HRET HIIN Virtual Event
Foundations for Change Fellowship

Wednesday, July 11 Call #10
11:00- 12:00 p.m. CT
Welcome and Introductions

Mallory Bender, Program Manager, HRET
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00-11:05</td>
<td><strong>Welcome and Introduction</strong></td>
<td>Mallory Bender, HRET</td>
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<tr>
<td></td>
<td>• Orienting participants to the program and platform</td>
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<td></td>
<td>• Introducing faculty and agenda for the call</td>
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<tr>
<td>11:05-11:15</td>
<td><strong>Action Period Discussion</strong></td>
<td>Kathy Duncan, IHI</td>
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<td></td>
<td>• Project summary submissions</td>
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<td>11:15-11:45</td>
<td><strong>Celebration</strong></td>
<td>Kathy Duncan, IHI</td>
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<td></td>
<td>• Discuss the opportunities for improvement noted in submitted work.</td>
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<td>• Facilitate the opportunity for cross-learning among fellows around the results and lessons learned from the QI projects</td>
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<td>11:45-11:55</td>
<td><strong>Next Steps</strong></td>
<td>Kathy Duncan, IHI</td>
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<tr>
<td></td>
<td>• Complete the final program evaluation</td>
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<td>• Complete the self-assessment</td>
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<td></td>
<td>• Refer a friend to next year’s program!</td>
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<td></td>
<td>• Continue to complete the Open School</td>
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<tr>
<td>11:55-12:00</td>
<td><strong>Assignments, Suggested Tasks &amp; Additional Materials</strong></td>
<td>Mallory Bender, HRET</td>
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<tr>
<td></td>
<td>• Office Hours</td>
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<td>• Final Survey</td>
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<tr>
<td>Date</td>
<td>Session Title</td>
<td>Date</td>
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<tr>
<td>January 17</td>
<td>Set Up for Success</td>
<td>March 28</td>
</tr>
<tr>
<td>January 31</td>
<td>What are you trying to accomplish?</td>
<td>April 11</td>
</tr>
<tr>
<td>February 14</td>
<td>What changes can we make that will result in improvement?</td>
<td>May 9</td>
</tr>
<tr>
<td>February 28</td>
<td>How will we know that a change is an improvement?</td>
<td>June 6</td>
</tr>
<tr>
<td>March 14</td>
<td>Testing Vs. Implementation</td>
<td>July 11</td>
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**Wednesdays 11:00-12:00 PM CT**
SELF-ASSESSMENT ANALYSIS
Self Assessment

• Pre-Assessment in February 2018
• Post-Assessment in June 2018
• We asked you...
  – to score yourself on the following scale:
    1. I have no knowledge of this
    2. I have heard of this but cannot apply/explain it
    3. I have a working knowledge of this and can explain it
    4. I have a working knowledge of this and can apply it with support of someone
    5. I have a solid working knowledge of this and can apply in my work
    6. I am confident and comfortable in explaining, applying, and teaching this
  – 18 questions related to QI tools/needs
### On Average...

