AHA Leadership Summit

Critical Success Factors for Becoming a High Reliability Organization: Lean, Six Sigma, Change Leadership and Value-based Purchasing

Presented by:

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Angela Lambert, CNO, CHRISTUS Santa Rosa Medical Center
Rick Morrow, Vice President, Reliability, Healthcare Performance Partners
Objectives

- CHRISTUS’ roadmap improving value-based purchasing scores providing safer patient care.
- Rapid improvement in clinical delivery of care.
- How to drive front line staff and physicians toward collaborative success across multiple sites for simultaneous improvement.
- Understand how to identify target priorities that lead to the biggest outcome potential.

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
CHRISTUS Healthcare - System-wide Improvement
Leaders Who Utilize the 3Ms
Healthcare Reform
Finding True North
All About

Leading Change with the 3Ms

1. **Measure** what you want

2. **Manage** to that measure

3. **Make it easy** to do the right thing
Higher Reliability Daily Visual Management

MC SCIP 9 Compliance

June 2014 - DAYS OF PERFECT QUALITY 236
“Circulate among followers consistently”

Abraham Lincoln
Every organization needs higher reliability to prevent harm.
Utilizing the 3Ms – Dr. Semmelweis
Surgical Site Infections & Hand Hygiene Compliance

![Graph showing SSI Rate vs. Hand Hygiene Compliance %](image)
The Roadmap Guiding High Reliability Teams
Grab Your Roadmap to High Reliability and Get Started

**Roadmap to High Reliability**

<table>
<thead>
<tr>
<th>Key Questions</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the customer's expectations?</td>
<td>Value Stream Map</td>
</tr>
<tr>
<td>What are the process capabilities?</td>
<td>SIPOC, SIPOC, Cause &amp; Effect Matrix</td>
</tr>
<tr>
<td>What are the current process performance?</td>
<td>PIPOC, SIPOC, Cause &amp; Effect Matrix</td>
</tr>
<tr>
<td>How can we improve performance?</td>
<td>SIPOC, SIPOC, Cause &amp; Effect Matrix</td>
</tr>
<tr>
<td>What are the potential gains?</td>
<td>SIPOC, SIPOC, Cause &amp; Effect Matrix</td>
</tr>
</tbody>
</table>

**Acronyms and Meanings**

- **VSM**: Value Stream Map
- **SIPOC**: Supplier, Input, Process, Output, Customer map
- **SPC**: Statistical Process Control
- **JIT**: Just-In-Time
- **QFD**: Quality Function Deployment
- **PFMEA**: Failure Mode & Effects Analysis

**Sponsor/Champion Tollgates**

- **Define Phase**: Tollgate for charter and process inputs.
- **Retrieve Phase**: Tollgate for validation of process inputs.
- **Experiment**: Tollgate for validation of process inputs.
- **Review Phase**: Tollgate for validation of process inputs.
- **Create Phase**: Tollgate for validation of process inputs.

**Tollgates**

- **Main Street**: Required for all decisions and tollgates.
- **Avenue**: Tollgates for validation of process inputs.
- **Roadmap to High Reliability**: Tollgate for validation of process inputs.

**A3 Problem Chart/Effect Matrix**

- **A3 Problem**: Chart/Effect Matrix
- **Definition**: Problem/Effect Matrix
- **In-Time**: Design/Effect Matrix
- **Value Stream Maps**: Value Stream Maps
- **Kanban**: Kanban

**Core questions and common tools**

- **Leadership**
- **Lean Six**
- **Tools**
- **Key**
- **Questions**
- **Tools**
- **Maps**
- **Diagrams**
- **Data analysis**
- **Data**
- **Analysis**
- **Customer**
- **Stakeholder**
- **Input**
- **Process**
- **Experiment**
- **Build Consensus**

**Quality Function Deployment**

- **Sponsor/Champion**
- **Process inputs**
- **Stakeholders**
- **Customer Effect Matrix**
- **Customer map**
- **Voice of the customer**
- **Data analysis**
- **Voice of the employee**
- **Data analysis**
- **Data**
- **Analysis**

**Mistake-Proofing**

- **FMEA**
- **Lean Six**
- **SQA**
- **SIPOC**
- **SPC**
- **JIT**

**Train, Enable, Empower, Hold Accountable**

- **Tollgate for validation of process inputs**
- **Tollgate for validation of process inputs**
- **Tollgate for validation of process inputs**
- **Tollgate for validation of process inputs**
- **Tollgate for validation of process inputs**

