HRET HIIN Virtual Event: Foundations for Change Fellowship

Celebration!!

Wednesday, November 8, 2017

11:00 – 12:00 p.m. CT

American Hospital Association

HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Welcome and Introductions

Mallory Bender, Program Manager, HRET

American Hospital Association

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Agenda

11:00-11:05	Welcome and Introduction	Mallory Bender, HRET
11:05-11:15	Action Period Discussion • Project Summary submission highlights	Lauren Macy, IHI
11:15-11:45	Celebration! • Identify and highlight examples of the use of the Model for Improvement in improvement projects • Discuss the opportunities for improvement noted in submitted work. • Facilitate the opportunity for cross-learning among fellows around the results and lessons learned from the QI projects	Lauren Macy, IHI
11:45-11:55	Next Steps • **Complete** the final program evaluation • **Complete** the self-assessment • **Refer a friend** to next year's program! • **Continue** to complete the Open School	Lauren Macy, IHI
11:55-12:00	Bring It Home	Mallory Bender, HRET

Foundations for Change Scheduled Sessions

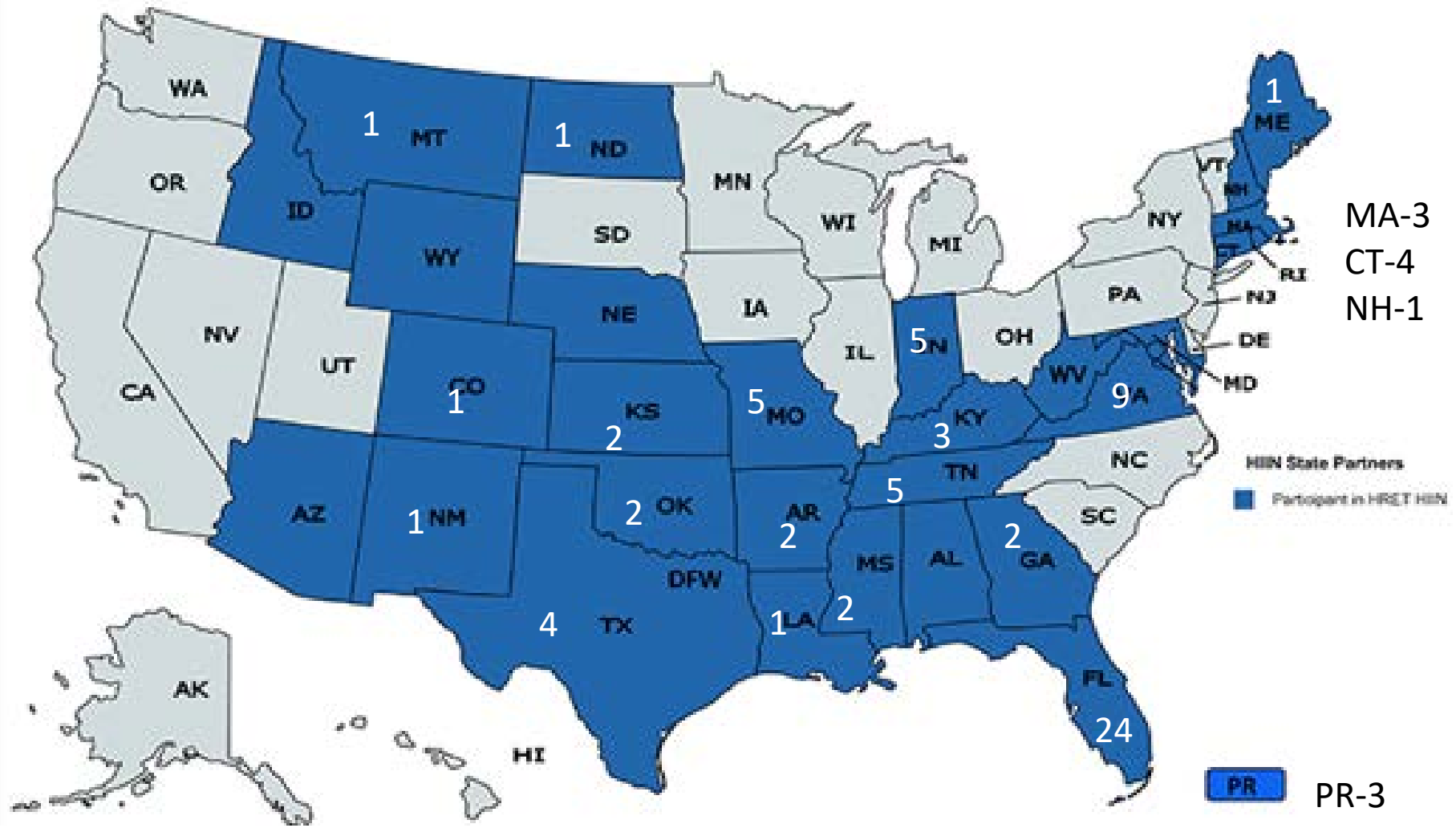
January 18 – The Case for Improvement	May 10 – Multiple Cycles, Multiple Tests
February 1 – Take your Aim – What are We Trying to Accomplish?	June 14 – Manage Time and Attention
February 15 – What Changes Can We Make That Will Result in Improvement?	July 12 – Be the Coach
March 1 – Map Your Course	August 9 – Treasure Chest: Shadowing a Patient
March 15 – How Will We Know That a Change is an Improvement?	September 13 – Identify and Spread Improvement
March 29 – Empower Teams to Engage in Improvement	October 18 – Sustaining Improvement
April 12 – Know Yourself, Know Others	November 8 – Celebration!

Project Summaries – Thanks!

63 Projects

83 Fellows

Submissions by state



MA-3
CT-4
NH-1

PR-3

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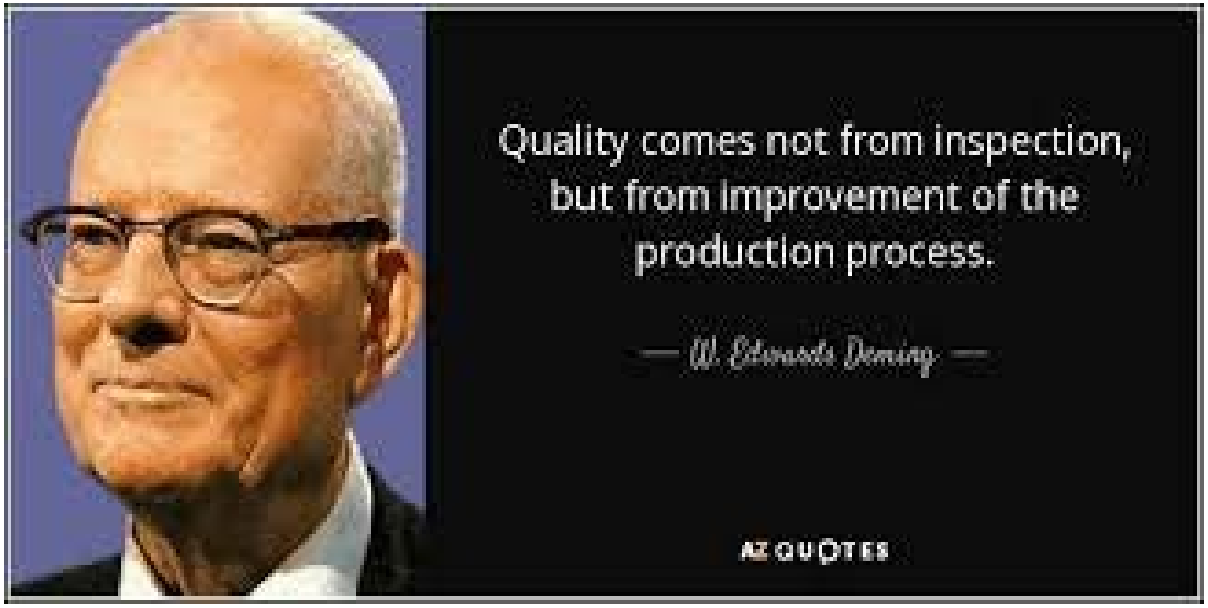
Reports by Topic

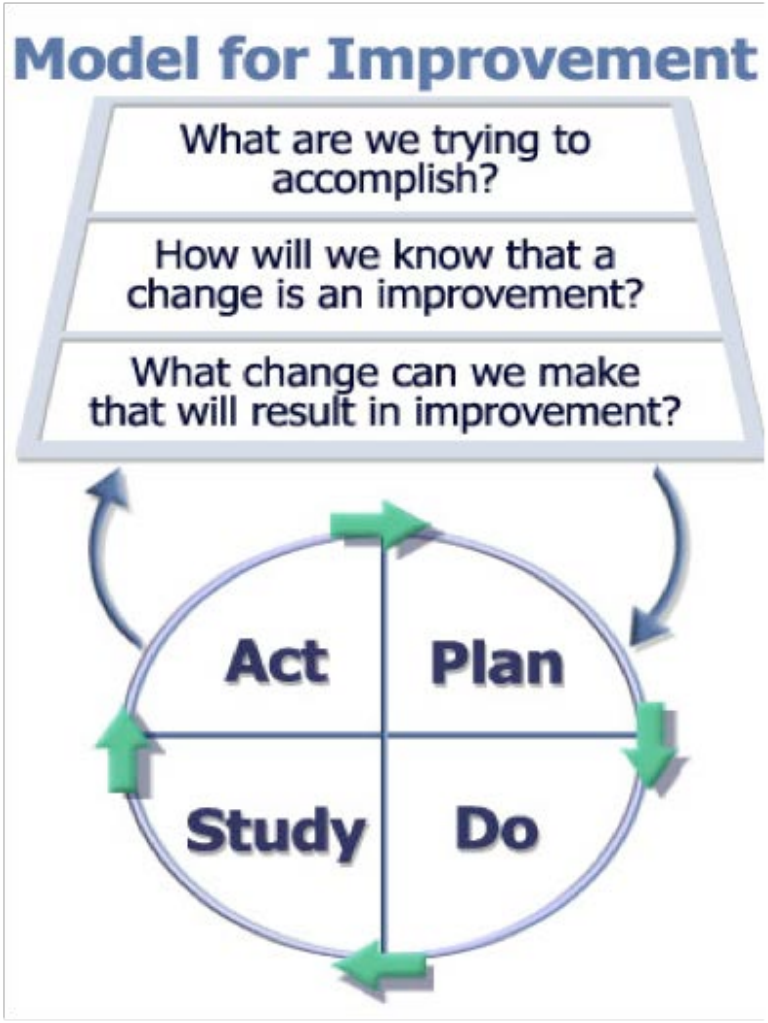
Readmission: 12	Fall Reduction: 10	Sepsis: 10
Event Reporting: 8	Antibiotic Stewardship: 6	Hand Hygiene: 5
Medication Rec: 4	CLABSI: 3	C. Diff: 2
Delirium Screening: 2	VTE: 2	Reduction of Cath Use: 1
Safety Coach: 1	Safety Huddles: 1	Safety Reports Filed: 1
STEMI Code: 1	Tobacco Cessation: 1	Patient Engagement: 1
Peer Review Complete: 1	Influenza Immunization: 1	Ensuring Implants Are Available: 1
SSI Reduction: 1	CT Reporting: 1	Decreasing Episiotomy: 1
CPOE Compliance: 1	Dysphagia Screening: 1	

Pending 'Asks"

- If you have not already completed the Final Evaluation and the Self Assessment, please do so before Friday!
- To Date:
  - Self Assessments completed: 110
    - Foundations for Improvement: 65
  - Final Evaluation: 47
    - Foundations for Improvement: 27


Quality comes not from inspection, but from improvement of the production process.
— W. Edwards Deming —
AZ QUOTES

Model for Improvement



Langley, G.J., Nolan, K.M., Nolan, T.W, Norman, C.L., & Provost, L.P. (2009). *The improvement guide: A practical approach to enhancing organizational performance* (2nd Ed.). San Francisco: Jossey-Bass.

