

The Mayo Clinic Value Creation System

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Abstract

The authors present Mayo Clinic's Value Creation System, a coherent systems engineering approach to delivering a single high-value practice. There are 4 tightly linked, interdependent phases of the system: alignment, discovery, managed diffusion, and measurement. The methodology is described and examples of the results to date are presented. The Value Creation System has been demonstrated to improve the quality of patient care while reducing costs and increasing productivity.

Keywords

value, quality, systems engineering, cost, productivity

Our premise and our experience have been the same. There is no trade-off between improving quality and decreasing cost. In fact, when viewed from the whole of a balanced portfolio of value creation, they occur concurrently if undertaken with a disciplined and balanced systems engineering approach while keeping the best interests of the patient in mind. Increased productivity and decreased cost structure are intended and rationally expected consequences of higher quality.

In this article on our Value Creation System, we present the definition; the opportunity; the system, which comprises the components of alignment, discovery, managed diffusion, and measurement; and the results.

The Definition

The Value Creation System is Mayo Clinic's coherent approach to delivering a single high-value practice. This work applies across our entire practice (ie, 5 states, 22 hospitals, primary care, community-based providers, tertiary referral practice). Delivering the highest value care is a core business strategy for Mayo Clinic. The resources supporting the Value Creation System are not viewed as an expense; they are an investment. Central to the success of this strategy is a systematic process to tap into and leverage our collective intelligence with intent to harvest the dividends from driving out clinically unwarranted waste, variation, and defects in our care of patients.

The Value Creation System is complementary to the Mayo Clinic Value Construct that we first defined in 2006.¹ The Value Construct established the foundation of 4 domains

that are requisite for the Value Creation System: infrastructure, culture, engineering, and execution. Mastery of each organizational domain is necessary, but insufficient, as all are required to transform to high reliability. Whereas the construct focuses on the broad strategy to build a quality program/environment, the Value Creation System focuses on prioritizing, developing, and standardizing to best practices.

The Opportunity

America spends 2.4 times more per capita on health care than the average spent in developed countries. We have nearly 3 times as many magnetic resonance imaging scanners per capita, undergo substantially more cardiac revascularization procedures, and are among the highest consumers of pharmaceuticals. Approximately 20% to 30% of the \$2.2 trillion spent on health care in America can be considered non-value-added expense that is directly attributable to providers, hospitals, and clinics. There is additional waste

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in administrative and insurance costs that are beyond the reach of providers, hospitals, and clinics. Our health outcomes (eg, longevity, infant mortality) are not what one would expect from the highest cost system.²⁻⁴

Although Mayo Clinic already has low overall intensity of care indices and low utilization rates during the last 2 years of life,^{5,6} there still is ample opportunity for further substantial gains in efficiency and waste reduction. We believe it is possible to annually reduce our cost structure by ~1% for the next decade and beyond. For Mayo Clinic's approximately \$8.0 billion annual revenues, this translates into \$80 million in productivity gains per year.

America's health care is essentially a cottage industry of fragmented, dedicated artisans who eschew standardization. Care is frequently highly variable, and performance is, in large part, unmeasured. Care is customized to individual patients by autonomous dedicated physicians working in silos.⁷

There are 3 main categories of clinically unwarranted variation, waste, and defects. They are overuse, preventable complications, and process inefficiency.⁸ As medical institutions address these issues in a patient-centered manner, they can deliver positive net operating income.

There still are perverse incentives within our health reimbursement system that encourage overuse and pay for defects. Most payers still "pay for volume" without regard to utilization, efficiency, outcomes, safety, or service—that is, they do not pay for value. Medicare spending rewards historic regional process inefficiency of selected procedures and tests rather than coordination of care. Nonetheless, a patient-centered approach to delivering health care demands concerted, integrated value creation efforts.

Mayo Clinic is an advanced integrated multispecialty group practice in an academic setting.⁹ Our Value Creation System is an approach to move the paradigm from one of the autonomous "independent contractor" mentality of a cottage industry to a postindustrial environment that is largely composed of interdisciplinary teamwork and standardization that encourages variation from established Mayo Clinic care only for patient-centered reasons. Both cultural and technical capabilities are necessary to achieve a single high-value practice.

