

MCHB/DHSPS

Introduction to Process Improvement and Plan-Do-Study-Act (PSDA) Cycles

May 5, 2009

JOHANNIE ESCARNE: Good afternoon, I'm Johannie Escarne from the Maternal and Child Health burrow. On behalf of the division I would like to welcome you to "Introduction to Process Improvement and Plan-Do-Study-Act (PSDA) Cycles".

Before I introduce our presenters today I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface. Select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your response will help us plan future broadcasts in this series and improve our technical support. We're very pleased today to have Andrea Brand, the product director and senior associate at Abt Associates. And Lisa LeRoy from

ABT Associates. We'll defer questions toward the end of the presentations but submit questions via email any time during the presentation. We want to begin the presentation. Andrea.

ANDREA BRAND: Thank you, Johannie, I'm on the agenda slide. I just want to give a quick overview about what we'll be covering today. I'll give a little background about the project in very broad terms. And then I'm going to be turning it over to Lisa LeRoy, who will be talking about the quality improvement techniques, which is really at the crux of what this presentation, this webinar is about. And she is going to be talking about the Plan-Do-Study-Act cycles. After Lisa has completed her part of the presentation, she is going to open it up for questions about what she's just spoken about. And then we're very fortunate today to have a couple of guest speakers. We have with us Chuck Ross, who is the clinical director of the STEPS program in Wooster, Ohio and Jessica Sanchez who is clinical quality division network of Colorado community health network. You'll hear from them as we move on with our webinar. Finally before I move on to the next slide I just wanted to remind you that we have two additional webinars planned that you've marked your calendars and can participate in. Monday, May 18th we'll be talking about readiness assessments on Thursday, June 4th we'll talk about topics and team formation. These will become clearer to you as we move on today in our discussions.

Next slide, please. In front of you, you should be looking at a time line of the ICC learning community project for the next several months. Basically this time line shows the activities that we've been working on and will continue to work on in preparation for the August grantee meeting. Rather than go through item by item of this time line, if I can just draw your attention to where we are now you'll see in the middle of the time line that we're on the second webinar. The last webinar was a couple weeks ago where you heard from our

partner, Kay Johnson delivering findings on interconception care that she worked on in the literature. And you'll see we are today at webinar two and you'll see the other two webinars that I just announced planned for may 18th and June 4th. And then corresponding to these webinars are activities or processes that we'll be working with you to help you understand. That we're preparing you for through the webinars. So again this is a broad overview of a lot of the activities that we're doing to prepare for the August meeting. One thing that I want to say,

I know there have been a lot of questions that the Healthy Start community has been asking their project officers at HRSA and CHB is about who should they be planning to bring to the August meeting. I know this is a big issue that has come up a lot. And we will be discussing that in detail in the webinar four. But just for your planning purposes now, the two people that I want to highlight from each grantee are the project director or project manager, whoever is the day-to-day person who oversees your Healthy Start project and also the lead care manager or care manager supervisor. We'll be giving a lot of instruction and help you figure out what other folks would be coming to the August meeting but that's just -- I wanted to give you that heads-up because I know there have been a lot of concerns raised.

Let's go to the next slide, please. In front of you now you should see an overview schematic of what this actual learning collaborative looks like. And I know that Kay Johnson, in the webinar she gave a couple of weeks ago, she did describe a little bit. She went into detail after giving the ICC findings, she did give you an overview of actually what our learning community process is, and this is just to give you a visual to go with it. So in the most simple terms what you see is that all Healthy Start grantees will be creating teams of people who will be working on issues that they will identify with our help, will give a lot of guidance to figure out something that they would like to work on that is

interconception care related over the course of the next several months. And we will give guidance about who should be on those teams and those are called your home teams. A subset of those folks will be members of your core team or traveling team that attend the August meeting that we've been discussing. In preparation for the actual meeting in August are all of the pieces that we've been working on now through the webinars and other tools that we'll be offering you. Those are the topics that were listed in the time line previously. We will be having team meetings for all the -- for all grantees including the traveling team members scheduled for this August, as you know, followed by another meeting in May 2010 and followed again by a third meeting in March 2011. The last two dates I just mentioned are approximate. The dates have not yet been finalized. There is some slight flexibility around those but roughly spaced nine months apart. During those periods between the meetings, what we call the action periods, we'll be guiding you to work on your Plan-Do-Study-Act cycles. That will be the topic you'll be hearing about today. Without delay I know we have a lot of material that we would like to cover. I'm going to pass the microphone to Lisa LeRoy who will introduce you and give you the information to carry this on. Thank you.

