



Developing A Sustainable Improvement Infrastructure

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Agenda

- The Nebraska Medical Center
- Operational Improvement (OI) Department Structure
- Project Generation and Prioritization Process
- Project Example
- Leadership Development
- Questions



The Nebraska Medical Center

- Formed with the merger of Clarkson Hospital and UNMC's University Hospital in 1997
- 624 bed not-for-profit hospital
- 5,758 employees
- 1,082 medical staff
- 450 medical residents
- Tertiary/quaternary academic medical center
 - \$750 million budget
 - 26,000 inpatient discharges
 - 141,000 patient days
 - 500,000 outpatient visits
- Patients from all 50 states, 42 countries
- National reputation in Cancer Care, Transplantation and Neurosciences



This is The Nebraska Medical Center, but the methods that will be presented today can be applied to an organization of any size. It is not necessarily healthcare specific nor is it 600 bed academic hospital specific.

The Nebraska Medical Center Recognitions

- Consumer Choice #1 Award – Omaha's Most Preferred Hospital
- The Edgerton Award of Progress (State Quality Award)
- BlueCross Blue Shield of Nebraska Recognition for Quality
- J.D. Power and Associates Distinguished Hospital
- Magnet Recognition by the American Nurses Association
- University HealthSystem Consortium Rising Star Award for Quality & Safety
- 100 Top Workplaces for Nursing

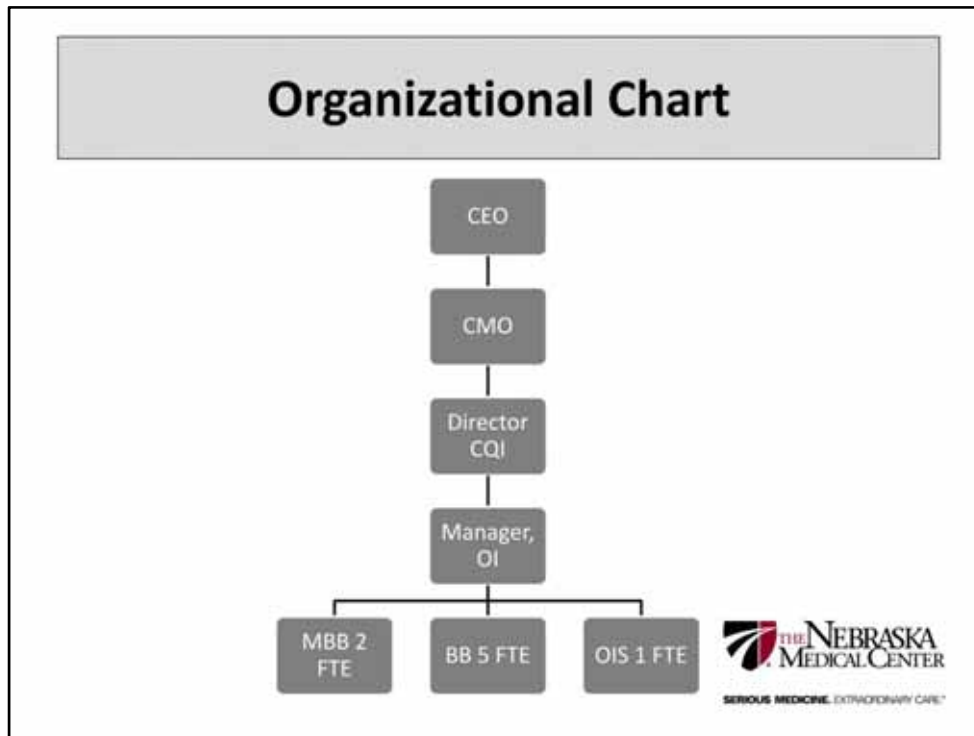


The Nebraska Medical Center has been recognized by multiple organizations. Some of these recognitions are:

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Operational Improvement Structure





Here is the organizational chart for our department. Our department reports to the Chief Medical Office, which is not very common. Most operational improvement department reports to the Chief Operating Officer. We are get involved in multiple quality improvement measures, like core measures, that for us it makes sense to report to the Chief Medical Officer.

OI Department Structure

Budgeted For:

- Manager, Operational Improvement
- 2 Master Black Belts (MBB)
- 5 Black Belts (BB)
- 1 Operational Improvement Specialist (OIS)



The Operational Improvement Department was previously known as Six Sigma. We decided to change our name because Six Sigma is one of many methodologies we use for problem solving. The department was created in 2002.

Currently the department is budgeted to have 1 Manager, 2 Master Black Belts, 5 Black Belts, and 1 Operational Improvement Specialist. The people in the department have different backgrounds, we have Industrial Engineers, Nurses, Business Administration, among others.

