



University of California
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TIPR Section 5.2: How to Implement a Quality Improvement Project

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“To create a true culture of safety and reliability, we need to engage everyone, and it can only be driven when we have strong alignment. Everyone can play a role in safety.”

Gary Yates, M.D.



Learning Objectives



Identifying and assessing key stakeholders



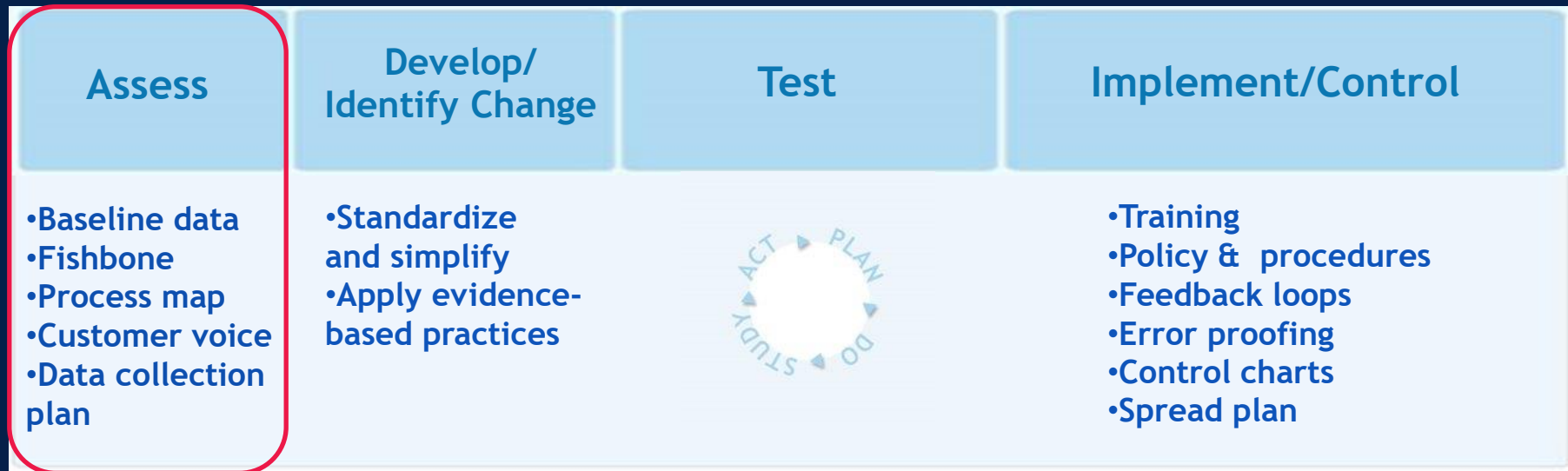
Conducting a root-cause analysis using process maps, cause and effect diagram and observation/data collection



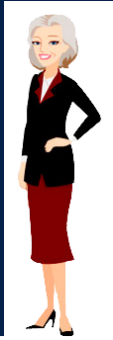
Implementing a PDSA cycle for test of change

Model for Improvement

- 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?



Stakeholders: Basic Team Roles



Sponsor

- Establishes the need & vision
- Allocates resources
- Removes barriers



Champion

- Promotes change in the organization
- Ensures change is sustainable



Project Lead (s)

- Assembles team
- Provides PI support and guidance
- Helps interpret data and results
- Helps team “see” their learnings & successes



Team members

- Does the improvement work
- Runs tests and collects data

Stakeholders: The Voice of the Customer

The VOC is the stated and unstated needs of our customers.

Customer: The end recipient of our work.



