

Using Physician and Nurse Partnerships to Facilitate Quality-Focused Care

October 21, 2011

Third Annual Summit on Quality

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The University of Kansas Hospital

Objectives

- Describe a successful model for engaging physician and nursing leaders in the achievement of quality goals
- Identify effective tools that support physician and nursing engagement in quality



Goal

- Review our fundamental strategies
- Examples of successes
 - Formal structures
 - Medical Director Partnerships
 - Standing Committees
 - Ad hoc examples
 - Safety Teams
- Lessons learned



Five Star Performance Goals

- Service: Patient satisfaction at or above the 95th percentile for both Press-Ganey & HCAHPS
- Quality: Achieve best performer status for mortality index when compared with all UHC hospitals
- People: Attract, develop, and retain the best people to accomplish the hospital's goals
- Cost: Achieve expense management performance equal to or better than budget and have an operating margin at the "A Rated" hospitals average
- Growth: Ensure appropriate growth in support of the organization's strategic plan

Key Initiatives

- Mortality Reduction
- Response Teams
- Blood Management
- Infection Reduction
- Medication Management
- Throughput
- VTE
- EMR Management



Primary Methods

- Medical Director Partnerships
- Standing Committees
 - Mortality Review
 - Performance Improvement Committees
- Ad Hoc Work Teams
 - VTE
 - Sepsis
 - Respiratory Failure



History of the Partnerships

- *“Previously”*
 - Few, random selected Medical Directors
 - No Hospital Director--No Partnership
 - Few expectations, little accountability
 - Compensation to Departments
- *1997-1998*
 - Medical Director (physician) partnered with Hospital Director (Nurse Manager, Department Head)
 - Huge menu of possible partnership functions
 - Accountability based on Medical Director log and self-described work product
- *Increased engagement; limited results*



Reorganization of Partnerships 2005

- *Goals*

- Increase effectiveness of partnership
- Improve Hospital administrative support
- Enhance accountability of partnership

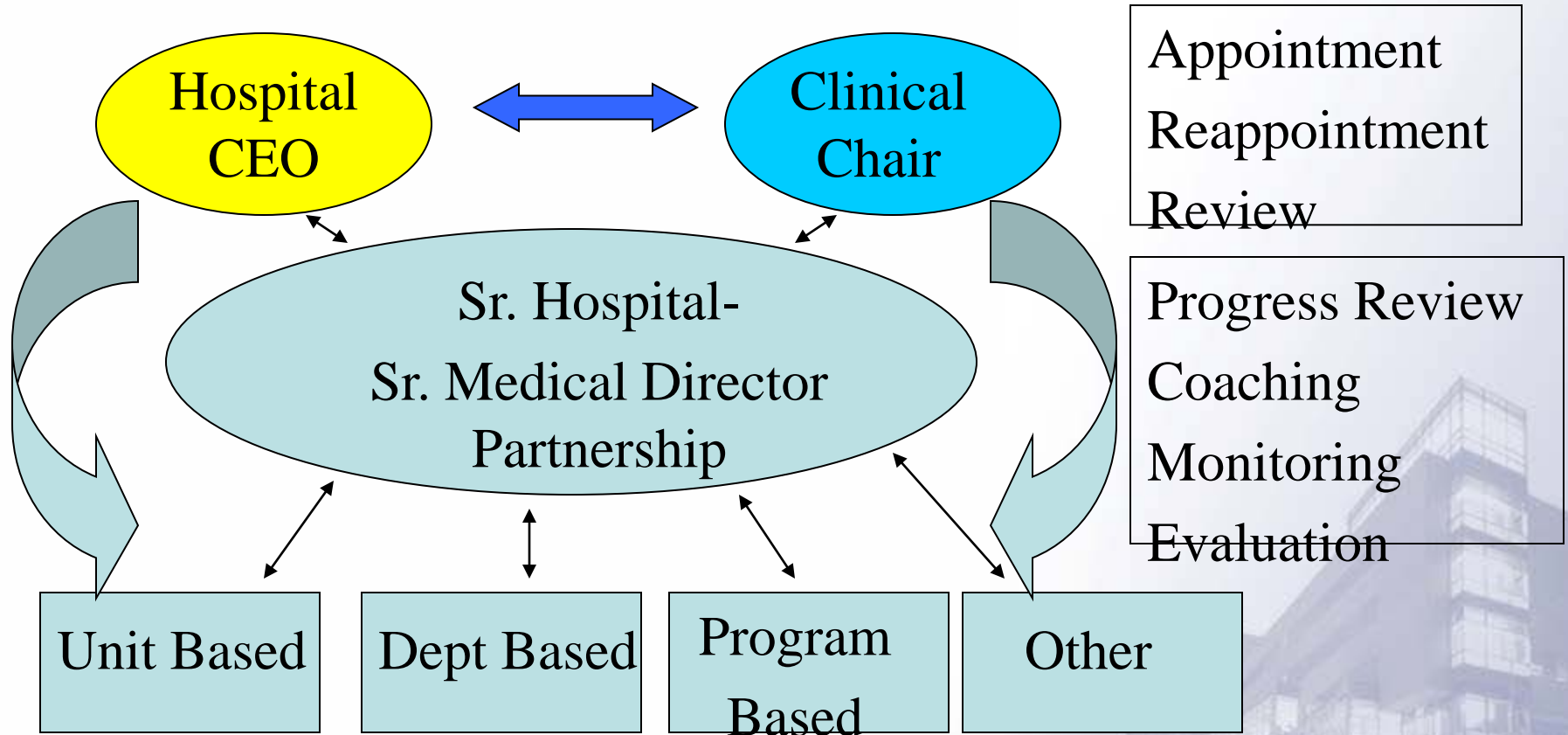
- *Methodology*

- Develop small number of focused goals/partnership
- Evaluate work product (performance) relative to outcomes of specific goals
- Compensation directly to physician

- *Ongoing engagement; more extensive results*



Continuing Refinement: 2006-Current The Structure



Stronger engagement; results linked to evidence-based medicine/ organizational priorities

Characterization of Partnerships

- Unit-Based Partnerships
 - MICU, SICU, CTS ICU, Pediatric ICU, Burn Unit, Neonatal ICU, Pediatrics, Family Practice
- Department-Based Partnerships
 - Radiology, GI/Endoscopy, Pathology, Respiratory Therapy, Pharmacy, Operating Room, Lab
- Programmatic-Based Partnerships
 - Transplantation, Stroke, Clinical Nutrition, Pain Management, Wound/Skin Care, Palliative Care, Trauma, Stem Cell, Liver Txplt, Infection Control
- “Other”
 - Clinical Information System Implementation, Utilization Review, Clinical Products, Rapid Response Teams

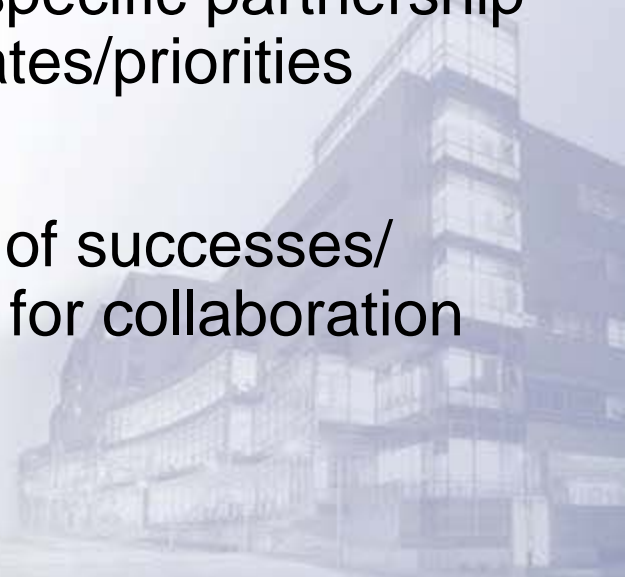
Partnership Goal Setting

- Specific goals developed early in fiscal year
- Partnership goals coordinated with Hospital strategic plan & 5 Star Performance Goals
 - Aligned with unit/department goals
 - Identified through benchmarking, evidence-based medicine
 - Linked to other hospital initiatives
 - Shared goals & projects when applicable
- Reviewed with Sr. Hospital & Medical Director



Partnership Work Process

- Weekly
 - Individual partnership meetings to discuss on-going work, completion of projects
 - Supported by data, research, evidence-based medicine, cross-functional interaction
- Monthly
 - Sharing Luncheon to highlight specific partnership reports and organizational updates/priorities
- Semi-annual
 - Review of results, identification of successes/challenges/needs/opportunities for collaboration
- Annual
 - Partnership results review



Partnership Accountability

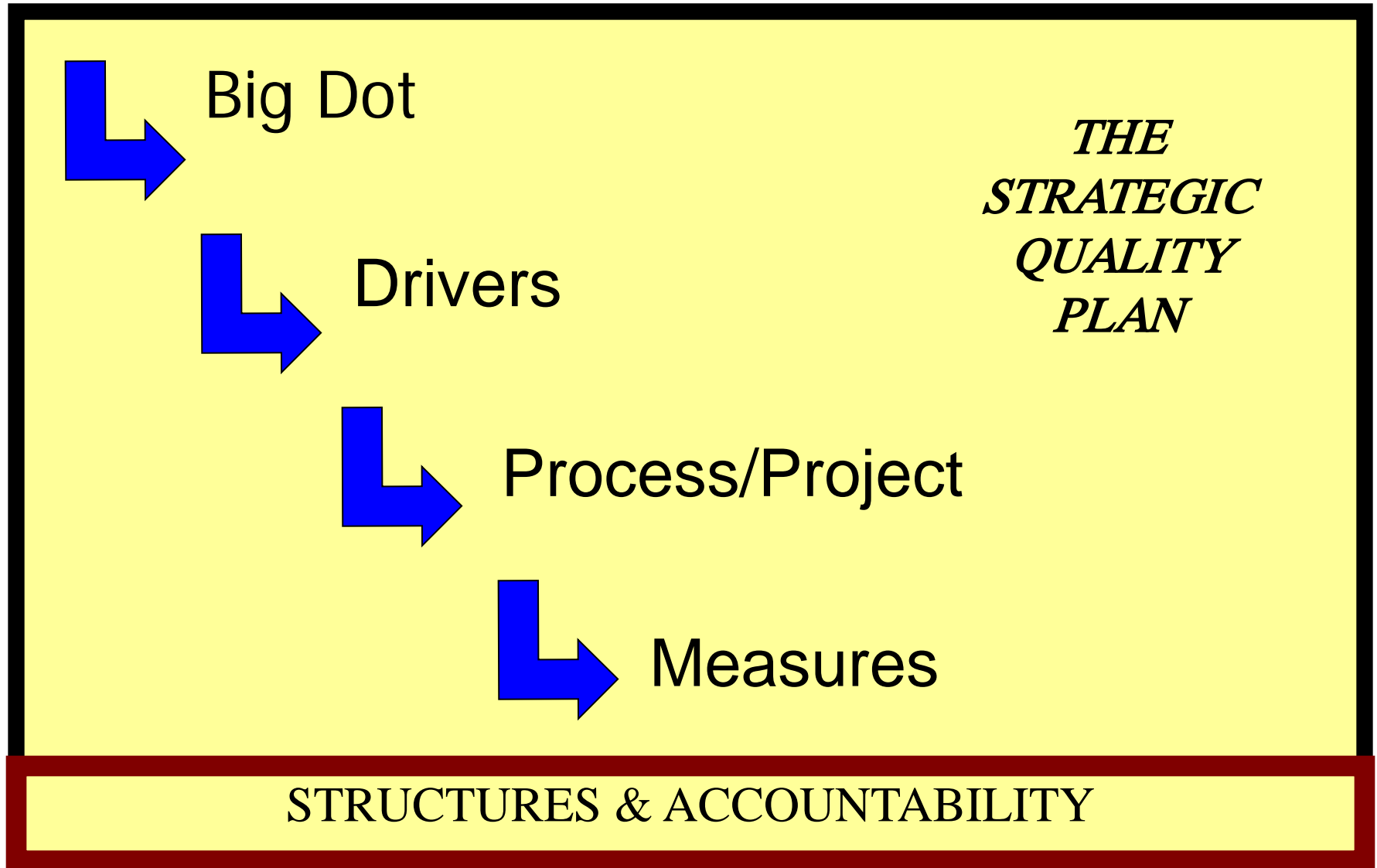
- Medical Director
 - Contract signature (s)
 - Monthly logs of hours worked
 - Compensation after logs received
- Hospital Director
 - Part of job description/performance goals
 - Linked to management incentive program
- Year-end summary of work product(s) by every partnership
- Year-end evaluation of partnership effectiveness by the partners
- Year-end review of all partnerships with the CEO

