MANAGEMENT INNOVATIONS XXVI

Poster Session

53rd Congress on Healthcare Leadership

March 22 - March 25, 2010

Chicago, Illinois
# Quality

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1. Objective of Program: The objective of the program is to improve quality, teamwork and collaboration for the nurses, nurse practitioners (NPs) and physician assistants (PAs) and physician providers on a general medicine unit, DOM5D, at Mayo Clinic Rochester. The NP/PAs and physicians will enter a patient’s room and ask the bedside nurse to give report on a checklist of safety items. The purpose of the checklists is to ensure that patient’s needs are addressed during morning rounds. This new way of rounding is an innovative approach that improves teamwork and quality of care.

2. Planning/research: The unit physician and nurse leadership met on a regular basis. A checklist of items was developed to be utilized by the bedside nurses. A process flow diagram was developed for the nurses as well as the NP/PAs and physicians. A communication plan was also developed. Success of the project will be measured by a reduction in readmission rates as well as staff satisfaction.

3. Implementation methods: The new multidisciplinary safety rounds were presented and endorsed at nursing and provider committee meetings. Small pilots were done to ensure the appropriate elements were listed on the checklist. The unit leadership team then communicated the new practice model for the unit. Nursing leadership shadowed the nurses giving report to provide them with encouragement and coaching. The physician leadership endorsed the new practice model and provided feedback to physicians who were hesitant to round in the new care model. Every provider that started service on the unit was sent an email reminder with the project background, checklist and suggestions on how to ensure successful multidisciplinary care rounds on the unit.

4. Results: The unit’s readmission rate has seen a significant decline since the implementation of multidisciplinary safety rounds with the utilization of a standard checklist. The readmission rate on DOM5D was at 15.6% when the project began. The readmission rate on DOM5D at the end of 2009 was at 9%. Provider satisfaction has improved with the utilization of checklists and new rounding model on the unit.

5. Conclusion: Multidisciplinary safety rounds on the unit were significantly enhanced with the utilization of checklists. Having the bedside nurse provide a report on the checklist components to the providers in the patient’s room effectively improved communication and teamwork among the nurses and providers on the unit. The new rounding model has also had a positive effect on the unit’s readmission rates. This rounding model is being spread to the rest of the Hospital Internal Medicine units at Mayo Clinic Rochester.
Title: Transformational Bedside Care Teams: A Retrospective Analysis

Objective of program: Robust multidisciplinary bedside care teams, rounding daily, improving patient outcomes while increasing patient satisfaction.

Planning/research methods: Hospital inpatients are increasingly cared for by multiple disciplines attempting to provide consistent treatment in a fragmented delivery system. The fundamental framework of care delivery hinges on the effective interaction and communication between disjointed disciplines. Social workers, case managers, rehabilitation therapists, and ancillary staff supplement the conventional framework of physician nurse teams to heal patients in a hospital setting; superior patient care is rooted in exceptional collaboration between these entities.

Implementation methods: Lankenau Hospital, a 330-bed suburban teaching hospital, recently undertook an extensive performance improvement initiative to redesign its internal medicine care delivery system in order to provide a foundation for collaboration. Multi-floor attending physician teaching teams were replaced with hospitalist led, geographically mapped care units compromising of a hospitalist, nurse manager, resident, intern, case manager, social worker, nurse practitioner and bedside nurse. These teams conduct formalized, coordinated patient rounds ensuring explicit daily care plan delineation, robust discharge planning as well as multidisciplinary clinical education while focusing on quality initiatives including, but not limited to, appropriate care measures, infection prevention, and family communication.

Results:
• Patient Satisfaction – HCAHPS
  – Rate Hospital 9 or 10 moved from 64% to 72%
  – Currently ranked in the 91st percentile in the state of Pennsylvania for Rate Hospital, and 97th percentile in the state for Definitely Recommend Hospital
• Clinical Outcomes
  – 25% reduction in complication rate index
• Core Measures
  – 25% improvement in Hip and Knee appropriate care score
  – 10% improvement in Pneumonia appropriate care score
  – 5% improvement in Congestive Heart Failure appropriate care score

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A Successful “Micro – Accountable Care Organization”
As a Model for Evolving Payment Reform in Massachusetts

Objectives
The Massachusetts Special Commission on the Health Payment System has proposed a move away from a fee-for-service payment methodology in favor of “global payment” that shifts payments toward performance measures and health outcomes. Global payments would be made to provider networks structured as “Accountable Care Organizations” (ACOs), collectively capable of providing a full range of services to encourage the formation of medical homes. Mercy Medical Center (MMC), in partnership with one of the larger physician practice groups affiliated with the health system, Hamden County Physician Associates (HCPA), developed a “micro ACO” designed to:

- Enhance care management to improve care and reduce costs
- Improve the management of chronic disease
- Reduce hospital admission and readmissions
- Improve patient satisfaction
- Manage financial risk for performance under a global payment arrangement

Methods – Description of the “Micro-ACO” Model
As an alternative to Medicare fee-for-service provider arrangements, MMC and HCPA entered into a risk arrangement with a managed Medicare plan and assumed care coordination and financial responsibility for 5100 members. A structural framework was designed and key competencies developed by both the physician practice group and health center to closely manage care, deliver disease management services to high risk patients, provide quality oversight and medical direction, and tightly manage budget and costs. Performance incentives were aligned so that health cost savings are shared by participating HCPA physicians and MMC if quality and cost effectiveness benchmarks are achieved, placing an emphasis on efficiency and quality rather than volume and intensity.

Implementation
Under the “micro ACO” care delivery is closely integrated and well-managed. Care is structured around a “medical home” model that includes close coordination of outpatient and inpatient care, case management, and disease management programs for select chronic conditions. The care management team includes the primary care physician, physician consultant-leader for disease management and care management elements, nurse care coordinators empowered with care management protocols, hospitalist care (hospital and nursing home rounding), and robust homecare nursing/therapy utilizing care monitoring technology (Phillips Telehealth system). Approximately 300 patients with COPD or CHF, representing the top 3% highest cost patients, were included in the disease management component of the program; the disease management team and the physician consultant serve as principle contact for daily patient care issues.

