Organization: Northwest Hospital, LifeBridge Health System**.**

Solution Title: Leveraging an Accountable Care Unit approach leads to sustained culture change of shared accountability and improvement of organizational patient safety and quality goals.

Program/Project Description, including Goals:
Recognizing the need for a construct that would replace the inherent silos of health care systems at a Hospital unit based level, we leveraged the Accountable Care Unit (ACU) model to foster a new culture of shared accountability to achieve the Triple Aim. First implemented by Emory in 2010, it was modeled for an academic hospital setting. Many of the defined structures and processes of the ACU model do not lend itself easily to the operations of community hospital setting, such as ours. However, recognizing the value of the ACU model of care, we took the tenets and customized it to form an organizational structure and process that we feel can be adapted to any healthcare setting.

We focused on:

1) creating forums for front line team input to their unit based ACU

2) creating multidisciplinary team leadership

3) zoning staff to the ACU to encourage team accountability

4) involving all possible department representatives into the ACU model

5) unit based outcomes metrics

6) creating a structure for multidisciplinary rounds that fosters team collaboration

7) ensuring that ACU operations supported the vision of patient-centered care delivery.

Over the course of 18 months, we used the structure of the ACU in our organization as a way to demonstrate to our teams the commitment to shared accountability and its ability to improve outcomes while increasing frontline team engagement. Additional goals included improvement of patient safety and quality outcomes such as CLABSI, CAUTI, C. difficile, and falls as well as an increase in patient safety awareness and event reporting.

Process:
Leadership understanding and support for the ACU model was established and critical to its success. The ACU model was piloted in one of our Acute Care Medical units in November 2014 to determine barriers prior to organization-wide implementation. This unit was selected based on their challenging mix of medical patients. The ACU team consisted of a Nurse Manager, a Physician Leader, Quality and Education

representatives, Care Manager, an Executive sponsor, and the front line team of the unit. The pilot period was set for 90-days. Elements of the core principles of the ACU model were incorporated into the pilot unit with particular focus on creating a shared accountability around multidisciplinary patient care rounds and identifying and addressing patient safety concerns and quality outcomes as a unit based team.

The ACU team, inclusive of leadership and front line staff, met weekly for 6 weeks to gather input on important components to address during multidisciplinary patient care rounds as well as how to educate the entire ACU on patient safety and quality concerns to improve outcomes. These weekly forums fostered the prioritization of quality and safety concerns and a comprehensive action plan was created which engaged the multidisciplinary care team. Operations of the unit were adjusted to meet the needs of patient-centered care model which included: zoning Hospitalists to the ACU, creating a new workflow between Nursing, Quality, and Education teams, designing rounds that focused on a daily plan of care rather than discharge planning alone. This promoted a change from the previously fractured model of care to a patient-centered and multidisciplinary model of care. At the end of the trial period, analysis of quality outcomes showed a number of improvements: decreased length of stay, decreased number of indwelling Foley catheter days, increased patient satisfaction and increased staff satisfaction.

With these encouraging results on the pilot unit, the ACU model was implemented hospital wide in April 2015. A Provider Leader was assigned to each Medical and Surgical Acute Care unit to act as a Co-Leader of the unit in collaboration with the Nurse Manager. Since this new model of multidisciplinary leadership required considerable cultural change, monthly meetings were held for all ACU Co-Leaders(Nurse Manager and Provider Co-Leader) along with Executive Sponsors to discuss progress and any barriers. All units became a part of the ACU model, including the ICU, Emergency Department, and Acute Care, to encourage inter-unit collaboration and sharing of best practice between units. A charter was created to outline the objectives and goals of the ACU model of care. Unit specific quality and safety outcomes dashboards were created in alignment with organizational goals. Executive leadership met with each individual ACU Co-Leadership team every 2 weeks to facilitate interdisciplinary communication and assist with removal of high level barriers on each ACU to facilitate process improvement with their front line teams.

