PA PQC Virtual Session
April 17, 2024

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.0 hours are approved for this course.**

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Agenda

1. **Welcome** – Sara Nelis, RN, PA PQC Project Manager, Jewish Healthcare Foundation

2. **Quality Improvement & Change Management** – Jennifer Condel, SCT(ASCP)MT, Manager of Lean Healthcare Strategy and Implementation, Jewish Healthcare Foundation

3. **Q&A** – Facilitated by Jennifer Condel, SCT(ASCP)MT

4. **Wrap-up and Next Steps** – Sara Nelis, RN, PA PQC Project Manager, Jewish Healthcare Foundation

Quality Improvement & Change Management

JENNIFER CONDEL, SCT(ASCP)MT

MANAGER, LEAN HEALTHCARE STRATEGY AND IMPLEMENTATION

Learning Objectives

➢ Describe a systematic approach to building quality improvement cycles for implementing PA PQC initiatives.

➢ Discuss approaches for managing quality improvement change in healthcare teams for PA PQC initiatives.

Definition of Quality Improvement

"In health care, quality improvement (QI) is the **framework** we use to **systematically improve the ways care is delivered to patients.**

Processes have characteristics that can be measured, analyzed, improved, and controlled.

QI entails continuous efforts to **achieve stable and predictable process results**, that is, to reduce process variation and improve the outcomes of these processes both for patients and the health care organization and system.

Achieving sustained QI **requires commitment from the entire organization**, particularly from top-level management."

https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod4.html

WE CANNOT SOLVE OUR PROBLEMS WITH THE SAME THINKING WE USED WHEN WE CREATED THEM

-Albert Einstein

"Every process is perfectly designed to get the results that it gets."

- W. Edwards Deming

http://pbs.twimg.com/media/CiKBaINUoAET1zS.jpg

An Organized Approach to Quality Improvement

PLAN - DO - STUDY - ACT

•Take action based on what you learned
•Adopt, Adapt, Abandon

•Identify your goal
•Understand the **current state**
•Design experiment/interventions
•Identify metrics
•Predict results

•Review the test
•Analyze results
•Assess learnings

Reducing waste while increasing value.

•Test the change
•Carry out a small-scale experiment
•Collect data

PDSA Thinking is Iterative and Continuous

Problems are solved one step at a time – each attempt gets you closer to success
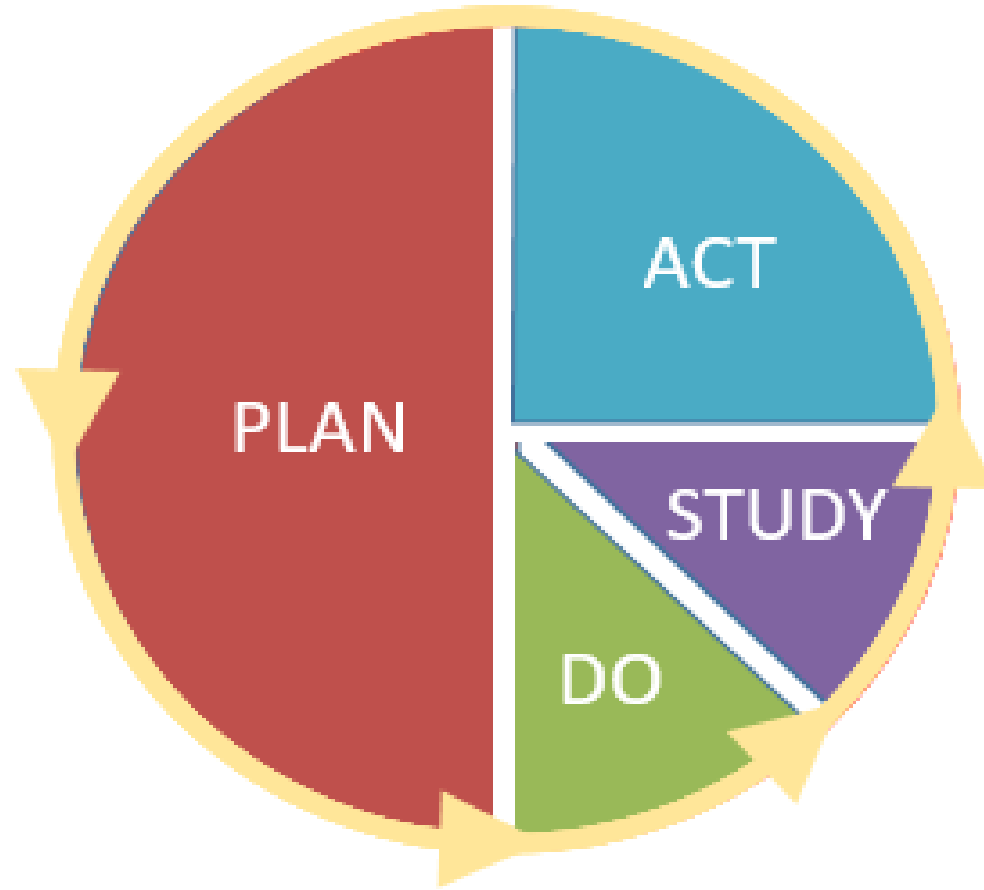
IDEAL

