AHA Team Training

Problems, Possibilities, and People: Using Human-Centered Design to Create and Scale Change for Teams

April 9, 2025

American Hospital Association™
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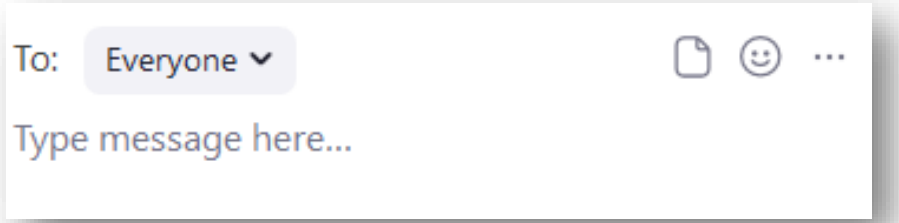

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- April 24-25 | Los Angeles, CA | UCLA
- May 6-7 | Chicago, IL | AHA Team Training
- May 19-20 | New Orleans, LA | Tulane

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Webinars

- May 14 – Leading the Way: Health Care Organizations' Commitment to Workforce Well-being, **register here**!

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> Our relationship with the TeamSTEPPS faculty and the on-site trainings were both phenomenal. **They did a great job of meeting us where we were** and customized a program that really helped us gain clarity about the problem we're trying to solve.
>
> – **Melissa Riffe-Guyer**
> Executive Director,
> Culture Cone Health

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Presenters for Today

Matthew Kelly
Partner & Business Designer

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Adam Kohlrus
Partner & Chief Health Strategist

do tank

Business design, redesigned.

Founded in 2014, Do Tank is an interesting collection of entrepreneurs, human-centered designers, developers, artists and seasoned strategy consultants. We have offices in Chicago (USA) and Glasgow (UK), and we help simplify complexity, align thinking, and move teams to real action. We provide tailored blend of high value consulting enabled by our market leading digital engagement technology.

Session Agenda

1. Design Thinking Overview
2. Design Thinking's Application to Leading Change
3. Case Examples and Tools-in-Action
4. Q&A

Learning Objectives:

- Understand some fundamental concepts and methodologies for human-centered design
- Learn from specific case studies and examples about how other teams have used human-centered design
- Discover key principles and best practices for engaging teams and shepherding change

Our Goal

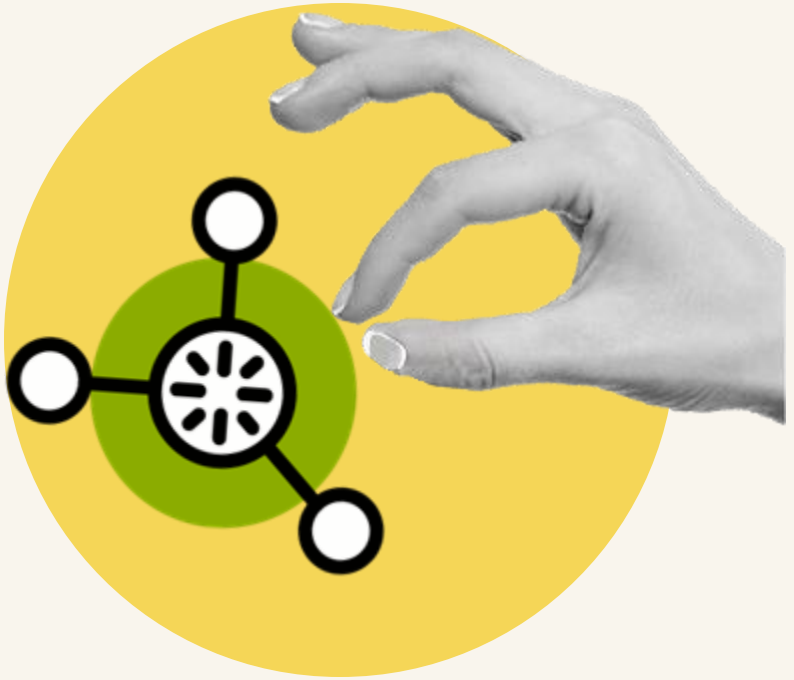
We will share processes and tools to spark ideas about how you can apply human-centered design techniques to shepherd change

We will rapidly bounce between examples

We will showcase tools/techniques you can use

Make use of chat for reactions

CLIMATE



01.

Design Thinking Overview

“If any field should be human-centered, it’s healthcare.

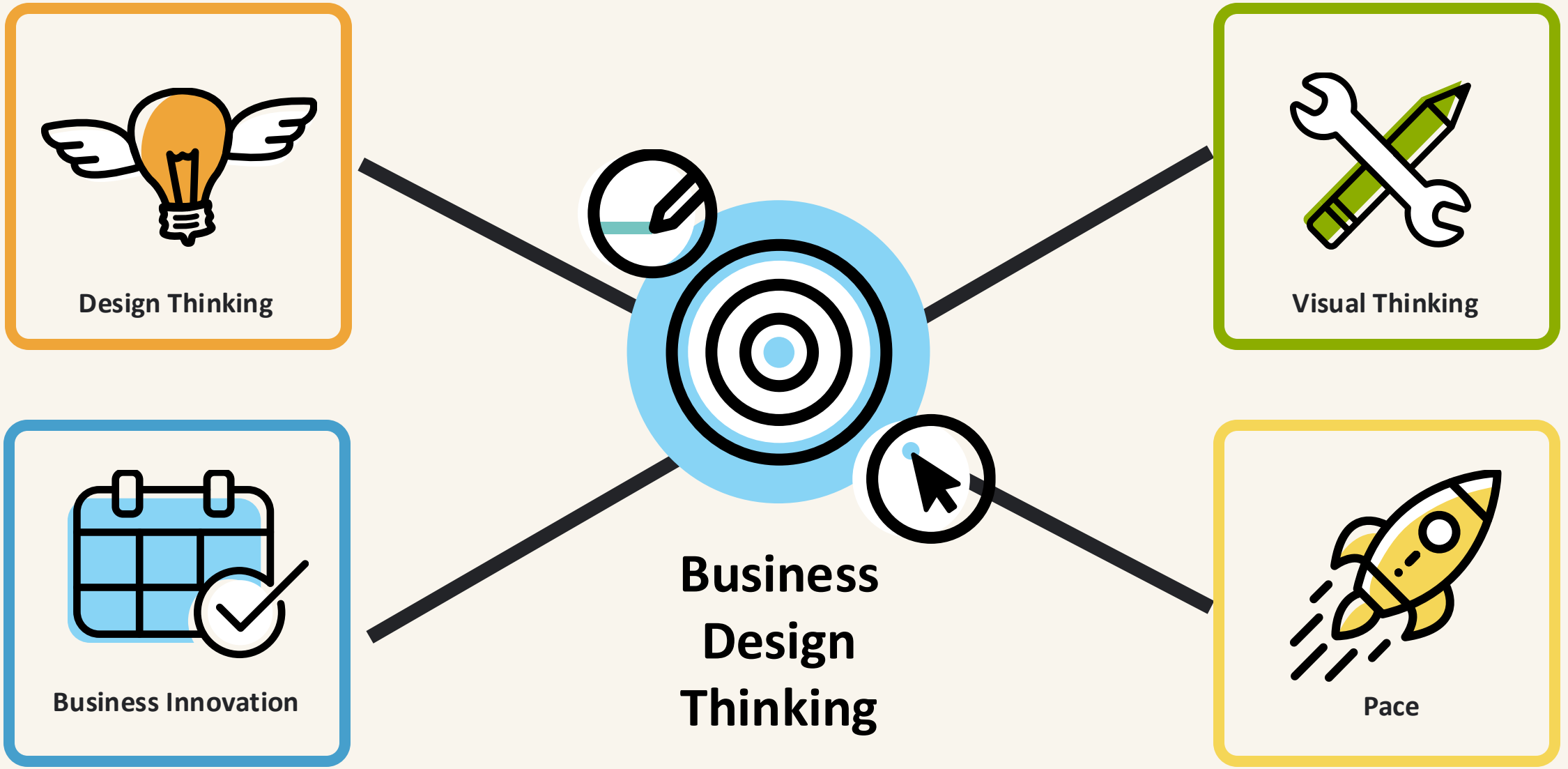
We help teams at the intersection of quality, equity, and innovation design a safer, healthier future.”

do tank

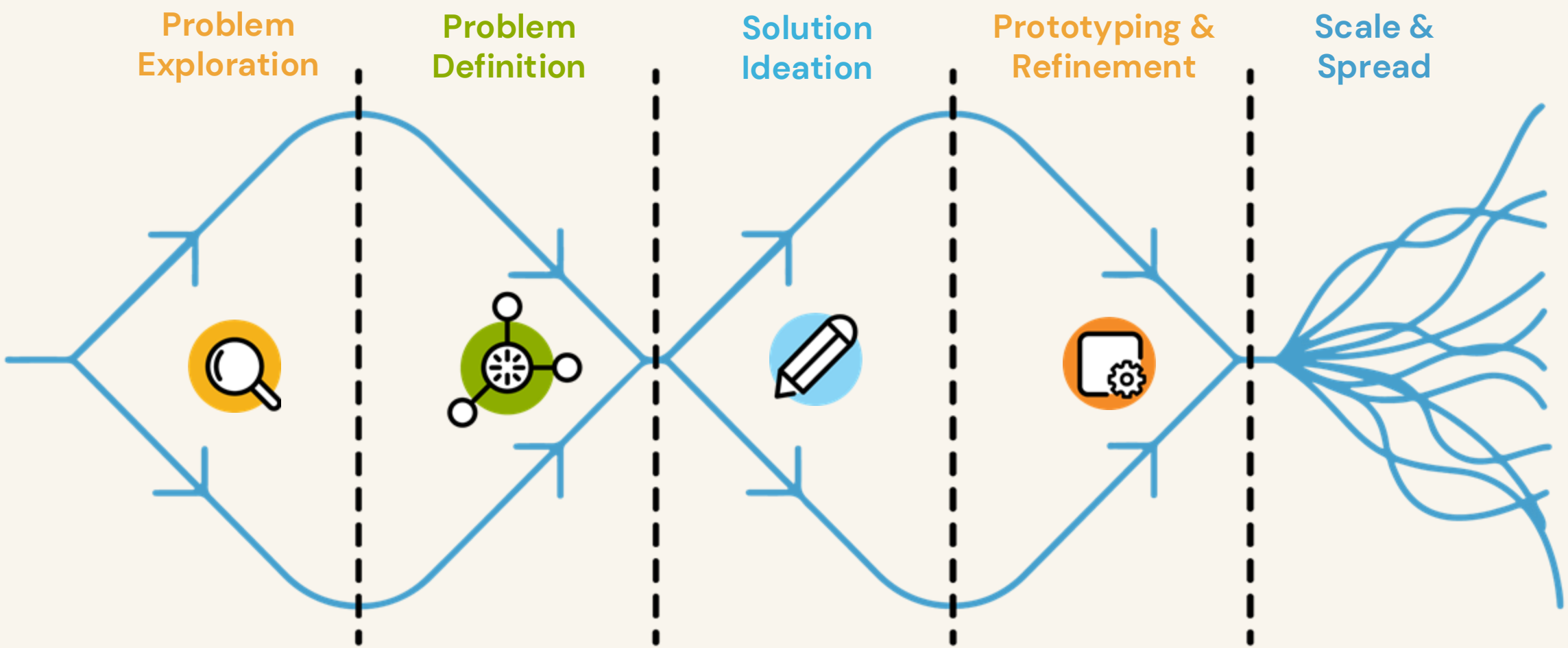
Business design, redesigned.

Human-Centered Design Means:

Designing solutions from a foundation of **empathy** and **understanding**.


Design Thinking
Visual Thinking
Business Innovation
Pace
Business
Design
Thinking

Human-Centered Design Process:



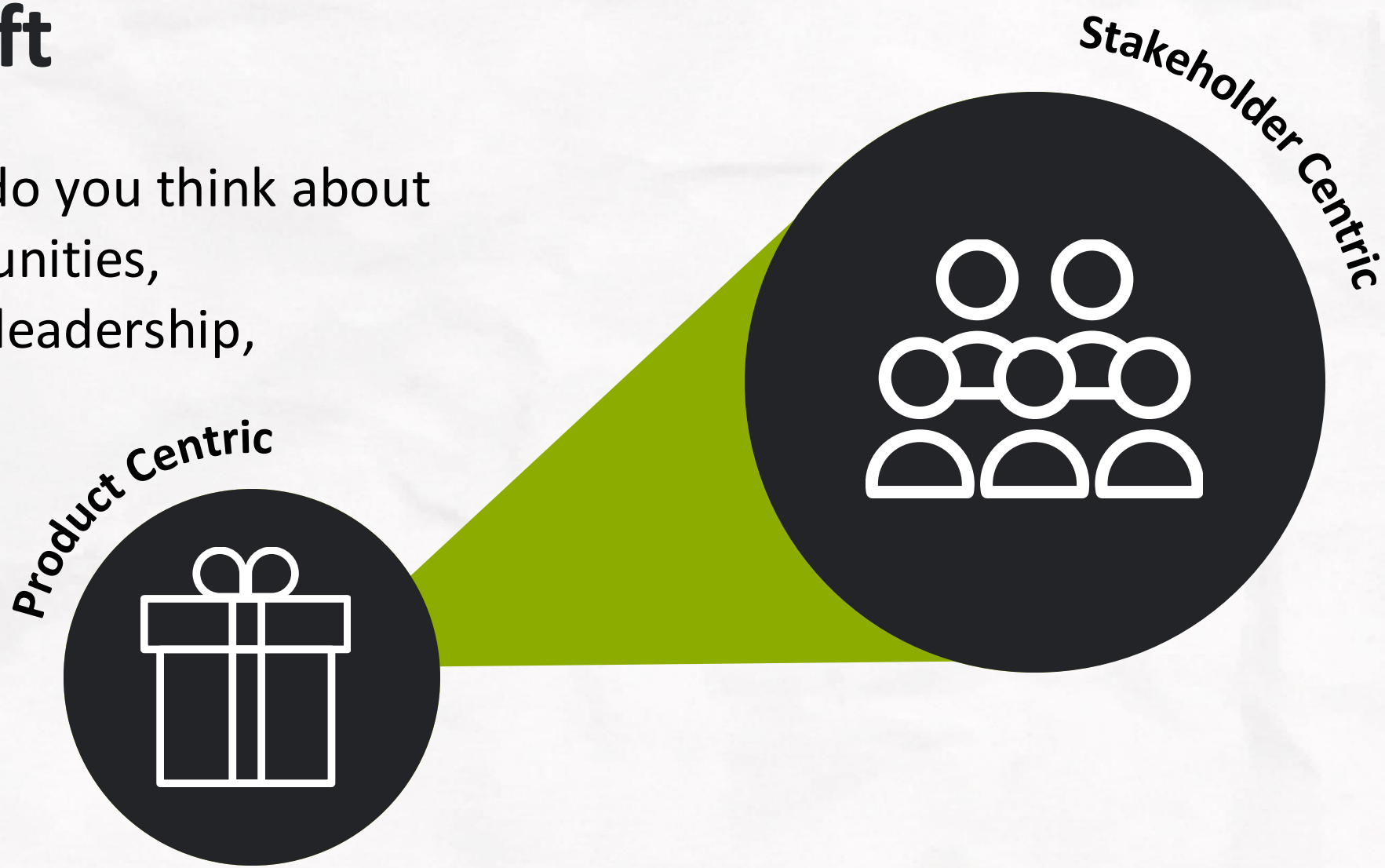
Stakeholder Research
How are people experiencing this problem?

Concept Validation
Does this concept meet the needs of the potential user?

User Testing
How does this functionally work? How can we iteratively improve our prototype?

The Shift

How often do you think about your communities, colleagues, leadership, audience?



02.

Design Thinking’s Application to Leading Change

Truths to Live By

"If I had an hour to solve a problem, I'd spend 55 minutes thinking about the problem and five minutes thinking about solutions."

– Albert Einstein

"AND... Once one has solved a problem, there is huge opportunity to harvest that solution.

The solution may apply to other challenges or tasks in one's own life, or that of colleagues. There may be a generalizable learning that emerges, an opportunity to recognize a person involved in the solution, or a story to tell publicly for broader benefit."

