Announcements

Patient Experience and Engagement Best Practices Forum
- Monday, March 30th from 11-12:30pm
- Location P117
- Focus on the Power of Storytelling

Quality and Safety Symposium-Tuesday, May 5th
- Poster presentation submissions due April 15th
- Innovation Grant proposals due April 1st
- Hand Hygiene Slogan Competition naming submissions due April 15th
Announcements

Nursing Contract Negotiations

• Negotiations continue this Thursday
• NNU continues to threaten a workforce disruption in both written communications as well as comments made at the negotiation table
• If 10 day notice is received the HICS structure will be implemented a town hall meeting will be called in P117 with additional details
FY15 People Initiatives Accomplishments

100% adoption of Management of Daily Improvement (MDI) boards across priority areas

57 of 80 priority areas adopted

We will continue the MDI adoption in coming months to achieve our target by end of FY15
## FY15 Patient Experience – Overall Rating of Care

*As of February 2015*

<table>
<thead>
<tr>
<th>Section</th>
<th>FY 14 (baseline)</th>
<th>Current Performance</th>
<th>Target</th>
<th>Points +/- Target</th>
<th>Depts/Units Above Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICU</td>
<td>86.9</td>
<td>96.1</td>
<td>91.3</td>
<td>4.8</td>
<td>NICU</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>n/a</td>
<td>93.5</td>
<td>92.9</td>
<td>0.6</td>
<td>NUSG, ANES, BRST, CARD, CARS, CHST, ENDO, GAST, GEND, GGGEN, GONC, GSUR, HEMA, MDRH, NEUR, NPH, OHNS, PCAR, PCDV, PGAS, PHEM, PNEF, PORT, PRHU, PURO, SILC, SSSC, THOR, TRSP, UROL, VASC</td>
</tr>
<tr>
<td>Inpatient</td>
<td>89.9</td>
<td>91.0</td>
<td>91.1</td>
<td>-0.1</td>
<td>3SW, 9W, 8W, 9E, 5SE, 10E, 10W</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>94.8</td>
<td>94.8</td>
<td>95.5</td>
<td>-0.7</td>
<td>DCAM</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>92.5</td>
<td>93.1</td>
<td>94.2</td>
<td>-1.1</td>
<td>PHTH, OCCT, PTRE, PSPA, CCAT, PT47, SDTN</td>
</tr>
<tr>
<td>Mitchell ED</td>
<td>73.9</td>
<td>75.6</td>
<td>81.4</td>
<td>-5.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Outpatient Oncology</td>
<td>94.8</td>
<td>94.3</td>
<td>95.6</td>
<td>-1.3</td>
<td>SILV</td>
</tr>
<tr>
<td>Inpatient Pediatrics</td>
<td>91.8</td>
<td>90.3</td>
<td>91.8</td>
<td>-1.6</td>
<td>No units above target</td>
</tr>
<tr>
<td>Comer ED</td>
<td>85.0</td>
<td>82.1</td>
<td>87.6</td>
<td>-5.5</td>
<td>n/a</td>
</tr>
</tbody>
</table>
FY15 Press Ganey Patient Experience Comments

This was a great experience. I was so nervous but the staff was great and the social worker helped me try to find a sleeper room... I cried with joy. The university has no clue how much you helped me and my family. (NICU)

The gentleman who transported me from the ER to my room was exceptional, kind & caring. He showed concern & compassion.

Very personal very thorough and employed user friendly analogies to create better understanding for my wife and I concerning my health care (CARD)

They came in every day and kept me up on what was happening truly experts. (3SW)

I had the best team that anybody could ask for thanks to Jerry and Yolanda for keeping me calm and comfortable throughout my procedure and a big thanks to Donna for calling and checking on me again thanks to my team. (DCAM)

I received great care by the whole team. (SILV)

The staff made an anxious experience more doable. They cared for us and thoroughly talked with us and respected our daughter. (SDTN)
FY15 Quality and Safety Initiative Metrics and Accomplishments

