2022 | 2023

NEXT GEN AHA Leaders Fellowship

Capstone Project Posters

A collection of year-long capstone projects from the 2022-2023 cohort of the Next Generation Leaders Fellowship.

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***Age-Friendly Fellows**

The national fellows class of 2022-2023 tackled key challenges affecting health care **equity**, **workforce**, **quality** and **safety**.

The health care landscape is continuously changing in unpredictable ways. New challenges and disruptions on multiple fronts across the health care continuum are pressing hospitals and health systems to seek and shape future leaders with bold perspectives and specialized skills across multiple dimensions of health care - from technology and innovation to equity and well-being. Tomorrow's leaders will have the knowledge, skills and adaptability to lead change and create a culture of innovation, resiliency and inclusion.

The **American Hospital Association's Next Generation Leaders Fellowship**, focused on developing leaders and empowering them to bring about real and lasting change in health care, announced its inaugural class of fellows consisting of 40 talented individuals, including 10 age-friendly scholars.

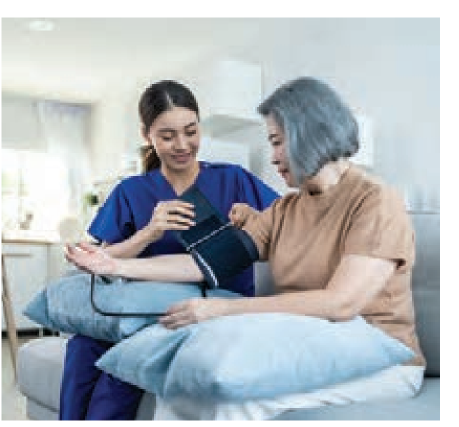
Fellows hailed from 20 states across urban, suburban, and rural communities, each making significant contributions to their respective hospitals through a wide range of roles, including quality, equity, nursing, patient experience, business development and geriatrics. During the 12-month-long fellowship program, participants honed essential skills, such as expanding innovation capacity, driving organizational change and digital transformation, and leading the shift from health care to well care.

Each fellow was carefully matched with a mentor for personalized guidance. Fellows worked one-on-one with their mentor to execute a transformation capstone project specific to a challenge within their organization. Participants engaged virtually through inquiry-based modules, discussions and challenge-based solution sprints.

> Our health care leaders face many serious challenges at once and must make difficult decisions that will impact their organizations, patients and communities.
>
> **The AHA Next Generation Leaders' fellows have demonstrated their ability to manage change in the face of uncertainty while also advancing health care transformation.** Throughout the yearlong program, they've gained the skills needed to lead behavioral and system-based changes at their organizations.
>
> **- Jen Braun**
> Director, Workforce and Organizational Development, American Hospital Association

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

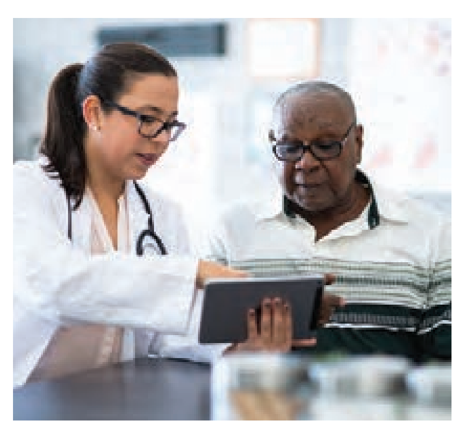
The AHA Next Generation Leaders Fellowship program prioritizes the unique **care needs of older adults.**



Age-friendly health care is an urgent need. There are more than 54 million people in the U.S. age 65 and older, and that number is projected to grow to 95 million in 2060. As we age, we are greater risk of experiencing harm in health care settings.

Health systems are working to meet the needs of the growing population of older adults. In 2017, The John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States, set a bold vision to build a social movement so that all care with older adults is age-friendly care, which:

- Follows an essential set of evidence-based practices;
- Reduces or prevents harms; and
- Aligns with What Matters to the older adult and their family caregivers.

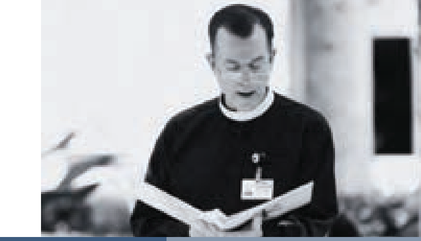


The John A. Hartford Foundation provides scholarships for a cohort of Age-Friendly Health Systems Fellows who will participate in the Next Generation Leaders Fellowship. These applicants are asked to implement the 4Ms (what Matters to the older adult, Medication, Mentation and Mobility) Framework at their organization for their change project in the fellowship program.

Class of 2023 | **AHA Next Generation Leaders Fellowship**

Ashley Abbondandolo
Director, Business Development & Physician Relations
Memorial Healthcare System

SPIRITUAL CARE JOURNEY



INTRODUCTION

Spirituality is how an individual finds meaning, hope, comfort and inner peace in life. Spiritual care involves caring for the whole person – physically, emotionally, socially, and spiritually. It also plays an important role in a patient's decisions about their care and their outcomes.

Spiritual care is integral to healthcare organizations. The spiritual care team is essential to ensuring patient wellbeing and is the provision of assessment, counseling, support and religious rituals. Spiritual care is a contributor to providing patient-and-family-centered-care.

Spiritual Health Association

PROBLEM

At Memorial Healthcare System there is a lack of knowledge, understanding, and staffing for spiritual care system-wide to serve our patients and staff.

RECOGNIZED VARIABILITY IN:

Spiritual Care Staffing (Paid vs. Volunteer)
Training & Orientation
Credentials, Education, & Certifications
Reporting & Structure
Documentation
Care Team Integration
Policy and Practice

RECOMMENDATIONS

- Conduct a system survey of spiritual care offerings at each facility
- Engage a best-practice vendor to complete an assessment of spiritual care staffing and services at MHS compared to other similarly structured organizations
- Increase spiritual care staffing across the system to a facility size and acuity adequate level
- Create tracking mechanisms - both temporary and permanent - for spiritual care visits
- Work with all leadership over spiritual care to develop an onboarding policy for our voluntary chaplains
- Eliminate variability amongst facility spiritual care visits and policies

GOALS

1. Improve the staffing, response, and assessments of the spiritual care departments at each of our 6 facilities and our cancer center.
2. Standardize the documentation, processes and procedures for spiritual care visits system-wide.
3. Improve the onboarding of new voluntary community parish members into the Memorial Healthcare System.

OUTCOMES

Consultant Analysis
- Fully executed contract with Healthcare Chaplaincy Network
- Beginning phase of analysis taking place with the consultant

Flagship Staffing Success
- Memorial Regional Hospital staffing increased from 1.5 FTEs to 3.5 FTEs
- 24/7 coverage with these added FTEs

Patient Bereavement Committee
- Deployed bereavement boxes to each unit for patients
- Created bereavement policies for Veterans, First Responders, and Employees

Schwartz Rounds
- Grand rounds facilitator teams created to respond to the emotional impact of patient care for staff stress management

Ethics Committee
- JDCH and MRH began their facility level ethics committees and are being consulted by inpatient physicians
- System ethics process is being evaluated and will be discussed during spiritual care consulting agreement

NEXT STEPS

- Integrate with palliative care and ethics teams
- Hire staff, roll out policies, procedures and expand spiritual care offerings as awareness expands
- Implement recommendations from the consultants
- Present the recommendations to Executive Leadership
- Complete the consulting assessment

Michael C. Backus
President/CEO
Oswego Health

CHANGE MANAGEMENT-

A ROAD MAP TO SUCCESS

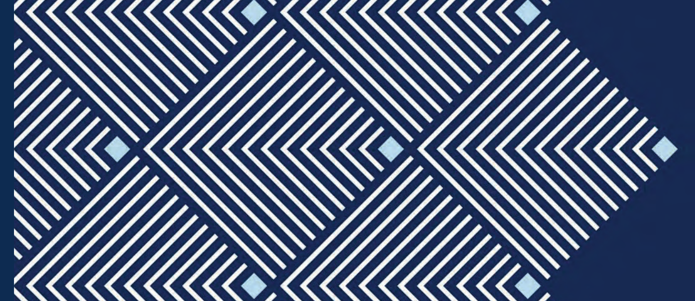
Effectively transitioning the leadership of an organization requires an attentive focus on change management that creates commitment throughout the hierarchy of an organization.

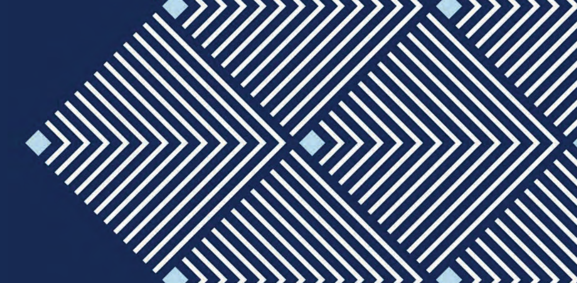
Everyone should be united around a well communicated and achievable goal - in this instance the retirement and succession of the President/CEO of Oswego Health.

1. Successfully on-board transitional figure
2. Create internal/external communication plans to foster buy-in
3. Rebuild and stabilize organizational structure

4. Deploy "WE CARE" marketing campaign to align with transition of leadership, culture of organization, and future direction

5. Adopt a growth strategy that focuses on a reinvestment in our people, services, programs, and footprint.





Vernee Belcher, MD FACP

Finding What Matters, an Age-Friendly Journey

Duke Regional Hospital

Finding What Matters, an Age-Friendly Journey

Situation Analysis

Duke Regional Hospital is a 388 bed hospital located in Durham, NC. 7,000 patients aged 65 and older are admitted annually. This population has complex needs that put them at higher risk of poor outcomes, including increased morbidity, mortality, and healthcare utilization. Duke Regional Hospital is participating as an Age-Friendly Health System with the goal of delivering Geriatric Care in a coordinated, patient-centered manner.

An Interprofessional team is utilizing the 4Ms framework to direct a multifaceted approach to care that addresses What Matters to patients, Mobility, Medications, and Mentation.

At the start of our Age-Friendly journey, What Matters conversations were conducted by Palliative Care, Chaplains, Therapists, and Case Managers. The Age-Friendly Steering committee sought to develop protocols for Hospitalists (Hospital Medicine physicians and APPs) to conduct What Matters discussions with patients. These discussions ask patients to share their goals for their health and extend beyond a code status discussion.

Project Goals

- Educate Hospitalist providers (Hospital Medicine physicians and APPs) on the Age-Friendly Initiative
- Task Hospitalists to have What Matters discussions to learn more about patient's goals for their health and care preferences.
- Encourage sharing the What Matters conversation with the healthcare team through documentation in the electronic record (in progress notes and the discharge summary) and through case discussions during Interdisciplinary rounds with team members from nursing, Pharmacy, Case Management.

Actions

- Hospitalists were educated on the Age-Friendly initiative through an information session during a Hospitalist Monthly meeting, informative emails, and during several Hospitalist Huddles (biweekly meetings where on-service team members discuss initiatives).
- A What Matters Most dot phrase was used to track the discussions using the EHR.
- Implementation was piloted on 2 medical units. Dot phrase usage is being monitored.
- A Qualtrics Survey of Hospitalists sought to gain insight into provider's awareness of the initiative and barriers/facilitators to engagement.

Outcomes

- The Qualtrics Survey of Hospitalist providers showed that a majority of the 16 respondents were aware of the Age-Friendly Initiative (93.75%), asked patients about their health goals (62.5%), documented the conversation (56.2%), and were willing to share the discussion during Interdisciplinary Rounds (81.25%).
- Barriers to What Matters discussions: Time limitations, documentation burden, forgetting to adopt a new process, and uncertainty regarding how the discussion would change management.
- Facilitators to What Matters discussions: knowing how to record the discussion (for example, using the What Matters Most dot phrase or an Advanced Care Planning Note).
- What Matters Most dot phrase is increasing. Recent EHR reports show 34 instances noted over 1 month, then increased to 74 uses over the subsequent month. (These values do not capture discussions documented without using the dot phrase.)

Next Steps

- Age-Friendly Care utilizing the 4Ms framework has been shown to improve patient satisfaction, reduce costs, and improve outcomes. We will provide ongoing team training and refinement of the processes.
- Provide Inter-professional education on the medical units to improve staff understanding of Age-Friendly Care across disciplines
- Increase Hospitalist awareness that other providers are also having What Matters discussions and incorporate an Interdisciplinary approach to information gathering
- Continue to monitor the usage of the What Matters Most dot phrase and support building the What Matters discussion into Hospitalist workflows.
- Monitor the incorporation of What Matters discussions of the patient's preferences for their care into Interdisciplinary Rounds.
- Achieve Age-Friendly Participant Level 2 recognition (Committed to Care Excellence) by continuing to collect data on implementation of all 4Ms.

Acknowledgements

Thank you to the DRH Hospitalist Team and DRH staff, DRH AFHS Steering Committee, John A. Hartford Foundation, and the AHA Action Community 4.

Class of 2023 | **AHA Next Generation Leaders Fellowship**

Floye Bradford
Director Quality
Northern Arizona Healthcare

Shared Leadership Improves Quality Outcomes

Situational Analysis

Persistent challenges sustaining high quality outcomes (e.g. healthcare acquired infections, injury falls, etc.)

- Variation in outcomes exacerbated by COVID pandemic related challenges

Quality measures perceived as "owned" by the Quality department

- Initiatives to improve outcomes led by Quality staff with variable participation
- Limited staff engagement in quality; improvement work considered "one more thing"

Project Goals

- Better patient outcomes
- Transition leadership & responsibility for clinical quality processes to clinical managers & directors
- Build structures to develop & support new leaders
- Increase executive involvement in understanding and promoting quality

Actions

1. Define committee structure for quality initiatives
2. Assign leadership roles to clinical managers and directors along with whatever additional members are needed – (physicians, IT, etc.)
3. Empower committees to determine process and outcome measures

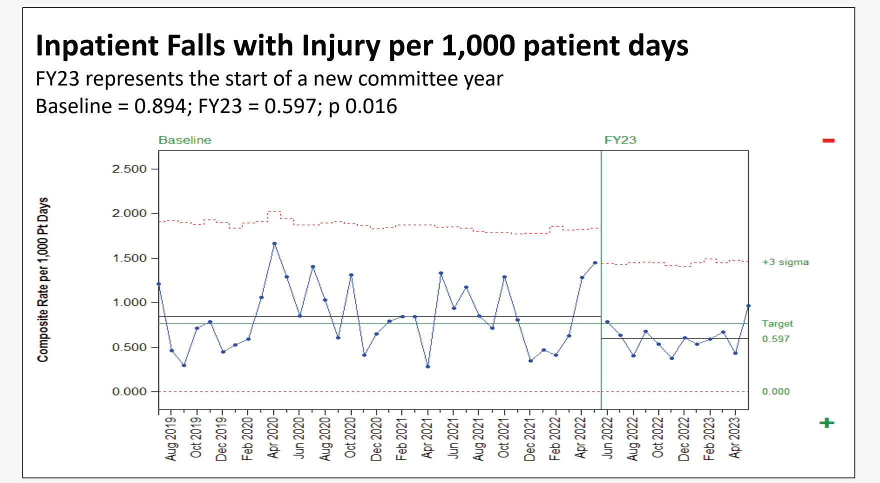
   For example: the Central Line-Associated Blood Stream Infection (CLABSI) subcommittee is responsible for tracking and improving process measures for blood culture contamination, CHG bathing, and central line audits as well as whether or not there is an infection
4. Provide mentorship & guidance for committee leadership
5. Monitor quality outcomes & provide assistance as needed
6. Celebrate success and recognize teams

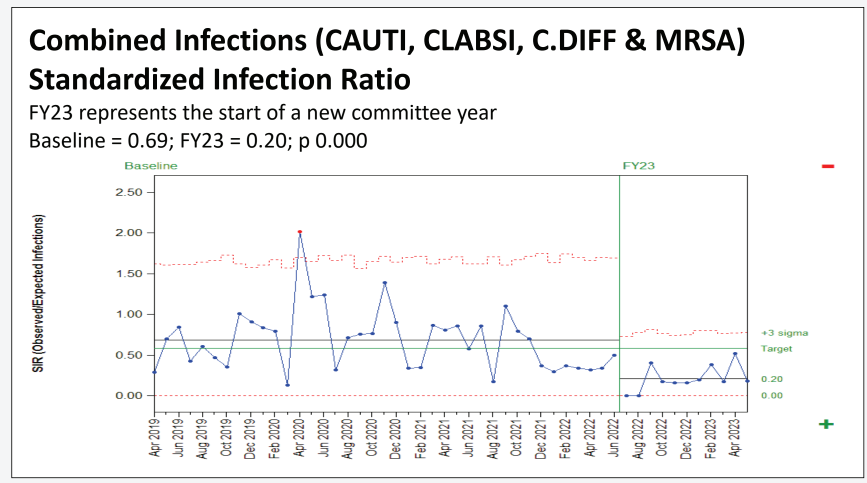
Outcomes

Giving leaders outside of the Quality department ownership over clinical quality initiatives and the right structure to support that work has decreased variation in care-delivery processes and led to significant improvements in healthcare acquired infections (HAIs), injury falls, length of stay, and other measures

Notable achievements:

- **>4% reduction** in Geometric Mean Length of Stay
- **>20% reduction** in hospital acquired pressure injuries
- **>30% reduction** in hospital acquired blood clots
- **>30% reduction** in injury falls
- **>60% reduction** in infections [central line-associated bloodstream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), Clostridioides difficile Infection (C.DIFF), and Methicillin-resistant Staphyloccus aureus infection (MRSA)]
  - 354 days CAUTI free & 448 days CLABSI free

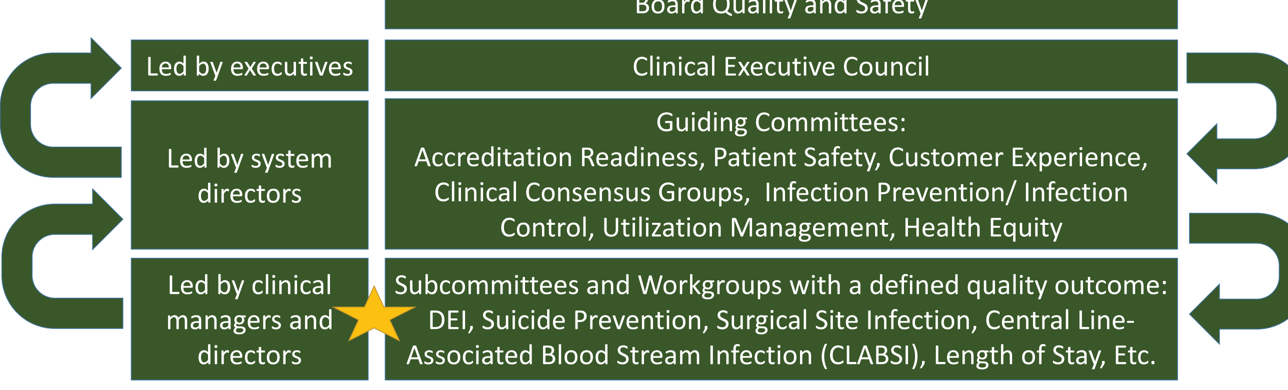




"The collaboration between the clinical leaders, quality partners, physicians and other ancillary staff has been incredible. It feels great to be a part of making real change in the quality of care we give our patients. Most importantly, we are creating a positive shift in how we care for our patients; putting safety first"

– Audra Carter VTE Subcommittee Lead and Nurse Manager

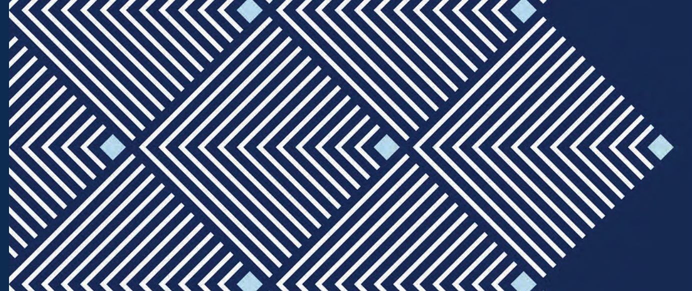
Quality & Safety Governance Structure



This structure empowers clinical managers and directors by giving them ownership over a defined quality outcome. Those leaders deliver regular reports to guiding committees that engage executives and the board.

Next Steps

- Standardize process improvement education and tools
- Track completed projects to ensure effective control plans



William Bryant
VP Perioperative Services
ChristianaCare, Newark, DE

Anesthesia Technician Training: The Future Model of Care

- **Situation Analysis**
  - The Anesthesia Technicians supporting care delivery within ChristianaCare are not currently certified and lack a career pathway for professional development and advancement.
- **Project Goals**
  - To develop an evidence-guided Anesthesia Technician training program that will create a pipeline of allied healthcare workers and promote career-enhancing opportunities, while optimally serving the needs of Delaware residents.
- **Actions**
  - Confirm the market need for developing an Anesthesia Technician Training Program.
  - Explore academic partnerships to facilitate the Anesthesia Technician Training Program.
  - Identify required knowledge, skill and competencies required for the Certified Anesthesia Technologist role.
- **Outcomes**
  - Conducted a current state gap analysis with the American Society of Anesthesia Technicians and Technologists (ASATT).
  - Established a strategic partnership with Delaware Technical Community College.
  - Received notification of the Practical Experience Pathway from ASATT, a bridge towards certification for experienced but uncertified anesthesia technicians.
- **Next Steps**
  - Gain curriculum approval from ASATT.
  - Launch Anesthesia Technician Training Program Fall/Winter '23.
  - Provide 2yr. ASATT membership to each ChristianaCare Anesthesia Technician.
  - Develop a Career Ladder to support caregiver inclusion, development and advancement.

