



Revolution: A Report on the UHC Annual Conference 2014

Academic Medical Centers Embrace Revolution at UHC Annual Conference 2014

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“Behind every revolution are vision and ideas,” explained Irene Thompson, UHC’s president and CEO, as she welcomed members of the nation’s leading academic medical centers (AMCs) to the UHC Annual Conference 2014 in Las Vegas, Nevada, last October. More than 1400 UHC members and 300 supplier partners gathered to share mutual challenges and inspiring solutions as they navigate the complexities of the health care revolution under way in the United States. Author and futurist Ian Morrison, PhD, served as conference moderator, urging attendees to create the future and turn groundbreaking ideas into routine best practices.

Providing Diverse Channels of Dialogue

The annual conference is a comprehensive learning opportunity where members attend ideation sessions, network with peers, and return to their hospitals and health systems with inventive strategies for performance improvement. The agenda covered a broad spectrum of topics, including Ebola treatment and infection risks, patient engagement, and key attributes of top-performing organizations. Members also received scorecards showing their organizations’ performance on key metrics, giving them an “at a glance” gap analysis.

Conference attendees were able to choose from among 70 rapid-fire sessions, during which targeted solutions were presented by their peers. The half-hour rapid-fire sessions, as well as almost 60 posters—all culled from more than 1200 submitted abstracts—conveyed concrete results and fueled dialogue on positive change. Attendees reported that they felt energized by the sessions, which gave them opportunities to connect with colleagues who are experiencing and resolving similar challenges.

The Twitterscape was alive during the conference with members responding to the plenary and rapid-fire sessions. UHC members continue to connect through blogs, LinkedIn, and Facebook to rapidly exchange ideas.

Integrating Technology and Creativity

All facets of innovation were on display at the conference, from simple crowdsourcing ideas to complex cell-generation techniques. Innovator and scientist Daniel Kraft, MD, urged members to embrace technology to deliver more personalized medicine. Five digital entrepreneurs competed in the UHC Start-up Challenge: Innovation Delivered, showcasing their concepts in a few minutes to try to win the audience’s vote for the most compelling innovation.

Members had an opportunity to view and even play with new devices at the on-site Technology Lab, a gallery of wearable technology, biosensors, apps and games, and 3D-printed prosthetics. Crowds gathered around the interactive Bluescape workspace to visually collaborate on ideas. Demonstrations of UHC Intelligence, a suite of business tools and services, helped members envision how to harness comparative data and produce measurable gains in quality, safety, and cost-effectiveness.

The human side of innovation also was front and center, as Grammy-winning composer Eric Whitacre broke down the creative process, showing how to nurture a “golden brick” idea into a robust success that uses the talents of the many, not the few. Ideas for fully engaging patients, family members, and the care team in a streamlined, results-oriented process permeated many of the member-led presentations.

Celebrating 3 Decades of Successful Collaboration

Throughout the conference, attendees were reminded of pivotal moments in UHC’s 30-year history, which began when 27 AMCs came together in 1984 to found the original consortium and drive the advancement of patient care. Today 117 AMCs and more than 300 affiliate hospitals

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overtime with no travel RNs. During the same period, the medical center significantly lowered turnover by over 3 percentage points, reduced overtime from approximately 8% of worked hours to less than 6%, increased staffing efficiencies, achieved Magnet status, and improved patient outcomes.

Surfing the Silver Tsunami

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Background. The aging of the population, sometimes termed the “Silver Tsunami,” adds complexity that health systems must consider when developing strategies to improve cost and quality. Acute Care for Elders (ACE) units utilize an interprofessional team model of care and have been shown to improve processes of care, prescribing practices, physical functioning, and patient/provider satisfaction. However, prior to our study published in *JAMA Internal Medicine* in 2013, there was a paucity of data evaluating variable direct cost as the primary outcome of ACE versus usual care (UC). *Intervention Detail.* We studied patients age ≥ 70 years admitted to the hospitalist medical service in fiscal year 2010 who spent their entire hospitalization on either the ACE unit or the hospitalist UC unit. All patients received medical care from hospitalist physicians. Patients on the ACE unit also received geriatric care from the ACE team that included proactive screens for cognitive or functional impairment, volunteer visits for feeding assistance, delirium prevention interventions, daily medication review for high-risk medications, and pet therapy. We had 818 patients included in our study: 428 from ACE and 390 from UC. Generalized linear regression was used to estimate cost ratios adjusted for age, sex, comorbidity, and case-mix index. *Results.* We found the average variable direct cost from patient care was $\$2109 \pm \1870 per patient on the ACE unit compared to $\$2480 \pm \2113 for patients receiving UC ($P = .009$). This was a savings of $\$371$ per patient. Significantly fewer ACE patients were readmitted to our hospital within 30 days of discharge compared to patients receiving UC (7.9% vs 12.8%, $P = .02$). Our study is consistent with other ACE unit studies in demonstrating that an interdisciplinary team can provide evidence-based geriatric care in the hospital setting. Our study further clarifies that this additional care coordination via a team also reduces costs and 30-day readmissions in this patient population. Thus, the ACE unit model provides higher value care. In an era when improving outcomes while reducing cost is a vital

objective for Medicare and the Affordable Care Act, the ACE model meets these goals.