LISA LeROY: Okay. Thank you, Andrea. And thanks, everyone, for joining us today. Next slide. We're going to talk today about some general principles of continuous quality improvement or quality improvement or process improvement. We're using all three terms. And then we're going to talk about the Plan-Do-Study-Act cycles. PDSAs and I want to just use two examples of -- from interconception care. Examples of things that grantee projects might take on as their quality improvement initiative. So just as background, continuous quality improvement came out of industry and in sort of post World War II and it was really adopted in healthcare in the last 20 to 30 years. So it's a relatively new -- a relatively new field in healthcare. And the purpose of continuous quality improvement

obviously is to improve your results. And improving your results and improving your outcomes requires change. And one of the things that people often say when they enter into one of these projects is, you know, why should we change? We do an excellent job now. And that is certainly true of the Healthy Start projects. But the conventional wisdom in quality improvement circles is that every system is perfectly designed to produce the results that it achieves. And I'm just going to pause there for a minute because it's kind of a profound thought. And we all are doing exactly what we should be to get the results we're getting. And if we want to get better results, then we're going to have to change things.

Next slide, please. One of the fathers of continuous quality improvement was Edward Deming and one of his famous sayings was that if you optimize human enjoyment in the act of providing services, you will optimize services. I think all of us want to spend more time doing the really rewarding parts of our jobs, and that requires changing, sort of streamlining processes, getting more efficient, in order to spend more time doing what we really want to do.

Next slide, please. On the left side of this table is what Deming said were the principles of transforming a system or transforming a process. On the right-hand side is kind of our translation for what that might mean for Healthy Start projects. So one of the first things we need to do is understand a system and understand what the processes that Healthy Start clients go through. We need to understand what causes variation in the system or why some clients have better results than others. We need to understand what incentives govern staff behavior when they're performing their jobs. In other words, why do we do the things we do. And we need to sort of focus on improving quality as our first goal and think about reducing costs second. So that will follow. That's not our starting point. And another

of Deming's principles is that on the job training for staff and ongoing programs of education and self-improvement are critical to changing processes. So one of the things we'll need to think about in this project is what kind of training do Healthy Start project staff need to make processes better? Next slide, please. We also want to think about breaking down barriers between departments, empowering front line staff and making sure that they are empowered to make the decisions that really impact their work. And ultimately provide better service for the client. One of the other important things that Deming wrote was that removing barriers that rob staff of their pride of workmanship is important in improving quality. We need to think about what changes will allow staff to take more pride in their work. And the last thing is to think about driving out fear. So continuous quality improvement is one of the famous sayings is there is no bad apples. It is not about identifying mistakes or laying blame, it is about looking at a system and trying to come up with improvements to the system. And the bottom line is that most people want to do a good job and if they aren't doing a good job, it's because we haven't given them the proper tools or training.

Next slide, please. So continuous quality improvement principles are first and foremost that the consumers' needs shape the products or services. We assume staff will do a good job when they have the skills and tools to do so. We want to shift from individual blame for mistakes to identifying system and process errors. Management job is to help front line workers and not the other way around. We want to shift from kind of looking at the product or the service at the end, what was the outcome, and look from the start and try and eliminate errors and streamline processes all the way through. It's a lot harder to fix something at the end than it is to improve steps along the way. And the other principle is that the organization adopt and integrates continuous quality improvement as a cultural value so it's not a series of special projects.

