
VIZIENT CONNECTIONS SUMMIT
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THE POSSIBILITIES
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Service Line and Strategy Executives Peer to Peer Education Meeting

Unlocking Capacity, Driving Growth: Evolving Health System and Service Line Strategy

Welcome, Overview and Engagement

Kate O'Shaughnessy, Senior Member Networks Director

Shannon Raveendran, PI Program Director

Vizient

Rob Edwards, Chief Strategy and Growth Officer, UK HealthCare

Jill Engel, Service Line Vice President – Heart and Vascular, Duke University Health System

Disclosure of Financial Relationships

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Learning Objectives

- Outline current trends, market forces and strategic considerations influencing the evolution of health system service lines.
- Discuss strategies to increase capacity within your system to meet future patient demand.
- Identify common challenges and emerging solutions related to access, throughput and service line growth.

Welcome!

Wi-Fi is available!

- Reference the Summit app for connection details.

Nearest restrooms are to the left outside this room.

- Next closest restrooms are to the left and at the end of the hall by the escalator.

- Sign in on your tables.
- We'll collect satisfaction via polling at the end of the session. We value your feedback!
- This session offers Continuing Education (CE) credit. We'll provide instructions at the end of the meeting.

Thank you to the advisory/executive committees

Cancer Service Line Strategic Network

Alex Zafirovski

Vice President of Administration - Cancer Service Line, Northwestern Medicine

Cardiovascular Service Line Strategic Network

Jill Engel

Service Line Vice President - Heart and Vascular, Duke University Health System

Chief Strategy Officers Network

Rob Edwards

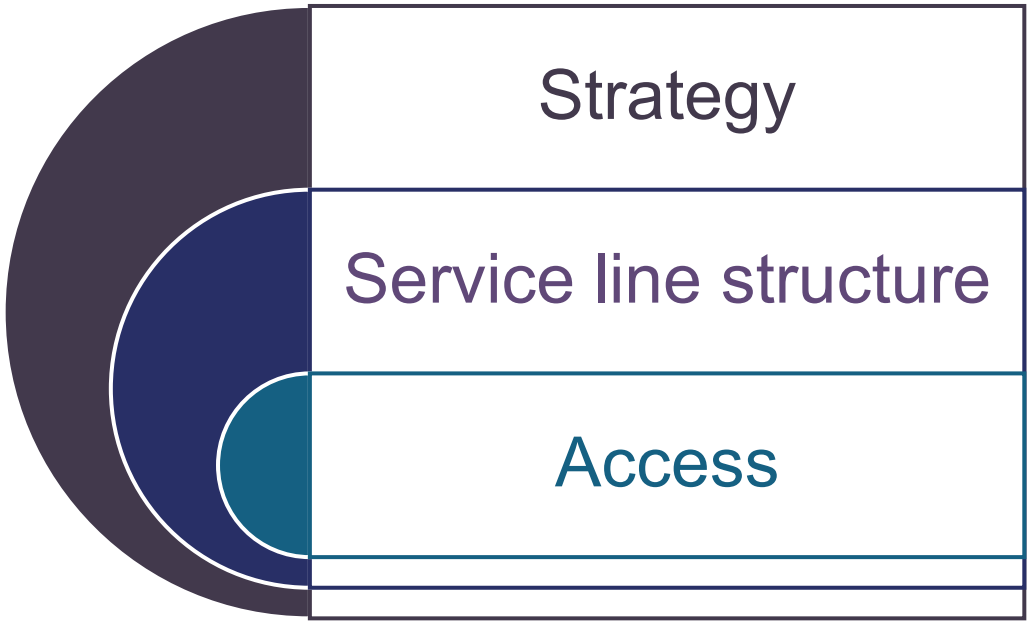
Chief Strategy and Growth Officer, UK HealthCare

Access – it's all we've been talking about and core to achieving market growth

Engagement questions

- Your role?
  - Strategy officer or other strategy leader
  - Service line executive or other service line leader
    - Cancer
    - Cardiovascular
    - Other or multiple
  - Operations executive leader
  - Other
- Medical group relationship?
  - Owned
  - Affiliated
    - How tightly?
  - Other or multiple
- Access constrained?
  - How do you measure?

Connecting the dots: A preview of today's meeting



- The state of strategy; turn strategy into action.
- Service line landscape; align service line authority and accountability.
- Patient access disruptors; redesign access.
- Hear from your peers on successes and challenges.
- **Take action at your organization.** Meet the demand in your market.

The State of Strategy: Navigating Healthcare's Next Horizon

Chad Giese, MBA, Vice President, Intelligence

Sg2, a Vizient company

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Which Planning Model is Right for You, Right Now?

	Pros	Cons
CENTRALIZED	• Leverages scale • Rationalizes capital expenditures	• Difficult transition post-merger • Loss of local market knowledge
HYBRID	• Balances corporate and local perspective • Common starting point post-merger	• Requires clearly defined roles
DECENTRALIZED	• Optimizes local market knowledge • Conveys less overt corporate control	• Lacks coordination • Leads to inefficient use of capital

Reasons to Lean Toward Centralized

- Standardization is a priority.
- Willingness to expand planning team
- Implementation expertise in pockets
- Service line leaders more operationally focused
- Newly formed system establishing brand
- Shift to value requires thoughtful distribution of services.

Reasons to Lean Toward Decentralized

- Local stakeholder buy-in is paramount.
- Far-flung geographies make local knowledge essential.
- Planning team small and unlikely to grow
- Pervasive culture of accountability
- Mature service lines with leaders who think strategically
- Organizational vision well established

Strategy Leaders Prioritize Relationships Across the Organization

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Top Priority Relationships

1. Service Lines
2. Medical Group
3. Hospital CEOs
4. Finance

Emerging Relationships

- Finance #1
- Service Lines, Med group
- Contracting/ ACO, facilities – big movers
- Hospital CEOs – biggest correction

Minimal Coordination

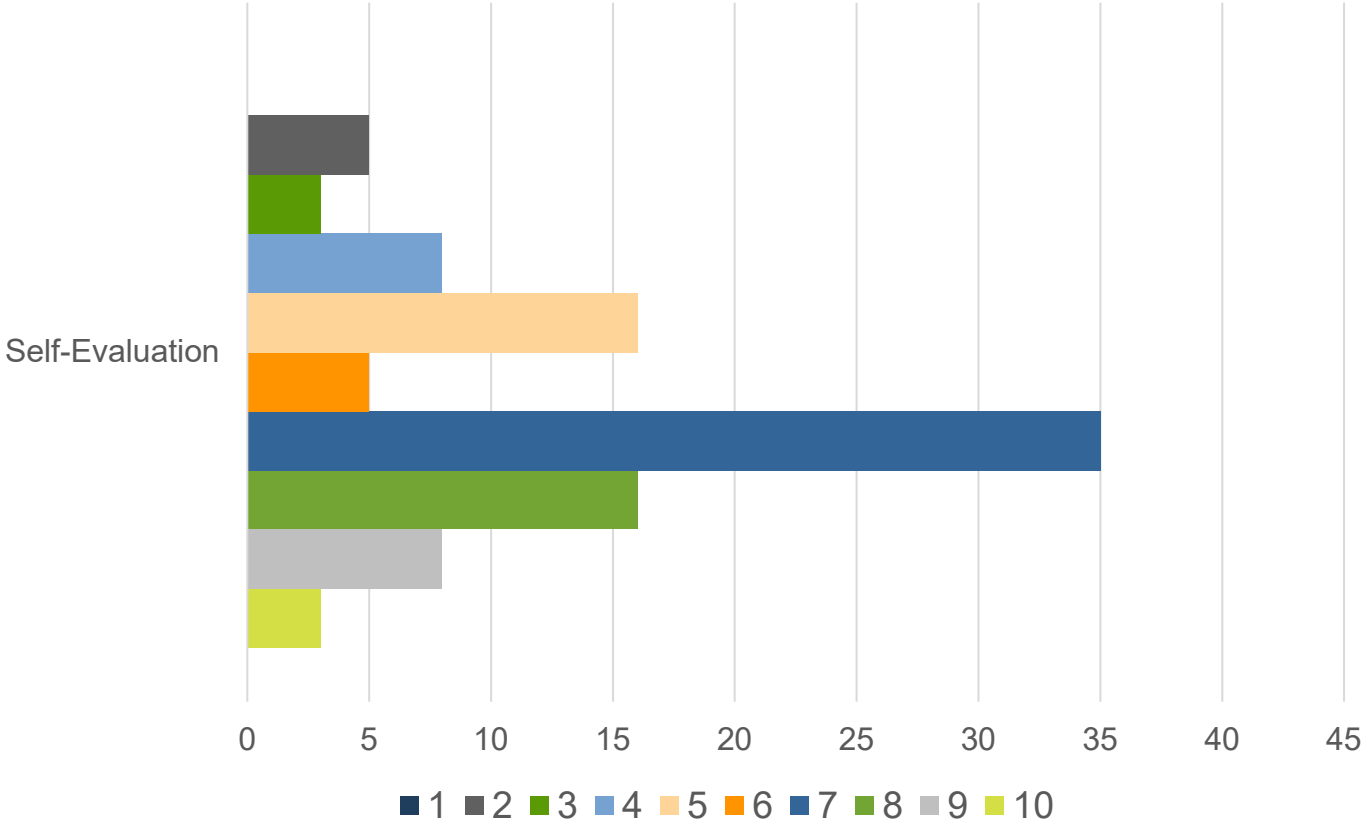
1. Contracting / ACO
2. Facilities
3. Marketing

Notes: For each survey question, the participants could choose up to 3 responses. Top priority Survey Prompt: Which teams are the top priority relationships for the strategy team? N = 56; Emerging Relationships Survey Prompt: Which teams do you anticipate you will need to spend more time within the future? N = 55; Minimal coordination: Which teams do you not coordinate with very much? N = 49

Pulse Survey Findings

How good is your organization at prioritizing strategic initiatives (10 = great)?

Total = 37



Themes

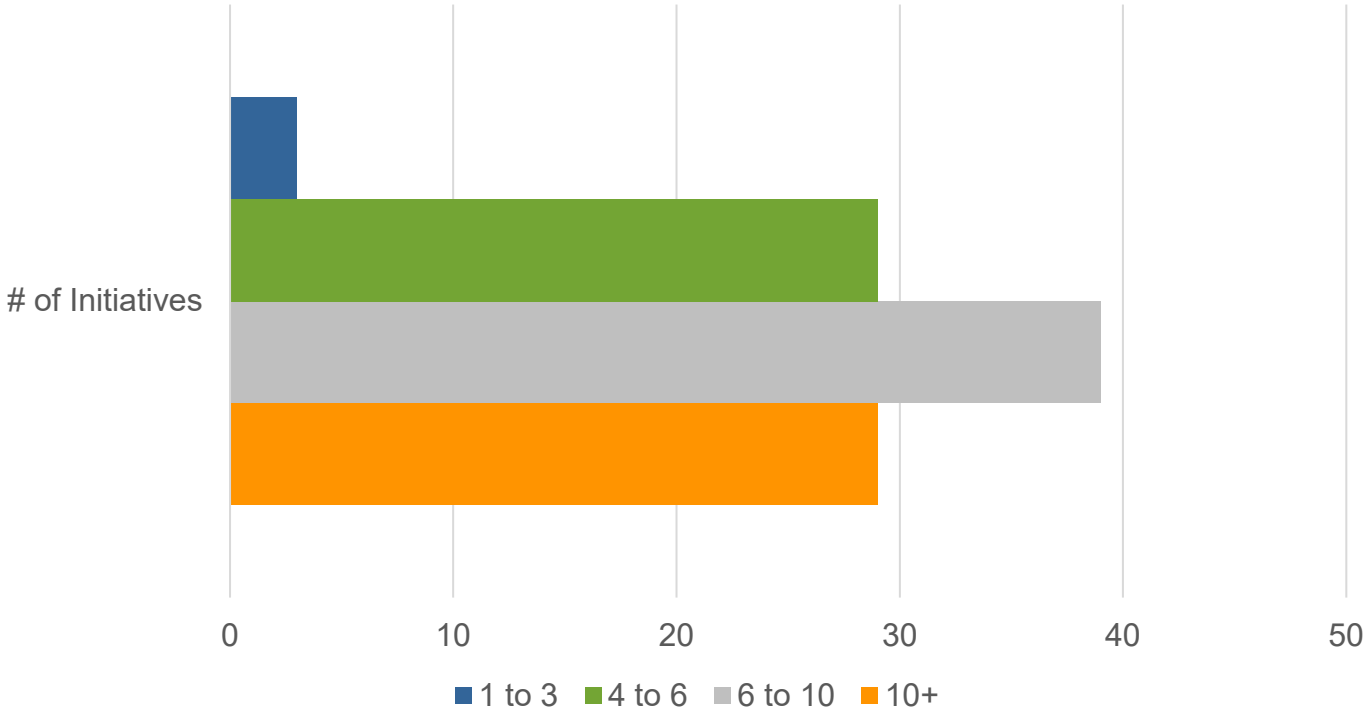
- Most organizations sit ‘somewhere in the middle’ (avg: 6.41)
- Potential to learn best practices from IT, PMO, market-based and SL teams
- Deselection remains elusive and/or work in progress

Source: Sg2 Strategy Exchange Pulse Survey February 2022, Sg2 report Next Generation Strategic Planning, 2019; Sg2 Analysis 2022.

Pulse Survey Findings

What's the ideal number of initiatives to track, manage and focus on?

Total = 38



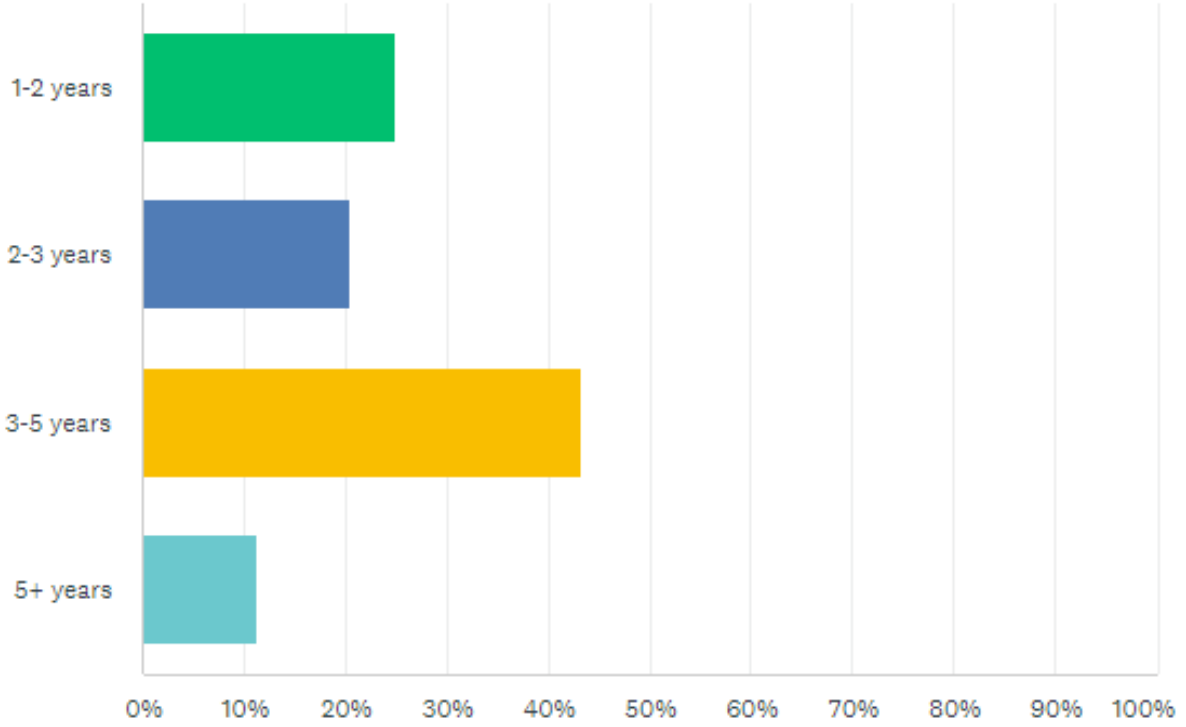
Trends and Story Lines

- Misalignment between 'ideal' and # of initiatives in strategic plans (range: 3 to 75+)
- Criteria for prioritization often includes
  - Alignment with vision, pillars, 'big rocks'
  - Financial: ROI, market share, margin
  - Senior leadership evaluation
  - Community impact

Source: Sg2 Strategy Exchange Pulse Survey February 2022, Sg2 report Next Generation Strategic Planning, 2019; Sg2 Analysis 2022.

2022 Strategy Exchange Snapshot: Enterprise Plan Timeframe

Timeframe for next enterprise strategic plan



- 61% are revisiting their enterprise plan right now
- Many are looking to incorporate new data; most commonly:
  1. More OP data
  2. Claims data/referral patterns
  3. Consumer insights
  4. Health equity/SDOH measures

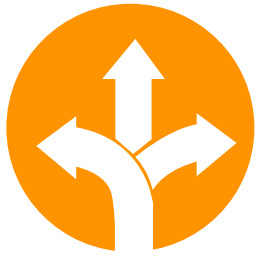
Source: Sg2 Strategy Exchange Pre-session survey, April 2022; 44 responses, Sg2 Analysis, 2022.

Don’t Separate Strategy Formulation From Execution

> “It’s impossible to have a good strategy poorly executed. That’s because execution actually is strategy—trying to separate the two only leads to confusion.”
>
> —Roger L Martin

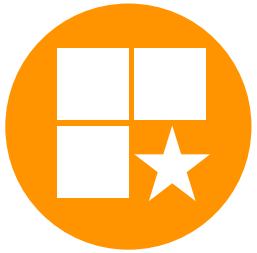
Source: Martin RL. Stop distinguishing between execution and strategy [blog]. *Harv Bus Rev*. March 13, 2015.

Why Are We Frustrated With Our Current Process?



1

Lack of **choice making** creates *overburden*.



2

Lack of **differentiation** creates *commodity*.

3

Lack of **effective alignment** creates *confusion*.

4

Lack of **rapid learning** creates *inertia*.

Source: Hunter, J. (2018). *Rapid Strategic Learning*. Catalysis. https://createvalue.org/wp-content/uploads/E-Manual-Rapid-Strategic-Learning-2.20.18.pdf. Accessed August 2025.

Questions?

Contact:

Chad Giese, chad.giese@vizientinc.com

This educational session is made possible through the collaboration of Vizient Member Networks.

UC DAVIS HEALTH

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Turning Strategy into Action: A Proven Approach to Aligning Goals and Driving Organizational Success

Jared Quinton, MHSM, CSSBB, Prosci, Interim Vice President
Jesika Krasts, MBA, CSSGB, CPHQ, Prosci, Interim Director
Caitlin Grassadonia, MHSA, CSSGB, Prosci, Senior Consultant
Jessica Koegel, MHA, DASM, CSSGB, Prosci, Senior Consultant
Daniel Norville, MBA, CSSGB, Prosci, Senior Consultant
UC Davis Health

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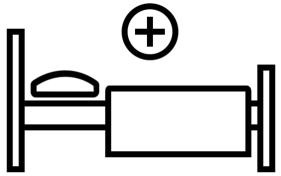
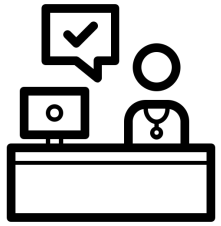
UC Davis Health – Our Mission

Grounded in equity, we provide unparalleled care across California, transforming lives and communities. Our teams research and develop trailblazing therapies and technologies, educate and prepare a future-ready workforce, and drive excellence into all we do.

Facts & Figures



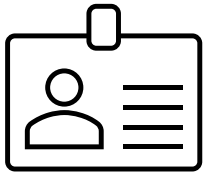
653
Licensed Beds



33,775
Admissions

1,023,188
Clinic/office visits

90,405
Emergency Room Visits



19,144
Employees

33 County
Service area

Bed count as of February 2025. Volume statistics for year ending Dec. 31, 2023

Meet the Strategic Alignment Team

Our team brings a wealth of experience within UC Davis Health, having collectively spent many years deeply embedded in the organization. Certified in change management and holding additional credentials in process improvement, we excel at driving both strategic alignment and operational efficiency. Our expertise in analysis, problem-solving, and strategic thinking allows us to consistently provide valuable insights to the UC Davis Executive Team, helping to align organizational goals across all levels. We work to ensure that every part of the organization is moving in the same direction, supporting the long-term success and sustainability of the enterprise. Known for our adaptability and flexibility, we are always ready to tackle new challenges and contribute wherever needed.

