**FROM THE CENTER**

**UPCOMING EVENTS**

Nursing Executive Center continues 2007-2008 national meeting series

Page 16

**MEETING HIGHLIGHT**

Service line-focused internship bolsters student nurses’ clinical experience

Page 6

**BEST PRACTICE SPOTLIGHT**

Using senior nurse rounding to connect with patients and identify care issues

Page 8

**NURSING NUMBERS**

Results from a 2006 survey indicate that nurse practitioners predominantly work outside the hospital.

![Pie chart showing distribution of nurse practitioners in different settings.]

Source: American Academy of Nurse Practitioners, 2006

**COVER STORY**

**Cleveland Clinic’s new CXO helps shape better patient care**

As hospitals focus on boosting patient satisfaction, Cleveland Clinic last year made the “extremely unique” move to appoint its first-ever Chief Experience Officer (CXO), who has been charged with ensuring a high-quality patient and family experience.

Page 2

**University of Pennsylvania Health System pilots unit clinical leadership model to spur quality gains**

To advance its clinical quality goals, Philadelphia-based University of Pennsylvania Health System has designed a unit-based clinical leadership model that fosters nurse-physician partnerships and has yielded promising results in staff-related metrics.

Page 4

**HIGHLIGHTS FROM THE JOURNAL REVIEW**

**Inflation-adjusted RN turnover cost model builds on earlier JONA analyses**

Page 9

**Fast Company: Honest, clear feedback essential to employee, team growth**

Page 10

**ON OUR WATCH**

- Mass. hospitals post pressure ulcer rates, NP scope of practices

Pages 11-15

---

*Programs in the News*

- Cleveland Clinic (page 2) • Mayo Clinic (pages 2)
- Univ. of Pennsylvania (page 4) • Vanderbilt Univ. (page 6)
- Univ. of North Carolina School of Nursing (page 9)
- Univ. of Illinois School of Nursing (page 12)
- Duke Univ. School of Nursing (page 12) • Abington Memorial (page 13) • Barnes-Jewish (page 13)
- Our Lady of Mercy (page 14) • West Chester (page 14)
Leadership buy-in essential to program roll-out

While Cleveland Clinic is one of the first hospitals to appoint an executive dedicated to patient experience initiatives, Planetree President Susan Frampton expects that other organizations will eventually follow. Frampton also notes that having a CXO signals to staff that leadership is aiming to change the culture of an institution, rather than simply focus on improving scores. At Cleveland Clinic, for instance, Duffy notes that the resources and high-level leadership behind the patient experience effort instilled confidence in employees that their efforts to incorporate the patient-centered model would be fully supported (Watch interviews, 1/24/08; 1/30/08).

University of Pennsylvania Health System pilots unit clinical leadership model to spur quality gains

To advance its clinical quality goals, the three-hospital, Philadelphia-based University of Pennsylvania Health System (UPHS) has designed a unit-based clinical leadership model that fosters nurse–physician partnerships. Developed in 2007 and currently being piloted in 13 units across the system, the model has yielded promising results in staff-related metrics such as physician–nurse interaction scores, nurse appreciation scores, and staff turnover as well as quality outcomes such as lower infection rates. System leaders are now considering the model for systemwide adoption, beginning with 20 additional units in the next fiscal year (Nursing Executive Center interviews, 10/6/07, 11/6/07; UPHS presentation for The Conference Board, 10/25/07).

Unit-based staffing promotes quality-focused teams

Under the clinical leadership model, hospital units work toward systemwide clinical quality goals—including reducing mortality and readmission rates—developed jointly by the CNOs and chief medical officers (CMOs) of UPHS, the Hospital of the University of Pennsylvania (HUP), Pennsylvania Hospital, and Penn Presbyterian Hospital. Rather than prescribing protocols and processes that dictate how each unit should accomplish these goals, UPHS clinical executives instead defer such decision making to unit leadership teams—each composed of a nurse leader, a physician leader, and a dedicated unit quality coordinator—and provide the teams with staffing resources that enable them to focus on quality. For example, the model calls for patient-to-staff ratios of 5:1 for RNs and 10:1 for certified nurse assistants, support from a clinical nurse specialist for 20 hours per week, a charge nurse focused on managing the unit—with no individual patient duties—and an assistant nurse manager during evening hours.

