2016 Volume 52 Number 1

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International
Hospital
Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

IHF Recognition Awards for 2015

- YACHIYO HOSPITAL; Center of *SUPER CARE MIX* - Comprehensive Care from Emergency to Home for the community
- Construction and Application of a Refined Hospital Management Chain
- Quality, Safety and Patient Centered Care – A Dream Come True in the Mountains of Northern Pakistan. *An Award winning project of "2015 Quality, Safety & Patient Centered Care Award" at, Chicago USA*
- St. Luke's Medical Center Global City – Global Trigger Tool (GTT) Project
- Paradigm of Professional Integration for Disabled People in Fundació Integralia Vallès: Key Success Factors
- Cognitive Training for Dementia Patients in the Community & Art Therapy Programs of 'Goyang Centenarian's Good Memory School'
- Why Hospitals and Payers are Recommending Home Care Upon Discharge Instead of SNF or Traditional Home Health Services - *Alternative Payment Model Hospital Incentives Aligning with Patient Choice*
- The Power to drive change: Working together for excellence. Creating a continuously improving consumer engagement framework for excellence in patient–centered care
- Decreasing Interferences and Time Spent on Transferring Information on Changing Nursing Shifts
- Improvement Initiatives of Resuscitation Service in a Regional Rehabilitation Hospital in Hong Kong
- Improving the Success of Strategic Management Using Big Data

Abstracts: Français, Español, 中文

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2016 International Awards

Supporting recognition of excellence, innovations and outstanding achievements in global healthcare leadership and management.

IHF/DR KWANG TAE KIM GRAND AWARD

ELIGIBILITY

- IHF Full and Associate Members ONLY
- Demonstrated fields of excellence and achievements with proven results at health system or facility level in several areas such as:
  - Quality and patient safety
  - Corporate social responsibility
  - Innovations in service delivery at affordable costs
  - Healthcare leadership and management practices

AWARDS TROPHY AND PRIZES

Winner:

- 5,000 Swiss Francs to cover travel and accommodation for attending the Congress
- Internal exposure through IHF publications and healthcare media network
- 3 complimentary Congress registration

Runners-up:

- 2 complimentary Congress registration
- International exposure through IHF publications

IHF EXCELLENCE AWARDS

CATEGORIES

- Leadership and Management in Healthcare
- Quality and Safety and Patient-Centered Care
- Corporate Social Responsibility

ELIGIBILITY

- IHF Members and Non-Members
- Demonstrated excellence and achievement at facility or unit level through an activity with the proven results

AWARDS TROPHY AND PRIZES

Winner:

- 2,500 Swiss Francs to cover travel and accommodation for attending the Congress
- 2 complimentary Congress registration
- International exposure through IHF publication and healthcare media network

Runners-up:

- 1 complimentary Congress registration/ category
- International exposure through IHF publications

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To submit, go to:
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Submission opens on:
15 February 2016

Submission deadline:
11 July 2016

Winner announcement:
05 September 2016

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Note for Asian countries:
If you are considering to enter the IHF International Awards, you may also want to enter the Asian Hospital Managements Awards at http://www.asianhospitalmanagementawards.com/

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IHF Newsletter is available in **https://www.ihf-fih.org/home?newsletter**

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ISSN: 0512-3135

Published by Nexo Corporation
for the International Hospital Federation

Via Camillo Bozza 14, 06073 Corciano (Pg) - ITALY
Telephone: +39 075 69 79 255
Fax: +39 075 96 91 073
Internet: www.nexocorp.com

Subscription
World Hospitals and Health Services is published quarterly. The annual subscription to non-members for 2016 costs CHF 270 or US$280 or €250. All subscribers automatically receive a hard copy of the journal, please provide the following information to marianne.bacani@ihf-fih.org:
-First and Last name of the end user
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World Hospitals and Health Services is listed in Hospital Literature Index, the single most comprehensive index to English language articles on healthcare policy, planning and administration. The index is produced by the American Hospital Association in co-operation with the National Library of Medicine. Articles published in World Hospitals and Health Services are selectively indexed in Health Care Literature Information Network.

The International Hospital Federation (IHF) is an independent non-political and not for profit membership organization promoting better Health for all through well managed and efficient health care facilities delivering safe and high quality to all those that need it. The opinions expressed in this journal are not necessarily those of the International Hospital Federation or Nexo Corporation.

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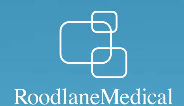

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IHF Recognition of Excellence

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In this issue of the World Hospitals and Health Services Journal, the International Hospital Federation (IHF) is showcasing the activities of groups that were honored with Awards at the time of the 2015 World Hospital Congress in Chicago.

The Awards were designed to recognize and honor hospitals and healthcare organizations for innovation, excellence, outstanding achievements and best practices in areas that are worthy of international mention. The winners highlight the extraordinary contribution made by IHF members and friends of the IHF to improve the care and services provided by the hospital sector globally.

The Ancient Greeks had a concept of ***arete*** which meant an outstanding fitness for purpose. This occurs in the works of Aristotle and Homer. Another related concept was ***eudaimonia*** which was the happiness which resulted from a life well-lived, being prosperous and fulfilled.

These concepts are very relevant to health care and the hospital sector more specifically. Hospitals are par excellence the ***arete*** of the health sector. It is not by chance that most policy analysts put the hospital sector at the "peak" of the health care pyramid. And although profit and other motives may play a role, it is often ***eudaimonia*** that motivates staff and collaborative groups to strive for excellence. There can be no greater personal satisfaction than working in a sector whose prime objective and focus is helping people with serious illnesses get better or relieve their suffering at the end of their lives.

More specifically, in selecting the recipients of the IHF Awards, excellence was seen as a talent or quality which was unusually good and so surpasses ordinary standards. The winners provide a high standard and benchmark for others to strive to achieve.

In modern public relations and marketing, "excellence" has become an overused "buzzword" that tries to convey a good impression often without imparting any concrete information (e.g. "center for excellence in ...", "business excellence", etc.).

This is not the spirit in which the winners of the Awards were selected. Rather than being a single moment of recognition, the Awards were seen as a "landmark" in a continuous process of improvement, moving towards a realistic target that can can be achieved in the foreseeable future.

The Awards recognize real and tangible achievements in leadership, actions of integrity, being frontrunners in terms of products/services provided, safety etc. under several headings.

The winner of the **IHF/Dr. Kwang Tae Kim Grand Award** was St Luke's International Hospital in Japan for their work on "Measurement and Disclosure of Quality Indicators (QI), which express the Healthcare Quality, and Improvement." Their project developed a systematic implementation of measures resulting in notable improvement in the quality of medical care delivered. A full presentation of this project is visible on the webinar section of the IHF web site.

IHF Webinars: https://www.ihf-fih.org/home?post_type=17

There were three winners under different categories of IHF Excellence Awards. Yachiyo Hospital in Japan won the **Leadership and Management in Healthcare Award** for a submission on a "Center of Super Care Mix - A Comprehensive Care from Emergency to Home." The Texas Children's Hospital in the USA won the **Quality & Safety and Patient-centered Care Award** for a submission on "Advancing Population Health: The Critical Role of Care-Delivery Systems." Mutua Terrassa in Spain won the **Corporate Social Responsibility Award** for a submission on a "Paradigm of Professional Integration for Disabled People".

All IHF award recipient are presented in the next section and this journal has provided an opportunity for readers to get more in depth with a selection of award recipients. It is possible to look for further experiences by browsing the IHF website in which all finalists have been posted. Each of these entries can contribute in advancing the healthcare services to the population and inspire any healthcare service provider to adopt one or other innovative approach that is presented.

In addition to the IHF awards, this journal is also giving an opportunity to feature the posters that were selected, during IHF Chicago 2015 by an international jury, for their contribution to the advancement of health services. Each of the article is describing more in details the experiences from healthcare facilities giving useful insights that can inspire any of us to improve our activities.

Finally several other awards were given away during the Venture Fair and Innovation Showcase side meetings on health impact, commercial success, management capacity and infection control http://bit.ly/Chicago2015VentureFairAwards.

These last awards, with complementary tickets provided by South Africa Airways to winners, were also a very strong message to move from IHF Chicago 2015 to IHF Durban 2016. The coming congress is an opportunity for any healthcare provider to take a chance to be recognized for achievements

Entries for award submissions are open: http://congress.ihf-fih.org/

Studies have shown that the most important way to achieve excellent performance is to practice. Achievement of excellence often requires years of dedication and practice with thousands of hours of effort. The IHF is committed to supporting its members move towards greater performance in the hospital sector through practice and enhanced focus on excellence.

DR. KWANG TAE KIM

IHF President (2013-2015)

DR. KWANG TAE KIM graduated from Catholic Medical University, Seoul, Korea, in 1961. He finished his general surgery residency in 1966, and he opened Daerim St. Mary's Hospital with 20 beds in 1969, eventually transforming it into a general hospital with 405 beds.

Dr. Kim has served in various positions at the Korean Hospital Association (KHA) and served as the KHA's president during 2002-2004. In the vision to have the KHA at the center of health care policy decision-making in Korea, Dr. Kim accomplished KHA become a legally recognized entity in 2003. KHA is now the representative body for Korean health care providers along with the Korean Medical Association. Dr. Kim is still actively involved in KHA's activities as the honorary president.

Dr. Kim's hope is that high quality health care service at affordable cost can be standardized nationally and internationally. He also initiated a bill that was eventually passed in national congress in 2009 that allowed recruitment of patients from abroad. Today, it is recognized as a medical tourism.

Dr. Kim served as the IHF president during 2013-2015. IHF Awards was initiated to promote IHF's visibility and its goal as a knowledge hub of health care. His hope is that IHF becomes the center of international integration with other organizations in setting global standards for patient-centered care at affordable cost. The first IHF Awards were presented at Chicago World Hospital Congress in 2015. Dr. Kim hopes that IHF Awards will become the most recognized award in world health care, encompassing all areas of medical field. Kwang Tae Kim, IHF President (2013-15), E-mail: ktkim@drh.co.kr

IHF/DR KWANG TAE KIM GRAND AWARD

WINNER

Measurement and Disclosure of Quality Indicators (QI), which express the Healthcare Quality and Improvement Activities
St Luke's International Hospital (Japan)
This project has developed a systematic implementation of measures resulting in notable improvement in the quality of medical care delivered. The healthcare data collated is used to analyse and measure quality indicators used as tools to implement improvement measures. Stakeholder engagement is multidisciplinary. Since initiation of the project 151 QI have been set, which are regularly measured, 56% of which have improved over time. Japan Hospital Association, the body that represents hospitals in Japan has been in charge of pioneering this IQ project since 2010. Participating hospitals have risen from 30 in 2010 to 327 in 2015.

HONOURABLE MENTIONS

Implementation of a Korean 'Global Standard' (Harmony between "efficiency" and "equity")
Seoul St. Mary's Hospital, The Catholic University of Korea (Republic of Korea)
Project vision, to be 'a hospital that represents hope based on love and innovation' The project involves the pursuit of improvement and innovation in the delivery of safe and quality care under a 3-step plan, whereby high standards of care and not just treatment per se is delivered to all population groups at affordable costs. Through the Nanumyiryo Project (Sharing Medical Care), overseas patients are also provided treatment at affordable costs. This has generated an effective international platform for the transfer of expertise and know-how. In March 2015, a Korean-style health promotion center was established in Abu-Dhabi, UAE. The hospital ranks 1st in gastric, colorectal, liver and breast surgery through its multidisciplinary cancer treatment approach.

The Power to Drive Change – Working Together for Excellence: Creating a Continuously Improving Consumer Engagement
Metro North Hospital and Health Service, Royal Brisbane and Women's Hospital (Australia)
The project's aim is to build a sustainable framework of engagement for a genuine patient-centered model of care, informed by best practice criteria as well as provide leadership and commit to developing an area of excellence. Implementation required a new and innovative model to replace the clinician –led model of healthcare historically featured in Australia and to support staff and consumers to engage meaningfully at all levels of the health system. Implementation of a consumer and community engagement framework with full leadership support has resulted in the creation of a measureable high performance organisational culture in patient experience and engagement within existing resources without re-alignment of work practices. The framework has been endorsed by the Australian Council on Healthcare Standards.

IHF EXCELLENCE AWARDS

LEADERSHIP AND MANAGEMENT IN HEALTHCARE

WINNER

YACHIYO HOSPITAL; Center of SUPER CARE MIX –A Comprehensive Care from Emergency to Home for the community
Yachiyo Hospital (Japan)

The project targeted the failings in post-acute and after care and overcapacity in emergency medicine through provision of more efficient seamless care from emergency to post-acute and home care. The seamless care provided has improved patient flow at city-wide level and the surrounding area. The hospital plays the role of a comprehensive post-acute care center and mediates patients among healthcare facilities. Collaboration and complementary as a result has eliminated competition in service delivery provision among health facilities. The problem of over-capacity in beds has been overcome through prompt transfer of patients to the appropriate hospital or facilities. The project was reported as successful and innovative by a major national paper having identified that 'municipal medical facilities should function as a single hospital'.

HONOURABLE MENTIONS

Establishing New Model of Lean-Hospitals with Asian Characteristics-- From a Hospital Lean Management Chain
Wuxi No.2 People's Hospital (China)

The project has introduced, within the Chinese context, a new theoretical and operative system of lean management chain applicable to modern hospital practices; effective control of hospital management mechanisms; a feasible, scale able, sustainable and innovative tool for hospital management. The project is contributing greatly to development in staff capacity and skills and as a result, patients are receiving high quality medical services. Patient satisfaction has increased. There is a steady rise in patient satisfaction and the hospital for the last 3 consecutive years, has ranked 1st in the country's provincial evaluation of hospitals

Developing new tools for analyzing financial management of hospitals and how to improve hospital management after merging of two hospitals, Shikoku Medical Center for Children and Adults (Japan)

The project has developed a new cost-cutting analysis technique offering managers invaluable tools with which to calculate medical costs for individual patients and for each clinical department. For the hospital merger exercise, the tools were used to compare/benchmark with other National Hospital Organisation (NHO), the biggest hospital group in Japan with 143 hospitals. Benchmarking of the financial status of all 143 hospitals has been made possible with the use of these tools. The hospital in its first year of operation made a profit and has been delivering high quality medical care. In addition hospital managers are able to apply them in determining policy and investment. The project's other aim was to secure intellectual property rights, patent registration prior to its release. The patent was obtained in April 2014.

CORPORATE SOCIAL RESPONSIBILITY

WINNER

Fundació Integralia Vallès: Paradigm of Professional Integration for Disabled People
Mutua Terrassa, Spain

A pioneer project in Europe that has involved the creation of a healthcare reference center managed exclusively by people with disabilities and degenerative diseases to enable their professional development and ultimately integration into the labour market. The environment created under this project enables effective training and building of skills, capacity and work experience as well as promoting social responsibility among a population group that is at risk of exclusion. The programme has been successful in raising social and corporate awareness on contribution people with disabilities can and do make.

HONOURABLE MENTIONS

'Good Memory until 100 years school', a local community based integrated dementia management service
Myongji Hospital (Republic of Korea)

The project, launched in Goyang-si provides elderly groups with high-risk of dementia, with local community based integrated dementia management service beyond the hospital, which include the patients and their families. Non-pharmacological therapies such as cognitive treatments, music and art therapies are administered. This project has raised awareness on dementia and helps the multidisciplinary stakeholders and professions involved with early detection and recognition of dementia.
The National Readmission Prevention Collaborative's Post-Acute Network - Memorial Hospital of Gardena, USA

By this programme a post-acute network has been developed as a means to collect best practice readmission prevention case studies from around the country, identify partners for bundled payments, develop an accountable care organization (ACO) and form a clinically integrated network. A true continuum of care and coordinated care model has been established between post-acute providers and acute providers that provide care to patients after discharge. Physician engagement has increased. By this project dialogue has been opened on exploring ways to better meet the needs of the underserved patients in the Gardena community.

QUALITY & SAFETY AND PATIENT-CENTERED CARE

WINNER

Advancing Population Health: The Critical Role of Care-Delivery Systems - Texas Children's Hospital, USA

The project has introduced quality improvement programmes which have transformed the provision of care and easy-to-access clinical data to populations of patients. The project has radically changed the means by which data is incorporated into the provision of care. Management of populations of patients within the health system, previously fragmented and uncoordinated has been revolutionised. Other unique innovations, include integration of various roles and shared accountability for population management. Over 170 projects with substantial financial savings have been successfully implemented. Classroom training on Error Prevention has been provided to more than 8200 faculty and employees within a 10 month period. Nationally, other Texas-based hospitals have joined to form collaborative efforts, using similar tools and methodologies.

HONOURABLE MENTIONS

Quality Improvement Initiatives by Aga Khan Health Service in the mountains of Northern Pakistan – Aga Khan Health Service, Pakistan

The project implemented ISO 9001:2008 QMS in 128 healthcare facilities spread across rural, urban and rugged mountains areas with a population of 1.6million people from diverse socio economic backgrounds, within a record 16 months. Quality, safety and patient-centric care was the driving force which has resulted in improvement in infrastructure, timely procurement of equipment, reduction in stock out and timely availability of medicines and human resource in all health facilities. Health education and awareness sessions have served as powerful tools for proactive engagement of patients, their families and medical staffs.

Global Trigger Tool - St Luke's Medical Center – Global City, Philippines

By the project the rate of adverse events over time in healthcare facilities are identified and measured. The methodology uses 'triggers' in detecting random adverse events and harms as well as measuring adverse events over time. From the data collected, impact and effectiveness of patient safety initiatives are able to be measured. With this transparent measurement tool, a culture of safety has been put in place. This Trigger Tool has introduced a retrospective and preventive method in improving patient safety through data collection that is used to initiate proactive and preventive improvement strategies.

Bridging the Gap between Innovation and Financing. Chicago 2015 Health Venture Fair Awards

ALEXANDER S. PREKER, JOHN CASILLAS, SUZANNE READ, KHAMA ROGO, IOAN CLEATON-JONES AND LES FUNTLEYDER

At the time of the 39th World Hospital Congress of the International Hospital Federation (IHF), Health Investment & Financing, Board Trust and the Chicago Arch-Angels hosted a Health Venture Fair as a side meeting to the main Congress. It was attended by over 50 investors from different countries as well as the World Bank, the International Finance Corporation (IFC), and the Consulates of Australia, Canada, Israel, and South Africa. Thought leaders from prominent organization such as Johns Hopkins Medical International, Harvard Partners, Mt. Sinai International, University of Chicago, HealthCareCan, the Australian HealthCare and Hospital Association, the American Colleague of Healthcare Executives and many others.

The Drive for Transformation in Hospital Sector

The 39th World Hospital Congress (IHF 2015), which brought together Healthcare professionals from around the world, including key decision makers, investors and leaders, was an excellent opportunity to also showcase new innovative technologies and approaches and for innovators to meet potential investors.

The healthcare industry, or medical industry, is an aggregation of sectors within the economic system that provides goods and services to treat patients with curative, preventive, rehabilitative, and palliative care.

The healthcare industry is divided into several vertical industry segments are often complementary but sometimes also competing with each other. They include

1. Clinical Services (Hospitals, Clinics, Diagnostics, etc.);
2. Non clinical services (Health Insurance, Management, Health Education, Research and Development); and
3. Manufacturing (Pharmaceuticals, Medical Equipment, and Health Information Technology,

Healthcare industry is the largest, fastest growing, and most complex industry in the world. The U.S. healthcare system accounts for almost $3 trillion in annual expenditures, which is over 17% of its nation's Gross Domestic Product (GDP). According to economists in the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), spending is projected to grow at an annual average rate of 5.8% through 2020, which is well above nation's projected GDP growth. By 2020, healthcare spending is projected to exceed $4.5 trillion. The rest of the OECD and most emerging economies face similar challenges.

Despite its size and growth trajectory, the healthcare industry is plagued with large-scale problems and inefficiencies that are prompting a massive transformation in how care is accessed, delivered, and reimbursed.

These challenges confronting healthcare have created opportunities for companies with innovative new technologies and disruptive business process innovation to service delivery to make a major contribution to the cost, outcomes and patient satisfaction in the health sector throughout the world.

Objectives of the Innovation Showcase Track

The Innovation Showcase provided **Companies** with an opportunity to showcase their products, build brand awareness, and generate sales with C-Suite executives from hospitals, purchasers, trade organizations, industry visionaries, government official and others.

It provided **Hospital Executives** with an opportunity to discover new and innovative approaches to on-line mobile payment systems, hospital infection control, patient engagement and disruptive new technologies. They learned how some of these new solutions can improve their bottom line, while at the same time providing higher quality care, and how to be more responsive to consumers.

Four "fireside discussions" focused on some leading topics that were of particular interest to senior hospital managers in the context of the Affordable Health Care Act and other recent reforms:

1. A vision on the role of innovation in information systems in the new healthcare environment.

2. How to manage the risk and rewards associated with the new accountable care organizations.
3. How to deal with the risk of penalties linked to Hospital Acquired Infections.
4. How to minimize the loss of revenues from incorrect billing and bad claims.

Objective of the Investor Pitches Track

The objectives of the Investor Pitches track of the Chicago 2015 Health Venture Fair was to provide a forum for "bridging the gap" between the recent explosion in innovation and the funding needed so that their solutions will contribute to a transformation in the way hospital care is delivered in the 21st Century.

The Investor Pitches Track provided a unique opportunity for **Participating Companies** (medical technology, pharmaceutical and health information) to present their innovative solutions to potential investors (industry leaders, investment bankers, fund managers, family offices, broker dealers, and high net-worth individuals who are actively looking for such investment opportunities).

It provided **Investors** with an opportunity to discover new and innovative companies with +10X potential for growth that can help hospitals improve their bottom line, provide higher quality care, and be more responsive to consumers, all aimed at high growth investment opportunities.

The format of the Investor Pitches Track was inspired by Shark Tank the American reality television series that premiered August 9, 2009 on ABC. Based on the worldwide television series format Dragons' Den that originally aired in Japan, Shark Tank has aspiring entrepreneur-contestants make business presentations to a panel of "shark" investors. The show featured a panel of potential investors, called "sharks", who consider offers from aspiring entrepreneurs seeking investments for their businesses or products. In the TV Series, the entrepreneur could make a deal on the show if a panel member is interested. However, if none of the investors liked what they saw, the entrepreneurs would leave empty-handed.

During the Investor Pitches track of the Chicago 2015 Health Venture Fair, the 10 minute pitches by the entrepreneurs and grilling by the panel of investors was similar, but the prize were cash awards by sponsors rather than investments.

The following summarizes the companies and technologies that were recognized by Awards during the Chicago 2015 Health Venture Fair.

Chicago 2015 Health Venture Fair: Investor Pitches

- Keiretsu Forum Central Canada Award was awarded to Danny Farin (CEO, PerFlow)
- Health Horizon Innovation Award was awarded to Tyler Wanke (CEO, Innoblative Design)
- Chicago ArchAngels Impact Award was awarded to David Cohn (CEO, Regroup Therapy)

Chicago 2015 Health Venture Fair: Innovation Showcase

- Aceso Global Emerging Markets Award was awarded to Mert Iseri (CEO, SwipeSense)
- AN Valuations Cross-Border Award was awarded to Gianluca Malaguti (CEO, 99 Technologies)

South Africa Wine Raffle

- Brand South Africa awards 6 bottles of South Africa White Wine
- Brand South Africa awards 6 bottles of South Africa Red Wine

South Africa Airways Raffle

- South Africa Airways awards Tom Furr (CEO, PatientPay) a free US-Durban airline ticket to the 40th Congress in 2016
- South Africa Airways awards Vineet Gulati (CEO, HealthExpense) a free US-Durban airline ticket to the 40th Congress in 2016

In the context of the 2016 World Hospital Congress in Durban, South Africa, there will once again be a unique opportunity for companies, not only from all over the world, but particularly from the Africa continent, to showcase their innovative solutions the most pressing healthcare needs of the hospital sector today.

Although the Africa region is the region with the greatest disease burden and income disparity, it is a region with tremendous potential. South Africa was the home of Christiaan Neethling Barnard (8 Nov 1922 – 2 Sep 2001) was the South African cardiac surgeon who performed the world's first successful human-to-human heart transplant.

More recently in the Kenyan cell phone operator Safaricom has partnered with PharmAccess Foundation and CarePay to introduce a new health payment platform that will deepen the ability of citizens to access healthcare. The 'M-Tiba' platform will deliver a mobile 'health wallet' that channels donor funds meant for health services directly to recipients – allowing for effective tracking and monitoring of use of funds.

As in many other low-income countries, the donor community is responsible for about 30 percent of all health payments in Kenya and often, donors are not able to track use of the funds that they disburse. Using M-Tiba, funds will be placed in specialized health wallets through M-Pesa and their use will be restricted to conditional spending at select healthcare providers who form part of a nationwide M-Tiba network. In this way, donors are able to receive real-time access to monitor the use of their funds.

The Pfizer Foundation is the first donor partner to use the

M-Tiba platform to reach people in the slums in Nairobi. In future, M-Tiba can include public and private health insurers as well, offering micro-insurance products though M-Tiba against very low costs to low-and middle-income groups that could not be reached before.

Venture Capital for Africa, the biggest online community connecting African entrepreneurs and investors, have recently posted nearly five hundred venture profiles, from over thirty-five African countries that have unique solutions adapted to the special health care needs of Africa.

Recently put together a list of innovative startups with potential to change the face of African health.

The following is Venture Capital for Africa's top ten pick:

Penda Health, Kenya, is a social enterprise that provides health services designed for low and middle income women in Kenya.

Ruby Cup, Kenya a menstrual cup, an alternative menstrual hygiene product made of medical grade silicone that can be re-used up to 10 years.

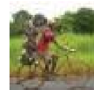
QuaWater, South Africa develops and delivers products and projects that significantly improve the quality of people's drinking water.

MobiSure, Kenya, is a disruptive mobile medical insurance for the poor. Families and individuals can buy insurance from as short as one day.

ClaimSync, Ghana, is an end-to-end claims processing platform that enables hospitals and other healthcare providers easily prepare medical claims and send them electronically to health insurance companies.

Santé Africa, South Africa, is a mobile app connecting doctors with patients, providing education to those who seek it and offering access to medical supplies at the convenience of your home.

MedicRAM, (Medical Records And Management) is an innovative modular health IT solution that is intended to transform the way healthcare is managed. Hospital patients will spend less time in hospitals as a result of quicker and better access to their medical records and laboratory test.



