Quality and Safety in Inpatient Cancer Care: Perspectives on Patient Acuity and Nursing Staffing

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Nursing Department
Research and Practice Development Section
Disclosure/Conflict of Interest

• The opinions expressed in this presentation are those of the author alone and do not necessarily reflect the views of the Department of Veterans Affairs, National Institutes of Health, Public Health Service, or Department of Health and Human Services.

• I have no conflicts of interest to report.
Acknowledgements

Mentors
• Barbara Daly, PhD, RN
• Patricia Higgins, PhD, RN
• Katherine Jones, PhD, RN
• Elizabeth Madigan, PhD, RN
• Neal Dawson, MD
• David Aron, MD
• Mary Dolansky, PhD, RN
• Gwenyth Wallen, PhD, RN

Collaborators
• Deborah Liedtke, MSN, RN
• Shelly Fiala, RN, BSN
• Terri McNamee, RN, BSN
• Jeffrey van der Meulen, ND, RN
• Many Registered Nurses who contributed time, effort, & expertise to development & validation of the Oncology Acuity Tool
Acknowledgements: Funding

• Pre-doctoral work
  – National Institutes of Health T32 Multiple Morbidities in Vulnerable Populations: Nurse Scientist Training Pre-doctoral Fellowship
  – Health Resources and Services Administration Faculty Loan Repayment Program
  – Frances Payne Bolton School of Nursing Alumni Association research award
  – Sigma Theta Tau International Alpha Mu Chapter research award

• Post-doctoral work
  – Veterans Affairs National Quality Scholars Program
Presentation Outline

• My background & story
  – Patient acuity
  – Quality improvement and patient safety

• Nurse staffing models
  – State of the science
  – Factors to consider (e.g., nurse staffing “bundle”)

• Broader quality and safety topics in cancer care
  – Institute of Medicine
  – Oncology Nursing Society
  – National Quality Forum
  – American Association of Hospice & Palliative Medicine
  – Hospice & Palliative Nurses Association
Objectives

At the end of this presentation, attendees will be able to:

– Define patient acuity & its relevance to nurse staffing decisions
– Describe two conceptual models/frameworks:
  • Holzemer’s Outcomes Model for Healthcare Research and
  • The Integrated Framework for a Systems Approach to Nurse Staffing Research
– Identify nurse staffing models/approaches and important factors to consider when developing them
– List key priorities of various professional organizations in the United States regarding quality in cancer care
NIH Mission

• To seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.
NIH Clinical Center

Mission
The NIH Clinical Center provides a model environment for:

- clinical research
- patient care
- training

Vision
• As America's research hospital, we will lead the global effort in training today's investigators and discovering tomorrow's cures

http://clinicalcenter.nih.gov/about/welcome/mission.shtml
Current position

• Clinical Center Nursing Department (CCND)
  – Research and Practice Development Section
• Program Director for Outcomes Management
  – Lead quality improvement and patient safety initiatives
  – Patient acuity & outcomes research
  – Nurse Practitioner, Pain and Palliative Care Service
• Improving systems of care
1998-2002:
• Bachelor of Science in Nursing Program
• Nurse Externship
2002: First nursing position, Cleveland, OH

Staffing & Geography
- Hematology/oncology/bone marrow transplant unit
- Primary nursing model
  - Primary, secondary, tertiary patients
  - Continuity
- Acuity tool
- 12- and 8-hour shifts
- Patient care assistants or technicians, unit clerk
- “L”-shaped unit with three “pods”