**Download free at www.rpmexec.com**
An Improvement Roadmap

- Leadership sponsored
- Charter to clearly define goal
- Stakeholder Analysis
- “Swarm” the current state
- Fishbone chart for root causes
- Improvements using Plan, Do, Study, Act
- Failure Modes & Effect Analysis to sustain
- Standard Work
Rewarding Quality and Beyond the Acute Care Hospital

Value-Based Purchasing Incentive Payment Schedule

- Incentive payment %
Rapid Improvement Requires Leadership

Utilizing the 3 Ms
Lincoln Measuring Daily

- Abraham Lincoln’s daily trek to the telegraph office
- From Lincoln, the movie
Managing to the Measure
The 3rd M - Making it Easier

- Lincoln 1. Measured the war’s progress daily – personally

- Lincoln 2. Managed to the measure daily including swapping out Generals more than any Commander-In-Chief

- How did Lincoln 3. Make it easier to win the war?

- How have you made it easier to do the right thing for patients?
Case Studies

- First Region
- First Projects
- First Successes
Identified “Must Haves”

• Get the Red Out

• Executive leadership participation – Corporate and Hospital – led by COOs
  ▪ A partner skilled in clinical integration
  ▪ Experienced professionals in performance improvement, both clinical and operational
  ▪ Resources to simultaneously lead change across three states and twenty sites
  ▪ Patience as we learn our own leader’s skills in leading great change
CHRISTUS’ Balanced Scorecard – Highlighted Need for Clinical Integration

### Summary Reports

<table>
<thead>
<tr>
<th>Scorecard Overview</th>
<th>Systemwide</th>
<th>St. Michael</th>
<th>SR Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Definitions</td>
<td>Louisiana</td>
<td>Atlanta</td>
<td>SR Medical</td>
</tr>
<tr>
<td>Regional Ranking</td>
<td>Ark-La-Tex</td>
<td>Schumpert St. Mary</td>
<td>SR New Braunfels</td>
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<tr>
<td>Facility Ranking</td>
<td>Northern LA</td>
<td>Schumpert Highland</td>
<td>SR Westover</td>
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<td>Best Perf Graph</td>
<td>Central LA</td>
<td>Cabrini</td>
<td>SR Alamo</td>
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<td>Dots Reports:</td>
<td>Southwestern LA</td>
<td>Cousshatta</td>
<td>Spohn Alice</td>
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<td>New Mexico</td>
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<td>Spohn South</td>
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<tr>
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<td>Jasper</td>
<td>St. Vincent</td>
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### Individual Scorecard Reports

<table>
<thead>
<tr>
<th>Scorecards with Graphs:</th>
<th>Systemwide</th>
<th>St. Michael</th>
<th>SR Children</th>
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<td>Jasper</td>
<td>St. Vincent</td>
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</tbody>
</table>

### Action Plans:

- Instructions for Use:
  - Please select the button to the left to go to the desired scorecard page.
  - To return to the main menu from each scorecard page, select the "Main Menu" button on the top of each scorecard page.
  - You may also still navigate the workbook using the worksheet tabs below as was done before.
Value-Based Purchasing Executive Summary
FY2016 Pro Forma

<table>
<thead>
<tr>
<th>Domains</th>
<th>FY2016 Score</th>
<th>Weight (Normalized if domains missing)</th>
<th>FY2016 Weighted Score</th>
<th>Hospital’s total annual base operating DRG payment amount (reimbursed)</th>
<th>Initial annual DRG payment reduction for hospital</th>
<th>Total V-BP earned back</th>
<th>Net change: Total annual reimbursement reduction &amp; Incentive or additional lost reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Domain Score (Normalized)</td>
<td>15.71</td>
<td>10%</td>
<td>1.57</td>
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<tr>
<td>Patient Experience Domain Base Score</td>
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<tr>
<td>Patient Consistency Score</td>
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<tr>
<td>Patient Experience Base Points + Consistency Score</td>
<td>8</td>
<td>25%</td>
<td>2</td>
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<td>Outcome Domain Score</td>
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<td>40%</td>
<td>12.57</td>
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<tr>
<td>Efficiency Domain Score</td>
<td>0</td>
<td>25%</td>
<td>0</td>
<td></td>
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</tbody>
</table>

Total Performance Score FY2013: 63.62; FY2014: 34.73; FY2015 est: 23.98

VBP Multiplier chart

- Readmissions 2014: Source CMS August 2013
- Readmissions 2013: Source CMS March 2013

Total Impact on Base Operating DRG (VBP + 2014 Readmissions until 2015 available)

Actual achievement performance for Clinical Process of Care and Patient Experience. All other values estimated using latest available data from CMS until organization supplies more recent data.