Partnership Support Structures

- Decision Support
 - Real-time, actionable data linked to key programs and to organizational and partnership objectives
- Human resources
 - Staff capable of consulting on Performance Improvement, Organizational Development, Best Practice Identification, etc.
- Leadership and Management
 - Senior Hospital Director, Senior Medical Director, Hospital Executive Engagement, Board Engagement



The Model



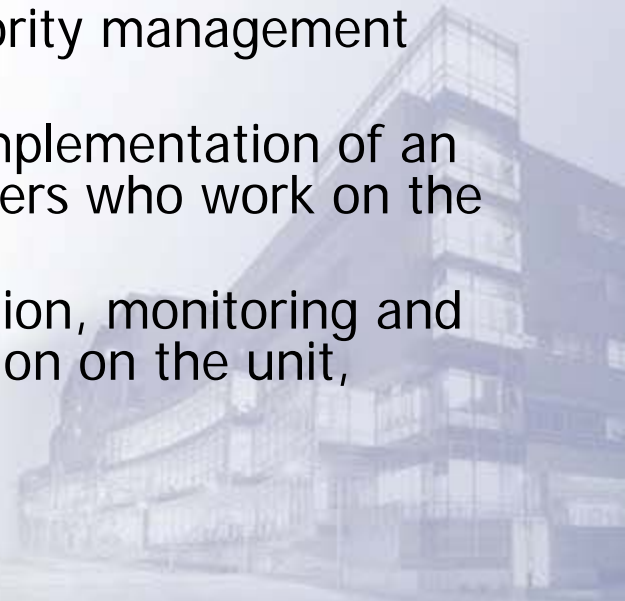
Medical Director Responsibilities: Medical Management

- Oversees the quality of patient care
- Responsible for triage of patients and development of admission and discharge criteria
- Develops critical pathways, algorithms, or protocols applicable to unit, service, or department.
- Develops and implements appropriate quality improvement standards.
- Monitors and reports variance to Chair, Quality Control Council, Hospital Authority Medical Staff and Hospital Authority.
- Develops opportunities for cost reduction, as well as an action plan for their development.
- Resolves conflicts among team members, patients, families and other medical staff



Medical Director Responsibilities: Leadership

- Monitors compliance with medical staff bylaws and other applicable standards.
- Works with partnership team to formulate budget and meet operating expenses and develop capital equipment needs, prioritization and acquisition.
- Assumes responsibility for adherence to and compliance with regulatory and accreditation agencies as TJC, ACS etc including preparation for and participation in relevant surveys.
- Participates in planning with the Hospital Authority management team.
- Assists Hospital Director in development and implementation of an orientation plan for students, residents, and peers who work on the service.
- Assists Hospital Director on methods of evaluation, monitoring and improvement of patient and physician satisfaction on the unit, service or department.



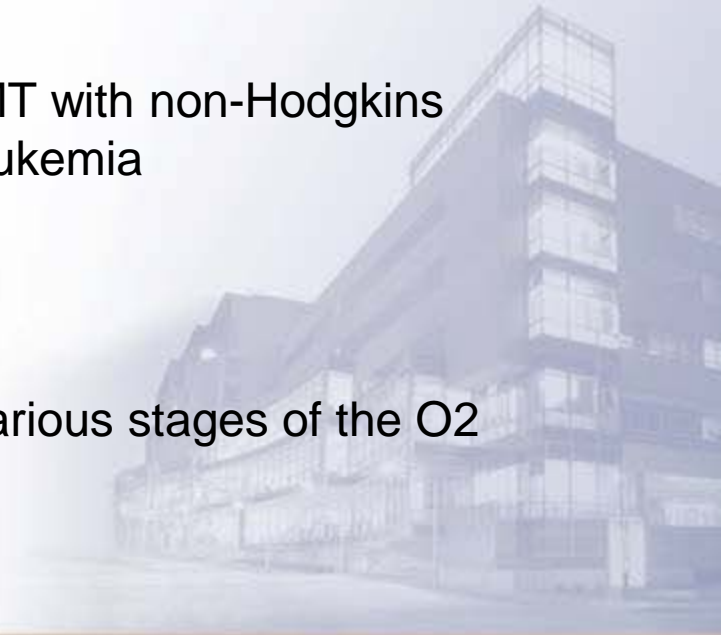
Medical Director Responsibilities: Communication

- Promotes the mission and values of University of Kansas Hospital Authority
- Communicates effectively with organization leadership, medical and hospital staff, internal and external referring physicians, and other community providers.
- Communicates with other departments and partnerships to ensure patient's needs are met.



Example of outcomes

- Unit-Based Partnership
 - NICU – Survival rate of 98% as compared to 95% with Vermont Oxford benchmark for small, younger babies.
- Department-Based Partnership
 - Drug Utilization program resulted in over \$900K savings in one year.
- Program-Based Partnership
 - BMT worked to \$143K on drugs for auto BMT with non-Hodgkins lymphoma and \$172K on drugs for acute leukemia
 - \$1.46M savings in blood utilization program
- “Other” Partnership
 - Core doc physicians were instrumental in various stages of the O2 install in hospital, now expanding to clinics



Standing Committees

- Engagement of Key Leaders
- Priority Focus Areas
 - Mortality Reviews
 - Service Lines
 - Maternal Child
 - Neurosciences
 - Trauma/Burn
 - Critical Care



Standing Committees

- Structure and Process
 - Physician/Nurse leaders
 - Quality & Performance Improvement
 - Systems Issues
 - Data Driven



Outcome Examples of Standing Committees

- Burn – successful Burn Center re-verification process for pediatrics and adults
- Critical Care – standardized, consistent protocols for sedation management, delirium management and ventilator weaning across 9 critical care areas.
- Neurosciences – re-verification as a primary stroke center; achieved Level 3 Epilepsy Center designation.

Mortality Review

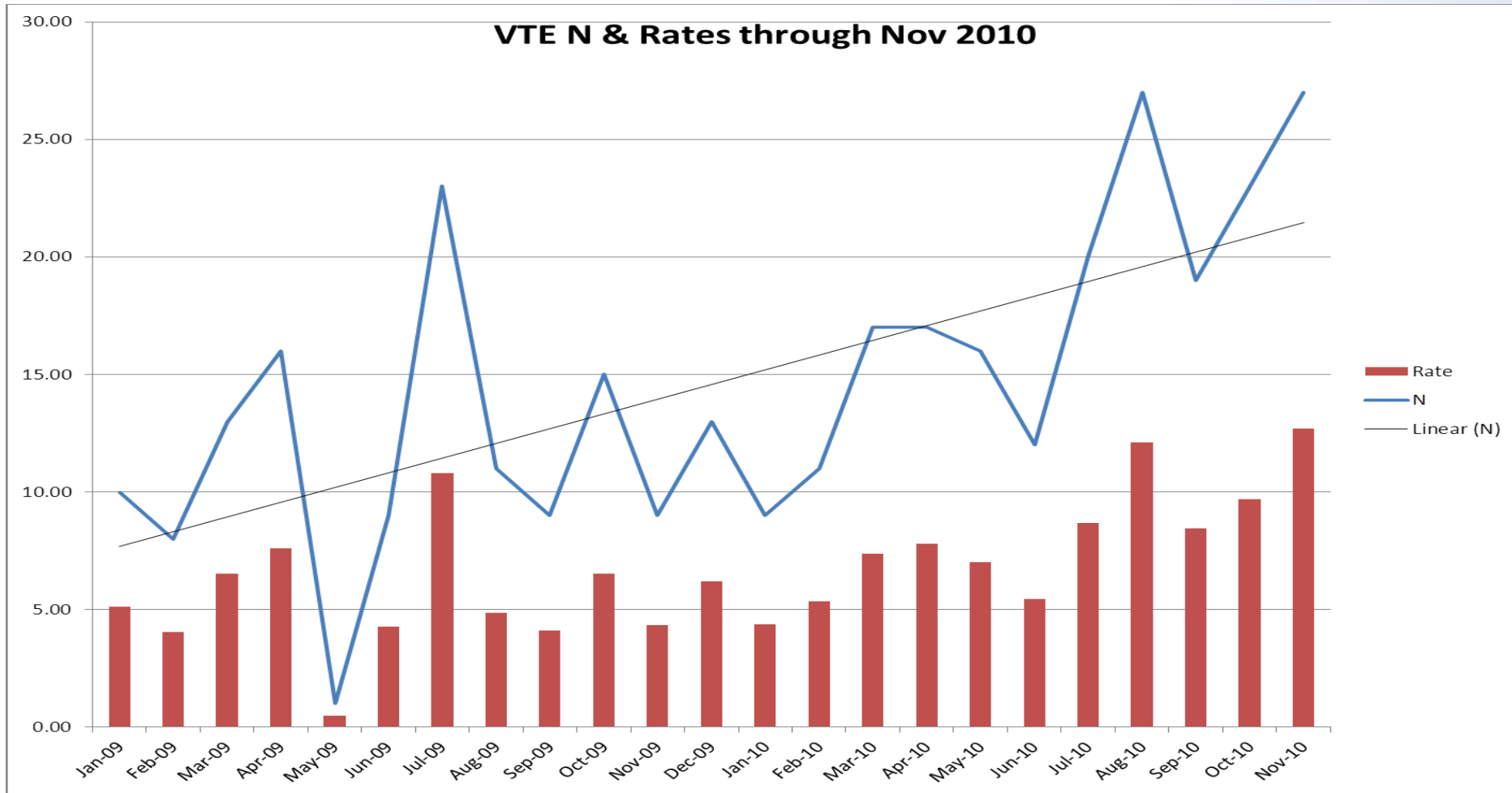


Ad Hoc

- Identified need
- Hospital and physician champions
- Quality, Safety or Systems Focused
 - EMR development
 - VTE Committee
 - Post op Respiratory Failure
 - AHRQ Safety Committees



The University of Kansas Hospital



VTE/PE Committee

- **Liz Carlton, RN** Director: Quality, Safety & Regulatory Compliance
- **Jeff Beasley, DO** Assistant Professor General and Geriatric Medicine
- **Lauren Gray, RN** Nursing Informatics
- **Michael Moncure, MD** Associate Professor Trauma and Critical Care
- **Rashaad Chothia, MD** Internal Medicine Resident
- **Sneha Phadke, DO** Internal Medicine Resident
- **Chris Wittkopp**, Director Quality Outcomes, Public Reporting Organizational Improvement
- **Tim Williamson, MD** Associate Professor Pulmonary & Critical Care Medicine
- **Vishal Jain, MMBS** Internal Medicine Resident
- **Michelle Homan, DO** Internal Medicine Resident
- **Chad Fisher RNFA** Department of Orthopedic Surgery
- **Anup Kasi, MBBS** Internal Medicine Resident
- **Karthik Vamanan, MD** Assistant Professor Vascular Surgery
- **Heather Cunningham, MD** Internal Medicine Resident
- **Nancy Page RN** Quality Outcomes Coordinator Organizational Improvement
- **Theresa King, MD** Assistant Professor General and Geriatric Medicine
- **Randy McMillen, PharmD** Clinical Pharmacist
- **Samaneh Wilkinson, PharmD** Pharmacy Assistant Director
- **Sue Pingleton, MD** Joy McCann Professor of Women in Medicine and Science Director, Quality and Professional Development Continuing Medical Education
- **Mark Cunningham, MD** Associate Professor Pathology and Laboratory Medicine
- **Kim Sanders** – Manager Continuing Education

Interventions

- Chart Reviews N=285
- Video – all clinicians
 - <http://www.youtube.com/watch?v=D63KHVpdtPY>
- Presentations
- Data dissemination
 - Chairs
 - Managers
 - Interested parties



Interventions

- 02
 - Order Sets
 - Dosing
 - Timing
 - BPA

Missing VTE Mechanical Prophylaxis Orders 4 hours after admission. Please Enter the VTE Prophylaxis orders for the patient.