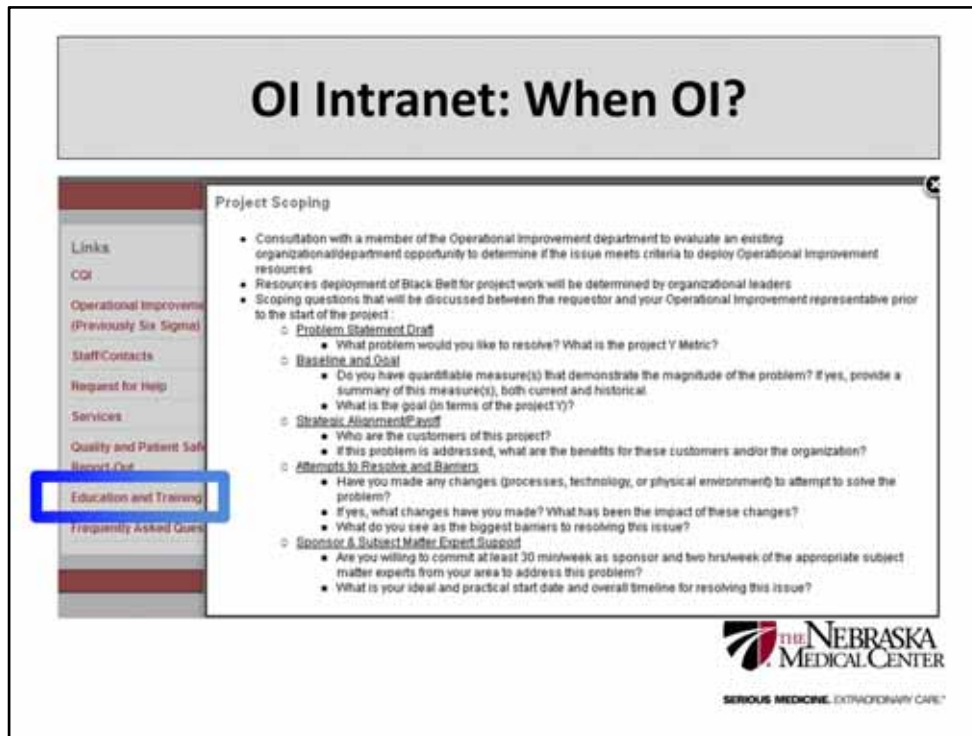
OI Services: Defined

- **Define, Measure, Analyze, Improve, Control (DMAIC)**
- **Lean**
- **Project scoping**
- **Consultation for measurement systems**
- **Consultation for data analysis methods**
- **Consultation for project initiation and management**
- **Discrete event simulation**



We see ourselves as internal consultants as our department offers multiple services to the organization:

- We use the DMAIC approach for problem solving.
- We offer lean consultations.
- Before we start a project and get a team together we will scope requests to understand the magnitude of the problem.
- We offer consultation for measurement systems to make sure we have accurate data, but more importantly to make sure we are collecting meaningful data.
- We offer help on how to analyze data. We don't analyze data for other areas unless we are working on a project.
- Finally we offer simulation consultations.

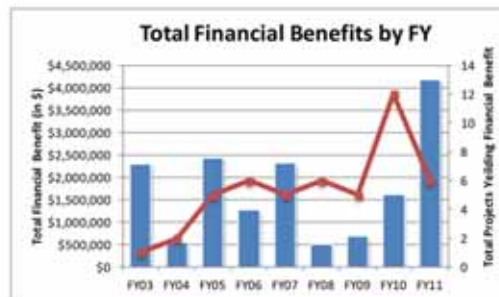


The Operational Improvement Department has an intranet page. We have examples from previous projects that we have worked on and the result of those projects. Employees can go to our intranet page and submit a project request. This is one way they can submit project requests.

One of our link deals with Education and Training. There we have a link to our scoping questions. These are the questions we use when we meet with our potential sponsor to get more information about the project. We get multiple requests and these questions help us determined if we should continue our scoping efforts. For example if the sponsor is not willing to commit 30 minutes per week for a meeting when the project is initiated then we wont continue to scoping efforts.

OI Projects Financial Benefits

- Financial benefit calculations are approved by Director of Budgeting
- Financial benefits are calculated using the Contribution Margin
- Payer mix is taken into consideration



The operational improvement department keeps track of the financial benefits for projects we have worked on. The financial benefit calculations are approved by our Director of Budgeting and we need to show her that the improvement was due to the changes made due to the project. The calculations are made using the contribution margin and we take into consideration our payer mix. This graph shows the net benefits not the gross benefits the projects have achieved.

Requesting a Project

Who can request a project?

- Anyone

How do I request a project?

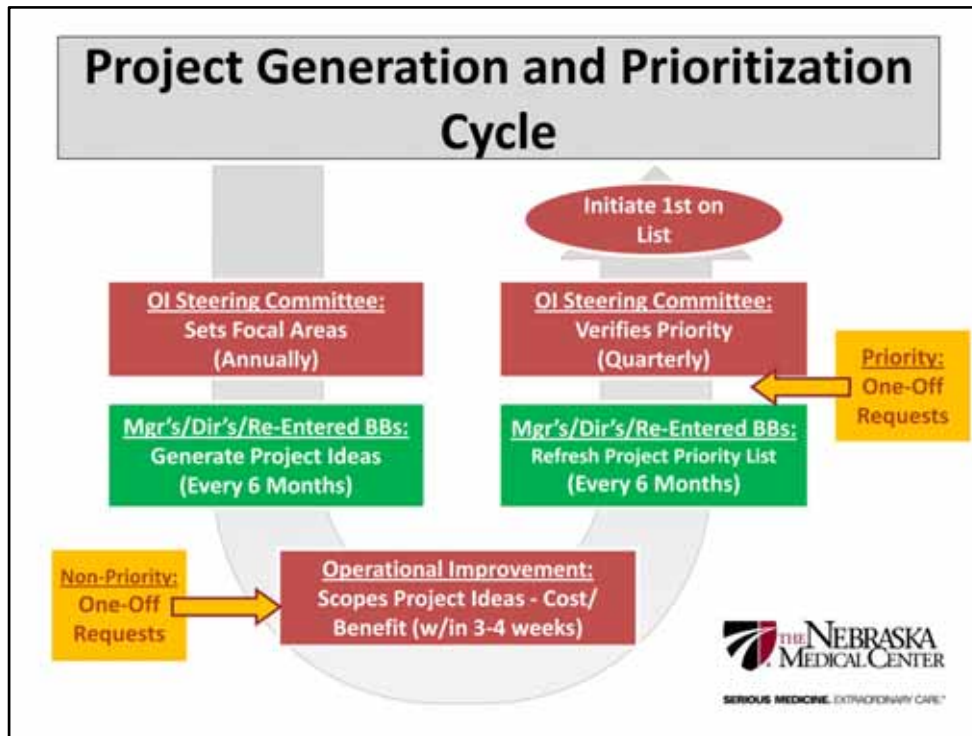
- Email or Call Manager, Operational Improvement
- Email or Call Black Belts
- Participate in Project Generation Meetings



