This presenter has nothing to disclose

Institute *for* Healthcare Improvement

Using Measurement for Learning and Strategies to Achieve Results

Gail Nielsen

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Session Objectives

Participants will be able to:

- Describe strategies for getting results in over burdened care delivery systems
- Apply strategies and tools for creating an action plan to coordinate and leverage all initiatives to improve care transitions
- Explain the recommended measurement strategy and rationale for using outcome, process and process measures to guide learning and assess progress

Achieving Desired Results

Strategies for Getting Results

- Building will for change
- Using the Model for Improvement
- Clarifying needs for implementation and reliability

Strategies for Getting Results

Building will for change

Strategies for Getting Results

Building will for change

- Scoping clear aims
- Focusing the aims on the Greater Good
- Having the aims on the organization' strategic plan
- Clarifying the gap: reinforcing why change is important
- Engaging frontline ideas and involvement
- Starting with small tests of changes - PDSA

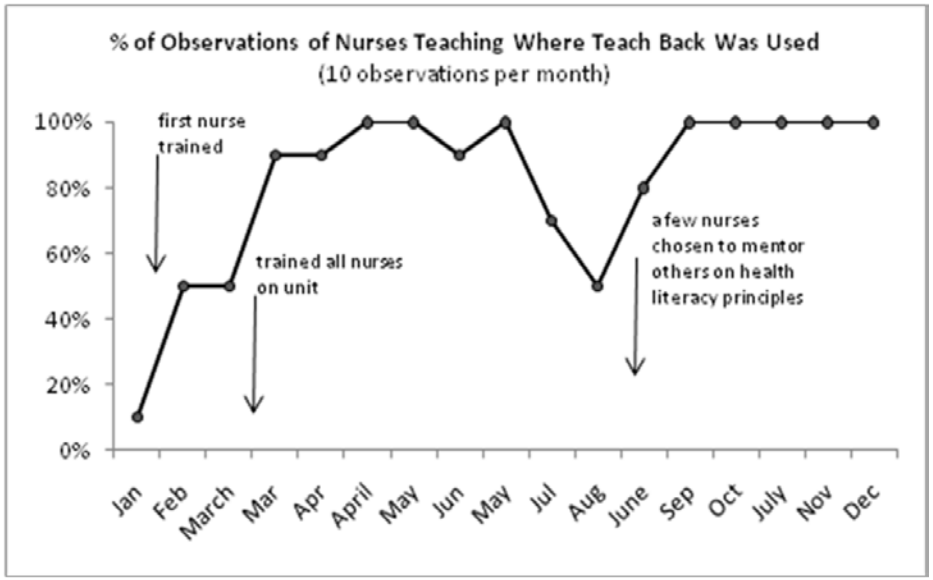
Engaging Frontline Clinicians

- Include them in:
  - Identifying the problems
  - Understanding problem from the patients' perspectives
  - Testing their ideas on how to improve
  - Seeing the impact of changes they make
  - Using observations to learn the real work
  - Honor their work
- Consider the work burden of change and new processes
- Test potential changes well in a small unit before expanding

Seeing the Impact of Changes We Make

Annotated run charts, give us feedback on the relationship between

- Our theory (the changes we are making) and the
- Outcomes for our patients (readmissions and overall experience)



Observing the Actual Processes

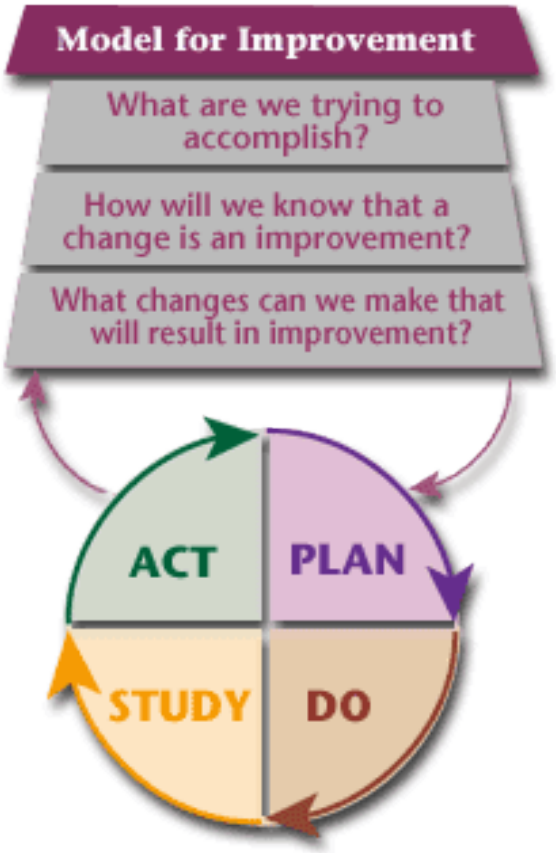
- Go see the real process
- Check assumptions: what really happens compared to what is described?
  - Observe and ask “Why?” five times to get to the root causes of current performance
- Identify process failures you can change
- Discuss changes that your team would like to test

