Building Capacity and Capability: The Really Big Challenge

Lisa Schilling, RN, MPH, Kaiser Permanente
Uma Kotagal, MBBS, MSc, Cincinnati Children’s Hospital Medical Center
Katharine Luther, RN, MPM, Vice President IHI, Facilitator

Sunday, December 8, 2013

Objectives

- Define the key components of a capacity-building strategy
- Identify key milestones in the capacity-building journey
- Assess their organization’s capacity for sustained change
Agenda

1:00 - 1:15 – Introductions/Overview
1:15 – 1:45 – Definitions, Framing, Key components
1:45 -- 2:15 – How We Did It -- Lisa Schilling
2:15 --2:30 -- Break
2:30 – 3:00 -- Table Exercise – World café
3:00 - 3:30 – Milestones – Uma Kotagal
3:30 – 4:00 -- Table Exercise -- Assessing your capacity
4:00 – 4:30 – Developing your plan – all faculty

Key Terms

**Capacity**

- The ability to receive, hold or absorb
- The maximum or optimum amount of production
- The ability to learn or retain information.”
- The power, ability, or possibility of doing something or performing
- A measure of volume; the maximum amount that can be held

**Capability**

- The power or ability to generate an outcome
- The ability to execute a specified course of action
- The sum of expertise and capacity
- Knowledge, skill, ability, or characteristic associated with desirable performance on a job, such as problem solving, analytical thinking, or leadership
- Some definitions of capability include motives, beliefs, and values
Framing our thinking

- Will: Change thinking
- Results: Get it done, Make it last
- Ideas: Innovate, Harvest, Package
- Execution: Get it done, Make it last

Framing our thinking

- Will: Change thinking
- Results: Get it done, Make it last
- Ideas: Innovate, Harvest, Package
- Execution: Get it done, Make it last
The Big Challenge -- Execution

Source: The Improvement Guide, API
Portfolio approach – Single Project

Aim

4) Zero Preventable complications

Maturing Your Efforts

(under development) Kathy Luther, IHI/ Steven J. Spear – High Velocity Edge

<table>
<thead>
<tr>
<th>Level</th>
<th>Characteristics</th>
<th>Description</th>
<th>“Results”</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Leaders lead</td>
<td>Leaders actively engaged in leading changes</td>
<td>Leaders work with teams to create improvement in the work areas. Leaders as coaches.</td>
<td>Continuous improvement system throughout organization. New levels of performance. Breakthroughs attained</td>
</tr>
<tr>
<td>4 Leaders cheer</td>
<td>Systems change organically creating value as they do</td>
<td>Local microsystems complete the work and solve problems and improve processes daily. Continuous PDSA cycles.</td>
<td>Pockets of continuous improvement. Leaders showcase work of top performers. Islands of excellence</td>
</tr>
<tr>
<td>3 Spectator x3</td>
<td>Systems stabilized; episodic process improvement</td>
<td>Repeated process re-build “Experts return”</td>
<td>Improvement occurs. Staff maintains, but does not continue. Sporadic good results, many sustained</td>
</tr>
<tr>
<td>2 Spectator</td>
<td>Adopting tools and systems</td>
<td>Chartered teams, Kaizen’s, redesigns as organizational initiatives. “PI team leaves, project ends”</td>
<td>No improvement beyond initial level. Same projects repeated again and again</td>
</tr>
<tr>
<td>1 Buffers</td>
<td>Some standard work</td>
<td>People in roles standardize their individual work (ex. Charge nurses, chief residents, managers)</td>
<td>Local order, system chaos; People and systems act as buffers. Small improvements – not replicable or sustained. “Positive Deviants” lead small workgroups and units</td>
</tr>
<tr>
<td>0 Chaos</td>
<td>“Winging it”</td>
<td>Daily work, daily problems</td>
<td>No processes, random variation. No improvement</td>
</tr>
</tbody>
</table>
Components of capacity-building strategy