Caitlin Grassadonia
Senior Consultant
UCDH Tenure: 4 years

Jessica Koegel
Senior Consultant
UCDH Tenure: 4 years

Jared Quinton
Interim Vice President
UCDH Tenure: 18 years

Jesika Krasts
Interim Director
UCDH Tenure: 10 years

Daniel Norville
Senior Consultant
UCDH Tenure: 4 years

Our Journey to Aligned Goal Setting

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Past
Chaotic and Siloed

50+ annual goals and measures across the health system.

Divisions created their annual goals in insolation.

No system, structure, or process to drive momentum for achieving goals.

Present
Align and Focus

12 institutional goals that align with our 3 primary drivers of excellence.

1 unified framework for how we ladder goals to divisions and teams.

Future
Enable and Improve

Annual goals shift to **quarterly** goals to accelerate improvements across our health system.

Progress on goals is regularly recognized and celebrated

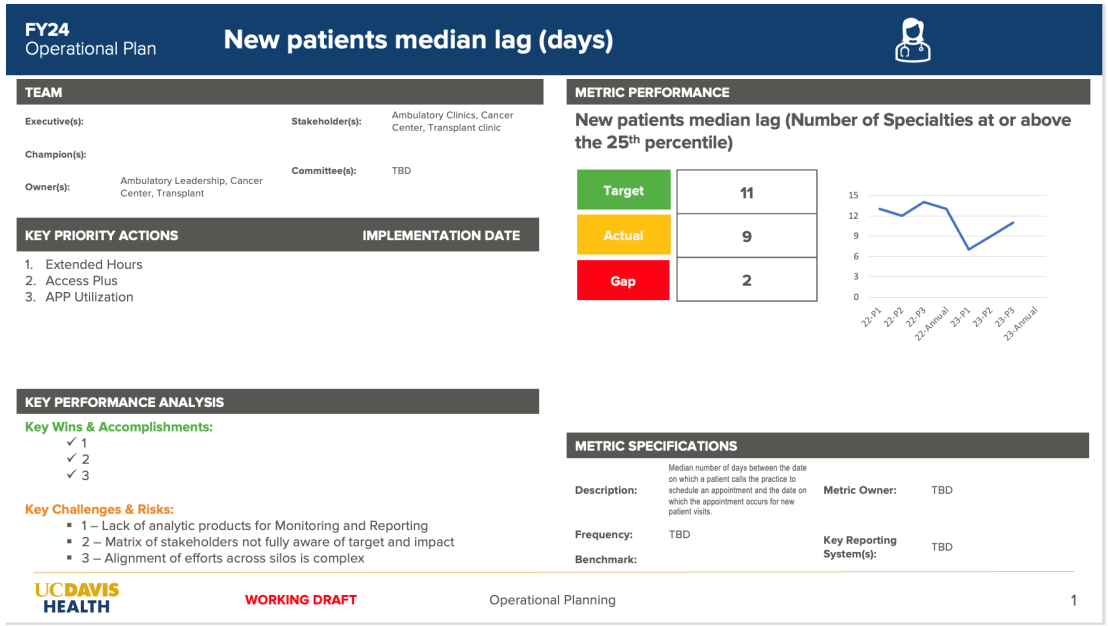
vizient.

Chaotic and Siloed – The Beginning

Initially, our approach was **siloed**, and each leader was focused narrowly on their respective area.

- Most initiatives were things already in flight and did not align to annual health system goals.
- There was no standardized approach or guiding framework and the process of goal setting varied from leader to leader.

But we had to start somewhere!



FY24 Operational Plan

New patients median lag (days)

TEAM

Executive(s):
Champion(s):
Owner(s): Ambulatory Leadership, Cancer Center, Transplant
Stakeholder(s): Ambulatory Clinics, Cancer Center, Transplant clinic
Committee(s): TBD

METRIC PERFORMANCE

New patients median lag (Number of Specialties at or above the 25th percentile)

Target	11
Actual	9
Gap	2

KEY PRIORITY ACTIONS — **IMPLEMENTATION DATE**

1. Extended Hours
2. Access Plus
3. APP Utilization

KEY PERFORMANCE ANALYSIS

Key Wins & Accomplishments:
- ✓ 1
- ✓ 2
- ✓ 3

Key Challenges & Risks:
- 1 – Lack of analytic products for Monitoring and Reporting
- 2 – Matrix of stakeholders not fully aware of target and impact
- 3 – Alignment of efforts across silos is complex

METRIC SPECIFICATIONS

Description: Median number of days between the date on which a patient calls the practice to schedule an appointment and the date on which the appointment occurs for new patient visits.
Frequency: TBD
Benchmark:
Metric Owner: TBD
Key Reporting System(s): TBD

UC DAVIS HEALTH — WORKING DRAFT — Operational Planning — 1

Data source: UC Davis Health internal planning and analysis database

Align and Focus – Our Framework

FY26 Institutional Goals

	Institutional Objective	Enterprise Key Results	Baseline	Target
Experience	Institutional Experience Objective	Experience Key Result #1	X	Y
		Experience Key Result #2	X	Y
		Experience Key Result #3	X	Y
		Experience Key Result #4	X	Y
Quality	Institutional Quality Objective	Quality Key Result #1	X	Y
		Quality Key Result #2	X	Y
		Quality Key Result #3	X	Y
		Quality Key Result #4	X	Y
Stewardship	Institutional Stewardship Objective	Stewardship Key Result #1	X	Y
		Stewardship Key Result #2	X	Y
		Stewardship Key Result #3	X	Y
		Stewardship Key Result #4	X	Y

Institutional Goal Framework

The Institutional Goal Framework is used to measure the progress of the organization towards priority objectives each fiscal year.

- **3 Objectives across Experience, Quality, and Stewardship** translates our mission, vision, values, and patient promise into a clear set of **Key Results.**

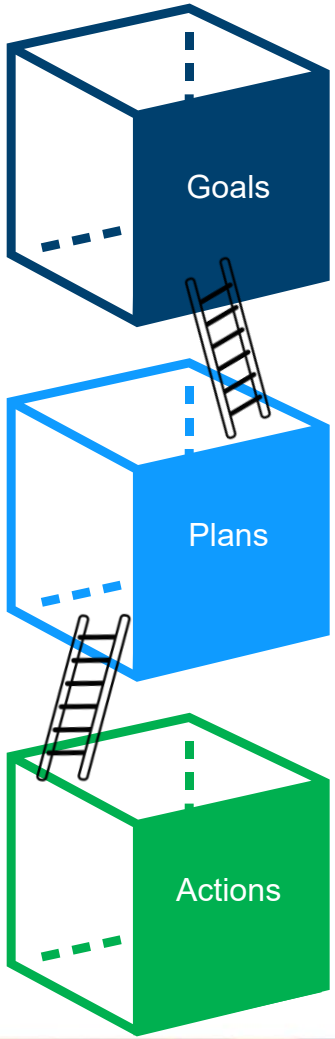
- **Objectives and Key Results** connect the dots between the **strategy & operations** of our organization.

Align and Focus – Laddering

From setting goals to getting results

After setting institutional goals, the next step is to “ladder” to the next level of the organization and build plans that articulate divisional goals for the year **across the experience, quality, and stewardship domains.**

By formalizing plans, teams have narrowed focus on what to prioritize and have a framework on how to measure their progress.



What do you want to accomplish this year?

How will you know you’re on the right track?

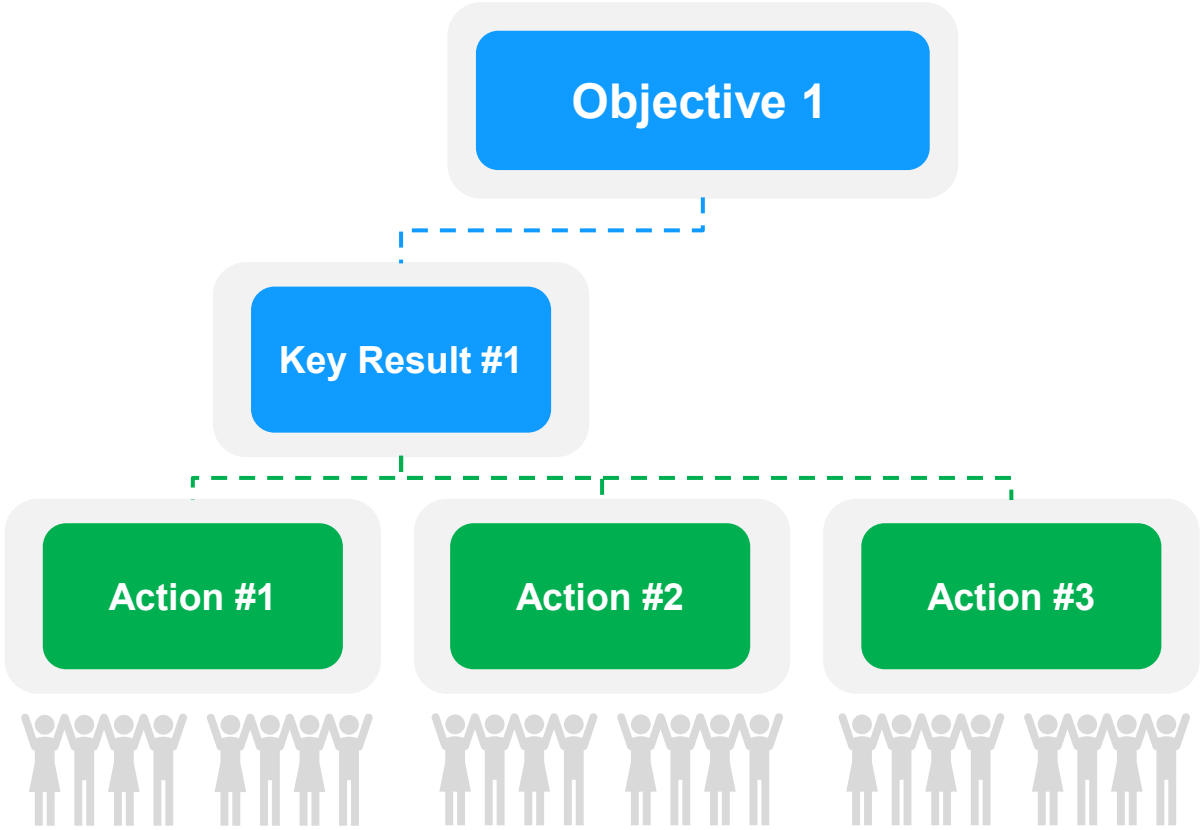
How will you get it done?

Align and Focus – Operational Plans

The next step is to create operational plans for each division by **setting objectives and defining key results** that support and align with the institutional goals.

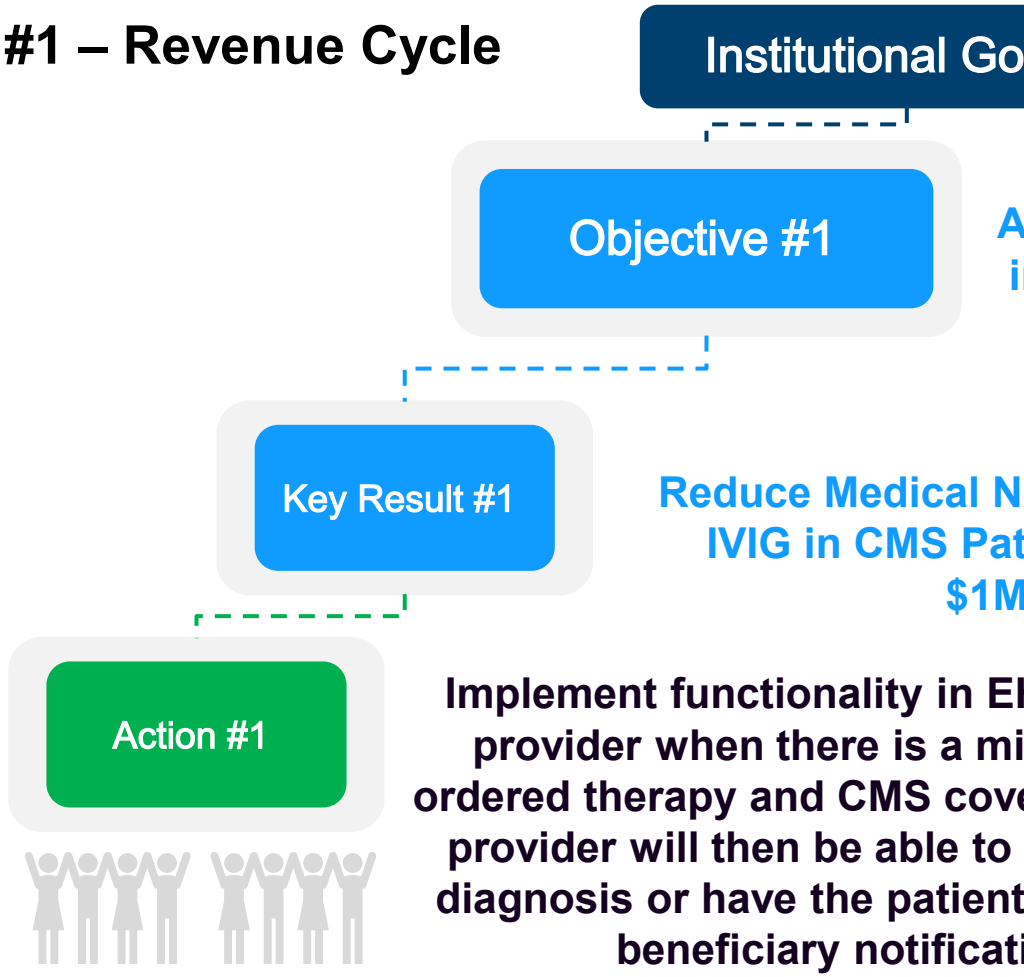
Once divisions have set their objectives and defined their key results within their plans, it's time to **take action!**

At this level, **teams are enabled to solve problems** and tackle their objectives and key results whenever and wherever possible.



Align and Focus – Operational Plans

Example #1 – Revenue Cycle



Pharmacy Objective

Pharmacy Key Result

Pharmacy Initiative

Optimize revenue cycle processes: Reduce hospital billing A/R days

Address critical gaps in current pharmacy workflows

Reduce Medical Necessity Denials for IVIG in CMS Patients to less than $1M/year.

Implement functionality in EHR that will alert a provider when there is a mismatch between ordered therapy and CMS covered diagnosis. The provider will then be able to choose a covered diagnosis or have the patient sign an advanced beneficiary notification (ABN)

This institutional goal needs to be laddered across all divisions/lines of business to be successful (Hospital Billing, Dental, Pharmacy, and Infusion)

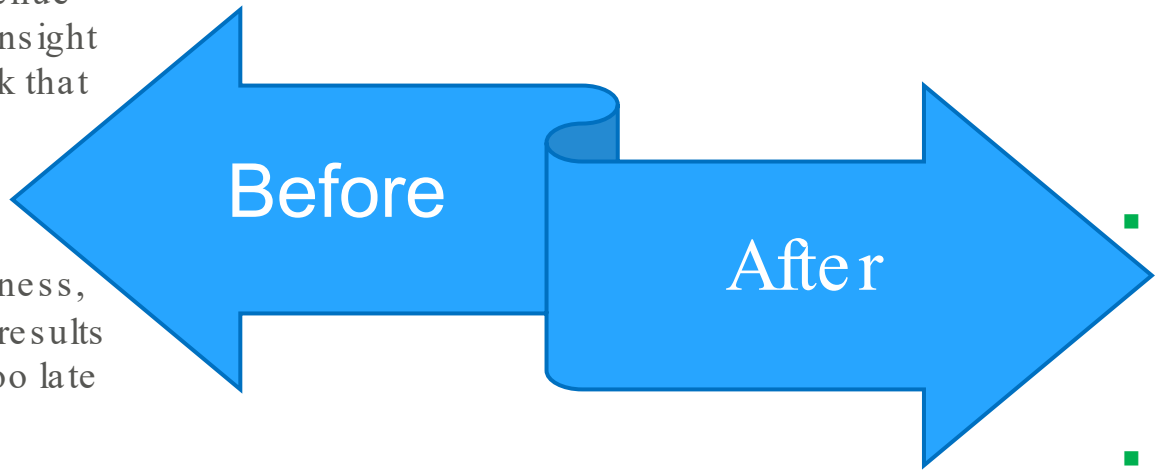
Align and Focus – Operational Plans

The benefits of laddering across all divisions/lines of business

Example #1 – Revenue Cycle

Siloed approach

- **0% awareness :** The Revenue Cycle team is accountable for revenue cycle institutional goals but lacks insight and awareness into divisional work that drives results
- **Inability to adjust in real time:** Without insight and awareness, adjustments to initiatives and key results are not able to be made until it's too late
- **Lack of accountability:** Divisions/lines of business are not accountable for driving success of institutional goals



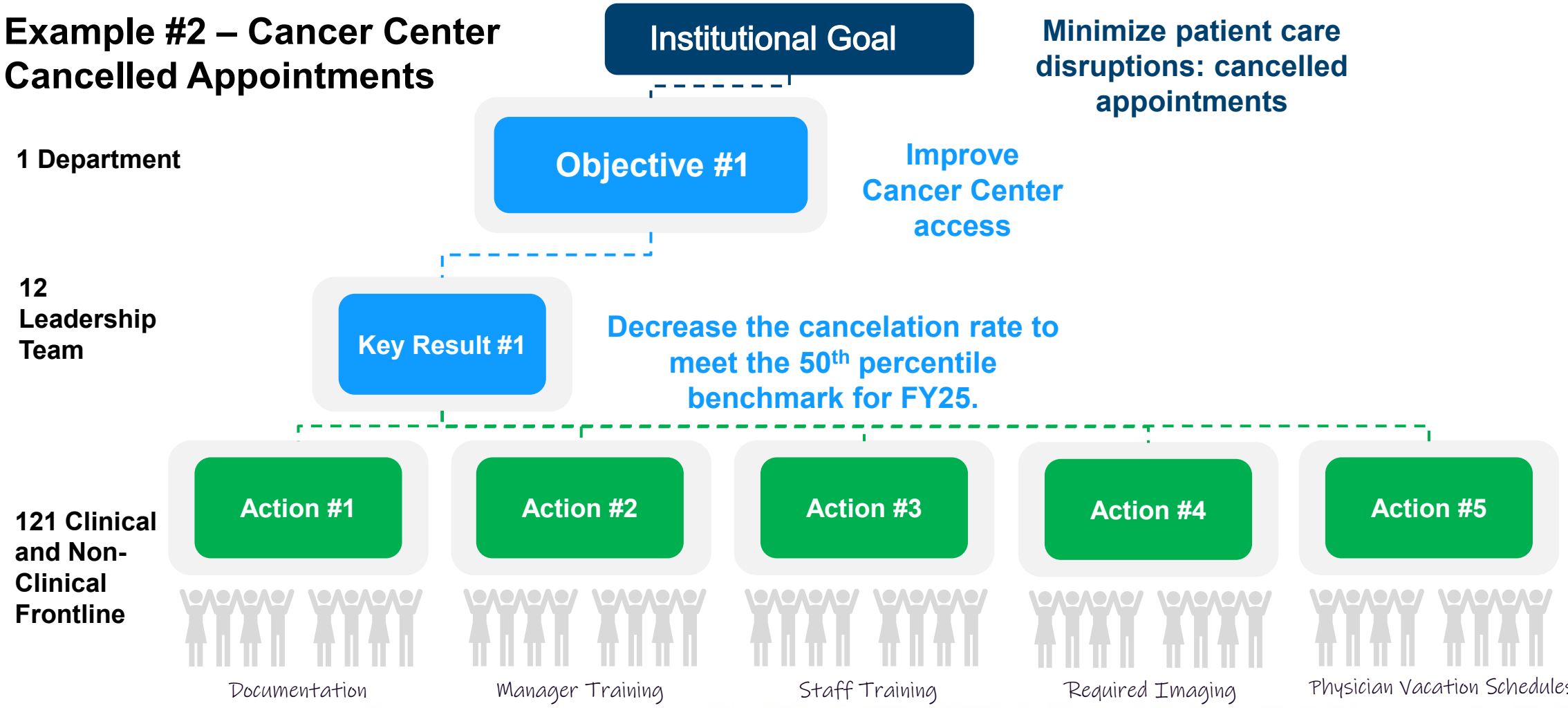
Visibility and collaboration

- **100% Awareness:** The Revenue Cycle team can visibly see the work of divisions/lines of business along with progress made towards achieving their goals
- **Real-time Adjustments:** The Revenue Cycle team can help divisions/lines of business adjust in real-time ensuring success before it's too late
- **Accountability :** Divisions/lines of business know how that impact the institutional goal and are accountable for results

