

# Great Lakes Partners for Patients Improvement Model



**GREAT LAKES**  
PARTNERS FOR PATIENTS

**Illinois | Michigan | Wisconsin**  
**Powered by the MHA Keystone Center**

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*Accelerating Improvement at the Point of Care*

# Key Components of HIIN Improvement Model

## **Engaging Stakeholders and Building a Team:**

Executive sponsor, leader, subject matter experts, front line staff, patient advisors

## **Clearly articulate goals or aims:**

Goals are specific, measurable and achievable

## **Perform gap analysis between current and ideal state:**

Develop action plan for ideal state with identified accountability for action plans

## **Perform small tests of change until measured aims are met:**

PDSA/PDCA

## **Spread and Sustain the changes:**

Develop communication plan, “lock-in” changes to hospital systems, share with other hospitals

# Getting Started

- How we know we have work to do:
  - Data indicates an improvement opportunity, or
  - A process or procedure is being changed or updated
- Who will do this work?
  - Who will be the Leader?
  - Who will provide senior leader support?
  - Who are the people that know how the work is done and will make the changes?
- Good improvement work takes a whole team



# The Role of the Project Leader

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- Someone with operational authority to ensure success
- Convenes stakeholders and team
- Keeps the project on track
- Keeps senior leaders informed
- Ensures project aims are met



# The Role of the Senior Leader Champion

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- Holds Project Leader accountable
- Has authority to allocate resources (capital and human)
- Asks for routine progress reports
- Attends meetings, but only as needed



# Engaging Stakeholders

- Advisory (Oversight, resources and insight)
  - Senior Leaders
  - QI/Safety Committee
  - Medical Staff
  - Patient advisors
- Implementation Teams (expertise)
  - Multidisciplinary
- Unit-based (do the work, know the best)
  - Front line
  - Point of care



# Advisory Level Stakeholders

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- To get maximum engagement and resources for the project to be successful:
  - Provide clear and concise information about the project: “Our hospital’s patient fall rate is higher than others, and we have a couple of ideas...”
  - Provide clear goals for the project
  - Provide context: “This is important because...”
  - Clearly request what you need: “We would like...”
  - Articulate the stakeholder’s commitment: “If you come to the first meeting, then we will update you periodically on our progress...”

# Project Team Members

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- To get maximum engagement and resources from this group:
  - Provide clear information about the project and assure authority from senior level stakeholders
  - Be honest about the time commitment – people will not sign up to participate permanently
  - Balance the team between managers, point of care staff, and disciplines
  - Be transparent with the team members and all staff about failing often and learning quickly from experiences



# Point-of-Care Staff

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- To get maximum engagement and resources from this group:
  - Provide clear information about the project and assure authority from senior level stakeholders
  - Involve them in meetings only as needed, but create a mechanism for their feedback as the project progresses

# The Role of the Quality Leader

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- Improvement Model Coach
- Is a resource to the team:
  - use of data to drive project success
  - provide advice to team leader if the project becomes stalled
- Is NOT the team leader



# Patients and Families

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- Invite a patient to be a team member
- If your hospital has a Patient and Family Advisory Council (PFAC), tap them for information and advice
- Do you know any patient stories that can help make the case?
- To get the information you need from patient advisors:
  - Provide clear and concise information about the project: “Our hospital’s patient fall rate is higher than others, and we have a couple of ideas...”
  - Provide clear goals for the project
  - Provide context: “This is important because...”

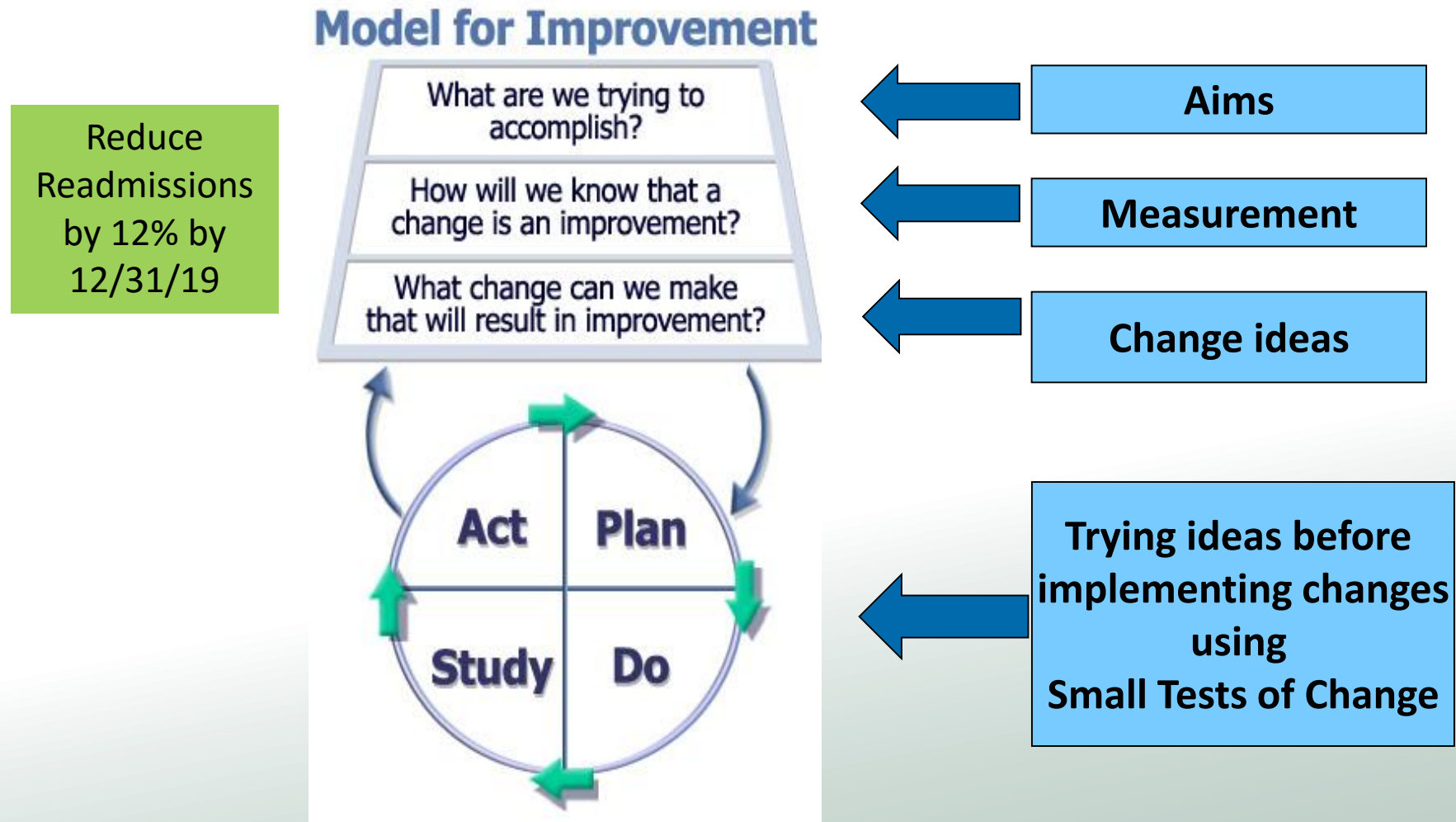
# Addressing Common Barriers to Quality Improvement

