DISCOVERY Stanford HEALTH CARE

A newsletter brought to you by the Office of Research,PCS

June 26, 2020

Meet the Expert

Blurb:
In this issue of Meet the Expert, we interview Patrice Duhon, MSN, RN, the Director of EPIC Optimization and Reporting for Patient Care Services. Learn more about the important role Patrice plays in enhancing the use of technology in professional practice. **Click here for the full article.**

Web Article:

Meet the Expert: Patrice Duhon, MSN, RN

QUESTION: Can you tell me a little about your background and experience? How long have you been with SHC?

ANSWER: The majority of my clinical career was in the ICU setting, primarily Cardiovascular Surgery and then later Neurosurgery. My career at SHC started on D3 in 2005. Pauline Regner, Patient Care Manager, and Katrina Sullivan, Assistant Patient Care Manager, recruited me and convinced me that I would be a good fit for their Intermediate ICU. I have never regretted a day since and am thankful for their persistence that started my journey. This year I will be celebrating my 15th year at SHC and throughout that time I have had many different opportunities such as, serving in the APCM role on D2, Relief Administrative Nursing Supervisor, Nursing Quality Coordinator, Nursing Quality Manager, then the Director of Nursing Quality. However, my interest and enthusiasm with the Electronic Health Record (EHR) and my current role started when I was asked to be a Super User in 2007 to help implement a new

EHR called EPIC. I have been hooked ever since. Many of the leadership roles and jobs I was employed in involved some aspect of optimizing or refreshing nursing documentation and how we collect and utilize nursing data.

In 2020 when the new position for the Director of EPIC Optimization and Reporting was established, I could not pass up the opportunity. To establish a department dedicated to optimizing nursing documentation and building reports that support all the work that Nursing does is a much-needed service. I have always been an advocate of efficiency while providing good quality and safe patient care. Nurses need to be able to work smarter and not harder. Nursing documentation should not be a burden or an obstacle in providing good quality care to our patients. The great quality of care that nurses provide at Stanford should be reflected in Nursing documentation. By working with efficient tools to document timely and effectively, we can leverage the technology to help us work smarter not harder. The EHR should be a tool to help nurses make good sound decisions that support our professional practice while providing excellent quality patient care. I am excited about this new role and the opportunity to collaborate with our bedside nurses, nurse leaders, and professional practice experts both here in Palo Alto and Valley Care to get this work done. Having a dedicated department to this work also give us an opportunity to better align with the SHC Medical Informatics and SHC Technology and Digital Solutions departments.

QUESTION: Can you highlight your role as the Director of EPIC Optimization and Reporting and support of PCS and SHC?

ANSWER: The Director of EPIC Optimization and Reporting is responsible for reviewing, facilitating, planning and implementing EPIC optimization in partnership with the SHC Information Technology teams. My role is key in staying attuned to the needs of clinicians across the enterprise to improve and optimize efficiency in documentation of care while maintaining quality standards. I work very closely with Gretchen Brown, the Associate Chief Nursing Informatics Officer (ACNIO) to strategize enterprise wide on EPIC documentation and implementation of new EPIC modules while enhancing existing EPIC modules to solve the problems that are prioritized in the Nursing and Enterprise strategic goals. My role as Director of EPIC Optimization and Reporting is also responsible for EPIC quality reporting and integration of metrics from other technical platforms to improve quality outcomes identified by the organization and Patient Care Services (PCS). Additionally, to utilize the data not only to optimize how we store and access, but to create great visualization tools and dashboards to help all levels of PCS better understand the data and know what to take action on.

QUESTION: What is your role in the COVID-19 Pandemic response at SHC?
ANSWER: Due to the “shelter in place orders”, the cancelation of all elective surgeries, and the temporary closure of some clinics and other departments, the organization quickly felt a surplus of staff and employees that needed work outside of their normal departments.

