice (National Council of State Boards of Nursing, 2008).

The profession of nursing has taken numerous initiatives to address the dilemmas just described. One example of this is the National Council of State Boards of Nursing (NCSBN) Consensus Model (2008), a policy document that further provides support for the VHA FPA initiative within the ONS Nursing Handbook. The Consensus Model identifies each APRN role and promotes standardized APRN regulation, which is aimed at ensuring uniformity across all jurisdictions. There are four APRN roles outlined by the APRN Consensus Model: Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA) and Certified Nurse Midwife.
(CNM). VHA’s proposed policy is consistent with the NCSBN’s Consensus Model. The VHA Under Secretary for Health, Robert Petzel, MD, cosigned a letter of support with Will Gunn, JD, from the Veterans Administration Office of General Council that was sent to NCSBN leadership. The intent of this letter was to demonstrate the cooperative support for the VHA endeavor to invoke Federal Supremacy in order to grant FPA to all APRNs working within VHA while also embracing the NCSBN APRN Consensus Model.

As is evident from this contextual picture we have just sketched, the efforts of Cathy Rick, and the ONS nursing leadership had ample guidance and validation for the FPA initiative. To achieve the goals we had set for ourselves, the next phase of our journey involved the VHA consensus process, which spanned the years 2010 through 2012. Each draft of the nursing handbook was distributed throughout VHA nursing. This was done to ensure transparency and garner feedback from the field by including nurse executives, APRNs, and staff nurses in the process. After consensus was reached within the VA nursing community, the policy document was ready for the full formal VHA concurrence process. This approval process requires that each VHA national program office review the document and either concur, with the option of offering comment, or non-concur. All program offices impacted by the ONS Nursing Handbook, including those impacted by the changes in APRN practice, were included and provided the opportunity to discuss or recommend alterations in the document. Following this two-year process, all VHA program offices concurred on the ONS Nursing Handbook.

This concurrence process increased the visibility of this proposed policy. As interest in FPA grew, it became apparent that additional expertise was needed to lead this major VHA health policy change. While Suzy had been present for the early phases of our story, it was at this juncture that Penny became a key resource in our developing story.

Dr. Penny Kaye Jensen began her career with the Department of Veterans Affairs in 1994 and has practiced for the past 17 years as a nurse practitioner in the Outpatient Primary Care Clinics of the VA Salt Lake City Health Care System. Throughout her career, Penny has been a strong advocate for and leader in nursing and an expert on NP issues at the international, national, state, and local levels. In addition to working with the White House and other federal agencies on healthcare reform while serving as the President of the American Association of Nurse Practitioners (AANP), she is a nationally recognized expert in the healthcare policy arena. As a result of her knowledge and experience on the national stage, Penny was assigned to ONS as the Liaison for National APRN Policy to lead the process
for final approval and implementation of FPA within VHA. It was at this time that we were able to more directly collaborate in our shared journey.

As Penny recounts, in order to move the FPA initiative forward, it was key to utilize evidenced based literature and recommendations to support FPA which included the 2010 Institute of Medicine (IOM) report, the National Council of State Boards of Nursing (NCSBN) Consensus Model (2008) and the National Governors Association (2012) publication from its Center for Best Practices that focused on access to primary care services and NP practice barriers. Examining the evidence and federal policy provided support for development of a formal VHA communication plan for FPA for APRNs. This became the basis for developing a strategic plan, as well as a formal Communication Plan to ensure consistent messaging for both internal and external stakeholders.

We led the development of this multifaceted document development with key ONS officials and other national program offices such as the Office of Patient Care Services (PCS) as well as the Principal Deputy Under Secretary for Health (PDUSU). The communication plan included the background of the ONS Nursing Handbook, key informational talking points, and frequently asked questions that were addressed at internal and external stakeholder meetings. Upon completion of a formal communication plan, we obtained concurrence from national program offices, which included the Office of Communications, Office of Congressional and Legislative Affairs (OCLA), Office of Public Affairs, and the Office of the Chief of Staff.

At this point, VHA’s intent to approve FPA for all APRNs was gaining momentum and interest was peaking at the national level. Congressional and professional organizations had begun to submit formal inquiries, and articles in the national media began to surface along with a request for interviews from a variety of media outlets including the Wall Street Journal and Washington Post. The VHA FPA Communication Plan included the identification of external stakeholders that were selected to meet with VHA officials in an effort to promote transparency. Penny, serving as the ONS subject matter expert (SME), accompanied both the Under Secretary for Health and the Principal Deputy Under Secretary for Health at a variety of national VA meetings and Congressional briefings. These 13 meetings included external professional healthcare organizations representing nursing, physicians, Veteran Service Organizations, special interest groups such as AARP® Real Possibilities (formerly known as the American Association of Retired Persons), and several members of Congress, specifically for the purpose of discussing VA’s proposed full practice authority policy for advanced practice registered nurses.
We also conducted a pre-implementation FPA evaluation. The purpose of this evaluation was to assess the current knowledge and context of advanced practice registered nurses (APRNs) and to obtain opinions from various key stakeholders within the Veterans Health Administration (VHA) regarding the proposed policy change to the VHA Nursing Handbook which will exercise federal supremacy through federal law, granting all APRNs practicing in VHA facilities full practice authority (FPA). A mixed method evaluation of the current state of APRN practice was utilized for this study. Telephone interviews were conducted with three groups within VHA: the Office of Nursing Service (ONS), various levels of administrators from field facilities, and individual APRNs. Responses were stratified by demographic characteristics of the participants, including gender, geographic location, and physician vs. non-physician. The Midwest region had the greatest proportion of satisfied APRNs (100%). The majority of the APRNs from the South were satisfied with their current practice (67%). Of those who were not satisfied with their current practice, 22% had reduced and 67% had restricted practice authority. The majority of the administrators (82%) and individual APRNs felt that the proposed policy change would improve access to care and would improve quality of care. Administrators also felt the VA will serve as a model for others and this may position the VA to become more competitive with the private sector.

This evaluation was helpful in providing us with a database from key respondents within the VHA. It also informed our responses to inquiries. Penny has had primary responsibility for the formulation of response letters for inquiries regarding the FPA APRN initiative for the Secretary of the Department of Veterans Affairs, the Under Secretary for Health, and the Principal Deputy Under Secretary for Health. Together, we worked closely with a variety of VHA national program offices, especially the Office of General Counsel, to develop response language that meets the legal and technical requirements to satisfy Congressional inquiries. Thus far, Penny, with Suzy’s assistance, has completed over 500 response letters formulated for members of Congress, medical and nursing professional organizations, academic institutions, non-governmental interest groups, Veteran Service Organizations (VSOs) and individual citizens. VHA continues to receive many letters of inquiry on a daily basis.

As congressional inquiries increased, Penny developed a VHA Congressional Information Guide that was made available to the VA’s Office of Congressional and Legislative Affairs (OCLA) and Office of Public Affairs (OPA) to address the barrage of incoming questions related to FPA. In addition, the Under Secretary for Health
was called upon to present several congressional briefings to the House Veterans Affairs Committee (HVAC) and the Senate Veterans Affairs Committee (SVAC), as well as to the White House. Numerous questions regarding the Nursing Handbook also appeared during the VA Congressional Budget Hearings. These inquiries required responses directly from the Secretary of the Department of Veterans Affairs, which is the Presidential Cabinet level position.

The VA’s FPA initiative has received support from the Federal Nursing Service Council. Penny served as the ONS representative on the Federal Nursing Service Council, Nursing Caucus Briefings. Membership of this council includes all Chief Nurses from each branch of the military service (both active duty and reserve), Public Health Service (PHS), VHA, and American Red Cross. This group of federal national nursing leaders joined together to promote the VHA FPA APRN policy through meetings with 12 Congressional representatives on Capitol Hill. These visits were very powerful and instrumental in gaining support for this initiative among members of Congress. Representative Lois Capps (D-CA) and Representative David Joyce (R-OH) supported the FPA initiative by co-sponsoring a “Dear Colleague Letter” in support of FPA which was signed by 28 members of Congress and sent to former VA Secretary Shinseki. As we prepare to publish this story, Congress and VHA have received over 10,000 letters of support for this initiative.

On numerous occasions, VHA officials were asked to explain the process for invoking Federal Supremacy, which provides authorization for implementing this national change. Under title 38, United States Code, the Department of Veterans Affairs (VA) is authorized to prescribe all rules and regulations that are necessary and appropriate to carry out its statutory role as a provider of a national health care system for the nation’s Veterans. This includes the authority to establish the qualifications of its health care practitioners and regulate their professional conduct. With the exception of controlled substances prescribing, which by Federal law requires adherence to State licensure requirements for such prescribing, VA determines the elements of clinical practice for its healthcare practitioners. In carrying out these functions, VA has an obligation to ensure that patient care is appropriate, safe, and provided by healthcare practitioners that meet or exceed generally accepted professional standards of care. While healthcare professionals must be licensed to practice their profession, they are required to follow VA rules and regulations for clinical practice, even if VA’s rules and regulations are more expansive or otherwise inconsistent with their State Practice Acts.
Invoking Federal Supremacy is not a quick and easy process. In order to invoke Federal Supremacy, there must be a regulation and/or law to invoke. Currently, VHA does not have a regulation enabling FPA for APRNs. Penny is now working closely with the VHA Office of Regulatory Affairs to complete final revisions of the proposed regulation, which will be published as an Interim Final Rule. Once placed in the Federal Register, the public will have an opportunity to provide formal comment on the proposed regulation. At that time, the VHA Under Secretary for Health has the authority to begin implementation of all or part of the Interim Final Rule. We believe that the national focus on the lack of access to healthcare, especially Primary Care Services for Veterans, is a driving force in expediting implementation of FPA for APRNs. Penny has utilized her leadership and expertise in healthcare policy to formulate APRN regulations that will increase access to healthcare for Veterans on a national basis.

This chapter describes the steps we have taken to facilitate approval of this health policy change in VHA. Implementation will be the next step and will require a well thought out strategy and coordinated effort. Penny is currently preparing a blueprint for FPA implementation throughout VHA and establishing an interprofessional FPA Steering Committee to ensure a successful rollout of this policy. She is working closely with the Chief Nursing Officer Dr. Donna Gage and Interim Deputy Under Secretary Dr. James Tuchschmidt. The implementation phase will require significantly more effort than the previous steps taken to attain FPA. A VHA Directive will likely be written, requiring navigation through the concurrence process. In addition, implementing an APRN privileging process, revising medical bylaws, reviewing the professional standards boarding processes, modifying pay scales, redistributing workload, accurately monitoring productivity, as well as providing additional training are all issues that will be addressed during the implementation phase of FPA.

In summary, the journey toward FPA for APRNs is one with a long and complicated history. The IOM’s report on the Future of Nursing provided a compelling recommendation that challenges constraints placed on professional practice for APRNs. VHA’s proposed nursing handbook is consistent with the IOM recommendation to remove barriers including the variation in APRN practice that exists across VHA as a result of disparate state regulations. The VA is uniquely positioned to play a key role in responding to this recommendation as the nation’s largest healthcare system and employer of APRNs. Our story describes a major component of the current VA response and chronicles the impact of FPA for APRNs and the nation’s Veterans.
REFERENCES


Chapter 5: Integrating the Clinical Nurse Leader Role in the VA System

Marjory Williams, Alice Avolio and Karen M. Ott
The Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* (2011) call for action is a call for transformation: transformation in the way we practice nursing, the way we prepare for practice, and the way we think about nursing practice. One of the key messages in the report is that “nurses should practice to the full extent of their education and training” (IOM, 2011, p. 29). If we view that message within the context of the other key messages, the integrated overall message becomes something beyond merely working to the full scope of our practice authority. *The Future of Nursing: Leading Change, Advancing Health* (2011) endorsement for transformation is a call for us to implement nursing practices and position nursing roles to leverage the impact of improved preparation in partnering for change and the creation of systems that are more responsive and reliable. The vision of VA nursing leadership foresees the Clinical Nurse Leader (CNL) role as one direct and powerful response to that call.

The CNL role emerged from the same phenomena in health care that led to the call for action in *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011). VA nursing leadership played a significant role in the collaboration between academic and clinical leaders that resulted in the creation of this new nursing role. The role was crafted in response to the imperative to educate and deploy health professionals who can actively engage in quality improvement to deliver patient-centered, interdisciplinary, evidence based care (AACN, 2007). To accomplish this goal, the CNL preparation positions the person in this role to have responsibility for translating and applying evidence based findings to the design, implementation and evaluation of care (AACN, 2007). Each of us played a role in integration of the CNL role in the VA and we continue to support this effort. Marjory Williams and Alice Avolio comprise the Office of Nursing Services (ONS) CNL Implementation and Evaluation Service team that operates within the ONS legislation, policy, and education work stream lead by Karen Ott, ONS Program Director. This chapter illustrates a portion of our journey.

The CNL is a master’s prepared nurse generalist educated and positioned to lead system transformation by influencing patterns of care and practice at the point-of-care. The sphere of influence for the CNL is positioned right where it most counts, embedded within the environment where the interface with the Veteran actually occurs, and where organizational culture and practice patterns directly impact patient outcomes. By being positioned at the point-of-care, the CNL is able to assess and address issues within the context of the immediate care environment. The CNL is also educated and positioned to increase
engagement of point-of-care teams in understanding and seeking to improve their performance and relationship to the larger system in ways that reduce risk and create conditions for sustainable excellence.

The Department of Veterans Affairs (VA) has a well-defined purpose: to provide care to Veterans who have served in the armed forces. According to the U.S. Census Bureau’s 2012 American Community Survey data, there are an estimated 21.2 million Veterans in the United States, of whom 27% live with a disability, 7% live below the poverty line, 8% are unemployed and 65% are 55 years or older (U.S. Census Bureau, 2012). The Veterans Health Administration (VHA, 2013) is America’s largest integrated health care system, with over 1,700 sites of care serving 8.3 million enrolled Veterans each year. Veterans are a group with complex health needs, often directly attributable to their military service.

The VA Office of Nursing Services provides leadership, guidance and strategic direction to a VA nursing workforce of over 77,000. As described in the ONS 2009 Annual Report, Cathy Rick, the Chief Nursing Officer for the VA Office of Nursing Services and James Harris, the Deputy Chief Nursing Officer recognized the value the CNL role could bring to improving care for the Veteran. They saw the need for a new role that could provide greater accountability and enhanced care management and coordination at the point of care (ONS, 2009). As a result of their leadership, the CNL role has been adopted by VHA as noted in the IOM report on the future of nursing (IOM, 2011, p. 72).

Our VA nursing leadership vision is to design a strategic approach to exploring the ways the CNL role can add value to our system and be a force for transformational change. We move forward toward this vision knowing that the VA’s massive national system of healthcare delivery is made up of individual point-of-care systems. These point-of-care systems are the functional units, or building blocks, of the larger system and are referred to as microsystems. Microsystems in health care organizations are defined as small teams of people who "work together on a regular basis to provide care, and the subpopulation of patients who receive that care." (Nelson, Batalden, & Godfrey, 2007, p. 233). We understand that the value of our national system of healthcare delivery is measured by the quality of the Veteran experience within each of the individual microsystems that make up the larger system. We believe that the whole system functions no better than the weakest subsystem, and that whole system transformation occurs microsystem by microsystem. To support system wide assimilation of the CNL role the ONS developed an integrated portfolio of multi-year activities that comprise the CNL spread initiative. The CNL Implementation &
Evaluation Service is one component of this initiative and was established to address the need from various stakeholder groups for consultative support in implementation of the CNL role. In our role as the CNL Implementation & Evaluation Service we provide VA facilities with information about how to strategically and thoughtfully implement this new role.

The CNL Implementation & Evaluation Service team is excited about the CNL role because we have seen the impact. We have had the pleasure of seeing growth and sharing the enthusiasm of nurses who are transformed through education and training into point-of-care clinicians ready and willing to lead change and embed reliability where it directly translates into patient care. We have witnessed the transformational response of point-of-care teams to the influence of nurses who practice within this new role. This influence extends to patterns of care and practice in the areas of competency, communication, collaboration, coordination, quality and safety. Our vision is for CNLs to be embedded at all points of care across the VA system. CNLs partner with nurse managers and function as influential members of high performing interdisciplinary teams. This approach will bring about transformational change and infuse high reliability in our care delivery systems.

The complexity of today’s health care environment presents challenges in trying to develop high reliability organizations where safe patient care is consistently provided. The goal is to design a system where safe and effective care is an integral part of daily practice. According to Weick and Sutcliffe, as cited in Sanchez and Barach (2012), highly reliable organizations share the “capacity to discover and manage unexpected events resulting in exceptional safety and consistent levels of performance despite a fast changing external environment” (p. 2). We believe the CNL is uniquely qualified to lead a microsystem towards high reliability by embedding patient safety concepts and consistent patterns within the system.

Another component of the ONS CNL spread initiative is the VA Academy for the Improvement of Microsystems (AIM) collaborative. This is a joint venture between the VA Office of Nursing Services and the Mid-West Mountain VA Engineering Resource Center (MWM VERC) that brings CNLs (as point-of-care nursing clinicians) along with point-of-care nursing managers, into a virtual learning environment to develop high functioning point-of-care teams. The training curriculum for the AIM collaborative is based on the VA systems improvement framework and is designed to enhance the ability of nurses to foster microsystem cultures characterized by responsiveness to the needs of Veterans and accountability for safe, effective and efficient care delivery (Department of Veterans Affairs, 2012, pp. 14-15).
The AIM collaborative provides CNLs, nurse managers, nursing executives and other interested healthcare professionals with the skills to support and lead high-performing Microsystems on a journey of continuous improvement. CNLs are positioned to assess inefficiencies that impact patient care and reduce role effectiveness and team morale. By increasing systems redesign knowledge and skills through training in VA lean improvement methodology such as flow mapping, run charts and use of the plan, do, study, act (PDSA) process, we are enhancing the ability of the CNL to effect transformational change. Our vision for the role of the CNL in the VA is multidimensional. Our vision is consistent with the description of the role provided in the *White Paper on the Education and Role of the CNL* (AACN, 2007) that outlines the fundamental aspects of the role. The CNL applies acquired skills and knowledge as clinician, outcomes manager, client advocate, educator, information manager, systems analyst, risk anticipator, and team manager. The CNL uses a collaborative approach in assessing and modifying microsystem patterns of care and practice that directly impact outcomes for Veterans and serves as role model, coach and champion of evidence based, high-reliability care.

The exemplar stories presented in this chapter provide an array of perspectives about CNLs and how they partner within point-of-care teams and integrate their knowledge of system improvement with expertise in complex patient care, change management, evidence based practice, and clinical leadership to promote transformation at the point-of-care. Our stories are growing and the impact of the role is being validated, yet there are still challenges to address to facilitate full implementation. We believe as knowledge grows and the CNL is supported to function in a manner consistent with the intent of the role, value will be demonstrated and will manifest in measures of importance to professional nurses and to the Veterans served. We have no doubt that the CNL will grow as a key asset to the healthcare delivery system decision-makers as they continue to improve the management of the system.

As the ONS CNL Implementation and Evaluation Service, we experience daily the passionate enthusiasm CNLs and CNL students have for this role. Their eyes sparkle when they talk about what they can do—and the difference they know they have and can make. They want everyone to see this role’s potential to impact and influence Veterans in profound and lasting ways. These are nurses looking to do more, to stay engaged in direct patient care, to tackle the most difficult and challenging healthcare issues for patients. These nurses are also acting as clinical expert resources, coaches, teachers, mentors,
role-models and inspiration to other nurses. It is amazing that even when the challenges to full role implementation become frustrating and seemingly insurmountable, CNLs never speak negatively about the role. We are most uplifted when we encounter a member of the nursing staff on a microsystem that has a CNL and they state, without any solicitation, how wonderful it is to have the CNL on the unit. Their comments reinforce our convictions about this emergent role. "I know we will be able to get through anything when I see our CNL on the unit". "She is so important to us for so many things, is there any possibility of getting another one". "I learn so much from him and he makes me feel comfortable asking for help; I am becoming a much better nurse". Nurses have transitioned from sometimes expressing concern that the CNL was not taking a full patient assignment to insisting that some other alternative to staffing be found so their CNL can be free to help across everyone’s patient assignment, a sentiment also shared by resident physicians.

Full role implementation across all points of care in the VA system remains an ambitious goal and we continue to expand and evolve our strategic approach. Paying close attention to lessons learned and particularly resistant challenges, we are able to remain adaptive and responsive in developing strategies. The AIM collaborative is a good example. Our initial plan was to bring microsystem teams together for face-to-face meetings in central locations with adequate training facilities. We felt this program design was necessary to foster the types of interaction needed for group learning and problem solving. Creating face-to-face communication was necessary for establishing credibility through relationship. Organizational stewardship priorities dramatically reduced the ability to conduct face-to-face training events so we had to explore virtual options and opportunities. Under the leadership of the Mid West Mountain VERC director and staff, the AIM collaborative effort quickly morphed into a virtual kick off with weekly training sessions in a virtual classroom environment that is proving to be quite successful in meeting the learning needs of the cohort participants.

As we move forward on this journey toward full implementation of the CNL role across all points of care in the VA system, we will continue to learn lessons and adapt to changing needs and demands. We will also increasingly learn from our practicing CNLs as they grow in numbers and influence. We see our Veteran patients benefitting as systems become safer with higher quality and reliability. We see our nation gaining as the system becomes more efficient and effective from the inside out. We face real challenges in achieving our strategic vision,
but it is clear that we cannot continue doing things the way we have
done in the past, and we cannot turn away from the transformational
potential of engaged and high-functioning microsystems. The future
of this role is ahead of us and we are excited about that future.

REFERENCES

education and role of the CNL. Washington, DC: AACN. Retrieved June 11, 2014 from
http://www.aacn.nche.edu/aacn-publications/white-papers/cnl-white-paper

Department of Veterans Affairs Office of Nursing Services (ONS). (2009) Office of
Nursing Services annual report 2009: VA Nursing: Connecting all the pieces of the
puzzle to transform care for Veterans. Retrieved June 11, 2014 from http://www.va.gov/nursing/about/Published_Reports.asp

Department of Veterans Affairs Office of Nursing Services (ONS). (2012) Office of
Nursing Services Annual Report 2012: VA nursing: shaping healthcare from the

http://www.nap.edu/catalog.php?record_id=12956


Sanchez, J. A., & Barack, P. R. (2012). High reliability organizations and surgical
microsystems: Re-engineering surgical care. Surgical Clinics of North America. 92,
1-14.


Veterans Health Administration (VHA). (2013). Veterans Health Administration. Retrieved
November 1, 2013 from http://www.va.gov/health/
Chapter 5.1

The VA CNL as a Transformational Leader

Susan Resti
Since 2011, the number of nursing home residents younger than 65 years of age has increased to about 22 percent, totaling approximately 203,000 residents according to an analysis of statistics from the Centers for Medicare and Medicaid Services as reported in the Huffington Post (Sedensky, 2011). There are two reasons for this increase. The first is the closure of mental health facilities. The second is medical technological advances that are keeping people alive after they have suffered traumatic injuries, especially in the Veteran population. (Sedensky, 2011).

In the Institute of Medicine’s (IOM) consensus report, The Future of Nursing: Leading Change, Advancing Health, it is recommended that nurses practice to the full extent of their training and education (IOM, 2010, p. 4) and to endorse variation based on a higher standard of care (Kinnaman & Bleich, 2004). Nurses are faced with multiple and various issues in a complex system of dynamic change. In its White Paper on the formation and education of the CNL, the American Association of Colleges of Nursing (AACN) states that as “Educator: [the CNL] uses appropriate teaching principles and strategies as well as current information, materials and technologies to teach clients, groups and other health care professionals under their supervision (AACN, 2007).

There are three units that comprise the Community Living Center (CLC) at the Bay Pines VA Medical Center. The microsystem where I practice as a CNL is “CLC –Central” because (its location is in between the other two CLC units.”) The CLCs at one time Veterans requiring long term care similar to a private sector/community nursing home: the residents were older but relatively medically stable, requiring custodial care in a static, linear structure. Most of the nurses who transferred to the CLC either left bedside acute care or transferred from traditional community nursing homes.

The CLC has experienced many changes in its case mix in the past four years. We are now admitting Veterans who are not only younger, but medically and psychologically more complex with varying co-morbidities. Caring for these Veterans who are more medically complex requires a higher degree of assessment and critical thinking skills. As the CNL on this unit, I coach my colleagues at the bedside to accommodate this higher level of care required for these Veterans. I have coached nurses and nursing assistants to use assessment skills such as listening for lung sounds in a Veteran who has a history of congestive heart failure, and to recognize external signs and symptoms such as using accessory muscles for breathing.

Other assessments that have been taught at the bedside are tracheostomy care, retrieving laboratory information to identify
neutropenia, using a Doppler to assess pedal pulses in a resident who has vascular disease, and identifying preventive measures for residents who are high risk for fall with injury. I have introduced the importance of hip protectors as an intervention to prevent hip fractures in the elderly Veteran. In the past, residents who required complex care such as recent post-operative orthopedic procedures, or head and neck cancer procedures, were transferred to VA-contracted nursing homes for rehabilitation. Now, patients are discharged from the hospital and admitted to the CLC for post-operative care and rehabilitation.

Transformational leaders influence others to acquire a skill or perform an important task. The transformational leader serves as the role model by showing colleagues what needs to be done, and then facilitates achievement of success for colleagues (Monaghan & Swihart, 2010). A transformational leader improves the environment of care by using evidence based practice which is tested and used to make policy changes (IOM, 2010). As a transformational leader, I take what knowledge the CLC nurses have and by collaborating with them, guide them into a higher level of decision-making based on the clinical and physiological presentations of the Veteran. In so doing, the CNL creates a culture that supports collaboration to get the best outcome for the Veteran. According to Bleich and Kinnaman (2004), collaboration is the utmost multifaceted interdisciplinary behavior because the purpose of everyone involved is focused on a common objective, which transcends disciplines and/or power struggles (Kinnaman & Bleich, 2004).

The CLC has evolved into a complex adaptive system where each nurse on the unit needs to be interactive in order to provide safe effective care. By building these relationships, I, as the CNL, help the nurses recognize this complex, but adaptive system (Lindberg, Nash, & Lindberg, 2008). The nurses are more resilient when adapting to the ever-changing environment, and, rather than voice dissention about it, accept the nonlinearity of the unit and focus on the interrelationships and interactions to the advantage of the Veteran.

At present, the Bay Pines VA medical center is downsizing its infusion team availability to the medical units so that the team can concentrate on the insertion and care of central lines. The infusion team was previously available to start peripheral lines to all who needed them. Now, however, staff nurses must attempt at least twice. In the past, it was very rare that residents would need to have an intravenous line while on this unit. With the increased acuity of the residents, starting intravenous (IV) lines has become a frequent need.
I also coached RNs on how to care for percutaneous intravenous central catheters (PICC lines). This is a crucial skill to master because many residents who are admitted to the CLC either need the PICC lines for chemotherapy, or are being treated with long-term antibiotic therapy. The CLC nurses have been educated on how to properly maintain these lines to preserve patency, which includes irrigating the lines aseptically and using the correct amount of normal saline to keep the line patent.

I improved residents’ diabetic education on the unit especially in preparation for discharge. Assessing resident knowledge of their diabetes and how they control their blood sugar is important to learn early so that education can be provided before the resident is discharged home. Education includes teaching the Veteran how to perform capillary glucose tests and insulin administration. One of the staff nurses has taken the responsibility to inquire if the Veteran has a glucose monitor and if not, we have the ability to enter an order for a monitor. Education is provided at the bedside by either me or the RN who is caring for that resident. The staff nurse and I have created an educational template as a means to validate that the teaching was implemented. This template is a permanent part of the electronic health record. Once the basic education is performed with the resident, the staff nurses on all shifts are asked to encourage the resident to perform his/her own capillary glucose test and administer his/her own insulin. This educational session is recorded by the nurses in the resident’s electronic health record and provides another way to validate the resident’s competency well in advance of discharge.

My role as a CNL has thus become a way for me to assist my nursing colleagues, helping them to provide a more complex and competent level of care through my collaborative, coaching and educational practices. I believe in this way I am able to make a difference in the health care of our Veteran patients here at the Bay Pines VA medical center’s CLC Central as a transformative CNL leader.

REFERENCES


Chapter 5.2

The Amazing Role of the Clinical Nurse Leader: Champion of Versatility in a Veteran’s Hospital

Frances Zarella
I have been a certified Clinical Nurse Leader (CNL) since graduating from the University of South Florida’s master’s program in 2007. As just the second CNL in my VA facility, forging a new path on a cardiac/post-cardiothoracic/medical-surgical unit was an exciting and daunting challenge. It helped me discover that becoming a CNL prepared me for an amazing role, and VA provided me with an ideal environment to “practice to the full extent” of my “education and training,” as supported by The IOM’s *Report on the Future of Nursing* (IOM, 2011, p. 85).

With the ever-increasing requirement for more complex and higher quality nursing, the CNL is particularly equipped with the education and skills required to make positive changes in every healthcare setting and at every level: in the microsystem, facility, system and profession. I believe that CNLs are empowered to “expand opportunities for nurses to lead and diffuse collaborative improvement efforts” (IOM, 2011, p. 279). I would add that we are also empowered to exercise our imaginations and natural curiosity: the sky’s the limit to what can be accomplished for the good of the patient.

I was fortunate to have a dynamic chief of acute care who was an early believer in the CNL role. She not only encouraged me, and others, to pursue the role but also shared her leadership knowledge as a guest instructor at the university. She believed that the CNL program prepared us for the important role of change agent. She assigned me to my unit with instructions to spread the Transforming Care at the Bedside (TCAB) model for performance improvement and work to reduce readmissions of heart failure (HF) patients. This was a formidable assignment, especially when some staff members were initially suspicious of my true purpose on the unit. Thanks to the data collection training in our program, I was able to help the staff celebrate their success with a recent process they had undertaken. The process they developed improved their post-operative coronary artery bypass grafting (CABG) patients’ outcomes, but they didn’t know it. By locating and amassing their pre- and post-intervention data, I was able to demonstrate to the nurses that they had dramatically reduced their urinary tract infections (UTIs), sternal wound infections and incidents of nosocomial pneumonia. This helped them accept me as a positive presence and made it possible for us to focus on our next challenges.

The high rate of heart failure readmissions was a problem throughout our facility. My supervisor decided that it would be my job to assemble an interdisciplinary team to tackle this problem. After the initial shock wore off, I sought the guidance of our primary professor at the university, Dan O’Neal. Dan was our evidence based practice specialist and knew many colleagues in our hospital. Together we made a list of the
Important stakeholders and content experts to include in the project and sent out invitations with an outline of our goals for the group.

The group was composed of the following stakeholders: three physicians; an expert in systems redesign/research; a data collector; the outpatient congestive heart failure (CHF) nurse practitioner (thus collaborating for the first time with in-patient/out-patient personnel); the cardiac rehabilitation physical therapist; two pharmacists; a CNL colleague, Lorraine Kaack; the patient and family education specialist; a care coordination home telehealth (CCHT) RN who was new in the hospital; an acute care nurse; and a coding specialist. Others were added as time revealed that we needed their expertise. This group met every month for six months, with everyone contributing their knowledge and experience. Through collaboration from all these professionals, we were able to identify and implement many important changes for the benefit of our heart failure patients.

The changes we were able to implement included: 1) new physician orders to simplify and standardize provider care for the HF patient; 2) an in-patient nursing algorithm of care (pathway); 3) a colorful magnet that patients could put on their refrigerators that indicated how they could recognize changes in their conditions and when to call a doctor or ambulance; 4) an HF-specific notebook with simple self-care sheets, e.g., dietary and fluid intake; and 5) post-discharge phone calls to patients to ensure they received and were taking all their medications as well as providing an opportunity for us to reinforce hospital coaching.

The first significant outcome from this project was a reduction in our readmissions from 15% to 7%. Our relative success in improving our patients’ knowledge and self-care took on a life of its own. From this first project we were able to initiate a funded research project to further improve patient self-care, followed by four poster presentations of our project and its outcomes in various venues across the country. We also created a webinar to share our project and outcomes with others. So as a CNL, I became a facilitator, co-investigator, specialized educator, public presenter, and advocate for the heart failure patient. Wow!

Another opportunity in this amazing role was the formation of the James A. Haley Clinical Nurse Leader Forum, the very first in the VA. We had already been meeting monthly as colleagues to discuss our challenges and share ideas. Our acute care chief suggested that we give credibility to the group by developing a mission statement and setting goals. We put their heads together and composed the documents stating our mission and goals, which we presented to our hospital’s coordinating council and were approved. The coordinating council is an official component within
the Magnet® shared governance structure which serves as advisory body
to all councils and has the authority to approve policy decisions that affect
nursing services. With our official status also came the privilege of having
a vote on that council. As the first chairperson, with Lorraine Kaack as co-
chairperson, we really felt the possibilities were limitless for our group.

The forum was notably successful in changing the hospital practice
of physician-ordered PRN insulin to scheduled insulin for our diabetic
patients. Incidents of omitted insulin administration improved and we
achieved 97% compliance, exceeding our outcomes expectations. The
Forum was invited to share our successes and formation experience at the
annual Clinical Nurse Leader summit in 2012 in a panel presentation.

When asked to describe what a Clinical Nurse Leader is or does,
where do I start? Our training truly places us in a unique position to fill
many shoes for many people in many healthcare venues. We search for
evidence, we facilitate, we grow our colleagues through lateral education,
we motivate, educate, exemplify, search out answers and all with the
added benefit of learning new knowledge and skills on a daily basis.

REFERENCE

Chapter 5.3

VA CNL Leadership – Journey from Novice to Expert

Lorraine R. Kaack
In this chapter I want to share my personal journey as a Clinical Nurse Leader (CNL) from a novice to an expert. The time from first becoming a CNL to where I am today has been one of a never-ending learning process. I began my CNL career at the James A Haley VA, Tampa, FL (JAHVA). Prior to that I had been a VA RN on the medical surgical/oncology unit at the Bay Pines VA Healthcare System (Florida). I was hired directly from the CNL program as a Clinical Care Leader/Patient Care Facilitator (CNL/PCF) on the JAHVA spinal cord injured/ventilator dependent long term care (LTC) facility. Recently, I transferred back to the Bay Pines VA healthcare system, inpatient psychiatric acute “recovery” care and mental health services in the role of a Clinical Nurse Leader. I want to share some of the highlighted successes I have experienced during my CNL role at both facilities.

As a CNL/PCF at JAHVA, I had the pleasure of not only working with the nurse manager but also with the spinal cord injured (SCI) LTC medical director as a core member of his treatment care team. I also worked with the medical director in the role of clinical research coordinator/project manager on various research projects. As a CNL, I was able to make significant professional, academic and research strides and contributions to the SCI field and shared some of these successes at the American Spinal Cord Injured Professional (ASCIP) annual conference through three poster presentations, sharing topics on SCI personal pass in the community; phimosis and the SCI individual; communication technology for the amyotrophic lateral sclerosis (ALS) individual and through a panel presentation discussing one of our SCI Personal Pass research projects.

Our Office of Patient-centered Care and Cultural Transformation opened its doors on January 17, 2011 and focused on creating custom, patient-centered models of care. That focus is derived from VA's patient-centered approach to health care. Pursuant to the VA mandate for cultural transformation, I was invited to assume the role of project manager on the sci medical director's research team for a project designed to identify concerns about and improve communication between residents and their families. This project resulted in improved quality of life for our Veterans and in making the long term care (LTC) more home-like. The Veteran population served includes those who have spinal cord injuries (paraplegics and tetraplegics), are ventilator dependent, or have either ALS or multiple scleroses (MS). Our work, championed by the SCI medical director, led to receiving a national VA Innovation grant to design and implement an augmented communication network (ACN) and brain wave clinical study for the LTC center, with augmented communication stations (ACS) tailored to the disability of the resident, especially with our amyotrophic lateral...
sclerosis residents. Rather than using the manual Alpha Board, which can be painstakingly slow and often stressful for the person with ALS, they would now have the ability to increase their communication using these trialed communication stations. Each device would be specific to the level of progression of each ALS resident. One of the communication devices tracked the eye’s movement with a laser, whereas for those more progressed the communication device tracked the blinking of the eyelid, or the lateral movement of the eye. And for those who no longer had the ability to move or blink an optical scanner communication device was utilized.

As a CNL, my leadership skills were instrumental in teaching our nursing staff skills related to the latest evidence. My goal was to enhance their clinical practice and share knowledge that would expand the quality of life for our SCI fragile population. We identified that the "personal pass program" did not promote spontaneity. For example, if our SCI resident wished to spontaneously take his wife out for dinner, this would not have been possible without several days of advance planning. This resulted in missed opportunities for the resident to participate in community activities or go home for a visit or even a spontaneous dinner with a loved one. One of the goals of patient-centered care is to afford LTC residents the opportunity for more independence over their leisure activities. An alternative option was needed that would safeguard the Veteran while off the hospital grounds on a medically approved personal pass.

As a CNL, I formed and led an interdisciplinary group to perform a healthcare failure mode and environment assessment (HFMEA). The Department of Veterans Affairs National Center for Patient Safety (NCPS) supports and leads the safety activities for all the VA medical centers. Since 1999, NCPS has developed tools, training, and software to facilitate patient safety and root cause analysis investigations. We conducted a proactive risk assessment using our developed model of the HFMEA in order to identify safe methods that would offer the SCI LTC resident greater access to the community. We realized that we needed to design and implement an improved personal pass process. One barrier that we identified was the need for “personal caregivers” that could be called within four hours to accompany a resident on a personal pass. To do this safely, we needed to develop caregiver competencies, providing the appropriate education and training that would prepare them to safely accompany these individual when on personal pass.

We conducted a quantitative study that included an examination of the various aspects of the personal pass program as it related to residents with spinal cord injuries/disorder and those who were ventilator
dependent. Today, the "personal pass/personal paid caregiver" option affords spinal cord injury Veterans the ability to expand their social environment outside of the confines of the JAHVH facility. A new personal pass process was implemented that included new safe methods such as caregivers, safe driving instruction, competency education, and offering annual review caregiver training. This process has helped empower our Veterans to seek a more contextual aspect to their lives through community involvement and has aided in creating a more home-like environment.

This initiative will also provide comprehensive new benchmarking data that will inform our health care practices and also create opportunities for adoption in our Community Living Centers. Our team's achievement resulted in a best practice change and an adaption of a Japanese business model of care to complement the VA's cultural transformation care model. Soon after our initial work, I assumed the role of principle investigator. Our group submitted a proposal to our research institutional review board (IRB) and was recognized for our instrumental work with the prestigious national Office of Nursing Services (ONS) innovation award of $10,000 for the theme "achieving patient-driven care through highly functioning teams".

In keeping with professional growth, the James A Haley VA, a Magnet facility, has experienced a strengthened professional model of care with the implementation of the CNL role. My colleague Frances Zarella and I combined our talent to bring a suggestion to the associate director, patient care, and the director of nursing professional development. We described a pathway to achieving higher rates of nursing certification among our nurses. We became the key drivers of the CNL led certification campaign and developed a REVIEW certification program. Our group consisted of four CNLs. We assigned each to a specific area of practice, and they then facilitated review courses for their assigned sections. In addition, plaques were developed for each unit that highlighted the names of the nurses who obtained certification. To promote licensed practical nurse (LPN) certification, we initiated an aggressive outreach, providing special classes and testing on site to improve the pass rate for this cohort.

However as with any major project, there are challenges that surface and need attention in order to achieve optimal outcomes. Prior to a planned weekend certification review course, Frances and I created and sent out a daily email blast (eBLASTS) to staff nurses with a minimum of 10 “test your knowledge” questions/answers along with rationales. The CNL group also promoted an online link so that no one was omitted from the opportunity to learn the material. These strategies built confidence, improved learning and enabled nurses to pass the certification exam. We
created and initiated what we titled “The Five 4 Five Campaign”, a CNL led contest. Awards would be given to the top five units who achieved the most new certifications during the contest’s five-month timeframe. The awards were sponsored by our shared governance advocacy council, awarding a first place prize of $500; a second place prize of $400; a third place prize of $300; a fourth place prize of $200; and a fifth place prize of $100 with a total of $1,500 in prize money awarded. This campaign reenergized both our nursing leadership and our staff nurses. We submitted an abstract for and were invited to the 2011 Magnet annual conference to provide a panel presentation about our shared journey, sharing with others how a “catchy” logo ignited our nursing staff to reach for higher certification and improved understanding of and care for the patients we serve.

After transferring back to the Bay Pines VA Healthcare System in June of 2012, my patient population changed from SCI to inpatient psychiatric acute care mental health services. This mental health service was already in the process of changing their model of care, now focusing on a recovery model of care. I was invited to join their recovery team. The team’s purpose was to encourage a partnership of care between the Veteran and their mental health providers that is based on a recovery model of care. In order to support the rehabilitation and recovery of every Veteran with a mental illness, VA has identified recovery as a guiding principle for its entire mental health service delivery system. Recovery is a journey that involves developing hope, self-direction, empowerment, respect and peer support. In our care approach, our Veteran is identified as the most important member of the treatment team. To achieve our goal the Veterans are encouraged to partner with us in identifying their treatment goals and recovery plan, becoming their own advocates through empowerment leading to more active involvement with their care.

As the “new CNL eyes on the floor” and after discussing with patients what is “missing” in their admission, I recommended a new process to implement new practices that meet the goal of the recovery model of care. The process includes a new “informational and discharge tracking tool” that will provide to our Veterans information about their day of admission, stay on the unit, and the day of discharge, and a resource information card and a map of facility with locations to help our admitted Veterans know more about our facility. In addition we include specific information about the patient’s diagnosis to make the recovery package more patient-centered. Finally, we created an “I” format discharge checklist for the actual day of discharge that walks our Veterans through the discharge process from the time the physician informs them of their
discharge and all the steps that must be completed before their final discharge instructions. Our goal is to provide our Veterans with a best practice change that will afford better understanding of what is ahead for them and will encourage them to become engaged in their mental health care. This meets our original goal to provide the best safest care possible by promoting a recovery driven environment of quality and safety thereby facilitating the achievement of the recovery model of care.

These experiences created my journey from novice to expert. Currently I am the CNL ambassador for the State of Florida. I was selected as one of 80 CNL subject matter experts (SME) nationally whose task was to review the current CNL curriculum, then travel to Washington DC, to participate in the American Association of Colleges of Nursing (AACN) initiative to update CNL educational standards. Our focus as expert panel members was to review the findings from the earlier SMEs, and making recommendations for changes to the CNL white paper and the Essential documents.

I recently joined the ONS CNL monthly planner workgroup that selects topics and speakers relevant to all CNLs for its monthly CNL national calls. Today, I am a core member and prominent in forming the VA ONS CNL transition /implementation group, developing a toolkit for new CNLs. And most recently, I was appointed to serve on the national marketing committee for the Commission on Nurse Certification (CNC) to create and inspire the promotion of the CNL role to key stakeholders, promote CNC brand image and national certification, and to evaluate their marketing plan.

The American Association of Colleges of Nursing (AACN) is the national voice for baccalaureate and graduate nursing education. The AACN has led the development of a series of Essentials documents that outline competency expectations for graduates of baccalaureate, master’s, and doctor of nursing practice (DNP) programs. AACN also has published quality indicators for research-focused doctoral programs, a white paper on the Clinical Nurse Leader, and guidelines defining the essential clinical resources for nursing education, research, and faculty practice. Additionally, I am a CNL exemplar reviewer and member of the group working with the schroeder measurement technology team, reviewing the CNL curriculum, CNL national certification examination and approval of the CNL national certification test bank questions. Our group consists of nursing university deans, hospital administrators, AACN members, and nurses from around the country.

These experiences validated for me the expertise I had acquired through my work as a VA CNL. Indeed, the move from novice CNL to expert has been a journey making it possible for me to reach my own potential to make a difference for our Veterans and in the care they receive.
Chapter 5.4

AIM Collaborative: Clinical Nurse Leaders and Clinical Nurse Managers Working Together

Kimberly Kirkpatrick, Michelle Rhoney, Jamie Connelly and Alice Avolio
The AIM collaborative was an opportunity for Clinical Nurse Leaders (CNLs) and nurse managers (NMs) to be introduced to a systematic framework for performance improvement. We were the CNLs and NMs asked to represent the Portland VA Medical Center (PVAMC) and attend the AIM collaborative for our VA regional network. Using a structured teaching approach, the CNL/NM pairs worked collaboratively to develop system redesign skills. We identified a problem, explored change management tools and techniques, and tested possible solutions. The AIM collaborative provided us with a structure of support and guidance as we moved through the steps of process improvement. The program also strengthened our CNL/NM partnership.

The AIM collaborative began with a two day, in-person conference. Because system redesign in the Department of Veterans Affairs (VA) is centered on the structured vision-analysis-team-aim-map-measure-change-sustain (VA-TAMMCS) framework, a considerable amount of time was spent discussing this roadmap. Detailed information was provided on each of the steps. This discussion also focused on the role leadership played in creating a culture of continuous improvement.

At this point, we divided into facility workgroups. Our PVAMC workgroup consisted of two CNLs and two NMs. The initial group exercise was an exploration of the vision and analysis section, the first part of the VA-TAMMCS framework. Our discussion of the vision identified the values that drive the care we deliver. What is it that our Veterans want and need from us? We also discussed the role of leadership in communicating the vision and values to staff.

Each facility developed a description of their “true north”; their mission for patient care. Our PVAMC workgroup brainstormed using sticky notes and incorporated input from all four of us. Brainstorming resulted in increased communication and dialogue among members of our group. Although achieving the goal of providing the most efficient and effective care to Veterans resonated with us, in the end the words of President Lincoln—“keeping the promise to care for those who have borne the battle” was chosen as our true north vision. We all contributed to the final true north statement and agreed it was most reflective of our combined values. True north statements were then presented by each facility.

Throughout the analysis section all workgroups identified their key focus areas. Each group used brainstorming to identify possible issues where system redesign could be successful. The number one goal during the brainstorming sessions was to generate as many ideas as possible in
the allotted time. The teams were clear that an evaluation of the ideas would come later and the objective was to think outside the box.

Our workgroup generated numerous performance improvement ideas, although not all of them were suited to a system redesign approach or feasible to complete within the time frame of the class. Given the different focus of our two roles (CNL versus NM) the problem list was comprehensive and included the perspective of each role. We engaged in a rich dialogue where pros and cons were explored. This process was effective in increasing our engagement and strengthening our identity as a CNL/NM team.

We collectively prioritized the problem list to identify the most important process to improve. We decided to address the process of ordering home oxygen ($O_2$) for patients discharging to a home or homelike environment. The home $O_2$ process was considered broken and frustrating to every discipline involved. The need for home oxygen inevitably caused delayed discharges, which resulted in the inability to admit new patients to the medical-surgical units. Because of the increased length of stay, there were additional financial costs. The ordering was complicated because determining correct home $O_2$ prescriptions was rarely finalized prior to the day of discharge.

In the third step in the VA-TAMMCS process (Team), we identified our project team. We discussed other key individuals who should participate. We gave diversity of team members a high priority to make our team stronger, since different disciplines have various skills and perspectives and can contribute in creative ways. In other words, we did not want only nurses as team members. Since our project team would work and interact closely with the home oxygen committee (a hospital process management team) we determined that we needed a member to be part of our project work team. We identified one of the CNLs to be the process owner of the change process. This CNL had credibility and expertise and was a member of the home oxygen committee. The chair of the home oxygen committee was identified as the process owner of the final product as oversight of the order menu is the responsibility of this committee. A major strength of our team was everyone’s commitment and dedication to fixing the process.

The structure of the AIM collaborative continued for 12 weeks and included weekly web-based modules with homework, as well as weekly, hour long web-based interactive learning sessions. All facilities participated in the web-based interactive learning sessions led by AIM collaborative instructors who emphasized hands-on demonstrations of the system redesign tools presented in the weekly curriculum. One strategy we employed at PVAMC was to book a classroom twice a
week, which allowed us to complete the self-learning modules and homework as a group and participate together in the web-based interactive education. Participating as a group improved our learning and enhanced our experience. According to Spitzer (2007) analysis of data is a social process. By emphasizing this social aspect, we discovered our understanding of the data was deeper and more meaningful.

The first project task of our group was to develop our aim statement. We used the SMART tool to ensure that our aim statement was: specific, measurable, attainable, realistic and time bound. This step was one of our most challenging and ended up requiring numerous iterations.

The next step was to create a process flow map of the current state. With a pile of sticky notes we clarified the start, end, and all the in-between steps of the home O₂ process. We also identified who was involved at each step. One of the best decisions we made was presenting our flow map to the larger home oxygen committee with key individuals and asked them to review our flow-mapped process. They clarified steps in the process, identified additional steps and the flow map was revised accordingly. The final flow map was the result of five separate meetings, each with different stakeholders including social workers, unit clerks, home oxygen committee members, charge nurses, and our project team.

By creating a process flow map and fishbone diagram we identified three major issues we could target for change. The first issue was that the electronic/computer-based link providers used to request a home oxygen education brochure was broken. Without this link patient education was inconsistently offered as providers had to either find an alternative electronic pathway to the patient education handouts or omit providing patients with informational materials. A second problem was a very complicated step in which family members were asked to bring in an oxygen tank for the patient to use for transportation home. This step was frequently missed, causing the discharge to be delayed while staff secured alternate arrangements. A third problem causing confusion was that providers could use two different electronic pathways to order home oxygen.

Our workgroup used the plan, do, study, act (PDSA) cycle to implement our performance improvement changes (Langley et al., 2009). During the Plan phase, we made numerous changes to correct the broken process. First, we reviewed and updated the home oxygen education brochure with the patient education committee and collaborated with information technology (IT) services to ensure the ordering link for the educational brochure was functional. Second, to help avoid delays in the discharge process, we decided every home O₂ patient would
be discharged with a vendor tank instead of asking family members to bring in a tank. Lastly, we updated the provider menu to ensure there was only one pathway for ordering home oxygen therapy.

We identified all stakeholders so we could communicate information about the upcoming changes. Information specific to each stakeholder group was identified and communicated. Stakeholder groups included unit clerks, the prosthetics department, the home oxygen committee, social workers, nurses, and all providers who order home oxygen. This improvement process was successfully accomplished and no barriers were identified, in part, because of the work done prior to implementation.

The AIM Collaborative introduced us to the VA-TAMMCS framework and provided us with valuable tools and skills to use when implementing process improvement. We discovered that meeting together as a group to complete modules and work assignments improved our learning, enhanced our experience and were key to our success. This group approach was more productive than working individually. The collaboration and relationship between the CNL/NM team was strengthened and improved by sharing the perspectives and focus of each role. A valuable lesson learned was the importance of identifying key members of the interdisciplinary team early in the process, which helped ensure a successful outcome. We plan to use the VA-TAMMCS framework to guide future process improvement activities.

REFERENCES


Chapter 5.5

CNL Partnership for Improvement: Rapid Recovery Ambulation Program

LaDonna Adkins and Rosa Colon
Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

While rounding with the surgeons on our 28 bed medical-surgical unit, I, LaDonna, received some rather dissatisfied feedback from the surgeons: our post-operative patients were not being adequately ambulated. I also observed during rounds on these same patients, the “no” responses of Veterans when asked by the surgeons if they had been out of bed. This “woke me up” one morning during our 6 am rounds, which incidentally, I had been making with the general surgical residents since I became a Clinical Nurse Leader (CNL) on this unit in April of 2009. I immediately knew that, as a CNL, I had to further assess my microsystem, an acute care inpatient setting with post-operative patients as the main focus. This became the impetus for the initiation of our rapid recovery ambulation program.

I enlisted the assistance of my unit’s assistant nurse manager (ANM), Rosa. Together, we developed a data retrieval tool and completed an initial retroactive chart review of 46 patient records. We were a little shocked by our findings and it became very clear that we would benefit from a process improvement. Fortunately, Rosa was beginning a Six Sigma green belt program and we were able to utilize these tools to review and improve our ambulation process. Soon after the initiation of this project, I, LaDonna attended the VA CNL academy for improvement of Microsystems (AIM) and became much more familiar with the Six Sigma concepts that we had been using and continued to utilize throughout the project. Together, we now had shared tools for our initiative.

A review of the patient care evidence supported early and frequent ambulation/mobilization in post-operative patients in order to prevent venous thromboembolism and reduce the risk of developing post-operative pneumonia. So, we began recruiting a team of staff nurses from our medical-surgical unit and enlisting their feedback and participation. We outlined the ambulation process from the surgeon’s order entry to the documentation of the ambulation. We mapped this out on a white board and identified 39 barriers that could impede or interrupt the activity/ambulation process. The team then focused on the barriers that we could address including non-specific orders, knowledge deficits, equipment needs, staffing, and inconsistent documentation.

Together we identified objectives for our process improvement effort. The objectives were: (1) to have appropriate and specific activity/ambulation orders on 100% of our post-operative patients, and (2) to have nursing documentation of activity/ambulation on 100% of eligible post-operative patients. We also wanted to decrease post-operative length of stay by 10% within 6 months. With these goals in mind, we organized meetings and engaged additional team members to assist with our mission. We
collaborated with the physical therapy department, multiple surgeons, the
nurse manager, the associate chief nurse (ACNS) of acute and critical care,
and facilities maintenance personnel to enlist their support and assistance.
These key stakeholders were very valuable as we moved the project forward.

We developed a data extraction tool for a chart review of documented
activity orders and had five staff RN’s use the tool to determine effectiveness.
With this tool, we defined appropriate activity/ambulation orders as
those that were very specific. Examples of this would be: ambulate twice
a day (ambulate BID), ambulate three times a day (ambulate TID), or
out of bed twice a day (OOB BID). We also defined orders that were not
appropriate because they lacked specificity. Examples included “ad lib”
or “as tolerated” as part of the order. We felt these orders did not guide
staff to proactively get the patient mobile. We communicated with the
surgeons to let them know that we needed specific and appropriate
orders that clearly communicated the surgeon’s goal for the patient.

We had learned that Veterans were frequently not ambulated because
staff reported that they were unable to locate the necessary equipment. We
obtained additional walkers that were donated from the hospice unit and
placed orange markers on these walkers so they could be located quickly
and easily, saving time in the patient ambulation process. We also felt
that the orange would be an indicator to staff that this equipment should
not be carried off our unit or accidentally sent home with the patient. In
addition, we obtained and issued gait belts to our nursing assistants after
they were trained on the proper use of these belts to assist in ambulation.

We partnered with the nurse manager to work on the reported issue
of “not enough staff” and “not enough time” to ambulate the patient.
Collaboratively, we decided to expand the role of the nursing assistants
on our floor. We engaged the physical therapy department and they
agreed to provide our nursing assistants with training of proper and
safe transfer and ambulation for Veterans’ post-operative recovery.
The nursing assistants were taught how to use the gait belts, walkers,
crutches, and canes for safe ambulation. They were also taught other
precautions related to specific surgeries, including total knee and hip
replacements. The nursing assistant role evolved to that of champion for
the rapid recovery ambulation program. We also decided to use a train
the trainer model so that our nursing assistants would be prepared to
train any future nursing assistants added to our staff during orientation.

To address our documentation goal, we developed a computerized
nursing documentation template that is quick and easy to fill out and
specifies what activity the Veteran performed, what equipment was needed,
any assistance needed, distance ambulated, and how the Veteran tolerated it. LaDonna presented the template at the nursing template review committee and it was approved. We trained the staff on the new documentation as well as on the importance and benefits of early mobilization for our post-operative patients. The template was then implemented.

Once we had all of these changes in place, we initiated a pilot of the rapid recovery ambulation program. At this point, the only change that we did not have in place was some type of floor, ceiling, or wall marking that staff could utilize for distance measurement. This was one of our biggest challenges. Initially, we had difficulty identifying an approved method of measuring distance. While we considered many different options, many of them were dismissed due to facility safety regulations. At this point we involved the ACNS of acute and critical care in a meeting with facility maintenance personnel. We collaborated and came up with changing the floor tiles to have a diamond shape every 25 feet on every hall. These tiles were installed and implemented after staff education. This aided in documentation that would demonstrate patient progress in and tolerance of the ambulation activity.

We conducted a two-month pilot of the rapid recovery ambulation program. We completed chart audits during this time on 100% of the post-operative patients. Prior to the rapid recovery ambulation program, we were unable to determine how many post-operative patients were in fact ambulated due to missing/inconsistent documentation. During the pilot, 80% of the eligible patients had documentation within 24 hours of surgery. Our initial retrospective chart review showed physicians had written appropriate/specific ambulation orders on less than 10% of the patients. During the pilot, this improved: physicians wrote specific orders on 70% of the patients. Our median length of stay decreased from a three day cycle prior to implementation to a two day cycle during the pilot.

Since the implementation of the rapid recovery ambulation program, ambulation equipment is readily available on our unit. It is much easier for the staff to locate the shared walkers. They are not confused with the patient’s personal walkers, and staff cooperate to ensure that equipment does not leave the unit. Our nursing assistants take pride in being the champions of ambulation. They are very engaged on our unit and are excellent team members who also provide ambulation assistance and advice to co-workers. We work to ensure that nursing assistants are scheduled to benefit the Veterans’ post-operative ambulation needs. Documentation is much more consistent and easy to locate in the charts. Our unit has received positive feedback from the
surgeons about the ambulation program and patients are answering, “yes” on morning rounds when asked if they have been out of bed.

In conclusion, the Veterans in this microsystem benefited a great deal when the nurses, especially the CNL and ANM partnered together and utilized the Six Sigma training provided by the facility. By working together and practicing to the full extent of their education and training, the nurses led the development and implementation of the rapid recovery ambulation program on this 28-bed medical-surgical unit. This collaborative effort improved evidence based care in this microsystem and was also later implemented in the intensive care units. The program is currently being considered for implementation on the telemetry floor.
Chapter 5.6

The CNL: A Lean Practitioner

Jamie Gilliam
Integrating the Clinical Nurse Leader (CNL) role into the Department of Veterans Affairs (VA) system and other healthcare systems is constantly evolving. The ambiguity of this role challenges CNLs to practice to the full extent of their education and training to improve care processes within their microsystems of care. “A microsystem in health care delivery can be defined as a small group of front-line people who work together on a regular basis to provide care. Microsystems are the places where patients, families and care teams meet” (The Dartmouth Institute, 2013).

The CNL role is beneficial in assisting many disciplines and services to improve patient safety and processes leading to improved quality of care. The CNL is a high functioning leader at the microsystem level. The CNL impacts care and outcomes. Healthcare is benefiting from the expert leadership skills and professional values demonstrated by this provider (Harris & Roussel, 2010).

CNLs facilitate process improvements at the microsystem level utilizing education and skills gained in graduate programs or in other formal training. CNLs collaborate with patients and care team members to improve patient outcomes such as quality, safety, and satisfaction, while focusing on performance improvement (PI) and quality assurance measures. Improving quality and efficiency while controlling costs is an imperative goal of health care systems today (Toussaint & Berry, 2013).

Other industries have been frontrunners in demonstrating the ability to produce products in a safe, efficient, and cost-effective manner. Over the last century, the technique of building motor vehicles to meet the needs of the consumer has advanced into a culture of “Lean” thinking. The Toyota motor company shaped the basic assembly-line principles deployed by Henry Ford into their own Lean methodologies, to become the largest automaker in the world in terms of overall sales. Unlike many other manufacturers, Toyota looks at the flow of the products through the total process to obtain low cost, high variety, high quality and very rapid throughput times (Lean Enterprise Institute Inc., 2009).

More recently, VA, along with many other institutions, has adopted Lean principles and adapted them to their approach to systems redesign (SR) and PI. Womack and Jones (2003) described this adaptation within the health care environment as one where the organization makes a commitment to applying scientifically grounded designs, performances and improvements so patients and other stakeholders achieve measurably better value in health care services. Lean is considered a journey and not a destination.
Lean is a cultural transformation that changes how an organization works. We must improve our daily work with new habits, skills, and often a new attitude (Toussaint & Berry, 2013). Our goal in Lean is to eliminate waste and non-value added steps to improve the efficiency and flow of processes. It shortens the time between start to finish of any given process by eliminating steps that are not valued by the end-user or customer. Overall, these techniques can greatly improve the efficiency and effectiveness of care delivered to our patients.

The biggest challenge for healthcare systems is continuing to meet increased workload with limited resources. Evaluation and standardization of healthcare processes has come and gone, but we continue to struggle to perfect our systems in order to provide the most safe and cost-effective care available. We need to be as efficient as possible, while ensuring that the highest quality of care is provided to our patients.

“Lean, in a sense, turns leadership upside down, with front-line workers doing much of the innovating and managers supporting and trusting them to do it” (Toussaint & Berry, 2013, p. 79). These workers are those who “touch” the process. These members should make up a Lean event team and change the process that they are directly involved in carrying out. Mutual respect between leadership and workers must be incessant.

Lean principles have a high correlation with the standards and education upheld by the CNL. Graduate programs prepare CNLs with the knowledge and ability to evaluate step-by-step processes using a range of tools including process mapping, Ishikawa or cause and effect diagrams, spaghetti diagrams, time observations, check lists, and many other tools in their repertoire. Lean training contains a very similar curriculum.

As a CNL, I noted the similarities between the CNL role and a Lean practitioner after attending a Lean training session. The underlying goal of Lean is to improve value for the patient or customer. My CNL program furnished me with a basic foundation for Lean thinking. As a CNL, my overarching goal is to improve value for my customers. Registered nurses (RNs) completing graduate level CNL education programs and becoming leaders within their microsystems are in many ways synonymous to Lean practitioners trained to function as facilitators in a Lean event.

My first Lean event involved evaluating preoperative processes in an attempt to decrease unnecessary preoperative hospital admissions. Most hospitals employ a team or department responsible for evaluating resource utilization such as length of stay, admission/discharge criteria, and cost. Our hospital’s utilization management (UM) team evaluates each admission to determine whether criteria
are met and a continued stay is warranted. Aggregate reports of this information are reviewed by a larger interdisciplinary committee on a monthly basis. Some surgical services were noted to have an increase in unwarranted preoperative admissions leading to a lack of available beds for necessary admissions. This also increased costs. The committee and our executive leadership team recommended that a Lean team investigate preoperative processes, and I was asked to lead this event.

I gathered and analyzed the preliminary data, interviewed the key stakeholders and process owners who were front-line workers and performed a "voice of the customer" interview to understand the patients’ perspective. Next, I developed a working charter to ensure strategic alignment with priorities of my facility. I reviewed financial implications and determined the cost of inappropriate admissions and increased length of stay (LOS). Finally, I formed a team and invited all of those who "touch the process" to a Lean event.

I attended to meeting logistics such as a room reservation, agenda and visual aide preparations. Full support from the organization's leadership team was a vital aspect of this entire process. I sent letters to all supervisors asking for their facilitation in team members' attendance at the Lean event, which was described as a one-time event lasting longer than a typical meeting. Questions and concerns were directed toward the team leader or owner who was a member of our facility's executive leadership team. Pre-work was assigned to all members and a time and goal specific agenda was distributed to the team.

In December 2012, I led this multidisciplinary team for an entire afternoon of Lean work to increase efficiency and effectiveness of preoperative services. We were all dedicated to removing waste and streamlining the processes and steps involved with all areas within the scope of this event. The team included pre-anesthesia clinic (PAC) nurses, UM employees, anesthesiologists, surgical service providers, our chief nurse of surgery, a Veteran patient, and operating room staff. I provided an overview of the basic principles and goals of Lean and described the meaning of removing waste and why our facility is now using Lean methodologies in our redesign process. I was able to utilize the skills learned in my CNL program and Lean training to assist in the steps of team building, facilitation, and process mapping.

Our team built a case to decrease the number of preoperative admissions that do not meet admission standardized criteria. We decided that an efficient streamlined process would: 1) decrease costs, 2) improve access for patients who meet admission criteria, and 3) improve patient
and staff satisfaction. I then led the team in a process known as value stream analysis (VSA) by clearly defining every step of the process. VSA is a very detailed map of each step in the current process. Short-cuts and work-arounds must be included in the process map. We used an interactive, hands-on approach where all team members entered comments and used sticky notes and arrows to create the most accurate depiction of the current state. “Clearly understanding the current state is essential to improving it and creating a detailed depiction of the process facilitates understanding” (Toussaint & Berry, 2013, p. 77).

Next, we went through each step to determine if it added value to our customer, the Veteran. The step was marked with a green dot if it was considered value added. This step must transform or shape material or information. The customer must be willing to pay for this step. And, finally, the step must be done right the first time to be deemed value added. Non-value added but necessary steps were those that were determined to have no value added, but could not be eliminated based on current regulations, policies or protocols, technology, and/or legal aspects. These steps were marked yellow. The last category was our non-value added steps that consumed resources and created no value in the eyes of the customer or patient. These steps were marked red and would be eliminated completely in our future state process map (Lean/Six Sigma Training, September 25, 2012).

We removed all non-value added steps and created a ‘future state’ map. The team discussed ways of streamlining the process and decreasing the total throughput time for the customer. The team uncovered many multifaceted process delays or ‘wastes’ and decided to develop a list of recommendations to report back to hospital leadership. This list included evaluating and/or developing the following:

1. a standardized process for documenting the need for surgery;
2. an education and communication plan for the dissemination of admission criteria to all providers;
3. a standardized process for administrating intravenous (IV) antibiotics preoperatively while the patient remained an outpatient;
4. retention and recruitment of providers in certain specialty clinics;
5. clinic space or a flexible area for providers to reserve;
6. improved and increased transportation to and from the facility for Veterans;
7. alternative off-site locations for Veterans to stay while preoperative outpatient procedures/tests are performed;
8. improved processes for scheduling and obtaining timely preoperative screening/tests as an outpatient; and
9. a prospective review and denial of inappropriate admissions rather than our current retrospective review.

The Lean event team members were not front-line workers on any of the forwarded recommendations for process changes. The recommendations were then assigned to other Lean practitioners for further review. As a “quick hit” Lean solution, admission inclusion and exclusion criteria were given to all providers to increase the knowledge of those process owners. Another positive result of the event was the feedback from the team regarding feelings of effective teamwork and facilitation. The entire team remained constructive towards a common goal of determining bottlenecks and process improvement recommendations to add value to our customers. Lean principles and ideals were determined to be imperative to improving the care that we deliver.

Donald Berwick, MD, the founder of the Institute for Healthcare Improvement noted, that we have a moral duty “to rescue American healthcare the only way it can be rescued – by improving it” (2011, p. 12). We are only beginning the integration of Lean concepts and ideals into VA and other health care systems. The CNL is the perfect healthcare professional to help lead this movement of evaluating, improving, and implementing Lean care. Working microsystem by microsystem towards a culture that ensures effective and efficient care for our customers is our primary goal. One of the many advantageous qualities of this role is the CNL’s ability to practice within the full scope of their education to improve patient care outcomes. The parallel between the CNL role and a Lean practitioner only further displays the significance and value of the CNL in health care systems today.

REFERENCES


Expanding the Primary Care RN Care Manager and RN Case Manager Roles in VA Care Program

Storm Morgan, Donna C. Vogel, Patricia Hryzak Lind, Joanne M. Shear, Amy Smith, Jeannette Richardson and Michael Bethel
The Office of Nursing Services (ONS) at the Veterans Health Administration (VHA) is committed to promoting a nursing work force that not only keeps pace, but also anticipates and responds to dynamic health care industry needs. This philosophy is aligned with the Institute Of Medicine’s (IOM) *Future of Nursing: Leading Change, Advancing Health* report that calls for increasing the number of nurses with baccalaureate degrees to 80% by 2020 (IOM, 2010, p. S10). As authors of this chapter, we represent nurse leaders at various levels of the VHA organization who drive change to move nursing forward. One way we do this is through the design, implementation, integration, or oversight of nursing care delivery by the evolving and expanding roles of registered nurse (RN) care managers in primary care and RN case managers throughout the Veterans Affairs (VA) system. Storm Morgan is in national dual roles as the Patient Aligned Care Team (PACT) Program Manager and the Pressure Ulcer Prevention Coordinator and reports to ONS. Joanne Shear is the national Primary Care Clinical Program Manager for Primary Care Operations and Primary Care Policy. Amy Smith is in a regional role as the Deputy Chief Medical Officer for Veteran South Central VA Health Care Network/Veterans Integrated Service Network (VISN) 16. Patricia Hryzak Lind is in the local chief nurse executive role as the Associate Director for Patient Nursing Services at the VA Western New York Healthcare System located in Buffalo, New York. Donna Vogel is the local Director of Case Management and Telehealth at VA Connecticut Healthcare System. Jeannette Richardson is the local Acting Director of the Education Division at the Portland, Oregon VA Medical Center. And Michael Bethel is local Program Manager in Primary Care Services at the VA Central California Health Care System.

Throughout our nursing careers we have contributed individually to the nursing profession in many ways but we have also collaborated together over the last several years to strengthen the impact of nursing, especially related to care management and case management. We collectively identify nursing as being well positioned, as a full health care partner, to improve access to care, lower costs, and improve quality (IOM, 2010). Capitalizing on advances in nursing, and using a redesigned, team-based focus provides many opportunities to positively impact the nursing profession, but equally important is the impact to Veterans, and the VHA healthcare system at large. Increasing the number of VA nurses with earned Baccalaureate degrees was one of the key initiatives we have collectively pursued to achieve our desired outcomes.
Creating a BSN Prepared Nursing Workforce

Nursing research has provided evidence that educational preparation does make a difference in clinical practice and patient outcomes. Studies show that nurses with baccalaureate degrees (BSN) have improved patient outcomes such as lower mortality and failure-to-rescue rates. BSN prepared nurses are more proficient in their ability to make nursing diagnoses and evaluate nursing interventions and demonstrate improved professional integration and research/evaluation skills (AACN, n.d.; Aiken, Clarke, Cheung, Sloane & Silber, 2003; Giger & Davidhizar, 1990). Nurse certification is also associated with better patient outcomes. However, nurse researchers have demonstrated that “no effect of specialization was seen in the absence of BSN education” (Kendall-Gallagher, Aiken, Sloane & Cimiotti, 2011). Magnet hospitals, as exemplar patient care facilities, usually employ more BSN-prepared nurses (59% as compared to 34% at other hospitals), with research showing a strong relationship between organizational characteristics and patient outcomes (Kramer & Schmalenberg, 1988; Aiken et al, 2011).

VHA, our nation’s largest employer of RNs, has established the baccalaureate degree as the minimum preparation that our nurses must have for career ladder promotion beyond entry-level positions. In the past few years, VA has committed $50 million dollars to support our nursing colleagues working toward obtaining baccalaureate or higher nursing degrees. Through the use of scholarship funding, we have been able to increase the number of BSN prepared nurses. Promoting a creative “grow your own” approach, we have supported online education, on-site BSN educational programs, community partnerships to promote BSN education and other methods. Implementation of the VA RN residency programs has assisted us to successfully transition BSN prepared nurses into VA clinical practice (see Table 6.1).

Advances in science and increasing patient complexity have accelerated the need for nurses with the skill and knowledge to manage challenging and increasingly diverse health care environments and patient populations (Polansky, Cain & Zimmerman, 2013). Health systems and their resources, including nursing knowledge, must be transformed from the current focus on acute care to an emphasis on wellness and primary care. Our current health care and nursing education systems, focusing on acute and long term care, have not adequately prepared nurses to move into roles that build on nursing’s knowledge of encouraging wellness and championing prevention. Our future as a profession and as primary care nurses compels us to build our knowledge, skills, and expertise around proactive health
promotion and chronic health management while maintaining patients in their homes. VHA recognized the need for this transformation and created the Patient Aligned Care Team (PACT) model, the VA brand of the patient-centered medical home in primary care, to ensure the transition. The objective of the VHA PACT model is to improve patient satisfaction, clinical quality, safety and efficiencies by providing a highly functioning care team that is focused on partnering with the Veteran to manage his or her health, ensuring access to care using diverse methods and coordinating care among the Veterans’ health care providers. With this new model of care, VA health care is focusing on transformation that integrates with VHA’s overriding principles to be people-centric, results-oriented, and forward thinking.

### Table 6.1 Veterans Health Administration Education Level of Registered Nurses by Year

<table>
<thead>
<tr>
<th>Education Level</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Direct Care RNs with at least a Bachelor’s Degree</td>
<td>60.4%</td>
<td>61.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td>% of Direct Care RNs with Bachelors only (nursing or non nursing)</td>
<td>51.3%</td>
<td>52.4%</td>
<td>53.4%</td>
</tr>
<tr>
<td>% of Direct Care RNs with a Masters or a Doctorate (nursing or non-nursing)</td>
<td>9.1%</td>
<td>9.4%</td>
<td>9.8%</td>
</tr>
<tr>
<td>% of Direct Care RNs with a Doctorate (nursing or non nursing)</td>
<td>0.42%</td>
<td>0.40%</td>
<td>0.40%</td>
</tr>
</tbody>
</table>

Source is Veterans Health Administration Demographic & Financial Cube, 9/18/12; RN Education Level Trend; Education Level: Diploma; Associate Degree; Bachelors-nursing; Bachelors-non-nursing; Masters-nursing; Masters-non-nursing; Doctorate-nursing; Doctorate-non-nursing; Professional Degree; Employee Count; All Facility T & L; HR Occupation code 0610; All Time - FY2008, 2009, 2010, 2011, and 2012 through 17 Aug FY12.

Figure 6.1 provides a graphic depiction of this transition as we move from hospital based care to longitudinal, patient-driven care that is home based. The VA implementation of PACT has been designed around principles of team-based care which includes an RN Care Manager on each primary care team. The inclusion of this RN Care Manager role dramatically increased the number of RNs within primary care, capitalizing on RN expertise in the areas of leadership, patient-driven care, wellness, systems thinking and outcomes management: all key competencies of BSN educated nurses.
VA primary care nurses function as an integral part of an interdisciplinary team (referred to as a teamlet) and impact outcomes across many teams within the VA’s primary care services. We practice with other professionals who recognize and value the need for higher education and know that the RN should not be the least educated member of a health care team. Indeed, the VA has been able to demonstrate in a variety of venues exactly how essential BSN prepared nurses are to ensuring that we meet our mission in our care of Veterans.

### The Expanding Role of Primary Care RN Care Managers

The complexity of the change in nursing that increased emphasis on primary care patients within the VA system is vast. PACT RN Care Managers (RNCMs) are expected to use population-based databases to target groups and individual patients in need of interventions. BSN prepared nurses are educated in and skilled at determining how data should be used to identify these patients. BSN prepared nurses have more comprehensive educational experiences focused on evidence based practice, outcomes measurement.
and population management. It is an expectation within VHA that evidence based approaches will be used to improve the health of a cohort of patients or an individual. As the PACT teams plan and implement these interventions, a BSN prepared nurse is the nurse expert on that team to influence the choice and efficacy of the interventions. Use of quality improvement concepts and measurements is a required skill to measure tests of change at the patient, teamlet, or health care system level and assist with monitoring results at the clinical microsystem level. A microsystem in health care delivery can be defined as a small group of people who work together on a regular basis to provide care to discrete subpopulations including the patients (The Dartmouth Institute, 2013). Teamlets are even smaller units of care teams. The patient is at the center of the teamlet, partnering with key members of their primary care team to promote optimal health. The primary care clinic microsystem may be comprised of multiple teamlets.

As interventions are planned, the RNCM is expected to develop a plan of care that assists the Veteran across care settings within and outside the VA system. Experience and knowledge of systems theory is essential and used constantly in this aspect of the nurse’s practice. Research shows that as patients enter and exit health care sites, the opportunity for care coordination increases to mitigate potential errors. Interventions such as medication reconciliation, assuring patient understanding of medication and treatment plans before and after an inpatient admission, and navigating through our health care system for specialty care referrals require an expert nurse guide. One of the core expectations for BSN prepared nurses is that we participate in the development and implementation of imaginative and creative strategies to enable systems to change (AACN, 2008). The VA system’s ongoing development of the PACT model and RNCM role requires that imaginative and creative level of nursing expertise to create the evidence based strategies for our future.

The BSN prepared nurse practices from a holistic, caring framework. Building on one’s education and knowledge focusing on wellness, BSN educated nurses have increased experiences in community settings focusing on health promotion and self-care. As VA nursing has expanded in ambulatory settings, concepts such as motivational interviewing and developing a personal health plan, promoting optimal wellness, and focusing on prevention are paramount to our nursing practice.

The leadership qualities of BSN educated nurses include the ability to lead within a system that is constantly changing. The talent to use sound negotiation and collaboration principles is a critical part of the daily work life of a VA PACT RNCM. As a team member and a team
leader, the RN assesses the dynamics of the teamlet and its relation to a larger whole, whether that is other primary care teamlets, care services within the medical center, or the local community. Leadership skills and systems thinking are critical success markers for nurse leaders.

The BSN prepared nurse must embrace lifelong learning to support excellence in nursing practice. As the initial and ongoing education program for PACT was instituted within the VA system, we have used a variety of educational venues to promote ongoing self-development. Nurses and other professionals share best practices and critical information through webinars, conferences, journal clubs, and computer based educational programs. One of the remarkable strengths of our VA system is our willingness to share our knowledge across care sites. A single email will elicit helpful responses from willing colleagues who work at other VA medical centers, ready to offer their assistance and share their improvement methods and lessons learned. VA PACT nurses openly share “tools for their toolboxes” at PACT Collaborative meetings and through social media. That quest for knowledge and improvement coupled with validating improvement using quality improvement tools or research are hallmarks of a BSN prepared nurse.

Effective strategic planning is not isolated to identifying and promoting the right actions such as preparing a highly trained workforce. Optimal timing must also be a key consideration. This is one area where we have been highly effective as a nursing service to take advantage of potential opportunities identified by gaps in health care delivery, revised VHA goals, and political influences including recent health care reform discussions and policy changes. Over several years, we have made consistent improvements in patient safety, access, and coordination of care through case management and our recent additional efforts and resources aimed at strengthening care management in primary care. Many of these changes were our direct response to VHA and ONS-specific goals, especially related to patient-driven care, prevention and wellness, coordination of care, and the identification and management of high-risk patient populations. For us, all of these achievements have validated the importance of increasing our workforce of BSN educated nurses, a validation strengthened as we implemented the PACT model in VHA.

Nurses Help Create and Implement the VA PACT Model

In April 2009, VHA published the Universal Services Task Force Report (Department of Veterans Affairs, 2009) that defined a comprehensive set of health care services epitomized by patient-centeredness as the foundational
Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

U.S. Department of Veterans Affairs

172

element. This report recommended the adoption of a team-based model of care led by a personal health care provider who provides continuous and coordinated care throughout a patient's lifetime in order to maximize health outcomes. This concept was also being explored in the private sector ignited by the 2007 publication of the Joint Principles of the Patient-centered Medical Home (PCMH) developed by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Osteopathic Association (AOA). The VA PCMH later became known as the Patient Aligned Care Team (PACT), the VA's brand of the PCMH, defined as “a team of health care professionals which provides comprehensive primary care in partnership with the patient and the patient’s personal support person(s) and manages, and coordinates comprehensive health care services consistent with agreed upon goals of care” (VHA PACT Handbook, 2014, p. 4). One main difference between the VA definition and some other PCMH definitions is that the primary care provider may be comprised of a physician, nurse practitioner, or physician's assistant in the VA version rather than limiting that role to a physician (American College of Physicians, 2014).

The Joint Principles of patient-centered medical home (American Academy of Family Physicians et al., 2007) provided a helpful platform for VHA's medical home model development. In April 2010, VHA hosted a “State of the Art” conference convening VHA stakeholders, and private sector subject matter experts to share cutting edge innovations for PCMH. This meeting laid the foundation for VHA's version of the medical home model, and the development of a proposal for implementation of the medical home model in VHA. VHA's medical home principles were customized to reflect Veteran centered care perspectives promoting effective, efficient, comprehensive care through continuous communication and improved coordination of services throughout the health care system, summarized in the graphic presented in Figure 6.2.

Nurses were essential, engaged stakeholders during early VHA PCMH discussions and continue to be critical partners throughout the entire PCMH design and implementation processes. The Primary Care Clinical Program Manager for Primary Care Operations and Primary Care Policy, (Joanne Shear), is a nursing leader who was one of the original designers of the PCMH model in VHA. She continues to be a key architect and decision-maker in the ongoing design, implementation, evaluation, and spread of the initiative.

In August 2009, the VA Chief Nursing Officer, Cathy Rick, appointed the Deputy Director, Patient Care Services from the Portland, Oregon VA, Kathleen Chapman, to establish and lead the Professional Nursing Practice
Model Workgroup in an in-depth and comprehensive evaluation and nursing practice design effort in Primary Care. Two of the authors of this chapter, the ONS PACT Program Manager, Storm Morgan, previously a nurse leader at a medical center, who assisted the Deputy Director to lead the workgroup, and the Associate Director for Patient Nursing Services, Patricia Lind, were two of the 35 nurses from 22 VA medical centers, representing 13 VISNs, who participated in this early design. Participants included primary care RNCMs, nurse managers, nurse practitioners, a licensed practice nurse, a nursing assistant, a Clinical Nurse Leader (CNL), a telehealth nurse, and a home-based primary care (HBPC) nurse manager. Most of these nurses spent between one and two weeks working in Washington, DC on this seven week workgroup assignment. The shared governance approach we utilized aligns with the IOM Report that states, “nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States” (IOM, 2010, p.4).

We began by briefing each nurse on the background information including the PCMH principles and history, the Universal Services Task Force Report (Department of Veterans Affairs, 2009), the VA Secretary’s

---

**Figure 6.2 Veterans Health Administration Principles of the Patient Centered Medical Home (PCMH)**

<table>
<thead>
<tr>
<th>Patient-Driven:</th>
<th>Focuses on the person rather than the condition/disease.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team-Based:</td>
<td>Interdisciplinary team that includes Veteran, their primary care provider, RN care manager, clinical &amp; administrative staff as well as other clinical services as necessary.</td>
</tr>
<tr>
<td>Efficient:</td>
<td>Technology is used to support optimal patient care.</td>
</tr>
<tr>
<td>Comprehensive:</td>
<td>Care addresses all medical, behavioral, psychosocial, and functional status issues.</td>
</tr>
<tr>
<td>Continuous:</td>
<td>Focuses on one continuous team providing care for the Veteran over their lifetime.</td>
</tr>
<tr>
<td>Communication:</td>
<td>Honest, respectful, reliable, and culturally sensitive communication guided by the Veteran.</td>
</tr>
<tr>
<td>Coordination:</td>
<td>Coordination of care across all elements of the health care system.</td>
</tr>
</tbody>
</table>

*This model is used by the Veterans Health Administration to visually present the principles of the PCMH.*
Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

Transformation 21 initiative (Kizer & Dudley, 2009), the work already accomplished by the VHA Medical Home Task Force (VHA Office of Patient Care Services, 2009), and other healing environments and patient-driven care philosophies such as Planetree (Robert Graham Center: Planetree, 2007; VA Healthcare Network Upstate New York, 2008). We worked with VA Library Services to obtain the available, related literature and reviewed it to identify strong practices. In doing this, we noted limited PCMH resources from a nursing perspective, and realized we were indeed functioning as frontrunners in our work. Additional resources we utilized included the American Nurses Association (ANA) Standards of Practice, The Joint Commission (TJC) Standards, American Nurses Credentialing Center (ANCC) Magnet Standards, and Professional Organization Position Statements and White Papers. (ANA 2004, 2009; ANCC, 2008; TJC, 2008)

Next, we evaluated the current “as is” state of nursing in primary care in VHA. We conducted nursing staff interviews at multiple medical centers and performed a strengths, weaknesses, opportunities, and threats (SWOT) analysis. We also conducted Veteran surveys to include their perspective in our planning. One of the most valuable exercises we conducted involved asking nursing staff at various levels of our national system to list the normal work actions they performed by the day, week, month, and year. We evaluated the information they provided, assessing whether the action was being performed by the person in the optimal nursing role or whether it would be better performed by another person in a nursing or other role. This exercise demonstrated that many primary care nurses had not been working at the top of their abilities; they were frequently performing actions more appropriately assigned to other staff. This stimulated rich discussion and prompted some other disciplines to also evaluate how they spend their time and how they could “share the care” so everyone contributed most effectively.

During the future state design of the optimal nursing model in primary care, we advised the nurses in the workgroup to envision their ideal model without limitations. Our idea was to focus on the “what” we hoped the model could be, knowing we would address the “how” of implementing operational details once we created our model. It was our hope that we would avoid limiting our ideas. We also articulated some of our key assumptions to help us avoid limiting ourselves: we would not focus on constraints such as time, ability to hire personnel, regulations, or funding; we would envision all staff working to the top of their job description, license, or training; and we would consider all roles on the team as equally valuable (VA Nursing Workgroup, 2009). We also considered other key priorities. We would view PCMH through a nursing lens and we would ensure
that the practice model would be aligned with the VHA Office of Nursing Services professional practice model. We identified two additional critical elements: the need to support RNs in establishing the requisite autonomy and authority to most effectively perform their role responsibilities, and the incorporation of the Clinical Nurse Leader role into the primary care professional nursing practice model (VA Nursing Workgroup, 2009).

As a result of the vision of the Chief Nursing Officer as well as other key leaders in ONS and the intense efforts of this workgroup, we designed the nursing foundation for PCMH. The resulting ONS Transformational Professional Practice Model for PCMH includes 5 components: Professional Values, Patient Care Delivery Model, Relationships and Roles, Recognition and Rewards, and Governance, all of which formed the underpinning for us to successfully implement PCMH in primary care (VA Nursing Workgroup, 2009). We also identified 34 recommendations necessary for successful PACT implementation. One of our most significant accomplishments included making recommendations regarding the nursing roles. Ultimately, we made the decision that primary care staffing would include a teamlet comprised of the patient at the center, a provider (physician, nurse practitioner, or physician's assistant), a RNCM, a clinical associate (a licensed practical or vocational nurse, health technician, medical assistant or nursing assistant) and a clerical associate (Figure 6.3).

**Figure 6.3** Personnel Composition of the Teamlet within the Patient-Aligned Care Team
Although the RNCM performs centralized coordinating functions for the teamlet, each member provides longitudinal, relationship-based care for a panel (assigned enrollees) of approximately 1,200 patients. Expanded team members, including the case manager, provide care for patients from multiple teamlets as the need is identified. This is graphically depicted in Figure 6.4.

Many of the workgroup’s recommendations and lessons learned proved true throughout the PACT implementation journey. Examples include the importance of leadership; the value of each person’s contribution to the team, including the patient’s active engagement; and the necessary attention, time, and training that is required to transform a medically-oriented organization to one that is patient-driven, proactive, and focused on wellness, prevention, and optimal health. In addition, we learned the value of the attention to detail that is required to fully analyze current practices, strategically plan the right actions at the right time, and the value of true collaboration and relationship-building to achieve a common goal.

**Figure 6.4 The Central Role of the RN and Expanded Team Members in the PACT Model**

*This model is used by the Veterans Health Administration to explicate the RN Care Manager Role.*
Refining the Role of the RN Care Manager (RNCM)

The above described process helped us refine our understanding of both care management and care coordination, the nursing cornerstones in the systems’ redesigned PACT model where the focus is on ensuring that patients receive the right care, in the right place, at the right time, and by the right person. Care management is the oversight and management of a comprehensive health care plan for an individual patient or cohort of patients. Care coordination describes the logistical steps taken to link patients with needed services, resources and opportunities, including VA and non-VA services across the continuum, for each Veteran in primary care. The RNCM role is the primary care staff nurse and a member of the PACT teamlet along with the provider, clinical associate, and clerical associate. The RNCM, as well as other teamlet members have an ongoing relationship with patients in their established panel. This is even more important in academic clinics where the provider may rotate off the primary care service but the RNCM remains a constant member of the teamlet. The RNCM is at the intersection of all of the care the patient receives and is the RN point of contact for all patients on the panel. The RNCM uses the nursing process, collaborates with the patient/family, teamlet, and expanded team to develop and implement the patient-driven holistic care plan, and manages the care for all patients on the panel.

We designed this position to be different from the previous primary care RN staff role in several ways. The focus is patient-driven, proactive care that emphasizes shared decision-making, patient goal-setting, self-management, prevention and wellness, health education, chronic disease management, coordination of care, and safety during transitions between care teams or care settings. Coordination of care and safety during transitions is a high priority for the RNCM. The RNCM also delegates to other members of the team who also have similarly higher levels of responsibility and accountability than they did prior to PACT implementation. One main priority of the RNCM is to maximize patient safety during transitions, recognizing that coordination of care also decreases duplication and costs of services.

These additional responsibilities and heightened critical thinking skills require nurses with a higher level of education and training, hence, the rationale for our recommendation that RNCMs have at a minimum a baccalaureate degree. Hiring nurses with this level of education is not always possible in all communities, so we created several alternative approaches to strengthen the competency of these RNCMs. One option is the ONS RNCM education series calls. These 50-minute monthly calls are similar to
Community of Practice calls. We organize an expert to present on a different topic of interest each month, followed by a question and answer period. If the presenter is not a nurse or works outside of primary care, we encourage RNCMs to co-present to “tell their story” about the topic, as well as share their lessons learned so the audience can learn how to operationalize the concept. This series of calls is well received and serves to inform RNCMs about new or expanded concepts. Rather than simply providing didactic information, we strive to make the content applicable to the nurses’ practice. We also encourage dialogue among RNCMs during and after the call.

Another example is that we encourage RNCMs to earn certifications in areas such as care or case management, diabetes, pain management or other areas of interest that would benefit their patient population. We promote effective communication through mandatory health coaching and training in motivational interviewing, requirements we included when we developed the RNCM’s role and responsibilities. This information is beneficial for general communication but the primary intent is to provide additional skills to guide patients in goal setting. Effective communication is required for the RNCM to successfully provide education and establish and maintain partnerships with the Veteran/family, primary care provider, other teamlet and team members including academic affiliates and those in other services such as specialty care and the community. A strong partnership is particularly crucial with the primary care provider. We learned the importance of team cohesion and the need to purposely provide team-building training as the failure to develop it also results in limited delegation and an overall ineffective teamlet.

RNCMs also hold their own face-to-face RN clinic appointments, telephone appointments, and participate in shared medical appointments and group visits, thereby improving clinic access. This is an area where we focused our efforts to ensure that all types of clinic appointments were set up properly to enhance accurate scheduling, maximum access, and to capture clinic productivity. The need for contingency planning is also important to ensure that clinics and appointments are held as scheduled, with the greatest continuity possible when the RNCM has a planned or unplanned absence. The intensity of the care management requirements varies from Veteran to Veteran but when the time or level of clinical expertise exceeds what the RNCM can provide, a case manager may be consulted.

Clarifying Care Management and Case Management

Case management is not a new concept. It has steadily evolved since the first known social-welfare oriented system was established in 1863. Today
the focus is on public and private-sector sponsored interdisciplinary teams working to improve the health, well-being, and productivity of individuals and populations while balancing the need for quality with cost-effective care (Coleman & Zagor, 1998; Kersbergen, 1996).

VHA has a long history of effective case management, partially due to visionary strategic planning for the many complex and intensive VHA programs that require specialized expertise. There is also heightened visibility of the role and increasing awareness of the value of nurses who can provide expertise in care coordination, patient education, and transitional care. These skill sets will have increased importance as health reform discussions evolve (O’Neil, 2009).

The emerging impact of reform for the private health care sector is foreshadowed in the visionary changes that the VA has been implementing for almost 20 years. In 1994 VA underwent a re-engineering when President Bill Clinton appointed Kenneth W. Kizer, M.D. as VA’s Under Secretary for Health, a role comparable to the chief executive officer of a nation-wide integrated healthcare system. Dr. Kizer led the VHA organizational transformation with a focus on quality, reducing cost, preventive care and wellness. He transitioned the VA from hospital-focused care to primary care and outpatient-focused care, promoted the patient as the center of the health care universe, and supported practices to provide “the right care in the right place at the right time” (as cited in Sheets & Mahoney-Gleason, p. 93, 2010). This positions VA to serve as an exemplar for many of the changes emerging in the larger health care community.

Today, case managers are in most elements of the payer and provider communities, including VHA, where we balance the need for quality with cost-effective care. We recognize case management as an area of practice for the coordination of care required by Veterans with chronic, catastrophic and complex high risk or high-cost health care, psychosocial needs, and/ or environmental issues. Currently there are many diverse case management roles and practices in place within VHA. Case managers are specially trained staff. Registered nurses and social workers are frequently employed as case managers; however advanced practice registered nurses, rehabilitation therapists, occupational therapists, physical therapists, rehabilitative counselors, and registered dieticians also provide case management.

The process of case management begins with identification of high-cost, complex-care individuals who meet criteria for and can benefit from case management services. Case management intervention can be individualized or population-based and begins with contact between the case manager and the patient/family, and continues as an
ongoing relationship for the duration required. We emphasize strategies to achieve positive outcomes, incorporating disease management and population management approaches and strategies.

Some key services provided by the primary care case manager include referrals to home and community based programs, referrals and management of services for a Non-VA Care Coordination (NVCC) program where the VA is the payer for community based services, and referrals and monitoring of referrals to various VA and non-VA programs to meet Veterans’ continuing care needs. The primary care case manager serves as an educator, resource and liaison for community based providers and as a patient advocate for access to community based programs. The primary care case manager assists with complex transitions of care and takes a lead role in coordination of care that involves multiple providers and the management of complex care needs.

Within VHA primary care, RNCMs perform care management, care coordination, and in some instances, case management actions to varying degrees for different patients at different times, depending on their care plan needs. We think of care management and case management as being on a continuum and there are multiple factors we consider when determining if and when to consult the case manager. The comparison between the two roles is summarized in Figure 6.5, demonstrating the high level of coordination implicit in the two roles.

**Figure 6.5  Aspects of Care Management and Case Management**

<table>
<thead>
<tr>
<th>CaRe Manager</th>
<th>CaSe Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PACT Teamlet RN (most common)</td>
<td>1. RN or MSW</td>
</tr>
<tr>
<td>2. Generalist</td>
<td>2. Specialist</td>
</tr>
<tr>
<td>3. All Pact patients on panel</td>
<td>3. More complex PACT patients</td>
</tr>
<tr>
<td>4. Continuous</td>
<td>4. Duration varies as needed</td>
</tr>
<tr>
<td>5. Intensity varies</td>
<td>5. Intensity varies</td>
</tr>
<tr>
<td>6. May delegate to another team member</td>
<td>6. Does not delegate but reports back to teamlet care manager on a regular basis</td>
</tr>
</tbody>
</table>

This model is used by the Veterans Health Administration to differentiate the Care Manager Role from the Case Manager Role.
The RNCM in primary care performs care management on every patient in his or her panel but the intensity of these actions varies from patient to patient and from episode to episode throughout the longitudinal care plan. Most patients on a primary care panel do not require intensive case management services, but when the time or expertise required to provide the care exceeds what the RNCM and teamlet can provide, they may discuss the case in a team meeting and refer the patient to the case manager. When we consider whether the RNCM can provide this higher level of care, several factors influence the decision. These may include the patient’s specific case management needs, the training and experience of the RNCM and the alignment to the patient’s specific needs, the time availability of the RNCM, whether the case management needs will be temporary or long term, and availability of case management resources. The RNCM’s time availability is heavily dependent on his or her panel size, panel acuity, and the presence, expertise, and cohesiveness of the full teamlet necessary to “share the care”.

We have concentrated on effectively training RNCMs about these concepts over several years. Part of the difficulty is related to the evolving teamlet roles, including that of the RNCM. It takes a period of time to raise the competency level of RNCMs to broaden their effectiveness as care managers. Historically, nurses have always performed many of these care management and care coordination activities but PACT is expanding the expectations and accountability that we will consistently provide the highest level of care that ensures safety and optimal outcomes during high-risk transitions.

Once the case manager becomes active in the patient’s care, the RNCM and case manager coordinate their services to ensure smooth transitions and to avoid duplication of services. The RNCM will stay engaged in the patient’s care, based on their role commitment to provide relationship-based care over the patient’s lifetime. However, their level of engagement may decrease during the case management episode, depending on the coordination decisions between the RNCM and the case manager. We have learned that this coordination becomes even more crucial when there is more than one case manager involved and ideally, one case manager takes the lead and the number of case managers involved is kept to a minimum. While all members of the team have a role in care coordination, we have learned that purposeful communications including huddles and team meetings are critical to prevent fragmentation and redundancy while optimizing coordination of care across the care continuum.
Summary

This chapter highlights potential contributions of baccalaureate-prepared RNs and details VHA achievements to recruit BSNs as well as strategies to increase the numbers and effectiveness of BSNs within our health care system. In 2009, VHA began the journey of PACT implementation and shifted the focus to improving access, care management and coordination, proactive planning, patient-driven goal setting, health promotion, wellness, and disease prevention. Full implementation of the PACT initiative occurs over several years but we are already seeing impressive improvements. Coordinating with patients before and after hospital discharge is becoming routine, and we have been able to collect some initial outcomes data. Between June 2010 and July 2013, there was an 1150% increase of 2-day post hospital discharge calls (Stark, 2014). Other findings during the same dates include PACT patients enrolled in home telehealth increased 93%, group visits increased 94%, PACT telephone visits increased 107%, urgent care visits decreased 33%, and hospital admissions for Ambulatory Care Sensitive Indicators decreased 1.2% overall but 4.2% for patients under the age of 65 (Stark, 2014).

Our shift from the traditional primary care model to the PACT model has been instrumental in achieving these successes. We are effectively responding to the challenges of a changing health care environment, including those associated with the Affordable Care Act. VA may serve as an exemplar to many other health care delivery systems as they choose to implement the PCMH model or expand the role and effectiveness of the RN in primary care.

Our RN Care Managers and RN Case Managers are well positioned to enhance Veteran safety, especially during crucial transitions. Nurses were at the forefront of the design and we are integral to moving the initiative forward. Although we have made significant progress to improve care for Veterans, we have many more opportunities to contribute as equal members of the health care team and to integrate PACT throughout VHA organizational culture.
REFERENCES


The Dartmouth Institute • Geisel School of Medicine at Dartmouth • Dartmouth-Hitchcock Medical Center • Dartmouth College. (2013). *Clinical Microsystems*. Retrieved February 5, 2014 from http://www.clinicalmicrosystem.org/about/background/


Chapter 6.1

Creating a Culture of Team-Based, Patient-Centered Primary Care: Expanding RN Roles

Michael Bethel
There is a VA saying that if you’ve seen one VA medical center, you’ve seen one VA medical center. This saying amongst Veterans Health Administration (VHA) employees is true for so many reasons. Each VHA healthcare system is influenced by its history, architecture, geographic location, available space, services offered, and priorities and interests of its local executive staff. Another way VHA facilities distinguish themselves from each other is the way in which programs are implemented. VHA often issues national policy statements known as directives defining nationally prescribed goals and requirements while leaving the operational details to the discretion of local leadership. Because of this, programs with the same goals and outcomes may differ among VHA facilities. This is the story of one such implementation and the role nurses played in its success. It focuses on the implementation of the primary care Patient Aligned Care Teams (PACT) in my VA.

As the Program Manager for the Primary Care Service of the VA Central California Health Care System in Fresno, I have had a unique view of the evolution of our system’s PACT program. Shortly after VHA announced that it would implement its own version of a patient-centered medical home, branded as PACT, facilities developed staffing plans for meeting the new goals. Initially, each facility did this without truly understanding how they would ultimately organize themselves. In Fresno, we used current staff members to train our new staff and, because we hadn’t really implemented the new patient-centered model, new staff received training in the old model. This later presented obstacles when PACT was more fully developed with the nationally defined VHA requirements and all staff members needed education in this enhanced patient-centered approach. We could have trained the existing staff in the new model, then relied on these trained staff to train our new staff, or we could have trained the new staff at their point of hire, so they started with the knowledge needed to successfully implement PACT, then provided this same training to the existing staff.

Either phased approach would have been preferable to what we actually did by spreading the old ways to the new people. This only meant we had additional staff members who had to adopt the changes, staff who had had time to become comfortable with the existing practices and to see PACT as a change in the way they had been practicing. In retrospect, it may have been most effective to integrate the new staff members when PACT had been more fully understood and embraced by everyone within the organization. Although I knew at the time that PACT would have a significant impact on our Veterans, I did not fully realize how quickly the positive outcomes would emerge from our implementation of a program where each Veteran was assigned to a dedicated primary
Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

U.S. Department of Veterans Affairs

188

U.S. Department of Veterans Affairs

Care team of health care professionals. Each patient has an assigned core team for their primary care services. These teams consist of a primary care provider (PCP: MD, NP or PA), an RN care manager, a clinical associate (LPN/LVN, health tech or medical tech) and a clerical associate. This creates a five-member team with the patient at the center of their team. Our nursing staff played a major role in the transformation of our system.

So much was asked of PACT team members. By emphasizing the role of nurses, I don’t want to minimize the roles of other core team members. For instance, primary care providers (PCPs) worked to manage their backlogs of future appointments while continuing to see those on the schedule and maintaining access for those patients with acute needs. We also found that we woefully underestimated the need for clerical associates, making the role so busy with records requests, scheduling appointments, answering phones, preparing correspondence, contacting patients, completing reminders, all while supporting each of these functions for too many teams. With one clerical associate covering multiple teams, we left it to the clerk, or the supervisor, to communicate between the teams about work capacity and priority. It wasn’t until later that we provided communications training to each team member, including the clerical staff.

The work ahead of us was significant, but the payoff was monumental for both our patients and the staff. We had to change from a system that focused on management of patients with return appointments or who presented with an acute illness to a system that focuses on maintenance and restoration of health, coaching for healthier choices, and prevention of disease. Before we implemented the PACTs our licensed vocational nurses (LVNs), commonly known as clinical associates in the PACT model, were responsible for pre-provider visit and post-provider visit work only. Prior to PACT implementation, we focused on today’s work related to those patients seen today and only PCPs held any responsibility for patient outcomes.

Of greater concern, prior to PACT implementation, our registered nurses had little connection to the system. Their expertise was available to the Veteran on a consult basis, which had to be formally requested and entered into our electronic record by the primary care provider. Locally, those RN services were called “case management,” but basically consisted of disease-specific education and repeated follow-ups. There were no defined outcome measures, no patient-set goals, no discovery of patient motivational factors, no negotiation with patients about lifestyle changes, no milestones to celebrate, no measurable timeframe to complete case management, and no programs to which successful patients could be transitioned. Patients were either in case management or not in case management. In fact, many
patients continued in case management for years with no discernible positive health outcomes, although many reported a high degree of satisfaction related to meeting their social needs. We realized that through the implementation of PACT, we were expanding the role of our nurses.

We recognized that our nurses needed the tools to be successful, so we built upon our strengths. One notable strength was our alignment. Primary care is a service unto itself, not a section of another service. All PACT core team members report up through primary care, not to separate services. This alignment of key staff in one planning and reporting structure has been critical in our ability to quickly effect changes. We redefined the case management process as care management and made it part of a continuum of care that also included home telehealth (HT). Our local RN protocol authorizes the nurse to refer patients to HT and many other services. Primary care providers were encouraged to consider HT for appropriate patients. We developed templates for electronic documentation that were specific to triaging acute patient needs, care management of the diabetic patient, and completing a phone call to patients within 48 hours of any hospital discharge. We embedded potential consults into the electronic note templates to prompt the RN to request appropriate ancillary support services.

We are very fortunate in California to have a liberal scope of practice for RNs, which permits ordering of lab tests and x-rays without a physician’s order. We included this in RN protocols to ensure our RNs can work at the top of their scope of practice and competency, and to assist Veterans with any acute needs as well as perform population management. LVNs continue to manage patient flow in our clinics, but their role now also includes reviewing schedules with the core team to determine the appropriateness of appointment types. Some patients’ needs are better served with a telephone or group appointment. Panels of patients are no longer assigned to just the primary care provider. The entire team is encouraged to think of the panel of patients as assigned to the core team.

Our teams huddle frequently to communicate about patient needs and to brainstorm difficult patient issues from a multidisciplinary standpoint. We have embedded mental health professionals, pharmacists, dietitians, and social workers directly in our clinics to provide immediate support to patients and staff, as well as to provide needed follow-up. We no longer see every patient concern as a need for a face-to-face provider visit, but as an opportunity to address that concern in the best, most convenient for the patient, way possible. By maintaining frequent communication with the team and with the patient, our nurses have been able to achieve these goals, maintain and improve patient satisfaction,
improve patient access to our system, assist patients with making better health choices, have significant positive change in health outcomes, and go home every day proud of their day’s accomplishments.

The process of our implementation has provided us with many important lessons. I share these in the hope that they will be of value to others. Review all your available resources; don’t overlook resources outside your agency. Look at your services and your identified resources as continuum of care options. Identify holes in this continuum and determine if these holes are within your core mission and should be further developed by you or if the need is better served by another agency. Involve your staff, and union partners, early in all your change processes. Change is always difficult and it is important to help staff understand the why of change and to listen to their ideas on the what, how and when of any planned change. While you are working with employees, don’t forget that they are one of your most important sources of information about what is good in your health care system and what needs to change. Ask patients what they want in their health care experiences.

Be creative. Use your imagination, and the imaginations of others, to visualize the health care continuum you’d want for yourself as a patient or family member and work to make that vision a reality. Sometimes the best solutions to creating a better system come from unexpected places. Move quickly. Where you see the need for change, make that change. But don’t be married to any one specific idea. Some ideas are great but don’t work well with your overall continuum. Be willing to make additional changes just as quickly as you made the first. Never be completely satisfied. Always strive for better outcomes and experiences for your patients.

We still have a long journey ahead of us but our system is very different than it was just a few years ago. Patients definitely notice and appreciate these differences and the health outcomes of our population continue to improve. Our nursing staff members have grown professionally through this process. Their days are busier but they express that they have more fulfillment at work.

One of our biggest factors for the success of the new PACT model has been the staff’s dedication to delivering the best health care product possible to the patients they love so much. It has been one of my proudest professional moments to watch the staff create this truly patient-centered environment, and one of my most challenging professional moments to step out of their way to allow them maximum creativity as this environment has evolved.
Chapter 6.2

Developing a New Position: Creating Your Own Path

Janice Morey Pedersen and Jacqueline Andersen
Two separate process action teams at our mid-sized VA Medical Center (VAMC) in Syracuse, New York met to improve imaging processes and customer service in our outpatient interventional radiology (IR) department. Expanding the service to include a nurse practitioner (NP) in our VA care programs was an unexpected and welcomed bonus. What has evolved over the last ten years is a wonderful example of how nurses can practice to the full extent of their education and training to create and implement a program that affects a large and expanding department and ultimately the whole facility through process, planning and innovation.

We are the two nurses who have led this initiative, Jackie is someone who can “think outside the box”, be visionary, understand the issues, and think through the process as nurse manager of the Same Day Unit where we care for our patients. Jan is a nurse practitioner with many years of related clinical and administrative experience who Jackie hired to expand the Same Day Unit service. With Jackie’s guidance, many years of seasoned VA experience, and close collaboration, Jan has been able to implement the vision with solid positive results. None of this has occurred with either acting singularly. Collaboration has been ongoing, including many interested parties who have a stake in improving the process. The NP role and related processes remain ever evolving. We have achieved success through the alignment of vision and creation of processes that enhance seamless care for our patients having interventional radiology (IR) procedures. We believe our experience can serve as an exemplar for other services in outpatient settings.

Our first focus was to define the problem we were facing, to assess our situation. Initially this meant giving our attention to the challenge of two service lines coming together. Nursing leadership met with the involved parties from the Medical Service Line (MVAC) and Diagnostic and Therapeutics (D&T) Care Lines to discuss issues related to management of IR patients, at that time a fairly new service in our facility. Both care lines were responsible for various parts of the services provided, including but not exclusive to RN staffing, technologists, equipment, scheduling, budget, supervision, and delineation of responsibilities.

There were numerous stakeholders voicing concerns about pre and post procedure management of IR patients, including patient safety, cost savings, obtaining timely orders, customer satisfaction and process improvement. At that time we didn’t have physician interventionists on staff, their services were contracted from a local area hospital, physicians coming in exclusively to perform the
procedure. Among the concerns identified was the observation that many times patients weren’t pre-tested and/or prepared adequately for a procedure and that led to many delays, cancellations, and/or extended lengths of stay. In addition, sometimes priorities at the physician ‘home’ hospital delayed or cancelled our physician coverage.

On the other end of the spectrum, patients sometimes had unnecessary testing done prior to procedures, creating numerous unwarranted lengthy visits for these patients. This translated into additional costs as well as wasted time for the patients, the families and the facility. Discharge instructions and patient education were too often limited or absent. At that time, patients on the Same Day Unit were managed by their primary care provider (PCP) who in most instances didn’t have the specific expertise or background to manage them in respect to this procedure. PCPs were often unavailable for timely placement of orders or were off site. This was particularly difficult to manage because computerized orders were not available for outpatients; the physical presence of the physician was required. All of these issues resulted in additional costs, time mismanagement, dissatisfaction and overall inefficiency. The same day unit nurses were often stymied, unsure where to look for assistance, discouraged, and sometimes annoyed. There were problems with the physician coverage for patients who needed to stay 23 hours for post-procedure related care or complications. Increased standards and requirements for moderate sedation as outlined by The Joint Commission (TJC) and current medical center policy impacted on provider time and patient care.

Having completed our sobering assessment, we moved on to developing our plan. The best solutions were identified by meeting and working with the key players of the two service lines. This part of the story was one Jackie spearheaded as the nurse manager.

I, Jackie wrote a proposal with a very specific plan. The proposal included hiring two nurse practitioners and a clerk to streamline the processes we were trying to improve. I divided the rationale for significant improvement into five areas. The improvement areas were categorized as patient safety, cost savings, improved patient throughput and improved internal and external customer satisfaction. Along with this information, I gathered and presented the number of patient cancellations that occurred by provider as well as by patient. This gave additional support to the proposal that we needed a nurse practitioner to review the patient’s status, teach the patient about his or her procedure, do the sedation pre-procedure assessment as well as manage
the patient’s outpatient stay and discharge. I believed that in this way the cancellation rate could be greatly reduced and the number of procedures could be increased since we would no longer be wasting our providers’ time with no-shows or failure to complete sedation assessments.

As nurse manager and chief stakeholder, I led that effort with the support of the care line officials. My high school senior picture described me as “motivated” and as my career unfolded I realized the message was both positive and true. My former nurse manager and mentor encouraged me to identify opportunities to improve processes that ultimately improved patient outcomes and patient satisfaction. The opportunity to realize this seemed imminent. Through this process of collaboration with other stakeholders, positive changes could lead to improved processes that included better utilization of our fiscal, physical and human resources.

Initially, I was not convinced that as a nurse manager, I could initiate this kind of improvement. The project and the process seemed so huge and overwhelming. However, with guidance, collaboration and my internal persistence (a.k.a. motivation) I was able to meet with others that had a stake in this particular project and I was able to make our shared efforts come to fruition. The most significant aspect of the solution was to create a new nurse practitioner role, a pivotal role in the coordination and care of IR patients. Not only did we need to create the role but also to hire the right person who would share our vision and insight and be ready to collaborate with us as we developed this important role together.

The care lines and key players approved the proposal, which was then sent to our facility Resource Board who then approved the hiring of one nurse practitioner for IR. Not exactly the 2 NPs and secretary we were hoping for, but success nevertheless, and so we were thankful we were awarded that position. Then we began the rigorous process of identifying exactly what the role of this NP would be, where our new NP would be located and how all this process change would be actualized. We realized that this required more planning and strategy. This NP was going to have a lot of responsibility resting on her or his shoulders. While I worked on the details of NP duties, I knew that the hiring of this person was paramount to ensuring our success. Human Resources Service assisted with a job posting and many NPs, both internally and externally, responded. As luck, perhaps fate, would have it, a highly qualified NP was referred to me. The credentials of this NP were stellar with related experience, administration, and education
as a NP. Her qualifications were exactly what we were looking for. She seemed a perfect fit. Getting her onboard quickly was the best strategy because she could assist in developing her own position as she had done in two previous positions. Her unique experiences made her highly qualified for the position and she would fill a role unlike any other NP in our facility. We were ready, together, to implement our plan.

As the newly hired nurse practitioner, Jan was also new to the VA but not new to developing a new role. The VAMC was a huge shift from the private sector where I had spent a long career, not bad certainly, just very different. I had spent a number of years in ICU/Critical Care/PACU/OR and management, academia, and a short time at a surgery center in a similar role to the one for which I was hired. I had a background with a significant amount of nursing and NP experience, and to my advantage, I am very organized. I looked forward to collaborating and developing this much-needed position with my supervisor, Jackie, also a nurse.

I had advanced my education, as a part time student, from a diploma nurse to baccalaureate in nursing, to master’s as a critical care clinical nurse specialist, and then post master’s programs in nurse practitioner and administration. I am the ultimate lifelong learner as it took me nearly 25 years to earn my advanced degrees after my basic diploma. I knew I was ready to tackle the tasks at hand.

How did the changes happen? Actually it’s a version of what we follow our whole careers: The Nursing Process! There really isn’t any magic to it. It’s a matter of nurses moving forward with their career and always remembering that the patient is first and foremost in our practice. If the patient is always the center of the process and decision making then it leads to more focused, clear and easier decisions.

Also having the impact of more nursing education allows us to think more globally and critically and hopefully apply what has been learned. Assess, plan, implement, and evaluate: our story tells how we did what we did using the nursing process. Developing a path isn’t as daunting a task as it may initially appear. It requires taking each step as it comes along, trying to make solid decisions at each fork in the road. It’s also important to know what you like to do, what you are likely to do well and what you are likely not going to enjoy and conditions that can potentially stress you and limit your success. That is another beauty of nursing; there are so many opportunities to grow and challenge us.

First and foremost when I started the position, I needed to listen to all involved parties to see where they were in the process and how the process actually worked (or didn’t!) in real time. This included
the patients, the nurses from the same day unit where the patients received pre and post procedure care and the interventional radiology (IR) nurses where the procedure actually occurred, the IR physicians, and the radiology technicians: I knew that all involved parties needed to be heard. Having listened, I knew speaking with the stakeholders was key as well as we began this process. They all had their own ideas about what worked, what didn’t, and how it needed to change. I soon realized care was to some degree a very disjointed, haphazard, hit or miss type of care. As I listened to the issues and problem areas, it seemed like all of it was problematic! I also made a lot of my own observations. I needed to assess what I learned, take note of any parallels and key information that was outstanding. Simple procedures that initially took up to 17 hours and three visits now take 1.0 hour and one visit! Jackie as nurse manager had identified the need for this position and worked with others in leadership positions related to this clinical area to create a vision for better care and better processes. It was my responsibility, with her guidance and our close collaboration, to move that vision forward into reality with major improvements.

Initially it seemed daunting and unwieldy. As we have moved forward on this path we have continued to remain open and flexible, to listen and communicate so that we can adjust our thinking and practices frequently, sometimes daily. We are always open to making the care for the patients better, and that remains our focus. After a short time it was possible to develop a plan of action for the NP role that included our mutually developed goals that described our destination. These were shared in staff meetings and with individuals as we worked with them through new venues and processes. The changes were large but usually most welcome as staff could see the benefits.

One of our challenges has been that interventional radiology physicians are a “hot commodity”. Because they are a newer medical specialty and we are located in a moderate sized city, their time is precious and scarce. Our medical center now contracts with two different physician groups who have their own practices in different hospitals but provide care for our patients on a regularly scheduled but limited time basis. It is an expensive but valuable service. Over time we have been able to secure our own part-time IR physician who is also the collaborating physician for the NP. It is our responsibility to make the most of the physicians’ time and services. Essentially the physicians come to the VA to do the specific procedures and leave the sedation assessments, management, orders, care, teaching, troubleshooting and
discharge to the NP. What has evolved in this path we have crafted is an NP role that is an inclusive combination of clinical care as a nurse practitioner and case manager for Veterans from start to finish.

We are proud of the results. The NP totally manages patients from the time they are scheduled to discharge. This includes calling or sending letters to prepare them for the procedure, and managing them on the day of their procedure through their discharge or admission. When patients are admitted, the process of care is taken over by the medical admissions team. When patients are admitted or discharged from the same day unit they have a follow-up appointment with the ordering provider or specialty, so the “loop is closed” and we don’t fail to follow-up. Follow-up for our patients includes knowing the results of their biopsy, medical follow-up, suture removal or wound evaluation. Another positive outcome is that we have eliminated unwarranted admissions and patients that do need to stay have a decreased length of stay. We believe this fits with the VA Patient Aligned Care Team (PACT) concept of total care and although we are not officially part of the primary care service or the PACT team, we are very much a part of that process.

Many times if a patient presents for a procedure Jan, as the NP, may recognize something abnormal for that patient and contact the primary care provider (PCP) to discuss or make an appointment for the patient, often for the same day, especially if they have traveled from a long distance. Sometimes this may even require that the patient be seen in the emergency department. The scenarios are endless but doing what is best or right for the patient is always foremost in the process. What the process of creating this position affirms is a lesson Jan learned in her various roles over the years: all experiences “play into” how a role may be developed, whether it is from clinical or academic settings. When we are all clear about the end results we desire; the rest of it is detail.

Over the last nearly 10 years this role has evolved and expanded and we have made the process a much-improved one for all involved, especially patients, and we get that feedback nearly every day.

“As leaders we are expected to challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart” (Kouzes and Posner, 2007, pp. 23-25). The process has not been without its challenges, setbacks, and annoyances, something we did anticipate and something we have overcome.

Having completed our successful implementation, we moved to the final step in the nursing process: evaluation. Have there been ‘bumps in the road?’ Of course there have been. Change is always difficult,
some stakeholders tend to think they are “in charge” or should be “the boss”. Not everyone is happy when they don’t get what they want. Communicating with and knowing the preferences of each physician or physician group can be a challenge, as can asking the nursing staff members to understand how important their role is to move efficiently and effectively to complete their tasks before the scheduled procedure. Readiness to make changes in the process when a special patient need arises is a vital element for success. Having the two units on different floors on opposite ends of the medical center can add to our challenges. With a positive and open attitude, no challenge is too insurmountable.

Communication with all involved parties is key. Responding to concerns and questions of patients and staff is always a priority. Everyone needs to know and understand that they are being heard and that their voiced concerns are important to us. We know that all of us need to understand that our individual role is a key piece of the whole process. When participants hear and understand the reasoning behind a decision or change they can “buy into it” and carry it forward. When we need to, we revise our processes. Along the way we re-evaluate our goals and decide what is best and what is meaningful for our practices and our patients. For example, when we first implemented this role, all outpatient processes were in hard copy; now we are totally computerized. There were challenges with that as well but we continued to persevere and improve. Now it’s hard to believe that we didn’t always have everything computerized or managed through the use of standardized templates. Again, it is better for a more seamless patient care process.

We think there are several take away messages we can share, based on our collaboration for the above described process:

1. Work with someone who recognizes your strengths, communicates openly, and supports you—collaboration is paramount.
2. Remember that skills you acquire in one position can always be utilized in another—build on those skills.
3. Learn to recognize a problem, listen, get to its core and resolve it with the other stakeholders.

Our goal to develop safe, quality, patient-centered care across our two outpatient areas of same day procedures and IR has more than been achieved. We continue to assess our practices, review
our processes, collaborate, plan and implement changes and then continually evaluate outcomes. Then we start the process all over again. It’s a continuous process of staying aware and cognizant of everything going on around us as well as practicing to the full extent of our education and training. On a daily basis we depend on our team to follow through with our goal of continuous improvement of positive patient outcomes. It’s a role we have been privileged to plan and develop as we continue to practice in the setting.

REFERENCE

Chapter 6.3

Mentoring Mid-Career RNs

Janice Morey Pedersen
I have been fortunate to be a nurse for many years and have been assisted along the way by many with more experience who took a personal interest in my career and me. I started as a diploma nurse, eventually earned my baccalaureate degree (BSN), then my master’s degree (MSN) as a critical care clinical nurse specialist. I then earned two post master’s degrees, as a nurse practitioner and nurse administrator. I have worked in a variety of settings starting as a staff nurse, then a hospital supervisor, a supervisor of critical care areas, and eventually working in academic recruitment and admission of students pursuing RN to BSN degrees and graduate nursing programs. While I truly enjoyed academia and students, I eventually returned to my first love of caring for patients as a nurse practitioner in the VA while concurrently continuing as an educator in an associate degree (AD) nursing program. For me, all these positions were related to one another in some way, each building on my previous experiences and knowledge. I felt I grew professionally and expanded my experiences as my career developed. Three of the positions were newly created, so I was able to develop them and each time I felt I reinvented or recreated myself. For me it was exciting and exhilarating to travel new pathways. At the same time, as I advanced my education and career, I raised a family and have been an active and involved community leader and participant.

Nurses are now working longer, later in life, and have more opportunities to take their career in new directions and to new heights. As an advanced practice nurse and a nurse with many years of experience, I have become convinced that perhaps we could do more to help direct, guide, and mentor mid-career nurses who have many years of experience and expertise and yet are looking to move their careers forward in education or practice or in a different direction. What are we doing to advance the profession as many older nurses prepare to retire? I can only speak from my experiences. Yet, as experienced nurses with advanced education, we perhaps have an opportunity to mentor these skilled nurses as they look for guidance in furthering their career, educational achievement, or a transition to other opportunities in nursing that make sense to them at a new juncture in their career.

There is much written about mentoring new graduate nurses and new nurse practitioners entering the work force. There are new role expectations, learning in actual practice what isn’t or cannot be learned in the classroom. It has seemed to me that there is a gap in the mentoring of skilled experienced RNs with ADs who want to move their careers forward in education or practice or in a different direction. I have learned that many of these expert bedside nurses yearn for someone to talk to and look for guidance in
furthering their career, educational achievement, or other opportunities in nursing that seem to make sense for them as their career advances.

Throughout my career as I gained more knowledge through education and experience, more opportunities arose that also matched my interests, more doors were open to me. I started back to school for my BSN when my daughter was fifteen months old and I finished my terminal degree when she was twenty-five! As a lifelong learner I have felt rewarded by mentoring, seeing others learn and grow and advance as I felt that I did. Working in academia for a number of years, I was able to encourage nurses to pursue educational opportunities and help them see how they could grow and advance their careers. What seems important to me now as I look back over the years is that I developed a philosophy of leading and demonstrated that philosophy by example, hopefully a good one.

As I encouraged these nurses I have learned that they are open and eager to have someone listen, hoping to test their ideas with this listener, and just generally explore their questions: “Does this make sense for me?” or “This is where my interest is; how should I go about getting there?”. Exploring these questions is enriching for me as I encourage others to follow their heart and do what they love. There are so many wonderful opportunities in nursing. I have also learned that there isn’t any set pattern; each response is individual. This is what has made my career so rewarding. There are so many opportunities to go so many different directions, many times with a common thread running throughout, sometimes not. When we discuss these diverse opportunities, many times there is an eye opening moment of realization. It suddenly dawns on the individual, a realization of what to do or how to get there.

“What is next for me?” mid-career nurses might be asking. They may be contemplating a move to another clinical area or an area of specialization or to another level of practice where more education might be required. Some might be bored with what they are doing and are looking to infuse new energy into their career. Some lack self-confidence in thinking that they could do something new. They are looking to weigh the pros and cons of a change in their practice. Many times nurse administrators or nurse managers are so busy with their own numerous responsibilities they find limited time for mentoring or may not realize these individuals who work for them are looking to advance themselves and are looking for guidance. This is through no fault of their own, merely a reality of their demanding workload.

As a nurse with many years of experience and more education, I have found that I have a perfect opportunity to mentor these mid-career nurses so that they might advance themselves in many areas. I also see this
mentoring as part of my responsibility. I have found that it is effective for me to demonstrate by example, most times not even realizing it myself, but hearing from others that I have influenced them and their careers. This has encouraged me to continue and build on previous successes. My number one driving force my whole career is positive patient (or student) outcomes, doing what is best for the patient or student as the case may be. Where does the patient (or student) need to go and how can I assist him or her to get there? Being consistent is a way to assist, being committed, doing today’s work today, being involved in professional organizations, developing relationships and networking within the community, thinking and generally seeing beyond the “tasks” at hand. I try to be ever mindful of how I might come across to others and be open to the guidance of those who have different and related experiences. I view this as implementing my years of education and experience.

Many mid-career RNs need career or professional support and guidance. They have different career needs and goals than new graduates or new nurse practitioners that are just entering the practice arena or entering it in a different role. I essentially see nurses as not being a whole lot different than patients- where do they need or want to go with their career or health? Psychologically and socially I need to go there with them or understand where they are and “bring them along” so that they can see themselves in a different way and in a different position or environment. As a “mature” nurse, I have this unique opportunity to assist in refreshing these nurses’ careers and assist them as they set new goals for themselves. For the mentee building a relationship this mentorship can be an exciting way of developing confidence and competence in a new role with the protection of a guide who provides opportunities and resources to promote the success of that RN. I can try to be a positive subtle influence and create a concept of what they can be, many times through my non-verbal behaviors as much as by what I say or suggest.

As an advanced practice nurse or nurse with many years of varied experience, I see one of our many roles is to teach and educate not only patients but also other nurses. Mentor them. It’s succession planning. We can move nurses forward in their careers by demonstrating it in our own practice, living it with our practice, and showing how we can make it work daily in our practice. It is well documented that as the nursing population ages and as the baby boomers retire it is our responsibility to train and guide those coming along behind us. The principles of mentoring a new nurse, nurse practitioner or experienced nurse are virtually the same, but at varied or different levels. I have tried to distill the
process I have used and found helpful in mentoring mid-career nurses, summarized using the framework of the familiar nursing process:

1. **The Goals** of mentoring mid-career RNs are to support them in meeting their professional goals and/or in promoting their career advancement, educational benefits, and/or personal development.

2. **The Assessment** of mentoring mid-career RNs involves collecting and analyzing data with the individual nurse, using helpful questions:
   - “Where do I want to go? What is my ultimate goal or end point? Where do I want to be in my profession? What do I like/love to do? What do I do well? What are my strengths/weaknesses?
   - How much time will it take me to achieve my proposed plan?
   - What are the consequences of my choice, if any?
   - What are the options and the effects that my plan might have on my personal life: What about my productivity? What, if anything, will it cost? Will it fit with my lifestyle?”
   - Can I get honest opinions from trusted professionals and family members about how they perceive me, what kind of person they think I am? Do our thoughts coincide or are they similar?
   - Am I willing to look at my options with a critical eye: consider the downside and the weaknesses of my proposed role and where I might excel?
   - What adjustments will I need to make? Will I need to work weekends or off shifts to attend classes if I need to return to school? Will I have a feeling of “stepping backwards” for a while? Do I need to step back professionally, temporarily and perhaps earn less pay as well? “Can I live with these changes for now to get where I ultimately want to go?”
   - Can I realistically anticipate why an idea may or may not work?

3. **The Plan** of mentoring mid-career RNs focuses on creating measurable goals based on the assessment information, using the following guidelines:
   - Allow for changes and revisions during the process
   - Use visual charts or visual aids to “map out” the proposed plan
   - Create a budget if there may be a pay cut or educational costs
   - Define what if any need exists to alter or change current practice, especially if the plan includes the need to alter hours, shifts, or a time schedule.
   - Plan ahead to understand, accept and adapt to the workplace culture in a new or different practice setting
• Identify what needs to be “given up” to go back to school in terms of personal/professional responsibilities; who can provide assistance or temporarily take on some of these responsibilities, including social obligations.

4. The Implementation of the Plan of mentoring mid-career RNs now involves taking action:
   • Go for it! Keep the end in sight, adapt to changes along the way, stay open to new possibilities, and remember that timing is everything.
   • Establish ways to take action in ways that match individual personal needs or preferences.
   • Develop a solution to challenges encountered in a different practice setting and work culture as needed.

5. The Evaluation of the mentoring of mid-career RNs includes determining success at meeting goals, finding role fulfillment and expressing self-efficacy.

Over the years I have found what works for me as a mentor. I also realize we all have our own strengths that we can build on. For me, it is important that we assist these skilled RNs in developing a career trajectory that also includes tips for interviewing and negotiation, as well as current and future trends in nursing. I have personally always taken great joy in seeing nurses go back to school, progress through their educational programs, earn their degrees, and assume new professional roles, applying their newly gained competencies. The investment of an advanced practice nurse or nurse with many years of experience as a mentor benefits the mentor and the mentee as the mentee blooms and validates both the effort and enhanced status. The mentor becomes a resource to ensure that nurses practice to the full extent of their education and training. We need the best of the best in nursing. The mentee benefits from the nurturing and opportunity for growth and advancement, and the mentor can experience immeasurable personal rewards and fulfillment. The profession or organization ultimately benefits from the growth and socialization of the individual. Everyone benefits. The mentoring process really is all about succession planning. I appreciate the opportunity VA has given me to actualize this vision.
Chapter 6.4

*Increasing the Number of Baccalaureate Prepared Registered Nurses*

Darcy Mortimer, Michiele Schrieber, and Salena Wright-Brown
Leadership at the Veterans Health Care System of the Ozarks (VHSO), Fayetteville, Arkansas, has held a long-standing commitment to transform nursing practice, education, and leadership. An example of that commitment can be seen in the support and encouragement of progressive formal education and continuing education for the nursing staff. The goal of these activities is to support nurses’ ability to practice to the full extent of their education and training. VHSO is a complexity level 2 healthcare facility, providing inpatient and outpatient services to over 55,000 Veterans in the beautiful Ozarks Mountains of Arkansas, Missouri and Oklahoma. The authors of this chapter were the senior nursing leaders within the facility, the Associate Director, Patient Care Services/Chief Nurse Executive and the two Associate Chief Nurses. The efforts described within this chapter are the result of the commitment of many nurses and others at VHSO.

Veterans Health Administration (VHA) has determined that the baccalaureate degree is the minimum preparation its nurses must have for promotion beyond the entry level of Nurse I (VA Handbook 5005/27, Part II). The American Association of Colleges of Nursing (AACN) (2013) indicated that a baccalaureate (BSN) degree in nursing is recognized as the “minimum educational requirement for professional nursing practice” (para. 2). Further, VHSO’s commitment is in line with the Institute of Medicine Future of Nursing report (2010) recommendation to increase the number of baccalaureate prepared nurses. From 2010 to 2013, VHSO increased our number of BSN prepared nurses to 29%. Currently, 100% of nurse managers hold academic credentials of a baccalaureate degree or higher.

We employed several strategies to achieve this level of academic achievement among our nurse leaders. Our strategies included incorporating the goal in the hospital strategic plan, exploring aggressive recruitment and retention initiatives, frequently disseminating information regarding VHA scholarship and educational programs, maintaining strong relationships with baccalaureate schools of nursing and student programs, and actively mentoring throughout our nursing service. Additionally, we engaged groups such as our Evidenced Based Practice Council and the Shared Governance Council as champions for increasing nursing education. These groups sought opportunities to identify barriers to advanced education and then made suggestions to overcome these barriers, including the development of a resource guide for nurses who were considering returning to school. They also developed mentorship relationships with students to support their studies and make suggestions to assist students with development of projects that reflected mission and goals of VHSO.
As part of the VHSO strategic plan, leadership committed to the pursuit of Magnet recognition status, which also recommends higher percentages of baccalaureate prepared nurses. Two specific strategic objectives speak to this. One is focused on meeting the Institute of Medicine’s goal of increasing “the proportion of nurses with a baccalaureate degree to 80% by 2020” (IOM, 2010, p. 3). The second recommends that by 2014, all of the nurse managers will hold a BSN or higher academic credential. According to the VA Office of Nursing Service (2012), in fiscal year 2012, 60% of VHA RNs held a BSN or higher degree with 6.9% of RNs holding a bachelor’s degree in a non-nursing and 3.7% with a master’s or doctorate in a non-nursing course of study. To date, we have met our VHSO fiscal year 2013 goal of increasing staff with baccalaureate degrees by 3%.

We have employed recruitment and retention strategies to attract and retain BSNs at VHSO. RN vacancies are posted internally and advertised externally as BSN preferred. Education level is a critical criteria for promotion based on the VHA Nurse Qualification Standards and is strictly applied (Table 6.4.1). VHA programs expounding benefits for current and potential nurses, such as the RN Residency Program for new graduates, the “Let’s Get Certified” campaign, and participation in shared governance are highly endorsed by our leadership. In addition, we make a concerted effort to recognize progressive education in staff meetings, employee functions, nurses’ week events, and most significantly in an annual ceremony celebrating the nurses who completed advanced degree programs during the year. A nurse from each degree category, BSN, MSN, PhD/DNP, presents their perspective on the impact of advanced education for them, their families, and colleagues. During the recognition ceremony, nurses completing their degrees are congratulated by their colleagues and guests, however it is also a time where they are able to share what the advanced education means for the care they provide to our Veterans.

We have found that conscientious information sharing about VA scholarship programs not only encourages nurses to pursue baccalaureate degrees, but also solidifies our commitment to scholastic achievement. We encourage staff to participate in the VHA Employee Incentive Scholarship Program (EISP) and National Nursing Education Initiative (NNEI) scholarship programs and monitor employee participation in those programs. EISP is a national VA program that provides financial support for employees going to school to receive their first nursing degree. NNEI is a scholarship program that provides financial support for tuition costs for those nurses who are returning to school for advanced education in nursing. We provide information

Part 2: Acting Strategically to Innovate • Key Message 1: Nurses should practice to their full extent

U.S. Department of Veterans Affairs
to prospective and new nurses during new employee orientation and regularly communicate to nurses that pursuing baccalaureate degrees and other progressive professional education is expected. We discuss that expectation during orientation, annual performance reviews, and in ongoing meetings and events. Staff members are encouraged to consider advanced education as part of their annual goals.

Table 6.4.1  VHA Nurse Qualification Standards, Educational level requirements

<table>
<thead>
<tr>
<th>Grade/Level</th>
<th>Educational Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse I-Level 1</td>
<td>Diploma or Associates Degree</td>
</tr>
<tr>
<td>Nurse I-Level 2</td>
<td>Diploma or Associates Degree</td>
</tr>
<tr>
<td>Nurse I-Level 3</td>
<td>Diploma, Associates Degree or Bachelor’s Degree</td>
</tr>
<tr>
<td>Nurse II</td>
<td>Bachelor’s Degree</td>
</tr>
<tr>
<td>Nurse III</td>
<td>Master’s Degree</td>
</tr>
<tr>
<td>Nurse IV and V</td>
<td>Master’s Degree</td>
</tr>
</tbody>
</table>


One of our important strategies was partnering with schools of nursing and nursing students. This was essential to transformational success by increasing the percent of BSN prepared nurses for our facility. Most recently, we have applied to participate in the VA Nursing Academy Program (VANAP). VANAP “is designed to enable stronger, mutually beneficial relationships between nursing schools and VA facilities…” (DVA, 2013, p. 2). Funding is provided for nursing faculty positions at the VHA facility and at the affiliated school of nursing with the goal of increasing enrollment (DVA, 2013).

Student program strategies we employ include participation in the VA Learning Opportunities Residency (VALOR) and student nurse technician (SNT) programs. VALOR is a national VA program that provides employment for student nurses coupled with clinical experiences during their last summer before graduation from nursing school. Recently we have converted 7 VALOR students and 11 student nurse technicians to RN staff nurses. This has proven to be one of our best recruitment strategies for baccalaureate prepared RNs.

Our nurse recruiter works closely with the local schools of nursing and the VHSO human resources management office so that the nursing school and the nursing students’ experiences are as positive as possible. For instance, the nurse recruiter and educators streamline the laborious
paperwork and online training required for student nurses and clinical instructors. We are collaborating with a BSN school of nursing to develop a RN immersion clinical experience so that cohorts of BSN students will complete most of their clinical rotations at VHSO.

Finally, our experience has been that one of the most important strategies, though difficult to measure, is nurse mentoring. Several nurses have completed formal mentoring training. Mentors have gone so far as to not only recommend appropriate degree programs to nurses, but to walk them through to enrollment. A professional development coordinator, under the supervision of the Associate Director Patient Care Service/Nurse Executive, facilitates and champions multiple professional nursing activities such as podium presentations, poster presentations, and publications. Furthermore, we have developed many opportunities for awards and recognition of those who have achieved their goals of advanced education or professional presentations.

Successfully increasing the number of baccalaureate prepared nurses has been the outcome of a culture that supports transformational nursing and a commitment to progressive education. There is strong support and encouragement for nurses to practice to the full extent of their education and training and for nurses to advance their education to the full extent possible. It encompasses a hospital-wide investment as demonstrated in the strategic plan, recruitment and retention initiatives, information sharing, the building of nursing student related relationships, and mentoring. Our VHSO culture, with strong nursing leadership, supports the expansion of nursing roles at all levels of the organization and positively reflects on the VA and local nursing communities.

REFERENCES


Chapter 7: Building Bridges for Continuity of Care

Mary Susan Biggins and Brenda Rushing French
The polytrauma rehabilitation field advisory committee (PFAC) is a component of the clinical practice program for the Office of Nursing Services (ONS) within the Department of Veterans Affairs (VA). We lead the bidirectional communication between the VA field of rehabilitation nursing and ONS in promoting patient-centered, quality care for our active duty Service members (ADSM) and Veterans returning from combat theaters including the Afghanistan, Operation Enduring Freedom (OEF) and Iraq, Operation Iraqi Freedom (OIF), later to become Operation New Dawn (OND). Mary Sue Biggins is the polytrauma rehabilitation clinical nurse advisor for the Office of Nursing Services clinical practice program and the polytrauma clinical nurse educator for the Edward Hines Jr. VA Hospital in Hines, Illinois. Brenda French is the polytrauma staff educator for the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia.

As we address this topic, we believe it is important to note that we are caring for the most severely injured combat warriors, many of whom would not have survived such catastrophic injuries in previous combat eras. Many innovations in pain management and research based advances stem from the polytrauma ADSM and Veteran population and their unique needs. We believe it is essential to paint a picture of the type of injuries sustained in order to portray the full extent of the challenges involved and the complexity of managing pain for these wounded warriors.

