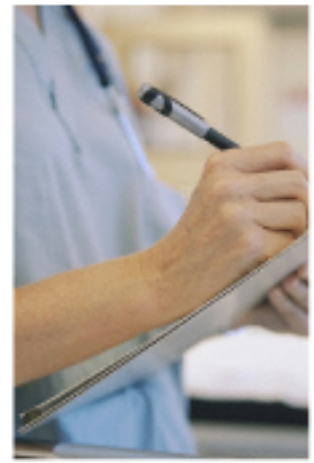
Destination Orthopedic Centers

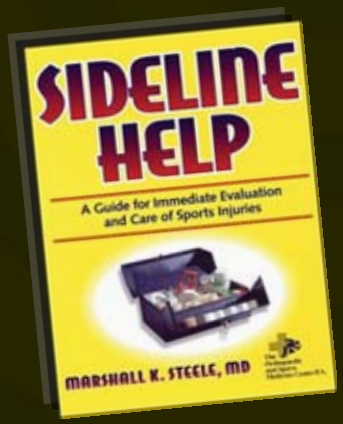
Healthcare Model for the Future

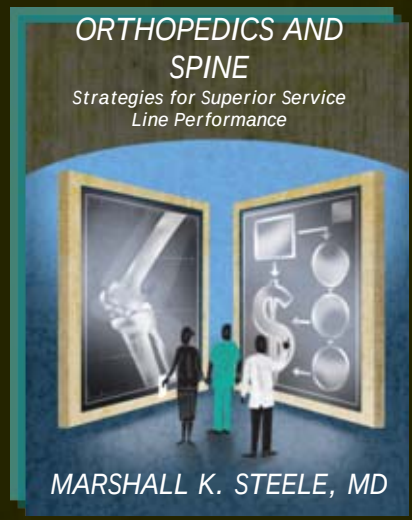
Marshall Steele, MD
CEO, Marshall | Steele



Marshall K. Steele, MD
CEO, Marshall | Steele

- Orthopedic Surgeon
  - Anne Arundel Medical Center, Annapolis, MD 1977-2008
  - Founder Orthopedic Sports Medicine Center 16 Surgeons
- Medical Director
  - Operating Room 1992- 2005
  - Surgical Business Development – 1995- 2005
- Orthopedic Destination Centers
  - Sports Medicine
  - Joint Surgery
  - Spine Care
  - Fracture Care
- Author





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Today's Agenda

- Few Stories – Current Reality vs. What's Possible Today
  - Mrs. Abbott – Total Joint Surgery
  - Mr. Dollar – Service Line Director
  - Mr. Smith – Spine Problem
  - Mrs. Bing – Hip Fracture

Huge Changes Coming Our Way

Orthoprenuer August, 2010

GUEST EDITORIAL

Knowsumerism, Healthcare Reform and Chicken Farming: Five Lessons to Help You Thrive

Author:
Marshall Steele, M.D.

Huge Changes Coming Our Way

OrthoKnow July, 2010

ORTHOKNOW®

STRATEGIC INSIGHTS INTO THE ORTHOPAEDIC INDUSTRY — JULY 2010

INSIDE THIS ISSUE:

EDITORIAL

Industry's New Customer: Hospital + Surgeon

By Marshall Steele, M.D.

I started practicing orthopaedics in 1975, when joint replacement was in its infancy. There is no doubt that, along with arthroscopy, joint replacement has created phenomenal value for patients and our healthcare system. That during the past 35 years, the number of patients having joint replacements and arthroscopy has risen, surgeon reimbursement has dropped quite dramatically, hospital reimbursement has stayed

3. Surgeon power and price insensitivity

Surgeons were independent and autonomous. They ordered the products they wanted to use, but it was the hospital that paid for them. Price wasn't important to the doctors, who saw wasteful hospital practices every day. Many surgeons did not feel that the hospital treated them as customers, so tension between

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The Squeeze on Healthcare Providers

Payment Reform

Hospitals
Physicians
Vendors
Outpatient Providers

Knowsumerism

"The most successful physicians will be those who most effectively collaborate with other providers to improve outcomes, care productivity and patient experience."

- Nancy DeParle
Director White House Healthcare Reform

Mrs. Abbott

Negative Cascade Effect

- Patients Are Not “Wowed “ By Experience
- Word Of Mouth Weak/ Negative
- Out Migration Occurs
- Surgeons And Hospital Lose Surgical Cases
- Surgeons Blame Poor Marketing Efforts, Competition
- Hospital Blames Surgeon Bed Side Manner

Negative Cascade Effect

- Marketing To The Rescue
  - Billboards
  - TV, Radio, Print
- Marketing Ineffective
- Profitability Wanes
- Hospital Believes More Surgeons The Answer
- Surgeons Don’t Want New Competition
- Hospital Physician Relationships Suffer

“It Depends” Medicine

Not an Effective Model for Future

What’s Possible Today?

What Is The Real Problem?

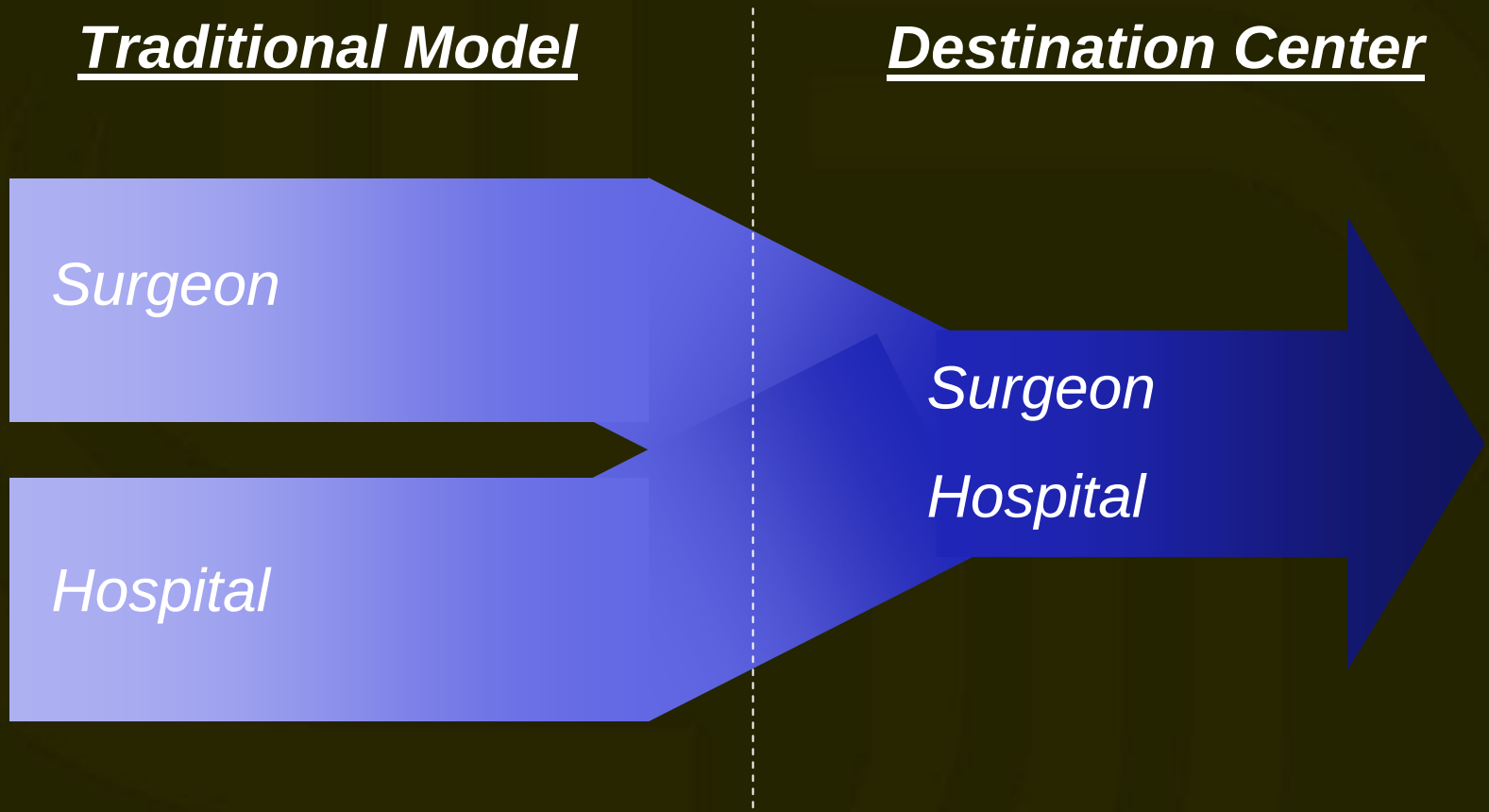
What Can We Do Differently?

Common Thought:

We Need To Replace

Physicians, Staff, Administrators

Engage Our Physicians



Create Superior Performance

Visible

Invisible

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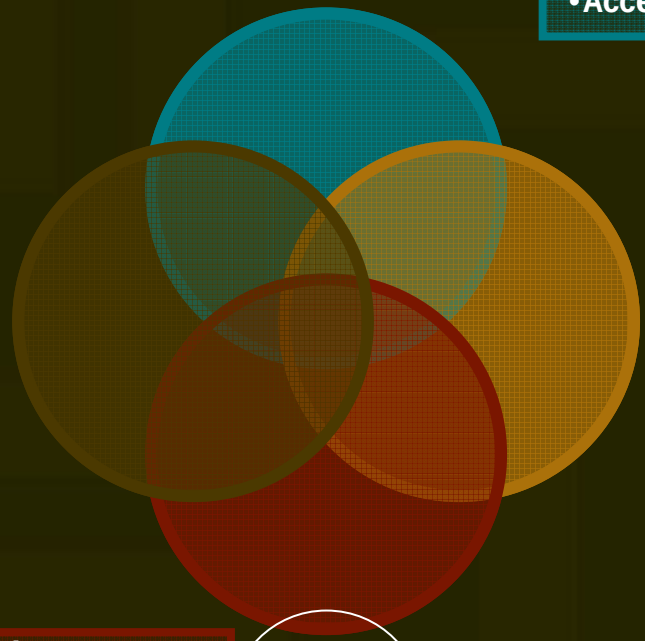
The Invisible Core Elements of Excellence™



- Physician
- Specialized Staff
- Access

- Leadership Team
- Accountability
- Strategy
- Teamwork / Collaboration

- Education/ Teaching/ Learning
- Coordinated Care (PCP, Specialist)
- Pre Intervention Readiness
- Efficiencies (Pre-Op, OR, Unit)
- Cutting Edge Technology
- Dedicated Facilities
- Standardized Care System
- Patient / Family Empowerment
- Ongoing Improvement & Innovation
- Marketing / Public Service

- Satisfaction
- Clinical
- Operational
- Functional Outcomes
- Financial

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Culture Change

- Responsibility – Leaders
- Generalists
- Physicians Complain
- Blame People
- Silos – Hierarchy
- Work-Arounds

- Responsibility – Staff
- Multi-Skilled Specialists
- Physicians Lead
- Solve the Root Cause
- Performance Team
- Shared Solutions

Culture Change

- Defend Status Quo
- Secrecy
- Fairness
- Tension
- Self-Focused
- Better People

- Strive for Perfection
- Transparency
- Excellence
- Collaboration
- Customer Focused
- Better Processes

Develop a Service Line Leadership Team

Medical Director

Administrator

Program Coordinator

- *Job Descriptions*
- *Mutual Goal Setting*
- *Written Expectations*
- *Strategies for Success*

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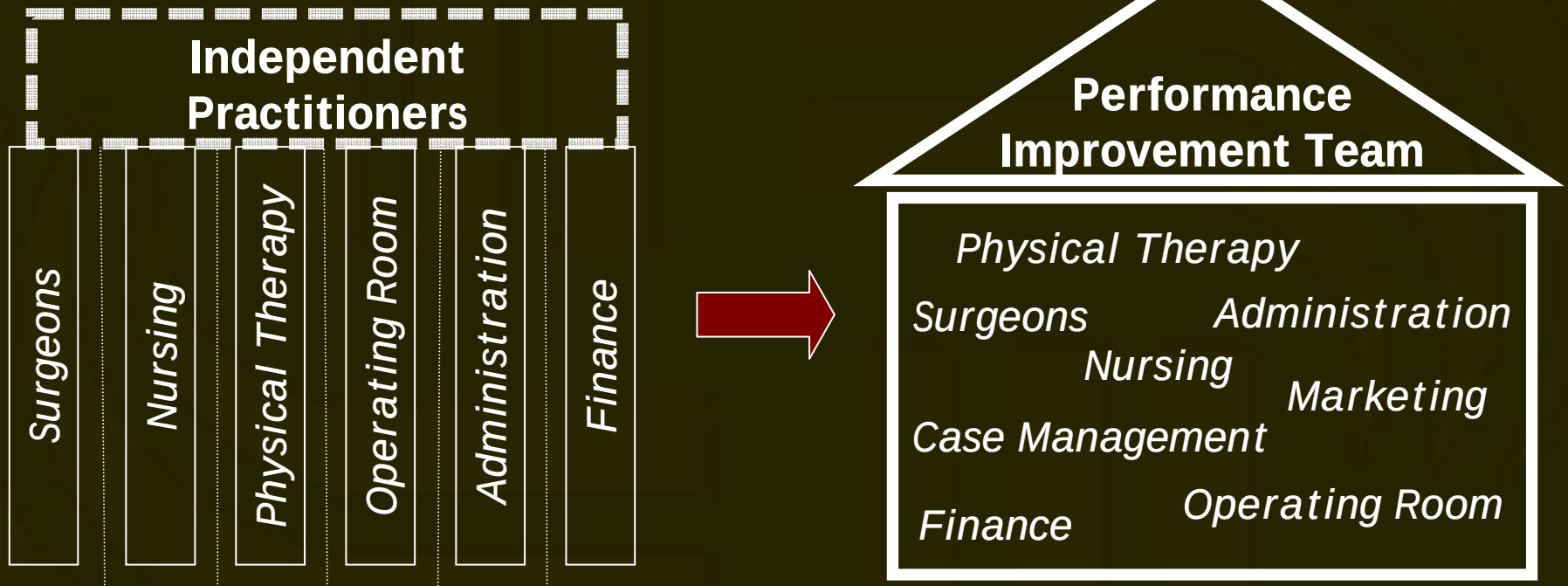
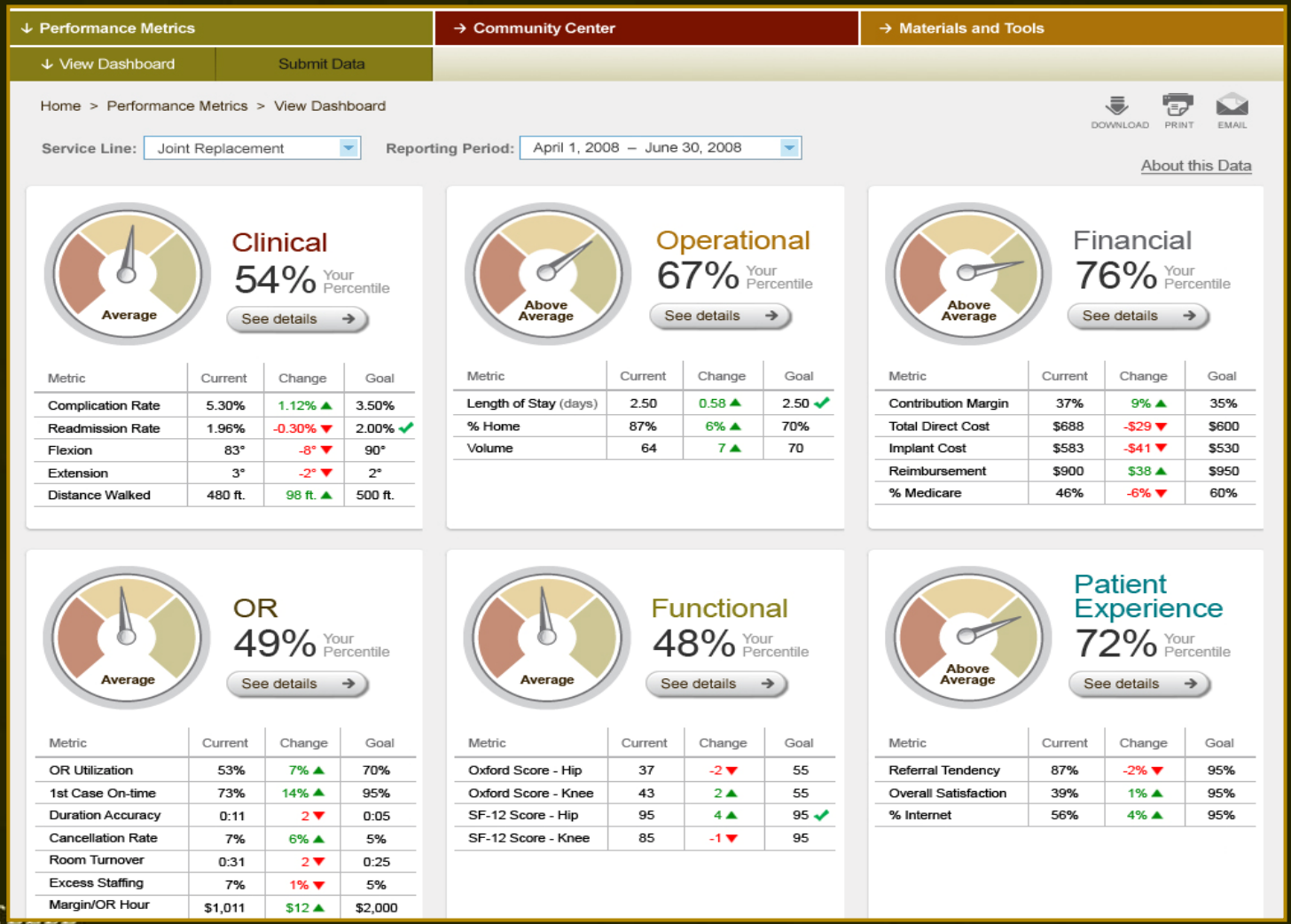
Performance Improvement Team