Acknowledge Reason:



- Open Order Set: ADULT VTE PROPHYLAXIS GENERAL [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - GENERAL SURGERY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - GYNECOLOGIC SURGERY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - NEUROSURGERY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - ORTHOPEDIC SURGERY: HIP ARTHROPLASTY & HIP FRACTURE [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - ORTHOPEDIC SURGERY: KNEE ARTHROPLASTY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - UROLOGIC SURGERY [preview](#)

Missing VTE Prophylaxis Meds 4 hours after admission. Please Enter the VTE Prophylaxis orders for the patient.

Acknowledge Reason:



- Open Order Set: ADULT VTE PROPHYLAXIS GENERAL [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - GENERAL SURGERY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - GYNECOLOGIC SURGERY [preview](#)
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- Open Order Set: ADULT VTE PROPHYLAXIS - ORTHOPEDIC SURGERY: KNEE ARTHROPLASTY [preview](#)
- Open Order Set: ADULT VTE PROPHYLAXIS - UROLOGIC SURGERY [preview](#)

The following are suggested order sets for a VTE-related diagnosis

Acknowledge Reason:



Consulting Provider

VTE Treatment in Progress or Completed

- Open Order Set: ADULT VTE TREATMENT [preview](#)

Interventions

THE UNIVERSITY OF KANSAS HOSPITAL
PERFORMANCE IMPROVEMENT PLANNING AND REPORTING TOOL
Plan-Do-Check-Act (PDCA) Cycle
Model for Continuous Performance Improvement

TEAM/DEPARTMENT NAME		PROJECT TITLE	
GOAL ALIGNMENT MEETING DATE	PDCA CYCLE START DATE	TENTATIVE COMPLETION DATE	

The Plan-Do-Check-Act cycle (also known as PDCA or PDSA cycle) can be used to carry out change. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous quality improvement... Excellence Has No Finish Line.

PLAN: Identify and Analyze the Problem

What is the current problem?

How do you know it is a problem? List the steps or create a flowchart of the current process and brainstorm problem areas within the current process.

Do any regulatory requirements related to the current process exist? Describe

Does data currently exist to measure your improvement? Yes No

How will you know there is an improvement?

What is the impact of the problem? Which of the following demonstrates how the project supports the mission/values of the organization? Select all that apply.

Patient Safety Concern	People	Cost	Quality	Service	Growth
Magnet Component: Exemplary Professional Practice			Magnet Component: Structural Empowerment		
Magnet Component: New Knowledge and Innovations			Magnet Component: Transformational Leadership		

What change do you plan to implement?

REPORTING DUE DATE	NOV/MAR
MANAGER SIGNATURE	DATE
DIRECTOR SIGNATURE	DATE

To be submitted to Director and Quality Liaison by Reporting Due Date Performance Improvement Planning and Reporting Tool


- Nursing Priority Focus Area

- Unit specific data
- Learning Module
 - Nursing Leadership
 - QSI's

- CME Event

- 9/27/2011
- Pre & Post Survey

Preventing VTE



Educational credits

Physicians: 1 CME
Register via jdarrington@kumc.edu

Pharmacists: 1 CE
Register via lhooper@kumc.edu

Nurses: 1 CNE
Register via education@kumc.edu

Tuesday, September 27
12-1 p.m.
G013 School of Nursing

Accreditation

Pharmacists: The Georgia Society of Health-System Pharmacists is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmaceutical education. This program is approved for 1 hour (1 CEU) of continuing pharmacy education. Statement of credit will be mailed within 4 to 6 weeks to participants who have successfully completed the program. ACPE #0268999-1-08&L14-P

Nurses: The University of Kansas Hospital Education and Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Physicians: The University of Kansas Medical Center Office of Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The KU Medical Center Office of Continuing Medical Education designates this activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

THE UNIVERSITY OF KANSAS HOSPITAL

VTE PROPHYLAXIS ASSESSMENT

Low Risk VTE Risk = 0.4%	Moderate Risk VTE Risk = 2-4%	High Risk VTE Risk = 4-8%	Very High Risk VTE Risk = 10-20%
One risk factor OR Outpatient/ minor surgery < 40 yrs of age	Two risk factors OR Moderate/major surgery in patient 40 -60 years of age	Three to four risk factors OR General moderate/major surgery in patients over 60 year of age	Five risk factors OR Elective major lower extremity arthroplasty (hip or knee)
Independently ambulatory medical patient with no other risk factors	Major gynecological surgery for benign disease with no additional risk factors	Major gynecologic surgery for malignant disease	Non-elective hip, pelvic or other lower extremity orthopedic procedure
	Risk factors and minor general surgery	Risk factors and general moderate/major surgery in patient > 40 years of age	Acute spinal cord injury with paresis
	Risk factors and laparoscopic procedures	Risk factors and major gynecological surgery for benign diseases	Multiple major trauma
	Non – surgical patients high risk medical conditions such as: ischemic CVA with limited mobility, Central venous catheter with 2 or more risk factors, ICU admission with 2 or more risk factors		

RECOMMENDED PROPHYLAXIS

Low Risk	Moderate/ High Risk	Very High Risk
Early aggressive ambulation	Intermittent pneumatic compression devices (must be in use 20/24 hours for effectiveness; usage alone is clearly inferior to chemical prophylaxis and should be reserved for patients who have contraindications to therapy) Early aggressive ambulation AND	Intermittent pneumatic compression devices, Early aggressive ambulation AND
	Enoxaparin 40 mg SC Qday OR	Enoxaparin 40 mg SC Qday OR
	Heparin 5,000 SC Q8 hours OR	Heparin 5,000 SC Q8 hours OR
	Heparin 5000 units SC Q12 hours if > 75 years of weight < 50 kg	Fondaparinux 2.5 mg SC Qday OR
		Warfarin INR 2-3

*RISK FACTORS

<ul style="list-style-type: none"> Age: 40-60 years (1 risk factors) Age: 61- 70 (2 risk factors) Age: > 70 (3 risk factors) Recent or present immobilization (>72 hours) Prior history of thrombosis (3 risk factors) Confining air/ground travel (>4h within one week of admission) 	<ul style="list-style-type: none"> Hormonal replacement therapy/ oral contraceptive use Myeloproliferative disease Known thrombophilia Decompensated CHF Tobacco use Spinal cord injury w/ paralysis (3 risk factors) 	<ul style="list-style-type: none"> Pregnancy/postpartum (< 1 month) Inflammatory bowel disease Nephrotic syndrome Sickle cell disease Active Malignance and/or oncologic treatment: surgery, chemotherapy, radiotherapy 	<ul style="list-style-type: none"> Dehydration Varicose veins/leg swelling or venous stasis Obesity (BMI > 29) Central Venous Access Severe chronic obstructive pulmonary disease Sepsis
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RELATIVE OR ABSOLUTE CONTRAINDICATION TO PHARMACOLOGIC PROPHYLAXIS

<ul style="list-style-type: none"> Lumbar puncture or epidural anesthesia within 24 hours Active bleeding Coagulopathy (INR > 1.5) or thrombocytopenia (platelet count < 60,000) 	<ul style="list-style-type: none"> Presence or history of HIT (Heparin induced thrombocytopenia) – <i>fondaparinux recommended</i> Recent intraocular or intracranial surgery or lesions Significant renal insufficiency (Creatinine clearance < 30 dose carefully) – <i>may also use UFH</i> Hypertensive crisis
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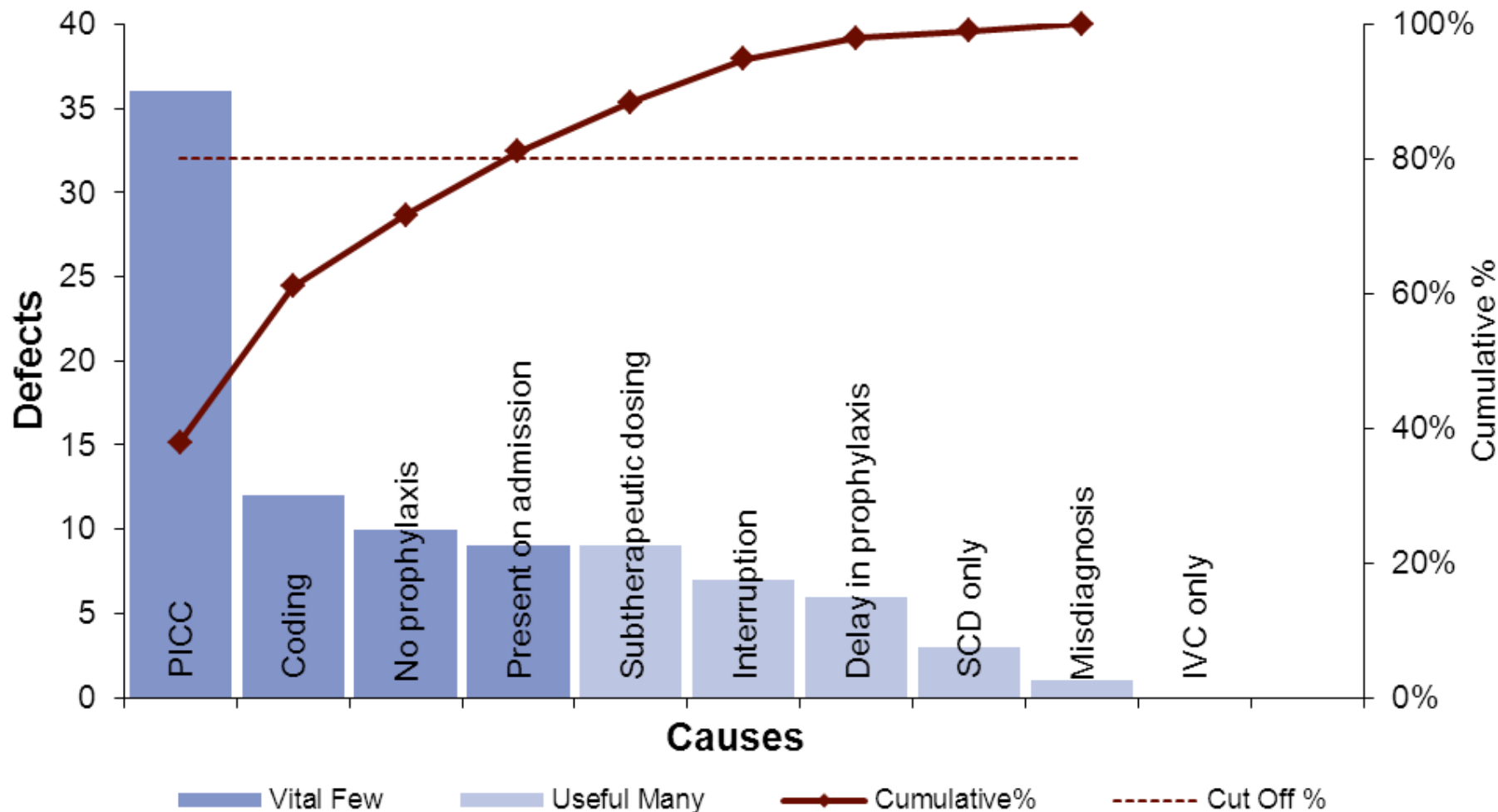
<p>SPECIAL CONSIDERATIONS: <u>Impaired renal function: CrCl <30 ml/min</u></p> <ul style="list-style-type: none"> Enoxaparin dosing : 30 mg Qday Use of fondaparinux is contraindicated in patients <p><u>Hemodialysis</u></p> <ul style="list-style-type: none"> UFH preferred agent 	<p>SPECIAL CONSIDERATIONS: <u>Obesity</u></p> <ul style="list-style-type: none"> BMI 40-50kg/m2: Enoxaparin 40 mg BID BMI > 50kg/m2: Enoxaparin 60 mg BID <p><u><50 kg</u></p> <ul style="list-style-type: none"> Fondaparinux should not be used in patients <50 kg <p style="color: red;">SCIP CORE MEASURES CONSIDERATIONS: Select surgical procedures have specific VTE Recommendations which may be in addition to the above. Those procedures which have post-order sets include the VTE recommendations.</p>
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DRUG COST