Polytrauma by definition is a term coined to represent two or more injuries to physical regions or organ systems, in a single incident, one of which may be life threatening (Kerns & Dobscha, 2009; Kent, Upp, & Buckenmaier, 2011). Therefore, the injured warriors who we are addressing in this chapter may have survived severe internal traumas, single or multiple limb amputations, burns, blindness/visual impairments, traumatic brain injury, hearing loss, fractures and the possibility of spinal cord injury. These injuries may be compounded by co-morbid post traumatic stress disorder (PTSD) and other mental health disorders such as depression, due in part to the repeated and longer deployments encountered by our military ADSMs.

The high incidence of survival, exceeding 90%, of these severely injured Service members and Veterans is attributable to several important factors: improved body armor, all military personnel being trained in life saving measures, Department of Defense (DoD) innovations in forward battlefield triage, expert treatment teams of nurses and physicians providing care at hospitals located in close
proximity to combat areas and critical care aero-medical transport teams comprised of physicians and nurses, to stabilize and transport the wounded to military treatment facilities (MTF) overseas, such as the United States Army DoD Landstuhl Regional Medical Center in Germany (Clark et al., 2007; Kent et al., 2011). These air transport vehicles are mini-intensive care units (ICUs) crammed into small spaces, with multiple severely injured patients aboard. The multiple life-sustaining infusion lines, changing cabin pressures, inadequate lighting and cramped quarters can make this trip very challenging for the treatment team, making their success rates even more impressive. Further stabilizing procedures occur at the overseas MTFs in readiness for transport of the patients to the United States.

The injured are transferred to MTFs in the United States (U.S.) as quickly as possible, to facilities such as Walter Reed National Military Medical Center (WRNMMC) or San Antonio Military Medical Center (SAMMC). The overall time frame from injury on the battlefield to arrival thousands of miles distant in the United States is relatively short, days to about a week on average, depending on the health team’s ability to stabilize the individual patient. The length of treatment at the MTF varies considerably from months to years.

When the Service member or Veteran has reached the point in their recovery that they are assessed and evaluated to be ready to enter the rehabilitation phase of recovery, they are transferred to one of the five VA polytrauma rehabilitation centers (PRC) located in Richmond, Virginia; Tampa, Florida; San Antonio, Texas; Palo Alto, California; and Minneapolis, Minnesota. If their injuries are blindness or spinal cord injury, they will be transferred to one of those facilities for rehabilitation. The ADSM or Veteran, family or significant other and members of the interdisciplinary transfer and receiving teams are involved in extensive and collaborative treatment and plan of care information exchanges, well in advance of the actual transfer.

This communication occurs via video teleconferencing, secure messaging, transfer and access of medical records, telephone calls and possible site visits. The interdisciplinary treatment teams discuss detailed treatment plans and examine care needs and goals to determine readiness for rehabilitation and a good fit for ADSMs or Veterans needs/goals with the receiving facility’s services. VA has created a new position, the VA/DoD polytrauma rehabilitation nurse liaison. This role is embedded in the MTFs to bridge the two distinct systems of care, DoD and VA, to coordinate the transfer process and
promote continuity between DoD and VA. This is structurally how we have built a bridge for continuity of care for our ADSMs and Veterans.

So where does pain management enter into this whole process? Obviously, pain management begins at the time of injury on the battlefield and continues through all the transferring stages of the wounded patient, but may be altered as the recovery phases change. The pain management challenge arises with multiple origins of pain that may be inherent in the types of injuries involved and multiple episodes of surgery. These challenges have led us to our current focus on pain management at all phases of the healing process for these ADSMs and Veterans. Nurse leaders in the VA set out to meet that challenge. In this chapter we tell the story of some of the innovations we created and nursing involvement in these innovations, beginning with our awareness of and focus on the importance of communication between levels of care and transitions of care, essential to the bridge of continuity.

A DOD/VA interdisciplinary collaborative electronic assessment tool known as the “DoD/VA transfer summary” was developed by a nurse in 2008 to address the crucial elements of information necessary to augment safe transitions from DOD to VA facilities. Brenda Stidham, the VA/DoD Nurse liaison at the Walter Reed Army Military Medical Center, noticed a problematic gap in essential information, lack of a standardized process and lack of electronic interface in transmitting critical information from the MTF to the receiving VA rehabilitation center, when an ADSM or Veteran was deemed ready for transfer. Brenda realized that a shared electronic template that could bridge the firewall and be utilized by both DoD and VA was needed. She realized there would be a high degree of risk involved for this information to flow freely and safely in a bidirectional manner between these two large government agencies, a process not previously available.

Brenda developed the transfer summary template, shared her idea with colleagues in VA and DoD for support, and submitted her idea to the highest levels of nursing, Cathy Rick, VA Chief Nursing Officer and her counterpart in DoD, Major-General Patricia Horoho. Approval to proceed with the template led to the next phase of informatics specialists building of the electronic process. Oyweda Moore, Brenda Stidham and John Garcia were the VA and DoD nurses who tackled the informatics (IT) challenge. Other nurses involved in the implementation of the template were Monica Seccula, Cynthia Abbadini and Laureen Doloresco. The unique feature and significant impact of the electronic transfer summary template is that it effectively and securely creates
a bridge for bidirectional communication between DoD and VA electronic health record systems, to enhance the continuity of care for the severely wounded warriors. This tool includes specification for detailed pain information, utilizing the traditional analog (0-10) scale as well as evaluation/assessment of pain for non-verbal patients. VA nursing staff Laureen Doloresco, Brenda Stidham, Margaret Veneman, Lea Rashka and Maureen Merkl were recognized for this achievement with the 2009 Office of Nursing Services innovations award.

Based on this initial work, we led the PFAC in launching an interdisciplinary VA/DoD workgroup to include essential spinal cord injury elements to the tool. These additions have been incorporated into the DoD and have been submitted to VA informatics to be an addendum to this electronic medical record bridge. Patricia D. Jackson, a member of the PFAC, led the workgroup that recently completed additional recommendations addressing communication during transitions in care with attention to pain management. Her workgroup’s recommendations focus on informing the receiving team of the current pain treatment plan, how effective is it and when it was last administered. This information alerts the receiving team to any potential needs that the patient may have upon arrival and enhances the seamless transition in care for all patients.

We believe that an important element for the ADSM or Veteran and family in transitioning of care is to assure compassionate, safe, state-of-the-art management of acute pain. Veterans Health Administration (VHA) had designated pain management as a priority transformational initiative, starting with the VHA National Pain Management Directive 2009-53 resulting in the VHA Pain Management Strategy (Department of Veterans Affairs, n.d.). This directive (policy document) provides comprehensive guidance to move forward on this transformation.

The pain management directive has helped develop a VHA system of pain management that focuses on providing the specific care elements for intensity of pain management that patients may require. As the patients’ pain management needs become more complex, the directive expands the team to a higher level and a broader team to include a greater number of specialists. A partial list of these specialists includes neurologists, psychologists, interventional pain practitioners, physical therapists, occupational therapists, rehabilitation physicians, orthopedic surgeons, psychiatrists, and of course, nursing.

We, as part of the polytrauma team, play a very active role in this extended team of pain management specialists. The team members work together over months and sometimes years to help these complex
patients in both the management of their acute and chronic pain and to improve their function over time. Christine Engstrom, Program Manager in the Office of Nursing Services clinical practice program (CPP), initiated the VHA national nurse pain workgroup, co-chaired by Susan Hagan and Janette Elliott. The pain workgroup designated a member to serve as the pain liaison for each of the CPP field advisory committees, including the PFAC. VA nurses work closely with other members of the interdisciplinary team to develop non-pharmacological pain interventions and enhance the accessibility between Patient Aligned Care Teams (PACT) and other pain team members. The VA team, including nurses, have initiated safe opioid clinical practice guidelines and measure and monitor outcomes.

The stepped care model is an integral component of this transformation, with screening and treatment of less intense pain, step one of the model, managed at the primary care outpatient clinic level, with the PACT team comprised of a primary care provider, registered nurse, nursing assistant and a clerical assistant. Step two, which addresses more severe pain, incorporates consultations with various specialists in the treatment plan of care. The very severe chronic pain and substance use disorders are referred to step three tertiary interdisciplinary pain centers that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), programs such as the one at the James A. Haley VA in Tampa, Florida (Hunt & Burgo, 2013).

Nurses are actively engaged and provide leadership as subject matter experts at all steps in this model. Advanced practice nurses Susan Hagan and Janette Elliott serve at the highest levels of pain committee decision making in the VA, such as the national pain management strategy coordinating committee and work groups. The national nurse pain workgroup members have created an array of VA options to meet the challenge of ongoing education needs of care providers. Training options include presentations at national conferences such as the VHA PRC/polytrauma network site (PNS) conferences and the polytrauma nursing conferences, dissemination of information through spotlight on pain management webinars and the OEF/OIF national pain management website (Department of Veterans Affairs, n.d.), monthly pain management leadership teleconferences and many other VA educational modalities.

We participated as members of the planning committee for the 2010 polytrauma nursing conference -5- titled “Learning from Each Other”. We recognized the importance of presenting the full spectrum of pain management challenges from the battlefield to the rehabilitation centers. We featured a presentation on the complexity of pain management from
Kathleen Martin, Trauma Program Nurse Director from Landstuhl Regional Medical Center, Landstuhl, Germany. She showed a memorable video depiction of the challenges the team faced in transporting as many as five critically wounded soldiers from the battlefield to Landstuhl. The transport occurred in a cramped mini-ICU air transport plane with multiple IV lines running, drainage bags needing attention, suction interventions and vital signs monitoring for each patient. All of the interactions from nurses and physicians were taking place under changing air pressures that impacted the functionality of equipment, while the team members performed life-saving measures, knowing full well that time was a critical factor in this arena. We organized a panel comprised of Kathleen, Cynthia Goldberg, a clinical nurse specialist from Walter Reed Army Medical Center MTF and Susan Hagan, the pain representative from the PFAC and member of the ONS national nursing pain workgroup, to highlight the different aspects of pain management across the continuum of polytrauma care from three major care sites.

Kathleen shared insight into the multiple sources of acute pain from severe trauma, such as musculoskeletal, nerve and visceral pain, informing the audience that pain management may require several different types of medications to achieve goals. Cynthia described MTF pain treatment modalities that included patient controlled analgesia (PCA) pumps, nerve blocks and ketamine, and several modalities that are not utilized in the VA rehabilitation centers which pose a challenge when converting the pain medicines upon arrival to rehabilitation.

Susan, who serves on the chronic pain management team at the Tampa, Florida VA, addressed issues and challenges of chronic pain management. She shared that in treating pain that is long standing, nurses find that such pain is not readily amenable to typical pain medicine interventions. She emphasized the need to access alternative treatments and specialists, such as psychologists. Susan also addressed the clinical finding that the origin of symptoms is not always readily identifiable, since concussion, post traumatic stress disorder and chronic pain can all account for similar symptoms of fatigue, sleep disorder and mood changes. She further explained that the 0 to 10 pain scale is insufficient in assessing pain in all instances of complexity. She emphasized the need to observe facial expression, mood and behavior; assess the patient at rest and with movement; and observe interactions with family and include family in evaluating the patient’s pain. We also learned from the panelists that opioids have the potential to increase pain and when we treat patients with mild traumatic brain injury (concussion), rebound headaches can result from a multitude of medications such as opioids, tylenol, triptans, fioricet and others.
We endorse the take home message from the panelists, that continuity of care in acute pain management requires a broadened array of assessment skills, along with pharmacologic and non-pharmacologic interventions, such as Reiki therapy, acupuncture, relaxation techniques and sporting activities. We have mentioned the use of state-of-the-art pain management technology, which is an evolving approach to pain management with differing interventions at the various stages of care, particularly in polytrauma. Data from Kent and colleagues (2011) indicate a 100% incidence of reported pain in their study of ADSM and Veterans at a PRC. The origin of these injuries in 60% to 71% of cases was attributed to improvised explosive devices (IED) with 71% affecting multiple extremities. Individual reports indicated 96% of these patients rated their pain as significant. In addition, the study subjects had undergone an average of 5.5 surgeries at the MTF, prior to transferring to the PRC, with potentially more surgeries occurring while in rehabilitation.

As clinicians, before we can decide on appropriate pain interventions, we need to complete a pain assessment. It has been determined that our old standby of the visual analog of the 0 to 10 pain scale is not only very subjective, but also lacks any element of assessing functionality of the individual (Kent, Upp, & Buckenmaier, 2011). Functionality assessment includes the following observations about our patients: are they capable of performing activities of daily living (ADLs), can they participate in the daily requirement of three hours of rehabilitation, and how is pain affecting their mood, emotions, and sleep patterns? Without this information, it is difficult for us to determine what adjustments to make to current medication dosages or in fact what medications or non-pharmacologic interventions to add or delete.

The DoD pain management task force is working to develop and validate a new pain assessment tool that is objective, incorporates functionality measures to aid the clinician in knowing what types of interventions to order, meets The Joint Commission’s pain standard and most significantly, is a tool that will be universally utilized by all branches of the military, MTFs and VA (Kent, Upp, & Buckenmaier, 2011). As VA nurses, we perform and document the majority of pain assessment information, monitor the effectiveness of the interventions, provide input to other clinicians and are interested in the development of this tool. We, as nurse educators, anticipate educating providers, nursing staff, patients and families on this new tool and can readily see the advantage of a universal assessment tool that is implemented across all areas of care.
The patients who we are working with are prone to having significant cognitive impairments due to traumatic brain injury or mental health issues. Therefore, we realized that we needed to look at a means of assessing pain for this segment of the population. It can be much more challenging to know if someone is having pain if they have a severely altered level of consciousness, post traumatic stress disorder (PTSD) or depression. We have integrated a range of valid pain assessment alternatives for this cohort of patients, including consistency in use of pain scale, checking of vital signs, continuity in staff assignments so that their familiarity with the patient will make it more likely that the staff member will notice changes in subtle body language or behavior changes in interpersonal interactions, mood changes, elicited sounds, facial expressions and input from family, who may be the first to notice changes in their loved one, all valid means of assessment for these patients (Gironda et al, 2009). Nurses utilize the nursing process to assess, plan, implement and evaluate patient’s care. With pain assessment having the potential for a significantly improved approach for the future, and nursing’s involvement in the process, we have impacted initiatives addressing pain interventions.

Though we have historically relied on opioids for acute pain management, viewing it as the gold standard, our VA pain management initiatives are expanding well beyond that assumption. The battlefield and acute MTF interventions are changing the methods and types of frontline medications being used. According to Kent and colleagues (2011) the military is utilizing continuous peripheral nerve catheters, with possible future pain treatment modalities to include intravenous and intranasal ketamine, patient controlled transdermal fentanyl, sublingual fentanyl and sufentanil with a sublingual patient controlled device that is in the development phase. Extended release epidural morphine analgesics are also being used.

We realize we will need to keep our sights focused on some of these new treatments on the horizon. While we are not yet seeing most of these forms of pain management, once the patient has arrived in a rehabilitation setting, we believe it is important to be familiar with treatment modalities that the ADSM or Veteran has encountered on their journey to recovery. Concurrently, we realize we need to look at the diverse non-pharmacological pain intervention methods that are options for use in rehabilitation. Gironda et al (2009) have indicated that because of the extensive healing process for the severely injured polytrauma patients, there is a greater risk of their acute pain becoming chronic and having a significant negative impact on future function and enjoyment of a healthy lifestyle.
The VA national nurse pain workgroup nurses have played a significant role in establishing cutting-edge VA initiatives to address opioid treatment and chronic pain. Because of the complex pain management challenges that our patients are faced with, we recognized that we need to expand beyond the traditional pain interventions that often prove to have ineffective outcomes. We have moved toward introducing some non-traditional methods of pain management that many nurses and providers are using for the OEF/OIF patients. We advocate for peer support, integrative health coaching and complementary alternative/integrative medicine (CAM/CIM) strategies for this expanded understanding of pain management. This extensive cadre of interventions includes relaxation techniques, sleep hygiene, stress management, cognitive behavioral therapy, biofeedback, behavior modification, therapeutic massage, pet therapy, ice/heat packs, stretches, acupuncture, Tai Chi, yoga, nutrition therapy, recreation therapy, humor, art and music therapy and ADSM/Veteran and family counseling to name a few. We teach our patients many of these techniques and offer referrals to other members of the interdisciplinary team as indicated for their expertise. Spirituality counseling can also have a significant impact as a pain intervention.

We recommend including physical exercise at the limits possible as another element of healing and pain management. There are extensive VA adaptive sports programs at the national and facility/regional levels available to ADSM and Veterans, programs that can serve multiple purposes: pain management, socialization and reintegration. The VA National Veterans Sports Programs and Special Events office offers a variety of venues that are available to wounded warriors from OEF/OIF and Veterans of all eras and age groups. A former PFAC nurse practitioner, Susan Pejoro, serves as the deputy director for this office. Many VA nurses are at the forefront of organizing these major sporting events, serving on the health management staff at the event or volunteering our time to facilitate the athletes’ successful participation. We believe that as nurses, it is important for us to encourage Veterans to try different self-management techniques to overcome or manage pain. We emphasize that it requires practice and persistence to gain the desired outcomes for relief or minimization of pain to a tolerable level that does not interfere with functionality.

While we have thus far primarily focused attention on pain management as it relates to those who were severely injured in the OEF/OIF/OND theaters of conflict, there is another large segment of OEF/OIF/OND returning Service men and women, who also suffer from pain disorders. These individuals are seen essentially in primary care outpatient clinics and specialty clinics such
as the women’s health clinic, mental health clinics and polytrauma/traumatic brain injury clinics. Helmer, et. al. published a study in 2009 that reflected the results of pain management for these Veterans. They showed that 1/3 of the subjects reported chronic widespread pain with 77.3% reporting back pain, 79% with arm, leg and joint type pain and 65% with both. They found a substantial correlation between more severe pain, PTSD and depression.

In dealing with this younger population of Veterans, functionality is uppermost in their goals as healthy civilians. We definitely want to help them achieve this goal in order to assure optimal reintegration into family, school, social activities, employment and community. To assist them, we believe we need to continue to be vigilant in our screenings, integration of primary care and mental health care with an all-encompassing, holistic, multi-disciplinary pain management approach. These Veterans will also benefit from implementation of the VHA national strategic plan for pain management and use of the stepped model of care. Nurses from the field advisory committees, including three from the PFAC, played an active role in the interdisciplinary creation of the VA specialty care access network extension for community healthcare outcomes (SCANECHO) program. SCANECHO was created to ultimately benefit Veterans with a focus on provider education, consultation and access to specialists for primary care and facilitation of the referral process when care at a tertiary care center is warranted (Kerns, 2009). The primary care outpatient team is the treatment team for these patients, but the SCANECHO component expands the available services with an outreach to specialists for consultation, education, or actual treatment for highly specialized care. Nurses are an integral component on the primary care team, but also serve as specialists in pain management.

Multi-modal non-pharmacologic pain interventions are also valid treatment modalities for the patients seen in VA outpatient clinics. We believe we need to continue to emphasize those interventions as well as good nutrition and regular exercise. Buis, et. al., reporting on a study in 2011 regarding the importance of physical exercise to alleviate pain and promote well-being, found that 90% of those interviewed agreed that physical exercise is necessary for optimal health; 70% stated it decreases stress; but over half (52%) indicated that pain limits their ability to exercise on a regular basis as desired. This limitation shapes how we approach pain management, helping the ADSM/Veteran achieve a healthy lifestyle that minimizes or alleviates pain. This includes being aware of unhealthy habits they may have chosen as alternatives to living with pain, such as alcohol and overuse of substances, legal or illegal, i.e. drugs, caffeine, tobacco. We believe it is our collective responsibility to assure that appropriate referrals, services
and resources are made available to replace these unhealthy habits with successful, positive alternatives. When we identify mental health issues such as depression, substance use disorder and PTSD, this triggers referrals to team members who can provide psychological treatments, balancing this with addressing our patients’ other needs such as sleep hygiene, anger management, and memory issues (Batten & Pollack 2008).

As we have documented, we find that pain is a significant issue for Veterans, most particularly in the OEF/OIF/OND population, which is essentially a younger cohort of service men and women. The IEDs, PTSD, body armor, longer and more frequent deployments are all contributing factors to significant pain issues. The VHA Pain Directive 2009-053 provided us with the blueprint for guiding VA nursing forward in the implementation of innovative pain treatment strategies and to go beyond the use of medications as the ultimate treatment intervention.

Nursing has been involved in thinking outside the box with many pain intervention strategies and means of promoting continuity of care for the benefit of the ADSM and Veteran. The development of the DoD/VA transfer summary template is just one such example. Nursing has served as active participants and contributors on pain committees for strategic planning at all levels of care and is an integral partner in the holistic, interdisciplinary stepped care model approach to pain management. We will continue to serve at the forefront of the VA pain management transformation initiative and will promote Veteran-centered continuity of care to decrease pain and suffering for those who sacrificed on our behalf.

REFERENCES


Chapter 7.1

"Nurses Own Pain"

Janette Elliott
To quote Dr. Jo Eland, University of Iowa, School of Nursing, from her presidential acceptance speech for the American Society for Pain Management Nursing (ASPMN), “Nurses own pain” (Eland, 2011). Nurses are in the forefront of advances in pain management in clinical areas, in education, in informatics, and in research. Nurses are in a unique position to mitigate a patient’s pain. This can be accomplished through improved assessment, treatment, education, and management strategies. My involvement within the California Palo Alto Veterans Affairs Health Care System (PAVAHCS) and nationally, with both Veterans Affairs (VA) and ASPMN pain management initiatives, speaks to this.

My journey in pain management began as a bedside oncology nurse in the 1970s. Wanting to do the best I could for patients by keeping their pain controlled was always a priority. As an oncology clinical nurse specialist I worked with both inpatients and outpatients. For most people with cancer pain, acceptably managing their pain was possible by manipulating opioid medications and dosages. However, over time it became obvious that opioids alone did not always adequately manage a person’s pain and other means were needed. In 1992 I had the opportunity to work with Stanford University pain medicine physicians to help establish a cancer pain clinic at the PAVAHCS. From that time forward I have continued to increase my knowledge of pain management and have striven to improve pain care within the VA and within the nation.

Within the discipline of medicine, the specialty of pain medicine is relatively new and is not as yet accepted as a specialty unto itself, but as a subspecialty under anesthesiology, neurology, physical medicine and rehabilitation and psychiatry (Dubois, 2009). During the first two years I worked in pain management I attended the twice-weekly pain medicine lectures provided for the Stanford University pain medicine fellows. These lectures followed the curriculum of the International Society for the Study of Pain (ISMP). I looked for other ways of adding to my knowledge of pain management as well, but even now there are very few programs where nurses can pursue concentrated study in pain management.

I immersed myself in the available pain management literature. I went to a nursing pain management conference that was focused on how to teach pain management. I wrote the initial policies and procedures concerning pain management issues for the PAVAHCS: patient controlled analgesia (PCA) policy, epidural policy, and pain management policy using the extant literature to develop best practices for patient care. I contributed to other pertinent hospital policies.
worked with the physicians to develop classes offered to all clinical staff. I wrote staff education modules and patient education handouts.

These things made me delve even deeper into the literature. Each learning opportunity built upon the others to develop a broad knowledge of pain management. It was only after this immersion in pain management that I understood that nurses need to know the basic physiology of pain; the pathophysiology of the typical type of pain with which they personally work; pain assessment and reassessment; pharmacologic and non-pharmacologic pain therapies, their uses and limitations; and the social and legal issues surrounding pain management. When nurses have these basics they can knowledgeably advocate on behalf of their patients and optimally treat their patients’ pain.

Clinically I made myself available to the inpatient nursing and medical/surgical and psychiatry staff. I made daily rounds to talk with nursing and medical staff to identify patients in need of better pain management. When the health care system developed computerized consult requests, I became the person who received the consults and took initial action on them. For consults on inpatients, I would do an initial history and physical on the patient, then call my attending physician for consultation to solicit recommendations. My knowledge continues to grow along with my confidence in that knowledge.

As an oncology nurse, I was a member of the Oncology Nursing Society and enjoyed sharing information and networking that was available through the organization. I decided to look for a comparable organization for pain management nurses. I found the fledgling American Society of Pain Management Nursing (ASPMN). At that time the organization was two years old. I attended my first ASPMN meeting in 1992. This organization has since proved to be a valuable source of education, support, camaraderie, shared information and personal growth. In 1999, the American Pain Society (APS) nursing special interest group (SIG) and ASPMN partnered to develop an Internet based list serve. A combination of the yearly ASPMN meetings and the list serve are valuable ways of staying up-to-date on national pain management issues, of staying abreast of The Joint Commission (TJC) recommendations, of gleaning information about best practices, of staying attuned to common concerns throughout the nation, of triggering ideas for improvements in patient care and for identifying common clinical trends. For me, the list serve has been a way to have lively discussions about pros and cons of various clinical interventions.

In 1998, Ken Kiser, Under Secretary for Health in the U.S. Department of Veterans Affairs, as part of the transformation of VA Health Care,
partnered with the Institute for Healthcare Improvement (IHI) to initiate a transformation of pain management within the VA. A nationwide conference on pain management was convened in early 1999 as part of this healthcare transformation. I was part of the PAVAHCS team sent to this conference. We learned ways to conduct quality improvement programs to identify areas of pain management in need of improvement, ways to address the needed improvement and ways to monitor the improvement over time. I took the lead for this process for the PAVAHCS. From those who attended this conference, the IHI developed the initial VA pain management email list serve. This led the way for establishing an effective approach for the VA pain management community to exchange information. This list serve remains a very viable entity for the VA pain management community. It adds a dimension that the ASPMN list serve lacks, that of pain management issues specifically concerning military Veterans and issues specific to the VA as a national system.

My involvement in ASPMN and in the VA pain management community developed in tandem. I became active in national ASPMN by being involved with various task forces and by attending yearly organization conferences. I was involved with designing the initial role delineation study of pain management nurses. I helped write the chapter on chronic pain management (Elliott, et al, 2002) of the first edition of the Core Curriculum for Pain Management Nursing (St. Marie, 2002) and then with the writing of educational guidelines for subsequent certification in pain management nursing. I was one of the first ten members of the master faculty for ASPMN. The master faculty taught the core curriculum content as preparation for the pain management nursing certification exam. When the time came for the second edition of the Core Curriculum for Pain Management Nursing (St. Marie, 2009), I was section editor for approximately half of the book, and was first author of the chapters on persistent pain (Elliott & Simpson, 2009) and pain and depression (Elliott & St Marie, 2009). As section editor, I made recommendations to many authors on additional content to include, or different ways to think about issues. We emphasized making these books evidence based and current. More recently, I was one of three reviewers to update the ASPMN curriculum on epidural pain management (Pasero, 2014).

As previously stated, the VHA National Pain Management Strategy was initiated in 1998 and established pain management as a VA national priority. The overall objective was to create a system wide approach to pain management to reduce pain and suffering associated with a wide range of illnesses. In 2007, the first national VA nursing task force on pain management was formed. The group reported to both national VA Office of
Chapter 7.1: “Nurses Own Pain”

Nursing Service (ONS) and to the VA National Pain Committee. The group’s mission was to promote best practices in pain management nursing. We were tasked to address bar coded medication administration (BCMA) qualifiers, documentation of pain assessment and reassessment, patient and staff education, nursing indicators, and patient satisfaction. We were to identify specialty nursing groups and roles in pain management, to encourage more effective collaboration among VA nurses, and to foster nursing research and evidenced based practice in pain management nursing and related issues.

This group was composed of a diverse group of nurses from throughout VHA. We were clinicians, educators, administrators, computer specialists and quality management specialists. Clinicians were from inpatient and outpatient venues, bedside nurses and advanced practice nurses. We were from various speciality areas: acute and chronic pain management, oncology, neurosurgery, and rehabilitation. Group representation was from nursing throughout the United States. We came together to discuss what we deemed to be the major issues for VA pain management nursing and to brainstorm ways of addressing these issues. Pain is some part of many illnesses and because of this we also became members of the other VA nursing field advisory committees (FACs): oncology, polytrauma, cardiovascular, metabolic syndrome, mental health, perioperative, and geriatrics. In 2014 the pain nursing task force gained full recognition as a nursing field advisory committee (FAC). Group members continue to act as liaisons between other nursing FACs and the pain nursing FAC with attention to pain management issues. Pain issues from the other FACs are presented to the nursing pain FAC for appropriate action. Group members are full partners in the VA’s National Pain Management Strategic Planning committee and also participate with sub groups of this committee.

Documentation of analgesic administration and of initial pain assessment and reassessment within VHA was inconsistent and sometimes difficult to identify. The group gave feedback to the informatics specialists about how we would like to integrate BCMA data into the computerized patient record system (CPRS). We wanted to optimize both documentation and retrieval of that information, and to minimize duplicate documentation for the bedside nurse. We worked with the VHA informatics specialists to develop a consistent initial nursing pain assessment template. We developed templates to use to document pain reassessment, both in cognitively intact and cognitively impaired patients. We queried the field for baseline information about reassessment after intravenous patient controlled analgesia (PCA) and collated that information to help us evaluate what was needed to optimize patient care. We worked with the polytrauma nursing FAC and the
Department of Defense (DoD) on pain concerns at the point of transfer from DoD facilities to VA polytrauma sites. We worked with informatics to optimize computerized patient flow sheets to include needed pain reassessment information. Much of this work is ongoing, but we have been able to ensure substantial improvement in the quality of pain documentation.

FAC members have been involved with a number of educational undertakings. Susan Hagan, a nurse practitioner (NP) at the Tampa, Florida VA, along with a number of VA nursing pain experts and other national pain management experts, revised and adapted the City of Hope Pain Resource Nurse (PRN) program to make it more specific for the VA. Betty Ferrell and colleagues at the City of Hope initially developed the PRN program in the early 1990s. The program is an excellent pain management educational vehicle for nurses and other clinicians. It is a program that has developed nurses who can advance the best pain management possible for patients. It increases pain management knowledge and promotes advocacy for patients with pain. This program as revised for the VA is now available for all VA facilities.

Another educational project through collaboration with resources outside of VA is Project ECHO, Extension for Community Healthcare Outcomes. Project ECHO was begun by the University of New Mexico and was designed to educate rural physicians on specialty topics; pain management is one of these topics. VA is working collaboratively with Project ECHO. Within VA this is called the Speciality Care Access Network project or SCAN-ECHO and has expanded to educate nurses as well as physicians. Pain nursing FAC members have acted as topic experts for SCAN-ECHO. As part of this project, one of the FAC members, Ariel Baria, a NP at the Greater Los Angeles, California VA, helped develop and produce video instructions for physical exam of the back, neck, hip, knee, and shoulder. These videos are available nationally through the VA national education system, Talent Management System (TMS). All of these excellent programs are available to all VA clinicians.

The FAC has also addressed patient education. We identified available educational materials and this information was communicated to the national pain management education committee. These materials are available for patients on My HealtheVet, a website where Veterans may access many educational documents as well as their health care records. One of the documents developed by FAC members was a patient education handout about chronic opioids titled *Taking Opioids Responsibly for Your Safety and the Safety of Others* (Department of Veterans Affairs, 2013). This was reviewed and approved by the national VA pain community and is based on available research. To my knowledge this document is the first of
its kind to address not only short term but also long term opioid concerns and potential side effects. Our FAC has also identified the lack of information about the postsurgical use of opioids after discharge from the hospital and will be developing a comparable document to address this concern.

FAC members have been involved with writing and critiquing the Veterans Affairs/Department of Defense (VA/DoD) clinical practice guidelines on chronic opioid therapy (VA/DoD, 2010) as well as American Pain Society (APS) guidelines on the treatment of low back pain (Chou & Huffman, 2007). FAC members are among the clinicians currently updating the 2002 VA/DoD clinical practice guideline on postoperative pain management (VA/DoD, in press). FAC members also participated in the combined VA/DoD pain management efforts to develop clinical tools for pain management.

As recommended by the Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011a), nurses within the VA act as full partners and significant leaders in healthcare. Susan Hagan, in 1988, developed the first VA inpatient chronic pain rehabilitation program at the Tampa, Florida VA. Clinicians from all over the United States travel to Tampa to learn from this premier program. Nancy Wiedemer, a NP, at the Philadelphia, Pennsylvania VA, developed the first opioid renewal clinic. Her model is being implemented in many VA facilities. Not only are these advances consistent with the recommendations from the IOM future of nursing report, but also consistent with the IOM report *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (IOM, 2011b). The latter report spoke to the need to foster a cultural transformation for pain care and stated that comprehensive and interdisciplinary approaches are the most important and effective ways to treat pain. The report also identifies the gaps in knowledge about pain and the lack of competence of providers in delivering appropriate pain care. We believe that we need to overcome barriers to collaborative care, to make education about pain management available and appropriate for providers. We need to continue to address patient and family education. We need to expand the number of people with advanced pain expertise. We need to more fully translate available research into practice.

The FAC broadened our initial mandate by electing to review VA nursing clinical practices. We developed pain nursing competencies and made them available to the nurses delivering care throughout the VA. We initiated, developed, and maintain a national VA pain nursing email group. This is used to query and share nursing-specific information as well as information about available educational offerings. Over 150 nurses are part of this group and the group continues to grow.
Throughout all of these efforts, the literature has been reviewed for the best research available and adaptations made accordingly. Evidence based practice is a mandate for all of the educational offerings. We have identified areas needing nursing research and forwarded this to VA nursing researchers.

Throughout this chapter I have referred to the contributions of nurses in pain management. Many times nurses have led the way in initiating and forwarding changes within the VA. Nurses work closely with other VA clinicians—physicians, psychologists, pharmacists, physical therapists, social workers, essentially all VA clinicians and most importantly, our Veteran patients. Mutual support and respect helps advance the cause of optimal pain care. Nurses are at the front line of patient care. They typically see patients before physicians or other health care providers. They are in inpatient and outpatient settings. They are bedside nurses and they are in outpatient areas. They are staff nurses and they are advanced practice nurses. Advance practice nurses are frequently the primary care providers for patients in pain as there is a dearth of pain medicine physicians. Nurses are well placed to act as a significant advocates for the best pain management available for their patients.

As is evident, I concur with Dr Eland in saying, “Nurses Own Pain”. It is through the efforts of nurses nationwide that patients receive good pain management. Pain management nurses exemplify the recommendations of the IOM. We practice to the full extent of our education and training, we improve staff and patient education, we are significant leaders within the nation, we are full partners in healthcare redesign, we are lifelong learners. It is my privilege to be counted among those nurses who have made, and will continue to make, major gains in improving pain care, not only for military Veterans, but for all people.

**REFERENCES**


Chapter 7.1: “Nurses Own Pain”


Chapter 7.2

Development and Implementation of a Multidisciplinary APRN Managed Colorectal Cancer Surveillance Program

Janet Cameron, Nancy Crandall, Maura Flynn, and Jennifer Ouellette
In this chapter we would like to share the story of the development and implementation of an innovative patient-centered advanced practice registered nurse (APRN) run clinic at the Providence Veterans Affairs Medical Center (PVAMC) in Providence, Rhode Island. Our clinic was the result of a multidisciplinary quality improvement process initiated by an APRN, and our story also describes the ongoing evaluation we pursue to ensure timely and appropriate follow up care for our Veterans. Maura Flynn is the gastroenterology (GI) nurse practitioner (NP) who started the process in 2005. Jennifer Ouellette is also an NP for the GI service who became part of the project because of the increased work load generated by our increased efforts to offer screening colonoscopy as the primary mode of screening. Nancy Crandall is an NP for the surgical service, and became involved in phase II of the colorectal cancer care collaborative (C4), acting as project manager for Phase II. Janet Cameron is a clinical nurse specialist (CNS) for the oncology service who runs the post treatment cancer surveillance clinic.

Colorectal cancer (CRC) is currently the third leading cause of cancer deaths in the United States (American Cancer Society, 2013, p. 10). In 2005 CRC was the second leading cause of cancer death in the United States (American Cancer Society, 2005, p. 13). Colorectal cancer incidence can be greatly reduced if polyps are discovered and removed early, so screening is a critical element. Jemel, Siegel, Ward, Hao, Xu & Thun (2009) reported that several methods of routine screening for colorectal cancer were acceptable, including fecal occult blood test (FOBT), barium enema, flexible sigmoidoscopy or colonoscopy. El Serag, Petersen, Hampel, Richardson & Cooper (2006) noted that FOBT was the most common method utilized in the majority of VA medical centers, but that research indicated that many patients who had positive FOBT did not have follow up diagnostic colonoscopies in a timely fashion.

In 2005 “the research and operation/clinical arms of the Veterans Affairs (VA) healthcare system formed a partnership aimed at improving the quality of CRC diagnosis and care” in the VA (Jackson et al., 2009, p. s38), with a goal of reducing the time from positive screening to diagnosis, and then improving the use of guidelines to guide decision making. This was a large-scale national project with support from the Office of Patient Care Services, the Office of Quality and Performance, the Office of the Deputy Under-Secretary for Health for Operations and Management (DUSH-OM), and the systems redesign program.

The Office of Nursing Services (ONS) became involved during phase II of the initiative. The goal of the C4 Initiative was to evaluate practice and develop programs to improve screening and follow up. Maura, the GI nurse practitioner secured support from our agency’s chief of staff
for PVAMC to become involved, and submitted an application to the national leaders of the initiative. The C4 Initiative leadership approved the application, and PVAMC became one of 21 VA facilities to participate in the C4 Initiative. Maura served as the project manager and champion for PVAMC and worked collaboratively with a physician colleague champion from primary care. The 21 teams across the United States participated in face to face meetings, monthly conference calls and an email discussion group to share effective process changes, tracking tools, and consult templates. The Quality Improvement aims that were addressed included colorectal screening and diagnostic follow-up, and once a Veteran was diagnosed, the timely treatment of colorectal cancer.

There were a number of obstacles that we needed to overcome. Although primary care providers (PCPs) are notified of a positive FOBT through a mandatory view alert in the electronic health record, timely notification to the patient and referral for colonoscopy were not consistent. We followed no standard process, and the PCP did not save electronic health record alerts after initial viewing. This lack of ability to track the process contributed to the lack of follow up colonoscopy.

We set timely notification to patient and follow up of positive FOBT as the first goal of our C4 collaborative. We chose to use rapid cycle process improvement strategies. This is a four stage quality improvement model that is used to evaluate and carry out change. The four stages of the model are: plan, do, study, act.

We initiated several tests of change including email reminders to PCPs, and reporting to primary care leadership and nurse managers. We also initiated education through meeting with primary care leadership and attending primary care staff meetings to report the results of our efforts. Ultimately, we discovered these actions led to increased awareness and improved compliance.

Once we had completed these steps, our next challenge became how to ensure the follow up of positive FOBTs and sustain improvement efforts. We participated in frank discussions regarding who should follow the patients and how we could ensure quality care in a consistent manner. Eventually we all agreed that the GI NPs would serve as back up to primary care. Initially positive FOBTs had been identified and the data reviewed retrospectively. Over time we collaborated with the laboratory staff and they now generate a weekly report of positive FOBTs that is sent to the GI NPs. The APRNs review the results and if they find that primary care has not yet notified a patient they call him/her to set up a screening colonoscopy.
In 2007 the Deputy Under Secretary for Health for Operations and Management (DUSH-OM) issued the “Colonoscopy Follow-Up of Fecal Occult Blood Test” monitor (Jackson, et al., 2009, p. s42) requiring all facilities to provide quarterly reports on the number of patients with positive screening (FOBT) and the percentage of patients who had a diagnostic colonoscopy within 60 days of the positive FOBT. PVAMC’s annual compliance with the goal was 36% in fiscal year (FY) 2007, which demonstrated that there was definitely room for improvement. Through our interventions, by 2011 we were able to report a 90% compliance. We realized that we were making a difference for our Veterans.

It was decided by the VA national C4 collaborative team that the national comprehensive cancer network guidelines (NCCN) for colorectal cancer would be used as the gold standard for diagnosis, treatment and follow up of colorectal cancer patients. With this standard, all involved then moved on to phase II: analyzing the guideline concordance and timeliness of colorectal cancer care. We then flow mapped our process to identify where we needed to intervene. There was no process in place to ensure that the patients had the necessary work up to accurately determine the state of their colorectal cancer and follow up. We realized that this needed to be developed.

As a first step the team developed presentations to increase awareness, and provided education about the C4 initiative to all involved in the diagnostic process including primary care providers and nurses. This process expanded the number of care providers who were more knowledgeable about our program and could support it. The primary care providers expressed that they felt overwhelmed by the large volume of patients they were carrying and were concerned about adding to their workload. The computer system’s readiness to address the requirements of our project was also an obstacle, but we worked together to formulate effective template notes and developed a clinical recall system that is still in place.

As previously noted, the C4 participants agreed to use the 2013 NCCN guidelines which included best known approaches for follow up after definitive treatment for those diagnosed with colorectal cancer. NCCN guidelines for colon cancer include, depending on the stage, colonoscopy one year after surgery, history and physical with carcinoembryonic antigen (CEA) every three to six month for two years, then every six months for a total of five years. CT scans of the chest, abdomen and pelvis are recommended annually for up to five years for patients with a high risk of recurrence. NCCN guidelines for rectal cancer are similar.

At the PVAMC our team, in reviewing our performance indicators, had evidence of improved compliance with colonoscopy and CEA.
We realized, however, that we needed to find a way to sustain the improvements. One solution we developed to meet that goal was the post treatment cancer surveillance clinic created and initiated January, 2008. As of February, 2013 we have 32 patients with colorectal cancer in the clinic being followed as recommended by the NCCN guidelines.

The APRNs at PVAMC do ongoing professional practice evaluation (OPPE) of each others' practices. Each APRN has a quality indicator that is evaluated by his/her peers. The quality indicator for the post treatment cancer surveillance APRN is "documentation of CEA follow up post treatment for colon or rectal cancer with criteria that there will be at least two CEAs in the medical record within a one year period for all patients enrolled in the clinic". The threshold for compliance is 87.5%. Patients with documented non-compliance or "no show" status are excluded (although these patients are called if they miss an appointment or blood work to prevent them from getting lost to follow up). Two charts are reviewed each quarter.

As of February 2013, all currently enrolled patients had documentation of having at least two CEAs in the medical record in a one-year period. We added a template to each progress note that outlines the appropriate NCCN guidelines for each patient depending on his/her cancer stage. The APRN CNS tracks and documents CEA results by date, last colonoscopy with results and when the next one is due, and schedule for the CT scan. We update this template at each visit; if a deficiency or potential deficiency is found, such as a potential delay to colonoscopy or delay in ordering of follow up CT scans it can be corrected quickly.

We have also developed a prospective database of patients diagnosed with colorectal cancer from the time they are noted to be FOBT positive. The secure database is accessible to all providers involved in the care of colorectal cancer patients, and can be updated by clinicians as data become available.

Our third innovation was the establishment of an electronic clinical reminder for clinicians to arrange for the recommended one-year post surgical resection follow up colonoscopy. The reminder is to be activated at the time of surgery. While this occurs most of the time, it is occasionally missed, and the oversight is then picked up in the Post Treatment Cancer Surveillance Clinic to ensure compliance with the guideline recommendations.

The APRNs in our group continue to work closely to ensure that Veterans enrolled at PVAMC receive timely notification of positive screening FOBT and are referred for follow up colonoscopy. Those who are diagnosed with colon or rectal cancer, and have received treatment with a surgical procedure, chemotherapeutic agents or a combination
of both are then followed appropriately. We are an example of a multidisciplinary group of APRNs who were presented with a deficit in the follow up care of Veterans with colorectal cancer, and responded by developing a forward looking solution. We are practicing to the full extent of our varied educational and specialty training in order to provide high quality specialized care to our Veterans with colorectal cancer.

REFERENCES


Chapter 8

The Intermediate Care Technician

Bruce Delphia, Jennifer Lee, and Karen M. Ott
In January 2012, the then Secretary of the Department of Veterans Affairs (VA), the Honorable Eric K. Shinseki, asked the Office of Nursing Services (ONS) to explore how to meet VA workforce needs by employing highly trained and skilled Department of Defense (DoD) medics and corpsmen who were returning to civilian life. The Secretary’s request was practical and timely. VA is facing significant workforce needs with 40% of the healthcare workforce becoming eligible for retirement by 2017 (Department of Veterans Affairs, 2011). In that same time period, it was estimated that over one million active duty Service members would transition to civilian life. In 2012 alone, according to the Secretary of Defense’s internal assessment, 10,000 medics and corpsmen left active duty with the number expected to increase each year as the United States withdraws from the current level of combat operations in Iraq and Afghanistan.

**A New Role is Created**

At the time this story was unfolding, Bruce Delphia, Education Project Manager, served as the Pilot Program Coordinator of the Intermediate Care Technician (ICT) project and Karen Ott as the Director for Policy, Education and Legislation in the Office of Nursing Services (ONS). Jennifer Lee provided physician leadership in the development of the ICT initiative. As the leaders for this initiative, we quickly realized the value in being able to use the significant training, skills and experience acquired by these separating military medics and corpsmen. We realized that they would benefit Veteran care and offer long-term value as talented and experienced VA staff.

Our first undertaking was to establish a multi-professional workgroup of VA clinicians, human resource and administrative advisors, legal counselors, union representatives, and DoD consultants to respond to the Secretary’s request. We became known as the Military Medic Work Group (MMWG). Of particular value and helpful to the work of the MMWG was our collaborative partnership with the National Partnership Council via the VA Labor Management Relations (LMR) Office. LMR helped identify a MMWG representative for each of the five labor unions: the American Federation of Government Employees (AFGE), Service Employees International Union (SEIU), National Nurses United (NNU), National Federation of Federal Employees (NFFE), and National Association of Government Employees (NAGE). All of the labor representatives were full participatory members of the workgroup and contributed meaningfully to pilot program development. As several of the labor representatives were Veterans themselves and one was a former Army medic, their insights and experiences were especially valued.
In April 2012, in an effort to more fully understand the training, experience and capabilities of medics and corpsmen, we travelled to the Medical Education and Training Campus (METC) located at Fort Sam Houston in San Antonio, Texas. Formerly the location for Army medic training, METC is now the primary military post for initial and advanced enlisted healthcare personnel training for all the services that provide military medical care. This includes U.S. Army medics, U.S. Navy and U.S. Coast Guard corpsmen, and U.S. Air Force medical technicians. The U.S. Marine Corps utilizes specially trained Navy corpsmen for medical support in the field.

Medics and corpsmen function in a wide range of military health care settings from stateside hospitals to remote clinics in overseas locations. Medics and corpsmen may be required to provide care on the battlefield while under enemy fire and in other hostile conditions. They often work independently under established protocols and standing orders. After our visit to METC and consultation with the command leadership, we unanimously and enthusiastically agreed to several key decisions. We:

1. Would develop a brand new role within VHA that would permit the effective utilization of the skills and abilities of medics and corpsmen.
2. Would give the new position a unique title, the Intermediate Care Technician (ICT).
3. Would not require ICTs to possess higher certifications or licenses before entering the VA healthcare system.
4. Would introduce the position as a pilot program in the emergency department (ED), the most logical clinical setting for ICTs with recent combat casualty support experience. Additionally, many medics and corpsmen were interested in working in the ED setting and many VA emergency departments needed staffing support.
5. Would use VA’s special hiring authorities to quickly recruit and hire recently separated military medics and corpsmen.
6. Would request central funding for the pilot to provide ICT salaries (for the first year), benefits, and training, and site visits for monitoring and consultation.

This understanding enabled us to realize the potential of utilizing the substantial knowledge, experience and skills of the medics and corpsmen for Veteran care. At the same time, we knew that we would need to create a challenging position with a robust scope of practice to attract them to the VA healthcare system and retain them as lifelong VA employees. Knowing that this program was a high priority for the VA Secretary, we quickly
identified the steps that would implement the pilot in the most expeditious manner possible. First, we needed to determine interest and support.

**ICT Pilot Program Implementation**

To ensure that there was sufficient interest and commitment for the ICT pilot program from facility leadership across the VA enterprise, we decided to query key officials at all VA medical facilities that provided emergency services. Our goal was to elicit their interest to pilot hiring former combat medics and corpsmen in this new ICT role with a scope of practice that would include advanced functions beyond the currently employed ED technicians to enhance their emergency services and augment the ED staff. Thirty-eight VA facilities responded to our query expressing a strong interest in being considered for the pilot.

This enthusiastic level of field support helped in obtaining approval from VHA leadership for the pilot program. Funding of nearly $3 million was approved, which would support salaries for 45 ICTs during the one-year pilot program. The vast majority of funding ($2.68M) was distributed to the pilot facilities for ICT salaries, benefits, and training for the 45 full time positions. A small amount, ($20K) was designated for evaluation which would include site visits. Given the robust interest, we next developed a list of criteria that would help us identify the most qualified facilities for the pilot. We then asked the 38 facilities to verify that they met the following criteria:

1. The presence of available mentors,
2. Staffing needs (the need for a technician role),
3. Clinical needs (e.g., volume, opening new beds, new urgent care),
4. The presence of board-certified emergency physicians,
5. Responsiveness/engagement with pilot concept,
6. Commitment to retain the ICTs and sustain the position post-pilot if it proved successful, and
7. Support for educational/career development opportunities for the ICTs.

After receiving the responses from the facilities, we scored and ranked them based on the criteria and submitted a list of the 15 most qualified sites plus four alternate sites to the VA Under Secretary for Health (USH) for final approval. The USH approved the 15 sites, listed in Table 8.1.
### Table 8.1 The Intermediate Care Technician VA Pilot Sites

<table>
<thead>
<tr>
<th>Pilot Site</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque, New Mexico</td>
<td>New Mexico VA Health Care System</td>
</tr>
<tr>
<td>Bronx, New York</td>
<td>James J. Peters VA Medical Center</td>
</tr>
<tr>
<td>Charleston, South Carolina</td>
<td>Ralph H. Johnson VA Medical Center</td>
</tr>
<tr>
<td>Cincinnati, Ohio</td>
<td>Cincinnati VA Medical Center</td>
</tr>
<tr>
<td>Cleveland, Ohio</td>
<td>Louis Stokes VA Medical Center</td>
</tr>
<tr>
<td>Denver, Colorado</td>
<td>VA Eastern Colorado Health Care System</td>
</tr>
<tr>
<td>Detroit, Michigan</td>
<td>John D. Dingell VA Medical Center</td>
</tr>
<tr>
<td>Hampton, Virginia</td>
<td>Hampton VA Medical Center</td>
</tr>
<tr>
<td>Huntington, West Virginia</td>
<td>Huntington VA Medical Center</td>
</tr>
<tr>
<td>Memphis, Tennessee</td>
<td>Memphis VA Medical Center</td>
</tr>
<tr>
<td>North Chicago, Illinois</td>
<td>Captain James A. Lovell Federal Health Care Center</td>
</tr>
<tr>
<td>Nashville, Tennessee</td>
<td>Tennessee Valley Healthcare System - Nashville Campus</td>
</tr>
<tr>
<td>San Diego, California</td>
<td>VA San Diego Healthcare System</td>
</tr>
<tr>
<td>San Juan, Puerto Rico</td>
<td>VA Caribbean Healthcare System</td>
</tr>
<tr>
<td>Spokane, Washington</td>
<td>Spokane VA Medical Center</td>
</tr>
</tbody>
</table>

Our next step was to create several subgroups within our large workgroup to work simultaneously on various aspects of the pilot including recruiting and hiring, clinical practice, continuing education, legal issues and a myriad of other factors. At the same time, we began a series of briefings to internal and external stakeholder groups. Our internal groups included the VA Office of General Counsel (OGC); several Veterans Health Administration (VHA) leaders including VA Central Office Chief Officers and Veterans Integrated Service Network staff. At the facility level, our briefings included the directors, associate chiefs for patient care services, and chiefs of staff. We also briefed external stakeholders such as the National Partnership Council (NPC), a council of five labor partners; Veteran Service Organizations (VSOs) including the Disabled American Veterans, the Veterans of Foreign Wars, and the American Legion; the Office of the Assistant Secretary of Defense for Readiness and Force Management (OASD [R&FM]); and The Joint Commission (TJC). All internal and external stakeholder groups responded positively to the ICT pilot program, and provided valuable advice, guidance, and in some instances resources.
Early in our work and often throughout the pilot we collaborated closely with significant stakeholders which included the OGC, the NPC, the OASD, and TJC. Before proceeding with the implementation phase of this program, we conferred with OGC to confirm that VA had the authority to hire unlicensed medics and corpsmen for this new technician role, who would work under the supervision of VA physicians. OGC indicated that the VA does indeed have the authority to determine the scope of practice for its staff under Article VI, Clause 2, of the U.S. Constitution, known as the Federal Supremacy Clause.

We asked The Joint Commission (TJC) for guidance related to any accreditation issues that may arise from the employment of unlicensed personnel in this expanded capacity. Initial feedback from TJC indicated that as long as VA has policies to ensure the competency of its workforce and abides by these policies, the hiring of unlicensed medics and corpsmen such as ICTs would not threaten hospital accreditation. TJC supported the concept and asked that we establish a baseline competency among the ICTs. To accomplish this, we developed a standardized psychomotor skills competency guide/checklist for clinical skills and a comprehensive written assessment based on subjects taught at METC. These included anatomy and physiology, history and physicals, universal precautions, medical emergencies, trauma, burns, and respiratory and cardiovascular emergencies.

**ICT Pilot Program Implementation**

We created the ICT pilot program to test several components and aspects of the ICT role including its appeal to recently separated military medics and corpsmen; the feasibility, utilization, practicality, and impact of the ICT role; and the satisfaction for both ICTs and ED staff. In the early stages, we realized that implementation of the pilot would require defining the program and obtaining long term commitment from the pilot facilities. To that end, we met frequently to discuss important issues in the development of the implementation plan with both the MMWG and the ICT pilot site coordinators. For the pilot, we established the following goals:

1. Demonstrate the viability and efficacy of the program concept,
2. Improve the quality of emergency care by adding additional skilled ICT staff to support the ED clinical team and enable ICTs to care for fellow Veterans,
3. Improve facility ED business management processes and operations by creating a pipeline to transition military medics and corpsmen into ICTs to help meet ongoing and future VHA workforce needs,

4. Increase VHA Veteran hiring and retention rates under VA’s transformation goals,

5. Collect and analyze data to measure the ability of the ICT role to enhance the delivery of Veteran healthcare in the ED,

6. Familiarize ICTs with VHA educational funding programs that will enable them to advance their healthcare education, and

7. Create a mentorship/sponsor program for ICTs to ensure a smooth transition into the VA healthcare system and culture and to improve retention.

Recruitment was the first and most immediate challenge of implementation, as we hoped to quickly launch the pilot within a few months. We sought multiple congruent avenues of communication and information that would enable us to adhere to a rigorous and aggressive ICT recruiting schedule to begin the pilot within a few months:

1. The web-based VA For VETS career center agreed to advertise the ICT position as a key feature of their website home page with a direct portal where persons interested could apply. Figure 8.1 shows a screenshot of the VA for VETs ICT recruitment webpage.

2. The VHA Healthcare Retention & Recruitment Office (HRRO) included the ICT pilot program in their marketing and recruitment initiatives.

3. The Office of Personnel Management included a “spotlight” and link to the ICT pilot program on their home page.

4. We established a dedicated e-mail address to accept any inquiry and all applicant packets directly from the VA For VETS website.

5. We collaborated with a single VA Human Resource (HR) Office located in Arkansas to process all applicant packets received through the VA For VETS and other VA recruitment portals to centralize and streamline the process.
To augment our recruiting efforts, we also reached out to our military contacts in the Office of the Secretary of Defense (OSD) and other DoD commands, and to multiple VSOs including the American Legion, Veterans of Foreign Wars, the Combat Medics Association, and the DUSTOFF Association to make them aware of this opportunity so they could help reach qualified candidates for the pilot. The DUSTOFF Association is not as familiar to the public as the other VSOs, yet is particularly relevant to the ICT project and is described in more detail in the references (DUSTOFF, n. d.).

Through these efforts, we received over 400 applications in less than two months. These applications were reviewed for completeness and for the appropriate Veteran qualifications established for recruitment under the Veteran special hiring authorities. Applicant processing began at the time the packet arrived in our mailbox. If the packet was sent to us directly, we immediately vetted and forwarded it to our central HR office, having established a 24-hour rule to evaluate, process, and post the packets on USAStaffing for the pilot facility or facilities where the ICT applicant had indicated a preference. The local facility assumed responsibility at that point to contact the qualified ICTs for an interview and make a final selection. We requested that local HR/hiring officials interview qualified applicants within five days and make a hiring decision and offer within seven days after the interview. We continued
to work one-on-one with local facility officials and HR staff to answer any and all questions and provide direction and guidance when requested.

We also received inquiries from Regional Veteran Employment Counselors (RVEC) working with VA For VETS. When appropriate we referred the applicant back to VA For VETS to assist in resume revision. By the recruitment close date, we had reviewed over 400 packets and resumes, and personally responded to over 400 requests for additional information exchanging more than 1,000 e-mails with both applicants and HR.

Recruitment was open to any Veteran who held a military enlisted medical specialty and who qualified under the Veterans Recruiting Authority (a special authority by which the VA may appoint an eligible Veteran without competition); the Office of Personnel Management General Schedule (GS) A; or any other Veteran Special Hiring Authorities. For Army Veterans, this was the Military Occupational Specialty (MOS) “68 Whiskey” designation for combat medics. For Navy and Coast Guard Veterans, this was the enlisted medical specialist designation as Hospital Corpsmen (HM). For Air Force Veterans, this was the Air Force Specialty Code (AFSC) “4N0X1” for Medical Technician. After the final applicant screening, 227 were deemed qualified. Applicants from every military service branch provided a diverse candidate pool for the pilot site facilities. Figure 8.2 provides a visual depiction of the distribution of applicants by military service branch.

**Figure 8.2 Intermediate Care Technician Applicants by Branch of Service Including Reserve Components**

As noted earlier, we had decided that we would not require ICTs to have higher certifications or licenses before entering the VA healthcare system. Instead, we sought to base the position and scope of practice on duties that
military medics and corpsmen assume in the EDs at stateside DoD hospitals and clinics. The ICT position would have clinical duties beyond that of a typical civilian healthcare technician but less than that of the scope of practice of a stateside military medic or corpsman. To accomplish this, we consulted with military experts to develop a scope of practice policy based on the core and specialty enlisted military education and training medics and corpsmen receive at METC. As a result, the ICT scope of practice reflected very closely that of a military medic or corpsman including such duties as minor wound repair, central line intravenous placement, venous cannulation, intravenous therapy, and several other skills that assisted medical and nursing staff, freeing them to perform the higher level responsibilities of their position.

In addition to the ICT scope of practice, we developed several other documents to assist the selected facilities with pilot site implementation. All documents were kept on a shared drive that we set up and have maintained.

1. **A Pre-Pilot Site Survey.** We developed and distributed a pre-pilot survey to all selected sites. The survey was designed to capture the essential data for contacts, organization and scope of practice commitments for the implementation of the ICT Pilot Program.

2. **An ICT Position Description (PD).** We developed and classified a new PD at the level of a GS-6 or a GS-7 depending on the scope of practice.

3. **An ICT Competency Checklist.** We developed a competency checklist to assist facilities with initial and ongoing verification of ICT competencies.

4. **A Pilot Orientation Guide.** We developed comprehensive guidance to both orient the ICTs to the ED and assist facilities to prepare the ED staff for the ICT role. As part of the guidance, we required that mentors and sponsors be selected from among staff Veteran volunteers, and that preceptors be assigned from the clinical staff in the ED.

Throughout the pre-pilot phase and the entire course of the pilot, we conducted numerous conference calls with multiple groups to discuss, clarify and resolve many of the issues that surfaced related to clinical practice, intraprofessional relationships, supervision, training, employee status, staff relationships and behavioral concerns. We met with facility site coordinators and ED points of contact on a monthly basis, and we met with facility HR and selecting officials on an “as needed” basis. In addition, a social media site was set up for informal communication among the ED staff and clinicians. To enhance communication with the ICTs, we held
a midpoint conference call and set up a separate Yammer website to foster communications among the ICTs and between the ICTs and us.

Throughout the entire course of the pilot, we received anecdotal feedback from both ED staff and from the ICTs. Samples of this anecdotal feedback are provided in Figures 8.3 and 8.4.

In addition, we received numerous positive media items that were disseminated about the ICT Pilot Program including locally televised news pieces and several print news articles. Figure 8.5 provides some examples of local print media coverage about the ICTs. The Veterans of Foreign Wars magazine published an article supporting the ICT Program, while taking the opportunity to highlight the overarching issue of Veteran unemployment and the licensing/certification gaps that existed between military occupational specialties and civilian employment positions in fields other than health care (Chandler, 2014). All media coverage noted the difficulty that former medics and corpsmen have in obtaining civilian employment in the medical field.

**Figure 8.3** Samples of Feedback on ICTs by ED Staff Members at Pilot Sites

**ED Feedback**
- “would be nice if we had an ICT on every shift”
- “increased our fast track patient throughput”
- “the Veterans feel comfortable being cared for by ICTs”

**Figure 8.4** Samples of Feedback from ICTs on their New Role

**ICT Feedback**
- "The program has been a godsend"
- "...allowed me to provide for my family"
- "...a ticket to a future in health care"
- "I will never leave VA"
- "Truth is, this job saved my life. I'm not sure if Washington understands the positive impact they have made on so many of our lives."
In addition, we received numerous positive media items that were disseminated about the ICT Pilot Program including locally televised news pieces and several print news articles. Figure 8.5 provides some examples of local print media coverage about the ICTs. The Veterans of Foreign Wars magazine published an article supporting the ICT Program, while taking the opportunity to highlight the overarching issue of Veteran unemployment and the licensing/certification gaps that existed between military occupational specialties and civilian employment positions in fields other than health care (Chandler, 2014). All media coverage noted the difficulty that former medics and corpsmen have in obtaining civilian employment in the medical field.

**Figure 8.5  Samples of Local Media Coverage of the ICT Pilot Programs**
ICT Career Pathways

The pilot was designed to provide ICTs with a pathway to licensed professional roles through advanced education. We accomplished this with the creation of two specific programs to support ICT career pathways.

1. A program titled Grow Our Own™ created a pathway for ICT’s to become physician assistants (PAs). Dr. James Martin, the American Federation of Government Employees (AFGE) representative on the MMWG and ED physician at the Captain James A. Lovell Federal Health Care Center (one of the ICT pilot sites) along with two facility staff members, Dr. John McGinley DDS and David Lash BS, MPAS, formed an agreement with the Rosalind Franklin University of Medicine and Science in North Chicago, Illinois. Under the Grow Our Own Program, Rosalind Franklin University has agreed to guarantee acceptance into their PA program for those ICTs that have met all the required prerequisites. In addition, future sites for program expansion are underway for academic affiliation agreements with PA and with nursing programs in other geographic locations.

2. A VA scholarship and clinical education program, designed to allow VA employees to return to school on a full-time basis, will include and target ICTs for funding support. Administered by the Healthcare Talent Management (HTM) national program office under the VHA Workforce Management and Consulting Office, this program, known as the VA National Education for Employees Program (VANEEP), will provide facilities with the salary dollars to allow ICT employee scholarship recipients to attend school and receive pay, benefits and tuition in exchange for a service commitment to the VA upon graduation as a licensed professional clinician. Although ICTs must still apply and compete for overall scholarship funds through their facility, HTM agreed to give ICTs priority funding at the national level.

ICT Pilot Evaluation

The pilot was evaluated for ICT satisfaction around the hiring process and the utilization of their role, and for ED staff satisfaction related to their readiness to accept the role and their understanding of the impact and utilization of the role. The VA National Center for Organizational Development distributed a voluntary online survey to ICTs and ED staff near the end of the pilot.
Survey data were collected from 105 ED staff. The data revealed that ICTs were very satisfied with the employment opportunity, and in particular, enjoyed being able to care for fellow Veterans. They also responded favorably when evaluating the pilot recruiting process and for the assistance provided with their resume preparation. The ICTs stated that they believed they helped reduce ED waiting times, kept the ED flowing smoothly, and were an asset to both physicians and nurse ED staff. Sixty-six percent of the ICTs reported being either satisfied or highly satisfied as an ICT. Their chief complaint was that ED staff underutilized them—using them frequently in roles that were considered below their scope of practice.

The data also revealed that a majority of ED staff agreed that the ICTs’ prior training and experience enabled them to meet the clinical responsibilities of their position, that they were valuable clinical team members, and that care improved in their ED as a result of the contributions of the ICTs. Among the ED staff members who were not Veterans, there was a lack of understanding about the historical roles/skills/experience of the combat medic/corpsman. Some expressed a concern about the facility not being prepared for the ICTs coming onboard. Most importantly, ED staff agreed that the ICT role should be extended to other ED’s and to other clinical settings.

**Lessons Learned from the ICT Pilot**

We learned many valuable lessons from the pilot that will be important as VA considers how to expand the ICT role in VA medical facilities. These include the following:

1. The ICT role can be an extremely valuable asset to VA. Medics and corpsmen were able to function effectively and safely with the scope of practice we developed. We were able to use competency-based verification of their skills and knowledge. The ICT role should be expanded to clinical settings in which their knowledge, skills, and experiences will benefit Veteran care and workforce needs to the greatest extent possible.

2. There were some pilot facilities and staff who were not initially comfortable with the ICT scope of practice, as an unlicensed technician, but over time successfully integrated the ICT role into their clinical team. We identified a priority requirement for successful implementation and that was to ensure that all clinical and non-clinical facility staff receive adequate
information and training about medics and corpsmen, the ICT role, how to verify training and competence, and how to appropriately utilize ICTs in the clinical setting.

3. Representatives of existing VA professions comparable in grade and duties and responsibilities to the ICT role, such as LPNs and health care technicians, expressed concern that the ICTs may compete with them for jobs. We plan to continually emphasize the differences in the scope of practice between the ICT and similar roles, and promote team-building among staff members filling all of the diverse healthcare roles. Pilot program site staff stated that a clear description of supervision and role expectations for the ICT was needed to reduce confusion and allow the appropriate utilization of the role. We propose that a national ICT program manager be established to ensure consistent and standardized implementation of the role in the future.

4. Acceptance of the ICT scope of practice was one of the biggest challenges we encountered during the pilot. While VA had the clear legal authority to create a role for trained Veterans without requisite credentials, the introduction of an unlicensed employee position with an advanced scope of practice would require the full understanding, support and cooperation of nursing and medicine as well as leadership at all levels at the pilot facilities. Our experience in implementing this pilot is that this can be successfully accomplished through repeatedly and consistently communicating clear information about the training, certification, ability and competency of medics and corpsmen to improve the quality of care in VA facilities. In the end, the most effective advocates for the utility of this new role were the ICTs themselves. In almost all cases, once staff began working directly with ICTs and had firsthand exposure to their knowledge, skills, and dedication to teamwork and to serving Veterans, they became ardent supporters of employing more Veteran medics and corpsmen within VA.

Conclusion

In conclusion, the ICT pilot program was overwhelmingly successful. We created a new position to allow former military medics/corpsmen an opportunity to utilize their skills and knowledge for Veteran care, in a role compatible with their training and experience, without additional credentialing or licensing requirements. This program offered valuable new
employment opportunities for Veteran medics and corpsmen who would otherwise not have been able to use their clinical skills in a civilian health care role. ICTs made a positive impact on patient care in the emergency departments at the 15 VA pilot site medical facilities. As this chapter was being written, six of the ICTs have been enrolled in academic programs for clinical licensure or healthcare administration. We now plan to propose continued expansion of the ICT program both for its value to Veteran care and for the long-term workforce pipeline it can provide for the VA.

REFERENCES


The Association derives its name, DUSTOFF, from the radio call sign given to the first aeromedical helicopter evacuation unit in Vietnam, the 57th Medical Detachment (Helicopter Ambulance), which arrived in-country in South Vietnam in 1962. The 57th initially communicated internally on any available frequency it could find. In Saigon, the Navy Support Activity, which controlled all words used in call signs in South Vietnam, allowed the 57th to adopt the callsign "DUSTOFF." This callsign epitomized the 57th's medical evacuation missions. Since the Vietnamese countryside was then dry and dusty, helicopter pickups in the fields often blew dust, dirt, blankets, and shelter halves all over the Landing Zone (LZ). Throughout Vietnam all evacuation helicopters assumed the call sign "DUSTOFF" followed by a numerical designation, such as DUSTOFF TWO TWO. The exception being the air ambulances of the 1st Cavalry Division which used the call sign Medevac. The DUSTOFF legend was born. The call sign "DUSTOFF," now synonymous with life-saving aeromedical evacuation, has taken on added meaning with the application of the Association’s motto: Dedicated Unhesitating Service To Our Fighting Forces.

Chapter 8.1
Intermediate Care Technicians in the Emergency Department: A Transition to Civilian Care
Nancy Robinson
I have been a nurse at the Cincinnati Veterans Affairs Medical Center (VAMC) for over twenty-three years and I can’t imagine working anywhere else. Currently, I am the nurse manager of a very busy and high volume sixteen bed emergency department serving over 25,000 Veterans per year. Over the years, I have seen many changes and advances in the VA system. When I began my employment in 1990 at the Cincinnati VAMC, popular opinion regarding the VA was very poor. I would tell people where I worked and they would feel sorry for me. Such a response was not surprising since at that time the VA had some negative publicity. Headlines read of remains of patients who had wandered off found near a medical center. Movies such as Born on the 4th of July depicted horrible scenes of poor care in dilapidated medical centers. Yet what I saw in the VA were America’s heroes. There was a sense of giving back to our country by taking care of those who put their lives on the line for us.

When I first started at the VA it was a very different place than it is now. Smoking was permitted throughout the hospital. Patients could smoke in large shared restrooms, and the nurses and doctors would actually smoke in the nurse’s station. Today smoking is still permitted on the VA campus, but only in designated smoking shelters. Years ago, the Cincinnati VA had 350 beds with two intensive care units and ten inpatient units, all with ward rooms that would accommodate four to six patients in a room. Today, the Cincinnati VA has ninety-one inpatient beds that are all private or semiprivate rooms. There are three inpatient units and two intensive care units. Much like the private sector, more and more outpatient services are provided, thus decreasing the need for inpatient stays. Care has moved out of the hospital, providing Veterans with increased access to care. The Cincinnati VAMC has six community based clinics and twenty-two primary care teams on the main campus. In the mid 1990s VA started “going paperless” and began utilizing an electronic medical record. VA has been significantly ahead of the private sector when it came to computerized documentation. Over the course of my VA career, I have witnessed major changes to our organization and dramatic improvements in Veteran centered care. The most recent improvement has been the introduction of Intermediate Care Technicians into our Emergency Department (ED).

In May of 2012, I received an e-mail requesting VA EDs across the nation to volunteer to participate in the Intermediate Care Technician (ICT) Pilot. The pilot included hiring medics and corpsman who had recently separated from military service and were in need of employment. VA was exploring a way to provide appropriate opportunities to engage transitioning medics and corpsman in the workforce. Army and Air Force medics and Navy
corpsman receive extensive training in medical care, but their experience does not easily translate into the civilian health care environment, that is, they lack comparable certifications and licensure. Many medics and corpsman were struggling to find employment in the civilian health care sector. The ICT pilot would support the hiring of Veterans and utilize their military training and experience to augment the staffing and skill level needed in the ED. Another goal of the pilot was to educate and support the upward mobility of the ICTs, facilitating their transition into other roles such as nurses and physician assistants, creating a path for them to become licensed professionals. Having such well-trained staff would support physicians and nurses to work at their full capacity by adding a new skilled workforce. With all the potential benefits that the pilot had to offer, the VA anticipated that the project could also improve both Veteran and employee satisfaction. I jumped at the chance and was able to gain support from my hospital leadership. The Cincinnati VA was honored to be one of the fifteen VAs that were selected for the pilot. Our journey began.

I received approval and funding to hire three ICTs, but chose to recruit only two. I wanted to be certain that I could assure our recruits of a manageable transition into this new role, with appropriate orientation, training, competency, and staff acceptance. I was fortunate enough to recruit and hire two of America’s best. One ICT was a recently retired 25-year Veteran, a Hospitalman Chief, who brought with him strong leadership skills and a passion for making improvements. The other ICT I hired had served six years as a reservist in the Army National Guard. He brought with him strong procedural skills and a goal to become a physician assistant. I must admit that the success of our program is truly due to their hard work and dedication.

After I made my selections for the ICT positions, my next decision focused on how I would introduce the new role to the ED’s registered nurses, health technicians, and physicians. This was a significant challenge for me since I wasn’t sure myself how the role would be fully utilized. At first some nurses were the least receptive to the idea. They were concerned about scope of practice issues, delegation of certain tasks such as starting intravenous lines to an unlicensed person, and the liability associated with delegation. The nurses also felt apprehensive since the ICT position description included many “nursing like” functions such as giving medications. They stated things like, “If we have ICTs doing all these things, what will be the need for nurses?” or “We went to school for four years and passed a strenuous licensure exam and they are just going to walk in and do our job?” Being a nurse myself I understood their concerns.
I realized that I had to make sure that the ICT role did not inappropriately encroach on their practice areas, but rather complement the work that nurses do. My strategy was to involve the nurses at the very beginning in the development of the ICT role to diminish practice threat or role confusion. As a result of their concerns, I made sure that our local unions were aware of the pilot from the very beginning. I negotiated details of the implementation of the ICT role through memorandums of understanding with our two local unions: the National Nurses United (NNU) and the American Federation of Government Employees (AFGE).

In contrast to the nurses, the health technicians were very supportive of the new role and many were excited that they too might be eligible for the opportunity for promotion to the position of ICT. The health technicians also seemed excited to have more support in their daily work since the ICTs would be able to take some of the burden off of their workday by assisting them with various tasks.

The last stakeholders were the ED physicians. I needed them to supervise, train, and ensure the competency of the ICTs for such skills as incision and drainage and wound closure. I needed the ED physicians to be comfortable delegating such invasive procedures and to be willing to take ownership and accountability of the ICT’s work. Understandably, the physicians had concerns regarding liability and risk with new unlicensed ICTs. It was thus my task to convince them that there would be little liability and the role would be possible due to the federal government’s Supremacy Clause which superseded state licensing boards and accreditation. I had to ensure that policies were followed and to maintain excellent record keeping of competency and continued training for the ICTs as required by accrediting agencies. Initially, convincing some of the physicians was a challenge since the ICT role was an unfamiliar innovation and I had to gain their trust.

My next step was to recruit volunteers who would serve as mentors to the ICTs. The mentors would receive training in coaching and mentoring which would require a sixteen hour class commitment. Criteria within the ICT pilot program required that the mentor be a VA employee and former medic or corpsman. Their task was to assist the ICT in transitioning to the VA system and civilian care. Our goal in assigning a mentor was to provide support in transitioning from providing care on a battle field or in a military setting to providing care in a hospital environment. Another objective of mentoring the ICTs was to ensure retention of the ICTs that were hired. I was lucky to find two excellent mentors: one was a licensed practical nurse who worked in the ED and the other was a licensed practical nurse who worked in the outpatient clinic. The mentors met all their obligations and were committed
to meeting with the ICTs regularly. The mentors helped the ICTs acclimate to the culture of our organization and assisted in a smooth integration.

It has been a year and a half since the pilot started and the impact the ICTs have made in our ED is apparent. The ICTs are the “jack of all trades”; they do just about anything and everything from assisting in triage to transporting patients, phlebotomy, starting intravenous and suturing lacerations. All this flexibility in one skilled employee has had a significant reduction in on our ED’s patient length of stay. For example, instead of a patient with a laceration waiting for hours in a busy ED for the physician to suture his wound, the ICT is able to assess the wound, prep the wound, and close the wound under the consultation of the physician through established competency. Our length of stay from the start to the finish of the pilot decreased by fifty minutes. Decreasing length of stay improves the care for all the patients in the ED by improving efficiencies and decreasing delays in care. Reducing patient wait times and throughput improves patient satisfaction. Staff members have shown improved satisfaction since the ICT pilot. The workload for the nurses and health technicians has decreased and patient surges are much more manageable. The nurses and physicians have more time to focus on their unique skill sets for improved safe, quality Veteran care.

The ICTs have become an integral part of the team providing care to our Veterans in our ED. Change is always threatening, but once trust in the ICT role was established, the value of utilizing their skills gained while in the military was obvious. It was a win-win for all. The ICTs benefited by gaining employment in a health care environment where they could apply their skills learned on the battle field. More Veterans now have opportunities for well-suited employment. ED flow has improved with decreased length of stay. Staff morale and satisfaction has improved and ultimately, and most importantly, the care for our Veterans has improved.
Chapter 8.2

The Intermediate Care Technician Pilot: A Home for Military Medics

Janet L. Henderson
Four years ago when I became the medical director of the emergency department (ED) at VAMC Hampton, I found that all the staff members were registered nurses (RNs). Missing were the ED techs, most of whom were off duty Emergency Medical Technicians (EMTs) and paramedics that had been in all of the community EDs I had worked in during the previous twenty years. After observing the work flow, it was clear that we could be more efficient if we had a blended staff so that the RNs could spend their time working at the top of their licenses and ancillary personnel could prepare the stretchers, draw blood, start IVs, apply splints and dressings as well transport patients to the inpatient unit or to radiology. Local Emergency Medical System (EMS) protocols allow paramedics to perform the same tasks in the ED as they do in the field, under medical (MD) supervision. When I discussed this with the ED nurse manager (NM) and Chief Nursing Officer (CNO), the reply I received was that there had never been EMTs or Paramedics in this VA ED and there was not a position description. Without a position description, I was told that it could not be done.

Three years ago, the national director for VA Emergency Medicine solicited interest in being a pilot site for placement of former military medics and corpsmen into a newly created Intermediate Care Technician (ICT) position. The pilot was being coordinated by the Office of Nursing Services with the support of Dr. Jennifer Lee, VA White House Fellow. I responded immediately. VA Secretary Shinseki realized that there was a wealth of talent that these former military medics and corpsmen had that did not easily translate into the civilian job market, particularly if they, while on active duty, had not obtained the formal training, education or certifications to become EMTs, paramedics or physician assistants. His vision was to transition these medics and corpsmen into positions within VA where they could utilize these skills.

The ED was chosen as the clinical site where the VA would launch the pilot program. Fifteen sites within the VA system would be identified for the first year of the pilot program, with national funding for three positions at each site. Leadership in nursing and human resources at each potential site would need to commit to the program because if the pilot was successful, these positions would be converted to full time permanent positions. The proposed program sites were required to have currently employed former corpsmen/medics at their sites serve as mentors for the ICTs. Both my Administrative Officer (AO) and ED Nurse Manager were former medics/corpsmen so I had mentors not only available but also in key leadership positions, which would make them
excellent mentors for our ICTs. In addition, our new CNO for acute care was committed to seeing if we could be a pilot site for the program.

VAMC Hampton was chosen as a pilot. We had more than 50 applicants for our three positions. We interviewed and made our selections. The nationally standardized ICT position description was written by VA Central Office leadership (a big plus) and was quite broad in what the ICTs might be asked to do. I knew we wanted to utilize their skills in simple laceration repair, incision and drainage of abscesses as well as removal of ingrown toe nails, skills that were normally only done by licensed independent providers (LIPs). I presented my plan to our Medical Executive Board (MEB) and they decided that we would use the same format that we do for LIPs, i.e. five procedures under direct supervision before being signed off to do the procedure independently. We would not be requiring a formal credentialing process but did require an official a sign off on demonstrated procedural skills. It helped that many on MEB, like me, either in training or in the military, had worked with medics and corpsmen in the past. I know I would never have survived the night shifts as the senior resident without Joey, a former Navy corpsmen who was working as a nursing assistant. He would “pull the curtain” and suture the deluge of intoxicated patients with lacerations while I attempted to keep the other patients moving through the department. This was during the days when the attending would leave the senior resident alone after midnight when they went upstairs to sleep with the parting comment of “a call for help is a sign of weakness”.

When one of the selected pilot program sites was not able to employ three ICTs, we were given a fourth position to be used in our pilot at VAMC Hampton. The ICTs were required to complete both our nursing orientation and our general employee orientation. One of ICTs actually had gotten his paramedic certification while serving as a flight medic. His wife was active duty and their official residence was in another state, and because Virginia requires that paramedics be citizens of the state, his certification was not recognized in Virginia. He had applied for fifty positions prior to being selected for the ICT program. Another of our selectees was retired and had completed a Licensed Practical Nurse (LPN) program, but wanted to use his former corpsmen skills. Our third candidate was just leaving active duty when selected. Our fourth selectee was actually deployed soon after starting. In the spirit of the program, we all agreed that we needed to hold her position so that she could return at the completion of her tour. In the end, she re-enlisted at the time the pilot was completed, but the position was converted to a permanent full time position and is actively being recruited.
Several of our ED physicians had previously served in the military, and were quite familiar with the skill sets the ICTs were bringing to the department. All were quickly signed off on their procedures and they became valuable members to our ED team. Our nurses were glad to have the help of the ICTs in bringing patients to the treatment site, sitting with mental health 1:1 observations, drawing blood for lab testing and starting IVs. Our physicians, nurse practitioners, and physician assistants have welcomed their assistance in doing the important functions that did not require LIP skills and were often time consuming procedures. The ICTs have become an integral member of our mock code blue training team as well.

As the year of the VA Central Office funded pilot ended, we decided that the ICT program was a resounding success and all four positions were converted to full time positions. When converted to full time positions, the FTEs were organizationally assigned to nursing. For the procedures that the ICTs perform, the MD staff will continue to sign off on those skill sets. Our throughput time for non-admitted patients is now at two hours. Many dressings and splints that previously delayed discharge are now done quickly, with our ICTs facilitating the discharge process. As our ED volume continues to grow, when space is available, our plan is to place an ICT in triage to initiate our standing orders (lab tests, EKGs, and x-rays) so that by the time the patient is placed on a stretcher for our direct care, that work up is well under way. Our Veteran patients relate to our ICTs as fellow Veterans. All three of our ICTs have plans to further their education. One is preparing for application to medical school and two want to pursue careers as physician assistants.

I am quite proud to have been a part of this pilot that finally has provided a “medical home” where our former military medics and corpsmen can continue to use the skills they had intense training and experience while serving on active duty.
Chapter 8.3

Just One More

Kristina Willin
Aries: You are efficient and follow through on every project you undertake. Your energy, vitality and enthusiasm are an inspiration to others as you take ideas and turn them into reality. You are open to new experiences, courageous and confident. When new opportunities come your way, you don't hesitate to take advantage of them. You have a sociable, lively and gregarious personality, always willing to help take care of others. In other words perfectly built for the ever-changing world of health care.

I have always been the girl that gets bored easily. When I feel like I have learned all I can in an area, I move on. Most people in my life would say I don’t commit to anything. In fact the only thing I have really ever committed to is my husband… and patient care. I found my passion for taking care of others early in life. When I was just finishing high school I entered into medical assisting school and got a job working for Kaiser Permanente in California, which has been known as the most respected of the private health care systems in that state. I moved through many different departments in Kaiser: primary care, pediatrics, internal medicine, urgent care, dermatology and emergent care. In fact I moved so many times during my four years with Kaiser that their Human Resources Department told me I couldn’t transfer any more. I was constantly searching for the work situation that would continue to spark my interest. I realized that as a medical assistant, I had few opportunities to do anything innovative.

Kaiser Permanente should have been the perfect place for me to commit, where I could retire. It was the perfect nine-to-five, same thing everyday job that paid well, yet I felt like I could do more. I also quickly got impatient with what I experienced as a flawed system of private care. It seemed to me that everything with private sector care was calculated. I couldn’t give out an extra Band-Aid without accounting for it, and the accounting often seemed more important than the care itself. I knew I didn’t want to be part of a health care system where I couldn’t give the patients every supply or every bit of care for which they have worked. I just didn’t know what that meant or where I could find something so different. Where could I serve where the money wasn’t the center of patient care, where I would be challenged and be part of the advancement of patient care?

I decided that I would leave Kaiser Permanente and join the military. I wanted to do something exciting that was bigger than myself. I enlisted to be an Aerospace Medevac Technician (AET), basically a flight medic. I was twenty-two years old when I enlisted, which is actually quite old to
Chapter 8.3: Just One More

start in the military. Most people that join the military and go through basic training have just graduated from high school, and never been away from home. Most eighteen-year-old recruits have never really had to take care of themselves. Before entering basic military training most recruits think about being part of what I call the “general population.”

I can remember telling myself to keep quiet, blend in, and try to make sure I could make it through the training course without being noticed by my drill instructor. Well, I blew that theory apart in the very beginning. I noticed that in the women’s latrine, toilet paper was not being restocked and we had to resort to using paper towels for personal hygiene. I marched into my drill instructors office, and with a passionate but very shaky voice said: “We have been out of toilet paper in the women’s latrine, and they are using paper towels for personal hygiene. Are you going to get toilet paper? Because, we could get sick from this.” He laughed and said, “Willin, you don’t know it yet but I’m going to have a job for you”. My new job was latrine cleaning crew.

The unforeseen job I eventually got was company medic. Soon I was able to get troops new boots if they had foot sores. I was able to recommend recruits to sickbay. I was able to procure medications for sick airman. My drill instructor started consulting me first if one of the women had a medical problem. This was the start, for me, of a very successful leadership role built of trust and respect for my abilities and medical knowledge. Making troop welfare your top priority and knowing how to take care of your population is key to being able to be a good leader and patient care advocate.

Every enlisted member who enters into the military takes an oath to defend and protect the constitution from all enemies foreign and domestic, but I believe military medical personnel take on an additional oath, an interpersonal oath, an oath that I like to call “just one more”. Medical personnel take on just one more patient. We work just one more hour. We manifest for just one more flight and perform just one more chest compression. We do whatever it takes for the patient just one more time all the time. It’s this kind of passion and selflessness that being a flight medic was all about for me.

I traveled all over the U.S. and got the best available training. I worked with both the Army and Navy. I was tri-qualified on the C-17 cargo aircraft, KC-135 refueler aircraft and the C-130 small combat carrier aircraft. I worked with the HH60 pave hawk helicopter. I accomplished Water Survival and Survival, Evasion, Resistance, and Escape (SERE) School. As an AE-Technician I was responsible for leading & directing medical technicians in the performance of aeromedical evacuation mission duties, treating trauma patients, traumatic brain injury (TBI) patients, burn patients, patients with
gastrointestinal and genitourinary problems, respiratory emergencies, pregnancy emergencies and cardiac compromised patients. I participated in over 75 flight-training missions in just a short period of time. At my unit I was able to order mission essential supplies and continue my ongoing education. I excelled in the Air Force. I received the rank of E-4 Senior Airman (SrA) “below the zone,” a competitive early promotion program for elite airmen who go above and beyond in the service. I was nominated for Airman of the Quarter. When it came time for my active duty time to end I knew I was ready to move on. This can be a scary thing because all military members work at a higher capacity than they do in the civilian sector. What do you do when your license is only an EMT-Basic? An EMT-Basic has a really limited scope of practice in the civilian sector. As an EMT-Basic working along with a paramedic, you are always the person driving the ambulance. To be honest I had never even driven an ambulance.

I completed my service in the Air Force and did what I think most Veterans do. I started attending school and got a simple job. I worked at a feed & pet store while I attended college. One day my husband sent me a generic email he had randomly received. The email said: “Attention Combat Medics, Med Techs & Corpsman, continue your medical career as a VA Intermediate Care Technician (ICT).” At first I thought this was spam email. My husband was an Artillery Marine Veteran; why would he get an email like this? The email had a link where you could apply for an ICT job, but I was convinced it was just some terrorist that wanted my social security number.

After about three to four months where I ignored this email, my husband confronted me and reminded me that I hated my pet store job and was getting really bored going to school. He suggested once again that I apply. I finally did. I promptly got an email back from a Veteran named Bruce Delphia. He told me they still had ICT positions available in Nashville, TN, Huntington, WV, and North Chicago, IL, and if I was interested to send in my resume. Unfortunately I wasn’t interested in any of those locations. My husband was leaving for Afghanistan and I wanted to move were we would know someone. Our whole family was from California and the only other people we knew lived in Ohio. Mr. Delphia and I spoke about Ohio and he told me that there was an opening in Cleveland. It was meant to be. I interviewed with Dr. Sarah Augustine. At the time Dr. Augustine was the Acting Director of the Emergency Department. At that time, Dr. Augustine was one of the ICTs direct supervisors, and the Associate Chief of Medicine. I was really nervous to have her interview me. Dr. Augustine gave me a chance, and a few weeks later human resources sent me an
offer letter. I was doing what I do best: changing up my life once again, and I was really excited about the opportunity to work with Veterans.

My husband left for Afghanistan in late November 2012 and in late December my mom flew in to California to help me with the 2400-mile long five-day trip to Ohio. This was going to be an interesting adventure. My husband left me with his massive lifted Ford truck, which I packed for my move with our three cats, two huge dogs and any belongings I could fit in the back, in the bed of the pickup. My mom and I would drive for ten hours each day and at night we would let the cats loose to run around the hotel room. In the morning we would round up all the animals and keep on driving. My husband and I had never stepped foot in Ohio before I got this ICT job. In the back of my mind the whole time I was driving I was constantly hopeful that this opportunity would turn out to be amazing. I had moved our whole lives to Ohio on the possibility that I would once again be a part of something bigger than myself.

I started as an Intermediate Care Technician in January 2013. Much like the military, our chain of command at first seemed like a mile long! The ICTs answered to the nursing staff, the assistant nurse manager, the nurse manager, the director of the emergency department and the associate chief of medicine. We also answered to the national project manager for the ICT pilot program and members of that project committee. All eyes were on us. Although the ICT program was part of VA's effort to increase the percentage of Veterans who work for the VA from 30 to 40 percent, I learned quickly that in the civilian sector not many people really knew what military medics did. It’s quite a challenge to convince people who have never been in the military that your scope of practice is really a mix of everyone's job. For example, a registered nurse (RN) has a clear cut, well-defined scope of practice and all RN's have to have a license to practice. An ICT has an EMT-Basic license, but a scope of practice that is made up of parts physician assistant, registered nurse and emergency technician practice activities. This program was designed to give medic Veterans an opportunity to utilize all their skills from active duty working in the VA helping other Veterans and I was determined to make that happen.

The team working with the ICT program here at the Louis Stokes Cleveland VA really went out of their way to make sure that the ICTs could be utilized in all areas of the ED. ICTs work in triage, fast track and the main ED. ICTs can work as nursing assistants, getting vital signs, performing EKGs, capturing a blood sugar reading and helping with the day-to-day stocking of the department. We can work as health technicians, performing venipuncture, placing peripheral saline locks,
accomplishing point of care rapid in-house lab work, bladder scanning/urine Foley catheter placement, enemas and C-Spine stabilization. Our scope allows us to perform nasogastric (NG) lavages / place NG Tubes, perform ear and eye irrigations, splinting, and casting. ICTs can carry out some duties usually performed by nurses. We are able to triage patients, perform tracheotomy care, and see wound care patients and perform dressing changes. ICTs are able to be discharge planners and transport monitored patients throughout the hospital. ICTs work side-by-side with the physician assistants performing incision and drainages, laceration repair with suturing, skin repair with stapling, assisting with the removal of foreign objects, and steristrip wound closer practices. ICTs can also administer a variety of medications. Most private hospitals would never allow a technician to administer medication but at the VA ICTs can administer basic IV fluids, administer oral glucose, use lidocaine for procedures, and administer aerosol treatments. Because of ICTs extensive military background we are formally part of the emergency department’s Rapid Response Team. ICTs respond to medical emergencies on the facility grounds. The ICTs don’t only work on the clinical side of the VA, but also administratively. I have been able to help order necessary supplies for the ED. Working with the emergency department director, Dr. Todd Smith, we have been able to create and start to implement local policy and procedure guidelines for the ICTs. I have been able to take part in the organizing of the ICTs employee folders. I have taken part in risk assessment management and competency reviews for the ICTs.

I have been fortunate enough to also be able to venture outside the emergency room and take on other roles as a member of my hospital’s community. I serve as a wound care committee member, representing the emergency department. I am an active member of the DEMS Team for Wade Park VA, the Natural Disaster Deployment Team. I am a member of the Wade Park Facility Decontamination (DECON) Team.

The ICT program has really been an inspiring experience for not only myself but for my coworkers. There are some amazing people that really understand the importance of and value in having ICTs be all they can be and strive to be more. Rose Burleson, Associate Chief of Ambulatory Care, has encouraged the ICTs to continue to expand their education and has personally helped to enroll the ICTs in ongoing VA leadership courses. Dr. Todd Smith, Director of the Emergency Department, has brought the ICTs on board for the revamp of Fast Track. Dr. Smith created an innovative way to improve the door-to-provider times in the Fast Track area using ICTs to facilitate flow. Recently I developed a new
pilot program changing the way the ED handles patient wound care/ dressing change follow-up appointments. The pilot is set to launch mid-2014. I have even been asked to be a member of the National ICT Steering Committee. In the future here at the Louis Stokes Cleveland VA, ICTs will be continually striving to expand their skill sets, adding to our already broad scope of practice by including arterial blood gas specimen collection. I’m really excited to see what our team has planned for us.

Working as an intermediate care technician has been an incredible experience and one where I am not likely to get bored. This innovative program has really measured up to all it can be and more. In no other hospital at this time can you have a technician of any background come up with new concepts for innovative programs, build upon such a vast skill set with limited formal licensure and yet be a part of a big picture team that is willing to take your ideas all the way. Taking care of our nation’s Veterans is what I am meant to do, and finally I am where I am meant to be. I am truly blessed to have found my way to the Louis Stokes Cleveland VA.
Chapter 8.4

Battlefield Experience Comes Full Circle
Maxine E. Lindsay-Shillingford, Bruce D. Oran and Sylvia M. Barchue
Chapter 8.4: Battlefield Experience Comes Full Circle

In 2012, our former Medical Center Director at the James J. Peters VA Medical Center (VAMC) in the Bronx, New York, MaryAnn Musumeci, received a memorandum from the Assistant Deputy Under Secretary for Health Operations and Management to explore novel ways in which Veterans Health Administration (VHA) may be able to transition military medics and corpsmen leaving the service into its workforce. A national VA task force proposed that medics and corpsmen had the necessary training and experience to fill staffing needs in VA Emergency Departments (ED) and was now seeking ED volunteers for a thirteen-month pilot.

The mission of this program would be to help transition soon-to-separate or separated medics and corpsmen from the Army, Navy, Air Force and Coast Guard to gain employment within the healthcare industry. This pilot program was being offered to VA hospitals across the nation. VHA had developed a thirteen-month experimental program that would be fully funded by VA central office, exclusively for the VHA to increase Veteran hiring. The initial phase would operate in fifteen VA Medical Centers across the country. Selection of these hospitals would be on a competitive basis. Paramount in the selection would be the commitment of the institution to see the program through, the agreement to offer employment to the individuals involved after the pilot period, and the completion of essays from a questionnaire stating why the hospital should be chosen for this honor. VHA leadership in central office would make the final selection.

On May 15, 2012 we completed our application informing the selecting committee that the James J. Peters VAMC (JJP VAMC) would be interested in this program, scheduled to be launched in July 2012. We were interested in competing for the following reasons:

1. To enhance professional development for corpsmen and medics
2. To improve emergency department throughput by relieving the nurses of time consuming procedural tasks, allowing the nurses to focus more on other patients and provide care appropriate to their education and competence
3. To increase access by improved throughput and decreased wait times
4. To improve patient satisfaction through Veterans caring for Veterans
5. To ensure licensed staff work at the top of their licensure while being supported by highly skilled unlicensed assistive personnel

The leadership of the Emergency Department, including Sylvia Barchue, Medical Surgical Patient Care Center Director, decided that...
this was an opportunity we wanted to strive to earn for our hospital. Once reassured by the hospital director and human resources program that we could keep the necessary commitments, our team went to work answering the survey questions, making our case for why the JJP VAMC would be best equipped to add these Veterans to our ED team as newly designated Intermediate Care Technicians (ICTs). We all worked together to put our best foot forward and in August 2012 we were informed that we would be one of fifteen VAs in the country to be funded for three ICTs and as participants in this national initiative. We were ecstatic when the announcement was made that ours was the only VA facility in the New England and Mid-Atlantic region to be so honored!

Around the same time period, JJPVAMC experienced an executive leadership change. MaryAnn Musumeci retired and Dr. Erik Langhoff, the previous Chief of Staff, was now moving into the role of Medical Center Director. We met with him to discuss the commitment that was previously made to hire three ICTs. Dr. Langhoff, without hesitation agreed to continue the program and offered his full support, which has been evident throughout the program.

With collaboration from the VA national project manager, Mr. Bruce Delphia, we began reviewing the documents from the numerous applicants selecting those we would like to interview. We formed a committee and chose several potential candidates. We started the interview and selection process. We selected three ICTs, each bringing a unique skill-set to the program. Each applicant had his/her own special strengths and weaknesses that they could bring to the ED team. We were most interested in applicants’ motivation, prior experience, knowledge and affability. They would be trailblazers, which required that they be adaptable, productive, and able to thrive in a dynamic environment.

The ICTs would function as members of the clinical team whose duties would overlap with those of the RN and physician. Their duties might include splinting, suture removal, triage, taking vital signs, electrocardiograms, phlebotomy, starting IVs, patient transport, dressing wounds, and documenting in the electronic patient medical record. They would be supervised by Dr. Bruce Oran, Chief of Emergency Medicine and Maxine Lindsay-Shillingford, Nurse Manager. A literature review addressing the use of unlicensed personnel in healthcare settings revealed an Oregon Medical Board “Statement of Philosophy” advocating that unlicensed personnel should be supervised by a licensed physician which we adopted as our policy (Oregon Medical Board, 2012).
We held several meetings with VA national leadership for this initiative. Jennifer Lee, MD, was at that time serving as the White House Fellow in the Office of Secretary Eric Shinseki at the Department of Veterans Affairs. Karen Ott, DNP, Office of Nursing Services Program Director was spearheading the program and Bruce Delphia, as noted above, was serving as the national project manager for this initiative. They reviewed the intricacies of the program with us and began to forward the ICT applications that they had received and screened.

We were surprised that we had applications from all over the country and that people were willing to re-locate for this opportunity. We agreed that our interviews were not meant to be stressful but designed to elicit the maximum information about each candidate. After weeks of interviews we were ready to make our offers. We chose three former Army medics, two men and one woman. Toward the end of the orientation period, one of our candidates had to drop out of the program due to family issues.

We scrambled and started the selection process again. We were thrilled to quickly find a wonderful candidate who could relate to our patient population and would be a good fit with our team members, given the diversity of our crew. She was currently living in Florida and willingly relocated to the Bronx. An unexpected gain was that she was a “Coastie”, a Veteran of the U.S. Coast Guard, having served as a corpsman. She became the only member of the Coast Guard to participate in this nationwide program. We now were back to full strength and ready to introduce our new ICTs to the ED staff.

Paul Singleton, a 20-year Veteran of the Army, had served as a medic in a combat zone in Bosnia and Paul was someone for whom this program could be particularly helpful. Prior to applying to the ICT program, Paul was homeless and unemployed. This opportunity would potentially turn his life around and it did. Paul was selected as the subject of the first video production explaining the ICT program, which was aired as an internal VA broadcast “American Veteran”, a monthly half-hour news magazine of the Department of Veterans Affairs (US Department of Veterans Affairs, July 6, 2013). Paul’s story is also available on YouTube (US Department of Veterans Affairs, August 2, 2013).

Alvin Strong, an active member of the Army National Guard had recently returned from a combat deployment in Iraq. Young, energetic and “gung-ho” Alvin was ready to jump in with both feet. The newest member of our group, Rebecca Doyle, our corpsman from the Coast Guard, had served aboard ship patrolling our national shores.
On October 22, 2012 during what would be the third and final Presidential debate with Governor Mitt Romney, President Obama made mention of a plan and the White House’s commitment to Veteran employment. He mentioned obstacles for these medics as they try to re-enter the work force in the private sector. In spite of very advanced medical training and often, combat experience, these soldiers, sailors, and airmen separate from the service with no transferrable certification. Without this form of recognition, gaining employment in healthcare within the private sector would be difficult if not impossible. Without some sort of medical certification, they would not be employable in the field for which they were so extensively trained. The hope and expectation is that once employed, these Veterans can take advantage of their military and VA educational benefits and pursue academic programs in nursing, medicine or as physician assistants to obtain the necessary credentials to expand their opportunities.

We structured the ICT orientation to uniquely meet the expectations we envisioned in their multifaceted role in the ED. They went through the same orientation designed for the RNs in our facility for three weeks. Following that, we provided a rigorous eight-week unit orientation that included rotation to our combined twenty bed intensive care unit, and urology service. For minor surgical procedures such as suturing and orthopedic procedures, they shadowed the ED Medical Director, Dr. Oran. We decided that our ICTs would attend classes for Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support, (ACLS), and Pediatric Advanced Life Support (PALS) and become team members for these services. They attended several clinical courses such as phlebotomy, electrocardiogram (EKG) and dysthymia recognition. Their position description was modified by Maxine to facilitate full use of their demonstrated skills. In this role the ICT performs some duties similar to those of the RN with the exception of giving medications. As highly skilled and trained professionals, while in their military roles, they were often the sole person making critical decisions in combat caring for their fellow soldier in arms. We ensured that our ICTs were able to work to their full potential with clinical and administrative duties such as work scheduling coordination where they managed a self-schedule system.

Following their orientation they were scheduled for continuing education classes offered on site as well as at distant locations. If a training need was identified, the ICTs were provided that opportunity through the nursing skills lab as well as in the ICU and the ED. The ICTs provide services in varying clinical capacities in the ED. By way
of example, they were assigned to serve as code team members, in triage, managing mental health patients, and responding to disruptive behavior situations through collaboration with the RN. Our ICTs transport stable and unstable critical patients. For those unstable patients going to the ICU, the MD, RN and the ICU transport the patient. If the patient is stable, the ICT independently transports the patient to the ICU. During their intense orientation, the ICTs have proven their competencies to care for these critical patients. All of this was accomplished by continuous education, evaluation of competencies and observation, utilizing feedback from other clinical staff.

The initial acceptance of the ICTs was mixed. Most of the nursing staff welcomed them with open arms! The ED had been staffed with only licensed professionals (RNs and MDs). This meant that the RNs had to do everything, much of which didn’t require their level of education, training and licensure. Most of the nurses welcomed the help. On the other hand, there were some nurses who didn’t like the concept of an unlicensed role designed to do what they did and more. They felt that they had worked hard to obtain their license and did not warm up to the notion of the ICT. They felt that their license to practice is what made them professionals and someone else, who did not go through the same rigorous certification process, regardless of how competent or well trained, diminished their value.

On June 19, 2013 we had a national all day mid-point conference review of the ICT program with Bruce Delphia and the administrative ICT team to discuss progress, concerns and issues. This was a very enlightening and informative session. Key insights we gained were that the JJP VAMC ICTs were being fully utilized in the new role; meeting and exceeding the goals of the program. In addition, we realized that not all of the ICTs were being used in the same manner across the fifteen pilot sites. For example, at JJP VAMC our ICTs have a degree of autonomy in collaborative practice. A major factor that made our program successful was the full support of local senior executive leadership from the beginning of the application process, support sustained throughout the program.

In time, the ICTs proved their worth. Regardless of the task assigned this group of ICTs worked hard and refined and improved their skills. Their role within the ED became more defined as they became integrated and accepted. Some developed interests and expertise in certain areas. Rebecca was given an additional duty as the staff coordinator for point of care testing. She was assigned this
additional responsibility due to her prior knowledge of working in a lab. She became proficient in point-of-care testing and ultimately reached a level of proficiency where she was training and certifying the other staff in the use of these devices for patient care.

We have received several inquiries about and positive feedback from Veterans who served in other wars such as the Vietnam War about the ICT program, including our own Veteran employees. Some Veterans have commented that they “wished that this program was around” when they had served in the military.

In addition to the American Veteran program referred to above, our program here at JJP WAMC has been featured in several media productions. The magazine Veteran of Foreign Wars published an analysis of the ICT program (Chandler, 2014) and the VA Central Office created an ICT Program final review video that included features of our ICTs (United States Department of Veterans Affairs, January 31, 2014). VHA published a story featuring our ICT, Paul Singleton on its homepage reporting on JJP WAMC (Cramer, 2013) and the internal VHA source for learning, called the Weekly Educator, provided a comparable story about Paul. These two latter sources are visually presented in Figure 8.4.1 and Figure 8.4.2.

**Figure 8.4.1** VHA Online News Story Describing the JJP VAMC ICT Program
The ICT pilot program at JJP VAMC not only gave these three Veterans the opportunity of a healthcare job, but they have also contributed to the improvement of throughput in the ED. In addition, the ICTs provided Veterans with a sense of ease when they learn that the ICTs are former military medics. They had an impact on customer service, improving our Veterans’ satisfaction with their care. We have also seen that the ICTs are more effective in dealing with the patients with mental health problems. This patient population seems to trust the ICTs more and subsequently these patients seems to be more open and respond positively during our clinical evaluation process.

VA healthcare facilities, as federal agencies, have the unique ability to pilot programs designed to help improve healthcare in general and the resources to provide care for our returning soldiers and sailors. In this instance we are paving the way to create a new group of healthcare providers that will enable separating medics and corpsmen to utilize their excellent training in the private sector.

Now that we have completed the initial thirteen months, we can qualify the program as a success. All three ICTs are currently enrolled part-time in educational programs pursuing degrees in health related fields using their military and VA educational benefits. Paul is in a registered nurse educational program; Alvin and Rebecca are in a physician assistant program. Paul and Alvin have elected to stay in the
ED while Rebecca has decided to transfer to another part of the hospital to broaden her experience, utilizing the skills she learned in the ED during this program to continue to serve our Veteran population.

REFERENCES


Chapter 9

Making Technology Work for Our Patients: Telehealth Nursing in the VA

David Newman
Mr. Fields (not his real name) is a rancher in northwestern Colorado. He was coming in for his first primary care visit at the Craig VA Telehealth Outreach Clinic in Craig, Colorado in 2007. I was the RN at the clinic and had seen him the week before to draw blood and obtain urine for lab tests and to do an electrocardiogram (EKG). At that time, I oriented him to the clinic and showed him the equipment we would be using to connect with his primary doctor who would be his Primary Care Provider (PCP), physically located at the VA medical center in Grand Junction, Colorado, 160 miles away. I also advised him that we would be completing a head to toe assessment using the equipment and that I would be with him during the visit to assist his PCP in completing the assessment.

On a snowy blustery day, I checked him in for the appointment, performed a preliminary nursing assessment including auscultation of his heart and lungs, and completed standardized health risk criteria via our electronic record system that alerts us using clinical reminders functionality. During my assessment, he let me know that he had not previously received care through the VA and, in fact, he had not received any medical care from anyone for several years. Since his discharge from the military during Vietnam, he had not accessed VA health care because he lived about 200 miles from the facility in Grand Junction and about 40 miles from the new VA clinic we established in Craig, Colorado.

I had established a good rhythm with the assigned PCP. I shared with the patient that I was going to connect the call and introduce him. I also advised him that the PCP would go over some history and would want to see his actual medication bottles from any other doctors he had seen, including over the counter medications. We would then complete a head to toe assessment and the PCP would want to discuss one or two of his most important healthcare issues. I connected the video call and we began the visit.

Just as this was Mr. Fields’ introduction to primary care through telehealth, working as a staff nurse at the Craig VA Telehealth Outreach Clinic was my introduction to the roles of telehealth staff RN and telehealth clinic manager as a nurse in the VA. While I later became the project manager and coordinator of the mobile telehealth clinic and later the facility telehealth coordinator at the Cheyenne VA medical center, the Craig VA Telehealth Outreach Clinic planted the seed of telehealth nursing in me. The setting in the high country of northern Colorado is typical of many patient settings in this Veterans Health Administration (VHA) region known as Veterans Integrated Service Network (VISN) 19, a rural area home to a tough breed of military Veterans who lived and worked in the majesty of the mountains and high plains. VISN
19 covers some 470,000 square miles and parts of nine states, with six medical centers and a variety of outpatient clinic settings.

My passion for telehealth is rooted in the care we can bring to those who previously had limited access to care, and that we function as a patient focused team with the goal of working with the patient to achieve the degree of wellness they seek. VHA has been an innovator and developer of telehealth services, and has been successful with the incorporation of nursing practice in telehealth. VHA also provided some of the earliest substantive research documenting the impact of telehealth as an important resource to improve access to healthcare services, especially in rural settings.

VHA began exploring the use of care through telehealth in the late 1990s, establishing a formal service between 2003 and 2007, initially called Care Coordination/Home Telehealth (CCHT). Key national level VHA officials set out to pilot test a care coordination and management program using telehealth technology to bring care to high risk, high cost Veterans who suffered from complex chronic conditions, including mental health problems. They also hoped to initiate a program where these Veterans could avoid unnecessary admission to long-term institutional care. This pilot achieved significant outcomes. The telehealth evaluation study report, published in 2008 (Darkins, et al.) indicated that the CCHT, serving 17,025 participating Veterans over a four year period of time, had reduced hospital bed days of care by 25% and number of hospital admissions by 19%. Perhaps more significantly, 87% of the participants reported satisfaction with the program.

The Center for Connected Health Policy (CCHP), a non-profit, non-partisan policy research, planning and technical support organization working to advance the use of telehealth technologies in health care, define telehealth as “…the use of digital technologies to deliver medical care, health education, and public health services, by connecting multiple users in separate locations…” (CCHP, n.d., para 1). VHA telehealth services aptly reflect this definition. They are subdivided into three modalities of service: Clinical Video Telehealth (CVT), Home Telehealth (HT) and Store and Forward Telehealth (SF).

As my introductory story indicates, I view my professional role in my care of Mr. Fields as the “expediter” similar to essential positions found in other high volume, high risk industries. For instance, the patient had a medication he had obtained in Canada, an over the counter product that was unfamiliar to the PCP. I looked it up in an online drug reference and shared the generic information with the PCP. While the PCP was
discussing lab results with the patient, I pulled the information from the VA Computerized Patient Record System (CPRS) and displayed it on the screen for reference. When the PCP indicated to the patient he wished to put him on a statin drug, I emailed our scheduler in Grand Junction to let her know the patient would need appointments in the Telehealth Outreach Clinic for labs in 6 weeks and 3 months, as that was the PCP’s routine orders for patients on new statin drugs.

My story of Mr. Fields shows the impact of telehealth on the care of our Veterans. After closing the call with his PCP, I reinforced the PCP’s information to the patient with nursing education and provided him with pamphlets that I printed from our online source on treatment for high cholesterol. Mr. Fields appeared exuberant. He told me he was quite happy and for years after returning from Vietnam, he feared coming to the VA due to the horror stories he had heard. Mr. Fields said the clinic was incredible; he loved the PCP and could not believe how well the technology worked. He closed the visit by stating he had been so worried about his health because his father died of a heart attack at Mr. Field’s current age. He was looking forward to receiving his medications in the mail and just knowing that the clinic was available to him was a huge relief.

We saw six or eight primary care patients that day and about four patients for mental health needs. I drew labs on a dozen patients and performed EKGs and clinic orientation for another four or five. It was a busy and very rewarding day. For me as a nurse, the key to my satisfaction was the extraordinary level of teamwork that allowed us to give the best possible patient focused care available.

The Primary Care Telehealth Outreach Clinic is committed to a high degree of teamwork and efficient workflow, which optimizes care for the patient. I often share the analogy of working in the Emergency Room (ER). A patient would check in with me at the window and I would complete an initial assessment and annotating a “SOAP” note (a format with subjective, objective, assessment, and plan information) then place it in a bin. A technician would pick up the documented assessment, obtain the patient’s vital signs, place the patient on a stretcher, and put the assessment note in a bin. A PCP would pick up the assessment note, talk to the patient, write orders, and drop it in the bin. I would pick it up, execute the orders, and put it in the bin. The PCP would write discharge instructions and put it in the bin. Finally, I would look at the orders, obtain the medications, give them and discharge instructions to the patient, and send the patient home.
This analogy of working in an ER as an example of teamwork can appear to be fragmented and disjointed. However, because the telehealth nurse can be with the patient throughout the process, a telehealth primary care visit can optimize teamwork and workflow centered on the wants and needs of the patient. I can advocate for the patient with the PCP and patients are more involved with conveying their health care needs.

Another example of a telehealth clinic visit involved a patient who confided in me while doing my assessment that he was homeless. He was clearly reluctant to share this information with the PCP. Wounds on this diabetic patient’s feet were the primary clinical focus of his visit that day. We assessed the patient together by Clinical Video Telehealth. The PCP ordered medications and a wound cleansing 3 times per day. In this case, it was critical that I share with the PCP the situation of homelessness, as the patient would have been unable to perform the regimen that the PCP ordered. So the PCP then was able to modify the treatment plan, to one that was achievable by the patient and would result in a good outcome.

As becomes evident, the VHA telehealth resources have proven to be invaluable to our patients, and enable nurses to use these new tools to provide the care their patients need. In Clinical Video Telehealth (CVT), a patient and PCP interact at the same time using videoconferencing with peripheral technologies such as stethoscopes or exam cameras as needed. In my venues, this was mostly done with primary care telehealth. The aim in primary care telehealth is to do exactly what is done in a face-to-face visit but without requiring the patient to travel many hours and miles to the PCP’s site of care. This requires a trained, committed, and trusting team whose knowledge of the technology allows the visits to occur seamlessly for the patient and PCP. I am able as a nurse to provide that service.

Telemental health is another common type of visit performed through the use of CVT. I have developed clinics that dealt primarily with medication management and other clinics that provided psychotherapy. These visits can be done individually or in a group structure. Often the first concern of those who have not been involved in such clinics is the risk of the patient escalating and causing harm. Personally, I have never seen this occur, which I attribute to a number of factors. When we do a Telehealth Service Agreement (TSA), we require that it include safety and emergency planning. Whether the plan includes a cell phone number for the mobile clinic PCP to call
the crew, the use of local 911 services, or key fob panic alarms, we believe a plan should exist that reasonably anticipates issues and is clearly communicated to all members of the team: PCPs, nursing staff, telehealth clinical technicians (TCTs) or other support personnel. With such an assurance in place, we are able to provide a VHA service that would not exist without the telehealth resources we use.

I indicated that I have never seen a patient escalate in a telemental health visit, however I have definitely seen patients in crisis during these visits. In my opinion and experience, many patients do much better receiving care through telehealth. I believe this is because the typical telehealth clinic is more low-keyed, staff members are familiar, access to care is easier and less stressful, and there is less perceived stigma. Again using the example of the Craig Telehealth Outreach Clinic, patients could go to this clinic for mental health care in contrast to trying to get to the main facility which is several hours away. These patients might previously have received no care at all due to the distance they lived from available care. Or, perhaps they may have driven 160 miles or more, over a treacherous mountain pass, to try and get to mental health services at the VHA facility in Grand Junction. After having gone through that arduous drive and perhaps after borrowing money for gas, then they had to find parking in the city. After finally locating a parking spot, they had to find the check-in desk, and then were directed to the elevators to reach the mental health department. For some of the Veterans, this is like running a gauntlet and it was easier to just not make the trip, regardless of their mental health issues.

In using the Telehealth Outreach Clinic, they travel a much shorter distance from their rural homes to the clinic in Craig, a town of about 9,500 residents (Craig, 2011). This outreach location is a more familiar venue to these patients and it provides an added level of convenience and comfort. The clinic, initially, was in a residential area inside a home that had previously housed a dentist. The patient parked on the street, walked up the sidewalk and into the clinic. In the clinic, I greeted the patient and was the familiar face in that clinic for the patient, the face seen for fulfilling health care needs including phlebotomy, primary care, mental health and so on. I would check the patient in and seat him/her. If there were a few other Veterans in the waiting room, they did not know if this Veteran was awaiting a primary care visit, an EKG, or a telemental health visit. Consequently, the Veterans I cared for in that clinic seemed to exhibit lower stress and displayed better agreement/engagement with scheduled visits and with the plans of care we jointly developed.
I also have been involved in a fair amount of specialty care through CVT. This can be done locally, to or from an outpatient clinic and the remote medical center. It can also be done through inter-facility visits, such as between two medical centers or even across VHA regional structures...other Veterans Integrated Service Networks (VISNs). For instance, we conduct an outstanding Orthopedics clinic using telehealth. The providers from the remote surgical teams see their patients both before and after their surgery via telehealth in clinics close to the patient’s home. Hence, we might remotely see a patient post-operatively who had a total hip replacement in our medical center but lives in Gillette, Wyoming, which is 250 miles away. This greatly eases the burden on the patient while reducing the cost of VA-reimbursed patient travel costs, and concurrently improving patient engagement in their plan of care.

Specialized services for women Veterans have also been provided via telehealth. These visits primarily involve pre-operative visits or consults for issues such as menopause. Additionally, we have a well-received tele-pain clinic and a fairly robust tele-endocrinology clinic. For the most part, unless the visit involves a very special type of equipment or technique, we have found that we can perform these visits through CVT.

When we use Home Telehealth (HT), a device is placed in a patient’s home that transmits questions or requests data from the patient, such as blood pressure or weights, depending upon the specific condition. The device transmits patient responses to questions and/or data to a professional care coordinator through a designated secure website. The care coordinator is most often a registered nurse, although depending upon the program and clientele, licensed clinical social workers and registered dieticians are often part of the team. The care coordinator reviews the data and coordinates the appropriate care. The care coordinator utilizes training, protocols, experience, and professional judgment to address any issues revealed by the data. This may involve communication with a PCP, entering a consult to a specialty service, coordinating transport to a local facility, or training and support of the caregiver.

The goal of HT is to allow a patient to remain in the state of wellness they desire and in the place of their choice. As noted above, HT has been found to have a positive impact on many clinical metrics, including reducing emergency room visits, lessening the number of days admitted in a hospital per year, and delaying the transfer to nursing home type facilities (Home Care Association of New York,
n.d.) It also provides an opportunity to those providing care to offer educational tips based on the symptoms and behaviors they are alerted to while answering Veteran or caregiver questions.

HT is arguably the most developed of the VHA telehealth modalities and has long designated registered nurses as the “care coordinators.” A care coordinator is key to facilitating the HT process. The care coordinator uses clinical judgment, chart review, knowledge of the patient, and guidance from PCPs and other services to properly position care and enhance the patient’s self-management.

Store and Forward Telehealth (SF) is a modality in which some data is obtained from a patient, typically a retinal image or dermatology image that is then transmitted to a provider such as a dermatologist or ophthalmologist, to evaluate. This is an enormous benefit to the patient because it provides screening and/or diagnosis in a manner far more convenient to the patient. Diabetic retinopathy is one of the most prevalent preventable causes of blindness. Teleretinal imaging allows a patient access to screening, typically in a location much closer to the patient’s home, thereby providing a service that historically would require multiple trips to a clinic. Similarly, Teledermatology enables a patient to save many hours and miles of travel, to have a lesion assessed, diagnosed and evaluated after treatment.

Nurses have successfully made their presence felt in the SF areas of telehealth, assuming a range of professional roles. They may conduct Teleretinal imaging or Teledermatology imaging and on the horizon will be wound care SF imaging. For many patients, telehealth will likely be the predominate way of meeting health care needs in the future and nursing students are now completing clinical rotations in this area. CVT, HT, and SF are the new skill sets nurses and other professionals will need to acquire as health care moves forward in the Information Age with the digital revolution.

Within the past decade, RNs have provided an increasing presence in VA CVT services. While this most frequently is in the primary care arena, nurses in specialty care areas also play key roles. In primary care, nurses have been involved as “telepresenters” in the patient locations. A telepresenter is the person who is in the room with the patient during a telehealth visit. This person is the hands, eyes, ears, and nose of the PCP. The nurse in this role utilizes strong assessment skills to assist the PCP in providing a complete assessment of the patient’s condition. The RN provides assessments of medical and mental health issues, as well as coordination of care with other services, both
in the local community and within VA. This includes but is not limited to specialty services such as cardiopulmonary and end of life care.

The Cheyenne VA’s most recent telehealth initiative is the Mobile Collaborative Clinic. I was fortunate to have an opportunity to provide leadership in the one we implemented with Northeastern Junior College in Sterling, Colorado. This clinic is conducted on the college campus and involves collaboration among nursing clinical instructors, nursing students, our mobile clinic RN and telehealth clinical technician (TCT), and the nurse practitioner PCP. The collaborative replicates the mobile telehealth equipment experience, with the same staff and identical equipment in the collaborative, as is used in the well-established mobile clinic. This on-campus collaborative has been an outstanding endeavor, as it has allowed us a venue with more space and amenities (such as a restroom) than we had with the previous mobile site in Sterling. It also has allowed us to increase the number of clinical hours per day because we no longer need to set up and disassemble the clinic each day. Additionally, it has allowed critical telehealth experience for both the clinical instructors and the nursing students. Thus, it has been a win-win all around.

Another example of a Mobile Collaborative Clinic is one we implemented in Laramie, Wyoming, in partnership with Laramie County Community College (LCCC) and the American Legion (AL). This clinic is housed in a building owned by the AL and is similar to the one in Sterling, but involves collaboration with LCCC clinical instructors and students. We have realized similar benefits here as with the one in Sterling, Colorado.

I am very passionate about telehealth nursing. There are two main things that fuel my passion for telehealth: patient-centered care and teamwork. Telehealth is the epitome of patient-centered care. The mission statement of the VA Office of Telehealth Services (OTS) states that we wish “…to provide the right care in the right place at the right time…” (OTS, 2013). Telehealth is the embodiment of patient-centered care and a vast change from the past. We no longer force a patient to seek care by leaving their homes and coming to us; instead, we bring care to them. Further, as a telehealth nurse in an outlying clinic in a highly rural area, I was able to be part of a tightly knit patient-centric team of patient, nurse, and PCP. I address concerns that the patient has but is reluctant to share and co-manage the plan of care with the PCP based on my assessment. I emphasize the PCPs’ orders in my patient education and I bring care to Veterans, many of whom had received little to no medical or mental health care of any type for years. VHA telehealth service has a huge
impact on patient lives and has forever created an elevated standard of health care services available to patients regardless of where they reside.

REFERENCES


Chapter 9.1

Developing Tele-ICU Competencies for VA Nurses to Ensure Optimal Patient Outcomes

Toni Phillips and Kay Clutter
The practice and art of nursing is a reflection of the assimilation of knowledge, skills, experience, and attitudes necessary to meet the needs of patients and families. Thus, new practice settings for nursing are emerging as important additions to the continuum of care in our ever-changing healthcare environment. In 2010 the Veterans Health Administration (VHA) created the National Tele-Intensive Care (Tele-ICU) Workgroup to support the development of Tele-ICUs in VA facilities. This workgroup proposed Tele-ICU models to provide remote real time monitoring, to perform rapid evaluation, and to provide intervention for critically ill patients within intensive care units (ICUs).

We, Toni and Kay, are two of the many nurses who were involved with the workgroup efforts which focused on delivering real time monitoring within intensive care units, utilizing tele-health care. Toni works for the national Office of Informatics and Analytics and Kay is the Operations Director for one of VHA’s regional offices (Veterans Integrated Service Network-VISN) Tele-ICU. Kay provided leadership in shaping VHA’s initial efforts for Tele-ICUs including delineating competencies for the Tele-ICU nurses. This task was challenging due to the fact that Kay was developing virtual teams. The use of cameras and long distance communication had to be understood and managed.

Tele-ICU (TICU) models emerged in the early 1980s and interest in their implementation has recently increased as a result of a shortage of critical care intensivists and the commercial development of Tele-ICU software (Grundy, Jones & Lovitt, 1982). The software used by TICU staff allows for patient population management. The TICU team has access to the same information that the bedside team does: waveforms, vital signs, assessments, computerized patient record system (CPRS), bar code medication administration (BCMA), x-rays labs, and of course, the camera. Due to increased utilization of critical care in the aging population, the demand for intensivists has increased and there is mounting evidence that intensivists can improve patient outcomes, increasing incentives associated with intensivist coverage (Duke, 2006).

The Tele-ICU model of care within VHA is enhanced by Clinical Video Telehealth (CVT) technology where patient encounters occur synchronously. “Real-time” interactive exchange between the patient and the provider via tele health technology is a key technical design for this program’s success. Programs have emerged which provide 24/7 monitoring of intensive care patients from a centralized monitoring support center. Within the support center, clinicians have access to the electronic health record, radiology imaging, and bedside monitors.
through the use of a two-way video camera. The high-resolution two-way camera also permits clinicians to perform visual assessments to identify declining health with emergent needs and to ensure rapid response interventions. The electronic link to the CPRS allows the clinicians within the support center to manage critically ill patients, write orders, implement interventions, and provide counseling and updates to patients and families within a critical care setting.

VA nursing has been key to collaborating on the development of the Tele-ICU models of care. Several pilot models have emerged to provide clinical services to critically ill Veterans separated by geographical distance or time, depending upon population needs. Once again a team approach is embraced for this new care delivery model, and practice is enhanced by the use of technology at the point of care. Core elements and integration of technology into nursing practice have been adopted from the American Association of Critical Care Nurses (AACN) recommendations on Tele-ICU guidelines (AACN, 2013). The early identification of insidious changes can result in quick interventions that contribute to positive patient outcomes.

In addition, VHA is analyzing internal and external Tele-ICU programs and lessons learned to gain insight on next steps. Cost data for set up and implementation as well as sustainment is currently being evaluated to calculate our return on investment. The pilot programs are collecting specific site data to establish metrics to measure added value to patient outcomes and staff satisfaction, as well as develop national strategies to explore the possible expansion of Tele-ICU programs within VHA.

One of the programs that emerged as an early leader within VHA Tele-ICU is the program from the VISN 23 in Minneapolis, Minnesota. VISN 23 was the first Tele-ICU in VHA to go live and began operations of its TeleICU on August 2, 2011, including both the Minneapolis Medical ICU and Surgical ICU. That was followed by Omaha, Nebraska and Fargo, North Dakota on August 4, 2011. We now have a total of 9 ICU’s operational between VISN 23 and VISN 20 (Northwest region) and will soon be expanding to 5 ICUs in VISN 15 which encompasses Missouri, Kansas, and southern Illinois.

Our shared journey in Minneapolis began in 2008 when Dr. Robert Bonello, Medical Director of the Minneapolis MICU, wrote a strategic initiative that was approved and funded by VISN 23, exploring the possibility for a Tele-ICU throughout that VISN. Over the next year many of the ICU directors and managers visited several non-VA Tele-ICU sites and observed how they operated. In May, 2009, the ICU medical directors and nurse managers from each facility in the VISN gathered in Minneapolis to discuss plans for a Tele-ICU. At the end of the meeting, Dr. Robert Petzel,
then VISN 23 Network Director, asked for a yea or nay vote on going forth with the project. It was unanimous; all sites voted to move forward with planning, developing, and implementing a VISN 23 Tele-ICU.

The TICU Medical Director and the Operations/Nurse Director, Kay, were hired in 2010 and the work of developing Tele-ICU began. One of the first jobs for the Operations/Nurse Director was to write a functional statement for the nurses that would be hired. Competencies also needed to be created specific to the needs of Tele-ICU nursing. The VA Office of Nursing Service (ONS) as well as the ICU managers in VISN 23 became our partners in accomplishing this. At a VHA Tele-ICU Summit held in Minneapolis in November 2010, the ONS, VISN 23 ICU managers, and Kay, as the Minneapolis Nurse Director, met to begin work on formulating the competencies we believe are necessary for a successful program and optimal outcomes. We also needed to align the competencies with the recommendations from the VHA national Tele-ICU workgroup. The lists of competencies we developed at the summit are displayed in Table 9.1.1.

**Table 9.1.1 Tele-ICU Nursing Competencies for VISN23: VHA’s First Tele-ICU Program**

<table>
<thead>
<tr>
<th>Critical analyzing and problem solving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritization</td>
</tr>
<tr>
<td>Takes initiative</td>
</tr>
<tr>
<td>Communication and collaboration</td>
</tr>
<tr>
<td>Advocate</td>
</tr>
<tr>
<td>Mutual respect</td>
</tr>
<tr>
<td>Mentor</td>
</tr>
<tr>
<td>Self-reflective and self-governing insight</td>
</tr>
</tbody>
</table>

The nurses also needed to be competent with the software program that is utilized by TICU clinicians. In order to help the bedside nurses with documentation needs, the TICU nurses became super-users for the Clinical Information System (electronic flowsheet) that is used in all VISN 23 and VISN 20 ICU’s. And because knowledge of ICU is extremely important, we required that any nurse that works for VISN 23 TICU would need to have a minimum of five years of critical care experience. Once all nurses were hired, an ICU instructor at the Minneapolis VA worked with Kay and the TICU nurses to further develop the competencies that had been formulated at the summit. Two months prior to our go-live date with our first ICU facilities, Sharon Stanke, ICU instructor, held a three-
day competency workshop for the TICU nurses. Part of the workshop was didactic with PowerPoint presentations and the rest was simulation.

We incorporated simulation into our training because it has proven to be a great tool for learning. With the competencies as a guide, the nurses were able to actually use the camera as a part of their training. We developed ICU scenarios so we could discover how the nurses would communicate and collaborate with bedside nurses. At the same time, we were able to get a clearer picture of where each nurse was in his or her knowledge of ICU as the scenarios played out. If there was an area where knowledge was lacking, we could then provide additional training options for that nurse. Using simulation for developing and demonstrating competencies, the nurses are able to provide immediate feedback to one another. Because they work over a camera, video etiquette is very important and one of our competencies. We also provided feedback about how the TICU nurses were experienced by members of the bedside team.

It was not smooth sailing when we finally flipped the switch and suddenly our faces started popping up on monitors throughout VISN 23 ICU’s. When VISN 23 Tele-ICU first went live, bedside staff members were very hesitant to call us. They did not know the staff in the TICU and frankly, were not sure they needed us or could trust us. It was up to the staff in the TICU to earn the trust and respect of the bedside team. The competency workshop that we required for the TICU staff helped however, especially our focus on communication, collaboration, and mutual respect. There were some tense, and at times, reactive moments between bedside and TICU staff. The change in how care was now being delivered was very different from any they had encountered in their careers…for both the bedside and the TICU staff. We were strangers to the bedside clinicians and now we were asking them to trust us and our suggestions regarding patient care. The only suggestions that served us well were to remain professional and courteous while on camera and remember the training we had just completed. Off-camera, we knew we still had some work to do.

VISN 23 TICU has been operational now for 18 months. Utilization of TICU is increasing and continues to increase. We have been working on standardization of our code (resuscitation) documentation since the TICU nurses are now the recorders for our ICU’s. And while relationships have been built, trust and respect have been earned on both sides of the camera, we still have much to do regarding competencies. The competencies that were developed for TICU staff are competencies that need to be taught for staff on both sides of the camera. We believe communication, collaboration, and mutual respect need to be
learned by all staff. And as we move forward with expansion, we plan on sharing our competencies with the ICUs that join our Tele-ICU.

REFERENCES


Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
Chapter 10: VA Nursing Academy: Lessons Learned from Successful Academic Partnerships

Mary Dougherty, Gwen Anderson and Anna C. Alt-White
Introduction

The Veterans Affairs Nursing Academy (VANA) was established in 2007 as a five-year pilot program to facilitate stronger and mutually beneficial partnerships between VA medical centers and Schools of Nursing (SON). VANA incentivized the development of a new model of academic partnership in nursing that builds on a strong existing collaboration and trusting relationships. The objectives for the partnerships focused on: (a) increasing baccalaureate nursing graduates; (b) enabling practice and education innovations; (c) enhancing recruitment and retention; and (d) facilitating professional development of VANA faculty. VANA was initiated and managed by the VA Office of Academic Affiliations (OAA) in collaboration with the VA Office of Nursing Services (ONS).

Although all VANA sites implemented their innovations with excellent intentions on both sides of the partnership, challenges arose at times due to (a) cultural differences between academia and service delivery; (b) differing priorities and organizational goals; (c) a lack of full understanding of the work involved in achieving core objectives; and (d) incomplete understanding of the intent of the new model of partnership.

In this chapter we will describe the methods we used to manage and consult with VA-SON partnerships to promote and enable collaborative, mutually satisfying, productive, and successful partnerships. We will describe the events that led to the formation of VANA, followed by a description of the processes we used to manage toward program objectives and enable successful partnerships.

Mary Dougherty serves as the Director of Nursing Education in the VA Office of Academic Affiliations. Anna Alt-White serves in a leadership role in the Office of Nursing Services as the Director for Research. Gwen Anderson brings to our story the perspective of a VA Nursing Academy Co-Director from San Diego State University who partnered with the California VA San Diego Healthcare System.

Background

A long-term goal of the Office of Academic Affiliations (OAA) and the Office of Nursing Services (ONS) has been advancing academic-practice partnerships to enhance the VA work environment, recruit nurses, expand options for Veteran-centric research and support academia in educating nurses. In 2004 the National Commission on VA Nursing submitted its final report that specified the desired future state and recommendations
for VA nursing. One recommendation was to establish national policy guidelines for schools of nursing comparable to the medical school model and actively promote nursing school affiliations (Department of Veterans Affairs, 2005). In response to this recommendation, the ONS leadership announced a program in 2006, Transforming Educational Affiliations for Clinical Horizons (TEACH), which offered VA facilities and nursing school affiliates opportunities to creatively design and implement innovative models of practice and education. The program announcement was sent to VA nurse executives and the American Association of Colleges of Nursing (AACN). There was strong interest in TEACH as evidenced by the 28 applications received. Leaders in ONS and the OAA coordinated a review of these applications; of these, five were funded, being awarded up to $50,000 per site.

TEACH served as the forerunner to the VA Nursing Academy (VANA): Enhancing Academic Partnerships Program established in 2007. This more robust five year, $60 million pilot program was designed to enable stronger, more beneficial relationships between VA facilities and Schools of Nursing (SON). This was to be achieved by (1) expanding faculty and professional development; (2) increasing student enrollment; (3) providing opportunities for educational and practice innovations and (4) increasing recruitment and retention of VA nurses as result of enhanced roles in nursing education. Three cohorts with a total of fifteen VA/Nursing School partnerships were selected between 2007 and 2010.

Coaching and Mentoring toward Successful Partnerships

The VANA model was designed to be a true academic practice partnership that demonstrated equity in roles and shared responsibility and authority for program implementation and logistics, strategic planning, program objective completion, and evaluation. Faculty members on each side of the partnership were expected to share similar roles and resources and have equal input into program management, curriculum development, and program evaluation decisions and processes. VANA faculty members were expected to contribute to committees and projects on each side of the partnership to enable knowledge and skill migration, as well as full immersion in the academic role. The initial assumption was that achieving a true partnership, despite a few start-up and logistical bumps, would be easily implemented. However, historic and traditional models of academic practice
partnerships influenced partners’ expectations of role relationships and expected outcomes. At times, these expectations interfered with development of the structures and processes needed to frame true partnerships between equals.

The historic relationships between SON and practice organizations have frequently been described as the academician – clinician divide. Rather than a true partnership model, the relationship is frequently depicted as operating in parallel processes. Within nursing education, expert knowledge is often linked to academic institutions, excluding the local knowledge and practice expertise that exists in a practice environment. Nursing service collaboration with academic programs is frequently operationalized as hospital or community based nurses functioning as preceptors for the experiential facility-based student learning experiences. This historical context also limited partnership expectations and increased some assumptions about the hospital based faculty role. The artificial boundaries assumed by some, due to prior practice and bias, could contribute to an inequitable perception of the hospital-based faculty role and significance to the educational mission. As a result, academic and practice partners have not always valued each other’s contribution to nursing knowledge (Andrew & Ferguson, 2008). It was our conviction that sustaining these patterns and biases would limit a relationship that requires mutual respect and acknowledgement of each member’s unique contribution and value.

The success of the VANA partnership necessitated an understanding of the historic differences, values, and perceptions of the academic and practice communities. We recognized that a true partnership necessitates mutual respect, equality in role designation, acknowledgement of the value each partner brings to the collaboration, and a willingness to listen, share, learn, and grow from each partner’s contribution. Shared responsibility for strategic planning, joint decision making, and management of the program required both partners to use problem identification, conflict resolution, and open communication. These basic principles and practices were not always identified or implemented. The challenge of cultural differences inherent in practice and academia, as well as various interpretations of the intent of the partnership, led to misunderstandings that needed to be recognized, discussed, and resolved before the partnership became endangered or dissolved. The national VANA Program Director, along with OAA and ONS leaders, were faced with the challenge of understanding and assisting VA nursing leaders to collaborate with partners that had
different nursing programs, multiple types and levels of nursing faculty, accelerated or traditional education platforms, and varying leadership positions and fiscal structures within colleges and schools of nursing.

The national Program Director undertook a journey of mentoring, coaching, and educating to provide clear definition, guidance, support, feedback, and communication about how each VANA partnership might develop, given the aims of the original call for proposals and the objectives to be accomplished. Deans and nurse executives were invited to envision the partnership as a way to bridge theory and practice in both classroom and clinical settings. To encourage this partnership, we offered them a creative strategic plan leveraging the knowledge, skills, and resources available from each partner within the experiential laboratory of the partnership, a process that could facilitate practice and education innovations aligned with partnership objectives.

Leadership in a Time of Transition

We realized that, as with any new venture, it is important to keep our goal in mind. Why are we doing this? Why is this important? What are the compelling reasons that justify the devotion of considerable resources to achieve the intended outcome? Everyone in the workgroup held demanding and all-encompassing “day jobs.” Most of us were leading large complex organizations that required 12-18 hour days on a 24/7/365 basis. While we knew that we could do some work during our “free time” at home, it was clear that we would need to meet periodically on a face-to-face basis. We recognized that this was going to be a daunting enterprise and that we should spend some time justifying the need to commit such significant amounts of time and energy. Our mandate became clear in light of the following realities.