Payment allocation includes monthly per-member, per-month payment to primary care physicians and a year-end pay out of pro-rata medical service fund surplus. Key differences in this arrangement from prior capitation models include the linking of performance measures with an emphasis on patient-centered care, an improved risk adjustment model, better health information technology infrastructure, and robust monitoring to measure activities and guard against unintended consequences (ensure quality care rather than limiting care). This approach also successfully engages the patient/consumer by involving the patient in their care, promoting healthier lifestyle and improving the self management of chronic illness.

Results
The “micro ACO” achieved the goals of reducing hospital admissions and readmissions and optimally managing chronic disease to improve care and reduce costs:

- Utilization was decreased to 173 admissions per thousand, compared to 380 admissions per thousand in a comparable, unmanaged population; length of stay averaged 5.8 days compared to 6.2 days in an unmanaged population.
- Patient satisfaction was improved with over 86% rating the program excellent or very good in overall satisfaction; patients scored individual survey categories as “excellent” or “very good”, with 1% or less rating “good” and 0% “fair” or “poor”.
- Financial performance was equally strong with a 3% surplus in hospital service fund expenses and 23% surplus in medical (physician) service fund. Overall spending for the program population was 12.8% lower than an unmanaged population of the same size while physician revenue was greater than conventional Medicare reimbursement.

This successful model is currently being used to develop a formal, comprehensive Accountable Care Organization designed to compete for provider contracts under the evolving Massachusetts payment reform movement.
Improving Stroke Care in Rural Wisconsin Hospitals

Objective- Wisconsin is working to improve the system of care to assure that all patients in every part of the state are being treated/transferred in a timely manner and are being treated with evidence based stroke guidelines. This is Year 2 of the project.

Planning/Research- The Office of Rural Health, The Wisconsin Hospital Association and the American Stroke Association continue to partner on this initiative and it has grown to 29 hospitals. Over 1500 patient records entered from this rural stroke group through Q1 2009. Through this data, trends, barriers, and overall improvement can be measured.

- State partners found that rural and critical access hospitals did not know many of the stroke guidelines, have appropriate transfer protocols in place and did not have any type of quality improvement process in place to collect and improve stroke measures.
- The Year 1 rural hospital data shows a large gap in stroke measure compliance in comparison to all Wisconsin hospitals. The Rural Stroke Improvement group plans to educate hospitals to be prepared to treat patients and work to improve outcomes.

Implementation Methods- Using the Get With The Guidelines online Patient Management Tool through Outcome, the hospitals enter patients that come through the Emergency Department with a TIA or Stroke.

- Hospitals that give tPA and transfer (or drip and ship) work to improve data on establishing the time frame of onset of symptoms, improving time to CT, understanding the eligibility and contraindications of tPA including best practices with transfer.
- Hospitals that have patients that present after the window for tPA work on in-hospital and secondary prevention measures to improve outcomes and reduce the risk of a reoccurring event.
- Four in-person group workshops took place and webinars offered monthly.
- Hospitals completed a team charter indicating the areas that need improvement based on measure gap analysis.

Results- Year 2 results are based on data from Quarter 4, 2008 through Quarter 3, 2009

- Improvement has been seen with defect free stroke care, meaning that all patients that are eligible for a stroke intervention receive that intervention. In Q4, 2008, defect free stroke care was given to 63.4% of stroke patients in the rural group. This has steadily improved and was 77.8% in Q3 2009.
- The data is also showing positive trends in shortening the time from triage to CT.
- The percentage of hospitals getting pre-notification from EMS prior to receiving a stroke patient improved to 70.5% in the rural community versus 64.7% in all WI hospitals.
- The 2 hour treated in 3 hour tPA measure remains the lowest performer at 29.3%

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Specifically, The Emory Clinic is moving into a new era of patient care delivery, operations and business management that is focused on transforming care by achieving “The Ideal Patient and Family Experience” in ambulatory care in an academic healthcare center setting that delivers consistent, reliable, and excellent clinical and service outcomes.

Planning: After identifying the need to create “The Ideal Patient and Family Experience,” The Emory Clinic implemented a Four Pillars of Ambulatory Care Management structure focused on Clinical Quality, Patient Access, Clinical Care and Service & Referral Management. The priority of the Four Pillars is to achieve a synchronized, efficient patient and family experience by partnering with clinical sections to create standard processes, defined accountability, and coordinated patient management.

Implementation: The Emory Clinic has aligned the Four Pillars with its governance model to ensure coordination among clinical sections. Twenty three workgroups have been formed to carry out the objectives of the Four Pillars. Each workgroup has defined roles and resources as well as a charter that defines the purpose, scope, project plan and metrics for success. “Four Pillars Tuesday” has been implemented to designate a day of the week for workgroups and leadership to conduct working meetings and provide report outs to integrate objectives and drive change.

