Prototype 4:
Preoccupation with System Failures

UC – StartStrong Team

Will Moravec, Clinique Davis, Alice Doren,

QI Support Team: Christina Williams Harding, Connie Stewart, Emily Johnson, Matt Frazier

Learning Objectives

- Identify key drivers for Prototype 4
- Understand at least two best practice PDSAs for Prototype 4
- Create a customized KDD for Prototype 4 with my team
- Plan out for my team at least 2 PDSA cycles or 1 Ramp for Prototype 4

Rev: 11-1-16 | Ver. 5

Preoccupation with System Failure: UC StartStrong - QI-Data Weekly Huddle KDD

Leader: Will Moravec

QI Lead: Christina Williams Harding

GLOBAL AIM

Eliminate Infant deaths & Premature Births at UC

SMART AIM

Increase the percentage of weekly *QI-Data huddle elements reliably completed from 0% to 80% by Dec 31, 2016

KEY DRIVERS "WHAT"

1. Committed Staff to Engage in a Huddle & Deliver Best Patient Care
2. Meticulous Management to Know & Deliver Best Care to Your Patient Population
3. Effective Teamwork and Trusted Relationships between OB's & CMs &RNs
4. Preoccupation with System Failures

INTERVENTIONS "HOW"

- HOLD SAME WEEKLY TIME FOR HUDDLE: (Wed 2 – 2:45 pm)
- USE STANDARDIZED QI-DATA HUDDLE TEMPLATE
- PRE-Huddle Data Work: Pre-populate data and come ready to report
- NO-SHOW INTERVENTION: OB & CM multiple phone calls, seek & find
- ANYONE CAN ASK – ASSIST: OB or MA when Case Manager is not available
- OB and Case Manager Patient Risk Report: Way to co-manage & ensure ALL patients needs are MET even when no Case Mng. present
- Alice to run the Avondale Population List each week to ID any failures like 45229 pts seen in another clinic
- Analyze FAILURES from previous week and ID PDSAs/interventions to test to mitigate those failures and improve processes

***Weekly QI-Data Huddle Elements:**

1. Hold the Huddle
2. Bring Data
3. Review failures & put mitigation in place
4. Send Huddle Report
5. Fix any misses reviewed w/in 48 hours

(e.g. Assist for any Smokers missed, referral to CHW missed)

FMEA Process Steps: UC Team's Reliable Execution of a Weekly QI – Data Huddle

= 5 **Weekly QI-Data Huddle Elements**

	Step 1: Commit to Weekly Huddle	Step 2: Identify Failures During the wk	Step 3: Run the Avondale Pt List	Step 4: Pre-Data Work to enter data	Step 5: Meet for Wed Wk huddle	Step 6: Debrief Failures & Mitigate	Step 7: Send Huddle Report	Step 8: Complete any misses by Fri.
INTERVENTIONS	SENIOR LEADER SPONSORS THE WORK AND ENCOURAGES TEAM TO TEST HUDDLE	WRITE DOWN AT END OF DAY ANY FAILURES TO MITIGATE NEXT TIME	ASSIGN RUNNING LIST TO A SPECIFIC ROLE PROCESS TO EMAIL THE LIST TO WILL IF UNABLE TO ATTEND	ASSIGN TASK TO A SPECIFIC TEAM MEMBER	PHONES OFF RULE COMMITMENT TO BE PRESENT AND ENGAGED IN HUDDLE	HOLD 10 MIN AT END OF HUDDLE TO MITIGATE FAILURES AND ID INTERVENTIONS	ROLE ASSIGNED FOR SENDING REPORT SEND REPORT BY COB WED	CM TO IDENTIFY ANY PTS NEEDING ASSIST, REFERRAL TO CHW
FAILURE MODES	PEOPLE COMPLAIN THAT THEY HAVE NO TIME TO MEET	NO TIME TO ID FAILURES	NO TIME TO COMPLETE IT BEFORE MTG PERSON WHO RUNS LIST IS NOT AVAILABLE	NO TIME TO RUN HUDDLE	ARRIVE LATE UNENGAGED MULTI-TASKING DURING HUDDLE CRITICAL TEAM MEMBER MISSING FROM HUDDLE	TOO MANY FAILURES TO GET THROUGH DURING HUDDLE TIME		UNABLE TO GET A HOLD OF PATIENT TO FIX HE FAILURE

