Reflection: Leave in Action: Complete the first cycle of a PDSA

- QI Team
  - After implementing the plan of action, meet to discuss the details
  - Determine if your actions led you in a positive direction and how you will respond to what you have learned.

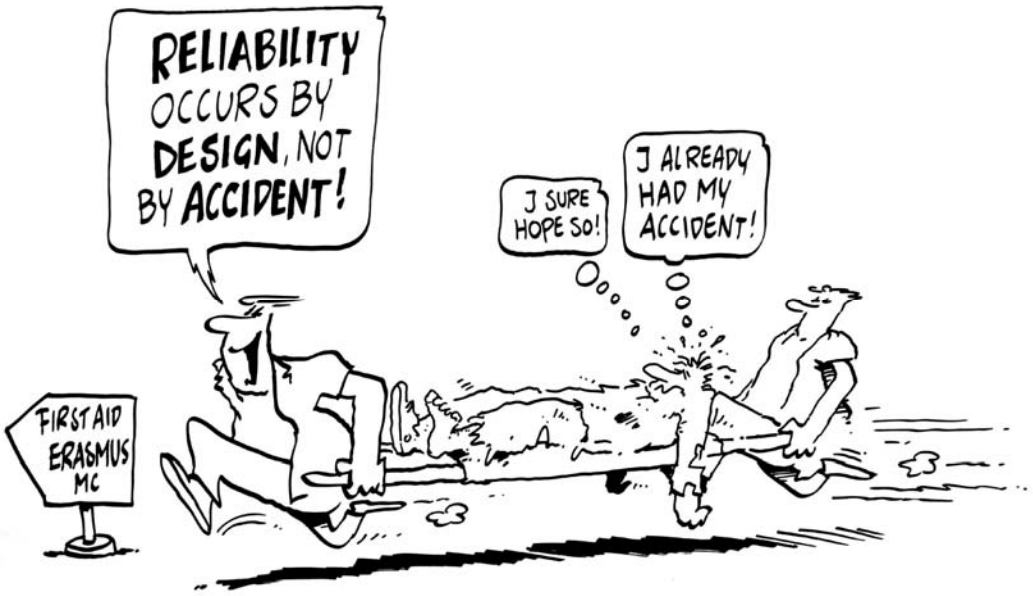
Share your PDSA details

- What happened when you took action? – "Do"
- How did this compare to what you predicted? – "Study"
- What did you do with this information? – "Act"
- What's next?

Creating a Reliable Process

Breaking Down the Flow Chart – Using Deliberate Strategies

Sherry Longacre, MS, RN
Telligen – ECHO QI Coach



RCA – Brainstorming the Reason Why

- Waterfall chat instructions:
  - **Group1:** First name starts with A-M
    - Start typing an answer into chat but **DON'T SEND!**
  - **Group 2:** First name starts with N-Z
    - Read through the chat response of group 1

- **Group 1:**
  - In chat type in:
    - **2 of the greatest difficulties related to transitions in care**
  - **DO NOT HIT SEND UNTIL GIVEN THE SIGNAL!**

RCA – Brainstorming the Reason Why

- Waterfall chat instructions:
  - **Group 2:** First name starts with N-Z
    - Start typing an answer into chat but **DON'T SEND!**

- **Group 2:**
  - In chat type in:
    - **Using the reasons group 1 states are the greatest issues; which one resonates with you the most**
  - **DO NOT HIT SEND UNTIL GIVEN THE SIGNAL!**

Getting to Greater Reliability in Your Process

- What are the processes you want to improve?
  - Examples
    - Preventing hospital readmissions and ED visits
    - Responding to changes in condition
    - Tracking data
    - Communications across transitions in care
- Clearly state in 2-5 words what you intend to design

Each box is a process with ATTRIBUTES
(characteristics of quality)

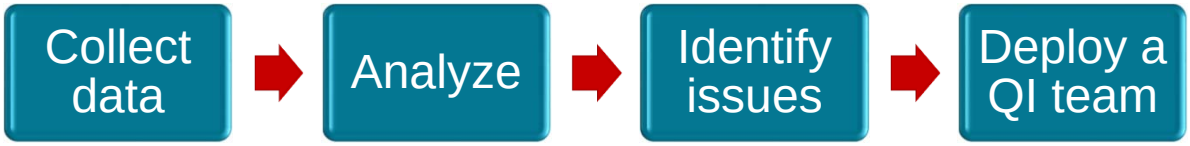
Example: Hospital readmissions/ED visits

- Who is responsible for collecting the data and analyzing it?
- Where is the data being collected?
- When is hospitalization data reviewed with the team?
- How do you communicate across care settings?
- What information is collected/shared in transition?

