

Interprofessional Leadership and Practice at Penn Medicine

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ABOUT PENN MEDICINE

The University of Pennsylvania Health System was created in 1993 and consists of four hospitals (Hospital of the University of Pennsylvania, Presbyterian Medical Center, Pennsylvania Hospital, The Chester County Hospital), a faculty practice plan, a primary care provider network, two multi-specialty satellite facilities, home care, hospice and a nursing home.

Licensed Beds	2,000
Total Employees	19,000
Physicians	1,900*
Total Admissions	94,000
Operating Revenue	\$4 Billion
Outpatient Visits	2.8 Million
Square Feet	5.5 Million
Research Awards	\$600 Million

Total Figures as of FY14

**Includes physicians with privileges at more than one hospital
+ Includes CCA/CHCA*

UPHS Hospitals

Hospital of the University of Pennsylvania



Beds: 821
Admissions: 40,302
Inpat Surgeries: 14,871
Outpat Surgeries: 11,259
ER Visits: 63,565

Annually recognized as one of the nation's best hospitals by U.S. News & World Report in its Honor Roll of best hospitals.

Pennsylvania Hospital



Beds: 567
Admissions: 24,099
Inpat Surgeries: 6,533
Outpat Surgeries: 12,850
ER Visits: 34,390

Nation's first hospital (co-founded by Benjamin Franklin in 1751), with many expert clinical programs, including the Women's Cardiovascular Center, orthopaedics, and maternity.

Penn Presbyterian Medical Center



Beds: 331
Admissions: 14,634
Inpat Surgeries: 4,786
Outpat Surgeries: 7,935
ER Visits: 38,048

Consistently recognized for delivering superior patient safety and high-quality care and as a center of excellence for cardiac surgery, cardiac care, orthopaedics, and ophthalmology.

The Chester County Hospital



Beds: 277
Admissions: 14,890
Inpat Surgeries: 3,488
Outpat Surgeries: 4,208
ER Visits: 43,240

Joined Penn Medicine in 2013 and provides cardiovascular services, oncology, radiation oncology and maternal health services to Chester County and the surrounding area.

Interprofessional Collaboration at Penn Medicine

Highlights of interprofessional collaboration that support our ability to speak with a united clinical voice:

- ◆ CMO/CNO Alliance
- ◆ Blueprint for Quality and Patient Safety
- ◆ Unit-Based Clinical Leadership Teams
- ◆ Transitions Steering Group
- ◆ GNE Project (HRSA supported)
- ◆ Nursing Strategic Planning Process
- ◆ EVD Preparedness

But, let's go back to the beginning of our journey...where a crisis created an opportunity.

The CMOs and CNOs have banded together across the continuum of care



CMO/CNO Alliance

The CMO/CNO Alliance spans the care continuum:

- All four **hospitals**
 - Penn's **Homecare and Hospice** services
 - Penn's **rehab** facilities
 - **Physician** practices
-
- Systematic interface of CMO/CNO leadership across the health system
 - Proactive strategic planning and work prioritization

CMO/CNO Alliance Budget Request

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

// We don't want Finance to set the margins for the hospitals without first getting input from the Quality strategy. We want to do that at a system level.

Can we count on you?

//

— UPHS CMO & CNO



We're getting out ahead of the budget cycle and speaking with a united clinical voice

The old way

First step — set margins for each hospital. Hospitals are locked in.

Hospitals (separately) submit budgets.

Negotiation — across hospitals and with Finance — occurs after budgets are submitted.

The new way

Discussion of system-wide quality initiatives before margins are set.

CMOs and CNOs submit a joint budget for system-wide quality initiatives they all agreed on.

Negotiation occurs before budgets are submitted.

We're making our job AND the CFO's job easier.

Developing a System-wide Clinical Strategy

Blueprint for Quality and Patient Safety

Aligning our efforts in support of quality and patient safety:

- In 2006, **24 people** contributed to the Blueprint.
- In 2010 just over **100 people** contributed to the Blueprint refresh.
- This year, over **600 people** provided feedback that informed our Blueprint revision.

We set clinical direction for Quality and Patient Safety

UPHS Blueprint for Quality and Patient Safety

UPHS' overarching quality goal is to reduce mortality and reduce 30-day re-admissions.