The national leaders lived through the implementation and logistical challenges of each of the 15 VANA partnerships. Ultimately, all but a few partnerships were highly successful, while other partnerships faced obstacles and challenges that required closer oversight, nurturing, and conflict resolution. The process of leadership undertaken at the national level to realize the vision and objectives of VANA could be described as an ongoing process of coaching, mentoring, and educating at each site as the partnership moved from the forming to the performing and sustaining stages. The success of the VANA program depended on appreciative leadership or appreciative inquiry, which is defined as “…a philosophy, a model of change, and a set of tools and techniques that
support discovery, dreaming, design, and creation of a vision that inspires people in an organization to move toward a collective destiny… it is grounded in observations, collaborative dialogue, and experimentation to create the logic of a vision” (Keefe & Pesut, 2004, p. 103). As a leadership style, it is particularly successful during times of change and transition, when expectations and rewards require clear articulation and realistic strategies to achieve objectives need to be set in place. Success is celebrated, growth is acknowledged, and successful progress is praised.

While we describe the “4 D cycle of appreciative inquiry” (Keefe & Pesut, 2004, p. 105) as a linear process, the lived experience of the national Program Director, Mary Dougherty, was nonlinear, with a complex evolution that was iterative and progressed at different speeds depending on each partnership. This cyclic process is aptly pictured in Figure 10.1.

**Figure 10.1** Visual Image of the 4 D Cycle of Appreciative Inquiry
Guiding Leadership Practices in Implementing the Veterans Affairs Nursing Academy
(Adapted from Keefe & Pesut, 2004)

Discovering

The first step in the cycle of appreciative inquiry required openness and trust building, while focusing on strengths rather than problems and obstacles. We encouraged VANA partnering organizations to share their strengths, as well as the contextual issues embedded in each setting. This
process involved clarifying expectations, opening lines of communication, and focusing on what works well in existing partnerships in terms of local resources, shared histories, past achievements, and common goals. Our intent was to support them in moving toward collaboration, consensus building, and buy-in from staff on each side of the partnership so that staff could capitalize on their synergy and begin to prepare for a new style of partnership. The national Program Director began the discovery step by asking questions in individual interviews and within focus groups of key partnership stakeholders. This facilitated partnership staff and leadership discussion of issues in a relaxed, non–threatening, and comfortable environment. Probing questions elicited information that built upon previous conversations, making possible the discovery of unacknowledged accomplishments along with system or logistical barriers and challenges. We asked participants to think creatively of potential solutions as well as alternate ways of managing the challenges identified. The dialogue affirmed the need and desire to celebrate success and positioned participants toward solution of issues, which greatly enhanced collaboration and good will.

At times, partnerships requested focused visits to ascertain the reasons for their specific partnership challenges. Alternately, we at the national level could schedule a visit due to concerns about communications or the content of products, such as the required Annual Report. A key component of these visits was appreciative listening. We conducted focus groups with each core constituent group, such as students, VA-VANA faculty, SON-VANA faculty, program directors, nurse managers, nurse recruiter, the SON dean, and the VA nurse executive. In these focus groups we emphasized discussion of issues relevant to each partnership, with the key organizing frame of reference being the core objectives identified in the VANA Request for Proposals (RFP) and the partnership’s initial proposal in response to the RFP solicitation. Through our appreciative listening and data collection, we had the opportunity to assess the current state of the partnership, as well as gather more complete detail to identify success and challenges for the partnership. This information was the basis for constructive recommendation for change to enhance success. Through this process, we also were able, with them, to celebrate their accomplishments.

Common issues requiring clarification and direction included: (a) misunderstanding of the role of VA faculty; (b) the outcome expectations pertaining to RFP objectives; (c) organizational and process elements supporting joint decision-making and conflict management; and (d) communication mechanisms to facilitate successful partnerships. At the end of each consultative visit, we provided a verbal summary report,
followed by a written report describing the partnership successes and suggestions to enhance the success of the partnership.

**Dreaming**

In the second step of the appreciative inquiry cycle, the national VANA Director encouraged leaders within the partnerships to “dream big,” to be innovative, and to be creative. Instead of maintaining the status quo relative to education and practice initiatives, we encouraged program directors on both sides of the partnership to consider alternate or innovative approaches to education and practice that would support a Veteran-centric approach consistent with VA organizational transformative goals. We encouraged this focus by creating work teams composed of VANA faculty and program directors to develop standard evaluation tools and data elements to assess implementation of RFP objectives. These cross enterprise work groups strengthened peer alliances nationally, enhanced interpersonal connections, and created a forum for sharing individual visions of opportunity for innovation in practice and education. The work groups also enabled effective communication of the intent and expectations of key program objectives amongst VANA faculty and contributed toward a better understanding of Annual Report goals.

Through site visits to each partnership by the national Program Director, as well as the gathering of all local program directors at a national conference, we created a forum for the sharing of examples from various partnerships. Lessons were learned from dialogue with each partnership, including the sharing of individual partnership implementation tactics to achieve program goals and the provision of insight into the innovative initiatives design, development, and implementation process. The listening process frequently became an opportunity for partnership participants to reflect, digest, and reconsider their successes, challenges and strengths identified in previous accomplishments. Appreciative listening made it possible for us to assist each partnership with exploring options, assessing choices, and guiding realistic planning.

**Designing**

During the designing step of the inquiry cycle, our task was to match the goals and objectives of the VANA Program with the characteristics,
resources, and choices available in each partnership. The program directors at each partnership site were encouraged to discuss practical ideas, challenges, barriers, and untapped catalysts for structuring their programs to fit the original vision and goals while staying focused on education and practice innovations and achievements. We taught them skills and techniques for sharing governance of their programs with representatives from each side of the partnership. This was a time of sorting out what was being contributed from each side of the partnership, thus crafting the desired outcomes with input from the national VANA Program Director and the local VANA directors and faculty. We gave special attention to conflict resolution, if necessary, and how to be an agent of change for nursing education and practice in healthcare reform. Our leadership style was supportive and encouraging, while identifying weaknesses and strengths that could be shaped to move beyond obstacles, recover from set-backs, or create new opportunities for professional development of VANA faculty, RN staff, and students.

**Delivering**

The last step in our appreciative inquiry cycle was to guide the entire set of partnerships toward reflective observation, accountability, and reporting of recognizable and valued outcomes. We provided guidance in terms of greater specificity and attention to both quantitative and qualitative evaluation components. Establishing a web-based portal to collect information that described the specifics of each program resulted in a massive amount of data to organize and analyze, but it enhanced rigor in reporting common denominator evidence of what the VANA partnerships had accomplished. We added a qualitative story-telling dimension to our data collection to recognize achievements that were not easily measured. Our goal was to describe collectively the value each partnership added to the nursing profession, to Veterans, and to the nation. This step required countless follow-up communications, re-clarifying previously stated expectations, answering questions, and coaxing partnership sites to recognize, take credit for, and record their activities and achievements. In some instances the national Program Director made sites aware of their reporting obligations to ensure that local program directors were aware of the importance of reporting measurable outcomes. Continuous sharing examples, coaching, learning, improving, and celebration of achievements were an essential part of this step in the cycle.
Summary

Appreciative inquiry exemplifies the principles of the new academic service partnership model, which fosters trust, affirms common goals, and catalyzes creativity by engaging nurse leaders to undergo organizational transition. Because of appreciative inquiry, mentorship, coaching, and education, leaders of VANA partnership programs across the country are still forging new collaborations and innovations that energize nursing education and practice reform. Both sides of the partnerships have advanced the profession by making classroom education more relevant, patient care safer, and health care practices improved through application of evidence based research at the point of care. In the words of Sherwood, “understanding both academia and practice is essential for both worlds and addresses the forces that drive the actions of each” (Sherwood, 2006, p. 557). At the end of this chapter we have included several sources that might be useful to others creating comparable programs in their environments. Through VANA academic service partnerships, VA has educated a growing portion of today’s generation of nurses who have experience with Veterans. Highly qualified nurses who are committed to Veteran healthcare have selected VA as their employer of choice or they have taken their knowledge about Veteran healthcare to other community-based settings.

Future Implications

We believe that respect for the logistical challenges and awareness of barriers to achieving a successful partnership are crucial knowledge elements required prior to implementing an appreciative listening dialogue. We learned that in order to provide timely and structured guidance to the partners, it is necessary to build on our prior experience and knowledge gained in working with individual partnerships to resolve conflict or disagreement over role and function and partnership outcomes. The VANA partners were not always timely in sharing partnership issues and challenges. The belief that “one does not air dirty laundry” encapsulated the problem, and that mindset frequently led to an unsuccessful partnership. Trust was a key requirement and needed attention for all individuals involved in leading, managing, and evaluating the partnerships. The idea of asking for help outside the individual institutions was anathema to some, preventing potential interventions that might alter a negative trajectory. We learned that
establishing a coaching/mentoring or consultative program with a structured approach was a core requirement to ensure success, as well as to provide appropriate fiscal stewardship of program monies. Thus, the second phase emerging out of the VANA pilot program, an academic partnership renamed the VA Nursing Academic Partnership (VANAP), provides the financial and consultative resources to enable substantive change in VA-nursing school relationships and to promote innovation in nursing education and practice. (VANAP, 2013).

Thus, lessons learned from VANA encouraged a more formal implementation of a coach/mentorship role in our program. The person holding this position would be available to the partnerships for visits each semester to assess, provide guidance, and provide the structure and processes necessary to develop true and vibrant partnerships. Lessons learned will be incorporated in the RFP to be issued each year until a full complement (18 partnerships) is identified. Truly, all involved in the VANAP initiative are learning, re-evaluating, and improving each day with the goal of leading positive change for education and practice.

REFERENCES


Chapter 10.1

VA Nursing Academy: Providing the Bridge to Connect Nursing Education with the Health Care of Our Veterans

Jane Wellman, Lyn Dubbs, and Mary Boland
The “talk story” is a time honored Hawaiian tradition of taking time to share history, ideas, and experiences from our lives. It is rooted in oral language where wisdom is transmitted through talking/storytelling. We hope that our “talk story” offers a snapshot of our journey of the past four years through our experiences building an academic practice partnership that embraces three very large and very different public organizations. We each played different roles in the story: Mary Boland as Dean of the University of Hawaii, Manoa campus; Lyn Dubbs as instructor, then Instructor/ Program Director; Jane Wellman as instructor, then Acting Program Director prior to Lyn, and eventually becoming Associate Director Patient Care Services/Nurse Executive at the VA Hawaii.

Our story takes place in the vast region of the Pacific. The VA Pacific Islands Health Care System (VA PIHCS) serves Veterans in the Pacific Basin, a geographically isolated and rural service area of 4.6 million square miles that includes the Hawaiian Islands, Guam and American Samoa (US Department of Veteran Affairs, 2013). It is home to a large community of active duty and retired military personnel and their families. The Tripler Army Medical Center (TAMC), the only federal tertiary care hospital in the Pacific Basin, supports 270,000 local and 191,000 regional active and retired military personnel, their families, and Veteran beneficiaries. VA PIHCS and TAMC share a campus and have a 17-year history of joint venture and sharing agreements for emergency department care, acute medical-surgical inpatient care and outpatient specialty care.

By 2008, the nursing leaders at the two healthcare organizations and the University of Hawaii Manoa, School of Nursing (UHM) recognized that we needed to address the looming nursing shortage and develop a strategic partnership to prepare Hawaii nurses to understand the influences of Veteran culture on health care delivery. We seized on the opportunity of the VA Nursing Academy (VANA) pilot as a means to increase educational capacity to address the looming shortage, increase the educational preparation of the VA PIHCS and TAMC nursing workforce, and create an enhanced environment for professional nursing practice. The initial proposal was not funded but we continued to work together and were successful in the year three competition. Our unique partnership was forged in 2009 with a common purpose to meet the workforce demand by increasing the number of locally accessible and culturally competent nurses.

In 2009, the nursing leadership at UHM, VA PIHCS, and TAMC agreed to participate in the creation of a new collaborative model to build a pipeline of baccalaureate prepared nurses comfortable in their competency to care for our military community in all healthcare delivery settings. Pacific Islands
VANA was designed to benefit UHM Nursing by increasing faculty, expanding learning opportunities for students, and increasing students’ understanding of Veterans’ healthcare needs while strengthening their partnership with the military community. Both VA and TAMC would gain by increasing their visibility with the next generation of baccalaureate prepared registered nurses (RNs), improved recruiting, and accessing academic development for their workforce. It was a natural progression of our already ongoing partnership with TAMC for the healthcare of our Veteran population.

Our program has evolved over the past four years into being a major component of the UHM undergraduate curriculum with VANA faculty integrated throughout the six-semester program. The instructors who have a military connection through previous employment, being a military spouse or a Veteran, contributed personal knowledge and commitment to the program development. We have generated new ideas that have been integrated into the curriculum to assure that all of our students are aware of the multifactor culture and needs of the Veteran population.

Our VANA faculty has worked closely with the VA PIHCS and TAMC staff to develop clinical experiences that are beneficial to both the unit and the student by becoming part of the nursing team, moving beyond supervision of students. Faculty are involved in giving unit in-services, providing research consultation, serving on facility committees, and being active in policy development. These activities have built trust and increased collaboration between the instructors and the nursing staff resulting in a fuller experience for the student with increased understanding of the healthcare needs of our Veterans.

Joint strategic planning involving instructors and leadership from VANA resulted in the implementation of a nursing orientation to the military culture and protocols for new students prior to their clinical rotation. We felt it was important for the student to have a basic knowledge of the rank structure and how a patient might react to interventions. For example, a Private might be reluctant to ask for assistance or question anything while a Colonel might question every detail. We also emphasized the military language to increase understanding of terminology not frequently used in the civilian sector world, such as the head (bathroom), chow hall or galley (cafeteria or dining room). This briefing eased some anxieties of the students and avoided some embarrassment and misunderstandings.

Additionally, our “talk story” includes an exploration of the generational differences of our Veterans and how their time of service might impact their behaviors. In their future, students will be caring for a WWII hero; a Vietnam Veteran who still cannot leave the trauma of the jungle or
forget the negative reception when he returned home; and an Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) Veteran who looks well but has a hard time hearing or processing thoughts due to traumatic brain injury (TBI) from an improvised explosive device (IED). Many Veterans experience survivor guilt when they lose their buddy yet they came home. The students are better prepared for what they might encounter and it gives them a better appreciation for the service given by these men and women and the sacrifices made by their families. We share with students that it is our belief that it is an honor to take care of a Veteran or a member of the active duty forces and encourage the student to ask the Veteran to tell their story. Students report that hearing the experiences Veterans share with them is life changing for the students.

In our clinical settings the community health students have been able to take on projects that give them autonomy and responsibility. Because we have clinical faculty who are VA staff, the students have the freedom to develop practical programs that will have specific desired outcomes. A cohort of 10-12 students completes a community assessment and population-based project each semester. One community health class chose to work with the homeless Veteran population by working in the US Vets Center homeless transition program. The students were able to make a community assessment, develop a plan, and implement a project that was then passed on to the next semester for evaluation and refinement.

Another recent two-year VANA student project is a community garden at the US Vets Center that has provided a venue for teaching nutrition, activity, and relaxation. The garden is a “safe” place for students and Veterans to engage in open communication. This environment provides an opportunity for “talk story” and an avenue for the student to learn about not only the health needs of the Veteran who is transitioning from homelessness but also the lived experience of the homeless Veteran. This knowledge supplied the basis for a student-developed and led health fair at the center that has resulted in student and Veteran satisfaction.

Other hands-on experiences include open clinics known as “stand downs” for outreach to the homeless, flu vaccination clinics, disaster simulation training and patient education events in the outpatient clinic. The students have reported a feeling of accomplishment and connectedness with the Veterans in these experiences.

Over these four years, 441 students have completed a clinical rotation at either the VA or TAMC. Many students have had multiple clinical placements at our facilities. One student expressed in her clinical evaluation that she “felt sorry for those students who did not
get to have their clinical placement at the VA”. A 2012 survey of UH Manoa students found that students who had two or more rotations reported an increased interest in working with Veterans from 42% in contrast to the 20% interest expressed by students who had not (Ishida, Misola, Li, Aczon-Armstrong, Kurihara, 2012). The students also reported an increased knowledge of Veteran’s and active duty military healthcare needs after they completed a clinical rotation at VA/TAMC.

We have developed a summer student internship for areas at the VA and TAMC. This internship was implemented in the summers of 2011, 2012 and 2013. The program, which includes 270 clinical hours with a preceptor and a small process improvement project, has resulted in increased hands-on experience for the students. The purpose of the internship is to provide an opportunity for the student to have a higher-level experience in the care of Veterans beyond the responsibilities as a student and with the guidance of experienced registered nurses. We found that preceptors become more involved in improvement activities in the area where they work and take pride in being part of the students’ growth. The VANA faculty who are embedded in the VA and or Department of Defense (DoD) unit with the staff augment these experiences. The synergy created between staff and faculty increased awareness of personal strengths and opportunities for professional development for both groups. We discovered that the early relationships between the faculty, the student and the staff preceptors provide a strong foundation for further staff development. The Institute of Medicine Future of Nursing goal of providing a nursing staff comprised of 80% bachelor prepared by 2020 gave us focus and supported our partnership for increasing the opportunities for baccalaureate nursing (BSN) students, not just for the VA or TAMC, but for the Pacific Island community. To date the goal of 80% by 2020, has been achieved by both the VA PIHCS and TAMC, which reflects our leadership role in the community and a source of pride for this partnership.

Our sixth semester (senior) nursing students do their complex (225 hours) experience with a preceptor. This experience provides a time to be fully integrated into the culture of the system. They have the everyday experiences within the unit and understand the complexity of the “real world”. All students are required to choose a quality improvement (QI) project, complete the project and then share their outcomes through a poster presentation. These projects provide an increased understanding of real world practice and specific experiences with the needs of the Veteran and active duty military. The QI projects have also been used for unit-based staff training and competency development. The close partnership of the
faculty member with clinic staff further developed a mutual respect and created a team approach to nursing education. We believe it is a successful example that reflects the union of education with the healthcare industry.

During the American Heart Association “National Wear Red Day” campaign, our students participated with staff and Veterans at a VA PIHCS sponsored event by wearing red shirts on February 13, 2012. This event titled “You Are The Cure” included patient education on nutrition and exercise, and a vaccination station. A question and answer session was conducted in the lobby of the Ambulatory Care Center with a panel of expert providers (physician and nurse practitioner) with specialized skills and knowledge in cardiac health, health promotion and disease prevention. The agenda concluded at noon with a walk around the campus. We enjoyed being part of a collaborative event shared by nursing students, staff, providers, and Veterans.

On any given day in the lobby of the VA PIHCS Ambulatory Care Center, you will see Veterans engaged not only in “talk story” but also sharing music. They will have ukuleles, guitars, and a variety of other musical instruments, sometimes singing, but always having a good time. At times providers, nurses, nursing students and staff join in and enjoy the moment. Our VA has become for Veterans their VA and the stories we have written here are truly visible, tangible examples of the connection between our VA and the Veterans we serve.

The VANA project continues to provide resources to address the need for professional development, career ladder progression, and partner collaboration. Both the VA PIHCS and TAMC implement their nursing education mission through education and research partnerships with the UHM. UH prepares students for careers in nursing, primarily for the State of Hawaii and the Pacific Basin. Programs offered include the Bachelor of Science in Nursing, Master of Science in Nursing, Post-Master’s Certificate (PMC), the Doctor of Nursing Practice, and the Doctor of Philosophy in Nursing. UHM and TAMC have a formal research academic practice partnership that supports seed projects.

Our shared goals for moving forward include: 1) ensuring a sustained partnership with support from VA PIHCS, TAMC, and UHM leadership, 2) continuing the clinical presence of UHM students at both TAMC and VA PIHCS, 3) stocktaking of the nursing education workforce and practice objectives, 4) developing interprofessional team based learning environments using simulation as well as clinical based modalities, and 5) developing a nursing residency program for VA PIHCS in order to increase employment opportunities for new graduates. We eagerly anticipate further
success and expansion of the partnership among our three agencies to continue increasing the number of BSN prepared nurses and supplying a workforce for the future. The vision of our partnership thus extends to the future with a resolve to continue providing an experience creating new healthcare relationships among active duty military, Veterans, and nursing students. We describe active duty military personnel as “Veterans in training”. The ultimate goal of the VANA partnership is to enhance the personal experience and care of our Veteran population along with providing optimal outcomes. Our “talk story” continues.

REFERENCES


Chapter 10.2

Building a Successful Academic Service Partnership: The San Diego VA Nursing Academy Experience

Carole Hair and Gwen Anderson
The authors acknowledge the United States Department of Veteran Affairs, Office of Academic Affiliations: Enhancing Academic Partnerships Program, and the Office of Nursing Services: The VA Nursing Academy program (VANA).

The authors wish to acknowledge and thank Catherine Todero, formerly Professor and Director, San Diego State University School of Nursing (SON) and Blanche Landis, Lecturer, San Diego State University School of Nursing, the first SON VANA Director, for their contributions to the initial development of the academic service partnership. We also want to thank all of the VANA faculty members and VA nurses for their contributions to making the partnership a successful endeavor.

For many years VA San Diego Healthcare System (VSDHS) and San Diego State University (SDSU) School of Nursing (SON) had a strong academic affiliation to support clinical education for students in both the baccalaureate (BSN) and masters degree nursing (MSN) programs. During the height of the nursing shortage in 2000, the SON implemented a funding campaign called “Nurses Now” to support hiring additional faculty and increasing student enrollment. The VA contributed to “Nurses Now” by funding a VA clinical nurse specialist (CNS) to serve as an adjunct faculty member. This was a full time position that enabled the CNS to teach students who came to the VA for a clinical rotation and students participating in the VA Learning Opportunity Residency (VALOR). The established academic service relationship and role of the VA academic educator became the genesis of our VA Nursing Academy (VANA) proposal.

The Director of the SON and the VA Associate Nurse Executive for Education embarked on the VANA journey by co-writing and submitting our proposal to the VA Office of Academic Affiliations (OAA). In the summer of 2007 we were notified that our partnership was among the first four VANA sites selected. The opportunity to enhance our existing academic service partnership and to work together to achieve objectives described in the request for proposals (RFP) was a dream come true. The objectives were to: a. increase student enrollment, b. expand and develop faculty, c. develop innovative educational and practice programs, and d. recruit and retain VA nurses.

This chapter describes the process of developing our academic service partnership using the group development model first described by Tuckman
(1965). This model includes four stages: forming, storming, norming and performing. We will provide specific examples of successes and challenges encountered as we trace our progress through our partnership. We have written from the perspective of the two program directors representing each side of the partnership, Carole Hair at the VA San Diego Health System and Gwen Anderson at San Diego State University School of Nursing. This chapter tells our story while we held those collaborative leadership positions.

Using Tuckman’s “Stage I: Forming”, we started the process of hiring our team, identifying our work, and expanding our existing resources and systems. The first objective of our partnership was to increase the number of faculty educators at the VA. Through increasing faculty, we increased the number of BSN students who could participate in a VA based healthcare clinical experience so they could better understand the VA mission and the healthcare needs of Veterans. An additional goal of this partnership was to enhance the experiences of BSN students participating in an existing VALOR program. We believe that it is imperative to attend to the students’ professional and emotional development during the challenging transition from student to new graduate. The VALOR program has expanded to include not only clinical practice on a home unit, but also "off unit" experiences in an area of interest to the student, enhanced education-focused experiences, and participation in a faculty led peer-support group. The rationale for these activities was to attract and prepare the best-qualified and most highly committed senior level nursing students for a career in VA nursing.

Our model for VANA faculty development was to assign academic educators to specific units in the clinical area of their expertise where they could become acculturated and embedded. Our goal for the VA faculty who were already embedded in a clinical unit was to amplify their role in academic nursing education. Faculty development activities were provided to broaden their knowledge of nursing and education theory, curriculum development, and methods of evaluating teaching and learning outcomes. Ultimately, we were expanding and enhancing the quality of nursing education at the point of care in the context of a supportive learning environment for students.

In the first three years of the program SDSU students in clinical rotations at the VA grew from 138 to 365 per year with the assistance of 10 full time equivalents (FTE) of VANA funded faculty. As described in Tuckman’s (1965) forming stage, students and faculty showed a great deal of positive energy and enthusiasm for the new teaching and learning opportunities. The VANA faculty also improved the entry process for students and faculty at the VA. As Program Directors, we worked closely to set monthly
meeting agendas, clarify role expectations, and develop innovative teaching methods. Frequent meetings helped VANA faculty to establish collaborative working relationships. When faculty and student issues arose, we ensured that these were discussed in a group context, and decisions were made with input from experienced faculty and partnership leaders.

Experienced SON faculty provided mentorship to new faculty to assist in the transition from expert clinician to academic educator. They shared their styles of teaching and assisted new faculty to learn methods for evaluating and documenting student progress including putting a few students on a performance improvement contract. The SON faculty welcomed and oriented the VA faculty into the university setting, school of nursing committees, simulation and skills labs, the teaching resources, and online academic webinars. VA faculty provided mentorship to SON faculty for orientation to clinical units, the VA nursing governance structure, and VA systems for online resources, email communication, work schedule timekeeping, and navigating the VA healthcare system.

One cultural difference identified between VA and SON faculty was the concept of work schedule. The VA “tour of duty” expectation clashed with the flexible schedule of the SON. The norm for SON faculty was discordant with the VA expectation of being present and at the VA facility during normal work hours. We were able to resolve these differences by having the VANA faculty discuss their roles, responsibilities, and accomplishments during VANA faculty meetings to demonstrate productivity and teamwork.

The lessons we learned in those first two years placed a heavy value on providing resources (office space, supplies and equipment), streamlining the student entry systems, and providing regular faculty and leadership communications via email, faculty meetings, and semi-annual strategic planning meetings. Activities for building and nurturing relationships included celebratory ceremonies for recognition of VANA students and faculty accomplishments. These strategies enhanced trust-building relationships and knowledge sharing across the partnership.

This moved us on to “Stage II: Storming” where we were now focused on simultaneous program design and grappling with implementation conflicts and challenges. Storming began early in the partnership when there were differing views about initiating the enhanced VALOR curriculum. The VANA Directors (Blanche Landis was the original SON Program Director) felt a need to begin the new program even if the curriculum was not fully developed in order to meet goals and timelines identified in the VANA proposal. Some of the VANA faculty felt reluctant to begin a student cohort before the full program was developed. A compromise was reached,
and the new program began in January of the first academic year rather than in September. The program directors assumed the responsibility for coordinating the didactic portion of the first cohort of VALOR (also known as VANA Scholars) while VANA faculty oriented to their new teaching roles.

Another activity that involved storming among the VANA faculty and other staff within the VA involved a research proposal. The VANA National Director encouraged our VANA faculty to consider developing a new graduate nurse residency program based on research evidence and the standards established by the Commission on Collegiate Nursing Education (CCNE, 2008). Simultaneously, there was a call for research proposals by the Health Resources and Services Administration (HRSA) for funding new innovations in nursing education. These new opportunities created a great deal of excitement and enthusiasm that fueled a decision by VANA faculty to support three goals: a. establish a New Graduate Nurse Residency Program (NGNRP), b. write a proposal for the HRSA funding for support of this endeavor, and c. submit the research proposal to the hospital IRB to assess the effect of the NGNRP on the transition to professional practice during the first year of practice.

The HRSA grant proposal, with a short submission deadline, was written by an academic-partner faculty over the Christmas holiday break when many VANA faculty were taking time off. This resulted in minimal opportunity to collaborate with key VA stakeholders who were responsible for developing the NGNRP curriculum and obtaining the commitment of content experts to teach. Months after the research proposal had been approved by the IRB, but not funded by HRSA, key residency program stakeholders voiced strong objections (storming) about what they identified as discrepancies between the research proposal and the current state of the residency program implementation. Areas of conflict included disagreements about the research questions, proposed schedule for recruitment of participants, and proposed data collection as a potential burden on new graduates who would volunteer to participate in the research. The VA norms for consensus-based decision-making at every stage of a practice change collided with the norms of an academic researcher to meet a grant deadline. The conflict contributed to a sense of violating the trusted relationships that had been formed among VANA faculty and with VA nurse leaders. It became clear to the VANA program directors that everyone had a passion for how the new graduate residency program was developed and evaluated. The research protocol was placed on hold and the VANA program directors and faculty focused on reaching consensus to stabilize the work environment, retain
the overall vision and the goals of the NGNRP, and manage the very real task of simultaneously developing and implementing the program.

During the storming stage, the program appeared to be faced with major setbacks, but in fact, the partnership team infrastructure established in Stage I enabled VANA faculty to regroup and reconnect with stakeholders via subsequent meetings, report writing, workgroups, and participation in semi-annual retreats. The team and stakeholders moved into the norming stage. When VANA faculty refocused on the vision and included stakeholders in the decision-making processes, we began to see progress toward achieving mutual goals. The team moved toward more harmonious working practices and relationships. The IRB protocol remained on hold and the NGNRP launched in the summer of 2010 with the first cohort of 10 new graduate nurses. With this reinvestment in collaborative relationships the VANA faculty and stakeholders accepted the vital contribution of each other, they came to know each other better, and they began to reestablish more open lines of communication and trust.

The major lesson we learned during our “storming” experience was that by being inclusive of the entire group of nurse leaders, the VANA partnership was restructured to better fit the context of the setting. VANA directors and faculty expanded the organizational reach by tapping into, and welcoming the input, expertise, and resources of the entire group of nurse leaders within the VASDHS. VANA directors and the faculty recognized the value of nurse leaders taking ownership and steerage of the NGNRP redesign, which was necessary to promote sustainability. VANA faculty and VA nurse leaders worked together to clarify, draw consensus around and implement components of the NGNRP such as evidence based practice (EBP) projects designed by new graduates, simulation education, and redesign of the preceptor education program.

We moved forward, through collaboration and continuing faculty development, into “Stage III: Norming”. By successfully negotiating the storming phase, we developed a broader vision and mission of our VANA program. Key external events also shaped the development of our partnership including the publication of the Carnegie Foundation study that called for improving nursing education (Benner, Sutphen, Leonard, & Day, 2009), the Institute of Medicine (IOM) report on The Future of Nursing (2011), and the core competencies for interprofessional practice (IECPE, 2011). We moved the activities of the partnership forward based on evidence from an expansive literature review of nursing education that included students’ perspectives of their classroom and clinical experiences, national goals, standards and guidelines for curricular...
redesign in nursing education, innovative teaching modalities, factors that support a healthy clinical work environment, the benefits of collaborative interprofessional teams, team building, and interprofessional education.

We think it is important to share some achievements of our VANA partnership that occurred in the norming phase of team development. Since 2010, VANA faculty and VA nurse leaders have refined the NGNRP curriculum and managed to juggle as many as three cohorts simultaneously to accommodate 64 new graduates who have received a certificate of completion by September 2013. We are particularly proud of the quality of the EBP projects completed by new graduates. They are also very proud to showcase their EBP poster presentations at their graduation ceremonies attended by nurse executives, nurse managers, clinical nurse specialists, staff nurses and VANA faculty. Many of the students continue to implement their projects beyond the residency program and projects are being adopted by nurses on other units, thus impacting clinical practice within the VASDHS.

In the second year of the partnership, eight VANA faculty and VA nurses enrolled in a master’s level academic credit nursing education course that focused on curriculum design, and teaching and learning theory taught at the VA by a SDSU faculty member. The knowledge and skills gained from that education improved the ability of VA faculty to design evidence based curriculum for the VALOR program, the NGNRP and the preceptor education program at the VA as well as actively participating as equal partners on the undergraduate academic Curriculum Committee at SDSU. One VA VANA faculty spearheaded VA and SON faculty development by promoting activities within the SON for integration of Quality Safety Education in Nursing (QSEN) within the classroom and clinical nursing curriculum. The VA obtained simulation equipment through a VA Innovations grant (written by VA and SON VANA faculty) to expand our simulation education capabilities. More recently, the Director of the SDSU simulation lab, who is also a VANA faculty, worked with VANA faculty and the simulation director from the University of California San Diego (UCSD) School of Medicine to initiate an interprofessional education class for medical residents and senior level undergraduate nursing students.

Two VA VANA faculty who are embedded in clinical practice in oncology and the emergency department at VASDHS have been recognized by both partners and in the community for their teaching excellence. They are called upon to teach and lecture at the VA, SDSU SON and in the community. A SON VANA faculty member completed her PhD and obtained NLN certification as a nurse educator. This faculty member initiated efforts to build relationships with the Veterans Center on the
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

Part 2:  Acting Strategically to Innovate • Key Message 2:  Nurses should achieve higher levels of education and training
U.S. Department of Veterans Affairs

SDSU campus. Another SON VANA faculty member is embedded in the VA ethics and research programs by serving as a member of the VA Hospital Ethics Advisory Team, as a member of the Institutional Review Board, and as a local site investigator for a VA national cooperative study.

During our “norming” process we learned that building a successful academic service partnership takes equal time, nurturing and commitment from partners, organizational leaders and nurse leaders. Frequent and open communication between partners and nurse leaders is necessary for successful identification and achievement of mutual goals and relationship building. A hallmark of the norming phase of the partnership was that faculty no longer identified themselves as SON or VA faculty, but rather as VANA faculty.

This moved us to “Stage IV: High Performing” where we were able to emphasize moving forward and sustaining our partnership. As the academic service partnership evolved, the VANA faculty members were ready to embrace new goals. VA nurse leaders along with VANA faculty were invited to attend meetings and semi-annual retreats where strategic action plans were discussed and developed. VANA faculty’s concept of a partnership shifted from being a vague theoretical construct to a collaborative relationship designed to improve and enhance nursing education within the SON and VASDHS. In this stage of development, VA and SON leaders and VANA faculty coalesced around four work groups: a. Community Education related to Veteran Care, b. RN Leadership Development and EBP, c. Recruitment and Retention Activities (VALOR student and New Graduate Nurse Residency Programs), and d. Simulation Education for students and new graduates (including interprofessional education).

VANA faculty and VA stakeholders continue to develop interprofessional education despite the challenge of limited personnel, space and equipment that hampered progress during earlier stages of the partnership development. Both the VA and the SON have committed resources for simulation education. With enriched capabilities, VANA faculty forged new relationships with the Hospital Ethics Advisor Team (HEAT), including physicians and chaplains who are actively participating in an ongoing end of life simulation education module for the new graduates (Muehlbauer, et al, 2014, in press).

The SON, VANA faculty and VA nurse leaders have committed support to the Joining Forces initiative. Joining Forces is a national initiative to mobilize all sectors of society to ensure that military service members and their families have support as they reintegrate into civilian life. The initiative was introduced by First Lady Michelle Obama and Dr. Jill Biden, and focuses on...
three key priority areas – employment, education, and wellness, with a goal to raise awareness about the service, sacrifice, and needs of military families.

A VANA faculty workgroup is moving the Joining Forces initiative into the academic setting by introducing Veteran-centric education in mental health and in simulation exercises for nursing students and to the Veterans Center at SDSU. Faculty members are sharing resources developed within the VANA partnership for the American Association of Colleges of Nursing (AACN)-VA Joining Forces toolkit. VANA faculty, in collaboration with VA nurse leaders have plans underway to build upon the work of other VAs who created academic courses that incorporate the Joining Forces goals by developing and hosting a “Joining Forces, Community Forum” in San Diego. The goal is to focus entirely on Military and Veteran culture, the health issues that impact Veterans and healthcare services/resources for Veterans and their family members. We anticipate that this forum will attract RNs, students, faculty educators, university alumni, professional nursing organizations, Veteran service organizations and the public. The idea is to begin to educate the community at-large, and healthcare workers in general, about Veterans in terms of their special healthcare needs.

The Recruitment and Retention workgroup is focused on further developing the NGNRP. The curriculum is documented in a standardized curricular format that provides the basis for a self-study evaluation that will be needed in the future for CCNE accreditation. A VANA faculty member is an active member of a national VA workgroup to develop a distance-education residency program as a way to standardize the curriculum and to share resources across VA facilities. Another VANA faculty member is leading work to finalize an Excel spreadsheet that will store a database of workforce indicators such as RN turnover rate, vacancy rate, new graduate retention rate, and recruitment cost avoidance. Other nurse sensitive indicators that could be affected by the quality of new graduate nurses’ transition to professional practice need to be operationally defined and tracked.

The fourth VANA work group, Leadership Development and EBP, is beginning to work collaboratively with the VA Shared Governance Council to develop an organizational strategic plan to roll out EBP and quality improvement projects in a systematic way that aligns with the goals and current interprofessional council structure. We encourage patient safety, quality of care improvements and cost avoidance calculations into the EBP projects as part of the curricular design for the NGNRP. Our goal is to evaluate these projects through the councils so that each initiative can be directed through a pathway that leads from ideas, to EBP project, to systematic collection of quality
improvement data, to multiple unit based-implementation and then to updating or creating new policies and procedures. As the new shared governance model unfolds at VASDHS, VANA faculty are collaborating with leaders in the councils to design an educational series that will enable nurses at all levels of practice to participate in professional development and evidence based practice improvement activities.

As in the prior stages, this “high performing” stage, provided us with lessons learned. At the beginning of this stage, most group members still questioned whether accomplishments achieved within the VANA program would stop and eventually disappear once the VANA program external funding ended. However, VANA partners understood that their hard work led directly to achieving shared visions, goals and processes integrated into the new organizational norms for the partnership. Joint efforts of the partnership were also changing the fabric of nursing education and VA nursing practice.

Reflecting back on our progress through the stages we have described and their outcomes, we view our partnership development as a journey of promise, challenge, disappointment, friendship, professional growth, and great achievement. As directors of this academic service partnership, we value the accomplishments of individuals as well as the entire team of faculty and nurse leaders from the VA and SON. By believing in the vision and working hard to overcome barriers and differences in order to grow and learn from each other, everyone involved in VANA contributed to excellence in nursing education and promoted sharing the knowledge and experience of caring for Veterans. During the six years of the VANA program we created a legacy of achievements that promotes an ideal level of quality patient care, teamwork, and scholarship that is recognized by VA leaders, VA and SON executives, and nursing leaders. We especially hope the new graduate nurses will feel our legacy as they progress in their nursing careers as well as the Veterans who are the recipients of their professional nursing care.

REFERENCES


Chapter 11

Creating Transitions to Ensure Successful Movement from Education to Practice

Karen M. Ott, Beth Taylor, and Mary Dougherty
Introduction

The Department of Veterans Affairs (VA) has as one of its four statutory missions the requirement to educate and train health professionals to meet the patient care needs of Veterans and the nation. This is accomplished through a national system of educational programs and experiential clinical training and partnering with the nation’s schools to train new graduates that will develop into high quality professional staff (Department of Veterans Affairs, Office of Academic Affiliations, 2013).

With the VA Nursing Academic Partnership (VANAP) program in place to provide the structure and processes to successfully achieve our nursing education goals, and the timeliness of the Institute of Medicine’s (IOM) Report on the Future of Nursing recommendation to implement transition to practice (residency) programs (IOM, 2011), we turned our attention to the important period of transition from academia to clinical practice for new graduate registered nurses.

This chapter describes the synergistic activities we undertook to meet entry-level practice expectations through two parallel programs created concurrently by two Veterans Health Administration (VHA) offices for the postgraduate RN with less than one year of nursing experience, the Employer-Based Transition-To-Practice (TTP) Program, and the Trainee-Based Post-Baccalaureate Nurse Residency (PBNR) Program. Each of us has had national leadership roles in these programs. Karen Ott is the Director for Policy, Education and Legislation in the Office of Nursing Services (ONS). Beth Taylor is the Director for Workforce and Leadership also in the ONS. Mary Dougherty is Director for Nursing Education in the Office of Academic Affiliations (OAA).

The Employer-Based Transition-To-Practice Program

Within the Office of Nursing Services (ONS), we sought to create a 12-month program based on objectives found in the literature for nurse residency programs. Successful programs provided structured opportunities for new nurse graduates to develop clinical judgment and effectively transfer knowledge and theory into practice, ultimately attracting and retaining the most highly qualified nursing staff for employers (Ulrich et al., 2010).

In 2008, we conducted a preliminary review of the literature and found that industry-wide the quick transition from classroom to clinical practice for newly licensed registered nurses can prove to be difficult, leading
to turnover rates as high as 60% (Casey, Fink, Krugman, & Propst, 2004). Among the total RN population within the Veterans Health Administration (VHA), new graduate RNs had the highest turnover rates (Department of Veterans Affairs, 2011). In fiscal year (FY) 2007 for example, the 12-month turnover costs for an identified cohort of 291 new RNs totaled $2.52 million. From this startling statistic we determined that the turnover rate for new RNs was significant enough for VA to begin the work of developing a transition to practice program to address this critical issue.

The model we chose for the VA’s first national nurse residency was a traditionally structured VA facility-funded model with a nationally developed standardized curriculum. Our goals were many. For the Transition-To-Practice Program, we sought to: (1) increase clinical competency, (2) build professional leadership, (3) develop self-confidence and autonomous practice, (4) create opportunities to enhance empowerment, (5) improve organizational commitment to Veteran care, (6) provide opportunities to understand the traditions of VHA culture, and (7) retain staff for lifelong VA employment.

Our program’s standardized curriculum focused on refining graduate nurse clinical competencies and developing professional roles and leadership characteristics. The comprehensive training program included didactic and clinical components, and utilized a variety of educational strategies that included classroom education, preceptor-supported clinical experiences, monthly meetings, group clinical debriefings, one-on-one mentoring, and an evidence based practice project. Each postgraduate RN was assigned a preceptor and a mentor; each met the criteria for experience and successful completion of either the RN Preceptor Training Course or the national VHA Mentor Training Course. The preceptors and mentors collaborated often to determine the RN’s level of progress.

In January 2009, we launched the 12-month RN Transition-to-Practice (TTP) Pilot Program at eight VHA facilities of various levels of complexity. The year-long program was structured in three phases: Phase 1 (months 0-3) consisted of a general facility and nursing orientation and a clinical introduction to area-specific scope of service, and generic and specific competencies. Phase II (months 4-9) consisted of clinical, professional, and leadership development, and Phase III (months 10-12) consisted of synthesis, assessment and evaluation. The TTP pilot facilities received a set of seven comprehensive resources to guide them throughout the pilot. Each resource consisted of a semi-structured and easily adaptable standardized guide/toolkit to assist nursing education teams at the facility to successfully implement the program. Accreditation through
the Commission on Collegiate Nursing Education (CCNE) was optional for TTP sites (Commission on Collegiate Nursing Education, 2008).

Our TTP pilot resulted in a 100 percent RN retention rate (zero regrettable losses) and additional findings indicated the program was successful with benefits realized by each VHA pilot facility. In 2011, the program was established as policy in VHA Directive 2011-039, requiring all VHA facilities to establish a structured development transition program for all levels of entry RNs utilizing the flexible 12-month RN Transition-To-Practice Program (Department of Veterans Affairs, 2011).

The-Post-Baccalaureate Nurse Residency

That same year, the Office of Academic Affiliations (OAA) initiated a VA centrally funded 12-month, trainee based residency pilot, the Post-Baccalaureate Nurse Residency (PBNR), in collaboration with ONS. OAA had historically funded accredited residencies for medicine, dentistry, psychology, pharmacy, and other clinical professions, but not for nursing. As such, our mission to provide a high quality clinical learning and practice environment, recruit and retain high quality professional staff, and provide excellent care to Veterans was now thus extended to nursing.

A program announcement to solicit applications for PBNR pilot sites was distributed to all VA medical facilities in August 2011. Facilities were requested to submit Letters of Intent by November 2011, and full proposals were requested by January 2012. Proposals were required to include several items: (1) demographic information about the facility, (2) the number of funded residency position requested (minimum of four / maximum of six), (3) a description of how the facility would benefit from a nurse residency program, (4) the purpose, philosophy, goals and objectives of the program, (5) a proposed Veteran-centric curriculum with specific clinical competencies and an adherence to CCNE accreditation standards, (6) a commitment to successfully obtain CCNE accreditation within two years of implementation, (7) a description of the program evaluation, and (8) strategies to sustain the program beyond the pilot. In addition, each proposal was required to include letters of support from the network and facility leadership, and the academic nursing dean.

Each application proposal was formally evaluated and scored by a review committee of OAA and ONS staff members. Six VA facilities were recommended and approved for a total of 30 residents by the OAA leadership and the PBNR pilot was launched for academic year 2012-2013. By 2014, the number of funded PBNR sites increased to eleven with three additional sites funded for 2015.
A Comparison of the TTP and PBNR Models

The differences between the two nurse transition/residency models are numerous and varied. The TTP Program is mandated by policy for VA-wide implementation. The PBNR program is optional and requires an application process for selection. In the TTP model, RNs hold a budgeted full-time staff position and are considered VA employees. Participants shift to a productive FTEE, incorporated in the staffing requirements in the patient care unit, during the one year program. The TTP participants report to the nurse manager on the assigned patient care unit and successful completion of an employer performance appraisal is a metric of successful completion of the program.

In the PBNR model, RN residents are postgraduate trainees that hold a one-year trainee position with no guarantee of a permanent job upon the completion of the residency. The resident remains in the postgraduate student status for the full year of the program and is not incorporated into the staffing allocation and reports to the residency director for the PBNR. The resident salary and benefits are paid to the sponsoring facility by the Office of Academic Affiliation which eliminates the cost of resident compensation and benefit expense to the sponsoring facility. PBNR residents utilize a PBNR competency tool to determine successful completion of the educational program. In FY 2013, 100% of PBNR residents were hired by the facility with retention in position over the first year of employment. In contrast, the loss rate for newly hired RNs after one year of VA employment was reported to be approximately 20% in 2013. In TTP, facilities are required to implement the program with local support and resources while the PBNR model provides facilities with central funding to support the salaries of the trainees, a part-time program director and RN preceptors.

Challenges

As our two residency models became fully established, we became increasingly aware of challenges experienced at the facility level. By 2014, only 30% of VA facilities had implemented TTP despite the requirement for implementation in a 2011 policy. Facilities cited challenges with the ongoing funding required for frequent small groups of new hires. Limited funding for nurse residents also impacted the growth in the number of PBNR sites. In addition, six facilities that implemented TTP had also applied for and were selected as a PBNR pilot site, receiving OAA funding for up to six residents.
At these dual program facilities, challenges became apparent almost immediately. These included difficulty managing dual programs, confusion among the RNs in both programs, and the sustainability of the employer model program (TTP) in times of fiscal uncertainty. In addition, dual sites reported that without budgeted and scheduled protected time, the experiences of the residents differed between the two models – even within the same organization. Challenges with CCNE accreditation also surfaced. CCNE’s policy to accredit a facility’s residency program or programs as one, regardless of the program’s administrative structures, funding and focus, became an unforeseen barrier. We learned that if both programs were not equitably supported by the facility, accreditation for the PBNR model would be jeopardized. CCNE also advised that PBNR programs would not be eligible for accreditation unless an employee-based model was in place. This focus on employer-based programs was required to assure adherence to PBNR accreditation standards which “require all eligible employees be participants in the program”. The CCNE standards do not support a postgraduate student-based residency similar to other traditional health professions postgraduate residencies.

We uncovered some additional challenges for the PBNR program during site visits that included accreditation readiness and the management of the educational program among the eleven sites.

Looking Forward

These challenges are leading us to reconsider the decision to continue to support two distinct models to ensure the successful transition from education to practice for VA RNs. To assist us with this decision, we created a taskforce co-led by the Office of Academic Affiliations (OAA) and the Office of Nursing Services (ONS). Our taskforce includes facility-based nurse executives, PBNR and TTP program directors, nurse educators, and a physician educator. Our goals are several: (a) to develop a national academic program with a structural framework to manage a fully integrated RN residency program available to VA facilities, (b) to create educational infrastructure systems that support nurses serving in all faculty roles including instructors and preceptors, (c) to focus on the use of evidence in clinical problem solving that residents will use in their daily practice, (d) to support a residency program that is valued as an investment as opposed to an expense, (e) to reinforce support systems for all academic and clinical faculty including preceptors in a professional collegial and learning environment,
to assure a robust curriculum, and (g) to create a participant model which was not incorporated into the patient care staffing structure.

Our strategic direction for OAA’s PBNR program is to address two of the most critical challenges we’ve recognized. These include working with CCNE and AACN leadership to recognize and consider the need for an alternate accreditation pathway: the student/trainee model. This model enables a one year educational program similar to other health professions postgraduate residencies as well as having external funding to support sustainability. There is considerable strategic, educational and financial value to this model, which would serve as a catalyst for nationwide implementation of PBNR residencies. The limitations of educational infrastructure may contribute to the curriculum variability observed in the eleven PBNR sites. A standard curriculum aligned with the CCNE accreditation standards for the PBNR is now being developed. This curriculum will also have an aligned experiential curriculum. This experiential curriculum will provide learning opportunity options for preceptors, which will enable a richer educational experience for both resident and preceptor.

In 2014, to continue building upon the success of our PBNR program within the OAA VA Nursing Academic Partnerships (VANAP), we established the VANAP-Graduate Education (GE) program for psychiatric-mental health nurse practitioners (PMHNP) adding a PMHNP residency component. The residency required interprofessional collaboration with psychiatry and/or psychology residencies to enable an interprofessional curriculum and student learning opportunity as well as to partner with these disciplines in shared didactic and clinical learning. We anticipate that this entry into graduate education residency programs will be the beginning of more postgraduate residencies to hasten the inter-professional clinical practice of a specialty area with an interdependent scope of practice such as mental health (Gilman, Chokshi, Bowen, Rugen & Cox, 2014).

VANAP–GE supports graduate students completing their clinical training in VA with a paid stipend and engages those same students as potential candidates for the VA postgraduate nurse practitioner residency. The primary purpose of this residency is the development of competent, confident and safe practitioners who value and will care for our nation’s Veterans, whether in VA or in other health care delivery systems. With the advent of additional VANAP-GE programs, we can be assured that preceptors are provided with the protected time required for the important transition of APRN residents to excellent clinical practice (Rugen, et al., 2014) and ensure external funding of resident compensation and benefit expense.
Beyond 2015, our vision recommends an increase in both PBNR and NP residencies throughout the VA. Achievement of this vision requires the development of NP accreditation standards and resolving the challenges described in the current employer based accreditation standards.

REFERENCES


Chapter 11.1

One Voice….for VA: A Personal Story of Transformational Leadership

Karen Spada
I have been a Department of Veterans Affairs, Veterans Health Administration (VHA) nurse for almost thirty years. I have personally witnessed the clinical transformation of how we have evolved in prioritizing patient care delivery, centered on evidence based practice (EBP) and how nurses can, with the support from our Office of Nursing Services (ONS) and their facility nurse executive, become empowered to make changes. Our ONS is comprised of a chief nursing officer, (CNO) who oversees all Veterans Health Administration (VHA) nurses, a deputy chief nursing officer (DCNO) and multiple directors who are responsible for specific strategic initiatives and oversight, such as workforce development.

From 1998 through 2002 I practiced as a family nurse practitioner (FNP) in primary care. It was through the leadership in ONS that those of us who had achieved NP status were supported to practice in such an exciting and responsible clinical arena. In 2001, Cathy Rick, our CNO for VHA, made rounds throughout VHA and met with NPs to discuss our practice and our nursing concerns. I was the NP lead for our group and I raised our issues and essentially asked for answers. Her comments still resonant within my inner voice, which sometimes makes noise that I cannot ignore. To paraphrase, she simply said: I cannot make practice changes within individual VHA organizations; as nursing leaders, as those who have accomplished the epitome of what nurses consider clinical excellence, it is incumbent upon you, as leaders, to find ways to enhance your scope and patient care delivery models. I was speechless! Certainly with the power of policy making ONS could make changes. But, she was correct. The power to make these changes had to come from us.

In the confines of my community based outpatient clinic (CBOC), run by two NPs, I began to collect data. I saw and felt the empowerment of expanding our scope of practice and leading others to be change agents within VHA healthcare delivery. In 2001, the signs posted on the CBOCs clearly indicated that patients would not be seen without a scheduled appointment. To me, this was contrary to the needs of my patients, especially those with congestive heart failure (CHF) who required immediate access to prevent emergency room visits and potential admissions. I brought my data and admission rates forward and when the administration saw the potential measurements of success in allowing my CHF patients to present as walk-ins, they agreed to change that rule. It was a beginning. A year later I left my role as an NP and began another journey but my work was not forgotten.

In 2001, VHA began to explore a proposed a national change initiative that promoted advanced clinic access (ACA), which simply meant patients would be seen when they needed to be seen (Department
of Veterans Affairs, 2001). Walk-ins, especially those with preventable admissions, like CHF, would have priority. By 2003 the program was at full speed. The goal was to teach primary care providers (PCPs) the underlying philosophy. Although I was no longer working as a PCP, I was recruited to become an ACA coach, which taught me the strength in advocating for change, even within a bureaucratic organization. Nurses at the point of care became empowered to expand our scope and partner with other disciplines to maximize patient clinical outcomes.

This was the first of a series of changes in my career, and they eventually led to my decision to take on the challenge of transformational leadership. I now had a chance to bring into my work world my vision of best practices as a leader. This chapter describes the process and outcomes that are my current story and the success of the team I work beside.

In 2007 I accepted a position as the associate director for patient care services (ADPNS) known by the title, nurse executive. This role is part of the VHA senior executive leadership model called a quadrad and is comprised of the director, chief of staff (COS), associate director for resources (ADR) and the ADPNS. This VHA quadrad executive team is comparable to the chief executive officer, chief operating officer, chief nursing officer, chief of staff (the C-Suite) in the healthcare private sector. Nursing, voluntary services and infection prevention fell under my organizational alignment. I knew I had to change that but first, I had to assess the current structure and make a plan that nurses would embrace.

I saw my new role as the privilege of leading a group of dynamic nurses to the very periphery of their practice. I was determined to empower those at the point of care to become involved with true clinical partnerships with physicians and other disciplines, to change the status quo, identify and achieve common goals and to advance our position within the organization. My plan was multifactorial but first, I had to do two things: 1) demonstrate that my leadership was both transformational and service oriented, and 2) garner trust by role modeling and providing support. I made unannounced rounds on all shifts and in all areas. I made it clear there were neither “gottcha” motives nor criticisms in my visits. My purpose was to learn from them what they needed and wanted to heighten their practice and how they felt I could best support them in the quadrad model. I asked the same questions and kept data which I later tracked and trended.

I learned that they wanted a stronger voice at the table. They wanted more involvement in decision making and they wanted to be seen and heard as full team partners, not simply those who took orders and carried them through. They also wanted nursing orientation changed. It was under the
supervision of a hospital wide orientation department and the staff nurses felt it would be a more effective program if our own nursing education department oversaw the process and even more powerful if staff on the units were directly involved. I was in awe of their spirit, their commitment to quality patient care and their trust in sharing their thoughts with me.

I developed a plan. Although it was a five-year plan, with the support and determination of the deputy, the associate chief nurses (ACNS) and the nurse managers (NM) we began our journey in early 2007 and by 2009 had captured and implemented the majority of our goals. In this chapter I want to share some examples of our collaborate success.

In my first ACNS and NM meeting I asked a simple question. “How many of us were taught to wake a patient at 5:00 AM, by shining a flashlight in their eyes and handing them a cup of pills?” Every hand, including my own, was raised. “Why do we do that?” I asked. The answer was predictable: “Because we have always done it that way.” I was carrying a heavy three ring binder and asked, “So, what you are telling me, is we do things because we have always done them a certain way and we either feel powerless to make changes or we agree with the logic of what we do?” The collective response clearly indicated that our practice was based on policies. Deviation from such policies was not an accepted direction. I took the book, held it high and stated: “The policies are written by us; the nursing team. We need to continuously ask ourselves why we do things the same way without ever asking, is there a better way? How can we implement change that is patient focused and nurse inclusive? Where do we want to go and how are we going to get there?” I took the notebook and let it fall into a metal wastebasket so that the echo could be heard around the room. “Today,” I said, “we begin to build the strongest nursing team in VHA!”

I took it to the next level. “Let me ask,” I said. “Is there anyone in this room who disagrees with this statement? We have a policy that states the largest med pass of the day, begins at 5:00 AM. This is the point in time, when the night nurse, and I emphasize the singular ‘nurse’, is the most fatigued, and unable to do any patient teaching?” There was silence. My response was quick and to the point. “Sometimes,” I said, “it is more important for us to recognize what we DON’T know, as opposed to being so sure of what we think we know. I am certain of two things: 1) I KNOW waking patients at 5:00 AM is not only disrespectful but is also ridiculous, and 2) I know that I DON’T know the correct time to pass morning meds. You are the experts. We may need to readjust but that is fine as it is part of the change process. You tell me, and I will make it happen. Can we agree to do this?” There were applause and smiling faces and I knew
I had captured their attention. Morning meds are now passed at 8:30 AM! Our in-patient satisfaction scores now exceed national targets.

The next month we began our exploration of other changes we wanted within our facility. On my rounds it became apparent our nurses lacked many of the physical assessment skills I felt were imperative for their true clinical partnerships. With the help of the NPs all nurses were provided a full physical assessment course. I contracted with one of our affiliates to use their simulation lab. Nursing orientation was realigned to nursing education and the staff built a mentor program that provides direct staff input and recommendations about the readiness of new employees to assume full practice responsibilities. The simulation lab is still used for new nurses. We continue to implement wider scope of practice and more empowerment and engagement of nurses. We implemented Nursing Grand Rounds in 2009 and it is broadcast to 5 off site affiliated VHA facilities.

In October of 2007 we removed restrictions for visiting hours. Restrictions for visitors are determined by the nurse, in collaboration with the physician, if needed. We redesigned shared patient rooms to private rooms. Veterans are encouraged to have persons of their choice spend the night in their rooms, staff nurses embraced cultural transformation within our Community Living Centers (CLCs), once known as nursing homes. The nurses at Central Texas Veterans Health Care System (CTXVHCS) however, were not satisfied with just reserving these dramatic cultural changes for the CLCs. They implemented nurse led change groups that developed individual meals and snack requests for each resident, in all areas. Patient/resident lounges were created by staff to enhance family time. Family suites were created in hospice units. Coffee became available on all units, for all patients and visitors, supported by a local Veteran service organization (VSO). Staff nurses raised issues of concern and their questions were provided answers by their nursing leadership team. Flat screen TVs, DVDs, headsets and snack baskets were placed at all chemotherapy chairs; a nurse team effort! Nurses implemented a program called “No Veteran will die alone” and they report, at each passing, that either family or staff members were with our Veterans at end of life.

By 2009 all nurse executives in VHA had the reusable medical equipment (RME) service, now known as sterile and processing services (SPS), realigned under our executive level responsibility. I took this opportunity and successfully campaigned to have environmental management services (EMS-housekeeping), food and nutrition (F/N), infection prevention (IP), SPS and patient advocates, to include women’s health, become my new organizational chart and voluntary
services were realigned under the ADR. This new alignment allowed for approximately 1490 of our 3400 staff to become part of our nursing team. Our partnerships expanded and the teams created new themes and re-wrote policies to better accommodate Veteran centered care and expand the nursing scope of practice. Nursing and IP partnered with EMS to use black lights to measure cleanliness of cleaned rooms, F/N partnered to accept replenishing food levels of pantries established on each unit with healthy snacks, frozen foods, and individual requests. Food service workers learned to gown and glove and bring trays into isolation rooms. These workers are also empowered to request that a dietician visit a patient, when they feel it is needed for better nutritional intake. They are recognized as part of our team and their contributions appreciated.

Nursing began making daily clinical rounds with hospitalists to ensure our Veterans were receiving the best care possible. The chief of staff and I role model this practice by making routine patient rounds together. Nurse managers tracked their top five diagnostic related groupings (DRGs) and partnered with nursing education to provide the best clinical pathways and physical assessment skills needed to reduce length of stay (LOS) and decrease recidivism rates in both acute and CLCs units. In collaboration with physicians and other disciplines, since 2007 we have reduced LOS by 45%! Nurses increased their scope, advocated for Veterans and stood tall.

The SPS staff tracked immediate use sterilization (IUS) flash rates and developed scorecards to measure success and identify opportunities for improvement. Data trending provided us a rationale for increasing equipment and improved departmental processes. We have had a 0% flash rate for more than 2 years. Each of our RME staff has been invited into the operating theater where surgeons praise them for their work and demonstrate how their contribution directly impacts Veteran care. They have seen how the instruments they sterilized are used and why their dedication to infection prevention is critical in patient outcomes. Our SPS staff has been recognized for multiple best practices by the Office of the Inspector General (OIG). Independently, the SPS staff implemented a 100% channel check on all scopes before being used on patients, although the regulations only require a 30% random check. Their rationale: “We want to be sure 100% of the time the scopes are ready for our Veterans.” This is true patient-centered care and team work!

Similar changes have occurred in women’s health, where all CBOCs provide women Veterans the option of having their gynecological care with their PCP or be seen by a specialist. Two beautiful mother friendly rooms have been developed to provide privacy for breast
feeding women. All women’s health nurses have special education for birth control advising and all diagnostic women’s health testing. Nurse case managers oversee women’s health for hypertension, ischemic heart disease, diabetes, timely mammography and PAP smears.

Children are welcome to visit patients in both the CLCs and acute care as well as in the outpatient setting. The decision to divert from this policy is based upon the nurses’ discretion as it relates to the safety of the child or the needs of the Veteran.

We have been 100% restraint free since 2007, except in medically required situations. Nurses assign 1:1 patient care for falls prevention or other reasons. Nurses can order precautions when they deem it appropriate. Nurses and our now deputy, Mr. Bryan Sisk, partnered with information technology service and the Texas Board of Nursing and wrote protocols where both RNs and LVNs can order labs, send consults, satisfy clinical reminders, or schedule visits in nurse run clinics, give flu and pneumococcal injections, without an MD order. The Medical Executive Board, under the direction of the COS, approved all of our recommendations. Since 2007, CTVHCS measurements in clinical metrics, which either meet or exceed a national target for success, indicating implementation of EBP, has risen from 76% achievement in 2007 to 96% in 2012. We believe this is a direct reflection on the work nurses have done in partnering with physicians and others, expanding their scope of practice, becoming empowered at the point of care and exercising their clinical knowledge to the periphery of their practice. We began nurse case management in primary care in 2008. We implemented the role of the Clinical Nurse Leader (CNL) in 2009 as an internal workforce development initiative. In September 2011 we were recognized for excellence by being selected to establish the CNL Implementation and Evaluation Service, designated to provide consultative support across the VA system. In 2012 the OIG recognized us for implementing a best practice for our staffing methodology.

Our nurse managers and ACNS team began this journey in 2007 by aligning their goals under those of ONS. As a result, based on hours of patient care required, we provide a daily report of the number of Veterans to whom we can safely provide quality care delivery. All nursing areas have huddle boards in the break rooms and all team members, regardless of their organizational alignment, are encouraged to post suggestions on how we can improve patient-driven care, expand our practice scopes, enhance patient and staff satisfaction and every day work toward doing the best we can, simply because it is the right thing to do. Engaging Veterans in participatory care has been a successful
intervention since 2007. Our nurses place our Veterans at the center of all they do. Partnering with and educating our Veterans and their significant others is critical in achieving positive clinical outcomes.

Transformational leadership is not about control. It is about working in the background and empowering and engaging those at the point of care, as a service leader, to provide the tools nurses need for success. Building confidence means “letting go”. It is not about the success of the nurse executive but rather the success of the team that is reflected in the quality Veteran centered care we deliver.

In my 39 years of nursing practice, I have never been more proud, more honored, or more humbled, to work with a group of nurses as I have been in being a team member with the nurses and all those services who work beside us in central Texas to create clinical excellence. Our successes have been multifactorial but the essence remains in the strong teams we have built and that our teams see themselves as the advocates for America’s heroes and each day they strive to improve our care and to thank our Veterans for their service.

REFERENCE

Chapter 11.2

Moving Forward

Kathleen L. Taylor
The military has been a part of my life since I was born. Growing up on a naval base, I was proud of my father and his service to our nation. He willingly gave his entire career to the Navy, and in turn, we received the finest medical care from doctors and nurses in uniform. I vividly recall holding my mother’s hand as we visited the naval base clinic for a routine checkup. The proud nurses in white pressed uniforms captured my eye. I look back and recall their compassionate nature and skilled care, a main driving force for my desire to become a nurse who tended to military service members. For years, this is all I talked about, even to the point of exhausting my friends and family. Finally, I stepped out of the shadow of day-to-day life and into the bright light of my dream. I enrolled at the highly acclaimed nursing program at Northern Illinois University. My passion drove me to excel. I received scholarships, achieved Summa Cum Laude recognition, and was inducted into Sigma Theta Tau International Honor Society of Nursing. When I graduated with a Bachelor of Science in Nursing in 2009, I had two things I wanted to accomplish: working for the Department of Veterans Affairs (VA) and entering a nurse residency program.

With diploma still in hand, I contacted the closest VA hospital only to discover it did not offer an RN residency program. My heart sank. Although I desired to work for the VA, I knew an RN residency program was essential for my initial year of practice. As I was studying feverishly for the National Council Licensure Examination (NCLEX) one afternoon, an email came across my desktop from my instructor: “Attention nursing students, Hines VA is recruiting RNs for their RN residency program, please consider applying”. Although this would create an hour and a half commute for me, I felt I could not refuse this opportunity. I immediately applied and joined one of twelve nursing students to start this exciting venture. My journey was about to begin.

As I walked the long hallways of the Hines, Chicago, Illinois VA to meet the other eleven nurse residents, I grew more excited and anxious about starting this new program. Two nurse educators welcomed us and guided us through this yearlong curriculum. They informed us about the wonderful opportunities we were about to embark upon. The goal of the yearlong Hines nurse residency program was to transition recently graduated RNs competently, toward assuming the responsibilities of a practicing professional nurse. The evidence based curriculum focused on leadership, patient outcomes, and the professional nurse role as designed and promoted by the University Hospital Consortium (UNC) and the American Association of Colleges of Nursing (AACN). It involved a series of learning and work experiences with an emphasis on providing support and
supervision for the new nurse. The program required us to provide patient care on various units of the hospital in addition to a unit of our choice.

Our group met monthly to share our experiences, challenges, and accomplishments. We supported and learned from each other as we discussed the trials and tribulations of being a new nurse. Our program coordinator encouraged us to strengthen our clinical skills; she arranged time for us to spend in areas where we felt we needed growth. She also encouraged us to keep a journal of our time spent as nurse residents so we could look back and reflect on the progress we made. One sunny afternoon our group visited the National Vietnam Veterans Art Museum in Chicago, Illinois. As I strolled through the museum intently taking in all the artwork, I felt an enormous sense of pride, appreciation, and honor to care for the Veteran population. We all learned something about our patients and ourselves that day.

My first clinical rotation was on the spinal cord injury unit. The nurses were an exceptionally tight knit group. They immediately took me under their wings and taught me how to care for the spinal cord injury patient in a compassionate and caring manner. The services offered on this unit were exceptional. For example, recreational therapy provided opportunities for Veterans to improve physical, mental, and emotional well-being by engaging in crafts, horticulture, and community outings. During the holiday season, volunteers sang Christmas carols and played bingo in the hallways with the Veterans. Camaraderie radiated between the nurses and Veterans on this unit; it was endearing to witness. After three months on the spinal cord injury unit, it was time to rotate to the progressive care unit.

The progressive care unit (PCU) was a fast-paced environment. I was impressed with this group of outstanding nurses. Although the group of nurses I worked with in my first rotation had taken me under their wings, this group encouraged me to fly. They had more confidence in me than I had in myself. Most of these nurses were board certified in at least one area of nursing. The manager on this unit was also exceptional. She encouraged me not only to join a committee, but also to consider conducting research on a systems redesign project. I immediately accepted the challenge. I was involved in creating a system redesign poster for the annual process improvement fair. The main goal of this pilot study was to increase patient satisfaction with the hospital discharge process. I worked with three other nurses to gather qualitative data from the Patient Advocate Discharge Call Survey and quantitative data from the Discharge Process Dashboard. Our resulting recommendations included increased communication between the healthcare team members and the patient and the use of a tool to stagger
discharges throughout the day to avoid discharging all the patients at the same time. The implemented changes resulted in an increase in patient satisfaction scores from 53% in October 2009 to 86% in December 2009.

With the recommendation from the PCU manager, I joined the nursing recruitment and retention committee and became co-chair of the council weeks later. VA provides opportunities for shared governance, which includes mentoring a direct care staff nurse in the co-chair roles of governing councils. I became enamored with this council and the initiative of empowering, rewarding, and valuing nurses. During nurse's week, I collaborated with several different areas of nursing and hospital staff to lead a fundraiser to raise extra monies so the entire nursing staff at Hines VA received an extra token of appreciation. In addition, I was in charge of providing popcorn to the hospital during nurse's week, thanking the Veterans and employees as a way of nurses "giving back". During the annual recognition and award ceremony, I collaborated with the Magnet coordinator and the associate director to plan the ceremony events and assisted the director in distribution of flowers and recognition plaques to the winners. At the end of the ceremony, I led the nurse residents in the Florence Nightingale poem. As I stood there looking out into the audience, I was in awe of the opportunities, and support that VA provided new nurses. It did not take me long to realize I was in an exceptional organization and the importance of joining shared governance councils and committees. Weeks later, I joined the national organization of Veterans Affairs (NOVA), special awards committee and became a Magnet ambassador.

My next and final rotation was on the hematology/oncology unit. I applied for a full time position and was accepted, therefore my nurse residency clinical rotation halted. Nurse residents who accept a full time position during their residency stay on that unit for the remainder of the program. During my time on this unit, I participated in a hospital-wide process improvement project with two other nurse residents, members from infection control, and a physician from Loyola University of Chicago. The purpose of this study was to observe, research, and justify the need for a new intravenous cap system to reduce central line infections and review the policy at Hines VA. This study also served as our year-end nurse residency project that we were required to complete and present during our final weeks of the program.

The Edward Hines, Jr. VA Hospital’s nurse residency program represents the ideal, bringing an education whose curriculum has a breadth no other nurse residency program could offer with many learning opportunities. For example, when I rotated to the spinal cord injury unit I received
certification in mechanical ventilation. After acquiring this knowledge, I felt confident in caring for patients with ventilators in a safe and effective manner. During my time on the PCU, I registered for an EKG interpretation class and received certification in Advanced Cardiovascular Life Support (ACLS). Finally, during my last rotation, I received many continuing education credits in caring for the cancer patient population through the VA online learning university. The VA Learning University (VALU) is VA’s corporate virtual university that supports the agency’s mission and objectives through high quality, cost-effective continuous learning and development that enhances leadership, occupational proficiencies, and personal growth.

One afternoon while driving home, I reflected upon all the accomplishments and lessons learned during my time in the VA nurse residency program and realized I was involved in an organization that supported their nurses, encouraged interdisciplinary teamwork, and took pride in nurses advancing their careers through education and volunteering. Within one year, I was involved in leadership, systems improvement, research, and health policy.

The VA nurse residency program provided an excellent foundation for the next steps in my career. After a yearlong journey at Hines VA, I enrolled in Loyola University of Chicago’s Master of Science in Nursing program. In addition, I accepted a nurse care manager position at an outpatient clinic affiliated with William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin. I was thrilled to discover Madison VA in January 2010, achieved magnet recognition for excellence in nursing services by the American Nurses Credentialing Center’s (ANCC) Magnet Recognition Program. Magnet recognition is the most prestigious distinction a healthcare organization can receive for nursing excellence and outstanding patient care.

Although we are still learning, I feel great pride and honor to be part of an innovative organization. I will forever cherish my time in the VA nurse residency program. VA provided a program that ensured a seamless transition from education to practice with support and opportunities to succeed. In addition, the program paved the foundation for my current achievements and future endeavors. VA is leading the way for new nurses. Providing exceptional healthcare to our Veterans is a privilege and a career filled with honor and commitment. Working for the Veterans Health Administration is who I am and where I belong.
Chapter 11.3

The Dream: An RN Residency Distance Program for VA

Ellen Jones, Merry Kuyper-Carson and Kattie Payne
This is the story of how an additional job responsibility, the RN Transition-to-Practice Program, led to an “idea” that grew into a dream, which is becoming a reality. Three nurses at the Boise, Idaho VA are responsible for this idea becoming a dream. Merry Kuyper-Carson, Associate Chief Nursing Service Education (ACNSE) is in charge of education programs for all nursing staff and fills the role of chief of nursing service at the time the chief and the associate chief nurse are not available. Ellen Jones holds a split position as nurse educator with the nursing education department and a staff nurse in the internal cardiac device (ICD) clinic. At the time of the “idea”, Kattie Payne was newly hired as the full-time clinical nurse researcher, which was her first experience in the VA system!

The story begins when Merry Kuyper-Carson was assigned the lead for the Boise RN Transition-to-Practice program when she became the Associate Chief Nursing Service Education (ACNSE). Michael Farruggia, the prior ACNSE, was a member of the Office of Nursing Service Steering Committee for the RN Transition-to-Practice (TTP) pilot program. The pilot program was in its first year with two new graduates enrolled in the Boise program. Running the TTP program involved scheduling and coordinating classroom content, securing expert presenters and clinical preceptors, and teaching classroom content as needed. Evaluations of the experience from the graduates, preceptors and staff were also required on a regular schedule. Running the program was very time-intensive! Merry had many other nursing education responsibilities, such as Basic Life Support/Advanced Cardiac Life Support (BLS/ACLS) training, competency evaluations, and new nursing employee education. She realized that someone else needed to be the lead person for the RN TTP program.

In the spring of 2010, Ellen Jones, Nurse Educator, was assigned the responsibility of running the RN TTP program, along with her other job responsibilities. Without prior familiarity with what a TTP program entailed and no formal teaching background, Ellen read all the materials provided on the Office of Nursing Service RN TTP SharePoint site. This Veterans Health Administration (VHA) intranet site provides a wealth of information, including the suggested curriculum for the 12-month program, a facilitator’s guide for the curriculum content, as well as additional tools for setting up and running an RN TTP program. Ellen also attended the RN TTP pilot summit in January 2011, became a member of the pilot steering committee, and participated in the national monthly calls with the Office of Nursing Service. There were four new graduates in the Boise, Idaho program when Ellen acquired responsibility for running the program. That year, Ellen delivered much of the content while she concurrently learned the role of facilitator.
Ellen had many challenges during her first year! As a new nurse educator, she feared that she was not covering the material thoroughly. Ellen researched the evidence so that she could present the content in which she had had little clinical experience. In addition, the Boise, Idaho VA is a moderately complex facility with four inpatient units (intensive care, step-down, medical/surgical, and psychiatric). Consequently, Ellen had limited access to clinical experts within the facility to deliver content and they had limited time to help support the program.

During that year, Ellen returned to Merry Kuyper-Carson to discuss options and find a possible solution to her problem. Merry suggested contacting other nurse educators in our VA integrated service network (VISN 20), which covers all VA facilities in the states of Washington, Oregon, Idaho, and Montana. Ellen sought assistance by requesting support through the sharing of content experts to present the TTP curriculum across the network. Much to Ellen’s surprise, she discovered that they were struggling with the same issues. They too had difficulty finding experts in their facilities who had the time to present the content.

It struck Ellen that we live in an era of rapidly changing technologies (e.g. computers, Facebook, telehealth, and Adobe Acrobat). She began wondering whether these innovative technologies could be used to support a VISN-wide RN TTP program. For example, the Boise VA uses telehealth equipment to assess, provide and treat patients through remote provider connection from the Portland, Oregon VA. Could it be used to support graduate nurse access to expert clinicians?

Sharing resources and expertise would enhance the efficiency of existing TTP programs within VISN 20 and strengthen the ability of smaller facilities to offer a RN TTP program. An inter-facility program would create an opportunity for interaction with regional, as well as, local experts in the curriculum content. In addition, the RN graduates that participate in an inter-facility program would be able to form connections with first year RNs at other facilities, which could increase new graduate retention in the VA system. The educators in an inter-facility program would have the option of selecting content areas that are of interest to them, utilizing their expertise more appropriately. For the Boise VA RN TTP program, and for Ellen, an inter-facility collaborative program would enhance the quality of the program and allow her to continue her other assigned duties. It was a win-win solution!

Merry and Ellen reached out to the nurse educators at the Spokane, Puget-Sound, Walla Walla, and Roseburg VAs by telephone to determine their interest and they received a positive response. In the spring of 2012,
the nurse educators at these facilities began meeting monthly through conference calls. The consensus was that, although all of the educators wanted a VISN-wide TTP program, they had very little time to devote to developing the infrastructure for sharing the content from a distance.

After a few months of teleconferencing and very little solid content development, Ellen returned to Merry to explore ways to support distance sharing or other options for improving the current Boise program. As luck would have it, Kattie Payne was in Merry’s office and they were in the process of developing proposals to submit for some VA Office of Nursing Services (ONS) funding. Ellen suggested drafting a proposal for a VISN-wide RN TTP program. Kattie countered with “why not involve other VISNs throughout the country?” and the idea began to take shape. And so we three dreamers composed a one-page justification for an RN TTP summit to be held at the Boise VA medical center in Boise, Idaho. Our intent was to invite about 15 VA nurse educators to establish a forum for discussing interest in, challenges and possibilities of a “distance” RN TTP program.

There was great excitement when we received word that the project had been funded! Next steps included planning and hosting the summit before the end of the fiscal year! We sent out an invitation to attend using the VHA VEIN (VA Educators Integrated Network) email group. Email acceptances came flooding in and within a few days, we had 22 nurse educators who wanted to join us. Since none of us had ever done anything like this, we had many questions: Where would we hold the summit and how would we organize the time? Would we have any speakers? What resources would we need? Where would the attendees stay? What about food? So much to do in so little time! As you can imagine, we had a huge job ahead of us and only about two months to get it all done!

Then, the summit attendees started coming in to Boise on September 26, 2012. Kattie and Ellen picked them up at the hotel bright and early on the 27th and transported them to the Boise VA’s new research building. We met in the conference room, where 22 VA stakeholders and our “dream team”, hosting the event, crowded around U-shaped tables. It was a tight fit but everyone was excited and enthusiastic about the task at hand. There was so much positive energy in the room that you could almost feel the vibrations.

The idea of a “distance” RN TTP program was blossoming! The morning of the first day, Ila Flannagan from ONS provided background regarding the pilot TTP program and expressed her support for a distance program concept. An Employee Education Services (EES) representative, Dave Roberts, provided information regarding opportunities for partnering with
Chapter 11.3: The Dream: An RN Residency Distance Program for VA

EES to create such a program. Discussions regarding the use of Blackboard technology as a platform for content delivery ensued. The summit group was excited about the possibility of using the technology and saw tremendous possibilities for sharing resources and expertise and developing the content.

In the afternoon, the summit group separated into four groups to address the curriculum content (care clinical practice, leadership, professional role development, and additional BSN content). We challenged each group with examining the content described in the ONS TTP Facility Implementation Guide, our VHA intranet resource, and identifying experts to present the material and the technology needed for effectively delivering the content. As day one drew to a close, the level of excitement remained and the RN TTP distance program began to evolve from a good idea to something more tangible. Our dream was forming!

Day two started with summit attendees sharing one of their own innovative teaching ideas. Ideas were shared freely and openly with fun and much laughter among the participants. Following those presentations, each content area group presented the work they had done on the prior day. Using a curriculum development grid, each content area group explained how they had envisioned the presentation of the material. The energy from day one channeled into innovative ways to provide quality education for our RN graduates in the distance TTP program. Each group shared curriculum plans that would include best practices that were exciting and definitely would strengthen any RN TTP Program in ways that exceeded our imagination.

As day two drew to a close, the summit participants acknowledged that, although a lot had been accomplished in this summit, all of those involved still had much work ahead of us. The “dream team” (Ellen, Merry, and Kattie) knew that we had to keep this level of enthusiasm, even as the summit participants went back to their individual facilities and other responsibilities. The dream team realized it would not be easy but the hard work ahead would be worth it because all the participants in the VA facilities would benefit from a distance program.

The dream continues to blossom! The summit participants became the virtual faculty, with Ellen and Kattie being identified as leaders. The virtual faculty decided to use Blackboard as the platform for the content delivery and Jan Wong (EES), Kattie Payne and others are loading the content into the platform. The Blackboard program will provide a support mechanism for preceptors, RN graduates and TTP faculty, as well as the curriculum.

The virtual faculty has continued to meet through live meeting on a regular basis. In September 2013, we held a “virtual 2-day summit”;

Realizing the Future of Nursing: VA Nurses Tell Their Story 355
the summit participants were very productive! After trialing Blackboard Collaborate, this summit’s leaders (Jan Wong from EES, Rebecca Long from the San Diego VA, Ellen Jones from the Boise VA) decided to use Adobe Connect.

Adobe Connect proved to have some challenges, such as participants were “kicked out” and were sent to the “main room” on return, and the inability to record discussions from the breakout rooms and the main room. However, the participants persevered and didn’t throw in the towel.

The first morning of the summit was spent providing an overview of Adobe, reviewing Blackboard basics, developing consensus regarding content development schedule and priorities, and sharing resources and tips for effectively teaching online courses. During that time, the faculty decided to use the Commission on Collegiate Nursing Education (CCNE) curriculum, which separated the content into 3 focus areas: clinical practice, leadership and professional role (Commission on Collegiate Nursing Education, 2008). The first afternoon was spent demonstrating the layout of content in Blackboard. Afterward, the content area groups went into breakout rooms to begin their work on content development. The charge for each group was to have at least one “module”, a group of individual content pieces, called lessons, by the end of the summit. At the end of day one, all participants regrouped in the main room for a review of the day’s activities.

The second day of the summit began with a review of Blackboard basics with all summit participants and then each content area group went back into their respective breakout room to continue their work on developing content. During the afternoon of the second day, the three breakout groups presented their content to all participants for feedback. Each group had 15 minutes to present their module. The summit ended with discussions regarding next steps and setting target dates for content finalization and piloting.

So, be careful what you dream, it may come true!

REFERENCES

Chapter 11.4

Creating Transitions to Ensure Successful Movement from Education to Practice

Brenda Rushing French and Mary Susan Biggins
In order to stay abreast of the latest information in the ever-changing field of nursing, the Veterans Health Administration (VHA) Office of Nursing Services (ONS) provides support to its nursing constituents in a multitude of ways that promote excellence in nursing practice, research, education and emergency preparedness across our national healthcare system. Certification in a specialty area of practice is one of the recognized means of identifying specialized knowledge, expertise and credibility in nursing practice. We have had ongoing support from ONS and local VHA leadership for the promotion of certification of our nursing staff.

Our story describes achievements that are a direct result of this program, particularly in rehabilitation nursing certification within the Hunter Holmes McGuire Veterans Medical Center in Richmond, Virginia (Richmond VA), Edward Hines, Jr. Veterans Hospital in Hines, Illinois (Hines VA) and among the members of the ONS Polytrauma Rehabilitation Field Advisory Committee (PFAC). Brenda French is the polytrauma staff educator and a certified rehabilitation registered nurse (CRRN) at the Richmond VA. Mary Sue (Sue) Biggins, also a CRRN, is the polytrauma nurse advisor for the PFAC and polytrauma nurse educator at the Hines VA. In this chapter we will share our personal experiences of the impact of this initiative and our involvement in promoting rehabilitation certification.

According to the American Nurses Credentialing Center (ANCC), as of 2011, there are 3.1 million registered nurses in this nation (ANCC, 2011). In their certification handbook, the ANCC describes certification as follows: “Certification is the process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications. Certification can be used for entry into practice, validation of competence, recognition of excellence, and/or for regulation. It can be mandatory or voluntary. Certification validates an individual's knowledge and skills in a defined role and clinical area of practice, based on predetermined standards” (ANCC, 2013, p. 4).

Certification, as defined by the American Board of Nursing Specialties (ABNS), is “the formal recognition of an individual’s specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes” (ABNS, 2009). According to personal communication with Melissa Biel, Deputy Director of the American Board of Nursing Specialties,

Every year ABNS conducts a member survey and asks the organizations to indicate how many certified nurses they have…. Not every organization responds to the survey but I would
estimate that this represents over 90% of the certified nurses in the United States and Canada. We do not collect information from other countries. But some of these organizations do certify in other countries and those certificants would be counted here. As far as I know, there is no other source that captures numbers of certified nurses, so this will be the most defensible estimate available. (M. Biel, personal communication, March 14, 2013).

Her data indicate that the number of active certificants holding credentials at the time of our conversation is 596,573. The number of non-RN certificants refers to licensed practical/vocational nurses (LPN/LVN). The number of advanced practice certificants has steadily increased as indicated in Table 11.4.1. As the information she provided demonstrates, no data were collected in 2008.

<table>
<thead>
<tr>
<th>Table 11.4.1 American Board of Nursing Specialties (ABNS) Comparison Data on Certification Rates Demonstrating Growth Over Time*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison of Certificants by Type of Certification, 2009 – 2012</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Non-RN Practice</td>
</tr>
<tr>
<td>Basic RN Practice</td>
</tr>
<tr>
<td>Advanced Practice</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentials</td>
</tr>
<tr>
<td>Active Certificants</td>
</tr>
</tbody>
</table>

*Data provided by Melissa Biel, Deputy Director, ABNS: personal communication, March 14, 2013

N refers to number of reporting organizations providing data

Depending on the specialty area, a nurse may have several options for certification. Each specialty has requirements for certification. The example most familiar to us is the Certified Rehabilitation Registered Nurse (CRRN) credential awarded by the Association of Rehabilitation Nurses (ARN). The
Rehabilitation Nursing Certification Board (RNCB) develops, administers, and evaluates programs for certification in rehabilitation nursing. The CRRN® program was first developed by the ARN in 1984. The CRRN credential is now administered by the RNCB, an autonomous component of ARN. The eligibility is determined by educational preparation and clinical practice experience.

In 2008 the leadership of the Department of Veteran Affairs (VA) Office of Nursing Service (ONS) created a “Let’s Get Certified” campaign for VA nurses. It was originally a three-phase program, later expanded to five phases, designed to encourage nurses to obtain certification in their field of specialization. Motivators included discount coupons, discounted membership fees, a certification contest, a winner’s circle recognition, and education funding. The discount coupons and reduced membership fees were negotiated by ONS representatives with the certifying bodies. ONS initiated the program to foster nurse retention and decrease costs associated with turnover, using the theme “Grow With Us” for the first three phases. Phase four carried the theme “Rising to New Heights” and the final phase, ending in 2013, was “Reach for the Stars”. The Tampa, Florida VA Medical Center used a creative approach to encourage nursing staff participation by using a poster with a tree that was growing money to promote certification.

In 2010, VA ONS leadership, represented by Seaman and Bernstein, published a report on an “innovative campaign to increase specialty certification for its nursing workforce that resulted in a one of a kind national initiative” (Seaman & Bernstein, 2010). The featured initiative “Let’s Get Certified” had been under way for three years. In this report they indicated that the purpose was to raise awareness of specialty certification with the VA staff. As a result of this awareness, according to Seaman and Bernstein, the nursing workforce is more educated and competent. They also report improved nursing satisfaction and a promotion of quality healthcare to the Veterans.

The campaign included two awards, the certification development award and the certification achievement award. The goal of the development award was to recognize VA facilities that demonstrated an increase in the number of nurses with national specialty certification and assessed the effectiveness of the strategies used to increase certification such as hospital wide promotions, leadership support and staff recognition. The goal of the achievement award was to recognize achievement of 25% or more certified nurses in a facility. Promotional materials were provided in the form of a toolkit and distributed to all VA nurse executives. The materials and information were shared with the Federal Nursing Service Chief (FNSC) council representing all federal nurses.
including the Department of Defense (DoD), Public Health Service (PHS), Department of Veterans Affairs (VA), and Red Cross. ONS also maintains a master list of certifications available for all registered nurses and licensed practical/vocational nurses accessible on the ONS internal website.

In 2008 the “Let’s Get Certified” campaign was getting underway. We both had taken on the role of rehabilitation nurse educators and saw this as an excellent way to gain credibility with the nursing staff. We developed certification exam study groups among the staff nurses on our rehabilitation units at the Richmond, Virginia and Hines Chicago, Illinois VAs.

As all good teachers know, the best way to learn something is to teach it. We encouraged nurses to review, study and discuss the core curriculum for the rehabilitation certification. We then developed a calendar and mapped out how we would present and cover the entire review book to prepare for this national certification examination. We met during lunch and after work. It was an informal class and we encouraged each other as we prepared.

After several weeks we completed our course of study and one by one we signed up, took, and passed our test. At the Richmond VA, in that first year, we went from three CRRNs to nine CRRNs. When the word got out about our 100% pass rate and success, other staff nurses approached us and expressed interest in attending our next review course. Two of the registered nurses were DoD employees and some nurses from the local academic affiliation also expressed interest. Thus, in Richmond, the following year, we scheduled a two day conference for our VA nursing staff at our facility and we invited the DoD nurses and nurses from the local academic affiliate to attend. The instructors for the conference included certified VA nurses and certified nurses from our local academic affiliate. We had 28 RNs in attendance. It was a great success and the fire had been ignited for continuing education, competency and improved quality care through increasing the certified nurses in our community. The next two years we moved the certification review course to the academic affiliate’s campus. This has proved to be a great collaboration for the nurses in our community. The Richmond VA has increased the number of certified nurses in the rehabilitation area from three to 29 since the “Let’s Get Certified” campaign started. The total number of certified nurses in other facilities has increased as well.

There are many reasons given to explain why a nurse would desire certification. They include commitment to excellence; a desire to update clinical knowledge, enhance practice and make contributions to the interdisciplinary team; an interest in broadening one’s knowledge base of rehabilitation practice to include public policy and social / cultural issues; a need to meet a requirement for Magnet recognition; pride in
an recognition of personal professional credibility and evidence based practice expertise; and perhaps most important, a desire to improve patient-centered outcomes and quality of life. What motivated us to get certified are the rewards that are described by the ARN on their website: “increased professional credibility, recognition of your expertise, greater impact as a job candidate, and a heightened sense of personal achievement” (Association of Rehabilitation Nurses (ARN), n. d.).

On March 19, 2013, nurses all across the USA celebrated the day that has become known as Certified Nurses Day. Our facilities in Richmond and Hines held programs presented by the educators of our hospitals. The names of the certified nurses were proudly displayed on a poster board. There were testimonials describing why we had become certified and words of encouragement to those that had not reached that goal. A year later, during the Certified Nurses Day, we proudly recognized 208 certified nurses at the Richmond VA. These local achievements became our point of departure for our national efforts to support certification.

As members of the ONS Polytrauma Field Advisory Committee (PFAC) we have disseminated information regarding certification to nurses across the nation. Our activities have included review courses for certification exams, notification of resources to prepare for the certification exam and sharing first hand information. Members of our committee have also promoted certification and continuing education opportunities by attending, speaking, and presenting posters at national conferences. There has been recognition in national reports to ONS, VA Under Secretary and annual reports. We are proud that we took the steps necessary to accomplish this milestone in our professional journey. We appreciate the support we have received from our peers and managers. The VA provided the opportunity for us, and so many others, to demonstrate excellence and to be rewarded for it.

We believe that nurse executives, associate chief nurses and clinical nurse managers need to continue encouraging, promoting, rewarding, documenting and tracking the increasing numbers of certified nurses within their organizations. This is a high standard of excellence that should be advertised and put on display. It also demonstrates a level of competency that the Office of Inspector General finds to be acceptable in promoting optimal Veteran’s care outcomes. It is a benchmark of expertise equal to that of board certification in other disciplines.

The VHA National Nursing Strategic Plan 2012-2016, objective 3.3, outlines our plan to promote avenues for increasing the number of nurses with certification. The plan identifies objectives for the continuation of the nursing certification campaign and the promotion
of data architecture to capture specialty certification data for nursing staff members. The performance measures were identified as increased numbers of certified nurses in VHA, increase in the number special advancement for certification achievement awards, percent improvement in clinical outcomes related to increased certification levels and increase in number of campaign participants. We also committed to implementing the data architecture needed to extract data from our electronic performance review system and internal learning management system. Thus the commitments we have described here are part of the next phase of strategic development by the ONS.

We have highlighted the significance of and a very successful method of preparation for achieving certification. The specialty for rehabilitation practice has a core curriculum that can be found in many VA facility libraries. The ARN website contains requirements to sit for the exam, electronic application forms, testing and registration dates, study resources and practice test questions that are helpful. The VA ONS internal website offers information on the master certification list, certification discount coupons and exam fees, marketing strategies, campaign contest rules, awards, references and study materials. Easy accessibility of these resources make it possible for us to pursue and achieve the strategic plan. Others can obtain copies or gain additional information regarding these tools and documents by contacting their local VA nursing colleagues.

The polytrauma nurse advisor and the members of the PFAC are certified rehabilitation registered nurses. We can personally attest to the importance of certification. Certification as a personal goal is a commitment to excellence and one we view as a constant source of achievement, clinical knowledge, evidence based practice expertise and professional credibility.

We and many others believe that certification of nursing staff lends itself to improving patient-centered outcomes and quality of life, attributable to the knowledge base from which individual nurses then practice critical thinking, utilize sound judgment and make decisions for care. We believe it also improves retention of qualified staff and decreases turnover rates. The PFAC recognizes the number and types of certifications held by its members in national reports to ONS, the VA Under Secretary for Health, the annual Nursing Report and through conference poster presentation.

After having achieved this certification accomplishment, we find it important to maintain it. Re-certification may vary for different specialties, so it is essential to know each specialty’s criteria. There is usually a specified timeframe within which one must achieve a certain number of continuing education hours or points to remain knowledgeable of changes that
occur in one's specialty. In the field of rehabilitation, we are required to have sixty points in the five years subsequent to our certification. There are multitudes of ways in which to accomplish this and we on the PFAC notify nurses in the field of rehabilitation education opportunities. This includes websites, journal articles, the bi-annual PFAC live meeting webinar, conferences and the VA Talent Management System (TMS) education system. The ANCC also has an online continuing education tracking system to facilitate individual tracking for the certificant.

We sponsor a recognition event for those nurses who are the certified staff at our VA facilities, with a reception, certification ribbons, and introduction of each nurse and his or her area of specialty certification. The 2013 celebration at the Hines VA was especially significant, since the guest speaker, James Harris, then the ONS Deputy Chief Nursing Officer, was in attendance to present the Gold Certification Achievement Award to our nurse executive and the nursing staff. The award includes $10,000 to support nursing shared governance activities. At the time of this writing, at the Hines VA, 350 or 32% of acute care nurses are certified. The increase in nursing certifications at Hines achieved from the initiation of the ONS “Let’s Get Certified” campaign in 2008 to March 2014 is substantial, with 273 certificants added during this time period. The number of rehabilitation RNs who earned the CRRN designation increased from 8 to 33 during this same time frame. The newly initiated LPN certification program, in existence for only two years, has resulted in 57 certifications at Hines VA with twenty more LPNs studying for the exam. These figures and data were provided at the recognition event by our Magnet coordinator to share this success with all who participated. This success is attributed in large part to an on-site educational program designed for the LPNs.

There is a plaque on the wall at the Hines facility recognizing all certified nurses. The facility newsletter congratulates and features all of those who achieve new certification. Monetary incentives may also be offered to fund a study course, pay the exam fee, or as an achievement award, but this varies among VA facilities and is determined by local policy. This successful achievement clearly reflects the support from ONS, facility leadership, the Magnet coordinator and VA staff dedicated to excellence.

ONS leadership has done a tremendous job of highlighting the significant importance to patient outcomes that are improved with certified staff, and has made great strides in promoting the certification of its nursing staff. ONS continues to support this goal as do the senior nursing leadership and the clinical nurse managers who allow the study time, encourage the candidates and celebrate their achievements. The
ultimate responsibility is really up to the individual to be motivated, to seek out the resources necessary and to reap the many rewards of becoming a certified professional nurse in their specialty of practice.

We encourage all our colleagues to meet the challenge and become part of the VHA transformational performance measure that sets VA nursing apart as a center of excellence with continued learning. There are many continuing education programs, scholarships, tuition assistance programs and leadership development programs available throughout VA. As healthcare professionals we must nurture those that work beside us and encourage those following in our footsteps. There are great opportunities in our system for successfully achieving certification. We believe that ONS has provided us with the incentive to maximize our professional development by enhancing our career growth through certification. The greatest accomplishment we can demonstrate is the ongoing improved patient-centered outcomes and quality of life for our Veterans, Servicemembers and families we are honored to serve.

REFERENCES


Chapter 12

Expanding the Cadre of VA Nurses with Earned Doctorates

Cathy Rick
The authors of the Institute of Medicine’s (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, describe the need for the nursing community to address the major changes in U.S. healthcare by making “profound changes in the education of nurses both before and after they receive their licenses” (IOM, 2010, p. 30). They noted that changes needed to occur in all levels of nursing education “to provide a better understanding of and experience in care management, quality improvement methods, systems-level change management, and the reconceptualized roles of nurses in a reformed healthcare system” (IOM, p. 163). Their recommendations are based on extensive data. They noted, “Nursing education should serve as a platform for continued lifelong learning and include opportunities for seamless transition to higher degree programs” (IOM, p.163).

These comments are summarized in Recommendation Five of their report:

Schools of nursing, with the support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.

- The Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission should monitor the progress of each accredited nursing school to ensure that at least 10 percent of all baccalaureate graduates matriculate into a master’s or doctoral program within 5 years of graduation.
- Private and public funders, including the Health Resources and Services Administration and the Department of Labor, should expand funding for programs offering accelerated graduate degrees for nurses to increase the production of master’s and doctoral nurse graduates and to increase the diversity of nurse faculty and researchers.
- Academic administrators and university trustees should create salary and benefit packages that are market competitive to recruit and retain highly qualified academic and clinical nurse faculty (IOM, p. 13).
Over the past decade, our VA national nursing strategic initiatives have addressed key objectives and action plans related to this vital recommendation in the report on the future of nursing. As I led the development of the strategic plan in 2000, I realized some of our efforts would be long term ones. I was committed to enhancing our ability to conduct research and disseminate evidence based findings to support nursing practice for Veteran specific needs.

Through shared decision making processes supported by our national shared governance structure, we chartered a Nursing Research Advisory Group (NRAG). Membership on the NRAG included nurse scientists from across the VA enterprise. Each member received endorsement from their local nursing leadership and appointment to the advisory group by me as the Chief Nursing Officer. Members seek to be involved in a variety of national nursing initiatives in order to shape and contribute to national nursing research efforts.

These representative nurse scientists, through their programs of research, contribute to expanding our knowledge to enhance nursing practice in clinical, administrative and quality improvement endeavors. Members have a responsibility to work collaboratively within the nursing and interprofessional scientific communities in order to best inform our strategic path forward. NRAG has proven to be a useful structure to advance collective efforts led by these doctorally prepared scientific experts. The chairperson of NRAG is a full member of the National Nurse Executive Council, the key advisory body for Office of Nursing Services. They thus play an influential role through our work focused on doctoral nursing and help shape the overarching research and academic agendas for Veterans Health Administration.

As in all of our system-wide initiatives, our commitment has been to ensure bidirectional communication and a pervasive impact through the work of NRAG. We have accomplished this in the national program Office of Nursing Services by developing a Director and team who direct, support and facilitate the work of NRAG. The Director and team manage a portfolio of responsibilities aligned with research and academic initiatives across the VA nursing community. Additionally, their portfolio includes responsibility to build consensus and partnerships among nursing and clinical program officials. These program officials have national level responsibility for comprehensive transformative initiatives such as Patient Care Services, Women’s Health, Informatics & Analytics, and Research and Academics. We have learned that there is a clear interdependence among all strategic
initiatives. The attention to scientific contributions brings richness to all strategic initiatives within other work streams in the Office of Nursing Services. It informs our data-driven and evidence based approaches to advance nursing practice as organizational stewards.

Thus, prior to the publication of the future of nursing report, we had made great strides in expanding our nursing research capacity and support for doctoral education. I take great pride in the accomplishments of the NRAG. By way of example, they developed a mentor and transition to practice program for junior scientists and provided guidance for nurse executives to expand scientific approaches in day-to-day practice. The collective work of NRAG has resulted in broad-scoped accomplishments such as a national nursing research agenda for VA, a directory of nurse scientists with their focus of study identified, and a toolkit for advancing scientific inquiry for nursing in the VA system. These scholarly efforts have raised awareness and the impact of nursing research within VA as well as with academic partners and interprofessional healthcare colleagues and communities.

Over recent years, we have expanded tuition support for VA nurses seeking both PhD and DNP doctoral education. As we have raised expectations for our nurse leaders to advance health and lead change in this time of healthcare transformation, an increasing number have pursued doctoral education. We launched our initiative to expand the number of doctorally prepared VA nurses in 2001. Our decade of experience placed us in a credible position to provide concrete examples to inform the work of the Institute of Medicine committee as they deliberated on the future of nursing recommendations. We also were able to provide data on our successes to further validate the possibilities indicated in Recommendation five. Figure 12.1 illustrates the steady increase in the number of doctorally prepared nurses in the VA over a five year period of time.

It is also noteworthy that these doctorally prepared nurses bring their expertise to a variety of professional roles within the VA, as demonstrated in Figure 12.2.

In addition to the leadership work of the NRAG, we developed several key partnerships as an important action item in our strategic goal to increase the number of doctorally prepared VA nurses. I entered into dialogue with the Uniformed Services Health Sciences University (USUHS) Graduate School of Nursing (GSN) in 2003 focused on providing doctoral level education for VA nurses. I added a full time faculty position to the Office of Nursing Services staff roster. This
position is dedicated to the USUHS doctoral program, which in turn then provides for in-kind tuition support for VA doctoral students. Through an official Memorandum of Agreement between the two agencies, VA nurses have been supported, tuition free, for their advanced education. In exchange for this tuition support, these nurses commit to a service requirement: to fulfill scholarly activities to advance health and lead change through research and faculty efforts across the VA.
More recently, at the invitation of the dean, we have collaborated by providing further guidance to USUHS GSN for the development of a doctorate in nursing practice (DNP) program. It is our vision that the DNP level of academic achievement will become a necessary requirement for advanced practice nurses and senior nurse executives as the demands of clinical and administrative work continue to expand. With the addition of this new academic option in our partnership arrangement with USUHS, there will be new opportunities for VA nurses to pursue doctoral level education for practice roles (clinical, informatics and administrative) in addition to research roles. Thus, this mutually beneficial academic/practice partnership has positioned VA well for achieving the goal of doubling the number of doctoral level nurses by 2020. Professional nursing organizations are intent on confirming professional parity with other health disciplines that have shifted to require doctorates. Our strategic approach targeting DNP preparation for advanced practice nurses is closely aligned with that intent.

Our commitment to increasing the percentage of VA nurses with master’s and doctoral education created a need to expand opportunities to strengthen our academic/practice partnerships. While this is described in more detail in Chapter 10 where we describe our VA Nursing Academy, I think a recent development of a partnership between VA and a private funder provides a good example of how we achieve our goals, a strategy, incidentally, specifically recommended in the future of nursing report.

I was invited to participate in a meeting convened by representatives of the Jonas Foundation. They wanted to discuss options to develop a Jonas Military Scholars program in 2011. Founded in 2006, the Jonas Center for Nursing and Veterans Healthcare philosophy is to improve healthcare through nursing. Its mission is to make grants that advance scholarship, leadership and innovation, and collaborate on initiatives with other leaders in the nursing field, with a focus on fostering new partnerships across the philanthropic, business, policy and education sectors. The Jonas Center is funded through the Barbara and Donald Jonas Family Fund, a larger initiative that also supports programs that focus on mental health and at-risk youth. (Jonas Center for Nursing and Veterans Healthcare, 2014). Mr. Jonas has a special interest in supporting efforts for nursing to advance care management and clinical practice for military service Veterans. Out of his interest, grew the Jonas Military Scholars Program.

I became a key advisor to the Jonas Center as they developed and implemented the Military Scholars Program in fall of 2012. The 2011 news release announcing the program proclaimed “recognition of the dedication and sacrifice of the nation’s Veterans with the establishment
of the Jonas Nursing Scholars Program for Veterans Health. The program aims to improve the health of Veterans, notably those of the Iraq and Afghanistan wars, by supporting doctoral-level nursing candidates who are committed to advancing healthcare, from patient care to policy and administration” (Jonas Center for Nursing and Veteran’s Healthcare, 2011).

The first cohort of PhD/DNP Jonas scholars included five students enrolled at the University of San Diego Hahn School of Nursing, the pilot site for the program in 2011. In fall of 2012, fifty additional scholars were supported by the Jonas Center with two years of $10,000 each for tuition support. Scholars were selected based on their commitment, interest and opportunity to address Veteran specific health care needs. Priority was given to candidates with Veteran health care experience, either through active duty or work with the Department of Veterans Affairs, Department of Defense or Public Health Service. Many of the scholars were Veterans themselves.

Darlene Curley, Executive Director, Jonas Center for Nursing Excellence noted in the announcement of the program that “The Jonas Nursing Scholars Program for Veterans Health will help change the landscape in two significant ways: first by providing returning Veterans with a significant academic opportunity to pursue the highest level nursing degree; and second, ensuring that Veterans, now and in the future, receive optimum care” (Jonas Center for Nursing and Veteran’s Healthcare, 2011). The Jonas Nursing Scholars Program gave priority ranking in the selection process to universities affiliated with VA. I provided guidance to the Jonas Director in identifying the key focal areas required for the scholars’ research and scholarly projects: mental health, polytrauma, traumatic brain injury, spinal cord injury, prosthetics, vision impairment, aging, homelessness, women’s health, informatics, care coordination/transitions of care and team-based care.

I provide ongoing advice to the Jonas Center and have developed a dedicated VA Office of Nursing Services advisory group to assist the Jonas Center in further development and evaluation of the program. As of Fall 2014, this partnership with the generous Jonas Center has resulted in over 600 new doctoral level nurses. As an added valued outcome, the program has contributed to an increase in research that improves Veterans’ healthcare and the preparation of faculty to educate future generations of nurses (clinicians, researchers, administrators and new faculty) on Veterans’ healthcare needs. In addition, in preparation for our advisory role for the Jonas Center, we solicited names of all VA nurses who had an interest in pursuing doctoral education. We thus created a useful database that the VA can use to provide career advancement advice and counseling.
The partnership with the Jonas Center has been met with great public interest in addition to the resounding support across VA. A Public Broadcast Service program was developed for the PBS Need to Know segment. This broadcast highlighted the benefits of the program from the perspective of VA nursing faculty, student scholars and Veterans receiving care. We are forever grateful to the Jonas Center for expanding our scholarly capacity. VA funded 261 RNs for doctoral degrees since 2006 and the generosity of the Jonas Center has funded twenty-nine additional doctoral scholars as of 2013. To date, the Jonas Center for Nursing and Veterans Healthcare has committed a large philanthropic contribution, nearly $25 million, specifically for doctoral level nursing education. The Center is directing close to $14 million and has secured pledges of another $10.5 million in leveraged funds to prepare 1000 nurse faculty and clinical leaders with PhD or DNP degrees nationwide by 2018. Of those 1000 nurse scholars, it is anticipated that we will have close to 100 new VA nurse scholars as a result of the targeted partnership between VA and the Jonas Center. In 2013 the program expanded to include 88 partner schools in all 50 states.

Yes, we have encountered challenges along the way. Developing incentives for individuals to pursue doctoral level education has been an issue often complicated by concerns about salary disparity and role confusion. Many doctorally prepared nurses consider lower salaries to be unfair when compared to physician colleagues in similar roles, such as providers or clinical executives. Some physician colleagues consider it unfair or confusing when doctorally prepared nurses use “doctor” in their title. Physicians voiced concern that “Dr. Nurse” would create role confusion for patients and others. Surprisingly, I had to address questions from physician colleagues such as “What is this new role that you’re designing for doctorally prepared advanced practice nurses? Are you getting rid of nurse practitioners and clinical nurse specialists?” I had to articulate the need to provide our advanced practice nurses with advanced academic preparation so they can meet the challenge of the increasing complexities of their functions and roles. The doctorally prepared advanced practice nurse is not a new role; it is the responsible approach to ensuring efforts to achieve high quality, efficient, effective care.

As the VA pursued its expansion of doctorally prepared nurses, the VA served as a microcosm of the challenges faced by the larger professional nursing community. Issues that surfaced about calling nurses “doctor” had to be addressed. We built coalitions with physician colleagues who shared our belief that the VA system of care supports all clinicians who advance their academic achievements to a doctoral level. We addressed
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

our physician colleagues through their communication channels on national conference calls and local interprofessional meetings. We carried the message of patient focused attention to providing the best care possible with a highly educated team of clinicians, many who have achieved doctoral education credentials. We have emphasized that nurses with doctorate credentials have earned the right to be called doctor.

It was evident that we needed to provide assurance that our doctorally prepared nurses understood the need to clearly introduce themselves to patients, families and co-workers as nurses so that there would be no misunderstanding of their role, one distinct from the role of their physician colleagues. Approaches that we found to be helpful while being respectful of nurses' achievements and attending to concerns of physicians revolved primarily around clear communication. For patients, we expect that doctorally prepared nurses introduce themselves in a truthful manner such as “Hello, I am Dr. Rick, I am your nurse provider”. This approach would be no different than psychologists, pharmacists, physical therapists and social workers who are in similar clinical positions with respected academic achievement needing to be transparent to the Veterans we serve.

The challenge of addressing salary disparity for comparable roles is an ongoing industry-wide issue in health care. It is an industry standard to set salaries for roles such as advanced practice nurses by comparing like roles with similar qualifications and functions in a local market. This same process is used in the VA. We have addressed the challenge of salary disparity between physician and nurse providers and executives by sharing communication about how pay scales are developed. Our message about these pay questions outlines the well-known market-driven pay principles that are not unique to nursing and certainly not unique to the healthcare industry. Pay comparison for like positions in a local market is what drives pay determination. It has not been easy for us to carry this message because it certainly doesn’t seem fair to those who are functioning in similar roles yet are not paid at comparable levels. We have emphasized our gratitude to those who are trailblazers in such roles, for it is their work, in our opinion, that will pave the way for others in these roles in the future…not always an easy pill to swallow.

What does the future hold for doctorally prepared VA nurses? I’d say that the future is very bright! We take great pride in the very talented nursing workforce of VA. And, we will continue to seek appropriate incentives and recognition strategies to advance our practice and research through the work of those who have pursued this advanced academic credential. I predict that VA nurses with doctoral education
will play a pivotal role in advancing health and leading change within
the VA system of care, both at a local and national level, and will
impact overarching healthcare transformation in the country.

REFERENCES

http://www.nap.edu/catalog.php?record_id=12956

Scholars Program for Veterans Health Established to Improve Care for National Servicemembers.*
Retrieved April 28, 2014 from

Retrieved April 28, 2014 from
http://www.jonascenter.org/what-we-do/mission-philosophy-of-giving
Chapter 12.1

Recognizing Ongoing Research Needs in Nursing and Patient Safety

Amanda Fore
As a staff nurse working in a small private hospital, I quickly learned about patient safety before realizing there was a name for it. Attending an undergraduate Bachelor of Science in Nursing (BSN) program in the early 2000s, curriculum included little to no information about patient safety. Aside from hand washing, low beds, and side rails, patient safety was not discussed; systems-thinking was not introduced. On the nursing unit (first medical-surgical, then labor and delivery) I remember thinking about system fixes very early on: Why couldn’t look-alike medications be separated in the drawer? Why couldn’t all physicians use a standardized dose of Pitocin? Why weren’t high alert medications pre-mixed? Why were adult and pediatric doses stored in the same space? Although most of these questions involved vulnerabilities with medication administration, this was just the tip of the iceberg. The system vulnerabilities that I encountered included information technology, organizational behavior, and much more.

I quickly decided that there must be more to nursing and, just a few years after obtaining a BSN from Eastern Michigan University, attended an open house at the University of Michigan. Although I believed I would someday be a nurse midwife, the first presentation on patient safety and quality improvement I heard changed my life. The new systems paradigm I acquired and my passion for patient safety led me to a Master of Science (MS) in Nursing Business and Health Systems from the University of Michigan.

I was first introduced to the Department of Veterans Affairs (VA), a seemingly wild stretch from my original goal to be a midwife, during a nursing theory class. Leonard (Len) Wall, a nurse manager at the time, approached me about a research position at the Ann Arbor VA Health Care System. I soon met Sonia Duffy, Principle Investigator for the VA Tobacco Tactics smoking cessation study, and was presented with my second passion: research. As a Research Health Science Specialist, I quickly learned vital research related components such as patient recruitment, survey administration, data entry, data analysis, grant writing, manuscript preparation, and institutional review board approval. From that experience, I knew I would someday obtain a Doctor of Philosophy (PhD).

My next step involved interweaving nursing and patient safety. At a local research conference, I approached Beth King, Program Manager at the VA’s National Center for Patient Safety (NCPS), after her speech on patient safety. NCPS was established in 1999 to develop and nurture a culture of safety throughout the VA. After completing an internship at NCPS, a requirement of my Master’s program, I soon found myself working with Beth as a Nurse Coordinator for The Daily Plan®. The Daily Plan® is a patient specific itinerary used to inform VA patients of what to expect each day in the hospital. It
is designed to encourage the active involvement of patients in their own care as a patient safety strategy; if patients know what to expect, they are more likely to identify and question the unexpected. Later, I became a Nurse Coordinator for Clinical Team Training (CTT), formally known as Nursing Crew Resource Management (NCRM) and Clinical Crew Resource Management (CCRM) and a Program Analyst working with multiple Veterans Integrated Service Networks (VISNs). My work at NCPS was a “dream come true” for a staff nurse crazed about safety at the frontline. I am still awestruck by the VA’s strong and ongoing commitment to improving patient safety.

First introduced to Crew Resource Management (CRM) by Gary Sculli, Director of CTT, in 2009, the concepts have driven my research interests. CTT fosters high-reliability teams using proven methods from CRM to reduce patient risk, enhance patient safety, and facilitate effective teamwork and communication. I was lucky to be involved with Nursing Crew Resource Management (NCRM) from its inception. As I learned more about CRM and its role in improving operational safety, I was once again consumed by thoughts that there must be more that nursing can do.

Additionally, as a Program Analyst, I have become skilled in the Root Cause Analysis (RCA) process. This has allowed me to stay current on system vulnerabilities that lead to errors. Each time I read a RCA I am reminded of my time as a direct care staff nurse. I think about the common reactions to error that I experienced and about how actions that include common human factor engineering principles can be implemented to reduce human error. Ten plus years after the landmark Institute of Medicine (IOM) report, *To Err is Human* (2000), and the founding of NCPS, we continue to be confronted with errors and near misses that impact patients and health care providers. With the needs for further study visible, I returned to school to pursue a PhD at the University of Michigan.

My journey to obtain a PhD began with considering Universities. I chose to return to the University of Michigan, where the PhD program, and my academic advisor and mentor, Beatrice Kalisch, were a perfect match for me. The VA’s collaboration with the Jonas Foundation to support nurses pursuing doctoral education has lessened the cost of tuition. The Jonas Veterans Healthcare Program supports scholarships for nurses to be trained at the doctoral level to ensure our Veterans are receiving the best possible care. Throughout the PhD program, I retained full time employment at NCPS while completing full time course work. Although challenging at times, the constant stream of information from courses provided me with the excitement and skills I needed to excel in my position at NCPS. I was able to apply many things from class directly to my current position. Whether
engaging colleagues in a stimulating discussion or running regression analysis on data collected for our projects, I was rarely short on ideas. I am an active team member at NCPS and attribute much of that to my ongoing educational efforts. Likewise, my work at the VA and NCPS has provided equal effects on my education. The knowledge and experience I have gained at NCPS has been highly applauded at the University.

As I complete my preliminary examination and dissertation, I continue to receive support and access to subject matter experts in the VA. Additionally, I plan to complete my research at VA facilities. Working in a national VA program office, I am privileged to have worked with many amazing nurse managers, patient safety managers, patient safety officers, staff nurses, and others in my role as Nurse Coordinator and Program Analyst at NCPS. I look forward to continuing my work in the VA and am excited about the possibilities that my research has on maximizing human cognitive resources, optimizing clinical decision making, and keeping patients safe.

My current work focuses on situational awareness, a CRM concept found to be central in the maintenance of operational safety in high reliability organization. Although multiple studies from other domains have suggested links between situational awareness, human error, poor performance, and poor outcomes, and the IOM recommended implementing practices from high reliability organizations over a decade ago, situational awareness remains underexplored in healthcare. Situational awareness is defined as the perception of the elements in the environment in a volume of time and space, the comprehension of their meaning and the projection of their status in the near future (Endsley, 1995). Defining attributes of situational awareness, in nursing, include perception, comprehension and projection (Fore & Sculli, 2013). Although situational awareness is related to other terms in nursing, there is increasing recognition that the concept, which is likely a consolidation of the related terms, has an impact on healthcare professionals. Nurses are essential to achieving vigilance in health care. Monitoring requires great attention, knowledge, and responsiveness on the part of the nurse; vigilance and monitoring requires that the elements of situational awareness are clearly identified, defined, and supported in practice. Additionally, as the healthcare industry increasingly participates in team training programs and strives to create high reliability organizations, the relevance of situational awareness becomes increasingly apparent. Failure to achieve and maintain situational awareness presents threats to patient safety. Situational awareness needs to be examined in a theoretical context, studied systematically, and openly recognized as a universal factor in patient safety.
For my dissertation, I am currently planning a qualitative, descriptive, exploratory study to understand the impact of situational awareness on the safety and quality of patient care on acute inpatient nursing units. The aims of the study are to (1) understand the impact of situational awareness on the safety and quality of patient care on acute inpatient nursing units and (2) identify requirements essential to the development and maintenance of situational awareness on acute care inpatient nursing units. The results of this study will likely improve the understanding of situational awareness in nursing, including improvement and measurement strategies.

Building on the foundation of current research, the results of this study will provide data to examine situational awareness in a theoretical context. The study may provide key information for further inquiry on the development and maintenance of individual and team situational awareness in nursing practice. Findings may also shed light on environmental, cultural, and technological factors affecting the development of situational awareness on acute inpatient nursing units. The results are also likely to provoke ideas that may lead to new interventions and appropriate strategies to support individual and team situational awareness and improve patient outcomes on acute care inpatient units. Additional insight on the measurement of situational awareness in the clinical environment may also be achieved.

As I continue my journey, obtaining a PhD will provide me with opportunities to balance my passion for nursing, patient safety, and research. Obtaining a PhD will make a difference in the care Veterans receive by providing a theoretical foundation for additional research in patient safety and nursing.

REFERENCES


Chapter 12.2

The Meaning of Life

Jemma Ayvazian
From a young age the philosophical questions of human existence and the meaning of life have always intrigued me. Searching for answers, I read books on philosophy during my high school years and took a course on Exploring the Human Spirit during my undergraduate studies. My questions were unanswered until I came across the book, *Tuesdays with Morrie: An Old Man, a Young Man, and Life’s Greatest Lesson*, by Mitch Albom (2002). Albom’s book gave me better insight and helped me to develop my own beliefs on the meaning of life. I learned to look at things differently, to appreciate the small things that I have in life, and to cherish things that we all take for granted at times. Most importantly, reading this book reinforced my decision for choosing the nursing profession as my life’s work as the right decision.

Born in Azerbaijan to Armenian parents, our family was forced to leave that country and become refugees in Armenia when we fled in November 1988. One month later, in December 1988, after a catastrophic earthquake in Armenia, we lost everything for the second time. Having little choice, we moved to Ukraine, where some of our relatives had settled and were willing to assist us. Life for us in Ukraine, a part of the Soviet Union until 1991, was not easy, but support from our relatives and the local Armenian population was immense. We managed once again to survive and go on with our lives.

I met my husband, who is a United States Army Officer, in 1998 and emigrated to the United States of America at the age of 18. Once again, I had to start all over. I felt helpless and powerless. At that time, I could not imagine myself accomplishing what I have at the present moment. I must admit that I was overwhelmed with the tasks of mastering the English language, attending nursing school as a full-time student, juggling a family life with two small children, and working at my job. However, I can attest that those countless late night study excursions have made me a much stronger person ready for any challenge that life can throw at me. Looking back, I am delighted that I pursued a career in nursing, which helped me to grow and develop exponentially in many areas, personal and professional.

As a military spouse, I witnessed firsthand the difficulties our soldiers and their families experience on a daily basis. I remember the emptiness of being left behind at the US Army installation in Germany with two small children on my hands when my husband was deployed to Iraq in March of 2003. I anxiously awaited any information from the frontline about the whereabouts and well-being of my husband. I was among thousands of spouses who were in the same situation. On the surface we all appeared strong, but I tried to hide my deep-seated fear of not being able to see my husband again and the constant worry about the future of my children. I believe the majority of my fellow military spouses had the same fears. War
scars change people… not only those who experience the frontline, but also those who are left behind. As we learned later, our soldiers were coming back from a war zone with multiple problems, physical and psychological, and their families had to learn to cope with disturbing issues. Having this personal experience, I wanted to explore ways of helping our Veterans and their families to heal the wounds of war and to recover their former lives.

On our return to the US two years later, I set myself a goal to go back to school, obtain a nursing degree, and begin to work with our Veterans. To this day, I continuously strive to do my best to advance my knowledge in the field of nursing in order to advance and improve the care we deliver to our Veterans. Upon completing a Bachelor’s of Science Degree in Nursing (BSN) from Regis College in Weston, Massachusetts, I accepted a registered nurse position at the Edith Nourse Rogers Memorial Veterans Affairs Medical Center (VAMC) in Bedford, MA, in 2008. At the same time, I decided to continue my studies and looked at several graduate programs in the Boston metropolitan area. My decision to attend Boston College was heavily influenced by the school’s stature among leading Catholic institutions of higher education and its proven record of providing a top-notch learning experience. I must note that the support and encouragement from my VA colleagues helped me greatly in being able, in 2010, to graduate with distinction and a Master’s of Science Degree in Nursing (MSN). And these words are not insincere gratitude or hollow praise. I was truly amazed at their willingness to adapt to my ever-changing school schedule and allowing me to adjust my work schedule accordingly. They were ready to step in and swap work shifts on short notice. I will be eternally grateful to the 6B team members at the Edith Nourse Rogers VAMC for their support and understanding.

As I adapted to my role as a nurse at the VA, I recognized that teaching plays a major and integral part in the nursing profession. I realized that I wanted to become a nurse educator and be able to serve in both roles, as a nurse and as an educator. Therefore, concurrent with my MSN degree, I pursued a Postgraduate Nurse Teaching Certificate at Boston College to specifically prepare me for the role of nurse educator. I built a solid theoretical and practical foundation in nursing education while a student in this program. I was able to apply newly acquired knowledge, not only to nursing education, but also to patient/family education programs at my workplace. In collaboration with my colleagues at the Edith Nourse Rogers Memorial VAMC, we designed and implemented an education program and developed a set of educational materials to address the unique needs of Veterans and their families.
Unfortunately, shortly after the completion of my graduate studies and transition into my new role as a Nurse Practitioner (NP) at the same VA hospital, my husband was directed to relocate to Wright-Patterson Air Force Base in Dayton, Ohio. Happily, I was able to transfer to the Dayton Veterans Affairs Medical Center, where I accepted a position as a Pain Management and Traumatic Brain Injury Nurse Practitioner in the Polytrauma Clinic. In this role, I also served as a Traumatic Brain Injury Program Coordinator with the privilege of joining a team of highly dedicated professionals. As in Massachusetts, I was surrounded with great support and colleagues willing to go an extra mile to lend a hand to a coworker. Our work in Dayton was focused on Veterans who returned from the Iraq and Afghanistan wars with multiple co-existing medical and mental health conditions. Many Veterans with traumatic brain injury (TBI) have co-existing diagnoses of post-traumatic stress disorder (PTSD), depression, chronic pain, and substance abuse issues. Frequently they exhibit a cluster of cognitive, emotional, and behavioral issues. These symptoms are disruptive to interpersonal relationships and cause enormous stress for Veterans and their families. Veterans with TBI and polytrauma have multiple needs that differ from those of the older generation of Vietnam Veterans and require innovative approaches to assure their engagement in treatment programs.

During the transition from Massachusetts to Ohio in 2011 I decided to continue my educational journey and began exploring various paths into a doctoral degree. Choosing between a Doctor of Philosophy (PhD) and a Doctor of Nursing Practice (DNP) was a challenging decision. After extensive deliberations I chose to pursue a DNP degree because it closely matched my interests in quality improvement, evidence based practice, and translational research. My experience with the issues faced by Iraq and Afghanistan Veterans and my very special and close relationship with individual Veterans led me to concentrate my doctoral studies in these areas at Johns Hopkins University. As part of my DNP program I designed a quality improvement project to evaluate an integrated, evidence based model of rehabilitative care focused on the simultaneous treatment of TBI, chronic pain, PTSD, anxiety, depression, sleep disorders, substance abuse, and other medical and mental health conditions prevalent in the Iraq/Afghanistan Veteran population. The purpose of my project was to promote rehabilitation and decrease the length of time Veterans spend in recovery. My goal was to help our Veterans to successfully transition back to their communities through a variety of evidence-based and practical clinical rehabilitative interventions identified in the literature.
To design a model of care that will optimize recovery and help Veterans re-integrate into the community, I conducted an extensive review of the literature to identify the essential components of comprehensive rehabilitation care for Veterans diagnosed with polytrauma. I also consulted with experts on polytrauma/TBI and conducted interviews with Veterans to examine their needs, preferences, and expectations for polytrauma care. After collecting numerous recommendations, my colleagues and I successfully designed an integrated rehabilitation care model for the management of TBI, PTSD, pain, and other health conditions within the context of polytrauma. Our model was pilot tested at the Dayton VAMC in 2012. The results of this project provided valuable information on the effectiveness of our integrated model of care. The new approach to treatment was also well received by the Veterans and their caregivers, who provided positive feedback during focus group discussions. I have to acknowledge the tremendous support that I received from my polytrauma team colleagues, Dayton VA leadership, and Johns Hopkins University School of Nursing professors, all of whom selflessly coached and supervised me while providing feedback on the project from its inception to its clinical implementation. Without their support this project would not have been possible. In addition, the support of the Jonas Foundation through the Jonas Veterans Healthcare Program has been instrumental with providing the necessary tools and funds that enabled me to conduct a scholarly knowledge translation project and design an innovative collaborative approach to care for polytrauma Veterans and their families.

I consider myself fortunate that all these doors of opportunity have opened for me during my tenure at the VA. These challenging and rewarding experiences helped me to better understand and to make a personal contribution to nursing’s quest toward providing leadership in the transformation of health care delivery for our military Veterans.

Another aspect of the nursing field that I always wanted to explore is the professional development of nurse leaders. My VA mentors continuously supported my pursuit of leadership roles and prompted me to advance my knowledge of organizational structures and procedures. They encouraged me to advocate for Veterans and promote the empowerment of VA nurses and their goal of providing exceptional care to our Veterans. Further, with improved professional skills nurses are better able to serve as agents of change when faced with the challenges of an immense organization, such as the VA. In conjunction with entering Year 2 of the DNP program, my professors at Johns Hopkins University encouraged me to apply for an exceptional executive nurse leader mentorship opportunity offered
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

by the Johns Hopkins University School of Nursing. After discussing the program extensively with Johns Hopkins University professors and my colleagues at the VA, I was convinced that this program would strengthen my competencies for successful and effective contemporary nursing leadership practice. After being informed that I was one of three students selected for this prestigious program, I requested that I have an executive mentor from the VA. At that time, I could not envision myself being a mentee of not one, but two of the greatest nursing leaders in the VA organization, Mrs. Catherine Rick, RN, NEA-BC, FACHE, Chief Nursing Services Officer, and Dr. James Harris, DNS, the Deputy Chief Nursing Officer.

For my practicum experience, I was assigned to the Department of Veterans Affairs Central Office (VACO), Office of Nursing Services (ONS), where I observed highly successful and accomplished Veterans Affairs leaders. I actively participated in meetings and discussions with the ONS leadership and field advisory groups, working on national level nursing workforce development projects. These experiences allowed me to build the necessary qualitative and quantitative skill sets, tools, and methods to meet the complex demands for effective contemporary leadership practice within the Veterans Affairs organization. Further, exposure to these activities, along with the theoretical knowledge and practical application of educational strategies, has unquestionably helped me to develop a strong foundation for being a successful nursing leader. I am indebted to my VA mentors, Mrs. Cathy Rick and Dr. James Harris, the entire ONS team, and Mrs. Anna Monnett, the Dayton VA Nurse Executive, for their tireless coaching and guidance in helping me master the attributes needed to develop the leadership skills of an effective and successful nurse leader in the setting of Veterans’ health care. I extend the same gratitude to my Johns Hopkins University mentors, Dr. Mary Terhaar and Dr. Maryann Fralic, for their unwavering support in helping me to achieve my goal of becoming a dynamic, competent, confident leader who is broadly-informed in the political, economic, and social aspects of health care.

I also would like to extend my appreciation to all my VA colleagues at the Edith Nourse VAMC, Dayton VAMC, VACO ONS, and Washington DC VA, where I was recently transferred due to my husband’s military service-related change of station. The support and understanding that I have received as a military spouse have been incredible. As a military family we relocated three times in the past three years. During this period I was working arduously on attaining my doctoral degree. With every geographical move, I was in a state of constant fear over leaving behind a cherished job and not being able to find a VA position that matched the rewarding experiences and career goals I was leaving, specifically working
interpersonally with Veterans and their families. But every time, there
was someone at the VA who understood my interests and dedication,
extended a helping hand, and opened a new door of opportunity for me
to successfully transition from one assignment to a new challenge.

I frequently look back at the chain of the events surrounding my life
experiences and wonder what obstacles I will next have to overcome.
Despite many difficulties in life, I have been diligent in my pursuit of nursing
as a career within the US Department of Veterans Affairs. Being able to give
something back to our Veterans and making a meaningful impact on their
lives are the greatest rewards for my motivation and persistence. Growing
up, I was constantly advised by my parents to continue the tradition of
becoming a teacher like so many family members over the generations
who followed education as a profession. Although I was always interested
in teaching, I am pleased that I decided to follow a different profession and
choose nursing, a path that has defined much of the meaning of life for me.

REFERENCE

Chapter 12.3

Springing from the Shoulders of Giants

Narda A. Ligotti
My mother was a giant in my life. As valedictorian of her high school with aspirations for a career in nursing, my mother’s stories and history were inspiring to me. My mother was born and raised on U.S. military bases. Her father, George, was a sergeant in the army for decades. Stories of his military life experiences lie in my memory as well as in letters tucked away among my personal treasures. Because my grandfather was a WWII Veteran and career sergeant, my mother’s family spent years on military bases far and wide. My Uncle Johnny, Mom’s brother, served in WWII and was a POW in Germany. My parents met on an Air Force base near where my mother lived and where my father was stationed. Both my father and my father-in-law served during the Korean War. Our family’s history is well grounded in service to our country. This history of service became the family tradition that shaped my first experiences caring for a patient.

My patient needed to take her medication with a pudding. Since I was going to the kitchen anyway, she asked me to get her a handful of graham crackers to stash away for later. The medical-surgical ward kitchen was just around the corner. I was back in a few minutes with the snacks, a spoon, a napkin, and a small supply of bendable straws for her to use during oral medication administration.

My patient required the use of bendable straws because she was unable to drink from a cup as others do. She was unable to bend her neck due to the progressively debilitating diseases Ankylosing Spondylitis (AS) and Rheumatoid arthritis (RA). Crohn’s disease added distressing abdominal complications to my patient’s AS and RA muscular/skeletal difficulties. My patient was in the hospital for a battery of medical tests, and her medication schedule was a complex poly-pharmacological routine. Pain control was our biggest challenge.

My patient was my mother and I was six years old. The ward nurses knew me by sight and name as I came and went in the medical-surgical hallways unfettered. The nurses trusted me to take good care of our patient, and if I needed something, they knew I’d ask them at the nursing station. I was my mother’s personal caregiver during frequent hospital stays and in our home. Science and math have always interested me, even as a young child and I possess caring qualities. I feel as if I was called to nursing at the tender age of six years old. Indeed, nursing is the career path I chose when the time came to decide.

My position as Nurse Educator at the VA Central California Health Care System (VACCHCS) for the past seven years has been fulfilling. Support and guidance from a giant in my professional life, Dr. Patricia Richardson, Chief Nurse of VACCHCS, is invaluable. In my VA position, I work with
staff and nurse managers to improve patient safety through nursing education, promote staff development, mentor student nurses and staff nurses and work to orient newly employed nurses to VACCHCS. I enjoy the communication and leadership challenges of being a VA nurse. My success with these experiences fueled my personal motivation for greater career goals, including pursuing a Doctor of Philosophy (PhD) in Nursing.

The decision to apply to an educational program that offered a PhD in nursing happened gradually as I worked my way through California State University, Fresno (CSUF) Bachelor of Science (BSN) prerequisite classes and the nursing program. In fact, it was a professor in an undergraduate class at the local community college called “group communication” that first mentioned “doctoral studies” to me. It was the last day of the semester and the professor asked me to stay after class. She told me that if I ever needed a letter of recommendation when applying for a “doctoral program” to let her know. This daughter of a blue-collar family thanked the professor kindly and walked away wondering “what does ‘doctoral studies’ mean?” A year later the concept came up again. One of my classmates in the BSN program leaned over and whispered to me during a lecture “Did you know there are ‘Doctors of Nursing?’”

I did not know!

I was a senior in the BSN program when I was truly informed what “Doctors of Nursing” do as professors, as advanced practice nurses and as researchers. Dr. Angela Hudson was my senior year mentor and assigned professor. Dr. Hudson, a nurse scientist, advised me that I had “potential for doctoral studies.” At that time Dr. Michael Russler was chairperson of the nursing department of CSUF. He got to know me through my work as Chair of the pinning ceremony for our class, and he too encouraged me to pursue doctoral studies. Both of these professors were giants in my life who influenced me to seriously consider applying for PhD programs as I reached for my personal potential.

Inspired to do some investigative “homework,” I discovered that CSUF was a host school for the Ronald E. McNair post baccalaureate program. McNair Scholar Program placements are competitive and the process requires preparation. For example, McNair candidates must interview individually as well as face multiple panel interviews and write a personal statement of career goals which include doctoral education. Once accepted, McNair Scholars attend advanced education workshops to improve skills needed in doctoral education, are socialized to the culture of doctoral studies, provided with a grant to support their Master’s thesis and are encouraged to apply for entry into PhD programs in the discipline of their choice.
I was accepted into the McNair Scholar program for the 2005 cohort and again in the 2006 cohort. Ronald E. McNair, PhD influenced me in a giant way through this academic program. The McNair program was incredibly supportive in advancing my educational goals and I am honored to have participated in the McNair program at CSUF. Through a great deal of effort on my part and with encouragement from the Ronald E. McNair program staff and from my McNair mentor, Dr. Angela Hudson (who is now a professor at UCLA School of Nursing), I strengthened a belief in myself and found the courage to pursue earning a PhD with nursing research as the focus of study.

As the first generation in my family to pursue education beyond high-school and attain a University degree, I am grateful to Dr. Michael Russler for his mentoring during my Master’s science of nursing program. He also encouraged me to apply to University of Nebraska Medical Center (UNMC), College of Nursing (CON) PhD program, which has a ‘distance learning’ system for out-of-area students.

Nursing programs offering a PhD course of study are not available in the Central San Joaquin Valley of California. The closest programs are in Sacramento or San Francisco. Unfortunately, due to distance, accessing these excellent academic programs is difficult for Central California residents. In contrast, the UNMC CON has been supporting students through distance learning since the 1970s. Their program is practical and applicable for the distance doctoral student. My McNair Scholar experiences helped me prepare for the individual and panel interviews required for entry into the PhD program at UNMC CON. I was accepted into their program in 2007.

As a UNMC CON student in the PhD program, I have been honored to be selected as a Jonas Scholar in 2012 and as a Bob Woodruff Foundation – Jonas Nursing Scholar (2013-2014), due to academic achievement in coordination with my dissertation topic. The scholarship was awarded through the Jonas Center for Nursing and Veterans Healthcare. “The goal of the Jonas Veterans Healthcare Program is to educate nurses in the special healthcare needs of our Veterans to get our wounded heroes healthy and back on their feet.” (Jonas Center, 2014).

In 2006, Barbara and Donald Jonas (giants in the lives of many) established the Jonas Center for Nursing Excellence, dedicated to improving healthcare by advance nursing scholarship, leadership and innovation. Its two main programs are the Jonas Nurse Leaders Scholar Program, which aims to address the dire shortage of nursing faculty by preparing nurses with doctoral degrees to step into this critical role, and the Jonas Veterans Healthcare Program, which seeks to improve the health of Veterans by supporting doctoral-level nursing candidates committed to advancing Veterans’
healthcare. These programs currently support more than 250 doctoral scholars nationwide (Jonas Center for Nursing and Veteran’s Healthcare, 2014).

Each Jonas Scholar is to work on a project guided by the Institute of Medicine (IOM) Future of Nursing (2010) recommendations. My Jonas nursing leadership project was the development, coordination and management of a nursing research conference entitled “Transitions from Research to Practice.” Several community organizations collaborated to make this conference possible: VACCHCS, Central California Nursing Research Academy, CUSF Nursing Department, Central California Center for Nursing Excellence and Fresno State Alumni Association, Nursing Chapter. Since 2009, VACCHCS has supported my participating on the Board of this community project that promotes evidence based practice and nursing research in central San Joaquin valley, California.

