Why clinicians?

- Firsthand insight into opportunities for improvement and likely solutions
- Expertise and knowledge of evidence base
- Influence and authority to change peers’ behavior
- Aptitude for scientific method and working with data
- High motivation to improve care for their patients
Why not clinicians?

• They’re too busy
• We pay them to do something else
• Performance improvement is outside their training and comfort zone
• Institutions ask them to work on quality goals that may not be their priority
• Physicians are recalcitrant, self-important children who don’t recognize the importance of systems
• They’re disengaged

Christus St. Vincent Regional Medical Center

• Founded in 1865
• Not-for-profit health system jointly owned by Christus Health and locally managed nonprofit organization SVHSupport
• 200 licensed inpatient beds
• Approximately 13,000 admissions per year
• Designated Sole Community Provider
• Small Family Medicine residency
• Medical staff of more than 500 providers with 200 employed
• Unionized nurses, technicians, and other healthcare employees
Where did our quality program start?

- Small quality department nearly fully occupied by maintaining compliance with reporting requirements, with little bandwidth for actual improvement
- Near exclusive focus on metrics used for external reporting programs
- Little interaction of clinicians and quality department, with minimal participation by clinicians in quality initiatives and widespread distrust of reported data
- Lack of influence/authority of quality department staff to change behaviors on the wards

“The Letter”

I. Improvement of communication between employed physicians and administration and increased physician role in decisions related to clinical processes
II. Institutional commitment to real quality improvement with structural integration of physicians
III. Improvement of nursing quality
IV. Improvement of administration response to problems with operations identified by physicians
V. Physician participation in development of policies and performance measures related to Value Based Purchasing and other externally reported metrics
VI. Partnership between administration and physicians
“The Letter”

I. Improvement of communication between employed physicians and administration and increased physician role in decisions related to clinical processes

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VI. Partnership between administration and physicians

II. Institutional commitment to real quality improvement with structural integration of physicians

“Current quality improvement efforts seem largely reactive (e.g. to specific incidents and ‘never events’) rather than focused on proactive process improvement (PI). Physicians interested in PI are not given the necessary support or administrative time. Efforts to measure outcomes are focused almost exclusively on items affecting accreditation and reimbursement . . . and there is little translation of reported data to actual PI. In general the hospital quality improvement program seems to operate on a separate plane from the clinical program.

“We believe that meaningful quality improvement must be driven by practicing physicians, and that an institutional structure must be put in place that facilitates this . . . . The important principles are that practicing physicians should drive process improvement in our hospital, and be given the necessary institutional support to be successful.”
Clinician-Directed Performance Improvement Program Initiated in September 2015

Mission statement
To give practicing clinicians at CSV hospital the protected time, support, and training needed to conduct successful performance improvement projects of their choosing

Ten CDPI Service Lines
Each with part-time clinical dyad (usually a physician at 0.2FTE and nurse at 0.5FTE)

- Internal Medicine (2 teams)
- General surgery
- Obstetrics/Gynecology
- Intensive care
- Pediatrics
- Trauma surgery
- Pharmacy
- Respiratory Therapy
- Palliative Care

Central Supports
- Medical Director (0.6 FTE)
- Electronic data collection
- Manual data collection (3.5 FTE)
- Statistical support
- Graphics development
- Training in PI methods
- Nurse to support implementation on units (0.5 FTE)
<table>
<thead>
<tr>
<th>Session</th>
<th>Theory</th>
<th>Practical Instruction</th>
<th>Hands-on</th>
</tr>
</thead>
</table>
| Session I Week 0 | o Managing clinical processes  
  o Quality as a business strategy: relationship of quality and costs  
  o Intermountain as a case study | o Project team structure and roles  
  o Mission statements  
  o Running a meeting  
  o Planning a project Exploratory data  
  o Researching best practices | Team meeting: Establish mission, assign roles, identify needed participants |
| Session II Week 3 | o Context for the national quality movement in healthcare  
  o Leading models of QI in healthcare (Lean, Six Sigma, PDSA, etc.) | o Process mapping and other common tools of PI | Team meeting: Review the literature, begin process mapping |
| Session III Week 6 | o Uses of data in healthcare: Selection and accountability versus measurement for improvement  
  o Principles of database design | o Brainstorming (affinity diagrams, interrelationship diagrams)  
  o Aim statements  
  o Primary, secondary, outcome and balance metrics | Team meeting: Finalize process map, identify primary metric and write aim statement, begin designing database |
| Session IV Month 3 | o Variation and standardization  
  o High reliability in healthcare | o Important Lean PI tools  
  o Leverage points and high impact interventions  
  o PI tools to prioritize interventions | Team meeting: Brainstorming/affinity and interrelationship diagrams and/or fishbone diagram |
| Session V Month 5 | o Professionalism and PI  
  o Statistical process control | o Interpreting control charts | Group workshop: Control charts |
| Session VI Month 7 | o Hardwiring and sustaining initiatives  
  o Juran trilogy and quality control | o Emotional intelligence and changing behavior  
  o Lean Daily Management boards | Team meeting: Design plan for data reporting and ongoing support of project |
| Session VII Month 9 | o The relationship between access to healthcare and quality | o Preparing presentations of PI initiatives | Team meeting: Evaluate early post-intervention data and need for modification |
| Session VIII Month 11 | | | Teams’ presentations of projects |
### Prototypical timeline