RN:Patient Ratios
- 30 beds
- Day: 8 to 9 nurses, each caring for 3 to 5 patients
- Evening: 6 to 7 nurses, each caring for 5 to 7 patients
- Night: 4 to 5 nurses, each caring for 8 to 9 patients
<table>
<thead>
<tr>
<th>Teaching</th>
<th>Reinforcement teaching</th>
<th>Initial teaching for treatment modalities</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatments</td>
<td>Drug change to single tube care-drains, chest tube, foley, CVC VRB Precautions</td>
<td>Trash care, multiple tube care, tubing feedings</td>
<td>Complicated and/or multiple dressings, frequent incontinence</td>
</tr>
<tr>
<td>Safety</td>
<td>Falls precautions, fall &lt; 72 hrs</td>
<td>Posey for confusion, neuro checks q4 hrs, severe neutropenia</td>
<td>Restraint monitoring, mental status changes, active bleeding, severe neutropenia with frequent fever work-ups</td>
</tr>
<tr>
<td>Special Meds</td>
<td>Continuous chemo, uncomplicated Ampho, heparin gtt, monitoring PCA pump</td>
<td>Vesicant chemo through Broviac, Ampho with rigors, high-dose chemo, triple chemo regimens, subsequent doses IVIG, ATG, Venoglobulin without reactions</td>
<td>Vesicant chemo through, peripheral IV, insulin gtt with CS, test dose } Ampho, first doses IVIG, ATG, Venoglobulin known to have reactions</td>
</tr>
<tr>
<td>Condition Changes</td>
<td>New onset febrile episode with workup, mild to moderate pain, documented emotional support</td>
<td>GI bleed, hypotensive crisis, intractable pain, respiratory distress, neuro changes</td>
<td>Potential unit transfer or arrest</td>
</tr>
<tr>
<td>IV Fluids</td>
<td>1-2 infusions, including IVF, electrolytes, dopamine, CSA, MS04 gtt</td>
<td>3-4 IV infusions</td>
<td>&gt;4 IV infusions</td>
</tr>
<tr>
<td>Blood Products</td>
<td>5-10 units of PLT, FFP, cryo</td>
<td>1-2 units PRBCs or PRBCs and PLT</td>
<td>PBSCT, BM return, granulocytes, &gt; 2 units PRBCs &amp; PLT</td>
</tr>
<tr>
<td>Tubing Changes</td>
<td>Making or hanging 1-2 tubing changes</td>
<td>Making or hanging 3-4 tubing changes</td>
<td>Making or hanging &gt;4 tubing changes</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Pre-op teaching, leading team meeting or ID rounds, CVC blood draws</td>
<td>Pt. Discharge, including teaching aid procedures</td>
<td>If pt has multiple items from one category, may rank as next higher rating</td>
</tr>
</tbody>
</table>
2003: Second nursing position
New York City

http://www.history.com/topics/new-york-city
Thoracic Oncology Unit

Staffing & Geography
- 60% surgical, 40% medical
- Long-term ventilator patients
- Staffing
  - By room number, some continuity
  - 12-hour shifts
  - High staff turnover
- New manager
- No acuity system; interest in developing one for unit

RN:Patient Ratios
- 42 beds
- Day: 6 to 7 nurses each caring for 6 to 7 patients, up to 10 in one shift
- Night: 4 to 5 nurses each caring for 8 to 12 patients
<table>
<thead>
<tr>
<th>Teaching</th>
<th>Reinforcement Teaching Emotional Support</th>
<th>Discharge</th>
<th>Initial or Discharge Teaching: New post-op Newly Diagnosed New Admit SQ Injections Pleurex/Pnuemostat Diabetic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatments</td>
<td>Dressing Changes to: CVC/CT Foley Care Isolation Precautions Preventative Skin Care 1-2 Continuous IVF</td>
<td>Trach/PEJorG care Tube Feeds Stage 1-2 breakdown Bronchoscopy CT insertion-Assist Frequent Inconvenience NGT/CT Care</td>
<td>Stage 3-4 breakdown Complex dressing: Eloesser Pleurodesis</td>
<td></td>
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<tr>
<td>IV Fluids</td>
<td>Fall Precautions Intermittent Cardiac IVPB medications PCA pump monitoring Epidural</td>
<td>Confusion/Agitation Neuro Checks 1:1 Companion Cardizem Drips</td>
<td>Restraints Mental Status Changes</td>
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<tr>
<td>Safety</td>
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<td>Special Medications</td>
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</tr>
<tr>
<td>Medications</td>
<td></td>
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</tr>
<tr>
<td>Condition</td>
<td>Fever Mild to Moderate Pain Sedation</td>
<td>Hypotension Intractable pain Actively dying ICU Transfer in Vented Actively Bleeding Low Urine Output</td>
<td>Not Accepted ICU transfer Out Code New onset A-fib Respiratory Distress</td>
<td></td>
</tr>
<tr>
<td>Changes</td>
<td>Post-Operative Management</td>
<td>CT with air leak Chest PT Ambulation with Equipment</td>
<td>CT to Emerson O2 Face Mask Ambulation with RN assistance Telemetry Monitoring</td>
<td>Non-Rebreather</td>
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TOTAL: ________
2004-2010: Graduate School

