KHC Monthly Webinar

October 28, 2020

Improve Anything in Six Meetings or Less

KANSAS MEDICAL SOCIETY Established 1859

Kansas Healthcare COLLABORATIVE

KHA Kansas Hospital ASSOCIATION

New Webinar Platform:

GoToWebinar

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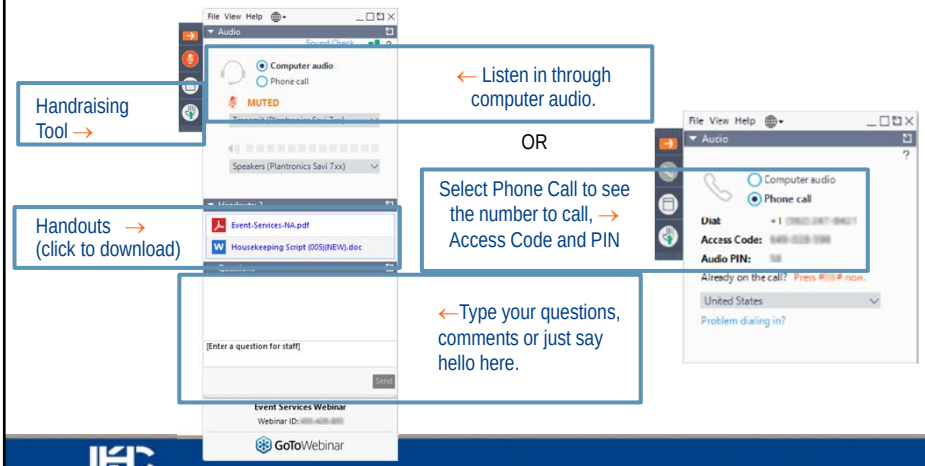

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Agenda

- Welcome
- Featured topic:

  Improve Anything in Six Meetings or Less
- Resources
- Wrap-up /evaluation

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Introductions

Special Guest

Stephanie Sobczak, MS, MBA
Project Manager
UW Health at The American Center
ssobczak2@uwhealth.org

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Polling Question #1

Let us know where you are joining us from:

- ❑ Hospital
- ❑ Clinic or ambulatory setting
- ❑ Partner organization
- ❑ Other

Kansas Healthcare COLLABORATIVE 5

Polling Question #2

Which of the following tends to slow down your improvement efforts the most? (check all that apply)

- ❑ Loose adherence to a defined Improvement Process
- ❑ Meetings scheduled "just-in-time" or rescheduled often
- ❑ Being O.K. with 9-18 months to implementation
- ❑ People are "too busy" and tasks get dropped
- ❑ Failure to involve the front line early enough

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How to Improve Anything in Six Meetings or Less

STEPHANIE SOBCZAK, MS, MBA
UW HEALTH – PROJECT MANAGER

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Some Background

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Common Missteps Slow Improvement

Loose adherence to a defined Improvement Process	Just-in-time scheduling of meetings; frequent rescheduling	Meeting time spent discussing personalities vs. processes
Being OK with improvements taking 9, 12, 18+ months to implementation	Willingness to accept dropping the ball on tasks; people are "too busy"	Failure to connect the improvement to the front-line; early and often!

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Six Meetings or Less!?!

How?

- Grounded in the standardized approach to improvement in your organization
- Willingness to use pre-defined agendas for each meeting
- Stakeholders committed to doing work between meetings
- Discipline to document and manage "Action Items"
- Plan, in detail, small tests of change to apply in operational areas
- Structured follow-up to emphasize sustainability

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Improvement doesn't happen here…

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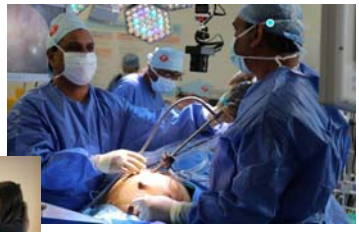
Improvement happens here!



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The Method

- Base framework is **6 one-hour meetings** with defined deliverables from each
- The goal is to work through problem definition, root cause identification and solution selection quickly
- Participants must commit to completing Action Items on-time
- The heart & soul of this method is engaging those who do the work, in the place where they work (a.k.a. our experts!)

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The Application

A few examples how this approach has been used in a variety of care settings:

- ✓Implementing clinical bundle elements: CAUTI, SSI, CLABSI etc.
- ✓Cross-functional coordination: Discharge checklist, Med Reconciliation
- ✓Process challenges: Ordering wound vacs, Gaps in supply stocking
- ✓Closing hand-off issues: ED to Inpatient admissions, Cardiology clinic triage

→Any need for improvement that has a defined scope

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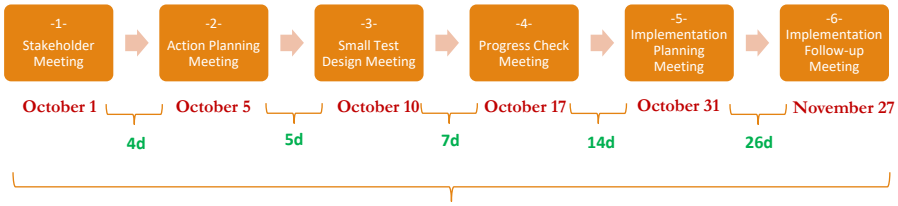
The 6 Meeting Structure

Schedule all 6 meetings in advance – avoid rescheduling



56 calendar days, 40 business days

Vary the time needed between meetings to allow for task completion

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Use the 6 meetings wisely

1) Stakeholder Meeting

AGENDA

- Brief Intros
- Overview of Purpose: Share data, safety reports, etc.
- Identify specific Gaps/Root Causes
- Determine "Just do its"
- Set Action Items

TASKS

1. Confirm gaps w/others
2. Gather input on OFI's
3. Assess readiness to change

Bite sized tasks

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Integrate Improvement Methods

	1) Stakeholder Meeting	2) Action Planning Meeting
AGENDA	• Brief Intros • Overview of Purpose: Share data, safety reports, etc. • Identify specific Gaps/Root Causes • Determine "Just do its" • Set Action Items	• Introduce anyone new • Round robin report out • Two lists: Low Hanging Fruit, Tests of Change • Identify invitees to change planning • Set Action Items
TASKS	1. Confirm gaps w/others 2. Gather input on OFI's 3. Assess readiness to change	1. Draft A3 or PDSA 2. Discuss planning ideas with others 3. Identify testing volunteers

