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Patient-centered care: What does it mean and how to implement it?

Jennifer Iannaconne is interviewed by Carol Lesser, Editor of this newsletter series

EDITOR'S NOTE

Improving the quality of medical and emotional care in IVF

Carol B. Lesser, MSN, RNC, NP

A recent article in *Human Reproduction* concluded that while patients and physicians put considerable emphasis on a clinic's pregnancy rates, there is insufficient value placed on the importance of patient-centered care.[1] The study demonstrated that patients are willing to trade a slightly lower pregnancy rate for care that was more responsive to their needs. The investigators reported that a lack of patient-centered care was the most common nonmedical reason for switching clinics. Patients were also willing to travel a greater distance for what they perceived to be better quality care.

IVF success rates have been steadily improving since the birth of Louise Brown in 1978. Improved patient screening, stimulation protocols, laboratory conditions and techniques, transfer catheters, and training have all contributed to advancement of our field and better pregnancy rates.

The greatest rate-limiting variable appears to be advanced maternal age and oocyte quality. While exciting new research is underway that will attempt to improve oocyte quality through mitochondrial regeneration, it will be years before we know if this, or other approaches, will be clinically relevant.

What vary considerably are how we deliver our care and what role nurses play in humanizing this part of the patient experience. We all work in a competitive economic environment, trying to attract the greatest number of new patients and to retain them once they see us. We can best accomplish this by constantly improving the quality of both medical and emotional care.

The physicians I am fortunate to work with at Boston IVF are representative of reproductive endocrinologists around the world and strive to achieve the highest success rates possible. Equally important is their commitment to offer care in a patient- friendly manner, as long as quality is not compromised. With this in mind, our nurses have been trained to offer medication regimens, patient education, and access to care.

Specifically, this means we offer extensive online patient education and medication instruction. In-person teaching is available for those who learn best that way, but it is not required. Our busy patients appreciate the choice and most opt to review their regimen online and by phone, which our nurses find to be effective.

When it comes to medication delivery, our center was the first to popularize the technique of mixing all injectables together in a single injection, thus eliminating the need for more than 1 shot in most instances. We have demonstrated that success rates do not suffer and patients are immensely grateful for the simplification in medication delivery.

We are able to respond to oncologists who request fertility preservation consults for their distraught patients within 24 hours, offering them prompt egg or embryo cryopreservation when appropriate. Our staff identified a need, and a program was established incorporating a prompt response.

As a large center we are fortunate to be able to offer stress reduction techniques, acupuncture, genetic counseling, nutritionist and weight loss services, as well as support

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groups and individual counseling. We believe that this array of services and the way we provide them has contributed to our success.

In this issue we explore the approach and services provided by another center: IVF New Jersey. I interview Jennifer Iannaconne, Director of Nursing, to examine how her center approaches the issue of patient-centered, patient-friendly care.

Advocating for a commitment to patient-centered care and patient empowerment

An interview with Jennifer Iannaconne by Carol Lesser

Jennifer Iannaconne, RN

Ms Lesser: Jennifer, please tell us about your role at IVF New Jersey (IVF NJ); how long you have worked there, how many physicians and nurses do you work with, and what are your primary responsibilities?

Ms Iannaconne: I am proud to say that I have just completed my 13th year at IVF NJ. I worked as an IVF Nurse Coordinator for the first 8 years and as the Clinical Nurse Manager for the last 5 years.

IVF NJ is one of the largest IVF centers in New Jersey. Our medical staff consists of 6 physicians, 1 PA, 10 RNs, and 6 medical assistants. We also have 3 nurses that work with our egg donors, recipients, gestational carriers, and intended parents.

My position is unique as I am considered a "working nurse" manager. I accepted the manager position 5 years ago with the understanding that I would continue to participate in the direct nursing care of patients. Although I do assume additional responsibilities as manager, I still work with my staff in providing excellent care to all of our patients.

My responsibilities include staffing and scheduling in all 4 of our offices, updating of policies and procedures, plus organizing our weekly IVF meetings, at which our physicians, PA, and embryologist discuss patients' protocols. If needed, I assist physicians with procedures such as sonohysterograms, practice transfers, and intrauterine inseminations.

I keep the lines of communication open with the staff in all offices through daily emails, phone calls, and visits. Quarterly meetings are also held with the entire nursing and medical assistant staff. I also act as a liaison between the nurses and physicians.

Ms Lesser: How have you ended up working in this field for so long?

Ms Iannaconne: For 20 years, I worked as a labor and delivery nurse at a level 3 hospital in central New Jersey. Then, after participating in thousands of deliveries, I developed a strong desire to work in the field of infertility. That's when I became a part of the IVF NJ family. As much as I loved being a part of the birth of a child, I truly believe there is no field of nursing more rewarding than infertility.