Why is it hard to get buy-in for this work?	How might we re-design our work to address this issue?
Takes time away from the work of the staff	<ul style="list-style-type: none"><li>• Ensure the focus IS patient care</li><li>• Keep the “ask” and the work simple and clear</li><li>• Minimize meetings; get creative about ways to communicate</li></ul>
Only a small group of staff are willing; get burned out	<ul style="list-style-type: none"><li>• Intentionally invite others</li><li>• Try engaging someone who will “do it once”</li></ul>
Staff are uncomfortable with trying new things so getting “buy-in” is hard	<ul style="list-style-type: none"><li>• Don’t make radical changes</li><li>• Break the tasks into “bite-size” pieces</li><li>• Make sure the reason for change is well understood – show evidence for patient care</li><li>• Allow staff to decline participation twice</li><li>• Create a 2-minute high level “elevator” speech of why this is important</li></ul>

# More Common Barriers to Quality Improvement

Why is it hard to get buy-in for this work?	How might we re-design our work to address this issue?
It's hard to get the right people involved, like those with the most expertise or experience	<ul style="list-style-type: none"><li>• Start with a core team, then invite those who are willing</li><li>• Re-invite others after an initial improvement is made</li><li>• Keep the ask clear and simple – what do they need to be able to participate</li></ul>
It's tough to get the authority to make a change	<ul style="list-style-type: none"><li>• Document your plan first; be specific and present it to leaders</li><li>• Present results and data before proposing next steps</li><li>• Ask leaders directly about concerns</li></ul>
Keeping the focus on the patient is a challenge – sometimes change becomes all about the staff	<ul style="list-style-type: none"><li>• Involve the patients and include their voice</li><li>• Keep asking “how does this work keep our patients safe?”</li></ul>

# Making PDSA Work for You



Institute for Healthcare Improvement

# Setting the AIM

- Goal Setting:
  - Make goals easy to understand by others
  - Stay focused on the patient
- AIM statements:
  - State the outcome (reduce or increase)
  - Define the measure of improvement (by x%)
  - Give a time span (by when)
- Example: Reduce Readmissions by 12% by 12/31/19



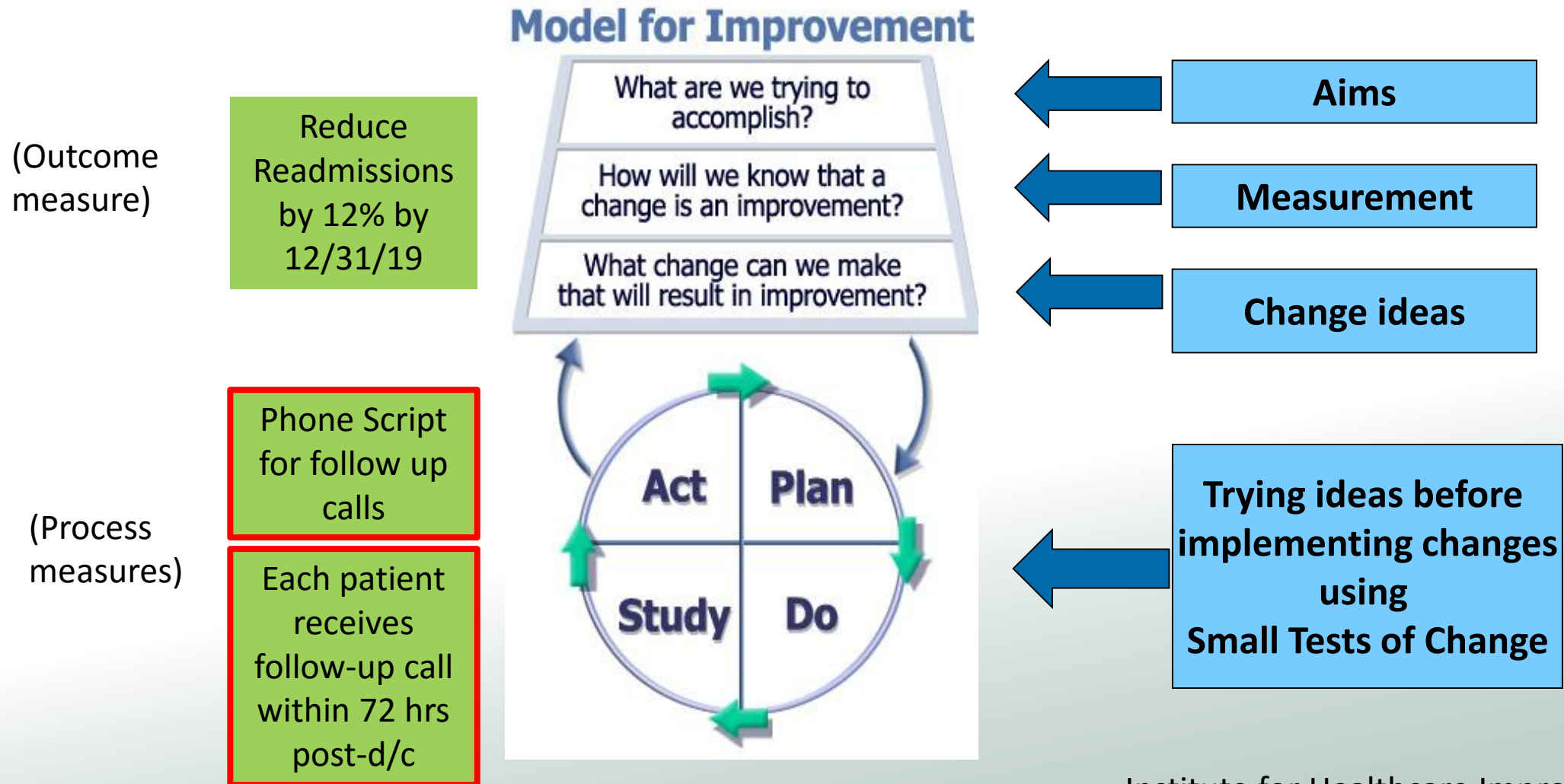
# Outcome Measures and Process Measures

- An Outcome Measure – how are we doing?
  - Mortality rates
  - Readmission Rates
  - Infection Rates
- A Process Measure – what are we doing?
  - Antibiotics prior to incision
  - Three-hour sepsis bundle protocols
  - Readmission risk assessment performed

