Current and Future Developments in the Acute Care Setting

2016 California Hospital Volunteer Leadership Conference

Edge of Possibilities: Refined Wisdom, New Volunteer Pathways

February 15 – 18, 2016
Monterey, CA

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Objectives

• Review ACA Changes
• Identify Emerging Trends in Health Care
• Hear the CNO Thought Leader Opinion poll on Traditional Acute Care Activity
• Understand Complexity and the need to CREATE change
• Listen to stories from the field and develop ways volunteers can accelerate care integration
MEDI-CAL AND COVERED CALIFORNIA ENROLLMENT

* California 2015 population – 39.1 million
Providing coverage to 12.8 million residents (half of all children)
Access barriers are amplified by low Medi-Cal payments
Expanding coverage without access is a problem
Facts / backlash
DEMAND FOR HEALTH SERVICES SURGES

- Medi-Cal expansion is driving increased demand
- More than 200,000 additional Medi-Cal inpatients
- 4 million more Medi-Cal outpatient visits
Demand for care increased Medi-Cal ED visits by 1 million
Low payments to doctors have reduced access
Medi-Cal patients turn to overcrowded hospital EDs
- Medi-Cal uncompensated care in hospitals exceeds $6 billion a year
- Cost shift reaches 55% in 2020
TRANSFORMING FOR TOMORROW
From Providing Care to Managed Care

A New Strategic Construct

Individual and Employer Enrollment

Health Benefit Exchange

Health Plan and/or TPA

Government Enrollment

Population Manager

Post Acute

Hospital

Physicians

Ancillary

Pharmacy

Behavioral

Other

Source: Kaufman Hall and Assoc.
Prepaid

Population Health Manager: Integrated delivery system and/or health plan with the ability to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to develop own insurance products and/or manage full provider risk

Population Health Comanager: Regional provider organization, clinically integrated with other organizations, that forms a value-based delivery system; well positioned to participate in PHM and risk-bearing arrangements, in a delegated and/or direct fashion

Multiproduct Participant: Provider organization that works within a network(s) managed by a Population Health Manager/Co-manager to provide a defined set of services for a broad population base comprised of both government and private-pay patients; critical role in future delivery system

Single Product Participant: Provider organization working within a network managed by a Population Health Manager/Co-manager, to provide specified and targeted services and/or population; these organizations will be critical components of narrow networks

Contracted Participant: Smaller niche providers, some of which may serve rural communities, that provide population access points under contractual arrangements; they face significant risk of commoditization
THE NEW HEALTH ECONOMY IS CHANGING THE HEALTH CARE LANDSCAPE AND DRIVING DEAL ACTIVITY IN THE MARKET

New Entrants & Disrupters

- **Fact:** Of the 38 Fortune 50 companies with a major stake in healthcare, 24 are new entrants

Risk Shifting

- **Fact:** By 2018, 50% of health systems are expected to apply for an insurance license

Convergences

- **Fact:** Total hospital transaction value increased from $1.9B in 2012 to $18.6B in 2013

Consolidation & Affiliation

- **Fact:** Consolidation has increased more than 50% since 2009

Health care leaders will need to adjust their strategy to align with the new definitions of success in the New Health Economy

Source: Hospital Physician Alignment. The Future of Integrated Health Care, PwC
Payment Reforms

Both public and private payers are shifting towards “retail” with extreme pressure on cost and delivery of value.

High cost procedures product lines move from assets to liabilities – focus on primary care and population health.

Extreme need for appropriate levels of social support, care management and care transitions outside the hospital walls….necessitating the need for fewer ED and inpatient admissions…..BUT
Misaligned Incentives and Inadequate Resources

• Inadequate levels of social resources, community supports, labor shortages in primary care, high cost wages, underfunding in government programs is leading to increased hospitalizations, increased ED admissions, lack of primary care providers

• CHAOS
The Journey is Treacherous

Significant change will depend on aligned incentives
FUTURE TRENDS

- Consumers’ involvement
- New capital models to finance healthcare transitions
- Transparency and data
- Disruptive technology & Innovation
- Workforce leadership/complexity competencies
- Population Health, wellness movement
- Massive Healthcare reengineering
- Behavioral Health Integration
So What Do Hospitals Look Like Today?