– Nell Derick Debevoise

Design Thinking Focuses on Problem Definition

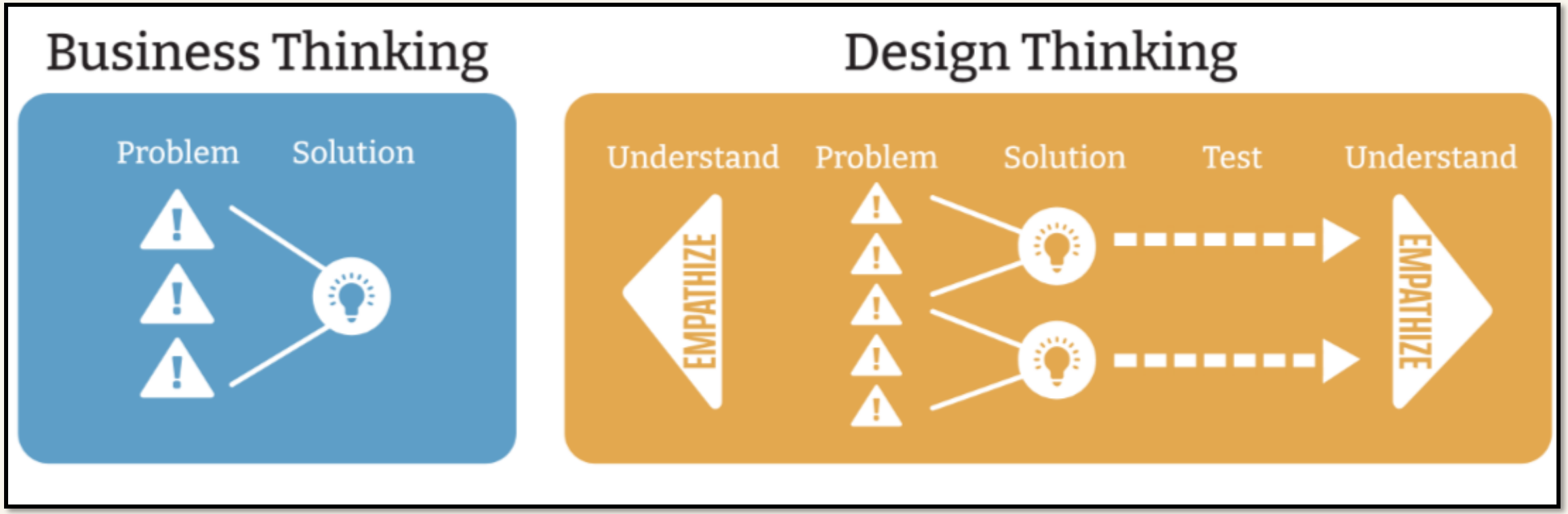


Image source: https://www.optimahg.com.au/news/using-design-thinking-to-improve-patient-care, 2024.

We've Taken Inspiration From Others

A high-reliability organization (HRO) is an organization that consistently performs safely, efficiently, and with high quality even in the face of complex challenges with high hazard potential. The HRO concept, which has connections to normal accidents theory, garnered attention in nuclear power and aviation.

Health care organizations are complex environments of rapid innovation; narrowly focused specialties; and crises, such as emerging diseases.

Many organizations have increasingly adopted the principles of high-reliability organizations to improve their safety and quality.

In the 70s, NASA developed Technology Readiness Levels (TRLs) to send things into space. They were originally created to measure the maturity of a technology on a scale of 1 to 9. This enabled innovation teams to stay focused, maintain pace and prioritize resources.

Organizations worldwide now use TRL's as a cross-disciplinary language that investors, engineers, sales/marketing and executives all understand.

We have taken the core elements of TRLs and reframed them to be relevant to BOTH product and service innovation.

This framework a grounding in proven methods (business rigor), with an adaptation to an expanded set of use cases.

Our Work Is Broken Into 3 Specific Buckets…

DO LEVEL
DESIGN THINKING METHODOLOGY

Opportunity Validation

Through field study, journey mapping, insight gathering, assumption testing, and root cause analysis, a deeper and richer appreciation of the problem is achieved.

Concept Development

Through ideation, rapid prototyping, field validation, minimally viable product (service) creation and business model creation, promising ideas turn into potential solutions.

Value Creation

Through pilot then scaled launch, promising ideas deliver impact to patients, families and care providers.

03.

Examples From the Field

Opportunity Validation

Understanding the goals, problem to solve and the people involved...

this is where you plant the seeds of change

1.) Gather the Right Cast of Characters

Invite People to Explore the Problem/Challenge…

Not just the solution! This will help develop individual understanding around the ‘Why’ for your change initiative.

2.) Create a Strong Foundation

Who You Are (Current State)
What's Around You (Context)
Where You Are Going (Vision)

2024

MISSOURI COMMUNITY FORUMS REPORT

On Maternal Rural Health Care

The Burning Platform

The need to assess the gaps within Missouri’s maternity care deserts

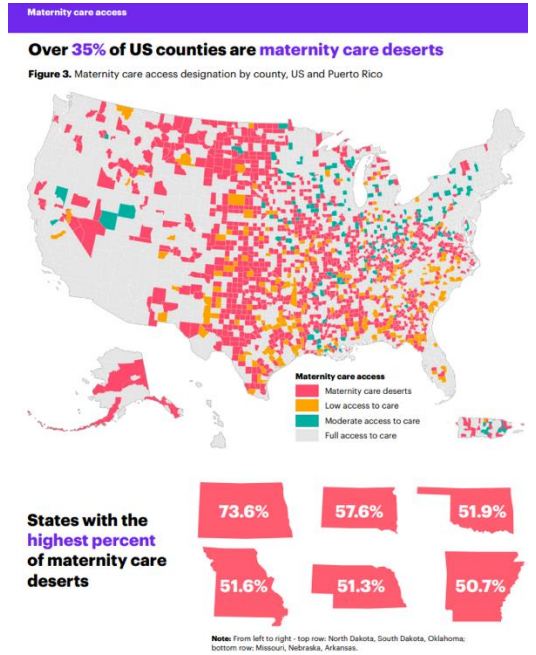
The desire to identify what supports are needed to improve outcomes

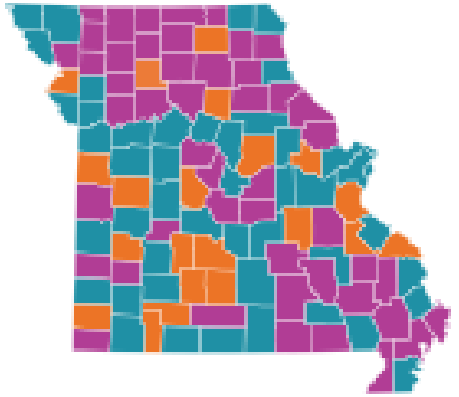
The opportunity to challenge stakeholders to ideate ideal future state actions which they believe would enhance maternal health outcomes

The Missouri Perinatal Quality Collaborative (PQC) and Missouri Hospital Association (MHA) partnered to address maternal health disparities in rural Missouri. The communities of Miner, Chillicothe, Hannibal and Joplin were chosen as the four sites to hold these Community Forums which would help PQC and MHA ascertain the strengths, weaknesses, opportunities and actions which should be considered as we all strive to enhance maternal health outcomes.

Our goal was to identify strengths, weaknesses, opportunities, and potential solutions to improve maternal health outcomes in these underserved areas.

INTRO





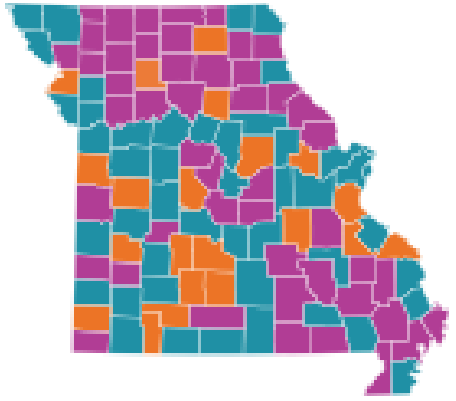
4 COMMUNITY FORUMS

24 HOURS OF PROGRAMMING

115 PARTICIPANTS

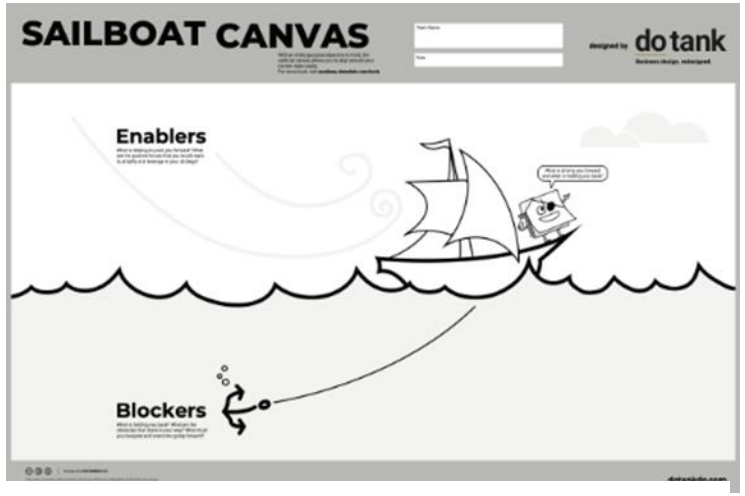
21 "BIG IDEAS"

1,700 DATA POINTS COLLECTED

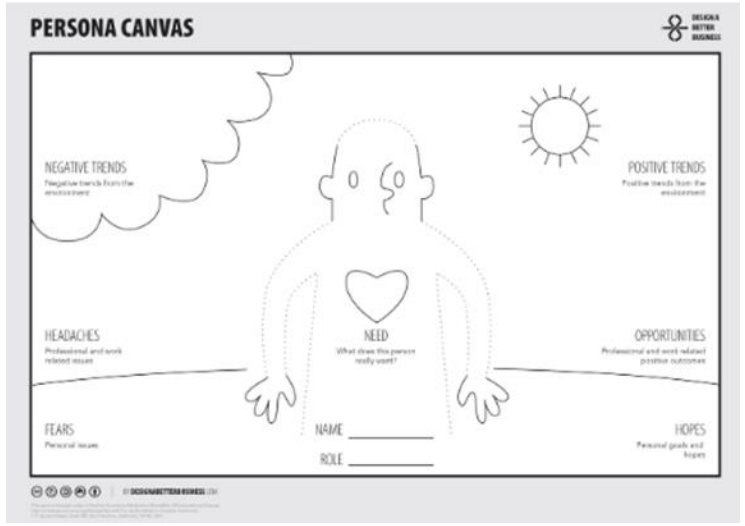


MISSOURI PQC
Perinatal Quality Collaborative

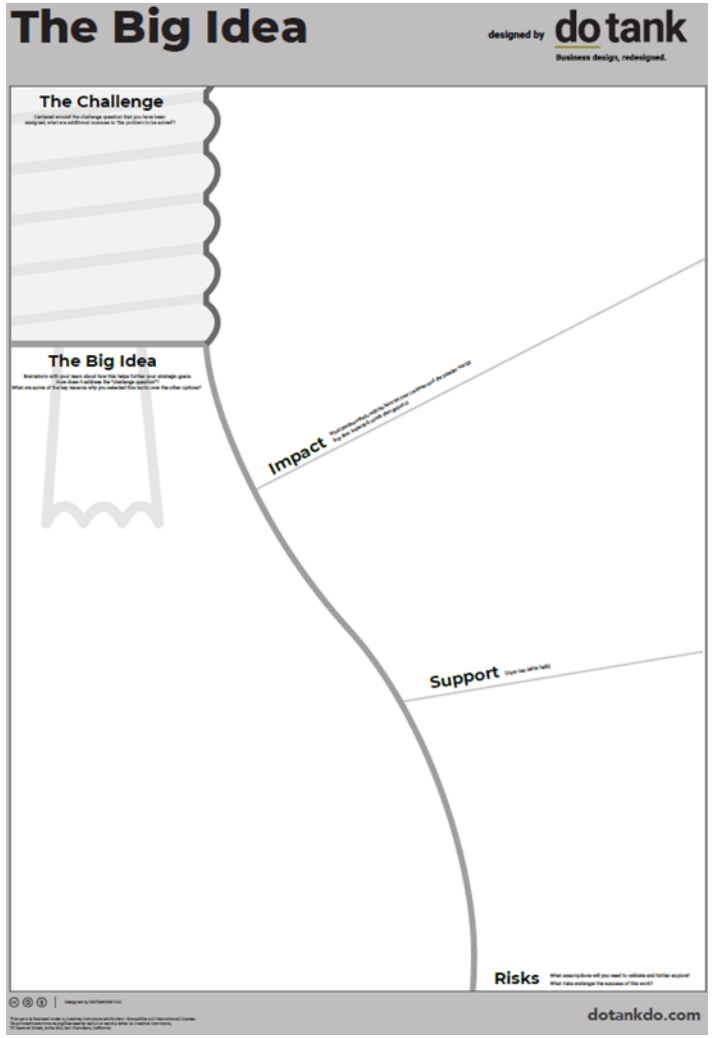
HCD Approach



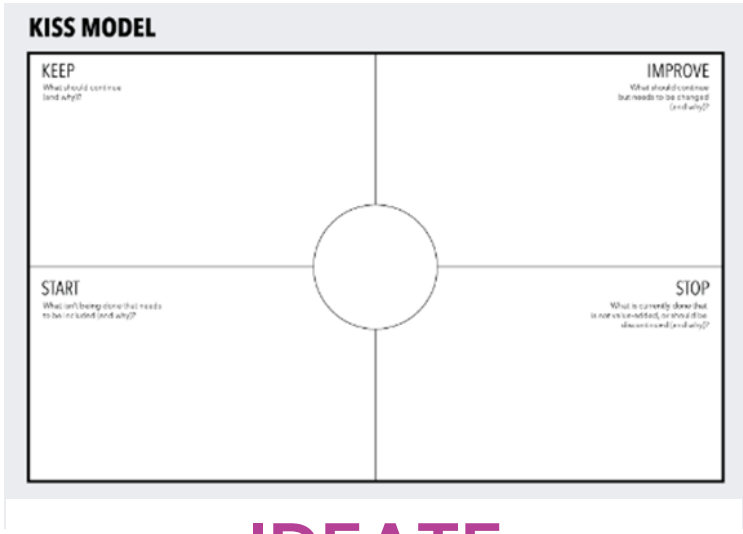
REFLECT



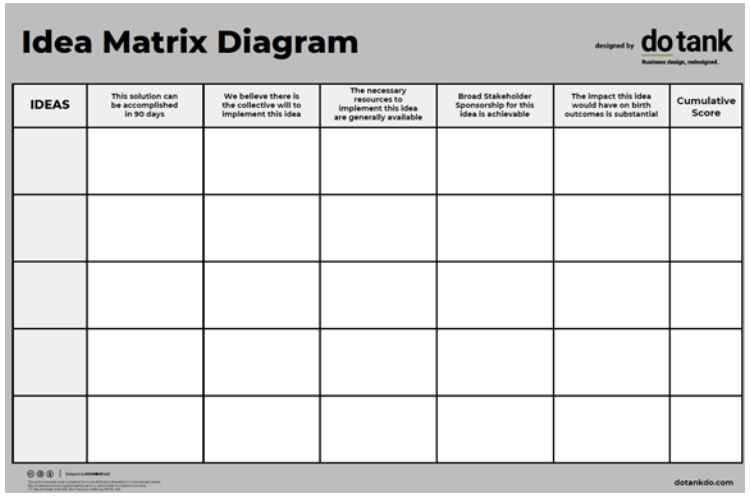
REFLECT



PLAN + SHARE



IDEATE



IDEATE

MISSOURI PQC
Perinatal Quality Collaborative

The State Report

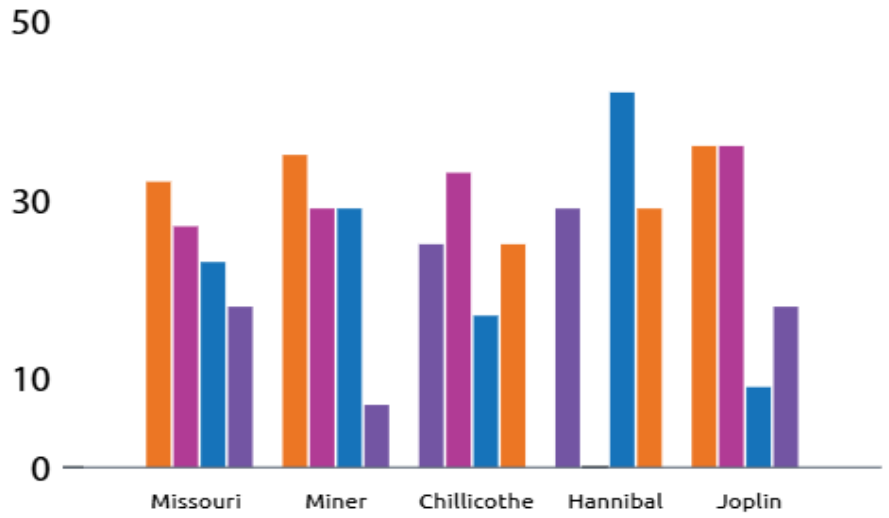
This report captures the data and feedback from these 4 maternity care deserts in Missouri

Both Regional and Statewide analysis are included in the report as well as future state ideas which should be considered

https://heyzine.com/flip-book/pqc_statereport#page/1

OPPORTUNITIES

After reflecting on their hopes, participants brainstormed the existing opportunities to improve maternal health in Missouri. A total of 62 data points on opportunities were collected across the state, with 14 data points from Miner, 12 from Chillicothe, 7 from Hannibal, and 11 from Joplin.



