



# New **Definition**

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## **Programs of Care: Governing Clinical Practice Across Time and Place**

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### **Introduction**

What would you as an administrator give to have the whole organization at all levels working together to improve the outcomes of patient care, not only inside but outside of your walls? Have you been struggling with fragmented services, turf issues, and other barriers that prevent all the disciplines working together for the patients? Have you been searching for a positive way to include community physicians and agencies in the overall plan for the patients and their families? A natural but more permanent extension of collaborative practice groups is the formation of Programs of Care, which will move your organization in a direction that reduces silos and improves outcomes for your patients. "Programs of Care provide the missing link between hospital administration, the physicians and other professionals and departments, and the community, and in doing so, establish and govern clinical best practice across time and place", states Karen Zander.

### **Definition and Purpose**

Programs of Care are basically self managing teams of clinical experts, supported philosophically and tangibly by administration. Rather than designated service lines or centers of excellence for some population, the Programs of Care at Arnot Ogden Medical Center in Elmira, NY, are permanent interdisciplinary teams that cover the standards of care for all patient diagnostic or otherwise homogeneous populations by one of 13 groups. (See Concept View, which includes all but the newly-added Bariatric POC)

The POC groups are imbedded in the organizational structure and process rather than outside of it (such as a quality improvement project) or short-term (such as a task force). The focus can be within or outside the organization, or both, based on the need of the population of patients being evaluated. Their scope seems very global but the teams can and do look at the structure, process and outcomes of patient care across the levels of care and for extended timeframes into recovery. Their work may include reviewing and revising a single small care-delivery task to solving a problem or developing of a large program such as clinical pathways or order sets.

The responsibility for the Programs of Care is to provide the oversight of care and anything that involves. They truly are the forum where care decisions for patient populations are made and disseminated through the organization based on researched practice guidelines. In other words, the Programs of Care have become the primary infrastructure to:

1. Review the practice structure inside and outside the organization
2. Identify areas that need improvement based on data
3. Making recommendations to the organization and physicians for changes in practice or system changes as appropriate.

4. Review and put into practice the current guidelines, order sets, and clinical pathways for patient care
5. Monitor the changes in practice
6. Data analysis
7. Quality improvement
8. Sentinel event review
9. Meeting regulatory requirements for a specific group of patients ( Core measures, HQI, QIO, JACHO, )
10. Monitoring the financial impact of care as it is provided for the group of patients they are monitoring
11. Education of the caregivers, facility and community about core measures and the changes recommended.

The activities of these groups are organized around measurable goals based on data, which helps each Program of Care focus on specific issues that can be addressed immediately. These first tasks get the groups up and moving quickly so that they develop as a team around their early accomplishments.

## Structure

There are 5 main roles which will be described below:

1. Program of Care Direction/oversight
2. MD Co-leader
3. Non MD Co-leader
4. Administrative Facilitator
5. Members

The structure is paradoxically simple and complex. Oversight and coordination is managed by someone who has the vision of the programs of care to bring to all the groups. At AOMC the direction is provided by the Senior Director, Continuum of Care, who also directs the acute- care Case Management Service. Consistency of vision is of utmost importance in organizations that need or are under a great deal of change. Having one person as a constant presence for these groups is imperative.

The leadership of each Program of Care is dual in nature. One leader of each group is a physician who cares for and knows the population of patients well. This role appeals to the physicians because they have always been the leader of patient care and now they are in a forum where they can educate and foster good care for their patients. Most physicians love it. The second leader is a staff clinical expert who cares for these patients daily and engages the staff in evaluating the care they and their co-workers render. This is a powerful way to engage the bedside staff in outcomes of care as well as engaged the medical staff in partnership with the clinical experts.

For example, in the Pneumonia/ COPD Program of Care, the Physician Leader is a pulmonologist and the clinical lead is a staff nurse from the ICU. The group is facilitated by the Senior Director of Nursing and membership includes respiratory therapy, education, infection control, ED nursing, and many other staff members. This group has achieved success by reaching the 2nd and 1st decile of core measures patients with pneumonia.

