



***University of Iowa Health Care***  
***Presentation to***  
***The Board of Regents, State of Iowa***  
***June 11-12, 2008***

## ***Today's Agenda***

- Replacement Hospital Additions and Renovations
  - Architectural Selection and Organizational Structure
- Ambulatory/Outpatient Facilities Project
- Communicating Our Vision
- Hardwiring Patient Safety at UI Health Care



***Replacement Hospital Additions  
and Renovations:***  
**Architectural Selection and Organizational Structure**

**Gordon Williams**

Interim Chief Executive Officer, UIHC

## ***Architectural Selection Committee***

Michael Artman, M.D.

Jean Robillard, M.D.

Mr. Jose Fernandez

Paul Rothman, M.D.

Mr. Ken Fisher

John Staley, Ph.D.

Mr. Tim Gaillard

Craig Syrop, M.D.

Mr. Rod Lehnertz

Mr. Doug True

Ms. Chris Miller

Ron Weigel, M.D.

Ms. Joan Racki

Ann Williamson, Ph.D., R.N.

Mr. Gordon D. Williams, Chair

Mr. Brandt Echternacht,  
Committee Staff

## ***Architectural Selection Process***

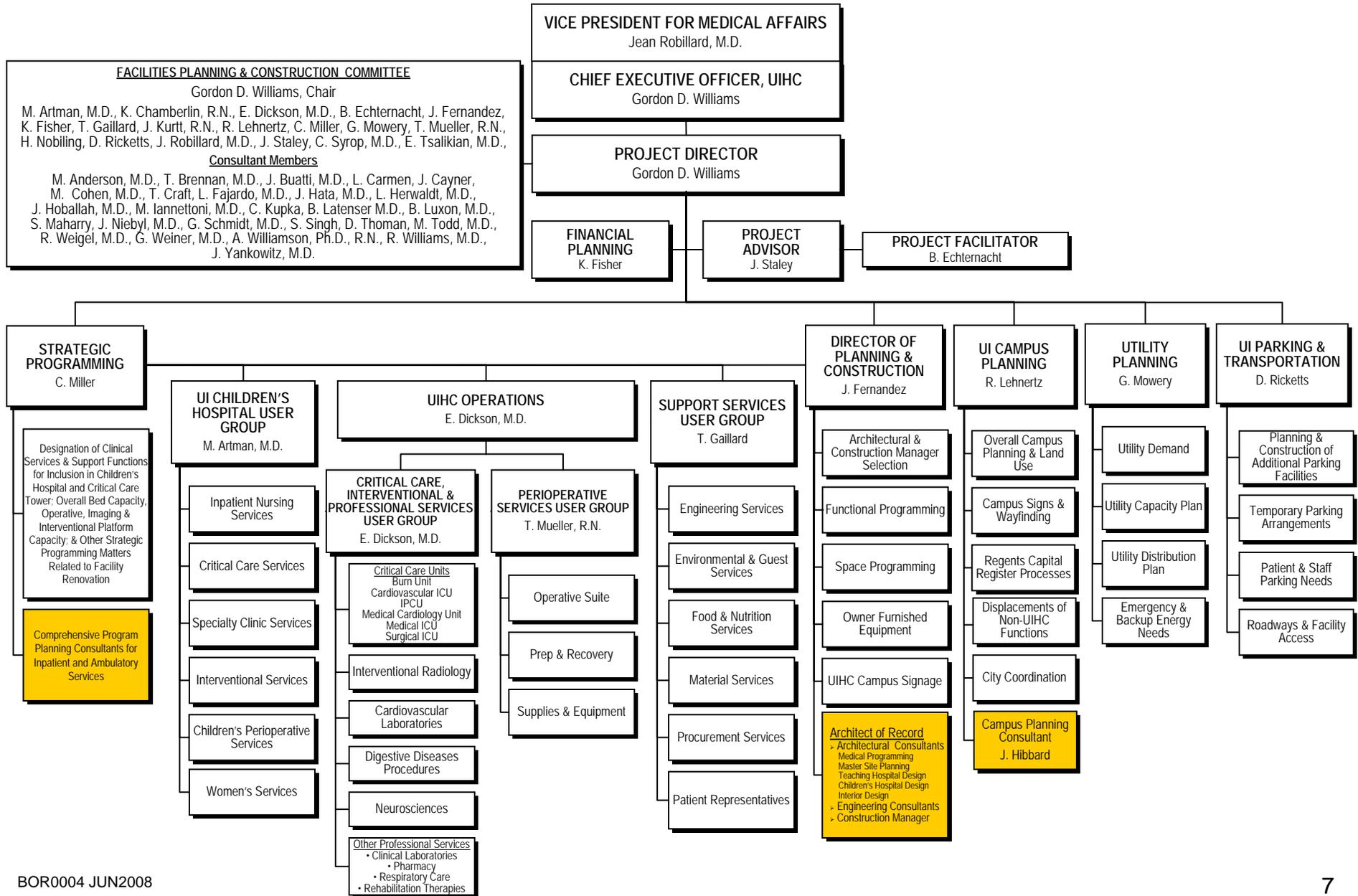
Process to select Architect of Record completed:

