

EXECUTIVE INSIGHTS  
RESILIENCY + RECOVERY



## BUILDING THE PATIENT-CENTERED CONTINUUM OF CARE OF THE FUTURE

Strategies to support the workforce and minimize patient care disruptions during construction

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# BUILDING THE PATIENT-CENTERED CONTINUUM OF CARE OF THE FUTURE

## Strategies to support the workforce and minimize patient care disruptions during construction

Health systems are expanding into the community with different models and making capital investments to elevate their capabilities to deliver patient care and better support their clinical care teams. A health care organization's investment in a significant capital project can serve as a change agent to address historic stressors in the environment of care, operational workflows and technology. However, deploying these capital investments to support an already overextended workforce often causes disruption to existing operations that can elevate stress for front-line workers if not carefully planned and executed. This executive dialogue examines strategies for health care organizations to meaningfully engage and support their workforce during capital project developments and times of operational disruption. ●

### 10 best practices to engage and support the workforce during capital project deployment

#### COMMUNICATE OFTEN

Overcommunicate in facilitywide town hall meetings, visual displays, employee forums and newsletters. Provide weekly updates from the leadership team and just-in-time education for department heads and charge nurses to use with staff communication tools. Alert staff with email and text blasts when construction starts and designate construction areas with colored indicators.

#### STAFF FEEDBACK

Involve and solicit feedback from staff and the community throughout the planning process with hosted virtual reality reviews and mock setups.

#### SUPPORTIVE WORK CULTURE

Celebrate the "why" behind the decision to make capital investments to improve the organization's environment of care.

#### SANDBOX SIMULATION

Create a sandbox and, using simulation, build scenarios in that new space to determine the safest care model. Use a simulation team that is interdisciplinary and interprofessional.

#### TEMPORARY STORAGE

To minimize disruption during construction, provide storage space and cubbyholes that are easily accessible for regularly used equipment and supplies.

#### INTEGRATED PRODUCT TEAMS

Implement Integrated Product Teams (IPTs), to foster cross-functional collaboration and resolve issues efficiently and effectively. The IPT reviews plans, specs and progress at each phase.

#### STRESS RELIEVERS

Create respite rooms and outdoor spaces in which to relax, like Zen rooms, lavender rooms, healing gardens and fitness trails with input from the clinical staff. Embed break areas in the units. Use massage chairs or bring in massage therapists for relief.

#### GO LEAN

Use lean processes with performance improvement teams and clinicians to design the build-out to improve patient flow and redesign care delivery.

#### KEEP STAFF SAFE

Ensure that security of staff and patients is a top priority. The security team needs to be visible and have designated space.

#### CONTINUE LISTENING

Encourage feedback on any issues with construction and safety concerns. Measure employee satisfaction with listening sessions, in-person rounding, employee engagement surveys and special portals for anonymous feedback on construction projects.





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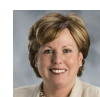
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**MODERATOR** (*Suzanna Hoppszallern, American Hospital Association*): **On a recent capital project, what would you have done differently to support your care teams better during the disruption on your campus and other care settings?**

**W. KEITH NEELEY** (*University of Tennessee Medical Center*): We are working to find and create respite rooms for our staff — safe places to relax and get away from the challenges they are facing. We've even created an outdoor space called the respite area. Some gift funding is helping to outfit that space. This will give folks an opportunity to get outside, not just to have a meal, but to recline, relax and decompress from stress. Respite rooms also are becoming popular now. We're also trying to build in or find spaces for lactation rooms.

We're building a new emergency department (ED), and some other parts of our facility. There are not enough spaces or alcoves created to put the equipment required to best serve patients. Staff become frustrated when they can't put equipment that they need regularly in a place that's easily accessible, but also doesn't violate egress requirements. Being mindful of having these alcoves and accessible storage areas is an important design component when executing a project that many people don't think about. In fact, they feel as though it's wasted footprint. But it pays for itself in clinical provider time to access and employ needed equipment and improving compliance.

**ROBERT ROSE** (*Atrium Health*): We're in the middle of a multimillion replacement hospital for our flagship campus in Charlotte. Having been through many iterations of projects, we all could say the same thing about needing storage. We've spent a lot on lavender and Zen rooms. When I do my rounds, I'll purposely open the door, and I never see anybody in there. Often, I'll see a blood pressure cuff, or a blood pressure machine in there. They start making it a storage room.