It is noteworthy to mention that the ACU model of care was presented and discussed at all levels of the organization in multiple forums so that every department was aware of why the ACU model was critical to help drive patient safety, quality, and performance improvement. This also encouraged the use of ACU forums to raise external departmental concerns and create innovative solutions.

Solution:

The original ACU model as outlined by Emory was implemented at an academic institution. Operationalizing this model of care in a community hospital setting presented

a number of challenges as resources and organizational structures differ significantly between an academic and community hospital.

The ACU model of care requires a change from the traditional Nursing Manager driven unit operations to a collaborative leadership model between Nursing and Provider Co-Leaders. Community hospitals typically do not have formalized Medical Directors on all units to fulfill this key role as a Provider Co-Leader. In the initial phase of the ACU implementation, we attempted to have Providers with defined administrative responsibilities in this role on each unit. As the model progressed, the ACU teams felt it was important to have a front line Provider in this Co-Leader role. Front line Provider Co-Leaders could best understand the workflow barriers to process improvement and serve as peer influencers to drive progress at the unit level.

We identified several front line Providers who were interested in this challenge. We recognized that leadership development would be required for this new role, therefore, created a focused development curriculum for these new leaders. These front line ACU Provider Co-Leaders were then coached by their Executive Sponsors as they assumed responsibility in this new role. Additionally, we recognized that forums for both inter-disciplinary as well as peer-based communication would be needed to support the newly formed Co-Leadership teams and ensure shared accountability. These were established with facilitation by Executive Sponsors.

The ACU model of care also encourages zoning of team members to help foster unit collaboration and prevent the need for patients to have multiple hand offs during their hospitalization. Community hospitals typically do not have the resources to implement a unit based zoned staffing model. After the ACU pilot, the benefit of zoning to improve consistency in patient care was clearly noted, therefore, a zoning plan was accelerated into operation on all units for Hospitalists. In addition, support departments such as Quality and Education were also integrated into a zoned based model to encourage shared accountability. Since it was not feasible to have one individual zoned to a single unit from these support departments, their leaders collaborated and created a team structure that not only supported the ACU model with the resources available but also improved inter-disciplinary communication and engagement.

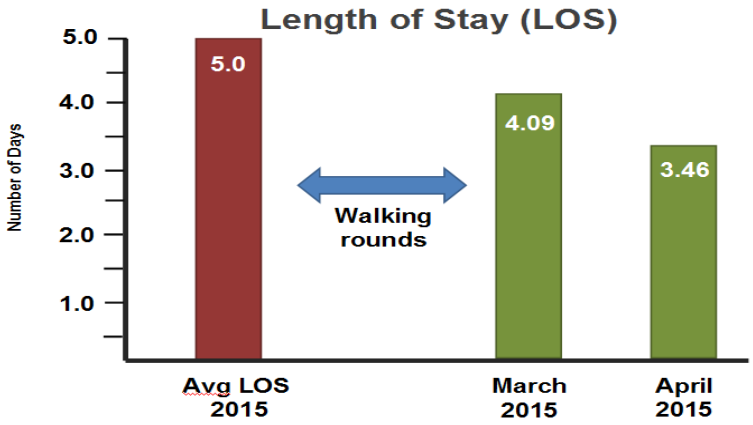
One of the major challenges of establishing the ACU model within a community hospital setting was the design and implementation of daily multidisciplinary patient centered rounds. Traditionally, multidisciplinary rounds are felt to be best suited to academic hospitals given the daily time commitment and focus on education. Additionally, in the Emory ACU model, team-members participating in rounds had defined role expectations and also included a larger resource team, such as residents and other care coordination staff. We had to develop and design a model for multidisciplinary rounds that truly worked for the team structure of a community hospital. This required extensive discussions with leadership and front line teams about the value of a multidisciplinary approach to patient centered care in order to get their buy in and input to move forward with this model of care since it involved significant changes to the workflow of every unit based team member. Even with this commitment to communication and partnership,

