Top Insights from the 2017 System Chief Nurse Executive Roundtables
Brief Introduction to the Roundtables

On June 8, 2017 and July 20, 2017, system chief nurse executives convened at Advisory Board’s offices in Washington, DC for the Nursing Executive Center’s annual System Chief Nurse Executive Roundtables. The goal for the annual Roundtables is twofold: to offer a forum for system chief nurse executives to discuss some of the most pressing issues in health care and to identify the specific role system nurse executives should play in overcoming those challenges.

The agenda included three areas of focus:

- **Health System Strategy in the Post-ACA Era**: Key lessons learned from the Affordable Care Act (ACA), no-regrets strategies for providers regardless of policy changes, and the impact of shifting patient demographics and clinical needs on the future of health systems’ business models.

- **Embedding Care Standards into Workflow System-Wide**: How to create care standards that improve quality, reduce costs, and make care at the bedside easier—not harder—to deliver.

- **Getting Multimillion Dollar Health Care IT Systems to Advance Clinical Strategy and Practice**: How to advance organizational goals with IT and maximize the value of the EHR without relying on customization.

This document highlights eight insights from the Roundtables. The insights are drawn from system chief nurse executive attendees and Advisory Board content. The Nursing Executive Center would like to extend a special thanks to the system chief nurse executives who participated in these full-day working sessions, all of whom are listed on the following page.
### Participants

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  *Universal Health Services, Inc.*
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System CNE Roundtable Insights, 2017

1. Widespread celebration of coverage expansion overlooks the rising challenge of uncompensated care.

2. Health systems should push for the expansion of APRNs’ scope of practice in acute care settings.

3. Inflexible reimbursement policies are preventing virtual technology from revolutionizing health care.

4. Health care executives striving to reduce labor costs should first consider exponential growth of administrative staff.

5. Most health systems must reduce unwarranted care variation to maintain positive margins.

6. Achieving a culture of high reliability care is the final step in minimizing care variation enterprise-wide, not the first one.

7. Think horizontally as well as vertically when prioritizing which care processes to standardize.

8. New care standards should make care delivery easier, not harder.
Widespread celebration of coverage expansion overlooks the rising challenge of uncompensated care.

The rate of uninsured adults reached a historic low in mid-2016: under 9% nationally. Twenty-two million Americans now have some type of health insurance coverage they didn’t have previously.

But when consumers have the option to choose their health plan, most opt for the plans with the lowest premiums—which also have high deductibles and high copays. Nearly 90% of exchange shoppers selected a high-deductible silver or bronze plan—which carry approximately $3,000 and $5,000 deductibles respectively. And individual consumers often go out of their way to preserve low premiums. Of the consumers with individual plans in 2015 who re-enrolled in 2016, 43% changed plans. On average, they chose plans with $42 a month lower premiums.

These high-deductible plans contribute to the challenge of uncompensated care. Many Americans struggle to pay even modest out-of-pocket medical expenses. A recent study by the Federal Reserve Board found that 47% of respondents couldn’t pay a $400 bill without selling an asset or borrowing the money.

This changing dynamic places a huge burden on providers. Historically, most health systems have focused their uncompensated care strategy on the uninsured. But now, leaders will need to more closely consider the impact of “underinsured” patients as well.
Health systems should push for the expansion of APRNs’ scope of practice in **acute care** settings.

Health care organizations in nearly all markets are striving to expand patient access and improve care affordability. But most are under-leveraging a key role that can help advance these aims: the Advanced Practice Registered Nurse (APRN).

Despite efforts to reduce unnecessary utilization, hospital admissions are still on the rise, and patients today are older, sicker, and more complex. This can place a heavy burden on inpatient care providers. A recent survey published in the Journal of the American Medical Association found that a significant proportion of hospitalists believe that their typical inpatient census regularly exceeds safe levels.

Nurse practitioners (NPs) are APRN providers who could alleviate this challenge. Progressive organizations are exploring possibilities for autonomous NP inpatient care. For example, some have started to use NPs as primary hospitalist staff.

Ministry Health Care in Wisconsin faced an acute shortage of PCPs, with only four physicians available to provide both ambulatory and inpatient care. In response, Ministry Medical Group’s physicians worked with Eagle River Memorial Hospital leadership to staff the facility full time with two NP hospitalists. These NPs are responsible for admitting, discharging, and managing all patients.
When designing this new staffing model, Ministry faced a common barrier: Wisconsin state laws do not grant admitting privileges to NPs. Ministry’s response serves as a reminder that health care organizations are not powerless in such situations. The medical group successfully pursued a waiver from state restrictions. To obtain the waiver, Ministry developed a six-month training program for NPs, created virtual access to hospitalists at a sister facility, and ensured that NPs used care protocols standardized by hospitalists.

