Reconfiguring the Bedside Care Team of the Future

The American Hospital Association (AHA) recently convened a roundtable (for a list of participants, see Appendix B) to discuss whether the traditional bedside care team could be reconfigured to meet the imminent needs of the U. S. population. These needs emanate from a more culturally and socio-economically diverse population, patients experiencing acute episodes with multiple conditions, and an aging population requiring more health care services. Driving the need for change is the reality that, in 2014, more than 25 million new patients will enter the U.S. health care system as a result of the *Patient Protection and Affordable Care Act* (ACA).

A summary of the roundtable's discussion follows.

The Need for a Paradigm Change

The changes confronting the health care system are so significant that many of the models that the health care system has relied on, such as the traditional bedside care team, may no longer be the best, or even a plausible, approach to care. The roundtable participants faced this difficult reality to discuss how to define "health care system" and the work of the health care team. Who is the team? Where will they provide care? Listed below are three likely shifts in thinking:

1. The acute care stay will be increasingly shortened with a focus on achieving a specific clinical outcome. This means that acute care will no longer be at the center of the care delivery system. Hospitals will be used for acute disease management, procedural intervention and post-interventional care, and/or when a failure in and/or incapacity in other care settings occurs. Acute care providers will need to reorient so that acute care is no longer the central hub of care with discharge into the community but, rather, realize that community-based and/or rehab alternatives will be the central and coordinating settings managing care to, and out of, the hospital. The roundtable members came to believe that the future bedside care team, out of necessity for both volume of patients and cost, will work more in a process-driven model designed to yield high satisfaction outcomes: the right care, at the right time, in the right setting, at the lowest possible cost.

   Acute care is the most costly component of the continuum of care. Short stays with high intensity, with high customer expectations will necessitate a reconfigured future bedside care team. Led by multi-disciplinary licensed professionals with an "intensivist" orientation, routine patient care will likely be delegated to more intensivist-oriented and specifically trained non-licensed staff. In the end, the reconfigured team will be designed for targeted patient-family needs during a short and intensive stay to address targeted outcomes. Some teams may be physician-led, with nurses, physical therapists and a social worker at the core; others may be led by nurses, therapists and a nutritionist, with a physician in a less prominent role. Again, patient and family need will drive the give-and-take design of a critical core of licensed professionals, supported by non-licensed providers trained to function in a maximally high-acuity environment. Training, engagement with the workforce and consultation with regulatory agencies will be essential to embracing the new paradigm, which must include letting team leaders practice to the full extent of their licensure.

2. Community-based settings in today's paradigm are based on a throughput model: see as many patients as you can in as short a time possible. The paradigm change will be to an engagement, education and health partner co-created compliance model. In theory, the transformed payment model supports this shift away from a throughput orientation. If this occurs, the acute care team may be less concerned with "being all things to all people." Patient education for disease management and aftercare may no longer belong to the acute care team.

3. Provider roles and responsibilities are changing, notably within advanced practice nursing (APRN), pharmacy and some of the therapy providers who are seeking advanced certifications to extend their scope of practice. In the hospital setting, we draw attention to the role of the APRN, particularly, who will increasingly be used as admitting provider and hospitalist, especially to manage patients requiring acute care when the community setting cannot fulfill a patient's needs. There will still be primary care and specialty care physicians on the acute care team, but APRNs will be full partners in collaboration with and complementary to primary care and specialty physicians. In our interpretation, full partnership does not mean performing diagnostic and interventional measures as a physician does, but working with a scope appropriate to knowledge, skills and abilities. They will be full partners in the design, implementation, improvement, and evaluation of health care delivery.

This shift has major implications for the bedside care team of the future. The team will have to adjust to one or more team leaders, moving away from having only the physician serve in such a role. The team members also will need more training in leading teams, developing a stronger focus on outcomes, and becoming aware of costs.

Six Principles Established

Guiding the paradigm change, six principles emerged from the roundtable that characterize movement toward a reconfigured bedside care team or system of care over the next five years. More than 40 ideas were generated from which the following principles were culled:

1. The patient and family are *essential members of the core care team*.
2. Bedside care team members are fully engaged at the broadest scope of their practice.
3. The bedside care team is focused, highly effective and autonomous, coordinating communication with the patient/family.
4. Evidence-based guidelines that improve care are developed and consistently followed by every bedside care team member.
5. Technology replaces some clinical tasks, augmenting decision-making and complementing the clinical judgment of the care team.
6. Patients needing acute care move safely through the health care system no matter where they are in the care cycle—whether at the onset of disease, in the middle of community-based care, or at the end of life.

