THE APAC FORUM ON QUALITY IMPROVEMENT IN HEALTH CARE
19-21 September 2012, Auckland, New Zealand

KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

COUNTIES MANUKAU HEALTH

Workshop 'nutshell' summaries

Thank you for attending the APAC Forum on Quality Improvement in Health Care in Auckland, we hope you enjoyed it.

Because it is difficult being in five places at one time, I asked the Ko Awatea team to capture a few notes from the workshops that we could then share with everyone.

This quickly-compiled collection of 'nutshell' summaries – in conjunction with the abstracts in the conference program – should prove handy as a kind of menu to the available presentations and videos of presentations.

Forum presentations (including presentations from 15 of the 21 workshops):
http://www.ihi.org/offerings/Conferences/APACForum2012/Pages/materials.aspx

Forum videos (including full coverage of 10 of the 21 workshops):
Thursday: http://koawatea.co.nz/apac-forum-day-1/
Friday: http://koawatea.co.nz/apac-forum-day-2/

The table on the next page shows which workshop presentations and videos are available. Also, above the table is a '**word map**' of the workshops. Just find the words that interest you – the larger the word, the more common it (or a synonym) was in the workshop abstracts – then look for the proximal codes: they signify related workshops.

I hope this information proves useful. It's a small example of the kind of collaboration and knowledge sharing that I hope will help us to achieve more with our valuable collective knowledge.

If you have questions or think we may be able to help you in any way, please email us at APAC2012@koawatea.co.nz.

Lastly, thank you to the 'volunteer' note-takers. It's wonderful what we can achieve when we share the load.

Jonathon Gray
Director, Ko Awatea

Key:
P = workshop presentation(s) available on ihi.org (as at 24/9/12)
V = workshop video available on koawatea.co.nz (as at 24/9/12)
Italics = delegate comment

Workshops 'word map'

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***P** = presentation available on ihi.org* *__V__ = video available on koawatea.co.nz* *See links on previous page.*

A1: Achieving the IHI Triple Aim (P)

John Whittington, MD, Faculty, IHI, USA**; David Grayson, MB ChB, FRACS**, Otolaryngologist and Clinical Lead, 20,000 Days Campaign, Counties Manukau District Health Board, New Zealand; **Peter Didsbury, MD**, Chairman of the Board, ProCare Health Limited, New Zealand

Most health professionals are familiar with the three components (or dimensions) of the Triple Aim (better population health, better patient care, lower per capita cost), but the full definition clarifies that the Triple Aim is really a single aim for 'system designs that simultaneously improve three dimensions'. The presentation outlined the framework needed to pursue the IHI Triple Aim at an enterprise level, and how to get started (through building infrastructure, activating community, and learning at scale).

Key messages included:

- Apply the Triple Aim to a chosen discrete population.
- Identifying the 'population' and selecting the portfolio of initiatives are part of building infrastructure.
- Have clear deliverables and short timeframes and don't overdesign measures.
- When activating community, shift away from a deficiency-focussed, needs-based view to a strengths-focussed, asset-based view that can involve, link, and empower the whole community.
- With more than 100 Triple Aim sites since 2007, there are numerous examples to learn from when trying to decide what to scale up.
- It is better to achieve one thing now than everything never - just get on and do it.
- Act for the individual - learn for the population.
- Primary Care is the foundation of all health systems.

Population outcome measures.

- For population health: Health outcomes, disease burden, risk status.
- For experience of care: Patient surveys (global questions, experience questions, likelihood to recommend), Set of safety measures based on key dimensions.
- For per capita cost: Total cost per member per month, hospital and ED utilisation rate and/or cost.

A2/B2: Equity in Health Care: the What, the Why and the How (P/V)

Pat Snedden, BA, B Com, Chair, Ports of Auckland and Former Chair, Counties Manukau DHB, Auckland DHB, Housing New Zealand; **Andrew Teuber,** Chair, Alaskan Federation of Natives and Director, Alaska Native Tribal Health Consortium, USA; **Lance O'Sullivan, MB ChB,** General Practitioner, Kaitaia, New Zealand; **Ross Bailie, MB ChB, MPhil, DM,** Senior Principal Research Fellow, Menzies School of Health Research, Australia.

Inequities in health care remain difficult to deal with despite a range of interventions by governments. Access is key to equity.