<table>
<thead>
<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
<th>Month 7</th>
<th>Month 8</th>
<th>Month 9</th>
<th>Month 10</th>
<th>Month 11</th>
<th>Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify mission - Establish project team - Understand baseline process - Review evidence/models - Develop aim statement</td>
<td>Identify metrics - Develop database - Write data manual</td>
<td>Develop interventions</td>
<td>Implement</td>
<td>Education, feedback, oversight</td>
<td>Analyze data - Hardwire or modify interventions as necessary</td>
<td></td>
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</tr>
</tbody>
</table>

**Planning projects, mission statements, process mapping, exploratory data**
- Designing databases, metrics, aim statements
- Making and interpreting control charts, statistical process control
- Presenting performance improvement initiatives

**Baseline data collection**

**Post-intervention data collection**

---

**Brent James, MD, MStat**
Executive Director of the Institute for Healthcare Leadership
Intermountain Chief Quality Officer
Lead Instructor for Intermountain ATP in Healthcare Delivery Improvement

**Christine K. Cassel, MD**
Planning Dean for Kaiser Permanente Medical School
Previous President and CEO of the National Quality Forum, and Chair of President’s Council of Advisors on Science and Technology

**Sam Bagchi, MD**
Vice President/Chief Medical Officer and Chief Medical Information Officer of Christus Health

**Kedar Mate, MD**
Chief Innovation and Education Officer, Institute for Healthcare Improvement, and Associate Professor at Weill

**David U. Himmelstein, MD, FACP**
Professor of Public Health and Health Policy CUNY School of Public Health at Hunter College, Adjunct Clinical Professor at Albert Einstein, and lecturer Harvard Medical School

**Steffie Woolhandler, MD, MPH, FACP**
Professor of Public Health and Health Policy CUNY School of Public Health at Hunter College, Adjunct Clinical Professor at Albert Einstein, and lecturer Harvard Medical School
CSV Advanced Training Program (ATP) 2017-2018: Projects

- Initiating treatment of alcohol abuse in the hospital
- Reducing hospital-acquired delirium through optimization of sleep
- Instituting early mobility in the ICU
- Improving the safety and efficiency of obstetric surgical processes
- Improving the efficiency of operating room turnover
- Preventing neonatal readmissions through support of newborn feeding
- Preventing patient falls in the hospital
- Improving end of life care for high risk hospital populations
- Opioid stewardship
- Optimizing imaging for common surgical problems
CSV Advanced Training Program (ATP) in Healthcare Delivery Improvement 2017-2018

CSV ATP 2017-2018 Participation
N=approximately 80

- Frontline nurses: 27%
- Physicians: 16%
- Nurse managers and directors: 9%
- Nurse clinical supervisors: 7%
- Administration: 7%
- Residents: 7%
- Respiratory therapists: 5%
- Midlevel providers: 5%
- Surgical technicians: 5%
- Physical therapists: 4%
- Pharmacists: 4%
- Speech therapist: 4%

Christus St. Vincent
The Scientific Method

“A method or procedure that has characterized natural science since the 17th century, consisting in systematic observation, measurement, and experiment, and the formulation, testing, and modification of hypotheses” (Oxford Dictionary)