Anybody can request a project and there are multiple ways they can request it. They can go to our intranet page and submit the project request form or they can simply call the Manager or Black Belts. We want the Black Belts to create a relationship with their project sponsors, owners, and team members because the majority of our project ideas come from repeated customers. Finally we incorporated a project generation meeting to get more people involve in submitting project ideas.

Project Generation and Prioritization





As a department we determine that we wanted to get more people involved in requesting projects. Each year our Operational Improvement Steering Committee will set our focal areas. With those in mind we asked for volunteers to come to a meeting to help us generate project ideas. From those ideas the Operational Improvement department will determine which ideas are appropriate for scoping and scope those ideas to determine the magnitude of the problem. After a 3-4 week period we bring the ideas back to the group for project prioritization. Our steering committee looks at the prioritization and determine if the ranking is accurate. Once a resource is available the department will start the first one from the list.

Generation and Prioritization Teams

- Teams rotate on six months basis
 - Always fresh ideas/opinions
 - Always some consistency and learning

Group A	Group B	Group C	Group D
RA	MB	MA	JB
AB	NB	PD	RC
LB	JB	TF	WD
AF	DF	NM	KG
BL	JG	CM	KB
CM	RP	DT	CL
CO	MT	KV	MM
MR	SS	AW	JT
	AY	KW	MW



Common Problems

- **Common Types of Problems:**

1. Are there processes that lead to **errors/defects/negative outcomes** that could be improved?
2. Are there any processes that do not meet your/NMC's **expectations of success** that could be improved?
3. Are there **cycle times/processes** that take too long but could be reduced?
4. Are there areas where you feel that given current processes there is a **lack of resources** (supplies, staff, space) but an opportunity to use them more efficiently?
5. Is there an area/service **that costs too much** to operate where efficiency could likely be improved, but it is not known how to proceed?
6. Are there processes where **scheduling/coordination** could be streamlined?
7. Are there processes where the **cost per unit** could be improved?
8. Are there occurrences where you might have **too much inventory or not enough space** to hold inventory?
9. Is there a **wait time** in an area that could be shortened?
10. Is there a process that does not meet **customer expectations** (either internal or external customer)?
11. Is there a process from your or another department that doesn't meet you or your **staff's expectations**?
12. Are there **balanced scorecard measures** that are not meeting expectations that could be improved?
13. Are there occurrences where **communication/ coordination** between multiple departments leads to errors or delays?
14. Is there a process (i.e. documentation, charge capture) that could be performed more accurately to **increase revenue**?
15. Is there a process where **patient volume could be increased** by either reducing their visit time or by utilizing resources (i.e. rooms, staff) in a different way?

- *In general, is there anything that needs to be **minimized, maximized, increased, decreased, reduced, eliminated, or executed more consistently**?*

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We send a list of questions to our volunteers to help them think of potential project ideas. We encourage them to start submitting their ideas before the meeting as we utilize these ideas to start the meeting and get people interacting. We also go through these questions throughout the meeting so we can get people engaged.

First Meeting: Project Generation

- All BBs are involved in the process
- Divide group into 2 tables
- 1 facilitator and at least 1 person at the table coordinating the group
- Ask for 3 things:
 1. Problem Description
 2. Y Metric
 3. Follow up person



For the first meeting we divide the participants into 2 groups. We divide them into groups because we want to have smaller groups so we can generate as many ideas as we can. Each group we have at least one group facilitator that will write the ideas on the board and 1 person that will coordinate the group.

Each idea must have 3 things to be considered:

1. A description of the problem
2. A Y metric or a way we can measure the magnitude of the problem
3. Who will be our contact person to get more information about the problem

Example of Ideas Generated

ID	Problem Description	Follow Up Person	Y Metric
1	Volunteers Demand	Manager, Volunteer Services	Y1 = Time to fill a departmental request for volunteers Y2 = Volunteers utilization
2	ED Sitters	Executive Director Adult Acute Care and Director Emergency/Trauma	Y = % of delay admissions
3	STAT EKGs	Manager, Non-Invasive Cardiac	Y1 = 10min or less between order and execution Y2 = Reimbursement
4	ED Handoff	Director Emergency/Trauma	Y = % of delay admissions
5	Storage Space	Manager, Facilities Management	Y = Time spent looking for equipment
6	OR Equipment Inventory	Manager, OR	Y = Time spent looking for equipment
7	OR staff Utilization	Director OR Services Business Administration and Manager, OR	Y = % of staff available at the correct time to match or demand
8	Endo scheduling procedures	Manager, Endoscopy	Y = % staff available at the correct time to match endoscopy demand
9	OR Billing	Director OR Services Business Administration	Y1 = Re-work time Y2 = Lost charges
10	Purchasing process	Manager, Asset Management	Y = Cost
11	Internal Medicine Clinic Appts	Director Emergency/Trauma	Y = Lost revenue
12	Neurology Clinic Appts	Manager, Oncology Clinics	Y = Lost revenue
13	Endo scheduling	Manager, Endoscopy	Y = % delays
14	Drug shortages	Director Pharmacy/Nutrition Care	Y = Timeliness for identifying substitute drug
15	Diabetes Clinic	Director Diabetes Services	Y = Staff Utilization
16	HBO Clinic	Manager, Burn/HBO/Wound Ostomy	Y = Staff Utilization
17	Blood Products	Manager, Transfusion and Manager, ICU	Y = Order to transfused time
18	STAT Labs	Manager, Lab Service and Manager, ICU	Y = Order to resulted for ICU
19	Patients follow up appt	Manager, Psychology Dept	Y = Time spent taking pts to appts

This is an example of the project ideas that were generated during the first meeting.