By using NPs as hospitalists (rather than for individual elements of patient care), leaders alleviate pressure on the organization, better leverage the skills and capabilities of NPs, and enable physicians to prioritize most complex patients.

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**From Overworked PCPs...**

- Four PCPs seeing both ambulatory and hospital patients
- Physicians working long hours, frustrated with lack of work-life balance

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**...to Independent APs**

- Two nurse practitioners admit, manage, discharge majority of patients; send complex patients to sister facility
- Practice under collaborative agreement with hospitalist director at sister facility
- Available days, weekends; PCPs take night call
Insight 3

Inflexible reimbursement policies are preventing virtual technology from revolutionizing health care.

Health care leaders’ interest in telehealth has exploded in the last several years, prompted by payment reform, consumerism, and developments in technology. But relatively few health systems can follow through with sizeable investment because so many virtual care services are not reimbursable.

Virtual care technology offers a host of potential benefits to both providers and patients. It can help providers prevent unnecessary ED visits, enable more effective management of chronic conditions, improve the safety of care transitions, enhance patient communication, and improve accessibility of specialists. It can enable patients to access timely care without leaving their homes and avoid long wait times in an office. As the graphic below shows, the majority of patients are ready and willing to use virtual care services.

Despite these benefits, health care leaders are hesitant to invest in virtual care. The largest obstacle is the lack of reimbursement for services. Medicare reimburses for only a small subset of rural consult-based telehealth, Medicaid coverage varies by state, and many private insurers remain hesitant to reimburse providers for most telehealth models. Policy issues, such as distance requirements and licensure limitations, are another major barrier.

Health care leaders should become familiar with the legal and regulatory requirements around telemedicine for the state(s) in which they operate, and work with industry groups to advocate for state- and federal-level legislation. These types of reforms, along with shifts in payer understanding, could lead to better reimbursement models in the future.

National Survey of Health Care Consumers

77% would consider seeing a provider virtually
19% already have seen a provider virtually
Health care executives striving to reduce labor costs should first consider exponential growth of administrative staff.

Many health care executives are under intense pressure to control costs. And some organizations have made real progress by reducing premium labor, improving care team efficiency, removing supply waste, etc. With much of the “low-hanging fruit” now gone, further cost reduction is a challenge. However, one slice of the labor budget—administrative costs—deserves special attention due to its explosive growth in recent decades.

Over the past 45 years, there has been a massive increase in the number of administrative staff in the health care industry; the growth of the clinical workforce pales in comparison. As the industry has become more complex and more highly regulated, health care organizations have created new positions to ensure they could capture their earned revenue. For example, in response to managed care in the 1990s, hospitals needed to hire scores of staff who could support medical billing, coding, claims processing, and other revenue cycle management services.

To manage labor costs, leaders need to think differently about opportunities for cost savings and expand their lens beyond the clinical workforce.

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1) Spans three occupational categories: management, non-financial administrative support, and financial administrative support.
Most health systems must reduce unwarranted care variation to maintain positive margins.

According to the CBO, sixty percent of hospitals will have negative margins by 2025 unless they significantly increase productivity or decrease costs. As a result, nurse executives are being asked to cut tens of millions from their budgets.

To find these savings, most executives must complement ongoing efforts to increase labor productivity with a much bigger cost-saving opportunity: reducing unwarranted care variation. CFOs now estimate that there are twice as many cost savings opportunities in care variation reduction (CVR) as in labor or supply costs.

CFO’s faith in the potential cost savings of CVR is well founded. For example, Advisory Board analysis of joint replacement length of stay for every facility in the Draper Health System, a pseudonym for an 11-hospital health system, found they would eliminate 1,168 avoidable days if all facilities matched the system’s 75th percentile length of stay. With an estimated savings of $500 per day, this equates to a total annual savings of $584,000 from minimizing variation in just two procedures.
Achieving a culture of high reliability care is the final step in minimizing care variation enterprise-wide, not the first one.

Building a culture of high reliability care is a laudable aim. There is no better way to ensure every patient receives the known standard of care, every time, and in every setting, than making the development of and adherence to common care pathways the cultural norm for your health system. Nonetheless, efforts to build a high reliability culture should focus first on more concrete and operational issues.

As suggested by the pyramid below, there are a number of operational prerequisites to securing a return on more aspirational efforts to reduce care variation across large, complicated health systems. For example, your system’s clinical analytics must be credible among clinicians and sufficient to prioritize myriad opportunities. Likewise, clinicians must feel vested in driving the health system’s larger strategic aims and think past consensus to adherence when developing care standards.

