Quality Improvement 101, Part 2

Improving team performance through redesigning processes

Hunter Gatewood
Improvement Advisor
Signal Key Consulting
QI = How do we do things better?

• Focus: Change at system (clinic) level; the Future
• Goal: Reliable, long-term processes that get us better results for population (people) we serve

QA = Are you doing things right?
(Did you ...?) Write these down

**System** – the clinic, a set of processes

**Process** – start-to-finish steps of a visit, after-visit follow-up, recruiting for groups, getting parents to sign #%$%! forms

**Population** – all patients, all overweight patients, all patients with asthma, all sexually active patients

**Complex (versus Complicated)**

**Standardization** – Some things should be done the same way every time.
Every **system** (clinic) is perfectly designed to give the results that it gets.
If you can’t describe what you are doing as a process, you don’t know what you are doing.

- W. Edwards Deming
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

AIM

MEASURES

many of which measure a PROCESS

RAPID TEST OF CHANGES in a PROCESS

From Associates in Process Improvement.
Process

• A series of actions that are performed, usually (hopefully) in the same way and sequence each time, with the purpose of providing a specific result.

• The care you provide is made up of dozens of separate - though integrated – processes.

... what about people who resist standard steps?
Primary care monthly improvement measures

Clinical quality examples

Percentage of patients ... 
- Who received Well-Child Visit in past 12 months
- With asthma who have a written asthma action plan
- Who were screened for tobacco use
- Between ages x and y, who received immunization z
- Age 2 who received lead poisoning test by second birthday
PDSAs test a change to (usually) a part of a process, to see how it affects rest of process, and results of the process

**Plan:** Shiloh will text moms with news of 2 $50 Safeway cards being given away at class #2 in three days. We predict that more moms will come to class #2 than came to #1.

**Do:** Shiloh has mobile numbers for 8 of 10 moms. She sends text. One reply said “who is this?” Two others responded with excitement. No other replies. At Class #2, 7 of 10 moms came, including one who didn’t get text.

**Study:** 7 of 10 was better than 5 of 10 at first class. One mom said she didn’t want class eating up her data plan.

**Act:** Do another PDSA with texting simple reminder, no raffle prize for attendance. Not PDSA, but new practice: Ask all moms to confirm their cell # at each class.
Studying processes means floating above the work, where you can see each step, each handoff, each way that the process is and is not working for you and for your patients.

Credit: Ohio State University College of Medicine
What happens when you talk about **process** (not individual) **performance**

- You mean I can stop telling people to try harder?
- What can we standardize in the EHR to help people use the new process?
- Hey, once we fix the process, we can update those old standing orders!
- We may finally fix this problem!
- Psst, I smell a webinar poll.
Tell us about your process work

Use **Questions** box in the webinar control panel.

What is a process that you redesigned that’s getting you better results? **AND**
What step or steps did you change?

**OR**
What process do you know is ripe for a calm review, to look for better steps?
Process Maps

• A visual aid for picturing our work processes

• Shows inputs, outputs, each step and links
Process Mapping

• Uncovers who is doing which part in best way
• Finds gaps in care
• Spotlights wasted efforts
  – Redundancy - time waster
  – Extra movement (paper, people, data entry)
  – Supplies (can you eliminate copying something?)
• Defines & standardizes steps and sequences
• Promotes deep understanding of purpose
• Builds consensus
Detailed, but not TOO detailed
Patient given FOBT cards

RN enters patient name and date into log (in lab)

Returned cards are processed by lab staff and results entered into log

Positive?

Lab gives results to PCP immediately. PCP calls and refers for colonoscopy

No

Results notification mailed

Yes

RN schedules appointment

But what about....?
Gaps addressed:

1. Follow up for FOBT cards that have not been returned

2. Ability to track if patient received colonoscopy and get results and plan to PCP
One more thing: Swimlanes
How to Draw a Process Map

**Basic structure**
A process map (also called a flowchart) is a diagram that represents a process or workflow, showing the process and connecting them with arrows to show their sequence. The basic element of a process map is a simple action, which can be anything from striking an anvil to making a cash payment. Each action, or process step, is represented by a box containing a description of the action. The mapping of the sequence of actions is shown with arrows between sequential action boxes, as shown in the illustration.

**Decision steps**
Processes become more complex when decisions must be made, when there are options to choose from or different steps to take based on different situations. A decision step is shown with a diamond-shaped box containing a simple question to which the answer is “yes” or “no.” It is simplest to frame every decision as a yes/no choice, and to have only those two options branching from the decision diamond shape that holds the question. More complex decisions are usually broken down into a series of yes/no decision boxes, as in the example below.
Questions?
Fun story (that you can type fast)?
Love process maps?
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From Associates in Process Improvement.
Quality Improvement 101

Part 1
Using Small PDSA Experiments to Test and Implement Changes, Without Driving Everybody Nuts
Completed, recording available

Part 2
Improving Team Performance through Processes
You are here.

Part 3
Moving toward Better Patient Care with QI Team Meetings
April 21, 2016 at 2:30 pm – 3:30 pm EDT
There will be ACTING!

More info: www.ihi.org “How to Improve” and IHI Open School