Equity in health care are is the right thing to pursue for moral reasons, and it is also the wise thing to pursue because the cost of acting is much less than the triple whammy of costs incurred if you don't act: poor health outcomes for selected groups in society, increased costs for all social agencies, and the inability of those affected to contribute to their communities and countries.

The main theme of this workshop was to bring ethnic groups and individuals into the health system and support their ownership of their own health services.

Those with the greatest desire to achieve equity in health care are those who don't have it.

Why don't we allow the population to be the owners of their health and give them resources and assistance to improve their health their way, as with the Alaska Tribal Health System?

Dr Lance O'Sullivan concentrated on cultural competency. Cultural incompetence is costing lives. It's not the same to provide health services *to* someone, to provide health services *with* someone, or to provide them with the capacity to provide services for themselves. Maori are dying prematurely.

Some health professionals say believe it is a strength that they treat all patients the same. Some say they got on best with people who are like themselves. We do not measure cultural competence outcomes. So we need to teach our workforces how to be culturally competent.

We need to understand and address the social determinants of health to keep populations well.

In Alaska, the money goes directly to the tribal health system. Care is delivered in the community with a support workforce tailored to meet the needs of patient and family. Culturally relevant education campaigns are run to raise awareness.

In Australia, institutional racism is prevalent and disadvantages minority and indigenous groups. Health starts where people live, play, and work. Ross Bailie talked about a framework to build capability to achieve equity in indigenous populations. Data, technology, and quality improvement cycles are all key to doing better.

A3/B3: Back to Basics: The Fundamentals of Improvement (P/V)

Nellie Yeo, MBA, MN, Chief Quality Officer and Executive Director, National Healthcare Group Pte Ltd, Singapore

Improvement requires us to understand where things fit. Testing a change differs from implementing a change. Don't assume – go and see. All teach all learn.

Quality Improvement is about the psychology of change and movement.

Singapore challenges – ageing, obesity, low birth rate – rely on immigrants
Singapore grew too fast – effects on health, housing etc. System is complex and the cost drivres are numerous eg chronic disease, waste.

Begin looking at value from patient perspective. Look at whole system approach to measuring quality and innovation. The aim is health not healthcare Patients are saying don't waste my money and give me the proper treatment (patient view point).

If I want to do a PDSA I need to ask questions around the 6 domains from the patient view
At what point of the patient journey do you deliver care?
Leadership, methodology, measurement = improvement.

All of us have two jobs – 1 is to do our job and 2 is to do our job better. You must first have the will to make things happen, vision for change, and execute changes. Change is at every level.

There is a sequential flow to an improvement journey. Important to document steps, collect data and repeat cycles until you reach your aim. When you want to solve a problem you need to work as a team and not rely on your leader.

Don't be in a hurry to change – think of the big picture and where you fit in.

A4/B4: Creating a Culture of Innovation (P)

Lynne Maher, PhD, Director for Innovation and Design, NHS Institute for Innovation and Improvement, United Kingdom

The most successful and innovative organisations are those that encourage every employee to innovate, and then reward them for doing so. What type of leaders do we have? ‘Leaders create the conditions that either hinder or aid innovation’. If we always do what we’ve always done we won’t improve. Tools and techniques are very important but are no good if your organisation is not willing to change. Learn from failures in a controlled environment. We challenge people with the ‘what’ but not the ‘how’. We need to encourage ideas for improving the ‘how’. Innovation is always a team effort – it’s about recognising teams, not individuals. Build idea generation capability from creativity to implementation.

The seven dimensions of organisational culture that support innovation that support innovation are: risk taking, resources, knowledge, goals, rewards, tools, and relationships.

*I like the solutions-based focus with celebrations and rewards. Intrinsic motivation – doing something meaningful and being given time to do it. Building capability is important, but we must support innovation from within the organisation – authority to act. Using PDSA cycles purposefully to work through solutions is a way of allowing the organisation to feel that testing is controlled, reducing risk. ‘Fail often but fail early’. Need communication and culture that it’s okay to fail. –**Penny Impey***

A5/B5: Patient- and Family Centred Care: Partnerships for improving the Patient Experience, Safety and Quality (P/V)

Beverley Johnson, President and CEO, Institute for Patient- and Family-Centred Care, USA

Patient-centred care is not the same as patient- and family-centered care. It's about mutually beneficial partnerships and about working with patients, not just to or for them. Patients decide who is family. Families are not 'visitors', they are allies for quality and safety.

Core concepts are respect and dignity, information sharing, participation, and collaboration.