About the Six Principles

Based on these principles, both foundational and cutting-edge care concepts and practices were identified. The "foundational" concepts or practices are ones that must be in place and functional before any innovative or "cutting edge" concepts or practices can take hold. These six principles must be deeply understood, valued and systematically applied and integrated into new care models for deep and lasting change to occur. We believe that hardwiring these principles into a transformed system should guide innovation toward population-based needs identification and individualized application.

1. The patient and family are *essential members of the core care team.*

This principle is integral to the success of the bedside care team's goal, and is connected to each of the other principles. If the patient/family is not integrated into all aspects of care from lifestyle preference, family role adjustments and care delivery support, the patient likely will not adequately return to optimum health.

Foundational: "Must-haves" for highly functioning teams

- The clinicians inform and guide health care decisions, always considering the patient/family perspective. With their active involvement, the clinicians encourage the use of evidence-based alternative therapies, particularly when they reduce cost and enhance the quality of life and patient/family preference for treatment.
- Advance directives are clearly presented and the wishes of the patient/family respected. This communication is even more important when considering the unique background of the family/patient, such as the patient/family's cultural belief system.
- Care is co-created and shared not only by the bedside care team, but with an engaged patient/family to uphold and share responsibility for care plan compliance.

Cutting Edge: New, innovative practices

- Listen to the communities we serve and define populations not only by disease, but by other factors that are population-sensitive, such as health practices, cultural and ethnic differences, age and gender considerations, and other factors that should influence the design and makeup of the care delivery model and who is necessary on the care team. Processes and practices should consider community resources beyond illness care in order to provide psycho-social support during transitions between/among agencies and providers.
- Leverage technology and other innovative systems so patients and providers can communicate easily and effectively.
- Integrate palliative care into the health care experience. The option to use palliative care should be given to patients anywhere along the birth to end-of-life continuum, regardless of their age or type of illness.
- Identify and promote behaviors that create a mutually engaged relationship between provider and patient.

2. Bedside care team members are fully engaged at the broadest scope of their practice.

This principle addresses one of the key paradigm shifts where provider roles and responsibilities will change. The concepts below are key drivers of a reconfigured bedside team model.

Foundational: "Must-haves" for highly functioning teams

- The key to an autonomous, focused and highly effective team success is ultimately about engagement in, and a full exercise of, the scope of their practice.
- The bedside care team's success is enriched and best supported with the engagement of highest level hospital leadership who support an environment where the bedside care team can do their very best.
- Physicians are important team members who must actively engage on committees and teams, providing visible leadership throughout the health system. In doing so, physicians are more than users of the system: they are co-engaged as true partners with other providers in designing and improving the care delivery system at the organizational level.
- Bedside care team members are educated/re-educated about systems knowledge within an intensivist environment. Team members must show agility and resiliency in this changed environment, easily adapting to change as a norm and these traits must be evaluated and expected.
- Team members must show respect for all health provider roles.
- Physicians and hospital leaders come together in leadership dialogue to determine ways physicians can contribute to bedside care team innovation and overall hospital leadership.
- All team members participate in leadership development opportunities.

Cutting Edge: New, innovative practices

- Physicians and other clinical staff practice in an environment where financial incentives are leveraged with satisfying work environments to create team motivation capable of achieving outstanding clinical outcomes. This involves all members of the bedside care team owning their individual contribution to the care process, while optimizing the talents, skills and abilities of team members.
- Team leadership development ensures more team members develop "big picture" understanding and can share in organizational decision-making.
- Hospital senior leaders model team behavior.
- Inter-professional education, with a targeted focus on role optimization, team functioning in a variety of clinical settings, advanced decision-making, and conflict resolution, will allow nurses, physicians, pharmacists, physician assistants and others to enter into practice settings as respected and high-functioning team members.

3. The bedside care team is focused, highly effective and autonomous, coordinating communication with the patient/family.

This principle is, in itself, cutting edge, because this type of team is not normalized currently in care settings. The bedside care team should be highly focused and autonomous, practicing together on a unit and limited to the patients/families on that unit exclusively. If not, the team will become fragmented and far less effective. Laying a foundation for this team is a primary care provider/team that is responsible for the overall care of and communication with a patient/family. If the patient needs hospitalization, he or she is cared for by the focused and autonomous acute care team.

