Partnership for Patients - National Priorities Partnership©

Patient Safety Webinar Series
Attaining Patient Safety through Rapid Cycle Improvement

February 23, 2012

convened by the
NATIONAL QUALITY FORUM

Today's Moderator

Camille Smith, MSPH, MSW
Project Manager, National Quality Forum

Today's Featured Speakers

- Lillee Smith Gelinas, MSN, RN, FAAN, Vice President and Chief Nursing Officer, VHA Inc.
- Cristin Sullivan, RN, BSN, Director of Quality, Eastern Wisconsin Division of Hospital Sisters Health System

Today's Featured Speakers

- The nursing team at Redington-Fairview General Hospital:
  - Sherry Rogers, RN, MSN, NEA-BC, Chief Nursing Officer
  - Norma Munn, RN-BC, BSN, Medical Surgical Nurse Manager
  - Susannah Warner, RN-BC, Medical Surgical Charge and Staff Nurse

Patient Safety Webinar Series: Recurring Themes

- Creating culture change through organizational leadership and empowered frontline providers
- Engaging patients and families in a meaningful way
- Coordinating the efforts of multidisciplinary teams and organizations
- Designing payment models that promote and incentivize quality and safe practices
- **Measuring quality consistently and reliably within and between organizations**

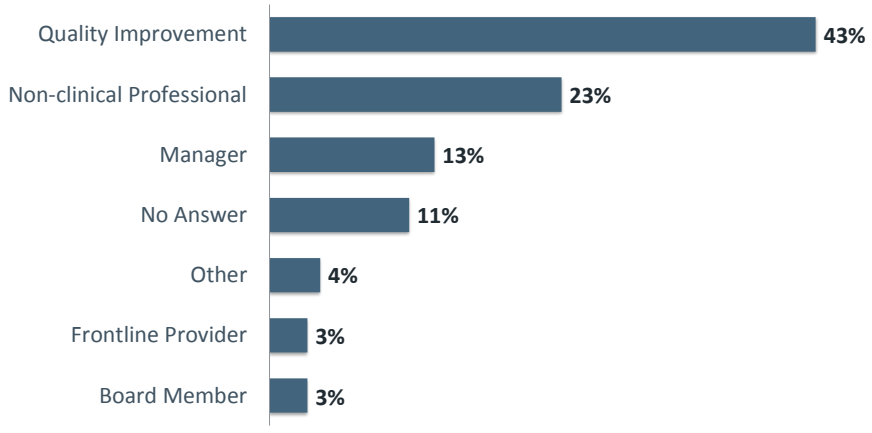
Objectives for Today's Webinar

1. Provide an opportunity for thought leaders in patient safety to share best practices, success stories, and strategies for improving systems of care
2. Provide an overview of the PfP-NPP public-private partnership and collaborative efforts under way to improve patient safety in alignment with the National Quality Strategy
3. Provide examples of hospitals successfully using tools, resources and care models to enable rapid cycle improvement
4. Generate action in organizations and communities nationwide

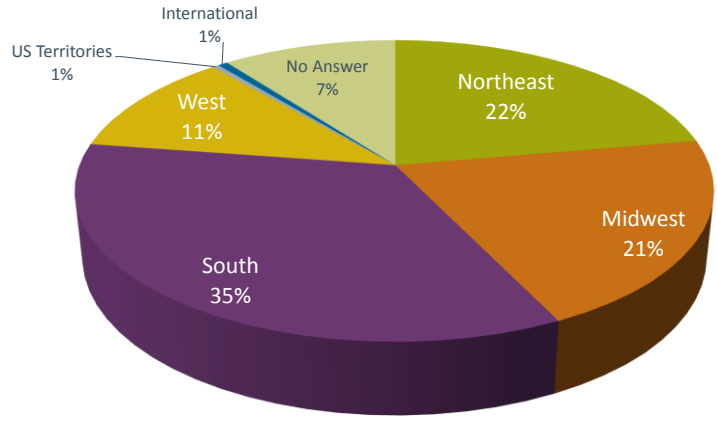
About the Audience
Type of Organization by Percentage

Organization	Percentage
Hospital	28%
Healthcare System	12%
Quality Improvement Organization	12%
No Answer	11%
Non-profit	8%
Government Agency	7%
Home Health, Long Term Care, Skilled Nursing Facility	7%
Other	5%
Academic or Research Institution	4%
Health Insurance or Healthcare Provider	3%
Primary Care	3%
Patient Advisory/Advocacy	1%
Pharmaceutical	<1%

About the Audience
Role in the Organization



About the Audience
Regional Location



Listening to the Audience
Polling Question

What would you like to hear about on this webinar about Rapid Cycle Improvement (RCI) tools?

- The big picture and long range vision of RCI
- Objective data and how to get results
- The process, planning and organizing needed with RCI
- How RCI connects your team and effects people in your organization
- No preference

Audience Feedback

Tell us about your experience

If you have any questions or comments for today's speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 800-967-7138, confirmation code 7374572.

Your questions will be answered throughout the webinar and during the audience discussion.

Featured Speaker

Lillee Smith Gelinas, MSN, RN, FAAN
Vice President and Chief Nursing Officer
VHA Inc.

NPP Input into the National Quality Strategy

- *October 2010*: NPP provides input to HHS to inform the development of the NQS
- *March 2011*: HHS issues NQS based on the triple aim
- *September 2011*: NPP input to HHS helps to make NQS more actionable:
  - Identification of goals and measures
  - Recommendation of strategic opportunities
  - Consensus across key leaders about where they should drive their organizations
  - Full report is available from the Links tab in the upper left corner of your screen

HHS's National Quality Strategy Aims and Priorities

NPP INPUT ON HHS'S NATIONAL PRIORITIES: Patient Safety

Goals:

- Reduce preventable hospital admissions and readmissions*
- Reduce the occurrence of adverse healthcare associated conditions*
- Reduce harm from inappropriate or unnecessary care

Measure Concepts:

- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index*
- All-cause healthcare-associated conditions*
- Inappropriate medication use and polypharmacy
- Inappropriate maternity care
- Unnecessary imaging

*Aligned with HHS's Partnership for Patients initiative. Healthcare-associated conditions include adverse drug events, catheter-associated urinary tract infections, central line blood stream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

Partnership for Patients Goals

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.
- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.

Partnership for Patients
Ten Areas of Focus

- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Adverse drug events
- Improving Maternal/Fetal Outcomes
- Pressure ulcers
- Surgical site infections (SSI)
- Venous thromboembolism
- Ventilator-associated pneumonia (VAP)
- 30 day readmissions

How Will Change Actually Happen?

And how will it happen at scale?

How Will Change Actually Happen?

- There is no "silver bullet," but we know we must:
  - Engage leadership
  - Engage patients and families, authentically
  - Work together
  - Provide thoughtful incentives
  - **Assist in the painstaking work of improvement**

VHA®
Results are just the beginning

National Quality Forum Patient Safety Webinars

***supporting the* CMS Partnership for Patients**

Lillee Gelinas MSN, RN, FAAN
Vice President and Chief Nursing Officer
VHA Inc.