• Opinion poll of CNO thought leaders across the state
• Most notable was slowing in inpatient and ED census increases, and sluggish social service, community and volunteer innovation
• With the need for more care integration, and social services, how can volunteers connect and cross fertilize the inpatient arena for success?
Traditional Acute Care Hospital Operations in Response to ACA and Health Care Reform
2015-2016 Comparison

Opinion Poll
Q1: Has your inpatient census increased?

- 2015: 68.75%
- 2016: 65.79%
Q3: Has your ED census increased?

100%

89.47%
Q5: Have you increased your licensed inpatient beds?

- 2015: 20%
- 2016: 5.26%
Q7: Have you added service lines?

2015 Service lines added include:
- Palliative care
- Short stay unit
- Observation and procedural patients
- Cardiovascular, neuro, oncology
- Complex care
- Building Ortho
- Neurosurgery
- Orthopedic Center of Excellence

2016 Service lines added include:
- Oncology
- Orthopedic
- Swing Beds
- Spine Program
- Tele Behavioral Health, Tele Cardiology Retail Pharmacy (Launching 7/2016)
- Primary Stroke
- Neurosurgery
- Urology
Q9: Have any of your departments been outsourced?

### 2015
Outsourced departments include:
- Housekeeping
- Dietary
- Engineering
- Billing
- Lab

### 2016
Outsourced departments include:
- Coding
- Therapy
- Revenue Cycle
- Facilities
- EVS
- Home Health
- Housekeeping
- PFS (Partial)
- HIM (Partial)
- JV
- Dialysis JV
- Outpatient Surgery (In Discussion)
Q10: Has technology changed your staffing or work flow patterns?

- 2015: 87.5%
- 2016: 60.53%
Q10: Has technology changed your staffing or work flow patterns?

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<tr>
<th>2015</th>
<th>Changes include:</th>
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<tr>
<td>• Centralized patient placement</td>
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<td>• Electronic asset tracking</td>
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<td>• Nurses spend more time completing tasks on computers rather than assessing the live patient</td>
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<tr>
<td>• Teletracking, bed placement, bar coding</td>
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<td>• EMR has increased over time to complete documentation - affects bedside care</td>
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<tr>
<td>• EPIC - enterprise wide</td>
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<tr>
<td>• Added chemo admin</td>
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<tr>
<td>• Workflow</td>
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<tr>
<td>• In a positive way</td>
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<td>• EHR requirements have pulled staff away for direct PT contact Insufficient resource for complete overhaul of systems to fix the add-on nature of EHR refinements and builds</td>
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<td>• CPOE has changed workflows</td>
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<td>• EMR implementation on 1/31/15</td>
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<table>
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<tr>
<th>2016</th>
<th>Changes include:</th>
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<tr>
<td>• Implementation of eHR</td>
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<td>• Surgical Robot</td>
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<td>• EMR has increased staff time to complete documentation</td>
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<tr>
<td>• RN workflow is highly integrated with documentation</td>
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<tr>
<td>• BCMA workflow has changed</td>
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<tr>
<td>• Workflow</td>
<td></td>
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<tr>
<td>• Implementation of CPOE and PDoc have changed workflow patterns for physicians and staff</td>
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<tr>
<td>• EHR requirements impacts every nursing area. Attending MDs are allowed to give verbal orders in high risk areas of ED, L&amp;D</td>
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<tr>
<td>• PerfectServe – used for timely and efficient communication between physicians and RNs</td>
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<tr>
<td>• Delays in ED care. Hybrid record most dangerous.</td>
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<tr>
<td>• Technology has not changed staffing but it has changed the way nurses carry out their duties. It has created some efficiencies in communication that were troublesome in the past.</td>
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<tr>
<td>• More difficult for nurses</td>
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<tr>
<td>• Significant workflow changes for nursing and medical staff with eHR, ePrescribing and CPOE</td>
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Q11: Has discharge planning staff increased?

- 2015: 57%
- 2016: 58%
Q12: Have new social or community services been added?

