

***Administration for Community Living
Affordable Care Act Training
Transitions and Long-Term Care:
Plan-Do-Study-Act Cycles and How They Can Help Accelerate
Quality Improvement in Your Organization
April 24, 2012
2:00 - 3:30 pm Eastern***

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session please press star 1 on your touchtone phone.

Today's conference is being recorded, if you have any objections you may disconnect at this time. And now I will turn the meeting over to Ms. Marisa Scala Foley. Ma'am, you may begin.

Marisa Scala Foley: Thank you, Pat. Good afternoon, good morning to those of you on the West Coast and in Alaska and Hawaii. My name is Marisa Scala Foley. I work in the Office of Policy Analysis and Development at the Administration for Community Living; a new agency under the US Department of Health and Human Services, which brings together the Administration on Aging, the Administration on Developmental Disabilities and the Office on Disability.

Thank you so much for joining us for this month's Webinar, our latest in a series of Webinars focused on opportunities for the aging and disability networks both state and local agencies within the Patient Protection and Affordable Care Act, also known as the Affordable Care Act or the ACA.

This Webinar series is designed to provide - to provide the aging and disability networks with the tools that you need to participate in ACA-related efforts in your area such as accountable care organizations, the community-based care transition program, health homes and more going on.

When many of us think of evaluation we tend to think of large-scale, expensive, multiyear studies that look at whether or not programs made a difference. But an important part of the rapid cycle improvements occurring in healthcare and long term supports and services as a result of the Affordable Care Act is being able to implement and test small changes within your organization to see if they lead to better outcomes and to quality improvement.

These short-cycle small-scale tests when coupled with analysis of the results of those tests can be helpful because they allow you and your organization to learn from these tests before you implement programs more broadly.

One such method for testing change and something called the Plan Do Study Act, or PDSA, cycle, which is what we will be focusing on in today's Webinar. First you will hear an overview of PDSA cycles and next you will see how one community is putting PDSA cycles into action in its community-based care transition program.

So before I introduce our wonderful panel of speakers we have a couple of housekeeping announcements. First if you have not yet done so please use the

link included in your email confirmation to get onto WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through the chat function within WebEx.

If you don't have access to the link that we emailed you you can also go to www.webex.com, click on the Attend a Meeting button at the top of the page and enter the meeting number, which is 660039618 and the passcode is aoa webinar - and that's all one word. Again the meeting number is 660039618 and the passcode is aoa webinar.

If you have any problems getting into WebEx please do contact WebEx technical support at 1-866-569-3239; again that technical support number at WebEx is 1-866-569-3239.

Second, as Pat mentioned all participants are in listen-only mode at this point. However we do welcome your questions throughout the course of the Webinar. There are two ways that you can ask your questions; one, as I mentioned before, is through the Web using the Chat function within WebEx. You can enter your questions, we'll sort through them and answer them as best we can when we take breaks for questions after each presentation.

And second after both sets of presenters wrap up we will offer you a chance to ask your questions through the audio line. When that time comes Pat will give you instructions as to how to queue up to ask your questions.

And as always if you think of any questions after the Webinar or have any questions you'd like us to follow up on you can email them to us at affordablecareact@aoa.hhs.gov. Again that's affordablecareact@aoa.hhs.gov.

Finally, as Pat mentioned, we are recording this Webinar. We will post the recording, slides and a transcript of this Webinar on the AOA Website as soon as possible. You can get to it by clicking on the Health Reform and the Aging Network button on our homepage. And we should have it posted hopefully by late next week.

So with that enough of the housekeeping announcements. I - we are thrilled to have with us there terrific speakers. Our first speaker will be Jane Brock, who is the Chief Medical Officer with the Colorado Foundation for Medical Care.

Our second speaker - actually we'll have a team of speakers giving the next presentation and that team will be Steven Touzell, Director of Long Term Care at the Philadelphia Corporation for Aging and Steven R. Carson, who is a Vice President at Temple University Hospital.

But first let me introduce Jane who will be presenting first. As I mentioned, Jane Brock is the Chief Medical Officer for the Colorado Foundation for Medical Care which is the Medicare Quality Improvement Organization, or QIO, for the State of Colorado.

She is currently the Medical Director of the CMS QIO (tenth) statement of work integrating care for populations and communities or ICPC - the National Coordinating Center.

The ICPC National Coordinating Center is providing leadership and support to 41 QIOs as they recruit communities of providers and people with Medicare to work together to reduce unwanted hospital readmissions. She also serves as an expert faculty member for CMS's community-based care transitions program technical assistance contractor.

So with that I will turn things over to Jane. And I'm getting your slides up right now, Jane.

Jane Brock: Thank you, Marisa. And thank you, everybody, for calling in. So I just want to review sort of the basic principals of - they're really called Shewhart cycles. So Shewhart was a statistician that worked his entire career for Bell Labs so was a - measuring and applying statistics to industrial processes.

We now mostly call this the PDSA or I've even - it's been verbed - we're going to PDSA that - that sort of thing, but it's really a Shewhart cycle. So I just wanted to introduce people to it if you've not used these extensively and/or review it for those of you that feel like you have the basic knowledge but haven't been over it for a while.