Results: The new model of patient and family centered care and service delivery is aimed to ensure The Emory Clinic excels in an increasingly competitive environment by improving quality outcomes, patient satisfaction, financial performance, revenue cycle management, physician and employee engagement, patient access and exam room utilization. Through the implementation of this structure, The Emory Clinic has initially achieved the following system-wide results: increased patient satisfaction scores as measured by Press Ganey to win three Journey of Improvement Awards for achieving statistically significant change of mean score points in overall satisfaction, developed the structure to incorporate twenty three Patient and Family Advisors on department and Four Pillars improvement teams, and was recognized at the University HealthSystem Consortium Faculty Practice Solutions Center Users Group Meeting for best demonstrating innovation and an effort to lead performance improvement. Specifically, the following outlines the key focus areas and accomplishments to date within each of the Four Pillars:

Clinical Quality: Focus areas include patient outcomes, safety, accreditation, Computerized Physician Order Entry, Emory Electronic Medical Record and quality improvement.
1) Implemented “Patient Safety Fridays” as a designated time, each week, to review general patient safety issues and requirements set forth by The Joint Commission.
2) Formed a Physician Steering Committee for Clinical Redesign that is responsible for reviewing and recommending strategies to redesign the academic practice model and manage two-way communication between department physicians and Clinic Administration.
3) Standardized medication and pharmaceutical management across seventy seven practice sites.
4) Implemented a patient survey tool to assess compliance with hand hygiene that continues to be used for monitoring purposes.
5) Continued implementation of the Emory Electronic Medical Record in the ambulatory environment with input from the Physician Steering Committee has resulted in further standardizing care across practice sites.

Patient Access Support Services (PASS): Focus areas include patient access, scheduling and call center management.
1) Developed and launched clinic wide access reports to include No-Show Rates, Third Next Available Appointment and Room and Appointment Utilization.
2) Launched pilot to target No-Shows and fill last minute cancellations.
3) Completed physician master schedule analysis for eleven clinical departments to optimize physician schedules, increase capacity and create efficiencies in the scheduling process.
4) Conducted current state analysis of pre-appointment communication and consolidated the management of appointment confirmation communication.
5) Continued implementation of industry best practices in call centers, including initiating the roll-out of a quality monitoring and workforce management tool and operational consolidation.

Clinical Care: Focus areas include initiatives to standardize care processes in the clinic environment.
1) Redesigned key processes for the following functions: prescription refill, patient check-in, patient rooming, patient checkout, medication reconciliation, medication administration and results management.
2) Developed and tested phone triage protocols in three clinical areas.
3) Developed new standard patient intake form with defined electronic process for dissemination of information across specialties.
4) Reviewed and monitored nursing job description competencies through Clinical Skills Fairs.

Service and Referral Management: Focus areas include patient and physician referral sources relationship and satisfaction management.
1) Standardized customer service education and training for front line supervisors across The Emory Clinic.
2) Redesigned Clinic Ambassador role to focus on patient and family experience improvement, coaching and training and complaint handling and service recovery.
3) Implemented Daily Huddles as a time, each business day, to review a behaviorally specific Service Standard and National Patient Safety Goal, recognize employees that provided excellent service and identify opportunities for improvement.
4) Developed an Emory Healthcare Referral Management structure to intentionally design, standardize, and coordinate system-wide referral management short and long term technical, operational, and communication solutions.
5) Designed the tool and processes to implement a single source for accurate internal and external provider information at Emory Healthcare, including clearly defined and documented processes and accountability for adding, updating, and maintaining provider information across various information systems.
6) Increased awareness of new physicians and their specialty areas as well as opportunities for internal and external referrals through the development of a New Provider Announcement.

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A Multi-Disciplinary Approach to Improving HCAHPS Scores

Objective

Join the Director of Environmental Services (EVS) to come up with a plan that would address our low Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score regarding cleanliness.

Planning

Our HCAHPS score in the cleanliness category was at an all time low. Of the patients surveyed, 43% answered “Always” when asked: During this hospital stay, how often were your room and bathroom kept clean?

To address this problem we confronted it from two approaches. The first approach looked at what the EVS department could do to help improve the scores. We decided to try and make the EVS technicians more visible. We accomplished this by adding a second room clean by the EVS Techs in the afternoon. We also added an evening “turndown” service that would require the EVS Techs to make a third visit to the room. We also added EVS Supervisor rounds in the morning to address any concerns a patient might have.

The second approach looked at what the Nursing department could do to help. We decided that many nurses could do a better job of keeping the patient room tidy. We also noted that nursing could do a better job of removing clutter after dressing changes and other tasks. We also felt we could do a better job of removing dirty linen in a more timely manner. The nursing managers would also make patient rounds to address any problems while soliciting feedback.

Implementation

The first step in implementation was to announce expectations at EVS staff meetings. The EVS Technicians received additional training in engaging the patient and developing a relationship with them. We would also share our HCAHPS results with the EVS Technicians on a monthly and ongoing basis.

The second step was to inform nursing managers of the findings, expectations, and interventions necessary to help improve scores. I met with each nursing manager individually to address concerns and explain the plan. They were to bring these issues up at staff meetings. We would also share our results with the nursing managers and their staff.

Results

We were able to increase our scores to 81% over a six-month period.

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OBJECTIVE OF PROGRAM:
Organizations constantly strive to offer the best possible care to their patients. Through systematic planning and feedback from internal and external stakeholders, modifications are made to how services are delivered to optimize services. Unfortunately, most data received from periodic regulatory reviews both internal and external to the organization, provide feedback to observations that in many cases should have been rectified earlier at the local level if a daily assessment was performed. This management innovation will demonstrate how organizations can utilize self-automated, real-time patient satisfaction data to better understand their patients’ preferences, needs, individual interaction with staff, access to services, and understanding of medical information provided when receiving care. Through the leveraging of technology, scan trons, written survey, and the employment of large staffing or outsourcing of businesses can be drastically modified, as good, strongly sampled patient feedback can be easily obtained in an efficient and timely manner.

PLANNING/RESEARCH METHODS:
Through the Competency Development for Leaders of the 21st Century Program offered within Veterans Health System, I worked with a team of professionals from the Miami, Orlando, Tampa, Bay Pines, West Palm Beach, and San Juan Veterans Affairs Medical Centers to investigate how our organization is currently collecting patient satisfaction data. We learned that although many of these facilities collected data in different ways, all patient satisfaction data was either collected via written feedback locally or outsourced through an external vendor. Clinical and administrative staff noted that although it was good to have feedback available to them, the information provided to them was typically not current. Staff also found that the sample size of the patients completing surveys was below 10% in all cases investigated. Through further assessment, we learned that the reasons most surveys are not completed is due to veterans feeling that many are too lengthy, hard to read (visual and/or language barriers), and not always clear as to how to answer certain questions presented. Reasons identified by staff as to why satisfaction data was not readily available was lengthy processing steps (input bubble sheets into scan trons, manually consolidate results) and having to take time to analyze the data before submitting on to staff.