Today, our multispecialty integrated group practice relies heavily on our culture and the telephone. We have a blueprint for a fully developed, integrated, information-aggregating system that seamlessly moves knowledge to delivery. The Mayo Clinic single high-value practice strategy will drive us further toward a standardized approach that ensures every patient, regardless of where or how he or she contacts Mayo, is assured of the same high-value care. Variations from the evidence-based standards should occur only when the individual needs of specific patients warrant a modified approach.

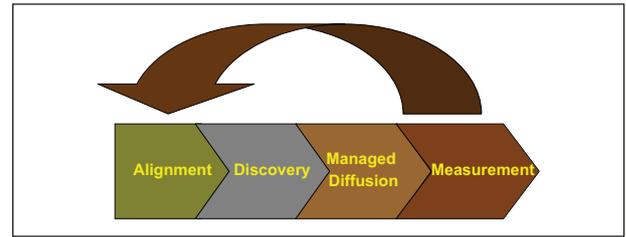


Figure 1. Mayo Clinic Value Creation System

The Value Creation System

There are 4 tightly linked, interdependent phases of the Value Creation System: alignment, discovery, managed diffusion, and measurement (Figure 1).

Alignment

The alignment phase entails a translation of our strategic plan to objectives and targeted initiatives by using a rational prioritization process and disciplined portfolio management. Alignment establishes which clinical processes will be prioritized for improvement and ensures adequate resources for our strategic priorities. Each effort must have an approved charter with explicit accountability, be allocated appropriate resources, and have solid methodology and value metrics. It must be guided with disciplined project management. Mayo's strategic focus on quality during the past several years has led to specific objectives and tactics. An example objective for the coming year includes "standardize, improve effectiveness (outcomes, safety, service), and reduce cost." Each objective is then translated into specific discovery and diffusion tactics as described in subsequent sections. The objectives are confirmed or modified with a corresponding set of new prioritized tactics as the plan is refreshed each year.

As the overall Mayo Clinic strategy expands to include value, our intense focus on quality is maintained. We define value as the quotient of quality (ie, outcomes, safety, service) and cost over time. Therefore, our portfolio now includes projects with a primary focus on improving quality as well as a defined list focused on reducing cost over time.

Discovery

Discovery is an approach to understanding the single best way to care for patients or provide other services. It involves identifying the optimal outcome, safety, service, and cost over time for a given service line or process. It is first and foremost about optimizing and standardizing care with the intent to eliminate waste in the process and

reduce variability as a means to improve patient safety. Fundamentally, systems engineering is the core work of discovery, and it includes dozens of tools, disciplines, and methodologies. Although we use a core set of methodologies and tools, which will be described, we use the generic term *discovery* because we have found that there are many ways to improve a process and there is benefit to keeping an open mind to any improvement regardless of the approach used to achieve it.

Our Value Creation System uses the DMAIC framework (ie, *Design, Measure, Analyze, Improve, Control*) as a template for most discovery work. The different aspects of the Value Creation System are taught in 27 courses within the Mayo Clinic Quality Academy. The academy covers a multitude of topics ranging from the overall strategy to more specific approaches/tools including lean, six sigma, change management, failure modes and effects analysis, project management, and champions training, among others.

The flagship course is a “TEAM’s Training” program that provides 8 full days of face-to-face training and coaching on a specific project over the period of 100 days. On completion of the initial project, the team is well positioned to use their expertise to replicate improvements with other processes in their sphere of influence. In this way, we are “teaching our staff to fish rather than feeding them a single meal of fish.”

Discovery also includes the work of colleagues directed by our Clinical Practice Committee (the enterprise multidisciplinary group accountable for all care of patients), departments, Specialty Councils (leaders of clinical departments from each Mayo Clinic site), and the Center for Innovation (the group leading much of our work to transform the way health care is delivered and experienced). Three case studies exemplify the work of discovery:

Central line-associated bloodstream infections. Central line infections are serious medical complications that extend hospital stays and have mortality rates of roughly 20%. Although Mayo Clinic has had excellent performance relative to national benchmarks, focused efforts to further refine and standardize care over the past 2 years have led to even greater reductions. Infection prevention leaders from all Mayo Clinic sites came together to standardize definitions, assess national standards, apply staff expertise, and develop a common guideline for the placement and ongoing management of patients with central lines.

