The presentation will begin shortly.

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Duke University Hospital
AHA Quest for Quality: Quality Improvement Lessons

Presented by:
Kevin Sowers, RN, MSN, FAAN
President, Duke University Hospital
Journey to Excellence
Dr. W.C. Davison, Founding Dean of DUSOM

“Culture of Continuous Improvement”
Duke University Hospital

Journey to Excellence

2000
Formally launched Baldridge Journey

2005

2010

2015
AHA Quest for Quality Finalist; Truven Top 100

New Mission and Vision and 3D introduced as PI framework

Introduce Transforming Our Future to deliver higher level of value with focus on innovation

2012
National Baldridge Site Visit/National Leadership Award; Truven Top 100; Truven Everest Award

2014
DUHS Magnet Designation; Truven Top 100

Lung and heart transplant programs treat 1,000th patient
5,000th adult bone marrow transplant

New Eye Center opens
Cardiothoracic surgery and ECMO programs treat

2011
DUH Re-designation for Magnet

Renovated 5 operating rooms; new hybrid OR (2010)
Duke Medicine Pavilion opens

2009
AHA Quest for Quality–Citation of Merit

Pediatric Cardiac ICU opens
Renovated Prep/PACU & surgical waiting area

2008
NCAFE Level 3 Achievement Award; Truven Top 100

Hospital Addiction For Surgery (HAFS) opens

2006
DUH named a Magnet Hospital

Emergency Department addition & renovation (2007)

2015

Enhanced employee engagement and communication approach
Implemented formal leadership processes and enhanced development programs
Aligned performance improvement priorities within the organization and deployed supporting tools
Established Patient Advisory Committee (PAC) to formalize patient engagement; 9 PACs in place today
Developed DUH Patient Safety Center to support evidence-based safety initiatives and create a culture of safety

Introduced the Balanced Scorecard (BCS) as a measurement tool and later expanded to create a systematic process to define organizational priorities, measures, and targets
Duke University Hospital…

- 957 licensed beds
- Main campus (3 million square feet):
  - Duke North inpatient bed tower
  - Duke Cancer Center
  - Duke Medicine Pavilion
  - Duke South Clinics
  - Eye Center
  - Children’s Health Center
- Off Campus
  - Ambulatory Surgery Center
  - Adult Bone Marrow Transplant
  - ~25 primary and specialty care clinics
- Largest employer in Durham Co.
  - Second largest employer in NC
CSU Structure: Since 1997

- Patient care services are grouped according to **Clinical Service Units (CSUs)**, which is an operational structure that aligns physicians, staff and administration to DUH priorities.

- Co-lead by Vice-President, Medical Director, & Associate Chief Nursing Officer, as deployed
  - Emergency Services
  - Med/Surg/Critical Care
  - Heart
  - Perioperative Services
  - Neurosciences and Psychiatry
  - Musculoskeletal
  - Women’s and Children’s
  - Ambulatory Practice
  - Oncology
  - Transplant
Period of Significant Change

Cancer Center Opens:
- 122 new exam rooms
- 73 Infusion stations
- 17 imaging rooms
- Leed Gold Certified

Duke Med. Pavilion Opens
- 160 crit. Care beds
- 16 new surgical suites
- Leed Gold Certified

Epic Go-live:
- Largest go-live to date

Transforming our Future:
- Operational
- Care Redesign
- Fixed Costs
- Revenue Cycle
- Supply chain
### Key Organizational Efforts:

- Transforming our Future and Driving Organizational Excellence
- Capacity Management and staff recruitment to accommodate growth
- Workforce engagement
- Community support and engagement
Duke University Hospital Today
2015 – A year of Unprecedented Growth