Four Imperatives	Priority Actions
Transitions in care	<ul style="list-style-type: none">▪ Transition planning▪ Medication management
Reduce variations in practice	<ul style="list-style-type: none">▪ Reduce hospital-acquired infections▪ Reduce medication errors
Coordination of care	<ul style="list-style-type: none">▪ Interdisciplinary rounding
Accountability	<ul style="list-style-type: none">▪ Unit clinical leadership

- ♦ **Version 1: 2007 – 2010: Building infrastructure**
 - Language: “Reduce in Harm”
 - Create infrastructure
 - Focus: Mortality and Infection Prevention
 - Learning about Transitions
 - Obamacare
 - Hitech – Meaningful Use

In 2010 we revised the Blueprint and focused on an ambitious goal

◆ Penn Medicine ◆ Blueprint for Quality and Patient Safety	
<i>Penn Medicine will eliminate preventable deaths and preventable 30-day readmissions by July 1, 2014</i>	
Imperatives	Priority Actions
Accountability For Perfect Care	<ul style="list-style-type: none"> ◆ “Always” events - strive to provide perfect care ◆ Implement clear lines of accountability that span inpatient and ambulatory environments
Patient And Family Centered Care	<ul style="list-style-type: none"> ◆ Provide consistent and thorough communication regarding plan of care ◆ Increase patient and family involvement in UPHS forums and integrate patient feedback into clinical and service improvement efforts
Transitions In Care/Coordination Of Care	<ul style="list-style-type: none"> ◆ Redesign clinical processes to ensure that patients and their information are safely transitioned from one setting of care to another
Reducing Unnecessary Variations In Care	<ul style="list-style-type: none"> ◆ Eliminate variations in care processes where evidence exists ◆ Balance conformity in practice with needs for personalized care ◆ Improve the value of our health care processes and outcomes
Provider Engagement, Leadership, And Advocacy	<ul style="list-style-type: none"> ◆ Strengthen organizational capacity and capability for continuous improvement ◆ Increase involvement of front line staff in quality, safety and service excellence efforts

◆ Version 2: 2011 – 2014: Getting Results

- From Reduction to Elimination of Harm
- Infrastructure in Place
- Experimentation
- Focus: Mortality and Transitions
- Reform not as important as payor policy
- Value

Connecting Blueprint imperatives through the years

2007

Transitions in Care
Coordination of Care

Reduce Variations in Care

Accountability

2011

Transitions in Care/
Coordination of Care

Reducing Unnecessary Variations in Care

Provider Engagement, Leadership and Advocacy

Accountability for Perfect Care

Patient and Family Centered Care

2014

Continuity

Value

Engagement

ACCOUNTABILITY

PATIENT AND FAMILY CENTERED CARE

DIVERSITY AND INCLUSION

SERVICE EXCELLENCE



Penn Medicine will improve the health of our patients and assure safe care.

 ENGAGEMENT

Involve faculty and staff as partners with patients and families to achieve goals of care.

 CONTINUITY

Deliver seamlessly coordinated care across all settings and service lines.

 VALUE

Provide high quality, efficient care and the best outcomes for all patients.

Implementing the Blueprint for Quality and Patient Safety

Unit-Based Clinical Leadership

Leadership at the frontline:

- Daily troubleshooting--**Readmissions data are available in time to take action on specific cases.**
- Long-term changes to clinical practice--**Tools, standards, education, faster turnaround, tighter feedback loops — based on opportunities we see in the data.**

And we bring clinical strategy to the frontline, through established “local leadership” on each hospital unit

Leadership Trio on Each Hospital Unit



We call these trios “UBCLs,” for “Unit Based Clinical Leadership”

We needed a multi-purpose solution on the units to handle almost any Quality problem.