These concerted efforts have led to a 50% reduction in central line infections per 1000 intensive care unit (ICU) patient days (ie, 2.3 in 2007 to 1.2 in 2010). This translates to 57 patients who have not experienced an infection and the associated harm during this period of time.

In addition to the enhanced quality of care, the overall costs of care have been reduced by roughly \$2.0 million (57 cases times an estimated cost per case of \$30 000-\$40 000).¹⁰⁻¹²

Manage to reimbursement priority projects. Two major systems engineering initiatives were chartered and initiated in 2009 with the goal of reducing cost over time. These included orthopedic joint replacement and cardiac surgical procedures, the goal for which was to reduce cost per case by 20% while improving or maintaining quality measures (ie, a value equation denominator-intensive project). The intent was to ensure that Mayo could be profitable at Medicare reimbursement levels. Physician-led multidisciplinary teams were created in both areas and used value stream mapping to evaluate every aspect of the procedures with a focus of “value add from a patient perspective.”

For both of these Discovery initiatives, we used many tools from our Value Creation System toolbox. However, the predominant method was lean deployed within the overarching DMAIC framework.

Cardiovascular surgery. This team was led by a cardiovascular surgeon and the chair of cardiovascular anesthesiology, supported by the 2 departmental chairs and championed by a board member. The support and champion roles are critical success factors. The team’s efforts demonstrated significant opportunity to reduce waste resulting from overstaffing related to a high degree of variability in caseload from day to day. This results in “staffing to peaks” in the operating room and also leads to staffing inefficiencies in the ICU. Interventions have been put in place to better accomplish demand-capacity management via sharing information with referring cardiologists and greater teamwork among the surgical staff to “level the load.” A reduction in daily operating room (OR) staffing (to match workload) by more than 30%, from 88 hours to 64 hours per day, was achieved. Additionally, care in the ICU has been improved through the concept of value-added processes by implementing a rapid recovery area to reduce “overcare” for the noncomplex patient and developing standardized care guidelines aimed at reducing postoperative time on ventilators and blood product utilization.¹³

The systems engineering work is still ongoing, but current results for 2010 demonstrate an annual savings of roughly \$8 million. This translates to an overall cost per case reduction of 5% for the collective cardiac surgery service line.

Beyond these primary reductions in cost, there have been meaningful quality improvements including an 8% reduction in blood product utilization, reduction in reoperations for bleeding by approximately 30% (1.69% to 1.19%), and an 11% shorter average ICU length of stay.

Orthopedic surgery. This effort was led by an orthopedic surgeon, supported by the department chair and championed by a board member. It resulted in substantial changes in preoperative care, scheduling, staffing within the operating suite, and postoperative care to reduce nonclinically warranted variation and waste.

At the beginning of the effort, no orthopedic surgeon had a cost structure at or below Medicare reimbursement levels. Today, nearly two thirds of the surgeons have met this benchmark for primary knee replacements. The entire process was studied by creating a value stream map (ie, a lean tool), measuring the time required for each step, and identifying the added value from a patient perspective. This led to a variety of pilot projects to test new process flows and staffing models to ultimately arrive at the recommended best practice. Ultimately, the key drivers of the savings were increased through OR efficiency and shorter lengths of stay for hospital patients.

The diffusion work is still ongoing, but results to date show an overall savings of approximately \$2.6 million each of the last 2 years. Beyond these primary reductions in cost, there have been meaningful quality improvements including a 40% reduction in blood product utilization, a 24% reduction in length of stay with no increase in hospital readmissions, reduced infection rates, and significant improvement in staff and patient satisfaction. Finally, a more efficient work environment is inherently safer and produces better outcomes for the patient while improving staff satisfaction.¹⁴

Discovery also involves understanding and then either adapting or adopting practices from improvement organizations, medical societies, or directly from the medical literature. Medical society guidelines are a rich resource of credible work already done. If national guidelines and protocols are not replicated, they can serve as a solid platform for improvement.

