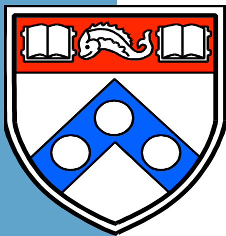
Clinical leadership on the unit and at the top — a "Swiss Army knife" for sustained performance

University of Pennsylvania Health System

September 19, 2008



University HealthSystem Consortium

2008 Quality and Safety Fall Forum

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Today's talk

1. First the basics
2. What it looks and feels like on the units
3. How we're getting there — and what we're doing to sustain the gains
4. A "campaign" approach to change

A new take on accountability

From “thou shalt” to developing the **everyday work practices — large and small** — that make it possible for people to take responsibility, up and down the organization.

And a new take on innovation

Helping the organization **learn from itself** — and look for places where pockets of innovation are **already beginning to emerge.**

The leader's job is to be **opportunistically strategic** — to develop the radar to recognize those opportunities and build on them.

It’s not the “Unit Clinical Leadership” model, it’s the approach

If you leave today saying, “This model doesn’t apply to us,” or “Penn has more money than we do,”

— then we haven’t done a good job **communicating what this talk is about.**

1 First the basics

We were here last year to talk about how we developed the Unit Clinical Leadership model — **those slides are in your packet.**

TOWARD AN INTERDISCIPLINARY MODEL OF CARE

October 2005
Dean of School of Medicine & Health System CEO charter a group of leaders to conduct a Professionalism Self-Study to identify why this is happening and how to stop it.

The leaders facilitate 18 focus groups to:
- ID stressors
- Seek out existing practices that other groups are using to reduce the impact of the stressors.

December 2005
Study identifies 22 key practices.

January 2006
Leaders prioritize the practices and create a plan to foster more widespread use.

Fall 2006
Pilot sites implement selected practices:
HUP OB/GYN
HUP Perioperative Services
HUP Emergency Department

PPMC Unit-Based Clinical Leadership
Creation of CMOs/CNOs Affinity

PORTS REPORT
Incident in the O.R. Physician lashes out verbally at Nurse.

ORTS REPORT
Disruptive rgument etween nurse d house aff.

INITIATIVES THAT FEED EACH OTHER

Professionalism

Winter 2007
CMO/CNO partner to develop *Blueprint for Quality and Patient Safety* as well as budget priorities.
- Results in 4 imperatives & 4 priority actions
1. Accountability - Unit Joint Leadership
2. Reducing Unnecessary Variations in Care - Reducing Hospital Acquired Infections
3. Coordination of Care - Interdisciplinary Rounding
4. Transitions in Care - Transition Mgt./Discharge Planning

May 2006
CMO Retreat

August 2006
PAH Budgeting for Quality

Fall 2006
CNOs/CMOs interview stakeholders

January 2007
Interdisciplinary rounding conference identifies criteria for interdisciplinary rounding at UPHS.

CNOs/CMOs commit to implementing interdisciplinary rounding

Feb - June 2007
CMOs/CNOs jointly work to ID roles, accountabilities and infrastructure to support implementation of clinical strategy and interdisciplinary rounding.

July 31st / Aug. 15th, 2007
Physician, Nurse Manager, Quality Coordinator Orientation for 13 pilot sites

Clinical Strategy

Magnet initiative mobilizes organization

June 2007
Magnet Status awarded to HUP

Fall 2006 - January 2007
Center for Evidence-based Practice recommends unified vision for Health System to address patient-centered transitions of care moving forward, *including: discarge efficiency, communication w/inpatient & outpatient providers, specific attention to "vulnerable" patients*

October 2005
HUP Patient Flow initiative chartered by Ralph Muller and Garry Scheib

January 2006
HUP Care Coordination meetings initiated

February 2006
HUP NaviCare "go-live"

February 2007
PAH Patient Flow commenced

March 2007
PAH Care Coordination meetings initiated

April 2007
PAH NaviCare "go-live"

