A bold move to improve collaboration

One hospital system is empowering frontline clinicians in all disciplines to move the quality journey forward.

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Interdisciplinary collaboration is the cornerstone of high-quality patient care. Several years ago at Orlando Health (Florida), we made a bold move and flipped the existing hierarchy to improve collaboration. The goal was to empower frontline clinicians in all disciplines to push innovative patient safety and quality improvement ideas to the forefront. In this article, we share our successful experience in the hope that other organizations can use a similar model.

To bring the vision of improved collaboration to life, Jamal Hakim, MD, chief quality officer, partnered with us and other likeminded leaders in the organization. Together we created a forum—the Collaborative Quality Advisory Committee (CQAC)—where nurses, physicians, and allied health team members could develop and send quality suggestions to the medical executive committee for approval.

Building the team

Our hospital system consists of eight hospitals with more than 14,000 team members and 2,000 physicians. It was important for the CQAC to represent all hospitals, specialties, and professional disciplines, so it was a daunting task to select members for the committee.

CQAC members needed to have certain personal attributes to make the group's dynamic succeed— respect, teamwork, and consistent demonstration of patient safety behaviors in clinical practice. Members also needed good listening skills and the confidence to offer justifiable opposing viewpoints to discussions. We wanted two patient and family representatives for the group as well. Each hospital's leadership team recommended members; the list of potential members was refined to ensure appropriate representation from hospitals and specialties.

Frontline nurses were well represented on the CQAC and included staff from medical telemetry, orthopedics, pediatrics, labor and delivery, critical care, and intermediate critical care areas. Later, we added a clinical assistant nurse manager, nursing operations manager, and chief nursing officer to partner with their frontline colleagues

A name isn't just a name

Names mean a lot. Members of the Collaborative Quality Advisory Committee at Orlando Health learned an important lesson about names in their journey to improve interdisciplinary collaboration. Previously, we'd used the term "ancillary" when referring to our allied health colleagues. Medline Plus® and Merriam-Webster define ancillary as "being auxiliary to or supplementary."

However, the U.S. Department of Labor, universities, and colleges consider allied health disciplines (which include physical therapy, pharmacy, and dietitians) far more than just supplementary to high-quality patient care. Merriam-Webster defines *allied* as "joined in a relationship in which people, groups, countries, etc., agree to work together."

After learning the true meaning of *ancillary*, our nurses and physicians were dismayed that we'd been using this term to refer to our valued colleagues. Our healthcare system currently is eliminating "ancillary" from job titles and other references. This long-overdue change is a positive step in our effort to respect and empower our team members.

in the group's initiatives.

Selecting allied health team members for the committee was especially challenging because of the number of potential participants. This large group includes staff from the cardiovascular, clinical nutrition, imaging, laboratory, pharmacy, respiratory care, and therapeutics (physical, occupational, and speech therapy) departments. To chair our allied health executive council, we added an administrator to be the voice of all the disciplines. Interestingly, we learned we hadn't been using the correct terminology for some of our colleagues. (See *A name isn't just a name*.)

Once our clinician members were in place, we asked them for recommendations of patients and family members from their clinical practice to consider for the committee. Through an interview process, we identified two valued individuals who shared many of the same attributes of the clinical members. The final committee consisted of about 40 regular attendees.

Establishing structure and priorities

Structured to be nimble and bureaucracy-free, the CQAC meets every other month. Official officers are limited to a chairman (our chief quality officer) and vice chairman. The director of patient safety, who traditionally has been a nurse, rounds out the group's leadership. The director is instrumental in planning the agenda and promoting discussion during meetings.

It was important to the group's leadership for members to establish their own strategic priorities. Before their first meeting, members received an email asking, "What keeps you up at night?" related to patient safety. These issues were compiled and used to form meeting agendas.

It became clear ineffective communication was the root of many problems. During interdisciplinary discussion, the team learned that communications that should be exchanged directly from physician to physician were being abdicated to nursing. Examples included the use of conditional orders, such as "Discharge home if OK with consultants" and "MRI of brain if OK with obstetrician."

Physicians and nurses gave examples of how these orders led to patient harm. Some physicians stated they'd written these orders to save time. Patient and family representatives said it was important to them for their physicians to take the time to speak to other physicians as needed about their care. Nurses stated that being placed in the middle of physician-physician communication was wasteful and dissatisfying and led to suboptimal patient care.

Taking action

After this discussion, the group unanimously decided that this type of communication shouldn't be permitted. The group worked with the chief of the medical staff and her team to win medical executive-committee approval of this idea. Medical staff bylaws were amended to reflect this practice change.

Everyone on the team believed the rationale for the change should be communicated to physicians by physicians. The physician chief quality officers at each hospital in our system volunteered to lead the communication plan with physicians in their buildings. Before the change, they discussed it with the physicians who'd been writing conditional orders. They also agreed to talk personally with physicians who resisted the change. This relieved nursing of the task of "policing" the change.

Allied health team members wanted an opportunity to identify how this change might affect colleagues. Historically, practice

changes hadn't been vetted sufficiently with allied health in the dominant physician/nurse culture. To address this, a core group from the CQAC and hospital leadership developed a communication and change plan for implementation that was targeted to physicians, nurses, and allied health staff. Nursing and allied health leaders communicated the changes to their teams in a series of huddles supplemented with written communication about the rationale for the change, which included frequently asked questions developed by the team.

Realizing results

The implementation plan succeeded. The entire team felt empowered by their "win" and were eager to take on additional multidisciplinary communication problems. The group currently is addressing physician-to-physician communication for consults and is transforming the process for disclosing harm to patients.

Our nursing members have expressed meaningful personal and professional satisfaction with their participation in the committee, such as:

- "I enjoyed meeting physicians and clinicians who practice outside my 'silo.' We talk about how we are trying to be less 'silo-ed' as an organization, but this group with corporate membership made it seem as if we were really taking action."
- "I got to learn the big picture for some of the problems, and now I can speak to my nursing colleagues about the 'why' behind the changes we're implementing."

Keep the atmosphere informal and encourage use of first names to help level the hierarchies.

Tips for success

Our experience over the past several years has taught us valuable lessons and tips to share. A small core group is crucial to keeping the committee focused and action oriented. This structure promotes direct interdisciplinary communication within the committee and throughout all system facilities. In addition, conducting the meetings with small group sessions promoted nurses' willingness to share their experience with physician and allied health colleagues. In addition, nurses benefited from feedback from colleagues regarding their perspectives and experiences.

Other tips include the following:

- Keep the atmosphere informal and encourage use of first names to help level the hierarchies found in many healthcare professional meetings.
- Be aware of the need for strong communication with staff members who aren't on the committee. Nurses often reported that their coworkers were unaware of the committee's existence and function. They also suggested a need for greater member input in setting the agenda, as well as guidance for topics the council should discuss and issues it should address.
- Consider a structured process for rotating off team members and incorporating new ones. Nurses suggested recommendations from current members that would improve the likelihood of recruiting motivated, engaged replacements.

The CQAC has shown us that empowering frontline team members in problem solving is the path forward in our quality journey. Committee members have successfully tapped into an abundance of collective knowledge from a diverse care team. The CQAC has helped bridge communication gaps and align quality and patient-experience goals with our organization's strategic priorities.

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