Use Better Management Tools: Metrics, Trending, Benchmarking



Better Processes: Think Like The Patient
"Think Lean"

Pull – What They Want
Push – What We Give Them

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What's Possible Today

The Patient Experience

Total Joint / Spine Surgery

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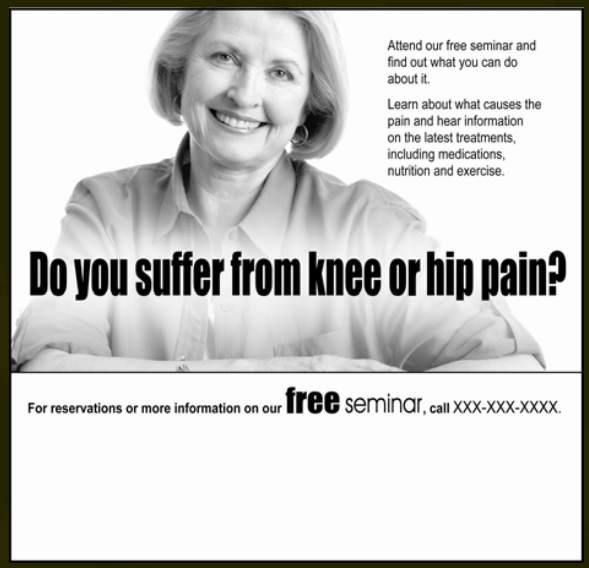
Community Education

Monthly Education by Nurse, PT



Top Ten For Arthritis

Back On Track

Scripted power point presentations with a strong call to action highlighting the "*need for a good diagnosis*"

Primary Care Physicians

Brochure Series – Program Results

- *Top 10 Things to Do for Arthritis”*
- *“Non-Surgical Treatment of the Spine”*

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Specialist Office

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Frequently Asked Questions

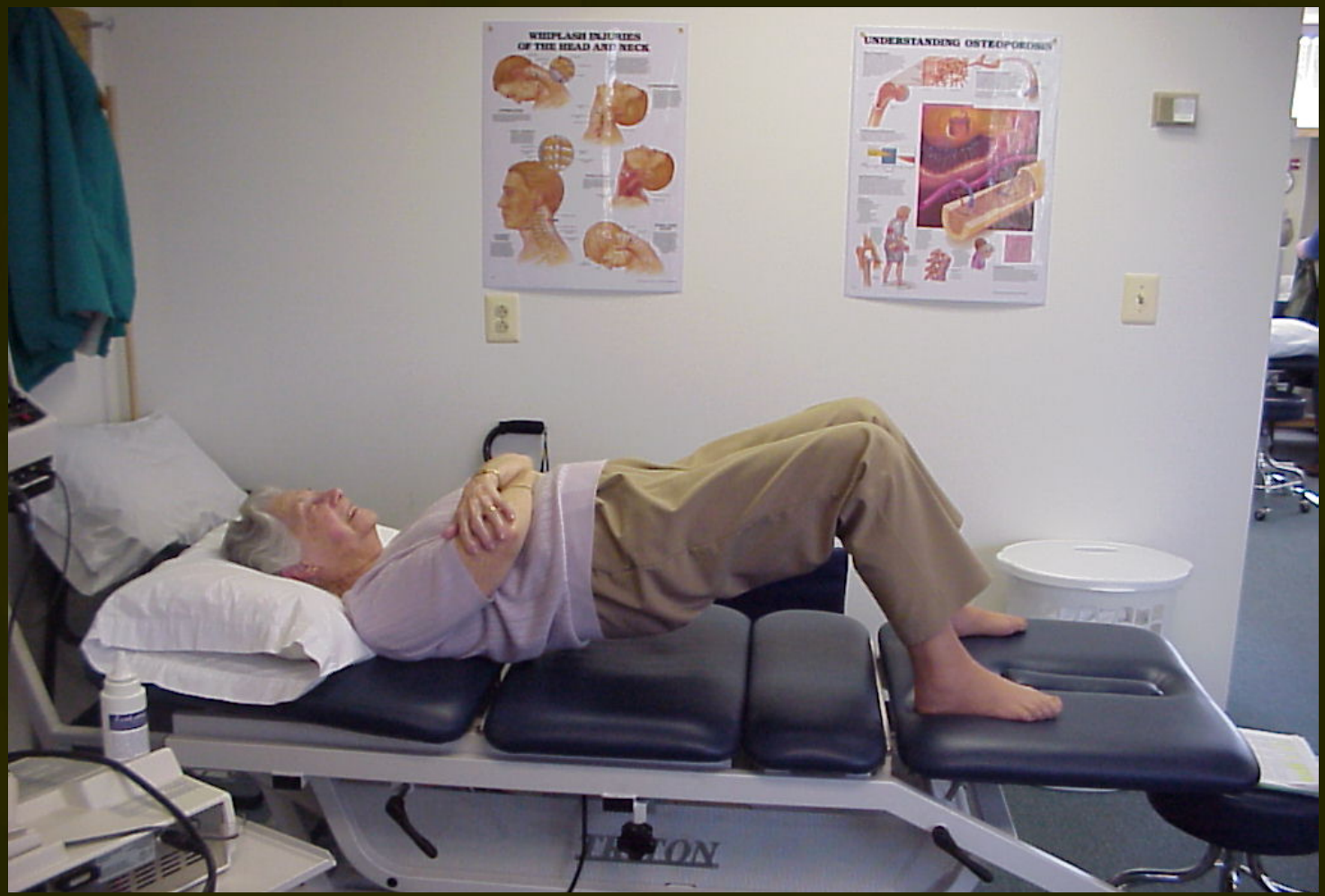
Top Ten For Arthritis

Top Ten For Back Pain

Physician's Office:
"The Passing of the Guidebook"

Pre-Operative Care

Fit for Spine Surgery Program



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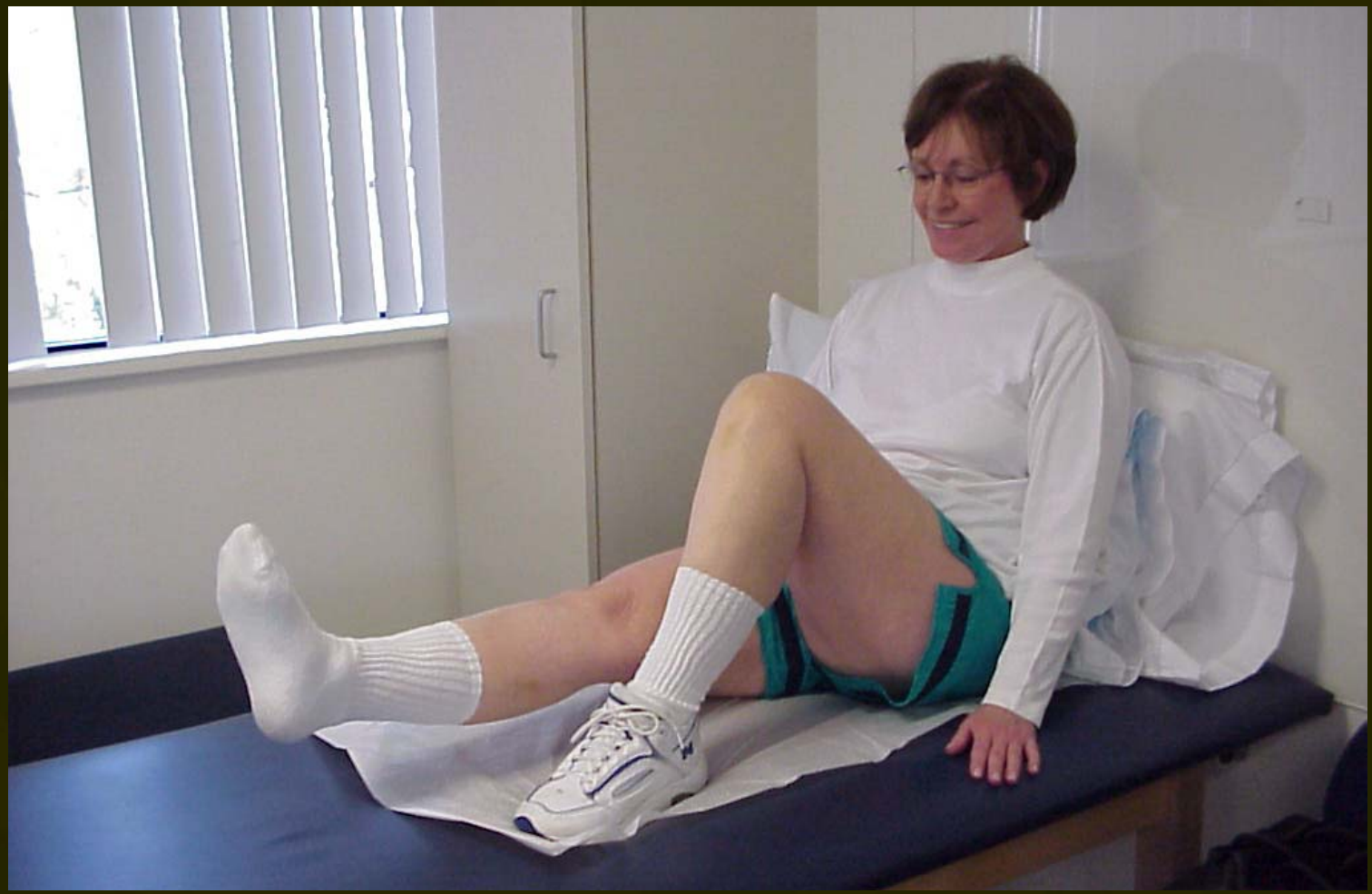
Fit For Joint Surgery Program



Pre-Op Class: Consistent Education

Setting Expectations and Personal Responsibility

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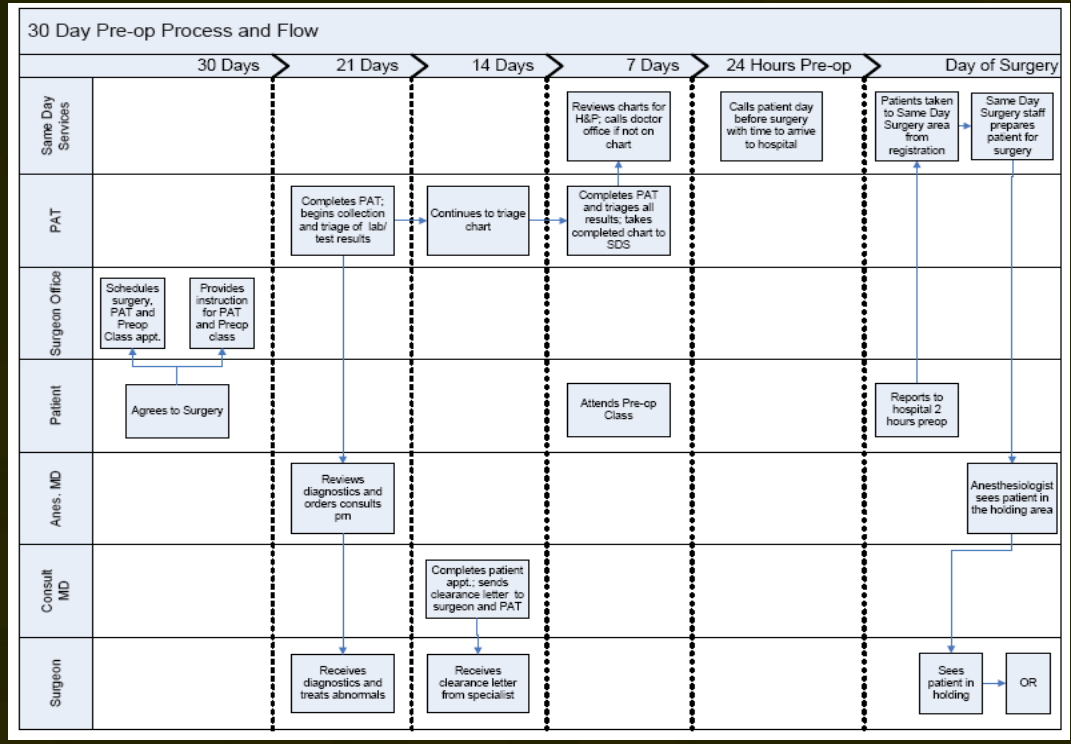
Preadmission Best Practice: Risk Management

- Blood Management Program
  - Lab work 30 days out
  - H &H noted
  - Anemia evaluated/ treated
- Pain / Nausea Management
  - Narcotics screening
  - Preemptive Rx
- Zero Infections Program



Case Conferences

Operating Room

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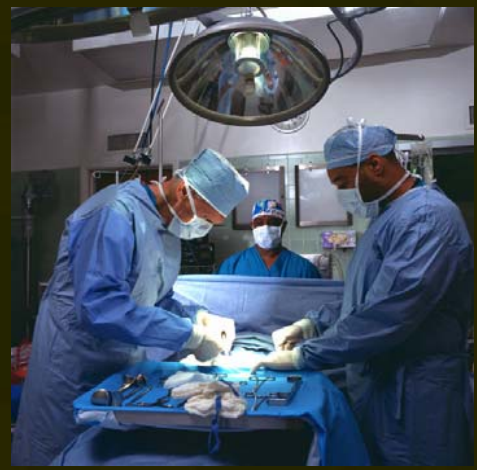
Anesthesia Best Practice: Protocols / Safety

- Dedicated Team
- Instruments Not Missing
- No Flashing Required



Best Practice: Efficiency

- Block Done in Induction Room
- Surgery Starts on Time
- Dedicated Team
- Limited number of Trays/ Instruments
- Turnover Team
- Parallel Processing

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Best Practice: 2 Rooms, 2 Teams

Room 1

- 0730
- 0950
- 1210
- 1430

Down at 1600

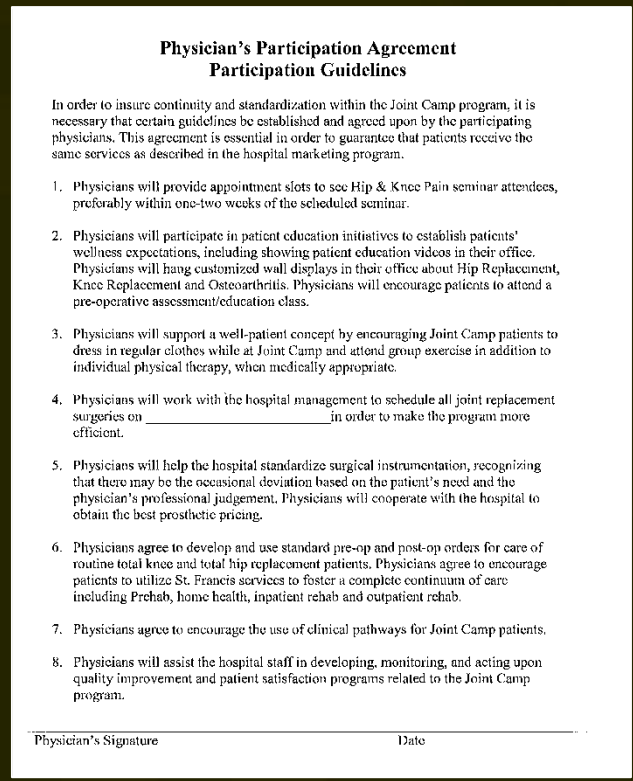
Room 2

- 0840
- 1100
- 1320
- 1540

Down at 1700

Hospital - Physician Contract

- Key Hospital Responsibilities
- Key Surgeon Responsibilities



Physician's Participation Agreement
Participation Guidelines

In order to insure continuity and standardization within the Joint Camp program, it is necessary that certain guidelines be established and agreed upon by the participating physicians. This agreement is essential in order to guarantee that patients receive the same services as described in the hospital marketing program.

1. Physicians will provide appointment slots to see Hip & Knee Pain seminar attendees, preferably within one-two weeks of the scheduled seminar.
2. Physicians will participate in patient education initiatives to establish patients' wellness expectations, including showing patient education videos in their office. Physicians will hang customized wall displays in their office about Hip Replacement, Knee Replacement and Osteoarthritis. Physicians will encourage patients to attend a pre-operative assessment/education class.
3. Physicians will support a well-patient concept by encouraging Joint Camp patients to dress in regular clothes while at Joint Camp and attend group exercise in addition to individual physical therapy, when medically appropriate.
4. Physicians will work with the hospital management to schedule all joint replacement surgeries on _____in order to make the program more efficient.
5. Physicians will help the hospital standardize surgical instrumentation, recognizing that there may be the occasional deviation based on the patient's need and the physician's professional judgement. Physicians will cooperate with the hospital to obtain the best prosthetic pricing.
6. Physicians agree to develop and use standard pre-op and post-op orders for care of routine total knee and total hip replacement patients. Physicians agree to encourage patients to utilize St. Francis services to foster a complete continuum of care including Prehab, home health, inpatient rehab and outpatient rehab.
7. Physicians agree to encourage the use of clinical pathways for Joint Camp patients.
8. Physicians will assist the hospital staff in developing, monitoring, and acting upon quality improvement and patient satisfaction programs related to the Joint Camp program.

