IHI Forum – Virtual Site Visit to Cincinnati Children’s Hospital Medical Center

Welcome Aboard: A Children’s Adventure
The Transformation Journey: Improvement, Caring, Integration, Transparency

Uma Kotagal, MBBS,MSc
Senior Vice President Quality, Safety and Transformation
James M. Anderson Center
December 9, 2013

It’s all about the kids
Full service, pediatric academic medical center with annual 1,161,000 patient encounters*
598 registered beds (549 in service) including inpatient and residential psychiatry beds*
Served patients from 53 countries and all 50 states*
Nationally ranked in all 10 subspecialty programs

3rd highest recipient of NIH grants for pediatric research
Ranked 3rd best Department of Pediatrics among all University Colleges of Medicine
Total Employees of 12,873, with 11,799 full time equivalents*
Employees from 97 different countries
Over 790 volunteers contributed 72,806 hours*

*For fiscal year ending June 30, 2013

What Inspires Our Success…

- **Vision** – to be the leader in improving child health

- **Mission** – Cincinnati Children’s will improve child health and transform delivery of care through fully integrated, globally recognized research, education and innovation.
  For patients from our community, the nation and the world, the care we provide will achieve the best:
  - medical and quality of life outcomes
  - patient and family experience and
  - value today and in the future.

- **Values** – Respect everyone. Tell the truth. Work as a team. Make a difference.
**Focus Statement:**
We will deliver demonstrably superior outcomes and experience at the lowest possible cost and discover and apply better ways to improve the health of more children, here and around the world.

<table>
<thead>
<tr>
<th>Our Goals</th>
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<tbody>
<tr>
<td><strong>Safety</strong></td>
</tr>
<tr>
<td>To be the safest hospital</td>
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<tr>
<td><strong>Care Coordination &amp; Outcomes</strong></td>
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<tr>
<td>To improve outcomes for our patients with complex and chronic diseases</td>
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<tr>
<td><strong>Community Care Delivery</strong></td>
</tr>
<tr>
<td>To strengthen our community’s system of care for children</td>
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<td><strong>Community Health</strong></td>
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<td>To measurably improve the health of local children</td>
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<tr>
<td><strong>Research &amp; Infrastructure</strong></td>
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<td>To accelerate the impact of our investment in discovery</td>
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<td><strong>Leadership Development &amp; Learning</strong></td>
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<tr>
<td>To help employees reach their potential and Cincinnati Children’s achieve its vision</td>
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<tr>
<td><strong>Reach &amp; Revenue</strong></td>
</tr>
<tr>
<td>To leverage our unique expertise to serve more children</td>
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<tr>
<td><strong>Philanthropy</strong></td>
</tr>
<tr>
<td>To provide abundant resources for the care and cures for children</td>
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<tr>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>To be more affordable for patients and maintain our financial strength</td>
</tr>
<tr>
<td><strong>Productivity</strong></td>
</tr>
<tr>
<td>To improve the experience for patients and more effectively utilize our people and physical assets</td>
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<tr>
<td><strong>Respect &amp; Professionalism</strong></td>
</tr>
<tr>
<td>To ensure that every employee feels valued and respected</td>
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</table>
Variation in CF Outcomes - 1999

BMI Percentile

FEV₁ % Predicted

34.8%

29.8%

Median values

Patients with Cystic Fibrosis in Nutritional Failure (2002)
Variation in CF Outcomes - 2006

Source: GT O'Connor/Cystic Fibrosis Foundation

Median BMI Percentile for Patients
2 to 20 years for 2008

National average for current year is for reference only. Not all care centers may have entered all relevant data as of the date of this report. Centers with fewer than 10 qualifying patients are not represented in this report.
Median Predicted Survival Age, 1994-2006

Predicted survival improves from 27.7 years to 28.6 years

Predicted survival improves from 28.6 years to 36.9 years

Source: GT O’Connor/Cystic Fibrosis Foundation

Our Quality Journey

- 1994: Evidence-based guidelines developed
- 1999: IOM Report: To Err is Human launched
- 2001: Strategic planning process launched
- 2002: Business: Units incorporated IOM dimensions into dashboards
- 2004: Strategic planning focus on integration of all 3 missions
- 2006: AHA McKesson Quest for Quality Award
- 2007: Launched Academic Collaborative
- 2009: Serious safety events reduced from 14 to 7 (50% reduction from 2007)
- 2010: RCIC launched
- 2012: AC External Advisory Council convened
- 2010: James M. Anderson Center generated new strategic plan with focus on safety, chronic disease and population health