- Nine Iowa-based firms responded to UIHC's request for submission of qualifications
- Following review of materials submitted, Architectural Selection Committee chose three firms for interviews
- On May 5 the Architectural Selection Committee met with each firm. Based on the three firms' presentations and documents, ***Heery International*** (Iowa City office) was selected as Architect of Record

## ***Architectural Selection Process (Cont'd.)***

- Process to select Design Architect initiated by April 10 correspondence to 15 national firms requesting submission of qualifications
- Thirteen national firms submitted qualifications and four were selected for initial on-site discussions
- Of these four, three have been selected for presentations to the Architectural Selection Committee and one will be selected as Design Architect

# ORGANIZATIONAL STRUCTURE FOR PLANNING AND CONSTRUCTING REPLACEMENT HOSPITAL ADDITIONS AND RENOVATING CURRENT FACILITIES



## ***Facilities Planning and Construction Committee***

- Committee meets on first and third Mondays each month
- Initial meetings in May devoted to:
  - Discussing overall organizational structure for planning and constructing replacement hospital additions and renovating current facilities
  - Role and membership of the Facilities Planning and Construction Committee
  - Recommendations from Kurt Salmon Associates for the UIHC Strategic Facilities Master Plan
  - Status of strategic operational and functional facility planning
  - Status of architectural selection process
  - Establishment of subcommittees



## **Ambulatory/Outpatient Facilities Project**

**Ken Fisher**

Associate Vice President for Finance and CFO, UI Hospitals and Clinics

**Christine Miller**

Assistant Vice President for Integrated Strategic Planning

## ***Key Steps***

- Background
- Goals
- Guiding Principles
- Proposed Solution
  - Site
  - Process
  - Timeline
  - Outcomes

## ***Background***

- Current situation and key issues
  - Patient volumes over 750,000 visits per year
  - Limited parking
  - Constrained road system
  - Continuous growth of our ambulatory patient volume
  - Additional clinic growth on main campus would increase congestion and parking issue
  - Increased demand for inpatient admissions to UIHC

## **Goals**

- Create new operating model for ambulatory patient care.
- Create a model environment for ambulatory care training
- Integrate clinical trials into ambulatory care clinic
- Create a patient-friendly ambulatory campus with easy access and way-finding
- Create improved access (geographic and convenience) to UIHC services and physicians, while reducing congestion within the campus
- Move significant programs and administrative functions off campus to provide opportunity for on-campus growth

## ***Guiding Principles***

- Exemplify patient/family-centered care
- Enhance interdisciplinary collaboration
- Provide an environment that supports the highest level of quality and safety
- Incorporate “evidence-based design” concepts
  - Create environments that are therapeutic, healing, supportive of family involvement, efficient for staff performance and restorative for workers under stress.
- Allow for future flexibility through design
- Incorporate leading-edge technology

## ***Guiding Principles (cont'd)***

- Incorporate Lean design to support highest operational efficiency
  - Eliminate non-value-added waste in both process of development and in the design of the products themselves
- Provide leadership in “sustainable design”
  - Designing physical objects and the built environment to comply with the principles of economic, social and ecological sustainability (aka “green design,” eco-design,” or “design for environment”)