So next slide. So really this is just a method of trying to change. So all improvements takes change but not all change is improvements. So I think about it like this, if you're going to try to do something better I think these are the three methods that people usually try.

The first one is if it's not broken don't fix it. I think there is a perception and it can be true that trying to change is worse than just trying to adapt to what you've got now. There's clear advantages in not doing anything in that it's obviously effortless. However I think we all know in anything having to do with healthcare today there's just basis in reality for feeling like things aren't broken.

So the second method, which I know my training was largely based on, was sort of a traditional research method. And so the advantages of research is that it's - collects the kind of data that in the end gives you an answer that is what I call truly true.

So, you know, you're going to take your - the target that you're trying to change, you're going to measure all these characteristics about the target, you're going to match those characteristics to a non-target population, you're going to introduce one change feature into the targeted population.

In the end you put it all into a big model, you know, a logistic regression model and at the end you get a P-value that's helpful because you can publish this. And in the end you can say truly for a population that is defined exactly like this this change was good.

The disadvantages for this is it's really not appropriate for measuring change for a number of reasons both statistical and practical. But for - the main thing is in the end you will know something about a very small slice of a very specifically defined population. And you may or may not be able to extrapolate those findings to any other situation.

In the practical sense it also takes a very long time. You know, a real research study you have to, you know, have a run-in period, you've got to randomize subjects and assign them here and there. It's quite expensive because it takes a long time.

And in the end it's inflexible to really prove the value of this intervention you have to rigidly adhere to the model even if, you know, one month into the protocol you realize, oh my gosh, the world has changed in the past month. I mean, I think that's characteristic of healthcare improvement is if you take too long to frame your question, test it, analyze those results and publish it sometimes the question itself isn't even relevant at that point.

So now we get to trial and error. And, you know, trial and error, in my opinion, has had kind of a bad rep. There are actually some advantages to trial and error. So the most important one I think is that it's often a spontaneous decision. You know, I just can't take it anymore I'm just going to try doing this a different way today.

It's very flexible. Usually it's - the best trial and error tests are very small. It's me and what I have to do today and I'm just going to try doing it differently so, you know, I don't have to get a protocol, I don't have to talk to anybody about it.

The expert who is affected by the process or the issue at hand is the one who decides to try this. It's very quick. And since you didn't tell anybody about it and you didn't change any infrastructure if it didn't go well you can just abandon it the next day; you know, really nothing lost.

So the main disadvantage to trial and error is that if you don't measure it to some degree you sometimes had some things about your little trial that were good and some things that weren't.

But if you don't separate that out what you risk is either just abandoning trying to change altogether or sort of testing the same thing over and over again so that the main disadvantage of trial and error is that it wastes the opportunity to learn. So next slide.

So PDSA or the Shewhart cycle really is just a way to be systematic enough to capture knowledge from trial and error. You want to keep it - the trials to be things that you can really just do today.

And the hope is that as you gain information from little spontaneous tests that your trials will get better over sequential tests because you've captured some knowledge about what was good and what wasn't good so that your modifications are not things like a total rejection of trying to change versus embracing a whole different change. But you can modify change over time and get better sequential tests.

So this is my story. This is how I became in the model for improvement. So I was trained by IHI, you know, in conjunction with their quality improvement collaboratives. And my role - the very first time I was involved in a collaborative my role was to teach the model for improvement.

And so I had sat through a number of sessions training on the model for improvement and PDSAs and in the end, you know, there were a lot of circles and errors and they kind of, you know, went in one eye and out the other eye.

And on the eve of realizing I was going to have to teach this I realized that I was perhaps not a total believer in the model for improvement myself, you know, having not really tried it in a complicated setting like what we were asking providers to do.

So if you read about the model for improvement it says you can use the model for improvement for any problem; you can apply this methodology to any problem in your life.

So at the time I realized I needed to really get some experience with this. The number one problem in my life was getting my kids to school on time. So my husband and I we have a lot of evidence that we can be effective at a number of things but we could not be effective at getting our kindergartener and first grader to school on time.

So at the time the kids went to an elementary school that was literally a block and a half from our house such that we could actually hear the bell ringing from our house - from the kitchen where we were typically still eating breakfast and/or trying to find stuff.

So our typical experience of trying to get the kids to school on time was, you know, a lot of shouting, where are your shoes, forget it, you don't need socks, you don't need that toy, whatever. And we would start sprinting. So it was an old fashioned school, they actually had a bell that somebody rang. So it rang for quite a while.

And occasionally we could actually sprint that block and a half to manage to get to the door before the bell started ringing so we technically weren't late. But really over time I started to think well why don't I just try to see if we can improve this using PDSA?

So now the first thing we did is collect baseline data. And I want to encourage people to realize you don't have to have comprehensive baseline data but - but at the time, you know, I was just making my transition from research. So I felt like oh I'm going to capture baseline data - I'm going to get an N of 10 - I want 10 data points.

And so I didn't know first how to start because the problem was it was the most chaotic hour of the day. And so now I was thinking oh gosh I have to collect data; how am I going to do that?

So the way I solved this problem is I just got a stopwatch and when I heard the bell ringing or when we got to school I started the stopwatch and measured the interval between the second events, either we were at school and I could

just measure the time until the bell rang or the bell started ringing and we weren't at school and I could start the and measure when we did get to school.