The acute care workforce is so busy, and it's hard to untether yourself. We want them to take a break. Taking lunch breaks is a goal at Atrium Health, because we know that they typically only take 10 minutes. We're looking at taking advantage of light and outdoor space. And we're working on well-being — not as a place but a process. Embedding break areas in the units to use with teammates is more important than having a room off to the side that doesn't get a lot of use.

**KATHLEEN GORMAN** (*Children's National*): At Children's Hospital, we not only care for the child, but their entire family as well. The spaces that we build are as important for our patients and families, as for our staff.

You asked, 'What are we glad we did early on and what could we have done differently?'

In 2017, we opened a healing garden focused on the patients and families who needed an outdoor space to help heal. During COVID-19, we realized that a respite space was critically important for our staff as well. I'm thankful that we built this outdoor space that has been so calming and relaxing for our patients, families and staff. We have recently added respite rooms or Zen rooms, to which the staff overwhelmingly responded positively. It is a calming space, when staff are able to get away from a busy patient care assignment.

If we could go back and change some of our COVID-19 decisions, it would have been more beneficial to accelerate some of the clinical capital projects that we need. Currently, we find ourselves with incredibly high volumes, making it difficult to free up the space for renovation, such as in our emergency room.

**WILLIAM STUEBER** (*West Palm Beach VA Health Care System*): I was in two facilities during COVID-19. When the pandemic first hit, I was in a facility where we didn't slow anything down. We

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accelerated construction, because we suddenly had vacant space. Administrative staff were sent home to telework. We were able to do a lot more. Plus, as other areas shut down work because they were afraid of working during COVID-19, more construction workers were available and we were able to staff up the crews.

Halfway through the COVID-19 cycle, I ended up in another facility, where they did the opposite. They literally shut every construction project down, and wouldn't let contractors in the building. Now we're struggling with half-done projects and time is running out on funding. We now must expedite to get them done. This is causing more of a disruption on the staff, because as they're trying to come back to some sense of normalcy, I'm having to move them out of wings to finish the projects. In addition, you also have infection-control issues. When you're only halfway through a project and you shut down, the flooring is taped and the negative air machines may or may not be running.

For us, the Zen rooms are called the whole health program. We have a two-person staff whose entire job is to create ways to improve employee morale. We have some of these rooms, but we log in and out of them, and we're able to monitor their use. I thought they were going to be a waste of space, but it turns out that these rooms are used quite a bit, and the program is expanding. The person in charge calls me regularly to tell me about available funding. We converted one area into an employee gym. We were also able to get funding for a fitness trail with 10 exterior exercise stations, so that employees can go outside and walk around the property.

When you talk about minimizing disruption you

must involve the end users, particularly clinical staff, about what projects are on the horizon and what the disruption will be. In the past, they were always being caught off guard and waiting for the next shoe to drop. We've implemented Integrated Product Teams (IPTs), to foster cross-functional collaboration and resolve issues efficiently and effectively.

For example, we're converting inpatient wings from two-patient rooms to single rooms and I must shut the wing down to do that. Instead of meeting with staff resistance, we engage in an important conversation: 'We're moving you here, and you'll have as many beds as when we're done. We're just doing the transition now, so that when you move into your new wing, you'll be at the population that you'll have for the future.' It's important to coordinate with the clinical staff.

**NICHOLAS HOLMES** (*Rady Children's Hospital—San Diego*): During COVID-19, while doing our campus master plan, we were getting ready to undergo the biggest project in our almost 70-year history. We're building new acute care towers, focusing on intensive care units (ICUs) and the ED. Like all of you who've done these types of projects, we include all our end users. Our staff and families who were involved in

this project were laser-focused on the clinical care areas. They did a great job focusing on the patient rooms, but it was challenging to redirect them to think about other spaces — respite areas, outdoor spaces, gardens — where they could eat lunch, or where families can have a private conversation.

Once they did, they designed their own lounges and respite rooms with massage chairs and essential oils. Getting them to focus on outdoor spaces was an absolute godsend during the pandemic, because

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people were able to get outside without having to wear a mask, and be able to eat, relax and enjoy the sunlight of Southern California.

**NEELEY:** Beyond staff engagement, some of our patient representatives are providing input into the recommendations for design and how they would use the space. It's important to engage all facets of your patient base.