Identifying projects

I. Clinician insight and experience: “What makes you worry about your patients?”

II. High clinical impact: frequency of process and anticipated effect on outcomes

III. Robust evidence-base supporting best care

IV. Documented poor performance relative to existing benchmarks or standard of care

V. Likely opportunities for change: success at other institutions, high impact interventions to change default work flow

VI. Clinical protocols rather than management

VII. Relevant to metrics used in pay-for-performance, public reporting, or accreditation

VIII. Potential financial savings
33 CDPI projects in first two and a half years

- Increasing hand hygiene
- Reducing inappropriate gastric acid suppression in the ICU
- Antibiotic stewardship
- Reducing CLABSI in the ICU by improving central line maintenance practices
- Reducing CLABSI in the ICU by improving central line insertion practices
- Reducing CLABSI in the ICU by reducing central line use
- Reducing CAUTI in the ICU by reducing catheter use and interruptions of sterile catheter systems
- Improving use of prophylactic antibiotics in surgery to reduce SSI
- Reducing the rate of early elective delivery
- Opiate stewardship
- Improving treatment of sepsis
- Preventing ventilator-associated pneumonia
- Improving pain management in labor
- Improving detection of ADEs using IHI Global Trigger Tool
- Improving accuracy of medicine reconciliation
- Reducing non-evidence based treatment of pediatric bronchiolitis
- Optimizing obstetric triage
- Reducing time to transfusion
- Improving management of neonatal abstinence syndrome
- Improving safety and efficacy of insulin use
- Optimizing sleep in hospitalized patients
- Improving treatment of fever in newborns
- Improving pain management in thoracic trauma
- Reducing the incidence of duplicate opioid orders
- Optimizing obstetric surgical processes
- Hospital-initiated treatment of alcohol abuse
- Reducing hospital-acquired delirium through preventive measures
- Instituting early mobility for ICU patients
- Preventing neonatal readmissions by optimizing newborn feeding
- Reducing operating room turnover times to increase efficiency and surgeon satisfaction
- Optimizing imaging for common surgical problems
- Preventing patient falls in the hospital
- Improving end-of-life planning for high risk patient populations

- Optimizing obstetric surgical processes
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- Preventing neonatal readmissions by optimizing newborn feeding
- Reducing operating room turnover times to increase efficiency and surgeon satisfaction
- Optimizing imaging for common surgical problems
- Preventing patient falls in the hospital
- Improving end-of-life planning for high risk patient populations
Improving the use of prophylactic antibiotics in surgery to prevent surgical site infection (SSI)

General Surgery
Cyrus Ali, MD and Melanie Smith, RN

Aim statement: To increase by 20% the proportion of surgery cases in which the patient receives totally appropriate prophylactic antibiotics (composite of choice, dose, timing, intraoperative redosing, and post-operative dosing) by October 2017
Baseline data suggested problems with antibiotic prophylaxis dosing, timing, and redosing

Interventions

- Electronic orderset for surgical antibiotic prophylaxis stratified by specialty and procedure, consistent with consensus guidelines (IDSA, SHEA, ASHP, SIS)
- Parallel paper orders for surgical clinics not using EMR
- Modified workflow with responsibility shifted from anesthesia to preop nursing
- Provider and nurse education
- Data feedback
Rate of totally appropriate antibiotic prophylaxis more than doubled (17% to 44%, p<0.0001)
Colorectal SSI rate decreased from 13% to 5% (p=0.01)

Colorectal SSI SIR fell below VBP threshold for the first time
Collaboration with Quality Department to reduce hospital-acquired C. difficile infections:
Three CDPI projects

1. Increasing rates of hand hygiene
2. Antibiotic stewardship
3. Reducing inappropriate use of gastric acid suppression in the ICU

Increasing Appropriate Hand Hygiene
Internal Medicine
Ben Stricks MD and Dominick Armijo RN

Aim statement: To increase appropriate hand hygiene rates (as measured by handwashing or alcohol based sanitizer on entry and exit) among all people entering patient rooms at CSV hospital by 20%, when comparing the year beginning in October 2015 with the previous year.
Interventions

- Education (multi-disciplinary)
- Run-charts with hand hygiene data displayed on units
- Feedback of data in huddles
- Small incentives (e.g. movie ticket certificates) to reward good hand hygiene and increase awareness
- Prominent signs