IMPLEMENTATION METHOD:
Developed a database using File Maker Pro 9 to collect veteran feedback and automatically mine data for real-time analysis. Both the Miami and Tampa Veterans Affairs Medical Centers’ Outpatient Diabetes Mellitus Clinics were utilized in the beta test. Training was provided to teams’ point of contact at each location on how to load the program, and was given administrative rights to analyze the data. Goals in Local Training Accomplished: 1.) Completed training in 30 minutes. 2.) Questions developed were based on information deemed most important to the clinic. 3.) Program automatically refreshed post each survey to ensure that staff would not need to oversee how veterans’ used the electronic tool. 4.) Query tool developed to rapidly answer provider, time, and/or service specific questions. 5.) Staff provided feedback on team and individual performance on a daily basis.

RESULTS:
Improvements in quality of services, cost savings, information management, operational structure, and patient care were demonstrated via the use of this satisfaction tool. Quality of services was improved as administration and clinical staff was able to immediately know when a veteran had a poor versus an excellent experience. Providers could be given feedback on interactions that just occurred versus having to rely on their past recollection of events. Timely feedback was identified as being positive by staff. Cost savings were noted as this application only requires File Maker Pro or a Microsoft Access application to obtain and manage satisfaction data. Hiring staff to manage this process, and analyze the results was not necessary, as the data is automatically mined in the application, and self-automated. Once the program is turned on, it runs itself. We found that utilization of touch screens allowed veterans to easily interface this application without any problem. Information management was improved as there was no need to independently assess individual feedback whenever reports were requested. Through automatic mining of data, all information is securely stored and readily attainable within seconds of each query via the administration portal. Questions were easily queried to obtain results at the service, provider, question level, or within a specific date range. Operationally this application demonstrated ease of use, requiring only 30 minutes for complete training to administrators in our beta test. For end-users operation of the tool was ideal as the questions were easy to read (large font size), required no writing (touch screen interface), and offered an area for free text to allow specific feedback to be provided when deemed important by the veteran. Lastly, and most importantly patient care was improved as staff that needed immediate coaching were provided with feedback at the end of each day. Staff actually began to seek out the on site administrator of each location for their results once they realized that it could be made available to them immediately. Due to specific information obtained via the questions used, providers decreased the wait times of veterans to below 5 minutes, improved their communication of information to patients at discharge, and identified times of the day that were most ideal for the veterans seeking care.

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Patient Safety Rounds Makes a Measurable Difference!

Objective: In January 2009 Patient Safety Rounds were implemented by the senior leadership team at North Shore University Hospital, a large 812-bed teaching hospital, part of the North Shore – Long Island Jewish Health System in New York. The objectives were to demonstrate commitment, foster a culture for change and provide opportunities for the leadership team to learn about and improve patient safety from all levels of staff.

Planning/research methods: The Patient Safety Round Program was implemented using the Quality Management methodology, Plan, Do, Check, Act (PDCA). A review of best practices in the literature reported senior leadership commitment, consistent day of the week and development of a database necessary for enhancing effectiveness of the rounds. To further enhance our approach, a site visit was made to one of the validated facilities. Both on-site and Health System Executive Leadership Support was obtained and an official kick-off launched our weekly Patient Safety Rounds initiative. A total of sixteen teams were created, each consisting of three to four members per team. The teams’ weekly visits included 45 inpatient units as well as our ambulatory surgery center. Topics were selected after review of our internal data and assessment of the greatest opportunity for improvement.

Implementation methods: Guidelines for Patient Safety Rounds were created:

- Every Friday 10 am – 12 noon, Off shift – 2x/year, brief education session at 10 am, rounding began promptly at 10:30 am
- No beepers or communication devices
- Assign a substitute if unable to participate
- Standing weekly question – “Ask if there were any safety concerns?”
- Refer issues for follow-up or fix on the spot
- Data turned in right after rounds
- Patient care always comes first

A communication plan was developed for staff promoting “Safety is everyone’s job” and that Patient Safety Rounds assists leadership in prioritizing efforts. Consistent “job aides” built on National Patient Safety Goals and internal “Hot Topics” were utilized to engage the staff. In addition to the job aide, each team received questions about the weekly topic for staff to answer to affirm their knowledge. The job aides were reviewed by the Chair of the Patient and Family Education Committee to enhance literacy and understanding.

Each week the staff was also asked if they had any safety concerns that were a risk to patients, employees or the organization. These safety concerns were often fixed on-the-spot. The data sheet also allowed for the issue(s) to be written out and referred to the appropriate department for corrective action. Administration would share findings, prioritize and develop action plans. The findings from patient safety rounds were e-mailed to the survey teams, directors, managers, and the unit-based collaborative care counsels on a weekly basis to assist in prioritizing the actionable safety items. In addition each survey team would receive a list of open or unresolved safety concerns.

Results: Over a period of 37 weeks we performed 1,665 patient safety rounds. There were 978 safety issues identified and 831 resolved (85%). Several topics were repeated throughout the year. For example, staff members were asked about Rapid Response in February and August. Our resurvey data improved 14% with knowledge of Rapid Response Teams. Closing the loop is our goal!

Data from the Hospital Employee Survey improved from the baseline data (Quarter 1 to Quarter 5) with 19 responses to questions improving that were statically significant. (Total 31 of questions all improved). Questions in the areas of employee engagement, patient focus and leadership all improved. In summary, leadership commitment and staff engagement are necessary for implementation of a successful Patient Safety Round Program and positive changes in culture.