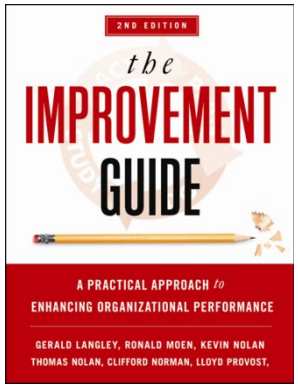
How Do You Build Will for Change?

Strategies for Getting Results

Using the Model for Improvement

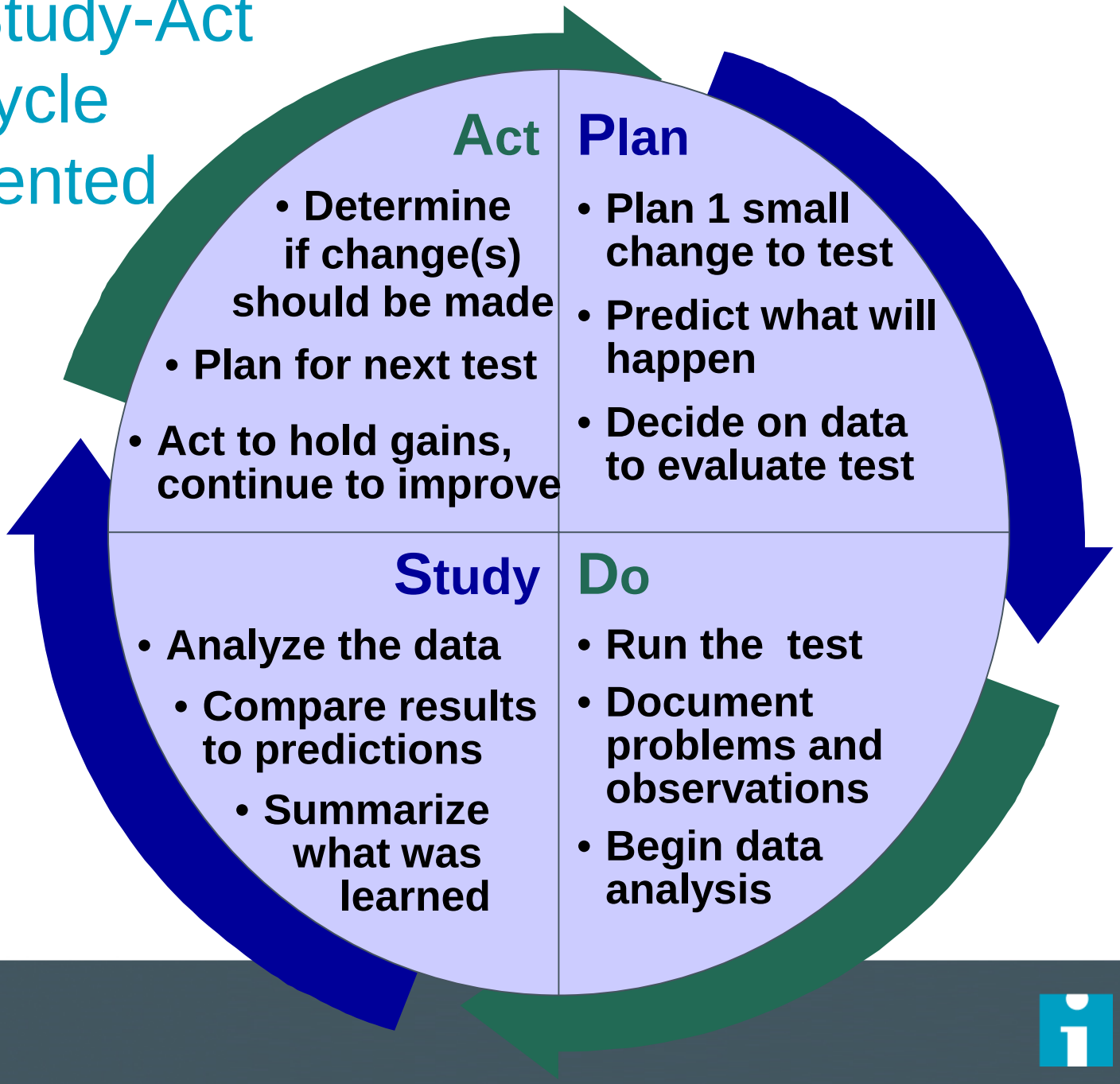
API Associates in Process Improvement





For more information, please visit the IHI Open School Course - QI 102: The Model for Improvement: Your Engine for Change at www.IHI.org

