Leadership “Machinery” for Transitions-in-Care at Penn Medicine

University of Pennsylvania Health System
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Who we are

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University of Pennsylvania Health System

- Hospital of the University of Pennsylvania
  #8 US News & World Report/ Magnet
- Pennsylvania Hospital
- Penn Presbyterian Medical Center
- Home Care & Hospice Services
- Good Shepherd Penn Partners
- Admissions — 18,000
  Employees — 450

University of Pennsylvania Medical School

- #2 NIH ranking
  Faculty — 1,347
  Med students — 741
  Grad students — 1,079
  Residents/ Fellows — 978
- Adult admissions — 77,500
  Employees — 12,700

Transitions in Care — What is UPHS trying to accomplish?

The aim is to keep patients safe and stable and give them a safe medical “landing.”

From the patient’s perspective, this means:
- Staying out of the hospital or the ED
- Connecting to a primary care physician
- Having the right pharmaceuticals
- Knowing what to do after discharge

We’re focused, for now, on the transitions in and out of the hospital.

Preadmission  Hospital Stay  Post-acute Care  Medical “Landing”
We've developed a Transitions model for UPHS — with seven “levers” that make the biggest difference

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<th>UPHS Transitions Model — Seven “Levers”</th>
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But ...

It’s the leadership “machinery” that makes the model work.

Today’s story about leadership machinery has three parts

1 “Speaking with a united clinical voice”
   The story of the CMO/CNO Alliance

2 “Mobilizing other people’s energies — and keeping the moving parts aligned”
   The story of the Transitions Steering Group

3 “Acting your way to new thinking”
   The story of local leadership
1 Speaking with a united clinical voice

The CMO/CNO Alliance spans the continuum of care

The CMOs and CNOs banded together across the care continuum:

- All three hospitals
- Penn’s homecare and hospice services
- Penn’s rehab facilities
- Physician practice
The CMOs and CNOs set clinical direction for UPHS — with Transitions-in-Care as a major element

<table>
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<th>Four Imperatives</th>
<th>Priority Actions</th>
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UPHS Blueprint for Quality and Patient Safety

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

To bring clinical strategy to the frontline, we established “local leadership” on each hospital unit (more on this later)

Three-Way Partnership Manages Quality on the Hospital Units

**Physician Leader** and **Nurse Leader** are paired at the hospital unit level — with a **Project Manager for Quality** who brings data and project management skills.

We call these trios “UBCLs,” for “Unit Based Clinical Leadership.”
“Choice within a framework” — we developed targets and worked with each hospital unit to pick theirs

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Transitions in Care — FY’10 Targets
1. Post-acute care referrals
2. Use of hospice
3. Med rec on discharge
4. Readmission rate for TCM follow-up program

Reduce Variations in Practice — FY’10 Targets
5. DVTs & PEs
6. BSIs
7. Falls with injury
8. Pressure ulcers
9. VAPs
10. SCIP
11. UTIs

Coordination of Care — FY’10 Targets
12. Interdisciplinary rounding
13. Nurse/physician collaboration (NDNOI)
14. Patient satisfaction (HCAHPS)

Quality outcomes at UPHS are moving in the right direction

MORTALITY  INFECTIONS  LENGTH OF STAY  READMISSIONS

PEER RECOGNITION  PATIENT & STAFF SATISFACTION  REFERRALS TO POST-ACUTE CARE  P4P IS ON TRACK
“Focusing attention” — we negotiated a Transitions metric in every senior leader’s incentive plan

**METRIC:** Increase post-discharge referrals to homecare, hospice, rehab, SNF, infusion, LTAC.

We picked this metric because it supports a key element of our Transitions model — and because Penn could measure it. We're setting the stage for a more ambitious “readmissions” metric next year.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>Hospital 1</td>
<td>HP</td>
<td>HP</td>
<td>HP</td>
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<tr>
<td>Hospital 2</td>
<td>HP</td>
<td>HP</td>
<td>HP</td>
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<td>HP</td>
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Threshold (3%) | Target (5%) | High Performance (10%)

We’re getting out ahead of the budget cycle and negotiating with a united clinical voice

**The old way**

- First step — set margins for each hospital or other entity. Entities are locked in.
- Entities (separately) submit budgets.
- Negotiation — across entities 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.
### We're bringing payers to the table