James M. Anderson Center
For Health Systems Excellence
Organizational Transformation

Pursuing Perfection Initiative challenged organizations to **transform** based on the IOM’s “New Rules” for Health Care

**Defining transformation:**
- Radical changes in how members of the organization perceive, think & behave at work.
- Fundamentally altering assumptions about how an organization functions.
- Significant shifts in corporate philosophy & values & structures that shape behaviors.

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Our Quality Journey

- 1994: Evidence-based guidelines developed
- 1998: National family-centered care conference
- 2001: Strategic planning for complete transformation
- 2006: Launched Intermediate Improvement Science Series (IIS2)
- 2010: AHA McKesson Quest for Quality Award
- 2002: IOM Health Care Chasm
- 2005: Serious safety events reduced from 14 to 7 50% reduction from 2007
- 2003: IOM Report: To Err is Human
- 2008: Serious safety events reduced from 14 to 7
- 2004: Strategic planning focus on integration of all 3 missions
- 2009: Serious safety events reduced from 14 to 7
- 2007: Launched Academic Collaborative
- 2012: Serious safety events reduced from 14 to 7
- 2010: AHCPI Launched
- 2011: AC External Advisory Council convened
- 2013: Serious safety events reduced from 14 to 7
- 2014: Serious safety events reduced from 14 to 7
- 2015: Serious safety events reduced from 14 to 7

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James M. Anderson Center
For Health Systems Excellence
Health Care Delivery System Transformation
Strategic Improvement Priorities and System Level Measures

ACCESS, FLOW, PRODUCTIVITY
- 3rd next available appointment
- % of patients delayed: ED, PICU, PACU
- Touch Time for care givers

PATIENT AND EMPLOYEE SAFETY
- Adverse drug events
- Bloodstream infection rate
- Surgical site infection rate
- Infection rates: VAP
- Serious Safety Events
- OSHA recordable injury rate

CLINICAL EXCELLENCE, OUTCOMES
- Codes outside the ICU rate/1,000 days
- MRT preventable codes outside the ICU
- Standardized PICU Mortality Ratio – Expected/Actual
- % use of Evidence-Based Care for eligible patients

TEAM WELLBEING
- Staff Satisfaction
- Nursing turnover rate

PATIENT AND FAMILY EXPERIENCE
- Overall Rating: Patient Satisfaction (best possible)
- Overall, Inpatient, Outpatient, ED, Urgent Cares, Ambulatory Surgery, Home Health

James M. Anderson Center
For Health Systems Excellence
Our Quality Journey

- 1994: Evidence-based guidelines developed
- 1998: National family-centered care conference
- 1999: IOM Report: To Err is Human launched
- 2001: Strategic planning process
- 2004: Strategic planning focus on integration of all 3 missions
- 2006: Launched Intermediate Improvement Science Series (I2S2)
- 2007: AHA McKesson Quest for Quality Award
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- 2014: Serious safety events reduced from 14 to 7
- 2015: Serious safety events reduced from 14 to 7
- 2016: Serious safety events reduced from 14 to 7
- 2017: Serious safety events reduced from 14 to 7
- 2018: Serious safety events reduced from 14 to 7
- 2019: Serious safety events reduced from 14 to 7
- 2020: Serious safety events reduced from 14 to 7
- 2021: Serious safety events reduced from 14 to 7
- 2022: Serious safety events reduced from 14 to 7
- 2023: Serious safety events reduced from 14 to 7
- 2024: Serious safety events reduced from 14 to 7
- 2025: Serious safety events reduced from 14 to 7
- 2026: Serious safety events reduced from 14 to 7
- 2027: Serious safety events reduced from 14 to 7
- 2028: Serious safety events reduced from 14 to 7
- 2029: Serious safety events reduced from 14 to 7
- 2030: Serious safety events reduced from 14 to 7
- 2031: Serious safety events reduced from 14 to 7
- 2032: Serious safety events reduced from 14 to 7
- 2033: Serious safety events reduced from 14 to 7
- 2034: Serious safety events reduced from 14 to 7
- 2035: Serious safety events reduced from 14 to 7
- 2036: Serious safety events reduced from 14 to 7
- 2037: Serious safety events reduced from 14 to 7
- 2038: Serious safety events reduced from 14 to 7
- 2039: Serious safety events reduced from 14 to 7
- 2040: Serious safety events reduced from 14 to 7
- 2041: Serious safety events reduced from 14 to 7
- 2042: Serious safety events reduced from 14 to 7
- 2043: Serious safety events reduced from 14 to 7
- 2044: Serious safety events reduced from 14 to 7
- 2045: Serious safety events reduced from 14 to 7
- 2046: Serious safety events reduced from 14 to 7
- 2047: Serious safety events reduced from 14 to 7
- 2048: Serious safety events reduced from 14 to 7
- 2049: Serious safety events reduced from 14 to 7
- 2050: Serious safety events reduced from 14 to 7
Alignment