Lillee Gelinas Brief Biography

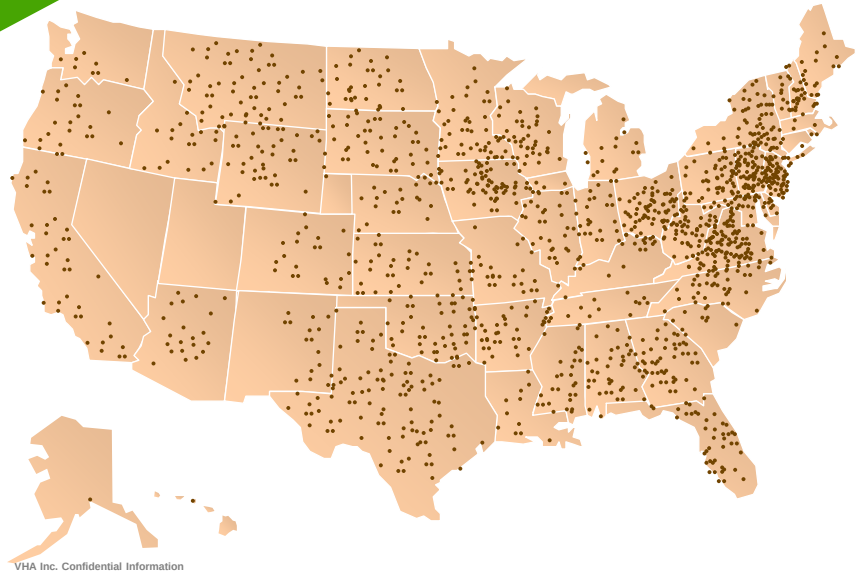
- 35 years in healthcare/5 years U.S. Navy Nurse Corps
- Facilitates VHA's national & regional networks for CNOs, perioperative and other nursing leaders
- Moderates VHA TV broadcasts and webinars reaching thousands every year
- Functions as the VHA national nurse planner for over 200 ANCC compliant educational programs annually
- Serves on committees & advisory groups for ANA, CMS, IOM, Joint Commission & NPSF

- For NQF, co-chaired the Nursing Care Performance Measures Project with the University of Pennsylvania's Dr. Mary Naylor, which resulted in the establishment 15 national voluntary consensus standards for nursing-sensitive care in the U.S. She also served on the NQF NPP Care Coordination Workgroup.

- A Fellow in the American Academy of Nursing
- On the Editorial Advisory Board of *American Nurse Today* magazine

The VHA Network

Founded 1977



Presentation Outline

I. Presentation Framework: Pictures vs Words

II. The Qualitative Approach to Rapid Improvement

- **What is it?**
- **Why use it?**
- **How does VHA use it?**
  - **RANs and Blueprints**

III. Resources

I. Presentation Framework: *Pictures Say a Thousand Words*

II. The Qualitative Approach to Rapid Improvement

•What is Qualitative Research?

- A method of inquiry aimed at gathering an in-depth understanding of human behavior and the reasons that govern it
- The qualitative method investigates the *why* and *how* of decision making, not just *what*, *where*, *when*
- Used in studying patient safety as a complement to (not a substitute for) quantitative approaches
- Captures people's insights and understandings about what causes events and how things work at the point of production in health care

Joint Commission Journal on Quality and Patient Safety

Research Methods

Studying Patient Safety in Health Care Organizations:

Accentuate the Qualitative

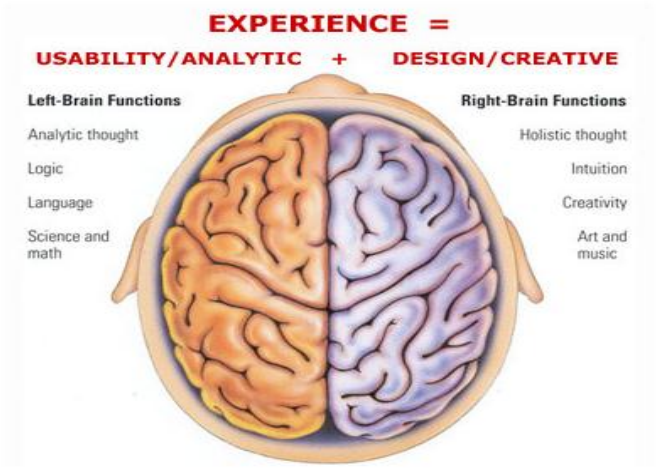
Timothy J. Hoff, Ph.D.
Kathleen M. Sutcliffe, Ph.D.

The study of patient safety in complex, dynamic, and idiosyncratic health care environments is challenging. It requires a diverse array of theoretical and methodological approaches, some of which can take into account the social, subjective, and contextual underpinnings of adverse medical events. This article emphasizes the need for and benefits of taking a more diverse approach to studying safety in organizations. The learning objectives include: (a) highlighting the complexity of how patient safety and medical errors play out in the everyday clinical setting, (b) identifying methodological approaches that capture this complexity and allow for more people-focused, contextually based, and "real-time" study of patient safety and medical errors in the everyday clinical setting, (c) highlighting the need to complement the use of deductive, quantitative approaches to studying safety and error in health care organizations, and (d) identifying action steps for

Article-at-a-Glance

Background: The study of patient safety can benefit from greater methodological diversity to improve scientific knowledge and to increase the effectiveness and tailoring of strategies aimed at improving it.

Methodological Diversity to Better Capture Causal Mechanisms and Processes: Additional methods for studying patient safety and errors to reflect the complexity of what goes on within health care organizations should be made routine. Interviews, focus groups, and observation—the predominant methods used in qualitative research—are infrequently used in health services research, generally and specifically in the study of errors and patient safety. However, they offer several advantages over quantitative designs. They often are less expensive and quicker to implement; they may not



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Why Use It?

To Capture Social and Cultural Issues

Quantitative: Serious safety event rate; malpractice claims, chart review with "trigger tools", sentinel event occurrence, Safety culture surveys, near miss reports

Qualitative: Observation studies, narrative inquiry, discussions and focus groups

Hoff and Sutcliffe; *Studying Patient Safety in Health Care Organizations: Accentuate the Qualitative;* Joint Commission Journal on Quality and Patient Safety; January 2006

Eliminating error is *impossible:* Identifying and eliminating risks is possible

A. Slips and lapses
B. At risk behavior
   1. Drift
   2. Lack of awareness
   3. Complacency
C. Mistakes:
   1. Skill based mistakes: routine activities
   2. Rule based mistakes: first level problem solving
   3. Knowledge based mistakes: complex problem solving

Source: Reason, 1992.