Hand hygiene compliance increased from 41% to 81% (p<0.0001)
Antibiotic Stewardship
Internal Medicine and Pharmacy
Ben Stricks MD, Dominick Armijo RN, Jasmina Demirovic PharmD, and Melinda Montoya PharmD

Aim Statement: To decrease use of broad spectrum antibiotics for hospitalized patients (as measured by percentage of total antibiotic use) by 25% when comparing the period of Jan 2014-May 2016 with June 2016-June 2017

Interventions

- Development of Antibiotic Stewardship Program with charter, committee, and 0.8FTE infectious disease pharmacy staff (2 pharmacists in CDPI program)
- Daily audit and feedback to providers about antibiotic use
  - 80 recommendations per month, ¾ deescalation
- Revision of multiple infection-specific ordersets to narrow coverage when appropriate
  - Critical care
  - Sepsis
  - Pneumonia (floor and ED)
  - Urinary tract (floor and ED)
  - Skin and soft tissue infection (floor and ED)
  - Surgery antibiotic prophylaxis
Reducing Inappropriate Gastric Acid Suppression in the ICU
Pharmacy and Respiratory Therapy
Jasmina Demirovic PharmD, Melinda Montoya PharmD, Sarah Lyon RT

Aim Statement
• To reduce by 20% the use (days of therapy/patient day) of gastric acid suppressants (H2-blockers and proton pump inhibitors) in adult patients in the ICU, when comparing the periods October-December 2016 and January-August 2017
Interventions

- Provider education (journal club)
- Development of protocol for GAS use in ICU
- Pharmacist enforcement of protocol on interdisciplinary rounds

Use of gastric acid suppression in the ICU reduced by 27% (p<0.0001)
Interventions associated with drop in SIR below VBP threshold for the first time

Rate of hospital-acquired C. difficile infections reduced to 1/3 baseline

Calendar days between hospital-acquired C. difficile infections before and after interventions

*\(p=0.001\) for difference in means (Wilcoxon)
Increasing Detection of Adverse Drug Events
Pharmacy
Jasmina Demirovic PharmD

Aim Statement: To increase detection of ADEs that cause harm by 20% by September 2015 and identify opportunities to reduce preventable ADEs

Interventions

• Implement Modified Institute for Healthcare Improvement (IHI) Global Trigger Tool using the following triggers:
  – Diphenhydramine
  – Naloxone
  – Flumazenil
  – Blood glucose < 50mg/dL
  – INR > 5
  – PTT > 100 sec + Heparin Infusion
• Triggers selected based on literature review and expert opinion (Pharmacy CDPI Team and PNT Committee)
• IHI Global Trigger Tool added to existing voluntary reporting method through EMR
Detection of ADEs nearly doubled and detection of ADEs causing harm increased more than 8-fold.

ADE detection rates before and after intervention

CDPI/Pharmacy Projects in response to analysis permitted by increased ADE detection

- Revision of DKA and Insulin Infusion protocols
- Pharmacy rules and revision of ordersets to prevent duplicate prn opiate orders
- Training of pharmacy technicians in standardized methods of obtaining home medication lists at admission
- Perioperative anticoagulation guidelines
Example of project prompted by ADE analysis

Proportion of patients with duplicate prn opioid orders before (Jan-Apr 2015) and after (Jan-Apr 2016) intervention

\[ p < 0.0001 \]

Rate of ADEs decreased almost to 1/3 baseline

Rate of Adverse Drug Events
Since Initiation of IHI Global Trigger Tool

\[ p < 0.0001 \] for difference in means post-intervention versus other
Improving the Management of Neonatal Abstinence Syndrome (NAS)

Pediatrics
Jennifer Achilles MD and Jennifer Castaneda-Lovato RN

Aim statement: For newborns with NAS, we will decrease the amount of opiates (number of doses and cumulative dose) administered in the hospital by 25%, when comparing 6 months after intervention in October 2016 with the previous two years.