Mozambikes, Mozambique – Lauren Thomas, brings lower cost, yet higher quality bicycles to the people of Mozambique. In rural areas, bicycles allow people to access better healthcare, as they can make regular visits to providers that are often located far from their homes.

Cardiopad Project, Cameroon, offers nurses and cardiologists innovative methods for performing cardiac examinations and remote interpretations, through a biomedical data acquisition processing and transmission process using the mobile telephone network.

Medexperts, Nigeria, is an online Community of Practice designed for Nigerian healthcare professionals and the Nigerian Public.

Groups like PharmAccess, the Investment Fund for Health in Africa (IFFHA), the International Finance Corporation (IFC), BlueCloud Health and the World Bank's Health in Africa Initiative are supporting a range of innovative investments that will be showcased at the 2016 World Hospital Congress in Durban from Oct 31 to Nov 3, 2016.

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YACHIYO HOSPITAL; Center of *SUPER CARE MIX* – Comprehensive Care from Emergency to Home for the community

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GENERAL SURGEON

ABSTRACT: Anjo City has two general hospitals. Kosei Hospital, a central medical center for advanced care, and our Yachiyo Hospital for regional care. Recently, Kosei Hospital faced over-capacity problem because of overflow in emergency visits and congested wards due to shortage of post-acute beds.
We planned a project to ease the congestion of the central hospital and manage post-acute patients.

Our project

- Build a new ward for low-grade emergency and post-acute comprehensive care.
- Enhance the staff for emergency and post-acute care.
- Provide comprehensive care and rehabilitation to go home or facilities promptly.

Outcome of our project

- Over-capacity problem is solved by optimal care and forwarding of patients to home or appropriate facilities.
- Our hospital plays a central role to mediate post-acute patients among medical facilities.
- Two hospitals cover each lacking part; advanced medicine in our hospital and post-acute and rehabilitation care in Kosei Hospital.
- Our project met the intention of City authorities, and was given the financial aid.

Thus, our project contributed to better community medical service.

Introduction

The City of Anjo is located in the southern center of mainland Japan and has a population of 185,000. The city has two general hospitals. Kosei Hospital (K-hospital) is located in the southern part of the city and provides the regional care in the area. K-Hospital also bears the responsibility for advanced treatments such as neurosurgery and cardiac surgery including highest-level emergency care as the central hospital in the district. Yachiyo Hospital was established more than 115 years ago in the northern part of the city and has been providing regional care for over a century. Yachiyo Hospital offers first and second grade (Table) emergency care, comprehensive post-acute and rehabilitation care.

The Ambulance department reported that more than 65% of the patients transferred were in the first, 26% were in the second and 9% in the third grade, and first and second grade patients had been increasing.

Principally, first and second grade emergency patients were sent to the nearest hospital and the third were sent to K-Hospital.

The policy based on the area of residence and severity has worked well. However, on many occasions, especially in winter season, K-Hospital reached overcapacity and could not accept the first and second grade patients. This caused anxiety among citizens.

Yachiyo Hospital had been making efforts to establish community cooperation and established the member meeting to discuss medical issues namely “Community network of medical care and social welfare in Anjo” in 2009. Members consisted

of representatives of the City Hall, hospitals, and care facilities.

Yachiyo Hospital board members were aware of the importance of the current problem and recognized that it was our mission to solve the problem for the community. Here we describe our efforts to solve the city-wide issue.

Analysis of the problem

Our board members analyzed the cause of the problem. One reason was too many emergency patients, walk-in to the third grade, visited K-Hospital. Another reason was K-Hospital is a principally acute-care hospital, so the capacity for post-acute and rehabilitation patients was limited causing congestion of the wards.

Our board members have a notion that K-Hospital is the only central hospital providing advanced treatments in the district, therefore Yachiyo Hospital should be the central hospital for post-acute and rehabilitation patients. Yachiyo Hospital has to manage the traffic of comprehensive post-acute and rehabilitation patients in corporation with geriatric care facilities. In addition, our hospital should accept more first and second grade emergency patients to ease the saturated emergency room of K-Hospital. This care mixture to enhance fluent, effective and prompt patient flow from emergency to home was named ***"super care mix"*** by our president Matsumoto, which became our fundamental policy. Based on the analysis and our policy, we started a project to enhance our hospital and solve the citywide issue in 2013.

Basic concept of our project

Our basic plan was to increase the bed number from 320 to 420 by building a new ward. A new ward should be for patients of second grade acute, post-acute and rehabilitation patients.

The Emergency department should be enhanced by employing new doctors and nurses. Our hospital accepts active post-acute patients from K-hospital whenever required. Trained staff must manage quick and appropriate transfer of the patients between departments and wards in the hospital. This project should be discussed with local residents, K-Hospital staff, members of doctor association, and City Hall authorities and must be approved.

Concrete plan of the project

1. Round table discussion of our idea with staff of K-Hospital, doctors' association, care stations, city and ambulance department.
2. Increase beds from 320 (originally acute and emergency; 200, post-acute; 52, rehabilitation; 52) to 420, half of them for emergency and half for post-acute care.
3. Introduce a 320-row CT and the second MRI and employ a radiologist, a neurosurgeon and general internists.
4. Increase staff for post-acute care and rehabilitation.
5. Train staff that can manage patient flow in and out of the hospital
6. Collaborate with city authority for financial aid and ambulance department for smooth transfer.

The process after the project started

In early 2014, City organization determined the financial aid for the construction of a new ward, advanced CT and MRI.

- April, 2014 a new ward was completed.
- May, 2014 opening ceremony and demonstration to community people was performed
- May, 2014 new CT and MRI started operating.
- June, 2014 a half of new ward was open.
- December, 2014 new ward was fully open.

In 2014, we employed a neurosurgeon, a radiologist and two general internists and 50 nurses.

Early outcome of our project

We surveyed the outcome of our project in March 2015 using following concrete targets.

- Increase of ambulance vehicle acceptance; Outcome 27.7% up
- Decrease of ambulance vehicle acceptance in K-Hospital; Outcome 9.1% down
- Increase of patients visiting emergency room; Outcome 11.2% up
- Increase of patients admitted from emergency room; Outcome 31.5% up
- Increase of patients transferred from K-Hospital; Outcome 24% up
- Increase of patients sent to home facilities; Outcome 6.1% up
- Increase if in-patients; Outcome 3.9% up
- Increase of utilization of CT and MRI; Outcome 5.0 and 25.0 % up respectively.
- Increase of practice income; Outcome 7.6 % up

This data clearly demonstrates that our project is progressing as expected. Some are shown with equivalent numbers in Fig. 1. In-hospital patient flow was outlined in Fig. 2.

Evaluation and recognition of our project

Our project was evaluated and recognized as described below.

Political activities

1. In the last annual meeting with board members, mayor, congressmen, chairman of city council, chairman of doctor association, and chairman of community association, the improvement of ambulance system and post-acute care system was evaluated and confirmed.
2. City council admitted the financial aid for next three years.
3. After the new ward was open, many city and hospital representatives in Japan had a great interest in our hospital policy and we had 11 inspection teams from all over the country. Among them three hospitals employed our idea for reconstruction.
4. National committee approved our hospital as a leading comprehensive care center in the area including five surrounding cities in 2014.

Press activities

1. One major press raised our project in the morning paper on July 29, 2013 with a headline "Municipal medical facilities should function as a single hospital" and reported our project as a successful and innovative example.
2. Nationwide newspaper Sankei Shinbun reported our project in 2015 quoting the interview with the Director Dr. Matsumoto. He called our strategy of care ***"SUPER CARE MIX"***.

Congress activities

1. Our basic idea was originally presented at the Japanese Hospital Association Congress and published in its official journal in 2010. (1)
2. Dr. Matsumoto presented the project and its outcome at the Japanese Hospital Association Congress in 2014 as a lecturer.
3. Summary and outcome of the project was published in the official journal of the Japanese Hospital Association in 2014. (2)
4. Dr. Matsumoto presented the data at the symposium of the annual congress of the Japanese Hospital Association in 2015.

Fig. 1 Change of patient flow in Anjo City after the project started. Outcomes are shown with number written in the text.

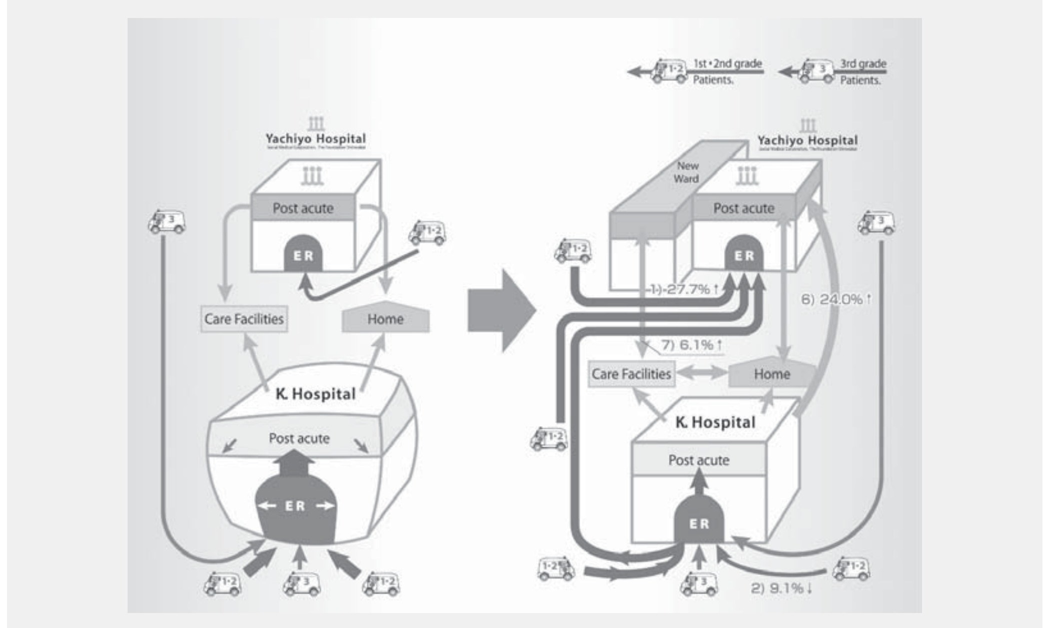
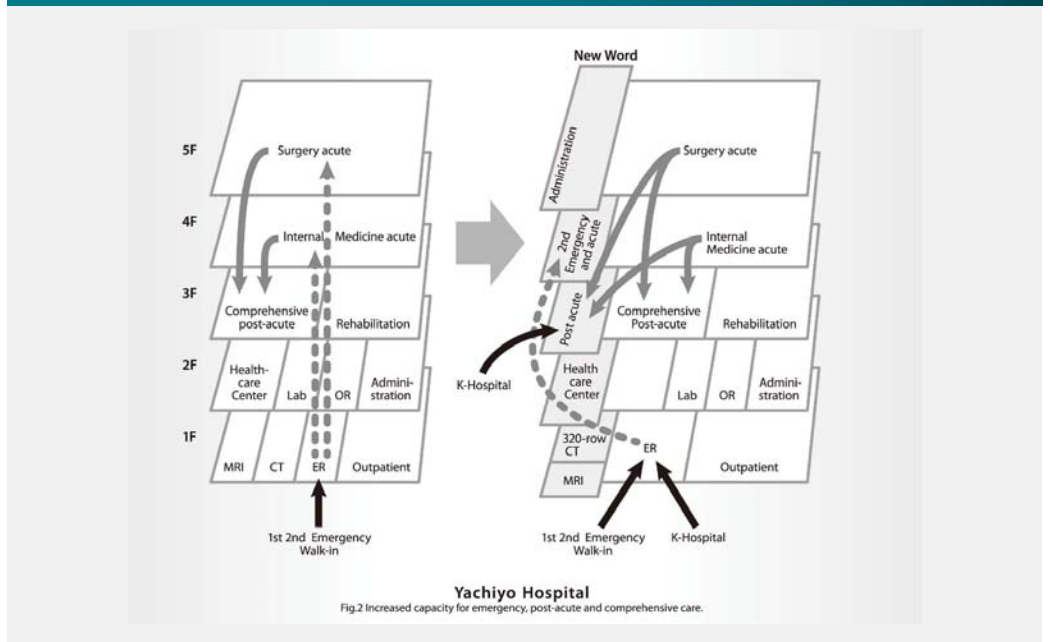


Fig. 2 Changes of patient flow in hospital after the project started.



Comments and conclusion

In most rural areas like Anjo City, hospitals are competitively pursuing profit. So are other medical facilities like geriatric care centers. However, medical resources are limited, so ideally complimentary share and corporation in hospitals and medical facilities are essential. For this purpose, communication and understanding of the policy in not only for medical staff but also for residents and officials as necessary.

With recognition of our project and cooperation with community, medical facilities and City Hall, we believe our project contributed to better community medical service.

Table	
Grading of emergency patients transferred in ambulance vehicles	
First grade emergency patients:	do not need to be admitted.
Second grade emergency patients:	need in-hospital care.
Third grade emergency patients:	require highly advanced care.

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Construction and Application of a Refined Hospital Management Chain

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ABSTRACT: Large scale development was quite common in the later period of hospital industrialization in China. Today, Chinese hospital management faces such problems as service inefficiency, high human resources cost, and low rate of capital use. This study analyzes the refined management chain of Wuxi No.2 People's Hospital. This consists of six gears namely, "organizational structure, clinical practice, outpatient service, medical technology, and nursing care and logistics." The gears are based on "flat management system targets, chief of medical staff, centralized outpatient service, intensified medical examinations, vertical nursing management and socialized logistics." The core concepts of refined hospital management are optimizing flow process, reducing waste, improving efficiency, saving costs, and taking good care of patients as most important.
Keywords: Hospital, Refined, Management chain

Introduction. Hospitals in China have a tendency to gain large scale success, which was quite common in the later period of industrialization. Extensive management methods have brought new "bottlenecks", such as medical staff shortages, impact of medical resource integration, medical service inefficiencies, and backward assessment mechanism.

Materials and Methods

Since 2003, the Wuxi No. 2 Hospital has introduced the concept of refined management which is based on the modern automobile industry. The hospital constructed a refined management chain, consisting of six organizational structure gears. These gears included clinical practice, outpatient service, medical technology, and nursing care and logistics to achieve the maximum scale and benefits by flat management, medical chief of staff, centralized outpatient service, intensified medical examinations, vertical nursing management, and socialized logistics.

Origin of the Refined Management Theory

As a concept and a culture, refined management was proposed by the pioneers of Toyota Japan represented by Taiichi Ohno in 1950's, who adopted the advanced management concept of the United States and created the famous "meticulous management". It was quite successful [1]. It transformed the extensive production method into a meticulous operation and greatly improved productivity and management efficiency. Refined management is an inevitable requirement in the social division of labor and service quality. This management method is based on the routine management yet goes deeper using effective scientific tools and management methods. Its main targets are to minimize management resources and to reduce management costs. The basic characteristics of refined management stress the details, processes, foundation, implementation, quality, and results [2]. It tries to do everything well and keeps improving.

Contents of Refined Hospital Management

The refined hospital management chain is a management method which goes through the entire process with six elements in medical management, improves operational efficiency and medical quality, and promotes hospital development by meticulous operation, control, accounting, analysis, and planning. The art of refined operation refers to the strict observation of every behavior in medical activities to the standards and requirements of the medical profession. Refined operation originates from the strict observation of the various standards to reduce deviation [3]. Every staff member of the hospital must conform to the standards. Inter-

nal operation of a hospital shall have a process in place for planning, executing, examining, and feedback. Controlling this management loop can limit the number of errors and loopholes of the system. Refined account is an important means to maintain good financial operation of a hospital. Refined analysis was used to detect problems of hospital management from various angles and trace problems from different levels by modern means. Hospital leaders work out medium and long-term targets based on a regional hospital development plan and formulate concrete plans to carry out the above targets.

Results

Synergetics is a new discipline formulated and developed in the 1970's based on a multidisciplinary study. It analyzes when an open system far from equilibrium has matter or energy exchange with the external world and, how an orderly structure of time, space, and function appears automatically through its internal synergetic action. Its main content consists of a synergetic effect, servo, and self-organization principle. The central target of synergetic management is to achieve synergetic effect, and its essence is the interaction and coordination of all elements to enable orderly and stable development of the system, and further multiply the integral performance of the system to get synergetic effect of 2+ 2>4.

Construction of a Lean Hospital Management Chain

Lean hospital management chain (LHMC) is a new concept developed and derived from the lean supply chains. It means that the client's satisfaction is the axial in management activities. The process of production, service, and supply shall be optimized constantly to reduce waste and cost.

The hospital's management quality system includes six important subsystems. They are as follows; medical quality, medical technology, service flow process, talent growth, internal control, and performance examination. They contain all the capabilities of the hospital and generate a synergetic effect. The six subsystems are the six key links of a hospital management system. Their combination and permutation become a dynamic-refined chain and form a refined quality control system of the hospital. Mutual coordination and efforts of each link increase the integral competitiveness of hospital management.

Optimize Organizational Structure, Carry Out Flat Management System

More than 20 functional departments in our hospital were reorganized into seven departments: medical development, nursing care, outpatient, comprehensive, communications, finance, and logistics. Flat hospital administration improved efficiency. For example, drugs, medical instruments, disposable articles, and supplies were once stored in departments of medical equipment, rear service, and pharmaceutical. Now, the purchasing center under the logistic department is responsible for it. The departments of personnel, supervision, and office were merged into one comprehensive department.

Reorganize Service Pattern, Carry-out Attending Doctor System

Attending doctor system is one of the most popular medical modes in the world. Wuxi No. 2 Hospital introduced this system in 2004. The attending responsibilities were defined, and qualifications were examined and the treatment groups were set up. The responsible doctor can select fellow doctors and nurses, and patients can select responsible doctors. Dynamic quantitative examination on medical quality, patient's satisfaction, and workload was carried out. We adopted the attending doctor system under the leadership of the department head, who has the power to check medical quality and safety of each treatment group, to recommend or recall attending doctors. Not only the chiefs, but also the backbones care for management and the development of the departments. In 2013, outpatients and emergency visits respectively reached 1.36 million person times, and 107,600 person times, with 8.61 % year-on-year increase.

Pay Attention to Service Details, Carry Out Centralized Treatment Centers

Drawing lessons from advanced modern service management, our hospital have established eight major diagnosis and treatment centers since 2008. Take the brain center as an example, all staff under the age of 40 have master's degree, and the advanced stroke unit management was established. 89 theses were published in last 3 years, including four papers in SCI. It has become a famous medical center in Wuxi. Our hospital also has set up centralized centers such as chest pain, coronary heart disease, cholelithiasis, and cerebrovascular disease for outpatients. We sponsored senior specialists' consultation system, adopting one (several) doctor(s) - one patient-one clinic.

Advocate Fast Flow Process, Carry-out Intensified Medical Examination

(a) Establish appointment treatment center with the aid of HIS platform through telephone, net, and spot appointment with doctors, specialists or see specialists at night. (b) Shorten waiting time of examination, such as CT, MRI, HOLTER, and ultrasonic cardiography. MRI starts at 6:30 and ends at 22:00 and the CT scan can be done within the day, enhanced CT and MRI shall be done within 48 h. There is a time limit for the report of other tests. (c) Carry out intelligent outpatient services, provide self-service facilities, such as self-service registration, newspaper and coffee selling, information. An automatic medical guide management system serves ultrasonic B room, admission and discharge offices, clinics of internal medicine, and dermatology. Patients can watch multimedia video while waiting. Good order is maintained and workload is reduced. Twenty-four self-service machines offer 24-hour appointment registration and charging. Patients can register 7 days in advance and pay with bank cards. Cooperated with Industrial and Commercial Bank

of China, we adopt "payment after treatment" to shorten waiting time of patients.

Give Professional Guidance and Carry-Out Vertical Nursing Management

Formerly nurses were managed by each medical department, but now the allocation of nurse professional promotion, performance rewards, and further study are managed by nursing department. Head nurses of each department have the right to make recommendations. Human resource allocation committee, quality and infection management committee, and nursing training committee are under the nursing department, while the chief of each department examines their service attitude, work discipline and working behavior. Nurses are classified into clinical and non-clinical. The former is further classified into grade 1–5 based on the ability, skills, and performances. Distribution is determined by post risk, technical content, labor intensity, and professional level. "Nursing Stars" are assessed dynamically so that every nurse has pressure and motive force. Vertical nursing management is an efficient, fair, and impartial mode promoting nursing rank and service quality. In 2012, 433 theses of nurses were published. Two nurses got the title of advanced nurses at provincial level and a ward was evaluated as the municipal nursing quality demonstration ward.

Strengthen Cost Control, Carry Out Socialized Logistics

Our hospital takes innovative measures continuously. "One doctor-one patient-one clinic" is well accepted; "one dispensary" can shorten 20 min of waiting time; "one-stop service center" offers comprehensive "housekeeper" service; "168 rear service hot line" makes the lives of patients easy; "a red wrist ribbon" for seriously ill patient implies priority of getting medical treatment and examination. We also have a telephone line for free-first aid, and rescue passage. Critically, ill patient can handle admission procedures at bedside and pay after treatment.

Discussion

Significance of Refined Management in Public Hospitals Reform

For the public hospital itself, it is necessary to explore and innovate the internal operational mechanisms, such as accurate accounting of operational costs, standardizing medical behaviors, improving humanistic service, perfecting encouragement mechanism, and increasing the competitive vitality of the hospital. It is no doubt that scientific means of refined management have very important practical significance and scientific basis for realization of above targets.

Scientific Significance of Refined Management in the Development of Public Hospitals

At present, public hospitals should be aware of "infinite expansion". The overall scale of a hospital shall not exceed 2,000 beds. So when the public hospital develops to a proper scale, it must enrich the manage development, talent training, medical quality, and service meticulously, forming a situation with unified scale and contents, connect between technology and academy, and combination of superiority and characteristics. In this aspect, Mayo Clinic and Hopkins Hospital of the US have set us a good example [4].

Strategic Significance of Refined Management, Which is Continuous Improvement, Not Subversion

Refined hospital management does not overturn the tradition. It is based on the present hospital management. Its main targets are to minimize management costs. It must also establish scientific quantitative standards and operable procedures in conformity with the long-term strategy of hospital development, transform the strategy into concrete management measures, pay close attention to the overall results.

Conclusion

The core concepts of refined hospital management are optimizing flow process, reducing waste, improving efficiency, saving costs, and regarding patients as most important.

BIOGRAPHY

Prof. Yi Lihua, President of Wuxi No. 2 People's Hospital, China. Prof. Lihua was nominated "Advanced Worker of Chinese Health System" and "Chinese National Excellent Hospital Director". Prof. Lihua has won 3 Chinese Medical Science and Technology Awards for Health Management, 5 Asian Hospital Management Awards and an IHF International Award.

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Quality, Safety and Patient Centered Care – A Dream Come True in the Mountains of Northern Pakistan.

An Award winning project of "2015 Quality, Safety & Patient Centered Care Award" at, Chicago USA

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ABSTRACT: Northern Pakistan remains very challenging terrain due to harsh weather all year round presenting an infrastructural, human resource and supply chain challenge of its own. Many times the facility had to move to different locations on emergency and ad hoc basis due to landslides, earthquakes affecting continuity of care. Providing quality healthcare to often resource constraint hard-to-reach areas has always been AKHS,P's unique forte. Breaking barriers for catchment population to access quality healthcare, AKHS,P embarked on an initiative of implementing, achieving and sustaining ISO 9001:2008 Quality Management System international standards certification.

This article shares the unique experience of AKHS,P in achieving and sustaining ISO 9001:2008 International Quality Management System Certification. After untiring efforts and the hard work of ground staff; AKHS,P achieved ISO 9001:2008 International Quality Management System Certification as well as 1st Surveillance Audit which itself proved that AKHS,P sustained quality systems and ensured continuous quality improvement in the Mountains of Northern Pakistan.

INTRODUCTION. Aga Khan Health Service, Pakistan (AKHS,P) is a community based, not for profit healthcare organization providing quality healthcare to ~1,600,000 people from diverse socio economic backgrounds through its 120 basic health centers (BHCs) and 08 comprehensive health center (CHCs) facilities spread from rural areas and rugged mountains to urban and peri-urban areas across Pakistan. AKHS,P's Basic Healthcare Service portfolio include Immunization, Growth Monitoring, Reproductive Healthcare, Adult Health Screening and Health Education in communities. The organization's Comprehensive Healthcare Service includes Obstetrics & Gynecology, Pediatrics, General & Orthopedic Surgery, Inpatient, Outpatient, Pharmacy, Laboratory, X-Ray and Ultrasound.

Providing healthcare to close to 1.6 million people every year demanded robust initiatives to ensure an authentic, continuous improvement process to maintain high standards of quality, safety and patient-centered healthcare across all of its facilities - be it the conveniently accessible urban metropolis of Karachi to the rugged hard-to-reach area of Broghole in Chitral, that can be reach only by Yaks or Horses.

Travel by Yaks and Horses

The untiring efforts of staff in accomplishing the aims of AKHS,P

QUALITY IS A SHARED RESPONSIBILITY

To initiate, implement, monitor and maintain International Quality Systems in rugged mountains was itself a difficult task. In this regard, Top management starting from the Board of Directors, Chief Executive Officers, Head of Departments including Human Resource, Finance, Marketing, Information Technology, Administration, Technical Support Unit, Procurement, Pharmacy and regional teams worked vigorously throughout the year in order to ensure best quality health care outcomes.

Criteria for evaluation of quality improvement, patient safety was measured through improvements reflected in customer feedback analysis reports, client satisfaction surveys, quality indicators, incident reports trends and analysis, stock outs monitoring, patient referral reports, volume and targets of utilization monitored by regular meetings held by Management Review Committee (MRC) and Quality Improvement Committee (QIC).