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

—UPHS CFO

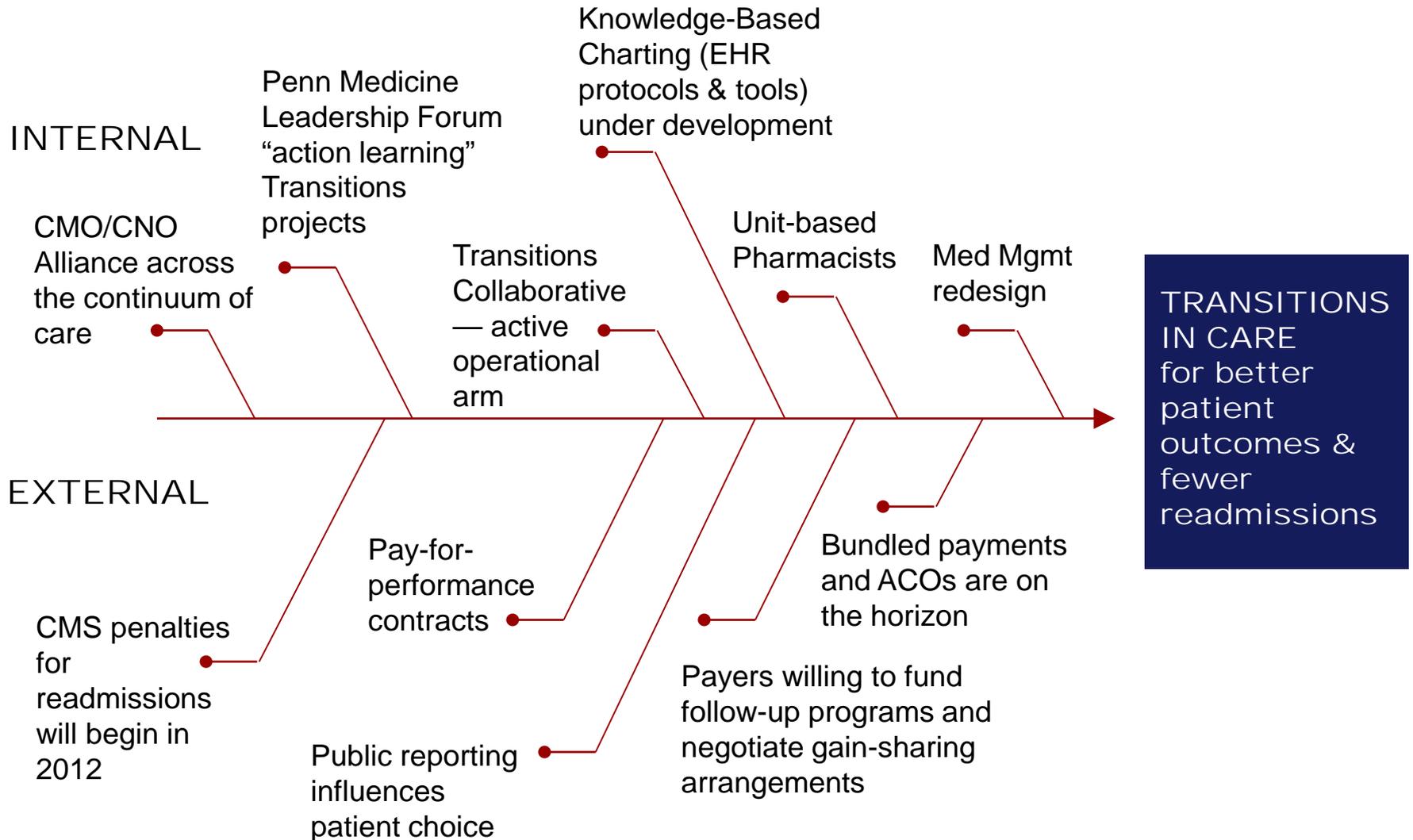
The Transitions Steering Group is in the integration business

Transitions Steering Group

This interdisciplinary group of senior leaders:

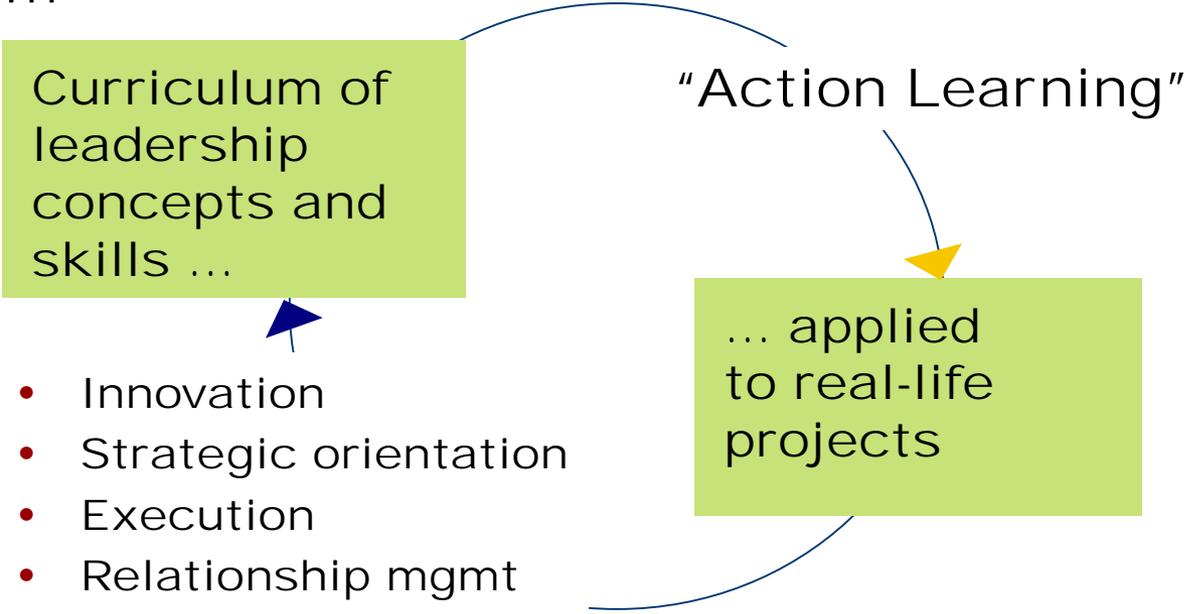
- Sets direction for Transitions-in-Care
- Integrates the moving parts
- Opens doors at the system level
- Troubleshoots to keep things on track