**Hand hygiene compliance rate of ≥75% in 10 units**
As of Jan 2015

- Target: 10
- FYTD: 0

**Barcode medication administration compliance**
As of Jan 2015

- Target: 96
- FYTD: 96

**Provider-level dashboard**

- Provider dashboard platform will be built starting this month
- Identified over 100 metrics
- On track to complete provider-level dashboard for 75% of providers
## FY15 Finance initiatives metrics

*As of January 2015*

<table>
<thead>
<tr>
<th>Key Performance Indicators</th>
<th>Budget</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Month</td>
<td>YTD</td>
</tr>
<tr>
<td>Operating Revenue</td>
<td>$123,694,000</td>
<td>$733,048,000</td>
</tr>
<tr>
<td>EBIDA Margin</td>
<td>12.9%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>4.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>FTE per Occupied Bed</td>
<td>7.94</td>
<td>7.98</td>
</tr>
<tr>
<td>Salary Expense per Adjusted Patient Day</td>
<td>1,687</td>
<td>1,693</td>
</tr>
<tr>
<td>Benefit Expense per Adjusted Patient Day</td>
<td>473</td>
<td>476</td>
</tr>
<tr>
<td>Supply Expense per Adjusted Patient Day</td>
<td>249</td>
<td>250</td>
</tr>
<tr>
<td>Outside Blood per Adjusted Patient Day</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Drug Expense per Adjusted Patient Day</td>
<td>262</td>
<td>263</td>
</tr>
<tr>
<td>Implant Expense per Adjusted Patient Day</td>
<td>108</td>
<td>109</td>
</tr>
</tbody>
</table>

- green = on target
- yellow = off target ≤10%
- red = off target >10%
FY15 Long-Term Positioning Initiatives Metrics

**Admissions**
As of Jan 2015

- **Comer**
  - Current YTD: 16,391
  - Budget YTD: 15,651
  - Prior YTD: 15,464

- **Adult**
  - Current YTD: 13,461
  - Budget YTD: 12,924
  - Prior YTD: 12,658

**Operating Revenue**
As of Jan 2015

- **Current YTD**: $863,842
- **Budget YTD**: $856,763
- **Prior YTD**: $820,737

**Case Mix Velocity**
As of Jan 2015

- **Mitchell/CCD**
  - FY15 target: 27.01
  - FY14: 26.48
  - FY15 YTD: 26.41

- **Comer**
  - FY15 target: 17.12
  - FY14: 16.78
  - FY15 YTD: 16.43

**Operating Revenue As of Jan 2015**
- **Mitchell/CCD**
  - Current YTD: $863,842
  - Budget YTD: $856,763
  - Prior YTD: $820,737

**Case Mix Velocity As of Jan 2015**
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- **Comer**
  - FY15 target: 17.12
  - FY14: 16.78
  - FY15 YTD: 16.43
HR as you know it
HR Tomorrow – A New Frontier

**HR Business Partners**
- Partner with Senior Leaders to **DEFINE** business solutions

**HR Shared Services**
- DELIVER services directly to employees

**Centers of Expertise**
- **DESIGN** programs, processes & practices

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**Strategic HR**

**Operational HR**

**HR Leadership**
What Improvements Can You Expect?

• Quicker, more **consistent** responses to your questions/needs
• **Easier access** to the information you need when you need it
• Increased focus on **data and metrics** supporting standardized work
• Increased **collaboration** and integration with your departments
• Improved **customer experience** for employees interacting with HR
• More time for **proactive**, strategic planning
HR Shared Services

• **Serves as first point of access for employees** seeking help to complete a transaction, initiate an inquiry and request policy/program information

• **Supports the business by leveraging HR specialists** who provide routine, day-to-day inquiry, transaction, administrative and specialty services

• **Uses standardized work, analytics and metrics** to continuously improve performance

• **Collaborates with Centers of Expertise and Business Partners** to provide a seamless and improved customer experience

• **Leverages HR technology platforms** to increase responsiveness and create a more intuitive, customer-centric experience
HR Shared Services

**Tier 0 (HR Portal)**
- Benefits
- Wellness
- Forms / Policies
- Self Service
- Leave Mgmt
- Other Content

**Employee Inquiry**
- HRServices@uchospitals.edu
- 2-xxxx
- Walk-In
- Chat

**Tier I**
- Customer Experience Specialist

**Tier II**
- Case Mgmt
- Knowledge Base

**Tier 0 (Applicant Tracking)**
- Recruiting
- On Boarding

**Tier I - Functional Specialists**
- Total Rewards
- Talent Acquisition
- E / L Relations
- HR Tech / Compliance
HR Shared Services
*HR Centers of Expertise*

Responsible for **developing HR strategy and designing HR programs, processes and practices** related to specific HR areas to address and solve real business issues.