Background of the Project

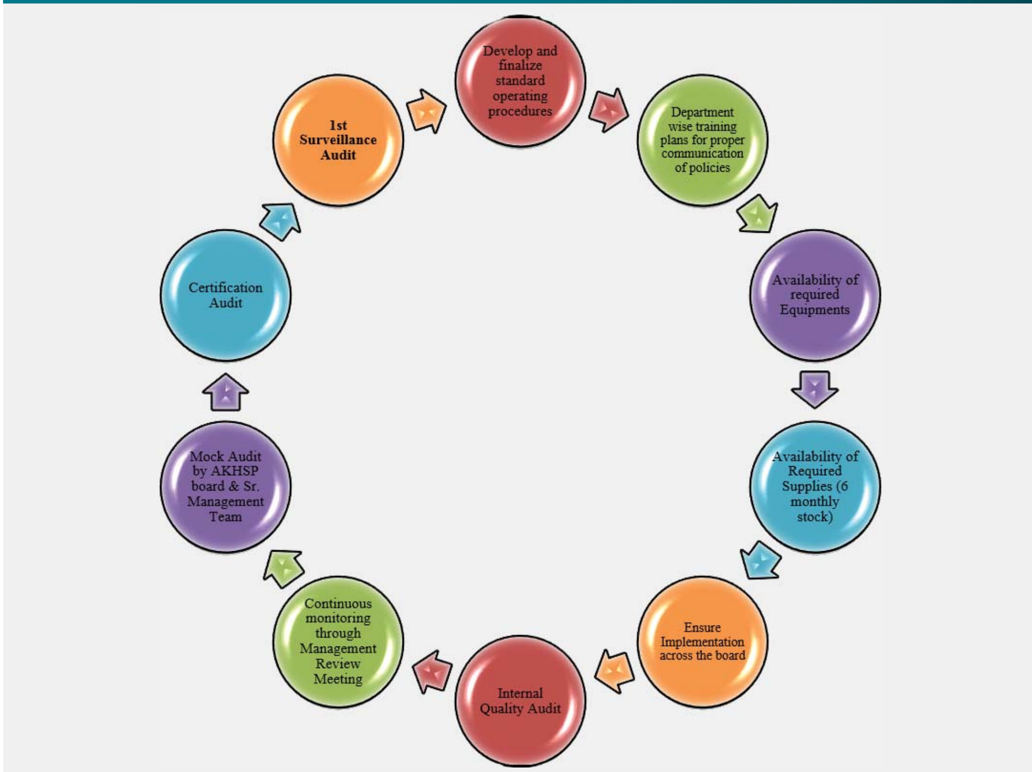
Providing quality healthcare to often resource constraint hard-to-reach areas has always been AKHS,P's unique forte. Breaking barriers for catchment population to access quality healthcare, AKHS,P embarked on an initiative of implementing, achieving and sustaining ISO 9001:2008 Quality Management System international standards certification at AKHS,P.

This involved commitment from the Board and dedication from Senior Management. Ensuring implementation, Quality Improvement Representatives (QIRs) from each department were appointed (voluntary position) to implement and sustain ISO 9001:2008 at AKHS,P through training and a series of internal quality audits. AKHS,P management developed a Project Plan from January 2014 till May, 2015 to sustain ISO 9001:2008 QMS Certification. After untiring efforts and the hard work of ground staff AKHS,P cleared 1st ISO 9001:2008 International Quality Surveillance audit in May 2015.

Trained LHV is giving health education to community

Training and Development of CMWs

FIGURE 1: PROCESS FLOW CHART OF ISO 9001:2008 QMS CERTIFICATION & SURVEILLANCE



ENDEAVORS OF QUALITY DRIVE:

Implementing and Sustaining ISO 9001:2008 QMS across all 128 healthcare facilities within record 16 months had been both innovative and challenging because it ensured authentic, integrated, defined international standards driven, yet continuously improving the process of patient centric and safe quality healthcare regardless of geographical terrain and diversity of socio-economic backgrounds realizing our value that high quality healthcare should be equally accessible to all whether it's a mountain or city dweller needing patient care.

AKHS,P has health facilities located 10,800 ft. high above sea level – very closer to the junction where

the three highest and mightiest mountain ranges of the world meet, namely Karakoram, Hindu Kush and Himalayas. In these rugged mountainous of northern Pakistan, due to harsh weather round the year, frequent land sliding and earthquakes, the implementation of international high quality healthcare standards and ensuring continuity of improvement is generally unimaginable. In winter seasons, these areas are cut off from rest of the country presenting an infrastructural, human resource and supply chain challenge of its own. Taking quality, safety and patient-centric care to these areas, where these standards have been otherwise unheard of was an innovative challenge, which drastically improved healthcare for communities.

The endeavor of quality drive resulted in improvement in availability of material and human resource, resolved issues raised by the community through customer satisfaction surveys and feedbacks. As a result, sustainability was improved. Management review committee ensured reviewing feedbacks and overall progress in terms of quality, patient care, patient and staff safety. Moreover, to monitor and ensure continuous quality improvement internal quality audits were held on a yearly basis. Further, clinical and managerial indicators were monitored to focus on the areas of improvement to ensure sustainability. The number of complaints (2014 vs. 2015) was reduced because of the improvement in infrastructure (esp. waiting areas), timely procurement of equipment, reduction in stock out and timely availability of medicines and availability of service brochures at all health facilities.

SIGNIFICANT RESULTS AND ACHIEVEMENTS

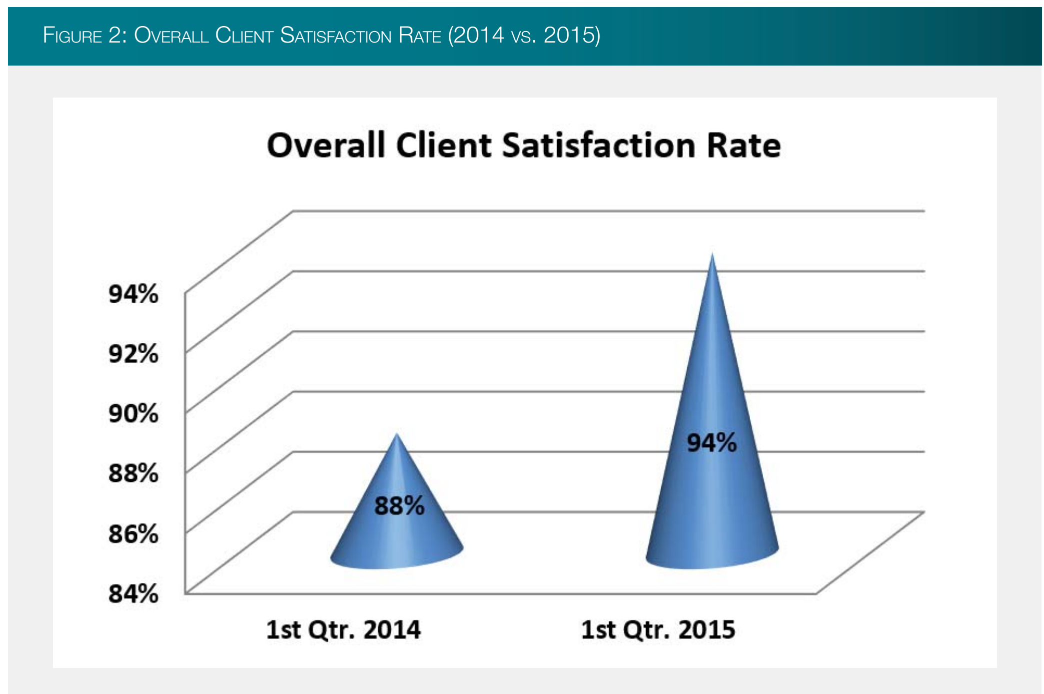
SMART Objectives were set for improvement in the quality of patient care measured through improvement in customer satisfaction, improvement in environment of care and bringing patient to the center of healthcare dynamics resulting in increased sustainability and healthcare indicators.

Client satisfaction survey in pre and post implementation of Quality Management System was evaluated and after ISO 9001:2008 Quality Management System Standard a survey was conducted in May, 2015 to analyze the impact of client perception which showed overall client satisfaction increased from 88% in 1st Qtr. 2014 to 94% in 1st Qtr. 2015.

Patient feedback recorded major improvements in environment from 78% to 98%, attitude of Doctors from 88% to 95%, communication of Doctors from 86% to 96%, attitude of Nurses from 91% to 97%, communication of Nurses from 73% to 98%, clinical skills from 95% to 98%, timings of health facility from 83% to 95%, waiting time from 83% to 95%, privacy of patients from 98% to 99%, availability of medicine from 50% to 85%, referrals from 91% to 97% and patient satisfaction in terms of value for money increased from 89% to 96% increasing patient and staff safety.

Similarly, improvement in clinical indicators e.g. C-Section rate decreased from 22% to 20%, Low Birth Weight reduced from 9% to 3% and Post-partum Hemorrhage Rate reduced from 1% to 0%. Incidence Rate overall decreased e.g. medication error from 4 cases to 2 and Needle Prick Injuries from 4 to 3.

Figure 2: Overall Client Satisfaction Rate (2014 vs. 2015)



ORGANIZATION STAKEHOLDERS

At AKHS,P patients are considered as the central stakeholder or beneficiaries of ISO 9001:2008 Quality Management System (QMS). Our stakeholders are broadly divided into internal and external stakeholders. Satisfaction of internal and external stakeholder is one of the most critical key performance indicator with which organization evaluates its performance.

Internal stakeholders include board, management, committees, departments, regions, administrative and support staff and clinical (medical and paramedical staff) directly and indirectly involved in delivering healthcare to patients.

Our external stakeholders involve patients, local communities, government, donors, vendors, suppliers, contractors and third party agencies.

In internal stakeholders, patient satisfaction was raised in more than 90% meaning 9 out of every 10 patient have experienced a satisfactory level of AKHS,P care after this initiative. Board and senior management considers this an important historic milestone to achieve its self-actualization through integrat-

ed continuous quality improvement process as a part and parcel of organizational culture.

The initiative led to organization wide change. All the staff, clinical and non-clinical, upgraded their credentials through rigorous training programs with patient-centric approach. The process improved infection control practices resulted in decrease of patient complains. Departmentally, human resource controlled its lead time for hiring, many new doctors, pharmacists hired, marketing department made sure service information is available for patients, equipment were procured and installed timely with calibration, all legal and financial processes were further streamlined to improve service provision and major improvements were made in infrastructure.

WORKING TOGETHER FOR QUALITY WITH GOVERNMENT THROUGH "PUBLIC PRIVATE PARTNERSHIP"

In external stakeholders, this initiative became one of the key differentiating factors of the organization where AKHS,P brand is considered synonymous with quality of healthcare. The majority of patients prefer AKHS,P over other healthcare providers thus meeting expectations of community. Government showed its confidence in AKHS,P through public private partnership of its 04 hospitals to AKHS,P. AKHS,P revamped the infrastructure, retained government employees and trained them at par with international standards, enabling them to successfully qualify for ISO 9001:2008 certification and surveillance audit. Due to upgraded and streamline documentation our donor reporting is proactive and most of the donors are satisfied with AKHS,P's performance. Increased quality built trust of vendors, suppliers, contractors and third party agencies up on AKHS,P enabling the organization to get preferred status in relationships due to its best practices.

Above all, organization discovered (and rediscovered) in its unique strengths and areas of improvement and developed a concrete program to bring organized continuous change in the future.

THIRD PARTY ARBITRATOR

AKHS,P invited System General Surveillance (SGS), an internationally renowned company based in Geneva, Switzerland, to conduct ISO 9001:2008 Certification and as well as for 1st Surveillance Audit. Auditors visited the facility and thoroughly audited compliance to international quality standards and gave excellent remarks to AKHS,P in terms of Documentation including availability of procedures and protocols, management commitment towards quality improvement, training of staff, provision of community care by dedicated lady health visitors conducting growth monitoring, immunization, reproductive health care, vaccinations, health education in community, IMNCI, adult health screening, deworming, improvement in nursing practices, infection control, resource management, facility management, biomedical and maintenance and supply chain management showed significant improvements (comparing last year, meeting 100% of compliance). All efforts resulted in enhanced trust by the community as reflected in the Client Satisfaction Surveys and Feedback.

The external evaluators appreciated the efforts made by the entire Regional teams and were amazed to see the newly constructed seismic proof health facility including quality systems which have significantly improved as compared to last year with the tireless efforts put in by the management in providing continuous quality health services to the community.

Conclusion:

"Caring and compassionate provision of quality assured health care" is one of the "Mission" statements of Aga Khan Health Service, Pakistan. The journey started with the implementation of "Quality Agenda" leading to ISO 9001:2008 International Quality Certification and sustaining Quality standards by clearing the Surveillance Audit. The milestone was achieved through the strong commitment of Doctors, Nurses, Para Medical staff including Pharmacist, Laboratory Technician, X-Ray Technician other ancillary staff of the AKHS,P who worked day and night to make the facility clean and maintained. Beside this, all departments - finance, human resources, technical support, IT, marketing, pharmacy, purchase and procurement, administrative staff were engaged in implementation through measureable quality improvement objectives with evidences.

AKHS,P always believes in continuous quality improvement and in order to achieve the next level, AKHS,P is preparing itself for 2nd Surveillance Audit which will be held in the month of May, 2016.

BIOGRAPHIES

Kashif Jassani is a Head of Quality Assurance at AKHS,P with more than 10 years of experience in health care quality assurance. He is a Certified ISO 9001:2008 Quality Management Auditor along with holding a Master's degree in International Relations and Master's degree in Economics. His major achievements included ***"Excellence Award Winner"*** for Quality Safety & Patient Centered Award at 2015 International Hospital Federation Awards in Chicago, USA. Moreover, he is also ***"Gold Award Winner"*** at Asian Hospital Management Awards, 2014, Cebu City, Philippines.

Rozina Roshan Essani is a Board Director & Chairperson, Quality Assurance Committee (QAC) at AKHS,P in voluntary capacity. She holds RN, BScN, MScN degrees along with Certified Six Sigma Green Belt and has around 18 years of experience of working at Aga Khan University, Hospital. Under her expert supervision AKHS,P achieved ISO 9001:2008 Certification and Asian Hospital Management Award, 2014.

Syed Nadeem Husain Abbas is a Chartered Accountant and associated with AKHS,P as Chief Executive Officer. He has 20 years of experience at senior management level both at national and multinational companies in the field of public health, corporate governance, strategic planning and organizational restructuring.

St. Luke's Medical Center Global City – Global Trigger Tool (GTT) Project

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ST. LUKE'S MEDICAL CENTER GLOBAL CITY

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ABSTRACT: The Global Trigger Tool (GTT) was developed by the **Institute of Healthcare Improvement (IHI)**, to identify and measure the rate of adverse events over time in a healthcare facility. It is a sampling methodology that utilizes "triggers" in the detection of random adverse events and harms and it also measures the adverse events over time. The Quality and Patient Safety Group of St. Luke's Medical Center - Global City initiated the implementation of the Global Trigger Tool as a proactive solution using retrospective information gathered to address the growing challenge that adverse events and harms impose in the institution with the ultimate goal of improving patient safety. St. Luke's Medical Center Global City is the first and only hospital in the Philippines to implement and utilize the Global Trigger Tool.

Introduction.

The Global Trigger Tool (GTT) was developed by the **Institute of Healthcare Improvement (IHI)**, to identify and measure the rate of adverse events over time in a healthcare facility. It is a sampling methodology that utilizes "triggers" in the detection of random adverse events and harms and it also measures the adverse events over time. The GTT is a useful instrument in identifying unreported harms to patients, monitoring the adverse events rates and utilizing the data gathered as a way to measure the impact and effectiveness of patient safety initiatives.

The Quality and Patient Safety Group of St. Luke's Medical Center - Global City initiated the implementation of the Global Trigger Tool in our hospital as a proactive solution using retrospective information gathered to address the growing challenge that adverse events and harms impose in our institution, with a focus on unreported adverse events and harms. Data from the program can likewise be used for improvement projects in patient safety and several on-going projects have also been identified that can benefit from the GTT data.

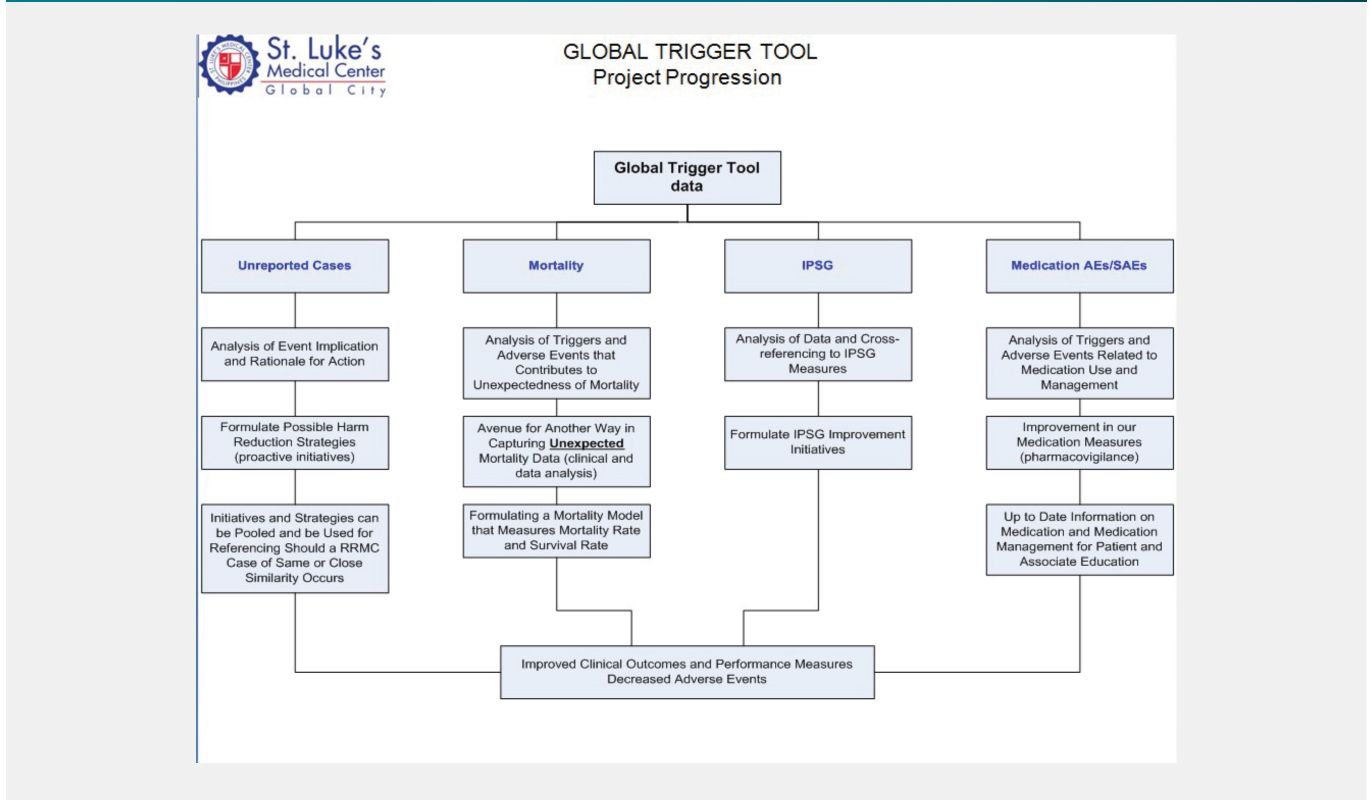
Exposition

Quality and Patient Safety developed a **PROJECT PROGRESSION MODEL** in which the data gathered from the GTT sessions will be used for various improvement initiatives. St. Luke's Medical Center is the first, if not the only, institution to develop a Project Progression Model for GTT that specifies improvement initiatives.

Since the GTT methodology employs utilization of closed chart reviews as data source of unreported adverse events and harms. That will be utilized and analyzed by the Risk Reduction Management Committee for the following: 1) pooling, monitoring and analysis of patient risk events for creation of preventive and pro-active measures & referencing against similar events; 2) mortality analysis; 3) International Patient Safety Goals measures monitoring, compliance and deviations; 4) Medication errors and drug adverse events. This will, in the end, translate to improved clinical outcomes and decrease in adverse events occurrence.

The Global Trigger Tool ensures patients that their safety and the quality of care they receive are of utmost importance in St. Luke's Medical Center. The project assures better patient safety through proactive measures that are developed in rela-

FIGURE 1. PROJECT PROGRESSION MODEL



tion to the collected data. Sentinel events can also be prevented immediately whenever sufficient triggers have been identified by the reviewers. Aside from their professional training as Nurses, Pharmacists and Physicians, the review team are also SLMC-certified Patient Safety Officers, with an ingrained focus on the safety of our patients. From training, they have been empowered to speak up and act immediately whenever they sense or identify possible harm to patients.

The project is geared towards the prevention and overall decrease of adverse events. The utilization of the Global Trigger Tool will and should have a longer lasting effect for our organization as it has been useful in gauging our baseline data on where we stand in terms of adverse events and how we can focus in areas that need improvement. In utilizing a transparent measurement tool, patients know that St. Luke's Medical Center is an organization committed to putting in place a Culture of Safety and can be assured that safeguards and improvements are constantly being developed.

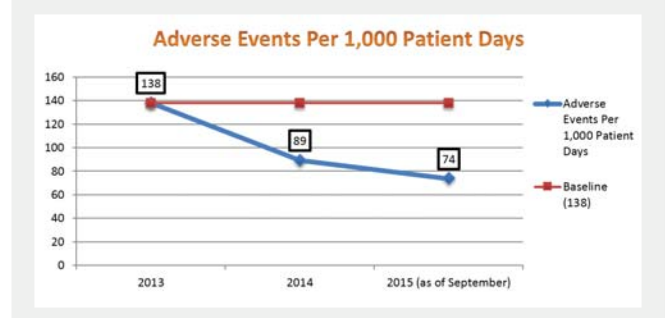
The GTT methodology included the formation of a closed patient chart review team selected from **Patient Safety Officers** (nurses, pharmacists and physicians) who were trained by the Quality and Patient Safety Group. The chart review is initially done by the nurses and pharmacists then the findings are forwarded to the physician reviewer for validation and finalization of the findings. The selected GTT review team conducted 10 chart reviews twice a month (20 total per month – pre-determined sampling methodology) to identify triggers to adverse events. The findings are then collated and entered into the GTT Database for monthly monitoring and reporting to the head of Quality and Patient Safety Group & Chief Quality Officer.

Guided by our Mission statement: "We are committed to deliver state of the art healthcare, because at St. Luke's Medical Center, the needs of our patients come first.", the Global Trigger Tool is demonstration of our commitment and dedication to learn from previous adverse events identified and to use the information to prevent these from recurring. The Global Trigger Tool presents both a retrospective and preventive method in improving patient safety, where the data gathered is used to initiate proactive and preventive improvement strategies.

One way the Quality and Patient Safety Group can quantify improvements would be through the three key performance indicators of the Global Trigger Tool. As per the Institute of Healthcare Improvement (IHI) guidelines, the three Key Performance Indicators of the GTT measurement are:

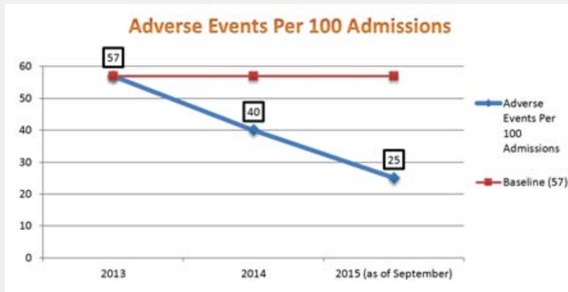
1. Adverse Events per 1,000 Patient Days
2. Adverse Events per 100 Admissions
3. Percent of admissions with an adverse event

FIGURE 2. ADVERSE EVENTS/ 1,000 PATIENT DAYS



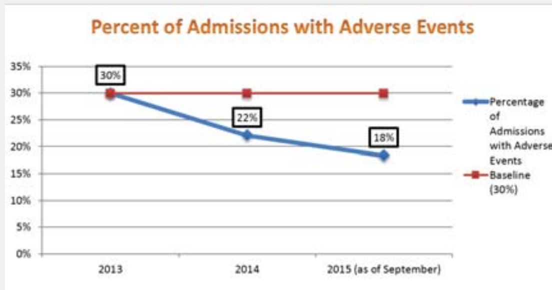
There was an average of **74 Adverse Events per 1,000 patient days** from January to September 2015; a marked improvement, decreasing from the average of 138 (2013) and 89 (2014).

FIGURE 3. ADVERSE EVENTS/100 ADMISSIONS



There was an average of **25 Adverse Events per 100 admissions** from January to September 2015; a marked improvement, decreasing from the average of 57 (2013) and 40 (2014) respectively.

FIGURE 4. PERCENT OF ADMISSIONS WITH ADVERSE EVENTS



There was an average of **18% of Admissions with Adverse Events** from January to September 2015; a marked improvement, decreasing from the average of 30% (2013) and 22% (2014) respectively.

FIGURE 5. OVERALL PATIENT SATISFACTION RATING

Several contributing initiatives may be attributed to these initial improvements such as:

- The development of Performance Improvement Team projects related to patient care and medication errors
- The conduct of a Root Cause Analysis for Medication Errors in 2014 up to 2015
- Risk Reduction Management Committee meetings conducted on specific patient safety incidents
- "Dear Dr. Dondi", an internal anonymous patient safety reporting system initiated by the Quality and Patient Safety Group
- A competition for International Patient Safety Goals (IPSGs) was conducted to promote stronger awareness for all staff
- Hospital wide conduct of IPSG Lecture Series for all medical and administrative staff conducted from August to October 2015 with attendance reaching as many as 500 participants per day.

In addition to the three key performance indicators, the **Patient Satisfaction rating** of St. Luke's Medical Center Global City is also being regularly monitored by the **Patient Relations Department**. This is done through the use of Patient Evaluation Forms for admitted patients and separate Outpatient Evaluation Forms for outpatients. The forms provide a measure of the overall satisfaction of our patients, with a rating scale of 0 to 5, with 5 being the highest and best rating.

Data from Patient Relations Department shows that from a Patient Satisfaction rating of 4.66 in 2013, the overall rating had increased to 4.68 in 2014 and has sustained consistency for 2015.

Conclusion

The implementation of the Global Trigger Tool in St. Luke's Medical Center Global City, is undoubtedly a valuable and useful tool in measuring adverse events. St. Luke's Medical Center Global City is the first and only hospital in the Philippines to implement and utilize the Global Trigger Tool.

To date, the Global Trigger Tool Project of St. Luke's Medical Center Global City, has garnered multiple awards regionally and internationally.

The project first won the highest distinction of **GOLD Award** in the Patient Safety Category in August from Asian Hospital Management Awards 2014, competing against high caliber healthcare institutions across Asia.

In the same year, the project won the prize of **GRAND Award** from the International Congress on Patient Safety in India, under Innovation in Staff Education category, again competing against top hospitals from all across Asia.