Plan-Do-Study-Act (PDSA) Cycle [action-oriented learning]

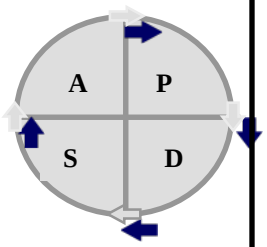


PDSA Worksheet

Team Name:_____

Cycle start date:_____ **Cycle end date:**_____

PLAN: Describe the change you are testing and state the question you want this test to answer (If I do x will y happen?)
What do you predict the result will be?
What measure will you use to learn if this test is successful or has promise?
Plan for change or test: who, what, when, where
Data collection plan: who, what, when, where



DO: Report what happened when you carried out the test. Describe observations, findings, problems encountered, special circumstances.

STUDY: Compare your results to your predictions. What did you learn? Any surprises?

ACT: Modifications or refinements for the next cycle; what will you do next?

Team or Table Exercise

- Work in small groups to:
  - Develop a test of change using the PDSA worksheet
  - Write the plan only
- Faculty available for consults
- Report out > one or two volunteer(s) will share a plan for a test of change

Model for Improvement Resources

Excellent resources for learning (or refreshing your memory) about the Model for Improvement and how to run PDSA cycles

- On-Demand Video: [free]
  - For the video, please visit On Demand: An Introduction to the Model for Improvement, listed under the Virtual Program section at www.ihi.org
- Open School Module: [free for students]
  - For the module, please visit QI 102: The Model for Improvement: Your Engine for Change, listed under the Open School course list at www.ihi.org
- Free whiteboard brief presentations
  - http://www.ihi.org/education/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx

What Works for you?

What Improvement Model do You Use?

Strategies for Getting Results

Clarifying needs for implementation and reliability

Implementation

- The change is **a specified part of daily work** - need to develop all support infrastructure to maintain change
- High **expectation** to see improvement (Eagerness to continue testing to achieve reliability)
- Increased scope will lead to increased **resistance** (Value of evidence from successful tests)

Sequence for Improvement and Spread

Make part of routine operations

Spreading a change to other locations

Test under a variety of conditions

Implementing a change (HTG)