Scoping Questions

Problem Statement Draft

(1) What problem would you like to resolve?

Problem Magnitude

(2) What is the project Y metric?

(2) Do you have quantifiable measure(s) that demonstrate the magnitude of the problem?

(3) Provide a summary of this measure(s), both current and historical data compared to the goal.

(4) What is the goal Y performance?

Strategic Alignment/Payoff

(5) Who are the customers of this project?

(6) If the problem is addressed, what will be the benefit for the customers/organization?

Attempts to Resolve the Problem

(7) Have you made any changes to attempt to solve the problem?

(8) What changes have you made? What has been the impact of these changes on the resolution of the problem?

(9) What are the biggest barriers to resolving this issue?

Sponsor & Subject Matter Support

(10) Are you willing to commit a minimum of 30 min/wk of your time as sponsor and a minimum of 2 hrs/wk of the appropriate subject matter experts' time from your area toward the resolution of this problem until it is addressed? (Y/N)

(11) What is a practical start date and overall timeline for resolving this issue?



The Black Belts are assigned to different project ideas to scope. The Black Belts and the Manager will determine who are the potential sponsors for the projects. They will first follow up with potential sponsor and go over the scoping questions. The Black Belts do not necessarily bring the handout with them, as they know they need to ask these questions and most of them have them memorized by now. From that meeting it is determined if we should continue with our scoping efforts or if the potential project should be put on hold.

Scoping

- Get more info about the project from the requestor
- Meet with the sponsor face to face to get approval for scoping. Go through the scoping questions
- Determine what data is needed to determine the magnitude of the problem
- Determine if the data needed is available and accurate if not determine if manual data collection is needed
- Analyze data
- Meet with sponsor to share information and to determine if the problem is big enough for them to request an OI resource



When the Black Belt decides to continue with his/her scoping, he/she will look into what data is currently available and determine if the data is accurate to make a decision or not. If data is not available or is not accurate then the Black Belt will look into doing some manual data collection. After the data is gathered, he/she will analyze it to determine the magnitude of the problem and baseline. The Black Belt will meet again with the potential sponsor to inform them about the findings and determine what would be a goal for the potential projects.

The benefits for the organization are determined by what would happen if we close the gap between the baseline and our goal. Are we going to see more patients? Are we going to be more efficient in any way? Etc.

Second Meeting: Project Prioritization

- Explain the criteria for project to be prioritized
 - No Sponsor Approval
 - No Outcome Metric
 - Some else currently working on it
 - Not OI Project
- Projects that meet criteria have the following information
 1. Problem Description
 2. Y Metric
 3. Baseline information
 4. Goal Performance
 5. Potential Benefits
 6. Strategic Priority Area
- Team members vote for projects
- Project with the most votes is ranked #1 and so on



During the second meeting the group will go over the project ideas that are not going to be prioritized and give an explanation of why the idea was not scoped. The criteria to determine if a project is not going to be prioritized is: the sponsor did not approve the project idea, the project idea did not have an outcome metric, somebody besides the Operational Improvement department is working on fixing the issue, or it is not a project for Operational Improvement (these could be ideas that a department needs more rooms).

The projects that are going to be prioritized have the following information: problem description, Y metric (or what is our measurement of success), baseline information (how we are currently doing), goal performance (how well we want to do it), potential benefits (financial or any other type of benefit), strategic priority area (the focus area that our Operational Improvement Steering committee establishes). We use the n/3 method to determine how many votes each person has. We count the number of projects that we are going to prioritize and divide the number by 3. The result is the number of votes each person has. Then we go through each project to determine who wants to vote on it. The transparency on the voting helps to initiate conversation between team members.