This quickly became a problem that needed an urgent response and solution. I was assigned the Clinical Lead and part of a team assigned to finding a solution to the staffing surplus problem. Salem Paschal, Director of Clinical Inpatient Access was assigned the Operational Lead of this project and Austin Wilson,

Sr. Program Manager who was responsible for managing the project were incredible partners and teammates for the project. Together we created the Contingency Staffing Operational Center (CSOC), better known as the Labor Pool.

The Contingency Staffing Operations Center (CSOC) was the centralized team that assisted the organization to maximize utilization of staffing resources across the organization by matching essential staff resource gaps to the appropriate resource surpluses across the enterprise. I also worked with Moses Albaniel and Darvin Antonio from the Professional Practice & Clinical Improvement team, who are experts at nursing data collection and visualization to get the CSOC fully operational online. We also created a staffing projection model that would help guide staffing decision making if and when a surge would occur.
It was an incredible experience to see how the organization could quickly mobilize and come together to help support our efforts.

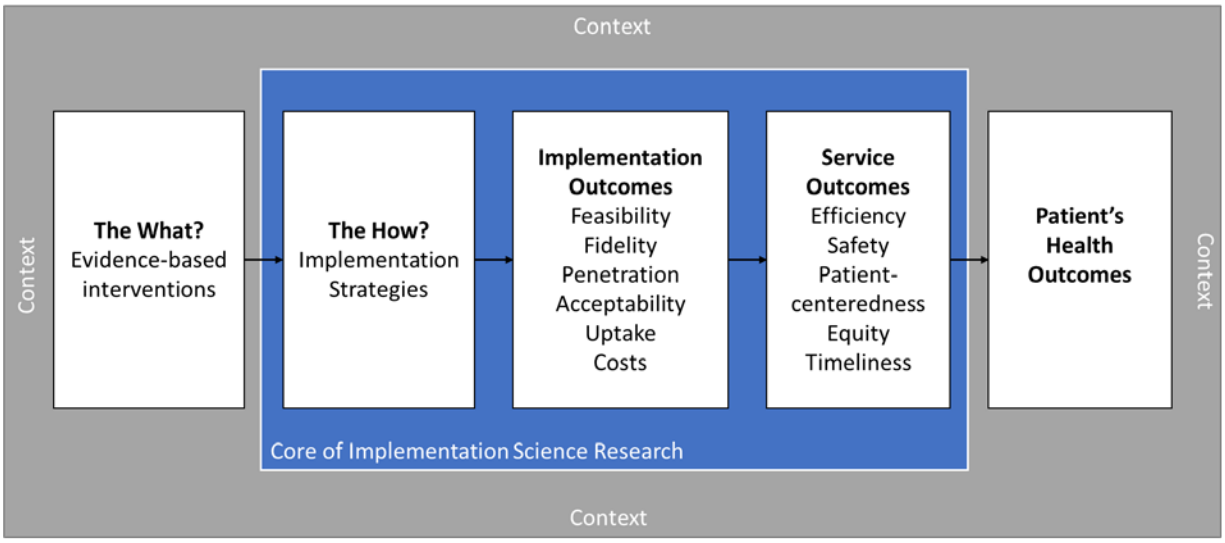
QUESTION: What challenges are you facing in improving user experience and productivity of EPIC?
ANSWER: The first component in trying to improve user experience is to try and develop an understanding of what users need to do their day to day activities and what value does it add. It also helps to understand user's abilities and limitations. Another component is to understand and evaluate where nurses spend most of their time in EPIC and compare to similar organizations to evaluate efficiency. Once we have a clear understanding of user experience, we can develop and design a systematic approach to evaluating all aspects of nursing documentation to ensure documentation matches our professional practice, reflects the most current evidence-based practice and industry standards, and incorporates nursing research wherever possible. To do this work effectively, we will need help from our end users to find solutions to reducing documentation burden and developing a systematic process for reviewing and refreshing the EHR. Leveraging technology to work better for the end user is a far better satisfier and experience than prioritizing the end user working for technology.