#	POPULATION / DENOMINATOR DATA: OB, Clinic Mng., Case Manager owns completing data	n =
1	TOTAL # of AVONDALE PATIENTS in the center's care ("Active Patients" List)	30
2	Total # of 45229 patients seen	5 (1:pp, 3:f/u, 1:new)
3	Total # of 45229 patients seen in "Walk-in/ APN"	1
4	Total # of 45229 OB patients seen anywhere else w/location seen (e.g. Clinic A, Clinic B, Clinic C)	1- Clinic B
5	Total # of 45229 patients NEW OB patients seen in clinic (or admitted to hospital)	1
6	Total # of 45229 patients who missed appointments	4
7	Total # of 45229 patients who delivered **(preterm/ full term)**	1 at 40 weeks
	EARLY ACCESS DATA: OB or Case Manager owns completing the data	
8	Total # of new OB patients seen with GA ≤ to 12 weeks	N/A
9	Total # of new OB patients seen with GA > than 12 weeks	1 at 26 weeks
	SMOKING/ TRUSTED RELATIONSHIPS/ PT CENTERED CARE / PT NEEDS w/ CHW/ HV: CM owns	
10	Total # of New OB patients who received SMOKING ASK step	4- all non smokers
11	Total # of New OB patients who received ASSIST step	N/A
12	# of OB patients seen who successfully met with CHW / HV and have a documented updated in EPIC (e.g. Case Manager knows name of CHW/HV, know date of last pt. meeting, received update from CHW and documented it)	**2 (**1 pt. came with CHW / 1 pt. referred to CHW)
13	# of OB patients seen with UNKNOWN referral status to CHW / HV (e.g. pt. has not connected with CHW, if patient has - CHW hasn't reported any updates to Case Manager, or updates NOT documented)	1 pt. left without seeing CHW

OB Teams: QI-DATA Huddle Template Week of X (to review previous week's data) ***PT 4: Preoccupation with System Failure Tool**

#	POPULATION / DENOMINATOR DATA:	n =
1	Total # of PATIENTS in X Center's care (Total Population "Active Patients" List)	
2	# of NEW OB patients seen (1st Visit)	
3	# of Follow-Up patients seen	
4	# of patients who MISSED appointments	
5	# of patients who DELIVERED	
	EARLY ACCESS DATA:	
6	# of new OB patients seen with GA ≤ to 12 weeks	
7	# of new OB patients seen with GA > than 12 weeks	
	SMOKING	
8	# of patients seen who were "ASKED" their Smoking Status at First OB Visit at X center	
9	# of patients seen Smokers Receive "ASSIST" Step	
10	# of patients asked smoking status at 28 Week Visit (Outcome Measure)	
	TRUSTED RELATIONSHIPS/ PATIENT CENTERED CARE / SOLVING PROBLEMS DATA:	
11	# of OB patients seen who successfully met with CHW / HV and have a documented updated in EPIC (e.g. CM knows name of CHW/HV, know date of last pt. meeting, documented update from CHW/HV)	
12	# of OB patients seen with UNKNOWN referral status to CHW / HV (e.g. Patient has not connected with CHW, if patient has CHW/HV hasn't reported any updates to Case Manager, or updates NOT documented.)	