So here is my baseline data. And as you can see we had a pretty big problem. The two - Observations 6 and 7 were when we arrived as the bell stopped ringing so technically we weren't late but I felt like I would like to eliminate that whole experience as well.

So the baseline data that we started with is that we were late or almost late 60% of the time. And now I also wanted to put in a balancing measure. And I would encourage everybody who is trying this to put in balancing measures. And what I mean by balancing measures, almost always, is the acceptability to the team of changing things.

So my concern was we could get to school occasionally on time. But it was really leading to a lot of - well a lot of shouting, you know, encouraging sometimes with an angry tone of voice - my kids to get it together.

So I wanted to measure as a balancing measure what I called negative parental interventions. Now keep in mind I was the PI; I was the only one I had to ask permission to do this. And it was my assessment of whether or not there were negative parental interventions.

But at baseline I felt we were later almost 60% of the time. And during that 10 item data collection phase there were 21 negative parental interventions or 2.1 per day. So this is where I started from.

Okay next slide. So my idea at the time - okay given that I wasn't totally bought into the model for improvement just yet was I thought okay we just

need to get up earlier. I mean, everybody knows you need to get up earlier and nobody really needs the model for improvement to know that.

So I decided that we were going to - for 10 data points we were going to get up 30 minutes earlier. So here's my data from that whole phase. And you'll notice I stopped at seven. So for seven days we got up 30 minutes earlier. And I have to tell you that Data Point 7 was the day that we came out of our house and the next door neighbors who went to the same school were stumbling out of their house at the same point, the bell was ringing and (Alaina), their oldest child, said something like can we sprint with you?

And I said yes of course. And her hair was all disheveled and all that. And she said oh my gosh we overslept; we just got up about 10 minutes ago. Okay so we had been up for an hour and a half at this point and (Alaina), who got up 10 minutes ago, was sprinting with us.

And so I said - of course I said, well you probably didn't eat breakfast did you? And she said oh yes, we ate breakfast. Okay. So I stopped data collection at that point realizing, you know, I think getting up earlier is not our problem. So at this point we were later almost 57% of the time so that was no improvement in my opinion.

And the negative parental interventions were 17 or 1.7 per day so there was slight improvement on that but really what probably happened is I just had more time, you know, an hour and a half getting up early so that I didn't have to be as urgent with my negative parental interventions.

All right so I decided okay I'm going to give the model for improvement a full test. So we did what you're supposed to do; we wrote (name) statements. Here's our N statement, increase the proportion of time arriving at school on

time by improving morning processes and workflow for all members of the family while reducing negative parental intervention.

Okay next slide. So how will we know change of improvements - well it'll be number of times on time, obviously and number of negative parental interventions. So I just want to point out this is the advantage of a balancing measure so my husband, who is not a clinician, said, you know, I loved that scene in the Sound of Music where the father has the whistle and he does the whistle and the kids have to sound off and so that was his idea.

And I felt like okay we could probably get to school on time using those methods but that's really not what I want and so the model for improvement really is about making it acceptable to all members of the team. And we're just going to test this method.

So this one thing that I did do is I bought the book the Improvement Guide. And I don't know if folks here are familiar with it and/or they use it. But it's by Langley and Nolan and it's quite a large book; it's several hundred pages.

But the thing that's the most valuable about this book is in the back there's probably 30 pages of actual concepts to test change in. It's just a list of change (unintelligible) ideas.

And so I actually went to this book and looked in the appendix to think about what changes could we test. So next slide. At the time we started here were my theories. And, see, they're not well formed theories but this is really where you start just with your basic idea of you as the sort of process owner.

Okay I thought we just were basically disorganized. We had no routine and no expectations. I felt that we probably had bottlenecks. I suspected that people

were spending a lot of time in the bathroom, you know, all they had to do was brush their teeth. But anyway there seemed to be a big gap of time in there. And then there was clearly a lot of wasteful activity at the very end where everybody was running around trying to find things.

So I then mapped our current state. So next slide. And so this just describes kind of the routine of how it went. So people would get up, there'd be this sort of transition period, they'd spend a certain amount of time in the bathroom. There'd be a transition period where they were getting dressed.

And keep in mind this is only two small children but it was really kind of a difficult process to measure. Then we would eat breakfast, then they would go back upstairs, they'd brush their hair and brush their teeth. Then we would get all our stuff together. And this was a very problematic interval. And then we would walk and/or sprint, depending on whether the bell was ringing, to get to school and then we would arrive at school.

So when I started thinking about what changes can we make I found this in the Improvement Guide. First of all you could smooth the workflow so change the order of activities. I wanted to eliminate the waste of movement, all this running around at the end. And I wanted to emphasize natural and logical consequences. And I realized this is the concept that is I think the title of a parenting book. But it's actually an improvement strategy in the Improvement Guide.

So I decided what we would do is eat breakfast last at the back door through which we exit to get to school in the kitchen. And we'll measure the before breakfast interval. Now this was just a decision made by the PI on the fly. I'm thinking that it's really before if we really eat breakfast last, I don't think

breakfast is the interval in and of itself that's driving us crazy. I want to measure the time to getting to breakfast.