Strategies for detecting errors

- **Self detection:** Works best for slips and lapses
- **System based detection:** Works best for predicable failures
- 

  Detection by others: Works best for at risk behavior and rule based mistakes

Source: Reason, 1992

Every job is supported within a micro-culture

Setting: Size of room, arrangement of equipment, availability of resources, communications, transportation

People: Number, level, communication style

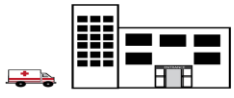
Environment: Light, noise, odors, temperature

Actually doing work as it relates to expectations and standards

How Does VHA Use It?

FEDERAL GOVERNMENT

Focus: Value Based Purchasing



LOCAL LEVEL

Focus: Market Operations

INDIVIDUAL LEVEL

Focus: People

VHA FOCUS: Clinicians

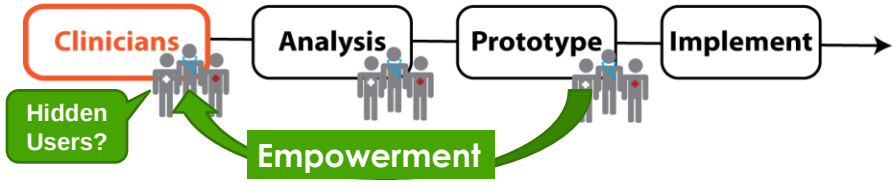
New Eyes, New Vision

Improving our Skills

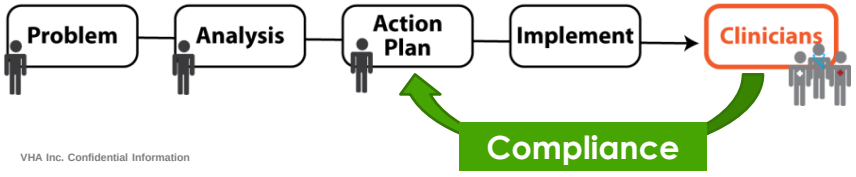
Observing for Understanding: *Because* Culture Matters