Ensuring transparency and visibility into the work in areas of indirect oversight

Align and Focus – Operational Plans

Example #2 – Cancer Center Cancelled Appointments

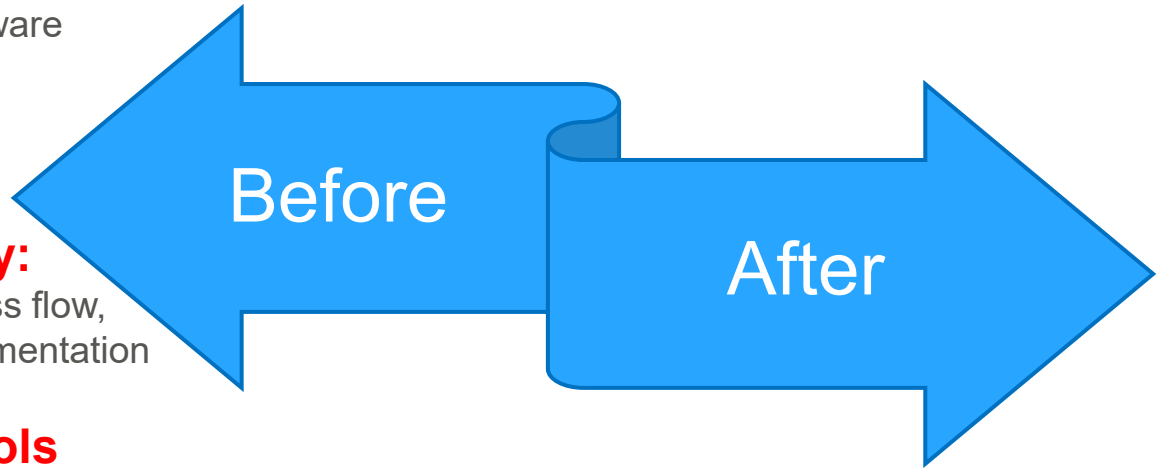


Align and Focus – Operational Plans

The Benefits of Aligned Goal Setting
Example #2 – Cancelled Appointments

12 Leadership Team

- **50% Awareness:** of the Cancer Center Leadership team was aware cancelled appointments was an institutional goal
- **0% Knowledge & Ability:** knowledge of the correct process flow, metric drivers and correct documentation
- **25% Reinforcement Tools and Process Engagement:** access to the data to monitor process, view performance and correct errors



Alignment and focused change management

- **100% Awareness:** Completed meetings for awareness - presenting the performance, metric definitions, and correct process flow
- **100% Knowledge & Ability:** Ensured managers had the ability to monitor the process through trainings and reports
- **100% Reinforcement Tools and Process Engagement:** Established monthly leadership meetings to review performance

Ensuring Leadership support is obtained, and leaders are visible and vocal

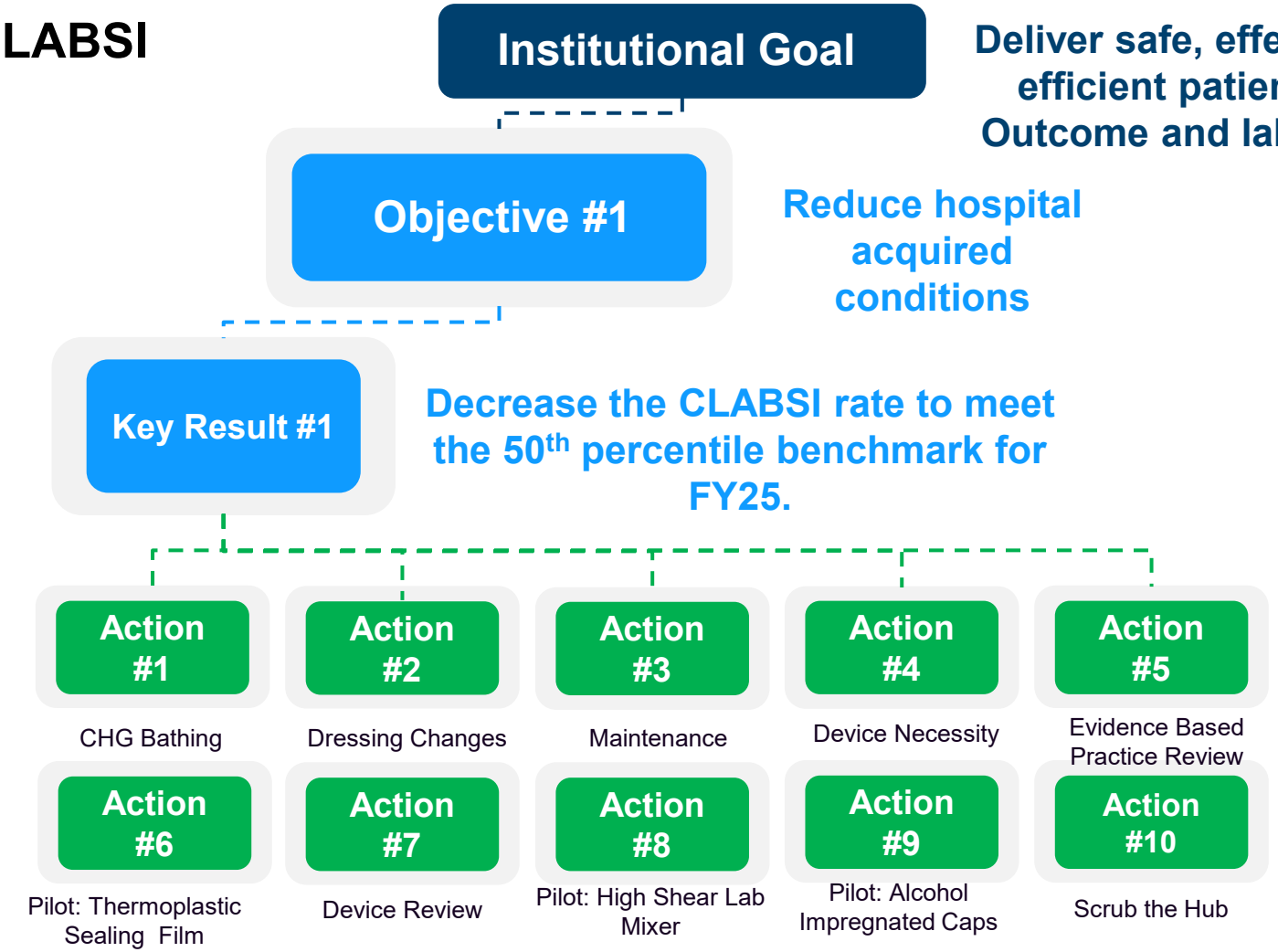
Align and focus – Operational Plans

Example #3 – CLABSI

27 Departments

60 Leadership Team - validate

Clinical Frontline



Success!

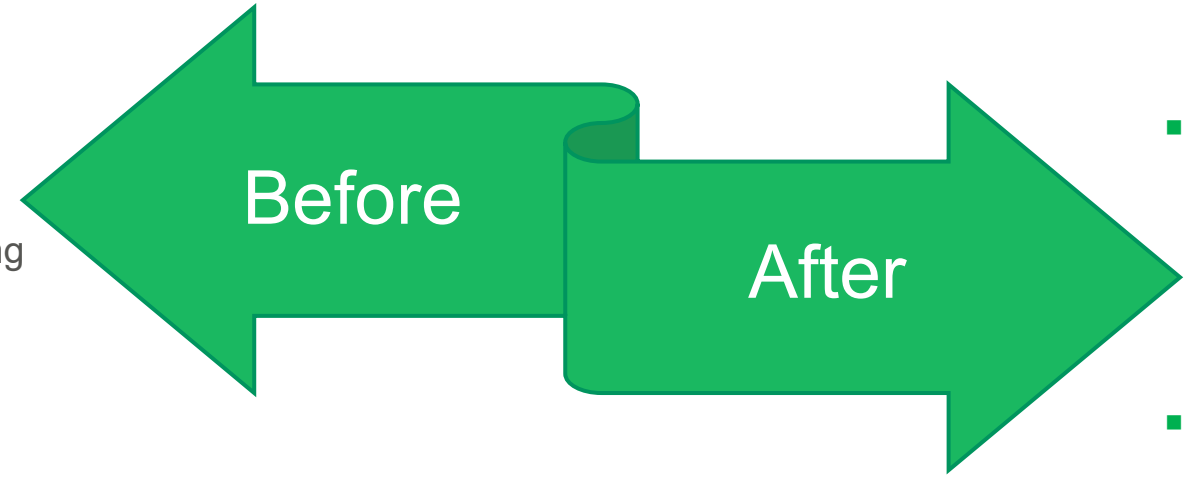
Surpassed FY25 goal increasing 25 percentile rankings in CLABSI

CHG = chlorhexidine gluconate
CLABSI = central line associated bloodstream infection

Align and focus – Operational Plans

The Benefits of Review Cycles
Example #3 – CLABSI

- **30% Action Visibility:** incomplete improvement - work effort underrepresented in many dated presentations.
- **Incomplete Review Cycles:** 1-hour biweekly reviewing partial paper project list often discussing a small fraction of actions.
- **10% Standard Work and Leading Measure Audits:** standard work and leading measure dashboards lacking for key actions.



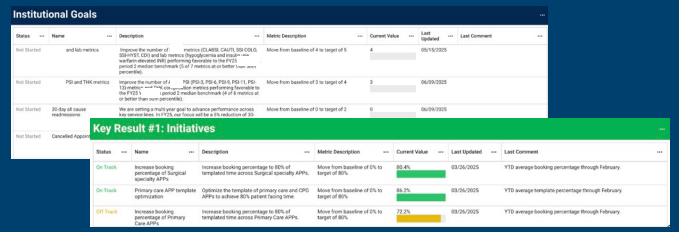
- **100% Action Visibility:** complete portfolio snapshot capturing status of comprehensive action portfolio in one location updated real-time.
- **Streamlined Review Cycles:** efficient 1-hour biweekly meeting reviewing leading/lagging measures, action issues and problem resolutions
- **100% Standard Work and Leading Measure Audits:** Established increased process transparency, performance and accountability

Utilizing Change Management and Process Improvement Framework Increases Momentum

Align and Focus – Keys to Success

Goal Setting Platform

- Investment in a goal setting platform or software
- Easy way to organize and share goals, plans, and create accountability



Snapshots of our goal setting software

Dedicated Support Team

- Having a team dedicated to the process of goal setting ensures alignment across the organization
- Creates a strong partnership between strategy and operations to set goals and build plans to achieve them

Backed by Leadership

- Leadership support and buy-in is a key part of how to successfully “ladder” a goal to the next level of the organization.
- Leadership is also key in recognition and celebrating wins!

Enable and Improve – The Future

- Continue to iterate on our standard process to shift from firefighting to a more strategic approach
- Implement assessment pipeline to better triage ideas and projects
- Bridge the gap between strategy and action

Lessons Learned

imagine THE POSSIBILITIES

Multi-Level Data Transparency is Key

Looking at leading, lagging, and process-level data is essential for a full picture of performance. By integrating leading indicators (predictive trends) and process metrics (real-time operational data), we can detect problems earlier, adjust strategies proactively, and align daily actions with long-term goals.

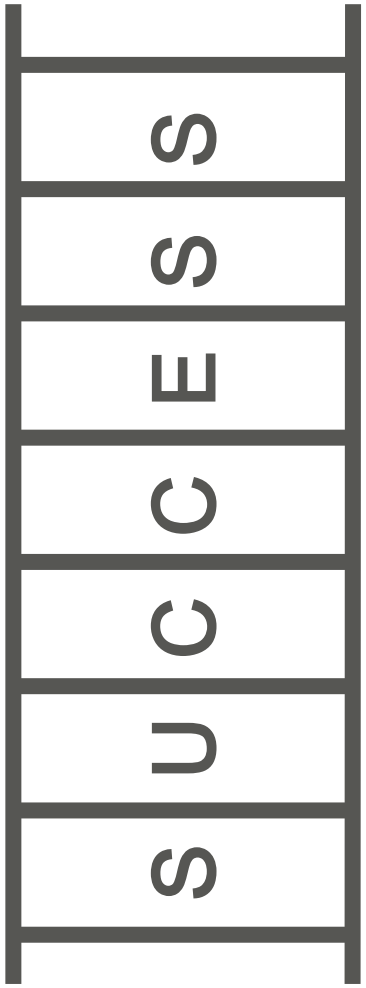
Clear Leadership Direction Drives Success

Leaders must have a visible and vocal role to guide the process and ensure expectations are clear. This creates accountability and enables success.

Utilizing Change Management and Process Improvement Framework Increases Momentum

By following a standard approach to change management and process improvement, teams are better equipped to confidently navigate change and can move from current state to future state more quickly.

Key Takeaways and Next Steps



- Simplify institutional goals
- Create a goal setting framework
- Ensure leadership support is obtained, and leaders are visible and vocal
- Establish data, change management, and process improvement framework and capabilities

Questions?

Contact:

Jared Quinton, jrquinton@health.ucdavis.edu

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Caitlin Grassadonia, clcrooks@health.ucdavis.edu

Jessica Koegel, jakoegel@health.ucdavis.edu

Daniel Norville, danorville@health.ucdavis.edu

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The Evolving Landscape of Service Lines

Chad Giese, MBA, Vice President
Sg2, a Vizient company

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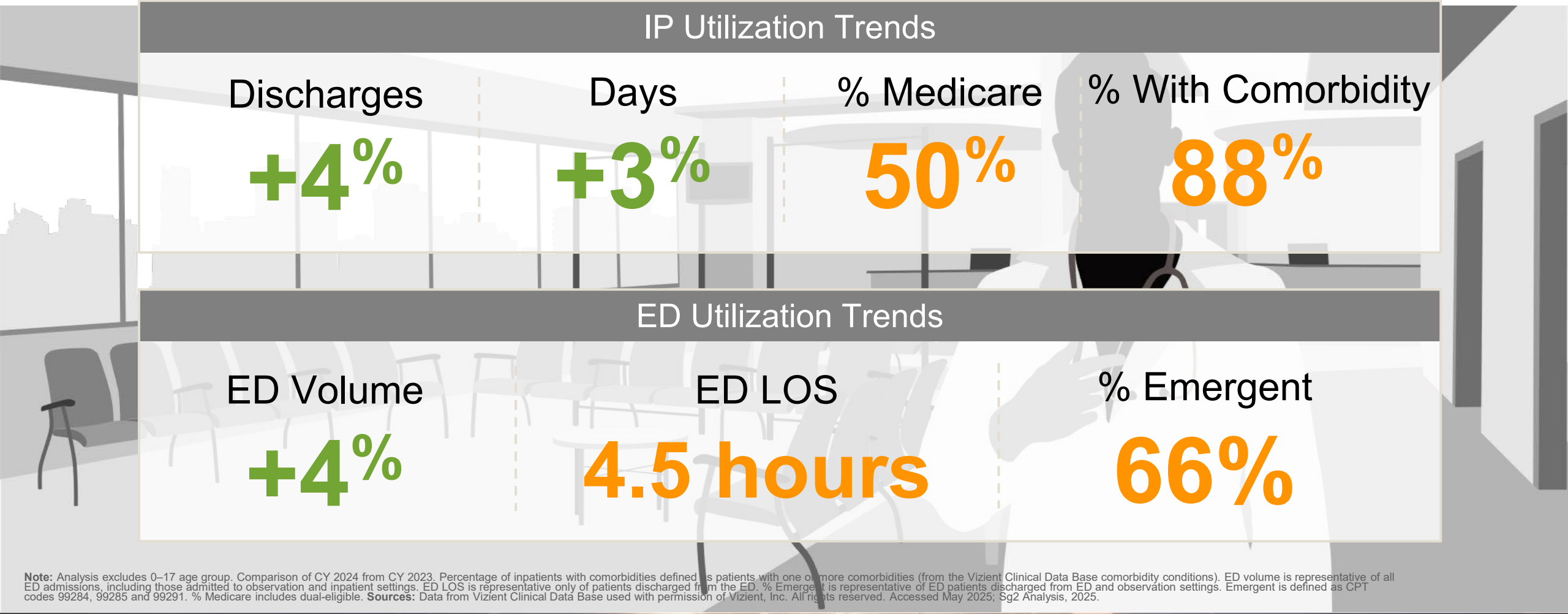
2025 Impact of Change Highlights:
Growth Expected Across Key Forecasts



IP Utilization Trends

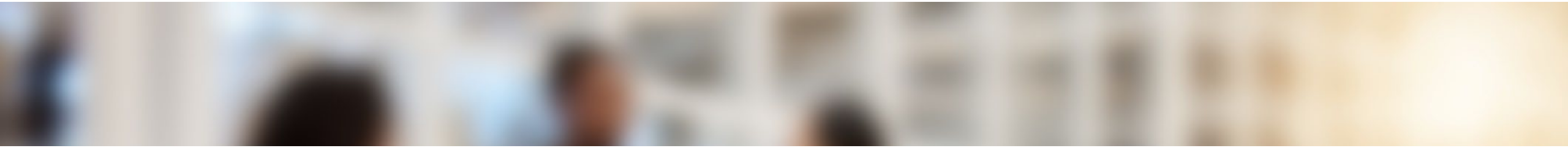
Discharges	Days	% Medicare	% With Comorbidity
+4%	+3%	50%	88%

ED Utilization Trends

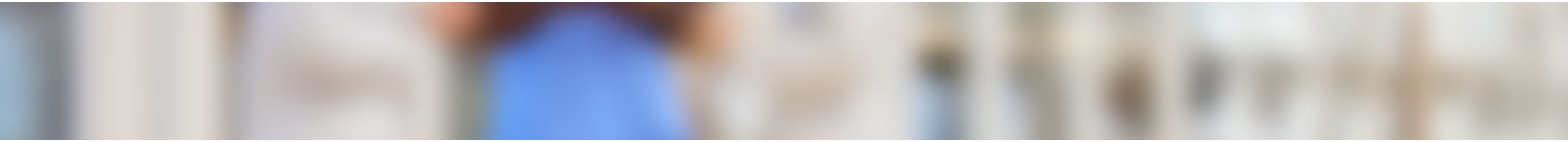
ED Volume	ED LOS	% Emergent
+4%	4.5 hours	66%

Note: Analysis excludes 0–17 age group. Comparison of CY 2024 from CY 2023. Percentage of inpatients with comorbidities defined as patients with one or more comorbidities (from the Vizient Clinical Data Base comorbidity conditions). ED volume is representative of all ED admissions, including those admitted to observation and inpatient settings. ED LOS is representative only of patients discharged from the ED. % Emergent is representative of ED patients discharged from ED and observation settings. Emergent is defined as CPT codes 99284, 99285 and 99291. % Medicare includes dual-eligible. **Sources:** Data from Vizient Clinical Data Base used with permission of Vizient, Inc. All rights reserved. Accessed May 2025; Sg2 Analysis, 2025.