CHW/HV Teams: QI-DATA Huddle Template Week of X (to review previous week's data)

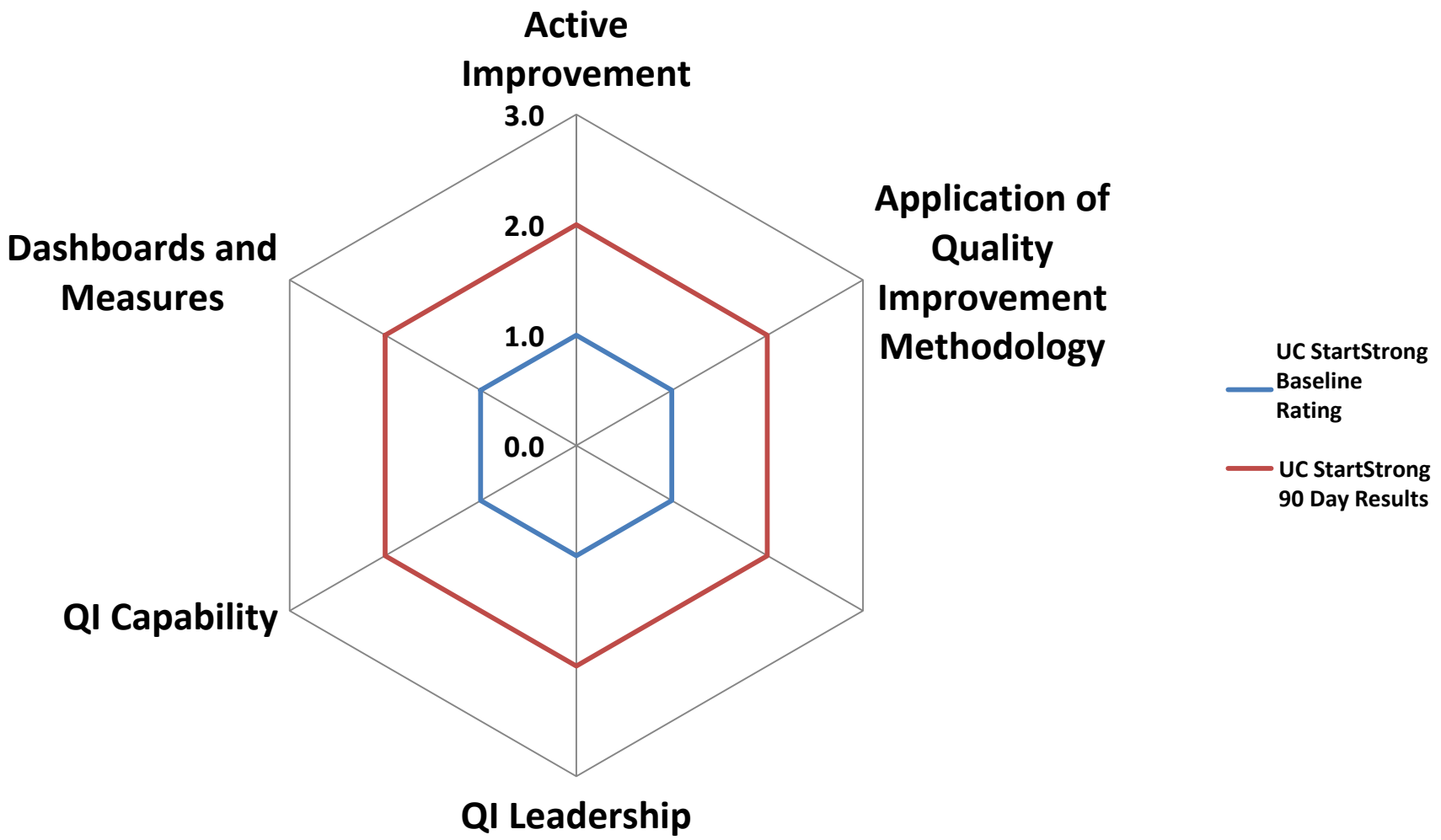
*PT 4: Preoccupation with System Failure Tool

