



## PRESIDENTIAL SELECT TASK TEAM FINAL RECOMMENDATIONS



<b>TEAM:</b>	<b>Clinical Enterprise</b>
<b>CHAIR:</b>	<b>John McCabe, MD</b>
<b>EC SPONSOR:</b>	<b>Phillip Schaengold</b>
<b>RECOMMENDATION #1:</b>	
<b>Culture</b>	
Embed a “Patient First” philosophy throughout the organization, including accountability and evidence of performance at all levels of the clinical system.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate – 3 years	
<p><b>BOLD = Highest priority strategies</b>  <i>ITAICS = Identified quick win/high reward strategies</i></p> <p><b>STRATEGIES:</b></p> <ul style="list-style-type: none"> <li>A. <b>Integrate Patient First philosophy throughout the employment experience for all. (pre-employment, interview, hiring, annual evaluation)</b></li> <li>B. <b>Adopt a “Patient First” process throughout the patient experience from registration to after provision of care (including, but not limited to items such as: customer focused trained staff, standard practices, registration Kiosk) that provides assistance with directions, parking, insurance questions, what to bring to appointment, reminder calls, management of billing issues and concerns, etc.</b></li> <li>C. <i>Revise current clinical Web content to provide greater patient friendly information resource.</i></li> <li>D. <i>Brand “Patient First” as an institutional logo(i.e. - tee shirts, screen savers, coffee mugs etc.).</i></li> <li>E. <i>Disperse patient experience team surveyors throughout the clinical system to assess patient experience in real time.</i></li> <li>F. <i>Track and publicize patient compliments.</i></li> <li>G. <b>Add adherence to customer service standards to annual performance reviews for all personnel (including Physician Medical Staff) with responsibility in clinical system.</b></li> <li>H. <b>Provide “Patient First” training refresher to all employees 3 months after initial</b></li> </ul>	

training.

- I. Provide incentives for the development and support of clinical care teams to enhance the “Patient First” philosophy.
- J. Empower all clinical staff to make decisions at the point of patient contact to help patients, and their families.
- K. Enhance system to solicit real time patient feedback on care provided that is disseminated in a timely fashion to physicians, nurses and other support areas, and leadership as appropriate.
- L. Implement system for the Timely recognition for those who support the “Patient First” philosophy (consider mechanisms for instant feedback).
- M. Implement process for Service recovery program that addresses clinical and administrative gaps in “Patient First” service delivery and quality medical care.

**EXPECTED BENEFITS:**

Improve everybody’s satisfaction  
Improve patient care  
Definable improvements in patient outcomes  
Recruitment and retention of staff

**MEASURABLE OUTCOMES:**

Patient and staff satisfaction  
Patient care outcome measure improvement  
Staff turnover rates

**RESOURCES NECESSARY (e.g. FTE, funding, space):**

Training materials  
Training staff  
(see budget recommendations)

**EXISTING POLICY IMPACT (if applicable):**



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**RECOMMENDATION #2:**

**Access**

Create environment with guaranteed, simple, timely access by patients and providers (internal/external) to programs and services we provide in a manner that recognizes the importance of Patient and Family Centered Care (PFCC).

**TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:** Immediate to 3 year

**BOLD = Highest priority strategies**

*ITAICS = Identified quick win/high reward strategies*

**STRATEGIES:**

- A. Institutionalize a one call philosophy – patients and providers have single place to call to get information that they need.**
- B. Throughout the Clinical System, ensure that a single phone call can result in an appointment, with no prequalification of patients to be seen within our system.**
- C. Recruit and retain appropriate numbers of motivated clinical faculty, to meet consumer and provider demand for services, and provide performance expectations that will facilitate Access goals.**
- D. Implement Institution-wide service standards for automated phone management, including Access to medical services and, management of referrals and consultations.*
- E. Survey referring providers to determine what they see as obstacles in getting their patients’ access to care and getting information back regarding their patients’ care.*
- F. Train and equip people receiving patient and provider calls to understand and have information about the programs we provide, and have ready access to provider schedules.*
- G. Expand MD Direct to allow it to function as first point of contact for patients requesting new access for services.*

- H. Develop Workforce projections for Non-Physician Staff to ensure access.
- I. Implement system to ensure that internal referral can be made at time of patient discharge from University Hospital.
- J. Ensure ease of access to clinical system services for referring community providers.
- K. Implement system to assist patients and providers to find access to services we don't offer.
- L. Practice Plans, Clinics, MD Direct in cooperation with Human Resources will review current staff mix and develop plans to ensure proper staff and skill mix to ensure that all services can meet access goals defined.
- M. Develop visible program to promote and recognize the value of the person who is first point of contact to the patient.
- N. Implement process to identify and assist patients in need of financial assistance.
- O. Enable systems that incorporate multiple technologies for easy access to clinical services by patients and providers (i.e. Web Based, phone, email, etc.)