QUESTION: When you are away from work, what activity do you enjoy in your spare time?
ANSWER: My husband and I are both Cajuns from South Louisiana. We love to travel and meet new people. We have a saying in our culture when we meet new people, "we were always friends, we just haven't met before." This is why we love learning about and are fascinated by different cultures and beliefs, traditions, and social customs. Learning about different cultures broadens our perspectives, bringing a new level of understanding, admiration, and respect for others, as well as deepening our shared experience in the world. This is also why we both love living in the Bay Area, a melting pot of different cultures and traditions to explore.

If you'd like to get in touch with Patrice to discuss EPIC reporting or for other questions, she can be reached at PDuhon@stanfordhealthcare.org.

Article By: Patrice Duhon, MSN, RN & ORPCS Team

Education



Blurb: Implementation science is the study of strategies that facilitate the uptake of evidence-based practice and research into bedside practice, but what should nurses know about it? **Click here for the full article.**

Web Article:

Introduction to Implementation Science for Nurses

One of the challenges nurses face at the bedside is infusing research evidence in their daily practice. **Evidence-based practice (EBP) interventions** can be procedures, policies, or products that have been demonstrated to improve health outcomes through research. For example, interventions such as handwashing or catheter-associated urinary tract infection bundles are known to reduce the spread of infections but not everyone adheres to them all the time. In addition, everyday research articles are published with new evidence for various interventions but not all of them make it into our clinical practice.

In fact, studies show that it takes on average 17 years[1] to carry out successful interventions from research setting and into routine care. What is more dire in this *research-to-practice gap* is that half of the evidence-based interventions never even reach widespread clinical usage[2].

So, how can nurses facilitate the translation of research findings at bedside?

There are many ways that nurses can implement EBP. **Implementation strategies** are the actions taken to adopt, implement, scale, and sustain EBP in clinical practice across the health system. These strategies vary in complexity, from single components, such as training sessions or reminders, to multifaceted implementation strategies (e.g. interdisciplinary rounds led by practice champions). They

can effect change on various levels, targeting bedside nurses and other clinicians, nurse managers, organizational policies, financing, or any combination thereof.

Nursing implementations have often focused on individual nurses employing education and skills training (e.g. in-service), as a commonly used implementation strategy. However, there are many other options. The table below provides some examples of strategies that can be used in implementing EBP in the clinical setting.

Implementation strategy	Examples
Use evaluative and iterative strategies	Assess for readiness and identify barriers and facilitators Audit and provide feedback Develop and implement tools for quality monitoring
Provide interactive assistance	Provide local technical assistance Provide clinical supervision
Adapt and tailor to context	Tailor strategies Use data experts
Develop stakeholder interrelationships	Identify and prepare champions Organize clinician implementation team meetings Obtain formal commitments Visit other sites
Train and educate stakeholders	Conduct ongoing training Develop educational materials Make training dynamic
Support clinicians	Remind clinicians Revise professional roles Create new clinical teams
Engage consumers	Involve patients/consumers and family members Prepare patients to be active participants Increase demand
Utilize financial strategies	Fund and contract for the clinical innovation Alter incentives Develop disincentives
Change infrastructure	Mandate change Change records systems Change physical structure and environment