Outside of meeting

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Engage Staff in Tests of Change

	1) Stakeholder Meeting	2) Action Planning Meeting	3) Small Test of Change Design
AGENDA	• Brief Intros • Overview of Purpose: Share data, safety reports, etc. • Identify specific Gaps/Root Causes • Determine "Just do its" • Set Action Items	• Introduce anyone new • Round robin report out • Two lists: Low Hanging Fruit, Tests of Change • Identify invitees to change planning • Set Action Items	• Introduce anyone new • Confirm what change(s) will be tested • Design testing phases • Confirm Action Items & assignments
TASKS	1. Confirm gaps w/others 2. Gather input on OFI's 3. Assess readiness to change	1. Draft A3 or PDSA 2. Discuss planning ideas with others 3. Identify testing volunteers	1. Engage staff testing changes 2. Use frequent informal feedback 3. Grow the testing pool

Keep in the loop

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Disciplined Progress Expectation

	1) Stakeholder Meeting	2) Action Planning Meeting	3) Small Test of Change Design	4) Progress Check Meeting
AGENDA	• Brief Intros • Overview of Purpose: Share data, safety reports, etc. • Identify specific Gaps/Root Causes • Determine "Just do its" • Set Action Items	• Introduce anyone new • Round robin report out • Two lists: Low Hanging Fruit, Tests of Change • Identify invitees to change planning • Set Action Items	• Introduce anyone new • Confirm what change(s) will be tested • Design testing phases • Confirm Action Items & assignments	• Overview of planned tests • Report from testers • Consensus decision: continue testing, move to implementation, convene leaders? • Confirm assignments
TASKS	1. Confirm gaps w/others 2. Gather input on OFI's 3. Assess readiness to change	1. Draft A3 or PDSA 2. Discuss planning ideas with others 3. Identify testing volunteers	1. Engage those testing changes 2. Use frequent informal feedback 3. Grow the testing pool	1. Continue testing or discuss incorporating the change into existing infrastructure 2. Discuss barriers

Critical step

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Plan the Implementation

	1) Stakeholder Meeting	2) Action Planning Meeting	3) Small Test of Change Design	4) Progress Check Meeting	5) Implementation Planning
AGENDA	• Brief Intros • Overview of Purpose: Share data, safety reports, etc. • Identify specific Gaps/Root Causes • Determine "Just do its" • Set Action Items	• Introduce anyone new • Round robin report out • Two lists: Low Hanging Fruit, Tests of Change • Identify invitees to change planning • Set Action Items	• Introduce anyone new • Confirm what change(s) will be tested • Design testing phases • Confirm Action Items & assignments	• Overview of planned tests • Report from testers • Consensus decision: continue testing, move to implementation, convene leaders? • Confirm assignments	• Introduce anyone new • Discuss implementation steps: measurement, audit, oversight • Assign accountabilities • Confirm assignments
TASKS	1. Confirm gaps w/others 2. Gather input on OFI's 3. Assess readiness to change	1. Draft A3 or PDSA 2. Discuss planning ideas with others 3. Identify testing volunteers	1. Engage those testing changes 2. Use frequent informal feedback 3. Grow the testing pool	1. Continue testing or discuss incorporating the change into existing infrastructure 2. Discuss barriers	1. Carry out implementation tasks according to plan 2. Share the work with others

Plan to sustain

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Accountability & Sustained Results

	1) Stakeholder Meeting	2) Action Planning Meeting	3) Small Test of Change Design	4) Progress Check Meeting	5) Implementation Planning	6) Implementation Follow-up
AGENDA	• Brief Intros • Overview of Purpose: Share data, safety reports, etc. • Identify specific Gaps/Root Causes • Determine "Just do its" • Set Action Items	• Introduce anyone new • Round robin report out • Two lists: Low Hanging Fruit, Tests of Change • Identify invitees to change planning • Set Action Items	• Introduce anyone new • Confirm what change(s) will be tested • Design testing phases • Confirm Action Items & assignments	• Overview of planned tests • Report from testers • Consensus decision: continue testing, move to implementation, convene leaders? • Confirm assignments	• Introduce anyone new • Discuss implementation steps: measurement, audit, oversight • Assign accountabilities • Confirm assignments	• Introduce anyone new • Report out on Implementation tasks • Develop plan to close gaps • Confirm ownership and assign tasks
TASKS	1. Confirm gaps w/others 2. Gather input on OFI's 3. Assess readiness to change	1. Draft A3 or PDSA 2. Discuss planning ideas with others 3. Identify testing volunteers	1. Engage those testing changes 2. Use frequent informal feedback 3. Grow the testing pool	1. Continue testing or discuss incorporating the change into existing infrastructure 2. Discuss barriers	1. Carry out implementation tasks according to plan 2. Share the work with others	1. Accountable owners monitor outcomes 2. Identify timeframe to revisit – annually?

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Key Tools

1. Six Meetings or Less Implementation Guide w/ Checklists – shared with you
2. Use an Outcome-based Agenda Format – shared with you
3. Use an A3 to document the work
4. Root Cause Analysis Tool: Cause & Effect, 5 Whys, etc.
5. Small Test of Change Design/Planning Tool – shared with you
6. Manage change tolerance: "Engage the engaged"

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Six Meetings or Less Implementation Guide

How to Improve Anything in 6 Meetings or Less — Stephanie Sobczak, MS, MBA

ESTABLISHING THE MEETING SERIES

To begin, two elements must be known in advance:

- What the gaps are, and what data supports that conclusion
- Whom the key stakeholders are, and their commitment to support desired outcomes

Establish Two Key Roles

Before the meetings can be put on calendars, it is vital to assign two key roles:

Senior Leader – This person should have decision-making authority in the organization and is able to commit to working with the meeting Facilitator and other key stakeholders in an oversight capacity. They are involved to champion the importance of the effort, to support the Facilitator, to witness key discussions and to assist in the problem solving and removing barriers as needed by the team. The title of this person isn't important as long as they can meet these requirements.