Theory and Prediction

Testing a change26

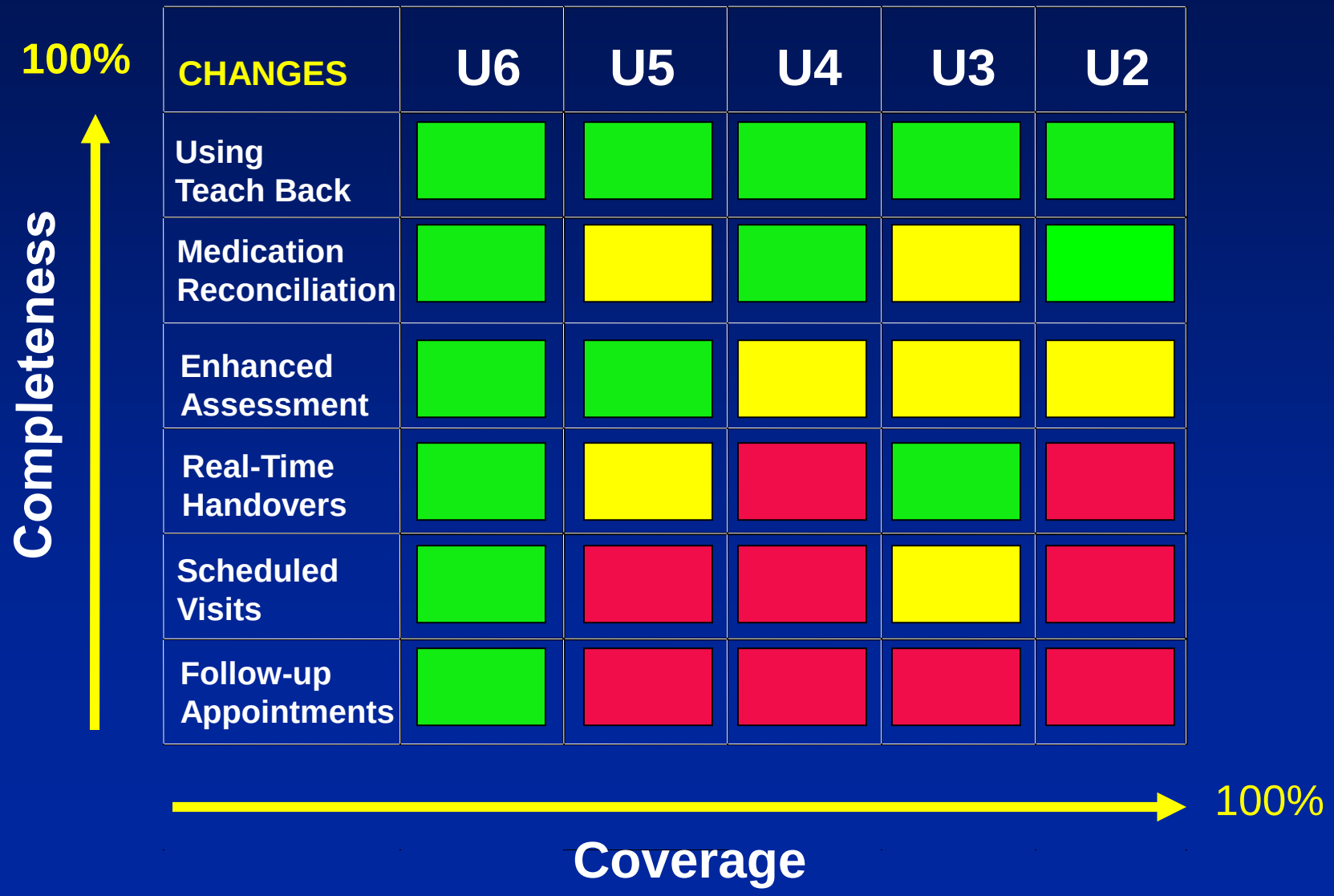
Developing a change

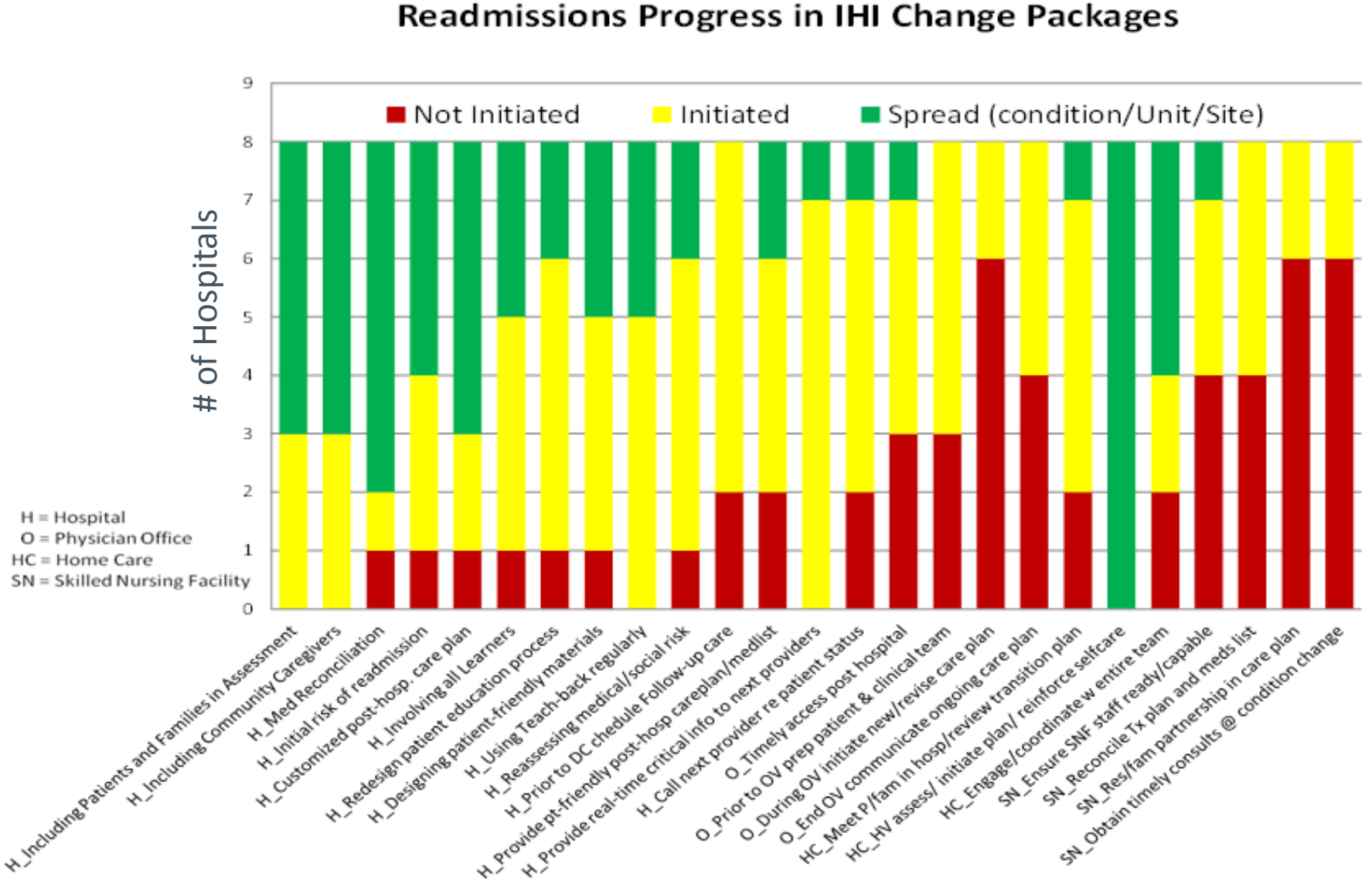
Slide by Robert Lloyd

Implementation Requires . . .

- PDSA: Testing implementation steps
- Established buy–in & consensus building
- Communication
- Training
- Policies & Procedure
- Supportive infrastructure including assigned accountability