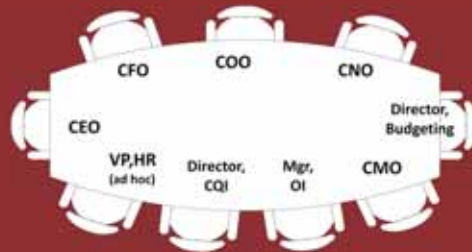
Example of Handout

#	Problem Description	Y Metric	Approval to Proceed by Appropriate Sponsor(s)?	Baseline Performance	Goal Performance	Potential Benefit(s)	Resources Required (# and hours)	CQI Strategic Priority Area
1	Pharmacy TAT - Order Entry	Y = % med orders entered into CE >=60 mins prior to scheduled admin time	Yes - Director Pharmacy/Nutrition Care	Y = 42.8%	Y = 75%	Patient Safety Reduction in NVA RN Time (looking for meds)	3 pharmacists, 2 pharmacy techs 2 hrs/week BB 20 hrs/wk for 4 months ~480 hrs	Inpatient Care Processes
2	Chemo Admin	Y = % of pump double checks	Yes - Executive Director Cancer Service Line	Y = 0%	Y > 99%	Increase in patient safety. Ability to track cumulative dosage.	5-7 team members @ 2 hrs/week for 3 months BB at 16hrs/week ~528 hrs	Inpatient Care Processes (Standardization of Practice)
3	Cardiology Clinic Access	Y1 = # days until 3rd available appt (urgent) Y2 = # days until 3rd available appt (emergent) Y3 = # days until 3rd available appt (routine)	Yes - COO Clinics	Y1 = 30 Y2 = TBD Y3 = TBD	Y1 = <14	Pt Satisfaction Increased OP/IP Volumes	5 team members @ 3 hrs/week for 3 months BB at 16 hrs/week ~312 hrs	Smart Growth
4	IR Supplies Expense/ Inventory Space	Y1 = \$'s Expired/year Y2 = Total Supplies on Hand	Yes - Executive Director Radiology/Lab	Y1 = \$105,571 Y2 = 40,511	Y1 = 0 expired products	\$105,571	IR Mgr, Lead IR Tech, IR Tech, Cardinal rep @ 2 hrs/week for BB @ 16 hrs/week for 3 months - 288 hrs	Financial Benefit (Cost Reduction)
5	ED Door to Doc Cycle Time Improvement	Y1 = % of pts seeing physician within 45 mins Y2 = Time from pt arrival to seen by MD in room	Yes - Director Emergency Services/Trauma	Y1 = 54% Y2 = 61 mins (avg)	45 minutes	Opportunity for add'l 1,945 pts/year ~\$180,885	ED RN's (2-3), ED MLP, MD, Res, BB @ 20 hrs -4 mos ~480 hrs	Financial Benefit (Cost Reduction)

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Here is an example of a handout we give during our prioritization meeting.

CQI Steering Committee



Accountabilities

- Define Focal Areas for Operational Improvement Resource Deployment
- Provides the vision for organizational quality
- Provides championship for the centrally supported quality improvement efforts
- Forces Bi-Directional Accountability for results
- Approve Operational Improvement Supported Projects
- Determines Annual Benefit Goals for OI resource deployment
- Actively Participate in Black Belt Selection and Re-entry
- Reviews Benefit Status of OI supported projects

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The Operational Improvement Steering Committee looks is the one who decides were the Operational Improvement resources will be deploy. The committee members are: CEO, COO, CNO, CFO, Director of Budgeting (she approves our financial benefit calculations), CMO, VP HR, Director CQI, and myself. The committee will look at the project queue and determine if the ranking is accurate or they might adjust it accordingly. The majority of the time they leave the ranking the same.

Project Example



Lab TAT

Leadership

Sponsor:
Dir Clinical Pathology
Dir Anatomical Pathology
Dir Oncology Services
Dir Emer/Trauma/Dis Svc

Owners:
Mgr Support Services-N
Mgr Support Services-S
Mgr Rapid Response
Mgr Emergency Svcs
Mgr Oncology Clinics

Black Belt:
José Rivera

Team Members

Assoc Professor ED
Staff Nurse ED
Medical Lab Scientist
Lead Clinical Lab Specialist
Lead Lab Support Assistant
Lead Lab Support Assistant
Lead Staff RN Oncology
Med Info Specialist



I am going to go over an example of a project that was brought up by the project generation and prioritization team.

Define

Problem Statement

From February 1st 2010 to April 30th 2010 the average TAT for the top 7 ED battery labs was 59.07 minutes, 65% of the labs were resulted in 60 minutes or less. The average TAT for the top 9 Cancer Center battery test was 88.68 minutes, 48% of the labs were resulted in 60 or less. The opportunity exists to decrease the TAT and increase the compliance percentage.

Goal

Increase % resulted within 60min for ED from 65% to 85%

Increase % resulted within 60min for Cancer Center from 48% to 85%

Y₁ = Top 7 ED battery labs TAT

Y₂ = Top 9 Cancer Center battery labs TAT



The problem that the team brought up was that ED and Cancer Patients need to have certain labs results before the MD can make a decision for his plan of care. During the scoping period it was determined that from February 1st 2010 to April 30th 2010 the average TAT for the top 7 ED battery labs was 59 minutes and only 65% of the labs were resulted within 60 minutes. For cancer patients we looked at the top 9 tests and they had an average of 89 minutes and 48% of the time were resulted within 60 minutes. The goal was to get these labs resulted within 60 minutes 85% of the time.

Scope

Process Start/Stop Points: From collected/order to resulted

Departments: Lab, ED, and Cancer Center

Focus on the top 7 battery test for ED and top 9 for Cancer Center. Tests needed to make a clinical decision.



We were clear that our clock started when the blood was collected and ended when the results appear in our computer system. We had members from the lab, ED, and Cancer Center to help us through the project.

Measure

% resulted within 45min $\frac{\text{\# tests resulted within 60 min from collected/order time}}{\text{\# tests performed}}$
from collected/order time

