Change Package

Global PROMISES Aim: Improve patient safety and decrease malpractice risk in ambulatory practices relating to medication management, test ordering and results, referrals and follow up and communication.

Framework Components, Design Concepts, Tasks & Foundational Change Ideas

In order to meet the Aim, each PROMISES Team is asked to strive to achieve progress in four major areas ("Framework Components"):

1. Building a Culture of Quality and Safety
2. Improved Communications
3. Developing Reliable Management and Tracking Processes for High Risk Medications, Tests and Referrals
4. Enhanced Operational Efficiency

In the next few pages, you will find these major areas ("Framework Components") with accompanying ideas for teams to think about, activities/changes for teams to undertake, and links to additional resources that all support these four areas. Following are some of these ideas "at a glance":

1. Building a Culture of Quality and Safety

a. Identify a leader within the organization who can assure that quality and safety is a key focus in the organization, can assure that resources can be allotted, can mitigate challenges, and who will take responsibility for the success of the improvement initiative
b. Build will for change and eliminate complacency
c. Identify a multidisciplinary guiding coalition/improvement team
d. Conduct training and familiarize entire improvement team with key improvement strategies
e. Cultivate a no blame reporting culture
f. Include patients and families in planning and execution of change

2. Improved Communications

a. Address health literacy
b. Develop mechanisms to listen to and learn from patients & families
c. Improve communications within practice
d. Improve Communications between practices and important customers & suppliers (e.g., practice: specialists, practice: lab, etc.)
e. Improve communications and support to patients, families & caregivers experiencing adverse events

3. Developing Reliable Management and Tracking Processes (Medications, Test Ordering and Results, and Referrals)

a. Develop consistent definitions
b. Develop standardized protocols and algorithms
c. Reduce variation in provider style
d. Use the clinical information system (CIS) to reliably identify patients "at risk"
e. Provide reminders, prompts, and helpful reports and information from the clinical information system for the care team and patients
f. Develop reliable mechanisms to communicate about patients at risk and to follow up with other providers, patients, and ancillary services
g. Educate and provide self management support for the patient and family

h. Develop standardized mechanisms for the internal care team to reliably follow up on results in a timely manner
i. Develop follow up plans in conjunction with the patient

4. Enhanced Operational Efficiency

a. Anticipate patient needs
b. Map workflow and seek opportunities to add value and reduced waste
c. Aim for high value office visit from patient perspective

Design Concepts	Tasks and Foundational Change Ideas	Specific Tests of Change	Resources & Links
Framework Component #1: Culture of Quality and Safety			

• Cultivate Improvement Capacity
• Care Team Optimized
• Patients Engagement
• No-Blame Culture
• High Risk Areas Identified
• Safety Lessons Learned and Shared
	• Create and communicate the vision for change and improvement.
	• Designate a leader sponsor who is involved and engaged
	• Provide Quality Improvement and safety training to all staff including Model for Improvement and efficiency concepts.
	• Assure adequate resources (money, staff time, etc.) for improvement
	• Incorporate performance improvement expectations into job descriptions and performance evaluations
	• Ensure that all staff working at the "tops of their licenses"—do work flow diagrams to look for improvements to more efficient
	• Standardize protocols whenever possible
	• Reduce variation in provider style by assuring that all providers educated and up-to-date on the most effective course of treatment and current medication guidelines; standardizing order sets for high risk medications and labs and for referral processes to specialists.
	• Look for opportunities to eliminate waits and delays as to provide un-interrupted patient care.
	• Address cultural competence (see Resources & Links for ideas).
	• Coordinate process for access to translators as needed.
	• Promote active patient self-management and engage the patient in an active role in health and health care including decision-making and health-related behaviors.
	• Use self management support core techniques.
		• Conduct regular and standardized meetings (e.g., using Seven-Step meeting or some other standard meeting process)
		• Assemble the care team at a predetermined time each day to look ahead on the schedule and anticipate the needs of the patients coming to the clinic that day (Huddle)
		• Weekly team meetings to review lessons from huddles, provide concentrated time together to plan roles and responsibilities, and discuss opportunities for improvement in work flow
		• Hold forums that facilitate discussion around error and potential solutions such as huddles and safety forums
		• Put the topic of safety on every meeting agenda—stories
		• Restructure staff assignment and tasks based on workflow diagrams and discussions
		  ○ Nurse or pharmacist run INR clinics
		  ○ Medication reconciliation started by MA
		  ○ Have nurses or MAs draw blood for lab work
		  ○ Someone other than provider return phone calls and process referrals
		  ○ Assign staff to do reminder call and determine the patients' agenda/needs for the upcoming visit
		• Write protocols for ordering an initial lab or radiology for certain symptoms at the office visit, or to replace a physician visit with a nurse visit.
		• Use flexible cues and sequencing as a type of communication that keep a practice flowing
			• Science of Improvement: Forming the Team [i]
			• Executive Review of Improvement Projects
			• Seven Leadership Leverage Points for Organization-Improvement.
			• "Leading Change" by John Kotter,
			• "Leading Change: Why Transformation Efforts Fail" by John Kotter,
			• Going Lean in Healthcare
			• On Demand Introduction to the Model for Improvement
			• TeamSTEPPS Training
			• Assess current staff roles, opportunities to mitigate interruptions and other parts of the system using worksheets from Outpatient Primary Care Workbook (Greenbook)
			• Association of American Medical Colleges' cultural competence education materials
			• Cross Cultural Health Care Program
			• National Center for Cultural Competence
			• Medical Assistants Addressing Language and Culture in Healthcare video
			• AHRQ Question Builder
			• Number Needed to Treat
			• How's Your Health Decision Aids for Older Adults
			• Ottawa Hospital Research Institute Patient Decision Aids
			• Effective Healthcare Program
			• Mayo Decision Aids Group
			• Set collaborative goals

