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Development of Patient-Centered Team-Based Care Certification

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Walden University

College of Health Sciences

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Stephanie Stewart

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2018

Abstract

Development of Patient-Centered Team-Based Care Certification

by

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MS, Walden University, 2012

BS, University of Colorado at Colorado Springs, 2005

Project Submitted in Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

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Abstract

Accountable care units (ACU™) provide a new model for integrated patient care. The ACU™ promotes patient centeredness in nursing units as team members work collaboratively with physicians to improve patient outcomes and reduce unwarranted variations. A health system in the southeastern United States incorporated the ACU™ as part of their care model. These units were held accountable for their clinical, service, and cost outcomes but lacked a validation process to demonstrate the effective utilization of their data. The purpose of this DNP project was to create a patient centered care (PCC) certification process, guided by the Donabedian model, that would provide hospital units the opportunity to access their process and quality improvement outcome data and to improve patient care. For this project, 12- key individuals were interviewed to gain their perspectives and input on the development and implementation of the PCC certification process. Results from the interviews were compiled and reviewed for common themes, which included Magnet™ recognition, patient experience, current unit goals, and hospital strategic plan. Using the results of the interviews, a PCC certification procedure was created to outline the steps required to achieve certification; and, an application was developed to provide a standard format for quality and process improvement projects and associated outcomes reporting. The certification procedure will be implemented in the health system in the next fiscal year. Evaluation of the effectiveness of the program and future refinement will be controlled by the Nursing Shared Governance. The project may promote positive social change as the staff nurses on the individual units use the unit metrics to improve patient outcomes and reduce variations in care.

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Dedication

This project is dedicated to my mentors, who have helped me succeed and have not let me stray from the path, and to my family for supporting me through all the struggles and tears.

Acknowledgments

This project is dedicated to my family, whose support helped me succeed and who understood the long hours and were patient when they kept hearing “not now.”

Table of Contents

List of Figures	iii
Section 1: Development of a Patient-Centered Team-Based Care Certification	1
Patient-Centered Team-Based Care	2
Phase 1	4
Phase 2	5
Phase 3	6
Problem Statement	7
Purpose Statement.....	7
Project Objectives	8
Significance to Practice.....	8
Evidence-Based Significance of the Project	9
Implications for Social Change in Practice.....	9
Definitions of Terms	10
Assumptions and Limitations	10
Summary	10
Section 2: Review of Scholarly Evidence.....	11
Specific Literature.....	11
Benchmarking.....	11
Certifications.....	13
General Literature	15
Shared Decision Making.....	17

Collaborative Relationship.....	18
Conceptual Models and Theoretical Frameworks	20
Section 3: Approach.....	23
PCC Certification Guidelines	23
Project Design.....	23
Project Evaluation Plan.....	24
Summary.....	25
Section 4: Findings	26
Introduction.....	26
Findings.....	26
Recommendations.....	31
Strengths and Limitations	33
Section 5: Dissemination Plan	35
Dissemination Plan	35
Analysis of Self.....	36
Summary.....	37
References.....	39
Appendix A: PCC Application Template	48
Appendix B: Patient Centered Care Certification PGR.....	49

List of Figures

Figure 1. Health systems patient-centered team-based care model 3

Section 1: Development of a Patient-Centered Team-Based Care Certification

Healthcare organizations exist, at the most basic level, to provide care for patients. In their seminal publication *To Err is human: Building a safer health system*, Kohn, Corrigan, and Donaldson (2000) demonstrated that hospitals have failed at keeping patients safe. The Institute of Medicine (2001) responded to this information with the publication *Crossing the Quality Chasm* which recognized patient-centered care as one of the six elements of quality care. Caregivers have utilized technology to ensure checks are being completed and triggers are activated when necessary. Nurses now scan medications at the bedside to ensure patient safety. Despite a multifocal approach utilizing technology, staff engagement, and patient-centered care, unintended deaths in the hospital are the third leading cause of fatalities (Johns Hopkins, 2016).

Healthcare is a complex and ever-changing industry tied to a competitive, consumer-driven market. Patients are actively shopping for their care, and hospitals respond by striving to meet consumer expectations. In response, a health system in the southern United States developed the patient-centered team-based care (PCTBC) model in 2014. The PCTBC model guides the structure and processes of the hospital unit by creating a culture in which medicine and nursing collaborate to provide care that is patient-centered. Within the PCTBC model are specific nursing units that have been recognized as Accountable Care Units (ACUs™). ACUs™ are high-functioning units that have been designed to create positive outcomes for specific patient populations. In ACUs™, there are daily rounds in which the patient care team (doctor, nurse, patient care technician, pharmacist, and case manager) perform a Structured Interdisciplinary Bedside

Round (SIBR™) that actively engages the patient in the discussion. These rounds were not implemented on all units due to lack of physician availability. Hospital administrators and care teams want to be able to develop a mechanism to verify that these designated units are meeting benchmarks to qualify them as a high-functioning ACUs™. Therefore, the aim of this project is the development of a patient-centered care (PCC) unit certification for the PCTBC ACU™ that will demonstrate sustainable benchmark levels and high-performing team skills.

Patient-Centered Team-Based Care

The PCTBC model is based on the following pillars: unit-based teams, nurse and physician coleadership, patient-centered multidisciplinary rounds, and unit-level performance management. This model is displayed in Figure 1. Within the pillars of the model is an outer ring that contains the daily components of care for the care team. This is a cyclical pattern that focuses on structured communication activities and includes change of shift team huddle, bedside shift report, assessment, diagnosis, multidisciplinary rounds, implementation, and evaluation. The inner ring consists of the nursing focus of care: quality safety checklists, patient goals, timely care, engagement, hourly rounding, leader rounding, and the nighttime care bundle. The patient is at the center of the model.

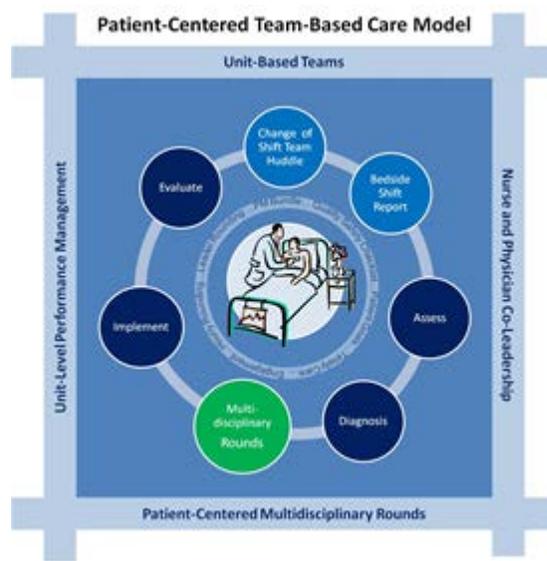


Figure 1. Health systems patient-centered team-based care model.

The health system leadership recognized that this model was not creating a new dashboard or action plan; instead, it was addressing the culture of the unit and the hospital. The PCTBC model can be applied to any nursing unit within the hospital. The model represents a change in the culture of the hospital favoring increased collaboration between nursing and medicine to promote improved clinical, service, and cost outcomes.