- System for “maturing” your organization
- Linked PI efforts and defined role
- Training program

L2: Building Capacity and Capability: The Really Big Challenge

Lisa Schilling, RN, MPH
Vice President,
CMI Center for Health Systems Performance

IHI National Forum
Orlando Florida
December 8-11, 2013
Kaiser Permanente by the Numbers

- 7 regions serving 8 states and the District of Columbia
- 9.1 million members
- 16,000 physicians (we hire just 10% of MD applicants in California)
- 174,000 employees (including more than 48,000 nurses)
- 38 medical centers (with hospitals)
- More than 600 medical offices (ambulatory care buildings)
- $50.6 billion operating revenue (2012)

Our System Is Based on the Attributes of High Performing Organizations

*KP builds capability in these six areas in order to achieve breakthrough performance*

- Leadership
- Learning
- Systems
- Capacity
- Measurement
- Culture

Best quality
Best service
Most affordable
Best place to work
Avoiding Death by 1000 Initiatives: Strategic Alignment

Top down
- Reduce variation
- Learning system
- Economic and social context for change
- Models of workplace learning
- Team performance
- Define organizational needs
- Create system view
- Plan/ manage improvement
- Align with strategy
- ID drivers and portfolios
- Build capability to improve
- Engaging the hearts and minds of the front line
- Creating “line of sight” to strategic goals
- Define high performing unit-based teams

Bottom up
- Learning and improvement
- High Performing Organizations Build Culture and Capability
- Principles
  - What we “do”
  - Align with strategy
  - ID drivers and portfolios
  - Build capability to improve

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Goal for Care Delivery Capability Development
Circa 2007

Assist regions and facilities in developing, testing and implementing a KP-wide performance improvement system that builds the capacity to execute on high priority initiatives in each KP region by 2010.

Drivers of Implementing an Operational PI System

**AIM**

- Capable of achieving breakthrough performance across KP

**Primary Drivers**

- Create unified KP Performance Improvement framework
- Create Improvement infrastructure
- Effective execution strategy of top quality priorities in operations
Building Will

- Define Breakthrough goals
- Spread and sustain
- Provide Leadership for Large system Projects
- Develop Capability
- Manage Local Improvement

Source: IHI 2008

Will: From Strategy to Execution

- Big Aim
- Strategy
- Dashboard
- Targets

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Inpatient Mortality: All KFH HSMR continues below US Medicare benchmark and variation lowest ever.

HEDIS: KP performance continues to trend above the national 90th Percentile.

Safety: Overall Program did not meet the goal of 10% reduction in SRAEs during Performance Year.

Risk Mgmt: A 15% reduction from 2009. (no change from last qtr)

Service-METEOR: No update. Programwide 15.3 point increase in Health Plan Rating & 10.5 point increase in Health Care Rating from Q2'10

Service-HCAHPS: Programwide significant improvement (+2.9 points) from previous year. Gap to top quartile is 1.9 points.

Resource Stewardship: No threshold has been established for this new (as of 2011Q1) top level metric, commercial HMO risk adjusted selected services cost PMPM.

Equitable Care: African American-White disparity became 1.0% smaller compared to a year ago.

T JC: For the first time, the combined TJC composite for all KFH hospitals is now less than one point from 100% - the national 90th percentile.
Identifying Levers of Improvement: Driver Diagrams

**INITIATIVES**

- **Wins To Show Value**
  - Deep dive into 2-3 value streams or portfolios of work with significant impact to organization. Show contribution to key results.
  - Systems and structures to harvest ideas/innovations from front line and quantify contribution to organizational goals.
  - Systems and structures to quantify contribution to organizational goals from SJW trainings.

- **Teach To Spread Knowledge**
  - Train our leaders (management, physicians, and labor leaders) with basic tools and methods for The San Jose Way.
  - Application of San Jose Way tools and concepts integrated into department operating plans, UBT work or key value streams/portfolios.
  - Create learning opportunities that leverage current meeting structures and forums for management and leadership teams.
  - Appropriate level of training for everyone in the organization.
  - Continue to leverage Wave training with KP PI Institute.