Patient Progression / Transition Planning

OCTOBER 2005

JANUARY 2006

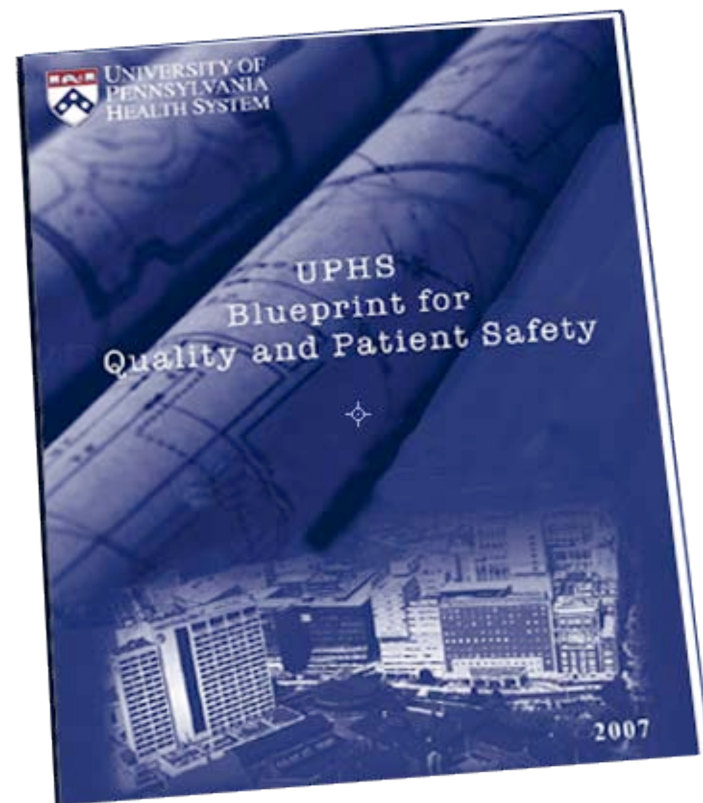
JANUARY 2007

03-05-08 REVISION

Blueprint for Quality and Patient Safety — the framework for clinical strategy at UPHS

The CMOs and CNOs from across UPHS' three hospitals and the homecare agency have **banded together to develop** the Blueprint for Quality and Patient Safety.

UPHS Blueprint for Quality and Patient Safety	
UPHS' **overarching quality goal** is to prevent the preventable — **reduce QIII/QIV mortality** and **reduce 30-day re-admissions.**	
Four Imperatives	**Priority Actions**
1. Transitions in care	▪ Transition planning ▪ Medication management
2. Reduce variations in practice	▪ Reduce hospital-acquired infections ▪ Reduce medication errors
3. Coordination of care	▪ Interdisciplinary rounding
4. Accountability	▪ Unit clinical leadership



We needed a “Swiss Army knife” — no more whack a mole

The institution was tired of playing “whack a mole.” Every year we’d develop three or four new initiatives — but then another problem would come along.

We needed a **multi-purpose structure on the units** to handle almost any problem.

“This isn’t a project, it’s a way of doing things. You can **bolt different strategies onto it.**”

—UPHS Chief Financial Officer

What does our “Swiss Army knife” look like?

Three-Way Partnership at the Core of the Unit Clinical Leadership Model

The Unit Clinical Leadership model is the partnership of a **Physician Leader** and **Nurse Leader** at the unit level — with a dedicated **Quality Coordinator** as the essential third member of the team.