The “Transitions from Research to Practice” conference was open to the nursing community in central San Joaquin valley, but we drew our audience from far beyond those borders. The theme of the conference was built on the Institute of Medicine (IOM) discussion of the Future of Nursing report (IOM, 2010). My advisor and mentor in the PhD program, Dr. Karen L. Schumacher (a current giant in my life) provided direction for me on the process for recruiting three dynamic nurse scientists as speakers for the Fall 2013 Nursing Research Conference.

Central California has extremely limited resources and is a rural area isolated from nursing research programs. There are few nursing research opportunities and no career nurse scientists in the area. Nursing research and evidence based practice (EBP) are not always well understood or utilized throughout the area. These nationally recognized nurse scientists drew over 100 participants eager to learn about nursing research and evidence based practice. As the 2014 school year continues, I strive to work as a Jonas Scholar to support promoting nursing research and evidence based practice in the central San Joaquin valley guided by IOM recommendation 2 as discussed by IOM:

Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. (IOM, 2010, p. 2).
My dissertation research plan has evolved during the past academic year. The dissertation title is: “Care for Veterans in the home: A qualitative study.” My population of interest for the study is community-based Veterans and my focus will be “Care at home by Veterans and their support person.” The project goals include exploration of how local Veterans care for themselves in their homes, and the roles of their support persons.

Because I anticipate my graduation within a year, I believe I will be springing forward off the shoulders of giants in my life as my progression through the UNMC CON PhD program is coming to an end. I plan to use what I have learned from these giants to promote evidence based nursing practice and nursing research to better care for our Veterans locally and beyond.

REFERENCES


Building a Business Savvy Community of Nurse Leaders

Chapter 13

Cynthia Caroselli
In this chapter I have set out to describe how a group of VA nurses created the continuing education tools to enhance business acumen of VA nurses. Our intent was to better equip these nurses to negotiate the business aspects of their job and to more successfully interface with the larger Veterans Health Administration (VHA) system.

Sheryl Sandburg, COO of Facebook, shocked everyone recently when she encouraged women managers to “lean in” rather than be laid back. Everyone, that is, except nurses. Long before Sandberg ever thought of writing Lean In: Women, Work, and the Will to Lead (Sandburg, 2013), nurses were fighting for their rightful place in the executive suite. Nursing, a female dominated profession with religious and military roots and founded on an apprenticeship model of education, has made great strides that have resulted in the evolutionary development of nursing as a profession. Education is now university based, graduate preparation at the master’s and doctoral level has contributed to the development of a robust research base of knowledge, and advanced practice role development has led to the ubiquity of nurse practitioners, nurse informaticists, nurse researchers, and even nurse legislators. We pursued our goal to enhance the business acumen of VA nurses and were fully aware of the larger context of women as leaders in our society.

Yet, despite all of these remarkable advances, the struggle for legitimacy in the executive suite for women has been less rapid. As health care delivery evolved from home based care into large hospital-based institutions, it became commonplace that a nurse led the group of nursing employees. This leadership role was generally referred to as the director of nursing or something similar. Yet, even as it became clear that nursing comprised the largest group of individuals providing care and was the only round-the-clock, 7 days a week, (24/7) presence in the patient care provided, the nursing leadership position held a relatively limited amount of organizational power and often merely influenced organizational action, often in a reactive stance, rather than driving the action.

Over time, RN education expanded and nurses became increasingly educated, the nursing leadership position evolved, as did nursing’s sphere of influence. Now, the nurse in a leadership role often assumes responsibility for disciplines in addition to nursing, and can often carry the title of vice-president. In fact, many nurse executives are responsible for clinical disciplines across multi-campus settings, thus exerting a great deal of influence over a wide-ranging scope of health care delivery practices (Caroselli, 2008).
While these developments have been encouraging and rewarding, not all nurse executives have enjoyed full acceptance in the executive suite. Additionally, many nurse executives are not fully prepared to assume full responsibility of the executive role, especially in acquiring and demonstrating financial expertise.

While VHA nursing leaders face many of the same challenges as nurse executives in the private sector, there are some major differences that relate to achieving business acumen. In general, VA staff at all levels are characterized by long tenure, many spending their entire careers in various sectors of this large national organization. Because the financial model for VHA is based on a congressional disbursement model, rather than on a reimbursement model, many VA leaders, including nurse executives, “grew up” in an organization in which generally accepted fiscal knowledge was not viewed as necessary or expected as a competency. Additionally, financial management was relegated to a non-clinical administrator, with little input from nursing leadership.

Times have changed! In a competitive health care environment, with health care reform a controversial topic, and with a national recognition that the current delivery system is unsustainable, it has become clear that VHA nurse executives must be competent in all aspects of administration, and notably, in financial execution. My own professional journey from private sector and academic organizations to VHA provides an illustration.

Having spent my entire previous career in private sector and academic organizations, I joined the VA as the Associate Director for Patient Services/Chief Nurse Executive of a multi-campus system designated at the highest level of acuity and complexity in VHA. Responsible for virtually all of the clinical disciplines except physicians, I brought with me a background of both clinical and administrative expertise, including a strong background in teaching nursing administration and finance at several universities. While attending a national meeting of VHA nurse executives, I discovered that I had something to contribute to VA on a national level. The chief nurse of VHA at that time, Cathy Rick, described a new strategic initiative designed to elevate the business acumen of chief nurse executives. The strategy was developed in response to concern that nurse executives were not prepared to “sit at the table” and effectively participate in financial decision-making. Obviously, this perception disadvantaged nurses as an employee group and had the potential to adversely affect efficiency and effectiveness of our nursing care delivery.

I saw this as an invitation and privilege: I had skills and experience that I could offer to my new organization. In the relatively short time
that I had been in my role, I had gained enormous respect for the goals and clinical outcomes that VHA had achieved, and was in awe of what the community of VA nurses had been able to accomplish. I approached Audrey Drake, then deputy chief nurse of VHA, and told her of my interest. I described how I hold an academic appointment at a local university where I teach health care finance, budgeting, and leadership to master’s and doctoral nursing students and indicated that I felt that I could make a contribution to the initiative that Cathy had described. She in turn introduced me to other nurse executives who were interested and had begun a task force to address this need. Even though I was a newcomer to VHA, they graciously welcomed me. We began a multi-year engagement that led to the development of a computer-based curriculum for nursing leaders across the VA system. It has currently been revised into a second edition and is available for nurse leaders to use as a self-directed, self-paced learning module. Our process of getting to this point is a story of VA nurses creating our own resource to meet our lifelong learning needs.

As we began our work, we realized that the notion of developing financial skill would be a foreign notion to many of our colleagues, especially those with long tenure in a system that had not previously required or provided this knowledge. I shared with the group that I had encountered similar difficulties in convincing aspiring and current nurse leaders that fiscal acumen is an essential skill for ensuring safe and effective nursing practice. We collectively conceded that this content could be intimidating and that resources had been sparse in the past. In addition, the prevalence of nurse practitioner positions, indicating a serious demand for nurses with this advanced preparation, had forced many universities to make hard choices in terms of program development. As a result, many schools had closed their nursing administration programs in order to devote resources to advanced practice curricula. Thus, while some nurses may have wanted to develop financial expertise, the opportunities to do so, without entering a non-clinical program (such as a traditional MBA program) were limited indeed.

Another concern we shared was more pragmatic: if we were to develop resources to address this need, what form should they take? While we all preferred a traditional, in-person instructional method, we knew that this was not possible. With 152 medical centers scattered across the country and United States territories, we would have had to develop the equivalent of a “traveling university” to reach the intended audience. Even utilizing annual conferences or regional meetings would not have allowed us to deliver a significantly comprehensive product in a timely manner.
manner. However, we realized that the world-class technology resources of VHA would provide a valuable platform in conjunction with the talents of the employee education system (EES). We soon asked Ramona Wallace, EES to join our work group. Over the succeeding years, she has creatively packaged the curriculum in a way that enhances the content and makes learning accessible to many levels of participants in a virtual platform.

Another important question we grappled with centered on the intended audience. While the initial driver had been to address perceived knowledge gaps among the chief nurse executive group, we quickly realized that the curriculum could act as a powerful tool for succession management. This is particularly important when one considers that by fiscal year 2018, 80% of the VA nurses in the highest executive level positions will be retirement eligible. Since VHA competes directly with the private sector for all health care provider populations, and since nursing positions will continue to be among the “hard to fill” positions, it is essential that all levels of nurses be afforded the opportunity to develop skills needed to perform in leadership roles. (VHA, 2013, p. 33). Thus, we concluded that while the primary audience for our curriculum would be current nurse executives, especially those new to the position, we would make it available to any nurse who was interested in learning new skills.

We realized that, as with any new venture, it is important to keep our goal in mind. Why are we doing this? Why is this important? What are the compelling reasons that justify the devotion of considerable resources to achieve the intended outcome? Everyone in the workgroup held demanding and all-encompassing “day jobs.” Most of us were leading large complex organizations that required 12-18 hour days on a 24/7/365 basis. While we knew that we could do some work during our “free time” at home, it was clear that we would need to meet periodically on a face-to-face basis. We recognized that this was going to be a daunting enterprise and that we should spend some time justifying the need to commit such significant amounts of time and energy. Our mandate became clear in light of the following realities:

- The IOM Report on the Future of Nursing states that nurses must be full partners, with physicians and other health professionals in health care redesign, in eliminating waste, in implementing plans for improvement, and in coordinating care (IOM, 2011, p. 28).
- At the end of FY 2011, VHA had over 269,000 employees making it the second largest employer in the federal government and one of the largest health care providers in the world (VHA, 2013, p. 5).
• Advances in care and policy implementation at VA facilities have wide-ranging effects on health care throughout the nation, since so many patients are served by so many providers from all of the health care professions (Caroselli, 2012, p. 182).

• While nurse executives are generally responsible for the largest group of employees in most health care organizations and thus can have highly significant effects on the fiscal health of the organization, many nurse executives lack the requisite fiscal knowledge to fully enact the role.

• Health care expenditures continue to constitute an increasing portion of the gross domestic product and a surprising number of health care organizations find themselves in dire financial straits, with a concomitant effect on the delivery of care.

• Healthcare will continue to be expensive, complex, and multifactorial, and will address an aging, increasingly acutely ill population in traditional and nontraditional settings.

• The bottom line is that nurse leaders must be fully equipped to address these challenges as equal partners in the executive suite and must be seen as competent experts who can advocate and achieve the necessary resources to provide excellence in care delivery.

With these imperatives in mind, we felt comfortable committing ourselves to a task that we knew would require a significant investment of time but one which would be worthy of our collective effort. We were on a mission!

Since I had been teaching courses on this topic for some time, we had a structure from which to work. I shared my syllabi, power point presentations, and experiences, and we decided that this would form the structure of our product. However, it was immediately clear that my material was constructed for an audience much broader than VHA nurses, and largely for those practicing in the private sector. It was necessary to translate the content in many instances into “VA language” while maintaining a broader perspective necessary for nurse executives to understand their role in the health care delivery system at large. This was a delicate balance: while we needed to address the needs of a unique audience, we needed to make clear that VHA exists within a larger context.

We proceeded to create the curriculum by developing appropriate modules. A major advantage in module development was the existence of a highly sophisticated, well-developed VHA employee
education system. This enterprise-wide resource provides and maintains computer based learning packages for a wide variety of employees on a myriad of topics. This tool is available on a 24/7/365 basis to all employees and the learning packages are self-paced.

We were fortunate to work with Ramona Wallace, a nurse gifted with a wide range of skills including module development. She quickly became an integral player in our work. As we developed the content, we often spoke about the need for content to be treated to “Ramona magic” in order to make a point clearer and to maintain user interest. Her skill allowed us to see the value of including glossaries, graphics, interactive exercises, and evaluation components. She also became a valued voice in asking questions that a user without previous experience might ask. Her voice grounded us and helped us focus on the needs of the end user.

A recurring dilemma for the group centered on the issue of certification of completion. We grappled with many questions. Should this initiative be mandatory? Is certification of completion necessary? If so, in what form? When in the tenure of a new nurse executive should this be completed? Should we restrict this resource exclusively to chief nurse executives?

Ultimately, we concluded that mandating module completion for all nurse executives was beyond the scope of our work group. We did conclude, however, that this resource held value for both the chief nurse executive as well as many other nurses in the organization. It could be used as a tool to develop aspiring nursing executives and middle managers. Also, since it has long been acknowledged that direct care providers exert a significant influence over the operating budget through their resource utilization, select modules could be used to raise awareness of the need to maintain the organization’s fiscal health as a means of providing quality care.

Finally, we realized that revisions would need to occur over time in order to keep pace with the evolving health care enterprise and changing political mandates. Currently, the curriculum is in version two. It is expected that revisions will be necessary on a regular basis. We proceeded to module development shaping our work by these decisions.

Content for each of the modules was chosen specifically to address overarching issues in health care finance and management, as well as to provide specific instruction in the “nuts and bolts” of processes related to assuring the financial health of the organization. Since we knew that the users of these modules had very diverse backgrounds in experience and education, we assumed no prior knowledge. In this way, we began with an assumption of a level playing field for all we hoped to educate. We realized that this approach has several advantages. It
does not create frustration or anxiety in the inexperienced user. Since it is self-paced, the experienced user can move as quickly as desired through the content, also decreasing frustration. Finally, it can be used as a developmental device for those aspiring to leadership positions. We also made an effort to broaden the perspective beyond that of VHA. With the advent of the Patient Protection and Affordable Care Act (ACA), we determined that it was critical that VHA leadership be much more familiar with the health care market in general if we are to be the health care agency of choice for Veterans. While developmental uncertainty surrounds implementation of the ACA, it is clear that many Veterans will enjoy expanded choice for coverage in an open market.

Each module is supplemented by links to valuable resources within the VA system, as well as links to glossaries and further descriptions of relevant items. An assessment exercise follows each module to validate mastery. Our brief description of each of the modules we developed is provided in Table 13.1.

<table>
<thead>
<tr>
<th>Market Orientation for Health Care</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential clashes between nursing core values from a cost unconscious orientation and a need for cost effectiveness</td>
<td></td>
</tr>
<tr>
<td>Gender issues</td>
<td></td>
</tr>
<tr>
<td>History of nursing administration/evolving roles</td>
<td></td>
</tr>
<tr>
<td>Increasing scope of nursing administration; move from unit based responsibility for nursing to system wide responsibility for a multidisciplinary work force</td>
<td></td>
</tr>
<tr>
<td>Influence of front line nursing staff on utilization of resources and overall financial status</td>
<td></td>
</tr>
<tr>
<td>Realities of the changing population</td>
<td></td>
</tr>
<tr>
<td>Trends in health care spending</td>
<td></td>
</tr>
<tr>
<td>Rise of nurse sensitive indicators/VA nurse outcome database (VANOD) data and their financial influence on care delivery</td>
<td></td>
</tr>
<tr>
<td>Relationship of a financial knowledge base to nursing’s place at the table</td>
<td></td>
</tr>
<tr>
<td>A budget as a reflection of organizational goals, a focus on the future, and a measurement device</td>
<td></td>
</tr>
<tr>
<td>Problematic issues: the intimidation factor; a complicated legislative process; unfunded mandates</td>
<td></td>
</tr>
</tbody>
</table>
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

Table 13.1. Descriptions of VHA Finance and Management Educational Modules Content (Continued)

<table>
<thead>
<tr>
<th>FOUNDATIONAL CONCEPTS IN BUDGETING: Things to Consider when laying out a budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>relationship of the VHA budget cycle, Veterans Equitable Resource Allocation (VERA) allocation, and continuing resolutions</td>
</tr>
<tr>
<td>types of budgets (operating, long range, program, capitol, cash, performance)</td>
</tr>
<tr>
<td>sources of revenue</td>
</tr>
<tr>
<td>link between the long range budget and the strategic vision</td>
</tr>
<tr>
<td>impact of funded and unfunded mandates</td>
</tr>
<tr>
<td>performance based budgeting</td>
</tr>
<tr>
<td>budget allocation process from Congress to the individual medical center</td>
</tr>
<tr>
<td>fixed, variable, and mixed costs</td>
</tr>
<tr>
<td>relevant range</td>
</tr>
<tr>
<td>direct vs. indirect costs</td>
</tr>
<tr>
<td>cost allocation</td>
</tr>
<tr>
<td>THE OPERATING BUDGET: Maintaining the health of a service unit</td>
</tr>
<tr>
<td>basic principles of the VHA operating budget</td>
</tr>
<tr>
<td>assumptions, methodology, and monitoring of the personnel budget</td>
</tr>
<tr>
<td>VHA Expert Panel-Based Nurse Staffing Methodology</td>
</tr>
<tr>
<td>VARIANCE ANALYSIS: Comparing results to projections</td>
</tr>
<tr>
<td>goals and definitions</td>
</tr>
<tr>
<td>drill down process and data sources</td>
</tr>
<tr>
<td>investigation of line-item variances</td>
</tr>
<tr>
<td>relationship of hours per patient day (HPPD) to Decision Support System (DSS)</td>
</tr>
<tr>
<td>COSTING OUT NURSING SERVICES: Decision Support System (DSS)</td>
</tr>
<tr>
<td>DSS components</td>
</tr>
<tr>
<td>data validation</td>
</tr>
<tr>
<td>variable and fixed costs in labor mapping</td>
</tr>
<tr>
<td>interface of Relative Value Units (RVUs) and DSS</td>
</tr>
<tr>
<td>PRODUCTIVITY ANALYSIS: How much is good enough?</td>
</tr>
<tr>
<td>benchmarking</td>
</tr>
<tr>
<td>gap analysis</td>
</tr>
<tr>
<td>calculating productivity</td>
</tr>
<tr>
<td>unit costing</td>
</tr>
<tr>
<td>cost effectiveness analysis</td>
</tr>
<tr>
<td>tools for improvement, e.g., Six Sigma, Lean, System Redesign</td>
</tr>
</tbody>
</table>
TABLE 13.1. Descriptions of VHA Finance and Management Educational Modules Content (CONTINUED)

<table>
<thead>
<tr>
<th>CAPITOL BUDGETS: Big Tickets, long life</th>
</tr>
</thead>
<tbody>
<tr>
<td>operating vs. capital budgets</td>
</tr>
<tr>
<td>depreciation</td>
</tr>
<tr>
<td>major, minor, nonrecurring maintenance, and clinical specific initiatives</td>
</tr>
<tr>
<td>capital lease</td>
</tr>
<tr>
<td>volume discounts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORECASTING: Developing business plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength-Weakness-Opportunity-Threat analysis</td>
</tr>
<tr>
<td>business plan components</td>
</tr>
<tr>
<td>break even analysis</td>
</tr>
</tbody>
</table>

Going forward in our shared enterprise, we were gratified to learn that nurses throughout the system were clamoring for the release of the second version of our work. While members left and joined our group, a core of original members remained, as did Ramona Wallace who provided continuing support in content packaging. It is expected that as use of the modules increase, more nurses will want to join the group for future revisions.

It is the fervent belief of the group that this knowledge is vitally important to the success of the chief nurse executive as well to other members of the nursing workforce. We feel that this skill set can be taught and that it is a valuable resource in securing nursing’s place at the “big table.” As health care evolves, and as the Patient Protection and Affordable Care Act unfolds, VHA must keep pace with the health care market. We believe that VHA chief nurse executives must have the same advantages as their private sector counterparts.

As the stewards of the largest group of health care professionals in one of the largest health care systems in the world, VHA chief nurse executives have an important mission. We believe that this curriculum can advance our mission and continue to provide superlative care to a population who has sacrificed so much for so many—our nation’s Veterans.

In closing, I would like to acknowledge the many individuals who made this initiative possible. Many talented nurses contributed to this work. Cathy Rick supplied the vision and described the need for this work to be developed. Audrey Drake assumed a major leadership role in advancing this work, and in formulating and guiding the initiative. Ramona Wallace
supplied invaluable assistance in translating our ideas into a useable product along with her EES colleagues. Other important participants include: Lizabeth Weis, former chief nurse executive of VA Buffalo, New York; Ruth Yerardi, former chief nurse executive of VA Chillicothe, Ohio; Don Wetzel, former chief nurse executive, VA Erie, Pennsylvania; Pamela Pickett; Elizabeth Shortle; Patricia Lind; and Mary Raymer, who contributed even through her retirement. James Harris provided wisdom through the revision process as did others from various departments. Most importantly, VA nurses in all capacities should be acknowledged for carrying out a noble and significant mission: to care for him who has borne the battle. We are indebted to our nurses—and we are further indebted to our patients.

REFERENCES


Chapter 13.1

Working Smarter

Andrea Millman
When I started as a VA nurse in 1975 the last thing I was thinking about was business savvy. I was worried about surviving my first day as a new nursing graduate. The nursing assistants clad in their VA-issued white dress uniforms weren’t too sure I would make it either. They were taking bets in the supply/break room if I would make it through the week. The acting nurse manager decided to go easy on me. She assigned me the “light” team by myself.

The light team was a four-bed room and a 16-bed room that had an extra bed squeezed into it to fit a seventeenth patient. The 16-bed room had a sink but no bathroom. There was no phone for the Veteran to use other than the pay phone down the corridor. The communal bathroom was down the hall. The medications had to be poured from bulk supply before being administered. There were no unit dose medications, no bar-coded medications; we had to mix our own IVs. The first day was a blur. Somehow I survived. I learned the unwritten rule: come into work an hour early to pour your medications and get organized. I knew the hospital was severely understaffed but I didn’t know how to prove it or fix it.

Now fast-forward 37 years. I worked on the design of a new nursing home, now known as a Community Living Center (CLC), for the VA in Orlando, Florida, which opened on December 2, 2013. Sixteen bed wards are a distant memory. Now the living quarters for Veteran residents are communities of houses with 15 private rooms. Each Veteran’s room has its own bathroom with a shower, a 42 inch flat screen television with internet access through the “Get Well Network”, a ceiling-mounted lift, a personal safe for securing valuables, and a sleeper sofa for the Veteran’s family members. Residents are able to watch television, view movies, listen to music, watch nature photos, access the internet, play games and get health information through their bedside televisions that are equipped with Get Well Network. Each house in the CLC has a fully equipped kitchen and a living room with a fireplace and two large flat screen televisions. Each house has a game room stocked with cards, books, newspapers, board games and a wheelchair accessible exercise machine. Each Village has a courtyard to encourage resident access to the outdoors. Houses are decorated for the holidays and music, games and socialization are present throughout the facility.

I reflected on how the VA and I changed over the years. I learned to work smarter due to continuing education. The first change was going back to college to enter the computer age. VA was leading the way in the computerization of the medical record. Since I graduated from college in 1975, I could barely save a file to a floppy disc. I went back to school and learned how to use Microsoft Office, Word, Excel, Access, and PowerPoint. Gaining these skills helped me adapt to the changing healthcare world.
I became skilled at developing databases, preparing clever and effective educational presentations and streamlining office practices. We changed how we prepared the nurses’ annual performance evaluations that we refer to as nursing proficiencies. Our nursing service technological support evolved from large typing pools with responsibility for typing proficiencies on paper forms to direct, electronic entry by the rater. This advancement established an efficient approach for the Nurse Professional Standards Board (peer review board) members to review for promotion consideration and then electronically sign on a Microsoft SharePoint which was designed to further our collaboration. Many meetings are now held using electronic meeting systems. These changes improved nursing administration processes.

Next I tackled my performance improvement skills and learned how to use SPSS, a statistical tracking system. Studying performance improvement principles helped me determine when processes were stable or out of control. In our CLC’s performance improvement group we look at our processes. For example, we are currently implementing consistent nursing assistant assignments in the CLC and we are tracking our progress and benchmarking it to the rest of the VA. Consistent assignments result in enhanced continuity for residents by having the same staff person caring for the resident daily to improve resident outcomes and satisfaction. Residents feel secure that the person caring for them can anticipate their needs and will notice changes more quickly.

The Safe Patient Handling training initiative revolutionized how nurses provided physical care to Veterans. Audrey Nelson PhD, RN from the VA’s National Patient Safety program located at the James A. Haley VA Hospital, actively advocated for the use of patient lifting equipment and not just to protect the nurse’s fragile back, but also to move patients safely. Through her team’s research, she demonstrated the risks and costs, to both the Veteran and the nurse, associated with moving patients manually. After attending the VA’s Safe Patient Handling Conference in Orlando, Florida, I was a convert. VAs across the country implemented use of appropriate lifting equipment and the workplace became safer for both the patient and the nurse. Nurses again learned to work smarter.

Another continuing education initiative that had a great impact on my practice was the Cultural Transformation initiative spearheaded by Christa Hojlo PhD, RN, director of VA Central Office Nursing Home Program. She paved the way for CLC nurse leaders to change VA nursing homes from a medical model to a resident-centered social model. We renamed the Nursing Home Care Units (NHCU), now calling them Community Living Centers (CLC) and worked on transforming them to become home-like.
Things once viewed as unacceptable in the VA, like allowing the residents to decorate their own rooms or bring in personal furniture, were now encouraged. We allow pets and give the Veterans a role in management of the CLC. Christa offered standardized training modules for nursing assistants to become proficient in evidenced based “Bathing without a Battle” techniques and resident-centered care principles (Barrick, Rader, Hoeffer, Sloane, & Biddle, 2008). Interdisciplinary resident care plans were changed from a focus on medical problems to focus on persons, using “I care plans”. Residents were now urged to participate in decisions about their care. We implemented the resident-centered Hatch model (Holistic Approach to Transformational Change) developed by the Quality Partners of Rhode Island to direct how we provided care in VA CLCs (The Hatch Model, n.d.). We were encouraged to evaluate our work practices, care practices, and environment of care. This continuing education initiative radically transformed and improved the care Veterans receive in our CLCs.

My next personal continuing education initiative was to read popular business books such as Good to Great (Collins, 2001). I learned that the best leaders were both modest and willful, humble and fearless (p. 22). I came away with a guiding principle: I would work to help my employees find their “right seat on the bus”. It crystallized for me an understanding that each nurse had strengths and weaknesses and I needed to help them find their best position. I realized some had the temperament to work with confused Veterans in a long-term care facility, some were able to do detailed paperwork, some could teach, others could lead, and some thrived in high energy emergency situations. I worked hard to find a place and project for each of them so each could achieve impact at their highest ability. At the Orlando VA we also implemented Talent Plus as a hiring tool to find the best candidates for a position (Talent Based Solutions, n. d.).

Another of my personal continuing education initiatives was to learn more about staffing methodology. It gave me, as a nursing leader, the tools to successfully defend requests/recommendations for appropriate levels of staffing. The VA Office of Nursing Services developed online training including standardized data-driven tools for implementation of VA’s expert panel based staffing methodology. I could now show how many staff members were required to care for residents using reliable data from Resource Utilization Groups (RUGS) that were derived from the residents’ Minimum Data Set (MDS) data. Researchers had determined the nursing hours per day needed to provide care to residents in each of the RUGS groups. Instead of relying on past practice, gut feelings and emotional arguments, I now had a respected tool. I no longer
went to medical center leadership frustrated and unable to explain why more employees were needed. I was able to discuss the staffing needs for our CLC with the executive leadership, using hard data from the Minimum Data set and using VA’s staffing methodology system.

It was through my own investment in my continuing education that I read *The Best Care Anywhere* (Longman, 2012). It led me to reflect on the changes and improvements within the VA healthcare system. I learned how VA advances resulted in advancements in the private sector: the computerized record, bar-code medications, and safe patient handling to name a few. Based on my personal experiences, I encourage nurses to achieve higher levels of education and training to learn how to work smarter.

How the VA has improved over my career! We are no longer the under-staffed, heartless VA of Oliver Stone’s 1989 film adaption of Ron Kovic’s autobiography *Born on the Fourth of July* (Kovic, 2012). We now live VA’s core values: I CARE- Integrity, Commitment, Advocacy, Respect, and Excellence. I am proud to be a VA Nurse.

**REFERENCES**


Realizing the Future of Nursing: VA Nurses Tell Their Story 409
Chapter 14

Creating a Culture of Inquiry and Evidence Based Practice

Beverly Priefer, Anna C. Alt-White, Wanda Bradshaw, Kathryn Rugen, Sheila Cox Sullivan, Melissa Taylor, and Mary Thomas
Introduction

Our evidence based practice journey is a story with an unfolding script created by the thoughtful and dedicated evidence based practice leaders who served, and by those who continue to serve, as active members of the Office of Nursing Services (ONS) Evidence Based Practice (EBP) workgroup. This chapter represents the collective voice and work of the EBP workgroup chairs and all those who have served as members of this group since its inception. The members of this group and their affiliations are provided in Table 14.1, providing a directory to the various contributions and voices identified in this story.

### Table 14.1 Nurse Leaders Who Have Championed VA Nurse-Led Evidence Based Practice

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna C. Alt-White, PhD, RN, FAAN</td>
<td>Director, Research and Evidence based Practice, Office of Nursing Services, Washington, DC</td>
</tr>
<tr>
<td>Sandra Janzen, MS, RN, NEA-BC, FAAN</td>
<td>Associate Director Patient Care Services (Retired), James A. Haley VA, Tampa, Florida</td>
</tr>
<tr>
<td>Kathryn Ward-Presson, RN, BSN, MSN, NEA, BC</td>
<td>Associate Director Patient Care Services (Retired), Durham VA Medical Center, Durham, North Carolina</td>
</tr>
<tr>
<td>Kim Radant, MSN, RN,</td>
<td>Associate Director Patient Care Services (Retired), Richard L. Roudebush VA Medical Center, Indianapolis, Indiana</td>
</tr>
<tr>
<td>Beth Taylor, DHA, RN, NEA-BC,</td>
<td>Director, Workforce and Leadership, Office of Nursing Services</td>
</tr>
<tr>
<td>Kathryn Wirtz Rugen, PhD, FNP-BC,</td>
<td>Nurse Consultant, Centers of Excellence in Primary Care Education, Office of Academic Affiliations and Associate Chief Nurse for Education and Research, Jesse Brown VA Medical Center, Chicago, Illinois</td>
</tr>
<tr>
<td>Sheila Cox Sullivan, PhD, RN, VHA-CM,</td>
<td>Associate Nurse Executive, Research, Central Arkansas Veterans Healthcare System</td>
</tr>
<tr>
<td>Melissa V. Taylor, PhD, RN,</td>
<td>Associate Chief Nurse for Research, VA Pittsburgh Healthcare System</td>
</tr>
<tr>
<td>Name</td>
<td>Title and Institution</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Beverly Priefer, PhD, RN</td>
<td>Associate Director, Research and Evidence Based Practice, Office of Nursing Services, Washington, DC</td>
</tr>
<tr>
<td>Mary L. Thomas, MS, RN, AOCN</td>
<td>Hematology Clinical Nurse Specialist, Palo Alto, California VA Medical Center</td>
</tr>
<tr>
<td>Wanda Bradshaw, MSN, RN-BC</td>
<td>Performance Improvement Facilitator, Mental Health Nursing, VA St. Louis, Missouri Health Care System</td>
</tr>
<tr>
<td>Marita Titler, PhD, RN, FAAN</td>
<td>Professor and Chair, Division of Systems Leadership and Effectiveness Science, University of Michigan School of Nursing</td>
</tr>
<tr>
<td>Susan Adams, PhD, RN</td>
<td>Illinois Eastern Community Colleges</td>
</tr>
<tr>
<td>Cynthia Coates, MSN, RN</td>
<td>Nurse Manager, VA Pittsburgh, Pennsylvania Healthcare System</td>
</tr>
<tr>
<td>Sylvia Barton, MSN, RN-BC, CNL</td>
<td>Patient Aligned Care Teams, Preventive Ethics Team Coordinator, Grand Junction VA, Colorado</td>
</tr>
<tr>
<td>Michelle Mountfort, RN, MSN, MBA/HC</td>
<td>Deputy Associate Director/Patient Care Services, Grand Junction, Colorado VA Medical Center</td>
</tr>
<tr>
<td>Mary Ellen Dellefield, PhD, RN</td>
<td>Researcher, VA San Diego, California Health Care System</td>
</tr>
<tr>
<td>Marthe Moseley, PhD, RN, CCNS</td>
<td>Associate Director, Clinical Practice, Office of Nursing Services, Washington, DC</td>
</tr>
<tr>
<td>Christine (Tina) Lund, MSN, RN</td>
<td>Associate Director, Patient Care Services (Retired), Minneapolis, Minnesota VA Health Care System</td>
</tr>
<tr>
<td>Deborah Clickner, DNP, RN, NE-BC</td>
<td>Associate Director, Patient Care Services, Providence, Rhode Island VA Medical Center</td>
</tr>
<tr>
<td>April Gerlock, PhD, APRN</td>
<td>PTSD Outpatient Clinic- Team Leader, VA Puget Sound, Washington HCS (Retired)</td>
</tr>
<tr>
<td>Cara Goff, BA</td>
<td>Technical Information Specialist, South Texas VA Medical Center</td>
</tr>
</tbody>
</table>
When first initiated in 2002, the EBP workgroup primarily concentrated on developing an electronic documentation system to capture and report nursing sensitive indicators (e.g., pressure ulcers). In 2005, after the appointment of Anna Alt-White as the ONS Director for Research, the focus of the workgroup migrated to that of evidence based practice and from that time until the present, the workgroup has been chaired by visionary nurse executives as well as associate chief nurses for research including Sandra Janzen, Kathryn Ward-Presson, Kim Radant, Beth Taylor, Kathryn Rugen, Sheila Cox Sullivan, and Melissa Taylor. The workgroup’s mission, as we articulated it, is to “facilitate infrastructure development to ensure VA nurses consistently engage in an evidence based practice to improve healthcare delivery and outcomes throughout VA.” This mission supports the VA’s commitment to evidence based practice as highlighted in the VHA vision statement: “VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence based” (Veterans Health Administration, 2014).

The EBP workgroup views evidence based practice as the integration of best available evidence, clinical expertise, and patient preferences at the point-of-care. This practice occurs within the context of the organization and because context varies, the look and feel of evidence based practice is different in each facility. Members of the workgroup meet monthly via a teleconference and yearly at a face-to-face meeting to develop, organize, and evaluate the workgroup initiatives. Nurse executive tenure on the group is usually two years while EBP experts serve on the group for two to six years. Today the EBP workgroup has three primary initiatives—consultation service, educational programs, and electronic resource center. These three initiatives evolved from the results of system-wide surveys, brainstorming sessions, an EBP summit, our regular meetings, and an electronic EBP toolkit developed by previous workgroup members.

Consultation Program

After reviewing the results of two field-based surveys, a small group of the EBP workgroup met in September 2010 to brainstorm new strategies for assisting facilities to develop and/or strengthen an EBP infrastructure that supports evidence based practice at the point-of-practice. One outcome of this meeting was the creation of the evidence based practice consultation service. The target audience for this service was nurse executives and the intent was to discuss the benefits
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

of EBP, introduce the EBP process, and identify the resources for the development and sustainment of an EBP culture. When EBP workgroup chair, Kathy Rugen, introduced this new service during a National Nurse Executive Council meeting, we were uncertain whether nurse executives would be interested in such an offering, but within a day of the announcement, we had requests from several Veterans Integrated Service Networks (VISNs) to attend their VISN nurse executive meeting.

Beth Taylor, Kathy Rugen and Beverly Priefer constituted the original consultation team members with Beth taking the lead for scheduling pre-consultation phone calls and visits and facilitating the discussion during the consultation visits. The different backgrounds of each team member offered rich and varied perspectives on evidence based practice. Beth, a former nurse executive, connected with nurse executives through a shared language and common leadership concerns and responsibilities. Kathy is an experienced educator, nurse practitioner, institutional review board (IRB) chair, and facility evidence based practice coordinator, and Beverly is an IRB member and a former Magnet program coordinator, nurse practitioner, and evidence based practice coordinator. Because of our varied experiences and our comfort in working together as a team, we were able to shift in and out of the teacher-diskussant role depending on the topic or questions asked.

As with all of our evidence based practice initiatives, the consultation service has evolved over time. Our initial consultations were brief, four hours or less, and generally part of a larger nurse executive meeting where the nurse executives in attendance represented different facilities with different needs. We often felt frustrated after the consultation visit because of our limited time and the inability to fully explore the needs of each nurse executive at his or her respective facility.

By the end of our first year, we decided to shift focus and to offer our consultation service as a one-day facility level consultation. We continue to precede each visit with two or more pre-consultation calls during which the facility’s nursing leaders describe their organizational and shared governance structure, identify their goals for the consultation, and discuss their current evidence based practice program. Together facility nursing leaders and the consultation team create a tentative agenda that includes:

- In-briefing with the facility leadership team and the consultation team. This in-briefing was recommended by the nurse executive members of the EBP workgroup during one of our yearly face-to-face meetings. This in-briefing serves as an opportunity for the consultation team to explain the purpose
of their presence in the facility and to discuss how an evidence based practice program supports the overall VA mission.

- **Facility tour.** Touring the facility inpatient and outpatient areas affords us the opportunity to experience the unit/department culture and listen to nurses as they describe their evidence based practice. This dialogue helps us to assess the consistency of nurses’ understanding and application of EBP throughout the facility.

- **Meetings with members of shared governance councils/committees.** During our pre-consultation calls, we discuss the facility’s shared governance structure and identify those committees and/or councils that have—or could have—strong linkages to evidence based practice. As scheduling permits, we meet with the members of these groups during the consultation visit.

- **Meeting with nursing leadership.** The meeting with nursing leadership focuses on the nursing vision, strategic plan, and the behavioral expectations for staff necessary for developing a culture of evidence based practice.

- **Other groups.** We may meet with other staff including the coordinator for the RN transition to practice program (often referred to by others as an RN residency program), advanced practice nurses, and nurse educators. Depending on the facility, these individuals may or may not be integrated into evidence based committees/councils or part of overall evidence based practice strategic planning. We discuss opportunities to align evidence based practice efforts and to capitalize on the subject matter expertise of nurse educators, clinical nurse leaders, and advanced practice nurses.

- **Out-briefing.** At the conclusion of the consultation, we meet with nursing leadership and share our observations, offer suggestions, and discuss how the consultation team might assist the facility to move forward with any or all of the suggestions. Follow-up activities might include facility wide presentations on the basic concepts of evidence based practice or a 2-3 day intensive workshop on the steps of finding and using evidence to implement and sustain a practice change.

Our goal is to conduct a minimum of eight initial consultation visits per year and four to eight follow-up visits. To accomplish this goal, we have expanded our consultation team to include Anna Alt-White, Sheila Sullivan, and Melissa Taylor. We also invite other EBP workgroup members to join us on consultation visits as participant observers to provide us with
feedback about how to improve our consultation service. For example, Mary Thomas, the liaison between the ONS Advanced Practice Nurse Advisory Group (APNAG) and the EBP workgroup, participated in a consultation visit and monitored the audience's reaction and participation during an EBP educational session presented by the other consultation team members. The consultation team was able to validate Mary's observations throughout the day as they toured the facility and met with nurses in various care areas. During the exit interview, the team shared with nursing leadership the ongoing observations that staff members were committed and enthusiastic about moving forward with a program of evidence based practice.

Wanda Bradshaw, our ONS National Nursing Practice Council liaison to the EBP workgroup, also participated in a consultation visits and reflects on this experience:

“When participating in the EBP consultation, my focus was on the shared governance committee members…most of whom were staff nurses fairly new to the EBP process. Seeing the enthusiasm with which they discussed the practice changes they wanted to implement was exciting, and I learned two things. First, the EBP roadmap (described below) is “user-friendly” and, therefore, searching for the evidence to improve practice would no longer be a “mystery” to the staff nurse, and second, staff nurses can become the catalysts to change nursing practice.”

Over the past four years, we have identified common opportunities for strengthening facility EBP programs. These include:

- Articulating a vision for evidence based practice and establishing a strategic plan or goals to realize that vision
- Ensuring that evidence based practice projects support the mission/goals of the organization
- Making explicit the behavioral expectations that will create a culture of evidence based practice
- Streamlining and increasing the efficiency of a shared governance structure through which evidence based practice projects are vetted and practice changes disseminated
- Focusing on evidence based practice as a way of practicing as opposed to a series of projects
- Identifying facility evidence based practice coordinator and evidence based practice champions
An unanticipated consequence of the consultation service is the intellectual stimulation these visits have prompted among consultation team members and the resultant evolution of our thinking and teaching about evidence based practice.

EBP Education

Our second EBP initiative, focused on education, has been realized through a variety of approaches.

Evidence based Practice Workshops. Since 2009, the EBP workgroup has sponsored yearly EBP workshops targeting different participants and focusing on a variety of topics. The first workshop faculty included Marita Titler and Susan Adams from the Iowa Institute for the Advancement of Evidence Based Practice along with EBP workgroup faculty. Forty-two nurses from 15 sites attended this 3-day workshop that educated participants about EBP process skills, the skills required to formulate clinical questions, to search, appraise, and synthesize evidence, and, when supported by evidence, to implement and evaluate a practice change. Participants focused on one of four topics: falls, catheter-associated urinary tract infection, nurse-physician communication, and bedside shift handoffs. Faculty provided monthly follow-up teleconferences for the participants in each of the four topic groups.

Cynthia Coates, Nurse Manager of a Community Living Center (CLC) unit at the Pittsburgh, Pennsylvania VA attended the 2009 workshop and selected the topic of bedside shift handoff as her EBP change project. Cynthia used the published evidence on the benefits of bedside shift handoffs in the acute care setting to support this practice in the CLC. In 2011, Cynthia presented poster sessions describing this practice intervention at the University of Maryland Evidence Based Practice Conference as well as at the University of Iowa Evidence Based Practice Conference where she won the award for best VA Poster.

Following the 2009 inaugural EBP Workshop, members of the EBP workgroup reevaluated the target audience for our annual EBP workshops. Given the Office of Nursing Services’ commitment to the education and appointment of Clinical Nurse Leaders (CNLs), we decided to focus our educational efforts on VA CNLs, since a critical role of the CNL is that of role-modeling evidence based practice “as a way of practicing” at the point-of-care. CNLs, rounding with point-of-care nurses, are able to assist these nurses in understanding what it means to integrate
best available evidence, clinical expertise, and patient preferences through deconstruction of clinical interactions with patients.

Between 2010 and 2013, 39 CNLs from 29 different facilities attended the EBP skills-building workshop sponsored by the EBP workgroup. We also invited the CNL’s respective nurse manager/supervisor to attend the workshop since we believe that the nurse manager-CNL partnership establishes the vision and behavioral expectations for the development of an EBP culture at the microsystem level. The CNLs asked a variety of clinical questions including questions about pain management, falls, handoffs, and delirium in ICU patients. Similar to our first group of participants, EBP faculty, via monthly teleconferences, provided guidance to assist the CNLs as they worked through the EBP process to determine whether there was sufficient evidence to implement a practice change.

Sylvia Barton, a CNL who worked in ambulatory care at the Grand Junction, Colorado VA, attended the EBP workshop with her supervisor, Michelle Mountfort. Sylvia identified the lack of a consistent approach to providing pain management education for orthopedic patients at her facility. After searching the literature to determine whether there was sufficient evidence to guide the development of a preoperative pain management education program for patients undergoing total hip or knee replacement, Sylvia and her colleagues developed an educational program and instructed nurses on how to provide pain management education to patients during preoperative visits. In 2012, Sylvia was selected to deliver a podium presentation at the University of Maryland School of Nursing Evidence Based Practice Conference.

Over the past 5 years, members of our ONS EBP workgroup have served as faculty for the basic EBP skills-building workshop. Faculty members include Kathy Rugen, Mary Thomas, Mary Ellen Dellefield, Anna Alt-White, Marthe Moseley, Melissa Taylor, Beth Taylor, Sheila Cox Sullivan, Christine Lund, and Beverly Priefer. These talented EBP experts, who hold a variety of positions at different VA facilities as well as at VA Central Office, all share a passion for and commitment to evidence based practice education. Since many of us have taught together for several years, we are comfortable debating EBP concepts, challenging each other’s world views, experimenting with new teaching strategies, and engaging in collaborative teaching.

**Advanced Evidence Based Practice Workshops.** In 2012, the EBP workgroup identified a need for those nurses, designated as facility EBP coordinators/program managers, to explore ways to strengthen EBP infrastructure at their respective facilities as well as to expand the way in which they thought about evidence based practice. Eighteen nurses, with
varied EBP programmatic responsibilities, attended the EBP advanced workshops in 2012 and 2013. Discussions during these workshops focused on how to move evidence based practice beyond a series of practice change projects to viewing evidence based practice as a “way of thinking” that drives a “way of practicing”. As workshop faculty dialogued with the workshop participants, we identified that a successful evidence based practice program requires a culture where nurses are expected to integrate best available evidence, clinical expertise, and patient preferences at the point-of-practice. We realized that this culture depends on a supportive infrastructure and that both culture and infrastructure are a function of nursing leadership.

**Evidence based Leadership Practice Workshops.** Shifting the focus of the consultation visits from the VISN nurse executive meeting to individual facility consultations afforded us the ability to more clearly understand the fundamental role nursing leadership plays in a developing and sustaining a successful EBP program. Additionally, we realized that we need to provide nurse executives time and opportunity to understand their role as leaders in developing a vision for and culture to support evidence based practice.

A subgroup of the EBP workgroup members accepted the challenge to create a workshop curriculum for nursing leadership that focused on how nurse leaders can both support clinical evidence based practice and role model evidence based leadership practice. Sheila Cox Sullivan, lead faculty of this new educational initiative, developed the workshop curriculum that she, along with colleagues Deborah (Debbi) Clickner, and Beverly Priefer, piloted in August 2013 in Columbus, Ohio. Over 50 nurse leaders from the Ohio VA facilities attended this 1½ day workshop that focused on an introduction to the multi-step evidence based practice process, leadership roles related to evidence based practice, development of evidence based infrastructure including shared governance and strategic planning, and the use of VA data as a source of evidence.

Based on feedback from the pilot workshop, and requests for additional workshops from other nurse executives, ONS funds continue to support four evidence based leadership workshops per year. The curriculum for the workshop continues to evolve and now includes clinical and leadership scenarios that are deconstructed to illustrate how evidence, clinical expertise, and patient/staff preferences are integrated at the point of practice. For example, Debbi shares documents and examples from the Providence, Rhode Island VA to illustrate how a clearly defined shared governance structure, strategic plan, and patient care delivery model provide the infrastructure to support an evidence based practice culture.
**Other Education.** In addition to the face-to-face educational workshops described above, the EBP workgroup provides ongoing webinar education to various national VA workgroups including the National Nursing Practice Council, the transition-to-practice coordinators, and the Clinical Nurse Leaders.

## Evidence Based Practice Resource Center

In 2005, the EBP workgroup began developing plans for the design and dissemination of an online Evidence Based Practice Toolkit housing information and materials for nurses to use to “improve patient care processes and outcomes.” The EBP Toolkit, created under the direction of April Gerlock and Marita Titler, was introduced to the field on a national call in 2008. This toolkit, readily accessible through a link on the Office of Nursing Services internal intranet website, featured several audiotaped PowerPoint presentations on topics such as basic elements of EBP, organizational infrastructure and support of EBP, teaching EBP, internet resources, an annotated bibliography, and EBP exemplars for nurses.

As happens with electronic-based materials, some of the information on the toolkit became dated, especially as the workgroup’s thinking about evidence based practice evolved and matured. In 2011, the yearly EBP workgroup meeting focused on updating the online materials and the group met with the ONS web designer, Cara Goff, who designed several different layout options. We changed the name from EBP Toolkit to VA Nursing EBP Resource Center to better reflect the variety of materials from which facilities are able to choose and adapt to their individual needs. Figure 14.1 provides a visual image of the face page of the resource center’s online presence.

The primary purpose of the resource center is to assist facilities in developing and strengthening evidence based practice infrastructure by providing documents such as an EBP business case, curriculum, videos and guidebook, project roadmap, and links to VA resources as well as other external resources. Following are brief descriptions of selected content.

**Business Case.** Beth Taylor, during her tenure as EBP workgroup chair, together with Anna Alt-White, drafted the EBP business case document. Following feedback and discussion with the EBP group members, we introduced the business case on the monthly nurse executive call and subsequently posted it on the EBP resource center. The purpose of this document is to provide nurse executives with a template they can
Figure 14.1 Face Page of the VA Nursing Evidence Based Practice Resource Center Website

Use to present rationale for the resources needed to implement an evidence-based program at the facility level. The document includes an executive summary, statement of use, recommendations, a program description, proposed timeline, return on investment information, references, and appendices and affords the nurse executive the opportunity to individualize a plan particular to his or her facility.

Curriculum. In 2010, the ONS Transitions to Practice Program (TTP), described in greater detail in Chapter 11, requested the EBP workgroup to develop an evidence-based practice curriculum for newly hired graduate nurses that met the Commission on Collegiate Nursing Education (CCNE) EBP requirements for nurse residency program accreditation. Informed by the evidence-based practice educational literature, Beth Taylor, with input from several workgroup members, created the first iteration of an EBP curriculum for the TTP program. This online curriculum includes seven topical areas: defining evidence-based practice, developing a clinical question,
accessing evidence, defining level of evidence, appraising the evidence, implementing a practice change, and evaluating and sustaining a practice change. Each of the seven sections contains several objectives, links to content material, and suggested learning activities.

Although this curriculum was originally developed for the TPP program, we soon realized that educators and EBP mentors could use this curriculum in a variety of settings. In 2014, Melissa Taylor redesigned the curriculum and created multiple individual modules from which educators can choose both topic areas and the sequencing of these topics to meet individual educational needs. Each module can be accessed either online or printed in a one page format. In addition to course objectives, the modules include an overview and key points about the subject, links to videos and PowerPoint presentation, teaching materials, suggested activities, other resources, references, and suggested time to teach the module. We have expanded the suggested activities section to include both practice application exercises and a personal commitment to EBP exercise.

**EBP Video Series.** In the fall of 2012, Anna-Alt White, Melissa Taylor, Sheila Cox Sullivan, Kathy Rugen, and Beverly Priefer met at the St. Louis Employee Education System (EES) to film 10 brief (5-10 minutes) videos that serve as an introduction to several different topics related to evidence based practice. Our goal for producing these videos was to disseminate to VA facilities consistent EBP content reflective of the national EBP workgroup’s perspective that educators could use as an introduction to each of the several EBP topics.

Melissa Taylor led the video project and worked closely with the EES production crew in writing the script and designing the accompanying PowerPoint slides. During the filming, Melissa had the opportunity to work behind the scenes with the camera crew and the producers and gained a new appreciation for the complexity of video production. We were all made “camera-ready” by a make-up artist and received instructions on how to use a teleprompter. Although we all knew that there are multiple “takes” when filming, we had no idea that 10 videos, totally less than 90 minutes, would take from 8 a.m. until 5 p.m. to film!

Colleagues from several facilities have told us that these videos are used in a variety of ways. The nurse educators at one facility play the first three videos during nurse orientation so that newly hired nurses learn how VA evidence based nursing
practice is viewed. At another facility, all of the videos are incorporated into an evidence based practice scholars program.

**EBP Roadmap.** As we travel on our consultation visits and as we talk with nurses who attend our various workshops, we are continuously impressed with the clinical questions nurses ask and the evidence based practice project teams that are assembled to answer these questions. We have discovered, however, that multiple facilities frequently ask, and answer, similar clinical questions. Nursing leadership as well as staff nurses asked if our EBP workgroup might develop a mechanism for dissemination of project work undertaken at various facilities to avoid duplication of effort and time. Although we recognized the need for and value of disseminating information about evidence based practice changes throughout our system, we also acknowledged that there was inadequate consistency of process and rigor across all VAs for conducting evidence based practice projects. Additionally, we recognized that facilities varied in the process used to implement and evaluate an evidence based practice change. Our challenge, then, was to develop a mechanism for disseminating evidence based practice changes while at the same time ensuring that the decision to adopt these practice changes were made using a systematic and rigorous process.

The dissemination mechanism developed by the EBP workgroup members is the EBP roadmap, a two-part electronic form that guides a project team through the EBP process from answering a clinical question to implementing a practice change based on the answer to the clinical question. Part I of the roadmap focuses on identifying project stakeholders, composition of the project team, the clinical question and the process used to search for, critically appraise, synthesize, and make a decision about whether there is credible evidence to answer the clinical question. Part II of the Roadmap describes, in a series of steps, the process used for implementing and evaluating the practice change.

The purpose of the EBP roadmap is two-fold: first, the Roadmap serves as a guide to help the project team navigate through the EBP process and second, the content of the Roadmap provides information about the rigor of the process used to answer the clinical question and implement a practice change. We encourage facility project teams to submit their completed roadmap for review by the EBP workgroup and, if the roadmap is complete and demonstrates rigor, the project is posted on the EBP resource center.
Conclusion

Our descriptions of the various EBP workgroup initiatives over the past several years demonstrate the commitment of our workgroup members to our national mission of developing an evidence based practice nursing culture throughout the VA. In addition to reaching out nationally to help other facilities through the various workgroup activities, workgroup membership also benefits the various members’ respective facilities. Several members of the workgroup offered reflections on their membership in the EBP workgroup. Melissa Taylor writes:

"My membership has provided a forum for me to expand my thinking about EBP to include more of an emphasis on the 'practice' of EBP as opposed to simply the 'process' of EBP – the ‘practice’ view being the integration of evidence, patient preferences, and clinical expertise. As a result, I emphasize this integrated view in all my interactions/collaborations with nurses on their EBP projects or practice changes; I also emphasize this view with leadership as we further develop the infrastructure to support a culture of EBP at VA Pittsburg, Pennsylvania Health System (VAPHS). These intentional discussions about the ‘practice’ of EBP are beginning to shape a view of EBP beyond ‘projects’ at VAPHS. Members of the EBP goal group have become my extended cohort of professional scholarly colleagues – so nice to be able to have a group of colleagues to share/debate different ways of viewing EBP."

Sheila Cox Sullivan, past EBP workgroup chair, shares her thoughts on her EBP workgroup membership:

"First, participating in the group broadens my own perspective of what EBP is, both theoretically and pragmatically. This personal knowledge growth translates to changing how I approach mentoring staff who are participating in projects as well as my expectations for the practice of nursing in our facility. Second, leadership believes in this refined perspective and promotes the application of evidence in every nursing encounter. Third, due to encouragement from EBP Goal Group members, the nursing staff is excited about how a ‘simple’ question can literally change their lives. We have nurses publishing articles, presenting at
Mary Thomas’ experience on the EBP workgroup benefits both nursing staff at the Palo Alto, California VA as well as members of APNAG. Mary provides the following reflections:

“I came to the EBP goal group as a representative from the Office of Nursing Services Advanced Practice Nursing Advisory Group (APNAG). A key function of the EBP goal group is to develop different methods to instruct others about EBP and I have engaged in activities to promote this activity within the Advanced Practice RN (APRN) network within VHA. One key instructional method was to develop and subsequently revise a comprehensive web-based resource center that is available to all staff via the VHA intranet. To increase awareness of this useful resource, I presented posters related to the website at two VISN-wide conferences and assisted in coordinating a national teleconference presentation of the resource center to APRNs throughout VHA.

Since my participation in the EBP goal group, I have more strongly encouraged the nursing service at my local facility to fully embrace the concept of basing practice on sound evidence. The process began with a more consistent format for using relevant references in developing and revising policies and procedures and the increased development of journal clubs. Nursing leaders have fully supported the development of an EBP fellows program within our facility, developed by the Associate Chief, Nursing Service for Research. Most recently, as a clinical nurse specialist (CNS) I am responsible for the initial development of chemotherapy order sets using a new software package. My heightened awareness of EBP has been valuable in evaluating data from relevant chemotherapy clinical trials and in assisting some providers to appreciate the value in basing treatment on quality research rather than small, pilot studies.”

Kathy Rugen, workgroup member since 2006 and past-chair from 2010 through 2012, states:

“I became a member of the EBP goal group as the representative from the Nursing Research Advisory Group (NRAG). I have had conferences, winning national awards, and receiving queries from other facilities, both VA and private, about their work.”
the opportunity to work with and meet wonderful, smart nurses throughout VA from my membership on this workgroup. We have accomplished a lot and continue to expand our work. It is so exciting and rewarding to see nurses that we have mentored and/or who have attended our workshops presenting at national conferences and getting national recognition. I have been able to bring resources, knowledge and skills back to my facility which has helped grow our local EBP program.”

Anna Alt-White, first ONS facilitator of the Evidence Based Practice workgroup, concludes this chapter with her reflections on evidence based practice in ONS.

“During my ten year journey with the EBP workgroup, exponential changes have occurred in how the Office of Nursing Services conceptualizes evidence based practice as well as the variety of services we offer to facilities and to VISNs. VA nurses are using this knowledge to advance their practice and the care they provide Veterans.”

REFERENCE

Chapter 14.1

Nurses Making Change with Evidence Based Practice

Marquetta Flaugher
For the past several years the healthcare industry has had a renewed interest in evidence based practice (EBP), reviewing what it is, what it's not, and how to encourage implementation of new nursing evidence based projects. Evidence based nursing practice actually started with nursing's iconic leader Florence Nightingale who conducted research during the Crimean War based on her observations of proper hygiene and the relationship to improved health. These findings have been utilized throughout the nursing profession to improve the hygiene and health of our patients. Nursing was thus a pioneer in EBP and remains active in reviewing practice to determine if modifications are needed to enhance care in our ever-changing healthcare system.

In our Veterans' hospital in southeastern Florida, one that employs approximately 550 registered nurses, it was difficult, initially to get ideas structured into evidence based practice projects. We all had ideas, but what do we do with them? Where do we go for help? When I started working at the southeastern Florida VA, little to no nursing research or EBP projects were being conducted. Since I always had enjoyed directing and organizing research, I decided I would get the ball rolling. I initiated a research project: “Perceptions of Nurses Treating Pain in the Elderly”, drawing on my expertise in geriatric nursing. After this, I was invited to be a member of our research and development and investigational review board committees. As a member of these committees I was provided the opportunity to help other nurses launch research and EBP projects. I started giving hospital wide in-services explaining research and EBP. During this time, I and another nurse developed the EBP committee. We encouraged leaders and other nurses to learn about the benefits of EBP, and I provided several in-services to nursing staff about EBP.

We worked diligently in the EBP committee to start projects within nursing though the initial responses we received did not leave us feeling successful. Many direct care RNs indicated that they thought they did not have time to devote to a project and felt it would be useless if changes did not occur following the project. So the members of the committee went back to ground zero and started working in conjunction with our Research Council (now known as the Research and Evidence Based Practice Council). We did blitzes to explain EBP, and actually started talking the "lingo" to make everyone comfortable with the change. As we started "walking the talk", nurses began to develop EBP projects and change was successful. I later wrote a book on building a nursing research program that was placed in our medical library for help with the
initiation of research projects (Flaugher, 2008). Since that time, I became a mentor in our facility to help nurses with research and EBP projects.

One patient situation that prompted me to start an EBP project was based on a problem encountered in our Sleep Clinic. As an advanced practice registered nurse (APRN) in the clinic, I was told by the director of the Sleep Section that while we were getting greater numbers of patients coming into the outpatient clinic for their formal sleep study (which is done in the evening hours), they were forgetting to bring their prescribed sleeping medication with them. At the time, we ordered a sleep medication for the patient when we saw them during consultations, sometimes as long as one month prior to the sleep study. We asked them to remember to bring their sleep aide with them on their scheduled study appointment. Many Veterans were forgetting to do so, taking their medications earlier, or stating that they had not received the medication in the mail. This caused a delay in diagnosis and treatment for the Veterans, prevented a $4600 sleep study from being performed, wasted time for our respiratory therapists, and led to the added workload of rescheduling patients.

Our first action was to conduct a review of relevant literature. We assessed the scope of practice of registered respiratory therapists to determine if they could administer a sleeping pill, discussing this possibility with appropriate team members. We decided we could alter how we were doing things to enhance care. As a group, we decided that the sleep clinicians would order the medications needed during the time of the consult, but keep the medication in our locked medication system. The respiratory therapists would then administer it when the patients arrived on the night of their study. This eliminated the need for the Veteran to remember to bring the sleeping pill with them. The outcome was 100% compliance with medication administration. This was a fairly simple project but it did require a multidisciplinary team approach including pharmacy, respiratory service, and sleep medicine providers. The therapists found that documenting the medication administration did not significantly alter their workload and our new practice was very beneficial for reducing our cost and enhancing patient care. This simple EBP project has saved our Sleep Clinic thousands of dollars over the past year.

We utilized the format of “PICOT” to guide us in developing this EBP project, a model that efficiently summarizes the process. PICOT is an acronym that stands for the EBP components of Population or Patient Problem, Intervention, Comparison treatment or intervention, Outcome, and Time Frame.
The PICOT statement we developed was as follows:

**P-** Costly sleep studies were not being performed because Veterans were forgetting to bring their sleep medications with them.

**I-** Sleep medications would be held in the locked medication cart and administered to Veterans when they arrive at the clinic on the date of their sleep study.

**C-** Literature review revealed little to no research on administration of sleep medications during sleep testing.

**O-** Sleep studies will be performed without delay, reducing waste of man-hours, cost to the department, and result in earlier assessment and treatment for our Veterans.

**T-** The pilot would last one month.

As our hospital became more enthusiastic about EBP, other nurses started journal clubs using email communication. While it was initiated on one unit, it later expanded to various other units. Nurses in some areas developed an EBP journal board with articles placed for nurses to read while on their break or during lunch. This allows us to share and discuss research and EBP during staff meetings. It also encourages questions about how we are practicing and if changes are needed. Currently, our Advanced Practice Council has decided to partake in a journal club and discuss clinical issues and EBP. This discussion will bring about knowledge and lead to investigations on whether current practice is based on the best evidence available.

Some nurses believe they are not actively involved with EBP, yet it is clear that we must live it every day. Our Standards of Care committee reviews protocols on current nursing activities and searches the literature for evidence demonstrating we are doing what is best. When changes are required, our hospital protocols are changed and this information is disseminated to our lead councils. Various team members serve on this committee bringing forth a wealth of knowledge and critical questions to be answered. This is EBP at work in a different format.

We also have a residency program where newly graduated nurses from a BSN program are given a year to learn more about their position at the facility. I interviewed the clinical nurse expert in charge of this program who told me during this year, new RNs are required to develop and implement an EBP project. Two new RNs initiated an EBP project called the "Buddy System". Their idea was to improve teamwork and morale on their medical-surgical inpatient units by pairing two RNs together so one could cover the other nurse's patients should she need...
to leave the unit for lunch or attendance at meetings. Their model of nursing was primary care before initiation of the intervention. The PICOT statement that guided their EBP project was as follows:

P - Nursing staff’s low perception of teamwork and morale on the unit and not being able to leave the unit for participation in hospital committees.
I - Trial of a staffing model called the Buddy System would be conducted on two units for a period of six weeks.
C - Literature review revealed no research on this specific type of staffing model
O - Staff perceptions of morale and teamwork will be increased among nursing staff.
T - The pilot would last 12 weeks

The nurses surveyed staff on their respective units eliciting perceptions of having a sense of teamwork, job and work environment, status of morale, and ability to rely on their co-workers for support if they needed to leave the unit for a short period of time. Results indicated a significant improvement in several areas including overall improved morale when using the Buddy System evidenced by staff offering to help team members with a positive attitude without hesitation. Assisting team members allowed their assigned buddy to attend important hospital meetings without worrying that their patients’ care might be neglected.

The Buddy System is currently being utilized on two units in our hospital with future plans to include additional units after education on this particular staffing method has been provided. Limitations of this project were also reviewed to examine alternative interventions that may be required. When staff members were asked directly about this new way of staffing, some responded they felt as if their Buddy was taking advantage of them and the off-tour nurses stated they felt they already had a high level of teamwork without the project. We have therefore proposed to continue this project and allow more time for staff to accommodate the change and develop increased trust with their co-workers. The specific type of staffing may not be appropriate for all units but has definitely shown to be beneficial especially on day shift when more than one RN is working on a specific unit.

Another EBP project completed by a nurse in our new grad residency program focused on a specific way to reduce cost and enhance care for our telemetry/cardiac Veterans. She noted that we were requiring some patients to stay an additional day in the hospital to complete their cardiac tests when they had not received the appropriate test preparation the night before. This
was frustrating for nurses and Veterans alike. The nurse found even seasoned nurses would sometimes forget the protocol of specific cardiac tests. She discovered that the average cost per day for hospitalized patients on her unit was about $2500. She estimated that if two tests per week needed to be rescheduled due to inappropriate preparations, the estimated cost per year would be $260,000.00.

So she developed a poster (placed on the unit for staff, patients, and visitors to see) and pamphlets that outlined an evidence based practice protocol for the most common and most problematic cardiac testing. The PICOT statement was as follows:

- **P**: RNs caring for cardiac patients in telemetry/cardiac progressive care units were not routinely following protocol.
- **I**: Create a handout and poster as a reminder of the protocol and to be available for the nurses to provide necessary education.
- **C**: Data on how many test are cancelled pre and post-creation of poster and handout would be collected.
- **O**: Increased RN expertise for telemetry/cardiac progressive care units; decrease the number of test/procedures cancelled due to errors in nursing protocol.
- **T**: The project would last 6 months

The project has dramatically reduced the number of problems associated with cardiac testing. The benefits of this EBP project included improved patient satisfaction, reduced hospital stays, reduced medication errors, and increased RN satisfaction and productivity.

In 2010, our telemetry unit cardiac nurses developed an EBP project based on their observation that there was an unacceptable prevalence of Veteran injuries due to patient falls. After in-depth discussions with staff, they discovered that the real issue was lack of standardization of treatment options i.e., one nurse would identify patients at risk for falls (admission Morse fall score of 45 or greater) and choose a set of interventions, while another nurse may choose totally different interventions. This inconsistency made fall prevention inadequate, particularly for high-risk patients. A multidisciplinary group worked to clarify the problem, review current research about fall prevention, implemented an intervention (or interventions) to be adopted, and monitored outcomes. They called their project "SAFE".

After review of the literature, the nurses developed a bundle of interventions to standardize care which included: timely documentation of high risk patients, participation in hourly rounding, mid-shift huddles to discuss patients identified
at risk for falls, using a "piggy tail" on the beds to alert the nurse if the patient was getting out of bed (which rang at the nurse's call station so the room could be identified quickly), use of a yellow arm band (which easily identified patients who were high risk for falls), "SAFE" stickers placed over the patient's bed and at the entrance of their room (again telling those who entered the room to monitor and assist high risk patients), and having the patient wear yellow non-skid socks for ease of identification. Some of the physical items needed for our bundles were put together by volunteers, allowing nurses to perform nursing duties.

At first some nurses felt this was time consuming but when they saw the results, they eagerly adopted the standardized care protocol which is still in use. The outcome over one quarter when compared to the previous year's same quarter was a 50% reduction in falls. The outcomes also revealed a significant reduction in the severity of injuries related to falls when compared to previous quarters. Overall, there was a 35% decrease in falls when 2010 SAFE data were compared to 2009 statistics. We hope to implement this in our other medical-surgical units.

The PICOT developed for this project was:

P - Telemetry patients are at high risk for falls and injuries.
I - Implementation of a "SAFE" bundle would reduce the incidence of patient falls.
C - Reviews of multiple research and meta-analysis data were conducted.
O - Incidence of falls and patient injuries from falls for high risk patients using the "SAFE" bundle would be decreased
T - The project would last for 3 months.

As our hospital becomes more "contagious" about EBP nursing projects, we will continue our efforts for excellence in healthcare for our Veterans, our staff, our community, and our nation.

**REFERENCE**

Chapter 15

VA Centers of Excellence in Primary Care Education: Interprofessional Education as the Future of Nursing

Kathryn Rugen, Stuart Gilman, and Laural Traylor
In this chapter we describe interprofessional education as a practice of the future, and tell our story about the VA Centers of Excellence in Primary Care Education, an innovation for education of physician residents, nurse practitioners and other primary care health profession learners. We highlight our experiences, demonstrating the potential impact on team-based, patient-centered care. We also share our lessons learned and describe the implications specific to nursing education and practice. Let us introduce ourselves. Stuart Gilman, MD, MPH is the director of the VA Centers of Excellence project, which is funded through the VA Office of Academic Affiliations. Kathryn Rugen, PhD, FNP-BC and Judith Bowen, MD are the nurse practitioner (NP) and physician consultants to the project, respectively. Laural Traylor, MSW is the project’s program administrator. Together we work as the coordinating center to assist the VA Centers of Excellence in Primary Care Education on their transformational and operational goals and objectives.

First we will provide background information. Health professions education has long been “siloed” in both the academic and practice setting. We use the word “siloed” to mean that the health professions are educated and trained separately; they have overlap in didactic content and train in the same practice setting but they do not come together to learn in the classroom nor in the practice setting. For over a decade now, experts have been adamant about the need to reform this antiquated way of educating health profession learners for the future health care system, which is undergoing radical change.

In 2003, in the influential report *Health Professions Education: A Bridge to Quality*, the Institute of Medicine (IOM) stressed that health professions’ educational reform is critical to improving the quality of healthcare delivery. The report concluded that health professions education is in need of a major overhaul. Clinical education simply has not kept pace with or been responsive enough to changing patient demographics and needs, the changing healthcare system, a focus on quality improvement, or new technologies. The report emphasized that reform efforts are needed to include all health professionals and to recognize each profession’s contribution. The IOM committee’s vision was that “all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence based practice, quality improvement approaches, and informatics (2003, p. 121).” How better to accomplish this than by having the professions learn together?

Since the IOM’s report to reform health professions education and collaboration, many policy, curricular, and/or accreditation transformations
have occurred to actualize interprofessional teamwork, education and collaboration. For example, the American Association of Colleges of Nursing (AACN) has integrated interprofessional collaboration behavioral expectations into baccalaureate, master’s and doctoral education (The Essentials of Baccalaureate Education for Professional Nursing Practice, 2008; The Essentials of Master’s Education in Nursing, 2011; The Essentials of Doctoral Education for Advanced Nursing Practice, 2006). The Accreditation Council on Graduate Medical Education (ACGME) and American Board of Internal Medicine (2012) have incorporated milestone competencies of professionalism, interpersonal and communication skills, and system-based practice with the expectation that medical residents effectively work in interprofessional teams to enhance patient safety and quality of care.

In 2011, the IOM published the report, *The Future of Nursing: Leading Change, Advancing Health*. Focusing on the topic of interprofessional collaboration, the report recommended “nurses be full partners, with physicians and other health professionals, in redesigning health care in the United States” (p. 4). The report recommends the best way to become partners with physicians and other health care professionals is to have early education and clinical experience with those individuals. In explaining Key Message #2 of the report, which recommends that “Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression” (p. 4), the report recommends that:

All health care professionals should receive more of their education in concert with students from other disciplines. Interprofessional team training of nurses, physicians, and other health care providers should begin when they are students and proceed throughout their careers. Successful interprofessional education can be achieved only through committed partnerships across professions (p. 32).

The World Health Organization (WHO) defined interprofessional education as an action that “occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (WHO, 2010, p. 7). D’Amour and Oandasan (2005) defined interprofessionality as:

…the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population…It involves continuous
interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient’s participation… Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. These characteristics must be elucidated (p. 9).

To clarify the interprofessional characteristics needed and guide curricula development at all health professions schools, the Interprofessional Education Collaborative (IPEC) developed the Core Competencies for Interprofessional Collaborative Practice (2011). The IPEC is sponsored by the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges and Association of Schools of Public Health. Their purpose is to promote and encourage constituent efforts that would advance substantive interprofessional learning experiences to help prepare future clinicians for team-based care of patients. The IPEC competencies are separated into four competency domains: values/ethics, roles/responsibilities, interprofessional communication, and teams and teamwork. These four competency domains are common across all health professions and are included across the educational trajectory of their students.

Concurrent with these calls to reform health professions education, there is a national call to rapidly redesign the healthcare delivery system. In January 2013 the Josiah Macy, Jr. Foundation, recognizing these concurrent initiatives, brought together leaders from health professions education and healthcare delivery to align the efforts of the two groups to better connect learning and practice. The five areas recommended for immediate action are:

- Engage patient, families, and communities in the design, implementation, improvement, and evaluation efforts to link interprofessional education and collaborative practice
- Accelerate the design, implementation, and evaluation of innovative models linking interprofessional education and collaborative practice
- Reform the education and life-long career development of health professionals to incorporate interprofessional learning and team-based care
- Revise professional regulatory standards and practices to permit and promote innovation in interprofessional education and collaborative practice
Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training

The need for healthcare redesign has been further stimulated by the Patient Protection and Affordable Care Act, most frequently referred to as the ACA. This federal law expands healthcare coverage to approximately 23 million additional Americans and increases benefits and lowers costs for consumers, provides new funding for public health and prevention, bolsters our health care and public health workforce and infrastructure, and fosters innovation and quality in the health care system. This will require interprofessional healthcare teams to provide care that is evidence based and outcomes-oriented, which necessitates redesigning the delivery of health care as it is today. This redesign will help health care professionals meet the Triple Aim concept put forward by the Institute for Healthcare Improvement (IHI) in 2007 which asserted three critical objectives that can lead to better models for providing healthcare: improve the health of the defined population; enhance the patient care experience, including quality, access and reliability; and reduce, or at least control, the per capita costs of care.

One model of redesign is the Patient-centered Medical Home (PCMH) designed specifically for redesigned primary care delivery. PCMH is a model of primary care transformation in which the goal is to meet the diversity of health care needs of patients and to improve patient and staff experiences, outcomes, safety, and system efficiency. PCMH encompasses five functions and attributes: comprehensive care, patient-centeredness, coordinated care, accessible services, and quality and safety (Agency for Health Research and Quality, 2010).

VA’s healthcare system recognized the importance of team-based care for primary care when we implemented the Patient Aligned Care Team (PACT) model throughout the system of care in 2010. PACT is VA’s adaptation of the PCMH as an emerging structure for delivery of primary care. Our adaptation maintained the emphasis on patient-centeredness, but in contrast to common PCMH definitions, VA’s PACT does not specify that the team must be physician-led. VA policies include physicians, nurse practitioners, or physician assistants as primary care providers on the team, and specify that the team can be led by any of these team members. The core members of the PACT teamlet are the provider, a nurse care manager, a clinical associate (nursing assistant, medical assistant, or licensed practical/vocational nurse, and a clerical associate.
All teamlet members have shared responsibility for providing care to a panel of patients. Additional healthcare clinicians such as social workers, pharmacists and psychologists are available to support the PACT teamlet.

To prepare healthcare professional trainees for practice in the PACT care delivery model the Department of Veterans Affairs (VA) Office of Academic Affiliations (OAA), in 2010, issued a request for proposals intended for visionary professionals across the VA healthcare enterprise to apply for funding to create a Center of Excellence in Primary Care Education (CoEPCE). The CoEPCE objectives and goals are to develop and test innovative structural and curricular models that foster transformation of health professional training from profession-specific silos to interprofessional, team-based educational and primary care delivery models. Five CoEPCE were selected and funded in 2011 to meet this charge. In collaboration with their academic affiliates, the five CoEPCE sites are: Boise, Idaho VA Medical Center, Louis Stokes VA Medical Center in Cleveland, Ohio, San Francisco, California VA Medical Center, VA Puget Sound Health Care System in Seattle, Washington and VA Connecticut Healthcare System (VACHS) in West Haven, Connecticut. A national coordinating center located in Long Beach, California provides transformational and operational support and an evaluation unit to develop core metrics and an enterprise-wide evaluation. The coordinating center is led by the physician director, Stuart Gilman, in collaboration with a physician consultant, Judy Bowen, nurse practitioner consultant, Kathy Rugen, and with the support of a program manager, Laural Traylor, and evaluation and administrative staff.

We have an ambitious five-year timeline. Each of the CoEPCE sites receives one million dollars per year for each of the five years (2011-2015) to pursue transformational, innovative and sustainable models of primary care education. The new models must allow interprofessional learners to have longitudinal learning experiences and sustained and continuous relationships with patients, faculty mentors, PACT staff and peer learners. Further, the CoEPCEs must prepare future healthcare professionals to work in and lead interprofessional teams that provide patient-centered care. The expected outcome of this five-year project is to generate transformative changes in clinical education and primary care delivery that are sustainable and translatable across VA and to the broader healthcare community beyond VA.

CoEPCE core requirements are: a physician and NP serve as CoEPCE co-directors, the academic affiliates (nursing, medicine, and other associated health professions) are joint sponsors and actively
engaged, the NP students, physician residents and other health professions learners spend 30% of their clinical time in the CoEPCE, and the learners are fully integrated into PACT teamlets. Learners receive a VA stipend separate from the CoEPCE funding. We also required that in addition to administrative staff and data managers, CoEPCEs would integrate at least four clinical educators, two primary care nurse practitioners and two primary care physicians, who had at least 25% protected time for teaching and mentoring. The funding for the program was designed to support directly related personnel and consultative services, educational materials, travel and supplies.

The core educational domains of the CoEPCE project are the core competencies of patient-centered care, which include shared decision-making, sustained relationships, interprofessional collaboration and performance improvement. In the shared decision making domain, care is aligned with the values, preferences and cultural perspective of the patient; curricula focus on the communication skills necessary to promote patients' self-efficacy. This domain also includes communication within the interprofessional team so that the patient is assured that all professions have provided appropriate input to assure maximum benefit from the interprofessional team at all stages of care. In the sustained relationship domain, care is designed to promote continuity of care; curricula focus on longitudinal learning relationships. Relationships may be sustained among the matrix components of patients, learners, faculty, and staff. In the interprofessional collaboration domain, care is team based, efficient and coordinated; curricula focus on developing trustful, collaborative relationships. In the performance improvement domain, care is designed to optimize the health of populations; curricula focus on using the methodology of continuous improvement in redesigning care to achieve quality outcomes.

While didactic or formal learning is the most prominent instructional strategy, the CoEPCE sites are encouraged to review the pedagogy and increase workplace learning and reflection (Rugen, et al., 2014).

Even though we established the requirements just described, each CoEPCE has a different locally developed program and training model. The core learners at each site include physician interns and residents in either internal medicine or family medicine, nurse practitioner students in either pre-master’s or pre-doctorate of nursing practice (DNP) programs, post-master’s and post-DNP nurse practitioner residents, post doctorate pharmacy residents, and psychology interns and doctorate psychology fellows. CoEPCEs also
engage learners from social work, nutrition, baccalaureate nursing students, medical students, and physician assistant students.

There have been many innovative practices developed at each site. We will highlight several of those here and specifically focus on those that impact traditional NP practice and NP education that may be of interest to our readers. Before the implementation of the CoEPCEs, in most circumstances, health professional training in the VA and other settings took place in professional “silos.” Nurse practitioner (NP) students commonly cared for the patients who were assigned to their NP preceptor, spending a half or full day each week in clinic for a period of time ranging from several weeks to a 15 week semester.

During this limited time and experience, the NP students might not have any significant interactions with other health professional learners even though other learners may have been present in the same clinic setting. In addition to the paucity of interaction with other professions, these traditional NP student experiences infrequently required the NP student to have a longitudinal relationship with patients and/or the preceptor. Further, VA’s typical clinical NP educational experience rarely provided NP preceptors with “protected time” for curriculum development, teaching, or supervision of NP students. Thus, the NP preceptor was frequently seeing patients at the same time that students were present, which left little time for educating and mentoring, and even less for interaction with other members of the health care team. Although these educational environments fulfilled program accreditation requirements, such educational models were not compatible with the goals and processes of emerging team-based, patient-centered settings, such as PACT (Rugen, et al., 2014). Providing protected time is similar to the physician training model and allows NP faculty and learners the opportunity to engage in mentoring and in-depth teaching and learning.

Another transformational example modeled in our CoEPCEs is the co-precepting model in which a physician-NP faculty dyad or faculty from all four engaged professions (nursing, medicine, psychology and pharmacy) precept all learners together. In the co-precepting models all learners have exposure to the role and expertise of each profession and role modeling takes place. In evaluation interview sessions, the interprofessional learners have overwhelmingly expressed that they value meeting and learning about other professions, value learning with and from other professions and value team-based approaches to patient care. For NP learners the longitudinal designs of the CoEPCEs help to overcome isolation in the clinical settings, unlike the traditional model of
NP training where NP learners rarely interact with other interprofessional trainees and infrequently encounter each other in designed workplace learning curricula. The implications for NP educational leaders is that they need to support longitudinal clinical experiences with other professions so learners can develop the competence and confidence needed for practicing in a redesigned, patient-centered health care system.

All five CoEPCE sites have developed post-graduate NP residency programs, which are one-year fulltime experiences. To date, collectively the five sites have trained 44 NP residents and the programs are very popular. The number of applicants has far exceeded the positions available. In the NP residency, the learners spend about 60% of their time in direct patient care and 40% developing scholarship, leadership, and teaching acumen. In their qualitative study to explore the perceptions and experiences of the CoEPCE NP residents, Zapatka et al. (2014) found four major themes associated with NP residency: 1. the importance of bridging into professional practice (student to clinician), 2. an expanded appreciation of other health professions roles, who had been trained in silos, 3. the value of developing a commitment to interprofessional teamwork, and 4. the benefit of mentorship. In the exemplar chapters that follow this chapter, NP residencies will be discussed in greater detail.

From our evaluation findings to date, no one model of interprofessional collaboration and team-based, patient-centered care has emerged as the best or superior model. We have been able to identify some guiding principles that lead to program success. Contextual factors can facilitate or impede interprofessional education programs including the degree to which PACT is implemented, facility space constraints and institutional commitment to faculty for educational roles. We have learned that it is essential to have a continuing focus on faculty and staff development, which includes all members of the teamlet. Topics of development must include interprofessional education and patient-centered practices. The curriculum needs to match the learner’s clinical readiness and interests. The curriculum is a work in progress and requires ongoing attention and tweaking to provide the right mix of instructional strategies that include workplace learning, formal instruction and reflection. Finally, one needs to be mindful of clinic team and faculty capacity constraints, which include the risk of burnout.

At the time of this writing, we are entering the final fiscal and academic year for learners under the CoEPCE funding. For the next phase of funding, we will be interested in improvement and refinement of curricula and best practices. The area of interest will be development
of products and dissemination of “implementation kits” for VA and the nation. We look forward to building on our achievements to date as we move the CoEPCE initiative to its next phase of development.

REFERENCES


Chapter 15.1

Development and Implementation of an Adult Interprofessional Nurse Practitioner Fellowship: The West Haven VA Prototype

Susan Zapatka, Rebecca Brienza and Jill Edwards
In the fall of 2010, along with many VA facilities across the nation, the VA Connecticut Healthcare System submitted a proposal to the VA Office of Academic Affiliations (OAA), to implement a Center of Excellence in Primary Care Education (CoEPCE). The aim of the proposed CoEPCE was to develop, implement and evaluate a transformative model of interprofessional health education that prepares graduates to work effectively in teams to provide high quality patient-centered care to Veterans. Applicants were required to focus on the training opportunities for medical residents and primary care nurse practitioners.

Rebecca Brienza and Jill Edwards, the physician and original nurse practitioner co-directors, submitted the VA Connecticut CoEPCE proposal. In response to the Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health (2010), we included a proposal for a new line item type of trainee, a full-time 40 hour post graduate adult interprofessional nurse practitioner (NP) who would complete a primary care "fellowship" or "residency". The goal of this new trainee position was to provide substantial and sustained time for the NP and MD trainees to participate together in educational and clinical activities and to establish nurse practitioners as trainee colleagues and collaborative practice partners. In January 2011, VA Connecticut was awarded one of the five national VA CoEPCEs (Department of Veterans Affairs Office of Academic Affiliations, n.d.). This was the beginning of the exemplar for nurse practitioner fellowships/residencies within the VA healthcare system.

Susan A. Zapatka merged into the CoEPCE in 2011 as core NP faculty and transitioned under Jill Edwards’s mentorship into her role as the new NP co-director. We designed the VA Connecticut CoEPCE to "immerse" its participants in concentrated team experiences providing direct and indirect patient care. The participants were medical residents from the Yale affiliated traditional internal medicine and primary care tracks and post graduate master’s prepared nurse practitioners and nurse practitioner students from our academic partners, Fairfield School of Nursing, Yale School of Nursing and Quinnipiac School of Nursing. Our objective in creating the Pulse Immersion Interprofessional Learning Curriculum (PILC) was to provide collaborative, longitudinal, comprehensive care to a defined panel of male and female Veteran patients in an interprofessional team based model. We ensured that the majority of this care was devoted to "direct" patient care activities, including 1:1 patient encounters, group visits, team huddles/meetings, telephone visits, secure messaging, home-based telemetry, home visits, and consultation with other providers within the context of the Patient Aligned Care Team (PACT), the VA’s version of a medical home (Rosland, et al., 2013).
We designed specialty experience so participants "immersed" within the CoEPCE would work with visiting specialists participating in didactic educational sessions and clinical consultation within the medical home setting. For each clinical session, a physician and nurse practitioner faculty dyad provide clinical supervision and oversight of the medical residents and nurse practitioners. Our goal in this design was to provide a vibrant interprofessional learning experience for both trainee groups while introducing them to the concepts of a practice partnership. The nurse practitioner postgraduate training emphasized skill development and transitioning into professional practice in a structured formally designed program. The nurse practitioner fellowship afforded VA Connecticut trainees the opportunity to participate in the full immersion experience and offered the medical residents firsthand experience working collegially and collaboratively with nurse practitioners as team partners. We proposed a six-month timeframe to move from a proposed fellowship to a fully implemented program.

In preparation for the CoEPCE, the co-directors met with leaders of the academic affiliates to discuss the proposal and obtain “buy in” from leadership for the NP fellowship. We developed a nurse practitioner fellowship brochure. We distributed this brochure to the Yale School of Nursing and Fairfield School of Nursing adult, geriatric, and family nurse practitioner students early in the spring semester. Concurrently, we developed an application for the fellowship, which included submitting transcripts, curricula vita, three letters of recommendation, and a brief essay on what each applicant wanted to get from the fellowship and what they would contribute to the program. In the first year, we received ten applications for three fellowship available trainee positions.

As co-directors, we conducted applicant interviews, assisted by our Fairfield School of Nursing affiliate faculty member supported by funding from the OAA CoEPCE grant. We had developed both performance-based questions and general information gathering questions. The answers were scored on a 1-5 scale rating system and we offered positions to the applicants with the highest ranking from the applicant pool. Once acceptance to the program was confirmed, we sent out formal applications and the process of hiring and credentialing the applicants into the VA system was initiated.

Three weeks prior to the initial immersion session we learned that the new nurse practitioner fellows would need to be fully credentialed as VA employees since they were no longer students. The process for credentialing can be a long and arduous process and could potentially...
end the program before it got started. The nurse practitioner co-director at the time, in an effort to advance the process, went to VA Connecticut leadership to get support for expediting credentialing and offered to complete all of the background credentialing herself. With the support of leadership, the credentialing office, the nurse recruiter, and the human resource staff, the three nurse practitioners were fully credentialed, had received their entry physical examinations and appointment letters, and were on board for the first immersion block in three weeks!

We designed the Pulse Immersion Interprofessional Learning Curriculum (PILC) to offer concentrated ambulatory interprofessional team experiences. During the four-week immersion, all members of the team are in the clinic setting. Nurse practitioner fellows and medical residents become active members of the CoEPCE PACT team providing care to their shared panel of patients. To achieve this, we modified the usual structure of the VA PACT model that includes the independent, individual provider/nurse/health technician. We developed and implemented a shared panel team management model of physicians and nurse practitioners working with the nurse/health technician collaboratively, caring for a joint panel of patients longitudinally. In this adaptation, medical residents and nurse practitioner fellows develop a practice partnership that fortifies their ability to function in team-based care in their future employment.

We divided each of the weekly sessions into a balance of clinical and educational activities. Each trainee was assigned six clinic sessions and four educational sessions. This design provided large blocks of uninterrupted clinical experience for residents and a controlled transition into practice for nurse practitioners. A sample of this structure is displayed in Table 15.1.1. It also allowed the residents the time needed to be away from the ambulatory setting for their required specialty and inpatient rotations. While the resident was rotating out of the clinic setting and away from immersion, the nurse practitioner fellow “practice partner” provided coverage for urgent patient needs and scheduled follow up care. We believe that setting up the system to enable the nurse practitioner fellow to function within this structure was crucial to our design.

VA Connecticut nurse practitioners work within the boundaries of a scope of practice and a formulary formalizing independent practice and allowing the authority to “prescribe, dispense, and administer medical therapeutics and corrective measures” according to state law (this policy is now under proposed revision to allow for full practice credentialing and privileging regardless of state practice act requirements using federal supremacy authority). As part of our initial program implementation, we
developed a nurse practitioner fellow functional statement (comparable to position description in the private sector) for the new trainee group to define and guide this new trainee practice. They were assigned within the system provisions that ensured them full capacity to order tests and prescribe medications within their individual scope and formulary, but required all of their notes to be co-signed electronically by attending faculty (either NP

Table 15.1.1 The VA Connecticut Center of Excellence in Primary Care Education Two-Week Sample Immersion Block Calendar Schedule

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 29</td>
<td>Conf RM not available Intern</td>
<td>Jan 30 Resident Switch Day</td>
<td>Jan 31</td>
<td>Feb 1</td>
</tr>
<tr>
<td></td>
<td>Switch Day</td>
<td>8-8:30 Team huddle</td>
<td>8-8:30 Clinic follow up</td>
<td>8-8:30 Team huddle</td>
</tr>
<tr>
<td></td>
<td>8-9 IHI</td>
<td>8:30-12 Firm A clinic</td>
<td>8:30-9:30 Grand Rounds</td>
<td>8:30-12 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td>9-9:30 Clinical Education</td>
<td>1-2:30 Dementia,</td>
<td>10-11:30 Ophthalmology</td>
<td>Women’s clinic</td>
</tr>
<tr>
<td></td>
<td>10-11:30 Teaching Session:</td>
<td>(scholarly time NPs)</td>
<td>1-2:30 Mgmt of Menopause Sx</td>
<td>1:30-4:30 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td>Ethical Case Studies</td>
<td>3-4:30 Mgmt of Menopause Sx</td>
<td>Part II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-1:30 Pre-clinic conference</td>
<td></td>
<td>3-4:30 Interprofessionalism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:30-4:30 Firm A clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb 4</td>
<td>8-8:30 Team meeting</td>
<td>Feb 5</td>
<td>Feb 7</td>
<td>Feb 8</td>
</tr>
<tr>
<td></td>
<td>8:30-9 Faculty Office hr</td>
<td>Conf Rm afternoon only</td>
<td>8-8:30 Clinic follow up</td>
<td>8-8:30 Team huddle</td>
</tr>
<tr>
<td></td>
<td>9-12 Firm A clinic</td>
<td>8-9 IHI</td>
<td>8-8:30 Grand Rounds</td>
<td>8:30-12 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td>1-2:30 Parkinson's</td>
<td>9-9:30 Clinical Education</td>
<td>9:45-11:45 Health Advocacy</td>
<td>Women’s clinic</td>
</tr>
<tr>
<td></td>
<td>3-4:30 IP Journal Club</td>
<td>9:30-11:00 Teaching Session:</td>
<td>1-2:30 OEF/OIF issues</td>
<td>1:30-4:30 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Faculty Office Hours</td>
<td>3-4:30 Teaching Session</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-1:30 Pre-clinic conference</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1:30-4:30 Firm A clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feb 6</td>
<td>Feb 7</td>
<td>Feb 8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conf Rm unavailable until 10am</td>
<td>8-8:30 Clinic follow up</td>
<td>8-8:30 Team huddle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-8:30 Team huddle</td>
<td>8:30-9:30 Grand Rounds</td>
<td>8:30-12 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-9 Nursing Grand Rounds: DVT</td>
<td>9:45-11:45 Health Advocacy</td>
<td>Women’s clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8:30-12 Firm A clinic</td>
<td>1-2:30 OEF/OIF issues</td>
<td>1:30-4:30 Firm A clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-2:30 QI</td>
<td>3-4:30 Teaching Session</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3-4:30 Primary Care Leadership</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 15.1.1 The VA Connecticut Center of Excellence in Primary Care Education Two-Week Sample Immersion Block Calendar Schedule
or MD). We believed that establishing the nurse practitioner as a trainee, colleague and peer provider member of the care team was essential to establish expectations and responsibilities for all members of the care team.

The OAA, through their grant requirements, defined the educational goals and objectives for the CoEPCE. These requirements were aligned with VA core values and patient-centered care principles. Shared decision making, sustained relationships, interprofessional collaboration, and performance improvement address the VA core requirements that health care should be patient-centered, continuous, comprehensive, team-based, efficient and coordinated. Specific curriculum content and methods of implementation were the responsibility of each site to design, implement, and evaluate. Table 15.1.2 presents the VA Connecticut design to meet these requirements.

The VA Connecticut CoEPCE curriculum needed to meet these requirements while meeting the training requirements for the medical residents and developing new core competencies for post-master's nurse practitioner fellows since none existed at the time. We initially examined the National Organization of Nurse Practitioner Faculties (NONPF) core competencies from April 2011 that were developed for the graduate NP student (National Organization of Nurse Practitioner Faculties, 2011). The physician faculty members at VA Connecticut were very experienced in mentoring and training residents in the primary care setting. All of the

<table>
<thead>
<tr>
<th>CoE Four Core Domains</th>
<th>VA Specific Courses</th>
<th>CoE Developed Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interprofessional Skills Training (Using EHPIC- Educating Health Professionals in Interprofessional Collaboration)</td>
<td>TEACH for Success (VA based training for patient-centered medical homes: focus on patient-centered communication, health education, motivational interviewing and health coaching skills)</td>
<td>Interactive Clinical Case Discussions and reflections Team development exercises and retreats Interactive Jeopardy Debates</td>
</tr>
<tr>
<td>Shared Decision Making – Ottawa Model</td>
<td>Facilitation and Conflict Management Training</td>
<td>Role play for cancer screening and biopsychosocial treatment decisions.</td>
</tr>
<tr>
<td>Sustained Relationships</td>
<td>Patient Home Visits</td>
<td>CoEPCE immersive workplace environment</td>
</tr>
<tr>
<td>Performance Improvement, Patient Safety and Quality Skills</td>
<td>Veteran specific issues Panel management</td>
<td>Health policy/leadership curricula Health Advocacy curricula</td>
</tr>
</tbody>
</table>
attending physicians have traditionally had resident trainees they supervise in clinic, but they were not experienced with mentoring and training other professions in the delivery of primary care. Primary care nurse practitioners took on the mentoring of nurse practitioner students as a collateral professional responsibility. Teaching trainees together was a new venture and it became clear to us that faculty development was needed. We realized that interprofessional training and mentoring require unique skills and knowledge.

VA Connecticut partnered with the University of Toronto to train faculty and key stakeholders in interprofessional learning (IPL) prior to the first immersion experience. They developed the Educating Health Professionals for Interprofessional Care Leadership Course (EHPIC) to develop educational leaders with competency in IPL who have the knowledge, skills, and attitudes to teach and practice the art and science of working collaboratively for patient-centered care. From the beginning of the immersion experience, the VA Connecticut CoEPCE faculty members have implemented skills and knowledge learned from the training session. All immersion sessions begin with "ice breakers." We schedule time for all of the trainees to sit together to learn about each other personally and professionally. This is often the first time resident trainees hear about the education and role of nurse practitioners in providing primary care. The faculty work to make these experiences fun and interactive, but with the clear intent that the trainees learn more about each other. We schedule these sessions throughout the year with each session resulting in trainees having a deeper appreciation for the skills others bring to the team in providing care and to the learning environment in the CoEPCE.

For our faculty, a key component of the curriculum was trainee based teaching. VA has a history of "watch one, do one, teach one" as a training model, and the CoEPCE faculty members were determined to move beyond this model, to develop the teaching skills for the trainees in a secure, supportive learning environment, while providing coaching, mentoring, and close supervision. Throughout the year each of the trainees also become participants in the training process; we have required residents and nurse practitioner fellows to provide an educational session to their peers under the mentorship of faculty.

During the first year, two of the resident trainees developed a curriculum on health policy and leadership. The health care policy curriculum stimulated lively debate among the disciplines as each brought their own unique perspective and experiences to the discussion. One NP fellow provided an overview of public health nursing, another clarified the NP role and function and the third NP fellow presented legislative changes impacting nursing in the State of Connecticut. Each of the sessions offered the trainee the opportunity to demonstrate individual interests and the
ability to engage colleagues in an interprofessional learning session. Some examples of such sessions included interprofessional journal club and teaching sessions as well as interprofessional national presentations.

Determining the means and methods of evaluation of the fellowship was initially problematic. Review of the literature resulted in no formal outcome measures or tools to evaluate postgraduate nurse practitioners that could be comparable to those used for the evaluation of medical residents. As a solution to this lack of available resources, we decided from the start to use a mixed methods design as our framework. During the first few months, based on the criteria based scale written in our VA functional statement, we developed a set of adult NP competencies and a chart audit tool to augment our data. Our mixed method approach to evaluation included collecting longitudinal semi-structured interviews with trainees as well as a variety of quantitative measures aimed at measuring mastery of our program’s core domains. Below are some examples of quotes from our NP fellow and medical resident trainees during qualitative interviews;

“I think it’s very fluid. We (the NP and MD trainees) definitely see each other almost on equal levels and, there’s never really an issue in terms of crossing professions… I see the NP fellows as just another trainee, so it’s been really good.”

We basically can go back and forth with patients. I trust that when my patient is seen by another resident or by a NP fellow, it’ll be done on the same level, the same level of excellence, so, the collaborative effort is almost seamless.”

“So there is not one particular event; it was the progression or multitude of events. We do have this one very complicated patient who, I think they gave him less than a year, based on the amount of time since being readmitted, to actually live and it was… It’s just interesting to see the way we all worked as a team. This is not just in terms of NP and MD, but RN, health tech, in terms of coordinating his care and making sure all his medications are given to him when he needs them, in terms of getting him appointments when he needs it and the amount of follow-up that he has. It’s just amazing to me.”

The VA Connecticut CoEPCE nurse practitioner fellowship was conceived to meet the intent of a proposal to place nurse practitioner students and medical residents in clinical training settings to learn together and from each other collaboratively and to develop understanding and trust of the others’ role on the health care team. The complexity of resident schedules and the limited
hours of clinical precepting required for nurse practitioner students made for a daunting task, as we worked to allocate adequate time to ensure that participants would have meaningful experiences.

The NP fellowship resolved this dilemma. It also resolved the resident/student dynamic that would need to be managed as the resident trainee moved beyond the student role into a care provider role. The nurse practitioner fellows had equal credibility and responsibility, having completed their education and basic clinical requirements. They too assumed a care provider role. We also designed the fellowship to provide opportunity to graduating adult, geriatric, and family nurse practitioners who might want an additional year of interprofessional training as they transitioned into practice.

The fellowship was designed to develop the new trainee skills needed to successfully practice within the primary care setting; it was not designed to ensure that they could independently manage a full panel of patients. The VA Connecticut CoEPCE adult interprofessional nurse practitioner fellowship provides a full year of structured clinical and protected educational time to develop as a nurse practitioner. While the first year of implementation was challenging for those of us who were accountable for pulling it together, it confirmed the value of postgraduate education for new nurse practitioners as their skills, knowledge, confidence, and ability to work effectively in an interdisciplinary team was demonstrated. The OAA coordinating center established early in the program a set of monthly calls to offer guidance. We are also engaged in a monthly five-site NP co-director call enabling collaboration, support and reflection. Our experience with the fellowship and the steps we took to implement this program were shared with the other CoEPCEs in the late spring of 2012. Our guide “How to Bring on an NP Fellow” was shared electronically and discussed on our monthly call.

Residencies in nursing are not new. There are many facilities around the country that take new registered nurses and provide them with yearlong "residencies" in their first year in practice, (Department of Veterans Affairs, 2011). Residencies for nurse practitioners are also not new, (Flinter, M. 2005; 2011). Residencies in specialty practices can be found within specialty organizations. The hepatology fellowship for nurse practitioners/physician assistants (NP/PA) providers offered by the American Association for the Study of Liver Diseases (AASLD) is an example of providing a specialty fellowship for nurse practitioners and developing their skills in that specialty care (American Association for the Study of Liver Diseases, n.d.)
Although nurse practitioners are most likely to choose primary care as their practice of choice, nurse practitioner residencies in primary care are rare. The opportunity to experience an additional year of training, supported by a federal organization, is almost unheard of in the realm of adult primary care interprofessional training for nurse practitioners. The opportunity exists for nursing to take this experience and the momentum for interprofessional training as a foundation for the development of standardized academically affiliated nurse practitioner residencies.

Medicine has a long tradition of providing structure and mentorship in a consistent trajectory from student to resident to attending physician, to academician. This model provides a steady stream of skilled and committed clinical and academic educators and leaders. For the discipline of medicine, it promotes their profession and the education of their trainees. The COE nurse practitioner fellowship is modeled on this principle. VA nurse practitioners have long supported and mentored nurse practitioner students. They have done this as a collateral responsibility and fit the work into their busy schedules.

The CoEPCE and the fellowship structure eliminate this as collateral work and place significant value on the role of the nurse practitioner faculty as a clinical educator. The nurse practitioner faculty members have clinical appointments with the academic affiliates. This model and affiliation needs to be developed and strengthened to provide skilled clinical educators for the future and standardized structured systems that support the transition of nurse practitioners into practice. If nurses and nurse practitioners are to participate in the healthcare of the future, the model of student, to nurse practitioner resident, to practicing clinician, to academician needs to be inherent in the profession.

At VA Connecticut our goal is to continue with this fellowship. We are developing future health care leaders and nurse practitioner clinical educators while promoting a transformative interprofessional model of post-graduate healthcare education through our post-master’s fellowship. We believe that support from the academic affiliates, the local leadership, the Office of Academic Affiliates, and the Office of Nursing Services are essential for us to continue our work in training future nurse practitioners for the interprofessional team-based primary care setting of the future.
REFERENCES


Chapter 15.2

Nurse Practitioner Residency Development in VHA: The Experience of the Louis Stokes Cleveland Department of Veterans Affairs Medical Center

Sharon A. Watts, Kristen Zimbardi, Mary A. Dolansky and Mamta K. Singh
Our story began in 2011 when the VA Office of Academic Affiliations (OAA) chose the Louis Stokes Cleveland, Ohio Department of Veterans Affairs Medical Center as one of five Centers of Excellence in Primary Care Education (CoEPCE). The VA primary care delivery model, named the Patient Aligned Clinical Teams (PACTs), is the VA version of the patient-centered medical home model. VA made a simple proposition: if we are planning on delivering care in a PACT model, we need to be training the future health care professionals so they can work in this new model. Therefore, the purpose of the Cleveland CoEPCE is to prepare nurse practitioner (NP) advanced practice registered nurse APRN students, NP advanced practice registered nurse (APRN) residents, medical residents and other health professionals to work in and lead patient-centered interprofessional teams that provide coordinated longitudinal primary care. The OAA leads VA's transformation of health professions education and provides a model for the five CoEPCEs to use in the development of the curriculum. The model has four domains: shared decision making, sustained relationships, interprofessional collaboration, and performance improvement. These domains emphasize the new skills that are not a part of traditional medical or nursing education, yet are recognized as the skills needed to deliver care in PACTs.

At the start of the CoEPCE our Cleveland VA leadership team consisted of Sharon Watts as nurse practitioner co-director, Mimi Singh as medical co-director, Mary Dolansky as deputy director and Kristen Zimbardi as clinical mentor in the primary care clinic. Kristen Zimbardi later became the nurse practitioner residency deputy co-director for sustainability of the program. VA has a strong tradition of helping clinicians transition from the classroom to expertise in the clinic. Our goal of providing an interprofessional learning milieu for NP student clinical rotations with first year medical residents for primary care took shape through the Cleveland CoEPCE. However, our team quickly noticed that the nurse practitioner APRN students were not at a commensurate level of clinical knowledge & skills to meaningfully interact with the first year medical residents or enter practice with expert clinical skills. Their clinical skills rotations provided in formal education enabled novice level competencies upon graduation. Thus began the journey to create a nurse practitioner advanced practice registered nurse residency at the Cleveland VA to fill the clinical skills gap and better prepare nurse practitioner APRNs for meaningful interprofessional learning with medical residents for the primary care shortages that our nation is facing.
Advanced practice registered nurses are recognized as valuable primary care providers. They deliver and coordinate cost-effective high quality care to patients in primary care but also in many specialty areas particularly in traditionally underserved areas (Newhouse, et al., 2011). The Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, recommended an expanded scope of practice for APRNs that includes educational initiatives (IOM, 2010). One of the four Key Messages of the report observed that nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Included in this broad educational goal is a specific recommendation that “State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program…” (IOM, 2010, p. 11).

The recommendation for transition-to-practice NP residency programs expands the clinical hour preparation requirements that were established in 1965. These original requirements have increased only minimally over the years, in spite of significant increases in the number of pharmacotherapeutics, treatment advances, and changes to the healthcare delivery system. There is general consensus that clinical preparation and comprehensive academic requirements have lagged behind the growing public recommendations for NP residency programs in primary care. In publishing their 2014 Fact Sheet on *The Doctor of Nursing Practice (DNP)*, the American Association of Colleges of Nursing (AACN), recounted the action they took in 2004 in their *Position Statement on the Practice Doctorate in Nursing*, where they voted to endorse moving the current level of academic preparation necessary for APRNs from the master’s degree to the doctorate level by the year 2015 (AACN, 2014). They noted that doctoral education through a practice doctorate in nursing is needed to meet the challenges of the complexity of patient care and nursing leadership roles. Moreover, this transition in nursing to a clinical doctorate is comparable to the practice doctorates offered by other health professions such as pharmacy (PharmD), psychology (PsyD), physical therapy (DPT), and audiology (ADD). They noted that expanding professional academic opportunities could increase the depth of academic knowledge, clinical skills, competency, and professionalism.

Hart & Macnee (2004) conducted a survey of 562 NPs to ascertain their opinion about the adequacy of the level of their preparation for practice after graduation from school. They found that there was a general sense that NP education was rigorous in theory, research, and “paper
writing” but lacked rigor in clinical practice areas. In fact, 87% indicated that they would have been interested in a clinical NP residency program. Advanced diagnostic skills were identified as training gaps that could be addressed in a residency. Specifically, skill gaps that were identified included performing microscopy, interpreting EKGs and X-rays, suturing, splinting, and simple office procedures, mental illness management, coding and billing, and complementary alternative medicine.

Flinter (2005) argues that perhaps nursing has developed a professional bias against clinical institution-based training in favor of preparation provided in institutions of higher education. Yet NP primary care practice requires both. Flinter goes on to point out that a NP residency program allows educational training to be translated into the broad and specific competencies in practice that are fundamental to safe, quality care.

The National Organization of Nurse Practitioner Faculties (NONPF) has identified the clinical competencies needed by nurse practitioners and the knowledge, skills, and abilities that are essential to independent clinical practice (National Organization of Nurse Practitioner Faculties, 2012). The nurse practitioner core competencies are acquired through mentored patient care experiences with an emphasis on independent and interprofessional practice, analytic skills for evaluating and providing evidence based, patient-centered care across settings, and advanced knowledge of the health care delivery system. The inclusion of these competencies guide the development and assessment of an NP residency program to prepare novice nurse practitioners for independent practice.

Given the growing evidence of nurse practitioners’ contribution to health care delivery and the increasing health care complexity of the twenty first century, expansion to a clinical NP residency would fill an existing clinical practice gap for NP students. By the end of the first grant year of our own CoEPCE, our NP students who were preparing to graduate felt that they could still improve their clinical skills. The students voiced frustration that they could not discuss patient complexities or demonstrate a level of skill commensurate with their physician resident partners who had two years of clinical outpatient experience in medical school. To address these issues, as the leadership of the Cleveland CoEPCE, we made the decision to begin planning a twelve-month NP residency program. Nurse practitioner residency programs were implemented at other CoEPCE sites and the addition of the program to our site seemed to be a natural next step. Across the country, the goal of the NP residency programs in the CoEPCEs was to strengthen the clinical, leadership, and scholarship skills of new NP graduates, thus improving their ability to deliver high quality, interprofessional primary care in the 21st century.
Our residency offers post-certificate NP graduates the opportunity to learn within outpatient interprofessional teams in a setting similar to other professional residency programs. The purpose of the program is to further develop the primary care clinical and professional skills necessary to achieve competence as a highly functioning PACT primary care provider within the VA healthcare system.

The clinical component of the NP residency program includes clinical rotations in the primary care clinic as well as providing specialty clinic experiences, including general cardiology, fast-track urgent care, pulmonary, and gastroenterology services. The NP residents also participate in hypertension and diabetes medical appointments shared with pharmacy preceptors, registered dietitians, and behavioral health psychologists. In Table 15.2.1 we provide a schematic of our NP residents’ weekly schedule.

We structured the program so the NP residents would have protected time for important functions such as panel management, addressing patients’ electronic health record reminders and making follow up patient phone calls. Four hours of didactic sessions per week provide additional opportunities for

| Table 15.2.1 Weekly Schedule of the Nurse Practitioner Program at Louis Stokes Cleveland Department of Veterans Affairs Medical Center |
|---|---|---|---|---|
| **MON** | **TUE** | **WED** | **THURS** | **FRI** |
| Primary Care | Specialty with GI Alternate. 0830 Module C&D Room 106. | APN Grand Rounds | Alternate DM SMA | Geriatric Grand Rounds |
| NP Resident 1 | Specialty with Parma Cardiology-Alternate-8am start | Primary Care | Alternate Panel Management | Didactic |
| Lunch | Lunch | M & M Grand Rounds | Lunch | Lunch |
| (NP-2) 3, 4, 5th | (NP-2) 1, 2, 3, 4, 5th | (NP-2)1, 2 | (NP-2)1, 2, 3, 4, 5th | (NP-2)1, 2, 3, 4, 5th |
| Alternate Fast Track (NP1)1, 2k | Alternate Fast Track-(NP1-3,4, 5th) | Alternate Fast Track-(NP1-3,4, 5th) | Alternate HTN SMA | Alternate Panel Management |
| Primary Care | NP Resident 1 | Primary Care | Primary Care | Primary Care |
| NP Resident 1 | NP Resident 1 | NP Resident 2 | NP Resident 2 | (NP-1) 3, 4, 5th |
| NP Resident 2 | NP Resident 1 | NP Resident 2 | (NP-2) 3, 4, 5th | (NP-1) 3, 4,5th |
nurse practitioner, medical and psychology residents, as well as NP students to learn together in the classroom. We integrated these six dimensions to guide the content of the classroom curriculum: culture and healthcare, proactive care, quality improvement, real time real patient, unified care, and virtual health. The dimensions are presented visually in Figure 15.2.1 which includes the four domains common to all CoEPCEs in the VA system.

**Figure 15.2.1 Conceptual Unified Framework of Components of the Nurse Practitioner Program at Louis Stokes Cleveland Department of Veterans Affairs Medical Center**

Another clinical requirement that we established for our NP residents is the interprofessional participation in a community project. The current community project involves providing foot care to Veterans in a homeless shelter. The NP residents also provide foot care education, administration of flu shots, mental health outreach services, and distribution of gift bags that provide clean socks, A&D Ointment, condoms, toiletries, and various patient education handouts.

In addition to the clinical and didactic components of the program, the NP residents also participate in various professional development activities. This involves the NP residents in mentoring, educating both peers and learners, and scholarly activities which include abstract
submission for a poster presentation and/or an article submission for a publication, and a quality improvement project. Each NP resident is paired with an NP expert clinician for mentorship. During formal weekly mentorship meetings, NP residents discuss complex cases and professional mentorship. A portion of this time is also used for comparison and discussion of the CoEPCE nurse practitioner trainee skills evaluation forms completed by both the mentor and mentee at the first, sixth and twelfth months of participation in the program. The assigned nurse practitioner expert clinician also serves as the main clinical preceptor in the primary care clinic, thus providing informal mentoring as well. We have noted with interest that NP residents have initiated informal mentoring with the current NP students not yet in the residency program.

With additional nurse practitioner faculty support each resident develops and delivers a 60-minute lecture on a clinical topic of their choice for the weekly Cleveland VA APRN educational series. The nurse practitioner resident is responsible for topic selection, defining the objectives, and developing the lecture. With NP faculty guidance, and with the availability of a statistician for consultation, each NP resident coordinates at least one journal club discussion and can coordinate additional sessions if desired. The NP residents also develop at least one educational seminar for the nurse practitioner students. This year nurse practitioner residents decided to work together in presenting a seminar for the new medical residents and NP students, focusing on office procedures such as suturing and orthopedic injections.

We believe that learning how to skillfully disseminate professional knowledge is an important ability. We also realized that traditional NP programs don’t typically equip students with this ability. In our NP residency program, faculty members assist each nurse practitioner resident in writing and submitting at least one abstract for a poster session or publication. This year each nurse practitioner resident has opted to coordinate this with the completion of their interprofessional quality improvement (QI) project. One of our current NP residents was selected to present her project at the Institute of Healthcare Improvement National Forum. The project focused on reducing inappropriate use of urgent care services.

The Cleveland VA CoEPCE NP Residency program provides a unique opportunity to learn and work in an interprofessional environment to strengthen clinical and leadership skills needed for 21st century healthcare. Nurse practitioner residents collaboratively learn and practice shared decision-making, continuity of care, quality care improvement, and interprofessional collaboration. At the Cleveland VA,
we are committed to continuous improvement of our program to ensure that our residency program contributes to the development of future healthcare providers who can meet the needs of Veterans in our country.

REFERENCES


Chapter 15.3

Interprofessional Education: Pressing for Sustainable Change and Growth

Melanie Nash and Amber Fisher
The Boise, Idaho VA Center of Excellence in Primary Care Education (CoEPCE) brings together baccalaureate senior nursing students, nurse practitioner students and residents, internal medicine and pharmacy residents and psychology interns and post-doctoral psychology residents to learn and practice in an interprofessional Patient Aligned Care Team (PACT), which is the VA’s equivalent to patient-centered medical homes (PCMH). An established internal medicine residency curriculum was the foundation for the interprofessional core curriculum: introduction to clinic, primary care seminars and curriculum of inquiry (ITC, PCS, CoI). Both Melanie Nash, CoEPCE co-director, and Amber Fisher, associate director for the CoEPCE pharmacy program, are foundational members of the Boise VA CoEPCE team and have grown with and through the process of building a sustainable interprofessional educational program.

The Boise CoEPCE has spent three years building a strong, integrated, interprofessional core faculty. Early in project implementation our core faculty learned that we couldn’t model collaborative behaviors if we didn’t practice them ourselves. We have come to the beginning of our third academic year realizing that there are many conceptual and practical points to explore and understand in order to help interprofessional practice succeed.

The first point is that interprofessional practice is more than a summative formula or a synergistic process. As each professional progressively provides clinical services closer to the top of their clinical expertise and licensure, there seems to be a logarithmic increase in team function. Team collaboration appears to become more than a summation of our parts when our collective expertise and understanding expands to meet client needs.

Another practical but necessary point we discovered is the importance of exploring team leadership. The team must decide which member or members have the right mix of skills and attitudes to transform and/or maintain the patient-centered practice model. Questions that assisted us in our exploration as a team included: should one clear leader be defined? should leadership be fluid, depending on the particular situation or patient need? In our experience, the clear leader for the patient-centered team is the RN care manager. Because of their unrivaled skills in patient and panel management, clinic flow, and care coordination, RN care managers can deftly coordinate team function and member roles in a seamless fashion that embodies the heart and soul of a true patient-centered practice. Our experience convinced us that the most effective educational preparation for an RN care manager is a Bachelor of Science in Nursing (BSN). It is our view that the optimal team leader for a PACT is an RN care manager with a
master’s of business administration (MBA). Selecting the RN care manager to lead or co-lead may be a key step in the successful progression to a full PCMH.

Another key point we began to understand is that the blurring of the walls around our professional silos and the overlapping of roles was uncomfortable but essential. A deliberate exploration of how professional roles overlap by explicitly discussing the intersection of the duties within those roles is not only important, but imperative. Each member of the team must be willing to give up, receive, and accept different levels of responsibility for patient care. Due to multiple changes in the health care landscape, including burgeoning patient numbers and primary care provider and physician shortages, the professional roles and scopes of practice of nurse practitioners and pharmacists have grown rapidly in the past decades. The once characteristic portrait of the autonomous, benevolent and solo physician caring for his or her patient has given way to an diversity of moving provider types. This has presented a significant paradigm shift for our physician colleagues who now must share the designation of primary care provider, trusting other clinicians to provide care that was once within the sole domain of medicine. Master’s degree prepared nurse practitioners have historically been educated for clinical roles, with minimal to no career pathways in the role of clinician-educator-academician.

Our center of excellence observation is that physicians more easily assume academic and leadership roles, possibly owing to historically greater opportunity to take on these roles. We believe that educational preparation through the doctorate of nursing practice (DNP) degree will lead to change, but for now, for the NP, there is a critical imbalance among competencies in effective administrative skills, performance improvement abilities, and the academic-educator role.

We have learned that one very important aspect of role identification is to neutralize provider-specific characterizations away from “physician” or “doctor” to “health care provider” or “clinician”. Pharmacy, psychology, medicine and increasingly, nurse practitioners have doctoral preparation for entry into practice, making the term “doctor” seem ambiguous. Additionally, using terms that are inclusive (such as “health care provider”) to multiple professionals helps to level the traditional hierarchy and enhance patient-centered care. Provider-specific language as a hierarchical and power-loaded construct was generally invisible to our medicine colleagues. Interestingly, we found that both our medicine and nursing faculty were unaware of the recent discipline-specific (pharmacy and psychology) trends toward seeking health care provider status.
Another aspect of role changes that we believe is important to understand in primary care surrounds referral patterns. Our experience has been that consultation and referral between NP and physician to pharmacy and psychology providers are mutually understood, but referrals from physicians to an NP are less settled. We have found that physicians are unclear when to consult an NP, however, clinic clerical and nursing staff members have reported that NP providers are more accessible than physicians for primary care consultations. We have yet to tease out any nuance surrounding physician versus nurse practitioner accessibility and availability but have implemented new programs to address this issue.

The first was to begin a medicine resident experience called practice management. The third year medical residents function as a “catch-all” consultant for the clinic. The second program is a professional practice buddy system. This program partners a medicine resident and NP resident to cross-cover each other’s patient panels. As these are both new programs this academic year, we do not have data analyzed, however, anecdotal experience tells us that both initiatives have provided improved trainee satisfaction with their primary care experience, improved staff satisfaction, and improved patient-centered care. The Boise CoEPCE continues to work through role definition, referral and responsibility for patient care.

Another compelling point we believe is noteworthy for teams to understand is member competency. Early in the implementation of our interprofessional training program, the co-directors and core faculty realized that we knew very little about each other’s educational preparation, licensure and the scopes of our practice. This discovery led to a two-year project comparing and contrasting each discipline’s preparation for their future health care roles. Nationally, our professions have undergone substantial role and scope of practice changes. Health professions education has not yet fully implemented competencies and curricula that prepare graduates to be “collaborative-practice ready” for interprofessional practice as called for by the World Health Organization (WHO, 2010, p. 7). Thus, most traditional primary care teams remain locked into their professional silos and collaborate only in disjointed and formal contexts. When interprofessional education becomes more widespread, each team member’s ability to practice together will improve because of a stronger foundation of mutual respect, trust, and understanding of each profession’s strengths. We have completed several team exercises resulting in better understanding of all roles on the team. Although this process must continue over time, we believe that once roles and responsibilities
begin to evolve and overlap, the mutual understanding gains momentum and fosters further collaboration for the good of the patient.

To address some of these issues with our own interprofessional trainees, we have developed curricula that are presented in a series of didactic classes. The core curricular materials are developed and co-taught interprofessionally and provide a rich experience that enhances concurrent workplace learning. Through our “introduction to clinic” course, we offer a wide range of foundational ambulatory care clinical skills such as structuring an effective and timely patient visit using the patient-centered interview; reporting, consulting or handing off a patient to another colleague; and the targeted efficient use of motivational interviewing. In “primary care seminars” we explore the grey areas of health care decision-making utilizing a case–method teaching style. Symptomatic and asymptomatic disease, somatization, harmful health habits and health screening are deconstructed into a specific case-based scenario. Interprofessional trainees critically evaluate targeted articles for each case-based module and choose to defend one of two dichotomous treatment decisions (usually a Yes/No scenario), which may be the exact opposite of the clinical judgment they would really make in clinic. In the “curriculum of inquiry” series we focus on practice-based quality and performance improvement, health care funding, and changes in the national structure of health care.

Each year those of us working in our center of excellence move closer to a more cohesive understanding of professional roles. We have found that our professional skills overlap in many ways that will serve to improve patient outcomes. We understand that a true team is much stronger than a group of individuals working side-by-side. We are focusing on defining, capitalizing on, and maximizing particular professional and individual strengths to improve collaboration and patient outcomes.

One clinical interprofessional education innovation trialed in the Boise CoEPCE this year was the integration of a nurse practitioner resident into the in-patient medical team. Characteristically, an inpatient team includes an attending physician, first, second and third year medical residents, medical students and physician assistants. The integration of a nurse practitioner positively changed team dynamics. The nursing lens of patient-centered, patient-context synergistically enriched team discussion and patient outcomes as interprofessional practice moved from a parallel experience to being part of the core team. We plan to integrate pharmacy residents into this longitudinal, intensive clinical block experience during the 2014 academic year.
As we, the most “mature” generation of health care providers, learn to work in an interprofessional capacity, our hope for the future is transdisciplinary practice, where collaborative interprofessional practice and patient care becomes the clinical standard.

Although interprofessional education is the newest iteration in health education trends, we believe that it offers the best opportunity for each professional in the primary care team to contribute their unique perspective, resulting in enhanced patient involvement and health outcomes. The Boise VA CoEPCE faculty have identified and worked through many interprofessional and educational roadblocks and barriers. We seek to continue to work through the struggles between professional identity and collaborative practice, the question of who should lead an interprofessional team, finding the most effective, efficient and productive referral patterns between professions, and how to maximize clinic time and improve access. Our experience so far has built a strong and viable foundation for moving ahead into true interprofessional, collaborative health education and practice. As with all worthwhile changes, we now must avoid settling for the status quo, resist stagnation and backsliding and direct our energies toward forwarding the momentum of change.

REFERENCE

World Health Organization (WHO). (2010). Health Professions Network: Nursing and midwifery at WHO. Retrieved March 13, 2014 from w w w.who.int/hrh/nursing__midwifery/en
Chapter 15.4

Academic PACT:  
The San Francisco VA Experience

Terry Keene, Bridget C. O’Brien, and Rebecca Shunk
We, at the San Francisco, California VA (SFVA) medical practice (MP) clinic and two community based outpatient clinics (CBOCs), began to implement the Veteran Health Administration’s (VHA) approach to the nationally known patient-centered medical home approach to care, the Patient Aligned Care Teams (PACT) model of care in 2010. Initially we understood little about this new model of care but began to comply with the VHA requirement to provide care as teams. We made a concerted effort to begin to work together as teammates, rather than as individuals, delivering care to Veterans. We did this, in part, through daily huddles. Rebecca Shunk, MD is the co-director for the center of excellence (COE) in primary care education at the San Francisco VA. This SFVA COE is one of five sites that was funded to pilot academic/practice partnerships for interprofessional education in primary care. She is one of the pioneers of the development of the interprofessional model of teaching at the San Francisco VA medical center. Dr. Shunk recalls that in the first days of PACT implementation the staff members were told that participating in team huddles was a requirement across all VHA primary care sites and that their schedules had been changed, effective immediately, in order to accommodate the huddles. The bundle of VHA evaluation metrics to determine compliance with implementation requirements of the PACT model included the frequency of using team huddles. As she remembers it, “Our team nurse rounded us up and we sat in a room for a few minutes asking, ‘Ok, we are supposed to huddle, hmm, what’s a huddle?’”

At the same time as our clinic began to acculturate to the PACT model of care, VHA announced a competitive grant to develop and become one of five VA centers of excellence in primary care education. The request for proposal (RFP) mandated co-leadership, a physician co-director and a nurse practitioner (NP) co-director as well as a robust evaluation of the project. Dr. Shunk was appointed as the Physician co-director and Dr. Susan Janson, NP, was appointed as the original NP co-director. Dr. Terry Keene, NP later replaced Dr. Janson after her retirement. Bridget O’Brien, PhD, from the University of California San Francisco (UCSF) is leading the program evaluation efforts as our academic partner.

We felt well positioned to apply for the VHA COE primary care academic grant because we had a close affiliation with UCSF Schools of Medicine and Nursing, with a strong track record for innovative educational programs. In 2011, we were awarded the five million dollar grant to develop, over five years, a Center of Excellence in Primary Care Education (CoEPCE), a new model of training internal medicine residents and NP students in an interprofessional environment.
Pharmacy residents, psychology fellows, social work interns and other trainees were included in our funded grant in order to develop innovative approaches in an interprofessional milieu with the goal of teaching team care to the new generation of providers.

At the time the grant was awarded, the culture in the MP and CBOC clinics was beginning to change. We were huddling, but doing so irregularly. We all addressed one another by first names and the teams were beginning to gel. There were still challenges with staffing, scheduling and the usual chaos that occurs when starting a new program, but the teams were beginning to work more closely together and learn the PACT model.

With PACT implementation underway, the clinical team-based environment was improving and we were now challenged to develop a curriculum to teach interprofessional trainees how to deliver team based care. We solicited guidance from experts in team communication and clinical care. We had workshops and faculty development sessions on how to design and deliver curricula. We enrolled interprofessional faculty teams in TeamSTEPPS training, an evidenced based training that was developed by the Agency for Healthcare Research and Quality (AHRQ) to improve teamwork and communication among healthcare clinicians (AHRQ, 2014). Our curriculum was branded with the name EdPACT or education in patient aligned care teams. It was important to us to model the teamwork expectations so there was a concerted effort to flatten the hierarchy among our faculty and within the clinic by respecting and acknowledging each team member’s contribution to the care of the Veteran. We quickly found that the key to delivering team based care was communication and the key to ongoing, open communication was to huddle daily. Thus it became a high priority to teach trainees to huddle with their teams.

The question we then needed to answer was how to teach teams to huddle with physician residents and NP trainees. We implemented a huddle coaching program, which included strategies such as use of a huddle checklist (Shunk, Dulay, Chou, Janson & O’Brien, 2014) and training the CoEPCE faculty to be huddle coaches. The huddle checklist was developed to provide a tool for huddle coaches to ensure the teams covered the important patient care aspects for the day, for the week ahead, and for overall patient panel management. In addition to making sure the team would address key patient-care requirements, the checklist documented which team members actually attended the huddle and if the huddle was held at the scheduled time. The coaches
used the checklist data to debrief team members on the huddle process which resulted in increased numbers of huddles completed, improved timeliness and increased positive perceptions of the value of the huddles. Coaches were able to facilitate team communication by pointing out examples of good team communication as well as missed opportunities. Additionally, coaches could answer systems/logistical questions in real time and help assure general adherence to the huddle structure.

Upon review of data gathered from huddle checklist debriefing sessions, we noted another challenge: how to get everyone together to huddle. Our coaches and trainees reported that staff members often had trouble making it to the huddle. We looked at the schedule for the teams and realized the registered nurse (RN) licensed vocational nurse (LVN), and medical support assistant (MSA) team members would likely be huddling at different times on different days depending on which trainees were present. Although trainees and staff had dedicated time on the schedule to huddle, we needed to map out which teams were huddling when, where and who was expected to attend, so that no team members had conflicting obligations. We also needed to take into account alternate work schedules (e.g. part time and staggered work shifts/arrival times).

After some logistical difficulties with getting teams to huddle, we decided teams needed a designated permanent huddle location and that trainees should be dispersed among all PACT teams in the clinic to share the increased work of trainee huddles. Since NP students have their own clinic space where they see patients, we selected their space as the place for the team to meet, which helped flatten the perceived hierarchy between the physician residents and NP trainees. The NP students then facilitated access to the computerized medical record where team members could find available information that enhanced comprehensive case discussion.

After reflecting on our experiences in the first year of our program, we made several improvements during the second year of our program. The physician and NP faculty were continuing to develop their teaching skills and enhancing the curriculum for the trainees. Monthly faculty development meetings and simply working closely with trainees and faculty peers facilitated this development. Although we were very proud of the excellent training we provided our NP students, it was clear that some NP students would benefit from a more gradual transition to independent practice. Thus a postgraduate yearlong NP Fellowship program was initiated. Our goal was to gradually increase the number of assigned patients (i.e. panel of patients) and independence of the NP
fellows to ensure full competence as independent primary care providers at the end of their fellowship. A panel of faculty interviewers selected the first cohort of NP fellows from the first cohort of NP trainees who were already entrenched in the PACT culture. We tasked them to help with delivering curriculum, precepting NP students and mentoring trainees. For example, NP fellows help teach quality improvement and mentor interprofessional trainee projects in our quality improvement curriculum.

During the second year of the pilot, a few NP trainees struggled with the demands of the interprofessional academic/practice program. One NP trainee elected to leave the program. We also found that episodic issues of disengagement occurred for some trainees throughout the year. In assessing this, we discovered that some trainees did not fully appreciate the significant workload and increased expectations related to truly being a team based primary care provider trainee for a panel of patients. We met these challenges by increasing communication with the trainees, meeting with each individually as needed. We also provided more detailed discussions of expectations with the next NP student cohort. During this time, the NP co-director, Dr. Janson, announced her retirement at the end of the academic year and a search for a new co-director was implemented.

In this, the third year of our program, a new NP co-director, Dr. Keene, joined our CoEPCE. She transferred from VA Puget Sound Health Care System, which was one of the other pilot sites for the CoEPCE and thus she was familiar with the grant expectations. At this point (2014) we have 9 NP trainees and 3 NP fellows training with 18 second year internal medicine residents. The trainees continue to work in triads comprised of two internal medicine residents and one NP student. The internal medicine residents’ alternate inpatient and outpatient blocks every two months and residents on opposite blocks are paired. NP trainees huddle and join curricular activities with the resident partner on their outpatient block.

In year three our primary challenge has been incorporating more clinical content into the curriculum. Program evaluations by trainees and feedback sessions have indicated a desire for more clinical content to be included in the discussions of team based care delivery. Our annual faculty retreat was devoted to challenging our assumptions about the current curriculum and brainstorming new ways to deliver content that includes clinical cases, relevant clinical issues and examples of how this content affects clinical decision making.

The future of the CoEPCE training model at the San Francisco VA has recently been secured. SFVA leadership has agreed to support
the program by providing local funding of the project going forward. This support acknowledges the role that the CoEPCE has had in implementing, supporting and sustaining the PACT model. It also demonstrates that an academic PACT is attainable and a valuable adjunct to a medical home model such as the VHA Patient Aligned Care Team approach. With the implementation of the affordable care act and with the primary care medical home model becoming the standard of care, this interprofessional training model is crucial to prepare our next generation of primary care providers (PCPs) for efficient delivery of care. We believe that the VA can, should, and does take a leadership role in this major health care transition.

Our experiences have convinced us that the development of a more standardized approach to NP fellowship/residency will have a significant impact on the future of NP education and practice. In the model at the SFVA, the NP fellows are training interprofessionally with the third year internal medicine residents who are also transitioning from supervised experience to independent practice while learning to collaborate with psychology, dietician, social work, psychiatry and pharmacy trainees. With standardization, the NP fellowship/residency program could in time become eligible for accreditation, which will improve the funding options for post-graduate NP experiential education, easing the transition from NP student to NP provider.

With the CoEPCE at the San Francisco VA we have introduced a new model of teaching interprofessional trainees, fostering interprofessional communication through our use of huddles and our huddle coaching program. Our trainees leave the program with skills that help them work more effectively in teams, which prepares them for new models of interprofessional care delivery. We are working to expand this program to the more rural CBOCs in the future and are working with our sub-specialty colleagues to design models of team based care in the sub-specialty clinics.

We are convinced that locating NP student training and NP fellowships/residencies in an interprofessional environment prepares NPs to become independent providers. The VA is the nationwide leader in leveling the hierarchical environment in primary care clinics by supporting recommendations by the Institute of Medicine (IOM) report on the future of nursing that nurses should practice to the full extent of their education, training and licensure and nursing should design systems for transition to practice for nurses (IOM, 2010). The
CoEPCE at the San Francisco VA has successfully enculturated this environment in their training program. VA's challenge now is to export these programs to other academic VA sites throughout the country.

REFERENCES


Chapter 15.5

VA Puget Sound Center of Excellence in Primary Care Education DNP Residency Evolution: Leveraging Established Best Practices for Transition to Practice

Kameka Brown and Joyce Wipf
The United States is poised for key changes in health care access and delivery. A projected 30 million people will gain access to care under the Patient Protection and Affordable Care Act of 2010. This increase has the potential to exacerbate a growing primary care physician shortage. Compounded by reductions in physician medical residency funding, nurse practitioners are increasingly viewed as a viable option to bridge the primary care provider gap (Iglehart, 2011). With recommendations from the Institute of Medicine (2010), The Joint Commission (2005) and the Carnegie Foundation (2009), nursing education and practice has extended preparation to include nursing residencies. These residencies serve as a transition to practice for novice practitioners and are focused on the clinical skill development and role socialization needed to address the increased complexity of patient care and health care systems (Bahouth & Esposito Herr, 2009; Flinter, 2010; Flinter, 2012). As the VA Center of excellence in Primary Care Education Co-Directors, Joyce and I approach DNP residency design with complementary skills and a shared passion for teaching. Joyce Wipf, MD is the physician director, section head of general internal medicine and full professor at the University of Washington. Kameka Brown, PhD, MBA, MS, FNP-C is the nurse practitioner director and clinical assistant professor at the University of Washington. We both share a commitment to training the next generation of primary care providers and to ensure clinical excellence.

Responsive to the American Association of Colleges of Nursing recommendation that the DNP serve as nurses’ terminal practice degree by 2015, the VA Puget Sound Health Care System, Seattle, Washington focused on supporting novice nurses who had earned DNPs in their transition to becoming proficient primary care providers (AACN, 2010). Our site launched VA’s first residency targeting post-bachelor to doctorate of nursing practice graduates. We designed our yearlong program to leverage best practices of established clinical residencies while appreciating the unique nursing practice underpinning that has guided advanced practice nursing for over 50 years. We created a transition-to-practice model focused on three key elements: advanced clinical practice, mentoring and leadership and scholarly inquiry.

As is apparent, this program was shaped by the overarching mission of the VA Centers of Excellence in Primary Care Education (CoEPCE) created by the national Office of Academic Affiliations (OAA): to transform primary care education. Boldly expanding requirements for primary care training for nurse practitioner students (30% of total clinical time) and physician residents (30% of total training time), the new training seeks to move education from discipline “silos” to blended interprofessional
learning, including associated health professions such as pharmacy and mental health. The mission and goals of Seattle CoEPCE at VA Puget Sound Health Care System include: 1) Learning the skills needed for primary care team-based practice during training, and not predominantly afterward on the job; 2) Providing longitudinal continuity experience for doctorate of nursing practice (DNP) trainees as well as enhance collaboration, understanding and respect for the unique roles and contributions of each profession, with development of exportable and sustainable curriculum, and 3) Creating a comprehensive clinical training experience for DNP psychiatry mental health students to contribute to future work force needs for nurse practitioner providers on mental health teams.

Our CoEPCE is embedded in VA Puget Sound Health Care System's academic primary care, which is a long-standing core continuity clinic training site of the University of Washington medicine residency program, in place since the 1970s. For the last decade this has included the multidisciplinary VA women's clinic, a national model for comprehensive care for women Veterans. CoEPCE was initially designed with a unique three-year longitudinal clinical experience for DNP students, in conjunction with medicine residents in a newly created CoEPCE Patient Aligned Care Team (PACT), “VA medical home pathway” within the primary care track. It was thus designed to foster interprofessional development and collaborative practice over their entire training.

Our core trainees in nursing and medicine spend two thirds of their primary care time in direct patient care and experiential learning in primary care clinic and women's clinic. The other one third of their time involves interprofessional education, with three interwoven “threads” conducted in half-day sessions. The first thread is panel patient management for continuous longitudinal care between clinic visits with analysis of clinical care and preventive measures. The second thread is team building activities with PACT team members and “Meet your Colleagues” in associated health professions, to develop interprofessional competencies. The final third thread is multidisciplinary clinical workshops on content about patient concerns typically under-represented in usual education programs such as wound care, urology, chronic pain, health literacy, women's health breast care and gynecology, addiction treatment, and complementary modalities. Exploration of this content includes “hands-on” demonstration and practice of specialized techniques, equipment and testing done, designed to expand primary care appropriate evaluation and consult care. We have also included second year DNP psychiatric mental health students in the CoEPCE trainee group as well as associated
health professionals in our well-established year-long pharmacy residency and participants in our psychology internship and fellowship programs, thus expanding mental health primary care integration.

Our CoEPCE has evolved as we have learned from our early experiences with trainees of markedly varying backgrounds, prior clinical experience as providers, and readiness for practice. Educational sessions have been adapted (such as motivational interviewing, design of “Meet your Colleagues” and creation of shared decision making curricula), so that successful learning does not depend on knowledge level on entry to the program, even though learning evidence based practice guidelines may be a dual mission. We also found challenges in our three-year experience for DNPs, since first year students enter our complex patient care setting when they are just starting to develop skills on history-taking and physical examination and before they complete their coursework in pharmacology, physiology and other basic sciences. Thus CoEPCE DNP trainees now enter our program at the start of their second year for a two-year experience.

In addition to our CoEPCE site unique focus on multi-year longitudinal primary care for DNPs, we have also designed and initiated a DNP residency framework for graduates of a three-year post-baccalaureate program. The impetus for starting a DNP residency included several factors. Most importantly, despite enhanced experience such as CoEPCE within the three years of DNP education, we saw that many graduates need additional time in an educationally supervised setting to ease transition to practice. This need has been identified by DNP graduates themselves, some seeking residency with us even before positions were created. Our literature review of non-VA post-master’s NP residencies and observations of other VA CoEPCE post-master’s training, indicated that no prior DNP residency had been designed specifically for three-year post-baccalaureate DNP graduates. These graduates bring added experience in leadership, quality improvement, completion of their scholarly capstone project, and more clinical experience. Finally, in our goals of enhancing interprofessional collaboration among DNP trainees, medicine residents and other professions, there is great potential that our DNP residents, based at our site full-time, can participate in block rotations.