Physician's Signature Date

In-patient Hospital Care

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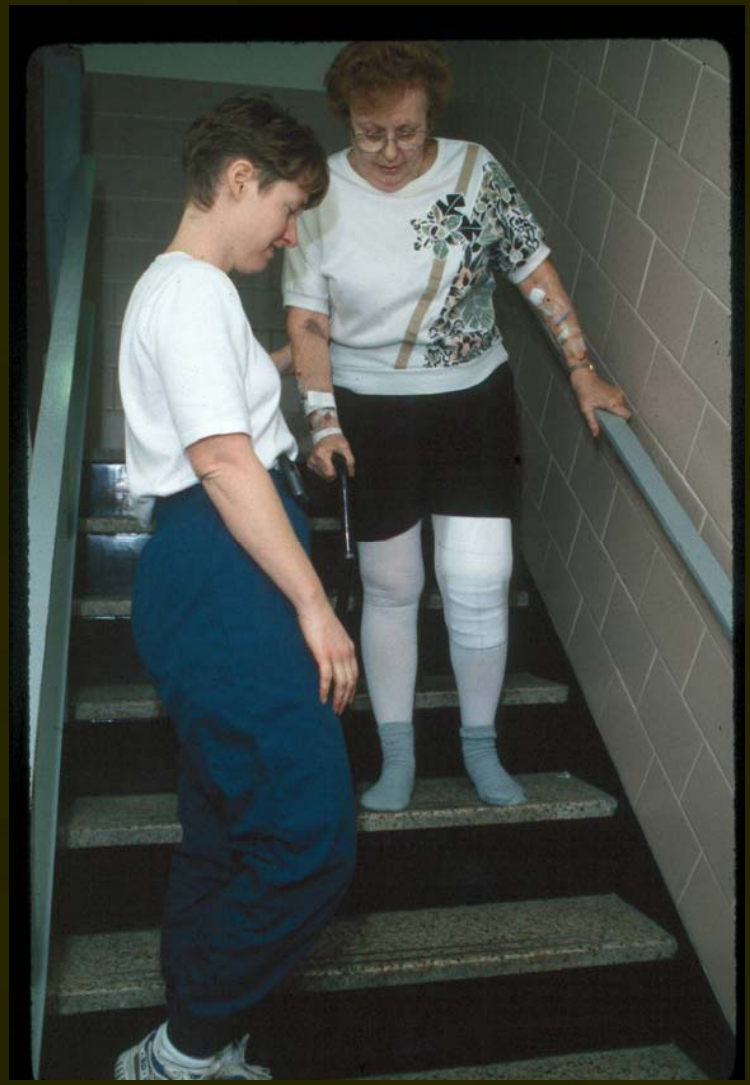
Best Practice: Dedicated Unit

Specialization Breeds Excellence

Best Practice: Dedicated Nursing and PT



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Best Practice:
Standardized Evidenced - Based Care

- Blood Management
- Infection Prevention
- Pain Management
- Nausea / Vomiting
- Anti-Coagulation
- Order Sets
- Nursing Care Plans
- PT / OT Protocols
- Bowel Regimen
- VTE Prevention

Best Practice: Scripted Patient Daily Routine

Joint Center – Example Daily Routine

POD 1

Time		RN	CNA	PT/OT
0400	Vital Signs		X	
0500	Labs – by phlebotomy/lab personnel			
0530 - 0630	DC basal rate on PCA – pain meds (begin oral analgesics) DC Foley Baths, Dressed, OOB, to recliner/strip beds	X X X	 X X	
	Order Breakfast		X	
	Glucoscan; coverage meds as needed	X	X	
0700	Breakfast		X	
0700	Shift Change starts; Shift Change reports; RN – Aides report	X X	X X	
0800	Vital Signs RN Assessments	 X	X	
7-12	Wound Dressing change/ drain pull per protocol	X		
0730-1130	Physical Therapy Evaluations/individual sessions Occupational Therapy Evaluations (as time allows)			X PT X OT
0900	Medications Regular schedule; DC PCA Group PT for patients evaluated on DOS	X		 X PT
0730-1230	Charting, break, lunch, other care plan items	X	X	
1100	Glucoscan; coverage meds; order lunch	X	X	
1130	Lunch		X	
1200	Vital signs		X	
1230	Pain Meds (prior to Group Therapy)	X		
	Toileting prior to group therapy	X	X	
	PT – coordinate w/nursing staff on system to gather the group	X	X	X PT
1300	Gather for group / Walk patient to group	X	X	X PT
1315 - 1415	Group Therapy (~1 hour)			X PT
	Walk back from Group therapy PT – individual treatment as required		X	X PT
1430-1600	OT evaluations per protocol			X OT
	Intake and Outtake time TBD		X	
1600	Vital Signs		X	
1600-1900	Glucoscan; coverage meds as needed	X	X	
	Dinner		X	
1900	Shift Change starts; Shift Change reports	X	X	
1930	RN – Aides report		X	
2000	Vital Signs RN Assessments	 X	X	
2030	Ambulate, before going back to bed for night	X	X	
2100	Scheduled meds; Glucoscan; coverage meds as needed	X	X	
2400	Vital Signs		X	

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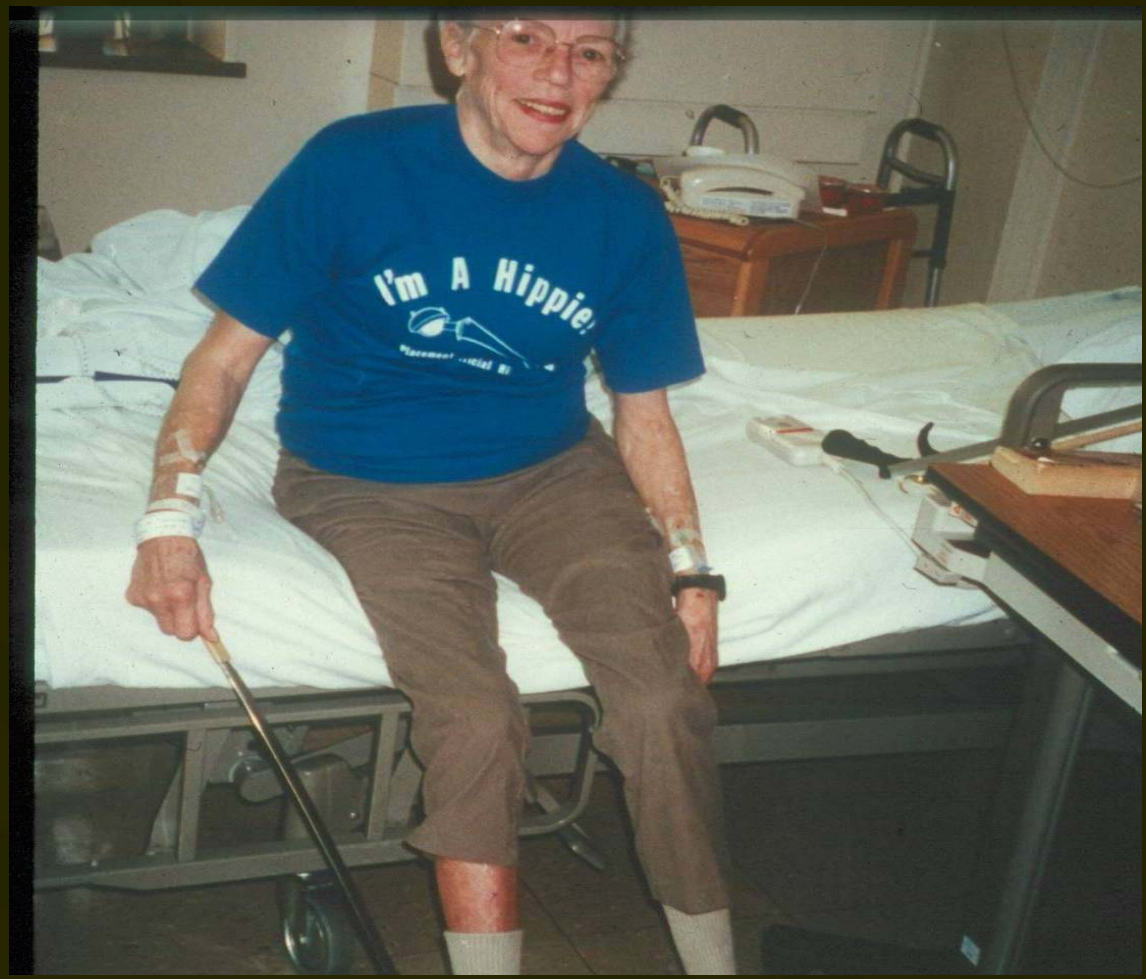
Best Practice: Co-Management
Pain, Nausea, Coumadin

- Hospitalist
- Pharmacy
- Anesthesia

Post-Op Day 1: Out of Bed



Dressed in Own Clothes

Wellness Model – Post-Op Day 1

- Recliner Chair
- Walking Early and Often
- Complete with Lipstick

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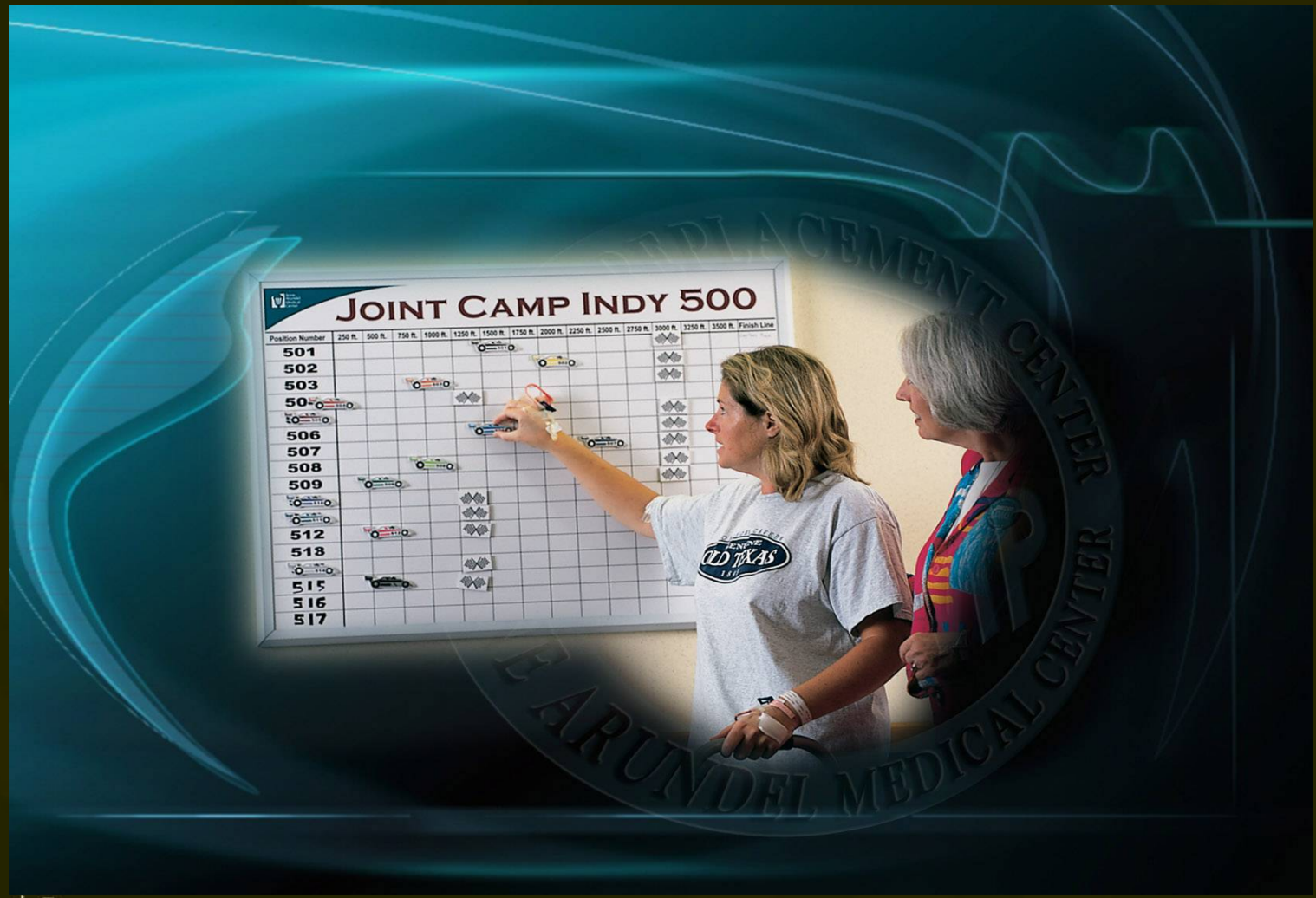
Daily Newsletters

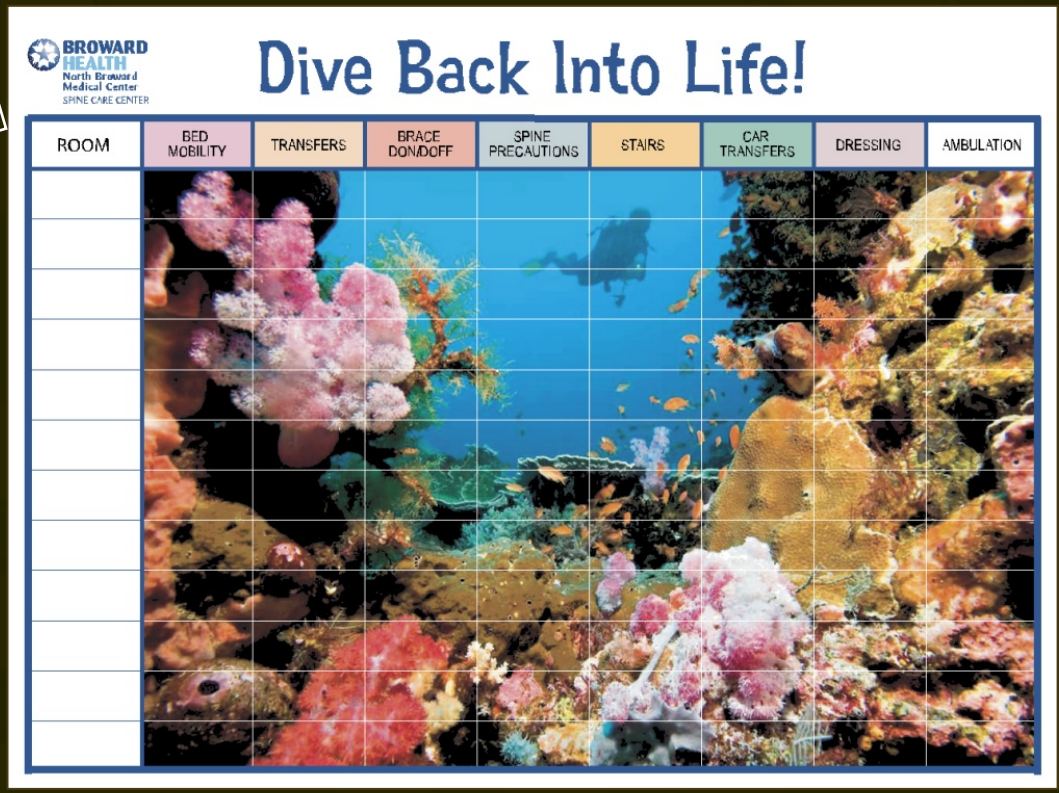
Posters – Frequently Asked Questions

Joint Ambulation Board – Incentivize Walking

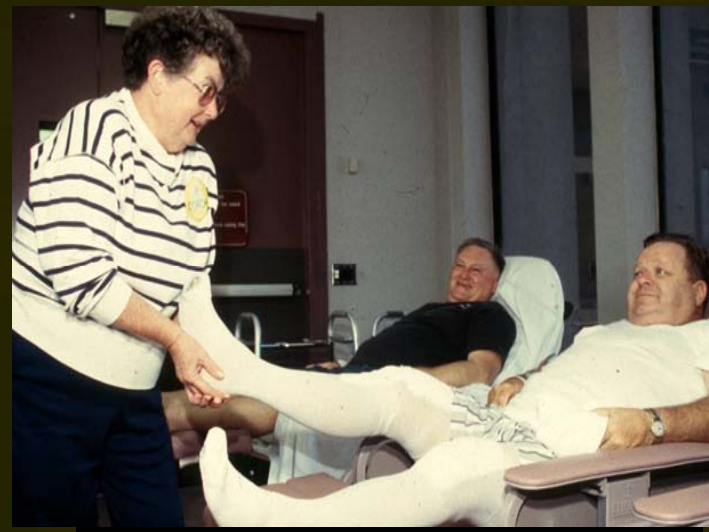


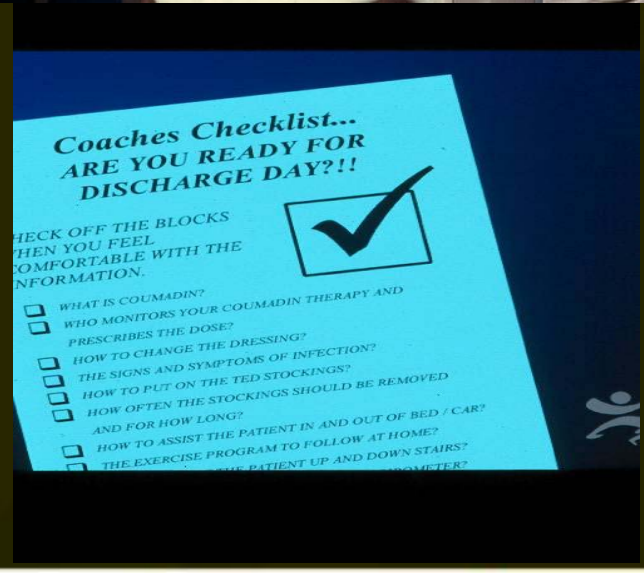
Spine / Self Care Skills

Fun with a Focus!