- Alignment:
  - Align measurement
  - Align strategy and accountability
  - Build improvement capability
- Integrate into daily work
- All strategic goals are part of each component of the organization with specific assignments

Organizing for Transformation

- Board Oversight
  - Senior Leadership Focus
    - System-Wide Goals
      - CSI Goals
      - Division/Microsystem-Based Goals
        - Individual Performance
Design Characteristics

1. Strategic improvement goals are part of our strategic plan and address the needs of our mission - patient care, research, education
2. Accountability for achievement of improvement goals is shared by all levels of the organization
3. Leadership for the improvement system is multidisciplinary and cross functional
4. Capability for improvement is built at the point of care and horizontally across CCHMC
5. Performance improvement is integral to the leadership system and integrated with daily work
6. Performance improvement is measurement-based/responsive/efficient/proactive/aligned
7. Consistent use of the science of improvement
8. Transparency of results and process
9. Constancy of purpose for improvement
Our Quality Journey

1994 Evidence-based guidelines developed
1998 National family-centered care conference
1999 IOM Report: To Err is Human Launched Strategic planning process
2001 Strategic plan called for complete transformation
- IOM Report: Crossing the Quality Chasm
- Focus on 6 dimensions of quality
2002 Business Units incorporated IOM dimensions into dashboards
2003
2004 Strategic planning focus on integration of all 3 missions
- CSI Teams launched Application of reliability science
2006 Launched Intermediate Improvement Science Series (I2S2)
2006 HA Inkson award for safety
2008 Serious safety events reduced from 14 to 7, 50% reduction from 2007
2008 CHCA Race for Results Award – reduction in PICU mortality due to reduction in hospital acquired infections
- Picker Institute Award – family centered care
- Codman Award for SSI reduction
2009
2010 RCIC Launched
2010 Serious safety events reduced from 14 to 7, 50% reduction from 2007
2012 AC External Advisory Council convened
2011 AILS Launched
2011 James M. Anderson Center Launched new strategic plan with focus on safety, chronic disease and population health

Deming’s System of Profound Knowledge

Values

Theory of Knowledge

Psychology

Understanding Variation

Appreciation of a system

W. Edwards Deming

The New Economics

For Industry, Government, Education

Second Edition
Capability vs Capacity

- **Improvement Capability**
  - An individual’s knowledge & skill to design improvement initiatives to achieve measurable results & the ability to execute (i.e. develop, test, measure & implement changes) improvement efforts & sustain results.

- **Improvement Capacity**
  - An organization’s resources which enable it to initiate & sustain a transformation effort. This includes capable individuals but also structures, processes, infrastructure including quality experts & measurement experts.

Operating Assumptions

- Building improvement capability at CCHMC goes beyond acquisition of knowledge and skills to action-oriented improvement that achieves critical results and accelerates transformation.

- As an Academic Medical Center, CCHMC’s strategy for building improvement capability focuses on engaging and developing faculty as improvement leaders, educating trainees and advancing the scholarship of health care improvement through rigorous methods and quality improvement research.

- Different groups of people will have different levels of need for improvement knowledge and skill to achieve results, and each group should receive the training they need when they need it and in the appropriate amount.