- Acuity measurement – focus area for doctoral work
- Started graduate school in New York City
- Returned to Cleveland, Ohio to finish graduate school at Case Western Reserve University
  - Validated acuity tool used in first nursing position
THEORETICAL PAPER

Patient acuity: a concept analysis

Caitlin W. Brennan & Barbara J. Daly

Accepted for publication 14 November 2008

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doi: 10.1111/j.1365-2648.2008.04920.x
Concept Analysis

- Holzemer’s Outcomes Model for Health Care Research

<table>
<thead>
<tr>
<th></th>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Patient</td>
<td>Severity</td>
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</tr>
<tr>
<td></td>
<td>• psychological</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider (Nurse)</td>
<td>Intensity</td>
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<tr>
<td></td>
<td>• nursing care needs</td>
<td></td>
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<tr>
<td></td>
<td>• workload</td>
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<td></td>
<td>• complexity</td>
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<tr>
<td>System</td>
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- **Definition:** Patient acuity is a measure of the severity of illness of patients and the intensity of nursing care patients require.

(Brennan & Daly, 2009; Donabedian, 2003; Holzemer, 1994; Holzemer & Reilly, 1995)
The Oncology Acuity Tool: A Reliable, Valid Method for Measuring Patient Acuity for Nurse Assignment Decisions

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Katherine R. Jones, PhD, RN, FAAN
Elizabeth Madigan, PhD, RN, FAAN
Case Western Reserve University

Jeffrey Van Der Meulen, ND, RN, OCN
University Hospitals Case Medical Center
Acuity Validation Study (dissertation)

- Oncology Acuity Tool
- 10 domains
- Indicators of care within each domain
  - 0, 1, 2, or 3 points
- Prospective measurement every shift
- Total score for each patient, 2 to 14 points
- Total score for each nurse, 20 to 40 points
  - Goal is for each nurse to be within a few points of each other \(\rightarrow\) balanced nursing workload

(Brennan, et al, 2012)
Psychometric Assessment

• Inter-rater reliability
• 3 types of validity
  – Content
  – Concurrent
  – Predictive

• Conclusion: Overall, the OAT demonstrated sufficient reliability and validity in this population

Patient Acuity & Nurse Staffing

• Nurse staffing research
  – Increasing focus on assessing patient demand for care (Needleman, 2011)
  – Patient acuity measurement is one way of doing this

• Acuity-based staffing theoretically allows for efficient allocation of supply of nurses with patients on unit
  – Supply (RNs) & demand (patient acuity) matched
Background: Nurse Staffing

• Seminal work that demonstrated an association between nurse staffing and:
  – Falls, pressure ulcers, failure to rescue, infections, etc

• If I am a hospital administrator or nurse manager, how do I make nurse staffing decisions today? Next year?