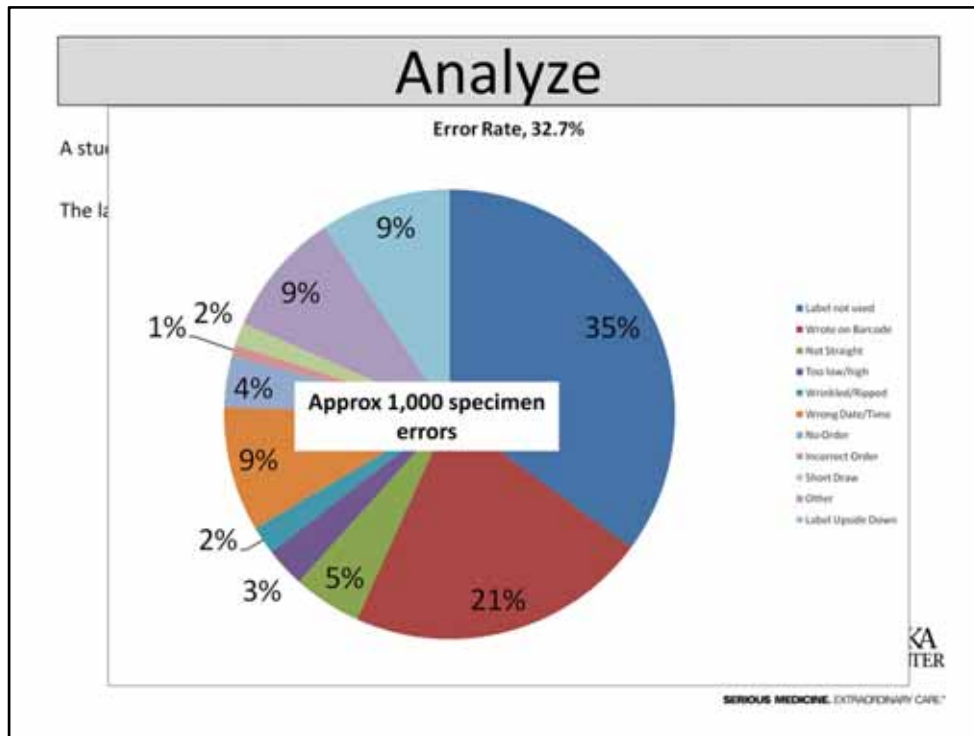
ED Tests

BMET, CMET, CBCP, PTTT, PTTS, TROP, and UMAC

% resulted within 45min = $\frac{14,440}{21,263}$ = **68% resulted within 60 min**
from collected/order time



There were the tests that ED was the most concerned about: BMET, CMET, CBC, PTT, PTTS, TROP, and UMAC and out baseline was 68%.



The team also perform a study on how many errors the lab receives a day in regards to labels. By labeling errors we mean the specimen had the right patient label but the specimen couldn't be placed in the analyzers before somebody could intervene and fixed the error. We determine that every day the lab received approximately 1,000 errors.

Analyze (Critical X's)

- Specimen waiting to be sent to the lab
- Specimen waiting in the lab to be received
- Specimen labeling issues
- Specimen waiting to be centrifuged
- Specimen waiting to be processed



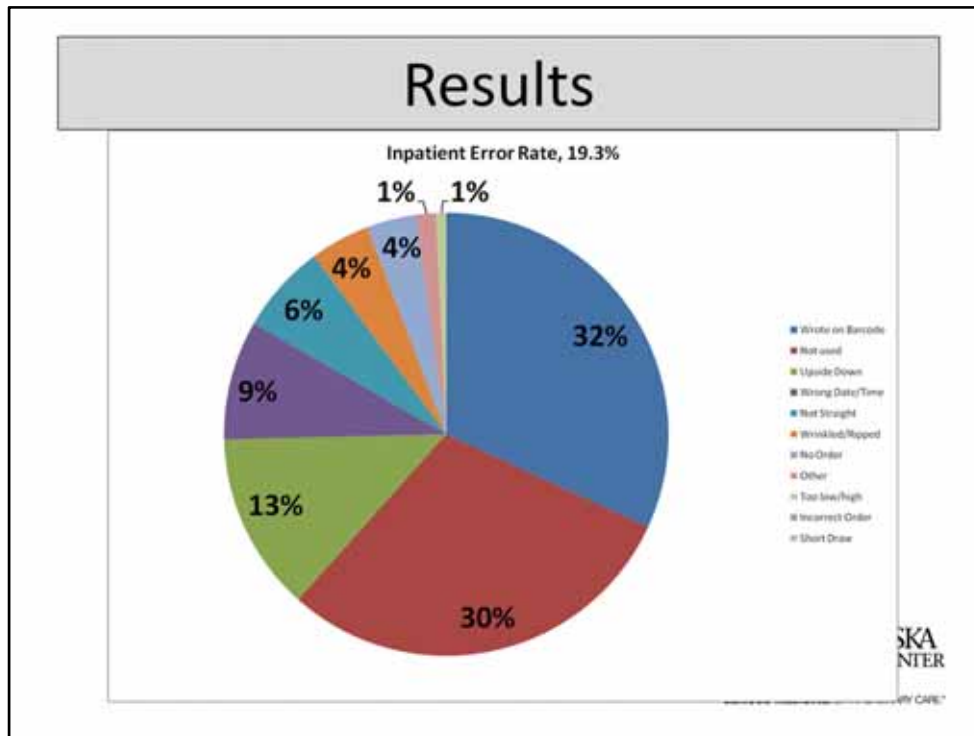
These were the areas where the team decided we needed to concentrate our efforts.

Improve

Critical X's	Solution
Specimen waiting to be sent to the lab	- ED Nurses partner with phlebotomist to send specimens as soon as they are collected
Specimen waiting in the lab to be received	- Install alarm system in tube stations - Cancer Center to use LIS labels - Clarify lab roles
Specimen labeling issues	- Created a poster - Created an educational video - Initiated lab tours to partner with Lab and Nursing
Specimen waiting to be centrifuged	- Clarify lab roles
Specimen waiting to be processed	- Clarify lab roles

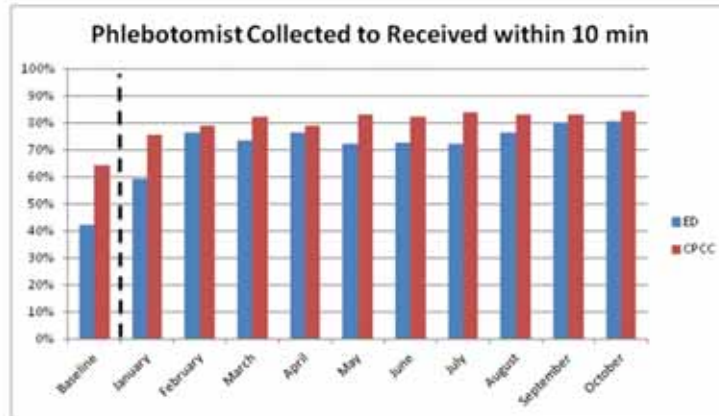
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Each area that the team decided to improve has a solution attached to it.