Primary focus is on **policy and program effectiveness**

**Our four UCMC Centers of Expertise are:**

1. Benefits & Employee Health Management
2. Compensation
3. Employee and Labor Relations Strategy and Planning
4. Organization Development
Benefits & Employee Health Management

• Design and communicate plans and services related to employee benefits

• Serve as strategic thought leaders and subject matter experts to the business and HR across all aspects of employee health

• Develop and make recommendations for long-term strategic priorities

• Provide support to the Shared Service team to resolve complex customer queries
Compensation

• Establish UCMC’s compensation philosophy, vision and strategy
• Determine priorities and develop a framework for compensation programs
• Develop policies and procedures to promote internal equity and external competitive employee compensation
• Implement effective programs to support UMC’s compensation strategy
Employee and Labor Relations
Strategy and Planning

• **Provide direction and leadership** regarding UCMC’s employee and labor relations philosophy, vision and strategy

• **Develop positive employee and labor relations programs** to optimize performance management, employee engagement, and organizational effectiveness

• **Review and develop policies** consistent with UCMC’s ELR strategy

• **Establish and provide reporting** on internal and external employee/labor relations trends

• **Diagnose challenges, identify gaps and opportunities** for improvement, recommend solutions and partner with the relevant teams for implementation

• **Work with leaders and HR to continuously improve employee engagement**, including the prevention and reduction of discipline or grievance claims
Organization Development

- **Create and execute a strategy** to develop a high performing organization focused on the delivery of world class care and service

- **Provide expertise and guidance** in employee engagement and change management to transform our organization’s culture

- **Build leader capability and organizational success** through leadership development programs, individual coaching and team development interventions

- **Create performance assessment tools and methodologies** to identify and recognize high performing and value driven employees

- **Develop training and education** to improve & enhance employee performance

- **Provide consultation** on organization design and leadership capacity and capabilities
What is a HR Business Partner?

• Have knowledge about human resource management and a deep understanding of business strategies, operations and requirements
• Dedicated to providing business unit specific strategic and consultative services to senior leaders, aiming at delivering people solutions to business problems
• Actively involved in the development and execution of business strategy, moving beyond the play of policy police, regulatory watchdog and provider of administrative HR services
• Broker technical expertise (e.g., compensation and benefits design, organization design, talent management, succession planning, workforce planning) from the Centers of Expertise to deliver HR solutions
High-Reliability Healthcare

Moving from theory to practice at UCM

Michael D. Howell, MD MPH
Associate Chief Medical Officer for Clinical Quality
Associate Professor of Medicine

Debra Albert, RN, MSN, MBA, NEA-BC
Senior Vice President, Patient Care Services
Chief Nursing Officer
Roadmap

• Why focus on reliability? Why is it hard in healthcare?

• Does UCM deliver reliable care today?

• High reliability as an organizing framework for clinical effectiveness

• How is UCM putting this into practice today?
Why focus on reliability?
Why reliability?

- Best evidence-based clinical pathway + Unreliable execution = Worse outcomes
- Best safety culture + Unreliable execution = Harm to patients
- Best customer service training + Unreliable execution = Poor satisfaction
- Best plans for efficiency + Unreliable execution = Worse margin
## Why reliability?

<table>
<thead>
<tr>
<th>Component</th>
<th>Effect</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best evidence-based clinical pathway</td>
<td>Happens as intended, again and again</td>
<td>Better quality</td>
</tr>
<tr>
<td>Best safety culture</td>
<td>Happens as intended, again and again</td>
<td>Safer care</td>
</tr>
<tr>
<td>Best customer service training</td>
<td>Happens as intended, again and again</td>
<td>Better satisfaction</td>
</tr>
<tr>
<td>Best plans for efficiency</td>
<td>Happens as intended, again and again</td>
<td>Improved margin</td>
</tr>
</tbody>
</table>
Why is reliability hard in healthcare?