Current Condition

PDSA PDSA PDSA

Defect-free, one-by-one, on demand, delivered immediately, no waste, safe

Plan Do Study Act

PRINCIPLES AND TOOLS

PDSA Thinking:
The Foundation of Quality Improvement

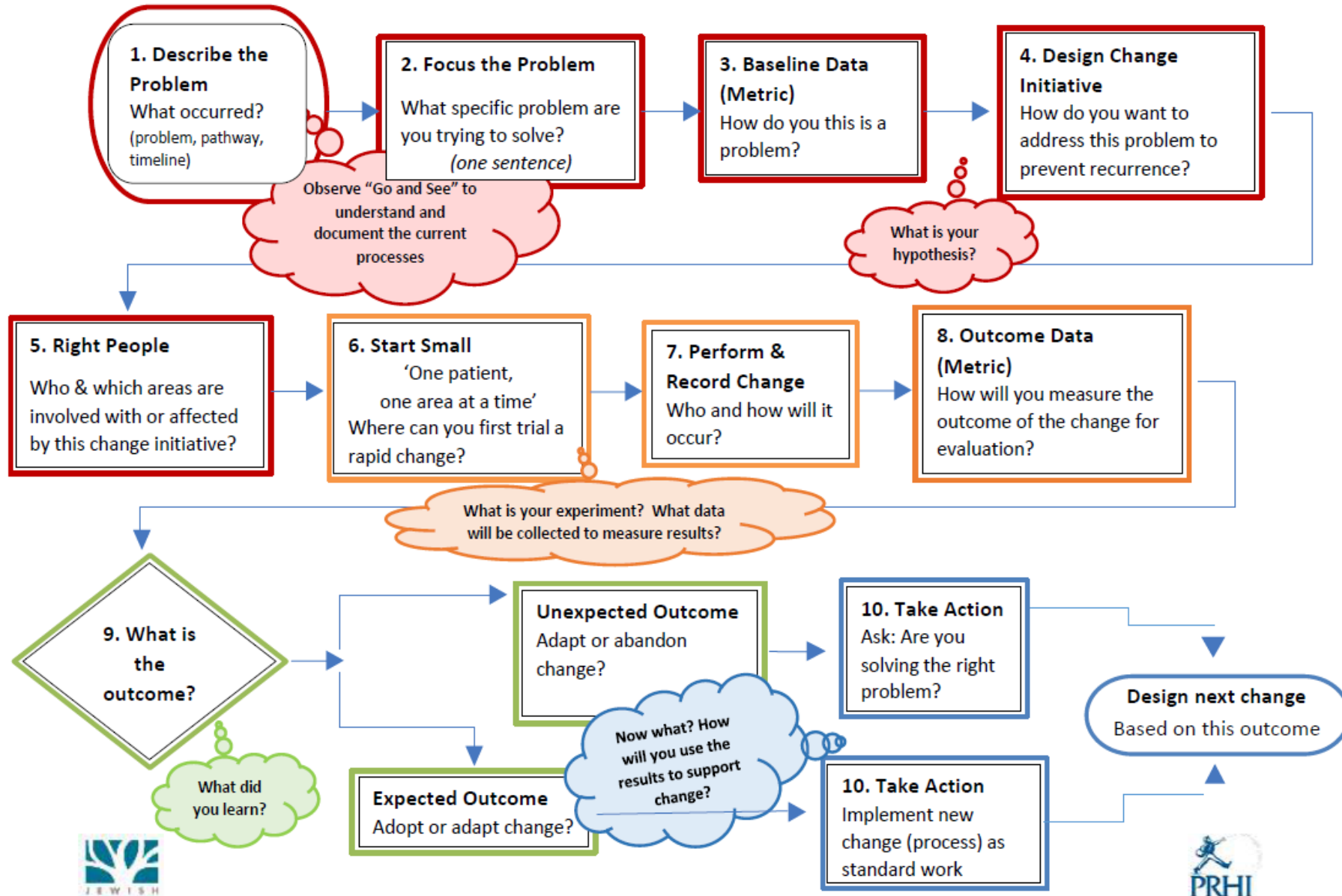An approach to **standardizing** problem solving

A way of **engaging and organizing teams** to continuously identify and act upon opportunities for improvement

Applied to process changes as well as behavior changes, and to problems big and small

Supports **deep examination** of problems

Flow Chart for Problem Solving Thinking (PDSA)

1. Describe the Problem
What occurred?
(problem, pathway, timeline)

Observe "Go and See" to understand and document the current processes

2. Focus the Problem
What specific problem are you trying to solve?
(one sentence)

3. Baseline Data (Metric)
How do you this is a problem?

4. Design Change Initiative
How do you want to address this problem to prevent recurrence?

What is your hypothesis?

5. Right People
Who & which areas are involved with or affected by this change initiative?

6. Start Small
'One patient, one area at a time'
Where can you first trial a rapid change?

7. Perform & Record Change
Who and how will it occur?

8. Outcome Data (Metric)
How will you measure the outcome of the change for evaluation?

What is your experiment? What data will be collected to measure results?

9. What is the outcome?

What did you learn?

Unexpected Outcome
Adapt or abandon change?

Expected Outcome
Adopt or adapt change?

Now what? How will you use the results to support change?

10. Take Action
Ask: Are you solving the right problem?

10. Take Action
Implement new change (process) as standard work

Design next change
Based on this outcome

Change Worksheet

Site Location: _____   Name of Initiative: _____

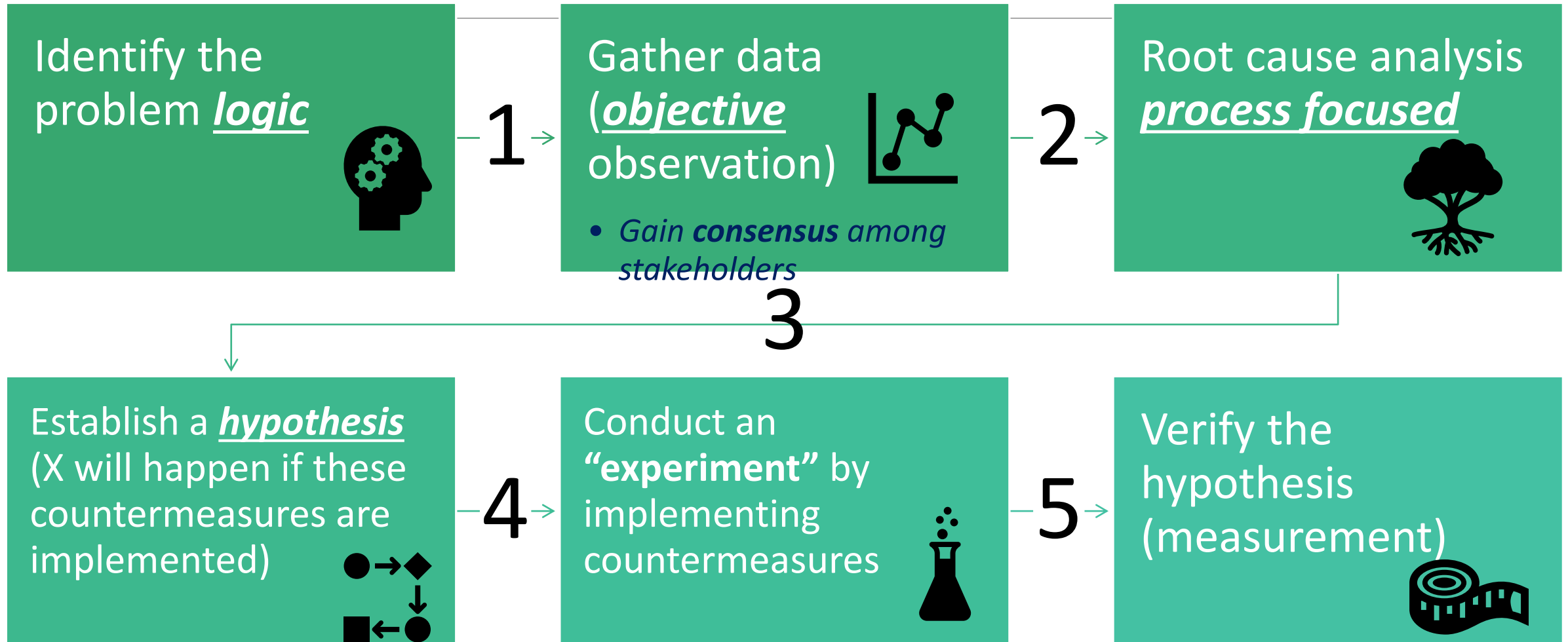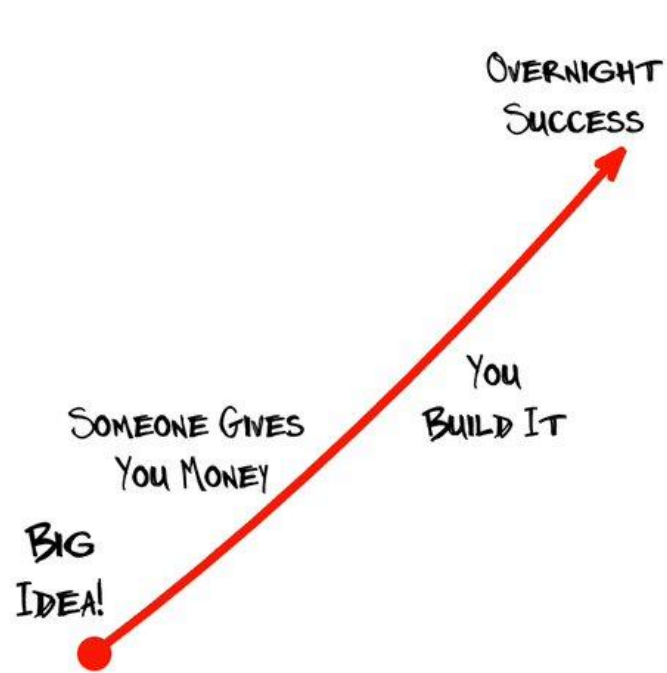| Date Started:	Before (Current State)	After (Outcome)
People Involved: Areas Involved/Affected:	Description (or Drawing):	Description (or Drawing):
	How do you know this is a problem (include any explanatory baseline data)?	How do you know this change helped (include any post-change data)?

