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# Impact of Improving Throughput in the Emergency Department

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Impact of Improving Throughput in the Emergency Department

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### Dedication/Acknowledgments

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### Abstract

The purpose of this project was to evaluate the patient experience in the emergency department (ED) and in the inpatient setting while correlating increased throughput and patient outcomes at a suburban Acute Care facility in Ohio. The culture in the organization has lacked accountability and ownership of the patients. The ED admitted length of stay (ALOS) was 358 minutes in the beginning of 2013. For the first time in the organization's history, the ED ALOS is now typically less than the recommended benchmark of 300 minutes. A report of findings among ED's surveyed showed the ALOS best practice is 244 minutes with a median length of stay of 309 minutes (Premier, 2006, slide 13). Throughout its recent history, the organization has failed to have a service-oriented approach to patient care. Quality improvement was identified and implemented through a hospital-wide Kaizen event focused on throughput of the admitted patient (Appendix A). According to King (2010), "the Japanese words Kai and Zen literally means "to change" and "for the better", and it has come to symbolize continuous improvement" (slide 5). Teams of individuals ranging from physicians to transporters spent one week of work time focused on the process mapping of the current state and future state of ED throughput. The use of information technology (IT) in the process improvement was integral to performance improvement, patient safety, and consistent ED ALOS less than 300 minutes. The transformation of the culture has aided in the success of maintaining patient throughput

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### Impact of Improving Throughput in the Emergency Department

A toxic culture coupled with inefficiency is a bad mixture in healthcare. This improvement project was performed to evaluate the successes, failures, and significance of changing the culture of the entire healthcare team in order to improve patient experience, outcomes, and throughput. The team was challenged to alter processes based on what is best for

the patient. To make the experience better for patients, performance improvement was the main driver to evaluating and implementing new processes. In addition, the organization failed to have a service-oriented approach to patient care. This project highlighted throughput in the hospital and the perceptions of patient experience in both the ED and the inpatient settings. The goal was to show the positive impact of improved efficiency to the staff and the community to help facilitate and sustain a positive patient experience. The implementation plan for throughput improvement consisted of a culture transformation to support what is in the best interest of the patient. In transforming the organizational culture, staff was challenged to own their patients where ever the patient was geographically located in the building. This ownership was established through accountability and tracking of the “pulling” of the patients to their respective home departments. The increased awareness of “patient first” did not only assist with throughput goals but also assisted with patient experience. All throughput metrics were evaluated through the electronic medical record (EMR) and bed tracking system (Awarix). All patient experience metrics were evaluated through Press Ganey and the value based purchasing points obtained by the hospital in all eight domains with emphasis on communication with nurses, communication with physicians, overall rating of care, discharge instructions, and explanation about medications. All throughput metrics were evaluated on a weekly basis by unit for a five month period of time. Press Ganey scores were evaluated and correlated to each inpatient unit and in the ED with a 6 week lag time from implementation.

## **Background**

The admitted length of stay in the emergency department of this acute care facility began in 2013 at 358 minutes. The organization had struggled with patient flow due to limited physical space, lack of processes, and accountability. In addition, the healthcare team never had made throughput a top priority. The culture lacked any metric driven goals and collaboration among

departments to achieve the goal of placing a patient in an assigned bed in less than 300 minutes. In addition, the culture appeared to lack ownership of the patient and acceptance of the value in good patient outcomes. The emphasis on the patient experience and family centered care was sub-optimal. The organization had struggled to meet the targeted value based purchasing points (VBP) required by the health system. According to Shoemaker (2011),

The Hospital Value-Based Purchasing (VBP) program, administered by the Centers for Medicare & Medicaid Services (CMS), marks an unprecedented change in the way Medicare pays healthcare providers for their services. The VBP seeks to reward hospitals for improving the quality of care by redistributing Medicare payment among them so that hospitals with higher performance in terms of quality receive a greater proportion of the payment than do the lower performing hospitals (p.61).

Year after year they had fallen short of the target 26 and 28 VBP's goal. Prior to the project, the organization sat at 23 VBP's and 72 points in overall rating of care (See Appendix B for detailed explanations of the VBP program). Development of defined metrics and processes that support accountability were needed to improve ED ALOS and patient experience. The EMR and bed tracking system were used to obtain specific metrics on decision to admit, admission to orders, orders to bed request, bed request to bed assignment, and bed assignment to exit (Appendix C-H). In addition, metrics associated with discharge times and housekeeping turnaround were evaluated when reviewing total ED ALOS. As a result of these findings, the organization developed very clear goals around each metric. All departments involved in patient flow owned a piece of throughput and the defined metrics to successfully meet their goals. Processes were developed in each area using Lean Six Sigma principles to assist with metric driven goals deployment. Use of these metrics assisted with accountability and collaboration in moving patients through the system to improve the patient experience, efficiency, and patient outcomes.

Once processes with throughout improved, the organization was challenged to sustain the ED ALOS and improve patient experience across the whole hospital. In this project it was hypothesized that culture and throughput greatly impact the patient experience and patient outcomes. Given the tumultuous state of healthcare, predictions and future state processes were hard to develop. The transformational nature of healthcare delivery models makes it difficult to become too attached to any process. Flexibility and adaptability to these changes are necessary.

The organization has struggled with transition in many areas of service and the culture has not supported or nurtured change. The main issue with the culture was the lack of patient centered decision-making and focus. The organizational culture did not put the patient at the forefront of all decisions that impacted how care was delivered. The objectives of this project were to 1) change the culture to a more supportive and nurturing environment that accepts innovation, transparency, and excellence, 2) identify and remove the barriers to fixing the culture, 3) implement and collaborate with both physicians and nursing staff to transform the culture, and 4) improve the overall experience for patients and families. A key initiative during this project was to provide supportive evidence that the shift in culture would assist with hospital throughput and patient satisfaction. Furthermore, the culture transformation would also facilitate increased physician and employee engagement. Although the hospital faced challenges associated with physical space, many opportunities existed to improve processes, collaboration among the healthcare team, and shift the main focus to the patient. The synergy created an environment that fosters nurturing, innovation, and excellence. This newly created environment then produced efficiency, satisfaction, and engagement.

The project took place at an acute care adult hospital in Ohio. The key stakeholders consisted of patients, patient families, physicians, community, employees, leadership, and various vendors and partners for care delivery. In order to move the organization forward, the

employees, leadership, and physicians had to set the stage for a cultural transformation. This transformation positively impacted the perception in the community, the work environment, and the desire for other healthcare departments to want to partner with the organization. During January of 2014, the organization began a series of steps towards transforming the culture to one that is more patient-centered and patient-focused. This was accomplished through training, self-learning, intense rounding on patients' families, and employee focus on quality operating systems, goal deployment methodology, employee engagement, multidisciplinary rounding, discharge rounding, accountability huddles, and co-rounding between physicians and nurses. Several initiatives were implemented to assist with collaboration, culture change, and patient experience. Senior leadership committed to weekly rounding for patient experience and quality/safety issues (See Appendix I). The team also committed to daily discharge rounds and an auditing system across the organization to reach at least 90% of the discharges (See Appendix J). Some specific initiatives that were put in place across the organization were a discharge checklist, medication stickers, the MD rounding button on the call light system, and the overall rating of care. Following the implementation of these key areas, the culture and patient experience scores were re-evaluated for improvement and consistency.

### **Problem**

The problem with the culture in this organization was that it did not have the patient as the center of decisions and processes to improve patient outcomes and hospital throughput. The healthcare delivery team never embraced the value of throughput and the effects that efficiency had on the patient experience. The hospital had historically struggled with physician and employee relationships. Patient centered care had not been a primary concern and healthcare providers had argued about different tasks and who is responsible for follow through. In addition, dealing with issues and complaints was a fear for many in administrative positions.

The lack of transparency and openness to this feedback made transformation and change difficult to lead. This type of culture had made it difficult to implement innovative ideas to transform the healthcare provided to the community. The organization continued to fear transition, transformation, and any type of change so this project was very challenging at all levels. Employees and physicians struggled with making changes to behaviors and practices. Many practice changes that seemed to be implemented in other organizations were difficult and resisted by the healthcare delivery team. Historically, the relationships between hospital administration, physicians, and employees had been non-collaborative and strained. When transition had been attempted in the organization, complaints from healthcare providers caused the need to abort the change. Accountability by both physicians and staff was strongly resisted and the perception in the community was negative compared to other healthcare organizations. This behavior created a culture of decreased accountability and lack of innovation. The organizational culture needed to be focused on changing professional behaviors in clinical practice. Theoretically speaking, the culture was socially awkward and unsupportive for patient and family centered care. These challenges with culture impacted the employee engagement, physician engagement, patient experience, and hospital throughput.

### **Intended Improvement/Purpose of Change**

The purpose of this project was to lead a change of culture and correlate patient throughput with patient experience and patient outcomes. The hope was to sustain throughput improvements while creating a culture far less resistant to change and more embracing of constant evaluation and evolution of processes. The dependent variables were throughput times for admitted patients and the value based purchasing points earned by the hospital. The independent variables were changes in processes and behaviors of the employees within the culture. These behavioral and cultural changes drove the outcomes of the project. According to

Yoder (2011), “Creating an environment that exceeds customer expectations is what it is all about; however, it is something that healthcare has been slow to warm up to and accept” (p. 43). The perception by the patients, based on patient experience scores and comments, were that the staff lacked any urgency in processing the patients in a timely fashion. This perception affected the experience scores and the perception of the overall care at the hospital in the community.

### **Review of the Evidence**

Based on The John’s Hopkins Nursing Evidence Based Practice (JHNEBP) Tools, all articles used in the project were evaluated and measured for level and quality. As stated by Hunt (2012), “Evidence-based practice has become the accepted term for a systematic approach by all healthcare professionals to service provision” (p. 8). The JHNEBP offers five levels of the strength of the evidence presented in the article. The tool also measures the quality of the scientific evidence using an A, B, C grading system. The strength of the evidence is measured as follows: level one is the highest representing experimental studies with randomized controlled trials (RCT) and meta-analysis of RCT’s, level two is quasi-experimental studies, level three is non-experimental studies, qualitative studies, and meta-synthesis, level four is systematic review and clinical practice guidelines, and level five is organizational, expert opinion, case study, and literature reviews. The quality rating for levels one through three is specific around appraisal of evidence that is research driven. The ratings go from high quality (A rating), good quality (B rating), to low quality or major flaws (C rating). Levels four and five are specific to the measurement of non-research driven evidence. The levels are also measured using a quality rating tool. They are also an A, B, C rating associated with high, good, and low quality (“Johns Hopkins Evidence-Based Practice,” 2014). The strength and quality of the evidence is displayed in Appendix K.

The length of stay in the ED is perceived as a key factor in ED overcrowding (Gardner, Sarkar, Maselli, & Gonzales, 2007). Many components contribute to ED overcrowding and instituting streamlined processes is viewed as an important consideration when attempting to improve times. As stated by Gardner et al. (2007), “Many emergency medicine physicians attribute suboptimal health care quality to chronically overcrowded departments, and the Institute of Medicine has recently issued a report describing a “national epidemic of overcrowded EDs” (p. 643). The quantification of the factors that contribute to long lengths of stay is not clearly defined. Several pieces of the process can be broken down and evaluated for bottlenecks in the systems. “Emergency department length of stay is usually defined as the time from when the patient registers in the ED to when the patient physically leaves to go home, to another facility, or to a hospital bed” (Gardner et al., 2007, p. 643). While some literature has focused on quality, others have focused on the financial/opportunity loss to the organization and decrease in inpatient satisfaction when boarding patients in the ED. According to Fee, Burstin, Maselli, and Hsia (2012), “Emergency department crowding has been associated with adverse effects such as the timeliness and quality of care, patient satisfaction, and increased rates of medication errors in both pediatric and adult populations” (p. 481). These components include labor associated with caring for boarded patients and the revenue loss associated with patients who leave without being seen due to wait times (Lucas et al., 2009). According to Lucas et al. (2009),

Significant amounts of time are spent boarding inpatients in the ED in a variety of hospital types and in different communities across the United States. In four of the five hospitals in this cohort, over half of all ED admissions board more than two hours after a request for an inpatient bed (p. 122).

Other organizations worldwide have attempted to set timeframes on the length of stay, rather than breaking up the components of the ED visit. England federally mandated hospitals to



complete admissions within four hours. As stated by Mason et al. (2012), “Targets and performance measures are increasingly being used to ensure quality (and value for money), but they run the risk of unintended negative consequences such as gaming or cheating, effort substitution, or distortion of clinical priorities” (p. 342). Findings have suggested that introduction of a four hour time limit has assisted in managing the proportion of patients within that timeframe (Mason et al., 2012).

According to White et al (2012), “the overall LOS of patients discharged from the ED increased by approximately 10% as the boarder burden increased” (p. 232). Therefore, the longer the admitted patients stay, the more likely the discharged patients will be delayed as well due to the workload of care providers. This causes major dissatisfaction with patients who are ready for discharge and leaves a negative impression in the final segment of the hospital stay. As stated by Pines et al. (2008), “Patient satisfaction is an important endpoint and a central goal of medical care. From a marketing standpoint, satisfaction is important because it allows organizations to maintain market share by generating repeat business through word-of-mouth referrals” (p. 829). Waiting for a bed in the hospital is stressful for both the patient and the family. As White et al. (2012) states, “as anyone who has ever waited on hold for customer service, or stood in line at a supermarket can attest, the downstream effects of an overburdened server can have up- or downstream effects on any patient in that process queue, regardless of their eventual disposition” (p. 233). The literature definitely suggests that the longer an admitted patient is in the ED, the longer all patients are in the ED. As stated by Henneman et al. (2010), “Crowding is at least partially due to both admitted patients and those ultimately discharged staying in the ED for a prolonged period of time” (p. 109).

Organizational culture and the challenges with transformation and change exist across many industries. Much of the literature supports the concepts and realities of the impacts of

organizational culture both on employee engagement and customer service. As stated by Rakichevikj, Strezoska, and Najdeska (2010), “Man creates culture in his work, which means that the work is a basic cause of culture.” (p. 1168). All organizations should adopt a code of ethics and code of conduct to elevate and support management within the culture. The working conditions of the organization partnered with ethical standards yield a positive culture and successful business outcomes.

Organizational culture is highly symbolic of the beliefs, values, and engagement of the employees. Some reviews conducted have attempted to identify objectives and strategies that contribute to the improvement of organizational culture and healthcare performance. According to Parmelli et al. (2011), “Organizational culture is an anthropological metaphor used to inform research and consultancy and to explain organizational environments” (p.1). The methods used in their study were a thorough review of an electronic database system for reviews and studies around organizational culture and interviews with experts in the field. None of the methods yielded any strategic objectives that had been used to positively change an organizations culture to improve healthcare outcomes. Recommendations for further research suggested that more reliable measurements of organizational culture should exist to strengthen the evidence of this topic (Parmelli et al., 2011).

Creating an environment in healthcare that focuses on patients and their families is integral to providing an excellent patient experience. In addition, patient and family centered care nurtures improved health and well being. Planetree Designated Patient-Centered Hospitals represent the highest level of designation in patient-centered care. Windber Medical Center, which is a Planetree Designated Patient-Centered Hospital, is an organization that has shown a strong correlation between a patient-centered care culture and patient satisfaction (Cliff, 2012).

Healthcare organizations need to focus on efforts to meet the needs of patients and families. All focus and decisions should be around the needs of the patients rather than the hospital and its employees. Federal healthcare reform is requiring hospitals to provide high quality care with fewer resources. Patient-centered care has proven to improve efficiency, satisfaction, and outcomes. According to Cliff (2012), “Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles” (p. 86). The ideal patient experience yields better outcomes and higher likelihood that patients and their families will return and commit to the brand. The linkage of the optimal patient experience to the brand creates a competitive advantage for the organization. Ultimately, connection to the brand facilitates a positive patient experience that yields commitment and return to the organization (Weiss & Tyink, 2009).

Patients and families have the innate need to feel safe, nurtured, and cared for in the hospital. Creating that environment of compassion and caring while remaining calm is integral in gaining trust and loyalty from the patients. All employees of the organization must adapt the culture and behaviors. It is about having the right values and the right culture (Snell, 2012). Healthcare is moving more towards an industry of customer service similar to the hotel and theme park industries. The most important component necessary when embarking on this cultural change is the right people and the right leadership. The leadership must be in full support for the organization to make this transition. Once leadership is reliable and accountable, it is essential that the right people are hired to work in the organization. The attributes during the hiring process are now more focused on personality traits and specific behaviors that are necessary to accomplish the customer service expectations. According to Yoder (2011), “Patients are scared, worried, stressed, and uncertain. They want communication, explanations, answers, compassion, and excellent care” (p.43). Changing culture and holding people

accountable within the organization assists in accomplishing these critical components of the patient experience. Sustaining and maintaining consistency is the key to impeding the culture into the everyday work environment.

### **Conceptual/Theoretical Framework**

The first conceptual theoretical framework used for this project was Kotter's eight step change management model (see Appendix L). This change management model consists of 1) Increase the urgency for change, 2) Build a team dedicated to change, 3) Create the vision for change, 4) Communicate the need for change, 5) Empower staff with the ability to change, 6) Create short-term goals, 7) Stay persistent, and 8) Make the change permanent. According to Bencivenga (2002) in an interview with Kotter, "Most corporations today are overly managed and underled. Management and leadership have two distinct, fundamental purposes. Management is about coping with complexity. Leadership is about coping with change" (para 8).

The second conceptual theoretical framework used for this project is the American Association of Critical Care Nurse's Synergy Model for Patient Care. According to Masters (2012), "The Synergy Model is a conceptual framework for designing practice competencies to care for critically ill patients with a goal of optimizing outcomes for the patients and families" (p. 76). The goal is to match the patient and family needs with the competencies of the individuals providing the care. The conceptual model supports patients and family centered care. As part of these goals, the organization operates using the Magnet Principles associated with shared leadership. The employees have adopted the model of patient and family centered care as guiding principles in the decision making process. This supports a culture with the patient at the center of the decision-making. This mind-set encourages care providers to think about how decisions, practices, and changes affect the patient.

### **Ethical Issues**

The speculated ethical concerns with the performance improvement project were around pushing patients through the system too quickly. Many of the concerns were alleviated once the Kaizen event took place. Given the philosophy behind a Kaizen event, in addition to using small tests of change for improvement, many of these misconceptions were eliminated. Shared leadership and boundaries to support making decisions and improving practice really set the stage for the changes. Furthermore, physician alignment and testing among the physician groups produced results and improvement. The outcomes created a “buy-in” from the healthcare team that was an assurance that the patients’ best interest was always at the forefront of any changes.

### **Setting**

The project took place in an acute care hospital in a suburb of Ohio. The organization is part of a large health system that has five acute care hospitals in the same city. Historically, the organization had never made throughput a top priority. Phase one of the project was illustrated earlier in Appendix A. Phase two of the project is illustrated in the project timeline in Appendix M. Both phases are illustrated using a Gantt chart. A Gantt chart is often used as a project timeline to illustrate action items and timeframes of completion. By its actions (or inactions), the organization’s culture has fostered a lack of accountability and ownership of the patients. In addition, the healthcare team never worked together to make improvements for the patient experience and practice. Leadership worked in a manner that isolated them from physicians. The leadership also worked apart from the management team. Operations and Nursing worked independent of each other and no concepts related to shared leadership were in place.

### **Planning the Intervention**

The intervention chosen for these issues contained multiple components. Following a thorough analysis of the current state, it was determined that interventions associated with

throughput needed to occur prior to and in conjunction with cultural shifts. The aim of the project was to decrease the admitted length of stay with a goal of less than 300 minutes, increase patient experience scores above 35 VBP's for the hospital and above the 65<sup>th</sup> percentile in the emergency department, and improve pre-OCAI results in the organization by 15%. Given the five focus areas for throughput, specific processes were tested and implemented in order to decrease the throughput time in the ED. The culture was assessed using the Organizational Culture Assessment Instrument (OCAI) located in Appendix N. The OCAI is an assessment tool that is a validated research method to assess organizational culture that was developed by Kim Cameron and Robert Quinn. According to Suderman (2012), "The tool, the Organizational Cultural Assessment Instrument (OCAI), was developed by Cameron and Quinn (2006) as a means for organizations to quantify organizational culture" (p. 52). Many steps were taken to change the behaviors, processes, and culture within the organization. The leadership began by reviewing the information with the management team, physician leadership, and staff members. A desired culture was established among the groups. The staff members developed a shared leadership structure with the leadership team. Processes that worked for frontline staff members were established to improve throughout and the patient experience. The physicians developed a co-rounding initiative through a hospitalist-RN task force. This was specifically done to build relationships within the healthcare team and make the experience for the patients and families much better. The leadership made a decision to hold themselves and their staffs accountable to the initiatives and processes established to improve performance. Through these commitments individuals who could not embrace the need to transform became casualties of the project. Teams for improving the patient experience were established at the hospital level as well as the unit level to help implement and sustain initiatives.

### **Implementation of the Project**

Actual implementation of the project happened in phases. The throughput project began in April of 2013. Many processes were developed in order to improve the ED ALOS so that patients and families felt the efficiency and importance of their loved one. Once these processes became the accepted practice with the staff, the ED ALOS began to decline and patient experience both in the ED and inpatient improved. In January 2014, the journey for changing culture began. Although the ED ALOS proved to impact the patient experience, the hospital was faced with closing a unit. Closing one of the inpatient units made it a challenge to sustain throughput. The struggle was to balance elective procedures with available beds for ED patients. Although healthcare is moving from volume to value, the transition has not yet been realized. Therefore volume remains extremely important to the organizations bottom line. When the unit closed, the ED ALOS increased again because occupancy within the hospital increased without the additional beds. In reviewing the data following this change, the ED patient experience was not impacted significantly by hold hours. Therefore, although it had been proven to help inpatient experience, it became evident that when throughput was compromised, the behavior of the healthcare team was critical. The cultural transformation that began in January 2014 was critical to the success of this project.

### **Planning the Study of Intervention**

In planning the interventions it was noted in a detailed plan of how to accomplish the aforementioned processes. The first component consisted of assessing the throughput metrics. A Kaizen event was then performed to assist with improving patient throughput. Even though challenges arose during the beginning of 2014 with throughput, the processes that were agreed upon still stayed in place. One of the inpatient units closed, which impacted the previously improved ED ALOS. After careful assessment, it was determined that even if patients were residing in the ED, the culture was ultimately the key change agent that needed to be focused on

to improve the overall patient experience. Mechanisms to improve organizational culture were put in place with the leadership team. The leadership team made a commitment to each other that owning the patient experience and throughput was instrumental to the success of the organization. Nurse leaders became ambassadors for their patient populations and embraced patients beyond their four walls. It did not matter geographically where the patients were located. The leaders and staff embraced the patients and became committed to providing excellent care and service no matter the location. This transformation and ownership is truly what drove the outcomes in this project. Development of leadership tools to assist with daily processes assisted managers on their journey to own their business and patients. See Appendix O and P for the document that was reviewed and agreed upon by all managers around requirements and accountability. Additionally, those units not meeting the requirements for the patient experience were expected to form patient experience action plans that were presented weekly at the hospital accountability huddle (See Appendix Q). Specific action items were created for each of the eight domains where the target was not being met. These action items were created with the shared leadership teams.