The PCTBC model was incorporated into the health system first, followed by the incorporation of the ACU™ structures into targeted units within the hospital to further incorporate collaboration and patient-centeredness. The members of the health system recognized the value in the ACU™ and decided to incorporate it into the PCTBC model on targeted units. The PCTBC model with the incorporated ACU™ structure was implemented in three phases.

Phase 1

The first phase of the modification of the PCTBC model on specific units was the implementation of the ACU™ following the model created at Emory University Hospital (Stein et al., 2015). The innovative design of the ACU™ addresses the asynchronous care that is created by the traditional model of care where physicians, nurses, and ancillary disciplines do not work cohesively to coordinate patient care, but work with segmented focus (Stein et al., 2015). The ACU™ is a clinical microsystem within the hospital that incorporates unit-level nurse and physician coleadership, unit-level performance management, structured interdisciplinary bedside rounds (SIBR™), and unit-based teams (Stein et al., 2015). The ACU™ design is very similar to the design of the PCTBC model; the primary difference is the use of SIBR™ versus multidisciplinary rounds that do not include the patient as an active participant. The use of SIBR™ promotes increased patient engagement and collaboration with the care team during the course of the hospital stay.

The ACU™ design geographically assigns patients to a unit based on the admitting physician group. For example, patients admitted to the family medicine medical group are assigned for room placement on a specific unit instead of throughout the hospital where a bed is available. The management dyad is responsible for the clinical, service, and cost outcomes produced for the unit (Castle & Shapiro, 2016; Stein et al., 2015). The ACU™ design provides physicians the opportunity for improved communication with the staff as the targeted nursing unit reduces the total number of staff involved in their patients' care. Each day, patient rounds are completed using the

SIBR™ model (Stein et al., 2013). The SIBR™ relies on a standardized communication format that has an embedded quality-safety checklist and collaborative cross checks to ensure that timely and up-to-date information is communicated to the patient and the care team. The model acts to reduce the barriers of clinical inertia, fragmented care, and low accountability with a shared mental model of teamwork (Stein, 2015).

The first ACU™ was on a Nursing Improving Care for Healthsystem Elders (NICHE)-designated Accountable Care for the Elderly (ACE) unit in April 2014. The ACE unit, which specializes in meeting the needs of the elderly population, is managed by the Palmetto Senior Primary Care group in conjunction with the hospital internal medicine group. Since then, five units have been added. Each unit has a different medical group focus: internal medicine, family medicine, neurology, senior primary care, hospitalists, and cardiology. Some units have specialty certifications such as heart failure, stroke, and NICHE. The units range in size from 15 to 26 beds and are managed under a dyad or triad leadership design with the teams actively managing their outcomes.

Phase 2

Phase 2 began with the introduction of the staff certifications. Certifications are available for employees who have been working with the units for more than 6 months and have completed an introductory workshop about the history of the ACU™ and structured communication processes that are in place. Unit level nurse management complete the training first to facilitate the role-modeling and buy-in of the staff. The nursing staff, patient care technicians, and ancillary personnel all receive training. The nursing staff, patient care technicians, and ancillary personnel all receive training. The

certifications specify high-performing behaviors involved in the structured processes incorporated into the ACU™ model (Stein, 2015). The residents and medical students of the teaching hospital included in this system are encouraged to participate in the process. Staff can be certified in SIBR™, bedside shift report, and rounds manager. High-performing staff members can also be designated as patient-centered care coaches and help facilitate the certification process. The SIBR™ certification is available to all staff members who participate in the rounds: physicians, nurses, care techs, case managers, social workers, pharmacists, and rehabilitative services staff. Bedside shift report certification is available to all nurses and care technicians on the unit. The rounds manager certification is available for charge nurses, assistant nurse managers, and nurse managers. The coach certification is available to staff members identified by management as being consistent high performers who excel in one or more of the certified skills. The certification is obtained through in vivo observation by the nursing research and program development department or those who have obtained the coach certification. The individual certifications have been successfully implemented, and all units have at least one PCC coach.

Phase 3

This project was Phase 3: the design and incorporation of a PCC unit-based certification. The current policy states that any ACU™ that has been active for 1 to 2 years is eligible for PCC certification. This project will define the process by which an ACU™ will attain the certification.

Problem Statement

The PCTBC model did not have guidelines and processes in place to determine the qualifications for the PCC certification. This created a problem, in that the ACUs™ are held accountable for their data but are not recognized for demonstrating the impact that knowledge has on outcome performance. The certification verifies that the unit is meeting and sustaining select benchmarks for ACUs™ that are demonstrating sustainable high-performing behaviors, engaging in collaborative improvement processes, and meeting Magnet benchmarks related to nurse sensitive indicators. This was an important issue because it provided the units with information on how to achieve the certification and promoted the units being sustainable, high-performing areas. High performance levels in hospitals are associated with a number of factors, including positive organizational culture, responsive senior management, effective performance monitoring, retention of the workforce, effective leadership, expertise-driven practice, and interdisciplinary teamwork (Kutney-Lee et al., 2015; Taylor, Clay-Williams, Hogden, Braithwaite, & Groene, 2015).

Purpose Statement

The purpose of this project was to design a procedure for obtaining PCC certification for the health system. The project focused on the creation of evidence-based practice certification guidelines so that the units could demonstrate that they have sustainable high-performing team-based behaviors. The aim of this project was the development of a framework consisting of procedures and guidelines that will create the PCC unit certification for the PCTBC model. The procedure was tested with current data

to identify whether the units are currently tracking relevant data. The certification will be designed for the use of the health system to promote high-performing units.

Project Objectives

The objective for this project was the creation of the procedure to obtain PCC certification. The sustainable metrics that are considered vital to ACUs™ were defined. The project also identified which Magnet benchmarks should be incorporated to promote PCTBC.

Significance to Practice

This project has significance in relation to nursing as a profession and the role of the nurse in patient satisfaction. Structured communication provides the nurse the opportunity to reinforce the care plan and the quality and safety measures in place for the patient. The certification will promote the use of structured communication activities and collaboration that may lead to improved patient outcomes (Benike & Clark, 2015).

The PCTBC model promotes the nurse as an equal partner with the physician. The role of the nurse is promoted as an integral and meaningful part of the daily rounds completed by the interdisciplinary team. The nurse is a valued part of the team who is actively engaged by the physician because of their frontline care of the patient. The service excellence components identify the role of the care team in the increase of patient satisfaction scores.

Additionally, the use of established benchmarks for the improvement of patient and unit outcomes were promoted by this project. Benchmarking is an approach to implementing best practice in the most cost-efficient manner and to measuring quality

improvement (Ettorchi-Tardy, Levif, & Michel, 2012). The identification of benchmark levels encourages high performance by establishing a minimum threshold.