Warfarin 5mg \$	Heparin 5,000 units \$	Enoxaparin 30 mg \$\$	Enoxaparin 40 mg \$\$	Fondaparinux 2.5 mg \$\$\$
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Warfarin<Heparin<Enoxaparin 30<Enoxaparin 40<Fondaparinux 2.5

VTE PE by Theme



PICC Plan

- Appropriate use of PICC
- Vascular Access Device Algorithm
- Education
 - EJ placement
 - Peripheral IV placement



University of Kansas Hospital Vascular Access Device Selection Algorithm

EARLY PICC ACCESS ASSESSMENT

Promote identification of patients that would benefit from early PICC orders and facilitate placing the line

NOTE: PICCS are for Non-Emergent use, Reassess daily for need

Considerations when assessing for appropriate vascular access device

Infusate characteristic

Central Access Not Required

Less than 10% dextrose
Isotonic Solutions
Osmolarity <600 mOsm/L
Meds pH between 5-9

Central Access Required

More than 10% Dextrose
Hypo- and Hypertonic Sol'n
Osmolarity >600 mOsm/L
Meds pH below 5 & over 9
Inherently irritating meds (see list)

Duration of Therapy

Less than 5 days

1-4 Weeks

Less than 3 months

More than 3 months

Vascular Integrity

Good

Poor

1st Choice of Device Selection

Contraindications for PICCs: Dialysis, ESRD, CKD, Quadriplegia, Bilateral radical Mastectomy, skin conditions or burns at insertion site, VAD or total artificial heart, previous ipsilateral thrombosis, existing fistula on extremity

See Non-Emergent Venous Access Algorithm

Peripheral IV

EJ

PICC

PICC

Tunneled Catheter

2nd Choice of Device Selection

Relative Contraindications for PICCs: contractures, previous mastectomy, existing thrombophlebitis, radiation therapy, pacemaker wires, crutch walking, trauma to extremity, future use of the extremity for AV fistula placement

EJ

PICC

Central Venous Catheter

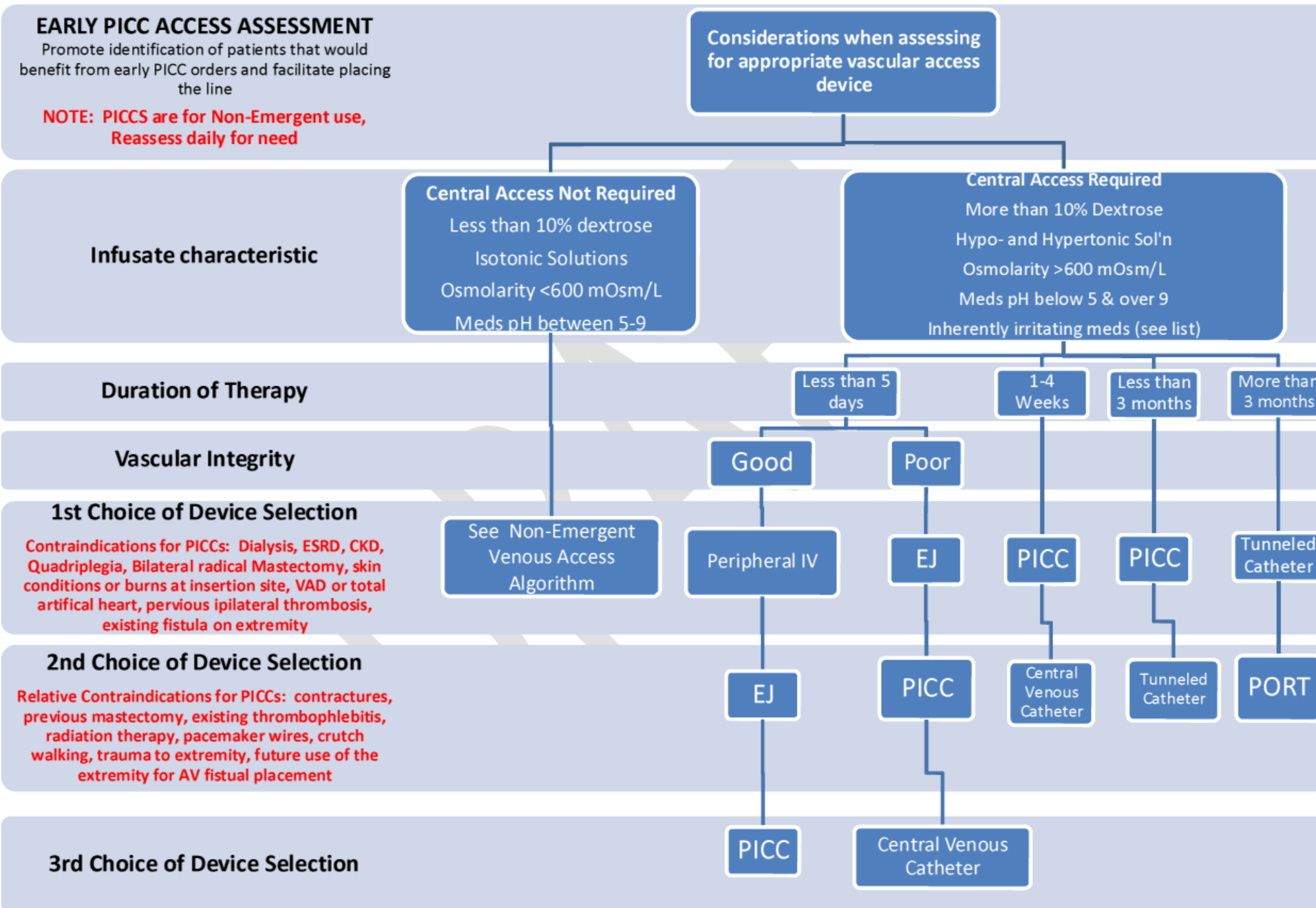
Tunneled Catheter

PORT

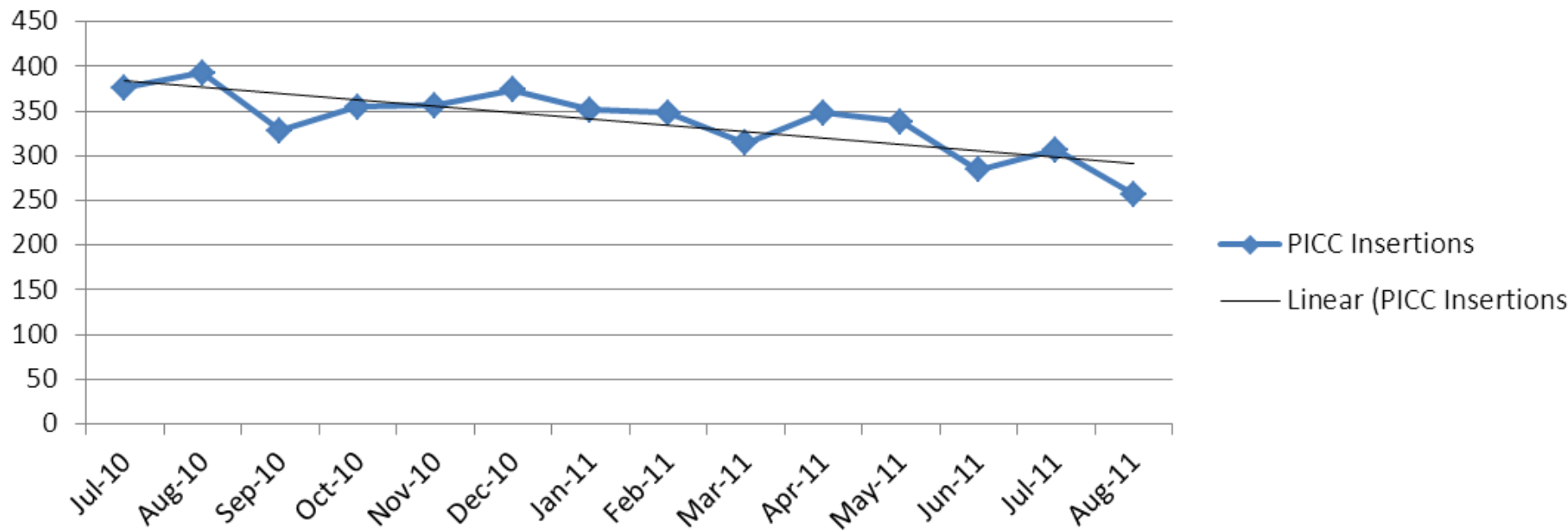
3rd Choice of Device Selection

PICC

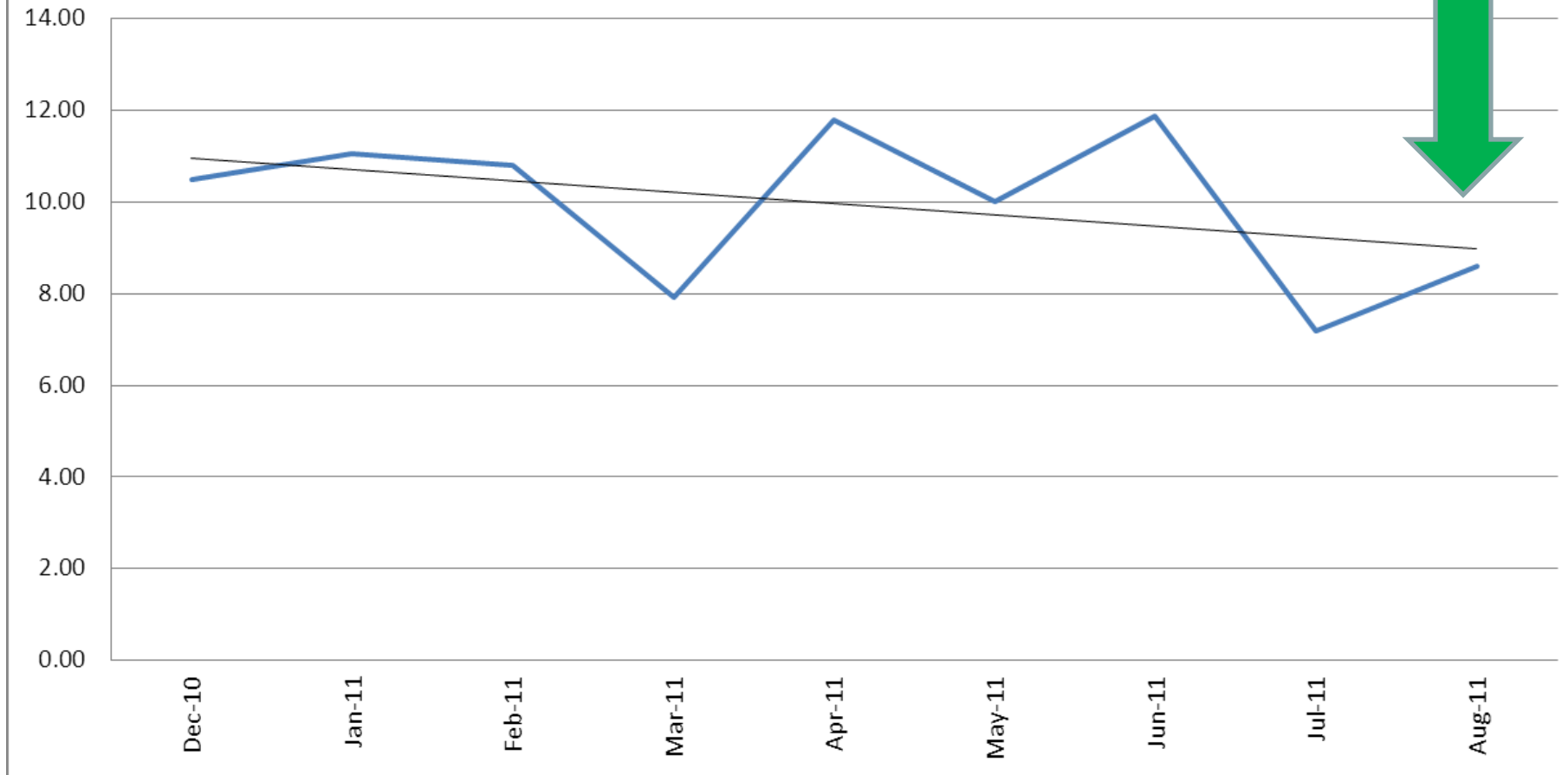
Central Venous Catheter



PICC Insertions



Housewide VTE PE Rates per 1000



Lessons Learned



Focus on Clinical Outcomes – not Financial Metrics



Our Guiding Formula

World Class
Patient Outcomes

+

World Class
Patient Satisfaction

Delivered by Competent,
Committed and Engaged Staff



Strong,
Sustainable
Growth

+

Strong, sustainable
Financial
Performance

Pay Attention to the Culture

- Sensitive to the historical impacts
- Proactive approach
- Delivered by Competent, Committed and Engaged Staff
 - Right Fit
 - Treating each physician as a partner in the delivery of care