Models of Understanding People

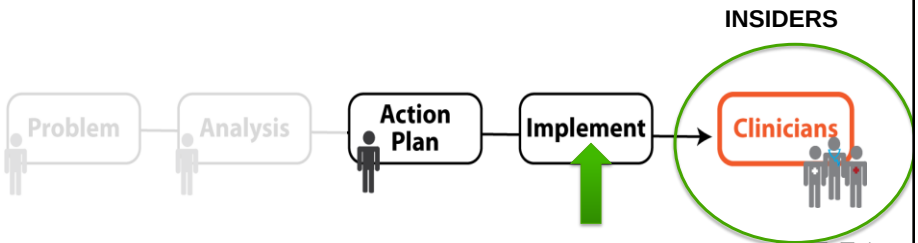
Contextualist Model

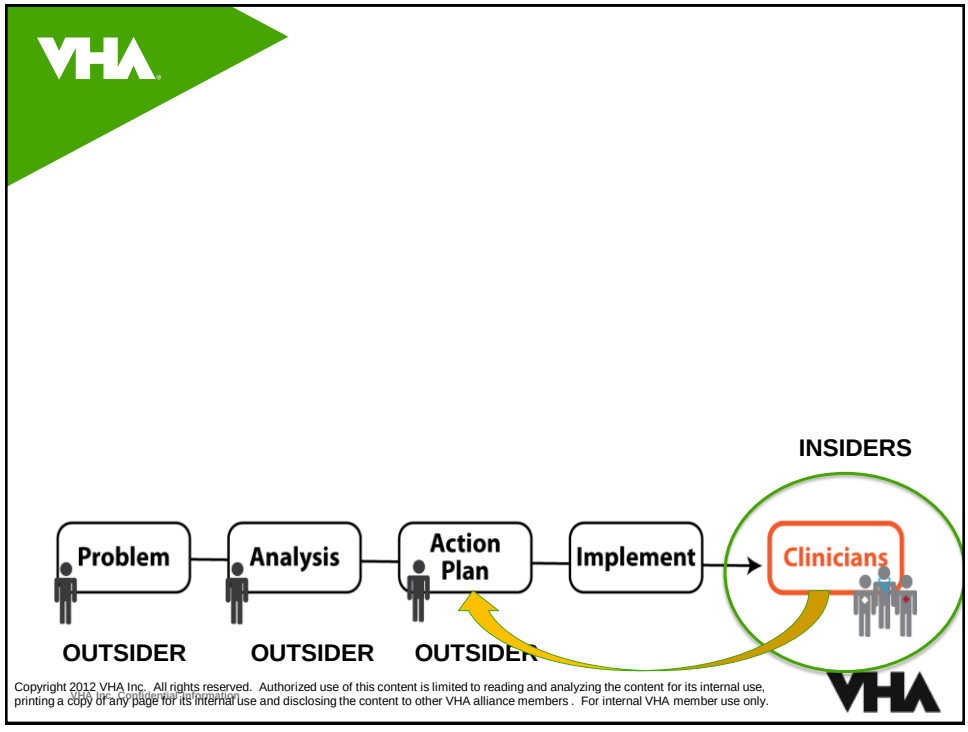


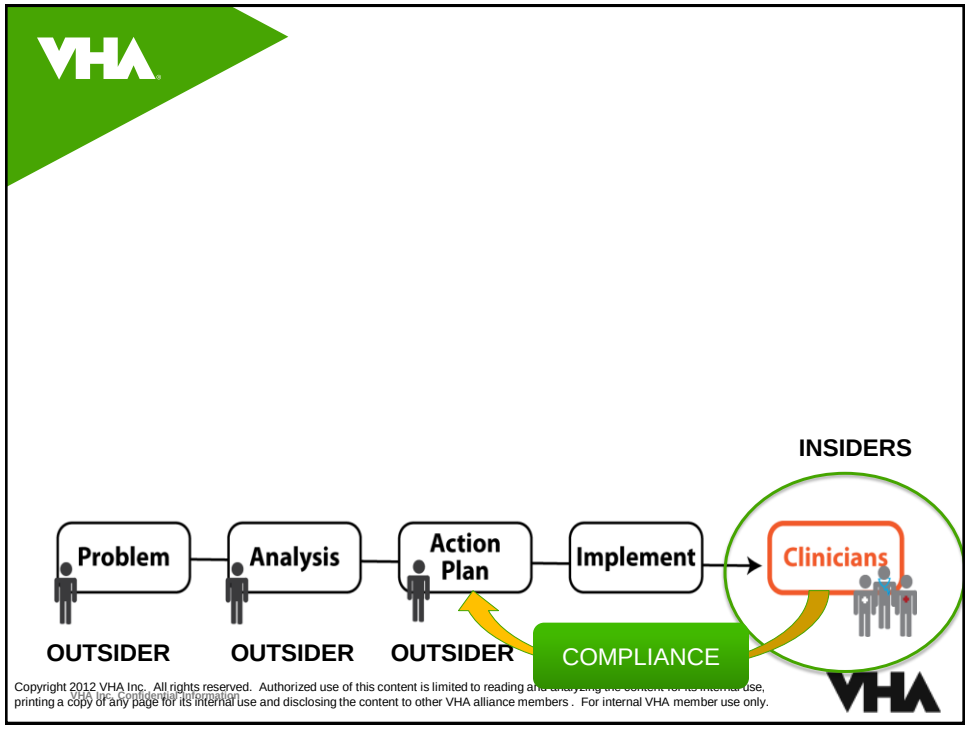
Traditionalist Model



Traditional Approach







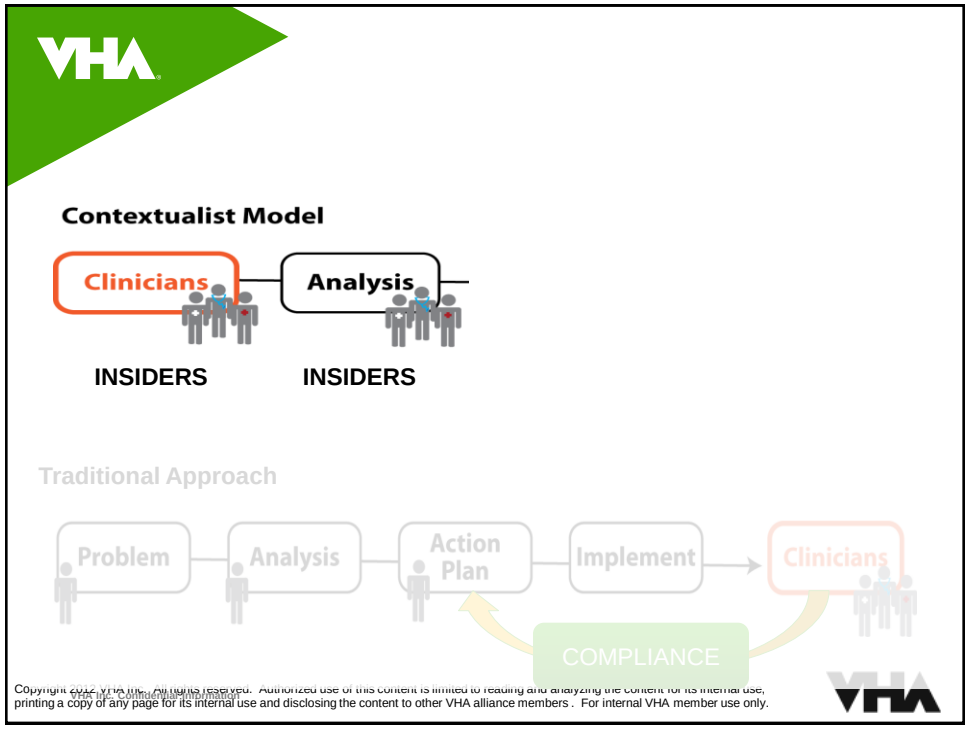
Traditional Approach

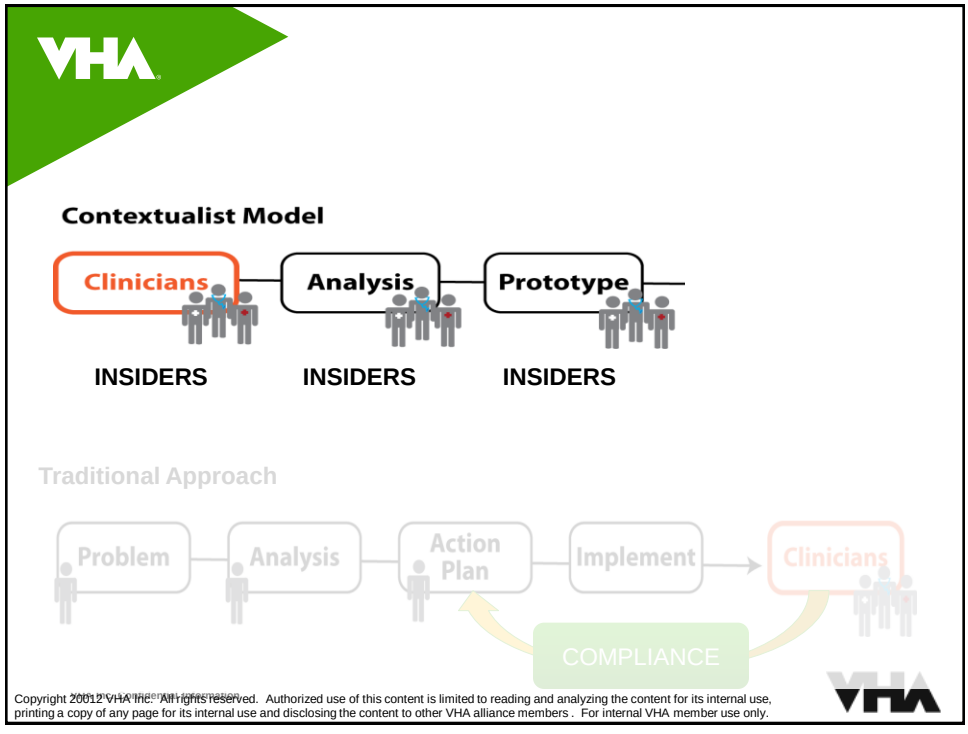
Contextualist Approach

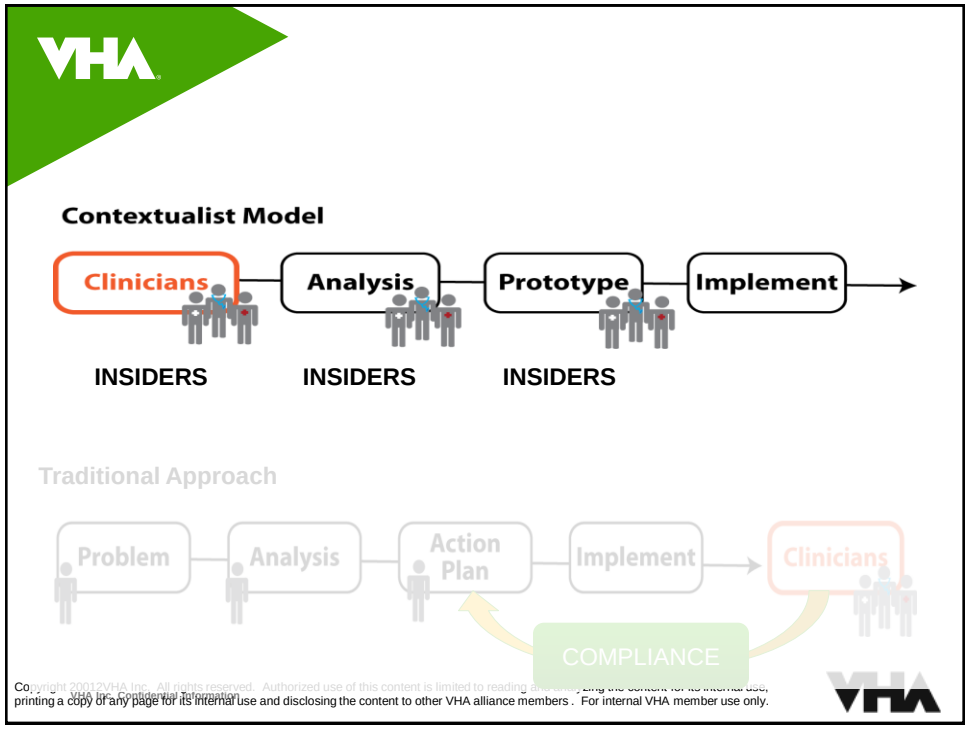
Inductive: Understanding from the Inside Out