<table>
<thead>
<tr>
<th>Volume Statistics</th>
<th>Current Year</th>
<th>Prior Year</th>
<th>% Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Daily Census</td>
<td>783</td>
<td>743</td>
<td>5.4%</td>
</tr>
<tr>
<td>Discharges, Obs., and OP in Bed</td>
<td>52,421</td>
<td>49,607</td>
<td>5.7%</td>
</tr>
<tr>
<td>Surgical Cases</td>
<td>40,055</td>
<td>38,220</td>
<td>4.8%</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>70,701</td>
<td>66,860</td>
<td>5.7%</td>
</tr>
<tr>
<td>Specialty Visits (PDC) – Total Visits</td>
<td>1,363,429</td>
<td>1,266,357</td>
<td>7.1%</td>
</tr>
<tr>
<td>Specialty Visits (PDC) – New Patient Visits</td>
<td>242,027</td>
<td>223,081</td>
<td>7.8%</td>
</tr>
<tr>
<td>Primary Care Visits (DPC total visits)</td>
<td>614,480</td>
<td>560,944</td>
<td>9.5%</td>
</tr>
<tr>
<td>OP Imaging (MRIs and CTs)</td>
<td>88,240</td>
<td>80,712</td>
<td>9.3%</td>
</tr>
<tr>
<td>Unique patients (DUHS)</td>
<td>665,911</td>
<td>620,301</td>
<td>7.4%</td>
</tr>
<tr>
<td>Cath Cases (including EP and Pedts)</td>
<td>7,646</td>
<td>7,334</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
DUH Blueprint for Success

**DUH Vision**
To discover, develop and deliver a healthier tomorrow.

**DUH Mission**
We put the person who needs our care at the center of everything we do.

<table>
<thead>
<tr>
<th>Quality/Safety</th>
<th>Patient Experience</th>
<th>Work Culture</th>
<th>Finance/Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>We strive to advance and provide the safest, highest quality of care for our patients.</td>
<td>We provide extraordinary service and care every time we interact with our patients and their loved ones.</td>
<td>We attract, engage and develop the best teams and foster a community of interdisciplinary excellence.</td>
<td>We have the resources, facilities and partners needed to provide care in our community.</td>
</tr>
</tbody>
</table>

**Continuous improvement in 3D (Discovering, Developing, Delivering)**

The DUH community of providers, nurses, staff, and volunteers

**Our Values**
Caring for Our Patients, Their Loved Ones & Each Other
Excellence • Safety • Integrity • Diversity • Teamwork

**Cycles of Improvement:**
- Redesign of Mission and Vision including input from:
  - Faculty
  - Staff
  - Patients
  - Community
  - Volunteers
Journey to Excellence
Continuous Improvement & Innovation

Duke University Hospital
Supported by our Core Competencies of:

- Culture of Continuous Improvement
- Collaborative Teamwork
Formalized the DUH Leadership System

**Key Cycles of Improvements:**
- Formalized the informal
- Full integration of key organizational processes (BSC, SPP, PR, 3D and integrated into our performance management processes)
- Cycles of improvements within each process.
Continuous Improvement & Innovation in 3D...

**Key Cycles of Improvement:**
- Long history of Performance Improvement with lean, six sigma and other PI skills deployed throughout the organization
- Trained over 100 BBs and over 200 GBs
- Implemented 3D to create a simpler framework that was inclusive of all PI and patient safety tools
- Framework for Knowledge Management (close to 300 3D stories submitted)
**DISCOVER**

**The Opportunity:**
- In the era of accountable care, health systems are developing care bundles with the intent of providing consistent, high quality, cost-effective care to patients with common conditions.
- During the fall of 2013, we identified an opportunity for improvement based on University HealthSystem Consortium (UHC) benchmarking data showing that our average length of stay (ALOS) for pediatric asthma admissions was 3.29 days with a LOS index of 1.29 compared to our peer group ALOS of 2.32 days with a LOS index of 0.89.
- We established a multidisciplinary care redesign committee charged with reducing variability in practice, ALOS, and cost of pediatric asthma admissions, while ensuring high quality care consistent with national guidelines.
- Our specific aim was to reduce the ALOS of pediatric patients admitted with asthma from 3.29 to 2.6 days within 12 months in an academic children's hospital by implementing a guideline that included use of a respiratory therapy-driven albuterol treatment protocol.