Always make sure that your tests of change are linked to your measures and your aim statement



# Making PDSA Work for You



Institute for Healthcare Improvement

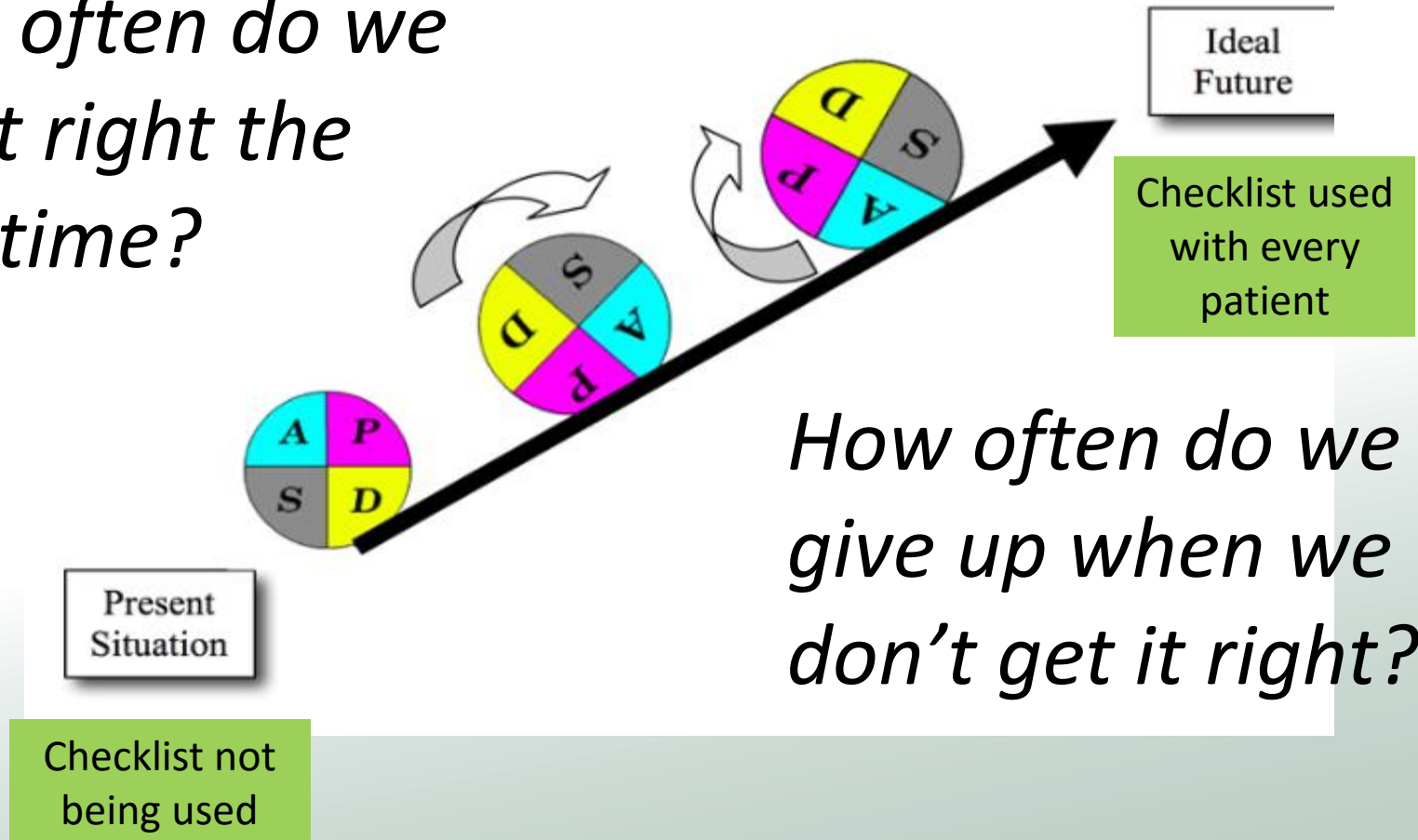
# Finding Ideas That Will Work

- Gap Analysis
- Top 10 Checklists
- Clinical Guidelines
- Literature
- Root Cause Analysis
- HIIN Improvement Action Networks and QuEST events
- Other hospitals or industries



# Small Tests of Change = PDSA

*How often do we  
get it right the  
first time?*



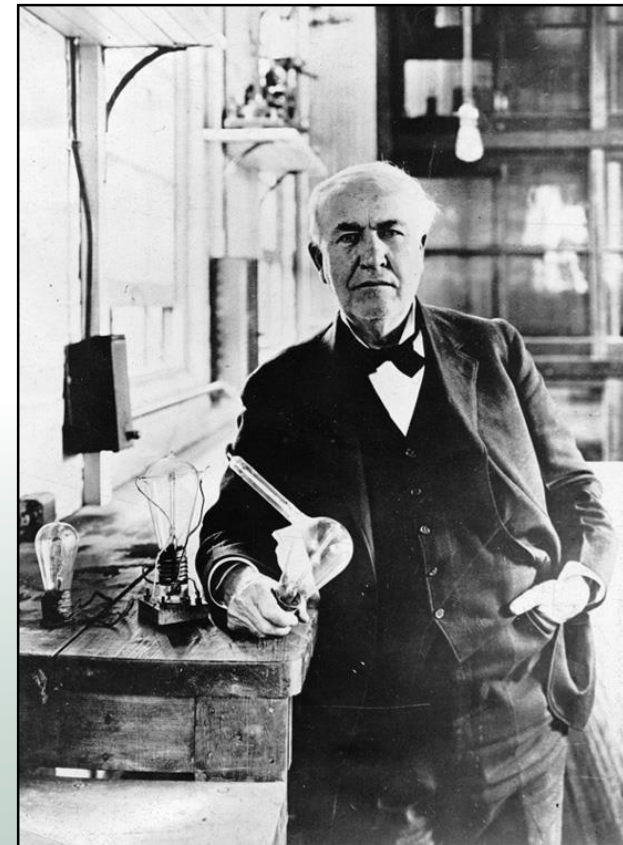
*How often do we  
give up when we  
don't get it right?*