<table>
<thead>
<tr>
<th>Transitional Care Program</th>
<th>Gain-sharing Arrangements</th>
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<tr>
<td><strong>IBC</strong> pays <strong>Penn</strong> to provide the “Transitional Care” (Naylor model) followup program to IBC patients who are elderly and at risk.</td>
<td><strong>IBC agreement</strong> has been finalized. <strong>Negotiations with AETNA</strong> are underway.</td>
</tr>
<tr>
<td>The same advanced practice nurse <strong>follows patients before and after discharge</strong> — with assessment and education about medications, symptom management, and nutrition. The nurse works with other members of the patient’s healthcare team to coordinate care.</td>
<td></td>
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### “Speaking with a united clinical voice” — lessons learned

- **One thing led to another.** We didn’t start out with a united voice, but each experience showed us a little more about what joining forces could accomplish.
- “It’s the work, stupid.” To paraphrase James Carville, we focused on the work.
- The experience of accomplishing real work turned us into a real leadership team.

A united clinical voice is based on actions, not just words. **The actions create “pull” for speaking with a united voice**, which builds over time.
2 Mobilizing other people’s energies

The Transitions Steering Group is in the integration business

This multi-disciplinary 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 developed the Transitions model for UPHS — with seven “levers” that make the biggest difference.

**UPHS Transitions Model — Seven “Levers”**

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In FY10, we focused on the first four levers

In FY11, we’ll concentrate in addition on the next three

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We’re taking good ideas from elsewhere — AND helping the organization learn from itself

- An organization learns best when it learns from itself
- Pockets of innovation are already emerging inside almost every organization — if it knows how to **look and listen**
- These innovations are the building blocks of culture change. Your organization’s culture is a “renewable resource.”
Learning from ourselves — three “system-in-the-room” Transitions summits

Three “system-in-the-room” Transitions summits of 100+ stakeholders each

- Transitions in Care “Pilots” Conference
- Transitions in Care “Marketplace”
- Transitions in Care “Connections” Conference

The summits helped the health system...

- Learn from each other what’s **already working** at UPHS
- Make commitments and momentum **tangible**
- Create “educated consumers” for the **changes to come**

We’re mobilizing and shaping “other people’s energies.” Our biggest job is keeping them aligned.

**INTERNAL**
- Penn Medicine Leadership Forum “action learning” Transitions projects
- Knowledge Based Charting is under development
- Unit-based Pharmacists
- Med Mgmt redesign is focused on Transitions

**EXTERNAL**
- CMO/CNO Alliance across the continuum of care
- New HUP Transitions Collaborative — active operational arm
- Bundled payments and ACOs are on the horizon
- Pay-for-performance contracts
- CMS reduced payments for readmissions is on the horizon
- Public reporting influences patient choice
- Payers willing to fund follow-up programs and negotiate gain-sharing arrangements.

**TRANSITIONS IN CARE**
**for better patient outcomes & reduced readmissions**
We took advantage of Penn’s flagship leadership development program

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

- Innovation
- Strategic orientation
- Execution
- Relationship mgmt

The purpose of Penn Medicine Leadership Forum is to develop leadership skills...

**“Action Learning”**

... and apply them to a strategic system-wide initiative

Each hospital unit team — with homecare and other partners — took up a **project to improve Transitions-in-Care** on their unit.

“Testbeds” — each team tested an aspect of the Transitions Model. They were all over the place, but look at the energy!

**Transitions Projects for Penn Med Leadership Forum**

- Real-time readmission analysis and intervention
- New approaches to interdisciplinary rounding
- House staff awareness of homecare & hospice services
- “Opt-out” for homecare referral
- Follow-up appointments with primary care
- Discharge summary follows patient to post-acute services
- Discharge “time out” safety check
- Patient & family education, with emphasis on self management
- Medication management

**UPHS Transitions Model — Seven “Levers”**
To pull it all together, we turned the teams’ work into an integrated Transitions process for the health system.

<table>
<thead>
<tr>
<th>Preadmission</th>
<th>Hospital Stay</th>
<th>Post-acute Follow-up</th>
<th>Medical “Landing”</th>
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<tbody>
<tr>
<td>Admission</td>
<td>Admission</td>
<td>Discharge</td>
<td>Discharge</td>
</tr>
<tr>
<td>Risk stratification</td>
<td>Screening tool on admission</td>
<td>Daily review of real-time readmissions report</td>
<td>Discharge “timeout” safety check (for selected patients)</td>
</tr>
<tr>
<td>Interdisciplinary rounds</td>
<td>Plan of care looks ahead to post-discharge</td>
<td>Referral to post-acute care as early as feasible</td>
<td>Discharge summary to primary care provider and post-acute services</td>
</tr>
<tr>
<td>Patient and family education</td>
<td>Education for post-discharge care and meds, with emphasis on self management</td>
<td>Med reconciliation on discharge</td>
<td>Schedule appointment with primary care (selected patients)</td>
</tr>
<tr>
<td></td>
<td>Discharge communication</td>
<td></td>
<td>Follow-up phone calls (selected patients)</td>
</tr>
</tbody>
</table>

Build each element into the process as far "upstream" as possible — prior to admission where that makes sense.