Formal Training for the Caregivers

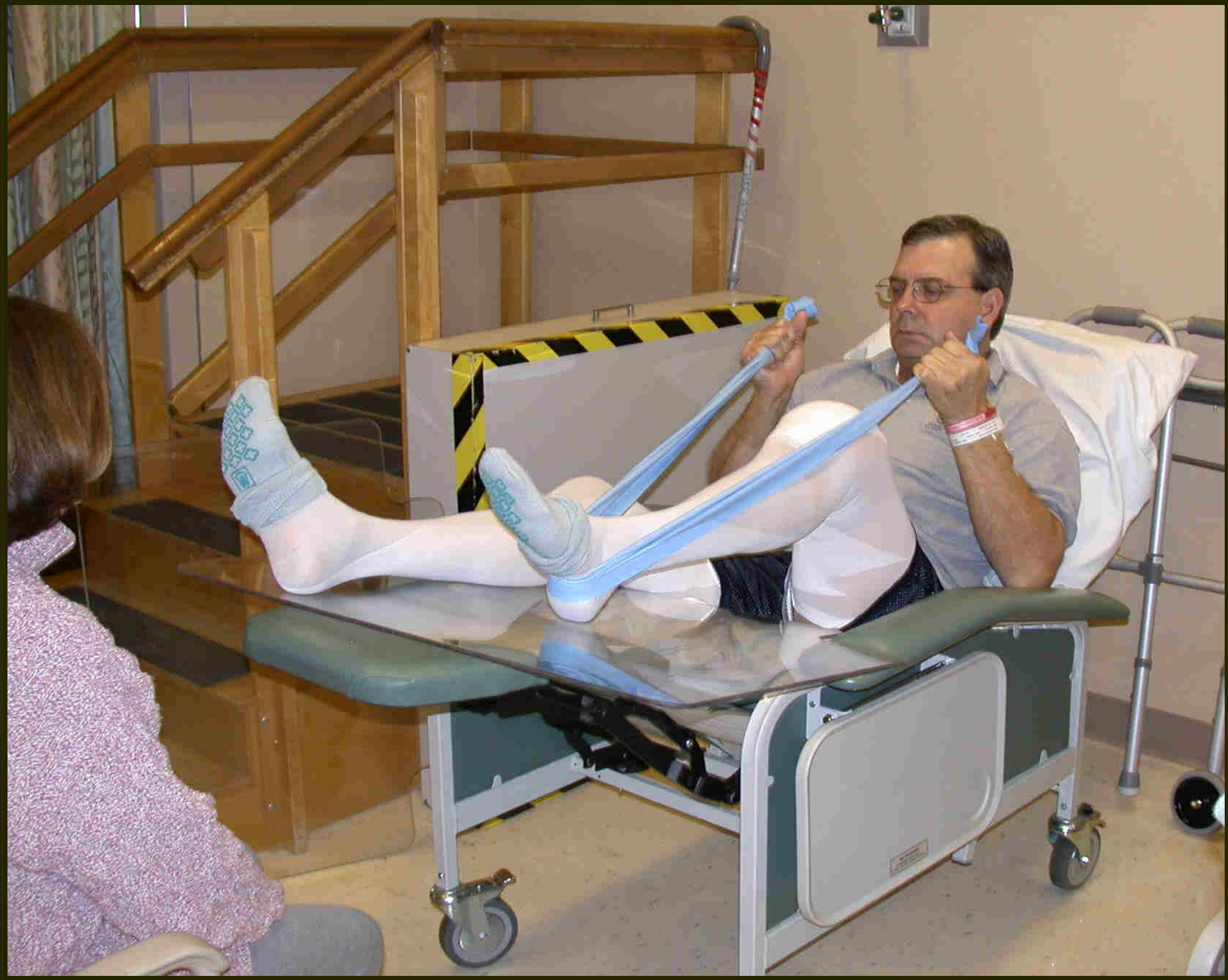




Socialization

Therapy

Lunch



Post-op Day 1

Exercise Boards for Home Use

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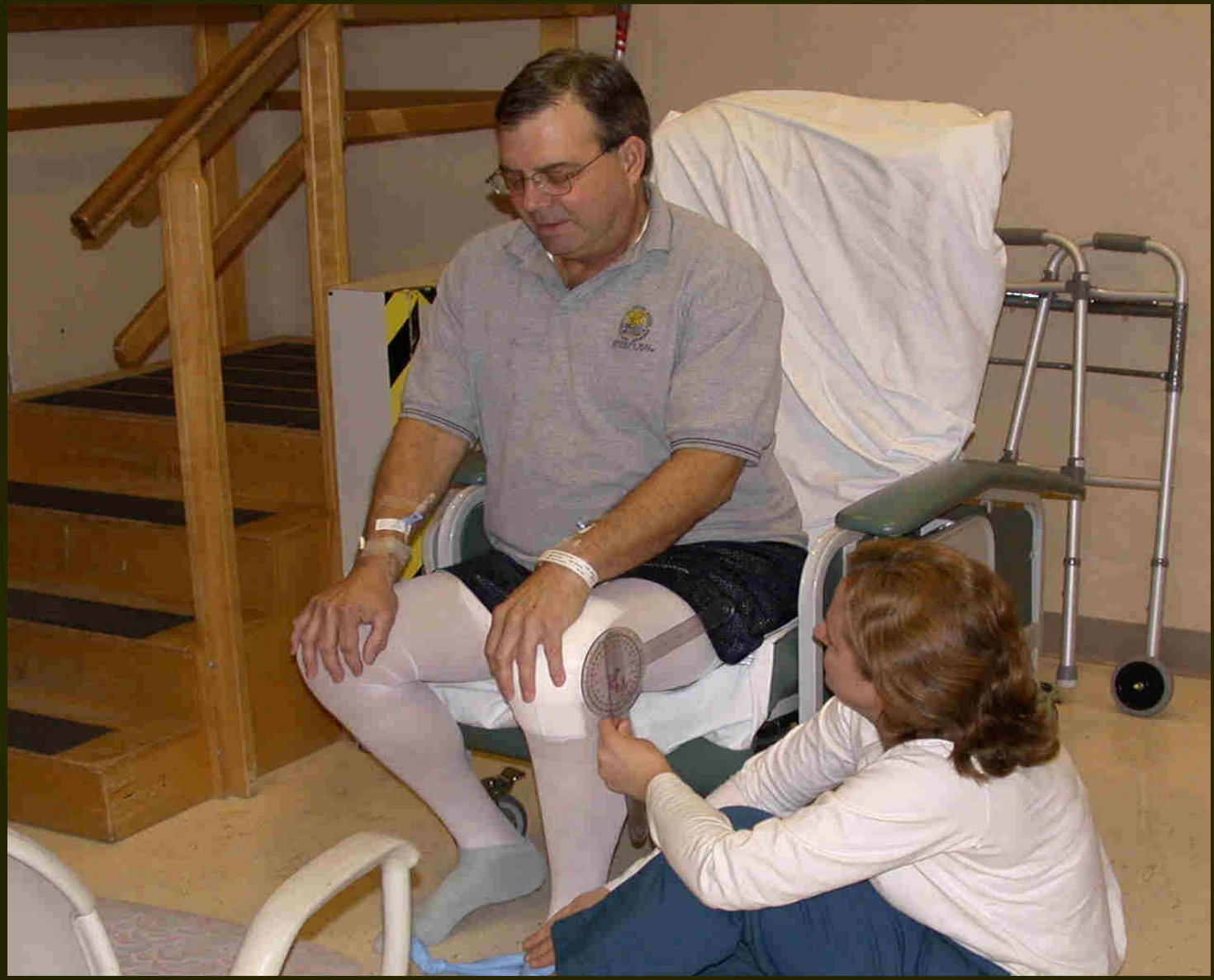

Post-op Day 2

Measurements Aggregated

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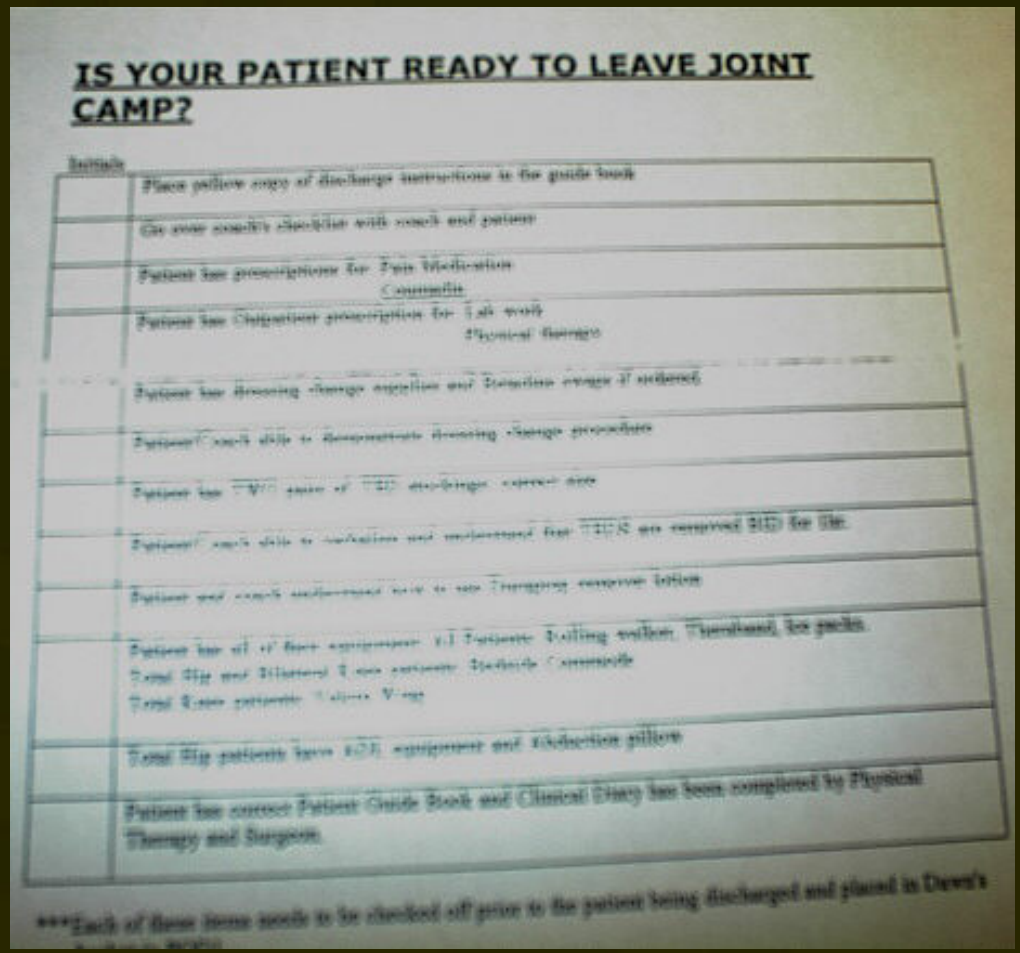
Interaction With Volunteers
Formal Training Competency

- Prepare supplies
- Assist therapists and staff
- Serve as a Coach
- Set-up group activities

Group Education Prior to Transition

Nurses Checklist at Transition



IS YOUR PATIENT READY TO LEAVE JOINT CAMP?

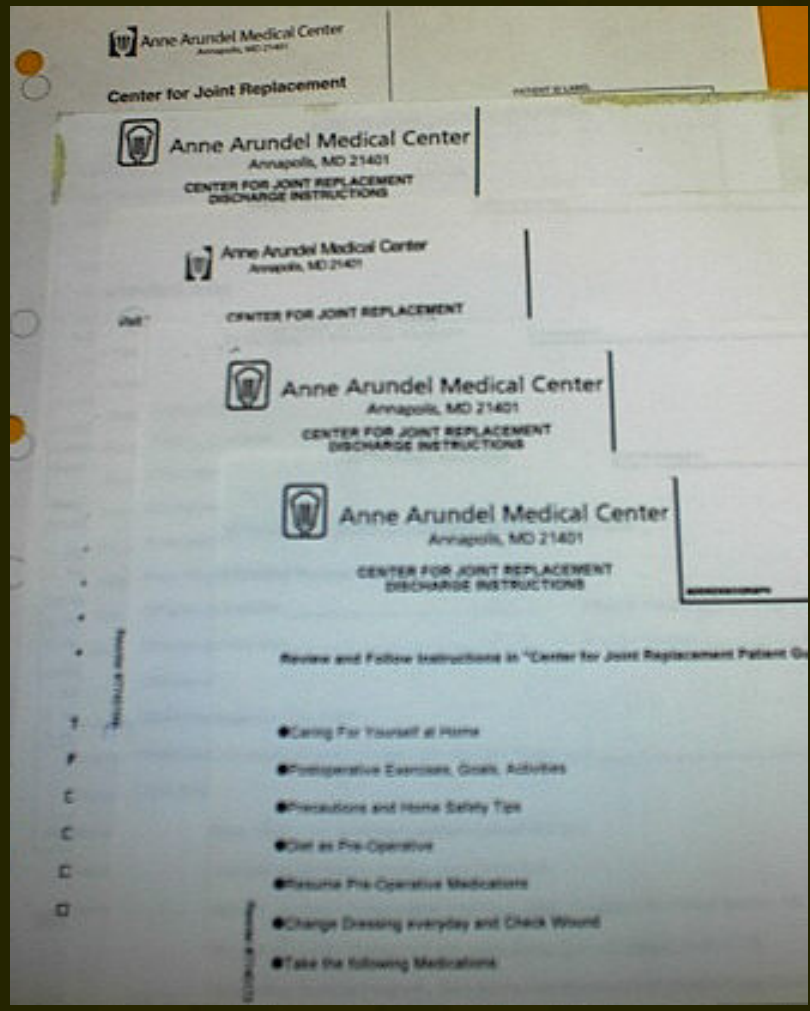
Initials

	Place yellow copy of discharge instructions in the guide book
	Go over couch's checklist with coach and patient
	Patient has prescriptions for Pain Medication Coumadin
	Patient has Outpatient prescription for Lab work Physical therapy
	Patient has dressing change supplies and Duration orange if ordered
	Patient/ coach able to demonstrate dressing change procedure
	Patient has TWO pairs of TED stockings current size
	Patient/ coach able to verbalize and understand that TEDS are removed BID for life
	Patient and coach understand how to use Emergency response letter
	Patient has all of their equipment (i.e Patients Rolling walker, Thermometer, Ice packs Total Hip and Bilateral Knee patients: Bathtub Commode Total Knee patients: Elbow V-up
	Total Hip patients have AFO equipment and Abduction pillow
	Patient has correct Patient Guide Book and Clinical Diary has been completed by Physical Therapy and Surgeon

***Each of these items needs to be checked off prior to the patient being discharged and placed in Dawn's

Standardized Transition Instructions

- Patient
  - General
  - Coumadin
- Outpatient Therapist
- Home Health
- Rehab Unit



Post-op Follow Up

Next Day Call Backs

Reunion Luncheon

Results: Anne Arundel Medical Center

Metric	1995	2009
ALOS	5.1	2.6
% Discharge Home	30%	95%
Volume – TJR	200	1500
Volume –Spine	500	1500
Range of Motion	60	97
Distance Walked (average)	150’	3000’
Infection Rate	2.17%	.5%
Market Share (extended)	17%	35%
Readmission Rate	3.5%	1%
Patient Satisfaction	Low	#1 in Country 2004-2009

Results: Parkwest Medical Center

Metric	Pre-Program 2007	Post-Implementation 2008
ALOS	4.5	3.28
Volume	758	862
Direct Costs	$ 12,255	$10,586
Contribution Margin	$ 1,451	$ 2,964
% Discharge Home	20%	67%
% Private Payor	37%	39%
Implant Cost Reduction	0	$800,000
Infection Rate	2.0%	1.3%
Mortality	1.2%	0.0%
Patient Satisfaction	79%	98%

Results: St. Joseph

Metric	Pre Joint Center	Post Joint Center
ALOS Primary Knee	3.05	2.65
ALOS Revision Knee	3.55	3.00
ALOS Primary Hip	3.01	2.58
ALOS Revision Hip	3.70	3.00
Discharge Home with Outpatient	27%	68%
Discharge Home with Home Health	37%	13%
Discharge to Skilled Nursing	31%	17%
Joint Volume	444 (87.6% Market share)	573 (25% increase in volume)

Don’t Get Fired:
Recommended to Friends

Outcomes Management

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Mike Dollar, RN

Surgical Services Manager

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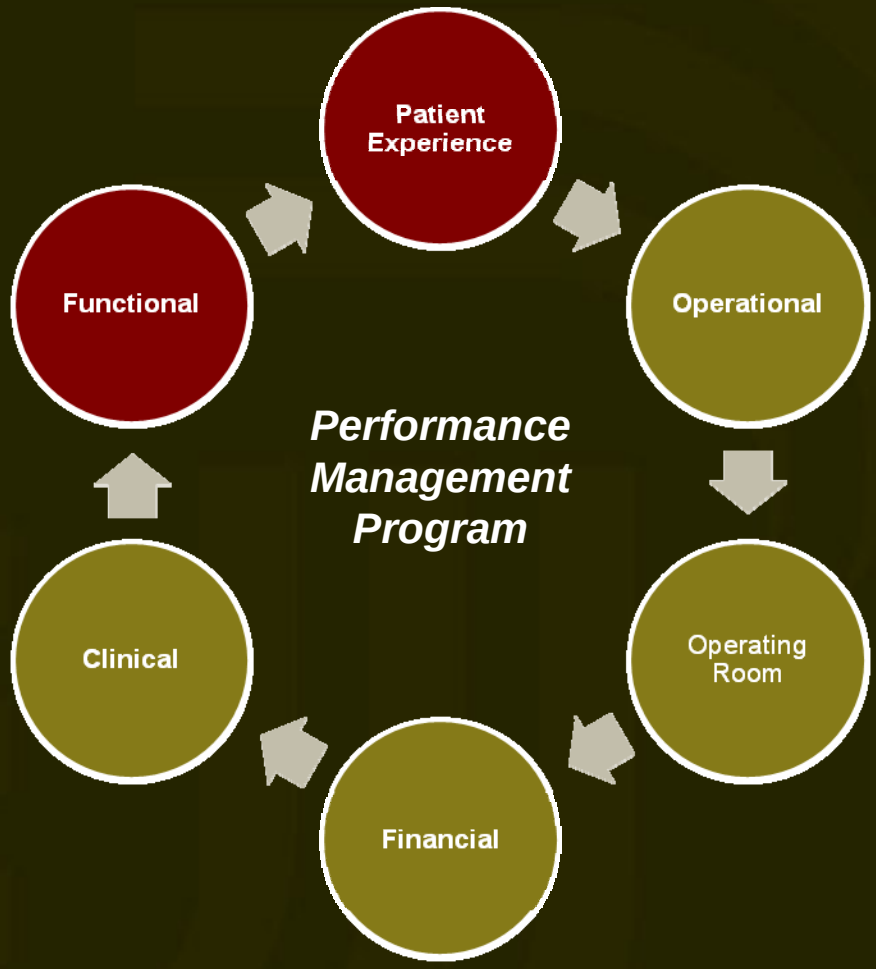
What Is The Real Problem?