The data on exisiting opportunities was categorized into four high-level themes:

- **Access and Service Delivery:** Opportunities to improve access to care. This includes expanding service models, improving transportation, and leveraging technology.
- **Collaboration and System Strengthening:** Opportunities to enhance partnerships, coordination, and communication within the maternal care system. This includes building relationships, streamlining processes, and fostering a shared vision.
- **Funding and Advocacy:** Opportunities to fight against the financial and policy barriers to improved maternal healthcare. This includes securing funding, advocating for policy changes, and optimizing resource allocation.
- **Workforce Enhancement:** Opportunities to bolster the quantity and quality of the maternal health workforce. This includes recruitment, training, retention, and optimizing provider roles.

In Miner, **Workforce Enhancement** was the most frequently discussed theme. Notably, there was little discussion around opportunities for **Funding and Advocacy**.

In Chillicothe, **Access and Service Delivery** was the most frequently discussed area for opportunity, with discussions around maternal telehealth and EMS.

In Hannibal, **Collaboration and System Strengthening** was the most frequently discussed area for opportunity, with discussions around perinatal networks, collaboration between small hospitals, and communication improving with technology.

In Joplin, **Workforce Enhancement** and **Access and Service Delivery** were the most frequently discussed themes. Notably, there was little discussion around opportunities for **Collaboration and System Strengthening**.

Overall, the data indicated there are opportunities to improve the maternal health workforce with increasing doulas, training, and mentorship across Missouri, in addition to opportunities to expand the use of maternal telehealth and coordinate EMS services in the Northwest region and increase networking and collaboration in the East region.

Women living in maternity care deserts traveled 3.6 times farther than women living in areas with full access to maternity care in Missouri.

IDEAL FUTURE STATE

During the community forums, participants were guided through the KISS model, an ideation tool which helps define what actions should be taken to achieve the ideal future state. During this activity, participants defined what existing structures they should **Keep**, what existing structures they should **Improve**, what they should **Start** doing, and what they should **Stop** doing.

The data from the four regions was aggregated and analyzed together to create 4 statewide themes for each of the KISS model categories (Keep, Improve, Start, and Stop). Those themes are discussed below. In addition, each region's data was analyzed seperately.

The top theme for each KISS category is provided for each region on the following page. A more comprehensive discussion of the themes pulled from the individual regional analyses can be found in the regional reports (see appendix).

KEEP

Access to Care & Resources:
Removing barriers to essential medical care and social services for birthing people and babies. Examples include existing home visiting, telehealth, transportation, and Medicaid expansion.
Community Engagement & Collaboration:
Fostering strong relationships between healthcare providers, community organizations, and individuals to improve coordination of care and address social determinants of health.
Funding & Sustainability:
Securing and allocating adequate financial resources to support staff and infrastructure, ensuring program viability and growth. Examples include existing mileage reimbursement, incentives, and funding for all home visiting.
Quality Improvement & Workforce Development: Strategies that enhance quality of care, track progress, support professional development, and cultivate a skilled and motivated workforce. Examples include the Bootheel Perinatal Network in the Southeast region.

IMPROVE

Access to Care:
The structures in place that ensure all mothers and birthing people have timely access to necessary healthcare services. Examples include access to transportation, telehealth, midwifery services, and prenatal care and education.
Provider Support & Education:
The structures in place to equip healthcare providers with the knowledge and support they need to provide quality maternal care. Examples include loan forgiveness, OB residency spots, and implicit bias and postpartum depression training.
Mental Health & Wellbeing Support:
The structures in place to help recognize and address the mental health needs of mothers and birthing people throughout the perinatal period (pregnancy and postpartum), including prevention, screening, and access to treatment.
Systemic & Community Support:
Communication, collaboration, and structures addressing social determinants of health. This includes policy, community engagement, and advocacy.

START

Access to Care:
Removing barriers that prevent individuals from receiving care. Examples include building new facilities, developing more transportation options in rural communities, developing mobile clinics, and creating incentives for providers to practice in rural communities.
Community Empowerment & Education:
Equipping individuals and communities with the knowledge, skills, and resources to make informed health decisions and advocate for themselves.
Systemic Change & Collaboration:
Improving the healthcare system through policy changes, innovative care models, and strong partnerships.
Financial Sustainability:
Securing and allocating resources to ensure the long-term viability of maternal health programs and services.

STOP

Systemic Inequities and Discrimination:
Issues of racism, sexism, and other forms of discrimination that create barriers to equitable healthcare.
Outdated Practices and Resistance to Change:
Practices that are no longer effective or beneficial, and the resistance to adopting new, improved approaches.
Financial and Resource Mismanagement:
Issues related to funding, resource allocation, and the financial pressures impacting healthcare.
Lack of Patient-Centered Care and Communication:
Not prioritizing patient needs and concerns, and miscommunication within the healthcare system.

Regional

MINER

KEEP: Existing Programming and Resources
IMPROVE: Quality Care
START: Community Education and Having Increased Shelters, Resources and Provisions
STOP: Not Treating the Patient as an Individual

CHILLICOTHE

KEEP: Addressing Workforce and Staffing Challenges
IMPROVE: Workforce Development and Support
START: Providing Healthcare Workforce Training and Infrastructure to Improve Access
STOP: Cultural and Social Barriers

HANNIBAL

KEEP: Workforce and Professional Development
IMPROVE: Communication and Knowledge Sharing
START: Community-Based Programs and Support
STOP: Ineffective Practices

JOPLIN

KEEP: Collaborative Care and Service Delivery
IMPROVE: Resources and Infrastructure
START: Offering Options for Access and Navigation and Working Toward Systemic Improvements
STOP: Systemic Barriers to Equitable Care

Patient Empowerment & Education

The aim statements within the Patient Empowerment and Education category all focus on improving maternal and infant health outcomes, primarily through education and enhanced care. They highlight a need for increased access to information, comprehensive prenatal and postnatal support, and community outreach.

19%

OF AIM STATEMENTS FOCUSED ON PATIENT EMPOWERMENT & EDUCATION

- **Empowering Mothers and Birthing People:** Providing education and resources to mothers and birthing people is central. This includes leveraging social media, expanding education programs and focusing on prenatal education like safe sleep practices and breastfeeding support.
- **Comprehensive Care:** Improving the quality and comprehensiveness of care is another major theme. This includes whole-person care, care coordination across departments, and essential perinatal services.
- **Community Engagement:** Reaching out to the community and building support for maternal health initiatives is emphasized. This involves increasing community outreach and education and securing stakeholder alignment.
- **Overcoming Challenges:** The aim statements acknowledge potential obstacles such as copyright concerns, political/religious pushback, and the need for data-driven justification for investment. Essentially, these aim statements reflect a multifaceted approach to improving maternal and infant health, with a strong emphasis on education, comprehensive care, and community engagement.

Collaboration & Partnerships

19%

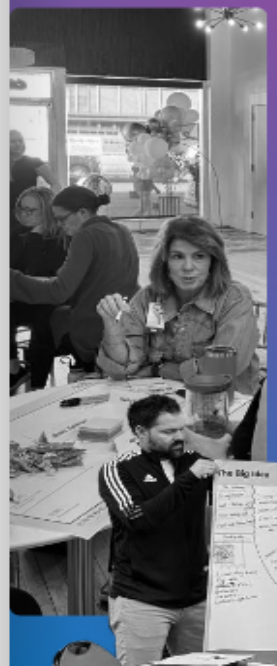
OF AIM STATEMENTS FOCUSED ON COLLABORATION & PARTNERSHIPS

The Collaboration and Partnerships aim statements emphasize a collaborative and comprehensive approach to improving maternal health outcomes with a focus on equity and addressing community needs.

- **Strengthening the System:** The aim statements emphasize improving the overall maternal health system. This includes expanding existing programs, increasing collaboration between programs and agencies, developing rural facilities, and establishing a state-wide standard of care.
- **Collaboration and Connection:** Building strong partnerships and fostering connections within the maternal health community is a recurring theme. This involves interagency coalitions, provider networking, and meaningful engagement within the maternal health community.
- **Allocation of Funds and Lobbying:** A focus on enhancing collaborative relationships with key funders and government agencies was a focus within these aim statements. Better partnerships with our key legislative stakeholders and an increase in lobbying over how funds should be allocated were key priorities.
- **Community-Centered Approach:** The statements highlight the importance of community engagement and responsiveness. This includes concerns about listening to community members and providing adequate resources.
- **Overcoming Barriers:** The statements acknowledge potential challenges such as funding limitations and ideological opposition to certain care options. The need for enhanced communication and the need to de-silo our workstreams were other key barriers.

Essentially, these aim statements reflect a commitment to building a more robust, collaborative, and equitable maternal health system that prioritizes community needs and expands access to care.

CLOSING THOUGHTS



The Missouri PQC and Missouri Hospital Association are committed to working with our members and stakeholders across the state to enhance maternity care outcomes. This Community Forum series was an opportunity for us to canvas the state and garner feedback from those stakeholders which are closest to the community. The prevalence of maternity care deserts in rural areas of Missouri are apparent, with 39.2% of women living over 30 minutes from a birthing hospital compared to 6.9% of women living in urban areas[1]. This report represents the voice of those mothers and birthing people.

Our state has adopted some important policies and functions aimed at enhancing maternity care outcomes throughout the state: Medicaid expansion, a federally funded Pregnancy-Associated Mortality Review program, a Fetal and Infant Mortality Review team, and a strong Perinatal Quality Collaborative[2]. These are foundational components that are going to move our state in the right direction, but, as this report demonstrates, there is a need for more investments if we are to enhance maternity care outcomes.

While there is much work to be done, there is ample energy, strengths, hopes and opportunities to lean into, as evidenced by this report. We can harness these positives and translate that energy into investments which need to be made. The rural stakeholders in maternity care deserts throughout the state voiced those investments they think need to be made for an ideal future state. As evidenced by the "Big Ideas" in this report, our rural constituents are calling for enhancements in access to care, workforce development, patient empowerment/education and collaboration/partnerships. Together, we can and will make a difference for mothers and birthing people across this state.

The Missouri PQC and Missouri Hospital Association are committed to being trusted voices and partners in this effort to enhance maternity care outcomes. Our teams want to thank all of the stakeholders who contributed their voices to these Community Forums and this report. We look forward to working with all of you on our quest to enhance maternity care outcomes for every mother and birthing person in Missouri.

APPENDICIES

View the regional reports here:

Miner

Chillicothe

Hannibal

Joplin

Sources

1. WHERE YOU LIVE MATTERS: MATERNITY CARE IN MISSOURI, March of Dimes, https://www.marchofdimes.org/peristats/assets/s3/reports/2024-Maternity-Care-Report.pdf
2. EXECUTIVE SUMMARY, March of Dimes, https://www.marchofdimes.org/peristats/assets/s3/reports/2024-Maternity-Care-Report.pdf

Aim Statements

from the Big Idea Canvas

Here is a link to all 21 of the Big Idea Canvases which teams framed out at the regional meetings. The aim statements in this report were synthesized from inputs into these Big Idea Canvases.

Miner

1. We aim to expand our existing maternal health programs and increase collaboration between programs by improving education, streamlining feedback processes, securing more funding, and developing our rural facilities. The impact of this work will be increased knowledge and access, improved maternal health equity, and more community voices being elevated. Prior to starting this work, we are worried about failing to listen to community members and providing inadequate resources as a result. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help us secure funding, educate providers, and provide networking opportunities for providers.

2. We aim to ensure better patient care and birthing outcomes for mothers by valuing patient experience, listening to patients, instituting implicit bias training, and reducing existing stigmas. The impact of this work will be more fulfilling birth experiences, equitable care, improved quality of care for all, and improved mortality rates. Prior to starting this work, we are worried about distrust, close-mindedness, a lack of collaboration, and a lack of funding being barriers to our success. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help us coordinate collaboration, provide training, and access funding.

3. We aim to provide whole-encompassing maternal and child health resources by having perinatal and postnatal nurse navigators that provide patients with resources throughout the entire birthing process. The impact of this work will be increased access to resources and education that leads to healthier lives. Prior to starting this work, we are worried about a lack of maintenance of the system we set up and a lack of collaboration. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help us create resources, advertise them, and collect data on the success of this initiative.

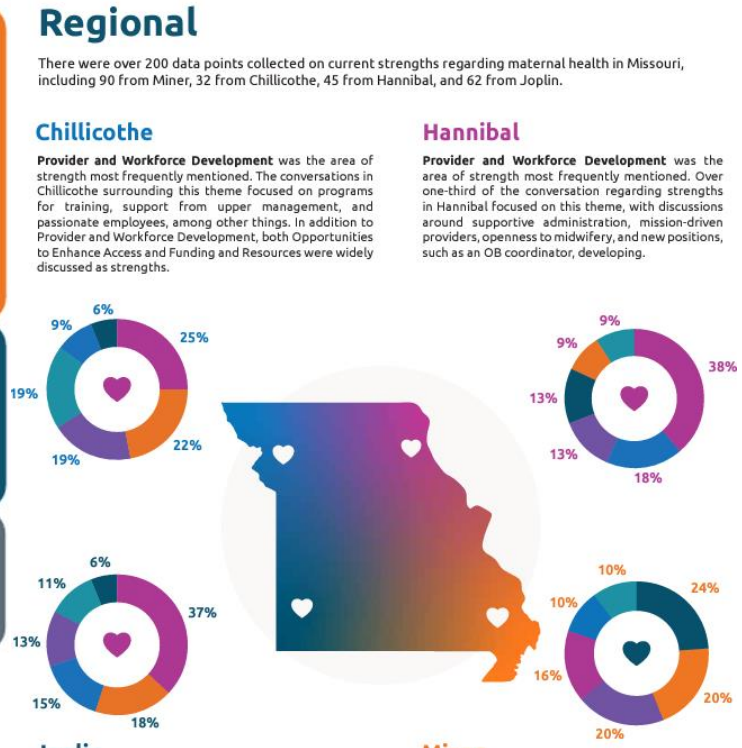
4. We aim to increase access to information by leveraging social media and providing education on pregnancy and breastfeeding. The impact of this work will be more informed and empowered moms. Prior to starting this work, we are worried about copyright, permissions, and information being misinterpreted. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help us provide social media training and share resources and content from other healthcare systems.

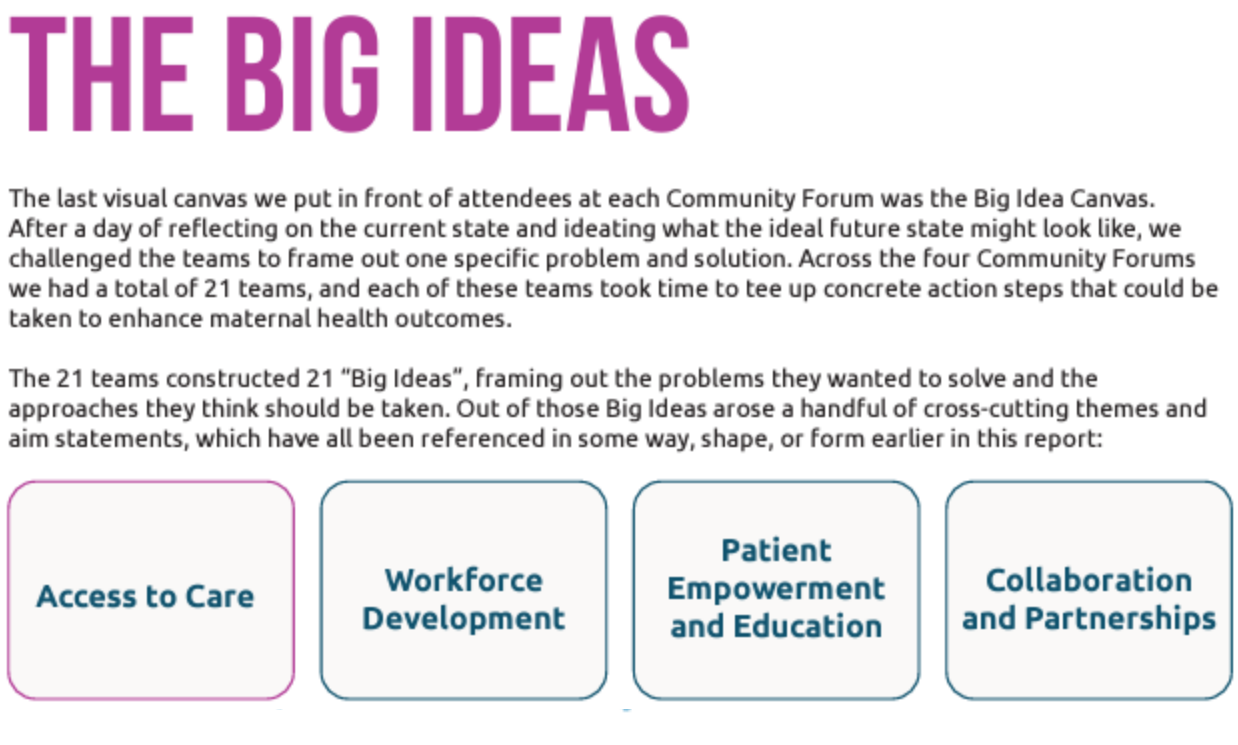
5. We aim to increase access to care by securing a grant to launch a transportation initiative. The impact of this work will be increased access to care, improved patient outcomes, and a healthier Missouri. Prior to starting this work, we are worried about securing funding and having strong community outreach. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help us secure funding.