<table>
<thead>
<tr>
<th>Skill</th>
<th>Pre</th>
<th>Post</th>
<th>Delta</th>
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<tbody>
<tr>
<td>Establish a QI team with roles defined</td>
<td>3.10</td>
<td>4.73</td>
<td>1.63</td>
</tr>
<tr>
<td>Create a burning platform for building will and engaging stakeholders</td>
<td>2.38</td>
<td>4.44</td>
<td>2.06</td>
</tr>
<tr>
<td>Create an aim statement</td>
<td>3.21</td>
<td>5.16</td>
<td>1.95</td>
</tr>
<tr>
<td>Develop a family of measures (process, outcome, &amp; balancing)</td>
<td>2.85</td>
<td>4.79</td>
<td>1.94</td>
</tr>
<tr>
<td>Build clear and unambiguous operational definitions</td>
<td>2.65</td>
<td>4.56</td>
<td>1.90</td>
</tr>
<tr>
<td>Construct and interpret a run chart</td>
<td>2.67</td>
<td>4.76</td>
<td>2.09</td>
</tr>
<tr>
<td>Use driver diagrams to define the system of interest and theories the system</td>
<td>2.23</td>
<td>4.84</td>
<td>2.61</td>
</tr>
<tr>
<td>Use flowcharting techniques to break a system down</td>
<td>2.94</td>
<td>4.77</td>
<td>1.83</td>
</tr>
<tr>
<td>Use creativity methods and tools to generate new ideas</td>
<td>2.73</td>
<td>4.70</td>
<td>1.97</td>
</tr>
<tr>
<td>Design, set up, and run PDSA cycles (i.e., tests of change)</td>
<td>3.20</td>
<td>4.85</td>
<td>1.65</td>
</tr>
<tr>
<td>Run tests on a small scale initially and then increase the scale and scope</td>
<td>3.04</td>
<td>4.83</td>
<td>1.78</td>
</tr>
<tr>
<td>Explain why implementing a change is fundamentally different from testing</td>
<td>3.22</td>
<td>4.87</td>
<td>1.65</td>
</tr>
<tr>
<td>Develop new structures and procedures to support an implemented change</td>
<td>3.36</td>
<td>4.76</td>
<td>1.40</td>
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<tr>
<td>Distinguish how testing, implementing, and spreading a change are all different</td>
<td>2.93</td>
<td>4.70</td>
<td>1.76</td>
</tr>
<tr>
<td>Create the structures and processes needed to promote successful spread</td>
<td>2.89</td>
<td>4.62</td>
<td>1.73</td>
</tr>
<tr>
<td>Identify the units or entities where spread will occur</td>
<td>2.95</td>
<td>4.65</td>
<td>1.70</td>
</tr>
<tr>
<td>Use the High-Performance Management System at the frontline</td>
<td>1.99</td>
<td>4.20</td>
<td>2.21</td>
</tr>
<tr>
<td>Develop organizational infrastructure to support improvements</td>
<td>2.55</td>
<td>4.43</td>
<td>1.88</td>
</tr>
</tbody>
</table>

**Overall Average**  
2.83 4.70
We moved from

2.8 = have working knowledge of this and can explain it

4.7 = Solid working knowledge and can apply in my work
Self Assessment Analysis

HRET self assessment survey results - Foundations for Change Track

- Establish a QI team with roles defined
- Create a QI plan
- Create a burning platform for building will and engaging stakeholders in improvement
- Create an aim statement to guide your improvement effort
- Develop a family of measures (i.e., process, outcome, and balancing measures)
- Build clear and unambiguous operational definitions for measures
- Develop a family of measures
- Build clear and unambiguous operational definitions for measures
- Construct and interpret a run chart
- Use driver diagrams to define the system of interest and theories about how the system works
- Use flowcharting techniques to break a system down into the numerous processes that define how work gets done
- Use creativity methods and tools to generate new ideas
- Design, set up, and run PDSA cycles (i.e., tests of change)
- Run tests on a small scale initially and then increase the scale and scope of testing as learning occurs
- Explain why implementing a change is fundamentally different from testing a change
- Develop new structures and procedures to support an implemented change (e.g., training, new policies and procedures, job…)
- Distinguish clearly how testing, implementing, and spreading a change are all different steps in the sequence of change
- Create the structures and processes needed to promote successful spread
- Identify the units or entities where spread will occur
- Use the High-Performance Management System at the frontline
- Develop organizational infrastructure to support improvements

Any reflections? Where do you feel you have grown the most?
Submissions by state

- MD-1
- NH-1
- MA-2
- PR-8

1- Commonwealth of Mariana Islands
## Reports by Topic

<table>
<thead>
<tr>
<th>Topic</th>
<th>Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>7</td>
</tr>
<tr>
<td>Falls</td>
<td>6</td>
</tr>
<tr>
<td>Handwashing</td>
<td>4</td>
</tr>
<tr>
<td>Readmissions</td>
<td>3</td>
</tr>
<tr>
<td>CAUTI</td>
<td>3</td>
</tr>
<tr>
<td>Antibiotic Stewardship</td>
<td>2</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>1</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>1</td>
</tr>
<tr>
<td>Patient Safety Culture</td>
<td>1</td>
</tr>
<tr>
<td>Clostridium difficile Infection</td>
<td>1</td>
</tr>
<tr>
<td>CLABSI</td>
<td>1</td>
</tr>
<tr>
<td>Adverse Drug Event</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>
Contributors and Speakers:

- Amy J. Goodman, Community Hospital, Munster, Indiana
- Elizabeth Hensley-Birky, CenterPointe Hospital, St. Charles, Missouri
- Angela Leach, Clark Regional Medical Center, Winchester, Kentucky
- Barbara Lennon, Nemours Children’s Hospital, Orlando, Florida
- Erin Bolton, Jefferson Regional Medical Center, Pine Bluff, Arkansas
- Valerie Hangman, Providence Medical Center, Wayne, Nebraska
- Socorro G. Bueser, Baptist Medical Center, Jacksonville, Florida
- Rene Betancourt, Orlando Health Central Hospital, Ocoee, Florida
- Lauren Lastovica, Donna Kurek, Megan Elwell, Southside Regional Medical Center, Petersburg, Virginia
- Hazelle Villaruel, Novant Health UVA Health, Culpepper Hospital, Culpepper, Virginia
- William S. Elton, Columbus Community Hospital, Columbus, Nebraska
Aim: To have a >= 95% Compliance Rate of Discharge Medications (Aspirin, Statin and Antiplatelet) in Eligible Percutaneous Coronary Intervention (PCI) in the Cardiovascular Outpatient (CVOP) Patient Orders by June 30, 2018
• Outcome Measure: % of Compliance of Discharge Medications for PCI

Start small, Enlist lots of help, Be patient
“Remember, nothing changes overnight”
• Sepsis survivability rate will be 98% by December 31, 2018
• Outcome Measures:
  Sepsis mortality.
• Process Measures:
  1. Sepsis bundle compliance.
  2. Sepsis screening for each patient at the point of entry.
  3. Patients screened positive for possible sepsis will have treatment started within one hour.
• Balance Measures:
  *None currently.*
SRMC will complete the SEP-1 core measure on 75% of appropriate patients by September 30, 2018

Recognition and Assessment
- Accurate sepsis screenings (spot-check random patient sample to ensure sepsis screen was completed and that it was accurate) *PDSA

Bundle Compliance
- Variance education forms (track element deficiencies by name/date, monitor for trends) *PDSA
  - Order set usage (track order set usage)
  - Lab responsible for repeat LA *PDSA
  - Use of job aid for time tracking and handoff *PDSA

Education
- Variance education forms (track element deficiencies by name/date, monitor for trends) *PDSA
  - Provide 1:1 education

Executive Support
- Weekly e-mails (sepsis audits, trends, order set usage)
  - Sepsis Committee (data presentation)
  - Medical Committee Meetings (data presentation)
Run Chart - Lauren Lastovica, Donna Kurek, Megan Elwell, Southside Regional Medical Center, Petersburg, Virginia

**Severe Sepsis Concurrent Review Data**

**AIM**
SRMC will complete the SEP-1 core measure on 75% of appropriate patients by September 30, 2018

- **1/9/18**: started issuing sepsis variance forms - PDSA
- **3/26/18**: lab to collect repeat LA - PDSA
- **4/1/18**: sepsis job aid @ sepsis alerts - PDSA
- **4/6/18**: audit sample of sepsis screenings - PDSA

**Severe Sepsis Concurrent Review Data**

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent Bundle Compliance</td>
<td>78%</td>
<td>86%</td>
<td>78%</td>
<td>79%</td>
<td>85%</td>
</tr>
<tr>
<td>Mortality Rates</td>
<td>9.46%</td>
<td>12.28%</td>
<td>11.67%</td>
<td>10.91%</td>
<td>15.00%</td>
</tr>
<tr>
<td>Order Set Usage</td>
<td>70%</td>
<td>34%</td>
<td>63%</td>
<td>74%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**1q18 SEP-1 rate=52.76%**

May 2018 mortality rate preliminary, pending additional info, expect lower rate
**Aim:** By March 31, 2018, our BMCS T5B nurses will increase their accuracy rate to 97% when screening for the patient’s immunization status.

<table>
<thead>
<tr>
<th>Increase Staff engagement/compliance</th>
<th>Person responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
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<tbody>
<tr>
<td><strong>Test of change:</strong> Engage one or two RNs on the floor to be Immunization Champions</td>
<td>Socorro (CQMS)</td>
<td>12/2017</td>
<td>T5B</td>
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</table>

**Plan**

**List the tasks needed to set up this test of change**

<table>
<thead>
<tr>
<th>Person responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get to know the nurses on the floor</td>
<td>Socorro (CQMS)</td>
<td>12/2017</td>
</tr>
<tr>
<td>Search out for and recognize one or two nurses who is passionate about making sure the patients are screened correctly and are immunized prior to discharge</td>
<td>Socorro (CQMS)</td>
<td>12/2017</td>
</tr>
<tr>
<td>Encourage these nurses as they become the Immunization Champions on their Unit, serving as resource persons for their team members.</td>
<td>Socorro (CQMS)</td>
<td>12/2017</td>
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**Predict what will happen when the test is carried out**

- Shared responsibility, empowerment and a sense of “I got your back” will be established among the team members.
- There would be a sense of satisfaction as they move towards their goal as a team in the unit.