**2015 Added services include:**
- CHF monitoring outside hospital
- Continuum of care clinics and navigators
- Transitions
- Care experience
- Increased senior outreach
- Adult day health increased
- Well Space

**2016 Added services include:**
- Community Benefit dollars support the Wellspace Clinics
- Ambulatory Infusion Clinical, Oncology and navigators
- Wellness Center
- Diabetes Clinic
- Respite for Homeless Placement
- Community Navigators in the ED
- Transitional Care Clinics
- Outpatient Social Workers in Community Health Center
- Increased Community Services
- FQHA – Community Navigation Program
- Spiritual Care
Q13: Have changes occurred to improve patient satisfaction?

Patient Satisfaction
“We are listening—”
Q13: Have changes occurred to improve patient satisfaction?

2015 Patient satisfaction improvements include:
- New director
- New focus; renewed focus programs
- Added number of NSQ assistants and volunteers
- There is a new patient experience leader/director and M-F senior leaders conduct patient rounds
- Focus on pt experience HCAHPS
- Senior mgmt parenting, effective communications, staff advocates
- Manager rounding; d/c f/u phone calls
- Pt experience efforts
- Support groups
- Integrated EHR
- Hourly rounds; huddles
- Our patient experience committee has been very active with honoring sleep, Care Channel for relaxation, Disability assistance program
- PXO appointed part time; focus at the highest levels of drivers of this experience

2016 Patient satisfaction improvements include:
- New building, staff simulations
- Renewed focus programs
- Committee set up to work on communication aspect of patient satisfaction
- Rounding and posting d/c f/u
- Focus on behaviors that convey the nurse is “listening carefully” or confirming that the nurse is “explaining in a way the patient can understand”
- Lean Work
- Private rooms, beside report
- Manager rounding
- Process surrounding Discharge Instruction Pain Committee
- Hourly rounds; pharmacist involvement in medication reconciliation and post discharge, f/u calls by nursing and pharmacist
- Training, education, communication
- Workflow changes at entry points, extended hours, culture shifting
- New Experience Leaders and Program
- Patient Survey
- Senior Leaders rounding, group debrief has resulted in improved patient experience as well as great team building and closer relationships among the management team
- Patient experience event for staff, physicians, volunteers
- Staff driven committees, patient centered advisory council development
Q14: Have you added new types of caregivers or assistants?

- 2015: 18.75%
- 2016: 15.79%
Q15: Have you changed your organizational structure?

- 2015: 31.25%
- 2016: 39.47%
Q15: Have you changed your organizational structure?

2015

Changes include:
• Create CAO's for programs and service lines
• Nurse assistants were terminated
• Care model back to primary nursing
• Mid mgmt assuming more duties and areas
• Added population-based Exec Admin Directors

2016

Changes include:
• Added Director of IP and ED Services
• Added CIO position, changed reporting to CNO/COO departments
• Rebid all RN positions, put a 75/25 FT/PT structure (previously 25/75)
• 12 hour shifts with consistent Charge RNs
• Added 3 Managers
• Promoted 2 Managers to Directors Pan and Palliative Care PA
• Combined positions
• Chief Clinical Officer has oversight of nursing services in the hospital and RHCs
• Turn-over of Hospital Executive Team and Directors
• Added a VP of Experience
• Adding a CNO level back into structure
• Reorganized Patient Care Services
• Reorganization with Quality and Risk
• Decreased administrative level FTEs with sharing responsibilities between hospitals
• President and CFO oversees 2 hospitals
Q16: Have you changed your use of volunteers?

### 2015 Volunteer usage:
- More in the ER
- Increased number of navigators
- Allow nursing students to volunteer and help with some manager assistant tasks
- Care partners for pts without families
- Not sure
- Already have robust volunteer program

### 2016 Volunteer usage:
- Helping patients with technologies available in rooms
- Additional responsibilities to improve patient experience
- Some nursing departments and ED developing their own programs for volunteers
- Added more clinical student / volunteers, COPE program
- We need to build a volunteer department

**Graph:**
- 2015: 42.86%
- 2016: 13.16%
Q17: Has your role changed?

2016
Changes include:
• Requires a deeper understanding of business principles and ability to educate upcoming leaders on those principles
• CNO/COO combined role with lab, nutrition, pharmacy, QU, Education, IPC, Case Management reporting in addition to all nursing departments
• Constantly evolving job role to encompass new programs and requirements
• Additional responsibilities
• Formal CNO position absorbed into the CCO role
• Broader oversight of all nursing and ancillary clinical departments
• Added Hospital Overview
• Major focus on regionalization, standardization and cost reductions
• Additional responsibilities over ancillary services and indirect responsibilities for initiatives such as PCMH, Wellness Center Development and Transitions in Care
• More hands on
• More focus on length of stay
Q18: Have you changed your nursing care model?