Next slide, please. Some of the misperceptions are that it involves sophisticated statistical techniques. That it's all about getting people to do more with less resources. That it takes a big investment of resources without much yield or in our healthcare field it's only applicable to clinical and medical practices and hospitals and not public health or systems of care. I'm sure there are other misperceptions that we could all name. Next slide, please. One of the organizations that has really been key in bringing quality improvement techniques to healthcare is the institute for healthcare improvement. They really developed the learning collaborative model, which is the model we're going to be using in this ICC project. And the characteristics of their model are that they bring together teams with a common goal. In our case, that would be improving ICC care. That the teams focus on a short term initiative. So they get focused on an aim that we can accomplish in six to 15 months. In our case it will be nine months. That there will be learning sessions, face-to-face meetings where we'll exchange peer-to-peer information. We'll hear from peer experts. Talk about our experiences during the periods in -- the action periods in between the learning sessions. And during the action periods we'll be implementing the PDSA model.

Next slide, please. The learning collaborative model is very exciting and it has been adopted by hundreds of organizations. And I have listed just a few here. The reason that it's proliferated is because it's worked in a lot of situations and it really gets people excited and energized around the things they really care about, which is better services for their clients. slide, please.

Next So the institute for healthcare improvements model for improvement asks three questions. What are we trying to accomplish, how will we know a change is an

improvement and what changes can we make that will result in improvement? And I'm going to walk through each of these and talk about Plan-Do-Study-Act. So the first thing is the aims statement. All of you are going to be coming up with aim statements. These are things that you want to accomplish. And effective aim statements are very specific. They have goals. They have a time frame for achieving them. They're very specific about what population is going to be served, and then they offer guidance on approaches to improvement.

Next slide, please. How will we know that a change is an improvement? We're going to measure. There are lots of different kinds of measures that we can use.

Next slide, please. And change concepts. What changes can we make that will result in improvement? And there are a couple of different ways that we'll generate ideas for this. We'll talk to clients and look at data that we have about what they're telling us needs to change. We'll think about the current process and maybe do a walk through. So have a staff call as if they're making an appointment as if they're a patient. Come in, fill out the paperwork, attend the appointment as if they're a real consumer and just then talk about what that experience is like. We'll look at peer programs. So Healthy Start projects that are doing something really well, they become the model, then, for maybe a change that another program wants to make. Next slide, please. So the PDSA cycle starts with planning. So you think about your aim statement, how you're going to -- what you want to accomplish. How you'll measure it, what you're actually going to do and you just plan that. Then you carry it out and then you study it. You look at did your -- did what you expect happen? What do your measures look like. Did you achieve the results you wanted to? Then you act. You decide are we going to keep our initiative the same, are we going to

change it, are we going to abandon it and do something else? Was it totally successful and we'll integrate it into our system?

Next slide, please. So PDSA cycles are really intended to accomplish rapid cycle improvement. And again, so this will take place in the nine-month period between the learning sessions. They are a way to test changes on a very small scale in real work settings so that you don't spend a lot of wasted time coming up with some grand scheme that then takes, you know, months and months to implement. It is -- you know, it is supposed to be something relatively easy that you can tweak and try again. And the bottom line is PDSAs are not research and they are not subject to the same standards as research. When we talk about measures it's measuring of very incremental change in your process. So now I want to walk through a couple of examples from interconception care.

The first -- these relate back to the content areas that Kay talked about last -- two weeks ago on the first webinar. She talked about areas that have, you know, where we've identified best practices for effective practices in interconception care so we looked at those content areas and thought okay, what would be some PDSAs that we might come up with out of those? The first topic we looked at was interconception risk screening. Again, these are just us coming up with examples to use for the purposes of getting us thinking about this. These are not necessarily things that anybody would take on for their PDSAs. You all will come up with your own PDSAs. A goal for the learning community is to assure that women have evidence-based general screening for interconception risks. So the aim statement might be at least 50% of women clients participating in the Healthy Start ICC component in our Healthy Start project will receive evidence-based screening for risks between October and December 2009. So very clear, concise aim statement. And the way we might measure that is to increase the proportion of women clients who receive

ICC screening with a standardized evidence-based tool during that same time period. So what would we actually do? We might -- the Healthy Start project might choose a standardized objective ICC screening tool based on a national recommendation to use in screening. Or they might already have a tool that they're using and they would train staff to improve staff knowledge and skills in consistent use of that particular tool.