- **Lead to Change Culture and Behavior**
  - Develop appropriate oversight structure for the San Jose Way that leverages our integration and partnerships.
  - Develop our Leaders as coaches for the SJW.
  - Connecting the dots—integrate operating plans and UBT work.
  - Individual accountability.
  - Share successes and best practices.

**MEASURE/TARGETS**

- **TIME**
  - Measure patients with deep plan of care.
  - Measure patients with high and medium level of chronic care.

- **QUALITY**
  - Measure patients with high and medium level of chronic care.
  - Measure patients with high and medium level of chronic care.

- **SUPPORT**
  - Measure patients with high and medium level of chronic care.
  - Measure patients with high and medium level of chronic care.

**KEY**

- In Maintenance
- In progress
- In progress

**HOSPITAL THROUGHPUT LOOP**

**DRIVERS**

**AIM**

- Efficiency
  - Targets: HC/PI=0.99
  - PI=0.99

**ACTIONS/INITIATIVES**

- **Wins To Show Value**
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**MCH ORGANIZATION CHARACTERISTICS**

- **MCH Value Stream**
  - HER Value Stream
  - Patient Flow Portfolio
  - 7 Day Hospital Portfolio
  - San Jose Way Action Plans
  - Visual Management Boards

**Medical Center Level: San Jose Implementation Strategy/Tactics**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Tactics</th>
<th>Actions/Initiatives</th>
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<tbody>
<tr>
<td>Wins To Show Value</td>
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<td>MCH Value Stream</td>
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<td>Visual Management Boards</td>
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<td>San Jose Way—Lego Simulation Training</td>
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<td>San Jose Way Action Plans</td>
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<td>3 Year Training Plan</td>
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<td></td>
<td></td>
<td>3 Year Training Plan</td>
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<td></td>
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<td>Gemba visits for senior leaders</td>
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<td></td>
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<td>Advanced LEAN training for Operational Leaders (Virginia Mason)</td>
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<tr>
<td></td>
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<td>Continuous messaging from leaders</td>
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<tr>
<td></td>
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<td>Training and application written into 2013 goals</td>
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<td></td>
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<td>Stand ups and storytelling</td>
</tr>
</tbody>
</table>
San Jose Portfolios/Value Streams for 2013

<table>
<thead>
<tr>
<th>Portfolio/Value Stream</th>
<th>Potential Projects in Portfolio/Value Stream</th>
<th>Sponsor</th>
<th>CO Leads</th>
<th>PI Mentor</th>
<th>Portfolio &amp; Project Mgr</th>
<th>Project Level Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Child Health Value Stream</td>
<td>End to End VS LOS Normal Neonborn Pre Natal Education Post Partum Service</td>
<td>M Lum</td>
<td>D Goeringer</td>
<td>A Liu</td>
<td>H Williams</td>
<td>Wave 7/Any Strong/Manager</td>
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<td></td>
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<td>UBT Support</td>
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<td></td>
<td>Post UBT (4) OR (Syn UBT) (4)</td>
</tr>
<tr>
<td>High Efficiency Rooms Value Stream</td>
<td>BER ASU / HER MDR</td>
<td>T Chavez</td>
<td>Y Wemple</td>
<td>A Liu</td>
<td>C Solis</td>
<td>MU UBT (3)</td>
</tr>
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<td>MOR (3)</td>
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<td>SPD (2)</td>
</tr>
<tr>
<td>Patient Flow Portfolio</td>
<td>ED to Bed @ Shift Change PACU Boarding Time DC Boarding Time IP Room Clean TAT DC Order Time Conditional DC Orders</td>
<td>D Goeringer</td>
<td>E Rosas</td>
<td>E Tran</td>
<td>T O’Connor</td>
<td>ED UBT (2)</td>
</tr>
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<td>OP Pharm (4)</td>
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<td>Transport (1)</td>
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<td>PCS UA (51)</td>
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<td></td>
<td></td>
<td></td>
<td>Social In (3)</td>
</tr>
<tr>
<td>7 Day Hospital Portfolio</td>
<td>CT-ED Orders CT-ED TAT</td>
<td>T Chavez</td>
<td>Y Wemple</td>
<td>E Rosas</td>
<td>J Crosier</td>
<td>Radiology UBT (2)</td>
</tr>
<tr>
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<td>PT (4)</td>
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<td>Respiratory (4)</td>
</tr>
</tbody>
</table>