**Measures to determine if prediction succeeds**

- The number of forms with accurate entries filled out within the first 24 hours of admission over the total number of forms filled out within the first 24 hours of admission for the week.
**Do**  
Describe what actually happened when you ran the test

The initiative to have a nurse “officially” function as an Immunization Champion was never started. However, one of the Charge Nurses on the floor has shown much enthusiasm about sharing the responsibility with us. She has stepped into the role without any difficulty. She was a great asset for the team.

**Study**  
Describe the measured results and how they compared to the predictions

The median performance from the December 1st week to Jan 1st week was at 95%, with a range of 88 to 100%. We are aiming for ≥ 97%. We are getting there…..

**Act**  
Describe what modifications to the plan will be made for the next cycle from what you learned

A role does not have to be officially designated to have the needle of improvement move towards the right direction. What is important is to have a dedicated person to step into the role and bridge the gap.

The initiative is still open for adoption on the Unit level. The Quality Department is always ready to walk hand in hand with our frontline clinicians to sustain improvement.
Aim

By June 1, 2018, we will decrease non-English speaking patient wait times by 50%

Group meeting about measuring wait times and setting our aim

Implemented our change of relocating two staff

We are seeing progress! This was an outlier due to a rescheduled appointment
Reflections and Next Steps- William S. Elton, Columbus Community Hospital, Columbus, Nebraska

• Key lessons included:
  – Early on staff worked within the broken process of wasted time and transportation.
  – Taking time to address the needs of the patient we were able to find a solution to reach our aim. The education from this fellowship helped us reach our goal and gave us the needed direction to be successful.

• Next Steps:
  – We will highlight this project for other departments to learn from the steps we took for improvement.
  – Continued measurement on wait times, we will be able to implement needed changes in a more proactive way to serve our patients.
Increase hand hygiene compliance among HCWs on the Acute Unit from 30% to 90% by December 31, 2018

Hand hygiene education per CPH policy IC 6.0

Access to hand hygiene product

Hand Hygiene Culture Change for Sustainability

Annual education - Hand Hygiene to have its own course

"Media Blitz" - Infographics of hand hygiene info, include 5 moments of hand hygiene, e-mail CPH monthly results of hand hygiene audits

Mandatory in-service, receive personal sanitizer at session

Work with Plant Ops to order/install hand sanitizer dispensers in hallway, in Nursing Station, outside of Med Room

Charge RNs and MHT IIIs as monitors

Discipline - verbal, written, etc., Reward - praise, giveaways (candy, stress balls, pens)

Provide signs/handouts to patients/visitors about hygiene and encourage them to ask HCWs to sanitize their hands

Review/update annual education material, "media blitz" - posters, handouts, emails, Nursing inservice sessions

Provide personal alcohol-based sanitizer to HCWs, evaluate and increase placement of hand sanitizer dispensers

Implement Nursing hand hygiene monitors, discipline/reward system, in the moment intervention, engage patients/visitors
Elizabeth Hensley-Birky, CenterPointe Hospital, St. Charles, Missouri

**Acute Unit Hand Hygiene Compliance**

- **Goal:** 90%
- **Median:** 39%

**Actions Taken:**
- Expanded hand hygiene auditors to other departments
- Placed “Ask me if I washed my hands” signs on medication carts
- Placed “Ask for safe care, Ask for clean hands” posters outside patient rooms and consult rooms
- Hand hygiene education with patients
90% of post op patients will be able to sit on the edge of the bed and dangle feet within 6 hours of arriving on MedSurg Unit from PACU. This will be achieved on June 30th, 2018

Staff Readiness

- Prepare for mobilization
  - Enough/Correct staff support (RN, PT)
  - SPH equipment, mobilization equipment (knee immobilizers)
  - Clutter free environment/ rearrange furniture/
  - Familiarize staff with precautions to moving ortho patients

Education/ Training

- Staff to train w/ PT

Fear / Anxiety

- Inform patients of the plan upon arrival and educate the patient on why mobility is important. Explain procedure prior and during mobilization

Pain

- Discuss/explain expectations of pain
- Medicate the patient prior to mobilization

Vitals/Hemodynamics stability

- Monitor vital signs, laboratory findings that will affect mobilization
- Identify any restriction (hap, knee, dural tear)

Physical readiness/status

- Improve Activity tolerance
- Disconnect or reposition IV tubings and pumps on IV site, reposition foley catheters, have assistive device ready to use (like pillows)
90% of post op patients sat up in bed and dangle within 6 hours of arriving to Med Surg from PACU
• Lessons learned:
  • PDSA is an excellent tool in finding out what’s the best step/s in achieving aim. It can be used multiple times until the goal is achieved.
  • It is important to focus on interventions that aligns to your aim.