• What does the literature say with regard to my type of patient care unit or patient population?
State of the Science: The Relationship Between Nurse Staffing and Patient Outcomes
Caitlin W. Brennan, Barbara J. Daly and Katherine R. Jones
West J Nurs Res 2013 35: 760 originally published online 26 February 2013
DOI: 10.1177/0193945913476577

The online version of this article can be found at:
http://wjn.sagepub.com/content/35/6/760
State of the Science paper

- "Meta-review" → review of reviews
- 29 reviews → 6 systematic, 23 reviews of literature
- Findings: inconsistencies across studies, inconclusiveness of results
  - Defining & measuring variables, design
  - Difficult to compare results across studies
- Lack of/implicit theoretical foundation to studies
  - Rare for studies to include system factors
- No clear recommendations for staffing guidelines on the unit level
- Need to focus on processes of care, system factors, & unit-level context

(Brennan, Daly, & Jones, 2013)
Theoretical Framework

Building from Holzemer’s Outcomes Model for Health Care Research…

<table>
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<tr>
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<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
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<tr>
<td>Nurse</td>
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<tr>
<td>Unit/Ward</td>
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<tr>
<td>System</td>
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</table>

- Integrated Framework for a Systems Approach to Nurse Staffing Research (IFSANSR)
- Stratifies structures, processes, & outcomes of care
- Patient, nurse, unit, and system levels

(Brennan, Daly, & Jones, 2013)
Figure 2. The Integrated Framework for a Systems Approach to Nurse Staffing Research.

*See Table 3 for a list of potential structures, processes, and outcomes to consider at the patient, nurse, unit, and organization/system levels of analysis.

(Brennan, Daly, & Jones, 2013)
Sample Conceptual Model (using IFSANSR)

Structure

Patient
- Severity of illness

Nurse
- Intensity (Nursing Care Needs, Workload, Complexity)
  - Acuity-based nurse assignments model
    - Balanced nursing workload
    - Ability to mobilize team to intervene

Unit
- Teamwork, RN-physician collaboration

Process

Outcome
- Infection, Failure to Rescue
The Effects of Nurse Staffing and Nurse Education on Patient Deaths in Hospitals With Different Nurse Work Environments

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College of Nursing, Rutgers, The State University of New Jersey, Ackerson Hall, Room 305, 180 University Avenue, Newark, NJ 07102, (p) 973.353.5060/(f) 973.353.1277

Donna F. Neff, PhD, APRN
College of Nursing, University of Florida, PO Box 100187, Gainesville, FL 32610-0187, (p) 352.273.2273/(f) 352.273.6505
Unit-Level Context

A Case-control Study of Patient, Medication, and Care-related Risk Factors for Inpatient Falls

Melissa J. Krauss, MPH, Bradley Evanoff, MD, MPH, Eileen Hitcho, MS, Kinyungu E. Ngugi, BS, William Claiborne Dunagan, MD, Irene Fischer, MPH, Stanley Birge, MD, Shirley Johnson, RN, MS, MBA, Eileen Costantinou, MSN, RN, Victoria J. Fraser, MD.

1Department of Medicine, Washington University School of Medicine, St. Louis, MO, USA; 2BJC HealthCare, St. Louis, MO, USA; 3Barnes-Jewish Hospital, St. Louis, MO, USA.

• Likelihood of a patient falling was:
  – 3 times higher for patients whose nurse was caring for 4 to 6 patients
  – 7 times higher for patients whose nurse was caring for 7 or more patients
  – Compared with patients whose nurse was caring for 3 or fewer patients

(Krauss, et al, 2005)
Nurse Staffing “Bundle”

• Acuity
  – Patient demand for care conceptualized separately from supply (nurse staffing)

• Nursing model of care
  – Primary nursing
  – Continuity (shorter length of stay)

• Geographic location on unit

• System factors: e.g., unit work environment (Practice Environment Scale of the Nursing Work Index)
  – Nurse participation in hospital affairs
  – Nursing foundations for quality care
  – Nurse manager ability, leadership, and support of nurses
  – Staffing/resource adequacy
  – Nurse-physician relationships