- All members of the organization should incorporate improvement into their daily work and have the ability to advance their improvement knowledge and skills to achieve critical results, and function at any level of the CCHMC improvement ladder.
Building System Improvement Capability

<table>
<thead>
<tr>
<th>Leverage Point</th>
<th>Target Audience</th>
<th>Competencies</th>
<th>CCHMC Target Categories</th>
<th>CCHMC Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macrosystem CCHMC (Whole System)</td>
<td>Sr. Leaders (e.g. CEO, SVPs, VPs)</td>
<td>Lead the whole system based on Deming’s System of Profound Knowledge</td>
<td>Approximately 28 SVPs &amp; VPs</td>
<td>Intermediate Improvement Science Series (I2S2)</td>
</tr>
<tr>
<td>Mesosystem (CSI site of care teams, Institutes, Business Units, and medical &amp; surgical divisions)</td>
<td>-CSI Leaders -Division Heads -AVPs - Strategic Improvement Project Team leaders</td>
<td>-Lead strategic improvement teams/complex cross-functional projects to get results -Articulate the role of the department/unit/division as a sub-system that is an interdependent part of the larger system of CCHMC -Coach others to do improvement -Disseminate results via external presentations &amp; professional journal publications</td>
<td>Dept. Heads/Division Heads, SVP’s, VP’s, AVP’s, selected MD’s, Sr. Directors, Directors (includes typically M3-M5 – approx. 380 people +) (Includes selected APNs &amp; possibly Clinical Directors, Faculty)</td>
<td>-Intermediate Improvement Science Series (I2S2) -JIT coaching and continued use of I2S2 learning while developing a portfolio of projects -Advanced Improvement Methods -Advanced Improvement Leadership, Systems Quality Scholars Program</td>
</tr>
<tr>
<td>Microsystem (Dept units, clinics, ORs, etc.)</td>
<td>-Clinical managers -Lead MDs</td>
<td>-Lead small teams/narrow scoped projects in a small system &amp; get results -Lead microsystem efforts to remove defects &amp; waste from processes of daily work -Effectively participate in cross-functional &amp; strategic improvement teams</td>
<td>Includes all clinical &amp; nonclinical front-line supervisors &amp; managers typically in the M1 &amp; M2 bands (approx. 250 people) (Includes Clinical Managers, Supervisors, Leads, Coordinators, Lead APNs, CNS’s, Care Managers when appropriate, Clinical Directors or at the next level &amp; “Faculty-Routine QI activities” (~200)</td>
<td>Rapid cycle Improvement Collaborative (RICC) &amp; team leader development -JIT coaching while participating in a QI project by I2S2 graduate, QIC, etc</td>
</tr>
<tr>
<td>Individual Contributors – Front Line Improvers</td>
<td>All front-line non-management staff</td>
<td>-Engage in the improvement of daily work -Effectively participate in improvement teams</td>
<td>Includes APNs, RN’s all attending physicians (~400), residents and fellows; medical, nursing &amp; allied health students &amp; Non-clinical employees</td>
<td>On-line Modules -“Intro. to Quality” -Basic Measurement (In development)</td>
</tr>
</tbody>
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Integrating Improvement and Operations

Stephen E. Muething, MD
Fred Ryckman, MD
Barb Tofani, MSN, RN

James M. Anderson Center
For Health Systems Excellence
The Journey Towards Zero Harm
Moving A Big Dot – The Story of Safety

Stephen E. Muething, MD
Vice President for Safety
James M. Anderson Center
December 9, 2013

It Truly Is A Journey
STRATEGIC GOAL FOR SAFETY

- **Safety**: Be the safest hospital. Implement systems that reliably deliver safe care to our patients and protect the safety of our employees.
Pyramid of Harm
(Patient and Employee)

Strategy:
Focus on the top of the pyramid and progressively move down

- SSE’s & Lost-time Injuries
- Serious Harm Index & OSHA Recordable Injuries
- Events of Minimal to Moderate Harm & All Employee Injuries
- Near-Miss Events
  Patient and Employee