In order to prepare for the culture transformation, the organization began the journey with ED ALOS. Processes were identified for improvement in ED ALOS. These processes were 1) ED arrival to decision to admit, 2) Decision to admit to orders, 3) Orders to ED exit, 4) Inpatient discharge, and 5) Inpatient discharge to room available. Using Lean Six Sigma principles, the organization performed a Kaizen event focused on these five sub-processes. As stated by King (2010), “Kaizen events are a very effective, proven way to make rapid improvements. Six sigma is a deliberate, structured, effective way to develop solutions for sustained improvement” (slide 2). According to King (2010), “the Japanese words Kai and Zen literally means “to change” and “for the better”, and it has come to symbolize continuous improvement” (slide 5). A project



charter was developed using the assumption that the goal outcome metric will be the ED ALOS. The hospital was striving to achieve less than 300 minutes for the admitted patient with constant consideration of right patient, right place, and right time. The Kaizen event was performed during the week of April 15, 2013. The event lasted for five total days. Three master black belt trained six sigma leaders facilitated the event. One of the facilitators was clinical and the other two were non-clinical. The current state of all five sub-processes was mapped during the first and second day of the Kaizen. The individuals that were present for all project teams included physicians, leaders, staff members from ED, inpatient, environmental services, lab, radiology, transportations, registration, IT, clinical supervision, quality, and case management. The executive leadership team was present for the first 15 minutes of each session to hear the report from the day before and provide support and encouragement. The executive sponsors were the East Market Leader/President and CEO as well as the Mercy Health Chief Operating Officer for the entire system.

As shown in the project timeline Appendix M, many events transpired during the project. In the first three months, an evaluation of all phases of the project proposal was completed. During this time, a thorough analysis of the leadership structure was completed. By December 2013, the final leadership structure was decided and the final structure implementation was completed by the end of January 2014. A baseline data collection was performed using the Organizational Culture Assessment Instrument (OCAI) seen in Appendix N. As stated by "Organizational Culture Assessment Instrument Online" (2010) the OCAI tool:

- Gives a validated and quantified image of overall culture as a starting point for change.
- It's timely and focused: It measures six key aspects that make a difference for success, and both assessment and change strategy can be done quickly.

- It's inclusive, as it is easy to include all the personnel and gives an idea of employee satisfaction, based on discrepancies between current and preferred culture.
- It's manageable with a step-by-step method for change that involves as many employees as you want, while no outside experts are needed.
- It supplies a clear vision on the preferred culture that can be adapted to become a road map for change that will mobilize your organization to sustainable change.

Following baseline data collection, the leadership team attended a retreat with explicit information about changing organizational culture. Weekly meetings were and continue to be attended by all management staff to discuss patient experience, productivity, and culture transformation. In addition, all leaders assist with patient experience and employee engagement rounds on every inpatient unit and the ED once per week. Follow-up will be provided weekly with all issues that were raised the week prior. Leaders will also create a working schedule that allows them to round on their own unit once per pay period and the opposite weeks will be covered by the clinical coordinator in the department. In addition, night rounds are performed every Thursday by a team of leaders across the organization (See Appendix R). All nursing leaders will participate in the American Association for Critical Care Nurses (AACN) Essentials of Nurse Manager Orientation (ENMO). The modules will enhance the confidence and knowledge of the nurse manager to function at a higher level and build communication skills. The cost for the ENMO is being funded by Catholic Health Partners (CHP) for professional growth and knowledge of the leadership staff. This has been approved and agreed to because the internal education for new leaders is suboptimal. The cost of this program is \$10,000 for 15 nursing leaders. In addition, nurse leaders will be working on these modules at work; therefore, there will be a labor cost associated with time used to complete the modules.

### **Methods of Evaluation**

Data collection for this project began in December 2013. Retrospective patient experience data was collected in the inpatient and emergency departments which was studied and evaluated. All domains were studied with specific emphasis on overall rating of care, communication with nurses, and communication with physicians, discharge instructions, and explanation of medications. The measurements for overall rating of the hospital and overall rating of ED care was evaluated and utilized as baseline data. A SWOT (Strength, Weaknesses, Opportunities, and Threats) analysis was performed to demonstrate the current state of culture and throughput prior to the beginning of the project. This analysis was used to assist with identifying focus areas for improvement.

#### *Strengths*

Several strengths were identified in the emergency department. The first strength was staffing ratios and standards related to skill mix and job descriptions. The ED had a balanced compliment of RN's, medics, physicians, and ED technicians prior to the start of the project. This balance allowed for flexible staffing and appropriate levels of care delivery based on patient needs. Secondly, the new physician group had brought an ED model called the physician in triage (PIT). The PIT crew is a team consisting of an RN, tech, and MD. This team quickly triages patients in the front area and identifies patients quickly who can begin work up or be treated immediately using the "treat and street concept." The third strength is the longevity of staff members and team work. The team had good working relationships with one another and mutual trust. This made the work environment extremely pleasant and inviting. The culture among staff in the department was family-like and supportive.

#### *Weaknesses*

More weaknesses than strengths were identified. Some processes continued to be done the same way because no one had ever encouraged or asked them to change. The ED had many

pieces of technology, including a tracking board and bed management system that were not being used to the fullest capacity. In addition, many phone calls between departments and caregivers inhibited the care and throughput in a timely fashion. The implementation of the electronic medical record (EMR) caused caregivers within the department to decrease the face to face communication. This caused barriers to understanding the plan of care and moving the patient through the system appropriately. Other barriers were the differences between each inpatient unit, triggers for consulting inpatient physicians, engaging case management, awareness of time gaps, the workload of the hospitalists, urgency of moving patients, testing procedures, and accountability. The cultural weaknesses were mostly around the relationships between the ED and inpatient staff. The staff lacked an understanding of the areas and workloads of the other departments.

### *Opportunities*

Some obvious opportunities for the ED were to streamline many processes. Some barriers that existed within the department were because many people struggle with change. The accountability structure needed to be improved. The clinical coordinators and charge nurses struggled holding their peers accountable to changes and process improvements. The final opportunity is to build strong and collaborative relationships among other departments. The ED was viewed in the organization in a negative light. Furthermore, the ED viewed the inpatient departments in a negative light. Both areas lacked mutual respect for each other. Many employees on the inpatient side felt everything revolved around the ED and moving patients. The inpatient departments lacked ownership and accountability for the patients. Instead of viewing and ED hold as an ED patient, the inpatient units had an opportunity to view them as a hold waiting for an inpatient bed. The consistent lack of collaboration caused many

communication barriers and tense relationships. Opportunity definitely existed among both cultures to pull the teams together with the patient as the main focus.

### *Threats*

The largest threat in the ED was the potential for turnover and decreased employee engagement. Many employees were hesitant for change and process improvement. In addition, the ED volume was low and the inpatient volume was high. The idea that ED care may need to shift to inpatient care was extremely unpopular among the ED staff. The ED was operating at a higher productivity standard due to the hold hours. With the predicted improvement in flow the staffing would need to be lowered. The inpatient units were holding beds and delaying admissions based on their own workflows. The threat was the loss of staff when holding nurses accountable for the new workflow. The largest threat to the cultural transformation was the employees who were openly in opposition to the changes. The concern was that the culture would prevent the strategy and implementation from succeeding. In order to prevent these behaviors, leadership had to be committed to the accountability of the processes.

The patients were measured through the Press Ganey Survey that was already used for all inpatients and ED patients. The overall rating of the hospital care on inpatient and top box score in the ED was measured for baseline data and then re-evaluated following the project period. There is a six week lag time with Press Ganey scores, therefore the pre and post patient experience data is delayed from the implementation of strategy. The data collection for the project will begin April 1, 2014 and will extend through August 31, 2014. This will provide 5 five months of data to show progress and improvements. Detailed records on each unit (inpatient and ED) were kept to ensure any and all methods of improvement are documented and accounted for to correlate with scores.

Detailed control charts with the Press Ganey data will be available and studied to observe improvement in each department (See Appendix S). These control charts represent value based purchasing points obtained by a unit. The control charts will be specific by unit and domain. These control charts allow departments to measure each domain and the interventions used to increase the scores. Scores are delayed by six weeks; however, the control chart displays trends and correlates them to the specific initiatives to increase the top box scores. The organization will consider a three month positive increase as a sustainable trend. When identifying a positive trend, the organization will commit to sharing the best practice in that domain across every department. The goal is for our patients to get the same experience no matter where they are located geographically in the hospital.

A baseline data collection was performed using the Organizational Culture Assessment Instrument (OCAI). This assessment was performed the last two weeks of December 2013. The baseline data showed a total score of 13,335 with a preferred total of 9,600. Results for the baseline data are seen in Appendix T. Originally, the survey was performed online; however, due to limited resources it was decided to use a paper tool. Two administrative assistants compiled the data for the pre-collection period. Survey monkey was used for the second data collection period. The difference in returned responses was much higher in the post-collection period. It was hypothesized that the ease of performing the survey electronically assisted with participation rate.

### **Analysis**

The team was evaluated again September 15, 2014 for a two week period of time for post-implementation data assessment. Following baseline data collection, the leadership team attended a retreat with explicit information about changing organizational culture. Weekly meetings were attended by all management staff to discuss patient experience, productivity, and

culture transformation. In addition, all leaders assisted with patient experience and employee engagement rounds on every inpatient unit and the ED once per week. Follow-up was provided weekly with all issues that were raised the week prior. Leaders created a working schedule that allowed them to round on their own unit once per pay period and the opposite weeks were covered by the clinical coordinator in the department. Data collected during weekly rounds was aggregated and compared to baseline issues that were reported retrospectively in the third quarter of 2013. The average amount of barriers identified per unit per week during the baseline phase was eight. The goal was to reduce identified barriers by staff by 25% from the baseline data. This data was collected weekly during rounds and aggregated and reported by the two administrative assistants (See Appendix U). The data consists of a series of questions leaders ask employees during the rounds. These questions are specific about the operations and initiatives in each department. The team discussed the current issues and what the target was for the initiative. This information facilitated the discussion on small tests of change that was occurring around the facility regarding throughput and patient experience improvements. The team identified barriers and discussed how these barriers can be addressed to support the future state. The information was gathered and kept in a central shared file on the computer. The follow-up and trends were tracked by the administrative assistants to help with follow-through and performance improvement. Throughout the project different methods of data collection ranged from survey monkey, EMR, Excel, Bed-Tracking, OCAI paper tool, and Press Ganey. All of these methods are well documented for use in data collection.

### **Program Evaluation/Outcomes**

Accomplishing the aforementioned objectives assisted with the improvements in patient experience and culture. The cultural transformation was measured by admitted length of stay with a goal of less than 300 minutes and patient experience scores above 35 value based

purchasing points for the hospital and above the 65<sup>th</sup> percentile in the emergency department. The expected outcome was that there is a positive correlation between these metrics. The organization was looking to obtain five VBP's in at least four domains: communication with nurses, communication with physicians, explanation about medications, and discharge instructions. These results for 2013 and 2014 are provided in Appendix V. The organization obtained six points in communication with nurses, zero points in communication with doctors, three points in explanation of medications, and three points in discharge instructions in 2013. The results for 2014 include six points for communication with nurses, three points for communication with doctors, five points in explanation of medication, and ten points in discharge instructions. The organization achieved 23 VBP's in 2013. In 2014, the organization has 38 VBP's.

In addition, Appendix W shows the results by unit since the cultural transformation was being measured in 2014. The results show that the organization is meeting the internal target of 28 VBP's for the first time on every unit. The other domains, not being measured for this project, also were positively impacted by the work performed in the key domains. As patients move through the system efficiently, patient experience was positively impacted. Shifting focus and behaviors within the culture drove the efficiency and patient experience both inpatient and ED.

Employees were encouraged to perform the OCAI tool pre and post during a two week identified period of time. The tool was available through the leadership staff in each department. The goal for the organization was 30% participation from employees, leadership, and physicians for both pre and post data. Approximately 300 people were needed to participate in the survey in order to meet the participation goal. Although the participation goals were not met, the pre and post data had greater than 30 participants. The post-collection results for 2014 are seen in



Appendix X. The total score went from 13,335 to 12,426. There was a 33% change to the positive under adhocracy and 1% changes to the positive in hierarchy. The patient experience was measured through the Press Ganey Survey that was already being used for all inpatient and ED patients. The likelihood to recommend top box score in the ED was measured for baseline data and then re-evaluated following the project period. For inpatient data, we measured VBP's achieved for communication with nurses, communication with physicians, discharge instructions and explanation about medications. There is a six week lag time with Press Ganey scores, therefore the pre and post patient experience data was delayed from the implementation of strategy. Detailed records on each unit were kept to ensure any and all methods of improvement were documented and accounted for to correlate with scores. Detailed control charts with the Press Ganey data will be available and studied to observe improvement in each department.

During the data review, evaluation of some key components that impact patient experience occurred. The organization was challenged with closing a unit in November of 2013, which negatively impacted patient throughput and patient experience. We knew that the longer the patient waited in the ED, the more likely they were to have a bad experience throughout the stay. Therefore, we implemented many strategies to prevent wait times from impacting the experience. Key strategies have helped improve patient experience despite wait times; however, the ED patient experience scores initially declined with the increase in hold hours. It was originally speculated that the scores were decline because the ED nurses were too busy with hold patients. After further investigation, it was determined that the correlation does not exist. As seen Appendix Y, there is no correlation with patient experience in the ED and whether or not the ED is holding inpatients. We looked at all scores at three and below and matched the number of hold hours. We also looked at surveys at different times of the day and days of the week. We found that most of the poor scores were in the evening and that this did not correlate with hold

hours. We did determine that there was a correlation by provider. There was not a pattern with the nurses; however, there was a pattern with the physician or mid-level provider. The patients were more likely to score a five if they were seen by a physician. Therefore, although there is a positive correlation with inpatient scores, it does not impact ED scores. Culture and processes became more important and much more valid as direct impacts to the patient experience. Once the ED staff embraced these facts, ownership became easier to sell. As seen in Appendix Z, the ED scores are climbing regardless of ED ALOS. In fact, July marked the highest ED ALOS for the organization at 312 minutes yet the ED patient experience scores were 65.2%.

Based on improvements led by this project, the organization was asked to present to the Ohio User Group regarding these findings. As seen in Appendix AA, Press Ganey asked the organization to present at the Ohio User Group Webinar highlighting improvements in patient throughput and patient experience. The presentation reviewed the ED ALOS and the indirect impact it has on the patient experience domains. The issues, methods, strategic approach, and measurable outcomes were discussed during the webinar. There was an opportunity to share changes in the culture and how that has impacted the patient throughput. Many organizations across Ohio have reached out to the team as a result of this webinar to inquire and visit the facility to learn more about our improvement project.

All units have been charged with improving and creating a robust action plan for patient experience. While we were confident the throughput was right thing for the patient, we still had to be able to handle bottle necks and kinks in the system. Initiatives that work and are hard-wired with staff must be consistent at the most challenging times. Again, this mentality was a change in the culture and the understanding that the patient comes first.

The cultural transformation was measured by:

1. Admitted length of stay with a goal of less than 300 minutes.

2. Patient experience scores above 35 value based purchasing points for the hospital and above the 65<sup>th</sup> percentile in the emergency department.
3. Re-evaluation of the OCAI tool will yield 15% improvement or 11,335 (re-evaluation occurred in September of 2014).

The expected outcome was a positive correlation between all the above metrics. As patients moved through the system efficiently, patient experience would be positively impacted. Shifting focus and behaviors within the culture would drive efficiency and a positive experience for the patients. The current ED ALOS for 2014 is 296 minutes. The current VBP's are 38 points and the ED is at 66<sup>th</sup> percentile. The OCAI assessment only yielded a change of 7% rather than 15%.

### **Summary**

Many resources have been reviewed to determine and evaluate the effectiveness of culture changes and shifts within the organization. Patient experience and throughput continue to be a challenge through the transformational times in healthcare. Many resources are attached as appendices to show the data and the evaluable action items to improve and continue to shift culture. Throughout this project transforming the culture seemed to be the center variable needed to make progress in the other areas. Changes in mindsets and workflows needed to happen to be successful. These changes needed to be embraced by nursing and operations. Owning the patient together and as an organization helped focus everyone on the reason we come to work every day. Given the findings of this project, the advanced practice nurse could utilize these process and improvements for clinical and leadership practices. The nurse practitioner, often the mid-level provider in the ED, can use the throughout process improvements to facilitate patient placement and patient experience. The advanced practice nurse in leadership/executive nursing can you use this information to help improve practices for culture and throughput in the

organization. The particular issues that were studied in this project are common issues for acute care facilities.

### **Relation to Other Evidence**

As displayed in the evidence table located in Appendix K, many studies have been performed that validate the results from this project. One study discusses the need to create a culture of extraordinary care. The importance of creating an exceptional experience that coincides with motivated and satisfied employees is critical to the success of culture transformation (Yoder, 2011). The article by Yoder was measured as a level five with a B quality rating. The organization has accomplished this buy-in from staff by implementing shared leadership principles. Another article, “Creating Sustainable Ideal Patient Experience Cultures,” takes it a step further by describing sustainable ideal patient experience culture that encompasses good clinical outcomes (Weiss & Tyink, 2009). The concept that solid cultures contribute to positive outcomes is so important. Furthermore, highly engaged staff assists both with positive cultures and good outcomes.

The use of computer tracking systems and measurable processes is highly supported in several articles. In addition, reduction in boarding patients in the ED reduces the discharge time for the ED patient (White et al., 2012). This research correlated with some of the information we studied related to the patient experience in the ED. It was found that those who were in the ED while there were hold hours took longer to discharge. This delay is due to ED staff being occupied with inpatient admissions in addition to their ED patients.

The most interesting article related to this project, “The Effect of Emergency Department Crowding on Patient Satisfaction for Admitted Patients,” concluded that ED over-crowding does impact the entire patient hospitalization (Pines et al., 2008). This research was a level one (highest) with a quality rating of B. This particular finding was a significant conclusion within

this project. Patient experience scores within the inpatient areas do correlate with ED ALOS. The efficient movement of inpatient admissions from the ED provides more open beds in the ED to reduce over-crowding. According to the article, “Emergency Department Overcrowding and Inpatient Boarding: Statewide Glimpse in Time,” there was a significant relationship with inpatient boarding and ED overcrowding. This research was rated a level one with a quality rating of B. Furthermore, the faster patients are moved to the inpatient unit, the perception seems to be that we care about the overall experience more. Finally, the article “The Effectiveness of Strategies to Change Organisational Culture to Improve Healthcare performance: A Systematic Review”, yielded recommendations of evaluating the culture in the organization prior to just making changes. The OCAI tool does exactly this to evaluate current and desired culture. This article was a level one with a quality rating of B. The results of this project related to some of the evidence that exists and in many ways contributed to validation.

### **Barrier to Implementation/Limitation**

Many changes are prevalent in healthcare today, so the speed and volume of changes were the largest barriers in the project. Change is difficult, especially when it is with a culture that is not used to making changes. Many healthcare providers created barriers in the process. The physicians and nursing staff were the largest problem in the beginning of implementation. We anticipated much of the resistance, so we included them in the planning of the intervention. Another barrier we had was the differences between the operations and nursing teams. We broke down the silos to eliminate some of these barriers. This is still a work in progress; however, it is well known that all areas in the hospital have ownership in change management to improve throughput and patient experience. Another limitation in this study was the number of participants in the baseline data for the project. Although an  $n > 30$  yields statistically significant

results, the participation would have been better if the electronic process was in place in the beginning.

Another limitation in this project was the tenure of the leadership team. In the last two years we have changed the entire leadership structure. In addition, many of the positions have been vacated and new leaders are now holding those positions. Changing a culture is extremely difficult. In addition, holding employees and yourself accountable is a very difficult attribute to have as an inexperienced leader. Many of the current employees have worked for the organization for a long time. Trying to break habits and develop new processes is difficult when the staff have worked together for 20 years or more. Advantages do exist to having a new management team, because the team is typically moldable. The hardest task was to get the team comfortable with holding others accountable without it being punitive. In having this expectation, the leaders were also held accountable to the commitment of the processes. Most importantly, the team was challenged to create a culture that supports mutual respect and shared leadership.

### **Interpretation**

In summary, throughput does impact whether or not patients perceive the experience is a good one. Those patients that score the organization lowest typically had to wait in the emergency room. Those patients that score ED a 4 instead of a 5 may be in the ED when patients are holding. Overall, the culture whether patients are holding or not, needs to be focused on the patient and their needs. When the patient perceives we do not have time for them, the response is typically poor.

The buy-in from the staff and physicians came easily once they saw the benefits of the processes. The throughout yielded more available ED beds and more engaged staff. Nurses who came to the ED to get their patients felt more prepared to take care of the patient and the family

after testing the process. The staff realized the processes really saved time. The improvements in the Press Ganey scores encouraged staff and made them realize the initiatives truly were driving the results. When scores were fluctuating the leadership team understood why and what needed to be done to correct the problem. Physicians became more cognizant of rounding with nursing because it decreased the unnecessary pages and interruptions to their day. They also responded to having their personal scores posted in the physician lounge for everyone to review.

### **Conclusion**

In conclusion, this project was necessary and relevant in this organization. In many ways, the healthcare team was begging for a change. The most obvious engagement of these changes is among the high performers in the organization. In fact, the project has assisted with making the lower performers stick out. The higher performers seem to be much more of the majority now. Certainly, shared leadership has assisted with this engagement. These strides emphasize the need to put the patient and their families first in the process of providing excellent care. The focus and energy around the initial project was a synergistic start to bigger and better changes. The second phase of culture transformation has set the stage for the expectations and accountability expected to provide exceptional care and an exceptional patient experience. Healthcare reform promises to be tumultuous and uncertain for many years to come. Transformation to a culture of adaptability and flexibility has never been more necessary and relevant. Healthcare is now viewed as a service industry and challenged to exceed the expectations. Healthcare is filled with procedures and encounters that invade and display an individual's most vulnerable and private issues. Organizations should feel privileged when a person chooses to come to their health system for care.

### **Funding**

The funding associated with this project is outlined in Appendix AB. The organization was willing to spend the funds over the two year, two phase project, to eventually reap the financial benefits of performance improvement. There were 4.2 additional RN FTE's (full time equivalents) in the ED to accommodate the hold patients that totaled approximately \$305,760/year. The most impactful cost savings was around RN turnover from 25% to less than 15% which yielded \$1.1M. In addition, the increased revenues associated with the payments for value based purchasing points also contributed to the overall savings. Ultimately the cost savings associated with this project were approximately \$1.4M. This total includes all expenses used to prepare and maintain process improvement.

#### References

- Bencivenga, J. (2002). John Kotter on leadership, management and change. *School Administrator*, 59(2), 36-40.



