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Clinical Service Lines

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Define

- Strategy including **physician/health care provider**, resource planning and allocation alignment within a particular discipline **across the continuum of care**- prehospital, hospital, post-acute, office, home

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Vision

- Focus- **Quality** and **Efficiency**
- Reduce unnecessary clinical variation
- Facilitate clinical integration - optimally address patients needs
- Physician led (physician from each hospital)
- Collaboration between service lines
- Facilitates strategic “nimbleness”

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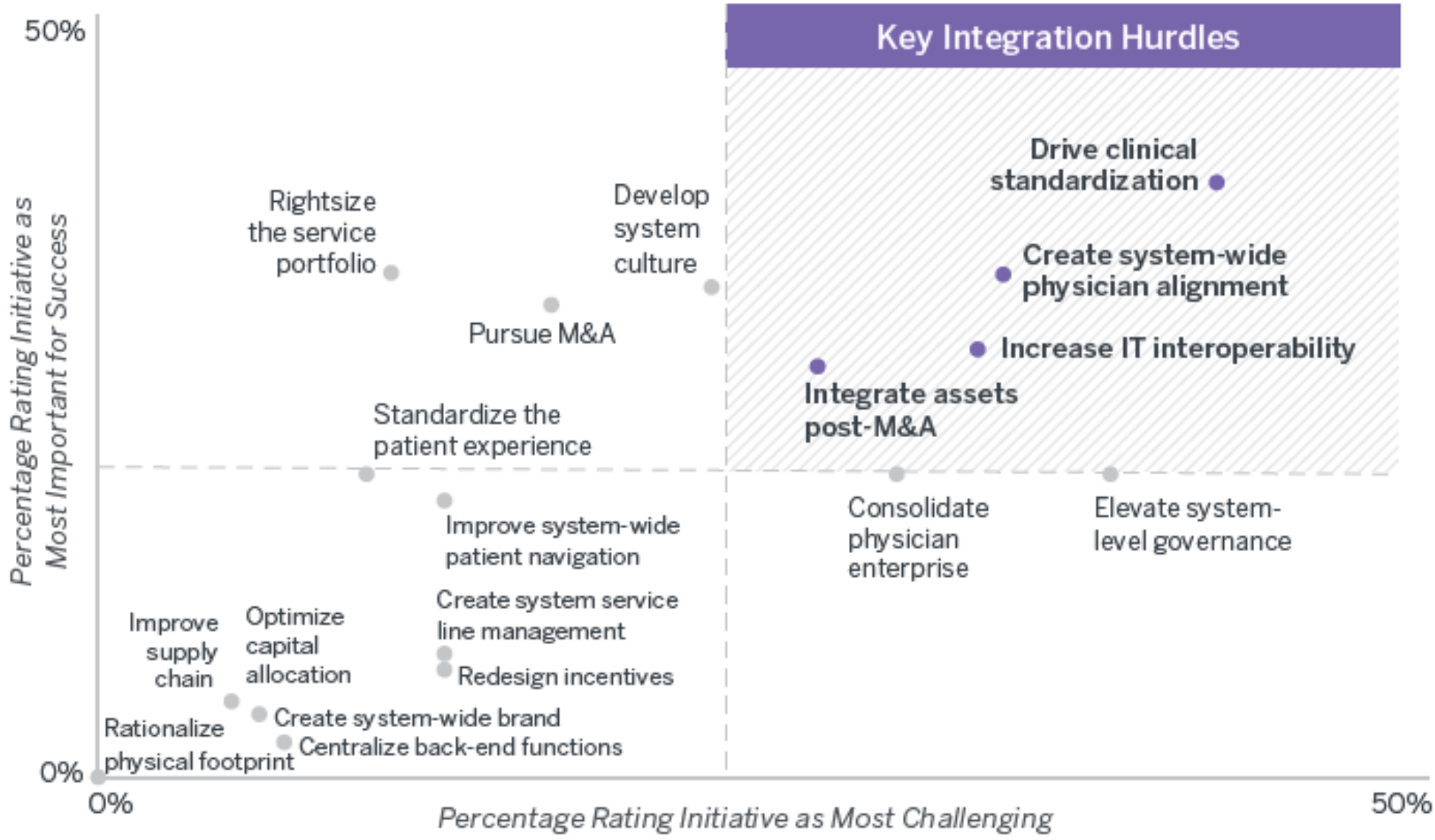
Systemness