Leigh Caswell
VP, Community and Health Equity
Presbyterian Healthcare Services

PRESBYTERIAN Healthcare Services

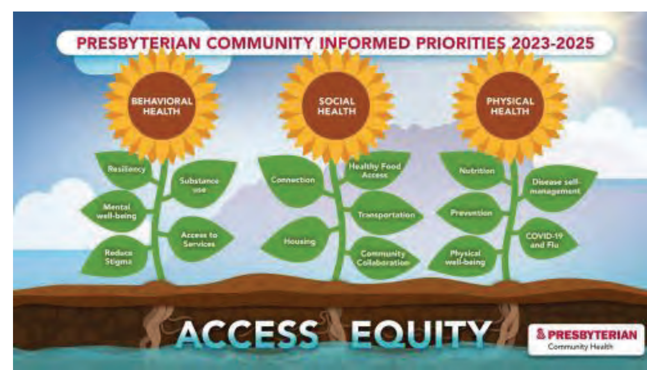
Improving Health Equity for our Patients, Members, and Communities

Our Why

Health Inequities Cause Moral Injury

"My inability to address social inequities created moral distress and a sense of powerlessness."
Claudia A. Finkelstein. M.D.C.M. Faculty University of Washington, Seattle

Equity is at the Core of Our Community Priorities



Project Goals

- Address social needs of our patients and members through universal screening, resource referral, and navigation
- Develop and implement a health equity curriculum for workforce and network providers
- Utilize and strengthen health equity analytics to increase understanding of patient outcomes to guide improvements in care and measure outcomes
- Strengthen communication with patients, members, and workforce regarding health equity
- Improve health care services for patients and members that experience inequities in outcomes

PRESBYTERIAN

Our Health Equity Framework

The Project Focused on Building a Foundation for Equitable Outcomes

Our Health Equity Foundation

Foundational infrastructure
- Leadership accountability for learning and prioritization
- Improved integration and collaboration
- Training/learning/tools
- Data collection of REaL/SOGI/SGN and stratification to prioritize
- Language access
- DEI
- Social needs screening and referral – over 2 million screenings
- Improving access
- Community investments and partnerships

Implement priority population action plans
- Perinatal
- LGBTQIA+
- Indigenous and Native American

PRESBYTERIAN

Next Steps: Priority Area Action Plans for 2023 - 2024

Katie L. Chieda RN, BSN, MSN/MBA, CENP
Chief Nursing Officer
Fisher-Titus Health

Care Model Redesign – Virtual Nursing Strategy

Project Statement: Develop and implement a virtual nursing care model trial to support the medical-surgical nursing units at Fisher-Titus Medical Center. Through this development, we will be redesigning the care model by introducing the role of a virtual nurse. Following the trial, we will then determine the impact on overall care delivery team, skill mix, etc.

Development/Actions

Developed virtual nursing role definition and process to engage stakeholders in virtual nursing trial.

Completed eight-week trial with virtual nurse completing admission, discharge, & patient education through iPad with limited technology.

Lessons Learned

- iPad offered significant limitations
  - The size of the trial is important
- Consistency in Virtual Staffing is vital

Next Steps

Complete outcome data review and establish 2024-2025 Strategy by identifying the appropriate technology to support the vision of virtual caregiver, fall prevention, and virtual provider connection.

Linsey Coster, LMSW
Vice President, Operations
Ascension Via Christi Hospitals Wichita

Limb Preservation Program

Situation Analysis

Nearly 2 million people in the United States are living with Limb Loss. With approximately 185,000 amputations occurring each year, by 2050 it is estimated that a staggering 3.6 million people will be living with an amputation.

Unsettling Statistics

The main causes of limb loss are diabetes and vascular disease.

Nearly half of individuals who have an amputation due to vascular disease will die within 5 years. This is higher than the five year mortality rates for breast cancer, colon cancer, and prostate cancer. (1)

Of persons with diabetes, having a wound immediately doubles one's chances of dying at 10 years compared to those without. In those who have a lower extremity amputation, up to 55% will require amputation of the second leg within 2- 3 years. (2)

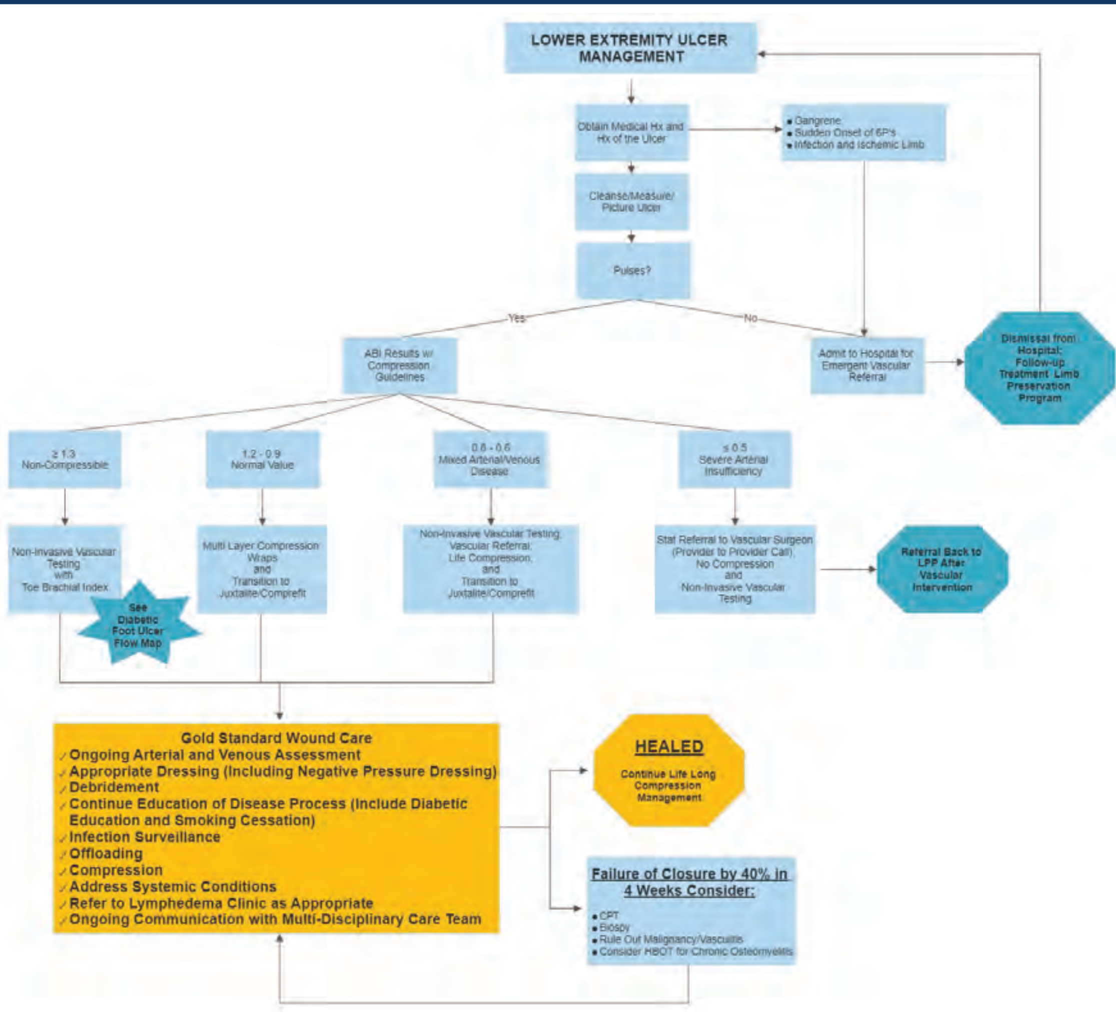
There are a variety of therapeutic approaches to patients with limb-threatening ischemia. Nearly 50% of patients undergoing major amputation have not had a simple diagnostic arteriogram to assess the possibility of limb preservation. (3)

References

1. (Robbins JM, Strauss G, Aron D, Long J, Kuba J, Kaplan Y. Mortality Rates and Diabetic Foot Ulcers. Journal of the American Podiatric Medical Association2008 November 1, 2008;98(6):489-93.)
2. (Pandian G, Hamid F, Hammond M. Rehabilitation of the Patient with Peripheral Vascular Disease and Diabetic Foot Problems. In: DeLisa JA, Gans BM, editors. Philadelphia: Lippincott-Raven; 1998.)
3. (Neville, R., Kayssi, K. Development of a Limb-Preservation Program. Blood Purif 2017;p. 218-225. DOI: 10.1159/000452746.)

Project Goals

Eliminate patients with ischemic limbs being seen in a fragmented manner without the benefits of coordination of care in order to prevent limb amputation; by expanding current wound management service through the use of an interdisciplinary team approach, bringing holistic care which sustains and improves the health of individuals, to the patient.



Next Steps

Anticipated go live for the Limb Preservation Program is late September 2023.

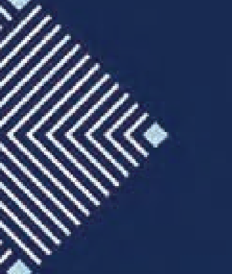
Actions Taken

- Perform business case review with proforma utilizing Assess, Analyze, Act Method
- Seek Executive Leadership approval for new business opportunity
- Identify key interdisciplinary team members
- Establish referral process: scheduling, authorizations, billing, benchmarking data collection
- Create order sets, protocols, algorithms and patient education
- Identify ancillary services included: clinic staffing, laboratory, non-invasive vascular studies
- Establish process for charge capture (professional and facility fees)
- Create Surveillance Program Algorithm
- Finalize marketing/media plan for go live

Outcomes

New Patient Goal
New Patient Show Rate

- Intervention Time - Admit to Treat
- Discharge Rate
- Hospital Amputation Rate
- Hospital Readmission Rate
- Use of Hyperbaric Medicine Therapy - HBO
- % of Vascular Assessment for New Chronic Wound/Ulcer Lower Extremity
- % of Off-Loaded New DFU Patients
- % of Compressed New VLU Patients
- % of Nutritional Screenings Completed
- Collection of Social Determinants of Health Information Sheets



Deepa Dierickx, MSOTR/L
Outpatient Therapy Manager, Brain Injury Services
Craig Hospital

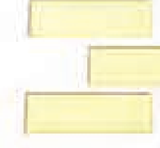
How Was the Road to the Emerald City Built?

GOAL

- Define Craig Hospital's role in assisting patients with brain injury in obtaining the right specialty services at the right time

CHALLENGES

- Wait list of 25 people ready for services
- No method of tracking general progress over the lifespan.



PROCESS & DATA COMPLEXITIES

- Multiple entry points into the system
- Rapid increase in demand for services
- EHR not built for complex coordinated scheduling
- Select populations receiving long term data collection
- Scarcity of standardized outcome measures for moderate to severe brain injury
- Inaccuracies transferring legacy patient demographics to new EHR

SOLUTIONS

- Created and implemented a coordinated, comprehensive patient-centered intake and scheduling process
- Identified valuable outcome measures
  - Disability Rating Scale (DRS)
  - Satisfaction with Life Scale (SWLS)
  - Continuity Assessment Record and Evaluation (CARE) tool

OUTCOMES

NEXT STEPS

- Gap analysis of continuum of care
- Implementation of standardized outcome measures
- Data tracking over time of wait list numbers, patient satisfaction, revenue, outcome measures

Danielle Gabele, DNP, RN

Chief Nurse Executive

Ventura County Medical Center and Santa Paula Hospital

Development and Implementation of a Nursing Strategic Plan

Situation Analysis

- Hired as CNE September 2022
- 180 bed Level 2 trauma center, 42 bed Psych unit, 49 bed rural hospital
- Frequent transitions in executive nursing leadership
- Strategic planning and goals for the hospitals were set by county Board of Supervisors for the county overall.
  - No specific goal setting or strategic planning existed for hospital.
- Nursing in the hospitals practiced traditional nursing model and did not look at current best practice to improve care.
- CNE wanted to introduce topic of Quadruple Aim to provide framework to nurses about the key pillars to practice.
- Development of a strategic plan would accelerate the CNE onboarding process.

Project Goals

- To accelerate assimilation into the organization as a new leader
- To create a blueprint for the nursing program in my organization
- To develop a set of common goals for my team

Actions Taken

- **Identify Strategic Pillars to guide nursing priorities**
  - Complete Full Assessment of Nursing Team
  - SLOT Assessment on All Leaders
  - Culture of Safety Survey review
  - Nurse Sensitive Indicator Review
  - Discuss CEO/COO priorities
- **Develop Strategic Plan pillars**
  - Adopt Quadruple Aim Concept
  - Get CEO and COO buy in
  - Literature Review from other organizations
- **Engage with Frontline Staff**
  - Quarterly Town Halls
  - Staff Meetings
  - Union negotiations
  - Core Skills Day presentations
- **Develop Plan and Timeline for Implementation**
  - Ask Directors to review feedback from frontline staff.
  - Assimilate lists and assign priorities in conjunction with nurse leaders
  - Identify performance metrics.
  - Perform PDSA as plan is launched and adapt as needed.
  - Determine what determines success and sustainment.
  - COMMUNICATION IS KEY- enhance nursing communication with weekly huddles and weekly night shift calls.

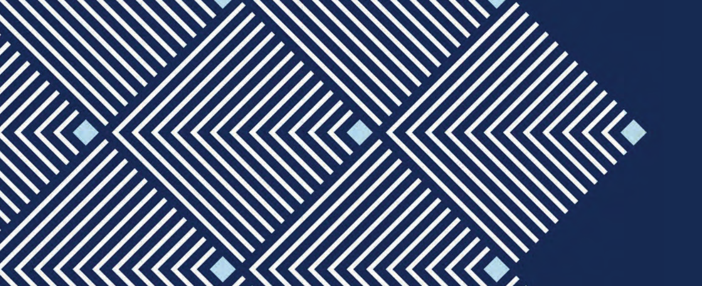
Patient Care (Quality)	Patient Experience	Staff Experience & Development	Growth & Stewardship
<u>Sustained improvement to NSIs:</u> Falls with Injury per 1000 patient days (transition to NDNQI) CAUTI and CLABSI per 1000 patient days HAPU stage 2 and above <u>Strategies:</u> • Bedside Handoff • Hourly Rounding	<u>Improve Patient Engagement:</u> How would you rate overall > or = NRC benchmark Discharge education Programs for vulnerable populations (Cal Bridge, Withdrawal Unit)	<u>Increase Staff Engagement:</u> • Improve engagement (utilize Culture of Safety survey as proxy) • Enhance recognition programs (Daisy, Daisy Nurse Leader) • Implement Shared Governance • Enhance MD/RN communication • Evaluate nursing documentation burden	<u>Improve Recruitment & Retention:</u> • Decrease RN vacancy rate • Decrease voluntary turnover • Implement new graduate RN residency program • Collaborate with nursing schools to build pipeline • Develop student nurse program
<u>Increase Clinical Efficiency and Improve Throughput:</u> • Decrease ED LOS and ED holds • Case Management department redesign • Multidisciplinary rounds • Discharges by 11 am program • Plan for OBS unit creation <u>Enhance Knowledge of PI methodologies and Data Collection:</u> • Introduce PDSA/A3 methodology • Develop NDNQI benchmarking • Enhance reporting and data transparency	<u>Patient Satisfaction:</u> • Leader Rounding program • Expansion of Volunteer Services • AIDET- consider hands-on skills training	<u>RN Professional Development:</u> • Formal career ladder • Increase BSN and specialty certification rates • Succession planning • Onboarding standardization • Formal preceptor/ charge nurse training programs • Enhanced specialty education (chemo, CRRT, EKG) • Build foundation for Pathway to Excellence • Implement leadership development curriculum (AACN HWE framework) to include the house sups	<u>Financial Stewardship:</u> • Decrease overtime hours by 10% • Decrease agency expenses by 30% • Sitter utilization project • Staffing agency consolidation • Centralized telemetry • Productivity and financial reports <u>Program Development</u> • Beacon Award for ICU • TJC Palliative certification
		<u>Enhance Communication:</u> • Open Forums (quarterly) • Teambuilding (consider TeamSTEPPS) • Standardize written communication methods	

LEGEND

1st 90 days	1st 6 months
Year 1	Year 2
Year 3+	If no color- ongoing

Positive Outcomes

- Shared goals across nursing
- Improved communication from top down and bottom up with staff feedback
- Consistent messaging from leaders and common language
- Ability for leaders to prioritize based on strategic goals
- Clarity of expectations
- Timeline to keep momentum going and hold the team accountable



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Adam Gobin
Assistant Vice President
Wellstar Health System

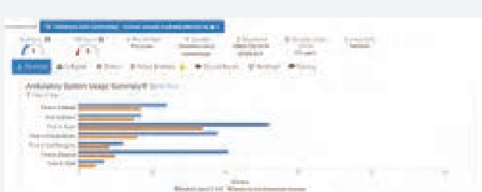
Reduction in open chart average days at Wellstar Medical Group

Background

Wellstar Medical Group historically has an industry leading and competitive overall charge lag of 3 days or less. There are several key checks and balances being used to monitor charge lag daily including missing charge reports, daily charge review emails to all leaders, monthly executive report outs, and weekly reports to service lines. Open charts, however, present a unique opportunity where there are ambulatory technical gaps in reporting and visibility of open charts and open chart trending. For these reasons, physicians are not frequently able to get the visibility and transparency into their open charts across the organization.

Identifying the root causes

Open chart aging can have impacts to the patient experience, clinical quality reporting timeliness, and cash turnaround time. The root causes of open chart aging at Wellstar Medical Group is 1) lack of visibility and reporting within Epic and 2) physician documentation streamlining and efficiency in Epic.



Current state

In fiscal year 2022, Wellstar Medical Group and Wellstar Health System executive leadership approved a physician open chart policy that removed work RVUs from physician compensation if the physician had any open charts greater than 60 days old (from date of service).

Once this open chart policy was enacted, there was an immediate drop in open chart aging, by over 60%.

1

Project Goal #1: Set a target

According to MGMA's nationwide poll, 79% of physicians close their charts within 72 hours (3 days).

With Wellstar's leadership approval, a new goal will be set for Wellstar physicians to abide by, that is aligned more closely with industry standards.

Action #1: Set a target

Wellstar Medical Group executive leadership agreed and approved on a 10-day policy requirement for open charts. Any open charts that are older than 10 days, physicians will have their work RVUs removed, and thus impact their compensation.

Outcome #1: Set a target

Awaiting final feedback and approval from the Wellstar Medical Group provider compensation committee prior to implementation of this revised open chart policy.

2

Project Goal #2: Create an action plan to address root causes

The root causes of open chart aging at Wellstar Medical Group is 1) lack of visibility and reporting within Epic and 2) physician documentation streamlining and efficiency in Epic.

Action #2: Create an action plan to address root causes

Root Cause #1: lack of visibility and reporting within Epic
Action item: Partnered with Wellstar Health Information Management to monitor and track the completion of open chart comparable to how we track deficiencies for providers regarding to hospital medical records completion.

Root Cause #2: physician documentation streamlining and efficiency in Epic
Action item: Partnered with Wellstar Clinical Informatics to target physician training needs using Epic's Signal chart proficiency dashboards.

Outcome #2: Create an action plan to address root causes

Root Cause #1: lack of visibility and reporting within Epic
Outcome: Epic built of a report to be able to monitor unsigned notes, unsigned orders, and open encounters is currently in discovery.

Root Cause #2: physician documentation streamlining and efficiency in Epic
Outcome: Implemented (no comparison data available yet).

3

Project Goal #3: Implement a revised open chart policy in 2023 that is in line with industry standards

A revised version of Wellstar Medical Group's open chart policy has been drafted to reflect removal of work RVUs for open charts greater than 10 days.

Action #3: Implement a revised open chart policy in 2023 that is in line with industry standards

The revised and currently draft version of Wellstar Medical Group's open chart policy that reflects a proposal to remove work RVUs for open charts greater than 10 days has been presented to Wellstar Medical Group's executive leadership team.

The proposal includes a financial analysis that compounds the importance of closing charts timely from a patient experience and clinical quality perspective.

Outcome #3: Implement a revised open chart policy in 2023 that is in line with industry standards

The revised and currently draft version of Wellstar Medical Group's open chart policy that reflects a proposal to remove work RVUs for open charts greater than 10 days has been approved by Wellstar Medical Group's executive leadership team, and awaiting final approval by the provider compensation committee.