The Characteristics of a Bedside Care Team

- Within this "intensivist" bedside care team structure, individual team members have flexibility in their roles in order to better meet the unique and timely needs of the patient/family. This flexibility becomes reality by increasing the scope of decision-making regarding responding to critical events, pain, engaging with families in delivering select treatments, documenting care that reflects a strong patient/family narrative, and using alternative therapies. Therefore, members of the team adapt to the needs of the patient/family based on the setting and clinical needs.
- The team always includes the patient/family or other non-clinical caregivers chosen as critical to meet desired outcomes.
- Teams are not ratio-based because determining the best care for a patient is complex, and many factors must be considered.
- The team is comprised of clinicians with a variety of capabilities determined to be in the best interest of the populations served so that optimum care for the patient/family is delivered.
- Team members maintain consistent contact with the patient/family. The team has a spokesperson who communicates clearly and directly with the patient/family, with the aid of an interpreter, if needed.
- The members of the core bedside care team constitute a stable core to optimize the patient and family experience. This benefits not only providers, who can offer consistency and better quality of care since they gain deeper knowledge about the patient, but it better serves the patient/family. By maintaining a consistent core team, the patient/family gains peace of mind as they become familiar with the team, and are able to understand what is needed and can contribute to that care.
- Some tasks, such as administering medication are effectively transferred to the patient/family, provided the patient/family has been thoroughly educated about these tasks before the patient is discharged.
- The team knows how to deliver care with confidence and understands how to fulfill all regulations without the need of further explanation or oversight.
- Ancillary services staff, such as unit secretaries, aides or housekeepers, are placed strategically in roles that complement and support the bedside care team.

More Cutting-Edge Concepts: New, innovative practices

- Team members are trained in or have conflict resolution skills.
- Teams have a defined purpose and are able to articulate who they care for and what they offer patients.
- Care is built on a staged continuum, along the birth to end-of-life continuum referred to in the AHA's recent paper, "Workforce Roles in a Redesigned Primary Care Model." Innovative designs are needed to manage this continuum, such as the one proposed here with the reconfigured bedside care team.
- "Crew Resource Management" (CRM) is a model used in aviation that has excellent application to health care redesign. CRM is a procedure and training system that focuses on interpersonal communication, leadership and decision-making to accomplish an agreed-upon mission. It is the effective use of all resources — from people to technology — to minimize errors, improve safety and improve performance.
- Additional innovations:
  - Develop a team where the service comes to the patient, as in home health care, and another where the patient comes to the hospital (or other facility) for treatment. One group would be the on-site "technical team," doing the majority of the basic care at the facility, and the second would be the "mobile team" that travels to wherever a patient is located to provide specialized care, as with telemedicine and telehealth.
  - Limit the number of caregivers involved in patient care coordination; ideally, such coordination is performed by nurses in a primary care setting.

4. Evidence-based guidelines that improve care are developed and consistently followed by every bedside care team member.

In present care delivery models, the physician remains dominant as the "captain of the ship" and nurses are central, yet adjunctive, to following physician orders and filling in for other disciplines in their absence. In the new paradigm, the team is balanced to meet patient and family needs, and team members calibrate and negotiate their presence based on a 24/7 model of delivery. This shifts the role of the nurse as a utility worker and recalibrates roles and functions of all team members so that there is no delay in moving the patient to a less intensive (and less costly) setting as soon as possible (such as during the weekend). Each health team member performs non-clinical, yet essential, tasks to keep the environment suitable for the intensivist patient experience. Some of these activities include documentation responsibilities, outcomes data collection, communication coordination and discharge planning. Positive change will not occur in health care delivery unless the status quo around making and following rules is challenged. In this reconfigured bedside care team model, nurses and all other clinicians take full advantage of their professional knowledge, training and skills in order to deliver the highest quality care possible as a team with balanced and negotiated responsibilities.