Now we’re asking “temporary owners” of each core element to figure out the details and carry it forward.

For example ...

<table>
<thead>
<tr>
<th>Core Element of the Transitions Process</th>
<th>&quot;Temporary Owner&quot; to Carry it Forward</th>
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<tbody>
<tr>
<td>Screening tool on admission</td>
<td>Workgroup already underway</td>
</tr>
<tr>
<td>Referral as early as feasible</td>
<td>Discharge Planners</td>
</tr>
<tr>
<td>Daily review of realtime readmissions</td>
<td>Transitions Collaboratives</td>
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The overall Transitions process will **build over time**.

Some parts of the process will **start before others**.

**Not everything needs to develop at the same speed.**
“Mobilizing other people’s energies” — lessons learned

- By tapping into other people’s energies and projects, you can create results and critical mass as you go.
- You get change that sticks, because people are creating it themselves.
- You don’t have to do all the work yourself.
- Your job is to align what might otherwise work at cross purposes.

Tapping into other people’s energy and momentum creates “pull” for the changes you want to make. Other people pull the changes along.

“Acting your way to new thinking” — The story of local leadership

3 Local leadership — two case studies

| Unit based clinical leadership |
| Real-time readmissions feedback |
Three-way partnership is Penn’s “Swiss Army knife” for managing quality on the hospital units

**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

Hospital unit teams take on Transitions — a case study

“Collaboration works”
Real-time readmission feedback is at the heart of Penn’s Transitions model

**Daily Readmissions Report**
- Readmitted patients (across UPHS hospitals), with chief complaint, facility, unit, service, attending.
- Detailed history of previous admissions.
- Full report distributed to Discharge Planners, Home Care and others. Hospital units see a version with their own patients, both “sending” and “receiving.”

**Daily Actions**
- Data available in time to take action.
- Hospital units, discharge planners, and home care work together to troubleshoot specific patients each day.

**Long-term Interventions**
- UPHS is tracking & trending the data.
- Hospital units, discharge planners and home care are changing clinical practice based on the feedback.

**UPHS Transitions Model — Seven “Levers”**

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Real-time readmissions feedback — a case study

“Collaboration works”
“Act your way to new thinking” — lessons learned

- Collaboration at the local level 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 a common problem — and bring our clinical expertise to bear.

Actions create pull for new ways of thinking about each other. It’s easier to “act your way to new thinking” than to think your way to new actions.

Q&A — We welcome your questions, thoughts, & experiences
It’s not about managing another change project. It’s about changing the way we work.

“Campaign” approach to change

1 Early Results that Build Momentum — the “Quiet Phase”
   - How do we figure out the changes that need to happen?
   - Set a “clear enough” direction?
   - Do the work that builds momentum?

2 Sweeping People In
   - How do we spread the changes across the system?
   - Keep things aligned?
   - Deal with the complexity?

3 Embedding the Changes
   - How does this become the new normal?

Result: Change that sticks and the skills to change again in the future
“Pull” is stronger than “push”

If you create pull, others will do the work of change for you.

New behaviors can’t be legislated. They begin to show up when an organization knows how to create pull for them.

A Campaign creates “pull” for new behaviors.

Your organization’s culture is a renewable resource

A useful definition of culture: “The way we do things around here.”

New behaviors are the building blocks of an organization’s culture. Each behavior by itself may be small, but together they can move the organization’s culture.

The raw material for a culture change is almost always already emerging in your organization.
A Campaign is top down AND bottom up

Top down, by itself, lacks the **resilience and creativity of grass-roots efforts.**

Bottom up, by itself, lacks **focus, alignment and the commitment of mainstream leaders** who can give resources.

A Campaign taps the creativity and commitment of the **whole system.**

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**The leadership skills you’ll need may seem counterintuitive**

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<td><strong>Listening and amplifying</strong></td>
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<tr>
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<td><strong>Creating pull</strong> for the changes</td>
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<tr>
<td>Trying to “motivate” or “empower” others</td>
<td>Discovering and <strong>freeing up energy</strong> and passion</td>
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<tr>
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<td><strong>Acting your way to new thinking</strong></td>
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A few resources — Campaign Approach to Change


To be in touch

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