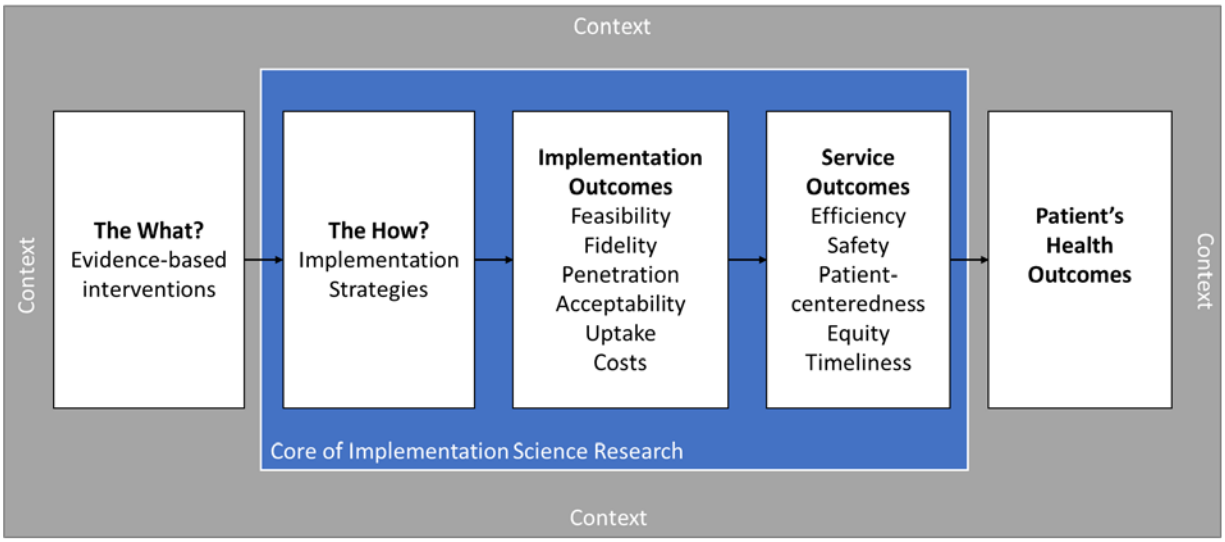
Adapted from Waltz, et al. (2015) "Use of concept mapping to characterize relationships among implementation strategies and assess their feasibility and importance: Results from the Expert Recommendations for Implementing Change (ERIC) study." Implementation Science. 10, 109 https://digitalcommons.wustl.edu/open_access_pubs/4149

But which strategies work best in what situations and for what EBP?

To answer this question, we may look to **implementation science**[3-4], a *study* of translating, applying, and disseminating research to clinical practice. It seeks to close the gap between *what we know* and *what we do,* drawing on knowledge and methods from various disciplines, including health services research, economics, sociology, and organizational science.

Implementation research seeks to understand and work in "real world" or usual practice setting. This contrasts with randomized clinical trial designs where researchers tightly control the conditions, trying to isolate the effects of the intervention from the influence of daily practice. Instead, it pays attention to the *audience* that will use the research (e.g. nurses, managers, policy makers), the *context* in which implementation occurs (e.g. clinic environment) , and the *facilitators and barriers* (e.g. time, resources, specific policies) that affect implementation, usability, scalability and sustainability of EBP.

To advance science, implementation research uses conceptual models to understand the relationships between these various factors and how they can be changed. An example is provided below. The model shows the general flow of how an EBP (or EBI) translates to health outcomes, depending on a set of implementation strategies and outcomes.



Adapted from Proctor, et al. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. Administration and Policy in Mental Health, 36(1), 24–34. https://doi.org/10.1007/s10488-008-0197-4

How is implementation science different from quality improvement?

Both implementation science and quality improvement (QI) efforts have the shared goal of improving quality of healthcare. However, there are some major differences. QI typically begins with identifying a problem in a specific setting, such as a single unit or clinic and tends not to seek to contribute generalizable knowledge. Implementation science, on the other hand, focuses on the solution, or the EBP to disseminate and contributes to knowledge by identifying generalizable technics that can be scaled across various settings. However, both use some overlapping methods and QI can be informed by implementation science in the selection of implementation strategies.

Conclusion

Nurses are uniquely positioned to implement EBP in clinical setting and can draw on implementation science findings to disseminate and scale these practices.