2016
Changes included:
• Transitioning from Marie O-Rourke to Watson’s Therapy of Human Caring
• New primary care and using LVNs to staff for swing beds
• Moving into new facility utilizing flex RN positions
• Focusing on patient centered care
• In transition due to limited LVN role

2015
2016

26.67%
15.79%
Q19: Have you added patient care extenders (PA/NP's)?

- 2015: 62.5%
- 2016: 42.11%
Q20: Have you added hospitalists?

- 2015: 43.75%
- 2016: 52.63%
Key Points for Volunteers

• Slowing of ED and Inpatient increases
• Decreases with technology, social services, patient satisfaction and community involvement
• Increased use of hospitalists, & minimal changes with caregivers, assistants, PA’s/NP’s
• Increased in organizational structure changes
• Decreased changes with volunteers
Complexity

• Chaos is a byproduct of the Information Age
• There are patterns of order hidden within the complexity of organizations
• Organizations are dynamic, complex, and unpredictable
Margaret Wheatley

• “Growth appears from disequilibrium, not balance”

• “Order comes out of chaos”

• Focus needs to shift from tasks to focus on facilitating processes needed to CREATE desired goals/outcomes
Conclusion

• Acute care hospitals are in the midst of major transformational changes
• Volunteers have a long history of caring for patients non-clinical needs through unique programs in multiple venues
• Volunteers have exceptional talents & community connections to assist hospitals in the journey
Addressing Real-Time Patient Needs through Structured Volunteer Rounding

Mary Alice McLoughlin
Manager, Volunteer and Customer Services
Community Hospital Long Beach California
The Challenge

How do you identify (and fix) the problems that may start out small but can escalate?

Patients may fear becoming a burden to clinical staff. Basic issues can go unreported – Until it's time to fill out that survey.
Why use Volunteers to uncover real-time needs?

- They are neutral.
- They are dedicated to one responsibility.
- Non-clinical so patients view them as a peer.
- They often have more time to listen.
- Contributes to staff satisfaction.
Establish the Program

- **Identify candidates**: self motivated, good communicators, problem solvers and ease interfacing with clinical staff
  - Referrals
  - Ask behavior based questions of them

- **Training**: role playing with trainees
  - Introduce new volunteers to key staff
  - Shadow experienced volunteers
  - Observe new volunteer-patient interactions and provide real-time feedback
Establish the Program

• **Educate clinical staff:** volunteers are there to assist

• **Monitor:** DVS checks logs daily to ensure proper documentation and follow up
How Does it Work?

• One Volunteer per day
• Volunteer checks census and identifies those admitted within the past 24 hours
• Names and Room numbers are logged
• Patients are visited and asked specific questions
How Does it Work?

• Any concerns are reported and logged by the volunteer

• Follow up is done same day

• Log sheet is submitted daily to DVS

• Rounding reports sent monthly to Administration
Provide Resources

Volunteer Resource - Who do I call?
Equipment problems – anything that’s broken or doesn’t work – call ENGINEERING at XXXX.

Phone issues: call XXXX

Environmental problems – trash, dirty floors, etc: page ENVIRONMENTAL SERVICES at XXX-XXXX

Lost property: call SECURITY at ext. XXXX


Talk to the AUM (Assistant Unit Manager) on duty.

I want a Social Worker – call ext XXXX
COMMUNITY HOSPITAL LONG BEACH
SECOND DAY ROUNDS LOG
VOLUNTEER: _______________ DATE: _______________

<table>
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<tr>
<th>Room</th>
<th>Patient Name</th>
<th>Item for Follow-Up</th>
<th>Action Taken</th>
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Second Day Rounds 2015

- 1,122 Visits
- 72 Complaints

Percentage of complaints by Quarter
Q1 - 11%
Q2 - 6%
Q3 - 5%
Q4 - 3%
Issues Reported

49%
Equipment
TV Remotes, Phones, etc.