We're working with "other people's energies." Our biggest job is keeping them aligned.



For example — We took advantage of Penn’s flagship leadership development program

Penn Medicine Leadership Forum



This year the Penn Medicine Leadership Forum is targeted to the unit-based leadership teams — along with homecare and other partners

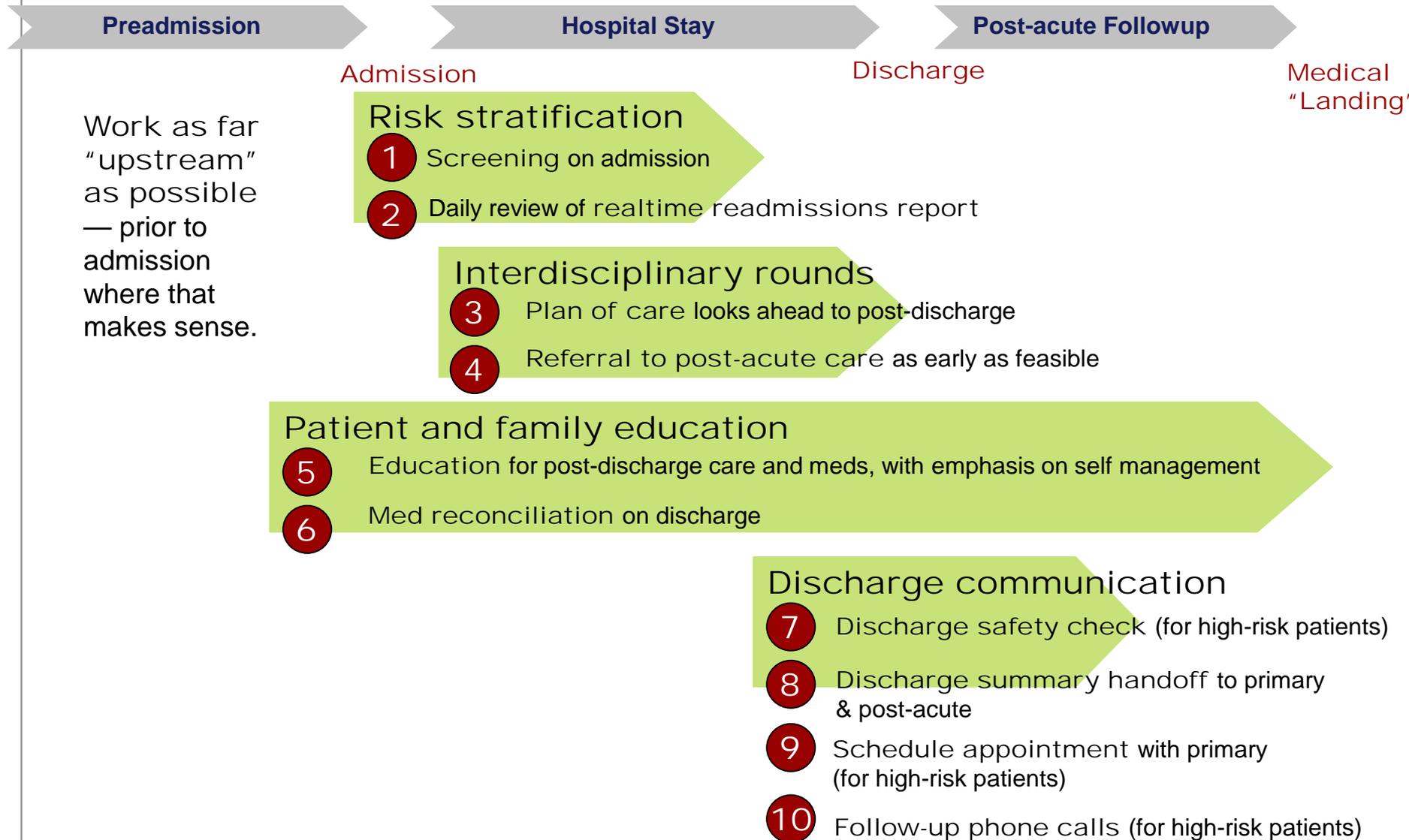
This year the projects are focused on a strategic system-wide initiative — Transitions-in-Care

