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Redesigning Cardiovascular Service Line

Rebecca Stepan
******@***fairview.org

Director of Quality, Regulatory and
Clinical Research Practice - Juris
Doctor (J.D.) Candidate, 2L
University of Minnesota Health
Minneapolis, USA

THE IMPORTANCE OF CULTURE

When Minnesota Heart merged with University of Minnesota Physicians, the cardiovascular service line was branded and redesigned, which involved integration of services across the academic medical centre and community hospitals and clinics. *HealthManagement.org* spoke to Rebecca Stepan, who was Director for Clinical Quality at the time, about the factors that led to a successful re-design.

How did you start to redesign the quality structure of the cardiovascular service line?

When the service line became the University of Minnesota Health-branded service line, Debra Rudquist was appointed the service line executive and I was hired to manage quality and to grow a quality team across the whole service line. This was done with partners on the academic medical centre side and on the community side. The focus was first on integration and the teams were called horizontal integration teams.

We knew that there would be a lot of culture work to do before we could move forward with improvement. The culture and practices are quite different between academic medical centres and community health services – for example in relation to prevention, intervention and surgery. We needed to come together and find common ground. For at least the first six months of my 18 months on the programme I worked on the culture and integration. The quote from Peter Drucker, “Culture eats strategy” is well known. No matter how we would have

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strategised the new structure, if we didn't have the culture first this would have failed and our leadership recognised that.

Our first focus was on patient access and satisfaction. We focused on services across the service line where it was proper for the transfer to occur from a community hospital to a tertiary care centre and for cardiologists to hand off to another sub-specialty. Once we found those common threads we could start working on patient journeys.

How were patients involved in the redesign?

Patient experience was one of our top strategic priorities, and we had a patient experience committee. As well as using retrospective data we worked with a health technology company to get rapid cycle feedback. Using tablet-based surveys we could get live answers from patients, targeted by population, with questions based on new models of access that we were designing in our service line. We also looked at the patient experience across the continuum of care. We targeted patients at admission, at discharge and up to nine months post-treatment. We stratified the results to see if patients were readmitted or admitted to the emergency room (ER), and also to see if patients who had a particular treatment or struggled with medication adherence were more likely to get re-admitted or go to the ER, for example. The process was very much data-driven.

What other challenges were there at the start of the redesign?

One example is finding space and funding for video conferencing rooms. This was important to get everybody involved and engaged and able to see each other, especially the personnel at different hospitals or clinics. That helped a lot when we first got started. It seems trivial, but if you don't put that in place, the teams just aren't as robust and not as likely to work together well as a true team.

The redesign project used Lean Six Sigma tools. What did these include?

Value Stream Maps look at waste in a production system, as originally developed by Toyota, GE and Ford. We built them as a patient journey map, and looked at where the patient is waiting, where patients spend time not receiving care. We mapped this as a patient journey to see where there is waste and time spent that is not valuable to the patient. For example, when patients were scheduled for a valve or coronary artery bypass graft surgery there is a lot of preop education and lab work. By looking at the whole day for the patient we found that there is a lot of time where the patients are waiting. Sometimes the labs were scheduled later in the day and they were still fasting, and they were hungry. We were just looking at when it was convenient for the labs, for the nurses and physicians and what worked in our schedule. We were able to rearrange clinic schedules and appointments, so that the patient didn't have to wait to eat anymore. If you don't focus on it you are never going to make an improvement. To quote Don Berwick from the Institute for Healthcare Improvement: "You have to change your process to get different results."

Structural changes were also critical. We produced Team Charters, which included the team purpose, deliverables, membership, reporting and how often it meets. The teams report up to the steering committee and to the board.

We demonstrated statistically significantly improvements in our patient care and experience. In the Press Ganey® Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) we

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received top scores for provider, front desk and staff communication across all the heart clinics. These improvements have been sustained.

What organisational changes took place for the redesign?

The most important was establishing the Performance Excellence Alignment and Knowledge (PEAK) teams. These evolved from the original Horizontal Integration Teams. We inverted the regular organisational chart, where the CEO is at the top, then the VPs, directors and so on. We drew it upside down, so that the board was at the bottom and the PEAK teams were at the top. For the redesign, the PEAK teams had autonomy. Each PEAK team had a community position and an academic position alongside me as quality administrator. The team included nurse representatives from inpatients, outpatients and clinics as well as data abstractors – registries are very important in heart care. We designed with our teams what our improvement efforts were and what we wanted on our dashboard. We reported to the steering committee for the service line and to the board.

These PEAK teams still exist, and they have taken on even more ownership of the work. The credit for the idea of the PEAK teams goes to Dr. David Laxson, a cardiologist at the University of Minnesota Health. He coined the term, as he saw that we were moving beyond integration and it was time to start striving and working at the top of that Maslow hierarchy of needs. Service Line Executives Dr. Laxson, Debra Rudquist and our quality physician leaders Dr. Stephen Battista, Dr. Robert Bache, and Dr. Ganesh Raveendran gave us the vision of getting up to the peak and staying there.

What was the most important lesson learnt from this process?

The dynamic between culture and strategy is so important. We thought the strategy would be most important, but we recognised that strategy is part of culture and we needed to spend time on the culture rather than just get up and get going. We had to be patient, get the structure in place. This is what contributed to the PEAK teams being able to thrive, and the structure of the teams directly impacted the care, the quality improvements projects, what we were measuring. If you don't measure the right things then you will never know you are not improving the right outcome. We saw our outcomes improve by having the multidisciplinary PEAK teams as part of our strategy after the work on the culture. This happened in 18 months overall.

Rebecca currently works for Transplant Services, where they have successfully replicated the same model. The intent is to emulate the model now in perioperative and other services.

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