2025 Impact of Change Highlights:
Growth Expected Across Key Forecasts



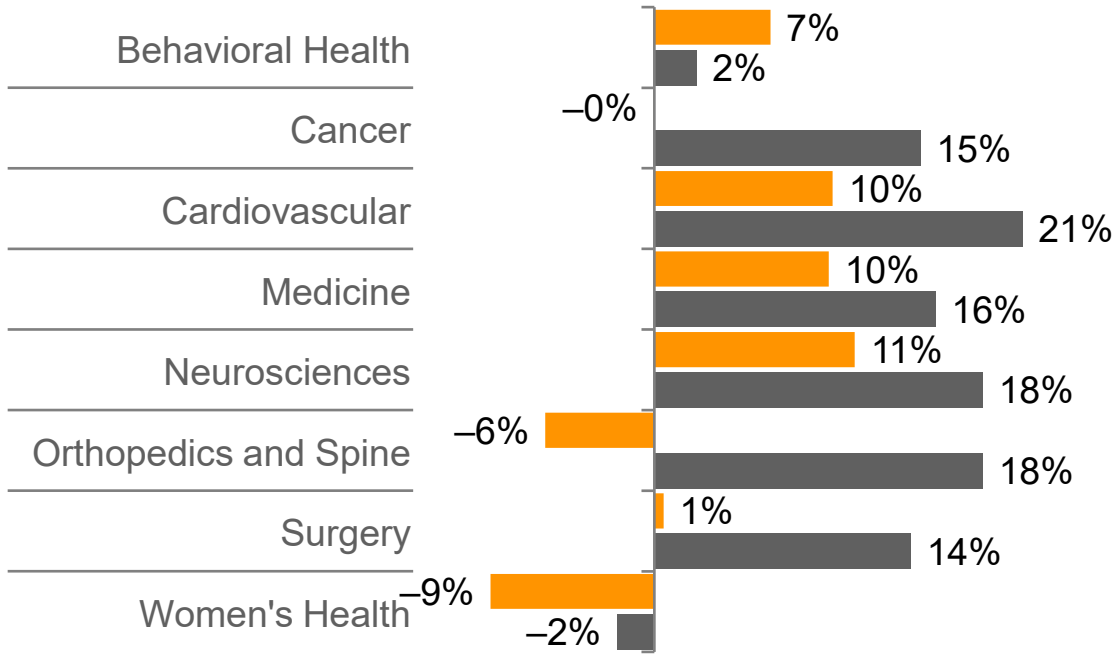
IP	Days	ED	OP	OP Surg	E&M	PAC
5%	10%	5%	18%	20%	17%	31%



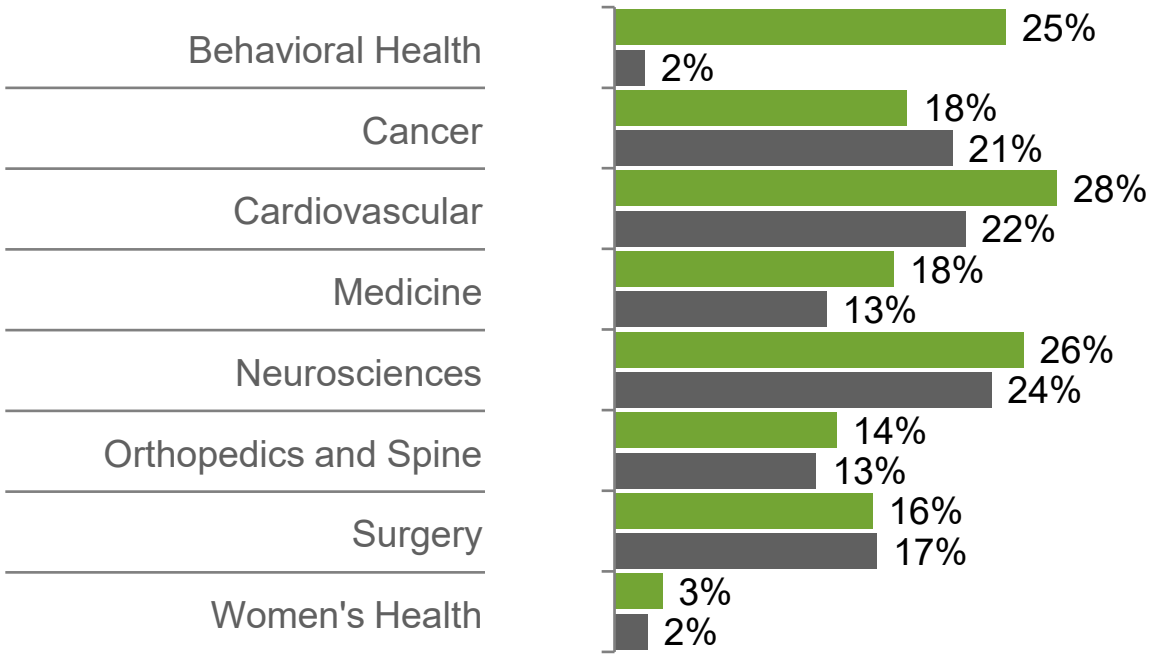
Note: Analysis excludes 0–17 age group. ED defined as visits—emergent and visits—urgent procedure group. OP surgery defined as procedures—major and endoscopy procedure groups. E&M visits defined as visits—evaluation and management, established patient visits—in person, established patient visits—virtual, new patient visits—in person, new patient visits—virtual; post-acute care defined as post-acute services: home and domiciliary hospice visits; home nurse visit; home visits other; hospice stays; SNF stays; procedures— minor: home infusion—chemotherapy; procedures—minor: home infusion—medications; rehab: home physical/occupational therapy treatments; visits—evaluation and management: home and domiciliary evaluation and management visits. E&M = evaluation and management; PAC = post-acute care; SNF = skilled nursing facility; surg = surgery. **Sources:** Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Utilization Trends Vary Across Service Lines

Inpatient Service Line Growth
US Market, 2025–2035



Outpatient Service Line Growth
US Market, 2025–2035



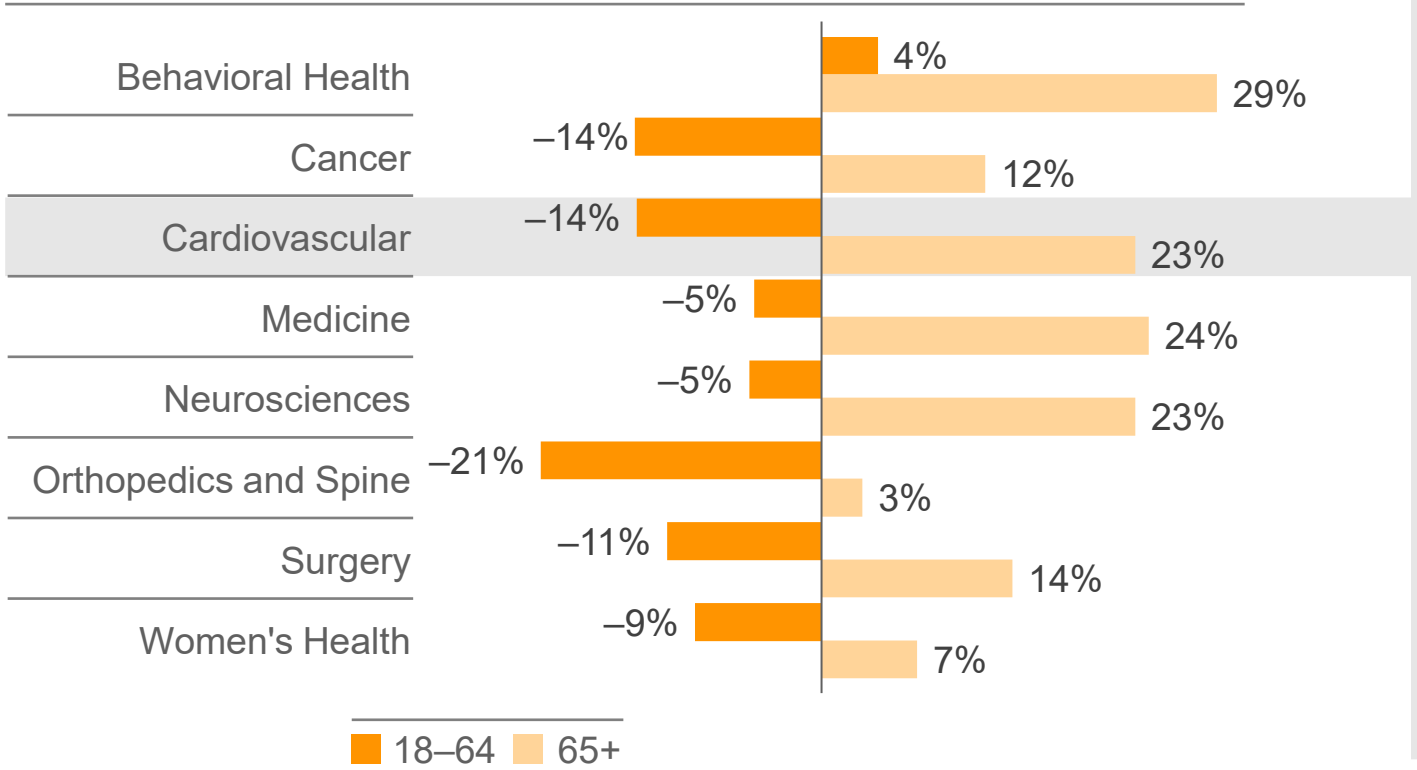
Sg2 IP Forecast | Population-Based Forecast | Sg2 OP Forecast

Note: Analysis excludes 0–17 age group. 0% indicates the forecast is flat (less than ±1%). Behavioral Health includes behavioral health service line and Poisonings—Commonly Abused Drugs CARE Family. Cardiovascular includes cardiology and vascular. Medicine includes allergy and immunology, dermatology, endocrinology, gastroenterology, genetics, general medicine, hematology, hepatology, infectious diseases, nephrology, pulmonology, and rheumatology. Surgery includes burns and wounds, otolaryngology, general surgery, ophthalmology, and urology. **Sources:** Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Rising Age, Rising Impact: Health Care Demand Pushed to New Heights by Aging Population

Inpatient Service Line Growth

US Market, 2025–2035



65+ Valve Procedures

+106%

65+ CV ED

+26%

65+ CV E&M

+34%

Note: Analysis excludes 0–17 age group. Valve procedures defined as surgical valve procedure and transcatheter valve procedure for the cardiovascular service line group. ED defined as visits —emergent and visits—urgent procedure group. E&M visits defined as visits—evaluation and management, established patient visits—in person, established patient visits—virtual, new patient visits—in person, new patient visits—virtual. **Sources:** Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

How Do You Ensure Your Sustainable Market Growth?
An Effective System of CARE

imagine THE POSSIBILITIES

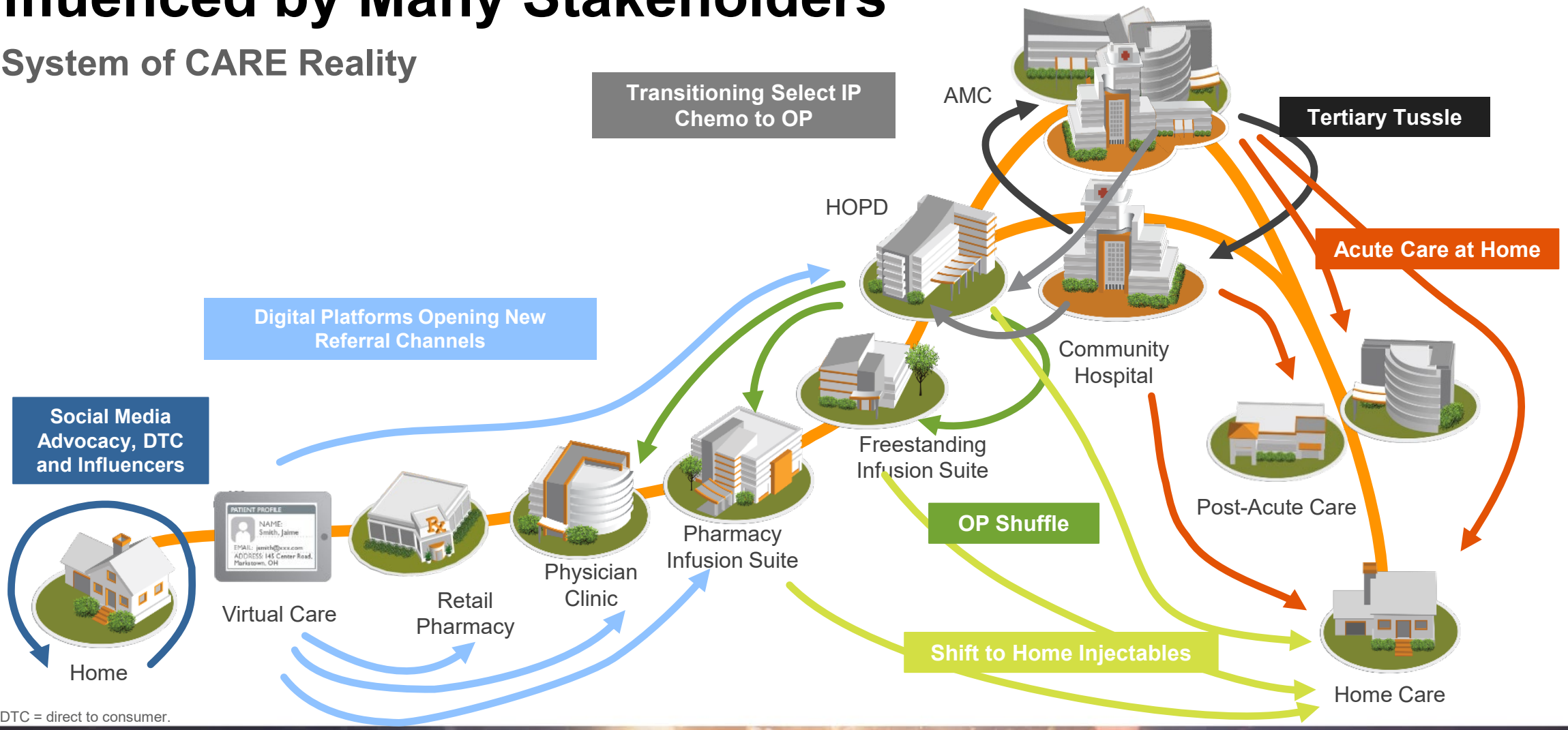
1. Size your local market and inventory your System of CARE
2. Build the right System of CARE to meet the needs of your market
3. Align System of CARE access channels to meet patients on their terms

CARE = Clinical Alignment and Resource Effectiveness.

vizient.

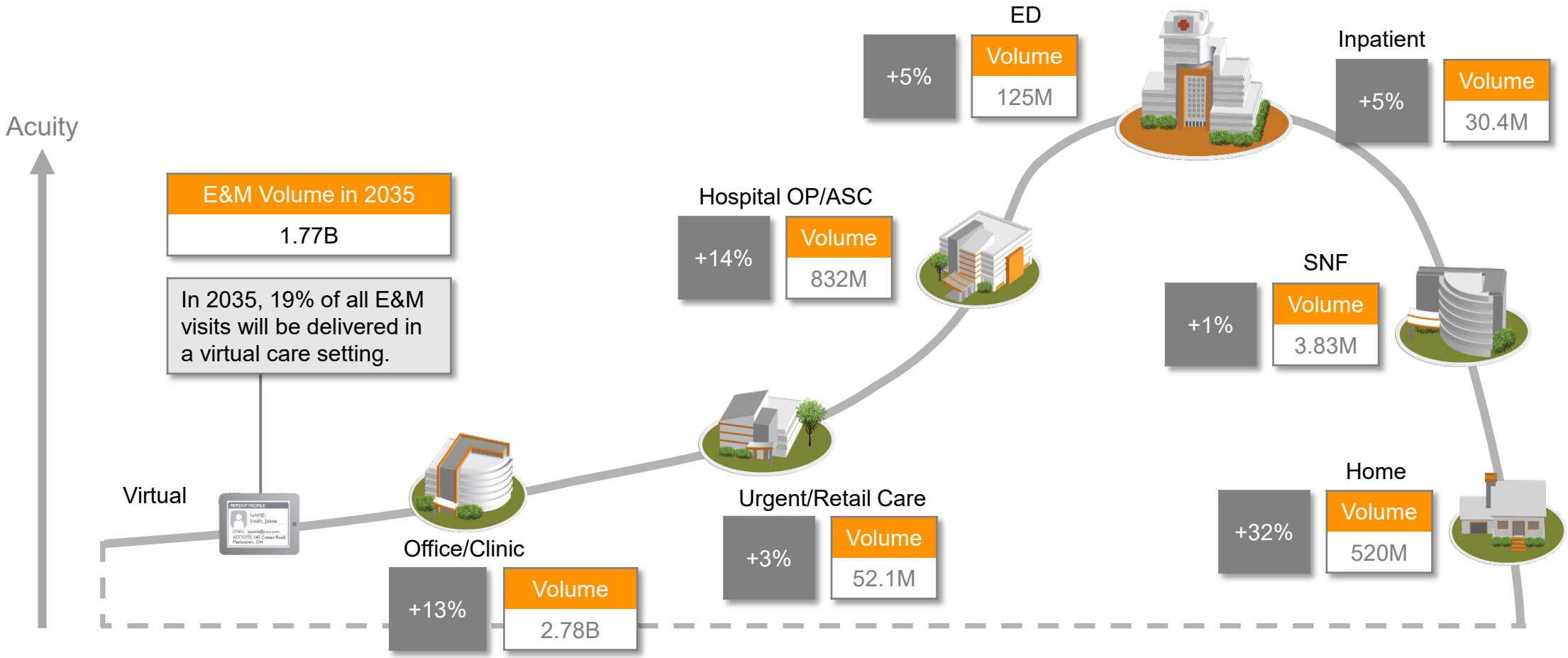
Patient Care Pathways Are Complex and Influenced by Many Stakeholders

System of CARE Reality



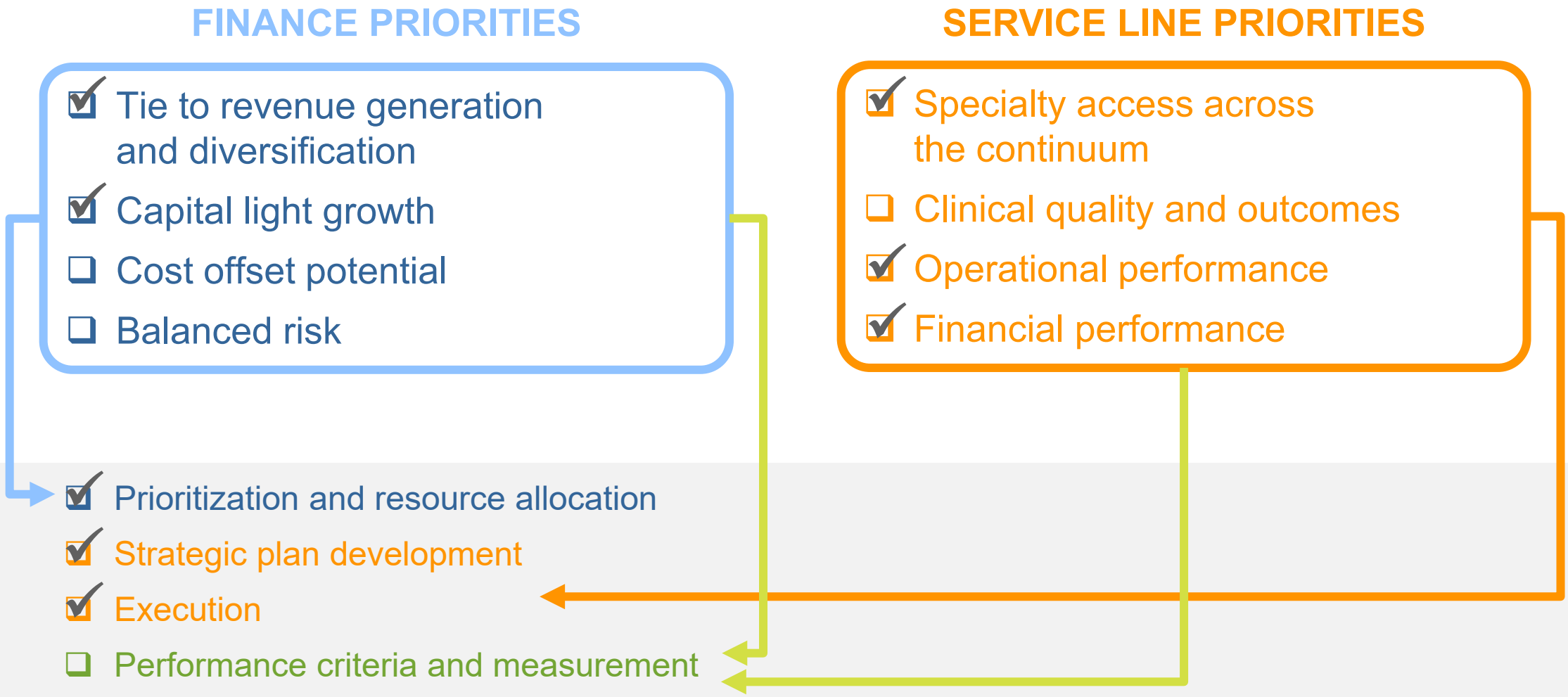
DTC = direct to consumer.