- Cesta, T. (2013). Managing Length of Stay Using Patient Flow - Part 1. *Hospital Case Management, 21(2)*, 19-22.
- Cesta, T. (2013). Managing Length of Stay Using Patient Flow - Part 2. *Hospital Case Management, 21(3)*, 35-38.
- Cliff, B. (2012). Excellence in patient satisfaction within a patient-centered culture. *Journal of Healthcare Management / American College of Healthcare Executives, 57(3)*, 157-159.
- Cliff, B. (2012). The evolution of patient-centered care. *Journal Of Healthcare Management, 57(2)*, 86-88.
- Emergency Nurses Association (ENA). (2006). *Emergency nurses association white paper of holding patients in the emergency department* [White paper]. Retrieved from <https://www.ena.org/practice-research/research/Documents/HoldingPatientsEDWhitePaper.pdf>
- Fee, C., Burstin, H., Maselli, J. H., & Hsia, R.Y. (2012). Association of emergency department length of stay with safety-net status. *JAMA. 307(5):476-482*. doi:10.1001/jama.2012.41
- Felton, B., Relsdorff, E., Krone, C., & Laskaris, G. (2011). Emergency department overcrowding and inpatient boarding: a statewide glimpse in time. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine 18(12)*, 1386-1391. doi: 10.1111/j.1553-2712.2011.01209.x
- Gardner, R. L., Sarkar, U., Maselli, J. H., & Gonzales, R. (2007). Factors associated with longer ED lengths of stay. *The American Journal of Emergency Medicine, 25(6)*, 643-50. doi:http://dx.doi.org/10.1016/j.ajem.2006.11.037
- Henneman ,P. L., Nathanson, B. H., Li, H., Smithline, H. A., Blank, F., Santoro, J. P., Maynard, A. M., Provost, D. A., & Henneman, E. A. (2010). Administration of emergency medicine: Emergency Department Patients Who Stay More Than 6 Hours Contribute to

- Crowding. *Journal of Emergency Medicine* [serial online]. n.d.;39:105-112. Available from: ScienceDirect, Ipswich, MA. Accessed August 10, 2013.
- Hodgins, M., Moore, N., & Legere, L. (2010). Full house: the incidence and impact of boarding admitted patients in the emergency department. *NENA Outlook*, 33(1), 13-15.
- Horwitz, L. I., Green, J., & Bradley, E. H. (2010). US emergency department performance on wait time and length of visit. *Annals of Emergency Medicine*, 55(2), 133-141.
- Hunt, J. (2012). Johns Hopkins nursing evidence-based practice. *Nursing Management - UK*, 19(7), 8.
- Johns Hopkins evidence-based practice. (2014). Retrieved from <http://www.nursingworld.org/Research-toolkit/Johns-Hopkins-Nursing-Evidence-Based-Practice>
- Khare, R. K., Powell, E. S., & Reinhardt, G., Lucenti, M. (2009). Adding more beds to the emergency department or reducing admitted patient boarding times: Which has a more significant influence on emergency department congestion? *Annals of Emergency Medicine*, 53(5), 575-585.
- King, P. L. (2010). *Kaizen events as lean six sigma projects: Rapid improvement with structure and discipline* [PowerPoint slides]. Retrieved from <http://www.iienet.org/uploadedFiles/Webcasts/KaizenPIDWebinar050410.pdf>
- Langhan, T. (2007). Do elective surgical and medical admissions impact emergency department length of stay measurements? *Clinical And Investigative Medicine. Médecine Clinique Et Experimentale*, 30(5), E177-E182.
- Lucas, R., Farley, H., Twanmoh, J., Urumov, A., Olsen, N., Evans, B., & Kabiri, H. (2009). Emergency department patient flow: the influence of hospital census variables on

- emergency department length of stay. *Academic Emergency Medicine*, 16(7), 597-602.  
doi:10.1111/j.1553-2712.2009.00397.x
- Lucas, R., Parley, H., Twanmoh, J., Urumov, A., Evans, B., & Olsen, N. (2009). Measuring the opportunity loss of time spent boarding admitted patients in the emergency department: A Multihospital Analysis. *Journal of Healthcare Management*, 54(2), 117-125.
- Mason, S., Weber, E. J., Coster, J., Freeman, J., & Locker, T. (2012). Health policy/original research: Time Patients Spend in the Emergency Department: England's 4-Hour Rule—A Case of Hitting the Target but Missing the Point? *Annals of Emergency Medicine*, 59341-349. doi:10.1016/j.annemergmed.2011.08.017
- Masters, K. (2012). *Nursing theories: A framework for professional practice*. Sudbury, MA: Jones & Bartlett Learning.
- Organizational culture assessment instrument online. (2010). Retrieved from <http://www.ocai-online.com/www.uiowa.edu/~nrcfcp/dmcrcc/documents/ocai.doc>
- Parmelli, E., Flodgren, G., Beyer, F., Baillie, N., Schaafsma, M., & Eccles, M. P. (2011). The effectiveness of strategies to change organisational culture to improve healthcare performance: a systematic review. *Implementation Science*, 6(1), 33-40.  
doi:10.1186/1748-5908-6-33.
- Pines, J., Iyer, S., Disbot, M., Hollander, J., Shofer, F., & Datner, E. (2008). The effect of emergency department crowding on patient satisfaction for admitted patients. *Academic Emergency Medicine: Official Journal of The Society For Academic Emergency Medicine*, 15(9), 825-831.
- Premier. (2006). *Emergency department benchmarks and best practices* [PowerPoint slides]. Retrieved from <http://www.premierinc.com>.

- Quinn, D., Amer, Y., Lonnie, A., Blackmore, K., Thompson, L. & Malcolm, P. (2012). Leading change: Applying change management approaches to engage students in blended learning. *Australian Journal of Educational Technology*, 28(1), 16-29. Retrieved from <http://www.ascilite.org.au/ajet/ajet28/quinn.html>
- Rakichevikj, G., Strezoska, J., & Najdeska, K. (2010). Professional ethics-basic component of organizational culture. *Tourism & Hospitality Management*, 1168-1177.
- Shoemaker, P. (2011). What value-based purchasing means to your hospital. *Hfm (Healthcare Financial Management)*, 65(8), 60-68.
- Singer, A., Thode, H., Viccellio, P., & Pines, J. (2011). The association between length of emergency department boarding and mortality. *Academic Emergency Medicine: Official Journal Of The Society For Academic Emergency Medicine*, 18(12), 1324-1329.  
doi:10.1111/j.1553-2712.2011.01236.x
- Snell, J. (2012). Get the culture of the organisation right, and good care will follow. *Nursing Standard*, 26(49), 12-13.
- Suderman, J. (2012, Fall). Using the organizational cultural assessment (OCAI) as a tool for new team development. *Journal of Practical Consulting*, 4(1), 52-58.
- Weiss, M., & Tyink, S. (2009). Creating sustainable ideal patient experience cultures. *MEDSURG Nursing*, 18(4), 249-252.
- White, B., Biddinger, P. D., Chang, Y., Grabowski, B., Carignan, S., & Brown, D. F. (2013). Impact of emergency department crowding on outcomes of admitted patients. *Annals of Emergency Medicine* [serial online]. n.d.; Available from: ScienceDirect, Ipswich, MA.  
Accessed August 10, 2013
- Yoder, E. (2011). A culture of extraordinary care: Part 2. *Radiology Management*, 33(3), 43-44.



		<b>ED ALOS &lt;300</b>																					
		<table border="1"> <tr><td style="background-color: yellow;">Spring 2013</td></tr> <tr><td style="background-color: orange;">Summer 2013</td></tr> <tr><td style="background-color: lightblue;">Fall 2013</td></tr> <tr><td style="background-color: lightgreen;">Winter 2014</td></tr> </table>				Spring 2013	Summer 2013	Fall 2013	Winter 2014														
Spring 2013																							
Summer 2013																							
Fall 2013																							
Winter 2014																							
EVENTS		Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14							
<b>SPRING-2013</b>																							
Baseline Data		2011/2012/Jan-March 2013																					
Kaizen Event planning		Jan-April																					
Kaizen Event					April																		
Rail development						May																	
Team development					April-May																		
<b>SUMMER-2013</b>																							
RAIL Maintenance							Jun-Aug																
45 day touchbase with blackbelts							Jun-Aug																
Team touchbases							Jun-Aug																
<300						May	June	July	August														
<b>FALL-2013</b>																							
<290										Sept	Oct												
<280												Nov	Dec										
<b>WINTER-2014</b>																							
<270														Jan									
265-270															Feb								
Maintenance less than 270																Maintain							

Appendix B: Value Based Purchasing Explanation

# VBP

## Understanding Value-Based Purchasing

September 2013

Starting in October 2012, Medicare began rewarding hospitals that provide high-quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. Hospitals paid under the Inpatient Prospective Payment System (IPPS) are paid for inpatient acute care services based on quality of care—not the volume of services they provide.

As the Medicare Quality Improvement Organization for Minnesota, [Stratis Health](#) offers technical assistance and support for Minnesota hospitals to be successful in a value-driven environment.

"Instead of payment that asks, *How much did you do?*, the Affordable Care Act clearly moves us toward payment that asks, *How well did you do?*, and more importantly, *How well did the patient do?*"

Don Berwick

### Measures

The VBP program has 24 measures for FY 2016. Measures cannot be selected for VBP until they have been adopted for the hospital Inpatient Quality Reporting Program and posted on the Hospital Compare for one year prior to the start of the VBP performance period.

### Points

Each hospital may earn two scores on each measure—one for *achievement* and one for *improvement*. The final score awarded to a hospital for each measure or dimension is the higher of these two scores.

**Achievement Points:** During the **performance period**, these are awarded by comparing an individual hospital's rates with the **threshold**, which is the median, or 50<sup>th</sup> percentile of all hospitals' performance during the baseline period, and the **benchmark**, which is the mean of the top **decile**, or approximately the 95<sup>th</sup> percentile during the baseline period.\*

- Hospital rate at or above benchmark: **10 achievement points**
- Hospital rate below achievement threshold: **0 achievement points**
- Hospital rate equal to or greater than the achievement threshold and less than the benchmark: **1-9 achievement points**

**Improvement Points:** Awarded by comparing a hospital's rates during the **performance period** to that same hospital's rates from the **baseline period**.

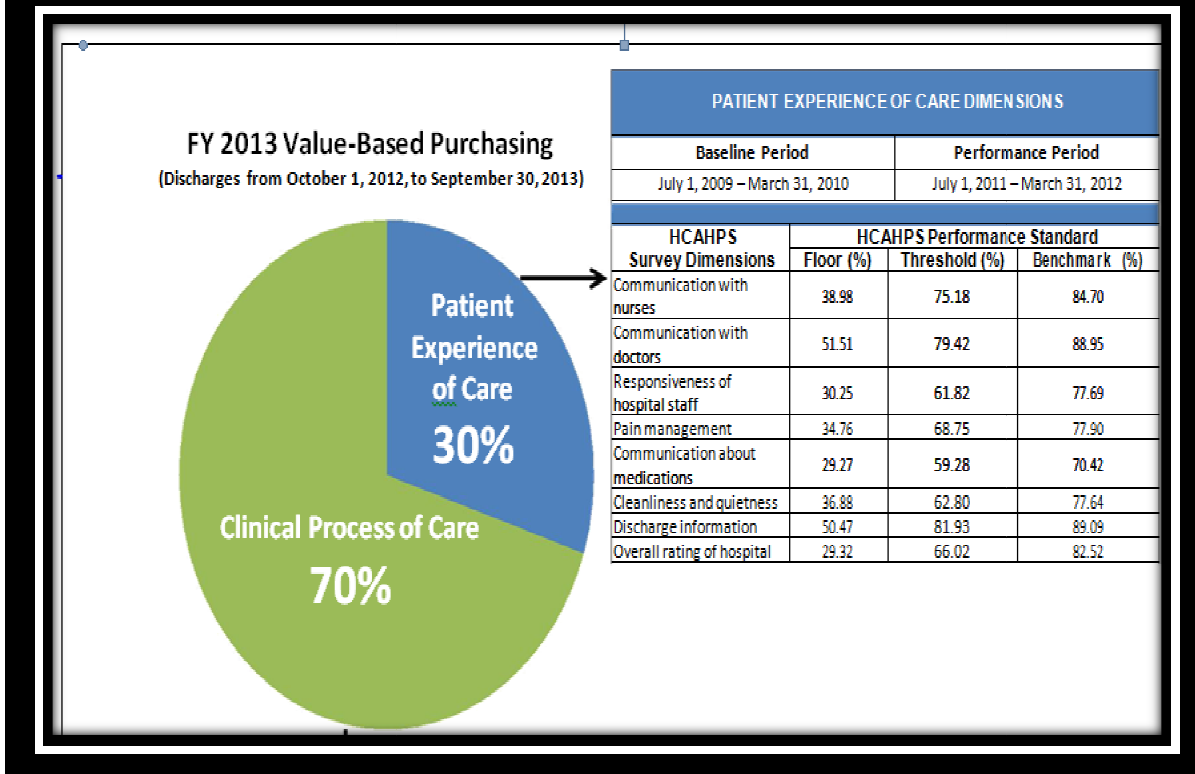
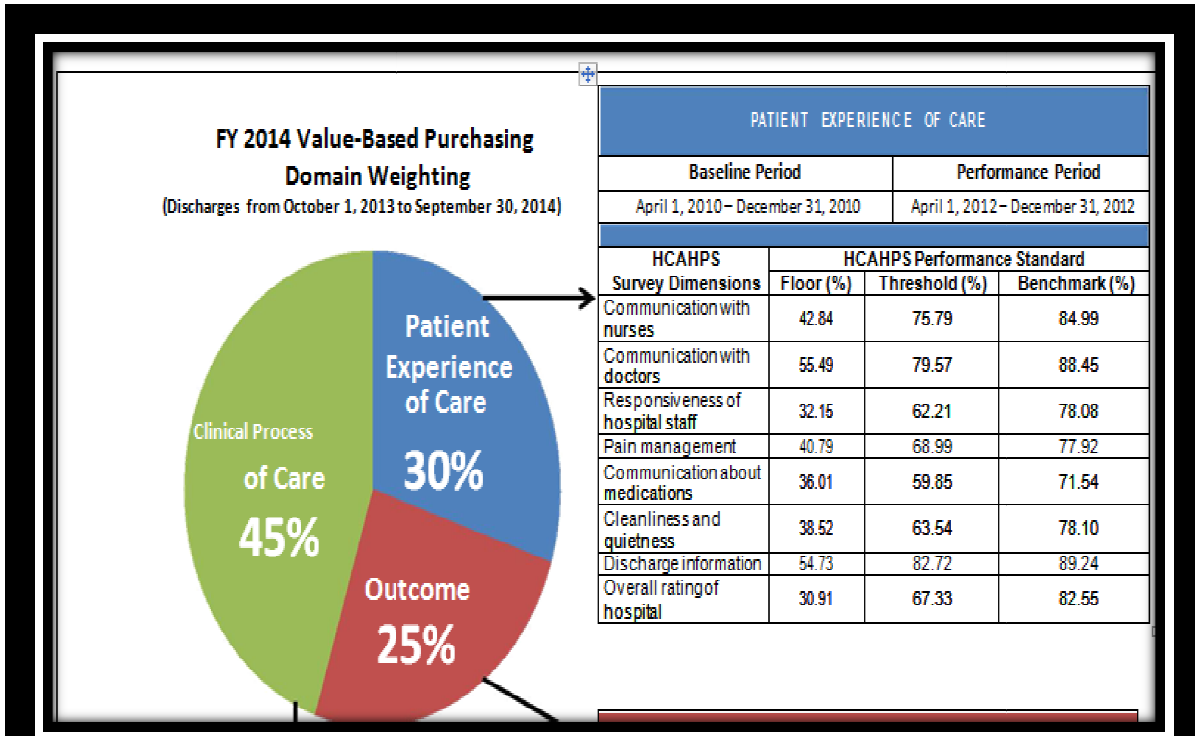
- Hospital rate at or above benchmark: **9 improvement points**
- Hospital rate at or below baseline period rate: **0 improvement points**
- Hospital rate between the baseline period rate and the benchmark: **0-9 improvement points**

**Consistency Points:** The consistency points relate only to the Patient Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50<sup>th</sup> percentile in ALL 8 dimensions of the HCAHPS. If they do, they receive the full 20 points. If they don't, the LOWEST dimension is compared to the range between the national 0 percentile (floor) and the 50<sup>th</sup> percentile (threshold) and awarded points proportionately. This formula is to be used for each dimension to determine the lowest dimension from the performance period:

$$\frac{\text{Your hospital performance period score} - \text{floor}}{\text{National achievement threshold} - \text{floor}}$$

\*For the Medicare Spending per Beneficiary measure, the threshold and benchmark are based on all hospitals' rates in the performance period, rather than the baseline period.

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Appendix C: ED Arrival to Decision

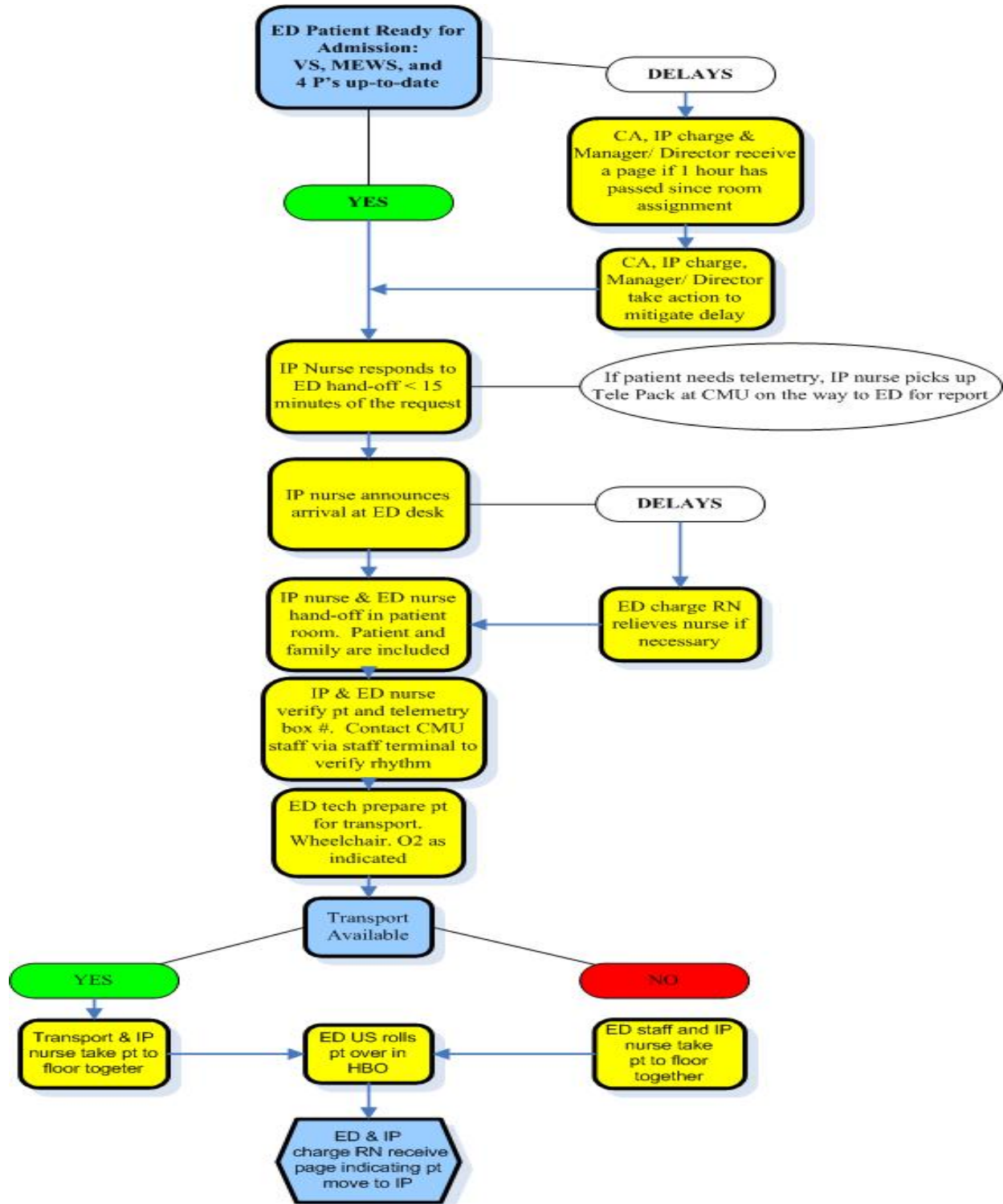
Rolling Action Item List (RAIL)							
FOCUS ED Arrival to Decision		LEGEND: PE: Patient Experience, MDE: Physician Experience, EEE: Employee Engagement, Q: Quality, S: Stewardship					
DATE		4/19/2013					
		Current 194 Goal 160 Savings 34 min					
Initiative	KRA	Responsible	Operational Counterpart	Deliverables	Comp Date	Committee/Status	
1 Mobile PIT team	PE, MDE, EEE, Q, S	Brian Pope	Kathi Edrington	Arrival to Decision: reduce from 194 to 160 YTD end 2013. ED discharge LOS reduce from 180 to 150 YTD end 2013. Counter measure DTP >85% in 30 min		1. Test of change 4/29/13- immediate bedding, triage takes place in room. PIT MD working out of Express area supporting PA flow. LPN/medic monitor WR & sort patients to room. 6/14 BP - Implemented. Utilizing CDs, currently establishing greeter. 2. Install computer work station with Dragon in Express area 4/29/13 3. During non-PIT hrs registrar completes quick reg & calls charge RN for immediate bed placement. 4/29/13	
2 MD preference lists set up with common radiology, US orders	PE, MDE, EEE, Q	Crystal Woodrich Dr Argus	Colleen Dehaan Dr Feagins	Complete by 6/1/13 to incorporate Radiant changes		6/14 BP - Crystal Woodrich list given to Dr Argus.	
3 MD preference lists set up with common RTD orders. Update BiPap orders through MIC	PE, MDE, EEE, Q, S	Cassie Herakl Dr Argus Brian Pope	Jasmine Rausch Dr Feagins Kathi Edrington	RTD treatment preference list complete by 5/15/13. BiPap orders approved by MIC 5/31/13		Dr Argus started updating preference lists on 4/17/13. Progress with a few physicians during the week of Kaizen. 6/10 CRH. No further progress. I spoke with Dr Feagins on 4/19/13 regarding taking the BiPap order change recommendation to the MIC. 6/10/13 CRH- Will not be able to change the BiPap order set in EPIC as it will affect all of CHP.	
4 Creatinine ISTAT trial in lab for all patients with order for CT with IV contrast 5/6 through 5/19/13	PE, MDE, EEE, Q, S	Chad Bahwanz	Linda Savage	Baseline overall ED door to decision 200 min. Reduce to 180 or less on patients involved in trial.		Creatinine cartridges have been validated. Patient testing began on May 6. Also seeing more serum pregnancy testing being ordered by the ED to shorten the LOS. 6/21 CB - working with unforeseen reporting issues involved with changeover to SOFT - will update as soon as possible.	
5 Lab performs POC Serum Pregnancy test if a patient is unable to produce a urine sample within 15 min. (Pending Radiology & US orders only)	PE, MDE, EEE, Q, S	Chad Bahwanz	Linda Savage	Baseline overall ED door to decision 200 min. Reduce to 180 or less on patients involved. Begin 4/29/13		6/21 CB - working with unforeseen reporting issues involved with changeover to SOFT - will update as soon as possible.	
6 Replace patient room PCs with optiplex 7010MT 3rd generation intel cor i3-3220DC 3.3 ghz for consistent bar code scanning	EEE, Q	Brian Pope	Kathi Edrington Will Woodward	Plan for Purchase/Approve. Cost \$700 ea- total cost 21K by 6/1/13. Barcode scanning compliance 90% med, 95% patient		6/14 BP - IT looking at this regionally. Currently investigating changing out computers a few at a time until all are upgraded.	
7 Lab label printer replacement or repair to address label alignment & printer jams	EEE, Q	Chad Bahwanz	Gyasi Chisley	Check warranty status. Engage purchasing to work with vendor. Plan by 5/15/13		6/21 CB - working with unforeseen reporting issues involved with changeover to SOFT - will update as soon as possible.	
8 Radiologist available at 7am & all films prior to 7am sent to Night Hawk for reading	PE, MDE, EEE, Q	Dr Asher Colleen Dehaan	Dr Feagins Gyasi Chisley	Begin 4/29/13 Goal- Test complete to results available 15 min			
9 Improve ultrasound labor productivity	PE, MDE, EEE, Q, S	Colleen Dehaan	Gyasi Chisley	1. Move US volume, equipment & staff from Five Mile to main hospital. Allows for US on both 1st & 2nd floors, reducing transport time. 5/15/13 2. Change US staff from on-call to on site on Saturdays reducing 9 hrs of OT to 8 hr of regular		Replacement of US unit currently used at Five Mile location is a 2013 capital budget request due to age of equipment.	
10 Designated transporters for ED to improve transport times to testing areas- US/CT & IP.	PE, MDE, EEE, Q, S	Brian Pope Cassie Herakl	Kathi Edrington Jasmine Rausch	1. Designated ED transport tech 6a-10a & 6p-6a 2. Designated transporter 10a-6p. 5/11/13 3. Communicate via designated phone Goal- patient ready for transport to transport complete 10 min.	COMPLETED COMPLETED	6/13 BP - ED tech avail to transport to 1st floor CT/US. CT still transports patients to and from upstairs CT/xray. 2. Designated Transporter from 10am-6pm in place. 6/10/13 CRH Complete. 3. Transporter carries Cisco phone and always has the same phone number. 6/10/13 CRH Complete.	
11 Improve communication of ED patient readiness for radiology exam	PE, MDE, EEE, Q, S	Brian Pope	Kathi Edrington	1. Use ED track board comment for all communications. Copy into chart. 5/1/13 2. ED MD talks directly to US tech on call prior to response. 5/1/13 Order to table: Plain film- Current 28 min improve to 20 min Order to table: US- current 59 min improve to 45 min Order to table: CT- current 62 min improve to 50 min		6/13 BP - Communication through trackboard is in process. 6/13 BP - ED MD communicates with US tech for after hours need (US places page)	
12 Oral Contrast Protocol	PE, MDE, EEE, Q, S	Dr Asher Brian Pope	Dr Feagins Kathi Edrington	Begin contrast as early as possible- even in waiting room. Patient drinks as much contrast as possible over 20 min prior to exam. CT- current 62 min improve to 50 min		6/13 BP - We are still have some inconsistencies with following our protocol. Need to evaluate times to see if we have moved this metric.	

