HRET HIIN Virtual Event:
Foundations for Change Fellowship Celebration!!

Wednesday, November 8, 2017
11:00 – 12:00 p.m. CT
Welcome and Introductions

Mallory Bender, Program Manager, HRET
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>11:00-11:05</td>
<td>Welcome and Introduction</td>
<td>Mallory Bender, HRET</td>
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<tr>
<td>11:05-11:15</td>
<td>Action Period Discussion</td>
<td>Lauren Macy, IHI</td>
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<td></td>
<td>• Project Summary submission highlights</td>
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<td>11:15-11:45</td>
<td>Celebration!</td>
<td>Lauren Macy, IHI</td>
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<td>• Identify and highlight examples of the use of the Model for Improvement in improvement projects</td>
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<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>Next Steps</td>
<td>Lauren Macy, IHI</td>
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<td>• Complete the final program evaluation</td>
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<td>• Complete the self-assessment</td>
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<td>• Refer a friend to next year’s program!</td>
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<td>• Continue to complete the Open School</td>
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<td>11:55-12:00</td>
<td>Bring It Home</td>
<td>Mallory Bender, HRET</td>
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<tr>
<td>January 18</td>
<td>The Case for Improvement</td>
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<td>February 1</td>
<td>Take your Aim – What are We Trying to Accomplish?</td>
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<td>February 15</td>
<td>What Changes Can We Make That Will Result in Improvement?</td>
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<td>March 1</td>
<td>Map Your Course</td>
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<td>March 15</td>
<td>How Will We Know That a Change is an Improvement?</td>
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<td>March 29</td>
<td>Empower Teams to Engage in Improvement</td>
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<td>April 12</td>
<td>Know Yourself, Know Others</td>
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<td>May 10</td>
<td>Multiple Cycles, Multiple Tests</td>
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<td>June 14</td>
<td>Manage Time and Attention</td>
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<td>July 12</td>
<td>Be the Coach</td>
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<td>August 9</td>
<td>Treasure Chest: Shadowing a Patient</td>
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<td>September 13</td>
<td>Identify and Spread Improvement</td>
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<td>October 18</td>
<td>Sustaining Improvement</td>
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<tr>
<td>November 8</td>
<td>Celebration!</td>
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Project Summaries – Thanks!

63 Projects

83 Fellows
<table>
<thead>
<tr>
<th>Reports by Topic</th>
<th>Readmission: 12</th>
<th>Fall Reduction: 10</th>
<th>Sepsis: 10</th>
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<tr>
<td>Event Reporting: 8</td>
<td>Antibiotic Stewardship: 6</td>
<td>Hand Hygiene: 5</td>
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<td>Medication Rec: 4</td>
<td>CLABSI: 3</td>
<td>C. Diff: 2</td>
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<td>Delirium Screening: 2</td>
<td>VTE: 2</td>
<td>Reduction of Cath Use: 1</td>
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<td>Safety Coach: 1</td>
<td>Safety Huddles: 1</td>
<td>Safety Reports Filed: 1</td>
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<td>STEMI Code: 1</td>
<td>Tobacco Cessation: 1</td>
<td>Patient Engagement: 1</td>
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<td>Peer Review Complete: 1</td>
<td>Influenza Immunization: 1</td>
<td>Ensuring Implants Are Available: 1</td>
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<td>SSI Reduction: 1</td>
<td>CT Reporting: 1</td>
<td>Decreasing Episiotomy: 1</td>
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<td>CPOE Compliance: 1</td>
<td>Dysphagia Screening: 1</td>
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American Hospital Association
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

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
### 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 this later measure)
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

- Hospitalist Education September
- Cerner optimization training w/all nursing
- ICU Education July
- PCU Education Aug
- ED Education June
- Cheats Sheets placed for antibiotics
- Trialed communication tool

% Compliance

01-Jan 01-Feb 01-Mar 01-Apr 01-May 01-Jun 01-Jul 01-Aug 01-Sep
• 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?
“You measure what you value. Conversely, you value what you measure.”  Brent James

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

“Without data, you are just another person with an opinion.”  W. Edwards Deming
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
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
Lakeland Regional Health Overall CLABSI SIR by Quarter

- 9/14/2014 PICC Protocol goes
- 5.2016 Mandatory Hand Hygiene
- 6.2016 Insertion bundle doc mandatory and available for reference within chart
- Sage CHG wipes unavailable 8/31-9/21/17, bath wipes unavailable 8/31 to return end of October
- 8.11.15 Medline here for housewide hand sanitizer education
- Automatic Daily LTD report emailed to managers to aid rounding
- Insertion Bundle added as reference within insertion charting section in Cerner
- 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

- Fall Rate/1000 PD
- Median
- Goal

- Re-educate of Morse Scale
- DON appointed falls champion
- Monthly falls data discussed with senior leadership and staff
- Purposeful rounding
- Audit fall identifiers
- Update fall protocol policy
- Update family education Pamphlet

Debra Kiley, Joseph Barrett, Massachusetts
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 Severe Sepsis Treatment Bundle Recommendations:
- Repeat Lactate if initial > 2.