Date Completed: _____   Outcome: ☐ Adopted   ☐ Adapted   ☐ Abandoned
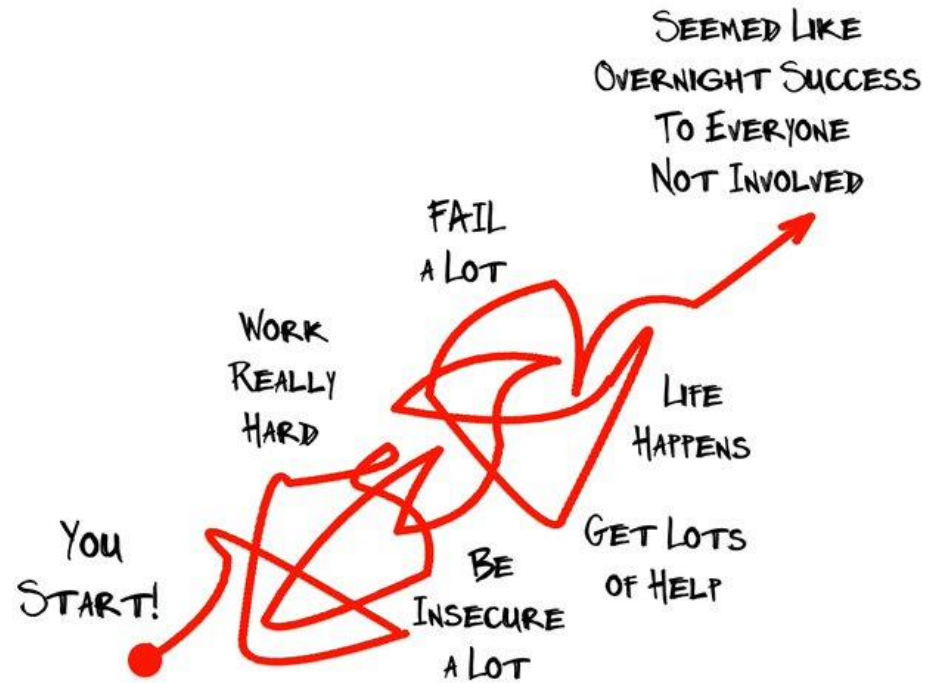
Form completed by: _____

Rooted in the Scientific Method

Identify the problem _logic_

1 →

Gather data (_objective_ observation)
- *Gain **consensus** among stakeholders*

2 →

Root cause analysis _process focused_

3

Establish a _hypothesis_ (X will happen if these countermeasures are implemented)

4 →

Conduct an "experiment" by implementing countermeasures

5 →

Verify the hypothesis (measurement)

Design safe and reliable systems anchored on the principles of excellence to meet the needs of the people served in that system

Quality Improvement is an enterprise-wide, 24/7 commitment

OVERNIGHT SUCCESS

SOMEONE GIVES YOU MONEY

YOU BUILD IT

BIG IDEA!

WHAT PEOPLE THINK IT LOOKS LIKE . . . .

SEEMED LIKE OVERNIGHT SUCCESS TO EVERYONE NOT INVOLVED

FAIL A LOT

WORK REALLY HARD

LIFE HAPPENS

GET LOTS OF HELP

YOU START!

BE INSECURE A LOT

WHAT IT REALLY LOOKS LIKE . . . .