Cutting Edge: New, innovative practices

- All of the ideas suggested are cutting-edge and provide innovative ways to challenge the status quo.
- Clinicians fully engage their professional knowledge, training and skills. The hospital's determination of provider privileges supplements the basic requirements of licensure and adds the specificity necessary to ensure quality care while not preventing individuals from adding their full potential value to the bedside care team. For example, should nurses prepare medications or does it make more sense for another team member to take on this task? This is just one type of challenge that needs to be addressed.
- Documentation that is repetitive/redundant or does not link to outcomes is identified and eliminated. For instance, the medical record is not only used as a research tool but is directly applicable to the medical practice and helps strengthen it.
- Better designs are created for admission and screening forms that only include essential questions.
- Electronic medical records (EMRs), or any information technology solution, is not seen as "the answer." In fact, if new technology "solutions" are not designed properly they can actually diminish the quality of care and take time away from the core of the bedside care team's work – patient care.

- Options regarding where care can be delivered are thoughtfully considered. As discussed in the first paradigm change, acute care will no longer be in the center of the care model. For example, does everything need to be done in the hospital or can some aspects of care be delivered in a primary care setting or even in a patient's home? The AHA paper, "Workforce Roles in a Redesigned Primary Care Model," discussed this topic in-depth, and stated that health care should be understood as happening on a continuum from birth to end-of-life, and that locations other than hospitals also can be highly supportive of quality patient care.

5. Technology should replace some clinical tasks, augmenting decision-making, and complementing the clinical judgment of the care team.

Foundational: "Must-haves" for highly functioning teams

- Before any new technology is designed or implemented it must first be evaluated for efficiency and its contribution to team impact and patient outcomes: How much time will it require at the bedside? Will the technology result in increased productivity and/or measurable outcomes? Has the clinical cost of using/supporting/fueling data into the technology been analyzed and proven to be positive for return on investment? If not, it should not be implemented.
- Technology is powerful and can support the bedside care team's care of the patient.
- Technology that replaces some tasks and helps clinicians focus on the patient/family is essential.
- Patient education tools are seamlessly integrated into new technologies, keeping top of mind that patients vary widely in their backgrounds and needs and that technology must be appropriately sensitive and flexible to language, culture and ethnicity.

Cutting Edge: New, innovative practices

- Tablet computers are provided in patient rooms; use technology for "web chats" between a provider and the patient/family and even direct communication with support services (i.e., ordering meals online); and interactive care plan communication.
- Technology supports decision-making and information management in the clinical and non-clinical arenas.
- A bedside care team member is designated as a "technology concierge" and assists and manages all technology-related matters for the team.

6. Patients needing acute care move safely through the health care system no matter where they are in the care cycle—whether at the onset of disease, in the middle of community-based care, or at the end of life.

This principle directly results from the implementation of the above five principles. Quality and safety are integral to the way the team operates, and by working synergistically, the team ensures the patient moves safely through the health system.

Foundational: "Must-haves" for highly functioning teams

- A culture of safety and a "Just Culture"—one that recognizes that competent professionals make mistakes and acknowledges that even competent professionals can develop unhealthy norms (shortcuts, "routine rule violations," etc.), but has zero tolerance for reckless behavior—are foundational elements of team care.
- Support and resources from leadership to ensure employee safety measures are put in place. To deliver safe patient care, employee safety must be considered equally as vital.
- Checklists are incorporated into the care process and into the technology infrastructure to keep care logistically safe, but not replace individual provider competence.
- Information is always provided to the patient in a clear, transparent way.
- The bedside care team is aware that human factors and interruptions can challenge a patient's safe passage through the care process and the team is constantly on alert so these issues can be avoided.
- Safety information is presented consistently and put in place prior to delivering various health care services. To deliver the highest quality care and improve outcomes, achieving a high degree of standardization in each and every process and ensuring that it occurs in every health care delivery setting is the goal.

- Continuing education in quality and safety is essential for all team members, as well as communications training so they understand how to explain safety information to patients effectively and consistently. Resources that can be used to build team strength in these areas include Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), training, huddles, continually assessing the culture and using self-reflection techniques.

Cutting Edge: New, innovative practices

- All team members are prepared to avoid risk, and do whatever they can to reduce it.
- Pre-, during- and post-discharge high-risk clinics are established to care for identified patients in order to devote more specialized attention to them.

