A New Clinical Operating Model Transforms Care Delivery and Improves Performance

The Unified Clinical Organization (UCO)

Paul Conlon, PharmD, JD
SVP, Clinical Quality and Patient Safety, Trinity Health
Given the critical challenges in healthcare, how can Trinity Health achieve its performance, quality and safety goals?
Combined Organization to Serve 21 States Nationwide

- Operating revenue $13.3 billion
- 82 hospitals
- More than 87,000 employees
- 4,100 employed physicians
- 89 continuing care facilities
- 2.75 million annual home health/hospice visits
- $1 billion in Community Benefit Ministry

Proforma statistics as of June 30, 2012
The Goal of the Unified Clinical Organization (UCO)

**Consistent** delivery of the highest quality, safest and the most efficient care for every patient, every time, in every Trinity Health location.
Clinicians Leading Change

Frontline Staff must:
1. Identify goals
2. Ensure that the local microsystems can execute on the goals
3. Monitoring performance
4. Improve performance
Learning Objectives

• Identify strategies to achieve better clinical quality and safety outcomes by leveraging technology
• Distinguish between clinician led transformation and IT led transformation
• Describe critical success factors that support enterprise wide care standardization
Unified Clinical Organization (UCO): The New Approach

- Allows clinicians to lead the effort
- Expands across the continuum of care
- Keeps clinical work *sacred*
- Builds upon existing high performance
- Collaborates in decision making
- Shares accountability
- Provides transparent, two-way communication
- Encourages data-driven decision making
- Makes it easy to do the right thing
- Comprehensive organizational support
Key Unified Clinical Organization (UCO) Change Process Elements

- Collaboratives are co-led by Ministry Organizations (MO) and Home Office leaders
- Collaboratives are made up of front-line care givers who have subject matter expertise and are supported from the beginning by change leadership, TIS, communications, finance and process excellence
- Each collaborative has a steering committee that makes the collaborative decisions based upon the input of the broader collaborative
- Fundamental premise is learning from one another and doing for all
- Decisions are based on what is the best care for the patient (NOT lowest common denominator; Not what is locally politically expedient)
- Collaboratives and their committees get together each month on conference calls and webcasts. Most collaboratives have 1 or more in person meetings.
- All collaboratives have a performance measure dashboard that tracks both clinical and financial metrics.
- Ministry Organizations are held accountable for executing the full UCO plan
  - Typically best when there is a triad of physician leader, nursing leader, and process excellence leader leading the work locally
- Transparency
UCO Collaborative Objectives

- Standardize care **across the continuum**
- Advance clinical leadership and collaboration
- Leverage technology, particularly the integration of electronic health records to improve clinical processes and practices
- Promote accountability
- Increase transparency
Unified Clinical Organization: Governance and Decision Making Role

UCO Governance puts patients, families and caregivers at the forefront.

- **Patients and Families**
  - Input into Design and Ongoing Improvement
  - Design, Implement and Sustain
  - Operational Execution
  - Strategic Oversight

- **Caregivers**
  - Collaborative Teams
  - Ministry Teams

- **Operations Team**
  - Sponsorship Team

- **UCO Management Team**

**Staff Support**
UCO Governance Objectives:

- Establish UCO clinical strategic direction and vision
- Set and achieve clinical quality and safety priorities
- Drive MO and Home Office accountability
- Recognize and credit MOs for achievements
- Connect front-line caregivers with “next best” practices based on evidence
- Recognize and coordinate interdependencies
- Enable effective and timely decision-making
- Integrate local and system efforts to support the achievement of clinical excellence
- Facilitate alignment with other Trinity Health initiatives and executive committees
- Remove obstacles, resolve issues and manage risks
- Measure outputs, outcomes and benefits against business case
UCO Collaborative and Ministry Teams: Roles and Responsibilities

**UCO Collaborative and Ministry Teams design, implement and sustain clinical improvement solutions.**

**Design, Launch and Refine**
*Examples: Sepsis; Peri-Natal;*

**Collaborative Teams**
- Made up of clinical experts from MOs
- Design clinical programs on behalf of all MOs
- Identify best demonstrated practice standards
- Supported by Trinity Information Services (TIS), process excellence, change leadership & project management

**Ministry Teams**
- Provide input into UCO decision making
- Implement clinical programs designed by Collaborative Teams
- Mobilize local resources to implement solutions
- Accountable to MO and UCO to achieve results
UCO Operations Team: Roles and Responsibilities

The UCO Operations Team provides day-to-day guidance and operational support for Collaborative and Ministry Teams.