- Service Line Data Unavailable or Difficult to Extract
  - Quality
  - Costs
- No One Person Accountable
- Not Broadly Shared

What's Possible Today:
Choose Important Categories

Patient Reported PRO

Hospital Reported HRO



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Hospital Reported Outcomes:
Choose important Metrics

Clinical
- Complications
- Blood transfusions
- Re-admissions

Rehab
- Flexion
- Extension
- Distance Walked

Operational
- Case Volume
- Length of stay
- Discharge home

Operating Room
- Duration Accuracy
- Prep Time
- PACU Time

Financial
- Contribution
- Direct costs
- Payor mix

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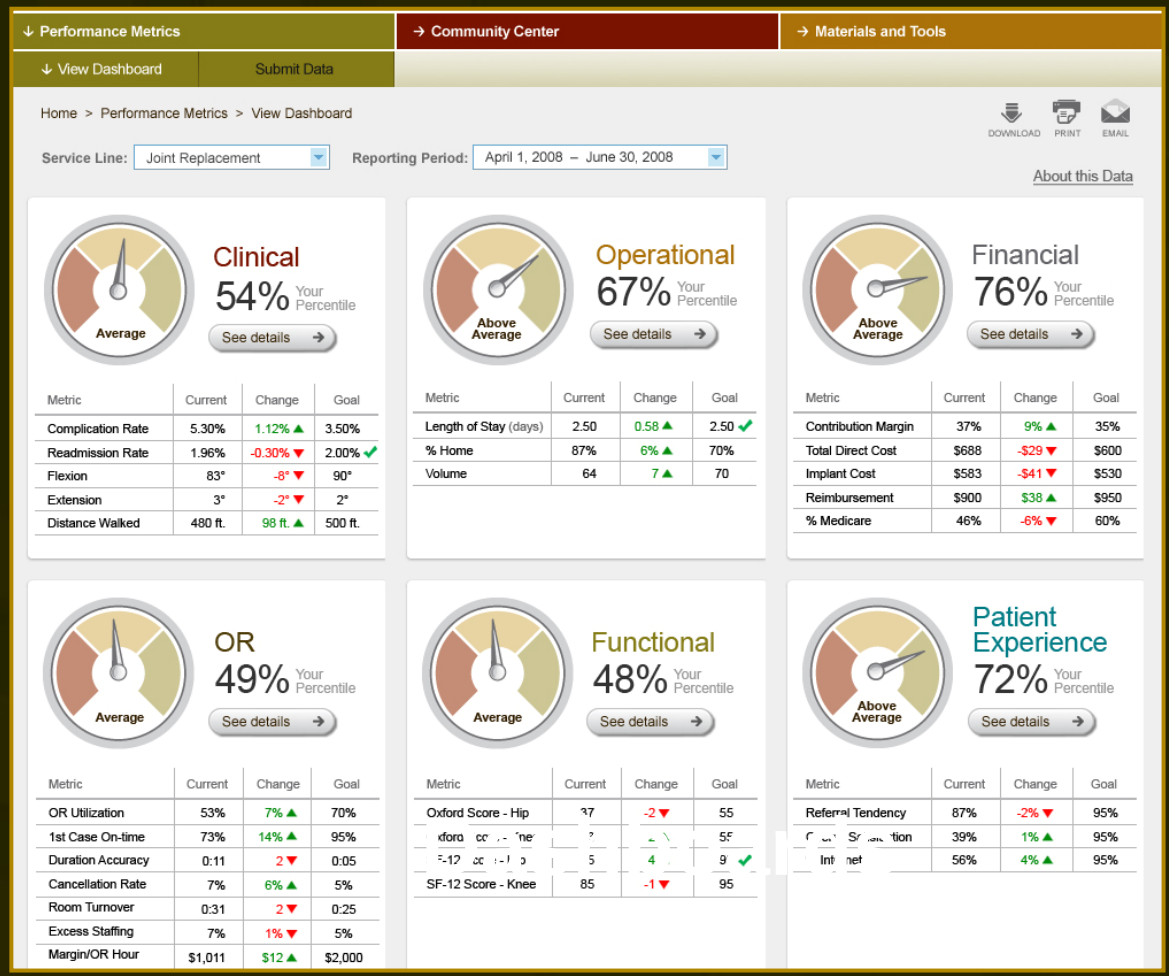
Use Technology: Dashboards



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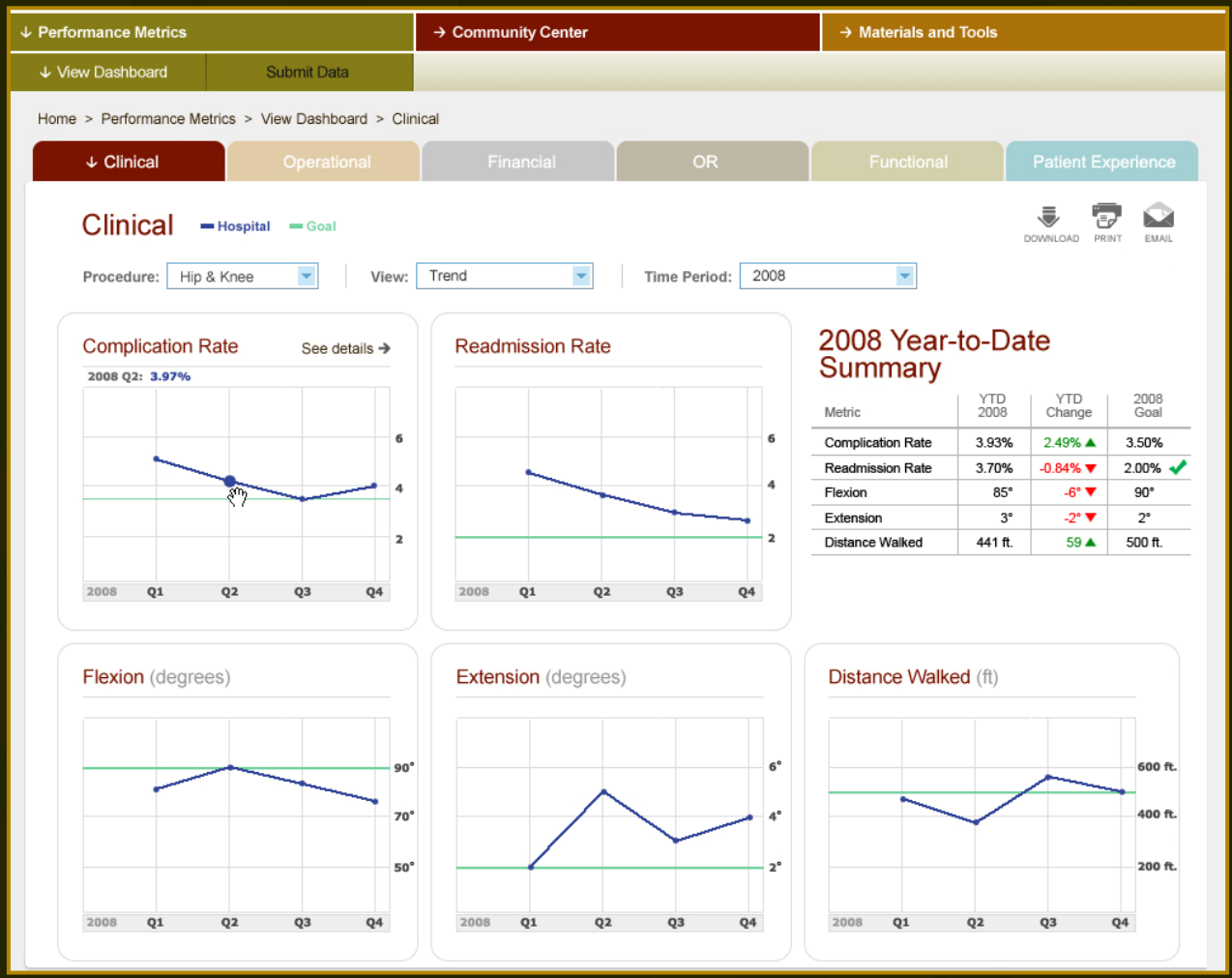
Join a National Registry - Benchmarking / Trending



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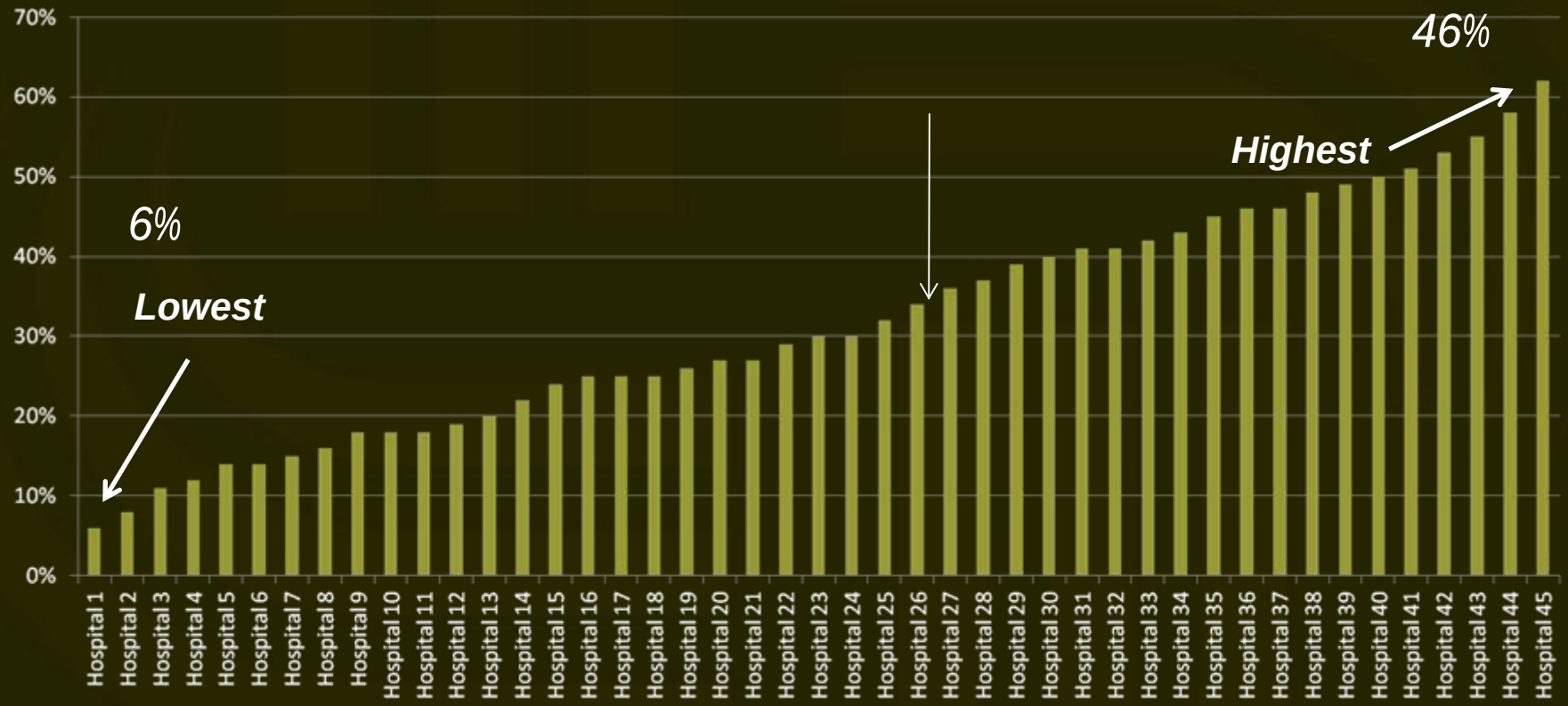
Analyze Where You Stand

Allogenic Blood Transfusion Rates (%)



Our Registry contains over 65,000 patient records

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Take Action

Complication	Jan – Mar 09	Apr – Jun 09	Jul – Sep 09	Oct – Dec 09	12 Month Average	12 Month M|S Average
SSI	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	**0 (0.0%)**	**0.5%**
PE	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.8%)	**1 (0.2%)**	**0.1%**
DVT	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	**0 (0.0%)**	**0.2%**
UTI	0 (0.0%)	1 (0.8%)	1 (0.7%)	0 (0.0%)	**2 (0.4%)**	**3.0%**
Major Nerve Damage	1 (0.8%)	0 (0.0%)	0 (0.0%)	1 (0.8%)	**2 (0.4%)**	**0.8%**
Dysphagia	0 (0.0%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	**1 (0.2%)**	**1.1%**
Hematoma	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.8%)	**1 (0.2%)**	**0.5%**
Dural Tear	3 (2.3%)	1 (0.8%)	3 (2.2%)	2 (1.6%)	**9 (1.8%)**	**0.2%**
Average	**4 (3.1%)**	**3 (2.5%)**	**4 (3.0%)**	**5 (4.0%)**	**16 (3.1%)**	**5.7%**

Identify complication problem areas and address them

Patient Reported Outcomes – PRO

Less than 2% Currently Collect

Pre-Intervention Survey

Intervention

Multiple post-Intervention surveys

Real-time

Dashboard Benchmarking

Performance Improvement / Marketing

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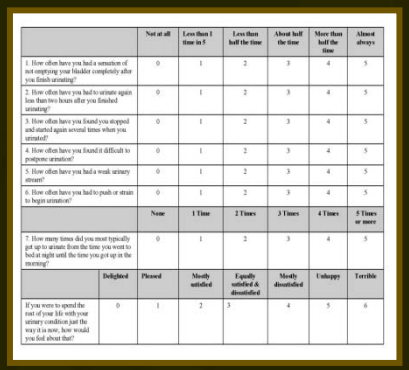
Why?
The Measurement Challenge



	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. How often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
2. How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. How often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. How often have you had a weak urinary stream?	0	1	2	3	4	5
6. How often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 Times or more
7. How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

	Delighted	Pleased	Mostly satisfied	Equally satisfied & dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Paper

Phone

Web

Handheld

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What's Possible Today?

- Simple Data Collection, Analysis, Benchmarking Tool
- 94% Patient Compliance
- Portable
- 25 Questions in 6 Minutes
- Customized

National Survey Tools

General	◆ SF-12	◆ Visual Analog Pain Scale
	◆ SF-36	◆ McGill Pain Questionnaire
Joint	◆ Oxford Knee/Hip	◆ Harris Hip Score
	◆ Knee Society Score	◆ KOOS/HOOS
Spine	◆ Oswestry Disability Index	◆ Roland Morris LBP
	◆ Neck Disability Index	◆ LBP and Disability Index

Use the Data

Self Improvement, Primary Care, Insurance, Informed Consent

Pain Improvement Summary

92% of our joint replacement patients have experienced mild to no pain walking and going up and down stairs 6 months after surgery.