We started modestly at first, so the teams could learn to work with each other

Four Core Activities in the Pilot Year	Raising the Bar in FY'09
◆ **Weekly operations meeting** to review metrics & plan ahead ◆ **Interdisciplinary rounding** ◆ **Orienting house staff** ◆ **Two improvement projects** aimed at health system objectives like reducing hospital-acquired infections.	**All these (and sustain the gains)** Plus a more **extensive set of improvement targets**

It takes the whole unit — ratios and leverage

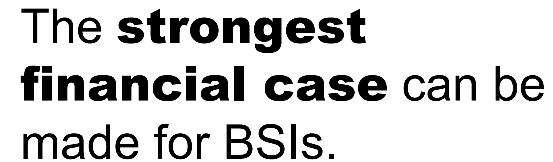
Unit leadership alone won't make the difference. The model includes the **staffing infrastructure to succeed.**

	Assist Nurse Manager on Off Shift and Weekends	Charge Nurse without Patient Care Duties	Clinical Nurse Specialist/ Educator	1:5 RN Ratio	1:10 CNA Ratio
What	One per unit on off shift. Units share on weekends.	One per unit. Rotational assignment.	At least .5 FTE per unit	5 patients per RN	10 patients per Certified Nursing Assistant
Why	Provides strategic view and continuity on off-shift and weekends	Handles the "air traffic control" that frees the nurse leader to partner with physician leader and frees the nurses to focus on patient care	Staff and patient education make the other roles more effective	Allows the unit to focus on quality agenda	Provides leverage for the nursing role

The Unit Clinical Leadership teams are showing results already — here are the headlines

On the 13 pilot units:

- **Bloodstream infections** are going down.
- **Urinary-tract infections** are going down.
- **Medication reconciliation** accuracy is improving at both admission & discharge.
- Additional projects aimed at **reducing variations in practice** are also showing results.



The **strongest financial case** can be made for BSIs.

98 fewer BSIs in FY’08, for a **cost savings of $1,881,404.**

A return on investment is also expected in **lives saved, fewer readmissions**, regulatory **compliance, patient satisfaction,** and interdisciplinary **collaboration and communication.**

And next year's targets are even higher

UPHS Blueprint for Quality and Patient Safety

UPHS' **overarching quality goal** is to prevent the preventable — **reduce QIII/QIV mortality** and **reduce 30-day re-admissions.**

Four Imperatives	Priority Actions
1. Transitions in care	• Transition planning • Medication management
2. Reduce unnecessary variations in practice	• Reduce hospital-acquired infections • Reduce medication errors
3. Coordination of care	• Interdisciplinary rounding
4. Accountability	• Unit clinical leadership

Transitions in Care — FY'09 Targets

All Units

- Increase use of homecare
- Med reconciliation on admission

Selected Units

- HUP only: 25% reduction in preventable readmits for CHF, Diabetes & Anticoagulation for patients from HCHS
- Increase appropriate use of hospice
- Core measures — heart failure discharge instructions
- Unplanned readmission to ICU

Reduce Variations in Practice — FY'09 Targets

All Units

- Reduce CR bloodstream infections
- Reduce urinary tract infections
- Time to admin of STAT antibiotics
- Decrease rate of DVTs & PEs
- Decrease falls with injury
- Decrease pressure ulcers
- Adherence to hand hygiene

Selected Units

- Ventilator-associated pneumonia
- SCIP (Surgical Care Improvement Program)
- Process improvements for high risk patient populations
- HUP only: Anticoagulation med errors (applies to HUP pharmacy, but goals are unit specific)

Coordination of Care — FY'09 Targets

All Units

- "Staff worked together" (Press Ganey)
- Likelihood of recommendation (HCAHPS)
- Anticipated discharge by patient (Patient Progression)