The project was also showcased by the Institute for Healthcare Improvement in their Storyboards during the 26th Annual IHI National Forum on Quality Improvement in Healthcare 2014, Orlando Florida, alongside quality projects from all across the United States.

In 2015, the project received an **Honorable mention** in the 2015 IHF International Award: Excellence Award for Quality and safety and Patient-centered Care held at the 39th IHF

World Hospital Congress in Chicago, USA.

BIOGRAPHIES

Dr. Alejandro C. Dizon has over 20 years of experience in administrative and executive positions in medical education and quality, patient safety, undergraduate and postgraduate medical education and training. He is a General Surgeon by training and clinical practice (Fellow, American College of Surgeons; Fellow & Board of Regents, Philippine College of Surgeons) with a special interest in Breast Surgery. He has dedicated the last 12 years in leadership positions in quality improvement and patient safety, currently he is the Vice President of the Quality and Patient Safety Group and the Chief Quality Officer of St. Luke's Medical Center and has been a pioneer in the advocacy and promotion of patient safety and quality in healthcare in various professional medical, paramedical and healthcare-related associations in the Philippines.

Ms. Eulalia C. Magpusao has over 20 years of experience in administrative and senior managerial positions in St. Luke's Medical Center. Ms. Magpusao is currently the Associate Director of the Quality and Patient Safety Group. Ms. Magpusao oversees the functions of three different sections: Performance Measures Management, Patient Safety, and Training and Education. Under the Chief Quality Officer, she has facilitated hospital wide preparations for more than five (5) accreditations for Joint Commission International, both for Hospital accreditations and a Clinical Care Program Certification, two (2) TEMOS certifications and several local government required certifications. Ms. Magpusao has a Lean Six Sigma Greenbelt Certification from Ateneo De Manila University, Graduate School of Business. She is also currently finishing her degree in Master of Business Administration.

Abraham Victorpaul J. Macaraig, RN handles the Performance Measures Section of the Quality and Patient Safety Group of St. Luke's Medical Center Global City. He is in charge of data management and analysis for hospital wide patient safety monitors and measures and also initiates writing articles, and collating and preparing projects for international quality and patient safety conferences such as Hospital Management Asia, International Congress on Patient Safety, IHI and IHF. Mr. Macaraig advises for the improvement projects of staff, using Lean Six Sigma and other quality methodologies. He is a Registered Nurse by profession with a passion for healthcare quality and patient safety. Mr. Macaraig is currently undertaking his postgraduate degree for a Master in Business Administration.

Acknowledgements:

Global Trigger Tool Chart – Physician Reviewers:

Bernard F. Laya M.D. Head of Institute of Radiology

Rodelio D.Lim M.D. Head of Institute of Pathology

Nathan David P. Concepcion M.D., Radiology

Delfin D. de Vera Jr. M.D., Orthopedics

Therese Narcisa Q. Fajardo, M.D., Quality Management Team Leader, Cancer Institute

Global Trigger Tool Chart – Clinician Reviewers:

Lynnie N. Pascua, R.N., Heart Institute

Dennis V. Capistrano, R.N., Central Sterile Supply Department

Snooky F. Baldonado, RPh, Clinical Pharmacy Department

Charminne Joan C. Crisologo, RPh, Clinical Pharmacy Department

Christian Joyce S. Sanada, RPh, Pharmacy Dispensing and Compounding

Elaine O. Alamo, R.N., Quality and Patient Safety Group-Patient Safety Section

Albert F. Casupang, R.N., Quality and Patient Safety Group

Khenjie C. Servino, Quality and Patient Safety Group

Gemma S. Galope, Quality and Patient Safety Group-Education and Training Section

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World Hospital Congress of the International Hospital Federation. https://www.ihf-fih.org/worldhospitalcongress

Paradigm of Professional Integration for Disabled People in Fundació Integralia Vallès: Key Success Factors

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ABSTRACT: Fundació Integralia Vallès is a pioneer contact center in Europe that has involved the creation of a healthcare reference center managed exclusively by people with disabilities and degenerative diseases to enable their professional development and ultimately integration into the labour market. The environment created under this project enables effective training and building of skills, capacity and work experience as well as promoting social responsibility among a population group that is at risk of exclusion. The major differentiating factor in Fundació Integralia Vallés is the quality of service provided by its staff, who are particularly sensitive to the issues of health, and who provide professional and human dimension in every attention.

Introduction. Creating a contact center meets one of the relevant strategic trends: outsourcing part of the customer managing process in sectors such as insurance, health, finance or retail. Our initiative transfers responsibility for this process and most critical asset in hands of a center exclusively staffed by disabled people.

There has been a major development in the call center landscape affecting significantly the understanding of the business and provision of services that goes beyond providing information and managing calls. Competition and growth in demand has forced to evolve into true and complete customer service centers, namely contact centers, by developing the required technologies to meet the needs of our customers, in which two essential elements are found: technology and human capital. Technology, in principle, is not a distinguishing factor since it is available to any company. The real distinctive competence of our experience, which can hardly be copied by competitors, is the quality of service provided by our employees. Faced with a certain tendency in the industry to implement the “bulk” service, our contact center is committed to careful and quality attention: its operators, who are especially sensitized to health issues and provide professional and human dimension in each call.

It is noteworthy that quality of service is in the hands of employees, in the sense that their skills and attitudes are the key differential factors of our service and the ones to make the difference among other companies.

Background

Fundació Integralia Vallès was launched in 2012 as the result of partnership between the DKV Fundació Integralia and MútuaTerrassa.

Fundació Integralia Vallès is a reference center that has been pioneer in Europe as a contact center attended exclusively by people with disabilities and specialized in the healthcare area. Its main objective is professional integration for disabled people. It is a contact center in the field of customer service providing added value to MútuaTerrassa’s catchment area. All of its workers are disabled and have been accredited in specialized training within healthcare.

MútuaTerrassa[1] is a non-profit health and social care organization serving a population of around 900,000 inhabitants in Catalonia. MútuaTerrassa was founded in 1900 as a Mutual Insurance company for occupational accidents, whose objective was to mitigate the consequences of work related accidents. The Entity has been gradually adapting to the needs of the community and strives to serve and offer a wider range of services, all related to health, personal autonomy and well-being.

MútuaTerrassa has kept within its values the social orientation towards people with difficulties throughout its over 115 years of existence. Our institution is deeply rooted in the region, which entails the Western Vallès, located 30km from Barcelona (Catalonia, Spain).

Currently, MútuaTerrassa activities involve: healthcare – (University Hospital and a network of community care services), social healthcare, insurance, healthcare logistics and healthcare research and teaching. MútuaTerrassa is currently employing 4,000 professionals from various disciplines within the health and social care sector.

La Fundació DKV Integralia[2] is a non-profit organization founded in 2000 as a result of the commitment of DKV Seguros (DKV Insurance) with corporate social responsibility whose aim is to facilitate social integration and employment of people with disabilities.

VALUES
Professionalism
Enthusiasm
Respect
Continuous learning
Solidarity

A strategic business and service initiative

Fundació Integralia Vallés is a strategic business and service initiative whose main innovation is the content given to their social purpose, mission and values, and is aimed at the effective integration of people with disabilities.

a. The strategic business objective and the corporate purpose

Although the strategic objective of Fundació Integralia Vallès is to improve customer service through a contact center, its main difference is in our social objective. The corporate purpose is based on the professional integration of people with disabilities who have particular difficulties in joining the labour market, such as people with severe disabilities and degenerative diseases. It aims at providing training and work experience in an environment that meets suitable conditions for professional development. Fundació Integralia Vallès is not thought of as a permanent workplace. It faces the challenge of promoting professional development for disabled people in ordinary companies in the long run.

b. Professionals profile

Choosing the right profile is a key element for future contact center professionals. You can describe basically three types of profile. First of all, we are talking about young people with severe disabilities, many of them performing their first job, who also tend to be family-dependent and do not even consider the possibility of being independent (at least before joining the labour market). Secondly, people over 50, especially women with degenerative diseases, sclerosis, fibromyalgia, arthritis, cancer, etc., who reconsider joining the labour market once their children are grown-ups, and third, young people who have had accidents, spinal cord injuries, or amputations, and must start a new professional career. The majority of them had not even considered going back to work or in many cases their training had been halted.

c. Values

The company would not make sense without the values that inspire the daily practice, professionals and managers. The values of Fundació Integralia Vallès are: professionalism, enthusiasm, respect, continuous learning and solidarity. Professionalism refers to the quality of service. We try to put ourselves in the position of our customers and suppliers, trying to see things from their perspective as well as value the emotional warmth, commitment, affection and sensitivity by working in a careful and thoughtful way, seeking excellence in our attitude, skills and tasks. Enthusiasm translates into activities that are stimulating, dynamic and full of energy. The availability, fighting spirit and pride of belonging to our entity governs the relations with our environment. Respect is based on supporting each other and striving to understand and respect individual peculiarities. Dialogue, respect, sharing and providing are permanent core attitudes for us. Continuous learning and teaching is everyone's task. Sharing and managing knowledge and adding creativity guarantee our future. Finally, solidarity entails a continuous attitude of acceptance and hospitality that facilitates the integration and learning for the new team members.

Singularities of social innovation

Fundació Integralia Vallès is a quite unique social project. In a first phase, there is a training and professional integration process with the support of Fundació Integralia Vallés, and in a second phase, there is integration to the ordinary employment local market network.

Implementing a project of this nature has transmitted an integrative culture code throughout the organization and stakeholders of MútuaTerrassa.

a. The involvement of all stakeholders

Fundació Integralia Vallès embodies in its relational framework of MútuaTerrassa 420 stakeholders and has brought awareness in a very effective way in projecting the social contribution of this initiative in the healthcare sector: healthcare organizations of our country; the knowledge sector: surrounding universities; the social sector: municipalities, neighborhood associations, and the business sector.

This project has been deployed to an area of entrepreneurs amidst economic dynamism, which are very important aspects to ensure economic viability and sustainability of this organization.

1 www.mutuaterrassa.com
2 www.fundacionintegralia.org

Our territory is inhabited by 900,000 people who account for 12% of the population of Catalonia (2% in Spain). It is a diverse area and a benchmark in the metropolitan area for its industrial and advanced services to businesses. It is the first area in Catalonia for economic activities with a good endowment to locate companies and represents 12% of Catalonia's GDP. It hosts 25,700 companies, 275,000 employees and 59,000 self-employed and has 135 industrial estates of 2,500 hectares.

b. The most significant factors contributing to promote social responsibility

- A contact center service of excellence that fosters accessibility for the population and minimize mobility and inadequate assistance. Fundació Integralia Vallès has a multi-platform next-generation technology, which allows real-time management of the various services, and flexibility to adapt resources as required. Ours is a paperless work philosophy.
- A viable and sustainable initiative, aimed at people with disabilities, mostly physical, who have failed to join or remain in the ordinary workforce. Fundació Integralia Vallès offers vocational training in telephone service specialized in healthcare, as well as specialized psychological and social support to help them reconcile their disabilities and their work.
- Integralia School in MútuaTerrassa University Health Campus provides training for people with physical disabilities. It entails alternative teaching in specific necessary knowledge to create career choices to help in the incorporation of ordinary companies.
- A pleasant and healthy work environment (green), a smoke-free working space near a park, designed to favor the ergonomics of disabled people where they can feel at ease.

Outcomes and achievements

Integrating people who are unemployed can be the response to social concern. The goal of Fundació Integralia Vallès is to promote the integration of people who are unemployed or at risk of exclusion. The high unemployment rate among disabled people entails excessive dependence, low self-esteem and frustration.

a. Social Objective

Our social objective is the integration of disabled people who have special difficulties in joining the labour market. This is envisaged to be achieved through training and work experience in an environment that enables their professional development.

b. Management Results

The Foundation has not only a social goal, but also a strategic and business objective. Figure 1 shows the most relevant figures in 2015 (source: Annual Report 2015)

2015 Main Indicators

Staff in contact center	
322 Integralia professionals	**30 Fundació Integralia Vallès**
206 professionals taken on in ordinary companies	
338 school students	
100% disabled people 80% of people with severe disabilities or degenerative diseases	
100% steady jobs 40% permanent contracts	
6% absenteeism in Integralia (10% work absenteeism in the sector)	
10% turnover in Integralia (23% sector turnover)	

Positioning
First place in the ranking of healthcare companies in telephone response
94% of our customers are satisfied or very satisfied with the care received in the center

Quality level
91% of calls handled
24-second average response time

Customer surveys
90.46% immediate response facility
92.53% effective response
92.12% quick solutions
92.12% quality solutions
94.61% treatment received

There are compelling reasons when choosing a contact center as a business model for a Special Employment Center:

- It is a growing sector, with professional development opportunities.
- It entails low mobility or no need for expensive job displacement.
- It offers the possibility to create mixed working environments.
- The Contact Center "cloud" technology helps to adapt the workplace to the needs of each professional as well as offering teleworking to people who have a walking impediment.
- Its activity allows direct contact with people.

Conclusion

Labour integration can become a first-rate experience when the company faces it as an opportunity for change and learning, and Fundació Integralia Vallès is a good example of this. These efforts are all the most noteworthy because our organization contact center offers a professional development opportunity to the people in our surroundings with severe disabilities. The key

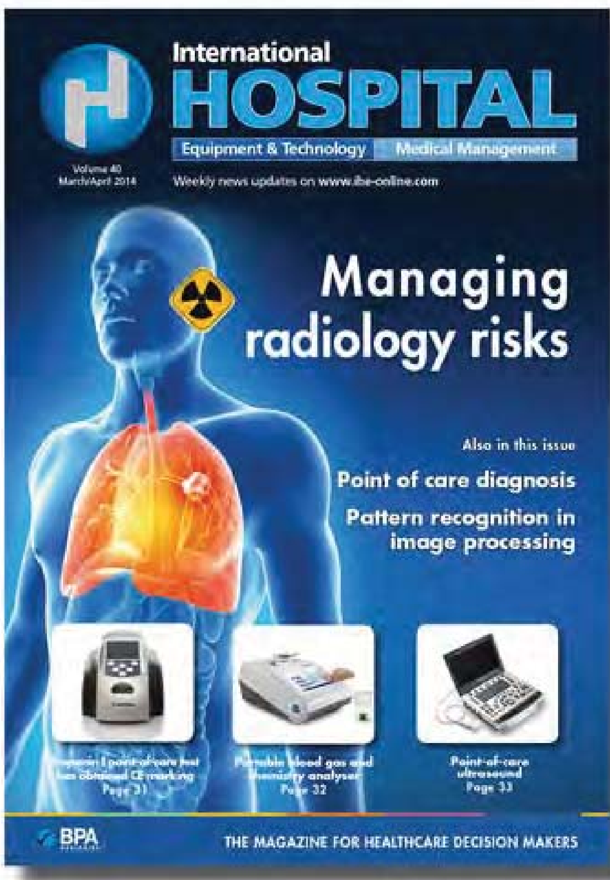
to success of this initiative is based on the quality of care offered by its professionals, the training given as part of their capacity building and the implementation of a management system where the person is first and foremost.

BIOGRAPHIES

Mª Emilia Gil she has been Deputy Manager of Mútua-Terrassa (Barcelona) since 2008, and is currently a member of the Foundation Board of Integralia Vallès, an initiative led by the Unió Catalana d'Hospitals. She is also Associate professor in the fields of Health Sciences in the Universitat Autònoma de Barcelona. She received the 2013 MC Award for managerial involvement in Human Resources. She has more than 30 years of experience in Healthcare Management assessing international strategic transformation of organizations in the Healthcare and Health services in insurance and social care. She has a degree in Sociology and Nursing from the Universitat Autònoma de Barcelona and specialized training in senior management by ESADE and IESE Business Schools. She has a Master's degree in Management of Organizations in Economy from the Universitat Oberta de Catalunya and a Master's degree in Health Economics from the Universitat de Barcelona. Founding partner and director of Antares Consulting for ten years, egil@mutuaterrassa.com

Javier de Oña is currently Director of Operations and Deputy Director of the Foundation employing 342 people in 8 different centers in Spain. Technical specialist in accounting, he has a degree in Business Administration from the University of Barcelona. His life changed radically on May 20, 1998 after a traffic accident. In November 1999, he joined the DKV Integralia Foundation for employment and social integration of people with disabilities working as a call center operator together with the eight people who started this project. He was later promoted to Responsible for training, supervisor and director of the Barcelona office. javier.deona@dkvseguros.es

Esteve Picola, nowadays CEO of MútuaTerrassa since 2005, has been working in different fields and positions in the healthcare and social system. After his degree in Medicine and Surgery (Universitat Autònoma de Barcelona. 1985) he undertook the managing path in both ways, academic (Health Services Direction – ESADE; Health Economics – Universitat de Barcelona; Finance & Economic Direction – ESADE; Business Management - EUNCET) and professional (Medical Direction, CIO, Elderly Residences, Insurances, Social Security, local and regional Hospitals). He is a member of the Executive Committee of "La Unió – Unió Catalana d'Hospitals", the catalan association of hospitals, health and social entities. epicola@mutuaterrassa.es



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Cognitive Training for Dementia Patients in the Community & Art Therapy Programs of 'Goyang Centenarian's Good Memory School'

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ABSTRACT: Myong Ji Hospital has launched the 'public health Service project team' for the first time in Korea as a private institution to carry forward and administer public health projects and services in a more structured way. Notably, Goyang Centenarian's Good Memory School has deliberately provided various art therapy programs to those who have a high risk of dementia in pursuit of promoting dementia prevention, and maintaining a positive mind and healthy body for any required daily activities for senior living. Participating patients have expressed remarkable satisfaction, and the art therapy programs have not only shown the effectiveness of strengthening the mental status of the cognitively-impaired patients but have also proposed a feasible non-pharmacological therapy option, which promotes the quality of their daily living and lowers the burden for their caregivers.

Introduction. The healthcare industry in South Korea needs to make some drastic changes to its over-flowing healthcare institutions and services. Considering the rapid development of medical technology which the healthcare industry heavily depends on in pursuit of high-class and high-tech medical equipment and competitive diagnostic devices.

In the current state, the economy of Korea has met with a slow growth period with decreasing customer spending. Conversely, the dilemma of over-flowing healthcare institutions intensifies the rivalry over customer demand for healthcare services. In addition, the portion of public health institutions is relatively small in Korea (only about 5.9% of hospitals in 2012). Korea has immense difficulties delivering public health services solely from public health institutions and without the assistance of any private hospital due to declining competiveness and prolonged deficits. (Wang-Jun Lee et al, 2015)

The course of action at this time is to address these needs to overcome management difficulties and to promote new and innovative policies.

Meanwhile, Myong Ji Hospital is fully equipped with the capabilities to creatively develop innovative strategies while acknowledging the new healthcare markets and trends. The hospital has been operating since 2009 by implementing the exclusive strategies and objectives to establish the most innovative global integrated healthcare system in Korea. Myong Ji Hospital has continuously grown and developed as a locally based facility with a "patient first" motto. The hospital has opened a Swine Flu Response Clinic Center, Pediatric Emergency Medical Center and Regional Emergency Medical Center, and has also been managing Gyeonggi Metropolitan Mental Health Improvement Center, Gangseo-gu Mental Health Improvement Center and Faint Support Center out of its special partnership. Furthermore, the hospital has been consistently providing activities for vulnerable social groups, such as sharing "love funds" and organizing volunteer medical services with a "love volunteer group" both domestically and internationally in Nepal and Uzbekistan.

Myong Ji hospital has been at the forefront of the public health medical services field that has systematically provided public health services and promotions. The hospital launched the public health Service project team for the first time as

a private hospital in February 2013, in accordance with the amendment of public health law in Korea. Based on the public health Medical services from public health institutions, Myong Ji hospital has broadened the professional services in pediatric emergency medicine and trauma medicine. It also conventionally offered to support mental health, suicide prevention, child welfare, single elderly households, multi-cultural families, fait prevent and public health education.

Exposition

Based on the successful achievements of the public health Service project team at the hospital while upholding the vision "to build a practicing public health model in a private hospital setting," the team has set the dementia management support project as their main focus in concert with the local community. The team then established the Good Memory until 100-Year-Old - Dementia Management Support Center.

Due to the population's extended life expectancy, Korea is changing from an aging country to an aged country, and it is estimated that dementia patients are currently reaching upwards to approximately 570,000 people. There has been a tremendous desire to relieve the pain of these dementia patients and their families, to provide them with proper medical services from the preventive stage to the progressing stage, and to make a connection with community resources organizationally. To be a leader in attaining this, Myong Ji Hospital has established the 'Dementia Management Support Center' along with the slogan 'Like youth health, good memory until 100 years old'.

The objective of Good Memory until 100-Year-Old - Dementia Management Support Center is to be a leading model of dementia prevention along with the general health improvement of an increasingly aging population based on the regional characteristics of the location of Myong Ji Hospital.

The project was focused on seniors over 60 years old residing in the city of Goyang, its main services targeted on the elderly (mild cognitive impairment or early stage of dementia) who are categorized as a high-risk group on the Dementia Screening Test (K-MMSE).

In conjunction with the local community, the Good Memory until 100-Year-Old - Dementia Management Support Center has been providing seniors with comprehensive mental health services in through each steps early detection, treatment, rehabilitation, and the progressive stage. Moreover, the center has been managing the Goyang Centenarian's Good Memory School and developing and promoting preventative dementia and health brain programs by providing counselors to give guidance on the senior welfare policies.

Generally speaking, there are not enough active hospital programs in Korea that both dementia patients and caregivers can participate in. Most hospitals merely prescribe medication to patients. Some local governments, including the city of Seoul, do provide dementia prevention education training, dementia early detection programs, and management services while managing dementia support centers. Unfortunately, Goyang City, where Myong Ji Hospital is based, has not been providing senior mental health programs other than the dementia early detection program. Our Good Memory until 100-Year-Old - Dementia Management Support Center has performed these public health activities based on an integrated, customized, and preventative approach in order to fulfill the social responsibility of a private hospital.

For a smooth and effective operation of the project, it entered into an agreement in cooperation with the Senior Welfare Center. It also raised awareness of dementia projects on a local community scale along with plans for future dementia policy. Besides this, it has helped the local community members with early detection of dementia through screening tests and with recognition improvement through monthly lectures. Although hospitals greatly rely on medication for treating mental health patients, it is vital to consider using various non-pharmacological therapy programs such as cognitive treatments, music and art therapy programs to prevent further deterioration.

'Goyang Centenarian's Good Memory School' has especially contributed to the prevention of dementia and maintenance of physical and mental health needed for elderly lives by continuously providing various prevention programs such as art therapy programs. The success in operating these art therapy programs relies on our art therapy center, which is Korea's first art therapy center that provides professional therapy to be integrated in a university hospital. The participants and caregivers of the Centenarian's Good Memory School are exceptionally satisfied, as the school's program is utterly based on the dementia patients and their families who require diversified and in-depth cognitive training rather than institutional care and medication treatments.

The goal of Centenarian's Good Memory School is to improve the level of knowledge about dementia and preventive measures, along with the increased satisfaction of the participants. A satisfaction survey was conducted after the program. Participants expressed a high satisfaction, giving an average score of 4.7 out of 5 and additionally confirmed that the Centenarian's Good Memory School's program was extremely helpful in helping them carry out voluntary dementia prevention practices in everyday life. Participants have again responded with a 4.7, expressing willingness to recommend the programs to those who are in need of such a well-developed dementia program, and also mentioned that they would like to participate again in the program in the near future when required.

"The outcomes of the program have shown positive clinical effects. The effectiveness on cognitive functions and mental health and the capabilities in everyday life have been analyzed for the participating patients who were already diagnosed with a cognitive impairment and Alzheimer's. The measuring tools for this performance goal is K-MMSE (Korean Mini Mental State Examination), S-GDS (Short Form of Geriatric Depression Scale), BAI (Beck Anxiety Inventory) and S-IADL (Seoul-Instrument Activities Daily Living). The evaluation results are as follows. S-GDS was on average 6.2±1.64 before music therapy, but 3.8±1.11 after music therapy, which is a remarkable improvement. BAI showed considerable decrease from an average of 10.5±4.94 before the therapy to

6.4±3.19 after the therapy. S-IADL also showed remarkable improvement from an average of 13.4±3.09 to 9.9±3.81 after the therapy. As shown above, S-GDS, BAI and S-IADL tested before and after the music therapy displayed statistically meaningful differences.

As previously mentioned, the art therapy programs not only gave suitable mental support but also increased the patient's daily life performance capacities so that their quality of life can be improved and the burden on caregivers can be lowered. This program could indeed grow into non-pharmacological therapy programs."(Hyun-Jung Han et al, 2014 : 109-110).

Centenarian's Good Memory School administered the dementia screening test at Goyang Deokyang Senior Welfare Center, which has good accessibility to seniors. The program was carried out on those from the senior center with a high risk of dementia.

Through the connection between treatment in the hospital and cognitive rehabilitation programs of Centenarian's Good Memory School, a multidisciplinary approach was made possible. The driving force behind this was the harmonization of medical care and welfare in which family therapy, cognitive rehabilitation therapy and mental behavior therapy were integrated. This project which is based on a desire from dementia patients and their families and is necessary for the local community, where public services for dementia seniors are insufficient.

This project focuses on its feasibility of being applied to the local community as well as on the desire of the patients and their families. The program has inspired local health centers that have up till now mostly provided only early diagnosis services, and made them recognize the need and importance of the cognitive rehabilitation programs.

Henceforth, Centenarian's Good Memory School give the patients and their families relief from mental, physical and financial burdens by establishing a systemic approach to provide 'community-based integrated dementia management service' beyond the hospital's capabilities.

Conclusion

Myong Ji Hospital has been at the forefront of the public health services sector with active participation from executives and faculty members at the hospital. In order to systematically conduct the public health and medical treatment service projects, the hospital launched 'the public health Service project team' for the first time as a private hospital. In order for the team to function in its entirety and to fulfill the necessities, the president of the hospital has been leading and directing any and all of the proposed projects. Due to the continuous noteworthy projects and services, Myong Ji hospital has become a prominent private hospital for performing public health and medical treatment service projects in Korea.

The city of Goyang, where the hospital is located, has acknowledged these distinguished contributions; as a result, the city was offered a partnership agreement with the hospital to tackle public health and medical treatment service tasks in February 2013.