Interventions

- Higher threshold for treating newborns with opiates
  - Focus on non-pharmacologic treatment
  - Change from standard Finnegan scoring to Eat Sleep Console (ESC) scoring as criterion for opiate treatment
- Change from scheduled Methadone taper to as-needed, short-acting morphine
- Extensive staff education
- Family outreach and education
  - Prenatal pamphlet in OB and Subutex clinics
  - Admission packet for families
- Improved maternal and newborn drug screening
Large decrease in opiate treatment of newborns with NAS

<table>
<thead>
<tr>
<th>Dose methadone equivalents (mg)</th>
<th>Mean</th>
<th>Dose LCL</th>
<th>Dose UCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
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</tbody>
</table>
| p=0.0001 for difference in means for both cumulative dose and number of doses

<table>
<thead>
<tr>
<th>Decrease in LOS for all exposed infants (mean 2.3 fewer days) and infants receiving opiate treatment (mean 8 fewer days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>p=0.001 for difference in means for both cumulative dose and number of doses</td>
</tr>
</tbody>
</table>

Hospital length of stay for newborns with NAS requiring narcotic treatment pre-intervention (Jan 2015-Sept 2016) and post-intervention (Oct 2016-Mar 2018)
Aim statements with post-intervention data
19/22 (86%) fully met, 21/22 (95%) statistically significant improvement

<table>
<thead>
<tr>
<th>Aim statement</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Improve hand hygiene compliance by 20%</td>
<td>Hand hygiene rate increased 41% to 81%, p&lt;0.0001</td>
</tr>
<tr>
<td>2    Reduce gastric acid suppression in the ICU by 20%</td>
<td>Rate of use decreased from 2.01 to 0.74 DEX/POD, p&lt;0.0001</td>
</tr>
<tr>
<td>3    Reduce use of broad spectrum antibiotics by 25%</td>
<td>Rate as a percentage of total decreased from 52% to 31%, p&lt;0.0001</td>
</tr>
<tr>
<td>4    Improve compliance with central line maintenance best practices by 20%</td>
<td>Compliance increased 83% to 96%, p&lt;0.0001</td>
</tr>
<tr>
<td>5    Improve compliance with central line insertion checklist by 20%</td>
<td>Compliance doubled, p&lt;0.0001</td>
</tr>
<tr>
<td>6    Reduce use of central lines in the ICU by 20%</td>
<td>Line use decreased from 0.37 to 0.28 lines/day/patient day, p&lt;0.0001</td>
</tr>
<tr>
<td>7    Reduce use of indwelling urinary catheters in the ICU by 20%</td>
<td>Catheter use decreased from 0.65 to 0.59 cath days/patient day, p=0.008</td>
</tr>
<tr>
<td>8    Reduce interruptions of sterile catheter systems in the ICU by 25%</td>
<td>Interruptions decreased by 27% to 16% (p=0.002)</td>
</tr>
<tr>
<td>9    Increase use of appropriate antibiotic prophylaxis for surgery</td>
<td>Rate of totally appropriate antibiotics increased 17% to 44% (p&lt;0.0001)</td>
</tr>
<tr>
<td>10   Reduce the rate of early elective delivery from historical rate of 3-5% to 2% or less</td>
<td>Zero EEDs 2016-2018</td>
</tr>
<tr>
<td>11   Implement a ventilator bundle with &gt;80% compliance with documentation</td>
<td>Implemented with 90% documentation of all elements</td>
</tr>
<tr>
<td>12   Reduce failure rate of epidurals for labor pain by 20%</td>
<td>Failure rate 27% to 13%, p=0.007</td>
</tr>
<tr>
<td>13   Reduce delays to epidural placement for labor pain by 20%</td>
<td>Delay rate 45% to 29%, p=0.05</td>
</tr>
<tr>
<td>14   Reduce average labor pain score by 20%</td>
<td>No decrease in average score (6.6)</td>
</tr>
<tr>
<td>15   Increase detection of AEs causing harm by 20%</td>
<td>Detection increased from 6.4 to 3.4 AEs/1000 patient days, p&lt;0.0001</td>
</tr>
<tr>
<td>16   Increase accuracy of medication history documentation on admission by 20%</td>
<td>Accuracy measured by composite score increased from 49% to 67%, p&lt;0.02</td>
</tr>
<tr>
<td>17   Reduce non-evidence based treatment of pediatric bronchiolitis by 25%</td>
<td>Appropriateness of treatment (composite) increased 62% to 80%, p&lt;0.0001</td>
</tr>
<tr>
<td>18   Reduce prolonged delays in obstetric triage by 25%</td>
<td>Prolonged stays reduced from 11% to 5%, p=0.0006</td>
</tr>
<tr>
<td>19   Reduce average time to transfusion of blood products on med-surg floors by 20%</td>
<td>Reduced by 18% (+1/2 hour), p=0.0001</td>
</tr>
<tr>
<td>20   Reduce the use of opiate treatment in newborns with NAS</td>
<td>Reduced cumulative dose methadone from 6mg to 1mg, p=0.0001</td>
</tr>
<tr>
<td>21   Reducing the incidence of duplicate prn opiate orders</td>
<td>Reduced from 40% to 7%, p=0.0001</td>
</tr>
<tr>
<td>22   Increase first testing “pass” rates on obstetric OR locations cleanliness (ATP Relative Light Unit testing) by 25%</td>
<td>Pass rate increased from 28% to 66%, p=0.0001</td>
</tr>
</tbody>
</table>
Increased electronic data reporting capacity