Evidence-Based Significance of the Project

One of the aims of this project was to substantiate the collaborative relationship of nurse and physician through the use of team-based and interdisciplinary communication. Promotion of the collaborative relationship can reduce the perceived differences in power that are present in the nurse-physician relationship. The aircraft safety model in which standard processes are used with shared goals and accurate communication to promote positive outcomes can be applied to improve the nurse-physician relationship (Zwarenstein & Reeves, 2002). The relationship is developed by each team member recognizing the skill set possessed by the other, as well as the underlying shared philosophical goal of patient care (EL Sayed & Sleem, 2011; Thomas, Sexton, & Helmreich, 2003; Zwarenstein & Reeves, 2002). Nurses and physicians will be able to strengthen their relationship through the findings of this project.

Implications for Social Change in Practice

Social change can be elicited when an act is performed for the betterment of others, the community, or society at large. The social change elicited in this project is within the health system community. ACUs™ currently exist all over the world (J. Stein, personal communication, August 22, 2016). This project elevated the outcomes and demonstrated sustainable high-performing behaviors of the ACU™ within the health system.

Definitions of Terms

In an innovative approach to the hospital unit and the care of patients, some terms are not readily understood. The *Accountable Care Unit (ACU)*TM is a geographic inpatient area consistently responsible for the clinical, service, and cost outcomes it produces (Stein et al., 2014). *Patient-centered team-based care (PCTBC)* is a model that signifies the importance of the patient as a priority at all times. Under this model, units have nurse and physician coleadership, with unit-level performance management and structured communication processes to promote consistent patient care.

Assumptions and Limitations

A limitation of this project is that the PCC certification was limited to the health care system. The process of certification was pilot tested on one unit and not all of the ACUsTM. Additional limitations include the assumption that the certification will improve the quality metrics for all units.

Summary

The PCTBC model incorporates structured communication processes into a hospital unit where patients have been geographically placed based on their admitting hospital group. The model has been introduced in phases (i.e., the incorporation of the ACUTM and the promotion of individual certification in structured communication processes). The next phase is the creation of PCC unit certification.

Section 2: Review of Scholarly Evidence

Specific Literature

This project involved designing evidence-based practice certification guidelines for obtaining PCC certification within the health system. There were no guidelines in place to determine the qualifications for the certification. The completion of a literature review provided evidence to support the certification procedure and design.

A literature review was completed focusing on the concepts of certification and benchmarking. These topics were selected based on their relevance to the development of the PCC certification. Boolean search was conducted in Medline, CINAHL, OVID, and Google Scholar. Results were narrowed to materials in English with abstract available that were published in 2010 or later. A review of the abstracts was completed to narrow the results to those related to healthcare. Reference lists were reviewed for any potentially valuable sources of information or repeatedly cited articles from outside the date range.

The literature review provided a definition of benchmarking as an internal comparison or external comparison. The sources for external and internal benchmarking were identified. The identified themes of certification are the impact of individual certification and organizational certification.

Benchmarking

The PCC certification should serve as the benchmark for ACUs™ that are demonstrating sustainable high-performing behaviors such as meeting Magnet recognition criteria, Hospital Consumer Assessment of Healthcare Providers and Systems

(HCAHPS) scores, and Joint Commission benchmarks so that the organization can attain high quality marks. Reporting of benchmarks provides a level of transparency to the public about the outcomes of the organization. Benchmarking allows an organization to gauge its performance against other organizations and identifies high performers and opportunities for process or structure improvement (Agarwal, Green, Agarwal, & Randhawa, 2016).

As demands for transparency and improved patient outcomes increase from patients, government agencies, and third-party payers, benchmarking has become a rapid indicator that many hospitals are participating in (Martin, 2016; von Eiff, 2015). These pay-for-performance measures in public and private settings mandate reporting measurements, and benchmarking is a method for measuring that performance (Burstin, Leatherman, & Goldman, 2016; Epstein & Street, 2011). Patient satisfaction scores such as HCAHPS (2015) scores are also used in pay-for performance measures.

Benchmarking is a continuous process of comparing performance indicators and process structures internally and externally to promote improvement (von Eiff, 2015).

There are four types of benchmarking: internal, competitive, functional, and generic. Each type of benchmarking provides different information. *Internal benchmarking* involves measuring the hospital against internal structures. *Competitive benchmarking* entails comparing the organization's performance to that of top-performing competitors (Martin, 2016). Comparison to the competition identifies strengths and weaknesses that may impact a patient's desire to seek care from a specific facility. In *functional benchmarking*, processes are compared against similar industries

(von Eiff, 2015). Finally, *generic benchmarking* compares processes against a nonrelated industry (von Eiff, 2015). The different types of benchmarking provide multiple approaches to identifying areas for improvement. Comparison data can be obtained from internal sources such as dashboards or external sources dedicated to acting as repositories for information. The Agency for Healthcare Research and Quality (2013), for instance, provides resources for the measurement and evaluation of benchmarks. Organizations such as the American Nurses Credentialing Center (ANCC) set benchmarks as well in their Magnet Certification (ANCC, n.d.; Kelly et al., 2011). The Magnet benchmarks are based on nurse-sensitive indicators that are tracked through the National Database of Nursing Quality Indicators (NDNQI; ANCC, 2008).

Benchmarking aids in the determination of best practice and helps to promote superior performance (Brown, Donaldson, Burnes Bolton, & Aydin, 2010). Changes seen from setting benchmark standards within an organization range from small to large and may vary based on the goals set (Benson, 1996). The number of certified personnel can also be used as a competitive benchmark (Briggs, Brown, Kesten, & Heath, 2006).

Certifications

Certifications can be applied to a hospital, unit, or individual to promote best practice. The process of attaining certification can help in identifying structure or process issues that can be corrected to improve outcomes (Friese, Ghaferi, Birkmeyer, & Banerjee, 2015). Certifications provide formal recognition of achieving or maintaining specific standards of knowledge or performance.

The American Board of Nursing Specialties (2005) defined *certification* as “the

formal recognition of the specialized knowledge, skills, and experience demonstrated by achievement of standards identified by a nursing specialty to promote optimal health outcomes” (p. 1). Nurses with higher education (i.e., bachelor’s degree in nursing and above) have a higher proportion of certifications (Mchugh et al., 2013). The perceived value of certification is higher in nurses who are certified versus nurses who are not certified (McLaughlin & Fetzer, 2015). Nurses who have certifications have higher perception of informal power and support (Fitzpatrick, Campo, & Lavandero, 2011; Williams, Lopez, & Lewis, 2013). Certification can help to promote patient safety and quality care (Briggs et al., 2006). The individual certifications for the PCTBC model can be applied as an internal benchmark (Briggs et al., 2006).

The process of seeking certification can help organizations to identify systematic problems. Certification may also be referred to as *accreditation*. Accreditation is a process of review that demonstrates the ability to meet predetermined criteria and standards of accreditation established by a professional accrediting agency. Accrediting agencies can help to provide structure to promote self-governance and define the scope of practice (Chassin & Baker, 2015). Certifications such as those provided by The Joint Commission can set standards to promote the highest levels of quality and safety (The Joint Commission, 2016). The American Nurses Credentialing Center (ANCC) Magnet Recognition Program identifies facilities that have made a commitment to quality improvement and increased the autonomy of nursing in direct patient care (ANCC, n.d.; Friese, Ghaferi, Birkmeyer, & Banerjee, 2015; Kelly et al., 2011). Magnet recognition requires participation in quality improvement and benchmarking.