Round Table Conclusions

Reconfiguring the model for a bedside care team is of utmost importance in order to respond to the shifting, expanding and evolving health care system. For hospitals just embarking on the journey to establishing and integrating a reconfigured bedside care model, the first step is to assess where you are and how you can take steps forward in order to ensure you will be able to continue to provide excellent patient care in the future. Other important steps to take include:

- Ensure all current and future clinicians are educated about inter-professional team work and their contribution to the team.
- Meet with key organizational stakeholders to discuss reducing the number and types of team members at the bedside and simplifying processes. Begin by discussing, "What are we trying to accomplish?" and then build the team that can accomplish those tasks. In many instances, you may discover that a smaller team works best, while other situations might require a larger team. The answer depends on the method of care delivery, where it is delivered, and above all, the needs of the patient/family.
- Begin to analyze how you use technology. For instance, look at and limit data entry into EMR systems that fails to convey patient status or clinical outcomes. Consider other technologies that could simplify and enhance safety and communication at your organization.
- Consider not only clinical needs, but other patient/family needs. For instance, when delivering care, consider the patient/family's unique background, such as their culture, language, belief system, education, age and other unique issues that might impact them. Ensure the care team is aware of and responsive to these needs, as well as clinical needs.
- Focus on the role of the acute care hospital as an entry, mid-point, or end-point to the clinical experience. Begin the process of building transitional care teams to facilitate the experience.

Appendix A

Examples of Leading-Edge Bedside Care Teams

Below are three examples of organizations with innovative, autonomous, highly effective, engaged bedside care teams that have had a significant, positive impact on the patients they serve. These organizations have developed teams that are already modeled on the six principles and can be considered strong models for the reconfigured bedside care team. They have taken the paradigm changes and adapted their models to reflect the evolution of health care.

Prairie Lakes Healthcare System, Watertown, South Dakota

This system developed a solution to address three inter-related issues of poor employee morale due to work intensity: lack of teamwork; high turnover; and low productivity. They developed the "Self Organized Agile Team," a three-person team that cares for 10-12 patients on a given unit. The composition of the team is varied, depending on the needs of the patients, but every team includes an expert nurse, making the bedside nurse the professional role that is defined by decision-making responsibility and accountability. This team model also includes two new roles: the Resource Nurse, an experienced RN who works 12-hour shifts and partners with the primary nurse caregiver to complete all hospital admissions, and the Care Technician, whose role was created by combining the responsibilities of the unit secretary and the nursing assistant.

The Self Organized Agile Team relies on an EMR, which allows all caregivers to access patient information from any workstation or laptop. The team grew out of collaboration among all hospital employees to create a more efficient system and to address ways to improve patient care at its core. The leaders of the health system supported the changes and provided staff the flexibility to innovate and truly transform their practice.

Brigham & Women's Hospital, Boston, Massachusetts

This organization's team-based bedside care model was developed as a way to improve physician training and it has been adopted on almost all general medicine units. The unit team includes attending physicians, residents, interns and medical students, pharmacy students and a faculty supervisor; nurses, a social worker, an RN care coordinator and a physical therapist. All team members work on the team for a minimum of four weeks, allowing for rotations of interns and residents. Patients are admitted to the unit only if there is a bed available, and interdisciplinary rounds are structured sequentially by nurse, rather than room number. These teams are proof that the traditional, hierarchical structures in existence in most health care systems today can evolve and change if supported by leadership and consistent education and evaluation by all involved.

Texas Health Resources (THR), Arlington, Texas

The leadership team at this organization took the concept of the "12 Bed Hospital" and adapted it to create a new care model based on the new role of the Clinical Nurse Leader (CNL). The concept began at Baptist Hospital of Miami as an innovation on one floor to address nursing turnover and patient satisfaction utilizing a new, baccalaureate-prepared role called the Patient Care Facilitator (PCF), and evolved it into a model where nurses serve as care integrators and inter-disciplinary team leaders along the entire continuum of a patient's care. At THR, the concept was first piloted on one medical-surgical unit in each of the 14 system hospitals, implementing both a PCF at the baccalaureate-prepared level and the CNL at the master's-prepared level. Texas Christian University in Fort Worth was approached by THR leadership to develop a CNL curriculum that did not yet exist in north Texas. As of this paper's publication, there are CNL positions for every 12-16 patients in each of the health system's facilities, both urban and rural. In the physician groups, there are CNLs assigned to work with a group of health coaches coordinating patient care with 600 physicians on the ambulatory side. The outcomes for this new model of care are impressive: Nurses have a clear, clinical career pathway; they are the focal point for communication and planning for patient care; and they partner with other clinicians in a team-based, inter-disciplinary environment to provide a seamless experience for the patient along the continuum of care.

Appendix B

AHA Bedside Care Team of the Future Roundtable List of Members

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Appendix C

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