- Drive Clinical Standardization, Integration
- Create System-Wide Physician Alignment
- Increase IT Interoperability
- Integrate Assets Post-M&A
- Elevate System Level Governance

Percentage Reporting Initiative as Most Challenging and Most Important for Organizational Success*

n=160 C-Suite Executives



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Essentials

- Order set development precedence
- Report- BH Physician Cabinet (leadership)
- Clinically Integrated Network (CIN) alignment
- Address cost improvement initiatives- physician preference items, right-sizing service portfolios, equipment standardization (service cost)

Other Systems

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Intermountain® Healthcare –Salt Lake City (22 Hospitals)

- 14 Guidance Councils- set quality strategy

Banner Health® -Phoenix (29 Hospitals)

- 22 Clinical Consensus Groups- create standards

MEMORIAL HERMANN® - Houston (13 Hospitals)

- Clinical Programs Committee- oversee care standards

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Barriers

- Medical staffs aren’t aligned across facilities
- Inconsistent care practices
- Lack of specialty specific representation at each locale
- Effective communication
- Leadership incentives and integration plans misaligned

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Current State

- Existing- Oncology, Emergency Medicine, Hospitalist, Critical care, Cardiovascular, Orthopedics, Imaging
- Future-
  - Anesthesia, Infectious Disease
  - Surgery, Behavioral, Women & Infants, Neurosciences

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Service line personnel

- Clinician led(typically physician) from each hospital
- Supported by “executive sponsor”- usually either hospital president , chief medical officer- assures barriers removed
- Nursing, pharmacy, quality, analytics, IT-complete make-up will vary some among service lines; some personnel “ad-hoc”

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Charter

- Enduring document
- Modifiable
- Address/Implement in initial meeting(s)
- Purpose- Address meeting dynamics- scope, duration, frequency, quorum, members, voting parameters (what constitutes “carried” motion - simple, super majority for example)

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Charter Example

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_____ COMMITTEE

I. PURPOSE:

A. The purpose of the _____ Committee is to support Baptist Health's mission to provide quality healthcare by enhancing the health of people and communities we serve.

B. The Committee is responsible for the following initiatives:

1.
2.
3.

II. COMMITTEE MEMBERSHIP:

A. The Committee is co-led by _____, {_____*Title*_____}, and _____, {_____*Title*_____}.

B. In addition to the Co-Leaders, the Committee shall have _____ members with representatives from across the System and from the following disciplines: _____.

C. The Committee Members shall be appointed by the Baptist Health Chief Executive Officer. Others may be asked to participate on an ad hoc basis as determined by the Committee Co-Leaders.

D. Committee Members will serve for a two (2) year term. Committee Members may be reappointed for additional two (2) year terms. Committee Members may resign and any resignation shall be submitted to the Committee Co-Leaders.

III. MEETINGS AND MINUTES:

A. The Committee shall meet on a quarterly basis. Meeting dates will be set annually in advance.

B. Special meetings of the Committee may be called by the Co-Leaders with seven (7) days advance notice.

C. Agendas and meeting materials will be provided to Committee Members at least three (3) days prior to a meeting.

D. A Member of the Committee or an executive assistant to the Committee shall take minutes of all meetings. Minutes will record Committee Members present and those who are absent, and all invited guests. Minutes will also record all recommendations and decisions of the Committee.

E. Draft minutes will be posted after a meeting as soon as reasonably practical. Draft minutes of all meetings will be approved at the next meeting. Approved minutes will be posted as soon as reasonably practical.

F. The Committee will develop a communication plan to communicate recommendations and decisions of the Committee to appropriate Baptist Health management.

G. Recommendations of the Committee will be presented by the Committee Co-Leaders to the Senior Executive Council for decision.

IV. QUORUM AND VOTING:

A. The Committee will endeavor to achieve unanimity in making its recommendations and decisions.

B. For any matter requiring a vote, a quorum of the Committee shall be present and a quorum shall consist of a majority of the Committee Members.