Pay Attention to the Culture

- Just Culture
 - Take Action
 - Tea with Lee
 - Systems vs Provider attributes
- Physician engagement survey



University of Kansas Hospital Staff Physician 2011
National Staff Physician Percentile Report

Item	University of Kansas Hospital Staff Physician 2011 (235)	University of Kansas Hospital Staff Physician 2011 Nat'l Staff Physician Percentile Ranking	Nat'l Staff Physician 50th Percentile	Nat'l Staff Physician 75th Percentile	Nat'l Staff Physician 90th Percentile
1 The nursing staff is responsive when I need assistance.	4.19	44	4.27	4.43	4.51
2 There is good teamwork between physicians and nurses at KUH.	3.88	8	4.12	4.27	4.41
3 There is effective communication between the nursing staff and physicians regarding patient care.	3.85	24	4.10	4.14	4.32
4 The nursing staff treats faculty physicians with respect.	3.77	N/A			
5 The nursing staff treats resident physicians with respect.	3.29	N/A			
6 If needed, the hospital night staff is attentive to my needs.	3.82	N/A			
7 If needed, the hospital weekend staff is attentive to my needs.	3.86	N/A			
8 Patient care between shifts is adequate at KUH.	3.70	N/A			
9 I am satisfied with the quality of care provided to my patients at all hours and shifts.	3.88	N/A			
10 I am satisfied with the clinical care provided by hospitalists at KUH.	3.99	N/A			
11 I am satisfied with the effectiveness of communication between hospitalists and staff physicians regarding patient care.	3.69	N/A			
12 Overall, I am satisfied with the performance of hospitalists at KUH.	3.87	N/A			
13 The nursing staff at KUH is committed to providing compassionate care.	4.36	42	4.40	4.45	4.64
14 Overall, I am satisfied with the expertise of the nursing staff at KUH.	4.08	54	4.07	4.23	4.40
15 Overall, I am satisfied with the performance of the nursing staff.	4.04	53	4.02	4.19	4.35
16 I am satisfied with the ease of the registration process for my patients.	3.16	1	3.65	3.90	4.03
17 I am satisfied with the ease of the scheduling process for my patients.	2.83	N/A			
18 I am satisfied with the availability of beds at KUH.	2.50	N/A			
19 I am satisfied with the appearance and cleanliness of the patient care areas.	3.62	23	3.92	4.15	4.44
20 The methods used by KUH to communicate with physicians are effective.	3.43	N/A			
21 I receive useful information about KUH (e.g., new services) in a timely manner.	3.65	20	3.89	3.97	4.07
22 I get the tools and resources I need to provide the best care/service for our patients (i.e., response teams, etc.).	3.62	27	3.88	4.04	4.37
23 I am satisfied with the amenities (e.g., lounge, food service) provided to the medical staff.	2.88	N/A			
24 KUH is appropriately staffed by nurses and other ancillary staff to provide high-quality care to patients.	3.77	72	3.62	3.87	3.94
25 KUH is a safe place for me to work.	4.33	N/A			
26 KUH makes use of new technology and clinical practices that will improve patient care.	4.10	85	3.93	4.03	4.23

Shaded areas appear for items where there is an insufficient number of observations in the Morehead database. These are either new or customized items.



Fundamental Requirements

- Co-Leaders -Physician Champion Required
 - Identify formal and informal physician leaders
- Early participation
- Transparent communication
- Select the right projects
- Define expectations and objectives up front
- Use meeting time wisely
- Support “offline” work
- Use credible data sources
- Communicate activities and results



80/20 Rule

- Expecting All Physicians to Agree From the Outset is a sure failure mode
- Drive expectations for Physicians by the physicians – not by the hospital
- Use small tests of change to identify quick results or failures



How Did We Do?



The Hospital was Named the Best Hospital in KC Metro for the 2nd Time-

- Pulmonology (29th)
- ENT (31st)
- Gastroenterology (35th)
- Kidney Disorders (37th)
- Heart & Heart Surgery (39th)
- Cancer (44)





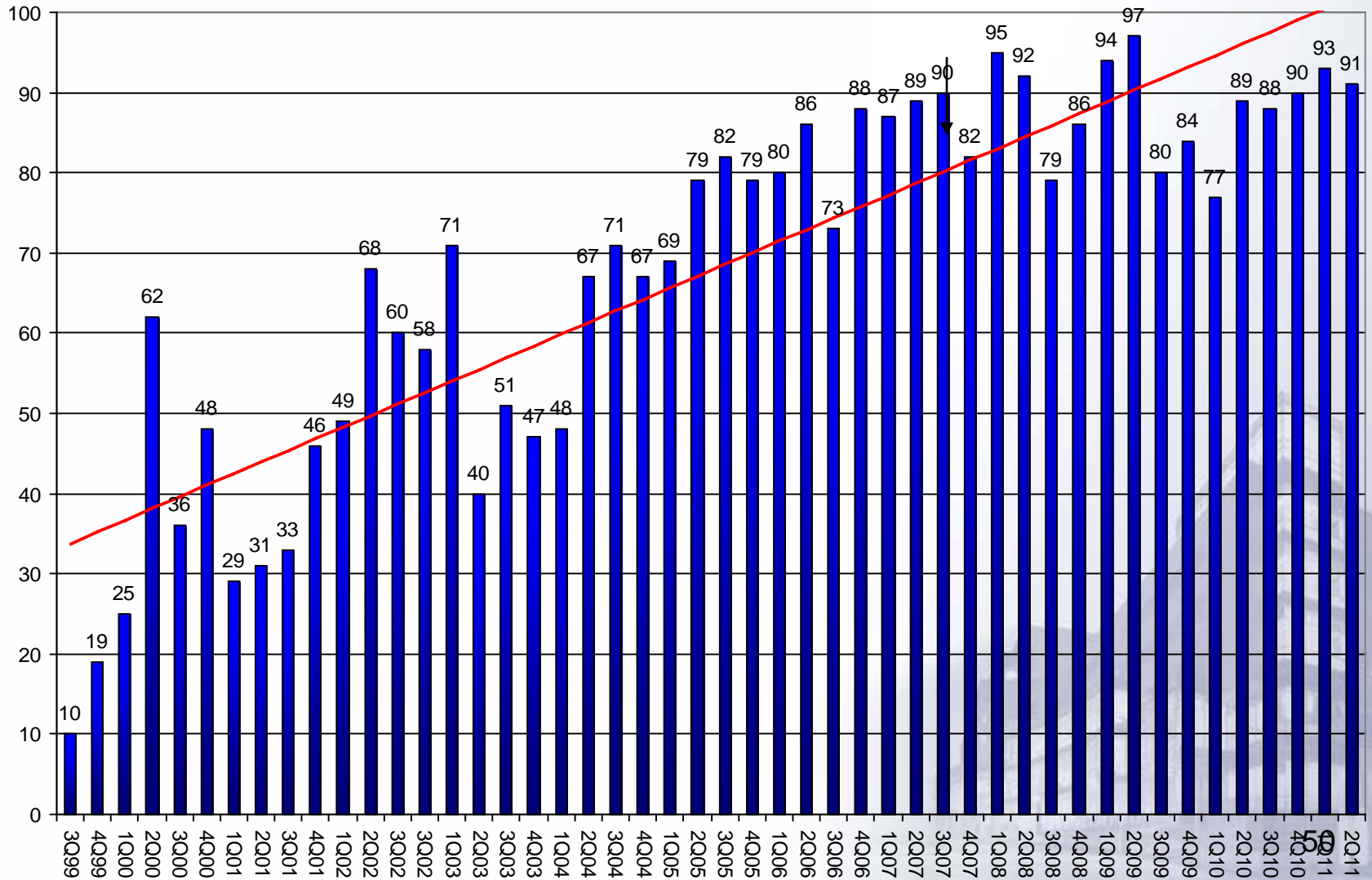
Six Additional Services Were Named High Performing

- Diabetes & Endocrinology
- Geriatrics
- Gynecology
- Neurology & Neurosurgery
- Orthopedics
- Urology

Service



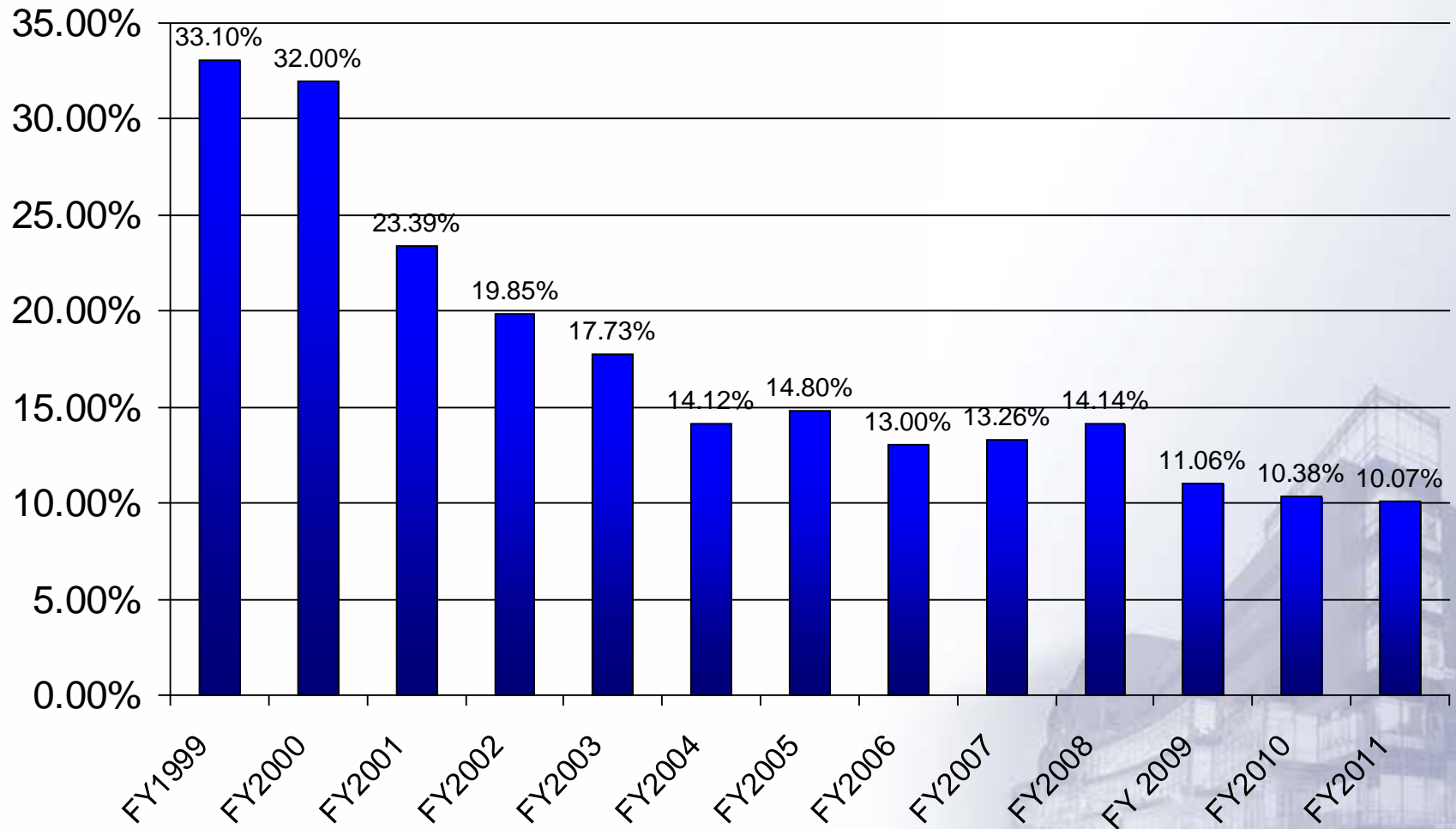
Patient Satisfaction (All Hospitals)