Being an academic medical center, we have become creative in how we're dividing rooms. During COVID-19, staff transformed underutilized space for visitor waiting into staff/faculty training rooms, conference and respite rooms. Now we're in the process of restructuring rooms to return some of that space to visitor waiting while keeping some of the footprint available for medical staff and students. We still must meet the mandated seating requirements per ICU room, according to the Facility Guidelines Institute's "Guidelines for Design and Construction."

While academic medical center project plans are expanding the footprint of simulation centers, conversely, the library is underutilized. There are so much data and information online that we are thinking about decompressing our library into more of a media center and meeting space.

During the pandemic, we had to amass personal protective equipment (PPE), other supplies and equipment, and there was no place to store it. We ended up commandeering some vacant or underutilized space for storage. I'd love to hear from the group if others encountered that challenge and used semi-trucks parked outside or had to get storage space in their community to stay ahead of the supply chain crisis that we're still experiencing.

**MODERATOR:** Did anyone have a response to that challenge?

**STUEBER:** In one of the facilities, they rented ware-

house space for the additional PPE. In the other location, we brought in environmentally controlled CONEX box containers, and we commandeered a remote part of the parking lot that wasn't being used. In the end, we used about 25 CONEX boxes for storage and workspaces, which provided a lot of flexibility. Once we had them set and everybody knew where they were, it was easy to get trucks to them, compared with being off-site with a lease.

**MODERATOR:** How do you evaluate staff satisfaction when you undergo a disruptive capital project? What measures have you found to be the most insightful?

**REBECCA SHUTTS** (*Alice Hyde Medical Center*): I'm relatively new to Alice Hyde. I've been here just a year, so I haven't been involved in any capital projects. In my previous role, we included staff members from the beginning on any planning committee as well as patients, former patients and family members of patients who were a good fit.

We built an entire inpatient, progressive care unit and had a multidisciplinary team that included those folks as well. At the end of every meeting, we did gut checks to find out how everybody was feeling? We asked, 'What can we do better? What should we talk about next time?' Staff involvement from beginning to end is key to engagement and satisfaction.

**ANNE STEWART** (*Beaumont Health*): At least one of the front-line staff needs to be at the table as we make the plans as well as proceed, which is difficult right now. Usually, you get one or two who are really invested, and they'll be there most of the time. That was key to everything we've been doing recently.

**SUSAN LANGELAND** (*Pine Rest Christian Mental Health Services*): We're a 100% behavioral health organization. We have unit practice councils on each inpatient unit. Unit practice councils come from the



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nursing caring theory. They're multidisciplinary councils. We have chaplains as well as doctors, nurses, psych techs and activity therapists. We try to leverage these groups because they already meet regularly. People are busy providing care, and we have a workforce shortage. Trying to get people to volunteer to be on different committees has been a challenge since the pandemic hit.

When we were building a new unit before COVID-19, we went to our community partners, people who were referring to us and asked them: 'This is what we're seeing in the data for additional services to meet the needs of our community. What do you think the needs are?'

**SALENA GILLAM:** (*Stormont Vail Health*): We use Vocera, so we can do a lot of real-time communication. We prepare as a leadership team, and we do a lot of just-in-time education. We tee that communication up, so we know for Week 1 and Week 2, and the next two weeks, that every charge nurse at their lean board is going to talk about everything that's going on in the department. It's teed up for the charge nurse, so when they walk in for the day, they're giving that information out. But you said that perfectly earlier, the harder we try, the more I feel like I'm pushing communication.

**CONNIE MARTIN** (*Fort Loudoun Medical Center*): I've tried to overcommunicate, and include people not just in project design and planning, but in a lot of things. I do a lot of personal, in-person rounding on the units, and I reinforce what we push out officially in casual conversations.

In addition, I've created a column in our newsletter, which goes out both electronically and in hard copy

to some locations. We plan to resume our in-person employee forums that we try to have two to four times a year, where all staff receive an update on operations and projects. This year, my plan is to spend less time on providing updates and more on listening sessions, really focused on the COVID-19 pandemic, staffing shortages and what's been folks' experience through that. We are trying to be more intentional about staff care. We've done some of the things that were already mentioned as far as respite rooms.

At my previous facility, we partnered with the local community college and their massage therapy program. On the days when massage therapists came in, our nursing leaders replaced the front-line workers on the units to give each staff person the opportunity for a therapeutic massage.