Meeting Facilitator – This person should be somewhat familiar with the topic, have the time and ability to organize the meetings, and be committed to serving the team. They may or may not have a managerial role in the organization. They must have the support of the clinical or operational managers of functions impacted by change resulting from this effort.

Schedule the Meetings

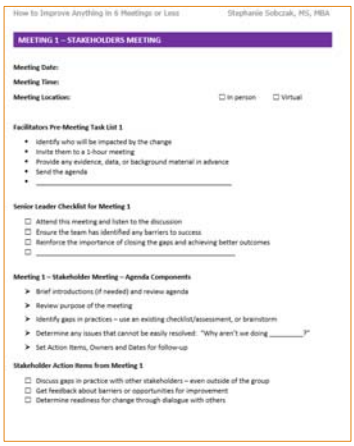
Precious time is lost when putting a meeting on calendars is delayed by lack of availability, space, or a cultural tendency to easily cancel meetings. In the Six Meetings or Less method, scheduled well in advance:

- The time between meetings is variable and depends on the complexity and scope of the issue.
- The more quickly the group can work through major steps and complete the work between meetings, the more efficient the process.
- The emphasis is on completion of work between meetings.

Example Meeting Structure

Schedule all 6 meetings in advance – avoid rescheduling

The length of time between meetings should vary to allow for task completion



How to Improve Anything in 6 Meetings or Less — Stephanie Sobczak, MS, MBA

MEETING 1 – STAKEHOLDERS MEETING

Meeting Date:

Meeting Time:

Meeting Location: ☐ In person ☐ Virtual

Facilitators Pre-Meeting Task List 1

- Identify who will be impacted by the change
- Invite them to a 1-hour meeting
- Provide any evidence, data, or background material in advance
- Send the agenda
- _____

Senior Leader Checklist for Meeting 1

- ☐ Attend this meeting and listen to the discussion
- ☐ Ensure the team has identified any barriers to success
- ☐ Reinforce the importance of closing the gaps and achieving better outcomes
- ☐ _____

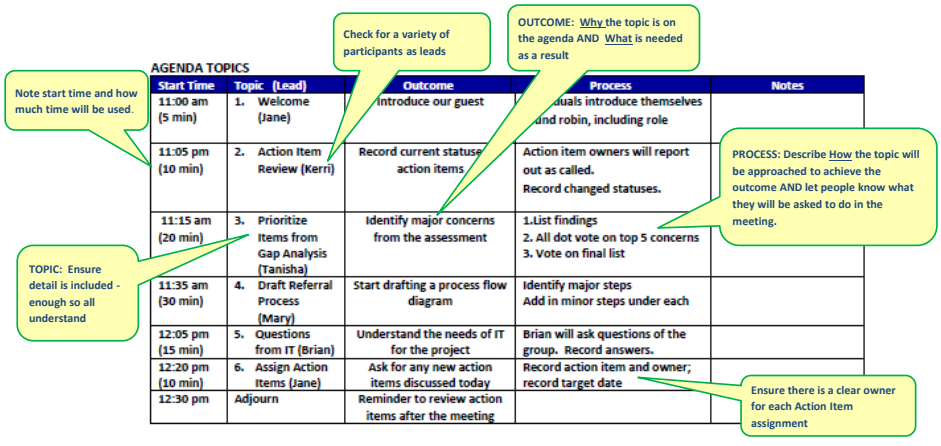
Meeting 1 – Stakeholder Meeting – Agenda Components

- Brief introductions (if needed) and review agenda
- Review purpose of the meeting
- Identify gaps in practices – use an existing checklist/assessment, or brainstorm
- Determine any issues that cannot be easily resolved: "Why aren't we doing _____?"
- Set Action Items, Owners and Dates for follow-up

Stakeholder Action Items from Meeting 1

- ☐ Discuss gaps in practice with other stakeholders – even outside of the group
- ☐ Get feedback about barriers or opportunities for improvement
- ☐ Determine readiness for change through dialogue with others

Use Outcome Based Agendas



Note start time and how much time will be used.

Check for a variety of participants as leads

OUTCOME: Why the topic is on the agenda AND What is needed as a result

PROCESS: Describe How the topic will be approached to achieve the outcome AND let people know what they will be asked to do in the meeting.

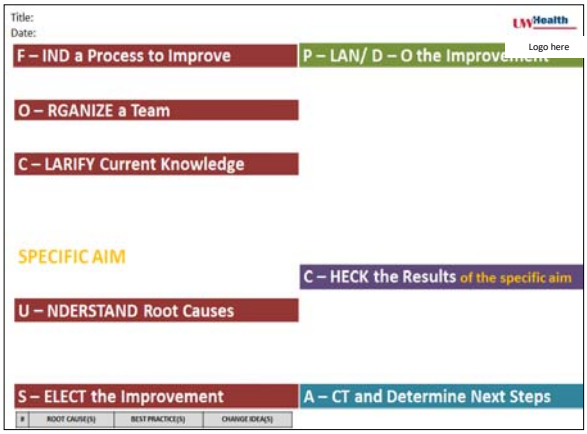
TOPIC: Ensure detail is included - enough so all understand

Ensure there is a clear owner for each Action Item assignment

AGENDA TOPICS

Start Time	Topic (Lead)	Outcome	Process	Notes
11:00 am (5 min)	1. Welcome (Jane)	Introduce our guest	…tuals introduce themselves …und robin, including role	
11:05 pm (10 min)	2. Action Item Review (Kerri)	Record current statuse… action items	Action item owners will report out as called. Record changed statuses.	
11:15 am (20 min)	3. Prioritize Items from Gap Analysis (Tanisha)	Identify major concerns from the assessment	1.List findings 2. All dot vote on top 5 concerns 3. Vote on final list	
11:35 am (30 min)	4. Draft Referral Process (Mary)	Start drafting a process flow diagram	Identify major steps Add in minor steps under each	
12:05 pm (15 min)	5. Questions from IT (Brian)	Understand the needs of IT for the project	Brian will ask questions of the group. Record answers.	
12:20 pm (10 min)	6. Assign Action Items (Jane)	Ask for any new action items discussed today	Record action item and owner; record target date	
12:30 pm	Adjourn	Reminder to review action items after the meeting		

Documenting Progress – The A3



This can be any similar tool; any format

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Case Study

Care coordination issue with external facility

There were problems with hand-offs between a residential care facility for persons with intellectual disability, EMS and hospital ED.