We get the best outcomes when patients and families participate in the health care. Put patients and families in real positions of influence, not tokenism, and involve them at the start of new initiatives.

Patient and family stories are key. Use effective methods for facilitating patient and family panels. Focus groups aren't enough. Leadership need to be engaged in patient groups and committees.

Staff need to manage visiting hours and numbers and be creative, but the emphasis is on welcoming family.

Taking a patient- and family-centred approach to healthcare can positively impact HR metrics, such as reduction in staff turnover.

When implementing patient- and family-centred care it's important to track outcomes and measure impacts.

There are handouts and tools available for download in addition to the presentation.

Beverley strongly recommended this article: Leape, L., Berwick, D., Clancy, C., & Conway, J., et al. (2009). *Transforming healthcare: A safetyi mperative*, BMJ's Quality and Safety in Health Care. Available at: http://qshc.bmj.com/content/18/6/424.full

*A thorough overview with lots of case studies. Makes it seem like common sense, yet we seem a long way from achieving it. –**Elizabeth Ryan***

B1: The Changing Face of Health Care: The Asia-Pacific Story (P/V)

Donald Berwick, MD, MPP, Former President and CEO, IHI, USA; **Chien Earn Lee, MBBS, M. Med, FAMS,** CEO, Changi General Hospital, Singapore; **Kevin Woods,** Chief Executive, Ministry of Health and Director General of Health, New Zealand

The 21st century is the era of the system and New Zealand's size provides it with a good opportunity to collaborate, teach, learn, and exchange to really understand the 'whole system' approach. We are actively searching for connectivity and are linking up.

- Connections – make links
- Cost – move away from volume to quality
- Reliability
- Patient-centeredness – patients being empowered to design care
- Measurement is important – not to judge, to learn
- Teach servant leadership and inter-dependence

Singapore's rapidly changing demographics are greatly impacting demand on health services. As with many nations, increasing morbidity is pressurising the health system.

Singapore has its own version of the Triple Aim and takes a life cycle approach to care and a scorecard approach to change management. They are investing for greatest impact (value based service planning), creating social movements (from bystanders to activists – an army of 10,000 health ambassadors), creating integrated patient journeys (keeping the patient in the community where possible), and redefining the role of the hospital. Singapore is developing a health ecosystem that promotes physical and mental health (over health care).

C1: Global Lessons: System Change Experiences from New Zealand and England (V)

Geraint Martin, BA, MSc, CEO, Counties Manukau DHB, New Zealand; **Maxine Power, PhD, MPH,** National Improvement Advisor and Safe care National Work Stream Lead, QIPP, Department of Health, United Kingdom, **Jonathon Gray,** Director, Ko Awatea, Counties Manukau DHB and Professor of Health Innovation and Improvement, University of Auckland

Hope is not a plan. Most deficiencies arise from poor systems not bad people.

No one part of the system has the solution and the way to do more is to do less.

We underestimate the value of convincing people there is a problem and calling them to action.

Get serious about data and feedback systems. The NHS safety thermometer is a great tool for tracking progress.

Avoid calling something a project as we are all doing it. Need to provide people with the right materials and have lots of resources online.

Celebrate your success. CLAB ZERO and 20,000 Days are our success stories.

Leadership needs to come from the top to the frontline. Youth – they are our future. Include them in the solutions. Think about sustainability from the start. Treat patients as a whole – not as a harm.

How has the frontline done it? Get goals, get bold, get together, get a model, get patients and families, get the facts, get to the field, get a clock, get the numbers, get the stories.

We need to get sophisticated in the techniques we have in place. Running at the problem with Excel reports isn't enough.

Need to make sure our processes are safe and well designed.

We need complex – adaptive leadership.

We have a moral imperative to provide safe care.

We need to create a health and safety agenda for New Zealand.

C2: From the Top: The Role of the Board in Quality and Safety (P)

Maureen Bisognano, President and CEO, IHI, USA; **Alan Merry**, Professor of Anaesthesiology and Head, Chair of HQSC

Fifteen years ago boards were not involved in quality and safety, they felt they had financial responsibility only, but a board's level of engagement has a direct impact on quality and safety.

Key questions a board needs to be able to answer:

- Do you know how good your care is? (Quality reports tell you.)
- Do you know where you stand relative to others? (Benchmarking tells you.)
- Do you know where the variation exists? (Beware of averages – they hide the best and worst.)
- Do you know the rate of improvement over time? Are you getting better?