**EXPECTED BENEFITS:**

Increased referrals  
 Increased patient, physician, and staff satisfaction  
 Improved physician productivity and reimbursement

**MEASURABLE OUTCOMES:**

Patient, staff, referring physician satisfaction  
 Time from call to appointment  
 Percentage of first call resolution  
 Number of providers referring into the system  
 Physician productivity  
 Measure of queue time per call/average speed of answer  
 Turnover rates within MD Direct or other front line staff  
 Exam Room Efficiency

**RESOURCES NECESSARY (e.g. FTE, funding, space):**

(see budget recommendations)

**EXISTING POLICY IMPACT (if applicable):**

UMAS practice standards  
 Job descriptions and/or alternate employment mechanism for front line staffing



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<b>RECOMMENDATION #3:</b>	
<b>Information Management &amp; Technology</b>	
Implement clinical information systems that support, enhance and promote the flow of information to provide efficient, high quality and safe patient care throughout the clinical enterprise, and provides an infrastructure that enables the deployment of future clinical applications and emerging technologies.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate to 5 years	
<b>BOLD = Highest priority strategies</b> <i>ITAICS = Identified quick win/high reward strategies</i>	
<b>STRATEGIES:</b>	
<ul style="list-style-type: none"> <li><b>A. Implement an information system planning process with strong clinical representation that prioritizes the need for new clinical applications and authorizes major changes to existing systems.</b></li> <li><b>B. Incorporate planning for capitalization and recurring investment in technology, including FTE's, into all clinical system budgeting process.</b></li> <li><b>C. Establish organization-wide 3-5 year IT strategic plan.</b></li> <li><i>D. Establish medical record documentation standards for all MSG practices and implement them through an EMR system, to ensure uniformity, transparency of medical information between practices.</i></li> <li><i>E. Implement a single sign-on portal page solution.</i></li> <li><i>F. Implement Medication Management software to supplement CPOE to maximize patient safety and quality of care.</i></li> <li>G. Identify and support emerging technologies that will support clinical system growth and change (i.e., Wireless/web capability, Radio Frequency ID, Telemedicine, etc.).</li> <li>H. Monitor and develop recommendations to replace current clinical systems (replacement of CAIS).</li> <li>I. Expand medical information sharing with key referring practices/care locations (i.e., MD groups, hospitals, SCHC, etc.) to improve patient care and build referral</li> </ul>	

base.

- J. Develop a mechanism for identification and timely implementation of quality and safety solutions within IT infrastructure.
- K. Automate the capture of real-time Quality measures (Rules Engine) and provide electronic reporting to regulatory (CMS, SPARCS) and benchmarking organizations (UHC).

**EXPECTED BENEFITS:**

Improved patient safety and quality of care.  
Improved clinical operational efficiency.  
Improved institutional stature.  
Enhanced recruitment and retention clinical staff.  
Improved patient and employee satisfaction.  
Improved patient care and safety.

**MEASURABLE OUTCOMES:**

Improved patient safety outcomes.  
Improved compliance with industry standards, CORE measures.  
Reduced length of stay.  
Reduced number of adverse events.

**RESOURCES NECESSARY (e.g. FTE, funding, space):**

Depending on the size and scope of new healthcare IT initiatives additional FTE's, funding and space will most likely be required (office space, space for computer, hardware, etc.).  
(see budget recommendations)

**EXISTING POLICY IMPACT (if applicable):**



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### **RECOMMENDATION #4:**

#### **Facilities**

Ensure a work environment for clinical staff, patients and visitors that promotes patient safety, quality of care, high patient satisfaction, and high worker satisfaction, efficiency and productivity.

**TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:** Immediate – 1 year

**BOLD = Highest priority strategies**

**ITAICS = Identified quick win/high reward strategies**

#### **STRATEGIES:**

- P.*** Create “Fix It” program to swiftly identify and rapidly correct work environment issues.
- Q.*** Institute Process for routine, scheduled refreshing / updating of clinical space (painting, counter replacement, window washing, screen replacement, furniture replacement).
- R.*** Ensure adequate and appropriate storage for clinical equipment in all clinical facilities to provide timely access for quality care and patient safety.
- S.*** Create and implement standards for office assignment, office proximities, and office design for clinical staff and support personnel.
- T.*** Implement regularly scheduled institutional “clean up” process with involvement of clinical staff.
- U.*** Decrease turnaround time and simplify process for physical plant work orders.
- V.*** Relocate responsibility for ongoing clean environment and equipment maintenance, workplace improvement to all clinical staff, supported by unit/department managers.
- W.*** Ensure use of Patient Family Centered Care (PFCC) established standards for all new construction and renovation of Clinical facility space.
- X.*** Encourage staff input at all levels in workplace design, renovation, and renewal.

<b>EXPECTED BENEFITS:</b>
Improved employee and patient satisfaction Cleanliness of work environment
<b>MEASURABLE OUTCOMES:</b>
Equipment replacement costs Equipment maintenance costs Work order turn around time
<b>RESOURCES NECESSARY (e.g. FTE, funding, space):</b>
(see budget recommendations)
<b>EXISTING POLICY IMPACT (if applicable):</b>



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**RECOMMENDATION #5:**

**Culture**

Establish a performance oriented culture where individuals strive to improve and to maintain operational effectiveness and efficiency throughout the clinical system, and where success is measured against industry standards and objective benchmarks.

**TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:** Immediate – 3 years

**BOLD = Highest priority strategies**

**ITAICS = Identified quick win/high reward strategies**

**STRATEGIES:**

- A. *Ensure orientation and ongoing training for all clinical staff that creates the expectation for excellent customer service, empowerment to problem solve, appropriate job specific training, and a focus on productivity and accountability*
- B. **Implement a Leadership Institute for management personnel, and clinical staff. (to include faculty and residents)**
- C. **Define teams of clinical staff or units within clinical system that should have accountability for specific productivity, quality, and patient safety standards and define consequences for not meeting standards.**
- D. *Expand the role of MD Direct in patient appointment, referral, consultation, and communications coordination throughout the Clinical System.*
- E. *Require that all annual performance reviews incorporate evaluation of adherence to customer service standards.*
- F. Ensure that all staff have identified performance standards that are evaluated through a regular Clinical Quality Improvement (CQI) process.
- G. Identify and share best practices for core services that can be centralized/coordinated (i.e., call center, denial management).
- H. Define standards for the processes of consult and referral throughout the

continuum of patient care, and implement systems to ensure compliance.

- I. Institutionalize focus on efficient hospital discharge management process, that starts when the patient is admitted.
- J. Define a process and mechanism for sharing of productivity and efficiency measures across the clinical system.
- K. Develop and implement a processes for “Service Recovery” that allow identified clinical or logistical problems/errors to be identified and corrected by in real time.
- L. Review/revise “provider based clinic” model.

**EXPECTED BENEFITS:**

Improved clinical efficiency  
Reduced length of stay  
Improved clinical system finances

**MEASURABLE OUTCOMES:**

Length of stay  
Earlier discharge times  
Decrease in payment denials  
Increased admissions and outpatient volume  
Decrease readmissions  
Improved Press Ganey scores  
Employee Satisfaction Scores  
RN Satisfaction

**RESOURCES NECESSARY (e.g. FTE, funding, space):  
(see budget recommendations)**

**EXISTING POLICY IMPACT (if applicable):**



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<b>RECOMMENDATION #6: Governance/Physician Practice</b> Implement physician practice structure/governance to maximize efficiency, consistency of practice, uniform access to patient and practice information.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> 1 year – 5 years	
<p><b>BOLD = Highest priority strategies</b>  <i>ITAICS = Identified quick win/high reward strategies</i></p> <p><b>STRATEGIES:</b></p> <ul style="list-style-type: none"> <li><b>Y.</b> Develop governance model that enhances uniformity across all MSG’s with respect to: quality of care reporting/finance/budget/contracting/clinical responsiveness/ billing/practice management/ information systems/ staffing/institutional resource use credentialing.</li> <li><b>Z.</b> Develop a single management contract between UMAS and UH for physician management services, oversight of clinical programs, on call services, and provision of clinical services.</li> <li><b>AA.</b> Develop information systems that allow clinical information exchange between UH and MSG physician practices.</li> <li><b>BB.</b> <i>Delineate specific academic and clinical functions of each clinical department in the College of Medicine and ensure accountable leadership for each.</i></li> <li><b>CC.</b> <i>Provide Clinical leadership training for chairs and other physician leadership, coincident with hiring and orientation, and on a regular recurring basis.</i></li> <li><b>DD.</b> Develop governance model that encourages shared support staff among MSG’s, and ensures sharing of clinical and practice information.</li> <li><b>EE.</b> Create position for Physician Executive to serve as a physician “leader” over all departmental MSG practices.</li> <li><b>FF.</b> Provide current UMAS services through integration of UMAS functions in new</li> </ul>	

governance model

**GG.** Provide current MedBest services through integration of MedBest activities in new governance model.

**HH.** Review and revise current UMAS practice standards/expectations, develop mechanism to ensure MSG and Department adherence to standards.