- These patients were typically non-communicative
- Caregiver presence and knowledge about the patient varied
- Near miss safety events were documented x 2 in one month
- A "Blue Folder" one-page intake form, brought with the patient, is used with area skilled nursing facilities
- A "Red Folder" might be a solution, but the team discovers the "Blue folder" compliance has declined after implementation

→ The team is exploring options for closing these gaps.

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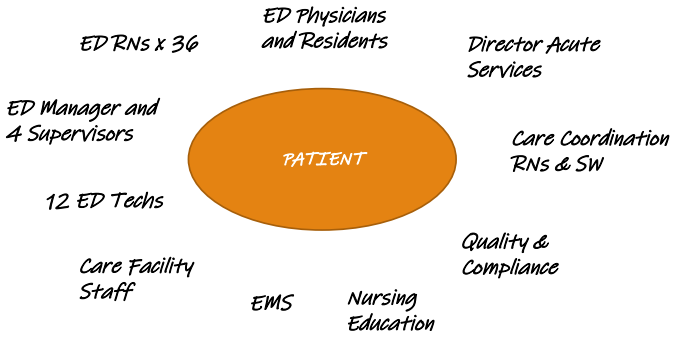
Key Stakeholders



A visual depiction of all stakeholders can be helpful.

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Meeting #1

CARE COORDINATION – STAKEHOLDER - MEETING 1
AGENDA and MEETING SUMMARY

Date: August 9
Time: 8:00 AM – 9:00 AM
Location: RM 2512
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: August 13
Time: 8:00 AM
Location: RM 2512

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care/Improvement Champion	Y	Stephanie Sobczak	Project Manager	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Tenisha Thomas	Coordinated Care/CM	Y
Joanna Jenkins	Nursing Education Specialist	Y	Lee Leverage	Coordinated Care/CM	N
Michele Marshall	Inpatient & ED/ Director	Y	Quint Quincy	Coordinated Care/SW	Y
Rebecca Right	Emergency Department/RN	Y	**Guest:**		

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
8:00 am (5 min)	1. Welcome to the Stakeholder Meeting (Kelly)	Learn who is part of this team	1. Introduce yourself 2. Summer vacation stories?	
8:05 am (10 min)	2. Introduction to the Issue (Kelly)	Understand the issue and the impact	1. Brief presentation 2. Share problem statement	
8:15 am (15 min)	3. Review of Known Data (Sam, Joanna)	What is the current state?	1. Share Data 2. Diagram current process as a swim lane flow diagram	Reviewed Data Handouts. Tanisha to provide draft description of current process.
8:30 am (20 min)	4. Discuss Gaps (Kelly and All)	Identify possible causes	1. Build Cause & Effect Diagram 2. Confirm root causes	Possible Gaps includes: documentation, lack of paperwork/information provided from facility at time of admission, how are statistics gathered
8:50 am (10 min)	5. Document/Assign Action Items (Stephanie)	Identify what we need to know or complete before the next meeting	Action item owners report out and state target dates	See Below

SUPER IMPORTANT!

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Request more information about data and how it is collected; send answer via e-mail	Sam	8/11	NEW
Request more information about process of information coming *from* facilities	Quint	8/13	NEW
Create list of Residential Facility contacts – primary and weekend/off hours	Kelly/SW Student	8/18	NEW
Whiteboard with ED staff to confirm root causes and identify any other possible causes	Rebecca	8/13	NEW
Shadow at least 2 ED staff to learn observe current process	Tanisha, Lee, Quint	8/13	NEW
Draft Cause & Effect diagram in standard format	Tanisha	8/13	NEW

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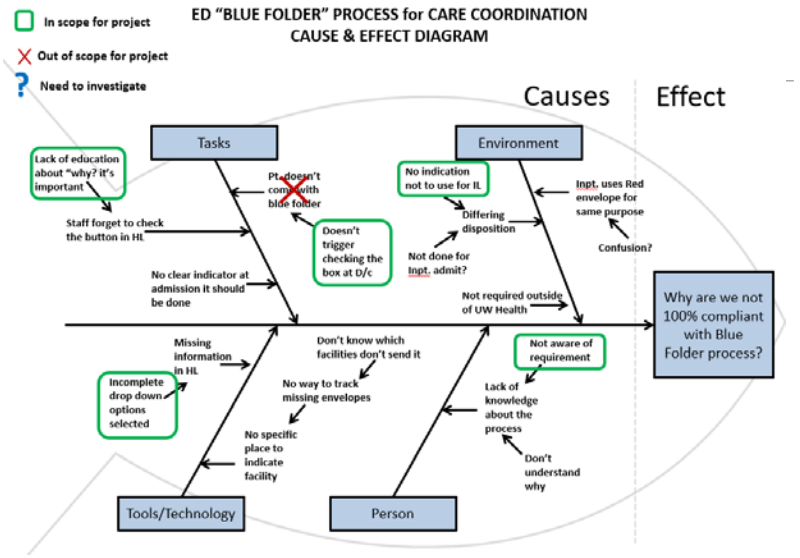
Work Product from Meeting #1



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Meeting #2

4 days later

CARE COORDINATION – ACTION PLANNING - MEETING 2
AGENDA and MEETING SUMMARY

Date: August 13th
Time: 8:00 AM to 9 AM
Location: RM 2512
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: August 8
Time: 1 PM to 2PM
Location: RM 2512

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care/Improvement Champion	Y	Stephanie Sobczak	Project Manager	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Tenisha Thomas	Coordinated Care/CM	Y
Joanna Jenkins	Nursing Education Specialist	Vac.	Lee Leverage	Coordinated Care/CM	Y
Michele Marshall	Inpatient & ED/ Director (optional)	N	Quint Quincy	Coordinated Care/SW	Y
Rebecca Right	Emergency Department/RN	Y	Guest:		