“Testbeds” — each team tried out a small part of the Transitions Model. All over the place, but look at the energy!

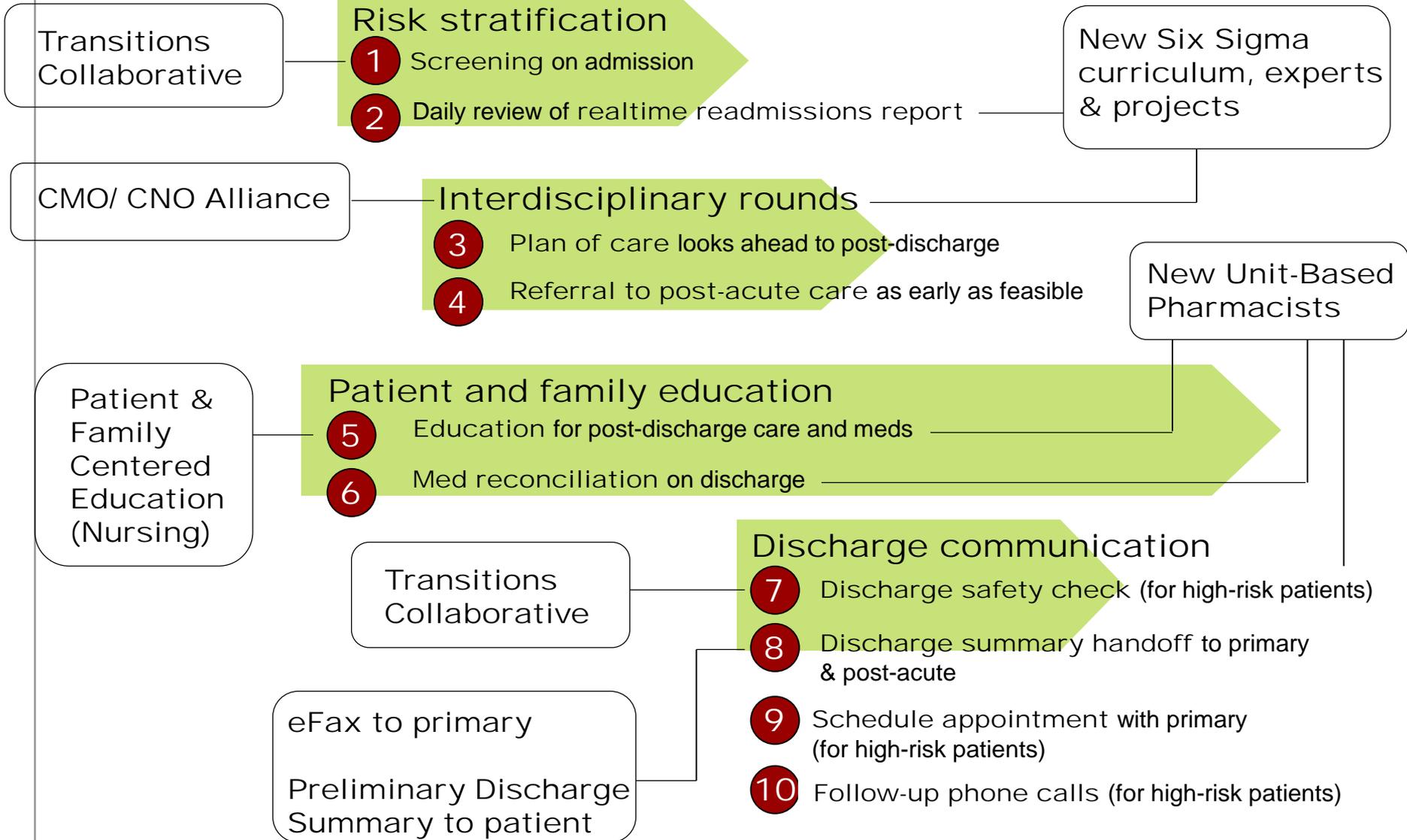
Penn Medicine Leadership Forum — Transitions Projects