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San Jose HERS Value Stream: Visual Boards and RIE

Ideas at Scale: Solving Population Problems
The National Medicare Challenge

Develop a Complex Care Medical Home that improves health and quality of life for patients and families, by providing high quality affordable health care

The Model for Complex Care

**Bundle Elements**

1. **Patient Identification**: The PST is loaded with updated data on patient segmentation monthly. Complex patients are identified as Care Group 4. This ID is used in partnership with the PCPs to identify patients that would benefit from the complex care program.

2. **Assessment**: The Medicare Total Health Assessment is used to determine a baseline for the patient's current condition. The MTHA identifies 6 triggers that, if positive, kick off further assessment with the Complex Care Team.

3. **Plan of Care**: Once the Complex Care team has assessed the patient, they meet to collaboratively create a plan of care, with oversight from the program's physician and PCP. POC is documented in the PCCN / (PCOP).

4. **Team Coordination**: The Plan of Care guides coordination of care for the patient, whether it’s proactive follow up in 2 months with our Navigator, Case Management with a Clinic Back Office RN, or Intensive Case Management with our Complex Care Case Management team.

5. **Transitions**: Patients who have an inpatient stay or require a transfer to a new location automatically receive the high risk transitions bundle to ensure a smooth, well-managed transition. Team monitors reports to identify people in hospital.

6. **Advance Care Planning**: All complex patients have a discussion with their PCP and / or a Social Worker to review goals of care and discuss Advance Care planning to ensure their wishes are understood.
**PDSA cycle: Over 30 ideas tested - 8 Adopted for Model**

<table>
<thead>
<tr>
<th>Component</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Care Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obtain advanced directives on appropriate patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Create path to appropriate referral to PC services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Expand criteria for HBPC to include some homebound</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Test ACP videos</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Automatic referral to SW for seg 4 patients admitted to ED</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Use MTHA to screen each patient in S4 to trigger the right care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Assess patient and caregiver needs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Understand the patient voice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Interdisciplinary care conferences in clinic</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Integrate ED physicians into the care planning process for Segment 4 patients that are high utilizers</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Pharmacists review med list for patients over 6 chronic meds</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Proactive team based care to make PCP visit more efficient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Longer PCP Visits for select patients - rotate team in to do assessments or goals conversation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Consider dementia or geriatric clinic - ID right patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Provide geriatric consult when needed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pharmacist will implement polypharmacy tool</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide home visit by provider to patients in need (PCP and/or KPCares)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Provide home visit by KPCares for &quot;episodic needs&quot;</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Special phone number to patients for EZ access to team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Navigator roles: aide or MA vs RN; central or local</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide case management, navigation as identified in care planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Pharmacist brown bag review of meds at clinic visit</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Document POC next steps using PCCN or alternative place</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Include patient in redesign process</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Understand and document patients goals of care in POC</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Identify follow up needs of patients and how they will be met in POC. (Min. annually)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Patients identified needing intensive case mgmt to NCQA complex case manager team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Connect with community organizations eg AAA, Alzheimer’s</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Each PCP at EIN ID which S4 pts need SW, CM, AICC, HV, UC</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Segment Entire population - make available in PST</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Hospitalists and CM will test access to PST - decide how to use</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>All patients who have a hospitalization will receive the High risk transitions bundle</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Plan of Care will be reviewed and updated after transitions</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>CCCM nurses making transition call coordinate with Complex Care Med Home team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>CCCM nurses look for who is in segment 4 - high risk transitions bundle</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>
| Comparison: Complex Care Across KP