Becky Trenkamp, Ruthie Rhodes, Florida
(Surviving Sepsis Campaign, CMS)
Helpful Tips

Just because you can measure everything doesn’t mean that you should.

— W. Edwards Deming —

AZ QUOTES
• 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.
Sepsis Bundle Measure Compliance Rates

- **Initiated sepsis screening tool**
- **Actual %**
- **Goal %**

- January: 33.33%
- February: 12.50%
- March: 50%
- April: 0%
- May: 66.67%
- June: 33.33%
- July: No data
- August: 25%
- September: 60%

Rachel Krueckerberg, Indiana
A good aim: 1) Identifies the system to be improved (scope, patient population, drivers selected) 2) Has specific numerical goals and 3) Includes timeframe
Primary Drivers:
Major processes, operating rules, or structures that will contribute to moving towards the aim

Secondary Drivers:

Specific Ideas to Test or Change Concepts:
Driver Diagram Components

**Primary Drivers**

- D1
- D2
- D3
- D4
- D5

**Secondary Drivers**

- Elements or portions of the primary drivers. The secondary drivers are system components necessary in order to impact primary drivers, and thus reach project aim.

**AIM**

**Specific Ideas to Test or Change Concepts**
Specific changes: Concrete actionable ideas to test.
Change concepts: Broad concepts (e.g., move steps in the process closer together) that are not yet specific enough to be actionable but that will be used to generate specific ideas for change.
Aim: Reduce patient falls on Inpatient Unit to less than 1/month by Dec. 31st, 2017.

Primary Drivers

- Risk Identification
- Fall risk interventions
- Communication
- Resources

Secondary Drivers

- Staff understand fall risk assessment process – when, what, how
- Staff understand to reassess fall risk after fall
- Link fall prevention interventions to what puts patient at fall risk
- Assess effectiveness of interventions in preventing patient falls.
- Staff to debrief fall, complete investigation tool for root cause of fall.
- Adjust interventions to address root cause of fall.

- Communicate fall risk to all shifts & disciplines
- Communicate all interventions that are in place to all disciplines that are caring for patient.
- Communicate fall risk to patient and family

- Additional staff to sit with patients
- New white boards to communicate fall risk and interventions
- Additional personal alarms

Carolyn Mikesell, Kansas
Aim: To reduce COPD readmissions by 12% by 9/30/17

Intense focus on readmitted patients (COPD) while in hospital

- Enroll appropriate patients in Care Logics.
- DC planning interview done within 24 hours.
- Test effectiveness of a pharmacist in ED for medication reconciliation assistance.
- Interview readmitted patients and providers to ascertain reasons for readmission.
- F/u phone calls made within 48 hours of DC by nursing.
- Develop an alternative follow up clinic for high risk patients who cannot see provider within 5-7 days.
- Develop Palliative care program – OR develop scripting and training for Home Health nurses and Providers to offer advice regarding advance directives.

Focus on pts at high risk for readmission after discharge from hospital

Rosemary Kertis, Indiana
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.

Primary Drivers
- Senior Leadership Support
- Staff and Management Engagement
- Robust Risk Management Event Reporting System
- Infection Prevention

Secondary Drivers
- Initially launched as a 6 week pilot. Summary report provided to Senior Leaders after 6 week pilot period. Desire for accountability and transparency.
- Formation of Daily Patient Safety Huddle Key Element Report distributed and posted for staff accessibility. Huddles are held in a consistent, convenient location. Huddles tagged to bed briefings that were already occurring daily.
- Patient safety events reported. Good catches reported. Software updates to increase ease of use. Accountable oversight designee to assure consistent reporting of events.
- Catheter Associated Urinary Tract (CAUTI) Infection team
- Central Line Associated Bloodstream Infection (CLABSI) team
- Surgical Infection team
- Infection Prevention team
- Central Line and Foley Catheter report
- Track days since last CAUTI and CLABSI
"If you can't describe what you are doing as a process, you don't know what you're doing."

- W. Edwards Deming
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

Driver Diagram:

Wellpoint Health, Tennessee
“The immediate improvement once a rounding tool was implemented” – Andrea Casas, 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

“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

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

“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

“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

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

- **Cycle 1**: 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**

**Honorable Mention: Change Ideas**

Jesusa Alfonso
Hialeah Hospital, Florida
Volunteer for 2018

Kathy Duncan
kduncan@ihi.org

Lauren Macy
lmacy@ihi.org
Next Steps

• Share your project with your leader.
• Complete the **final program evaluation**:
  – It’s open until Friday, November 10\(^{th}\)
• Complete the **self-assessment**:
  – It’s open until Friday, November 10\(^{th}\)
• 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