Okay, so next slide.

So the proposed future state then would look like this. I think I explained that so next slide.

So here's my data. Now I did collect nine data points on this. So I was following them around last March but mostly measuring the interval between getting up and arriving at breakfast and then the interval between the bell and arriving at school.

And here's what I found. So here's - my hunch was right that it was this whole before breakfast thing, breakfast is not the problem. It's the before breakfast interval that's obviously out of control. Moreover it directly correlates with our being late or not being late.

So at the end of this PDSA cycle I felt that we were late. I mean well we were late about 40% of the time. And I accepted this as improvements. And I hope I'm making a point here. This is not the (hardly) scientific. And nobody's going to get a P value out of this.

But we went from 60% to 40% and the negative parental intervention seemed better although I wasn't really happy with this. And I suspected really that the negative parental interventions were just slightly more effective because now they could be something like well you know you won't get to eat breakfast because you're going to leave for school anyway.

So next slide, so if I had to summarize this as a PDSA cycle here it was. Test number one, use the workflow, eliminate waste. This is called moving up and down to breastfeed and that sort of thing. Emphasize natural and logical consequences.

What I did was make breakfast last and measure the time until breakfast. What we studied was the time until breakfast as it relates to the outcome.

And my action was I thought this was good. There was enough improvements. It's clearly insufficient. And I felt like, you know, I might need to measure other types of intervals.

All right, next slide. So I thought all right, what am I going to do for my next test.

So there is an improvement guide. A lot of the change concepts, reduce setup/startup time by doing external work ahead of time.

So what this meant to me is, you know, this whole getting dressed interval seems to be very chaotic. Why don't we lay out clothes the night before to reduce the workload of the morning and I wanted to keep the before breakfast interval measurements.

So next slide, so here was my data.

All right, this is doing activities the night before. We were going to unload in the morning. And as you can see we really had no improvement here; later almost 50% of the time. Negative parental interventions were slightly better. What I really probably did was transfer those parental interventions to the night before, you know, you have to get yourself ready now.

And so I don't know, I gave that a slight improvement. This is the advantage I think to PDSAs. They're small. You as the PI get to decide whether you think there was improvement to a certain extent.

So next slide, this is the way I summarized this test; reducing the setup and startup time by doing some things ahead, specifically setting out clothes, collecting stuff to go. It was really not better. I thought this was insufficient improvement and honestly I was really surprised at this.

So this is when I really started to believe I think in the model for improvement. So I felt that we should probably keep this but this is the first time it occurred to me that maybe time is not our issue. Now you would have thought that I could have had a hint that this would be the case because getting up 30 minutes earlier didn't make any difference.

However, you know, I think my preconceived notions about what the problem was sort of driving my test of change. And this is again a huge advantage for the model for improvement. I didn't have to accept or reject in total. It was really a chance to test further potential iterations of what is the issue of this time management in this and what are the other issues.

So next slide, all right so for the third test of change what changes can we make.

I went to back to the improvement guide and there is an item, reduce demotivating aspects of the pay system by providing instances.

So we started a points earning program where if they were on time for breakfast they would get points and you would accumulate towards the

opportunity for ice cream because ice cream is the favorite food of the principal investigator of this study.

So I got - I did engage them. We were going to collect marbles in a dish. And when there were enough marbles we would go and get some special treat.

So next slide, and so here's what happens, as we were providing incentives, the before breakfast intervals finally showed what I would describe as significant improvements; we were later almost 20% of the time and the negative parental interventions were much down; sort of like well don't you want ice cream?

And so I felt this was a real step in the right direction.

However I wasn't going to accept 20%. The 20% failure rate is still way too much. So I decided to do another test.

So for my next test I went back to the improvement guide. And there is an item that's potentially problematic because it was so big of find bottlenecks.

Now I had to note. There's just this black hole of time that I wasn't finding. It was clear that incentives were the problem and not time at this point. But I still didn't know exactly where the waste was coming.

So 20% of the time with kids who are getting everything ready ahead of time, right, eating breakfast last, earning points towards ice cream, but we still weren't really - it didn't feel as I hadn't managed the chaos as much as I wanted to.

So I finally decided I would capture measures of specific intervals. So we at the time were living in a house that had one bathroom. And I was thinking oh gosh, everybody knows you need more than one bathroom. What I'm going to find is that we have a flow problem through the bathroom.

Next slide, so I just want to point this out. This is not what I would describe as the ideal data collection strategy.

But I was collecting this data during the most chaotic intervals of the day, that hour between getting up and getting to school. So I just captured snapshots of activity as I was able to do.

So this actually did not take ten times. This took more like 20, 25 times where I could capture a snippet of this or that, you know, kid doing some activity.

And I put them all into the same, you know, sort of just one chart type method. And as you can see, well maybe you can't see, but it's the pink line that really correlates with getting to school on time and it was this getting dressed interval.

Now we were still - I really hadn't improved too much over the last cycle. We were still at 20% later almost. The negative parental interventions were roughly the same.

But this is a really informative test to me because if you'll recall these were kids who were putting their clothes out at night. And yet the get dressed interval was first of all quite variable; and secondly, directly correlated with our outcome measure.