Next slide, please. So the cycle would start planning the process, doing it, studying it and acting it. Acting it out or -- adapting it to the next phase.

Next slide, please. So as part of the planning phase, the Healthy Start team would choose their home team, they would hold disciplinary meetings to discuss how to implement the change. They might conduct a walk-through again taking on the role of a client. They might just map the current ICC risk screening process. Look at what tools are currently used and why. How often the tool is administered and what is the effect on clients and develop a change plans and the associated tools to make the change. The do phase would involve implementing the change.

Next slide, please. I'm on the study slide. I apologize. I am not remembering to say that I'm advancing to the next slide. So in terms of studying the process, the home team would discuss what happened with the first couple clients where the change was applied, examine the process, did the change get implemented the way they planned. Compare the measures after the change with the measures before so is the percentage of women getting ICC screening going up, down, staying the same? And then were there any unintended effects like case managers might find the visits take much longer and therefore client dropout increases. That will be another part of the studying the change.

Next slide, please. The last part is to modify the change and to start and conduct a PDSA cycle again. Next slide, please. A second example that I'll just quickly walk you through is on the topic of family planning, or reproductive health. The goal for the ICC learning community would be to assure Healthy Start consumers who wish to plan their next pregnancy have family planning and reproductive health screenings early in the postpartum period. The aim is to assure that Healthy Start consumers who have delivered in the last month and do not wish to conceive currently have had a family planning visit, have chosen a contraceptive method and are using the chosen method.

Next slide, please. So how would we measure that change? We might look at -- if there is an increase in women who have had a family planning visit within the first month or increase the percentage of women who have chosen a contraceptive method, or look at the increase in women who are using a contraceptive method. Again, each Healthy Start project would be picking one measure, not necessarily three measures. What change could the Healthy Start project make that would result in improvement? They might decide to develop a relationship with a local family planning organization that serves low income women. Or another change would be to develop a protocol and associated tools for use by Healthy Start staff to promote early family planning for women who desire it immediately postpartum. Or assuring that Healthy Start staff make contact with the consumer in the first weeks postpartum to discuss facilitated family planning or reproductive health visits or obtain a contraceptive method.

Next slide, please. So if there are any questions I'll take questions now. And if not, what I would like to do is introduce our guest speakers.

>> We have one question, Lisa, before you introduce your speakers. The question is could you provide us with general interconception care topics so we can begin to plan?

>> Yes. So I would suggest that you look at the first set of slides from the last webinar that Kay Johnson presented and the topics are in that set of slides. And I would also say that we are going to be providing you with more materials in the coming weeks, and so examples like the ones I just walked through, we will start giving you some topic areas to think about, so that's also forthcoming.

>> All right, Lisa. Go ahead.

>> Okay. So now I'm very pleased to be able to introduce our two expert speakers, and these are two individuals who have participated in learning collaboratives and started just like the Healthy Start projects are with their own internal change projects and carrying out PDSA cycles, and both of them are now coaches for other peer organizations. And they're going to talk a little bit about their experience. And I want them to have ample time to answer questions. So I've asked them to each talk briefly and then open it up for questions after they've both spoken. So first I'm going to introduce Chuck Ross. He is the clinical director at the STEPS program in Wooster, Ohio. STEPS stands for substance abuse treatment education services and Chuck was one of the -- Chuck and staff, his organization, was one of the founding members of the NITEX learning collaborative. The network for improvement of addiction treatment. He was a leader in that first -- their first learning collaborative in his organization. They worked with 12 other grantees and implemented very successfully a number of PDSA cycles. And Chuck is now consulting with other -- so the organization has grown to be over 1,000 organizations and Chuck is a

coach and consultant to other addiction treatment services in Ohio, Michigan and Indiana.

So now I'm going to turn it over to Chuck.