Matt Gubba   @MattGubba   Jul 7, 2016
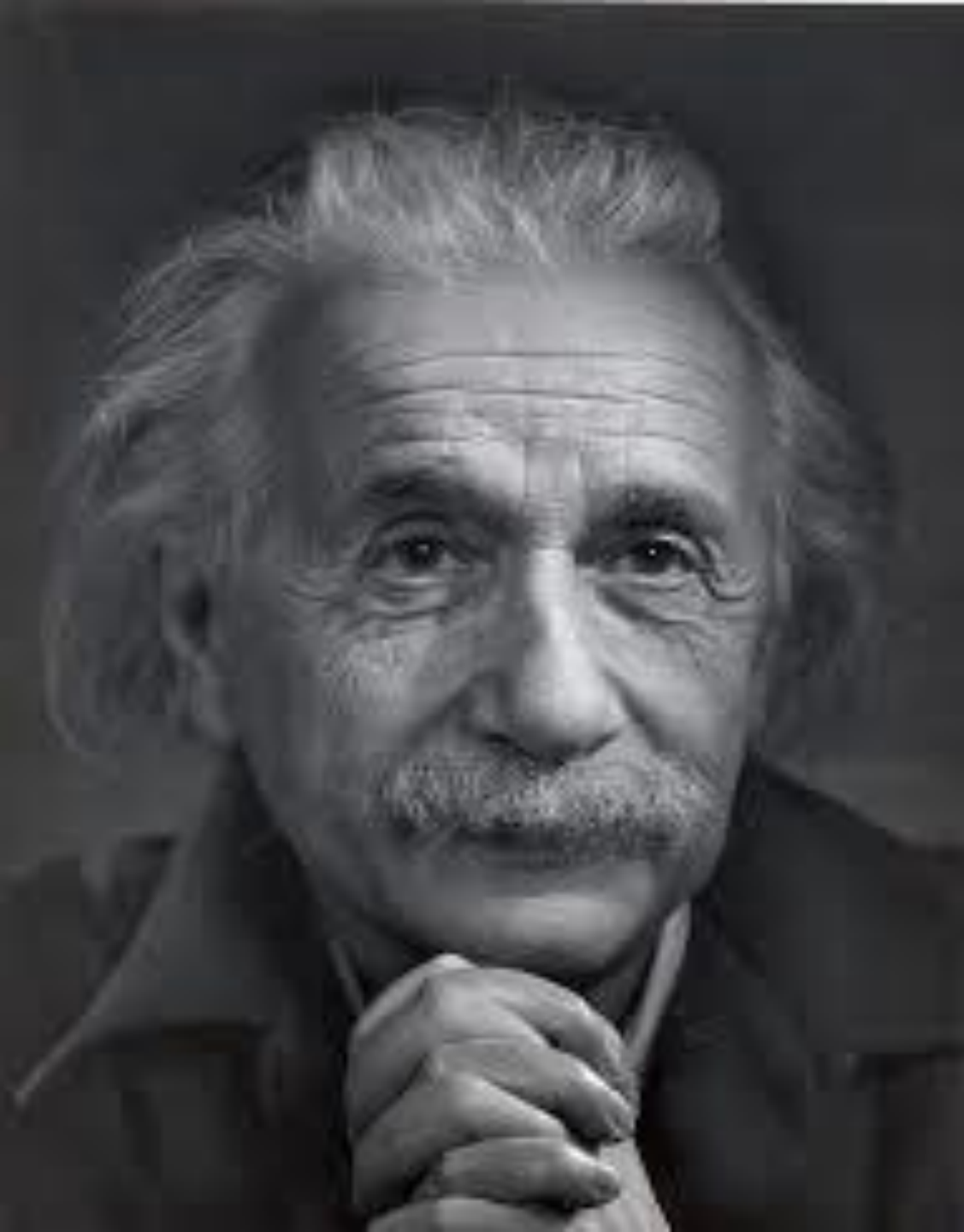
"If I had an hour to solve a problem, I'd spend 55 minutes thinking about the problem and 5 minutes about solutions."

-Albert Einstein

Data are essential to each step in the process improvement journey.

Revise

"Diabetes testing, outcomes, and P4P payments are below expectations."

"32% of diabetes patients had missing or overdue testing."

"Staff are unaware of >90% of overdue tests when patients are seen."

"80% of primary care sites now have active diabetes care reminders."

"Automated diabetes care reminders have been added to all of diabetes care protocols."

"In the last three months we reduced overdue testing from 32% to 15% and increased P4P by $4000."

"Implement a diabetes test reminder system at time of care to reduce overdue testing by 1/3 in the next 3 months."

Where do I start?

What do I collect?

How do I analyze it?

Data Dilemmas

Defining the Problem Approach

Problem
- What is the problem or need?
- How do we know this is a problem?
- Why is it important to solve

Scope
- Who is experiencing the problem?
- Where is the problem occurring?
- When and how often is the problem happening?

Team
- Who owns the problem (Executive in Charge)?
- Who has an interest in the problem (Stakeholders)?
- Who can make decisions about the problem (Management)?
- Who is directly involved in the problem (Front-line)?

Understanding the current condition

PROCESS MAPPING

Benefits Of Process Mapping

Explore a complicated process involving
- different people
- lots of tasks
- important decisions

Identify opportunities to improve the process
- things that work
- things that don't work
- delays

Help people learn about the work to be done
- new employees
- care team
- supervisors
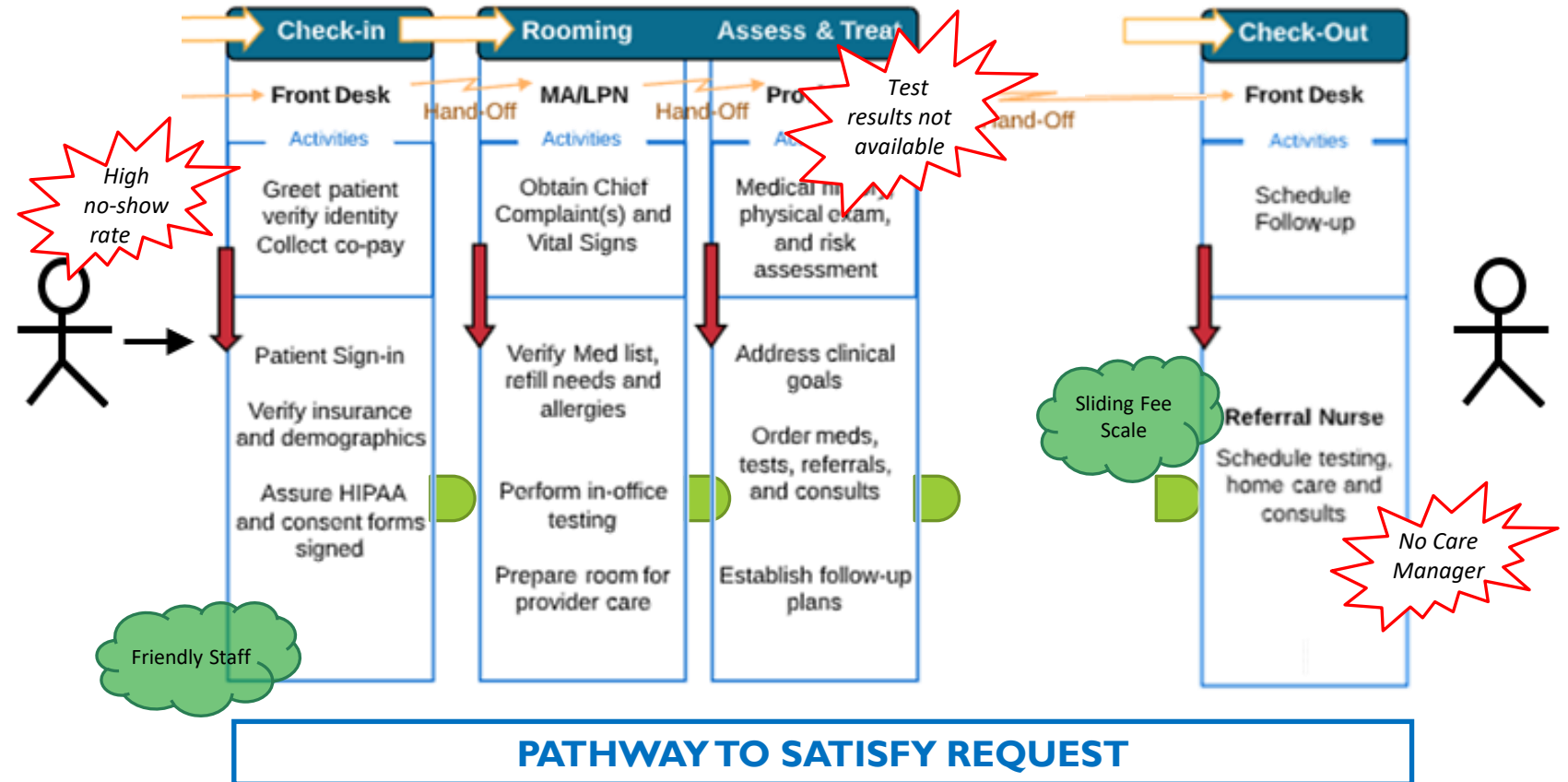
Root Cause Analysis