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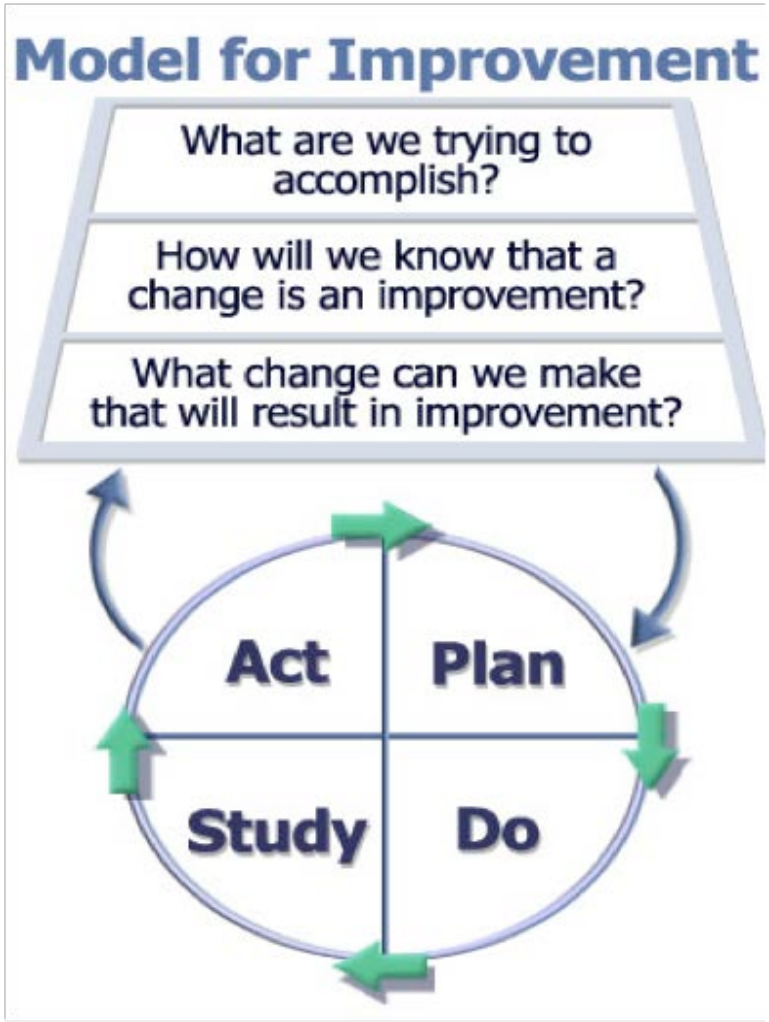
Model for Improvement



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A Good Aim Statement

- Identifies the *system* to be improved (scope, patient population, processes to address, providers, etc.)
- Has specific numerical *goals*
  - Ambitious but achievable
- Includes *timeframe* (by when)

AIM

Elizabeth Hernandez Puerto Rico	• To reduce the incidence of Infections Associated to Central Line Catheter in a 20% by February 2018.
Darcy Tolbert Oklahoma	• Our aim is to decrease falls by 50% by September 30, 2017 in our Med/Surge Department.
Krista Staton Virginia	• Acute CVA results will be reported to the ED Physician within 45 minutes of arrival 85% of the time by 12/31/17.

Foundations for Change 2017

Sepsis

Kristine Larson
Quality Coordinator/Quality and Safety

Henry Community Health
New Castle, Indiana
October 16, 2017

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Aim and Background

Aim

Henry Community Health will decrease sepsis mortality by achieving a 50% compliance in the SEP-1 measure by December 2017.

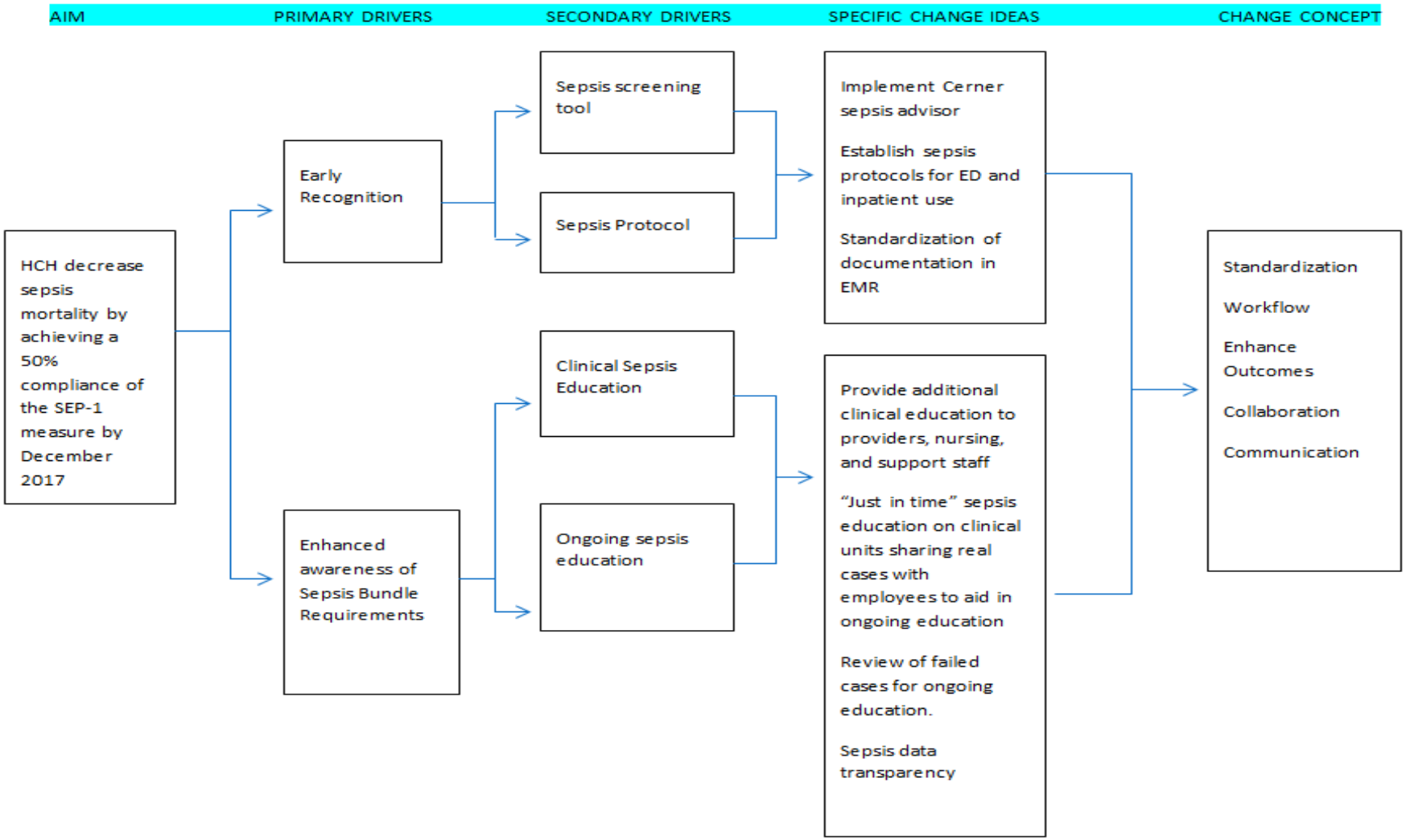
Background

Henry Community Health has continually had difficulty consistently meeting the benchmark for SEP-1. It is the lowest of our quality scores and could lead to an increased length of stay and/or mortality rate if we continue not to meet this measure.

Measures

- Outcome Measures:
  - *Percentage of cases that meet the SEP-1 measure.*
- Process Measures:
  - *Compliance with the initial lactate level*
  - *Compliance with repeat lactate level*
  - *Compliance with appropriate IV fluid administration and documentation*
  - *Compliance with appropriate antibiotic administration*
- Balance Measures:
  - *Compliance with documentation of focused exam by provider (as we improved on meeting the early elements of the measure we began to fail in the this later measure)*