People



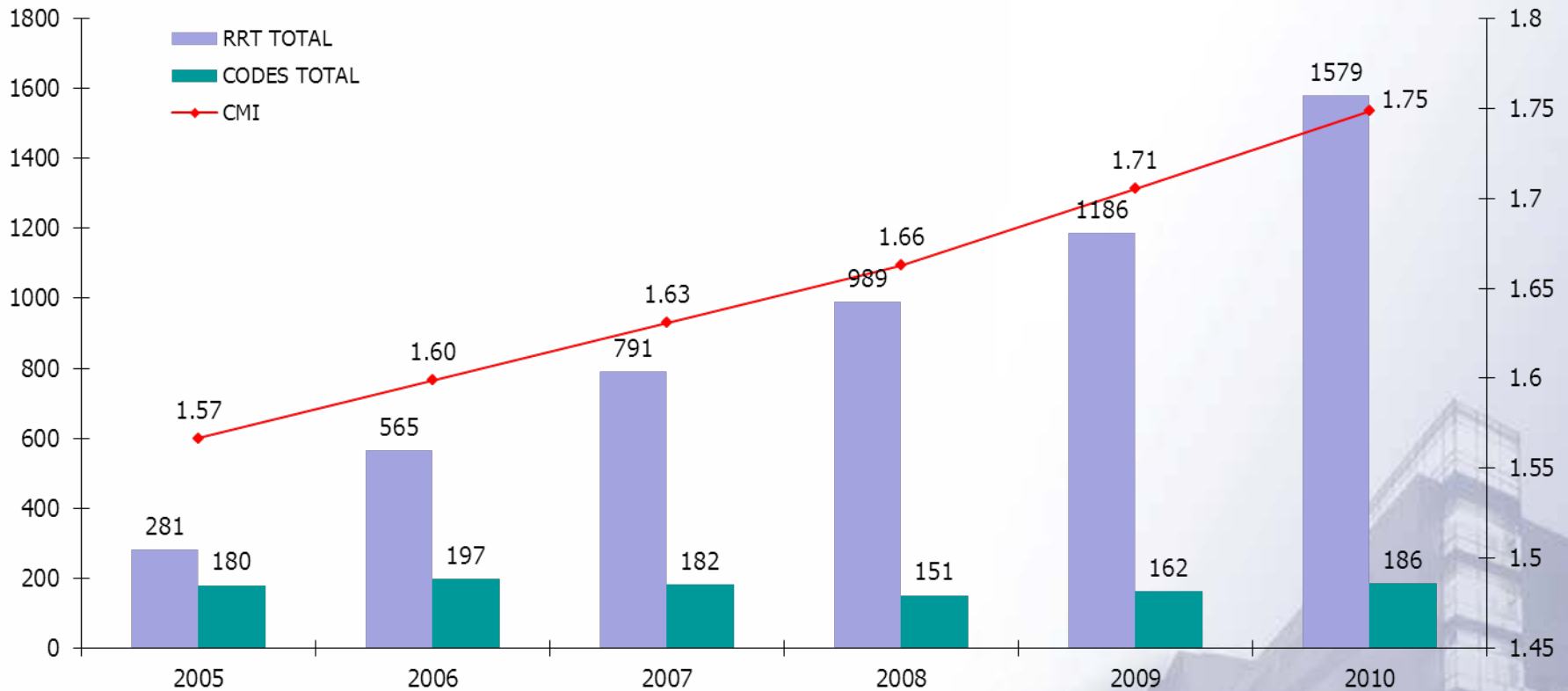
All Hospital Employee Turnover



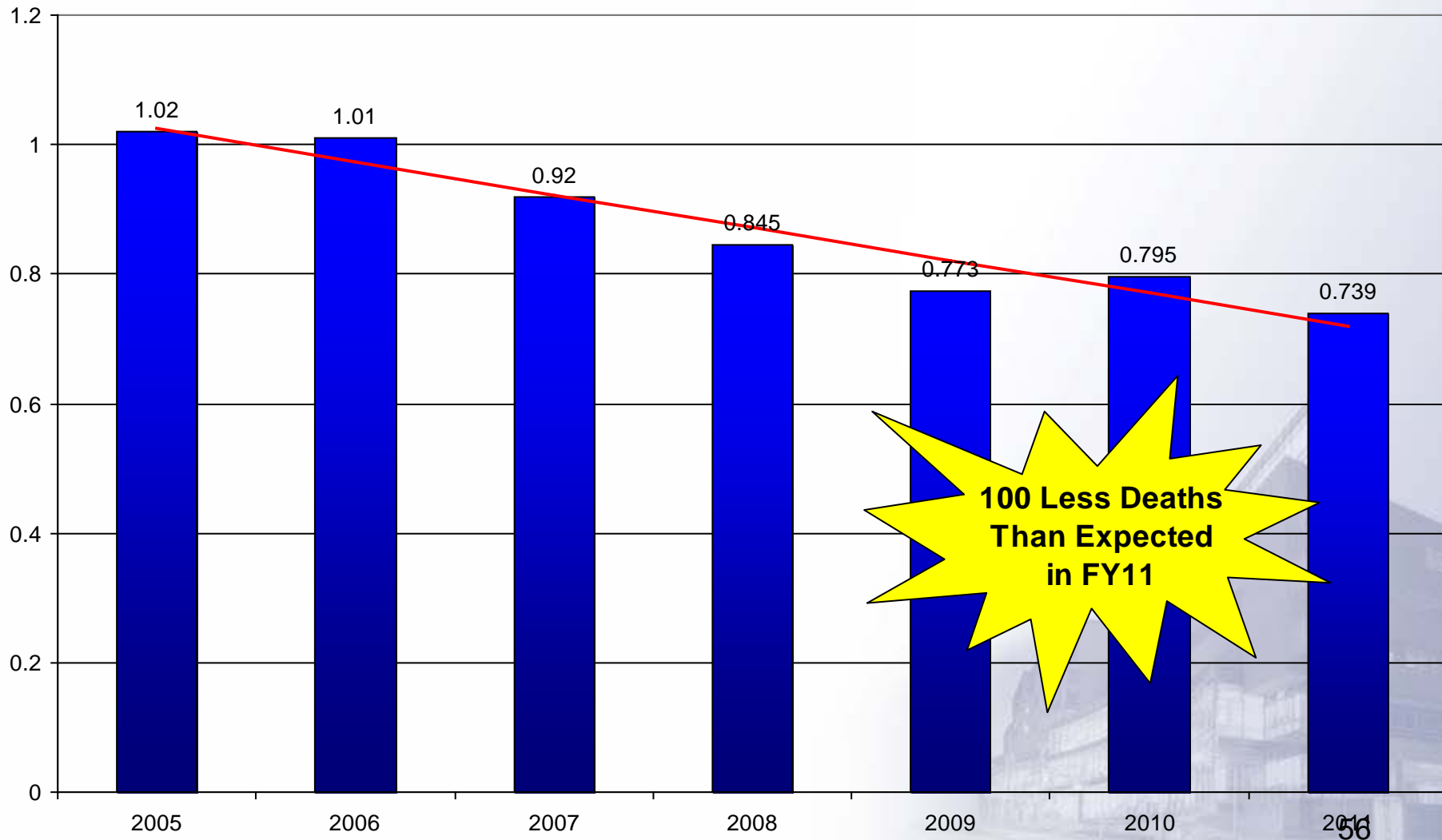
Quality



RRT Calls and Codes/Census

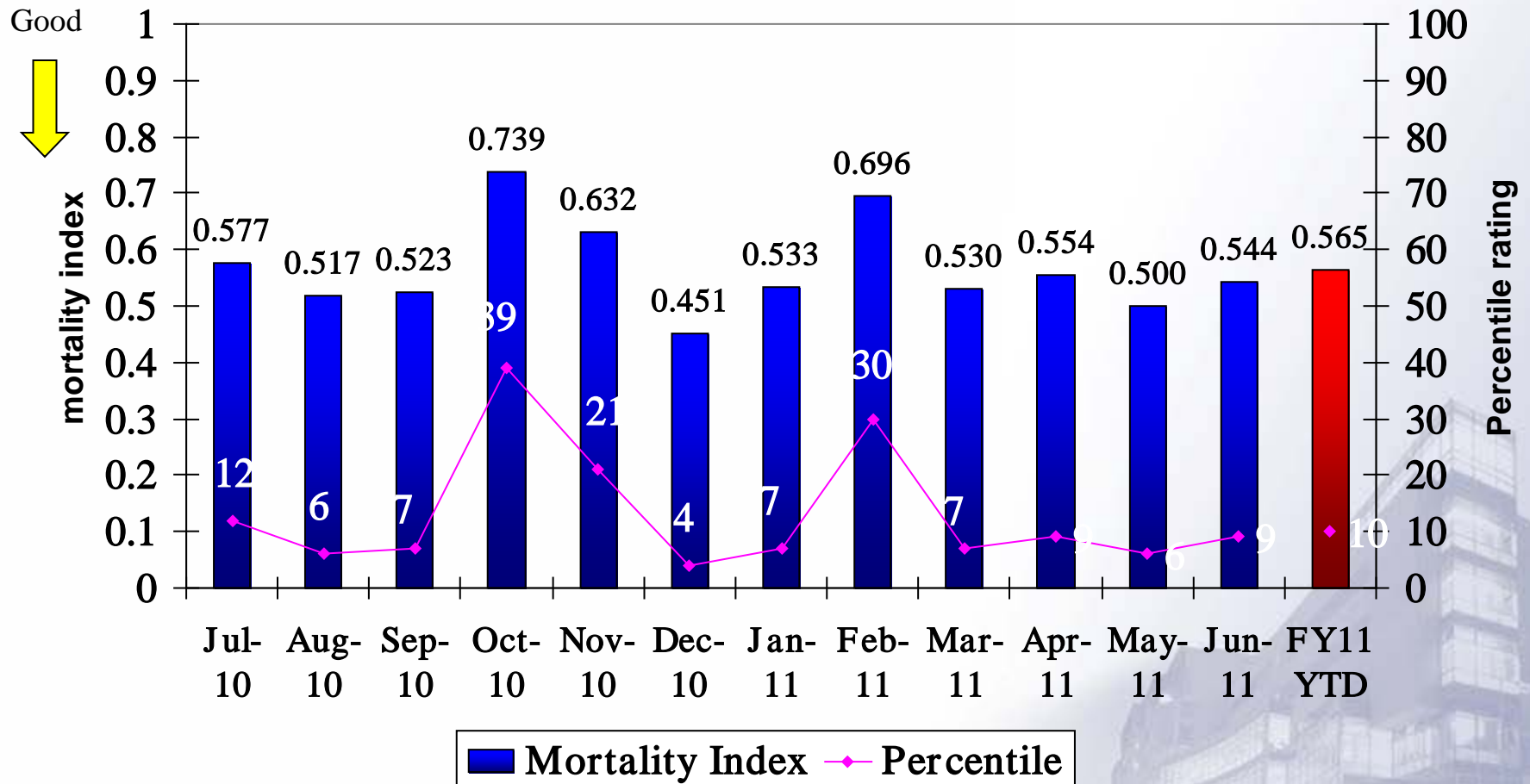


Sepsis Mortality Index



Mortality Index

(Actual Deaths/Expected Deaths Based on Severity of Illness)