Accountability — FY'09 Targets

All Units

Selected Units

Timely launch of Unit Clinical Leadership team

University of Pennsylvania Health System

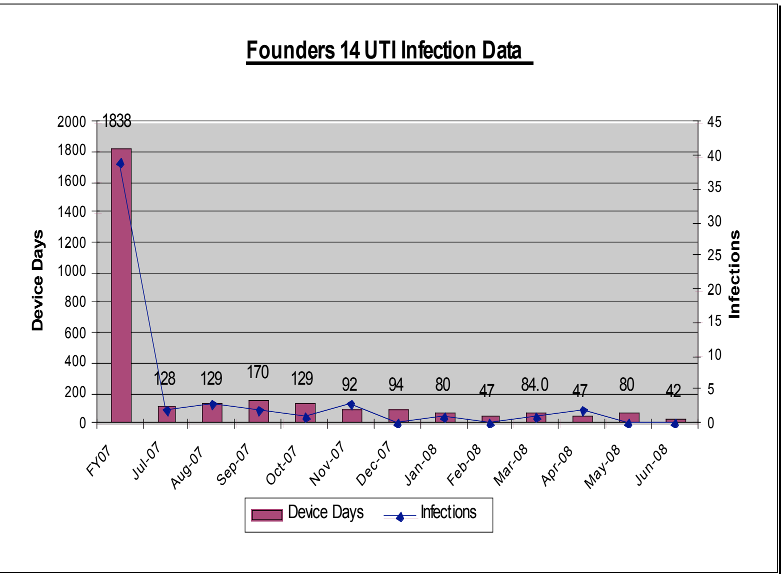
UPHS has committed to thirteen more units in FY'09 — with more over time, if results sustain

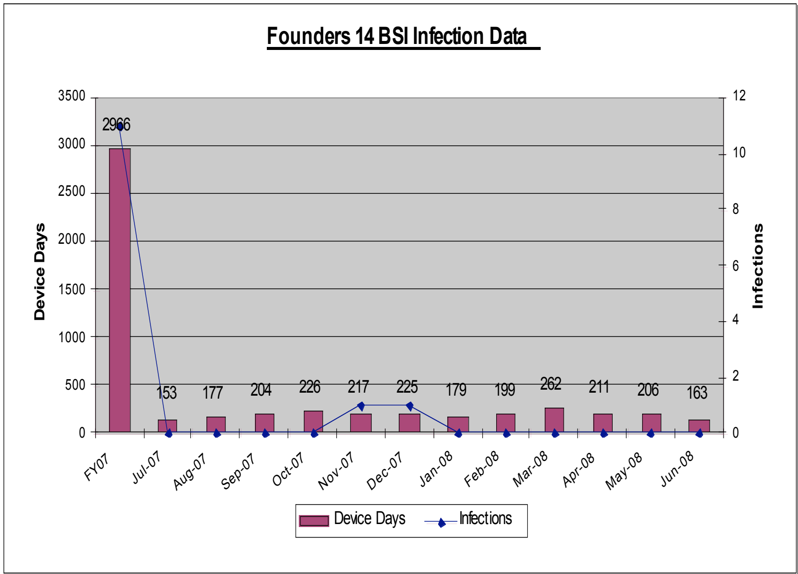
Hospital	FY'08 — 13 units	FY'09 — 13 new units (26 cumulative by end of fiscal year)				FY'10	FY'11
		Q1: Jul-Sep	Q2: Oct-Dec	Q3: Jan-Mar	Q4: Apr-June		
HUP	◆ Founders 12 ◆ Founders 14 ◆ Silver 11 ◆ Rhoads 6 ◆ Rhoads 7				Fully up and running: ◆ Founders 10 ◆ Silver 10 ◆ Rhoads 1 ◆ Rhoads 3 ◆ Ravdin 6 ◆ Dulles 6	◆ Founders 11 ◆ Silver 9 ◆ Silver 12 ◆ Rhoads 4 ◆ Ravdin 9	◆ Founders 5 ◆ Silver 7 ◆ Rhoads 5 ◆ MICU ◆ SICU ◆ CCU ◆ ICN
PPMC	◆ 4 South	Recruiting, Orientation, & Education			Fully up and running: ◆ 5 South ◆ 5 East ◆ MICU	◆ ACE ◆ CCU ◆ SICU ◆ 3 East ◆ 3 South ◆ 4 East Evaluate remaining: ◆ ORs	
PAH	◆ 5 Cathcart ◆ 6 Cathcart ◆ 7 Scheidt ◆ CCU ◆ ICCU ◆ ED ◆ L&D				Fully up and running: ◆ 4 Cathcart ◆ 7 Cathcart ◆ 4 Preston ◆ 5 Preston	Evaluate remaining: ◆ ORs ◆ ICN ◆ Inpatient psych	