**EXPECTED BENEFITS:**

Reduce redundancy in clinical practices

Improve MSG finances

Improved patient care

Improved contracting

**MEASURABLE OUTCOMES:**

MSG Finances

MSG reimbursement rates

Number of MSG employees

Clinical faculty turnover rates

**RESOURCES NECESSARY (e.g. FTE, funding, space):**

(see budget recommendations)

**EXISTING POLICY IMPACT (if applicable):**



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<b>RECOMMENDATION #7:</b>	
<b>Culture</b>	
Establish an environment where quality and patient safety are the primary drivers of healthcare delivery.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate – 2 years	
<b>BOLD = Highest priority strategies</b>	
<i>ITAICS = Identified quick win/high reward strategies</i>	
<b>STRATEGIES:</b>	
<ul style="list-style-type: none"> <li>A. <b>Identify areas for comparison to national and regional quality/safety standards (UHC, Health Grades, CMS, NACHRI, MGMA, JC, etc.), disseminate standards in a public way; develop goals for achievement, designation within the standards, and mechanism and resources to ensure accountability among staff to accomplish goals.</b></li> <li>B. <b>Establish a coherent method for collection and communication (in real time) of quality outcomes with clinical and administrative leadership system wide, with accountability for Quality improvement planning and implementation.</b></li> <li>C. <b>Develop and implement a Quality and Safety Training Program for all staff that identifies institutional quality and safety goals and is provided at the time of hire and periodically throughout every staff member’s employment.</b></li> <li>D. <i>Identify and promote visible Rewards systems linked to quality improvement.</i></li> <li>E. <i>Utilize dedicated “roving quality reviewers” for real time review of patient quality indicators and to institute corrective action before completion of the episode of care for core measures.</i></li> <li>F. <i>Create mechanism for the visible and regular dissemination of quality reporting internally to Physician and clinical staff.</i></li> <li>G. <b>Ensure that all staff understand (at the time of employment and on an ongoing basis) the vital role of patient safety and quality improvement for in their job description.</b></li> </ul>	

- H. Require all physician practices (MSG's) to have a quality and safety plan that is reported on and updated annually.
- I. Create a public awareness campaign emphasizing the quality of our care to patients, employers, insurers, and providers.

**EXPECTED BENEFITS:**

Better patient care  
Fewer adverse events  
Positive press/public relations

**MEASURABLE OUTCOMES:**

Adherence to CMS core measures  
Adverse events  
Malpractice statistics  
Market share

**RESOURCES NECESSARY (e.g. FTE, funding, space):**  
(see budget recommendations)

**EXISTING POLICY IMPACT (if applicable):**



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<b>RECOMMENDATION #8:</b>	
<b>Governance/Physician Practice</b>	
Define and enforce the role of the attending physicians as the primary provider of care in the teaching setting, with the resident physician as a member of the health care team.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate – 1 year	
<b>BOLD = Highest priority strategies</b> <i>ITAICS = Identified quick win/high reward strategies</i>	
<b>STRATEGIES:</b>	
<ul style="list-style-type: none"> <li><i>II. Define expected role for attending physicians in patient care, develop mechanism to assure accountability to such standards.</i></li> <li><b>JJ. Define expected role for resident physicians in patient care, as directed and supervised by faculty, and develop mechanism to assure accountability to such standards</b></li> <li><b>KK. Define and enforce practice standards that ensure the primary role of the faculty physician in the care of all patients, including standards for faculty involvement in communication with patients and family, documentation in the medical record, scheduling /performance/supervision of care and procedures, and participation in the consult process.</b></li> <li><i>LL. Create ongoing Program for residents and attending physicians that communicate the goals of clinical enterprise.</i></li> <li><b>MM. Provide Resident training and ensure broad participation in quality improvement activity and in the evaluation and improvement of systems based care.</b></li> </ul>	
<b>EXPECTED BENEFITS:</b>	
Improved patient care Fewer patient complaints	