We created the specifics of the DNP residency year in response to our applicants’ requests to solidify clinical skills as a paramount goal. Approximately 50% of time is spent in continuity patient care (30% in primary care center [PCC] 10% in women’s clinic, and 10% on panel management/indirect patient care). The remaining 50% of their time has flexibility and evolves over time with experience and
is based on individual DNP resident preferences. Their options may include one-half day per week in specialty clinics, one-half day per week co-teaching (i.e. women’s clinic co-precepting, co-teaching panel management and other interprofessional education (IPE)).

A requirement of our CoEPCE DNP residency is the completion of a scholarly project activity or quality improvement/patient safety project, resulting in presentation at a meeting and/or a publication. We are also designing some new unique opportunities including a “transitions of care rotation”, in which the DNP resident works with CoEPCE medicine faculty attending on an inpatient medicine team. The DNP resident’s activities on this rotation include reviewing every patient admission, identifying factors leading to acute hospitalization, assessing the role of the primary care team pre-and post-admit, and working with unit team members, including pharmacy residents, nursing, administration and other services to optimize discharge planning.

We have expanded ambulatory CoEPCE block rotations designed initially for medicine residents to include, as possible, opportunities for DNP residents. The new rotations were created due to the added CoEPCE primary care time required in medicine training (30% total primary care training). Because of this change, our UW medicine residents have reduced inpatient required rotations from over 50% to 40% of their total training time. This results in two additional full-time primary care CoEPCE rotations in each of three years, in addition to an average of three half-days per week of experience providing services in a direct care continuity clinic. The new CoEPCE rotations that we have designed to date include: first year rotations in homeless care and deployment health and second and third year rotations in leadership/introduction to health care administration, home care, palliative care, group visits, women’s health, clinician-teacher rotation, and a quality improvement (QI) specific rotation.

A core tenet of our DNP residency framework is that the year be defined and constructed based on the needs of our residents to enhance their transition to practice. In doing this, we consider their educational experience and the skills they achieved in their core DNP post-baccalaureate program. However, we also believe it is instructive and potentially useful in creating the DNP residency to consider the practices of other disciplines that have well-established residencies. Internal medicine residencies today are nearly unrecognizable from the original design of post-MD inpatient training after four years of medical school predicated on basic science knowledge and clinical rotations in all core specialties. “internship” and “residency” were terms for living in or near the hospital, and done without duty hour limitations.
Now medicine residency is a highly complex three-year structure with extensive national requirements for training programs, closely regulated and monitored by the American College of Graduate Medical Education (ACGME). Comprehensive clinical training is required on inpatient, outpatient and subspecialty services, and is usually structured in monthly block rotations. Primary care continuity clinic is required for all three years of physician residency with a panel of patients assigned to the resident. We learned about interprofessional education challenges from our CoEPCE design. On the one hand, the medicine interns who enter residency are relatively experienced clinically and ready for supervised practice, based on their medical school in all of 3rd and 4th year clinical rotations. Conversely the DNP trainees are students from programs organized on a graduate academic calendar, and who have numerous academic study assignments with far fewer hours of clinical experience.

The pharmacy residency model is an optional clinical year after the award of a PharmD degree, required for advanced clinical practice pharmacists. Our pharmacy residency is structured with rotations of several weeks, diverse inpatient and outpatient experiences and continuity clinic experience either in primary care or specialty care. Additionally, there is extensive computer training, medication panel management and all graduating pharmacy residents are required to complete a scholarly product for publication.

Mental health trainees, including psychology residents, have in-depth interprofessional education, clinical care conferences and team-based coordination. Psychology interns who are stationed at our VA for their pre-doctoral residency rotate through primary care as well as other clinical sites. They have longitudinal therapy clinics in mental health service. They work on mental health care teams that include other trainees, including post-doctoral psychology fellows and psychiatry physician residents, and rotating medical students. Primary care clinics and deployment health are core experiences. All mental health trainees rotate through clinics completing intake evaluations for new patients and follow-up appointments, and may also co-facilitate a group. This past year our site received additional funding in mental health for more trainees to expand primary care-mental health integration, and collaboration with trainees on CoEPCE primary care PACT teams.

These diverse disciplines have informed our design of the residency for nurses. A critical element of our nurse practitioner residency is experiences designed to enhance clinical preparation to effectively manage the growing complexities of our patient population. Within advanced
Chapter 15.5: DNP Residency Evolution: Leveraging Established Best Practices for Transition to Practice

clinical practice, our site has delineated clinical preparedness and didactic enrichment. Leveraging the medical residency design, our NP residents are assigned clinical “blocks” to provide balanced preventive and chronic care training. All DNP residents attend their own continuity clinics, engage in specialty care rotations and participate in inpatient transitional care. This care is conducted in a patient-centered, team based approach.

Continuity clinic assignment offers residents the opportunity to develop relationships with patients as well as manage healthcare issues longitudinally. Residents are assigned to teamlets within our medical home model Patient Aligned Care Team (PACT), which includes a nurse and a clerk. The resident serves as an associate provider with a collaborating nurse practitioner attending during their clinical session. The NP resident partners with their team members to clinically manage patients seen in clinic as well as ensures those assigned are managed effectively.

Our specialty care rotations target specialty care skills that will benefit primary care providers. These rotations include dermatology, mental health and orthopedics. Inpatient transitional care offers our residents the opportunity to participate in inpatient clinical or “wards”. During this time, they gain insight into hospital based care management and key discharge needs that follow patients when they move to the ambulatory care setting.

Didactic enrichment fosters our residents’ classroom-based learning beyond their certification. Each interprofessional seminar promotes deeper understanding of the myriad of psychosocial challenges our patients may face when managing their health issues. By learning with pharmacy, psychology and medicine, our nurse practitioner residents share their unique lens in patient care while gleaning from these clinicians how they approach panel management.

A unique offering in our residency design is inpatient transitional care. Appreciating that many of our chronic care patients will have intermittent inpatient stays, our DNP residents attend inpatient rotations alongside medical residents. During this transitional block, our NP residents work in clinical teams, assess patients and develop robust discharge plans. This provides our residents with a rich appreciation for these skills that serves them in continuity clinics when managing the patient after discharge.

We have interwoven role development and mentoring throughout our model. Our residents are assigned to a master’s prepared nurse practitioner who has a minimum of five years of clinical experience and a medicine advisor. The medicine advisor meets weekly to cosign Medicare forms and discuss medically complex cases. The experienced nurse practitioner preceptor serves as the attending
nurse practitioner during each clinic session. Like medicine resident attending, the nurse practitioner preceptor/attending manages medication refills, requests for referrals, reviews all charts and meets weekly with NP residents to discuss clinical cases. Leveraging practices from psychology and social work known as “clinical supervision”, our residents present challenging and unique cases to their attending nurse practitioner and explore key practice implications.

A final critical aspect unique to our residency is the importance of generating a scholarly product. Akin to the end products of yearlong pharmacy programs, we view graduates from DNP residency programs as future nurse practitioner leaders shaping quality improvement and informing practice policy. For each of our residents, we encourage site based quality improvement and scholarship generation that will improve the care of our Veterans and inform their practice. The end result for each resident is a manuscript or quality improvement project of his or her choice.

Most important to our design is the retention of the key element of nursing practice. While we are pleased to recognize these established disciplines, we uphold the uniqueness that comes with being nurses. Throughout clinical and didactic blocks, elements of holistic nursing are the underpinning that guide our residents. This serves as the basis for their developing a repertoire, shared decision making, patient engagement, motivational interviewing, and establishing common goals. Viewing nursing practice as the lynchpin to our residency, our residents approach patient care as an expression of their nursing practice rather than a separate skill set. By combining the rigorous methodology of medicine, pharmacy, psychology and nursing disciplines, we believe our learners are aptly trained to treat and manage the complex patient both in the community and within the VA setting.

Nationally, the five VA Centers of Excellence in Primary Care Education embarked on an ambitious endeavor; to train unique learners in an interprofessional setting. Our setting saw this as an opportunity to appreciate the myriad of changes uniquely facing nurse practitioners: new terminal degree, expressed role anxiety and concern about lack of preparation, increased patient complexity, and burnout. We developed a model of what we believe is the nation’s first nurse practitioner residency targeting post bachelors DNPs, and one that leverages established practices from medicine, pharmacy, and psychology. Because we are a site that trains learners for two plus years, we have the benefit of shaping new providers for an additional year with our residency. This affords us the opportunity to engage them as they define
themselves as leaders and define their clinical practice. As a VA center of excellence, we see this as an honor and use this time to develop our leaders by providing them with opportunities to engage in pre-clinical conferences, master grand rounds, TeamSTEPPS (a structured team building exercise), and other shared experiences before our residents enter the workforce. The final ultimate goal is to offer a robust multi-year experience for our doctorate of nurse practitioner leaders.

In summary, we believe that the DNP residency is emerging as one of the most important new educational developments in many years. Trainees may enter DNP residency with their highest priority focused on expanding clinic care skills and fund of knowledge, including clinical efficiency and organization, to enhance their readiness for future practice. We believe we have gone beyond those essential components of a residency. In our CoEPCE we are gaining tremendous insights into interprofessional education among trainees of diverse disciplines and varying background, education, even philosophical differences in approach to learning. DNP residents based at one site for a year are immersed in one setting, able to engage with medicine residents and other trainees in interprofessional collaboration. As DNP residents enhance their care practice and leadership abilities, they learn how to function as the provider leader of a primary care team, and how to do panel management to improve clinical performance and outcomes, all essential to a smooth transition to practice after education.

REFERENCES


Part 2: Acting Strategically to Innovate • Key Message 2: Nurses should achieve higher levels of education and training


Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
Chapter 16

Reframing Nursing's Leadership Role in Crafting New Partnerships

Anna Monnett and Linda Lake Boyle
When we first read the four key messages in the Institute of Medicine’s (IOM) report about the Future of Nursing, we felt some concern about Key Message #3, “Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States” (Institute of Medicine, 2011, p. 7). We had difficulty with the word “should”, as if nurses were not doing our part and we had better get busy? Were nurses somehow not collaborating and demonstrating collegiality? We both realized we were having cognitive dissonance because it was our conviction that in the Veterans Affairs (VA) healthcare system, nurses ARE full partners with ALL of our professional colleagues in designing healthcare services. We realized that perhaps we were taking for granted not only this special environment of practice, but also the culture that creates it.

Anna is the Associate Director for Patient/Nursing Services at the Dayton, Ohio VA medical center and Linda is the Associate Director for VA Office of Nursing Services at the Alaska VA healthcare system. Each of us has had experience with collaboration at all levels of the organization and within our communities. Both of us have served on the VA Office of Nursing Services National Nurse Executive Council and each of us has been asked to serve on national VA committees. As nurse leaders, a commonality we share is our love for nursing and for the care of our Veterans. And we both have always been outspoken and collaborative individuals who look for opportunities for nurses to shine.

In our current, complex healthcare environment, collaboration and coordination among healthcare professionals is critical to effectively manage the healthcare issues facing us as a nation (Stein-Parbury & Liaschenko, 2007). Such collaboration between nurses and physicians leads to improved patient care outcomes and patient care satisfaction. This collaboration and cooperation among disciplines provides for better patient care, and decreased patient morbidity and mortality (Nelson, King, & Brodine, 2008). Additional benefits include improved communication among healthcare workers, improved efficiency, improved understanding of the nursing role, and decreased patient length of stay (Dailey, Loeb, & Peterman, 2007).

Collaboration with other disciplines has been a hallmark of VA nursing. VA nurses understand that effective collaboration with clear communication leads to improvement in the quality of patient care (Nelson et al., 2008). When the VA policy document on case management was being rewritten by social work services, VA nurses provided input to assist in delineating the roles of the social worker and the registered nurse in accomplishing case management for complex patient care requirements. With the conversion of Veterans Health Administrations (VHA) primary care services into a medical
home model, called the Patient Aligned Care Team (PACT), nurses were involved at the national level as the model was being developed. Nurses were able to define how registered nurses, health technicians, and licensed practical nurses could do some of the work currently being done by primary care providers. By better using the competencies of all members of the team, each would be able to work at the top of their education and licensure. And as this new paradigm was disseminated to the field, nurses were at the forefront in the process of educating staff, working alongside the other healthcare disciplines. In each VA facility, the chief nurse was working with the chief of staff and associate director (role comparable to chief operating officer in the private sector) to ensure this new model of care was being appropriately disseminated and implemented.

The transition in VA healthcare today is one where we place a greater emphasis on preventive modalities of care, using the medical home model of the Patient Aligned Care Team (PACT), and shifting our focus from a medical care model to a Veteran-centric care model. In the Veteran-centric care model, the emphasis is no longer on the healthcare providers, asking the Veteran, “What is your health problem?” Instead the question to the Veteran is, “What really matters to you in your life?” This relationship-based care model is well suited to nursing. It focuses on the individual and explores how each illness or family change leads to a response that is unique to that individual.

As VHA executive leadership builds its model of care around the Veteran rather than the healthcare team, members of the various disciplines are involved in creating the vision that is being implemented within the system. Meeting this mandate requires collaboration among various VHA departments and among the disciplines to bring the vision to fruition. Key stakeholders realized the need to have nursing expertise as a driver in moving the organization forward. Central to nursing’s focus is an understanding of relational processes, of the uniqueness of each individual’s humanness, of the importance of care being holistic, designed to foster health (O’Connor, 2011). Nursing’s core focus is people, and how each individual responds to whatever diseases, emotional crises, or family issues are being experienced by that individual. Nurses bring coherence to all factors affecting the individual patient’s response to that current condition or situation. Nursing assures a human face in healthcare (O’Connor, 2011).

In order to provide guidance in implementing this paradigm shift, VHA offered all healthcare providers an opportunity to serve on their New Horizons Committee, a small cadre of individuals selected to meet with known private sector healthcare leaders who specialized in innovation. Several people from VHA field-based facilities were chosen based on
the short resumes each potential participant submitted to the national leadership. To be selected to serve on this committee was an honor and a privilege. Conferring with national leaders, the voice of the nurse was heard as the team worked on how to make this paradigm shift. Many of the ideas for collaboration, for Veteran-centric care practices, for moving away from a medical model to an integrative healthcare model, came from the various disciplines on the team. The idea that the Veteran should and would be in charge of his or her health began to resonate with participants.

Nurses who serve on VHA national committees serve as advocates for the individual Veteran. Nurses participate in shaping VHA health policy, ensuring that the Veteran’s voice is heeded. When others begin the discussion with prevention of illness as a top priority, nursing supports this while advocating for a holistic approach to Veteran care. Working with the VHA Office of Patient-centered Care and Cultural Transformation, nurses are collaborating on the National Veteran Experience committee and serving on several of the subcommittees aimed at education and training of staff and Veterans and developing new metrics for this work that is more relational based. At nursing’s core are the relational processes, knowledge and skills to provide the support Veterans need to overcome the obstacles they face, making it possible for them to get on with their lives. Nursing promotes health while recognizing that each individual has the right to self-determination (O’Connor, 2011). Because of this focus, nurses are able, while collaborating with other professionals, to point out that whatever is decided concerning metrics, patient care, preventive healthcare, and integrative healthcare, the Veteran must be at the center of the model. In discussions with Veterans concerning this change in focus, nurses have refined their understanding of where VHA is going and they laud VHA for making this transition. By carefully reviewing current directives, laws, and policies, members of the team can begin to point out those directives, laws and policies that do not promote a Veteran-centric healthcare experience and then work with national leadership to make changes as needed.

Collaboration and relationship building are influenced by the culture of the organization. Culture is the shared beliefs and values of a group – the customs, practices and social behavior of a particular people. We, the nurses of VA understand that our culture is unique. We have a mission driven healthcare system with paramilitary processes, funded by a discretionary, appropriated Congressional budget. Our facilities predominantly use an employed provider model. We are teaching and research giants. We are throughout the nation; there are a lot of us. We are well educated, connected, and powerful. We exercise an unusual amount of control over
our professional practice. We have a voice, both individually and collectively. Most importantly, we always have a plan.

So, functionally, how does this culture imprint on us as nurses? VA nurses are comfortable with communication and a high degree of visibility. It is not unusual for Presidential Cabinet level officials to visit our workplace, or for our RN leaders to testify before Congress. As staff nurses, we hone our emotional intelligence. We soberly reflect that each Veteran we care for took an oath to defend, even with his or her life, our rights and freedoms. It is more than a slogan that it is our privilege to serve those who have served; it is a way of being. Our culture produces experience, not just practice.

Wherever we work, we are a part of a dynamic continuum of care spanning age, periods of service, and gaps in bio-psycho-social-spiritual well-being, maximizing available resources to meet identified needs. We are called, every day, to a challenge of matching unknown demand to unknown supply, and while guidelines, protocols, policies and procedures are helpful, leadership and accumulated wisdom prevail. We are good followers, understanding that effective followership is an active role. Our affiliation to military culture imparts an expectation that leaders and followers are separate, but equal. Without skilled and experienced followers, leaders face serious limitations. We have established professional qualifications and standards for advancement, a rigorous, long standing process for peer review, and serve as agents of the Undersecretary for Health (top VHA official) in recommending appointment, retention and promotion of our colleagues.

We enjoy a high degree of interprofessional collegiality at all levels. Staff nurses are in cardio-pulmonary resuscitation class with physicians, or serve on performance improvement teams championed by the associate medical center director, or work with the engineering design team to improve our unit environment. RN managers serve on search committees to select professional colleagues in other services, or represent the local viewpoint at the Veterans Integrated Services Network (VISN) level. Nurses serve on the executive leadership team at our facilities, and represent their facilities in collaborative initiatives with university affiliates and local hospital associations. There are nurses in every kind of position, program, and service line at all levels of the organization. We do all of this in partnership with organized labor, with at least one and sometimes more than one union representing our staff. Finally, our culture demands that we, at every level of our organizations, be expert at making strategies operational to achieve effective, efficient, high quality outcomes for Veterans.

Reframing our role is the product of our comfort in both leading and being led. The Five Practices of Exemplary Leadership, commonly associated
with the Leadership Practices Inventory (Leadership Practices Inventory, n.d.), are second nature to our Chief Nursing Officer and her leadership team, who “model the way” at a national level. We are employed locally, but engaged nationally. Disjointed, incremental processes and decision-making are normative in national systems, yet we VA nurses flourish under a model structure of shared leadership through the National Nurse Executive Committee (NNEC).

We have a shared vision. Our national nursing strategic plan channels our hopes and dreams into real, specific actions and plans that challenge current thinking and processes. It was conceived in Crossing the Quality Chasm (Institute of Medicine, 2001), grew up to meet the key messages of the IOM report on the future of nursing (Institute of Medicine, 2011), and married the VHA vision of patient-centered care. Having a living plan with a past, present and future anchors us and enables us to act, managing people, processes and situations. Our national Office of Nursing Services (ONS) has exemplary team leaders and staff, who strengthen and empower us to act as we serve at the national, regional and local levels, leveraging the power of our plan to not just redesign, but design patient care services. Our hearts are encouraged by recognition like the Secretary’s Awards for Excellence in Nursing and rewards like the Annual Innovations in Nursing Practice competitions. We have a structured mentoring process, which provides leadership development within the context of existing relationships.

We know that VA, like most hierarchies and healthcare systems, is designed vertically, and we know that our patients and residents experience the system horizontally. However, our culture – our beliefs, values, customs, practices and social behaviors – prepare us to reframe our role, and when the time was right, we became leaders in crafting new partnerships to create patient-centered care.

As the healthcare landscape is changing, a new relationship is being forged. There is a strong correlation in the minds of both healthcare professionals and the public between the redesign of healthcare and the concepts of patient-centered care, and for VA that translates into Veteran-Centric Care. It is clear that there is a presumptive desired state for healthcare however the decisions about how to achieve that desired state rests with the individual patient and not the healthcare professional. The desired state presupposes open access to high quality, effective and efficient care, resulting in responding to what the Veteran has defined as important to him or her. In translating this into essential characteristics, as VA nurses we recognized that at its most basic level,
the delivery model would have to change to achieve the desired state. That state included:

- Access to quality care means clinically integrated,
- Effective and efficient means accountable,
- Good experience means Veteran centered.

We believe that the VA healthcare system does a better job than most at establishing *clinical integration*. We are both a provider and a payer, and have within the system the full continuum of services: primary care, specialty care, tertiary care, mental health care, residential treatment programs, extended care, home care, and even virtual care. We were an early adopter of the electronic medical record, which facilitates continuity and access. We have a national pharmaceutical formulary, an appetite for protocols, pathways and performance measurement, and built in collaboration mechanisms to spread best practices. Of course, because our mission is sacred, anytime the trust is broken and we fail in our coordination or care planning, it is noteworthy. However, the great majority of the time, we have excellent outcomes through clinically integrated care and services.

As VA began to focus on Veteran-centric care, the models that were being implemented in the delivery lines of the system describe the end state of the cultural transformation. Our nursing homes had become community living centers (CLC) and embraced cultural transformation. Mental health care was expanding to meet the demands of returning Veterans and employing the recovery model across its continuum. Mental health and social work services are increasingly being integrated into primary care, as an individual does not have discretely compartmentalized health challenges requiring “mental health care” or “primary care”. They are integrated. We were becoming leaders in the medical home concept through the Patient Aligned Care Team (PACT) delivery model in primary care. Within the inpatient services, the patient’s daily plan has been implemented, thus providing a partnership with the Veteran and the staff as care is planned.

It is much easier to measure effective and efficient care than it is to measure *accountable care*. At the national level, VHA is held to the highest standards, not only in the provision of care and its outcomes, but also for the use of resources and clinically and administratively ethical behavior. At the local level, our leadership colleagues, with us, certainly feel accountable for everything that does, might or could happen at our facilities. Yet, somehow, if everybody is accountable, the diffusion can lead to no one person clearly being held accountable. Reflecting about Donna Wright’s (2005) model for
Accountability in Organizations, we recognize that VA has no shortage of articulated expectations, assessments of quality improvement, responses, action plans and follow-ups, but, somehow, personal accountability, paramount to Veteran-centric care, is not always as readily evidenced. Effective and efficient care demands systems of accountability for staff at all levels, and a system of shared leadership and/or governance seems to us to be the key to matching responsibility to authority at all levels of the organization. We believe that any strategies for redesign of healthcare need to model this concept.

It is easy to see that a good health care experience is Veteran-Centric, and that a Veteran-Centric modality of care focuses on the Veteran’s perception of what is a good experience as a key outcome indicator. When hospitalized, the focus of providers can often be on the immediate needs rather than taking the time for a discussion concerning individual requirements. Yet, we know that even then the Veteran can be the driver of his or her healthcare moving toward next steps in that care. And if we had done a better job to begin with, the primary care provider and the teamlet would have had the discussion with the Veteran so that those needs and desires would have been evident in the record. Thus we continue to identify challenges in implementing our model, and places where we can improve our performance and the care of the Veterans we serve.

★ ★ ★ ★ ★

Anna’s Story

My journey into Veteran-centric, relationship-based care came when I read the book Relationship-Based Care: A Model for Transforming Practice, edited by Mary Koloroutis (2004). This book and the philosophy contained within it led to my local team’s transformation. It became their touchstone and changed their thinking. The team members remembered why they became nurses, and considered the possibilities of changing their daily practice to focus on the Veteran and the Veteran’s family and what was most important to them. We realized that this was the way to leverage our clinical integration, institute accountability and create the good experience with our care that we wanted our Veterans to experience and report.

We loved everything about implementing Relationship-Based Care (RBC), creating shared leadership, committing to co-workers, focusing on what we wanted more of, and creating a caring and healing environment, hoping to establish a primary delivery model for inpatient care. However, we were not
naïve; we knew that we would have to change for us to be successful. This would have to be a medical center-wide initiative and commitment.

I began developing the partnership with my colleagues, our chief operating officer (COO) and our chief of staff (COS), to make this shared nursing vision a shared medical center vision. With significant assistance from our colleague Susan Wessel at Creative Health Care Management, we agreed to collaborate to use RBC to create a culture that was Veteran centered, and implement a primary delivery model across our continuum of care. Essentially, we were “all in” for RBC as the overarching strategic plan for our medical center.

Meanwhile, our VISN as a whole was struggling with both patient and employee satisfaction, despite good outcomes in clinical and administrative performance measures. Again, the access to high quality, clinically integrated care was there, but the accountability and good experience was not at the level we sought. Being a Maslow (1954) fan, I thought about the hierarchy of needs. We were doing a great job of meeting biological and physiological needs as evidenced by excellent clinical outcomes, morbidity and mortality metrics, and external reviews. We had devoted many resources to safety needs, such as safe patient handling, the national patient safety goals, and physical security. However, our satisfaction scores were screaming that we were at a dead stand-still on moving up to belongingness and love, for both patients and employees. Many of our sister VISNs, as well as local private-sector healthcare system “competitors”, were instituting formal customer service programs, but I abhorred the idea that healthcare was a social or business transaction that could be scripted. The stage was set, but could the story unfold to a happy ending where there was a VISN vision for Veteran-centered care?

I am the chairperson of our VISN Strategic Planning and Analysis Council. This is somewhat non-traditional for VA to have a nurse executive chair a regional council, and is a reflection of the culture I am describing, where nurses actually do lead and shape planning and policy. I knew it was an opportunity for forging partnerships and leading change. Typically, strategic planning is about the healthcare planning model, actuarial data, potential construction solutions and plans for how to meet the national performance expectations. This particular year was different.

Our VISN Director, Jack Hetrick, challenged our council to use our strategic summit meeting to design a network wide unified approach to improving satisfaction. There was much discussion about the relationship between customer service and satisfaction and there were several models for customer service already in play at various facilities in the VISN. Our RBC journey at the Dayton, Ohio VA medical center afforded me the opportunity to distinguish between customer service and patient-centeredness. The most successful customer service
programs seemed to have been created for the hotel and resort industries. Their strategies came across somewhat disingenuous when applied to the healthcare setting, particularly when applied to inpatient services. It was safe to assume that our “customers” did not save up all year for a trip to the hospital and send postcards home to family. Scripted responses ring hollow for personal, healthcare transactions. “My pleasure” is not quite the right declaration after catheterization.

The dominant paradigm for the evaluation of the quality of healthcare is still structure, process and outcomes (Donabedian, 1966), but I was coming to understand that “culture eats structure for breakfast” and if we were really going to be a Veteran-centered organization, our “way of being” was going to have to change. I had developed partnerships with a diverse group of leaders who were serving as the planning committee for the strategic summit meeting. We had different backgrounds and perspectives (psychology, pharmacy, planning, administration, education), but a commonly held belief that identifying and meeting Veterans’ needs in real time at every interaction was likely the way to achieve improved satisfaction. We held divergent views about whether satisfied staff made for satisfied patients or if being a part of great care, evidenced by satisfied patients, was actually the key to staff satisfaction. We had spirited discussions about what the VISN wide model to achieve both goals should be, knowing that facility leaders were invested in their current customer service training and practices, and that primary care, mental health and CLC leaders had strong investments in their patient-centered delivery models, including PACT, recovery, and the established cultural transformation initiatives.

For us, however, Relationship Based Care was at the heart of the transformation we believed was possible, and was the overarching framework for designing our care and transforming our culture across the network. This was a tougher sell than it had been at the local level. For some, RBC was viewed as a “nursing thing”. Others struggled to understand how it directly related to improving patient and employee satisfaction scores, and how it could apply to every area and discipline of our organization.

After much discussion and analysis, the amazing partnership that comprised the planning committee produced an agenda for the Strategic Summit that eloquently demonstrated the potential value of having a shared leadership framework, a common language, and a commitment to appreciative inquiry and therapeutic relationships across our entire care delivery continuum. Clearly, the “good experience” was the outcome when engaged staff felt responsible and accountable for each caring interaction and were empowered to act in that manner. Attendees actually “got” that RBC was not an added structure or process to the delivery model, but rather a way of being while you were in the structure, doing the processes, which resulted in a caring and healing
environment where Veterans were the center of our practice and employees were satisfied to work. At the end of the summit, there was consensus among the interdisciplinary participants that we would enter into an agreement with Creative Health Care Management to implement Relationship Based Care as our VISN model for Veteran-centered care.

Looking back now, and assessing the impact of that decision, I can report that the culture at Dayton VA medical center really has changed. We are well underway to establish unit practice councils as the shared leadership structure for every department of the organization. We inoculate all of our new employees with an introduction to RBC, and refresh the spirits of our workforce with “Reigniting the Spirit of Caring” sessions. We have had two more strategic summits that have deepened our commitment to a Veteran-centered culture, and kept the RBC principles central to all of our strategic planning, goal setting and milestones. We are working to assure that we are self-sustaining as we strive now for personalized, pro-active Veteran-driven care.

★ ★ ★ ★ ★

**Linda’s Story**

Linda’s journey began many years ago when she left Philadelphia, Pennsylvania and joined the United States Air Force. Stationed in Alaska in the late nineties, she retired from active duty in 2001 and immediately returned to Alaska, the State she calls home. Alaska is a place where relationships are key to sustaining life. If someone’s car breaks down when it is minus 20 degrees fahrenheit, it would be a crime not to stop and help. Alaskans understand that and it is part of our culture to reach out and assist.

The horrific events of September 11, 2001 (“911”) drove home the concept of being dependent on each other. With no air traffic for several days, no supplies were delivered into the state. Each of the healthcare facilities in Alaska called the other facilities to determine medical supply levels and the possibility of shifting supplies if needed. It was understood that we only had each other to jointly meet Alaskans’ needs until the planes were allowed to fly again. Unsure of when the air traffic ban would be lifted, the Alaska VA staff ordered medications to be barged up from Seattle, Washington to ensure supplies would be forthcoming.

I tell this story only to drive home the fact that Alaskans recognize that we are often up here on our own and need to be collaborative with each other to meet joint needs. That collaboration is seen locally with the Federal Healthcare Partnership. This healthcare partnership has representatives from Department of Defense (DoD) services, VA, and the Alaska Native Tribal Health consortium.
By combining assets among the federal and tribal partners and through our Congressional delegation, the rural areas of Alaska are well connected through telemedicine. Further collaboration occurs based on partners’ needs.

Because we recognized that neither of our two facilities needed to create separate resources, our VA hospital has collaborated with the Air Force (USAF) and through that partnership have the only DoD/VA facility in the state, our shared intensive care unit (ICU) that is managed by VA in an USAF managed facility. The multi-service unit has VA nurses caring for patients that include pediatric patients, thus meeting our partners’ needs as well as our own. This joint venture is built on a policy of equal access for all beneficiaries to inpatient care and excess capacity for VA to outpatient services. Decisions to “make” rather than buy are made jointly, based on beneficiary needs and have led to several successful joint incentive funds that have given us increased capacity in both inpatient and outpatient services.

As a partnership, the joint venture is one that requires constant communication among the individuals involved and clear direction from the senior leadership. I, along with the VA chief of staff and associate director, evaluate potential sharing opportunities and work with the VA director to develop areas for collaboration with our DoD counterparts. DoD also identifies their needs and come to VA for potential sharing of resources. The DoD motto has been “how can we say yes—safely” and that drives joint decisions with each of us, determining if what is being proposed makes sense to jointly pursue. The success of this partnership has been lauded at the national levels of DoD and VA. When asked by our visitors how we make this joint venture work, we are quick to state: “it is all about relationships and mutual respect”.

We have additional partnerships with other DoD services. In Juneau, Alaska we have an outreach clinic co-located with the Coast Guard. In Fairbanks, Alaska we are part of the Bassett Army Hospital with the VA having one wing of the Army facility for our community based outpatient clinic. We use the Army laboratory, radiology, and pharmacy to provide direct care to our VA beneficiaries. The VA nurse manager in Juneau and the VA nurse manager in Fairbanks are the face of the VA. They work closely with these partners to provide care to our beneficiaries.

Partnerships have also been developed through 26 sharing agreements with our tribal partners. These sharing agreements permit us to pay for Veteran care provided by various tribal organizations in remote areas of Alaska. This care is not only for Alaska Native Veteran populations but also for other Veterans who live in remote areas of the state, many of which are off the road system. No longer do our Veterans need to travel to Anchorage for primary care. Now many of these Veterans living in extremely rural areas can use the medical facilities available for native beneficiaries. We have also used these partnerships to provide primary care
access for our Veterans in populated areas when we have had difficulty recruiting primary care providers.

Working with our national Office of Patient-centered Care and Cultural Transformation, I serve on the National Veteran Experience Committee (VEC) and several of the VEC’s subcommittees. The committee is truly a flat organization with each person being an equal partner in determining how best to change the VA culture to one that is more Veteran-centric. As the co-chair of the VEC Communications and Education Committee, I am able to provide nursing insight into the development of education and training of staff and Veterans. Another subcommittee of VEC with which I work is the Organizational Alignment Subcommittee. The emphasis of this subcommittee is on developing VHA metrics that are more focused on Veteran-centered care and a partnership between the Veteran and the healthcare system. At the VEC or in the subcommittees, I am able to be a voice of the nurse, and assist the groups in ensuring the conversation stays core to VA mission—Veteran-centric care where the Veteran is the center of his or her care.

During my service on the VHA Voices Steering Committee, I was able to provide insight into the Southcentral Foundation’s (SCF) Nuka System of Care in Anchorage, Alaska. This is a model of care that national VA leadership is interested in deploying. The model focuses on customer-driven, multidimensional wellness in relationship with Alaska Native people. Nuka is an Alaska Native word that means a strong, living, and large structure. It is a system built on relationships as the key to healthcare. In SCF’s Nuka System of Care, patient care is integrated, the patient is the customer-owner and patients and providers are partners in the health care provided (Trahant, 2010). It is a model many have taken note of because of its emphases on a team approach to healthcare, helping patients improve their quality of life, and a sincere effort to build personal relationships among providers, staff, patients, and the surrounding community. In addition, their outcome measures of disease management and customer and staff satisfaction are very positive.

The Alaska VA’s leadership team embraces these concepts and sees the relationship of SCF’s Nuka System of Care to the VA’s Patient Aligned Care Team (PACT) model. Through a grant from the VA Office of Patient-centered Care and Cultural Transformation, a structural change in how team members will work together is being initiated, working to mirror how the teams work together in SCF’s Nuka System of Care. The care team, consisting of the primary care provider, RN, LPN or health technician and medical support administrative staff will be collocated in shared space. In this same area will be the PACT social workers with dietitians and pharmacists close by. This removal of separate office walls will increase communication among team members with the focus on the Veteran-owner’s self-identified needs.
Key to this partnership is the role of the registered nurse (RN) as the care manager for patients assigned to the team. The RN collaborates with other team members while orchestrating each Veteran-owner’s care. Each team member is respected for what that team member brings to the dialogue. Each team member and Veteran-owner has a story. It is the individual’s story that helps staff to be in tune with what matters to the Veteran-owner and to the patient’s family. The team collaborates to surround the Veteran-owner and the Veteran’s family or significant others with the support needed depending on the circumstances and where, on the wellness continuum, each person lives.

Structural change cannot by itself change how teams work together. This requires a change in culture. To make this cultural shift, the Alaska VA Healthcare System partnered with SCF to provide staff training on the Nuka System of Care. Most of the staff from primary care and social and behavioral health spent a day with SCF Nuka Institute to learn why and how SCF made this transformation to include the structural change in the work space. This was to assist staff in understanding how by working together in shared space the Veteran’s care needs could be better coordinated.

In addition, the Alaska VA was selected as a pilot site for VHA Voices. VHA Voices is a cross-collaboration among the Director of Primary Care for Patient Care Services, the Office of Patient-centered Care and Cultural Transformation, the Director of Healthcare Talent Management and the Deputy Undersecretary for Informatics and Analytics. VHA Voices was adapted from SCF’s core concepts training and is built on relationships and staff understanding of the importance of storytelling. Through storytelling, each of us will have a better understanding of how our stories affect how we interact in life and with each other. Just as we have stories, so do our Veterans. By learning those stories, relationships are built that foster trust and open the door to honest communication. Through mutual respect, partnerships are strengthened.

The Alaska VA Healthcare System believes that the changes being made in how we conduct our business will greatly enhance our Veteran-owner and staff satisfaction. The key is being willing to take that first step. Our remoteness makes it easier to reach out, find alternative solutions, and use available partners. Our leadership team sees a clear vision that puts the Veteran in the center of his or her care surrounded by a team that works together to meet the Veteran-owner’s unique needs. We envision partnerships among our federal and tribal counterparts to be critical to our success. It really is all about relationships, collaboration, and mutual trust. Respecting cultural difference while seeking common ground has built solid collaborative relationships among the Alaska VA, federal partners and community partners.
Summary

A key concept of relationship-based care is demonstrated by the third key message of the Institute of Medicine (IOM) future of nursing report (2011). Nurses, acting as full partners with physicians and other healthcare professionals, are leveraging the power of relationships to redesign health care. We are strategically positioned to create movement, alignment and change in systems. Every chapter of this book demonstrates that we are leaders in partnering to create strategic responses – clinically, technically, academically, administratively, and culturally, across all healthcare settings.

We are problem solvers, solution finders and storytellers. We see, understand, and can provide context to the relationships among and between the services delivered, the people delivering them and the people to whom they are delivered. We agree that we should be full partners in redesigning healthcare in the United States, and assert that across VHA, we are modeling that desired future state. Nursing’s inclusion and engagement on the national steering committees that are driving this change demonstrate VHA’s commitment to seek collaboration with nursing and other disciplines to meet the needs of our Veteran population. Being a voice that understands relationships, that encompasses autonomy and collaboration with others (International Council of Nurses, 2010) while alleviating suffering by understanding the human response to changes in the health continuum (American Nurses Association, n.d.), nursing is both aiding and leading the VHA transformation of 21st century healthcare. The voice of the nurse will continue to be heard as VHA advances its healthcare model to be more integrated and built on what matters to the individual as it serves the Veteran.

REFERENCES


Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners


Chapter 16.1

Collaborative Partnerships:
The Key to Innovation and Increasing Standards of Care through New Models of Cooperation and Coordination

Lori Hoffman Hōgg and Christine Engstrom
In order to develop collaborative partnerships, elements of strong leadership, cultivation of novel networks and execution of common goals are paramount to successful outcomes. We believe that VA nursing leaders are at the forefront, with our interdisciplinary collaborative partners, in the development, implementation, and evaluation of transformational healthcare initiatives. We achieve this while also ensuring the projects developed can spread to other areas of practice, while creating sustainability of major healthcare initiatives that continue to transform patient-centric healthcare. The basic tenets of the nursing process, ingrained in nurses from our earliest academic and clinical work, follow us into practice making nurses highly reliable and engaged content and process experts.

Nurses are patient-centric, assessing the physical, psychosocial and spiritual domains within the patient’s entire environment. While often complex, we find that these areas are all linked. Nurses understand where true healing lies and recognize that the basic premise of practice is to care for others as they would if they could for themselves. This shared and collective expertise fits with many of the initiatives for ensuring high quality health care today. We are fortunate for the lifelong experiences from a number of academic and practice settings in our journey and are excited to be practicing in the largest integrated healthcare system in the country at this pivotal time in our history. As advanced practice nurses with national leadership responsibilities, we are afforded the opportunity to view healthcare at multiple vantage points. This extends from front line day-to-day “real world” experiences to national strategic planning and policy development for guidance on clinical practice to support our field-based operations and organizational priorities.

We are empowered by VA leadership to be a full partner, with physicians and other health professionals, in redesigning health care in the United States as outlined in the Institute of Medicine (IOM) report as a key recommendation in the need to transform leadership (IOM, 2011). We believe that VA is ahead of the curve in part due to the establishment and integration of advisory groups, further enhancing rapid bidirectional communications. Some may view government as a bureaucratic entity, while we’ve witnessed a very fluid and dynamic healthcare system that creates change quickly with clearly defined goals and metrics with measurable outcomes. We are thus able to continuously deploy new initiatives that improve our system through innovative models of care. Our story describes one such initiative designed to strengthen the standards of care for our Veterans.

The Veterans Health Administration (VHA) Cancer Care Collaborative is one of the innovative models of collaboration and coordination created, one
that we had the opportunity to help develop and implement. In this chapter we describe this collaborative. Lori served as a planning committee member and faculty and Chris was on the planning committee, served as faculty and team coach. The Cancer Care Collaborative focused on the timeliness and the reliability of cancer care, addressing timeliness from first evidence (i.e. positive chest x-ray or positive mammogram) to tissue diagnosis as well as timeliness from diagnosis to treatment for cancer care in VHA. Highly reliable systems, a major commitment of the collaborative, provided a focus for the appropriate evidence based treatment for those diagnosed with cancer. The Cancer Care Collaborative provided the mechanism to measure, analyze and implement changes to assure timely diagnosis and the timely initiation of evidence based treatment. The collaborative occurred over a three-year period. There were three generations or phases of collaborative teams with three to four learning sessions for each generation. Over the three-year period, a total of 60 multidisciplinary teams across the country joined together at various face-to-face or virtual sessions to focus on the timeliness and reliability of cancer care through collaboration and coordination.

As the largest integrated healthcare system in the US, VHA includes 152 hospitals and 827 outpatient clinics across the United States and its territories (National Center for Veterans Analysis and Statistics, 2013). Approximately 40,000 new cases of cancer are reported in the VA Central Cancer Registry annually (Zullig, et al, 2012). A recent study reported that more than 500,000 Veterans receiving care in VHA were cancer survivors (Moye, Schuster, Latini, & Naik, 2010). Our Cancer Care Collaborative committed to providing increased access to evidence based treatment for all our Veterans. The Collaborative set out to provide the mechanisms necessary to measure, analyze, and implement changes to our respective and collective system. These mechanisms allowed for spread to other cancer types and/or teams who could focus on the same cancer type but spread their best practices to other VA facilities within their Veterans Integrated Service Networks (VISN). In all efforts, our intent was to achieve sustainability. Once the Collaborative learning sessions were completed, teams continued to measure and sustain their gains.

Many VA nurses, along with our interdisciplinary team members, played key roles on these teams providing the voice of those who “do the work, know the work”. Nurses effectively participated with their teams and/or led changes for success. Overall, teams representing a myriad of medical, surgical, and subspecialty areas for many cancers not only met the aims set forth, but a number of quality advisory panels were also created and were instrumental in numerous outcomes achieved with products nationally.
disseminated. Advisory panels were developed by the teams in areas of interest that related to quality and extended beyond the initial aims of access and timeliness of care. Topics of the advisory panels included: Tumor Boards; Clinical Trials; Patient Education; Cancer Care Coordination/Nurse Navigation; Survivorship; Standard Order Sets and Progress Notes; Highly Reliable Handoff Communication between facilities; Chemotherapy; Make versus Buy Tools; Toolkits for various cancers including the Head and Neck Cancer Toolkit; Workload Capture for Metastatic Cancer through the Veterans Equitable Resource Allocation (VERA); Clinical Documentation; Chemotherapy Efficiency and Workload Capture.

Our Collaborative stemmed from previous VHA systems redesign projects and included multidisciplinary members and industrial engineers from the VHA Center for Applied Systems Engineering (VA-CASE). VA-CASE is comprised of interdisciplinary members of the Veterans Integrated Service Network - VISN 11 and Veterans Engineering Resource Center (VERC). They facilitate operational systems engineering. Advisory panels became an important aspect of the collaborative and were key focal areas of innovation, with the goal of raising the standard of care. VA nurses served as partners, collaborating in the development and testing of numerous patient care toolkits. These included toolkits focused on specific cancers such as lung, prostate, colorectal, and head & neck cancers, along with palliative care and cancer survivorship. Ellen Ballard, RN BSN OCN®, a collaborative nursing team member and valued member of the National VA Oncology Nursing Field Advisory Committee, led the co-development of the VHA Survivorship Special Interest Group with physician partner Dr. David Haggstrom. This diverse group continued to meet at the conclusion of the collaborative with their work culminating in the VHA National Cancer Survivorship Toolkit. This toolkit provides a collection of care improvement tools that target a specific problem, in this case cancer survivorship, and offer ready-to-use concrete innovations enabling care providers to address the challenges and survivorship issues that may emerge. Implementation of the toolkits improves care provision as substantiated by documented levels of performance in various quality indicators and timeliness measures. It also provides readily available resources for immediate application. Resource examples include order sets, patient education material, care coordination agreements among partnering services, flowcharts and team assessments. Patient confidentiality is secured by ensuring that protected components are on the VHA intranet located behind the VA firewall.

Quality indicators relate to diagnosis, staging, workup, treatment planning, treatment therapy and surveillance. Collecting the necessary
quality data is built into the toolkit ensuring an evaluation process. Specifically, the Survivorship Toolkit contains modules on care plans, treatment summaries, and models of care (including case studies) for implementation of Survivorship Clinics. As noted earlier, the VHA Center for Applied Systems Engineering (VA-CASE), an interdisciplinary Veterans Engineering Resource Center (VERC) provided the unique and instrumental partnership with the interdisciplinary teams for the collaborative and toolkit development. The industrial engineers partnered with teams and advisory groups to assist us with data, workflow, value stream mapping, and guiding groups through numerous cycles of tests of change through the Plan, Do, Study, Act (PDSA) model to effect and transform healthcare delivery and quality outcomes. Many healthcare systems look to implement systems redesign principles to create change, but this innovative use of expert industrial and operational system engineers with VA administrative and clinical partners were catalysts to rapid and effective sustainable change in our large healthcare system.

An example of nurse leaders creating a positive change through this collaborative process involves one of our teams from the West Haven, Connecticut VA. Laura Hunnibell, DNP, APRN, AOCN® and Clarice Humanick, APRN, FNP-BS, AOCNP®, along with their interdisciplinary team, implemented a Lung Nodule Taskforce with a dedicated Cancer Care Coordinator/Nurse navigation innovation to improve timeliness in lung cancer care. Implementing this role, in order to identify, expedite and track all new lung cancer patients from suspicion of cancer to definitive treatment enable this team, along with the systems redesign changes gleaned from the collaborative, is a proven recipe to achieve and sustain improved care for Veterans with lung cancer. Outcomes include earlier diagnosis of lung cancer at earlier stages of the disease. This is evidenced by 53% of Veterans being diagnosed at stages 1 and 2, a 20% improvement through a model for raising standards of care through lessons learned in the Cancer Care Collaborative and advisory panel development of the Cancer Care Coordinator/Nurse Navigator role specific to newly diagnosed lung cancer patients.

One of the most impactful aspects learned from these VA care improvements and one we continue to incorporate is that once access and timeliness to care is improved, and many of the initial aims are met, it is paramount to include the “voice of the customer”. To highlight this important aspect of our efforts, patients presented stories of their experiences during the collaborative sessions. Patients came to share their very poignant journey through our healthcare system, often commending VA for the wonderful care received, while providing examples of where we could further improve
with their thoughtful insights one would never know if not travelling on their unique path. For example, a patient and his wife told the story of their care during one of the most challenging times in their lives through a difficult course of complex head and neck cancer treatments. They told us that their journey was made easier by the improved systems within VA and the kind and compassionate care provided. Another patient, with colorectal cancer, also expressed appreciation for the expert care he received but shared his story about the human and often intangible obstacles not picked up by our technically advanced imaging, our procedures and a whole host of surgical and chemotherapeutic options we provide. Rather this Veteran, who worked in our system and knew and respected it well, shared a very tangible emotional challenge he experienced. VA staff members wanted to be helpful to him by encouraging inclusion of his parents in his journey for support. This Veteran initially agreed as he lived alone but shared with us that this burdened him more since his parents were elderly. He noted the effort it took for them to accompany him to treatments and observed he would rather endure treatments alone than burden them. The perception of experts could be misplaced if the focus is not patient-centric with shared decision making that is integral and tailored uniquely for each and every patient.

The long-term focus of VHA collaboratives is to emphasize the spread and sustainability of all our initiatives. Continuation of collaborative work continues to proceed across the VA enterprise. Lori is working with Colleen Walsh-Irwin, DNP, CCRN, ANP in co-directing the Surgical and Specialty Care Collaborative, along with surgical and specialty care physician leaders. Our goal is to create partnerships that establish the infrastructure necessary to improve access and efficiency of surgical and specialty care delivery. While this chapter has focused on the Cancer Care Collaborative, the model of creating new partnerships to improve the care of our Veterans continues to expand with nursing in leadership and membership and/or consultant roles across many of the VA national program offices. For example, Patient Care Services collaboration with National Oncology Program Director, Dr. Michael Kelley has been ongoing. This collaboration aids in a comprehensive perspective while developing national policy and guidance. Another example includes Lori’s work with the VHA Radiation Oncology group, led by National Program Director Dr. Michael Hagan and including representatives of all the disciplines associated with radiation oncology. Additionally, she participates in external collaborative work as a VA representative along with Dr. David Haggstrom to the National Cancer Institute’s (NCI) Quality Cancer Care Committee, a trans-governmental agency committee that ensures decisions about cancer services by the federal government are consistent with the best
scientific evidence available regarding quality outcomes. She is also invested in our VA Comprehensive End of Life Initiative led by National Program Director Dr. Scott Shreve. This initiative is focused on efforts to ensure reliable access to quality end of life care for Veterans and their families. Lori continues to work with the VHA National Center for Ethics in Healthcare as an advisory board member for implementation of the VA Life Sustaining Treatment Handbook. Within this initiative, nurses are key partners in advising and providing Veterans with information on life sustaining treatment options for seriously ill Veterans to ensure patient treatment preferences combined with honoring their decisions. Additionally, Chris and Lori have been appointed to the IOM: Chris, to the Committee on Best Practices; and Lori on the IOM’s National Cancer Policy Forum.

Our commitment to honor America’s Veterans by providing exceptional healthcare that improves their health and well-being cannot be accomplished without a strong focus on the Veteran’s experience and shared decision-making. VA nurses continue to ensure that the Veteran’s voice is heard. VA nurses are essential leaders in creating, implementing and evaluating innovative models of collaboration and coordination to further partnerships that redesign healthcare in the VA system.

REFERENCES


Chapter 16.2

Research and Evidence Based Practice for the Professional Nurse: Advancing Healthcare through Rigor and Partnerships

Margaret Gound
In 2008, Veterans Administration Nebraska-Western Iowa Health Care System’s (NWIHCS) nursing leadership, under the direction of Eileen Kingston, Associate Director of Patient Care and Chief Nursing Executive, recognized that nursing lacked a cohesive approach to the professional development of its nursing staff. It was a time of great introspection and excitement for the possibilities of nursing’s pursuit of excellence. We made a deliberate and collective decision through both nursing leadership and nursing staff to adopt the gold standard of practice and pursue Magnet designation. We also were committed to developing a more scholarly mindset among our nursing staff, a goal congruent with the Magnet journey.

A consultant was contracted to provide guidance and identify weaknesses through a gap analysis. One major deficit identified through this exercise was the lack of an established evidence based practice and research program. Nursing leadership decided to invest in a nurse researcher position in order to develop a program that would be aligned with the expectations of a Magnet facility. The candidate needed to have conducted original research and possess extensive experience in translating research findings into practice. I was selected for this position and this chapter tells the story of my work in that position.

In order to establish a comprehensive program, it was apparent we needed to reassess our present structure as it related to research and evidence based practice, professional development and collaboration with other disciplines and institutions. We wanted to create a new infrastructure and were determined it would be borne out of rigor. To this end, we set about determining which nursing theory would capture the culture we wanted to create and provide the theoretical underpinnings to achieve it. After interviewing Veterans, staff and the members of the Nurses Executive Board, we decided that Dr. Jean Watson would become NWIHCS’s nurse theorist. Her caring science theory became central to NWIHCS’s professional nursing model, which was subsequently developed, visually presented in Figure 16.2.1. The Nursing Research/ Evidence Based Practice Council developed a program to educate staff on this theory through presentations, articles and exposure of staff to Dr. Watson at conferences. Our focus at this time was nursing but soon a wonderful gift arrived. The NWIHCS was awarded a VHA $1.35M Improvement Capability Grant (ICG) entitled Creating A Systems Redesign Culture that I co-wrote and then co-directed with Gale M. Etherton, MD.

Medical school does not emphasize a theory of medicine and certainly not nursing theory. My physician grant co-director was open to learning about caring science and as we all became more familiar with Dr. Watson’s writings, we realized her theory transcended one discipline and is applicable
to many. We were able to invite Dr. Watson to speak at our facility, which she did in April 2011. Her presentations were inspiring. We held a reception in the evening that was attended by area deans, chief nursing officers, directors, faculty members and NWIHCS’s leadership. The feedback from this visit was so positive we decided to use grant funding to underwrite a three day Human Caring Program by Dr. Watson in January 2012. We held this program at the University of Nebraska Medical Center’s Sorrell Center. The event was opened to all disciplines and to Omaha Nebraska’s academic and medical facilities. All attendees, consisting of staff from NWIHCS, as well as faculty and staff from eight colleges and medical centers, embraced the program. Many disciplines were represented, including medicine, nursing, occupational therapy, nutrition, chaplain service and ethics.

Once the basic component of the new infrastructure for best practice, our nursing’s professional practice model, was created and disseminated, we realized that to fully integrate our model, we must strengthen our relationships with our academic partners in the community. Although
NWIHCS has been an academic medical center with educational ties to the major universities of University of Nebraska Medical Center and Creighton University for decades, only medicine had forged a mutually beneficial alliance with these institutions.

We in nursing, therefore set out to strengthen our alliance. Supported by the Associate Chief of Staff of Education, Dr. Joann Porter, we worked with these institutions to have their students conduct their clinical rotations in our facilities. Our nursing staff became preceptors to these students and their performance was observed by the clinical instructors from these institutions. As a result, several of our VA nurses were approached to become clinical instructors and received appointments at these local colleges. This has contributed greatly to the professional development of the VA nurses involved.

While addressing professional development, we also realized we could benefit from having nursing professors from area colleges come and assist me with educational classes and work with nursing staff on evidence based practice research projects. We now have three faculty members from Creighton University College of Nursing and the University of Nebraska Medical Center College of Nursing who work with staff as a 10% investment of their workload. Two of the nurses are doctorally prepared and one is near completion of her doctoral studies.

We have charged these professors to offer not only educational classes on research and evidence based practice but also to facilitate our nursing journal club. The nursing journal club presently has 44 members in Omaha. There are plans to expand the nursing journal club beyond Omaha and include the VA campuses of Lincoln and Grand Island. The journal club began solely in an online format. However, as staff moved towards implementation of projects, we shifted to a face-to-face format. The main focus of the journal club was to assist nurses in their ability to critique literature. Online discussions and educational materials were provided.

We believe that both the educational classes and nursing journal club are critical to the involvement of all nurses in research and evidence based practice independent of their credentials. The ongoing educational classes address such subjects as evidence based practice, research design, instruments and statistics for the non-statistician, change models and research issues and ethics. We also have staff spend time in our computer training room with our librarian so they learn how to access articles for their literature reviews. We teach the participating nurses about how engagement in research and evidence based practice activities can increase their professional development and opportunities for advancement. The journal club set the stage for our next investment in meeting our goals.
When we looked at establishing a comprehensive research and evidence based practice program, we knew we had to offer an in-depth learning opportunity for nurses. To meet this need, we developed a nursing research/evidence based practice fellowship that is supported by our associate director of patient care/chief nurse executive. This competitive fellowship is open to VA bachelor of science (BSN) prepared nurses who are then partnered with a master’s or doctorally prepared nurse mentor. The fellows are awarded eight hours of release time per month for twelve months to complete either a research study or an evidence based practice project that results in meaningful practice change. They attend five didactic classes.

We have had five fellows complete the fellowship. The completed projects varied from wound care (The Use of a Content Management Platform and Virtual Team Collaboration to Standardize Wound Care in Several VA Facilities), documentation (Catheter Associated Urinary Tract Infection Prevention in the Intensive Care Unit: An Evidence Based Approach), nurse residency program (The Development of a Nurse Residency Program) and the creation of a self-care sanctuary for nurses (Self Care Sanctuary). One project, An Evidence Based Approach to Central Line Care, realized a cost savings for our facility of over $220,000 in one year. All the fellows chose to conduct evidence based practice projects. The first two fellows have since gone on to complete independent research studies.

Concurrent with my VA position, I also served as both a preceptor and advisor to both doctoral and master’s students from several colleges. Their projects are conducted at NWIHCS and are aligned with needs of the facility and nursing’s strategic plan. This relationship has resulted in many final capstone projects that have been disseminated both locally and nationally. These scholarly projects have been mutually beneficial to all parties. NWIHCS has benefitted not only through the final outcomes of projects but also through the role modeling of doctoral and master’s students to our VA staff.

In order to assist all nurses in dissemination activities, I created an educational opportunity focused on development of poster presentations and, more recently introduced a Writer’s Circle for those who want to pursue publishing. In the past four years, nurses have presented 25 projects including both podium and poster sessions at local and national conferences. Their ability to present their work and network with other nursing professionals beyond the VA has widened their worldview and has generated new enthusiasm for practice change.

As nurses throughout the NWIHCS became more knowledgeable about evidenced based practice, they were able to contribute more fully to meaningful practice change. They became empowered to identify problems
and seek solutions that would enhance both patient and staff outcomes. They became more competent contributors to committees and were able, through their enhanced skills, to ensure that NWIHCS’ policies and procedures are both current and evidence based.

In May 2013, we held our First Nursing Evidence Based Practice and Caring Science Day. The keynote speaker was Dr. Suzy Harrington, the Director of Health, Safety and Wellness for the American Nurses Association (ANA). One of the areas she oversees for the ANA is the Safe Patient Handling and Mobility. NWIHCS has an outstanding Safe Patient Handling program that was developed under the direction of Ronda Fritz, a dynamic speaker who presented at the conference on her program. I was able to arrange for Dr. Harrington to stay beyond the conference and tour the NWIHCS facility and observe Ms. Fritz and her team. Dr. Harrington was so impressed with Ronda’s breadth of knowledge and the extent of implementation in this area, that she invited her to become part of ANA’s national rollout of its new Safe Patient Handling and Mobility Standards in June 2013.

In addition to contributions at conferences and implementation of evidence based practice projects, nurses at NWIHCS contribute to research in many capacities. They serve as principal investigators, research coordinators, research team members and as members of the Institutional Review Board (IRB). A random look at a database for NWIHCS’ annual Research Week in May 2013 demonstrated that nurses were involved in sixty-six research protocols.

As we focused on research and EBP, we were fortunate to have nursing staff who served on the institutional review board (IRB) where they interact with physicians and research scientists to review and critique research protocol submissions. Nursing has found great support from the Associate Chief of Staff of Research, Dr. Debra Romberger. In 2011, Dr. Romberger wanted to expand the Research Educational Enhancement Committee to include nursing, and invited me to become part of this committee. As a result, nursing now participates in the planning of weekly research seminars and its annual VA Research Week. We have had many notable nurses present at these seminars. The most recent presenter was Dr. Barbara Braden, developer of the Braden Scale for Predicting Pressure Ulcer Risk in February 2013. She presented to a packed room attended by research scientists, physicians and nurses.

The benefits to serving on the IRB led to another collaborative project. The IRB often receives requests for review of quality improvement and evidence based practice projects, clearly not research activities. They occur because the submitters erroneously think their work must receive the blessing of IRB in order to be published (Nerenz, Stoltz & Jordan, 2003). However, we realized that in 2009, the Office for Human Protections stated, “The intent to publish
is an insufficient criterion for determining whether a quality improvement activity involves research” and thus dispelled that notion (U.S. Department of Health and Humans Services Office for Human Research Protections, 2010). The subcommittee tasked Dr. Etherton and me, as co-directors of the ICG, to develop a process to provide guidance for submission to the IRB for these proposals. The project was entitled the Non-Research Determination Process to align it with the existing VA policy that identifies quality improvement and evidence based practice projects as non-research activities. We were able to achieve that goal and, in addition, provide a searchable registry for quality improvement (QI) and EBP projects. The project mimics the process of IRB with an initial and continuing review and its format is entirely online. (VA Nebraska-Western Iowa Health Care System, n.d.). We designed it for easy access, determination and tracking. This endeavor was piloted for six months and received full approval of the IRB subcommittee in September 2012.

The Improvement Capability Grant (ICG) also provided another avenue of collaboration for the VA. As co-directors of this grant, we crafted a memorandum of understanding with UNMC’s Michael F. Sorrell Center for Health Science Education. The grant underwrote the cost of a high fidelity mannequin known as SimMan3. We housed it at UNMC’s Sorrell Simulation Center. The facility has free use of this mannequin. In exchange, NWIHCS obtained free use of this state of the art simulation facility and benefitted from the expertise of its director.

We now conduct core competencies for nursing at this facility. In order to provide rigor and objectivity to the simulation experience, we obtained permission from Creighton University College of Nursing to use their Creighton Simulation Evaluation Instrument. Nurse educators complete training on the use of this tool prior to core competency evaluation. We designed the scenarios to focus on high risk, low volume situations nurses encounter such as displaced tracheotomy tubes. We have completed three years of core competencies through simulation. The director of the Sorrell Simulation Center, Patricia Carstens, and I co-authored a poster entitled Obtaining Core Competencies through Partnerships and presented it at a simulation conference in 2012 in Overland Park, Kansas.

In conclusion, the quest for nursing excellence, scholarly development of nurses, and Magnet designation provided the impetus for change and resulted in the establishment of a new infrastructure for best practice based on evidence. Our approach was methodical. It required introspection and the awareness of existing deficits. We identified a nursing theory that is compatible with the VA’s mission of patient-centered care. We established a system that now encourages autonomy and accountability for nurses’
professional growth in research and evidence based practice activities and we have provided the tools so nurses can be successful. We have enhanced the ability of members of the nursing procedures and policy committees to review and update related procedures and policies based on evidence. This infrastructure supported an advanced modality in obtaining core competencies. We have provided the educational strategies to involve nursing in the conduct of evidence based practice. By doing so, they have successfully completed and disseminated 25 projects.

Our strategies and experiences have shown that overcoming barriers and investing in the structure for research and evidenced-based practice supports the professional nurse to be a strong leader and improve patient outcomes. We achieved our goals, in great part, through our collaboration and partnerships with other disciplines, colleges and academic medical centers. We worked cooperatively with others to change our infrastructure and in doing so have broken down barriers that previously held us apart from the collective organization at NWIHCS. It is actually difficult at this place in time to visualize our research and evidence based practice program without our partnerships. These relationships have broadened our understanding of our greater community. They have enhanced our ability to contribute to our nursing profession and learn from professionals in a variety of disciplines. We are confident that our journey has served our nurses well. By nursing taking a leadership role in crafting new partnerships, we have heeded the Institute of Medicine’s message and are striving to become full partners with other disciplines and entities to redesign healthcare.

REFERENCES


Chapter 16.3

Sharing Governance: Decentralization of Nursing Decision-Making and Nurse Satisfaction

David Przestrzelski
Four days after receiving my bachelor’s degree in nursing, I started orientation at the same south Philly hospital in Pennsylvania where I had completed my final undergraduate clinical rotation. At 8:30 AM, the chief nursing officer came to the door of the classroom, motioned with her index finger to come to the door and, as I starting walking to the door, she stopped me saying, “No, bring your things.” She then told me that my head nurse had her gall bladder removed the night before and would be out for at least six weeks and that she needed me to be the RN on day shift until she returned. When I explained that I was not yet licensed, she explained that the RN on the adjacent ward, the Knife and Gun Club (yes, that was the name of the unit), would cover me as the licensed registered nurse. Fortunately, the nursing assistants and licensed practical nurse (LPN) on the unit knew me from my days as a student and worked well with me that week.

On Friday, Hattie, one of the senior nursing assistants, approached me and asked when they were all supposed to work the following week. Yes, the posted schedule for that week was the end of the schedule and the next week was Christmas. So, on Friday, December 19, 1975, I discovered the power of self-scheduling and, after covering the weekend, the staff of that unit sat with me and wrote the scheduling rules for all three shifts. When the head nurse came back in March, the eight subsequent weeks were already posted and the summer vacation schedule was started. When she challenged me, indicating that Hattie would call in sick with a six days on, two days off schedule, I pointed out that we only had three sick days other than hers used in the nine weeks she was away.

That experience taught me the power of group, the power of professionals and all clinical nursing staff coming together to do the right things at the right time on behalf of patients. After another private sector experience with less than stellar leadership, I proudly was commissioned as a U.S. Navy nurse. While very proud of my service and delighted that my greatest Navy benefit was meeting my wife of 35 years on my first day in Officer Indoctrination School in Newport, Rhode Island, I was again faced with leadership that failed to recognize the professionalism of the nurses they led. The autocratic style of leadership that we experienced in that post-Vietnam military era convinced me that management in nursing could be better than what I had seen so far in my career.

Committed to serving those who served, I transitioned to the VA at what was then the North Chicago, Illinois VA Medical Center. My first VA chief nurse was Kay Santorum who many saw in the 2012 Presidential campaign standing on stage beside her son, Rick. Mrs. Santorum always impressed me while scaring many others. When she made rounds, she made her nurses
feel like professionals, asking for a presentation of your patient, your plan of care, your reasons for the plan, the pathophysiology of the disease process, the medications he was taking and she asked us to teach her about the technology we were using in the intensive care unit (ICU). She asked us for our opinions and how she could support us. While some may not remember her as fondly, I was inspired by her leadership and connection with nurses at the bedside, inspired enough that I enrolled for my master’s in nursing administration at the University of Illinois so that I could make a difference in the culture of nursing leadership.

My thesis research, published later as “Decentralization; are nurses satisfied?” explored the impact of moving the locus of control of a professional practice environment to a collaborative decision-making process with nurses at the bedside. Exploring that impact on nurse satisfaction at four Chicago-area hospitals, the results solidified what I and others were finding in the early “80s”, specifically that well-educated nurses practicing in real patient environments could be trusted with decision-making capacity about more than the patients to whom they were assigned. Those nurses could create practice microsystems, could create process and measure outcomes, could ask the why questions that opened new doors in nursing research, could overcome severe nursing shortages and could create collaboration with physician colleagues that would move beyond subservience.

In my first position as a manager, I met my mentor, Margaret Thomas, at the Edward Hines VA Medical Center (Illinois), one of the first three black nurses in the VA. Her leadership style was exactly what I needed in my life to grow my own style. She gave me the room to grow that I wanted to give to those I would lead. She gave me room to excel and room to make mistakes and I did that very well. After growing for four years through four different roles, I went with her to the VA medical center in Indianapolis, Indiana and the invitation was unique. On her first day as the new nurse executive, she called to tell me that her associate chief decided that day to retire. She had a mess on her hands; she didn’t need anybody to take time to learn what she liked and what she didn’t and that the previous nurse executive told the head nurses they were decentralized and they should make their own decisions. Her predecessor had closed her office door and actually meant that the head nurses should make their own decisions. Despite her call coming only two weeks after the birth of my son, I followed this wild woman knowing that I would be able to share something special.

Shared governance, as Tim Porter-O’Grady described it, was lived and breathed for the next five years in Indy VA as we experimented, created and
grew a new generation of nurses well positioned to lead others to grow professionally. We were fortunate to have Dr. Angela Barron-McBride next door at Indiana University and Vernice Ferguson very actively present in Indy serving as President of Sigma Theta Tau International while the Center for Nursing Scholarship was being built just down the street.

My first VA nurse executive experience, in Tucson, Arizona, was a re-birth for me. After my first week in Tucson, I phoned my mentor with a question and she literally cut the cord saying, “I raised you to make your own way; you don’t need me anymore. You need your staff——use them to lead the way I used you. I have to get to a meeting. Bye.” What a great mentor! Many years after her retirement, I called her just to share good wishes and she again had to get to a meeting at the Ocala, Florida Regional Medical Center where she was coordinating three research studies and on the board of their Foundation. She had to get to a meeting and I knew that she did not want to risk telling me what to do.

For ten years in Tucson, I created opportunities for nurses to grow to their greatest level of accomplishment. I listened and learned from them. When VA nurses created the Tucson Nurses Week Foundation, now a 16-year legacy of a city-wide celebration of professionalism, when VA nurses grew our VA Learning Opportunity Residency (VALOR) program to be emulated to the extent that every rising senior nursing student in Tucson had a summer residency, when our nurses created a practice environment to garner the VA’s first pre-doctoral and post-doctoral nurse fellows, when a nurse with a BSN and a piece of qualitative research sat at a table with the four PhD-prepared nurse recipients of the first round of the Nursing Research Initiative, when a shy and humble Post-Anesthesia Care Unit staff nurse rose to the Presidency of the Nurses Organization of the VA (NOVA), I stood back and marveled at the power of getting out of the way and supporting great nurses to do great things.

Even with those accomplishments, I still sought a nursing organization in which nurses really felt professional ownership, the responsibility to build and sustain, the accountability to try and fail then try again and again, and succeed. I looked for structure and process that would finally bring problems and issues to the table with a complete analysis, a developed program solution, a cogent business plan, an equipment request with manufacturer quotes, a policy or procedure or protocol to codify, an education plan and a plan for sustainability. That dream has come to fruition in my eleven years at the VA medical center in Asheville, North Carolina. The shared governance structure we have created at the Charles George VA Medical Center is no different than the one we had in Indy or Tucson but people
take the structure to a new level. Blessed with many challenges on arrival, listening to staff, some who stayed and some who shared why they were leaving, allowed me to understand what had to be different this time to make our shared governance councils truly a source of professional growth and actualization.

Natalie, a passionate clinical nurse specialist who is now our Magnet® Coordinator, explored, during site visits and interviews, the processes developed at two other Magnet® designated VA’s in Atlanta, Georgia and Madison, Wisconsin. Natalie’s proposal was bold. Seriously, full day meetings every month for a nurse from every unit for practice, quality and professional development? That would be a tough sell but hearing the message and knowing the frustration of some brilliant nurses who were not able to foster their passion project through to completion convinced me that I had to support the effort.

Compromising on two of the three councils meeting full days and expanding the other councils to more than the one-hour meetings they had tried to productively manage, I have been astounded at the degree to which nurses have responsibly taken license to build and create. They have developed a new professional practice model, using the help of nurse theorist, Dr. Anne Boykin, who retired to Asheville just in time to support our nurses. That practice model includes a commitment to caring expressed in the model as a “Nursing Pledge to Our Veterans,” worthy of the public celebration they organized in January of 2013 for all our nurses to sign the pledge. They created new deep vein thrombosis prevention programs, new feeding tube placement processes, new central line processes, new systems for garnering questions for research, enrolled in the National Database of Nursing Quality Indicators (NDNQI), totally re-created a professional competency validation process, codified processes that were previously ill-defined, mutually recognized each other with the “Shining Lights” program and have drawn nurses throughout the facility into an enthusiasm for the next improvement project.

Why? While we are probably very close right now to being able to prepare our application for Magnet® designation, the ring is far less important than the journey we are enjoying. I know the nurses will tell me when they are ready for that application; it will not be my call. I will figure out the budget. I know that I already have the support of our leadership team and our regional/VISN Director who invited two nurse executives of VISN 6, my VISN, to share with him the efforts being made in shared governance and nurse satisfaction. The real outcome for me that has made shared governance worth the investment, worth the listening, worth the
balance between self-governance and shared governance, worth the conflict that changing management styles engenders, are the results we have seen in patient satisfaction with their care experience at our medical center and, just as important, the incredible improvements in nurse satisfaction that we have seen in the last two year in VA Nursing Outcomes Database (VANOD) RN Satisfaction scores. I thank the “co-authors”, those who with me created this story, for their influence on our success in this journey of professional realization.

REFERENCE

Chapter 16.4

A Pledge to Our Veterans

Julie Azar, Sabrina Thomas and Natalie Parce
In June of 2011 the nursing shared governance structure for the Charles George VA Medical Center (CGVAMC) in Asheville, North Carolina was formed. This represented a rebirth and organizational commitment to the engagement of nursing staff in defining, leading and further developing nursing practice.

One of the first challenges presented to our newly created Professional Practice Council (PPC) was to establish a professional practice model (PPM) for our facility. There was already pressure to achieve our goals and assure administration and executive leaders that the councils were worth the expense and scheduling challenge of allowing staff nurse members to meet for one full day each month. This task felt daunting to all members but especially to the co-chairs for the council, Julie Azar and Sabrina Thomas.

We as a council could not grasp the concept of a model, in part, because we couldn’t envision the relevance it would have to direct Veteran care. Why did we need a model to tell us how to care for Veterans? We were nurses. We knew how to care for our patients. How could this improve practice? Heather McCloy compiled nursing models from several theorists and presented them to the council. We discussed the theories, reviewed the diagrams and deliberated. We looked at the models and tried taking what we liked from each one and tried to blend it into something that was ours. Shelley Wheeler stressed the point that it just didn’t seem to fit. It just wasn’t working. The question that kept arising was, “How does this really impact our care? How will this make a difference?” Without an answer, we pressed on.

Most PPMs are based on a published nursing theory or perhaps even a combination of two theories. We soon became overwhelmed at the diversity and appeal of them all. Because we were only representatives from our larger groups, we did not even feel confident in recommending theories developed by Orem over Watson, for example. We viewed power points and had probing discussions. We wanted our PPM to be our own. We wanted the work that came out of our council to be done with intention.

One of the turning points in our journey was the discovery that Dr. Anne Boykin, who authored the “Nursing as Caring” theory, had recently retired right here in Asheville (Boykin & Schoenhofer, 1993). The premise of her model was defining how nurses illustrate caring in their everyday practice. Dave Przestrzelski, our Associate Director of Patient Care Services, had already talked with Dr. Boykin and suggested that we invite her to our meetings for insight and direction for our model. Sabrina
Thomas made the contact, explained our dilemma and asked if she would be willing to assist. Lucky for us, she generously agreed.

At the first meeting she attended, we explained our roadblocks and how we were basically stuck. It didn’t feel genuine to just adopt a model and move on. We wanted something that was our own. She talked to us for a long time about caring and the importance of telling our own stories. She encouraged us to compile these stories and assured us that it would come together. She did write a description of the concept of Nursing as Caring, which utilizes Mayeroff’s work defining the different ways that nurses illustrate caring (Mayeroff, 1990). We sent the written description of the Nursing as Caring to all nurses and encouraged them to submit their stories of caring to us.

While Dr. Boykin was inspiring when speaking to the council, the email we sent out did not inspire much feedback from our peers. One important factor in this process was that our group dynamic was already evolving. By the time we sent the email that presented Dr. Boykin’s words and our request for stories, we had grown closer as a group and more comfortable working with each other, being honest with our feelings, and feeling free to speak openly. Also, our group was becoming defined as a group of hard-working, smart nurses that liked to “get things done”. It was the meeting after we sent the request for stories that it was suggested by Natalie Parce, our shared governance coordinator, that we not use an established nursing theory or theorist’s ideas, but rather create our own.

As we began to speak about our dedication to service, everyone contributed certain concepts and thoughts about OUR story. We felt the nurses at our facility all share a true dedication to the service of our Veteran population. The Veterans that come to the Charles George VA truly are a special group of people. These are men and women mostly from rural backgrounds with multiple co-morbidity. They are a very dedicated, independent, and strong-willed group of individuals who have served our country with their bodies and souls. As a group, the Practice Council members felt like our PPM had to incorporate our specific desire to serve these special people.

In a moment of inspiration, one of our members, Matthew Dickens, said, “Why don’t we just make a pledge to our Veterans?”. He was passionate about his idea. The talking stopped and we just sat there and listened. That was when everything changed. We believed. We really believed that we could write something that was meaningful and centered on caring for Veterans. It mattered now that we do this. We were motivated and energized to make it happen. Matt provided a draft of his vision and along with the input from
other members and our collective tweaking, we wrote the final version which included our pledge as a separate component of our model. This pledge became the cornerstone of our PPM. While it is not attached to a published nursing theory, it captures our version of “Nursing as Caring” specifically for OUR Veterans and it is attached to the hearts and spirits of the nurses at CGVAMC. The pledge is presented visually in Figure 16.4.1.

**Figure 16.4.1 Charles George VA Medical Center Nursing Pledge to Our Veterans**

We pledge to be part of your unit or team, working toward the goal of getting you the help that you need in order to achieve your healthcare goals.

We respect the sacrifices you made in service to our Country, and we pledge to treat you, your family, and each other with the respect, compassion, and trust that we all deserve.

We pledge to treat you as an entire person, not a bundle of diagnoses. We will listen to you in order to understand your concerns and needs.

We pledge to honor, respect and support your choices.

We pledge to advocate for you when you have a voice and when you have none.

We pledge to work with you as part of your care team to provide safe, competent care and earn your trust.

We pledge to consult with you, your family, your Doctor and the Clinical staff to get you the tools and assistance you need to meet your healthcare needs.

We pledge to work to better ourselves by furthering our education and professional development in order to provide you the highest quality of healthcare possible.

After approval by the CGVAMC Nurse Executive Council and because this model was so unique, the council felt strongly that there should be a public roll out presenting the model to all staff and the Veterans themselves.
Sabrina Thomas found a graphic designer who designed a beautiful printout of our pledge. Our Medical Center Director, Cynthia Breyfogle, and our Nurse Executive, Dave Przestrzelski, presented the model in a public area of the hospital. The final speaker was Matthew Dickens who read the entire Pledge to Veterans, which was an emotional and meaningful conclusion to our journey of creation.

At the same time, it continued the journey of caring for our Veterans for all of us. All nurses were then invited to sign the pledge in front of our Veterans to emphasize the significance of our promise to them. Framed copies are displayed in all of our nursing areas signed by the nurses who practice on that unit not only as a reminder to us but as a public display to our Veterans and their families of our caring promise, our pledge to them.

REFERENCES


Chapter 17

Creating Innovative Models of Nursing Care

Suzanne Thorne-Odem, Christine Engstrom, Evelyn Sommers and Amy Daly
Introduction: Defining Nursing Innovation

According to Everett Rogers, innovation is defined as “an idea, practice, or object that is perceived as new by an individual or another unit of adoption” (Rogers, 2003, p. 137). Diffusion of such innovation is a process by which an innovation is communicated through certain channels over time among the members of a social system (Rogers, 2003, p. 5).

Models and practices of nursing care contribute to the environment that serves as a context for nursing care. In Veterans Health Administration (VHA), we want to ensure such models enhance and empower our Veteran patients and smooth operations for us and for our interprofessional partners as we work together. To do this, we use a variety of approaches: grass roots recognition through the Office of Nursing Services’ (ONS) annual Innovation Awards, projects in the National Nursing Strategic Plan to address VHA priorities, and community and culture transformation for effective diffusion and open dialogue. As thirty percent of the VHA workforce, we nurses contribute to the fabric that is the social system of VA, and together we have and are still actively forming channels using shared governance for sustaining and spreading our collective efforts.

In this chapter, we will describe processes that showcase nurses’ strengths, the application of national initiatives to create, reinvent, and streamline existing models, and the organizational communication nurses employ to continue global professional growth. Such a philosophy spreads from the macro level discussed in this chapter to the micro level of individual healthcare systems and individual nurses. The process of engaging coordinated, patient-driven care is demonstrated across the continuum through transitional care coordination post-discharge and tailoring care plans to meet patient needs. Exemplars also highlight the process of innovative model development and transformational change, and the impact any one of us can have by transforming our own practice and the system where we work. These illustrate how empowered nurses enhance patient care by advancing the progression of innovation development and diffusion. While we do not exhaust the many innovations we have collectively implemented, we have tried to provide a sampling of our efforts and their impact on Veterans’ health care.

We have all contributed to the nursing innovations described in this chapter. Chris, Suzy and Evelyn provide the ONS leadership perspective in developing, implementing, and evaluating nursing innovations. Amy provides the staff nurse perspective, as a key individual leading and
implementing a national innovation, utilizing the talent of staff nurses from a variety of VHA medical centers across the country.

Recognizing Innovative Nurses

To nurture nursing innovation, in 2003 the ONS initiated the Innovation Awards program. These awards give recognition to nurses who create and implement nurse-led interdisciplinary system improvements. The awards emphasize recipients’ initiatives that contribute to VHA becoming a high reliability organization. We notice how bedside care can be improved and take the initiative to create solutions to benefit our patients. To reward those with this perspective and drive, for the past ten years, the Office of Nursing Services has annually recognized ten nurse-led teams with an Innovation Award.

For several years, ONS showcased the awardees at a national conference attended by all of the chief medical and nursing officers within the VHA. Projects focused on a variety of topics including improved communication among teams through huddles, creation of new forward-thinking nursing roles and models (e.g., Clinical Nurse Leader candidate roles, and nurse management of heparin), application of technology in new ways (e.g., tele-dermatology), and improvements in patient flow processes (e.g., advanced clinic access). When our budget could no longer accommodate such national meetings, we moved our showcasing to other modalities such as external trade conferences and virtual teleconferencing. No matter the venue, nurses were excited to participate in learning from each other and discussing their work to foster a community.

The Innovation Awards program did more than showcase successful VHA practices. The awards program gave nurses an opportunity to showcase their work beyond the bedside. We mentored each other to grow professionally. Nurses continued to present their work in posters at external professional conferences, conducted webinars, and published work in professional journals. Nurses who won innovation awards even created manuscript trainings, so other nurses could follow in their footsteps and publish information about their innovation. After nurses won innovation awards, some had their work recognized by the Under Secretary for Health (the top VHA system executive) through creation of national VHA initiatives such as elimination of methicillin-resistant staphylococcus aureus (MRSA) infections and development of tools designed to reduce patient falls. ONS created national workgroups from award-winning topics in pain management and implemented national initiatives from winning projects regarding pressure
ulcers. Finally, several nurses who received innovation awards progressed in their leadership career to become nurse executives, who continued to foster innovation and growth in their staff.

**ONS National Initiatives**

**New Models of Care**

In 2009, through a variety of initiatives, VHA invested in changes designed to transform our healthcare system, including primary and specialty care. One dimension of this transformation was shaped by the VHA commitment to providing healthcare to Veterans using the “medical home” approach for the delivery of primary care services and the “medical home neighborhood” for the delivery of specialty care services. In the delivery of care using this new model, VA called the Patient Aligned Care Team (PACT), VHA mandated care be provided by a team, as a team. The definition of what it is to provide health-supporting services in a team model continues to evolve to fit Veteran-centered service delivery. The specialty care services redesign provided a significant opportunity for VHA nurses to improve Veterans’ transitions between specialty care and primary care.

Frontline VA nurses were involved in these national initiatives from the beginning by serving as subject matter experts in decision-making processes. They determined the type of work nurses should accomplish on the team. They emerged as leaders, showcasing their best practices on national calls and assisting national nursing experts with education and training. In specialty care, nurses worked to develop smooth consultation practices and developed training to assist nurses in assuming the role of Patient Aligned Care Team (PACT) RN care managers. They continue to examine evidence, make differences locally, and use their lessons to create national change.

VA nurses have utilized available evidence, as well as current practice to illustrate the difference nurses can make in specialty practice, resulting in new models of care. Advanced practice registered nurses (APRNs) have demonstrated positive outcomes in heart failure (HF), spine, and endoscopic practices. Through APRN practice, HF patients had significantly fewer HF and all-cause admissions after one year, as well as, lower mortality rates after both one and two years (Lowery, et al, 2010). APRNs demonstrated a consistently lower twelve-week wait time for spine consultation clinic compared to 10-52 week waits in conventional clinics, while their diagnosis was 100 percent in agreement and treatment was 95 percent in
agreement with surgeons, with patient satisfaction at 97 percent (Sarro, Rampersaud, & Lewis, 2010). Nurse endoscopists who trained with GI fellows in 150 colonoscopy procedures, demonstrated cecal intubation rates of ten minutes with equally high satisfaction as compared to GI fellows (Koornstra, Corporaal, Giezen-Beintema, De Vries, & Van Dullemen, 2009). Their unassisted cecal intubation rates grew from 80 percent in the first 25 procedures to 96 percent in the last 25 procedures (Koornstra, et al, 2009). Evidence like this provides opportunities for us as VA nurses to examine our current practices and explore opportunities for applications within the VHA, improving the care provided to our Veterans.

Our VA APRNs, taking lessons from such successes and extending the concept of APRN-run clinics, created programs to effectively manage complex patient populations. We work as integral members of the VA team to implement evidence based care, resulting in quality patient outcomes. APRNs manage erectile dysfunction clinics, heart failure and hepatitis C clinics, as well as, effectively performing colonoscopies.

RNs provide care coordination and care management, assisting in clinic efficiency by coordinating group visits. RNs are the first point of contact within their PACT and provide care using protocols for stable chronically ill patients. Certified diabetes educator RNs are coordinating team care for diabetic patients, including shared medical appointments. Licensed practical nurses (LPNs), trained to provide nail care for diabetic patients, complement the roles of the APRNs and RNs on the team, fulfilling diabetic Veterans’ needs. Each role meets a different need to ensure maximum efficiency. VA nurses are improving care across specialties by improving access, managing care, and redesigning practices to be optimally effective.

Specialty Care Collaborative

Another approach VA nurses used to help implement and spread care improvements is through an interprofessional approach called a specialty and surgical care collaborative. VA staff from the VHA High Reliability Systems Redesign and Specialty Care Services designed this collaborative, adapting the Institute for Healthcare Improvement’s (IHI) model (Institute of Healthcare Improvement, 2009) to fit the VHA approaches. In this model, groups of front line staff members engage as improvement teams over a period of six to twelve months. All of the teams focus on the same aims while adapting them to their specific site with individualized improvement targets, specialty care areas and quality indicators. The overarching aims are to improve access, redesign practice for increased efficiency and improve care coordination. The teams participate in a set of required meetings that
provide them with evidence, suggestions for strong practices, measurement tools to use for data collection, and time for open discussion. The combined focus on aims, group interaction and support are thought to be critical for success. For this specialty care collaborative, the teams’ members were to include APRNs, RNs, LPNs and unlicensed nursing staff.

The teams examined the current practice of nursing staff, while also receiving strong evidence based practice recommendations for change to maximize the contribution of nursing to achievement of the aims. A specific outcome included incorporation of chronic disease management interventions for dually managed specialty and primary care patients. These patients, who in the past had care only from their primary care provider, often without any focused specialty care, now became part of the care responsibilities of the RN team member. The RN team member role also expanded to providing the management of the transition back to primary care, after a period of specialty care management. On most teams, the APRN staff provided autonomous care to these specialty care population. At those sites not fully functioning at this level, we provided presentations and tool kits to help spread this practice more uniformly, making it possible for additional sites to expand care to these Veterans. Incredibly, as we observed this process unfold, the teams changed from the experience, not only in the achievement of the aims, but in the advancement of the nursing role in specialty care.

Innovative Approaches for the Care of High-Risk Populations

We have also been able to implement nursing innovations designed to address the unique needs of our high-risk patient populations. These innovations expanded and enhanced care both at various individual facilities, as well as through national initiatives. We have described here some examples including care for homeless Veterans, and Veterans with mental health conditions.

Homeless Veterans

VA nurses have evolved in their care for homeless Veterans over the past ten years. We first recognized an exemplar site addressing the needs of this high-risk population in the ONS Innovation Awards in 2006. The innovation involved embedding primary care for homeless Veterans with Veterans seeking mental health care, thus serving both populations. This exemplar VA clinic was managed by a nurse practitioner, with support from nursing
staff, and consultation services from clinical nurse specialists (CNSs). In their Innovation Award submission, the nurses noted opportunities they could capitalize upon in their patient care situation. The short distance between the clinic and emergency department (ED), where homeless Veterans sought care, made it possible to create a collaborative patient care approach, utilizing clinical staff and outreach workers to deliver more efficient care to homeless Veterans on the streets. It was their hope that using these opportunities, they could bring these homeless Veterans into the clinic and transition them to additional services.

Since winning a 2006 ONS Innovation Award, the team expanded their services for homeless Veterans, partnering with interprofessional staff to embed a Homeless Patient Aligned Care Team (H-PACT) in the ED, with evening hours. In addition, they initiated a Homeless Assertive Community Treatment Team (H-ACT) delivering street care with a nurse practitioner, social worker, psychologist and a skilled outreach worker network. The H-PACT and H-ACT teams are valuable, and have been able to extend the continuum of services to homeless Veterans. The teams are now considered experts in the delivery of homeless care through these new models, and continue to reinvent service delivery for this population.

These nurses and others are now forming a community of practice to share experiences and to create helpful products and training tools for other nurses who wish to expand their care programs to include outreach to homeless Veterans. Collaborating nurse educators and nurse researchers further enhance their efforts, all sharing their work with interprofessional staff members from a variety of disciplines. Thus, these nurses were able to take their local innovations and transform them into an initiative that can be disseminated and then sustained at a national level.

**Mental Health Patients**

The mental health nurse has a unique relationship with the patient, providing care and bridging relationships between the patient, the treatment team members, and other patients (Deacon & Fairhurst, 2008). The mental health nurse is best positioned to develop and utilize a therapeutic relationship with the patient, facilitating recovery and transition outside the hospital. In today’s care environment, staff nurses often have difficulty developing a therapeutic relationship with patients due to conflicting priorities (Deacon & Fairhurst, 2008). The revised American Nurses Association (ANA) Psychiatric Mental Health Nursing: Scope and Standards of Practice (2007) has affirmed the nurse’s roles of patient educator and manager of the therapeutic milieu. For nurses seeking American Nursing
Credentialing Center (ANCC) certification as a psychiatric nurse generalist, knowledge and application of group process is required.

In 2009, the ONS Mental Health Field Advisory Committee (FAC) members identified a specific concern about a potential gap in staff nurse competencies. They questioned whether staff nurses had the knowledge and skills necessary to lead patient groups on mental health inpatient units, although this is a common expectation. In an effort to improve care to mental health patients, they decided to develop a guide designed to teach staff nurses how to lead patient groups in an effective manner.

Over the course of two years, workgroup members completed a literature review and developed six evidence based modules which included information on conceptual frameworks, group process and dynamics, group leadership, conflict management, group techniques, as well as, implementation and evaluation. A toolkit was also developed and included group examples, RN competency forms, pre/post-tests, and group evaluation forms for participants. In 2011, this product was completed and ready for piloting.

In 2012, nearly 200 participants, representing 23 inpatient mental health units at various VA facilities across the country, volunteered to participate in a pilot regarding use of this guide. Following completion of this pilot, we made content revisions based on RN input from front line staff. Each facility received bound copies of the guide, Leading Psycho-educational Groups: The Nurses’ Role (2011) for use by mental health inpatient staff. Currently, this guide remains on the ONS internal website for staff use. The ONS mental health FAC is preparing to begin a content update, with expansion for use by nurses in outpatient mental health services. With this innovation, staff nurses were given access to the resources they needed to expand their competencies and improve the care they provided.

Shared Governance as an Innovation in VA Nursing

The Institute of Medicine (IOM) report titled The Future of Nursing: Leading Change, Advancing Health promotes the efficient use of resources and enhanced workforce development to coincide with an ever-changing healthcare environment (Institute of Medicine, 2010). The ONS, congruent with the IOM promotion, embraced the implementation of a shared governance structure. ONS integrated this professional practice governance model into the clinical practice work stream portfolio as a vehicle to establish evidence based practice, standardize professional practice and policy, share knowledge, and measure outcomes of success as defined through the
ONS VHA National Nursing Strategic Plan for 2013-2018. The integration of this system-wide shared governance structure encourages the transition of intentional ideas into actual measurable outcomes through power and transformational leadership (Burkman, Sellers, Rowder, & Batcheller, 2012).

ONS has empowered nursing professionals across the country through this practice model which has had a direct impact on the improved quality and safety of patient care, containment of overall costs and retention of nursing staff (Barden, Quinn, Donahue, & Fitzpatrick, 2011; Kear, Duncan, Fansler & Hunt, 2012; Hoying & Allen, 2011). As the largest healthcare organization in the country, VA, through this professional practice model, has provided flexibility to adapt to the increased complexity of patient care needs across the entire continuum of care; including but not limited to primary and specialty care, telehealth, women’s health, homeless Veterans, and geriatrics/extended care (Burkham et al, 2012). We have described below two examples of the shared governance creation process as an innovative force: the Clinical Practice Program and the National Nursing Practice Council (NNPC).

Clinical Practice Program

The Clinical Practice Program (CPP) is the name we use to identify a group of specialty care field advisory committees (FAC) composed of RNs from in the field, with various nursing roles and levels of education. Currently, this program is comprised of FACs from ten specialties, targeting high-risk Veteran populations.

The evolution of the clinical practice program began in the spring of 2008. As members of the ONS leadership, we wrote an executive decision memo (EDM) to the VHA Under Secretary for Health (USH) outlining our proposal to implement a nursing practice program, with the identification of six potential options. Our recommended option included the implementation of a formally structured, nationally funded ONS clinical practice program to include nursing representation for all national clinical program initiatives. We had stated that this option would produce the anticipated outcomes of: (a) standardization of nursing practice and coordinated advisory processes for other program office initiatives; (b) spread of nursing innovations within the VHA and other VA healthcare facilities; (c) dissemination of best nursing practices aligned with strategic initiatives; (d) assistance in the development of metrics that complement national performance measures and monitors; (e) development and evaluation of nursing sensitive indicators, care paths, and evidenced based standards; and (f) proactive strategic focus on clinical nursing practice. The
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

National Leadership Board (NLB) and the USH approved this funded proposal in 2008.

The first seven field advisory committees mirrored, in their clinical focus, existing physician-based field advisory committees in other national VHA program offices. A clinical nurse advisor (CNA) was appointed to each of the seven FACs, which included nursing practice in oncology, geriatrics and extended care, mental health, perioperative, polytrauma, metabolic syndrome and diabetes, and cardiology. The first CNAs were selected from experts that were already currently working in the ONS due to both their practice expertise and their knowledge of our national change management practices that we would want to implement in order to ensure the growth of the program. Following their terms in the CNA role, the ONS leaders asked others in the field to be appointed to the role to ensure the professional growth of field-based nurses and to facilitate succession planning.

We used a rigorous process to select CNAs from a variety of nursing experts in VA facilities across the country. This same process was utilized by CNAs to select members for their FAC, ensuring representation from all roles and educational backgrounds, within each specialty. Thus, the clinical practice program became a reality, with front line nurses providing national guidance on practice issues, while supporting field-based operations and promoting organizational priorities.

The current administrative structure of the program consists of the clinical practice program manager, a program assistant, all of the clinical nurse advisors and the FAC membership. Each of these positions is managed as a virtual ONS staff member, with individuals’ time investment ranging from 1.0 full time to 0.25 positions. The ONS director for clinical practice, whose authority encompasses a portfolio of programs and projects including the CPP, serves as an executive sponsor and champion of the program while a health system specialist provides project management expertise and administrative operational support.

During the first year of the program, it was evident to us that we needed to expand the CPP in some areas where significant clinical issues were emerging. As a result, work groups were initiated in the areas of sterile processing service, pain management, emergency department, and intensive care. As these additions demonstrate, we expect our workgroups to change as needs and priorities change in our Veteran population.

The CPP FACs and workgroups have demonstrated their value by providing tools and resources for frontline nurses. These groups have also collaborated with a variety of external stakeholders. As a result, our polytrauma FAC worked with the Integrated Health Services Center of the
Walter Reed National Military Medical Center, part of the Department of Defense (DoD) health services, to improve the transition process of Veterans with polytrauma between the DoD and the VA. Our metabolic/diabetes FAC collaborated with DoD to establish shared diabetes and hypertension clinical practice guidelines. Our oncology FAC partnered with The Joint Commission to build evidence for breast and lung cancer care quality indicators. Currently, the FACs are involved in building evidence based competency assessment processes into their work. The CPP is a successful program, consisting of over 100 members, producing relevant products for VA nurses and the nursing community by building interprofessional and nursing stakeholder partnerships. Their work has created a focused innovation enhancing the quality of Veterans health care, particularly in response to high priority clinical concerns.

**National Nursing Practice Council**

The ONS shared governance model is unique in promoting collaboration among nursing professionals from all roles and educational backgrounds, throughout VA, across the nation. ONS envisioned utilizing a grass roots approach by providing structural empowerment to frontline staff nurses through the implementation, in the fall of 2011, of the National Nursing Practice Council (NNPC). The NNPC is composed of two practicing staff nurses per VA facility who are nominated by their nurse executive and confirmed by the ONS. They elect their officers from among their membership. The NNPC is designed to provide nurses with the opportunity to give their perspective on issues and activities impacting nursing practice. Through the NNPC, these RN caregivers have immediate access to information, resources, support and opportunity through formal or informal lines of power and structural design (MacPhee, Wardrop & Campbell, 2010).

NNPC is a formally recognized body of the ONS shared governance structure that facilitates bidirectional communication to and from stakeholders through facility-based nursing structures and local leadership. Strong emphasis has been placed on the importance of NNPC providing ONS with frontline staff nurse perspective on resolution of various clinical and operational issues. NNPC representatives, in being appointed by their facility leadership, are identified as a nursing practice leaders within their local facilities. Most NNPC representatives are also active members of their local practice councils and assist with the dissemination of information to and from the national stakeholders.

Since its inception, the NNPC has collaborated with content experts from around the country to address topics such as nurse bullying/lateral violence,
vascular access best practice recommendations, telemetry monitoring, clinical documentation and liability, and health and humor to name a few. We have also provided NNPC representation on various national workgroups such as pressure ulcer prevention, hypertension management, immunization recording, falls documentation, as well as the ONS supported groups focused on goals, nursing practice transformation, evidence based practice and workforce and leadership. The role of these NNPC representatives on these groups is to provide clinical expertise/perspective, insight and feedback into national initiatives and best practice recommendations that will ultimately impact the nurses at the point of care. This governance structure is also an excellent way for our nursing staff to develop themselves professionally and network with other healthcare professionals from around the country.

With every new program, we have had our own challenges and barriers. We have found it very challenging for our direct care nurses to attend regular meetings as patient care is their primary responsibility and they are not always able to participate to their fullest extent. It has also been challenging to accommodate appropriate meeting times across five time zones, meanwhile keeping in mind the day-to-day functions (e.g., medication-pass times, lunch breaks, shift change) of our direct care nurses. Many of our representatives have voiced desires to participate more, but due to heavy patient-care assignments, staffing restrictions, or lack of administration time, are unable to do so. With that said, this group of nursing experts have demonstrated dedication and commitment to providing the best nursing care anywhere and are continuing to develop and expand their involvement and influence on professional nursing practice at a national level.

Expanding External Collaboration

Some of our innovations have emerged from our efforts to expand our external collaborations and partner with others who share some of our goals or are pursuing initiatives congruent with our strategic plans and our mission. One of the most satisfying for us was our engagement in the “Joining Forces” initiative.

Joining Forces

Joining Forces is a national initiative that First Lady Michelle Obama and Dr. Jill Biden started in 2011 after meeting with military families and deciding to make support of Veterans, service members, their families and caregivers a national priority (Joining Forces, n.d.). The goal of the program is to engage all sectors of society in giving our service members and
Chapter 17: Creating Innovative Models of Nursing Care

their families the opportunities and support they have earned. On April 11, 2012, Michelle Obama and Jill Biden met with nursing leaders at the national launch event, celebrating nursing’s support for the Joining Forces campaign at the University of Pennsylvania, School of Nursing. Cathy Rick, VA Chief Nursing Officer was one of those nurse leaders in attendance, along with school of nursing deans, as well as officers from all professional nursing organizations.

In July 2012 ONS leadership joined with the American Association of Colleges of Nursing (AACN) to develop a toolkit to be used by nursing faculty to teach nursing students how to care for Veterans. The steering committee divided into 4 workgroups: military resources, nursing school curricula, community resources, and other nursing organizations (ANA, etc.). We had participating stakeholders from VA, military, nursing faculty, American Association of Nursing Practitioners (AANP) and other professional organizations, totaling 23 members. We identified and evaluated each resource, using a tool to determine the level of evidence with relevance to nursing students and faculty. Once resources were selected, an AACN web page was created so resources could be categorized and made available to schools of nursing.

The biggest challenge we faced in leading this large national initiative was the organization and evaluation of so many excellent resources, some of which were created by ONS FACs. All sources needed to be accessible outside the VA and a few needed to be vetted before release for public use. More information about Joining Forces and ongoing interagency nursing partnerships can be further explored at the AACN website (American Association of Colleges of Nursing, n.d.).

Overall Summary

Nurses are inherently creative. They develop mechanisms to improve patient care on a daily basis. Providing a formalized mechanism for nurses to develop and implement innovations enables them to utilize their strengths and knowledge to improve patient care on a broader scale. Many of these innovations become national initiatives that positively impact Veterans across the country. Unlike nursing in other healthcare systems, ONS has had the unique opportunity to provide a national platform, to facilitate communication and promote sharing of ideas throughout VHA. Staff nurses have the opportunity to develop, implement, and evaluate innovations resulting in improved care to Veterans and enhanced job satisfaction for those who participate.
REFERENCES


Chapter 17.1

The Journey: Building a Nursing Practice Model for Boise Veterans Administration Medical Center

Linley Stanger
My journey into the world of practice model development began in the spring of 2008 when my father’s health led to the very difficult decision to leave my position as Assistant Administrator for Patient Care Services at a hospital in California and move to Boise, Idaho. My father was a World War II Veteran, and like many men of his generation, he was very proud and self-reliant. Needless to say, he was having a very difficult time confronting the challenges of being 90 years old and in poor health. I dearly loved and admired my father, and so there was really no question that I had to move to be near him. Since my father was a Veteran and received his care at the Boise VA, I was happy to accept the Associate Nurse Executive (ANE) position at the facility.

Soon after assuming the ANE position, the Chief Nurse Executive, Gail Collier, RN, MSN, shared her desire for the facility to seek Magnet recognition, which, among other things, required a formal model for nursing practice and two years of nursing research. Little did I know at the time that I would be one nurse contributing to both of these requirements! And that was the beginning. I didn’t know it, but I was embarking on one of the most memorable journeys of my life! A journey that proved to be challenging, but very rewarding because it renewed my dedication to the nursing profession.

My first step was to review the nursing model literature. Nursing models, as described by Martin and McFerran (2008), are “abstract frameworks, linking facts and phenomena that assist nurses to plan nursing care, investigate problems related to clinical practice, and study the outcomes of nursing actions and interventions” (p. 344). Having a defined nursing practice model for a healthcare facility provides the facility’s nurses with a common framework for understanding their role and a focus for their care. In search of the perfect model for our nursing staff, I read numerous books and articles (Arfond & Zone-Smith, 2005; Hoffart & Woods, 1996; Koloroutis, 2004). Yet I could not find one that truly “fit” the personality of the Boise VA nursing staff.

Then, at the 2009 annual Magnet conference, I attended a session by Kathleen Stolzenberger, PhD, RN and Judith Bahr, MSN, RN, CIC entitled Building the Professional Practice Model from the Ground Up (Stolzenberger & Bahr, 2009). I was intrigued by their belief that nursing practice is embedded within the nurses’ beliefs and those beliefs can be revealed through qualitative research. After the presentation, I spoke with Dr. Stolzenberger and she shared more of the details about their development of a practice model.

I didn’t know how to do a study to discover nursing practice beliefs, but as luck would have it, the Boise VA had just hired a nurse researcher, Dr. Kattie Payne. When I shared my idea with her, she became as excited as I was!
I knew I wanted to conduct focus groups with our nurses so they could tell their story and I knew we would be creating a model. Neither Dr. Payne nor I had conducted a qualitative study and so I really had some work to do to get myself up to speed on qualitative methods, particularly grounded theory (Charmaz, 2006; Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Seidman, 1998). I read everything I could get my hands on about the topic and talked with other local nurse researchers who had experience with qualitative studies (Krueger, 2004; Morgan, 1997, 1998).

As stated above, I wanted to conduct a qualitative study with the goal of lending meaning to a phenomenon, event or situation, nursing practice at the Boise VAMC. I identified grounded theory as the appropriate approach. Grounded theory is a systematic process of identifying concepts and discovering their relationships to form a theoretical explanation of the phenomenon, in my case, the nurse practice model (Glaser and Strauss, 1967). First, I defined some common terms so that my research team had a clear understanding of what we were attempting to do. The terms and definitions I created are presented in Table 17.1.1.

<table>
<thead>
<tr>
<th>Table 17.1.1 Definitions of Terms Developed to Inform Research Team for Creating Our Nursing Practice Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Term</strong></td>
</tr>
<tr>
<td>Nursing</td>
</tr>
<tr>
<td>Nursing Professional Practice Model</td>
</tr>
<tr>
<td>Nursing Practice</td>
</tr>
<tr>
<td>Nurse-Patient relationship</td>
</tr>
</tbody>
</table>
Before submitting the lengthy paperwork to our medical center’s research and development committee (R & D) and the institutional review board (IRB) seeking approval of my proposed study, I sought and received permission to use the focus group questions that Dr. Stolzenberger had used in her project. My next step was to identify research team members. I have provided a picture of my team (Figure 17.1.1).

**Figure 17.1.1 The Nursing Practice Model Development Research Team**

(Bottom row, left to right): Laura Perry, RN, MBA/HCM (Nurse Analyst); Kattie Payne, RN, MSN, PhD (Nursing Research/Evidence Based Practice Coordinator); Linley Stanger, RN, MSN (Principal Investigator and Associate Chief Nurse); Mary Fisher, RN (CBOC/CCHT/Informatics Coordinator); Mary Black, RN (Community Oversight Nurse). (Second row, left to right): Merry Kuyper-Carson, RN, MSN, ACNS-BC (Associate Chief Nursing Service-Education); Bryan Cruthirds, RN, BSN, MBA (Nurse Educator/RNOD); and Jane Dunn (Education Secretary).

The IRB approval process extended over three months, involving what seemed like unending questions regarding the qualitative research design, protection of human subjects and the data collection process. In the meantime, I met several times with my research team, which now included six nurses and the education department secretary, Jane Dunn, who had a graphic arts background. I reviewed the study design (especially grounded theory approach), the protocol and each member’s role on the team. Lucky for me, everyone was excited and motivated by this project and agreed to do whatever it took to see it through. Since the IRB would not allow me to facilitate the focus groups, I began to train...
those who would be facilitators and those who would be recorders in the focus groups and the delay in approval assured that the members were prepared for their roles.

I wanted a representative sample of nurses from throughout the facility, including all inpatient and outpatient programs. Hence, I began by seeking support from the nursing managers to support the participants’ involvement, which would include on-duty time to attend a one and a half to two-hour focus group. Next, members of my research team placed personal invitations in all the nurses VA mailboxes. Since I was the principal investigator in this study, and my position is Associate Nurse Executive, and thus had some authority over all nurses in the facility, I wasn’t allowed by the IRB to have access to the names of participants. I therefore charged the research team’s administrative assistant with assigning the volunteer participants to focus groups, attempting to place nurses from different units in each of the scheduled focus groups.

I set out to create a convenience sample of eight to ten registered nurses from each clinical area, totaling 50 participants. I anticipated that we would reach saturation of the data at that point. It was a challenge to get the staff nurses away from their usual work commitments for 2 hours at a time. We chose different days and different times of the day for the focus groups to try to accommodate all shifts. The research team held fourteen focus groups from September 2010 through March 2011. Participants weren’t asked to sign an informed consent, however, they did have to sign-in for the focus group and complete the VA permission for audio-taping. The focus group facilitator asked four semi-structured, open-ended questions to the participants, presented in Table 17.1.2.

**Table 17.1.2 Focus Group Questions for Nurse Participants**

<table>
<thead>
<tr>
<th>Creating Our Nursing Practice Model through Grounded Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Following Questions Were Discussed in Each Focus Group:</td>
</tr>
<tr>
<td>1. Imagine your mother is a patient, what kind of a nurse would you like to take care of her?</td>
</tr>
<tr>
<td>2. Tell us about a patient you cared for that you can’t forget. What made the experience memorable to you as a nurse?</td>
</tr>
<tr>
<td>3. Describe an ideal day to be a nurse at BVAMC.</td>
</tr>
<tr>
<td>4. A reporter asks how a nurse’s job is different from other caregivers in the hospital. What would you tell him/her?</td>
</tr>
</tbody>
</table>
Since the focus group discussions were audio taped, I asked that no participant names be spoken during the group sessions, though there were a few names that the team members had to delete during transcription of the audiotapes. To ensure confidentiality, I asked the research team to store all study-related paper documents (coding lists, etc.) and audiotapes in one of the research team member’s office in a locked file cabinet.

The focus group facilitators and recorders reported that within each focus group, participants stated that the focus group experience had renewed their feelings about why they had chosen nursing as a career. The facilitators and recorders also were very touched by the stories that were shared. All members of the team wished that I could have been a part of the focus groups and heard these comments and stories directly.

The focus group sessions were transcribed in their entirety. A complex job to say the least! Two of the research team members (Bryan Cruthirds and Mary Fisher) learned the Dragon Speak program in order to transcribe the data into a Word document. Transcribed data were kept on password protected files on one team member’s office computer and audio files were copied to disks, then deleted from the tape recorders.

I concluded the data collection when it seemed saturation had been reached and no new data were emerging (Strauss, 1987). Saturation is a process Glaser & Strauss (1967) refer to as “theoretical saturation, the point at which no new data are emerging“ (p. 111). It was at this point that I realized I had exceeded the number of participants approved by the IRB. We were approved for 50 participating nurses however 54 nurses had participated in the focus groups. OOPS! So, I had to submit a Report of Other Problems to the IRB. Thankfully, the IRB allowed me to continue the study and use the data from the extra four participants!

My analysis plan was to follow the steps of the Coliazzi’s method (Sanders, 2003), which are:

1. First the informant’s descriptions of the experiences are read in order to acquire a sense of the whole.
2. Significant statements are extracted.
3. Meanings are formulated from the significant statements.
4. The formulated meanings are organized into themes.
5. The themes are integrated into exhaustive descriptions.
6. The essential structure of the phenomenon is formulated.
7. Finally, for validation, the informants evaluate the result of the analysis for congruence with their original experiences.
After transcription, I had 275 pages of data! I very naively thought that scientific software would speed up the analysis process. So, I asked the IT department to purchase ATLAS.ti (a qualitative analysis software program).

After an intense weekend of training in Santa Barbara, California on the ATLAS.ti qualitative software, I was anxious to download the 275 pages of data into the ATLAS.ti software so I could begin the analysis. I went through the data and identified key phrases and themes (codes). By the end of my review, I had 126 different codes! The research team helped assemble these codes into 8 categories. At that point, I considered whether the categories could be rank-ordered according to number of codes in each category. When the team tried that, it seemed that much of the meaning and depth of the data were lost. So, I went back to the data.

As Dr. Payne and I reviewed the transcripts and codes for agreement, there was an “ah ha” moment! I realized what the nurses were saying: their nursing practice was for them “The honor of caring for the Veteran”. I was struck by the passion for nursing and the commitment to our Veterans in the nurse’s words. The degree of kindness, caring and compassion the nurses had for their patients, our Veterans, was overwhelming. One nurse summed it up like this: “… certain patients really touch your heart and you touch theirs.”

I knew that I had to go back to the participants and validate (completing the member checking of the findings) that I was interpreting the data correctly. So, I submitted an IRB request to hold two follow-up focus groups with a sample of 8-10 of the original participants. My goal was to have the participants review the final codes (30) and their respective categories (8) and validate the findings. These categories and codes are presented in Table 17.1.3.

During the first follow-up focus group, which I was allowed to facilitate, the participants condensed the themes to one over-arching theme: “It is an honor to care for the Veteran”, and three additional themes within that central theme: the Veteran, nursing practice, and VA culture. In the second focus group, the nurses identified symbols for the final categories, designed the emblem that would become our nursing lapel pin, and wrote the nursing philosophy. After each of these focus groups, I was extremely touched by the devotion and passion that the nurses have for caring for our Veterans.

Once our secretary, Jane Dunn, a graphic artist, had created the image for the lapel pin and it was validated by the follow up group participants, we held two celebrations: one for my research team, the focus group participants and the nursing research committee and the other celebration for all nursing staff. Each person was given a bookmark with the nursing philosophy and the lapel pin.
Table 17.1.3 Categories/Codes/Statements from Analysis of Data Generated in Creating Our Nursing Practice Model through Grounded Theory

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Practice</td>
<td>Broad Scope, Holistic Care, Quality care, Autonomy, Ethical</td>
<td>“…the best part of nursing is that you’re taking care of the patient as a whole; physically, mentally, spiritually and emotionally. You’re taking care of the person, not the disease.”</td>
</tr>
</tbody>
</table>
| Nursing Characteristics                        | Compassionate, Caring, Patient Advocate, Leader | “…nursing as a calling as opposed to a job.”  
“… The patient … is in need of care and compassion.”  
“I see us (nurses) as the hub of the wheel and everyone else (health professionals) as the spokes.” |
| Boise VA Medical Center Culture                | Honor to care for the Veteran, Learning culture, Positive, Respectful, Mission Focused | “And the first time I saw the flag ceremony, when one of the Veterans died, I was really blown away. The mission …, it’s integrated with the care we provide.”  
“I think it’s a privilege to serve the people who have served our country and they’re … so grateful for everything you do.”  
“This place feels like family.”  
“The fact that it is an educational academic center, that also makes the culture different.” |
| Nurse/Patient Relationship                     | Strong bond (connecting with another human being), Mutual Respect, Helping Relationship, Long Term Relationship | “…Talk about experiences, life experiences, and death experiences. It was just the bonding and the common grounds that we established that made the experience most memorable.”  
“… Connect with them. I think that’s where the reward comes in nursing.”  
“We know them and they know us so I think we are a lot closer to our patients than probably they are at an outside hospital.”  
“…A spiritual, a metaphysical connection somehow and your heart opens and closes around them.” |
<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Veteran Uniqueness    | Have many losses, Strong bond with each other, Earned the right to best health care, Trust in nurses | “Have lost so much control.”  
“He makes you feel good personally as a person, as a nurse giving care.”  
“They are the ones that put their life on the line.”  
“When two Veterans are in the room they watch out for each other.”  
“We have a very specific population of Veterans. I try to make an effort when I first meet them, to thank them for their service and recognize the sacrifices they have made and give them the best care.” |
| Teamwork              | Mutual Appreciation, Good coordination of care                      | “It’s teamwork that makes things go better for the center of our work, which is the patient.”  
“You know that no matter what comes through that door you’re going to have a great day. Because, everybody is there for everybody else. And that’s an awesome day.” |
| Environment           | Safe Environment, Efficient Processes, Quality Resources            | “The overall calm of this hospital is really impressive and I hear that from patients almost on a daily basis.”  
“You know it’s an ideal day when everything (equipment) is functioning properly.” |
| Outcomes              | Good patient outcomes, Physical and emotional well being, Professional satisfaction | “Did he get good care? That’s the bottom line.”  
“A good day (is) coming away feeling fulfilled that I did something good, that made a difference whether it was small or big and that I had positive interactions with my coworkers.” |
Now, Boise VA Medical Center’s nursing staff members have a practice model. The model that they developed belongs to them and presents to patients a unified staff. The outcome for our nurses is increased pride and satisfaction in their work and for the Veterans it is better patient outcomes.

So concludes my journey. When I started this journey, I was not aware that I was going to be looking into the heart and soul of the Boise VA nurses. I feel truly honored to have been the principal investigator of this research and to have had the opportunity to know the Boise VA nurses on a much deeper level. The Boise department of nursing has a beautifully stated nursing philosophy and a significant nursing practice model designed into a lapel pin. Each nurse in the facility received the lapel pin and a bookmark with the philosophy at a “pinning” ceremony and they wear it with pride. The label pin and philosophy are presented in Figure 17.1.2 and Figure 17.1.3 as a conclusion to the story of my journey.

**Figure 17.1.2 Boise VA Medical Center Nursing Practice Model Lapel Pin**

The silhouette of the Veteran at the top of the pin symbolizes the Veteran being at the top and center of our care, the American Flag represents our unique VA Culture and the Nightingale lamp represents Nursing Practice. The over-arching theme is the honor of caring for our Veteran.
**Figure 17.1.3 Boise VA Medical Center Nursing Philosophy**

This philosophy was developed by staff nurses at the Boise VA to represent their beliefs about nursing practice and their commitment to the Veterans.
REFERENCES


Chapter 17.2

Change and Countering Resistance to Patient-Centered Visiting Hours

Kimberly Radant
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

Nothing inspires patient-centeredness and common sense like a personal, emotional experience. That’s what happened to me when my husband of 17 years, Wayne, died in the month of July 1998, at the ER of a teaching hospital. The details of that are stories for another time, but as a 40-year-old widow with too much time on my hands, I reflected on the times that he and I were apart. I didn’t resent the times VA required me to travel, or my time on active duty. My resentment instead centered on the times that the staff in his private-sector hospital tried to boot me out of his room at 8 PM when we were watching our favorite television programs. And so, after his funeral I returned to Indianapolis, Indiana as a nurse executive on a mission to eliminate visiting hour restrictions.

Fifteen years ago, our VA received on average two patient/family complaints a week surrounding nursing’s enforcement of visiting hours. Staff inconsistently enforced the visiting hours. Some didn’t enforce them at all while others enforced them so strongly that they were warning family members in advance about the end of visiting hours, that they would need to leave promptly at 8 pm. Animosity emerged among staff members and between staff members and family members. I watched our intensive care unit (ICU) nurses at the top of every two hours (even numbered hours only), herd anxious family members to the bedside of their loved ones for an oh-so-precious ten minute visit before they were herded out to the waiting room to wait for the top of the next even hour. Individual deviations in the policy were controversial because staff members feared that one family might perceive that another was receiving special treatment. Hence, the “ten minute every two hour” visitation rule was fairly rigidly enforced. I was horrified.

At the time, we had (and still have) some of the best ICU nurses in the city. They often beat other ICU nurses in a citywide jeopardy-style “critical care bowl” and they stay abreast of current technologies in a way that has always humbled me as their nurse executive. So, it seemed reasonable to ask these brilliant nurses to review the literature on hospitals that allowed unlimited visitation and make a recommendation for our hospital policy on visiting hours. We asked them to report back to us in one month. After two extensions on the report-back time had been granted, the nurses reported back that the literature indicated that unrestricted visitation seems related to higher patient satisfaction scores. They noted anecdotes in the literature that patient falls and other incidents may actually go down with the attention and extra sets of eyes that visitors bring to the bedside, and that coordination and communication of care seemed better when the patient had a family member in the room.
Their recommendation? **Don’t change anything about the hospital’s visiting hours.** Our population was different, they reasoned, and it would interfere with the patient’s privacy to have “an outsider” in the room since not all rooms were private. Furthermore, they explained, patients would not get rest and it is the job of the nurse to advocate for the patient and the patient’s rest, not for family member visitation rights. To underscore their position, they cited that the physicians, too, would not support open visitation, as it would interfere with their teaching rounds to have a family member present in the room. Housekeeping employees did not think it appropriate to provide linen to visitors, and they were clear that housekeepers were there to clean up after patients, not families. Food and nutrition service employees were concerned that family members would expect to be fed if they visited in the hospital for a long period of time, and they emphatically stated the logistics of doing so would be expensive and overwhelming. Oh, and the VA police were very worried about the potential security concerns that would be caused by open visitation. In short, there was fierce resistance to open visitation at multiple levels of the medical center.

Our executive management team discussed this extensively. Why do people resist change when common sense, research, and personal experience seem to indicate it is the right thing to do? In their book designed to answer that question, the Heaths describe that for change to occur it must appeal to our emotions as well as our minds (Heath & Heath, 2010). And too often, they note, the heart and the mind do not agree. We realized we were trying to appeal to the mind of the employees through a review of the evidence, but had neglected to appeal to their emotions, their hearts. Sure, I had a passionate, emotional commitment to the change to unrestricted visiting hours, but I needed to figure out how to instill this in our staff. Executive management agreed…the visiting policy needed to change, but we needed to sell it differently if we were to be successful.

We set about to collect heartwarming stories of the patient and family appreciation that came from being allowed to stay with a family member for extended periods of time during their hospitalization and shared them in staff meetings. We asked staff to share stories of their personal experiences during hospital visitations. We made note of decreased patient and family complaints. And I shared the story of Wayne’s hospitalizations and the overwhelming loneliness I would feel when I left his hospital room promptly at eight PM just as the Jerry Seinfeld show was starting.

The nurse clinical practice committee eventually developed a policy that allows for treatment teams to work individually with patients and families.
surrounding their visitation needs. Visiting is generally open, except in that ICU where the staff still adheres to a one-hour time for shift report when visitors are discouraged. I’m not a big fan of that one-hour restriction, but their practice is so much more flexible and individualized for the patient’s needs that I’ve accepted it for now. You know what still amazes me? Even today, a decade and a half later, signs limiting visiting hours still show up in areas of the medical center. I don’t know where they come from! Meaningful change takes more than altering the environment and appealing to hearts and minds of employees …it requires vigilance and oversight to be sure that the culture does not push back to return to prior practices.

REFERENCE

Chapter 17.3

Educating the Community About Perioperative Nursing

Sheila Thompson
I began my nursing career in the operating room (OR). In 1981 it was highly unusual for an OR to select a new graduate nurse for a staff position but the local community hospital (Tucson, Arizona) could not find nurses with OR experience and took a chance. In nursing school I had one rotation through the OR and loved the teamwork I saw between the nurses, anesthesiologist, and surgeons. I knew it was the place I wanted to work.

Traditionally television and cinema portray the physician as the leader of the health care team; the most educated, the most esteemed, the captain of the ship. Rarely is the registered nurse portrayed as a full partner with the physician. Instead, nurses are portrayed as assistants, practicing a less educated version of medicine rather than the equally important, patient-focused nursing science.

The public understands the role of the perioperative nurse even less. Throughout their surgical experiences, their fear and the medications we give to them prevent our patients from remembering the nursing staff caring for them pre-operatively, in the operating room, and post-operatively in the recovery room. The main role of the perioperative nurse is to assure the safety of the surgical patient. Perioperative nursing expertise includes surgical procedures, anesthetics, positioning, emergency care, and sterilization / aseptic technique. Perioperative nurses function in a variety of roles; circulating RN, scrub nurse, first assistant, or recovery room RN.

In whatever role we are assigned, perioperative nurses work collaboratively with the surgical team to assure the best outcome for the patient. As patient advocates, my fellow operating room nurses and I zealously protect our patients’ rights, privacy and physical body. The surgeons dictate the surgical procedure to be done but we operating room nurses control the sterile field. Whenever there is a question of sterility, nursing judgment rules. As the circulating RN in the OR there have been many times when I have ended a question about sterility by simply reaching out and touching their sterile gloves so that they must be changed, thereby protecting the patient from potential infection.

So how do we educate the public about the critical leadership role nurses play in the operating room? November 14th is designated as Perioperative Nursing Day to celebrate and recognize perioperative nurses. Our local southern Arizona chapter of the Association of Operating Room Nurses (AORN) also sees this day as an opportunity to educate the public about the important role of nurses in the Operating Room. Many of our local hospitals, including our Southern Arizona VA Health Care System (SAVAHCS), have had open house tours to showcase the operating room staff and the latest technology used in surgical procedures. While these events reach
many hospital employees, they reach very few non-health care workers and do not reach out to the community as a whole.

Our AORN chapter members brainstormed ways to share the importance of perioperative nursing with our community. When we saw other groups having events at the local shopping malls, we decided this was a great opportunity to reach the public. The mall was a non-threatening place very unlike the hospital setting. We knew many people like to have their blood pressure (BP) taken so we decided to have a station with BP machines to attract people to our display. As we discussed other ideas for the display we decided that brochures and posters couldn’t capture the extreme technical complexity of the OR. Since we really wanted to demonstrate the knowledge and professional dedication required to be an OR nurse, we decided to create a mock OR display in our local shopping mall.

When I contacted the mall management group they were at first delighted to support a nursing group and then became guarded when I presented our idea to create a mock OR in their center court. We needed to constantly reassure them that there would not be anything gruesome, disturbing, or dangerous in our operating room display. We did ultimately get permission to set up a mock OR in the center court.

Creating an operating room in a shopping mall is a huge undertaking. Much of the equipment is very expensive so facilities are not easily convinced to allow items to leave the OR. Many of our SAVAHCS OR RNs are members of the local AORN chapter, including the manager at that time, so we had facility leadership support to use the same process used to borrow equipment between local hospitals to borrow equipment for the display. All of our local facilities collected clean, unused supplies such as gowns and gloves to use. The equipment can also be very heavy (OR tables can weigh hundreds of pounds) so transporting items was a challenge but with borrowed trailers and trucks, everything arrived for our big day.

We set up the perimeter of the court with tables for our blood pressure stations, educational literature, and a “dressing room” with gowns, gloves, caps and masks that could be donned before moving into the center area: our main display of an actual OR table with a Resusci Annie simulation mannequin draped for an abdominal procedure. We had real instruments (though nothing sharp) set up as they would be for the procedure. Visitors were free to just look or to have an OR nurse guide them through the display. We had a steady stream of visitors all day long. The children were my favorite visitors. They were so eager to dress up for the OR and step up to the OR table to perform “surgery”. They were very interested in all the instruments
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

asking what each was used for. None of them showed any fear in the mock OR and all asked if they could take their gowns and gloves home with them.

I used a short pre and post test to measure the effectiveness of our mock OR as a teaching tool. We asked visitors to complete an eight item matching quiz of the operating room RN roles of cell saver nurse, certified RN anesthetist, circulating nurse, industry representative, nurse practitioner, organ donor representative, RN first assistant, and scrub nurse with their descriptions. The test scores increased from a pretest mean of 71% to a posttest mean of 90% showing that the display was effective for teaching the roles of the operating room RN. Visitors told us they liked seeing the mock OR and enjoyed talking with our nurses.

The role of the perioperative nurse continues to grow. Recent headlines warn the public about the potential for infection from the use of endoscopes that are not properly cleaned. The VA is a leader in taking corrective actions. One of the first actions was to move the responsibility for oversight of sterile processing to the nurse executives at all 152 VA facilities in recognition of both nursing’s expertise and role as the patient advocate. New roles continue to emerge as nurses become laser safety officers and robotics nurses. All of these roles require nurses to act as equal colleagues with all other health care professionals.
Chapter 17.4

Creating Your Own Job When You Don’t Even Know Where to Find It!

Nancy L. Martin
I am not new to nursing. I have a baccalaureate degree in nursing (BSN) and 17 years of nursing experience, but I was brand new to the specialty field of wound care when I joined the team at the Northern Arizona Veterans Administration Health Care System (NAVAHCS). This was also my first experience with the Veterans Health Administration (VHA), and the first job I’ve ever had that carried such a wide range of responsibilities.

I have always been attracted to the specialty field of wound care, and I began to prepare myself for this specialty training by obtaining, in 2005, my BSN from Northern Arizona University, nine years into my nursing career. Five years later I finally had the opportunity to attend the wound, ostomy, and continence course offered at Emory University in Atlanta, Georgia. I chose Emory because it offered an onsite, full-time, ten-week program. It was also the only program that would prepare me to become certified in all four fields of wound, ostomy, continence, and foot care. My course instructor, Dorothy Doughty, gave me a high standard to strive for as I began my career as a certified wound, ostomy, continence nurse (CWOCN) and certified foot care nurse (CFCN) at NAVAHCS in the summer of 2011.

NAVAHCS covers a large area. It extends north from just outside of Phoenix, Arizona to the Utah border. It extends east from the California border nearly to New Mexico. At the heart of NAVAHCS is the historic Bob Stump VA Medical Center in Prescott, Arizona. This medical center includes acute care units, two community living centers (CLCs) for long-term care, specialty units for hospice, rehabilitation, and dementia, and numerous patient aligned care teams (PACT) to provide primary care service to our local Veterans. NAVAHCS also includes five community based outpatient clinics (CBOCs) to serve the rural population and home based primary care (HBPC) teams that visit those Veterans who are unable to travel to our facilities.

It would take a lot of work to see that all of these Veterans received the wound care that they deserved. The task seemed a bit daunting, but I was eager to get started. In my toolkit, I had 16 years of nursing experience, an excellent education, certification in the fields of wound, ostomy, continence, and foot care, good reference books, a passion for my new job, and an eagerness to teach and empower the staff nurses and the Veterans. Other resources included my telephone lifeline to the Emory University wound care program, and an email group of diverse VA wound care nurses from across the country. I also had a good working relationship with the wound care nurse (WCN) from our community hospital, our friendship dating back to
the days when I was a nursing student completing a clinical rotation under her guidance.

I soon found that I would need all of these resources to face the personal and professional challenges of my new position. My predecessor had been gone for nearly a year and a half when I accepted my position and I had no one to shadow for continuity. First of all, I had to find my job. What needed to be done to continue the wound care program that my predecessor had already established, and what needed to be changed or added? What were the priorities? Where were we strong and where did we need to improve?

The reference book and revision of the skin care policy that my predecessor had begun needed to be finished. I needed to continue with the weekly wound care rounds she had established with the providers, and I needed to continue teaching the new employees. I recognized early on that the caring attitude and professionalism of the staff, from the certified nursing assistants (CNAs) to the primary care providers, was one of our strongest assets, and I needed to help maintain that attitude.

I found that during the year and a half vacancy period, wound care science and technology had advanced at an astounding rate, and I learned that NAVAHCS needed to update its inventory of supplies and equipment. One of my patients jokingly called me “the wizard of gauze” because gauze was the basic dressing I had to work with when I started at NAVAHCS. The previous WCN had, of course, used some advanced dressings; but these had since expired. Our foam mattresses were also near or at the end of their life expectancy. Equipment such as negative pressure wound therapy had been improving over this time, and NAVAHCS had also purchased some tele-video equipment and was just beginning to install it.

I quickly found my job. My job was to continue doing the good things my predecessor had been doing, while incorporating the new wound care technology all around us into our program. It was not quite as easy, however, to create the job that I had found. My predecessor had been a licensed independent practitioner (LIP), therefore she had prescriptive authority and autonomy over her own practice. I was certified in my fields, but I was not an LIP. The difference in our levels of autonomy made it a bit challenging for me to establish my new role.

I didn’t have much time to ponder how I was going to do this because my services were immediately in great demand. So, I hit the floor running and I did what I was trained to do: I took care of wounds. I was extremely busy – exhausted even – yet I was thrilled to be able to finally practice in my specialty field of wound care.
I treated wounds using the evidence based knowledge that I had gained at Emory University. I often referred to my old textbooks, shared information with my colleagues, and I always explained my rationale for a treatment. I consulted with other disciplines (nutrition, pharmacy, lab, radiology, physical and occupational therapy, case management, social work) to help formulate plans of care for the Veterans. I worked side by side with the Veterans’ direct caretakers: the providers (physicians and nurse practitioners) and with those who knew the Veterans the best: the unit and PACT team nurses. We worked together, as full partners of the health care team, and eventually, together, we began to redesign and rebuild the wound care program at NAVAHCs. But not without running into a few glitches.

As mentioned, my predecessor had been an LIP; she had prescriptive authority and autonomy over her practice. I had evidence based principles to guide my treatments, but officially, from the VA standpoint, I didn’t have any written standing protocols. Now that I had found my job and gained some experience at NAVAHCs, I needed to officially create my job.

The Future of Nursing report contends that “... nurses must see policy as something they can shape rather than as something that happens to them” (IOM, 2011, pg. 8). In my case, I needed to create a policy that would cover my specialty practice as a non-LIP CWOCN and CFCN. My vision was also to create an innovative model of nursing care that would empower bedside nurses through an evidence based educational program about skin and wound care, one that would allow them to practice to the full extent of their education.

As it turned out, the greatest resources in my toolkit proved to be the email network of other VA wound care nurses and my professional practice module from Emory University. I was able to draft a position statement that was approved through Administration fairly quickly. Next, I drafted CWOCN specific protocols for practice with the help of other VA (non-LIP) WCNs. I combined several of their standing order sets and tailored them to fit my level of expertise along with the needs and limits of our institution. Multiple committees scrutinized and honed them including pharmacy, logistics, nurse executive board, medical executive board, and the executive leadership team. In the meantime I was able to function in my job with a lower level of autonomy. Understandably, it took nearly a year for my CWOCN set of standard protocols to proceed through the governance process. Finally, one day in my mailbox, I found the last version of my protocols. Scrawled across the top, my supervisor had written in red ink: “As Approved!!”

These finished protocols specified the treatments that I, as a CWOCN, could administer as standing orders for particular symptoms, circumstances,
and types of wounds. The protocols could only be applied if there was no variation between the symptoms I was treating and the symptoms described in the CWOCN standard protocols. The protocols were fashioned in this manner to ensure the safety of the Veterans, while also allowing me to practice in my specialty field to the full extent of my training without overstepping my bounds as a non-LIP caregiver. NAVAHCS, and in reality the VA wound care nurses as a team, had defined the role of a specialty RN, and it is transforming the way we are managing wound care.

The committee that wrote the Future of Nursing report states that “...the goal in any transformation of the health care system should be achieving innovative, patient-centered, high value care” (IOM, 2011, pg. 250) and that solutions to many of the issues plaguing our health care system “require a transformation of the nursing profession” (IOM, 2011, pg. 250). At NAVAHCS we are increasing access to care, giving holistic Veteran-centered care, and empowering nurses as we develop our own innovative model of the specialty field of wound care nursing for the NAVAHCS Veterans. This model of care includes input from all disciplines as full partners in the care of the Veteran. It also reaches out and integrates the role that nurses play in wound care and prevention of skin breakdown for all our Veterans, ranging from the acute care inpatients to the outpatient Veterans who are seen and treated by HBPC.

When I meet Veterans with their PACT team nurses in the primary care setting, I assess their wounds and, using my approved protocols, I recommend treatment or dress the wound accordingly. At the same time, I am explaining my rationale and technique for the recommended treatment to the provider, the PACT team nurses, and the Veterans. Everyone learns more about skin and wound care this way. I consult with the Veteran’s provider when a more complex level of treatment is needed. For example, I cannot order antibiotics, but I can recommend that a provider consider them, and I can culture a wound that looks infected and treat it by using a dressing with antimicrobial properties. My protocols allow me to practice to the full extent of my competency and scope of practice.

Practicing in this manner not only empowers me as a specialty nurse, but it also helps to create a culture that “...encourages and supports leaders at the point of care...” (IOM, 2011, pg. 234) by empowering the PACT team nurses and the Veterans as they learn about wound care. It increases access to care for other Veterans since the providers are able to see more patients while the PACT team nurses and I see and treat the Veterans with wounds.

NAVAHCS is also increasing access to wound care via our telehealth program. Knowledge flows in all directions through our computer
connections! I meet with Veterans and their team nurses at the CBOCs via televideo consults. I view the wound over the computer, ask pertinent questions, and then make recommendations based on my protocols. Conversely, I consult with the spinal cord injury (SCI) hub in San Diego, California via a televideo conference when I need their advanced expertise to meet the wound care needs that are unique to Veterans with a spinal cord injury. The SCI hub also presents difficult cases and educational programs through televideo conferences monthly. Several disciplines collaborate, and we empower each other as full partners in the management of Veterans’ health care. Interdisciplinary alliances such as this one are essential to wound management.

My instructor at Emory University, Dorothy Doughty, shared my dream of empowering nurses to practice to the full extent of their training. She developed a program through the Wound, Ostomy, Continence Nursing Society (WOCN Society) that trains nurses and military medics about skin and wound care. The course is not as extensive as the course I took at Emory University, but it does teach about skin and wound anatomy and physiology, principles of wound healing, support surfaces, and some important technical skills. Once the nurses (they do not have to be BSNs) or the military medics complete the online course, pass the online tests, and pass the hands on competencies they will be given a certificate that validates their increased knowledge and they will become an official wound treatment associate (WTA).

I had a list of over 30 nurses who wanted more extensive training and responsibility for wound care at our facility, and we needed each one of them. As WTAs, they, the bedside and PACT team nurses, would have a vital role in our developing model of wound care nursing at NAVAHCS. I eagerly filled out the forms that confirmed my role as the WTA program coordinator and instructor for the hands on portion of the course. Next, I had to show the education department and administration how the WTA program would fit into the mission and goals of NAVAHCS, and how it would help us to meet national and VA goals on reducing pressure ulcers and travel expenses for training. After several months of working with the administration, the WTA program was finally in place, with funding to train the first ten nurses.

These nurses will soon be a valuable resource to help prevent, properly stage, and document pressure ulcers. In addition, they will understand how skin physiology, etiology of the wound, and systemic issues relate to wound care. This will empower them to alert providers early of potential problems and to proactively prevent them.
The impetus for change is huge. Our Veterans and our nurses are aging, and budgets are tight. We will have to be flexible and innovative as we navigate the new waters of the Affordable Care Act. Our courage to implement such a change is fueled by a common goal – we all strive to give excellent, safe, holistic, efficient, Veteran-centered care to our patients. We also know that we must be good stewards, using our resources wisely and ethically.

Key Message #1 in the Future of Nursing report is that nurses should practice to the full extent of their education and training (IOM, 2011, pg. 4). Key Message #3 is that nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States (IOM, 2011, pg. 7). In a small way, we at NAVACHS have made progress towards these goals. We have defined a role for specialty certified RNs who are not LIPs that will allow them to practice to the full extent of their training. We have also created a new innovative model of wound care nursing within our system, which will allow bedside nurses to practice within the full scope of their education by establishing the WTA program. Both of these accomplishments were made possible because nursing had full input, along with physicians and other health professionals, in redesigning the wound care program at NAVAHCS.

In retrospect, I can smile to myself now and see that the extremely long list of goals I had set for the wound care program at NAVAHCS two and half years ago when I was hired was perhaps a bit naïve. Yes, I believe these goals can and will be met; but they will take leadership, time, cooperation, effort, and maybe even a few miracles. As the Future of Nursing report explains “… leadership and practice produce change over time” (IOM, 2011, pg. 228).