Once a certification has been attained, there are set criteria for the process of renewal that can prevent the individual or agency from becoming complacent. Renewals for most certifications are on a 2- to 5-year cycle (ANCC, n.d.; Kelly et al., 2011). Individual certifications such as medical-surgical certified registered nurse renew every 5 years with required continuing education hours (Medical-Surgical Nursing Certification Board [MSNCB], n.d.). Joint Commission (2016) accreditation is renewed every 3 years and requires site visits and other supplemental information. Magnet recognition is renewed on a 4-year cycle and requires participation in quality improvement and benchmarking (ANCC, 2008).

The types of benchmarking help to inform the types of metrics selected and how to collect comparison data. The previous phase of the PCTBC model included implementation of the individual certifications. Understanding the implications of individual certifications can guide their inclusion in unit-based certification. The impact of organizational certification provides information about the certification and recertification process.

General Literature

The concept of patient-centered care was reviewed to ensure that the certification was reflective of the common themes. Boolean search was conducted in Medline, CINAHL, OVID, and Google Scholar. Results were narrowed to those in English, with abstract available, from 2010 or later. Search terms included *patient-centered care*, *accountable care unit*, *patient engagement*, *patient centric*, and *collaborative care*. A review of the abstracts was completed to narrow the results to those related to healthcare.

Reference lists were reviewed for any potentially valuable sources of information or repeatedly cited articles from outside the date range.

The Patient Protection and Affordable Care Act (2010) implemented a value-based purchasing program, which created reimbursement incentives for improving the patients' experience (Epstein & Street, 2011). The importance of the patient experience has been emphasized in the use of the HCAHPS (2015). Patient-centered care became a focus of efforts to improve the patient experience. Improvement in communication among staff can help to decrease service gaps and improve patient-centered care. PCTBC involves team dynamics that can promote the power of a team or impede its progress.

Patient-centered care is a broad concept that is central to the concept of the PCTBC model and the ACU™. In 1988, the Picker Institute coined the term *patient-centered care*, which is focused around the concept of “never about me without me” (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993). Patient-centered care is not the addition of greeters or calming paint colors alone; it reflects a change in the culture of the hospital system that demonstrates patient inclusion in the health care journey (Epstein & Street, 2011; Gerteis et al., 1993) According to Hobbs (2009), patient-centered care programs should contain interactions between patients, nurses, physicians, and other disciplines that focus on communication and shared control of the decision-making process. Shared decision-making and interdisciplinary relationships were concepts that were repeatedly identified.

Shared Decision Making

Promotion of patient-centered care includes the physician engaging with the care team and the patient in shared decision-making. Shared decision-making is a process of education and communication to promote patient satisfaction and improved outcomes. As promotion of the patient-centered care concepts increases, governing bodies have begun incorporating the concepts into their requirements.

Shared decision making has been recognized as a focus area for legislation and certification. A stipulation encouraging an increase in the use of shared decision-making was included in Section 3506 of the 2010 Affordable Care Act (Lee & Emanuel, 2013). Shared decision-making is reflected in portions of the HCHAPS scores, which are part of pay-for-performance measures (Burstin, Leatherman, & Goldman, 2016). The Joint Commission has standards related to shared decision-making as part of its safety and quality aims (The Joint Commission, 2011).

Shared decision-making is a continuous process to increase patient knowledge and promote the personalization of the care plan (Hoffman et al., 2014; Stein et al., 2013). There are some instances, such as a broken bone, where there is one path that is the superior choice; however, there are many instances in medicine where there is more than one reasonable choice and the patient should be included in those decisions, such as the decisions facing cancer patients (Barry & Edgman-Levitan, 2012). The patients' decisions are respected in the decision-making process; however, they are not mindlessly enacted (Gerteis et al., 1993). The involvement of the patient in the decision-making process has shown increased satisfaction with decreased adverse events (Berger,

Flickinger, Pfoh, Martinez, & Dy, 2014; Pannick et al., 2015; Small, 2008). Stewart et al. (2000) published a cohort study that determined that a positive correlation with PCC resulted in fewer tests and procedures, stronger patient feelings of patient and physician communication, and perceived better efficiency of care delivered (Stewart et al., 2000).

Collaborative Relationship

Collaboration involving the patient, physician, and other team members in the decision-making process is integral to the concept of patient-centered care. Barriers to communication and methods to promote collaboration are important in the development of team-based care. The collaborative relationship promotes the value of each team member's knowledge and skills in the care of the patient.

Promotion of the collaborative relationship can reduce the perceived differences in power that are present in the unit team member-physician relationship. The aircraft safety model involving standard processes with shared goals and accurate communication can be applied in the effort to improve the nurse-physician relationship to promote positive outcomes (Zwarenstein & Reeves, 2002). The aircraft safety model promotes the value of each team member; safety concerns can be voiced from any level, which triggers a review. Application of this model in the hospital would promote the importance of the bedside nurse in the safety process. Following the implementation of the ACU™ with the built-in collaborative process, adverse events have shown a decrease (Methvin et al., 2012).

Team members who strongly identify with their profession constitute a potential barrier to this collaboration. These team members may hold onto their role and

responsibility and potentially create communication issues (Mitchell, Parker, Giles, & Boyle, 2013). There is also the potential for a breakdown in communication if a team member does not value the knowledge and ability of the others (Matziou et al., 2014). Matziou et al. (2014) identified physicians undervaluing nurses' knowledge as a persistent issue in communication.

Team situation awareness is the understanding of how the individual impacts others on the team. Team situation awareness is developed by team members recognizing the skill sets possessed by the others as well as the underlying shared philosophical goal of patient care (EL Sayed & Sleem, 2011; Endsley, 1995; Thomas, Sexton, & Helmreich, 2003). Teams who have situational awareness are sharing a mental model of teamwork (Kuziemyk & Varpio, 2010; Stein et al., 2015).

Improved communication and decreases in service delivery gaps can lead to improved patient satisfaction and outcomes (Dabney & Tzeng, 2013). Strong interdisciplinary working relationships, high employee engagement, and increased physician engagement create an environment of excellence (Manary et al., 2015). The process of facilitating change is guided by conceptual models that provide a framework for directing change.

To identify a unit as providing patient-centered care, the concept of patient-centeredness must be reviewed and understood in the context of the ACU™ and PCTBC. The themes identified as relating to teamwork within the ACU™ are reflected in the literature and provide context for the actions and the unit culture.

Conceptual Models and Theoretical Frameworks

The process of developing a certification requires a framework for guidance. The selected frameworks promote the process of identifying the relationship between the various parts and the goal of improved outcomes. The Donabedian model and complexity science theory (complex systems theory) are the frameworks on which this project has been built. The Donabedian healthcare quality model provides a framework for evaluating the quality of healthcare, and complexity science theory provides information about the interrelatedness of the components of healthcare (Kannampallil, Schauer, Cohen, & Patel, 2011).