Of particular note, the effectiveness of the art therapy programs at the Centenarian's Good Memory School was published as a research paper in the "Korean Society of Nerves." In addition, the important outcomes of the dementia services were broadcast on Korean National TV, including the MBC News Channel and the KBS program called "The secret of the four phases of Life-Dementia." The hospital was bestowed with the position of a Long-Term Care Insurance for the Aged education institution from the Ministry of Health and Welfare of Korea because of its accomplishment of the dementia management support projects, including Centenarian's Good Memory School. The Ministry of Health and Welfare and local governments have consigned a significant number of public health medical service projects to Myong Ji Hospital.

With all that said, Myong Ji Hospital is faithfully contributing to the local community by carrying out meaningful and plentiful social activities such as supporting dementia management, supporting single living elderly, supporting victims from violence in households and school, preventing sexual violence and suicide, supporting multi-cultural families and supporting people with cerebral palsy and mental health projects.

BIOGRAPHY

Dr. Lee is the CEO of Seonam University, College of Medicine, Myong-Ji Hospital and is running two more general hospitals along with 3 long term care facilities. Also, Dr. Lee is the President of South Korea's most influential healthcare news & publishing company, 'The Korean Doctors' Weekly,' founded in 1992.

In addition, as a board member of the Korean Hospital Association, he is in charge of secretary general of the Korean Healthcare Congress, which is top healthcare related annual congress in Asia.

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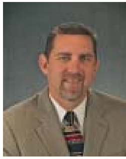
Why Hospitals and Payers are Recommending Home Care Upon Discharge Instead of SNF or Traditional Home Health Services
- Alternative Payment Model Hospital Incentives Aligning with Patient Choice -



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ABSTRACT: Seniors and other hospital patients in the United States have traditionally had the option of being discharged to a skilled nursing facility (convalescent home) for post-acute services, or home with nursing and therapy services provided in the home setting. Traditionally, these home based services have been referred to as "home health." As more Americans have retired, home health services have expanded and are readily accessible. This growth put tremendous stress on the Medicare fund which pays for senior care services. However, "Home Care," which traditionally has been viewed as non-medical home based services, has also become a booming industry for the cost conscious in recent years as more Americans reach retirement age. With the passing of the Affordable Care Act in 2010, providers and payers are now finding themselves responsible for post-acute care and continuous patient health, so cost efficient solutions for post-acute care are thriving. For the first time in history, American hospitals and Insurers are recognizing Home Care as an effective model that achieves the Triple Aim of Health Care reform. Home Care, which is no longer completely non-medical services, has proven to be an integral part of the care continuum for seniors in recent years and is now becoming a viable solution for keeping patients well, while still honoring their desire to age and heal at home. This paper analyzes the benefits and risks of home care and provides a clear understanding as to why American hospitals are emphasizing SNF Avoidance and skipping home health, opting instead to refer patients directly to home care as the preferred discharge solution in a value based model.

INTRODUCTION: AFFORDABLE CARE ACT INCENTIVES FOR HOSPITALS & PAYERS TO DISCHARGE HOME

Healthcare spending for seniors continues to balloon at alarming rates as ninety percent of seniors prefer to age and heal at home, as opposed to in a healthcare facility, With approximately 8,000 baby boomers a day turning 65 years old, the nation's senior population is estimated to increase by more than thirty percent by 2025. As a result, Medicare expenditures are projected to double to greater than $800 billion by 2018.[1] These expenditures will have a significant impact on hospitals, health systems and payers as Alternative Payment Models (APMs) become law.

The Patient Protection and Affordable Care Act (PPACA) of 2010 marked the beginning of a transformation in how acute care hospitals are reimbursed by the Federal government for care delivered.[2] While the triple aim of (PPACA) is improved care, improved patient satisfaction and lower delivery costs, recent recommendations from the Center for Medicare and Medicaid Services (CMS) also emphasize the importance of involving the patient in decisions related to their care. The pa-

tient's perception of his or her health care delivery correlates with outcomes and ultimately, satisfaction.[3]

In October 2015, CMS reinforced its desire for including patient preferences in the hospital discharge process in a press release. "CMS is proposing a simple but key change that will make it easier for people to take charge of their own healthcare. If this policy is adopted, individuals will be asked what is most important to them as they choose the next step in care -- whether it's a nursing home or home care," said CMS Acting Administrator Andy Slavitt.[3]

It is the final part of that quote, "whether it's a nursing home or home care," that will prove to be the driving factor in hospitals sending fewer patients to skilled nursing and home health in 2016 and beyond. Put simply, when given a choice, patients will opt not to go to a skilled nursing facility (SNF) unless it is viewed as a last resort.

As further evidence of the Federal Government's drive to reduce inpatient post-acute care utilization, the Affordable Care Act mandated the creation of the Community Living Assistance Services and Supports" Act (CLASS), a national long-term care insurance program with a daily financial benefit that covers up to (the industry standard) of three hours of home-based care per day per enrollee.[4]

Fee for Service Drove Inefficient Hospital Discharge Habits & Excessive Spending

Case managers and discharge planners have historically been charged with developing a comprehensive discharge plan for each patient in an acute hospital. However, through the years the time constraints and information-overload facing doctors, nurses and discharge planners led to discharge plans that were brief, free of detail and oftentimes non-existent beyond an order for "discharge to SNF."

Hospital discharge planners are some of the most overworked professionals in all of the healthcare industry, being asked to manage the constant flow of multiple patients a day. With new patients being admitted daily, coupled with a new case load that completely turns over every four to five days, case managers in the 1990s and 2000s expressed a mounting pressure to facilitate timely discharges of the patients to keep hospital costs low. The requirement of additional time to arrange discharge accommodations for acute patients led to less time and less reserved resiliency to adequately document the patient's needs in the discharge plan and summary.

These added pressures led discharge planners to the path of least resistance to discharge patients in a timely manner. In short, for patients with a Medicare benefit, the quickest and easiest way to get the patient out the door quickly was to discharge them to a SNF or home health agency (in the event that the patient refused SNF) and open up the hospital bed. Additionally, doctors were hesitant to avoid skilled nursing and home health services even when a patient refused due to concerns should the patient experience an adverse outcome or deterioration in health status after discharge.

Lost in this ever-eroding discharge process during the fee for service era was the notion that patients would prefer to not be admitted to a SNF. Essentially, patient preference in level of care was not proven to be a factor. The topic of patient preference was simply a means of allowing the patient or family member to choose their preferred SNF, and not whether or not they truly needed SNF level care that could not have been given in a home setting.

Subsequently, SNF and home health volumes increased dramatically. Patient involvement and preference to avoid skilled nursing was no longer a factor in the conversation.

US Supreme Court Rules Patients Should be Discharged Directly Home

For years, the Federal Government has had legal muscle to encourage doctors and hospitals to send patients home and avoid the SNF unnecessarily, but has had little success doing so. However, the reimbursement model for physicians and providers in the fee for service era was prohibitive and inconsistent with that objective. The landmark United States Supreme Court ruling in 1999, Tommy Olmstead v. Lois Curtis stated that "Patients in an acute hospital have the right to be discharged to the least restrictive environment when the care team determines that community placement is appropriate and the patient does not oppose the transfer."[5]

Furthermore, the ruling stated, "Continued institutionalization of patients who may be placed in less restrictive environments often constitutes discrimination based on disability." Thus, operationally, both physicians and hospital case managers must first rule out the least restrictive environment as a safe discharge before considering institutionalizing a patient for post-acute services."[5]

The Care Plan Act: Episode Based Care Gives Way to the Permanent Care Taker

One of the benefits of home care as an alternative to traditional home health services, is that the care taker becomes the long term care taker, and not a short-term episode based care taker as is the case in SNF, home health and other levels of post-acute care. CMS clearly stated their preference to reduce the noise or the episodes of care and the volume of caretakers that come along with the episode. This leads to enhanced continuity, efficiency, and improved outcomes. While SNF length of stay varies it is often 20 days or less, and home health is normally a 2-3 month episode, neither range allows for a long term care taker who assumes responsibility and knowledge of the patient's needs as is the case in home care or assisted living.[3]

"The proposed rule emphasizes the importance of the patient's goals and preferences during the discharge planning process. These improvements should better prepare patients and their caregivers to be active partners for their anticipated health and community support needs...This rule puts the patient and their caregivers at the center of care delivery," said CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc. "This leads to better care, smarter spending and healthier people."[3]

Incentives for Hospitals and Payers to Consider a Home-First Discharge Option

Hospital Incentives to Utilize Home Care as an alternative to SNF or Home Health

- Increased revenue as demonstrated through improved Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores
- Reduced Merit Systems Protection Board (MSPB) financial penalty exposure
- Reduced readmission financial penalty exposure
- Accountable Care Organizations (ACO) risk pool savings
- Bundle risk pool savings

Stating the Case for Home Care as a First Option

According to the Center for Medicare and Medical Services (CMS), the national readmission average for home bound individuals in 2012 was approximately twenty percent.[3] At least one study conducted in 2012 indicated a hospital readmission rate of 6.3% for patients receiving non-medical home care services (The Hospital to Your Home™ Study, http://bit.ly/24HrHomeCareStudy). However, preventing unnecessary readmissions is just one of many incentives to implement more affordable and efficient home based care practices.

Home care has proven to be an integral part of the care continuum for seniors receiving other levels of health care and support. For example, research indicates that not only do home care services increase the hours of care and supervision available to a senior, but reduced doctor's visits by as much as 25 percent.[1] In fact, that same study provided evidence that patients suffering from Alzheimer's disease or dementia experienced a reduction in annual doctor's visits of almost fifty percent. It further indicated that home care can delay or prevent the need for additional formal medical care.[1]

Is it Safe to Skip a SNF Episode and A Home Health Episode?

A recent CMS public comment document stated that "Patients discharged to community settings (home and assisted living) may incur lower costs over the recovery episode as compared with patients discharged to institutional settings.[2]

A recent article in the Annals of Long Term Care, Ostrovsky (2015) stated "The low cost and community connectedness of long term support service providers in the home may give them an advantage over traditional providers of care transition services, especially when their services are augmented by emerging mobile technology."[6]

The article further stated "the historical progression of bundled payments from acute to post-acute care, combined with a growing recognition of the value of home and community-based services, creates an interesting opportunity for sustainability integrating medical services and long term support services into bundles to more effectively achieve triple aim."

An abundance of evidence suggests high utilization of skilled nursing upon hospital discharge is more likely a result of an episode based reimbursement model for providers and doctors, than a clinically justified necessity. Further, when a patient declines skilled nursing care the default option has been traditional home health services. Again, a short-sighted approach as home health services are often capped and limited to benefit allowances despite if a patient is in need of additional care or therapy.

Home care, for the most part, has not been offered as an option for patients being discharged from the hospital. There are two main drivers of home care not often being offered upon hospital discharge. First, hospital discharge planners make an assumption that the patient (and family) do not have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Second, financially vetting each patient and family upon discharge can be a time consuming process and may delay discharge. Thus, as a result of these two factors, patients are often denied the opportunity to be informed that home care is an option upon discharge from the hospital.

Home Care is Often a Higher Level of Care than Traditional Home Health

Home Care services include providing services to those requiring daily living assistance due to physical, cognitive, or chronic health conditions.[5] This workforce includes personal care attendants and other essential care providers who serve non-medical functions. Non-medical workers are involved in 8 to 10 hours of paid services to older patients and to individuals with disabilities and there is growing evidence that these workers can improve patient experience and outcomes.[6]

As mentioned earlier, traditional home health services are often capped and limited to what the benefit allows – even if a patient is in need of additional care or therapy. With CMS approving reimbursement for home visits, chronic care management and transitional care management, home care providers who partner with physician house call groups are able to offer a higher level of care and less spending than home health, as a physician or nurse practitioner visit is not a covered home health benefit and therefore, not offered as part of the home health episode. Thus, home care often includes a physician, physician assistant or nurse practitioner visiting the patient in the home, whereas in traditional home health the visit occurs primarily with a nurse.

The Argument for Cost Savings for Payers and Conveners

Payer Incentives to Utilize Home Care as an alternative to SNF or Home Health

- Improved patient satisfaction
- Extended home based services times
- Diverse patient-specific needs not limited by home health benefit
- Risk pool saving

Although home care was traditionally viewed as non-medical care and therefore a non-covered benefit, organizations nationwide have started bucking this trend by employing non-medical home care services as a covered benefit that comes with a cost much less than that of traditional home

health services. For example, "the average non-medical worker is paid an hourly salary that is approximately seventy percent and ninety percent less than the salary of a nurse or physician, respectively."[6]

Conclusion

Alternative Payment Models have driven payers and providers to consider non-traditional methods of caring for patients to improve outcomes and control costs. While traditionally non-medical services (assisted living was viewed as "rent," and non-medical home care was viewed as "babysitting" by many) were not covered benefits, insurers and conveners are finding that utilizing these non-traditional levels of care can ensure patient satisfaction and lead to significant cost savings. Assisted living placement often causes delays in discharge. However, home care referral and same day start of care is often the best approach from a quality and financial standpoint as the patient's desire to return to home is honored.

Although on the surface it may seem brash, payers are focusing on how the patient can best be cared for in the home, and when done correctly patients can avoid admission to a SNF as well as Medicare or Insurer based home health services which are often limited and capped at specific amounts. The IMPACT Act (Improving Medicare Post-Acute Care Transformation Act) requires greater patient involvement in discharge planning. This patient involvement will lead to more specific discharge plans, with the primary goal of allowing a patient to age, recover, and heal in a home based setting.

Ultimately, the patient/s specific needs may be less expensive and less acute, than a $200-$800 per day SNF stay, or $3,600 home health episode. As a result, hospital discharge planners and payers are moving quickly to consider home-based care, with non-medical home health as a first-option before considering a SNF stay or home health order.

Hospitals and payers should not only be revising discharge protocols to consider a home-based discharge first, those who are doing so are experiencing enhanced patient engagement and improved patient satisfaction scores. Home care and a "home-first" mentality upon discharge not only reduce the risk of infection that comes along with a SNF stay, but improves patient satisfaction, reduces spending for care, minimizes exposure to readmission penalties and over-utilization of Medicare funds, and enhances an organization's ability to maximize risk pool residuals in Alternative Payment Models. Hospitals who do not adopt a home-first mentality will incur significant losses in alternative payment models and will continue to feel the financial sting of allowing fee-for-service motivated physicians to dictate oftentimes inappropriate post-acute plans, without offering the patient the option of going home.

For insurers, medical groups and other payers, spending a dime to save a dollar often comes with great risk. Home care, however, is not a new service and has proven to enhance the care continuum for years. Thus, payers are increasingly more willing to suggest discharge home with home care as an option before considering skilled nursing or traditional home health services.

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The Power to drive change: Working together for excellence. Creating a continuously improving consumer engagement framework for excellence in patient–centered care.

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ABSTRACT: The World Health Organization has acknowledged Patient Safety while receiving hospital care as a serious global public health issue, with patient empowerment and community engagement key to continuously improving safety and quality of care for the best possible clinical and patient outcomes. In Australia, the introduction of ten mandatory National Safety and Quality Health Service Standards in 2011 provided the catalyst for all Australian health facilities to review their systems.

Standard 2: Partnering with Consumers required health facilities across Australia to assess commitment to, and capacity for consumer and community engagement and participation. At this time, the Royal Brisbane and Women's Hospital did not have a strategic perspective and understanding, or an organizational structure for engaging with consumers (patients, families, care givers and community members). The concept required a new model to replace the clinician-led model of healthcare historically featured in Australia, with a change in culture and core business processes to partner with consumers at all levels of the system, from individual patient care through to participating in policy development, health service planning and delivery, and evaluation and measurement processes. The challenge for the hospital was to build a sustainable framework of engagement for a genuine patient-centered model of care informed by best practice, and provide leadership and commitment to developing as an area of excellence in patient engagement and experience. A successful and sustainable framework for consumer and community engagement has been embedded in the hospital, with resultant culture change, achieving accreditation across all core and developmental criteria for the partnering with consumer standards including several Met with Merit ratings.

Background. The emerging evidence that health consumers can play an active role in addressing issues and improving outcomes and that patient-centered approaches to care can lead to improvements in safety, quality and cost effectiveness, as well as improvements in patient and staff satisfaction, lead to the development of a National approach in Australia.

Ten National Safety and Quality Health Service Standards (The Standards) were introduced by the Australian Commission on Safety and Quality in Health Care to drive the implementation of safety and quality systems and improve the quality of health care in Australia. This provided a nationally consistent statement about the level of care consumers can expect from health service organizations. Accreditation to these Standards commenced for hospitals and day procedure services across Australia from January 2013.

The first two (2) overarching standards concern governance of safety and quality (Standard 1), and partnering with consumers (Standard 2), which together provides the context for the implementation of the other eight clinical standards.

Like many health care facilities in Australia at the time, The Royal Brisbane and Women's Hospital (RBWH) did not have an organizational perspective for consumer and community engagement. A redesign process was undertaken to implement the organizational change, systems and processes to meet the partnering with consumer standard.

Working together: Commitment

Significantly, the Executive Director of the hospital believed in the potential for the organization, and provided the initial vision and commitment, investing in and embracing the philosophy. The hospital committed to engaging consumers in a manner that is meaningful and value adding to outcomes. This meant moving past ensuring compliance to embrace the true intent of the standard.

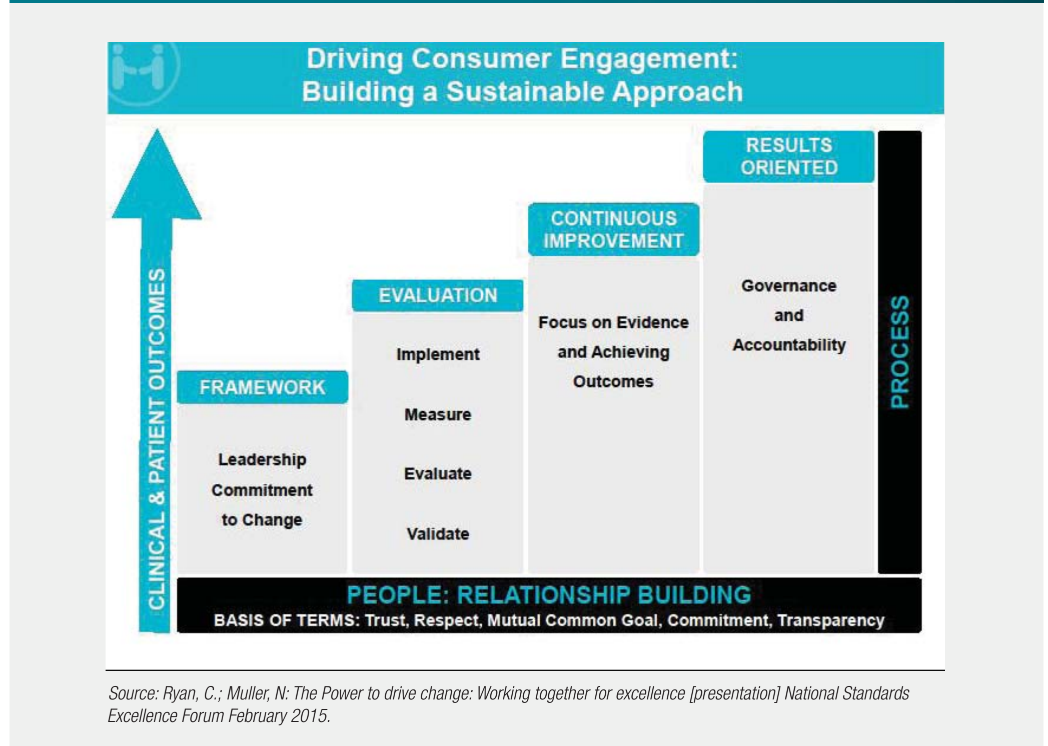
Adopting the partnership principle, the redesign commenced with a collaboration of consumer participation and staff engagement, and included extensive consultation and participation to develop a world-

class model of engagement.

Experienced consumer representatives were engaged to work with staff to develop the systems to support partnering with consumers, and to implement these systems to ensure consumers, clinicians and other members of the workforce use the systems to improve the safety and quality of care.

As core business for health services, consumer engagement is the responsibility and accountability of each staff member to actively engage with patients, families, care givers and other consumers.

FIGURE 1: BUILDING SUSTAINABLE CONSUMER ENGAGEMENT



Source: Ryan, C.; Muller, N: The Power to drive change: Working together for excellence [presentation] National Standards Excellence Forum February 2015.

Building a sustainable approach

Strong governance for this working partnership was established within the Safety and Quality framework of the hospital, with the introduction of the Consumer and Community Engagement Committee (CCEC). CCEC was formed with staff from each service and discipline, and consumer representatives to work in partnership to develop the framework of systems to enable the culture change required for sustainability, effectiveness and continuous growth.

As the systems were developed, staff and users of the services across the hospital implemented the systems to enable the new model of engagement, further developing engagement activities specific to individual patient and service needs to improve patient safety, experience and outcomes.

The results-oriented approach identified in Figure 1 was used to develop the framework with three key drivers:

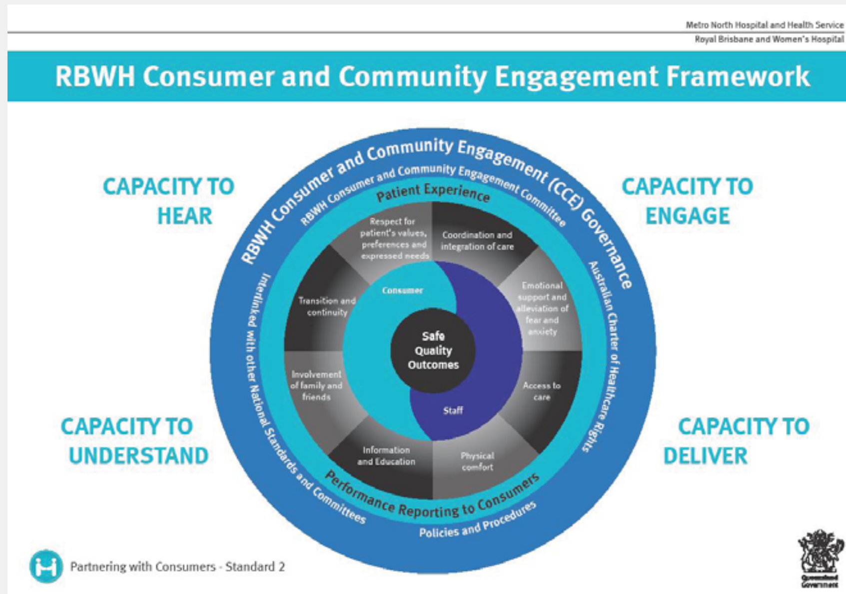
1. *People* acknowledged as fundamental to consumer engagement success; the interactions they create critical; and the culture they operate in central to patient experience success – staff and consumers developing a relationship built with trust, respect, working towards a mutual common goal, commitment and transparency;
2. *Process* established with systems developed to support engagement and build skills and capacity to engage. Patient Experience was introduced as a key measure. Measurement provided structure, evaluation, continuous improvement, clarity and commitment;
3. *Outcomes* to be achieved were communicated from the outset with a clear vision and messages to staff and consumers of the results to be achieved.

The Framework

The framework (Figure 2, 3) established for embedding and improving our partnership with consumers consists of several systems:

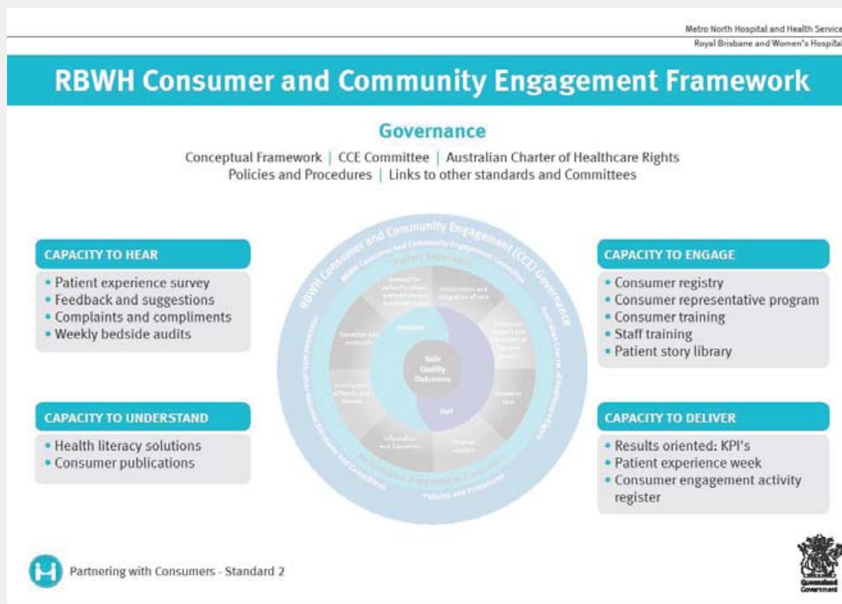
- **Governance system** to ensure a cohesive organizational perspective to consumer and community engagement, including:
  - The CCEC structure models the principle of partnership, incorporating collaboration of staff and consumers;
  - The Australian Charter of Healthcare Rights is the core governing tool for the intent of Partnering with Consumers. Implementation of Healthcare Rights training as mandatory for all staff to ensure staff understand and can explain the rights to consumers and importantly implement into everyday practice;
  - Implementation of agreed policies and procedures for engagement;
  - Partnering with consumers linked to all other national standards;
  - Development of Key Performance Indicators (KPI) identified in *Consumer and Community Engagement Results Orientated Plan* and reflected in Safety and Quality Committee Plan, Service line plans and the RBWH Organizational Plan.
- **Staff engagement system** provides education for skills development and incorporates training of staff by consumers to increase organizational capacity to engage:
  - Evidenced based staff education sessions “Consumer and Community Engagement for Patient Centered Care”;
  - All RBWH executives, senior leaders and key multidisciplinary members of the workforce have undertaken training. Ongoing sessions quarterly for staff;
  - Implementation of Consumer and Community Engagement principles in all educational programs;
  - Consumers are involved in staff training through a varie-

Figure 2: RBWH Consumer and Community Engagement Framework



Source: Ryan, C: RBWH Consumer and Community Engagement Framework [presentation] Royal Brisbane and Women's Hospital 2015.

Figure 3: Systems of the Consumer and Community Engagement Framework



Source: Ryan, C: RBWH Consumer and Community Engagement Framework [presentation] Royal Brisbane and Women's Hospital 2015.

ty of means including co-facilitating training, sharing their experience, providing feedback and perspective from the consumer view;

- Further development of educational framework to a sustainable model with champions for patient-centered care established in each service delivery area to educate, coach, and critically evaluate care to continuously improve patient-centered care (using key principles and concepts and established organizational systems for engagement). The champions undertake a development and learning pathway, linked to their annual staff performance appraisal and development processes for professional development in patient centered care.