Total financial impact of the 10-day policy proposal - $950,775 in quicker cash turnaround per month ($11.4M annually)

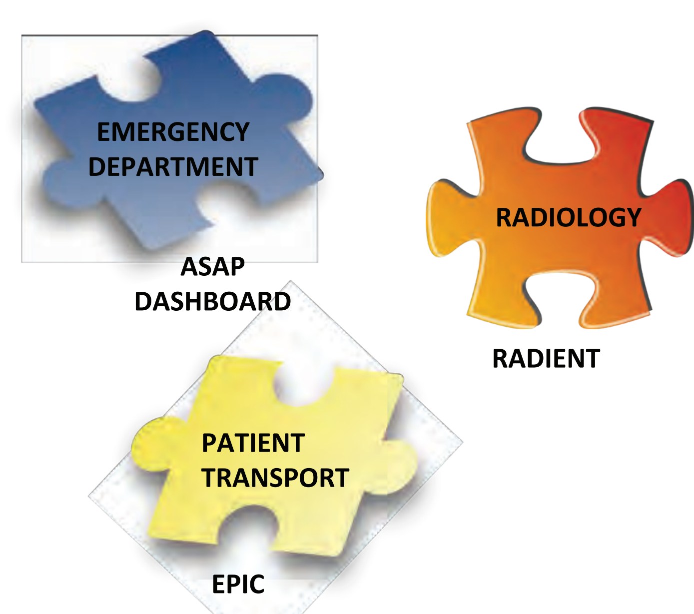
Next Steps

1. Provider Compensation Committee Presentation & Approval – July 2023
2. Wellstar Health System Executive Leadership Approval & Signature – September 2023

Danneil Hamilton
Associate Director
NYC Health +Hospitals

Optimizing Patient Flow: A Holistic Approach to Improving Healthcare Delivery

DEPARTMENTS (in Silos)



Elmhurst has the longest TAT for CT with & without contrast (6 Hours)

Radiology Zone Transport Volume

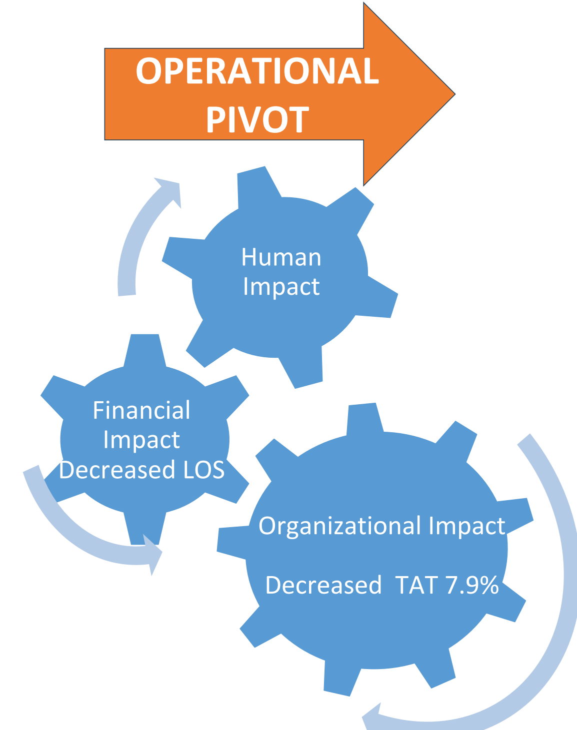
- 5,962 Transports per month
- 198 transports per day
- 38 min turnaround time

Overall

- 14,473 Transports
- 482 transports per day
- 47 minute turnaround time

"There is a *strong correlation* between patient satisfaction and length of stay. *Patients who are satisfied with their care are more likely to be discharged sooner.*"
- Johns Hopkins Medicine

OPERATIONAL PIVOT



April	May	June
4:13hrs	4:12hrs	3:45hrs

CTs with contrast

April	May	June
3:20hrs	2:55hrs	2:51hrs

CTs without contrast

DEPARTMENTS (in Synergy)

Radiology Zone Transport Volume

- 6,822 Transports
- 227 transports per day
- 35 min turnaround time

Overall

- 15,747 Transports
- 525 transports per day
- 45 minute turnaround time

NEXT STEPS

- Centralize communication between depts with appoint staff
- Scale work flow to other high volume areas

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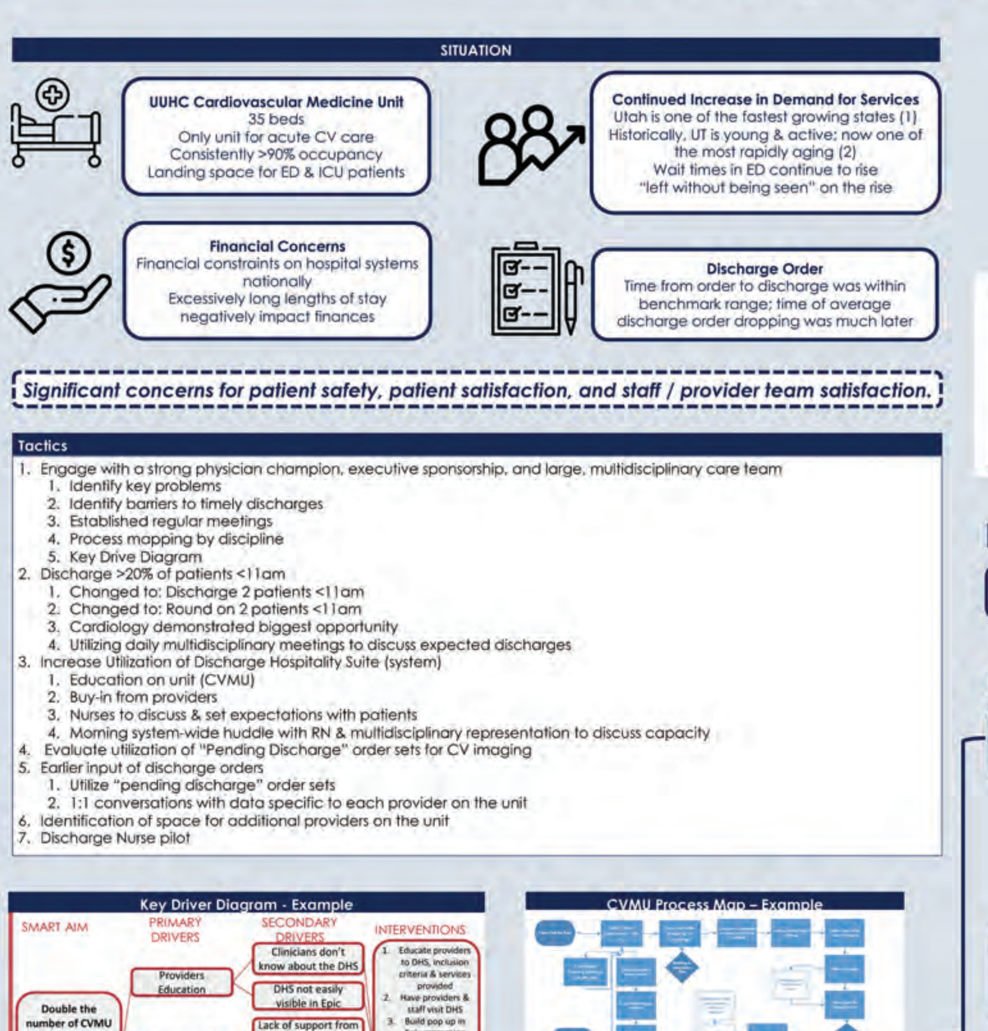
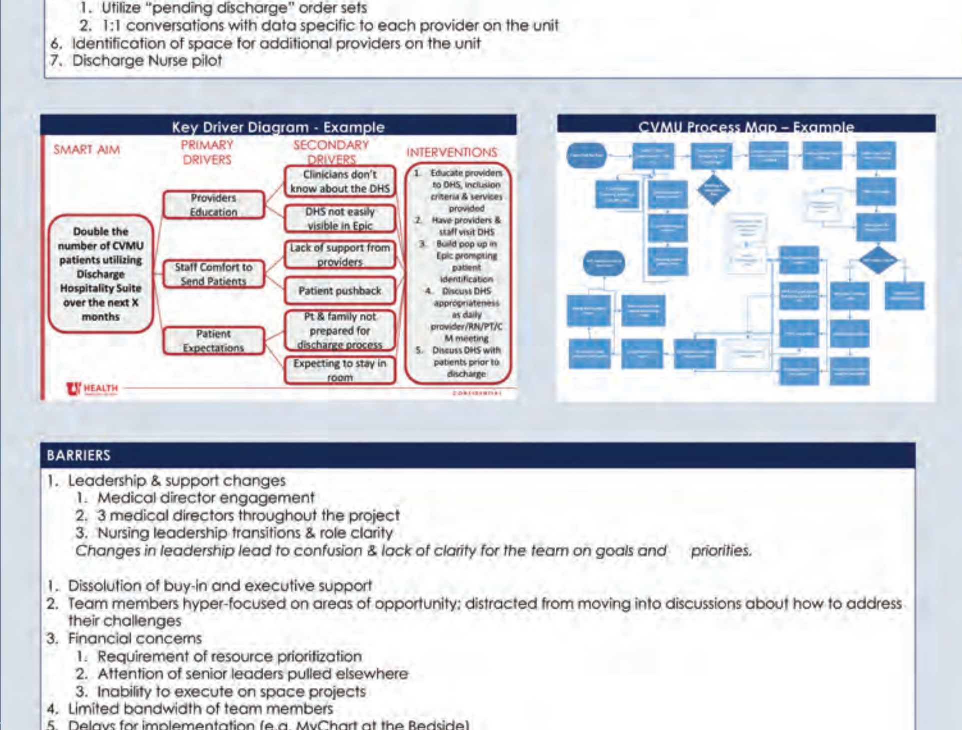
Brynn Harris, MPH
Senior Projects & Office Manager to the CEO
University of Utah Hospitals & Clinics

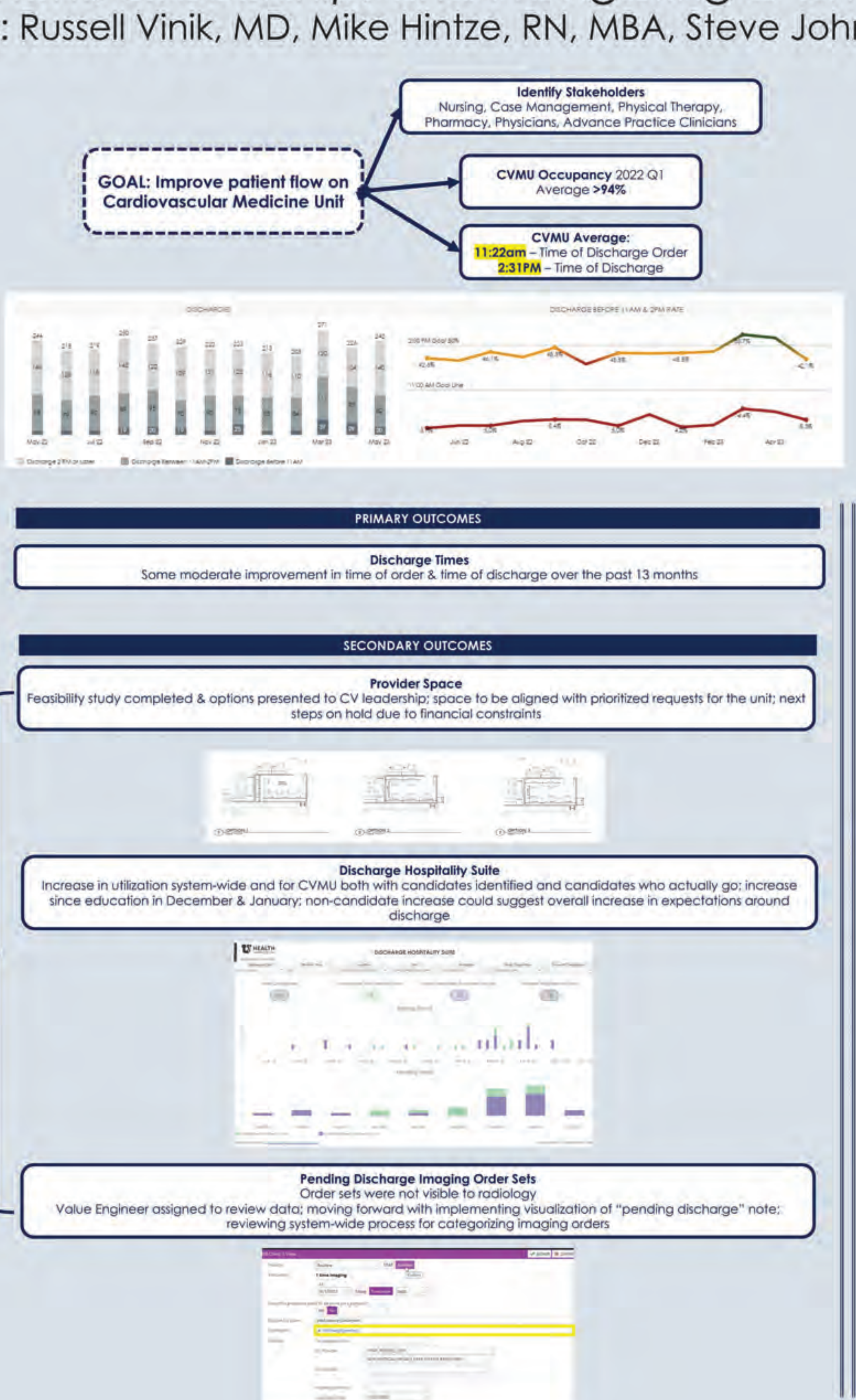
Addressing Patient Flow on a Cardiovascular Medicine Unit

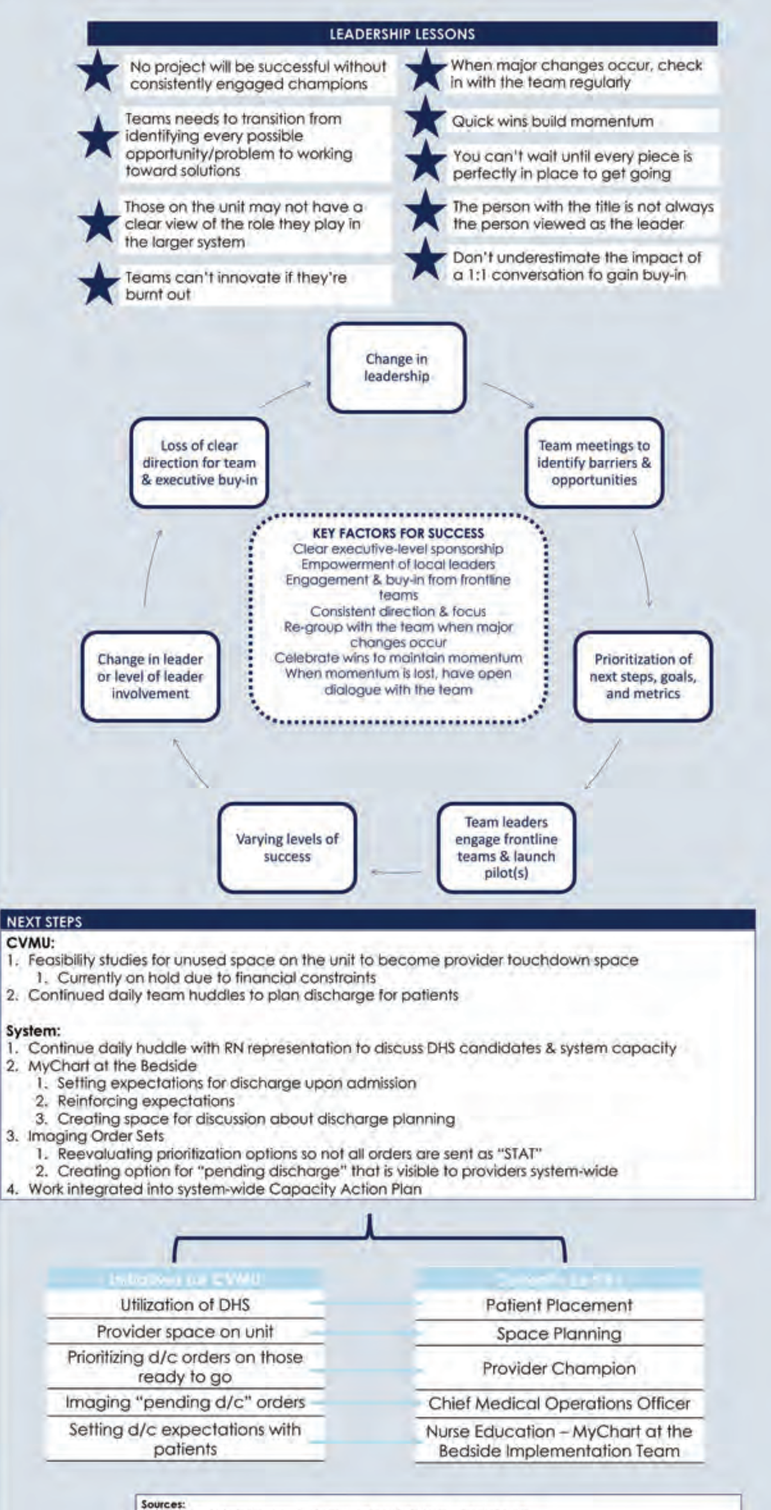
Lessons on Quality Improvement, Leadership, and Navigating a Changing Environment

Acknowledgements: Russell Vinik, MD, Mike Hintze, RN, MBA, Steve Johnson, MBA









Sources:
(1) https://worldpopulationreview.com/state-rankings/fastest-growing-states
(2) https://gardner.utah.edu/wp-content/uploads/CensusEd-Age-FS-Jul2022.pdf

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Identifying Risk Factors for Delirium : An Observational Study in an Outpatient Setting

Oluwasegun Akinyemi, Terhas Weldeslase, Eunice Odunsanya, Kenyatta Hazlewood, Mallory Williams, Christine Waszynski

Presented by Kenyatta Hazlewood, Howard University College of Medicine, Washington DC, USA

HUH HOWARD UNIVERSITY HOSPITAL

BACKGROUND

- ❑ Delirium is a complex neuropsychiatric syndrome commonly associated with poor outcomes in various healthcare settings.
- ❑ Several risk factors have been implicated in the onset of delirium.
- ❑ However, understanding these relationships in the outpatient contexts remains relatively unexplored.

OBJECTIVE

- ❑ This study aimed to identify and evaluate the factors associated with an increased risk of delirium in an outpatient setting.

METHODOLOGY

- ❑ This observational study involved a total of 67 patients in an outpatient setting.
- ❑ Baseline characteristics and risk factors for delirium were analyzed.
- ❑ A composite variable was employed to derive the outcome variable, delirium score, which was further stratified into three distinct categories: patients unlikely to have delirium, patients manifesting cognitive impairment, and patients exhibiting definitive signs of delirium.
- ❑ Furthermore, a multinomial regression analysis was conducted to examine the relationships between delirium and various risk factors including age, sex, race/ethnicity, recent falls (recent fall within 90days) , hospitalizations (recent hospitalization within 90days), and advanced age (>71 years).

RESULTS

- ❑ In this investigation, we explored a cohort of 67 patients, of whom 89.4% were black and 67.2% were female.
- ❑ The median age was 71 years, with an interquartile range of 68-75 years.
- ❑ Out of the total population, 24 (35.8%) patients exhibited cognitive impairment, while 5 (7.5%) were identified with delirium. Significant disparities in age, frequency of recent falls, and hospitalization were observed within the study group.
- ❑ The multinomial regression analysis indicated recent falls (OR=55.13, 95% CI: 2.91-1044.66, p=0.008) and age greater than 71 years (OR=1.25, 95% CI: 1.01-1.55, p=0.041) as critical risk factors contributing to an elevated risk of delirium.
- ❑ Nonetheless, despite recent hospitalizations being significantly associated with cognitive impairment (OR=3.95, 95% CI 1.15-13.61, p=0.029), they did not represent a substantial risk factor in the onset of delirium.

Baseline characteristics and risk factors for delirium among patients in an outpatient setting

Variables	Total Population (n=67)	Unlikely (N=38)	Cognitive Impairment (N=24)	Delirium (N=5)	p-value
Age (median age, Interquartile range)	71 (68-75)	70 (65-72)	72.5 (69-75)	80 (79-87)	< 0.001
Female	45 (67.2%)	26 (68.4%)	16 (66.7%)	3 (60.0%)	0.929
Race					0.41
Black	59 (89.4%)	35 (92.1%)	21 (87.5%)	3 (75.0%)	
Others	7 (10.6%)	3 (7.9%)	3 (12.5%)	1 (25.0%)	
Education level					0.668
High school	28 (42.4%)	15 (39.5%)	10 (41.7%)	3 (75.0%)	
Above high school	38 (57.6%)	23 (60.5%)	14 (58.3%)	1 (25.0%)	
Marital status					0.661
Single	44 (65.7%)	23 (60.5%)	17 (70.8%)	4 (80.0%)	
Married	23 (34.3%)	15 (39.5%)	7 (29.2%)	1 (20.0%)	
Falls	16 (23.9%)	4 (10.5%)	8 (33.3%)	4 (80.0%)	0.002
Frequent Hospitalization	40 (59.7%)	29 (76.3%)	10 (41.7%)	1 (20.0%)	0.003

Multinomial regression showing factors associated with increased risk of delirium among patients in an outpatient setting

Delirium Score	Odds Ratio	Lower Confidence Interval	Upper Confidence Interval	p-value
Unlikely	Reference group			
Cognitive Impairment				
Recent Falls	4.26	1.03	17.55	0.045*
Hospitalization	3.95	1.15	13.61	0.029*
Age > 71 yrs.	1.02	0.93	1.12	0.642
Delirium				
Recent Falls	55.13	2.91	1044.66	0.008*
Hospitalization	5.31	0.36	78.32	0.224
Age > 71 yrs.	1.25	1.01	1.55	0.041*

FUNDING

John A. Hartford Foundation Age-Friendly Health Systems Scholarships for the American Hospital Association's Next Generation Leaders Fellowship.

LIMITATION

- ❑ The primary limitations of this study include a relatively small sample size and the concentration on a single outpatient setting, which may limit the generalizability of our findings.
- ❑ This study also relied on observational data, which inherently precludes definitive conclusions regarding causality.
- ❑ Lastly, potential confounders such as comorbidities, medications, and other individual health characteristics were not examined in this analysis, which might have influenced the associations observed between the risk factors and delirium.
- ❑ Future research should address these limitations and further investigate the mechanisms underlying these associations

CONCLUSION

- ❑ This study highlighted recent falls, and advanced age as significant risk factors for delirium in an outpatient.
- ❑ However, recent hospitalizations were not identified as a significant risk factor for cognitive impairment.

POLICY SIGNIFICANCE

- ❑ This study underscores the need for healthcare policies to focus on fall prevention and specialized care for elderly patients (>71 years) in outpatient settings, as these were identified as major risk factors for delirium.
- ❑ Such strategic actions could lead to improved health outcomes and patient safety.

REFERENCES AND ADDITIONAL INFORMATION

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Disclaimer: The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the University of Maryland or Howard University. The authors have no competing financial interests (direct or indirect).

