Leading Quality Improvement: Essentials for Managers
Session 9: Empower Teams to Engage in Improvement

The Sarah Kadish Case

Overview
Leading Quality Improvement: Essentials for Managers is designed to build the knowledge, skills, and capabilities needed to empower participants to lead quality improvement efforts within their organizations. Past sessions have introduced key elements to consider including leadership, management, systems thinking, patient safety, and quality improvement.

This last session now shines the spotlight on the concept that achieving meaningful improvement requires genuine teamwork among various departments and functions within an organization. Such teams are often led by middle managers, who may not have formal authority over the other team members. These middle managers must find strategies to engage and empower their teams toward reaching common goals.

The following case looks at an effort to improve outpatient wait times at Dana-Farber Cancer Institute. This example illustrates the power of engagement and empowerment of the team, while also showing how the many lessons learned through Leading Quality Improvement: Essentials for Managers can truly come together in a real-world setting under the direction of one middle manager who set out to create measurable change.

The Sarah Kadish Case
The Dana-Farber Cancer Institute, located in Boston, Massachusetts, provides the latest in cancer treatment to pediatric and adult cancer patients. Following the death of two patients due to medication errors, the organization became nationally known for its work in patient safety and patient and family engagement. At that time, pediatric and adult patient and family advisory councils (PFACs) were established.

Phase 1: Sarah Kadish, a quality improvement manager at Dana-Farber, was asked to support a tough issue that the hospital had been unable to solve: reducing outpatient wait times. It wasn’t the first time the issue had come up at Dana-Farber, but initiatives to revise scheduling, staffing, and patient education had had little impact in the past. The issue was raised again at an Adult PFAC meeting, where patient Scott Vierra made it clear that the organization needed to find a way to resolve the problem for once and for all.

“The number one thing I want Dana-Farber to fix is the wait time,” Scott said, as other patients in the room nodded their heads. “I have cancer and a family and a full-time job. My time is precious. It is simply unacceptable to come here and have to wait so long to see my doctor and then have my infusion started,” Scott explained.

Sarah was sympathetic about the frustrations faced by Scott and the other patients, but she wasn’t sure what the hospital could do that hadn’t already been tried to reduce wait times. Their current
process was to periodically have QI staff stand with clipboards and stop watches to clock providers and patients as they went in and out of exam rooms, or to combine time stamps from various electronic systems to determine patient arrival and service times. But due to the labor-intensive nature of using the information gathered through these measurement systems, wait time was primarily assessed through the patient satisfaction results — which had not budged in years.

**Discussion Questions:**
1. What are the first things that have to happen for real improvement to take place?
2. Like many quality improvement initiatives, this problem seems difficult to solve. What must be in place to really have an impact on such a difficult-to-solve problem?
3. How should Sarah get started? Where should she begin?

**Phase II:** Dana-Farber valued the voice of the patient, yet the organization did not have any meaningful way in place to respond to the patients’ number one issue: long wait times. This was because there wasn’t any system in place that could continuously measure performance and apply the findings in a meaningful way. After listening to the patients’ concerns, Sarah realized that starting a concrete measurement system was critical to improving wait times, so she reached out to the senior management team for help. After hearing repeatedly at a QI training program, “You measure what you value, you value what you measure,” the leadership realized that they were not valuing the patient voice because they were not investing in measuring wait times.

To measure patient wait times, they decided to do a pilot test using a real-time locator system (RTLS). RTLS can automatically identify and track the location of objects or people in real time.

Sarah was assigned to be the team leader for the pilot test, which was focused on just a few Dana-Farber clinics to start. The pilot test would enable the organization to determine if the technology worked and if the system added value by reducing wait time before they adopted the effort on a broader, system-wide level.

As part of this effort, RTLS devices were installed throughout the clinic, such as at entrances to every exam room, at the area where vital signs were checked, and at the registration area. Staff and patients were required to wear RTLS badges so that their locations could also be tracked throughout the area. Using this system, the clinic staff could identify the location of all workers, providers, and patients by looking at a screen on their computer or the wall to coordinate care. From these screens, they could see the icons walking around the floor and proactively identify patients who had been waiting a long time to have their vital signs done, see a doctor, or check out. The system also provided a wealth of data to identify patterns in wait times overall. Sarah was tasked with leading the team’s process improvement efforts to respond to the findings.

**Discussion Questions:**
1. What tools might Sarah have used to design the pilot? Where should the pilot take place?
2. What could Sarah do to effectively lead a team made up of members who did not report to her? How could she engage them in the quality improvement initiative?
3. What support systems needed to be in place for the pilot to be truly effective?

**Phase III:** The pilot demonstrated that the RTLS technology did work to lessen wait times, but it also revealed numerous operational problems that needed to be addressed. For example, some staff—
particularly physicians—were initially reluctant to wear the badges. Further, many patients walked out of Dana-Farber still wearing their badges. As a result, the loss rate was projected to cost almost $35,000 per year.

**Discussion Questions:**
1. How might patients and families and/or PFACs be involved in designing and testing RTLS?
2. What could Sarah and the team do to persuade reluctant staff to participate in RTLS?
3. How could the staff remind patients to return the badges before leaving the premises?

**Phase IV:** Eventually, RTLS was installed in all the clinics, with the exception of the registration, lab, and infusion areas. Sarah continued to serve as the project manager, distributing data and working through operational problems. Over time, with turnover of key staff, including the Chief Operating Officer and Chief Medical Officer, the RTLS task force involved new staff. Over the next three years, wait time data helped to identify problems with the assignment of clinic rooms, scheduling, staffing, and patient communication. Each issue was resolved, one-by-one. Wait time and throughput times decreased over the next three years. With greater staff acceptance, RTLS was eventually implemented throughout the entire new building, including in the lab, clinics, and infusion unit.

**Discussion Questions:**
1. How could Sarah bring RTLS to scale across Dana-Farber?
2. How should Sarah try to keep the team focused on this initiative over time, so that the advances made won’t decline?
3. Why were Sarah’s efforts ultimately successful? What did she do that helped the project be effective? Is there anything she have done differently?