**DEVELOP**

**The Plan:**
- Interventions were tested through multiple ‘plan-do-study-act’ cycles.
- We implemented a validated Modified Pulmonary Index Score (MPIS) for assessing severity, use of a respiratory therapy-driven albuterol treatment protocol, revision of asthma order sets, provision of targeted education, and promotion of the guideline in the Duke Children's Emergency Department and inpatient units.
- Readmission rates were monitored as balancing measures.

**KEY DRIVER DIAGRAM**

**DETERMINE**
- Asthma care pathway available and used by all providers, nurses and respiratory therapists
- Bronchodilators are weaned based on asthma scores
- Location of care (ED, inpatient & subacute, intermediate units) based on asthma scores and response to therapy
- Nurse management plan of care (NHPC) provided for all patients prior to every discharge
- Multidisciplinary leadership committed to improving the efficiency & reliability of inpatient asthma care

**INTERVENTIONS**
- Making the process visible: Develop electronic health record (EHR) asthma score workflow, provider documents, nurse asthma order set/audit.
- Standardization: Develop multidisciplinary asthma pathway (ED, inpatient & subacute).
- Intake: NHPC upon admission: Develop standardized NHPC tool in EHR
- Identification & mitigation of noncompliance with asthma care guidelines: Measure pathway compliance. Measure CQI compliance. Communicate use of the asthma care pathway

**DETERMINE**
- ALOS by Discharge Month
- Mean Target ALOS (Apr 2014) & Control Limits

**DELIVER**

**The Results:**
- We successfully reduced the ALOS for pediatric asthma admissions by 0.7 days from a baseline of 3.29 to 2.59 days, and decreased length of stay index from 1.29 to 1.00 in FY13 compared to periods 1-6 of FY15.
- We observed a decrease in direct cost and variability of cost compared to our peer group.
- Thirty-day readmission rates remain stable.
- We continue to monitor our results monthly and respond to special cause variation.
Innovation

• GME Innovation dollars since 2007
• Duke Innovation Health Institute
  – Two RFP cycles since 2013
• Held first Innovation Summit
• Conducted first Innovation Jam
• Integration with the Vendor summit
Duke Health Innovation Jam

September 15, 2015
8:30 AM - 12:00 PM
Duke North 2002
Meet The Investors

Pitch your innovative clinical products and business ideas for investment!
Patient and Family Centered Care

**Key Cycles of Improvement:**
- Development of first Patient Advisory Council.
- Expansion to 11 through FY 15.
- Integration into operational and facility planning efforts
- Patient navigators
Driving Organizational Excellence

*Cycle of Improvement*

- Launched as a result of our SPP
  - Identified key improvement opportunities
- Targeted performance improvement efforts
  - Designated Physician leaders with central support from Performance Services
  - Aligned with FY 15 BSC goals and measures
- Structured oversight process aligned with organizational processes
Driving Organizational Excellence
Business Owners

<table>
<thead>
<tr>
<th>Measure</th>
<th>Business Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Evidence-Based Care Scores IMM, VTE, PC</td>
<td>Dr. Lisa Pickett</td>
</tr>
<tr>
<td></td>
<td>Dr. Phil Heine</td>
</tr>
<tr>
<td>Mortality – Observed Mortality - Expected</td>
<td>Dr. Lisa Pickett</td>
</tr>
<tr>
<td></td>
<td>Dr. Momen Wahidi</td>
</tr>
<tr>
<td>Readmission Rate; Length of Stay</td>
<td>Dr. David Gallagher</td>
</tr>
<tr>
<td>ED LWBS; ED LOS (TAR and Admitted)</td>
<td>Dr. Charles Gerardo</td>
</tr>
<tr>
<td></td>
<td>Jessica Thompson</td>
</tr>
<tr>
<td>Patient Safety Indicators</td>
<td>Dr. Lisa Pickett</td>
</tr>
<tr>
<td></td>
<td>Dr. Momen Wahidi</td>
</tr>
<tr>
<td>Hospital Acquired Infections (CLABSI; CAUTI; C. Diff; MRSA)</td>
<td>Dr. Luke Chen</td>
</tr>
<tr>
<td></td>
<td>Pamela Isaacs</td>
</tr>
<tr>
<td>HCAHPS Responsiveness; Hospital Cleanliness and Quietness</td>
<td>Carolyn Carpenter</td>
</tr>
<tr>
<td></td>
<td>Tracy Gosselin</td>
</tr>
</tbody>
</table>
# Driving Organizational Excellence