Once such foundational elements are in place, your organization should invest in all four elements necessary to spin what Advisory Board calls the CVR flywheel: Prioritize, Design, Embed, and Measure. In particular, organizations struggling to drive system-wide adherence to a multitude of standards should be wary of zeroing in too narrowly on the “embed” phase of this virtuous cycle because all four phases are key to overcoming this challenge. For example, leading organizations are working to limit the number of new standards they are developing at any one time (to what their design, IT, and educational teams can realistically support) and to design standards that are easier to follow by incorporating existing workflows.

To be clear, building a high reliability culture is a worthy aim from the outset. Most organizations, however, need to make more progress in “walking the walk” before “talking the talk.”
Think horizontally as well as vertically when prioritizing which care processes to standardize.

Many organizations are striving to better leverage data in order to prioritize which care processes to standardize. They increasingly start by isolating a subset of DRGs with significant patient volumes where outsized differences in cost per case suggest a high degree of care variation. They then charge a clinical consensus group with determining which processes within the DRG account for a disproportionate share of the variation and what should be standardized organization-wide.

This “vertical” approach to prioritization should be complemented by “horizontal” analysis—looking across targeted DRGs or clinical pathways for common foundational care processes that have not been standardized system-wide.

Absent this complementary analysis, organizations may overlook the aggregate impact of variation in more routine care processes. For example, Foley catheter removal didn’t rise to the top of the list for system-wide standardization at one organization applying stringent prioritization criteria until they added this second perspective.

Additionally, standardizing foundational care processes eases implementation of the complex clinical pathways that build upon them and minimizes physician bottlenecks in developing new standards. More specifically, nurses and other clinicians should be empowered to develop most foundational care processes with minimal physician involvement.

### Importance of Foundational Care Processes by Clinical Pathway

<table>
<thead>
<tr>
<th>Care Processes</th>
<th>CABG</th>
<th>Hip Joint Replacement</th>
<th>Septic Shock</th>
<th>Severe Pneumonia</th>
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</thead>
<tbody>
<tr>
<td>Antibiotic Stewardship</td>
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<tr>
<td>Discharge Planning</td>
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<tr>
<td>Foley Catheter Removal</td>
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<tr>
<td>Ventilator Protocol</td>
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<td>DVT Prophylaxis</td>
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<tr>
<td>Blood Utilization Criteria</td>
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<tr>
<td>Vital Sign Capture</td>
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**New care standards** should make care delivery easier, not harder.

Most organizations respond to poor adherence to care standards by doubling down on their implementation efforts. For instance, leaders might retrain staff, send another email about a new order set, un-blind performance data, or hire an additional educator.

But the root cause of poor adherence is often poor standard design. Frontline staff often have trouble embedding new care standards into practice because they involve extra care steps, require additional documentation, or call for using equipment that is unfamiliar or not easily accessible. Such oversights can make new standards difficult, and sometimes impossible, for clinicians to follow consistently.

Instead of force-fitting standards into workflow, leaders should invest in designing new care standards that mesh with—or even improve—frontline workflow. The goal should be to create standards that integrate seamlessly into frontline workflow and make care easier, rather than harder, to provide.

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**Dual Perspective Key to Standardizing a New Sepsis Protocol**

<table>
<thead>
<tr>
<th>Clinical Requirements</th>
<th>Compliance Realities</th>
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</thead>
<tbody>
<tr>
<td><strong>Standard Creation</strong></td>
<td><strong>How can we ensure steps take place?</strong></td>
</tr>
<tr>
<td>What steps need to be taken?</td>
<td>Do all units have adequate lactate tubes and request forms available?</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Can the lab meet a 48-hour turnaround time with existing capacity?</td>
</tr>
<tr>
<td>Draw serum lactate levels for every SIRS(^1) positive patient</td>
<td>Are physicians alerted to SIRS(^1) positive result in real time?</td>
</tr>
<tr>
<td><strong>Consultation</strong></td>
<td>Is an antibiotic cheat sheet available in EHR(^2) for physicians to reference?</td>
</tr>
<tr>
<td>Draw two blood cultures after antibiotics are administered</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
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<tr>
<td>Administer antibiotic within three hours of SIRS positive</td>
<td></td>
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<tr>
<td><strong>Follow-Up</strong></td>
<td></td>
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<tr>
<td>Adjust antibiotic based on blood culture results</td>
<td></td>
</tr>
</tbody>
</table>

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1) Systemic inflammatory response syndrome.
2) Electronic health record.
“We put so much effort into creating the standard—we reviewed evidence, sought input, came to consensus—and it still failed. We realized we didn’t fail because we didn’t have a standard, **we failed because we didn’t have a functional standard that could actually be adopted.**”

System CMO,
Large Health System in Northeast
### ADVISORY BOARD AT A GLANCE

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