2 What it looks and feels like on the units

On the ground at 4 South, Penn Presbyterian Medical Center

On the ground at Founders 14, Hospital of the University of Pennsylvania





3 How we're getting there — and what we're doing to sustain the gains

We’ve stuck together as a CMO/CNO alliance …

Our alliance is getting stronger and stronger — and we’re **doing it through the work we’re taking on:**

- Unit Clinical Leadership
- Transitions in Care
- Medication Management
- Quality Redesign

Unit Clinical Leadership is the **foundation that makes the others possible.**

It’s taken some **hard conversations among ourselves,** but we’ve stuck together through that as well.

We've sneaked up on the institution …

For example, **no one believed we'd be able to recruit enough physicians** for the Unit Clinical Leadership teams.

But we tried things like this:

- Looked for **natural affinities and career goals**
- **Uncovered** physicians already playing the role
- **Asked the nurses** who they wanted
- Put **"medical quarterbacks"** on surgical floors
- Focused on **hospitalists** where that makes sense

We're going for the **tipping point** where momentum and expectations begin to feed on themselves.

We've focused on the everyday infrastructure of accountability …

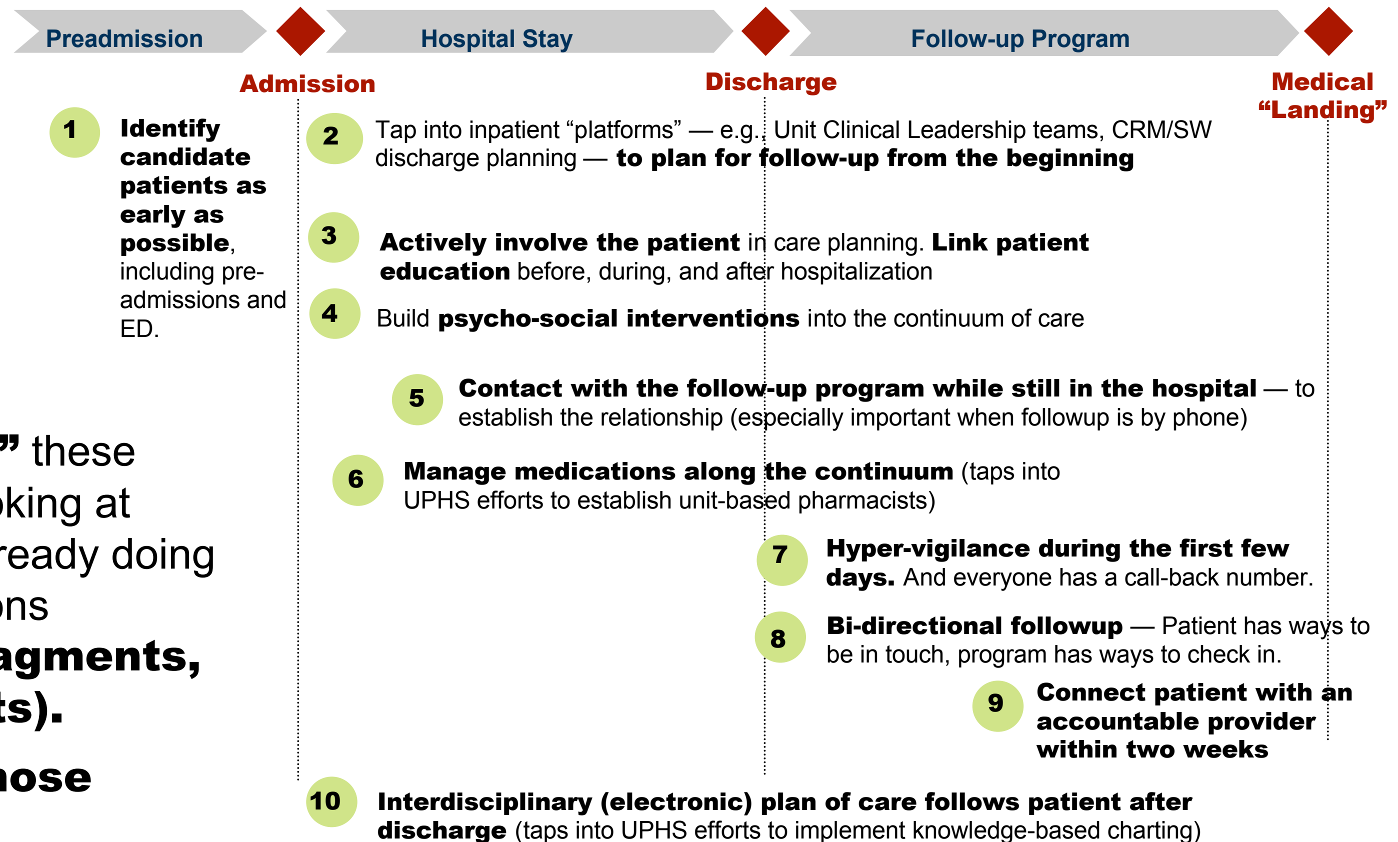
The ordinary, everyday work practices — some big, some small — that make it possible for people to take responsibility:

- Teams meet (monthly) one-on-one with their CMO/CNO pair, for coaching and troubleshooting
- Reallocated an FTE to establish a project manager for the overall program.
- Engaging the Clinical Directors and Medical Directors to take on the coaching role over time
- Clinical tools and resources for improvement targets — BSIs, UTIs, DVT/PE, falls, pressure ulcers, surgical infections.
- CMOs & CNOs meet together (monthly) to strategize and keep things on track
- Reporting the teams' metrics across the health system
- Ongoing communication with the UPHS community embedded into existing committees and venues.
- Regular links to existing governance committees

We're tapping into larger efforts and other people's energy …

- Two more hospitals seeking **Magnet** recognition
- **Unit-based pharmacists**
- "Unit Clinical Leadership meets **Transitions in Care"**
- **IBC** looking to support transitions programs, to keep readmissions down
- **Patient Progression**
- Appetite to **decentralize aspects of the Quality function**
- **Knowledge-based Charting** (electronic medical record)
- UPHS looking for **leadership development** programs

We're helping the organization learn from itself …



We **"discovered"** these principles — by looking at what people are already doing to improve transitions **(early pilots, fragments, pieces and parts).**

And we drew those people into our alliance.

We've trusted ourselves and the organization to figure it out …

We don't know what the final product will look like.

We're **relying on the organization to experiment** and learn from itself — and we're trying to **build that capacity into the culture.**

“ **Culture eats process maps for lunch.** ”

— UPHS Chief Nurse Executive

We're creating "educated consumers" …

Conferences for 100+ stakeholders

Transitions in Care Conference — To learn what's available and give feedback to the transitions programs

Transitions in Care "Marketplace" — To match specific hospital units with specific transitions programs

Interdisciplinary Rounding Summit — To learn from units at various stages of implementing interdisciplinary rounding, and to develop a system-wide set of design specifications

We’re offering “scarce goods” to attract people ...

For example, **it’s a tight market** for the kinds of Quality Coordinators we need to recruit.

So we:

- Offered **Six Sigma Green Belt and Black Belt** certificates. On site, can use educational benefits.
- Not a required “program,” but an opportunity to **develop a competency**
- The credential has attracted three cohorts to the training so far — **with a waiting list** for the next class
- And it has created a **pipeline** for the Quality Coordinator job.

We’re building a new alliance with the financial side of the house …

The 7:00 am breakfast meeting with the health system CFO

“We don’t want Finance to set the margins for the hospitals without input from the Quality strategy first. And we want to do that at a system level.