6. We aim to increase the use of maternal health services by improving the existing services in our community. The impact of this work will be improved health outcomes for Missouri. Prior to starting this work, we are worried about the demands being greater than our infrastructure can meet or existing services continuing to be unused. In order to minimize these risks and succeed at this initiative, we would like MO PQC and MHA to help organize transportation to existing services and outreach about these services.

Human-Centered Design Process:

Problem Exploration | **Problem Definition** | **Solution Ideation** | **Prototyping & Refinement** | **Scale & Spread**





S

H**ow are people** experiencing this problem?

Concept Validation

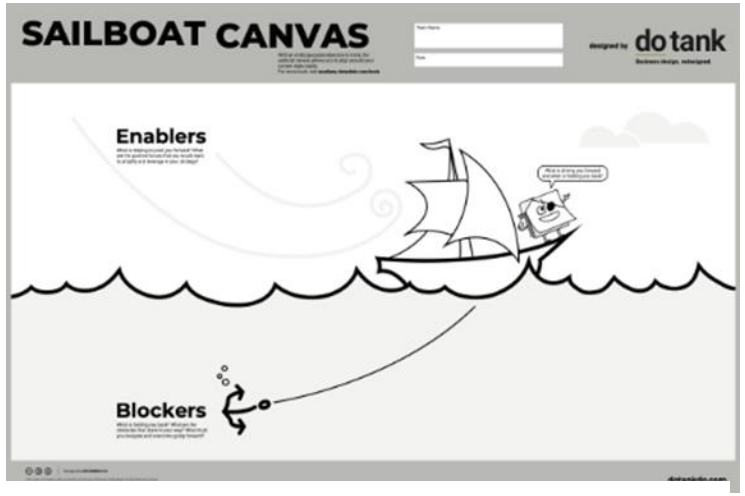
Does this concept meet the needs of the potential user?

User Testing

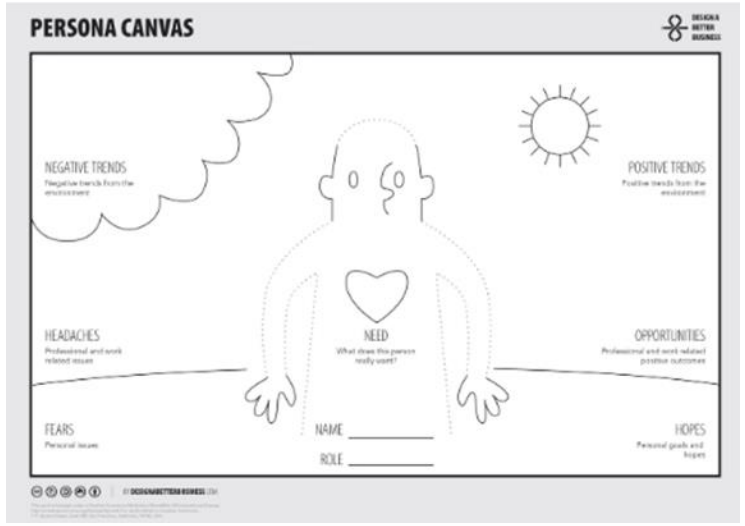
How does this functionally work? How can we iteratively improve our prototype?

MISSOURI PQC
Perinatal Quality Collaborative

HCD Approach



REFLECT



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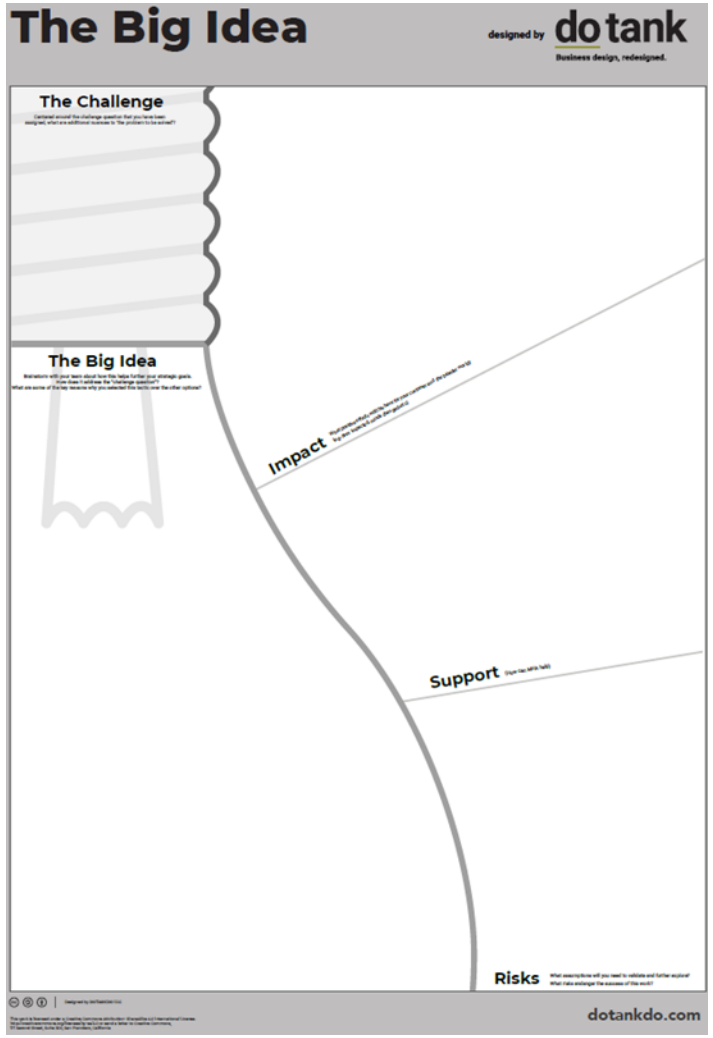
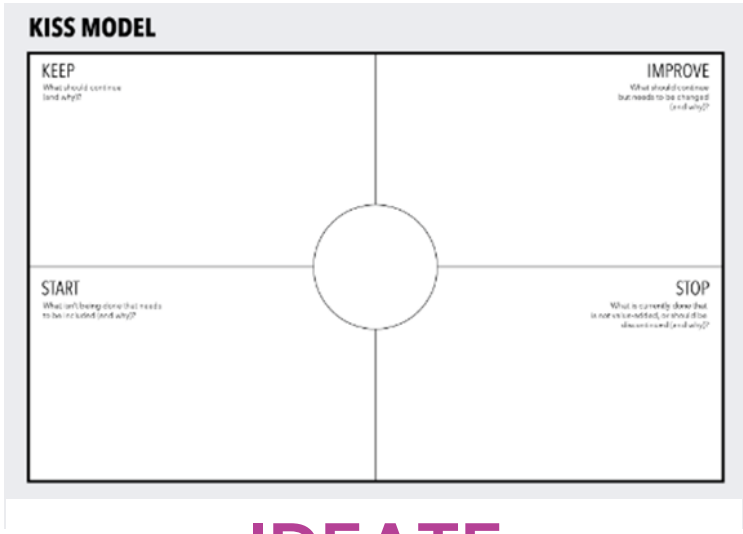
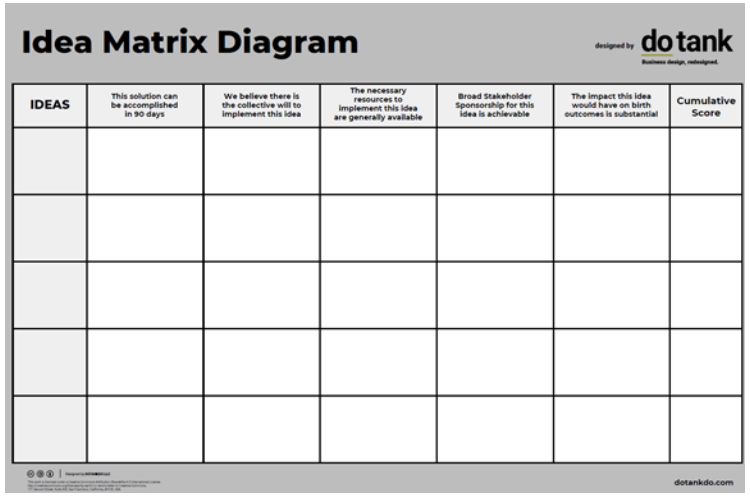


PLAN + SHARE



IDEATE



IDEATE

MISSOURI PQC
Perinatal Quality Collaborative

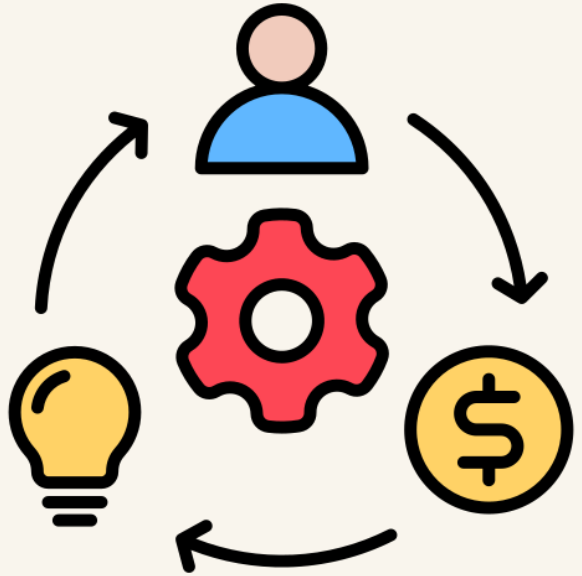
Concept Development

1.) Your Change Initiative Has a Business Model

A Business Model

Describes the rationale of how an organization creates, delivers, and captures value.

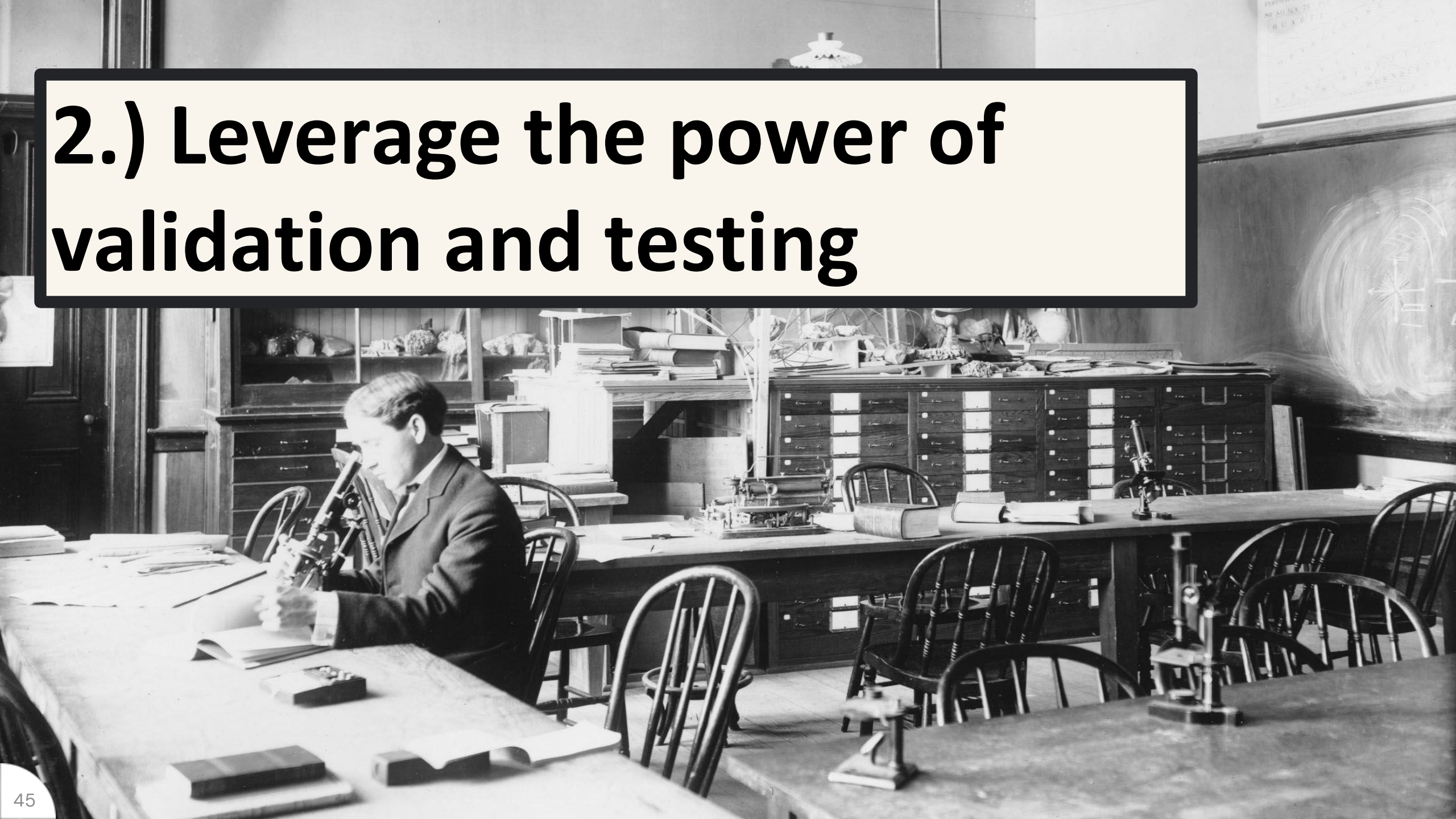
– Business Model Generation



Regarding your proposed change…

- What key internal people will it impact?
- What value does the change provide THEM?
- Through what channels will you communicate with your audience?
- What value will the change create?
- Will new resources be required to make and sustain the change?
- What key partners will be required?
- What are the associated costs?

2.) Leverage the power of validation and testing



The stated rationale is the improvement of the the change initiative…

BUT by giving people the space and respect to offer their input, you invite creative thinking along with deeper understanding and ownership of the change.

What is a MVP [S]?

The minimum set of features for an initial product that you can afford and that will solve an important enough problem for target customers. A customer's purchase and use of your MVP will provide vital feedback for you to improve the product for a broader market.

It will also demonstrate to potential funders that your product or service has real potential.