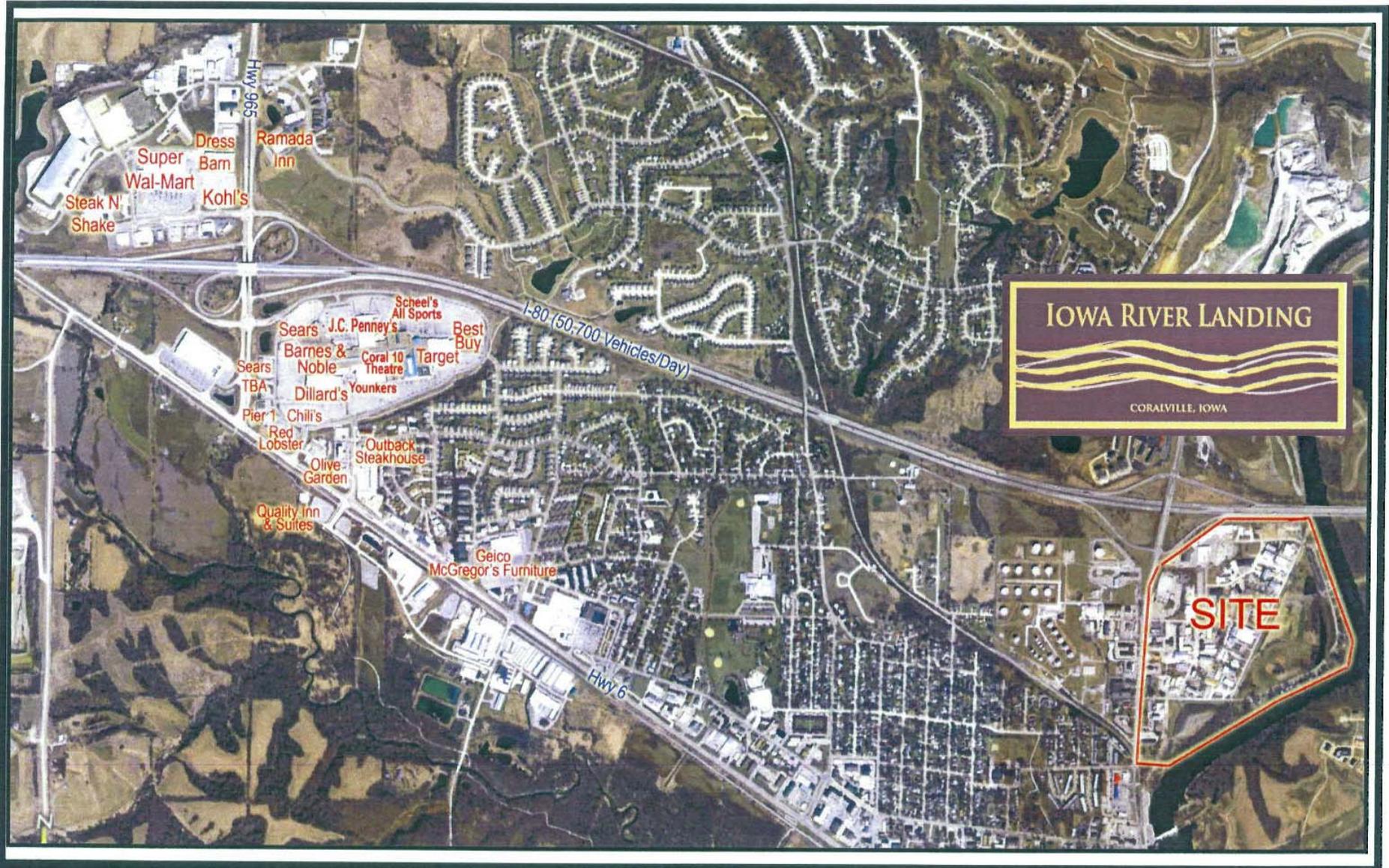
## ***Proposed Solution***

- Site
  - Iowa River Landing, Coralville
  - UI Health Care has been in active conversation with the City of Coralville about the site
  - Location – east of 1<sup>st</sup> Avenue and south of I-80
  - Size – 156 acres
  - Timeline – over the next 15 years
  - Current development
    - Marriott, Coralville Convention Center, retail and housing, infrastructure

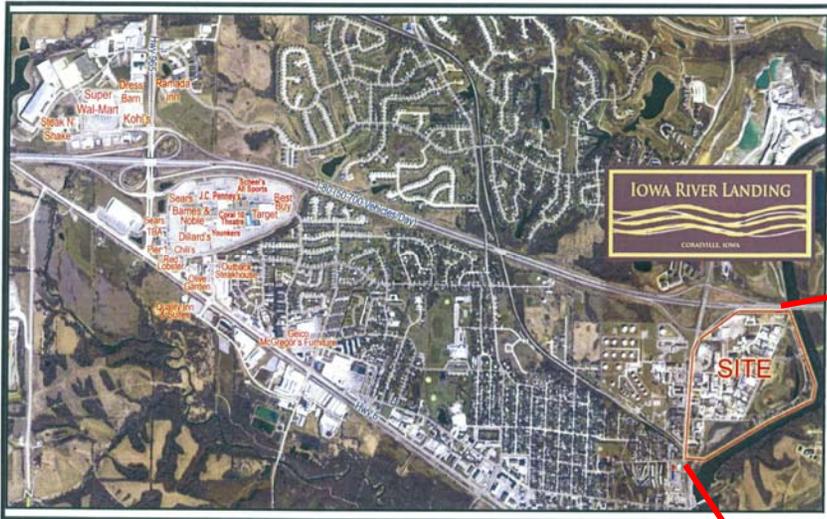
## ***Proposed Solution***

- Site
  - City owns all land east of 1<sup>st</sup> Avenue, north of 9<sup>th</sup> Street and south of I-80
  - Planned to be a new urban downtown for the City of Coralville including retail, office, housing, entertainment and lodging

