VTE Improvement Action Network

IN-PERSON WORKSHOP
MAY 23, 2017

GREAT LAKES
PARTNERS FOR PATIENTS

Illinois | Michigan | Wisconsin
Powered by the MHA Keystone Center

Accelerating Improvement at the Point of Care

Welcome!

WE ARE HAPPY YOU'RE HERE!

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Goals for Today

- Take another dive into clinical VTE content
- Evaluate your identified process gaps to create individualized, concrete next steps to improve your VTE prevention strategies
- Discuss socio-adaptive processes of change
- Learn how to use several performance improvement tools to quickly identify drivers for improvement

Agenda

- Introductions
- VTE Prevention
  - *Must Do's, Measure Weakness, and What to Do About It*
- Showcasing the Gap Analysis Tool
  - *Where are you now?*
  - *Process Mapping – How do we know what's broken?*
- Break
- Improvement Workshop
  - *VTE Process Mapping*
  - *Measurement*
  - *Driver Diagrams as a Plan for Change*
  - *Preparing for Change*
- Final Thoughts

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Introductions

IHA Facilitators

- Adam Kohlrus – Springfield
- Brigette DeMarzo – Naperville

VTE Guru

- Dr. Steve Tremain – Cynosure Health

IHA HIIN Staff

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VTE Didactic

- Placeholder slide for Steve content

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Gap Analysis

What we think is happening…after all…it's in the Policy!!

Gap Analysis

Prevention #1	Prevention #2	Prevention #3	Prevention #4	Prevention #5

Gap Analysis

- Multi-disciplinary team
- Staff roles and responsibilities in VTE prophylaxis
- VTE data analysis
- VTE prophylaxis - mechanical, chemical
- Education to clinical staff on VTE prophylaxis
- EHR supporting VTE prophylaxis
- Physician order entry
- Pre-populated orders according to risk level
- VTE risk assessment
- Patient ambulation
- Hardwired process for physician compliance
- Process failure identification process in place
- Culture

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Gap Analysis

- Discussion:
  - How did your gap analysis go?
  - What did you learn? What surprised you?
  - What didn't you know you needed to know?
  - Did you have skeptics? How did you win them over?
  - What are you going to do now? How did it change the way you look at your "VTE problem"?

Pass the Baton…

Gap Analysis

- Compare actual performance with desired performance across a number of key indicators/goals

Process Mapping

- Define activities in what you **actually do**, who is responsible, what is the standard, and how do we know we've been successful

Process Mapping

- Process mapping helps us to define the process as it **actually happens** in the real messy world

- Let's try an example…

Process Mapping

Create a process map for the following process:

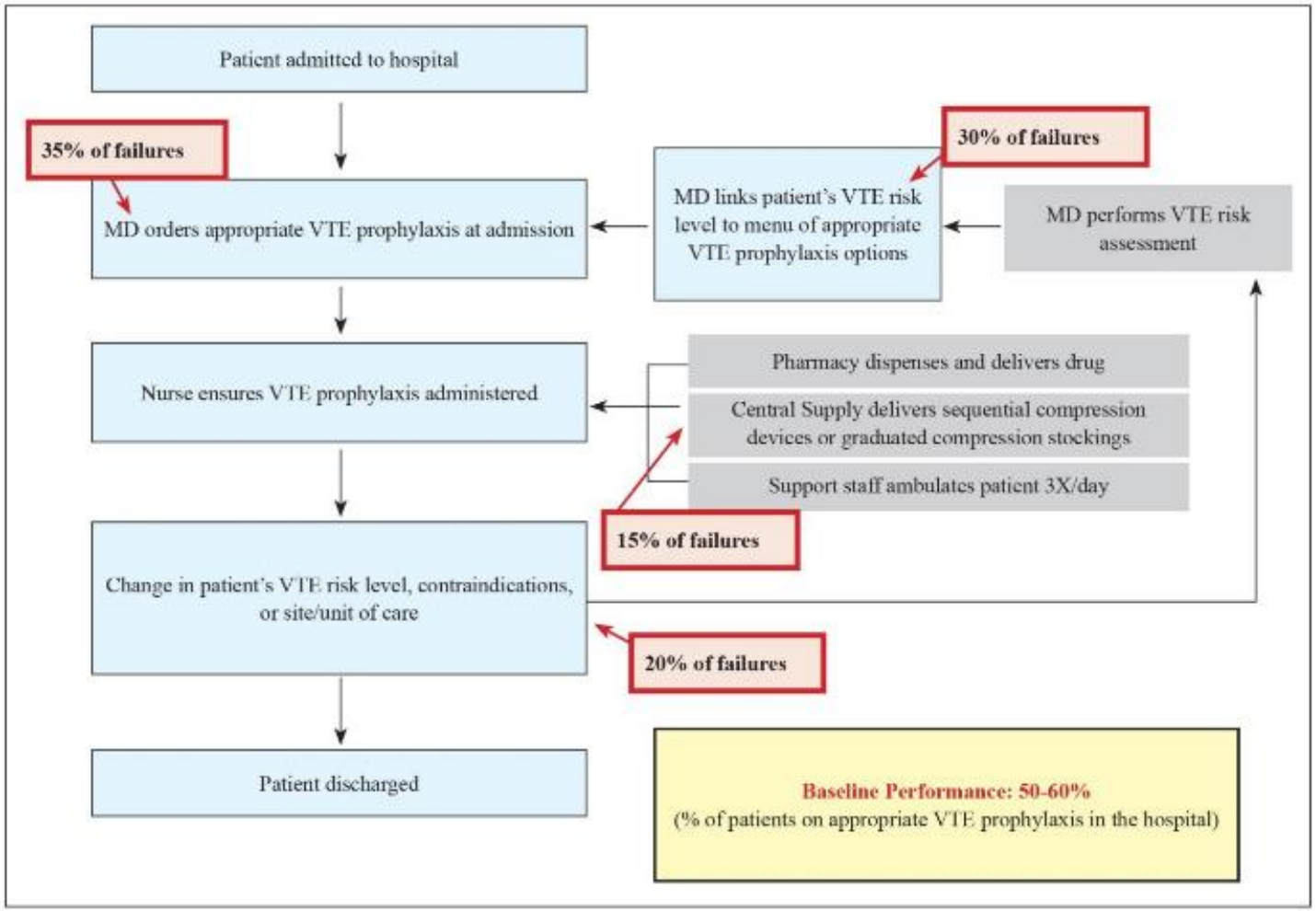
Driving to work in the morning

Process Mapping

- Process mapping allows you to see what is happening at each step in the line.
- Sample to see where **failure** occurs at each step
  - Steps with high failure = good candidates for improvement
- Creates a shared language among team members/stakeholders
- Moves beyond the policy