Tracking Progress in Changes

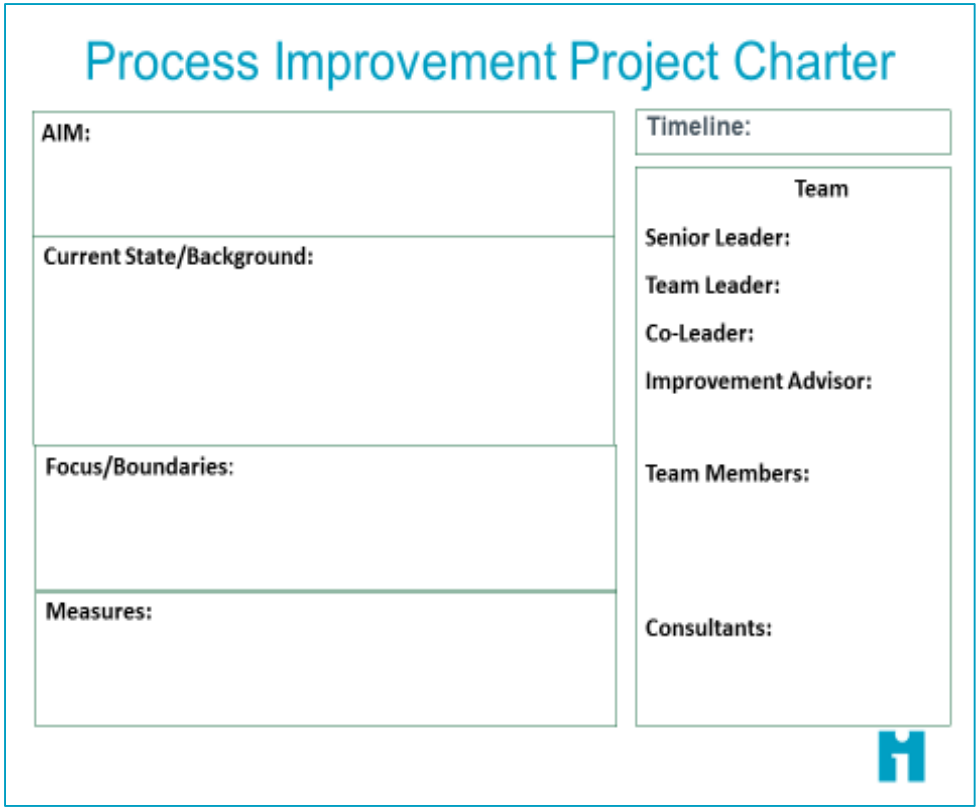



Readmissions Progress in IHI Change Packages
Not Initiated
Initiated
Spread (condition/Unit/Site)
# of Hospitals
0
1
2
3
4
5
6
7
8
9
H = Hospital
O = Physician Office
HC = Home Care
SN = Skilled Nursing Facility
H_Including Patients and Families in Assessment
H_Including Community Caregivers
H_Med Reconciliation
H_Initial risk of readmission
H_Customized post-hosp. care plan
H_Involving all Learners
H_Redesign patient education process
H_Designing patient-friendly materials
H_Using Teach-back regularly
H_Reassessing medical/social risk
H_Prior to DC chedule Follow-up care
H_Provide pt-friendly post-hosp careplan/medlist
H_Provide real-time critical info to next providers
H_Call next provider re patient status
O_Timely access post hospital
O_Prior to OV prep patient & clinical team
O_During OV initiate new/revise care plan