Next slide, so in the end I realized that it's this getting dressed interval that is the source of our problem. It is not actually a bottleneck in the bathroom so thank goodness I didn't look at this problem from the beginning and decide to get up two hours early and spend \$60,000 on a, you know, putting a big addition on our house to get another bathroom.

Next slide, what was happening is that the kids weren't - most of you who have children I suspect this is a common problem. But the kids had laid out their clothes but would make a decision in the morning after they got up to go find their favorite whatever, and it was typically in the laundry, sometimes it was wet in the washing machine. It didn't really matter to them. They were dead set on getting certain types of things to wear.

So what we did then is incentivize wearing the prearranged clothing specifically and that was what they had to do to earn points for ice cream.

So next slide, I don't know if I put the final slide in here. So we went to perfect after that. We were on time; absolutely on time everyday for like two months without missing.

So in terms of summarizing what I learned from doing this series of things so getting up earlier was no change; now I should have reflected on that just a little bit more.

How can 30 minutes not help?

Rearranging the order of activities did improve. Now removing activities is no change. And this is a wasted test in retrospect. I couldn't have predicted this based on the fact that 30 minutes was not our problem. Providing incentives

led to improvement and providing incentives specifically really got us to improvements.

So that's my story. That's why I believe in PDSA. I thought it was a very powerful strategy. Since then we've seen all kinds of more work related situations improved fairly dramatically by just being a little bit systematic about thinking what tests you're going to test. What you expect to learn from that test.

And then taking the time to reflect on what you learned; to inform your next test. To not start out with a whole series of we got to do this, then this, then this, but to provide testing as you go along. To see in fact you're extending your efforts in the right direction.

So thank you, Marisa. That's all I have.

Marisa Scala Foley: All right, thank you so much, Jane.

So we did get a question. And the question that we got was how important is buy-in from the sort of other subjects I guess in your Plan-Do-Study-Act cycle? In this case I guess it would have been your two kids and your husband?

Jane Brock: Yes. My husband just thought I was nuts and that our kids were headed for serious psychiatric therapy because I was following them around with stopwatches. But that's peripheral.

You know that is a great question. And honestly the very best thing I did was to present this at our very first Surgical Infection Prevention Collaborative. And I seriously had five Quality Managers from enormous hospitals or

hospital systems come up to me later. I hadn't quite finished it. We hadn't done the very last test where I was thinking about conducting training on how to put out the clothes you laid out.

And that was exactly the suggestion I got. A very delightful woman from one of our big hospital systems in Colorado, she said, you know, if you engage your team a little better you would probably get better and faster results.

And she said give the stopwatch to the kids. And I did and she was absolutely right.

So really what I should have done is presented this to a bunch of female, grandmother, Quality Managers right from the get go and they probably would have told me that. But anyway in the end I did learn that was a critical component of what I should have done from the beginning.

Marisa Scala Foley: Okay, we've got another question in from Ellen who asks can you give - can you talk a little bit more about what a balancing measure is?

Jane Brock: Yes. A balancing measure is intended to illicit potential adverse consequences. So I would say almost always the balancing measure that I value the most are measures of acceptability to the team making the change.

So, you know, if you decide and especially this - you're especially at risk if it's - have a large team and you have sort of a small core of that team making decisions about what to test.

So it's easy to say, you know, out of our team of ten, let's just have - you know let's just have Ellen do it all. I mean not that anybody intends to do that.

So in the end you need a balancing measure to make sure it's not causing damage in some place you didn't think about in the beginning.

So by far the easiest balancing measure is acceptability to the people most directly affected of the test. Do you feel like it makes your job easier or harder?

Do you like this?

Keep in mind the real strengths to PDSA is to try to leave it at almost the trial and error level so that you don't spend a lot of time collecting data. So on a day when you decide just to do things differently, we're going to enter this thing in this place or we're going to, you know, whatever, you want to at the end of the day just basically check out with people. You know tell me harder, easier or the same.

And so that's a great balancing measure. And there are much more sophisticated balancing measures and I'd be happy to give response on specific questions if people have them.

Marisa Scala Foley: Okay, great. Thank you Jane. And Ellen, if you have any further questions or you'd like more specific examples feel free to send that in through Chat or email us offline and we can connect to you with the resources that Jane mentioned.

So with that I think we are - have gone through the questions that we had from Chat.

So with that I think we are going to turn things over to our team from the - from Philadelphia to talk about how they put PDSA cycles into practice with their community-based Care Transition Program.

So I'm going to queue up the slides. Then I'll introduce our speakers so bear with me for one moment.

Okay, so first let me introduce our two speakers from Philadelphia. First, Steven Touzell is a social worker with over 30 years of experience in a variety of clinical and administrative roles. He's currently the Director of Long-Term Care at the Philadelphia Corporation for Aging or PCA which is the Area Agency on Aging for the City and County of Philadelphia, Pennsylvania.

In this capacity he oversees a broad range of state and federally funded long-term services and support programs which provide home and community-based services to over 15,000 older adults and people with disabilities on an annual basis.

Teaming with Steven Touzell will be Steven Carson. Steven Carson is a Registered Nurse with over 30 years of experience serving a variety of leadership roles in both clinical and administrative hospital operations. He holds a Masters of Science Degree in Healthcare Administration from St. Joseph's University and Bachelors of Science in Nursing from Gwynedd-Mercy College.