As a nurse caring for a woman in labor, you develop a bond for a relatively short period of time. As a nurse caring for an infertile couple, you develop a bond that may be shared for days, weeks, and possibly years. You can become not only their nurse but also their confidant and friend. At the end of their journey when you rejoice as they celebrate over a positive pregnancy test or cry as they experience a negative beta human chorionic gonadotropin (HCG) test, no words can describe this experience. As a result, I think of my relationship with IVF NJ not as a career, but as an extension of my life.

Ms Lesser: Do you find it easy or difficult to find highly qualified nurses who are also well suited to providing this type of nursing care?

Ms Iannaconne: Unfortunately, I find it quite difficult to find highly qualified nurses who are well suited to providing this type of nursing care. I feel that nursing degree programs do a disservice to nursing students by not including reproductive endocrinology in the curriculum.

When I interview a nurse for a position, I find it very beneficial if the applicant has experience in OB/GYN or maternal child health. Qualities important to me are eagerness and enthusiasm to learn, as well as hand holding, hugging, and not being afraid to cry. I explain that the field of infertility nursing is unique. A nurse must be prepared to ask a lot of questions and realize it takes nearly a year to grasp the basics.

A new nurse at our practice is oriented by an experienced nurse and they are provided with our protocols as well as policies and procedures.

Ms Lesser: Are your nurses specialized in their role or do your nurses cross train for all types of patients?

Ms Iannaconne: The largest of our 4 offices, located in Somerset, has a fully equipped operating room (OR) and recovery room. At this site, we do our egg retrievals, transfers, and hysteroscopies. All of our nurses are cross-trained for all of these procedures and environments.

In our OR, we have a medical assistant who will scrub for procedures as the RN circulates. Our recovery room is staffed by 2 RNs. All RNs are BLS and ACLS certified. In the event that the OR schedule is light, nurses may assist with procedures such as sonohysterograms, practice transfers, patient medication education, or an IVF orientation.

Our satellite offices are each staffed with 1 or 2 RNs and a medical assistant. In these offices, the nurse is primarily involved in assisting with procedures, patient education, and IVF orientations. RNs will occasionally work in our main office to maintain their skills in the OR and recovery room.

Ms Lesser: Do you see yourself and your nurses as patient advocates? If so, in what way?

Ms Iannaconne: I speak for myself, my RNs, and medical assistants in saying that we are advocates for our patients. Our primary commitment is to our patients and we continually strive to protect their health, safety, and rights.

The advocacy relationship starts with the initial visit to IVF NJ at which time the patient and spouse/partner will first sit down with the nurse. After welcoming her and obtaining vital signs, the patient will then meet with one of our physicians. Immediately following the physician visit, the patient will again sit with the nurse; at this time many patients are truly overwhelmed. Serving as her advocate, we review and reinforce every aspect of the physician's plan one step at a time. At the end of the initial visit, the patient is given a letter reinforcing our commitment and to assure her that she is never alone. We are only a phone call or email away during each step of her journey.

Ms Lesser: Does your clinic seek to deliver care that is patient-centered? If so, what do patients think of this approach? Can you give us some examples of how you provide this type of attentive care?

Ms Iannaconne: Our center is committed to patient-centered care. There are 3 main areas that our patient care team addresses:

1. *Whole patient care*. While the patient may have a diagnosis of infertility, we are concerned with both the patient's physical and emotional well-being. Numerous studies indicate that the primary reason for a woman to discontinue treatment prior to conceiving a pregnancy is stress, particularly in her relationship with her spouse/partner. At IVF NJ, we recently started a support group where couples share their concerns and feelings with their peers in a warm nurturing environment. Relaxation techniques are taught, which help patients deal with stress. This results in their regaining some sense of control, which assists in decreasing the impact of stress on fertility. Unfortunately, less than 5% of our patients attend these sessions; however, almost every patient that has attended has successfully achieved a pregnancy!
2. *Coordination and communication*. We establish lines of communication via phone and internet with our patients at the time of the initial visit. On subsequent visits, IVF NJ uses an enhanced method of face-to-face communication; while many centers utilize a phlebotomist to perform blood draws, our nurses are responsible for this activity. This is an excellent opportunity to interact with the patient, provide support, and answer questions. These daily "meetings" with the nurse decrease patients' stress levels and help to eliminate errors in medication administration.
3. *Empowerment and patient support*. We provide patient support as needed and encourage patients to become active members in their own care. With a diversified clientele, we also have to recognize and respect patients' cultural traditions and individual values.