(Lake, ET, 2002 & 2007)
Nurse Staffing Models

  - Patient factors
    - Individual patient’s nursing needs (acuity/dependency)
    - Other factors based on holistic assessment (e.g., risk for deterioration)
  - Ward factors (turnover of patients)
  - Nursing staff factors
    - Communication with family, other healthcare staff
    - Managing nursing team/ward
    - Mentoring & supervision
    - Audits, staff appraisal, performance reviews

(NICE, 2014)
American Nurses Association

• Staffing Recommendations (2014)
  – Recognizes unique settings, times of day
  – Patient acuity/intensity
  – Unlicensed personnel
  – Skills, education, and training within specific settings
  – Number of admissions, discharges, transfers
  – Unit layout
  – Availability of resources (assistive personnel, technology)

(ANA, 2014a & b)
American Nurses Association

- Registered Nurse Staffing Act (federal)
- State laws
- 3 main categories
  - Nurse driven staffing committee
    - CT, IL, NV, OH, OR, TX, WA
    - MN (chief nursing officer or designee)
  - Mandate specific nurse-to-patient ratios
    - CA
    - MA (ICU only)
  - Disclose staffing levels (public reporting)
    - IL, NJ, NY, RI, VT

(ANA, 2014a & b)
States with legislation/regulations

Enacted legislation/adopted regulations to date: CA, CT, IL, MN, NV, NJ, NY, OH, RI, TX, VT, and WA

ANA, 2014b
## Nurse Staffing “Bundle” (revised)

<table>
<thead>
<tr>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| **Patient** | • Acuity  
• Other factors (holistic assessment) | | • Mortality  
• Failure to rescue  
• Morbidity (infection, pulmonary embolism) |
| **Nurse** | • Skills, education, training, experience | • Nursing model of care  
• Indirect care  
• Communicating  
• Mentoring, supervising  
• Managing | • Burnout  
• Turnover  
• Retention  
• Satisfaction  
• Surveillance, vigilance  
• Missed care |
| **Unit/Ward** | • Layout  
• Shift-specific  
• Resources (unlicensed assistive personnel; technology) | • Turnover of patients  
• Work environment | • Efficiency  
• Throughput |
| **System** | • Setting-specific  
• Overall number of staff needed  
• Mandated ratios | • Committee decides policies  
• Disclose staffing levels | • Costs |
Importance of Measurement

• Before nurse staffing bundle can be tested, need reliable, valid measures for various concepts:
  – Acuity, other factors
  – Indirect care
  – Surveillance, vigilance
  – Missed care

• Similarly, need quality & outcome measures in oncology and palliative care
Postdoctoral Fellowship: 2010-2013

• Veterans Affairs Quality Scholars Program
• Quality improvement & patient safety content
• Systems approach
• Interprofessional teamwork
• Concurrently, completed Master of Science in Nursing degree & worked as Adult Nurse Practitioner
  – Oncology and Palliative Care Master of Science degree
    • Case Western Reserve University, 2011
      – Saw patients in palliative care (20% effort, ~1 day/week)
• How do we evaluate the quality of cancer care?

www.vaqs.org
Quality of Cancer Care

- Institute of Medicine (IOM)
  - “…independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.”
  - Interdisciplinary (physicians, nurses, researchers, pharmacists, public health experts, foreign associates, etc)
  - IOM reports:
    - Topics that are timely & important for healthcare
    - Objective advice for decision-makers, public
    - Evidence-based
    - Collaborative process
    - Consensus from experts

(IOM, 2013a & b)
Institute of Medicine Report

• “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”
  – “Cancer care is often not as patient-centered, accessible, coordinated, or evidence based as it could be.”