Looking back, I sometimes wonder if I would have done anything differently. I do regret that I didn’t spend more time building stronger relationships on all levels of the “social architecture” within NAVAHCS. I naturally fostered the relationships with the nurses and providers I worked with because we spent time together caring for the Veterans. The Future of Nursing report advises however that “… the fast pace of change can be managed only if it is accompanied by leaders who can track the context of the ‘social architecture’ to sustain and implement innovative ideas” (IOM, 2011, pg. 228).

I realize now that finding and creating my job would have been much easier had I invested more time fostering relationships with my supervisor, other service line managers, and with other members of the leadership team. Fostering these relationships would have given me a better
understanding of the “social architecture” of NAVAHCS, and this would have helped me navigate through the VA system. Relationships take time, energy, and effort, but they are essential to forming and sustaining an excellent team and an outstanding facility. They are worth the time invested.

NAVAHCS and I have both grown over these years. I have learned to recognize both my strengths and my limitations. I have experienced and contributed to the VA process of choosing and procuring new equipment with much help from contracting and logistics. NAVAHCS now owns twelve wound V.A.C.s, a type of negative pressure wound therapy equipment that will save us rental fees and give us immediate access to equipment when the Veterans need it. We have just replaced the foam mattresses on our CLC beds with new low air loss mattresses to prevent pressure ulcers and homelike beds that are in keeping with the VA’s cultural transformation of the CLCs. We have updated our stock to include many of the newer, advanced, evidence based dressings. We have purchased some true-to-life models of wounds and ostomy systems to train both our nurses and our Veterans.

I’ve definitely found my job and I am constantly creating and recreating it. I am now using my expertise as a certified foot care nurse to help out in the podiatry clinic. I am technically not just “the wizard of gauze” anymore. (Although I must admit, I do love the images that title conjures up!) It is an inspirational title to me now, as wizards are known to possess the miraculous power to change things, even themselves.

The many case studies and nurse profiles in The Future of Nursing report (IOM, 2011) confirm that a dedicated, focused individual or team of nurses, collaborating with others, are also known to possess this miraculous power to change things and to reinvent themselves. I feel honored to be a member of the team of nurses at NAVAHCS that is working for positive change for both our Veterans and for our health care system.

REFERENCE

Chapter 17.5

Post Hospital Transitional Care Program

Lou Etta Hicks and John McIntosh
The United States health care community is concerned about frequent and costly hospital readmissions, especially within 30 days of discharge. Medicare has begun to reduce payments to hospitals with higher than expected rates of readmissions for certain conditions such as heart failure, acute myocardial infarction and pneumonia (Vaduganathan, Bonow & Gheorghiade, 2013). As hospital administrators and health care providers scramble to find ways to reduce the 30-day hospital readmissions, patients often end up back in the hospital because of poor follow-up care from hospital to home (Park, Branch, Bulat, Vyas, & Roever, 2013). The Department of Veterans Affairs (VA) is not immune to the negative impact that costly hospital readmissions has on a tight VA budget. In this chapter, we describe one example of the VA nursing response to this challenge.

In 2009, at the Bay Pines, Florida VA Health Care System, a social worker who was an administrative assistant and a registered nurse who was a home and community director for geriatrics and extended care (GEC), wrote a VA grant requesting funding for a post hospital transitional care (PHTC) discharge program that would provide resources for four full-time positions: an advanced practice registered nurse (APRN), two registered nurses (RN) and a social worker (SW). Their goal was to decrease the current readmission rate of 19.24% by 10%, which would result in a rate of 17.32% or less. The Veterans enrolled in this PHTC would be those with at least three hospital admissions within one calendar year. The program’s staff would make home visits with Veterans within three days of discharge from their acute hospitalization, creating a bridge during the first 30 days after their acute care discharge until a follow-up clinic appointment could be made with the patient’s established primary care provider (PCP). The proposed program was designed to be nurse-led and focused on meeting the special healthcare needs of the Veterans.

The grant was approved and the PHTC program was started in the summer of 2010, but faced some early implementation challenges. None of the staff of this new program had recent VA home care experience although two, one RN and SW, had former positions in the community. Four supervisors of the GEC provided guidance to the PHTC staff, serving as an advisory committee. Unfortunately, the two administrative staff members who had originally written the proposal for the grant were not subsequently involved in decision-making or developing policies for the PHTC program. All of these factors converged making the first year of the PHTC program unsuccessful in meeting its goal of reducing 30-day hospital readmissions to 17.32% or less.

In August 2011, the PHTC program, due to this rocky start, was dissolved and the staff members were transferred to the home based primary care (HBPC) program to assist in meeting their performance measures. The few
Veterans currently enrolled in PHTC were referred to the HBPC program. In October 2011, two of the staff, a RN and SW, returned to PHTC while the other RN and APRN stayed with HBPC. The PHTC program was now reduced to one RN and one SW.

It was at this time that the first author of this chapter, Lou Etta, stepped into the story. Since I had been working in HBPC for the past 16 years as an APRN and primary care provider, I felt that I needed a change and asked if I could take the APRN position in PHTC.

Although I joined a team still recovering from a lack of success, I was determined to make this program work and meet the performance goal of reducing 30-day hospital readmissions by 10%. I knew that if the PHTC program was not meeting that goal, the program would not continue past the date the funding ended, September 30, 2012, and that I would be working "somewhere else". The fear of the unknown made me work even harder.

Initially, working with the RN already in the program, I screened Veterans and began to accept patients back into the PHTC program. Since I was new to this position, I did not want to interfere with the RN and SW who had worked there in the past, but set out to create my own approach. I began making frequent home visits in HBPC, with a slightly different emphasis. I wanted to keep the Veterans out of the hospital for at least 30 days. I began to ask myself, "What can I do to keep these Veterans out of the hospital for 30 days and keep them at home where they are more comfortable?"

Because I have a background and experience in nursing research, I began educating myself, searching the Internet for information about transitional care programs. I found that no two programs were alike and there were a variety of staffing patterns. I also participated in a webinar provided by the physician who worked at a VA in Madison, Wisconsin who had found success with their transitional care program. I conferred with the home and community director and with the coordinator of a nearby VA within the same Veterans Integrated Service Network (VISN). They provided me with some much-needed guidance. Both of their transitional care programs were very successful with one having a 30-day readmission rate of 5%. I also attended a training conference in May of 2012 where I learned two important lessons: transitional care programs that reduce hospital readmissions have staff that work as a team to care for their patients and make at least weekly home visits with face-to-face contacts with the Veterans they serve.

I returned from the training conference and shared what I had learned with my team members. By this time, we had acquired another RN and were now fully staffed. The other team members agreed to make more frequent home visits, at least once a week. We also decided that I, as the APRN, would
screen all PHTC admissions by making the initial contact with the Veterans during hospital rounds before they were discharged to their homes. I would also make the initial home visit. To my amazement, after making changes in our program, our PHTC 30 day readmission rate had dropped to 16% by August 2012, down from 58% in April 2012. Yes, we were finally making progress!

After I had been working in transitional care for five months, I decided to begin to collect basic statistics, believing this might provide information that could shape our program. 38.6% of our patients were over 75 years of age. 61% had a diagnosis of coronary artery disease (CAD) and 47% had congestive heart failure (CHF) while 49% were diagnosed with chronic obstructive pulmonary disease (COPD). My biggest revelation was that 69% of the Veterans had medication discrepancies, which I discovered on my initial home visit. This extraordinarily high number alone could account for the many hospital readmissions within 30 days of acute care discharge.

While I felt comfortable in computing basic statistics, I was not knowledgeable about how to link these statistics with cost factors I could share with our VA administrators, showing them and our Veterans the value of our PHTC program. Fortunately, the new RN, John McIntosh, was hired to complete our program just after I had completed my 5 months of basic statistics. I discovered that John has a background of working in a bank, owning his own business and was a finance major prior to becoming an RN. John came into the program with no bias or ideas of limitations. I quickly realized the value he could add to the process and enlisted his help almost immediately.

Within a week of John being employed, we began meetings with quality systems and the coordinator of the Veterans Equitable Resource Allocation (VERA). John was instrumental in explaining the different departments and the required formulas that we needed to build to demonstrate the monetary value of the services we were providing to our Veterans. He assisted me in demonstrating the cost factors of my statistics and showed me how Microsoft Excel, a spreadsheet program, could be beneficial with our calculations. Thus John, the second author in this chapter, entered our shared story.

I, John, was hired in April of 2012 and was assigned to the PHTC department. Almost immediately I was informed that this was going to most likely be a temporary position. I was told that the grant for this project would end on September 30, 2012 and it was highly probable that the PHTC program would be dissolved.

Prior to being hired by VA, I was employed as a case manager with a local home health company. I was able to quickly understand the value that the PHTC program provided. One of the most frustrating parts of my previous
position was the lack of support offered to the patients after discharge. It was next to impossible to contact the primary care provider (PCP) for these patients and if I did, the PCP would require our patients to make an office visit prior to making any changes that might keep them out of the hospital. Bay Pines VA Health Care System had figured out the importance of having a qualified APRN on the team. I believed that this inclusion was instrumental in preventing readmissions, primarily because the APRN is able to react in a timely manner to the Veterans’ needs.

Understanding the value of this Veteran centered program, I decided that I needed to do everything in my power to help Lou Etta demonstrate the value of the PHTC program. Lou Etta explained to me that she had been compiling data over the last 6 months. She opened a three ring binder and showed me months of hand written data on the Veterans served within the PHTC program over the last five months. I explained to her that there is an easier way to record and process the information in a way that would allow us to provide proof of the value added by the PHTC program.

These numbers not only showed the benefit to the hospital, but also demonstrated the program’s ability to positively impact the quality of life of the Veterans. Recognizing that, I began working on creating spreadsheets with formulas that would illustrate this fact. Once I had everything in a spreadsheet form, I then presented the information to our quality systems group. They were able to take my formulas and create usable reports from the already established and readily accessible database. This development changed Lou Etta’s understanding of the use of data to manage an innovative program of care, and she completes this shared story.

As my skills needed updating, I signed up to take multiple computer training classes, including training in the use of Excel. I learned how to create graphs and charts so that I could present our data to administrators in a clear manner. John and I were able to re-organize our database to include information that was important to our success and our continued service to our Veterans.

With my new skills, I was able to expand my exploration of our program data. I looked at bed-days-of-care six months prior to the Veteran receiving PHTC interventions and six months after. To my amazement, one Veteran had a prior 62 bed days of care compared with only 3 after our PHTC interventions. The data on my research are graphically presented in Figure 17.5.1.

We were able to demonstrate the cost savings of the PHTC program’s bed days saved on these Veterans from 10/1/11 to 9/30/12 to be $2,678,814.00. The PHTC team made 838 home visits and generated a potential of $1,299,080.00
in VERA (Veterans Equitable Resource Allocation) dollars by making at least ten home visits to our Veterans. We were thus able to demonstrate that the return on investment (ROI) based on cost avoidance annualized is 197%. The PHTC program over the fiscal year 2012 was beneficial to Veterans and profitable to the VA and contributed substantively to non-institutional care.

**Figure 17.5.1** Monthly Comparison of Bed Days of Care 6 Months Pre PHTC (Gold Bars) with 6 Months Post PHTC Interventions (Purple Bars) January 2012 through August 2012

Since I have now been on PHTC for over a year, I am able to look at the bed-days-of-care twelve months pre and twelve months post PHTC interventions and the reduction rates. It is truly a remarkable estimated cost savings to the medical center due to the work of our PHTC team. We have presented our PHTC program and outcomes at our local VISN and at national levels. Currently, our average readmission rate for the past several months is 10% with the month of October 2012 actually achieving a 0% readmission rate. Figure 17.5.2 provides a visual presentation of these data, including the fifth month results of 0% readmissions. PHTC is not only meeting the goal of reducing 30-day hospital readmissions by 10% from its current rate of 19.24%, but is exceeding it.

I continue to evaluate, reevaluate and try to improve upon what we are currently doing in our PHTC program. Now that our grant has ended and our PHTC program has proven to be successful, the GEC service has absorbed our full-time staff members’ positions into their budget. Although we still face challenges, we are able to be beneficial, profitable and productive, and successfully document our impact on our Veterans. Working over the past
year in transitional care has been a lot of hard work, but the benefits of what we have achieved as a team have been rewarding. The PHTC program at Bay Pines VA Health Care System is nurse practitioner-led and has proven to be successful and beneficial to both Veterans and to the medical center.

**Figure 17.5.2** Re-Admission Rates for Post Hospital Transitional Care (PHTC) From April 1, 2012 - October 31, 2012

<table>
<thead>
<tr>
<th>Month</th>
<th>Rates of Reduction in Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 1-Oct 29</td>
<td>22%</td>
</tr>
<tr>
<td>May 1-Oct 29</td>
<td>22%</td>
</tr>
<tr>
<td>Jun 1-Oct 29</td>
<td>24%</td>
</tr>
<tr>
<td>Jul 1-Oct 29</td>
<td>15%</td>
</tr>
<tr>
<td>Aug 1-Oct 29</td>
<td>9%</td>
</tr>
<tr>
<td>Sep 1-Oct 29</td>
<td>9%</td>
</tr>
<tr>
<td>Oct 1-Oct 31</td>
<td>0%</td>
</tr>
</tbody>
</table>

### REFERENCES


Chapter 18

Building Collaborative Interdisciplinary Partnerships That Promote Best Practice for Patient-Centered Care

Richard Wing
Mid-year in 2009, Mary Sue Biggins was appointed to serve our rehabilitation Veterans as the polytrauma rehabilitation clinical nurse advisor. This position was within the Department of Veterans Affairs (VA) Office of Nursing Services (ONS) clinical practice program. In this newly initiated role, Sue was tasked to convene a Polytrauma Rehabilitation Field Advisory Committee (PFAC) that would serve as a bidirectional conduit between ONS and the field of VA polytrauma rehabilitation nurses. Under her direction the PFAC was charged to address the standardization of clinical practice, promote evidence based practice and certification, develop policies and clinical practice guidelines and disseminate education and best practices to nurses working in VA health care facilities. The committee found it expedient to collaborate on many levels with other program offices, other field advisory committees and members of the interdisciplinary rehabilitation teams. In this chapter I describe my role and the activities that changed the role of nursing in the quality care for visually impaired Veterans. My story is an example of the efforts of VA nurses to build interdisciplinary partnerships to achieve that goal.

With the wars in Afghanistan, Operation Enduring Freedom (OEF) and Iraq, Operation Iraqi Freedom (OIF), later to become Operation New Dawn (OND) in full combat operations, the VA initiated the polytrauma system of care (PSC). Currently, the PSC is comprised of several components. There are five polytrauma rehabilitation centers (PRC) located at Richmond, Virginia; Tampa, Florida; San Antonio, Texas; Palo, Alto, California and Minneapolis, Minnesota. There are also twenty-three polytrauma network sites (PNS), eighty-three polytrauma support clinics teams (PSCT), a multitude of point of contact sites (POC) and five polytrauma reintegration treatment program sites (PTRP). This PSC with descending levels of interdisciplinary teams of experts is essential in treating the Service members and Veterans who have sustained severe complex wounds with an unprecedented survival rate of greater than ninety percent. The extreme severity of wounds, both visible and invisible, in conjunction with the integrated care treatment between Department of Defense (DoD) and the Veterans Health Administration (VHA), along with the addition of geographical movement of these wounded Service members across long distances, tasks all clinicians to find optimal ways to decrease the burden of this care on the wounded and their families.

Polytrauma rehabilitation covers a broad spectrum of injuries such as blindness/visual impairment, spinal cord injury, musculoskeletal injuries, traumatic brain injury, burns, and amputation and can include co-morbidities of post traumatic stress disorder (PTSD), depression, other mental health disorders and hearing loss, to name the most prevalent. Therefore, Mary Sue Biggins found it imperative to have PFAC membership
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

be national in scope, draw members from the various levels of the PSC, serve in a variety of roles within the system of care and be comprised of subject matter experts that could address this broad spectrum of rehabilitation needs. One of her goals was to focus attention on the area of our nursing leadership in the blind rehabilitation system of care, the challenges that have been encountered, the progress made and the work still to be done by members of the PFAC. This chapter focuses specifically on my efforts to address the challenges of polytrauma blind rehabilitation nursing.

VA Blind Rehabilitation: A History

As chair of the PFAC, Mary Sue Biggins initially selected a polytrauma associate chief nurse from the Palo Alto VA, who had extensive knowledge and experience with their blind rehabilitation center. She in turn, recommended that as the current blind rehabilitation clinical nurse manager I be asked to serve as a blind rehabilitation representative on the PFAC regarding the need to elevate nursing as a full-fledged, contributing integral member of the interdisciplinary team. This led to more dialogue and discussion of the issues, to investigate approaches to changing the perception of nursing serving in a secondary role on the team. As nurse manager I was tasked with writing a white paper that described the lack of standardization within the various nursing units across the national VHA blind rehabilitation system of care. The depth and detail of the White Paper served as a blueprint to address this fragmentation within the current thirteen VA blind rehabilitation centers. Mary Sue Biggins then encouraged utilizing the PFAC as the tool to initiate change in practice and promote excellent Veteran-centered care, with nursing as a full partner on the interdisciplinary team. The national scope of the PFAC provided the necessary leverage for us to promote standardization of practice, discover and disseminate best practices, with an ultimate benefit to Veterans and their families.

Steve L, a blind rehabilitation vision specialist recently asked me about Mr. W: “Richard, Mr. W, a patient with an undiagnosed neuromuscular problem and vision loss, reports that his vision is sometimes good, sometimes bad, and sometimes just OK. We are unable to really define when this happens or what to do to help him. Do you think nursing could help us by checking on him throughout the day and documenting what he is doing, the time, and how he reports his visual acuity? This would really help us in trying to decide if there is some visual aid we can help him use.”

As this was the first time nursing had been asked to collaborate in this manner, I was of course more than willing to assign this task to the
nursing staff. What a breakthrough, I thought. The vision department wants to teach new skills and evaluate a new vision tool to use that will perhaps provide more independence for the Veteran. He wants to include nursing observations and assessments in providing a workable treatment intervention. Maintaining or improving self-care and independence, the ultimate goal for the patient in rehabilitation, would emerge as a direct result of a multidisciplinary approach to patient care!

When reviewing the U.S. Department of Veterans Affairs web site home page for Blind Rehabilitation Services (n.d.), we learn that for more than five decades, the leadership, programs, and principles established within VA blind rehabilitation program have contributed significantly to raising the level of quality services for the blind in the United States and abroad. It has been through the VA's pioneering and sustained efforts in research, education, and training that many innovative advances have been realized.

Further noted from the website is that on January 8, 1944, President Franklin D. Roosevelt made an extraordinary commitment to our nation's war-blinded servicemen when he signed an executive order declaring: “No blinded servicemen from WW II would be returned to their homes without adequate training to meet the problems of necessity imposed upon them by their blindness.”

The first VA blind rehabilitation center was established at Edward Hines Jr., VA Hospital in Chicago, Illinois. Through the years various aspects of skills needed by blinded Veterans for improved confidence, safety and the development of ability to become more independent were developed. Manual skills, orientation and mobility capacity, and living skill classes were formulated and included. Eventually further breakthroughs in adaptive visual devices led to the addition of visual skill classes to allow maximum use of any remaining vision. The advancement of computer technology led to the inclusion of computer access training through computerized adaptive devices for skill development for the visually impaired and blind. The resultant model developed became based more on a school, classroom type of services provided by classes for skill development with the Veteran as a student rather than using a traditional hospital setting with the Veteran as a patient.

The Vietnam War, combined with the earlier inclusion of non-service connected Veterans eligible for training in these services, had a major impact. Beginning in 1967, VA created visual impairment service teams (VIST). The VIST essentially became VA's marketing section for the blind rehabilitation program. VIST staff members were charged with the responsibility of coordinating outpatient services for eligible blinded Veterans and they would serve as the VA's frontline diagnostic and treatment agents for blindness.
The VIST program was subsequently strengthened when VA began establishing full-time VIST Coordinator positions in order to meet the additional demands being created by an aging Veteran population. As a result, VA and professionals across the healthcare industry gradually became more aware of the benefits derived from Veteran participation in the VIST and blind rehabilitation center programs. Consequently, this tremendous increase in case identification led to a greater demand for blind rehabilitation training.

The combination of these various events would subsequently lead to an increased need for services and a steady expansion and availability of VA’s residential blind rehabilitation program. The VA established nine additional blind rehabilitation centers (BRC). The BRC sites include: Palo Alto, California, established in 1967; West Haven, Connecticut, established in 1969; American Lake, Washington, established in 1971; Waco, Texas, established in 1974; Birmingham, Alabama, established in 1982; San Juan, Puerto Rico, established in 1990; Tucson, Arizona, established in 1994; Augusta, Georgia, established in 1996 and West Palm Beach, Florida, established in 2000. As the number of VA BRCs expanded, so did the number of accomplishments and innovations. New adaptive training techniques and prosthetic devices were developed to meet the needs of Veterans with multiple disabilities due to the Korean and Vietnam conflicts. Research fostered further advances in electronic travel aids, reading machines, low-vision devices, and computer access equipment.

In 2008, VHA established 55 new outpatient blind and vision rehabilitation clinics in the expansion of the continuum of care for patients that have been identified in eye clinics as having vision loss that has degraded independence and quality of life, adding more since then. VHA also created a blind rehabilitation outpatient service (BROS) training program that employs a multi-skilled and experienced blind rehabilitation instructor who teaches skills in the Veteran’s home environment and/or local VA medical center.

In order to care for Veterans with significant visual impairment, VA also created the Visual Impairment Center to Optimize Remaining Sight (VICTORS), a concept developed to complement existing inpatient blind rehabilitation centers. The interdisciplinary VICTORS outpatient program represents a unique team approach to vision rehabilitation using the disciplines of optometry, ophthalmology, social work, psychology and low vision therapists. VICTORS provides rehabilitation through definitive medical diagnosis, functional vision evaluation, prescribing and training in use of low vision aids, counseling and follow-up. The first VICTORS
programs were established in Kansas City, Missouri; Chicago, Illinois; Northport, New York and Lake City, Florida with additional sites added through the years.

As the country moved from the post WWII, Korea and Vietnam eras, changes in the models of health care delivery and availability of resources, further shifted both within VHA for Veterans and DoD services for active duty military personnel. The major changes were a decrease in the number of DoD hospitals and clinics for active duty Service members (ADSM) and an increase in provision of more outpatient services for Veterans in the VHA through community based outpatient clinics (CBOCs).

The September 11, 2001 terrorist attack and resultant numerous years of conflict caused another need for realignment of national health care resources. This resulted in the blending of DoD resources within VHA resources. Thus many VA hospitals and CBOCs are now serving both Veterans and ADSMs. A goal of both departments is to provide a timely, seamless transition into an appropriate level of care and provider of specialty service needed for the ADSM with continued follow up care.

A new defining injury of the current conflicts in Iraq and Afghanistan has emerged. Concussive, moderate or severe brain injury due to improvised explosive devices has resulted in visual loss, traumatic eye loss, or delayed eye disturbances and blindness. This has led to a new field of neurological visual loss and comprehensive neurological visual rehabilitation diagnostic tests, treatments and research. Further, these emergent health concerns have resulted in additional new VA blind rehabilitation centers opened as recently as 2011 and 2012 in Cleveland, Ohio; Biloxi, Mississippi and Long Beach, California.

Today, VA has over 200 beds committed to the blind rehabilitation instructional program and is staffed by more than 300 blind rehabilitation specialists and personnel. VA is continually enhancing and expanding its blind rehabilitation programs to meet the needs of an aging Veteran population, as well as meet the needs of new Veterans and ADSMs returning from the current conflicts.

The multi-disciplinary team approach now includes, in most areas, a physician, nurse, optometrist, dietitian, social worker, and psychologist in addition to the blind rehabilitation specialists. Regardless of discipline, all team members focus their efforts on promoting health, developing skills of independence, and improving adjustment to sight loss with the goal of successfully re-integrating the blind Veteran back into the family and community environment.
VA Blind Rehabilitation Nursing: The Historical Role of the Nurse

There are currently three primary policy documents/VHA Handbooks that describe, define and guide the practice of blind rehabilitation for the Veteran population and define personnel for this practice.

The Physical Medicine and Rehabilitation (PM&R) Service Procedures-VHA Handbook 1170.03 states that “Rehabilitation care is always patient-centered. The Veteran is a crucial member of the team whose goals should be at the center of the rehabilitation process…” (U.S. Department of Veterans Affairs, PM&R Handbook, n. d.). This policy describes the rehabilitation nurse as one member of the PM&R inpatient team. In the Blind Rehabilitation Center Program Procedures-VHA Handbook 1174.04 medical and nursing staffs are described as essential members of the interdisciplinary treatment team. It notes that “Nursing staff provide round-the-clock nursing care and medical support and are involved in health education activities that include teaching self-medication management skills, nutritional instruction and diabetes education”. (U.S. Department of Veterans Affairs, Blind Rehabilitation Center Program Procedures-VHA Handbook 1174.04, n. d.). Finally, the third resource, the Outpatient Blind and Vision Rehabilitation Clinic Procedures-VHA Handbook 1174.3 states that “Outpatient vision and blind rehabilitation clinical programs in BRS are staffed by blind rehabilitation specialists who work with licensed, credentialed eye care practitioners (optometrists and ophthalmologists), other professionals in Blind Rehabilitation Service, social workers, and other VHA healthcare and rehabilitation professionals to assure that Veterans with visual impairment are provided state-of-the-art blind and vision rehabilitation.” (U.S. Department of Veterans Affairs, Outpatient Blind and Vision Rehabilitation Clinic Procedures-VHA Handbook 1174.3, n. d.). Perhaps nurses are included in the group of “others”, however there are no full time equivalent positions assigned to nursing service to provide nursing staff specifically for the nursing needs of the Veteran with vision loss in these outpatient clinics.

Despite these directives identifying the essential members of the interdisciplinary team, in a phone survey I conducted in 2010 of nurses at the VA blind rehabilitation centers, I found that there was a “disconnect between nursing and the rest of the rehabilitation team” that was widely reported to be the common practice. The outcomes of that survey are presented in Table 18.1 summarizing the concerns of the nurses I interviewed.
From comments by nurses with years of experience in several VA blind rehabilitation centers across the country, I learned the role of nursing within the VA blind centers had historically been one of a “supportive” role to the rehabilitation teaching team. Delivering blind rehabilitation services in blind centers had used a “school model”, where classes for the Veterans, known as “students” and not “patients” were held Monday through Friday,

**Table 18.1 VA Blind Center Nursing Survey Summary Data: Summer 2010**

<table>
<thead>
<tr>
<th>Blind Rehabilitation Center</th>
<th>Admission Restrictions</th>
<th>Concerns For Improvement</th>
<th>Performance Improvement Projects</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Electronic health records reviewed by Optometrist, Social Worker, RN, NP and BRC Chief. Only pts with IVs for therapy excluded</td>
<td>Nursing staff to be included with rehab staff; Funding needed to attend conference to update current practices</td>
<td>Education instructions, Telephone follow-up questionnaire, Information booths and participation in local health fairs</td>
<td>Unit had LPNs, but no longer</td>
</tr>
<tr>
<td>2</td>
<td>Medical Rehab MD, then Psychiatry MD on call</td>
<td>Some Polytrauma and active duty service members, prefer no more than 4 admits a week</td>
<td>Training of walk-in outpatients, with blind rehab needs, done by inpatient staff, but workload not counted; Staffing levels do not cover patient needs; Equipment outdated; Disconnect between rehab staff and nursing staff</td>
<td>Concerned about ability to meet VA national initiatives due to outdated staffing plans; Increased # of young active duty Service members</td>
</tr>
<tr>
<td>3</td>
<td>M-Th 8:00am to 4:00pm Hemodialysis fee-based to community; No Polytrauma</td>
<td>Proposal for 2 staff for all shifts; Plan for move and increase in beds</td>
<td>Patient satisfaction; PRN effectiveness; Fall Prevention; Patient Education</td>
<td>Concern regarding competency of nursing staff and plans to increase bed capacity to 20</td>
</tr>
</tbody>
</table>
### Table 18.1  VA Blind Center Nursing Survey Summary Data: Summer 2010 (Continued)

<table>
<thead>
<tr>
<th>Blind Rehabilitation Center</th>
<th>Admission Restrictions</th>
<th>Concerns For Improvement</th>
<th>Performance Improvement Projects</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Accept/admit everyone, but slow to take patients with psych history, new amputations, insulin pumps, and dialysis; No patients needing assistance with baths</td>
<td>Limited nursing input for patient admission decisions; Pharmacy labeling of meds for “Scriptalk”; Improve availability of current med information: Audiology, Labs, &amp; EKGs</td>
<td>Self-med program; Discharge with follow-up telephone calls; Participation in interprofessional treatment planning; Emphasis on patient independence</td>
<td>Variable staffing patterns for census fluctuation; VIST coordinators not sending all required information for medical evaluation/clearance; All patients manage their own medications (except controlled substances) using pill box under supervision; No nursing students; Using Functional Independent Movement (FIM) form for nursing as similar to other areas; Nursing does participate in interdisciplinary team treatment meeting</td>
</tr>
<tr>
<td>5</td>
<td>No patients with wounds, mental health diagnosis, Hemodialysis; Admit only Mon, Tues, &amp; Weds</td>
<td>Veterans do not know meds; Many Veterans without a VA primary care provider; Fee basis of many Veterans due to physical plant; Nursing staff is aging and not retiring or being replaced</td>
<td>System redesign from Dartmouth; Decreased wait time for admissions; Improve backlog of computer access training program; Use of Optometry meds; Improved sleep hygiene and exercise program Provide health education to rehab staff</td>
<td>Having more patients for functional blindness and more with memory issues; Clinical setting for peer mentoring for BSN program nursing students</td>
</tr>
</tbody>
</table>
### Table 18.1 VA Blind Center Nursing Survey Summary Data: Summer 2010 (continued)

<table>
<thead>
<tr>
<th>Blind Rehabilitation Center</th>
<th>Admission Restrictions</th>
<th>Concerns For Improvement</th>
<th>Performance Improvement Projects</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Only “stable” patients</td>
<td>Limit admissions to 2 days a week due to understaffed nursing services</td>
<td>Pain management; Fall prevention; Monthly orientation to all new hospital staff about care of the visually impaired or blind Veteran</td>
<td>Pain management; Fall prevention; Monthly orientation to all new hospital staff about care of the visually impaired or blind Veteran</td>
</tr>
<tr>
<td>7</td>
<td>MD/RN collaborate to determine appropriateness for admission</td>
<td>NP attendance at grand rounds is liaison between rehab and nursing staff</td>
<td>Review of ER visits; Fall review; Urgent care by NPs</td>
<td>If patient is in need of personal care, living skills rehab class will provide that as the first class of the morning; Unit is not a clinical setting for nursing students</td>
</tr>
<tr>
<td>8</td>
<td>Only 4-5 admits per week prefer admits only Weds and Thurs</td>
<td>Improved relations with rehab staff; Expanded medical coverage; Improved coverage by Pharmacy for med reconciliation</td>
<td>Nursing documentation improvement for patient ability to use prescribed assistive devices; Improved standardized teaching format and methodology by nursing; Fall reduction; Post discharge telephone follow-up for continued use of prescribed devices; Patient satisfaction</td>
<td>Patient satisfaction</td>
</tr>
</tbody>
</table>
usually from 8AM-4PM. These classes, eight periods a day, each lasting 40 minutes, are taught by master’s prepared rehabilitation specialists in one or more of the topics of orientation & mobility, vision, manual skills or living skills. These classes are designed to assess student ability for a multitude of adaptive skills the visually impaired student may have developed or may need to learn to improve or maintain independent life or vocational skills. The students were described as generally young, i.e. under 60, and other than having visual impairments or being blind, were in fairly good health. Veterans with co-morbid medical conditions were generally not eligible for the blind rehabilitation programs and thus not admitted into the “school”. It was the duty of nursing staff to keep the student safe when “school” was not in session and there were no other personnel available in the setting. Nursing care was relegated to after school hours, weekends, and holidays with a responsibility to keep the student healthy to attend “classes”. As students were generally considered healthy, nursing staff were minimally available in the centers. Those nurses present were usually licensed vocational nurses (LVN) or licensed practical nurses (LPN) who provided a nursing practice more task oriented and limited in scope than that of the registered nurse (RN). There was usually one LVN assigned to the evening and night shift or sometimes provided by nursing staff from neighboring nursing units.

This historic pattern of nursing engagement was in sharp contrast to the vision of the VA Chief Nursing Officer Cathy Rick who had stated in the 2009 VA Office of Nursing Service Annual Report: “The VA nursing community is recognized for being at the forefront of visionary efforts to ensure quality and safety, while transforming nursing practice for the future. With a focus on efficiency and effectiveness, VA nursing plays a pivotal role in shaping care for Veterans with a commitment to being Veteran centered, results-oriented and forward looking.” (U.S. Department of Veterans Affairs, 2009, p. 2). This vision shaped our reappraisal of the role of the nursing in the blind rehabilitation centers.

Creating the Future of Nursing in VA Blind Rehabilitation Centers

In an effort to understand how this “pivotal role of the nurse” was being implemented in the VA blind rehabilitation centers (BRC), as noted earlier, during the summer of 2010, I conducted a telephone questionnaire with nursing staff at the 10 BRCs that were within the VA health care system at that time. What role did nursing staff view themselves as having in the care of the visually impaired or blind Veteran? What problems were nursing staff
having in providing care? What kind of patients were being admitted and taught in the blind rehab centers? Did nursing have any voice in deciding which patients would be admitted? Did nursing have a voice in the program at all? What was the relationship between nursing staff and the rest of the rehabilitation team? These were the concerns I wanted to explore.

I made contact and initiated a personal discussion with a nurse representative from the blind center or unit at 80% of the centers. The nurse representative was self-identified as a nurse manager, charge nurse, assistant chief nurse or staff nurse. Questions were asked about number of beds in service, numbers of nursing staff, nurse manager duties, service line responsibilities, medical coverage, admission restrictions, concerns for improvements (nursing) and performance improvement projects. I identified the centers by assigning each a number. They reported a range of 12-32 residential blind rehabilitation beds and nursing coverage provided by a range from 4-14 RN or LPN nursing staff members.

While the interviewed nursing managers from the respondent VA Blind rehabilitation centers were in agreement, enthusiastic and supportive of striving forward for nursing excellence as the then nursing chief, Cathy Rick had described, the discussions with these nursing managers suggested there were a number of common difficulties in achieving these goals. For me, the most striking revelation of these nursing leaders was their stated belief that nurses working in BRCs were viewed as a “support service” and not considered as a part of the “rehabilitation team.” I found this same “disconnect between the rehabilitation team and nursing” at my facility.

The physical layout of the building housing the blind rehabilitation center at my facility could best be described as school-like with a dormitory style housing capacity. While originally designed to promote the school-like atmosphere of a learning center, individual student living rooms, classrooms and offices were set off a long central hallway. This individual room design did not support ease of interaction among staff members or students. While a large central dining room, recreation area and TV lounge did allow gatherings of students and staff, the overall physical layout did seem to promote a feeling of isolation when an individual was in an office or classroom area. Entered from the main hallway, the nursing station consisted of a small room where a clerk, surrounded by file cabinets, would greet students entering for nursing attention. The student would then be taken into an inner office that had a work desk for nursing staff. This room included a chair for the student to sit on to allow vital signs to be taken and for medication administration and interviewing. The same space also contained a small medication refrigerator, medication storage and
administration carts as well as a wall storage unit with supplies. Another door led into yet another adjoining room for use by the physician or nurse practitioner for interview and physical examination of the student.

It had been customary for a LVN to work alone on the midnight to morning shift. The responsibility of the LVN was to observe for safety and security during the night and awaken students in the morning to allow them to prepare for the day, assist with breakfast meal assistance and administer any medications that were ordered. The two day shift nurses were usually busier with admission and discharge of students as well as arranging for any medical care that might be needed at the hospital located on the same grounds. This care was for urgent needs; its intent was to return the student to continue blind rehabilitation classes. If further care was needed, the student would be transferred to the hospital. Nursing also contributed a health update and discussed any possible conditions that might interfere with the progress of the student. As students generally were fairly healthy, any medical condition which might slow or interfere with the blind rehabilitation goals usually meant the student would be discharged until the medical condition stabilized. Once stabilized at a care facility or at home, the student could apply to return to school.

The day shift nurse did attend an assessment and planning meeting where all of the multidisciplinary rehab staff and the patient met to discuss visual rehabilitation needs and goals of the student and estimate how long the student would need to be in the program to learn the skills needed to manage with their vision loss. A “graduation” date would be determined. Nursing would continue to monitor for safety and security, administer medications and perhaps do a few minor treatments such as foot checks in the evening for students with diabetes. Nursing staff on all shifts did obtain and provide finger stick blood glucose monitoring for those students with diabetes. Blood pressure monitoring needs, medication administration, teaching about medications or other health matters of concern for nursing would be done when patients did not have classes, and would be “squeezed” in between classes, between recreational activities, or after classes were completed and on weekends.

At the completion of the school day, on weekends and holidays the recreation therapist would frequently have recreational activities planned. These would be based on an assessment done by the recreation therapist to learn of the student’s leisure skills. This was also part of social skill building that is provided to reintegrate the Veteran into the community and offer social interactions to overcome the isolation commonly developed by those with visual loss.
Psychologist assessments and counseling were offered to the Veteran who may be dealing with emotions associated with visual loss or other preexisting cognitive or psychological concerns. When a social worker was available, family therapy was arranged for the student’s caregiver to come into the program and participate in classes with the student, enabling them to learn about the new skills the student was developing, and how these could affect family dynamics. If there were nursing skill care interventions or other health education needs these would be provided by nursing staff around and between all of these activities as well. Each service appeared to work separately in providing skill development specific for their area. Nursing was not generally included in providing health education care on a regular scheduled basis.

Veteran students who successfully completed all phases of their classes in blind rehabilitation would celebrate with a graduation ceremony. A certificate of completion would be presented in a gathering of the community of students, staff members and family members who may be present. While nursing staff members were to be at the graduation, not all members of the nursing staff would attend. This was true of other celebratory events at the center. Nursing staff would be minimally present, mostly to assist Veterans in preparing their meals and to attend to being sure students were eating appropriate foods. Most nursing staff would take their meals back to the nursing office and eat as a nursing peer group in the isolation of the work area.

In summary, I realized through this assessment that my nursing staff members did not feel that we were a true part of the rehabilitation team but were considered more of a support service to keep the patient physically able to attend rehabilitation classes. We would report this at the assessment and planning meeting, describing students’ physical health status and where appropriate, their medications. While nursing care needs of the student were considered, any need for medications or blood glucose or blood pressure monitoring was to be done between classes, or at the end of the day when classes were completed. Reminding the staff that nurses too are professionally trained and licensed, and the practice of nursing was not being implemented at its fullest potential, I challenged the staff to reexamine our nursing process and practice in our blind rehabilitation center setting.

We undertook a shared journey. Ultimately, some nurses evolved to accept and acknowledge their role as professional practitioners with a fund of health knowledge as important for the Veteran to learn in maintaining self care for independence, as are the skills being taught by the other members of the rehabilitation team in teaching the patient to manage his vision loss or blindness. Our nursing rehabilitation mission, philosophy and goals are
all focused on assisting and teaching the students to be as independent as possible in all activities of daily life and to gain knowledge necessary to be responsible for their own care needs. This was in total alignment with the basic skill building being done by the rehabilitation specialists, but was provided by nursing staff according to each nurses’ knowledge about the topic, and provided in a manner as time would allow. To minimize confusion to the student by individual teaching methods or topics, and to begin to standardize the teaching that nursing conducted, the staff developed a teaching tool to provide a step by step instructional format for each nurse to utilize for teaching skills development for the visually impaired student to learn, for example, how to do their own finger stick blood glucose monitoring. This step-by-step tool became known as a competency checklist. This tool was for documenting not only the student’s ability to perform a task, but also scored progress and noted specific steps the student missed, as the focus of teaching for the next nurse instructor. Additionally over time questions were added with a Likert scale to provide nursing with outcome measures for student ease of performing a task, and a student independence level that measured pre and post teaching changes. A scale that recorded time spent teaching was added to validate use of nursing staff time. This led the staff to develop additional teaching/competency tools for other skill building being taught by nursing, such as tools for training on talking blood glucose measuring devices, voice-guided blood pressure cuffs, eye drop administration tools, voice-guided scales, pill organizers, and use of insulin pens. Others are being discussed and planned.

Every week the student is given a large print schedule of classes so they know when to attend the various training classes. At a weekly departmental supervisor meeting held by the chief of blind rehabilitation services, I requested that nursing service be scheduled for some of this formal teaching time. This would meet specific Veteran learning needs, and by integrating them into the schedule, give credibility to the skill building that nursing offered. I believed that it would also promote student acknowledgement of the importance of the self-care skills they were learning. Subsequently, nursing now has allocated scheduled time designated on the student’s weekly class schedule. This change in practice also had implications for nursing staff. They were now more clearly accountable to be available and present for the student to perform the teaching, and more clearly a member of the team. Table 18.2 provides a sample of a student’s weekly schedule, showing the inclusion of nursing as part of the structured program.

We began to change other nursing staff practices that promoted nursing’s presence, visibility and professional interactions with all other
staff members. I encouraged the nursing staff to attend the student’s formal school hour and informal non-school hour activities to foster opportunities for multidisciplinary interactions. Spontaneous professional viewpoints were shared about student challenges exhibited by medical conditions in conjunction with the visual limitation or loss and the learning being demonstrated by the student. This was exemplified in a patient with congestive heart failure. While having a fairly stable cardiac status, he became short of breath on walking long distances for an extended period of time. As a nurse briefly explained the cardiac function with the orientation and mobility instructor, a new plan of care was developed. Rather than attend a full forty-five minute class and a walk with instructions on use of the white cane, a 10-15 minute lesson plan was developed for the Veteran. The student could physically manage the shorter walk times with less distance, rest a few minutes and then resume the walking and learning. While this may have increased the student’s time in the program by a couple of days in order to learn the full lessons of safe mobility, he also benefited by some reconditioning of his physical stamina and ability to walk for longer times and distances without shortness of breath or fatigue.

Because our facility also has a VA polytrauma rehabilitation center (PRC) we became the only VA facility with both a PRC and a blind rehabilitation center on the same campus. The field of comprehensive neurological vision rehabilitation (CNVR) is fairly young. The proximity of Veterans with traumatic brain injury and concussive types of previously unrecognized or undiagnosed neurological visual pathway disturbances has provided an opportunity for expansion and creativity in our nursing interventions. These types of visual disturbances are similar to those found by patients who have experienced strokes or other cerebrovascular problems. A condition of heminaopsia, or loss of vision in half of the visual field may take place. Nursing now plays an important role in the assessment and data gathering
process designed to determine appropriate interventions for a student who had had a stroke and suffered heminaopsia in addition to previous diagnoses of age related macular degeneration and loss of function on one side of his body from the stroke. These students were still determined to maintain as much independence as possible. A particular student had taught himself some adaptive abilities to minimally provide and care for himself, and while he could maintain some useable visual field to function to some degree, he would experience total loss of his visual field and orientation with any change of position or movement of his head.

Together with the CNVR certified vision rehabilitation specialist, we developed a “scan and plan flow sheet measurement” tool to track the student’s ability to remember the process to maintain his visual field. The tracking sheet required nursing on all shifts and all times to note if the patient implemented a scan and plan of his movement prior to any change of position, from lying to sitting, from sitting to standing, and so forth. Nursing would note if the student would do the movement of his head side to side or scan to see his pathway and then point to the goal for his direction of movement, his plan. We would note if he did these activities spontaneously, needed a reminder, or needed a full reinstruction of the process. This process was shared with interdisciplinary team and utilized by them when interacting with the student. This flow sheet would be tallied each day to measure the student’s scan and plan progress. This multidisciplinary tool and the results of testing it aided greatly in documenting the level of assistance the Veteran needed at discharge.

These types of nursing assessments have become the expectation of all the instructors, with information sharing and on the spot planning becoming the norm. Nursing staff participation and observations have become an essential element of the formal multidisciplinary coordination of care during the assessment and planning meeting of each student. Nursing staff developed a checklist of important medical and nursing information to be shared at these meetings.

I continued to encourage the visibility and participation of the nursing staff, which heightened their involvement and interest in the overall functioning and management of the center. They began to attend program committee meetings and play an active role on fire and safety, communications, and technology issues affecting the program. Nursing provided input on discussions about technological tools being taught to students. Could the easy use of a hand held magnifier help some
Veterans read their medication labels? What other tools were students learning to use that nursing could utilize in teaching health education? Since students are now learning to use computers, iPads and iPhones, nursing, provided with an iPad, began to explore implementation of appropriate health education and maintenance applications to teach the students.

As the silo of nursing practice within the BRC was dismantled and nurses established a more collaborative practice, the rehabilitation field advisory committee, in an effort to enhance our nurse colleagues’ knowledge about blind rehabilitation services, gave me the opportunity to present a VA webinar to the primary care RN care managers about services provided by the VA to our active duty Service members and Veterans with visual loss or blindness.

Following this, I presented a second VA webinar on establishing collaborative practices between nursing and recreation therapy. An additional webinar to primary care RN case managers explained blind rehabilitation nursing and interventions. Further work with the DoD Vision Center of Excellence and VA Blind Rehabilitation and central nursing office through the RFAC has resulted in the publication of two single page resources available to all VA health care givers: “Caring For Patients Who Are Blind or Visually Impaired: A Fact Sheet for Inpatient Care Teams” and “Caring For Patients Who Are Blind or Visually Impaired: A Fact Sheet for the Outpatient Care Team”.

A recent two day Western BRC (WBRC) sponsored workshop invited all of the vision staff from our regional VA service area to discuss referrals to the program, improving communication with our providers and co-workers throughout the region and beyond. Nursing staff were in attendance and were very active participants. I was invited to share with those in attendance on site, and via video teleconferencing, a vision and plan for implementing a blind rehabilitation nursing telehealth program to our clinic locations throughout the Pacific islands. This concept has been accepted and work is in progress to provide this telehealth program with Hawaii within the next few months.

For our students with chronic disease management care needs, nursing has developed health education programs that begin during the student stay. This is done using various adaptive devices our students are utilizing, including iPads and iPhones that our computer access training (CATS) program has taught. To improve discharge follow-up we made the step toward, and are connecting our students with chronic disease concerns to our VA telehealth home care program.
The nursing staff, now with fifteen (15) licensed staff continues to expand rehabilitation and nursing collaboration within the BRC and other services. We care for more aging and medically compromised Veterans who have more complex diagnosis, including stable mental health diagnosis, cognitive impairments due to aging, trauma recovery issues, substance abuse, hemodialysis, parkinson’s disease, multiple sclerosis, wheelchair bound, double amputees, and almost any other diagnosis. Nursing is called on to provide the rehabilitation team with in-service training about many of these medical conditions, and together we develop a plan of care in consideration of the professional expertise each specialty has to offer that will benefit the skill building for the visually impaired or blind student needs to maximize their independence.

As the nursing service representative for the WBRC, I review all applications for admission into the WBRC. I review and consider any medical condition that may affect the student applicant’s ability to fully participate in this active, vigorous program. Denials for application are extremely rare. I am not looking for reasons to exclude an applicant from receiving services in blind rehabilitation, but as I have said at every opportunity I have, I am looking for those issues that may be of concern in the student’s ability to fully participate in the program. Through further consultation and alerting our psychologist, social worker, dietician, recreation therapist, all the rehabilitation specialists, we begin to develop our interdependent interprofessional action plan for the admission of the student. As a service we have learned that the sharing of our nursing knowledge with Veterans and with all staff affects the Veteran’s ability to fully participate in a true multidisciplinary rehabilitation program. We have learned that the physical layout of the nursing service area and the physical facility can provide challenges for nursing to be noticed as present and participating in the blind rehabilitation of the Veteran and active duty Service member.

Under the direction of Mary Sue Biggins the polytrauma field advisory committee has provided a platform to bring forward the practice of blind rehabilitation nursing in a manner consistent with best professional nursing practice. As individual professionals we have learned the meaning of working to the full extent of our licensure, and the meaning of professional responsibility and accountability and the excitement of continued individual and professional growth and development of our nursing knowledge and skills. As a multidisciplinary team we work together to find the best way we can to serve those who have served.
REFERENCES


Chapter 18.1

Interprofessional Teams in Action: Our Emerging Leadership Gains in Patient Care in the VA Diabetes Management Improvement Initiative

Sharon A. Watts and Michelle Lucatorto
The Veterans Health Administration (VHA) national nursing shared governance structure connects field based clinical leaders within specific facilities or regions with national central office leaders, creating teams led by nurse leaders who collaborate to enhance patient care. We believe that a perfect example of how this works can be seen in our unfolding story where nurses who provide system wide leadership within the Office of Nursing Service (ONS) in collaboration with field based diabetes nurse experts planned and implemented several clinical innovations. We are the two nurses who led this initiative. Sharon is a nurse practitioner (NP) and certified diabetes educator as well as the chairperson of the metabolic syndrome and diabetes nursing field advisory committee (FAC). Michelle is the national central office program manager for specialty care nursing. We achieved collaboration through the alignment of field and central operations and believe our story can serve as an exemplar for shared governance in other areas of nursing.

In 2011 the ONS metabolic and diabetes nursing FAC faced an enormous challenge: to help nurses improve care delivery for Veterans of the 21st century. Escalating rates of obesity, aging and sedentary lifestyles in the Veteran population had created care gaps ripe for metabolic disorders. Our initiatives were first directed at helping nurses identify at-risk populations through panel management. Panel management is a quality improvement strategy used in chronic disease management. A key component of panel management is the use of a disease based registry of patients that contains data used to determine patient risk and monitor quality. VA had just implemented such a tool, the primary care almanac (PCA). Nurses using the PCA are able to view the patients in their team and then sort by diagnosis or risk for admission or death using a statistical algorithm. Quality information that is used to report to the Centers for Medicare and Medicaid (CMS) through the Health Effectiveness Data and Information Set (HEDIS) such as recent laboratory data, vital signs and evidence based medication use is available to nurses using the PCA.

The metabolic and diabetes nursing FAC created a vision, recognizing that together with Veteran stakeholder input and partners in nutrition, behavioral health, pharmacy and medicine, we could create a diabetes program to provide state of the art evidence based interventions that are timely and Veteran-centric. Happily, the ONS is highly coordinated with FAC chairs. The metabolic and diabetes nursing FAC shared the ONS vision of nursing led innovation in diabetes management and soon we developed a plan with several significant nursing innovations. We also recognized that interprofessional partnerships were essential to making our plan a success.
In this chapter we describe some of our most effective initiatives, ones we believe can readily be replicated among other nursing care provider groups.

Our understanding of the importance of self-management skills shaped our innovations for Veterans with diabetes. This disease, like no other chronic disease, requires that our Veterans master an inordinate burden of knowledge, skills and attitudes to navigate day to day living. While many health care facilities offer certified programs that teach comprehensive diabetes management classes, we realized that our patients have work schedules, distance barriers and cost constraints that can interfere with attendance at these vital self-management sessions. Therefore, we created an alternative program to bring the class to the Veteran daily through a telephone application.

The ONS diabetes experts collaborated with the VA national home telehealth department and nutrition field advisors to compile daily prompts, knowledge and affirmations in diabetes safety and self-care. The program was field tested with patients and continues to teach diabetes self-management skills on a daily basis through short mobile telephone messages that meet the patient’s learning needs with short bursts of learning. For example a daily prompt reads “Did you wash, dry, and visually inspect your feet today?” If the patient answers “NO” then a “High Alert” goes to a dashboard that the nurse receives. Also a prompt comes up to remind the patient to do this every day.

The Institute of Medicine Future of Nursing report encourages RNs to work to the top of their professional expertise as vital contributing members of the healthcare team. Specifically nurses are encouraged to be full partners, with physicians and other health professionals, in redesigning health care in the United States. When we moved our outpatient clinics to a primary care medical home model of care, we noticed a gap in the care management follow-up for chronic disease management in diabetes.

The nursing staff members of the healthcare team voiced confidence and interest in assisting patients to achieve blood glucose level goals. Additionally they would hear patients voice frustration in their inability to attain more frequent access to the clinic provider above the usual three-month follow-up visits. This resulted in management inertia about insulin dosage adjustments based upon their home and laboratory glucose values. Patients knew that they needed to change their medications, but had no power to do so.

Members of the medical and nursing FACs worked together to create an insulin titration protocol to be piloted at five VHA facilities. We brought together an interprofessional team of field based diabetes experts including physicians, clinical psychologists, pharmacists and nurses and created a training program based upon the Project ECHO model from New Mexico.
Project ECHO (Extension for Community Health Outcomes) is a telehealth program started in 2009 (Scott et al., 2012). Weekly videoconferences were held by specialists for rural clinicians. Theoretical didactic content was presented by a panel of experts who then mentored the learners in utilizing theory by talking them through actually patient case presentations. Best practices were taught by theory and then integrated into practice.

The training of our VA version of ECHO called SCAN-ECHO (Specialty Care Access Networks) consists of a 13-week hour-long program. The didactic content was delivered by lectures that focused on safety in diabetes such as hypoglycemia management, insulin and medication management rules as well as the impact of diet and exercise on blood glucose readings. Each week, as the learners presented cases, the experts continued to mentor the use of content from previous as well as the current lecture. It was amazing to hear the increasing complexity of clinical questions and the shift of the learners to a role displaying confidence. We implemented this program with all five sites participating using video-tele-conferencing. The program consisted of basic physiology, pharmacology and management of diabetes. Particular attention to safety in hypoglycemia prevention was stressed. The nursing FAC developed three additional self-directed training modules and six clinical competencies to provide additional support for the nurses. We also created a program evaluation that collects clinical quality, safety and cost effectiveness data.

Veterans Health Administration has since identified this program as a national model for training RN healthcare team members. This program demonstrates the advancements in nursing that can be created using a shared governance program that leverages national support with local implementation through collaboration with our interprofessional partners. We believe that the strength of nursing clinical leadership in the form of a FAC, with a direct communication line to both nurses caring for patients and a national nursing leadership program is an exemplar for maximizing nursing's contribution to the healthcare team.

This project has demonstrated that nurses want to practice at a higher professional level with advanced training in an area of chronic disease management. We have collaborated with other healthcare professionals in medicine, nutrition and pharmacy to create didactic materials and protocols that are safe and reflect current evidence to assist in redesign of the RN chronic disease management role. The unique contribution of nurses in the outpatient setting working as full partners with the Patient Aligned Care Team (PACT) optimize chronic disease interventions in a safe environment of protocol advancement. We believe this is a good example of redesigning the healthcare environment to ensure a safe and effective manner of care around
the patient’s needs and utilizing an expanded scope of professional practice for the Registered Nurse.

Just as the ONS shared governance structure creates an environment to advance RN practice, it also contributes to the advancement of advanced practice registered nurse (APRN) practice. Again our examples are from the metabolic and diabetes nursing FAC working with the national office to create opportunity and change. Diabetes is the most common cause of kidney failure. The chair of the ONS metabolic syndrome & diabetes nursing field advisory committee together with the ONS & clinical pharmacy specialists (CSP) at the VA partnered with the National Institute of Health (NIH) to produce a prevention program to slow the progression to renal disease in diabetes using APRN and CPS skills sets. This again is an excellent example of the VHA’s strong response to the IOM Future of Nursing Report. Our APRNs and our CPS partners are highly capable practitioners able to manage this chronic disease population. We created an APRN/ CPS team structure to support our patients and colleagues in the primary care setting to target early identification and intervention for at-risk diabetes patients who do not meet current diabetes performance measures.

The APRN/CPS team provides support to primary care teams by identifying patients with a high risk for renal failure using national data sources, and providing direct care to the patients to improve their experience living with diabetes, helping them manage their lipid levels and blood pressure. The APRN/CPS team engages both patients and primary care team members in participation in shared medical appointments. These appointments empower patients and providers to focus specifically on discussion and education designed to slow the progression of renal disease. Primary care team members and patients combine their knowledge with the APRN/CPS experts to create healthcare plans to prevent renal disease in the patients at the highest risk. APRN/CPS teams also provide mentoring, clinical decision support and disease registry resources to assist the primary care team in ongoing prevention of renal disease.

We are now planning to further strengthen our program. We plan to invite nutrition experts to provide guidance during shared medical appointments, providing education on low sodium and fat diets, the importance of consistent carbohydrate diets and the way to manage any potassium and phosphorous restrictions that may arise. Registries to identify at-risk patients with declining estimated glomerular filtration rates (eGFR) and urine samples of raising microalbumin/creatinine as markers of kidney function decline directly related to diabetes will allow us to both provide intervention as well as conduct program evaluation. Specialty training of the
APRN/CPS team will be conducted virtually in collaboration with VA national Nephrology experts and experts from NIH.

We believe that our experience with the APRN/CPS teams demonstrate that the two professional groups complement each other in working to the top of their professional expertise to provide specialized Nephrology interventions that would redesign healthcare in the prevention of chronic renal disease. We believe slowing the progression of renal disease and spreading improved diabetes management to the primary care environment are paramount to the success of this intervention. We recognized that the large number of diabetes patients at high risk for renal disease and the high cost of treating this disease indicated a gap in our services that we could change. We realized that we could create services that could help stem the progression of this disease. We are now moving to our next initiative: group visits led by an APRN/CSP team to target high-risk patients not meeting health measures. We believe APRNs can step in to offer chronic disease management along with our CPS colleagues as full partners of the primary care teams.

In summary the metabolic and diabetes nursing FAC in concert with the ONS program manager for specialty care nursing embrace the IOM Future of Nursing report to challenge nurses working with patients with diabetes to provide increased training, collaboration with health care interprofessional teams and system redesign to foster optimal outcomes in our patient populations. A mobile application program was created to foster patient self-management disease education. Additionally, two pilot projects in protocol use for RN case management for insulin titration and collaboration with NP’s and clinical pharmacy specialists are being implemented to help mitigate the complications of diabetes. We, VA nurses are answering the call to be full partners with other health care professionals to make meaningful health care redesign that has a measurable impact on the trajectory of a rampant chronic disease that threatens to overwhelm the current healthcare system.

REFERENCE

Chapter 18.2

Collaborative Interdisciplinary Pain Management During Transitions in Care

Mary Susan Biggins and Brenda Rushing French
The polytrauma rehabilitation field advisory committee (PFAC) and an overview of its work and responsibility were introduced in chapter seven. Here, we plan to share the work and results accomplished by the PFAC, tracing the development of the interdisciplinary partnerships we created to address a specific pain management issue of concern. More specifically, we were to address the use of patient controlled analgesia (PCA) pumps, used by patients while they were transitioning from a military treatment facility (MTF) to the Department of Veterans Affairs (VA) polytrauma rehabilitation center (PRC). Mary Sue Biggins is the polytrauma rehabilitation clinical nurse advisor for the Office of Nursing Services (ONS) clinical practice program (CPP) and the polytrauma clinical nurse educator for the Edward Hines Jr. VA hospital in Hines, Illinois. Brenda French is the polytrauma staff educator for the Hunter Holmes McGuire VA medical center in Richmond, Virginia and charter member of the PFAC. Working in the field of rehabilitation nursing, early on we came to value the importance of and strength that is derived from being a member of a well-functioning interdisciplinary team. We see this same flexibility, resiliency, respect and sharing of ideas among the PFAC members as we address challenging polytrauma rehabilitation Veteran care issues. We never cease to be amazed at the adaptability and perseverance of members of the PFAC team in their continued exemplary accomplishments on behalf of the polytrauma Veterans and their families. Frequently, we find that the end results far exceed our initially anticipated expectations. While the PFAC is an all nurse committee, the ingrained interdisciplinary team concepts are alive and well within the committee.

PFAC nurses represent a multitude of VA nursing roles: administrator, clinical nurse manager, assistant nurse manager, direct patient care giver, case manager, educator, polytrauma coordinator, pain nurse, rural clinic medical director, researcher and consultant. The members are representative of the different levels of the VA polytrauma system of care, both large and small facilities, and across the United States geographic regions, north to south and east to west, where VA nurses provide care. Most of our work is done through conference calls and emails, with an annual face-to-face (F2F) meeting. We have found that one of the great strengths of the PFAC in achieving its goal to improve the care of our polytrauma Veterans and their families is the committee’s skill in tapping into the expertise of others, keeping the doors of communication open and embracing adaptability and perseverance. After all, that is exactly what we expect from our Veterans as they work toward their rehabilitation.
During our October 2011, F2F meeting, we discussed areas of concern and future focus. PFAC member, Valerie Rodriguez-Yu offered to lead a workgroup to investigate these concerns. We highlighted an area needing further exploration. This was the MTFs use of patient controlled analgesia (PCA) pumps for pain management of active duty service members (ADSM) and Veterans who were being transitioned from the acute phase of recovery to the rehabilitation phase of recovery at a VA PRC. We know that pain management in rehabilitation is absolutely essential. It can facilitate the ADSM’s or Veteran’s ability to participate in the required three hours per day of rehabilitation activities so they can then reap the optimal benefits of this rigorous program. We realized, however, that we do not normally associate a PCA pump with rehabilitation, as this is not a common pain management modality in our specialty.

To ensure that our responses to this issue were grounded in our practice realities, we initiated an evidence based project to evaluate this process, discover best practices and make recommendations. Our investigation revealed that two of our five PRCs did not accept ADSMs and Veterans into their rehabilitation program if they were using a PCA pump. While the remaining three sites accepted the patients with PCA pumps, reported consensus was that it was an infrequent occurrence. We immediately saw this as a red flag, raising new concerns regarding “high risk” and “problem prone/low volume” situations, where care for some may be prohibited or inadequate due to an unexamined policy. Exactly how infrequent were these occurrences?

Based on these findings, our workgroup determined that we needed more information in order to make any informed decisions on the matter. We believed that our first responsibility was to advocate for patient care safety standards and for staff, patient and patient caregiver training and education regarding pain management. More specifically, we set out to explore the integration of patients using a PCA pump into our existing rehabilitation programs of care and what that would ask of all involved.

This focus guided our first steps in our process. We identified the need for potential oversight of this process in the field. We developed an action plan with several components. We decided to conduct a literature review to discover and evaluate the evidence base for this practice. We would seek out the knowledge and expertise of subject matter experts in the realm of pain management for this population. We would collaborate with the Department of Defense (DoD) MTFs to explore our shared pain management options.
We would then evaluate the gathered information and collaborate with appropriate parties involved to draft recommended actions. Our recommended actions would be ones that support Veteran-centered care and safety, and comply with the standards of The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF). We would also have the recommendations vetted by subject matter experts. We would then disseminate the recommendations to the field for a practice change, providing our VA nurse colleagues with the essential tools, resources and evidence. Finally, we would evaluate the results and effectiveness of our recommended practice change.

We had determined the “why” in this project in questioning the efficacy and safety in transitioning ADSMs and Veterans from MTFs to VA rehabilitation centers with PCA pump pain management. We designated our patient population as that of polytrauma adult ADSMs and Veterans. We identified a multitude of stakeholders to contact for further insight. This included the following: ADSMs, Veterans, family/caregivers, military treatment teams, VA nurse liaisons at the MTFs, nursing leaders, staff nurses, physiatrists, case managers, pharmacists, pain resource nurses and transfer coordinators.

We solicited clinical expertise from a diverse array of colleagues. This included members at the five PRCs, the PFAC members, the Office of Nursing Services (ONS) pain workgroup representatives, members of the MTFs treatment teams, VA nurse liaisons, VHA national program director for pain management and the polytrauma national coordinator. Initially, we sought to gain insight by comparing different practices. We learned that where one MTF might always wean their patients off the PCA pump prior to transfer, another MTF might elect to maintain the use of the PCA pump as a viable pain management option during transition. This helped us face the obvious question: were we being callous and lacking in compassion and understanding of the severity of pain issues experienced by these severely injured ADSMs and Veterans? We knew we were neither lacking in compassion, nor callous in our understanding of what is involved here. We realized that we were all intimately aware of the sacrifice, the severity of injuries and the pain and suffering of these ADSMs and Veterans. We knew, too, the cost to their families. We all, as VA and MTF health care providers, strive for the same goals. We all wanted the same thing for our patients: healing, rehabilitation and reintegration back to a life with the highest possible level of independent function. We wanted to find the best means of pain management, the one that is most effective, with the fewest side effects that our state-of-the-art technology has to offer these patients.
As our next step forward in gathering information, Valerie Rodriguez-Yu and Mary Sue Biggins met in June 2012 with the polytrauma national coordinator and the VA nurse liaison from the Walter Reed National Military Medical Center (WRNMMC). Our goal was to draft a plan to gather data about potential transitioning patients in lieu of an F2F meeting at the MTF. We decided that the nurse liaison would provide a monthly report of any ADSM or Veteran who transferred from the MTF to VA with a PCA pump. The data included the name of the patient transferred, date of transfer, and the recipient VA location. In turn, we would collect VA data on the patients received with a PCA pump, looking at length of time they remained on the PCA pump, disposition of the PCA equipment, issues encountered in the weaning process and any additional information that the sites chose to share regarding the transfer process for patients with PCA pumps. Due to the infrequency of working with a PCA pump on a rehabilitation unit, we also decided we would conduct a competency assessment of the nursing staff receiving and caring for these patients, viewing this new nursing care responsibility as a relevant high risk, problem prone safety issue. Implementing our plan, we gathered data from WRNMMC, the San Antonio Military Medical Center and the five VA PRCs located at Richmond, Virginia; Tampa, Florida; San Antonio, Texas; Palo Alto, California and Minneapolis, Minnesota. Data were gathered over a six-month period, from June 2012 through December 2012.

After six months of gathering this information, our data revealed several important facts. While three patients were transferred with a PCA pump, further investigation revealed that during this time, only one patient with a PCA pump was received at the PRC in Richmond, VA where we were able to capture useful data. The type of PCA device used by the MTF was not compatible with VA equipment. VA nursing staff exposure to PCA pump technology in rehabilitation settings was very limited. We learned that the weaning of the ADSM/Veteran from the PCA device at Virginia occurs in a relatively short time period without complications. The chain of custody of narcotics in the PCA device during transfer was a concern. Finally, we learned that there was no standard operating procedure for returning the PCA device to the MTF. We had identified several major areas of focus from these results that required immediate attention. We thus began to resolve the issues we had identified.

We saw nursing competency and chain of custody of a controlled substance as our two top priorities. In October 2010, the Association for the Advancement of Medical Instrumentation (AAMI) and the United...
States Food and Drug Administration (FDA) convened an infusion device summit in Silver Spring, Maryland to identify and create action plans for the top patient safety concerns in the use of these devices. The summit prioritized thirteen key concerns. Among the identified concerns were the following two that clearly related to our efforts: “incompatibility across devices and systems,” and “lack of knowledge/familiarity with infusion devices and a lack of effective training in their use” (Association for the Advancement of Medical Instrumentation, 2010). This further validated our concerns, and to address them, we reached out to our VA colleagues: the ONS pain workgroup, the PRCs, the national nursing practice council and several other facilities. We sought their help in identifying a PCA competency tool that is evidence based and Veteran centered.

We are now working collaboratively with the PRCs, WRNMMC, pharmacists and the polytrauma national coordinator, to develop and implement the required TJC standard operating procedure (SOP) that allows documentation of the controlled substance chain of custody and can be utilized by both DoD and VA systems. Once we have these two issues resolved in a safe, TJC and CARF compliant manner, we will utilize our ONS multi-modal methods for expediting dissemination of these recommendations to our colleagues in our relevant practice settings. We will utilize the routinely scheduled conference calls for the polytrauma system of care group, the national nurse executives council, the nursing practice transformation goal group, the national nursing practice council and the polytrauma nurse email group, as the most expedient means to disseminate recommendations on these two priority issues. We will also continue to collaborate with the MTF contact and nurse liaison for development and dissemination of the chain of custody documentation tool compatible with both DoD and VA systems.

Having addressed this priority, we continue to address the issue of open communication and dialogue with the MTF team and the VA PRC interdisciplinary team via video-teleconference calls, the DoD/VA jointly developed patient transfer summary template and the PFAC transitions in care recommendations document. These are now designed to convey both verbally and in writing the type of pain management plan for transitioning the ADSM or Veteran to the rehabilitation facility. This allows timely dialogue and discussion to occur between the transferring and receiving facilities about the optimal pain management modality for any given patient. If this plan involves a PCA pump, the VA PRC team is alerted to the need to be prepared to switch out the PCA device for
the existing VA equipment without delay, so there is minimal disruption to the ADSM or Veteran's pain relief. It also provides an opportunity to proactively be prepared to complete the required chain of custody documentation for the controlled substance. Furthermore, we are discussing the development of a SOP and documentation for tracking the return of the PCA equipment to the MTF, since replacing it costs approximately $364.00, in addition to the time and delays encountered accounting for and replacing lost equipment.

This collaborative team effort started out with the PFAC’s two simple questions: “Why are ADSMs and Veterans being transferred to a rehabilitation facility with a PCA pump? Is this a safe practice?” Our process showed us that this was the proverbial “tip of the iceberg.” Our two simple questions became many. How often is this event occurring? Are the PCA pumps received at all five PRCs? What is the source of the transfer? Is equipment compatible from MTF to VA? How is the controlled substance chain of custody being handled to meet TJC standards? When the PCA pump needs to be returned, what is the process? How long does the patient remain on the PCA pump at the PRC, before being weaned? And, most significantly, are we doing the best job possible in managing the ADSM or Veteran’s pain during the transition to the rehabilitation phase of care?

We have broadened our outreach to the many stakeholders identified previously, keeping the ADSM and Veteran’s needs as the central issue. In doing this, we have identified and prioritized the necessary work as we go forward to resolve all of the concerns uncovered. We will disseminate a completed evidence based product, once all of the issues are finalized in a satisfactory manner, using the modalities sited earlier and, in our long-range plans, use additional dissemination resources that include the PFAC Live Meeting Webinar, the ONS clinical practice program’s intranet product page and a future conference poster.

We would like to highlight the importance of the mutually collaborative teamwork among the PRC staff, the MTFs, the VA nurse liaison, the VHA national pain program director, the ONS pain workgroup co-leaders, the polytrauma national coordinator and members of the PFAC that produced these results for the benefit of improved safety and care of our polytrauma ADSM and Veteran patients. Our work is not finished, but has centered our focus on several important Veteran care and safety issues. The teamwork and the research is ongoing in an effort to discover the optimal ways to transform pain care and improve pain management at all phases of our Veterans’ healing and
rehabilitation process. The PFAC nurses will continue to reach out to all the stakeholders involved in this process and will steadfastly advocate for optimal pain management on behalf of the active duty service member, the Veteran and their family at all phases of recovery from trauma.

REFERENCE

Chapter 18.3

We Are All on this Team for Our Veterans: Striving for Veteran-Centered Care

Barbara Galbraith and Kathy Wieneke
Stories throughout time have laid the road for future hopes and dreams. The Veterans Healthcare Administration (VHA) initiated the Patient-Centered Care (PCC) initiative to promote commitment to our Veterans. The PCC initiative honored the Veterans’ individualized personal goals for their health with a proactive integrated holistic approach. PCC focused on combining the VHA vision of providing Personalized, Proactive, Patient-Driven, Evidence Based, Veteran-Centered Care with the focus of PCC to influence health care practice and the Veterans’ experience. The practice element incorporated a personalized health approach and the components of well-being. The experience element incorporated healing relationships and healing environments. Recent updates included integration of complementary and alternative healthcare resources for our Veterans.

At the time of this writing, Barbara Galbraith was the program director for quality resource management at the Sioux Falls, Iowa VA Health Care System. Barbara was designated as the lead facilitator for the pilot initiative of the patient-centered care collaborative for the Sioux Falls VA Health Care System. Kathy Wieneke was the nurse manager of the Spirit Lake community based outpatient clinic (CBOC), which is an outreach clinic for the Sioux Falls VA Health Care System. Kathy was a patient-centered care facilitator for the Sioux Falls VA.

The Sioux Falls VA Health Care System employees were the fortunate recipients of an organizational assessment of our PCC practices during a bitter cold week in January 2011. The brave VA national PCC field implementation team and their consultant specialists ventured to the frosty midwest to assess the current state of affairs for PCC practices at our health care system. They also came to provide recommendations to the leadership team, comprised of the director (position comparable to private sector CEO/president), Associate Director (position comparable to private sector COO/vice president), associate director for patient care services/nurse executive and the chief of staff to advance our PCC practices. The PPC field implementation team, in conducting their comprehensive facility assessment, included numerous facilitated listening sessions, involving Veterans from all eras, both male and female, our community based outreach clinics (CBOC) Veterans, Veteran’s family members and employees representing all levels of the facility including CBOC employees and our volunteers. The team’s facilitators demonstrated proficiency and skill in identifying specific opportunities for our facility during these listening sessions. The outcome of this PCC organizational assessment was a customized roadmap that outlined
priorities for Veterans that incorporated the practice and environmental elements of PCC. As noted above, the focus on PCC practice included a personalized health approach in alignment with the components of health and well-being and the Veteran experience focused on the areas of healing relationships and healing environments.

The comprehensive facility assessment had several recommendations, including one supporting the implementation of PCC staff engagement sessions. To implement these sessions, we identified individuals who we considered to be change agents from various departments and invited them to attend a PCC facilitators training program. This interprofessional team of PCC facilitators included some employees who were also members of our health promotions disease prevention (HPDP) committee.

The HPDP committee’s mission was to ensure integration of health promotion and disease prevention services into our overall program of care for our Veterans. The HPDP communicated and coordinated services focusing on the following healthy living messages: be tobacco free, be physically active, eat wisely, strive for a healthy weight, be safe, manage stress, limit alcohol, get recommended screening and immunization, and get involved in your health care. The dual membership design (PCC facilitator and HPDP committee member), promoted the practices of personalized health plans, complementary and alternative medicine (CAM) and opportunities for environmental changes which positively influence the PPC focus.

Our PCC staff engagement sessions have spread the positive energy of focusing each employee’s daily work on goals that are important to Veterans. We introduce actual examples of health care team members providing individualized holistic patient-centered care for Veterans in this chapter. For the purpose of individual privacy, we use fictitious descriptions for the Veterans in these examples. The journey of Veteran-centered care in our examples could be from any VA healthcare center, from anywhere across the nation and the stories include experiences of Veterans of any sex, any race, any age, any military era, and any military operation, war or conflict. For ease in telling the story, we have assigned gender in our story, describing the Veterans in these stories as men. The stories, however, are a composite and could as easily be the stories of a Veteran who was a woman. As we collaborated to develop these shared stories, we focused on the privacy of individual Veterans from our actual experiences.
A Nurse Tells A Story of a Veteran Seeking Care:

Stooped over and shaking, this Veteran arrived at my office with his significant other, seeking assistance with locating the Prosthetic’s Department. Both he and his significant other regularly arrived at my door asking for guidance after this first “Please help us find this” interaction. Over the years of these “pop-in” interactions, I would come to hear this Veteran’s story. He had endured a horrific experience while in the service which resulted in memories and dreams that haunted him for years. This Veteran dealt with this trauma by over consumption of a chemical that physically and mentally affected his health status. The result of over consumption had influenced the Veteran’s personal relationships leaving him estranged from many family members. After years of treatment and counseling, the Veteran developed a healthy relationship with a significant other. Noteworthy, this Veteran had a tendency, on first approach, to seem angry especially during initial conversations with staff members. Over time, the healthcare team grew to accept his tone of voice as a “smoker’s voice”, which is raspy and harsh sounding.

The diagnosis of Parkinson’s was the next insult to this Veteran’s health. The diagnosis of Parkinson’s disease, or as the Veteran called it “palsy”, negatively influenced his emotional state. The Veteran’s significant other also had increasing anxiety after using “Google” and learning about all of the negative consequences of Parkinson’s. Over the years, the Veteran had excused the tremors as “too much coffee in the morning”. He described the unexpected falling as “clumsiness”, or “why I could never play basketball”. The “golden” years had evaded him. It seemed to the Veteran that the world was falling apart. The lack of dopamine meant the brain cells were slowing dying off and the messages to the brain had broken roadways.

The worst symptom for the Veteran was shaking so badly that he could no longer safely pour coffee for family or friends much less drink coffee without spilling it all over the morning newspaper. Walking was beginning to feel like the Veteran was dragging extremities that were asleep, heavy and useless. The drooling was very embarrassing. Kind people would say, “I miss your smile” to the Veteran, who wanted to smile, but the Parkinson’s disease had taken away his ability to have any facial expression. The Veteran missed writing; all fine and small movement was no longer possible, something we all take for granted. The continuous shaking was frustrating for the Veteran. Mostly he feared the end; when the dementia would finally set in and he would no longer be able to control his mind.
The healthcare team took a Veteran-centered approach, working with the Veteran and his significant other on their personal goals to improve the Veteran's health. The team provided easy to understand instructions and the team was always just a phone call away for any questions. The team had those difficult conversations about Parkinson’s disease, including the fact that the disease is not curable. The focus for the Veteran, the significant other, and the health care team was to control the symptoms with medication, other supportive therapies, and to ensure that the home environment was safe.

This Veteran had one goal, “Travel with the one I love as long as I physically am able”. We worked to make that possible through our care provisions. During this travel, the Veteran sought to reconcile broken family relationships. Some reconciliation attempts were successful, and some were not. This Veteran spoke of great appreciation for “the team” who put concrete actions in place toward his goal. The team understood the Veteran's personal goal. Time took a toll on this Veteran. Gradually the Veteran lost emotional control. This resulted in medication adjustments, which dulled the Veteran's cognitive senses. Gait changes and loss of bodily functions were next.

As this Veteran's health continued to fail, his significant other maintained a supportive caring relationship. When he was no longer able to express his personal goal, the significant other relayed the goal, which the Veteran had developed years prior. The living will, which the healthcare team had encouraged in earlier years, provided us with the goals of the Veteran in the final stage of life. The Veteran transitioned to palliative care, focused on improving quality of life while addressing pain and the stress of his declining medical condition. The Veteran successfully obtained his last goal, to have a peaceful dignified exit from earth.

★ ★ ★ ★ ★

A Nurse Tells A Story of a Veteran Seeking Care:

I once cared for a Veteran who had a wound that had been an issue on and off for almost 30 years. This was a wound that had been infected and had to be reopened several times over the years and just would not heal correctly. At the time I cared for him, the wound was again infected. The Veteran was very depressed as he saw as this yet another battle with the wound. In an attempt to heal the wound, a wound vac was ordered. We helped the Veteran understand that the wound vac is a devise designed to pull the drainage out of the wound and keep the base of the wound clean.
and dry. The wound vac required twice per week dressing changes. Changing a wound vac dressing is not a complicated or difficult procedure; however, this Veteran’s wound was very odoruous. Upon removing the old dressing, the room would fill with an offensive smell. None of the nurses wanted to assist with the dressing change because of the odor. Whenever it was time for this dressing change, all of the nurses in the area found something else to do so they were not “stuck” changing the dressing.

The doctors had checked the wound and it was healing well. The wound vac was working and had to be continued. Finally, my co-worker and I decided to “claim” this Veteran as our own. We planned a dressing change schedule that worked well for the Veteran, ensured our supplies were always ready and made the most of the situation for the Veteran. The Veteran knew the wound smelled bad and constantly apologized for the smell. The dressing change was also very painful for the Veteran. My co-worker and I advised the Veteran to take pain medications prior to the dressing change. This provided significant pain relief. When it came to the smell of the wound, we all simply ignored it. We captured the Veteran in conversation.

During the two to three months of the twice per week dressing changes, we learned a lot about the Veteran’s past, about how the injury came to be and everything that the Veteran had been through in attempts to heal the wound. In learning about the Veteran, I learned that he did not have many family members or friends at his side. The Veteran was very quiet when we started our care, but once we developed a healing relationship with this individual, he began to trust us and started to open up and talk. As time went on, we would laugh and tell stories during the dressing change to the point that we did not even notice the odor any more. At one time, the Veteran made the comment that the dressing changes were not only good for the wound, but they were also a therapy session! Instead of dreading the dressing change, the Veteran began to look forward to it! The patient was very excited to see the progress that the wound was making week to week. The day that the wound finally healed was an awesome day for this Veteran.

To me, this is the essence of Veteran centered care. The Veteran needed the wound healed, but he needed more than that. He needed to know that someone cared about him. The wound was only one little part of what was a health need for this Veteran. The Veteran was also depressed and lonely. Caring only for a Veteran’s wound or disease is not enough. We have to look at the whole person, the whole body, mind and spirit.
Veterans depend on their health care team when they are most vulnerable. Their physical illnesses are most visible, but what is often unseen are the struggles with mental and social effects from their military experience and/or their physical illnesses. We believe that we must be ready and willing to do our part as a health care team to ensure each Veteran is cared for with a Veteran-centered care approach. We demonstrate this Veteran-centered approach when we take the time to listen to the Veteran. As we listen to our Veterans, we discover their personalized health mission and goals. The patient-centered care field implementation team encourages us to embrace the military mindset of Veterans to help them to be “mission ready” with their personal health goals, much like they were “mission ready” when serving our country to protect and defend our freedom. Holistic Veteran-centered care partnerships develop in a culture of collaboration and cooperation with the Veteran, the Veteran’s family and the healthcare team when the focus is on the Veteran’s goals.
Chapter 18.4

Building Interprofessional Partnerships: VHA’s Pressure Ulcer Prevention Initiative

Mary Ellen Dellefield and Storm Morgan
Veterans Health Administration (VHA) and its Office of Nursing Services (ONS) have an ongoing commitment to eliminating pressure ulcers throughout the VHA healthcare system. In 2006, ONS published the first VHA Handbook for Pressure Ulcer Prevention in the effort to provide an evidence based policy on the subject for nurses practicing in all clinical settings.

We are the leaders for the national hospital acquired pressure ulcer (HAPU) initiative. I, Mary Ellen Dellefield, research nurse scientist, VA San Diego, California health care system have been an active member of the VHA HAPU prevention workgroup since its inception in October, 2011. I, Storm Morgan, ONS pressure ulcer prevention coordinator was appointed the chairperson when joining the effort approximately six months after the workgroup’s inception. I assumed the chairperson role in July 2012, upon the VHA retirement of the former chairperson, Janet Yaeger, ONS special projects officer. In addition to participating in the large workgroup, Mary Ellen is the chairperson of the HAPU research subgroup. Storm also co-chairs the HAPU communications and marketing subgroup. Several members of our workgroup were also contributors to developing the original and revised handbooks.

The initial policy document/handbook was developed by an interdisciplinary group of diverse workgroup members. The workgroup members included certified wound nurses from different regions of the United States, physicians, dieticians, nurse researchers, and an administration representative. Participants were selected because of their specialized knowledge in pressure ulcer prevention and care. The majority of the work was conducted virtually with only one face-to-face meeting in Washington, DC.

In 2008 the National Quality Forum (NQF) introduced industry-wide innovations that influenced healthcare system practices related to HAPUs. NQF endorsed the definition of serious reportable events in healthcare or 28 (now 29) “never events” (NQF, 2006) that included HAPUs. “never events” are defined by the Agency for Healthcare Research and Quality (AHRQ) as patient care events that are “unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), usually preventable,” and result in significant unreimbursed costs, and high morbidity and mortality (AHRQ Patient Safety Net, 2012). In response, the healthcare industry, including VHA, intensified its efforts to heighten awareness of the importance of preventing “never events,” including HAPUs.

In July 2011, ONS published the revised VHA Handbook 1180.02, “Prevention of Pressure Ulcers” in response to the heightened emphasis on elimination of HAPUs and the importance of collaborating across diverse health care professions in this effort. ONS took the lead to engage the interprofessional VHA workforce to prevent HAPUs. This included dieticians,
pharmacists, physical and occupational therapists, social workers, physicians from spinal cord injury service, plastic surgeons, podiatrists and advanced practice nurses. The handbook provides specific recommendations for pressure ulcer prevention and clinical practice expectations for all staff throughout the VHA who are involved in the care of patients at risk for pressure ulcer development.

Following the issuance of the revised handbook, ONS developed the national HAPU prevention initiative. The initiative consisted of three strategies. The first was the development of a communication plan to introduce the handbook and share information with VHA leaders, especially the nurse executives. The second was the development and broadcast of a PowerPoint presentation to all facilities to inform health care professionals in the field about the clinical HAPU Prevention Initiative. The final strategy led to the creation of the national VHA HAPU prevention workgroup charged with implementing the handbook and developing strategies for “Getting to Zero” throughout VHA.

Development of a comprehensive workgroup charter has been fundamental to the success of the national workgroup. We wrote the initial charter in 2011 by focusing on two objectives. The first objective was to develop a communication and implementation plan to inform leaders and staff throughout VHA about the initiative itself. The second objective was to develop reliable deployment strategies, including accurate data collection and analysis and collaboration with external healthcare agencies. Later, over several months in 2012 and 2013, we revised our charter to clarify and refine priorities related to the agreed upon objectives (VHA HAPU Charter, 2011; VHA HAPU Charter, 2013). These priorities included an emphasis on interprofessional teams; effective bidirectional communication among the point of care staff, Veterans Integrated Services Networks (VISNs), the national VHA HAPU prevention workgroup, and ONS; avoidable versus unavoidable HAPUs; and promotion of a just culture (VHA HAPU Charter, 2011; VHA HAPU Charter, 2013). We also ensured that the language of the charter accurately reflected our work and the needs of the initiative, and responsibilities of each subgroup were clearly identified.

Laying this strong foundation has enabled us to keep our sense of mission and focus on the ultimate purpose of the workgroup. By February 2013 the final version of the charter was available. Our in-depth and active discussions during the charter revision process were rich, with workgroup members sharing their perspectives, priorities, and strategies. Our discussions also prompted us to review the current literature on pressure ulcer prevention “hot topics”.

In October 2011, shortly after the revised handbook was issued, we began the formal handbook implementation planning process. This workgroup included advanced practice nurses, many of whom were certified in wound and ostomy care and/or doctorally prepared, as well as dieticians and physicians. We needed this high level of educational preparation and nursing expertise to ensure the superior quality and implementation of the handbook.

At the same time, our workgroup began bi-monthly conference calls. Over the next 9 months, we accomplished several things. We began our process by eliciting the expertise of the person who led the VHA Methicillin-resistant Staphylococcus aureus (MRSA) campaign to understand the lessons learned from that successful campaign. This was a wonderful example of benefitting from a prior but similar VHA effort. We identified HAPU sub-groups with targeted emphasis on education, data collection, marketing, collaboration with external healthcare agencies, information and business reporting, and implementation. Over the next several months, each sub-group reported on their evolution and progress. We benefited from members sharing their individual expertise through presentations about a range of pressure ulcer prevention topics. One of the best characteristics of our workgroup at this time was that we were able to have candid and respectful conversations about many aspects of pressure ulcer prevention and treatment in VHA. While several members had never met one another, we developed effective working relationships through our bi-weekly interprofessional conference calls.

Our HAPU workgroup members are very effective leaders and followers and we have capitalized on their attributes. Despite several challenges, including the fact that these assignments were typically collateral duties, the team has been very cohesive, productive, and flexible. We had to alter our course several times and remind ourselves to focus on prevention rather than treatment because, unlike the handbook we were replacing, the new handbook focuses exclusively on prevention rather than treatment. When implementing the handbook, we also needed to ensure inclusion of staff from a variety of VHA clinical settings such as small community based outpatient clinics (CBOCs) to complex major medical centers. We specifically considered variances in local processes, such as those related to assessments and data collection, by clarifying the definitions and identifying how specific clinical staff would contribute to the assessment and documentation process.

Our workgroup has been successful in completing our assignments but the work is ongoing and will continue beyond the initial three-year goal. Throughout our journey we learned valuable process-related lessons about group work. Comprised of 24 members, the size of the workgroup
is manageable and not too large. When specialized knowledge is required beyond what we have, we contact other VHA experts to share their specialized expertise on an ad hoc basis. Although many of the assignments are complex and volume-heavy, we break down the work into manageable sections, delegate accordingly, and maximize the benefit of small teams. We also strike a balance at times by having the content be applicable to all clinical settings, while including specific information relevant to individual types of settings. This standardized approach for core content minimizes the number of training modules we need to develop.

In July 2012 we began another phase of our HAPU initiative when our national workgroup held a face-to-face planning meeting in Denver, Colorado. This meeting gave us an opportunity to review our progress over the 10 months and reassess our priorities, challenges, and strategies. We were able at that time to begin revision of the main workgroup charter, and start developing a crosswalk between the main workgroup charter and the goals and strategies of the sub-groups. The revised focus for sub-groups included responsibilities related to staff education, research, data utilization and informatics, communications and marketing, and implementation at the point of care. This was a transition meeting because the workgroup chairperson position rotated to a new leader due to the retirement of the previous leader. The transition was seamless, largely due to the highly effective communication and organized efforts of the previous leader. In addition to the progress we made with strategic planning during the meeting, we also gained momentum from the formal and informal face-to-face interactions.

At this point, a strong enough foundation was laid for our momentum as a workgroup to significantly increase. By the end of October 2012 we had made substantial progress and were thus able to expand the interprofessional membership of all workgroups, as well as raise the visibility of the initiative. We also named co-chairpersons for all the workgroups, which helped us balance the time commitments required for those roles and improved contingency and succession planning. Our interprofessional membership expansion included adding representatives from a wider range of services and disciplines. For example, we added an RN from the VHA National Center for Patient Safety (NCPS), a communications expert, podiatrists, physicians from plastic surgery and spinal cord injury, an RN from the employee education center, nursing wound experts from additional VHA facilities, and other stakeholders. These individuals added richness to the workgroups by providing different perspectives, high energy, and bidirectional communication channels with their service or discipline-specific colleagues.
Specific contributions were made by each of these members. The RN from NCPS reviewed, summarized, and disseminated information about HAPU-related root cause analyses. She also led discussions about just culture with the VHA National Center for Ethics in Healthcare and provided a forum to educate safety officers throughout VHA about our new VA skin bundle. The skin bundle is a document that succinctly summarizes evidence based interventions for pressure ulcer prevention in five areas and includes the levels of evidence, providing support for each intervention. It is available across VHA electronically in a variety of formats. The communications specialist provided guidance and expertise to the communications and marketing sub-group. The podiatry and physician experts added expertise about their specialties and served as champions with their national and facility-based colleagues. We benefited from this enhanced membership by being able to conduct our work with a heightened awareness of other VHA programs and resources.

One particular challenge we identified with the HAPU prevention initiative is related to accurate data reporting at the point of care. We recognized the need for accurate assessment and documentation early in the initiative. As a result we have directed great efforts to improve assessment and data collection processes, as well as training for staff in those areas. We developed and offered numerous formal presentations and served as subject matter experts for questions from VHA staff. We routinely update nurse executives and other leaders on national calls. We directed specific training efforts for Veterans administration nursing outcomes database (VANOD), and ASPIRE, a web based dashboard that documents quality and safety goals in all VA hospitals. Our nursing informatics specialist and the chairperson of the data utilization and informatics subgroup, as well as other data experts led these. We also expanded training options to include a variety of resources such as virtual methods and decision-simulation, in addition to traditional approaches.

As of February 2014, we have succeeded in accomplishing several things, including completion of the revised charter, an expanded and diverse membership, release of the approved version of the VHA skin bundle, and development and additional planning for Veterans Health University (VeHU) trainings related to pressure ulcer prevention. VeHU is a virtual training resource available to VHA staff that provides real-time and on-demand state-of-the-art training content on a range of topics. A national list of nurses certified in wound and ostomy care has been collected. Storm has continued to report and interact with the ONS and national nurse executives at facilities to keep them informed of our activities. We have now initiated
a strategy to include local facility leadership in activities related to pressure ulcer prevention, particularly train-the-trainer efforts. This improvement in communication and training is partially the result of establishing a list of points of contact for the initiative at the regional and facility levels. We recently renamed the HAPU Initiative, which is limited to acute care settings, to the pressure ulcer prevention Initiative that is better aligned with the organizational goal to eliminate pressure ulcers throughout all clinical practice settings. This change promotes pressure ulcer prevention as a priority in other areas such as outpatient, mental health, home care, and community living centers. A sustainable infrastructure for future efforts to support the pressure ulcer prevention Initiative will be possible because of the comprehensive strategy and dedication that involves the entire VA health care team.

REFERENCES


Chapter 18.5

Collaborative Partnerships Promote Improved Veteran-Centered Outcomes in the Field of Spinal Cord Injury and Disease

Mary Susan Biggins and Linda Madaris
The Veterans Health Administration (VHA), through the leadership of the Office of Nursing Service (ONS) has initiated several collaborative partnerships that have made significant improvements in patient outcomes. We will describe a variety of such innovative collaborative projects related to VA nurses’ impact on spinal cord injury initiatives.

One of the projects that we are most proud of is the revision of the Department of Defense (DoD)/Department of Veterans Affairs (VA) transfer summary template note to include spinal cord injury (SCI). Active duty Service members (ADSM) injured overseas are stabilized at DoD field hospitals and then transferred to military treatment facilities (MTF) in the United States (US). Once they are medically cleared for rehabilitation, they are transferred to one of five VA polytrauma rehabilitation centers (PRC) across the country.

The ONS polytrauma field advisory committee (PFAC) collaborated with the DoD and VHA SCI national leadership to develop an electronic transfer note that included essential SCI criteria for the safe transfer of these patients between facilities. This electronic template is accessible by both VA and DoD, thus improving communication of the transition/hand-off of patients and their care from and to both facilities. As PFAC nurse advisor, Sue provides system wide leadership and direction for nursing practice in the areas of rehabilitation, polytrauma and spinal cord injury; she is the direct link with the Office of Nursing Service (ONS) clinical practice program. Linda has been serving as an active member of PFAC since 2010, providing knowledge and expertise in the field of SCI and polytrauma.

The DoD/VA transfer summary template note, which provides clinically pertinent information that is necessary when transferring patients to a different level of care, was originally drafted in 2008. Brenda Stidham, VA nurse liaison at Walter Reed Army Medical Center and Marti Veneman, nurse manager at Tampa, Florida James A. Haley VA, jointly developed the note with staff input from both facilities, as well as Bethesda, Maryland National Naval Medical Center. The template electronic note, originating at the transfer facility, contains details of the care being provided to the injured active duty Service member (ADSM) and was accessible electronically by the receiving facility. This was a major informatics accomplishment between the DoD and the VA, since their electronic records, up to this point, had been distinct and separate entities. On the day of patient transfer, the transferring nurse updates the note with the most current nursing care information. The receiving nurse reviews the note prior to the patient’s arrival to ensure a smooth transition of care. After reviewing the
note, the receiving nurse may contact the transferring nurse to clarify any information related to the transfer.

In 2010, we identified a gap regarding transfers of polytrauma patients with spinal cord injury and disorders (SCI). ADSMs with SCI are normally transferred to VHA SCI rehabilitation units, either at a PRC or a polytrauma network site (PNS). Some of these transfers from the east coast to the west coast can require a two-day travel period. We recognized that the original DoD/VA Transfer Summary note did not include important care requirements related to SCI.

We were invited to work collaboratively with Brenda Stidham to offer revisions to the DoD/VA transfer summary template note to include care needs of ADSMs with SCI. Sue initiated this outreach, proposing a partnership among DoD, SCI leadership, Brenda and subject matter experts on the PFAC. Linda solicited input from other PFAC members with SCI field expertise and other SCI field nurses to capture the unique needs of this patient population. We held multiple conference calls to articulate the information that would improve continuity during transfer and prevent delays in re-establishing care routines at the receiving facility. We made several revisions before we felt that we had the right amount of information in the note to give the receiving nurse an adequate hand-off related to the SCI care needs and the ADSM a safe transition in care. The revisions included sections on level of injury, safety considerations related to SCI, and level of assistance needed with activities of daily living (ADL), including bowel/bladder elimination, respiratory status, pressure ulcers, and other potentially life threatening conditions. This approved document was a culmination of VA nurses partnering with MTF nurses and VHA SCI national leadership. The revised DoD/VA transfer summary template note is awaiting VHA informatics implementation and is being utilized by the MTF’s. It has been shown to be an effective tool for safe continuity for DoD/VHA care transitions.

In 2011 the PFAC was invited by the ONS to participate in a workgroup to make recommendations for implementing staffing methodology in SCI centers. Expert panel based staffing methodology, an objective evidence based practice model, was established in the VA medical-surgical units in late 2010, with the expectation that all VA hospitals would have this staffing methodology implemented by the end of 2011. SCI was a specialty care area designated for Phase II of this implementation and would require specific data elements related to SCI nurse staffing to be in alignment with the standardized methodology approaches. This required SCI data requirement/template revisions and pilot testing. In February 2011, we
attended the first conference call with Alan Bernstein, director of career development and workforce management in ONS, and Teresa England, chief nurse of extended care and nursing operations at Mountain Home, Tennessee VA and the chairperson for the national personnel steering committee. The revised SCI template was a collaborative effort including Teresa England, the PFAC SCI experts, SCI national leadership and ONS and incorporated SCI factors that determine direct care staffing. The turbulence factors built into the original staffing methodology template accounted for rapid turnover of patients in acute care, which we realized did not apply in SCI where length of stay was longer.

We saw representing the PFAC and the interests of all of the SCI units nationally as a serious responsibility that was not to be taken lightly. Staffing in SCI centers has always been a challenge because the relevant VA Directive 1176.01 outlines a minimal staffing requirement for SCI centers of 1.42 full time equivalent nurse (FTE) per required staffed bed (VHA Handbook 1176.01, 2011), and many hospital executives use the 1176.01 provision to justify their staffing. Most SCI nurse managers would propose that the minimum staffing is not enough to address the unique needs of the SCI population, and staff well above the minimum requirement of the 1176.01 provisions. To ensure that we understood the concerns about staffing for SCI, we surveyed the SCI nurse managers requesting input for the workgroup. The following responses are representative of the feedback that we received and helped to clarify the staffing issues:

- The workload duties for nurses varied among the SCI centers.
- The 1176.01 directive does not define an average staffing recommendation, limiting the nurse managers ability to justify increased staffing.
- The concern that the complexity of care requirements for SCI patient family care and education is far greater than the patient turbulence factors defined for acute care.
- Some SCI units were included in Phase I acute care staffing methodology implementation.

Communication related to SCI staffing methodology was ongoing with the national Paralyzed Veterans of America (PVA) in Washington, DC. Early in 2013, a staffing methodology pilot was initiated among six SCI centers in VHA facilities located at Tampa, Florida; Hines, Illinois; Dallas, Texas; Houston, Texas; Milwaukee, Wisconsin; and San Juan, Puerto Rico. VHA Talent Management System (TMS) (n.d.) online training
and mentoring via conference calls were developed and initiated to support pilot implementation. This initial pilot demonstrated the need for further testing and evaluation of the SCI staffing methodology. The results of the pilot were inconclusive and, in June 2013 Beth Taylor, who had replaced Alan at ONS, was asked to lead the development of a second pilot. A steering committee of collaborative subject matter experts was created, including Dr. Barry Goldstein, VHA SCI consultant, Lana McKenzie, associate executive director for PVA and nursing representatives from 4 additional pilot sites including those located in Hampton, Virginia; Long Beach, California; Palo Alto, California and Memphis, Tennessee. Linda and Sue attended the face-to-face meeting that was held in March 2014 to develop a more structured training and implementation plan for the second pilot. This pilot will be conducted over a six month period in 2014 followed by an in-depth evaluation of the process and outcomes before a decision is made to implement the methodology across all VA SCI centers.

Members of the PFAC who work in spinal cord injury also recognize the value of belonging to the Academy of Spinal Cord Injury Professionals (ASCIP), a unique and dynamic organization (http://www.academyscipro.org/). The ASCIP has a membership of 860 interdisciplinary members, including physicians, nurses, therapists, psychologists and social workers, all of who have a common interest in providing the best care for persons with SCI. This organization is truly interdisciplinary in governance, leadership and education. Linda is the current president for the nursing section of ASCIP. Her involvement in the program committee and the nominating committee has opened opportunities for networking and sharing VA nursing success and challenges in SCI. The ASCIP produces the Journal of Spinal Cord Injury Medicine, where the editorial board ensures the highest quality of research reports and manuscripts. Linda, and other PFAC members have been afforded multiple opportunities to share VA research initiatives and performance improvement projects through poster and podium presentations at the ASCIP national conferences. In turn, they bring ASCIP information to their PFAC colleagues related to current initiatives and practice improvements in SCI. In 2012, Linda was selected to be the Audrey Nelson Lecturer for the ASCIP national conference, a distinct honor. The PFAC chose this conference for our face-to-face meeting, and many PFAC colleagues were on hand during the lecture and award. Similarly, in 2013 Sue was recognized for her ongoing multiple contributions to improving outcomes for persons with SCI, and presented the ASCIP Expanded Role for Excellence in Nursing Award.
On May 5, 2010 President Barack Obama signed the Caregivers and Veterans Omnibus Health Services Act into law. The primary purpose of this law was to provide benefits to caregivers who support the Veterans and ADSMs who have been seriously injured during Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq). Over the next year, members of the PFAC, among many other subject matter experts from various disciplines, were invited to participate in work groups aimed at developing an effective implementation plan that addressed the clinical components of the new law.

Several members of the PFAC participated in the various work groups providing expertise on caregiver education, stipend benefits and eligibility. Sue led the education workgroup in the development of the curriculum, competencies and access to multi-modal education and training opportunities via electronic, classroom or self-study options. Linda worked with the stipend workgroup to determine the stipend amount that would be paid to a caregiver. She was the only nurse in this workgroup and felt a huge responsibility to ensure the committee members had a clear understanding of the amount of time and work that a caregiver contributes towards completing bathing, grooming and hygiene needs for service members. In addition, PFAC nurses represented ONS in establishing eligibility criteria that limited participation in the program to service members who were injured in combat after the terrorists attacks of September 11, 2011.

Until 2011, there was no reliable, valid, and/or sensitive tool that assessed pressure ulcer healing in persons with SCI. Practice among SCI centers ranged from using tools found reliable and valid for the non-SCI population or locally developed tools lacking psychometric testing. The Pressure Ulcer Scale for Healing (PUSH) (National Pressure Ulcer Advisory Panel, 2012) and the Bates-Jensen Wound Assessment Tool (BWAT) (Bates-Jensen, 1995) were two tools that were sometimes used. Although determining the success of treatments is based on the trajectory of pressure ulcer healing, methods to accomplish this were inconsistent (Mullins, Thomason, & Legro, 2005).

To address this concern and work toward consistency, the VA Health Services Research and Development (HSR&D) program funded a longitudinal study to develop the SCI-Pressure Ulcer Monitoring Tool (PUMT) to measure pressure ulcer healing over time. The SCI-PUMT is an evidence based tool to help monitor progression of the healing process and generate data on pressure ulcer healing using a 26-point scale. In addition, the SCI-PUMT helps contain the time and costs in the healing process of pressure ulcers, which will improve the quality
of life for individuals with SCI. Several PFAC nurses were identified as champions for their facilities during the introduction of this tool in 2011. They assisted with local training and implementation of the PUMT tool to improve care on the SCI units for Veterans who had pressure ulcers.

As nurses, we have discovered the positive personal impact of involvement in national committee work. Being selected to serve on the PFAC expanded the scope of our national opportunities and contributions to practice. Our experience working on this committee disseminating best practices, standardizing care and developing competencies has resulted in personal and professional growth. In addition, we have participated in establishing national and local policy and document reviews that have an impact on quality outcomes and care across the continuum. Our involvement with the PFAC has helped to shape our careers and has increased our confidence as experts in the field of SCI. A good example of this was the work done involving the expansion of service animals and pet therapy in VA.

Service animals and pet therapy, including that of personal pet visits, are becoming more accepted in the health care professions for their therapeutic benefits. Many Veterans that have diagnoses of blindness, post traumatic stress disorder or SCI, eagerly await trained service animals. Sue was privileged to collaborate on a workgroup at Chicago, Illinois based Edward Hines Jr. VA hospital to establish guidelines for personal pets, either dogs or cats, to be able to visit with their respective owners on the SCI unit. Veterans were always full of anticipation looking forward to a visit of their beloved pets, pets that brought comfort, humor, relaxation and relief from tedium, depression and loneliness to Veterans who may have been hospitalized for many months. Therapeutically, pet visits may positively impact vital signs, and common ailments seem to diminish such as colds, aches and pains (Rovner, 2012). There have been books and articles published by Veterans who served in Iraq or Afghanistan, relating poignant stories of relationships developed overseas with wild dogs, where both sought needed love and relief from stress.

In 2011, because the VA recognized this expanding therapeutic treatment modality, an opportunity arose for a member of the PFAC to serve on a multi-disciplinary committee to develop the national VA policy and guidelines to address guide dogs and service dogs accessing VA facilities. This collaborative workgroup had representation from nursing service, infection control, prosthetics, operations and management, environmental services, mental health, community living centers, rehabilitation service, police service, office of general counsel and the chief veterinary officer. The outcome was the development of a policy document, VHA Directive
Chapter 18.5: Collaborative Partnerships Promote Improved Veteran-Centered Outcomes

2011-013, Guide Dogs and Service Dogs on Veterans Health Administration Property (2011). The policy addresses Veterans and members of the public who enter VHA facilities accompanied by guide dogs or other service dogs. Guide dogs and service dogs are those acting in the capacity of a service animal performing guide and service duties for a disabled individual. Again, this was an opportunity for a PFAC nurse to partner with other disciplines to meet the needs of Veterans whose lives would be more meaningful, having “man’s best friend” at their side, be they blind, struggling with PTSD or in need due to SCI.

Our shared concern over the quality of life for our Veteran patients also applies to the environment where we provide their care. When we accept a position in nursing at a particular facility, this usually entails accepting all of the inherent shortcomings of the physical unit as well. Wow, imagine being the VA clinical nurse manager on an SCI unit in 2001 that included mostly four-bed rooms, an improvement from the previous six or eight-bed rooms. The room had television sets mounted on opposite walls, no bathrooms in the patient’s rooms, but rather a large communal shower/bathroom at the end of the hall, dubbed by Veteran patients “the car wash”, manual paper documentation, manual medicine carts, and a small dark nurse’s station, to provide just part of the story.

One of our PFAC members received a wonderful invitation to participate on a multi-disciplinary task force involved in the planning and activation of a new SCI hospital. This was only the second all-new SCI facility to be constructed in the VA in recent years. It was a golden opportunity to obtain input from the Veterans and nursing staff to modernize the unit. She was able to represent all of us on the task force. A bathroom with a shower in every patient room topped our wish list. We also recommended single-bed rooms with a sprinkling of semi-private rooms. We knew we could provide better care if we had a large, spacious, accessible nurse’s station with multiple computers for charting, automated medication and supply dispensing machines. We asked for a pneumatic tube system connected to the pharmacy and laboratory, for timely transfer of specimens or medicines that would facilitate implementation of treatments. We recommended state-of-the-art equipment to use in providing care for the Veteran and ceiling lifts to facilitate the transfer of patients, and prevent injury to staff.

Our efforts were successful. We had spacious well-equipped rooms for patients on ventilators or those needing negative pressure. There was uplifting artwork for the walls, an improved locker room for staff and two walled-in courtyards. One courtyard was for physical training on various surfaces and obstacles. The other courtyard was for Veterans to plant flowers,
have a raised garden and, though not in our plans, provide a not so well-chosen location for a Mallard duck to make her nest and hatch her ducklings each spring, a very unique and entertaining event for Veterans and staff. It was very important for nurses to have a voice in the construction and activation process and to utilize this experience to serve as a resource to other facilities planning new construction for SCI facilities in other states. Our involvement in the activation process significantly improved care for our SCI Veterans.

Ceiling mounted lifts installed in SCI facilities were mentioned earlier as a means of preventing serious injury to nursing staff due to frequent lifting and transfers of patients in SCI. The location of the ceiling tracks varies depending on the facility, and includes full or partial room coverage, bathroom access and hallway coverage. Ceiling lifts were being used to transport Veterans from their beds to bathrooms and showers. Stakeholders raised issues concerning dignity, privacy and skin integrity during the transport. New construction of SCI centers was occurring in 2010 when these issues were raised. This brought a moratorium to the installation of ceiling lifts at new construction sites and retrofitting at other centers, until the issues could be investigated and resolved.

Nursing members from the PFAC were invited to participate in a multi-disciplinary workgroup directed by VA central office to investigate these concerns. The workgroup consisted of PFAC members, SCI staff nurses, VA researchers, and SCI national leadership. We developed a survey to gauge current applications, usage and any reported skin integrity breaches. We used the results of our survey to develop an action plan that included guidelines for the use of ceiling lifts in relation to dignity and privacy issues. The action plan led to changes in practice for all SCI centers and was shared with key stakeholders including the ONS, the PVA, the Office of Congressional Affairs and the Secretary of the VA. The survey also led to a research study currently in progress where sensors are being used to measure pressures from slings, first in healthy volunteers and subsequently with SCI Veterans. The PFAC nurses anticipate involvement in the development and dissemination of any future recommendations stemming from this research.

Our dissemination modalities are far-reaching and national in scope. We utilize video teleconferencing, conference presentations/posters, and webinars. In addition to our VHA SCI nursing email group, we have access to the national practice transformation goal group, a group consisting of the highest echelons of VHA nursing leadership: the ONS chief nurse, ONS leadership members, nurse executives from various VHA facilities, who lead the changes for the future of VA nursing, and the national nurse practice council, comprised of representatives of clinical nursing staff in the many VA facilities.
Because of the wealth of nursing subject matter expertise represented on the PFAC, in 2011 we were given the unique opportunity to develop the SCI education content for the electronic Veterans health library, which opened in May 2013. The SCI content was the first subject content area to be original in its development that specifically reflected SCI care in the VA. Prior to this time, subject content had been a modification of available commercial content which was then related to care in the VA. Our focus throughout the content highlights an active lifestyle, prevention of complications and life-long care. It focuses on the self-care education, and suggested actions in situations related to autonomic dysreflexia, pressure ulcer management, bowel and bladder care and infections. In addition, the content promotes an active lifestyle with an emphasis on staying physically fit and maintaining good nutrition and weight management. We provide numerous helpful resources for health and physical fitness such as the easily accessed and informative websites of the U.S. Department of Veterans Affairs Spinal Cord Injury & Disorders (n.d.), the PVA (n.d.), and the Consortium for Spinal Cord Medicine, all of which provide access to pertinent clinical practice guidelines (CPGs) and national events such as the national Veterans wheelchair games.

The PFAC not only developed the education content for Veterans, family members and providers, but as PFAC nurses, we “walk the talk.” An advance practice nurse (APRN) on the PFAC served as a steering committee member for the SCI consortium for the CPGs, with the revised publication in 2011 of “Sexuality and the SCI Patient”. Our SCI nurse members have also served as care providers for the Winter Sports Clinics and the National Wheelchair Games. An APRN from the PFAC, fully embracing the concepts of practicing at the top of her license, as a role model for nursing leadership, was appointed to the position of deputy director, Office of National Veterans Sports Programs and Special Events. This role allowed her to continue her dedicated advocacy for a healthy interactive lifestyle for Veterans with SCI and supported the key concepts found in the Institute of Medicine (IOM) Report on the future of nursing.

We continually emphasize the important role that education plays in healthcare self-management for the Veteran, education for providers and the continual pursuit of new knowledge and expertise to promote quality care outcomes. We have highlighted several significant projects in which the PFAC nurses have been instrumental in leading the way to innovative practice improvements. We want to share several educational accomplishments and products that have had an impact on the SCI population. Posters presented at national conferences addressed a diverse array of topics,
including “Innovative Use of the Nurse Practitioner: Augmenting Primary Care Medicine in SCI Care”; “COPE: Community Outreach & Prevention Experience”, “Expert Rehab Staff Retire – The Next Generation Emerges”; and “Low Frequency Ultra Sound for Tibia Fracture Healing”. PFAC podium presentations shared with audiences our expertise on “Polytrauma Staff Education”; “Transitioning Home: Comprehensive Case Management for America’s Heroes”; “Caring for the ALS Patient in SCI”; and a DNP research project “Turning Every Two Hours–Is It Really Necessary?” PFAC nurses have made four educational presentations via national conference call to the Patient Aligned Care Team (PACT) registered nurse care managers on the topics of “Traumatic Brain Injury”, “Blindness/Visual Impairment”, “Amputation Rehabilitation System of Care” and “Medical Complications: Management of Secondary Sequelae in Persons with SCI”. Presentations to this group for 2013 include stroke with its treatment implications and the VA’s new guidelines regarding embedded fragments. One of our doctorally prepared research nurses served as one of the co-authors of the VA book, “A Lifeline for Stroke Caregivers, Information and Resources” and co-authored the “Rescue Newsletter” (n.d.), which offered ongoing support for stroke caregivers.

We are proud to acknowledge the collaborative teamwork demonstrated by the PFAC nurses in many improvement initiatives for our Veterans with SCI. We know without a doubt that this exceptional work by these VA nurses is attributed to each individual’s commitment, dedication and advocacy in serving these Veterans and through their ability to effectively partner with others to make these gold standard outcomes possible. These collaborative partnerships demonstrate the strength of nursing’s contribution to the redesign of healthcare in the VA.

REFERENCES


Chapter 18.5: Collaborative Partnerships Promote Improved Veteran-Centered Outcomes


Chapter 19

Organizing Change and Innovation Using an Integrated Enterprise-wide Quality Framework

David Sine and Karen M. Ott
Re-organizing a national healthcare system to become the Veteran’s most trusted choice for high-quality, safe and reliable care is a formidable but essential undertaking. To achieve this, the Veterans Health Administration (VHA) realigned the Office of Quality, Safety, and Value (QSV) in 2011 to support the Under Secretary for Health’s vision for healthcare excellence and patient-centric care, and to transform the manner in which VHA assures that the services provided to Veterans are of the highest possible quality. Any such realignment of VHA provided services would necessarily be driven primarily by the social contract made with all military service Veterans expressed by Abraham Lincoln during his second inaugural address on March 4, 1865. With the words, “To care for him who shall have borne the battle and for his widow, and his orphan,” President Lincoln affirmed the government’s obligation to care for those injured during the war and to provide for the families of those who perished on the battlefield (Department of Veterans Affairs, n.d.). Thus began our obligation to provide care for Veterans’ unique war-related injuries, which are now understood to include a range of injuries unique to warfare or so complex and interrelated that in 2004, a new term “polytrauma” was coined to describe them. In 1997, the Department of Veterans Affairs (VA) was given congressional authority to bill, collect, and retain third-party reimbursements for treatment of non-service-connected medical conditions and the inevitable comparisons of care quality and value began which continue to this day.

A previous VHA clinical realignment between 1995 and 1999 sought to improve quality, increase accountability, encourage innovation, and enhance value (Kiser and Dudley, 2009). The 2011 realignment differed from that previous broad effort as we sought to integrate the non-clinical functions of quality, patient safety, systems redesign, risk management, and compliance, some functions which did not even exist as concepts in 1995. The intent was to support an enterprise-wide framework for high reliability, a culture of safety, evidence based practice, and continuous measurement and improvement. This renewed desire for integration was partly informed by seminal works in quality and patient safety such as Lucian Leape’s 1994 paper on patient safety and the 1999 publication of To Err Is Human: Building a Safer Health System by the Institute of Medicine (IOM) (Leape, 1994; IOM, 1999). To Err Is Human was the first of four reports issued by the IOM relating to patient safety and healthcare quality and estimated that total national costs for adverse events (lost income, lost household production, disability, health care costs) were between $38 billion and $50 billion annually, calculated in 1999 dollars.
That 1999 IOM report was followed by Crossing the Quality Chasm: A New Health System for the 21st Century in 2001, Patient Safety, Achieving a New Standard for Care in 2003, and Keeping Patients Safe: Transforming the Work Environment of Nursing in 2004. Key recommendations of these reports influenced congressional action (IOM, 2001; IOM, 2003; IOM, 2004) as well as the eventual realignment of the VHA office of QSV. These and other publications illustrated that not only should quality and patient safety be more closely aligned but that there was room for improvement in even the most robust systems. These revelations reached a crescendo in 2005 with the passage of the Patient Safety and Quality Improvement Act. This law encouraged the reporting, in a systematized and coordinated manner, of adverse events and near misses and established confidentiality protections for patient safety related work products in much the same manner that quality improvement work is protected and privileged. Those protections, intended for private sector organizations, are reflective of 38USC 5705, which established in 1980 similar confidentiality protections for federal quality assurance and patient safety records. The VHA Office of Quality, Safety and Value (QSV) where David Sine serves as the Chief Risk Officer, and the Office of Nursing Services, where Karen Ott serves as the Director of Policy and Legislation, partnered on this chapter to tell the story of the VHA transformation to be the best and most trusted choice for high-quality, safe, and reliable care.

With the understanding that efficiency without quality is unthinkable but quality without efficiency is unsustainable, our new QSV office enabled a comprehensive and integrated approach towards positioning VHA to be the provider of choice for the Veterans served. We were now positioned to align with the most common definition of healthcare quality first promulgated by the 1998 IOM National Roundtable on Health Care Quality and now widely accepted: “Quality of care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Chassin & Galvin, 1998).

Our current QSV office originated partly in response to Public Law 111-163 known as the Caregivers and Veterans Omnibus Health Services Act of 2010. Section 505 of the law mandated the designation of a principal quality management officer that reports directly to the Under Secretary for Health (USH). The office was to establish and enforce the requirements of a national quality assurance program to include the designation of leadership roles at all levels of the agency to deliver health care that is safe, effective, patient-centered, timely, efficient
and equitable. Our QSV office was an enterprise-wide framework, created to vertically and horizontally align the organization for quality, through transformational change, organizational accountability, business integrity, and compliance with regulations and standards.

Predating the QSV office, we had started a national effort to develop a culture of safety throughout the organization and build reliability into its care systems. The centerpiece of this national effort was the 2010 realignment of the VA National Center for Patient Safety (NCPS) within QSV. NCPS, with the goal to reduce and prevent harms related to patient care, was informed by studies of communication among nurses and between nurses and other healthcare professionals. One study (Makary, et al, 2006) found a significant disparity between surgeons and nurses in their respective perception of the quality of communication in surgical suites. Another (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005) found nurses had concerns about shortcuts, incompetence, and disrespect, yet there was a general reluctance by nurses to speak up when seeing a safety issue.

In response to these nursing concerns NCPS implemented several structured communications tools that laid the foundation for programs like VHA’s Stop the Line initiative, a measured response from VHA staff members when detecting errors, or identifying areas of concern in the health care delivery process, or use of the three W’s (what I am seeing, what I am concerned about, and what I want to happen). Our intent was to facilitate better communication and make safety concerns more visible to care teams. Thus informed, NCPS and VHA nursing contributed to our QSV goals by promoting a “systems approach” to problem solving that focused on prevention rather than punishment in an environment that supports a “just culture.” VHA leadership believes that this approach is the key to developing a framework that supports a culture of safety.

NCPS applies concepts from high reliability industries such as aviation to the nursing process to identify and reduce latent vulnerabilities in the systems used to deliver healthcare and build “safer systems” that support safer care and the reduction of iatrogenic injuries. The application of some tools and techniques (often adapted from the aviation industry) to healthcare pioneered by NCPS include root cause analysis (RCA), checklists, cognitive aids, structured communication, pre-action briefings, and failure modes and effects analysis (FMEA). Many of these VHA approaches to improving patient safety once thought to be unique in healthcare are now so standardized and accepted that, through national leadership and advocacy of the VA National Center for Patient Safety, they are now included in the curriculums in many schools of nursing.
Our vision for collaborative innovation to alter care delivery in a positive way and enhance outcomes has reached beyond the initial goal of leading VA to become the Veteran’s most trusted choice for high-quality, safe and reliable health care. Representatives from 12 foreign nations, including Denmark and Australia, have attended NCPS programs on patient safety and subsequently implemented national programs based on the VA model. In addition, NCPS cooperates with numerous agencies and organizations including the Department of Defense and the American College of Surgeons and shares initiatives and programs with both public and private partners. One such shared program, clinical team training or CTT, was demonstrated to improve communication and teamwork on 11 nursing units at nine VA facilities. The results of this and other programs have shown reductions in medical errors and related research has been published in the Journal of Nursing Administration (Sculli, Fore, Neily, Mills & Sine, 2011; West, et al, 2012) and the Journal of Nursing Management (Fore, Sculli, Albee, & Neily, 2013). Two of these authors have also published a book to make the methodologies used by the VA to enhance safety available to a wider audience within the health care community (Sculli & Sine, 2011).

Models for the integration of quality and safety can be found in other industries and healthcare has relied heavily on those found in aviation. In patient safety, contributions are sought from engineering, social sciences, psychology, psychometrics, health services research, epidemiology, statistics, philosophy (theories of justice, accountability), ethics, education, computer sciences, and more, all in an effort to gain greater consistency and predictability across the continuum of care. Each discipline uses its own particular methods; patient safety takes each on its own merits and selects the method most suited to the topic or question at hand. (Emanuel, et al, 2008).

The departure for healthcare from an audit culture and movement toward a model based on high reliability has often been difficult. Healthcare quality pioneer Dr. Avedis Donabedian successfully divided health care evaluation into structure, process, and outcomes for the purpose of measurement (Donabedian, 1988). However, one of the many challenges has been that healthcare is unlike other industries. In many industries quality improvement science has been successful through managing inputs and component parts of systems with detailed specifications. Healthcare outcomes, however, are largely dependent on nonlinear processes that are best described as complex adaptive systems. Unlike linear processes that have well defined process steps and outcomes measures, healthcare processes adapt and adjust in near real time to produce quality and care outcomes that are responsive to an individual patient’s preferences, cultural
traditions, values, family situations, and lifestyle. These adaptive processes tend to have bifurcations and recursive loops that then amplify even the intentional but small process deviations into larger outcomes variations that confound and frustrate those intent on measuring quality.

Some have argued that a strict adherence to a “patient-centered” care delivery model carries with it the potential for latent conflicts between patient safety and patient autonomy. (Sine and Sharpe, 2011) However, we argue that the potential for such conflicts add strength to the VHA proposition. Quality and safety can be integrated so both quality improvement and patient safety can then work together in a coordinated manner (although on different ends of the same continuum) to improve the overall quality of care provided. While quality improvement works to raise the upper limits of safety (increase the ceiling of what is possible) patient safety works to raise the floor (and embed safer systems). Taken together the overall effect is a reduction in variability and a lifting of the spectrum of the care being provided with a net effect of an overall improvement in quality, safety, and value.

Figure 19.1 depicts the relationship between quality improvement and safety. The left side of the graphic portrays a number of patients that may typically experience medical care within a range of quality from low to high. The middle section portrays the goal of quality improvement to “raise the ceiling” to enable the patients to achieve higher levels of care. The right side portrays the goal of patient safety to “raise the floor” so fewer of the

**Figure 19.1** Relationship between Quality Improvement and Patient Safety
patients receive poor quality or harmful care. Ultimately, we believe that quality improvement and patient safety must work together to improve quality of care (Stevens, Matlow & Laxer, 2005).

VHA has been at the forefront of the “disclosure movement” and no discussion of the trajectory of the reorganization of quality, safety and value would be complete without mentioning how, this too, has informed the integration of these three all too often disparate elements into a collective function at VHA. Many other healthcare organizations in both the United States and internationally have initiated disclosure programs but few if any, have been as widely acknowledged as effective as the effort spearheaded by the VHA Office of Integrated Ethics.

It is worth noting that while disclosure of care related to patient harm may lead to the accrual of financial, ethical, legal, as well as patient safety benefits to an organization, the Lexington, Kentucky VAMC’s initial impetus to pursue and practice a policy of disclosure in 1987, which essentially served as a pilot for the VHA, was based on ethical, and not financial considerations after investigation of an adverse event. Subsequent to the implementation of a policy of full disclosure this VHA facility was able to demonstrate a decrease in litigation expenses compared to similar VA medical centers without this policy (Kraman, Crandfill, Hamm, & Woodward, 2002). But more importantly, and certainly germane to our discussion, if disclosure resulted in only decreased litigation expenses without a corresponding increase in quality of care, the outcome may not be ethically justifiable. We needed to ensure that reduced costs did not reflect injured patients being deprived of appropriate compensation and the potential for an erosion in the public’s (and the Veteran’s) trust in the VHA.

There exists a longstanding practice in both the quality and safety disciplines of retrospectively (and often independently) evaluating adverse events to try to understand their etiologies and prevent their reoccurrence. Disclosure effectively marries quality and patient safety in the crucible of litigation through providers’ moral and ethical obligations to a patient injured by an adverse event. Honesty and respect for patient autonomy are two prominent ethical principles that we believe should direct providers’ subsequent actions. Patients’ knowledge of adverse events is central to the trust relationship between provider and patient, which is necessary for safe, effective healthcare. Patient safety and quality should both be thought of as a property of systems or organizations rather than one belonging exclusively to individuals. Disclosure requires coordination and cooperation performed in an integrated environment and thus presents yet another strong argument for the integration of quality and safety and value.
REFERENCES


Chapter 19.1

Patient Emergency Response System: Improving Resuscitation Care to the Veteran

Natina Dudley and Melissa L Hutchinson
Our story began years ago at the VA Puget Sound Health Care System in Seattle, Washington. Puget Sound is comprehensive health care facility with over 200 inpatient beds, which includes 28 intensive care unit beds. We provide care to Veterans who come from the five states of Alaska, Montana, Idaho, Washington and Oregon requiring diverse services such as medical, surgical, and psychiatric. Our treatment specialties include bone marrow transplant, spinal cord injury, inpatient rehabilitation, and long-term care.

We began our VA careers in the surgical intensive care unit (SICU), Melissa in 1997 and Natina in 1999. We pursued master’s degrees and transitioned into positions outside of the unit. Melissa became the clinical nurse specialist in the medical intensive care unit (MICU) and Natina became the clinical nurse educator for the surgery service line. Our paths crossed often, particularly because of our passion for resuscitation, which helped drive this quest for process improvement in our facility.

As members of the emergency care committee and cardiopulmonary resuscitation (CPR) committee, our duties included working with an interdisciplinary team to review all cardiac and pulmonary arrests (Code Blues), which provided a great experience related to resuscitation successes and also helped us identify areas for improvements. Additionally, we both became advanced cardiac life support (ACLS) instructors, which gave us an excellent working knowledge of the most current evidence based information related to emergency responses. We both identified that our facility’s in-house Code Blue resuscitation processes could be optimized and the members of our interdisciplinary team agreed. We believed there were possibilities to improve outcomes and decrease morbidity and mortality for our Veteran patients.

Possibilities for improving our emergency procedures were also noticed by others at the medical center, despite the positive outcomes of our resuscitation events. Although our “survival to discharge” rates were significantly above the national average (over 30% versus the national average of 19%) we felt we could do better. Resuscitation improvements were important to the facility but no formal position existed to lead this important project. We had traditionally both worked on resuscitation process changes because of a passion to do so but we did this when we had time, between our primary responsibilities, which often did not leave any additional time for resuscitation process improvement activities. We knew organizational processes had to change in order to make a lasting difference.

Busy health care professionals everywhere face competing demands for time utilization and our situation was no different. We had limited time to devote to complex resuscitation process change but we knew it was
important, realizing that some changes, as previous efforts by others showed us, had failed to demonstrate lasting success. There was no designated role or person available to accept this responsibility and challenges such as crossing service lines (silos) and competing job demands further limited assignment to a specific person.

Our senior leadership determined that redesigning our facility’s emergency processes was a priority that needed to be addressed by an interdisciplinary team. In the years prior to this realization our facility conducted several root cause analyses (RCA) and two healthcare failure mode and effect analyses (HFMEA) relating to areas of the Code Blue processes. The HFMEA process was designed by the VA National Center for Patient Safety to assess risks and hazards of a particular process or event. Findings in the RCAs and HFMEAs often noted an inconsistent “responsible” person or group to carry out process change and improvement projects. In 2013 a rapid process improvement workgroup (RPIW) was approved and convened with the goal of identifying opportunities for improvements in our patient-centered emergency response system and a plan to make lasting changes.

The RPIW convened its first meeting over a three day period with 10-15 staff members designated as participants. This process was a major cost and resource commitment by our facility. Our health systems specialist for systems redesign, Stephanie Billings, facilitated the RPIW meeting, with participants being those who contribute to the Code Blue process at some point. This group included representation from the laboratory, MICU, SICU, anesthesia services, nursing staff, respiratory services and medical staff. We assessed the strengths and weaknesses of our current Code Blue response processes, identified the barriers to successful process outcomes and determined that we lacked accountability and overall structure. The process clearly identified that a specific responsible person was necessary to effect lasting outcomes. The RPIW workgroup proposed a pilot program that would designate one full-time employee equivalent (FTEE) to focus on system improvement and program development related to emergency processes. The pilot program was called patient emergency response system (PERS).

The RPIW group considered who should fill the PERS role temporarily to get the pilot project rolling, and recommended that we serve together, since we each had skills that would be of benefit and neither of us could devote all of our time to this project. One of the biggest challenges was creating a plan that would allow both of us to function in this pilot role for 50% of our time. Our primary roles have a variety of responsibilities that could not be absorbed by others and we realized that we would need to negotiate to
make it possible for us to devote work time to the pilot as well as maintain our own role responsibilities. Eventually, support from both of our work areas was agreed upon and we were officially able to begin the pilot role of PERS Coordinators.

As we delved into the pilot and assessed the overall function of our resuscitation and emergency processes, we discovered multiple internal practice process variations. Staff verbalized frustration over practice inconsistencies. We also found we needed a better understanding of all of our resuscitation issues and a valid way to accurately measure every element during resuscitation events. This can be very challenging to do when documentation is handwritten on paper because time intervals are usually inconsistently recorded and can only capture minute-to-minute activities.

The ability to record activities electronically offers a significant improvement in the real time capture of events which are recorded down to the second. Fortunately, in 2005 our facility purchased an electronic code recording system, CodeNet, described in more detail in Chapter 23.3, which could improve documentation of Code Blues and create a stronger code review process. However it wasn’t until our Code Blue review group expanded and became interdisciplinary in 2012 that we were able to drill down and adequately analyze the extensive data we had generated and stored during resuscitation events.

The interdisciplinary team of reviewers is comprised of physicians, nurses, respiratory therapists, and quality improvement specialists. As a team we were able to parse the data into meaningful pieces that could be used to make improvements. We noticed that as we were able to more succinctly measure our critical time elements, we were able to identify additional areas for process improvements that had not been apparent in earlier years. Critical intervals recommended for tracking resuscitation effectiveness often are time to first shock, time to advanced airway management and time to administration of first medications. The electronic format created data points that were more discrete, and could more clearly identify timing issues. For example, without measuring to the second it is very difficult to identify that the “time off chest” measurement is truly less than 10 seconds, as recommended by the American Heart Association. When we were able to accurately measure this crucial data element we could set objectives such as “time off chest no more than 10 seconds” and verify that we were actually achieving our goals.

We continued to look for areas of improvement and one area that continued to receive feedback from resuscitation event staff was related to team roles and responsibilities. We are a teaching facility and physician residents rotate every four weeks so this issue was actually a bit challenging.
More specifically, the issues identified included lack of leader identification, role confusion at the bedside, number of staff attending events, and lack of debriefing. We needed feedback and a strong group to support and help guide our decision making related to performance improvements and the order of project implementation.

Fortunately the RPIW team felt it was crucial to continue supporting the PERS coordinators to help facilitate the forward motion of the projects. In considering interventions aimed at creating the necessary changes in teamwork and communication, we needed the entire group to produce success. The group continued to meet on at least a biweekly and sometimes weekly basis, for the twelve months following the PERS pilot initiation. The initial PERS vision was to “improve effectiveness and functioning of Code Blue responses”, which required the PERS coordinator to oversee change, ensuring education for nursing and medical staff and improving signage within the medical center. Training was developed for staff that included the “First Five Minutes” of an emergency response, reinforcement of the requirement to “Dial 911” (rather than the “operator”) for any type of emergency, and as we continued, to develop training into the development of what we called the STAT Nurse role. Each task was approached from several angles along with contributions from different RPIW team members in order to meet the different learning styles or group dynamics.

Our goal was to tackle every project on our redesign list, particularly those that had failed previously. We had lofty, but noble, goals. Several of the goals were met within the first month, and as we realized how well the core group functioned, we moved to further redesign the Code Blue structure both during and after an event to create an even stronger emergency system for the future.

One project that had been under development since 2012 but we realized that we faced difficulties in our efforts was to establish an official “brand” for emergency processes. Branding is a mechanism to create a logo and/or slogan to help people recall or develop an association with a company, product or service. In this case we wanted the “emergency processes” services to have a particular design on posters, information material or email announcements that people would remember and associate with PERS. On an international scale, Nike is a company that has done branding well. Remember the logo, the Nike “swoosh”? The “swoosh” is actually the wing of the Greek goddess Nike and personifies victory. Nike’s logo says as much about the company as their slogan “Just Do It” does. Of course we hoped for that same success with our emergency processes “brand logo”!
Originally in 2010 Melissa and the then director of patient safety, Elizabeth Mattox ARNP, created a new emergency systems brand logo and emergency signage which are pictured in Figures 19.1.1 and 19.1.2. The project had not been completely integrated for a variety of reasons, so this provided an excellent opportunity for PERS and the RPIW group to revisit the process of embedding this into the medical center culture. Now you can see emergency processes information posters, internet information, and reference material throughout the facility using these images for branding.

**Figure 19.1.1**  VA Puget Sound Health Care System Emergency Systems Brand Logo

**Figure 19.1.2**  VA Puget Sound Health Care System Emergency Systems Signage Example
The next process change we undertook was the roll out of new facility-wide defibrillators. The new series defibrillators were on order prior to the PERS project and fortunately we were able to coordinate the roll-out with the PERS coordinator implementation, perfect timing for the PERS role. We were able to provide a well-coordinated training program on the new defibrillators for all staff; over 800 staff were trained over a two week time period thanks to the clinical support from our vendor. Not only were we able to update inpatient nursing and medical staff on defibrillator use but we also reviewed our educational material and incorporated the new emergency processes brand into the crash cart books as shown in Figure 19.1.3. Melissa and her graduate student, Jenny Alderden, PhDc, RN, developed and created the original crash cart reference guides which were placed on all 55 crash carts in the facility.

**Figure 19.1.3 VA Puget Sound Health Care System Emergency Systems Brand Logo on Crash Cart Books**

The new defibrillators and several content updates created an opportunity to update these reference books. We were able to redesign the books using the new branding logo. The reference book helped us address another project completed by the MICU staff over five years prior, which had not come to fruition. This was an excellent project focused on improving
the knowledge of crash cart contents. The reference book allows staff to peruse the cart contents without opening the cart, thus saving money but still improving knowledge. Contents of each drawer are shown with a corresponding number which aligns to the description on the following page. This format allowed for staff testing and review for example “tell me which medication is located in drawer 1, space 13”. The Office of Inspector General (OIG) noted the reference books during one of the regular visits as a “strong practice”.

As we addressed each individual process that occurred during the actual code event we were able to identify numerous ways to improve and refine how the codes were run. Clearer definition of participant roles was needed so “scripts” were developed to help guide the code leader and recorder. Lanyards, shown in Figure 19.1.4, were provided to code team members for quicker identification of critical staff. This identification process allows the leader to ask other auxiliary staff, without lanyards, to move aside or leave and significantly reduces overcrowding at code events. These lanyards also afford a rapid notification if a team member is missing. We developed a schedule for regular mock codes and conducted these throughout the medical center, particularly in “hard to locate” areas. The code team rapidly improved performance in mock emergencies and post-code debriefing increased to 100%.

The most significant impact we have had on patient outcomes is the creation of the “STAT Nurse program” which gained momentum through the initiatives of the PERS project. This STAT nurse program was designed to provide nursing support in all situations where nurses were caring for patients with deteriorating conditions. This included in-patient locations,
community living centers, and psychiatric and rehabilitation units. Once prepared for this role, the STAT nurse was instrumental in early recognition of sepsis in several patients, as well as playing a role in early interventions potentially preventing a Code Blue event from happening at all. Fourteen intensive care unit (ICU) nurses, with three or more years of ICU experience, volunteered to staff this 90-day, 24/7 pilot program. The original objectives were: to round on all patients who transferred out of the ICU in the previous 24 hours, to respond to all Code Blue’s and rapid responses (previously the SICU responded only to RRTs and MICU responded to Stroke and Code Blue events), and to provide care for acute care patients who require an increased level of care for a short period of time but not an ICU transfer or a higher acuity patient awaiting ICU bed availability. We evaluated this position using a cost avoidance perspective related to the prevention of sepsis. We estimated the STAT RN intervened or pre-identified one septic case per week, which was a conservative estimate. Early identification and initiation of early goal directed transfer of one patient per week, we estimated, equated to a facility cost avoidance of $1.2 to 1.6 million per year. This was a significant cost avoidance, since the only intervention we evaluated was early treatment of septic patients, and we recognized other patient risk factors would have a comparable impact.

An unexpected outcome potentially related to the STAT RN emerged. There were no preventable Code Blues during the 90-day trial and only 2 total Code Blues occurred at all. This was the lowest number of codes at this facility for the same period of time since we started code blue tracking in early 2000. Our yearly average for the past 5 years had been over 80 per year, often over 100. Although we cannot directly link the outcomes to the STAT program, we believe it is an interesting finding during this time frame. We are thrilled with the feedback and patient outcomes during this time and are currently pursuing senior leadership approval for a permanent full-time 24/7 STAT RN role in our institution.