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Transformation of Surgical Services: Crossing the Quality Chasm
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Background and Objectives:
The operating room is a complex, high-risk area in a hospital environment. The Institute for Healthcare Improvement (IHI) reports that more than 100,000 preventable fatal medical errors occur every year. In more than 70% of wrong site/side surgeries, communication breakdowns between the patient/family and surgical team members factored into the medical error. The transformation of the surgical services team in the operating room at Scripps Memorial Hospital La Jolla included development of a matrix to promote cultural change and to decrease adverse events for patients having surgery in the operating room.
The objectives included the following:
• Improve the quality of care in the operating room evidenced by a decrease in adverse events and lessened severity of patient occurrences
• Engagement of staff and physicians in the team approach evidenced by compliance with protocols and established standards of care; elimination of deviations in the operating room
• Improve employee satisfaction evidenced by decreased turnover and improved perception in the quality of patient care provided in the operating room

Method:
The matrix included CRM (crew resource management) training for staff and physicians, flattened leadership structure, and departmental realignment with goals of the organization: quality, efficiency, and respect.

Results:
The implementation of the matrix resulted in the following:
• The Great Place to Work© scores for the question “I feel we have improved quality of patient care over the past year” increased to 88% for 2009 from 82% in 2008.
• Overall turnover of staff decreased to 2.3% in FY2009 from 14% in FY2008.
• Severity of adverse events also decreased to those that resulting in no patient injury and required minimal intervention.
• All temporary labor was eliminated with this new structure saving the department almost half of $1 million.

Conclusion:
The journey to excellence first has to start with a leadership structure that promotes a culture of safety for patients and staff in the operating room. The culture of safety was reinforced through CRM training leading to minimized errors in the operating room and improved perception of quality among employees.

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The Fiscal and Quality Impact of Computerized Decision Support and Point of Care Testing on Anticoagulation Therapy

OBJECTIVE
According to studies sponsored by the Agency for Health Care Policy and Research, inappropriate or insufficient use of anticoagulation therapy results in 40,000 strokes and 600 million dollars in avoidable health care costs annually. Sub-specialty anticoagulation clinics have been shown to improve clinical outcomes compared to traditional care. The objective of this study was to quantify the difference in fiscal and quality outcomes between a group of patients undergoing traditional anticoagulation therapy and a group experiencing anticoagulation therapy in a sub-specialty anticoagulation clinic using a Point of Care device and a computerized decision support system in an effort to develop a new system of care that can reduce complications and decrease the avoidable costs of care.

METHODS
Two primary care clinics were compared. The control clinic (n=51) employed a centralized laboratory testing model with paper-based record keeping and data analysis and phone-based patient interaction. The test clinic (n=139) employed an experimental approach using Point of Care testing, computerized record keeping and data analysis and face-to-face patient interaction. There was a high degree of similarity between the groups with regard to age, gender, INR goal and indication for therapy.

Frequency of test results within therapeutic range and documentation of treatment indication, INR goal, therapy duration and testing intervals were tracked over a three month period. Treatment-related complications and costs and fiscal impact on participating systems were evaluated over a one year period.

RESULTS
- Frequency of test results within therapeutic range was 62% for the test group and 38% for the control group.
- Compliance with testing intervals was 86% for the test group and 51% for the control.
- Documentation of INR goal was 100% in the test group and 40% on the control group.
- Documentation of Indication for Therapy was 100% in the test group and 35% in the control.

Quality Impact:
Risk of significant bleeding or thrombosis temporally associated with an out-of-range INR was reduced by 89% in the test group. The test group experience four complications all of which were handled on an outpatient basis, none requiring an ED visit or hospital admission. The control group experienced 13 complications requiring an ED visit or hospital admission.

Fiscal Impact:
Complications related costs in the control group totaled $336,347.44; the test group’s total complications cost was $225.00. A total cost reduction of $6,614.00 per anticoagulated patient per year was realized. Additional revenue of $320.56 per patient per year was generated (based on Medicare minimum allowable charges).

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Achieving Success When You Can’t “Pay for Performance”

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Background:
Mayo Clinic in Arizona (MCA) is an integrated, multi-specialty, and academic practice delivering tertiary health care services. Each year, MCA treats over 100,000 unique patients with complex disease processes who receive care in more than 65 specialty and surgical disciplines. Within the surgical practice, Mayo Clinic Hospital supports the majority of surgical activity with 18 operating rooms and 244 licensed beds. With 53 surgeons operating at Mayo Clinic Hospital, completing over twelve thousand surgical cases in 2009, an increase of 5% over the prior year.

Mayo Clinic is committed to preserving the highest standards of clinical practice as established by the rich heritage of the Mayo brothers. These standards are identified within the Mayo Clinic Model of Care. A key component of the Mayo Clinic Model of Care is professional compensation that allows a focus on quality, not quantity. Mayo Clinic physicians are compensated in a salaried model, without additional compensation based upon productivity. This model ensures patients receive high quality care without concern for financial incentive, and increases the challenge of maintaining and increasing surgical productivity and resource utilization.

Problem Statement:
Over the last few years, growth, profitability, and operating room utilization of the surgical practice at MCA has remained fairly flat. Physician and administrative leadership desired implementation of a system that would provide accurate productivity metrics, in hopes that such a system would intensify internal competition leading to improved financial and operational performance.

Project Description:
MCA participated in a research project in collaboration with the Advisory Board Company called Surgery Compass. The Surgery Compass Program provided measurement and analytics of the surgical practice, including operating room performance drivers, physician performance drivers, and comparative benchmarks. Additionally, the Program provided high-level dashboards, specialty level, and physician level data. This combination of tools allowed MCA to identify key performance variances, isolate possible causes, and recognize opportunities for improvement. Although the desired metrics were available in Surgery Compass the system lacked the ability to graphically compile the metrics onto a one-page scorecard. Internal resources were used to develop a one-page view of surgeon productivity.