# The Value of “Failed” Tests

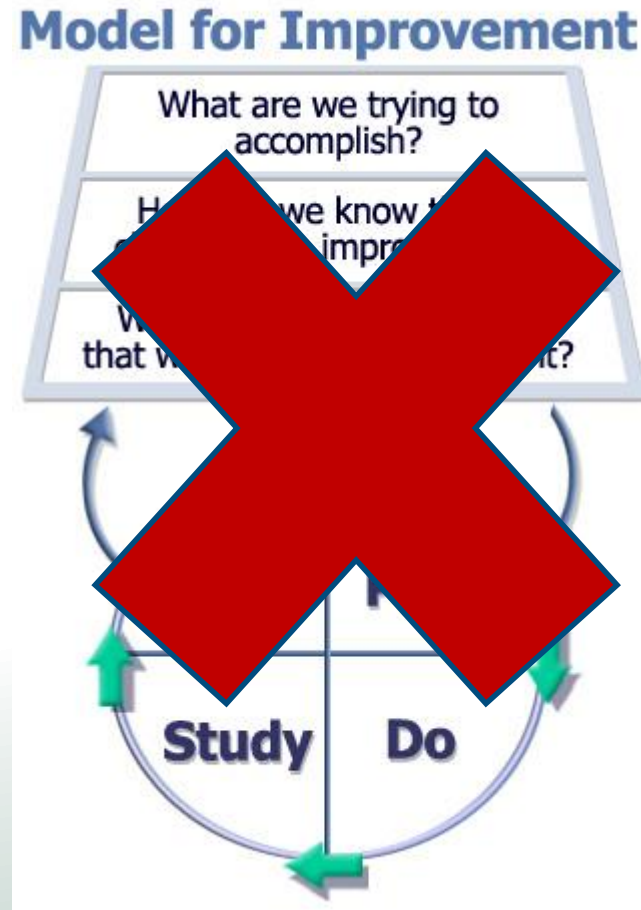
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*“I did not fail one thousand times; I found one thousand ways how not to make a light bulb.”*

*Thomas Edison*



# Sometimes You Should “Just Do It”



# This is Not How You Do Small Tests of Change.....



# Designing Small Tests of Change

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## Key Information before beginning:

- What is the test?
- What is the smallest unit of change?
- Who has to change?
- How many staff need to change?
- How many staff need to test the change?
- When will the testing take place?



# Time to Test the Ideas

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**Aim:** *Reduce readmissions of patients discharged to home from Med-Surg 4 achieving a 12% reduction by December 31, 2019.*

**Measure:** A consistent phone script will be used for 100% of follow-up calls.

**Test:** Develop standardized phone script for discharge calls.

**Idea Testers:**

- People that do the work should be testing the ideas
- Bedside nurses

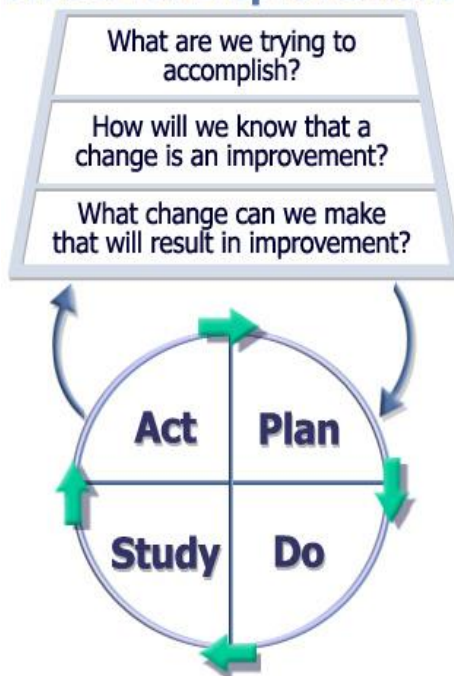


## PLAN – DO – STUDY – ACT PLANNING DOCUMENT

**AIM Statement:** *What are we trying to accomplish?*

*Reduce readmissions of patients discharged to home to Med-Surg 4 achieving a 12% reduction by December 31, 2019*

### Model for Improvement



**Measures:** *How will we know that a change is an improvement?*

*How Much?*

*By When?*

1. A consistent phone script will be used for 100% of follow-up calls.	At least 90% of follow-up calls made between July 1 and Aug 31 will have a documentation of the standard script being followed.	August 31, 2016
2. Each patient discharged to home will receive a follow-up call within 72 hours of discharge	90% of patients discharged to home will have received a call from the discharging RN.	November 15, 2016

**Tests of Change:** *What change can we make that will result in improvement?*

PLAN What changes are to be made?	DO What do we predict? Plan?	STUDY Document observations:	ACT What is next?
1. Develop standardized phone script for discharge calls	Staff feedback is needed for new script. Pilot script on the unit and gather feedback.	60% of nurses have trialed and approved the new script.	Implement new script with all nurses making discharge calls.
2. Discharging RN will call patients, discharged to home, within 72 hours of discharge	Develop and trial a process that makes it easy for nurses to make these calls every time.		

# How Small Is Small?

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Remember the “Rule of One”

One nurse

One patient

One shift

One hour

One time





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## DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: Readmission reduction Intervention: Develop standardized phone script for discharge calls

Smallest Change: 1 RN Scope: All RN's on 4<sup>th</sup> Med Surg Total # of Staff Impacted: 40

Planned Testing Timeframe: August 1, 2016 to August 31, 2016 Total # of Staff to Test: 10

	Test Description	Test Plan	Testers	Lesson(s) Learned	Decision	Adaptation
	1 Draft a new script and test with 2 patients each	Draft new script by 8/4 and test with two patients by 8/8	Sue, Alice and Mary	Medication question was confusing to patients	<input checked="" type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	Reword the medication section and trial again
	2 Test the revised script	Each person to make two calls the week of 8/11 using the revised script	Sue, Alice and Mary	Script works well and helps direct patient questions and follow-up	<input checked="" type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	Test script next week with 5 additional nurses
	3 Test script with 5 additional nurses	Each person to make two calls the week of 8/14	Sue, Alice, Mary, Tom, John, Jill, Beth, and Anne	Script works well	<input checked="" type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	Add two more to the test and trial for one more week
	4 Test script for one more week with 10 total nurses	Each person to make two calls the week of 8/21	Sue, Alice, Mary, Tom, John, Jill, Beth, Anne, Joe and Ginger	Test script for one more week with 10 total nurses, each make 2 calls	<input type="checkbox"/> Adapt <input checked="" type="checkbox"/> Adopt <input type="checkbox"/> Abandon	Script works well – implement with all staff
	5				<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	