Shivani Jindal, MD, MPH
Geriatric Medicine Hospitalist
VA Boston Healthcare System

VA Boston Healthcare System: Implementation & Operationalizing Age-Friendly Health Systems on Unit 2 South medicine ward

Situational Analysis

- Older adults are at greatest risk of hospital-associated complications and disability
- Almost 50% of the Veterans that we care for in the VA system are ≥ 65 years old
- The VA is poised to experience a significant growth in older adults in the coming years
- The VA has set a goal to become the largest integrated healthcare system to become Age-Friendly

Project Goals

- On Unit 2 South: we will operationalize assessment of the 4Ms on older adults (≥ 65 years old) admitted to inpatient medicine
- To apply for Institute for Healthcare Improvement (IHI) Level 1 certification: participant level

Actions

- What Matters:
  - Establish Nursing Documentation workgroup to review and revise current documentation of "What Matters"
- Mentation:
  - Trial bCAM assessment every 12 hours
  - Train 2 South nursing staff in STAR-VA
- Mobility:
  - STRIDE* program implementation
- Medication:
  - High-Risk medication review by pharmacy technician

	ASSESS	ACT ON
What Matters	**- Patient goal of hospitalization** **- Health care proxy, life-sustaining treatment orders** *** Responsible: nursing, medical team**	- Age-Friendly Toolkit - Social Work - Care alignment
Mentation	**- Delirium Screen on admission and every 12 hours by nursing (tool: Brief Confusion Assessment Method - bCAM)** *** Responsible: nursing, medical team**	- Delirium Precautions - STAR-VA - Behavioral Recovery Outreach (BRO) program - Age-Friendly Toolkit - Sensory aids (i.e., hearing aids, glasses)
Mobility	**- Supervised walking** **- AM-PAC 6 Clicks** *** Responsible: nursing, medical team**	-STRIDE* -Physical/Occupational Therapy Assessment
Medication	**- Regular screen of high-risk medications** *** Responsible: Medication Reconciliation Technician, Pharmacy, medical team**	- Pharmacy - Med Rec Tech Program - Deprescribing

*STRIDE: assiSTed eaRly mobility for hospitalizeD older vEterans

Outcomes

- Interprofessional group meets regularly to continue progress
- What Matters:
  - Nursing Documentation workgroup assessing revised documentation tool
  - Patient goals are documented on admission
- Mentation:
  - STAR-VA Training: 4/28 nurses to date
  - bCAM being done every 12 hours
- Mobility:
  - STRIDE* program assessments initiated on 2 South
- Medications:
  - Program funding approved
  - Recruitment of pharmacy technician initiated

Next Steps

- Hire Personnel: BRO, Pharmacy Programs
- Nursing Documentation workgroup to revise documentation to support Age-Friendly principles
- Inpatient Age-Friendly team meetings to monitor progress
- Complete Level 1 Certification application and submit by end of July 2023

FINANCIAL DISCLOSURE:
Supported by the HMS Dean's Innovation Award. Supported with resources and the use of facilities at the Veterans Affairs Boston Healthcare Center and the New England Geriatric Research Education and Clinical Center. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

Caitlin E. Jones, MD
Assistant Professor
Atrium Health Wake Forest Baptist Medical Center

Implementation of Age-Friendly Care for Older Adults Admitted to Trauma Services

Situation Analysis

- More than 1 in 6 Americans is 65 or older.
- Trauma (particularly falls and motor vehicle collisions) is a leading cause of morbidity and mortality in all ages, but older adults are disproportionately affected due to increased number of underlying comorbidities.
- The Age-Friendly Health System initiative incorporates evidence-based medicine through the 4Ms (*Mentation, Mobility, Medication, Matters Most*) to improve the care of older adults.

Project Goals

1. To implement delirium screening using the UB-CAM on patients aged 65 and over admitted to the trauma surgery floor.
2. To analyze the trauma service 30-day readmission data to assess for areas of intervention.
3. To achieve Level 2, Committed to Care Excellence, Age-Friendly Health System recognition for the trauma floor at AHWFB by July 2023.

Actions:

1. To standardize delirium screening

- Development of online training modules for UB-CAM
- Staff training in delirium screening tool
- Implementation of UB-CAM tool into Electronic Medical Record

2. To evaluate readmission data

- Development of 4M chart auditing tool

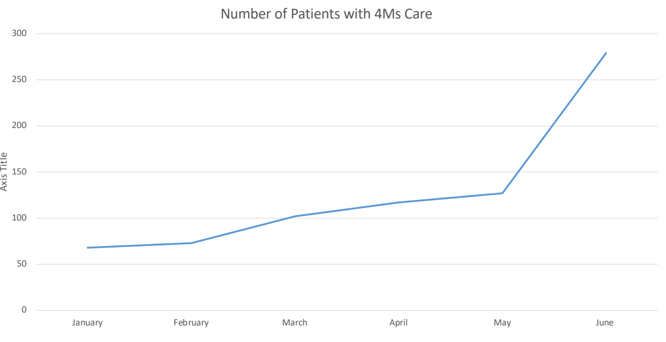
Demographics	• MRN • Age • Gender • Race/ethnicity • Mode of trauma • Hospital Diagnosis • Length of stay
Mind	• PMH of dementia • Admission for TBI • Hospitalization with delirium • Delirium screening tool
Medications	• Anticoagulation PTA • New Benzodiazepine use • New antipsychotic use
Mobility	• PT or OT evaluation • AM-PAC basic mobility
Matters Most	• Code status on admission • Change of code status during admission • Geriatrics consultation (first admission) • Palliative care consultation (first admission) • Discharge destination (first admission) • Discharge destination (second admission)

3. To implement and measure age-friendly practices on trauma floor

- *Mind:* Completion of UB-CAM twice per shift
- *Mobility:* Capture mobility data using the AM-PAC Basic Mobility Form.
- *Medication:* Appropriate use of antipsychotics and anticoagulant agents through a) pharmacy monitoring, b) resident and staff education, and c) EMR notes and reminders.
- *Matters Most*: Use of innovative documentation that can be viewed and modified in both inpatient and ambulatory settings.

Outcomes:

- 766 patients received 4M age-friendly care→ meeting criteria to achieve Level 2, Committed to Care Excellence Recognition.
- Implementation of UB-CAM delirium screening twice per shift of trauma floor.



Next Steps

- PDSA cycles to improve use of delirium screening tool in EMR.
- Complete review and analysis of readmission data
- Institutional standardization of protocols for age-friendly practices.
- Implementation of Age-Friendly initiatives into rural and medically underserved hospitals, including Project ECHO training of healthcare workers in the community.

Chris Keeley
Chief Operating Officer
Humanitarian Emergency Response & Relief Centers
NYC Health + Hospitals

Scaling a Medically-Minded Humanitarian Response for Newly Arrived Asylum Seekers in NYC

1

I intended to build an adaptable, scalable model to effectively deliver medical care and a wide range of wrap-around services for individuals who are seeking asylum and newly-arrived in New York City.

2

My initial goal was to build infrastructure that could scale from 3,000 guests in October to 10,000 in January.

That goal remained unchanged, and was reached.

3

Through the course of the fellowship the HERRC Program:

- Provided over 1 million hotel nights to guests, administered over 15,000 vaccinations, and delivered over 5 million meals
- Housed over 20,000 individuals, including 13,000 today
- Built a managerial, data, contracting, HR, communications, and emergency response apparatus, growing from 3 to more than 4,000 employees
- Managed countless medical and non-medical emergencies, including various infectious disease outbreaks, attempts at self-harm, and police interactions.
- Supported the births of 18 babies per month
- Launched New York City's first 24/7 arrival center since the days of Ellis Island

4

The primary outcomes prove once again that the public sector can effectively respond to large-scale emergencies on behalf of the City of New York.

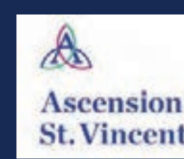
We have supported 40% of guests with exit planning resources to help them move beyond City-funded housing and onto the next chapters of their lives.

5

In the future, the program will:

1. **Improve exit planning interventions** that further support guests to successfully move onto the next chapters of their lives
2. **Streamline processes** to deliver more efficient and more economical services, without losing the compassionate underpinning that has driven the program's success to date
3. **Support documentation** of the model design to share learnings and how they might be applied to other scenarios of mass homelessness and migration
4. **Sunset the emergency response** phase of the program

Jackie Divine Lannan BS, BSN, RN, FCN
Director, Community Collaboration
Ascension St. Vincent Evansville



Student-Led Volunteer Program to Expand Recruitment Pipeline

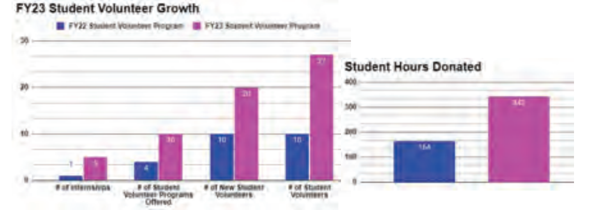
Situation Analysis

- Ascension St. Vincent Evansville (ASVE) experienced a decrease in volunteer engagement post-pandemic.
- Additionally, consumer & associate experience scores have not rebounded to pre-pandemic scores, often attributed to lack of people resources.
- Parallelly, the health system experienced an increase in student requests for volunteer opportunities, an avenue not previously explored by the hospital.
- By creating a student-led volunteer program, our goal is to connect students to meaningful opportunities based on their interest, hospital need, & student availability.
- Program implementation will create a long-term recruitment pipeline for our system through increased leadership team engagement with local high school & university students without additional FTE support.

Project Goals

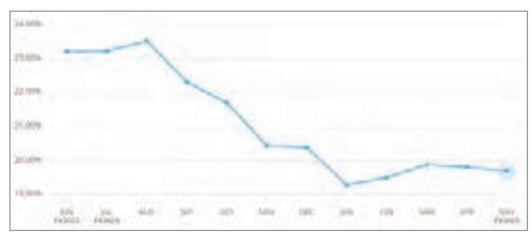
- Create an unpaid internship opportunity for a Student Volunteer Coordinator (SVC) giving a local student the opportunity to help facilitate our expanded Student Volunteer Program (SVP).
- Grow SVP participation at least 5% by the end of FY23.
- Develop three new SVPs through the end of FY23.
- Sustain SVC internship & SVP year round to further measure the impact of SVC & SVP.
- Long term goals include:
  - Increase in associate & consumer satisfaction resulting in decreased vacancy & turnover rates.
  - Development of a mentor program for incoming students with those who've previously served in SVP.
  - Earlier entry into the recruitment pipeline for students in addition to insight regarding potential recruits who may otherwise not be known to the organization.

Increasing Student Volunteer Presence

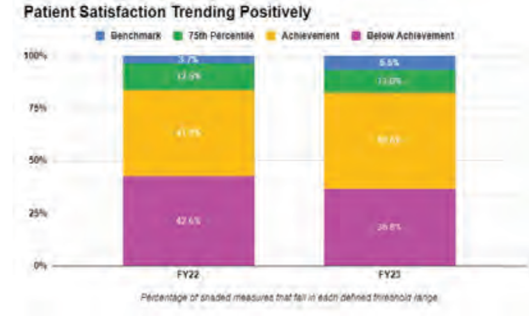


Surpassing Organizational Associate Satisfaction

Declining Voluntary Turnover Rate



Rebounding Patient Experience Scores



Actions

- Marketed pilot program locally & accepted two SVCs.
  - High School SVC & College SVC.
- HS SVC created marketing materials, socialized program, created volunteer schedule, & assisted with interview process for student volunteers.
- College SVC created & delivered SVP orientation to student volunteers, rounded on team, and collaborated with area university career programs as well as hospital leaders to develop non-clinical intern opportunities.
- Met with SVCs weekly to review opportunities, wins, & pivot student volunteer program as indicated.

Outcomes

- Increased student volunteers over prior year by 170%.
  - 17 new students onboarded prior to end of FY23.
  - 13 new students scheduled for onboarding: July 2023.
- Increased number of SVPs by 150%.
  - Six additional offerings, including but not limited to: Rotary Reading Wagon, Patient Positivity Partners, Communication & Collateral, etc.
- Created, posted, & hired five new ongoing internships for health administration students within finance, community outreach, and recruitment pipeline.

Next Steps

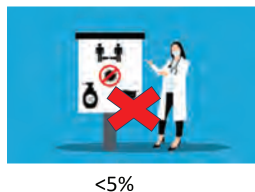
- SVCs designing end of year event as recruitment & retention tool for current & potential student volunteers.
- Measure program satisfaction at six month mark with volunteers & impacted departments, subsequently scheduling time for ongoing feedback from current students & leaders regarding program opportunities.
- Plan weeklong student healthcare intensive for FY24 with volunteer support from retired nursing instructors & healthcare leaders.

Ernest I. Mandel, MD, SM
Chief Medical Officer
Hebrew SeniorLife/Hebrew Rehabilitation Center

Implementing an Age-Friendly Antimicrobial Stewardship Program in Long-term Care

Situation Analysis

Antimicrobial prescriptions in Hebrew Rehabilitation Center's Long-term Chronic Hospital (HRC LTCH) are inconsistently reviewed by a pharmacist, and, when reviewed, stewardship recommendations are variably implemented by primary teams. Reasons recommendations are not implemented include:


<5%

No Data

Project Goals

The goal of this project was to implement an Age-Friendly Antimicrobial Stewardship Program (ASP) in HRC LTCH which would:
(1) provide pharmacist review of all new antibiotic starts in HRC LTCH
(2) include input and oversight of an infectious disease specialist
(3) incorporate the 4M's into antibiotic recommendations
(4) achieve buy-in of primary teams

Actions

(1) Conduct focus groups on ASP with medical staff
(2) Create and disseminate education on ASP via Learning Management System
(3) Engage an infectious disease consultant to provide ASP input
(4) Identify discrete ways in which 4Ms inform antimicrobial choice
(5) Design self-contained EHR-based ASP documentation
(6) Operationalize ASP review for all antimicrobial starts in HRC LTCH
(7) Collect process and outcomes data on ASP

Age-Friendly

Identified 4Ms prompts for ASP
-Diagnostic consideration (what Matters - invasive procedure, hospitalization)
-Treatment consideration (Medications - route, duration, dose/pill burden)

Outcomes

Table 1 Antimicrobial Stewardship Program Data January–June 2023

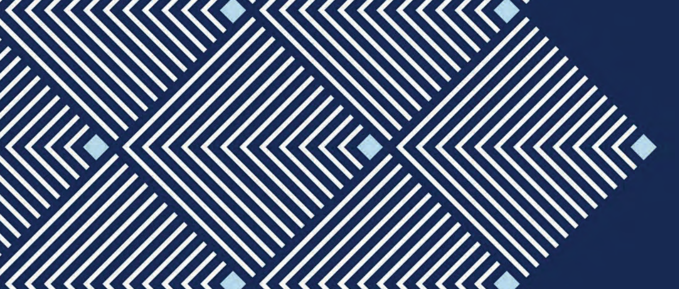
	Total	Percentage
Patients Served	864	
Patients with Antimicrobial Starts	312	
Total Antimicrobial Orders	399	
Pharmacy Review	377	94%
Pharmacy Substantive Input	98	26%
Infectious Disease Review	344	83%
Infectious Disease Substantive Input	60	18%
4Ms Considered	241	64%

Next Steps

(1) Build and implement EHR documentation
(2) Incorporate 4Ms into EHR documentation
(3) Explore data acquisition, management and clinical decision support software to integrate with EHR
(4) Collect further outcomes data including savings from medication and hospitalization cost avoidance

Acknowledgements

Melissa Pikor, PharmD, BCGP; David Feldman, MD, MBA
American Hospital Association; John A. Hartford Foundation



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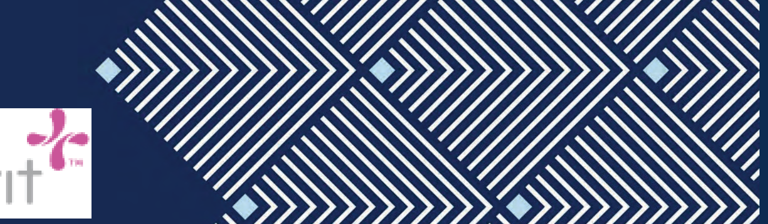


Strategic Workforce Optimization as an Access Initiative

Problem Statement

- Medical Group Regional Patient Connection Center (PCC) infrastructure manages patient calls, provider scheduling, RN triage, back-office support, with a goal of optimizing access and experience
- Reported patient diversion to Urgent Care for acute needs due to lack of access, unable to meet patient preference for same day or virtual
- Potential to develop a Virtual Advanced Practice Provider (APP) role housed in the Connection Center to virtually manage patients as extension of the medical group practice
- Goal: Impact patient access, patient experience and avoid loss of patient due to inability to meet needs—ultimately avoiding loss of revenue, patient dissatisfaction, missed opportunities to close care gaps, higher cost to system
- Plan: *Assess current provider capacity/schedule optimization and connection center workflows to determine feasibility and gaps in access that could be served by a virtual PCC APP role.*

Outcomes:
Improved Access and Integration of Virtual Care into the Delivery Continuum

Provider Workforce optimization= 20% improvement APP Productivity +5% Physician Productivity

PCC + Care team + workflow to optimize access and experience =Improved first touch resolution patient needs

Planned future state: Utilize existing team to cover virtual demand via 4-hour block coverage of PCC

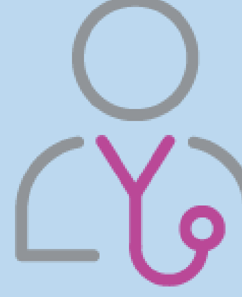
Planned future state: Once access maximized assess potential for Virtual APP Connection Center role

Feasibility Action Plan and Assessment Findings

Calculate % current Connection Center call volume without resolution and subsequent diversion:
Estimated 5-8% Calls did not meet patient demand or escalated out of RN triage diverted to outside care/potential loss to f/u

Assess current provider capacity/schedule template optimization to manage existing demand across region:
Pilot market assessment Primary Care APP capacity opportunity significant—Variable schedule template <10 patients per day with only 40-60% template booked + availability for in-person or virtual visits

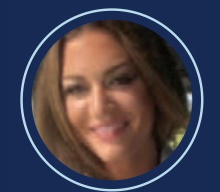
Determine potential APP visits and revenue associated with Optimized Clinic + Connection Center APP Role:
Based on current clinic team capacity project goal shifted to maximize team productivity through schedule template optimization and wrap around support to decrease no shows, optimize inbox management and convert 1/2 day schedules to virtual visits to meet PCC needs



APP Role Optimization:	PCC Virtual APP Role 12 patient visits/per day	Clinic APP Role Optimized 18 patient visits/per day
Projected Revenue (99212/99213)	$122,047.20	$228,859.20
Provider + Resource Cost	$171,507.44	$241,811.44
Total Provider/APP + Staff Resource Net Revenue	$(49,460.24)	$(12,952.24)

Next Steps and Lessons Learned

- Regional Connection Center Infrastructure tracking patient call resolution and escalation to track unmet demand and quantify future provider and care team staffing needs
- Sun setting of the PHE and future CMS changes to telehealth delivery and reimbursement have further reinforced continued focus on hybrid approach to staffing in-person/virtual
- Strategic Workforce Planning and Optimization emerged as an essential foundational component to PCC work in partnership with the National Office of Advanced Practice
- Initially started with the end in mind- Launch a virtual APP Connection Center Role. Feasibility assessment revealed untapped resources and capacity. This work has changed our approach to workforce optimization.



Taylor, McMahon, RN, CNDLTC

Director of Nursing
Presbyterian SeniorCare Network, Pittsburgh, PA

Situation Analysis

Seniors in Affordable Housing Communities lack easy access to health care resulting in poor health outcomes. Presbyterian Senior Care Network is committed to helping seniors age in place. We partnered with Curana Health Clinics to bring healthcare to seniors living in 32 affordable housing communities. Among older adults, low wealth is associated with a decline in physical and psychosocial functions. Using the Age-Friendly Health Systems, 4Ms model of care we can assess what matters to seniors and align medications, mentation and mobility to improve quality of life.

Presbyterian Senior Care Network's collaborative wellness model is designed for at-risk supportive housing residents that integrates Curana Health's primary care services and "what matters" with the current Service Coordination program within the communities. This provides seniors with accessible, person-centered health care services to promote healthy living.

Age-Friendly Health Systems

Project Goals

- Integrate Age-Friendly Assessments into Curana Health Clinic's electronic health record, GEHRIMED for Medicare Annual Wellness Visits
- Educate providers, team members and seniors that live in affordable housing on Age-Friendly Health Systems
- Utilize Service Coordinators within each affordable housing community to connect seniors with Age-Friendly Resources

Actions Taken

- IHI co-recognized Presbyterian Senior Care Network and Curana Health Clinic as an Age-Friendly Health System Participant, count of patients cared for with the 4 M framework begins in efforts to be recognized as an Age-Friendly Health System- Committed to Care Excellence.
- Dignity of Care Question in EHR- " What do I need to know about you as a person to provide the best care possible?"
- Patient Worksheet developed for based on 4 MS to empower the senior in their healthcare
- Monthly meetings implemented with a work group committed to development and sustainability of the 4 Ms in Affordable Housing
- Focus group held with seniors living in the communities to engage them in the process
- Age-Friendly Education developed for virtual/in person learning
- Formal education provided for healthcare workers in Curana Health Clinics utilizing Age-Friendly experts to support the evidence-based framework
- Crosswalk developed between 4 M framework and Annual Medicare Wellness visit
- Tangible/electronic Age-Friendly resource guide developed for service coordinators

For detailed information, visit:
www.aha.org/center/next-generation-leaders-fellowship, www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems, or contact tmcmahon@srcare.org

Acknowledgements:
John A. Hartford foundation, Jewish Healthcare Foundation

Outcomes

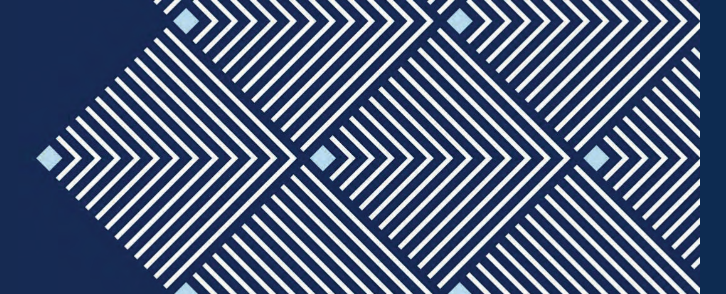
- Received provider buy-in with utilization of Age-Friendly Framework within the Annual Medicare Wellness Visit
- Received approval to purchase medication tote bags, improving medication reconciliation process
- Patient feedback, "to have a team of providers that wants to listen to me and what matters is going to be life changing and I will be more willing to go to a doctor instead of pushing it off." - Kathijo M.