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	• Engage patients, families and community in improvement work. • Create processes for active reporting of errors and quality problems through system redesign • Be proactive about identifying possibilities for error in the system. • Build leaders vision of culture of safety no-blame culture into all office trainings, orientations, publications, or other types of messaging. • Develop consistent definitions of high risk events and areas. • Develop mechanisms for sharing safety and improvement data with all staff (e.g., data walls).	smoothly without the need for verbal or face-to face communication. Examples include: ○ A chart in the blue basket means that the patient has arrived and is ready for rooming, and a chart in the red basket means that the patient has gone for testing ○ Flags on the room indicate which member of the care team is in the room, or if the patient is ready for the next prearranged "hot-spot" for immediate attention • Develop and test telephone policies to mitigate interruptions • Permit patients access to records. • Use decision aids with patients such as videos, pamphlets, brochures, interactive computer programs, motivational interviewing, prompt cards for patients to use with providers, and education to name a few. • Assess client confidence in self managing their health and particular aspects of prevention and set collaborative goals with patients—create action plans based on collaborative goals • Care management for most complex patients • Engage patients, families and community, as appropriate, in forums to support improvement work (e.g., focus groups, surveys, just-in-time surveys, improvement teams, teams meetings, committees, etc.) • Perform failure mode effective analysis (FMEA) on one of the 3+1 areas.	• Create Action Plans • Partnering in Self Management Support—A Toolkit for Clinicians • Motivational Interviewing • Impact BC (British Columbia) • When Things Go Wrong • FMEA Example of Anticoagulants • Standardized Communication Tool • Huddles
Framework Component #2: Effective Communication and Collaboration			
• Address health literacy • Develop mechanisms to listen to and learn from patients & families • Communications	• Train staff in important health literacy key concepts • Design communication systems to improve f/u with patients re: medications, referrals, and tests • Review and improve on written communications • Listen to and honor patient and family perspectives • Standardize processes for internal office	• Confirm patients' and families' understanding using Teach Back method • Test systems to track and reinforce knowledge and action plans like phone calls, automated call systems, emails, mail, f/u visits, etc. • Delegate one position to do all f/u with patients • Create forms for patients and families to	• AHRQ Health Literacy Resources • Help People Understand Health Literacy Video • NC Health Literacy PowerPoint Training Slides w/ notes • Teach Back Method and Medication Review • Literacy Partners of Manitoba Health

Design Concepts	Tasks and Foundational Change Ideas	Specific Tests of Change	Resources & Links
within practice • Communications between practices and important customers & suppliers (e.g., practice: specialists, practice: lab, etc.) • Communication and support to patients, families & caregivers experiencing adverse events	communications • Create (adapt) and adopt a process on communication with patients, families, and caregivers "when things go wrong"—be proactive about potential adverse events and develop process for communication with patient, support to patient & family, f/u care for patient & family, support for care givers, and overall management of the event) • Develop protocols for what to do when potential opportunities for litigation occur (e.g., where to refer) • Develop criteria for selection of events for formal root cause analysis, with priority given to events which are fatal, cause significant morbidity, represent a significant breach in practice, or for which investigation is requested by a clinical team member	provide feedback on various health communications from the practice • Distribute and respond to patient and family surveys • Engage patients in the review of patient education materials • Prior to visit, anticipate potential biases/pitfalls that could influence communication such as prior history, experience and cultural biases • During visit, use good listening, communication, inquiry, and respectful engagement to understand the principal complaint/ symptoms • Involve patients in improvement work and in walk-throughs when doing work flow mapping • Adopt a care plan that can travel with the patient • Provide patients with a referral checklist to use for f/u visits to specialists • Where possible, organize staff to support patients during transitions and handoffs (care coordination) • Use spontaneous huddles as a standard way to communicate about patients throughout the day • Use visual displays (e.g., large white boards in a staff workroom) to coordinate emerging patient needs or to show assignment of responsibilities • Develop and role play disclosures and apologies—standard techniques for addressing patient anxiety, anger, difficult personality (e.g., 3 Rs responsibility, remorse, reparation)	Literacy Materials • Plain Language Initiative • Readability Formulas • Plain Language Thesaurus for Health Communications • "In Other Words, Can They Understand?: Testing Education Materials with Intended Readers" • The Practice of Patient and Family Centered Care in Primary Care and Other Ambulatory Settings Getting Started Guide • Patient Referral Check Lists • Relationships and Agreements: Improving Chronic Illness Care • Referral Tracking Guide • Care Coordination Practices • Specialty Care Compact • When Things Go Wrong
Framework Component #3: Reliable Tracking and Management Processes			
• High risk labs, meds, referrals and tests identified • Standardized protocols and algorithms utilized	• Define high risk labs, meds, referrals and tests • Using the practices definitions of high risk, generate a list of the high risk patients • Standardize protocols and algorithms to increase reliability and decrease opportunities for error • Educate patient regarding purpose of and	• Use list generated of high risk patients during spontaneous huddles to determine appropriate responsibility and follow-up • Use list generated of high risk patients to determine labs that could be ordered in advance of office visit	• Sample Definitions of High Risk Tests • Sample Outpatient Anticoagulation Flow Sheet • Ask Tell Ask Technique • Six Steps of Shared Decision Making • Improving the Reliability of Health Care