# Designing the Tests

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- A. Begin with the smallest unit of change possible
  - “Rule of 1’s”: One care team, one patient, one day
- B. Plan for easy and efficient collection of feedback from your volunteer ‘testers’
- C. Spread systematically:
  - 1 day → 2 days → 4 days *and/or*
  - 2 teams/ 1 patient → 2 teams/ 4 pts → 4 teams/ 8 pts
  - Pair an experienced tester with someone new
- D. Know when to report progress & to whom

# Successful Cycles to Test Changes

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- Plan Multiple Cycles For A Test Of A Change
- Think A Couple Of Cycles Ahead
- Make The 'Ask' Small By Starting Small
- Test With Volunteers
- Do Not Wait To Get Total Buy-in Before Starting
- Be Innovative To Make Test Feasible
- Collect Useful Data During Each Test
- Test Over A Wide Range Of Conditions

# Gathering Feedback during Tests

You will be more efficient, and improve faster, if you do not rely solely on scheduled meetings to gather feedback:

- Quick “standing” huddles
- Patient Feedback
- White board / sticky notes
- E-mail
- Quick surveys
- 5 minute phone calls



# Adapt - Adopt - Abandon

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The basic decision point after each cycle of testing:

- **Adapt** – the test shows improvement is needed OR the tipping point has not been reached yet
- **Adopt** – the test shows the process or tool is stable and is ready for use
- **Abandon** – the test didn't work OR some aspect of change should be abandoned

# How to Move Forward with Testing

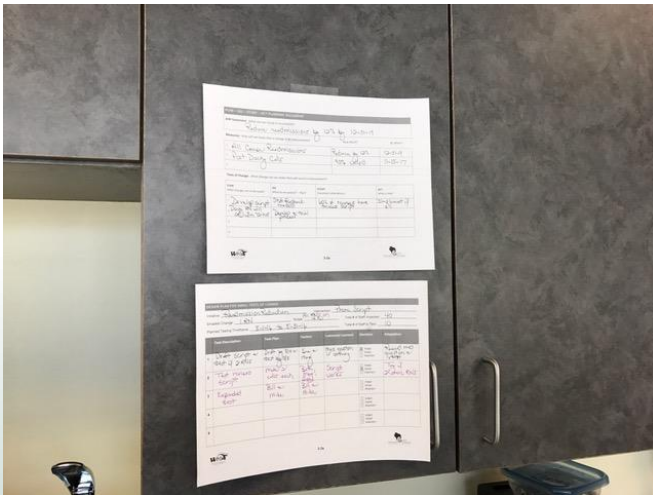
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- Expand the number of participants
- Expand the scope of tests
- Expand the conditions of the test – weekends, nights, etc.  
*(i.e. the tests are not abandoned when census is high or staffing is low)*
- Document what is learned from each cycle of testing
  - Keeps the team “on task”
  - Clarifies the reason for testing
  - Demonstrates clear accountability
  - Enhances the learning from small tests because you can see what happened virtually in “real time”.



# Be Transparent and “Public”

1. Post the PDSA sheet where staff can see what you are up to
2. There should be something new on it every few days – this is a living document
3. Show how your data looks – post it
4. It's okay to post copies of hand-written PDSA sheets



# *How Do We Know that a Change is an Improvement?*



“In God we trust.  
All others bring data.”  
W. E. Deming

***We measure!***

# Analyzing Data for Monitoring Progress

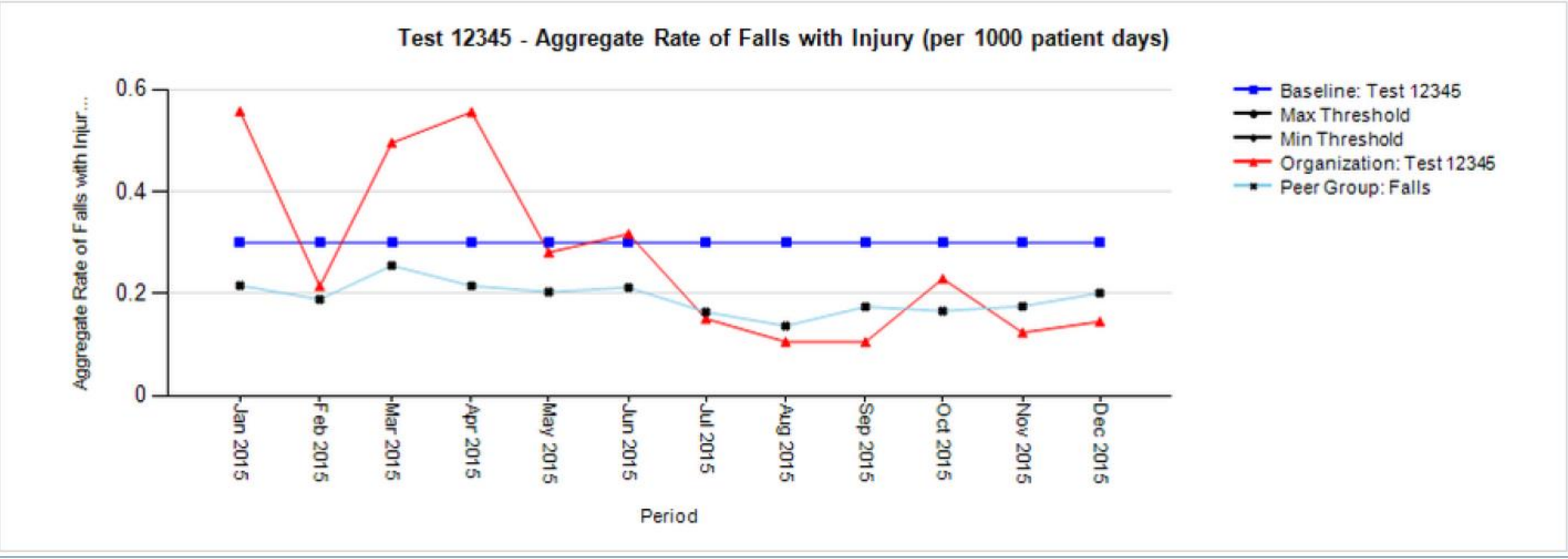
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# Tracking Your Results

## Trend Charts

There is one trend chart for each measure. Each trend chart shows the performance of this organization and each peer group relative to the measure baseline over each of the periods in the selected performance window.