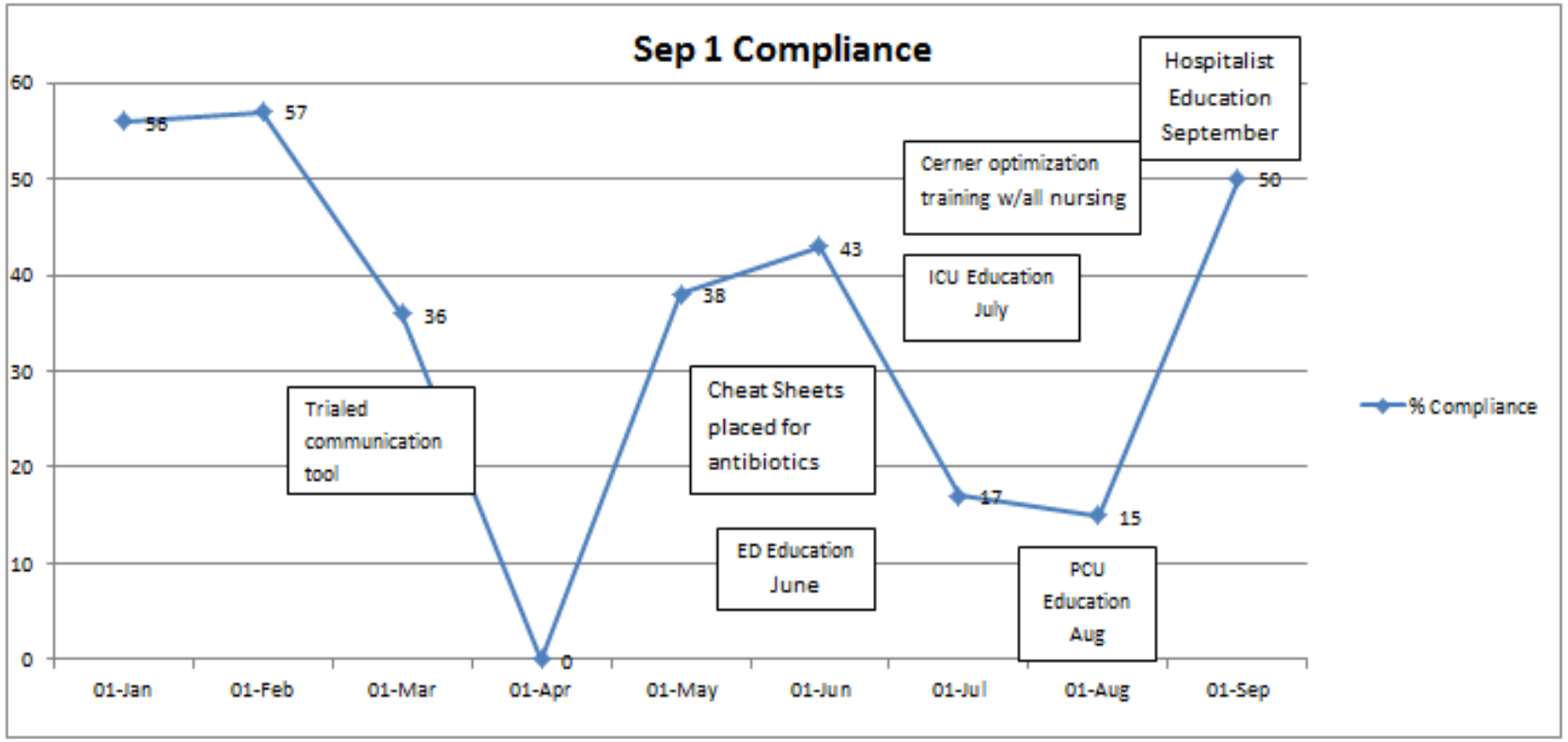
Driver Diagram



Change Ideas

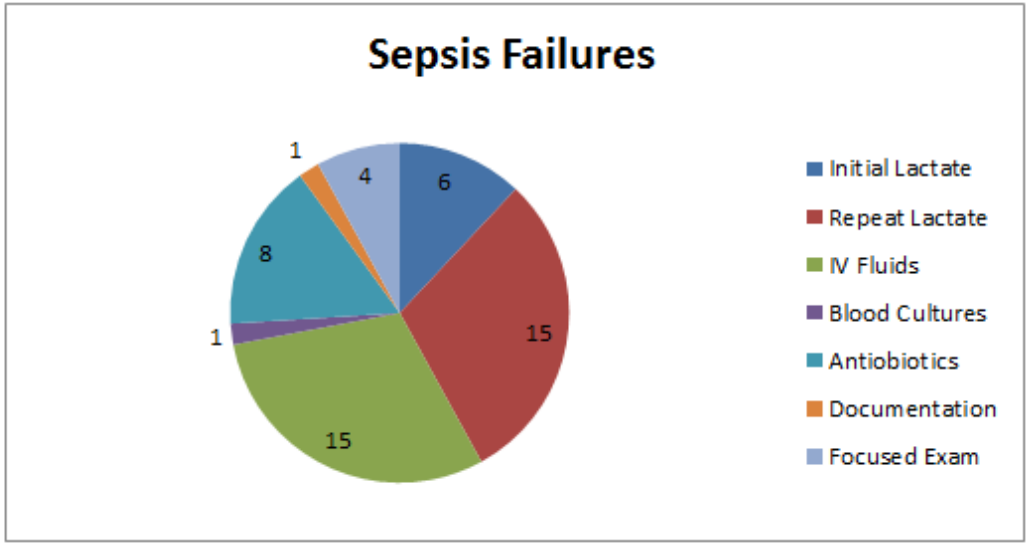
- *Communication tool completed by ED nurse to let unit nurse know when second lactate due.*
- *Changed how nurses documented IV fluids to be consistent between units.*
- *Placed a "cheat sheet" for antibiotic hierarchy in medication room of med/surgical unit.*
- *Education provided to ED staff on elements of SEP-1.*
- *Education provided to four hospitalists on specific orders and documentation needed to meet the SEP-1 measure.*
- *Planned to implement a sepsis advisor through our EMR.*
- *Sepsis documentation included in Cerner optimization training done with all nursing staff.*

Data


Sep 1 Compliance
60
50
40
30
20
10
0
56
57
36
0
38
43
17
15
50
01-Jan
01-Feb
01-Mar
01-Apr
01-May
01-Jun
01-Jul
01-Aug
01-Sep
Trialed communication tool
Cheat Sheets placed for antibiotics
ED Education June
ICU Education July
Cerner optimization training w/all nursing
PCU Education Aug
Hospitalist Education September
% Compliance

Data

- There have been 50 element failures YTD.
- 60% of the failures are related to the repeat lactate level and the IV fluids (15 each).
- The next most common reason for failure is antibiotic selection and/or order of administration.



Reflections

What were some of your key barriers and how did you overcome them?

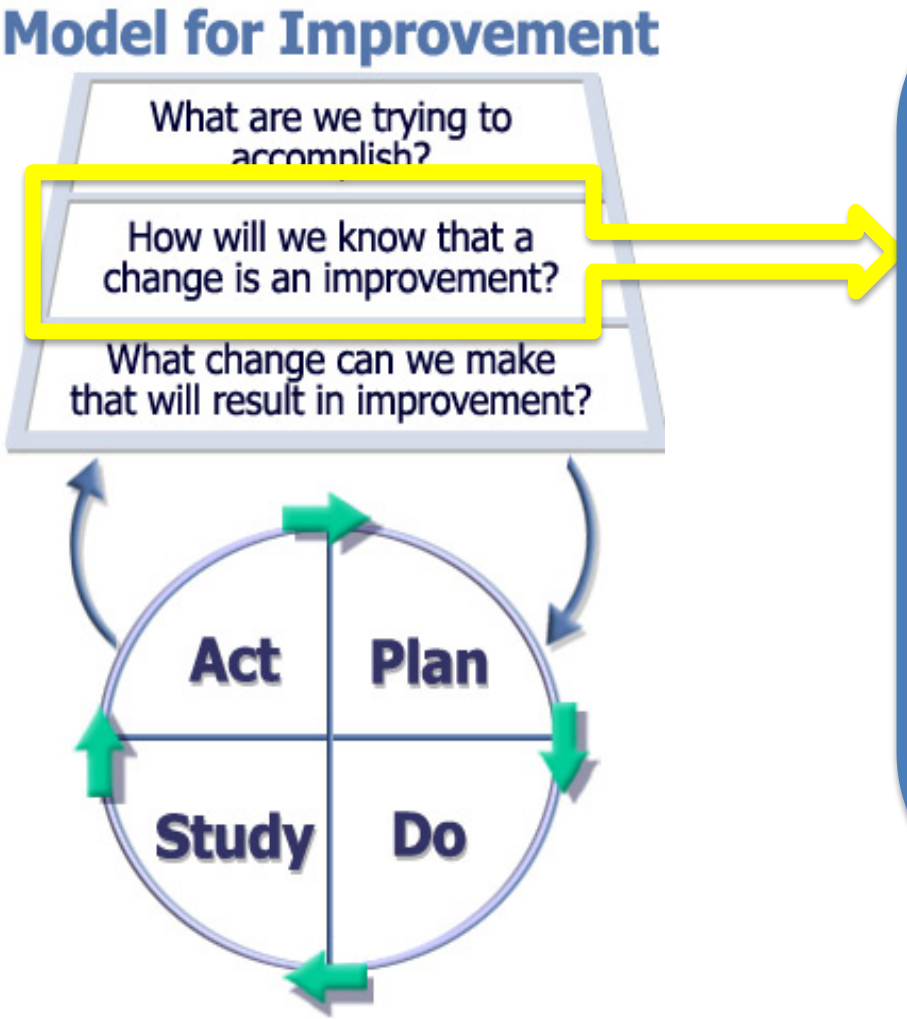
- *Provider pushback- once our permanent CMO/Hospitalist Director came on board he became our physician champion.*
- *Limitations of our EHR- we are still working on this*

What surprised you the most about this work?

- *Physicians respond better to education from other physicians*

What advice do you have for others?

- *Simplify explanations and processes as much as possible, this helps increase understanding and buy in.*
- *Celebrate even the smallest success to keep the momentum going.*



How will we know a change is an improvement?

Langley, J. et al. The Improvement Guide. Jossey-Bass Publishers, 2009.

The Value of Measuring

"You measure what you value. Conversely, you value what you measure." *Brent James*

"Without data, you are just another person with an opinion."
W. Edwards Deming

All measures have limitations, but the limitations do not negate their value for learning.

Types of Measures to Evaluate Impact and Progress

Outcome

- Measures directly relate to the aim of an initiative.
- How is the system performing? What are the results?

Process

- Measures reflect how well processes in the work get done.
- Are the steps of the process performing as planned?

Balancing

- What happened to the system as we improved the outcome and processes? (unanticipated consequences)

Measures

FALLS a)Outcome: *Falls rate per 1000 patient day*
*b)*Process: *% compliance to patient with three identifiers present. % compliance of safety environment. % compliance with new education pamphlets at the bedside*

c) Balance: Number of direct patient care shifts that fall below staffing guidelines to monitor falls protocol.

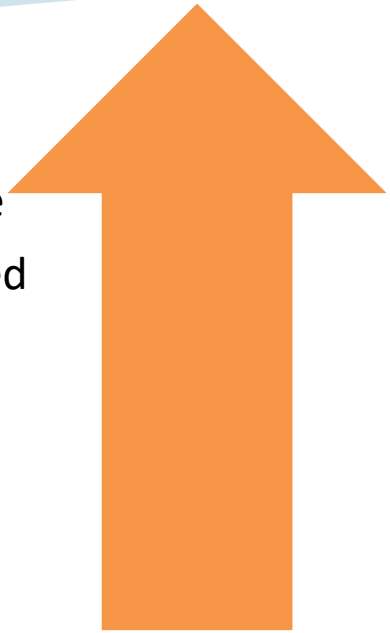
Debra Barret, Joseph Kiley, MA

MED REC a)Outcome: Focused Med History Audit Compliance

b) Process: Track the reasons for inaccuracies and successful med history taken

c) Balance measures: Duration of time spent on med history, Engagement.

Jason Perry, Pharmacy, Florida



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Measures should operationalize the aim

- Numerical aims provide a reference point to evaluate performance
- Used to guide improvement and test changes