Each year the Mayo Clinic Clinical Practice Committee refreshes the annual work plan for value creation (Figure 1). The 2010 value portfolio of discovery projects includes the following:

- Quality (outcomes, safety, service) intensive (ie, value equation numerator-intensive):
 - Thirty-day readmissions (heart attack, heart failure, pneumonia)
 - Chronic disease management (hypertension in patients with diabetes)
 - Mortality (failure to recognize sepsis and shock)
 - Health care–associated infections
 - Handoffs: Joint Commission (eg, from emergency department to ICU to floor)
- Cost reduction/revenue enhancement intensive (ie, value equation denominator-intensive):
 - Physician Quality Reporting Initiative

- Blood utilization
- Manage to reimbursement (urology and transplant)

Managed Diffusion

Human factors and safety research has taught us that reducing variation can reduce errors and defects and, therefore, costs. The care will provide superior outcomes as the processes are measured and improved. Delivering a best practice consistently throughout even a single hospital organization is challenging. It does not happen without disciplined management. Our early efforts allowed each hospital or clinic to implement the defined best practices with a more passive diffusion model in which they were provided the best practice and expected to implement the practice in their site. However, we found that this more passive approach resulted in a lack of consistency, wide variability in time lines, and differing levels of outcomes performance. This led us to research and understand the science of diffusion in much greater detail.

Diffusion is the scientific term for the spread or dissemination of ideas, knowledge, or processes. Diffusion has been a scientific discipline for most of the last century, evolving formally in the early part of the 20th century.¹⁵ Sustainable managed diffusion (ie, spread, replication, dissemination) of standardized practices throughout an organization and health care system is a fundamental of value creation.

Measurable sustained diffusion of a leading practice necessitates a receptive culture, accountable leadership, a structured process with appropriate tools, and a network of skilled resources to facilitate widespread and rapid implementation (Figure 2). Key infrastructure components of a managed diffusion system require planning, education, and awareness; a clinical knowledge management system; and the ability to meet specific needs associated with the practice (eg, equipment, supplies, information technology [IT] system support). An ongoing mechanism to ensure maintenance of best practices also is critical to sustain credibility of the standard over time.

An accessible central repository of Mayo Clinic guidelines and information regarding how, when, where, and to whom to apply them are requisite. We use an intranet-based resource called *Ask Mayo Expert* as our source for the “truth.” We are populating it with our guidelines, the appropriate references, and a refined catalog of our internal experts in any given discipline. *Ask Mayo Expert* is a sophisticated intranet resource available to all Mayo Clinic staff.

The concepts of managed diffusion seem relatively straightforward. However, we have found that the complexity of standardization in a culture of health care autonomy with 22 hospitals across 5 states is no small challenge.