Pain Level	None to Mild
Walking	94%
Stairs	89%
In Bed	84%
Sitting / Lying	88%
Standing	93%
Total	**90%**

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Results – California Hospital

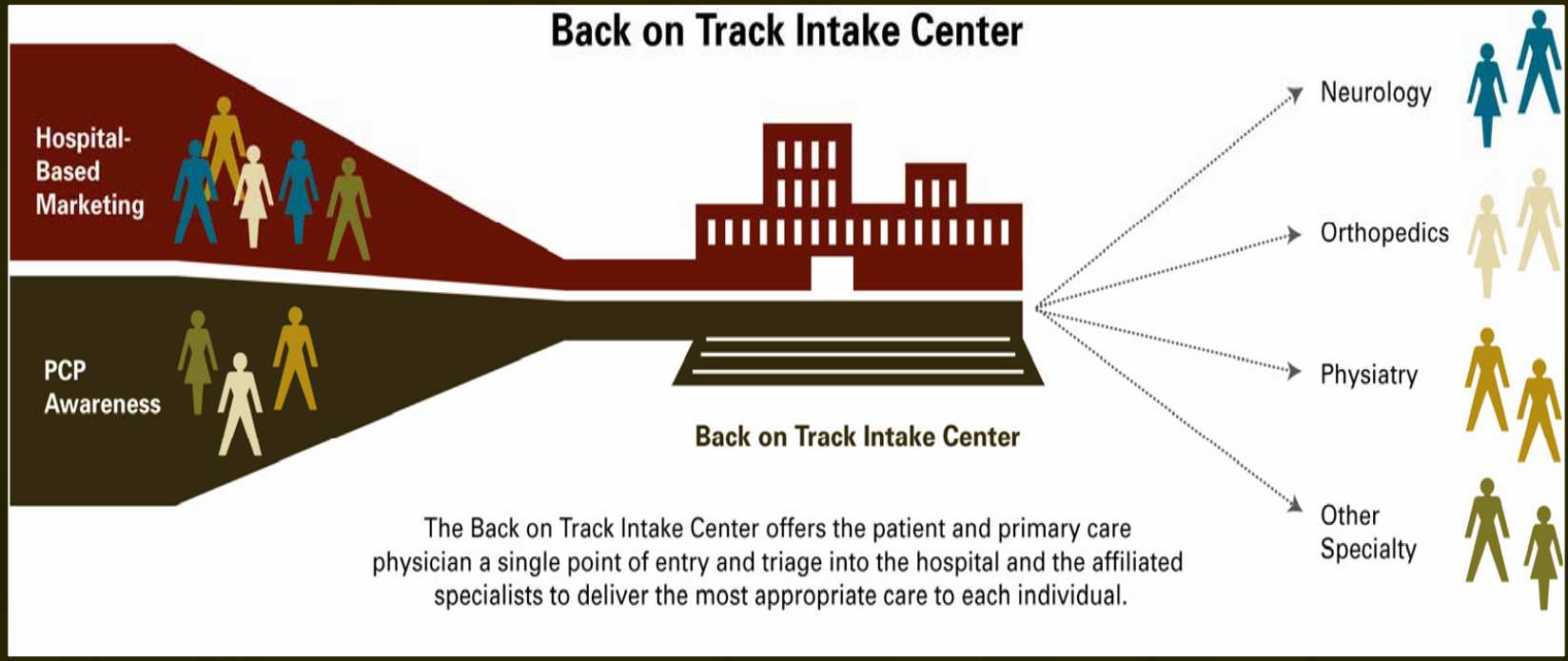
- Patient satisfaction >90th percentile
- Reduced Costs By $800,000 First Year
  - Most Profitable Service Line
- Discovered They Had A 30% Blood Transfusion Rate
  - Best Practice Of 6%
- Increased Volume 20%

Mr. Smith

Results

- Unhappy Patients
- Seek Care Elsewhere
- Loss Of Ancillary Revenue
- Surgeons – Low Surgical Yield

What's Possible Today



Calls: 1 -800 -310 -BACK

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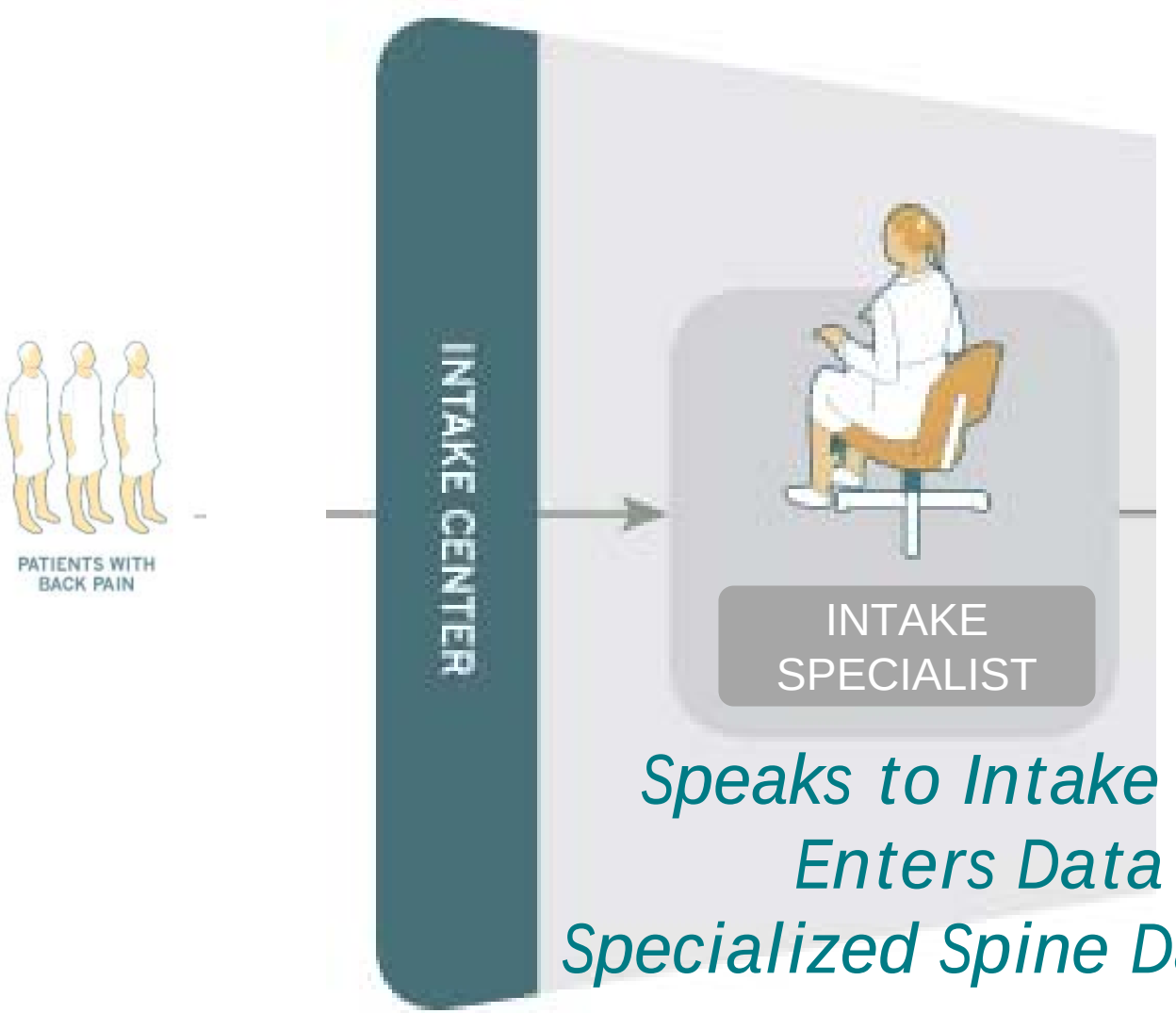
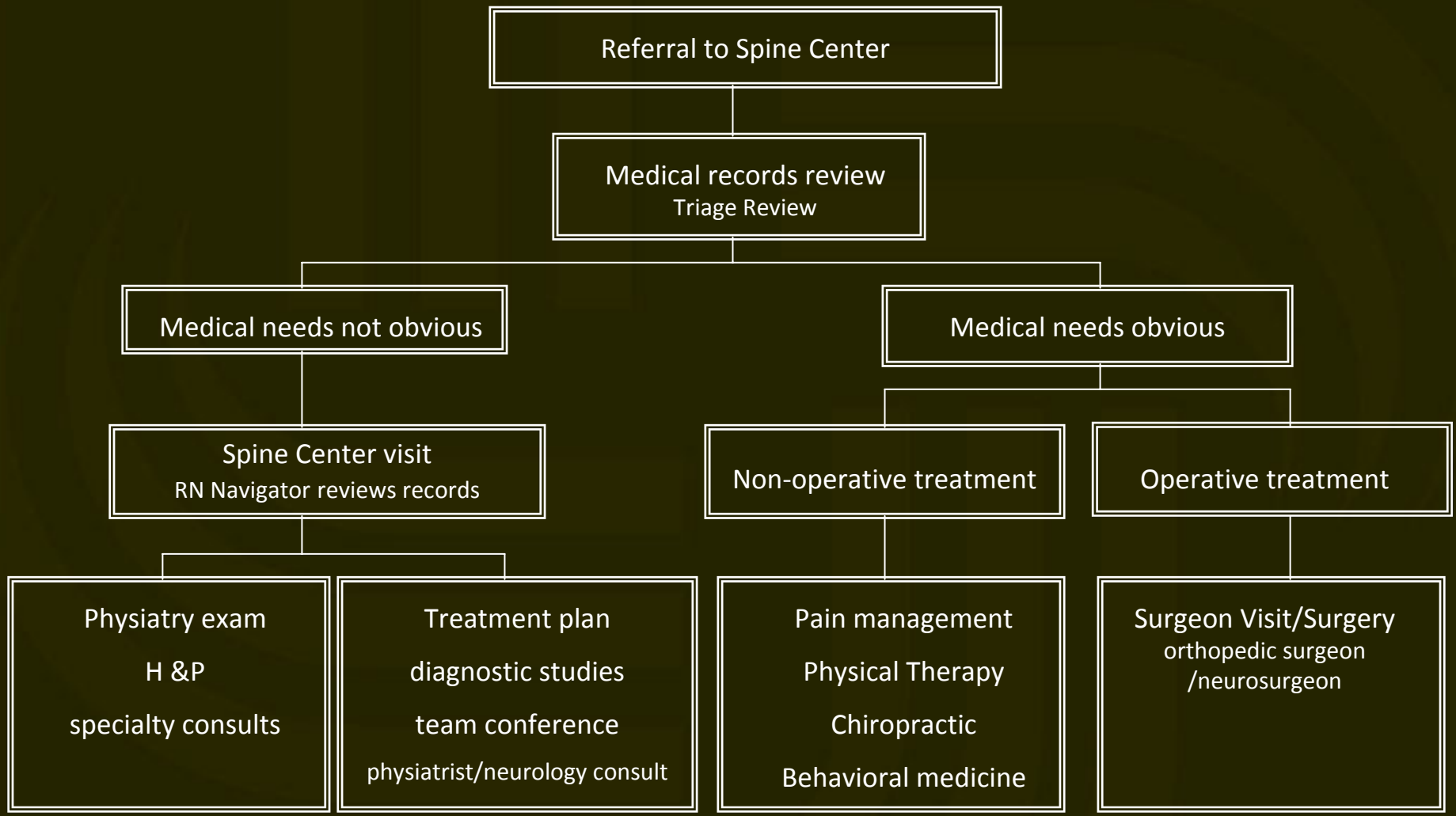
Guiding the Patient Experience Journey

The Intake Center – Intake Specialist



Speaks to Intake Specialist
Enters Data Into
Specialized Spine Data Program

Intake Specialist Goes through Algorithm



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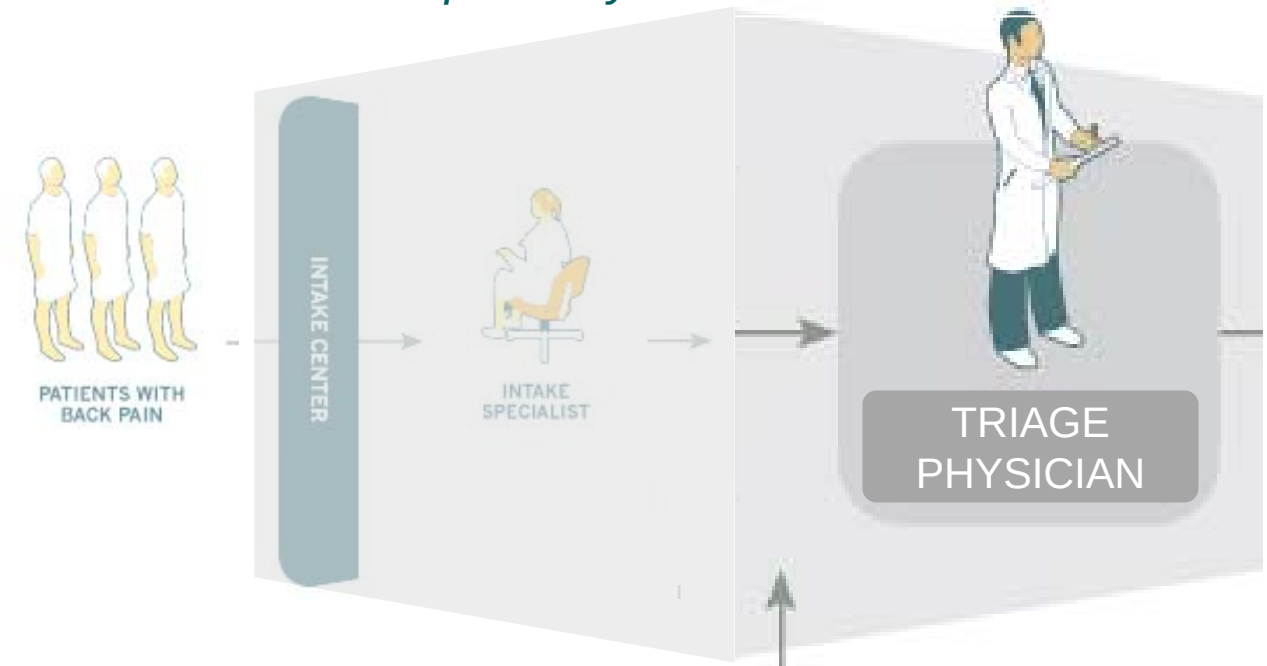
Guiding the Patient Experience Journey

The Intake Center - The Triage Physician - Spine Physicians



Spine physicians align triage algorithms and rules of engagement

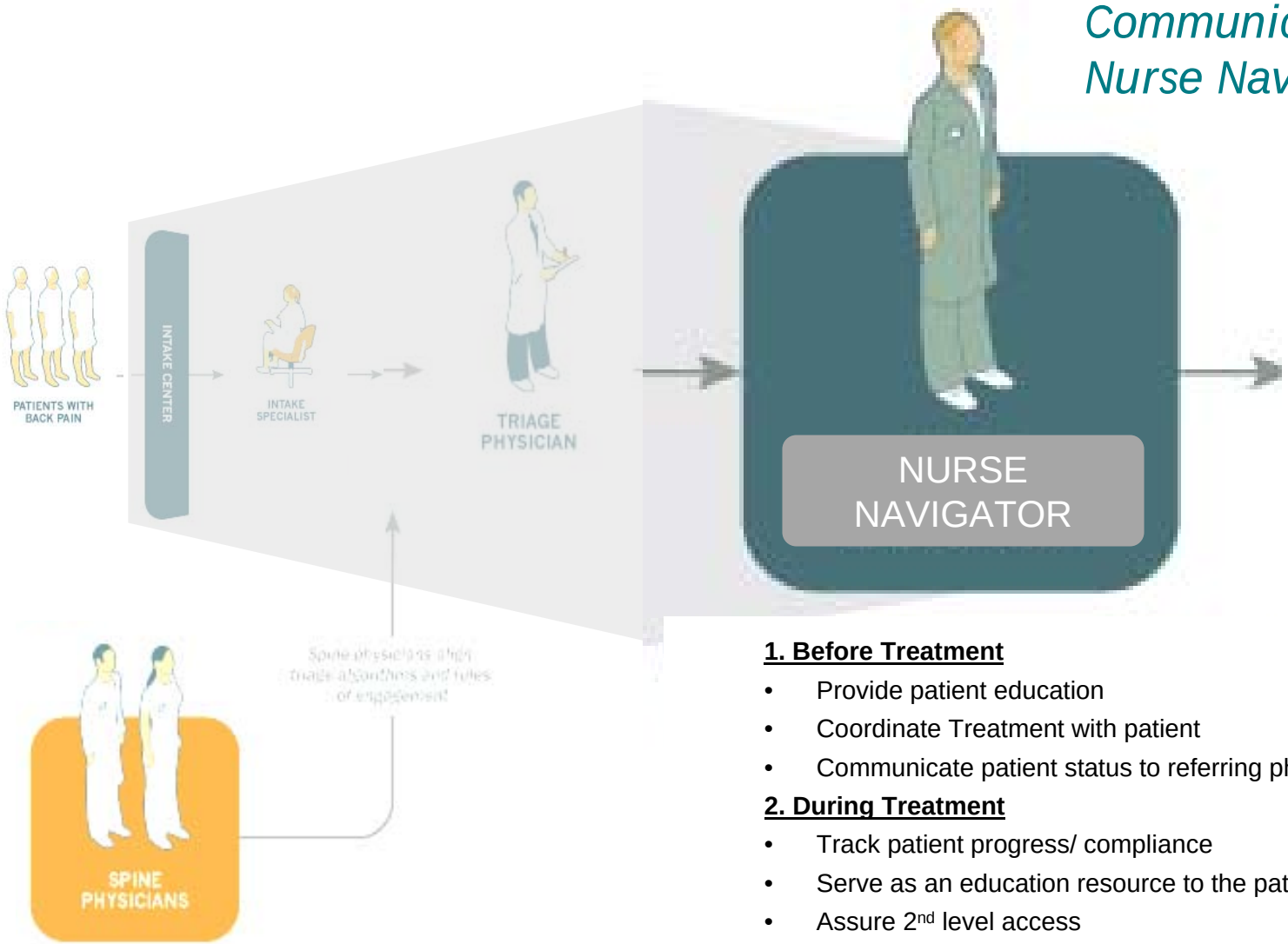
If Unsure

Prepares Chart for Triage Physician

Who Makes Recommendations

Guiding the Patient Experience Journey

The Intake Center - Nurse Navigator



Communicates With Nurse Navigator

1. Before Treatment

- Provide patient education
- Coordinate Treatment with patient
- Communicate patient status to referring physician

2. During Treatment

- Track patient progress/ compliance
- Serve as an education resource to the patient
- Assure 2nd level access