# Iowa River Landing



# Iowa River Landing



## ***Proposed Solution***

- New Ambulatory Care Campus
  - Approximately 20 acres
  - Up to 500,000 gross square feet of medical office space and parking to support active campus
  - Four to six buildings in a range of size from 75,000 to 150,000 gross square feet
  - Park-like campus designed for easy patient access
  - Parking would be surface or ramp based as would be needed and could include some underground parking

## ***Proposed Solution***

- Types of clinics and services to be relocated to ambulatory campus currently under review
  - Homogenous clinics that have a large outpatient demand or mostly practice in an outpatient environment
  - Diagnostic services to support these clinics

## ***Proposed Form of Ownership/Lease***

- Move from ownership model to lease model
- Need to provide capital to support main campus development
- Availability of capital to support ambulatory development
- Other health care systems have moved this direction
- Faster development cycle

## ***Proposed Form of Ownership/Lease***

- Consider contracting with a national medical office building developer
  - Design
  - Build
  - Manage
  - Turnkey
- UIHC (or UI subsidiary) would master lease the completed facility
- UI would retain the right to purchase completed buildings at various points along the way

## ***Process***

- June 2008--Board of Regents to authorize proceeding with engagement of developer
- Complete discussions with the City of Coralville about ground lease and covenants/restrictions
- Issue “request for information and qualifications” that would include the following key provisions

## **Process**

- **Qualifications**
  - Willingness to develop up to 500,000 gross square feet over the next 10-15 years to our specifications
  - Methodology to understand the total cost of ownership for the effective useful life of the buildings
  - Willingness to include Iowa-based partners in the development group
  - Willingness to have an “open book” process of building the entire complex

## **Process**

- Qualifications (cont'd)
  - Willingness to allow purchase of the complex at key dates under terms and predetermined pricing methodology
  - Methodology to establish master lease payment, annual operating cost funding and building reserves
  - Other items to be identified
  - Establish due dates

## ***Target Dates***

- October 2008—Board of Regents to execute turnkey contract with selected firm and partners
  - Finalize clinical services to move
  - Present design concept of campus
  - Present design concept of the first buildings

## ***Target Dates***

- January 2008—Progress Report to Board of Regents on project status
  - Complete design of campus
  - Complete design of first buildings
  - Construction of site, initial buildings and parking
- Developer completes construction of site, initial buildings and parking by July 2010
- UIHC moves clinical operations into new building by September 2010



## Communicating Our Vision

**Terri Goren**

Goren & Associates

## ***Cohesive approach***

- For the first time, UI Health Care has a comprehensive marketing communications approach and philosophy that encompasses the entire enterprise and its priority initiatives:
  - UI Hospitals and Clinics
  - Carver College of Medicine
  - UI Physicians
  - UI Foundation
  - *Campus Evolution*
  
- Going forward, we communicate as one entity.

## ***Applied positioning***

***“As part of the University of Iowa, we bring together innovation, inspired ideas and an unmatched intellectual drive – a level of collaboration that improves the lives of patients today. Our recognized prominence in the pursuit of discovery and the dissemination of new knowledge transforms medicine in Iowa and beyond.”***

In short, ***Changing Medicine. Changing Lives.*** applied in all communications, enterprise-wide.

## ***Campus Evolution***

Communicating the Replacement Hospital Additions  
and Renovations

*Four-phase approach*

## ***Leveraging campus evolution:*** **Plan highlights**

- Build understanding about the **promise of the future**
- Inform audiences about impact and progress
- Reinforce the need for investing in the AMC mission:  
**higher quality care**
- Further enhance UI Health Care image and brand

## ***Audience focused***

- Consumers (community-at-large)
- Current and prospective donors
- Employees
- UI physicians
- Referring physicians
- Media
- Volunteers
- Business and civic leaders
- Alumni
- Prospective students
- Iowa political leadership

## ***Phase 1: Pre-construction***

- ***Relentlessly communicate via all channels:***
  - Educate audiences:
    - What's the plan? Why now? What it means to Iowans
    - What are funding opportunities?
  - Showcase milestones:
    - Architect selection
    - Timelines

## ***Phase 1: Pre-construction***

- ***Relentlessly communicate via all channels:***
  - Campaign theme tied to:  
*Changing Medicine. Changing Lives.*
  