## Key Successes

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline FY 14</th>
<th>Current Performance</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality Index</td>
<td>0.85</td>
<td>0.79</td>
<td>7%</td>
</tr>
<tr>
<td>VTE</td>
<td>84.0%</td>
<td>95.0%</td>
<td>13%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>59.1%</td>
<td>92.1%</td>
<td>56%</td>
</tr>
<tr>
<td>PSIs</td>
<td>0.83</td>
<td>0.79</td>
<td>7%</td>
</tr>
<tr>
<td>CLABSI</td>
<td>1.1</td>
<td>0.88</td>
<td>20%</td>
</tr>
<tr>
<td>CAUTI</td>
<td>3.4</td>
<td>1.7</td>
<td>50%</td>
</tr>
<tr>
<td>ED LOS (TAR)</td>
<td>294</td>
<td>265</td>
<td>10%</td>
</tr>
<tr>
<td>ED LOS (Admitted)</td>
<td>428</td>
<td>423</td>
<td>1%</td>
</tr>
</tbody>
</table>
Duke University Hospital
Mortality Index by Calendar Month

Epic go-live
Focused doc efforts begin

**Patient Safety Indicator**

### AHRQ Patient Safety Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Relative Performance</th>
<th>Denom</th>
<th>Observed</th>
<th>Target</th>
<th>UHC Median</th>
<th>Rank</th>
<th>Score</th>
<th>x/n</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

#### AHRQ Patient Safety Composite Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Relative Performance</th>
<th>Denom</th>
<th>Observed</th>
<th>Target</th>
<th>UHC Median</th>
<th>Rank</th>
<th>Score</th>
<th>x/n</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**Surgical (Rate per 1000)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Relative Performance</th>
<th>Denom</th>
<th>Observed</th>
<th>Target</th>
<th>UHC Median</th>
<th>Rank</th>
<th>Score</th>
<th>x/n</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS108 Post-operative hip fracture</td>
<td>○○</td>
<td>2,061</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>15/123</td>
<td>○○</td>
<td>7,969</td>
</tr>
<tr>
<td>PS109 Perioperative hemorrhage or hematoma</td>
<td>○○</td>
<td>3,072</td>
<td>8.1</td>
<td>8.5</td>
<td>7.1</td>
<td>64/123</td>
<td>○○</td>
<td>12,062</td>
</tr>
<tr>
<td>PS110 Post-operative physiologic / metabolic</td>
<td>○</td>
<td>1,947</td>
<td>1.5</td>
<td>0.8</td>
<td>0.8</td>
<td>81/123</td>
<td>○○</td>
<td>7,648</td>
</tr>
<tr>
<td>PS111 Post-operative respiratory failure</td>
<td>○</td>
<td>1,471</td>
<td>10.9</td>
<td>13.8</td>
<td>10.2</td>
<td>59/123</td>
<td>○○</td>
<td>5,667</td>
</tr>
<tr>
<td>PS112 Perioperative PE/DVT</td>
<td>○○</td>
<td>3,225</td>
<td>5.0</td>
<td>6.6</td>
<td>7.7</td>
<td>23/123</td>
<td>○○</td>
<td>12,657</td>
</tr>
<tr>
<td>PS113 Post-operative sepsis</td>
<td>○</td>
<td>376</td>
<td>8.0</td>
<td>13.1</td>
<td>11.3</td>
<td>47/123</td>
<td>○○</td>
<td>1,627</td>
</tr>
<tr>
<td>PS114 Post-operative wound dehiscence</td>
<td>○</td>
<td>413</td>
<td>7.3</td>
<td>2.2</td>
<td>0.0</td>
<td>0/115/123</td>
<td>○○</td>
<td>1,607</td>
</tr>
</tbody>
</table>