He is currently the Vice President of Clinical Integration for Temple University Health System and his primary areas of expertise include performance improvement, organizational change, home health and population management related to community case and disease management.

So with that I will turn things over to Steven.

Steven Touzell: Thank you, Marisa. And I'm very happy to have this opportunity to say a few words about the North Philadelphia Safety Net Initiative. And then introduce my colleague Steve who will offer an illustration of how the partnership made use of PDSA in the planning process.

If you can move to the next slide, this slide here is basically the storyboard that we put together for a learning collaborative that we recently attended regarding the Community Care Transitions Program.

And I'll sort of be walking through this a little bit but we'll leave this up for the entire time that I'm speaking and certainly you can read through some of the items on there as well.

The partnership as you can see includes PCA which is the Area Agency on Aging in the City of Philadelphia and two Safety Net Hospitals, Einstein Medical Center of Philadelphia and Temple University Hospital.

The collaborative is one of, or the partnership I should say is one of 30 nationally selected collaboratives to provide community-based care transition services by the Centers for Medicare and Medicaid Services under Section 3026 of the Affordable Care Act.

The goals of the Community Care Transition Program are to provide transitions of beneficiaries from inpatient hospital setting to other care settings to improve quality of care, to reduce readmissions of high risk beneficiaries and to document measurable savings to the Medicare Program.

The North Philadelphia Safety Net Partnership selected the Illinois Transitional Care Consortium's Bridge Model which is an evidence-based social services model of Community Care Transitions based on our root cause analysis - on a root cause analysis which was conducted by both of the hospitals and PCA and identified a highly impoverished and medically underserved population.

The intervention will follow Medicare fee-for-service patients who are being discharged to home from the hospital setting for a period of 30 days. The patients will be referred to the Community Care Transitions Program by a hospital-based navigator who will coordinate a number of pre-discharge activities including medication reconciliation.

PCA will then assign a Bridge Care Coordinator who will ensure patients follow-up with their discharge plan including their primary and specialty care, pharmacy and home care needs through a variety of motivational interviewing and other patient activation strategies either in person or by telephone.

The level of patient's activation will be measured by the patient activation measure, PAM, both at the onset of the intervention and at the end of the 30 day period.

Just by also by way of background, this collaborative really came on the heels of a number of years of working experience between the two hospitals and PCA. In addition to our role as the Area Agency on Aging one of the things that we did at both hospitals was the outpatient assessment workers for a period of time which work directly with the care management and social service teams at the hospitals and led to referrals directly to the Area Agency on Aging as well as to other community-based organizations.

We've been working on this project for over a year now. And it's been a brilliant process that included the executive level staff of both of the hospitals as well as PCA, planning staff and development staff and that's culminated in the application that we submitted in response to CMS's solicitation.

As of today actually we are doing a trial run of our process. And some of the things that Steve will be talking about will include some of the metrics that we've been working on over the past year or so in putting this project together.

So with that I'd like to introduce to you Steve who will walk through how we've made use of PDSA within our planning process.

Steven Carson: Thank you, Steve. Good afternoon everyone or good morning. I want to just build off of a lot of great examples Jane gave. And Jane I wish I would have done this when I was trying to get my daughter off to school and on time so I definitely think and I can appreciate where you were in your process.

As we go through the PDSA cycle I think it's really important to understand and emphasize really the planning and the testing component of it because I really think that that's where a lot of the true learning comes from as we work through the process.

We will cover all of these four quadrants of the PDSA cycle and the work that we've done and actually this particular element that we'll be focused are really part of the larger group that Steve focused on as part of our Care Transitions Program.

Next slide please.

From a data collection communication standpoint I think what's really important when you fall under the planning section it's really, you know, what - define what your goal is. What are you really trying to accomplish in this process?

And really for us what we were trying to accomplish as part of the larger picture is to identify a methodology for data collection and we wanted to be able to do it with as minimal manual of data collection because there's a large amount of outcomes data that we need to be able to submit so we were always looking for a methodology to be able to create some electronic format in that process.

And as I indicated this particular initiative was a larger part of the overall execution of our Care Transitions Program.

Next slide, so as we kind of went through this process as Jane describe in her presentation, I think what really is important as you walk through and go through what the current state is.

And for us the current state really became our baseline for what we needed to accomplish in the implementation of the program.

While we identified what the current state was, it was really all about trying to determine what information systems were available to us, not only within Temple Hospital but also with what information systems were available within the Philadelphia Corporation for Aging, how we can get the two to interact.

Or do we need to identify a third-party system in order to make that process more smooth for us? In addition to that, while we're looking at what those

common systems were, we wanted to be able to understand what data elements were available.

So when we're looking at demographic information, name, address, you know, admission information, admission diagnosis, data transition -- I'm going to use that data transition because I think it's really important for us is really the fact that the transition date many people will refer to as the discharge date.

And for us, that transition date is really that movement into the bridge care coordinator program overall. So it was really identifying what were the current systems and what were the current activities and what we were doing already today.

And as Steve mentioned, we had a longstanding relationship before in the past with regards to having staff on site at each of our facilities. So it was how could we do that job better? What change systems had changed over a period of time? And then really to flow that out overall as we moved through the process.