Because it was so well-received, we've carried that over into less stressful times. Rather than doing a single event for holidays and Hospital Week, we did 12 days of Christmas, which was two weeks of different activities and treats plus small gifts and recognition. We did something similar for Hospital Week.

We are planning an expansion of our acute care unit. It's a small expansion, but it doubles our private-room capacity. We have some involvement

from front-line staff and, we hope at an appropriate point, to include some community patients and families as well.

**MODERATOR:** How do you engage your workforce in capital project planning to mitigate the disruption?

**ROBIN ROLING** (*Cheyenne Regional Medical Center*):

**"When you talk about minimizing disruption you must involve the end users, particularly clinical staff, about what projects are on the horizon and what the disruption will be. In the past, they were always being caught off guard and waiting for the next shoe to drop. We've implemented Integrated Product Teams, to foster cross-functional collaboration and resolve issues efficiently and effectively."**

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As we look at our master planning process, we pull in a variety of end users to engage them from the beginning. It's not just leaders, but also end users. As we continue to move through that process, we involve end users throughout the project's life cycle. We've also hosted virtual reality reviews as well as some room mock-ups, and have received feedback from end users in that way as well. Our facilities administrator, Jackie Van Cleave, does an outstanding job of presenting and providing ongoing written communications to people. I do a lot of rounding as well. Therefore, we have opportunities to catch up with people while we're out and about.

**MARY KATHERINE BELL** (*Brentwood Hospital*): We did a couple of things on our last project that were effective. We presented a few key go-to's, or indicators, to the staff at our town hall meetings throughout the facility. We use color-coded signs when we plan to have contractors on-site. We show them the construction plans before it begins. Then, when it comes time for construction to start, we send an email and text blast reminding them of the indicators and the location of the construction. It is a targeted communication effort to raise awareness.

As a leadership team, we rounded hospitalwide and specifically addressed whether anyone was having issues with the construction. We reminded the team to vocalize any safety concerns that surfaced. Our chief nursing officer put a carafe of coffee on a cart and spent the day rounding and talking to the nurses. She gave them an opportunity to share their frustrations with her directly.

**NEELEY:** We took a unique approach in the process of putting together a project to expand and renovate our ED. Our performance improvement group, which is nonclinical, led it and collaborated with the user team — ED physicians, administrators and nurses — using lean approaches to create the most efficient flow process. The real users developed the way they wanted the facility to be built to improve

patient flow, with sections for admitting and likely to release within the ED. They helped build and design the elements of the ED before facilities staff became involved. It's novel to engage our lean process team with users to come up with a plan to improve the build-out and say, 'This is what we want, go build it.'

**GORMAN:** We utilize the lean process and have found it an effective way to identify opportunities for efficiency and redesign of care delivery. The teams go deep into the process and tap into the expertise of the front-line staff as we're designing new spaces and care delivery.

Currently, we're designing new pediatric ICU beds and dialysis beds, and in this process we also involve our parents. Our Parent Family Advisory Committee (PFAC) has given us feedback that we need more showers in our pediatric ICU for those patients who have long stays. Utilizing this family advisory committee has been critical, and we have even created a PFAC seal of approval from this critical part of our team. How we're building parent and family input into the facility has been critical.

We also use an interdisciplinary simulation model to test the care model within the space. We create a 'sandbox model' to simulate the space. We create scenarios in that new space, and determine the safest care and the safest care model utilizing that simulation.

**STUEBER:** We have 110 projects to do over the next three years, about \$480 million. We put an IPT together that includes the end users, sterile processing, materials management, administrative services, information systems, anyone who might be involved in the space. We initially meet to determine who needs to be on the team and then have a roundtable meeting, a charrette, on the overall intent of the project, to lay out the owner's priorities and where we want to end up.

Then it goes into my project section for design and



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construction. During design, at each phase review, we bring in the IPT to review the plans and specs. At the end, usually two to three months ahead of closing out a project, they identify the location of everything we may have to put in the room, from furniture to sharps boxes.

Now that we're doing that, we don't run into as many conflicts because they've already bought into the project before I start the design, and then they're kept current.

Some of our projects can take a while. The only issue we run into is staffing changes at the leadership level of a particular clinical service. We might have a project ready to go to construction, but a new chief may not agree with the space setup. Then we must have serious conversations about the impact. We promote short-term pain and long-term gain — it's going to hurt now, but then we'll be out of your way in six months to a year.