Can we count on you?”

— UPHS CMO & CLO

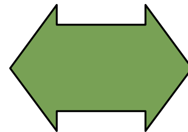
We're getting out ahead of the budget cycle ...

The old way	This year
First step: set margins for each entity; entities are **locked in.**	Discussion of system-wide quality initiatives **before margins are set.**
Entities **(separately) submit budgets.**	CMOs and CNOs banded together to submit a **joint budget** for system-wide quality initiatives they all agreed on.
Negotiation occurs **after budgets are submitted.**	Negotiation occurred **before budgets were submitted:** ◆ Across entities ◆ With the financial side of the house (two big planning retreats)

We're reframing the negotiations across the separate hospitals and with Finance ...

A "Two Goods" Framework for Problem Solving

System-wide quality initiatives to improve patient outcomes



Fiscal accountability — Individual hospitals are responsible for their own bottom line

Both are clearly "good," but they can appear to be in conflict — how can an individual hospital fund system-wide quality initiatives if it also has to meet its bottom line?

But what if system-wide quality initiatives can actually increase revenues for the separate hospitals?

We're making the case that Quality can improve the bottom line ...

Quality, Public Policy and Revenue are beginning to Intersect

Nationwide pressure to manage healthcare costs & utilization

Sharp declines in length of stay constrain the functions that hospitals once provided

IBC pay-for-performance contract — $13M at stake for UPHS over next five years

Attracting faculty who do translational research depends on the quality and accessibility of an institution's clinical data

MS DRG changes — $4M additional opportunity for UPHS in Medicare re-imbursement, if new MS DRGs are captured correctly

Public reporting of patient satisfaction scores, hospital infections, etc., influences patients' choice

Gain-sharing contracts with insurers, as readmissions fall.

Present-on-admission indicators — unless we document it, UPHS "owns" the financial responsibility

Clinical risk reduction means fewer claims and less money tied up in reserves

Quality initiatives not only **improve patient care,** but give UPHS an **advantage in the marketplace** and help us **attract faculty** with a reputation for translational research.

We're knitting with hard wire — aligning financial incentives across the system …

Alignment Worksheet — How Can the Chairs Support Quality on the Units?

		CPUP Departments																		
	Quality Targets for Hospital Units - FY'09	Ophthalmology	Radiology	Emergency Med	Path & Lab Med	Surgery	Neurosurgery	Orthopaedic Surg	Maxillofacial Surg	OBGyn	Neurology	Anes & Crit Care	Otorhinolaryngology	Radiation Onc	Dermatology	Phys Med & Rehab	Medicine	Neonat. & Newborn	Family Medicine	Psychiatry
	I. Transitions in Care																			
	All Units																			
1	Increase use of homecare			X																
2	Med reconciliation	X						X			X		X	X						X
	Selected Units																			
3	HUP only: 25% reduction in preventable readmits for CHF, Diabetes & Anticoag. for patients from HCHS																			
4	Increase appropriate use of hospice																X			
5	Core measures — heart failure discharge instructions																			
6	Unplanned readmission to ICU					X											X			
	II. Reduce Unnecessary Variations in Practice																			
	All Units																			
7	CR BSI					X											X	X		
8	UTI																			
9	Time to admin of STAT antibiotics			X													X			
10	Decrease rate of DVTs & PEs					X	X	X		X	X	X				X	X			
11	Decrease falls with injury						X				X					X				
12	Decrease pressure ulcers										X					X				
13	Adherence to hand hygiene	X		X					X	X	X	X		X	X	X			X	X
	Selected Units																			
14	VAP					X						X					X			
15	SCIP (Surgical Care Improvement Program)					X		X		X		X								
16	Process improvement for high risk pt. populations																			
17	HUP only: Med errors (applies to HUP Pharmacy, but goals are unit specific) (NEED PHARM INPUT)																			
	III. Coordination of Care																			
	All Units																			
18	"Staff worked together" (Press Ganey)																			
19	Likelihood of recommendation (HCAHPS)																			
20	Anticipated discharge by patient (Patient Progression)																			
	IV. Accountability																			
	Selected Units																			
21	Timely launch of Unit Clinical Leadership team																			

We negotiated with Chairs and other UPHS leaders to **align their year-end bonus targets** to support quality on the units.