Value-Based Purchasing Negative $ Impact

Total VBP + Readmissions Negative $ Impact
## Swarming the Right Problems

<table>
<thead>
<tr>
<th>Clinical Process of Care Measures</th>
<th>Achievement Target Opportunity (Red = Performance &lt; Threshold)</th>
<th>Larger of Achievement or Improvement Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF-1 <strong>Discharge instructions</strong></td>
<td>![Green Icon]</td>
<td>5</td>
</tr>
<tr>
<td>SCIP-Inf-4 <strong>Cardiac surgery patients with controlled 6AM postoperative serum glucose</strong></td>
<td>![Red Icon]</td>
<td>4</td>
</tr>
<tr>
<td>SCIP-Inf-9 <strong>Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2</strong></td>
<td>![Red Icon]</td>
<td>2</td>
</tr>
</tbody>
</table>

### Chart Description:
- **Black** = CMS National Benchmark
- **White** = CMS Minimum
- **Orange** = Hospital’s Performance
- **Blue** = Hospital’s Baseline

### Net Loss from Penalties from VBP and Excess Readmissions

$1,209,849
Project One

Urinary Catheter Removal (SCIP-9)
# Mapping Discovered Inputs that Varied, Missing, Failing

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Process</th>
<th>Output</th>
</tr>
</thead>
</table>
| • Doctors                   | Pre-Op (Review H&P) | • Identify patients who will have a foley  
| • Nurses                    |                  | • Fail to identify patients who will have a foley  
| • Patient education         |                  |                                      |
| • Handoff                   |                  |                                      |
| • Surgeon                   | Surgery          | • Staff aware of SCIP 9 patient  
| • Nurse                     |                  | • Staff unaware of SCIP 9 patient  
| • Handoff                   |                  |                                      |
| • Intensivist               | PACU             | • Staff aware of SCIP 9 patient  
| • Hospitalist               |                  | • Staff unaware of SCIP 9 patient  
| • Nurse*                    |                  |                                      |
| • CAN                       |                  |                                      |
| • Patient/family involvement|                  |                                      |
| • White board communication |                  |                                      |
| • Handoff                   |                  |                                      |
| • Charting                  |                  |                                      |
| • EHR documentation         | Documented SCIP 9 Compliance | • Catheter removals are in compliance  
| • Communication of results  |                  | • Catheter removals are not compliant  
| • Core Measure Nurse involvement |                  |                                      |

**SCIP 9**

- We identified the following top concerns:
  - Failing to recognize SCIP 9 patients
  - Doctors failing to order foley removal
  - Busy shifts created an environment conducive to forgetting
  - Doctors failing to document why foley should remain in place
Root Causes of SCIP 9 Non-Compliance

POD 0
- Failure to identify SCIP 9 Patient
- Poor handoff
- Discontinue foley POD 2 order not written
- Staff unaware of SCIP 9
  - Physician unaware of SCIP 9
  - Undear on what patients qualify for SCIP
  - Staff unaware of the risks associated
  - Failure to initiate SCIP tool/handoff tool
  - Failure to read the foley removal
  - Nothing in EHR to remind the nurse

POD 1
- Poor handoff
- Failure to identify SCIP 9 patient
- Failure to complete chart checks
  - Failure to educate patient and family on process
  - Failure to use white board as a communication tool
  - Staff unaware of SCIP 9
    - Failure to address SCIP 9 patients during huddles
    - Failure to document removal
    - Physician unaware of SCIP 9
    - Failure of physician to document why foley should be
    - Staff unaware of the risks associated with a foley

POD 2
- Nurse convenience
  - Physician fails to list a SCIP approved reason for foley remaining in place
  - Failure to document foley removal
  - Failure of nurse to communicate POD 2 foley w/o orders to Physician
  - Physician fails to write the order
  - Staff unaware of SCIP 9
  - Poor shift change communication
  - Failure to complete chart checks
  - Failure to obtain order from doctor to remove foley
  - Physician fails to document that foley needs to stay in place
  - Failure to remove foley

Failure to Comply
Root Causes:

- ID of patient with UC

- Nothing in EHR to remind

- Order to remove

- Order missing to maintain
- Make it easy:

- Identify what helps nurses remember to address UC

- Pink box initiative

**Table:**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Text/ Ord</th>
<th>Status</th>
<th>Src</th>
<th>Frequency</th>
<th>History</th>
<th>Next Scheduled</th>
<th>Prtl</th>
<th>Assoc Data</th>
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</thead>
<tbody>
<tr>
<td>Nursing Rounds</td>
<td>A</td>
<td>PS</td>
<td>Q2H</td>
<td></td>
<td></td>
<td>11/05 0001</td>
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<tr>
<td>Vital Signs: Standards Units / MEWS</td>
<td>A</td>
<td>PS</td>
<td></td>
<td>08,12,16,20,...</td>
<td></td>
<td>11/05 0400</td>
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<td>Intake and Output</td>
<td>A</td>
<td>PS</td>
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<td>14,22,06</td>
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<td>Assess IV/Invasive Line Status</td>
<td>A</td>
<td>PS</td>
<td></td>
<td>08,16,00</td>
<td></td>
<td>11/05 0800</td>
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<td>Meal Intake</td>
<td>A</td>
<td>PS</td>
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<td>10,14,18</td>
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<td>11/05 1000</td>
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<tr>
<td>Fall Risk Assessment</td>
<td>A</td>
<td>PS</td>
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<td>08,20</td>
<td></td>
<td>11/05 2000</td>
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<tr>
<td>Braden Scale (Ages 9 and Older)</td>
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<td>Urinary Catheter Removal</td>
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<td>Admission Data (Med Surg/ICU)</td>
<td>A</td>
<td>PS</td>
<td>On Admission</td>
<td>69 days</td>
<td></td>
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<tr>
<td>Admission Data (Med Surg/ICU)</td>
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<td>On Admission</td>
<td>69 days</td>
<td></td>
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<td>Admission Assessment (Med Surg)</td>
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<td>On Admission</td>
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<td>Allergies Updated on Admission</td>
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<td>On Admission</td>
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<td>Shift Physical Assessment</td>
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<td>PS</td>
<td>Q2SH</td>
<td>PRN</td>
<td></td>
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<tr>
<td>Height &amp; Weight (English Units)</td>
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<td>PS</td>
<td>On Admission</td>
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<td>TV/Invasive Line Insertion (Adult)</td>
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<td>PS</td>
<td>Q2SH</td>
<td>PRN</td>
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<td>Shift Pain Assessment</td>
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<td>Q2SH</td>
<td>PRN</td>
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<td>Notify Provider / Event Charting</td>
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<td>PRN</td>
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<td>PRN</td>
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<td>PRN</td>
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<td>Discharge Education for Patient</td>
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<td>PS</td>
<td>On Discharge</td>
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</table>

**Note:**

- Urinary Catheter Removal will now turn pink on date for removal.

**Diagram:**

- Once Catheter is removed, change status to COMPLETE. This solidifies nursing documentation and ensures our compliance for SCIP 9.
Root Causes and Improvements

**Root Causes:**
- ID of patient with UC
- Nothing in EHR to remind
- Order to remove
- Order missing to maintain

**Improvements:**
- Singular responsibility-PACU/ICU initiate UC log
- PACU/ICU nurses initiate EHR “Pink flag” POD 1 or 2
- Physician and nurse engagement
- Daily managing to the measure → heightened awareness → appropriate order needed
Sustain from “Managing to the Measure” – Leaders and Staff

Karen, a frontline RN, owns the daily visual management.

Daily Compliance Chart on the Floors

Root causes for continuous improvement engaging everyone.
Higher Reliability Daily Visual Management

MC SCIP 9 Compliance

June 2014 - DAYS OF PERFECT QUALITY 236

% Compliant
### 250+ Days of Higher Reliability
#### Three Hospitals – 9 Projects

<table>
<thead>
<tr>
<th>Process of Care Targeted Opportunities FY2015</th>
<th>CHRISTUS SANTA ROSA HOSPITAL</th>
<th>Improvement Ratio (Higher the Rank = Higher Opportunity)</th>
<th>Larger of Achievement or Improvement Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Discharge instructions" /></td>
<td><img src="image2.png" alt="Cardiac surgery patients with controlled 6AM postoperative serum glucose, FY15" /></td>
<td><img src="image3.png" alt="Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2, FY15" /></td>
<td></td>
</tr>
</tbody>
</table>
Round 1 Issues and Successes