Part 1: Remember where you work.
What it’s like to carry a clinical pager

1. hi Dr. Howell, can you come see pt. suctioning blood from airway?

2. the MICU in significant respiratory distress, anesthesia

3. and GI tract, now on 1000ml fio2 thx sarah

4. coming to intubate. Think she would benefit from thrombectomy. Karen
Our environment is …

- Complex
- Complicated
- High stakes
- Predictably unpredictable
Why is reliability hard in healthcare?

Part 2: The Neuroanatomy of Low Reliability
The brain sees what it expects to see

To err is human

According to a research at Caridmbge Univristey, it dsoen't matetr in what oerdr the Irettes in a word are. The olny iprtnmoat tinhg is that the frsit and last leettr be in the rghit pclae.
Humans are bad at grading our own performance.

- A concrete example of significant practical impact in healthcare
  - Background: setting life support machines (mechanical ventilators) to give smaller breaths results in a 30% decrease in the risk of death in patients with respiratory failure: really important!

80% of our patients get this life-saving approach to programming the life support machine

Actually, it’s 19.7% if I’m an easy grader. If I grade strictly, it’s 2.6%.

Human beings have predictable, inducible cognitive failures.
Our thinking

Brain sees what it expects to see

Unable to accurately grade our own performance

Predictable neurocognitive failures
In this context, is there any hope?
Does UCM deliver reliable healthcare today?

Yes.
Congestive Heart Failure: Three Measures of Quality

13 months of perfect care for all three measures
Pneumonia: Three Measures of Quality

13 months of perfect care for all three measures
Pediatric Asthma Care: Three Measures of Quality

Two months of perfect care
Not isolated examples: We’ve been good at some things for so long we’re going to stop following them

<table>
<thead>
<tr>
<th>What are we measuring?</th>
<th>How are we measuring it?</th>
<th>Desired Direction</th>
<th>Baseline and Rolling 12 Months</th>
<th>Our Performance Results</th>
<th>Current Month</th>
<th>FY15 Target</th>
<th>Current Status (PITT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin prescribed at discharge - AMI 2</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Statin prescribed at discharge - AMI 10</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Releivers for inpatient asthma (age 2 years through 17 years) - CAC 1a</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Systemic corticosteroids for inpatient asthma (age 2 years through 17 years) - CAC 2a</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Evaluation of LVS function - HF 2</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>ACEI or ARB for LVSD - HF 3</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Initial antibiotic selection for CAP in immunocompetent - IPN 6</td>
<td>Percent</td>
<td>▲</td>
<td>88.5</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Prophylactic antibiotic selection for surgical patients - SCIP Inf 2a</td>
<td>Percent</td>
<td>▲</td>
<td>99.5</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Cardiac surgery patients with controlled 8 A.M. postoperative serum glucose - SCIP Inf 4</td>
<td>Percent</td>
<td>▲</td>
<td>91.6</td>
<td>Nov</td>
<td>90.9</td>
<td>97</td>
<td>94+</td>
</tr>
<tr>
<td>Surgery patients on beta blocker therapy prior to admission who received a beta blocker during the perioperative period - SCIP CARD 2</td>
<td>Percent</td>
<td>▲</td>
<td>99.5</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Liminary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero - SCIP Inf 6</td>
<td>Percent</td>
<td>▲</td>
<td>99.4</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>VTE patients receiving unfractionated heparin with dosages/platlet count monitoring by protocol - VTE 4</td>
<td>Percent</td>
<td>▲</td>
<td>99.4</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Antibiotics selection - OP SCIP 7</td>
<td>Percent</td>
<td>▲</td>
<td>98.6</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Bundle of 8 best practices for heart attack treatment</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>98.5</td>
<td>100</td>
</tr>
<tr>
<td>Primary PCI received within 90 minutes of hospital arrival - AMI 8a</td>
<td>Percent</td>
<td>▲</td>
<td>100</td>
<td>Nov</td>
<td>100</td>
<td>97</td>
<td>100</td>
</tr>
</tbody>
</table>
We are starting to see this reflected in national measures.
CMS Hospital-Acquired Conditions