C. A vote by a majority of the Committee Members present at a meeting at which there is a quorum shall be an action of the Committee.

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Dashboard

- Metrics determined by service line
- Ideally actionable- facilitates being “data-driven”
- Avoid collection of data “just to collect”

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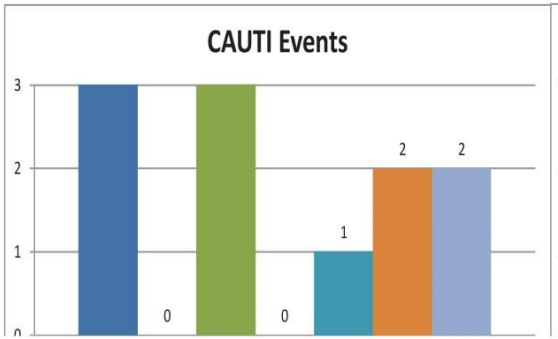
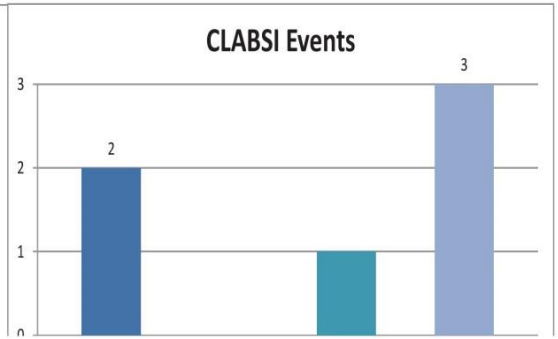
Service Line Dashboard

Critical Care Dashboard

CY 2016 YTD (August 2016) Baptist Health Comparison

Overall						MAD	BHPAD	HMH	Baptist Health
Ca									
ICU Admissions						1042	1675	990	8,412
ICU Days						3,596	4,905	3,100	30,513
ICU Avg LOS						3.5	2.9	3.2	3.6
Qu									
Mortality Rate						8.91	10.96	6.95	8.01
Mortalities						86	139	67	690
CLABSI # of Events						0	3	0	6
Central Line Days						1,609	1,905	0	11,986
CAUTI # of Events						2	2	0	16
Foley Catheter Days	3,648	193	4,507	403	1,063	1,899	2,274	0	13,987
Sepsis Mortality Rate	24.79	11.11	23.08	10.00	14.29	31.03	25.93	25.93	20.03
Sepsis ICU CCU Cases	505	49	268	156	276	235	215	58	1,704
Vent Days	1640	65	3044	127	531	1375	1399	347	8,181
Ventilator Utilization Ratio	0.19	0.11	0.33	0.10	0.24	0.38	0.29		0.23
Central Line Utilization Ratio	0.32	0.19	0.53	0.16	0.23	0.45	0.39		0.32
Foley Catheter Utilization Ratio	0.42	0.32	0.49	0.31	0.48	0.53	0.46		0.43





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Goals

- **SMART**- **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**imely
- Association with system goals
- Build goals around safety, quality, patient experience, efficiency
- 2-3 goals maximum (should also address other issues throughout the year)
- Readdress yearly

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Goal examples

		Goal 1	Goal 2	Goal 3	Goal 4
	Executive Sponsor	now - 12/2016	now - 12/2016	now - 12/2016	
Oncology (updated 03/21/16 A. Henson)	Andy Sears/ Amanda Henson	Implementation of data interfaces for the GRN and begin clinical trial matching for current BH clinical trials by June 2016	Continue to work towards integrating the clinical research network with the goal of meeting our cooperative group expectations (average 8 pts over a 3 year period with 3 NRG; 5 Alliance)	Standardization of chemotherapy care plans with Epic Beacon prior to BH Lou Go-Live March 2016	Host a Cancer Symposium Fall 2016 targeted at oncology physicians across BH
Emergency Medicine (updated 04/18/16 N. Wilson)	Nathan Wilson	Chest Pain Protocol	CAUTI/CLABSI	Patient Experience: ED Leader Rounding competencies(completed); ED Leader Rounding Log implemented (complete); ED Wait times shared with families and pts (in process); standardized white board elements (complete)	