**Obstetric (Rate per 1000)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Relative Performance</th>
<th>Denom</th>
<th>Observed</th>
<th>Target</th>
<th>UHC Median</th>
<th>Rank</th>
<th>Score</th>
<th>x/n</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS118 OB trauma - vaginal with instrument</td>
<td>○</td>
<td>42</td>
<td>142.9</td>
<td>188.7</td>
<td>130.4</td>
<td>61/105</td>
<td>○○</td>
<td>171</td>
</tr>
<tr>
<td>PS119 OB trauma - vaginal w/o instrument</td>
<td>○</td>
<td>471</td>
<td>12.7</td>
<td>24.7</td>
<td>16.2</td>
<td>38/107</td>
<td>○○</td>
<td>1,855</td>
</tr>
</tbody>
</table>

**Other (Rate per 1000)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Relative Performance</th>
<th>Denom</th>
<th>Observed</th>
<th>Target</th>
<th>UHC Median</th>
<th>Rank</th>
<th>Score</th>
<th>x/n</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS103 Pressure ulcer (Decubitus ulcer prior to 2007 Q4)</td>
<td>○</td>
<td>2,525</td>
<td>0.4</td>
<td>0.5</td>
<td>0.4</td>
<td>61/123</td>
<td>○○</td>
<td>10,030</td>
</tr>
<tr>
<td>PS106 Iatrogenic pneumothorax</td>
<td>○</td>
<td>6,497</td>
<td>0.3</td>
<td>0.5</td>
<td>0.3</td>
<td>50/123</td>
<td>○○</td>
<td>26,108</td>
</tr>
<tr>
<td>PS107 Central venous catheter-related bloodstream infections</td>
<td>○</td>
<td>4,564</td>
<td>0.4</td>
<td>0.8</td>
<td>0.4</td>
<td>65/123</td>
<td>○○</td>
<td>18,453</td>
</tr>
<tr>
<td>PS115 Accidental puncture / laceration</td>
<td>○</td>
<td>7,300</td>
<td>1.6</td>
<td>4.1</td>
<td>1.6</td>
<td>48/123</td>
<td>○○</td>
<td>29,000</td>
</tr>
</tbody>
</table>

### Quarterly Rank

- **2014Q1**: 55
- **2014Q2**: 50
- **2014Q3**: 32
- **2014Q4**: 15

**Approaching Top Decile**

- Quarterly Rank (out of ~125)
Pay for Performance Results

- DUH Performance has been in the top 15% nationally for past three years
- Key organizational priority managed through our Leadership system
- 85% of COTH hospitals lose money in the CMS pay for performance programs

Source: AAMC
Community Engagement

• Community Needs Assessment

• Community Programs
  – Project Access, LATCH, Northern Piedmont Community Care, School clinics

• Population specific improvements through care redesign efforts (Heart Failure, Sickle Cell)

• Service line specific improvements:
  – Duke Outpatient Clinic readmission improvement
  – Readmission rates
  – Emergency Department familiar faces program

• Engaged our community partners:
  – EMS
  – Lincoln Community Center
Community Involvement & Impact

• **$222 Million** = DUH’s total community investment
• **58%** of all visits to DUH’s ED reflected some level of charity care.
• **68,000** = number of enrollees in Northern Piedmont Community Care Program
• **$37,000** = Total cost of medical equipment that was secured for patients in the LATCH program
• **316** = Number of Duke Learners with specialty training in community-based health care delivery
• **3,758** = number of encounters at school-based clinics.
  – **35%** = percentage of parents who would have taken their child to the ER
  – **8%** = percentage of parents who would have not received/delayed care for their child
Concluding Comments
Quality Improvements Through Community Partnerships

Schneck Medical Center
Seymour, IN

Presented by: Tammy Dye, Chief Quality Officer/VP Clinical Services
Topics

• Partnering with Community Stakeholders
  – Providing resources and education to long term care facilities to improve readmissions
  – Teaming up with a competitor hospital to improve population health of both of their communities