- ***Create a micro Web site devoted to campus evolution project***
  - Push email program, construction web cams, virtual tours

## ***Phase 1: Pre-construction***

- ***Consumer communications***
  - Neighborhood communications program
  - Sunday newspaper supplement

## ***Phase 1: Pre-construction***

- ***Employee communications***

- Manager toolkit to explain plans, benefits
- Countdown to groundbreaking promotion

## ***Phase 2: Construction***

- ***Maintain ongoing exposure***
  - Proactive media relations program
  - Constant progress reports to all audiences  
(key milestones)

## ***Phase 2: Construction***

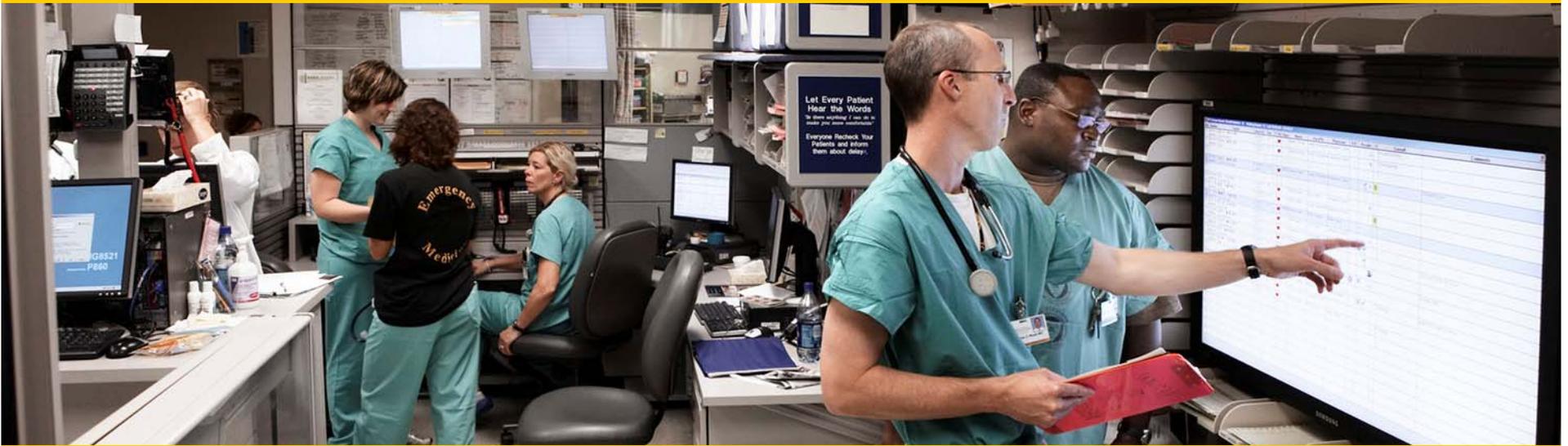
- ***Maintain ongoing exposure***
  - Regularly, widely communicate short-term changes
    - Temporary entrances, road closings, parking
  - Invite community participation
    - Selection of interior, exterior art

## ***Phase 3: Opening***

- ***Leverage opening opportunities***
  - Plan and host special opening receptions for select audiences
  - Develop informational DVD

## ***Phase 4: Post-opening***

- ***Continue communications via all channels***
  - Media opportunities: highlight “firsts”
  - Evaluate and refine wayfinding/signage



## Hardwiring Safety at UI Health Care

**Doug Merrill, MD**

Patient Safety Officer

**Eric W. Dickson, MD**

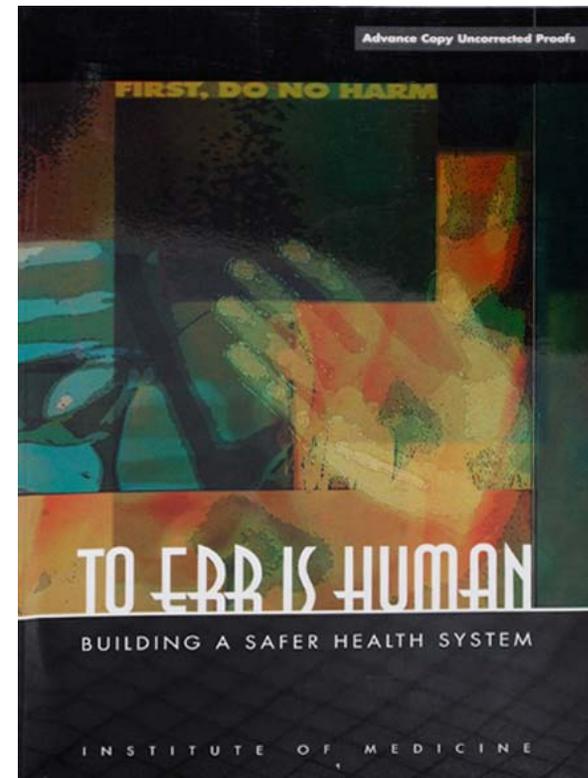
Interim Chief Operating Officer

## *Overview*

- The Institute of Medicine reports on the safety of our health care system
- What we are doing now to create a safe environment for our patients
- What we need to do if we want to become one of the best