Lessons Learned

- Implementation of Age-Friendly Framework takes time and resources but the reward is vast.
- The 4 M model of care defines human-centered, holistic healthcare and will lead to improved outcomes for at risk seniors

Next Steps

- Continue efforts to disseminate and sustain the 4 M framework in affordable housing
- Collect data on quality metrics related to the model of care
- Introduce Age-Friendly Health Systems to Presbyterian Senior Care Network's LGBTQ+ Friendly Affordable Housing Community that is breaking ground this fall.



Class of 2023 | **AHA Next Generation Leaders Fellowship**

Krystal D. Moyers, M.Ed, CHES
Administrative Director of Community Outreach & Partnerships
Augusta Health

Work It!: A DEAI Approach to Workforce Development

Augusta Health

Situation Analysis

The World Health Organization predicts a shortfall of 15 million health care workers worldwide by 2030. Innovative solutions to workforce shortages are necessary to ensure Augusta Health has a future pipeline of clinical and nonclinical candidates.

In order to have a diverse and inclusive representative of the community, it is critical to work in tandem with Augusta Health's internal teams, including Community Outreach and Partnerships, Human Resources, and Nursing Leadership, as well as collaborate with numerous community partners such as Avant Healthcare, Embrace Center for Community, LEARN, and On the Road Collaborative.

Project Goal One

Work with Augusta Health's Community Outreach and Partnerships Team to partner with Learn English And Reading Now (LEARN) to offer a pilot cohort of English as a Second Language classes at Embrace Center for Community. Each participant's final class meeting will include information about open Augusta Health job opportunities. The purpose of this program is to provide English language classes to Spanish-speaking community members to increase language skills and eligibility for Augusta Health career opportunities.

Actions

- Held planning meetings with involved community partners
- Promoted first class cohort, predominately in Hispanic neighborhoods
- Began first class at Embrace Center for Community with five (5) tutors

Outcomes

- Improvement in speaking English as a Second Language
- Improvement in employment and career advancement goals
  - 50% improvement in learning interview skills
  - 50% improvement in communication with teammates, customers and supervisors

Next Steps

- Offer second cohort of classes at an Augusta Health community practice to better connect participants with Augusta Health job opportunities.

Project Goal Two

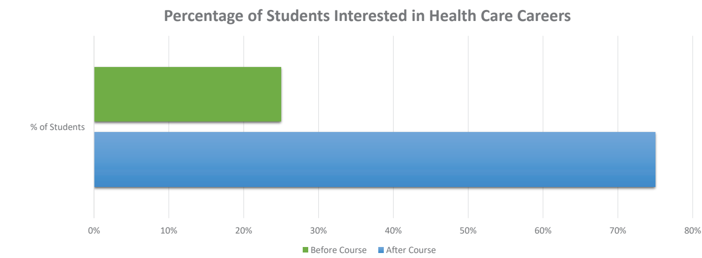
Partner with On the Road Collaborative (OTR) to develop spring semester career enrichment courses at Kate Collins Middle School focused on an array of health care careers. The goal of the program is to reach underserved and at-risk youth who may not otherwise be exposed to health care career options.

Actions

- Developed health care course curriculum for On the Road Collaborative partnership
- Contacted Augusta Health team members to confirm teachers and class schedule
- Began career enrichment program, including mid-semester field trip to Augusta Health's campus
- Provided a pipeline for students interested in health care careers and working at Augusta Health, including mentorship and scholarship opportunities

Outcomes

- Increase in students' knowledge of health care career opportunities
- Increase in percentage of students interested in pursuing a career in health care



Next Steps

- Partner with OTR to offer spring semester course in 2023-2024 with expanded health care career offerings.
- In addition to career exploration, Augusta Health will provide consistent workforce development leadership at each session.

Project Goal Three

Partner with Augusta Health's Human Resources and Nursing Leadership teams to develop an effective onboarding model for Avant Healthcare International Nurses (AHIN) working at Augusta Health, as well as cultural training for Augusta Health team members. The purpose of this program is to provide a welcoming culture for AHIN, with the goal of retaining AHIN as Augusta Health team members after their initial two-year commitment.

Actions

- Surveyed 50% of the AHIN to learn about their on-boarding experience to determine how Augusta Health can improve
- Based on feedback, created an implementation plan for onboarding new AHIN to build a greater sense of community, including:
  - Standardized Augusta Health Welcome Baskets
  - Community Resource Guide containing community and cultural resources
  - Diversity Training held for all preceptors and nursing leaders; Elective training available for all team members
  - Peer Mentorship Program matching AHIN on-boarding in 2023 with a buddy from a similar country (see below)

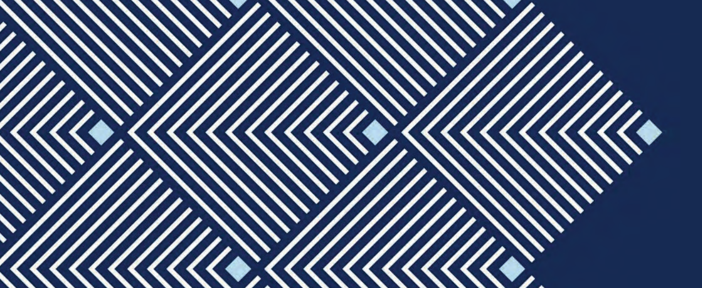
Outcomes

- Increase in conversion rate (baseline is 86%)
  - Will measure in November 2025 for two-year retention of 2023 on-boarding AHIN.

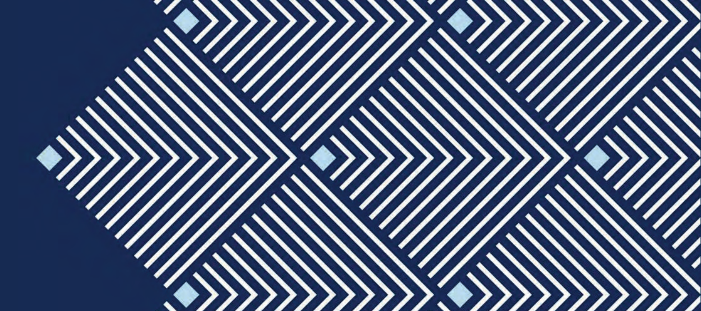
"I feel very supported" – AHIN, 2023

Next Steps

- Implement International Tour highlighting home countries of AVIN.
- Create AVIN email listing to coordinate group activities.



Rachel L. Murkofsky, MD, MPH
Expanding Age-Friendly Health Systems across the VHA SCI&D System of Care
VA Pacific Islands Health Care System, Honolulu, HI



Expanding Age-Friendly Health Systems across the VHA Spinal Cord Injury & Disorders System of Care

Situation Analysis

Veterans with Spinal Cord Injuries and Disorders (SCI/D) are medically and socially complex and vulnerable to numerous secondary effects of SCI/D.

The traditional medical model of care for these patients takes a disease-focused approach, which is necessary. However, as approaches to health care evolve, so too should the approach to the care of Veterans with SCI/D.

Age-Friendly Health Systems (AFHS) is an initiative that seeks to provide evidence-based practice to every older adult at every care interaction.

Our local VA SCI/D program achieved AFHS - participant and AFHS - Committed to Care Excellence designations in 2021 and 2022.

Project Goals

This project sought to bring Age-Friendly Health Systems (AFHS) principles to the National VA SCI/D System of Care by:

1. Educating staff within VA SCI/D Programs across the country about AFHS principles and the 4Ms.
2. Standardizing processes to support VA SCI/D programs in adopting and tracking the 4Ms.
3. Creating note templates and clinical reminders within the VA electronic medical record system (CPRS) to collect 4Ms data.
4. Creating a VA dashboard to pull facility and program AFHS 4Ms data at a glance.
5. Beginning to look at the impact of AFHS principles on costs of care and patient outcomes.

Actions

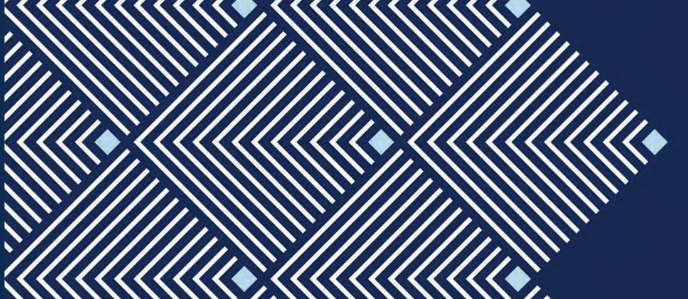
1. Gave talks to all of the SCI Chiefs and SCI social workers / coordinators about AFHS, the 4Ms, and Our Journey to AFHS Care.
2. Educated SCI/D staff nationally about Plan-Do-Study-Act (PDSA) cycles.
3. Joined the National VA AFHS Action Community team to assist VA SCI/D programs across the nation in implementing AFHS care.
4. Facilitated trainings and served as mentor for VA SCI/D programs seeking to gain certification nationally.
5. Selected for poster presentation at National PVA Summit about Our Age-Friendly Health System Journey.

Outcomes

1. VA SCI Chiefs (hubs) and SCI social workers/coordinators (spokes) became familiar with AFHS principles.
2. Several VA SCI/D teams across the country began implementing the AFHS framework into their programs and sought AFHS certification.
3. VA SCI/D programs became a focus within the National VA AFHS Action Community to implement AFHS care.
4. Implementing AFHS care became an area of focus for the National SCI/D Program Office.

Next Steps

1. Continue to work with National VA AFHS Team and the National SCI/D Program Office to spread the AFHS framework system-wide.
2. Determine how many VA SCI/D teams across the nation achieve AFHS recognitions this fiscal year.
3. Explore creation of clinical reminders to track each of the 4Ms.
4. Explore creation of a VA dashboard to pull facility and program AFHS 4Ms data at a glance.
5. Begin to evaluate the impact of AFHS principles on costs of care and patient outcomes.



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Kimberly Pfeifer
System Director, Quality Optimization and Regulatory Reporting
Henry Ford Health

Creating a Clinical Council Infrastructure for Enterprise Quality Improvement

SITUATION ANALYSIS

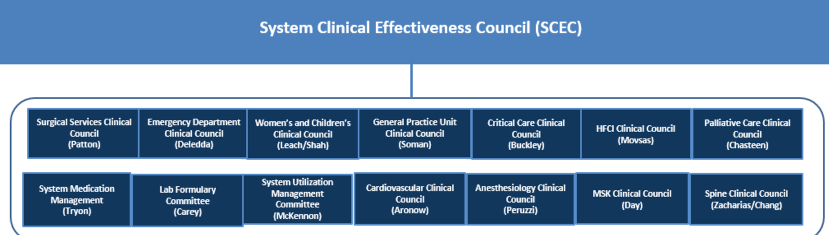
While Henry Ford Health strives for its True North Vision, ***We will be the trusted partner in health, leading the nation in superior care and value***, transforming and improving our care delivery system is at the forefront of our strategic priorities.

Over the years the health system has developed many project-based improvement initiatives that have realized some quick gains, but often struggle with **long-term sustainability and scale.** While our multi-disciplinary project teams were passionate about improving patient care, they often were not accountable for the implementation and sustained outcomes of the project.

To achieve long-term sustainability, we need to develop a management system[1] and leverage/enhance our current clinical council structure to achieve our goals.

The System Clinical Effectiveness Council (SCEC) and the clinical council framework was created in 2014 to serve as the steering committee within Henry Ford for systemwide clinical improvement work.

Henry Ford Health Clinical Councils report to the System Clinical Effectiveness Council which is led by our Executive Vice President, Chief Clinical Officer and Associate Chief Clinical Officer/Chief Quality Officer



PROJECT GOALS

- *Create a strong management system to support the clinical improvement work for the health system*
  - *– Align people, process and technology*
- *Create standardized reporting from the Clinical Councils to the System Clinical Effectiveness Council including annual review of their goals and priorities*
- *Provide resources (where appropriate) to the councils to support improvement activities*
- *Align CMO/CNO/CQO to clinical councils to create a stronger sense of accountability for the councils*

[1]A management system describes the way in which companies organize themselves in their structures and processes in order to act systematically, ensure smooth processes and achieve planned results.

ACTIONS/OUTCOMES

TIMELINE:

Dec 1, 2022 - Obtained feedback from our Chief Medical Officers, Chief Nursing Officers, Quality Directors and current Clinical Council Chairs on the current state of the clinical councils as it relates to quality improvement.

Question Asked: "What are the clinical councils' strengths and opportunities for improvement? How can our clinical and quality leadership systems accelerate the implementation of clinical priorities within Henry Ford Health so we can achieve our vision of being "the trusted partner in health, leading the nation in superior care and value""

Feedback provided (summarized): There should be a stronger feedback loop to the SCEC and at local leader committees to understand and monitor the work of the clinical councils.

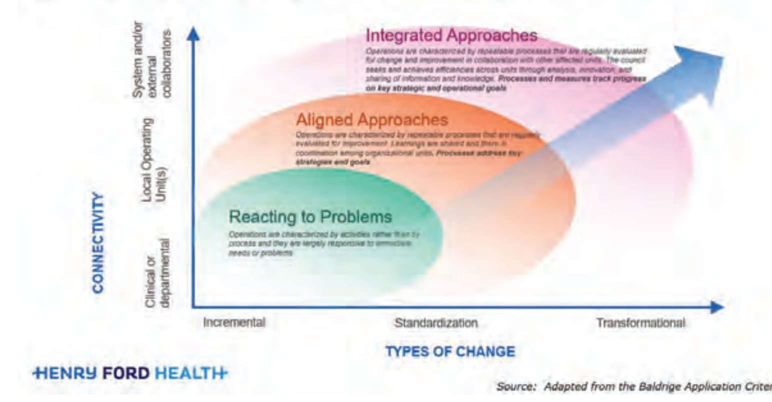
Dec 8, 2022 - Met with senior leaders of the care delivery system to review feedback and develop a plan for the clinical council structure.

Jan-Feb 2023 - Worked with System CMO/CQO to develop a vision and objectives for the revamped clinical council structure.

Mar 24, 2023 - Held a clinical council retreat for all current/future clinical council chairs to discuss the 2023 objectives and review the example maturity model and clinical council infrastructure (illustrated below). Obtained feedback and lessons learned from "mature" council leaders.

The maturity model depicted below is adapted from the Baldridge application criteria and is meant to illustrate the evolution of a council. At the retreat, it was also used to demonstrate that we understand that councils may be in different places on their maturity journey. Our plan is to meet councils where they are at and work with the council chairs to enhance the infrastructure based on the people, process, and technology framework.

Clinical Council Maturity Model - *example*



ACTIONS/OUTCOMES

TIMELINE:

APR-MAY 2023-

- Worked with the System CMO/CQO and developed a plan to meet with all 14 clinical council chairs from May-Sep 2023. In these meetings we will review council objectives, discuss the clinical council infrastructure model (illustrated below) as it relates to their council, and develop a plan to close any gaps in the model that are identified. Each council will have a plan that is unique based on this conversation.
- Developed a calendar for councils to report to the System Clinical Effectiveness council for accountability, reporting and monitoring of the council objectives.

Clinical Council Infrastructure

NEXT STEPS

SHORT-TERM NEXT STEPS:

- Continue to meet with council chairs and develop enhancement plans based on the people, process, and technology framework.
- Create a Lunch and Learn framework based on feedback from the council retreat. Many council chairs and their members would benefit from learning more about the topics below. The plan is to work with our content experts and leaders who oversee our LMS to provide content for topics below.

Lunch and Learn Options

LONG-TERM NEXT STEPS:

- Meet with council chairs bi-annually to proactively create and refine council objectives.

Implementing a Supportive Care Medicine Program at Cedars-Sinai Marina Del Rey Hospital

Jennifer G. Poole, DO, MS, FACP
Clinical Chief, General Internal Medicine, Cedars-Sinai Medical Center
Medical Director, Inpatient Hospice, Cedars-Sinai Medical Center
Supportive Care Medicine Consultant
Cedars-Sinai Medical Center, Los Angeles

Situation Analysis

- Supportive Care Medicine (synonymous with Palliative Care) is the medical sub-specialty specializing in the care of people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness through medical, social, and emotional support. The goal is to improve quality of life for both patients and families.
- Cedars-Sinai Medical Center is a quaternary referral center located in Los Angeles County with a robust multi-disciplinary Supportive Care Medicine (SCM) consulting team to service patients. Since acquiring Cedars-Sinai Marina Del Rey Hospital (CSMDRH), it has now seen an increase in total volume of patients, severity of illness, and ICU usage. Additionally, both hospitalist and intensivist groups have increasingly identified the need for specialty palliative care consultative support to address these factors.
- CSMDRH is currently undergoing a transformation with a new nine-story hospital slated to be completed in 2026. The new larger hospital will feature an expansion of enhanced services and programs to service a growing community.
- The percentage of U.S. hospitals with Palliative Care Medicine Programs has tripled since 2000 and is becoming standard of care **(Figure 1)**.

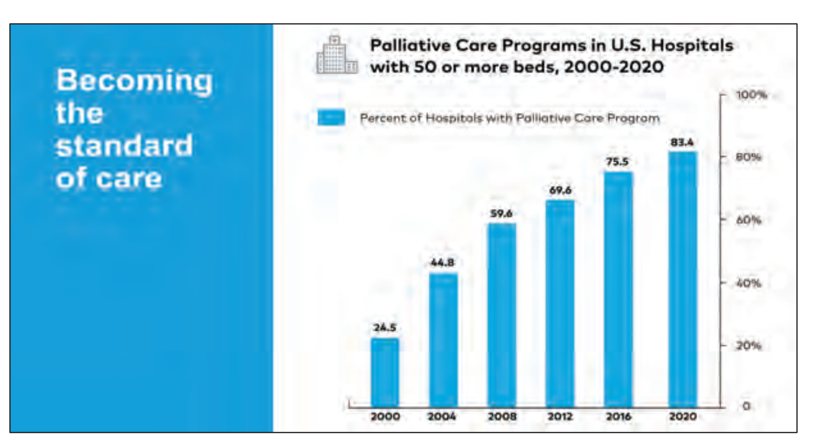
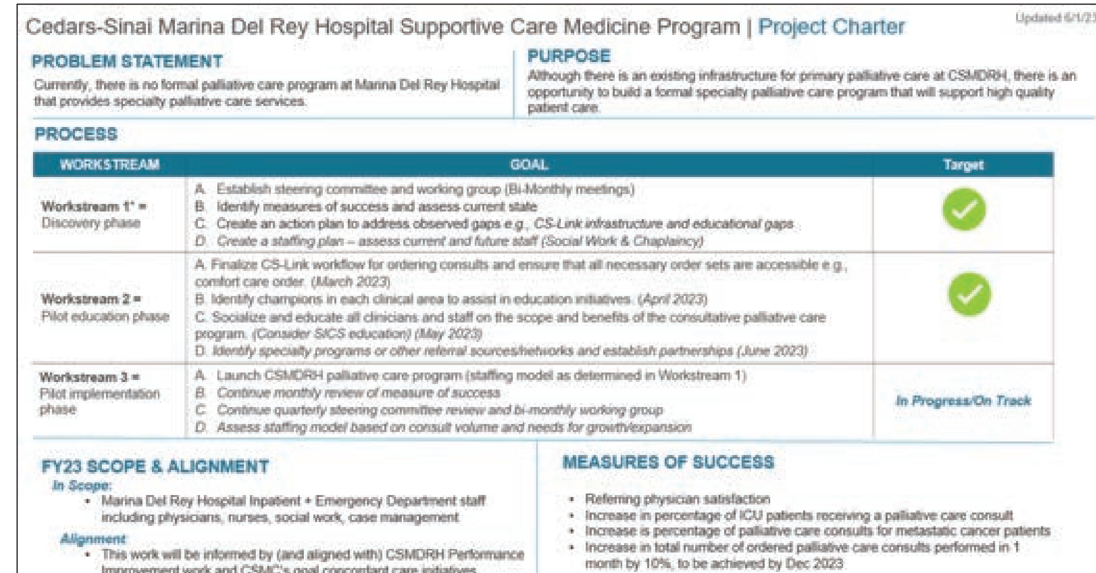


Figure 1 _ Becoming the Standard of Care
Graph depicts the increase in number of palliative care programs in the US from 2000 to 2020.



Cedars-Sinai Marina Del Rey Hospital Supportive Care Medicine Program | Project Charter

Updated 6/1/23

PROBLEM STATEMENT

Currently, there is no formal palliative care program at Marina Del Rey Hospital that provides specialty palliative care services.

PURPOSE

Although there is an existing infrastructure for primary palliative care at CSMDRH, there is an opportunity to build a formal specialty palliative care program that will support high quality patient care.