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
8:00 am (5 min)	1. Welcome to the Action Planning Meeting (Kelly)	Clarify purpose of today's meeting	1. Review Agenda 2. Invite questions	
8:05 am (10 min)	2. Confirm Root Issues Identified (Tanisha)	Complete Cause & Effect Diagram	1. Review Cause & Effect 2. Cross out what can't be changed 3. Identify what can be impacted	
8:15 am (15 min)	3. Review of Data (Sam)	Understand what the data is telling us about	1. Come to agreement on conclusions 2. Document gaps or questions	
8:30 am (20 min)	4. Discuss Gaps (Kelly)	Learn of potential issues that could impede progress	1. Record Gaps 2. Prioritize - Low Hanging Fruit - Small Tests of Change	
8:50 am (10 min)	3. Document/Assign Action Items (Stephanie)	Identify what we need to know, or do before the next meeting	Action itemowners report out and state target dates	

Completed action items come off the list

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Share gaps with ED and Coordinated Care staff in Huddles	Kelly	8/18	NEW
Request information from Facilities	Quint	8/18	In process
Can we hard code the Coordinated Care drop down in EMR – questions for IT	Lee	9/11	NEW

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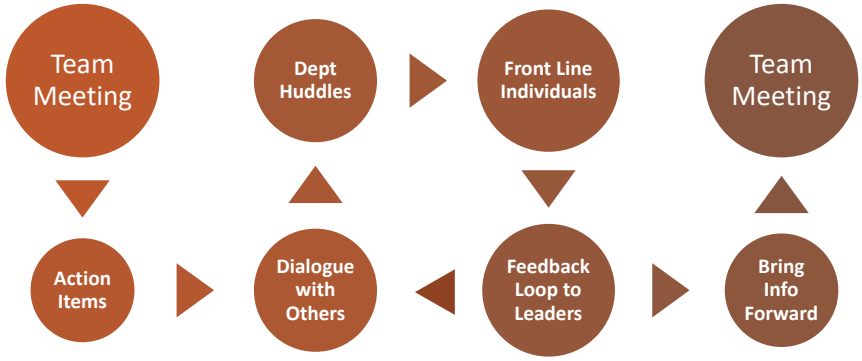
Work Product from Meeting #2

Information Flow between Meetings



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Meeting #3

5 days later

CARE COORDINATION – SMALL TEST DESIGN - MEETING 3
AGENDA and MEETING SUMMARY

Date: August 18
Time: 8:00 AM to 9 AM
Location: RM 2512
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: August 25
Time: 9:30 AM to 10:30 AM
Location: RM 1009

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care	Y	Stephanie Sobczak	Project Manager	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Tenisha Thomas	Coordinated Care/CM	Y
Michele Marshall	Inpatient & ED/ Director (optional)	N	Quint Quincy	Coordinated Care/SW	Y
Rebecca Right	Emergency Department/RN	Y			
Guest: Marc Cain	LD Supervisor	Y	Guest: Julie Kromer	LD Supervisor	Y

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
1:00 pm (5 min)	1. Welcome to the Small Test Design Meeting (Kelly)	Clarify purpose of today's meeting	Review Agenda Invite questions	
1:05 pm (5 min)	2. Brief Review of Action Items (Kelly)	Update reflecting work completed	Owners report on changed statuses	Can hard code dropdown in EMR
1:10 pm (10 min)	3. Confirm Process changes to test (Sam)	Come to agreement on what changes may impact the problem	1. Discuss understanding of test scope 2. Check for consensus agreement	
1:20 pm (30 min)	4. Complete the Small Test of Change Plan (All)	Documented what, who, and when with target dates	1. Determine what will be tested 2. Determine who is involved 3. Determine when and how the test will occur	
1:50 pm	5. Document/Assign Action Items (Stephanie)	Identify what we need to know, or do before the next meeting	Action itemowners report out and state target dates	

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Coach staff according to Small Tests of Change plan document, post results in real time; share at huddles	Marc & Julie	8/25	NEW
Draft A3 document; share via e-mail	Quint	8/23	NEW

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Work Product from Meeting #3

DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: *Improve intake information from residential care*		Intervention: *Test shared intake form*
Smallest Unit of Change: *1 patient, 1 RN*	Scope: *RN with transfer from residential care*	Total # of Staff Impacted: *36 RNs in ED*
Planned Testing Timeframe: *4 Weeks: August 20 – September 25*		Est. # of Staff in Testing: *12 RNs in ED*

	Test Description	Test Plan	Testers	Lesson(s) Learned	Decision	Adaptation
1	Conduct two phone tests by contacting care facility and asking for intake form by e-mail – check for completeness	2 night RNs to do phone contact test of process either Mon or Tues	Julie K Marc C		☐ Adapt ☐ Adopt ☐ Abandon	
2	Confirm red folders are in hand; next 3 night admissions to "Red Folder" intake form. Notify night staff in huddle.	Night RNs Wed – Sat should receive Red Folder intake with admissions	Julie K, Marc C, Jon F, Keisha M		☐ Adapt ☐ Adopt ☐ Abandon	
3	Implement on Days including PMs, next admissions to receive Red Folder; document SBAR with information	Tues – Friday – any ED admission form care facility; all shifts	Keisha M, Sue P, Marlys Z, Joe J, Jack B		☐ Adapt ☐ Adopt ☐ Abandon	
4					☐ Adapt ☐ Adopt ☐ Abandon	
5					☐ Adapt ☐ Adopt ☐ Abandon	
6					☐ Adapt ☐ Adopt ☐ Abandon	

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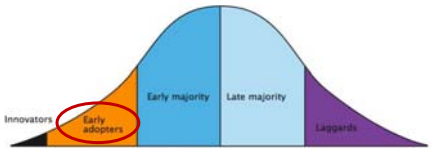
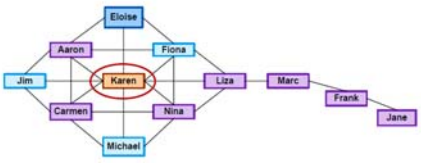
Engage the Engaged!