Since 2006: Rate has Decreased 80%
Since 2004: Rate has Decreased 80%

Since 2001: Total number Has Decreased 50%

NEW CENTER LINE: 5.35
Since 2005: Rate has Decreased 50%

Journey to Reliability – The Next Zero

- Optimized Outcomes
- Human Factors Integration
  - Intuitive design
  - Obvious to do the right thing
  - Impossible to do the wrong thing
- Reliability Culture
  - Core values & vertical integration
  - Behavior expectations for all
  - Hire for fit
  - Fair, just, and 100% accountability
- Process Design
  - Evidence-based best practice
  - Focus & Simplify
  - Tactical improvements (e.g., process bundles)
Reliable Key Processes

- Dozens across organization
- **Standardization**
- Sustainability built into the system
- Real-time failure awareness
- Data feedback to the microsystems
- Making the right thing, the easy thing

Real Time Failure Awareness

**Patient Safety** Sept. 9 - Sept. 15

- Events of Harm
  - CA-BSI 9/10 A5N
  - 9/10 A5S
  - 9/11 B6HI
- VAP 9/2 B6HI (disease progressed to classify this week – effective date 9.2)
- SSI 9/1 (upon review – met criteria for SSI)

**Employee Safety** Sept 14 – Sept 20

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>PAST WEEK</th>
<th>FY 13 YTD</th>
<th>FY 12 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total OSHA Recordable cases</td>
<td>4</td>
<td>48</td>
<td>59</td>
</tr>
<tr>
<td>Lost-Time</td>
<td>1</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Blood Borne Pathogen Exposures</td>
<td>1</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Slips, Trips, Falls</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Patient Interaction</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Late Incident Reports (These are incidents called in to 803-OUCH beyond the day of injury)</td>
<td>2</td>
<td>28</td>
<td>N/A Until 2/23/13</td>
</tr>
</tbody>
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Characteristics of
High Reliability Organizations

1. **Preoccupation with failure**
   Regarding small, inconsequential errors as a symptom that something is wrong; finding the half-event

2. **Sensitivity to operations**
   Paying attention to what’s happening on the front-line

3. **Reluctance to simplify**
   Encouraging diversity in experience, perspective, and opinion

4. **Commitment to resilience**
   Developing capabilities to detect, contain, and bounce-back from events that do occur

5. **Deference to expertise**
   Pushing decision making down and around to the person with the most related knowledge and expertise
Development of a High Reliability Culture

Leadership
- High functioning microsystems
- Executive reinforcement to front line.
- Daily and shift huddles; Organizational Daily Brief
- Multiple improvements going on simultaneously
- Just culture
- Managing by Prediction rather than Reaction

Developing Mindfulness
- Aware of all harm – EVERYDAY
- Aware of all risk – CONTINUOUSLY
- Harm reduction owned by front line leaders
- Learning to find the cause
- Alignment of the strategic plan with the front line

Global Aim
Eliminate all serious harm by 2015

Key Drivers
- Culture of Reliability
- Leadership Committed to Safety
- High Reliability of Safety Critical Processes
- Microsystem focus on Situation Awareness and management by prediction
- Technology designed using human factors expertise
- System detects all harm immediately and predicts risk of harm.
- Patient and family integrated into care team
- High functioning clinical microsystems

High Reliability for Safety Affects the Entire Organization
• Pre-Briefs/Debriefs
• Checklists
• Flattening Hierarchy
• Standardizing Communication
• Huddles
• Situation Awareness

HUDDLE
Delivering on Operations Reliably in a Mesosystem

Barbara Tofani, R.N., M.S.N
Frederick C. Ryckman, M.D.

Peri – Operative Services - CCHMC

- 34,000 Operative Procedures / Year
- 31 Operating Rooms
- 2 Cath Labs; 3 Interventional Suites
- 3 Endoscopy Proc Suites
- 84 Employed Surgeons; 180 Pt Services Staff
- 110 Anesthesia Providers
- Level 1 Trauma Center
- Solid Organ Transplant Center
- Airway Reconstruction
- All Major Services
Getting to the “Big Dot” in Peri-Op
Amelia’s Challenge – Work as a Team

• Develop “Micro-Systems” that preform similar work
  • Prior system “Silos” – Surgeons, Anesthesia, Nursing