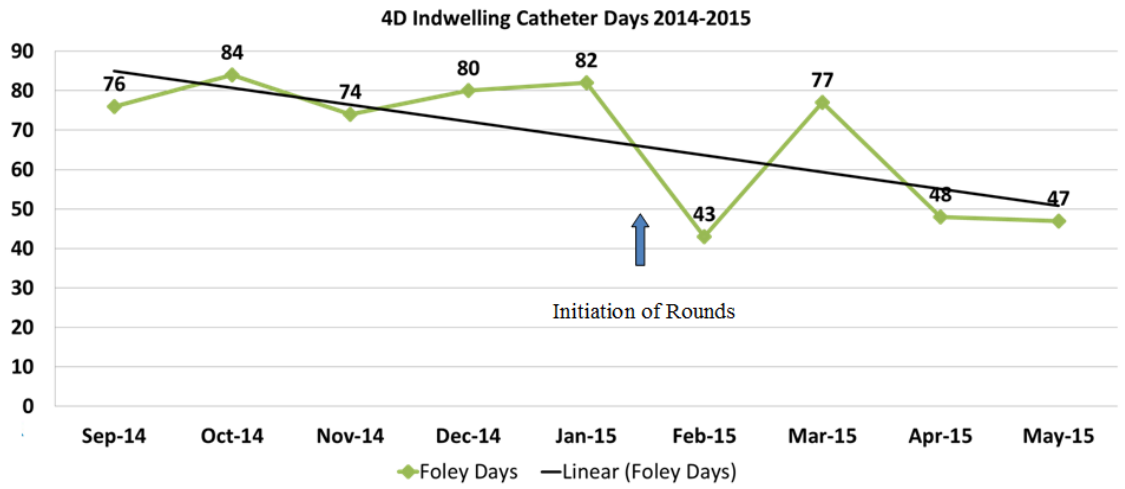
significant concerns were raised from all front line disciplines particularly regarding the time commitment of rounds and a perception that rounds would duplicate work rather than add value. Ultimately, it was only by performing ACU rounds for several weeks that front line teams began to see its value:

1) Nurses realizing they were receiving information from Providers that prevented delays in care or miscommunication
2) Providers realizing they were getting fewer phone calls from Nursing asking for clarification of the plan of care
3) Care Managers able to implement the plan of care earlier in the day
4) Charge Nurses identifying issues around care coordination or patient quality concerns before it escalated.

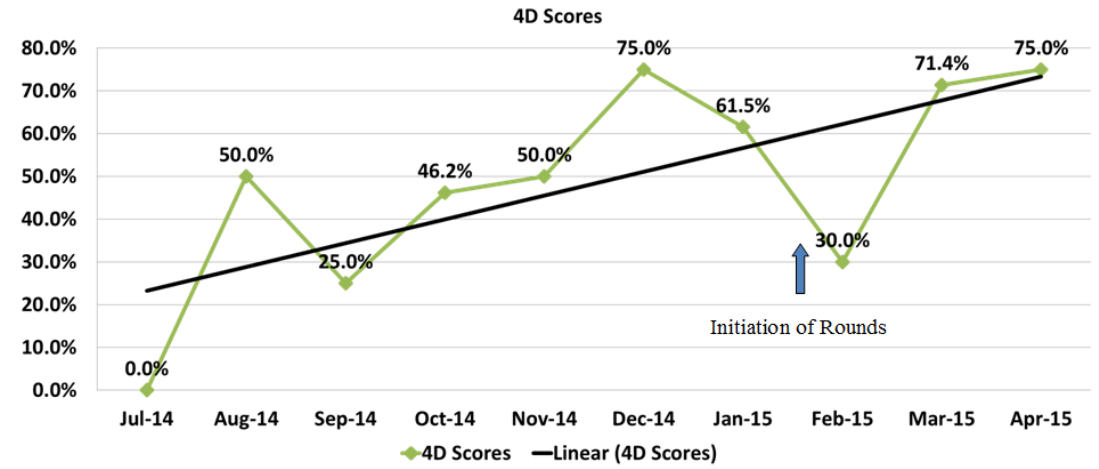
As the ACU model progressed, the front line teams began to demand high level performance from their peers. This resulted in a "Ground Rules for Rounds" document, created by front line teams, which defined the role of each member of the rounding team and high performance behaviors: a concept created by the Emory ACU model, but re-engineered to meet the specific needs of a community hospital team.