## *To Err is Human, 1999*

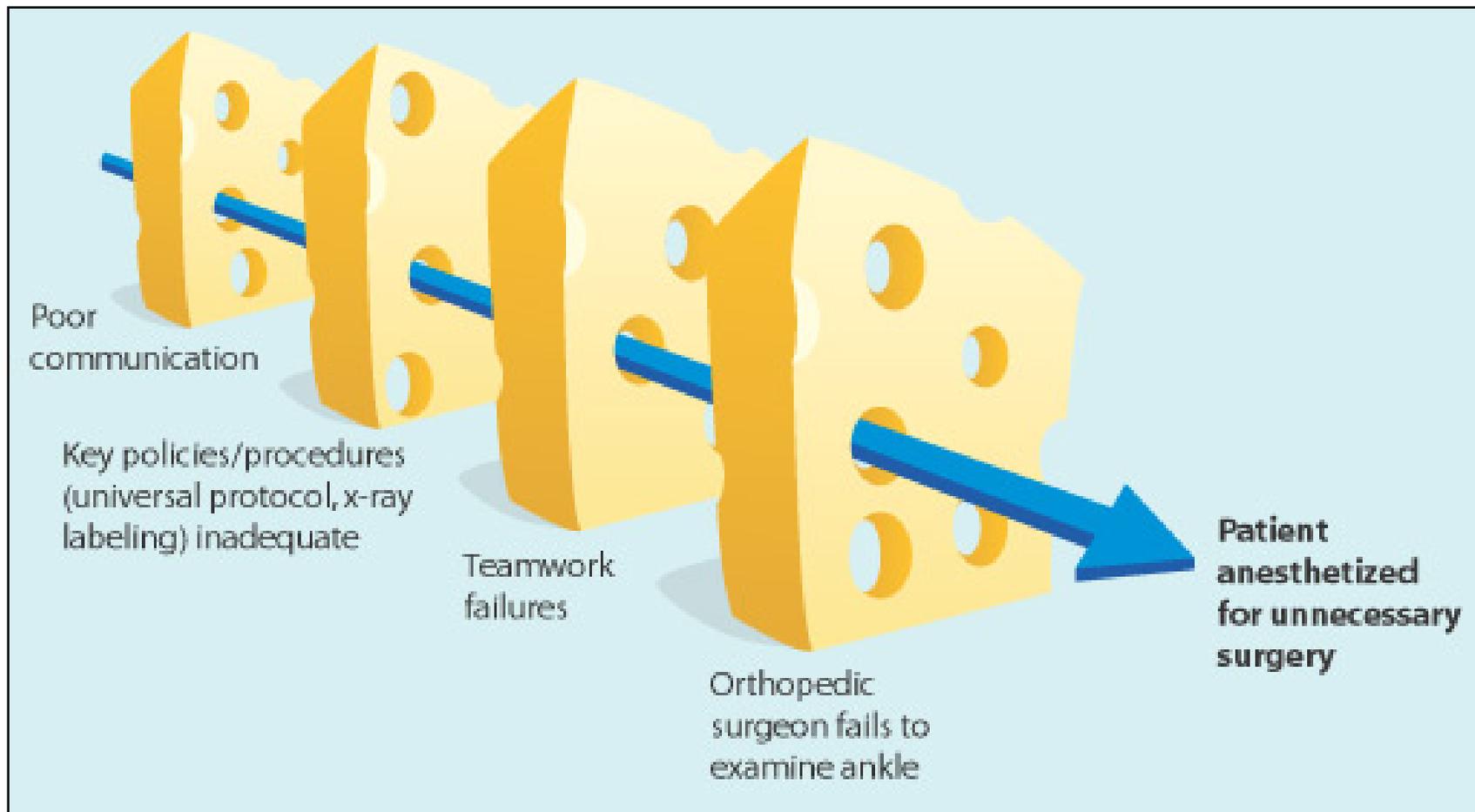
- 44,000 – 98,000 people die each year in the United States due to avoidable medical errors.