If you want to learn more:

Watch a video from Duke Clinical Research Institute on "Implementation Science: Bridging the Gap from Clinical Research to Population Health" https://www.youtube.com/watch?v=jOKdaRantZI

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Article By: Maria Yefimova PhD RN

Research

Reference: https://www.military.com/daily-news/2020/03/23/why-navys-hospital-ship-mercy-going-la-instead-hard-hit-washington.html

Blurb:
Global Health Engagement missions performed by the U.S. Military are conducted to improve the well-being of populations worldwide. From 2015 to 2017 Monique Bouvier PhD, RN, C-PNP worked with a multidisciplinary team interviewing U.S. Navy health care personnel about their experiences on global health engagement missions. **Click here for the full article.**

Web Article:

Essential Lessons for Military Healthcare Personnel

Monique Bouvier, PhD, RN, C-PNP is a research nurse scientist who works in the Office of Research Patient Care Services (ORPCS) at Stanford Health Care (SHC). Previously Monique was as a research nurse for the United States Navy where she worked on many different research studies. One project was a multisite qualitative research study titled, **Global Health Engagement (GHE) Missions: Lessons Learned Aboard US Naval Ships.** Monique was a member of a team that interviewed over 140 military health care personnel who were part of the shipboard GHE mission. Their overall aim was to capture experiential learning during global health engagement missions and provide narratives of GHE missions.

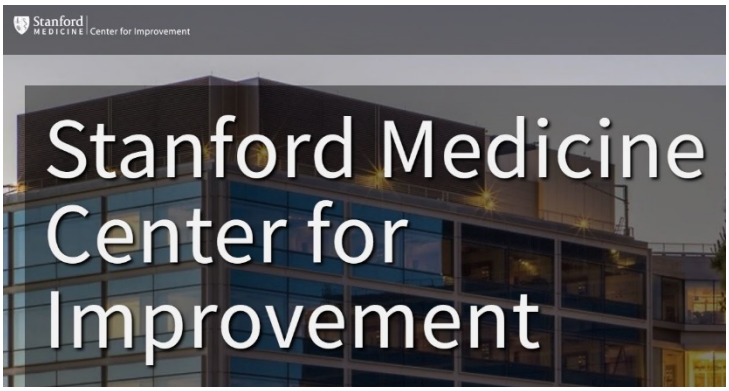
Monique and the multidisciplinary team analyzed the interviews using an interpretive ethnographic approach. They were able to take the information from the interviews and summarize essential lessons that military healthcare personnel need for GHE missions. Five essential elements to prepare military healthcare personnel for missions were identified: mission clarity, preparedness, experiential knowledge, lessons learned, and flexibility/adaptability. This information was recently published in the November/December 2019 issue of the journal *Military Medicine*. Click here to read published article.

Citation:

Heather C King, NC, USN, PhD, CRNA, Monique Bouvier, PhD PNP, Natalie Todd, BA, Coleman J Bryan, Jr., MC, USN, Gregg Montalto, MC, USN, Christine Johnson, MC, USN, Robert Hawkins, NC, USN, PhD, DNP, MBA, Lisa A Braun, NC, USN PhD, MBA, JD, FNP-BC, FAANP, John Malone, MC, USN, MPH, Patricia Watts Kelley, PhD, RN, FNP-BC, GNP-BC, FAANP, FAAN, Shipboard Global Health Engagement Missions: Essential Lessons for Military Healthcare Personnel, *Military Medicine*, Volume 184, Issue 11-12, November-December 2019, Pages e758–e764, https://doi.org/10.1093/milmed/usz113

Article By: Monique Bouvier PhD RN

Spotlight



Blurb:

In October 2019, the Stanford Medicine Center for Improvement (SMCI) successfully launched a new website. The goal of SMCI is to become the best at getting better. SMCI seeks to create a community of improvers in all disciplines and at all levels. **Click here for the full article.**

Web Article:

Stanford Medicine Center for Improvement (SMCI)

What is SMCI? How did it begin?