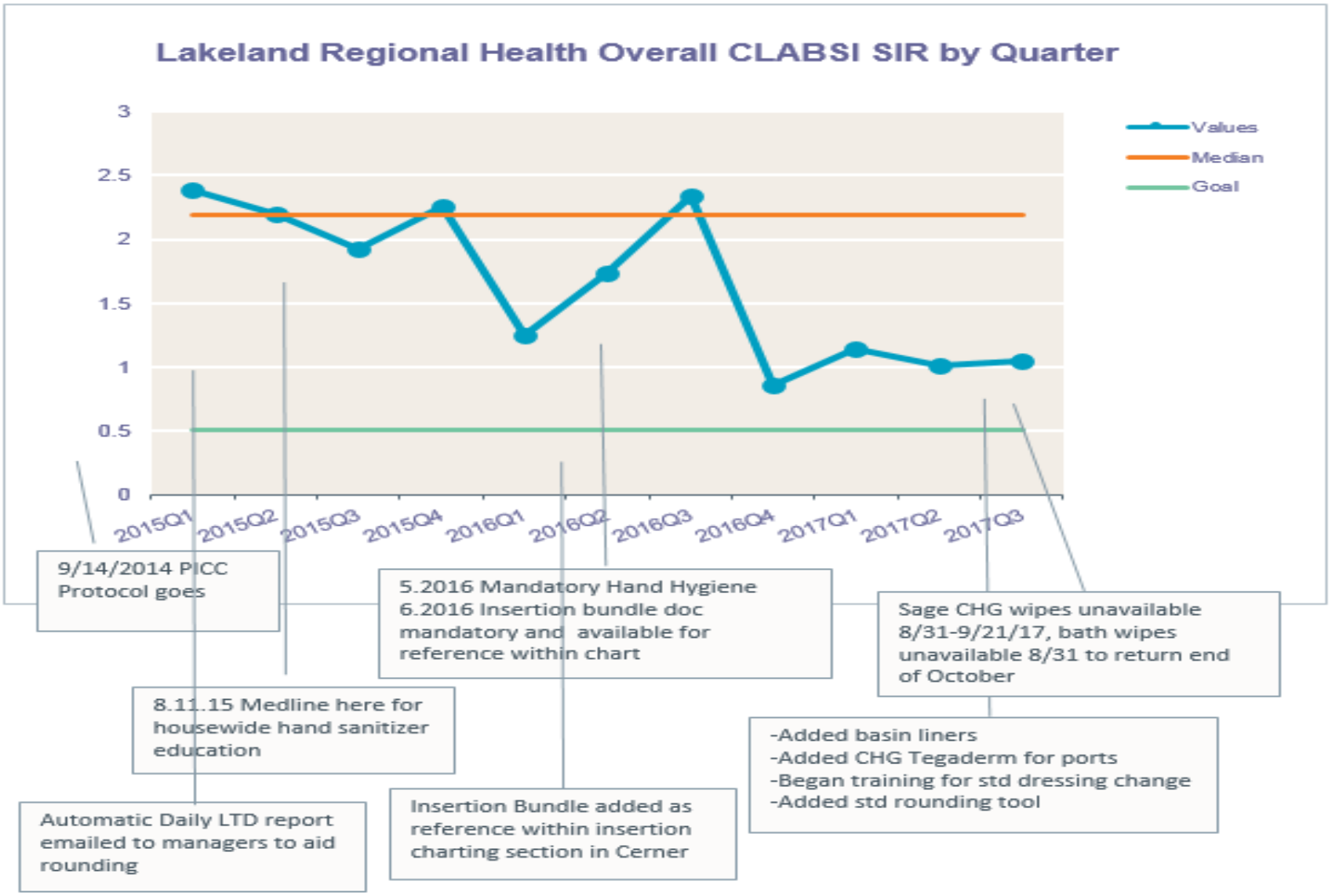
Data should be plotted over time

- Data tells a story
- Annotated is best

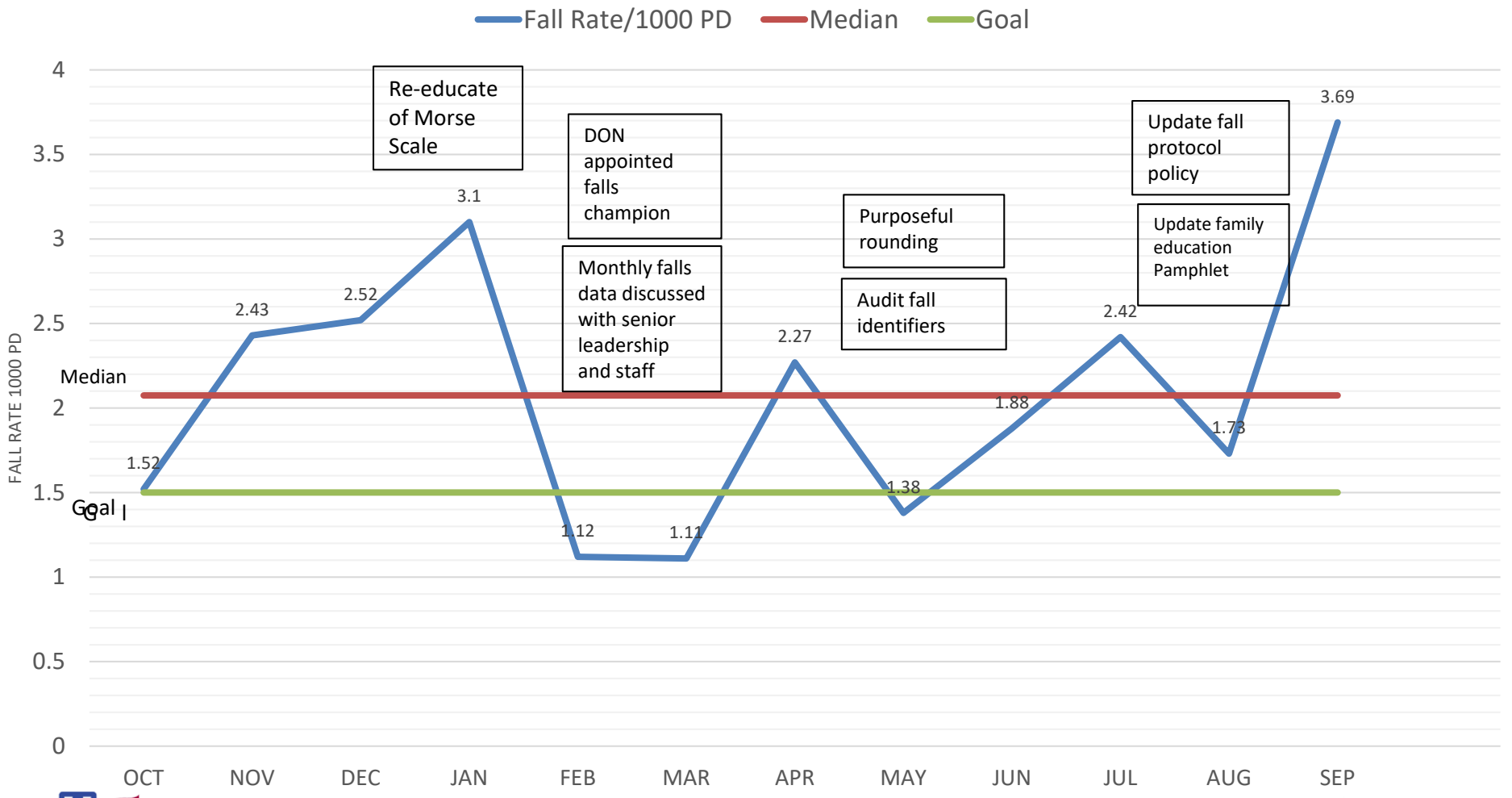
Improvement Measures

- Focus on the vital few
- Is for learning not for judgment
- Integrate into team's daily routine

Data


Lakeland Regional Health Overall CLABSI SIR by Quarter
3
2.5
2
1.5
1
0.5
0
2015Q1
2015Q2
2015Q3
2015Q4
2016Q1
2016Q2
2016Q3
2016Q4
2017Q1
2017Q2
2017Q3
Values
Median
Goal
9/14/2014 PICC Protocol goes
8.11.15 Medline here for housewide hand sanitizer education
Automatic Daily LTD report emailed to managers to aid rounding
5.2016 Mandatory Hand Hygiene
6.2016 Insertion bundle doc mandatory and available for reference within chart
Insertion Bundle added as reference within insertion charting section in Cerner
Sage CHG wipes unavailable 8/31-9/21/17, bath wipes unavailable 8/31 to return end of October
-Added basin liners
-Added CHG Tegaderm for ports
-Began training for std dressing change
-Added std rounding tool

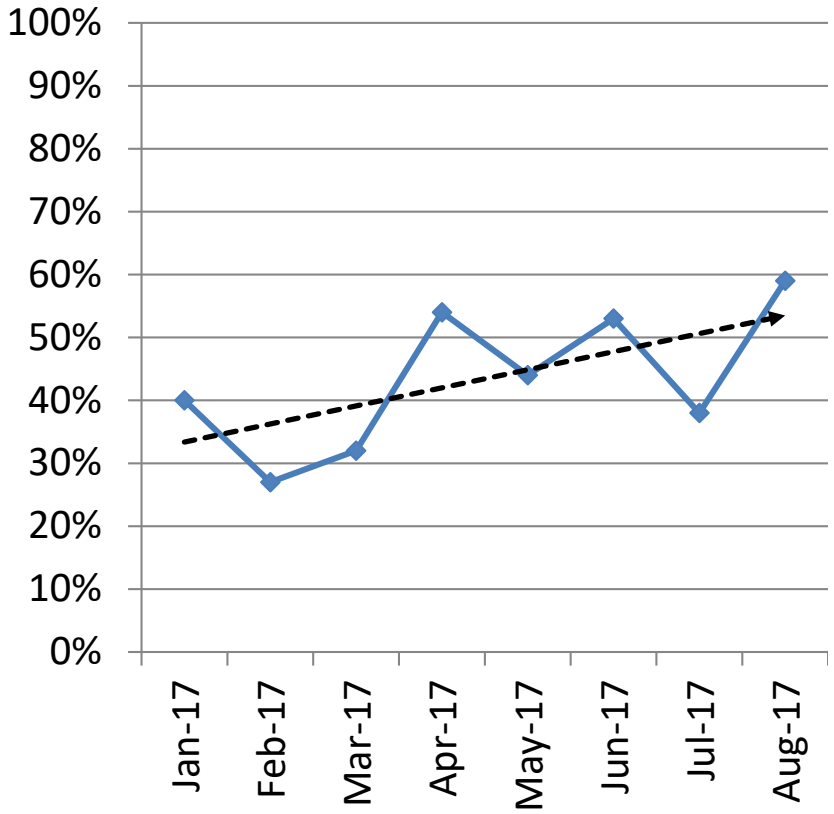
Medical Surgical Unit Fall Rate /1000 PD



DATA

Adherence to Sepsis Care Recommendations—Severe Sepsis

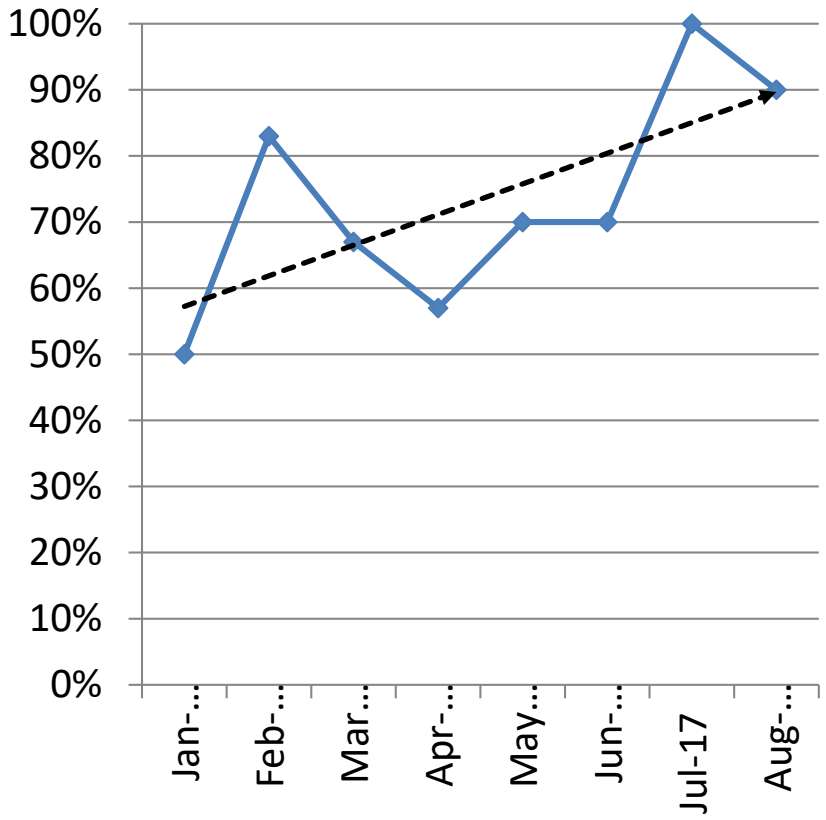
3 Hour Treatment Bundle



3 Hour Severe Sepsis Treatment Bundle Recommendations:

- Initial lactate (6 hours before and up to 3 hours after presentation of severe sepsis)
- Blood cultures before antibiotics
- Broad Spectrum antibiotic (24 hours prior to and up to 3 hours after presentation

6 Hour Treatment Bundle



6 Hour Severe Sepsis Treatment Bundle Recommendations:

- Repeat Lactate if initial > 2.