- **Consumer engagement system:**

- Consumer representatives program: All new consumer representatives at the governance level attend a series of orientation and training processes to assist them in undertaking their role and in understanding the safety and quality agenda for the hospital and broader health service.

There is consumer representation across each of RBWH key governance committees and service line governance committees.

A consumer advisory group has been established as a key part of the organizational structure to enable consumers actively participating throughout the hospital to formally advise Executive and operational processes as a collective group. This complements the Clinical Council, which has been established as a system to enable clinician engagement in operational and service planning and redesign.

- Consumer representative register.

- Endorsed *Model of local consumer participation* developed with consumer representatives to assist service lines to implement and build consumer participation in the local area.

- **Consumer feedback system** is embedded to unit level to support the model of local consumer participation, providing consumer feedback from a diverse range of consumers including Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse communities. The system includes multiple avenues to gain the consumer perspective and participation, including:

- Feedback and suggestions process provides a proactive response at the point of care;
- Compliments and complaint management processes;
- Patient Experience survey; and
- Weekly bedside clinical audit undertaken as part of hospital monitoring.

- **Health Literacy System**
  - A key strategy for improving patient centered care has been to enable consumer participation in developing and reviewing patient information to ensure it meets consumer needs and health literacy principles.
- **Measurement and evaluation system**
  - Consumer Engagement Activity Register: Development and implementation of a Register using Standard 2 (Partnering with Consumers) criteria as the framework, to ensure a coordinated organizational response and identification of gaps/areas for improvement to ensure safe practice. This process assists in identifying best practice to inform and build skills and capacity of staff and the organization in engagement. Each department records activities partnering with consumers in service planning, safety and quality issues, and quality improvement initiatives to evidence ***Safe Quality Outcomes***.
  - **Patient Experience implemented as a new and important measure of the safety and quality performance of the hospital.** A validated methodology (Care Quality Commission and the Picker Institute Europe) was introduced for the RBWH Patient Experience Survey in 2012 establishing a base line to measure, improve and evaluate health service performance in inpatient and outpatient departments. Measuring patient experience is an important step in making the patient experience a priority for staff and for the organization. This measure includes both qualitative and quantitative (scoring methodology out of 10) information. Service lines and their individual areas receive specific data enabling identification of priorities for improvement at unit level, with action plans for improvement developed and monitored through the governance structure. While there are several areas of excellence, the target is to achieve overall organizational excellence by 2017.
- **Performance and accountability system**

Along with commitment as a driving force, organizational and individual focus and accountability is embedded along with strong governance to develop and continuously improve both the framework and outcomes. A suite of cascading plans ensures the required actions, accountability and measures are clear. This is supported by a regular reporting system at all levels of the organization to monitor and record improvements, and to inform staff and consumers on performance.

Several key strategies for informing consumers on the Safety and Quality performance of the hospital include:

- Report for consumers: In 2013 the RBWH initiated the *Quality Care Counts, Quality of Care Report* to identify key safety and quality information on RBWH's performance for consumers which included a feedback mechanism. Provided throughout the hospital and on the RBWH internet page.
- Safety and Quality Performance Boards at the entrance to each clinical area: Safety and Quality information provided for patients and visitors to facilitate a consumer focus and transparent safety culture, populated with ward specific data from weekly clinical ward audits.
- Consumers participate in the analysis of RBWH safety & quality performance through representation on the Executive Committee and key safety and quality governance committees. Consumers also assist through dedicated engagement and quality improvement activities including audit.

- **Summary**
  - The framework is built on the Picker Eight Dimensions of Patient Centered Care, which express the components of care that are most highly valued by the patient, family and care givers. The dimensions are used to report all survey, feedback and audit findings to ensure an integrated feedback system and responsive actions remain consumer focused.

Lessons learnt

A defining moment in the RBWH journey as the key to successfully changing the culture was moving past compliance to commit to the true intent of working in collaboration with our patients, families, care givers and community members.

This is the key to sustainability. Tokenistic gestures become difficult over time and fall away. Standards are required to set the minimum benchmark of acceptable practice but we need to change the culture of our organization to achieve and sustain the outcomes the standard seeks to improve.

Core elements for success include:

- Leadership vision and commitment to change. Executive leadership is critical, however, success requires leaders at all levels of the organization providing the persistence and resilience to manage the cultural change required. Leaders provide the catalyst for reorienting the model of care and the commitment in terms of providing focus, purpose and intent, setting a clear strategy and accountability;
- Appropriate resourcing includes a dedicated position resourced to lead the portfolio, and funding for framework development. However, most of the work is undertaken within existing resources. This concept includes not just a financial resource allocation but more importantly employing the right people with the appropriate skills (work experience and education) and the most talented in terms of the behavior expected and determination for the change management role. Engaged employees are builders and are the key to high performance.
- Key principle to the success of the framework is empowering and engaging staff and consumers to work together, starting a dialogue and developing a relationship. A sense of alignment, collaboration and shared purpose ensure activities are successful. Continual feedback from patients, families and care givers drive improvements at all levels from individual care to systemic change.
- Clear messages, reportable goals and accountability ensure the change is effected across the hospital. This requires a consistent, integrated program of activities, rather than a series of small random projects. A clear plan with key performance indicators (KPI), timeframes, accountability and reporting processes is essential.

- Measurement to drive improvements is crucial. With an emphasis on continual feedback from patients, families and care givers the RBWH has embedded the Patient Experience measure as a key indicator of the safety and quality performance of the hospital.
- Consistent, effective communication is achieved when all employees know what the organization is working towards, what the individuals' role is and how the organization is tracking in terms of achieving the goals. Literature supports this as a key component of all high performing organizations in patient experience.

Conclusion

Embedding consumer and community engagement as a high priority and core business has been a journey to strengthen performance and provide health services and programs to meet the needs of our community. Creating an enabling environment and developing a sustainable framework has been the first phase of the journey. Measuring performance has enabled the hospital to develop a high performance organizational culture in patient experience and engagement and will ensure staff and consumers continue to strive to further improve with quality improvement initiatives based on consumer feedback.

RBWH will continue to build on this philosophy. The release of the *World Health Organization global strategy on integrated people-centered health services 2016-2026* identifies five interdependent strategies for meeting current health challenges. These strategies are embedded within the framework discussed, and validate the RBWH approach, providing further focus for the years ahead.

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Decreasing Interferences and Time Spent on Transferring Information on Changing Nursing Shifts

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ABSTRACT: The exchange of clinical information on patients is a common component in nursing shift changes where professionals have limited time to transfer this information. There is no standardized or structured methodology for transferring information, which requires increased time to complete. Also, during the exchange, some interruptions can disrupt the communication among professionals, which can affect the patient's safety. A descriptive study was developed for five months, the information transfer arrangement among nurses was changed in order to determine which interruption increased the time spent on shift change and, therefore, decreased the safety of pediatric patients. The results obtained on the type of interruption caused us to rethink the organization that includes pediatric patient care.

Introduction

The exchange of clinical information on pediatric patients is a common component in nursing shift changes where professionals have limited time to transfer the patient's information.

In our hospital, we have fifteen minutes to perform this transfer. During this exchange of information, outgoing professional nurses transfer the responsibility of patient care assistance to another incoming professional.

The documentation used to change shift is a very important issue, which cannot include the patients' medical record.

A good transfer of information should ensure a better and more personalized care plan by nurses.

Although it is difficult to determine which type of information must be reflected[2], most authors agree that there should be a document that minimizes the errors and omissions of information[2] and that should lead to better patient care[3], including families and, at the same time, reduce the excess of time spent on the change of shift.

According to the authors, the use of computerized medical record promotes nursing record in real time, which gives us the option to register computerized document resulting from an existing data[2].

We have observed that there are various types of interferences, such as phone calls, interruptions by other professionals, by patients or relatives, which increase the time spent on transferring information. These disturbances may also negatively affect the patients' safety, the efficiency in communication between professionals[4] and the satisfaction of professionals and users.

Objective

To create a standardized model for minimizing and detecting interferences in shift changes by nurses of a pediatric ward.

To shorten the time spent on transferring information.

Methodology

A descriptive study was conducted for a period of five months, from October 2014 to February 2015, using a checklist, which consisted of a questionnaire that a mem-

ber of the nursing team developed during the shift changes. This tool is created for assessing, by direct observation, the most common internal and external interferences. The most outstanding quantitative variables included in this survey where the total duration of the shift change, the interruptions by other professionals, the phone calls, the attention to patients and families, and arrivals in the ward.

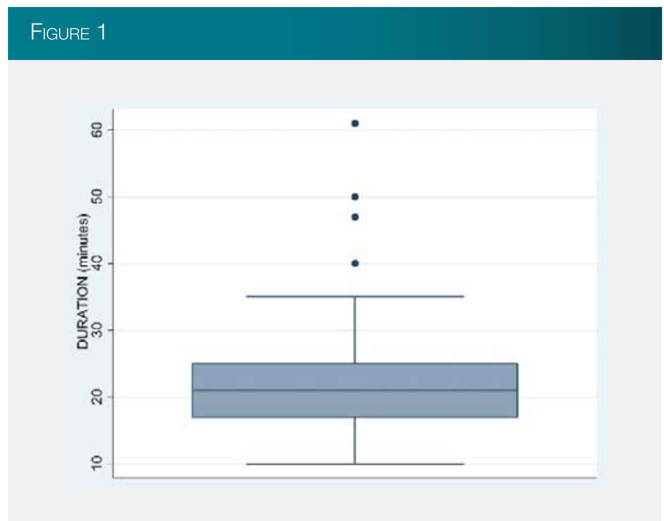
Results

A change was made in the way and in the place to transfer information between nurse shifts in our children hospital ward, so that the nurses office remained closed, free from interruptions, and the auxiliary nursing staff stayed out, taking care of the patients and their families. A sign was designed and put on the nurses office door during the shift change where information was transferred for fifteen minutes as before (Image 1).

Image 1

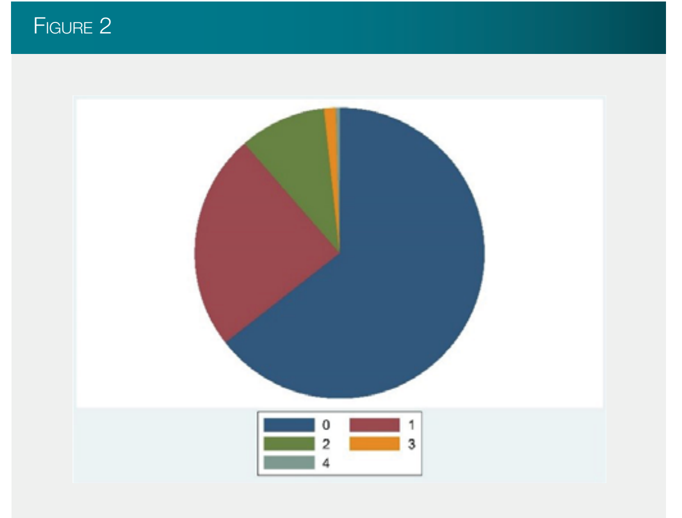
A total of 235 observations were obtained with an average of 22.3 minutes (Standard Deviation, SD, 7.1, min 10, max 61). We collected 7 observations with a duration of more than 35 minutes. Finally, a total of 228 observations were obtained with a mean duration of 21.6 minutes (SD 5.6, min 10, max 35) (Figure 1).

Figure 1



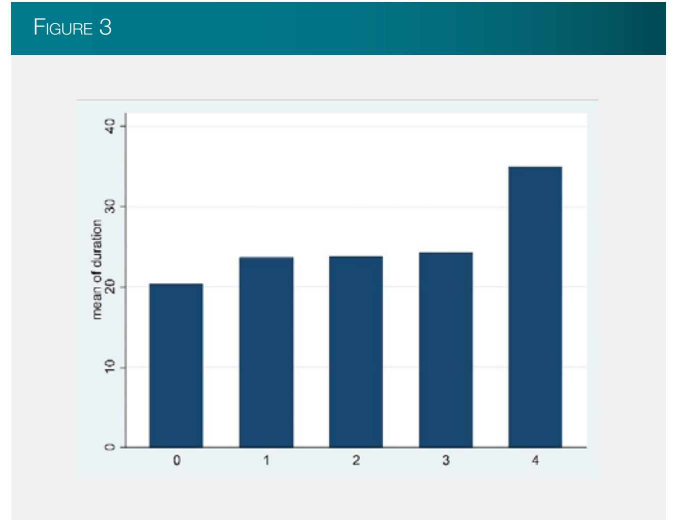
When comparing the average duration of the shift changes and the number of interruptions, in most cases the shift change occurred without interruptions, and in the remaining cases the shift change was interrupted on 4 occasions (Figure 2).

Figure 2



These interruptions were caused by families, emergency situations, new arrivals and interruptions by other professionals. We observed that the length of the shift change was directly proportionate to the number of interruptions that occurred (Figure 3).

Figure 3



When comparing the average duration based on the number of interruptions we saw that shift changes where there were no interruptions were shorter. For shift changes with 1 to 3 interruptions the average increase was not significant and in the only case with 4 interruptions the duration was higher, but the difference was not statistically significant.

From this analysis, we wondered if the type of interruption might be relevant when the shift change increases in duration. To perform this analysis, we focused on the interruptions by families, doctors and incoming telephone call.

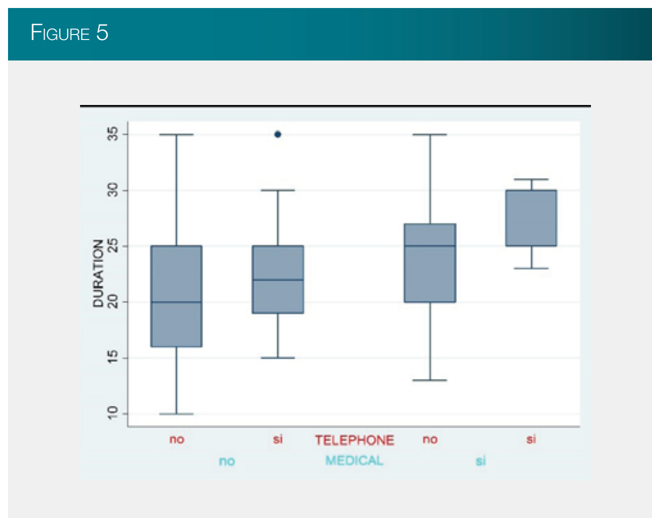
(Figure 4)

FIGURE 4

	N	Average	Standard Desviation	Significance
Telephone interruption	30	23,7	5,03	0,01
Family interruption	23	23,6	5,4	0,03
Medical staff interruption	36	24,5	4,9	0,003

Since the most significant interruptions seemed to be from telephone calls and the medical staff, we compared the duration of the shift changes with these two interruptions. It was noted that in cases where the interruption was by the medical staff, regardless of the existence of phone calls, the averages duration increased. (Figure 5).

FIGURE 5



Discussion

Currently, there is no standard model for transferring information[1]. However, there is a tendency to exchange information at the bedside.

This practice has many advantages. On the one hand, they include an improvement in the effective communication among professionals, while providing the opportunity to ask questions during the shift change, this promotes patient safety and involvement, because the patient can collaborate and is aware of the assistance provided. This fact provides the patient with knowledge that often is incorrect when searching sources of information on the internet.

On the other hand, this practice gives the patient the idea that nurses work as a team, because these professionals are less concerned about the inaccuracy or lack of information, because the communication includes the real time presence of the patient. Once the bedside shift change is over, the nursing team is more aware of the needs of their patients so they can think about a better and more personalized care plan[1].

In our institution, there are some structural and ethical issues (existence of double rooms) we cannot carry out this practice in all cases. Because the transfer of information must ensure the patient's privacy and must include the role of nursing[2].

Moreover, since the patient is present and can interact with the nurses, sometimes the time spent on shift change is increased. The bedside shift change works better in the morning and afternoon shifts, while the evening shifts can lead to a disturbance in the rest of the patient. Sometimes, for reasons of sensitivity to the patient, nurses have to perform a second exchange of information only among nurses. It also requires the use of a written document that is exchanged between the outgoing and the incoming shift, because oral communication often entails a loss of information or irrelevant data is communicated while other which is essential is lost[1].

Another point that makes the bedside shift change impossible to realize is the nurse-patient ratio, because many studies say that the more workload the professional has, the lesser is the safety of the patient[5].

Despite the general trend towards transferring information at the bedside, in our case, and because of the many disadvantages for the patient and professionals explained before, this could not be implemented. However, we could develop a new model of closed nursing shift change which means an increase in the patiens' safety and a decrease in interruptions during when transferring information among nurses.

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Improvement Initiatives of Resuscitation Service in a Regional Rehabilitation Hospital in Hong Kong

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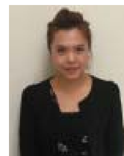

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ABSTRACT: Limited accessibility to resuscitation equipment and non-standardized instrument layout in trolleys would cause difficulty for the team members to access appropriate emergency equipment for delivering prompt resuscitation service in Tung Wah Eastern Hospital (TWEH). Improvement initiatives were implemented in September 2012 after endorsement by the resuscitation subcommittee: (i) standardization and installation of resuscitation equipment including resuscitation trolleys, emergency drug kits, automatic emergency defibrillators, designated response team (DRT) kit; (ii) guidelines revision involves the workflow, staff deployment, and designated areas for resuscitation during different service hours and (iii) staff training by workshop and video. Periodic resuscitation drill was held to monitor staff performance after training and the debriefing provided a chance for discussion and feedback from frontline staff. The compliance audit result for this exercise and the staff performance in the drills were improved, showing that the initiatives were successful.

KEY WORDS: Resuscitation, Accessibility, Standardization, Drill.

Tung Wah Eastern Hospital (TWEH) was opened on 27 November 1929 and its building is a Grade 2 historic building classified by Hong Kong Antiquities & Monument Office Classification. It is a regional rehabilitation hospital providing a selected range of 24-hour in-patient (total 256 beds) and ambulatory services mainly for the population on the Eastern part of the Hong Kong Island. This catchment areas covers an estimated population of 0.8 million, which accounts for around 11% of the Hong Kong population.

The clinical specialty services are managed under the Department of Medicine and Rehabilitation (M&R) and the Department of Ophthalmology (Oph) which are the two pillar departments of the hospital. The M&R Department operates 224 beds and covers rehabilitation of sub-specialties including pulmonary, cardiac, stroke, neurology and neurosurgical, orthopedics and traumatology as well as muscular-skeletal rehabilitation. The Ophthalmology Department operates 32 beds. And provides a comprehensive general and specialty services including glaucoma, posterior segment, anterior segment and refractive clinic. With multi-disciplinary support, the hospital

runs a number of ambulatory centers namely Rehabilitation Day Hospital, Integrated Diabetes Mellitus Research and Training Centre, Integrated Community Rehabilitation Centre and Cardiac Rehabilitation and Resources Centre.

Provision of a prompt resuscitation service for collapsed victims within the hospital complex is an operational priority. However, the design of the building allows limited accessibility for resuscitation equipment on the same floor. Non-standardized instrument layout in trolleys would cause difficulty in accessing appropriate emergency equipment. Besides, the average cardiac arrest cases are 26.75 per annum in TWEH. Our resuscitation teams are made up of on-call junior doctors and nurses who have the responsibility but less experience in dealing with this most acute medical emergency as compared with the acute hospital. Current studies illustrated that the resuscitation team dynamics should not be developed for the first time at the patient's bedside but require specific training to improve the maintenance of team structure and skills, application of problem-solving strategies, communication, and the execution of plans and task prioritization (1, 2, and 3). Therefore, standardization and modernization of the resuscitation equipment and consistency of resuscitation practice to meet the contemporary standard is of utmost importance. The objectives of this project are to (1) ensure that adequate, appropriate and standardized resuscitation equipment is available on the hospital premises, and (2) enhance staff knowledge of resuscitation and the use of equipment.

Improvement Initiatives through Resuscitation Committee

TWEH Resuscitation Sub-committee is responsible for reviewing the guidelines, training, equipment, outcome, audit and drills with debriefing regularly in line with the Hong Kong Easter Cluster Resuscitation Committee and contemporary international resuscitation practice framework (4, 5, and 6). Members are composed of different disciplines including doctors (medicine & rehabilitation, ophthalmology and anesthesiology), nurses and pharmacist. Currently the UK Resuscitation Council has set up the quality standards with recommended equipment and drug list for cardiopulmonary resuscitation in acute and primary care, but these standards in community health were still being developed. The proposal of purchasing new equipment for standardization, training manikin and details, revising guidelines, and newly developed DRT audit checklists were sought from members and onward submission to Hospital Management Committee for discussion and approval by Hospital Chief Executive, Heads of Clinical and Administrative Department. Our Improvement initiatives were implemented in September 2012 as follows:

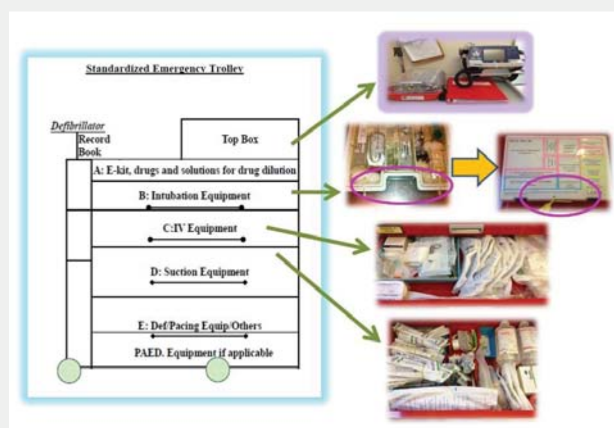
Standardization of equipment

a. Same model resuscitation trolleys were purchased to replace existing different types of trolleys. The new trolleys were relocated to ensure that standardized resuscitation equipment was available throughout the hospital for clinical use and for training (Figure 1 and Figure 2);

FIGURE 1 AND FIGURE 2

b. Instrument layout was standardized with photo labels posted (Figure 3);

FIGURE 3



c. Emergency drug kits were unified to drop-and-shock proof cases secured by tie-locks with lock number and tear-off function to facilitate drug searching during an emergency, drug recall and security (Figure 3);

d. 3 Automatic Emergency Defibrillators (AED) were installed in the main gates of 3 building blocks for easy access by public or staff to facilitate Designated Response Team (DRT) in responding to medical assistance request in the vicinity of hospital (Figure 4);

FIGURE 4

e. The bulky DRT kit was also replaced by a handy one (Figure 5);

FIGURE 5

Revision of Policy and Guidelines

f. The "Policy for Cardiopulmonary Resuscitation" was revised and Standard Operation Procedure in "Handling Persons in Need of Emergency Medical Assistance in the Vicinity" and audit checklists were developed including the workflow, staff deployment, designated areas for resuscitation during office and non-office hours;

Staff Training

g. Staff in-service training started with familiarization on the use of resuscitation equipment, such as defibrillator, Ambu Bag and manikin with real-time audio-visual feedback, was purchased for training and drill (Figure 6);

FIGURE 6

h. Training video on the use of AED was uploaded on the web for staffs' easy access (Figure 7).

FIGURE 7

Performance Evaluation and Feedback Mechanisms

Hospital Resuscitation Sub-committee set up performance monitoring and feedback mechanisms in resuscitation, to allow the CPR team and the Committee to evaluate, maintain and improve CPR quality and staff performance in line with their expected abilities and roles. On top of the quarterly held CPR drill, scenario-based DRT drills were also conducted every six months in which the manikin with audio-visual feedback and video recording of the teams' performance was used during the drill respectively. The objectives of the drill were (1) to boost the smooth workflow logistic of the DRT and ensure readiness of emergency equipment, and (2) to provide recommendations for CPR service improvements and staff training needs. The performance of individual team members throughout the procedures, including telephone operator, foreman, doctor, nurses and overall supervisor were reviewed and discussed with the aid of an audit checklist and a video recording of the procedures in the debriefing. The compliance rates improved from 95.24% in 2013 to 100% in 2015. Resuscitation trolley audits were also conducted after their standardization. The objectives were to check the availability of essential resuscitation equipment in the resuscitation trolleys in service and study nurses' com-

pliance with checking and recording equipment in Resuscitation Trolley. Audit result was also improved from 97.32% in 2013 to 97.92% in 2014.

Conclusion

The high compliance in the audits of resuscitation trolley standardization and DRT drills showed that the improvement initiatives were successful. The standardization of emergency trolleys and availability of emergency equipment could facilitate smooth delivery of resuscitation service. DRT drill provided additional resuscitation training involving full-scale simulation and a post-event debriefing which helped to improve the confidence of the resuscitation team and enhance communication and skills in the cardiopulmonary resuscitation.

BIOGRAPHIES

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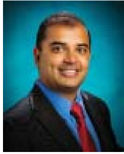
Improving the Success of Strategic Management Using Big Data



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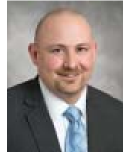

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ABSTRACT: Strategic management involves determining organizational goals, implementing a strategic plan, and properly allocating resources. Poor access to pertinent and timely data misidentifies clinical goals, prevents effective resource allocation, and generates waste from inaccurate forecasting. Loss of operational efficiency diminishes the value stream, adversely impacts the quality of patient care, and hampers effective strategic management. We have pioneered an approach using big data to create competitive advantage by identifying trends in clinical practice, accurately anticipating future needs, and strategically allocating resources for maximum impact.

Introduction

Meeting the needs of both patients and practitioners is increasingly challenging in today's rapidly changing world of healthcare. The influx of new technologies, increasing patient savviness about their health, and more restricted fiscal environment require a thoughtful approach to major capital expenditures, some of which can cost millions of dollars and take several years to complete. Misjudging the needs of the customer base can adversely impact the value stream and greatly diminish operational efficiency.

Identifying the infrastructure and operational changes that will meet the needs of patients and practitioners requires accurate and precise forecasting. The cost-effectiveness and expected utilization of evolving service lines need to be properly predicted after considering both local and national trends in health care. A well-constructed risk assessment is critical to ensuring that potential threats to the organization are properly mitigated.