Unit leadership teams monitor quality data, identify solutions to boost performance

Each unit leadership team meets weekly to review metrics, troubleshoot problems, and develop plans for short- and long-term projects, including two annual improvement projects aligned with UPHS goals. In addition, the leaders also support their colleagues’ interdisciplinary rounding; under the model, nurses and physicians meet daily with patients, social workers, pharmacists, and educators at a designated time to make decisions about the plan of care. Meanwhile, as each unit leadership group gains traction, members take on a more active role in orienting staff to expectations for unit practices, care protocols, and metrics. Although nurse leaders are selected because of their explicit leadership positions as unit directors, physician leaders—many of whom are hospitalists—are chosen because of their frequency of contact with the unit and demonstrated rapport with staff members. Moreover, because increasing income pressures often deter physicians from participating in hospital-based initiatives, designated physician leaders receive a stipend for the two to five hours per week they dedicate to the program. To support the nurse and physician leaders in helping their units meet quality targets, quality coordinators—0.33 FTE per unit—provide real-time unit data collection and analysis, troubleshoot problems, and help identify solutions. In recognition of their integrated role within clinical teams, quality staff have received Six Sigma training to boost their leadership and project management skills.
Model an outgrowth of previous successful projects

The development of the unit leadership model drew on many sources and initiatives. One primary project, for example, was the systemwide professionalism self-study launched in October 2005 by system CMO Patrick J. Brennan in response to reports of disruptive behavior across the organization. With the support of UPHS Chief Learning Officer (CLO) Elizabeth Riley-Wasserman, he partnered with clinical and operational leaders to convene focus groups with system stakeholders. The groups identified stressors that undermine clinician professionalism—such as unclear care plans, lack of knowledge about other clinicians’ expertise, and insufficient on-boarding for new clinicians—and shared work practices already emerging at UPHS—many of which involved physician–nurse partnerships—that overcome those sources of stress.

At HUP, Chief Nurse Executive Victoria Rich and Riley-Wasserman seized the opportunity to test some of the practices identified by the focus groups on three units whose troubled nurse–physician relationships threatened to stall the organization’s Magnet application. These pilots yielded positive results; for example, the system’s obstetrical services unit saw improvements in nurse–physician interactions, patient satisfaction, and staff turnover, and HUP was awarded Magnet status in June 2007.

At the same time, the other hospitals in the UPHS system were also developing physician–nurse leadership at the unit level. Administrators at Pennsylvania Hospital aimed to establish physician and nurse leaders on all units, while at Penn Presbyterian Medical Center, administrators began pairing physician leaders with nurse leaders on a number of units. Throughout the model’s development, the UPHS leaders have partnered with an external consultant, CFAR, to facilitate organizational change through a campaign approach.

In preparation for the fiscal year 2008 budget process, the system CMOs and CNOs banded together, creating a physician–nurse partnership at the highest level. Collectively, they established clinical quality goals for UPHS—and priority actions to achieve them—in a “Blueprint for Quality and Patient Safety.” One of those priority actions was to establish unit clinical leadership teams across the institution as a basic “accountability” structure that would support the implementation of other strategic imperatives identified by the Blueprint.
Model expected to yield clinical, financial rewards

Over time, the model is expected to improve quality and safety by reducing rates of infection, medication errors, and mortality, in turn boosting financial return through higher performance-based reimbursement rates, fewer readmissions, lower malpractice rates, and better staff retention. Because the model fosters collaboration and improves communication among nurses, physicians, and other staff, UPHS expects it will also yield higher patient and employee satisfaction, as well as better support physician practice. For instance, because physicians and nurses will round together each day to make key decisions about patient care plans, the model should result in fewer off-hours calls for physicians, and they should experience fewer interruptions during office hours and procedures.

UPHS providing training, infrastructure to sustain model, extend its reach

To sustain the unit clinical leadership model and prepare for extending it across the health system, the CMOs and CNOs continue to work closely with Riley-Wasserman. For example, system unit leadership teams regularly meet one-on-one with the CMO and CNO of their hospital, supported by the system CLO’s staff. The unit teams within each hospital and across the health system also pull together to learn from each other and share their accomplishments in work sessions focused on topics such as interdisciplinary rounding or orienting house staff. Based on the model’s successes to date, UPHS’s Home Care and Hospice Services is interested in adapting the clinical leadership model to create teams focused on effective care transitions.

For more information

To learn more about the nursing leadership role in fostering clinician professionalism at UPHS, see the Nursing Executive Center’s 2007 study Engaging the Nurse Workforce: Best Practices for Promoting Exceptional Staff Performance.

MEETING HIGHLIGHT

Meeting Highlight: Service line-focused internship bolsters student nurses’ clinical experience, meets hospital needs

Recognizing the dearth of new-graduate nurses with specialty skills, administrators at Vanderbilt University Medical Center (VUMC)—an 830-bed academic medical center in Nashville, Tenn.—in 2006 collaborated with the Belmont University School of Nursing to create an enhanced student nurse internship that affords specialty experience to select students. Under the program, students choose one of seven service lines as the focus of their eight-week summer program. To encourage student participation, the nursing school offers interns course credit for completing the program, and hospital administrators provide limited tuition reimbursement. Administrators view the program as a valuable recruitment tool and have seen a return on investment through program graduates’ enhanced specialty clinical skills.

Case element #1: Hands-on specialty experience improves student comfort, skill level

After selecting a clinical specialty at the start of the summer and completing orientation, student interns rotate among units within the service line, spending roughly one week on each unit working 12-hour shifts, side-by-side with an RN preceptor. To simulate real-world working conditions, students complete their clinical rotations by interning four weeks on day shift and four weeks on night shift.