The Donabedian model has been identified as a framework for evaluating the quality of healthcare for 50 years (Ayanian & Markel, 2016; McDonald, Sundaram, & Bravata, 2007). The seven pillars of quality, identified by Donabedian, were incorporated into the report *Crossing the Quality Chasm* (Ayanian & Markel, 2016). Value-based purchasing of healthcare, patient-centered care, and the focus of reduction in fragmented care of the ACU™ have roots in the Donabedian model (Ayanian & Markel, 2016).

The model has three categories of focus: structure, process, and outcomes (Donabedian, 1988). The structure is the capacity to deliver quality. This includes the physical, operational, and financial processes that support an organization (McDonald, Sundaram, & Bravata, 2007). The structure of care may apply to the organization, the unit, or the individual (Kleinman & Dougherty, 2013). The processes fall in the middle because they are driven by structures providing resources for patient care. Process is how

the healthcare is delivered; this includes technical care and interpersonal care (Donabedian, 1988; McDonald, Sundaram, & Bravata, 2007). Outcomes are the result of the structure and process of care. This project provides structure to a process, and through the application of this model the identified units should have improved outcomes.

The structure includes the context of the care of the model. This includes the training, supplies, and environment of the patient-centered care. The structure is impacted by the individual certification and the training provided in the ACU™ workshops. Upon testing the design of the certification process, the workshop may be altered to improve the input level.

The process of the Donabedian model includes steps that are initiated to achieve the outcome of patient-centered care. The steps include individual certifications, the collaborative process, and the coordination of care. This project includes another step that involves processes for improving the patient-centered care experience.

The desired outcome is improved cost, service, and clinical outcomes associated with the PCTBC model. The PCC certification will be a method of evaluating whether the units are functioning at the highest sustainable levels.

Complexity science theory is applied to the relationships for the team competencies and the relation of this to outcomes. Complexity science theory has been selected because it represents a collection of theories and tools from multiple disciplines that can be applied to the complex system that is healthcare, in which there are many areas that are interdependent (Hast, Dagioia, & Wolf, 2013; Plsek & Greenhalgh, 2001).

A healthcare system must be viewed as a complex system, in that one component cannot be isolated without considering its interrelations with other components (Kannampallil et al., 2011). A complex system is one that includes many other microsystems or networks that combine to create a larger, more complex system (Cordon, 2013). The systems may be viewed in smaller components while focusing on some relationships; however, these must be viewed in context (Kannampallil et al., 2011). The application of the complexity science theory guides the understanding that this process and structure may need to be further refined when it is not viewed in a silo, but as part of the whole system. This is an important concept to understand, as the results of testing may differ widely from the expected results. The impact of the process is designed in a silo and then applied with other previously not considered factors becoming relevant. Therefore, the project should be tested in vivo to determine if it is truly applicable and if there are external factors affecting it. Once external factors are identified, the process can be adjusted and then applied to the system.

Section 3: Approach

PCC Certification Guidelines

The project identified the standards, benchmarks, and process for PCC certification and the next phase of the PCTBC model. This approach to the design included interviews with members of the department currently managing the ACU™ and the chief nursing executive, a review of the literature, identification of national benchmarks, and the creation of the process application template with accompanying policy and procedures.

Project Design

The design of the PCC certification was guided by the Donabedian model and complexity systems theory in conjunction with the current process and structures in place. The Nursing Research and Program Development department is currently responsible for the facilitation of the ACU™. The team was interviewed to ascertain members' recommendations for inclusion in the PCC certification. Additionally, the chief nursing executive and some of the physician coleads were interviewed to identify areas that they felt were important to address in the context of certification. Preliminary discussions took place to identify some of the criteria. There were more formalized interviews to explore the issues in depth.

A literature review was then completed to determine which metrics had been identified by the current certifying bodies associated with the individual ACUs™, such as Heart Failure, Stroke, or NICHE, which may be universal standards. Metrics of organizations such as the Joint Commission on Accreditation of Healthcare Organizations

(JCAHO), Centers for Medicare and Medicaid Services (CMS), and NDNQI were reviewed for inclusion in the universal standards. National benchmarks were reviewed following the literature review to identify quality metrics associated with hospitals.

The information obtained from the certifying bodies and the literature review were used to set select benchmarks for the ACU to meet and develop an application process. The application process included a self-study template for each unit to demonstrate the usage of data relevant to the individual unit. The policy and procedures were modified to reflect the addition of the use of the template. The application template was tested using a pilot unit as part of the evaluation plan.

Finally, the Nursing Research and Program Development department implemented the PCC certification. The final product included the template with some additional requirements.

Project Evaluation Plan

The project was evaluated by completing pilot testing on an eligible unit with the available data. This allowed for identification that relevant data were being measured and tracked. Once tested, the design was modified as needed to ensure reliability for the program. The current policy was evaluated for possible refinement at this time. Unit data and management goals were reviewed to determine whether there were any missing metrics. Identified metrics may be added to the unit dashboards or other applicable tracking system. Policy alterations were addressed at this time. Finally, the PCC certification procedure was presented to the hospital, and units are now eligible to begin the certification process.

Summary

The approach to creating the procedure for PCC unit certification has been described. The potential deliverables have been reviewed. The process of implementation began following approval from the Institutional Review Board (IRB) of Walden University and approval of the proposal.

Section 4: Findings

Introduction

The Patient Centered Care Certification program was developed based on identification of a gap between the requirements of the units within the hospital system being responsible for knowing their metrics and demonstration of their outcomes. The PCC certification will provide the nursing units with the opportunity to obtain recognition for the demonstration of outcome performance and the involvement of nursing in the interdisciplinary care of the patient. This project created the framework for the procedure and guidelines for PCC certification.

Findings

The PCC Certification process was introduced to the health system to fill the identified gap in the system. Interviews were completed with multiple individuals throughout the system to identify needs and requests for inclusion in the program. The current unit dashboard was reviewed for a pilot unit to determine whether the identified metrics were currently being captured and reported. The PCC Certification application (see Appendix A) was created for the system, in addition to a description of “Procedure Steps, Guidelines, or Reference” (see Appendix B), which guides the process.

Twelve key individuals were interviewed to gain their perspectives and input on the PCC Certification process. Interviews with the six Nursing Research and Program Development (NRPD) department staff members identified their recommendations for criteria to include in the PCC Certification. They were interviewed first because they represented the department responsible for the development of the ACU™. Interviews

were then completed with three nurse managers, two physician coleads, and the senior PCC unit medical director to identify their recommendations for inclusion, as well as to identify the common metrics for each unit. The physicians were also able to provide additional information on the medical perspective as part of the collaborative leadership team. In that the certification will influence the unit as a whole, the inclusion of the medical perspective is important. The chief nursing executive for the largest campus within the health system provided her perspective on the impact the certification could have on the health systems Magnet™ journey. Finally, the Patient Family Advisory Council (PFAC) provided the patient perspective and expressed a desire to participate actively in the certification process. The recommendations from the interviews were compiled and reviewed for common themes.