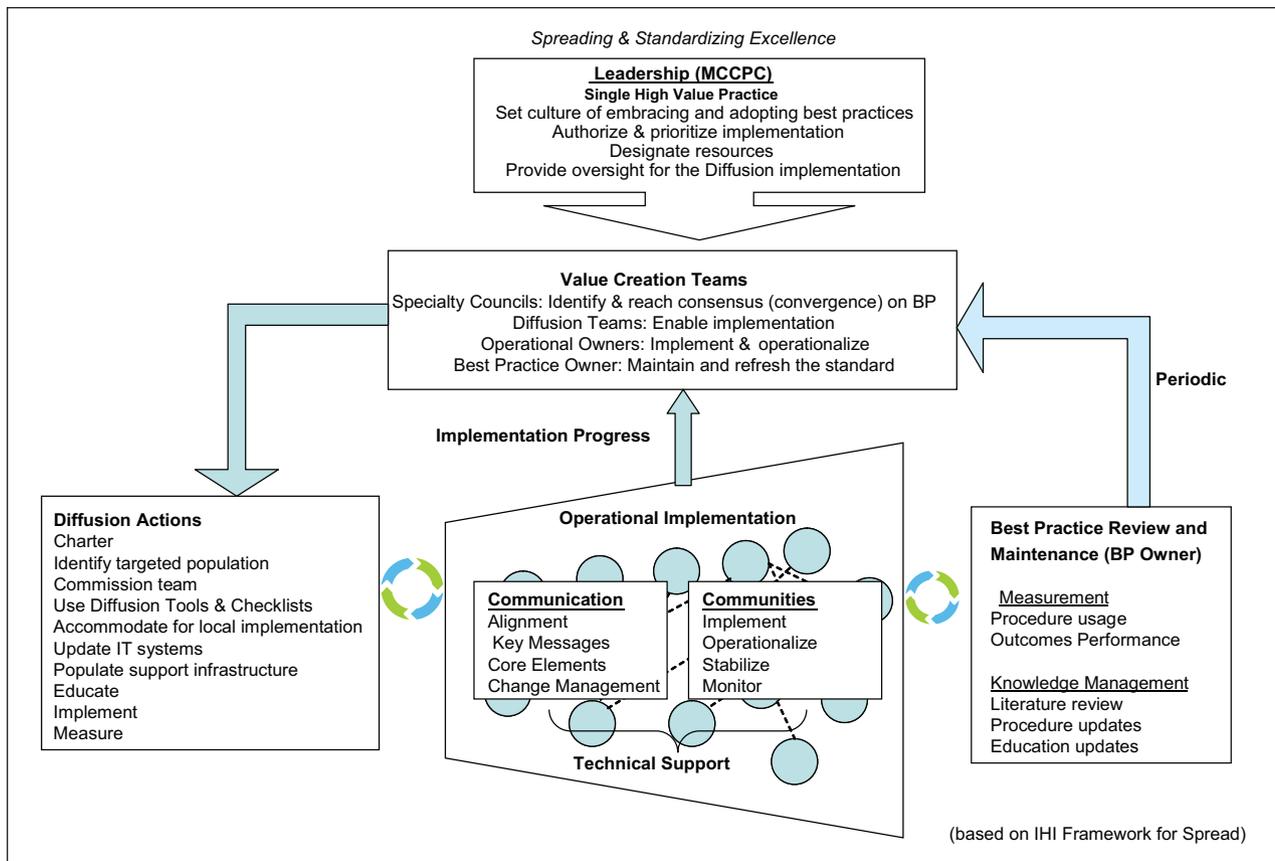


Figure 2. Mayo Clinic model of diffusion

Abbreviations: BP, best practice; MCCPC, Mayo Clinic Clinical Practice Committee

In addition to developing a systematic approach to diffusion and creating a network of resources to support this process, we have learned that the nature of the leading practice may dictate how one diffuses it. Our Model of Diffusion allows for this variability (Figure 2). These 3 cases exemplify the managed diffusion process and challenges:

Central venous catheter practice standardization. Improper placement of central venous catheters can lead to harm to patients, including death. Through the discovery efforts of expert physicians across Mayo Clinic, a guideline was approved by our Clinical Practice Committee. This guideline sets expectations about who has privileges to insert catheters, staff competencies, use of ultrasound and confirmatory tests using pressure transduction, as well as the associated infection prevention guidelines noted in the Discovery section of this article. This is a well-defined guideline with clear procedures. Anyone placing a catheter, regardless of specialty, patient indication, or location, is expected to follow it.

The challenges of diffusion are addressed with our templated approach. They focus on how to communicate the expectations, train (or retrain) staff through the use of instruction and simulation techniques, test for competency,

and ensure that the support systems make the “right thing to do, the easy thing to do.” Success will be monitored based on compliance with the guideline and reduction in the number of adverse events and infections associated with the management of central venous catheters.^{10,11}

Warfarin management. Warfarin is a high-risk medication. Administration can be a lifesaving intervention but also can cause harm to patients. Approximately 18 700 Mayo Clinic inpatients receive warfarin annually. Initial studies found that 654 or 3.5% (~5.5% at the Rochester campus) of our patients experienced some level of defect (identified as an international normalized ratio of greater than 5). A discovery effort led to a guideline, and a new process was established for how best to manage these patients. The systems engineered protocol that is activated by computerized physician order entry and administered by a pharmacist reduces nonclinically warranted variation, waste, and defects of care. In general, the managed diffusion of this standardized process was welcomed because it simplified the workflow and freed up physicians and nurses to spend more time with patients or on other priorities.

By standardizing the overall approach and articulating expected outcomes, we have reduced our defect rate over

4-fold in Rochester and 2-fold enterprise-wide—to less than 1.5%. Without genomic testing (work we are pursuing now), we believe that we have achieved the quality improvement entitlement (ie, our 1.5% defect rate is the irreducible minimum at the current level of science).¹⁶

Long QT syndrome alert and decision support. Long QT syndrome is a rare, life-threatening cardiac rhythm abnormality. Most physicians outside of cardiology would not be expected to recognize this disorder and understand the treatment options and ramifications. They do not know what they do not know. In other words, there is a knowledge gap.