The PERS coordinator role originated from an RPIW initiative aimed at improving Code Blue responses at the VA Puget Sound. We were fortunate enough to be able to take this role and build it into a program that has made a difference for our Veterans. Although the PERS coordinator is currently not a permanent role, our facility is dedicated to assessing options so this, along with the STAT nurse, can become a permanent position. The process changes have been significant in our facility. These have included increased mock codes, improved team dynamics and communication, improved Code Blue algorithm compliance, improved interdisciplinary code review, and greater participant feedback regarding improvement opportunities.
Our story demonstrates how a small group of people with a clear vision can make a difference in the quality of care provided to our Veterans. We feel honored to have had the opportunity to work with this interdisciplinary group to make such significant improvements in our organization’s resuscitation process. We can proudly say that through our dedicated efforts we have helped to improve staff confidence, education and performance during difficult and stressful life and death events. More importantly we have ensured that the very best coordinated and evidence based care is provided to our Veteran patients.
A patient-centered or better yet, patient-driven care model, requires attention to a workforce that is well prepared to understand values, preferences and needs of the individuals and their families in their care. VA nursing is committed to advancing the principles of patient-driven care by embracing a diverse workforce with culturally sensitive competence. I agree with the premise that diversity begins with leadership as Georgia Coffey, VA Deputy Assistant Secretary for Diversity and Inclusion has been known to promote. The VA Office of Diversity and Inclusion (ODI) sets forth expectations and provides extensive references and resources to support recruitment, retention and advancement/promotion with an emphasis on workforce diversity across the enterprise. ODI has attended to understanding and eradicating barriers to equal employment opportunity, reflected in the focus of their mission “to build a diverse workforce and cultivate an inclusive workplace to deliver the best services to our nation’s Veterans, their families, and beneficiaries” (Department of Veterans Affairs, n.d.). Nurse leaders in the Office of Nursing Services and in the field have benefitted from ODI's leadership in ensuring a diverse nursing work force.

There are various dimensions of diversity that we have found to be essential in our quest to honor our commitment to a well-balanced workforce: age, gender, ethnicity, race, sexual orientation, and mental/physical abilities and characteristics. Beyond these primary dimensions we consider multiple secondary dimensions: socio-economic status, communication style, work style, marital status, parental status, geographic location, work background, shift work, functional level, religious beliefs, thinking style, education, and political affiliation. This commitment to a robust understanding of the word “diverse” has enriched both our workforce and the care we are able to provide.

Our dedication to these dimensions is further called out in our departmental core values of Integrity, Commitment, Advocacy, Respect, and Excellence—“I CARE”. These core values require leadership at all levels to address aligned workforce competencies. In the words of Secretary Shinseki at the annual Alternative Dispute Resolution Excellence Awards and Diversity and Inclusion Excellence Awards ceremony “Trust is essential to caring, compassionate leadership—you cannot have a successful organization without it. You don’t find trust in organizations that don’t represent the communities they serve, and you cannot serve those communities well unless you look something like them” (Shinseki, 2011).

We have included elements of trust and respect as representative metrics in our all employee surveys as a means to address diversity-specific challenges and disseminate best practices. Questions include opinions related to whether employees treat each other with respect, whether
disputes and conflicts are resolved fairly and whether our employees consider their work environment one where it is safe to take risks. Our focus on psychological safety is a demonstration of leadership that supports and encourages a diverse workforce while acknowledging that diversity can create stressors among employee groups.

One very successful program that has contributed to our advancements towards a healthy, diverse workforce is the “civility, respect and engagement in the workplace” (CREW) initiative. The details of the CREW initiative are described in Figure 20.1. As is evident, the CREW initiative articulates expectations for all VA employees and their relationships. The CREW process requires facilitated work to address barriers and challenges in the work climate that suppress civil and respectful behaviors. Regularly held meetings with key players address how the individuals relate to each other. Using nationally standardized evidence based tools, facility leaders assist participants to tackle barriers and transform employment situations into a healthy work environment that creates trust and engagement of the workforce.

**Figure 20.1  VA Initiative for Civility, Respect and Engagement in the Workplace**

*Civility, Respect, and Engagement in the Workplace (CREW)*

is a VA-wide culture change initiative. First launched in 2005 by the VHA National Center for Organization Development (NCOD) in response to employee feedback that low levels of civility affected their level of job satisfaction, it has since been utilized by over 1,200 VA workgroups to establish a culture of respect and civility in their organization.

- **Civility** is an essential behavior of all employees in all organizations. These are the interpersonal “rules of engagement” for how we relate to each other, our customers, and our stakeholders; the fundamentals of courtesy, politeness, and consideration.

- **Respect** connects us at a personal level. It reflects an attitude developed from deep listening and understanding, cultural and personal sensitivity, and compassion. It honors all the participants in an interaction by creating a safe place to have difficult conversations and leads to an environment of honesty and mutual trust.

- **Engagement** is the result of respectful relationships within an atmosphere of trust. It provides all staff with the charge, the parameters, the training and the support to make decisions “on the spot” in the best interest of the Veteran.
VA nursing-specific activities have been aligned with recruitment, retention and advancement/promotion of a diverse workforce. As early as 2004, the Office of Nursing Services (ONS) announced the theme for the annual Innovations Award would be “Enhancing the Diversity of the VA Nursing Workforce and/or Addressing Culturally Sensitive Patient Care”. The Office of Nursing Services Innovations Award program is a nursing-specific, national award program that honors the top ten teams that demonstrate nursing leadership in innovative quality improvements which have a positive impact on patient care. ONS, by announcing this 2004 theme for the awards, reinforced for all VA nurses the commitment nursing leadership had made to enhanced competence in and sensitivity to diversity in the workplace.

All national nursing councils, taskforces, workgroups, and committees seek a diverse membership from our rich array of potential nursing representatives. Our interest is to have groups with varied perspectives to build solid approaches that will be sensitive to diverse Veteran populations and coworkers across our national enterprise. As chief nursing officer, I turned to the definition of cultural competence from Duke University as my guide: A defined set of values and principles, and demonstrated behaviors, attitudes and structures that enable employees and leaders to work effectively cross-culturally (Duke University Office for Institutional Equity, n.d.) Duke’s “managing diversity” toolkit for managers provides helpful guidance for nursing leaders to consider. The toolkit describes the following:

**Purpose of Cultural Competency:** Cultural competence is an experiential understanding and acceptance of the beliefs, values, and ethics of others as well as the demonstrated skills necessary to work with and serve diverse individuals and groups. This involves an experiential understanding, awareness, and respect for the beliefs, values, and ethics of other cultures and the cross-cultural skills necessary for delivering services and working with diverse individuals and groups.

**Do’s:**

Do recognize that cultural competence is a developmental process for both individuals and organizations.

Do commit to building awareness, knowledge and skills related to cross cultural teamwork and communication over an extended period of time. This is not a one day workshop.

Do remember that people and work systems develop the capacity for being reflective and adapting new work styles.

Do know that both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.
Don’ts:
Do not assume that only employees with direct patient care benefit from cultural competency skills and awareness. All employees at Duke would benefit from better understanding the diverse students, faculty, patients, staff, visitors, and researchers who make up the Duke community.

Do not try to evolve a formula for working with different groups. Although you can develop awareness about ethnic or religious or gendered or generational groups, do not assume that everyone within that group will fit into a formula. People are ultimately individuals and appreciate being treated that way.

Do not forget about elements of diversity that can be overlooked: sexual orientation, region, country of origin, and generation are also elements that impact communication, marketing, educational styles, and safety for some of the different groups you come into contact with at your job. (Duke University Office for Institutional Equity, n.d.)

Additionally, I have found that Berlin and Fowkes offer a very useful model for cross-cultural communication. This model is supportive of nursing practice. The model is a tool that provides guidelines for clinical competence using the following “L.E.A.R.N” approach: Listen to patient’s perception of problems, Explain your perception of problems, Acknowledge and discuss differences and similarities, Recommend treatment, and Negotiate treatment (Berlin & Fowkes, 1983, p. 935).

In summary, the leadership imperative for ensuring a diverse workforce with cultural competence is a vital element in forging a desired future state where nurses lead change and advance health. These elements are key to transforming our healthcare delivery system to a patient-driven model that respects individual values, preferences, and needs based on trusted relationships that encourage patient engagement.

REFERENCES


Chapter 20.1

Diversity and Cultural Competency in Patient Care

Vilma Cong Divinagracia
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

The author wishes to gratefully acknowledge the assistance of Dr. Gwen Anderson in the preparation of this manuscript.

--- • ---

I started working at the San Diego, California VA in 1987. I was the night shift charge nurse on the 60-bed nursing home care unit (NHCU). Staffing at that time consisted of one registered nurse (RN) who was in charge of the two front pods, each with 15 patients. The two back pods had one licensed vocational nurse (LVN) passing medications, and two nursing assistants who provided the physical care. My other duties consisted of reviewing all 60 paper charts for new orders from the last 24 hours, making rounds on all four pods, calling the emergency room doctor (medical officer on duty/MOD) for telephone orders, and of course taking care of my 30 patients in the front pods. Back then, patients were sent to the medical-surgical units if they developed a fever, and we did not admit anyone with intravenous lines, but I clearly remember we had a patient with a Groshong catheter and total parenteral nutrition (TPN). We had one physician who was also the attending for the hemodialysis unit. Each pod had a pod leader and I vividly remember that a few nurses were Veterans themselves.

Our patients were primarily Caucasian. A smaller number were African American, Asian (i.e. Filipino, Japanese, Korean), and Hispanic. Nearly everyone spoke English. I do remember that a few of the Filipino patients who had dementia reverted back to speaking their native Filipino dialects which our Filipino nurses were able to understand. We also had a culturally diverse staff.

Even back then, family members brought food from home, and visited extensively, especially the patients with a diagnosis of dementia or those who were terminally ill. We had a well-established recreational therapy program where residents made ceramic statues, had reading clubs, went out on passes or outings, and had pets visit. It is very interesting to me to note, then, that a couple of decades after that, terms such as age-specific care, cultural sensitivity, and cultural competency started to emerge. I could see that these “new” concepts could be matched with common practices that we had even back then.

In those times now long past, our walls had murals. Years later, they were changed to beige and equipped in ways that made them look more like an acute care unit. Recreational therapy was scaled down. Patients were sicker and more likely to be bed-bound. Just about every patient was admitted for long-term antibiotics. Patients who only needed what we then
called “custodial care” were admitted to community nursing homes. Nurses changed from white uniforms to colored scrubs. We had nurse practitioners in addition to physicians. Documentation, medication administration, and physician order entry became paperless. Taped report and communication logs were replaced with face-to-face hand off communication. Paper care plans were replaced with electronic “I Care Plans”, which addressed care in the first-person, from the resident’s point of view.

Almost two decades after I first joined the VA, I started teaching classes on cultural sensitivity and culturally competent care. It came very naturally to me to address these topics with references to my Filipino background, and my involvement in special emphasis programs. In 2004, I even won an Innovation Award from the national program office, Office of Nursing Services for a group project titled: Nursing Leadership in Enhancing the Diversity of the VA Nursing Workforce, and Addressing Culturally-Sensitive Veteran Care. My involvement in diversity at the VA started through my efforts to educate staff about the Veteran populations we serve. Cultural knowledge of existing Veteran cultures leads to cultural awareness of the differences and similarities among Veteran cultures. Understanding and acceptance of these cultural differences leads to cultural sensitivity.

What then is cultural competence? It is the ability to deal with diverse people with diverse backgrounds. It is also manifested by respect for the Veteran’s beliefs and practices. All this, when incorporated into health care interventions, unfolds into culturally-competent care.

The classes I teach to staff, new graduates, students, and even in nursing conferences, start with getting to know the Veteran populations we serve. There are still more male than female Veterans but the latter group is increasing. With it comes the shift of health services to include those which serve the needs of female Veterans. Hence we have a women’s clinic, and diagnoses that involve the gender specific needs. Recent OIF-OEF (Iraq-Afghanistan eras) female Veterans are typically younger and often of child-bearing age, or mothers to young children. The majority of our Veterans are from the Vietnam War era, some with behavioral health needs such as post traumatic stress disorder (PTSD), depression, suicidal thoughts, and substance abuse much like their counterparts in the OIF-OEF eras. As such, special programs and services have been designed and developed to address these specialized needs. This includes programs for the treatment/ management of substance abuse, HIV/AIDS, spinal cord injury, homelessness, and traumatic brain injury (TBI).

Cultural sensitivity and cultural competency can be focused on a specific topic. One that we often focus on is palliative care. Age, religion,
family composition and family dynamics come into major play when death is a prime concern. Endless stories are shared after a Veteran dies to help celebrate the Veteran's life, and reflect on the Veteran's death. Advance directives, and final arrangements are very challenging areas of discussion and debate starting with the dying Veteran, and his or her family. Staff education for cultural competence in this area addresses varying beliefs on the meaning of death, attitudes towards death, grief reactions, and breaking or maintaining ties with the deceased based on cultural background. To avoid stereotyping in responding to these differences, staff members are encouraged to ask the Veteran questions to clarify his or her beliefs and wishes.

Cultural transformation and Planetree initiatives, and cultural competency standards from hospital accreditation bodies were introduced across the VA in somewhat generic terms. Locally, it was our challenge to shape and integrate these initiatives into our existing processes and systems. For the Community Living Center (CLC), this was not a giant leap in various measures. Artifacts of culture change were incorporated into the design of the new CLC giving way to private rooms instead of four-bed rooms. The CLC resident council meets at least monthly and additional informal discussions take place during meals in the dining room, during monthly theme meals, or during “social hour.” The healing environment was promoted through “quiet times”, discontinuation of non-emergency overhead paging, aromatherapy, guided imagery, the healing garden, and massage. The nurturing aspects of food were enhanced by 24-hour snacks, ordering from alternate menus, and the theme meals and social hour mentioned above. Spirituality and diversity have been addressed through memorials for deceased Veterans, draping the body with the American flag during transport to the morgue, and bereavement sessions for staff following a series of deaths.

For someone not open to cultural sensitivity and culturally competent care, extra effort might be viewed as a waste of time. Quite the contrary, those extra steps and effort make interventions and interactions more purposeful and hence, more effective. Taking patients’ cultural views on health into account helps maintain their right to be treated with respect. Patients also respond better to their care when their beliefs and practices are taken into consideration.

From the standpoint of cultural sensitivity among staff, cultural information breeds more than just knowledge and tolerance. Acceptance, respect and integration of different cultural beliefs and practices lends itself to improved interactions and teamwork. The special emphasis programs (SEP) highlight different health practices and beliefs among different
cultures, in addition to native delicacies, national costumes and traditional dances. SEP events including one which addressed celebrating holidays among different cultures have also been very informative and have sparked genuine interest among otherwise different cultural groups. It draws staff from different cultural backgrounds as well as from different levels in the VA hierarchy to celebrate events in a truly fun fashion.

Through these various measures, we have been able to increase our cultural competence, enrich the care we give Veterans, and learn more about other cultures through our sharing, the answers to our questions, and through our self-education.
Chapter 20.2

My Personal Experience with Diversity in the VA

Gloria Martinez
During my years in the VA I have found the work environment full of both people of diverse backgrounds, but also people truly interested in diversity. Educating staff members about the uniqueness of each ethnic and culturally diverse group brings this awareness to the table. The sensitivities that might be needed to deal constructively with diversity have been a key driver at all the VA facilities in which I have worked.

My memories of this includes my first VA assignment, where I worked with the Hispanic employees group to set up for our Hispanic heritage day celebration. What fun it was working with all the staff that evening! Even better was the great turn out we had from all over the medical center, to hear the music, try the food and meet the staff.

To VA’s credit, all sites, whether east or west region, have taken seriously the commitment to recognize the many diverse cultures represented by our workforce. I think one of the many stories gathered from my travels involved introducing my nurse executive to tamales (homemade by my mother) and her, in turn, introducing me to perogies (made by her mother). Boy did we have fun sharing; of course the wine was shared as well.

Diversity, as we all know, can only make us better. That being said, my experience with diversity at the associate director level has been a different kind of eye opener. Initially, when as a nurse executive, I became a member of the executive team and sat at the table as a colleague with the chief of staff, I realized that this was a huge moment (a very good one) for the system, patients and profession. I think having a voice and being at the table was very instrumental in moving the profession forward which in fact therefore moved the care forward. A director asked me once what I thought about my title change, which one I preferred. I stated that I didn’t care about my title, as long as I was at the table with an equal voice. I realized that by being at the table, I was part of the VA process of ensuring diversity in our workforce and our leadership.
Chapter 20.3

Diversity and Inclusion

Alesia Coe
I view cultural competence as the ability to collaborate and communicate with people of different genders, cultures, ethnicities, ages, races and religions in a manner that facilitates inclusion and appreciation for differences. This then leads to individuals knowing that they are respected and valued. I spent the first ten years of my career in private sector health care organizations in the Chicago, Illinois area. I engaged with others from varied backgrounds and cultures and was encouraged to attend diversity training opportunities. I took advantage of these opportunities and based on them, early in my career, I developed an appreciation for the importance of cultural competence, a commitment to diversity and inclusion.

Some of the advantages of cultural competence in the workplace are improved communication, increased productivity and creativity. I joined the Department of Veterans Affairs (VA) over 13 years ago, and now serve as the associate director/nurse executive of the VA Illiana Health System in Danville, Illinois. As a leader with the Veteran Health Administration, I work to guide others in understanding that diversity involves how they perceive themselves as well as their co-workers and the patients/families who they serve. The message that I promote is simply that these perceptions directly impact their interactions and ability to communicate and collaborate effectively. The end result is improved communication and collaboration among co-workers, with patients and our community partners. I can recall multiple times when the different ideas and suggestions of employees of varied backgrounds, experiences and levels of educational preparation resulted in positive employee, patient and/or community outcomes. The effort of the diversity and inclusion committee in my organization is a great illustration of this.

The goal of our diversity and inclusion committee is to improve diversity awareness and inclusion within our workforce. The committee plans events and activities to enhance cultural awareness, appreciation, and community outreach. The committee reports to the customer service executive board. As chairperson of this board, I support their recommendations and partner with them to reach organizational goals. Examples of the work they accomplish include monthly diversity educational sessions and an annual “diversity day” event. During this event, employees educate others by sharing their culture and heritage with them. This activity entails employees manning booths, while dressed in their native garb, with their co-workers sampling foods and music from around the world!

A community event that I am very proud of is the college fair that the committee organized this past September. The college fair was designed to provide information and resources to help young people in their pursuit
of higher education. In partnership with the local high school, this event was the first of its kind in our county. Nearly 600 attendees made their way through the high school gym where exhibitors discussed academic options that are offered at their colleges and universities.

VA is committed to creating a diverse workforce within an inclusive work environment to best serve our Veterans. I count the ability to be involved in such important and necessary work a privilege. As the nurse executive, I own the responsibility to lead by example and to promote cultural competence and workplace harmony.
Chapter 21

Optimal Impact through Innovative Projects with New Partners

Lori Hoffman Högg, Janet Cogswell and Christine Engstrom
Introduction

In this chapter we want to tell the story of the impact of innovative models of partnering by describing two partnerships. The first was crafted between the Department of Veterans Affairs (VA) Office of Nursing Services (ONS) and the Oncology Nursing Society, the Oncology Nursing Society Foundation and The Joint Commission for a Breast Cancer Pilot. The second partnership was between the VA Office of Nursing Services, Patient Care Services and the VA Pharmacy Services working with the Vanderbilt Center for Better Health for a Chemotherapy Ordering Project. We will describe in detail these enhanced partnerships in care, exemplifying an integrated implementation paradigm for new models of care. It is our hope that these models will provide a sample framework for others committed to creating partnerships that benefit their patients.

Each of us played a role in the crafting of these partnerships. Lori led the Breast Cancer Care Pilot Project (BCC) for VA and Janet represented Oncology Nursing, developing and testing the nursing modules for the Chemotherapy Ordering Management System (COMS). Dr. Engstrom, as Director of the ONS Clinical Practice Program, had the vision to strategically place national nursing field advisory groups with other VHA program offices to develop internal partnerships and then encouraged external partnerships as described in this chapter. Additionally, she worked with the BCC group in obtaining a data use agreement (DUA) in order to partner with the Oncology Nursing Society and The Joint Commission. Additionally, as an oncology nurse practitioner, she participated in site visits to abstract data for this pilot.

According to the Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, nurses should be full partners with physicians and other health professionals in redesigning the health care system (IOM, 2011, p. 32). A growing body of research has begun to highlight the potential for collaboration among teams of diverse individuals working to generate successful solutions in complex, knowledge driven systems. Indeed, the IOM report actually substantiates its recommendations grounded in this research (IOM, 2011, p. 33).

Key recommendations from the IOM Future of Nursing Report, published in 2011, validated many of the initiatives already developed by visionary VA nursing leaders. These were implemented nationally throughout our very large and well integrated healthcare system. In celebrating 81 years of nursing excellence, our 2011 Office of Nursing Services Annual Report clearly demonstrated the linkages between the IOM Future of Nursing Recommendations and the National VA Nursing Strategic Plan and
As VA nurses, we were accustomed to contributing our efforts to the broader collaborative leadership partnerships that were grounded in years of VA nursing’s earlier work. This work afforded us an opportunity to expand our leadership and diffuse our collaborative improvement efforts. We accomplished this through evidence based practice workshops, the Specialty Care Transformation initiative and the Clinical Practice Program Advisory Committee (Department of Veterans Affairs, 2011).

As we became aware of how our nursing outcome achievements were linked to the IOM recommendations, our goals were further fortified. Moving forward, we recognized that we were not only on the right path or had already met key recommendations, were likely blazing the trail through our nurse led innovations and the cultivation of collaborative partnerships.

VA Nurses Leading Transformation in Healthcare

As described in many other chapters in this book, VA nursing strategically fosters leadership and both intramural and extramural partnering initiatives through the ONS Clinical Practice Program. The Oncology Field Advisory Committee (ONC-FAC) activities provide an example of how this is realized, creating innovations and crafting partnerships. As background, we are a group of 22 oncology nurses. We are diverse geographically, educationally and in terms of the professional roles we have in the VA. Located in 18 states in all regions across the country, our members have earned BSN, MSN, DNP or PhD degrees, practicing as clinical nurse leaders, researchers, nurse educators, staff nurses, nurse managers, clinical nurse specialists, administrators, care coordinators, program directors and nurse practitioners. This diversity adds to the depth and breadth of nursing experience and expertise across the spectrum of complex specialty care that spans the continuum from screening, diagnosis, treatment, follow-up, surveillance, and survivorship to palliative, end of life and hospice care.

Developed and championed by Christine Engstrom, the ONC-FAC serves as an expert resource for the field and partners on numerous VA nursing clinical practice initiatives and multiple VA program offices. She gave priority to leadership and mentorship to launch, spread and sustain the ONC-FAC. Another key strategy was to focus on and develop some initial ONS projects while fostering a culture of creative innovation for unique collaborative partnerships to come. For example, the ONC-FAC serves as an active partner with organizations external to VA. Appointed as the VHA national oncology
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

U.S. Department of Veterans Affairs

Innovative Projects with New Partners

As part of the implementation of this mission, members of the ONC-FAC collaboratively partnered with national nursing organizations, the Oncology Nursing Society (ONS) and the Oncology Nursing Society Foundation (ONSF). We served as expert task force members for a multi-site research core data set team, the Oncology Nursing Society’s quality indicators project team and the quality summit. This led to VA nurses’ participation in an innovative breast cancer care (BCC) pilot project.

Transformational leadership requires nurses to cultivate new allies in healthcare, government, and business and develop new partnerships with other clinicians, business owners and philanthropists to help realize the vision of a transformed health care system (IOM, 2011, p 33). The BCC Pilot Project afforded such an opportunity and we were ready, willing and able to support such an initiative. Breast cancer care in Veterans is a priority for VHA. The Oncology Nursing Society Foundation (ONSF) received a grant from the National Philanthropic Trust’s Breast Cancer Fund to develop and test quality measures. The Joint Commission (TJC) was contracted to conduct testing. Diverse pilot sites across the U.S. participated in performing retrospective data abstractions on patient charts. Eight measure sets were examined: pre-treatment assessment; continuing assessment; interventions
for distress, fatigue, sleep-wake cycle; assessment for chemotherapy-induced nausea/vomiting; education of neutropenia precautions, along with assessment of colony stimulation factor usage. The objective of the pilot included development of a comprehensive approach to quality cancer care; exploration of opportunities to test nursing sensitive quality indicators for reliability; and ensure patients receive evidenced based care that is linked to positive outcomes that can be influenced by nursing.

Some challenges faced by VA nurses included navigation of and approval processes for pilot participation. Partnering with VA central office staff to obtain a data use agreement (DUA) in order to abstract records across our multiple sites not only ensured compliance with regulatory standards but also made it possible for more VA sites to participate across the largest integrated healthcare system in the country. Our partners, ONSF and TJC, found the inclusion of VA sites to be value added due to patient, Veteran and geographical diversity. Another, and unexpected, challenge arose when we began to abstract the records at various VA participating sites. For some time, the health care industry has recognized that VA has one of the best electronic medical records in the country, an assessment supported by the IOM (Muhleman, Dorn, Hurford, & Kolodner, 2003; Department of Veterans Affairs, 2003). We were very excited to commence this pilot, knowing we would access the Veteran health information systems and technology architecture (VistA), our enterprise wide information system built around an electronic health record (EHR). And, having worked with the computerized patient record system (CPRS) interface, we anticipated timely abstraction of records from over 1,700 hospitals, clinics, community living centers and other VA facilities.

However, even though care is documented electronically, we soon learned that the electronic templates, notes and other areas where nurses entered information were not consistently recorded in the same location in the record from VA medical center (VAMC) to VAMC. Often, the note titles varied, and some VAMC’s employed templates to document while others used narrative notes. We overcame this challenge through our geographically diverse ONC-FAC membership located in or near many of the abstract sites identified and through the enthusiastic support of other VA nursing and interdisciplinary colleagues who graciously stepped up to support this initiative so we could access data from every region of the country. All members were either able to abstract locally and/or conduct regional site visits to obtain the requisite data. Through this lesson learned, a future goal of the ONC-FAC is to provide further guidance on comprehensive assessment/intensity of symptoms, interventions employed
and documentation of care that may be standardized across our system similar to the currently implemented VA nursing standardized skin care assessments and fall assessment documentation. One methodology is through standardized nursing documentation in the COMS project discussed later in this chapter.

Outcomes from the BCC collaborative partnership demonstrate that measure sets are meaningful. We learned that quality measurement scores can be examined for any gaps in care and documented symptom intensity can be improved. We also were able to demonstrate that clarification of descriptions made for measures can increase reliability. (Fessele, Beck, Matthews, Yendro & Mallory, 2012). We learned that nurses have an opportunity to further improve assessment and documentation of pre-treatment practices and continuing assessments and interventions for common symptoms in breast cancer patients undergoing chemotherapy.

The impact of cultivating this unique partnership not only provided us with a first-hand experience demonstrating that valid and reliable quality measures provide an instrument to link high-level evidence based practice and implementation to improve quality cancer care, it also demonstrated that national testing across diverse practice sites ensures “real world” performance of quality measures and allows use of results for future benchmarking. (Fessele, et al. 2012.)

One of the most meaningful impacts of partnering is the ongoing relationships developed throughout this process. For example, all nurses, regardless of position or practice area, can benefit from learning to say “yes” when invited to participate on a committee, task force and other opportunities that present themselves. These opportunities often lead to future collaborations and projects. This was the case when we were invited to participate on the first task force. Initially, Lori Hoffman Högg served as the liaison for the National Oncology Nursing Society’s (ONS) Department of Veterans Affairs focus group. She was subsequently asked to represent VA on the ONS multi-site research core data set project team; consensus conference; the quality indicators project team; quality summit and the breast cancer care pilot. As one project led to another, the multi-year participation culminated in the outcome of a prototype model for identifying, developing and testing in order to prioritize quality measures and then to test the measures in the breast cancer patient population undergoing chemotherapy. As oncology nurses, we were very excited as we believed this work would help to reduce the burden of cancer symptoms, improve the quality and quantity of life for patients that would continue treatments if symptoms were managed, all while decreasing costs. We also
believed we could create “spread” of the tested measures and interventions that can translate to the many other patient populations within the VA and beyond, with patients who also experience distress, fatigue, sleep/wake disturbances and neutropenia or the additional candidate measures including prevention of infection, anxiety, depression and pain.

Our success story of this pilot is even more impactful because of its dissemination to the larger global nursing community. The pilot results were presented by the multi-organization project team members at numerous national nursing and interdisciplinary conferences through abstracts and posters and publication in the Clinical Journal of Oncology Nursing. Our collective efforts received international recognition for research at the International Society for Nurses in Cancer Care conference. Nurse-sensitive patient outcomes represent the impact of nursing interventions on key areas such as patient's symptom management, functional status, safety, quality of life, psychological distress, costs and utilization of health care resources. (Given, et al., 2004). The nurses, nursing students, faculty, and nursing administrators alike can continue to share and promote the importance of quality measures that have evidence based interventions and are unique to nursing.

Another sample framework for partnering is exemplified by VA nursing through our participation in the multiple partnership collaboration among key VA national program offices and VA staff in our health care facilities along with an external partner, the Vanderbilt Center for Better Health Innovation Center. The chemotherapy ordering management system (COMS) project started as an innovation program led by Dr. Michael Kelley, VHA national program for oncology, and Gail Johnson from the VA innovation program office. In 2008 VA was grappling with an important question: whether it was better to create a technology solution for the task of entering chemotherapy orders or to purchase a commercial product. VA nursing ONC-FAC members participated as key stakeholders with an active voice from the commencement of the project development teleconference calls to preparations for the face to face meetings to launch the project. However, in 2009 when ONC-FAC member Janet Cogswell attended the VHA innovation program on chemotherapy order entry, the scope of the project had grown into a healthcare redesign project. The task of entering chemotherapy orders was still included, but the vision had grown to include the use of technology to improve the quality of oncology care within the VHA.

VA medical centers use a variety of methods to input chemotherapy orders including computerized order sets in CPRS, paper order sets which are entered by pharmacy into VISTA, instant medication order sets and
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

manual entry into CPRS. These methods are widely identified as weaknesses with potential for errors and with no value added. Some VA medical centers have purchased technology solutions to interface with CPRS and VISTA to allow for chemotherapy order sets to eliminate the risks of individual orders. In addition the program had flow sheet capabilities, which are important in oncology with its multiday complex treatment regimens.

The vision of the VHA innovation program was to utilize technology to enhance the quality of oncology care. It would affect the process from start to completion. The program would identify and promote best practices utilizing evidence based treatment plans. It facilitated direct real time communication among healthcare providers for best collaborative practices. As value-added features, it incorporated all practices recommended by our professional society, the Oncology Nursing Society, from the pretreatment to survivorship phases of cancer treatment. The same is true for the physicians and pharmacists. At the same time the functionality goal to improve ease of use and efficiency of chemotherapy order entry was maintained.

The analysis of chemotherapy order entry as a system design occurred in the Vanderbilt Center for Better Health Innovation Center over the course of two workshops held in November 2009 and February 2010. The Vanderbilt Center for Better Health is an organization that provides a specialized environment, a facilitation team and a proprietary process to accelerate group learning. Within this center they sponsor an innovation center. It is affiliated with the Vanderbilt Medical Center located in Nashville, Tennessee. They use a design-build-use plan to create organizational change. We met in November 2009 to design a chemotherapy order entry system. All disciplines were represented: staff nurses, advanced practice nurses (APRNs), physicians, pharmacists, software engineers, information technology personnel, safety officers, data registrars and systems engineers.

In February 2010 we met again to build a software program that would allow us to implement our vision. Again this was truly an interdisciplinary brainstorming sessions. For nurse participants, knowledge of the role of other professions grew tremendously. By way of example, we as nurses could now understand the challenge of pharmacists using a VISTA package that has a different screen than the CPRS screen nurses use. We learned that communication is improved when we have full knowledge of the role of all users. For example, we learned that we do not all use the same definitions for terms within our practice. “Start” and “Stop” already have defined pharmacy definitions, and we needed to learn these definitions. Our intravenous infusions would have to be initiated and ended. We need to do more than just talk to each other, we need to communicate and validate
the nomenclature of our professional languages to ensure that our nursing terminology is defined in the same way as our pharmacy and physician partners when building and developing electronic solutions to avoid misinterpretation of the meaning of our various clinical phrases. It became clear to all of us that those who do the work are the best equipped to ensure this needed clarity. They know the work and the related process steps and how they are defined. Building consensus through partnerships in this area improved the development of this system.

Utilizing the iRise platform, by April 2010 we were “using” a simulation of how we wanted the software to perform. iRise is a software development product that allows users to create a simulation of web applications without the use of written code. The screenshots looked like the proposed program and behaved like it in an interactive activity. It allowed us to “use” or “test” the program before it was written to ensure that what we built in February would allow our vision of improving oncology care to be achieved.

The chemotherapy ordering management system is a work in progress. When completed it will provide an option for VA facilities to redesign the process by which chemotherapy is ordered and administered. We have partnered with other healthcare providers in this project from its inception. The positive impact of VA nursing as partners on this project is twofold. The first is the improvement of the overall product through the inclusion of nursing insights throughout the system, including discipline-to-discipline communication and development of specific nursing modules. The second is the creation of a system that includes the tools we need to practice to the full extent of our licenses. Realizing transformational healthcare requires a practice environment that is fundamentally transformed so that nurses are efficiently employed, whether in the hospital or community, to the full extent of their education, skills and competencies (IOM 2011, p 30). When our professional responsibility and accountability are recognized at the inception of the system redesign, we define how we will practice in the process instead of leaving this delineation to other healthcare providers. This is further supported in the Future of Nursing Report. “To be effective in re-conceptualized roles, nurses must see policy as something they can shape rather than something that happens to them” (IOM, 2011, p. 8). By being an active partner throughout the COMS project, the expert VA nursing voice and actions shaped the design of the future of practice.

While the importance of partnering with others in healthcare design is clear, challenges to participation exist. Project development moves quickly and does not wait until we are ready to partner. In VA oncology nursing we were ready to take advantage of the opportunity provided in the COMS
Innovation Project. The ONS clinical practice program provided a mechanism for rapid response. This program supports nursing clinical practice, develops policies and disseminates information through direct communication with appropriate nurse groups. There are seven ONS field advisory committees and three workgroups, one of which is oncology.

In creating the oncology field advisory committee, the ONS convened a pool of oncology nurses from all practice areas: staff nurses, infusion nurses, managers, clinical nurse specialists, APRNs and educators. Utilizing email and teleconferencing we are able to exchange critical information rapidly, usually within 24 hours. Before we, as a group of experts, were convened, however, we had already conducted an internal review of the state of VA oncology nursing. We were assessing our own VA practice to identify areas for improvement. As part of an identified issue in chemotherapy administration, the oncology field advisory committee had already compiled sample chemotherapy documentation tools. When the invitation arrived in October 2009 from the innovation program office for nursing partnership, we were prepared with a potential pool of participants and knowledge of what the field of VA oncology nurses felt they needed to practice fully and safely. We took the information we had and analyzed how it could be incorporated into an electronic ordering system to not only provide a superior documentation tool but to design a standardized process for the VA which would improve oncology nursing care. This was accomplished in time for participation in the workshop held one month later in Nashville.

We learned that to be able to take advantage of the unique opportunities to partner with other healthcare workers and organizations in today’s rapidly evolving timeline, we must be prepared. Our preparation included identifying oncology nurses who are dedicated to building their profession. We recognized that our preparedness must also include the continual appraisal of our profession to identify areas for improvement and emergent trends. As in our own local practice, on a professional level we realized we needed to be in a state of constant readiness.

The second workshop focused on this innovation was held in Nashville in February 2010. We identified a second champion in our successful participation in this healthcare system redesign project. Our participation would not be possible without the full support of nursing administration and our peers. Nurses were released from clinical duties by nursing administrators to participate in this meeting. Colleagues supported this decision to permit nurses to contribute to our healthcare system. With creative scheduling and the cooperation of our peers, this was done without utilizing overtime. We learned that without administrative
support, nurses will find the effort to be full partners far more difficult. We also believe that our colleagues must support our efforts. Education and communication of professional activities must include our colleagues as well as our administrators.

Investment in a project such as this one, where partnering is central to our goals, can be approached in a way that all colleagues can benefit. When any nurse is involved in projects of this nature, it means a heavier assignment for colleagues, in this case during the four days of workshop participation in Nashville. This burden on others can be made more acceptable. Janet Cogswell, who was a participant, tried to ease this with a full report of the activities during the meeting, both to supervisors and peers. When the first iRise software simulation was reviewed in April 2010, Janet invited every staff nurse and APRN in her unit and outpatient clinics to participate. Thus, when she sent the final report from her facility, it was sent as a group report with all local participants named. Hence, they supported the absence of one nurse and in turn, they were all acknowledged when their work was presented in Nashville, Tennessee as a group vision.

Another strategy she used was to find a peer partner. The program designed in Nashville was sent to software coders who built an actual web application of the COMS. User acceptability testing of this web application was undertaken in June and July of 2012. It required a time commitment of 4 to 6 hours weekly. Janet partnered with a nurse from the outpatient clinic, and the work was divided. Thus, by taking turns, each of the two units was impacted with 50% of the time away from direct care, rather than 100% from one unit.

This work in the COMS demonstrates that we nurses can be full partners in healthcare redesign thereby shaping that process so we can practice to the full extent of our licenses. In order to be ready for any future endeavors we must continue our ongoing self-assessment and be prepared for the next challenge.

VA nurses are both empowered and entrusted to be fully engaged in leading change, and advancing health through the promotion of collaborative partnerships for patient-centered, evidenced based care. (Department of Veterans Affairs, 2011). We look forward to leading by furthering our innovative partnerships in the transformation of healthcare. This chapter provided an overview with examples from the national VA nursing perspective. The challenges of healthcare transformation will be exemplified through the individual stories of success of VA nurses and their creative development of unique partnerships to overcome challenges identified. Lessons learned can be applied in redefining role expectations to
ensure the optimal impact of nurses as full partners in new and enhanced partnerships in care.

REFERENCES


Chapter 21.1

Nursing Collaborative Approach Leading to the Transformation of Day Treatment to a Psychosocial Rehabilitation Recovery Center

Pam McNutt, Gayla Gift and Ellen C. Fagan-Pryor
Our chapter tells one story of transforming patient care in the Department of Veterans Affairs (VA) through creative partnering with other disciplines and our Veterans. It takes place at the VA Northern Indiana Health Care System (VANIHSC). The three of us played key roles in writing this story. Our creative partnering allowed us to be part of the national transformation creating recovery based, person centered-care for Veterans with serious mental illness. Substance Abuse and Mental Health Services Administration (SAMHSA), the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation, defines recovery as, “A process of change through which individuals improve their health and wellness, live a self-directed life, and reach their full potential.” (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011). Our efforts enabled us to transform our day treatment center (DTC) into a recovery based, person-centered psychosocial rehabilitation recovery center (PRRC). Pam is the PRRC coordinator, Gayla is the family education registered nurse (RN) and Ellen is a mental health case manager.

The transformation of our day treatment center to a PRRC met with great success. The Veterans, as one of their first actions, named the PRRC of VA NIHCS the Veteran’s community resource center (VCRC). Visiting the VCRC, you see Veterans attending classes and working with recovery coaches. You see families participating in a family psycho-educational program. You may see Veterans actually teaching classes. For example one Veteran, after participating in an independent living class and meeting his goal, was so inspired he designed and now teaches a class entitled “Happiness”. You will see Veterans interactively involved, participating in individualized programs, meeting their independent living goals, enjoying activities they choose, taking steps to own their own cars and handle their own money. You will see recovery staff acting as cheerleaders, coaches, and educators, encouraging Veterans to continue working toward self-directed goals. If a Veteran relapses, you will see staff members coaching the Veteran back into recovery and encouraging him or her to learn from the situation in order to be better prepared in the future. You will not see large numbers of Veterans at VCRC, as it is no longer a place to “hang out”. Veterans are living in the community and working on their hopes and dreams. Veterans are usually in the program for about two years.

You will see Veterans actively involved representing stakeholders in the Psychosocial Rehabilitation and Recovery Center (PRRC) executive council meetings. The PRRC executive council meets monthly, advising staff on
The composition of the interdisciplinary staff who work in the VCRC include the PRRC coordinator, psychology technician, recreational therapist, peer support technician, family education registered nurse, social worker, psychologist, and PRRC program support assistant. Every VCRC Veteran has a recovery coach who works closely with the Veteran developing assessments and recovery plans, meeting on a regular basis to discuss goal progress and barriers. Pam, as the PRRC coordinator/registered nurse oversees the functioning and overall direction of the VCRC. The PRRC coordinator participates in other campus-wide committees such as the morning huddle, a fifteen minute meeting with other program coordinators and leaders to identify opportunities for improvement and challenges to achievement for excellence within the hospital. She participates in continued readiness, a VHA program that ensures that the provision of health care is maintained to the highest standards of goals and practice. She also provides information and education to other staff on recovery, psychosocial rehabilitation, and person-centered care in our inpatient recovery services. The psychology technician teaches skill building classes that include social skills, ending self-stigma, relaxation and management of co-occurring disorders. The part-time recreational therapist designs and directs activities according to the assessed needs of the Veterans. These are recreational in nature with a focus on increasing Veterans’ awareness of recreational resources in their community and utilizing these resources. The peer support technician provides peer support to Veterans in the program and functions as a role model to peers by exhibiting competency in personal mental health recovery and using coping skills. Gayla, the family education RN, works with the Veterans and their family or significant others to provide education and training on serious mental illness, communication skills, problem-solving skills, and crisis management. The social worker teaches skills classes including an evidence based Illness management and recovery class that focuses on relapse and relapse prevention, setting and meeting goals while collaborating with the Veterans and their families in developing individual recovery plans and providing individual cognitive therapy. The part-time psychologist participates in program screenings, completes mental status assessments and global assessment of functioning scores, and participates in interdisciplinary recovery planning sessions with Veterans. The program support assistant answers the phone, scheduling appointments for screenings, individual sessions, and group sessions, ensuring an efficient, smooth and well-coordinated encounter for each Veteran. Interdisciplinary curriculum and planning activities for its Veteran members. The council is governed according to Veteran-developed bylaws.
treatment team meetings are held to review recovery plans with Veterans, to assist in developing partnerships and to make sure staff members are providing integrated care. In addition, staff members meet every morning to evaluate the program and to discuss issues.

Since the program’s inception, 15 out of 60 Veterans have met their goals and are discharged from the program. Veterans being discharged from the PRRC are considered to be in alumni status which means they are not actively involved but are eligible to participate in all or part of the program in the future if they desire to continue their education and/or receive support. Recently an alumnus Veteran reconnected with the VCRC program (for a couple of days) after losing her spouse, to help her with the grief process. Because Veterans and staff have been so successful, staff are currently seeking new referral sources and working with inpatient staff to reintroduce person-centered recovery care approaches.

In order to help you, as the reader, understand the transformation process, we will describe the DTC as it was in the 1990s and early 2000s. Providing a place for Veterans to socialize, participate in leisure/recreational activities, and offer some skill programming was the primary focus of the DTC. Staff members were in charge and made all program decisions. Staff included two RNs, a part-time recreational therapist, and a part-time social worker. If a Veteran relapsed or slipped in some expectation, staff set forth consequences, i.e. the Veteran could not attend DTC for the week. The goal of the program was to maintain current status. Veterans stayed in the program for many years. Neither staff nor Veterans were aware of the possibility of recovery and full integration into the community. Staff and many Veterans viewed themselves as being unable to change, of needing to be kept safe, and of not being able to be full partners in their care.

At the same time, the facility’s inpatient units were struggling with long lengths of stay and related quality of care issues. Seeking consultation with the Boston Center for Psychiatric Rehabilitation, the professionals working in the units began the process of incorporating a recovery based psychiatric rehabilitation program. Gayla and Ellen were actively involved in this effort, which is described more completely elsewhere for those interested in this topic (Fagan-Pryor, Haber, Harlan & Rumple, 2009). Implementing recovery based psychiatric rehabilitation programming enabled discharge of Veterans who staff members had once thought of as never able to leave the facility. These Veterans began attending DTC while living successfully in the community in places they chose. In fact, one of these Veterans bought his own home, re-established contact with his wife and children, and after a couple of years retrieved his driver’s license and a car. Seeing Veterans,
such as this individual reach their goals and live their dreams increased our awareness and desire to change care in the DTC.

Because of our increasing awareness of the reality of recovery, witnessing recovery first hand, and hearing individual recovery stories, the DTC staff and Veterans, under the leadership of Pam, began searching for opportunities to enhance DTC participants’ life satisfaction. A potential answer to this dilemma was discovered at the national level in articles from the Mental Health Service Package recommendations for Recovery Based Programs throughout the Veterans Health Administration (VHA Handbook 1160.01, September 2008) and The Veteran’s Hospital Administration Handbook on Psychosocial Rehabilitation and Recovery Centers (VHA Handbook 1163.03, July, 2011). These publications contained recommendations and requirements for psychosocial rehabilitation and recovery centers. Moreover, recommendations in the final report from the President’s New Freedom Commission on Mental Health (2003) called for person-centered recovery based programs providing more support for this needed change.

Even in light of the recovery success seen at our VA, growing national recognition of the importance of person-centered recovery based care, and the VA trend for DTCs to become PRRCs, as with all change, everyone did not greet the transformation with enthusiasm or immediate action. While this seemed like a roadblock, we chose to use it to our advantage and gently but persistently presented the fact that it was indeed best practice and a national trend. Recommendations from The Veterans Hospital Administration Handbook 1163.03 on Psychosocial Rehabilitation Recovery Centers (July, 2003) provided a blueprint that we followed in restructuring the DTC and advocating for additional staff. Believing that the Veteran benefits outweigh the risks and difficulties of putting the directive into action gives us the energy to take the steps we need to make the directive a living, breathing reality.

Some of the Veterans who participated in the DTC enthusiastically welcomed this change, while others did not, and resisted our efforts. We provided Veterans with opportunities to discuss the changes, try out the new system, and to be active in creating the new VCRC. DTC staff, with input from Veterans, conducted a full day retreat to identify Veteran driven program strategic goals. One retreat activity helped members to say goodbye to the DTC. Every member wrote down what they missed about the DTC on a slip of paper. The papers were put in a coffin and buried. Then a new bright and sunny VCRC appeared while everyone sang, “Let the Sun Shine In”.
We continue to hold hope for our Veterans until they find it within themselves. When Veterans get discouraged we help them focus on their strengths and how far they have come. We help and support them if they want to stop working on a goal and try something else. Not all of the Veterans desired to make the transition and thus chose not to participate in the VCRC. Some of the Veterans went into vocational rehabilitation and/or other community resource programs. It is important to note some of the Veteran’s who initially decided against attending VCRC have returned to take one or more classes, to participate in the stakeholders meetings, or make appointments with staff members they have found to be helpful over their lifetimes.

It was tempting for some hospital wide interdisciplinary staff members to think that this new model was a passing fad, which would be replaced by another fad in a year. Making the change was difficult, requiring a shift in thinking from doing, telling or fixing to empowering and partnering with Veterans, focusing on their strengths, believing in them, supporting and coaching them toward reaching their goals. As staff members heard recovery stories, experienced Veterans achieving positive outcomes, and learned about rehabilitation and recovery, an internal desire to be actively involved in the process began to grow within them. Now staff members role model the recovery process, follow staff-developed ethical guidelines to provide recovery, person-centered, psychosocial rehabilitation, and experience the joy of helping another become empowered. If staff members think a process or procedure might be too cumbersome, they try it and then help improve it. Just as with our Veterans, we focus on our strengths, looking for the best in each other, and provide hope and encouragement when we get discouraged. We look at how far we have come and where we want to go.

Our facility leaders in mental health and nursing administration support our efforts. We seek out leaders who believe in the process and willingly assist our efforts. We approach conflict calmly and matter-of-factly, supporting our initiatives and proposed changes with health policy, the standards of our accrediting agencies, both the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission (TJC), relevant research, and national directives. We have a persistent mantra: We need to do this because it is in our accreditation standards or it is in the VHA directives. It is best practice/care. When encountering roadblocks we evaluate, calmly and persistently do what we know is the most ethical, recovery-based approach, asking for forgiveness later if we happen to step on the proverbial toes. We persistently work toward our goals, modeling this skill for staff and Veterans. When overwhelmed we take a time out, ventilate,
and start working toward the goal, finding that as long as we persist the answers reveal themselves.

Sometimes we experience communication problems and resource competition from non VCRC staff causing conflict and boundary issues. For example, for over a year one VCRC staff member (educated in social skills training) has been conducting social skills classes. Therefore, when another program’s staff member attended the same social skills training, collaboration was suggested, however, she did not wish to do so, creating a potential duplication of services. We continue to work through these challenges.

Occasionally staff who follow a medical model or have a more paternalistic viewpoint interact with VCRC Veterans which causes conflict. For instance, two Veterans wanted to marry but inpatient and case management staff of other programs involved in the Veterans’ treatment were adamant that this was not in the Veterans’ best interests and told the Veterans they would not support their decision. After working with this couple, recognizing strengths and resources within this relationship, VCRC interdisciplinary staff supported the Veterans’ decision championing the benefits this couple experienced in their relationship. The Veterans eventually eloped and lived happily until the recent death of one of the Veterans.

This experience reinforced for us the importance of persevering in doing what you believe is right and best for the Veteran. We also developed a class on managing and dealing with external and internal stigma to help Veterans deal with such conflicts. This class recognizes the stigma associated with a diagnosis of mental illness. This class helps Veterans overcome the limitation of judgments and prejudices others attempt to place on persons diagnosed with a mental illness. The class helps Veterans understand they may fall victim to under-valuing themselves because of a diagnosis of mental illness. Once a person understands this stigma may be external as well as internalized, skills training focuses on breaking the patterns of prejudice regarding mental illness and self-defeating behaviors that accompany internalized stigmas.

When conflict arises we engage staff in dialogue and present our views in a matter-of-fact way, supported by research, accreditation standards, or VHA directives (policies), using our mantra: “We need to do this because it is best practice and care”. We also continue to find allies among non VCRC staff. For example, inpatient staff had us teach one of our classes in a very noisy distracting day room. One of the staff nurses took it upon herself to find and clear out a room so that it could be used as a more appropriate classroom.
We continue to strive to improve the VCRC, conducting biannual satisfaction surveys, making program adjustments as needed. Veterans evaluate classes and provide suggestions on program improvement. In order for staff to be utilized effectively, we are also investigating what changes need to be made to our referral process to increase the number of appropriate referrals to VCRC.

Leadership qualities that have helped make the transformation successful include maintaining an open mind and being willing to listen to other’s concerns. Additional qualities that assist with transformation include using a problem solving approach, acquiring program development skills, possessing a wide knowledge base, and modeling while being clear about our vision. Kindness and forgiveness are very useful tools. Using the ability to help people become better, as well as capitalizing on and utilizing other’s experiences help staff feel invested in the program. Strongly advocating for change helps the transformation process which frequently occurs when a staff member identifies a need for a new class and then develops the class.

We celebrate program success at the completion of classes each quarter and commemorate each individual Veteran’s graduation from the program. We recently celebrated accreditation by the Commission on Accreditation of Rehabilitation Facilities.

By participating in the developmental activity of transforming the DTC to a VCRC we witnessed the transformation of individual Veterans and staff as they are empowered to live their best lives. The experience has allowed us to live and witness the power of recovery, experiencing each Veteran’s uniqueness, witnessing them change as they realize their hopes and dreams. We learned that when you do the right and best thing for Veterans, everything else falls into place.

REFERENCES


Chapter 21.2

Integration of Palliative Care in Oncology

Grace Oligario
Palliative care is a philosophy and structured system of care provided by an interdisciplinary team that is focused on the relief of suffering and providing support for the best possible quality of life for patients with serious, life-threatening illnesses, as well as their families, regardless of the stage of the disease or other the need for other therapies (National Consensus Project for Quality Palliative Care, 2009). According to Von Gunten (2008), there is a unified refrain in the medical community “that oncologists, as a group, are the most difficult to deal with in the provision of palliative care in the end of life” (p. 813). Back (2000), an oncologist, acknowledged that medical oncology has not always done the right thing when it came to dying.

Jackson et al. (2008) note that in a 1998 survey conducted by the American Society of Clinical Oncology of over six thousand oncologists, less than a third of the participants felt that their formal training was very helpful in transitioning goals of care. Jackson et al. (2008) conducted a study on 18 academic oncologists in two medical centers in Boston, Massachusetts and Pittsburgh, Pennsylvania. They found that all of the participants believed their role is to provide therapies intended for cure or to improve survival but not all of them felt their role involved psychosocial care. In this study, psychosocial care was defined as communication and building relationships with patients and their families. One of the participants who described an oncologist’s role as solely to provide medical therapy also expressed the belief that physicians are focused on cure and the focus on care is reserved for nurses. Another participant in the study went on to say that “nurses are divorced from the responsibility of curing the patient so are much more willing to give up” (Jackson et al, 2008, p. 897).

Valente (2011) looked at nursing challenges with end-of-life care and found that they stem from inadequate knowledge and social skills and the nurses’ struggle with their own values. They also identified conflicts between nurses who advocate for patients’ wishes for end-of-life care and physicians who have difficulty agreeing with the patients’ decision because they remain hopeful that they are able to delay the patients’ decline.

These studies shed light on the relationship between health care providers who identify with oncology and those who identify with palliative care as the focus of their practice. Oncology is viewed as a science that is largely driven by research outcomes. Palliative care evidence based outcomes on the other hand have been sparse compared to more established medical specialties (Penrod & Morrison, 2004). The identified reasons for limited focus on palliative care outcomes include the fact that while symptom evaluation typically uses patients’ self-report, this is not always possible in palliative care due to the overwhelming symptom
burden or cognitive impairment from terminal illnesses. They also note that randomized controlled trials, the gold standard design for conducting clinical research to establish cause and effect relationships, may be difficult to use in palliative care as it is unethical to test a treatment for the randomized group and withhold it from the control group.

These studies provide context to my story about the integration of VA palliative care in oncology, a story of redesigning health care through partnering with both patients and colleagues. I have been a VA nurse since 2001, caring for cancer patients now for twelve years. I started as a registered nurse in a medical-oncology unit and, inspired by VA’s efforts to encourage pursuit of higher education among its staff, I went back to school and completed my master’s degree in nursing and became an advanced practice registered nurse (APRN) with a focus on family practice. I now serve as the oncology and palliative care nurse practitioner at the Detroit, Michigan VA hospital. I remember going for my job interview in 2001 and not being able to clearly articulate the difference between palliative care and hospice care as my knowledge of both was somewhat limited. Having provided palliative care for some time now, I look back and realize that as a bedside nurse, I was already providing palliative care in oncology.

According to Davis, Walsh, LeGrand and Lagman (2002), an advanced practice palliative care nurse is capable of effective communication, promotes informed decision making, competently manages complications, symptoms, psychological care and care of the dying, and oversees coordination of care. These are very exciting times for palliative care providers as more and more people are becoming aware of the benefits derived from incorporating the services of this specialty in patient care. In 2012, the American Society of Clinical Oncology (ASCO) released a statement supporting the combined use of standard oncology care and palliative care early in the course of illness for patients with metastatic cancer and/or high tumor burden (ASCO, 2012).

I am fortunate to work with knowledgeable and compassionate individuals in palliative care and oncology who share the same goal of optimizing patient care outcomes. There is mutual respect and appreciation for what each member of the healthcare team is able to contribute in delivering the best possible care to our Veterans. Instead of struggling to have both services co-exist harmoniously while serving as their nurse practitioner, I had the benefit of being able to bridge understanding and communication between the two. Serving as a representative of both services, there was also an improved sense of accessibility among the providers. My close contact to providers and team members of both services
facilitated getting messages across, allowed for clarification of uncertainties, and provided for improved understanding of the different processes in place for each service that tend to impact the other. These processes included, among others, educating both services on how visit and appointment schedules are determined, individual provider preferences in approaching care, and guidelines followed by the respective services.

In my role, I was also able to establish a working relationship with some patients in oncology before they were in need of hospice care. I was able to initiate supportive care through oncology using my palliative care knowledge and experience alongside the oncologists as they continue to render disease-modifying therapies to their patients. This allowed for a smoother transition of care to a focus on comfort through hospice for both the oncologists and the patients when they reach the point that oncologic treatments are no longer beneficial. The concept of supportive care in oncology also seemed to be more appealing to providers, patients, and their families, initially. Over time they were able to see palliative care as a service that can provide supportive care along with various other approaches.

Both services provide a substantial amount of psychosocial support to patients and their families. I was able to team up with other members of the interdisciplinary team, particularly social work, in many of the patient visits that allowed us to render a holistic approach to care in the convenience of a single visit. I was also invited to participate in committees, programs and projects to weigh in on issues and offer improvements pertaining to cancer and end-of-life care for Veterans. In 2009, I joined a team of cancer care providers in our facility in a project that called for a palliative care referral for all lung cancer patients that are newly-diagnosed with stage IIIB or IV lung cancer. In essence, we set out to create bridges between oncology and palliative care specialty services. During this team collaboration, initiated by one of our oncologists, both specialties observed respectful boundaries. Palliative care did not lose sight of the fact that the oncologists continue to be the main providers of cancer care and the role palliative care played is that of a consulting service. The extent of participation and involvement of palliative care was determined by the type of assistance requested by oncology. A similar respectful approach for delineation of roles was also adapted and resulted in a successful collaboration at the University of Texas M.D. Anderson Cancer Center (Bruera & Hui, 2012).

The positive experiences and outcomes we derived from this project have resulted in an improvement in the number of referrals palliative care has received from oncologists. The referrals include many of the other advanced malignancies and the needs for assistance range from goals
of care discussions and symptom management, to early involvement of palliative care for support. In our role, we assist not only in prescribing medications to treat symptoms but also participate in end-of-life care discussions. These discussions include planning for home safety and support, providing education and preparing patients and families on physical changes that can be expected as a result of the progression of their terminal illness, assisting patients and families cope and reach acceptance of the terminal nature of their family member’s condition, and facilitating identification and completion of remaining attainable goals in life.

I serve as a resource person to oncology nurses and other oncology staff for end-of-life questions or concerns. As Valente (2011) discussed, nurses have their own struggles with end-of-life. I am able to listen to their concerns and extend an understanding from one nurse to another. As I continue to follow many of their patients in hospice after they are no longer able to receive chemotherapy, it gives them comfort to know that they have not abandoned their patients and continue to be indirectly involved in their care through contact with me. I also facilitate helping them reach emotional and psychological closure by updating them as our mutual patients continue to decline, and eventually die a comfortable and peaceful death.

Although we have improved the integration of palliative care in oncology and have started reaping its benefits, there are still opportunities for growth and improvement. My next goal is to work toward increased staffing and structure to be able to conduct more interdisciplinary palliative care visits with patients during times that are more convenient for them such as during the days of their oncology or chemotherapy appointments.

I have been invited by our chief of oncology to represent palliative care in a project that he is heading. It is an on-going project between oncology and gastroenterology (GI) to formulate action plans in improving the care of Veterans with gastrointestinal malignancies. We hope to identify and address the needs of our specific Veteran population in all aspects of their cancer care. I am also working with nurse leaders, clinicians, and educators in our facility to foster the conduct of nursing research and scholarly work. In an era of evidence based practice, I believe that palliative care’s impact on patient outcomes can be best demonstrated through the conduct of research. According to the Robert Wood Johnson Foundation Task Force on Palliative Care, Last Acts Campaign, for palliative care to build systems and mechanism of support, it has to be involved in research-based standards, guidelines, and outcome measures (Robert Wood Johnson Foundation Task Force on Palliative Care, 1998). I agree and am working toward this goal in my role.
As I continue to fulfill my role, I hope to continue to make meaningful contributions to the integrated services of palliative care and oncology. I hope to see more improved outcomes from this integration as we strive to continue to provide excellent cancer and end-of-life care to our Veterans. I hope to inspire other nurses to find opportunities to make a difference within their practice.

REFERENCES


Chapter 21.3

Pioneering Cancer Care in the Last Frontier
for Veterans in Alaska

Karyn Overturf
Only a few years ago Veterans in Alaska traveled to Seattle, Washington, 2,266 miles down the Alaska Highway or a 4-hour plane ride from Anchorage, to receive their cancer care through the Department of Veterans Affairs (VA). Traveling to Seattle for care often meant months in a hotel without family support or the comforts of home while they underwent chemotherapy and radiation therapy. Although this was physically exhausting and emotionally difficult for patients, Seattle was the nearest major city and the closest tertiary VA facility. In 2010, VA made the decision to purchase cancer care in the local community due to these extreme distances.

It was just shortly after this policy change that my military husband and I were transferred to Alaska, and I began my VA career as the newly hired oncology nurse case manager for the Alaska VA. At that time I had 15-20 patients for whom I coordinated cancer care in the local oncology community. Now that number is nearly 200 Veterans. The increased accessibility to care has been dramatic, and I am often asked, “Why has this program grown so quickly?” And some have even asked, “Is there a cancer epidemic?”

The program's growth is not about a sudden influx of Veterans in Alaska nor is it about an escalation in cancer diagnoses. It's about improving communication and forming partnerships, and it begins at the front door. When Veterans with newly diagnosed cancer conditions come to the Alaska VA for the first time, I personally meet them at the front door, walk them to the eligibility service section, warmly look them in the eye and tell them that we are here to help. I am keenly aware that it takes a lot of courage for them to come to our front door because many Veterans have heard negative stories or have had negative experiences with the Department of Veterans Affairs. Some have heard they'll have to go to Seattle for cancer care, and because they don’t want to do that, they forego care or don’t follow through with treatment. Some have found other means of care that have not been helpful. And still others didn’t know VA care was available for them. But the word is out there now, and I have received dozens of calls from Veterans who had not previously sought care in the VA healthcare system, but had heard from a friend or a community physician that they should call Karyn. I welcome their calls, and I am grateful for the opportunity to care for our nations heroes. We have a beautiful VA facility in Alaska, and I proudly welcome new patients and take the opportunity to showcase VA while calming any anxieties they may have, thus building trust.

Just as building a trusting relationship with Veterans is the beginning of patient-centered care, networking within the local medical community...
is a concurrent and key step toward building dependable, collaborative partnerships for the delivery of quality care. It is vitally important for VA to establish trust within the local healthcare community as a credible partner in care. “Collaboration, credibility, compassion, and coordination have been identified as skill sets that exemplify nurse professionalism to members of the health teams” (Valentine, 2013, p. 35).

I have found that personal communication with physicians and other healthcare team members needs to be conducted with confidence and ease and is key to successful partnerships. As contributing partners in patient care, we all need to view ourselves as members of a collaborative team who exercise healthy mature teamwork skills for the common goal of quality patient care. Building and maintaining these professional relationships starts with effective, warm, respectful and consistent communication.

Patient-centered care is a phrase that seems to be in vogue in healthcare. There are many definitions and the terminology is often vague and poorly understood. I find value in the Institute of Medicine’s quality report that defines patient-centered care for cancer patients as being respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (IOM, 2011). In its simplest form, this concept dates back to Florence Nightingale who identified nursing as focusing on the patient rather than the disease.

To me, patient-centered care means so much more than knowledge and competence about the Veterans’ type of cancer or what treatment options are available to them. I want to truly know my patients and engage them in their own care. I want to understand the culture of the Veterans and their specific lifestyle in rural Alaska. I want to respect and honor their strong independent spirit and pride while I empathically provide evidence based education. I want to assist them with access to resources related to the cancer diagnosis, and I want to support them in their personal decisions about their care.

Many people in the United States have not had the opportunity to visit our great state of Alaska, and know very little about it. Alaska is 2½ times larger than Texas and the largest of our 50 states. Alaska covers 570,640 square miles and in 2012 had a population of just over 700,000. Alaska also has the highest Veteran population per capita, and 17% of the adult population are Veterans. Alaska is referred to as the last frontier for good reason. Our rural and rugged geography combined with harsh weather can present significant and unique barriers to care. To illustrate this point, let me share a few stories with you.
A Veteran in a remote part of southeast Alaska needed his blood counts monitored each week after completion of his cancer treatment. To accomplish this, I was able to send him to a small clinic near his town through our native sharing agreement. This clinic, weather permitting, flies the specimen out on a floatplane that transports labs once per week to the nearest processing center. I don’t remember anyone in nursing school teaching us to factor in sharing agreements, floatplanes and snowstorms when ordering labs.

Another Veteran in central Alaska wasn’t able to follow-up with his oncologist in the spring because he lives on an island that is only accessible by snow machine or skiff. It becomes nearly impossible for him to leave the island in the spring because the ice is not stable enough for him to ride his snow machine across and there is too much ice to run his skiff. In this particular situation, there were no creative solutions except to wait on mother nature, but thankfully the Veteran was safe and able to follow up with his oncologist after break-up.

One Veteran who was diagnosed with cancer told me he would deal with his cancer as soon as he got back from his buffalo hunt. In Alaska, getting drawn to participate in a buffalo hunt is a once in a lifetime opportunity, and he knew the meat from the buffalo would feed him and his family for years to come. Because I understood and respected the significance of this event for him, I knew how to educate him on his treatment options, support his personal decision and coordinate his care for his return after the hunt.

Another Veteran shared with me that the most important thing to him in the world was his dog, and because he lived alone, he worried about the care of his dog if he had to be hospitalized or in the event of his death. As we discussed this, we were able to come up with a plan that made him comfortable and gave him peace. In another example, we flew in an old battle buddy Veteran, under a travel grant, for a patient who could not be released after surgery without an escort because he had no one else for support. The number of stories I have like these could fill this entire book.

Cancer care closer to home can still be quite a distance for Alaskans. As nurses we are accustomed to considering patient's abilities to perform activities of daily living (ADL's) before sending them back home after treatments or hospitalizations. In early winter I had the opportunity to care for a Veteran whose diagnosis was discovered because he had complained of shortness of breath while hauling water up to his cabin. A computed tomography (CT) scan was performed and showed a 13cm mass in his chest. It was then that this frightened man heard the word cancer for the first time. After staying in Anchorage for four months to receive his cancer...
treatments, he was to return home to his cabin where he lived alone. His ADL’s, like many Alaskan’s, included much more than bathing, dressing, and meal preparation. In Alaska, hauling water, chopping firewood, collecting coal from the beach to use for heat, hunting, fishing, gardening, and canning are not hobbies. ADL’s for many Veterans in Alaska are complicated and strenuous, but essential for their survival. When I can establish a trusting, caring relationship and really listen to the patient, I can then apply my nursing knowledge and work with community partners to implement a plan that is centered on the patient’s needs and lifestyle. Only with this type of compassionate and comprehensive patient-centered care can a Veteran such as this man make a successful transition.

Patient-centered care means that we must take the time to listen to our patients to learn what's important to them. “Clinicians should know the patient’s family circumstances and cultural norms well enough to help him/her with decisions about care and adherence to treatment regimens and self-management to promote healing and prevent illness” (Epstein, Fiscella, Lesser, & Stange, 2010, p. 1490). In Alaska this means addressing questions such as how far away the nearest clinic is to the Veteran? Does the Veteran have a support person? Do they have any neighbors to help plow and check their pipes in the winter if they have to be away from home? Do they have farm animals or pets? Can the animals get to their food? Many Alaskans live in areas where there is no pharmacy nor any home health care, hospice services, or meals-on-wheels.

Cancer care is complex. When a Veteran has a serious illness like cancer, the number and complexity of medical service providers can be overwhelming to them. A healthy patient may have just one point of contact such as a primary care provider (PCP). A Veteran with cancer not only has a VA PCP, but they may also have a surgeon at one of the community hospitals or in Seattle, a CT scan provider at our partner Air Force hospital in Anchorage, a PET scan provider at a contracted radiology group in town, a medical oncologist, a dietician, a physical therapist, a pulmonologist, a radiation oncologist and the list goes on. The number of partners necessary to provide cancer care is extensive. One of the challenges of utilizing so many community partners is that the Veteran’s personal preferences can easily “fall through the cracks” in a fragmented system of care.

My role as nurse coordinator provides a continuum of oncology care that incorporates almost every specialty, and I serve as the chief point of contact to assist with things that include: retrieving all of the records and getting them scanned into the VA electronic chart, communicating all the information to the Veteran regarding time and location of appointments
and the results of each appointment, facilitating conversations between all the members of this expansive healthcare team, and ensuring proper authorizations are in place for all of this care. It is not a small feat. The population in Alaska does not justify the full complement of in-house VA specialists, so partnerships have been developed with the Alaska Native Tribal Health Consortium, the Department of Defense, and the community. The amount of communication, coordination and collaboration with all of these services across so many different agencies for an individual Veteran, especially one who is ill, can feel insurmountable to him or her. Many Veterans in Alaska have described the role of a nurse coordinator as a lifeline.

The Alaska VA has the largest integrated care service in the nation with over 3,800 consults received and processed monthly. To better coordinate care, I established a designated fax number for oncology care, and personally visited each community partner in Anchorage and Fairbanks to introduce myself. I distributed business cards with my direct phone number (which doesn’t require pushing multiple numbers on a phone tree) and a copy of our VA request for care form pre-addressed to my attention with the designated fax number. This was so well received that the potential problems coordinating this level of complexity are essentially nonexistent. I routinely go back to the offices for follow-up visits, relationship building, to meet new staff members and to address any questions or concerns. Establishing relationships, earning trust and being accessible are key to having successful partnerships.

However, when multiple physicians from separate facilities are all ordering tests for a Veteran, the potential for fragmentation of care increases greatly and can create negative outcomes for the patient. These community partners may all be involved in the Veteran’s care, but they do not share the same medical record, and, therefore, a lack of care coordination can be a very real concern. To alleviate this fragmentation, I designed my role as nurse coordinator so that all requests for care funnel through me. For example, a Veteran was recently sent to several specialists during his initial work up for cancer. Three of the specialists ordered different imaging studies, all with contrast and some overlapping. Due to the patient’s diagnosis and potential for renal failure, he should not have had any of these studies with contrast. Without effective and timely proactive communication and coordination this patient could have suffered harm. It would have also been an unnecessary use of resources.

Many Veterans in Alaska travel from remote areas, and it is important for a nurse coordinator to effectively coordinate all of the diagnostic tests and medical appointments for him/her so the Veteran can accomplish all
that is needed in one trip. This coordination, especially during initial staging and re-staging, is essential for providing timely care, reducing stress, and decreasing travel and financial burden. To increase our continuum of care services, we have created partnerships not only with community providers in Anchorage, but also across the state. This has proven to be a very effective and efficient way to deliver services. For example, I was notified by a radiologist in Juneau about a patient with impending superior vena cava syndrome, and because of this contact, I was able to immediately get the Veteran and his wife to Anchorage for the care he needed. In another situation I was asked to help a Veteran from a small remote community. The nurse there had heard of my name from another Veteran, and she asked me to help a Veteran who was just diagnosed with colon cancer. Our community relationships and partnerships are invaluable to Veterans who would otherwise be isolated and underserved.

To promote mutual respect and collaboration with community partners, I also attend the Anchorage citywide tumor board each week, and I have found this to be very beneficial. It provides me with the opportunity to maintain relationships and facilitate communication with community partners and participate in the treatment planning which ensures timely care for Veterans. Prior to establishing a presence in the community, physicians told me repeatedly that although they enjoyed taking care of Veterans, they sometimes declined referrals because they found the bureaucracy of the VA too difficult. However, since I became the Alaska VA nurse coordinator for Veterans in need of cancer care, VA and community providers have welcomed me as a full and respected partner in care. As stated in the IOM report on the future of nursing, “…nurses have the well-grounded knowledge base, experience, and perspective needed to serve as full partners in health care redesign” (IOM, 2010, p. 32). This partnership is based on mutual respect and coordination, and it has shaped the culture of cancer care for Veterans in Alaska. We now have a program where the nurse is a full partner with physicians and other health professionals, and this has become an essential, effective and efficient design for the Veteran’s cancer care.

In my position as nurse coordinator I have the privilege and opportunity to tell Veterans how the VA can help, and in both of the support groups that I co-lead, I love hearing the Veterans all talk about the excellent care they are receiving. They don’t just share this with me. They also reach out to other Veterans to get the word out that “the VA will take care of us.” For many Veterans, especially Vietnam Veterans who have an agent orange related cancer, this is a big shift in perspective and hope, and a trust that I do not take lightly.
Additional essential components of compassionate patient-centered cancer care are hope and humor. Recently I visited a Veteran, who was hospitalized for complications with his advanced cancer. He asked me, “Karyn, will I be able to catch a silver salmon this year?” I know that the silver salmon run in Alaska is in August, and that this was his way of asking if he would live to see another summer. My reply with a wink was, “That depends. You didn’t tell me if you’re a good fisherman!” This was received with a giant smile and a hearty laugh.

REFERENCES


Chapter 22

Magnet Status as Transformational Nursing Leadership

Becky Kordahl
How do we, the most trusted professionals in the United States of America, tell the truth about our nursing practice?

You should not call yourself an Olympic gold medalist or a Noble prizewinner or a Magnet registered nurse (RN) unless you have the outcomes to prove it. For each of these examples, it is also true that the standard of excellence does not remain stagnant. A record-breaking sprint time is always around the corner, a new scientific discovery on the horizon and the quality outcomes in Magnet organizations continuously open to improvement. Unless we use data and benchmarking we cannot truly practice to the full capabilities of our profession. The best way we can tell the truth is through facts. Public recognition sends a strong message and it is especially needed in healthcare in the United States. Data, even data that are not perfect, compels thinking people to challenge the current state and helps us imagine a vastly different future.

In this chapter I will tell the story of one VA hospital’s journey toward Magnet status and how it created for all nurses involved an experience of transformational leadership. This journey became our collective experience of what the Institute of Medicine (IOM) future of nursing report described as “redesigning health care in the United States”, both for nurses and with our health care provider colleagues (Institute of Medicine, p. 7).

In 2004 I arrived at the Madison, Wisconsin VA to interview for the nurse executive position. It was my first encounter with the Department of Veterans Affairs (VA) healthcare system and I was unsure that it was to be a good fit for me. I met with many individuals and I was surprised when one of the questions asked of me was related to the organization gaining Magnet Recognition®. The executives openly admitted they had recently applied for the Baldrige Award and fallen short. Their honesty gave me confidence that this was the right place for me. I accepted the position and gave them a promise that I would do my best.

My first priority began with meeting staff from all the different departments and developing relationships internally within the Madison VA medical center. I also set out to understand the external environment within the Madison and Wisconsin nursing communities. I developed relationships within the Veterans Integrated System Network (VISN) 12, which includes seven VA hospitals and their respective long term care facilities and clinics spread over a geographic area of Wisconsin, Illinois and part of Michigan. I expanded that relationship-building effort to the national level, which included over 152 healthcare entities spread throughout the United States. This was certainly the most complex
healthcare system in which I had ever worked, and it took mental
discipline and a process action approach to fulfill my initial promise
to the leaders and staff at the Madison VA. I studied the strategic
links across the facility, the VISN and the entire VA in order to assure
congruence with our own Madison VA nursing goals. In this way, I
analyzed the support available to us at the macro level while beginning
to put in place the micro level actions.

A gap analysis was the first action at our micro level. At my request,
representatives from each of the services and nursing staff gathered
for a day. I presented and led the discussion related to the Magnet gap
analysis data, which resulted in a consensus within the group to go
forward and pursue Magnet Recognition. Through this process I gained a
clear vision of the strengths and weaknesses of the organization. Clearly
we didn’t have much money to spend on this effort and yet I knew we
could do it. We had a collective passion to deliver better patient care
and create an effective strategic plan for achieving Magnet designation.
In the following paragraphs, I will chronicle for you some of our most
important steps in our achievement of nursing excellence.

One of our greatest challenges was to collect data that was accurate
and meaningful and that could be benchmarked with other VAs and
private sector hospitals. We joined the National Database for Nursing
Quality Indicators (NDNQI), at that time sponsored by the American
Nurses Association (National Database for Nursing Quality Indicators, n.
d.). Concurrently, the VA Office of Nursing Service (ONS) was developing
the VA Nursing Outcomes Database (VANOD), which could provide
additional benchmarking information.

Over the next year the Madison associate director (Allen Ackers,
now retired) and I organized and led a strategic planning retreat. Many
of our key staff from every area within the Madison VA participated in
this event. The results of this effort culminated in the creation of an
organizational strategic plan that was linked to the VA national strategic
plan. The plan was our guide in developing the structure, processes and
outcomes that infused the entire organization with system goals based
upon our values. The development of an interprofessional palliative care
team came to fruition through incremental increases in staffing of a
social worker, registered nurse and physician and is a concrete example
of implementation of our strategic plan.

During this same time, I wrote an initial nursing strategic plan, using
the data from the first nursing gap analysis, and I used the action plan
format. This simple format is clear and concise and we use it as a dynamic
document; we continuously update it as we make progress. We are in our twelfth revision. It is not only a plan. It has been our historical reference to what we have accomplished over the last seven years. We also use the plan when we complete our end-of-year self-assessment. The plan is a great asset both in viewing past accomplishments and setting future goals. I have included one page of our current strategic plan. It is easy to read and we can quickly update it as we complete projects or begin new ones.

**Table 22.1 Sample Page from Current Nursing Action Plan of Madison, Wisconsin Veterans Hospital**

<table>
<thead>
<tr>
<th>Strategic Goal (Determined by gap analysis)</th>
<th>Tactics/Actions</th>
<th>Measurement</th>
<th>Follow-Up Date – Open/Closed</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>New knowledge, innovations and improvements Supports national nursing strategic goals 1, 3 Supports VHA strategic goal 1 Supports local strategic goals 1, 3 Supports IOM goals 2, 6</td>
<td>• Sustain unit hourly rounding/safety rounds • Implement daily plan in at least one inpatient unit</td>
<td>• Rounds in each acute care unit • Daily plan implemented in one inpatient unit</td>
<td>Carole will provide data at NEC meeting</td>
<td>Karen Anderson</td>
</tr>
<tr>
<td>• Gap analysis information from nursing retreat (Dec 2011) and May 2012 review</td>
<td>• Integrate actions into strategic plan</td>
<td>Review: December 2011 NEC meeting; June 2012 NEC meeting; Oct 2013 NEC meeting</td>
<td>Elizabeth Fayram</td>
<td></td>
</tr>
</tbody>
</table>
### Table 22.1: Sample Page from Current Nursing Action Plan of Madison, Wisconsin Veterans Hospital (continued)

<table>
<thead>
<tr>
<th>Strategic Goal (Determined by gap analysis)</th>
<th>Tactics/Actions</th>
<th>Measurement</th>
<th>Follow-Up Date – Open/Closed</th>
<th>Accountability</th>
</tr>
</thead>
</table>
| New knowledge, innovations and improvements | • Develop methodology to track equipment that nursing staff request | • Summary of checklist data will be communicated at least two times per year at Nurse Manager meeting | Present updates at NM meeting in September/March | Beth Davidson  
Elizabeth Fayram |
| Supports national nursing strategic goals 1, 3 | • Work with Education Department on standardized process to educate staff on all shifts on new equipment | • All new equipment will have standardized education | Practice Council will take lead and develop plan by August 2014 |
| Supports VHA strategic goal 1 Supports local strategic goals 1, 3 | • Create plan to equip each patient room to eliminate bringing equipment in and out of isolation room | • Small workgroup will develop action plan | |
| Supports IOM goals 2, 6 | • Develop and implement unit/clinic performance improvement initiatives | • Each unit/department has a minimum of one ongoing PI initiative with data displayed on unit/department boards | Nurse Managers monitor to ensure project is always ongoing | Rhonda, Kelly, Dave, Karen and Heidi will report to NEC on compliance two times per year. Angie will add to standing agenda for the NEC meeting for September and March |
Simultaneously we developed our professional practice model. As we developed our model, we had much discussion about what theory we should use and we finally decided that systems theory was a good fit for us. Systems theory depicts our organization as a complex set of dynamic, interdependent, interlinking subsystems, with all subsystems working together as a whole. We understand that as a complex social organization we need a theory to knit all areas and disciplines together. I use the example of the importance of environmental services staff (ESS) and I stress the major role they have in preventing infections by properly cleaning the operating rooms, the intensive care units and the medical/surgical units. They are the first line of defense in the fight to prevent hospital-acquired infections. We work hard to avoid falling into the trap of thinking that one group can make a change without reverberations and unintended consequences in other parts of our system. We know we need to anticipate how all parts of the system will react to any change.

Beverly Priefer, RN, PhD, now the Associate Director, Research & Academics for the Office of Nursing Service (ONS) was Madison VA’s first Magnet and evidence based manager. She worked with me to develop how our professional practice model should be displayed. Bev and I had many discussions about having a model that each and every nurse at Madison VA could apply to their practice, no matter where they practiced. The framework that nursing collectively agreed upon for our professional practice model includes five essential components (Hoffart & Woods, 1996). These five components include values, professional relationships, care delivery model, governance, and rewards and recognition. Our model is knitted together through our understanding of systems theory.

At first, I had difficulty applying our professional practice model to real nursing situations. I knew that I finally understood what it meant when I presented our model to nursing leaders at an ONS conference in 2007. I opened up my umbrella and explained the model in less than 15 minutes. More recently, I used the opening of our new community living center (CLC) to apply the model and explain how nurses control their delivery of care in that setting. I explained that our stated VA core values (Integrity, Commitment, Advocacy, Respect and Excellence) led us to realize that we had a gap in our services to Veterans. Because of VA values, the construction of our CLC was funded. As systems thinkers, the Madison VA nursing staff knew this was a magnificent opportunity and one we would not squander. We understood that it would create consequences throughout the entire organization and community.
We knew that by applying all the components of our professional practice model we would be comprehensive in our planning and implementation. Recognizing the importance of our professional relationships, nursing led and partnered with many different disciplines to plan the optimal care environment. Nursing and other disciplines defined the system of care delivery for the CLC which includes the structure, process, outcomes and environment in which all disciplines practice at their highest potential to deliver safe and effective care. A very effective part of the CLC care delivery system includes two nurse practitioners (NP) who practice independently and in collaboration with a part time medical director. The governance structure was developed at the executive team level to ensure that clear communication was the norm and that responsibility and accountability were in place. One way in which the rewards and recognition for a job well done came was when the national-level survey team members gave high praise to all CLC staff and management team.

Madison VA nursing uses the professional practice model to help us map out complex patient care experiences both in the present tense to immediately improve our care and to dissect past situations from which great learning takes place. Figure 22.1 shows the graphics we developed to help others visualize our model.

**Figure 22.1** Madison, Wisconsin Veterans Hospital Professional Nursing Practice Model

A second important process we that initiated was the creation of a nursing clinical practice council. This was a transformational culture change and was the beginning point for all Madison VA nurses to come together and define our professional clinical practice. Tom Clancy describes a self-managing team as one who follows rules “but members are working
toward a common goal where decisions are far more complex and management exerts some control” (Clancy, 2009, p 106). I believe that this is an accurate description of our clinical practice council. Because our nursing clinical practice council makes decisions based on the most current evidence, nursing is held in the highest regard at the Madison VA. We recently had site reviewers here and in their closing comments they said that they were heartened that patient care at this facility is nursing driven. We are so proud and at the same time we feel so accountable to the Veteran.

As their leader, I activated the power of their imagination to create a new mental model and together we moved away from the notion that “if I am a nurse in the clinic, my practice has no relevance to the practice on a medical surgical unit”, building on our understanding of systems theory. I asked them to define the qualities of the best nursing environment they could ever imagine and then charged them to create it. I explained that if they could create this new environment for nursing that our common goal of giving the best care possible to our Veterans would follow. As system thinkers, we would know that when we made positive change, many other good changes follow. They agreed and we created a better nursing environment. We hardwired the structure and processes and now we concentrate on the outcomes of our care.

**Figure 22.2** Madison, Wisconsin Veterans Hospital Nursing Council Structure
In addition to the practice council, the nurse executive council guides our nursing quality council, education council, nurse management council and research/evidence based practice council. The goals of each of these councils are flexible, yet congruous, in the effort toward steadfast improvement in the care of Veterans. Most importantly, staff nurses from every unit have a voice and the ability to control their nursing practice through this type of representation. I have found that the Madison VA nurses do just that. They have autonomy over their practice and as systems thinkers they understand that their actions impact others. This high level of thinking enables them to unravel complex clinical situations and make sound, evidence based practice decisions.

Anecdotally, it is a common thought among nursing leaders that it takes about five years for an organization to hardwire the structure and processes that lead to superior outcomes. Our experience at the Madison VA would substantiate that. I have included, in Figure 22.2, our simple, yet effective shared governance nursing council structure, which shows our awareness of our interdependence.

In 2010 the Madison VA was recognized as a Magnet facility. We understood that this was recognition of our nursing excellence but to us it meant far more. As systems thinkers we did not lose sight of the fact that our success was interdependent with all of the parts of the whole. We also understood that we were part of a nation-wide high-performing team, the VA healthcare system. Without the system focus on quality and safety we would have been unable to achieve this mighty credential. Our strength was in our ability to leverage the transformation within the entire VA healthcare system. It is a high-performing system in which opportunity abounds. This was further evidenced in 2012 when ONS funded, and the Veterans Health Administration employee education system produced a 15 minute video called, The Magnet Journey. Its purpose was surely met: to inspire and educate VA leaders on the intangible and tangible outcomes through implementing the Magnet principles. This video exemplifies the partnerships inherent in any organization that chooses to apply the Magnet principles to their operational strategy. I believe the video will become even more important as the VA healthcare system competes for excellent nurses in this new and evolving healthcare environment. VA facilities will need to demonstrate in tangible ways their support of nursing practice and this video is a great example of that.

To create a high-performing organization the focus on quality and safety must come first. The VA leadership at both the national level and local level are aligned in this effort. My observation is that as the VA culture was
transforming over the last 15 years, each VA facility had the opportunity to raise the bar locally. VA created the expectations that only our best effort will do. Do we still falter and make mistakes? Yes, without a doubt we do. The thing that has changed is our insistence on transparency when both successes and failures occur. Our need to place blame has moved to an approach of discovery related to fixing the problem.

We honor and reward anticipatory problem solving. We place great store in retaining and hiring the highest caliber of employees. Over the last years we have had our times of despair and yet, we seem to have the capacity to bounce back. Our blues are not everlasting. A good example of our perseverance began in 2009. The Department of Veterans Affairs health system was in the news for improperly cleaning procedural scopes. Immediately, and across the country, there was a negative spotlight on all the VA hospitals. The nurse executives were catapulted into political and clinical chaos. There were dark days when nothing seemed right or fair. But as with any system, equilibrium returned. Highly motivated and skilled individuals and teams in each of the VA facilities nationwide led system improvements in reprocessing and sterilization of equipment. This is truly an example of people caring about quality and safety and an exemplar of transformational leaders bringing about system-wide sustainable change.

I have found in my tenure with the VA that our mission of caring for Veterans compels us to keep costs down and have the best quality outcomes. Here at the Madison VA, that mission is reflected in our patient and staff satisfaction data, our outcome data and our united drive to continually improve care with innovative programs. A good example of this innovation occurred in 2003 when the Madison VA, along with the other VAs across the nation, introduced the home telehealth (HT) program.

The term home telehealth applies to the use of telecommunication technologies to provide clinical care and promote self-management as a supplement to traditional face-to-face care. It involves the ongoing assessment, monitoring, and case management of patients in their homes to provide care at the right place and the right time. The goal of HT is to improve clinical outcomes and access to care while reducing complications, hospitalizations and clinic or emergency room visits for Veterans in post-acute care settings and high-risk patients with chronic disease.

The growth of telehealth as a method of health care delivery is inevitable and will be the catalyst for many changes, not only in the VA, but across all healthcare systems. Nursing has been an active driving force in the development and implementation of the HT program, leading the way into the future. The result is a prototype for the entire nation to consider to
improve care in an innovative and efficient manner through the effective use of professional nurses. This program breathes life into two key messages of the Institute of Medicine’s report, *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine, 2011, pp. 4-7). It is an exemplar of nurses practicing to the full extent of their education and training and becoming full partners, with physicians and other health professionals, in redesigning health care in the United States.

I believe that as nursing leaders we have a moral obligation to actively engage all employees in bridging boundaries and emphasizing communication and collaboration. Because I am part of a national health system, sometimes my VA colleagues point the way. A stellar example of this began at the Boston, Massachusetts VA Healthcare System. At a national VA conference, the Boston nurse executive (NE) and chief of staff (COS) presented their innovative program. The goal of this program was to introduce medical students to the real time practice of nursing. They hired medical students to work over their summer break and then paired each of them with nursing staff. At the end of the conference presentation the NE and COS played a short video of the comments the medical students had regarding their experience. One very moving moment occurred when one of the students described caring for a Veteran who was dying. She said that she would never have had that experience without this program because doctors and others can come and go, but nurses remain at the bedside to care and comfort.

I brought this idea back to Madison and our leadership team agreed to replicate the Boston VA program. The first year we hired three medical students. They were the only ones who applied. These three had such an amazing experience that they spread the word about the program and thereafter we have had five each year and many applicants from which to choose. Each year the students “debrief” with our leadership team. Some of the things they talk about during the debriefing include what a life changing experience it was for them. They discover the richness of the VA and want to continue to serve the Veterans when they become doctors. They talk about how writing an unclear order can waste time, present a safety issue and cause much rework. They talk about how much they respect nurses and that they have completely reframed their ideas of how to properly care for people. One wanted to be a surgeon prior to this experience and now is considering palliative medicine instead. I am now lobbying to make this a VISN (Veterans Integrated Service Network) program. In VISN 12 we have two rural hospitals and I believe this program could introduce the medical students to the complexities of rural
healthcare and could possibly become a way to recruit medical doctors to underserved areas.

During my childhood a favorite aunt, Margie, was a powerful influence. She was always kind and she had a terrific sense of humor. I remember that she would refer to herself as a “sham-expert.” We would laugh heartily. While I do consider myself a Magnet leadership expert, I think most would consider me a “sham-expert” in what it takes to achieve a Baldrige award. Nevertheless, I am going to attempt to compare and contrast the Baldrige Award program with the American Nurses Credentialing Center’s (ANCC) Magnet Recognition/Pathway to Excellence Program.

I got a bit of a head start on this when I was asked by our national chief nursing officer, Cathy Rick RN, NEA-BC, FAAN, FACHE, to be part of a national task force that would “evaluate the outcomes and potential benefits of quality designation programs, and recommend the use of these programs to achieve organizational results and align strategic goals.” We had a diverse team with members from across the nation. Each of us came in with biases and by the time we gave the presentation with our recommendations, we had genuinely developed a deep respect for any and all who achieve any national quality award.

For over 25 years the Baldrige program has overseen the only United States Presidential award that recognizes performance excellence in America in six sectors which include education, health care, manufacturing, nonprofit/government, service and small business. The Baldrige framework includes categories for leadership, strategic planning, customer focus, measurement, analysis and knowledge management, workforce and operations and results focus. It is a guide to organizational excellence and requires analysis of organizational outcomes.

In contrast, Magnet Recognition is an international credential that is granted by the American Nurses Credentialing Center. There is no limit on the number of organizations that can achieve this accreditation, although only 5-6% of all hospitals within the United States currently have this designation. Once an organization is designated it must be reaccredited every four years. The purpose is to focus on nursing with the intent to recruit and retain nurses and to have outcomes that demonstrate high quality and safe patient care. Magnet recognized organizations are also expected to focus on nursing research and evidence based practice. The Magnet application document requirements are far more extensive than Baldrige. The magnet application process truly requires a dedicated nurse to manage the organization and submission of benchmarking data, to manage the ongoing communication and analysis of that data, to implement and sustain
nursing research and system redesign projects, and to coordinate the writing and submission of the document.

Both quality programs use a framework that is grounded in similar principles and both focus on structure, process and outcomes within an organization. Both focus on transformational leadership and quality outcomes. There is evidence that organizations that achieve either Magnet or Baldrige have better outcomes than others without either designation. The national task force that I referred to above came to four conclusions. They are:

- Either framework offers a valuable journey to organization improvement;
- A thorough organizational assessment will determine which framework better fits the organization;
- Current organizational state will determine the amount of time required to initiate either of the frameworks;
- All organizations should pursue one of the two frameworks/journeys, aligned with strategic goals and expectations.

I feel fortunate to have served on a task force that made such definitive recommendations. So many in the VA and private sector wonder aloud, “Are these programs worth the effort and money?” “Why should we spend the money on a nursing focused recognition?” My own response to these questions is one of bewilderment. Why would the mediocre and wasteful healthcare system in the United States quibble about promoting quality? Why wouldn’t we require organizations to achieve at least one of two quality designations in order to receive the greatest amount of reimbursement? Why don’t we require concrete evidence of quality that is embedded in the rigor of attaining and sustaining any quality credential? Why would we restrict the pleasure, honor and hard work that are required to attain these lofty goals?

And in conclusion, I return to my opening question and paragraph. How do we prove our worth when it comes to quality care? Can we simply say it? Many do through their billboards and advertisements. I have heard it said by some that they consider themselves a Magnet/Baldrige organization based upon their outcomes even if they don’t formally have the credential. I do not argue with that, and I believe we must reframe this issue. We must talk about the honor and responsibility linked to the achievement of a quality designation. We must ask others to imagine themselves receiving a high honor or being part of an organization that can pull together in good times
and hard times and consistently produce the best in the complex world of healthcare. We must remind ourselves that each and every member of an organization that has been the recipient of a quality award is expected to continually improve care. We need to tell truthful stories backed by data to provide the proof to all who expect us to protect them from harm and always do right by them.

And so, here is my final story. In 2011, nurses in our emergency department (ED) identified a knowledge gap related to the immediate recognition and management of patients who present with sepsis/septic shock symptoms. They received institutional review board (IRB) approval and conducted a pre-test. From that effort, along with other evidence, they developed staff education and a nursing protocol. They implemented both and measured the outcomes. Thirty-eight patients who met either the criteria for severe sepsis or septic shock were identified in the first six months post implementation.

The data revealed 73% less progressive worsening of septic symptoms, a 10 minute decrease in the time spent in the ED, and that average costs per bed-day-of-care for each of these patients were reduced by 55% or $14,465.00 per patient. The protocol and the results of the project were disseminated to a broader nursing audience at the VA Clinical Nurse Leader conference in New York city and this team was also awarded the “Best Poster Project” at the Wisconsin Nurses Association 2012 annual conference.

This is a true story about the most trusted professionals in the United States.

REFERENCES


Chapter 22.1

Transformative Nursing Leadership in the Journey Toward Excellence

Kathleen Chapman
When my children were young, they were enthralled with *The Neverending Story*, a movie of possibility and hope (Eichinger & Petersen, 1984). Not only was the story neverending, but it was so compelling that they watched it over and over. The story seems to be an apt metaphor for a journey of excellence, with all of its twists, turns, and compelling power to engage.

The story is about several interesting characters. There is Artreyu, the Childlike Empress; a horse named Artax; Falcor who is a very large, flying, dog-like creature with pink scales; Rock Biter; Night Hob; and Engywok. I think you can see where this is going. Some of the characters are enabling; others are sabotaging. Some see the possibility of a different and wondrous world, others can’t possibly do what they dream because they have to “keep their feet on the ground.” Still others are the doers and are determined to push forward at any cost. Sound familiar?

The story soars at times only to lead to the next obstacle around the corner. But it is also a wonderful adventure. Dread and fear are overcome with drive and ingenuity. The vision of a better, more perfect world propels the characters forward with renewed resolve—kind of like a journey of excellence. What follows is my story.

I am the Chief Nursing Officer (CNO) of the Portland VA Health System in Portland, Oregon. It was early 2000 and I was chairing our Nursing Professional Council (NPC) meeting. One of the items on the agenda was “Should we pursue Magnet designation?” A significant event had occurred a couple of months earlier: Providence-St. Vincent’s was designated a Magnet hospital by the American Nurses Credentialing Center (ANCC)—the first in our state.

There was a lot of discussion at the meeting. “What is involved; does anybody know?” “This sounds really big; we’re all so busy.” “I don’t think we’re good enough to be Magnet.” “I don’t know if we have the time.” “We’d have to do a lot; I don’t think we’re ready.” “We have a lot of things in place; I think we should go for it.” “If St. Vincent’s can do it, why couldn’t we do it?” “Maybe we can invite someone from Providence to come talk with us.” “Wouldn’t it be great if we were the first VA Magnet Hospital!” By the end of the meeting, we reached consensus. We decided to join the journey.

Talk is easy; actions are harder. I ordered several copies of the Magnet manual, but that was the only thing we did until several months later. The hospital’s Director (chief executive officer) was going to be out of town and couldn’t go to a mandatory training. He asked me to represent him and bring back the information. On the plane for the four hours there and back, I read the Magnet manual from cover to cover and I was hooked! I made notes in the margins about those things I believed were gaps in our health system,
and jotted down examples that I thought met the intent of the criteria. I was struck by how “right” the criteria seemed. The manual was a roadmap to everything a professional nursing entity should be. Even so, when I returned home the excitement faded a little and the work in front of me prevailed. Magnet took the back burner to a nursing shortage up-cycle, and a looming budget down-cycle.

Then seemingly out of the blue came the announcement in March of 2001 that the Tampa, VA had received Magnet; the 26th of all US hospitals to receive the designation. We wouldn’t be the first in the VA, but we could be the second! No one knew that Tampa had even been on the journey. This was the tipping point for us.

On August 12, 2002 we had our first NPC retreat focused on the Magnet journey, specifically the elements of outcome measure dashboards, shared governance, and the 14 Forces, themselves. This was new information so there were questions and a “parking lot” of items that needed to be addressed. It quickly became evident that we needed a group to lead this very large effort—a steering committee. The steering committee was slow to find its legs. Who would be on it? How large should it be? What should it focus on? An RN service line manager volunteered to chair the group. Through several conversations, we agreed the group should be kept small. We identified directors of nursing research and education, a division director, a clinical nurse specialist, and the American Federation of Government Employees (AFGE-labor organization) professional vice president as members. The group would be responsible for the big picture, organizing and managing the entire process from gap analysis through document submission and, hopefully, site visit. My role was consultation and coaching, plan approval, and addressing barriers others would identify, e.g. resources, people, and lack of necessary structures.

The members of the steering committee began to meet to educate themselves. They combed through the Magnet manual, identifying very specifically what we had in place to meet the criteria, and what the gaps were. They soon recognized that communication to all stakeholders would be essential. This would ensure that everyone would be aware of the Magnet journey and their role in it, understand the foundational concepts, and direct, develop, and participate in the necessary enhancement of our professional practice and our clinical practice environments.

A recent addition to the Oregon Nursing Association (ONA) staff was a gentleman who managed a successful campaign for the election of a local politician. The steering committee chair suggested he be invited to one of their meetings. He would be asked to consult with them about
communication strategies he used and how they might relate to our Magnet “campaign”. The union’s professional VP said that would be in violation of our AFGE contract—the ONA was another union—and as an ONA employee, he couldn’t meet with the group. Discussion ensued! Another committee member, relatively new to the VA, said that perhaps we should think of “getting rid” of our union and asked how to do that. Someone else answered factually about what the steps would be. Needless to say, an Unfair Labor Practice (ULP) was filed on November 19, 2002. There were nine charges. The steering committee was disbanded.

While the ULP was being addressed externally, work continued using the Magnet roadmap to examine our structures, provide education about quality criteria, and address identified gaps. During this time, I partnered closely with the Director of Human Resources (HR) and the Chief of Employee Relations and Labor Relations (ERLR) to assure we were acting within management’s rights and were not in violation of the union contract.

During the Spring and Summer of 2003, I conducted listening sessions with RNs at all sites and on all shifts. I began the session by asking, “What are the barriers preventing you from doing the best work that you can every day?” The purposes of the listening sessions were to get a pulse on the issues facing staff, evaluate their level of satisfaction or frustration, address rumor with fact, introduce Magnet concepts, gain personal visibility, and, of course, use their input to solve meaningful problems that would improve their clinical practice environment. Managers were invited to observe, if desired. My executive assistant (EA) attended all of the sessions and took notes for me. The notes were distributed to both the staff who attended and their manager. Some issues that were raised were easily addressed. Others were organized into themes and used for future planning retreats. Staff received feedback periodically on decisions made and outcomes. Listening sessions were one of the most exhausting, personally satisfying, popular, and high-yielding interactions I have ever had with staff.

You can imagine the interest in early 2003 when, at an annual conference sponsored by the VA Office of Nursing Services (ONS), the Tampa VA Chief Nurse Executive, Sandra Jensen, was on the program. She had been asked to give a panel presentation describing their Magnet journey. Her approach was unexpected. She made the introductions, but it was staff nurses who spoke. They were inspiring! I was struck by their ownership of the process and their ability to articulate its value.

In October, three staff members and I attended our first national Magnet conference in Houston, Texas. The experience was again inspiring, especially when Tampa, Florida VA staff members were called to the stage as the
winners of the first Magnet Prize. They were being recognized for their VA Patient Safety Center of Inquiry, a nurse-led multi-million dollar research entity. We, too, were filled with pride as the hundreds of nurses in the audience jumped to their feet and gave them a standing ovation.

The next day the conference sponsored a site visit to MD Anderson, a Magnet hospital (2001) in Houston, Texas. Their Magnet program director (MPD) hosted the visit, introducing the members of her team who spoke about their role in the Magnet journey. We took a lot of notes. She then led a tour, pointing out elements of the 14 Forces in action along the way.

Back at the conference and filled with renewed emotion and energy, the four of us took advantage of the scheduled breaks and began to plan how we were going to organize ourselves to initiate our journey in earnest. I asked the infection prevention (IP) clinical nurse specialist (CNS) whether she would be willing to be our Magnet program director (MPD). We identified all of the things she was involved in outside of her normal clinical assignment that supported professional nursing. We saw that she was already spending half of her work time on those initiatives. I believed I could find volunteers or make assignments to others, freeing her to focus on the MPD role. She wasn’t ready to say, “Yes,” immediately. She wanted time to think about it and wanted to consider what it would mean to her IP colleagues.

Back home, the CNS and I had several conversations. She ultimately felt comfortable enough to go forward. I met with her manager to negotiate release time for her work on Magnet. At our facility, nursing is decentralized. The CNS did not report to me. The chief of medicine, the chief of infection prevention, and I looked at a list of tasks and projects that she provided, and identified things that could be assigned to others. I was successful in assuring her supervisor and his boss that the effort on Magnet would take no more than 50% of her time. We captured the discussion in a memorandum of understanding (MOU). I had a Magnet program director!

In the background, I was working with our regional counsel and HR to answer questions of the Federal Labor Relations Board. We were asked to submit many documents about Magnet and about our intention behind pursuing the recognition program. Ultimately VHA General Counsel and ANCC lawyers were involved. At the core was confusion about the relationship between the parent organization of ONA, the ANA, as a professional organization, the ANA as a labor union, and how the ANCC Magnet arm fit. On October 21, 2003, almost one year after filing, the ULP was settled with no findings. The settlement was that the agency, through the Portland VA Medical Center (PVAMC) Director would post a notice to
all employees acknowledging that our two AFGE locals were the exclusive representatives of the employees at our facility. The unions did not appeal.

Our communication strategies became more visible and we were now able to go public with our education efforts. A reinvented steering and cheering committee was formed, co-chaired by the MPD and the lead document writer, and I began meeting with the MPD several times a month. The MPD called our conversations “brutally honest.” She was direct in bringing issues to me: questions, concerns, what naysayers were talking about, and her perception of the level of morale. I soon realized that I had made the perfect selection for the MPD role. She was well respected from clinical and personal standpoints, she had a long tenure, and as an infection control CNS, she had a role that took her to all sites and campuses, interacting with all types of staff. She was “in-the-know”.

In an effort to involve more staff and share the workload, I created a list of nine “job openings”. The communication committee job advertised for chair and members who would be responsible for creation of a theme, development of communication methods, a newsletter, and the Magnet kick-off. The quality committee job advertised for chair and members who would be responsible for cataloging all existing data sources, diagramming data feeders and communication paths, and monitoring action plans and performance improvement (PI) initiatives. The other seven jobs were announced similarly. Some of the committees were time-limited (communication), others morphed into a permanent feature of the shared governance structure (quality).

Crucial to our success was nurse manager engagement. We held a facilitated two-day retreat that soared at times, and then crashed with discontent. Two surprising areas of discourse surfaced. One was concerning the composition of our Nursing Professional Council (NPC) and the perceived lack of inclusion by some of the managers. Although all were members, it was pointed out that the agenda predominately focused on inpatient nursing. To address this concern, we were together able to create a solution: one manager from an inpatient setting and one from outpatient would meet with me prior to each NPC meeting to form a balanced agenda.

It became obvious that as our geographically dispersed services had grown and more assistant managers and supervisors were hired, they did not know one another and there was little opportunity for interaction. Over time, all managers, regardless of level, were included as members in NPC so they would be able to share their perspective, hear the same conversations, have input into decisions, and build relationships. That approach facilitated
Part 2: Acting Strategically to Innovate • Key Message 3: Nurses should be full partners

A second outcome of the managers’ retreat was in response to the facilitator’s interruption of one particularly animated conversation with, “So what do you stand for?” This brought the disagreement to a halt and re-focused the rest of the afternoon. The question generated many subsequent conversations among us, resulting in further discussion at the next NPC meeting. Subsequently, we charged a workgroup to explore the question further and compose an answer. They presented drafts that we then discussed, and sent back multiple times. The process took us two years, but resulted in our P.R.O.M.I.S.E. statement that stands, unedited, today. It is presented in Figure 22.1.1, and represents how we are expected to treat each other and our patients. The lengthy process of discussion, itself, was unifying.

Figure 22.1.1 Keeping the PROMISE, Our Statement of “Stand Fors”
Portland, Oregon VA Health System

A second crucial milestone for us was expanding our governance model to include unit based councils (UBCs). The councils were to be chaired by an RN, and the council was empowered to make decisions and solve problems concerning their professional practice. Some managers were very threatened by the prospect of UBCs. What would be their

...
role? What if they disagreed? We soon understood that it would be the managers who had to change the most. Through education, networking, and coaching they were able to learn to let go. They took on a mentoring role, helping the UBCs discern (1) what was in their control to address, (2) what needed to be handled by the manager and (3) what was a more universal issue that needed to be referred to one of the medical center-level nursing committees. We assured the managers that they were still the manager and they could still say, “no”. But if they could not agree, they were obligated to get back to the UBC with their decision and tell them why they disagreed.

During Nurses’ Week 2004, the steering and cheering committee sponsored a Magnet ‘cruise’. We held it in the auditorium, open to all staff around the clock. Upon entry, each person received a passport. There were 14 “ports of call”, one table with a poster for each of the 14 forces of magnetism. Staff responsible for the poster spoke about that force and what it meant. Then cruisers were asked to give an example about how they thought the force was being exhibited in their work area. They were able to ask questions, and gain clarification about what the journey was about. We were thus able to guide them through demonstrating how the experience was meaningful for them in their daily work. At each port of call, the passport was stamped. After they accrued all of the stamps, they turned it in for a Magnet token.

It was also during 2004 that the Houston VA became the second VA facility to earn Magnet designation. Of course we were happy for Houston, but a little disappointed. We would not be the second VA Magnet, either.

But back to Portland…the communication committee settled on a Star Wars theme: “May the Force be with you”. Our mascot was Yoda. Star Wars characters began to appear everywhere—on posters, bulletin boards, announcements, and buttons handed out to staff. We identified “magnetizers” for each nursing area. Their role was to provide information to their peers, as well as bring concerns or issues to the steering committee so they could be addressed. Everyone was asked to submit exemplars. Writing of the document had begun.

March 8, 9, and 10 of 2005, PVAMC nursing hosted an official Magnet kick-off. All medical center staff members were given Star Wars themed invitations to a two-hour Magnet presentation. Star Wars posters were all over the medical center announcing the event, Star Wars buttons were being handed out, a life-sized Chewbacca was in the auditorium, as well as Leia with my face! I presented the first hour and we dedicated
the second hour to presentations by the Magnetizers who shared their experiences. I referenced key VA resources in my remarks. The VA Office of Nursing Services commissioned a study of the Tampa VA to develop a business case for Magnet designation. The VA Chief Nursing Officer (CNO) and the Tampa CNO testified before Congress outlining the benefits of Magnet designation. I included the compelling content from both documents in my presentation, one I gave multiple times during all shifts and on both campuses. We also videotaped it and sent the tape to community clinics for their viewing.

On June 30, 2005, our Magnet application document was submitted to the American Nurses Credentialing Center (ANCC) Magnet Program Office on a compact disc (CD) holding 199 megabytes of data. The regulation at the time was that the documentation could not exceed 15 inches. When printed on 8 reams of paper, ours reached a height of 13.5 inches and weighed 35.6 pounds! We were among the first to submit on a CD. The appraisers initially had difficulty navigating the disc and conveyed several questions through the Magnet office. A nerve-wracking conference call was scheduled between the two appraisers and our MPD and document writer to help them navigate. We were asked for additional information (2 more inches), which we submitted on November 30, 2005.

In Spring ANCC notified us that we had a high enough score to take us to the next step, the site visit. The 3-day visit occurred in March, amid much excitement and celebration. The appraisers said they spoke with more than 400 staff. On May 15, 2006, at 2:15 P.M. we received the call we were waiting for. In a packed auditorium, the voice on the phone said we had achieved the Magnet level of excellence! The joy was deafening.

We were eager to invite the entire medical center staff to celebrate, but there was a delay. We were in the midst of a norovirus outbreak! There would be no sharing of food or large gatherings until it was safe to do so. Our celebration finally occurred in July, with VA CNO Cathy Rick, and Yoda, in attendance. Over a series of days, all staff members on all shifts were treated to a catered meal. They signed a guest book, received a Magnet pin, and proceeded to a room decorated with white lights, tablecloths and candles, and listened to stringed instruments playing in the background. Staff members were invited to have their picture taken with the Magnet obelisk. We replicated the atmosphere as best we could in the outpatient clinics where I enjoyed a locally catered lunch with staff.

While we travelled along our journey, I was a member of the national ONS Workforce Committee. The Office of Nursing Service was committed
to supporting a Magnet-like environment, recognizing that not all VA medical centers would choose to formally embark on the journey. Several Workforce Committee products were developed to support this goal, recommended to the CNO through the National Nursing Executive Council (NNEC), and a number were subsequently implemented. CNOs at each medical center were invited to compete for $10,000 grants to support their local workforce improvement efforts. Recognizing that the relationship of physicians and nurses is key to a professional practice environment, the VA annually held joint CNO and Chief of Staff (COS) educational events. We started a monthly national Magnet conference call and developed a VA Magnet website. We also began to showcase Magnet posters and presentations about the Magnet forces at national VA conferences. We implemented an annual survey of VA hospitals to determine which were implementing the Magnet philosophy, which were on the formal journey, whether they had formally applied, had submitted their document, or had a site visit.

We also initiated networking for VA participants at the national ANCC Magnet conference. In addition, ONS made a commitment to sponsor an annual 1 ½ day VA Magnet conference to support CNOs and their key staff interested in achieving Magnet designation. The conference was designed to include presentations about the Magnet criteria, presentations from staff of VA Magnets, and networking around strong practices. The first conference was held in Portland, Oregon in 2005.

ONS also developed a Magnet video to promote the journey to directors, associate directors, chief financial officers, all clinical and administrative staff, and nurses. I used the video in my presentation at our annual Professional Practice Council retreat. Because of our expansion of services due to increasing numbers of Veterans coming to us for care, fifty percent of all of our staff nurses were not PVAMC employees five years prior to that retreat. They did not live through our transformation and had gaps in their understanding of the journey. We also recognized that even tenured staff members needed occasional renewal. I used the video to educate, inspire, and demonstrate VA nursing’s commitment to the Magnet journey.

Soon after Portland became the third VA Magnet, the VA CNO contacted the ANCC Executive Director for a meeting. One of the VA facilities had recently participated in a site visit but was not designated. Since only four VA hospitals had participated in the program to-date, she wanted to have a conversation about issues we had with the application process, with addressing the Magnet criteria, and with addressing
appraiser questions. She also wanted to give Magnet program staff an opportunity to voice difficulties from their perspectives and ask questions to understand how the VA could better prepare its applicants. The goal was improved communication and clarification of issues intrinsically present when a government agency seeks participation in a private sector recognition process. In December 2006, a meeting was held in Washington, DC with the national VA CNO, CNOs of the VA Magnets: Tampa, Houston, and Portland, the VA CNO of the site not designated, the ANCC Executive Director, Magnet Program Director, and other key staff. The outcome of the meeting was the development of a document for Magnet appraisers outlining key differences between VA hospitals and those in the private sector. Included were things like organizational structure, governance, position nomenclature, funding pathways, strategic planning, acronyms, and other significant distinguishing characteristics.

At industry conferences through the years, I became introduced to the Baldrige program for quality excellence. I discovered that even though Magnet criteria are nursing-focused and Baldrige criteria are focused on the entire organization, both programs' criteria are arranged in similar categories, visually presented in Table 22.1.1.

<table>
<thead>
<tr>
<th>Magnet</th>
<th>Baldrige</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Transformational Leadership</strong></td>
<td><strong>1. Leadership</strong></td>
</tr>
<tr>
<td><strong>2. Structural Empowerment</strong></td>
<td><strong>2. Strategic Planning</strong></td>
</tr>
<tr>
<td><strong>3. Exemplary Professional Practice</strong></td>
<td><strong>3. Customer Focus</strong></td>
</tr>
<tr>
<td><strong>5. Empirical Outcomes</strong></td>
<td><strong>5. Workforce Focus</strong></td>
</tr>
<tr>
<td><strong>6. Operations Focus</strong></td>
<td><strong>6. Operations Focus</strong></td>
</tr>
<tr>
<td><strong>7. Results</strong></td>
<td><strong>7. Results</strong></td>
</tr>
</tbody>
</table>
Both Magnet and Baldrige pathways are roadmaps for redesign, with a capital “R”. They keep us focused on empowerment and transparency, which are foundational to patient safety. They keep us focused on structures and processes to ensure hardwiring of our systems and enculturation. And they keep us focused on the measurement of outcomes and the demonstration of continual improvement. The roadmaps challenge us to redesign nursing practice and the healthcare system to one described as zero defect, high reliability, and sustainable. Three words not to be taken lightly! Nurses are well positioned to participate fully—and lead—in these major redesign efforts.

The annual ONS nursing survey of VA hospitals now also asks us, as respondents, about pursuit of Carey and Baldrige, in addition to Magnet. The national 2013 VA Leader Performance Contract included the following language:

“CE 2b: Culture of Continuous Improvement and Learning and Innovation:
…The Senior Executive determines the best option for the journey to organizational improvement considering industry frameworks (e.g. Baldrige, Carey, and Magnet).“ Source: 2013 VHA Performance Contract, VHA Internal Document

After our Magnet designation in 2006, re-designation in 2010, and our Critical Care Beacon Award in 2011, exploration of the Baldrige pathway for excellence at the PVAMC organizational level seemed the logical next step. Our medical center director was familiar with the program and he agreed. I found myself designated as the executive champion for our Baldrige initiative in 2011. We chose “Keeping the P.R.O.M.I.S.E., Advancing Excellence” as our tag line.

We identified a team, received training on the requirements, and wrote and submitted documents to two programs. The national Carey Award is a quality program internal to the VA based on Baldrige criteria. In 2012, the Portland VA received second tier Performance Excellence Carey Award, and in 2013, we were humbled to learn that we had received the highest award, the Carey Trophy. Also in 2012 and 2013, we received a second tier California Award for Performance Excellence (CAPE). CAPE is a regional private sector award based on Baldrige criteria.

Fueled by VA’s focus on quality excellence and the support provided by the Office of Nursing Services, we continue our Neverending Journey.
Re-designation for Magnet is every four years, due again in 2014. We intend to apply for the national Baldrige Award in 2015.

As the Narrator says at the end of the movie, “Bastian made many other wishes, and had many other amazing adventures. But that’s… another story.”

**REFERENCE**

Effective workforce planning and policy making require better data collection and an improved information structure.
Chapter 23

Using Data and Evidence to Manage Change and Add Value

Murielle Beene, Mimi Haberfelde, Pamela Pickett and Toni Phillips
Informatics is no longer an option for the nursing discipline; it is a necessity for the transformation of nursing practice and to capture nursing information. Nursing informatics is a discipline-specific entity within the broader category of health informatics. This specialty integrates nursing science, computer science, and information science to translate and manage data, information, knowledge and wisdom to support the advancement of nursing practice. This support is achieved through the use of information structures, information processes and information technology.

The primary goal of nursing informatics is to optimize communications and information management for health improvement of populations, communities, families, and individuals. One objective of the nursing informatics discipline is to develop applications, tools, structures and processes that facilitate data management. In the absence of a systematic process for collection, storage, and retrieval of nursing data, the loss of valuable information is evident. Nursing specific data is required to demonstrate nursing contributions to patient care and patient outcomes and to validate the allocation of nursing resources. The VA Nursing Outcomes Database (VANOD) provides reports related to the identification and nursing treatment outcomes of patients at risk for skin breakdown and hospital acquired pressure ulcers as examples of how data are used to impact patient outcomes and provide information related to nursing workload. These reports are discussed in more detail later in this chapter.

It is imperative that nurses understand the significance of data. Nurses need to know what elements of data are essential for documentation. If there is no evidence that represents nursing activities, there will not be substantiation of the nursing role in the healthcare delivery system and the impact of nursing’s involvement in patient care. The contributors to this chapter are the following individuals: Dr. Murielle Beene is the Chief Nursing Informatics Officer for the Veterans Health Administration; Pamela Pickett, Toni Phillips and Mimi Haberfelde are Nursing Informatics Specialists for the VA Office of Nursing Services (ONS).

VA ONS officials have long been aware of the need for data that provides information and evidence, to determine the impact of nurse staffing in relation to resources and nursing outcomes. Hence, over ten years ago, ONS began efforts to obtain the information needed. In 2002, the National Nursing Executive Council (NNEC) charged the national data management workgroup to operationalize the strategic goal of developing a standardized methodology for collecting data related to nurse sensitive quality indicators that would be integrated into a national nursing database. Three co-directors, Dr. Martha Buffum, nurse researcher and Alice Naqvi
and Deloris Leftridge, nurse executives, were appointed by ONS to develop the database, which was called VA Nursing Outcomes Database (VANOD). In addition to conducting a comprehensive literature review, they sought consultation from external nursing database groups, including the California nursing outcomes (CalNOC) project and the tri-service military nursing outcomes database (MILNOD) to achieve consistency across the various indicators for the nursing profession. The selected indicators were: nursing hours per patient day (HPPD), RN satisfaction, nursing staff injuries, and pressure ulcer prevalence. Published evidence pointed to these indicators as having a direct correlation with patient outcomes. The overall goal of the program was to provide reliable data to determine appropriate nurse staffing proven to have a direct relationship with positive patient outcomes. These data are essential for nurse executives to have as evidence based rationale for efficient and effective staffing when we articulate and defend resource plans to senior officials and quality managers.

In 2003, an implementation coordinator, Alicia Levin, and education coordinator, Mimi Haberfelde, were contracted to implement a 16 month pilot, in collaboration with VA nurse scientists. Twelve facilities across the nation, reflecting the diversity of the VA system relative to size, location and resources, were randomly selected to serve as pilot sites for the project. Following development of education and communication tools, and site training, we collected data using specialized Excel spreadsheets managed by the facility liaison/coordinator. These data were sent electronically to a database created by our research/technical team, Seattle, Washington-based health services research and development (HSR&D), our VA collaborators. Based on these spreadsheets, other HSR&D collaborators in Boston, Massachusetts created detailed comparison reports on a quarterly basis that were distributed electronically to each facility.

At the end of the 16-month pilot, the pilot sites had successfully submitted 4 quarters of data and the HSR&D team was able to create 4 sets of comprehensive reports. Sites reported usefulness of the data for accreditation standards, Magnet status application, and facility level administrative and quality improvement projects. While sites developed familiarity with the process, it became clear to us that manual data collection and individual reporting were time-consuming and cumbersome for a long-term expansion of the database. We had, however, taken an important first step toward meeting our primary goal.

In August 2004, responsibility for VANOD as a program was transferred to the Office of Nursing Services under the direct leadership of Cathy Rick, Chief Nursing Officer. Ms. Rick charged the VANOD team
to expand the project to all acute care facilities within the VA and to work with national level VA groups in regard to electronic data capture and extraction. An informatics site liaison, Diane Bedecarre, was hired to complement the team. Given the complexity of national expansion, ONS hired a program manager, Bonny Collins, formerly of the Office of Quality and Performance, to supervise the VANOD team and oversee a way forward to VA system-wide automatic data extraction.

Our next project was to initiate an electronic data collection and reporting process using the original VANOD pilot sites. The HSR&D team created a VANOD VistA data extractor (V-VDE), a MUMPS program with a graphical user interface (GUI), to extract data from VistA, the common VA health information architecture platform. We installed the V-VDEs in each of the original 12 pilot sites, and then made comparisons between the retrospective extracted data and the originally submitted spreadsheets to cross-validate the data. In addition, we used a web-based analytic program to allow facilities to create real-time customizable reports at the nursing unit level for comparison purposes. Eventually, we were able to expand this work to 59 facilities, which ran a monthly extraction to capture the data from local financial, human resources and occupational injury data. At the end of a one year study, we determined that consistent facility manual data extraction was problematic. We found that there was a lack of consistent documentation, as well as variations in practice that existed among facilities across the VA enterprise. Hence, data were ultimately not useful since neither comparisons nor conclusions could be drawn.

To ease the financial and resource burden on facilities, and improve report usefulness, the VANOD team formulated two goals: automatic extraction from existing national data repositories, and flexible, automated reporting accessible to all VA stakeholders. An agreement was made with the VHA support service center (VSSC), which already had personnel with the skills and experience to provide this service. The VANOD team also created a set of business rules to provide the infrastructure for data collection and reporting. Our business rules included:

- Avoidance of additional data collection or reporting burden;
- Capture of data as a by-product of existing documentation (such as patient care);
- Ability to roll up data nationally (from individual nursing units to unit types to facilities to nationally);
- Provision of resources for understanding the data (e.g. data dictionaries and validation tools).
To accomplish this, our team attempted to leverage existing data sources where possible. Where data were elusive, as with clinical documentation, we developed the tools to capture the desired data. Based on indicators to be gathered, we determined report subject groupings, including administrative (e.g. nursing demographic and financial data), clinical (e.g. pressure ulcers), satisfaction (nursing and patient), and summary (e.g. number of registered nurses nationally in VA). We also required that data definitions were to be provided for all reports, including purpose of the data, the data source, the data elements included, the reporting format, data caveats, and the desired data “direction” for trending purposes (e.g. for pressure ulcers, a lower number is better). The definitions provide a way of understanding what the data include, and information for critically looking at and validating the data.

We recognized that since there was institutional confidence in payroll (PAID) and financial systems, our initial VANOD focus would be on demographic and financial nursing indicators, to provide nursing stakeholders information that would be useful in managing resources. For example, these data provide numbers of nurses by licensure, retirement eligibility, and costs of overtime. Apart from nursing skill mix (registered nurse, licensed practice nurse, nursing assistant), there was no data infrastructure in place to parse out type of nursing role, such as a direct care nurse, nurse manager, nurse practitioner, and nurse researcher. Therefore, the VANOD team created a crosswalk between HR coding, licensure level, and type of work to identify and group administrative, direct care, hospital consultative, and advanced practice nursing roles.

Based on feedback from relevant ONS workgroups and the field, we identified gaps in existing assignment codes (job type, such as staff nurse) and an ONS liaison worked with national human resources (HR) officials to modify the HR PAID manual for nursing occupational coding. This work enabled the VANOD team to group nursing assignment codes by nursing role and thus create assignment definitions. As a result of this work, the first automatically generated VANOD report, demographic and financial, was created, providing information about the VA nursing workforce relevant to nursing roles, with the added ability to segment skill mixes. This work was pivotal, as it provided the nursing identification for other administrative reports that followed.

Administrative reports currently provide a variety of nursing demographic, financial, workload and location reports on over 85,000 nursing staff. VA is at a huge advantage over other national nursing databases because we have national data systems to capture this information on a large scale. We can delve into how resources are
distributed across a network region or within a facility; we can review number of employees, overtime costs, nursing staff injuries, nursing turnover, and patient turnover. Some of these reports have been created by VANOD, while others represent a nursing subset from other databases. Reports from other data sources include patient turnover (admission-discharge-transfer), nursing staff injuries, and nursing staff turnover.

Clinical data capture and reports rely on our ability to obtain data through standardized documentation, which is difficult given the variety of clinical applications currently used across VA. Pressure ulcer prevalence was being captured by other national nursing databases, and initially by VANOD, but required tremendous manual effort for both data collection and reporting. In 2006, a national VA workgroup of wound care nursing experts was convened by Mimi Haberfelde from the VANOD team to consult on relevant skin assessment documentation, and desired skin care process and outcome information. Using VA technology tools, a standardized skin risk documentation template was developed, including embedded data elements that are automatically captured as a nurse is documenting patient assessment and care events. Skin risk process indicators (e.g. percent of patients with a skin risk assessment on admission) and outcome indicators (e.g. percent of patients who develop hospital-acquired pressure ulcers) were developed using the workgroup’s input. A standardized skin risk documentation template was tested and released by the VANOD team in 2007. Using the embedded data elements, our VSSC programmer colleagues created monthly, retrospective reports for discharged patients that could be compared and trended at the facility level, as well as compared to like facilities and nationally across VA. Reports included patient-level information for authorized users, to assist in data validation processes. Facilities can use the data to determine staff educational needs, monitor improvement processes and track hospital-acquired pressure ulcer trends.

Concurrent with our developmental work on clinical nursing data, we have been able to expand our database on nurse and patient satisfaction. Satisfaction reports are available by all nursing skill mixes, RNs only, and patients. All nursing skill mix satisfaction is obtained from a subset of the annual VA all-employee survey data, which is administered annually through the VA National Center for Organizational Development. RN satisfaction with professional practice is obtained through the annual online RN Satisfaction survey, using the PES/NWI (Practice Environment Scale of the Nursing Work Index) which is a National Quality Forum endorsed tool. This survey is coordinated by VANOD staff in collaboration with other enterprise partners. Patient satisfaction is obtained from
the VA Survey of Healthcare Experiences of Patients (SHEP) survey, based on a sample of discharged inpatients, in conjunction with the VA Office of Performance Management and VANOD. The data are reported using the nursing-related questions at the nursing unit level.

The purpose of the satisfaction reports is to provide information regarding staff satisfiers as well as areas for improvement. Satisfaction data can be compared with nursing turnover data, as well as comparisons with patient satisfaction at a nursing unit level, and staffing methodology for nurse staffing.

The many success stories we were able to create influenced the decision of the VA Office of Nursing Services (ONS) to expand the nursing informatics voice across VA informatics priorities and projects in order to standardize and coordinate nursing informatics tools and processes. As a result, in 2009 Murielle Beene was appointed as the ONS chief nursing informatics officer (CNIO). The CNIO role was designed to provide a global informatics direction for VA nursing. The VANOD team was consolidated as an office of nursing services informatics (ONSI) team. We created a conceptual model for the ONS informatics vision, which is displayed in Figure 23.1.

**Figure 23.1 Conceptual Model of the Vision of the VA Office of Nursing Services Informatics**
The Veteran is at the heart of the conceptual model, surrounded by the intended stakeholders and information needed:

- **Front line nurses** have the tools and environment to support patient care (decision support, for example, built into their documentation) and adequate hardware (documentation systems, for example, that support the workflow).
- **Nurse managers and executives** are provided with current and granular data to support resource management.
- **Researchers** have the data needed to develop evidence for patient care.
- **VA Central Office and Program Offices** have access to the information needed to establish policy.

Our next work effort focused upon the need for comparative nursing unit level data. The VANOD team collaborated with programmers from the VSSC to create a crosswalk that would provide information at the nursing unit level and allow for comparison across VA facilities by nursing unit type. Historically, data and reports were available only by physician treating specialty and/or medical administration service (MAS) units. Reports by treating specialty (e.g., medical or surgical) did not provide useful information for nursing unit managers who needed specific information to measure and improve outcomes. Similarly, reporting by MAS unit would require that managers access reports for the many MAS units that make up their specific nursing unit.

The first version of the nursing unit mapping application (NUMA) was developed and deployed in 2010. Being new to the office of nursing services informatics (ONSI) team, this was Pam Pickett’s first national project to develop, deploy and maintain, and improve. Significant work had been done previously to define nursing unit type to match industry standards. This provided the foundation upon which NUMA was built.

Ultimately, the NUMA application mapped several inpatient MAS units to one nursing location (unit), however, the development and deployment was not without challenges. As we worked with the VSSC developers to create NUMA, we soon realized that local practices and “workarounds” would present some interesting situations that we would need to address. For example, many facilities had created “units” in the emergency department that were used for patients awaiting admission to an inpatient location. While not insurmountable, we needed to provide guidance to our colleagues in the field to address the local “workarounds”
Chapter 23: Using Data and Evidence to Manage Change and Add Value

Realizing the Future of Nursing: VA Nurses Tell Their Story

and NUMA. The NUMA tool requires that a facility contact make necessary changes to the application (as units are opened, moved or closed), however, we believe that the value of the reports available at the nursing unit level outweighs the effort required to update the entries. Version 2 of the NUMA tool incorporated information (input by facility contact) beneficial for the staffing methodology process. Targeted nursing hours per patient day (NHPPD), as established by unit / facility expert panels, is available for facilities to compare like units across the organization. Figure 23.2 provides an example of this information from one unit at a facility.

**Figure 23.2  Example of Targeted Nursing Hours per Patient Day (NHPPD) Report by Unit in VA Nursing Unit Mapping Application (NUMA)**

![Example of Targeted Nursing Hours per Patient Day (NHPPD) Report by Unit in VA Nursing Unit Mapping Application (NUMA)](image)

Another example of a report that has been developed using the NUMA tool includes an admission, discharge, transfer (ADT) report that provides managers with data related to unit activity and patient turnover. Refinements in that report have resulted in more granular data related to time of day and day of week activity. Both are important data elements for unit staffing. The nursing staff turnover report utilizes information from Human Resource databases and reports and provides trended nursing turnover information at the unit level. Analysis of these data, in combination with satisfaction data, provides our nurse managers with valuable insight related to staff retention.

The NUMA tool has allowed clinical reports to be presented at the unit level. Retrospective skin reports, which include processes and pressure ulcer outcomes, have been available since NUMA was deployed in 2010. Concurrent (“daily”) reports related to skin care were made available in late 2011 and are valuable tools for monitoring active inpatients, reports used by our direct care staff, wound care nurses and nurse managers. Additionally, the NUMA mappings were incorporated into the bed management software application, to maintain congruency in MAS and nursing locations within reports.

Another clinical indicator, managing scanning failures (MSF), reported through VANOD is available through an existing VA database, the bar code medication administration system (BCMA).
The purpose of the MSF data was originally to track and trend BCMA system issues, particularly problems with scanning technology and medications, which is useful for BCMA coordinators, pharmacists and nurse managers. However, it also provides a workload proxy for medication administration by nursing unit. This information can be compared by the facility or nursing unit or at an individual facility level. This report has proven useful to people working on staffing methodology processes for nurse staffing and workload.

With the establishment of the ONSI team, the nursing leadership role in informatics was further solidified. In 2010, a new VA Office of Informatics and Analytics (OIA) was established with the charge to consolidate all informatics activities into one overarching national program office. As a result, the former ONSI team was transitioned from ONS into the OIA health informatics group, which is involved in a variety of informatics efforts. This work now includes improvement in the creation and support of clinical documentation tools and support of the VA electronic patient record - Computerized Patient Record System (CPRS). We also contribute to integration efforts for the electronic medication record between the VA and the Department of Defense (DoD) as well as involvement in numerous integrated project teams for requirements gathering, and bringing forth global issues of usability, interoperability, patient safety and data capture. Using lessons learned in a collaborative enterprise, VA is poised to capture data seamlessly using platforms and tools that allow for interoperability within and outside the enterprise.

This work confronts us with a variety of challenges. Organizations such as the Leapfrog Group (Paige, 2002) and the Institute of Medicine (Institute of Medicine, 1999) have developed guiding principles, centered on improving patient safety, which promote and provide recommendations as well as critical analysis regarding the integration of computerized technology within healthcare. Overarching goals include but are not limited to increasing clinician efficiency and measurement of health outcomes. However, these goals also present challenges with measuring nursing practice and outcomes within electronic documentation tools. Explicit nursing actions are often embedded within other clinical interventions such as orders management within computerized electronic records. In addition, nursing practice is documented within electronic silos, either homegrown or commercial, which lack integration into the existing VA electronic health record (EHR). As a result, we must deal with the lack of a seamless, transparent representation of nursing care across practice settings and time.
These challenges make it difficult to measure nursing actions and outcomes across care settings and often confine measurement to a single encounter within a specific practice setting. Nursing informaticists are then confronted with linking nursing interventions and outcomes across the various practice settings and documentation tools which have varied interface architecture. As nurses adapt and support the changing complex healthcare environment at the point of care, the documentation tools they use to support patient hand-offs from one practice setting to another (intra- and extra-facility) in addition to shift-to-shift must also reflect current and seamless electronic information regarding the care of the Veteran or their family.

Another impediment we have grappled with is that many legacy systems were designed and implemented to complement individual or independent clinician roles with a one-to-one interface with the computer. Historical systems failed to include input from the patient, and newer systems are emerging with this as an essential requirement. This is an area where nursing contributions are valuable because the domain of nursing has been built upon a collaborative multi-disciplinary approach in which the patient is the center of care. Information that is needed to care for the patient within these historical technology designs have produced negative effects to nursing practice data in terms of usability, design of physical environment, as well as impacts to workflow. Collating information and managing it from multiple disciplines is essential to nursing practice and documentation tools.

Patient goals need to be standardized to measure attainment of positive health outcomes and surveillance, but they also need to be customizable to reflect the needs of the patients and their families. The “blue button technology” released originally in 2010 by the Department of Veteran Affairs and Department of Health and Human Services fosters a portal for Veterans to securely update and download their personal health records. Patients can update their demographic information as well as securely obtain their care team’s progress notes. Therefore nursing instructions and interventions embedded in progress notes will be valuable information for Veterans and their families as extensions of information shared originally within face-to-face encounters.

For VA nursing, an output of information management is task management, and the ability to pre-populate patient information, customize and modify lists and tasks, as well as save data for outcome measurement are key designs for nursing documentation tools. In February 2004, the VistA care management tool was deployed to provide VA nursing with an application that could display orders and results for their patient
assignments. This was advantageous for nursing because these multi-patient views assist nurses in following-up, as well as tracking nursing tasks and interventions embedded in modules such as orders management and visible within the electronic record within nursing documentation. In addition, care management is an electronic tool which complements the use of situation, background, assessment, recommendation (SBAR) format as a framework to achieve successful hand-offs.

Other VA developed tools for clinical documentation, across practice settings are clinical flow sheets and the patient assessment documentation package. Clinical flow sheets are a tabular presentation of physiological measurements, observations, and interventions to facilitate tracking and trending of clinical data for clinical decision support across time. These flow sheets are incorporated into the functional design to automatically download clinical data from validated peripheral monitoring equipment in critical care practice settings and integrate this information into our progress notes as well as our vital signs legacy packages. Clinical flow sheets provided an alternative for nursing to document practices such as intake and output, activities of daily living, and patient controlled analgesia monitoring, in a structured format which permits flexibility across practice settings.

The patient assessment documentation package, which is discussed in Chapter 24, has been in development for several years and was designed to provide a standardized format for recording the initial and ongoing nursing observations and interactions with patients from admission through discharge. The tool was designed using branching logic that supported the routine documentation responsibilities of staff. The PADP was comprised of 4 interdependent modules: an admission assessment, shift reassessment, interdisciplinary plan of care, and a discharge plan. The PADP (development, challenges and halted deployment) is discussed extensively in Chapter 24.

Fortunately, VA nursing has always recognized that performance measurement and data collection on patient and organizational outcomes should be a by-product of documentation and the documentation tools should be developed with this as a goal. Reuse of core content such as demographics and allergies across VistA core systems decreases documentation redundancy. The use of the Computerized patient record system v.1.0 (CPRS) as well as bar code medication administration (BCMA), which became the benchmark for the use of technology within medication administration, affords measurement of specific nursing actions and interventions as a by-product of electronic documentation tools as cited earlier within the VANOD database as well as managing scanning data. These graphical user interfaces, built upon existing
Veterans health information systems and technology architecture (VistA), support clinical decision-making and increase patient safety. VA nursing informaticists continue to seek opportunities within current and new documentation tools to eliminate redundancy and proliferate the re-use of core data elements within nursing documentation tools. Comprehensive documentation templates display timely, patient-centric information, including active problems linked to SNOMED CT, allergies, current medications, recent laboratory results, vital signs, hospitalization, and outpatient clinic history. The use of dialog templates and clinical reminders permit linkage of core data elements, as well as provide a method to extract nursing actions and interventions for performance measures. A key feature of CPRS nursing documentation tools is the ability to integrate standardized documentation templates such as the VANOD skin and wound templates into local documentation tools. This produces a progress note with a pre-defined consistent layout for easier data retrieval, which complements chart review processes utilized by accreditation teams, and are now available for patients to download and print through VA “blue button” technology.

As with any legacy system, VA nursing has recognized the need to evolve electronic documentation into collaborative tools for documentation. New designs currently being tested and validated include nursing documentation within smart forms which tag data elements for extraction into clinical data warehouses. Requirements for new platforms are including specifications to extract outputs from other clinician interventions such as orders management, to include a subset of defined nursing interventions which are essential to practice, as well as mobile application technology to keep our nursing clinicians at the point of care. VA nursing informatics experts recognized that new approaches were needed to complement practice at the point of care and not complicate it and continues to build new tools to integrate with existing and future architectures.