**ROSE:** In a large organization like Atrium Health, it's tough to get the word out everywhere. We started with our mock setups off-site, where the team can touch and feel. There was a real sense of participation. We have town hall meetings and forums where people can talk about what's going on, and there are many visual displays. We're in the process of finishing our freestanding rehab hospital, which will open the first phase of the construction on the Charlotte campus.

As far as measuring satisfaction, we use a survey technology from Glint. You can home in on a specific topic. If you want surveys about communication or construction, you can do that. It's a good way to measure the pulse, as well as just walking around and listening to teammates.

Security is top of mind for our teammates. We have a visible and supportive security team here. They work well with our nursing teams. As we design spaces, we make sure that we have areas for security officers. We've had to install metal detectors throughout all the EDs in our system. We are now planning to do it in our freestanding EDs, which typically tend to be in highly affluent areas, but they're seeing the same thing.

I love the designs that are open with a lot of light, because not only is that great for our patient care, but it also helps with staff visibility and lets them know that they're not 'boxed in.'

We look at security access points. During the design phase, you must think about security and safety from guns or other attacks.

**MODERATOR:** Does anybody else want to add to the security issue? What are you doing to ensure safety, while you're disrupting the environment or in your new construction?

**NEELEY:** That's a great insight that Robert provided: Security is paramount. Here at UTMC, we have canines that help. We have a canine program that communicates the right facility security

message overall.

From a space-planning standpoint, if you're building an area like an ED, and probably anywhere else, build in a location for the security staff to have an outpost. In our area, we have a kennel in there as well, because we keep dogs near the ED for crowd control on gunshot wound issues and gang violence that creep into our community.

**ROSE:** The urban academic medical center was the first to have a metal detector. Being a Level I

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trauma center for both children and adults, we see all kinds of victims of gang-related incidents. The first two months after the metal detector was installed, people would walk up, see it and go back to their cars and then come back. As far as patient perception of care, they appreciated it and felt more secure. You can't even go to a ballgame today without going through a metal detector. It's become a way of life, so, why should it be any different in a hospital?

**MODERATOR:** Deb, would you like to share some perspectives, and fill in some of the gaps in terms of what we've been talking about?

**DEB SHEEHAN** (*DPR Construction*): I wanted to echo the communication of not losing sight of the tenacity and duration of these build cycles. It's six months or it could be six years for some of the bigger projects. Stay thoughtful about celebrating the 'why' statement behind that capital build, the investment.

I do a lot of clinical shadowing when we go on-site. I've often heard from the front-line clinical staff: 'They tapped me for my expertise in the planning or the logistics sequencing, but I'm still not sure why we're doing this, and spending this money here instead of there.' Every single nurse with whom I've had the pleasure of working is purpose-driven first. It's important for them to understand how their purpose aligns with the organization and the investments the organization is making. I want them to be proud of the fact that their organization is making these investments.

While there are tactical day-to-day issues to discuss, workarounds and important briefings, don't forget to instill pride in the decision to make investments that you've prioritized for the organization.

On understanding staff pain points, we have consistently seen communication is more authentic in small group settings than larger, all staff town hall meetings. I encourage health leaders to utilize clinical huddles, daily rounding or department/unit listening sessions to gain real time insight and understanding of construction impacts. Additionally, many organizations create portals on their websites when they're doing major capital investments to cultivate engagement and build awareness regarding their capital investments.

In planning for phased construction, sometimes we experience unintended consequences that even our best-laid planning can't always anticipate. Toward that end, we've used the simulation software on the planning side and the phased logistics for the build.

When you begin to understand the phased construction sequences and start to understand anticipated closures of hallways, or potential disruption of patient care areas, applying simulation study to the phasing plans is a great way to virtually 'pressure test' outcomes. Test the impact on your operations and logistics, bring in your team, design partners and build partners, and tear it apart before you work forward with a construction phasing assumption.

Too often, the goal of mitigating short-term pain drives the phasing and logistics. Trying to shorten the time of disruption as much as possible can have some unintended consequences on clinical operations. Often we discover that through pressure testing the phasing and sequencing of construction logistics, it helps to advance solutions that you wouldn't have thought would be tolerated, but certainly have an enhanced outcome for both patients and the care team. ●

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