Themes identified from the NRPD, nurse managers, and physician interviews included incorporation of the PCTBC model, recognition of current work, simplicity of the application process, and ability to include new units in the process without requiring large alterations to the process. The PCTBC model includes dyad leadership, unit-based teams, patient-centered multidisciplinary rounds, and unit-level performance management. The simplicity of the application process was important, in that the program is voluntary and should not be so cumbersome as to impact the workload of the unit manager (or person identified to complete the form). Recognition of current work reflects the differences between the units; some of the units have Joint Commission disease-specific care criteria they must maintain. Finally, the ability of the form to adapt as new units become eligible for the program was important. It was suggested that the

application be built into iRound, which is currently used by the health system. iRound is an IT system that can be used for the patient and employee experience. The platform has the ability to build forms and reports customized to the user. Building the form in the iRound system allows the most up-to-date form to be readily available and provides a Health Insurance Portability and Accountability Act (HIPAA)-compliant server for the information.

The interview with the chief nursing executive (CNE) identified the importance of making the certification meaningful to the hospital and unit, as well as not adding additional workload to the unit managers. Currently, the health system is on the Magnet™ journey, and the requirements for certification should include a method to incorporate and support the *Forces of Magnetism* (ANCC, 2008). The forces are identified as transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovation and improvements, and empirical quality results (ANCC, 2008). No specific suggestions were provided related to incorporating the forces beyond promoting nurse autonomy. The simplicity of the design was important, in that further workload should not be added to the process of preparing and applying for the certification. The CNE felt that the managers have a large workload and should not be asked to complete redundant work that could be easily accessed through other means.

The director of the NRPD team recommended incorporating the patient experience as part of the certification. The PFAC was interviewed to provide the patient experience to the process. The PFAC currently does a lot of work on promoting patient-

and family-centered care within the hospital. Its members apply the core concepts of dignity and respect, information sharing, participation, and collaboration in their work (AHRQ, 2014). The PFAC requested participation in the certification process through a unit visit to ascertain whether a culture of patient-centered care existed.

The Joint Commission disease-specific care criteria, national quality measures, and Magnet recognition requirements were identified in the nurse manager and physician interviews as sources for the common themes related to metrics. The ANCC and the Joint Commission sites were reviewed to validate which shared metrics should be tracked within the unit dashboards. Common metrics included harm events (central line associated infection, catheter-associated urinary tract infection, hospital-acquired pressure ulcer, fall with injury), 30-day readmission rates, and length of stay. The Magnet™ metrics were omitted because they were specific only to nursing and detracted from the collaborative nature of the PCTBC model. The primary metrics of Magnet™ are the nurse-sensitive indicators (ANCC, 2008). These metrics were identified to determine whether the unit dashboards currently in use are reporting the necessary metrics.

A pilot medical-surgical unit was selected after the metrics were identified. The dashboard for this unit was reviewed to ensure that the unit manager and physician coleaders would be able to actively track their information. It was determined that all of the necessary information was currently available to the leadership team through the unit dashboards. It was also determined that all of the nurse managers had access to a unit-specific dashboard and had received education on how to use the information.

A PCC Certification application (see Appendix A) was then created. This application was designed to be an easy method for the units to report the information, which is currently the focus of the unit-based goals and the hospital strategic plan. The application provides an open text format for applicants to describe the work completed and how they have been managing their performance. The pillars of the PCTBC model and the *Forces of Magnetism* including empirical outcomes, staff empowerment, exemplary professional practice, and new knowledge were incorporated into the design (ANCC, 2008). The goals of the test unit were reviewed for the two previous years to ensure that the application demonstrated what they are doing based on current goals and the strategic plan, which may be fluid year to year.

A Procedure Steps, Guidelines, or Reference (PGR) description was created to provide structure to the process of the PCC Certification program (see Appendix B). The PGR follows the standard health system format and the current phrasing used by the health system. The PGR reviews the minimum expectations for a unit applying for PCC Certification. The high-performing behaviors are reviewed, and those processes that need to be validated for reporting purposes on the self-study application are listed.

The procedure for the PCC certification is listed in the PGR (see Appendix B). The first step is for the unit to identify its intention to apply for the PCC certification. The Shared Governance Council must be notified of the intent to apply a quarter before the application will be submitted. This allows a 3-month review period for the PFAC to assess the patient centeredness of the unit. PFAC must approve the unit as having a patient-centered culture based on the standards it determines, before the application for

PCC Certification may be submitted. During the period prior to application submission, the unit educator will ensure that the skills validations for the required standard communication processes (see Appendix B) are complete. Following completion of the requirements, the unit can complete the PCC Certification application (see Appendix A).

The PCC Certification application (see Appendix A) was designed to allow the units to demonstrate the impact of quality (QI) and process interventions (PI) that they have completed in the 2 years prior to submission. The 2-year period was determined based on the ANCC timeline for many certifications. The unit must demonstrate the QI and PI projects completed by the unit-based council and from the leadership level.

The professional development committee within the Shared Governance Council will perform evaluation of the PCC Certification application. The committee will review each application for the demonstration of outcomes related to the metrics identified by the applicant. The committee will verify that the unit has met the requirements of certification as listed in the PGR (see Appendix B) and has demonstrated successful outcomes. The PCC Certification is valid for 2 years following recognition.

Recommendations

The PCC Certification process should be implemented for the ACUs™ that meet current requirements. Following a PDSA cycle to identify any barriers, the PCC Certification should be implemented as a systemwide program. The PCC Certification application can be applied to any unit within the health system. The PGR needs to be submitted through the Nursing Shared Governance Council for review, as the professional development committee would be responsible for the evaluation of the

applications. Once approved, Shared Governance will submit the PGR for the final review process. The PFAC will also have to be engaged to finalize the standards for evaluation of units that wish to apply for the certification. The PFAC will identify the criteria it will evaluate units by prior to the first unit evaluation.

The application (see Appendix A) should be built into an electronic form in the iRound system. The health system currently uses this IT system for patient rounds, employee rounds, and tracking of data from ancillary nursing departments. The inclusion of the form in the IT system provides a streamlined method for application and ease of modification when necessary. The template has been built in Excel for submission to iRound for the build of the final form. The form should be available for completion by the dyad/triad leadership team, or in conjunction with the unit-based council.

A PGR was created to define the process by which certification could be obtained by the units. The PCC Certification PGR is provided in Appendix B. The determination of whether a unit is meeting expectations, as initially evaluated by the professional development committee, should be built into the iRound system with the template. The iRound system has the ability to perform word recognition to look for specific terms within the self-study. The NRPD department and professional development committee can identify the key terms as the template is being built. The word recognition format for determining certification can be designed based on one currently used by the health system to provide continuity among programs.

Strengths and Limitations

The strengths of the PCC Certification are focused on the program being limited to the health system. The limitations are related to the limited implementation of the program during pilot testing. The PCC Certification has many strengths related to its applicability within the health system. However, the program is limited, in that it is focused on the unique health system, which limits its widespread application.

The primary strength of the PCC Certification is its focus on elevating the individual units within the health system to promote practices that are patient centered and focused on improving outcomes. The program will help to promote individual units to high functioning levels in support of the Magnet™ journey. The addition of the PGR promotes a robust format in which information can be exchanged in a structured format while reducing variance to promote patient safety (Gluyas, 2015). Finally, the program was designed in a manner that allows for the inclusion of new units without making large changes.