Appendix D: Decision to Orders

Rolling Action Item List (RAIL)							
FOCUS: Decision to orders			LEGEND: PE: Patient Experience, MDE: Physician Experience, EEE: Employee Engagement, Q: Quality, S: Stewardship				
			Current door to orders 241 min. Goal 190 min. Savings 51 min.		Current Consult to orders 47 min. Goal 30 min. Savings 17 min.		
DATE		4/19/2013					
Initiative	KRA	Responsible	Operational Counterpart	Deliverables	Comp Date	Committee/Status	
1	"Early Purple"- Change patient status to admit pending orders as soon as likely admission identified.	PE, MDE, EEE, Q,S	Dr Argus	Dr Feagins	STOC 4/17/13 Arrival to orders currently 241 min, reduce to 190 min YTD end of 2013	COMPLETED 5/1/13	Allows Case Management, Clinical Administrator, ED nurse & pharmacy tech to intervene & prepare earlier. Begin 4/9/13. <b>6/12 Dr Argus</b> - Complete - Door to Admit - Pending down in May. <b>6/18 Dr F</b> - Discuss at hospitalist and ED section meetings. Reminder at ER Workstation.
2	Case Manager determines criteria ,IP or OBS, places OP with community resources, palliative care referrals	PE, MDE, EEE, Q,S	Pam Tritch	Janice Maupin	1. Prepare work station in ED near physicians 5/3/13	COMPLETED	Completed
					2. Fill open position 5/15/13		FT position filed and in orientation. 0.5 FTE still open <b>6/11 PT/JM</b> - no change
					3. Make reference book for ED staff to use during case manager off hours 5/15/13		In progress - <b>6/11 PT/JM</b> - no change
					Arrival to orders currently 241 min, reduce to 190 min YTD end of 2013		
3	Consult process: US places consult order & page in < 5min & copies note to chart.	PE, MDE, EEE, Q,S	Dr Mc Keen Brian Pope	Dr Feagins Kathi Edrington	STOC 4/17/13 Consult to order goal <30 min. Improve from 47 min		<b>6/13 Dr McK</b> - I have not seen a single page copied to Progress Note in chart. <b>6/13 BP</b> - in process, will report data soon <b>6/18 Dr F</b> - in place, periodic evaluation of execution.
							Consult process: Consult returns call to discuss with ED MD < 5min.
4	ICU admissions called directly to ICU hospitalist phone 7a-7p	PE, MDE, EEE, Q,S	Dr Argus Dr Weeks	Dr Feagins	Begin 4/29/13 Consult to order goal <30 min. Improve from 47 min	COMPLETED	<b>6/12 Dr Argus</b> - Complete. Multiple exaples of directly calling and patients leaving for ICU much earlier than norm <300 min <b>6/18 Dr F</b> - Executed, continue to monitor.
5	Eliminate batching of admissions by ED MD. Hospitalist writes blind orders.	PE, MDE, EEE, Q,S	Dr Argus Dr McKeen	Dr Feagins	Begin 4/29/13 Consult to order goal <30 min. Improve from 47 min		<b>6/18 Dr F</b> - Spuradic execution. Discuss combined leadership agenda 6/18.
6	Pharmacy Intern position reinstated	PE, MDE, EEE, Q,S	Bill Carroll	Gyasi Chisley	Terri Martin & Bill Carroll to complete ROI by 5/3/13	COMPLETED	ROI complete <b>6/6 BC</b> ROI completed. Continue to place pharmacy interns in ED 5-9pm daily to clarify/correct patient home medication lists. A registered pharmacist is assigned to B3 in the morning and ED throughout the afternoon Monday through Friday until 5pm, clarifying and correcting patient home medication lists.
7	Create virtual beds in ED, cath lab, PACU, CDU to capture IP charge if patient in hold status.	EEE,Q,S	Kathi Edrington	Kathi Edrington	In progress. Status TBD. May be cost prohibitive. Currently charge capture is occurring on paper.	=CLOSED=	<b>6/17 K E</b> - Remove from RAIL - This will be happening on paper indefinitely.
8	Create new color in EPIC ED track board legend to designate potential admission	EEE,Q,S	Maurine Langford	Denise Izarry	1. New color designates potential admission		
					2. Purple designates admit pending orders for CMS ED core measure reporting Time line TBD		

Appendix E

**ED to IP Hand-off & Transport Process Future State**



Appendix F: Orders to Exit

Rolling Action Item List (RAIL)

FOCUS: Orders to Exit ED

LEGEND: PE: Patient Experience, MDE: Physician Experience, EEE: Employee Engagement, Q: Quality, S: Stewardship  
 Current 87 min. Goal 45 min. Savings 42 min.

DATE	Initiative	KRA	Responsible	Operational Counterpart	Deliverables	Comp Date	Committee/Status
4/19/2013	1 Sterile Cockpit	PE,MDE,EE E,Q,S	Brian Pope IP Managers	Kathi Edrington Kristin Shelley	1. 645-745 am/pm no patient movement to floors	COMPLETED	Begin 4/29/13 6/13 BP - Sterile cockpit has been implemented
2. 7-730 am/pm ED nurse takes patient to IP unit for bedside report.					COMPLETED	6/13 BP - ED is taking patients between hours of 7-7:30a/p.	
3. IP nurse incorporates patient into their assignment- 1st priority on arrival							
4. CA assigns beds 24x7 throughout sterile cockpit time.					COMPLETED	6/13 BP - Ca's are assigning beds a 24/7.	
Goal- Room assigned to exit <30 min.							
2 Bed Request Bed Assignment Role Clarification	PE,MDE,EE E,Q,S	Brian Pope IP Managers Molly Grooms	Kathi Edrington Kristin Shelley	1. ED RN responsible for bed request in AWARIX < 5min		STOC 4/17/13 ED RN responsible for bed request. Process in place by 5/6/13. 6/13 BP - Need to run latest awarix data. ED RN/CHG requests bed through awarix	
				2. CA contacts IP charge. If unable to give a bed with 1st call CA assigns. < 15 min			
				3. CA routes ED track board note to CMU fax. Goal- orders to bed assigned < 15 min		Issues with faxing function in Epic - help desk states that function may be disabled in future. Currently ED is faxing tele box request to CMU 6/4	
3 Hand-off role clarification	PE,MDE,EE E,Q,S	Brian Pope IP Managers	Kathi Edrington Kristin Shelley	1. IP nurse responds to ED, via CMU for tele box, in <15 min. No phone call from ED patient to floor		Process in place by 5/6/13. 6/13 BP - Need data points for <15 min goal	
				2. Waits at blue tile by US desk		Install blue tile at US desk- Chad Bruns by 5/3/13 6/13 BP - No blue tile installed	
				3. US contacts ED nurse & transport		6/13 BP - on target	
				4. Bedside report includes call to CMU		6/13 BP - on target	
				5. Transporter/ED staff/IP nurse take patient to floor		6/13 BP - on target	
				6. US rolls pt over in HBO Goal- Bed assigned to exit < 30 min		6/13 BP - <30 min goal need awarix report	
4 IP Units ready for next admission	PE,MDE,EE E,Q,S	IP Managers	Kathi Edrington Kristin Shelley	Assign 1st, 2nd, 3rd, 4th admit at 7a, 3p, 7p, 11p Goal- Orders to bed assign <15 min		Begin 5/6/13 6/12 M Yorio - I have been talking to charge nurses about this. We'll start auditing. Our challenge is the volume of DC's, admits and transfers. Patient acuity/priorities are always changing, and it's hard to stay the 1,2,3 order consistently.	
5 ICU pulls patient from ED	PE,MDE,EE E,Q,S	Beth Butz Molly Grooms	Kathi Edrington	1. ICU charge nurse assigns bed independent of CA, if no barriers 2. ICU nurse/team respond to ED for bedside report Goal- orders to exit <45 min		STOC date to be determined	
6 Bed Czar 10a-10p M-F	PE,MDE,EE E,Q,S	Molly Grooms	Kathi Edrington	1. Clinical Administrator monitors all stages of throughput using AWARIX & EPIC. 2. Gives feedback in real time to keep all processes hardwired. ED admitted patient LOS < 300 min YTD end 2013		1. Determine what Clinical Administrator responsibilities can be delegated when in Bed Czar role 2. Specifically define Bed Czar role Next CA meeting 5/14/13 - discussed barriers (staffing responsibilities, RRT and Code, customer service calls/complaints, IT issues) 3. Round Robin- CA assigns all beds upon request within 15 min, to include ED, PACU, Cath Lab, SSU, ICU & Progressive Care down grades. No beds held for future admissions. By 5/15/13	
7 Utilize all open beds	PE,MDE,EE E,Q,S	Nursing & Physician leaders	Kathi Edrington Dr Feagins	Universal telemetry placement on all floors outside of ICU & Progressive Care ED admitted patient LOS < 300 min YTD end 2013		1. Med/surg nurses complete EKG class- in progress 2. Med/surg nurse education on nursing care of telemetry patient population 6/12 M Yorio - I am working on Universal telemetry. Utilize all open beds. I'm reviewing our current policies regarding admission and discharge criteria for Telemetry, Progressive Care and ICU. I'm also reviewing literature for evidenced based practices that will help. I'm in the planning stages, and hope to start some initiatives the last week in June. 3. Leaders develop specific transition plan/ guidelines/ protocols. By year end 2013	
8 IT optimization	PE,MDE,EE E,Q,S	Maurine Langford	Susan McMurray	1. EPIC note routed to fax sometimes stuck in a queue		5/1/13 Planning meeting scheduled with Susan McMurray 6/20 SM - Ticket was placed for resolution. Awaiting confirmation that it is fixed.	
				2. Request color designation for tele patient in AWARIX		Color designation for tele completed 5/1/13. Other changes can be made with a TBD AWARIX downtime within the next 30 days. 6/20 SM - The TELE was changed to Red/Bold	
				4. ED & IP charge nurses have independent AWARIX log on		Other changes can be made with a TBD AWARIX downtime within the next 30 days. 6/20 SM - This is in process with all the access issues	
				5. AWARIX upgrade		Other changes can be made with a TBD AWARIX downtime within the next 30 days. 6/20 SM - Part of a project for both Anderson & Fairfield to bring them to the same version as West and Clermont	
				6. Determine specific AWARIX pager alerts & reset reminder time frames		Other changes can be made with a TBD AWARIX downtime within the next 30 days. 6/20 SM - We have worked on some of the EVS pagers. Not exactly sure what they are asking here, but can follow up.	

Appendix G: Inpatient Discharge

Rolling Action Item List (RAIL)							
FOCUS: IP Discharge							
LEGEND: PE: Patient Experience, MDE: Physician Experience, EEE: Employee Engagement, Q: Quality, S: Stewardship							
Current 211 min. Goal 150 min. Savings 61 min.							
DATE: 4/19/2013							
Initiative	KRA	Responsible	Operational Counterpart	Deliverables	Comp Date	Committee/Status	
1	Physician assigns estimated DC goal within 24 hours of admission: Establishes plan of care	PE,MDE,EE E,Q,S	Dr Ali	Dr Feagins	Reduce discharge order to exit from 211 min to 150 min by end of 2013 Goal 10 VBP HCAPS Communication with Doctors		Begin by 6/1/13. Planning at May 9 Hospitalist/A1 nursing meeting. <b>6/13 Dr Ali</b> - No end of shift note currently being utilized. Hospitalist improvement in Progress notes. <b>6/18 Dr F</b> - monitoring execution
2	New white boards that reflect plan of care and DC goal	PE,MDE,EE E,Q,S	Sarah Varney	Kathi Edrington	Finalize template & place order for 5 trial boards on A1 by 5/31/13 Goal 10 VBP HCAPS Discharge Information.		<b>6/10 SY</b> 2 new boards currently being trialed in 114-1 & 114-2.
3	Improve communication about the plan of care among caregivers	PE,MDE,EE E,Q,S	Sarah Varney Pam Trich	Kathi Edrington Janice Maupin	1. Create, share, implement nursing shift hand-off template to address plan of care, length of stay & discharge needs		1. Mary Beth Taylor- Template created. Taking to RN-MD task force for review 6/13/13. <b>6/10 SY</b> After review will implement week of 6/17/13
					2. Create, share, implement case management note template for a glance identification of discharge plan.	COMPLETED	2. Melissa Rodenberg by 6/1/13 Completed
					3. All Arch pages to physicians are copied and pasted into a note by nursing		3. Communicate process to nursing- begin by 5/11/13 <b>6/10 SY</b> Hardwired on A1. Next step to spread to other units.
4	Specialty Consults convert their recommendations to orders & acknowledge or sign off on discharges	PE,MDE,EE E,Q,S	Dr Feagins	Dr Buckley	Communicate this request to medical staff through Medical Staff Newsletter & other appropriate venues. Reduce discharge order to exit from 211 min to 150 min by end of 2013		With 6/1/13 roll out or before <b>6/18 Dr F</b> - monitoring execution
5	Script Process	PE,MDE,EE E,Q,S	Inpatient Managers Dr Ali/ Carrie Rollins	Kathi Edrington Kristin Shelley Dr Feagins	1. Unit secretary maintains script printer & places unsigned scripts in black bin next to printer.		Begin 5/6/13 <b>6/13 Dr A</b> - Working much better.
					2. Physician places signed scripts in front of chart.		
6	Mercy Health Medical Transportation meets 2 hour pick up window request or subs out to another vendor.	PE,MDE,EE E,Q,S	Janice Maupin	Pat Kowakki	1. Case manager reinforces this request		<b>6/1/13 JM</b> - Case Management is reinforcing this with MHMT.
					2. Delays entered in Safe Care to monitor performance.		<b>6/14/13 JM</b> - I have received 3 Safe Care reports since the week of Kaizen
					Goal- Ambulance pick up <2hr of request		<b>6/14 JM</b> - In progress
7	Respiratory Therapy identifies patients in need of home oxygen.	PE,MDE,EE E,Q,S	Cassie Herald Pam Trich	Jasmine Rausch Janice Maupin	Nursing or Case Management order up to 48 hours prior to DC. Reduce discharge order to exit from 211 min to 150 min by end of 2013		Begin 5/6/13. RTD to use sticky note function for note to CM <b>6/13 CRH</b> - Moved to Nursing to address (not RTD function). <b>6/1/13</b> Case Management ordering RT when notified by RT or Nursing of patient need.
8	Case Management weekend support	PE,MDE,EE E,Q,S	Pam Trich	Janice Maupin	Evaluate case management staffing/position control to increase support on weekends. Currently 1 person covers the house. Reduce discharge order to exit from 211 min to 150 min by end of 2013	COMPLETED	Recommendation by 5/18/13 - Evaluation completed. With current FTE complement, cannot add additional support on weekend without additional resources.
9	Restore unit based clinical pharmacists	PE,MDE,EE E,Q,S	Bill Carroll	Gyasi Chiskey Will Woodward	Complete ROI or evaluate pharmacy staffing/position control, to restore unit based clinical pharmacists Goal 10 points HCAPS Communication About Medicines		Recommendation by 5/18/13 <b>6/12 BC</b> - currently at 7 points.
10	Education	PE,MDE,EE E,Q,S	Pam Trich	Janice Maupin	1. Augment Care Giver Orientation education with an enhanced understanding of case manager role	COMPLETED	1. Beth Shannon by 6/1/13 2. Melissa Rodenberg, Neil Fedders by 6/1/13 (1st mtg scheduled 5/7) 3. Kim Rahe, Carrie Rollins by 6/1/13 COMPLETED
					2. Update physical therapy staff on 2013 insurance changes that impact certifications & admissions to the next level of care. CM monitors # of avoidable days & placement denials via Midas focus screen	COMPLETED	Completed
					3. Educate nursing & physician staff on information needed on Continuity of Care (COC) form.		<b>6/14/13 PT</b> In Progress: Educational Posters created and placed on units and physician's lounge today.
					CM polls ECF leaders at scheduled meetings & audits 5 COC forms per month per unit for completeness. Goal >90% complete		<b>6/6/13 PT</b> - ECF meeting: Talked about improvement initiative in COC. Ask to monitor this month and provide feedback at next meeting.
11	MD Rounding selection added back to Responder 5 Staff Terminal	PE,MDE,EE E,Q,S	Jasmine Rausch Dr Ali/Carrie Rollins	Kathi Edrington Dr Feagins	1. MD Rounding selection available by 5/31/13		<b>6/12 JR</b> - will add next downtime <b>6/13 Dr A</b> - not in yet & not utilized <b>6/18 Dr F</b> - Awaiting IT implementation during downtime 6/22.
					2. Physicians use MD Rounding selection to notify nurse that they have arrived.		<b>6/12 JR</b> - will add next downtime

Appendix H: Discharge to Room Available

Rolling Action Item List (RAIL)						
FOCUS: Pt Discharge to Room Available			LEGEND: PE: Patient Experience, MDE: Physician Experience, EEE: Employee Engagement, Q: Quality, S: Steward			
Current 94 min. Goal 45 min. Savings 49 min						
DATE 4/19/2013						
Initiative	KRA	Responsible	Operational Counterpart	Deliverables	Comp Date	Committee/Status
1. Maximize use of AWARIX for efficient operations of EVS team	PE,MDE,EE, E,Q,S	Yeni Zewdy	Chad Bruns Susan McMurray	1. Supervisor training on AWARIX program & reporting		1. Yeni Zewdy 4/24/13 <b>6/11 YZ</b> = training completed, still need contact information to talk to AWARIX rep concerning reports.
				2. Redistribution of pagers		2. Yeni Zewdy 4/24/13 <b>6/11 YZ</b> = waiting for system to be upgraded.
				3. Assignment of Individual staff AWARIX logins & responder 5 locator badges		3. Yeni Zewdy & Susan McMurray 5/30/13 <b>6/11 YH</b> - almost completed have 4 to go / ongoing.
				4. AWARIX user training for staff		4. Yeni Zewdy & Susan McMurray 5/30/13 <b>6/11 YZ</b> - Main staff completed / ongoing
				Patient DC to room ready for next patient Current 94 min goal 45 min- Monitor by each employee, unit & overall		<b>6/11 YZ</b> - Current Barrier - weekend staffing issues plus quiet time. Need way to block room without effecting turnaround time.
2. Evaluate placement of biohazard waste container in each patient room	PE,MDE,EE, E,Q,S	Yeni Zewdy Nicole Barnett	Chad Bruns	1. IC, EVS manager, Safety Officer meet to evaluate products & determine feasibility	COMPLETED	First meeting by 5/15/13 <b>6/11 YZ</b> Meeting on May 28th, Group decision was not to change.
				Identify cost reduction goal.		na
				Monitor biohazard waste disposal cost over time.		na
3. Nursing staff address cleanliness of room environment during bedside report & remove unused equipment, supplies, meal trays. At DC nursing must remove medications from lock box & IV bags from IV pump.	PE,MDE,EE, E,Q,S	Kim Hammock Yeni Zewdy	Kathi Edrington Chad Bruns	1. STOC on A3 week of 4/29/13- completely implemented by 5/30/13		Patient DC to room ready for next patient 45 min- Communication to nursing team 5/3/13 <b>6/11 YZ</b> memo has been sent. Mgrs are working / In progress.
				2. Room environment included in the new end of shift template being developed by DC team.		<b>KH</b> April 2013 letter sent out to managers regarding expectations of nursing with cleanliness of the room, rooming unused equipment, and removing Meds and old ivs. <b>6/11 YZ</b> in progress
				EVS records # of items left in the room at DC & reports to manager weekly. Goal trend down to zero.		<b>6/11 YZ</b> in progress
4. Standardize personal care items provided on admission to eliminate waste at DC & reduce cost.	PE,MDE,EE, E,Q,S	Kim Hammock Allison Schlinkert	Kathi Edrington Kristin Shelly	1. Form a team identify standard items, communicate & implement		Cindy Salyer from Premier to assist the team. First team meeting by 5/31/13 Project completed by 7/31/13
				2. Determine product reduction goal 40-60% & associated dollar savings		<b>6/12 KH</b> - Group Decision from today's mg to supply water pitcher/cup to all patients. Suggestion to have sign "Personal care items upon request" and have items on rounding carts. Information shared that CHP is looking into finding smaller size versions of personal care items.
5. Use Responder 5 staff terminal to communicate patient discharge to Unit Secretary	PE,MDE,EE, E,Q,S	Jasmine Rausch IP managers	Kathi Edrington	1. Add US selection to Responder 5 staff terminal. By 5/31/13		<b>6/12 JR</b> - will add Responder 5 features with next downtime
				2. Upon exiting room at DC, staff member uses staff terminal to alert US to discharge patient in HBO		<b>6/12 JR</b> - will add Responder 5 features with next downtime
				3. Patient is removed from HBO by US		
				4. No US- deferred to registrar to remove patient from HBO.		
				Goal < 10 min from request. Monitor via Responder 5 & AWARIX reporting		
6. Clinical Administrator prioritizes beds to be cleaned by EVS using AWARIX priorities 1,2,3,4	PE,MDE,EE, E,Q,S	Yeni Zewdy Noelle Stoner	Kathi Edrington Chad Bruns	1. Define specific expectations for priority 1,2,3,4		1. By 5/10/13 <b>6/11 YZ</b> - using 1-3 numbers for prioritizing - Both parties are clear on expectations.
				2. Communicate to Clinical Administrator & EVS teams		2. By 5/17 13 <b>6/11 YZ</b> completed
7. Implement EVS discharge team 1p-9p	PE,MDE,EE, E,Q,S	Yeni Zewdy	Chad Bruns	1. Evaluate current position control & staff schedule		<b>6/11 YZ</b> staffing still an issue / working on it.
				2. Designate team members & define responsibilities of discharge team.		<b>6/11 YZ</b> dependant on staffing / training
				Patient DC to room ready for next patient Current 94 min goal 45 min-		<b>6/11 YZ</b> when fully staffed we were able to get to 59min average during week.