Definitions Matter

Prototype

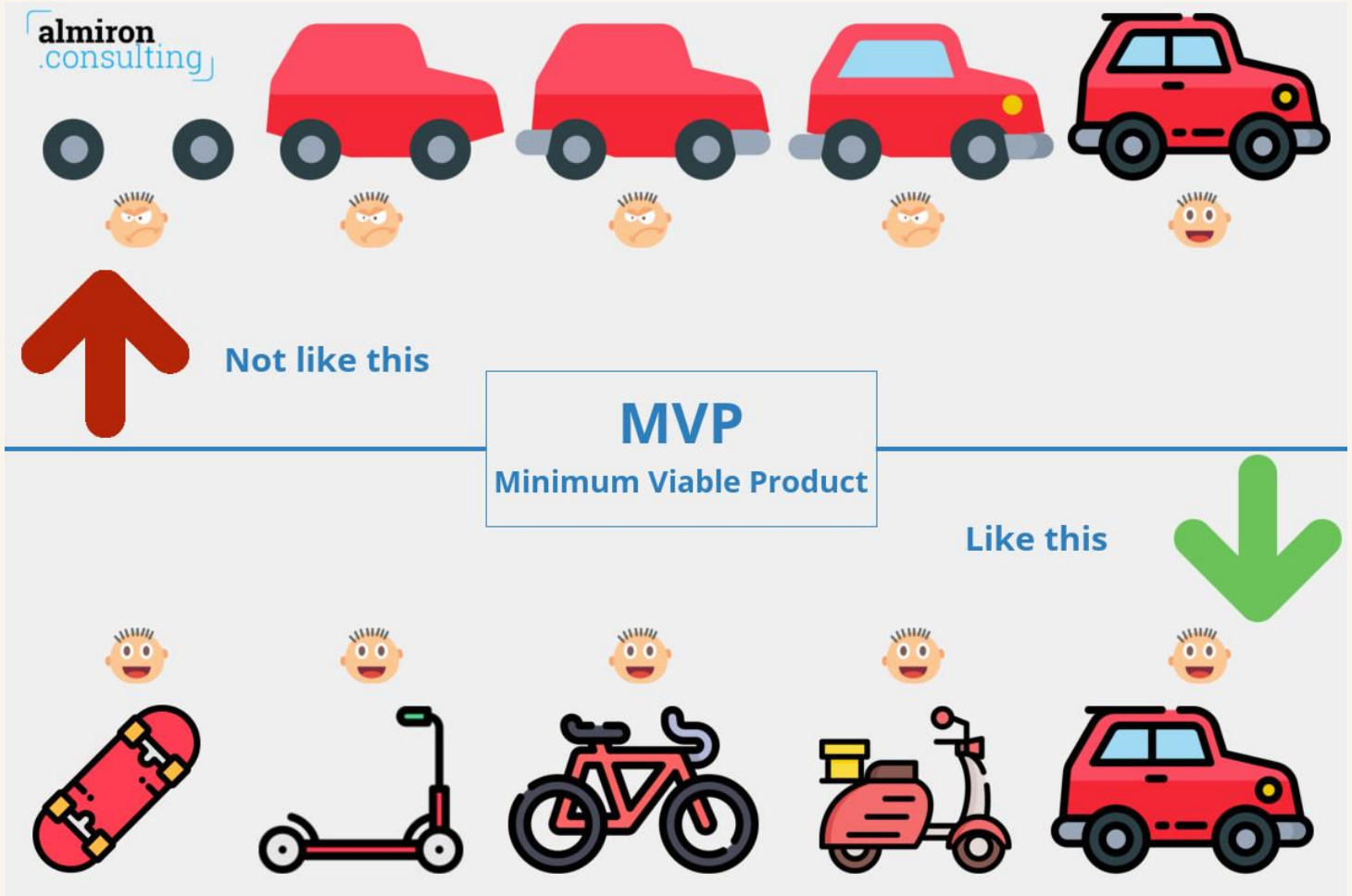
Feedback Only

Minimally Viable Product

Minimally acceptance
first launch

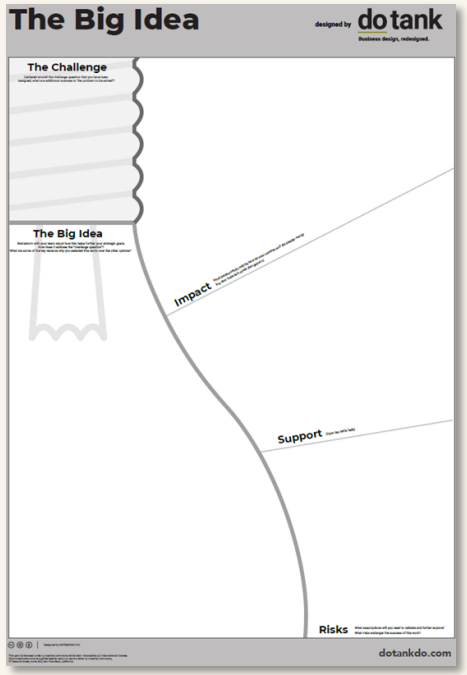
Scaled Product Launch

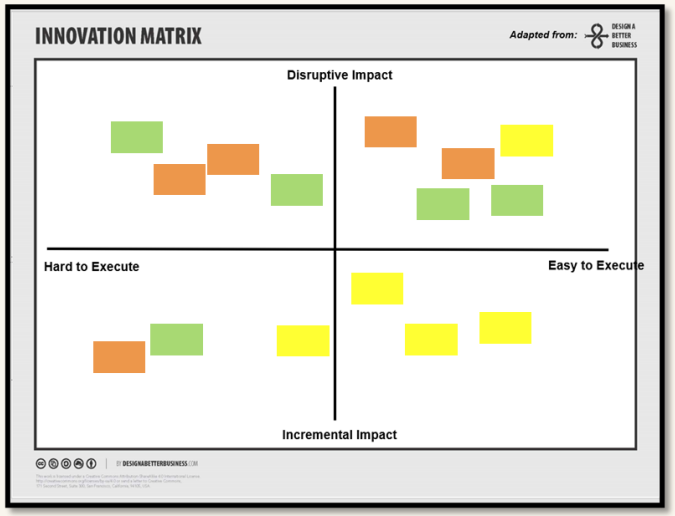
MVPs Need To be Valuable AND Allow for Iterative Improvements

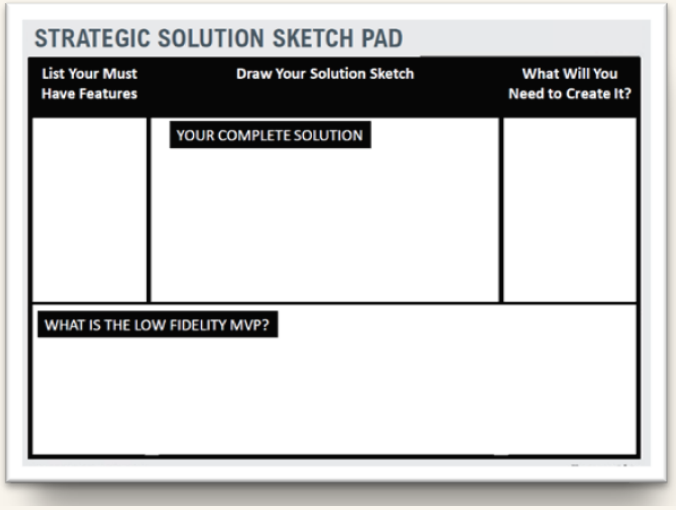


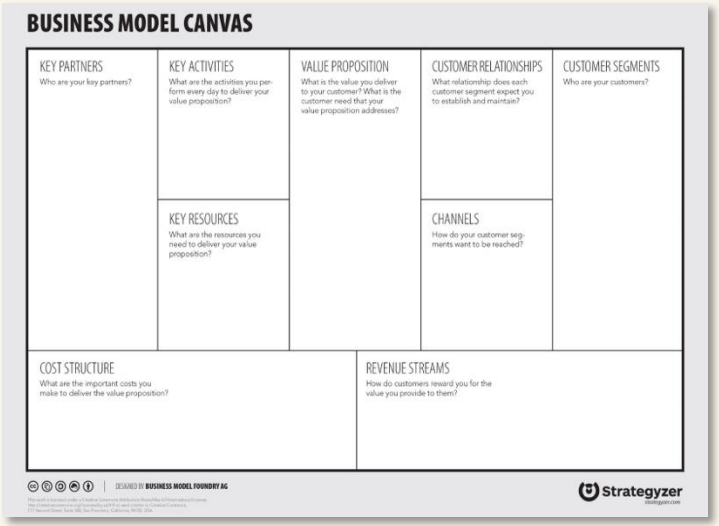
Source: https://almironconsulting.com/marketing/mvp-minimum-viable-product-agile-scrum-lean-startup-371/#.W3gmq-hKjlU, 2018.