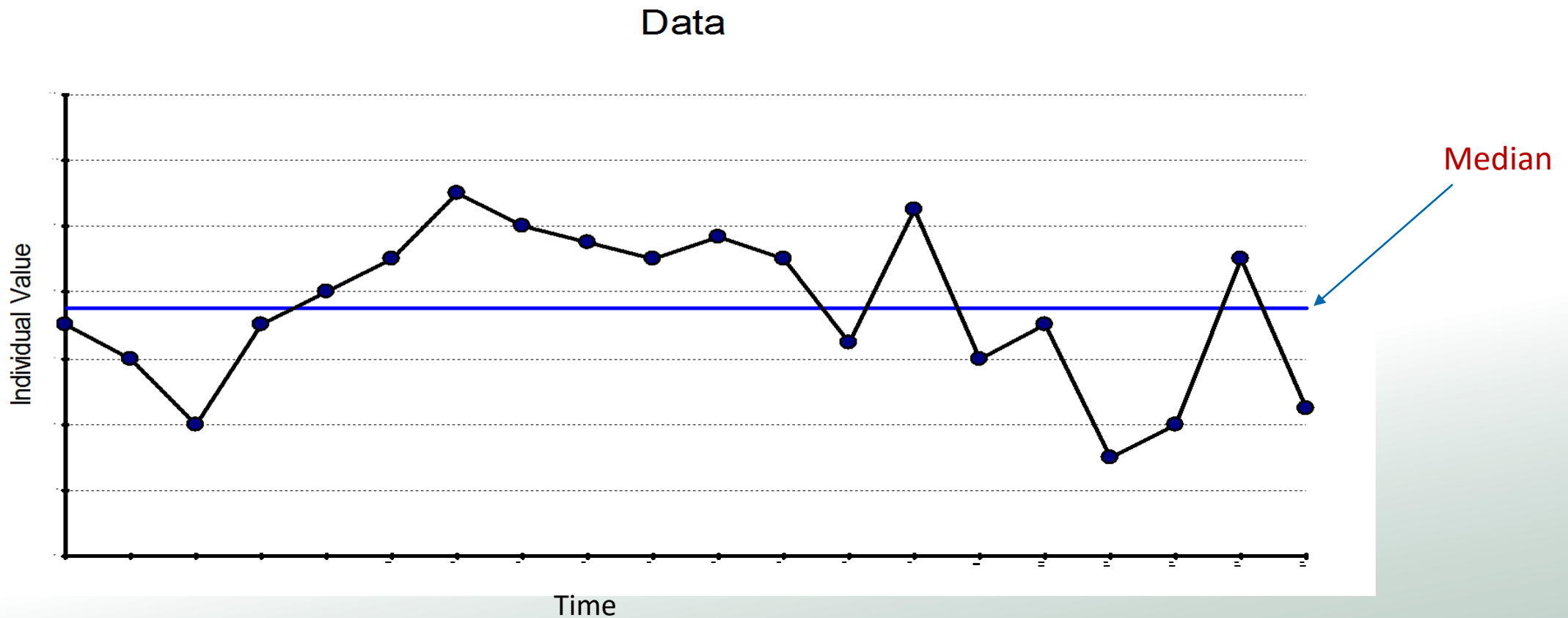


# Analyze Variation in Your System

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*Run Charts are the best tools to determine if our improvement strategies have had the desired effect*

# Elements of a Run Chart



“Plot the Dots”

	Set of Numbers	Sorted Order
The Median allows all of the numbers in the set to be counted – including 0's	10	2
	7	3
	3	3
	10	5
	10	6
	8	6
	12	7
	8	7
	6	8
	7	8
Calculating the Median: 1. Take a set of numbers and sort them in order 2. Find the MIDDLE number in the set – that is the median 3. If there is an even number of numbers, calculate the average of the middle two numbers – that is the median	13	9
	6	9
	9	10
	3	10
	10	10
	2	10
	9	12
	12	12
	5	13

**8** Median: 10<sup>TH</sup>  
 [9 smaller, 9 larger]

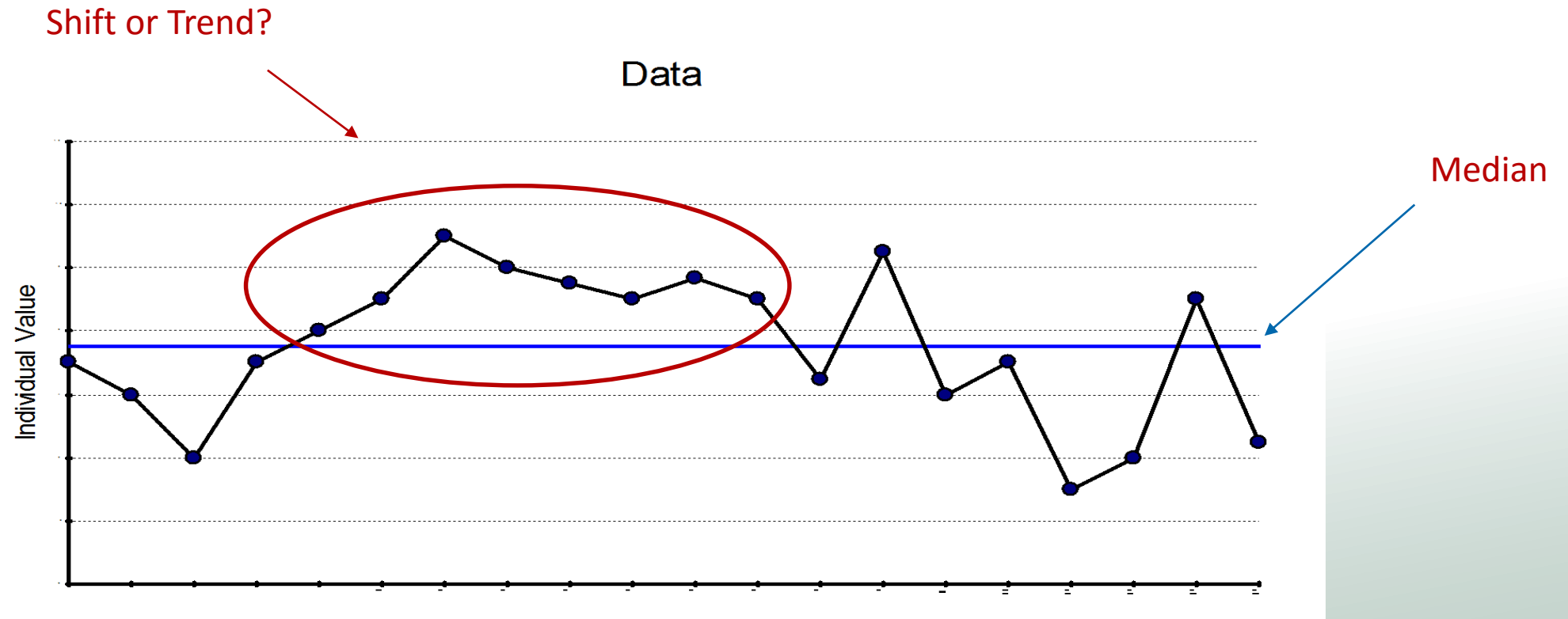
# How to Analyze Your Run Chart

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- **Shift:** A consecutive sequence of 8 or more points ALL on one side of the median
- **Trend:** A sequence of 6 *successive* increases or decreases
  - (If you have fewer than 20 data points, use 5)