In addition, interagency collaboration with the Department of Defense will ensure sharing meaningful data to improve healthcare and continue to embrace preventative care among our Veterans and their families transitioning from active duty military service. Early pioneering work of the Department of Veterans Affairs will complement the recent legislation regarding the stages of meaningful use, which have been defined from data capture through measured outcomes (HealthIT.gov, n.d.). Nursing informatics will be essential to each stage of this legislation. Current and historical literature reviews regarding these goals have resulted in mixed reviews of projected clinician and patient outcomes. Nonetheless, a key foundational phase associated
with successful information technology integration into nursing practice is the recognition and importance of each phase of the system development life cycle. As becomes increasingly apparent, VA nursing informatics has become an essential resource in managing health care improvements for our Veterans while ensuring added value to their care.

REFERENCES


Chapter 23.1

A Nurse Executive’s Perspective on Using Data and Evidence to Manage Change and Add Value

Linda McConnell
Nurse executives, as collaborative partners at the executive table, rely on VA information systems and the data infrastructure for decision-making and strategic planning. Nurse executives understand how data drive decisions related to quality and safety to create value. The medical center director (equivalent to private sector chief executive officer/president position) relies on the nurse executive to find solutions to complex problems, meet new challenges and to manage resources efficiently. Data are required when developing new programs, planning nurse staffing and budgets, and for evaluating new patient care initiatives. Various data sets are available to ensure evidence based decisions and to drive innovative practice changes.

As the nurse executive at James H. Quillen VA Medical Center in Mountain Home, Tennessee, I oversee a nursing management team that faces complex situations in this rapidly changing health care environment and VA data have helped our team to ensure value in our endeavor for quality and safety. Data have helped identify opportunities for improving patient care and satisfaction because we can monitor trends and compare ourselves to the “best in VA”.

VA data have been essential for developing annual nursing service briefings. Each briefing affords nursing service leaders the opportunity to demonstrate our contribution to patient care and the facility strategic plan, whether it is building a new program, forecasting change or downsizing programs to meet budget constraints. The briefing allows for data displays to show trends in personnel costs and staffing levels, patient satisfaction trends, staff satisfaction trends and outcomes. Data, specifically nursing costs, are vital to decisions in program planning. As newly designed patient care units featuring private rooms were opened at our facility, staffing decisions were made based upon the review of data trends and projected changes that would impact nurse staffing. Plans were developed to meet patient care needs in the new environment.

VA nurse executives use standardized VA data sets for planning budgets and for Justifying resource management decisions. VA data infrastructure allows for comparisons with other facilities. For example, we compared nursing hours per patient day (NHPPD) for various patient care units, including medical, surgical, mental health, critical care, and extended care units when justifying nurse staffing levels for our facility. We compared our facility data to other facilities within our Veterans integrated services network (VISN), facilities that matched to our complexity level, and to Magnet facilities. This comparison of NHPPD and other quality outcome data such as hospital-acquired pressure...
ulcer rates (HAPU), staff satisfaction and patient satisfaction was used to determine effective nurse staffing levels for the inpatient care units.

To best achieve efficiency while ensuring quality and safety, VA nurse executives are expected to blend their knowledge of operations with cost data to make recommendations and solidify decisions. We use the administrative and clinical reports found in VA Nursing Outcomes Database (VANOD) to link nurse staffing, cost, and quality data. Nurse managers use the data in VANOD reports for proposing nurse staffing requirements. For example, the data for average daily turnover and unit hours per patient day was reviewed when determining the number of registered nurses (RNs) required on medical surgical units as part of staffing methodology implementation. RN levels of education and years of experience were also reviewed to determine RN levels. The data were used to make recommendations to the medical center director for nurse staffing levels.

In VANOD, the executive briefing books allow for review of key indicators that VA nurse executives and nurse managers need to identify changes in staffing and cost related data. Information displays drill down to facility and patient care unit location showing data trended over time. Since the number of nursing staff available to provide direct patient care impacts the quality of patient care, the nurse executive and other management officials closely track variances. Variances in available direct-care staff occur when staff members are absent from work. The report includes the number of staff worked hours, administrative leave/absence, annual leave/vacation hours, compensatory time hours, leave without pay hours, military leave/duty hours, sick leave/time hours and sick leave/time care hours used. These are summarized in a standardized report that is generated from nationally determined data definitions and pulled from a centralized database. The report is presented in table format that reflects non-productive time used. Tracking variances in non-productive time as well as NHPPD allow for data analysis by key managers. For example, at our facility we have experienced several nurses being absent from work on maternity leave in the same year on one unit, coupled with staff being off of work for other family medical leave reasons. Management actions for such issues are required to ensure NHPPD standards are consistently met. Also in the executive briefing book, the manager or executive can track overtime to ensure expenses do not exceed budgetary allowances. Considerations are given when establishing a ceiling/budget for nursing unit full time employees (FTEs) to include a review of these indicators of annual leave, sick leave, military leave, leave without pay and overtime paid. The VANOD report includes a breakdown of
these indicators by categories of staff to include registered nurses, licensed practical/vocational nurses, medical technicians, and clerical personnel.

Retention of qualified nurses is important to consistently delivering quality patient care. Staff satisfaction is important to reduce nurse turnover. Staff satisfaction data are available in VANOD for review. Staff turnover information, which is also available in VANOD, is used to identify the hours of education required for orientation and training of new staff for individual patient care units.

Patient and staff safety are always a critical consideration when planning and evaluating equipment that supports patient care delivery. Resources are prioritized each year and the nurse executive is in a key role to advocate for budget dollars to support direct patient care equipment. The use of data to demonstrate the relationship of staff injuries to the use of patient ceiling lifts was very helpful to me in demonstrating the value of this equipment purchase. VANOD provides nurse executives with ongoing trends of nurse injuries for quick reference and reports. Monitoring of staff injuries allows the nurse executive to evaluate any increase in injuries and a quick re-evaluation of compliance with practice standards applied to the proper use of the patient lifts. Productivity is often reduced with on-the-job staff injuries.

Medication administration is another area of concern for patient safety. The VANOD data set allows for comparisons of the number of medications dispensed, the number of medications scanned, and the number of scanning failures. Data regarding the number of medications administered allows for workload comparisons among units when determining staff skill mix and number of staff required for a given patient care unit. Unit-based staff nurses have used these data when proposing staffing requirements. The scanning failure report is a useful set of data to identify opportunities for improvement in medication processes. Nursing time is saved when scanning failures are minimized, resulting in more nurse time with patients at the bedside. Medication errors have been minimized at our facility when bar code medication administration (BCMA) processes were strictly adhered to. This all supports a patient safety culture, striving for zero medication errors.

Nursing workforce demographic information available in the VANOD data set such as age, education level, years of experience, and retirement-eligible information assists workforce planning by the nurse manager and nurse executive. For example, VA seeks to increase the number of staff with a bachelor’s degree. I have used the VANOD data set to track our facility’s progress toward this goal. Scholarships for education support are prioritized annually and these data assist me in identifying resources needed to support
nurses who desire to advance their education. To ensure a balance in the number of experienced nurses on each unit, the years of experience of staff members are reviewed as a part of staff planning and hiring. The number of nurses eligible for retirement assists the manager in recruitment planning, particularly in areas that require specialized knowledge, training, and skills.

The computerized patient record has enabled VA nursing leaders to implement computerized templates that guide documentation by nursing staff. The templates reflect required steps in patient care processes. As a nurse executive, I value a checklist approach to ensuring standardized documentation and sustained quality and safety. Similar to checklists, standardized documentation has ensured implementation of best practices and a comprehensive approach to documentation of care provided by nurses. The reporting function that is available from the automated documentation system has led to improved reliability and sustained performance at our facility. The computerized patient care documentation system is critical when making changes in practice as required fields ensure that specific elements of evidence-based practice are addressed in care. For example, to ensure patient teaching was accomplished prior to discharge for patients with congestive heart failure (CHF), we revised the electronic discharge note at our facility to require documentation about patient education. Education for CHF patients improved after the implementation of the standardized documentation.

VA facilities conduct comparative analyses against like facilities to identify best practices within the unique patient population that we serve. With a few clicks on a computer, VA nurse executives compare unit level information to drive improvements at local facilities and across VISNs as well as across the entire national enterprise. With the ability to compare multiple indicators across units, we often identify the root cause for a problem or a key process for improvement. In reviewing hospital-acquired pressure ulcer (HAPU) rates within our VISN, we noted that there was variability in success in achieving low HAPU rates. Drilling down to facility level data such as the percentage of skin assessments completed daily at each facility allowed us, as nurse executives, to identify performance variances. We discovered that ensuring skin inspections were completed was important to prevention of skin breakdown. Clinical data were captured on the national standardized documentation template used by front line staff nurses and allowed for data collection. The data captured allowed for daily and monthly reports for review by clinicians. Through practice changes we achieved great success and notably low HAPU rates at our facility.
In our nursing journey for excellence we have used VA data to compare various indicators. We strive to achieve the highest level of patient-centered care and high patient satisfaction. Patient satisfaction results are readily available to managers. As new roles were implemented we were able to evaluate the impact on patient satisfaction as well as other quality indicators. RN specialty roles were designed and implemented to promote team-based care, reduce errors associated with transitions in care levels, reduce length of stay (LOS), and to reduce readmissions. We also implemented specialty roles to enhance education, training and competency of staff. We have tracked trends to demonstrate improvements in care and to justify nursing staffing requirements.

We have used the relevant data and our accomplishments to achieve quality awards and recognition for our facility. Nursing has led many improvements in patient outcomes and patient satisfaction. The VA data infrastructure lends itself to comparisons that drive decision-making for quality and high reliability. Sustained excellence leads to the highest levels of quality care, for which VA is well known. Thus, as a nurse executive, managing change and adding value has been significantly enhanced through my use of the data and evidence made available through VA’s data systems.
Chapter 23.2

A Team Approach to Pressure Ulcer Identification

Kelly Machuca and Tracy Weistreich
The VA Roseburg Healthcare System (VARHS) is an interdisciplinary facility serving medical, surgical, and behavioral health inpatient and outpatients and long term care patients. The 26,000 male and female Veterans served range from the adult, aged 18, to the elderly adult, aged 65 and older. The population is comprised primarily of rural and remotely rural Veterans located in southern Oregon who are served by the main campus in Roseburg, Oregon and community based outpatient clinics located in Eugene, North Bend, and Brookings.

VARHS employs approximately 900 personnel and, of these, nursing and patient care services accounts for 390 nursing and allied health personnel. Tracy is the Associate Director of Patient Care Services (chief nurse executive) and Kelly is the Deputy Nurse Executive. Our philosophy for patient care and nursing includes a holistic, patient-centered approach to care delivery and a belief in the synergy of the interdisciplinary team. As the nursing leadership, we feel it is vital that nurses are engaged in evidence based discovery and application to ensure we provide the most appropriate, safe, comprehensive care to America’s heroes.

We believed that the population we served posed an increased risk for pressure ulcer formation due to co-morbidities, immobility, and advancing age; however, our data demonstrated high variability in the prevalence. In the United States, the overall prevalence of pressure ulcers is 12.3% with acute care representing 5% of this overall prevalence compared with 3.8% in long-term skilled care, 5.2% in long-term care, and 4.7% in rehabilitation. The incidence of acquired pressure ulcer is noted to be strongly correlated with the inconsistencies of assessment and reassessment of skin integrity (Ayello, 2011). At the start of this process, we were uncertain about our prevalence in the VA Roseburg Healthcare System (VARHS), what our employees perceived their needs were that would enable them to address this concern, and where we needed to improve. We concluded we needed first to conduct a review to answer these questions.

As a leadership team, we created an interdisciplinary skin and wound care committee to evaluate care delivery across the continuum and ensure compliance with Veterans Health Administration (VHA) policies and best practices. Our initial review revealed that our nurses had varying degrees of understanding about pressure ulcer identification, staging, and intervention for both prevention and treatment. In particular, the nursing personnel in the acute medical-surgical unit were not consistently assessing skin integrity on admission and were inconsistent in conducting a daily reassessment. Further, we noted that staging, a standardized way to describe wounds with emphasis on the depth of impairment to intact skin, was inconsistently
being applied from nurse to nurse and shift to shift, resulting in variability in the documentation and the evaluation of skin integrity. As a result, our plans of care were inadequate for those patients recognized as having a high risk for formation of pressure ulcers. We also discovered that the certified wound care nurses conducting pressure ulcer prevalence surveys had a thirty-nine percent error rate in identifying and staging pressure ulcers. It was evident that the current processes were ineffective and a team approach with engagement from the nursing personnel on the inpatient unit would be essential to turning this around. We created a project to make this happen.

The aims of the project were to improve consistency of assessment on patient admission and daily reassessment, reduce variability in staging, and improve documentation of the plan of care for at risk patients. Ultimately, we wanted to change the culture around pressure ulcer prevention and provide a patient-centered approach that was consistent and effective. From the outset, we decided to emphasize teamwork in our project.

The VARHS had an existing skin integrity committee that was comprised of acute care and long term care nurses, certified wound care specialists, licensed independent practitioners, dietitians, and physical therapists. We believed this team was the ideal group to tackle the challenge. The team set out to develop a comprehensive pressure ulcer assessment and prevention education program to improve early identification of potential and actual skin breakdown among patients in the acute care units.

Our first step was to look at policies, procedures, and protocols. These were developed using evidence based guidelines for the prevention and treatment of pressure ulcers, developed by the VHA national pressure ulcer advisory panel (2009) with input from front line employees who would be responsible for implementing them. We identified a standardized and validated tool, the Braden Scale for Predicting Pressure Score Risk, which would provide consistency of assessment and documentation. We also incorporated documentation requirements, skin integrity assessment tools, pressure ulcer risk tools and protocols for skin care products and adaptive equipment into the policies and procedures for healthcare clinicians. We then shared the draft documents with clinical leaders across the organization and adopted them into practice in the inpatient, outpatient, and long term care areas.

Our team then developed an education curriculum that included assessment, identification, staging, prevention, intervention, treatment, patient education, and documentation. We based the curriculum on the above advisory panel recommendations and included input from education specialists, front line personnel,
and subject matter experts. Having completed these initial steps, we then focused our strategic planning on deployment.

We began by engaging the stakeholders, who included the leadership, nurses, nursing assistants, providers, pharmacists, physical therapists, and dietitians. Information was presented at staff meetings, committees, councils, and individual discussions with formal and informal leaders, and we provided brochures about the program. Our team developed flyers, instituted a rounding program, and incorporated discussion about skin assessment as part of the hand off process. We provided the front line personnel with individual education after they completed a pre-implementation questionnaire. We implemented skill mastery necessary for this change in the simulation lab, through online education, and through individual modules developed in collaboration with the education department. We trained all acute care clinicians who then completed a post implementation questionnaire for comparison with their pre implementation scores.

Our team discovered that a national skin assessment template based on the Braden Scale for Predicting Pressure Score Risk was available but not complete or consistently used at VARHS. We evaluated the VARHS template against the policies, the national template, and tested it among a group of super users. We included this assessment template in the curriculum training so the staff would be familiar with it. We then deployed it live into the electronic medical record after completion of the training.

The team developed an educational program for our patients and their families that included strategies for prevention of pressure ulcers and treatment of pressure ulcers. Along with this, our team developed a trifold brochure, in collaboration with the facility patient education resource committee. We evaluated the best way to make these brochures available to those who need them. We provide the brochures to patients when they are admitted to acute care units. We make them available in the patient education resource center and give them to families for patients identified as high risk for development of pressure ulcers.

Once we had implemented our project, we set out to assess whether our aims were met. For ninety days following completion of our training phase of the project, members of the team performed daily surveillance through medical record review. We also conducted pressure prevalence surveillance every two weeks during the same ninety days to assess inter-rater reliability with identification and staging of impaired skin integrity. For patients identified as at risk for development of pressure ulcer, our record reviews included evaluation of treatment planning, interventions,
and reassessments for the duration of admission. We included all charts in our review, evaluating them for documentation of patient and family education. Thirty days after completion of our education program, we asked all clinicians to complete a questionnaire to evaluate retention of education. The team decided that the twice-monthly pressure ulcer prevalence surveys and monthly skin risk reports acquired through our VA Nursing Outcomes Database (VANOD) would provide validation of retention and application of the knowledge of assessment, prevention, and treatment of pressure ulcers. The data for the documentation aim are directly retrieved from the electronic medical record when the healthcare clinicians use the document templates for skin assessment and reassessment.

The final stage of our project was thus focused on an extensive assessment of outcomes. Our team collected baseline data elements in March, April, and May of 2011 and compared them to March, April, and May of 2012, after the interventions had been implemented. The daily medical record reviews demonstrated that, post-intervention there was improvement in documenting skin assessments compared to our 2011 baseline data, as indicated in Figure 23.2.1.

**Figure 23.2.1** One Year Comparison of Three Months of Data on Completion of Daily Skin Inspection by Nursing Personnel

![](image)

By performing pressure prevalence surveillance every two weeks and comparing each patient’s surveillance to the nursing personnel documented assessment in each patient’s medical record, we were able to document that there was an improvement in assessing, identifying, and intervening in impaired skin integrity. Our second project aim, to reduce the variability of
staging showed improvement compared to our baseline. The baseline error rate for identification of impaired skin integrity was 39% in 2011. The post-intervention error rate was reduced to 13%, as presented in Figure 23.2.2.

Figure 23.2.2 One Year Comparison of Pressure Ulcer Prevalence Survey Error Rate (Consistency of Staging)

Our third project aim was to increase a documented plan of care for patient’s identified as at risk for pressure ulcer formation in the acute care unit. We discovered that this aim was met, and indeed our improvement in outcomes was statistically significant. Using the daily medical record data, the team demonstrated that post-intervention there was improvement in documenting a plan of care, compared to our baseline data (displayed in Figure 23.2.3) through evidence available in the daily medical record reviews.

Figure 23.2.3 One Year Comparison of Three Months of Data on Documented Plan of Care

In looking back over our project from beginning to now, we believe that our overall success has been demonstrated with the implementation of the team approach to an evidence based guideline for the identification of
pressure ulcers. Our team felt the outcome was significant enough to deploy the program throughout all units within the organization and improvements have continued. The team will continue monitoring of all measures through a facility-developed scorecard and anticipate the data will substantiate sustained improvement. We also realized that our constructive use of data had made a significant impact on the care we provided to our Veterans.

REFERENCES


Chapter 23.3

Electronic Resuscitation Documentation: Improving Documentation at the Point of Resuscitation

Melissa Hutchinson
You can’t change what you can’t measure. This has been my driving principle since I began working to improve resuscitation care and outcomes. Without accurate, to-the-second measurements, how could we truly and effectively improve our practice and patient outcomes? This question drove me to search for a better system which all started with resuscitation documentation. As a critical care clinical nurse specialist at the VA Puget Sound Health Care System in Seattle, Washington, evaluation and management of resuscitation events were a key function of my professional responsibilities, and excellence in care of our Veterans was important to me.

Accurate documentation during a resuscitation event is essential for patient care planning, assessing compliance to the American Heart Association (AHA) algorithms, and quality improvement process reviews. Documentation using paper records of some form are still used today as the standard of practice for many hospitals, even though most patient care is documented electronically. I have provided examples of paper record documentation in Figures 23.3.1 and 23.3.2.

**Figure 23.3.1 Example of Handwritten Paper Documentation of Resuscitation Event Data**

What are the “time off chest“ intervals?
One prospective study demonstrated that time discrepancy, a critical element of resuscitation documentation, was only 3 seconds when an electronic format was utilized and 77 seconds when the event recorder utilized a paper format, a finding significant at the P<0.001 level (Peace, Yuen, Borak, & Edelson, 2014). A delay in defibrillation of even one minute can reduce the survival rates from 39% to 22% (Grady, 2008). I believed that an improved recording process leading to more accurate event data could help our hospital identify both the strengths and weaknesses of our current resuscitation processes.

Paper recording was antiquated. Our patient care documentation had been electronic for years, so why should this event continue to be handwritten? I continued to ask this question, primarily because I wanted better documentation so we could accurately assess for data inaccuracies such as misreported intervention times. Recognition that accurate data collection during resuscitation events was necessary to improve outcomes was first described in 1995 in
Utstein Abbey, Norway at a symposium gathering of international resuscitation experts. The data collection sets were henceforth termed Utstein-style data collection. Four critical intervals were recommended for tracking: time to initiation of cardiopulmonary resuscitation (CPR), time to first defibrillation, time to advanced airway management, and time to administration of first medications.

What has yet to be defined though is a best practice recommendation regarding a preferred documentation method. Bergrath et al. (2011) assessed Utstein-style written documentation consistency between October 2007 and December 2008 in several UK hospitals and noted the number of compression cycles, number of shocks, and other intervals were not documented in 52% of the cases. Although many studies that evaluated resuscitation and consistent use of Utstein variables occurred after our transition to an electronic platform, current data supports the concerns that originally drove the decision to change our recording method.

To this day, most hospitals continue to record resuscitation events using paper and pen, just as we did for years. I knew there had to be a better system. Then, in 2003, our facility began research to purchase new defibrillators. The current defibrillators were monophasic technology and it was time to upgrade to the new biphasic technology, which demonstrated improved defibrillation outcomes. We spent several months reviewing salient characteristics of the available defibrillators and finally settled on a specific series biphasic. After our defibrillator research was complete I found an additional product that looked intriguing which was also produced by the same vendor. The product was new to the market and it provided improved data utilization and process improvement of resuscitation events through computerized event recording. I was fascinated. Although this was not part of our current evaluation plan I wanted more information on cost, feasibility and usability.

The documentation system was called CodeNet. CodeNet was able to time stamp and synchronize event information with the defibrillator data once the resuscitation was complete. The synchronized data could provide clinicians with a complete and accurate timeline of an entire cardiac arrest event including cardiac waveforms and shock levels. A report generator allowed for easy event review and provided a means to improve adherence to AHA Advanced Cardiovascular Life Support (ACLS) guidelines using event icons organized by the
ABCDs (airway, breathing, circulation, and defibrillation) framework. This device and its screen content are pictured in Figure 23.3.3.

**Figure 23.3.3** Code Net Device Screen Designed to Record Defibrillation Events Using the American Heart Association Advanced Cardiovascular Life Support Guidelines

A special feature of the device was a medication timer that flashed when medication dosages were due. At the time, these were for epinephrine and atropine. The personal digital assistant (PDA) was moderately intuitive, as this technology had just come into wide public use, and most early adopters of technology understood the basics. Working with the information after an event was fairly simple as well. After an event, resuscitation data were downloaded from the defibrillator and merged with the PDA data and from there it was uploaded to a computer for review of interventions. An example of this review data is pictured in Figure 23.3.4.

Reports from the aggregate data were easy to generate. We were able to monitor trends that have included aggregate data on survival by arrest type, location, initial rhythm, or time to first CPR, epinephrine, intubation, or shock. These reports helped to measure the quality of existing resuscitation programs. Along with more accurate event time intervals we now had the
potential to improve patient outcomes since the data analysis could be fed back into our resuscitation process improvement programs.

Our administration was supportive of this product because of the quality improvement benefits. An added, perhaps more significant incentive was that we were able to take advantage of a bundle purchase option through the vendor that rolled the price into the defibrillator purchase.

My plan seemed to be progressing without any issues. Unfortunately, it didn’t stay that way. Most people loved the thought of the new computer program but a few key people were opposed to a computerized system. These were the late adopters of technology and their feedback usually argued that “we just needed a better paper and pen system”.

We addressed those concerns quickly and then continued to move forward. The next challenge then became determining who owns the system and who is responsible for recording? This question seemed to generate the most debate and concern. We realized that if these questions were not answered appropriately the program could be derailed.

We were not the first VA to implement CodeNet, so I queried my resources to determine how recording was done at other VAs. Many different answers surfaced. The recorder at one facility was the pharmacist, another opted for any nurse available, and yet others were in the situation we were in, not having a strong, designated recorder. So we
wondered what the current best practice was in this area. I decided to implement the role myself and initially became the primary recorder. By doing this myself, I would be able to implement the electronic recording process quickly and work out any issues with recording, downloading and quality improvement prior to training others.

Once I was satisfied with the process of electronic recording, I worked on a training plan for the next recorders. The vendors provided a training course for new users and I also created mock code recording competencies experiences where people could practice their recording skills. The individuals I initially chose for training were those I thought would be the most consistent and also did not provide direct patient care during resuscitation; these were those who took on the responsibility of the "nurse officer of the day" (NOD) similar to a nursing supervisor. Although this seemed like the most logical group for this recording role, I learned that their resuscitation expertise was not as well developed as the intensive care unit nurses. I experienced push-back related to both the new device and the new leadership role we were asking the NODs to assume. We utilized the NODs in this role for about a year and then decided to re-evaluate both the function of the recorder and reassess our personnel options for this position.

In order to evaluate the best function for the recorder role we convened a small group of invested people to assess the recorder role, where the recorder belongs within the resuscitation event, and who might fit best in the role. After some discussion we decided that we would elevate the role of the recorder to the team co-leader and move the role to the emergency department (ED) nurses. As the co-leader, the recorder would be the monitor of the compression rounds and efficiency and timing of defibrillations and medications. This new role then left the leader to determine how best to treat the patient. Since the recorder was elevated to co-leader we needed a strong recorder/co-leader with the experience to intervene when the team went off course. The assistant nurse manager and nurse manager of the ED both felt the ED nurses would be a great option for this new role. The ED was building the experience of their staff as they moved to a new and bigger ED and at the time the assistant nurse manager coordinated the advanced cardiac life support program and could assist with training the staff in this new important role. This seemed like the perfect solution.

We began training and education on the electronic format with the ED nursing staff. Overall the nurses took to the new process quite well. As with all electronic media some are more naturally drawn to it than others and asked to be the super-users. The ED nurses were very engaged and over several years they assisted in providing feedback on the PDA system and
provided a great deal of input into the new recording system developed by the vendor on the Windows platform. Our nurses assisted in the beta testing of the new platform as they had made requests to the vendor to make recording easier and provide better post resuscitation information.

In 2013, we received our new recording devices and we were proud to say that our nurses helped create the system that is now available nationally. The ED nurses provided feedback that created the one step compression recording button (push button on-off recording) which then flashes when 2 minutes of CPR is reached, along with improved ease of use for recording medications and other interventions. I believe the ED was proud to be part of this system redesign and their information was important in making the electronic system more usable and user friendly for a national recording program.

The electronic recording platform has also been important for our interdisciplinary code review team. During our monthly interdisciplinary code review meeting the code event plays back, in real-time, for the team to review and assess for areas of strengths and improvements. We watch the recording which displays the ECG tracing and all interventions are time stamped on top of the ECG recording, as presented visually in Figure 23.3.4. This feature allows us to assess the ECG and whether the intervention was appropriate in that situation. The graphing capabilities also display the compression depth and consistency and the most important monitor of all, “time off chest”.

Prior to this graphing capability our “time off chest” intervals were often above 2 minutes as compressions were stopped for various procedures such as intubation or central line placement. Now we have a “no stopping” rule and compressions do not stop unless it is time to change compressors or if the compressor cannot continue for some reason. We have significantly decreased the time off chest average to 5-8 seconds per compressor change. Without the precise measurements we would be unable to quantify this improvement to this extent. It is very easy to measure and track our progress using the real time graphs from CodeNet. This feedback is then provided to the team members present at the event and summarized and reported out monthly to the Emergency Care Committee. In addition, certain events are also shared with the Executive Board using these data.

Through our thorough review of the resuscitation events that have occurred over the past several years, we know our resuscitation process has improved and is much more streamlined than ever before. Despite these improvements our “survival to discharge” outcomes have declined over the past year even with optimizing the resuscitation intervals and processes.
What we realized, however, was that we needed to look at other factors that influence outcomes that include patient characteristics, systems variables, staffing, time of day and, because we are a teaching facility, time of year.

We determined that one variable we needed to study in greater depth was patient characteristics and beliefs related to resuscitation, what the patient believes resuscitation can and cannot do. In many instances Veterans that we attempted to resuscitate were effectively so ill that resuscitation was neither appropriate nor effective. No matter how excellent the resuscitation team, not everyone can be saved, even by the best code team.

A future goal for our team is to assess why Veterans that would not benefit from resuscitation continue to have resuscitation directives and what we can do to improve our education for both Veterans and families related to end of life issues and resuscitation. I would personally like to see goals of care discussions occur with primary care providers early in a Veteran’s experience with a difficult diagnosis such as congestive heart failure or cancer. By using this approach we allow time for information to be delivered in small doses, which are much easier to digest than having our initial “goals of care” discussion when a loved one is admitted to an intensive care unit. Upstream discussions at the point of primary care provide time and access to information so Veterans and families can reflect on and determine their important future healthcare goals or needs. Goals of care should be a thoughtful discussion far in advance of any hospitalization. Actually, I think we all should consider having this discussion early in our lives so our loved ones are not left stressed and guessing what our healthcare preferences are if we are unable to speak for ourselves.

In summary, through an enhanced electronic code recording process and an in-depth multi-disciplinary analysis of each cardiac arrest, we hope to continue our timely, appropriate, high quality of care for our Veterans requiring resuscitative efforts. Additionally in the future, we hope to improve our understanding of end of life and resuscitation issues so we can provide education that is critical to the issues our Veterans and families face every day.
REFERENCES


Chapter 23.4

Wound Prevention and Management from Staff Nurses in the Community Living Center

Jessica Watkins and Jason Sork
Wound care is constantly changing and improving. It is not only focused on management strategies but also on prevention. These changes are due to evidence-based research. Changing the care that is provided in a facility can occur in a short time but in a government facility, the process can take much longer because of the procurement process. Taking on the responsibility to change or create a wound care program in this setting can be challenging and at times frustrating, especially if you try to do it on your own. In the beginning, the wound care program was started by me.

My name is Jessica Watkins MSN, RN, CNL. I achieved my associate degree in 2003, and my master’s degree in nursing in May of 2012 and a post master’s Clinical Nurse Leader certificate (CNL), in 2014. I began my VA career in the community living center (CLC) in 2005. The VA CLC is an extended care, long-term care setting. Prior to the VA, I worked at a local community hospital on the surgical floor. It was not until 2012 that Jason joined the team. My name is Jason Wayne Sork. I have an associate’s degree in nursing. I am currently enrolled in a baccalaureate nursing program, and expect to graduate in 2017. My past nursing experience includes working as a tuberculosis coordinator, central supply coordinator, interim director of nurses, and staff nurse.

In 2005, the current community living center was known as the nursing home care unit (NHCU). The client setting was long-term care for Veterans. Some Veterans' plan of care included wound care, but our NHCU did not have a certified wound care ostomy nurse (CWCON) although there was one in a clinic at our main hospital. At that time, the NHCU staff nurses completed skin assessments, provided wound care, and completed documentation. Skin assessments and wound assessments were to be completed on a weekly basis. However, the provision and documentation of wound care was inconsistent and the accountability was unclear.

In December of 2007, I, Jessica was asked if I would lead the skin team with a nurse practitioner as my medical provider. My background was in surgical wounds, not pressure ulcers. I was instructed to monitor wound assessments, serve as a resource for other nurses, and become a member of the skin committee where I would provide CLC summary reports each month. Another RN would be in charge of monitoring the weekly skin assessments. I sought training and educational days to follow our CWCON in the main hospital.

I was able to spend one day a week for a few months with the CWCON nurse in the hospital-based wound clinic learning how to
assess and clean wounds properly. The majority of wounds I would attend to in the hospital were diabetic foot ulcers, venous stasis ulcers and arterial ulcers. The majority of the wounds I would manage in the CLC were pressure ulcers. During that time, the skin committee decided to introduce wound photography at our facility. I worked alongside the CWCON nurse and created a policy on how to accurately photograph wounds and upload the images into the Veteran’s electronic health record. I continued spending one day a week with her for about six months until she left her position for personal reasons.

Now I was on my own. I was the only one who had been trained to download pictures of wounds, which meant I would be called to other units to download wound photos for other staff nurse’s patients. I didn’t know what else to do. I no longer had a mentor and I knew I needed more training. The entire situation was frustrating for me.

In October of 2008, I was approved to attend an educational wound care conference for four days. The conference was not VA sponsored, however, several VA employees attended. During the conference I learned the difference between types of wounds, proper staging, treatment, and prevention strategies that included, offloading, and barrier creams, reference sites and wound journals. Once I returned to work, I began researching barrier creams. At that time vitamin A&D and zinc were used as barrier creams only after the Veterans had perineal dermatitis. In addition, only licensed staff could apply them. I wanted a product that the nursing assistants could apply when they made rounds. I researched products using Google, Google Scholar, Woundcare.org, National Institute of Health (NIH), National Alliance of Wound Care and Ostomy, National Pressure Ulcer Advisory Panel, Agency for Healthcare Research and Quality (AHRQ), and the Wound Care Education Institute. As a result of my thorough review of best known practices, I found two clear moisture barrier creams, one that adheres to intact skin and one that adheres to intact and denuded skin. Both are easy to apply and remove and allow the nurse to see the area of skin after application.

I presented my findings to the skin committee and gained approval for a trial. I contacted the product representative for my area who provided details on the selected products. Ten Veterans were included in our two-week trial. The participating staff members completed an evaluation tool and were interviewed at the end of the trial. Upon completion of the trial, we discovered that the staff preferred the product that could be used for intact and denuded skin. The information was provided to the skin committee and was approved to bring
the results to commodities standard committee for purchase. While the process of shifting the procurement process was very lengthy, impacted by a change in local leadership, it was finally approved in 2010. The barrier cream is now in our general stock, can be ordered by qualified nurses and can be applied by qualified nursing assistants.

In February of 2009, while the procurement process was working its way through our system, I continued to seek approaches to improve the wound care program in the CLC. I decided to focus on pressure ulcer prevention by reinforcing recommended turning and repositioning of patients (Aust, 2011). Our facility did not have a pressure ulcer prevention plan in place. I began evaluating evidence based repositioning reminder tools to support nursing practice. I created a turn clock schedule for every hour and every two hours with various turning options depending on the location of the wound. I also created a standard operating procedure (SOP) for use of the turn clock. Once the SOP was approved, I distributed it to all staff via email announcing the SOP and then I conducted short in-service sessions. Weekly monitoring was completed to ensure staff compliance. The turning and repositioning schedule helped. I noted a decreased incidence of CLC acquired sacral pressure ulcers; improving from an average of four a month to two a month.

We recognized that documentation of wound assessments and skin assessments were still not at a desirable level. Our best rate of compliance for required documentation was 70%. Our nursing leadership decided that weekly skin assessments would be assigned to every registered nurse. This had an impact on increased compliance for skin assessment ranging from 80-85%. Our nursing leadership directed a best practice of designated RNs to be responsible for weekly wound assessments. Since I had the most experience with wounds in the CLC, I would assume this responsibility with a back-up RN for when I wasn’t available. Wound assessment documentation increased to 90%, however there were times when both of us were off-duty and the documentation did not get done. Realizing that a wound team should consist of more than a RN and NP, the wound team was created. The wound team consisted of a nurse practitioner, a nutritionist, my nurse manager, and myself. I made rounds on a weekly basis, taking photo images of the wounds, assessing them and then met with the team to discuss progress and the treatment plan.

In September of 2010, I was notified that the facility hired a CWCON nurse for the wound clinic. She later became part of the wound team and completed weekly rounds on Veterans with
pressure ulcers and any wounds that were chronic and non-healing. She became my mentor. I began spending time with her in the clinic once a month to expand my knowledge on wound care.

By April of 2011, our wound care program had grown. More help monitoring was needed. Collaborating with the wound care team, we decided to create a wound care champion on every shift. The CWCON nurse scheduled an all-day training event on wound assessments, treatments, and prevention, wound vacuum training, and compression dressing training. I choose a team of LPNs and RNs to attend the training. The CWCON created a wound resource nurse responsibility form and distributed to all the RNs in the group. LPNs assist the RN with assessments, prevention techniques, monitoring of wounds and education of staff and patients regarding wound care.

As a result of declaring wound champions in the CLC, I felt the need to keep staff informed of wound care so I created a newsletter entitled Prevention, Assessment, Continuous Monitoring and Nurturing of Wounds (PACMAN). In each newsletter we provide a list of all wound care champions on each shift and tips on preventing, assessing, treating, and monitoring wounds. The tips come from evidenced based research journals and expert sources such as the National Institute of Health (NIH), National Alliance of Wound Care, and National Pressure Ulcer Advisory Panel.

By June of 2011, the facility was changing its focus from long term care to hospice and rehabilitation services. At this time, we added a surgeon to the wound team. The CWCON nurse no longer made weekly rounds with the team but continued to consult as needed. Physical therapy was also added to consult as needed.

During this time, the skin assessment assignments were changed again. Each charge nurse was to complete a skin assessment daily. The completion rate for skin assessments increased to 90% percent each month. Although we had impacted improvement in several aspects of wound care management and prevention, we experienced increasing occurrence of heel ulcers, averaging one to two a month. I researched products to help off load the heels while the Veterans were in bed. Pillows would go flat or not stay in place and wedges were considered a restraint. I completed my review of research journals and market research on the internet and found two types of cushion. One type offered a thigh support with sides to prevent the leg from rolling off and one did not.

I presented my findings at the skin committee and received approval to complete a trial. I contacted the supplier of the preferred
cushions and was given one of each cushion for our trial of these products. Staff members were educated on appropriate use of the cushions and four Veterans agreed to trial the products for us. The Veterans participated in our trial by testing each cushion for a week. The cushions were appropriately cleaned between uses. After the thirty-day trial, each Veteran was asked their opinion of the products. Both cushions suspended the heels off of the bed and prevented pressure, both stayed in place when the resident turned and both had to be readjusted when the head of the bed was elevated for meals due to the nonskid bottom. However, the cushion with thigh support and sides was reported as the most comfortable from the Veteran’s and prevented their legs from rolling off the cushion while the other one required readjustment if their legs rolled off the cushion, thus disturbing their sleep. The findings were brought to the skin committee and then to commodities. The products are considered reusable medical equipment and could be purchased by the unit. In September of 2011, my unit had purchased the cushions and I again created a SOP.

The number of CLC-acquired pressure ulcers on the heels decreased to zero with the proper use of the cushions on the unit. However, during this time, pressure ulcer development in our hospice patients began to rise. The Veteran, and sometimes the family members, would refuse to let staff turn and reposition a patient even after being medicated for pain management. In December of 2011, the NP and I created a hospice skin care SOP. It focused on the Veterans’ right to refuse treatment and prevention measures but required that the Veteran would also need to be educated on the risks of refusing prevention measures and the risk of infection of wounds that could ultimately lead to death. The SOP is currently in place and still used.

By September of 2012, the wound care program had improved and grown and so did my responsibilities. I was a member of more committees and the main resource nurse for wounds in my facility. I no longer could complete everything by myself. My original back up RN only completed wound assessments when I was not working and she was transferring to another shift. However, Jason Sork RN was taking her place on day shift. In October of 2012, after discussing the responsibilities of the wound care program, he agreed to be my partner for the CLC wound care program.

Together, we track pressure ulcers, arterial, venous and diabetic ulcers, surgical wounds and skin tears. We assess every Veteran with a wound while being accompanied by the wound care physician.
Bedside rounds engage Veterans and their families as we discuss the wound progression and adjustments to the treatment plan including consideration of consults with other disciplines such as a vascular or orthopedic surgeon or the infectious disease physician. Every wound is measured, photographed and documented weekly. We monitor the effectiveness of treatments and the progress of wound healing, and we research ways to improve overall wound care. We complete care plan assessments for every Veteran admitted to the CLC and update care plans in order to reflect progression and healing of all wounds and skin breakdowns set by the standards from Centers for Medicare and Medicaid Services (2013).

Both of us are authorized as wound care team members to follow through and implement our wound care plans. We are the resource nurses for staff, Veterans and their families on pressure ulcer prevention, wound care management, staging of pressure ulcers, proper identification of wounds and documentation. To help staff nurses improve documentation, each nurse was given a skills sheet on pressure ulcer documentation from the National Pressure Ulcer Advisory Panel (n.d.). Every three months an in-service regarding wound care is provided to staff. Pressure ulcer occurrence is down to an average of one every other month, skin assessments are up to 95% a month and weekly wound assessments are up to 100% a month. In 2013, Jason became involved with the VA skin committee, where he provides monthly CLC wound care management reports. After reporting, recommendations from the VA skin committee are discussed with the wound team and care providers for incorporation into treatment plans.

Currently, some of our projects to improve our program include researching ways to ensure that the treatment books are updated with the most current wound care orders to prevent miscommunication of treatment orders, educating staff to refer Veterans to the wound care team for advice and opinions about wound healing to prevent conflicting communication with the Veteran about the healing progression of a wound, and updating annual competencies for our wound care program.

As our care changes, we will continue to improve and educate staff and Veterans about the wound care program. Neither one of us is currently certified in wound care but we are both exploring this option. We feel that this will further improve each of us as professionals and our wound care for Veterans. We have learned from data collection and research to improve our wound care program and nursing practice at our facility. We will continue to
use evidence based approaches and documented research to improve our program and the quality of care for our Veterans.

REFERENCES


Chapter 23.5

Clinical Roles in Barcode Medication Administration: Overcoming Resistance to Changing Practices

Kimberly Radant
I cringe a bit when I think of my days as a VA staff nurse on a 50 bed medical unit in the early 1980s. Unit dose medication administration was non-existent. Medications were stored on the unit in a large double-door cabinet that contained over two hundred pill bottles. A clerk would hand-transcribe a single medication order onto a piece of flimsy cardboard no bigger than a credit card. An RN in a way-too-crowded nurse’s station would check the accuracy of the clerk’s transcription on the card, verify the doctor’s order, and give the card to the medication nurse. Because patients often had ten or more medications prescribed, the medication nurse would juggle literally hundreds of individual medication cards while trying to fill small medication cups from the vast unit-based pharmacy stock. 

Passing medications involved “setting up” medications for 20-30 patients. One by one, trying to keep the cards organized by individual patient name and room number, I would read the card, pull the appropriate pills or liquids from their bottles in the cabinet, dump them into a medication cup, and place the cup with others on a rolling cart with several shelves. If I dropped the medication cards, spilled something on them, or got interrupted, I stopped what I was doing to reorganize, recopy, and sometimes even “re-set” up the medications I had already set up to begin with for fear they had gotten mixed up while I was distracted. Then I’d roll the big cart full of pills into the first six-bed room, paying close attention to name and bed number and armband, lest I give a brimming cup of pills to the wrong patient. Did I mention that the beds were never exactly numbered the same way from room to room, and that bed #1 in one room might be bed #6 in another room? But, I digress.

Five years later, in the mid-eighties, unit dose in VA was evolving but there was still much room for improvement. Since aspiring VA leaders were encouraged to assume leadership roles in small facilities and “get their feet wet” before going to larger VA medical centers, I accepted a position as Associate Chief Nurse at the VA Medical Center in Prescott, Arizona. My fellow emerging clinical leaders were young, ambitious, and eager to take on new challenges. When we were offered the opportunity to be a test site for electronic medication order entry, we jumped at the chance. The computerized medication order entry system worked like this:

1) A physician would write an order in the chart.
2) Someone would type that order into the computer.
3) An adhesive medication label would print.
4) The medication label would be peeled off of its protective backing and stuck on a paper continuing medication record (CMR) that contained the patient’s name and identifying information.

5) The clerk, pharmacist, and nurse would verify that the printed label was on the correct patient’s CMR and place their initials on the paper in a column to the left of the medication label.

6) The pharmacist would fill unit-dosed medications in the medication cart using the paper CMR.

7) The nurse would administer the medication listed on the CMR.

Sound simple? It was fraught with vulnerabilities for patient safety. First of all, there was the potential for the doctor’s handwriting to be misread, leading to the order being typed into the computer with the wrong medication or the wrong dose. Medication label printers spit out long streams of medication labels not separated between patients or identified by patient name, resulting in Mr. R’s medication labels being placed on Mr. J’s CMR. Nurses and pharmacists and clerks all competed to gain possession of the single paper CMR so they could complete their respective portions of the work.

“Turf wars” ensued between nursing, pharmacy, and ward administration (unit clerks), each insisting that the other should be responsible for typing the doctor’s written order into the computer. For years that battle raged, and not just in Prescott, but throughout VA. “Who enters the doctor’s orders at your facility? Nurses? Pharmacists? Ward Clerks? What do you do if the person cannot type? Doesn’t it take too long to enter the orders? Does it delay patient care?”

There was an elephant in the room. While the battle wore on, deep down we knew that the medication order entry system was never designed for anyone other than the originator of the order to enter the order. It was a rare, brave moment when someone would whisper the real solution to making order entry safer. We needed providers to enter their orders.

When Dr. Kenneth Kizer, Veterans Health Administration’s Under Secretary for Health, mandated provider order entry (POE) in 2000, I felt an overwhelming sense of relief. Armed with direction that would clearly make patients safer, we began to detail nurses and pharmacists and informatics staff to work with physicians who were now struggling with the same issues surrounding typing skills and timely order entry that we had been addressing since the early Prescott trials.

By 2000, I had moved on through three more VA leadership roles and was now a nurse executive at a large VA tertiary hospital. As energizing
as the mandate for POE was, it brought new challenges as well. New staff, students, and frequently rotating residents required lengthier orientation before entering the care environment. Concerns over the distractions caused by overcrowded nurse’s stations were replaced by concerns that people were working in offices at their computers behind closed doors and weren’t talking to each other. Relationships suffered. Some staff strongly resisted the move to POE. Staff found themselves waiting in line to use a computer to enter orders, and work, in general, slowed while we addressed very real shortages of desktop workstations.

To address both the orientation of staff and students and to counter resistance, we assigned nursing staff to work directly with individual physicians in developing standard order templates for common procedures that would expedite order entry. We also had to really LISTEN to what the staff was telling us and not just chalk up their concerns to resistance. And, we had to remove any obstacles that stood in their way of POE implementation.

Fast-forwarding more than a decade, POE has served as an underpinning of a vast array of patient safety improvements in VA. We could not have established a robust system for barcode medication administration without it. POE allows us to collect critical patient care data on both provider and nursing practices and use that information to make care safer. Examples of its use include enabling nurse-driven protocols for everything from weight-based heparin administration to removal of indwelling urinary catheters to reduce urinary tract infections. We use it for protocols for central line and ventilator care and glucose management. We are able to assess prescribing practices and make recommendations for standardizing care. We can crosscheck everything from lab values to drug-drug interactions to allergy information.

It is difficult to remember a time when there was not a computer on each desk, or reference materials available to us at the click of a mouse. And we never have to fight over the medical record nor try to find multiple paper charts. A few years after the successful implementation of POE, a physician leader who had been a strong and vocal opponent of it came into the executive suite to complain that the computers were down and our contingency back up required him to handwrite his orders. “How can you expect me to get my work done? This is unacceptable!” he lamented. My, how times have changed.
Chapter 24

Creating Essential Electronic Patient Assessment Systems

Pamela Pickett, Storm Morgan, Amy Smith and Donna C. Vogel
Today’s dynamic health care environment requires real-time, accurate information that is available to the health care team, regardless of when and where in the system patients receive their care. Immediate access to assessment data is an essential requirement of the system, a basic expectation of the health care team, and vital to patient safety and health care cost containment. Patient assessment systems at the Veterans Health Administration (VHA) have been evolving for several years and more changes are underway. The authors telling this story include Pamela Pickett, a national Nursing Informatics Specialist; Storm Morgan, in dual national roles as the Patient Aligned Care Team (PACT) Program Manager, the VHA’s brand of the patient-centered medical home model in primary care, and the Pressure Ulcer Prevention Coordinator; Amy Smith who is the Deputy Chief Medical Officer for Veteran South Central VA Health Care Network/Veterans Integrated Service Network (VISN) 16; and Donna Vogel who is the Director of Case Management and Telehealth at VA Connecticut Healthcare System.

The development of a standardized nursing admission assessment/reassessment electronic documentation tool was a significant undertaking that we, the Office of Nursing Services Informatics (ONSI) team began in 2008. The Patient Assessment Documentation Package (PADP) is a suite of documentation templates that are designed for use upon admission and for reassessment throughout the inpatient stay. By design, the reassessment template reuses information from the previous assessment, serving as both a cognitive aid and a reference to alert the nurse to changes that occurred since the last assessment. In addition, we designed the PADP to use tagged data elements that provide for national clinical process and outcome reports.

The ONSI Director of the Clinical Application Development Team (CADT), Alicia Levin, convened groups of subject matter clinical experts to review admission assessment templates that were currently in use at individual facilities. These were evaluated to determine if the locally designed template could be updated and adapted for national deployment. The workgroup selected an admission template that was currently being used at the Phoenix VA Medical Center. The Delphi format of the Phoenix template(s) allowed the nurse to save a template that had been started and finish the documentation at a later time. We believe that this functionality is important as it relates to workflow on busy inpatient units.

Various groups of clinical experts were then convened to develop the content and ensure that the PADP met current clinical and regulatory standards. We designed the PADP to allow all disciplines to use the package, however the primary users would be nurses. One component of the PADP is an interdisciplinary care plan that is created and updated
by re-using assessment and reassessment information to develop a plan of care. Our “PADP team” worked diligently to ensure that content reflected the needs of all clinical disciplines. For example, several sections of the PADP provided the nurse the ability to enter a consult order using criteria established by the consulting service and this integrates into our electronic health record. The PADP incorporates the use of branching logic and facilitates the re-use of information (“document once, use many times”). The PADP was also developed to include several hundred tagged data elements (VA Health Factors) that would provide information for national clinical process and outcome reports.

Following the retirement of the ONSI Director of the Clinical Application Development Team, the PADP project was taken over by Nursing Informatics Specialists in Applied Informatics Service within the VHA Health Informatics Division. Several delays ensued as the PADP was being developed and tested. As a result of these delays, a significant amount of time passed and other clinical applications were released, creating situations of possible conflict with the use of the PADP across acute care practice settings. For example, the ICU Clinical Information systems (CIS) are commercial off the shelf (COTS) products that have been purchased and implemented by several VISNs. Due to these products having the capability to include an admission assessment, we found it necessary to establish guidance related to the use of the PADP in an effort to minimize the need for direct care staff to document the same information in multiple places.

Although having the PADP implemented across all settings was the original intent, we reexamined the deployment plan to incorporate the new CIS systems being implemented. While concerns related to duplicate documentation were valid, equally concerning were issues related to the lack of transparent information flow across practice settings (e.g. intensive care and medical surgical units) if two disparate applications and systems (PADP and stand-alone CIS systems) were used. We decided to focus the initial deployment of the PADP on “early adopters”. Then, based upon an evaluation of their experiences (to be conducted in collaboration with VHA Product Effectiveness Office, an expert evaluation team that gathers and analyzes information related to various health IT products), we planned to make recommendations regarding the use of the PADP across clinical settings.

Following a very lengthy period of testing and several iterations of change and repair of defects found in the testing process, we released the PADP nationally in April 2012, approximately 4 years after the initial work was started on the product. Immediately after the national release there were concerns about the content needing to be updated, impact upon
workflow, and technical challenges related to wireless infrastructure. These concerns, combined with some challenging software issues (related to the health factors used for data capture) led us to pause the deployment while an informatics technical patch was developed to address the issues. We believed that the pause would be short (less than 30 days); however, we discovered additional issues that have caused a very lengthy delay in the deployment of necessary fixes. Recently, the Office of Nursing Services decided to not test and deploy the PADP. Concerns related to the inability to update the clinical content and the impact on nursing workflow (feedback related to the time to complete the assessment ranged from 45 -60 minutes) were major drivers behind this decision. Although it was exciting to envision the deployment of a standardized product that would be used across settings, it is disappointing that the project has endured so many delays.

Given the opportunity to rewind this project, there are several things that we might do differently. For example, as designed, the PADP is a lengthy assessment that is the same for all patients. Designing the suite of templates into various modules would have allowed more flexibility for direct care staff to customize the assessment/reassessment using the modules that are applicable to a particular patient's clinical condition. Certain core modules would be required that focus on assessments that all patients need, including skin and falls risk assessments. The ability to update content periodically is also necessary because clinical care and accreditation standards change. In the current VA environment, updating existing software requires that a new project be developed and funding allocated. This is a lengthy process that is not conducive to the rapidly changing clinical environment. Although our involvement in this significant project has been challenging at times (due to the many frustrating delays), it has also been rewarding to work with very dedicated nursing professionals who have worked tirelessly to realize deployment of this product.

Our work is embedded in the VHA's electronic health record and numerous computerized sources of information that are rich with patient-related data. But it is challenging to maximize the use of that data to effectively drive decision-making. Nurses at all levels, especially those at the point of care, have limited time, knowledge, and expertise to retrieve the right information at the right time to prioritize and plan care. The shift to the Patient Aligned Care Team (PACT) model of care, the VA's brand of the patient-centered medical home, is another force influencing the need for ready access to useful data. In this model, we proactively identify patients with the greatest needs and collaborate with them to plan care, especially for those that are high-risk. These
new approaches to planning care for better patient outcomes made us acutely aware of the need for improved technological tools to support systematic and population based assessment encompassing ambulatory care as well as acute and extended care patient encounters.

The Care Assessment Needs (CAN) Score utilizes predictive analytics and data from various sources including VHA’s electronic health record, the Computerized Patient Record System (CPRS) to identify patients at the highest risk. Dr. Stephan Fihn, the VA’s Director of the Office of Analytics and Business Intelligence, led the efforts to develop this high-risk stratification model. It uses standard and multinomial logistic regression to identify patient’s risk of hospitalization or death within 90 day and one year intervals (Fihn, 2012). Data points, predicted to increase from the current number of approximately 160 to more than 250 at the final modeling are used to compare a particular patient’s risk against other VA patients’ risk. These data points include information such as patient characteristics, demographics, coexisting conditions, vital signs, inpatient and outpatient utilization, pharmacy information, and test results (Fihn, 2012). Scores are listed as a percentile with zero being the lowest risk and 99 the highest risk (Fihn, 2012).

Care Assessment Needs Scores are available to primary care staff through the Primary Care Almanac, located on the VHA Support Service Center (VSSC) internal website. These scores were designed for provider use (physician, nurse practitioner, physician assistant) but nurses are also using this information to identify high-risk patients and drive care planning decisions. Rather than using traditional (frequently manual and unscientific) methods to identify high-risk patients, we now use these scores as our baseline determinant. But this information has not always been readily available to RN Care Managers on primary care teams. In early PACT implementation during 2010, only providers had automatic access to the Primary Care Almanac for their panel of patients. We worked hard to change this and now the RN Care Manager, along with the primary care provider, is authorized and encouraged to view the information listed in the Primary Care Almanac, including the CAN scores. These CAN scores are also available on some facility-specific dashboards. RN Care Managers in the PACT now routinely utilize the CAN report to identify high-risk patients for their work focused on intensive care management and care coordination.

While we were thrilled with our ability to identify high-risk patients using the CAN Score, it became clear to us by 2010 that both RN Care Managers and Case Managers need tools and information technology not only to improve efficiency and timely identification of high-risk patients, but also to assist in the monitoring and tracking of patients.
Given the transformation of the primary care RN role to have significant responsibility in coordinating care and managing care transitions, we heard from front line nursing staff that there was a great need for tools to organize workload, manage large patient panels, and set priorities for critical and timely planning and intervention. Consistent with the Future of Nursing report (IOM, 2010) recommendation that health care organizations should engage nurses in the design, development, implementation, and evaluation of health information technology products, the VHA team that brought us the CAN Score is hard at work creating the next essential assessment system. The phased-in deployment of this system is underway, with many facilities being granted access to the system in 2013.

Stories of innovative and creative nurses utilizing useful but separate sources of decision support system data, individualized spreadsheets, and calendar reminders to address these needs provided the rationale for developing a sophisticated information system – the Patient Care Assessment System (PCAS) for deployment across the national VA enterprise. The (PCAS) is a web-based application to provide the PACT RN Care Manager and other members of the PACT team with information and tools to manage their assigned/enrolled patients, especially those that are high-risk (Box, 2012).

One drawback of having so much data available through a variety of resources is the time it takes for the nurse to pull and review data from the various sites. We dreamed of a “one stop shop” for nurses that would allow us to turn on our computers, pick up our phones, and begin our day, making sure the Veterans we prioritized were the ones that needed the care the most. We wanted these decisions to be not only based on statistical modeling as the data we obtain from CAN. We also wanted to prioritize patients who are at higher risk for other reasons: medication risk factors, provider-placed risk flags, homeless or marginally housed Veterans, and high utilizers of emergency care and inpatient hospitalizations. Furthermore, we dreamed of being able to complete or update an electronic Nursing Plan of Care in the course of our interactions with the Veteran. The Nursing Care Plan envisioned would allow the interdisciplinary care team to review the plan and instantly be apprised of important information to support whole-person care. Additionally, the ability to document care management activities in an efficient manner would provide time for nurses to focus on activities more aligned with their education and training.

Our nurses demonstrated resourcefulness and perseverance to locate the data they needed to perform their new RN Care Manager roles, yet the processes were inefficient and inconsistent. We discussed this
Part 2: Acting Strategically to Innovate • Key Message 4: Workforce planning and policy require better data and information

U.S. Department of Veterans Affairs

acute gap in our information systems with the interprofessional team during an early CAN Score presentation. The IT experts and leaders responded to the needs of direct care clinicians by researching the problem further and ultimately developing PCAS. We served as subject matter experts in what was originally called the High-risk Patient Tracker and later renamed to PCAS to more accurately reflect that the system can be utilized for proactive planning for all patients, rather than just those at high-risk. Nurses involved in the design and piloting of this web-based application included national PACT experts to RN Care Managers providing direct care on PACT teams… end-users.

The overarching goal of PCAS was to ensure effective, efficient, and timely patient follow-up, thereby preventing patients from falling through the cracks. It provided the RN Care Manager with a tool to identify specific patient and/or population needs, document the interventions to meet those needs, and a way to effectively monitor and evaluate the patient’s response to the plan and interventions. Lastly, this tool was designed to provide a mechanism to delineate responsibilities of individual team members, which is helpful when we coordinate care and delegate actions to specific staff. This function is particularly useful since the PACT model of care promotes all staff to work at the top of their license and training and includes the need for the RN Care Manager to effectively delegate to other members of the team. Some of these delegated tasks may include calling a patient to follow up on their progress with goals, making patient appointments, arranging travel, or getting medical records from non-VA providers.

When each member of the team functions to the top of their licensure and training, the RN Care Manager can focus on population management and proactive care planning to ensure the right care is provided at the right time, by the right person, and in the right place. This includes timely care management and care coordination, chronic disease management, and wellness and preventive health care planning. To identify patient care needs in a timely manner, the RN Care Manager is alerted to patients identified to be at risk for decline, including patients seen in the emergency department (ED)/urgent care, admitted to the hospital, or discharged from the inpatient setting. This information is readily available from the CAN Score, which contributes to the information in PCAS. More information sources may be included in later PCAS versions. For example, early PCAS development plans were to phase in inclusion of information from the National Discharge List (includes patients discharged from other VAs) and the Fee Package (includes patients in
a community facility paid for by VA). These technological tools further support patient care planning and coordination across transitions of care.

Using PCAS allows RN Care Managers and Case Managers access to critical information at their fingertips. It provides needed information that allows nurses to accurately and efficiently manage the needs of patients in their panel through sorting according to standardized and user-chosen criteria. Patients that have a high-risk of hospitalization or death within ninety days or a one-year time period are clearly identified through CAN information. In addition, resource utilization including emergency department visits, hospital admissions, and use of other VA services is displayed. It identifies new patients, those due for interventions, or patients with abnormal vital signs or test results. For example, the system will identify patients with an elevated blood pressure, glycated hemoglobin test or glycohemoglobin (HbA1c), or cholesterol result on a specific panel of primary care patients during a specific time frame. This ready access to information allows for effective proactive planning prior to scheduled clinic visits, early identification of patients that require follow up, and effective chronic disease management. PCAS is being developed and implemented nationally to primarily allow the RN Care Managers, as well as other PACT team member’s easy access to the following information and options (Box, 2012):

- Task Lists
- Summary of patient risk factors
- Views of patient information across multiple VA facilities
- Storage of information about community providers and care
- Integration with other VA case management systems
- Tracking capacity for patients designated by PACT team as high-risk
- View of site-specific services with entry criteria for patient placement
- Ability to create a care plan and write it back to the VA electronic health record as a standardized note

Another advantage of PCAS is that it allows input from the entire team to contribute to the interdisciplinary care plan to develop and revise patient goals, as well as to note progress and dates goals are met or updates are due. Using an interdisciplinary care plan improves communication and coordination among members of the team and limits duplication of care. Identifying patients’ caregiver(s), functional status, living arrangements, psycho-social issues, and risk identification greatly
improves our ability to meet patient care needs, promote patient safety, and improve staff efficiency. Risk types identified in PCAS (Box, 2012) include:

- High Intensity Medical Management
- Flagged as High-risk
- Suicide Risk
- Homelessness
- Frequent Emergency Department User
- Polypharmacy
- Frequent Primary Care Provider Visits
- Frequent Admissions
- Medication Non-Adherence
- Medication Complication (MUET)
- Operation Enduring Freedom/Operation Iraqi Freedom Operation New Dawn High-risk

To support quality coordination of care, the PCAS provides a framework for completing and reviewing comprehensive assessments; identifying patient problems and goals; developing the plan of care; and implementation, monitoring and evaluating the plan. A follow-up/re-evaluation date is identified in the system, and then the system tracks the follow-up dates to alert responsible team members. This tracking ability is another feature designed to ensure timely follow-up and patient safety. Veterans identified to be at risk, either because of the statistical calculation or because the provider manually identified the patient, may then have additional services ordered including case management. The system also identifies information about key contacts for communication and coordination of care for the Veteran. Utilizing the PCAS also maximizes team effectiveness by promoting effective time management, appropriate delegation, and data-driven decision-making. Overall, the benefits of PCAS support the PACT model of care delivery and effectiveness of the RN Care Manager and Case Manager to positively impact health care delivery through improved quality and cost effectiveness. Given the responsiveness of VHA leaders to support development of tools for nurses at the point of care, RN Care Managers and Case Managers are well positioned to make a significant impact on health care delivery.

Health care organizations must design systems and processes to maximize patient safety and efficiency to effectively compete in today's evolving health care environment. VHA has a history of creating and utilizing essential assessment systems to support these priorities and,
consistent with the Future of Nursing report (IOM, 2010), engages nurses in the design, development, implementation, and evaluation of health information technology products. Equally important, VHA leaders are responsive to changes in priorities and advancing technologies, even when it results in the termination of long-term projects to adopt a superior approach. Through the design and utilization of essential, accurate assessment systems such as the CAN Score and PCAS, nurses have immediate access to consolidated patient information— all necessary for patient safety and care delivery efficiency in the complex VHA system.

REFERENCES


Chapter 24.1

Developing an Outpatient RN Assessment Tool to Facilitate Delivery of Patient-Centered Care

Wendy Morrish and Bree Holtz
In early January 2010 Veterans Health Administration (VHA) initiated the Patient Aligned Care Team (PACT) program. Later that year, the VA Ann Arbor Healthcare System (VAAAHS) was selected as one of five PACT demonstration laboratories (Demo Lab) in the VHA national healthcare system. Each Demo Lab was tasked with either evaluating or implementing new ideas for patient-centered care. The VAAAHS Demo Lab, as described in more detail by Piette and colleagues (Piette et al., 2011), was focused on developing and testing innovative ways of improving patient care through technology-based, patient self-management programs. This was a collaborative effort between the local Health Services Research & Development (HSR&D) service and ambulatory care leadership. Bree Holtz, a new post-doc fellow with a background in health information communication technologies and Wendy Morrish, a practicing registered nurse (RN) with 27 years of nursing experience and clinical knowledge were tasked with the initial development and implementation of a new technology-based product to help achieve the Demo Lab’s goals.

We started our work on an August afternoon in 2010. Our first meeting included Bree, along with other staff from the VAAAHS HSR&D service, one of the Demo Lab co-leaders from the Geriatrics Research Education and Clinical Centers (GRECC), and Wendy as the sole representative from ambulatory care. Among the staff providing support and input were Jennifer Davis (data specialist), Ashley Beard and Molly Harrod (researchers), Mary Hogan (nurse and informatics expert) and Caroline Blaum (physician/geriatrician).

We had a vague, general description for the project that was provided in the PACT Demo Lab proposal. We were to “develop a Navigator system that matches Veterans to programs based on their preferences and needs”, as the proposal described it. However, what we developed was up to us. Less than a week after our first meeting, a smaller core group (Bree, Jennifer, Mary and Wendy) met again. It was at this point that we developed a vision of what we thought this tool might actually look like, how it would function, and how it would be used. During this small group meeting we developed an outline of our vision and began to think about how to operationalize it. Bree developed some storyboards of ideas, much like a strategic plan of how the system would work. With that beginning process, Mary was anxious to begin working on developing the actual tool.

The authors would like to acknowledge Sarah Krein for her invaluable assistance in writing this chapter.
Mary, Bree and Wendy met to decide on the functionality of the tool and determined that the primary end-user would be PACT RN care managers. To help brainstorm ideas, Mary was very attentive to functionality of the application and instructed Wendy to respond to her questions with whatever came to mind. For example, Mary asked “If you had a computer page up, how would like the patient demographics to be displayed?” or “How would you like to be able to go from one page to the next?” At the very hint of an idea, Mary instructed Wendy to tell her what the idea was, as she may or may not be able to create it. She was basically asking, “In a perfect world with no limitations, what would we like this Navigator tool to look like?” This approach provided us with the opportunity to have significant influence and responsibility as this tool could have far-reaching implications for all VHA outpatient RNs. Wendy reached out to other primary care RN care managers to ascertain if the input she had given Mary was on point or not.

While Mary was busy setting up the foundation of the Navigator, we were busy trying to determine what the content of the tool should be; there were two specific steps. The first step was to identify what supplementary care programs were available at the VAAAHS medical center. We asked if there was a binder that listed resources and programs available to Veterans at the VHAAHS that included the contact person, phone numbers, contact email addresses and copies of program brochures. There was nothing written so we set out to gather this information and make it available to everyone in the VAAAHS. Bree then created an online resource guide that would eventually be a key component of our Navigator tool.

The second step was to come up with questions to ask patients that would elicit their preferences and goals to help us in guiding them to our available programs. We scoured journal articles for validated survey items and scoring sheets and consulted with several medical specialists in the hospital to get their suggestions on questions to ask. The initial list of questions for the Navigator came together rather quickly. As it happened, Wendy was already contacting Veterans for other reasons. During her calls she began conducting some pilot testing. She would ask the Veteran if they would be willing to answer some additional questions and provide feedback so we could change the wording in the questions if they seemed awkward. The very first test call was to a homeless Veteran on a TRAC phone. We had thought Veterans in this situation would not want to use the TRAC phone minutes. To our surprise, he said he would be proud and happy to answer the questions, especially if it might help another Veteran.
Everyone Wendy spoke with answered the additional questions. In fact, they seemed a little disappointed that there were not more questions!

Once we had some feedback on the wording of the questions, we worked to carefully consider what would drive the Navigator’s referrals to any of the available programs. We decided that if the question did not directly lead to a program recommendation, that question would be dropped. This took a little negotiation with some of the various program heads, as many of them wanted the Navigator team to use their whole screening process for their particular program. We explained that we wanted to offer additional self-management or care support to Veterans based on their needs and preferences, which the program leadership agreed was important.

We recognized the need to specify which Veterans would benefit from our Navigator tool. While we were working on the Navigator tool itself, other members of the Demo Lab, including Sarah Krein, a HSR&D nurse researcher, had been developing a population-based patient registry. The idea behind using this registry was to identify patients who were considered to be at high-risk for being hospitalized or developing certain complications and who would likely benefit from self-management resources and between-visit support. Thus, our initial registry targeted the diabetic Veteran population with specific risk factors, for example Veterans with a Hemoglobin A1c (HgbA1c) greater than 9 who were not on insulin or those Veterans with an HgbA1c greater than 8 and less than 55 years old, also not on insulin. In addition to the high-risk diabetes groups, we discussed future high-risk target groups such as Veterans with heart failure, depression or patients recently hospitalized, who might benefit from the Navigator program. We had a lot of ideas and a great deal of work under way.

Remarkably, things were shaping up quicker than expected with the development of the actual Navigator tool and soon we had a working, albeit clunky, instrument to test. The questions and referral calculations, however, seemed to be in a constant state of flux with constant changes being made based upon Wendy’s experiences working in the primary care clinic and input from Veterans. The test calls were very helpful and we found that the smallest details could be important. Therefore, Wendy began to keep a notebook to track the changes in the wording of the questions, the order of the questions, and how the calls were being made. At one point, a call was almost made to a Veteran who had recently died. Based on this event, we instituted a process that involved reviewing Veterans’ electronic health records before we made the calls.
in order to have specific background information about the Veteran. We also added a brief chart review checklist of basic information in the Navigator, which the RN was expected to complete prior to phoning the Veteran. We found this process to be an important step, as it helps the RN focus on the Veteran and their most current medical issues and care. Because of Wendy’s past experiences with the Veteran population, it was also apparent that we would need some scripting to facilitate moving from one set of assessment domain questions to the next as well as a running comment box as the Veterans frequently relayed information that was not found in the chart, such as financial difficulties or not knowing what medications they were taking. By early November 2010, we had an integrated product that we could test. This initial prototype included patients identified through the registry, the chart review component, the assessment questions and the referral calculator.

Our initial calls using this newly integrated product led us into new territory, for example some Veterans were not using the VA for the majority of their health care, which would disqualify them from the self-care programs offered. So we added “stops” that would end the assessment when it was clear there would be no benefit to the patient for us to continue. We also added skip patterns if Veterans answered questions a certain way in order to block irrelevant questions and improve the flow of the interview. During demonstrations to the clinical staff, some noted that many questions were related to our standardized clinical reminders, so they asked if we could add pop-up boxes to remind the RN to use the electronic record and complete the appropriate clinical reminder. We then recognized a need for two computer screens to work on notes and look up additional information simultaneously and with ease.

Few Veterans answered the questions in a straightforward manner. Many times, it would have been easy to shift from a Navigator call to a case management call and ask for more clinically detailed information, such as the measures of the Veteran’s blood sugars or blood pressures during the last few weeks. However, it was important for us to keep in mind that the purpose of the Navigator assessment was to offer the patient additional resources or care support, such as care management, based on their goals and preferences. On the other hand, while we were purposeful about clearly identifying the difference between the Navigator calls and a care management call, we also recognized that the Navigator calls provided teachable moments. For example, there was a Veteran who thought Simvastatin was a blood pressure medication, rather than a cholesterol-lowering agent, and the Navigator call was an opportunity
to explain the actual purpose of this medication. We recognized that almost every call required some critical decision-making, clinical judgment and assessment, thus our early thought that licensed practical nurses could complete the calls went by the wayside. Sometimes the Veteran handed the phone to a caregiver to answer, so we added a caregiver component and recognized the need for caregiver support. It seemed the opportunities for positively impacting Veteran care were limitless!

Another key to the Navigator was to have some follow-up with the Veteran after an initial assessment was completed and program recommendations or referrals were initiated. Therefore, we added a process for follow-up calls to determine if someone from the recommended/referred program had made contact with the Veteran, if the program was a good fit, and if the program met the Veteran’s desired results. In terms of call frequency, we opted for a short, two-week interval to ensure care coordination of referrals as well as three, six, nine and twelve-month follow-ups, using parts of the original assessment to help determine effectiveness.

We were ready for roll-out to the primary care RN staff. Our original target date was late December 2010. With the holidays just ahead, we decided to push the date back to late January or early February 2011. We went to the RN staff and made presentations and were initially not met with much enthusiasm. Some of the RNs said there was too much to remember so we created a manual, presentations and tools to assist in the education process. During our training sessions, the RNs also expressed their concerns about not having enough time for the Navigator calls; the average time for an initial assessment was about 20-25 minutes and the longest call was a little over an hour. The RNs heard “a little over an hour” and clung to that time frame. Also, because diabetes is a prevalent condition, some of the RNs were concerned that their assigned panel of primary care patients of approximately 1200 Veterans were almost entirely made up of people with diabetes. We analyzed data on the primary care patient panels, and found the average number of high risk diabetes patients per panel using the Demo Lab definition was 68, which the RN’s felt was “doable”.

However, despite our efforts to answer the nurses’ concerns, their adoption and use of the tool was minimal. Interviews being conducted by some of the HSR&D researchers soon alerted us that the RNs were experiencing a considerable amount of uncertainty and anxiety about their work in general, as they were in the midst of transitioning to the primary care PACT medical home model. Thus,
some RNs expressed concerns that learning and using the Navigator was just one more thing for them to do in this already stressful PACT change process. This helped us to better understand the real barriers to adoption and we were certainly sympathetic to their situation. While acknowledging the demands on the nurses who were coming to terms with the transformation of primary care model of care, we were able, through the PACT Demo Lab, to hire an RN whose sole role was to make Navigator calls and allow us to continue moving forward.

It was really great to have a dedicated Navigator RN on board since she was able to increase the volume of calls being made. With her input, we were able to further streamline the process. She also served as a Navigator trainer and elicited additional feedback from the RNs regarding more user-friendly changes for the Navigator. Having another RN Navigator definitely allowed us to make headway with training the primary care RNs with the Navigator tool. Although some RNs were still struggling with how to integrate use of the Navigator into their everyday work, many recognized the potential value of the tool as evidenced by comments such as: “This will help prevent re-admissions, urgent care visits, and walk-ups” or “The Navigator will help patients to not fall through the cracks.” The input from the RN staff was invaluable and allowed us to fine-tune our product.

In addition to issues related to work flow, it was difficult for some of the RNs to realize that some patients might not choose a face-to-face visit with them. They might prefer another program such as home telehealth or CarePartners, another technology-based program developed by a research team at the VAAAHS that was being offered to patients as a way to supplement their between-visit care. During our initial beta-testing calls using the Navigator, we found that 76% of the Veterans contacted preferred alternate means of care rather than face-to-face visits. This statistic was met with unease by some RNs as it did not meet the traditional definition of RN-patient care. It did, however, validate that we may not be providing the type of care that the Veteran actually preferred.

Veterans have been surprisingly receptive in their responses to the Navigator approach. One Veteran in particular who was well known in the primary care clinic surprised himself and us! He had a HgbA1c around 13%, which is well beyond the higher limits of normal, was morbidly obese, and did not follow the medically recommended plan of care. He was happy to have an unsolicited call and answered all of the questions. When he completed the Navigator call, he had a social work consult and home evaluation for mobility issues as he was identified as a positive fall risk, which was one of the assessment domains. Staff had
tried many times in the past to get this particular Veteran to attend the MOVE program, a VHA weight loss program. After the Navigator call and home assessment, he said he wanted to enroll in the MOVE program. Several months later, he was in our waiting area and had lost 17 pounds. He was really motivated at this point and had signed up for diabetes classes and reported, for the first time in years, he was taking all of his medications as prescribed. We were all excited at this report as previously he had steadfastly refused MOVE and diabetes classes. However, these choices were his choices based on recommendations from how he had answered the Navigator questions; it made all the difference!

To date, our overall experience has been generally positive. We are able to solicit actual Veteran preferences and goals as well as caregiver concerns in a real way by asking the Veterans or caregivers themselves. Moreover, we have developed a system that allows us to use this information to help guide Veterans to programs and resources that assist them with key issues for managing their health conditions. We have preliminary data that suggests that Veterans who have been contacted as part of the Navigator program are more aware of the breadth of programs available through the VA. This increased awareness is evidenced by comments made by Veterans during the calls, e.g., “I didn’t know you had different things I can do.” In addition, remarks made during the calls, such as “It’s nice that the VA cares enough to ask these questions”, suggests that the program is appreciated and well received by the Veterans.

The Navigator tool has been a central product of our Demo Lab, and we are excited about its potential use on a broader platform both within our own medical center and other VA medical centers around the country. We have presented the Navigator tool to a variety of audiences and the feedback has been quite favorable with some wanting to implement this innovative approach to patient-centered care as soon as possible. While we continue to deal with certain technological challenges to make the system more user-friendly and transferable, we now understand the basic structure, function and potential impact of the Navigator tool in facilitating the delivery of patient-centered care. We feel that the Navigator assessment concept for soliciting patients' preferences and needs has potential to guide patient self-management programs that could be used to identify problems not otherwise known during transitions of care which, in turn could prevent readmissions and other known challenges to a patient-centered efficient, effective healthcare system.

It IS an honor to serve, and we have been especially honored with this opportunity to think outside the box and develop a new tool that can
make an impact on patient care. We published an article in January 2013 AJN about the Nurse Navigator tool (Holtz, Morrish & Krein, 2013) and look forward to more collaborative efforts in the PACT model at the VHAAHS.

REFERENCES


Chapter 24.2

Using Patient Assessment Data to Drive Improvements in Care

Sheila Ford
In 2007, I accepted a position as a primary care RN Care Manager, in a small VA outpatient clinic in Oakland, California. By doing so, I was saving myself an hour each day in commute time. The clinic was old, but full service, with multiple specialties, a small lab, radiology department, pharmacy, even an urgent care capacity with telemetry. I happily settled in, with plans of reviewing charts my providers suggested, creating outpatient care plans, and assisting Veterans with their needs as best I could. I had business cards made, and gave my number to everyone.

But my plans changed quickly, as neither the staffing nor the patient access were what I expected. While I knew primary care would be busy, I didn’t expect my panel of patients would be thousands of unique Veterans, with an expectation that we would provide comprehensive care for each of them. Provider wait times were longer than expected, and Veterans often just dropped in because they wanted to be seen sooner than they could schedule an appointment. They came to me.

I also discovered communication concerns. It was not only difficult for Veterans to contact the person they needed. It was difficult for me, as well. Without effective ways to contact appropriate staff within VA, I often simply did their simple tasks; it was quicker and easier than trying to “hunt folks down”. Within months, I was on the phone, in face-to-face visits, and being paged overhead, and I was fulfilling dozens of roles except my own. It was busy and stressful. I often thought that there had to be a better way.

I decided that if I were going to try to change anything, I would need more tools and training. I had a baccalaureate degree in nursing (BSN), which had served me well for a quarter-century, before primary care became the focus of my nursing career. My nurse manager encouraged me to enter a new program, for a Master’s in nursing (MSN) leadership degree that would prepare me for my Clinical Nurse Leader (CNL) certification. When I took my first class, after 25 years away from the classroom, I had to pay my daughter to show me how to use a statistical calculator. By the end of 30 months I was teaching her items I had learned.

“If you want to teach people a new way of thinking, don’t bother trying to teach them. Instead, give them a tool, the use of which will lead to new ways of thinking.”

-Richard Buckminster Fuller
In 2010, the same year I graduated, the VA also launched a new national primary care initiative designated as a Patient Aligned Care Team (PACT). It was a team-based, shared responsibility model that incorporated four staff team members: primary provider (either nurse practitioner, physician assistant or physician), RN care manager, clinical associate (licensed vocational/practical nurse or unlicensed assistive personnel), and clerical associate. The full team was to work with the Veteran to provide coordinated, comprehensive, patient-directed care. Patient panel sizes were reduced down to 1200 Veterans, and extra resources would be provided to the clinics. Apparently, I wasn’t the only one who felt the need to make changes in primary care.

Soon, we had our new RNs in the primary care clinic (three of them!). I had fewer patients to care for, but my responsibilities had multiplied. Working with my team, we all needed to address the following care needs of the Veterans:

- All preventative care/screenings/follow-up,
- Chronic care, dictated by the Veteran’s preference,
- Transitional care, and emergent care follow up,
- High-risk preventative care,
- Care coordination, both within VA and in the community,
- Efficient, timely two-way communication, and
- Improvement of access.

I sat down and figured out the number of hours I worked each year (after vacations and holidays were deducted) and then divided that 1200 Veteran panel into those hours. Even with the smaller PACT panel, it only worked out to 1.5 hours (I called them “Veteran hours”) per year. That meant, if PACT was going to be anywhere near the success that we all wanted it to be, I needed to make the most of my time. In addition to being as organized as I could be, I needed to set limits, find better ways to communicate, and delegate more (while trusting that the job would be done right). Finally, I either needed to find, or work to help create those new tools that would help me do my job.

Fortunately, VA has the most amazing computerized patient record system (sensibly named CPRS) that I’ve ever seen. Which means we have tons of data. I knew that going through that data was going to be an important part of finding out which patients needed what care. I set aside two 30 minute time periods, an hour a day, to begin becoming the “data-driven” RN that I realized I would need to become. In time, I have developed a systematic process of doing just that.
Before the first clinic appointment begins at 8:30 AM, I pull and review information on my patient panel from:

- VA Urgent Care/ED visit data, for follow-up,
- Non-VA community hospitalizations data (we’re not always made aware of it all, but that’s changing), and
- VA hospital data - from any VA around the country.

I use that information as my own morning report, and make sure, as I go through my day, dealing with many items from different areas, that my Veterans on those electronic lists receive the transitional care or the follow-up they need.

Then, at the very end of the day, from 3:30 to 4:00, when the primary provider’s final patient is checking in, I pull more data. This review is for the Veterans who are on the next day’s schedule. Working with the PACT clerical and clinical associates, we quickly review:

- The date the provider requested the return appointment,
- Imaging and lab testing ordered at the last visit for completion, and
- Our performance measures for ischemic heart disease and diabetes, by Veteran.

Having completed this, we have a short period to make calls together. Veterans who schedule themselves back early, with no notation as to why, often have a simple concern that can be addressed by either myself or the provider over the phone (freeing up an in-person appointment). Veterans who need to have labs done are asked, if they can, to come in 60-90 minutes early to get labs done prior to their scheduled visit with their provider (lab results create more effective appointments) or we’ll just give simple instructions or reminders (“Mr. Smith? Can you make sure to take your morning medications as directed, at least an hour before you come in? Your provider wants to see if any adjustments are needed”). Finally, before we leave for the day, we meet with the provider to discuss any concerns such as patients who may need to be scheduled for recommended preventive or chronic care measures or new appointment slots that were opened for the next day.

Is this “working at the top of my license” nursing? I have this debate all the time, from nurses and providers who feel that data review and panel coordination isn’t what they should be doing. I say phooey. When my panel’s performance measures for ischemic heart disease are addressed, I know I’m decreasing my Veteran’s risk for myocardial infarction and stroke.
When a Veteran can be seen on the same day he requests, I’m avoiding complications that could arise from a delay of care and enhancing access. Reviewing data is just as important as making follow up calls, providing education or going over changes to a plan of care. Through the month, working together, we also pull data “prn” (as needed). We review our provider panel every 2 months to identify Veterans whose last clinic visit was 12 months before, or longer. The provider may need to adjust medication dosages based on new FDA guidelines, and we can pull lists of any medication, the Veterans on it, their dosages, last pick up date and estimated compliance. Our LVN Clinical Associate will pull hypertension data, and, if there’s a recently recorded high result, call patients to ask them to drop in, anytime, so we can see if this needs to be addressed.

Addressing all of these data makes a noticeable difference in the way the panel operates. There are more daily appointments. Preventative and transitional care is addressed. The number of “drop-in” patients has decreased because we’re addressing their needs ahead of time. I’m back to thinking about – and doing care plans with my Veterans. The only thing I wasn’t addressing well were the needs of high risk patients. It’s hard to know where to focus. Were the Veterans I tended to spend a higher percentage of time with - more of my precious “Veteran Hours” - really the ones that it benefitted the most?

In 2011, Dr. Stephan Fihn, national Director of the Office of Analytics and Business Intelligence, gave an online presentation for VA staff. These presentations were part of a VA series that ran at lunchtime on the west coast, and anyone could listen in. Dr. Fihn detailed a high-risk predictive tool that he and his team were working on. By using 160 data attributes obtained from various sources, including a Veteran’s unique health record documented in the VA electronic health record, the team was able to target high-risk Veterans (those at higher risk for hospitalization) with accuracy better than any models currently described in the existing literature.

I tried to imagine what my job could be if suddenly I knew who all the high risk Veterans on my panel were. I could review charts and make calls on simple items - medications going unordered or poor compliance percentages, appointments missed, which in this population could make a huge difference. This was more than a great tool, it was my future. I assumed it would take a long time to be completed, as it sounded so very complex. I was lucky.

The next year, in May of 2012, I opened a VA computer application called the “Primary Care Almanac” that I hadn’t looked at in some time, and saw “Care Assessment Need (CAN) Scores” listed as one of the links.
I clicked on it, entered my location, my site and my provider’s name and was amazed. There were scores (expressed as a percentile, ranging from 0, which was the lowest risk, up to 99, the highest risk) that would tell me who in my panel was at the highest risk of hospitalization or death in either 90 days or a year. Most of the Veterans I knew by name but there were some, one with a very high score (a score of 99 indicates an approximate risk of 45% for an event within 90 days), that I hadn’t seen in months.

I emailed Dr. Fihn. Was this analytic tool, ready to use? It was.

Within the week, I had showed the CAN tool to most of the providers and RNs in our clinic. It was like showing them a magic trick. They all wanted to see the names and they’d stare, mesmerized, as they’d remark on its accuracy. The RNs in clinic conferred as we tried to figure out what would be the best way to utilize these data and address these Veterans. We had no path to follow; this was all new. We knew it was very important, though.

The CAN data doesn’t only give you a patient risk score. It also provides information on what types of care management services (home based primary care, telehealth or palliative care) the Veterans are enrolled in, for ease in reviewing and creating referrals. In evaluating the data as it related to the resources, we saw that the Veterans who needed these care management services, in our small clinic, were too often not the ones receiving them.

So, first step: we could target getting the right services to the right Veterans.

The CAN tool provides a list of each Veteran’s diagnoses, which would be helpful to use when sending out shared medical appointment invitations for diabetes, hypertension, congestive heart failure classes or special dietary services. We could work to get more of our higher-risk Veterans into shared medical appointments for their specific shared disease processes. It was our hope that this approach would give these high risk Veterans more focused care. So, second step: we’d try to get more of our higher-risk Veterans into shared medical appointments for different disease processes, hoping this would increase their ability to care for themselves, and decrease hospitalizations.

We knew we’d be doing a lot of this follow-up ourselves. If a Veteran declined to have telehealth (as some did, because it was a daily commitment) or palliative care services, or to switch panels to a home based provider, who would visit them at home, we’d need to still be able to address their high risk concerns. What, we wondered, was the best way to do it?
Chapter 24.2: Using Patient Assessment Data to Drive Improvements in Care

We were using VA cellphones in the “beehives” (the shared space that the members of the PACT use when not engaged in direct face-to-face care) as they allowed us to walk into a private area if someone else began speaking on another line. Some of the RNs had given their cell numbers to their panel Veterans who had extensive concerns, so they could reach their team directly during work hours. It seemed like a good approach to use with all the high CAN score Veterans that didn't have care management services provided.

Most of us had 25-30 Veterans on our panels who had scores that placed them in high percentages of risk (9-45% chance of an adverse event in the coming 90 days). We began making our first calls. It took some time at the start. We would explain why we were calling, and provide our cell numbers. We would carefully explain to Veterans the line wasn’t for urgent concerns (we gave them all the 24 hour hotline number) but if there was a non-urgent concern or question for their provider or nurse, during clinic hours, we were there.

I would, with permission, speak to wives and children, and in a couple of months we were flying through the calls (we did them weekly, since the scores are updated that frequently). We knew the patients, their concerns, and their families. Sometimes if the Veterans had been seen recently, I'd only review charts (you can head off simple, but important concerns doing that, e.g., all of my dialysis patients with high CAN scores had been scheduled, at least once, into appointments on their dialysis days) or leave short messages.

We were concerned at the outset that, on the cell phone, we’d be bogged down with non-nursing concerns that we couldn’t address and have no way to forward them to the people that could. That didn’t occur very often. Communication, within PACT, was also improving. What we did receive were calls from Veterans saying yes, their weight was up, or their glucose was low, or they were feeling a little dizzy every time they stood up after a medication adjustment. These were items that we could quickly address and then follow up in a day or two. RNs in our system also created a great electronic "reminder" tool, with our computer applications coordinator, that makes sure no one falls through the cracks.

We have a PACT “phone note” in our VA electronic health record system, which the outpatient RNs assisted in creating, that makes note entry faster, and allows me to track our individual work loads and types. In the record, I'd enter this quick note that detailed the conversation with the Veteran, my assessment, initial instructions, and the plan, and send the note electronically to the primary provider. Happily, we already had an “alert system” in our electronic health record for this. Thus, if the primary provider was not in the beehive, I’d get a response, usually within
the hour. If the provider was in the beehive, we could usually address the concern right then and there once the patient was identified.

When I reviewed the CAN data, using the month of May as the baseline, I found that we had, after only the first 4 months, increased the use of our care management services (our clinic home telehealth utilization went up by a third) and, by much smaller amounts, steadily decreased both our emergency department utilization rate and our unnecessary inpatient admission rate. I also received positive feedback from families and other health care providers and facilities. My favorite example of positive feedback was when a discharge planner at a non-VA facility called to tell me one of my high-risk CAN patients had been hospitalized. She heard the dejection in my tone, and laughed. “WHAT are you guys doing over there? We used to see him every other week! It’s been at least six months!!”

I’m still a nurse, dealing with the same nursing items (not too many of the non-nursing ones, though) that I’ve dealt with since I started in primary care. But, with a 1200 Veteran panel size, and accountability for so many items, I’m moving towards a role that embraces the use of data in my daily work. I’m looking forward to more tools that I can use not only to make my workday more efficient - but also, to keep my Veteran panel healthier than I ever could before.
Chapter 24.3

Nursing-Sensitive Indicator Data: A Pathway to Better Patient Outcomes

Sheila Thompson
The American Nurses Association (ANA) defines nursing-sensitive indicators as those that reflect the structure, process and outcomes of nursing care (ANA, n.d). Nursing-sensitive indicators demonstrate improved patient outcomes when there is a greater quantity or quality of nursing care. Pressure ulcers are considered a nursing-sensitive indicator because they can be prevented with good nursing care that includes accurate risk assessment, care planning, and nursing interventions such as frequent repositioning. Pressure ulcers are localized injuries to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. The National Pressure Ulcer Advisory Panel (NPUAP) defines six stages of pressure ulcers, each of increased seriousness, based on the amount of tissue loss (NPUAP, n.d.). Pressure ulcers that evolve during a hospitalization are commonly referred to as hospital acquired pressure ulcers (HAPU).

My concern for preventing HAPUs has spanned my entire career. As an operating room nurse one of my most important nursing duties was to properly position and protect patients’ skin to prevent HAPUs from developing during their surgical procedures. When I became a Quality Manager I monitored and analyzed many performance indicators including HAPU occurrences. Now as the coordinator for the VA nursing outcomes database (VANOD) at the Southern Arizona VA Health Care System (SAVAHCS), I not only monitor our performance but can influence the quality of the data reported and help drive improvement activities.

Hospitals have traditionally monitored their own performance by looking for changes in the number of specific events over time, taking action if the number of pressure ulcers, falls or infections increases. Driven by quality recognition programs such as Magnet and Baldrige, as well as new reporting requirements from accreditation and regulatory bodies such as The Joint Commission and the Centers for Medicare and Medicaid Services, hospitals are now comparing their performance against other facilities to measure the quality of nursing care.

But can these rates be compared and do they provide a true picture of the quality of care provided? Does a hospital with a hospital acquired pressure ulcer rate of 2 provide better care than a hospital with a higher HAPU rate of 4? The answer: not necessarily. A quick search of HAPU rates on the web shows there is great variance in how HAPU rates are calculated. Some rates include only Stage III or higher ulcers while others include Stage II ulcers. Some rates are calculated based on 100 patient days of care while others use 1000 patient days of care. In my search of the web, I found rates that required patients be admitted for at least 2, 3 or even 5
days before they were included in the rate. An even more basic question is whether the HAPU rate is an incidence rate (all new HAPUs during a time period) or is it a prevalence rate (all HAPUs on a particular date). These many differences make it very hard to truly compare HAPU rates.

I am fortunate to be a VHA nurse; VHA is a leader in the adoption and meaningful use of our electronic medical record. The Office of Nursing Services (ONS) saw an opportunity to use the electronic record to quantify nursing quality of care surrounding HAPU rates. Working through the VANOD team, ONS created a nursing note template for both the RN initial skin assessments and daily skin reassessments that would automatically pull data on many important attributes including Braden Score, a risk assessment score for pressure ulcers documentation, and of course the occurrence of HAPUs (Braden Scale, 2009). Having a standardized VA database and HAPU rate data set assures that the rate is calculated using the same methodology. This allows all VA facilities to compare rates and look for opportunities for improvement.

As a Quality Manager, I have found that comparative data is always much better received when we are performing well than when we are performing poorly. Our initial VANOD data indicated a high HAPU rate and this was not well received. Much like Elizabeth Kubler-Ross’s five stages of grief (Kubler-Ross & Kesssler, 2005), our nurses and unit managers doubted the accuracy of the data, explained the high quality of care provided in their areas, and denied needing to take any action. With time, and continuing poor performance data, came acceptance that something had to be done.

Our biggest concern was that our Veteran patients were developing pressure ulcers while in our care. I was able to mine the data to the patient name level, which provided a small bit of relief when I found that some of the reported HAPUs were documentation errors; some of the ulcers were community acquired (meaning they were present on admission) while others were types of wounds that were incorrectly documented as pressure ulcers. Mining the data also provided other interesting insights including a surprisingly large number of HAPUs occurring behind our patients’ ears from nasal cannulas. Data analysis helped me better understand the challenges we faced and suggested a direction we could take to improve care for our Veterans.

I shared the data with our facility’s two certified wound, ostomy and continence nurses who lead the SAVAHCS wound care team. These nurses lead our wound care program across the continuum of care from outpatient clinics to inpatient consultation. Armed with the data, the wound care nurses met with our inpatient area clinical nurse managers (CNMs) and clinical
nurse leaders (CNLs). Their first concern was to ensure all nursing staff were well educated in wound assessment, identification and staging of pressure ulcers, wound care, and proper use of the electronic record documentation templates: VANOD Skin Initial Assessment and Reassessment Notes.

Together the wound care nurses, CNMs and CNLs developed an education plan that provides wound care training to new RN employees during their orientation and ongoing training for all RN staff. Their education includes unit presentations, interdisciplinary wound and skin rounds, online education, and a peer review process for all identified HAPUs. The CNLs created wound care tips and reminders using colorful paper. These are placed on the computer monitors using Velcro and changed frequently to constantly update nursing staff with information. The wound care nurses expanded their efforts to include the outpatient areas and developed a patient education booklet titled, “Only You Can Prevent Pressure Ulcers.” Our primary care nurses use this booklet to teach patients who are assessed to be at risk for skin breakdown.

The wound care nurses also reviewed all the different wound care products available throughout our facility and standardized the products across the continuum of outpatient and inpatient care areas, which allowed for standardized training. New products were trialed including nasal cannulas made of softer material as one of the recommended quality improvement steps. Pressure ulcer preventative products such as skin covers and positioning devices were also trialed and purchased.

In 2011 the national VANOD group developed a Daily Skin Report that generates a report of all VANOD notes with pressure ulcer documentation for the previous day. Again I met with the local wound care nurses, CNMs and CNLs to determine how we could best use this new information source. We created a process where I, as the VANOD coordinator, distribute the section of the report that lists any patients identified as having a HAPU to all the CNMs, CNLs and wound care nurses. This process provides real time information on patients with newly identified pressure ulcers so that each case can be reviewed for clinical and documentation issues.

One final pattern in our data showed an unusually high number of patients who developed pressure ulcers died within a few months of the ulcer development. While some literature links this mortality pattern to septicemia (Redelings, Lee, & Sorvillo, 2005), this did not appear to be the case with our data. A more useful explanation for our data was the work of Karen Lou Kennedy-Evans, RN, FNP, APRN-BC, who described the Kennedy Terminal Ulcer (Kennedy Terminal Ulcer, 2011). The Kennedy Ulcer is a unique butterfly-shaped ulcer with a rapid onset that is often followed by death.
within 24 hours. Again our data did not appear to include many of these distinctive ulcers but did seem to highlight an association with end-of-life.

Our facility is a clinical site for the University of Arizona Geriatric Fellow program and the fellows showed an interest in this unusual finding. Now an interdisciplinary team of physicians, fellows, wound care RNs, hospice RNs, and informaticists in the hospice unit have joined with Karen Lou Kennedy-Evans to develop a longitudinal study of pressure ulcer occurrence at end-of-life. The intent of this research is to learn more about end-of-life skin failure as associated with pressure ulcer development and prevention.

Over time and with continued improvement activities, we have lowered our pressure ulcer rate though we have not yet reached our goal of zero HAPUs. Documentation errors still occur. Pressure ulcers still develop. But our nursing staff and leaders have rallied around improvement activities, using the data to monitor progress and suggest improvement activities. We have all discovered that accurate and timely patient outcome data can be invaluable in improving patient care.

REFERENCES


Chapter 25

Enhancing Staffing Methodologies to Improve Workforce Management

Alan Bernstein and David Przestrzelski
In this chapter we tell the story of VA nursing's initiative to enhance staffing methodologies in our collective commitment to improve workforce management. Alan Bernstein, who is currently the Associate Director for Patient Care Service for VA North Texas Healthcare System (comparable to Vice President for Nursing/Patient Care Services in the private sector), was the Director for Workforce and Leadership in the national VA Office of Nursing Services (ONS) from September 2007 until December 2012. In this ONS role he directed the development and implementation of the Veterans Health Administration (VHA) Nurse Staffing Methodology program including national policy development, program development, national education and chairing the Staffing Methodology Steering Team. David Przestrzelski is the Associate Director for Patient Care Services at the Charles George Veterans Administration Medical Center (VAMC) in Asheville, North Carolina. He was a founding member of the Staffing Methodology Steering Team, and was instrumental in all aspects of the development and implementation of the VHA Nurse Staffing Methodology program. In this chapter, we describe the steps we took to create a significant shift in our VA staffing methodology, a process that continues to evolve.

Our story starts as it does in many health systems. Most modern day VA nurse executives have heard the question from nursing staff, “Why don’t we use a patient acuity system or classification system for staffing?” The short answer is that we did. In the early 1980s, VA completed the final validation stages of its Automated Management Information System (AMIS) Patient Classification System. At that time, VA's Office of Manpower Planning modeled our system on the San Joachin classification system, which was based on a multiple regression analysis of weeks of time and motion studies conducted. When this office was disbanded, as VA nursing leaders we found ourselves with a rapidly changing healthcare delivery system that exponentially increased outpatient visits and continuity of care clinics while closing inpatient units and slashing patient lengths of stay. We knew that without revalidation with time and motion studies, the classification system would not hold validity for the changing complexity of our health care system and our patients. Staff nurses began to question that validity as care was accelerated and intensity of nursing care escalated.

In 1989, Margaret Thomas, who had been an Associate Chief Nurse at the Hines VA in Chicago, Illinois during the last of those time and motion studies, was serving as the Chief Nurse Executive at the Richard L. Roudebush VAMC in Indianapolis, Indiana. Her expertise in planning and policy led her to recognize that our staffing needs were
not being met with the conservative nursing hours per patient day (NHPPD) that were specified in the outdated classification process.

A master of relationship building, she attracted the chiefs of fiscal service, human resources and primary care along with one of her associate chiefs to hear an organized presentation about nurse staffing from each of the nurse managers. She specified the data to gather. Her comprehensive list included historical census, patient turnover, patient demographics, patient functional status, patient diagnostic and procedural categories, the layout of the nursing unit, the availability of support services, the academic preparation and experience of the unit staff, the skill mix of staff on the unit, the care delivery model, the numbers of medications administered, the engagement of medical and nursing trainees and other factors specific to the work unit that might impact staffing.

Mrs. Thomas encouraged each nurse manager to engage the staff in a discussion of the importance of the various data elements in deriving their recommendations for NHPPD on inpatient units and direct staff support in outpatient and procedural areas. The collaboration with other services provided a reality check and strong challenging questions to ensure clear consideration of all factors and to gain the support of important resource partners.

Concurrently, Vernice Ferguson, who was then the VA Chief Nursing Officer and Ronald Norby, who was at that time the Chief Nurse Executive at the Long Beach, California VA Medical Center were often in Indianapolis as the Sigma Theta Tau International Honor Society Center for Nursing Scholarship was being constructed and both were directly involved. Conversation during one of those visits about the Indianapolis staffing expert panel experience led to a VA task force focused on nurse staffing that included Mrs. Thomas, Marianne Dunn from the Buffalo, New York VAMC, Ron Norby and Dr. Paulette Cournoyer from VA Central Office-ONS, Sue Hudec who was then at the Washington, DC VA, Jane O’Donnell from the Gainesville, Florida VA and Margo Donaldson Snider from the Houston, Texas VA along with a Joint Commission Consultant.

This task force concluded that the industrial engineering model had outlived its usefulness and the expert panel nurse staffing methodology was the best mechanism to utilize the professional expert judgment of nurses to analyze the myriad of data elements inherent in staffing and to recommend appropriate levels of staffing. This expert panel staffing methodology was strongly endorsed by The Joint Commission. Dissemination through training for such a widespread initiative predated, and hence did not have the benefit of electronic training methods and relied on written training materials.
and telephone conference calls. In addition VHA did not require the expert panel approach through a written national policy (directive or handbook). However, with excitement about the new approach, most VA medical centers pursued the expert panel methodology and developed staffing recommendations. Timing was not optimal for making major resource changes in nursing. The early 1990s were resource-challenged times for VA and the nation faced a significant nursing shortage. Nonetheless, expert panel staffing methodology increasingly became accepted as a valid mechanism for determining nursing resource needs, solidified through a descriptive analysis of the methodology published in 1996 (Valentine, 1996).

At the same time, Congress was hearing from their constituents and Veterans organizations about their concern that “VA needs more nurses.” Congress realized that they did not know how to measure “more” or whether more nurses were truly needed to meet Veterans' needs in VA. Congress acted and mandated the establishment of a valid data based mechanism for determining nurse staffing needs for Veterans Health Administration. In 2003 the Office of the Inspector General (OIG) conducted a review of VHA nurse staffing and in 2004 published part of a review of all VHA clinical disciplines. The OIG concluded that VHA must establish a single methodology for determining appropriate staffing for each clinical discipline within VHA. VHA charged the national program office for human resources, later re-organized to the office of Workforce Management and Consulting (WMC) to develop a national directive that guided clinical disciplines to comply with the OIG recommendation. WMC developed a draft for a national policy in 2005, however that policy remained unpublished and in WMC until late 2010 (Department of Veterans Affairs, 2010).

In September 2007, Alan Bernstein was appointed as the ONS Program Director for Professional Development. In that role he was responsible for national strategic planning and program development for nursing workforce initiatives; staffing methodology for VA nursing personnel had become a priority item. That same month the ONS National Nurse Executive Council (NNEC) convened a retreat in Cleveland, Ohio in which they developed the nursing strategic plan that included a goal to fully develop and implement a standardized, reliable Nurse Staffing Methodology. The Professional Development goal 1a of the strategic plan was to create or adopt an automated scheduling system across the VHA enterprise from which data could be derived to support the work of nurse staffing expert panels. However, goal 1b: development of an automation-supported staffing methodology process became the priority focus for the next several years. In 2008,
ONS and the NNEC experienced organizational and leadership changes and Alan became the Director of Nursing Workforce and Leadership and was charged to facilitate the NNEC Workforce goal group which was co-chaired by two nurse executives: Linda Boyle from Anchorage, Alaska and David Przestrzelski from Asheville, North Carolina.

Many people were involved in the VHA journey to develop a standardized national nursing staffing policy as well as a standardized national approach (and policy). We realize that we may fail to include all those who made contributions, however some are noted here. Initially a workgroup lead by Sue Haddock, nurse researcher from the Columbia, South Carolina VAMC reviewed literature about nurse staffing, seeking a solid evidence base for making staffing decisions. Little existed beyond correlational research and co-variables identified in the original expert panel work. Linda Aiken had done foundational work in regard to ICU staffing and determining that greater numbers of RN staff decreased adverse events (Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Aiken, Clarke, Sloane, Lake, & Cheney, 2008). While the research group was doing their work, Karen Ott, ONS Program Director for clinical practice, worked with us to look at the work that had been done by WMC on the national staffing directive. Through collaboration with Brian McVeigh in WMC, we developed a draft for the national staffing directive, which we disseminated in 2010, prior to the publication of the national directive on Staffing Methodology for VHA Nursing Personnel (Department of Veterans Affairs, 2010).

By late 2008, it had become apparent to us that there was still not solid evidence available to definitely provide direction to ONS on a singular staffing methodology. The workgroup decided to resurrect the 1996 expert panel process and incorporate developing data sources. Four VA regional groups, referred to as Veterans Integrated Service Networks (VISNs) had already implemented standardized VISN wide nurse staffing approaches. Each VISN had unique attributes in their process, however all were using some form of expert panel based decision-making. We invited representatives from each of those VISNs to a meeting in Atlanta, Georgia along with key stakeholders from national VA program offices (VA Central Office (VACO)). We invited guests who might help us in our deliberations, including a representative from the Chief Financial Office and Eileen Moran, who had been working on approaches for standardizing parameters for physician staffing in outpatient settings using relative value units (RVUs) as a workload indicator. Also in attendance was Ron Norby from the original expert panel staffing group, this time as Director of Desert Pacific VA Healthcare Network. The meeting was well attended and provided
direction to ONS. We determined that utilizing workload and administrative indicators through a robust data collection was indeed the way to go.

Marla Weston was working in ONS as the Program Director for Nursing Workforce during this time. Marla had done work with nurse staffing experts outside VA with Ann Van Slyck, founder of Van Slyck and Associates. Van Slyck and Associates later changed their company name, becoming “Labor Management Institute” (LMI) which is a data repository for NHPPD in all care settings. LMI publishes their report annually and is used by many organizations for comparative analysis of NHPPD data (Labor Management Institute. 2013). Marla offered to set up a meeting between ONS and nationally recognized nurse staffing experts, including Kathy Malloch and Ann Van Slyck. At the Phoenix, Arizona meeting the expert advice to ONS was “just do it”: do something, because nobody is really doing anything. ONS representatives left the meeting with the intention of publishing a national nurse staffing directive for VHA that would utilize an expert panel approach to evaluate workload (both patient care and administrative) indicators to determine NHPPD and nursing skill mix in every care setting.

In 2009, extensive work was underway to develop the staffing methodology and the national nurse staffing directive. We determined that we would initially develop staffing modules for inpatient care settings that included acute medical-surgical, critical care, long term care and mental health. This would be Phase I of implementation. Phase II would include specialty care areas such as emergency department, operating room and primary care settings. Finally, phase III would be the development or acquisition of a comprehensive “resource management system” (RMS) that would automate data collection linking with the VHA payroll system and human resources. The RMS would include a daily staff scheduling tool and the ability to pull reports related to nurse staffing for analysis and determination of NHPPD.

The experts from across VHA provided expertise in creating the staffing modules. The work group blended the modules from the VISNs that had already been exploring these issues. Dave Przestrzelski and Teresa England became the experts in module development. Teresa England had been working on module development at Mountain Home, Tennessee VAMC and became the expert in creating the formulas and drafting spreadsheets that are currently used today across VHA. Her exemplar chapter in this book describes her work on this effort. Karen Ott and Alan Bernstein wrote the national nurse staffing policy with the input of the Staffing Methodology Steering Team. Becky Kellen, the ONS Associate Director for Workforce and Pam Picket, Informatacist led the team.
to develop indicators for the process. Teresa England, Dave Przestrzelski and Linda Boyle pursued development of educational materials for a national pilot in collaboration with the VHA Employee Education Service.

The Staffing Methodology Workgroup collaborated with members of the Office of Nursing Services Informatics (ONSI) team to establish the indicators and data sources that expert panels would need to use for the staffing methodology process. Table 25.1 provides a summary of variables included in the staffing methodology indicators. Once the indicators were established, a toolkit was developed that provided guidance outlining the various data sources and reports that could be used by unit and facility expert panels. Nationally developed reports from the VA Nursing Outcomes Database (VANOD) as well as locally developed reports were included in the Staffing Methodology toolkit, which was published to the ONS Staffing Methodology website.

Table 25.1 Workload Factors for Projecting VA Nursing Personnel Requirements

<table>
<thead>
<tr>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average daily midnight census</td>
</tr>
<tr>
<td>Average # admissions/day/shift</td>
</tr>
<tr>
<td>Average # discharges/day/shift</td>
</tr>
<tr>
<td>Average length of stay/diagnostic categories</td>
</tr>
<tr>
<td>Average # of diagnostic categories/day</td>
</tr>
<tr>
<td>Average # transfers in/day/shift</td>
</tr>
<tr>
<td>Average # transfers out/day/shift</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Turnover Rate (Fiscal Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
</tr>
<tr>
<td>LPN</td>
</tr>
</tbody>
</table>

| Unlicensed Assistive Personnel                             |

<table>
<thead>
<tr>
<th>Additional Workload Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative support available (i.e., clerical, nurse manager, charge nurse)</td>
</tr>
<tr>
<td>System support available (i.e., bar code administration, electronic health record, patient transport service, housekeeping, food service)</td>
</tr>
<tr>
<td>Performance improvement projects</td>
</tr>
<tr>
<td>Patient characteristics (i.e., mobility, skin integrity, pain management, cognitive status, risk for falls, risk for infection)</td>
</tr>
<tr>
<td>Academic affiliation impact (nursing, medical, etc.)</td>
</tr>
</tbody>
</table>
The toolkit provided guidance about how existing reports could be used to provide information needed by expert panels. For example, medication administration represents a significant amount of workload in the inpatient setting, yet a report that provided the number of medications administered was not available to expert panels. There was, however, a bar code medication administration (BCMA) report that provided the number of medications successfully scanned. This report was included in the toolkit to provide a “proxy” for medications administered. The creation of a report that identified number and type of medications (by mouth, intravenous) has been identified for development when necessary files are available in the VA corporate data warehouse. Enhancements of nationally available reports occurred as staffing methodology was implemented. For example, the admission /discharge /transfer reports have been enhanced to include information related to turbulence, length of stay and average daily census. As more care settings implement staffing methodology, we recognize that it will be necessary to identify additional data sources, and develop reports and toolkits for those care settings.

Five VISNs were chosen to participate in the Staffing Methodology Pilot. All medical centers in those VISN’s were expected to implement the methodology by September 2010. In late fall 2009, we hosted a three day, face-to-face pilot training session where we reviewed the methodology with representatives from the pilot sites. Each facility identified a staffing methodology coordinator who attended along with key nursing personnel and the nurse executive. These VISNs were charged to evaluate the functionality of the tools and provide feedback in regard to the application of the process as well as the ease of data mining. We then established monthly staffing methodology calls with coordinators to assist them with implantation and justification reports. The coordinators, who identified areas in which they were having difficulty, set the call agenda. All the members of the steering committee hosted the calls.

The pilot was completed and feedback revealed little to no difficulty with the modules. However, data mining was an issue that many organizations faced. Access to data, data silos and data analysis were topics brought forward. This became the focus of our next initiatives, and point to the ongoing nature of staffing methodology as a professional responsibility that is implemented in complex and constantly changing health care systems.

In this chapter we have summarized a period of intensive work by VA nurses to model a marked improvement in staffing methodology, a process that continues to evolve. In addition to creating the methodology, the outcomes of this work have been disseminated to share with the
Part 2: Acting Strategically to Innovate • Key Message 4: Workforce planning and policy require better data and information

U.S. Department of Veterans Affairs

discipline of nursing (Fasoli, Fincke & Haddock, 2011). We believe our work begins to answer the question of staffing needs in providing nursing care not only to our Veterans, but all patients. And in the process, we have been able to demonstrate that effective workforce planning and policy are an investment worth the time and resources invested.

REFERENCES


Chapter 25.1

Creating a Staffing Methodology: A Personal Search for Excellence

Teresa England
While I am currently the Associate Director for Patient/Nursing Services at the Salem VA Medical Center (VAMC) in Salem, Virginia, my experience developing tools for use in staffing methodology began in the 1990s. As a new nurse manager I sought to find a data-driven approach to justify nurse staffing requirements on my medical/surgical unit. At that time I was using the tools and methods I had gained in my master’s degree program under the direction of Dr. Janne Dunham-Taylor at East Tennessee State University. As a relatively new nurse manager, I had gained understanding from finance courses taught by Dr. Dunham-Taylor and our VA nurse executive, Mr. Juan Morales, who taught with Dr. Dunham-Taylor. It was exciting to me as I felt I was learning under the direction of my nurse executive. I must admit, I tailored my assignments to meet my needs on my unit in the VA, therefore, hoping to gain his full attention and possible approval.

My colleague on another medical/surgical unit at our facility, Lori Bird would collaborate with me as we worked in Microsoft Office excel to develop a tool that would be user friendly yet meet our requirements for staffing assessment at the time. We had been using patient acuity tools that had been developed in the 1980s. However, we found methods to define things more clearly within those tools so we could predict nurse staffing needs for our units. I remember sitting with her in my office, brainstorming, as we sought to define simple things such as productivity measures.

As time passed and my experience expanded, I accepted a position as the Administrative Officer for Patient/Nursing Service, working directly for Mr. Morales. I was responsible for staffing methodology for all inpatient units and decided to expand my toolbox in order to meet facility needs. I visited Cathy Locher, nurse executive at the Huntington VAMC and a former data informatacist for the VA. Cathy and I used her work-study analysis to justify our staffing hours per patient day to include workload such as turbulence (admissions/discharges/transfers). She worked with me to ensure we were capturing all nursing workload measures beyond the basic midnight acuity measures. Turbulence (admissions/discharges/transfers) was a concept that had not been considered in the past. Cathy and I worked diligently to determine the best method for incorporating this concept into existing tools.

My initial worksheets were always developing, expanding in order to consider unit specific needs, which is the heart of VA staffing methodology for nursing personnel. I would create new calculators (with my colleagues), new tools that would be easy to use and allow me and others to constantly assess new policies. One policy I remember that impacted us was isolation procedures for Methicillin-resistant Staphylococcus aureus (MRSA) and other nosocomial infections. Nurses were now mandated to gown and
glove for MRSA. This was a significant workload consideration and I developed a method to assess the time they were now spending that they had not spent before. Other workload indicators that had to be considered were patient transport time and one-to-one observation.

Adding those considerations to the already developed tools made them more cumbersome and I knew I would have to find a way to make them easier for the end user or administrators to understand. All of this impacted nursing hours per patient day, which was the heart of our tool: determining averages across patient units. Mountain Home VAMC had a useful tool. VHA is organized into 21 regions referred to as Veterans Integrated Service Networks (VISN). In 2006 and 2007 I visited many medical centers in our VISN 9 to assist them with the tools I had available. I also consulted with VISN 6 and met with Rebecca Fox, a VA staffing expert at the time. VISN 6 had developed staffing methodology tools for nursing long before VISN 9. I used that information to guide our tool development for VISN 9. Ms. Fox used different calculations to determine requirements. Yet our tools, although they had used different calculations, generated comparable results. There are several methods to analyze staffing (units of calculations), for example some use annual data while others use weekly data. Regardless, they all projected the same needs in the end.

I was surprised to be asked by the VA Office of Nursing Services (ONS) to join a group meeting in Atlanta, GA in 2008 and later in Miami, FL. Mr. Alan Bernstein, ONS Program Director led the group with the goal to deliver a standardized staffing process and policy across the VA. At those meetings, I was impressed by the many attendees with so much knowledge of VA and the history of staffing methodologies. I was relatively new in my development of tools for staffing methodology and was impressed that my views and processes were studied and discussed by the group. As a group, we collaborated to develop a standardized tool for all VAMCs to follow. I realized at that meeting that my tools were not consistent with the expert panel based staffing methodology being discussed, however, they could be used to assist others as they embarked on the journey of refining staffing methodology.

I agreed to further develop the final tools we use now and incorporated aspects of extensive input from the many tools that were available. I used the staffing model developed by VISN 6 and incorporated a daily calculator developed by the Boston VAMC to formulate an easy to use excel document. I also discarded a great deal of what I had developed in VISN 9. This resulted in a process that was consistent with the true meaning of expert panel based staffing methodology. I am very proud
of our work and know it was done as a team. We gained input from many VA regional networks, many medical centers and took the best of everything to develop our current staffing tools. Mentors such as David Przestrzelski, Linda McConnell, Alan Bernstein, Sue Haddock, and Betsy Shortle have ensured we now have a product for VA medical centers to use that is based on nursing research and evidence based practice.

We thus made it possible for all of us to assign nursing hours per patient day and assist VA nurses to analyze staffing requirements in a cost effective and evidence based method. Each unit develops a summary of data, description of needs and proposed staffing needs based on data that reflects typical patient needs and workload factors by day of week and variations by work shift. As is evident, the comprehensiveness and detail of the assessment provides a well-grounded data based report that supports the unit’s staffing needs for forecasting a nursing personnel budget. This method projects staffing requirements by day of week, work shift (days, evenings, nights) and by skill mix.

In summary, many talented VA nurses with expertise in nurse staffing in partnership with union representatives came together to ensure a product that we can all be very proud of. A team approach assured a product that could be used across the nation. It is quite an accomplishment for all who were involved and is a process that continues to evolve as feedback is obtained through monthly calls with staffing methodology coordinators across the nation. Tools have been redesigned for ease of use and new models for specific patient care settings are being developed sensitive to these settings' realities. Our work, we believe, has made it possible for all VA nurses to work within a pattern of staffing practices that support appropriate nursing care for our Veterans
Chapter 25.2

A Nurse Executive’s Perspective on Using Data to Determine Nurse Staffing Requirements

Linda McConnell
VA nurse executives have historically used various automated or hand calculated methods to determine the number and type of nursing personnel required for the delivery of safe and effective patient care. With the advent of the VA expert panel based staffing methodology, we were able to establish standardized processes with “built in” calculator tools that require specific data elements to be collected and analyzed to predict the required number and type of nursing personnel required. The calculator tools allow for local facility level input so the numbers of registered nurse (RN) and total nursing hours per patient day (NHPPD) could be determined by each facility. Nurse executives, having implemented the staffing methodology, are able to demonstrate how data drives decision making related to nursing budget and staffing requirements.

The deployment of the automated approach for the nurse staffing methodology was a significant challenge in the field initially. In some Veteran Integrated Service Networks (VISNs), the nurse executives worked together to implement the methodology, to share knowledge and gain support at the VISN level for use of this new methodology. As the nurse executive at James H. Quillen VA Medical Center, Mountain Home, Tennessee, I believe this collaborative approach was useful to the facility and nursing staff.

At each facility a staffing methodology coordinator was identified to lead the implementation process. At the James H. Quillen VA Medical Center, Dr. Teresa England provided leadership for the initial implementation. Dr. England identified sources of data that would influence executive decisions about nurse staffing requirements and guided nurse managers to consider using other unit specific data. Nurse managers identified their unit-based expert panel members and assisted unit staff to identify the data that reflected nursing workload indicators.

To generate this information, nurse managers first defined data elements for each patient care unit: patient population and demographics such as types of patients on the patient care unit, including age, frequent diagnoses and population risk factors. They also identified frequent nursing tasks and the defined complexity of the patient population. Additional relevant workload indicators were included in nurse manager reviews of staffing requirements: geographical layout of the nursing unit and its impact on nurse time and the availability of support services. They then collected and analyzed unit specific data. This included key elements such as bed days of care, patient turnover, staff turnover, number of medications administered, the level of education of nursing staff (associate, baccalaureate, or master’s degree preparation), the
number of years of nursing experience of the unit staff, off-duty factors that impact staffing requirements and other unit specific characteristics.

The unit-based expert panel reviewed all data and recommended the percentage of RN, licensed practical/vocational nurse (LPN), nursing assistant (NA) and other technical staff as well as the RN and total NHPPD that their unit required. When determining the recommended NHPPD, we gave consideration to the nursing care delivery model on the unit and the nursing care requirements of the defined patient population. We also considered related data that identified specific nurse challenges such as “patient sitters” for vulnerable patients requiring one-to-one observation, monitor technicians for telemetry, and specialized skills such as chemotherapy administration. We recognized that differentiating the number of nursing staff that worked on the unit in direct patient care and those in non-direct patient care roles was important in our analysis. Data that supported time for staff participation in quality improvement activities, committees, evidence based practice and educational activities were factors we included in our considerations. Patient satisfaction and patient outcomes such as hospital-acquired pressure ulcers were also part of the data review.

Data were entered on the various standardized, automated staffing methodology spreadsheets and the staffing requirements were calculated. For example, to determine the required leave/off-duty factor for a specific patient care unit, we enter the vacation and sick time typically used by staff members to calculate a unit replacement factor. We include data for vacation, time, sick time, education, research and administrative time in our review. Total staff required on the unit is calculated after consideration of requirements for direct and non-direct nursing care time. Formulas built within the spreadsheets predict the variance from the current budget of full time equivalent employees (FTEs) and the required FTEs to meet the recommended NHPPD. This process made it possible for us to use unique unit specific data to drive decisions about staffing.

Nurse managers and their staff members were creative and very comprehensive in compiling their unit specific reports. The spreadsheets with formulas enabled accurate and consistent approaches to predicting staff requirements. The analysis of data showed managers and staff how direct patient care time and non-direct time were both important components of building a patient care unit budget. Average salary costs are required data fields for the spreadsheet and these data are used to calculate projected personnel costs for the unit.

We also recognized that we could use external resources to compare our data analysis and further evaluate it. Facility unit-based expert
panel members recommend the NHPPD, both RN and other support staff, based on comparisons with similar VA units, comparable units as defined in the Labor Management Institute (LMI), and similar types of units as defined by the National Database for Nursing Quality Indicators (NDNQI). The facility expert panel and I, in my role as nurse executive, review the unit data before determining staffing requirements.

We have discovered that this has been an improvement compared to methods previously used to predict personnel costs for budget forecasting at the unit level and has been particularly valuable when planning for organizational change that impacts nurse staffing. In the process of implementing the staffing methodology, we were able to demonstrate to ourselves and others that we could improve the care of Veterans through responsible staffing based on the complexity of factors that predict its adequacy.
Part 3
Conclusions
Conclusions

VA Nurses Stories: A Foundation for the Way Forward
Chapter 26

Summarizing the Process of Transformation

Phyllis Beck Kritek
In my introduction discussing the *Why and How of this Book*, I noted that a convergence of forces catalyzed my commitment to this enterprise. One of those forces was my conviction that “in the VA was an amazing panoply of nurses’ stories, and they need to be told”. Each distinct story in the book, like a thread in a tapestry, adds dimension, contrast, and perspective to the book, contributes to the whole. Each author adds a unique voice, both alone and with colleagues who share a story.

These stories can also be viewed as a composite; one can study the tapestry itself, finding colors, themes, noteworthy images. By using the four key messages of the IOM Future of Nursing report to shape this project, we were weaving a tapestry of transformation. Thus, one can study the tapestry for clues to transformation. As I noted at the outset, our authors “were a critical mass of frontrunners in not merely influencing and responding to the recommendations of the report, but in having actually implemented many of recommendations embedded in the report, many before the report emerged.”

So now I am standing back a bit, reflectively studying the total tapestry, noting the images, the clues, the possible templates for others drawn to the challenge of transformation. In this scrutiny of the big picture, we can find the patterns others might find that can guide their response to that challenge. We can describe the tapestry as a summary of the book.

**The Brightest Light**

As a lifelong student of the work of Monet, I have learned the importance of light in visual art. In our tapestry, the brightest light, the yarn that is luminous, is the driving catalyst for all our authors: Veteran-centric care. Every author eventually reminds the reader that this is why we do what we do. In the words of the authors of Chapter 16.4, we have made “a pledge to our Veterans.” Repeatedly, even when the book’s authors confront the most onerous challenges and obstacles, they persevere because of this pledge. There is transcendence in this commitment. Realizing that this may serve as a template, one can hope that our readers will notice the impact of patient-centered care, how an investment in this conviction makes all the difference. I think many nurses will identify with this intentionality.

This “brightest light” in our tapestry takes patient-centric a step further, however, by introducing “patient voice” into the transformation process. It is not enough to simply use ones expertise to give good care.
One must first engage the patient: ask the Veterans and their families what would work best, how they hope to experience their environment, what programs are needed or how they might be improved, indeed, what might best be discontinued. A shared decision process alters what nurses do and how they do it. This is genuinely transformational, setting an example for what might ensure superior health care services. This imperative to integrate patient voice shapes our stories and changes their outcomes.

The Warp and Woof

Weaving effectively depends on the quality of the loom, the assurance of a viable warp and woof. In our stories, we find that looms made a difference. The most early and apparent was a commitment to what the authors describe as “bidirectional” communication, the deliberate creation of a structure that ensured the purposeful exchange of ideas and information between the various levels of a large, complex, high stakes organization. Staff nurse voice had an impact and nurse executives would both speak and listen. Ideas emerge from every level of the organization, and if they are good ideas, they are discussed, designed, piloted, evaluated and disseminated. While the Chief Nursing Officer describes in Chapter 1 her commitment to bidirectional communication, the stories demonstrate that this became a norm, an organizational practice.

The national leaders in the Office of Nursing Services (ONS) act only in structured interaction with what our authors call “the field”, the rich array of nurse experts throughout the system. ONS realizes that they have experts everywhere, and structuring the tapestry under the guidance of these expert co-weavers is common sense. Channels of exchange are created to ensure bidirectional communication, policies established to institutionalize bidirectional communication, and using this loom becomes the norm. Thus transformation becomes structurally grounded.

A second significant loom is related to the first: shared governance. The exchange of ideas can merely be a blue sky exercise unless structures are in place to deliberate, take action, make recommendations, create policy, establish action plans and accountabilities, doggedly follow up, and increase what many authors call “spread”, getting the word out to everyone and selling the idea. Shared decision-making alters the process. Governance structures emerge from identifiable needs for these
structures, where individuals and groups discover the need for a loom for the work of weaving. This gives solidity and a future to transformations. While Chapter 2 described the intent of shared governance, throughout the book it manifests as a way of doing business, an organizational practice implicitly judged as essential.

Images of Innovation

The IOM Future of Nursing report urges nurses to concentrate their efforts at transformation on three key focal areas: nursing practice, nursing education and nursing leadership. A cursory review of the stories in this book would seem to indicate a focus on nursing practice, but a more careful analysis reveals that transformation is described in all three focal areas. In all cases, they are stories of innovation. The stories describe nurse lead initiatives that created something totally new, something needed to address a problem or improve a service, something that would simply be better for Veterans or their families, something that would change and improve the VA in some substantive way. While numerous partnerships are described, nurses as the prime movers in these partnerships are the norm. These are the images of innovation on display in our tapestry.

Transforming Nursing Practice

Images of innovation that focus on nursing practice are the most apparent in our tapestry. As the Chapter 17 stories relate, sometimes VA nurse innovators create transformations in very specific practices embedded in existing structures. Other times whole new images emerge, such as the Clinical Nurse Leader (CNL), a practice role that VA helped craft and has implemented more completely than any other health care resource, a process described in the stories in Chapter 5. The refinement and integration of the CNL role has not only improved the care of Veterans but also provided models of role refinement for the entire health care community.

This frontrunner role is even more apparent in the stores in Chapter 6, where the idea of a medical home as an emerging primary care model in the national health care conversation is created out of whole cloth by VA nurses and their partners, with the concurrent emergence of the roles of primary care RN case manager and RN care manager. While conversations about medical homes were encouraging some modest pilots throughout the nation, in the VA it became a large scale
nation-wide initiative, dramatically altering the primary care provided to Veterans and showing others not only how to create a medical home but also the essential role nurses play in that model and its potential for quality care.

In creating the medical home model that had fit with the VA, and responding to the need for more primary care providers, the VA created what may be its most powerful contribution to nursing innovation, breaking through the barrier of state controlled practice restrictions on Advanced Practice Registered Nurses (APRNs). Invoking the Federal Supremacy provision in the US Constitution, VA nurses were able to ensure that APRNs practiced to the full extent of their education and training, as recommended in the Future of Nursing report. Thus the Patient Aligned Care Team (PACT), the VA medical home, has physicians, physician assistants and APRNs as primary care providers on these teams. The PACT, as described in Chapters 4 and 6, and invoked repeatedly in many other stories, brings together many pieces of the innovations described in this book, including Veterans’ voice, with the Veteran as the center of the PACT. The PACT also evolved as a catalyst for transitions in care, coordination across historically disconnected services, expansion of the avenues available to access care. Concurrently, Community Living Centers (CLC) emerge, a further expression of Veteran-centric care that attends to transitions in care, creating real homes for Veterans in need of these homes. Nurses are the engines in this evolution as evidenced in the stories in Chapter 7, with examples interwoven through numerous stories throughout the book.

Role expansion as an innovation reaches a new level of creativity in the stories told in Chapter 8 as the commitment to Veterans is merged with innovations in practice. These stories describe a new care provider role, the Intermediate Care Technician, created to integrate the competencies of medics and corpsmen from all branches of the military services who had left active duty but could now make a substantive contribution to Veteran care, freeing up other providers, including nurses. It is an excellent example of the concept of tapestry, where many of the threads woven through all the stories come together in a new, promising, truly innovative new image.

Transforming Nursing Education

Our tapestry provides images of nursing practice innovations, yet moves beyond these to stories of images of innovation in nursing education. The Future of Nursing report places a strong emphasis on
furthering nurses’ education through a variety of initiatives. The VA stories in this book provide templates. The VA was one of the first health care systems to require Baccalaureate preparation for advancement of its nurses, creating a myriad of pathways to achieve this outcome. The powerful impact of VA Nursing Academy, described in the stories in Chapter 10, becomes the nexus of successful academic partnerships, complemented by the Chapter 15 stories of nurse practitioner (NP) residency programs sponsored by the VA Centers of Excellence in Primary Care Education. They also highlight VA leadership in interprofessional education, a national movement still finding its anchor but already a reality in the VA.

The Future of Nursing report recommends doubling the number of nurses with doctorates by 2020, and the stories in Chapter 12 tell of VA leading in this effort, describing the partnership with the Jonas Foundation to support VA nurses taking part in meeting the goal. The report recommends implementing nurse residency programs to ease nurses in transitions from student to practitioner, and the stories in Chapter 11 describe VA leadership in meeting this goal, complemented by the stories in Chapter 15.

These chapters provide images of VA’s role in formal educational endeavors that contribute to nurses’ national pursuit of transformational education. VA also, however, creates its own educational initiatives to meet the learning needs that continuously evolve in complex health care environments. Chapter 13 stories describe the expansion of business competencies in nurse leaders through capitalizing on the expertise within the VA, and Chapter 14 stories focus on expanding evidence based practice competencies utilizing the knowledge and skills of an array of nurse leaders. In both of these “in-house” endeavors, nursing education has transformed how VA nurses do what they do, changing the culture of the total enterprise.

As recommended in the Future of Nursing report, VA nurses are lifelong learners. This is simply necessary to be a VA nurse, as the steady stream of innovations requires expanding competencies. Chapter 9 stories describe the innovative leadership role VA nurses are playing in using telehealth to extend access to care and to maximize the use of scarce professional resources and ensure quality outcomes. Interestingly, they also indicate how these innovative practices in the VA are being integrated into academic programs where VA partners with schools of
nursing. While Chapter 9 stories give a specific example of this life long learning, most stories eventually tell the story of learning to innovate, of searching out relevant evidence before implementing an innovation, of studying existing models to imagine a new, better one for a specific health care need of Veterans.

**Transforming Nursing Leadership**

Early in the book, in Chapter 3, three nurse authors who are also nurse leaders in the VA provide an introductory image of transformative leadership in their experiences in the VA. This sets the stage for stories of leadership and how leaders have transformed the enterprise of VA nursing, creating images of innovation that shape the role of the nurse leader in the VA. The commitment to evidence based practice is manifested in the stories of transformative leaders: data counts.

Hence, the stories in Chapter 19 tell how nurse leaders use the sophisticated data systems of the VA to organize change and create innovations that optimize quality. In the stories in Chapter 23, an array of stories tell of how VA nurses use data and evidence to manage change and add value, to improve work at the point of care through mining data that can make a difference. They find the data, then lead the change. This same pattern emerges in the stories in Chapters 24 and 25, where assessment and staffing are transformed through data merged with competent leadership and imagination. In all these stories, readers are provided with insight into the utility of a national data base to guide decision-making and action plans, echoing the recommendation for the comprehensive collection and analysis of data recommended in the Future of Nursing report.

Some leadership transformations are familiar to nurse leaders and are described from a VA perspective: Diversity in Chapter 20 and Magnet Status in Chapter 22. In these cases the VA leadership community merges with larger health care initiatives to translate the opportunity to a transformative leadership opportunity within the rich options afforded by the VA.

While these specific chapters are noteworthy for their focus on a specific dimension of leadership, all stories are really stories of leadership. They tell us about a nurse or group of nurses who saw something that could be transformed, specifically in a way that would benefit Veterans, and then set out to create the transformation. In that sense, they are indeed all leadership stories.
Part 3: Conclusions  • VA Nurses Stories: A Foundation for the Way Forward

Partnerships as Cohesion

The tapestry provides us with vivid images of innovation. They cohere through a sometimes explicit and sometimes implicit network of relationships. This is described repeatedly in our stories as an investment in partnerships, planned and focused networking. While the stories seem responsive to the Future of Nursing report recommendation that nurses should be prepared and enabled to lead change to advance health, they are not stories of a silo mentality. They describe partnerships.

The first and most evident partnerships are the ones achieved through bidirectional communication and shared governance structures and practices. Many stories describe specific partnerships where stakeholders are systematically identified and linkages established. VA nurses do not achieve their goals going solo. They partner.

Some chapters tell stories of specific partnerships. Chapter 16 tells stories of how partnerships are used by nurse leaders to achieve identified goals. Chapter 18 tells stories of interdisciplinary partnerships that promote best practices for patient care. Chapter 21 tells stories of innovative projects with new partners. And as noted earlier, all the education chapters point to academic partnerships. These are highlights, a focus on a specific expression of partnering. Yet, the reader will quickly discover that all stories in this book point to partnering, and hence serve to provide both context and cohesion for our tapestry.

The somewhat legendary technological sophistication of many VA projects, processes and resources serve as an assumed asset in many of these stories, almost an invisible acknowledgement. They are a key resource in creating and sustaining partnerships. The far flung boundaries of the VA make technology essential to partnering, and VA nurses are experts in utilizing this technology not only for enhancing patient care but also for exploring emergent challenges, sharing information and data, marketing ideas, educating large cohorts, conducting meetings and conferences, organizing research teams…. there is a long list here. In all cases, the technology serves to make the partnerships possible, and then ensures that they can be sustained.

Invitation to Weaving

Leadership counts. I noted this at the beginning of the book. Most of the stories in this book recount the impact of my coeditor, Cathy Rick: her values as a leader become manifest in these stories. They are not
merely the key concepts of a group of nurses but a shared consciousness that is experienced as a “given”, as that which is simply true. This places her as master weaver in our tapestry, a place where the final product, a collage of stories that create images of innovation, can guide our readers in replication, adaptation, adoption, or imagination. It is our hope that you too can create your tapestry, find your brightest light, master your warp and woof, partner creatively with technology as a resource…and join us in transforming nursing.
Chapter 27

Looking Forward

Cathy Rick
Privilege, honor, inspiring, fulfilling…these are descriptors that are commonly used by the VA nursing community as we talk about our work. The stories told in this book are just the tip of the iceberg when I think about the power of the VA nursing talent pool. We’ve described our contributions to advancing VA nursing practice and its impact on the profession and healthcare industry. We take great pride in aligning our work with the four Key Messages of the *IOM Report on the Future of Nursing* (2010). We are confident that the details of each story can be adapted for public and private sector settings.

Our journey began over a decade ago with a vision to enhance our collective efforts to realize a vision of full scope of practice based on data-driven evidence for nurse-led innovations to shape an efficient and effective care delivery model. We envisioned an approach that would embrace academic partnerships and foundations of research. The context for our work was always focused on interprofessional interdependence while we crafted our nurse-led initiatives.

When we decided to write about our journey, we had a well-paved path for our vision. That path required a national approach that embraced shared decision-making and bidirectional communication. It was the national nursing strategic plan and the structure of a shared governance model that brought the vision to life and unleashed the talent of the VA nursing community. Hundreds of VA nurses and their partners have been engaged in the success of this journey. Working hand in hand with the national nursing program office, field-based experts have made the right things happen. This has been hard work and we’ve experienced plenty of hurdles but we stayed focused on what nursing can and should do in order to shape the best care for our Veterans. We attended to today’s challenges while shaping our desired future state… and it worked!

This book has been a labor of love and a clear demonstration of how VA nursing can be viewed as a national treasure. The two-plus year venture of writing the book took commitment and perseverance by a cast of thousands; ok, maybe not thousands, but it sure felt like it. I am personally grateful to each and every author, their colleagues and VA nurse leaders across our enterprise for the support they showed throughout this endeavor. We all realize that the innovations and initiatives described in this book have not been accomplished by our nursing efforts alone. So, I extend gratitude to all of our nursing colleagues as well. This collection of VA nursing stories would not
have come about without the expertise, support and tireless effort of Dr. Phyllis Kritek who worked with us every step of the way.

Where do we go from here? Well, we keep doing the important work of shaping the most efficient and effective care imaginable. A solid foundation has been laid. The healthcare industry and federal government have committed to multiple complex changes for transforming care delivery approaches, payment structures and locus of control. VA nursing will continue to advance health and lead change within the VA healthcare system and beyond.

Looking forward will require constant vigilance to shared decision-making and open communication with a willingness to think and act beyond whatever today’s challenges are. It will be important to address nursing-specific requirements for technological advancements that relieve workload and enhance safe practice as the journey continues. Additionally, shaping the ever-evolving desired future state will require additional innovative efforts that embrace partnerships that will achieve patient-driven care. As I move on to my life as a VA retiree, I leave the rest of the story in very capable hands.