I want, I need, I HAVE to have!

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Learning Objectives

At the end of our session, leaders will be able to:

- Identify key components when submitting a request for resources
- Identify and communicate the expected benefits of request submissions
- Discuss specific examples and identify tactics to implement future references/requests

Before you start

- Internal competition for resources
- Improve your changes of approval by prioritizing the need
- Pay attention to the frequency of your requests
- Resolve your gap without expenditure, if at all possible
  - If you do, brag shamelessly
- Think, what happens if I don't move forward? ...or denied?
Define
Justification for proposed resources on the basis of the expected benefit OR potential negative impact

Translation
How GREAT could it be if [you] have it
OR
How AWFUL it will be if [you] don’t

Types
Perfora (Generally high dollar requests with expected tracking of benefit)
Business Case (SBAR, Facility-specific forms)

You may be asked to produce one of the above when you request
✓ New equipment
✓ New roles or Replacements
✓ New Programs
✓ Renovations/Upgrades
✓ When your 1-up needs to decide between you and someone else

Common Mistakes
Asking before you are prepared
Not having the cost or forgetting a piece of the cost (IT builds and parts/pieces)
Personal interest/Not vetted with key stakeholders (end users, MDs)
Unwilling or unknown ability to share resource
Unknown benchmark or standard of care
Making a promise you can’t keep
“We really, really need it”
Key Components

Provide a concise, comprehensive overview for your leader to prioritize your request.

5 Key Components
1. Tell them what the heck you want
2. Why the heck you want it
3. What the heck does it cost
4. What the heck happens if you do/don’t get it
5. Leave them with what the heck they should do

#1 Tell them what the heck you want

Be clear, concise, specific
- Equipment name, model, series
- FTE Title, Role Description, Hours
- Program Title, Vision, Alignment with goal

Example Equipment

GE Mobile FHR Monitors with Central FHR Monitoring
#2 Tell them why the heck you want it

Background or Assessment
Data Driven Decisions
HCHAPS/Patient Satisfaction Comments
Physician or Staff Requests
Quality/Standards of Care
Regulatory Requirement
Volume/Growth

Example - Equipment

Electronic fetal heart rate monitoring and documentation is the recommended standard of care (AAP/ACOG, 2012). All pregnant patients are monitored via OBIX when on the OB units and FHR monitoring is able to be reviewed by providers both on the unit and via VPN while in the office or at home to ensure fetal well-being.

#3 What the heck does it cost

- What’s the expense (real $ or otherwise)
- What’s the savings (real $ or otherwise)
- Have quotes ready
- Cost of new versus used
- Cost between brands
- What have others paid?
- Any value to buying in bulk? Does anyone else want the same thing?
Example

Cost

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHR Monitor</td>
<td>$15,892.50</td>
</tr>
<tr>
<td>Cart</td>
<td>$2200.00</td>
</tr>
<tr>
<td>Computer</td>
<td>$140.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$18,252.80</strong></td>
</tr>
</tbody>
</table>

Requests

- CHN (2) $38,505.60
- CHE (3) $19,252.80
- NIS (2) $38,505.60

Cost Avoidance

If the patient is stable and patient is on the monitor, we would not need to leave a nurse at the bedside. A nurse or PCC from the OB unit would be responsible for tending to that strip, assessing, and documenting, but they could be given an additional assignment in Maternity Services to promote productivity. The primary RN off unit and the OB RN would collaborate at the beginning of each shift and throughout the shift to ensure the patient is stable and the FHR strip is reassuring. Given the average hourly rate of the nurse is $30.00/hr, each 12 hr shift we have a nurse off our unit is a cost of $360.00 or 720.00 per day.

Break Even Analysis

- Cost of RN productivity for 24 hours - $720.00
- Cost of 1 monitor, computer, cart - $19,252.80

Break Even - 26.74 days of use per cart

It is estimated that after the first year of use, we would hit the break-even point through use off unit, ICU, ED, and overflow. Lastly, the monitors could be in use in the Operating Suites when not in use off unit which would further reduce risk and liability to the organization and reduce number of days to break even. The monitors are generally good for 10+ years of service before replacement is needed.