Specific HCD Tools Help with Idea Selection and MVP Creation

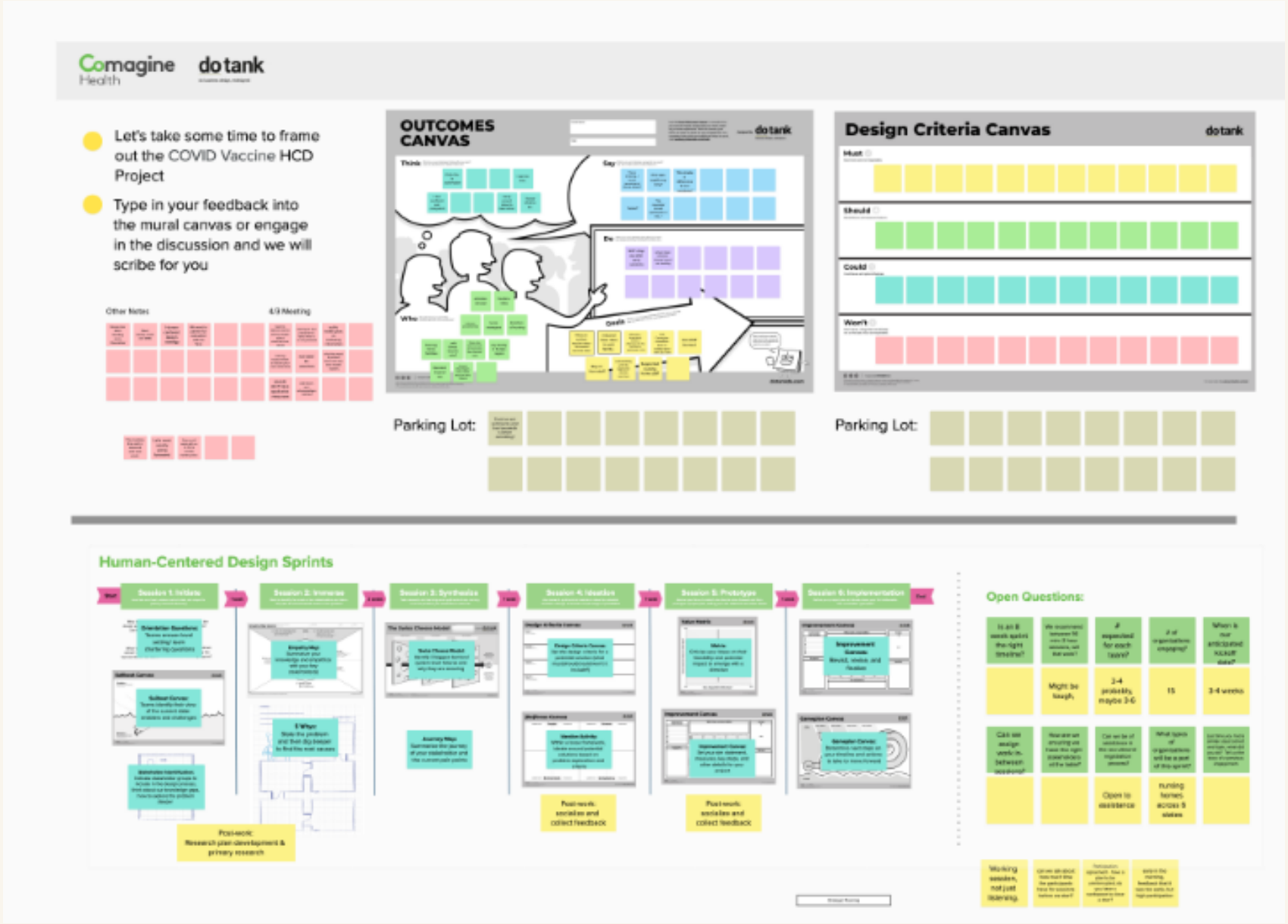






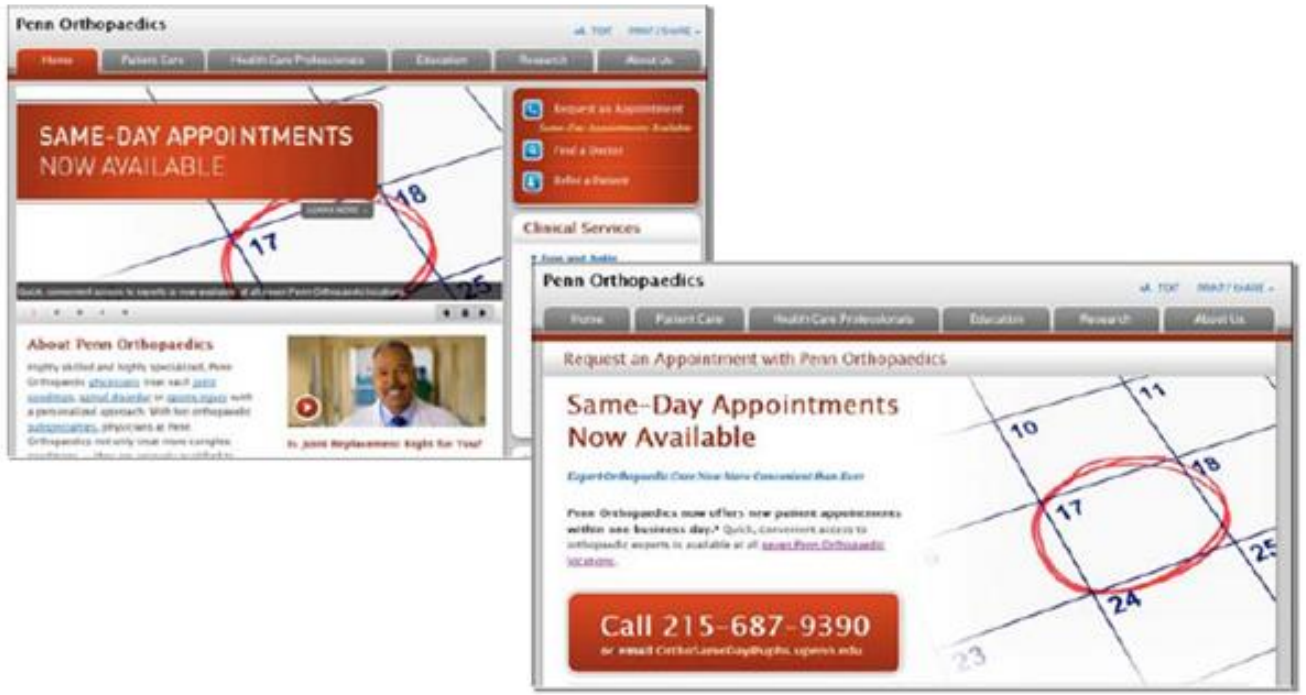


Example: Creation of a MVP to Address Vaccine Hesitancy



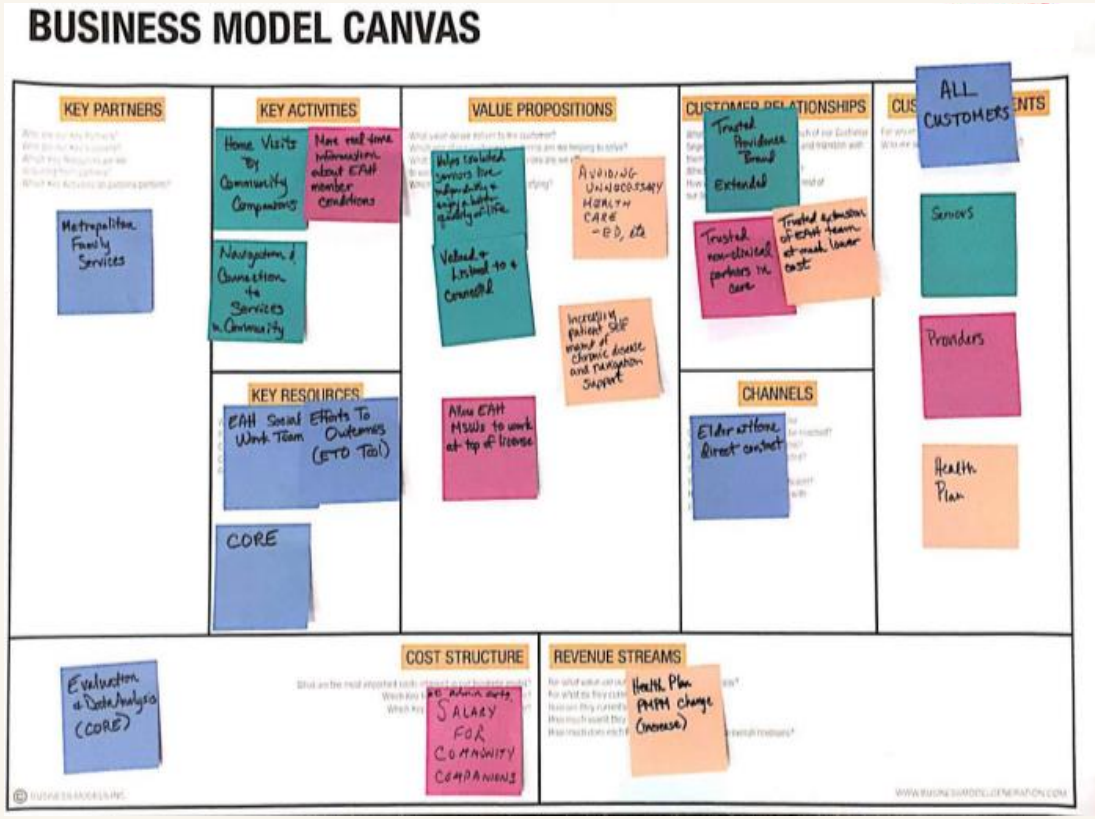
Example: An MVP for Same Day Scheduling

Ortho at Presby: Same Day Scheduling

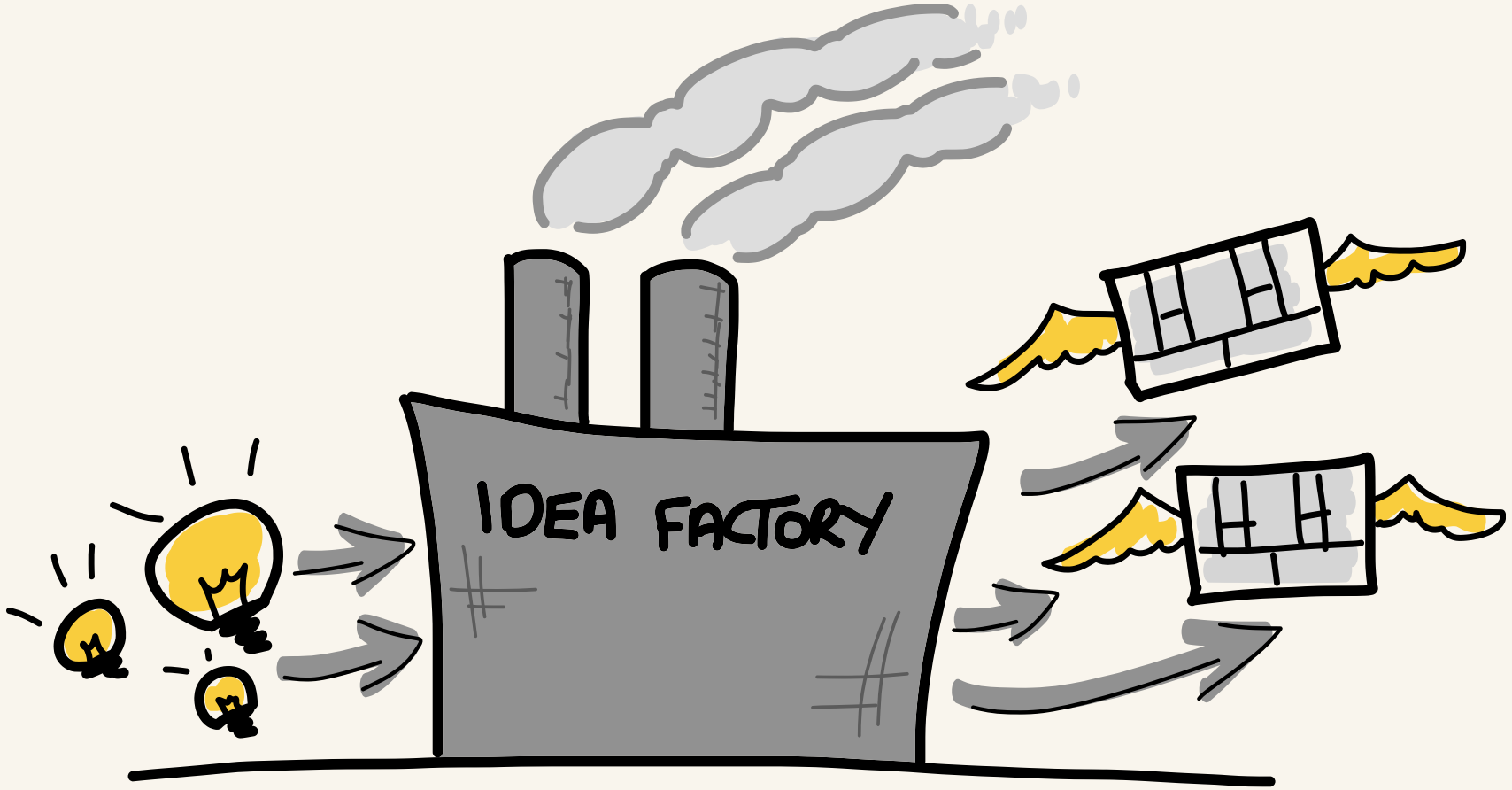


3 days, 40 inquiries, 29 appts, IBC mix 20->79%, 46% new to Penn

Example: New Approaches to Senior Peer Networks



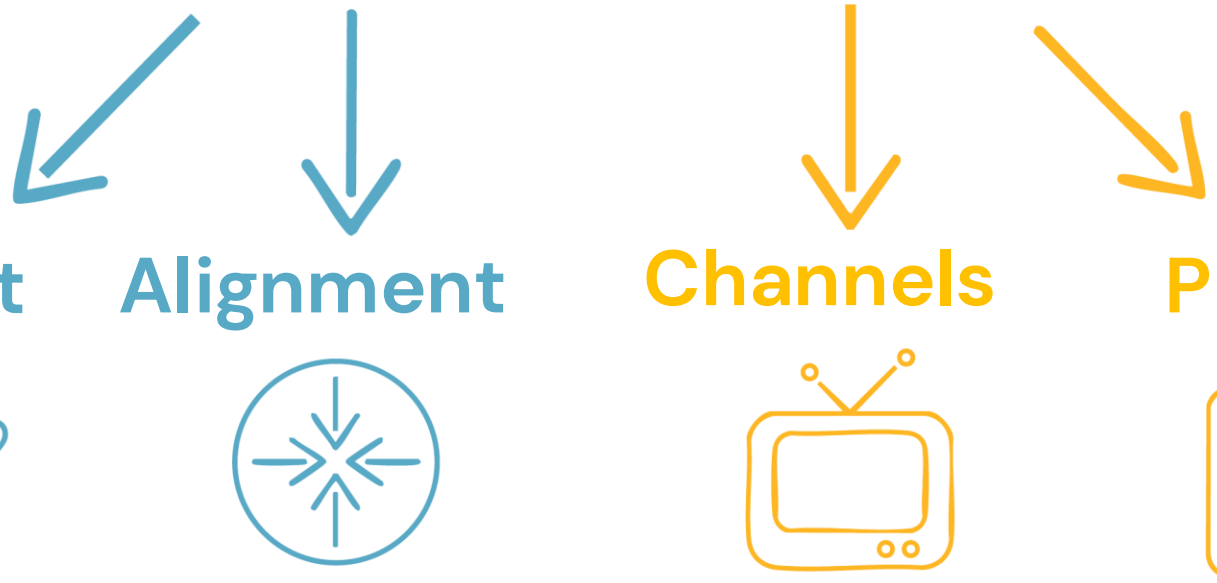
Viable Business Models Anchor the Hand-off From Concept Development to Value Creation



Value Creation

1.) Storytelling is critical

Story + Telling



“Storytelling” helps you refine your strategic plan and fortify your team culture. It accelerates your work and helps you reach your goals.

Head

Heart

Eyes

2.) It is important to create experiences for people

You can’t just give people a recipe. Teach them how to cook…

It is critical that you go beyond updated operational manuals and KPIs (those are important though) and think about interactive workshops, town halls, short video interviews, etc.

Value Creation:
Best Practice, Scale & Storytelling

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Accelerating Improvement at the Point of Care

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

GREAT LAKES
PARTNERS FOR PATIENTS

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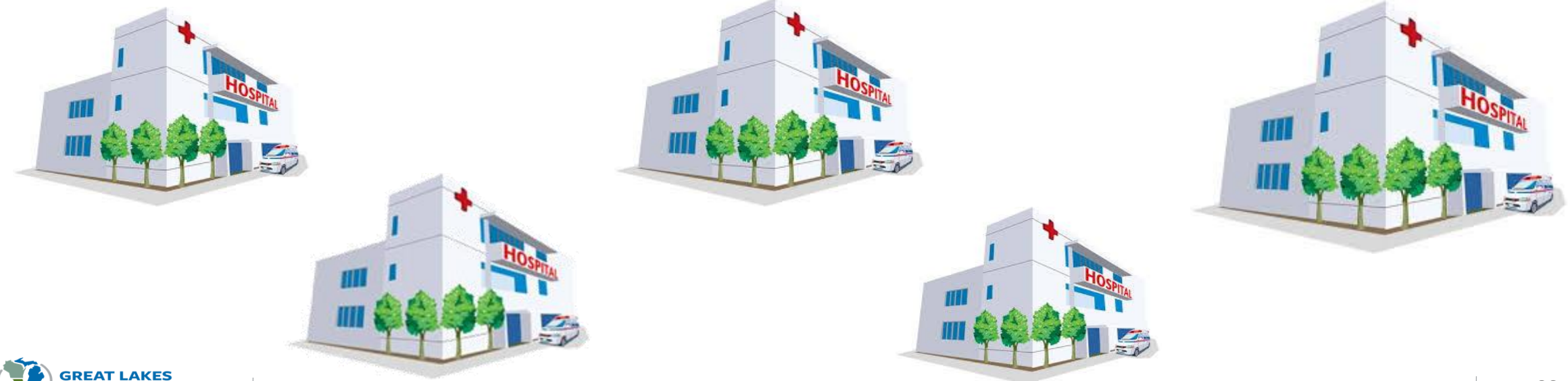
Accelerating Improvement at the Point of Care

IHA
Illinois Health and Hospital Association

MHA
Keystone Center

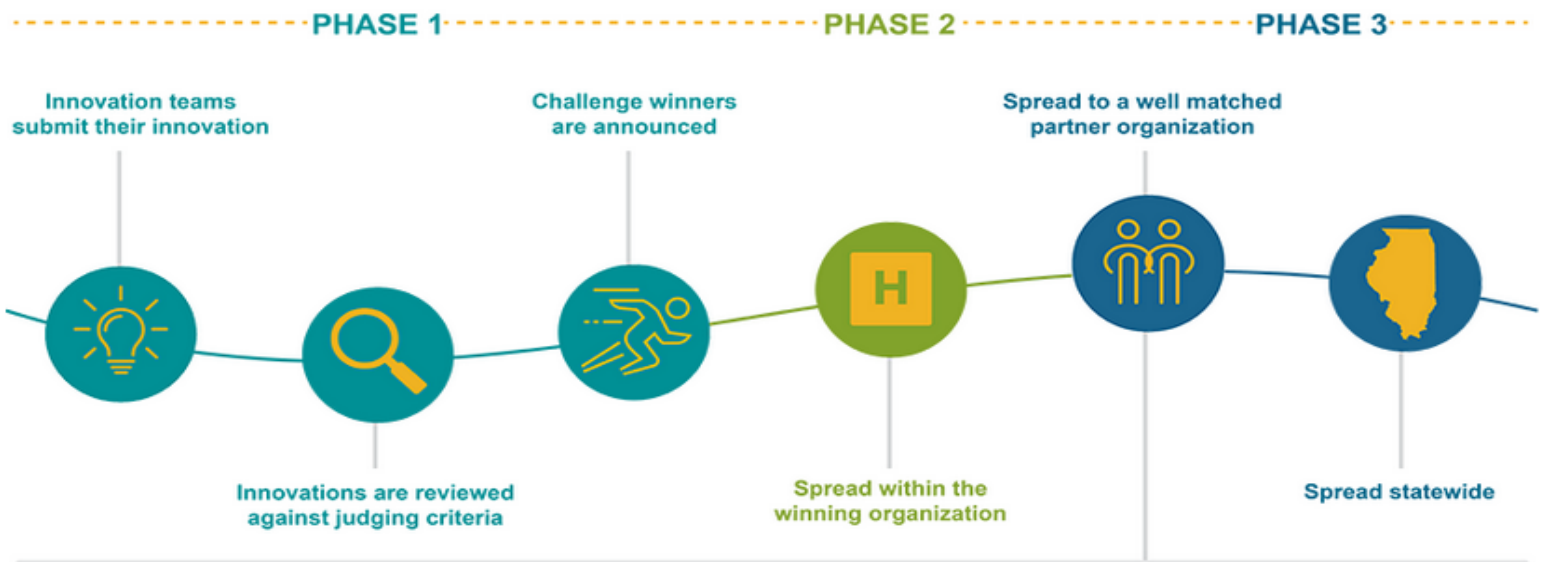
WHA
WISCONSIN HOSPITAL ASSOCIATION



Innovation Challenge

THE JOURNEY

The *Partners in Progress* Challenge addresses innovations that are having a positive impact in any of the CMS-designated 11 harm areas. Innovations that are submitted to the Challenge need to be supported by a dyad consisting of an "in the trenches" innovator and a leader who can make change happen. Teams need to be from an Illinois-based HIIN hospital or health system.



PAYING FORWARD IS A REQUIREMENT FOR PARTICIPATION

The winning teams need to be willing to partner with another well-matched hospital within Illinois who has been identified as an 'adopting-ready' organization for this particular innovation. Each winning team actively works with a partner organization for 6 months to introduce that innovation. IHA continues to serve as a core project resource to both organizations, bringing the full strength of the Association to this Challenge.


PERSONA CANVAS
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Clinical Playbooks

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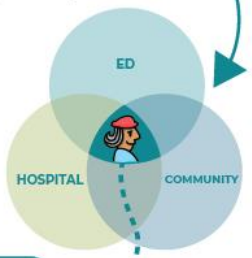
INDIVIDUALIZED CARE PLAN

ED Recidivism & Unnecessary Hospital Admission & Readmission

The ICP program identifies the ED recidivist patient and then uses a team approach to facilitate access to appropriate care, treatment and resources for that patient. The goal is to create a unified and safe approach that is unique to the patient. The care plan begins in the ED but the success of the innovation is the collaboration with family, community and hospital resources. The interdisciplinary core group treats the patient holistically: body, mind and spirit.



Recidivist Patient

We had a A-HA moment . . . when we get to the root cause of why people keep coming back to the ER we can actually make an impact

Dawn Moeller
Innovation Challenge Awardee
Clinical Manager for Emergency and Trauma Services
Emergency Department at Advocate Aurora Health

Jennifer Mowen
Spread partner
Administrative Director, Performance Improvement & Management Systems
Illini Community Health

After launching the ICP progra our 3 recidivist had 9 visits combined in 3-months.

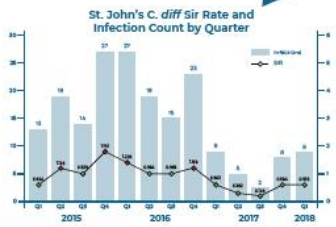
RESULTS

- ED recidivism reduced by **61%** projected cost savings is **$4,093,068**
- ED readmission reduced by **53%** projected cost savings is **$1,994,070**
- **5** year projected cost savings is **$6,897,138**
- Human impact: over **900** lives touched

IP TESTING REVIEW

Reduce hospital acquired C. difficile infection

The implementation of a collaborative team review process for C. difficile infection exposed that testing was being done for the wrong reasons. The IP team then evolved the process to continuously monitor C. difficile infection. This new process resulted in a sizable reduction in infections.



At first there was some resistance from physicians but we provided the data about why this was important and made it clear this was designed to be a partnership.

Matt Yarnell
Innovation Challenge Awardee
Director, Quality
HSHS St. John's Hospital

Connie Noltemeyer
Spread Partner
Director, Quality and Patient Safety
Amita Health Presence Health

Physician buy-in is essential, once we had the chair of internal Medicine on board we knew we were going to be OK

RESULTS

- **78%** Reduction in HAIs in One Year
- **Easily** Adaptable
- **Simplistic** Approach
- **$600k** Annual Savings

PLINARY

red infections

- Increased awareness and accountability
- Devices are in place for fewer days
- Patient safety increased

RESULTS

- **15** minute Daily Interdisciplinary Huddle
- **90%** reduction in CLABSIs and CAUTIs
- **$498k** estimated cost savings

INTRODUCING THE PLAYBOOK

IHA INNOVATION CHALLENGE: IMPLEMENTATION PLAYBOOK

Emergency Department Recidivism & Unnecessary Hospital Admission & Readmission

900 Patients Impacted

53% Drop in ED Readmission

61% Reduction in ED Recidivism

17 Hospital implementations

Illinois Health and Hospital Association

AdvocateAuroraHealth

ABOUT THIS PLAYBOOK

Playbook Steps

STEP 1
Read the playbook guidelines and appreciate the context and the people that are involved.