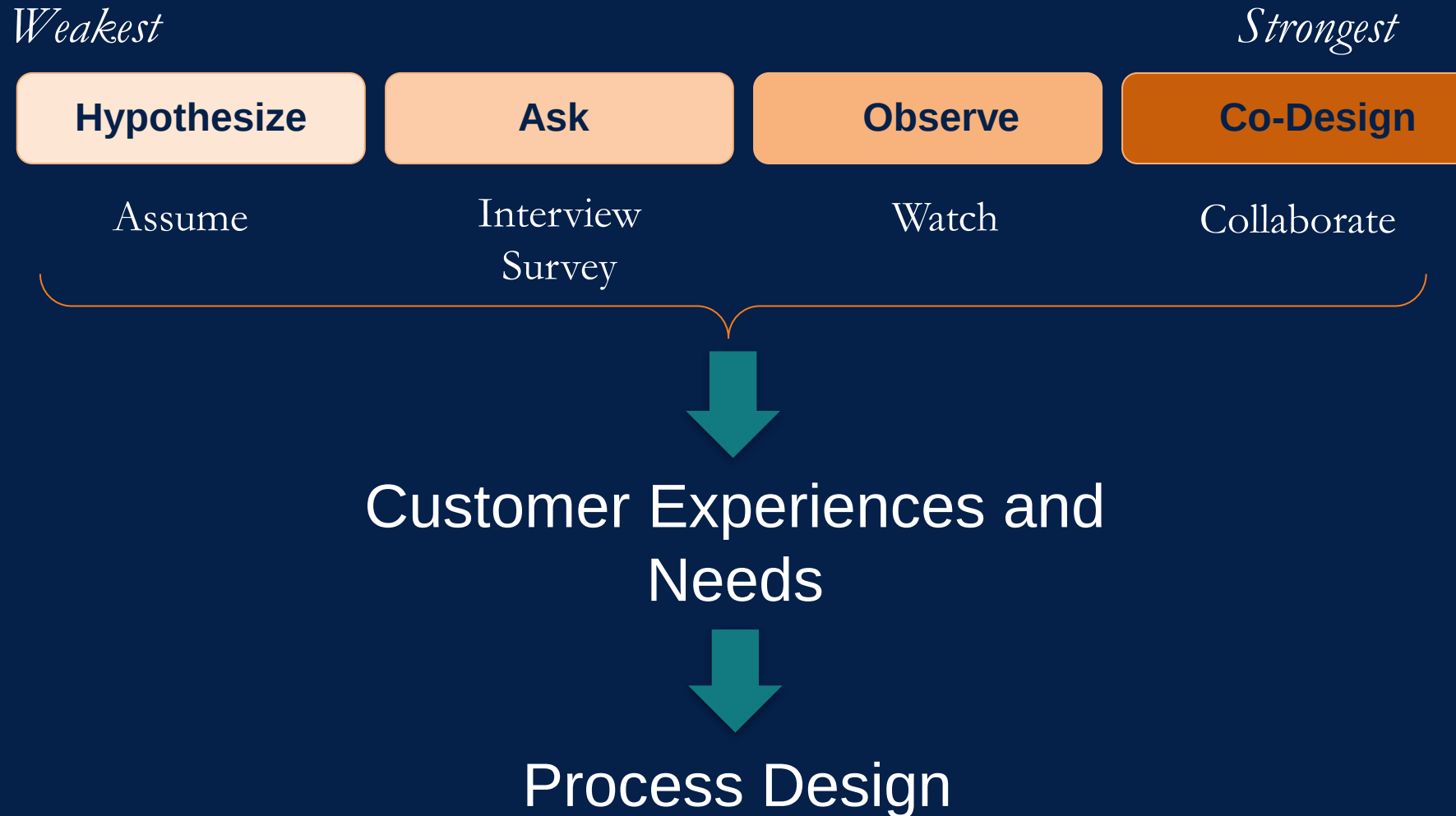
Customers may be internal.
(Our colleagues)



Customers may be
external. (Our members)

Customers define value from their perspective, not ours.

Different Ways of Gathering the VOC



Stakeholder Analysis: Flu Shot Example

- **Example of Case of Flu:** *Flu shots are an important intervention when trying to reduce the severity and persistence of a contagious illness, especially elderly patients with comorbid conditions. We miss opportunities to remind patients to get flu shots during routine clinical visits resulting in 30% missed flu shots annually. This likely results in an increase hospitalizations during flu season costing patient lives and health care billions of dollars annually.*
- **Who are the key stakeholders? What do they want /need?**

Patients

“There is a lot of mis-information about effectiveness of flu shot. I don’t know why it is important for me to get a flu shot annually.”

Medical Assistants

“Sometimes I notice that a patient is due for a flu shot; however, I am unclear if it my job to remind the patient or the provider, so I am inconsistent in my reminders.”