• Medicare grades hospitals on injuries and infections that happen to patients:
  – Medicare uses data from mid-2011 through 2013 to create a 10-point score that combines following:
    • Central line associated bloodstream infection rates (CLABSI)
    • Catheter-associated urinary tract infection rates (CAUTI)
    • Eight “serious complications”, determined from ICD-9 billing codes
  
• 1% of Medicare DRG-based revenue at risk
Compared to Chicago Academic Medical Centers

- In this measure, UCM outperformed the following Chicago academic medical centers:
  - Northwestern Memorial
  - Rush
  - Loyola
  - Northshore - Evanston
  - University Of Illinois
Compared to major national Academic Medical Centers

- In this measure, UCM outperformed the following major national academic medical centers:
  - Harvard
    - Brigham & Women’s
    - Massachusetts General Hospital
    - Beth Israel Deaconess
  - Barnes Jewish Hospital
  - University of Pennsylvania
  - Yale-New Haven Hospital
  - Duke University Hospital
  - Stanford Hospital
  - NYU Langone Medical Center
  - New York-Presbyterian
  - North Shore – Long Island Jewish
  - Univ. of Pittsburgh Medical Ctr
  - Cedars-Sinai Medical Center
  - Harbor-UCLA
  - San Francisco General Hospital
  - Univ. of California - Davis
  - Univ. of California - San Diego
  - Emory University Hospital
  - University of Iowa Hospital
  - University Of North Carolina
  - Dartmouth Hitchcock
  - Harborview Medical Center (WA)
  - University of Wisconsin
Compared to well-known high-performing systems

• UCM outperformed these centers that are nationally known for Lean deployment and/or outstanding, nation-leading performance:
  – Intermountain Medical Center
  – Geisinger Medical Center
  – Virginia Mason Medical Center
CMS Patient Safety
PSI-90
Medicare VBP Report

- Medicare uses an aggregate Patient Safety Score called PSI-90 to judge hospitals.

- This measure combines performance on eight individual Patient Safety Indicators (e.g. pressure ulcers, accidental puncture and laceration, etc).

- We improved our performance by **56%** between the baseline period (2010-2011) and grading period (2012-2013).

- This puts UCM not only in the **top decile** in the country, but better than the average score of the top decile (so, approximately **top 5%**).

<table>
<thead>
<tr>
<th>Medicare VBP Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Period: 10/15/2010 – 06/30/2011</td>
</tr>
<tr>
<td>Performance Period: 10/15/2012 – 06/30/2013</td>
</tr>
<tr>
<td>FY 2015 Baseline Period Totals</td>
</tr>
<tr>
<td>FY 2015 Performance Period Totals</td>
</tr>
<tr>
<td>AHRQ Patient Safety Measure</td>
</tr>
<tr>
<td>Index Value²</td>
</tr>
<tr>
<td>Achievement Threshold</td>
</tr>
<tr>
<td>Benchmark</td>
</tr>
<tr>
<td>Improvement Points</td>
</tr>
<tr>
<td>Achievement Points</td>
</tr>
<tr>
<td>Measure Score</td>
</tr>
<tr>
<td>Complication/patient safety for selected indicators (composite)</td>
</tr>
<tr>
<td>1.02537</td>
</tr>
<tr>
<td>0.448910</td>
</tr>
<tr>
<td>0.616248</td>
</tr>
<tr>
<td>0.449988</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>
Does UCM deliver reliable healthcare today?

No.
UCM has many examples of reliable processes, but a long way to go to always deliver reliable care

- Hand hygiene rates routinely at 30%
- Many inadequately specified clinical pathways, leading to substantial variation in decisions made by physicians
- Inconsistent use of some safety techniques in practice
- Substantial opportunity for improvement in patient engagement and experience
High reliability as an organizing framework
High reliability is an organizing framework for clinical effectiveness

• Today, we have many different parts in motion – all of which are critically important
  – Lean transformation
  – Magnet journey
  – Patient engagement and experience
  – Culture of safety
  – External quality and safety measurement
  – Improving margin
  – Adapting and thriving in new reimbursement models

• But, these frameworks may seem unaligned to frontline providers, or even disconnected.
What are the two most important points?