# Elements of a Run Chart

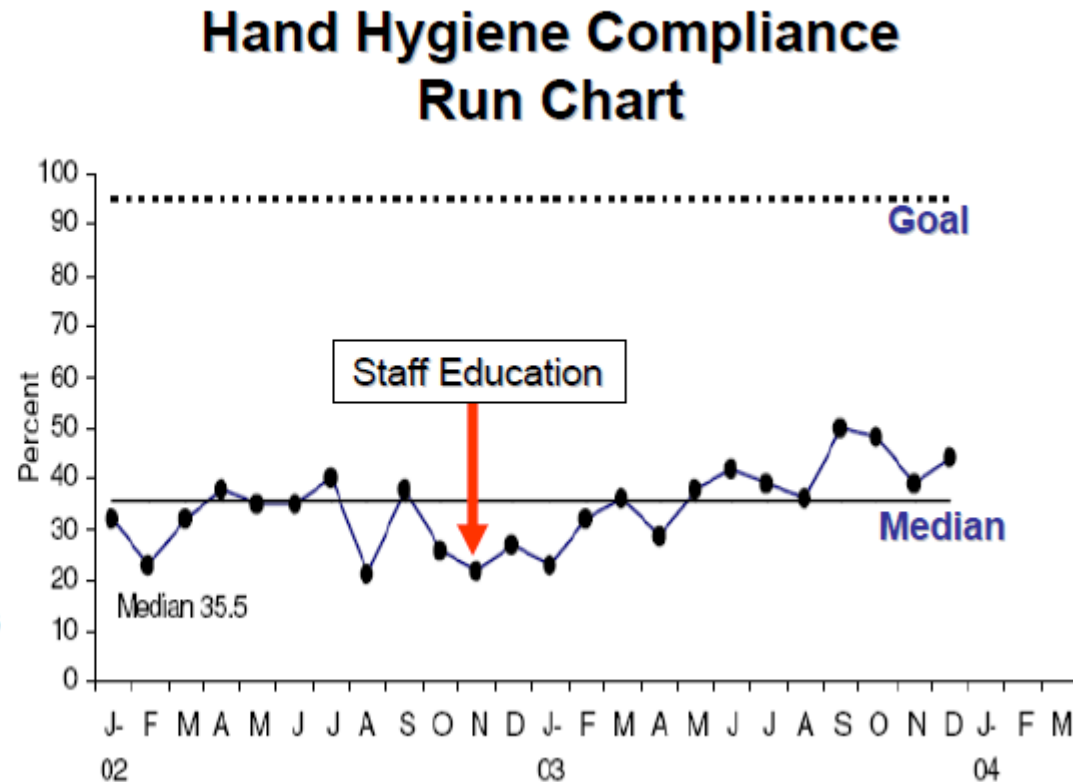


“Plot the Dots”: Data over time

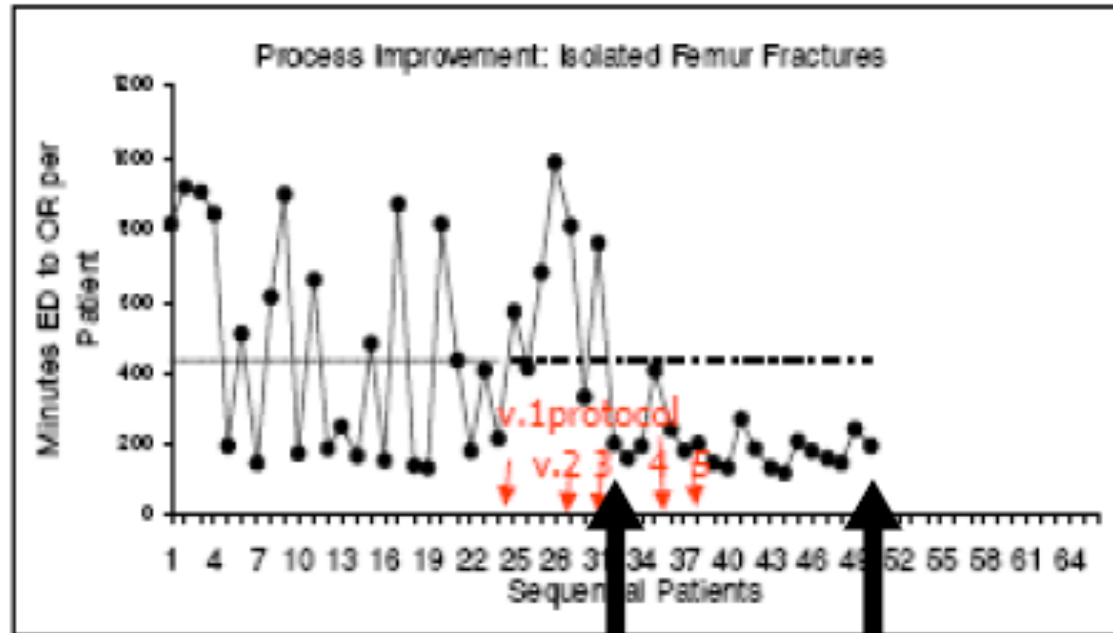
# Annotation Example: What is Happening Here?