Role of the UCO Operations Team

- Commission Collaborative Teams
- Direct Collaborative Team activities
- Provide tools, data, experts and resources to Collaborative and Ministry Teams
- Recommend UCO priorities
- Select and manage Structured Innovation models
- Review progress toward UCO metrics/objectives
- Resolve issues and risks
- Review recommended scope changes
- Communicate about the UCO in formal and informal settings

Membership

- Accountable Clinical Executive (ACE) at each MO
- SVP, Clinical Quality and Patient Safety
- COOs
- Accountable Health Network Representative
- Other support resources as needed
Each UCO Ministry Team has a UCO Accountable Clinical Executive accountable to:

- Lead work of UCO Ministry Team(s) at their ministry organization (MO)
- Identify MO resources to implement UCO solutions
- Integrate UCO solutions with other local priorities
- Inform UCO solution design
- Share good work being done at MO
- Assure voice of care givers is integrated
- Lead transformational change at MO
- Ensure interdisciplinary implications at MO are addressed
- Serve as officer of the system, representing best interest of all MOs
The UCO Sponsorship Team serves as the UCO “Board” and is accountable to Trinity Health Executive Management Group (EMG).

Role of the UCO Sponsorship Team (Board)

- Define UCO strategic direction
- Approve UCO priorities
- Establish annual objectives for quality and safety improvement
- Approve roadmap defined by UCO Operations Team
- Ensure UCO alignment with Trinity Health strategic direction
- Recommend resource and funding needs
- Engage with stakeholders
- Communicate, communicate and communicate
Relationships Between UCO Initiatives
Quality/Care Improvement, Safety & Culture of Safety
Interdependencies

- Emergency Department
- FY'14
Unified Clinical Organization (UCO) Initiatives

**Quality and Improved Care Process Initiatives**

**Patient Safety Initiatives**

**Culture of Safety**

**JUST CULTURE**

**Sustaining Initiatives**
- Blood Stream Infection
- Deep Vein Thrombosis (DVT)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Medication Reconciliation
- Pressure Ulcers
- Suicide Initiative
- Unified Enterprise Ministry (UEM) Pharmacy & Therapeutics
- Ventilator-Acquired Pneumonia (VAP)
- VOICE

**Perioperative Services**
- (e.g., Surgical Safety Checklist)

**Perinatal Patient Safety**

**Sepsis**

**FY'12**
- Falls Prevention
- Heart Failure
- Joints
- Spinal Fusion

**FY'13**
- Ambulatory Diabetes Care
- Ambulatory Heart Failure
- Palliative Care
- Telemedicine

**FY'14**
- Emergency Department

**Ministry Led Initiatives**

**Excellence in Care Experience**
Trinity Health’s Approach to Change

*The Change Pyramid*

**Least Difficult**

**Most Difficult**

**Technical**
What We Do
Tools, Technology, Outcomes

**Process**
How We Do It
Systems, Structures, Processes

**People**
How We Do It Through People
Behaviors, Development, Training

**Culture**
Why We Do It
Collectively: Mission, Core Values, Vision, Guiding Behaviors
Individually: Attitudes, Beliefs, Thoughts, Purpose & Meaning

**Why**
**Ministry**
**Enterprise**
**Unified**
**What**

Adoption begins at Pre-Design!
Rapidly Changing Environments Require New Approaches
A carefully defined portfolio is required to organize and deliver meaningful and sustainable results.
Examples of Clinical Collaboratives and Information Services Support

- Sepsis (detailed)
- Medication Reconciliation
- Falls Reduction
- Palliative Care
- Joints and Spine
Sepsis in Trinity Health Ministry Organizations

- For FY 10 (July 1, 2009—June 30, 2010):
  - 12,481 patients had a diagnosis of sepsis
  - 15.8% of these patients died
  - 4,868 (39%) of these patients had acute renal failure
  - 2,021 (21%) of these patients had mechanical ventilation

WE CAN DO BETTER!!

Severe sepsis was defined by either or both ICD-9 codes 995.92 Severe Sepsis w Organ Dysfunction of 785.52 Septic Shock.
Sepsis Collaborative Structure

UCO Operations Team

Sepsis Steering Team
Clinical Experts in Sepsis Care (25-30)
Home Office UCO, TIS

Sepsis Collaborative
Clinical Experts in Sepsis Care, Change Leaders, Quality Experts, Clinical Documentation Specialists, Infection Preventionists, Pharmacists, ID Physicians, from all clinical venues, and Home Office leads (200-300)

Rules & Alerts Team
Clinical Experts in Sepsis Care (2), Cerner Associates (2), TIS (4) and Home Office Leads (2)

Sepsis Reports
Reports Team (2), Cerner Associates (1-2), & Home Office Leads (2)

Sepsis Design Team
Clinical Experts in Sepsis Care (5), Clinical Informatics, Cerner Associates (3-4), TIS (10), and Home Office Leads (4)
Goal: 40% reduction in mortality for patients with severe sepsis and septic shock by December 31, 2011