PROCESS

WORKSTREAM	GOAL	Target
Workstream 1* = Discovery phase	A. Establish steering committee and working group (Bi-Monthly meetings) B. Identify measures of success and assess current state C. Create an action plan to address observed gaps e.g., *CS-Link infrastructure and educational gaps* *D. Create a staffing plan – assess current and future staff (Social Work & Chaplaincy)*	✓
Workstream 2 = Pilot education phase	A. Finalize CS-Link workflow for ordering consults and ensure that all necessary order sets are accessible e.g., comfort care order. *(March 2023)* B. Identify champions in each clinical area to assist in education initiatives. *(April 2023)* C. Socialize and educate all clinicians and staff on the scope and benefits of the consultative palliative care program. *(Consider SICS education) (May 2023)* D. *Identify specialty programs or other referral sources/networks and establish partnerships (June 2023)*	✓
Workstream 3 = Pilot implementation phase	A. Launch CSMDRH palliative care program (staffing model as determined in Workstream 1) *B. Continue monthly review of measure of success* *C. Continue quarterly steering committee review and bi-monthly working group* *D. Assess staffing model based on consult volume and needs for growth/expansion*	*In Progress/On Track*

FY23 SCOPE & ALIGNMENT

In Scope:
- Marina Del Rey Hospital Inpatient + Emergency Department staff including physicians, nurses, social work, case management

Alignment:
- This work will be informed by (and aligned with) CSMDRH Performance Improvement work and CSMC's goal concordant care initiatives.

MEASURES OF SUCCESS

- Referring physician satisfaction
- Increase in percentage of ICU patients receiving a palliative care consult
- Increase is percentage of palliative care consults for metastatic cancer patients
- Increase in total number of ordered palliative care consults performed in 1 month by 10%, to be achieved by Dec 2023

Figure 2 _ Cedars-Sinai Marina Del Rey Hospital Supportive Care Medicine Project Charter
Project outline displaying the objective, scope and proposed timeline.

Actions + Outcomes

- Developed a project charter and established both a steering committee and working group comprised of several disciplines (hospitalists, pharmacy, nursing, intensivists, social work, case management, emergency department, chaplaincy) to help guide the program's development and implementation.
- Completed a current state assessment of CSMDRH's existing primary palliative care infrastructure to identify and inform on key measures of success for the program's development.
- Assessed and modified electronic health record infrastructure including clinical order sets to be able to refer patients and provide appropriate clinical care (e.g., symptom management and goals of care documentation) to support a high-quality consultative service.
- Identified clinical area champions to lead education initiatives for multi-disciplinary clinicians across the hospital on the program's scope and benefits.

Project Goals

- Our primary goal is to build a formal specialty Supportive Care Medicine Program that will support high-quality patient care at Cedars-Sinai Marina Del Rey Hospital **(Figure 2)**. Although there is an existing primary palliative care infrastructure at CSMDRH, there is currently no formal program to provide specialty palliative care services.
- Our secondary goal is to align the program's development with CSMDRH's ongoing Performance Improvement work and Cedars-Sinai's Goal-Concordant Care initiatives.

Next Steps

- Continue to align our work with current and future Goal-Concordant Care initiatives at CSMDRH.
- Evaluate and track the program's consultative penetration rate at CSMDRH on a monthly basis **(Figure 3)**.
- Increase the total number of Supportive Care Medicine consultations performed in one month by 10%.
- Increase SCM consultative volume in the Intensive Care Unit by 10% over 6 months.
- Assess referring physicians' satisfaction with specialty SCM consultative service annually.

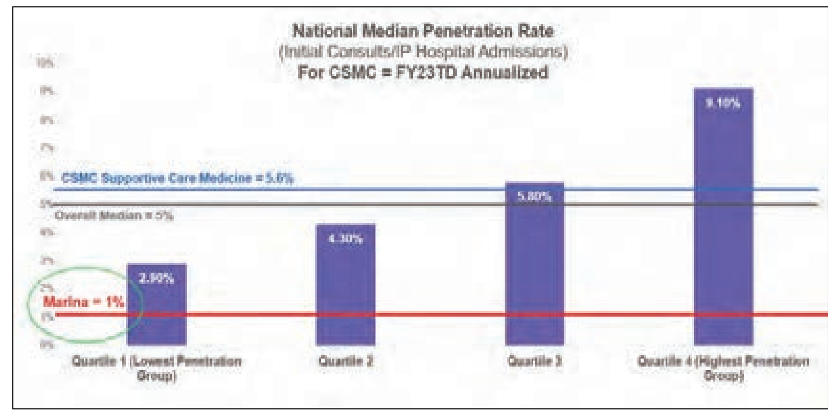


Figure 3 _ National Median Penetration Rate
Graph displays comparison between the national median penetration rate, Cedars-Sinai Medical Center Supportive Care Medicine Program and existing Marina Del Rey Hospital primary palliative care infrastructure.

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Lily Powell

Director, Strategic Planning & Business Development
Dartmouth Health

TeleLife Safety: Virtualizing On-Demand Support for the Bedside RN

Situation Analysis

Situation: Dartmouth Hitchcock Medical Center is building a large patient pavilion to address growing need for complex inpatient medical-surgical care. With this expansion, the distance covered by "Life Safety" RNs that support inexperienced RNs and prevent deterioration is expected to double. DHMC only has the resources to fund a limited expansion of Life Safety and is expecting to rely heavily on less experienced RNs to staff the new pavilion.

Background: The US is facing a significant nursing shortfall as >20% of RNs expect to retire in the next 5 years while new RNs have not been entering the field at a sufficient replacement rate.[1,2] Throughout and following the COVID 19 pandemic, DHMC has experienced high vacancy rates, increasing reliance on new grads and travelers. Telemedicine has historically been used in the inpatient setting to extend medical management services of limited experienced staff resources like critical care intensivists, respiratory therapists or experienced RNs. Dartmouth Health has a robust portfolio of virtual care programs, including an intensive ICU management program designed to improve ICU outcomes through the remote engagement of experienced ICU physicians and RNs at regional hospitals by less experienced bedside teams. DHMC has an established "Life Safety" program wherein RNs round on patients with the potential for deterioration and respond to non-emergent requests for assistance from bedside RNs in need of coaching across the medical center.

Assessment: DHMC faces a greater need for Life Safety services in the new pavilion to support a less experienced nursing workforce and this need will likely grow over time as experienced RNs retire. Providing these services will be significantly more challenging given a large physical footprint and limited ability to expand the Life Safety service. There is potential to minimize the impact of this mismatch through telemedicine services that connect Life Safety RNs to RNs at the bedside remotely, increasing the efficiency of consultations.

Recommendation: DHMC should extends its TeleICU platform to provide remote visibility into the new pavilion via two-way cameras and engage in remote clinical surveillance. DHMC should establish a new nursing program staffed by Life Safety RNs, called TeleLife Safety (TLS), to leverage this program to provide virtual surveillance and consultation in support of the bedside RN.

Project Goals

- Procure, install, and test two-way A/V systems in all 64 pavilion rooms
- Design Life Safety RN rounding, intervention, and consultation workflows
- Install virtual platform and run pre-pavilion sandbox pilot to define key alarm parameters to surface worsening patients without creating alarm fatigue
- Execute stepdown unit pilot to validate and refine workflows pre-pavilion opening to ensure pavilion launch success
- Train pavilion med-surg and stepdown staff to ensure robust usage and acceptance of TLS service such that pavilion patients experience fewer escalations in care and fewer codes
- Launch TLS program to coincide with the opening of the new pavilion

Completed Actions

- Obtained senior leadership approval and funding for the procurement of hardware, software, and staffing in support of the TLS Program.
- Established multidisciplinary program design team consisting of Life Safety RNs, TeleICU RNs, bedside med-surg RNs, unit leadership, and IRN Director
- Conducted detailed interviews and process design sessions with multidisciplinary team and technology leads to develop processes
- Developed draft TLS protocols covering patient rounding, intervention, consultation, and emergency response
- Installed and tested hardware and software in new pavilion

Incomplete Actions

- Planned pilot activities and program launch were delayed due to staffing shortages and leadership turnover (CNO sponsor left the organization during this time)

Outcomes

- Physical resources required for any in-room virtual care programs are ready for deployment
- Organizational resources were educated in program design methodologies by technical experts and are prepared to leverage education to conduct design efforts in house
- Virtual care concepts and language are now familiar and accepted among staff who will lead and engage with future care programs

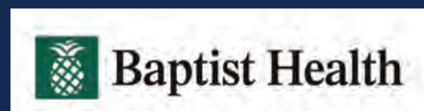
High-fidelity, two-way camera systems were purchased and installed allow remote clinicians to interact with patients and their counterparts to augment bedside care

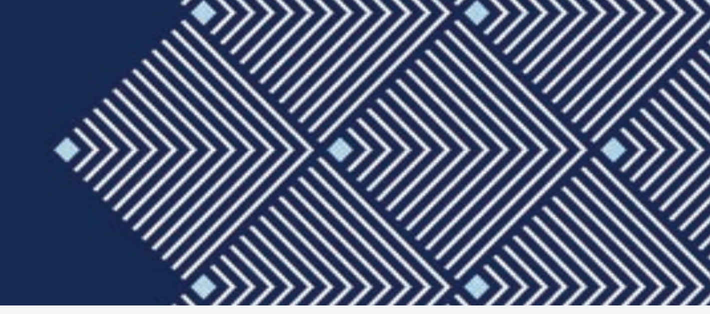
Next Steps

- Reconvene multidisciplinary design team to conduct protocol redesign program to leverage fewer new FTE, supporting steps include exploring TeleICU RN workflow for opportunities to include new pavilion monitoring, viability of fully remote workforce, and/or a partial nights and weekends service
- Present and obtain approval for redesigned program from DHMC CNO, COO, and CMO
- Socialize redesigned concept with Life Safety Committee and VP-level leadership for nursing, emergency response, hospital medicine, and intensive care functions
- Design and deploy new software pilot leveraging patients in wired new pavilion beds
- Design and deploy on-unit pilot to gather information about intervention frequency and efficacy
- Launch TLS program in August 2023

1. Smiley, Richard A., et al. "The 2020 national nursing workforce survey." *Journal of Nursing Regulation* 12.1 (2021): S1-S96.
2. Auerbach, David I., et al. "A worrisome drop in the number of young RNs." *Health Affairs Forefront* (2022).

Alex Pucci
AVP, Corporate Strategy
Baptist Health South Florida





Baptist Health is the largest healthcare organization in the south Florida region - with 12 hospitals, more than 26,000 employees, 4,000 physicians and 200 outpatient centers, urgent care facilities and physician practices spanning Miami-Dade, Monroe, Broward and Palm Beach Counties.

System Service Line Strategy Example: Orthopedic Care

BACKGROUND

Baptist Health has internationally renowned centers of excellence in brain & spine, cardiac & vascular, cancer care and orthopedic care. Baptist Health is transforming its care delivery model from multiple centers of excellence to a System Service Line design across the network. The System was fragmented in distinct and separate clinical silos for Orthopedic Care.

Using Baptist Health Orthopedic Care (BHOC) as the case study, the goal of this project is to enable integrated, comprehensive care (site agnostic). The purpose of this work is to accomplish the mission that no matter which "front door" a Baptist patient enters to receive Orthopedic Care, that experience will be coordinated and delivered at the highest quality across the Baptist Health network.

SCOPE

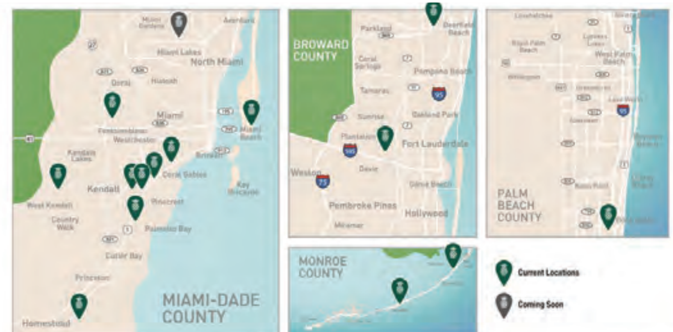
Entities impacted include:

- Hospitals
- Baptist Health Medical Group: Includes employed physicians and clinical practices
- Baptist Health Medical Staff Providers
- Baptist Outpatient Services (BOS): Includes ambulatory service centers (ASCs), off-campus ED's (OCEDs), urgent care sites, virtual health

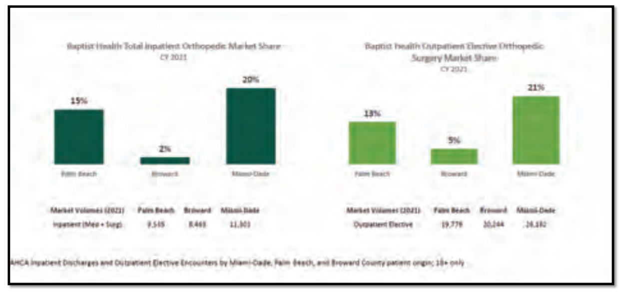
SCENARIO ANALYSIS

BHOC has experienced years of success as a center of excellence, with centralized services on the campus of Doctors Hospital in Miami-Dade County. Recognized by U.S. World and News Report for excellence in orthopedics, hip replacements and knee replacements, Baptist is the sports medicine provider for teams such as the Miami Dolphins, Miami HEAT, Florida Panthers, and Florida International University athletics.

Baptist Health Orthopedic Care: Practice Locations

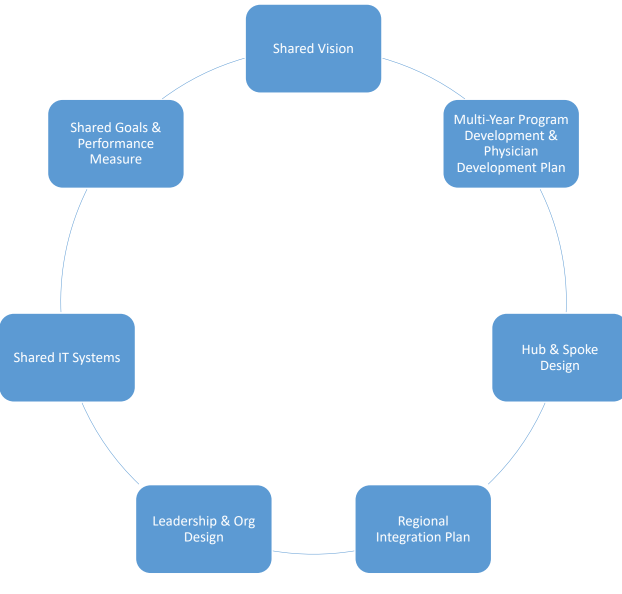


Since 2018, Baptist has significantly expanded its service area reach across the South Florida region through the acquisition of 3 hospitals in Palm Beach County and expansion of Baptist Outpatient Services, and there is market opportunity to geographically grow and expand leveraging an enterprise-wide strategic plan to extend a consistent model from the southern service area up north.



GOALS

Goal 1: Develop Service Line Plan Framework: create service line plan for Baptist Health Orthopedic Care.



Goal 2: Identify key points along the patient journey to define opportunities to maximize care coordination.

Goal 3: Navigate/facilitate physician and leadership buy-in to support System level vision

OUTCOMES

BHOC developed a comprehensive, enterprise-wide strategic vision and plan to guide the future for the service line, including:

- An integrated market development strategy for the 4-county region
- A multi-year business and capital plan
- Performance Excellence Dashboard and plan to harmonize over the next 3 years

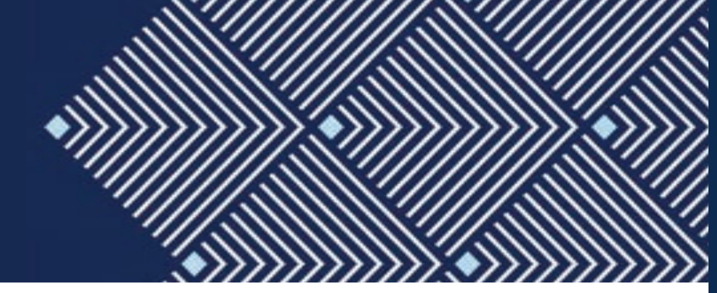
Strategic Objectives
FY24-FY26

- Destination Orthopedic Programs
- Operational and Clinical Excellence
- Regional Integration
- Academics and Research
- Smart Growth & Development

NEXT STEPS

- ❑ Finalize all System approvals for Orthopedic Care strategic plan
- ❑ Multi-disciplinary team to ensure strategic execution of the plan, led by Accountable Executive
- ❑ Further refinement of System Service Line roles and responsibilities

Jonathan Rosenthal, MHA
Director, Clinical Operations
Ascension - Illinois Market



From Agency To Associate

Situation Analysis

Ascension Illinois was highly dependent on contract labor to supplement our nursing workforce due to high staff vacancies and an inflexible workforce caused by burnout from the pandemic.

- 500+ agency FTEs per month
- $12 million contract labor expense per month

This increasing cost was not financially sustainable, so we needed to find a solution to reduce agency expense and to **replace agency workers with permanent associates** for the longevity of our ministry.

Actions Taken

Increased Internal Staff Options

- Rapidly grew our own **internal agency** (Short-Term Option program) as a pipeline for agency to become permanent associates (converted 200+ agency)
- Instituted **registry (PRN) tiers** for more hiring options and staffing flexibility to attract 'gig economy' candidates
- **Expanded Float Pool** by adding benefitted positions and specialties

Built a Flexible Resource Pool

- Implemented a **regional float model** for increased mobility across the market to better match staffing to demand
- Partnered with *CareRev* to create a **local on demand network** for per diem shift assignments
- Integrated with Ascension's national **travel program** for additional temporary staffing support

Optimized Staffing

- Launched **staffing planner tools** in all acute nursing departments in partnership with HR, Finance and Nursing Administration
- Utilized various **incentive programs** for more proactive staffing and balanced assignments
- Adopted **scheduling best practices** for increased scheduling effectiveness and staffing efficiencies

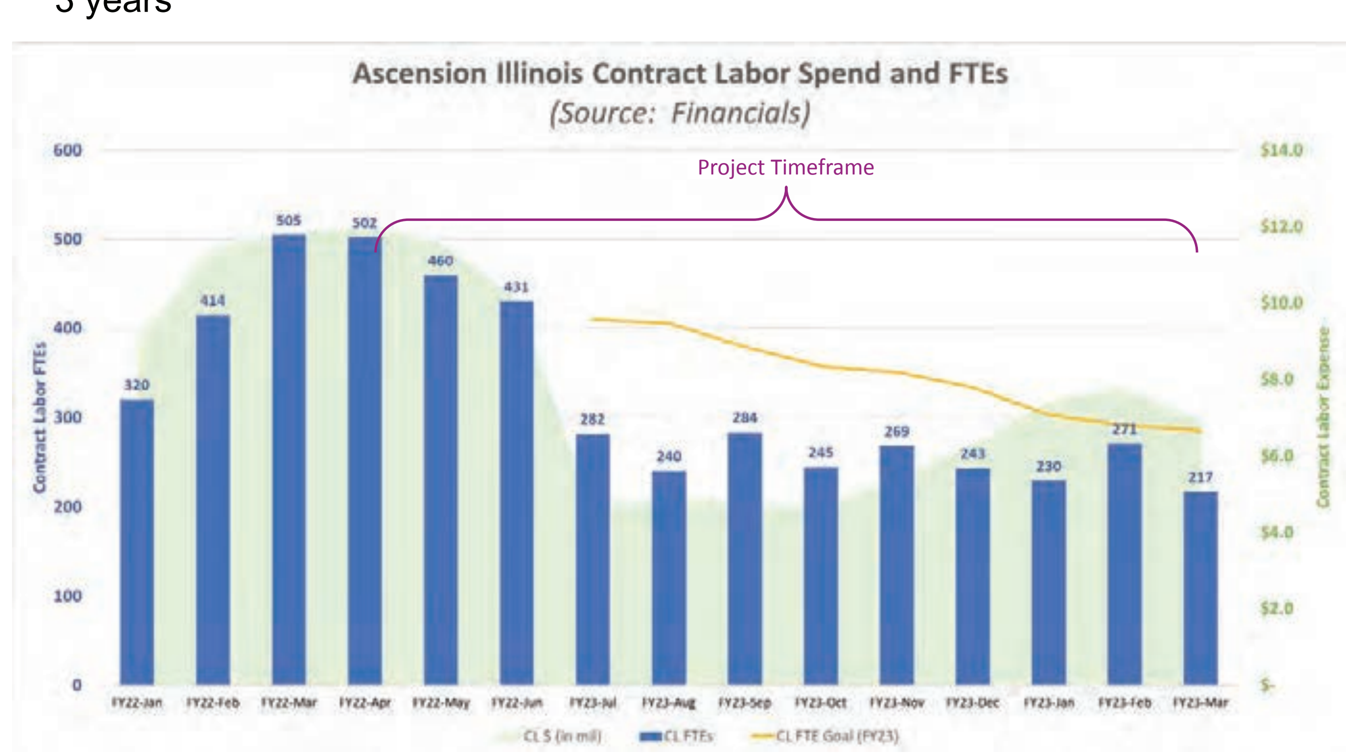
Project Goals

Reduce premium labor spend across the Ascension Illinois Market through workforce stabilization and optimization.

- Decrease external agency utilization (FTEs) 50% by end of FY23
- Increase size and scope of internal Float Pool
- Deploy standard staffing and scheduling practices market wide

Outcomes / Benefits

- Reduction of $55 million in contract labor expense realized in the first 9 months of FY23
- Expanding the Float Pool is projected to save >$10 million in premium labor expense in the first full year (currently ~33% filled at 49.8 FTEs hired)
- Improved labor management that is expected to save >$17 million over the next 3 years



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Praveen Shanbhag
Vice President
Main Line Health

Main Line Health

The Evolution of Ambulatory Care Delivery

What is Driving Renewed Focus on Ambulatory Services at Main Line Health?

13% Decline in inpatient market volumes over the past decade	Inpatient Market Declines	Physician Group Mergers	Consolidated and capitalized with VC funding, target high-margin services in physician owned facilities
Flat population with **16%** growth in seniors driving high Medicare inpatient mix	Aging	Margin Pressure	Average regional IP margins in 2023 were **-0.9%** and average ASC margins were **23%**
Profitable low-to-mid acuity procedures continue to shift to outpatient settings	Outpatient Shift	Payors & Disruptors	Payors shift site of care and acquire physicians; Non-traditional players focus on managing specific patient cohorts to maximize economic value capture

Four Work Streams Drive Implementation of Ambulatory Strategy

Reorganization

Reorganizing the leadership and management structure that puts greater resources and emphasis over the ambulatory space.