• Barriers addressed:
  • Patients were still drowsy and not ready to move yet within 6 hours from arrival to MedSurg - For drowsy patients- changing positions or elevating the head of the bed before sitting up in bed
  • Patients were still in pain - make sure patients are medicated appropriately and/or before mobility.

• Next Steps: Our team is planning to add more advance and complex activities such as walking at bedside, to ambulate to bathroom and in the hallway within 6 hours after surgery. We are also going to spread this to other units of the hospital which is Stepdown and Family Birth Center.
Aim and Outcome Measure: Valerie Hangman, Providence Medical Center, Wayne, Nebraska

• Aim: Improve care of STEMI patients by January 1\textsuperscript{st}, 2019 by ensuring that 50% of STEMI patient transfers are accomplished within 60 minutes of patient arrival.

• Outcome Measure: Improve care of STEMI patients by January 1\textsuperscript{st}, 2019 by ensuring that 50% of STEMI patient transfers are accomplished within 60 minutes of patient arrival.
Process Measures: Valerie Hangman, Providence Medical Center, Wayne, Nebraska

• Percentage of STEMI patients that had EKG done within 10 minutes of arrival.

• Percentage of STEMI patients receiving TNK that had an arrival to TNK administration time of 30 minutes or less.

• Percentage of STEMI patients that provider called receiving facility within 10 minutes of reading EKG.

• Percentage of STEMI patients that had arrival of patient to notification of provider by nurse done within 10 minutes.
• Percentage of STEMI patients that had all measures for the Emergency Department Transfer Communication Project completed.

I speculate that as we push to get these patients out of our facility quicker we may miss getting some information required for the EDTC project on our transfer paperwork.
Great Comments

— Erin Bolton, Jefferson Regional Medical Center, Pine Bluff, Arkansas

• Open and honest communication with physician staff about days from insertion to infection.
• Communicate that we are not “assigning” blame but rather evaluating a process to see what we can improve to help keep our rates down
• Make sure the data you are collecting is the data that you want/need to collect and matches the process that is in place
• Continue to look for other improvements that could be made to the process to improve patient outcomes (new central line dressing)
• Rounding had a HUGE impact!! When they know you are watching, they stay on top of things!

— Angela Leach, Clark Regional Medical Center, Winchester, Kentucky

• Frontline staff involvement early on is critical for your projects success. How quickly compliance with best practice measures occurs once background knowledge is provided.
• Next steps:
  — Sepsis background and bundle education is to be provided in orientation.
  — Maintain Sepsis Champions on all units to provide staff resources.
  — Staff recognition celebrations to maintain sustainability. d)
  — Report progress to the staff, MEC and Board of Directors.
Aim: Improve Hospitalist group HCHAPS scores by 5% by 12/31/18

Background:
- This is the largest hospitalist group at our facility. This group touches about 85% of all Inpatient admissions.
- A 5% increase in HCCAPS scores would trigger a big bounce in our overall Patient Experience scores.

The physicians are very interested in the dynamics of scoring well in HCCAPS. The interpretation of each question from a patient’s point of view versus how our physicians interpret the questions are worlds apart.
• Change Ideas:
  — Develop standard communication cues for physicians to determine if a patient is truly understanding
    • Do you understand what is happening next?
    • Do you have any questions for me today?
  — Encourage physicians to refer to the white board as a communication tool
Upcoming Office Hours

• July 25, 11:00 AM-12:00 PM CT
• August 22, 11:00 AM-12:00 PM CT
• September 12, 11:00 AM-12:00 PM CT

Office Hours Topics TBA by July 23rd

Email Kathy Duncan (kduncan@ihi.org) with topic suggestions and questions
Bring It Home

Mallory Bender, Program Manager, HRET
WE WANT TO HEAR FROM YOU! Take our survey to let us know what you thought of the fellowship program.
THANK YOU!