Design Concepts	Tasks and Foundational Change Ideas	Specific Tests of Change	Resources & Links
• Patient and family engagement and education supported • Measurement/ assessment of processes enhanced • Proactive plan of care with f/u developed	meaning of results of testing and referrals • Establish a reliable process for shared decision making • Optimize the clinical information system assuring timely access to key clinical information at all points of care (internal and external) and identifying data needed on a daily, weekly, and monthly basis by each segment of the organization (care team, improvement team, leadership, community) to assure reliable testing and tracking • Share improvement results and data with all staff • Incorporate reliability principles into the practices' processes • Identify and Mitigate failure: Identify failure when it occurs and intercede before harm is caused, or mitigate the harm caused by failures that are not detected and intercepted—redesign process based on failures identified • Use data for improvement (identify, collect, report and analyze multiple measures; annotate graphs to see the effects of changes being tested; use graphs to provide timely feedback to team on improvement efforts; build data collection into the daily work of staff; and, when at all possible, use run charts to look at data over time • Make sure that all high risk patients have a written plan of care	• Test standard protocol related to communication of results • Test standard protocol related to training for personnel receiving results • Test standard process for timing of critical results from the time tests are done until they are communicated to the patient • Test standard procedures for internal and external communication • Use Teach Back as a way to determine patients' understanding of education regarding test results and referrals • Test shared decision making technique with one patient, eventually scaling up to additional patients (see links) • Test Ask-Tell-Ask technique (see links) • Build reminders and prompts into existing clinical information systems to improve in the 3+1 areas • Use standard order sheets and guidelines, checklists, feedback mechanisms regarding compliance • Test use of reminders, differentiation, constraints, and visual clues to mitigate harm and process failure • Provider test collaboratively developing a visit agenda with the patient and family, handling as many concerns as possible including planning of return visits as appropriate • Test development of care plans with and for high risk patients	White Paper • Action Plan Checklist Based on Collaborative Goals • Shared Care Plan • Improving Office Practice: Working Smarter Not Harder (Christine Sinsky, MD)
Framework Component #4: Enhance Operational Efficiency			
• Patient needs anticipated • Efficient workflow and reduced waste • High value office visit from patient perspective	• Pre visit planning with patient • Use planned interactions to support evidence-based care for individuals • Set up internal mechanisms for ongoing communications about patients • Map the current process and identify bottlenecks and improvement opportunities • Use quality improvement tools such as flow charts and cause & effect diagrams to assess systems and identify the biggest improvement	• Ensure labs and screenings are up to date, & referral/specialty care information is available at visit • With the next opportunity to deal with a patient or task as it presents to you, do so. Don't batch and queue and keep the process flowing continuously.	• Information for Providers: Educate your Patients to be Better Partners in Their Care • Ask Me Three • Watch a Planned Care Visit

Design Concepts	Tasks and Foundational Change Ideas	Specific Tests of Change	Resources & Links

	opportunities
	• Standardize processes so that employees follow the same steps every time, eliminating the need for guesswork
	• Simplify the process wherever possible with fewer steps and fewer people involved.
	• Eliminate waits and delays both within and between steps.
	• Correct errors or defects at the moment they occur. Don't send them ahead to the next step in the process
	• Apply key concepts of improving efficiency
	  ○ Use continuous flow: streamline key processes – e.g. prescription refills
	  ○ Standardize work, rooms, equipment, procedures
	  ○ Anticipate patient needs at appt: huddle agenda
	  ○ Synchronize pt, provider, info: Start AM & PM appts on time
	• Reduce any of the following:
	  ○ Patients having to come to clinic on different days for different tests.
	  ○ Time spent finding the necessary equipment or information.
	  ○ Time spent doing things again, such as the paperwork or diagnostic tests.
	  ○ Unnecessary appointments and follow ups in outpatients
	  ○ Unnecessary diagnostic tests and re-doing diagnostic tests.		

[i] Some links require login to the IHI website which is a free resource.