The PCC Certification program was designed for one health system based on its current PCTB practice model. The primary limitation of this project was that, due to time restrictions, it was not able to be implemented fully on the pilot unit. Recommendations were made based on the next steps needed for a full implementation of the PCC Certification program. They allow the streamlined implementation of the PCC Certification program. They are based on structures currently existing within the health system. The recommendations would also allow the certification application to be evaluated objectively rather than subjectively. Another limitation to the program

submitted to the health system is that the PFAC had not yet established the standard guidelines for its approval for a unit to be recognized as patient centered beyond the incorporation of patient- and family-centeredness (AHRQ, 2014).

The strengths and limitations of the PCC Certification can be used to determine the applicability of the program to areas outside the health system. Recognizing the limitations of the program enables the health system to strengthen the program as the system further develops it.

Section 5: Dissemination Plan

Dissemination Plan

Dissemination of a work is as important as the project itself. Dissemination allows others to review the work completed and evaluate it for possible implementation in other areas. This project cannot be fully implemented within the health system unless it is adequately shared with decision makers. The dissemination plan for the project is based on sharing it first within the health system, and then sharing it in a larger forum. The NRPD department will initially implement the program on the ACUs™ that currently meet the basic requirements. The decision for a systemwide implementation will take place at an executive level.

Dissemination of this project will be completed through the use of an executive summary. This format was selected because it summarizes a longer report in a manner that rapidly conveys the pertinent information to the reader. The summary was submitted to the director of the Nursing Research and Program Development department. The summary was presented in hard copy and electronic format to allow for easy dissemination to interested parties within the health system. The PGR and certification application were submitted in hard copy and electronic formats.

Future dissemination of the project will be in poster format during a patient-centered care symposium hosted by the health system in October. Those attending the symposium represent a large number of regional health systems and area nursing schools. The poster presentation allows for the attendees to get quick information about the project and ask questions of the presenter.

Analysis of Self

Throughout the course of this experience, I have grown as a scholar and practitioner. I have learned to be a better steward of the resources of the health system and the effects of policy on the system. As I journeyed through this project, I developed a true grasp of the Donabedian model (1988) and the effects of structure, process, and outcomes in the health system.

I have developed skills in systems thinking and thinking beyond the boundaries of one area and in a more organizational manner, as reflected by DNP Essential II (AACN, 2006). I have applied the DNP essentials in expanding my knowledge base. I was able to learn information technology systems specific to my health system and helped to implement parts of it throughout the system in line with DNP Essential IV (AACN, 2006). I have helped to develop the structures to support my project through the guidance of my preceptors. These structures were created through multidisciplinary collaboration to help promote a system that is dependent upon teamwork and being situationally aware. Through the work I have completed, I have become more comfortable in presenting new material, creating solutions, and promoting nurse autonomy. When I began the program, I was not accustomed to presenting to system leaders. I knew little of the politics of the health system. I have grown to understand the principles of presenting to this specific audience and knowing what information will be important to its members.

Summary

The PCTBC model did not have guidelines and processes in place to determine the qualifications for PCC certification. This created a problem because the ACUs™ are held accountable for their data but are not recognized for demonstrating the impact that knowledge has on outcome performance. The purpose of this project was to design the procedure for obtaining PCC certification for the health system. The project focused on the creation of evidence-based practice certification guidelines so that units can demonstrate that they have sustainable high-performing team-based behaviors. The aim of this project was the development of a framework consisting of procedures and guidelines that would create the PCC unit certification for the PCTBC model.

A literature review was completed on the topics of benchmarking and certification and the concept of patient-centered care to ensure that the certification is reflective of common themes. Two concepts were repeatedly identified in relation to patient-centered care: shared decision making and interdisciplinary relationships.

The design of the PCC certification was guided by the Donabedian model and complexity systems theory in conjunction with the current process and structures in place. Interviews were completed with multiple people within the organization to identify their recommendations for criteria to include in the PCC certification. Following the information gained in the interviews, a PCC Certification application (Appendix A) and PGR (Appendix B) were created. The PGR was created to provide structure to the process of the PCC Certification program. The PGR reviews the minimum expectations for a unit applying for PCC Certification. The project was disseminated by use of an

executive summary in hard copy and electronic form to the director of the NRPD department. Included in the summary were the identified gap in practice that the project filled, the deliverables of the PGR and the PCC Certification application, and a list of recommendations.

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Appendix A: PCC Application Template

PCC Unit Certification			
Campus			
	Baptist		
	Parkridge		
	Richland		
Unit			
	list all hospital units		
Number of staff with ALL PCC Competencies			
	[Total %]	[Nurse %]	[UAP %]
Number of staff with a professional Nursing Certification			
	[comment box]		
Has the Unit Based Council (UBC) completed any Quality or Process improvement projects?			
	Yes		
	No		
Describe the QI/PI projects and the outcomes			
	[comment box]		
Does your unit have a specific designation?			
	Yes		
	No		
<i>*next question is dependant upon a yes answer</i>			
What certification does your unit have?			
	NICHE		
	Disease Specific Stroke		
	Disease Specific Heart Failure		
Describe the metrics which are currently tracked on your unit related to Unit Goals, Hospital Strategic Plan, Unit Specific Designation. Describe how they affect your clinical, service and methods to reduce unwanted variation.			
	[comment box]		
Decribe any QI/PI projects (outside the UBC) including outcomes which have been completed on your unit in the last 2 years. Clinical, Service and Reduction in unwarrented variation must be addressed)			
	[comment box]		

Appendix B: Patient Centered Care Certification PGR

Patient Centered Care Certification

Effective: xx/xx/xxxx

Review: xx/xx/xxxx

Definition:

1. Patient Centered Care (PCC) Certification is a method for units to demonstrate that they are utilizing their data to complete process and quality improvements to improve their outcomes.
2. The phrase “Patient Centered Care” is based on the Patient-Centered Team-Based Care (PCTBC) Model and the pillars of: Nurse and Physician Coleadership, Unit-Based Teams, Unit-Level Performance Management, and Patient-Centered Multidisciplinary Rounds.
3. PCC certification is operationalized by hospital units demonstrating through self-study application how they contributed to achieving organizational goals and outcomes based on the PCTBC model. Recognition is tied to outcome attainment documented in the self-study.
4. Accountability: Being responsible and answerable for actions or inactions of self or others in the context of patient care.
5. The phrase “Quality risks” is defined as a minimal expectation to review: level of monitoring, Foley necessity/risk, central line necessity/risk, Braden score less than 18, high fall risk, high Hypoglycemic risk, DVT risk.
6. The phrase “Safety risks” is defined as a minimal expectation to review: Code status (DNR), restraints, suicidal, isolation, communication barriers

Responsible Positions (Title):

- Medical Staff (MD/DO)
- Nursing Staff (RN, LPN)
- Unlicensed Assistive Personnel (UAP/PST)
- Ancillary Staff

Procedure Steps, Guidelines, or Reference

1. Application Process:
 - 1.1. Declare intent to seek certification one quarter prior to submission of the PCC Certification application.
 - 1.2. Schedule patient-centered care review from the Patient and Family Advisory Committee.