Good forecasting and risk management require access to timely and pertinent data. Many hospitals utilize third party services that condense complex patient data into accessible dashboards. Some of these vendors provide information about national standards to permit benchmarking. While this data is both timely and pertinent for the day-to-day operation of a healthcare system, it does not provide insight into clinical trends that can significantly impact the triple bottom-line of a healthcare organization.

Evaluation of clinical trends requires the ability to identify trends, evaluate efficacy of treatment, and determine meaningful revenue sources that positive impact the value stream. Such data is available in several national patient databases, such as the National Inpatient Sample (NIS) provided by the Agency for Healthcare Research and Quality (AHRQ), the American College of Surgeons National Surgical Quality Improvement Project (NSQIP), and the Centers for Medicare and Medicaid Services (CMS) database. Familiarity with advanced statistics, forecasting, decision analysis, lean six sigma quality improvement principles, and various business management techniques is crucial for success as the findings from these databases could underpin multimillion dollar capital investments. The purpose of this article is to demonstrate several examples and outline the methods that a healthcare organization could use to improve their strategic management and operational efficiency.

Business Case

One of the issues that a successful hospital faces is with operating room utilization. As one of the primary revenue sources, ensuring a high rate of resource utilization and minimizing down time are some of the key priorities. Many organizations are reasonably adept at resource management and scheduling and are able to maintain a high level of efficiency despite the many human factors involved. However, there are two issues that many hospitals have started to grapple with over the past several years.

The first issue is that many hospitals are reaching peak utilization with room utilization. As caseload increases, there are not enough rooms available to complete all of the surgeries on a timely basis. The second issue is the desire to build hybrid operating rooms that feature an integrated radiology suite with full open surgery capability. This capability is desired due to the increase in number of minimally invasive, X-ray guided endovascular procedures that are now taking

place. Some of these procedures require both a radiology team and traditional surgery team as a component of the operation may involve open incisions. There is also the possibility of converting from an endovascular procedure to a traditional open procedure. Most interventional radiology suites are not equipped to do this conversion, and the use of portable fluoroscopic imaging in an open surgical suite lacks the imaging resolution and flexibility to do the procedure in a timely basis.

Building a hybrid surgical operating room requires a great deal of strategic management. The capital costs are several million dollars and sometimes an existing operating suite needs to be converted to a hybrid suite due to space constraints. Since construction can take several months, there must be careful consideration about resource utilization and capital planning.

The surprising aspect of this discussion is that if a hospital system does not yet have a functional hybrid operating suite, it may actually need two in order to meet the needs of the patients and physicians. The rationale for this would be difficult to muster if using only local institutional patient databases as the source. Instead, one must evaluate national databases for trends stretching back at least 15 years to understand the relevant clinical issues. Using this "big data" could have significant implications for strategic management.

Methods

The big data source that we have utilized for many of our strategic management projects is the National Inpatient Sample. The NIS is a part of the Health Care Utilization Project (HCUP) that is maintained by the Agency for Healthcare Research and Quality (AHRQ). The NIS is the largest all-payer inpatient database and includes a stratified 20% random sample of all non-federal inpatient hospital admissions throughout the United States. We have compiled this database to have access to nearly 150 million patient records between 1998 and 2013 (the most recent year available). If we require more timely data, we can utilize our local patient database to ensure the trends remain valid between 2013 and present day.

This information source is very large and requires a dedicated, purpose-built machine to mine it efficiently. Files that are many gigabytes in size are routinely generated, so there are many issues around information technology where the services of a knowledgeable consultant may be helpful. In this particular case, we are interested in evaluating the business case for a hybrid operating room. Vascular surgeons often utilize this room, and one of the chief procedures they do in this room is endovascular abdominal aortic aneurysm repair. For the sake of simplicity, we will evaluate this procedure only for this article. In reality, there are half a dozen other procedures that are completed and a true strategic management project would evaluate all of them to ensure that a precise forecast is made.

This database is managed using the use of the IBM SPSS software package (SPSS version 22.0; SPSS Inc., Chicago, IL), which is an advanced statistical tool that has a pleasant graphic user interface for ease of access. Patients are selected over a 16-year period between 1998 and 2013 with the use of International Classification of Diseases Ninth Revision (ICD-9) diagnosis and procedures codes and Current Procedural Terminology (CPT®) procedure codes. A diagnosis of abdominal aortic aneurysm (ICD-9 441.4) and a procedure code for endovascular aneurysm repair (ICD-9 39.71) are used to select patients from the database.

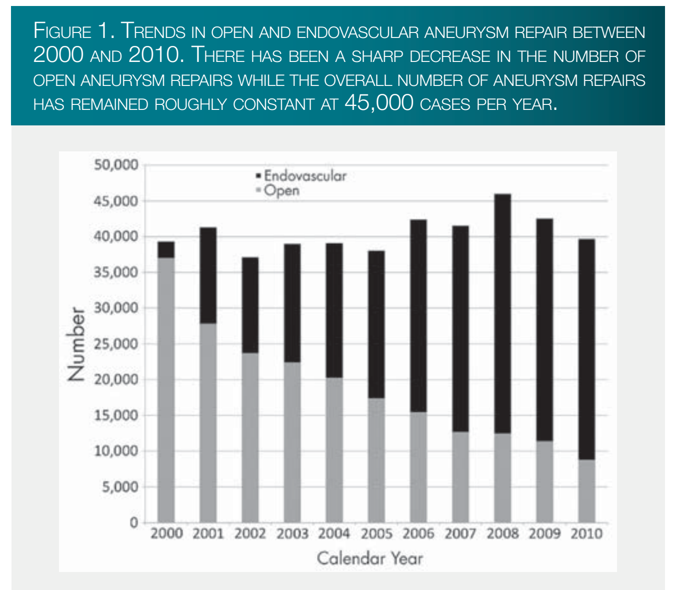
Statistical analysis is completed with the use of analysis of variance for continuous variables and chi-square for categorical variables. The Mann-Whitney U test is used for cost comparisons. Odds ratios and 95% confidence intervals are calculated using multivariate logistic regression analysis. Trend analysis is completed using the Mann-Kendall test. Statistical significance is set at a level of $P < 0.05$. Population estimates are made by means of discharge sampling weights included within the NIS and data published by the U.S. Census Bureau. These estimates are used to adjust for population growth over time and present data as incidence per 100,000 people. Cost data is adjusted for inflation using the Consumer Price Index. TreePlan (TreePlan Pro 2016; TreePlan Software, San Francisco, CA) is used for the decision analysis model created for cost calculations. A risk-adjusted model is sometimes created through the use of propensity score matching for additional financial calculations.

A business case is then made using the lean six sigma framework of DMAIC (Define, Measure, Analyze, Improve, and Control). Appropriate financial risk calculations are done through the use of a risk register / FMEA (failure modes effect analysis) and generating the proper pro forma reports. We often also use computer-based simulation using the Simul8 software package (Simul8 Corporation, Boston, MA) to graphically demonstrate to the executive leadership what the impact of our proposal will be. This powerful tool allows customization of input variables and allows a more clear understanding of the potential outputs. It is a particularly effective method for showing the financial impact of two hybrid operating suites over one – and even just having one over none.

Results

We were surprised to learn that while the total number of abdominal aortic aneurysms being repaired annually has stayed the same at 45,000 cases in the United States, the number of open aneurysm repairs has decreased precipitously over the past decade (Figure 1).

FIGURE 1. TRENDS IN OPEN AND ENDOVASCULAR ANEURYSM REPAIR BETWEEN 2000 AND 2010. THERE HAS BEEN A SHARP DECREASE IN THE NUMBER OF OPEN ANEURYSM REPAIRS WHILE THE OVERALL NUMBER OF ANEURYSM REPAIRS HAS REMAINED ROUGHLY CONSTANT AT 45,000 CASES PER YEAR.



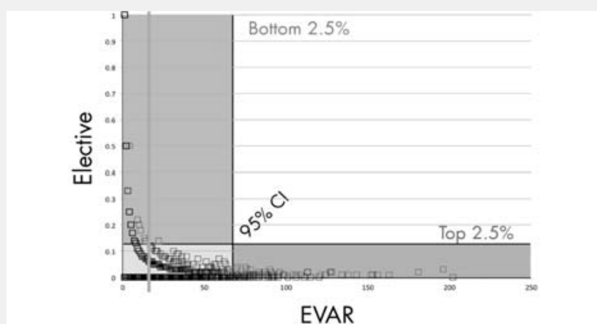
Forecasting the number forward to present day reveals that less than 10% of aneurysms will be repaired using the open method.[1,2] Furthermore, as the minimally-invasive technology has become more wide-

spread, over 50% of the emergency surgeries for a ruptured aneurysm are now being repaired using the minimally invasive approach.

These results have translated to increased survival for patients who require emergency surgery, and a markedly decreased length of stay. While a one week long stay was typical for patients who undergo open surgery, most stay just overnight following the endovascular procedure.[1,3] Many savvy patients now request endovascular surgery to repair their aneurysms. Due to limitations of portable imaging, these procedures are best completed in a hybrid operating room to maximize patient safety and operator effectiveness.

An additional finding that we were able to glean from this database analysis is an understanding of the relationship between provider volume and overall mortality.[3] It is well known that high volume providers tend to have very good outcomes, but the relationship between low volume and mortality is not always clear. The data from this national database includes outcomes on almost a thousand providers who complete these procedures. Their annual volume over a 16-year period can be tabulated and correlated to patient mortality. This data is graphically provided and we identified a break point of eight cases per year (Figure 2). Surgeons who do fewer than eight endovascular aneurysm repairs per year are more likely to have complications and patient mortality compared to their counterparts who do more than eight.[3]

FIGURE 2. ELECTIVE ENDOVASCULAR ANEURYSM REPAIR NUMBERS FOR ALL PRACTITIONERS AROUND THE COUNTRY. THE X-AXIS HAS THE NUMBER OF CASES WHILE THE Y-AXIS PORTRAYS MORTALITY. MORTALITY IS HIGHEST FOR PRACTITIONERS WHO HANDLE FEWER THAN EIGHT CASES PER YEAR.



Discussion

A proper financial analysis would incorporate our findings and correlate them to physician volume at the hospital. A hospital that employed three or more vascular surgeons may be able to make a strong case for two hybrid operating rooms, while a hospital with at least one vascular surgeon could make a strong case for at least one hybrid operating room. Combined with the sharp increase in number of endovascular procedures, not just aortic aneurysm repairs, it is expected that these hybrid operating rooms would be running at full capacity within a few short years, thus maximizing the return on their investment.

Use of big data resources combined with a thoughtful analytical approach and computer-based simulation allow hospital systems to make informed decisions about the care they provide.[1-6] Capital investments, strategic management, and new health care initiatives all benefit from this approach. Big data allows personalization of health care and tailors solutions to anticipate the needs of the local market. National benchmarking is possible and permits meaningful planning and resource allocation to support your strongest performers.[3,5] Identifying clinical trends and planning for the future through precise and accurate forecasting develops competitive advantage and allows positioning of resources to meet future demands. Combined with computer-based modeling, this permits a sophisticated level of business intelligence and confident decision-making.

BIOGRAPHY

Dr. Sapan Desai is a vascular surgeon, vice chair of research, and medical director of the surgical skills center at Southern Illinois University in Springfield, Illinois. He is also director of the quality alliance and predictive analysis and on the board of directors for the healthcare quality alliance. He is a nationally regarded expert on quality improvement, medical informatics, and business intelligence.

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IHF Recognition Awards for 2015 2016 Volume 52 Number 1

Résumés en Français

YACHIYO HOSPITAL; Center of *SUPER CARE MIX* – Prise en charge globale de la situation d'urgence à domicile pour la communauté

La ville d'Anjo_a deux hôpitaux généraux. L'hôpital Kosei, un centre médical central pour les soins avancés et notre hôpital Yachiyo pour soins régionaux. Récemment, l'hôpital Kosei fait face au problème de la surcapacité en raison de dépassement de capacité dans les urgences et de services encombrés en raison de la pénurie de lits en phase post-aiguë.

Nous avions prévu un projet visant à soulager la congestion de l'hôpital central et de gérer les patients en phase post-aiguë.

Construction et application d'une chaîne de gestion de l'hôpital redéfinie

Le développement à grande échelle a été assez fréquent dans la période postérieure à l'industrialisation de l'hôpital en Chine. Aujourd'hui, la gestion de l'hôpital chinois fait face à des problèmes tels que l'inefficacité du service, le coût élevé des ressources humaines et le faible taux d'utilisation du capital. Cette étude analyse la chaîne de gestion redéfinie de Wuxi, n.2 de l'hôpital des personnes. Il s'agit des six engrenages, à savoir, « structure organisationnelle, pratique clinique, service de consultations externes, technologie médicale et des soins infirmiers et logistique ». Les engrenages sont basés sur les « cibles de système de gestion, chef du personnel médical, service ambulatoire centralisé, intensification des examens médicaux, gestion verticale des soins infirmiers et logistique socialisée ». Les concepts fondamentaux de la gestion hospitalière redéfinie sont l'optimisation des processus de flux, la réduction des déchets, l'amélioration de l'efficacité, les économies de coût et la prise en charge des patients, ce qui est le plus important.

Qualité, sécurité et soins centrés sur le patient – un rêve qui se réalise dans les montagnes du Nord du Pakistan.

Un projet de "2015 Quality, Safety & Patient Centered Care Award" (« Prix 2015 des soins centrés sur la qualité, la sécurité et le patient ») primé à, Chicago USA

Le nord du Pakistan demeure un terrain très difficile en raison des intempéries tout au long de l'année ce qui présente du défi d'infrastructure, de ressources humaines et de chaîne logistique. De nombreuses fois, la structure a dû déménager à différents endroits, ponctuellement et en urgence, en raison de glissements de terrain et de tremblements de terre qui affectent la continuité des soins. Fournir des soins de santé de qualité, souvent une contrainte de ressources dans les zones difficiles d'accès a toujours été la seule force de AKHS,P. Briser les barrières pour que la population du bassin puisse accéder aux soins de santé de qualité, AKHS, P a lancé une initiative de mise en œuvre, pour obtenir et maintenir la Certification Internationale du Système de Management de la Qualité ISO 9001:2008.

Cet article fait partager l'expérience unique de AKHS, P pour obtenir et maintenir la Certification Internationale du Système de Management de la Qualité ISO 9001:2008. Après les efforts inlassables et le travail acharné du personnel de terrain ; AKHS,P obtient la Certification Internationale du Système de Management de la Qualité ISO 9001:2008, ainsi que le 1er Audit de Surveillance qui prouve que AKHS, P maintient des systèmes de qualité et assure l'amélioration continue de la qualité dans les montagnes du Nord du Pakistan.

St. Luke's Medical Center Global City – Projet Global Trigger Tool (GTT) (outil de déclenchement global)

Le Global Trigger Tool (GTT) (outil de déclenchement global) a été développé par l'**Institute of Healthcare Improvement (IHI) (Institut d'amélioration des soins de santé)**, pour identifier et de mesurer le taux d'événements indésirables au fil du temps dans un établissement de soins de santé. C'est une méthode d'échantillonnage qui utilise les « déclencheurs » dans la détection des événements et des préjudices indésirables aléatoires et qui mesure également les événements indésirables au fil du temps. Le groupe Qualité Sécurité des patients du centre médical St Luke - Global City a lancé la mise en œuvre du Global Trigger Tool (outil de déclenchement global) comme une solution proactive qui utilise des informations rétrospectives recueillies pour relever le défi croissant que les événements et les inconvénients indésirables imposent à l'institution dans le but ultime de l'amélioration de la sécurité des patients. Le centre médical St. Luke - Global City est le premier et le seul hôpital dans les Philippines à avoir implémenté et à utiliser le Global Trigger Tool (outil de déclenchement global).

Paradigme de l'insertion professionnelle des personnes handicapées dans la Fundació Integralia Vallès : Facteur clé de succès

Le Fundació Integralia Vallès est un centre de contact pionnier en Europe qui a impliqué la création d'un centre de soins de santé de référence géré exclusivement par des personnes ayant une déficience et des maladies dégénératives pour permettre leur développement professionnel et ensuite l'insertion sur le marché du travail. L'environnement créé dans le cadre de ce projet permet une formation efficace et un renforcement des compétences, de la capacité et de l'expérience de travail ainsi que de promouvoir la responsabilité sociale des entreprises parmi un groupe de population qui est à risque d'exclusion. Le principal facteur

de différenciation de la Fundació Integralia Vallés est la qualité du service fourni par son personnel, qui est particulièrement sensible aux questions de santé, et qui donne une dimension professionnelle et humaine à toutes les préoccupations.

Formation cognitive pour patients atteints de démence dans les programmes Thérapie communautaire & art thérapie « Bonne école de la Mémoire de Goyang Centenarian »

L'Hôpital Myong Ji a lancé l'« équipe de projet du service de santé publique » pour la première fois en Corée comme une institution privée pour faire avancer et gérer des projets et des services de santé publique d'une manière plus structurée. Notamment, la Bonne école de la mémoire a délibérément dispensé divers programmes d'art-thérapie aux personnes avec un risque élevé de démence dans l'objectif de promouvoir la prévention de la démence et de maintenir un esprit positif et un corps sain dans toutes les activités quotidiennes requises pour la vie des personnes âgées. Les patients qui ont participé ont exprimé leur satisfaction remarquable, et les programmes de thérapie de l'art ont non seulement démontré l'efficacité du renforcement de l'état mental des patients ayant une déficience cognitive, mais ont également proposé une option de traitement non pharmacologique possible, ce qui favorise la qualité de leur vie quotidienne et réduit le fardeau pour leurs aidants.

Pourquoi les hôpitaux et les payeurs recommandent les services de santé à domicile à décharge à la place des services d'infirmiers qualifiés ou des services traditionnels de santé à domicile

- Modèle hospitalier alternatif de paiement des primes aligné avec le choix du patient -

Les personnes âgées et les autres patients de l'hôpital aux États-Unis ont toujours eu la possibilité d'être transférés dans un service d'infirmiers qualifiés (maison de convalescence) pour les phases post-aiguës, ou à la maison avec des soins infirmiers et des services de thérapie fournis à domicile. Traditionnellement, ces services à domicile ont été qualifiés de « santé à la maison ». Comme plus d'américains ont pris leur retraite, les services de soins à domicile ont été développés et sont facilement accessibles. Cette croissance a mis un stress énorme sur le Fonds d'assurance-maladie qui paye les services de soins aux personnes âgées. Toutefois, les « soins à domicile », qui traditionnellement ont été considérés comme des services non médicaux à domicile, sont également devenus une industrie en plein essor pour le coût conscient ces dernières années, comme plus d'américains atteignent l'âge de la retraite. Avec l'adoption de la Loi sur protection des patients et des soins abordables en 2010, les fournisseurs et les payeurs sont maintenant responsables des soins de la phase post-aiguë et de la santé continue des patients, donc les coûts des solutions efficaces pour les soins de phase post-aiguë sont en plein essor. Pour la première fois dans l'histoire, les hôpitaux américains et les assureurs reconnaissent les soins à domicile comme un modèle efficace qui permet de mener à bien la réforme Triple objectif des soins de santé. Les sons à domicile, qui ne sont plus complètement des services non-médicaux, se sont avérés être une partie intégrante de la continuité des soins pour les personnes âgées au cours des dernières années et sont en train de devenir une solution viable pour garder les patients, tout en honorant toujours leur désir d'être et de guérir à la maison. Cet article analyse les avantages et les risques des soins à domicile et explique clairement pourquoi les hôpitaux américains préconisent de ne pas utiliser les services d'infirmiers qualifiés et les services de santé à domicile, préférant, à la place, orienter les patients directement vers les soins à domicile comme solution de décharge préférentielle dans un modèle basé sur la valeur.

Le pouvoir de conduire le changement Travailler ensemble pour l'excellence

Créer une amélioration continue du cadre de l'engagement du consommateur pour l'excellence dans les soins centrés sur le patient

L'Organisation mondiale de la santé a reconnu la sécurité du Patient qui reçoit des soins hospitaliers comme un problème grave de santé publique mondial, la responsabilisation du patient et l'engagement de la communauté sont une clé pour améliorer continuellement la sécurité et la qualité des soins pour les meilleurs résultats possibles pour la clinique et pour le patient. En Australie, la mise en place de dix normes obligatoires nationales de sécurité et de qualité du service de en 2011 santé a servi de catalyseur pour que tous les établissements de santé revoient leurs systèmes.

Norme 2 : Le partenariat avec des consommateurs a nécessité des établissements de santé en Australie pour évaluer l'engagement et la capacité de l'engagement et de participation du consommateur et de la communauté. À cette époque, le Royal Brisbane and Women's Hospital n'avait pas une perspective stratégique et de compréhension ou une structure organisationnelle pour s'engager avec les consommateurs (patients, familles, les soignants et membres de la communauté). Le concept a exigé un nouveau modèle pour remplacer le modèle de médecin-chef de file des soins de santé en vedette historiquement en Australie, avec un changement de culture et la base des processus opérationnels de partenariat avec les consommateurs à tous les niveaux du système, en allant des soins aux patients individuels jusqu'à la participation à l'élaboration de politiques, à la planification des services de santé et à la livraison et au processus d'évaluation et de mesure. Le défi pour l'hôpital était de construire un cadre durable et d'engagement pour un véritable modèle de soins centré sur le patient inspiré des meilleures pratiques et de faire preuve de leadership et de s'engager à développer comme un secteur d'excellence en ce qui concerne l'engagement patient et l'expérience. Un cadre efficace et durable pour les consommateurs et un engagement communautaire ont été intégrés dans l'hôpital, avec le changement de culture qui en résulte, la réalisation d'accréditation dans tous les principaux critères de développement pour le partenariat avec les normes de consommation, y compris plusieurs « Met » avec notations de mérite.

Diminuer les interférences et le temps passé pour le transfert de l'information sur les changements des postes des infirmiers

L'échange d'informations cliniques sur des patients est une composante commune dans les changements d'équipe en soins infirmiers où les professionnels ont peu de temps pour transférer ces informations. Il n'y a aucune méthodologie standardisée ou structurée pour transférer des informations, ce qui nécessite

plus de temps pour le faire. De plus, au cours de l'échange, quelques interruptions peuvent perturber la communication entre les professionnels, ce qui peut affecter la sécurité du patient. Une étude descriptive a été menée pendant cinq mois, le transfert de l'information auprès des infirmières a été changé afin de déterminer quelle interruption a augmenté le temps consacré au changement d'équipe et, par conséquent, a diminué la sécurité des patients pédiatriques. Les résultats obtenus sur le type d'interruption nous ont conduits à repenser l'organisation qui comprend les soins aux patients pédiatriques.

Initiatives d'amélioration du Service de réanimation dans un hôpital régional de réadaptation à Hong Kong

L'accès difficile aux équipements de réanimation et la disposition d'instrument non normalisés en chariots causerait des difficultés pour les membres de l'équipe d'accéder à un équipement d'urgence approprié pour fournir un service de réanimation rapide à l'hôpital Tung Wah Eastern Hospital (TWEH). Des initiatives d'amélioration ont été mises en place en septembre 2012, après approbation par le sous-comité de la réanimation : (i) normalisation et installation d'équipements de réanimation, y compris les chariots de réanimation, défibrillateurs automatiques de secours, trousses de médicaments d'urgence et trousse d'équipe désignée de réponse (DRT) ; (ii) révision des lignes directrices impliquant le flux de travail, déploiement du personnel et des zones désignées pour la réanimation pendant les différentes heures de service et (iii) formation du personnel au moyens d'ateliers et de vidéos. Des exercices périodiques de réanimation ont été réalisés après la formation et le debriefing a donné une opportunité pour la discussion et le retour du personnel en première ligne. Le résultat de l'audit de conformité pour cet exercice et la performance du personnel dans les exercices ont été améliorés, montrant que les initiatives ont réussi.

Améliorer la réussite de la gestion stratégique à l'aide du Big Data

La gestion stratégique consiste à déterminer les objectifs de l'organisation, à mettre en œuvre d'un plan stratégique et à allouer correctement les ressources. Le manque d'accès aux données pertinentes et opportunes ne permet pas d'identifier des objectifs cliniques, empêche l'allocation efficace des ressources et génère des pertes à partir des prévisions inexactes. La perte d'efficacité opérationnelle diminue le flux de valeur, a un impact défavorable sur la qualité des soins aux patients et entrave la gestion stratégique efficace. Nous avons mis au point une approche à l'aide du big data pour créer un avantage concurrentiel en identifiant les tendances dans la pratique clinique, en anticipant avec précision les besoins futurs et en allouant stratégiquement des ressources pour un impact maximum.

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Resumen en Español

HOSPITAL YACHIYO ; Centro de *SUPER CARE MIX* – Atención integral de Emergencias al Hogar para la comunidad

La ciudad de Anjo cuenta con dos hospitales. El Hospital Kosei, un centro médico central para la atención especializada, y nuestro Hospital Yachiyo para la atención regional. Recientemente el Hospital Kosei se vio desbordado en su capacidad de consultas de emergencias y salas congestionadas debido a la falta de camas para pacientes post agudos.

Planificamos un proyecto para aliviar la congestión del hospital central y gestionar los pacientes post-agudos.

Creación y Aplicación de una cadena de gestión Hospitalaria Perfeccionada

El desarrollo a gran escala ha sido bastante común en el último período de industrialización hospitalaria en China. Hoy en día, la gestión de los Hospitales chinos enfrenta problemas como ineficiencia del servicio, elevados costos de los recursos humanos y bajo porcentaje de capital utilizado. Este estudio analiza la cadena de gestión perfeccionada del Hospital Wuxi No.2 People. Éste se compone de seis engranajes, concretamente «estructura organizativa, práctica clínica, servicios ambulatorios, tecnología médica, cuidados de enfermería y logística.» Los engranajes se basan en «objetivos de sistemas de gestión plana, Jefe de personal médico, servicios ambulatorios centralizados, exámenes médicos intensificados, gestión vertical de enfermería, logísticas socializadas.» Los conceptos fundamentales de la gestión hospitalaria perfeccionada son optimización de los procesos de flujo, reducción del derroche, mejora de la eficiencia, ahorro de costos y buena atención para los pacientes como el más importante.

Calidad, Seguridad y Atención Centrada en el Paciente - Un Sueño hecho Realidad en las Montañas del Norte de Pakistán

Un proyecto ganador del «Premio 2015 a la Calidad, Seguridad y Atención centrada en el Paciente» en Chicago, EE.UU.