O_End OV communicate ongoing care plan
HC_Meet P/fam in hosp/review transition plan
HC_HV assess/ initiate plan/ reinforce selfcare
HC_Engage/coordinate w entire team
SN_Ensure SNF staff ready/capable
SN_Reconcile Tx plan and meds list
SN_Res/fam partnership in care plan
SN_Obtain timely consults @ condition change

Strategies and Tools for Building an Action Plan

- Using charters
- Planning/tracking progress of changes
- Tracking/exploring connections to other initiatives
- Using balanced measures
- Specifying the measurement plan for collection, analysis and reporting for the frontline to the boardroom

Using Charters to Drive Results



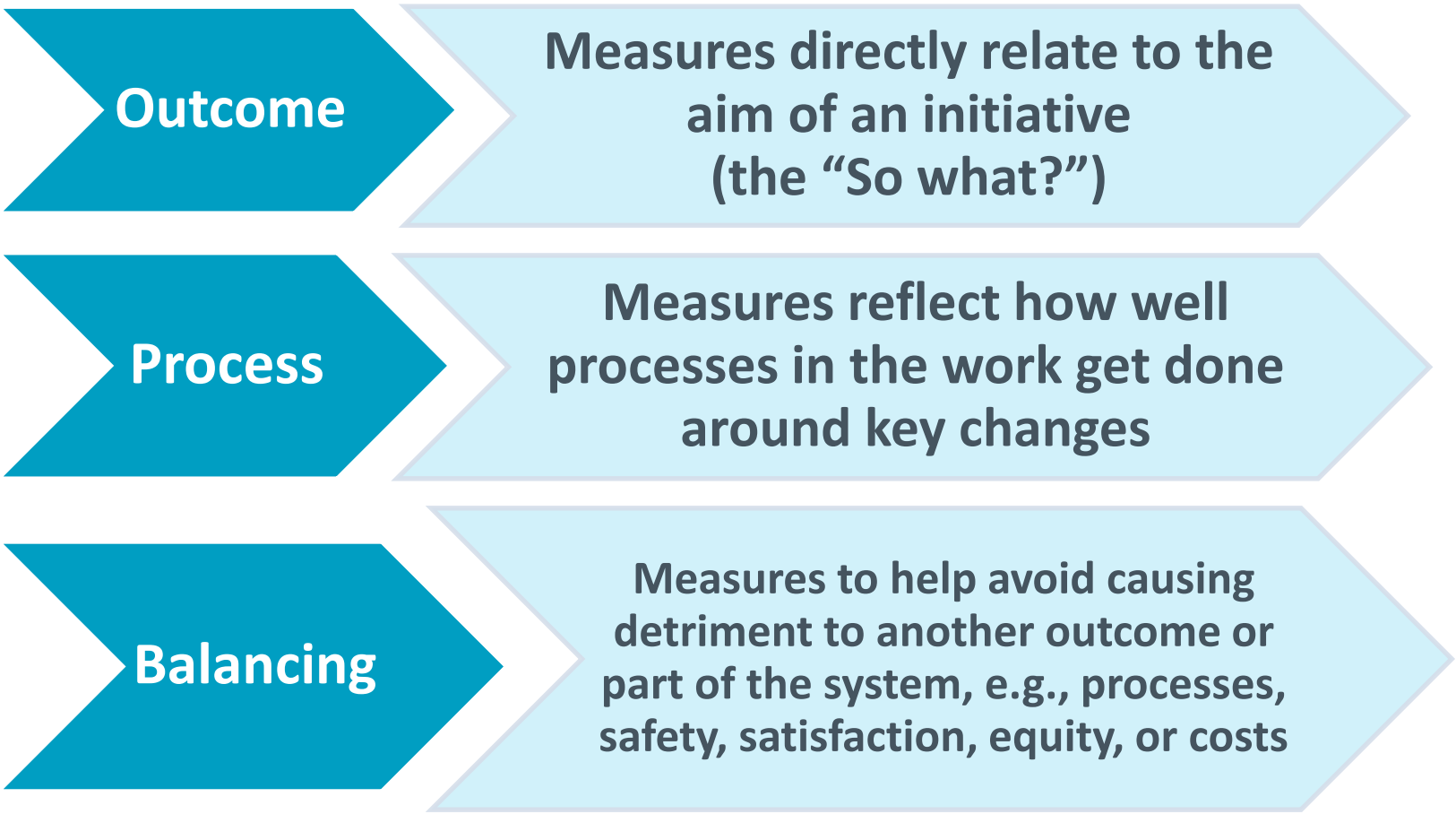
- Signal strategic work across the organization and attract resources
- Frame and enable strategic initiatives
- Keep the team focused through regular review of the aim, timeline, and measures