- 1.3. Ensure validation of the structured communication processes by the unit educator.
- 1.4. Complete the PCC Certification application.
2. Eligibility:
 - 2.1. Units must be functioning under the PCTBC model for a minimum of 1 yr.
 - 2.2. Patient-Centered Multidisciplinary Rounds must occur a minimum of 5 days per week.
 - 2.3. Approval of the Patient Family Advocacy Council following a unit visit.
3. PCC Certification is a voluntary program.
4. Program Steps:
 - 4.1. Select quarterly submission date (January 1, April 1, July 1, October 1)
 - 4.2. Complete the PCC Certification self-study in iRound
 - 4.2.1. If you do not have the self-study template email
iRound@palmettohealth.org
 - 4.3. Self-study applications will not be accepted after the submission date.
5. Structured communication processes of: SBA+RD TEAM Huddle, Bedside Shift Report (BSR), Structured Interdisciplinary Bedside Rounds (SIBR™), and Charge Nurse Report, and Charge Nurse Evaluation will be performed at the minimal process expectations.
 - 5.1. SBAR+D

SBA+RD is a handoff communication tool to be used for: calling the doctors, during charge nurse report, patient handoff, TEAM huddle, Bedside Shift Report, Charge Nurse Evaluation, and SIBR (on ACU's).

Review the current state or problem as the purpose for initiating the conversation. Review the information related to the situation including milestones of the hospital stay, key events during the shift, pertinent medical history. Review quality risks and safety risks. Request or share recommendations and identify any barriers to move to the next level of care and what actions need to be taken to help the patient move to the next level of care.
 - 5.2. TEAM Huddle

Duration of no more than 5 minutes
Follows the TEAM format
Includes both on-coming and off-going shifts (UAP and nursing staff)
Reviews: RTDC status, scripted positive evaluation of previous shift, evaluation of what went well and what can be done better, identify families

in need of emotional support. Review quality risks and safety risks. Identify the goal or the focus for the shift. Consider quality and service opportunities. End with a motivational quote.

5.3. Bedside Shift Report

Perform AIDET, use of Workstation on Wheels, low use of medical jargon, engage the patient and family

Use the SBA+RD communication process including a complete focused assessment to include a skin check, integrity of lines, tubes and devices. Review eMAR for medication status, expected orders, procedures and tests. Review the expected discharge date and needs including barriers to discharge.

Review the plan for the day, including: goals, activity, tests/procedures, and multidisciplinary rounds.

Update the whiteboard with team names, goal(s), next pain medication, anticipated discharge date.

Evaluate the patient for pain, potty, position and possessions (4P's) and provide an expected return time.

5.4. Structured Interdisciplinary Bedside Rounds (SIBR™)

Should occur on patients daily with a duration of less than 5 minutes per patient room, low use of medical jargon, minimize the use of electronic devices, engage the patient and family in the discussion to verify or correct information shared. SIBR™ ends after the plan-for-the-day has been reviewed with the patient and the care team.

The script:

Provider: Welcomes and introduces the team to the patient, gives an overview of the patient's course of stay.

Nurse: Patient goal, overnight events, current assessment, review the quality and safety risks, and nurses meaningful goal

UAP: Intake & output with last BM, activity level, UAP's meaningful goal.

Pharmacist: Significant med changes and review of medications as needed

Rehab Service: Current treatment plan, discharge needs

Care Coordinator: Home situation prior to admission, barriers to and needs for discharge

Provider: Closes with a recap of information, plan for the day and discusses current D/C plan

Rounds Manager role: Conducts pre-SIBR™ briefing which includes a team introduction and a review of quality and service issues.

Remains outside the room and ensures the ground rules are upheld, collects IP phones prior to staff entering the room, ensures real time order entry, alerts team when approaching 5 minutes in patient room. Maintains the flow of SIBR™ by alerting the upcoming nurse and/or UAP. Directs the team to the next room, announces team member changes. Submits service recoveries as needed. Conducts SIBR™ debrief providing recognition and providing coaching and feedback.

5.5. Charge Nurse Report

Focus is removing barriers to move patients to the next level of care.

TeleTracking is utilized for report in an SBA+RD format.

Situation: Name, Age, Code Status, Provider Group, Diagnosis, Consults, Level of Care

Background: Milestones for hospital stay, key events from previous shift, pertinent medical history and isolation status, procedures and high-risk interventions

Assessment+: Quality risks, safety risks, and additional information including 1:1 feeder, family support, and care (drips, NG, PEG)

Recommendations: identify the barriers to discharge, identify needs for SIBR™ (interpretive services, PPE), enter pre-discharge orders as needed, Identification of discharge disposition.

Discharge: Review discharges expected by 2pm. Update/Review the “R Sheet” for pending/confirmed discharges and discharge needs.

5.6. Charge Nurse Evaluation

Briefly review the SBA+RD for changes in patient status. Review the quality and safety risks.

The UAP should update environmental needs and patient care needs.

TeleTracking and the “R sheet” should be updated with quality and safety information, and scheduled diagnostics or procedures and over-shift events.

Pending and potential discharges should be updated/validated for the next shift.

6. Essential elements of the structured communication processes to be validated includes:

6.1. SBA+RD

- 6.2. TEAM Huddle
- 6.3. Bedside Shift Report
- 6.4. SIBR™
- 6.5. Charge Nurse Report
- 6.6. Charge Nurse Evaluation
- 7. Review Process:
 - 7.1. PCC Certification application is approved following evaluation by the Professional Practice committee
 - 7.1.1. Units must demonstrate process and quality improvement projects and outcomes from the unit-based council and the leadership dyad.
 - 7.2. PCC Certification applications are not blinded.
- 8. Appeal of Denial:
 - 8.1. Units who do not receive recognition as a PCC unit have the right to appeal the decision by:
 - 8.1.1. Meeting with a review team to review and discuss data relevant to the criterion that was not met.
- 9. Specific Submission Requirements:
 - 9.1. All submissions must reflect the work completed within the last two years.
 - 9.2. PCC Certification application requirements:
 - 9.2.1. The minimum staff competency percentage is 65% and reflects a 1:1 ratio of nurses and UAP.
 - 9.2.1.1. UAP competency: Bedside shift report, SIBR™
 - 9.2.1.2. Nurse competency: Bedside shift report, SIBR™
 - 9.2.1.3. Charge Nurse competency: Charge Nurse Report, Charge Nurse Evaluation, TEAM Huddle, SIBR™ and Bedside shift report.
 - 9.2.2. All reported outcomes must be measurable.
 - 9.2.2.1. A minimum of two projects from the Unit Based Council must be reported.
 - 9.2.2.2. An outcome representing each of the pillars of service, clinical and reduction in unwarranted variation must be reported.
 - 9.2.3. Complete all parts of the application.
- 10. Renewal Process:
 - 10.1. If the unit chooses to remain recognized as a PCC unit after the two-year achievement, a new application must be submitted by the expiration of the quarterly submission date.
 - 10.1.1. There is no guarantee that you will maintain PCC certification. Certification renewal will be based on the outcomes you have achieved over the past two years.

10.1.2. Failure to resubmit before the two year expiration date will result in forfeit of the PCC Certification.