So we really wanted to be able to understand how we could collect data and then also how to do it in that, as I indicated, automated fashion.

Next is a process map that we actually put together that helped us understand the current state but also helped us identify what were those steps that we needed to go through and I think there's a couple of pieces within this process map that are really important and that's really the flexibility of the process map because if you notice, this is a photograph of an existing process map.

And even as late as today, we've made adjustments to that process map and added some additional elements to it. It's a series of sticky notes that really are

able to identify the individual steps of the process, any decision points that need to occur, what is the flow and the process.

So we look at how new patients get enrolled and then what happens when a previously enrolled patient is at our -- within our emergency room or is going to be readmitted, you know, what are those step in the communication and then what are the data elements that we need to be able to collect in each one of those steps.

So what this process map enables us to do is to be able to identify them, be able to easily change the steps because they are on post it notes, so you can move them around relatively quickly and be able to create the process that you want to pilot over a period of time.

So this is -- this flow map is really a key tool in identifying the plan. And then also as we make adjustments to our plan, it's easily changed altogether and fairly flexible in that process.

Next slide, please. So as we create our new current state, really what we're taking the opportunity to do is be able to identify all the different steps in the process.

So what we came up with as we went through the planning process was really just to look at how we did our referrals. We identified the unique individual information system that we could share between all three facilities and then we looked at what the documentation process needed to be from the navigators at each of the hospitals as well as what the information at the bridge care coordinator was also going to document.

So we identified our metrics. Those metrics included outcome measures, readmissions, return to physician offices post discharge, including activation scores, so based on a survey tool that we'll be utilizing, what are those scores that will help us understand how that patient changes within the care treatment process, patient satisfaction and just the transition services overall.

So what type of services are we going to put in place and how they'll work and the coordination of that over a period of time.

We confirmed the fields that we needed to put into the data entry process and also confirmed that referral process. And last, but not least, we also wanted to incorporate some test reporting formats so we can understand based on the data that we enter into the system what are those test formats as we continue.

So from the next step perspective, what you really see in this process is really the different screens that we're showing you are moving forward to the different tools that we're utilizing. So for this particular slide, it's really how we've created the referral.

So these are the referral information we're actually sending off to PCA which includes names, social security, phone numbers, all those different elements that we identified that we needed to report on in the process.

And then at the end, this particular referral that's entered in at the hospital level will actually go to the local level down in the Philadelphia Corporation of the aging, so they'll be able to see the referral and be able to react to the process and have the bridge care coordinator come into the facility.

And the next slide is really what PCA has begun to build within -- into their computer systems. So you'll see the one through 20. These are all the different

levels of metrics that we've identified in this process to be able to make sure that we note them and be able to create outcome measures around.

Next slide, please. So today, as Steve mentioned early in the process, we are really in the do phase of this process, so really the do is about performing the test and identifying problems within the process and then also document those observations in between.

So actually today we started our pilot program. So based on that flow map that we showed earlier, we're actually beginning to enroll patients into the program. So from a pilot perspective, we identified a specific diagnosis within our work group to be able to move that patient through each of the steps so we could understand does the process work well. Are the tools appropriate? Do we need to make changes in our consent form, our script?

And actually the data that we enter into the system and then begin to run some reports around the data that we put in altogether so we can understand what that process is.

This particular pilot's going to run for a two-week period of time but we meet on a regular basis because what our goal is is to keep that process map in place and we will continue to refine and change each one of them as we identify issues, problems and concerns and we want to be able to do this during a very short window of time so we can be able to begin to make changes and do our final implementation product.

Next, please. So that leads us really to the study component of it. So when we work through our process overall from the study, it's really summarizing what our lessons learned are. So as we go through it, our lesson, we will be focused on several key areas.

It'll be focused on the electronic referral system -- did the system work as it was intended? If not, what do we need to change, what processes we need to add and how do we need to revise it?

From a communication perspective, we want to make sure that the electronic notifications work as intended. Built into the process are automatic emails and communication to the bridge care coordinators and to the PCA to identify members. We want to make sure all those email correspondences work.

Did the messaging process provide a value-added component? So if we sent the email out to the bridge care coordinator, is it something that really made a difference on how they did their work or was it an unnecessary component in that work and was it a step that we need to eliminate?

From a documentation perspective, you know, do the tools meet the documentation requirements that we were looking for from a bridge care coordination perspective?

So does the information require duplicative entry into the PCA system? Is it the right information going back into PCA that they need to be able to create their treatment plans to be able to come in to speak with the patients?

Is there sufficient information for follow up? So do we have enough phone numbers and backup addresses and contact individuals to make sure that that process is in place? And then what additional education is needed from our perspective?

Who else needs to be involved in the communication about the program? Some of the early things that we've identified through our process is, you

know, there are elements of departments, both internal to our organization as well as external audiences that we need to train and communicate to.

So, for example, what is the role of the bridge care coordinator with the home care agency? So we have our home care agency is going to come in and have an in-service education.

What is the role of the bridge care coordinator as they work with our physician practices and we have a large number of FQHCs that are in our community? So how do we work with the FQHCs that actually have wraparound services?