Appendix I: Leadership Rounding

First Quarter

rev 1/7/2014		QOS	QOS	SFTY	QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS
2014		1/7	1/14	1/21	1/28	2/4	2/11	2/18	2/25	3/4	3/11	3/18	3/25
A	EVS A1 FBC	3				2		1	4			5	4
B	CMU A2 B3	4		1		3		2				1	5
C	A3 IMAGING 1ST FLR IMAGING 2ND FLR	2				4		3	5			2	1
D	TRANSPORT B1 EMERG	1		4		5		4				3	2
E	ICU CATH LAB PERIOP	5				1		5	3			4	3

1

Kristin Shelley - Ldr  
Angie Ferrell  
Bridget Kirk  
Bill Carroll

2

Carrie Herron - Ldr  
Jasmine Rausch  
Angela Thacker  
Joy Douglas

3

Kathi Edrington - Ldr  
Adam Momper  
Melissa Fritz  
Molly Grooms

Subs

Robin Flynn  
Katie Cook  
Tiffany Scherzinger  
Justin Wallace  
Kim Hammock  
Mary Beth Taylor

4

Beth Shannon - Ldr  
Roger Leinberger  
Sarah Varney  
Angela Joyce

5

Neil Fedders - Ldr  
Steve Feagins  
Mary Yorio  
Brian Pope

Date:	1/7	1/14	1/21	1/28	2/4	2/11	2/18	2/25	3/4	3/11	3/18	3/25
SECURITY			3	1					5			
CENTRAL			3	1					5			
STERILE PROC			3	1					5			
PLANT OPS			3	2					1			
PHARMACY				2				5	1			
HOSPITALISTS				3				2	2			
CASE MGMT			5	3					2			
VOLUNTEERS			5	4					3			
DIETARY				4				2	3			
ADMIT / REGIST				5					4			
HUMAN RES			2	5					4			
REHAB		5	2			4					3	
CTU / SSU		5	2			4					3	
RESP THERAPY		1	2			5					4	
SPIRIT CARE (call)		1	5			5					4	
LAB		2				1		2			5	
MAASC		2				1		1			5	
HIM		3				2		1			1	
WMNS CNTR		3				2		1			1	
OB CLINIC		4				3		1			2	
CARD REHAB			5			3					2	
SLEEP CENTER	5											

Safety Walk Rounds

4 teams - 3 units / 30mins each dept

1 Night Team - 3 units / 30mins /dept/ 12 midnight

## Second Quarter

rev 5/19/14

2014		SFTY	QOS	QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS	SFTY	QOS
		4/1	4/8	4/15	4/22	4/29	5/6	5/13	5/20	5/27	6/3	6/10	6/17	6/24
A	EVS A1 FBC			3		2		4	5		THURS			4
B	CMU A2 B3	4		2		3			THURS		4		3	5
C	A3 IMAGING 1ST FLR IMAGING 2ND FLR			4		5		3	2		3			1
D	TRANSPORT B1 EMERG	3		1		4			4		1		5	2
E	ICU CATH LAB PERIOP			5		1		5	3		5			3

**1**

Kristin Shelley - Ldr  
Angie Ferrell  
Bill Carroll

**2**

Carrie Herron - Ldr  
Jasmine Rausch

**3**

Kathi Edrington - Ldr  
Molly Grooms

Date:	4/1	4/8	4/15	4/22	4/29	5/6	5/13	5/20	5/27	6/3	6/10	6/17	6/24
SECURITY	2	4				3					2	1	
CENTRAL	2	4				3					2	1	
STERILE PROC	2	4				3					2	1	
PLANT OPS	2	5				4					3	1	
PHARMACY		5				4	4				3		
HOSPITALISTS		1				5	1				4		
CASE MGMT	1	1				5					4	2	
VOLUNTEERS	2	2				1					5	2	
DIETARY		2				1	1				5		
ADMT / REGIST	5	3				2					1	5	
HUMAN RES	5	3				2					1	4	
REHAB				2					1			4	
CTU / SSU	5			2					1			4	
RESP THERAPY	5			3					2			4	
SPIRIT CARE (call)	1			3					2			2	
LAB				4			1		3				
MAASC				4			2		3				
HIM				5			2		4				
WMNS CNTR	1			5			2		4				
OB CLINIC				1			2		5				
CARD REHAB	1			1					5			2	
SLEEP CENTER							5						

**4**

Lisa Richardson - Ldr  
Beth Shannon  
Shana Clepper

**5**

Neil Fedders- Ldr  
Steve Feagins

**Safety Walk Rounds**

4 teams - 3 units / 30mins each dept

**1 Night Team** - 3 units / 30mins /dept/ 12 midnight



Third Quarter

rev 7/8/2014

		QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS	
2014		7/1	7/8	7/15	7/22	7/29	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30
A	EVS A1 FBC		1		2	3		1		5			4		3
B	CMU A2 B3		4		3			5		1	2		3		5
C	A3 IMAGING 1ST FLR IMAGING 2ND FLR		5		4	1		3		4		THURS			1
D	TRANSPORT B1 EMERG		THURS		5			2		3	THURS		2		4
E	ICU CATH LAB PERIOP		2		1	2		THURS		2			1		2

1

Kristin Shelley - Ldr  
Angie Ferrell  
Bill Carroll

2

Jasmine Rausch  
Pam Tritch  
Carrie Beckman

3

Kathi Edrington - Ldr  
Molly Grooms  
Shana Clepper

4

Joy Douglas - Ldr  
Beth Shannon  
Lisa Richardson

5

Neil Fedders - Ldr  
Steve Feagins  
Lori Mondary

Date:	7/1	7/8	7/15	7/22	7/29	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30
SECURITY			1					5		5				
CENTRAL			1					5		5				
STERILE PROC			1					5		5				
PLANT OPS			2					1		5				
PHARMACY			2		3			1		THURS				
HOSPITALISTS			3		5			2						
CASE MGMT			3					2		4				
VOLUNTEERS			4					3		4				
DIETARY			4		5			3						
ADMIT / REGIST			5					4		4				
HUMAN RES			5					4		3				
REHAB	5					4				3	3		2	
CTU / SSU	5					4				3	3		2	
RESP THERAPY	1					5				3	4		3	
SPIRIT CARE (call)	1					5				4	4		3	
LAB	2				5	1					5		4	
MAASC	2				4	1					5		4	
HIM	3				4	2					1		5	
WMN'S CNTR	3					2					1		5	
OB CLINIC	4					3					2		1	
CARD REHAB	4					3					2		1	
SLEEP CENTER							THURS							

**Safety Walk Rounds**

4 teams - 3 units / 30mins each dept

1 Night Team - 3 units / 30mins /dept/ 12 midnight

Appendix J: Manager

Auditing Tool

		A1	A2	A3	B1	ICU	B3	FBC		NEW PROCESS-ALL	Goal
D/C Checklist	Current Process	US keeps log of all discharges using patient stickers.	Daily report printed to mgr with all patients with dispo of "home" from day prior.	Daily report printed to mgr with all patients with dispo of "home" from day prior.	US keeps log of all discharges using patient stickers.	US keeps log of all discharges using patient stickers.	Uses assignment sheet from day prior to determine d/c's.	Start on admission & updated throughout stay. PEI nurses also have d/c checklist.	New Process	Daily report printed to mgr with all patients with any type of dispo from day prior.	98%
	Current Measurement	Copy of d/c checklist submitted to mgr. Compared to discharge log.	Copy of d/c checklist into bin at desk. Compare those returned w/ report.	Copy of d/c checklist into bin at desk. Compare those returned w/ report.	Copy of d/c checklist submitted to mgr. Compared to discharge log.	Copy of d/c checklist submitted to mgr. Compared to discharge log.	Copy of d/c checklist submitted to mgr. Compared to d/c's on assignment sheet.	US collects the data monthly and compares # of d/c w/ # of checklists.	New Measurement	Compare copy of d/c checklist with d/c report.	
D/C Phone Calls	Current Process	US, mgr, clinical coordinator, rounder, volunteer conducts call 1-2 days post d/c.	Varies as to who calls. Uses phone log. Aim is to call within a week.	Was using light duty person. Need to change.	Clinical coordinator making all calls.	Charge nurse making phone calls.	US writes d/r phone number, etc in log book. Charge nurse & clinical coord call.	PEI nurses call 3-4 days post d/c. Attempt x3.	New Process	Designated person(s) must call within 7 days of d/c. Standardized questions/scripting. Attempt 2 times per patient. Leave scripted message.	80%
	Current Measurement	Compare phone logs to d/c log. Compliance measured by attempted phone call.	Compare phone logs to d/c log. Compliance measured by patients actually contacted.	Compare phone logs to d/c log. Compliance measured by patients actually contacted.	Measuring if up-to-date on calls. not percentage compliant.	Compare phone log to d/r log.	Compliance measured by percentage of call sheets completed.	Not currently measuring compliance.	New Measurement	Compare call log (at least one attempt made) with d/r reports.	
Hourly Rounding	Current Process	Keeps a log. Each hour signed up and initialed when complete. Using rounding button.	Testing process. Staff doing their own hourly rounding. No log. No button.	Will have log with time slots for sign up.	Keeps a log. Each hour signed up and initialed when complete. Using rounding button.	Clinical coordinator owns this initiative and monitors log. Staff sign up for time slots.	Keeps a log. Each hour signed up and initialed when complete. Using rounding button.	Rounding conducted q2h. Keeps a log.	New Process	Keep a log. Staff sign up for individual time slots as determined by unit process. Must use hourly rounding button.	85%
	Current Measurement	Percentage compliant from log. Spot checks using Responder 5 reports.	Asking one nurse per day if they completed their hourly rounding.	Percent compliant from log.	Percentage compliant from log. Also does more detailed individual compliance.	Tracking compliance on a monthly basis.	Percentage compliant from log. Also does more detailed individual compliance.	Clinical coordinator monitors compliance on a monthly basis.	New Measurement	Percentage compliant from log. Spot checks using Responder 5 reports and/or surveillance of individual compliance.	
Med Stickers	Current Process	Medicated bedside & AVS w/ stickers & smart phrases. Copy of medication order at d/r.	Using smart phrases on AVS for new meds.	Med stickers on AVS.	Med stickers on AVS. Copy of AVS to mgr at d/c.	Currently open hearts only. Stickers at bedside & on AVS.	Med stickers on AVS.	If a med starts with any new meds. Name of new med written on d/c checklist.	New Process	Minimum requirement: Med stickers or smart phrases on AVS. Best practice: additional education prior to start bedside.	90%
	Current Measurement	Detailed chart review & compare w/ med sticker/education compliance.	Chart audits 3x/week. Looks at AVS in media table.	Using d/c list to conduct chart audits to review AVS in media table.	Check for stickers on AVS for compliance percentage.	Spot audits while patient is here & upon discharge.	US checks AVS for stickers at d/c and log for mgr.	Not currently measuring compliance.	New Measurement	Compliance with med stickers/smart phrases on AVS. Spot checks to verify all new meds have sticker or smart phrases in place.	
D/C Rounds	Current Process	Keeps a log at desk.	Keeps a log at desk.	Clinical coordinator doing them all currently.	Keeps a log at desk.	Charge nurse alerts manager of d/c's. Mgr rounds.	Keeps a log at desk.	Keeps a log at the desk.	New Process	Keep a standardized log of d/c rounding. (ICU continue current process)	80%
	Current Measurement	Compares logs vs d/c log.	Compares logs vs d/c log.	No formal tracking process yet.	Compares logs vs d/c log.	Keeps track daily of compliance.	Compares logs vs d/c log.	Not currently measuring compliance.	New Measurement	Compare d/c rounding log with d/c report.	

Appendix K: Evidence Table

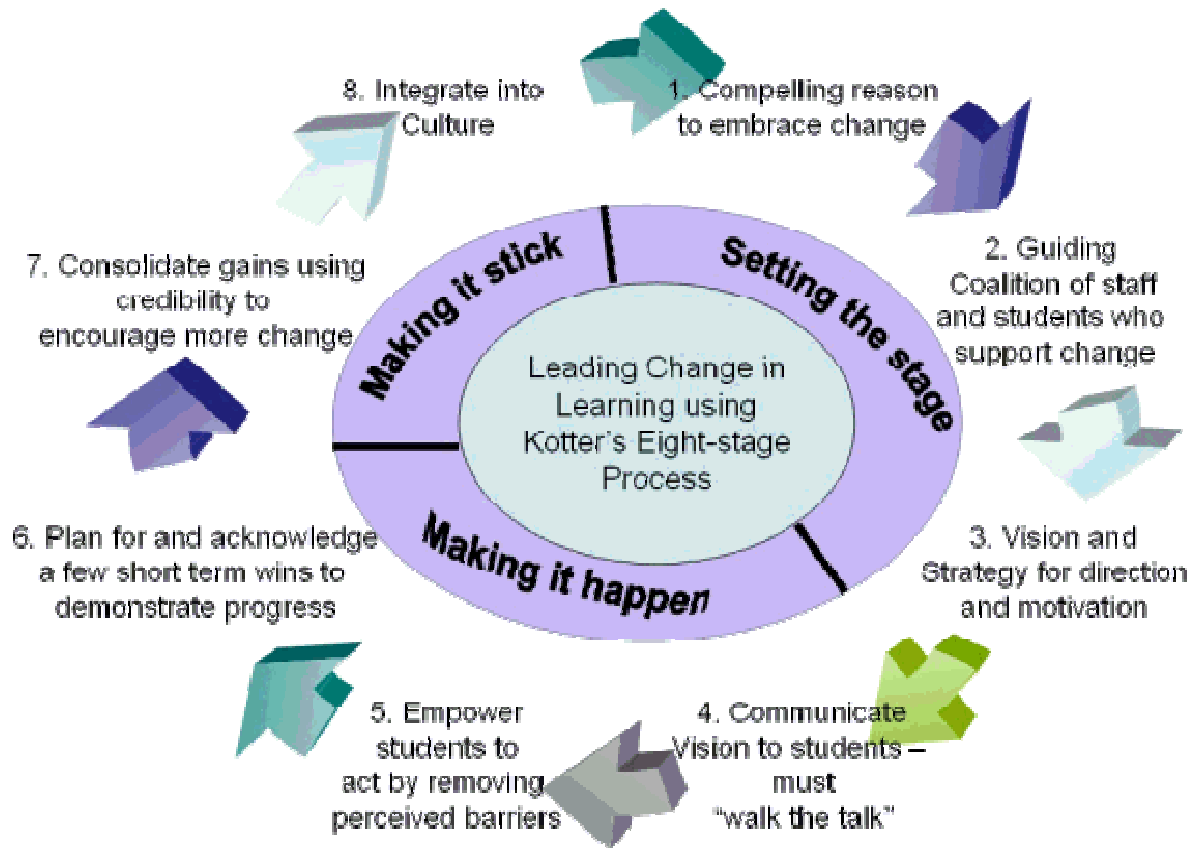
Author	Title	Outcome Variables	Performance Improvements	Evaluation Methods	Results	Johns Hopkins Nursing Evidence Based Practice Strength of Evidence & Quality Rating
Cesta, T. (2013).	Managing Length of Stay Using Patient Flow - Part 1.	Primary variable is patient flow through the entire experience in the hospital	Queuing Theory: Applying this theory to hospital processes	Demand and capacity management, use of vacant hospital areas, appropriate discharge times	Improved bottom line to hospital and patient experience/quality of care	<b>Level 5:</b> Expert Opinion. Case Study, Literature Review <b>Quality Rating B:</b> Good Quality
Cesta, T. (2013).	Managing Length of Stay Using Patient Flow - Part 2.	Primary variable is patient flow through the entire experience in the hospital	Patient Flow Management: Several different levels	admission, registration, precertification, ED, bed tracking and management, utilization review and transfers	The ability to manage and sustain a short length of stay in an environment where lengths of staff are already short is a challenge	<b>Level 5:</b> Expert Opinion. Case Study, Literature Review <b>Quality Rating B:</b> Good Quality
Cliff, B. (2012).	Excellence in patient satisfaction within a patient-centered culture	A patient-centered culture can facilitate improvements in HCAHPS scores	Patient satisfaction in patient-centered culture Financial Performance	A great patient experience coupled with superior clinical outcomes can result in stronger financial performance	Excellence in patient satisfaction within a patient-centered culture can result in improved outcomes. The voice of the patient is critical to success	<b>Level 4:</b> Research and experiential evidence review <b>Quality Rating A:</b> High Quality, expertise is clearly evident
Cliff, B. (2012).	The evolution of patient-centered care	Patient-Centered Care	Including patients' cultural traditions, their personal preferences and values, their family situations, and lifestyles	Embracing a Philosophy: The Planetree model of care is a patient-centered, holistic approach to healthcare, promoting mental, emotional, spiritual, social, and physical healing	The patient is central to his or her own care and the family is a component of that unit of care	<b>Level 4:</b> Research and experiential evidence review <b>Quality Rating A:</b> High Quality, expertise is clearly evident
Emergency Nurses Association (ENA). (2006).	Emergency nurses association with paper of holding patients in the emergency department	Input-Throughput-Output Model	Admitted patients have to get the same level of care if they are holding the ED	Delays are hospital-wide systems problems	Strategies that eliminate artificial variability in patient census and inefficiencies at the system level are needed to improve flow	<b>Level 4:</b> Clinical Practice Guidelines. <b>Quality Rating A:</b> High Quality, expert is clearly evident
Fee, C., Burstin, H., Maselli, J.H., & Hsia, R.Y. (2012).	Association of emergency department length of stay with safety-net status	Descriptive ED compliance with proposed length-of-stay for admissions ( 8 hours) and discharges, transfers and observations (4 hours)	ED LOS measure compliance by disposition and safety-net status	Analyzed from 2008 National Hospital Ambulatory Medical Care Survey (NHAMCS). ED visits from 2008 stratified by disposition and hospital safety-net status	Compliance with proposed ED length-of-stay measures for admissions, discharges, and transfers, and observations did not differ significantly between safety-net and non-safety net hospitals	<b>Level 2:</b> Quasi-Experimental, manipulation of independent variable. <b>Quality Rating A:</b> High Quality, consistent results, literature review, and sample size, definitive conclusions
Felton, B., Relsdorff, E., Krone, C., & Laskaris, G. (2011).	Emergency department overcrowding and inpatient boarding: statewide glimpse in time	The primary goal of this study was to determine the magnitude of statewide ED overcrowding and inpatient boarding at a single point in time	As a solution to the problems of overcrowding and boarding, several initiatives have been proposed. Using a computer simulation model, investigators examined ED length-of-stay after increasing the number of ED beds versus a reduction in inpatient boarding times.	Questions included data on annual census, bed number, number of admitted patients within the ED, ambulance diversion, and ED length of stay	There was a significant relationship with inpatient boarding and ED overcrowding	<b>Level 1:</b> Meta-Analysis, summary statistics show significant relationship <b>Quality Rating B:</b> Good Quality, reasonable sample size, fairly definitive conclusions.

Author	Title	Outcome Variables	Performance Improvements	Evaluation Methods	Results	Johns Hopkins Nursing Evidence Based Practice Strength of Evidence & Quality Rating
Gardner, R. L., Sarkar, U., Maselli, J. H., & Gonzales, R. (2007).	Factors associated with longer ED lengths of stay	Primary outcome variable was the length of stay in the ED, in minutes.	Diagnostic testing and language barrier improvements.	predictor variables: provider type and procedures/tests performed during visits	ED LOS in mins median 255	<b>Level 1:</b> Experimental study, randomly assigned. <b>Quality Rating B:</b> Good Quality, sample size large, reasonably consistent recommendations
Henneman, P. L., Nathanson, B. H., Li, H., Smithline, H. A., Blank, F., Santoro, J. P., Maynard, A. M., Provost, D. A., & Henneman, E. A. (2008).	Emergency department patients who stay more than 6 hours contribute to crowding	ED LOS < 6 hours versus ED LOS >6 hours comparing patients	Evenly spread admissions throughout the week (non-ED and ED admits) Reserve ED beds for predicted admissions by day of the week. Observation Unit, bedside registration, and use of tracking system	From door to departure from ED	ED LOS >6 hours in mins median 328	<b>Level 2:</b> Quasi-Experimental Study. Only one ED was evaluated. <b>Quality Rating B:</b> Good Quality, reasonable sample size, fairly definitive conclusions.
Hodgins, M., Moore, N., & Legere, L. (2010).	Full house: the incidence and impact of boarding admitted patients in the emergency department	What ED cases resulted in hospitalization? What factors contributed to ED boarding of admitted patients? What effect does ED boarding have on patient outcomes?	Working on more questions now and a body of evidence to support a 2 hour cut-point	Data collection and analysis using the 3 main questions or outcome variables.	17% resulted in hospital admission. 69% admitted with medical problems were boarded greater than 2 hours. 36% were critical care greater than 2 hours. Analysis was done on five most common diagnostic categories (GI, cardiac, respiratory, muskloskeletal, and symptoms not yet diagnosed). 3 of the 5 yielded longer hospital stays if they boarded in the ED longer than 2 hours.	<b>Level 3:</b> Non-experimental study. Comparative in nature, weak correlations <b>Quality Rating C:</b> Low Quality, little evidence with inconsistent results and literature to support
Horwitz, L. I., Green, J., & Bradley, E. H. (2010).	US emergency department performance on wait time and length of visit.	The purpose of this study is to describe hospital-level performance on ED wait time and visit length.	Prolonged emergency department (ED) wait time and length of visit reduce quality of care and increase adverse events. A total of 48% of EDs admitted more than 90% of their patients within 6 hours, but only 25% of EDs admitted more than 90% of their patients within 4 hours.	Measures included EDs' median wait times and visit lengths, EDs' median proportion of patients treated by a physician within the time recommended at triage, and EDs' median proportion of patients dispositioned within 4 or 6 hours	A minority of hospitals consistently achieved recommended wait times for all ED patients, and fewer than half of hospitals consistently admitted their ED patients within 6 hours	<b>Level 1:</b> Experimental study using randomly assigned control group <b>Quality Rating B:</b> Good Quality, reasonable sample size and definitive conclusions
Khare, R. K., Powell, E. S., & Reinhardt, G., Lucenti, M. (2009).	Adding more beds to the emergency department or reducing admitted patient boarding times: Which has a more significant influence on emergency	Evaluate a computer simulation model designed to assess the effect on emergency department (ED) length of stay of varying the number of ED beds or altering the interval of admitted patient departure from the ED.	In this ED, the admitted patient departure rate is the key bottleneck. If alterations are made in other areas first, ED length of stay and congestion will likely be only marginally affected	We created a computer simulation model (Med Model) based on institutional data and augmented by expert estimates and assumptions. We evaluated simulations of increasing the number of ED beds, increasing the admitted patient departure and increasing ED census, analyzing potential effects on overall ED length of stay.	The computer simulation modeled that improving the rate at which admitted patients depart the ED produced an improvement in overall ED length of stay, whereas increasing the number of ED beds did not	<b>Level 2:</b> Quasi-Experimental Study. Only one ED was evaluated. Independent t variable was manipulated <b>Quality Rating B:</b> Good Quality, reasonable sample size, fairly definitive conclusions.
Langhan, T. (2007).	Do elective surgical and medical admissions impact emergency department length of stay measurements?	Access block of greater than 85%	no recommendations were made since the results yielded no relationship	Linear Regression analysis of the number of daily elective admissions and median emergency department length of stay to establish relationship	Regression analysis determined there was no relationship between daily ED LOS and the number of elective admissions	<b>Level 1:</b> Summary statistics were expressed in terms of direction (no relationship) <b>Quality Rating B:</b> Good Quality, reasonably consistent results and sample size