Description of Scorecard:
A model providing individualized surgeon metrics, the Surgeon Scorecard incorporates key performance indicators with best practice initiatives. As shown in the example above, the Surgeon Scorecard compiles various metrics and goals which originate across multiple systems, and graphically exhibit the results on one-page for each surgeon. The scorecards are generated and distributed monthly.
**Results:**
MCA has experienced a dramatic improvement, in both productivity and efficiency as of year to date December 2009.

- Direct income for the hospital surgical services and surgical practice improved by 96%.
- Surgical patients and operating hours have increased by 5% while the staff only increased by 0.7 FTE.
- Block utilization improved from 73% to 79%. This is a tremendous accomplishment; more revenue is generated without the incremental expense of building another operating room.
- First case on time starts improved 74% while delay minutes decreased by 8,800 minutes.

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**Background:**
As reimbursement decreases and employee related costs continue to rise, it is important to have an effective tool in place to balance workforce with workload demands. Employee related expenses continue to be the largest expense line in both inpatient and outpatient settings. Although matching workforce to workload has occurred within hospitals for years, outpatient clinics and group practices have been less attuned to this practice.

This presentation will describe how to develop and implement a strategy for matching workforce to workload, ultimately maintaining patient satisfaction while achieving higher efficiency and improved financial outcomes.

**Project Description:**
In October 2008, in response to decreasing margins, a cross section of administrators representing medical and surgical specialties were given the task of developing a fiscally responsible low workload model that would meet the needs of Mayo Clinic Arizona’s outpatient practices. The resulting model provides tools for implementing a low workload system that optimizes productivity while maintaining a high level of patient care. Each practice has identified triggers for implementing the plan that best aligns staffing levels with practice demand, for example: number of procedures, number of providers, or volume of incoming calls.

In conjunction with optimal staffing plans, a process has been implemented requiring additional justification to replace open positions.

**Example of Model:**

**Results:**
The results of the project support the value and applicability to all outpatient practices. From May 2008 to May 2009, the following improvements occurred:
- 6.3% reduction in paid FTE (59.25 FTE)
- 56.5% reduction in monthly overtime FTE
- 16.7% improvement in RVUs
- 17.1% improvement in productivity (RVUs/FTE/Workday)

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Objective of the Program: Using communication and team building to foster a culture of creativity and innovation to achieve success

Planning/Background: In 2005, Children’s Hospital Boston built a satellite facility 20 miles northwest of the city to expand services within the suburban communities and to decant healthy patients from the main campus. The satellite is equipped with a six room peri-operative suite. The peri-operative inventory was set up and managed remotely by Boston staff with a 1.0 FTE inventory specialist on site to process and stock orders. The system was failing. Complaints about supplies and inventory were reported daily from surgeons and nursing staff. Everyone blamed the inventory specialist for recurring issues with inventory and supplies. With continuous growth, case type and complexity changed almost daily. It seemed almost impossible to keep up with the changing needs of the unit. Management and staff had nearly given up on the situation. People were angry and frustrated with the system and rumors spread throughout both campuses that the inventory specialist was incompetent. Management was prepared to fire or relocate the satellite inventory employee and start fresh. A new manager with limited surgical inventory experience was assigned as the final attempt to rectify the worsening situation.

Implementation Methods: With a daunting task at hand, the first step was to build a small inventory team including the current inventory specialist and four other employees, already employed in the unit. Next, the group actively listened to coworkers to understand the problems. Any perceived issue, no matter how insignificant, was written down and prioritized with the inventory team. Initial goals were small and achievable. Each team member played an active role in the discussion and implementation of potential solutions. Small successes were celebrated with consistent recognition of hard work, diligence, and creative ideas. Any reasonable idea was discussed and trialed. Successful ideas were shared and those that failed were modified appropriately without blame or criticism. Goals were modified and expanded in scope. Through open communication, it became clear that the solution was not to mimic the strategies developed on the main campus but to modify those strategies to fit the needs of our satellite facility.

Results: Over the past year, there has been a transformation of the unit’s culture. The peri-operative staff now understands that the single inventory specialist was placed in a difficult situation with inadequate resources or support to succeed. Staff complaints have decreased from nearly daily to less than once a quarter. The available on hand inventory within the unit has decreased significantly due to more accurate par levels and knowledge of the unit’s surgical inventory requirements. While cost savings cannot be accurately captured due to a lack of documented initial par levels, they are significant, saving the organization several hundred thousand dollars. Today, the inventory team is thriving and continues to take on new complex projects that increase efficiency or reduce cost. In summary, despite the manager having limited experience with inventory management, a solution was achieved by building a new culture of communication, trust, and creativity.

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“Complementary Queueing and Simulation Analysis of St. Louis VAMC Pharmacy Phone Services”

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Objective

Like many others, the St. Louis Veterans Administration Medical Center (VAMC) Pharmacy help desk receives far more calls than can be processed by current staffing levels. The objective of the study is to improve pharmaceutical services provided by the call center, by using queueing theory and discrete event dynamic simulation to analyze incoming telephone traffic to the help desk. Administration’s objective is a service threshold of 90% of callers served with less than a 30 second waiting period prior to their call being answered live.

Methods

Archival data from Global Navigation (GNAV) telephony software was used to generate distributions for call arrival streams. The call center operations were physically observed for a six week period to generate distributions for service times. A queueing theoretic model was developed using Queueing Tool Pak (QTP) to determine the number of servers needed under idealized conditions. This model was then refined as a discrete event dynamic simulation (DEDS), in order to incorporate server variations such as breaks. Human server behavior is incompatible with pure queueing theory, but is capable of being modeled with DEDS. Additionally, generating the model first as a queueing theoretic model greatly reduced DEDS development time by providing a system template in a far less complex modeling environment.