- The only variation in care is driven by what the patient and family need

  and

- What happens is what’s intended, again and again
## Highly reliable healthcare

<table>
<thead>
<tr>
<th>Who</th>
<th>Actions</th>
</tr>
</thead>
</table>
| For the leader             | • Think of care as sets of processes that themselves are composed of units of standard work  
• Invest in the analytics to see and understand when the standard work is used and when it is successful  
• Train, empower, and unleash 7,000 independent problem solvers                                                                         |
| For the manager            | • Take the time to develop and document the standard work  
• Help the unit’s team see the connection between their standard work and the organization’s mission, vision, and values  
• Manage to standard work                                                                                                             |
| For the front-line provider| • No need to invent care every time  
• Devote more cognitive bandwidth to the things that only clinicians can do                                                            |
| For the patient and family | • Experience consistent care – *regardless* of provider or location                                                                       |
Patient-driven care variation

• Care should vary whenever needed by the patient or family.

• The only variation in care should be that driven by the needs of the patient or family. Patient’s care should not vary because of
  – Random noise in the system (Inability of the system to execute on clinical decisions)
  – Individual provider actions, such as
    • Physician preference (Physician A makes different choices from Physician B)
    • Arbitrary decision-making (Physician A makes different decisions on different days)
  – Bias and discrimination
  – Financial drivers
Isn’t this a hard argument to make with clinicians?

“High reliability? Aren’t you just telling me how to practice? There’s a reason I trained for SEVEN years after medical school to do this job!”
An easy argument to make from a clinical point of view

1. We should deliver infinite variability in care when needed by the patient or family

2. Variability that is not driven by the needs of the patient or family means there is a problem

3. If there is variation not driven by the patient or family, only two things are possible:
   • We don’t know what to do (which means we need research)
   • We know what to do, but aren’t doing it (which means we need quality improvement)

OK, that’s actually a pretty good argument.
Simple points, complex execution

- The implications about how to do this:

  1. **Clinical standard work**, delivered consistently and reliably
  2. **Measure** to understand when the standard work is being used
  3. **Manage** to the standard work
How is UCM putting this into practice today?
Catheter Associated Urinary Tract Infection (CAUTI)
Catheter Associated Urinary Tract Infection (CAUTI)

Q1FY14

CAUTI Prevention Taskforce formed

- Nursing Competencies: Insertion, Care and Maintenance, Specimen Collection, Alternative to indwelling catheters & prompt removal

Q2FY14

- NSA Competencies: Urine Specimen Collection
- Patient education instructions for clean catch created & posted in patient bathrooms

Q3FY14

- Urinary catheter kits standardized to all-in-one. Individual components removed from supply carts/rooms
Catheter Associated Urinary Tract Infection (CAUTI)

Q4FY14

• MD education: CAUTI Prevention, Appropriate catheter placement indications, EPIC urinary catheter orders

• MD Best Practice Advisory initiated: Reminder every 24 hours to renew urinary catheter order or discontinue urinary catheter if indications not met

• Support Staff education provided: transporting patients with urinary catheters

Q1FY15

• Work begins on Standard Pathway for the Prevention of CAUTI
Catheter Associated Urinary Tract Infections (CAUTI)
University of Chicago Medicine

Obs:Exp Ratio


0 0.2 0.4 0.6 0.8 1 1.2 1.4
Patient Experience: Overall Rating of Care
Patient Experience: Overall Rating of Care Overall Summary Time Line

Q3FY14

• Bedside shift handoff was implemented in all inpatient areas in January of last year
• iPad nurse leader rounding was implemented in February 2014

Q4FY14

• The Discharge Care call Center with service based care calls, had a go-live of April 1
• Interactive patient care committee optimized use of the GetWellNetwork in the CCD service areas in May 2014, with the implementation of patient experience data voice from patients which pushes out to areas for real-time service recovery.
• June was dedicated to imbedding practices and leaders to focus in on the efforts of rounding, leader and purposeful.
Patient Experience: Overall Rating of Care Overall Summary Time Line