Identify the early adopters



Leverage the social network



Understanding this is important for successful change adoption

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Meeting #4

7 days later

CARE COORDINATION – PROGRESS CHECK - MEETING 4
AGENDA and MEETING SUMMARY

Date: August 25
Time: 1:00 PM to 2:00 PM
Location: Room 1007
Conference Line:
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: September 12
Time: 8:00 AM to 9:00 AM
Location: RM 1500

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care/Improvement Champion	Y	Stephanie Sobczak	Project Manager	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Tenisha Thomas	Coordinated Care/CM	Y
Michele Marshall	Inpatient & ED/ Director (optional)	N	Quint Quincy	Coordinated Care/SW	Y
Rebecca Right	Emergency Department/RN	Y			
Marc Cain	ED Supervisor		Julie Kromer	ED Supervisor	

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
1:00 pm (5 min)	1. Welcome to the Progress Check Meeting (Kelly)	Clarify purpose of today's meeting	Review Agenda Invite Questions	
1:05 pm (10min)	2. Quick Review of Action Items (Kelly)	Update reflecting work completed	Owners report on changed statuses	
1:15 pm (20 min)	3. Report out on Test Cycles (Marc & Julie	Understand learnings from test cycles	1. Presentation 2. Q & A	
1:35 pm (15 min)	4. Decide on next steps (All)	Reach consensus on Adapt, Adopt or Abandon	1. Revise Small Test of Change Plan accordingly	
1:50 pm (5 min)	5. Document/Assign Action Items (Stephanie)	Identify what we need to know, or do before the next meeting	Action item owners report out and state target dates	

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Continue with test cycles according to plan	Marc & Julie	9/12	In process
Update A3	Rebecca	9/12	Ongoing
Submit change request to IT	Kelly	9/12	NEW

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Work Product from Meeting #4

DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: *Improve intake information from residential care*	Intervention: *Test shared intake form*	
Smallest Unit of Change: *1 patient, 1 RN*	Scope: *RN with transfer from residential care*	Total # of Staff Impacted: *36 RNs in ED*
Planned Testing Timeframe: 4 *Weeks: August 20 – September 25*		Est. # of Staff in Testing: *12 RNs in ED*

	Test Description	Test Plan	Testers	Lesson(s) Learned	Decision	Adaptation
1	Conduct two phone tests by contacting care facility and asking for intake form by e-mail – check for completeness	2 night RNs to do phone contact test of process either Mon or Tues	Julie K Marc C	Process worked, facility RN liked the form; easy to use. Need more in contact section	☒ Adapt ☐ Adopt ☐ Abandon	Make change to contact person section
2	Confirm red folders are in hand; next 3 night admissions to "Red Folder" intake form. Notify night staff in huddle.	Night RNs Wed – Sat should receive Red Folder intake with admissions	Julie K, Marc C, Jon F, Keisha M	3 admissions, two had completed form. 1 missing – was a Saturday admission.	☒ Adapt ☐ Adopt ☐ Abandon	Conf call with facility to discuss training materials they may need to cover all shifts
3	Implement on Days including PMs, next admissions to receive Red Folder; document SBAR with information	Tues – Friday – any ED admission form care facility; all shifts	Keisha M, Sue P, Marlys Z, Joe J, Jack B	2 admissions, both had form, SBAR to provider was more complete. 1 form was "lost" temporarily.	☒ Adapt ☐ Adopt ☐ Abandon	Continue testing plan – involve ED Techs
4	Continue to receive Red Folder, involve all shifts, train ED Techs to look for form	Sun – Friday all shifts any admission	Joe J, Marc C, Pam P, Jose A, Ann R, Aimee F, Alex H	5 admissions, form present; all had complete information.	☐ Adapt ☒ Adopt ☐ Abandon	Proceed with developing work instructions, training and incorporate into on-boarding packet
5					☐ Adapt ☐ Adopt ☐ Abandon	

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Meeting #5

15 days later

CARE COORDINATION – IMPLEMENTATION PLANNING - MEETING 5
AGENDA and MEETING SUMMARY

Date: September 12
Time: 8:00 AM to 9 AM
Location: RM 2512
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: 10/25/19
Time: 8:00 AM to 9 AM
Location: RM 2512

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care	Y	Rebecca Right	Emergency Department/RN	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Stephanie Sobczak	Project Manager	OOO
Joanna Jenkins	Nursing Education Specialist	Y	Tenisha Thomas	Coordinated Care/CM	Y
Michele Marshall	Inpatient & ED/ Director	Y	Quint Quincy	Coordinated Care/SW	N
Guest:			**Guest:**		

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
8:00am (5 min)	1. Welcome to the Implementation Planning Meeting (Kelly)	Clarify purpose of today's meeting	Review Agenda Invite questions	
8:05 am (10 min)	2. Brief Review of Action Items (Kelly)	Update reflecting work completed	Owners report on changed statuses	
8:15 am (25 min)	3. Review & Draft Implementation Checklist (Sam)	Have a plan for implementing the process changes	1. Use Checklist tool 2. Discussion 3. Test for Agreement	
8:40 am (5 min)	4. Nursing Council presentation (Joanna)	Determine who will present implementation plan/A3	Discussion	
8:45 am	5. Document/Assign Action Items (name)	Identify what we need to know, or do before the next meeting	Action item owners report out and state target dates	

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Develop staff education plan; share at ED huddles for feedback	Joanna	9/19	
Present to Nursing Council	Kelly & Tanisha	9/21	
Train ED staff in "Red Folder" Intake process	Joanna	10/1	

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Work Product from Meeting #5

Ready to Implement?