DEEP EXAMINATION

Root Cause Analysis: Key Points

As a result…

Because…

SYMPTOMS

PROBLEM

CAUSE   CAUSE   CAUSE   CAUSE
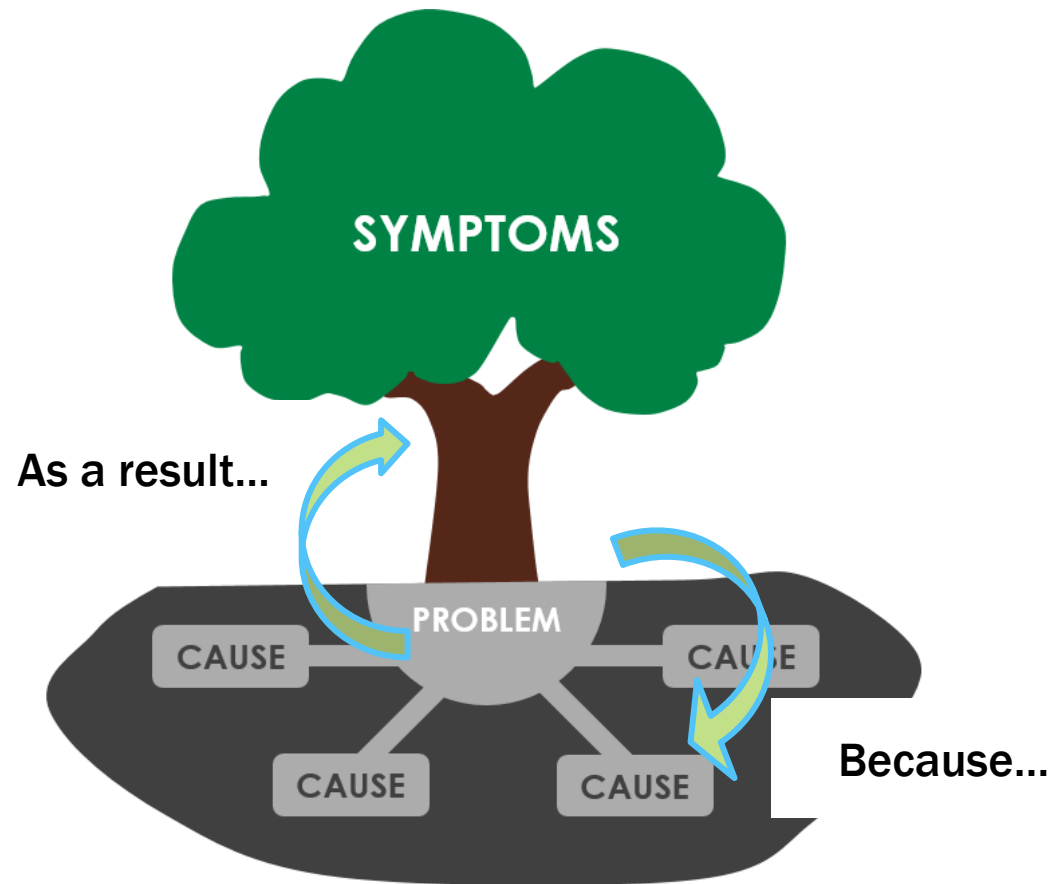
Listen to the people on the front lines, especially staff and consumers

Explore each suggestion, rather than judging it

Identify the causes of the problem not the symptoms

Tools: fishbone diagram, 5 WHY's

WHY, not Who

It's the process, not the people

Understanding Root Causes
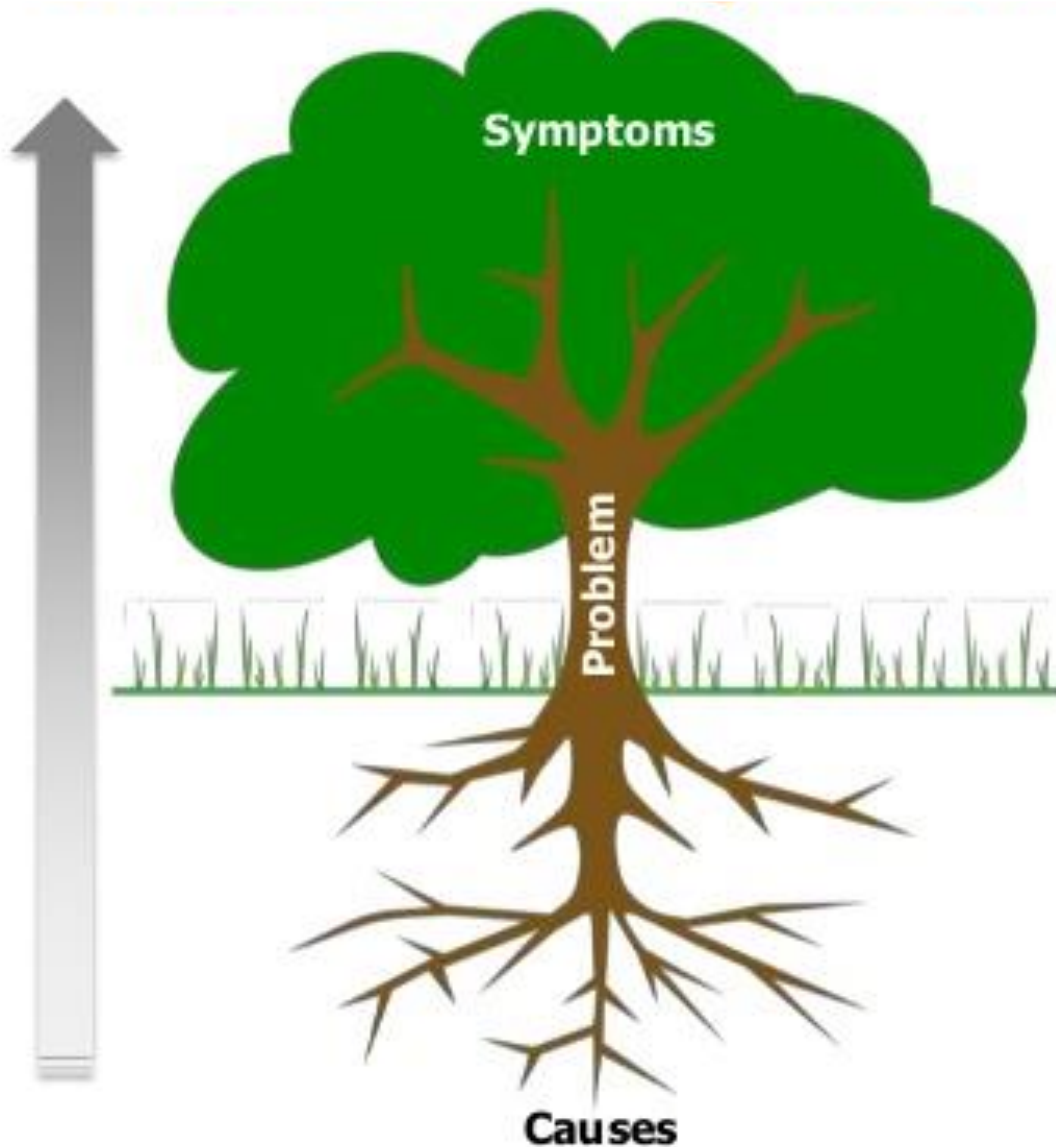
Addressing symptoms will allow continued *recurrence* of the problem