STEP 2
Walk through each of the process steps and take advantage of the external information where available. You may need to refer back to the guidelines from time to time. The Playbook aims to inspire hospitals to be able to pick this up, knowing nothing about the process, and after reading it have a good handle on what the process is and what steps they could take to replicate it.

STEP 3
Digest the results and impacts and review where the process steps make sense and/or could be a challenge for your hospital.

STEP 4
Gather your team and gameplan your critical next steps to making this happen at your hospital.

How it Came to Be

Our strategic partner, Do Tank, worked closely with the IHA and hospital teams throughout the Innovation Challenge to design strategies, implementation plans, and these playbooks. The document that you are reading emerged over a 4 week process that involved interviews, mining documentation, reflections on the yearlong Challenge, and multiple iterations.

do tank
do business design, redesigned

The Cast of Characters

The storyline behind the Playbook involves these wonderful people, places and organizations.

Additional Content

You will find additional content in the Playbook via links to external resources.

DON'T MISS THEM!

(Look for this icon)

Extra Resouces

Innovation Challenge Awardee

Dawn Moeller

Clinical Manager for Emergency and Trauma Services

Emergency Department at Advocate Aurora Health (Award Site)

Spread Partner

Jennifer Mowen

Administrative Director, Performance Improvement & Management Systems

Illini Community Health (Spread Site)

CHALLENGE

ED Recidivism & Unnecessary Hospital Admission & Readmission

Project background

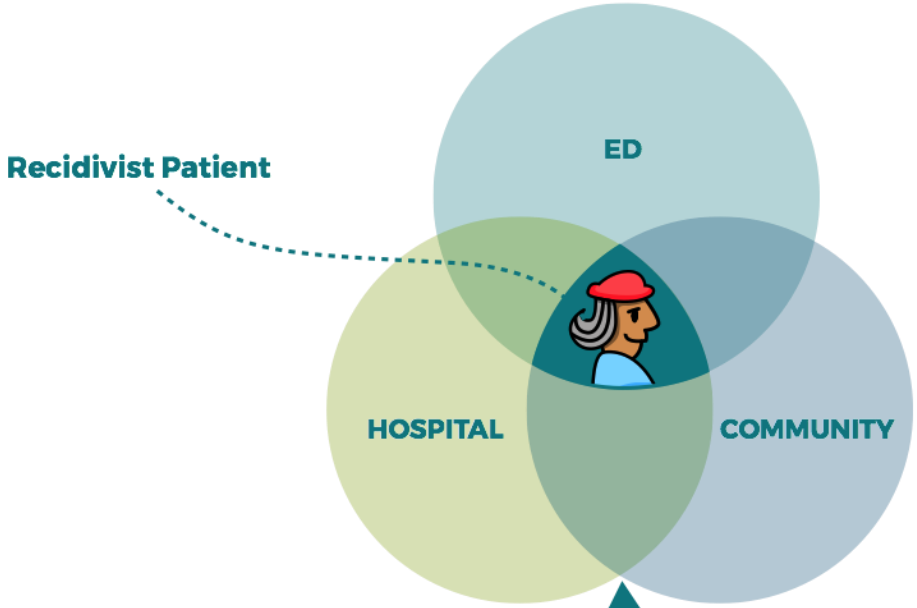
Hospital ED recidivism and readmissions are up due to a number of factors including increased substance use disorders and mental illness. ED recidivism and readmission can be reduced, and with that a tremendous cost savings, by developing an ICP (Individual Care Plan) for frequently admitted patients in order to best meet their needs.

Why it's IMPORTANT to do

The ED delivers episodic care, and patients get fragmented care when they keep coming back. Providers feel frustrated when they can't deliver the kind of care these patients need. The ICP was designed to get at the root causes of readmission by providing a plan for frequent ED patients and a network of resources to address these problems. The team was able to empower patients to access community resources that make a difference in their own care.

Recidivism and readmission was reduced dramatically.

AdvocateAuroraHealth



INNOVATION

ED ICP Program Overview for IHA

Facility Assessment Worksheet

ICP
(Individualized Care Plan)

The ICP program identifies the ED recidivist patient and then uses a team approach to facilitate access to appropriate care, treatment and resources for that patient. The goal is to create a unified and safe approach that is unique to the patient. The care plan begins in the ED but the success of the innovation is the collaboration with family, community and hospital resources . The interdisciplinary core group treats the patient holistically: body, mind and spirit.

UNIT REPORTING

Each unit reports variables at DISH, including device use, indications and plans for removal. Isolation cases in their units are also reported.

3

KEY ACTIVITIES

- Daily 15-minute DISH meeting at 8am
- CVC and IUC usage are reported by nurse managers. The ICP reviews indications, duration, and plans for device removal.

KEYS TO SUCCESS

- Increased awareness of central venous catheters and urinary catheters and their impact on device utilization
- A new, holistic level of awareness for front line staff
- Better collaboration amongst staff - a healthy and interactive culture of safety
- Reduction in device use.

CHALLENGES

- When barriers for removal remain, such as provider preference, the CNO, Medical Director of Infection Control or Chief Quality Officer are involved
- Ensuring same day resolution of issues.

WHO IS INVOLVED?

Representatives of all units and departments in the hospital.

Key Participants Include:

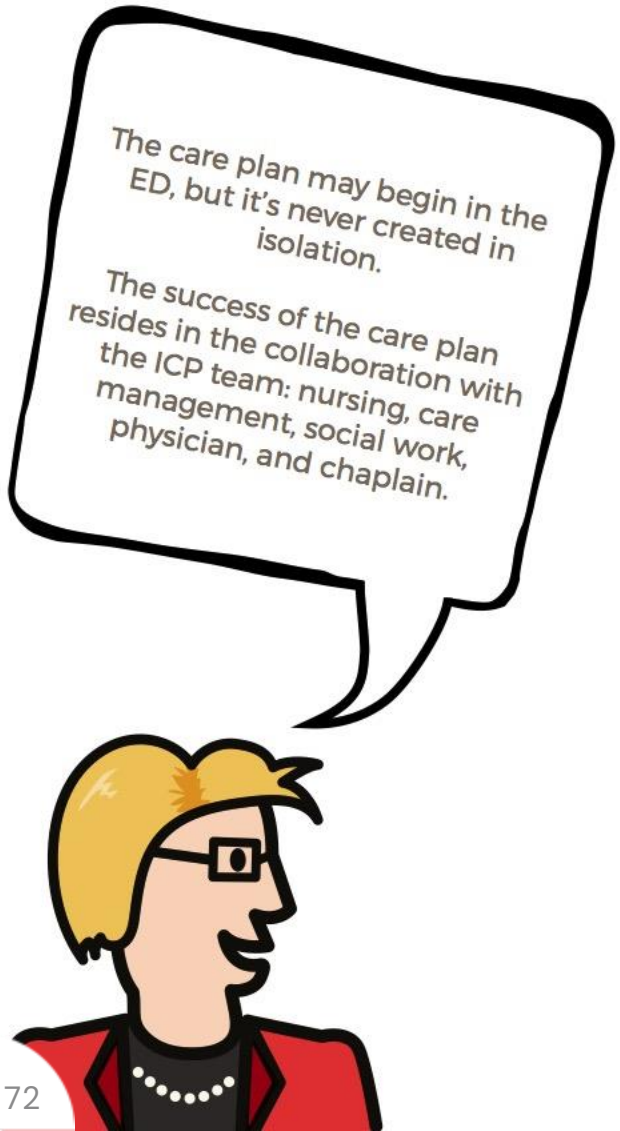
- Chief nursing officer (CNO)
- Infection control practitioner (ICP)
- Managers of all hospital units.

Impact of Hospital Wide DISH

Some of the barriers were changes in leadership, commitment from leadership but the results speaks for itself

We attended rounds to increase awareness of physicians by asking "why do we need to have that device?"

RESULTS & IMPACT



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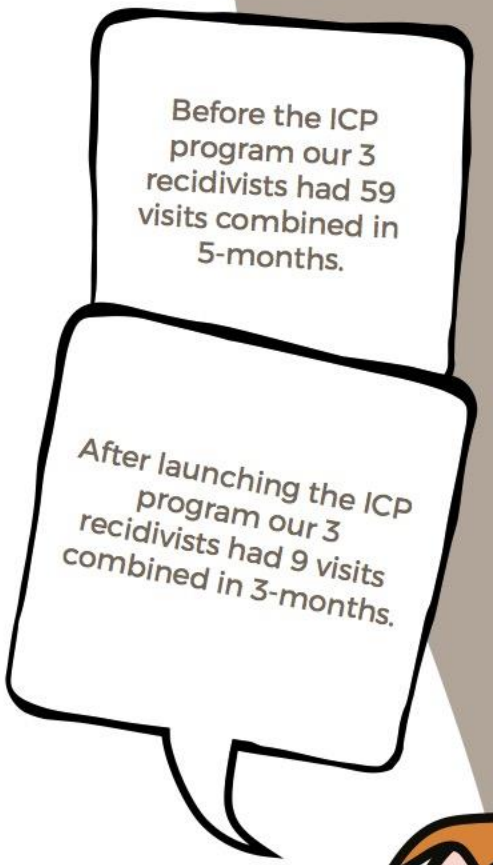


This program really works and is powerful!

Since implementing the program, our organization has learned many lessons. The ICP program is intuitive and practical. It makes sense to the health care team members because it is relatively easy to implement and even more importantly, it is easy to sustain.

Dawn Moeller

REFERENCE MATERIALS

Introduction Materials

- ICP Program Overview

Implementation Plan and Preparatory Work

- Pre-ICP Program Implementation Check List
- Facility Assessment Worksheet
- ICP Program Implementation Education Plan
- Baseline ICP Data Expectations
- Process and Outcome Data Measure Timeline

Health Information Technology

- Leveraging the Electronic Medical Record

ICP Plan Guidelines

- Emergency Department Individualized Care Plan Program Operational Guidelines

ICP Algorithms and Standard Work

- ED Team Practical Application Process Map for Implementing the ICP Plans
- ED Team Practical Application Process Map for Referral Request for New Patients to ICP Program
- Managing Confirmed Cases of Child Maltreatment Care Pathway

Forms and Tools

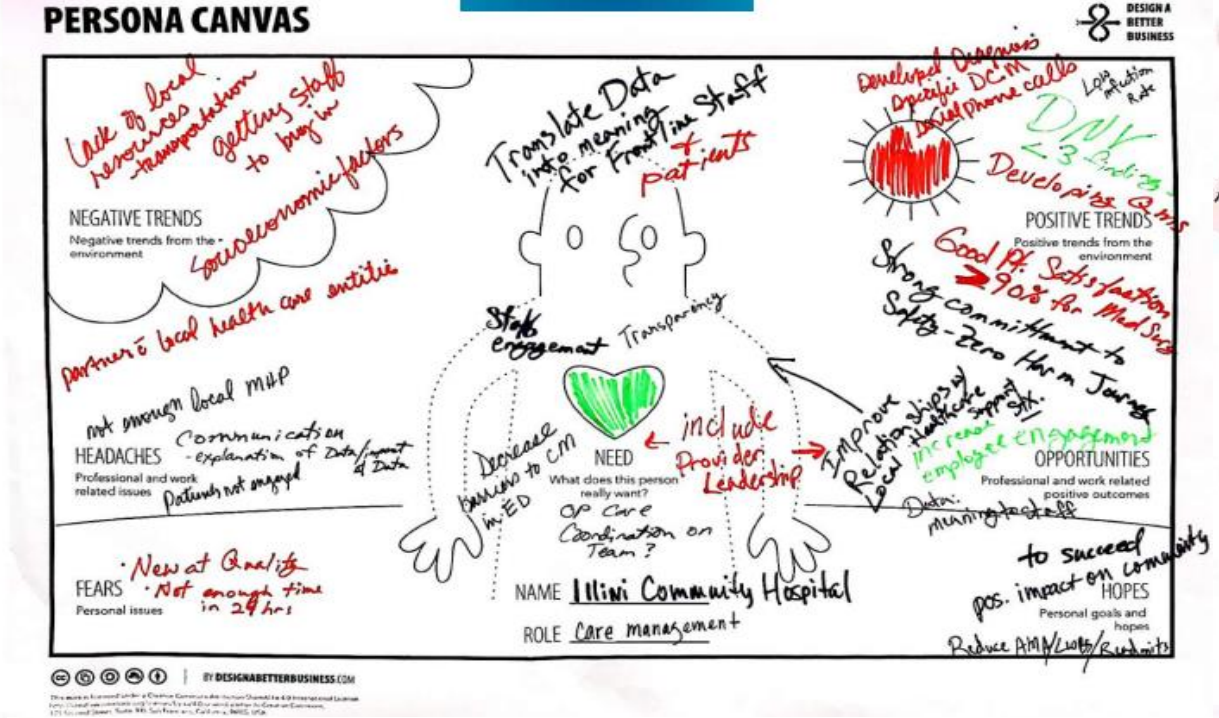
- Emergency Department ICP Template, ED Therapeutic Agreement
- ED Chronic Pain and Narcotic Management Guidelines Flyer (Patient Education)
- Physician Notification Letter Template
- Patient Notification Form for Chronic Conditions and Special Needs Template
- Patient Notification Form for Chronic Pain
- Child with Special Needs Letter
- Child with Special Needs Emergency Information Form