Using *Ask Mayo Expert* and decision support alert systems in our electronic medical records, we employ a notification algorithm that connects with the provider who ordered the electrocardiogram of any long QT abnormality. We are able to monitor the system performance, physician actions, and outcomes. The alert links to all the knowledge resources of *Ask Mayo Expert*, allowing the provider to access guidelines, appropriate staff experts, and appointments in the Long QT clinic.

The long QT notification and knowledge management system is now standard across Mayo Clinic. We have documented lifesaving outcomes.

Discovery efforts from the preceding year led to defined Mayo Clinic best practices. These, in turn, are implemented as the following year's diffusion projects to ensure that known best practices are systematically built into all of our delivery unit protocols. Diffusion examples for the 2010 portfolio include the following:

- Central venous catheter practice standardization (ie, guidelines for line placement, management, infection prevention)
- Blood product management guidelines for cardiovascular surgery
- Obstructive sleep apnea preoperative screening guidelines
- Nursing Bedside Handoff Rounds (defined approach for bedside nurse communication during shift changes)

The final phase of managed diffusion is public presentation and publication of our work and results in peer-reviewed publications. The expectation of future presentation and publication encourages greater rigor upfront in the chartering and improvement method.

Measurement

A health care system provides safer and more efficient care if processes and systems are standard throughout the operating entities. Measurement is a key to the

maintenance and control of embedded process and system improvements. Measurement informs the organization what work actually created value (or not) and by what magnitude. It includes both process (ie, adherence to the protocol or guideline) and outcome (ie, did the infection rate improve?) metrics. Optimal measurement requires an enterprise information management infrastructure and active monitoring of value metrics (ie, composites of numerator dimensions such as outcomes, safety and service, and a denominator of cost or cost over time).

The existing measurement at Mayo is done predominantly via ad hoc reports from disparate electronic systems (eg, electronic medical record, departmental systems, clinical databases) or manual abstraction. It is clear that the manual approach used today is not scalable to support the Value Creation System and many times is the rate-limiting factor in assuring compliance or understanding the true impact of changes. Mayo Clinic is developing an enterprise information management environment to meet these needs, but much work is yet to be done. Key components of this environment include the electronic transfer of information from source systems (eg, electronic medical record, registration system, departmental systems) to an enterprise data trust environment; standardized reporting tools are then applied against these repositories to generate the needed reports. Significant challenges exist including the development of standard nomenclature across all sites, collecting data in discrete data fields that can be electronically managed, building out the architecture, and obtaining the funding to build such a comprehensive solution. This environment ultimately will allow us monitor progress as well as to assess the relative merits and effectiveness of various solutions in both near-term improvement activities and long-term research studies.

Whenever possible, metrics are benchmarked and based on actual clinical care, not administrative documentation and coding of clinical care. For example, the Mayo Clinic Department of Orthopedics has developed a comprehensive database on joint replacements by recording data on nearly all of the over 100 000 joint replacements performed since 1969. The database is purposefully kept separate from billing data to ensure accuracy.

Ideally, the metrics should be available within 24 to 48 hours to allow “real-time” feedback to the frontline staff engaged in the care delivery. We achieve this with the door-to-balloon time metric for our STEMI (ST Segment Elevation Myocardial Infarction) protocol. A shorter door-to-balloon time for STEMI patients lowers mortality approximately 8% for every 30-minute time reduction. The initial improvement from a median door-to-balloon time of 97 to 67 minutes and subsequently to 28 minutes has been maintained over a 6-year period, in part because of “real-time” feedback of a relevant metric to the frontline team members.^{17,18}

Results

Our experience over the past 4 years has shown that we can measurably improve the numerator (ie, outcomes, safety, service), the denominator (ie, cost), and the quotient, which is value. “Numerator-intensive” work included better performance with medication administration, specimen labeling, retained foreign objects, high-risk drugs, health care–associated infections, and care of patients with pneumonia, heart failure, and heart attack, to name just a few. “Denominator-intensive” work has included streamlining the care of total knee and hip arthroplasty, coronary artery bypass, and heart valve patients. Asset utilization efforts in operating rooms, cardiology, and radiology are other examples.