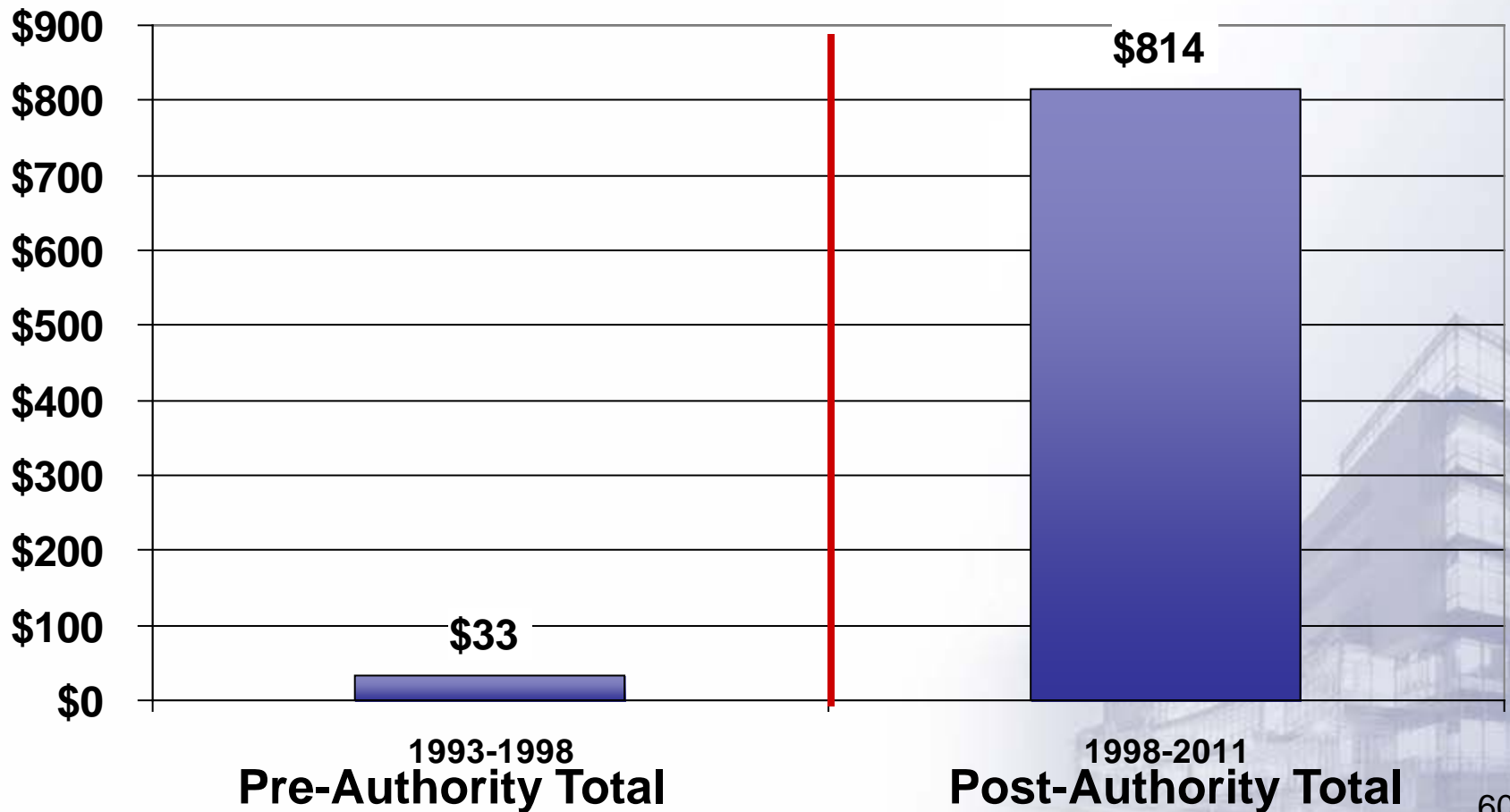
407 Fewer Deaths Than Expected Based on Patient Acuity FY11

54 consecutive months with Mortality Index <1.0

Cost



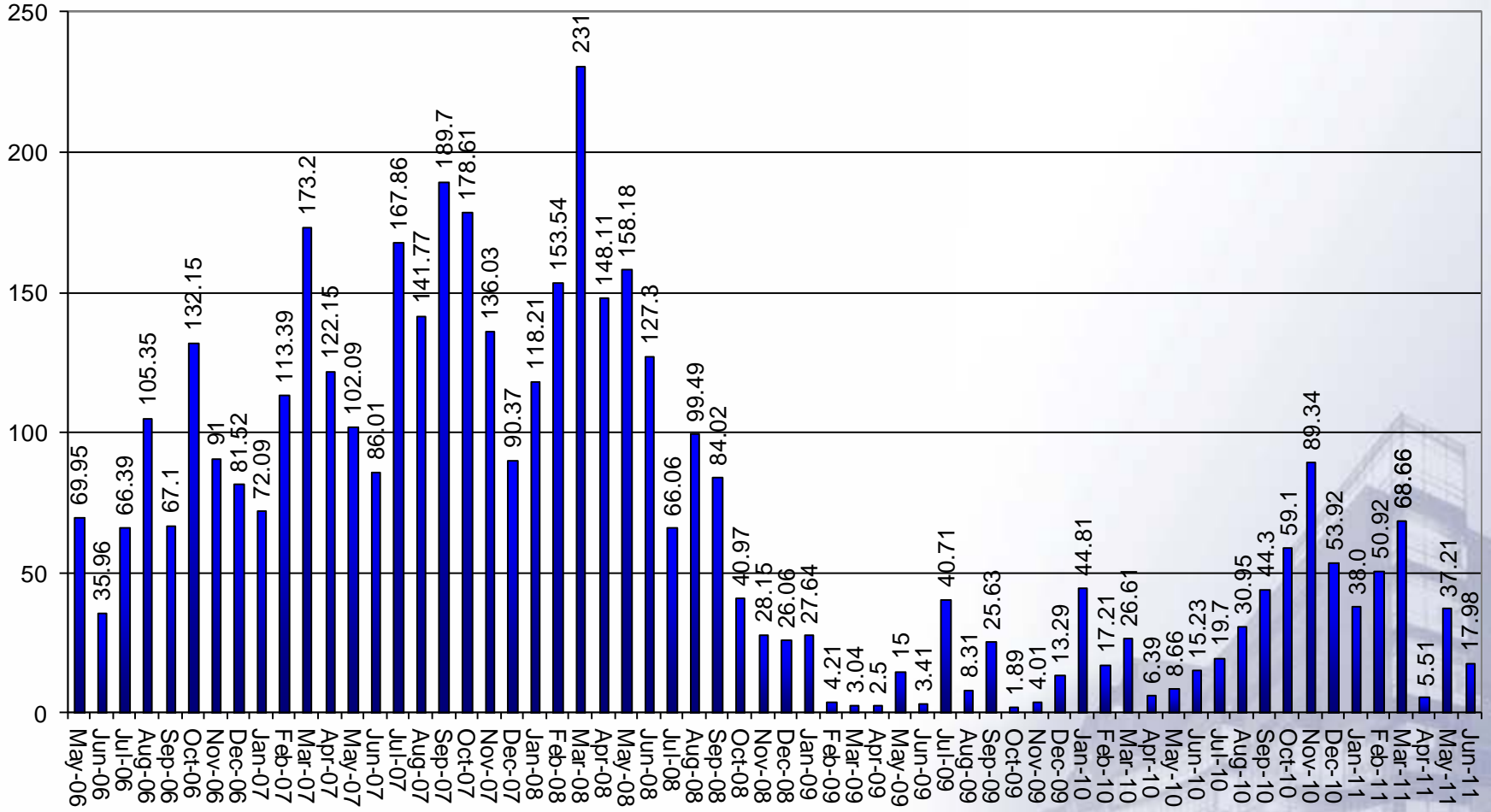
Capital Investments (\$ Millions)