## Run Charts

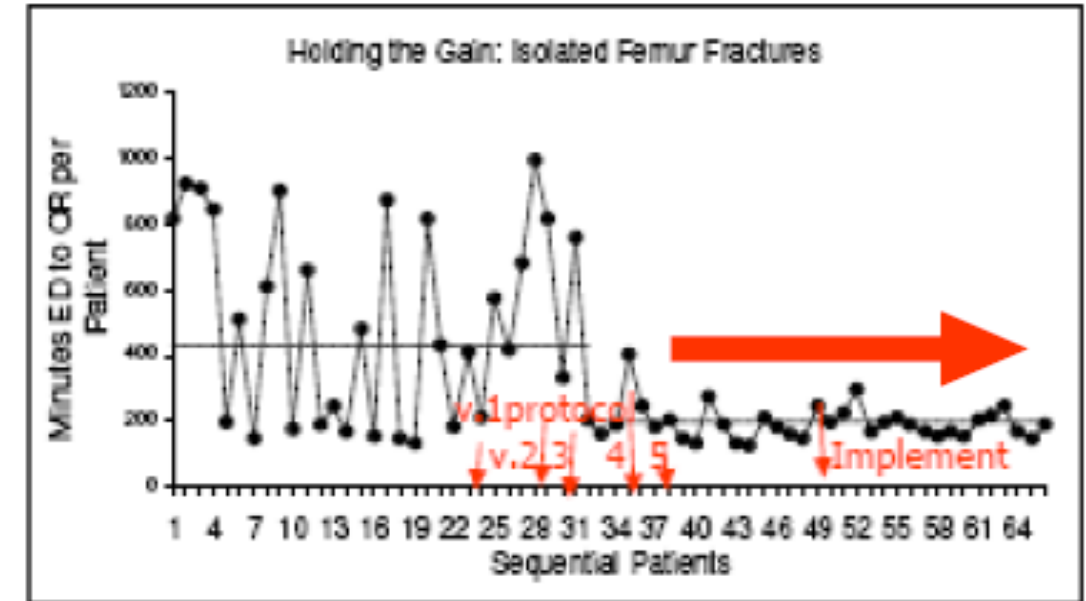
- Obtain data
- Plot date on x-axis
- Plot data on y-axis
- Draw a median line
- Place a goal line
- Annotate any changes



# Has the System Changed?



**Improvement!!**



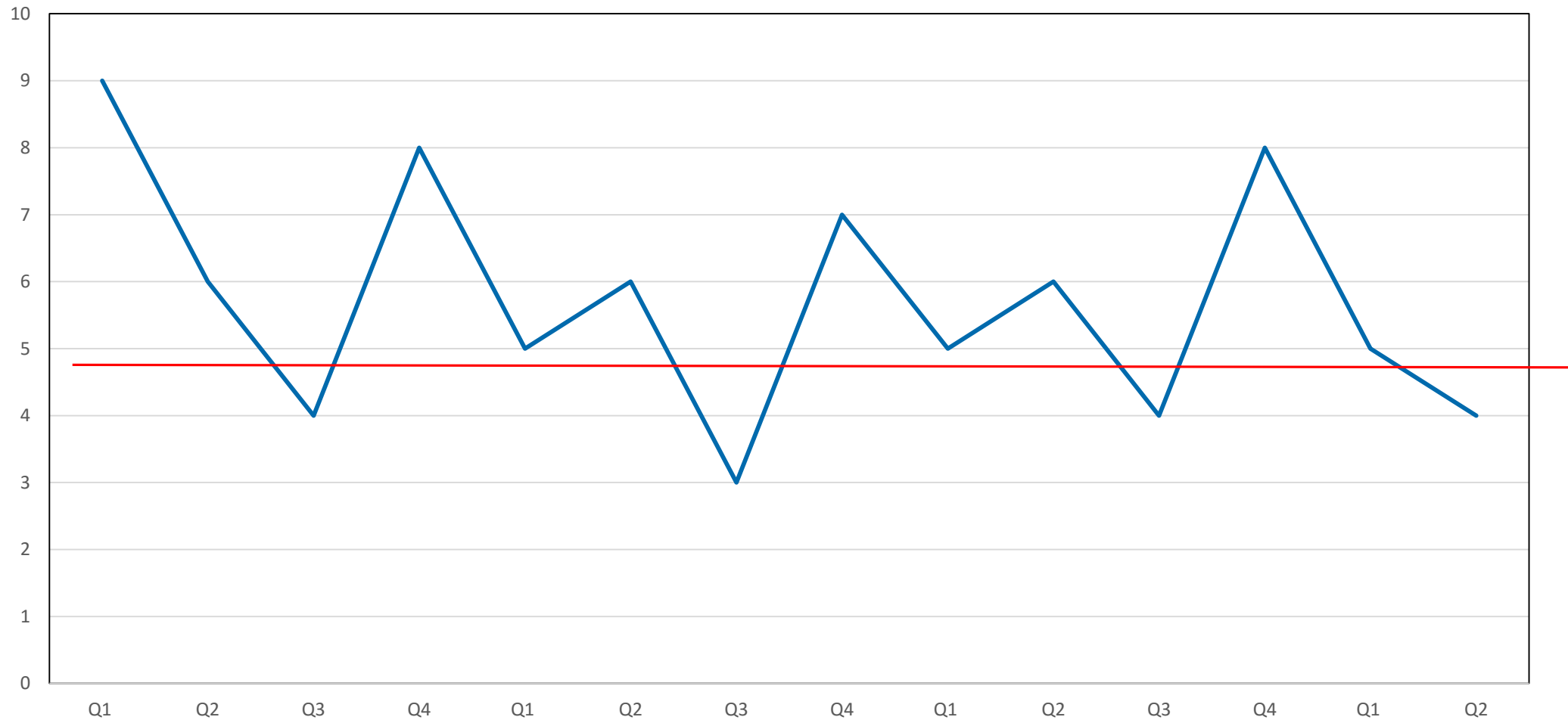
**Can you hold the gain?**

# What Run Charts Don't Tell You

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- The reason(s) for unusually big or small data points
- Is the performance of the process acceptable?
- How the process should actually be improved or redesigned

## “Perfectly Stable” – A Place You Don’t Want to Be, if You are Trying to Make a Change



# When are you “done” with testing?

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- Everyone who needs to test the change has
- The process is stable, with few changes
- Staff are satisfied with the current state
- **Your measure is moving in the right direction**

# Making Change “Stick”

- Update policies and procedures
- Ensure everyone is trained
- Build the process into orientation guides
- Build the process into your electronic record
- Decide who will continue to monitor this



# Making it “Stick”

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- The changes should be tied to an existing accountability structure:
  - Quality Committee
  - Patient Safety Committee
  - Shared Governance
  - Management Team
- At least an annual spot check of the outcome measure; may need a process measure if the outcome is “slipping”
- Think about a contingency plan – new PDSA cycles – if performance starts to slip
- Hospitals that are highly reliable have cultures that support sustained quality and safety work



# HIGH RELIABILITY MODEL

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# Principles of Highly Reliable Organizations

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- Five key principles that highly reliable organizations have in common:
  1. Pre-occupation with Failure
  2. Reluctance to Simplify
  3. Sensitivity to Operations
  4. Commitment to Resilience
  5. Deference to Expertise

# More Resources to Help You Start

- Designing Small Tests of Change User Guide
- Improvement Action Network (IAN)
  - Contact your hospital's Improvement Advisor for the next IAN in your area
- Quality Essential Skills Training (QuEST)
  - Two-day QI training, semi-annually in your state
- Your team at WHA – IHA - MHA