Enhanced resident teaching
<b>MEASURABLE OUTCOMES:</b> Attending notes on all charts Reduced MSQI cases due to communications issues Improved OR, ED throughput Reduced LOS
<b>RESOURCES NECESSARY (e.g. FTE, funding, space):</b> (see budget recommendations)
<b>EXISTING POLICY IMPACT (if applicable):</b>



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<b>RECOMMENDATION #9:</b> <b>Clinical Service Menu</b> Develop a system that ensures a uniform process for development, implementation, and ongoing review/continuation of clinical services and programs.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate – 2 years	
<p><b>BOLD = Highest priority strategies</b>  <b>ITAICS = Identified quick win/high reward strategies</b></p> <p><b>STRATEGIES:</b></p> <ul style="list-style-type: none"> <li><b>NN.</b> Institute Process for on-going review of existing clinical services, including review of quality of care, and assessment of need for continued service delivery.</li> <li><b>OO.</b> Include UMAS, UH, and MSG's in a process to review requests for new clinical programs and/or new clinical faculty with consideration of broad clinical system issues and resource impact as part of the decision making process.</li> <li><b>PP.</b> Define clinical system governance structure that can coordinate recruitment needs across clinical system (OR time, equipment, office space, staff, ancillary services, impact to other department faculty).</li> <li><b>QQ.</b> Promulgate definitions for creation of new <u>programs</u>, <u>initiatives</u>, <u>institutes</u>, and develop criteria to be used for review and approval.</li> <li><b>RR.</b> Perform community needs assessment on a regular basis to guide decisions regarding development, implementation, and continuation of clinical programs.</li> <li><b>SS.</b> Institute Mechanism to ensure sound business planning, and secure operational funding with new program development.</li> <li><b>TT.</b> Identify decision making process for evaluation and approval of new programs, with empowerment of single final authority for decisions.</li> <li><b>UU.</b> Encourage joint venturing between MSG groups, University Hospital, and other interested entities in the region.</li> </ul>	

<b>EXPECTED BENEFITS:</b> More successful programs Reduction in waste in clinical system Reduction in redundant programming
<b>MEASURABLE OUTCOMES:</b> Market share Referring doctor satisfaction
<b>RESOURCES NECESSARY (e.g. FTE, funding, space):</b> (see budget recommendations)
<b>EXISTING POLICY IMPACT (if applicable):</b>



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<b>RECOMMENDATION #10:</b>	
<b>Facilities</b>	
Establish long term, realistic, sustainable and renewable facilities plan that supports clinical system growth and recognizes research and education needs.	
<b>TIMEFRAME FOR HIGHEST PRIORITY STRATEGY:</b> Immediate – 5 years	
<p><b>BOLD = Highest priority strategies</b>  <b>ITAICS = Identified quick win/high reward strategies</b></p> <p><b>STRATEGIES:</b></p> <p><b>VV.</b> Review/revise and implement a plan for a clinical ambulatory care teaching facility utilizing reasonable practice standards, to maximize operational efficiency, and meet community medical needs.</p> <p><b>WW.</b> Integrate plans for clinical ambulatory facility with view for entire clinical system ambulatory practice, and regional needs assessment, including implications for off-site and regional program and space development.</p> <p><b>XX.</b> <i>Establish decision making guidelines space utilization that balances priorities of individual stakeholders with institutional long range planning and strategic initiatives.</i></p> <p><b>YY.</b> Recognize in all new construction and renovation the need for non-clinical facility space to support to clinical and academic enterprise (faculty offices, simulation sites, training and development center, support personnel).</p> <p><b>ZZ.</b> Incorporate academic and research space into all clinical facilities planning.</p> <p><b>AAA.</b> Develop governance and decision making processes that can integrate campus/University Hospital /MSG facility planning.</p> <p><b>BBB.</b> Expand UH capacity and/or develop plans to off load and/or develop clinical programs and support services at other sites.</p> <p><b>CCC.</b> Explore joint venture, new financing models for development/expansion of future clinical facilities.</p>	

- DDD.** Ensure that all new clinical facility construction and renewal is guided by accepted, realistic industry benchmarking standards.
- EEE.** Develop long term plan to improve clinical staff access to affordable, available, proximate parking.

**EXPECTED BENEFITS:**

Additional clinical capacity  
Market share growth  
Operational efficiency

**MEASURABLE OUTCOMES:**

Market share  
Patient volumes  
Exam room efficiency

**RESOURCES NECESSARY (e.g. FTE, funding, space):  
(see budget recommendations)**

**EXISTING POLICY IMPACT (if applicable):**