Process Mapping

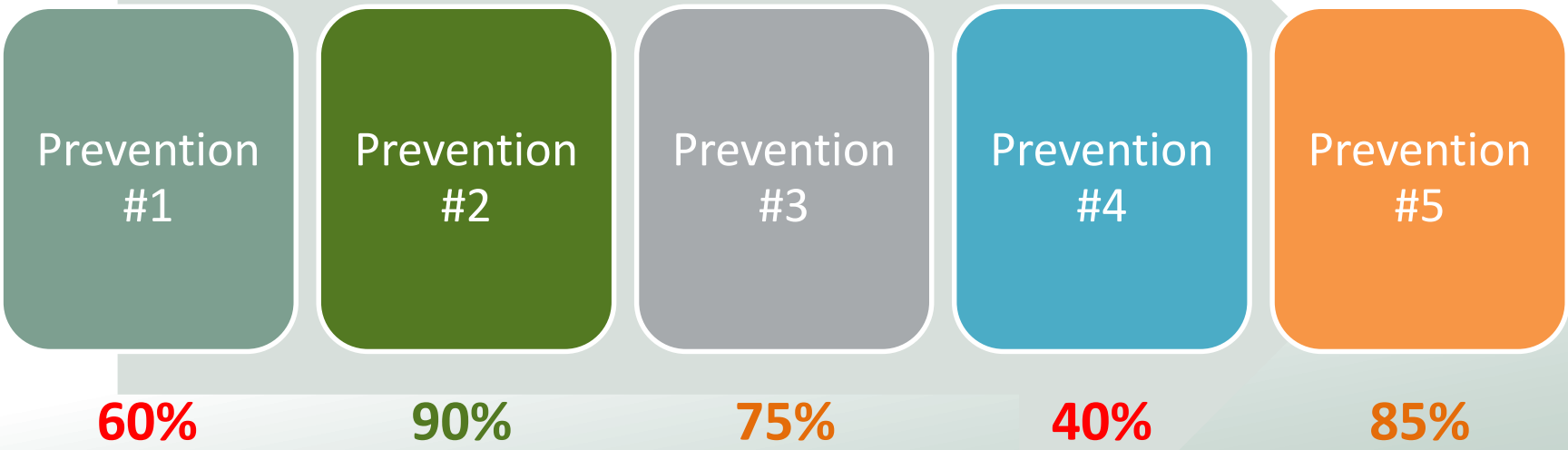
Figure 2.1: Process Map of VTE Prophylaxis With Common Areas of Failure



Gap Analysis + Process Mapping + Measurement

What we think is happening…is not really happening.

Let's fix it.



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Break

15 MINUTES

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Video

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Improvement Workshop

- VTE Process Mapping
  - Take XX minutes to map out the VTE process that your **gap analysis** has told you is of greatest concern.

- We'll come together and hear a few examples from both **medical** and **surgical** populations.

Improvement Workshop

- How do you use measurement in process mapping?
  - Choose measures that are **easy to collect quickly**.
  - Go with the **best measure**…which may not be the "perfect" measure.
- Engage the frontline in measurement
- Share your data!

Improvement Workshop

So you have a process and measures—great!

Now what…? What are you going to change?

Pass the Baton…

Gap Analysis

- Compare actual performance with desired performance across a number of key indicators/goals

Process Mapping

- Define activities in what you **actually do**, who is responsible, what is the standard, and how do we know we've been successful

Driver Diagram

- Visually demonstrate the causal relationship between your aim, factors that contribute to achieving the aim (drivers), and change ideas

Improvement Workshop

Investigate Your Problem and Implement Best Practices

Driver diagrams: A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package is organized by reviewing the components of the driver diagram to first, help you and your care team identify potential change ideas to implement at your facility and second, to show how this quality improvement tool can be used by your team to tackle new process problems.

Aim	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
	Primary Driver	Secondary Driver	Change Idea

AIM: *A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.*

PRIMARY DRIVER: *System components or factors that contribute directly to achieving the aim.*

SECONDARY DRIVER: *Action, interventions or lower-level components necessary to achieve the primary driver.*

CHANGE IDEAS: *Specific change ideas which will support/achieve the secondary driver.*