Measurable Outcomes:
From the initial pilot unit, the ACU model resulted in notable improvements in length of stay, decrease in indwelling Foley catheter days, and improvement in unit based HCAHPS score even within the 90 day pilot period. Of interest, there was an initial decrease in HCAHPS Overall Rating in the month after initiation of multidisciplinary rounds on the pilot unit. With the new ACU multidisciplinary structure, collaborative root cause analysis was performed on the unit to determine the cause of the decline and corrective action put in place to address the appropriate etiology. Previous to this ACU process, the multidisciplinary input needed to perform such an analysis and put together a collaborative action plan had been a significant challenge.

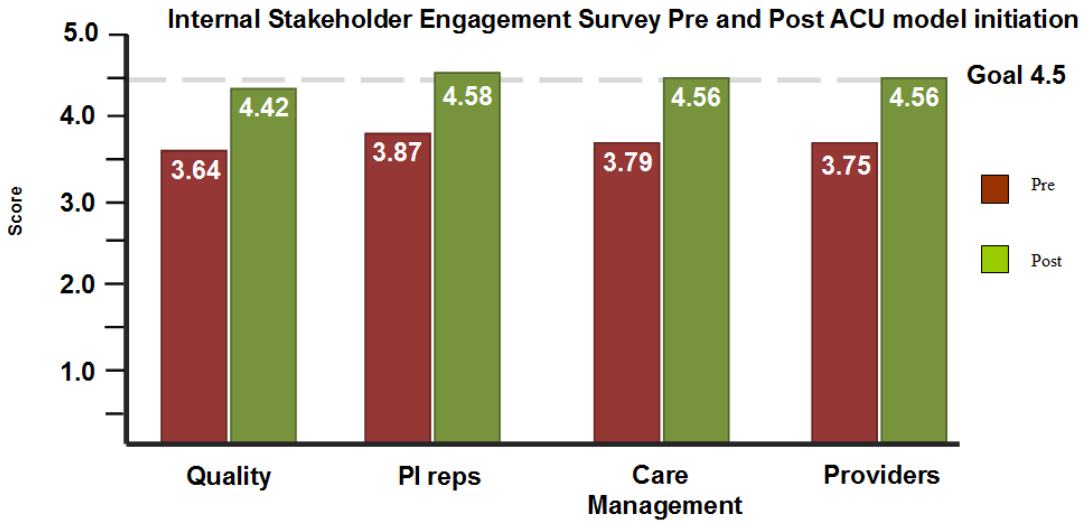


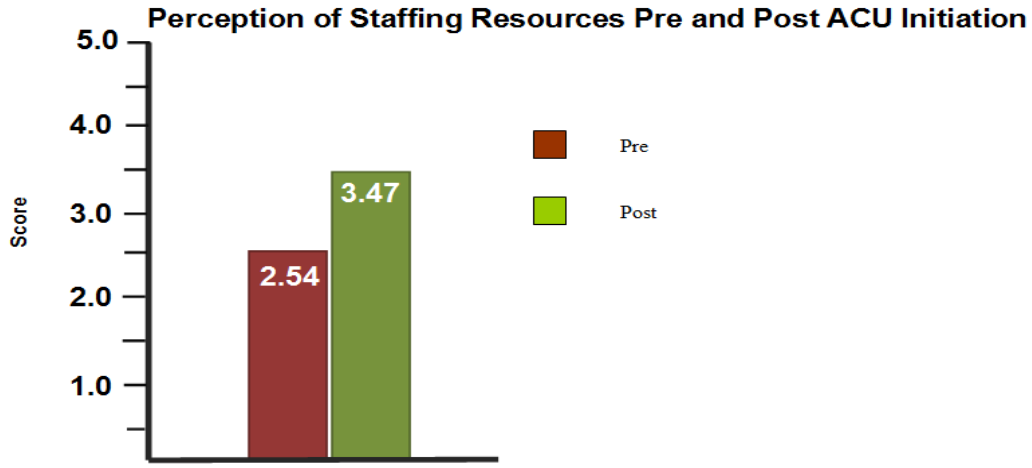


HCAHPS: Overall Rating

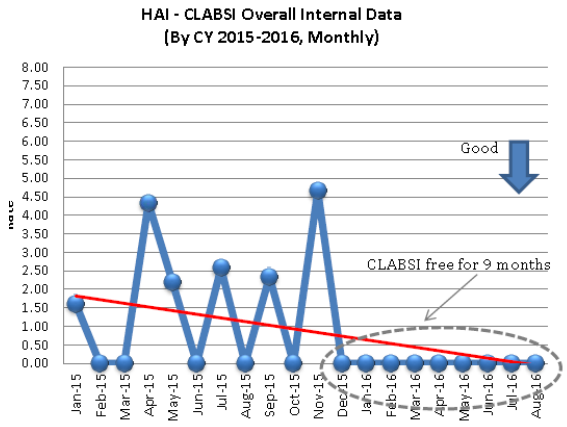


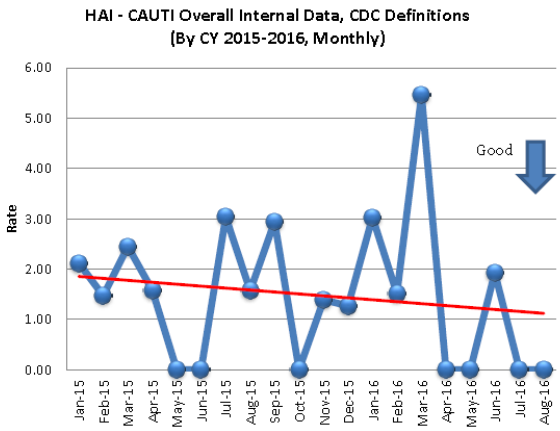
As part of the pilot, an informal engagement survey was conducted of the unit based nursing staff prior to the implementation of the ACU model, and again between 30-60 days. Surveys assessed their perspectives on interdepartmental support and resources. Post ACU implementation, there was a significant improvement in their perception of multidisciplinary team member support. Of note, nursing teams felt their staffing resources had also improved with the ACU implementation, even without an actual change to the staffing model.