Orchestrate Seamless Care Across the Care Continuum

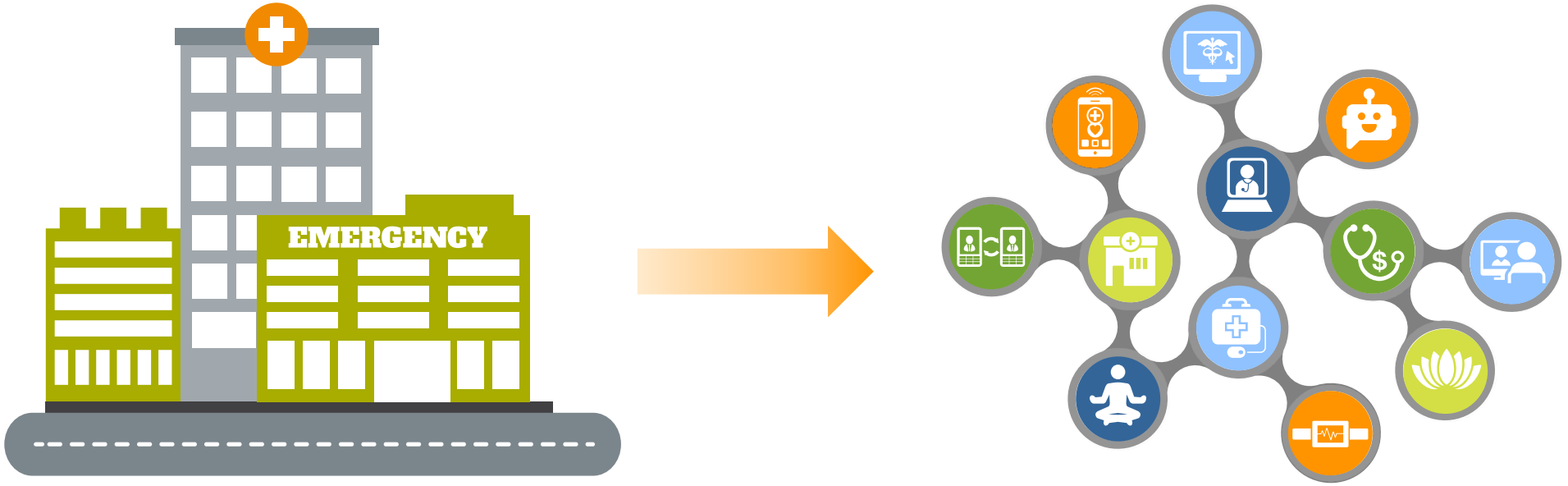


Notes: Analysis excludes 0–17 age group. ED forecast defined as urgent and emergent visits. E&M visits defined as visits—evaluation and management, established patient visits—in person, established patient visits—virtual, new patient visits—in person, new patient visits—virtual. ASC = ambulatory surgery center; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Learn What Matters to Stakeholders



Future of Care Delivery Moves Beyond Traditional Care Pathways



Care orchestration—a continuous connection to care—is required to optimize care delivery to meet rising consumer demand.

Questions?

Contact:

Chad Giese, chad.giese@vizientinc.com

This educational session is made possible through the collaboration of Vizient Member Networks.

Service Lines 2.0: Herding Cats … Strategically

Steven Chew, MBA, CPC, Sr. Vice President, Service Lines
FHSC, Tampa General Hospital
Stephanie Jackson, MBA, Vice President, Service Lines
Tampa General Hospital

Disclosure of Financial Relationships

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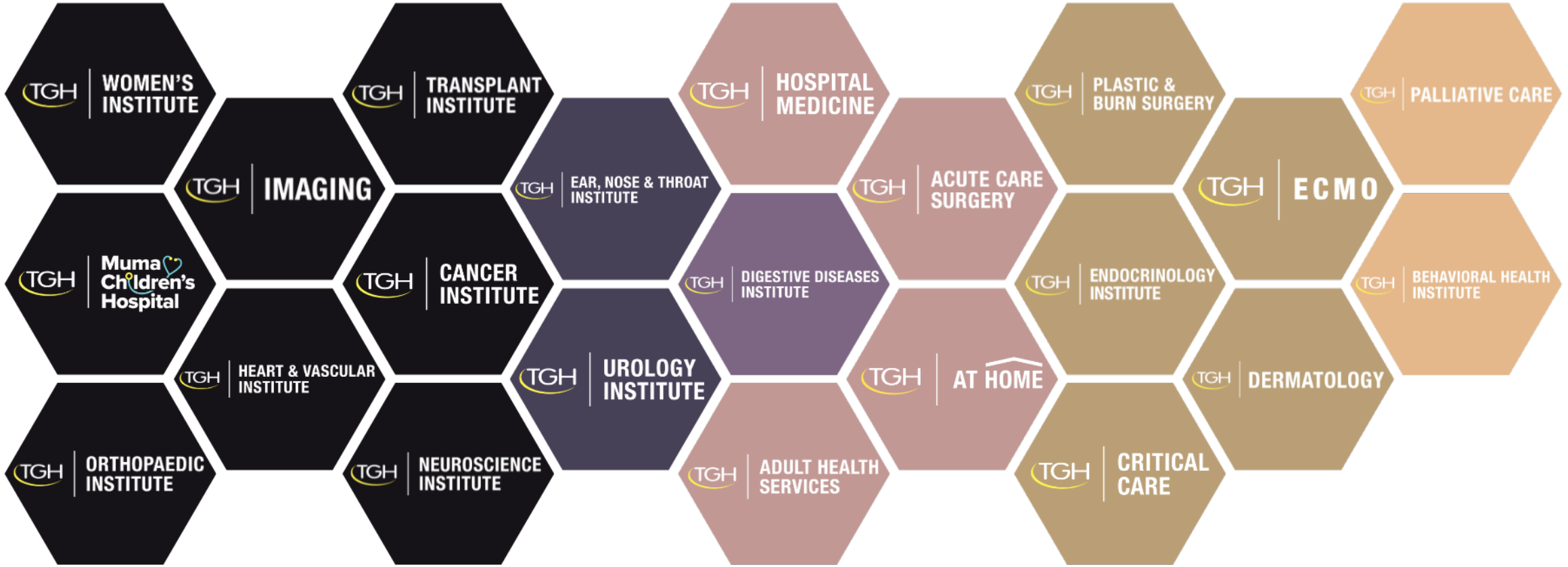
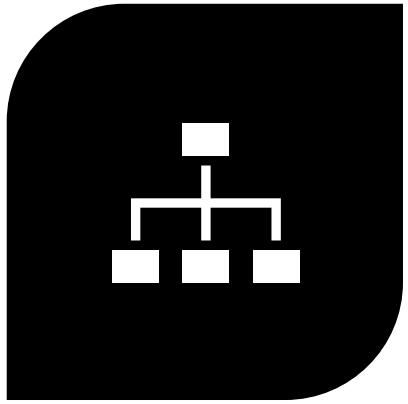
Service Lines Overview

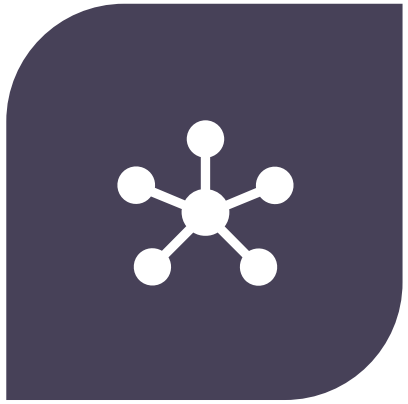
imagine
THE POSSIBILITIES



The Winning Formula



EXECUTIVE BUY-IN & AUTONOMY



COMMUNICATION & ALIGNMENT

DATA, VISUALIZATION & ACCOUNTABILITY

Executive Buy-in & Autonomy

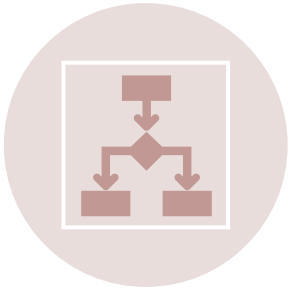
- Backed by an engaged and accessible C-suite that actively participates, listens and supports alongside teams
- Leadership across the health system is bought into Service Lines from the top down
- Transparent communication with leaders and shared accountability
- Trust in Service Line leaders to drive growth and outcomes
- Fail-fast culture that encourages innovation, learning and rapid course correction without fear off failure
- Empowered decision-making at the service line level

A Strategic Planning Guide

imagine
THE POSSIBILITIES

Partner closely with our Institute Chiefs to define a **mission and vision** tailored to the unique needs of each service line

Conduct in-depth assessments to understand the **current health and performance** of each area we lead



Build **three-year strategic plans** grounded in data, opportunity, and clinical input - unique to each institute

Align institute strategies with the **broader TGH organizational goals**, contributing directly to the systemwide action plan

Communication & Alignment

- Maintain regular communication with operators to share strategies and business plans, ensuring full engagement and alignment
- Conduct frequent touch points with the C-suite to keep leadership informed of progress and emerging needs
- Leverage executive support to identify and remove barriers swiftly when needed
- Foster alignment across the institute by clearly communicating goals, outcomes, and ongoing progress
- Host larger events like the annual Service Line Strategic Retreat to engage teams, deepen collaboration, and drive unified planning

Data, Visualization & Accountability

- Surgical Services Dashboard
- Service Line Attribution
- Global Service Line Dashboard
- Finance & Productivity
- *Future: Digital Infrastructure Projects*

Lessons Learned from the Trenches

imagine
THE POSSIBILITIES

01

EXECUTIVE BUY-IN

is a nonnegotiable. Visible and consistent support from c-suite is a critical driver to overall progress.

02

COMMUNICATION

must be relentless and multidirectional at all levels of the institution, from bedside to c-suite, across the system.

03

FAIL FAST CULTURE

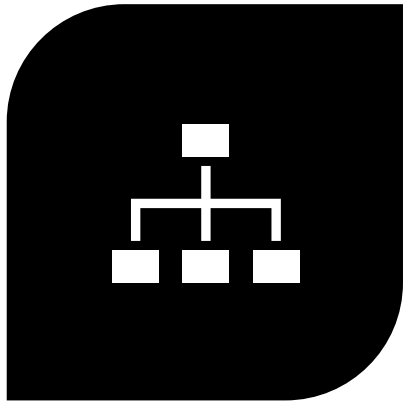
allows teams to test, learn, and iterate without fear. This cultural permission was essential for innovation and agility.

04

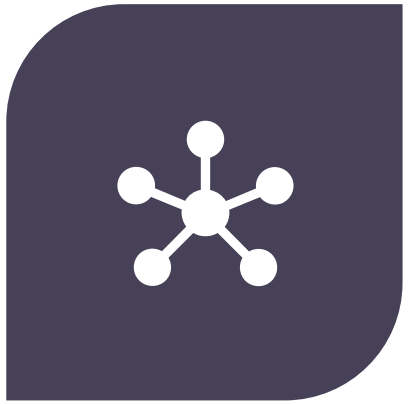
UPFRONT CLARITY & SHARED UNDERSTANDING

should be prioritized to enable sustainable growth and accountability.

Key Takeaways: The Winning Formula



ENSURE EXECUTIVE BUY-IN & AUTONOMY



COMMUNICATE & ALIGN

LEVERAGE DATA, VISUALIZATION & ACCOUNTABILITY TOOLS

Questions?

Contact:

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Stephanie Jackson, slgrimes@tgh.org

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Pulse Check: What Have You Heard? What's Resonating?

Josh Aaker, PhD, Senior Consulting Director, Intelligence
Kara Marlatt, PhD, Consulting Director, Intelligence
Setu Shah, MPH, Senior Consultant, Intelligence
Sg2 a Vizient company

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Pulse Check

- What have you heard so far that you agree with?
- Have you heard anything surprising?
- Are you seeing different trends in your market?

Break Time
Return at 10:15

The Disruption of Access: What's Now, What's Next

Chad Giese, MBA, Vice President
Sg2 a Vizient company

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Consumers Demand More From Us

2 in 5

switched PCPs in last three years.

~40%

used multiple health systems in the last three years.

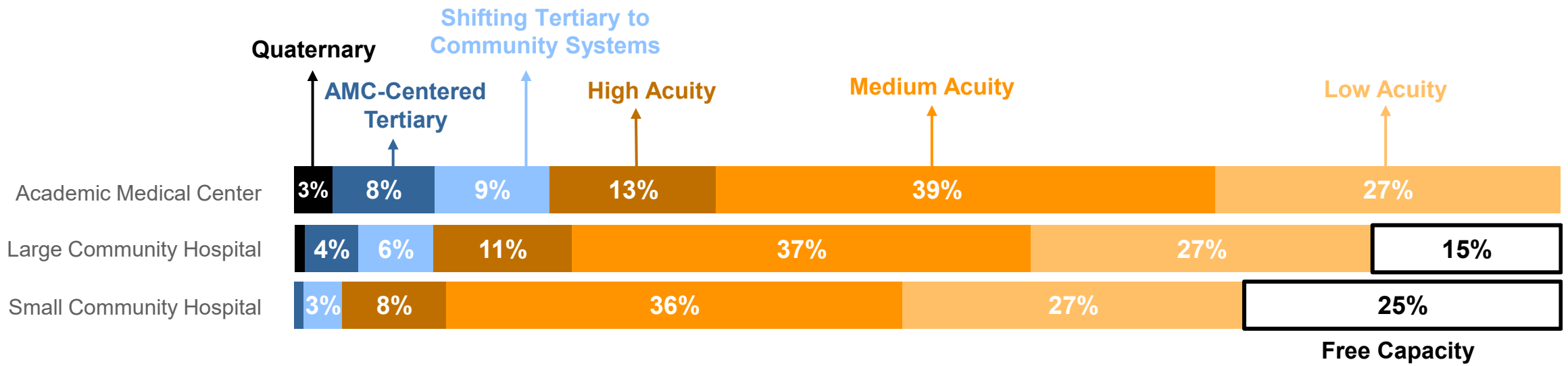
~50%

reported major frustration.

Note: N = 25,209. PCP = primary care provider. **Source:** Sg2 National Consumer Survey, 2025; Sg2 Analysis, 2025.

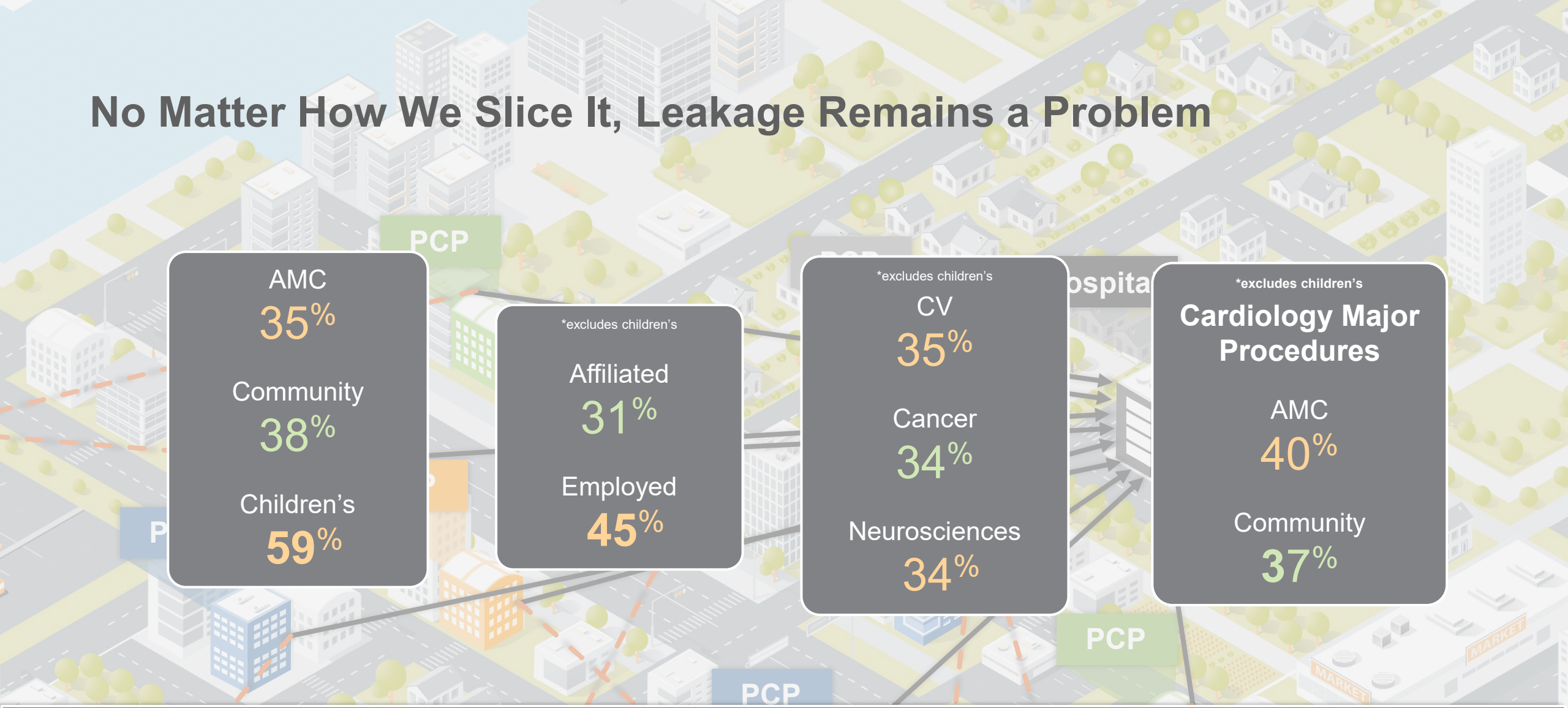
Enhance Competitive Capture by Balancing Across Sites

Inpatient Portfolio
US Market, 2024, Intersystem Analysis



Note: Analysis excludes 0–17 age group. Percentages may not add to 100% due to rounding. Percentages less than 3% have been removed. Quaternary is Sg2 2024 quaternary MS-DRG list. AMC-centered tertiary is Sg2 2024 tertiary MS-DRG list. Shifting tertiary to community systems = MS-DRGs removed from Sg2 tertiary list from 2017 to 2024. High acuity: CMS-weighted DRGs > 2.0; medium acuity: CMS-weighted DRGs 1.0 to 2.0; low acuity: CMS-weighted DRGs < 1.0.
Sources: Sg2 Optimal Service Mix Planning Tool, 2023; Vizient Clinical Data Base/Resource Manager™. Irving, TX: Vizient, Inc.; 2024. https://www.vizientinc.com; Impact of Change®, 2024; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Claritas Pop-Facts®, 2024; Sg2 Analysis, 2024.