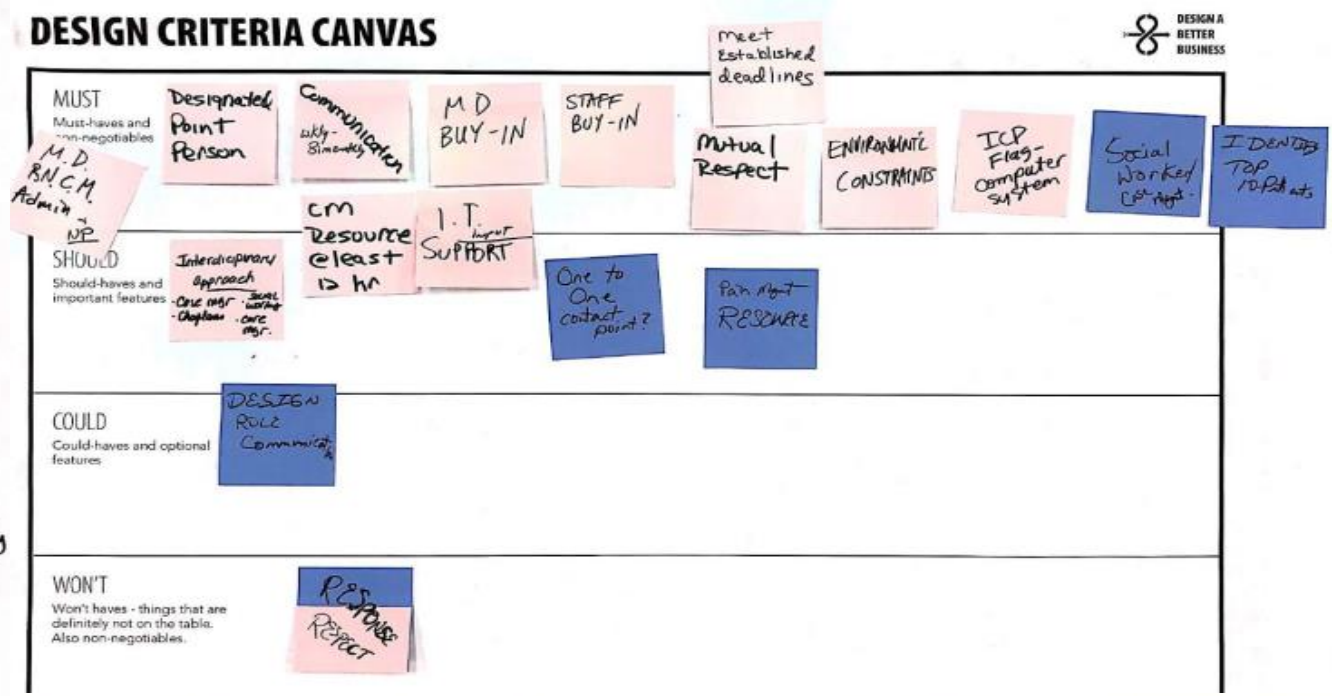
Staff Education Reference Material

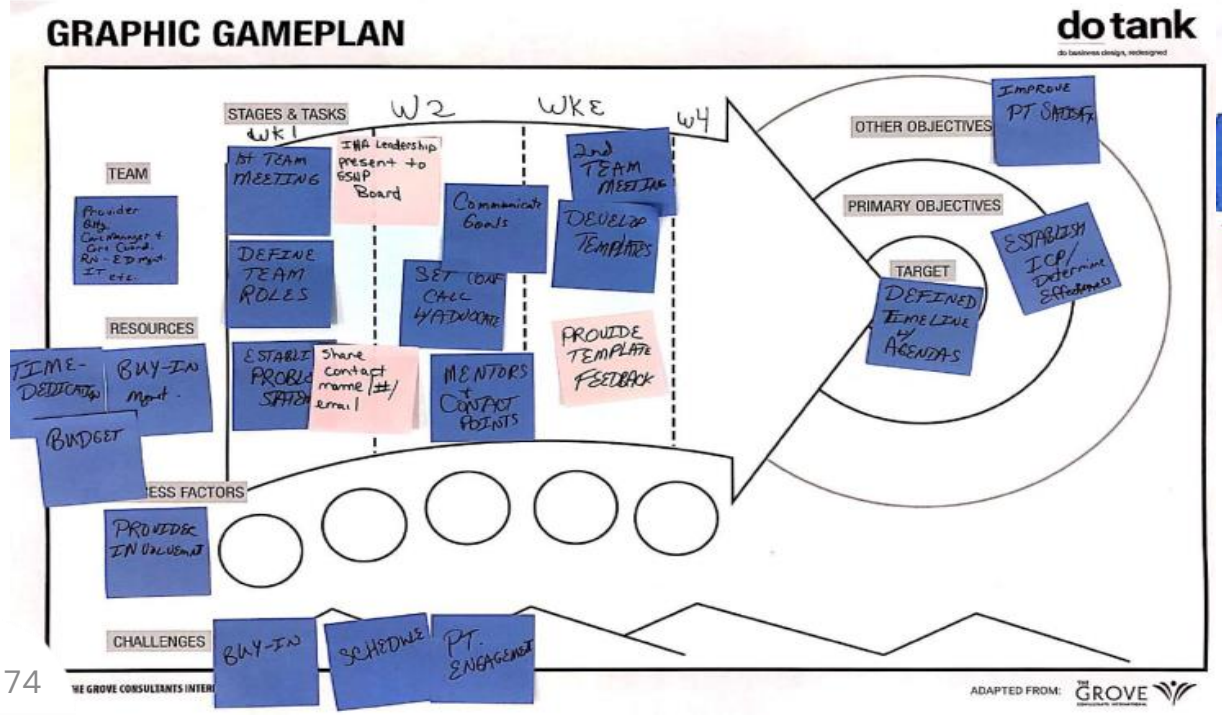
- Motivational Interviewing in substance use disorder
- AAIDET: Pain Script
- Crucial Conversations: Topics of Conversation
- Guideline for ED Staff to Request Patients for Care Planning Consideration
- Create a Network of Healthcare Providers & Community Agencies

This bibliography consists of many different types of documents provided by Advocate Good Shepherd Hospital that are instrumental to implementing the ED Recidivism & Unnecessary Hospital Admission & Readmission program. They are here as reference material and to help you implement & sustain this program in your hospital.

As you begin your work you may find a need to modify and change some of these to fit your operations, which is fine.


PERSONA CANVAS
DESIGN A BETTER BUSINESS
NEGATIVE TRENDS
Negative trends from the environment
POSITIVE TRENDS
Positive trends from the environment
HEADACHES
Professional and work related issues
NEED
What does this person really want?
OPPORTUNITIES
Professional and work related positive outcomes
FEARS
Personal issues
HOPES
Personal goals and hopes
NAME Illini Community Hospital
ROLE Care management
BY DESIGNABETTERBUSINESS.COM


DESIGN CRITERIA CANVAS
DESIGN A BETTER BUSINESS
MUST
Must-haves and non-negotiables
SHOULD
Should-haves and important features
COULD
Could-haves and optional features
WON'T
Won't haves - things that are definitely not on the table. Also non-negotiables.


GRAPHIC GAMEPLAN
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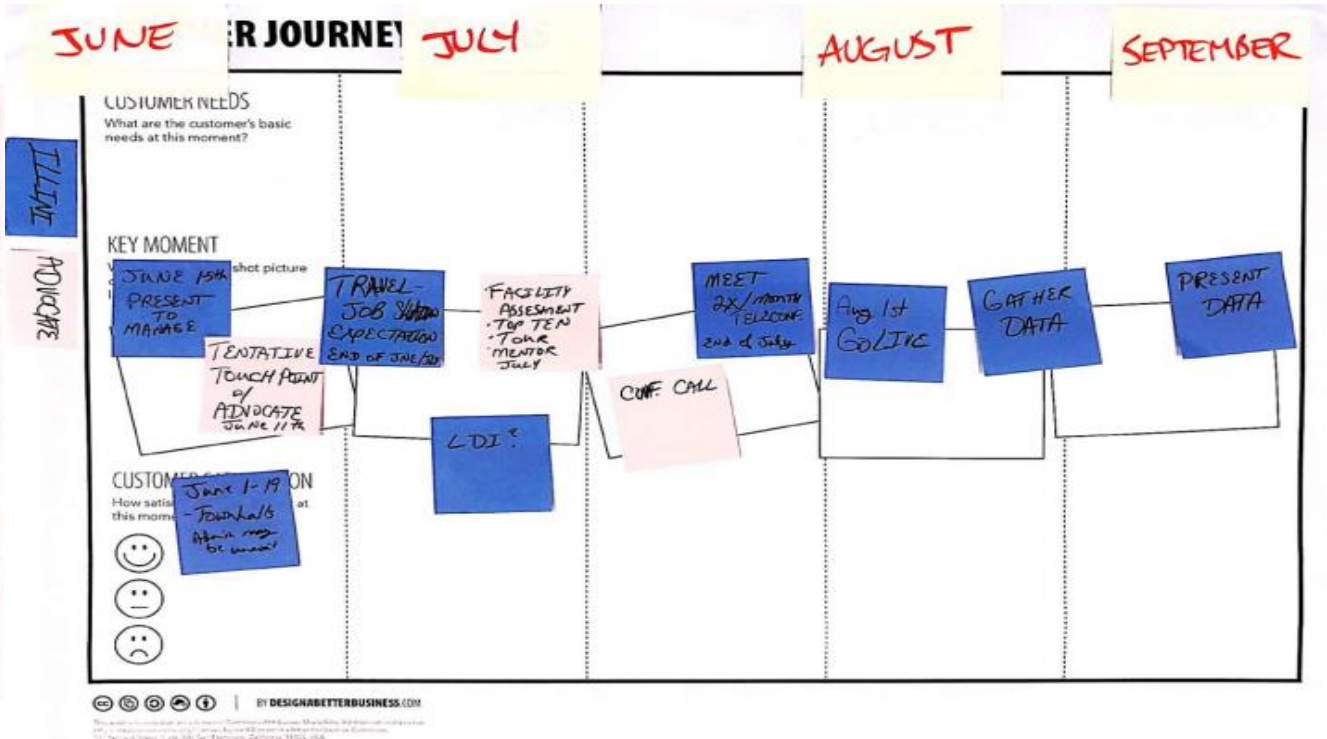
do business design, redesigned
STAGES & TASKS
TEAM
RESOURCES
CHALLENGES
OTHER OBJECTIVES
PRIMARY OBJECTIVES
TARGET
ADAPTED FROM: THE GROVE


JUNE
JULY
AUGUST
SEPTEMBER
CUSTOMER NEEDS
What are the customer's basic needs at this moment?
KEY MOMENT
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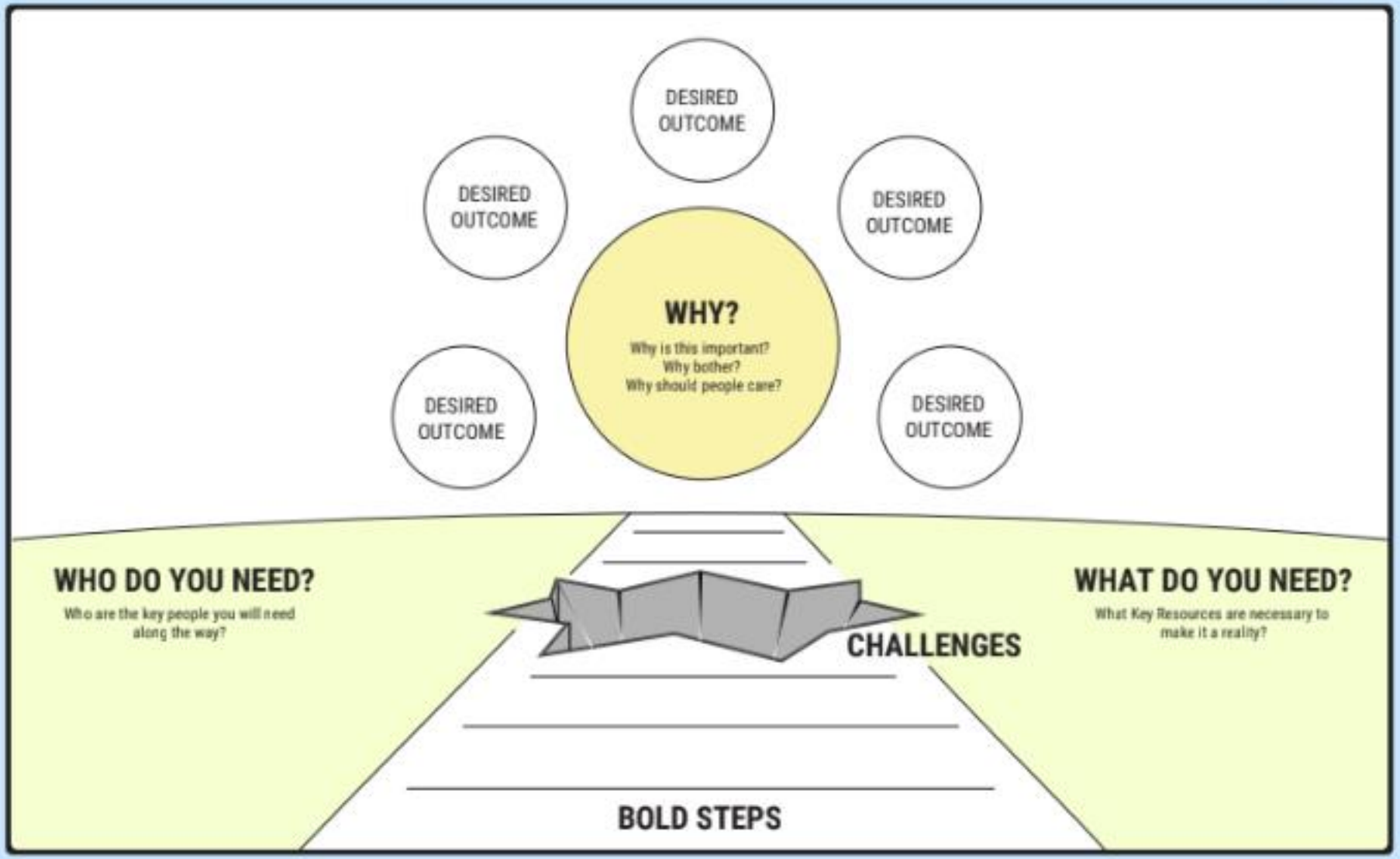

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Gameplan Canvas

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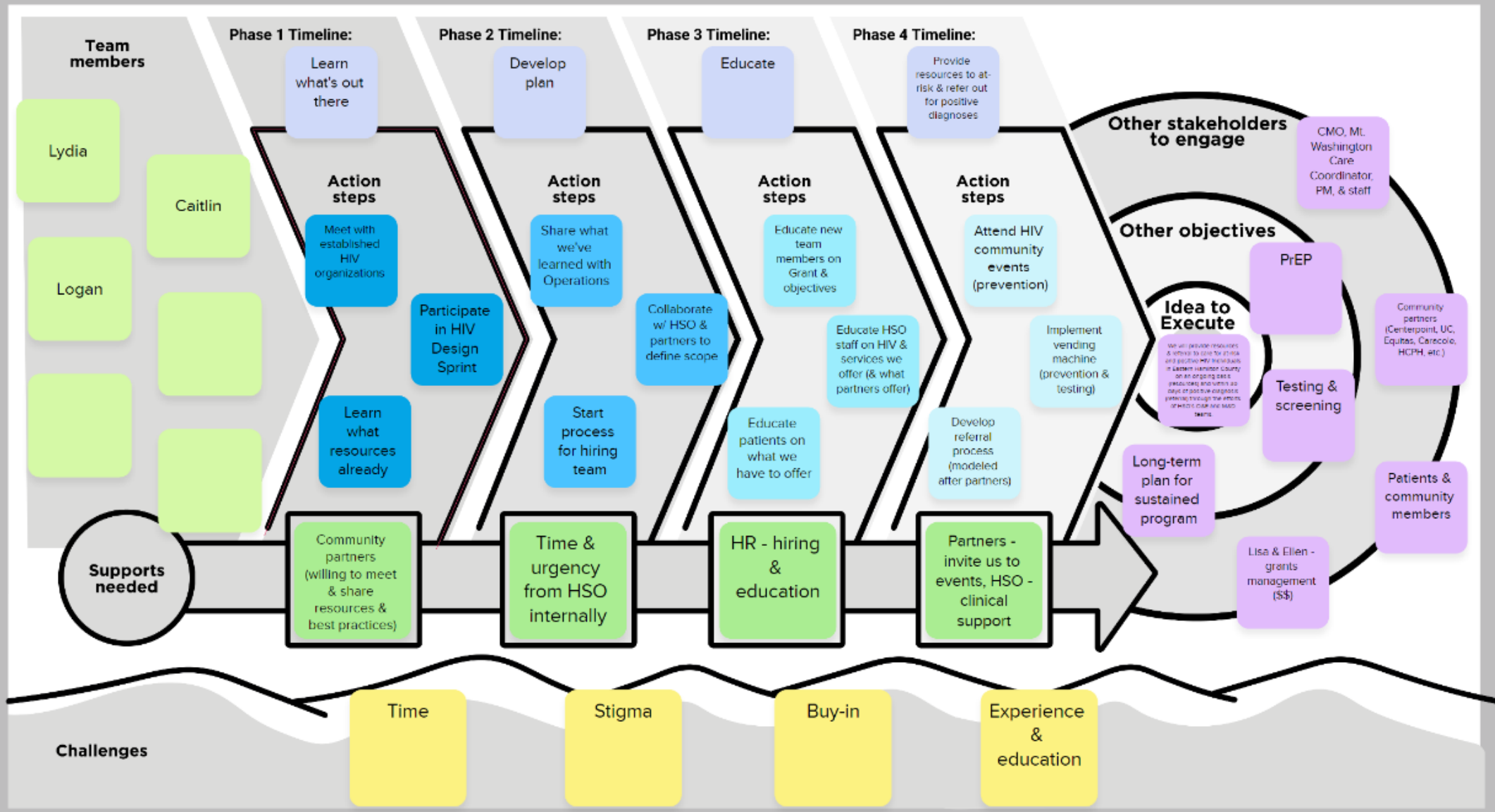
Business design, redesigned.



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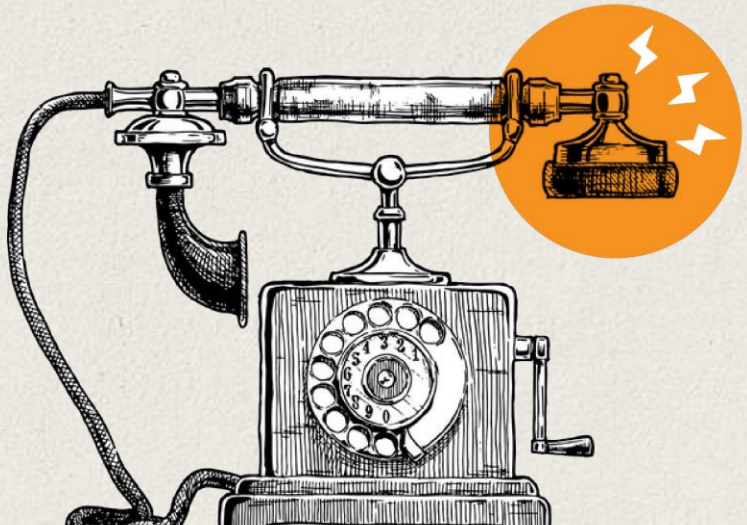

Final Reminders

- **Evaluation**
  - Please complete the evaluation form that appears on your screen once the webinar ends
- **Continuing Education**
  - Create a Duke OneLink account if you have not done so
    - Instructions can be downloaded from the Files pod or your registration confirmation email
  - **Text ZAHTAV to (919) 213-8033 within 24 hours**

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