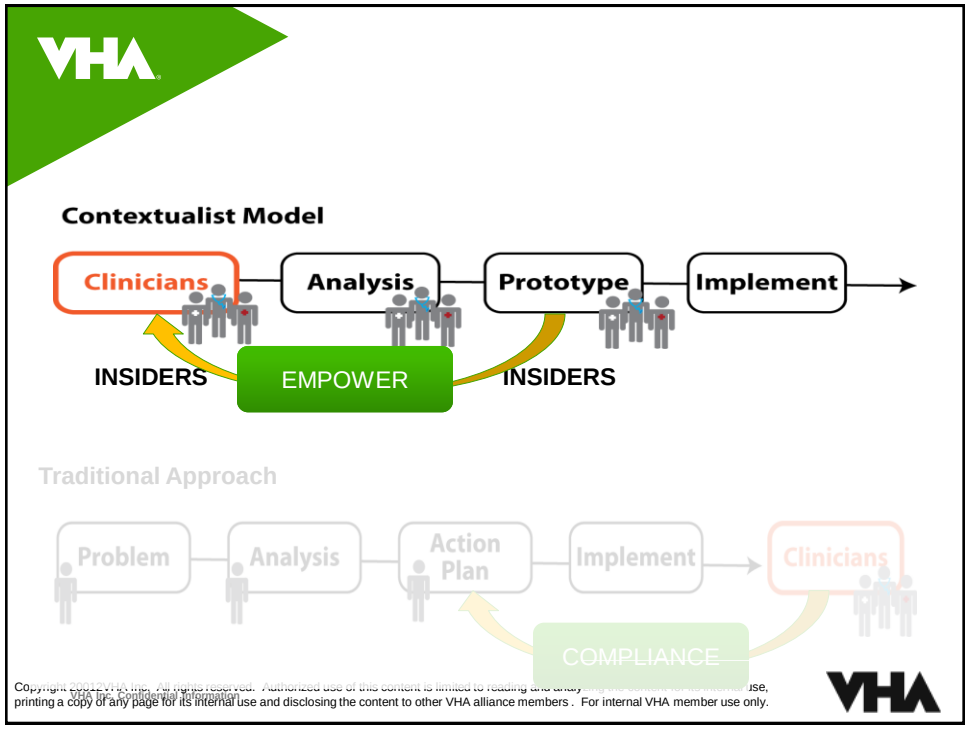
INSIDERS

Traditional Approach



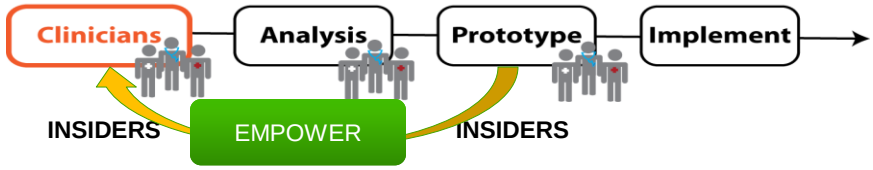




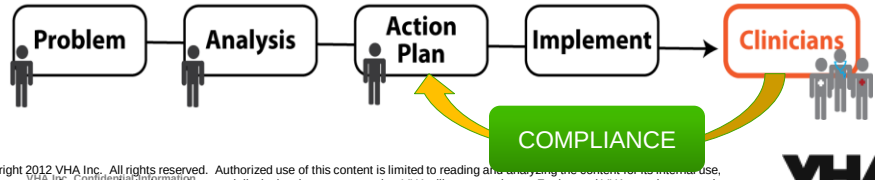


Rapid Adoption Network (RAN) Approach

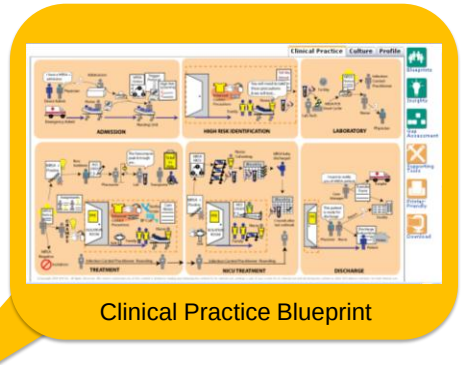
Contextualist Model



Traditional Approach

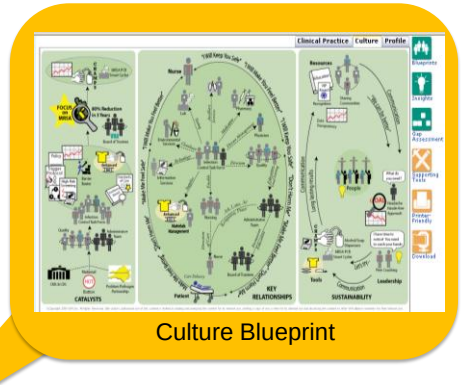


What's a Blueprint?



Clinical Practice Blueprint

Leading Practice Blueprints



Culture Blueprint

Leading Practice Blueprints

Observation Method: Seeing, Hearing, & Connecting

- **Dynamic interaction of multiple variables**
- **Explicit and implicit findings**
- **Underlying work culture in relation to safety and errors**
- **Safety issues that workers do not recognize as such**

Hoff and Sutcliffe; *Studying Patient Safety in Health Care Organizations: Accentuate the Qualitative;* Joint Commission Journal on Quality and Patient Safety; January 2006

Now What?
Honing Your Skills – *Getting Started*

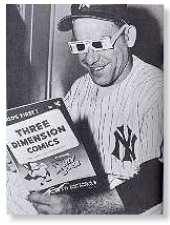
- **Spend some time *just observing.***
- **Record your observations.**

- **You have observed:**

What do you now understand about your culture?