Facts

- 2017 hospital top 10 inpatient diagnoses for hospital admission: https://www.hcup-us.ahrq.gov/faststats/NationalDiagnosesServlet
  - #2 Septicemia
  - #9 Pneumonia
- Four types of infections most often associated with sepsis http://www.cdc.gov/vitalsigns/sepsis/index.html
  - 35% pneumonia or respiratory infection
  - 25% urinary tract infection
  - 11% GI infection
  - 11% skin infection

4 Box Flow Diagram
(for readmission/ED visits)



Collecting Data

- Tracking hospitalizations/readmission/ED visits – includes:
  - Reason/symptoms for transfer
  - Onset of symptoms prior to transfer
  - Location of resident room
  - Date of most recent prior hospital stay/ED visit
  - Outcome of transfer
  - Determined diagnosis
  - Non-planned transfers

Guide to Reducing Disparities in Readmissions
https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Analyzing Data

- What did you learn?
  - Trending diagnosis'
  - Lack of early detection/reaction to symptoms
  - Repeat hospital stays
  - Common unit among residents transferred
  - Several unplanned transfers
  - Other….

Identifying Issues

- Leadership action
  - Discusses and prioritizes issues
  - Creates a goal for improvement
  - Develops a team charter
  - Deploys an improvement team
  - Support the improvement team
    - Follows-up, communication
    - Provides resources
    - Available

Improvement Team

- Dives deeper into the data
  - Understand contributing factors
  - Performs RCA
- Develops a plan to mitigate prioritized causes
  - Measures the planned interventions
- Places sustainable actions
  - Ongoing monitoring
  - Action plan for deviations identified

LET'S BE DELIBERATE

THE "WRONG WAY" PROCESS DESIGN STRATEGIES	THE "RIGHT WAY" PROCESS DESIGN STRATEGIES
1. **EXPERT MEETINGS**: design a comprehensive process over **A LOT** of meetings.	1. **STANDARD WORK** is created to provide the appropriate infrastructure (**WHO, WHEN, WHERE, HOW** and **WHAT**).
2. The result of the expert meetings is a process considered by the team as a **FINISHED PRODUCT**.	2. The **WHAT** or **WHY** is clearly articulated and based on **SCIENCE**.
3. Changes to the process are **INFREQUENTLY TOLERATED**.	3. The **WHO, WHEN, WHERE**, and **HOW** reflects the **UNIQUE SEGMENTS** of the organization.
4. The standardized process designed is expected to be use by all (**ONE SIZE FITS ALL**).	4. Initial standard work should be **TESTED REPEATEDLY** on a very **SMALL SCALE** (hoping for failure in order to learn).
5. Implementation strategy is primarily **VIGILANCE** and **HARD WORK**.	5. **CHANGES** to the standard work in the initial stages should be **REQUIRED** & **ENCOURAGED**.
6. Emphasis is on **OUTCOMES** rather than process reliability by leadership.	6. **FAILURES** are studied and used to **REDESIGN** the process.

Let's Be Deliberate by Roger Resar and Frank Federico, IHI, Marla DeVries, THE GREEN HOUSE® Project, and Arkansas COVID-19 Action Network

Resource

https://pathway-interact.com/

Leave in Action: Discover reliability in your process around hospitalizations/ED visit tracking and mitigating challenges

- Review your data/tracking system or start tracking; determine if it has multiple elements for measuring to support analyzing for identifying contributing factors to hospitalizations/ED visits. Discover contributing factors, prioritize and decide if an improvement team will be deployed.

Next week, share:

- What tracking system you use
- What you learned while analyzing the data
- Do you have enough information to identify contributing factors?
- What is your plan? – start an improvement team, map out a process, etc.