Real-time readmissions analysis and intervention	New approaches to interdisciplinary care planning	Post-discharge phone calls	Med management across continuum
End-of-life goals of care	House staff awareness of homecare & hospice services	Discharge safety check	Patient & family education, with emphasis on self management
Screening tool for post-acute referrals	“Opt-out” for homecare referral	Team-based Discharge Planners	Follow-up appointments with primary care
		Improve internal Transitions	Discharge Summary follows patient to post-acute services

To pull it all together, we turned the teams' work into an integrated Transitions Process for the health system



To build out the Transitions Process part-by-part, we're "respectfully hijacking" other people's projects and efforts





Developing Geriatric Resource Nurse-led Interprofessional Collaborative Practice

◆ Project Foundations:

- UBCL teams
- NICHE program

◆ Overall Project Goal:

- Prepare nurse-led interprofessional teams to deliver safe, efficient, and effective gero-focused care

◆ Project Aims:

- Establish a process for efficient and effective nurse-led geriatric IPCP
- Improve clinical and organizational outcomes



Team Members' Perspectives

- ◆ *“By directly participating in morning rounds, all members of the team are able to understand the GRN’s concerns, and a specific treatment plan or intervention is recommended after discussion with the patient and family. The presence of the GRN on the unit has also indirectly increased our awareness of frailty and cognitive issues in all of our geriatric and non-geriatric population.”* V. Ahya, MD, Pulmonary Section Chief
- ◆ *“This collaboration has allowed for better patient outcomes because we are better able to obtain the entire patient picture versus bits and pieces .”* K. Fleming, PT, DPT
- ◆ *“We collaborate on multiple medication-related issues, for example, is a particular drug safe/effective for a particular geriatric patient, how can we ensure compliance with a particular with regard to scheduling, medication reminders, etc.?”* R. Hickey, RPh

Strategic Imperatives Overview

- ◆ Qualitative descriptive IRB-approved study
- ◆ Data collected via 42 focus groups with 197 nurses:
 - Clinical nurses from all HUP units
 - Clinical nurses from select outpatient areas
 - All nursing leadership groups
- ◆ Data analysis method: Thematic Analysis
- ◆ Emergent themes defined strategic imperatives

Phase II: Theme Teams

- ◆ Theme Teams will elucidate **how** to achieve each imperative
- ◆ Interprofessional
- ◆ Purpose of Theme Teams session:
 - Translate imperatives into ***“specific, well-defined, on the ground actions and behaviors”***
 - Unpack how work is currently done, how it could be improved, where best practices may already exist

Preparing for a potential patient with Ebola Virus Disease has been a team effort

EVD Prep

Rapid system-wide integration has pulled together:

- Nursing and physician **care teams** to prepare in new space under difficult circumstances.
- Laboratory, Pathology, Environmental Services, Nutrition, Transportation and others have **aligned to prepare for seamless care.**
- **Education** of nurses and physicians to don and doff Personal Protective Equipment.

Ebola Virus Disease Readiness

- ◆ Since October 18, 2014, 90+ UPHS employees gathered to have Ebola Virus Diseases (EVD) Planning Meetings to assess UPHS' readiness to accept and care for EVD patients.
- ◆ In addition to other agenda items, breakout groups assessed readiness of three critical areas: Recognize and Triage, Isolate and Notify and Transport and Return to Normal Operations.
- ◆ The breakout groups identified additional opportunity to be assessed. These opportunities were categorized by People, Process and Technology:
 - People – Opportunities associated to employee, patient and family needs
 - Process – Opportunities associated to processes that require additional analysis
 - Technology – Opportunities associated to technology and equipment usage
- ◆ Timely interventions to manage identified opportunities are critical to ensure a safe and effective process for proper care of an EVD patient. These opportunities should be addressed immediately to ensure our overall readiness.

“Changing the way we work” — lessons learned



Collaboration didn't happen overnight. One day at a time, we earned new reputations for what each other could bring.

We focused on the work — which led to new ways of thinking about each other.

It's not just about “educating” each other. The best way to collaborate was to work together on common problems — and bring our clinical expertise to bear.

It's easier to “act your way to new thinking” than to think your way to new actions.