Author	Title	Outcome Variables	Performance Improvements	Evaluation Methods	Results	Johns Hopkins Nursing Evidence Based Practice Strength of Evidence & Quality Rating
Lucas, R., Farley, H., Twanmoh, J., Urumov, A., Olsen, N., Evans, B., & Kabiri, H. (2009).	Measuring the opportunity loss of time spent boarding admitted patients in the emergency department: A multihospital	Opportunity loss defined as the number of additional waiting room patients who could have been seen on the time used to board inpatients.	Assumptions of opportunity loss and potential economic loss aside, boarding incurs costs by reducing the quality and timeliness of ED care and appears to be the main cause of overcrowding	Opportunity loss financially (left without being seen)	ED LOS in mins average 240 mins	<b>Level 2:</b> Quasi-Experimental, manipulation of independent variable <b>Quality Rating B:</b> Good Quality, reasonably consistent with literature review with some reference to scientific evidence
Lucas, R., Farley, H., Twanmoh, J., Urumov, A., Olsen, N., Evans, B., & Kabiri, H. (2009).	Emergency department patient flow: the influence of hospital census variables on emergency department length of stay	The objective was to evaluate the association between hospital census variables and emergency department (ED) length of stay (LOS). This may give insights into future strategies to relieve ED crowding.	This multicenter cohort study captured ED LOS and disposition for all ED patients in five hospitals during five 1-week study periods. A stepwise multiple regression analysis was used to examine associations between ED LOS and various hospital census parameters.	Data were analyzed on 27,325 patients on 161 study days. A significant positive relationship was demonstrated between median ED LOS and intensive care unit (ICU) census, cardiac telemetry census, and the percentage of ED patients admitted each day. There was no relationship in this cohort between ED LOS and ED volume, total hospital occupancy rate, or the number of scheduled cardiac or surgical procedures.	ED LOS is correlated with the number of admissions and census of the higher acuity nursing units, more so than the number of ED patients each day, particularly in larger hospitals with busier EDs.	<b>Level 1:</b> Positive relationship was demonstrated between median ED LOS and ICU census, cardiac telemetry census, and the percentage of ED patients admitted each day. <b>Quality Rating B:</b> Good quality. Consistent results, sufficient sample size, and fairly comprehensive literature review
Pines, J., Iyer, S., Disbot, M., Hollander, J., Shofor, F., & Datner, E. (2008).	The effect of emergency department crowding on patient satisfaction for admitted patients	The objective was to study the association between factors related to emergency department (ED) crowding and patient satisfaction.	Measures of ED crowding and ED waiting times predicted ED satisfaction ( $p < 0.05$ ), but were not predictive of satisfaction with the overall hospitalization.	The authors performed a retrospective cohort study of all patients admitted through the ED who completed Press-Ganey patient satisfaction surveys over a 2-year period at a single academic center	A poor ED service experience as measured by ED hallway use and prolonged boarding time after admission are adversely associated with ED satisfaction and predict lower satisfaction with the entire hospitalization. Efforts to decrease ED boarding and crowding might improve patient satisfaction.	<b>Level 1:</b> Meta-analysis, findings must be considered in light of threats to validity. <b>Quality Rating B:</b> Good, Reasonable results, sample size, and consistent recommendations
Mason, S., Weber, E. J., Coster, J., Freeman, J., & Locker, T. (2012).	Time patients spend in the emergency department: England's 4-hour rule- A case of hitting the target but missing the point?	The primary outcomes were LOS in ED and the length of time to first clinician visit	4 hour time limit set for all ED visits	Whether 4 hours was met or not and factors associated with admitted patients in that 4 hour time frame	ED LOS in mins median 186	<b>Level 1:</b> Experimental study, using 15 ED's <b>Quality Rating A:</b> High Quality, consistent results, sufficient sample size, consistent recommendations and literature review
Parmelli, E., Flodgren, G., Beyer, F., Baillie, N., Schaafsma, M., & Eccles, M. P. (2011).	The effectiveness of strategies to change organisational culture to improve healthcare performance: a systematic review	The objective of this review was to determine the effectiveness of strategies to change organisational culture in order to improve healthcare performance.	Researchers wishing to evaluate the effectiveness of strategies to change organisational culture should conduct evaluations using appropriately robust designs if the intent is to offer generalisable findings	Studies could be set in any type of healthcare organisation in which strategies to change organisational culture in order to improve healthcare performance were applied. Our main outcomes were objective measures of professional performance and patient outcome	Current available evidence does not identify any effective, generalisable strategies to change organisational culture. Healthcare organisations considering implementing interventions aimed at changing culture should seriously consider conducting an evaluation	<b>Level 1:</b> Experimental with Randomized Controlled Trials with positive results <b>Quality Rating B:</b> Good Quality, reasonable results and sample size. Reasonable use of literature
Rakichevikj, G., Strezoska, J., & Najdeska, K. (2010).	Professional ethics- basic component of organizational culture.	Culture is the main driving force that led the organization to its goals.	With the organizational culture is determined that the activities of human resources is desirable and which are unacceptable. In addition, external and internal organizational culture is basic variables on which senior managers have determined the rights of employees.	Employees carry their company culture which is expressed through customs and language. On the other hand, organizational culture affects the individual values, ethics and attitudes. Each company has its own organizational culture that is recognizable in the manner of administration	Each company should adopt a written set of ethical rules which determine the standards of appropriate behavior.	<b>Level 4:</b> Research and experiential evidence review <b>Quality Rating A:</b> High Quality, expertise is clearly credible

Author	Title	Outcome Variables	Performance Improvements	Evaluation Methods	Results	Johns Hopkins Nursing Evidence Based Practice Strength of Evidence & Quality Rating
Shoemaker, P. (2011).	What value-based purchasing means to your hospital.	Value versus volume	Intricate ways to measure hospital's quality of care to determine whether the hospital qualifies for incentive payments.	Determine performance, measuring quality, potential impact of the program, and increasing DRG payment reductions to fund incentives	Because the thresholds for earning incentive points are set at the 50th percentile, it would be reasonable to expect that about half of all participating hospitals will experience reduced Medicare payment.	<b>Level 5:</b> Expert Opinion <b>Quality Rating B:</b> Good Quality, expertise appears to be credible
Singer, A., Thode, H., Viccellio, P., & Pines, J. (2011).	The association between emergency department boarding and mortality	The association between length of ED boarding and outcomes. The authors expected that prolonged ED boarding of admitted patients would be associated with higher mortality rates and longer hospital lengths of stay (LOS).	Emergency department (ED) boarding has been associated with several negative patient-oriented outcomes, from worse satisfaction to higher inpatient mortality rates.	This was a retrospective cohort study set at a suburban academic ED with an annual ED census of 90,000 visits. Consecutive patients admitted to the hospital from the ED and discharged between October 2005 and September 2008 were included.	Hospital mortality and hospital LOS are associated with length of ED boarding.	<b>Level 3:</b> Non-experimental study. Descriptive with positive results <b>Quality Rating B:</b> Good Quality, reasonably consistent conclusions and sample sizes
Snell, J. (2012).	Get the culture of the organisation right, and good care will follow.	A culture of caring and compassion	Right culture and right values start at the front door	Evaluation of staff across all settings, not just nursing	It is all about creating a culture that people feel safe and calm. Treating people with respect and caring for them at their most vulnerable time	<b>Level 5:</b> Expert Opinion <b>Quality Rating B:</b> Good Quality, expertise appears to be credible
Weiss, M., & Tyink, S. (2009).	Creating sustainable ideal patient experience cultures.	Patient-centric strategies	Create, Connect, and Captivate	Design, Deliver, and Differentiate	A well-designed experience can eliminate variability to allow patient outcomes to be defined, understood, and ultimately felt.	<b>Level 4:</b> Research and experiential evidence review <b>Quality Rating B:</b> Good Quality, expertise appears to be credible
White, B., Biddinger, P. D., Chang, Y., Grabowski, B., Carignan, S., & Brown, D. F. (2012).	Boarding inpatients in the emergency department increases discharged patient length of stay	Primary: discharged patient LOS Secondary: Daily boarder burden and the median ED LOS	No specific actions were suggested. The only thing suggested is to reduce boarder burden to decrease LOS for both admitted and discharged patients.	Time interval between patient registration in the ED and leaving the ED	Between 11a and 11p expected 57 mins longer ED LOS for discharged patients with high boarder burden in ED	<b>Level 3:</b> Qualitative Study. Observational <b>Quality Rating B:</b> Good Quality, reasonably consistent conclusions and sample sizes
Yoder, E. (2011).	A culture of extraordinary care: Part 2.	Creating an environment that exceeds customer expectations.	Motivated and satisfied employees	Communication, Explanations, Answers, Compassion, and Excellent Care	Your culture will either do two things: It will drive great strategy or drag it down.	<b>Level 5:</b> Expert Opinion <b>Quality Rating B:</b> Good Quality, expertise appears to be credible

Appendix L: Kotter's 8 Step Change Management Model







## Appendix N: OCAI Assessment Tool

Developed by American Professor Robert Quinn and colleague Kim Cameron (2006)

**Organizational Culture Assessment Instrument**

Instructions for completing the Organizational Culture Assessment Instrument (OCAI).

The purpose of the OCAI is to assess six key dimensions of organizational culture. In completing the instrument, you will be providing a picture of how your organization operates and the values that characterize it. No right or wrong answers exist for these questions, just as there is no right or wrong culture. Every organization will most likely produce a different set of responses. Therefore, be as accurate as you can in responding to the questions so that your resulting cultural diagnosis will be as precise as possible.

You are asked to rate your organization in the questions. To determine which organization to rate, you will want to consider the organization that is managed by your boss, the strategic business unit to which you belong, or the organizational unit in which you are a member that has clearly identifiable boundaries. Because the instrument is most helpful for determining ways to change the culture, you'll want to focus on the cultural unit that is the target for change. Therefore, as you answer the questions, keep in mind the organization that can be affected by the change strategy you develop.

The OCAI consists of six questions. Each question has four alternatives. Divide 100 points among these four alternatives depending on the extent to which each alternative is similar to your own organization. Give a higher number of points to the alternative that is most similar to your organization. For example, in question one, if you think alternative A is very similar to your organization, alternative B and C are somewhat similar, and alternative D is hardly similar at all, you might give 55 points to A, 20 points to B and C, and five points to D. Just be sure your total equals 100 points for each question.

Note, that the first pass through the six questions is labeled "Now". This refers to the culture, as it exists today. After you complete the "Now", you will find the questions repeated under a heading of "Preferred". Your answers to these questions should be based on how you would like the organization to look five years from now.

**The Organizational Culture Assessment Instrument**

<b>1. Dominant Characteristics</b>		<b>Now</b>	<b>Preferred</b>
A	The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.		
B	The organization is a very dynamic entrepreneurial place. People are willing to stick their necks out and take risks.		
C	The organization is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.		
D	The organization is a very controlled and structured place. Formal procedures generally govern what people do.		
	Total		
<b>2. Organizational Leadership</b>		<b>Now</b>	<b>Preferred</b>
A	The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing.		
B	The leadership in the organization is generally considered to exemplify entrepreneurship, innovating, or risk taking.		
C	The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.		
D	The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency.		
	Total		
<b>3. Management of Employees</b>		<b>Now</b>	<b>Preferred</b>
A	The management style in the organization is characterized by teamwork, consensus, and participation.		
B	The management style in the organization is characterized by individual risk-taking, innovation, freedom, and uniqueness.		
C	The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.		
D	The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships.		
	Total		

<b>4. Organization Glue</b>		<b>Now</b>	<b>Preferred</b>
A	The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.		
B	The glue that holds the organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.		
C	The glue that holds the organization together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.		
D	The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.		
	Total		
<b>5. Strategic Emphases</b>		<b>Now</b>	<b>Preferred</b>
A	The organization emphasizes human development. High trust, openness, and participation persist.		
B	The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.		
C	The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.		
D	The organization emphasizes permanence and stability. Efficiency, control and smooth operations are important.		
	Total		
<b>6. Criteria of Success</b>		<b>Now</b>	<b>Preferred</b>
A	The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.		
B	The organization defines success on the basis of having the most unique or newest products. It is a product leader and innovator.		
C	The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is key.		
D	The organization defines success on the basis of efficiency. Dependable delivery, smooth scheduling and low-cost production are critical.		
	Total		

**A Worksheet for Scoring the OCAI**

**NOW Scores**

	1A
	2A
	3A
	4A
	5A
	6A
	Sum (total of A responses)
	<i>Average (sum divided by 6)</i>

	1B
	2B
	3B
	4B
	5B
	6B
	Sum (total of B responses)
	<i>Average (sum divided by 6)</i>

	1C
	2C
	3C
	4C
	5C
	6C
	Sum (total of C responses)
	<i>Average (sum divided by 6)</i>

	1D
	2D
	3D
	4D
	5D
	6D
	Sum (total of D responses)
	<i>Average (sum divided by 6)</i>

**PREFERRED Scores**

	1A
	2A
	3A
	4A
	5A
	6A
	Sum (total of A responses)
	<i>Average (sum divided by 6)</i>

	1B
	2B
	3B
	4B
	5B
	6B
	Sum (total of B responses)
	<i>Average (sum divided by 6)</i>

	1C
	2C
	3C
	4C
	5C

	1D
	2D
	3D
	4D
	5D



<b>A</b>									
<b>B</b>									
<b>C</b>									
<b>D</b>									
<b>Total</b>	100								

<b>Scores</b>									
<b>A</b>									
<b>B</b>									
<b>C</b>									
<b>D</b>									
<b>Total</b>	100								

**PREFERRED**

<b>Scores</b>									
<b>A</b>									
<b>B</b>									
<b>C</b>									
<b>D</b>									
<b>Total</b>	100								

<b>Scores</b>									
<b>A</b>									
<b>B</b>									
<b>C</b>									
<b>D</b>									
<b>Total</b>	100								

## Appendix O: Requirements for the Manager

**Requirements for Managers**

- 1) Staffing:**

The manager has the responsibility of the staffing and balancing of the schedule on the unit. They are responsible for following staffing guidelines and premium policy. In addition, maintaining position control and needs. The manager is responsible for setting time with recruitment to review needs and focus areas. Request for positions will be given to the appropriate director. It will be reviewed in FAC on Wednesdays. If the committee approves the position, the leader will submit a form to CHP. If premium is needed for a schedule the Request for Premium Pay Approval Form is submitted for Director and VP Approval. No incentives from the CNO toolbox are used unless approved by the CNO.
- 2) Patient Experience/Accountability Huddle:**

The manager is responsible for getting into Press Ganey and running their patient experience numbers at least every other day. Any survey that is marked below a 9 should be reviewed for trends in care, quality, and clinicians. The manager is responsible for attending and participating in this huddle 100% of the time while on campus. If there is an extenuating circumstance, the nurse manager will get approval from their director and provide designee to report out. During huddle the manager will report productivity, ED flow times, patient experience, and initiatives to improve patient experience. Report out should include: 1) Changes to Domains (higher or lower) and number of surveys, 2) Comments on surveys and trends, 3) Action Items to Improve.
- 3) Time and Attendance:**

The manager is responsible for approving the employee timecards. In addition, any trends of sick or tardiness are followed and the corrective action policy is adhered to consistently.
- 4) Optix/Productivity:**

It is responsibility to review and manage your productivity every day. Please make sure you are familiar with OPTIX and the daily checkbook.
- 5) SafeCare:**

All SafeCares from the previous day will be reviewed by the manager prior to safety huddle. Any issues or trends will be reported.
- 6) Corrective Action/PIP:**

The manager is responsible for monitoring the performance and competency of the staff. There should be consistent “on the floor” meetings with the clinical educators in the unit to discuss education and on-going competency. If corrective action or a PIP is required, the nurse manager implements and monitors as stated in the policy.
- 7) A3/KRA:**

Your A3/KRA should be updated by the 5<sup>th</sup> of every month. It should be posted on your QOS board and your staff should be able to speak about all the initiatives you have developed in collaboration with your team.
- 8) Staff meetings:**

The manager should have staff meetings (accommodating all shifts). The attendance of the staff meetings should be tracked and incorporated in the mid-year and annual performance document for all employees. Attendance for every employee should be a minimum of 75% per year.
- 9) Daily Huddles:**

Daily huddles should be performed at a minimum of 2 times per day in your department.
- 10) Patient Safety Huddle:**

The manager is required to attend patient safety huddle at least 80% per week (or 4 out of the 5 days) unless on PTO. The day that is not attended must be covered by a designee from your department.
- 11) Daily Discharge Rounding (M-F):**

The nurse manager is required to participate 100% of the time in daily d/c rounding when they are on campus. If they are on PTO, they will have the d/c rounds covered by a designee. Operational departments will assist with d/c rounds as designated by their director.
- 12) QOS rounds:**

The manager is required to participate and coach staff (100%) during the QOS rounds in their department. If they are on PTO, a designee is assigned. The QOS board is required to be updated the Monday after pay day.

**13) Off shift coverage:**

The nurse manager is responsible for working one off shift every pay period. In addition, the nurse manager is also responsible for having a clinical coordinator work an off shift once a pay period.

**Friday huddle follow-up:**

The nurse manager is responsible for providing a quick patient experience update following huddle on Friday's. Report out should include: 1) Changes to Domains (higher or lower) and number of surveys, 2) Comments on surveys and trends, 3) Action Items to Improve.

**14) Audits:**

The nurse manager is responsible for ensuring initiatives for quality and patient experience are being performed. Weekly audits should be reported to your director using the template entitled "Weekly Audit". The audits include:

- D/C checklist compliance
- Whiteboard compliance
- D/C phone call compliance
- Hourly rounding compliance
- Med-Sticker compliance
- D/C rounding compliance
- Any JCAHO audits that are required for continued readiness
- Any Quality audits if areas are identified as HARM issues
- 

**\*\*\*\*Audits required for Operations will be assigned by your director\*\*\*\***

**15) Shared Governance:**

The manager is responsible for implementing a Shared Governance Committee in their department by the end of 3<sup>rd</sup> quarter 2014. Neil Fedders and Jasmine Rausch are available for assistance with the structure of these committees.

**16) Visibility on your unit:**

With the reduction in meeting time, it is expected that the manager spends 1/3 of the day out in the department seeing patients, rounding, talking with staff, and developing physician relationships. Please make every effort to facilitate seeing your admissions.

**17) Admission Welcome:**

Nurse Managers: Patients should be provided with your business card so that they know you as the manager and know how to reach you (this responsibility could be delegated to a charge nurse or clinical coordinator as well).

**18) Patients holding in the ED:**

In the event that we are holding patients in the ED for more than 60 minutes, the CA will notify the MOC. The MOC will round in the ED with the ED manager to perform service recovery. On the weeks that the ED manager is the MOC, he will notify the most appropriate unit so that someone can round with him

**19) Daily MOC duties when you are MOC:**

- Make yourself available. Answer phone calls/texts in a timely manner. Make sure CA always has a phone number that you can be reached at.
- Have a good understanding of the state of the hospital. Read clinical reports. Attend huddle. Check in with CA/staffing periodically, as needed.
- Communicate to department managers regarding current/upcoming staffing concerns. This is meant to be supportive and transparent in creating staffing solutions.
- Assist in decisions to open/close overflow areas (A3, CTU).
- Work with CA's in the escalation of patient care issues as they utilize their chain of command.
- Reach out to AOC for support and to assist in decision making, as needed.
- Gauge the need to physically respond to the hospital. CA's to help determine this need. Troubleshoot other options and resources, prior to response.

**20) Domain Meetings:**

You are required to send a representative to the domain meetings weekly. The meetings will be held at 12 noon (over lunch) in the B1 community room. They will be held every Monday and Thursday with rotating domains. The domains will be paired as follows:

D/C and Medication domain



Nursing Communication and Physician Communication

Pain and Help from Hospital Staff

Overall rating of care and Environment

The 1<sup>st</sup> Meeting will be Monday May 5<sup>th</sup>. It will be D/C and Medication Domain followed by Nursing and Physician Communication on Thursday the 8<sup>th</sup> (and the following week will be the next two pairs...)

**2.1) Required Monthly Meetings:**

- Management Meeting
- Team Meeting (example Team Shelley, Fedders, Rausch, Beckman)
- Team Edrington will be held the 4<sup>th</sup> Tuesday of the Month at 1230pm prior to patient sat. Please bring your lunch!!!

If for any reason you are unable to meet these requirements, please see your director or manager to discuss the alternatives. I understand the expectations

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Please sign and return to your director

Appendix P: Manager Weekly Audit Tool

Nurse Manager Weekly Audit Tool					
	Date	Date	Date	Date	Date
	29-Sep	30-Sep	1-Oct	2-Oct	3-Oct
% Compliance D/C checklist	100%	100%	100%	100%	100%
% Compliance with White Board Usage	100%	100%			100%
% Compliance D/C phone calls	100%	100%	83%	100%	100%
% Compliance Hourly Rounding		100*		100*	
% Compliance with Med-Stickers (complete)	100%	100%		100%	
% Compliance with D/C Rounds	100%	100%	100%	83%	100%
Readmissions	3	0	2	0	1
Number of times observed bedside handoff		100%		100%	
Number of times observed RN/MD rounding		2	2	2	
ED Throughput Times	24:5	32:4	24:6	38:2	35
Day:	25	34	20	50	39
Night:	23	24	25	26	32
PACU Throughput Times					
Unit: <b>A2</b>					
Manager:					
<b>Notes:</b>					
* our hourly rounding is in the small test of change phase. Allie Luna will focus on this. She starts in her clinical coord. Role this week.					

Appendix Q: Patient Experience Action Plans

Patient Experience Action Plan		
Department: A1 Telemetry		
Overall Rating of the Hospital		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Leadership Discharge Rounds</b> - Every M-F immediately following Safety Huddle rounds are made on all patients who have a discharge order or have the potential to be discharged. We focus on the overall rating of care, questions around the domains, questions regarding plan of care and communication, as well as pushing/encouraging the survey to be filled out.	Sarah Varney, Cassie Herald, Brian Pope, Mary Beth Taylor	A rounding tool is utilized. The tool tracks the rating, if f/u is needed, and who completed the round. Goal of 80% or greater to be seen.
<b>Rating on Discharge</b> - The discharge checklist has the overall rating of care component added under the patients signature line. The RNs ask this as their final talking point when going over the discharge instructions. At this time the survey is also discussed/encouraged.	A1 Nursing Staff	The discharge checklist audits are conducted daily. Goal of 100% completion/compliance.
<b>Rating Asked Q12</b> - Every shift the RNs are asking the patient how they would rate their overall rating of care. If the patient rates any less than a 10, the RNs are asking what can be done to make that a 10. If the patient rates any less than a 9, the RN immediately reports that to myself for immediate service recovery. The rating is then written on the white board every shift, black for days and blue for nights.	A1 Nursing Staff, Manager, and Charge RN who conducts white board audits	White board audits are conducted every shift no later than 10a and 10p by the Charge RN for compliance. Goal is 100%
<b>Discharge Phone Call Script</b> - The discharge phone call script includes the overall rating of care and encourages survey return.	Charge RNs	Audits and tracking are conducted daily
Communication with Nurses		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Bedside Report</b> - Bedside report will happen with each handoff, every shift.	A1 Nursing Staff	Observations, Charge RN will also share responsibility for ensuring this happens.
<b>White Boards</b> - Every shift the white board will be updated with the most current information RN name and #, Plan of Care, etc.	A1 Nursing Staff	White board audits are conducted every shift no later than 10a and 10p by the Charge RN for compliance. Goal is 100%
<b>Commit to Sit</b> - While discharging a patient, the RN hands off the phone to the buddy RN. The RN then sits at the patients bedside to go over the discharge checklist, explain medications, remove the IVs, etc. Night shift is expected to ask the patient what time they like to go to bed. The RN will then attempt to wrap up treatments, meds, etc. by this time. The RN will also sit at the bedside to review potential interruptions such as lab draws, vital signs, etc.	A1 Nursing Staff	Using a tool that allows us to track number of patients in RN assignment, number of discharges, and number of patients we were actually able to sit with and complete.
<b>Discharge Business Cards</b> - When the patient is discharged, the RN gives the patient a business card with his/her name written on it along with how to reach her and the time she leaves. This way the patient may call if there are any further questions once they are home.	A1 Nursing Staff	
<b>RN-MD Rounding</b> - The RN and the Hospitalist will round daily at the bedside to discuss the plan of care. If bedside rounding is unable to happen with the primary RN, the charge RN will conduct the rounds. If neither party is successful at completing rounds, the expectation is that communication between the MD and RN will happen 100% of the time via phone or face to face.	A1 Nursing, Charge RN, Buddy RN	
Help from Hospital Staff		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Hourly Rounding</b> - The buddy system is utilized to complete hourly rounding. The RNs take turns hourly rounding with their buddy on each others assignment (max 10 patients). The US and PCAs are required to complete every third hour (0700, 1000, 1300, 1600, etc). The focus remains on the SP's and environment/cleanliness.	All A1 Staff	The staff will sign off each hour they completed on the log, that is then turned into management. Compliance is checked through R5 room activity reports. During discharge rounds the manager will also ask if the patient was rounded on hourly.
<b>Hourly Rounding Contract / Call Belongs to All Contract</b> - To hold staff accountable and stress the importance of hourly rounds and the call belongs to all culture, the staff will sign a contract stating they understand the expectations and understand they will be held accountable if they fail to meet these expectations.	All A1 Staff	All contracts due by July 7th to Manager.