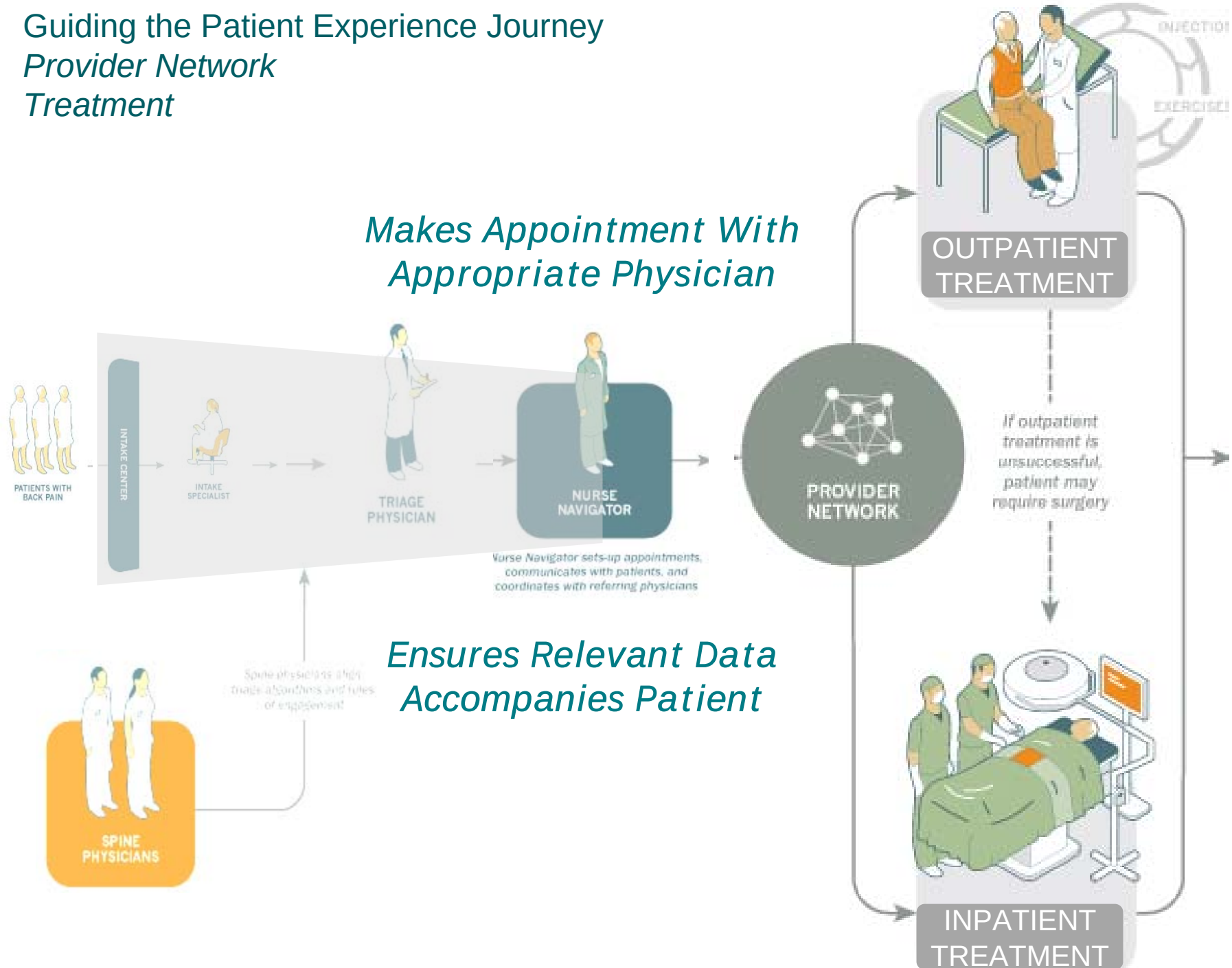
3. After Treatment

- Review outcome of treatment with patient
- Communicate patient's response to treatment to referring physician
- Return to surgeon or discharge

Guiding the Patient Experience Journey

Provider Network

Treatment



Navigates and Coordinates Care Until Better

- Pain Management Program
  - Anesthesia
  - Physiatrist
  - Interventional Radiologist
  - Neurologist
  - Physical Therapist
  - Psychology
- Surgical Program
  - Neurosurgeon
  - Orthopedics

Regular Case Conferences

Outcomes Tracked:
Surgical and Non-Surgical

- Simple Data Collection, Analysis, Benchmarking Tool
- 94% Patient Compliance
- Portable
- 25 Questions in 6 Minutes
- Customized

Results

- Patients
  - Better Care
  - Better Experience
- Surgeons / Pain Management Physicians
  - Higher Percentage Of Surgical Candidates
  - Results Are Tracked And Shared
- Hospital
  - Surgery And Non Surgical Volume Goes Up
  - Hospital Receives More Ancillary Revenue

Mrs. Bing

Results

- Post-operative Delirium Rate Is Approximately 80%
- Complications Common
- Only 20% Return To Their Pre-injury Level Of Activity
- 30-50% Die Within The First 12 Months
- Long Length Of Stay
- The Hospital Often Loses Money
- Likely To Break Another Bone If They Survive

What's Possible Today?
St. Francis – January, 2007

- Reduce Pain, Narcotic Use, Delirium, Complications
- Reduce LOS
- Increase Patient Satisfaction Scores

What's Possible Today?
St. Francis – January, 2007

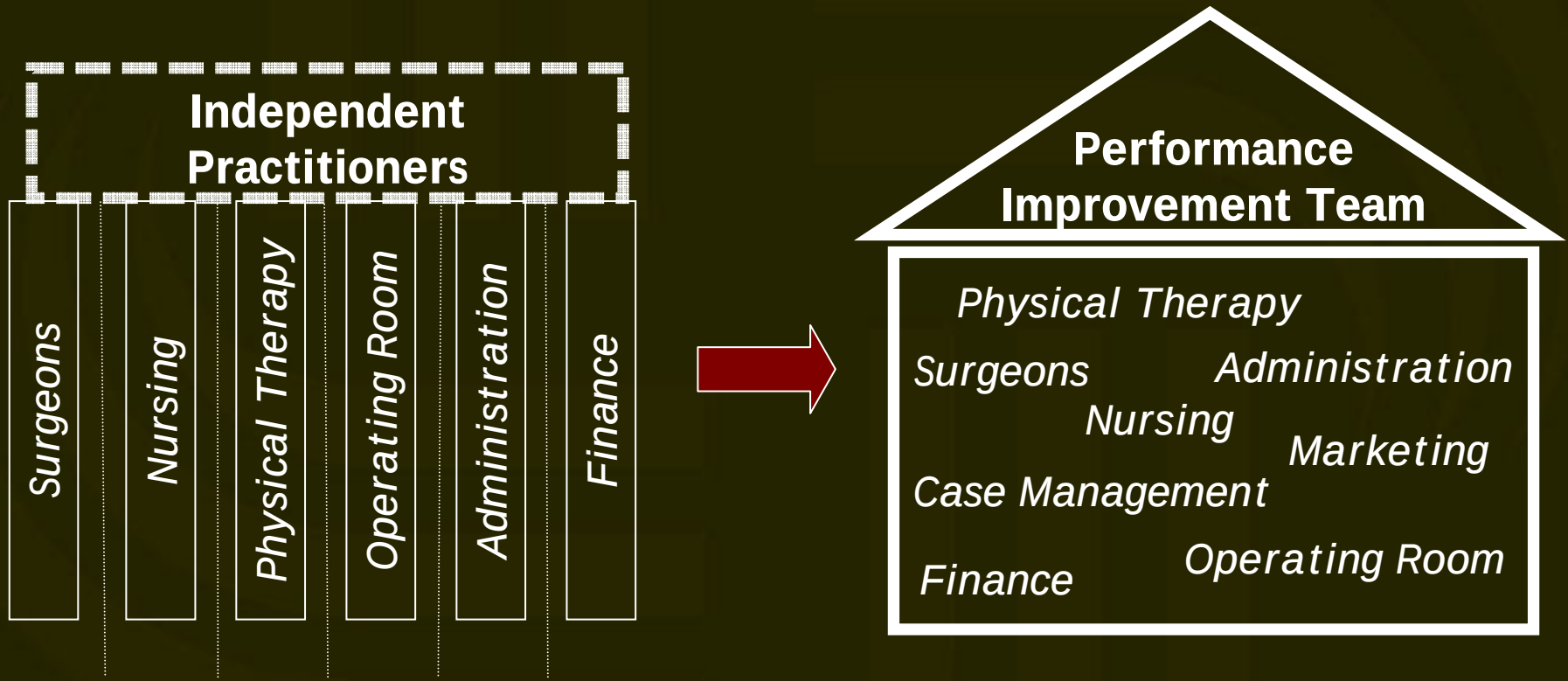
- Improve Long Term Functional Outcomes
  - Reduce Nursing Home Placements
  - Return Independent Living
  - Reduce Mortality In The First Year Following Fracture
- Reduce Subsequent Fractures
  - Provide Education For Bone Health And Injury Prevention
  - Provide Screenings For Osteoporosis

Structure

- Fracture Center Coordinator
  - Facilitation
  - Internal & External Liaison
- Physician Champion

Stacie Cox, RN & Alana Miller, RN

Performance Improvement Team



Process

- Speed Of Care
  - Transition From ER To Nursing Floor Within 4.5 Hours
  - Transition From ER To Surgery Within 12 To 24 Hours
- Dedicated Beds
- Dedicated / Specially Trained Staff
- Aggressive Therapy
- Early D/C Planning
- Patient / Family Education

New Patient Flow

Patient Arrives at ER, usually by EMS

⇩

ER Physician stabilizes pt. and notifies Hospitalist

⇩

Fracture care coordinator sees patient begins Discharge planning

⇩

Hospitalist admits, clears medically, and prepares for OR within 12-24 hours of ER arrival

⇩

Geriatric Fracture Center network orthopedist is consulted to perform surgery

⇩

Hospitalist continues to follow pt. on nursing floor as the attending physician

Results – Geriatric Fracture Care

Metric	Pre-Program	Post -Program
12 Months Mortality	30-50%	Less than 20%
Return to independent living	20%	80%
Post-operative delirium rate	80%	Less than 4%
Complications	20%	1%
Second fractures	Common	Less than 50%
Financial Performance	Not Profitable	Profitable
ED to Floor	6 hours	3.9 hours
ED to Incision	68 hours	17 hours
LOS	7.3	4.0
Profitability	--	+$2,000 per case

Key Questions to Ask

- What is Your Current Reality?
- Are You Doing Everything Possible?
- How Will You Achieve It?

Principles: 4 A's of Implementation

- Assess
  - Define Superior Performance / Measure Yourself Elements
- Architect
  - Create a Plan For Better Delivery System
- Assemble
  - Implement Quickly to a Timeline
- Assure
  - Measure, Trend, Benchmark and Manage

Most Hospitals Fail at Implementation

Why?

Everyone is Busy Putting Out Fires

Fire Fighters Don’t Build Buildings

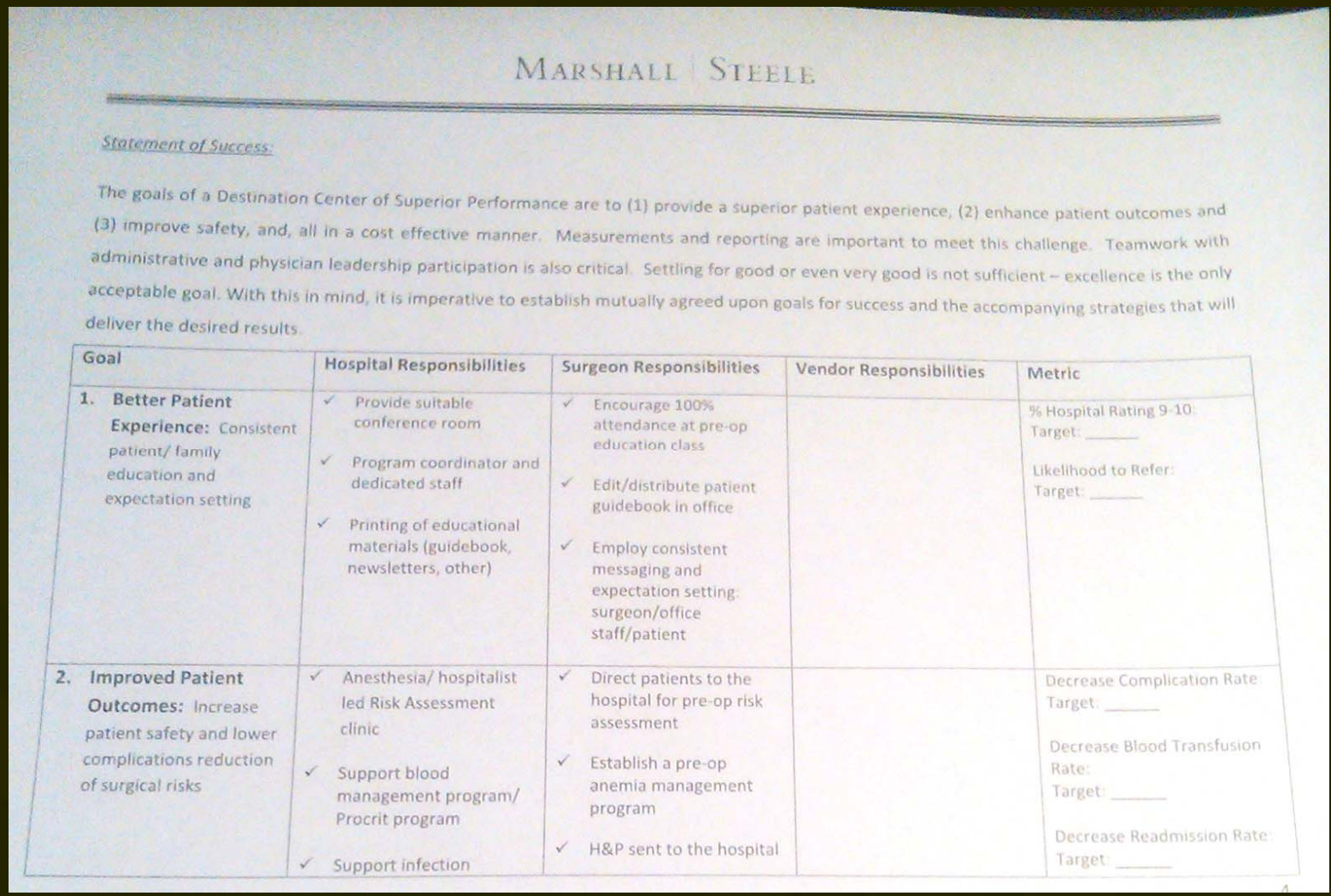
> 328 Elements

			22-Oct	4-Apr
Establish the process and frequency for a Leadership Team update		JCC/Project Leader	22-Oct	4-Apr
Develop Project Charter / Unit Philosophy Statement		Leadership Team	22-Oct	19-Nov
Identify center opening date		Leadership Team	22-Oct	29-Oct
MS&A Premier site visit		MS&A / JCC		
Medical Director			22-Oct	5-Nov
2.1.1	Develop job description and post position	Administration	22-Oct	22-Oct
2.1.2	Identify and interview candidates	Administration	29-Oct	5-Nov
2.1.3	Select Medical Director	Administration	5-Nov	5-Nov
Joint Care Coordinator			22-Oct	12-Nov
2.2.1	Review role and determine staffing approach	Administration	22-Oct	29-Oct
2.2.2	Develop job description and post position	Administration	29-Oct	5-Nov
2.2.3	Identify and interview candidates	Administration	5-Nov	12-Nov
2.2.4	Select JCC	Administration	12-Nov	12-Nov
Anesthesia Liaison			22-Oct	22-Oct
2.3.1	Identify JC anesthesia liaison	Administration	22-Oct	22-Oct
2.3.2	Continue to engage anesthesia lead in program development	Administration	22-Oct	22-Oct
Nursing			19-Nov	31-Dec
2.4.1	Gain approval for staffing plan / candidate profile	Nursing	19-Nov	10-Dec
2.4.2	Interview staff candidates	Nursing	17-Dec	31-Dec
2.4.3	Make selections and extend offers	Nursing	31-Dec	31-Dec
Physical Therapy			19-Nov	31-Dec
2.5.1	Gain approval for staffing plan / candidate profile	PT	19-Nov	10-Dec
2.5.2	Interview staff candidates	PT	17-Dec	31-Dec
2.5.3	Make selections and extend offers	PT	31-Dec	31-Dec
Volunteer Program			31-Dec	18-Feb
2.6.1	Determine role of volunteer staff	JCC / PT	31-Dec	7-Jan
2.6.2	Develop guidelines / responsibilities matrix	JCC / PT	14-Jan	14-Jan
2.6.3	Recruit Joint Center volunteers	JCC / PT	21-Jan	28-Jan
2.6.4	Prepare orientation session for volunteers	JCC / PT	4-Feb	4-Feb
2.6.5	Hold orientation session for volunteers	JCC / PT	18-Feb	18-Feb
New Hiring Training			25-Feb	17-Mar
2.7.1	Plan Skills Day program for staff	JCC / MS&A	25-Feb	3-Mar
2.7.2	Conduct Skills Day for staff	JCC / MS&A	17-Mar	17-Mar

> 70 Tools

Performance Management	
Tool	**Description**
Digital Outcomes Collection (DOC)	A hand-held device for efficiently collecting patient reported outcomes pre and post operatively using industry validated survey questions. Outcomes results are available in real time via the Web. Patient experience and other important demographic data can be collected and managed as well with this device.
Performance Analytics Manager (PAM)	A Web-based dashboard that tracks and trends service line specific clinical, operational, financial, and patient experience metrics. PAM includes benchmark comparisons vs. other institutions, analysis of best practice results, and identification of areas that need improvement.
Clinical Outcomes	
Tool	**Description**
Blood Transfusion/ Disposition Tracking Form	The Blood Transfusion / Discharge Disposition tracking form is a tool designed to help the Joint Care Coordinator collect data during a patient's hospital stay on two fronts – key factors that may contribute to physician's decision to order a blood transfusion and patient discharge disposition. The column headings can be changed to capture any issue of interest for the purpose of further analysis and evaluation by the Performance Improvement Team.
Post-Op Nausea/Vomiting (PONV) and Pain Management Tracking Form	The PONV / Pain Management tracking form is a tool designed collect data during a patient's hospital stay to identify the effectiveness (or ineffectiveness) of interventions selected to relieve PONV and post-op pain.
DCOSP PT Communication Worksheet	Sample form for PT to communicate and track key patient performance and clinical data for the health care team. This information can then be used to analyze and critique current practices and protocols.