CEO Perspectives on Leading Sustainable Change

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Witt/Kieffer

David Feinberg, MD, MBA

UCLA Health System

Carol Geffner, PhD

Newpoint Healthcare Advisors

Richard Liekweg, MBA, MHSA

BJC HealthCare

Background. It is critically important for health care reform efforts that chief executive officers’ (CEOs’) voices are heard. This presentation shared insights from current CEOs of health systems and academic medical centers, distilling their ideas into 5 dimensions of health care C-suite transformation. *Intervention Detail.* Input was gathered from one-on-one interviews with 20 experienced, prominent CEOs of health systems, hospitals, and academic medical centers. Once collected, the data were broken down to outline major challenges organizations are facing and unique initiatives and strategies that CEOs are using to create meaningful change. David Feinberg and Richard Liekweg, 2 of the study’s participants, shared with the audience specific approaches, models, and dashboards they are employing to further build an integrated executive team to lead system-wide performance improvement. *Results.* The combination of original feedback from actual CEOs and the context provided by Feinberg and Liekweg made for a unique educational experience for the UHC 2014 audience. As evidenced by these discussions, CEOs are experiencing tremendous pressure to continuously improve performance while also dramatically transforming systems and processes that will support the move toward population health management. Room for error is small, given that reimbursement is tied to evidence-based outcomes and patient satisfaction metrics that are fully transparent. These leaders understand that if they want their organizations to survive and thrive, they have to think differently, challenge long-standing assumptions, and move decisively to build cultures and infrastructures that support a post-reform system of care. Aligned with the presentation, a white paper has been drafted outlining a “Transformation Road Map” for the health care C-suite based on 5 core ideas: Integration Is a Performance Mandate; The CEO Is the Primary Agent of Change; Culture Is a Business Imperative; A New World Calls for New Executive Capabilities; and Focus on the Critical. The CEO role itself is changing dramatically. “I

don't have all the answers!" is a common refrain. This presentation's objective was to raise questions and provide some answers so that health care organizations can begin to transform their leadership practices.

So Easy an ICU Doc Can Do It! Simple Interventions to Decrease Unnecessary Labs in a PICU

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Background. Unnecessary labs result in harm and unwarranted health care costs. Effectively decreasing unnecessary labs via simple means has been elusive, however. *Intervention Detail.* The multidisciplinary pediatric intensive care unit (PICU) collaborative practice workgroup identified unnecessary labs as a concern. A physician and nurse champion from the PICU Quality and Safety Committee worked with laboratory and finance to obtain lab volume and charge numbers, which were adjusted for patient volume (LPPD). Lab numbers also were adjusted for patient acuity using daily case-mix index (dCMI LPPD). Individual labs could not be evaluated to determine the necessity of each. The assumption was made that if labs decreased from baseline, that decrease reflected unnecessary labs. Nine months of retrospective data were collected as the baseline. In determining why unnecessary labs were sent, providers reported that scheduled labs remained in the computerized orders day after day, the night resident would order morning labs "just to make sure," and lab schedules were not a routine part of rounds, so no formal opportunity for changes existed. Interventions included adding the word "labs" to the rounding checklist, minimizing recurring orders without an end date, and writing the anticipated lab schedule on the plan section of the patient room dry-erase board. This board is used by staff who were not on rounds, including night residents to guide morning lab orders. Changes were implemented over 6 months. Postintervention data were collected for 26 months. *Results.* The preintervention monthly average LPPD and dCMI LPPD was 12.51 and 3.04. Post intervention, the LPPD and dCMI LPPD dropped to 7.9 ($P < 0.001$ vs pre) and 2.82 ($P = NS$). LPPD has remained low over the entire postintervention time period. However, dCMI has begun to rise in the latter half of the 26 months, perhaps because there were less severely ill patients in the PICU. A lower CMI may not correlate with the same proportional drop in required labs. Preintervention monthly average lab charges per patient-day were \$1618.80, while post intervention, they dropped to \$1377. Over the 2 time periods there

was no change in patient length of stay or observed-to-expected mortality, suggesting no negative unintended consequences from these variables.

Moving Quality Metrics to Green: Nursing and Supply Chain Form Strategic Partnership to Improve Patient Outcomes in the CLABSI, CAUTI, and HAPU Domains

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Background. Nursing-sensitive measures are driving health systems to develop innovation in care delivery models. These models require the development of new partnerships under the leadership of a chief nursing officer and other hospital senior leaders. When metrics such as pressure ulcers were above institutional set benchmarks, actions plans were implemented that were patient-centered, collaborative, and cost-effective. *Intervention Detail.* First, it became clear that a partnership between organizational leaders, supply chain, and frontline clinicians required optimization. Second, with this partnership firmly established, cost-effective solutions in supply chain allocation, product array selection, and translation of this to nursing practice were prioritized. A skin care bundle (a consortium of known evidence-based products coupled with nursing practice principles) was developed in tandem with a skin care champion nurse whose purpose was to deliver best practices to the patient environment. Invocation of culture was infused into all practice areas that centered on unit ownership, creative problem solving, and streaming of real-time data collection. *Results.* In 2010, prior to the implementation of our strategic partnership, pressure ulcer prevalence rates were well over benchmark at 5%. In 2011, the gradual introduction of best practices/product array to the clinical area reduced prevalence averages below 3%, and we have consistently performed below this benchmark to this day. To date, the return on investment is tracking at 2:1—for every dollar spent on prevention, \$2 are saved.

The Catheter Rebellion: Leveraging Technology to Win the War Against CAUTIs

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Background. Catheter-associated urinary tract infection (CAUTI) is the second leading cause of nosocomial