#4 What the heck happens if you do/don’t get it

- What's the impact?
- WHO does it impact?
- Is there an operational or strategic impact?
- Regulatory impact?
Example

When a patient is admitted off the primary OB floor (such as ED, CHVH, PCU/ICU or is an overflow OB patient) and requires monitoring, we are unable in current state to monitor the patient electronically and must run paper FHR monitoring strips. The OB unit and MD are not able to see the strip from the unit, office, or home. The unit must send a nurse to sit at the bedside to assess the FHR monitoring strip. We also must save all paper documentation, date, initials and label all sheets (sometimes due to the length of the stay this can be up to a box worth of strips per patient). This is a Risk/Liability issue in the event a case is ever called to court it would be difficult to piece the entire strip together on paper and we risk losing parts of the strip and/or poor documentation r/t the strip due to the paper process.

Our current IU MFMs have the ability in other facilities to view their patients electronically. During the onboarding of Dr. So-and-So (MFM), she expressed desire to be able to see her high-risk patients that are off unit electronically.

#5 What they heck they should do

- Make recommendation
- Strongly consider offering alternative recommendation

Example

Approve fetal monitor, cart and required wiring to support active surveillance of pregnant patients for each region: East, North, South to align with the standard of care and promote high-quality outcomes for mothers and babies.

Recommend purchase of at least 1 for each facility with intention to increase based on usage.
What has been accomplished with this method?

- 11k IT Equipment – RN satisfaction
- 40k OR Lights – Physician Request/OR Productivity
- 90k Dinemaps – RN satisfaction/Productivity
- 20k Mobile FHR-monitor
- 60k+ FHR Monitors
- 150k Radiant Warmers
- 6k OR Bed extensions
- 150k Couches – Patient Satisfaction/Growth
- 50k Recliners – Patient Satisfaction/Growth
- 6k Roaming lights – Physician Request
- 500k Triage Build out – RN, MD, Growth
- 75k Labor Beds

100% Approval Rating

How can this benefit you?

- Staff can use to clearly communicate their requests
- Desires for conferences
- Request for special accommodations or schedule
- Request purchases for the unit (let them experience this discovery!)
- If they have a proposal for you to consider

Educator Example

Situation

The Network Educator role now covers CHN, CHE, and CHS. CHN houses a large high-risk patient population as serves the highest acuity maternity patients in the Network. These patients often have complicated diagnosis and required extensive plans of care. Due to the extensive skill mix (triage, labor, delivery, OR, PACU, postpartum, newborn care, newborn procedures, etc.), this unit necessitates a unit based Educator to provide new hire and ongoing education to staff. In 2016, the State of Indiana will begin assigning Levels of Care to delivering units. It is the desire of CHN Maternity Services to be designated a Level III Perinatal Center. In order to meet that designation, one requirement step to meeting that designation is an OB Educator.
**Educator Example**

**Background**

Delivery volumes continue to grow. Births/Year, Maternal Admissions, and Newborn Admissions have all doubled in volume since 2001. This volume excludes observation and triage patients (served over 5,000 triage patients in 2014). We anticipate continued increased volumes with the finalization of the Women’s Pavilion. Despite these changes, the Educator and coverage is a Network 0.8 FTE. This unit is unique in its skill mix and serves both an adult and pediatric population (with both Obstetricians and Pediatricians to collaborate). Current 0.8 Network FTE supports central orientation for the Network, residency training for new grads, and coordinates OB-ACLS. No unit-based education is available from the current FTE and structure. Support for onboarding orientees and moving them from novice to competent and onto expert is provided by the nurse manager(s), Director, and any time available delegated to a PCC to organize orientee schedules. Education is slim at best and most often education is not able to be adequately rolled out to staff. Education consistently is given via email to our staff in an effort to try to reach staff, however, this is not effective learning.

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**Educator Example**

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**Educator Example**

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**Educator**
**Educator Example**

Failure to have this role may result in inability to obtain Level 3 Designation

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**Tips**

- Before you ask your 1 up, this work should already have been completed
- Ask for only what you need
- Seek out alternatives
- What are you willing to give up, if needed?
- Prioritize your list
- Prep for next request/budget/capital seasons
Learning Objectives

- Identified 5 key components when submitting a request for resources
- Identified and communicated the expected benefits of request submissions
- Discussed 2 specific examples and identify tactics to implement future references/requests

Questions?