Symptoms
- Result or outcome of the problem
- What you see as a problem (*Obvious*)

  Achy, weak, tired

The Problem
- Gap from goal or standard

  Fever

Causes
- "The Roots" – system below the surface, bringing about the problem (*Not Obvious*)

  Infection

Addressing the root cause will *eliminate* the problem

Cause and Effect or "Fishbone" Diagram
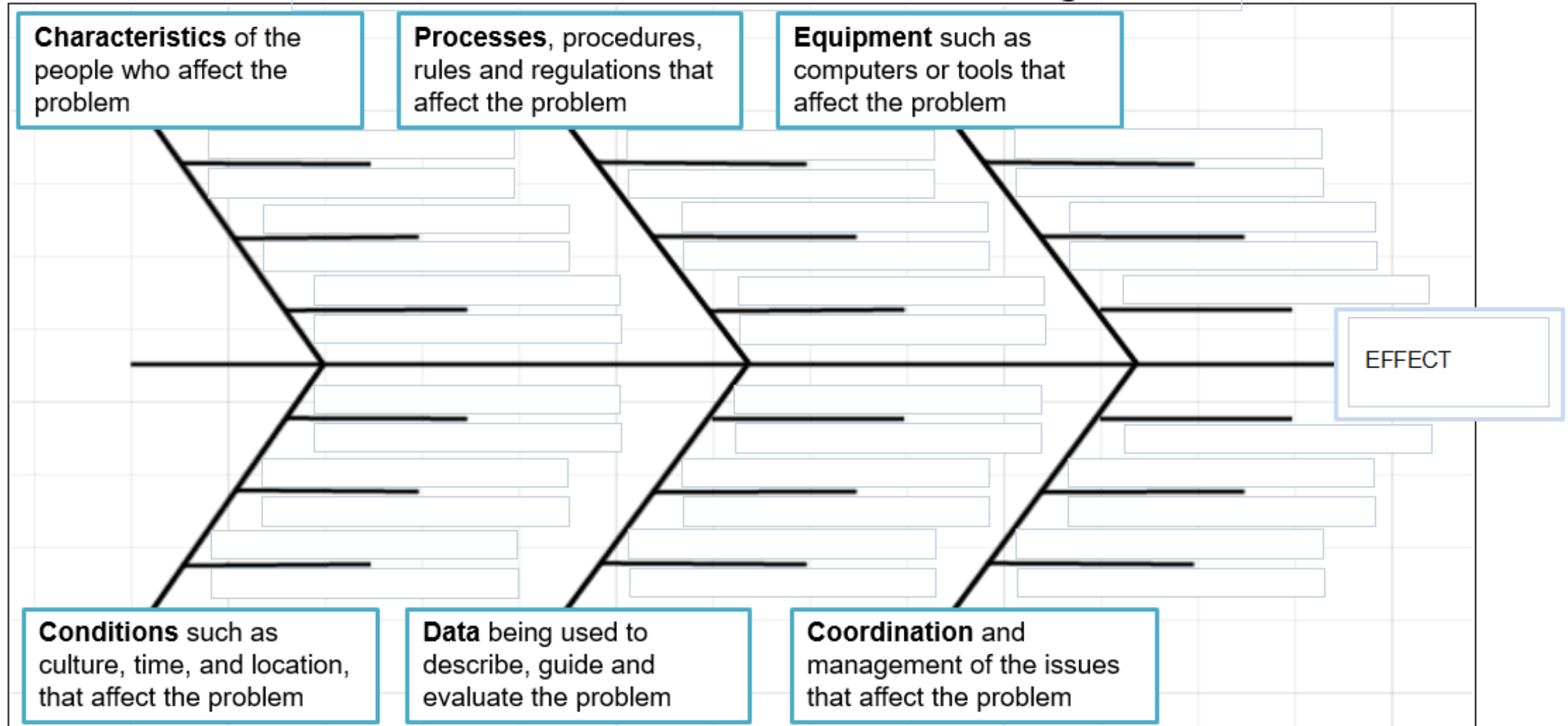
Form a Hypothesis...

Explain exactly what you hope to achieve, with whose cooperation, in what context, over what period of time, and how you will measure your success.

Specific
Measurable
Attainable
Realistic
Time bound

A good hypothesis is simple, clear, and <u>written as a statement</u> that connects the countermeasure with associated metrics.

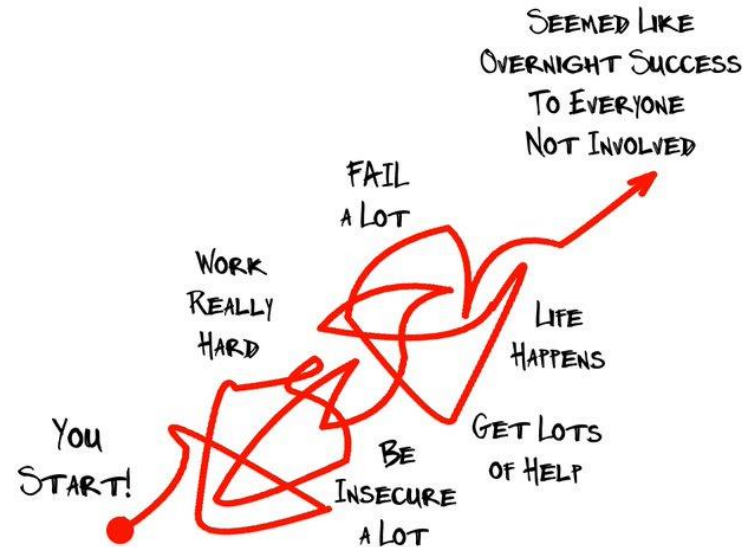If I do *'that'*, then *'this'* will happen.

Countermeasures ≠ Permanent Solutions

Countermeasure:

an action or device designed to negate or offset another

Solution:

a bringing or coming to an end or into a state of discontinuity

OVERNIGHT SUCCESS

SOMEONE GIVES YOU MONEY

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WHAT PEOPLE THINK IT LOOKS LIKE...