Results

Results suggest that telephone traffic congestion in this setting may be alleviated by increasing the number of staff responsible for telephone services from two to six throughout the week, with an additional part time pharmacy technician serving on Monday. The current service threshold of between 17% and 29% (varying by day and hour of the day) can thusly be improved to 90%-95% of all calls serviced within 30 seconds. Additionally, current abandonment due to long waits ranges from 42.2%-52.6% of all calls. Under the proposed staffing regimen, fewer than 5% of callers are projected to abandon.

Conclusion

Queueing and simulation models can be used to improve overwhelmed pharmacy call centers, by determining the theoretical minimal staff needed to reach a service threshold. Complementary use of dual methods allowed for rapid development of the models, and concordant results from dual method analysis demonstrates robustness of methodology.

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ED Call: Response or Results
Transforming ED Call into a Physician Alignment Strategy that Stabilizes Costs and Improves Quality

Objective:
To assure Emergency Department Call Coverage and stabilize costs at competitive market value, Scripps Memorial Hospital Encinitas and Connect the Docs Multi-Specialty Network, Inc. collaborated to shift ownership of these issues from Hospital Administration to the Medical Staff resulting in a model that rewards physicians for Quality Outcomes and working towards “Perfect Care” (zero opportunities for improvement).

Planning/Research Methodology:
Nationwide, a crisis is evolving with more and more hospital physicians selecting lifestyle over traditional medical staff responsibilities, such as ED Call and Inpatient consults. When Hospital Pay for Performance initiatives become realigned to include physicians as partners in hitting these targets they become achievable. Physicians develop ownership of these Medical Staff responsibilities shifting the control from Hospital Administration to the Medical Staff and suddenly quality indicators are improved and coverage is assured.

Implementation methods:
In 2009 a hospital system partnered with a local independent physician association, Connect the Docs Multi-Specialty Network, through a Management Services Agreement for a global fee to obtain coverage for all required service lines for Emergency Department Call Coverage. A bonus system was instituted for improved quality outcomes in pay for performance initiatives; including SCIP, CORE measures, and Patient Satisfaction. A quality scorecard was developed with a point system for targets achieved which correlates to bonus dollars.
This new partnership provided physicians with a data driven, equitable, compensation plan for providing Emergency Department Call that drives quality patient care. The bonus payment incentivizes physicians to respond to the needs of their colleagues resulting in better care to patients. Physicians across all specialties receive fair and equitable ED call compensation through a tiered stipend payment structure. Physicians do self-billing, with no additional pay for unassigned or no-pay patients. 20% of the stipend payment is withheld and placed in a bonus pool to be distributed quarterly.

Results: (Metrics and tools will be displayed on the poster)
- Physician component of Press Ganey Patient Satisfaction Score Ranking 2008 42% 2009 81%
- CORE Measures Composite Bundle Opportunities For Improvement (OFI’s) 2007-79, 2008-41, 2009-18
- CORE Measures months of “perfect care”: 2007-0, 2008-1, 2009-5
- SCIP Measures months of “perfect care”: 2007-0, 2008-1, 2009-1
- No hospital acquired conditions occurred in 2009
- Stabilized Call coverage with set pricing for three years
- Reduction of 1.5 days in LOS partially due improved consultant responsiveness to the Inpatients and the Emergency Department
- Enhanced physician and hospital alignment

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Cost effective care in a nonprofit hospital: the surgical spine implant cost reduction initiative at Huntington Hospital

Objective:

Our objective was to improve efficiency and cost effective care for the surgical spine program at Huntington Hospital. When reviewing the average cost of a spine surgery case, the largest portion of the expense went to implants and medical supplies. This constituted 59% of the total cost per case. The high level need was to reduce the costs of the spine subservice line while maintaining the quality of care. The overarching goal was to strengthen hospital and physician relationships to achieve service excellence. Engaging the team and making use of Lean Six Sigma methodology, persuasion, negotiation and nonprofit self-reliance leads to success and enhanced distribution of resources to maintain financial viability.

Planning & research methods:

The spine implant cost reduction initiative was a programmatic goal of the neurosciences’ service line business plan. The project alignment with Huntington Hospital’s 2010 strategic plan is service excellence; improve quality through operations; strengthening physician relationships; financial viability. The Quality Management Lean Six Sigma program and the service line collaborated in preparation for the project. Project scope:

- Included all associated direct costs
- All spine surgeons
- All spine vendors
- Elective surgeries only
- DRGs limited to: 455; 457; 460; 473; 490; 491

Working side-by-side with the neurological and orthopedic surgeons, service line administration, materials management, nursing management, and a process improvement Six Sigma black belt using the trend data analysis the surgical spine implant utilization was profiled.

Implementation methods:

- Nonprofit self-reliance
- Team formation with surgeon champions
- Lean Six Sigma trend data analysis
- Persuasion Hugh Rank
- Negotiation Strategy RFP
- Communication “On the Outlook” alerts

Results: (Trend data analysis, process flow charts, and implementation plan timeline displayed on poster)

- Hospital – surgeon decision making system for spine implant utilization with a process model
- 35% reduction in the average direct implant cost per case
- $3 million savings for the surgical spine program during the 2009 project year
- Qualitative benefit of strengthened hospital and surgeon relationships
- Sharing our success - featured as “Solving complex issues with high ROI potential” on the internet at:
  gehealthcare.com/usen/service/performance_solutions/docs/Huntington_Case_Study.pdf

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OBJECTIVE:
An engaged workforce is paramount to any successful hospital. Lankenau Hospital, a 330-bed suburban teaching hospital with 2500 employees embarked on a robust performance improvement journey and identified the need for culture change and a need to increase employee engagement. Underpinning our engagement strategy was the collaboration between human resources, senior executives, and performance improvement engineers.