Optimization

Realigning the network to ensure appropriate distribution of sites, services, and capabilities across the market geography.

Standardization

Creating operating standards across practices and ambulatory sites to ensure patients receive consistent high-quality care and patient experiences.

Strategic Direction Setting

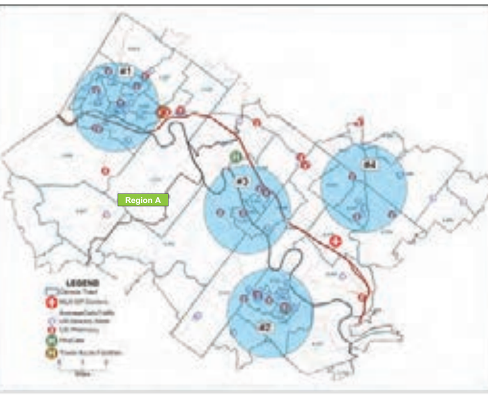
Refine ambulatory strategy to articulate priorities and make new investments leveraging current assets and strengths.

Optimization of Geographic Asset Distribution Based On Micro Market Analysis

	Population			Commercial					
Region	Adults	Growth 5-Yr	Density /Sq Mile	% Cover	IP Mix %	OP Growth %	IP Share	MLHC Vol	HH $$$ > 100K
Region A	97,707	4.9%	1,240	71.5%	37.5%	11.8%	24.2%	13,344	53.1%
	49,912	2.5%	1,065	58.2%	28.4%	13.8%	6.7%	3,497	35.3%

Hot Spot Details			
Hot-Spot	Drive Time To Health Center	Drive Time To MLH Hospital	AADT
1	20 min	39 min	806,781
2	13 min	15 min	336,956
3	11 min	30 min	471,458
4	6 min	28 min	235,074

- Regional market analysis determines optimal geographies
- Prioritized markets identified in regional analysis scrutinized via micro market analytics to determine seed points down to most optimal intersections



- First new seedpoint identified; detail market assessment, volume model, and preliminary programming developed for the location
- Financial proforma developed for the proposed programming
- Site identified in target seed point and LOI signed to acquire first site
- Site acquisition due diligence currently underway

Making Ambulatory a Strategic Priority

Annual Plan Objectives

- Develop ambulatory serviceline and asset strategy
- Determine optimal network size and locations
- Define clinical programs and stacking models for future health centers
- Design standardized facility models
- Identify and acquire assets in desired locations

Drive Strategic Growth and Deliver Outstanding Value

C. **Strategically grow outpatient services and develop new ambulatory health center models that are financially sustainable**

4C2. Develop the future model for ambulatory health centers and deploy them in optimal location(s) to grow volume in broader geographic markets

Standardization: Prototyping Guiding Principles

- Patient centric, providing a delightful experience for the consumer
- Consistent with brand standards
- Speed-to-market through use of standards and prototypes
- Cost predictable/competitive models
- Modular prototype components with stacking plans
- Changes to guidelines should be clinically justified
- Flexible, integrated platforms, and multi-use spaces
- Vertical expansion and use of shell space should be avoided

INFUSION
SPECIALTY 6 PHYSICIANS
SESSION 6 EXAM
MRI
MOBILE IMAGING
LOADING DOCK
SUPPORT
IMAGING / LAB
URGENT CARE
LOBBY/ BUILDING SUPPORT

PRIMARY CARE 12 PHYSICIANS
CARDIOLOGY 6 PHYSICIANS
PT / OT
LOBBY/BUILDING SUPPORT

Enabling Strategies

Expansion of Employed Providers	Enhanced Access	Digitization
Primary Care & Procedural Specialties	One Contact Does It All	Online Scheduling
	Advanced Contact Ctr	Virtual Care

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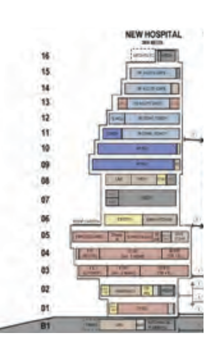
David Steuer

Director, Strategic Design

UCSF

Designing the Hospital of the Future

1. Creating the Vision



2. Getting Executive Sponsorship

3. Onboarding and Initial Scope

4. Hitting Roadblocks

Challenges

- Roll-on of (new) team, unclear roles + responsibilities
  - Until mid-Nov, only had designers (no product or Sol. Architect), so initial plan focused on design activities on agreed upon prioritized areas
  - Not properly oriented into the ICDC
- Expectations of the team were and remain unclear
  - Lack clear alignment between ClinOps, IT, and Architects/physical space stakeholders
  - Team has served as a "Rorschach" to different audiences
- Lack of alignment on scope, ExD deliverables, approval process
  - Leadership/governance ambiguity

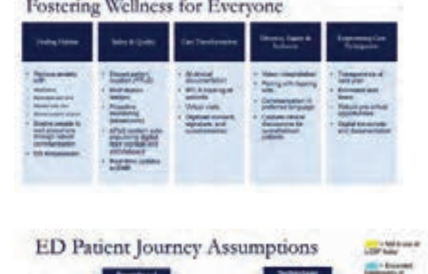
What we have observed and learned

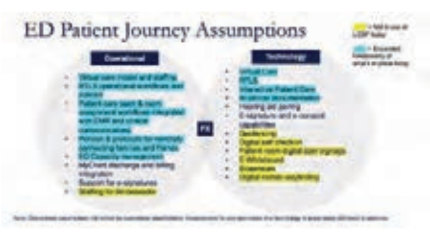
- HDR/HDM Design teams are conducting a limited user engagement process
- There are few documented operational assumptions,
- Current best practices being adopted for design decisions
- Lack of holistic future state vision

NHPH + Enterprise Innovation

- Through our discovery work, we are gaining insights and opportunities that could deliver value TODAY, but we lack clear resourcing/team structure to develop and run experiments, and then deploy.
- Integrate NHPH ExD with Receiving Care Product/Exp. Teams
  - NHPH ExD team to define future state, provide input into enterprise roadmap based on needs/opportunities, validated through concepts/prototypes,
  - Align product/experience teams (PCMC, VC, Patient/family Exp., Mng Sys 2.0)
- Develop a governance model that differentiates NHPH/Inpatient Experience from IT/Tech
  - Evolve IT Visioning into two functions: NHPH Tech oversight, NHPH Experience Team (stakeholders across 3 domains: Tech, Ops, Space)

5. Trying new approaches



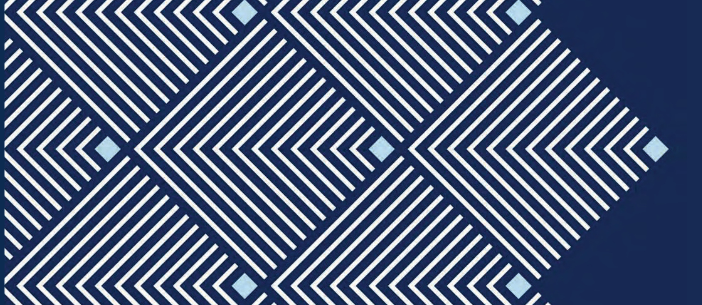


5. What's next

- **Align leadership:** Strengthen alignment and connection to Ops
- **Enterprise+NHPH:** Work with platform owners (i.e. clinical comms, virtual nursing) to develop enterprise roadmaps
- **Product/Design led:** Co-design, prototype, validate key workflows from identified journeys

6. Lessons learned

- **Governance** structures were insufficient and needed closer management
- Missed opportunity with **team onboarding** to set scope, process, integrated workplan
- Under-estimated **entrenched culture**
- **Failure**….is an option



Wade Swenson, MD, MPH, MBA
Medical Director
Lakewood Health System

Innovating Rural Cancer Care: The Integrated Palliative Care and Oncology Program at Lakewood Health System

Introduction

Access to palliative care services remains challenging for rural Americans. [1]

American Society of Clinical Oncology (ASCO) Clinical Practice Guidelines recommend that patients with advanced cancer receive dedicated palliative care services, early in the disease course, concurrent with active treatment. [2]

A holistic and tailored palliative care model that standardizes care delivery, referral and coordination, including family caregiver support programs, can improve care access. [1]

Lakewood Health System, a critical access hospital in Staples, Minnesota, created a cancer program with integrated palliative care services to better serve their patients.

EHR Referral Prompts

Patients will be automatically screened for a referral with any of the following:

1) ECOG performance status of 2 or greater
2) Stage IV disease
3) Change in immunotherapy or chemotherapy
4) Esophageal, head/neck, or pancreatic cancer diagnoses

Literature cited

1) Cai Y, Lalani N. Examining Barriers and Facilitators to Palliative Care Access in Rural Areas: A Scoping Review. Am J Hosp Palliat Care. 2022 Jan;39(1):123-130. doi: 10.1177/10499091211011145. Epub 2021 Apr 28. PMID: 33906486.
2) Ferrell BR, Temel JS, Temin S, Alesi ER, Balboni TA, Basch EM, Firn JI, Paice JA, Peppercorn JM, Phillips T, Stovall EL, Zimmermann C, Smith TJ. Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol. 2017 Jan;35(1):96-112. doi: 10.1200/JCO.2016.70.1474. Epub 2016 Oct 28. PMID: 28034065.

Results

Lakewood Health System in Staples, Minnesota, developed an innovative rural cancer program integrating palliative care services, supported by a new Epic EHR implementation. Automated prompts for palliative care team review are triggered by specific clinical parameters, facilitating early referral. The program incorporates the role of a dual-trained nurse case manager, strengthening service delivery.

Current System of Referrals

Manual Identification: Healthcare providers usually identify the need for palliative care manually based on their judgment and experience. It often relies on direct observation, routine follow-up, or a reactive response to an acute issue.
Subjectivity: Because the process is manual, it is subject to individual biases or oversight. Some patients who might benefit from palliative care might not be identified in a timely manner.
Inconsistent Criteria: The criteria for referrals might vary between providers, leading to inconsistencies in the referral process.
Delay in Referrals: With the reliance on human detection, there might be delays in recognizing the need for palliative care, leading to potential delays in initiating the service.
Limited Coordination: Communication between oncology and palliative care teams may be limited or require additional administrative effort, slowing the process down.

EHR Prompting System

Automated Identification: The EHR system is programmed with specific clinical parameters to automatically identify patients who may benefit from palliative care. For example, criteria such as ECOG performance status, stage IV disease, or certain diagnoses can trigger a referral.
Objective: The process is based on clear, predefined criteria, reducing subjectivity and ensuring that all eligible patients are identified.
Standardized Criteria: The criteria for referrals are consistent across the board, ensuring a uniform approach to patient care.
Timely Referrals: Since the EHR system can instantly flag patients meeting the criteria, referrals can happen quickly, sometimes even in real time.
Enhanced Coordination: The automated prompts facilitate better communication and coordination between oncology and palliative care teams, as alerts can be directly sent to the appropriate care providers.
Data Tracking: The EHR system allows for robust tracking and analysis of referral trends, patient outcomes, and other metrics that can inform continuous improvement.

Conclusions

This project illustrates the utilization of digital health tools to standardize care delivery, promote early referrals, and improve the quality of care in a rural setting. The holistic approach, integrating palliative and oncology care, meets ASCO's guidelines and addresses existing care delivery challenges.

Current Metrics:

Patient Referrals: Since implementing the integrated oncology and palliative care program, there has been a 40% increase in early patient referrals to palliative care services within the rural community.

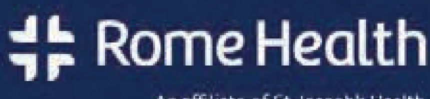
Future Metrics:

1. **Patient Referrals**
2. **Time to palliative care consultation**
3. **Patient satisfaction**
4. **Caregiver satisfaction**
5. **Symptom burden and management**
6. **Quality of life:** Measure patients' quality of life using validated assessment tool.
7. **Healthcare utilization:** Monitor the frequency of hospitalizations, emergency department visits.
8. **Advance care planning**: Track the percentage of patients with documented advance care planning discussions and completed advance directives.

Next Steps

The program will begin on August 14, 2023, with the electronic medical record "Go Live".

Ryan Thompson, MBA
Chief Operating Officer
Rome Health



Aligning Ambulatory and Acute Care

Situational Analysis

Rome Health is an independent not-for-profit healthcare system located in Central New York. As an independent health care system our sustainability is a direct result of our individual activities. The triple aim focus of healthcare delivery (increasing access to care, increasing quality of care, and reducing the cost of care) requires a greater focus on a system of care rather than a fragmented delivery system. Rome Health has built its network of care to include both acute care and ambulatory care. However, in many aspects the model is still very fragmented.

Rome Health as adopted a "shrink to grow" mindset to maximize efficiency and revenue at the same time as reducing expenses to create a more sustainable health system. Bringing acute, post-acute, and ambulatory care delivery together will position Rome Health for long term sustainability. Prior to 2019 Rome Health was awarded two separate grants from New York State totaling $11.3 million dollars; both of those grants were for projects that were deemed not appropriate to move forward.

Elements of a Fragmented Delivery System

- Rome Health has a complex physician practice organizational structure; there are three separate corporate entities providing pediatric, primary, and specialty care to the community.
- Each entity utilizes a separate instance of the same electronic health record making the transition of patient care difficult. This electronic health record is different than the health record for the remainder of the acute and ambulatory practices.
- Two of the corporate entities are captive PCs and one of the entity is a New York State Article 28 Hospital Outpatient Department. For similar patient encounters Article 28 HOPD reimbursement is 16.5% greater.
- Based on 2019 visit volumes Rome Health had 42 excess exam rooms.

Ultimate Outcome Measure

Project Goals/Actions/Outcomes/Next Steps

Goal 1 – Create an Integrated Acute/Ambulatory Electronic Health Record through the transition of all physician practices to Paragon Ambulatory to align with our Acute Care platform

Actions

- Design/Build completion of Paragon Ambulatory module
- Train of Providers and Staff
- System information migration
- Optimize new health information system

Outcomes

System "go-live" was scheduled for January 17, 2023. Project management structure developed (below) with weekly meetings scheduled to review milestones and barriers within a structured format. A charter developed with an overall project name, Project Unity. The week before go live we hosted provider training sessions. Cut over was slightly fragmented due to the amount of time available due to delays in system design and build for completion. The team developed a plan to work through cutover issues on an ongoing basis through the pre-visit planning process.

On January 17th the new ambulatory electronic health record went live. We developed a "go-live" call center and deployed super users to all practices to assist in working thorough 1st day challenges. The system went live and significant system functionality deficiencies were discovered. We attempted to work with the vendor for nearly two months to resolve the deficiencies.

Early March, an analysis of the previous electronic health record system was completed determine feasibility to return to a baseline plus state to unify all ambulatory practices into one single instance of their program. A physician strategy meeting (comprised of both internal stakeholders who use the system and external stakeholders who represent our medical staff) reviewed go forward options and concurred that the return to a "baseline plus state" was the best path forward.

Within two weeks a baseline plus state of our previous electronic health record was achieved. With 6 weeks of go live of our previous system the modified goal of a single physician practices electronic health record was achieved.

Next Steps

- Continue to review and optimization of our electronic health record system for optimization opportunities. A new informatics role was developed focused on working with the clinical and non-clinical leadership to develop opportunities for improvement.
- Continue to look for funding opportunities to entertain options for a single system wide electronic health record.

Project Management Structure

Goal 2 – Work to simplify the physician practice organizational structure including maximizing the utilization of Article 28 HOPD owned facilities and unifying the employees of the health system.

Actions

- Design/Build Rome Health Medical Center
- Create streamlined workflows through development of best practice operational workflows
- Implement new workflows

Outcomes

The Rome Health Medical center was designed by a cross functional team of stakeholders that represented nursing, non-clinical, and physicians. A key principle in the design focused on building space that could be utilized for patient care by multiple providers because of its repeatable/predictable design (in other words all exam rooms and provider offices are set up the same).

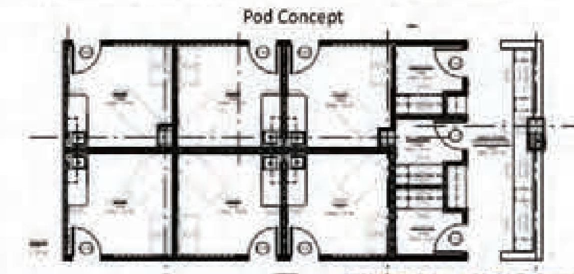
November 2022 the first group of providers successfully transitioned into the medical center. During the first week of transition a group of leaders (including myself, our director of plant operations, or director for the physician practices, and our Chief Information Officer) rounded on the staff twice a day as well as provided opportunity for improvement boards within the provider pods to record opportunities in real time. The improvement boards recorded opportunities and task completion so that staff could have an understanding of the status of their requests.

As of June 2023 provider visit volume is better than baseline state.

Next Steps

- Continue to review opportunities to maximize the utilization of space.
- Complete a 2nd phase facility masterplan based on "shrink to grow" strategy

Pod Concept



Goal 3 – Develop and implement a structure that supports daily operations as well as strategic service line development for ambulatory physician practices

Actions

- Transition all employees to single enterprise
- Design a new structure for leadership responsibilities with two focuses (1) daily operations and (2) service line development
- Implement service line leadership metrics and goals
- Hold semi-annual physician leadership strategic meetings

Outcomes

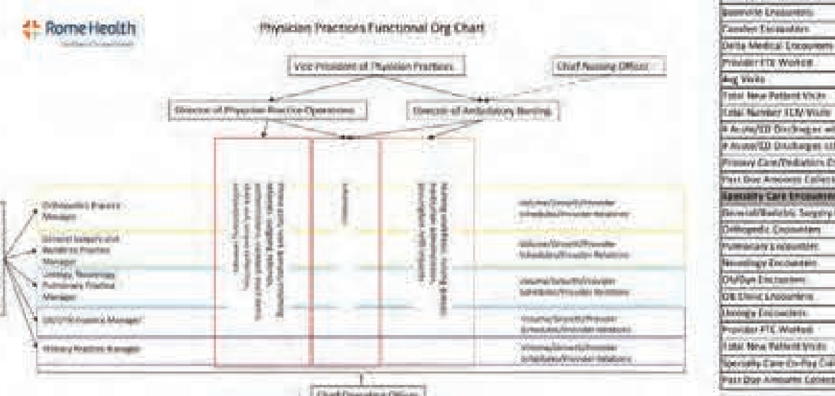
All employees have been successfully transitioned to a single enterprise and appropriately leased back to any separate institution. All sites have been included in executive leader rounding leading to greater collaboration and inclusion (structure below).

A matrix service line leadership structure has been successfully rolled out. Continual monitoring of operational efficiencies and new volume growth is achieved through the existing daily dashboard and tiered huddle process.

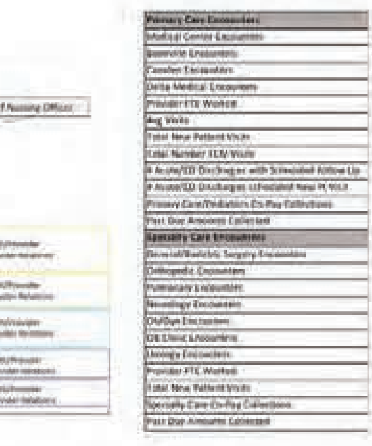
Physician leadership strategic meetings helped to set the course of action for the 1st goal of choosing the right next step for a single electronic health record. A 2nd physician leadership strategic meeting is scheduled for the fall.

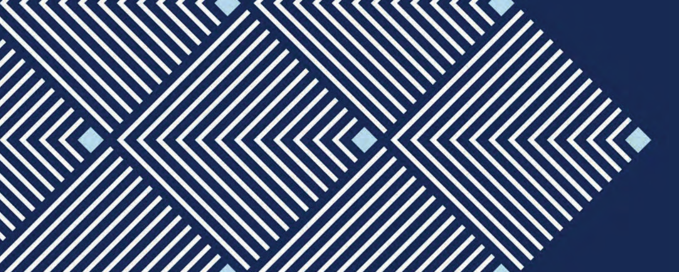
Next Steps

- Monitor daily metrics to track towards goal physician visit volumes
- Develop a physician specific metric card to review monthly with each employed provider focused on visit volume and quality metrics.



Daily Dashboard Metrics





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Kristen Vargo, DNP, RN, NE-BC
Director of Nursing
Cleveland Clinic

Work Smarter, Not Harder: A Review of Roles in the Spine Center of the Neurological Institute at Cleveland Clinic Main Campus

Situation Analysis

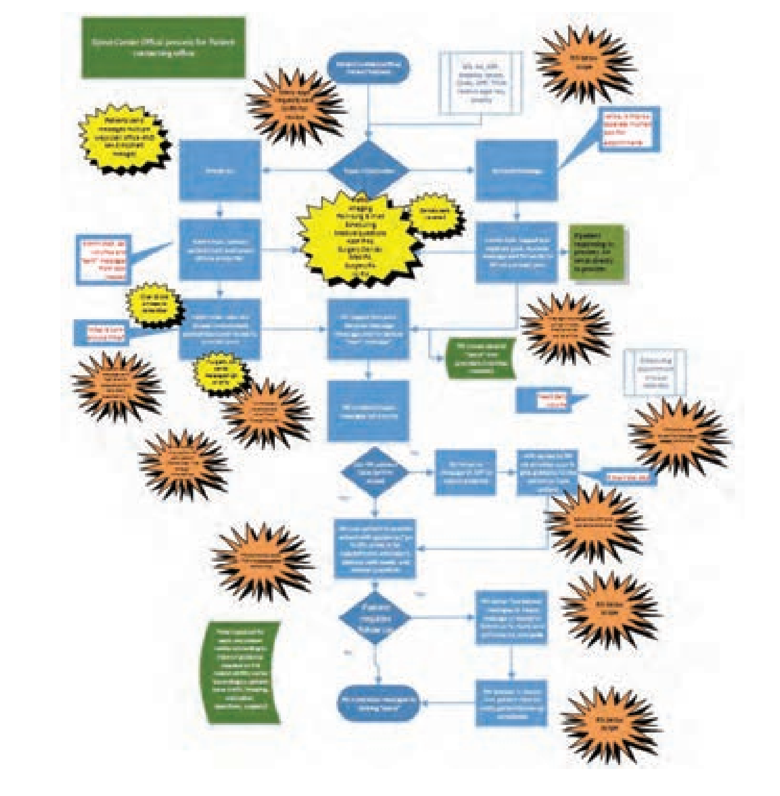
- The Neurological Institute at Cleveland Clinic is comprised of 15 centers.
- The Spine Center has seen the highest increase in patient volumes of 5% over the last 4 years.
- With increased volumes, the RN Care Coordinators are experiencing significantly higher volumes of administrative patient encounters (surgery scheduling, clinic visits, phone encounters, MyChart messages, and forms).
- An in-depth review of roles and responsibilities of the current ambulatory nursing and administrative support staff of the of the Spine Center is warranted for the following reasons:
  - Improve efficiency
  - Ensure caregivers are working at top of licensure
  - Ensure nursing is completing clinical work
  - Promote professional well-being

Project Goals

- Reduce administrative tasks completed by the Registered Nurses in the Neurological Institute by 25% by September 31, 2023.
- Reduce Registered Nurse position in the Neurological Institute by 10% by December 31, 2023.