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GET LOTS OF HELP

WHAT IT REALLY LOOKS LIKE...

@Matt Gubba- July 7, 2016

Roadmap: Work Design Principles

Rule 1: *Activities* - highly specified work of a position (content, sequence, timing, location)
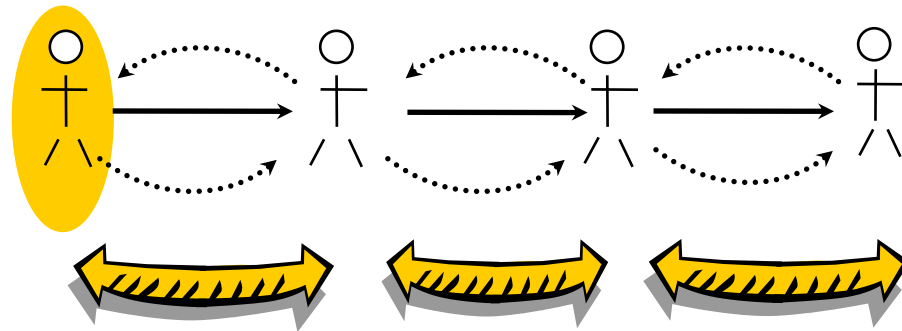
Standard work is the foundation of continuous improvement.

We can't improve a process unless we know how it happened in the first place.

Rule 2: *Connections* – direct relationship between people or processes (unambiguous)

Rule 3: *Pathways* – process is defined & simple

Rule 4: *Improvement* - respond to problems immediately, where they occur, design an experiment, with those doing the work, with a teacher

Call for Help
(Pull the 'Andon Cord')

Team Leader restore the system

Source: S. Spear and H. Kent Bowen, "Decoding the DNA of the Toyota Production System", Harvard Business Review, Sept.-Oct., 1999, p. 96.

Rule 4: One Rule of Improvement

Improvements are:

- Direct responses to a problem
- Made as close as possible to the problem
- Experiments using PDSA thinking
- Made by those doing the work
- Guided by a teacher/coach
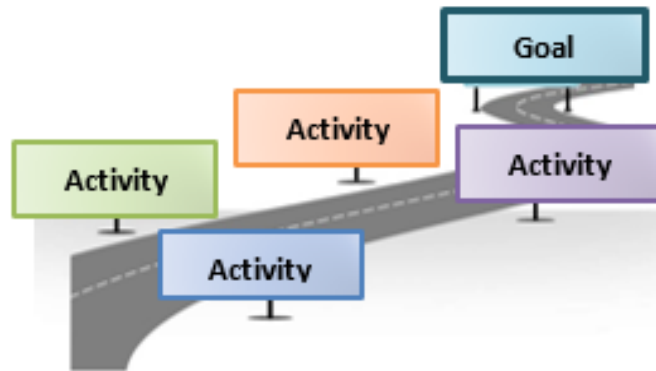- Made aiming toward perfection
- Continuous!

Action Planning

What do you plan to do (roadmap)?