• Micro – System Teams – Engaged Leadership at all Levels
  • Co-Leadership – Surgeon : Nurse : Anesthesia
  • SDS / OR / PACU / SPD
  • Work Across the System – with the flow of the Patient
  • Culture of Mutual Respect : Professionalism

• Team Responsibilities
  • Pre-Operative Planning – Pre Briefs on Complex Cases
  • Day of Surgery Room Staffing / Staff Rotation
  • Post Procedure Review and Handoff of Care

• Situational Awareness surrounding Patients / Staffing

Situational Awareness Prediction

Situational Awareness Model
Peri-Operative Services
Risk Escalation / Communication

- Definition of a “Great OR Nurse / Doc” is no longer based on “work-arounds” and “solo-saviors”
  Emphasis now on getting the right assistance / team to deliver the safest care
- **↑ Risk ↔ Automatic ↑** staff / support in room
- Skill level ↑ with escalation
  - Not just more people, more of the **right** people
- Predictive Planning for anticipated risks
  (advanced prediction = considered plan)

Situational Awareness - Day of Surgery Mitigation
Peri-Operative Services

Staffing
- Prior Day S.A. Huddle
- Predict Risk
- Team Concerns
  - Correct RN/Tech Team
  - Correct Anesthesia Team
  - Experienced Surgical Team
  - Other Situations
- Equipment Concerns
  - New or Unfamiliar Equipment
  - Competencies in Use/Set Up
  - Loaner/Trial Equipment
  - Unique Supplies/Trays

Materials
- Go
- Identify and Resolve
- High Risk
- Hard Stop

Anesthesia Concerns

Surgeon

Room Schedule

Patient Factors

Local Environment

Escalation to Leadership of Peri-Op Services

- Contact PFC or FRONT DESK RN
- If Unresolved or Progressive
  - **ESCALATE CONCERN TO SURGICAL SAFETY OFFICER OF THE DAY**
- Reliable Escalation of Risk
- Rapid Reassessment and Communication
- Reasses Prior to Beginning Cases

Techniques
- Automatic Escalation of Concerns
- Culture Communication
- System Specific

Mitigation Plan
- Rapid Response to Unanticipated needs

Rapid Reassessment

Contact
Amelia’s Challenge – Cheerleading

- “Anyone on the team can stop the routine at any time”
- Rule – We Will NOT Proceed in the face of Uncertainty
Amelia’s Challenge – I am Unique

- “Sometimes I am having Simple Surgery”
- Complex Patients receiving Simple Procedures
  - Structured Pre-Brief
- “Even a Simple Procedure for me may not be Simple”

Even though patients are unique ..... Process to care for them should not be Unique

Key Process Definition

- A process where there is a clearly defined “Best Practice” and process steps for uniform execution
- A process that when flawlessly executed will lead to safer care for the patient or staff
Peri-Op Key Processes

- **Time outs**
  - Pre Induction, Pre Surgical, Post Procedure
- **Consents – OR and Anesthesia**
  - All consents 100% correct for all safety indicators
- **Announce and Count**
  - No foreign bodies into body cavities without identification and recording for input and removal
- **Specimen labeling and handling**
  - Every specimen correctly labeled, nothing lost
- **Equipment and supply management**
  - All approved equipment, correct training, no surprises

**Goal** – 100% reliable execution every time
Amelia’s Challenge – Starting on Time

- Other “Key Processes” involve Process Reliability
- Execution of Key Process Steps is essential for Safety

Staffing Considerations

- Staffing based on competence rather than tenure
- Designated levels of competency (Limited, Experienced, Resource) – P. Benner Model
- Standardized staff training (Toyota Methods)
- Risk Assess equipment to determine training frequency and methodology
- Automated training to easily track and validate training/competency

Intentionally staff OR suites/cases based on identified risk and staff competence.
Amelia’s Challenge – Listen to Me

Olivia
Partnering With Patients
Shared Decision Making

Operational Excellence

Optimizing Outcomes, Experience & Value

- Empowered & Accountable Leadership
- Build Engaged & Committed Teams
- Reliably Execute Key Processes
- Maintain Resilient Staffing
- Reliably Implement Situation Awareness
- Partner with Patients & Families

Patient Experience
Employee Experience

Every Patient
Integrated Care Delivery
Every Time