Q1FY15

• Slight dip experienced in these months due to challenges of sustainment

Q2FY15

• Decided on effort to create an accountability action planning process for those leaders that had service units not meeting their overall rating of care goal

• Patient experience and engagement team members are partnering with areas to support advancement of action plans
Patient Experience: The Long View

These data reflect CMS Hospital Compare public reporting.
Inpatient Overall Rating of Care by Discharge Date

- Bedside Shift Handoff
- Get Well Network
- Ipad Care Rounds
- Discharge Care Calls
- Unit Accountability Planning

Target: 91.1
Sepsis

• Background
  • Sepsis is a severe infection and the body’s response to it.
  • It strikes >750,000 Americans per year, of whom about 215,000 die.
  • Remarkably easy to miss because it can look like other diseases.
  • Treatment is effective but complicated and very time-sensitive.
Sepsis

- July 2013:
  - No defined standard work:
    - No agreed-upon approach
  - No routine monitoring of process or outcome
- FY14 approach
  - Clinical standard work
    - Pathway, supported by decision support
  - Measurement
    - Develop data systems
  - Manage to the standard work
    - with individual provider feedback
- Today
  - FY14 vs. FY13

50 Fewer deaths in FY14
One example where you can have impact tomorrow
Preventing Infections

Preventing infections using new techniques for hand hygiene

• Why?
  − ~75,000 opportunities for hand hygiene at UCM every day
  − If we improve hand hygiene by 1% -- we will prevent 250,000 patients per year from being exposed to a higher risk of infection.
  − Hand hygiene is 30-40% at most hospitals, and we are no better.

• How?
  − Crisply defined standard work
  − Real-time electronic monitoring tools provide – for the first time – visibility into practice for managers and providers to use to improve (previous lag ~ 1 month, and less reliable)
  − Collaboration and deployment with Operational Excellence using Lean techniques, such as integration into MDI (Managing for Daily Improvement) board
    • Moving Lean into a core clinical process
Progress on a Pilot Unit

8 South Interventions

• Build discussions about HH performance into existing workflows, create multi-disciplinary dialogue:

  Discuss progress at weekly multi-disciplinary rounds

  Add to MDI board for discussion every shift with visible goal

  Pilot multi-disciplinary MDI huddles

• Challenges
  ▪ Multi-disciplinary attendance
  ▪ Identifying countermeasures when we aren’t at goal
Progress on a Pilot Unit

8 South Interventions - Dispensers

- Added dispensers closer to door entry for easier access

- Focused JDI on ensuring dispensers are always full:
  - Defined best process for checking dispensers
  - Added checking process to EVS workflows:
    - Daily cleaning
    - Daily room cleaning
    - Discharge cleaning

Image: gojo.com
Progress

8 South
Baseline: 29%
March 2015: 45%

PICU
Baseline: 43%
March 2015: 68%

On the two units we’ve worked the most (8S & 8W): 69,738 more clean hands
(139,476 if you count both hands)
Other Examples

Throughput work

LOS reduction: Early Discharge
Discharge Planning
Clinical Pathways

Wait Time Elimination

Appropriate Patient Placement
Right patient, right level of care, right bed
What is the role of leadership?
Leadership’s Role

• Look for opportunities to create a standard approach
• Involve the appropriate staff in defining the best solution – Standard Work, EBP
• Ensure thoughtful implementation process
• Observe, Monitor, and Audit for Consistency and Accountability – MDI boards
In summary
We talked about

• Why focus on reliability?
  – The only variation in care should be driven by the patient and family
  – What happens is what’s intended, again and again

• Reliability in healthcare is hard.

• Does UCM deliver reliable care today?
  – Yes (in ~30 national measures, with top decile performance in CMS’ safety measure)
  – No (in many others)

• High reliability as an organizing framework for clinical effectiveness
  – Three steps
    • Define and document clinical standard work
    • Invest in the analytics to see and understand when the standard work is used
    • Manage to standard work

• How UCM is putting this into practice today
Closing Commentary
Wrap up and General Info

Next Forum tentatively slated for May 13, 2015

An e-mail will be sent to all invitees with a link to the presentation and the video recording of this session

Survey Monkey will be e-mailed asking for feedback

Your feedback is critical to our continuous improvement

Thank You!