Implementation Checklist:

- ❑ The tested process is stable and can be documented
- ❑ Process is immune to census/staffing
- ❑ Ready to train others; plan for how
- ❑ Ensure policy, procedure, work instructions, etc. are accounted for
- ❑ Leadership supports formal adoption
- ❑ Defined accountability for sustaining results

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Meeting #6

43 days later

CARE COORDINATION – IMPLEMENTATION FOLLOW-UP - MEETING 6
AGENDA and MEETING SUMMARY

Date: October 25
Time: 8:00 AM to 9 AM
Location: RM 1500
Meeting Leaders: Kelly Karter
Recorder: Stephanie Sobczak

Next Meeting Information
Date: TBD – in 6 months
Time:
Location: Teleconference

ATTENDANCE

NAME	DEPARTMENT/ROLE	Present?	NAME	DEPARTMENT/ROLE	Present?
Kelly Karter	Coordinated Care	Y	Michele Marshall	Inpatient & ED/ Director	Y
Sam Simon	Emergency Department/Nurse Manager	Y	Tenisha Thomas	Coordinated Care RN	Y
Rebecca Right	Emergency Department RN	Y	Stephanie Sobczak	Project Manager	Y
Guest:			**Guest:**		

SUMMARY OF DISCUSSION

Start Time	Topic (Lead)	Outcome	Process	Notes
8:00am (5 min)	1. Welcome Implementation Follow-up Meeting (Kelly)	Clarify purpose of today's meeting	Review Agenda Invite questions	
8:05 am (20 min)	2. Summarize post-implementation data	Document degree of improvement	1. Review Data 2. Review A3 documentation 3. Edit, if needed	
8:25 am (15 min)	3. Identify steps needed to sustain the results	Confirm owners and audit steps	1. Approve audit plan 2. Plan for test	
8:40 am (10 min)	4. Confirm process measure thresholds	Determine key metric and trigger value	1. Document thresholds in A3	
8:50 am	5. Document/Assign Action Items (Kelly)	Identify what we need to know, or do before the next meeting	Action item owners report out and state target dates	

ACTION ITEMS

ITEM	OWNER	TARGET DATE	STATUS
Test Audit Report process	Sam S	10/27	NEW
Schedule touch base teleconference in April	Stephanie	April 1	NEW
Submit Audit reports monthly to Quality & Compliance	Sam S	Nov. 1, ongoing	In process

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Work Product from Meeting #6

Transition Plan

This is included on the back of the Small Test of Change Design document

Operational Transition Plan:		Start Date:
Owner(s) of New Process: Emergency Department Supervisors		Accountable Leader: Sam Simon
Process Measure(s) to Monitor: Admits from CWC w. Red Folder	Oversight Group: ED/Acute Care Council	
Method of Data Collection: 10 CWC admission audit and Safety Incident Reports		Frequency of Data Collection: Monthly
Value to Trigger Process Review: No Less than 80% CWC Admissions have Red Folder x 3 months		

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Documented outcome

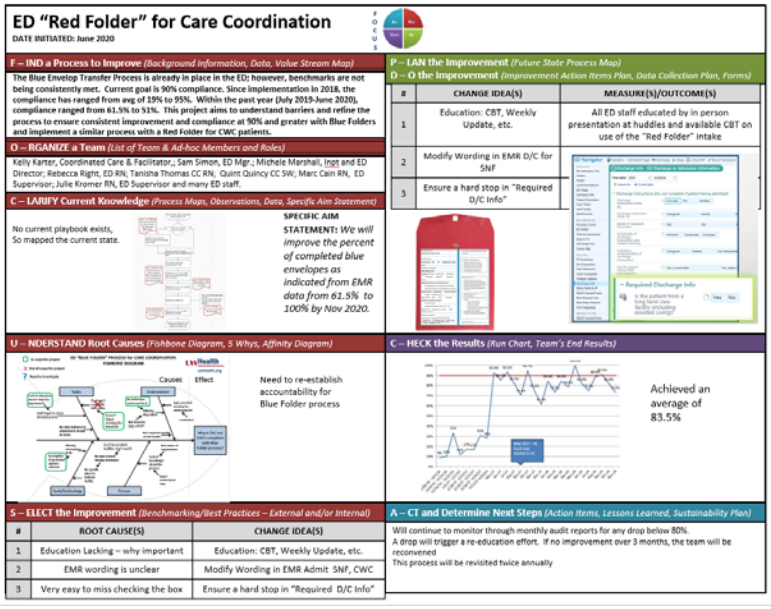
Process map

Education plan

Work instructions

Audit plan

Clear accountability



ED "Red Folder" for Care Coordination

DATE INITIATED: June 2020

F – IND a Process to Improve *(Background Information, Data, Value Stream Map)*

The Blue Envelop Transfer Process is already in place in the ED; however, benchmarks are not being consistently met. Current goal is 90% compliance. Since implementation in 2018, the compliance has ranged from avg of 19% to 95%. Within the past year (July 2019-June 2020), compliance ranged from 61.5% to 51%. This project aims to understand barriers and refine the process to ensure consistent improvement and compliance at 90% and greater with Blue Folders and implement a similar process with a Red Folder for CWC patients.

O – RGANIZE a Team *(List of Team & Ad-hoc Members and Roles)*

Kelly Karter, Coordinated Care & Facilitator,; Sam Simon, ED Mgr.; Michele Marshall, Inpt and ED Director; Rebecca Right, ED RN; Tanisha Thomas CC RN; Quint Quincy CC SW; Marc Cain RN, ED Supervisor; Julie Kromer RN, ED Supervisor and many ED staff.

C – LARIFY Current Knowledge *(Process Maps, Observations, Data, Specific Aim Statement)*

No current playbook exists, So mapped the current state.

SPECIFIC AIM STATEMENT: *We will improve the percent of completed blue envelopes as indicated from EMR data from 61.5% to 100% by Nov 2020.*

P – LAN the Improvement *(Future State Process Map)*

D – O the Improvement *(Improvement Action Items Plan, Data Collection Plan, Forms)*

#	CHANGE IDEA(S)	MEASURE(S)/OUTCOME(S)
1	Education: CBT, Weekly Update, etc.	All ED staff educated by in person presentation at huddles and available CBT on use of the "Red Folder" intake
2	Modify Wording in EMR D/C for SNF	
3	Ensure a hard stop in "Required D/C Info"	

U – NDERSTAND Root Causes *(Fishbone Diagram, 5 Whys, Affinity Diagram)*

Causes Effect

Need to re-establish accountability for Blue Folder process

C – HECK the Results *(Run Chart, Team's End Results)*

Achieved an average of 83.5%

S – ELECT the Improvement *(Benchmarking/Best Practices – External and/or Internal)*

#	ROOT CAUSE(S)	CHANGE IDEA(S)
1	Education Lacking – why important	Education: CBT, Weekly Update, etc.
2	EMR wording is unclear	Modify Wording in EMR Admit SNF, CWC
3	Very easy to miss checking the box	Ensure a hard stop in "Required D/C Info"

A – CT and Determine Next Steps *(Action Items, Lessons Learned, Sustainability Plan)*

Will continue to monitor through monthly audit reports for any drop below 80%.
A drop will trigger a re-education effort. If no improvement over 3 months, the team will be reconvened
This process will be revisited twice annually

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Why does this approach work?