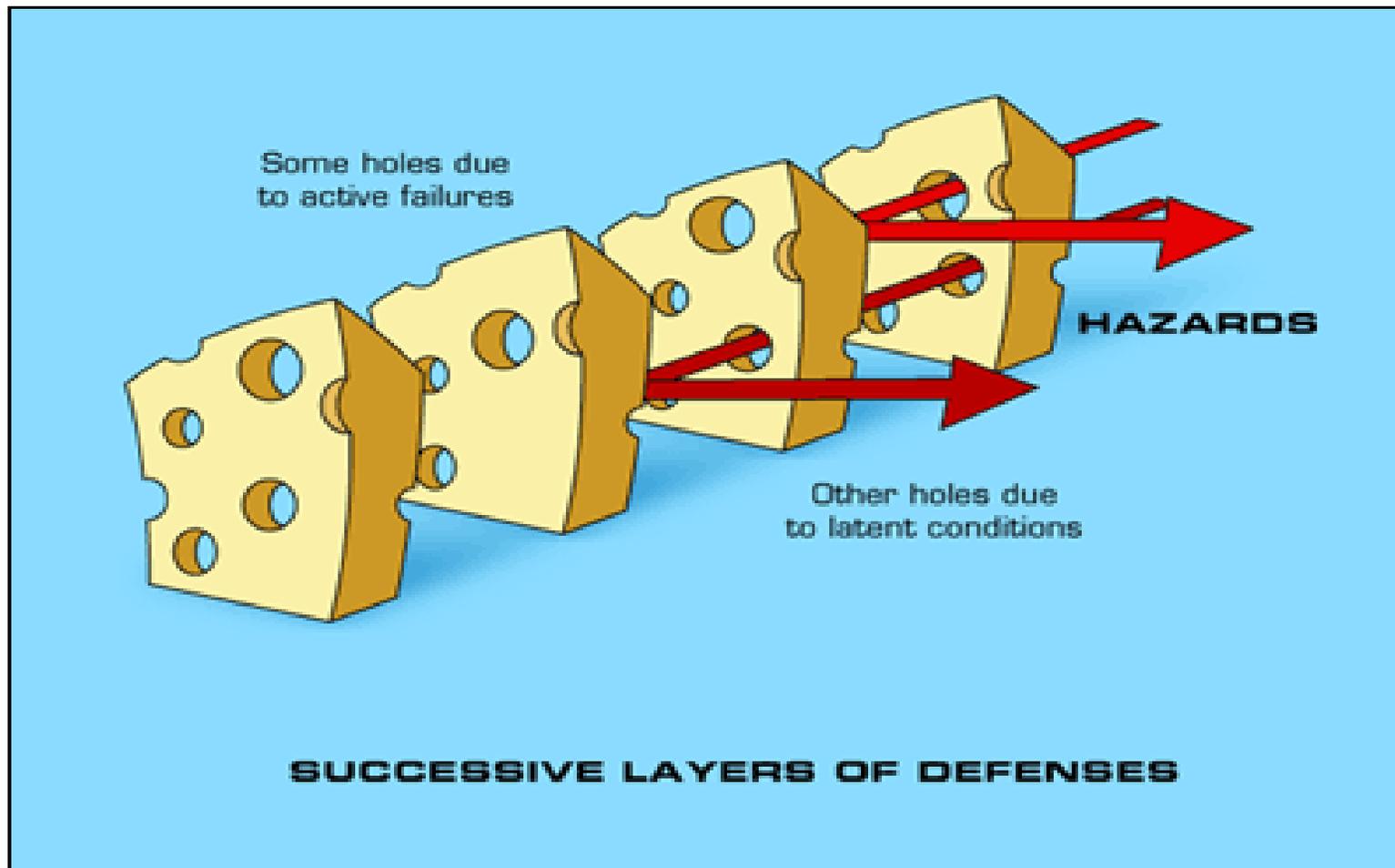
## ***Core Conclusions from IOM report***

- There are serious problems in safety of care
- The problems come from poor systems...not bad people
  - *In its current form, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves*
- We can fix it...but it will require changes

***Errors occur when “holes” in health care processes align.***



## *We need to patch the holes before an error occurs*



***What are we doing now at UIHC to create a safe environment for our patients?***

***We are constantly working to close the process holes by making it easy to report near misses***

- All front line caregivers have two jobs; taking great care of patients and finding ways to take better care of patients
- We make it easy for staff to report potential problems using the PSN (Patient Safety Net)

## ***The Patient Safety Net (PSN)***

- Web-based incident reporting system
- Reports patient, visitor and staff incidents at UIHC
- Available on all public workstations
- Easy to use in all settings
- Allows benchmarking with other academic medical centers



***We are also working to build error-free processes***

- The UIHC Computerized Barcode-Based Tracking System for Blood Transfusions has essentially eliminated blood transfusion errors.