No Roadmap to Success



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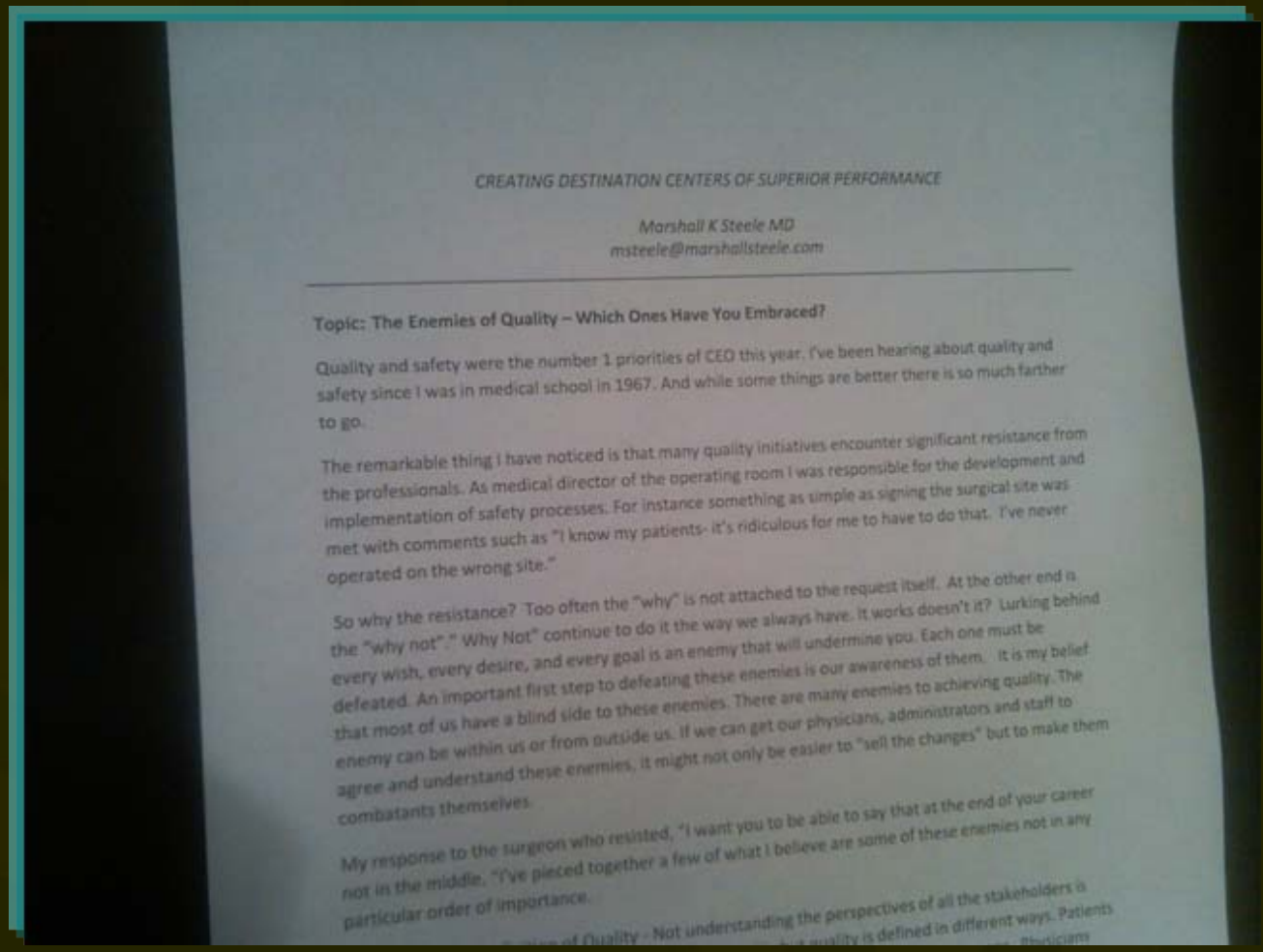
Statement of Success:

The goals of a Destination Center of Superior Performance are to (1) provide a superior patient experience, (2) enhance patient outcomes and (3) improve safety, and, all in a cost effective manner. Measurements and reporting are important to meet this challenge. Teamwork with administrative and physician leadership participation is also critical. Settling for good or even very good is not sufficient – excellence is the only acceptable goal. With this in mind, it is imperative to establish mutually agreed upon goals for success and the accompanying strategies that will deliver the desired results.

Goal	Hospital Responsibilities	Surgeon Responsibilities	Vendor Responsibilities	Metric
1. **Better Patient Experience:** Consistent patient/ family education and expectation setting	✓ Provide suitable conference room ✓ Program coordinator and dedicated staff ✓ Printing of educational materials (guidebook, newsletters, other)	✓ Encourage 100% attendance at pre-op education class ✓ Edit/distribute patient guidebook in office ✓ Employ consistent messaging and expectation setting: surgeon/office staff/patient		% Hospital Rating 9-10: Target: _____ Likelihood to Refer: Target: _____
2. **Improved Patient Outcomes:** Increase patient safety and lower complications reduction of surgical risks	✓ Anesthesia/ hospitalist led Risk Assessment clinic ✓ Support blood management program/ Procrit program ✓ Support infection	✓ Direct patients to the hospital for pre-op risk assessment ✓ Establish a pre-op anemia management program ✓ H&P sent to the hospital		Decrease Complication Rate: Target: _____ Decrease Blood Transfusion Rate: Target: _____ Decrease Readmission Rate: Target: _____

Inadvertently Embrace "The Enemies of Quality"



CREATING DESTINATION CENTERS OF SUPERIOR PERFORMANCE

Marshall K Steele MD
msteele@marshallsteele.com

Topic: The Enemies of Quality – Which Ones Have You Embraced?

Quality and safety were the number 1 priorities of CEO this year. I've been hearing about quality and safety since I was in medical school in 1967. And while some things are better there is so much farther to go.

The remarkable thing I have noticed is that many quality initiatives encounter significant resistance from the professionals. As medical director of the operating room I was responsible for the development and implementation of safety processes. For instance something as simple as signing the surgical site was met with comments such as "I know my patients- it's ridiculous for me to have to do that. I've never operated on the wrong site."

So why the resistance? Too often the "why" is not attached to the request itself. At the other end is the "why not"." Why Not" continue to do it the way we always have. It works doesn't it? Lurking behind every wish, every desire, and every goal is an enemy that will undermine you. Each one must be defeated. An important first step to defeating these enemies is our awareness of them. It is my belief that most of us have a blind side to these enemies. There are many enemies to achieving quality. The enemy can be within us or from outside us. If we can get our physicians, administrators and staff to agree and understand these enemies, it might not only be easier to "sell the changes" but to make them combatants themselves.

My response to the surgeon who resisted, "I want you to be able to say that at the end of your career not in the middle, "I've pieced together a few of what I believe are some of these enemies not in any particular order of importance.

...of Quality - Not understanding the perspectives of all the stakeholders is ... quality is defined in different ways. Patients ... physicians

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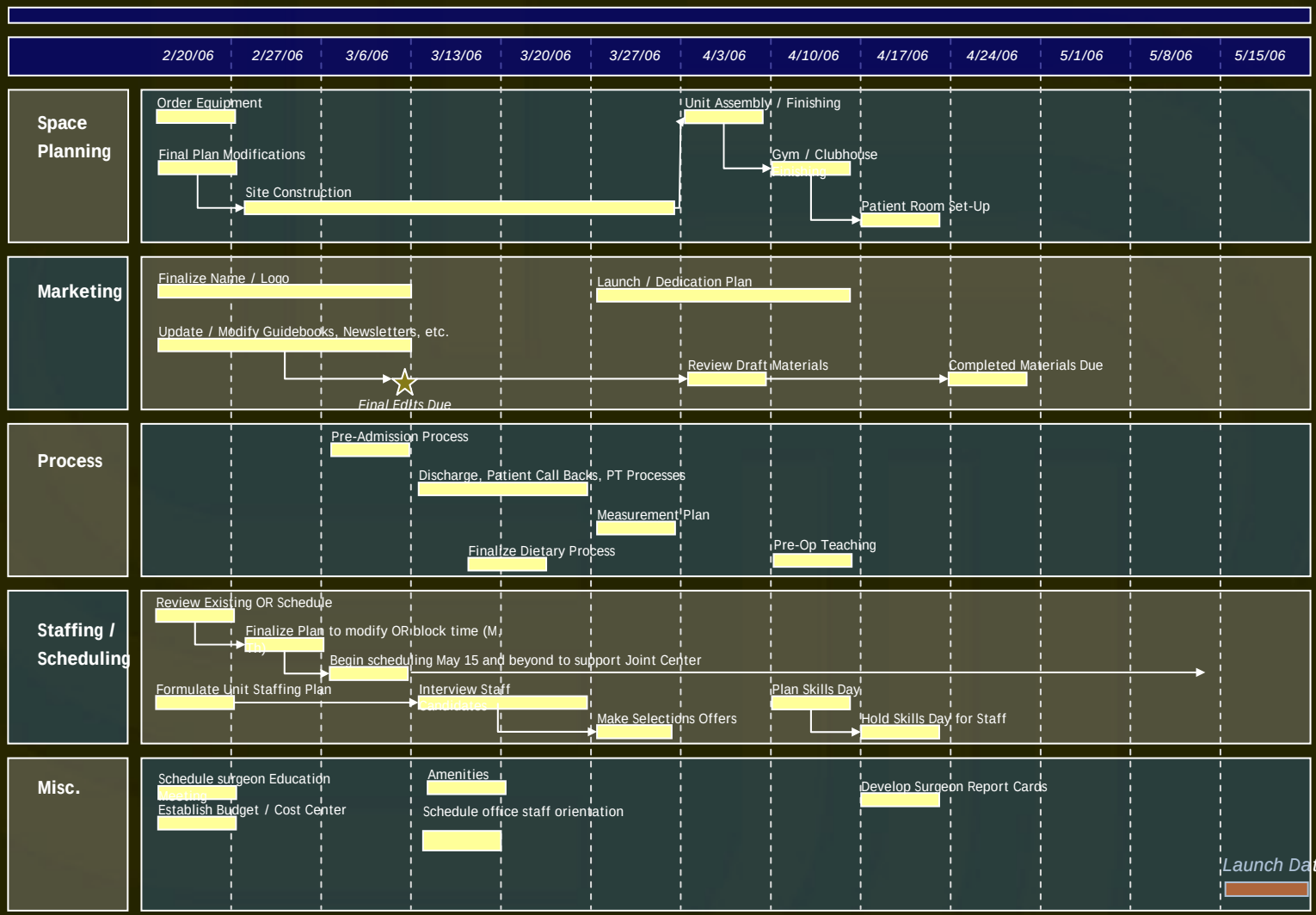
Lack of a Timeline to Success



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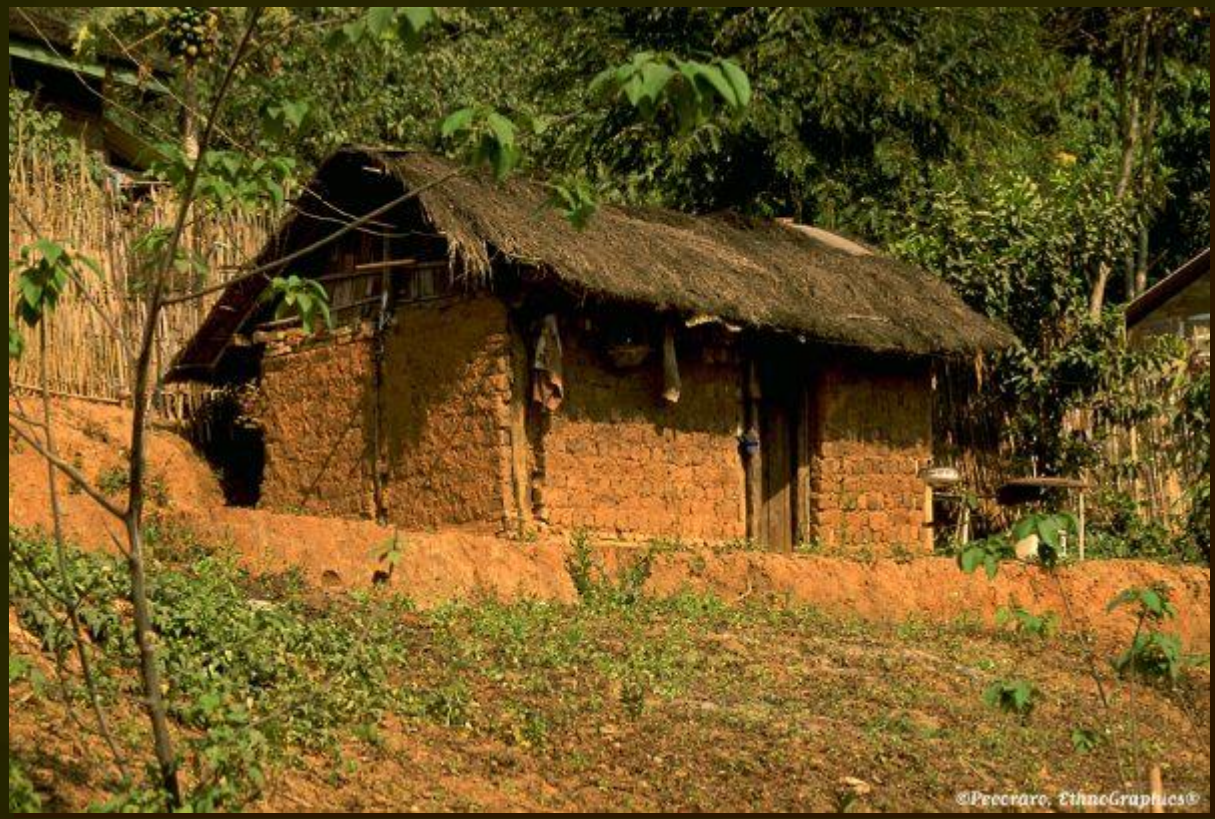
Lack of Expert Project Management / Support

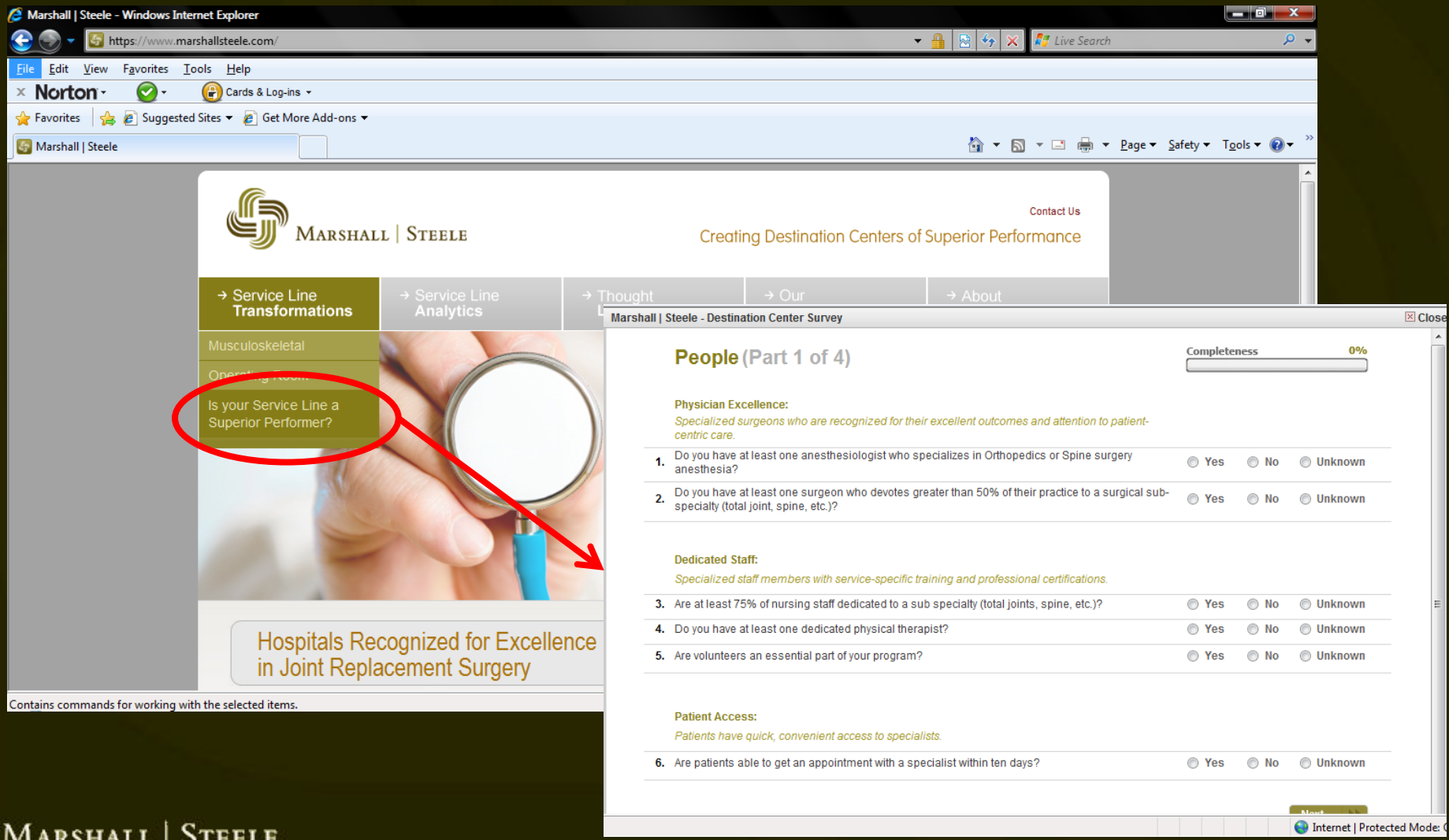
- Surgeons
- Project Directors
- Nurses
- Physical Therapists
- Analysts
- IT
- Graphic Artists
- Outcomes Software

Big Changes are on the Doorstep



“ Just Painting the Shack isn’t the Answer”

Destination Center Survey:
www.marshallsteele.com



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Destination Centers of Superior Performance

The Model for the Future

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