Cross-Continuum Team: _____ Population: _____
Aim Statement: _____

Key Changes	Processes	Action Plan	Timeline?
Identifying Opportunities for Improvement and Developing Aims	a. CEO selects an Executive Sponsor and a Day-to-Day Leader to lead the improvement work		
	b. Executive sponsor convenes a Cross-Continuum Improvement Team	Include Connections to Other Initiatives	
	c. Team identifies opportunities for improvement using: • In-depth review of the last five re-hospitalizations • Patient experience data on communications and discharge preparations • 30-day all-cause readmission rates		

Preparing to Test: Your team is collecting baseline data; meeting with key informants or team members and constituents; flowcharting or observing the process.
Testing: Your team is trying a change to see if the change results in improvement; there is no assumption that the change tested is permanent yet. A test of change involves complete Plan-Do-Study-Act cycles:
Implementing: Your team is making a successful change permanent. Implementation will often require changing documentation, written policy, hiring, training, and organizational infrastructure - activities usually not required in the testing phase. Implementation, like testing, will requires the use of multiple Plan-Do-Study-Act cycles for continued learning.
Standard Work in Place (with >90% reliability): Your team has developed a highly specified process which is currently in use; documentation exists that indicates the process is followed at least 90% of the time.

Measures to Evaluate Impact and Progress



V. System of Measures

Outcome Measures: Readmissions				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
30-Day All-Cause Readmissions	Percent of discharges with readmission for any cause within 30 days	Number of discharges with readmission for any cause within 30 days of discharge Exclusion: Planned readmissions (e.g., chemotherapy schedule, rehab, planned surgery)	The number of discharges in the month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) **The number of discharges after you remove the exclusions is your denominator (or "index discharges").** 2a. Through the unique medical record identifier, identify those (index) discharges that resulted in readmissions within 30 days of the discharge 2b. Remove exclusions (planned readmissions like chemotherapy, radiation, rehab, planned surgery, renal dialysis) **The number of (index) discharges that resulted in readmissions within 30 days will be your numerator.**
Readmissions Count	Number of readmissions (numerator for % readmissions)	N/A	N/A	Use the numerator specified in the measure above
30-Day All-Cause Readmissions for a Specific Clinical Condition or pilot population	Percent of discharges with a specific clinical condition or pilot population readmitted for any cause within 30 days of discharge	Number of discharges with a specific clinical condition or pilot population readmitted for any cause within 30 days of discharge Exclusion: Planned readmissions (e.g., chemotherapy schedule, rehab, planned surgery)	Number of discharges in the month with the specific clinical condition or pilot population Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	*See above*

V. System of Measures

Outcome Measures: Patient Experience				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
HCAHPS Discharge Question 19	"Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?"	Number patients surveyed in the month who answered, "yes"	Number of surveys completed in the month for the hospital with an answer for this question	Use your organization's HCAHPS data *Note that the CTM 3 (questions 23-25) have been newly incorporated into HCAHPS. CMS has not yet indicated how they plan to analyze this data.*
HCAHPS Discharge Question 20	"Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?"	Number patients surveyed in the month who answered, "yes"	Number of surveys completed in the month for the hospital with an answer for this question	
HCAHPS Care Transitions Measures Question 23 (adopted from CTM3 question)	"During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left."	Number patients surveyed in the month who answered agree or strongly agree	Number of surveys completed in the month for the hospital with an answer for this question	
HCAHPS Care Transitions Measures Question 24 (adopted from CTM3 question)	"When I left the hospital, I had a good understanding of the things I was responsible for in managing my health."	Number patients surveyed in the month who answered agree or strongly agree	Number of surveys completed in the month for the hospital with an answer for this question	
HCAHPS Care Transitions Measures Question 25 (adopted from CTM3 question)	"When I left the hospital, I clearly understood the purpose for taking each of my medications."	Number patients surveyed in the month who answered agree or strongly agree	Number of surveys completed in the month for the hospital with an answer for this question (excluding those with the response "I was not given any medication when I left the hospital")	