Our organizational engagement strategy is centered on providing the superior patient experience using the principles of communication, robust feedback and accountability mechanisms. Our plan includes the following elements:
- A communication plan for managers, physicians and employees; Implementation of management accountability using specific measureable tools; A strategy of climate sensing; Leadership Development; Sharing of Best Practices

PLANNING AND RESEARCH METHODS AND PREREQUISITES:
Commitment of resources from the hospital president and other senior leadership; Alliance with the strategic direction of the organization; Conducted employee focus groups centered around employee engagement; Tested industry best practices in employee engagement on all levels of employees throughout the Hospital.

IMPLEMENTATION METHODS:
We used the below performance improvement equation to drive our strategy:

\[
\text{Best Process} + \text{Best Communication \\& Culture} \quad \text{(Robust Feedback \\& Accountability)}-1
\]

We implemented the below engagement strategies:
- Developed tools to assess the current environment through specific and targeted climate sensing activities; Developed a detailed internal communication plan; Developed management accountability system; Developed management engagement retreats focused on patient safety and individual purpose and value; Developed an engagement council aimed to connect our patients to our management, employees, and medical staff.

RESULTS:
- Increase in HCAHPS Survey Scores
  - Definitely Recommend this Hospital 2nd Quarter 2009 – 85th percentile.
- Increase of Compliance Rates – PPDs, Hand Washing Compliance
- Increase employee and knowledge of Patient Safety Plan / Performance Improvement
- Decreased Vacancy Rates in Nursing from 8.01 to 6.31
- Gallup Employee Engagement Score Improvements:
  - Overall engagement raw score increased by .13 (statistically significant improvement)
  - Management Engagement increased by 32 percentile points (75%tile)
  - Registered Nurse Engagement Scores increased by 14 percentile points.

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Data Driven Approach to Marketing and Public Relations in a Competitive Health Care Environment

Objective of Program

To improve the effectiveness of marketing and public relations (PR) at Windber Medical Center by enhancing basic marketing concepts of the “3 Cs” (customer, company, and competition), market segmentation and positioning, and the “4 Ps” (product, place, promotion and price).

Planning/Research Methods

- Examination of marketshare data
- Analysis of market survey data
- Exploration of then current web site and marketing efforts
- Gap analysis
- Exploration of best practices for marketing and PR effectiveness

Implementation Methods

- Selection of a multi-faceted marketing partner
- Meeting with all key stakeholders to identify needs
- Development of clear and concise goals
- Establishment of marketing objectives and priorities
- Development of marketing plan with alignment to strategic plan
- Identification of target audiences
- Creative redesign of web site
- Pilot testing of new look to campaigns to spur emotional connectivity
- Design of multiple methods for marketing processes

Results

- Qualitative analysis of value of media placements demonstrates 10% increase in the organization being prominently featured
- 4 percent increase in growth objectives of specific programs (breast care center, fitness center, women’s health)
- Hits to website have grown by 15% overall with growth of hits to particular sites even greater
- Positive results from pilot testing
- Favorable return on investment, return on objective and return on engagement, although not yet fully quantifiable
- Anticipate growth in marketshare and market survey data at point of measurement

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Managing Payer Mix While Maintaining a Moral Compass
Mayo Clinic Arizona

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Objective:
As a large, multi-specialty, integrated practice, it is difficult to continually absorb the financial impact of declining Medicare reimbursements or Medicare reimbursement rates which do not keep pace with inflation. Three years ago, multiple strategies were developed to reduce our government payer mix in our outpatient practice, while parallel strategies were implemented to address cost in our healthcare delivery systems. For an institution with high brand recognition and a core value focused on the “needs of the patient”, implementation of payer mix strategies presented a significant challenge to balance financial viability, preservation of our integrated care model and alignment of our actions with our primary value.

Planning and Research Methods:
This review analyzed the institution’s government payer mix over a three-year period, 2007 through 2009, based on billed volumes of activity within the inpatient and outpatient environments. Laboratory volumes were excluded from the study due to year-to-year changes in “bundling” and “unbundling” requirements that would have provided inaccurate trending information. The changes in payer mix were mapped against the implementation of progressive strategies to manage payer mix over this same three year period. To assess the amount of practice integration disruption, the measure of out-of-state patients who had their initial episode of care completed within five days after their initial outpatient evaluation (12-month moving average) was studied for the same three-year period and compared to the organizational benchmark.

Implementation Methods:
The institution utilized five overarching strategies in our payer mix initiative:

- Management of access restrictions occurred at the point of initial access, with no payer mix restrictions once the patient had begun their episode of care within the integrated specialty practice.
- Aggressive payer mix management would occur in practice lines not part of the core specialty practice.
- Well defined exception criteria with centralized control for exception review would be utilized.
- Broad and transparent communication would be provided to all staff, with particular focus on educating “front-line” staff who directly interact with the patient.
- Physician staff growth would be constrained to allow payer mix management within a defined capacity.

Appointment access was restricted through a progressive approach with the following tactics:

- 2007 - No new Medicare patient access for primary care practices; no “in-state” Medicare access for regional medicine practice; implementation of appointment types only for commercial/contracted patients; no access for fee-for-service Medicare Advantage plans.
- 2008 - No outpatient access for new Medicare Advantage Plan patients; no Medicare access for regional medicine practice; additional increase in appointments only for commercial/contracted patients; constrained staff growth.
- 2009 - No outpatient access for any Medicare Advantage Plan patients; constrained staff growth.

Results:
Utilizing the overarching strategies and tactics previously described, our organization has been able to reduce government payer mix from a high of 63.3% in January of 2007 to a low of 58.3% in December of 2009. The institution achieved 83% of its original three year payer mix goal while maintaining appropriate levels of practice integration by managing payer mix at the point of initial access. Measurement of practice integration remained above the organization benchmark of 85% compliance for the three year period of the study. In addition, transparent communication plans, focused on our allied health staff that directly interfaced with the patient, allowed us to effectively communicate and explain the rationale behind our access changes to manage payer mix.

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