The improvements have come from reducing variation (eg, consolidation of dozens of approaches to warfarin anticoagulation to 1 approach with a 4-fold reduction in defects), reducing waste (eg, institutional review board review cycle time reduced ~50% to 17 days using 6 fewer staff, reduction of door-to-balloon time [and therefore mortality] for STEMI patients by approximately two thirds, and the Staffing to Workload initiative, which has delivered savings of millions of dollars), and reducing defects (eg, fewer hemorrhagic complications from warfarin over-anticoagulation leads to shorter lengths of stay and nonreimbursed care for complications).

Distinguishing “numerator-intensive” from “denominator-intensive” work is artificial in a sense because our systems engineering approach and the tools deployed are the same. Furthermore, work on one part of the value equation necessarily affects the other part, usually in a positive way.

We track our financial return on investment with a structured tool. The return has been positive. The financial analysis involves monitoring investments and distinguishes hard from soft dollar savings. Hard dollars are defined as savings/revenue that have a definite impact on cash flow and are quantifiable within a reasonable period of time (eg, within the fiscal year). Soft dollar savings are ones that are related to cost avoidance and increased efficiency or capacity in a system or process. The incremental out-of-pocket investment has averaged \$3.5 million over each of the past 5 years to expand the quality staff, establish the Quality Academy, and support the resource needs of selected projects. Realignment of existing resources including physician time, IT staff, training of existing staff, and bandwidth of operational leaders also has been a major investment. Every effort is made to estimate revenue impact, but we have found this to be the most challenging part of the financial analysis; an efficiency improvement can prove to be very positive in a capitated environment (eg, Medicare diagnosis-related group payment for an inpatient stay), whereas the same improvement can negatively affect the revenue stream in the fee-for-service reimbursement.

Such are the vagaries of the current payment systems. However, our goal remains the same—improve patient value and the financials ultimately will work out.

Based on our performance, we can confidently and conservatively expect to harvest at least a 5:1 return on investment for value creation work. Our recent experience has shown annual hard savings in the range of \$15 to \$20 million per year and soft savings of \$30 to \$40 million per year. With discipline, and often great diffusion and measurement efforts, these savings can be sustained and cumulative.

Summary

Our Value Creation System (alignment, discovery, managed diffusion, measurement), used in pursuit of a single high-value practice, is part of the solution to the imperative to reduce health care costs and improve quality. Alignment fits with well-tested strategic/project planning principles. Discovery acknowledges that there are many effective models for improvement while seeking to be inclusive of many different disciplines and groups (ie, quality improvement belongs to everyone). We have come to understand that passive diffusion models will not move us to a higher level of performance in an acceptable period of time; therefore, it has been necessary to learn and develop the Mayo Model of Diffusion to actively manage and expedite the spread of best practices. Although we have a great appreciation for the need and value of a comprehensive measurement system, it is clear that it will take years for this to evolve.

To further demonstrate the model, we would like to expand on how central venous catheter and associated bloodstream infections were managed through the Value Creation System. In November 2009, the Mayo Clinical Practice Committee identified this area as at the top of our quality priorities for the coming year (ie, this was the alignment phase). The focus of this operational objective was on safety and was, therefore, one of the numerator efforts. Five Mayo physicians representing anesthesia, infectious diseases, and the ICUs from a variety of sites were identified to lead the “discovery” process and to return in 3 months with the recommendations for the standardized Mayo Clinic best practice. During this period, they reviewed performance and processes at each location, researched the literature, and assessed results from a variety of pilot initiatives each site had conducted (ie, this is where the use of lean and six sigma tools were applied). The recommendations from this group were then approved in March 2010 and the diffusion process was kicked off. During the remainder of 2010, the time has been spent on understanding who is placing lines currently, what processes they are using, modifying order sets, developing/implementing simulation and other training programs, as

well as purchasing ultrasound equipment, as this is required as part of the new standard. These are all elements of a typical diffusion effort. Metrics were then defined (ie, measurement phase) and reports created to monitor compliance with the new standard and the associated improvement in outcomes. This is a short synopsis of how the Value Creation System works with an individual area of focus.

The Value Creation System is a methodology that we have demonstrated improves the care of our patients while increasing productivity. Although the individual components are not necessarily unique, we have found that consistently pulling them together in this fashion allows for improved performance as well as a common approach and language within the organization that allows for widespread understanding and impact.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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