CHUCK ROSS: Well, good afternoon. It's great to be a part of the conference here and have an opportunity to share a little bit about what we have been involved in. And I guess the one thing I would like to say right off the top, both myself and the executive director here at STEPS. We've been in the field much longer than we care to admit. But in the past 25 years or so I think we both would agree this is probably one of the most exciting things we've been involved in since we have been in the field. And as Lisa was describing, it started out as a tiny little initiative with just a couple dozen different providers. And we've grown a tremendous amount over the last few years and the reason that we have grown so much is that it has worked. The outcomes from been very impressive. The first couple groups of folks that were involved with this, we were looking at things like decreasing our no-shows for admissions and decreasing wait time to get to services. Increasing retention rates. Increasing the number of people we could serve without increasing our resources. And what we found were not, you know, 5% or 10% improvement rates on those things but what we were finding across the board were 25 to 40% to 50% improvements in those areas by applying some of the things that, you know, Lisa was talking about. So it's been very exciting and we've been, you know, very much enjoying, as far as the process we've seen with this. And I guess the one -- one of the big advantages that we saw as far as with the learning collaboratives was right up front when I had very patiently explained to my boss why we had such a long waiting list for two or three years and that there wasn't really anything that we could really do without increased resources. Then when I saw my colleagues across the country, who were making those differences, then I had to relook at some of the things that we were doing, learn from my colleagues and I think that, you know, that has allowed us to be making changes here where, you know, our average wait

time to get into addiction treatment services, if you were calling in for just a routine assessment was 72 days when we started. And surprise, surprise, a lot of the folks didn't show up after they waited that long. We're now down to less than four days on an average wait time to get in and that's counting Saturdays and Sundays and also averaging in when the client themselves choose to delay coming in. We had probably 45 to 50 minutes worth of paperwork when people first worked -db walked through the door. If they weren't upset when they first came in they certainly were after filling all the paperwork. We have that down to less than three minutes now. Things we really didn't think were possible, a lot of people said were not possible, we reassured ourselves they were not possible but then through the learning collaborative we were able to work together and challenge ourselves to do that. One of the things I think I have seen as I've worked with programs in various research branches with the NITEX is this. For the initial sites getting into the initial project it was extremely competitive. There were 400 or 500 different organizations trying to be a part of the initial project. And so we were lucky enough to be able to be one of those. What I'm seeing in some other projects where it is easy to be part of it, sometimes folks are seeing it as another duty is assigned. And are a bit more hesitant to be involved in. Let me suggest to you that it is a wonderful opportunity and it is great that you have this. Just a couple things I'll toss out as far as what my experience has been working with the various programs in the various states that I've been doing consultation with. As to what some of the challenges will probably be for you, and also what some of the keys are, I think, as far as with that success. My guess is that a number of you have been thinking about how do I come up with the time to do this? That I think is the most common first response. There is a learning curve. And I think that as you listen to Lisa describe it, there is a whole lot that you are probably sitting back saying what's new? Those are things that we have done for a long time. Those are elements that we have tried. And I think that the learning curve is, okay, how do you -- how do you take that principle and really apply it in

the whole concept as to what it means? I'll explain that, I guess, in a moment or two. As far as the time that you spend with it, it really isn't -- once you learn the process, it is not new time. You're all doing program development now. You're all doing some type of quality improvement. You're all doing some type of outcome types of things. What these principles allow you to do is have better results with the time that you're already investing. It's a little different way that you may apply that time but, you know, in the long run you simply are doing the same work and the same investment, just getting better results. The other thing that we really struggled with was as far as with data. Data is such a key element with this. I liked what Lisa was talking about when she described it to you. This isn't always high-end research type of data. You don't have to do the double blind control group research where you're figuring the two scores and all that good stuff. One of the programs I'm working with in Michigan the other day told me that they tried the initiative. It was only 16 clients but what they went from was an 80% dropout rate to a 100% retention rate. That tells me that they're on to something and they really didn't have to do the high-end stuff. A lot of times when you're looking at is to get direction from your data, not necessarily precision. But you want to have it so it's easy to gather so you can sustain it. And also to be able to ask those second line questions at times. We were tracking no show rates. We were able to look at it from the standpoint as to why was it that our females referred by family and friends had twice the no show rate of our 20-year-old males that were referred? We were able to drill down and get better answers and thus get better results. One of the other things that we struggled with, the big challenge, was being able to make those quick changes. We were used to processing for about six months and then spending another six months drawing up all the policies and procedures and then trying something and sometimes getting frustrated because it didn't work quite the way we wanted it to. This whole approach is to take a very small chunk, take a step at a time. Try it for two or three weeks and see what your outcomes are. It's very freeing. People are