#	POPULATION / DENOMINATOR DATA:	n =
1	Total # of clients in X CHW/HV care (Total Population "Active Patients" List)	
2	# of NEW CHW / HV clients seen (1st Visit)	
3	# of Follow-Up / Return clients seen	
4	# of clients who MISSED appointments	
5	# of clients who DELIVERED	
	EARLY ACCESS DATA:	
6	# 1st CHW/ Home visit with women < 16 weeks GA	
7	# 1st CHW/Home visit with women < 18 weeks GA	
8	# 1st CHW/Home visit with women < 20 weeks GA	
	SMOKING	
9	# of clients who smoke and had visits last week	
	TRUSTED RELATIONSHIPS/ PATIENT CENTERED CARE / SOLVING PROBLEMS DATA:	
10	# of NEW clients seen who successfully completed their 1st visit with CHW / HV by 10 days of referral receipt (e.g. CM knows name of CHW/HV, know date of last pt. meeting, documented update from CHW/HV)	
11	# clients who were "Co-managed" with a PROVIDER TEAM (e.g. Talked on phone to CM, shared home visit REPORT with CM, problem solved together with RN on smoking cessation)	
12	# of Client OB Visits where CHW/HV attended appointment at OB office	

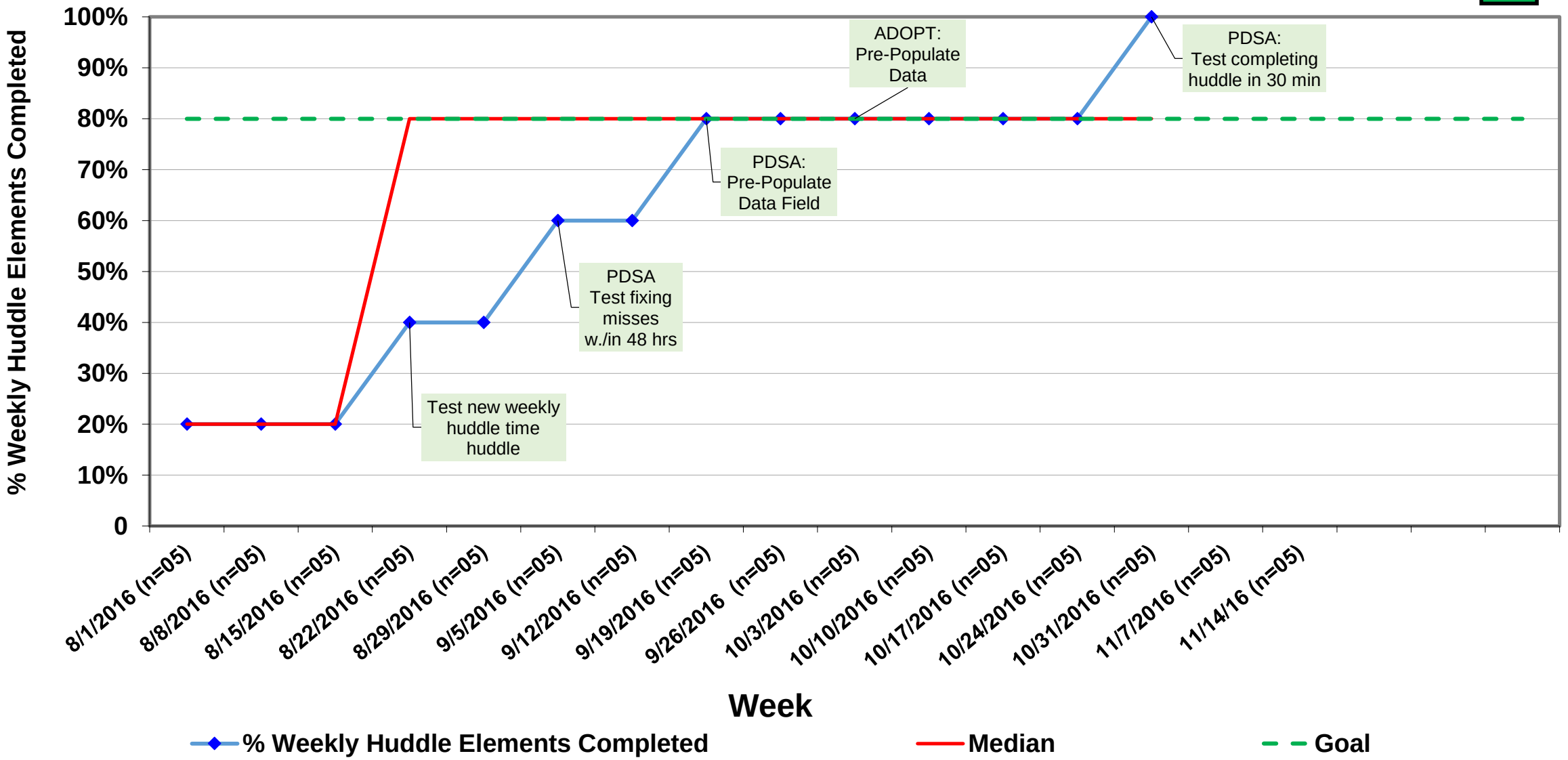
CCLC Team Assessment/ Maturity Tool: UC STARTSTRONG AVONDALE TEAM