Shifting Paradigms!

Group membership is flexible based on need in the meeting. (This isn't a club.)

It is easier to recruit participants from operations for a defined length of time.

Actively discuss with others the work of the improvement team in real time.

Less focus on filling out the "right" document: A3 or PDSA or DMAIC – and taking meeting time to do it. Pro tip: this can be done on the side.

Progress is steady so people do not lose interest.

The front-line is "in the loop" from the beginning – results in less resistance later.

Crystal clear expectations for accountability and consistent leader involvement as an antidote to cultural "sludge."

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Recommendations

- **Start with something lower risk and smaller in scope, conduct 2-3 projects**
- **Make the defined deliverables an expectation**
- **Works well with a 'train the trainer' model of spread** — *Front-line staff have led projects with this method*
- **Engage the leader** — *Keep them apprised of the progress of the improvement*

Also - Highlight the "Meta" improvements that result from the method: Consistency, Accountability, Rapid Adoption, Engaging the front line

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#1 Takeaway

YOU WILL NEVER CHANGE ANYTHING THAT YOU ARE WILLING TO TOLERATE.

- MYLES MUNROE -

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Questions

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Contact Information

Stephanie Sobczak MS, MBA
Project Manager
Certified Just Culture™ Champion

UW Health at The American Center

SSobczak2@uwhealth.org

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Polling Question #3

Which of the tools shared in this presentation might be the most helpful to you
(check any that apply)

- ❑ Outcome-based agendas
- ❑ Use of the Action Item box
- ❑ Root Cause Analysis diagram
- ❑ Small Test of Change design/planning tool
- ❑ 6 Meetings or Less Structure

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Compass HQIC – New CMS Patient Safety Initiative for Hospitals

KHA Current Report
Oct. 16, 2020

*KHA encourages eligible hospitals to enroll with the **Kansas Healthcare Collaborative** for the Compass HQIC Network.*

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

(Oct. 16, 2020) – Kansas Hospital Association's partner, Kansas Healthcare Collaborative, is now enrolling eligible hospitals for the Compass Network, a hospital quality improvement contract funded by the Centers for Medicare & Medicaid Services over the next four years. This new, national initiative builds upon the solid foundation developed through the recent Hospital Improvement Innovation Network and focuses on rural and Critical Access Hospitals, as well as those identified by CMS as needing technical assistance.

The Compass HQIC is a four-state hospital network supported locally by KHC and KHA. Compass is led by the Iowa Healthcare Collaborative and includes more than 250 similar facilities in Kansas, Iowa, South Dakota and Mississippi. IHC has been a valued and long-term partner of KHC in support of quality improvement initiatives in Kansas, including the recent Compass Practice Transformation Network.

The Compass HQIC will use innovation and data-driven quality improvement interventions to help hospitals achieve CMS goals and ensure patient safety, as well as quality of care. HQICs also will support efforts and help address needs in the areas of infection control, pandemic readiness and response, and a concerted response to the opioid epidemic.

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Upcoming Events

Date	Event
October 29 12:00 to 1:00 p.m.	**Getting started in HQIN** For participating physician practices.
November 4 11:00 a.m. to 12:00 p.m.	**Compass HQIC Office Hours** For more than 80 participating Kansas hospitals
November 18 10:00 to 11:00 a.m.	**KHC Webinar** Topic: Lung Cancer Screening

Register online
https://www.khconline.org/events/full-events-list

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QHi Training Session

Thursday, November 5
1:00 to 2:00 p.m. CT

In this QHi training session, we will review the basics of selecting measures, entering data and running/scheduling reports. Bring questions your questions!

Here is the link to register:
https://cc.readytalk.com/r/s5o89c3fw6y0&eom

Kansas Hospital Association KHERF www.qualityhealthindicators.org

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2020 *Virtual* Kansas Opioid Conference

Registration is now open.

https://www.dccca.org/2020-kansas-opioid-conference/

Kansas Healthcare Collaborative

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Upcoming Events

Advance Care Planning Series *(Continued)*	
January 27 10:00 to 11:00 a.m.	**ACP 201** Important principles guiding clinicians in carrying out ACPs.
March 24 10:00 to 11:00 a.m.	**ACP Medical Orders** Role of standardized medical order sets in ACPs.

Save the dates!
Registration to open soon at www.khconline.org.

In Partnership with

HQIN Health Quality Innovation Network

Center for Practical Bioethics — Guidance at the Crossroads of Decision

Advance Care Planning 101
Conducted 9/23/2020
Recording and handout available in KHC Education Archive:
www.khconline.org/archive

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KHC Education Archive

Topic- and date-based archive for KHC education

→ *www.KHConline.org/archive*

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Monthly emails compiling information from KHC and other sources of interest to hospitals and practices in Kansas.

→ *www.KHConline.org/updates*

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Questions? Comments?

Thank you for joining us.
We invite your feedback.
https://www.surveymonkey.com/r/khc-oct-2020

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785-235-0763
info@khconline.org

Allison DeGroff
Executive Director

Rhonda Lassiter
Executive Assistant/ Office Manager

Treva Borcher
Project Specialist

Phil Cauthon
Communications Director

Michele Clark
Program Director

Eric Cook-Wiens
Data & Measurement Director

Jill Daughhetee
Quality Improvement Advisor

Azucena Gonzalez
Health Care Quality Data Analyst

Malea Hartvickson
Quality Improvement Advisor

Mandy Johnson
Quality Improvement Advisor

Rosanne Rutkowski
Program Director

Patty Thomsen
Quality Improvement Advisor

Rebecca Thurman
Quality Improvement Advisor

→ *Find contact info, bios, and more at:* **www.KHConline.org/staff**

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