willing to try their hunches, try their ideas. If they don't work, then you learn from that and try something else. That's been a challenge initially but once you do it and get a feel for it, I think typically it works well. The other thing is -- this is where, you know, as I say, we've done things for years but we haven't always done them quite the way that is being suggested here, that's a whole aspect of client involvement. If you look at all the factors that have an impact as far as successful change, and research has identified like 100 of these, you can add up the impact that number 2 through 99 has and you won't get as big of a result as clients' involvement. That doesn't mean a client satisfaction survey once a quarter, that means talk to your clients, have focus groups, have conversations, hear their stories. That is a way that we are learning to do things much better than what we ever did as far as client involvement. I'll just toss out what I think are four keys in the process. And again just from our own struggles here and also from other organizations, it's so important to have your CEO, your executive sponsors, as we put it, involved. We talk about pick something that keeps your CEO up at night. Pick that key problem because the CEO then will hopefully be able to give you the support and priority that you need and that, you know, the things that you're trying to do that -- the leader of those changes has that CEOs phone number on speed dial so you can get things moving quickly. Another one has to do with the whole business case scenario. That even wonderful changes with good results, if you don't see a positive impact on the bottom line, typically it's hard to sustain them. That may be more dollars crossing the threshold. Client fees or grants or funding or it may be that you have better retention of your staff so people aren't getting frustrated and leaving. One of the other things that Lisa had mentioned was as far as to have fun. And that is so important particularly as far as getting that staff involvement. You have a great potential to be working with some of the best and brightest across the country. That's fun. It is fun when you see the positive response and engagement of your clients and patients that you're working with. And the bottom line is excellence is fun. When you are doing things

better than you've ever done them before, when you see that excellence and those results, that's motivating. That's what we all want whether it's athletics or performance or providing clinical services. And the last thing that I think that I'll toss out to you is what I think is a real key, and that is to believe that the process can have positive results. You can look at the data, you can look at the information that Lisa provided within the presentation, but also listen to the stories that some of the programs that have done this. That's what really gets you inspired and allows you to maintain that momentum. With that, I will wrap up my part.

LISA LeROY: Okay. Chuck, thank you for that wonderful talk. And I'm now going to introduce Jessica Sanchez and then open it up for questions for both Chuck and Jessica. Jessica is a family nurse practitioner and is also the clinical quality division director at the Colorado community health network. And she has been involved in a number of learning collaboratives. She was involved in the initial development of HRSA's health disparities learning collaborative. She also participated in the perinatal learning collaborative started in 2001. Like Chuck, she now does a lot of consulting and coaching to other health centers and organizations around these principles. So with that I'm going to turn it over to Jessica.

JESSICA SANCHEZ: Hi. Hi, Lisa and thank you, Chuck. That was such a motivating speech, I don't know what else I can add to this. I just wanted to add I have ten years of experience in quality improvement and the benefit of it is that I am a nurse practitioner so I get to also be in clinic and see the benefits of doing quality improvement. So I would want to talk about three keys to success. One is to build upon what you already -- what is already working really well. So don't reinvent the wheel. There are several people participating in this collaborative so I would say develop a learning community and a