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Becky Trenkamp, Ruthie Rhodes, Florida

(Surviving Sepsis Campaign, CMS)

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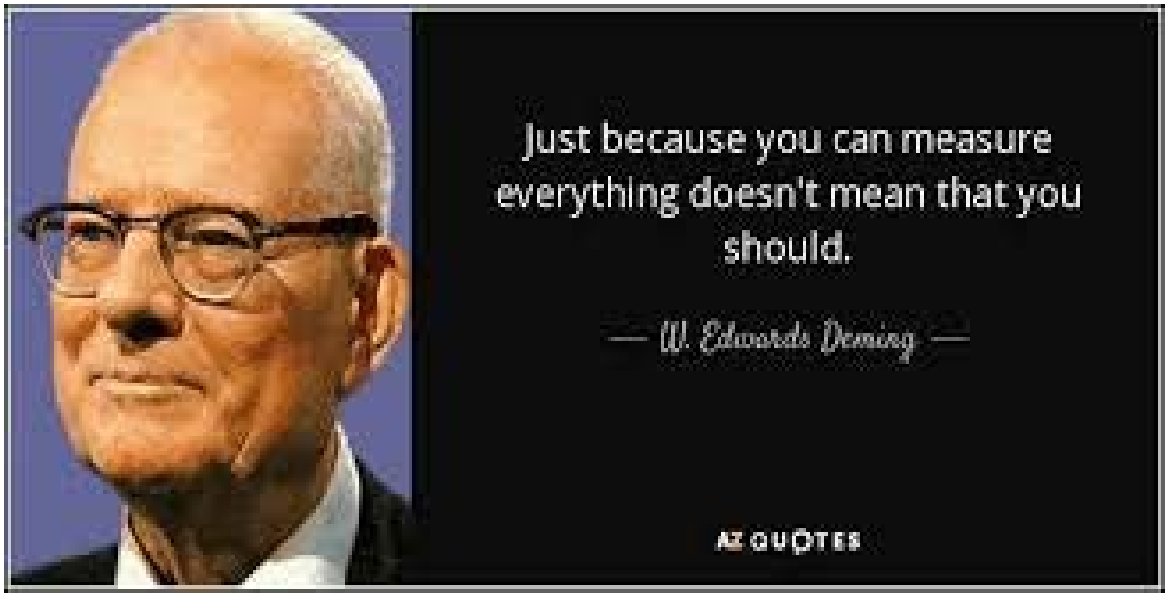
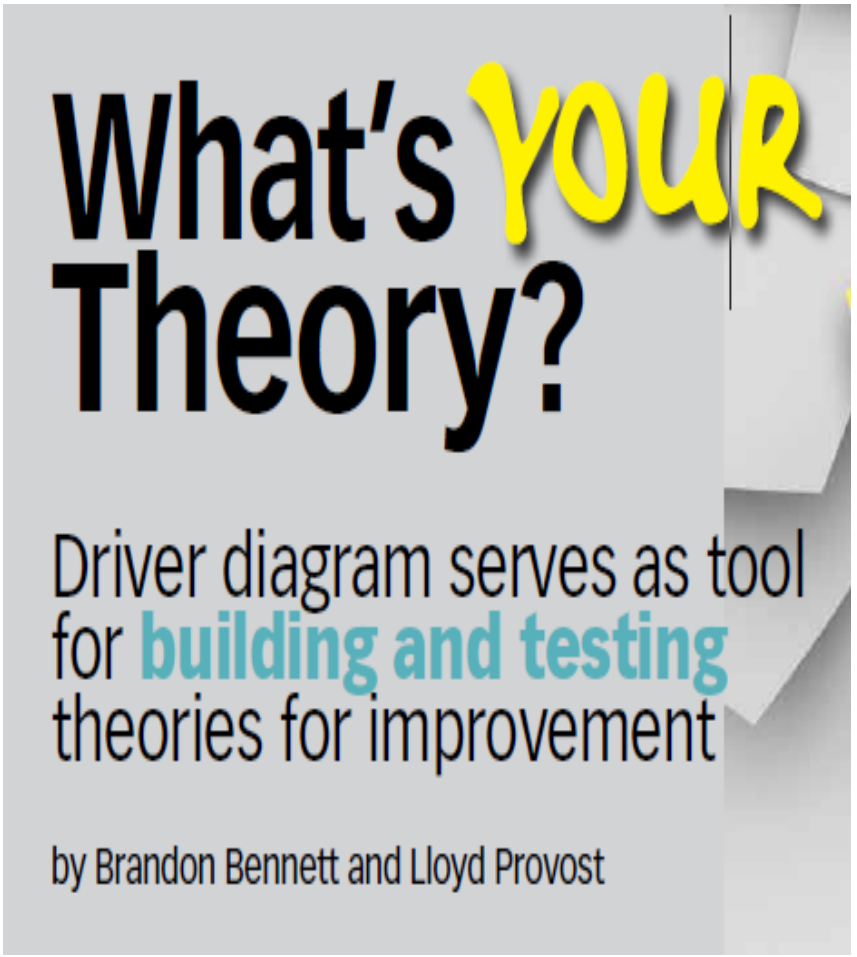
Helpful
Tips

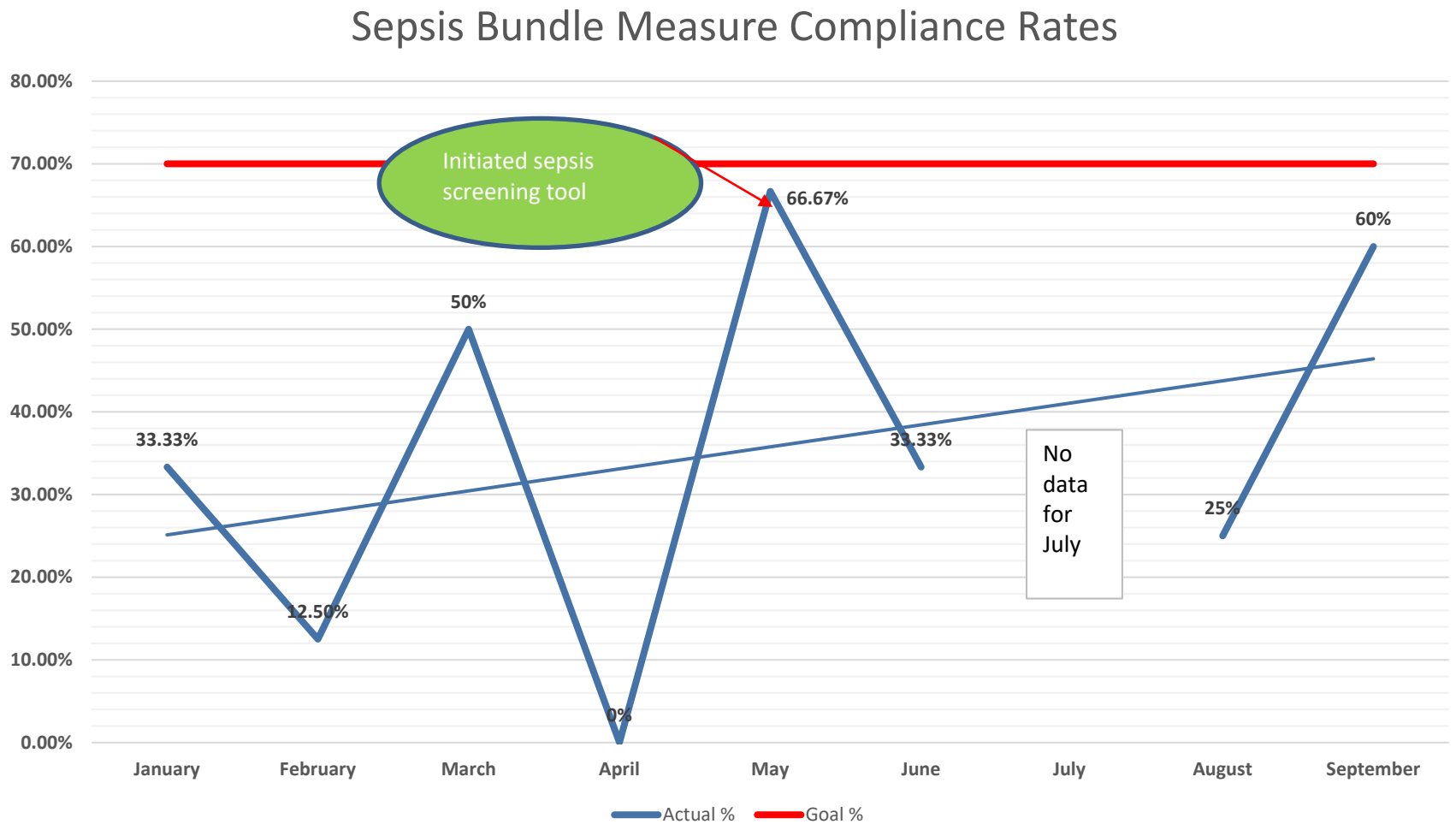

Just because you can measure everything doesn't mean that you should.
— W. Edwards Deming —
AZ QUOTES

Driver Diagram

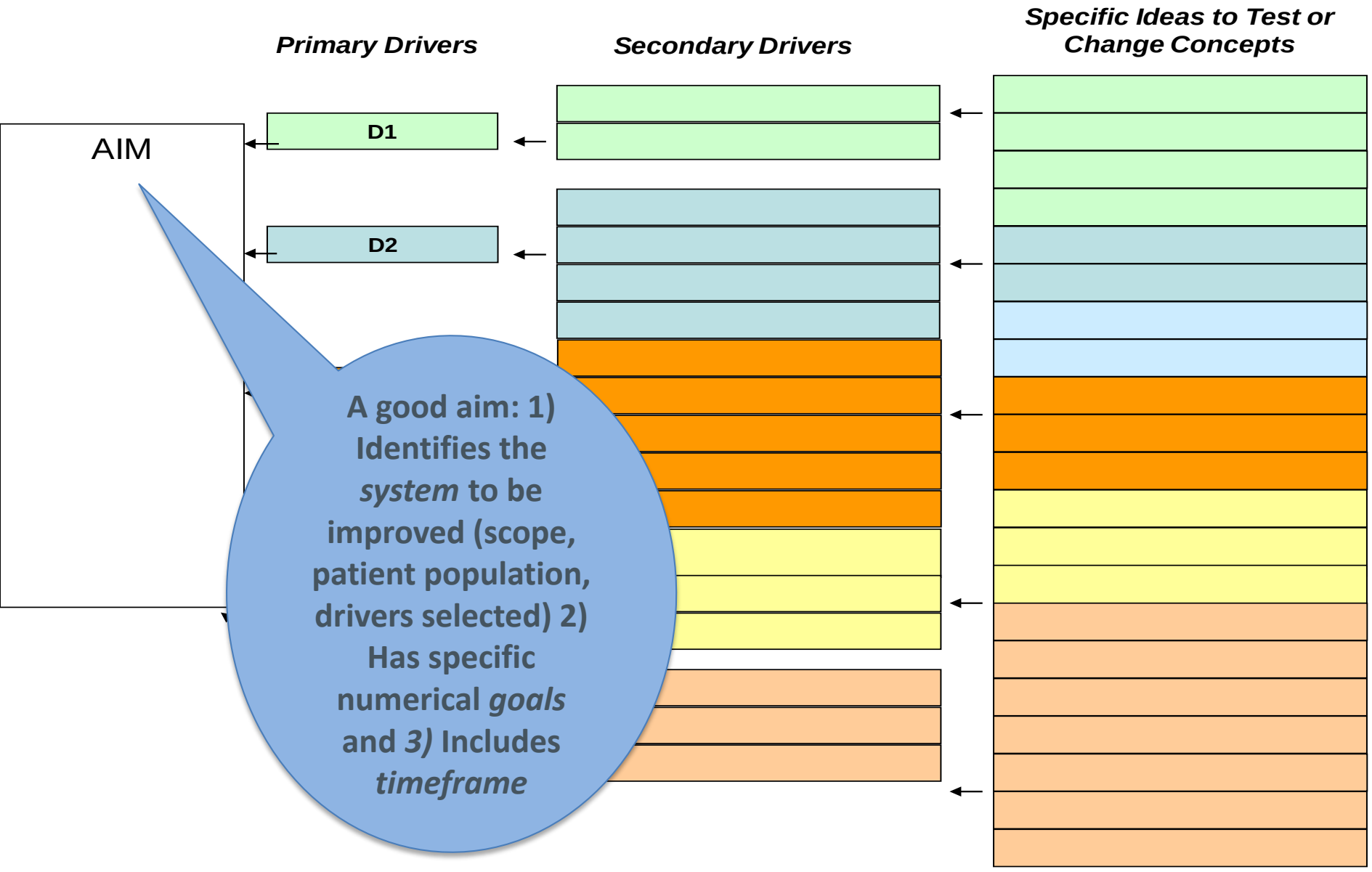
- The Driver Diagram is a tool to help us understand the system, its outcomes and the processes that drive the outcomes.
- It helps us understand the messiness of life