<b>Orientation to Call Light</b> - At the beginning of every shift, the PCAs will utilize their 0700 & 1900 round to orient the patient to the call light, phone, and menu service. They will also use that opportunity to introduce themselves, explain how the patient can reach them, and briefly introduce what they will be assisting with/taking care of.	A1 PCAs	
<b>Unit Secretary Welcome Rounds</b> - The unit secretary will be responsible for rounding on all new admissions. They will provide the patient with our welcome letter, and briefly introduce what they expect: hourly rounding, bedside report, etc. They will also orient the patient to the call light, phone, menu service, etc.	A1 Unit Secretaries	A log will be kept and turned into management daily. The goal is 80%. If rounds not complete (d/t no sec, etc) the manager/cc will round.
<b>Communication with Doctors</b>		
<b>Action Item/Process</b>	<b>Responsible Person(s)</b>	<b>Success Measured By</b>
<b>Treatment Team</b> - No later than 0800 & 2000 the RN will have the treatment team updated with her name and phone number. The prior nurse will also be removed from the treatment team. This is imperative to maximize communication for the physicians.	A1 Nursing Staff	I have my list set up to show treatment teams. As part of my AM routine I log into EPIC and check compliance. If needed I provide real time feedback to that RN.
<b>RN-MD Rounding</b> - The RN and the Hospitalist will round daily at the bedside to discuss the plan of care. If bedside rounding is unable to happen with the primary RN, the charge RN will conduct the rounds. If neither party is successful at completing rounds, the expectation is that communication between the MD and RN will happen 100% of the time via phone or face to face.	Hospitalist, A1 Nursing	
<b>RN-MD Task Force</b> - A Monthly task force with RNs and Hospitalists that meets the last Thursday of every month to discuss and tackle various topics/issues.	Sarah Varney, Carrie Rollins, Dr. Stivers, Nursing	
<b>Hospital Environment</b>		
<b>Action Item/Process</b>	<b>Responsible Person(s)</b>	<b>Success Measured By</b>
<b>Hourly Rounding</b> - The buddy system is utilized to complete hourly rounding. The RNs take turns hourly rounding with their buddy on each others assignment (max 10 patients). The US and PCAs are required to complete every third hour (0700, 1000, 1300, 1600, etc). The focus remains on the 5P's and the environment/cleanliness.	All A1 Staff	
<b>Armbands, Stickers, Signs</b> - The Unit Practice Council has developed a campaign to raise awareness around noise at night. They have developed neon reminder bracelets that say "shh..take it to the lobby," stickers with various sayings that the charge will hand out to staff that are not being quiet, and signage.	Unit Practice Council, Charge RNs, A1 Staff	
<b>Quiet Time</b> - The unit has a designated quiet time from 2pm-3pm. At this time lights are out, voices utilized are a whisper, and patient interruptions are at a minimum.	All A1 Staff	
<b>2200 Bedtime Round</b> - The 2200 round is designated for "tucking patients in." The healing menu is presented, ear plugs are offered, etc. The TVs are turned down or off, doors are closed, and the patient is prepared for the night.	All A1 Staff	
All cisco phones are set on the same low tone ringer with a volume of 2 at all times.		
<b>Pain Control</b>		
<b>Action Item/Process</b>	<b>Responsible Person(s)</b>	<b>Success Measured By</b>
<b>Huddle</b> - Any patient requiring pain meds every two hours or less is announced in huddle to increase awareness.	A1 Charge RN	
<b>White Board</b> - The patients pain medications, time given, interventions, next dose available are maintained on the white board for the patient to see.	A1 Nursing Staff	White Board Audits are conducted daily. Pain is also asked about during leadership discharge rounds.
<b>Explain about Medications</b>		
<b>Action Item/Process</b>	<b>Responsible Person(s)</b>	<b>Success Measured By</b>
<b>Medication Education Sheets w/ Stickers</b> - On admission, a medication education sheet is initiated. On this sheet are stickers for every NEW medication the patient is started on. The sticker provides a quick glance of what the medication is used for and the common side effects of the medication. Every time the RN gives that new medication she is initialing under the sticker that she completed education with teachback on the new med.	A1 Nursing	Strict Audits are conducted daily for accuracy and completeness.
<b>Observations</b> - Mary Beth completes 5 observations a week on medication passes and teachback. She then provides real time feedback to the RN and suggestions if indicated.	Mary Beth	
<b>Discharge Rounding</b> - During Leadership discharge rounding we specifically ask the patient if they are receiving information on their new medications and if they understand what the medicine is for and side effects.	Sarah Varney, Brian Pope, Cassie Herald, Mary Beth Taylor	

Discharge Instructions		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Discharge Checklist</b> - A discharge checklist is completed on ALL patients. The patient then signs the checklist after it is reviewed. The patient is sent home with the original and a copy goes in my mailbox. If the patient is going to an ECF, the checklist is utilized to give handoff.	A1 Nursing	I audit these every day, we are 100% for completing the checklist and getting a signature. The discrepancy is overall rating of care being listed. I have individual conversations with those staff that are not compliant.
<b>Buisness Card</b> - At discharge the patient receives a buisness card with the discharging nurses name and phone number so that the patient or family may call if questions arise once they are home.	A1 Nursing	
Hourly Rounding		
Action Item/Process	Responsible Person(s)	Success Measured By
The buddy system is utilized to complete hourly rounding. The RNs take turns hourly rounding with their buddy on each others assignment (max 10 patients). The US and PCAs are required to complete every third hour (0700, 1000, 1300, 1600, etc). The focus remains on the 5P's and the enviornment/cleanliness. The Charge RN is responsible for checking in with the staff and monitoring that it is being completed.	Nursing, Charge Nurse	1.) During Leadership discharge rounds the patient is asked if they were rounded on hourly. 2.) The staff maintain a log that contains their initials signing off that they completed hourly rounding for the shift. 3.) Responder 5 reports
Discharge Phone Calls		
Action Item/Process	Responsible Person(s)	Success Measured By
The Charge RN is responsible for making the daily discharge phone calls on the previous days discharges. A total of 2 attempts are made. If no contact made on the second attempt a scripted voicemail is left thanking the patient and mentioning the overall rating of care. Once complete the Charge RN leaves the feedback/completed call in my mailbox.	Charge RN	Audits and tracking are conducted daily
Thank You Cards		
Action Item/Process	Responsible Person(s)	Success Measured By
Every discharged patient receives a thank you letter from A1 that is signed by the staff. The thank you letter also explains the overall rating and encourages the survey.	Unit Secretary	
Staff Engagement		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Unit Practice Council</b> - Our shared governance has organized several things around engagement such as Reds games, picnics, outings, etc. They also survey the staff every couple of weeks to seek information and feedback around our activities.	Unit Practice Council	Retention/Gallup
<b>Year Long Secret Santa</b> - Our year long secret santa is exactly that! The staff have had a blast with this. At the beginning of the year we draw names and you have that person for the entire year. You can bring them gifts on their birthday, anniversary, etc. We reveal one anothers secret santa at the Christmas Party.	A1 Staff	Retention/Gallup
<b>A1 Facebook Page</b> - We have a facebook page exculsive to A1 team members that we utilize for recognition, announcements, communication, etc.	Sarah Varney	Retention/Gallup
<b>"You Pick The Topic"</b> - Every 2 months Mary Beth allows the staff to pick an education topic. For example, the staff like to have mock codes. We utilize Christian (the dummy) and hold mock scenarios. We use a crash cart as well so the staff can become familiar with and comfortable with the components. The feedback is awesome.	Mary Beth	Retention/Gallup
<b>Teambuilding</b> - Before every meeting and sometimes at huddle we do a teambuilding exercise. The staff have come to look forward to these and I feel it has helped boost attendance outside the required 80%	Sarah Varney	Retention/Gallup
<b>Employee Spotlight</b> - Similar to what we did in the management team meeting, an employee name is drawn from a bag and they are spotlighted for a month. They utilize the board to tell their story. They bring in pictures, etc. Our first spotlight is in July!	Unit Practice Council	Retention/Gallup
Addressing Low Performers		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Three Strikes Rule</b>	Sarah Varney	Has resulted in 2 people going into verbals
<b>Real Time Feedback</b> - On the spot coaching if needed	Sarah Varney	
<b>Contracts</b> - Having contracts around expectations has made it easier to hold staff accountable. Employees have signed commitments to hourly rounding, overall rating of care initiative, etc.	Sarah Varney	
<b>Transperency</b> - We post staff members ER times, medication education sheets that are incomplete, scanning compliance, and other fall outs.	Sarah Varney	

Patient Experience Action Plan		
Department: B1		
<b>Overall Rating of the Hospital</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Round on 75% of patients within 24hrs of admission	T. Scherzinger RN	Increase in scores
Karen and Doug askings the Overall Rating on 75% of the Ortho pts.	Karen, Doug, Tiffany	Increase in scores
<b>Communication with Nurses</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Help from Hospital Staff</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Responder 5 tracking sheet	Unit Secretary/Charge RN	Lack of reported issues from Responder 5
Weekly lunch meetings with B1 and Therapy teams- starts 7/	B1 staff and Therapy staff	Better processes and increased team work
<b>Communication with Doctors</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Hospital Environment</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Proper chair placement in the patient rooms	B1 staff/ Therapy	Reporting of less moving of the chairs, disruption
<b>Pain Control</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
<b>Explain about Medications</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Using bright yellow stickers for the side effects for AVS	B1 staff/ T. Scherzinger	Increase in scores for explanation of meds.
<b>Discharge Instructions</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
On track		
<b>Hourly Rounding</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Track compliance by staff member and ask for explanation if not completed.	T.Scherzinger	Increase in compliance by staff member and reported score from Press Ganey
Action Item/Process	Responsible Person(s)	Success Measured By
On track- continue to follow up with any issues that are reported		
<b>Thank You Cards</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
On track		
<b>Staff Engagement</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Outings set by Unit Advisory Board	UAB	Participation in outing and better attitudes!
<b>Addressing Low Performers</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Pulling info from surveys and addressing with the staff member. Ask for written explanation.	T. Scherzinger	Positive change by employee.

Patient Experience Action Plan		
Department: B3		
<b>Overall Rating of the Hospital</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Discuss quality of care rating at huddles every shift next week to set expectations on when it should be done, how to do it and why we are doing it	charge nurse/CC/manager	Increased knowledge and compliance
Check with patients during rounds to make sure initiative is being done	CC/Rounding team	90% of patients say staff are asking and understand why
<b>Communication with Nurses</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Increase rounding with physicians in patient rooms	nurses and physicians	Tracking tool we previously used when first implementing
<b>Help from Hospital Staff</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Adding 9am - 1pm PCA into 2nd call stop for PCA in nurse call	unit secretary	calls answered in a more timely manner per patient feedback
Trialing a report sheet and re-structuring of 9am - 1pm PCA job duties	Nikki Allen/PCAs	Beds/baths done by time extra PCA leaves
Have nightshift PCA's round at 6am and refill water pitchers	PCAs	Staff feedback
<b>Communication with Doctors</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Increase rounding with nurses in patient rooms	nurses and physicians	Tracking tool we previously used when first implementing
<b>Hospital Environment</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Quiet time 2p - 3p on unit	all staff	feedback from patients/staff
<b>Pain Control</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Meeting goal		
<b>Explain about Medications</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Meeting goal		
<b>Discharge Instructions</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Audit checklist to make sure they are completely filled out - accountability for those not	CC/manager	95% compliance completely filled out
<b>Hourly Rounding</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Meeting target last two reports		
<b>Discharge Phone Calls</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
meeting target		
<b>Thank You Cards</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
write a thank you note to staff in their birthday month	manager	
<b>Staff Engagement</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
will be meeting with nightshift team to devise plan	manager and staff	staff satisfaction
Engage in more personal conversations specifically with nightshift	manager	staff satisfaction
One activity at each unit meeting	manager	staff satisfaction
<b>Addressing Low Performers</b>		
Action Item/Process	Responsible Person(s)	Success Measured By
Sherry Petit - holding discussion around initiatives and attitude - will implement PIP if not improved	Angela Joyce	White board quality of care 100% next week and discharge checklist completely filled out
Emily Bohlinger - transferring to Jewish for full time position - just passed nursing boards		
Kelly VanPelt - holding discussion around initiatives and attitude - will implement PIP if not improved	Angela Joyce	White board quality of care 100% next week and discharge checklist completely filled out

Appendix R: Night Shift Rounds

		Third Quarter NIGHT ROUNDS											
rev 7/10/2014		QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS
2014		7/10	7/17	7/24	7/31	8/7	8/14	8/21	8/28	9/4	9/11	9/18	9/25
A	A1 FBC EVS			7					5				
B	CMU & Transport A2 B3				1					6			
C	PHARMACY SLEEP CENTER					2					7		
D	ICU / RTD B1 EMERG	5					3					1	
E	IMAGING		6					4					2

- |   |   |   |
|---|---|---|
| <p>Team</p> <div style="border: 1px solid black; background-color: #00FFFF; padding: 5px; display: inline-block;">1</div> <p><b>Kathi Edrington</b><br/>Nathon Montgomery<br/>Cassie Herald<br/>Jen Macrae (ED)</p> | <p>Team</p> <div style="border: 1px solid black; background-color: #008000; padding: 5px; display: inline-block;">2</div> <p><b>Jasmine Rausch</b><br/>Chad Balwanz<br/>Tiffany Scherzinger</p> | <p>Team</p> <div style="border: 1px solid black; background-color: #FFFF00; padding: 5px; display: inline-block;">3</div> <p><b>Kristin Shelley</b><br/>Mary Yorio<br/>Yeni Zewdy<br/>Angie Ferrell</p> |
| <p>Team</p> <div style="border: 1px solid black; background-color: #FFA500; padding: 5px; display: inline-block;">4</div> <p><b>Neil Fedders</b><br/>Mary Beth Taylor (A1)<br/>Justin Wallace</p>                   | <p>Team</p> <div style="border: 1px solid black; background-color: #FF69B4; padding: 5px; display: inline-block;">5</div> <p><b>Carrie Beckman</b><br/>Angela Thacker<br/>Joy Douglas</p>       | <p>Team</p> <div style="border: 1px solid black; background-color: #8A2BE2; padding: 5px; display: inline-block;">6</div> <p><b>Sarah Varney</b><br/>Brian Pope<br/>Molly Grooms</p>                    |
| <p>Team</p> <div style="border: 1px solid black; background-color: #00008B; padding: 5px; display: inline-block;">7</div> <p><b>Bridget Kirk</b><br/>Angela Joyce<br/>Melissa Fritz (OR)<br/>Bill Carroll</p>       |   |   |

Teams will make rounds as scheduled. Rounding on other units may be necessary as per current issues or requests by manager.

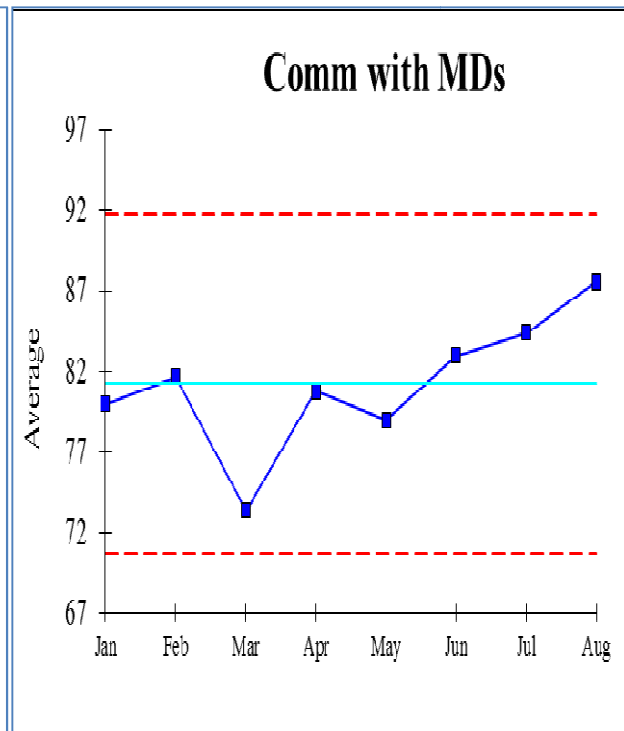
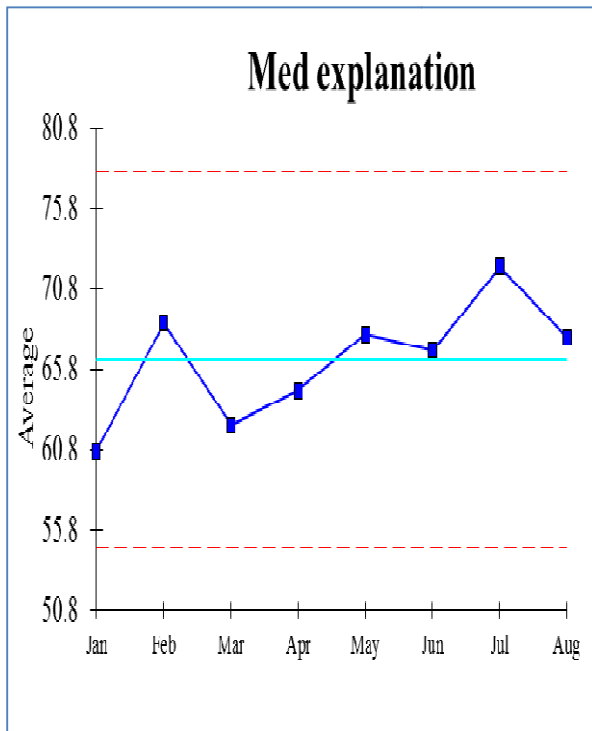
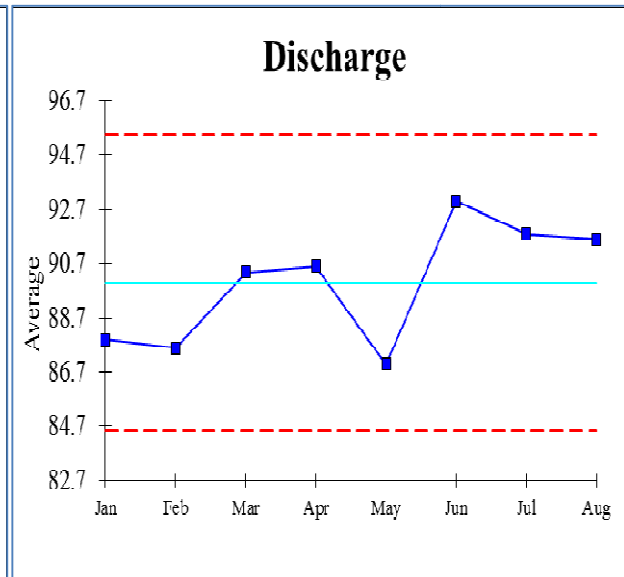
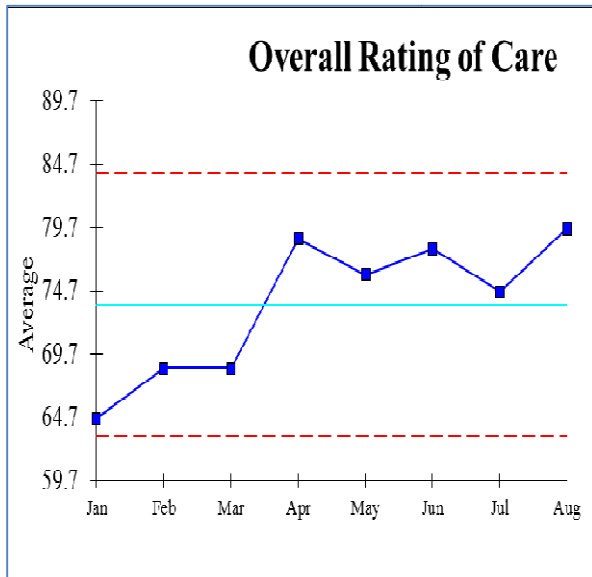
		Fourth Quarter NIGHT ROUNDS												
rev 10/1/2014		QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS	SFTY	QOS	QOS	QOS	QOS
2014		10/2	10/9	10/16	10/23	10/30	11/6	11/13	11/20	11/27	12/4	12/11	12/18	12/25
A	A1 FBC EVS	3					1						6	
B	CMU & Transport A2 B3		4				2						7	
C	SLEEP CENTER PHARMACY			Cancelled due to Mgmt retreat					3					1
D	ICU / RTD B1 EMERG				6					4				
E	IMAGING					7					5			

- |   |   |   |
|---|---|---|
| <p>Team</p> <div style="border: 1px solid black; background-color: #00FFFF; padding: 5px; display: inline-block;">1</div> <p><b>Kathi Edrington</b><br/>Nathon Montgomery<br/>Cassie Herald<br/>Jen Macrae (ED)</p> | <p>Team</p> <div style="border: 1px solid black; background-color: #008000; padding: 5px; display: inline-block;">2</div> <p><b>Jasmine Rausch</b><br/>Chad Balwanz<br/>Tiffany Scherzinger</p> | <p>Team</p> <div style="border: 1px solid black; background-color: #FFFF00; padding: 5px; display: inline-block;">3</div> <p><b>Kristin Shelley</b><br/>Mary Yorio<br/>Yeni Zewdy<br/>Angie Ferrell</p> |
| <p>Team</p> <div style="border: 1px solid black; background-color: #FFA500; padding: 5px; display: inline-block;">4</div> <p><b>Neil Fedders</b><br/>Mary Beth Taylor (A1)<br/>Justin Wallace</p>                   | <p>Team</p> <div style="border: 1px solid black; background-color: #FF69B4; padding: 5px; display: inline-block;">5</div> <p><b>Carrie Beckman</b><br/>Angela Thacker<br/>Joy Douglas</p>       | <p>Team</p> <div style="border: 1px solid black; background-color: #8A2BE2; padding: 5px; display: inline-block;">6</div> <p><b>Sarah Varney</b><br/>Brian Pope<br/>Molly Grooms</p>                    |
| <p>Team</p> <div style="border: 1px solid black; background-color: #00008B; padding: 5px; display: inline-block;">7</div> <p><b>Bridget Kirk</b><br/>Angela Joyce<br/>Melissa Fritz (OR)<br/>Bill Carroll</p>       |   |   |

Teams will make rounds as scheduled. Rounding on other units may be necessary as per current issues or requests by manager.