• Improving Quality of Care and Patient Experience in the Emergency Department
Not-for-profit, county owned hospital

Facilities include:

• Main Campus, 93 all private suites
• Several specialty physician practices
• Three Convenient Care Clinics
• Cancer Center
• 3,900 admissions
• Over 107,000 outpatient visits
• 30,000 ER Visits
• 4,000 surgeries
• 136 Active Physicians
Approximately 900 employees

Schneck Medical Center

2011 National Baldrige Award Recipient

Schneck Medical Center is in constant pursuit of ways to provide excellent care. In the last 100 years, we have evolved from a 17-bed hospital to one of the most respected health institutions in the region.
Reducing Readmissions

• Multi-disciplinary rounding

• Patients identified as high risk will have medicine reconciliation completed by pharmacist before discharge

• Free home visit

• 30 day supply of medications sent home with qualified patients

• Follow-up discharge phone call
Partnering with Long Term Care

- Transitional Care Team
  - Monthly meetings with representatives from area long term care facilities to drill down on readmissions

- INTERACT program (Interventions to Reduce Acute Care Transfers)

- Provided Medical Director, physicians and NPs for coverage at long term care facilities

- Sponsoring 10 RNs to become Nurse Practitioners as additional resources
Long Term Care – COPD Management

• RT department shifted hours and hired Disease Management Coordinator

• Provided end tidal CO2 monitor for each nursing home

• Respiratory reaching out to Home Health to help design a process so RT can go to the home for a visit.

• RT going to four nursing homes weekly and PRN

• RT department assisting with discharges to home and nursing homes.
COPD Readmissions

COPD 30-Day Readmission Rates (All Payers)
Source UHC
Overall 30-Day Readmissions

Schneck Medical Center
Overall 30-Day Readmission Rate by Year

- 2010: 6.76%
- 2011: 7.23%
- 2012: 7.22%
- 2013: 4.94%
- 2014: 5.43%
- YTD 2015: 4.35%

TOP QUARTILE 9.14
TOP DECILE 7.21

81 patients out of 1,864
Collaborating with Competitor

Reduce STEMI Times
Partnering with Competitor

• History of successful collaboration for STEMI patients
Next Collaboration - CIN

Benefits:

• Coordinated care
• Ability to recruit and retain providers
• Alignment of provider and hospital and quality and safety efforts
• Access to a more holistic view of individual patients across practices and sites of care
• Increased value for healthcare dollars spent

Produce a value added product to create a larger market so each entity can benefit from increase market share
“State of Emergency” in the ED

– Door to provider time for 2012 - 52 minutes

– Length of stay for low acuity patients (ESI 4/5) 2011, is 118 minutes (42.3% of SMC’s ED population)

– Left Without Being Seen (LWBS) for 2012 is 2.23%.

– Customer service scores have averaged at the 25th percentile in the last 6 quarters.
Where We Are Today

• Average door to provider time has decreased to 23 minutes.

• Length of stay for low acuity patients has decreased on average to as low as 66 minutes for Split Flow patients.

• LWBS has decreased to 0.54% in 2014

• Customer service scores have increased to 87th percentile as of the 4th quarter of 2014
ED – Door to Provider Time

Implemented Split Flow

Main ED
Split Flow

2012
2013
2014
YTD 2015

52
23
19
16

2012
2013
2014
YTD 2015

50
40
30
20
10
0

2012
2013
2014
YTD 2015

12
18
22
23

50
40
30
20
10
0
Left Without Being Seen

Left Without Being Seen (LWBS) Rate

- 2012: 2.23%
- 2013: 0.81%
- 2014: 0.54%
Measure/Analyze

Overall Satisfaction

- 2012: 19
- 2013: 49
- 2014: 87
- 2015 YTD: 74
Please click the link below to take our webinar evaluation. The evaluation will open in a new tab in your default browser.

https://www.surveymonkey.com/r/hpoe-webinar-12-17-15
Upcoming HPOE Live! Webinars

• February 23, 2016
  – Going Beyond REaL Data Collection: Collecting Social Determinants of Health

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