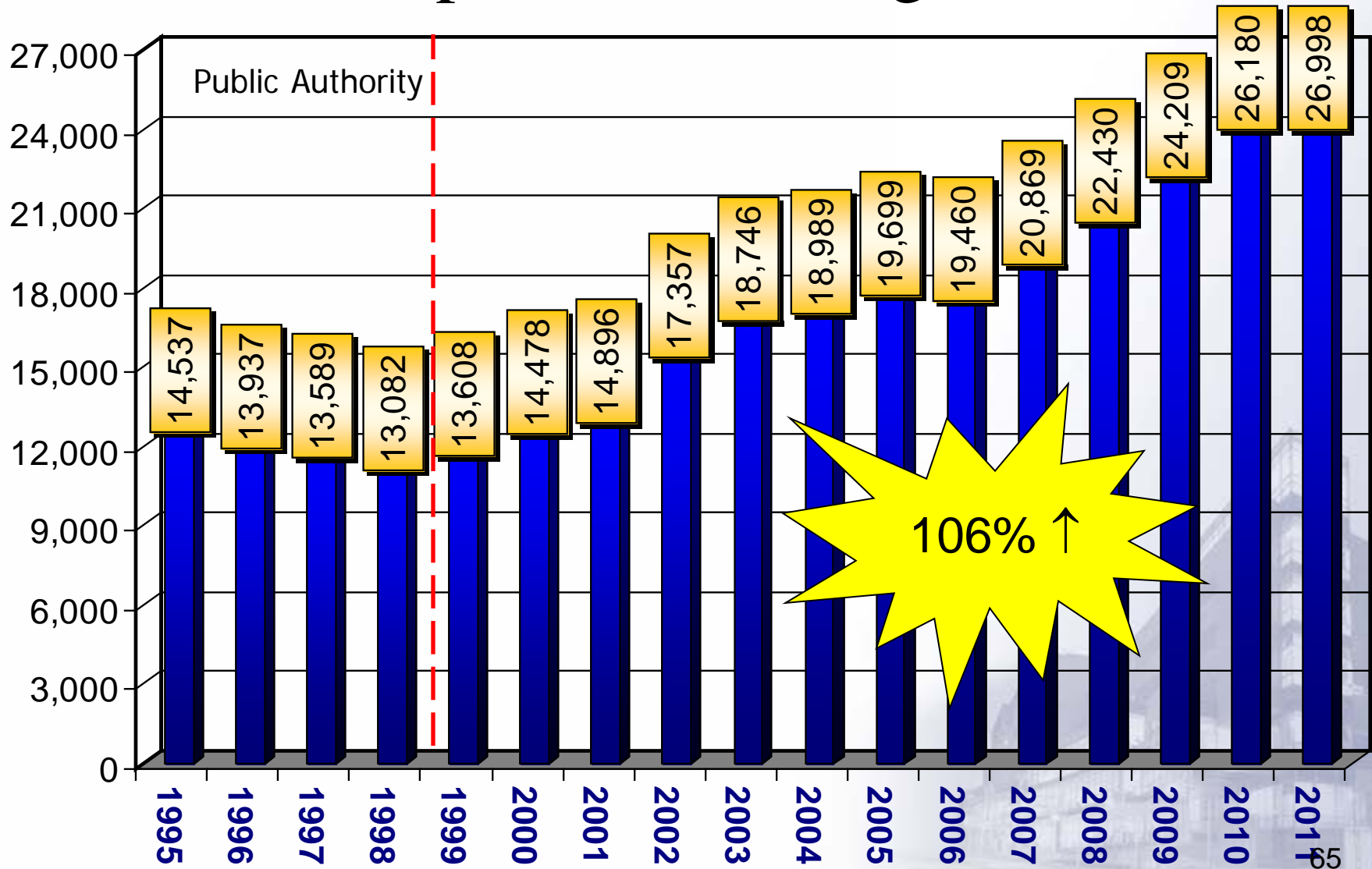
Growth



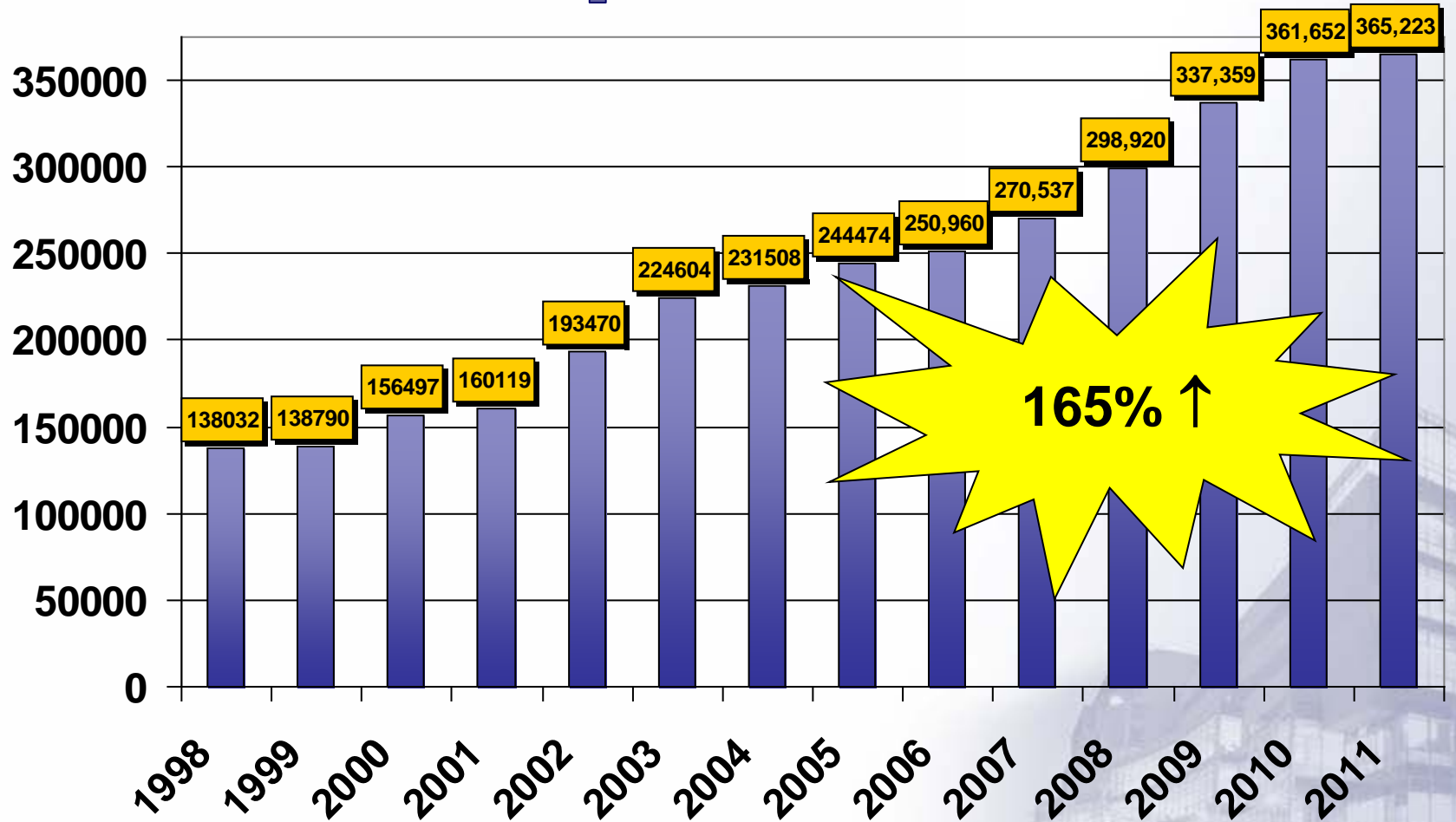
Total Diversion Hours



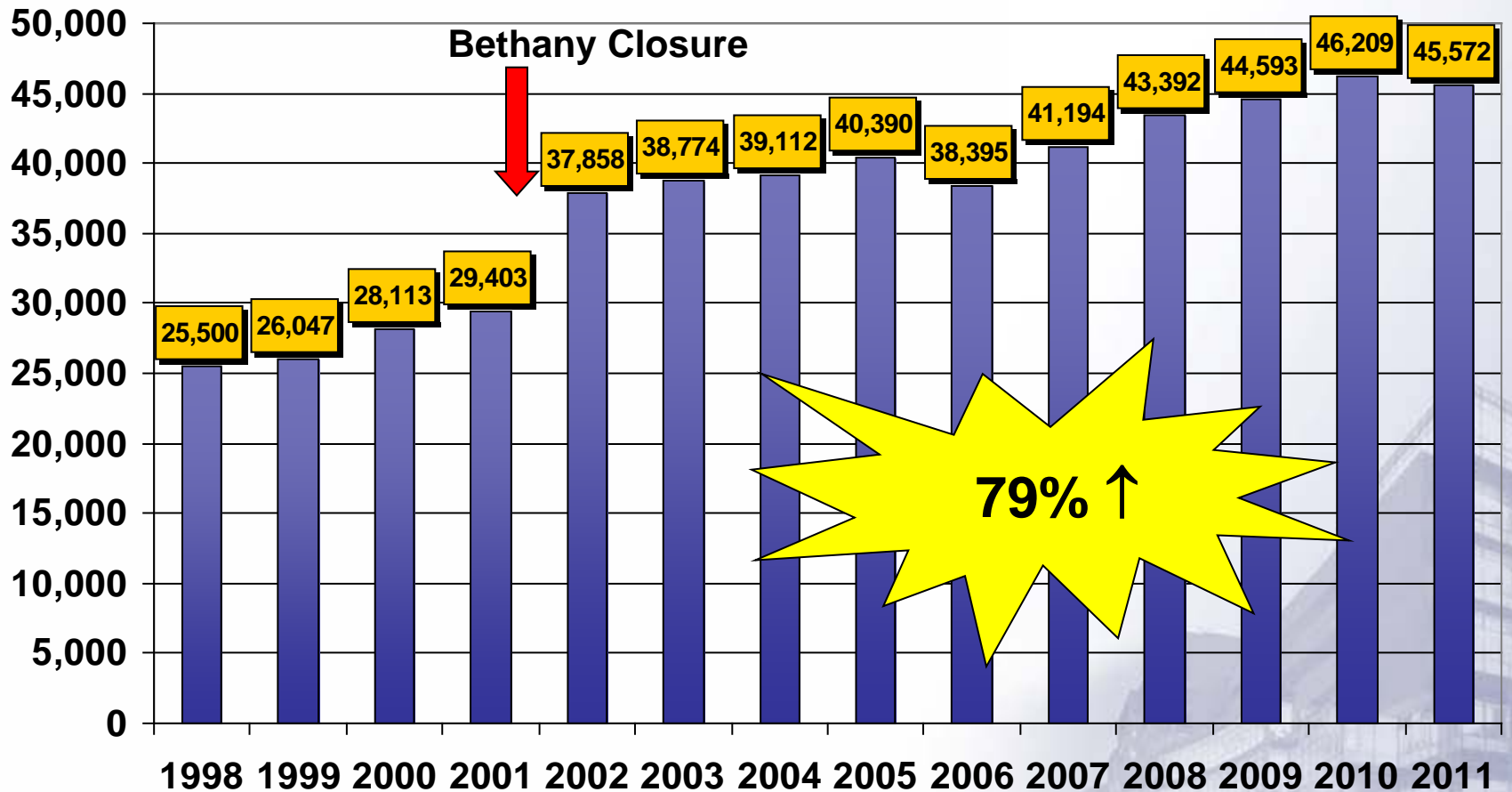
Inpatient Discharges



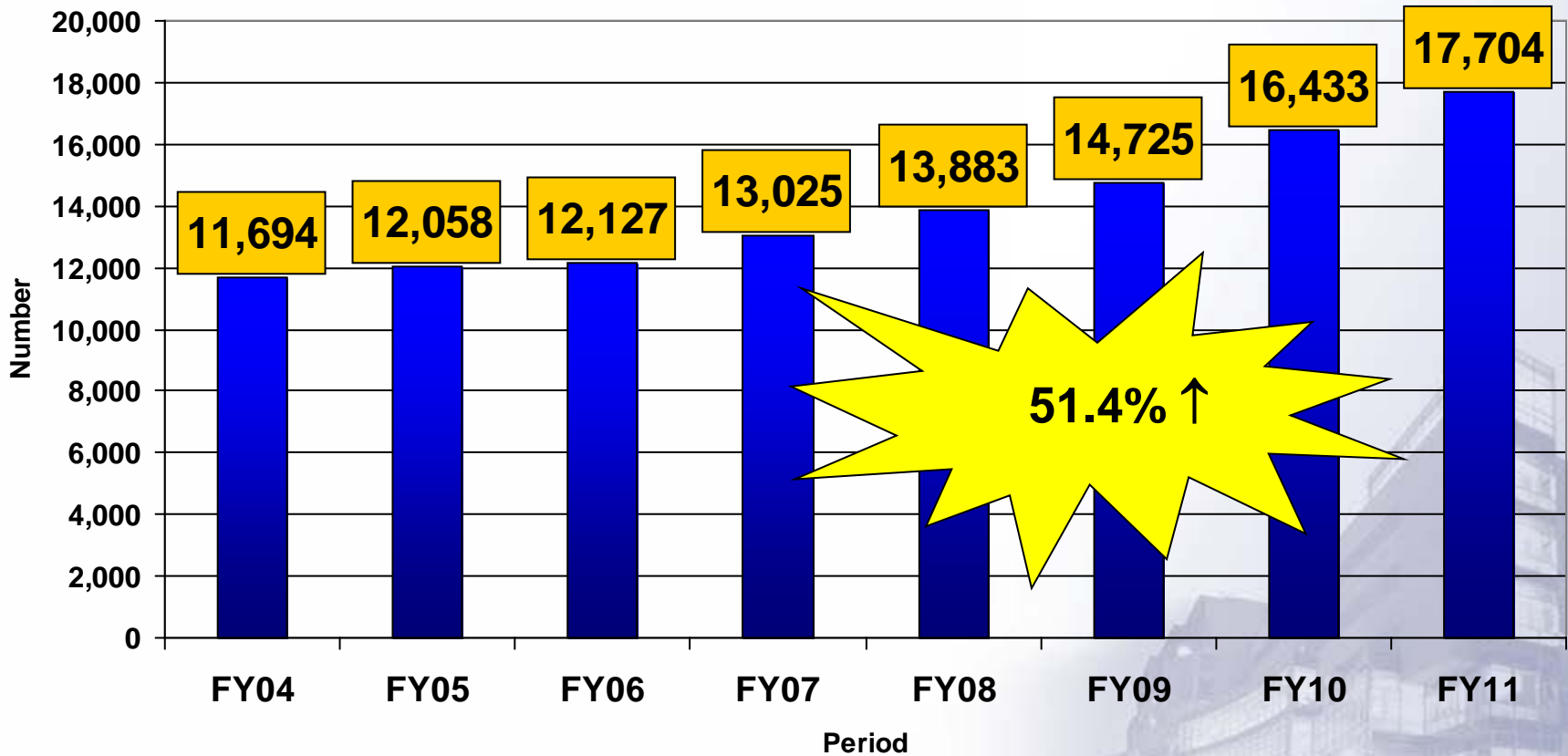
Growth - Outpatient Encounters



Growth - ED Visits



Growth - OR Volume



Final Lesson Learned

“When a team
outgrows individual performance
and learns team confidence,
excellence becomes a reality.”

Joe Paterno