Process Mapping

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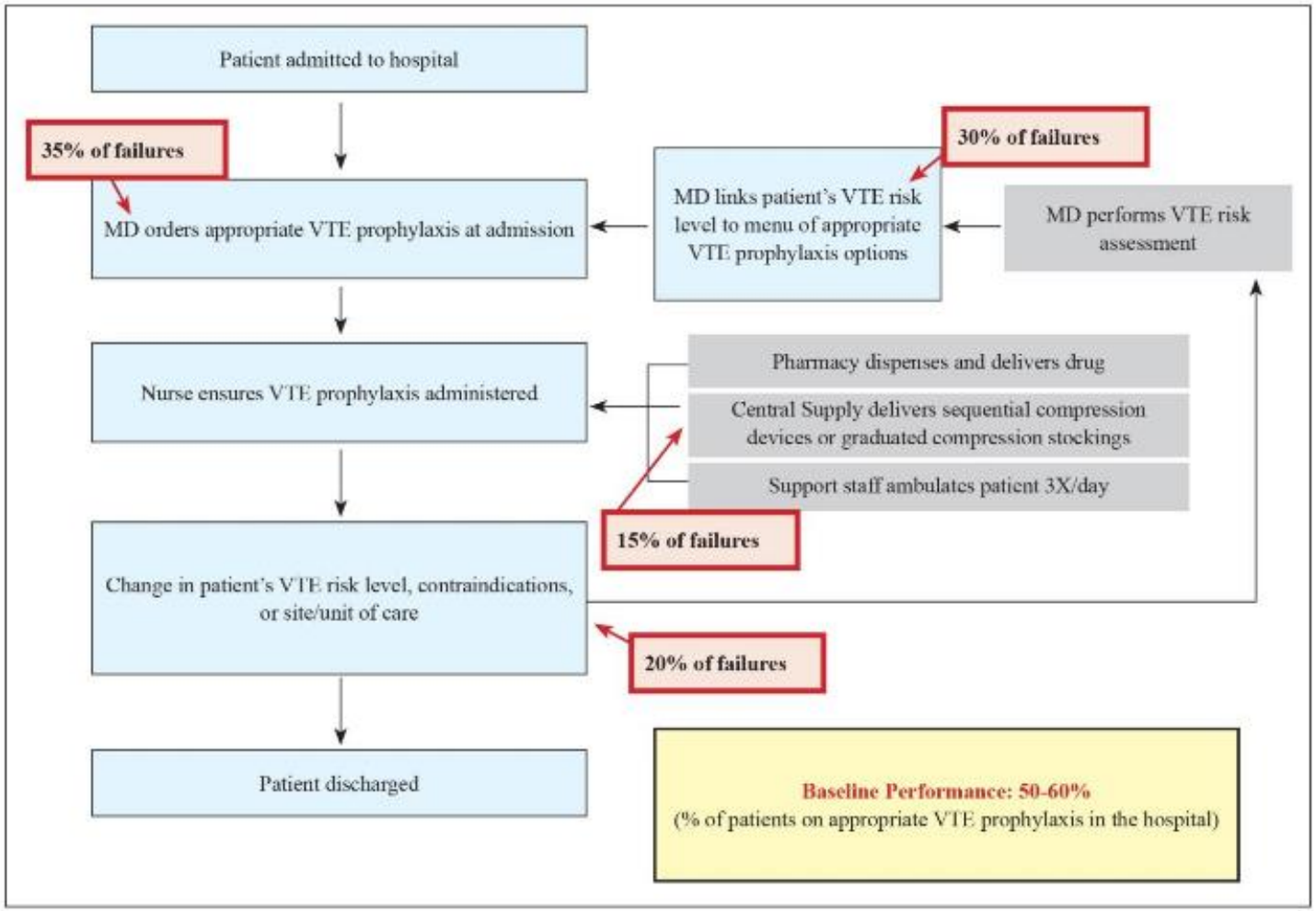

Improvement Workshop

Aim	Primary Driver	Secondary Drivers	Change Ideas
Prevent VTE	Order appropriate VTE prophylaxis at admission	Ensure MD is aware of patient risk level	
		Ensure risk level is accurate and up-to-date	

Improvement Workshop

- A note on change:
  - First order change = do more, do less
  - Second order change = create a new way to do things completely
- Change should start **small**
- How small is small?

Improvement Workshop

- ❑ Define the scope of your change idea, including target audience and stakeholders
- ❑ Identify barriers that are **within your control**
- ❑ Elevator speech
- ❑ Newspaper – What happens if we succeed? What happens if we fail?

Wrap-Up

- Placeholder for housekeeping – including dates of upcoming calls

Thank you!

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