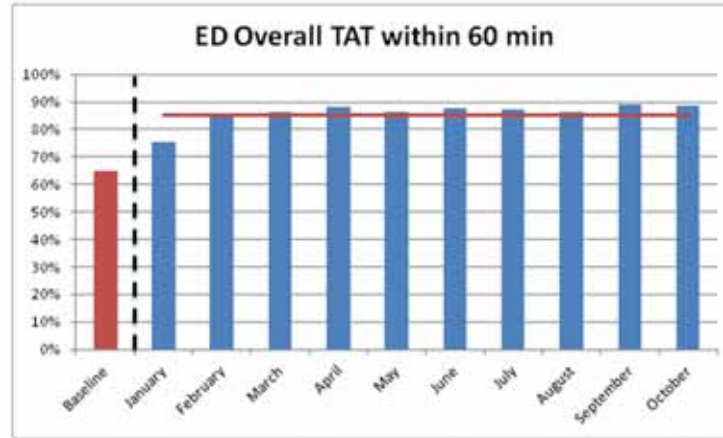
We showed some improvements in the error rate. We are continuing to work on it because it affects our lab TAT not only for the ED and Cancer Center but for the entire hospital.

Results



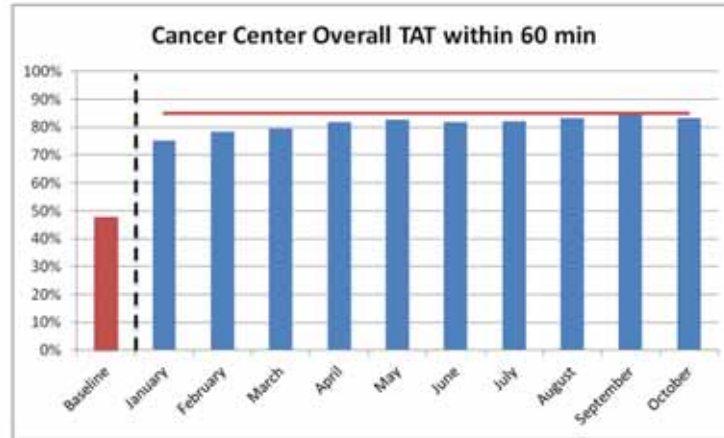
The team started to look how quickly we were sending specimens to the lab after collecting them and we saw a tremendous improvement in this process. Both the ED and the Cancer Center look at this graph on a monthly basis.

Results



Our ED is consistently at our goal. We are starting to look if we can improve our TAT to 45 minutes.

Results



Even though we made significant improvements in our Cancer Center results we are still not reaching our goal consistently. We are looking into this a little bit more and have been discovering that cancer patients specimens require a lot of manual interventions. The lab is looking at how we can alert lab personnel faster about this manual interventions.

Control Plan

Improvement Item	Monitoring Plan	When is Monitoring Plan Executed?	Monitoring Plan Owner	Data Collectors	Data Analyzer	Data Recipients	What is out of control?	If out of control, then...	Next Level Owner
Y - CPCC and ED Overall TAT	Monitor the collected to resulted time for CPCC and ED specimens	Begins monitoring in July 2010 with a weekly frequency.	Mgr ED, Mgr CPCC, and Mgr Lab	LIS Analyst	Jose Rivers	Team	CBCP, CAET, DIFFB, LD, BMET, PTTPT, PTIME, CBCM, CBCPR, PLTCT, LD, DFFND, PTTT, LDLM, PTTMX, LMAC, and TRDP < 45 min 85% of the time	Owner to follow up with nurse, phlebotomists, SR, and lab techs	Dr ED, Dr CPCC, and Dr Lab
X - ED Collected to Received time	Monitor the collected to resulted time for phlebotomist and nursing	Begins January 2011 with a monthly frequency	Mgr ED and Mgr Lab	LIS Analyst	Jose Rivers	Team	Phlebotomist < 10 min Nursing < 12 min	Owner to follow up with phlebotomist or nurse	Dr ED
X - CPCC Collected to Received time	Monitor the collected to resulted time for phlebotomist and nursing	Begins January 2011 with a monthly frequency	Mgr CPCC and Mgr Lab	LIS Analyst	Jose Rivers	Team	Phlebotomist < 10 min Nursing < 15 min	Owner to follow up with phlebotomist or nurse	Dr CPCC
X - CPCC and ED Received to Resulted time	Monitor the received to resulted time for CPCC and ED specimens	Begins January 2011 with a monthly frequency	Mgr Lab	LIS Analyst	Jose Rivers	Team	CBCP, CAET, DIFFB, LD, BMET, PTTPT, PTIME, CBCM, CBCPR, PLTCT, DFFND, PTTT, PTTMX, LMAC, and TRDP < 35 min	Owner to follow up with SR and lab techs	Dr Lab
X - Clinic Courier Drop offs	Monitor the # of drop offs the courier does per hour	Begins January 2011 with a monthly frequency	Mgr Lab	SR receivers	Mgr Lab	Team	> 2 drop offs per hour	Owner to Follow up with Chris Tracy	Dr Lab