We asked them to focus on **what they can do, at their level,** to support the unit targets.

The "X's" in the Chairs worksheet indicate connections that are potentially most relevant.

What’s next?

Breaking News — The Dilemma of Success

In July and August, **empty beds caught us by surprise.** Partly because of fewer BSIs and VAPs, we’re seeing reduced days and a lower census.

We’re **committed for the long haul.**

We plan to step up **conversations with our payers;** we’re looking for **gain-sharing arrangements** that take account of how we’ve been able to keep our patients healthy.

4 The “campaign” approach to change

There’s good **social science behind what we’re doing**

To change behavior, you change the everyday work practices. They're the building blocks of culture.

New work practices create new behavior — what people actually do, on the ground.

These work practices are the **building blocks of culture.** Each by itself may be small, but **together they can move the organization's culture.**

To change work practices, you have to put in place the supports and infrastructures that attract people to the new practices and make them easier, not harder.

"You are Here"

We're been intervening here,

in order to make a difference here.

System of Supports, Large and Small

- Data
- Tools
- Scheduling
- Coaching, peer learning
- Funding
- Aligned financial incentives

An organization can learn from itself how to make the changes it needs to make

"**The future's already here — in bits and pieces.**"

Pockets of innovation are already emerging inside almost every organization — if it **learns how to look.**

The **raw material for culture change** is already present in your organization — in pieces and parts. Your organization's **culture is a renewable resource.**

“Pull” is stronger than “push.” And you can create pull for the changes you want to create.

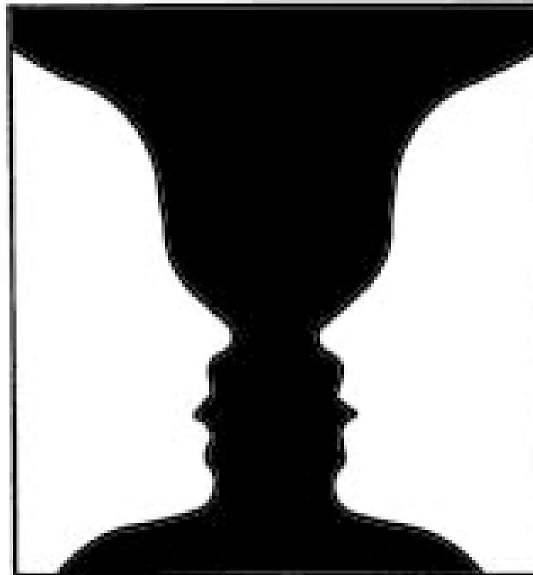
Creates pull for the changes you’re trying to create

- Tapping into **other people’s energy & momentum**
- Creating an **infrastructure of tools and supports that make it easier,** not harder
- Attaching to **something “bigger”**
- Drawing on the **urgency of deadlines** and windows of opportunity
- Establishing a **“scarce good”**
- Piggybacking on what people are **already committed to doing**

The leadership skills you'll need may seem counterintuitive

Not ...	Instead ...
Telling and selling	**Listening and amplifying**
Pushing people to change	**Creating pull** for the changes
Trying to "motivate" or "empower" others	Discovering and **freeing up energy** and passion
Thinking your way to new actions	**Acting your way to new thinking**

Figure/ground — your leadership development dollar at work



Resources — Campaign Approach to Change

Hirschhorn, Larry and Linda May. "The Campaign Approach to Change." *Change,* Vol. 32, No. 3, May-June, 2000.

Hirschhorn, Larry, "Campaigning for Change," *Harvard Business Review,* July, 2002

We welcome your thoughts, questions, and experiences …

To be in touch

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