Actions

- Analyzed current tasks completed by the Registered Nurses using process mapping.

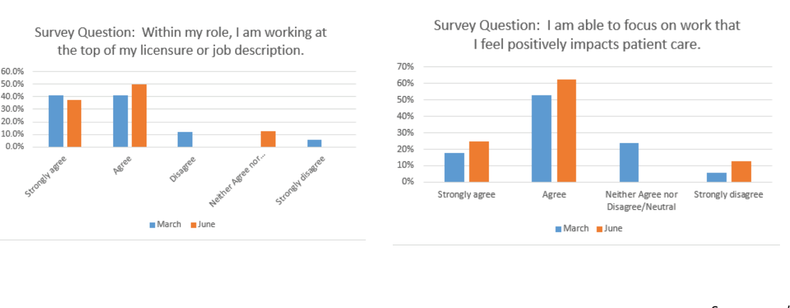


Process mapping depicting the office process in the Spine Center

- Assessed potential technological opportunities.
- Explored opportunities to hire supportive nursing positions and non-clinical roles.

Outcomes

- Implemented several countermeasures to improve efficiency and decrease workload, including
  - DocuSign technology to assist with form completion
  - Hired an LPN to support form completion
  - Reduced form completion from a median of 8 days to 3 days
  - Revision of Dot Phrases used by our administrative assistant team from 12 to 1
  - Partnership developed with Nursing Informatics Leadership to continue exploration of IT solutions to assist in the ambulatory setting
- Through countermeasures, Initiated Nursing Transitions of Care Calls for postoperative spine patients
- Survey analysis of the caregivers shows an improvement of RNs feeling they are working at the top of their license and an increase in positively impacting patient care.



Survey results

Next Steps

- Implement countermeasures adopted in the Spine Center across the other 15 centers of the Neurological Institute
- Continue individualized analysis of each center of the Neurological Institute for additional areas of opportunity
- Track qualitative and quantitative data to assess project success
- Create a toolkit that other institutes across the Cleveland Clinic can utilize to conduct a job analysis in the ambulatory setting

Class of 2023 | **AHA Next Generation Leaders Fellowship**

Nada Wakim, PhD, RN, NE-BC
AVP of Nursing
South Miami Hospital

Utilizing HRO tools to improving HCAHPS Score

Situation Analysis/Background

At SMH, the historical average for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) has not met the top 5% of the National Hospital's benchmark. The RN Communication score FY 2019 was 83%, with a benchmark of 89%, and the MD Communication score FY 2019 was at 86%, with a benchmark of 91%. This performance is affecting patient satisfaction and reducing the reimbursement rate for Medicare Hospital Value-Based Purchasing (VBP).

Goal (s)

Implement processes and cross-checking procedures in order to set the foundation to create a high-quality and safe environment, working with doctors and nurses to improve communication with patients. The goal was to increase RN and MD Communication scores to above CMS benchmark focusing on courtesy and respect, listening, and explaining.

Actions

HCAHPS RN/MD Communication Domains :

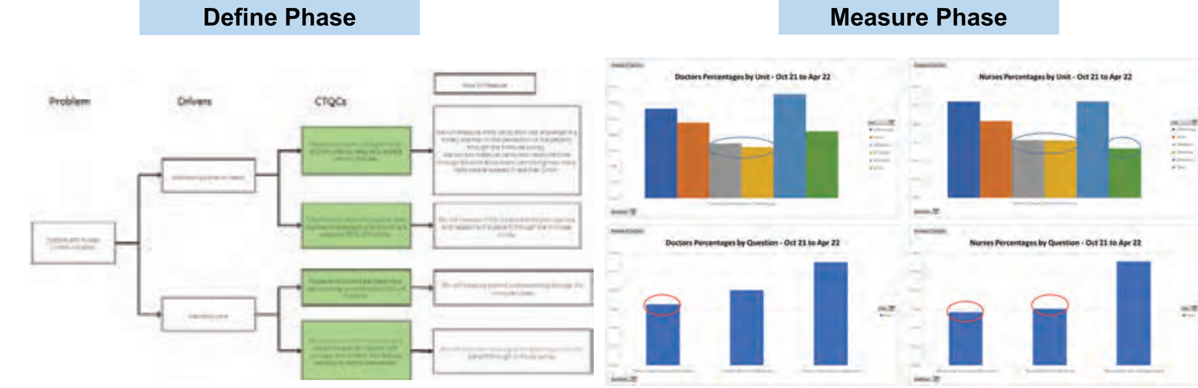
- Added alternative numbers (Supervisors/Manager) to the communication boards in patient rooms.
- Reiterated during huddles to RNs and CPs the need to always carry their assigned hospital phones.
- Revised all text alerts received by RNs minimizing receipt of busy signal by patients when calling RN/CP.
- Created an RN/CP competency validation tool on Patient communication skills.
- Conducted mandatory education on "Elements of Human Connection" followed by simulation and role play on (Compassionate, Authentic, Respectful, Empathetic) C.A.R.E initiative for all Med Surg RNs/CPs.
- Included education in Onboarding class of new hires.
- Conducted In-House Survey targeting RN communication to receive timely feedback ahead of HCAHPS survey and shared results with leaders.

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

HRO Methodology

Define Phase

Measure Phase

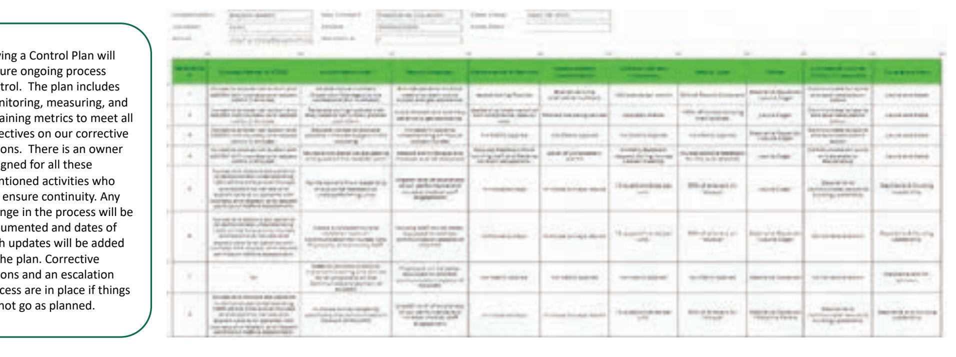


Analyze Phase

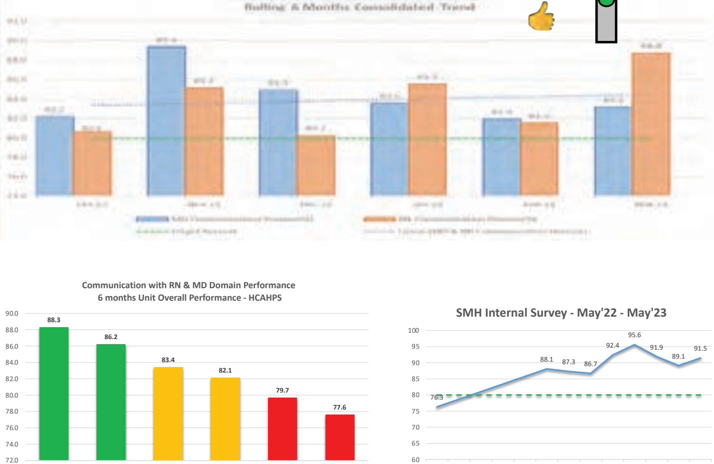
Improve Phase

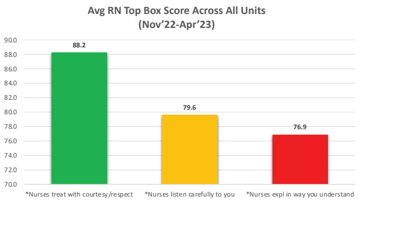
Control Phase

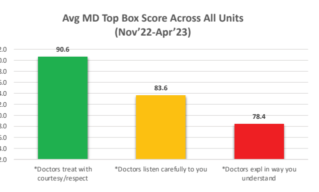
Having a Control Plan will ensure ongoing process control. The plan includes monitoring, measuring, and obtaining metrics to meet all objectives on our corrective actions. There is an owner assigned for all these mentioned activities who will ensure continuity. Any change in the process will be documented and dates of such updates will be added to the plan. Corrective actions and an escalation process are in place if things do not go as planned.

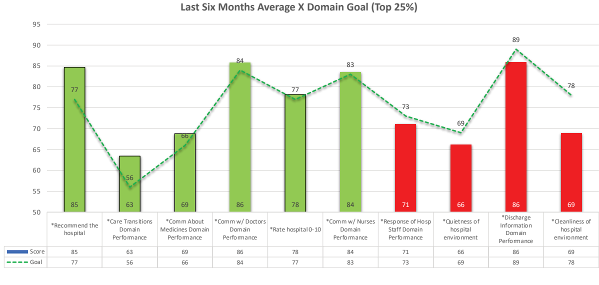


Results/Outcomes









Next Steps

- Continue Mandatory education for all remaining clinical and non-clinical areas.
- Complete physicians' training for Hospitalists, Intensivists, and Emergency Department Physicians.
- Continue training all newly hired staff/physicians.
- Continue to conduct In-house surveys targeting questions on RN/MD communication to receive timely feedback.
- Continue to provide performance metrics and follow up during Kaizen monthly meetings.

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Donna Wellington, MBA, BSN

SVP, Chief Ambulatory Officer
VP, System Primary Health
COO, Behavioral Health Services
Henry Ford Health

HENRY FORD HEALTH
Primary Health

From Fee-For-Service to Value-Based Care: Creating A New Financial Model

Situational Analysis

My project involves the proposal and the initial phase of implementation of a financial model which will support value-based care success. It includes a redesign of our networks and supporting infrastructure, value-based contracting, value-based funds flow and provider incentive alignment to drive success in value-based care. Our newly proposed model will position us well for success and ensure that we can achieve our growth, clinical performance outcomes, and financial objectives. Currently, HFH has 4 networks, each with its own largely independent infrastructure, and at least 6 different contracting entities. There are multiple disparate and unaligned value-based care entities, programs, and initiatives across the Health System. Value-based care expertise is fragmented, often sporadically embedded within multiple networks, business units, and geographic regions. Moreover, there is no systematic approach to reinvestment in value-based infrastructure and little alignment of provider incentives with value-based goals and objectives. Overall, there is organizational and leadership interest and curiosity regarding value-based care, but value-based care concepts and principles are often unknown, misunderstood, and/or actively not in practice across many parts of the Health System.

Project Goals

- Create a System strategic and operation plan to pivot from a FFS model to a VBC organization. Obtain approval to develop a financial model that supports the achievement of value-based care objectives
- Develop & Initiate Exploratory Phase after System leadership approval Identify the proposed financial model, including changes to the system, why those changes are needed, a comprehensive comparison of current vs. future state, and the anticipated impact to the System overall and key stakeholders
- 2023+ Initiate the planning phase of the operational work plan

Actions

- Developed a high-level conceptual financial model to present to senior leadership & obtained input from key stakeholders across the System, including next phase objectives and deliverables
- Socialized the strategic plan with senior leadership team, received approval to proceed
- Created a confidential steering committee with various stakeholder leaders, including representatives from legal, contracting, networks, HR, & senior Primary Health leadership
- Developed 3 phases for this plan (Exploratory, Planning & Execution)
- Created workstreams (partnerships, networks & contracting, funds flow, & provider incentive compensation)
- Identified leadership, membership, deliverables and scope for all workstreams
- Created a white paper to share the final proposal with senior leadership
- Socialized proposal with senior leadership & secure approval to proceed from exploratory to planning stage by end of year
- Identified workstreams needed and key stakeholders required
- Determined workstream leadership, membership, timelines & deliverables
- Socialized and educated key system stakeholders to ensure a smooth transition
- Secured senior leadership approval to transition from planning to execution phases

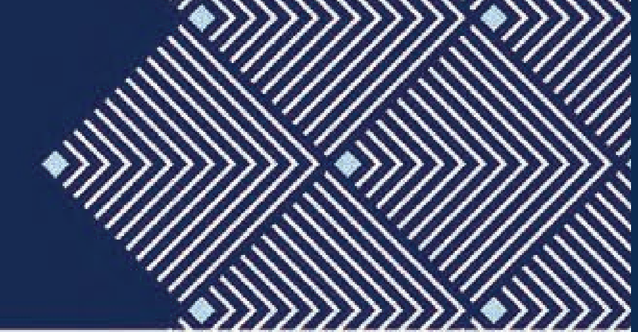
Outcomes

- Obtained approval from senior leadership to create a white paper, and environment scan on the disruptors within market and propose a new System financial model for VBC
- White paper completed and submitted to Senior leadership. Senior leadership approved the proposed financial model outlined and authorized proceeding from the exploratory to the planning stage which includes System stakeholder support and socialization.
- Completed initial four-part value-based learning series for senior leadership, thus increasing the Executive leadership's understanding, awareness, and need for change so that we are better positioned for VBC performance. The series sparked great interest and resulted in numerous requests for the series to be expanded to additional audiences within the Health System.
- Actively engaged in the planning phase of the CIN development which is track with workstreams – Network Governance, Network support , Change management, Communication, Contracting, Financial & Revenue, Care Delivery Model Redesign
- Create the road map for implementation of the proposed and approved financial model, including timelines, resource procurement, administrative support structures needed, communication plans, HR changes, etc.

Next Steps

- Continue leading the multidisciplinary team to develop a comprehensive road map and implementation plan of the proposed and approved financial model, including timelines, resource procurement, administrative support structures needed, communication plans, HR changes, etc..
- Expand and strengthen System and senior leadership value-based care education program
- Begin to expand value-based care programs across other areas, such as by implementing a System-Level Value-Based Care Contracting Committee

Nathan Ziegler, PhD
System VP, Diversity, Leadership and Performance Excellence
CommonSpirit Health



Equity Heals: Addressing Chronic Kidney Disease

July 17, 2023

Building on Decades of Scholarship and Advocacy

The NEW ENGLAND JOURNAL of MEDICINE

Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms

2020 Aug 27 | Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

WAYS & MEANS COMMITTEE
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Fact Versus Fiction: Clinical Decision Support Tools and the (Mis)Use of Race

List of 13 clinical calculators using race as factors in calculation of severity of disease, risk of procedure, or likelihood of diagnosis

- Some are used frequently
- Some have undergone review & modification
- Some are awaiting further research

Concern in use of MDRD/KDOQI 2012 Equation

Utility of Calculator

Calculates estimated glomerular filtration rate based on serum creatinine, thus identifying kidney function status.

Equity Concern
(as stated by Vyas et al in Hidden in Plain Sight)

Calculator reports higher eGFR values (thus better kidney function) for patients identified as Black. **These higher eGFR values may delay referral to specialist care or listing for kidney transplantation.**

Background

Black Americans are about 4 times more likely than White Americans to develop kidney failure. The United States Renal Data Service reports kidney failure prevalence of 5,855 cases per million for Black Americans compares to 1,704 cases per million for White Americans.

What is eGFR?

Estimated Glomerular Filtration Rate

Creatinine | Age | Sex | Race??
Body mass | Diet | Clearance

Afferent arteriole
Efferent arteriole
Glomerular capillaries
Bowman's Capsule
1. Filtration
2. Reabsorption
Peritubular capillaries
3. Secretion
Urine
Renal vein
4. Excretion

1. Filtration
2. Reabsorption
3. Secretion
4. Excretion

Excretion = Filtration – Reabsorption + Secretion

Disparity Illustrated

	Younger patient, **worsening** kidney function		Older patient, **steady** kidney function	
	WHITE	BLACK	WHITE	BLACK
AGE	55		80	
GENDER	Female		Female	
WEIGHT (kg)	80		60	
HEIGHT (cm)	160		160	
Creatinine	2.8		1.0	
MDRD	17.5	21.3	53.3	64.7
2009 CKD-EPI	18	21	53	62
2021 CKD-EPI Cr	19		57	

This equation itself has changed to make eGFR more accurate – it does not simply remove race.

HOW YOUR RACE CAN CHANGE YOUR MEDICAL CARE

NON-BLACK PATIENT

A blood test is used to evaluate kidney health

- The lab reports the patient's GR score.
- A low GR score indicates poor kidney function.

What could happen next:

- To be safe, certain drugs aren't prescribed, or when they are dosages may be kept low.
- The patient gets referred to a kidney specialist earlier.
- If a transplant is needed, the patient is eligible earlier.

BLACK PATIENT

A blood test is used to evaluate kidney health

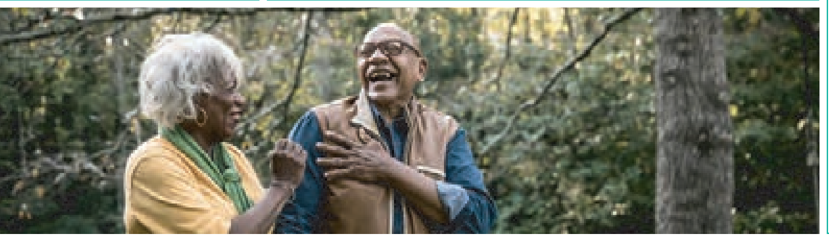
- The patient's GFR score is **increased by as much as 25%.**
- A higher GFR score indicates better kidney function.

What could happen next:

- More medications and higher dosages are considered safe for this patient.
- The patient gets referred to a specialist later.
- If a transplant is needed, the patient becomes eligible later.

Purpose & Goals

The current eGFR formula has implicitly disadvantaged Black patients with end-stage renal disease (ESRD) by overestimating eGFR values for patients, resulting in a delay of care.



Purpose:

To test the feasibility and impact of a brief, racial justice informed, patient/community education and awareness intervention on chronic kidney disease

Determinants:

- Transition of facility- based laboratories to new 2021 CKD eGFR calculator
- Low patient kidney knowledge is associated with worse clinical outcomes including less use of permanent dialysis access, and shorter times to dialysis initiation
- Understanding basic concepts about kidney function, symptoms of disease progression, and individual disease status are controllable risk factors
- Identifying and treating CKD at the earliest stages is an equity imperative

Strategies, Measures & Actions

Strategies & Transitioning eGFR Calculation

Change the eGFR calculation to remove the race-based coefficient for African Americans

Clinical Education & Clinical Outcomes Pilot

- Design a clinical research pilot study to identify staging changes in amb pts from CKD stage 3 → 4 → 5 and track & measure Care Delivery Pathways
- Communicate transition to new eGFR measurement to Physicians and APPs

Patient & Community Outreach Pilot

Collaborate w community partners to improve kidney health awareness & CKD education

- To test the feasibility and impact of a brief, racial justice informed, patient/community education and awareness intervention on chronic kidney disease

Community Outreach, Awareness & Education

Increase Awareness of CKD Risk Factors

- Are you the 33% Campaign
- Health Literacy to empower the patient/provider interaction on eGFR

Screening

- Increased Access & Activation
- Co-morbidities & Risk

CKD & Racial Justice

- Structural Determinants
- Community Partnerships

Increased urgency from internal & external forces to improve health outcomes and reduce disparities

Alignment

- Mission/Community Benefit
- Hospital Equity Roadmap

Mandatory Reporting

- Joint Commission Healthcare Disparities
- SDoH Screening
- Readmissions

Public Interest

- CA / AG Letter Inquiry Racialized Medicine
- Algorithm Updates
- Artificial Intelligence

Outcomes

Metric Category HEALTH EQUITY	Measure	Target	Current YTD Performance
System laboratory changes in dGFR kidney function measure	100% of labs changes	76%	100% MAXIMUM
Design Clinical Research Pilot	Pilot designed (IRB, Pilot identified, denominator & numerator defined)	100%	100% MAXIMUM
Educate Physicians & APPs on lab changes	10,000+ Providers reached	100%	100% MAXIMUM
Launch a Patient & Community Education Pilot	1,000 people reached in screening & events	100%	100% MAXIMUM

Next Steps

Implementation

Implement community facing awareness, education and screenings to increase the number of African American community members who have received CKD education and screenings.

Implement the completion of an impact analysis of eGFR equation update for CKD diagnosis across a pilot market, establishing the Standard of Care for patients with CKD, and identification of barriers to adhering to the standard of care in the index pilot market.

Special Acknowledgements | Mentor: Ron Werst, CEO, Cottage Health | Co-leaders: Gaye Woods, System VP of Equity and Inclusion | Dr. Ankita Sagar, System VP of Clinical Standards and Variation Reduction
Dr. Gary Greensweig, System Senior VP and Chief Physician Executive | Anjali Jones, System Director of Diversity, Equity, Inclusion and Belonging

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