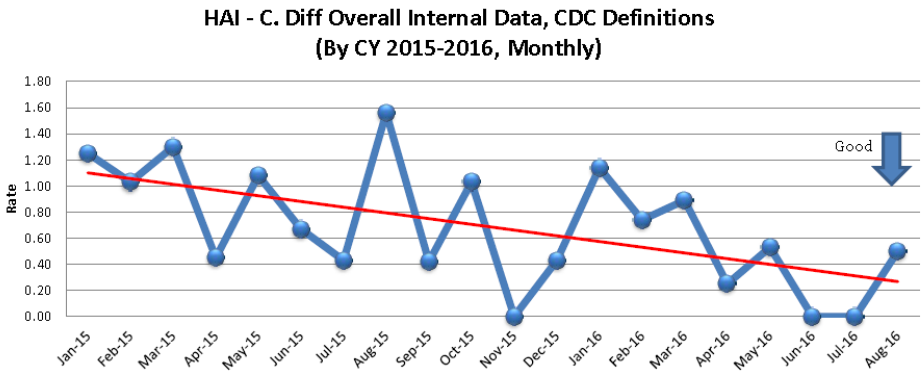


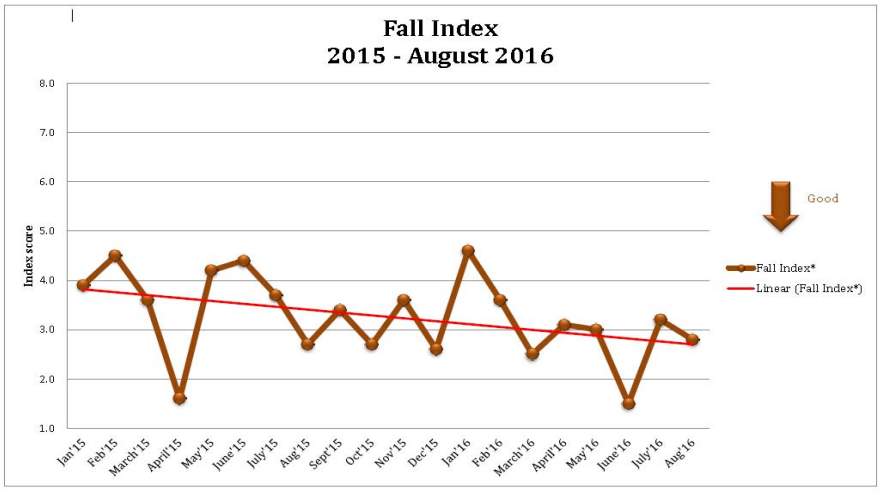


After organization wide implementation of the ACU model, with its focus on multidisciplinary rounds, there was clear improvement in a number of quality and patient safety outcomes: CAUTI, CLABSI, C. Difficile, Falls, and event reporting. The improvement in these goals was particularly noticeable once multidisciplinary rounds were operationalized in late 2015 and early 2016 on the units as part of the ACU process. In the graphs below, the sustained improvements in these outcomes were noted in 2016 as the ACU Co-Leadership and front line members built team trust and adjusted workflows as part of their process improvement in this new model of shared accountability to patient safety and quality outcomes:

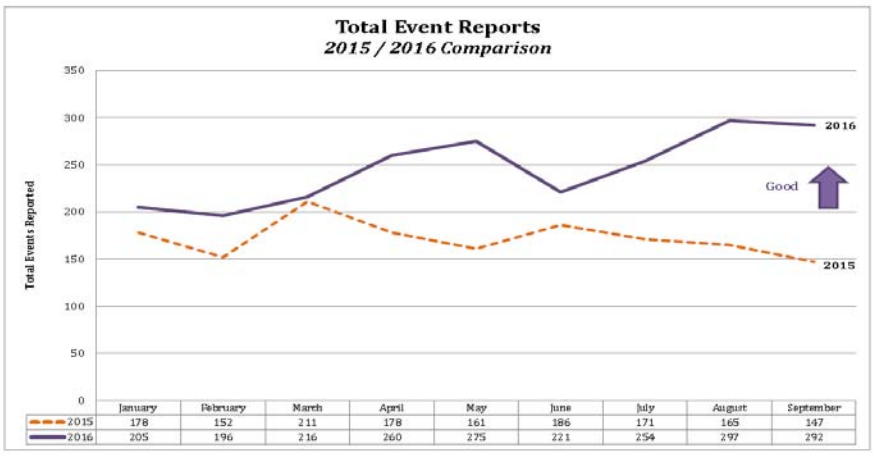








* Fall Index= (number of falls/ patient days) x 1000



Sustainability:
Critical elements to sustaining this model of care were defined early on in the process and included frontline team engagement and willingness for continual process improvement.

Once leadership and frontline teams were educated about the ACU model and initial structures put in place, ongoing conversations with the team, their ACU Co-Leadership, and their Executive Sponsors revolved around the operational changes needed to implement and sustain the model throughout the organization. Front line team members were engaged in every step of the process of the ACU model implementation and their Co-Leadership recognized the need to communicate how operational changes were put in place based on their input to reinforce buy-in and sustainability.

Outcomes were discussed openly so that frontline teams could track how the processes they put in place were having an impact on patient safety and quality on their units. This created conversations around process improvement with commitment by frontline teams to shared accountability to their unit based quality outcomes. ACU teams also began to recognize that incremental process improvement was a necessary part of any process improvement project, which allowed them to celebrate incremental successes and share innovative solutions, further enhancing the shared accountability structure of the ACU. This created a culture around the ACU model that was amenable to piloting changes quickly, assessing outcomes, and adjusting the implementation process based on feedback.