Clinical Protocols Committee

Formalized process to request EMR changes

Data governance

Process to regularly review old ordersets and policies

Quality Department

Nursing

Information technology

Respiratory Therapy

ICU

Emergency Department

Pharmacy

Lab

QI project approval process

CDPI
# Financial Analysis

<table>
<thead>
<tr>
<th></th>
<th>Program Costs</th>
<th>*Clinical Savings</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2016</td>
<td>$1,179,290</td>
<td>$1,043,324</td>
<td>($135,966)</td>
</tr>
<tr>
<td>FY2017</td>
<td>$1,189,887</td>
<td>$1,861,177</td>
<td>$671,290</td>
</tr>
<tr>
<td>Total</td>
<td>$2,369,177</td>
<td>$2,904,501</td>
<td>$535,324</td>
</tr>
</tbody>
</table>

*Note: Does not include savings from VBP or HAC programs

8 year commitment to CDPI could yield approximately $24M net savings (does not include P4P program savings)
Trends in Broad Indicators of Institutional Quality

- National Percentile (HCAHPS and Physician Engagement) or Percentage of Items above national median (Culture of Safety)
- Christus Harm Index (Includes Patient Safety Indicators, HAIs, and EED)

Legend:
- Patient Experience (HCAHPS)
- Physician Engagement
- Culture of Safety
- Christus Harm Index

CDPI
“The question we have been asking—’How can we engage physicians in the hospital’s quality agenda?’—could also be rephrased as ‘How can the hospital engage in the physicians’ quality agenda?’”

IHI Whitepaper: 
*Engaging Physicians in a Shared Quality Agenda*


“**The Letter**”

I. Improvement of communication between employed physicians and administration and increased physician role in decisions related to clinical processes

II. Institutional commitment to real quality improvement with structural integration of physicians

III. Improvement of nursing quality

IV. Improvement of administration response to problems with operations identified by physicians

V. Physician participation in development of policies and performance measures related to Value Based Purchasing and other externally reported metrics

VI. Partnership between administration and physicians
Lessons learned: Develop infrastructure for working with unit management to hardwire and sustain initiatives

- Clinical PI Coordinator responsible for interface with units
  - Attends nursing leadership meetings
  - Supports unit managers in maintaining quality initiatives
  - Attends huddles and staff meetings
  - Conducts audits
  - Shares unit-specific data regularly on unit whiteboard
  - Provides hands-on support to frontline nurses to achieve quality goals
- Managers involved in developing explicit proposals for operationalization and sustaining
- Considering implementation of Lean Daily Management Boards

Image from IHI Whitepaper “Sustaining Improvement”
Physicians have a powerful voice when they speak together on behalf of their patients.
Thank you

- Board of Directors and Senior Executive Team of Christus St. Vincent Regional Medical Center
- John Beeson, Chief Medical Officer
- Joahnna Bell, Executive Director of Quality
- Dr. Brent James

Thank you

CDPI Teams
Thank You!
Thank you for your commitment to patient safety, and your dedication to improving health and health care worldwide.

How to Receive CE Credit

To be eligible for a continuing education certificate, you must select your sessions prior to the end of the conference.

- You will receive an email on Friday, May 25, with a link to complete a survey
- Complete the survey within 30 days to obtain your continuing education certificate

Visit the registration edits desk for assistance.