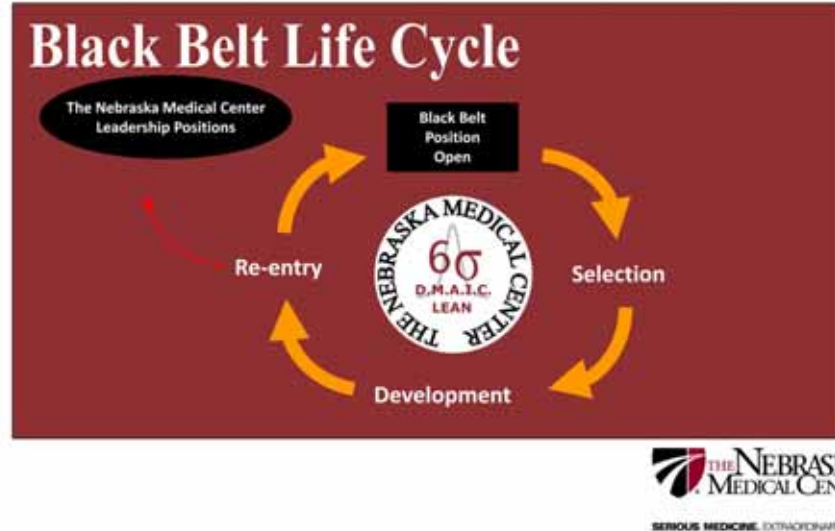


Every project has a control plan. This control plan help the project leader to transition and hand off the project to the project owner. At this point the Black Belt needs to make sure data is been collected and shared with the team. The Black Belt will follow up with the project owner if an improvement item is out of control.

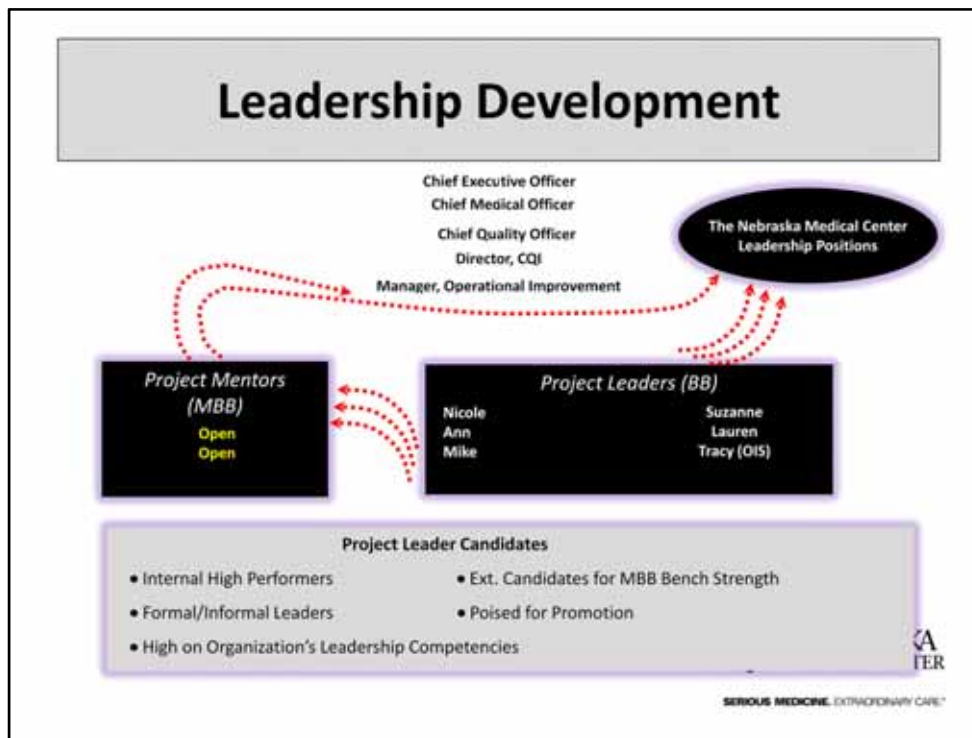
Leadership Development



Leadership Development



Our Black Belts are seen as leaders in the organization. The reason why they are seen as leaders is because they get exposure to the entire hospital. They gain knowledge of how departments interact and have the tools to solve problems by using data. The operational improvement department is the first place where people from the organization look into for filling openings for manager positions or above. Our Black Belts are required to create a development plan. This development plan helps the manager and the director of the department to determine which areas of the hospital the Black Belts will be interested on working on. Also the development plan help us determine what areas the Black Belt would like to have more exposure too.



There are two potential paths the Black Belts could take in their careers. The quality path meaning becoming a Master Black Belt and continue their career on quality efforts or they could take the operations path which mean at some point go back to the organization.

The majority of the Black Belts are hired internally. Potential Black Belt candidates are individuals that have interest in quality and have shown leadership skills. We have hired staff nurses, lead nurses, business managers, engineers, etc. All the Black Belts go through our own Black Belt Training that was developed with the help of GE. This training is performed by the MBB or the Manager.

The time a Black Belt spends on their role depends on their own development and organizational needs. On average a Black Belt spends 2-3 years on their role before taking on another opportunity.

Leadership Development

Black Belt Re-entries...

Director, Neurological Sciences
Business Operations Analyst, HIM
Clinical Quality Coordinator, Diabetes Center
Director, Critical Care
Manager, Facilities Planning
Manager, Employee Development
Director, CQI
Director, Patient Experience
Manager, Asset Management
Physician Relations Coordinator
Manager, Operations OR
Manager, Operations ICU



Here is a list of past Black Belts that have move on to other areas of the organization.

Questions



José Rivera

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