You Can Observe a Lot by Watching: "What I've Learned About teamwork from the Yankees and Life"

By Yogi Berra



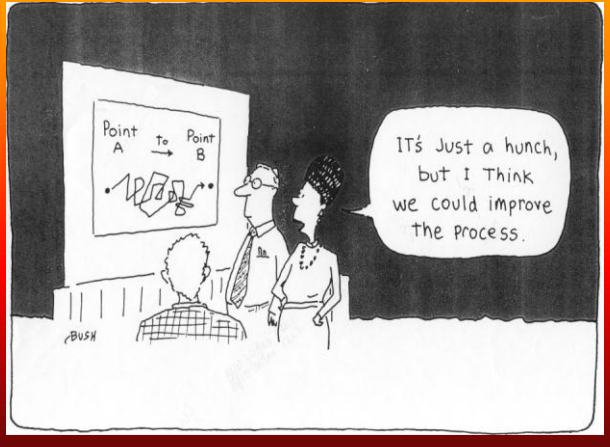
III. Resources on Qualitative Methods

1. Denzin N.K., Lincoln Y.S.: *Strategies of Qualitative Inquiry,* 2nd ed. Thousand Oaks, CA: Sage Publications, 2003.
2. Kvale S.: *Interviews: An Introduction to Qualitative Research Interviewing.* Thousand Oaks, CA: Sage Publications, 1996.
3. Krueger R., Casey M.A.: *Focus Groups: A Practical Guide for Applied Research,* 3rd ed. Thousand Oaks, CA: Sage Publications, 2000.
4. Miles M.B., Huberman A.M.: *Qualitative Data Analysis: An Expanded Sourcebook,* 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.
5. Morgan D.L. (ed.): *Successful Focus Groups: Advancing the State of the Art.* Newbury Park, CA: Sage Publications, 1993.
6. Patton M.: *Qualitative Research and Evaluation Methods,* 3rd ed. Thousand Oaks, CA: Sage Publications, 2002.
7. Pope C., Mays N., eds.: *Qualitative Research in Health Care.* London: BMJ Books, 2000.
8. Strauss A., Corbin J.: *Basics of Qualitative Research,* 2nd ed. Thousand Oaks, CA: Sage Publications, 1998.
9. Yin R.K.: *Case Study Research: Design and Methods,* 3rd ed. Thousand Oaks, CA: Sage Publications, 2003.
10. Yin, R.K.: *Applications of Case Study Research,* 2nd ed. Thousand Oaks, CA: Sage Publications, 2003.
11. Maxwell, J.A.: *Qualitative Research Design – An Interactive Approach*, 2nd. Education. Sage Publications, 2005.
12. Hoff and Sutcliffe; *Studying Patient Safety in Health Care Organizations: Accentuate the Qualitative;* Joint Commission Journal on Quality and Patient Safety; January 2006

Featured Speaker

Cristin Sullivan, RN, BSN
Director of Quality
Eastern Wisconsin Division of Hospital Sisters Health System

Heart Failure & Rapid Cycle Improvement



First Steps

- Review your strategic plan and purpose
- Understand your practice/organization

Rapid Cycle & LEAN

- Ideal State - Current State = Gap Analysis
- Gap Analysis + strategic plan = Future State

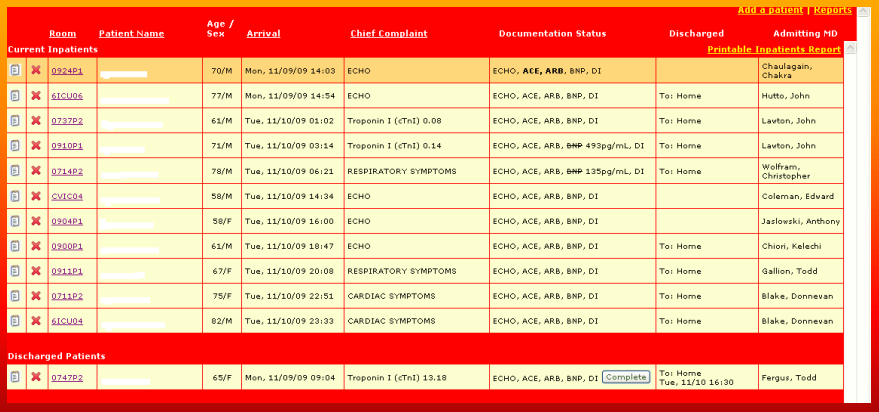
Plan

- Strategic plan
- HF onsite visit
- Brainstorming
- Research
- Gather data

Do

- Order sets
- **Tracking Board**
- Patient Education
- Hospital Visit Summary
- Home Health Care
- Skilled Nursing Facilities