• Aging population
• Reliance on family caregivers
• Rising costs of care & complexity
• Majority of cancer diagnoses, deaths, & survivors are older adults

(IOM, 2013c, pg 5)
Institute of Medicine Report

• Focus on patient-centered care
  – Asking patients’ preferences
  – Using decision tools & visual aids for treatment plans

• Importance of:
  – Measurement, quality indicators
  – Integration of palliative care concepts into cancer care

(IOM, 2013c)
Institute of Medicine Report

Conceptual Framework
1. Engaged Patients
2. Adequately staffed, trained, and coordinated workforce
3. Evidence-based cancer care
4. A learning health care Information Technology (IT) system for cancer
5. Translation of evidence into clinical practice, quality measurement, and performance improvement.
6. Accessible, affordable cancer care

(IOM, 2013c, pg 11)
Goals of the Recommendations

1. Provide clinical and cost information to patients.
2. End-of-life care consistent with patients’ values.
3. Coordinated, team-based cancer care.
4. Core competencies for the workforce.
5. Expand breadth of cancer research data.
6. Expand depth of cancer research data.
7. Develop a learning health care IT system for cancer.
8. A national quality reporting program for cancer care.
9. Reduce disparities in access to cancer care.
10. Improve the affordability of cancer care.

(IOM, 2013c, pg 14)
Incorporation of palliative care across the care continuum

Provision of Palliative Care
Exclusively at End-of-Life

- Curative or Life-prolonging treatment
- Diagnosis
- Palliative Care
- End-of-Life Care

Incorporation of Palliative Care
Throughout the Cancer Care Continuum

- Curative or Life-prolonging treatment
- Diagnosis
- Palliative Care
- End-of-Life Care

(IOM, 2013c, pg 18)
Institute of Medicine Report & Resources

• [www.iom.edu/qualitycancercare](http://www.iom.edu/qualitycancercare)
  – Briefing Slides
  – Press Release
  – Questions for patients with cancer to ask their care team
  – Report Brief
  – Videos

(IOM, 2013d)
Oncology Nursing Society (ONS)

- Professional association in the United States for oncology nurses
- More than 35,000 members
- “…committed to promoting excellence in oncology nursing and the transformation of cancer care.”
- Many resources/benefits:
  - Continuing education
  - Certification
  - Policy & advocacy
  - Networking
  - Evidence-based practice
  - Quality improvement registry

https://www.ons.org/about
Oncology Nursing Society (ONS)

- Priority: Improve the quality of cancer care.
  - Ensure that inpatient and outpatient quality measures used are meaningful, relevant, and promote quality cancer care.
  - Identify opportunities related to medical homes, accountable care organizations, and other emerging healthcare delivery models.
  - **Participate in the National Quality Forum (NQF) Measures Application Partnership (MAP) to promote the adoption of measures that are meaningful to cancer care and patients with cancer.**

(https://www.ons.org/advocacy-policy/priorities)
National Quality Forum (NQF) Measures Application Partnership (MAP)

- NQF: Sets standards for measurement of various healthcare indicators
- MAP: Focuses on “measuring what matters”
- Identifying measurement gaps & availability of measures
  - Person-Centered Communication
  - Quality of Life and Functional Status
  - Shared Decisionmaking
- Applying measures across care delivery settings

(NQF, 2015)
Palliative Care: Measuring What Matters

- American Association of Hospice & Palliative Medicine
- Hospice & Palliative Nurses Association
- Partnering to develop quality measures for palliative and end-of-life care

http://aahpm.org/quality/measuring-what-matters
Conclusion

- Career Mission:
  - To be a leader in improving systems of care
  - Linking data and research to the bedside
  - Goal of improving patient safety and the quality of care provided in hospitals

- Lead quality improvement and research initiatives focused on studying the influence of various health care system factors on patient outcomes.

- Patient acuity, nurse staffing, processes of care

- Measurement

- Quality of care in oncology & palliative care
Other Resources

• Institute of Medicine Future of Nursing Report (2010)

• End-of-Life Nursing Education Consortium (ELNEC)
  – http://www.aacn.nche.edu/elnec

• Thank you!
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