**Key Components**

<table>
<thead>
<tr>
<th>Component of Complex Care Programs</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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</thead>
<tbody>
<tr>
<td>Patient Identification - Risk stratification / Tailored care</td>
<td>CG4</td>
<td>CG2-4</td>
<td>duals</td>
<td>Hi-util stratification</td>
<td>CG4</td>
<td>CG2-4</td>
<td>Hi-util stratification</td>
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<tr>
<td>Standardized assessment of patient needs</td>
<td>THA</td>
<td>THA</td>
<td>Hi-util stratification</td>
<td>CG4</td>
<td>CG2-4</td>
<td>Hi-util stratification</td>
<td></td>
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<tr>
<td>Coordinated plan of care</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Interdisciplinary Team Coordination</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Excellent Transitions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<tr>
<td>Systematic Advance Care Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>In home care delivery</td>
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<td>X</td>
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</tr>
</tbody>
</table>
Develop Capability for Execution

Define Breakthrough goals

Manage Local Improvement

Provide Leadership for Large system Projects

Provide Day-to-Day Leadership for Micro Systems

Develop Capability

Spread and sustain

Large system Projects

What are we trying to accomplish?

How will we know that change is an improvement?

What change can we make that will result in improvement?

KP Performance Improvement Model

Assess

Develop/Identify Change

Test

Implement/Control

- Process map
- Charter project
- Create portfolio
- Data collection plan

- Standardize and simplify
- Reduce waste
- 6S
- Reduce defects
- Apply evidence-based practices

- Training
- Policy & procedures
- Feedback loops
- Error proofing
- Control charts
- Spread plan

Source: IHI 2008

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Execution is Everybody’s Job

A key operating assumption of building capacity is that different groups of people will have different levels of need for PI knowledge and skill.

Our approach will be to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts.

Continuum of PI Knowledge and Skills

Deep Knowledge

40,000

1,500

Shared Knowledge

Continuum of PI Knowledge and Skills

Execution is Everybody’s Job

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Continuum of PI Knowledge and Skills

Deep Knowledge

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Shared Knowledge

Testing to Implementation Across a System:
Planning to Achieve Big Results Over Time

Cycle #1
- Improvement Advisor
- Leadership
- First project
- Oversight responsibility
- Several teams
- 90 days

Cycle #2
- Several Improvement Advisors
- Prioritization and portfolios
- Oversight groups
- Sponsor and champion accountability by service
- Team development and alignment of goals

Cycle #3 and beyond
- Service line IA’s
- All leaders know role and skills
- Prioritization and oversight in operations
- Alignment of portfolios
- Standard work
- Teams know goals and test change

Learning and sharing systems regionally and program-wide Improvement Institute

Project

Portfolio

Whole system

Continuous Improvement

Mentors

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Improvement Institute: Delivering Value

Week 1
- Assess, Plan

Week 2
- Test, Implement

SPC
- Control

Medical Center Results
- 1,500 Graduates
- $300 Million

90 Days: Apply Learning and Get Results

<table>
<thead>
<tr>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
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<td>2010</td>
<td>2011</td>
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</tbody>
</table>

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dramatic reduction in risk adjusted hospital mortality

inpatient outcomes: hospital standardized mortality ratios

KP - All Facilities
US Medicare Overall
Kaiser Foundation Hospital

Ratio of observed to expected mortality

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Exercise: IHI Improvement Capability Self-Assessment Tool

**DIRECTIONS FOR USE**

For each of the six areas, select and record below the level of capability that you think best fits your hospital’s current improvement capability and briefly describe the data/evidence you used to make your decision.

---

**Break**