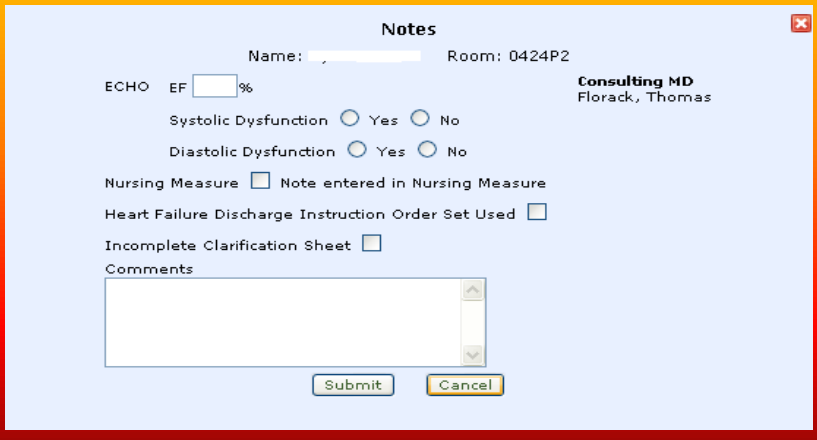
Do - Heart Failure Tracking Board



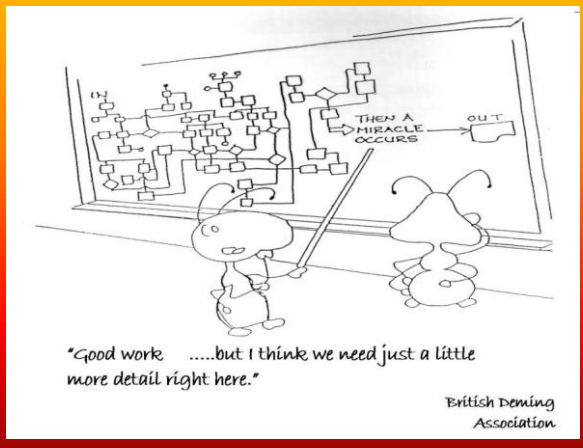
Add a patient | Reports

		Room	Patient Name	Age / Sex	Arrival	Chief Complaint	Documentation Status	Discharged	Admitting MD
Current Inpatients									Printable Inpatients Report
		0924P1		70/M	Mon, 11/09/09 14:03	ECHO	ECHO, **ACE, ARB**, BNP, DI		Chaulagain, Chakra
		6ICU06		77/M	Mon, 11/09/09 14:54	ECHO	ECHO, ACE, ARB, BNP, DI	To: Home	Hutto, John
		0737P2		61/M	Tue, 11/10/09 01:02	Troponin I (cTnI) 0.08	ECHO, ACE, ARB, BNP, DI	To: Home	Lavton, John
		0910P1		71/M	Tue, 11/10/09 03:14	Troponin I (cTnI) 0.14	ECHO, ACE, ARB, ~~BNP~~ 493pg/mL, DI	To: Home	Lavton, John
		0714P2		78/M	Tue, 11/10/09 06:21	RESPIRATORY SYMPTOMS	ECHO, ACE, ARB, ~~BNP~~ 135pg/mL, DI	To: Home	Wolfram, Christopher
		CVICU4		58/M	Tue, 11/10/09 14:34	ECHO	ECHO, ACE, ARB, BNP, DI		Coleman, Edvard
		0904P1		58/F	Tue, 11/10/09 16:00	ECHO	ECHO, ACE, ARB, BNP, DI		Jaslowski, Anthony
		0900P1		61/M	Tue, 11/10/09 18:47	ECHO	ECHO, ACE, ARB, BNP, DI	To: Home	Chiori, Kelechi
		0911P1		67/F	Tue, 11/10/09 20:08	RESPIRATORY SYMPTOMS	ECHO, ACE, ARB, BNP, DI	To: Home	Gallion, Todd
		0711P2		75/F	Tue, 11/10/09 22:51	CARDIAC SYMPTOMS	ECHO, ACE, ARB, BNP, DI	To: Home	Blake, Donnevan
		6ICU04		82/M	Tue, 11/10/09 23:33	CARDIAC SYMPTOMS	ECHO, ACE, ARB, BNP, DI	To: Home	Blake, Donnevan
Discharged Patients									
		0747P2		65/F	Mon, 11/09/09 09:04	Troponin I (cTnI) 13.18	ECHO, ACE, ARB, BNP, DI Complete	To: Home Tue, 11/10 16:30	Fergus, Todd

Do – Tracking Board Notes Page



Study



Study

- Things that went well…
- HHC utilization
- Scales/telemedicine
- Post discharge visit
- Order sets

- Things that didn't go well…
- Cookbook
- Restaurant book
- SNF follow up
- Order set usage
- Provider knowledge
- Tracking mechanisms

Study

And the results are…

Act

- HF Medical Home / Clinic
- Aligning Forces for Quality (AF4Q)
- Centers for Medicare and Medicaid Innovation – Innovation Advisors Program

Audience Feedback

Tell us about your experience

If you have any questions or comments for today's speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 800-967-7138, confirmation code 7374572.

Your questions will be answered throughout the webinar and during the audience discussion.

Featured Speakers

The nursing team at Redington-Fairview General Hospital

Sherry Rogers, RN, MSN
NEA-BC, Chief Nursing Office

Norma Munn, RN-BC, BSN
Medical Surgical Nurse Manager

Susannah Warner, RN-BC
Medical Surgical Charge & Staff Nurse

Redington-Fairview General Hospital Skowhegan, Maine

Sherry Rogers, RN, MSN, NEA-BC
Chief Nursing Officer

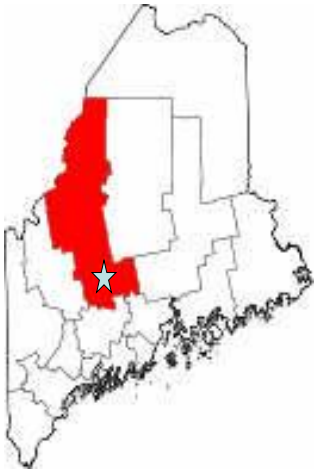
Norma Munn RN-BC, BSN
Medical Surgical Nurse Manager

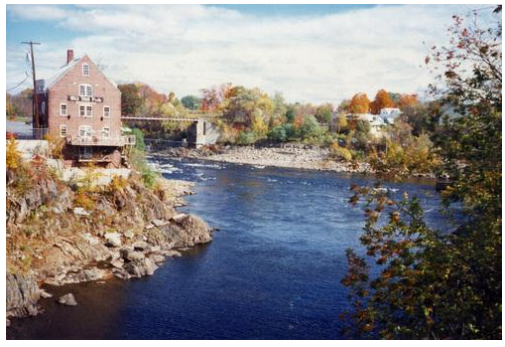
Susannah Warner RN-BC
Staff Nurse and Relief Charge Nurse

Skowhegan, Maine

- Somerset County Seat
- Population 8,800
- Host of the annual Skowhegan State Fair
- Skowhegan School of Art
- On the Kennebec River
- Abenaki Indians

Critical Access Hospital





Independent
- 25 acute beds
- 25,000 ED visits per year
- Service 30,000 people
- 7 Physician Practices
- Specialty Services

Transforming Care at the Bedside

A Collaborative Program of the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement and Aligning Forces for Quality (AF4Q)

Robert Wood Johnson Foundation

Aligning Forces for Quality Improving Health & Health Care in Communities Across America

What is TCAB?

Improving the hospital work environment on medical/ surgical units by empowering frontline nurse and the team they work with to discover and test strategies.

- Patient-Centered
- Added Value/Efficiencies
- Safe/Reliable
- Vitality/Teamwork

Foundation of Transformational Leadership

How do you do TCAB?

- Establish aims with a team
- Snorkel
- Rapid Cycle Improvement
- Adopt, Adapt or Abort
- Storyboard
- Measure Results

Five Strategies to Succeed

1. Start with purpose
2. Go with the interest
3. Communicate

4. Take Chances

5. Celebrate and stay committed!

Why TCAB?

- We wanted our staff to know that we respected and trusted their judgment
- We wanted our staff to enjoy professional satisfaction
- We were a top-down decision making culture and wanted to change

Why Rapid Cycle Tests of Change Work For Us

- Frontline staff initiate and lead changes based on their experience
- Ideas are tested and voted on by frontline staff to adapt, adopt or abandon
- Multiple tests of change to “work out the bugs”
- Staff have a voice so are more engaged in changes
- You don’t have to be perfect the first time!

How did we get staff excited?