The inter-disciplinary structures created to implement the ACU model, also ensures its sustainability. The new ACU Co-Leadership forum shifted focus from operationalizing the model and discussing barriers to reinforcing the significant cultural change towards shared accountability on their units. There was recognition early on about the time intensive process involved to fully implement the ACU and the need to ensure the model enhanced, rather than supplanted, other unit operations or priorities. While units were expected to incorporate all elements of the ACU model of care, Executive Sponsors worked with the individual units to ensure that the timing of implementation of the discrete elements aligned with the strengths of the unit and their Co-Leadership team.

Utilizing this deliberate approach, other organizational departments entered into the fold of the ACU model in a phased manner, allowing it to spread throughout the organization. The model has now expanded outside of the original Acute Care, Intensive Care units and Emergency Department and is being implemented in our SubAcute Unit and planned for our Behavioral Health Unit.

Role of Collaboration and Leadership:
The ACU model is built on the foundation of multidisciplinary collaboration. We recognized that multidisciplinary collaboration not only requires will and support, but also a defined structure, in order for the ACU model to succeed. Prior to implementing the model, our front line teams had little understanding of one another's work flows or operations, creating a significant barrier to collaborative conversation and problem-solving. This led to frequent misunderstandings and the perception that accountability to patient care was an individual department problem versus a shared multidisciplinary responsibility.

With our ACU teams, we established new forums for both frontline and Co-Leadership teams, to ensure that Providers, Nursing, Care Managers and other support Departmental teams could work through a specific problem together and discuss what each group needed from the other in order to be successful in their shared goal. The robust and very transparent conversations in these forums have led to a culture of shared accountability and patient safety. Recently, an ACU survey was performed on all units to help inform our ongoing process improvement strategy for the ACU model. All disciplines gave high positive ratings to their unit based ACU model and specifically cited the collaborative approach to patient care with other disciplines as the greatest benefit of the ACU model.

As the ACU model progressed, our Quality, Education, and Infection Prevention representatives discovered that their current structure of communication to the front line unit teams was not optimal and began to use the new ACU meeting and communication structure to create a more collaborative relationship with front line teams. This led to a better understanding on the unit of quality and safety based concerns and resulted in a rapid method of disseminating information when issues were identified so they could be evaluated and solutions put in place.

Additional collaboration was fostered between the ACU and the Quality Department to help each unit drive organizational quality and safety goals. Together, the ACU Co-Leadership and Quality Department members identified critical elements to be incorporated in unit based dashboards as well as the Patient safety and quality checklist used on multidisciplinary rounds. The dashboard and checklist were based on quality metrics that were not meeting top benchmarking performance goals, content from quality referrals, reported near misses, or patient safety concerns identified by the front line teams. This partnership led to a significant cultural change in that the Quality Department came to be viewed as a key stakeholder of each ACU team.

Critical to the success of the ACU model was the clear, visible, and ongoing support of all Leaders of the organization at every level. Executive Leadership helped to remove any operational barriers that arose as the ACU model was implemented. Executive Sponsors helped to create new ACU multidisciplinary forums and continue to individually coach the Co-Leadership teams. ACU Co-Leadership worked with their front line teams to outline priorities and create ongoing process improvement plans to achieve their unit based goals. Trust was a key determinant in the success of this model and very transparent conversations were required at all levels of Leadership to ensure true shared accountability within all Departments to achieving organizational patient safety and quality goals through the ACU model of care.

Innovation:
Since the ACU model of care is, in itself, innovative, the solutions created to operationalize this model in a community hospital setting needed to be equally forward thinking.

The newly created ACU forums have led to an entirely new process in our organization whereby the ACU is the structure by which operations at the unit level are discussed and vetted before they are implemented, inclusive of all disciplines. While all ACU teams are working toward quality and patient safety goals, the Co-Leadership now use an approach whereby specific ACU teams work on a safety and quality initiative such as CAUTI or Fall prevention. Once a successful process is fully implemented and barriers addressed, there is then discussion at the ACU Co-Leadership level of how to implement this across all units as a best practice. Utilizing the ACU model in this manner allow units to tackle multiple priorities and maximize time and resources.