TEAM ATTRIBUTES	COMPONENTS	BASE LINE	90 Day Goal	1: Aug 1, '16	2: Nov 1, '16	3
Active Improvement and Getting Results	1. Active improvement	1	2	□ Projects not tracked or uncoordinated active improvement.	□ **Results for 50% of CCLC measures are demonstrated on a run or control chart..** □ **20% improvement in at least 1 CCLC measure** □ Inventory of some active and planned QI work	□ Results for 100% of CCLC measures are demonstrated on a run or control chart. □ Change in outcomes by 20% for at least 3 measures □ Inventory of ALL active and planned projects exists and is monitored.
	2 . Application of Quality Improvement Methodology	1	2	□ Lack of standard approach to improvement work. □ Data does not direct improvement work □ Measures include only process measures. □ No routine PDSA testing rhythm established	□ **Data is used to predict and improve more quickly.** □ **Rhythm of PDSA testing at least weekly.** □ All projects are managed based on 90 day plans.	□ Results for 100% of CCLC measures are demonstrated on a run or control chart. □ Change in outcomes by 20% for at least 3 measures □ Inventory of ALL active and planned projects exists and is monitored.
Leadership and Improvement Capability	3. QI Leadership	1	2	□ QI leaders and Care Delivery Team have not been identified.	□ **QI Leaders Empowered.** □ **Care Delivery Team actively involved in QI planning development (including prioritization and goal development).**	□ Active Care Delivery Team that is capable of moving large measures. □ Care Delivery Team actively uses portfolio management. □ Leaders work across organizations (e.g. OB teams, community health worker and home visiting organizations) to accelerate improvement.
	4. QI Capability	1	2	□ Small number of staff are involved in isolated improvement efforts. □ Very few MD's and staff have completed QI training	□ All Team Leaders (MD, RN, Case Management) are QI trained □ Most front-line staff have QI training □ **At any one time approximately 50% of the team members are involved in active improvement of daily work**	□ All team members have completed QI training □ All leaders and staff have integrated improvement into their daily work and their strategic work.
Data and Measurement	5. Data Driven Decision Making and Data Entry	1	2	□ Decisions are made based on retrospective data. □ Critical Data is reviewed month or Qtr □ There is not a well defined process for data entry □ Not currently entering CCLC Data measures	□ **Data are routinely being used to identify and act upon opportunities for improvement.** □ **Critical Data reviewed weekly.** □ **Measures are reliably collected** □ **CCLC Data measures are entered monthly for at least 50 – 75% of measures**	□ Data are routinely being used to predict performance and drive real time decision making. □ Critical Data reviewed weekly/daily. □ All of the measures are standard, well-defined, and have been documented in standard form. □ CCLC Data measures are entered monthly for ALL measures

UC StartStrong Spider Chart Output:
Baseline Assessment (Aug 1, '16) & 90 Day Results (Nov 1, '16)



% of Weekly QI-Data Huddle Elements Completed
August 1- October 31, 2016



Dr. Shaffer & Dr. Moravec
UC Avondale 45229 DAYS SINCE LAST PRETERM BIRTH
Jan 1, 2014 – Nov 7, 2016
*Data excludes twins