Providers

“As a new physician, I have so many things to remember that I forget to remind my patients to get their flu shot.”

What are the key issues?

- Lack of information
- Workflow/role clarifications
- Lack of standardization

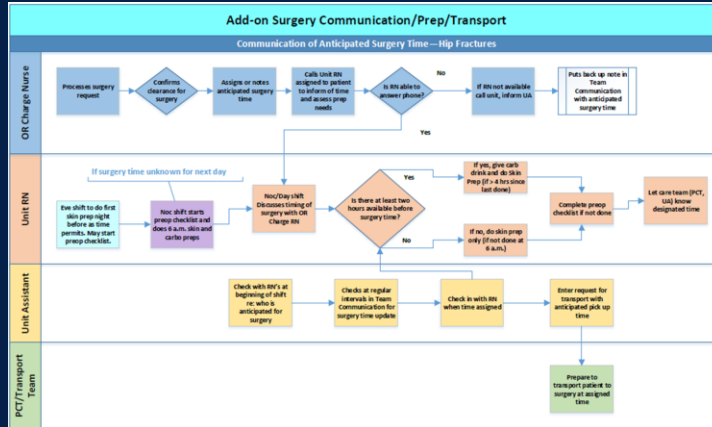
How do needs translate to testable changes?

- Create a flyer with information to be handed out one month before flu season begins
- Update the workflow and train MAs on new process
- Set automatic reminder to check flu vaccine at every visit