No Matter How We Slice It, Leakage Remains a Problem

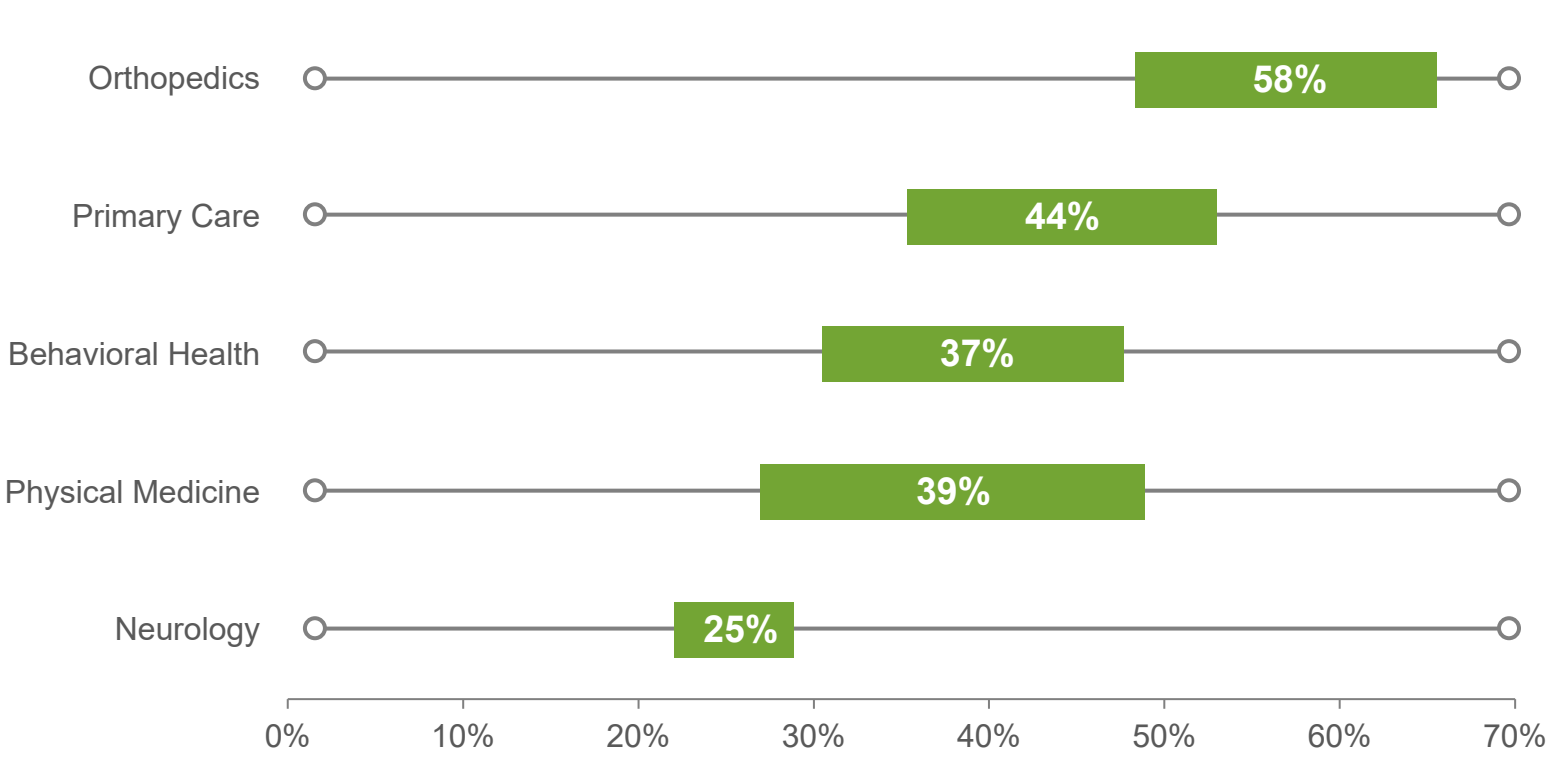


Employed and Affiliated Medical Group Keepage

Note: 180 days after PCP E&M visit from affiliate and employed primary care providers. All downstream procedures.

We've Made Some Strides in Access

Percentage of Patients Seen Within 10 Days
Range of 25th to 75th Percentile, 2024



~12%

of E&M visits forecasted to be conducted virtually in 2025

*Percentage of E&M visits occurring virtually. **Note:** Analysis excludes 0–17 age group. E&M visits defined as visits—evaluation and management, established patient visits—in person, established patient visits—virtual, new patient visits—in person, new patient visits—virtual. E&M = evaluation and management. **Sources**: Data from AAMC-Vizient Clinical Practice Solutions Center® (CPSC) Access and Throughput used with permission of Vizient, Inc. All rights reserved. 2025. Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Resolve Tension Between Scale and Access

imagine THE POSSIBILITIES

SCALE

Advanced Imaging 10-Year Forecast **14%**

OP Diagnostics 10-Year Forecast **21%**

VS

ACCESS

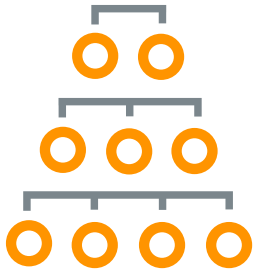
40 Days

between E&M office visit and imaging encounter*

*Median wait time for fee-for-service Medicare patients. **Note:** Analysis excludes 0–17 age group. **Sources:** Centers for Medicare & Medicaid Services. (n.d.). CMS Innovator data [Medicaid Restricted data set]. Accessed via CMS Virtual Research Data Center, June 18, 2025; Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

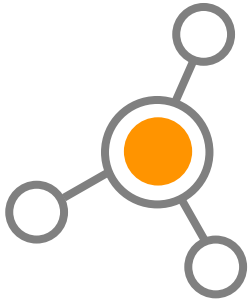
Health System Incremental Innovations in Primary Care to Improve Access

New Roles



Consumer Segmentation

AI Ambient Listening



Virtual as the Default New Patient Visits

Questions?

Contact:

Chad Giese, chad.giese@vizientinc.com

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UCI Health

imagine THE POSSIBILITIES

Breaking the Queue: Redesigning Patient Access

Prasana Ruxmohan, MHA, Ambulatory Operations Transformation Strategist

Laurie Johnson, EdD, Vice President of Ambulatory

Sunil Verma, MD, MBA, Associate Chief Medical Officer, Associate Dean Ambulatory

UCI Health

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ABOUT UCI HEALTH

$4B
Total Operating Revenue

900K
Outpatient Visits

$355M
Research Awards

59,300
Patient Discharges

12,300
Total Co-workers

215,000
Emergency Visits

1,317
Licensed Beds

41,000
Surgeries

HOME TO ORANGE COUNTY'S ONLY

- Academic health system
- Level I trauma center
- High-risk maternal/fetal program
- American Burn Association-verified Regional Burn Center

RECOGNIZED AS

- One of America's Best Hospitals by U.S. News & World Report
- Magnet® hospital for nursing excellence
- NCI-designated comprehensive cancer center
- Age-Friendly Health System
- Gold Level I Geriatric Emergency Department
- One of the best Maternity Care Hospitals in the county
- LGBTQ Healthcare Equality Leader by Human Rights Campaign
- Top 150 Best Places to work in healthcare by Becker's Hospital Review

UCI Health

About UCI Health

UCI Health is the clinical enterprise of the University of California, Irvine, and the only academic health system based in Orange County. UCI Health is comprised of five hospitals and many ambulatory care centers across the region.

5+
Hospitals

1,317
Licensed Beds

100+
Locations & Affiliates

$355M
Research Awards

12,300
Total Co-workers

59,300
Patient Discharges

41,000
Surgeries

1.4M
Outpatient Visits

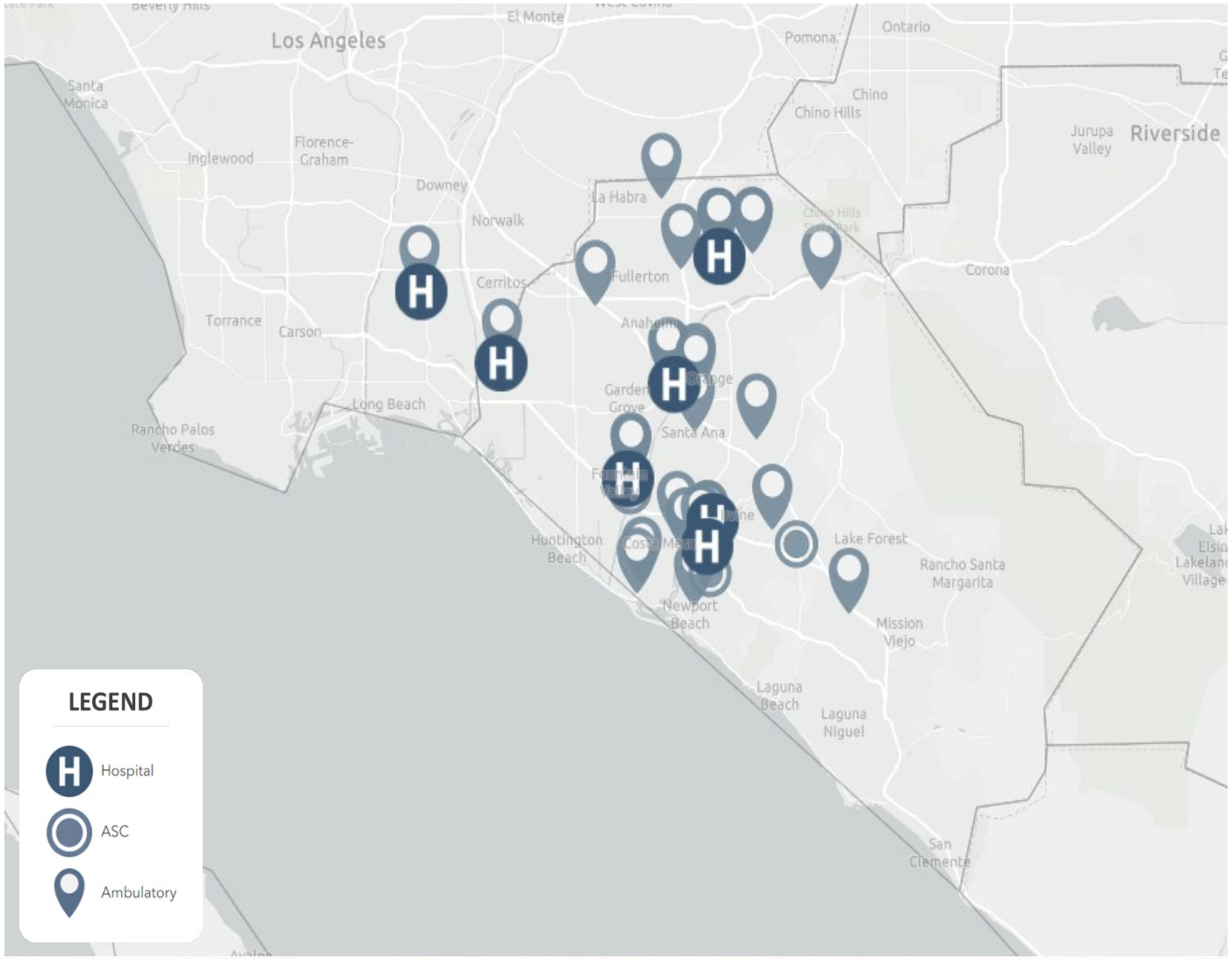
$4B
Total Operating Revenue

215,000
Emergency Visits

UCI Health

vizient.

UCI Health Locations



UCI Health Vizient AQA Performance

BACKGROUND

Observations

92%

of patients wait several weeks for an appointment

↑9%

Year-over-year real estate prices in California.

~31 days

U.S. Median Lag Days

Access and demand for **care is more** of a challenge than ever. Lag days have **increased 67%** since 2013.

Extending **resources** by adding **space** or physicians is challenging.

UCI Health has experienced increased demand due to improved brand reputation.

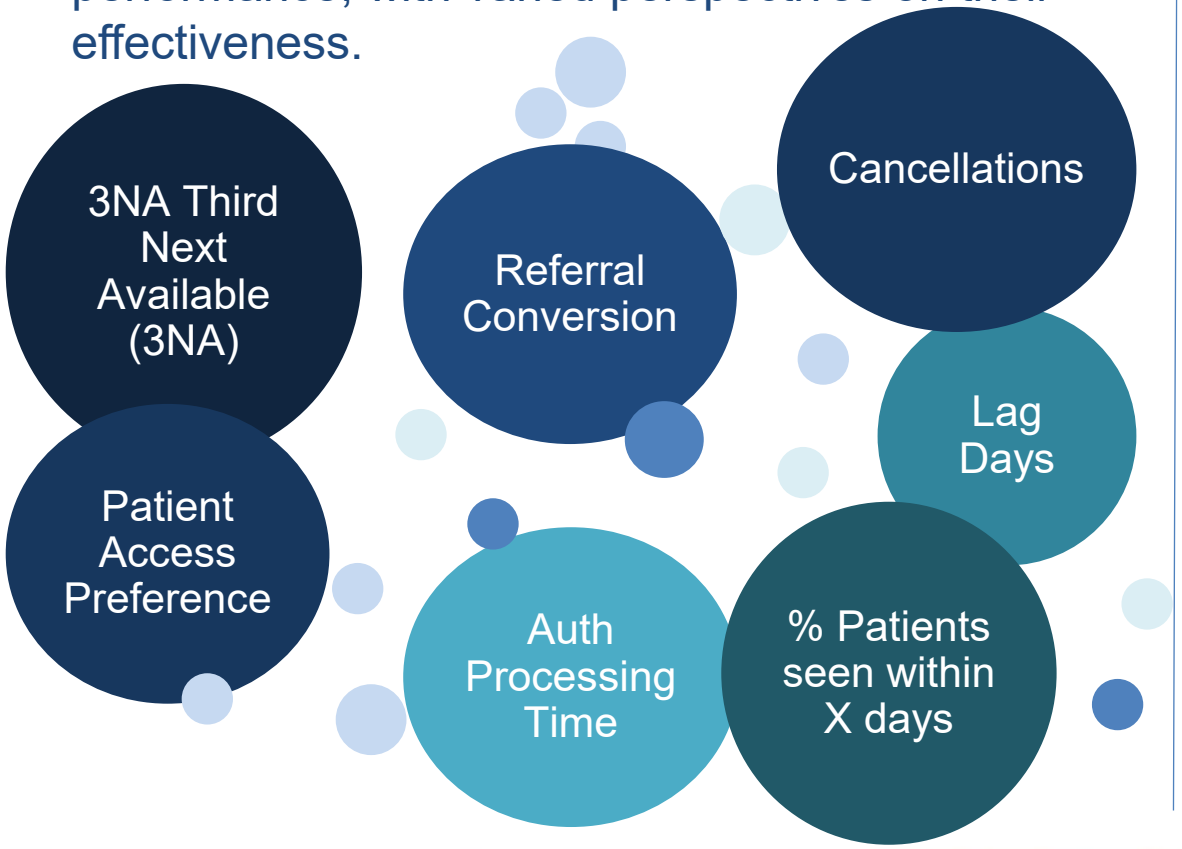
Healthcare worker shortages exist across the U.S.

Access to care is a key component to **quality of care.**

Sources: Gooch, K. (2025, May 27). *Physician appointment wait times climb: 4 survey findings - becker's Hospital Review: Healthcare News & Analysis*. Becker's Hospital Review | Healthcare News & Analysis. https://www.beckershospitalreview.com/quality/hospital-physician-relationships/physician-appointment-wait-times-climb-4-survey-findings/#:~:text=The%20survey%2C%20which%20focused%20on,from%20both%202022%20and%202004.
The waiting game: New-patient appointment access. Healthcare Consulting | ECG Management Consultants. (2025, July 25). https://www.ecgmc.com/insights/whitepaper/3138/the-waiting-game-new-patient-appointment-access-for-us-physicians

Access initial state

The previous approach relied on **numerous access metrics** to monitor and measure performance, with varied perspectives on their effectiveness.



Progress was limited under this approach and the initiatives are subject to the following **challenges and limitations**:

- **Readiness:** Competing priorities and resources created confusion and delay
- **Alignment:** Administrator and physician engagement was uncoordinated
- **Accountability:** Unclear decision-making bodies lead to delays of work
- **Prioritization:** Project teams struggled to align
- **Culture:** Patients waiting 3 months for an appointment was a source of pride

UCI Health Approach

These four pillars emphasize organizational and data alignment, scheduling foundation, and creative collaboration to enhance patient flow and clinical efficiency.

01

Governance

Create alignment across the organization to enable systemic change.

02

Data

Real time data communication to allow strategic decision making and agile daily adjustment.

03

Foundation

Created an infrastructure around template design to optimize resources.

04

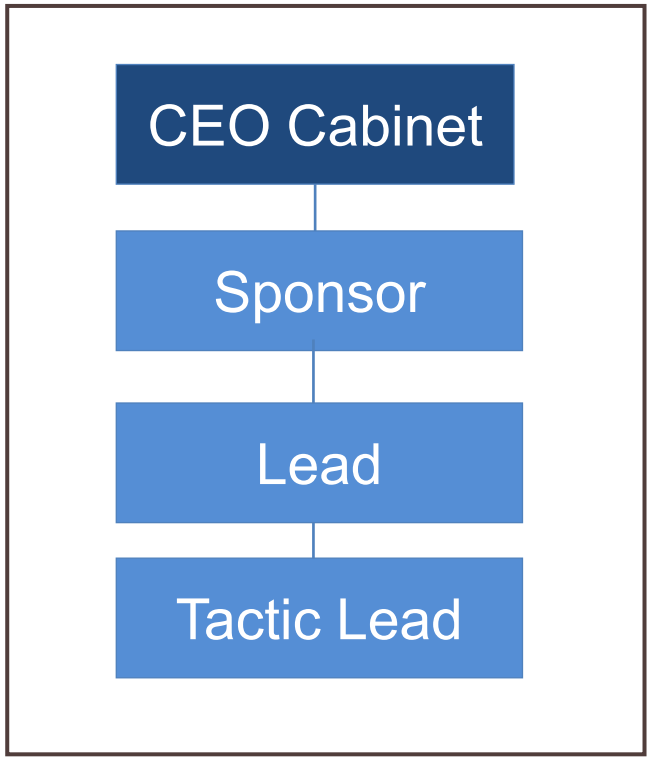
Innovation

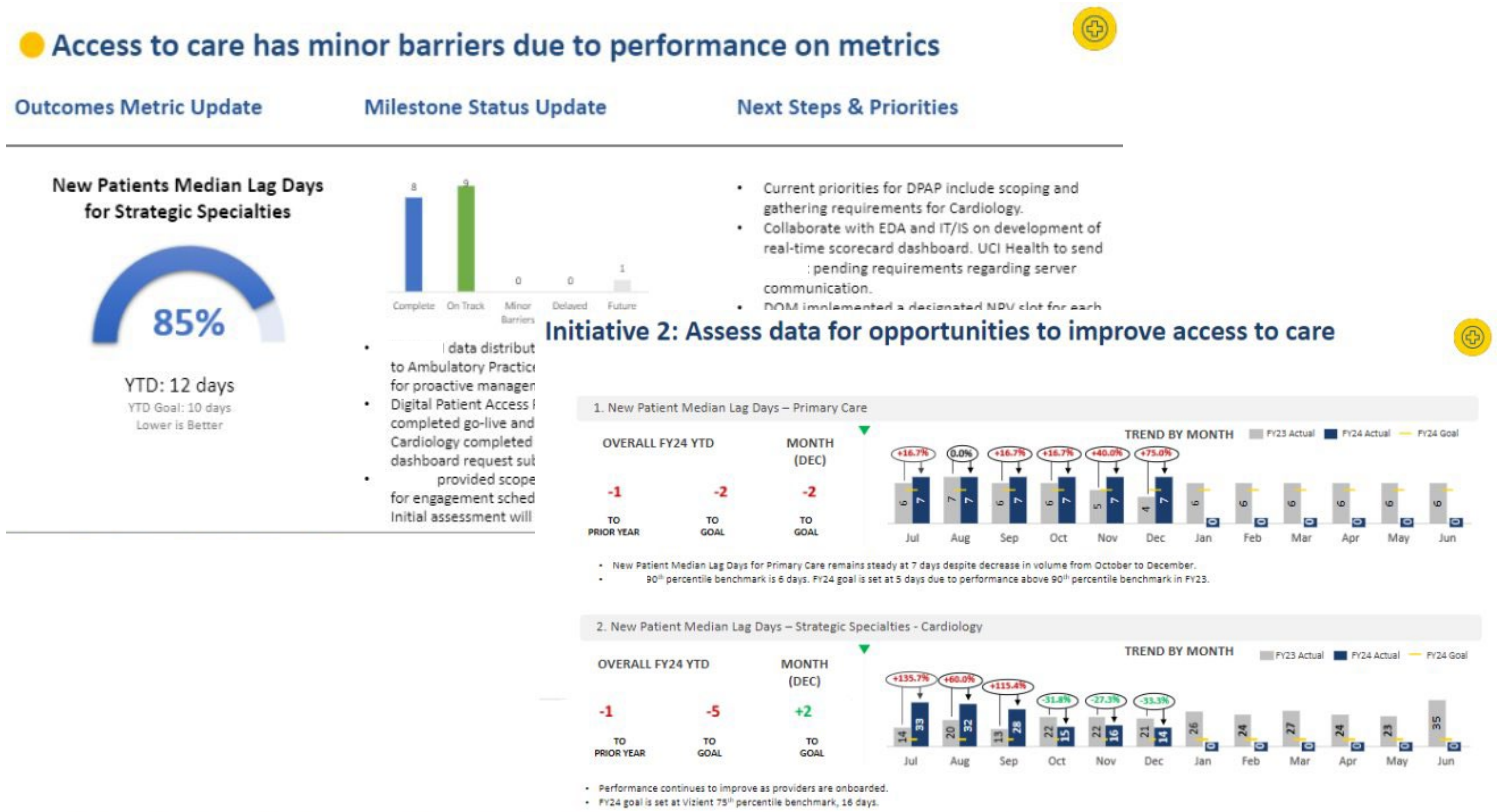
Use creative problem solving and collaborate on patient flow & clinical workflow

GOVERNANCE

C-Suite Lead Strategic Operating Plan

Enterprise-wide decision to prioritize access, making it the identity of the health system. This focus was driven by executive leadership through a strategic operating plan which reported out monthly.