network of peers so you can learn from each other. If you are getting started with change involve all people involved affected by the change in your process. If you make a change in medical records, make sure you have your medical records staff on board. I would say identify an area that really bothers you. When you come to work every morning, what is it about your process that really gets your blood pressure up? And how can you make that better? And how can you that system more efficient by reducing your waste and improving the value for you and for your patients. The other piece I would say as Chuck said is have fun. This is a fun process, it is fun to see the outcomes in both the staff changes and the patient changes. And I would say celebrate early on all of your successes. Post your metrics, post your outcomes, share this at staff meetings. Get yourself on your staff agenda and talk about your changes. Some folks will put this in their health center newsletter. They talk about it to their boards. They talk about it to their community. Just make sure you are celebrating your successes. The other piece of this is that it's a real opportunity for staff development. So early on it's your way to engage key clinic staff to help deliver the message and to motivate other staff to do the work. So part of the reasons that you might want to do this is to expand existing roles. You want to integrate the changes into your job description and roles and responsibilities so that they're integrated in your system and early on you want to identify a champion. Your champion is really going to lead this work and motivate the team and keep them going. The other piece of this is you want to have leadership engagement. Meaning that you want to have your senior leadership engaged in the day-to-day work. You want them to be visible and you want them to be able to sustain that leadership to lead the cultural changes and to improve quality and to also help spread and sustain your changes. Your senior leadership is also responsible for establishing the QY team and making sure the quality improvement team has the resources to meet on a regular basis. The other piece that key leadership does is they really ensure that the team, the providers have -- and the providers have the

protected time to do the activities beyond your direct patient care. You're probably wondering how will I fit this into the 80 other things I have to do every day? I really don't have a lot of administrative time. It is part of your leadership's role and responsibility to make sure that you have that protected time to do these non-direct patient care type of activities. The other piece is to build the practices for quality and value for quality into your staff training and hiring processes. So if you early on as you're recruiting providers and staff, talk to them about your quality improvement projects. Show them your quality improvement models so they know what they're getting into when they accept a job in your facility and make sure quality is part of your staff training. The other -- the third step I want to talk about is really to have some early successes and with the PDSA cycle that Lisa talked about it will give you the early successes. One is -- one reason to have early successes it's a motivator to continue. It will -- one of the things you want to do is choose the low-hanging fruit as your first PDSA. Don't choose anything really hard. It's what you can do by next Tuesday. I think those were the three areas I really wanted to stress. The other piece Chuck spoke of was try to integrate measurement for your team so that your staff don't feel like they have to collect the measure for HRSA. They aren't collecting a measure for their grant requirement. They're collecting the measures for them and the positive outcomes of the patient. All right. That's all I have, Lisa.

>> Thank you, Jessica. So let's open it up for questions for Chuck and Jessica.

>> Hi, Lisa, there are a few questions. I was working my way through them. The first question actually is for you, Lisa. Will there be any TA regarding how to pick the team members. I think you talked about this a little bit in the beginning but I know this is a question that Healthy Start grantees have been very concerned about. If you could just reiterate what and when they would be able to pick their team members for their process.

>> Okay. So yes, there will be TA on selecting the team members. That would be covered in the fourth webinar on June 4th. But I think that Jessica gave some great advice, which is, you know, your team members should be those involved in the improvement project that you select. And so it would be great for folks to start thinking about, you know, what is a -- what is an ICC improvement change that they would like to start working on? And who, then, would be on the team? But we will definitely provide TA and we'll talk a lot more about this in June.

>> Okay. Thank you, Lisa. The next question please address the time lag between a process occurrence/outcome in a client's life and the availability of that data. Not sure who best would answer the question.

>> Can you read the question again?

>> Please address the time lag between a process occurrence/outcome in a client's life and availability of that data.

>> Well, let me toss out maybe a response. I think that that is one of those key questions when you're looking at a change. How can you determine quickly whether that is going to be an improvement? I think that's the part where you really need to be having that discussion. As to what, you know, some dashboard items might be. Typically you don't get that long term outcome as successfully completing treatment but what you can do is research tells you that client satisfaction is going to improve retention, or one of the things we look at is that we know that the great majority of clients, if they get to that fourth treatment session, 65% of them or something thereabouts are going to be successfully

completing treatment, which may be down the road a number of months. So you try and find those indicators that you may have a turnaround in two or three weeks for that bigger outcome.