33%
RN/MD Communication
Noise

12%
Food issues

6%
Lost Property
Supplemental Programs

Additional or “Niche” projects are piggybacked on original volunteer rounds

- Pharmacy hotline information distributed by rounding volunteers
- Targeted questions can be included; during a noise reduction initiative volunteers are instructed to target that topic, thus providing real-time data to Administration
Vanderbilt Volunteer Services
Inpatient & Peer Visitor Programs

Andrew Peterson, CAVS, M.Div., MMHC
Director of Pastoral Care & Volunteer Services
Vanderbilt University Hospital & Vanderbilt Health
Vanderbilt University Hospital & Psychiatric Hospital: 834 Beds
Monroe Carell Jr. Children's Hospital at Vanderbilt: 271 Beds
Total Licensed Beds: 1,105 Beds
Level 1 Trauma Center

Hospital Discharges: 59,118
Surgical Operations: 53,468
Ambulatory Visits: 1.85 million
Emergency Room Visits: 118,590

Lifeflight Air Transport Patients: 4,756/year
   5 Helicopters & 1 Fixed Wing Aircraft

Employees: 19,600
   Students: 1,880
   Trainees (Residents, Clinical & Postdoc Fellows): 1,442
Inpatient Visitor

New-Patient Visitor/Inpatient Visitor

Need Identified: Skylight System
Education Videos
Fall Prevention Info.
Call Light Response
Quiet Time Protocol
Patient Handbook
Discharge Video

Hospital Information

Each button contains important hospital information in a variety of areas for patients and family members.
Develop Tracking Log

- Communication between volunteers
- Communication with patient/clinical staff
- Each unit may be different or have different forms
- Way to track volunteer impact
Quiet Time &
Pass with Care Protocols

What EVERYONE can do:

- Reposition call light, telephone, bedside table, chairs, trash can, tissues or other personal items within reach
- Assist with making phone calls or answering the telephone
- Change TV channels or turn the TV on or off
- Turn on lights or dim lights for the patient
- Reduce clutter
- Give patient a book or magazine
- Before providing the following items, please check with a nurse: blanket, towel, washcloth, slippers, earplugs, eye mask, toiletries, pen and pencil

If unable to help, please find a nurse

What must be done by the Patient’s NURSING CARE TEAM:

- Explain clinical matters/treatments as appropriate to your discipline
- Manage an IV and/or infusion pump (RN/LPN only)
- Turn off any alarms (RN/LPN only)
- Receive pain relief requests
- Physically assist a patient
- Assist patients with eating and drinking
- Remove meal trays or water pitchers (RN/LPN/CP/Nutrition Services)
- Raise or lower a patient bed
- Pick up linens
- Enter isolation rooms to assist patients

Quiet Time Protocol

Interventions to Reduce Noise from 11 pm – 4 am

- Standard overhead announcement at 9 pm to identify the end of visiting hours and the start of quiet hours from 11 pm-4 am
- Conversations in nursing stations and other areas are minimized or conducted using quiet voices.
- Burned care – limit patient interruptions during quiet time
- Dimmed lights in hallway and patient rooms
- Overhead paging is minimized
- No audible television volume allowed in semi-private rooms - ear phones for TV's required
- No audible televisions/music noise in hallways
- Ear plugs and masks available for patients who send a "Too Noisy To Rest!" alert through the Skylight system or upon patient request
- Use of Skylight fan for white noise

Visitors are encouraged to honor the Quiet Time Protocol
Inpatient Training

Role of Inpatient Visitor
Log Book
Tips on Visiting Patients
  • Foam/Gel In and Out – Every Patient, Every Time
  • AIDET
  • Active Listening
When not to visit
Skylight System
  • TV/Cable/Movies/Games
  • Internet
  • Education Videos
  • Environmental/Nutrition Services
Patient Handbook
  • Infection Control
  • Fall Prevention
  • Who’s caring for you
Quiet Time & Pass with Care Protocols
Convey questions & concerns with Nurse
Current Units:

Cardiology Units (ICU & 2 Step Down)
Women’s Health
8th Floor Medical/Surgical
Acute Care of Elderly Unit
Burn Unit
9 Floor (Urology & Orthopedics)
7CCT - Transplant
Palliative Care

Future Expansion:

Myelosuppression Unit
Oncology Unit
6 North - Neuroscience
Divide Cardiology Units
General Medicine
MICU
SICU
Peer Visitors at Vanderbilt

- Cancer Clinic – Hope Connection
- Trauma Unit – TSN
- Cardiology – Bypass & Heart Transplant
- Trans Peer/Buddy
- Laryngectomy
Hope Connection

Patient Advocacy Program

- One-to-One telephone support
- Available to all cancer patients and family members
- Matches patient with a survivor/caregiver who has experienced the same type of cancer
- Does not replace the medical team
Trauma Survivors Network

- Provides one-to-one support for patients and family members from former patients and family
- Assist staff with support groups
- Provide resources/info. for time in hospital/rehab/home
- Educate families to TSN website
TSN Peer Training

Training:
- General Volunteer Orientation
- Overview of Trauma Unit & TSN
- Who are Peer Visitors
- Visitor Logistics
- What to say and what not to say
- Active Listening
- Body Language & Nonverbal Communication
- Recovery Process
- Cultural Concerns
- Spirituality & Recovery
- Report back
Trans Peer Buddy

The goal is to increase access to care and improve healthcare outcomes for transgender people by providing support to transgender patients. We emphasize a patient-centered approach, with the goal of empowering the patient to make informed healthcare decisions.

What is the need?
Transgender people face significant obstacles to informed, compassionate care. As a result of past discrimination or fear of discrimination, many transgender people put off seeking healthcare, resulting in health disparities and poor health outcomes. In a national survey by the National Center for Transgender Equality, 50% of transgender respondents report having to teach their providers about their transgender identity, and 48% of transmen and 27% of transwomen report postponing their healthcare due to fear of discrimination by a provider (Grant et al., 2011). By providing support and patient-centered advocacy, the Trans Buddy Program and its patient advocates will help to reduce postponement of care by transgender people.
Trans Buddy Training

Day 1:
• Trans 101
• Logistics
• Volunteer Service Procedures
• Values Clarification
• Autobiography
• Health Systems, Team Based Care & Professionalism
• Tough Questions Workshop

Day 2
• Expectations, Do’s, Don’ts & Schedules
• Reading Body Language
• Case Studies
• Self Care
Identify Stakeholder/Champion

Current Inpatient Volunteer Supervisors:

• Cardiology – Marketing Manager
• ACE Unit, Palliative Care & Burn Unit – Nurse Educator
• Med/Surge & Transplant – Unit Manager
• Women’s Health – Charge Nurse

Current Peer Visitor Supervisors:

• Hope Connection – Patient Advocacy Coordinator
• Trauma Unit – Trauma Outreach Coordinator
• Laryngectomy – Nurse Manager
• Trans Peer Buddy – LGBTQI Health Program Coordinator

To be successful:
Need a “Champion” in each area
HCAHPS Survey Domains

- Communication with Nurses
- Responsiveness of Hospital Staff
- Communication with Dr.
- Cleanliness of Hospital Environment
- **Quietness of Hospital Environment**
- Pain Management
- Communication about Medicines
- Discharge Information
- **Overall Hospital Rating**
- Willingness to Recommend
- Care Transitions
HCAHPS Improvement Committee

Provided a seat at the table with clinical staff and administration

In-Patient Visitors were written into the new Quiet Time and Pass with Care protocols

Institution wide rollout March & July 2014

Quiet Culture  Responsive Culture  Service Recovery
Patient & Family Centered Care Resources

1. Crossing the Quality Chasm: A New Health System for the 21st Century Printed in 2001 by the Institute of Medicine
   www.iom.edu

   www.theberylinstitute.org

3. Institute for Patient & Family Centered Care
   Includes Picker Institute Documents – “Always Events”
   www.ipfcc.org
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