Tools for Assessing the Issue

Process Maps



Fishbone



Brainstorming

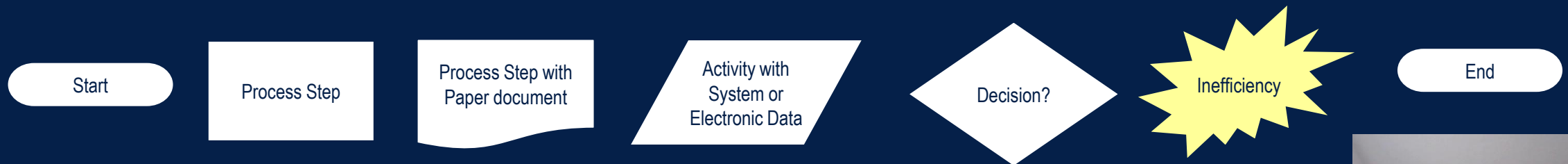


Data Collection/Observation

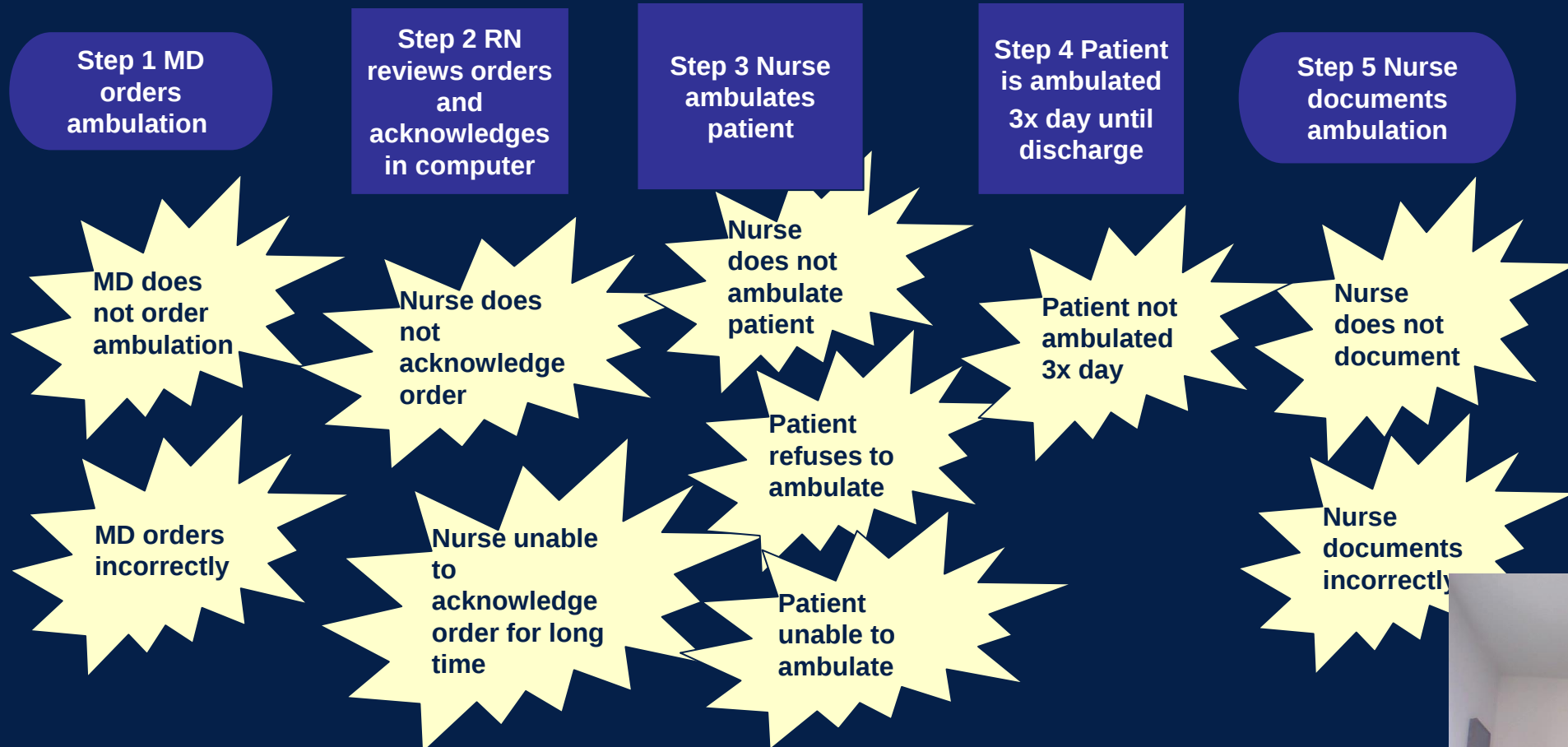


Assessment Tool: Process Map

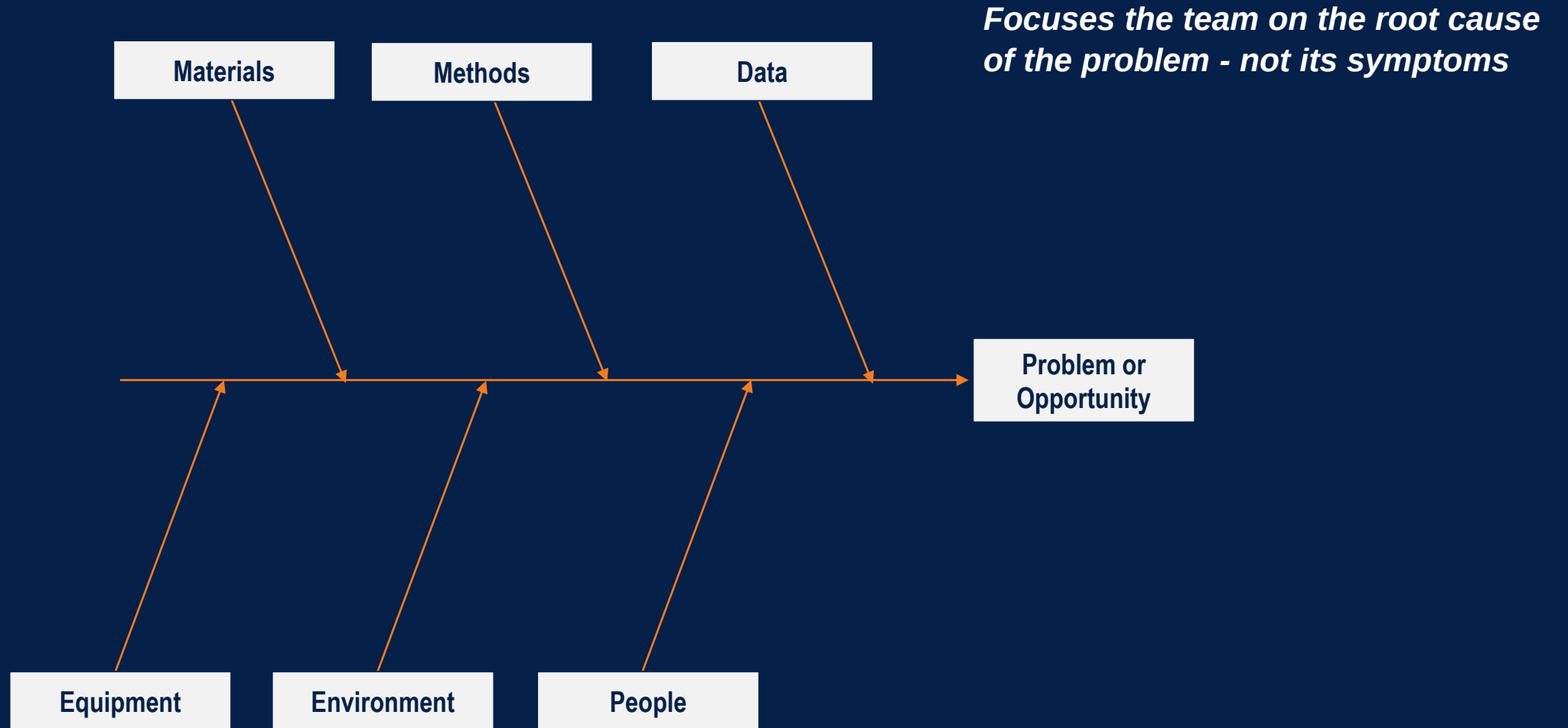
A process map is a visual representation of a system or process.