1. CHF Discharge Instructions to reduce readmissions and complications – Achieved 100% Zero Defects

2. Urinary Catheter Management to reduce infections – 99% with only one fallout

3. Blood Glucose Management to reduce cardiac patient infections – 100% in 2013 and only one fallout with the much tighter 2014 requirements

Reimbursement and reduction in healthcare acquired conditions estimated to save > $230K

Readmissions REDUCED by 108 patients and $1.4m
Lessons Learned

- Local leadership correlates with success
- A Steering Committee is key, but takes time to learn the roles and responsibilities to act faster
- Rapid improvement, even in core measures, is possible and sustainable
- Scalability of successes occurs, but we need to speed up
- We needed more help than we or MedAssets expected
- Collaborating with a trusted partner to extend the scope of work across disparate geography and shorten timelines has assisted the organization’s learning curve and achieved quick results
Rapid and Continuous Improvement

MedAssets and CHRISTUS Start Teams
Round Two Projects

- Influenza Immunization for inpatients older than 6 months
  - Westover Hills
  - Med Center
  - New Braunfels
  - Children’s

- Patient Experience – Raising the score on Responsiveness of Staff first
  - Westover Hills
  - Med Center
  - New Braunfels

- Pneumonia
  - New Braunfels
Value Based Purchasing
CHRISTUS Santa Rosa

Improving Patient Experience starting with improving the Hospital Staff Responsiveness experience.
Patient Experience – Improving Responsiveness – the Biggest Opportunity

- Focused on 1st improving the worst scoring of 8 questions – Responsiveness
- Growth in a highly competitive market demands reliability in patient experience
- Daily Cadence of Accountability begins May 12 engaging physicians, nurses, and ancillary staff. They and multi-factorial analytics will discover root causes and show early improvement – so difficult for many organizations
CHRISTUS Santa Rosa’s Hospital Staff Responsiveness Score Compared to CMS Minimum Threshold and 5th Percentile Benchmark – 1Q2013
Strategy to Raise Patient Experience Scores

- HCAHPS process is not for performance improvement as much as it is to compare hospitals for CMS’ purpose and now reimbursement.

- Thus, a “Daily Cadence of Accountability” chart was created focusing on the “Responsiveness” composite question from the HCAHPS inpatient survey.

- Root cause analysis of the lack of responsiveness will lead to improvements and the teams will see improvement in the HCAHPS surveys on this question, others that are correlated, and the team can then move on to the next highest issue in the HCAHPS survey.

- Impact will be on the HCAHPS measure scores, overall rating, and financial reimbursement from CMS’ Value-Based Purchasing and other Payers who reinforce quality in reimbursement.
Daily Measure – the Scoreboard to show Baseline and early progress and sustain

Medical Center

Patient Experiences - Staff Responsiveness Measurement
SOMETIMES IT TAKES TIME, BUT NEEDS ARE MET
NURSES NOT GETTING MESSAGES
FLOOR CLEANERS COMPLAINT
CONSIDERS 8 TO BE A GOOD SCORE
CALL LIGHT DID NOT WORK
SLOW TO RESPOND
TAKES A LONG TIME
GOOD AT ANSWERING, BUT NOT ON FOLLOW-THROUGH
SOMETIMES IT TAKES TIME, BUT NEEDS ARE MET
Fitted Line Plot

Hospital staff responsiveness = - 0.02181 + 0.9290 Doctor communication

S       0.0152850
R-Sq    90.4%
R-Sq(adj) 89.4%
Root Causes and Improvements

Root Causes to Poor Experience

- Slow to respond for getting out of bed
- Slow to respond to request for help (Call light)
- Labs taken at 2 AM inconvenient

Improvements for each Root Cause

1. Hospital-wide communication of current state and need to improve patient experience to grow
2. Manage to the measure daily with all staff
3. Engage all staff in root cause analysis and celebrating quick wins
4. Lab leading effort to get physician orders changed to allow night before
Simple Leadership Standard Work
Utilising the 3Ms for High Reliability

1) Measure accurately and frequently
   1) Keep score - the more real time the better
   2) Use statistical process control to validate changes
   3) Ensure everyone can see the score – “the entire game”

2) Manage to the Measure - Just-In-Time
   1) Swarm the problem
   2) Reinforce swarming and celebrating to the charts
   3) Share the charts daily
   4) Be a role model

3) Make it Easier - To measure and to do the right things:
   1) Equipment ready to go
   2) Know what the customer wants
   3) Do standard work