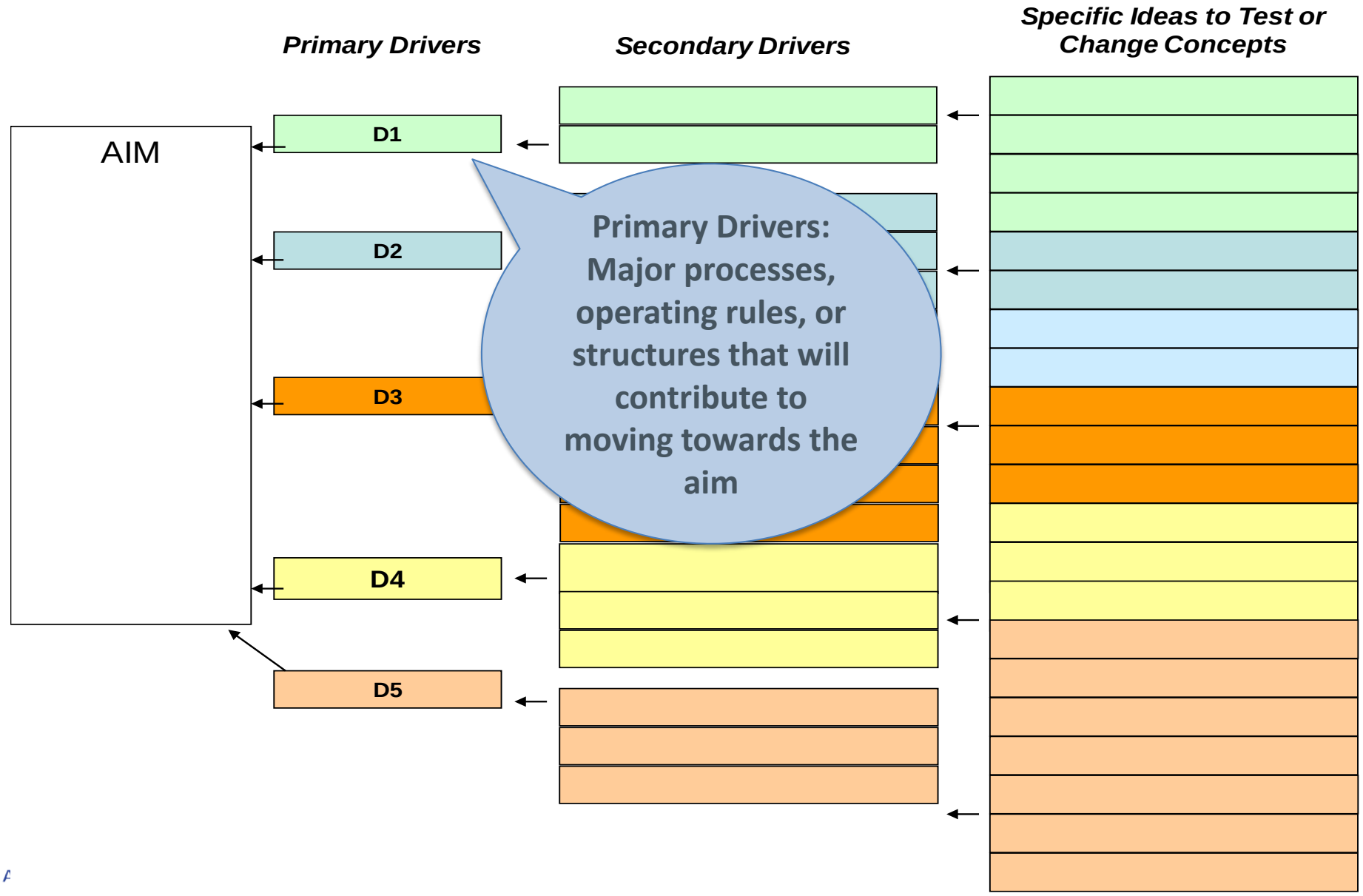
Data


Sepsis Bundle Measure Compliance Rates
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Initiated sepsis screening tool
33.33%
12.50%
50%
0%
66.67%
33.33%
No data for July
25%
60%
January
February
March
April
May
June
July
August
September
Actual %
Goal %