Simple Process Map with Waste identified: Basic Pneumonia Ambulation



Assessment Tool: Cause and Effect (Fishbone) Diagram



Assessment Tool: Observations

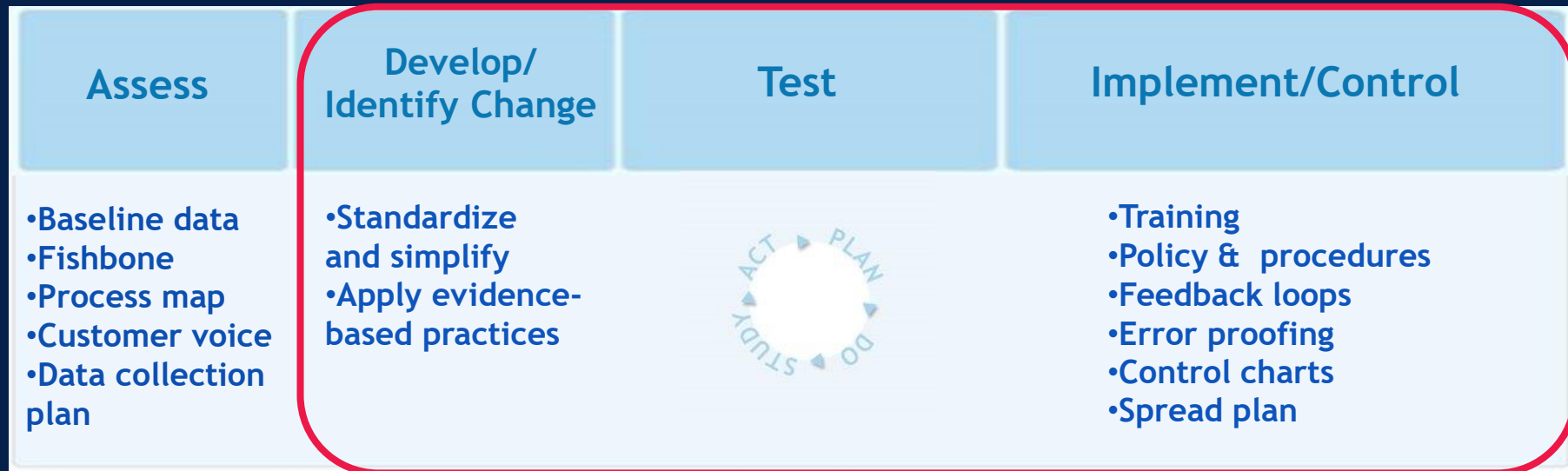
Observation: The action or process of observing something or someone carefully in order to gain information.