It wasn't easy

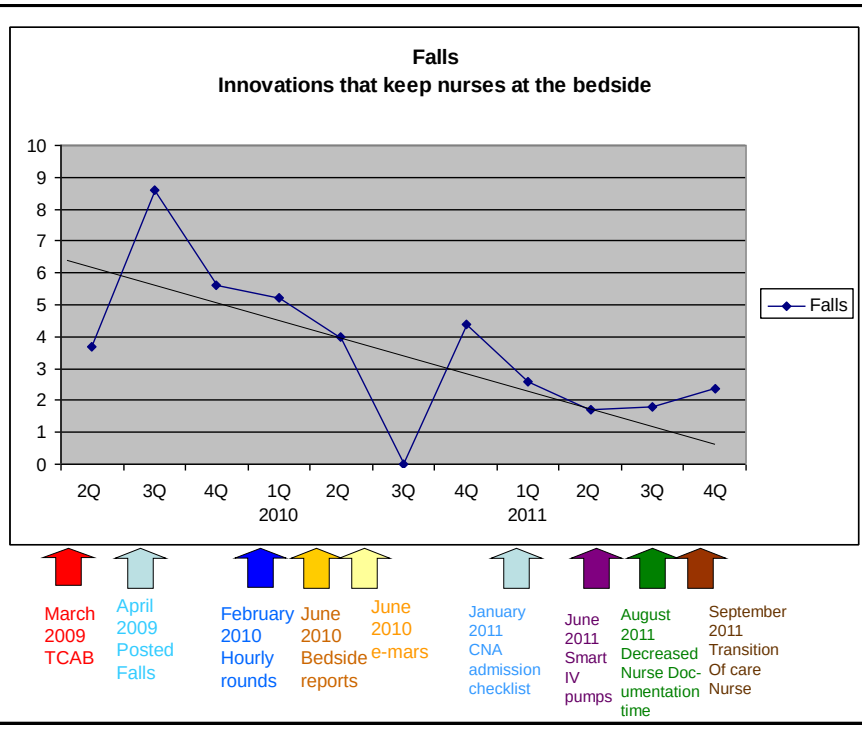
- We had a great core group who did not give up!
- Sometimes the manager coaxed, supported, reminded and compelled the team to persevere
- It has taken almost 3 years to get the majority of staff involved
- Know what your tipping point is

Tips to keep staff interested

- Allow staff to truly be staff led
- Low hanging fruit for early success
- Allow time to do the work
- Encourage champions
- Encourage best practice; staff do the research
- Expectation: *one nurse, one shift, one time* tests of change
- Manager needs to be available for guidance

March 2009:
Our Aim Statement

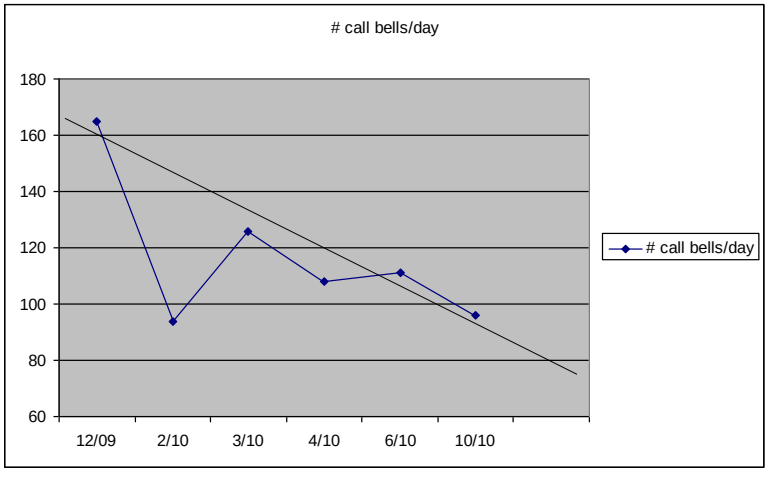
60% of the nurses time will be at the patient bedside by June 2011



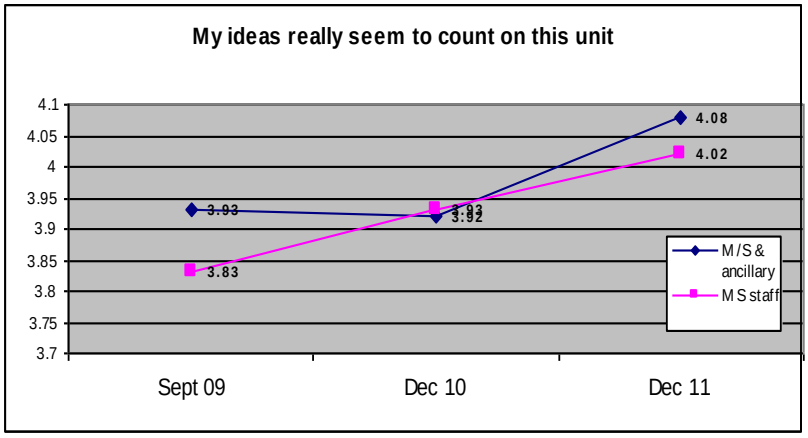
What else have we done to keep our eye on the goal?

- We are transparent with our fall data
- We celebrate success
- We collaborate with other disciplines
  - Hospitalists
  - Rehab
  - Surgical Services
- We are spreading TCAB

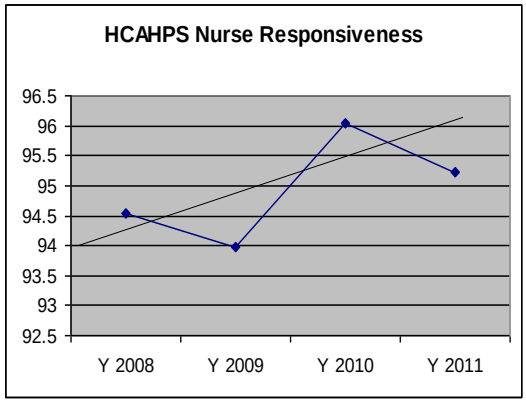
Response Time



Staff Satisfaction



Patient Satisfaction Scores



Redington - Fairview
General Hospital

Health Strong Achievements
2011 – 2012
Best in Strength

Top 20 Critical Access Hospital
Top 20 Rural Hospital
Best in Region
Best in State

Top 100 Hospital Nationally

Resources

- Rutherford P, Lee B, Greiner A. *Transforming Care at the Bedside.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004. www.IHI.org
- Keefe S. *Leaders of the Pack*. New England Advance for Nurses; October 5, 2009. www.advanceweb.com/nurses
- Robert Wood Johnson Foundation Toolkits www.rwjf.org/pr/product.jsp?id=72584
- Aligning Forces For Quality. *Transforming Care at the Bedside.* http://forces4quality.org/
- AONE. *Care Innovation and Transformation. www.aone.org/resources/CCIT/ccit.shtml*
- Websites are available in the Links tab of this presentation

Audience Discussion

Tell us about your experience

If you have any questions or comments for today's speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 800-967-7138 confirmation code 7374572.

Conclusion

Next Steps, Further Resources, and Concluding Remarks

Further Resources

Resources, links, and PDF documents are available now in the ***top left corner of your screen in the Links tab,*** including:

- Partnership for Patients website
- National Priorities Partnership (NPP) website
- National Quality Forum patient safety webpage
- NQF 2012 Annual Conference "Building a Patient and Family-Centered Health System" on April 4-5, 2012, in Washington, DC
- Information for both available online at **www.qualityforum.org**
- "Introduction to the Community Tool to Align Measurement" webinar on March 7, 2012

Thank You

A recording of this webinar will be available on the National Quality Forum website within a week. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact
priorities@qualityforum.org