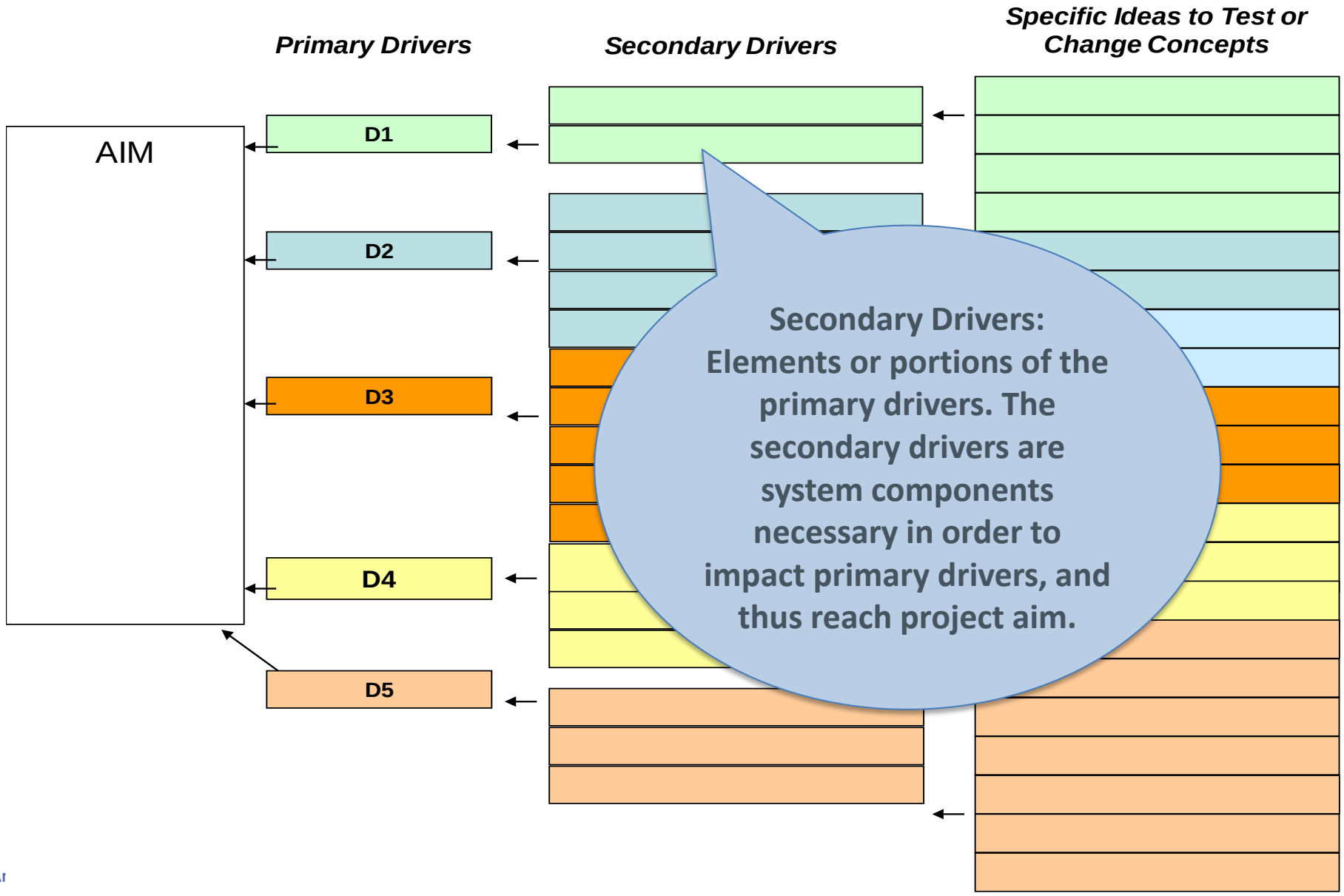
Driver Diagram Components



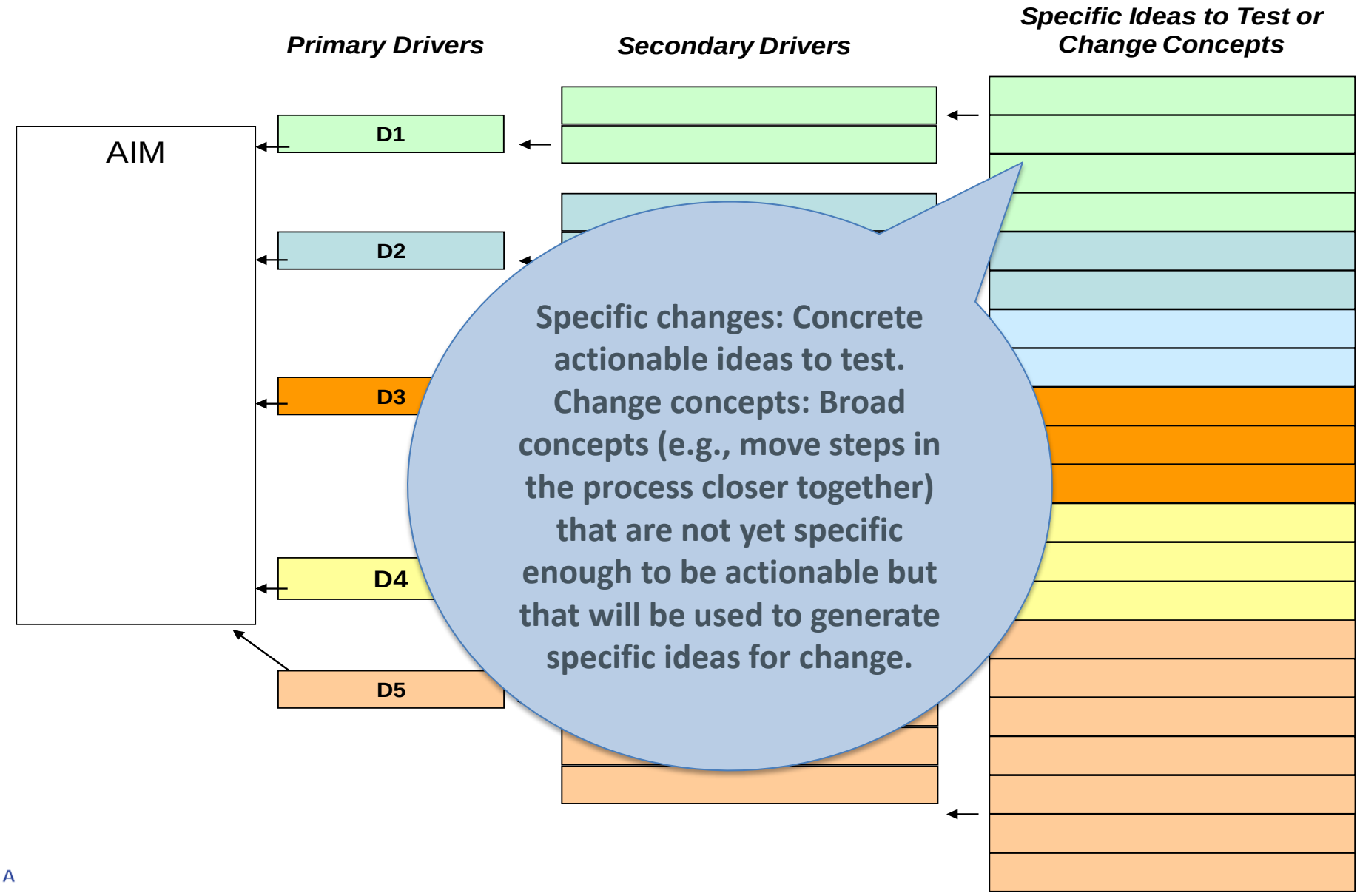
Driver Diagram Components



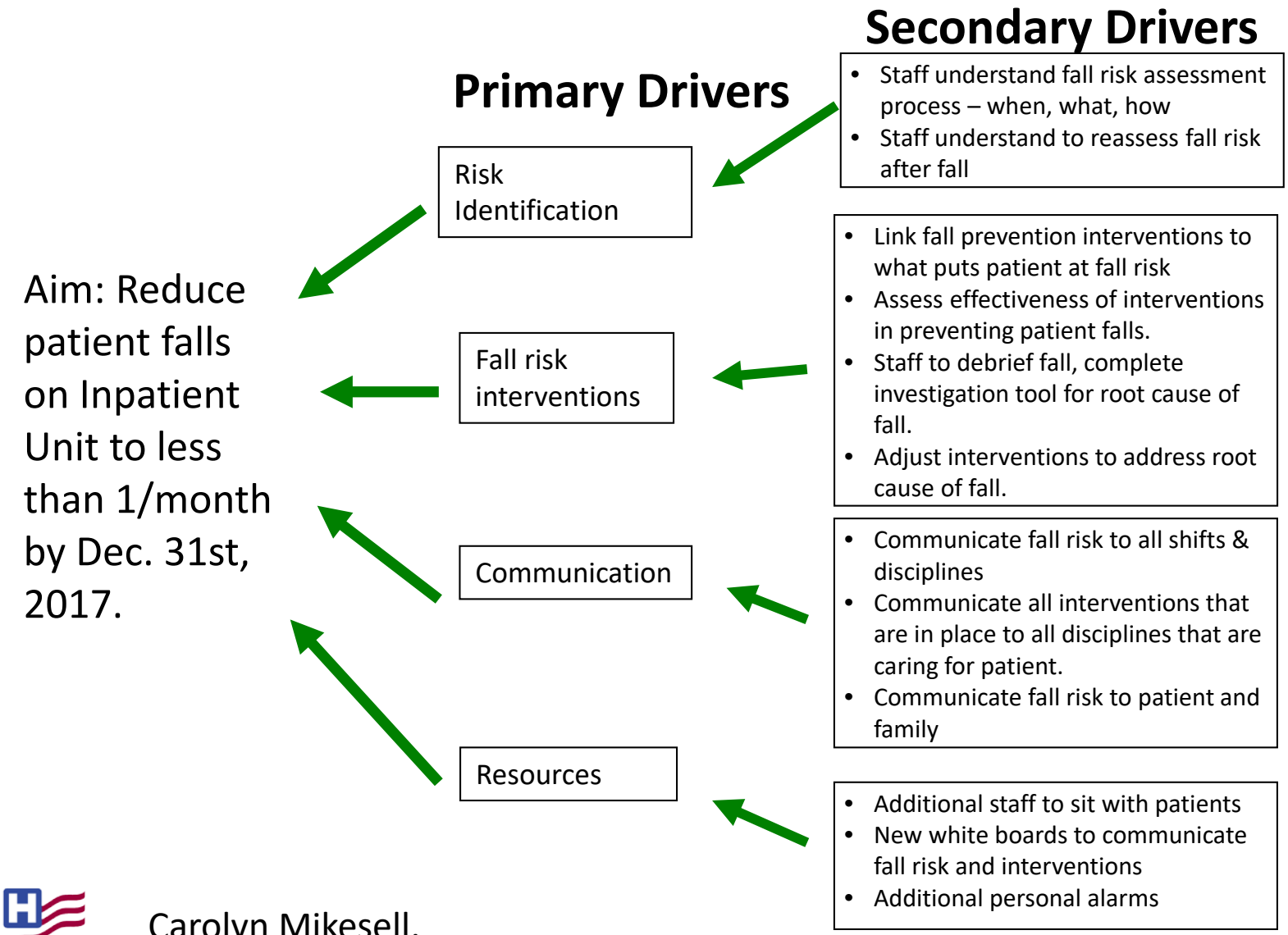
Driver Diagram Components



Driver Diagram Components



Driver Diagram



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Carolyn Mikesell, Kansas

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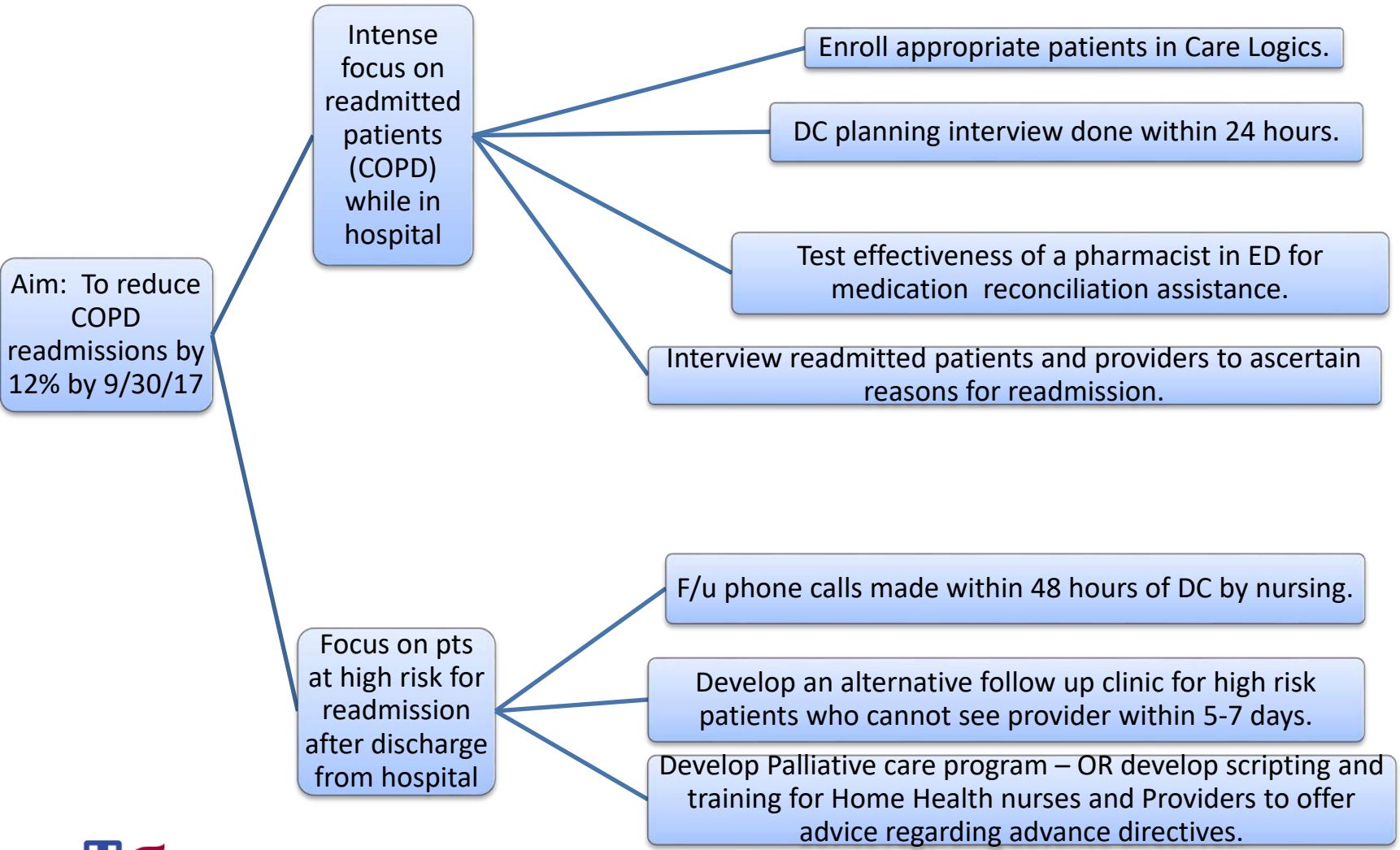
Driver Diagram



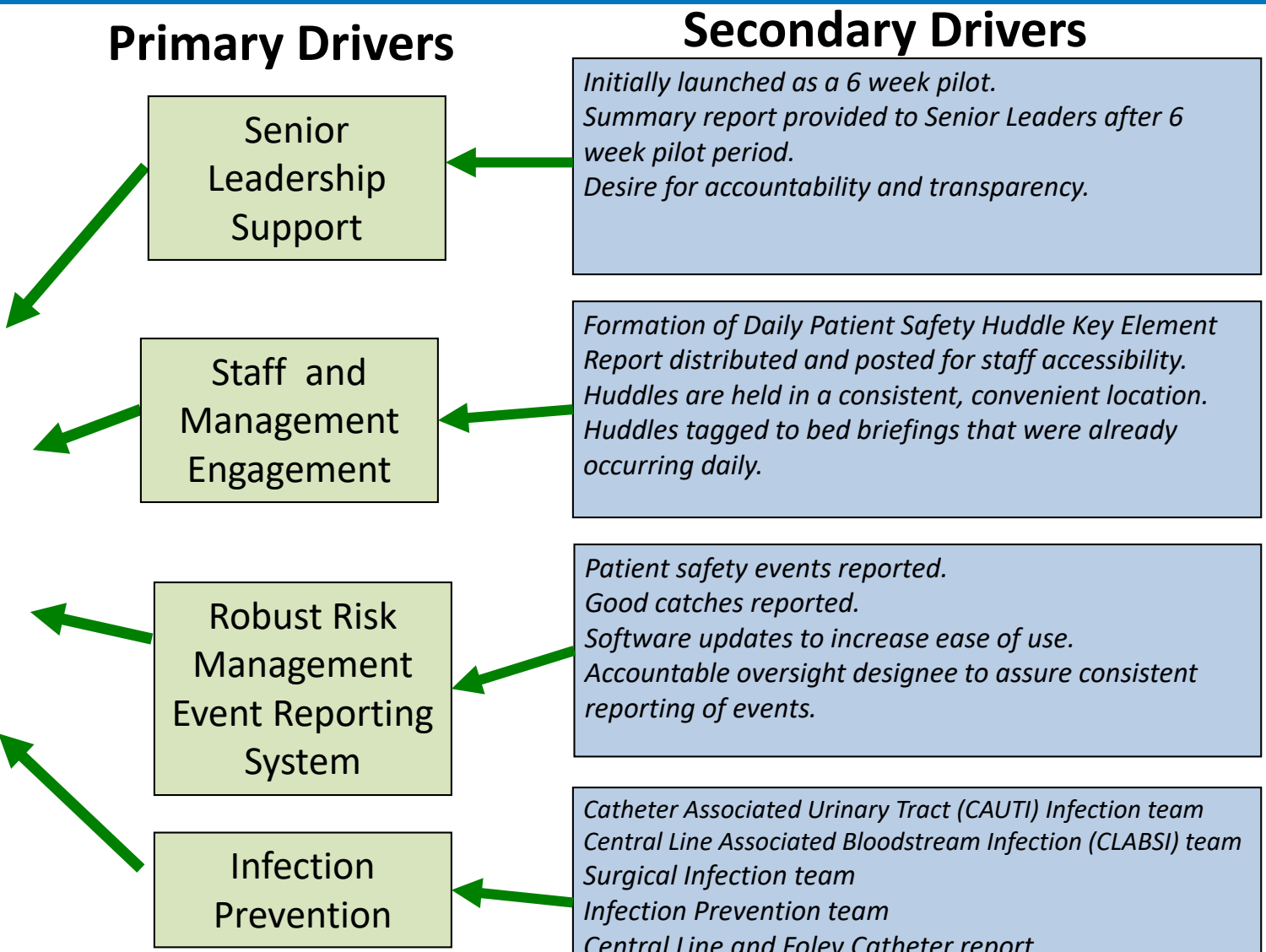
Driver Diagram

Aim:

Implement Daily Patient Safety Huddles by 9/5/2017 to promote the culture of safety demonstrated by a 25% increase in the agree strongly response to the survey question: "Do you believe the huddles are impacting patient safety?"

Outcome Measure:

Increase patient safety culture and transparency.



Process measures matter

1900-1993

"If you can't describe what you are doing as a process, you don't know what you're doing."

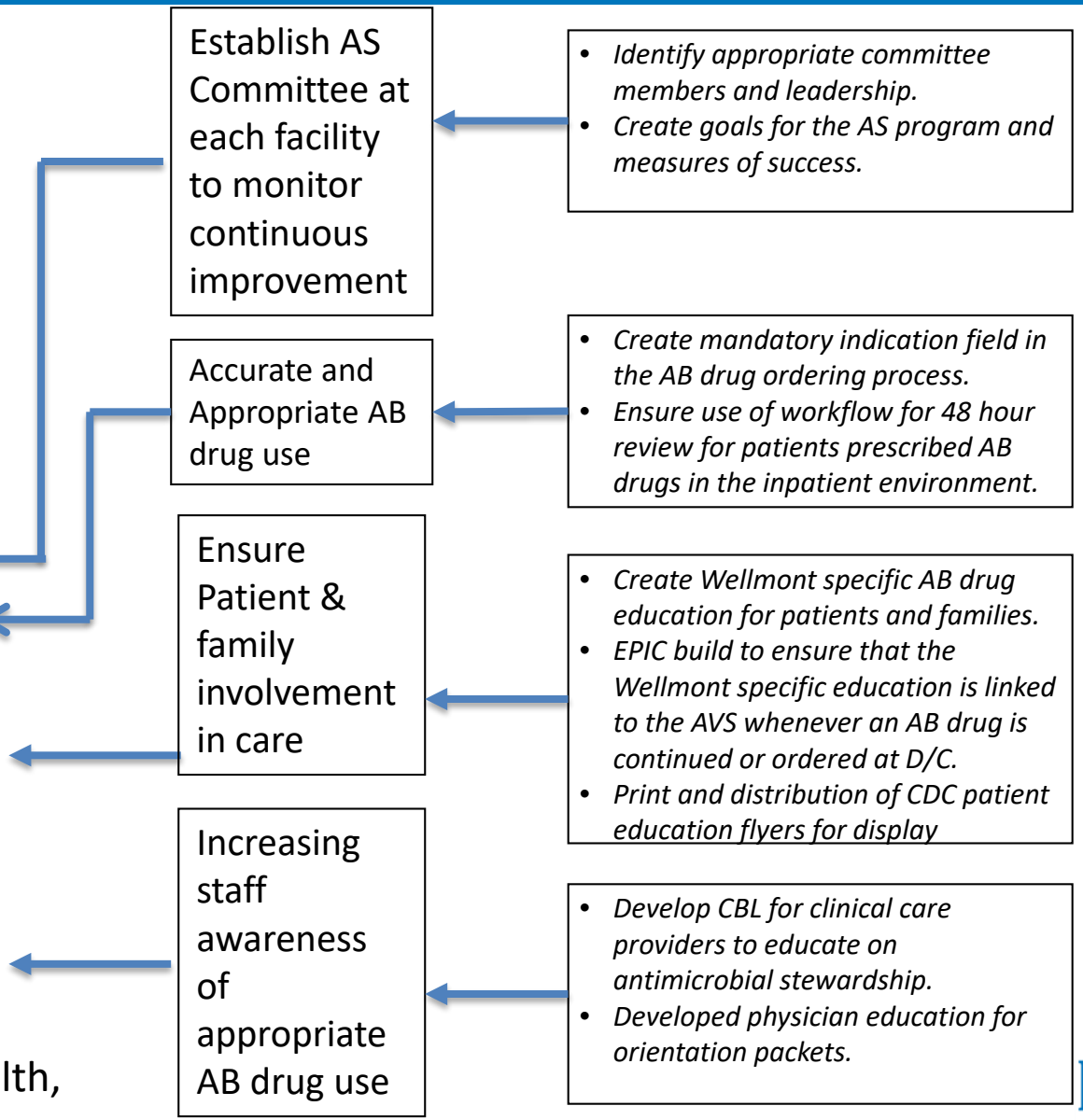
- W. Edwards Deming

Driver Diagram:

Aim: Wellmont Health System will achieve 100% compliance in implementation of the Antimicrobial Stewardship Standards set by The Joint Commission by June 1st, 2017,

Outcome Measures:

1. An indication for every antimicrobial drug ordered.
2. Education for every patient discharged on AB drugs
3. Educate all clinical staff that may order or monitor AB medication



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Wellpoint Health, Tennessee

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Surprises!

"The immediate improvement once a rounding tool was implemented" – Andrea Casas, Texas

"What surprised me the most about this work was how even the stakeholders that want the goals met needed to be encouraged. Competing priorities sometimes makes achieving a goal difficult" -- Bamiro Olulana, DFW, Texas

"The most surprising thing was finding what simple measures we were missing that should have been checked or followed and we were not completing" --Darcy Tolbert, OK

"It is important to provide staff education but it is also important to make sure that they can put the education to practice. Sometimes physicians get left out of education because we assume they already know and that isn't always the case. It is important to include all caregivers/providers in education and training for new processes."-- Jennifer Reno, Georgia

"Sepsis is such a big project and the patients are the sickest of the sick. I have learned that little changes can make the biggest difference in a patients life. We are not just trying to meet a goal or score but trying to make a difference in a patients life."-- Stephanie Long, Missouri

Advice

"Don't underestimate physician buy-in. Create urgency and importance for your project. Stories are incredibly helpful." -- Breanne Piazik, New Hampshire

"Make sure you are listening and responding to staff when you ask for help. We created a survey to get a bulk of our data and made sure we thanked each person. They really appreciate that and felt that we were taking them seriously and that we valued their feedback."-- Alison Margolies, Massachusetts

"Just start. Sometimes you have to stop planning and just jump in with a PDSA cycle to get started Involve the front line staff—it is key if you want something to change." -- Darcy Ost, Nebraska

"It can be done, but has to be tested, followed up on, and tracked for a long period of time before it is hardwired. Always allow the staff to be part of the decision making whenever possible, for increased buy-in."-- Wendi Hulett, New Mexico

Next Steps

Samantha Gaddie

Kentucky

Sepsis: Antibiotics given within 1 hour of diagnosis

Once our goal in met for 3 consecutive months plan to increase the goal to 90% compliance for antibiotics received within one hour of Sepsis diagnosis.

Alyssa Franklin, PharmD, Colorado

Our detection rate of sepsis will improve to >90% for patients presenting through ED by August 1, 2017

Implement this in our ICU and PCU areas

Look into a pediatric screening process

Breanne Piazik, New Hampshire

Reduce preventable ADE's by 20% in one year in the Elliot Health System

Provide daily report out to management including senior Explore provider/pharmacist alerts for hypoglycemic episodes

Honorable Mention

- Show off your teams

Rehab Fall Prevention Team

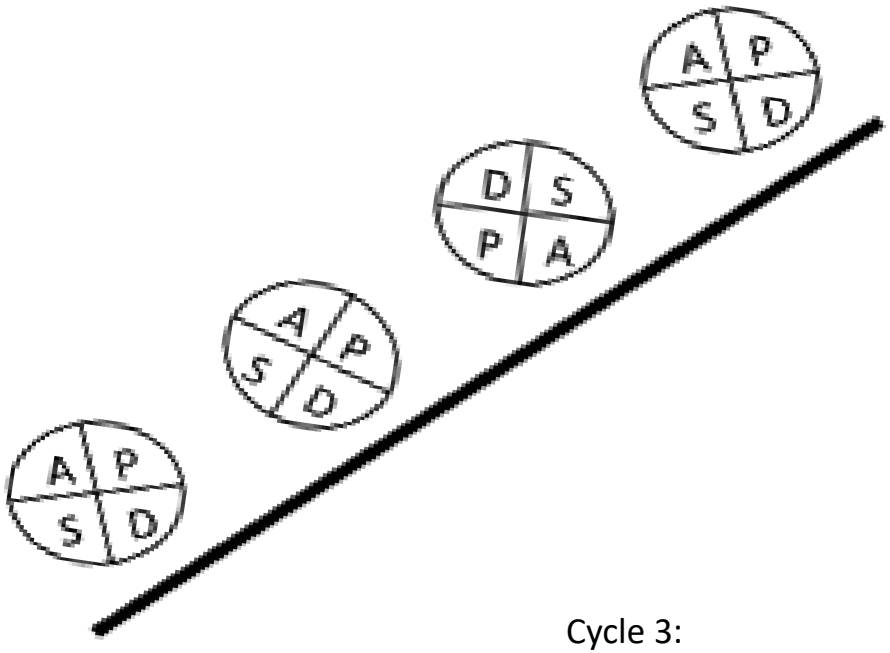
Activities Director – updates tally daily and changes board monthly

Andrea Casas, TX

Honorable Mention: Change Ideas

Jesusa Alfonso
Hialeah Hospital, Florida

Change Idea: Ask one discipline at a time to attend bed huddle in Telemetry Unit (average census of 55)



cycle1. conduct huddle with nrsg/casemgr/ transition of care coordinator

Cycle 2: include respiratory therapist/ pharmacy

Cycle 3: include dietitian/physical therapist/ ARNP case mgt. dept.

Cycle 4: daily huddle not attended by all disciplines; huddle taking too long due to high volume

ABANDON

Volunteer for 2018

Kathy Duncan
kduncan@ihi.org

Lauren Macy
lmacy@ihi.org

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Next Steps

- Share your project with your leader.
- Complete the final program evaluation:
  - It's open until Friday, November 10th
- Complete the self-assessment:
  - It's open until Friday, November 10th
- Talk the Fellowship up to your Friends – New fellowships starting mid-January.
- Continue to complete the IHI Open School
  - It's available to you until September 2018

Bring It Home

Mallory Bender, Program Manager, HRET

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