Data source: UCI Health internal planning and analysis database

Tactic: Governance

What We Mean

Ensure alignment, accountability, and transparency to improve patient access to ambulatory care services across our healthcare organization.

Why It Matters

Governance creates a **unified** forum for leaders to set priorities, identify barriers and implement **standardized** access policies and practices.

Goal

Develop strategies, policies, and **procedures** to enhance **patient experience** and **streamline access** processes by **empowering departments.**

imagine
THE POSSIBILITIES

DATA ALIGNMENT

Ambulatory Integrated Scorecard

Historically productivity, demand and access data were independently reported. Numerous teams collaborated to connect various streams of data.

Connecting strategy, access, and space information to partner with various divisions.

Teams:

- Clinical Affairs
- Ambulatory Operations
- Clinical Departments
- Finance
- Information Technology Systems

Dynamic Dashboard:

- Workforce productivity – provider wRVU production relative to benchmark
- Provider availability – template capacity, utilization and operational efficiency
- Access – timeliness to patient appointments

All-in-One:

- Operational Improvements
- Patient Demand vs. Provider Supply
- Workforce Planning Insights
- Space Planning

Ambulatory Integrated Scorecard Background

cFTE:

- Provider clinical effort
- Options – time based; financial; wRVUs; service model
- Faculty physicians = Teaching + research + direct clinical care
- How to standardize this?
  - Methodology = 1 – buy down
    - Buy downs – grant funding, medical directorships, program director
  - Clinical department administrators maintain monthly

wRVU Targets:

- Utilized specialty-specific benchmarks
- Initially placed goals at 50th percentile productivity
- Correct to cFTE
- Salary tied to benchmarks
- In the five years since using this metric we have found physicians to be at or above wRVU targets

Ambulatory Integrated Scorecard Example

imagine THE POSSIBILITIES

Utilized scorecard data to identify performance gaps and guide targeted tactics for each division. This data-driven approach ensured that interventions were tailored to specific needs, promoted accountability, and aligned with system-wide access goals.

							Provider Capacity & Utilization						Vizient Data					Where are patients coming from?								
Physician Name	Specialty	Sessions	Average Clinicial cFTE Benchmarks	FY 24 Actual cFTE	FY 24 wRVU Actuals	Adj wRVU Benchmark	Committed Clinic Hours	Schedule Openings	Scheduled Clinic Hours	Same Day Cancel/ No Show	Arrived Clinic Hours	Template Utilization	% of New Patients Visits	New Patient Median Lag Days	Patient No Show Rate	Clinic/Provider Cancellations	Appointment Automation	PSA - Irvine	SSA - Coast	SSA - South	PSA - Orange	SSA - North	SSA - East	SSA - Coast North	Not in Market	New Patients Waiting
		2.0	1.00	1.91	16,599	8,670	726.67	11	737.67	-41.8	695.83	95.8%	41.1%	13.0	11.8%	3.7%	10%	288	297	169	951	291	70	14	304	18
		4.5	1.00	1.01	8,779	8,670	573.5	191	764.5	-41	723.5	126.2%	61.5%	8.0	16.1%	11.1%	14%	308	281	258	595	205	77	18	236	19
		3.0	0.57	1.2	6,174	5,152	317	188	335.75	-15.8	320	100.9%	75.3%	5.0	12.8%	13.4%	1%	139	253	116	380	136	37	11	183	57
		3.0	1.00	1.15	10,359	9,012	608	188	796	-54.5	741.5	122.0%	82.3%	4.0	15.3%	3.6%	0%	438	376	275	1021	337	72	8	405	62
		4.0	0.75	1.18	7,957	6,729	573.5	191	764.5	-41	723.5	126.2%	68.5%	n/a	10.8%	2.3%	9%	224	447	159	765	289	82	15	409	15
		3.0	1.00	0.48	4,237	8,895	753.75	-257	496.75	-23.5	473.25	62.8%	62.7%	7.0	17.0%	6.8%	7%	107	152	113	521	147	45	10	158	6
		1.0	0.33	0.14	499	3,523	278.5	-113	166	-12.3	153.75	55.2%	33.3%	13.0	11.4%	18.8%	0%	8	14	11	40	19	7	1	16	5
		3.0	1.00	0.97	10,368	10,674	607.25	-260	347	-24	323	53.2%	32.7%	20.0	13.7%	10.1%	11%	193	248	366	575	204	85	4	262	7
		3.0	1.00	0.52	3,839	7,359	513.5	-209	304.83	-20.5	284.33	55.4%	76.6%	6.0	18.4%	5.5%	0%	48	59	63	183	69	45	8	158	2
		3.0	1.00	1.44	7,359	10,588	386.25	146	532.33	-23.3	509.08	131.8%	59.5%	9.0	16.8%	2.8%	9%	104	192	252	542	186	82	21	317	13
		3.0	0.84	1.08	11,174	10,354	107.25	130	237.17	-7.5	229.67	214.1%	30.5%	34.0	9.7%	2.3%	22%	129	247	200	181	92	29	0	219	71
		4.0	1.00	1.35	16,622	12,327	733	-256	476.58	-32.3	444.25	60.6%	62.8%	8.0	19.6%	14.5%	2%	187	223	243	449	200	54	4	203	30
		5.0	1.00	0.91	11,199	12,327	897.5	813	978.83	-57.5	921.33	102.7%	34.3%	15.0	14.9%	3.3%	5%	306	402	318	941	472	129	29	555	32
		5.5	1.00	0.89	8,127	9,125	932.5	-137	796	-49.5	746.5	80.1%	62.6%	8.0	16.1%	10.6%	1%	248	266	256	721	394	85	14	252	97
		4.0	1.00	1.38	12,560	9,125	799.75	-63.8	736	-32.5	703.5	88.0%	88.0%	4.0	14.5%	2.4%	0%	392	542	285	695	288	79	25	409	57
		2.0	1.00	0.87	8,341	9,609	247	188	435.33	-58.5	376.83	152.6%	52.3%	7.0	17.4%	2.5%	8%	59	148	70	408	115	30	14	146	8
		2.0	1.00	0.98	9,432	9,609	239.33	145	384.25	-44.7	339.58	141.9%	72.3%	16.0	18.0%	2.5%	0%	30	100	49	501	163	24	10	145	11
		1.0	0.55	1.65	8,727	5,285	143	193	335.75	-21	314.75	220.1%	61.6%	7.0	14.3%	3.3%	0%	28	130	76	384	138	24	6	147	12
		56.0	**16.04**	19.11	**162,352**	**157,033**	9,437.25	188	9,625.24	-601	9,024.15	95.6%	62.3%	7.0	14.9%	6.0%		11%	14%	11%	33%	12%	3%	1%	15%	
Source:				*Internal FY23*	*Internal FY23*	*Internal FY23*	*Internal FY23*	*Internal FY23*		*Internal FY23*		*Internal FY23*	*Vizient Data FY23 Benchmark 75th: 63.67% Benchmark 90th: 72.48%*	*Vizient Data FY23 Benchmark 75th: 6 Benchmark 90th: 6*	*Vizient Data FY23 Benchmark 75th: 12.83% Benchmark 90th: 9.99%*	*Vizient Data FY23 Benchmark 75th: 3.08% Benchmark 90th: 1.72%*	*Internal Data FY24*	*Internal: FY23*								

Data source: UCI Health internal planning and analysis database

vizient.

Ambulatory Integrated Commitment

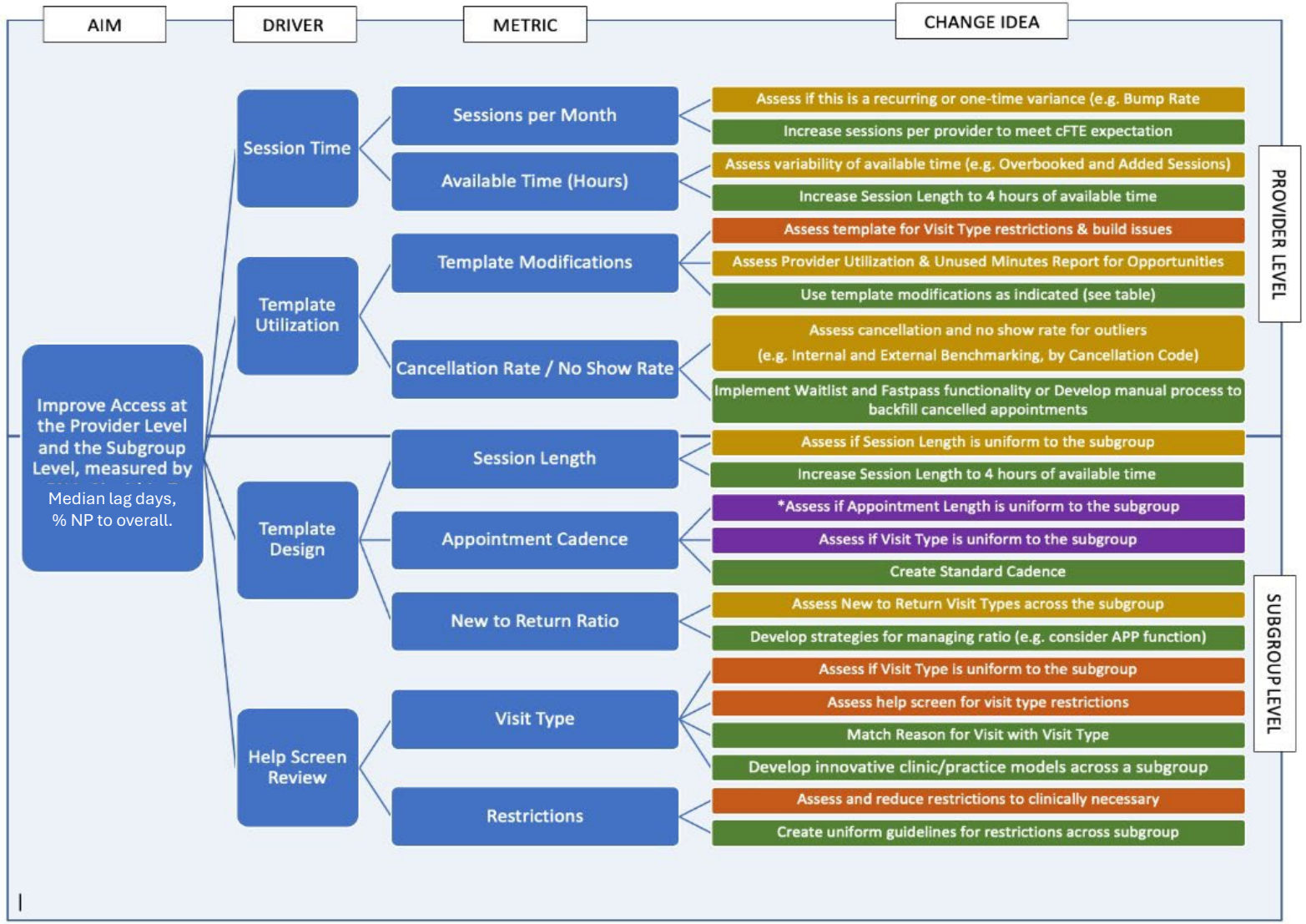
- Sessions (4 hours) per week
- Adjusted to cFTE
- Straightforward in strictly ambulatory facing specialties
- Less clear for proceduralists, surgeons and those with inpatient time
- 44 weeks per year

Department Name:

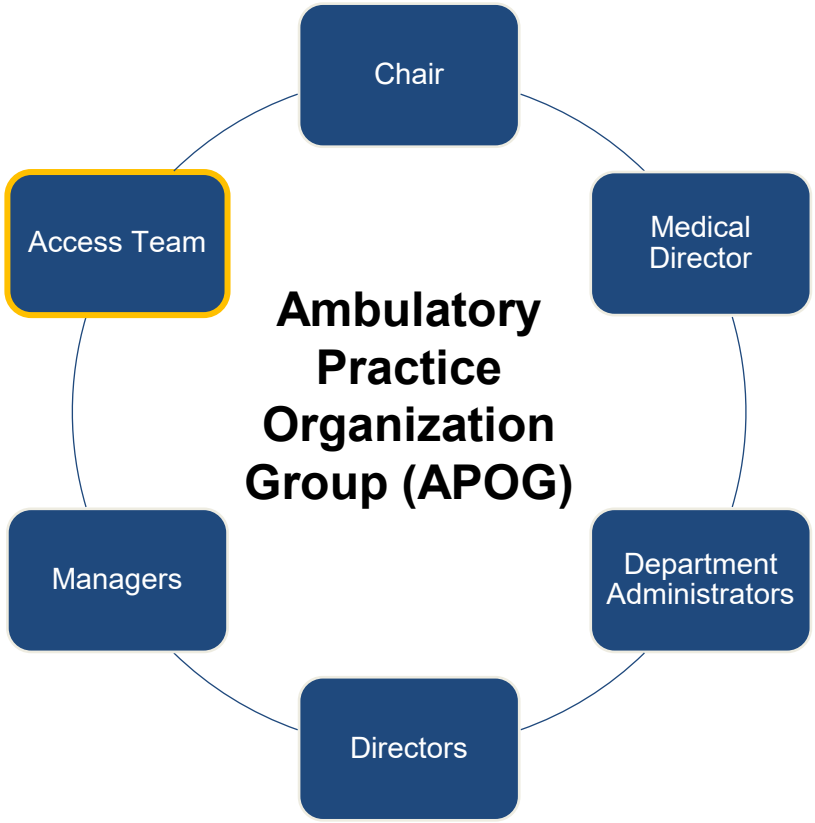
Instructions: Input items in BLUE on an annual basis or as changes arise to faculty or clinical services

	Outpatient Clinics		Inpatient Services																Surgeries, Procedures, or Interpretations *(Dedicated Sessions sutside of clinic or IP setting)*			
			Service 1 Name, e.g., Consult			Service 2 Name			Service 3 Name			Service 4 Name			Service 5 Name						Procedure 1 Name (Avg. Hours/ Session)	Procedure 2 Name (Avg. Hours/ Session)	Procedure 3 Name (Avg. Hours/ Session)	
Weeks per Year	Hours per Clinic Session	Total Clinic Hours per Year	Days per Week	5		Days per Week	5		Days per Week	5		Days per Week	5		Days per Week	5		Total IP Weeks per Year	Total IP Hours per Year	Total OP & IP Clinical Hours	Are Clinics Cancelled when on IP Service? Yes = leave column calc; No = zero out				
44	4		Hours per Day	8	Hours Per Year	Hours per Day	8	Hours Per Year	Hours per Day	8	Hours Per Year	Hours per Day	8	Hours Per Year	Hours per Day	8					8	5	4	
Faculty Name	# of Clinic sessions per Week		# of Weeks			# of Weeks			# of Weeks			# of Weeks			# of Weeks							# Sessions per Week	# Sessions per Week	# Sessions per Week	Total Surgery, Procedure, or Interpretation Hours
Faculty Name 1	5	880	3		120			0			0			0			3	123	1,003	60			2	352

Ambulatory Integrated Scorecard Interventions



Culture & Collaboration



- Division level automated reports
- Targeted monthly review of access data with APOG team
- Action plans created and implement based on data
- Facilitated accountability and collaboration on process improvement, market intelligence and workforce planning

FOUNDATION

Template Optimization Phases

Templates lacked standardization and were primarily designed at the individual physician level, leading to significant variability among providers within the same division. UCI Health has implemented a phased approach to enhance and streamline scheduling practices.

1. **Visit Type Consolidation**
2. **Template Redesign**
3. **Scheduling Guidebooks Creation**
4. **Digital Optimizations**

Template Optimization | Visit Type Review

Visit Type

Consolidated visit types in peach.

Number of visit types went from 30 to 10.

Prc Name	UCI CM NEURO EMG	UCI COHS INTG NEURO	UCI LAGUNA HLS NEURO	UCI NWPT MAC NEURO	UCI NWPT NEUROLOGY	UCI PAV1 NEUROLOGY	UCI PLAZA NEURO	UCI SAMUELI AUTISM	UCI TUSTIN NEUROLOGY	Grand Total	NOTES:
COGNITIVE TESTING ACCESS						1				1	Consolidate to Procedure
FEEDBACK BRIEF VISIT								6		6	Consolidate to BV
HOSPITAL FOLLOW UP						58	8			66	
INTEGRATIVE BRIEF VISIT		24								24	Consolidate to BV
INTEGRATIVE INTERNAL REFERRAL		2								2	Consolidate to BV
NEURO PROCEDURE	21		85	129	610	364	17			1,226	
NEW INTEGRATIVE PATIENT		7								7	Consolidate to New
NEW NEURO PATIENT			199	78	867	1,371	1,429		43	3,987	
NEW PEDS PATIENT								263		263	Consolidate to New
NEW THERAPY PATIENT								11		11	Consolidate to New
NURSE						97	3			100	
PSYCHO THERAPY					2					2	Consolidate to Procedure
PSYCHOLOGICAL TESTING								13		13	Consolidate to Procedure
SPECIALTY FOLLOW UP								109		109	Consolidate to BV
THERAPY BRIEF VISIT								755		755	Consolidate to BV
UCI TELEMEDICINE VISIT			3	8	107	241	318	581	1	1,259	
UCI VIDEO NEW			1					11		12	Consolidate to Patient portal
UCI VIDEO RETURN			2		1	4	23	333		363	Consolidate to Patient portal
UCI PATIENT PORTAL VIDEO NEW			6		16	324	30	180		556	
UCI PATIENT PORTAL VIDEO RETURN			26	34	169	818	724	1,807	13	3,591	
Grand Total	**21**	**33**	**617**	**343**	**3,778**	**5,441**	**8,196**	**7,164**	**88**	**25,683**	

Data source: UCI Health internal planning and analysis database

Template Optimization Phases | Design Strategy

imagine THE POSSIBILITIES

Template Design

Visit Type Name	Legacy	Optimized
New Patient	60,40,30	60
Return Patient	40,20,30	30
Nurse Visit	30,20,15	30

Removed variation in visit type length and set division standards.

LEGACY SYSTEM

- Open access which could limit capacity for new patients as returns would fill the schedule for sooner appointments.

FUTURE STATE

- Designation of patient slots (auto-release if unfilled)
  - New Patients
  - Brief Visits
  - Employees

Thursday - Laguna Hills						
Time	Regular	Overbook	Pri?	Length	Block ID	Block
8:00-8:30 AM	1	1	0	30		BRIEF
8:30-9:00 AM	1	1	0	30		BRIEF
9:00-9:30AM	1	1	0	30		NP
9:30-10:00 AM	1	1	0	30		
10:00 - 10:30 AM	1	1	0	30		BRIEF
10:30 - 11:00 AM	1	1	0	30		BRIEF
11:00-11:30 AM	1	1	0	30		NP
11:30-12:00PM	1	1	0	30		
1:00-1:30PM	1	1	0	30		BRIEF
1:30-2:00PM	1	1	0	30		BRIEF
2:00-2:30PM	1	1	0	30		NP
2:30PM-3:00PM	1	1	0	30		
3:00PM-3:30PM	1	1	0	30		BRIEF
3:30PM-4:00PM	1	1	0	30		BRIEF
4:00PM-4:30PM	1	1	0	30		NP
4:30PM-5:00PM	1	1	0	30		

Ideal session design:
New Patients: 2
Total Patients: 6
% NP to Overall: 33%
75th % Benchmark: 26%

Data source: UCI Health internal planning and analysis database

Template Optimization Phases | Help Screen

Help Screen Review

Restrictions eliminated:

- Not accepting referrals from Doctor X
- Only 1 New Patient per session can be booked
- No Same Day Appointments
- Call XXX-XXX-XXXX to book new patient

Reason for visit alignment:

- General Neurology
- Epilepsy
- Stroke
- Movement Disorders

Template Optimization Phases | Digital

Digital Optimization

Schedule Automation:
All new patients added to automated waitlist.