>> Thank you, Chuck. The next question how much prerequisite training was required on CQI basics? Did the team require to more appreciative culture focused on customer-centered needs? I'm not sure who best -- would best answer that.

>> I'll just tell you what our experience was and some of the other folks I've worked with. Typically it's jump in and, you know, start working with it. And, you know, having those discussions that as you go, that -- and I think that -- but maintaining as far as the focus and keep going back to how do we get more of that appreciation and how do we incorporate that? To answer your question, no, there wasn't tons of training.

>> I would say that the models that Lisa spoke of of developing your aim stands and the cycles and the learning model that you go through in this

>> We had an in-service learning how PDSA cycles actually operate by taking the best evidence-based practices as to how to build a paper airplane and then to make adjustments as to whether you could make fly it straight or not. Different things along that line.

>> Thank you, Chuck and Jessica. Another question directed to you. What tips can you offer when addressing the inevitable topic of financial deficits and more money solutions when more money is not available?

>> We usually ask for the second idea then. You know, yeah, I mean, that's always been the -- almost always been that first, you know, idea. And I think that that's where, when Jessica was talking about kind of picking that low hanging fruit, having some early successes so that folks can see that the process was, you know, the key in making that change and being able to be more efficient. And, I mean, because, yeah, that's always going to be one of those first suggestions and that's simply in most of the cases not really an option.

>> I would agree with Chuck. If you can approach a problem first with two basic rules that we're going to change a process and not hire anymore staff or ask for anymore money, you would be surprised what ideas can come out of that. And what sort of brainstorming discussions you can have. It may turn out that once you flow map a process and realize what steps it takes and what resources it takes, it may not be doable without extra money or extra staff. But it's first and for most the first step I would take to flow map out a process and see what areas you could eliminate of waste or steps that you're taking. And then from there move on to asking for additional resources.

>> Thank you, Jessica. Along the same lines of working through this process, another question. Low hanging fruit and topics that keep me up at night are in opposition. How do we break down these topics that really bothers me and into those low hanging fruits that we can see results?

>> I think one of the things the PDSA is you could have your overall goal of what you would like to accomplish. Your overall goal is probably the stuff that's keeping you up at night. You just want to improve overall interconception care for your patients. It is like that broad goal. But when Lisa talked about the PDSAs is that they're short, rapid cycles. So

you can have several PDSAs going at one time to get you to your big outcome or your big goal. So what you want to do when you're thinking about that overall objective or PDSA, you want to think about all the small little PDSAs it will take you to get there. And so I think -- my recommendation would be to start small with the low hanging fruit as we're calling it and accomplish those first steps to actually get you to your big overall goal of improving care for your patients. I don't know if that made sense or not.

>> I think it did.

>> I would certainly support that. I think that the other framework to maybe apply to that is if what you're doing is that you're going ahead and taking those small steps along the way, the stepping stones, you then have the benefits of those improvements right away versus waiting until you have everything in place. And that may be six months down the road.

>> That's a good point.

>> Thank you, Jessica, and Chuck. The next question I believe is for Lisa. And Andrea. According to the time line slide, the first date of the August meeting, is it on August 1st? If I'm looking at this correctly. I think it was meant the first week of August. If you want to answer that.

>> The meeting is actually Monday, August 3rd and Tuesday, August 4th.

>> The time line represents the weeks in August, not the dates, correct?

>> Correct.

>> Okay. I think that is all of the questions I have right now. While we give the audience a couple more minutes, does anyone else have anything they would like to add? Everyone is silent. Let me see here. I haven't seen anything else coming in. Well, I guess you guys did such a great job that we have no more questions. So I guess we'll have to go ahead and close out the webcast. On behalf of the Division of Healthy Start and Perinatal Services I would like to thank our presenters and our guest speakers and the audience for participating in this webcast. I would also like to thank our contractor, the Center for Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website The Community Task Force Mchcom.com. We look forward to your participation in future webcasts.