El Norte de Pakistán sigue siendo una tierra de grandes desafíos debido a las severas condiciones climáticas durante todo el año, con una infraestructura, recursos humanos y una cadena de suministro que es un reto de por sí. Muchas veces las estructuras deben desplazarse a diferentes lugares en emergencia y bases ad hoc debido a los aludes y terremotos que afectan la continuidad de la asistencia. Ofrecer calidad de asistencia sanitaria a menudo con limitaciones de recursos, en zonas de difícil acceso ha sido siempre la única fuerza del AKHS,P. Superando barreras para que la población de captación acceda a la atención sanitaria de calidad, AKHS,P emprendió una iniciativa de implemetación, mejora y manteniendo del Certificado ISO 9001:2008 de conformidad con las normas internacionales de Gestión de Calidad.

Este artículo comparte la experiencia única de AKHS,P en la mejora y el mantenimiento de la Certificación del Sistema de Gestión de Calidad Internacional ISO 9001:2008. Después de una labor incansable y de un duro trabajo del personal de campo; AKHS,P alcanzó la certificación del Sistema de Gestión Internacional de Calidad ISO 9001:2008 así como la 1° Auditoria de Control que demuestra que el AKHS,P mantiene sistemas de calidad y asegura la mejora continua de la calidad en las Montañas del Norte de Pakistán.

Proyecto St. Luke's Medical Center Global City – Global Trigger Tool (GTT)

El Global Trigger Tool (GTT) fue desarrollado por el **Institute of Healthcare Improvement (IHI)**, para identificar y medir el porcentaje de eventos adversos con el tiempo en un centro sanitario. Es una metodología de muestreo que emplea «indicios» para detectar eventos aleatorios adversos y perjuicios midiendo, además, los eventos adversos con el tiempo. El Grupo de Calidad y Seguridad del Paciente del Centro Médico St. Luke - Ciudad Global comenzó la implementación del Global Trigger Tool como una solución proactiva empleando información retrospectiva recopilada para orientar el desafío creciente que los eventos adversos y los daños imponen a la institución con el objetivo último de mejorar la seguridad del paciente. El St. Luke's Medical Center Global City es el primer y único hospital de Filipinas que implementa y emplea el Global Trigger Tool.

Modelo de Integración Profesional para Personas Discapacitadas de la Fundació Integralia Vallès: Factores Clave del Éxito

La Fundació Integralia Vallès es un centro de contacto pionero en Europa que se ha involucrado en la creación de un centro de atención sanitaria de referencia gestionado exclusivamente por personas discapacitadas y con enfermedades degenerativas para permitir su desarrollo profesional y, en última instancia, su integración al mercado laboral. El ambiente creado con este proyecto permite la formación efectiva y el desarrollo de habilidades, capacidades y experiencias de trabajo y estimula la responsabilidad social en un grupo de la población bajo riesgo de exclusión. El factor primordial de diferenciación de la Fundació Integralia Vallés es la calidad del servicio prestado por su personal, que es particularmente sensible a los problemas de salud y que ofrece una dimensión profesional y humana en cada atención.

Entrenamiento Cognitivo para Pacientes con Demencia de la Comunidad y Programas de Terapia Artística de la ‘Goyang Centenarian’s Good Memory School’

El hospital Myong Ji presentó por primera vez en Corea el ‘equipo de trabajo del Servicio Sanitario público’ como una institución privada que lleva adelante y gestiona proyectos y servicios de sanidad pública de manera más estructurada. Especialmente la Escuela Goyang Centenarian’s Good Memory voluntariamente ofreció varios programas de terapia artística para aquellos individuos con alto riesgo de demencia con la intención de promover la prevención de la demencia y de mantener una mente positiva y un cuerpo sano para quienes solicitaban actividades diarias para la vida de los ancianos. Los pacientes participantes expresaron una extraordinaria satisfacción y los programas de terapia artística mostraron no solamente la eficacia en fortalecer el estado mental de los pacientes con deterioro cognoscitivo sino que además propuso una opción terapéutica no farmacológica factible, que favorece su calidad de vida cotidiana y disminuye la carga de sus cuidadores.

Por qué Hospitales y Pagadores están recomendando la Atención Domiciliaria después del alta en lugar del SNF o de los Servicios Sanitarios Domiciliarios Tradicionales

- Modelo de pago alternativo de Incentivos Hospitalarios de acuerdo con la Elección del Paciente-

Los ancianos y otros pacientes hospitalarios en los Estados Unidos tradicionalmente han tenido la opción de ser llevados a centros de enfermería especializados (centros de convalecencia) para servicios post agudos o en el hogar con servicios de enfermería y terapia suministrados en el ámbito doméstico. Tradicionalmente, estos servicios suministrados en el domicilio se conocen como «asistencia médica domiciliaria». A medida que más americanos se jubilan, los servicios de asistencia médica domiciliaria se han ido expandiendo y volviendo de fácil acceso. Este crecimiento sometió a un tremendo estrés al fondo Medicare que paga por los servicios de asistencia a los ancianos. En cualquier caso, la “asistencia domiciliaria,” que tradicionalmente se ha visto como un servicio domiciliario no médico, se ha convertido en una industria en auge por el costo consistente en los últimos años dado que más americanos alcanzan la edad de la jubilación. Con la aprobación de la Ley de Atención Médica Asequible en 2010, proveedores y pagadores son ahora ellos mismos responsables de la atención post aguda y de la atención continua del paciente, por lo tanto las soluciones rentables para la atención post aguda están prosperando. Por primera vez en la historia, los hospitales americanos y las aseguradoras reconocen la Atención Domiciliaria como un modelo efectivo que consigue el triple objetivo de la reforma de la asistencia sanitaria. La asistencia domiciliaria, que ya no es completamente un servicio no médico, ha demostrado en los últimos años ser una parte integrante de la asistencia continua para ancianos y actualmente se ha convertido en una solución viable para mantener bien a los pacientes, respetando su deseo de envejecer y curarse en el domicilio. Este estudio analiza los beneficios y los riesgos de la atención domiciliaria y ofrece una comprensión clara de por qué los hospitales americanos están enfatizando evitar el SNF y pasando por alto la atención médica domiciliaria, optando en su lugar por enviar directamente a los pacientes a la atención domiciliaria como la solución preferida después del alta en un modelo centrado en el valor.

El poder de impulsar el cambio: Trabajando juntos por la excelencia

Creando una estructura comprometida con el usuario y en constante mejoramiento para lograr la excelencia en la atención del paciente

La Organización Mundial de la Salud ha admitido la Seguridad del Paciente mientras recibe atención hospitalaria como un serio problema de salud pública global siendo la participación de la comunidad y la potenciación del papel del paciente las claves para mejorar continuamente la seguridad y la calidad de la atención a fin de conseguir los mejores efectos clínicos y para el paciente. En Australia, la introducción en 2011 de diez Normas Nacionales del Calidad y Seguridad para el Servicio Sanitario proporcionó el catalizador para que todas las estructuras sanitarias revisaran sus sistemas.

Norma 2: La colaboración con los Usuarios requería instalaciones sanitarias en toda Australia para evaluar el compromiso y la capacidad de la comunidad y de los usuarios para participar y comprometerse. A su vez, el Hospital Royal Brisbane and Women’s no tenía una perspectiva estratégica ni el conocimiento ni una estructura organizativa para interactuar con los usuarios (pacientes, familias, cuidadores y miembros de la comunidad). El concepto requería un nuevo modelo que reemplazase el modelo de médico principal de la sanidad históricamente característico en Australia, con un cambio de cultura y de los procesos fundamentales empresariales a asociar con los usuarios a todos los niveles del sistema, desde la asistencia a cada paciente mediante la participación en la evolución de la política, la planificación del servicio sanitario y de suministro y los procesos de evaluación y medición. El desafío para el hospital fue crear una estructura sostenible dedicada para un modelo de atención genuino centrado en el paciente, informado mediante las prácticas idóneas, ofreciendo liderazgo y compromiso para desarrollarse como un área de excelencia comprometida y con experiencia para el paciente. Una estructura exitosa y sostenible comprometida con el usuario y la comunidad se incorporó al hospital, dando como resultado un cambio de cultura, obteniendo certificaciones en todos los temas fundamentales y criterios desarrollados para colaborar con las normas del usuario incluyendo varios objetivos alcanzados con calificaciones con mérito.

Disminución de interferencias y Tiempos de espera en la Transferencia de Información en los Cambios de Turnos de Enfermería

El intercambio de la información clínica de los pacientes es un componente normal en los cambios de turnos de enfermería donde los profesionales cuentan con un tiempo limitado para transferir esta información. No existe una metodología estructurada o normalizada para la transferencia de información, que requiere un tiempo cada vez mayor para completarse. También durante el cambio, se presentan algunas

interrupciones que pueden interrumpir la comunicación entre los profesionales y que pueden acabar afectando la seguridad del paciente. Un estudio descriptivo se llevó a cabo durante cinco meses, el mecanismo de transferencia de la información entre enfermeras se cambió para establecer qué interrupción aumentaba el tiempo empleado en el cambio de turno y, de ese modo, disminuía la seguridad de los pacientes pediátricos. Los resultados obtenidos sobre el tipo de interrupción nos llevó a repensar la organización que incluye la atención de los pacientes pediátricos.

Iniciativas de mejoras en el Servicio de Reanimación en un Hospital Regional de Rehabilitación en Hong Kong

El acceso limitado a equipos de reanimación y a estructuras con instrumental no estandarizado en carros puede causar dificultades para los miembros del equipo para acceder a equipos de emergencia apropiados para ofrecer un servicio de reanimación inmediato en el Hospital Tung Wah Eastern (TWEH). Las iniciativas de mejoramiento se implementaron en septiembre de 2012 después de la aprobación por parte del subcomité de reanimación: (i) estandarización e instalación de equipos de reanimación incluyendo carros de reanimación, kit de medicamentos de emergencia, desfribriladores automáticos de emergencia, personal responsable designado (DRT); (ii) revisión de las líneas de trabajo en relación con el flujo de trabajo, distribución del personal y áreas designadas para la reanimación durante las diferentes horas de servicio y (iii) formación del personal mediante cursos de capacitación y vídeos. Un simulacro periódico de reanimación tuvo lugar para comprobar la preparación del personal después de la formación y la reunión ofreció una oportunidad para discutir y comentar con el personal de primera línea. El resultado de la auditoría de conformidad para este ejercicio y la preparación del personal en los simulacros mejoró, demostrando que las iniciativas fueron exitosas.

Mejoramiento del Éxito de la Gestión Estratégica empleando Big Data

La gestión estratégica involucra objetivos organizativos determinantes, el establecimiento de un plan estratégico y la asignación de recursos de forma apropiada. El escaso acceso a los datos pertinentes y oportunos identifica incorrectamente los objetivos clínicos, impide la asignación efectiva de recursos y genera el despilfarro debido a previsiones imprecisas. La pérdida de eficiencia operativa disminuye el flujo de valor, impacta negativamente en la atención del paciente y afecta la gestión estratégica efectiva. Somos pioneros en proponer el uso de big data para crear ventajas competitivas identificando las tendencias de las prácticas clínicas, anticipando con precisión las necesidades futuras y asignando estratégicamente los recursos para lograr la máxima eficacia.

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中文摘要

八千代医院；*高级护理中心——为社区而设的从急诊到家庭的综合性护理*

安静市有两家综合医院。俱知安医院是一家提供高级护理的中央医疗中心，而我们八千代医院主要从事区域护理。最近，因为急诊病人过多，俱知安医院面临满员的问题，而且，由于急性患者后期护理病床短缺，病房也人满为患。

我们计划了一个项目来缓解中央医院超负荷，管理急性患者的后期护理。

高级医院管理链的建立和应用

大型开发项目在中国的医疗产业化后期是很常见的现象。今天，中国的医院管理面临着诸多问题，例如服务效率低下、人力资源成本高、资本使用率低，等等。本研究分析了无锡第二人民医院的高级管理链。它主要由六个部分组成，分别是"组织结构、临床实践、门诊病人服务、医药技术和护理与后勤"。这几个部分基于"单一管理目标、医疗人员领导、集中式门诊病人服务、密集型医疗考核、垂直护理管理和社会化后勤"。高级医院管理的核心理念是优化流程、减少浪费、提高效率、成约成本和患者至上。

质量、安全和患者至上的护理——在巴勒斯坦北部山区，这一梦想成真。

美国芝加哥"2015年质量、安全和患者至上护理奖"的获奖项目

因为全年气候条件恶劣，巴勒斯坦北部的区域条件很差，为基础设施、人力资源和供应链提出了挑战。因为滑坡、地震，这家机构在出现紧急特殊情况时多次改变工作场所，从而影响了护理工作的持续性。向资源受限、交通不发达的地区提供高质量的护理服务一直以来都是巴勒斯坦AKHS医院的专长。巴勒斯坦AKHS医院打破了蓄水区人口为获得高质量保健服务的障碍，启动了一个项目来实施、获得和保持ISO 9001:2008质量管理系统国际标准的认证。

本论文分享了巴勒斯坦AKHS医院获得ISO 9001:2008国际质量管理体系认证的独特经历。通过地勤人员的不懈努力和艰苦奋斗，这家医院通过了ISO 9001:2008国际质量管理系统认证和1级监督审查。这本身就证明了巴勒斯坦AKHS医院在北部山区维持了质量系统，确保了医疗质量的持续提升。

圣鲁克医疗中心国际化城市——全面性触发工具（GTT）项目

由美国健康照护促进机构（IHI）开发的全面性触发工具（GTT）用来发现和测量医疗机构中不良事件的长期发生率。这种采样方法使用了"触发"技术在侦测随机不良事件和危害。它还可以长期计量不良事件。"圣鲁克医疗中心——国际化城市"的"质量与患者安全小组"开始实施全面性触发工具，并将它作为前摄性方案，通过使用收集的历史信息来解决因为不良事件和危害对机构形成的与日俱增的困难。其最终目标是提高患者安全。圣鲁克医疗中心国际化城市是菲律宾群岛第一家也是唯一一家实施和使用全面性触发工具的医院。

Fundació Integralia Vallès残疾人专业整合的案例主键字：成功因素

Fundació Integralia Vallès是欧洲的一个先锋联系中心。它建立了一个完全由残疾人和变性疾病患者来管理的保健咨询中心来让这群人有职业发展，并最终进入劳动力市场。这个项目所创建的环境为这个被外界排斥的人群提供了有效的培训，提升了他们的技能、能力和工作经验，并促发了他们的社会责任感。Fundació Integralia Vallès最主要的不同之处在于其服务质量由自己的人员提供，他们对保健问题特别敏感，在每件需要关注的事情上提供了专业和人性的空间。

社区痴呆患者的认识性训练与艺术治疗法计划"Goyang百岁老人的好记性学校"

Myong Ji医院在韩国首次启动了"公众健康服务项目小组"这个私营机构来以更为结构化的方式来发展和管理公共健康项目和服务。值得一提的是，Goyang百岁老人好记性学校特别向那些有高痴呆风险的学员提供了各种艺术课程，希望这样能促进痴呆症的预防，并且为老年人的生活所需的日常活动保持积极的想法和健康的身体。参与这个项目的患者表现出了极大的满意度。这个艺术治疗项目不仅展示了有认知系统损伤患者的精神状态增强的效果，而且也提出了一种可行的非药理学疗法的选择。这种疗法提升了患者的日常生活质量，减轻了其护理人员的负担。

为什么医院和付款方建议出院后采取家庭护理而不是专业疗养院或传统家庭保健服务

——符合患者需求的其他支付模式院方激励机制

传统上，美国的老年人和其它入院患者可以选择在出院以后进入专业疗养院（休养所）进行急症后期护理，或者在家里进行护理或接受治疗服务。传统上，这些在家里提供的服务项目被称为"居家照护"。由于美国的退休人员越来越多，居家照护业规模也有所扩大，能满足大众的需求。因为老年人护理服务是由联邦医疗基金支付的，这一增长对联邦医疗基金造成了很大的压力。但是，随着越来越多的美国人进入退休年龄，传统上被视为非医疗类家庭服务的"家庭护理"因为其得当的成本控制，在近年来高速发展。随着2010年《平价医疗法案》的通过，供应商和支付方发现他们需要对急症后期护理和患者的持续健康负责，于是，低成本的急症后期护理方案越来越繁荣。美国的医院和保险公司有史以来第一次把家庭护理当作一种有效的模式来配合"保健的三个目的"这项改革。家庭护理不再是绝对的非医疗服务。它被证实是近年来老年人护理系统中的一部分，并且正在成为一项可行的方案，在保证患者健康同时能让他们在家养老并得到护理。本文分析了家庭护理的优点与风险，明确地解释了为什么美国的医院会强调避免专业疗养院和

居家照护，而向患者直接推荐家庭护理作为一种价值模式下的理想出院护理方案。

推动变革的动力：共同合作，共创佳绩

构建持续改善型消费者参与框架，提供优质的患者护理服务

世界卫生组织发现住院治疗是一个严重全球公共健康问题后，已认可了“患者安全”计划。其中，患者的权力和社区参与是持续改进住院治疗安全与质量的关键，有助于尽可能达到最佳的临床和患者效果。在澳大利亚，2011年实施的十条强制性《国家安全与质量健康服务标准》为国内所有的保健机构审查自己的系统提供了激励机制。

标准2：“与患者合作”要求澳大利亚的卫生保健机构对消费者、社区配合和参与的承诺与能力进行评估。这个时候，皇家布里斯班妇女医院没有战略性观点和理解，或者组织结构来配合消费者（患者、家庭、护理人员和社区成员）。这一理念要求用新的模式来替代澳大利亚传统上以诊所为先导的卫生保健模式，从文化和核心业务过程上在系统的各个水平上配合消费者，从单个患者的照料到政策开发的参与、保健服务计划与交付，和评估与计量过程。院方的难点，在于通过最佳操作的指导，为真正以患者为中心的护理模式建立一个可持续的框架，并为发展提供领导和承诺，从而在患者参与和经历上形成良好的氛围。医院已经成功地包含了适用于消费者和社区接合的可持续性框架，形成了文化上的改变，在与消费者配合标准上，所有核心和发展标准赢得了信任，并获得了多个优秀等级。

减少护士换班时信息交接所需的工作和时间

交接患者的临床信息在护理人员换班的过程中是一项常规任务。而在这个过程中，这些专业人员用来交换信息的时间非常有限。这些信息的交接没有标准或结构性的方法，因为这些方法会增加这个过程的时间。另外，在交接过程中，一些事情也会打断专业护理人员的交流，从而可能影响患者的安全。一项描述研究已经进行了五个月，它改变了护士之间的信息交接安排，来决定哪些事情会增加换班时间，从而危及儿科患者的安全。从这类事情中所得到的结果使我们去更进一步地思考包括儿科患者护理中的安排情况。

香港的区域内康复医院恢复服务的改善运动

有限的康复设备和手推车不标准的仪器布局会为东华东院（TWEH）向小组成员提供适当的紧急设备用来及时进行康复服务造成困难。在2012年9月得到康复委员会的许可以后，开展了一系列改进运动：（1）康复设备的标准化及安装，包括康复推车、紧急药品箱、自动紧急去纤颤器和专门的反应小组（DRT）工具箱；（2）工作流程修改后的再版指南、员工部署和为各个服务时间指定的康复区域，以及（3）通过小组和视频进行员工培训。我们举办了定期康复演练来监督员工经过培训后的表现，而一线员工的简要说明提供了讨论的机会和适当的反馈。这项练习的合规审查结果和员工的训练表现都得到了提升，确定了这是一项成功的行动。

用大数据提升战略管理的成功率

战略管理涉及决定机构目标、实施战略计划，和适当分配资源。缺乏及时的相关数据就不能发现临床目标、防止资源有效分配，并会由于不准确的预测而产生浪费。运营效率降低会减小价值流、对患者护理质量造成不利影响，并妨碍有效的战略管理。通过使用大数据，我们首创了一条途径，通过发现临床实践中的趋势、准确地预计未来的需求，和为强化影响而战略性地分配资源来形成竞争优势。

IHF events calendar

2016

IHF

40th World Hospital Congress
October 30 – November 1, Durban, South Africa
Visit www.worldhospitalcongress.org
For more information, contact sheila.anazonwu@ihf-fih.org

2017

IHF

41st World Hospital Congress
November 7 – 9, Taipei, Taiwan
For more information, contact sheila.anazonwu@ihf-fih.org

2016

MEMBERS

AUSTRIA
National Congress
May 9 – 11, Villach, Austria
Bundesministerium Für Gesundheit
www.buko-krankenhaus.at

BELGIUM
Annual Congress
June 1, Diamant Center, blvd Auguste Reyerslaan, 80, 1030 Brussels, Belgium
Association Belge Des Hopitaux - ASBL
www.hospitals.be/announced-events.php

GS1 HEALTHCARE CONFERENCE - DUBAI
April 18 – 20, 2016, Marriott Hotel Al Jaddaf, Dubai, UAE
IMAGINE one world, one standard, one vision: improving PATIENT SAFETY
GS1 AISBL
http://healthcare-event.gs1.org/

COLOMBIA
5th International Health Forum - MEDITECH 2016
June 28 – July 1, Centro Internacional de Negocios y Exposiciones, Corferias, Bogotá
Asociacion Colombiana De Hospitales
www.meditech.com

FRANCE
Paris Healthcare Week
May 24 – 26, Paris Expo, Paris, France
Federation Hospitaliere De France
www.parishealthcareweek.com

World Cancer Congress
Theme: Mobilising Action, Inspiring Change
October 31 – November 1, Palais des Congrès, Porte Maillot, Paris
Unicancer – Federation Francaise Des Centres De Lutte Contre Le Cancer
www.worldcancercongress.org

GERMANY
German Hospital Conference
November 14 – 17, Düsseldorf Fairgrounds, Düsseldorf, Germany
German Hospital Federation
www.medica.de

HONG KONG
Hospital Authority Convention 2016
May 3 – 4, Hong Kong Convention and Exhibition Centre
Hospital Authority
www.ha.org.hk/haconvention/hac2016

INDONESIA
Regional Seminar
Theme : Strategy to Win Hospital Market Through Optimum Human Resource in Asean Economic Community and Universal Health Coverage Era.
April 19 – 21, Grand City Convex, Surabaya, Indonesia
Indonesian Hospital Association
www.pdpersi.co.id; www.hospital-expo.com (Conference is in local language)

KOREA
The 7th Korea Healthcare Congress 2016
November 17 – 18, Ninetree Convention, Seoul, Korea
Korean Hospital Association

NORWAY
National Congress, Rehabilitation
May 19 – 20, Oslo Kongressenter, Oslo
Norwegian Hospital & Health Service Association (Event is in Norwegian)

PORTUGAL
6th International Hospital Congress
November 24 – 25
Theme: Innovation in Health – Myth or reality?
Portuguese Association for Hospital Development (APDH)
www.apdh.pt/

USA
AHA Annual Meeting
May 1 – 4, Washington Hilton, Washington DC, USA
Theme: Leadership-Advocacy-Transformation
American Hospital Association
www.aha.org

UK eHealth Week
April 19 – 20, Olympia London, UK
HIMSS
www.ukehealthweek.com

2016 VIZIENT CONNECTIONS SUMMIT, *(VIZIENT members only)*
April 14 – 15, Bellagio, Las Vegas, USA
Theme: Connections Summit - Vizient

2017

MEMBERS

2017 Congress on Healthcare Leadership
March 27 – 30, 2017, Hilton Chicago/Palmer House Hilton
American College of Healthcare Executives
www.ache.org

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: sheila.anazonwu@ihf-fih.org or visit the IHF website: https://www.ihf-fih.org/ihf-events

International Hospital Federation

STUDY TOUR

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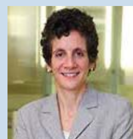
Key Speaker:



Prof. Sherry Glied
Dean of New York University's Robert F. Wagner Graduate School of Public Service; Former Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, where Prof. Glied played an extensive role in drafting the policy contents of President Barak Obama's Affordable Health Care Act.
Policy Overview: *Implications of the Affordable Health Care Act*

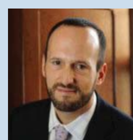
Program, Visit & Meetings Facilitator:

Eric de Roodenbeke, PhD
Chief Executive Officer
International Hospital Federation

Approached Institutions and Proposed Speakers:

Office of the Commissioner of Health, New York Department of Health
Policy Overview: *Expanding Coverage to Vulnerable Populations*

Dr. Kenneth L. Davis
President and Chief Executive Officer
Mt. Sinai Hospital and Health System
Clinical Excellence: *The New Era of Accountable Care*



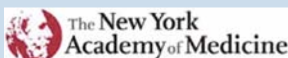
Orin Herskowitz
Executive Director & Vice-President Intellectual Property & Technology Transfer
Columbia University Technology Ventures
Research & Development: *Frontiers in Bio Medical Research*

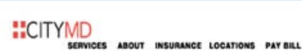
Dr. Jo Ivey Boufford, President
New York Academy of Medicine
Health in the Community: *Bridging the Network of Community Care*

Mr. Alexander Preker
President & Chief Executive Officer, and Former Chief Economist for Health
World Bank
Health Insurance & New Exchanges: *Interface between Investment and Financing*

Proposed Site Visits and Face- to-Face dialogue with Key Executives

Columbia University
Medical Center





PARTICIPATION

__Early Bird__

US$ 2000/person (includes 4½ day study programme, facility visits and 3 dinners;

½ Day private programme organised upon request

Deadline for full payment is on 31 March 2016

US$ 2500 after 31 March 2016
Min 15 – Max 25 participants on first come, first serve basis

IHF Members get 10% discount contact IHF Secretariat for discount code

__To register:__
http://www.eventbrite.com/e/new-york-2016-ihf-hospitals-and-health-services-study-tour-tickets-21495216772?utm_source=eb_email&utm_medium=email&utm_campaign=new_event_email&utm_term=viewmyevent_button

__Closing date:__ 15 May 2016

Participants will be responsible for covering service fees

__Download Provisional Program:__
Please go to https://www.ihf-fih.org/activities?type=training

Transportation:
Participants are responsible for organizing and covering their local and international travel costs

Accommodation:
Recommended Study Tour Hotels:
Hotel Wales / Hotel Courtyard
Participants will be responsible for making their reservations. Participants may select other hotels close to the recommended hotels

Food:
Participants will be responsible for covering lunch for the 5 days and 2 dinners

FOR MORE INFORMATION, CONTACT:
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International Hospital Federation
Email: sheila.anazonwu@ihf-fih.org
Tel: +41 22 850 9422

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