As a supplement to other analysis, directly observing helps convey how the process really occurs.

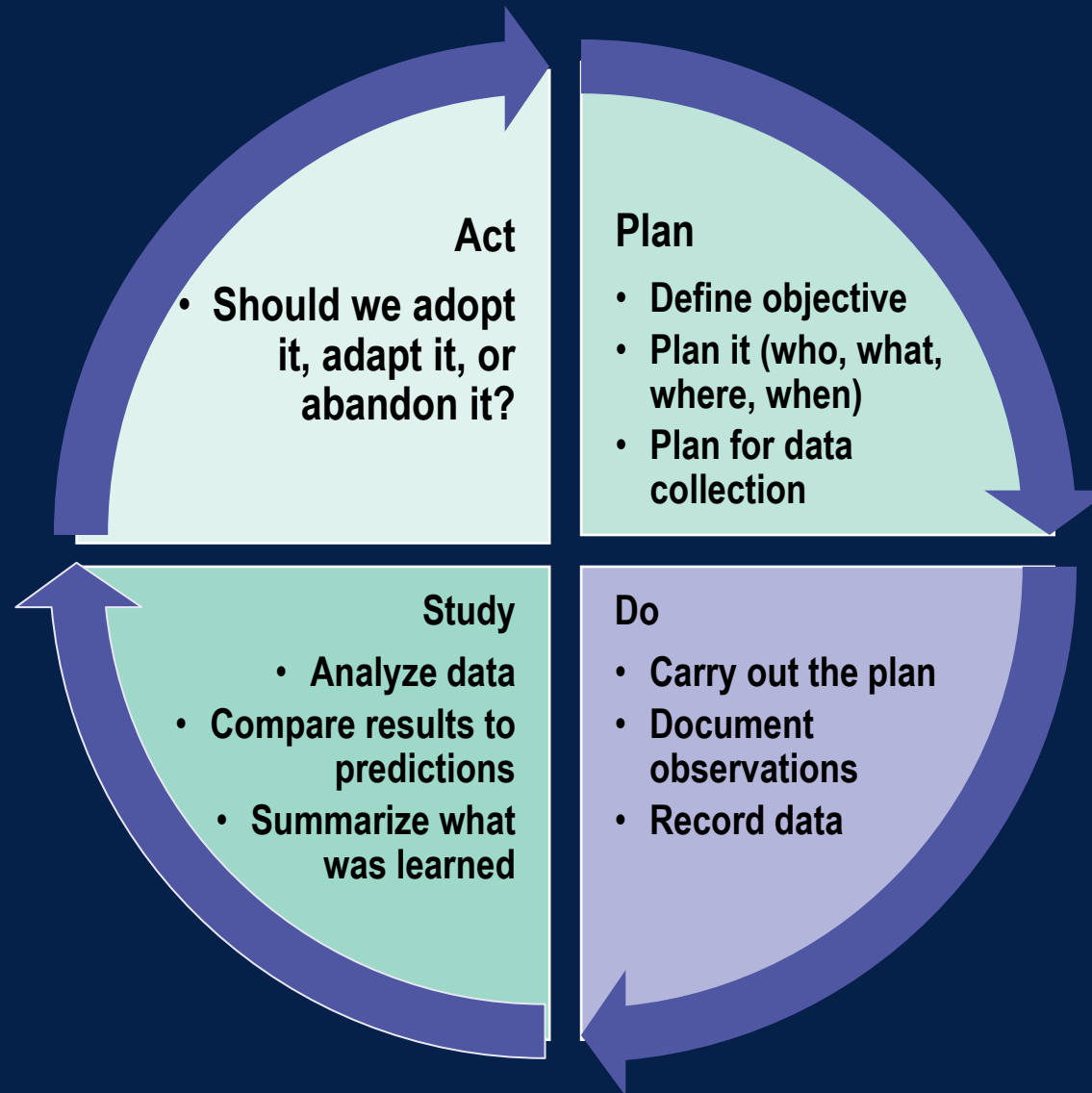


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The Plan-Do-Study-Act (PDSA) Cycle