V. System of Measures

Process Measures				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
Patient and Family Involvement in Identifying Post-Discharge Needs	Percent of admissions where patients and family caregivers are included in identifying post-discharge needs Guidance: In order to determine whether patients and families were involved in discharge planning, you will need to define a process you want your staff to use. See change 1A for ideas.	Number of admissions in sample where patients and families were included in identifying post-discharge needs	Number of admissions in the sample	• Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if patients and families were included in identifying post-discharge needs
Patient Teach Back	Percent of observations of nurses teaching patient or other identified learner where Teach Back is used to assess understanding This data can be measured for other disciplines (e.g., physician, dietary, pharmacy, etc.) as necessary.	Number of observations of nurses where Teach Back is used to assess understanding	Number of observations of nurses teaching	Observe 10 to 20 teaching opportunities: 2 to 5 per week for 4 weeks a month until the process appears effective and reliable.
Teach Back Communication	Percent of discharges where patient/family understanding of Teach Back is documented in the electronic medical record	Number of discharges where patient/family understanding of Teach Back is documented in the electronic medical record	Number of discharges in the sample	Retrieve from the Electronic Record.

V. System of Measures

Process Measures				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
Timely Handover Communication	Percent of time critical information is transmitted at the time of discharge to the next care site or person continuing care (e.g., home health, long-term care facility, rehab care, physician office, or carer at home) Guidance: In order to determine whether critical information has been transmitted you will need to know what you mean by critical information. We recommend you work collaboratively with your receivers to make this determination. See change 4B for ideas.	Number of discharges in the sample where critical information is transmitted at the time of discharge to the next care site or person continuing care (e.g., home health, long-term care facility, rehab care, physician office, or carer at home)	Number of discharges in the sample	• Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – for example, collect copies of the transfer forms and count them up, or keep a tally sheet
Patient-Friendly Post-Hospital Care Plan	Percent of patients discharged who receive a customized post-hospital care plan written in patient-friendly language at the time of discharge	Number of patients in the sample who receive a customized post-hospital care plan written in patient-friendly language at the time of discharge	Number of patients in the sample	• Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – for example collect copies of the care plans and count them up, or keep a tally sheet.

V. System of Measures

Process Measures				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
Post-Hospital Care Follow-up	Percent of patients discharged who had a follow-up visit scheduled before being discharged in accordance with their level of assessed risk	Number of patients in the sample who had a follow-up visit scheduled before being discharged in accordance with their level of assessed risk	Number of patients in the sample	• Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if appointments were made in accordance with risk assessment

V. System of Measures

Balancing Measures				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
30-Day All-Cause Readmission to Observation Status	Percent of patients readmitted to observation status within 30 days of a hospital discharge	Number of discharges with readmission to observation status for any cause within 30 days of discharge	The number of discharges in the month. Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) **The number of discharges after you remove the exclusions is your denominator (or "index discharges").** 2. Through the unique medical record identifier, identify those (index) discharges that resulted in admission to observation status within 30 days of the discharge **The number of (index) discharges that resulted in observation status admission within 30 days will be your numerator.**
Count of Observation Admissions within 30 Days of Hospital Discharge	Number of patients admitted to observation status within 30 days of a hospital discharge	Number of discharges with readmission to observation status for any cause within 30 days of discharge	NA	Use the numerator specified in the measure above

V. System of Measures

Balancing Measures				
Measure	**Description**	**Numerator**	**Denominator**	**Data Collection Strategy**
Emergency Room Visits within 30 Days of Hospital Discharge	Percentage of patients who have ED Visit within 30 days of hospital discharge	Number of patients with ED visit within 30 days of hospital discharge	The number of discharges in the month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) **The number of discharges after you remove the exclusions is your denominator (or "index discharges").** 2. Through the unique medical record identifier, identify those (index) discharges that resulted in an ER Visit within 30 days of the discharge **The number of (index) discharges that resulted in ER visits within 30 days will be your numerator.**

Reflections

- What ideas did you hear that you might apply?
- What was most exciting for you?
- What was confusing?
- Need more information about….?