## ***Epic: Technology improving safety***

- A major innovation now in progress at UI Health Care is the new electronic health record, Epic
- Electronic health record technology has been shown to markedly improve safety:
  - Computerized physician ordering
  - Automated alerts to medication allergies or incompatible medications
  - Automated alerts to abnormal labs or trends in vital signs

**Aspden P et al. *Patient Safety: achieving a new standard for care*. Natl Acad Press 2004.**

## ***Our Formula for Success***

**Clinical  
Expertise** + **Implementation  
Expertise** = **Great  
Results**

  
***Clinical Quality, Safety &  
Performance Improvement  
(CQSPI)***

## ***Clinical Quality, Safety & Performance Improvement (CQSPI) and Operational Improvement (OI) Representatives***

- Perform Root-Cause Analyses and address systems issues
- Develop real-time graphical displays of concurrent information
  - Results by provider
  - Status of metrics
- Share information with leadership and front-line staff

*(Will show here short video comparing our helicopter pilots' use of checklists to assure safety and our central line checklist)*



***We need to patch process holes by teaching residents and students to use standardized checklists***

***What is needed to make our UI Health  
Care system the safest it can be?***

**We are creating an environment of health care delivery, education and research in which the safety of our patients is the number one priority.**

## ***What makes health care safe?***

### **A passion for safety among the leadership:**

from the Board of Trustees to the CEO to the physician leaders, the CFO, the CNO, the nursing managers, and on down the line.

## *The single most important barrier to safe care*

- “Lack of inspired, consistent, and forceful leadership...**no organization can make the significant changes that are necessary to develop a culture of safety without vigorous leadership at the top...**”
- We need to reach higher in the organization and get boards of trustees of hospitals and Health Care organizations involved. **If boards have patient safety as a concern, then so will CEOs.**”

- Lucien Leape, Hlth Aff 2007;26:w687-96.

## ***What is this cultural change we are undergoing?***

- A culture of safety (a “just” culture):
  - Where every employee feels safe if they “stop the line” to fix errors or defects in the care we provide
  - Every employee looks for ways to make what he or she does safer for the patients
  - All employees know that they are expected to uncover their own errors and help find a way to prevent their recurrence
  - We reward discovery of error

## ***Safe Care Requires***

- **Systems** that consistently monitor for error to prevent it from causing harm
- A culture of **blameless evaluation of errors** to find ways to make them impossible to happen, not to shame those who commit them
- Physicians and nurses who embrace **teamwork** and shared decision-making
- Physicians and nurses who embrace the **best practice**, not “this works for me”
- **Education and research** that emphasizes these new ways of providing care

## ***What could we have?***

- In excess of \$20M savings on direct costs of care annually
- Safer management of lab specimens
- More accurate medication prescription and administration
- Fewer patient falls
- Automatic alerts to patients in failing health inside and outside the hospital
- Fewer cardiac arrests
- More highly trained hospitalists and intensivists available 24x7

## ***What could we have?***

- Training for our next generation of nurses, physicians and administrators to think of safety in every thing they do
- A higher level of continuing education for our current physicians, nurses, staff and administrators
- Advanced practice nurse safety teams rounding on “at risk” patients
- Wider use of simulation training to improve response to emergencies
- Better coordination of policies among hospital units to identify and replicate ‘best practices’

## ***Systems and Accountability***

- We need to make our **systems** of care excellent
- But we still insist on accountability
- We don't punish people for discovering error
- We don't reward people for ignoring it

**“Accountabilities drive structure and structure drives culture.”**

*F. Lee, If Disney Ran Your Hospital*

## ***Our patients expect us to keep them safe***

We will succeed if the Board, the President, the CEO  
and every member of the UI Health Care team puts

at the top of their personal list

the safety of every single patient, every family, every  
visitor, and every staff-member at UI Health Care.

***“Safety is the number one priority at UI Health Care”***

## ***Quality and Safety Council***

- Members:

- Co-Chair: Eric Dickson, MD
- Co-Chair: Richard LeBlond, MD
- Michael Cohen, MD
- Steve Hata, MD
- Charles Helms, MD
- Loreen Herwaldt, MD
- Douglas Merrill, MD
- Heidi Nobiling, RN
- Gregory Schmidt, MD
- Sabi Singh
- Craig Syrop, MD
- Debbie Thoman
- Marita Titler, PhD, RN
- Todd Wiblin, MD
- Gordon Williams
- Richard Williams, MD
- Ann Williamson, PhD, RN

**Role:**

- Commitment
- Accountability
- Review results of measures



***Questions?***