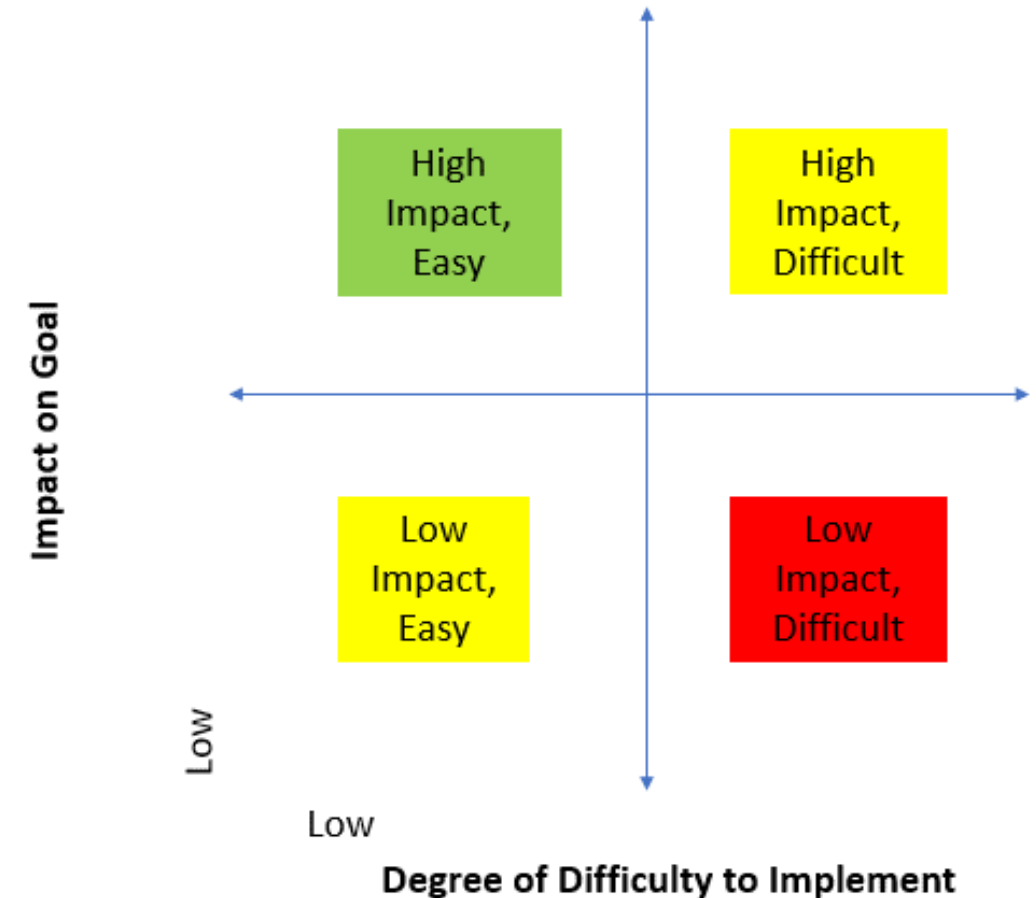


Prioritize your improvements with a “Pick Chart”

Create a flyer with information to be handed out one month before flu season begins

Update the workflow and train MAs on new process

Set automatic reminder to check flu vaccine at every visit



Take Away Points

- ✓ Involving key stakeholders in all aspects of the project is essential in moving the QI initiative forward
- ✓ Solving a QI problem requires getting to the root cause
- ✓ Using tools such as VOC, fishbone diagram and process maps are useful in root-cause analysis
- ✓ Choose small interventions to test through Plan-Do-Study-Act cycles
- ✓ Track outcome measures to ensure interventions are leading to an improvement

Acknowledgements

- Shannon McDermott, PhD; Santa Rosa Kaiser Permanente
- Matthew Symkowick, MD, Napa-Solano Kaiser Permanente
- Hela Issaq, MD, MPH, San Jose Kaiser Permanente
- Juleon Rabbani, Dr.PH, Division of Research Kaiser Permanente
- Associate Improvement Advisor (AIA) Program, San Jose Kaiser Permanente