Each line is a specified activity

Goal

Activity

Activity

Activity

Activity

Designate a team member and their role for each activity

Determine a due date for each activity

Track progress toward the due date for each activity

NOT STARTED

IN PROGRESS

BEHIND SCHEDULE

NEEDS ADDRESSED
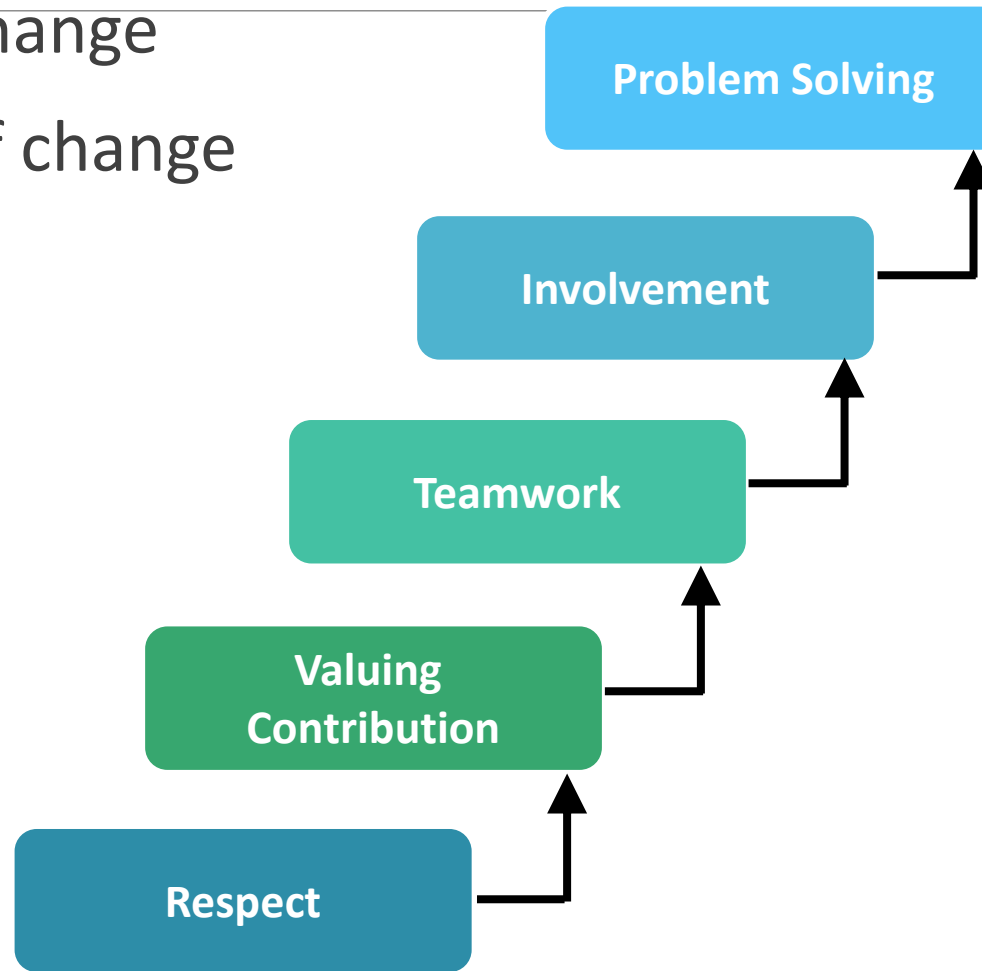
COMPLETED

Indicate the findings for each activity

Clearly identify any barriers to achieving the designated activity
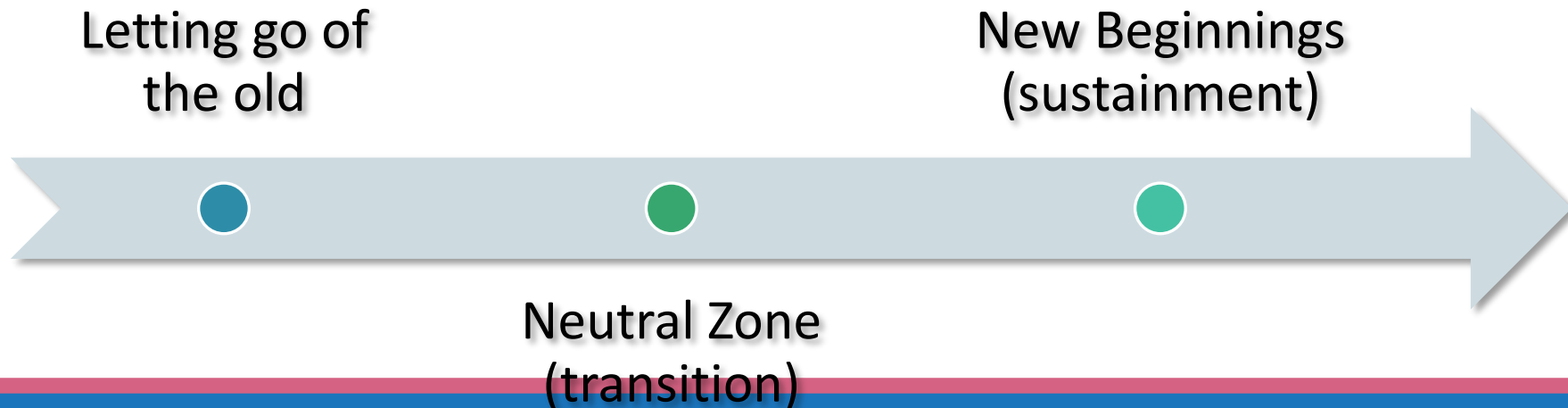
What Makes Change Successful?
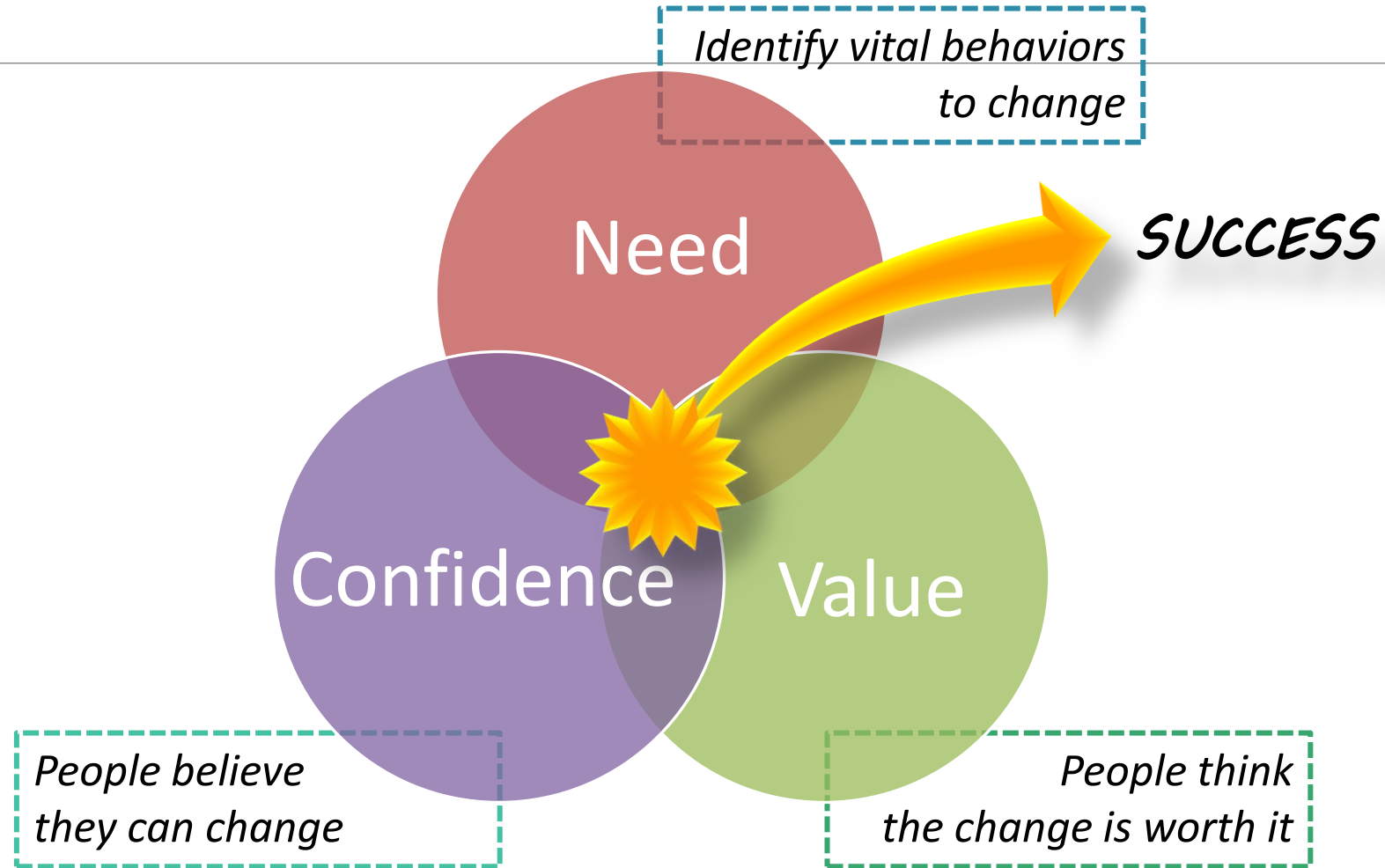
Summary

✓ Core values for change

✓ Building blocks of change

Problem Solving

Involvement

Teamwork

Valuing Contribution

Respect

Summary

✓ Core values for change

✓ Building blocks of change

✓ Three stages of behavior change

Letting go of the old

New Beginnings (sustainment)

Neutral Zone (transition)

Q&A
Facilitated by PA PQC Quality Improvement Coaches

Wrap-Up

SARA NELIS, RN

Upcoming Learning Sessions

JUNE 27

TBD

11:00 a.m. – 12:00 p.m.

Zoom

JULY 25

Motivational Interviewing

11:00 a.m. – 12:00 p.m.

Zoom

Learn about the Initiatives

Access Session Materials

https://www.papqc.org/

PA PQC QI Coaches

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Optimization Advisor,
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NEPaPQC

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MSHSA, BSN, RN
Nurse Project Manager,
Jewish Healthcare
Foundation

Credentialing Guidelines:

PLEASE complete the electronic evaluations by Wednesday, April 24th:

https://www.surveymonkey.com/r/XH6ZQ3R

Please indicate on the evaluation which CEUs you are requesting:

CME, CNE or Social Worker credits.

1. The UPMC Center for Continuing Education will follow up with you, via email, after Wednesday, April 24th to notify you about how you can claim your credits.
   - ☐ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

Thank You!

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papqc@whamglobal.org