Appendix S: Control Charts Showing Improvement Trends 2014

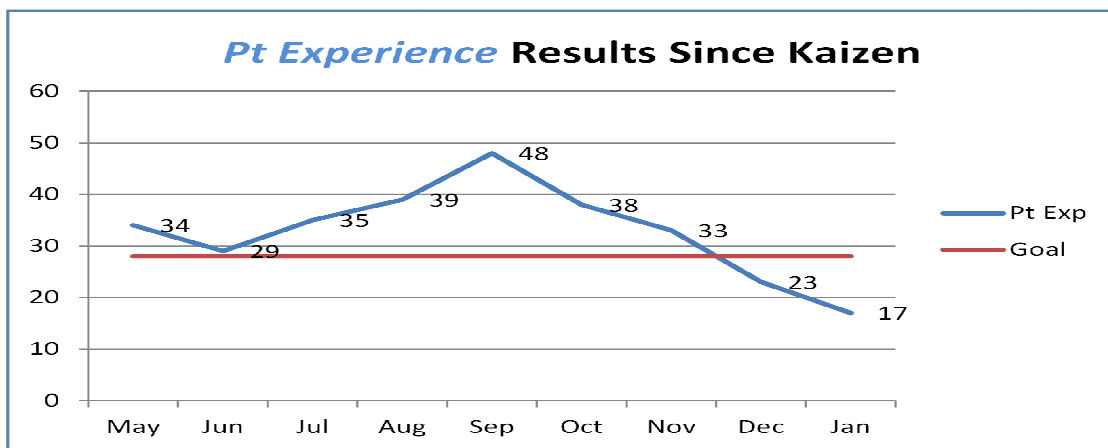
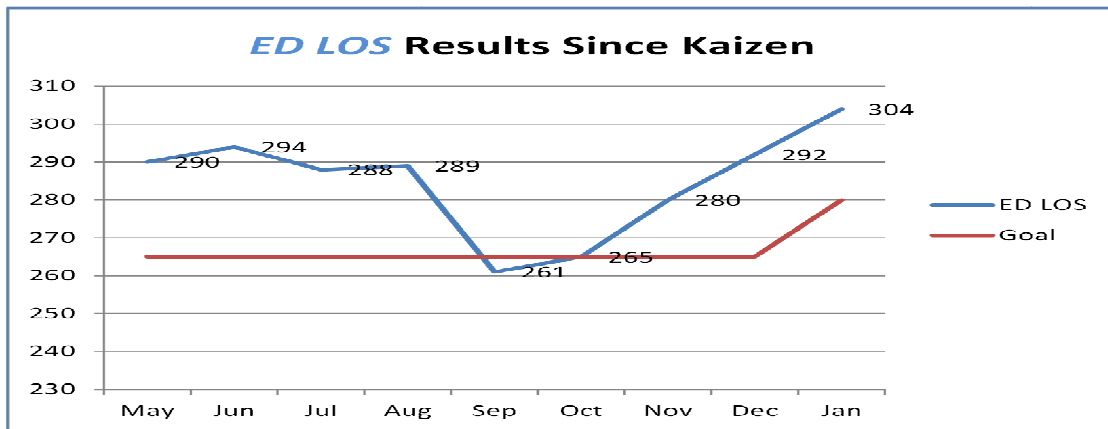


Appendix T: OCAI Baseline and Throughput

Results from OCAI survey from December 2013 (30 participants)

TOTALS	NOW	PREFERRED
A=Clan	3580	4245
B=Adhocracy	3145	1705
C=Market	3145	1570
D=Hierarchy	3465	2080
TOTAL	13335	9600

2013:



Appendix U: Sample QOS Team Log with Barriers

<b>QOS Weekly Log Sheet</b>			
<b>QOS Team</b>	=Actionable Item Moved to list		
unit			
Participating Staff			
<b>What is the Current Condition?</b>			
<b>What is the Target Condition?</b>			
<b>What are the Barriers?</b>			
<b>What Barriers are you addressing now?</b>			
<b>What test of change are you doing to address the barrier?</b>			
<b>When do you plan on seeing the result/when can you show us the result?</b>			
<b>What can we do to help?</b>			
<b>Are there barriers you feel are outside your scope?</b>			
<b>Additional Topics Discussed</b>			
<b>Safety Events Report</b>			
<b>Staff Recognized</b>			

## Appendix V: Patient Experience Domains and VBP's

2013 Jan-Dec

	<b>YTD</b>	<b>Points</b>
Overall Rating of the Hospital	72.7	3
Communication with Nurses	81.7	6
Help from Hospital Staff	68.4	3
Communication with Doctors	78.9	0
Hospital Environment	60.1	0
Pain Control	73.6	5
Explain about Medications	64.5	3
Discharge Instructions	85.3	3
Unit Points		<b>23</b>
Target Points		28
% VBP Points		29%
Number of surveys		<b>2,093</b>

2014 April-Aug (YTD)

	<b>YTD</b>	<b>Points</b>
Overall Rating of the Hospital	76.9	5
Communication with Nurses	82.7	6
Help from Hospital Staff	68.2	3
Communication with Doctors	82.6	3
Hospital Environment	62.3	0
Pain Control	75.3	6
Explain about Medications	67.5	5
Discharge Instructions	90.5	10
Unit Points		<b>38</b>
Target Points		28
% VBP Points		48%
Number of surveys		<b>936</b>



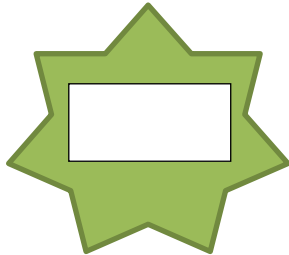
ICU	APR		MAY		JUN		JUL		AUG		YTD	Points	Median	75th %ile	Status
Overall Rating of the Hospital	100	10	100	10	100	10	100	10	100	10	96	10	69	76.2	
Communication with Nurses	93.3	10	86.7	10	100	10	75	0	100	10	88	10	78	80	
Help from Hospital Staff	80	10	40	0	58.3	0	58.3	0	100	10	65.4	1	65	68	
Communication with Doctors	60	0	73.3	0	95.2	10	100	10	100	10	81.3	2	80	83	
Hospital Environment	70	4	50	0	50	0	54.2	0	50	0	54.9	0	65	70	
Pain Control	100	10	66.7	0	100	10	50	0	100	10	86.7	10	70	73	
Explain about Medications	75	10	25	0	64.3	2	83.3	10	100	10	64.1	2	62	64	
Discharge Instructions	90	9	100	10	85.7	2	100	10	100	10	87.5	5	85	85	
Unit Points	63		30		44		40		70		40				
Target Points	28		28		28		28		28		28				
Number of surveys	5		5		7		4		1		32				
<b>FBC</b>															
FBC	APR		MAY		JUN		JUL		AUG		YTD	Points	Median	75th %ile	Status
Overall Rating of the Hospital	87.5	10	78.8	6	76.9	5	67.6	0	100	10	80.8	8	69	76.2	
Communication with Nurses	82.3	6	85.9	9	84.6	8	84.3	8	73.3	0	85.4	9	78	80	
Help from Hospital Staff	80	10	82	10	91.2	10	81.6	10	70.8	4	83.2	10	65	68	
Communication with Doctors	84.4	5	88.9	10	89.7	10	80.4	1	100	10	87.7	9	80	83	
Hospital Environment	67.2	2	68.2	3	75	7	69.1	3	60	0	70.2	4	65	70	
Pain Control	79.3	10	72.6	3	82	10	68.2	0	83.3	10	77.6	9	70	73	
Explain about Medications	71.9	9	88.2	10	84.6	10	88.9	10	50	0	84.3	10	62	64	
Discharge Instructions	91.9	10	92.2	10	100	10	95.6	10	100	10	94.8	10	85	85	
Unit Points	62		61		70		42		44		69				
Target Points	28		28		28		28		28		28				
Number of surveys	32		33		26		34		5		225				
<b>B3</b>															
B3	APR		MAY		JUN		JUL		AUG		YTD	Points	Median	75th %ile	Status
Overall Rating of the Hospital	63.6	0	63.2	0	64.7	0	71.1	2	84.6	10	67.8	0	69	76.2	
Communication with Nurses	82.6	6	74.3	0	64.1	0	80.7	4	84.6	8	75.8	0	78	80	
Help from Hospital Staff	68.3	3	59.2	0	59.1	0	61.8	0	68.3	3	61.6	0	65	68	
Communication with Doctors	78.8	0	70.9	0	78.3	0	83.6	4	92.3	10	79.5	0	80	83	
Hospital Environment	56.1	0	60.5	0	58.4	0	46.4	0	67.9	2	56.9	0	65	70	
Pain Control	77.3	9	74	5	70.4	1	75	6	81.8	10	75.5	7	70	73	
Explain about Medications	66.3	4	73	10	50	0	68.8	6	75	10	65.6	3	62	64	
Discharge Instructions	85.9	2	84.8	1	87.3	5	89	7	76.9	0	86.9	4	85	85	
Unit Points	24		16		6		29		53		14				
Target Points	28		28		28		28		28		28				
Number of surveys	33		38		34		38		13		271				
<b>A3 Short Stay</b>															
A3 Short Stay	APR		MAY		JUN		JUL		AUG		YTD	Points	Median	75th %ile	Status
Overall Rating of the Hospital	100	10	100	10	100	10	60	0	100	10	66.7	0	69	76.2	
Communication with Nurses	100	10	83.3	7	100	10	80	3	100	10	86.7	10	78	80	
Help from Hospital Staff	100	10	50	0	100	10	87.5	10	100	10	70.8	4	65	68	
Communication with Doctors	100	10	100	10	100	10	93.3	10	100	10	90.5	10	80	83	
Hospital Environment	100	10	50	0	100	10	30	0	100	10	60	0	65	70	
Pain Control	0	0	100	10	0	0	100	10	100	10	81.2	10	70	73	
Explain about Medications	0	0	0	0	100	10	66.7	4	100	10	75	10	62	64	
Discharge Instructions	100	10	75	0	75	0	90	9	100	10	86.7	4	85	85	
Unit Points	60		37		60		46		80		48				
Target Points	28		28		28		28		28		28				
Number of surveys	1		2		2		5		1		71				

Appendix X: Post-Implementation OCAI Results 2014

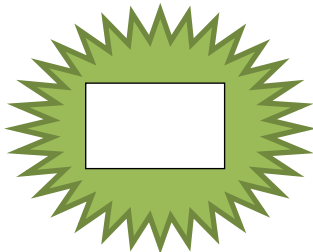
Results from OCAI survey from September 2014 (131 participants)

TOTALS	NOW	PREFERRED	
A=Clan	3502	4245	
B=Adhocracy	2113	1705	↓ 33% change to the positive
C=Market	3375	1570	
D=Hierarchy	3436	2080	↓ 1% change to the positive
TOTAL	12426	9600	↓

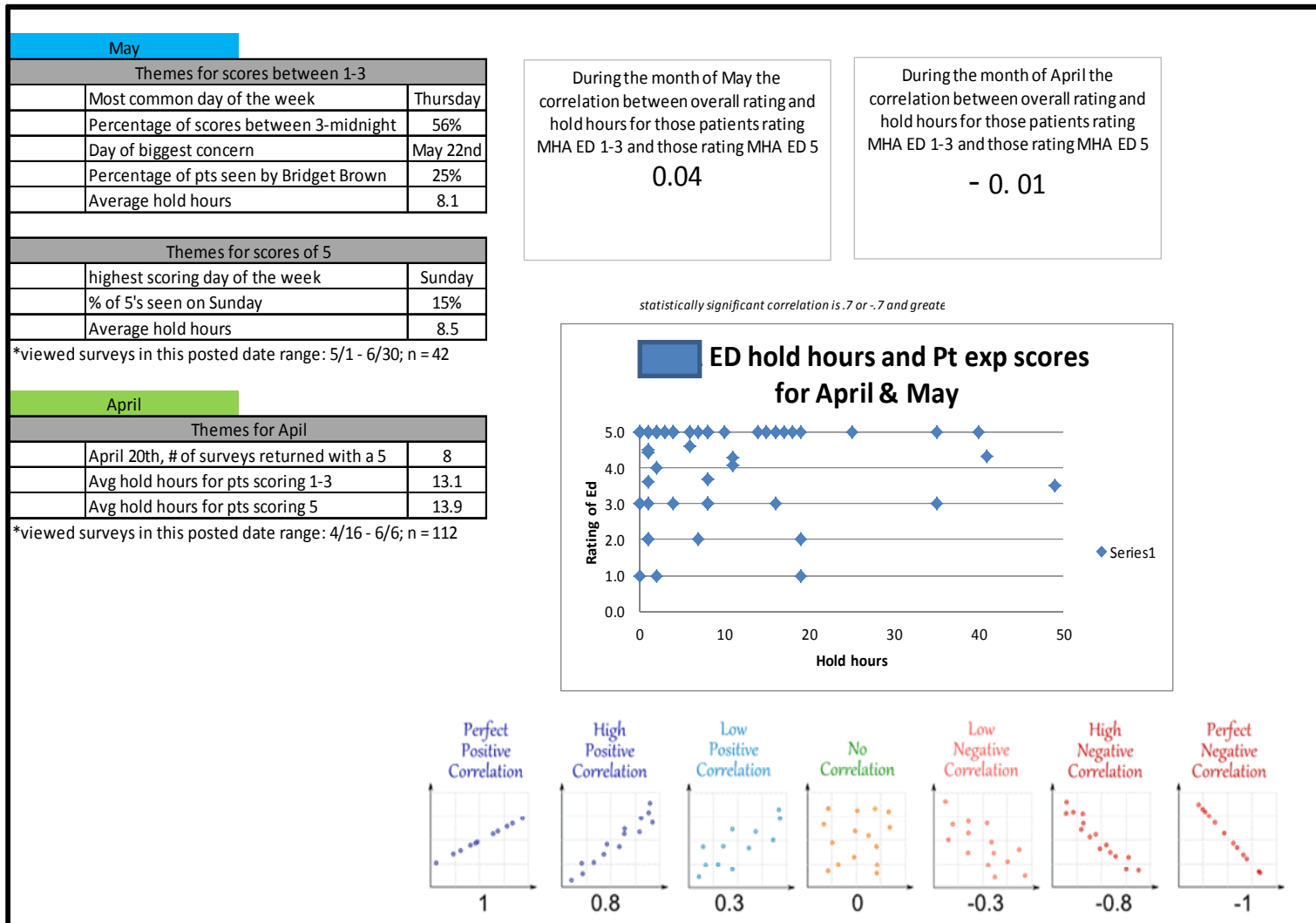
Current ED LOS April-September 2014



Current VBP's April-September 2014



Appendix Y: ED Hold Hours and Patient Experience Scores





Appendix Z: ED Patient Experience Results and Correlations with ED ALOS

Question	2013 YTD	2014 ED												YTD
	Top Box %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Std Overall	66.1	67.7	69.6	65.1	64.1	65.8	58.8	68.0	72.8					66
Std Arrival	61.5	60.2	66.4	56.0	57.0	60.5	52.6	63.8	64.4					59.7
Std Nurses	70.3	72.6	74.7	69.0	67.1	69.2	66.6	71.0	75.2					70.4
Std Doctors	69.2	71.4	72.3	70.5	68.9	69.9	63.9	71.6	73.5					69.9
Std Tests	67.2	71.7	72.3	72.5	66.5	69.1	58.7	75.2	86.7					70.2
Std Family or Friends	68.9	68.8	71.7	68.6	73.4	68.9	60.3	68.8	81.8					69.3
Std Personal/Insurance Info	66.6	71.3	70.4	65.0	63.9	63.6	59.6	69.0	69.0					66.5
Std Personal Issues	59.4	60.3	60.9	55.9	57.3	59.8	49.1	57.1	66.4					57.9
Overall rating ER care	66.8	66.9	67.7	68.0	63.9	66.1	58.3	65.2	76.7					65.7
Likelihood of recommending	67.7	66.9	68.2	66.1	62.0	70.0	60.4	72.4	76.7					66.6
N	1887	166	155	169	155	112	108	89	30					1028

DOMAIN	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Correlation with ED LOS	2012	2013	yr ovr yr change
Rate hospital 0-10	68.6	71.6	74.9	69.7	72.7	74.9	73.4	75.6	73.6	71.9	78.3	73.6	-0.52	69.7	73.1	3.4
Communication with Nurses	79.8	81.8	80.7	79.8	82.9	82.7	82.9	81.1	84.1	82.5	83.1	78.9	-0.55	80.5	81.6	1.1
Help from Hospital Staff	62.8	67.9	61.6	68.7	71.3	66.9	73	70.9	74	67.2	64.2	62.5	-0.51	69.4	67.5	-1.9
Communication with Doctors	78.7	78	79.3	77.3	76.1	77.3	82.2	80.7	80.6	81.5	78.2	77.4	-0.27	77.9	78.9	1
Hospital Environment	56.6	56.1	61	61.3	61.8	58.8	64.8	60.2	61.5	59.3	61.8	58.8	-0.55	58.4	60.1	1.7
Pain Control	72.9	73.8	69.5	73.3	74.2	74.9	73.3	74	77.5	74.8	74.5	70.7	-0.52	73	73.5	0.5
Explain about Medications	64	57	59.8	62.3	66.7	66.8	66.1	70.4	66.7	66.9	64.1	63.1	-0.68	62.7	64.4	1.7
Discharge Instructions	78.7	84.2	84.9	84.3	87.3	84.6	86.7	89	89.5	91.5	90.2	87.1	-0.88	84.7	86.3	1.6
Overall Rating of ER care	60.4	63.2	65.0	56.8	65.0	70.4	72.6	68.4	73.4	72.6	64.6	72.9	-0.70			
ED LOS	395	368	361	326	290	294	288	288	261	265	280	288				

Appendix AA: Press Ganey Ohio User Group

2014 Press Ganey Ohio User Group

**Title**

ED length of Stay and its indirect impact on the domains

**Overview**

This proposal will outline the indirect relationship between our ED length of stay and 2 CAHPS domains. During 2013 Mercy Health Anderson placed a significant focus on decreasing our ED length of stay. This process on throughput and the implementation of several initiatives resulted in higher top box scores, especially in the areas of: communication about medications and discharge information.

**Situation/challenge**

In January and February of 2013 Mercy Health Anderson hospital was faced with an ED length of stay close to 400 minutes. Our goal was to be below 300 min. At that moment in time we created a KAIZEN to address throughput for our patient flow. Our action plans following the KAIZEN not only addressed throughput from our ED to the acute care floors, but also addressed the throughput of our acute care patients. During Jan and Feb we averaged top box scores for communication about medications to be 63.4%. During the same time period we averaged top box scores for discharge information to be 81.7%.

**Strategy and approach**

In April of 2013, Mercy Health Anderson performed a KAIZEN. This group believes process allowed the hospital to focus on several key action items: (a) Throughput from ED; examples: floor nurse comes to ED for hand off, 30 min expectation, and measurement from admit order to time patient arrives on floor, (b) creating and implementing house wide discharge checklist for acute care patients, (c) medication stickers for new meds and (d) co-rounding (RN and MD rounding on patients)

**Barriers that were overcome**

Breaking down the silos between nursing and MDs, moving top box scores greater than 1.5% from beginning of year to end of year in 4 domains, hardwired a discharge check list across 5 units and decreasing ED length of stay below 300min for last 8 months of 2013.

**Measurable outcomes**

		2012	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2013	% change	
Date			%														Indirect correlation
Rate hospital 0-10	'9-10'	69.7	68.6	71.6	74.9	69.7	72.7	74.9	73.4	75.6	73.6	71.9	78.3	73.6	73.1	3.4	-0.52
COMM W/ NURSES	'Always'	80.5	79.8	81.8	80.7	79.8	82.9	82.7	82.9	81.1	84.1	82.5	83.1	78.9	81.6	1.1	-0.55
RESPONSE OF HOSP STAFF	'Always'	69.4	62.8	67.9	61.6	68.7	71.3	66.9	73	70.9	74	67.2	64.2	62.5	67.5	-1.9	-0.51
COMM W/ DOCTORS	'Always'	77.9	78.7	78	79.3	77.3	76.1	77.3	82.2	80.7	80.6	81.5	78.2	77.4	78.9	1	-0.27
HOSPITAL ENVIRONMENT	'Always'	58.4	56.6	56.1	61	61.3	61.8	58.8	64.8	60.2	61.5	59.3	61.8	58.8	60.1	1.7	-0.55
PAIN MANAGEMENT	'Always'	73	72.9	73.8	69.5	73.3	74.2	74.9	73.3	74	77.5	74.8	74.5	70.7	73.5	0.5	-0.52
COMM ABOUT MEDICINES	'Always'	62.7	64	57	59.8	62.3	66.7	66.8	66.1	70.4	66.7	66.9	64.1	63.1	64.4	1.7	-0.68
DISCHARGE INFORMATION	'Yes'	84.7	78.7	84.2	84.9	84.3	87.3	84.6	86.7	89	89.5	91.5	90.2	87.1	86.3	1.6	-0.88
ED LOS			395	368	361	326	290	294	288	288	261	265	280	288		304	

**Innovative and creative aspects**

MHA re-created our weekly accountability huddle for patient satisfaction. We created patient experience subcommittees on several floors throughout the house. We implemented a MD rounding button using the nurse call light system

AB: Project Cost and Savings 2013 and 2014

Project Cost and Savings 2013												
	13-Jan	13-Feb	13-Mar	13-Apr	13-May	13-Jun	13-Jul	13-Aug	13-Sep	13-Oct	13-Nov	13-Dec
Salary expense current												
4.2 FTE's additional in ED to cover holds	\$ 305,760											
Salary future												
Reduce 4.2 FTE's additional in ED												\$ (305,760)
Cost for Kaizen event staff				\$ 5,600	\$ 350			\$ 350				\$ 350
Black Belts			\$ 6,000	\$ 6,000	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100
Senior Leadership			\$ 3,150	\$ 180			\$ 180					\$ 180
Physicians			\$ 8,500									
Cost of Tools for OCAI												\$ -
Cost of Retreat												
Decrease in turnover/Increased retention												
Average RN wage \$35/hr and 12 weeks orientation												
Current turnover 25%	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080	\$ 2,026,080				
Reduction to 20%									\$ 1,620,864	\$ 1,620,864	\$ 1,620,864	\$ 1,620,864
Reduction to <15%												
Total expense per month	\$ 2,331,840	\$ 2,026,080	\$ 2,032,080	\$ 2,049,330	\$ 2,026,710	\$ 2,026,180	\$ 2,026,180	\$ 2,026,710	\$ 1,620,964	\$ 1,620,964	\$ 1,315,204	\$ 1,621,494
Increased Revenues with patient experience increase					\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175
Total expense reduction	\$ 2,331,840	\$ 2,026,080	\$ 2,032,080	\$ 2,049,330	\$ 2,011,535	\$ 2,011,005	\$ 2,011,005	\$ 2,011,535	\$ 1,605,789	\$ 1,605,789	\$ 1,300,029	\$ 1,606,319

Project Cost and Savings 2014									
	14-Jan	14-Feb	14-Mar	14-Apr	14-May	14-Jun	14-Jul	14-Aug	14-Sep
Salary expense current									
4.2 FTE's additional in ED to cover holds									
Salary future									
Reduce 4.2 FTE's additional in ED									
Cost for Kaizen event staff				\$ 350				\$ 350	
Black Belts	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$100
Senior Leadership				\$ 180				\$ 180	
Physicians									
Cost of Tools for OCAI								\$ 300	
Cost of Retreat	\$ 1,500								
AACN Modules ENMO	\$ 10,000								
Decrease in turnover/Increased retention									
Average RN wage \$35/hr and 12 weeks orientation									
Current turnover 25%									
Reduction to 20%	\$ 1,620,864	\$ 1,620,864							
Reduction to<15%			\$ 1,215,648	\$ 1,215,648	\$ 1,215,648	\$ 1,215,648	\$ 891,475	\$ 891,475	\$ 891,475
Total expense per month	\$ 1,632,464	\$ 1,620,964	\$ 1,215,748	\$ 1,216,278	\$ 1,215,748	\$ 1,215,748	\$ 891,575	\$ 892,405	\$ 891,575
Increased Revenues with patient experience increase	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175	\$ 15,175
Total expense reduction	\$ 1,617,289	\$ 1,605,789	\$ 1,200,573	\$ 1,201,103	\$ 1,200,573	\$ 1,200,573	\$ 876,400	\$ 877,230	\$ 876,400
<b>Total Cost savings throughout the project</b>	<b>\$ 1,455,440</b>								