Facilitation comes from upper level management. In our case the Assistant Vice-Presidents and Vice-Presidents took the role of facilitator, sending a message to the organization about the importance of the POC structure. This arrangement also gets to the financial piece right away; i.e. when discussions arise about the need to purchase something, we have someone at the table that can say right now whether or not money is available.

Membership depends on the diagnostic group that the team is working on. The membership should include as many physicians as possible.

Physician membership can be enhanced by supporting their leadership role with the partnership leader model. The facilitator makes sure the minutes are done and sent. The non-physician leader does a lot of the detailed “grunt work” between meetings. Identifying a time and place that is best for the physicians greatly supports their attendance. Once they attend, they see the importance of their leadership for the group. In addition, the patient focus of the projects appeals to them a great deal. At that point they are engaged and they continue to be so. We started out with the 2 year contract with physicians but many physicians and members have been on the teams for 4 years because they don’t want to give up their projects.

## Practical Strategies

### **How to get started**

1. Start with an administrative steering committee to educate and negotiate support.
2. Identify the diagnostic groups the organization wants to impact, paying special attention to including all populations, but focusing on commonalities between diagnoses. Large hospitals will probably need about 18-20 Programs of Care, smaller hospitals between 10-12.
3. ROLL OUT 1-2 program groups AT A TIME, so that over the period of 2-3 years, the POC infrastructure is established
4. Identify the oversight person for the entire structure.
5. Identify the group or person that will provide data
6. Prepare/educate the leadership and facilitator of each group first
7. Create and discuss leader and member contracts so that everyone knows their responsibilities
8. Get the groups together and educate them about the process
9. Arrange a master monthly schedule to make sure there is not overlap in centralized resources needed for the groups
10. Get started

### **How to keep going:**

Staying focused comes from the central person who maintains the vision and visits each team to assess forward progress. The oversight person meets with the facilitators regularly as a group (between official POC meetings) to discuss progress and barriers in the system to forward progress. The facilitator

group is constantly negotiating and creating ways to remove the system barriers and support the POC in their mission.

## Case Study

The Cancer POC was brought together to review the care of cancer patients provided in the community. We focused first on the care of the breast cancer patient. There was a concern that the patient who had an abnormal mammogram was not managed to their benefit. The process from abnormal mammogram through diagnosis and treatment was reviewed and many changes were made. One such change was the process of the sentinel node biopsy. We found we were finding the sentinel node only 10 % of the time. We looked at the process and included the surgeons, the OR, the Lab, the pathologist, the oncologist and any one else who had a hand in the process. We totally changed our process and some equipment and were able to increase our rate of finding the sentinel node to 90%. Results like that speak to the clinicians on the team in a way that no other quality improvement process has.

## Summary

The benefit of Programs of Care to the organization is a strong focus on patients and the care they receive. By concentrating on patient outcomes, the care we give becomes more outcome-focused. These permanent governance groups move the

organization in the direction the JCAHO and CMS has been attempting to move us through regulation, but with processes tailored to the patients and clinicians dealing with specific disease entities in our community. We have to pay attention to not only practices inside hospital walls, but beyond. By looking at the care we provide, these teams automatically start to measure outcomes. The POC groups become the central repository of data and by virtue of the role they have in care management, develop responses to the data by using quality improvement techniques. Programs of Care extended to every patient population go beyond task forces, service lines, and six sigma methods because they are a *permanently aligned structure* with administration for the governance of clinical practice. They provide sustained progress and a foundation on which to integrate high-quality, individualized care across time and place.

## About the Author

**Tina Davis** is the Senior Director, Continuum of Care, for Arnot-Ogden Medical Center, Elmira, NY. AOMC provides healthcare services to a diverse population residing in the Finger Lakes region of upstate New York and the Northern Tier of Pennsylvania since 1888. Tina also serves as a Consulting Associate for the Center for Case Management, and faculty member for nursing programs.