Block Release:
Specific unfilled visit types release within 72 hours.

Holds:
Revised security to place holds and override visit types.

Appointment Reminders:
Revised cadence to include 60- & 30-day notifications.

IMPACT:

25
FY 24: 20
Days Saved

92%
FY 24: 63%
Refill Rate of Patients

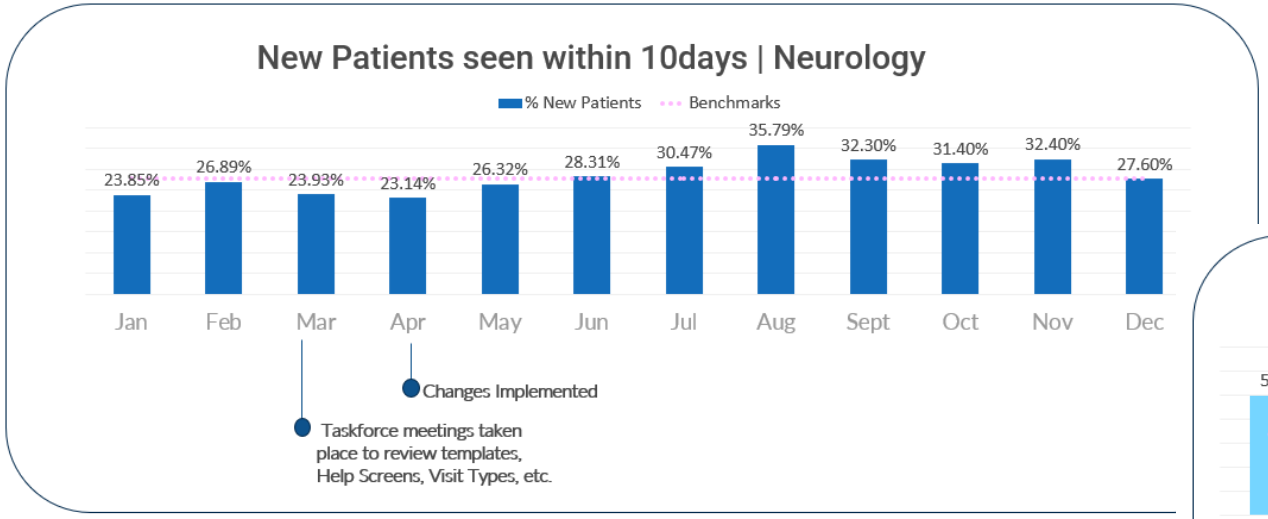
~201,000
FY 24: 337,309
# of Slot Holds

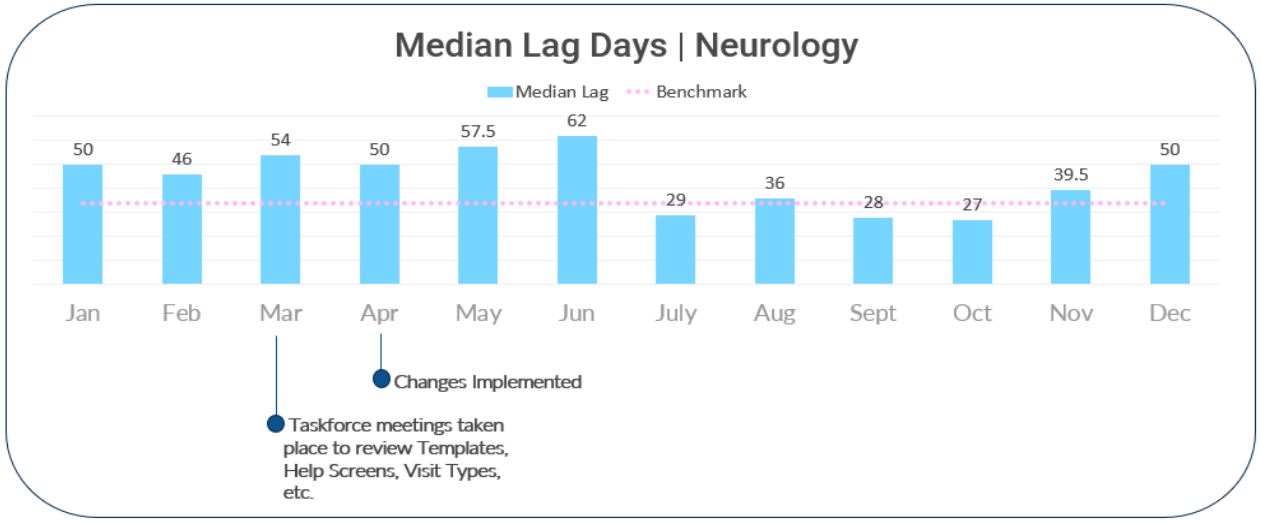
5%
FY 24: N/A
Cancellation Refill

Data source: UCI Health internal planning and analysis database

Template Optimization: Neurology

Neurology went through template optimization by redesigning access templates, usage and performance. A decrease in wait times was realized.





Departmental support is essential to the continued success of the template optimization and patient access.

Data source: UCI Health internal planning and analysis database

CLINICAL CARE PATHWAYS

Clinical Care Pathway

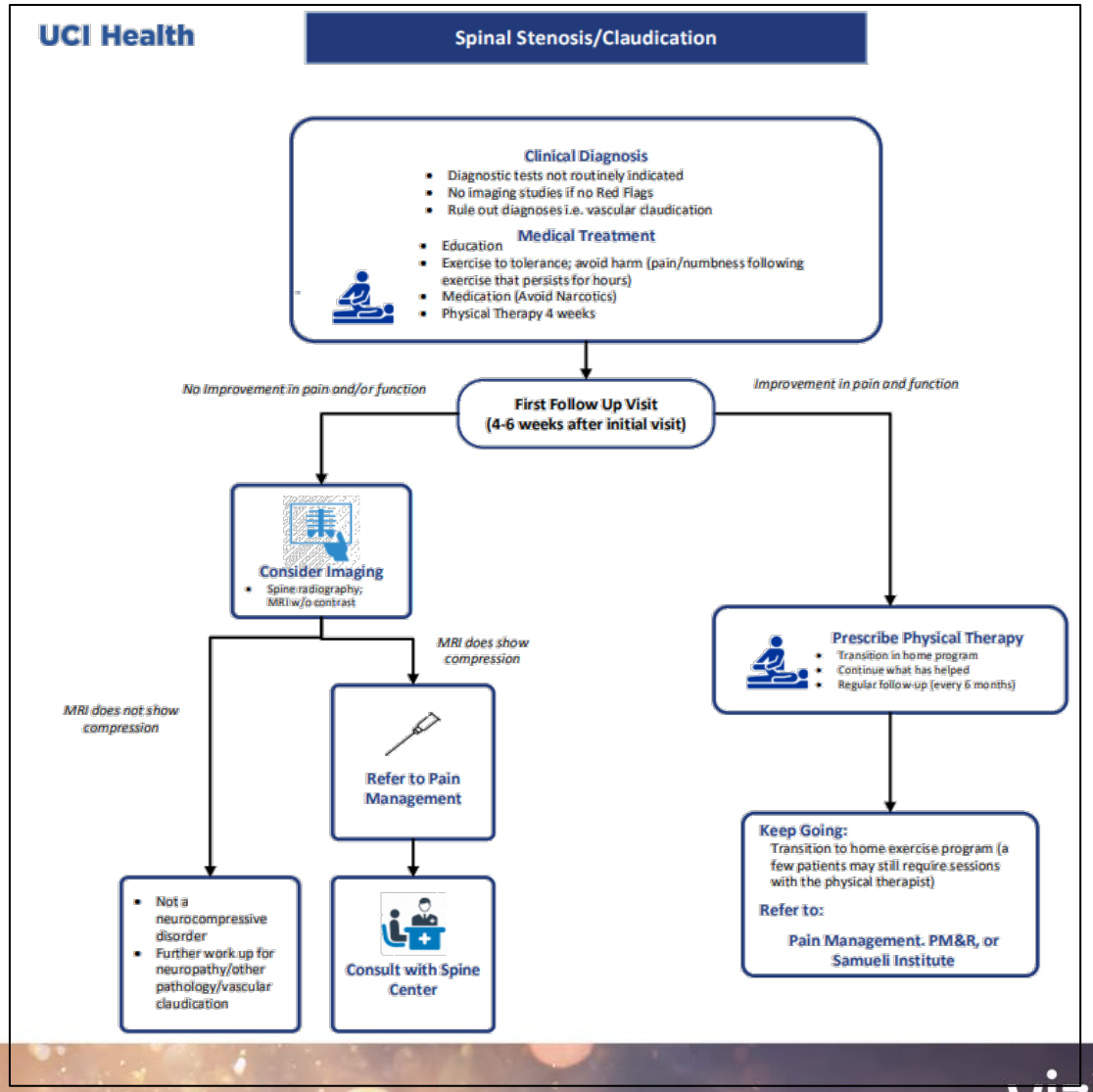
1. Design Clinical Care Pathway
2. Communication Plan & Patient Experience
3. EMR Advancements
4. Impact of Pathway

Clinical Care Pathway| Workflow Design

Pathway Design

Spine Pathway:

- Meaningful first visit.
- Number of surgeries, appointments to offer and return appointments impact.

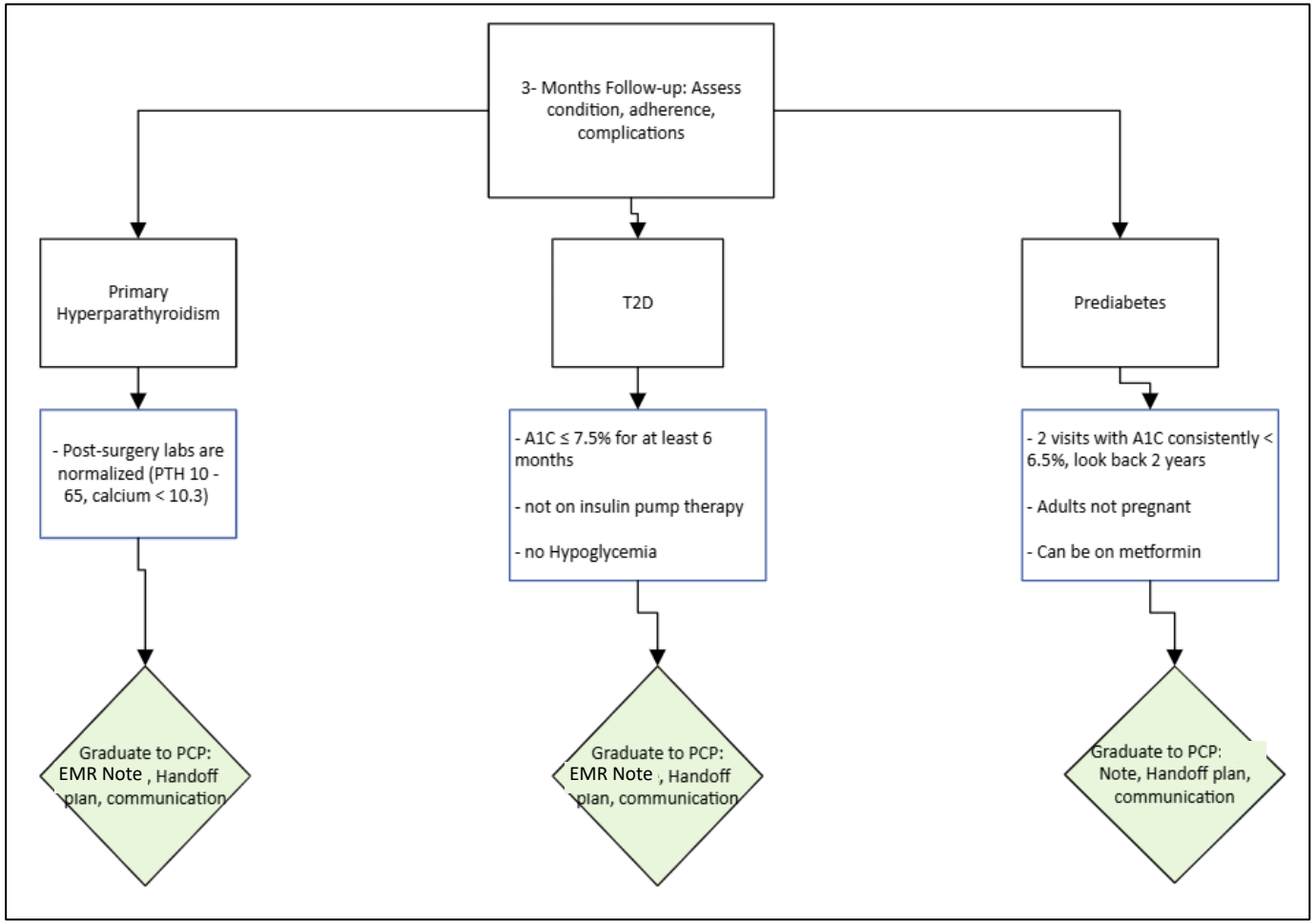


Clinical Care Pathway| Workflow Design

Pathway Design

Endocrinology Pathway:

- **Graduation of patient.**
- **Thresholds defined to support patient stability & create new patient access.**



A1C = hemoglobin A1C ; PTH = parathyroid hormone; T2D = type 2 diabetes

Clinical Care Pathway | Communication Plan

imagine THE POSSIBILITIES

Engagement

Patient Experience

- Physician and patient care transitions
- Convey when a patient is stable and ready for repatriation

Integration

- Graduation letters
- PCP communication of stability
- Call center trainings

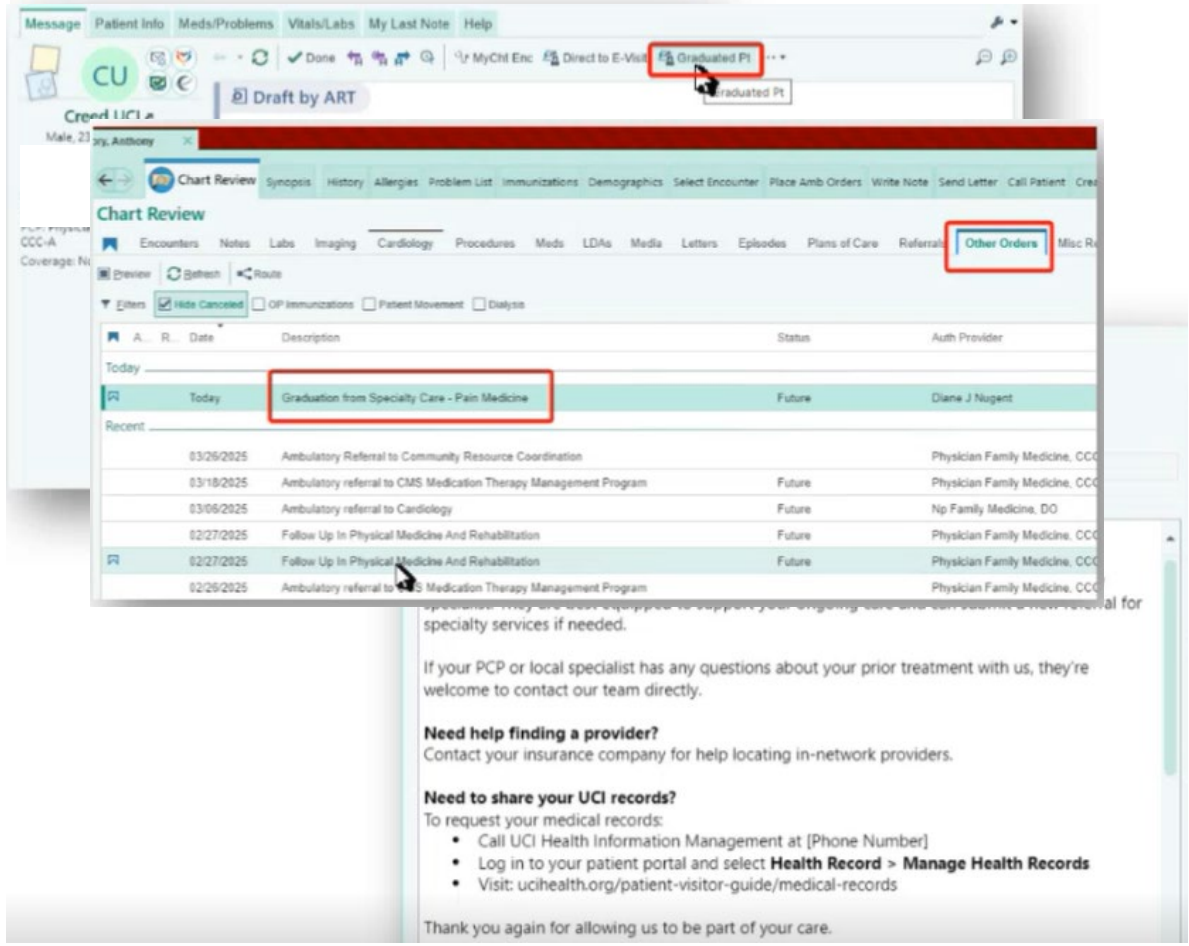
Clinical Care Pathway | EMR Advancement

EMR Enhancement

1. Follow Up Button & AVS Update:
Selects Graduation from Specialty Care button in the follow up section to populate on AVS.

2. Patient Portal Quick Action:
Patient requests additional treatment via portal after graduating, support staff can leverage a compliance/marketing designed response to kindly inform the patient to return to PCP.

3. Front Desk Workflows:
Patient Calls Requesting for an appointment, team could reference tab to see if patient graduated from the Division.



AVS = after-visit summary

Fictitious patient data shown

Clinical Care Pathway | Physician Engagement

imagine THE POSSIBILITIES

Teamwork Impact

Endocrinology Pathway

6	1	60+
Pathways Designed	Implemented in EMR	Patient Graduations

CHALLENGES:

1. Pathway consensus amongst physicians from Endocrinology & Primary Care to manage care.
2. Work queue list created, not all patients should graduate since multimorbidity and physician review is necessary.

IMPACT FROM ENGAGEMENT:

1. Review at monthly meetings patients ready to graduate from the division, creating a culture of collaboration.
2. Supporting access and creating capacity for new patients to be seen.

Physician support and engagement is essential to the continued success of patient graduation and access to care.

Lessons Learned

- Governance without alignment leads to fragmentation.
- Pair data with real-time collaboration.
- Sustainable change requires operational and clinical partnership.

Key Takeaways

By establishing clear governance, organizations can align priorities and drive consistent action. Coupled with real-time insights and innovative problem-solving, this approach ensures sustainable improvements in access, resource utilization, and care delivery.

01

Governance

Create alignment across the organization to enable systemic change.

Culture & Best Practice

02

Data

Real time data communication to allow strategic decision making and agile daily adjustment.

Dashboards & Data

03

Foundation

Address technical infrastructure around template design to optimize resources.

Template Optimization

04

Innovation

Use creative problem solving and collaborate on patient flow & clinical workflow

Pathway Development

Questions?

UCI Health imagine THE POSSIBILITIES

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This educational session is made possible through the collaboration of Vizient Member Networks.

Roundtable Discussion: What are You Doing to Improve Capacity and Grow Key Service Lines?

Rob Edwards, PhD, MBA, Chief Strategy and Growth Officer

UK HealthCare

Jill Engel, DNP, ACNP, FNP, NEA-BC, FAANP, Service Line Vice President – Heart and Vascular

Duke University Health System

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Roundtable discussion

- What are your current initiatives to ***improve capacity*** in key service lines?
- What are your current initiatives to ***increase access*** in key service lines?
- What else are you doing to ***enable growth*** in key service lines?

Questions?

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This educational session is made possible through the collaboration of Vizient Member Networks.

Wrap-up and closing

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