So as we go through our study part of this process, we will identify, A, that the process works extraordinarily well where we'll make modifications to the process and then build on our education plan that we need to be able to do in the process.

So in the end, in the perspective of it is really determining how we want to hard wire our process overall. So we -- and when we're finished we will make final modifications of the flow. We will memorialize the final process.

So when we're finished, we will know each step, each communication point, each decision point in the process that we'll be able to create a smooth transition of the patient as well as understanding the data that is necessary for the reporting cycle that we need to complete.

And then if we need to, we will redesign and retest the process. Our goal for our particular initiative is really to move forward and have a final deadline for implementation by June 1st.

So that's our target date that we believe that these small, little cycles of PDSA as we move through it will actually help us define the process and make it a very secure process when we open up beyond the test patient population and implement our fuller program with our Medicare fee-for-service patients starting in June. With that, I'll take questions.

Marisa Scala Foley: Okay, well, thank you so much. Thank you so much, Steve. Before -- let me see what questions have come in. Let me go back -- there we go -- and talk a little bit about -- as we always do, we wrap up with just talking about some resources that we found to be helpful in putting this together as we were thinking about the concept as well as talk a little bit about our next training.

First, just a resource, you heard Jane mention the Institute for Healthcare Improvement and how they have worked on PDSA cycles and done some training on this. We included a link to their site, which is their how to improve site, so you can learn more about PDSA cycles.

In addition, as always, we've included some resources on care transitions, since that's been a large part of our focus of this Webinar series over the course of the past year plus now; and finally some resources on the Affordable Care Act.

For those of you who may be frantically scribbling down links, we will be posting the recording, slides and transcript of this Webinar on the AOA Web site. Again, you can click on the health reform and the aging network button on our home page which is www.aoa.gov and, again, click on the health reform and the aging network button on that page and that will bring to our ACA page which lists our Webinars.

So our next training, we will continue our training series in May. Likely it will be late May probably before Memorial Day. We're still working out -- we have a couple of ideas in terms of topics. We're still -- so the date and topic are to be determined but please do watch your email. It will come out in one of our AOA enews which comes out on Mondays. You can sign up for those as well on the AOA Web site, which is, again, www.aoa.gov.

And we'll send out that registration information in early May. So with that, one last thing first, if you have any questions, if you think of any questions, we're going to open things up for questions in a moment. But if you have any additional questions that you think of after we've concluded our Webinar or if you have comments, stories about how your organization has implemented cycles or suggestions for future Webinar topics, we do welcome those and you can send those to affordablecareact@aoa.hhs.gov.

With that, Pat, if you could give people instructions as to how they can queue up on the audio line.

Coordinator: Certainly, thank you. At this time, if you would like to ask a question on the phone lines, please press star 1 on your touchtone phone. Please unmute your phone and record your name when prompted.

To withdraw your question, press star 2. Again, please press star 1 on your touchtone phone to ask a question remembering to unmute your phone and record your name; one moment please.

Marisa Scala Foley: All right, while we're waiting for people to queue up if they have questions, we did get a question in from Ellen who asks, for Steve and Steven: have you seen any major differences between dealing with long-term care

institutions to which patients are discharged from your hospital versus going home?

And I should mention you all are just in the beginning stages of starting your work, so I'm not sure you necessarily have anything to comment on. But please do feel free to do so if you have experience which you can use to answer this question.

Steve Carson: This is Steve Carson. I'm going to answer the question in a different way. I think what's important that we've been able to create in this process is really our relationship between the Philadelphia Corporation for Aging and our -- the acute care hospitals that are part of this initiative.

I think the partnership and our ability to be able to open the lines of communication among one another and to be able to create a system that will assist in that transition process is going to be much different than some of the work that we've done before in the past has been, you know, Philadelphia Corporation has been a service that's been out there in the community.

And this is really about creating a different kind of relationship and creating more of a partnership than a vendor hospital perspective. So I would suspect as we continue to move forward, if that partnership is going to improve our ability to transition there.

Marisa Scala Foley: Okay terrific. Oh, I'm sorry. Go ahead. Okay, Pat, have we gotten anyone on the audio line?

Coordinator: No, ma'am. I'm showing no questions at this time.

Marisa Scala Foley: All right, we'll give everyone one more moment and I'll just remind folks that, again, if you have questions you can put them into chat or certainly queue up in the audio line and, if not, we will close things out. Pat, anyone queue up at this point?

Coordinator: No, I'm not showing any.

Marisa Scala Foley: Okay, with that, I want to then thank -- say thank you to our speakers, to Jane, Steve and Steven for wonderful though provoking presentations and thank all of you for being on the line today and on the Web with us.

And, again, if you think of any additional questions or if you have suggestions for future Webinar topics, we invite you to email us at affordablecareact@aoa.hhs.gov. We do want these Webinars to be as useful to you as possible, so we welcome your suggestions.

Last call, Pat, anyone queue up?

Coordinator: No, ma'am. I'm not showing any questions at this time.

Marisa Scala Foley: Okay, well, then with that, we will say thank you all for joining us today and look forward to have you with us on future Webinars. Thank you very much.

Jane Brock: Thank you.

Coordinator: Thank you for your participation on today's conference call. You may disconnect at this time.

END