Projected Results:
- 685 lives saved
- 1,954 fewer patients with acute renal failure
- 1,058 fewer ventilated patients
- $17 million saved
Severity Distribution Over Time

Trinity UEM Sepsis Inpatients Percentage Distribution (Progression Control)
Desired Trend is to Shift Patients to less Severe Category
(Source: DSS)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Simple Sepsis</th>
<th>Severe Sepsis</th>
<th>Septic Shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2010</td>
<td>42.6%</td>
<td>33.9%</td>
<td>23.5%</td>
</tr>
<tr>
<td>FY2011</td>
<td>43.3%</td>
<td>33.3%</td>
<td>23.4%</td>
</tr>
<tr>
<td>FY2012</td>
<td>42.7%</td>
<td>36.1%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Oct. YTD FY2013</td>
<td>43.2%</td>
<td>35.9%</td>
<td>20.9%</td>
</tr>
</tbody>
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ALOS (FY2010 – Oct. YTD FY2013)

Trinity Sepsis Inpatient Average Length of Stay Overview
Source: DSS

A Focus on Sepsis
From July CY2008 To June CY2012

Sepsis inpatient Volume, Expired Count and Mortality Rate
(Source: DSS; Time Frame: July CY2008- June CY2012)
Medication Reconciliation Information Services Support

- Medication Reconciliation Dashboard
- Improved Medication Reconciliation conversion rates.
- Improvement of the Cerner Tokens that produce our Patient Discharge Instructions and Clinical Summaries.
- Electronically captured a scanned home medication list and stored in PowerChart.
- Implemented rule that notifies physician that the medication history is done, and the admission medication reconciliation can be performed.
- Assisted in creating the finished products for the Med Rec job aids, tips tables and process flows.
- Organized and facilitated the refresh training for Medication Reconciliation
- Facilitating the development of the Medication Reconciliation mPages.
Medication Reconciliation

Trinity Health

- Exceptional Performance: 90%
- Target: 89% - 85%
- Above Median: 84% - 75%
- Median: <75%

Med History Completed
Admission Med Rec Completed
Discharge Med Rec Completed
Composite Med Rec Completed

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Falls Reduction Information Services Support

• Enhanced documentation of patient fall risk characteristics
• Creates 'real time' assessment and pulls forward medication list, clinical assessment, diagnoses, and the Morse fall risk assessment to place patients into specific segments of risk
• Created targeted evidenced based interventions to prevent falls
• They also created unit level reports for monitoring proactively for the managers/falls champions.
• Created the IView presentation of the risk category
• Updates the Interdisciplinary Plans of Care for targeted fall reduction interventions.
Palliative Care Information Services Support

• Revise and standardize Palliative Care Electronic Health Record according to national palliative care quality standards
  • Patient Identification
  • Documentation
  • Assessment

• Standardized Reportable Measurement Domains: Operational, Clinical, Customer, and Financial, according to national palliative care quality standards

• Data Collection
• Data Reporting
Joint Replacement and Spinal Surgery Collaborative

Data and Analytics

- Agreement on Complications of Care measures
- Agreement on process of care measures
- Agreement on financial metrics

System-wide distribution of performance reports

- Merged clinical, finance and supply chain data
- Unblinded at the MO level
- Blinded at the physician level yet can be unblinded by MO leaders
Top 10 Safety Accomplishments for Trinity Health

- 406 lives have been saved due to Sepsis collaborative work in FY12 and there was a savings of $16.6 million compared the baseline year of FY2010

- The redefined policy on Vaginal Birth After Cesarean Section (VBAC) has resulted in no new serious reportable events (SREs) since April 2009.

- Elective deliveries before 39 weeks = 0.1%; decreased from 4.7% in April 2010

- The Medication Reconciliation composite score (both admission and discharge data) has improved to 81 percent and discharge alone has risen to 93 percent. (Oct. 2012)

- Saw a 5% reduction in actual Adverse Drug Events (FY2012)

- The Pressure Ulcer rates have declined from 3.8 percent in FY2008 to 0.8 percent in FY2011.

- Ventilator Associated Pneumonia performance has improved from 2.25 in Jan 2007 to 0.60 per 1000 ventilator days in July 2012.

- The risk of Central Line Blood Stream Infections has improved from 1 per 1000 central line days in Jan 2007 to 0.75 per 1000 central line days in July 2012

- The FY2012 Severity Adjusted Mortality rate was 63 percent of the expected rate.

- The five rights medication barcode administration (Right Patient; Right Drug; Right Dose; Right Route; Right Time) has led to a 39 percent reduction in medication errors (Comparison of FY2011 v. FY2012).