Ms Lesser: Do you see yourself as an agent of change in the service of improving both the care provided and the way you deliver that care?

Ms Iannaconne: I strive to improve patient care by evaluating processes and implementing change as well as improving the education and skills of my staff. I frequently attend seminars and nurse advisory boards where new information about clinical or emotional care of patients is identified and brought back to our medical staff and physicians. We reinforce information exchange through quarterly nurse meetings and educational in-service throughout the year. This helps us follow guidelines and implement new processes. I also encourage our nurses to become members of the NJ Society for Reproductive Nurses and to attend their informative meetings.

Ms Lesser: What change(s) have you implemented that have improved your patients' experience and how did you accomplish this?

Ms Iannaconne: There are several changes I have implemented over the last 5 years, most of which focus on alleviating patients' stress levels and improving patient care. In addition to initiating our "welcome to IVF NJ" letters and our stress reduction classes, I also changed some of our calling patterns. Along with calling patients the day

after their retrieval, we now call patients 2 to 3 days after their transfers; this change was based on study results showing that patient stress levels are the highest following the transfer and days leading up to the first beta HCG test. This simple phone call can help to alleviate fears and reassure patients that we care. We also reach out by phone and send them a card after a negative IVF cycle. Once again, we let them know that we care. As difficult as it may be for the nurse to make this call, this gesture is well appreciated by patients.

Another change was a move away from group teachings. Patients' learning curves are different and these teachings often resulted in confusion, numerous questions, follow-up phone calls, and errors. We now do individual teachings and IVF orientations, both of which result in a better understanding of procedures, improved compliance, more efficient use of a nurse's resources, decreased patient stress, and fewer errors. This also increased patients' confidence and feeling of empowerment.

One of the biggest and most welcome changes implemented over the past 2 years is to give patients the option of intramuscular (IM) or vaginal progesterone use beginning the day after their retrieval. After an intense review of several studies documenting the efficacy of vaginal progesterone and comparable pregnancy rates with IM injection, our physicians decided to give patients the choice of which administration route to use. The majority of patients choose vaginal supplementation.

Ms Lesser: How have your patients reacted to this change, since progesterone is a significant part of the medication regimen, and an IM administration can cause anxiety for patients?

Ms Iannaconne: We found that giving patients the choice of IM or vaginal administration allows them to have some control and a sense of empowerment (also, our patients are a lot happier without a sore bottom!). I am sure that I speak for most reproductive endocrinology nurses when I say that IM injections may be the most stressful aspect associated with infertility treatment for both the patient and spouse/partner. As an added benefit, eliminating the need to teach and demonstrate IM techniques shortens the length of the medical teaching and enables the nurse to review other important information.

Ms Lesser: What is your greatest challenge to delivering the best care possible for your patients?

Ms Iannaconne: As a hands on manager, one of the greatest challenges I face is providing patients with adequate time to help them obtain the positive experience and professional care they deserve. Whether it's alleviating their stress through teachings or empowering them to make choices like electing to use vaginal progesterone, it is difficult to balance my day between dealing with staff issues, managerial issues, and patient needs. Most days I do meet my goals of providing positive outcomes simply by concentrating on the needs of the patients in whatever form they may be. Ultimately, our physicians, staff, and I find great satisfaction and many rewards working with infertile patients. We have a positive team approach, which goes a long way, as exemplified by a recent letter from a patient announcing the birth of her son. She stated: "The nurses and physicians never said *if* I get pregnant, it was always *when* I get pregnant." This is why I love working at IVF NJ.

Reference

1. van Empel IW, Dancet EA, Koolman XH, et al. Physicians underestimate the importance of patient-centeredness to patients: a discrete choice experiment in fertility care. *Hum Reprod*. 2011;26(3):584-593.

DISCLOSURES

Carol B. Lesser MSN, RNC, NP, reports that she has served as a consultant and on the speakers bureau for Watson Pharmaceuticals. She received compensation from Watson for her participation in preparing this newsletter.

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Comments or questions for Carol Lesser? Email your thoughts to SRMnurses@QHC.com

Resources

AMERICAN FERTILITY ASSOCIATION
A resource for infertility prevention, reproductive health, and family building
www.theafa.org

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
A multidisciplinary resource for patients and professionals providing information on all aspects of infertility
www.asrm.org

REPRODUCTIVE FACTS.ORG
Information and news from the field of reproductive medicine, supported by the American Society for Reproductive Medicine
www.reproductivefacts.org

RESOLVE
Offers support, education, and advocacy on infertility, reproductive health, and family building
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