The Stanford Medicine Center for Improvement (SMCI) is the realization of the vision of Dean Lloyd Minor, MD, of the Stanford University School of Medicine, to bring together safety, quality, improvement and patient experience leaders across Stanford Medicine with the goal of inspiring and enhancing the delivery of consistent, excellent care. This includes all staff at Stanford Health Care and Stanford Children's Health, School of Medicine administrative staff and faculty, Valley Care, University HealthCare Alliance (UHA) and Packard Children's Health Alliance (PCHA). Beginning with the Safety, Quality and Value (SQV) Committee's work in 2015, the idea for the Center came from the 2017 Stanford Medicine Integrated Strategic Plan. In 2019, a multi-disciplinary work group met from January through July and created the vision and plan for the new Center. The work group submitted the Center application in July 2019, and three months later in October 2019, the Stanford Medicine Center for Improvement (SCMI) was approved and established.

SMCI is guided by the following principles:

- We create value for patients
- People are our most valuable resource

- We strive to be the best at getting better
- Leaders fostering an environment for improvement

What are the future goals for SMCI?

SMCI aspires to be a place where improvers from all over the world can gather to share knowledge, build relationships, and talk about the future of healthcare improvement. SMCI will offer multi-faceted, interdisciplinary, and web based education resources for improvers and a platform to showcase projects and research in improvement. Venues such as the annual Stanford Academic Lean Conference will provide a platform to make this happen.

Who is involved in SMCI?

SMCI is co-led by Executive Directors Dr. Lane Donnelly, MD and Dr. Karen Frush, MD, both of whom are the Chief Quality Officers of Stanford Children's Health and Stanford Health Care, respectively. Together, they and the SMCI team are engaging interested parties as affiliates or fellows in SMCI to realize the vision of everyone in the Stanford Community playing a role in improvement in every environment, every day.

SMCI is guided by a prestigious Advisory Committee of local and national improvement experts and thought leaders. SMCI has four primary work groups/committees focusing on Education, Research, Data Analytics and Teamwork.

Pictured from Left to Right: Celina Meza; Terry Platchek; Lane Donnelly; Karen Frush; Nilushka Melnick; Lisa Freeman; David Larson. Not pictured – Ben Elkins.

Why should I join SMCI?

All of us at Stanford Medicine strive to improve our work environment, and the quality and safety of care and want those improvements to last. As a member of SMCI, you will become part of the culture of improvement that enhances the quality and effectiveness capacity within your area.

A Message from CNO Dale Beatty about SMCI
"We are fortunate to have the Stanford Medicine Center for Improvement (SMCI) as a structure/resources to further enhance our quality and efficiency. Interprofesssional participation and collaboration is critical to assure the acceleration and quality of our improvement efforts. Physicians, nurses, and other professional disciplines are strongly encouraged to actively participate in the SMCI. Together we can collective elevate the quality of care that we provide for our patients, families, and the communities we serve."

How do I join SMCI?

SMCI invites **EVERYONE** to join as we build our community of improvers. We seek to connect improvers across Stanford Medicine in every discipline to solve problems together. We want to break down siloes across organizations, share learnings and tools. You can join SMCI at either the affiliate or fellow level on our **website** https://smci.stanford.edu/ at no cost.

Pictured: Benjamin Elkins

What Improvement resources exist?

The SMCI team communicates and elevates resources such as the Realizing Improvement through Team Empowerment (RITE), Clinical Effectiveness Leadership Training (CELT), Packard Quality Management Systems (PQMS) and Process Excellence tools so they are broadly understood and used across the Stanford Medicine community. You can find out more information about these programs on our website. Additionally, the SMCI team has created an Advanced Course on Improvement Science (ACIS) to be launched in September 2020 to train those interested in advanced improvement science tools and theories and/or a career as an improvement leader. Our website provides links to improvement resources in a variety of disciplines.

Who can I contact if I have questions?

If you have questions about joining SMCI or want to engage in one of our workgroups or committees, please contact Lisa Freeman, Senior Advisor, SMCI, at lisafree@stanford.edu. Thank you!

Article By: Elizabeth (Lisa) Joyce Freeman