Traditionally, Providers do not enter leadership positions with a defined education curriculum or coaching to support them in their new roles. Recognizing that the new role of Provider Co-Leader requires specific skills in peer influencing, providing feedback, and presenting, a focused professional development course was created to teach these skills accompanied by coaching by established Provider leaders in the organization. Additionally, feedback is regularly elicited from Nursing Co-Leaders to ensure that the new team structure provides the level of support they require on the unit to move process improvement forward.

During discussions regarding the need for a multidisciplinary team rounding approach, our Emergency Department Co-Leadership team created a team based model that was uniquely suited for the workflow and patient volumes of the ED. The ED team created an “Efficient Encounter” approach, which allows the Provider and Nurse to create a care plan together at the patient’s bedside with input from the patient and family.

Culture of Safety:
Implementation of the ACU model resulted in significantly increased communication to frontline teams of their unit based patient safety and quality outcomes. The partnership with the Quality and Infection Prevention departments through the new ACU forums led to more robust conversations around the need for event reporting and root cause analysis

to help prevent future quality and safety concerns. The combination of communication and partnerships significantly improved the understanding of the unit based teams that a culture of safety is a shared accountability.

The greatest transformational element of the ACU model as part of the culture of safety revolved around creation of the "Patient Safety and Quality checklist" used for multidisciplinary rounds. The checklist was created to avoid reliance on an individual team member's memory or vigilance regarding specific patient care concerns such as the need to discontinue Foley catheter or central lines when no longer clinically indicated, the dietary intake of the patient to ensure nutrition was being monitored, or if the patient was a high risk for readmission. Each member of the team: Provider, Nurse, and Care Manager, own a portion of the checklist. They are responsible for gathering the information of their checklist accurately and discussing it with the team during ACU rounds. Initially, team members wanted to only mention items on the checklist by exception due to concerns of time constraints on rounds. After extensive discussions between Executive Sponsors, Co-Leadership, and ACU frontline teams, the decision was made to mention all items of the checklist for every single patient to ensure that no one on the team missed hearing critical information as the lack of communication could potentially cause harm for the patient.

This was a defining moment in our ACU transformation. Our teams had clearly moved from creating workflows that revolved around individual team member convenience to creating workflows that were centered around patient care and fostering a culture of safety. Once this critical step was taken, team members were noted to be more open to correcting each other on rounds to ensure accurate information was given, encourage each other to maintain hand hygiene when going in and out of patient rooms, and if errors were noted in the care of the patient, encourage reporting to the Quality department.

Patient and Family Integration:
The ACU model ensures that care delivered is patient and family-centered. The multidisciplinary rounds encapsulates that ideal by changing workflows of the unit based team to revolve around the needs of the patient and create a cohesive plan of care with input from all team members, rather than the traditional fractured approach that often led to miscommunication and delays in patient care. Throughout the implementation of the ACU model, feedback was elicited from patients and their families to inform changes needed for unit based operations.

Prior to the initiation of multidisciplinary ACU rounds, patients and families were queried about their perceptions of communication regarding plan of care, daily updates, and seeing the unit members functioning as a team on their behalf. This input informed the timing and content of rounds significantly. The Unit Welcome from the bedside nurse was also changed to inform patients and families about the significance of rounds so they could be prepared to participate and gather information from the team they felt was critical to understanding their plan of care.

As the new multidisciplinary rounds were being piloted, ACU Co-Leadership would ask patients and their family members about the new team based approach and incorporate suggestions into the model to ensure patient and family centered care delivery. Early on in the implementation of multidisciplinary rounds, feedback revealed confusion from patients and families whether they would be seeing members of their team only during the rounds itself. Based on this feedback, both the Unit Welcome message as well as the team script during rounds were adjusted to clarify to patients and their family members that they would continue to see the members of their team throughout the day to progress the plan of care discussed during rounds.

Related tools and resources:

Stein J, et al. Reorganizing a Hospital Ward as an Accountable Care Unit. *Journal of Hospital Medicine*. 2014; 00(00): 1-5

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