Boards need a quality champion and should be building their capability about quality and prioritising:

- Setting aims – using the Triple Aim.
- Patient stories - they are vital to show the whole system and where the barriers are.
- Establishing system-level measures
- Presenting data in a variety of ways to ensure meaningfulness
- Changing process and culture – include the whole executive team, including the CFO
- Common language, brokering conversations, engaging physicians

*Interesting ideas about how to engage the board in quality and safety through a range of means. Think of new ways of having meetings – walk arounds instead of in the board room. Engage with staff and see connections between management decisions and impacts at the bedside. –**Penny Impey***

C3: Thinking Differently to Transform Care (P)

Lynne Maher, PhD, Director for Innovation and Design, NHS Institute for Innovation and Improvement, United Kingdom

Innovation needs to be core business as it can make a real difference in quality, cost, and the patient experience, but you need a structured process to move good ideas into implementation.

Lynne spoke of Edward de Bono's 'mental valleys', and that we consciously and purposefully connect with a different valley (industry). Thinking differently is about making creative connections.

Health services are concerned with how patients access and flow through services. McDonalds, Fedex, and many airlines have changed how their customers 'access and flow'. We can learn from them (there is a drive-thru flu-jab service at the Virginia Mason Medical Center at Seattle).

Thinking differently is a 3-step process: Stop before you start (pause, notice, observe), generate ideas, select and test ideas.

We need to challenge and change usual thinking. Notices on the floor, for example, impart more than notices on walls.

You need 100 ideas for one to be implemented.

The description of the innovator is very useful (someone who can apply ideas out of context), as is the notion that innovation is doing things differently and doing different things, and the 3-step process to thinking differently. – ***Suzanne Proudfoot***

C4: Measuring All-Cause Harm: Using the IHI Global Trigger Tool (GTT) (P)

Carol Haraden, PhD, Vice President, IHI, USA; **Gillian Robb, MPH, NZRP,** Quality Improvement Manager, Ko Awatea, Counties Manukau DHB and Professional Teaching Fellow, University of Auckland, New Zealand

It's safe to say that reducing harm is a priority at virtually every health care delivery organisation in the world today. Progress is also notable in many places when it comes to significant reductions in infections associated with use of central lines, ventilators, resistant bacteria, or with events such as preventable patient falls. That's the good news. The mixed news is that when independent researchers dig deep into patient charts and look for signs (or triggers) of adverse events using the IHI GTT, they're finding higher rates of harm than even the most committed improvers realise. The goal of this session is to learn how to use the IHI GTT to first understand your harm rates and to ultimately improve patient safety

- A Global Trigger Tool involves a retrospective review of a random sample of inpatient hospital records using "triggers" or clues to identify possible harm. Used in conjunction with voluntary reporting, the Trigger Tool allows facilities to identify adverse events, assess the level of harm and track the effectiveness of improvement efforts in reducing harm.
- Audits on random sets of global notes increase the volume of data and broaden the perspective
- Incorporate a measure of all-cause harm into current safety practices
- Use the GTT to distinguish harm and error.
- 'Error' definition bears upon concept of preventability and human mistake.
- 'Adverse event' describes harm to the patient regardless of error and is often system-based.
- The tool has more answers than we have questions at the moment.
- Shows an organisation which areas they need to work on or investigate further to prevent patient harm.
- Identifying likely hotspots.
- Not focussed on providing a root cause .
- It provides a consistent way of looking at things.
- If you're not going to do anything about something, don't bother recording it.
- The belief that there is nothing you can do about something it's a self-fulfilling prophecy.

I see the Global Trigger Tool as a compass or some sort of GPS tool. It tells me where to look.
*–**Hayden Tseng***

C5: Future-Proofing Child Health (V)

Russell Wills, FRACP, Paediatrician, Hawkes Bay Hospital, New Zealand; **Adrian Tranholme, BChir, MB, FRACP,** Paediatrician, Counties Manukau DHB, New Zealand

Dr. Wills began by emphasising that future-proofing child health is a 'wicked problem'. ie, it has multiple causes, high stakes, uncertainty of funding and evidence-base, and often competing interests.

Some wicked problems have been tackled with success in the last 10 years e.g reducing domestic violence/child abuse. The key is to keep an "eye on the quality ball" or else the statistics can easily reverse.

Future negative health/social outcomes can be predicted from a child's behaviour at four years' old. But, programmes like "Incredible Years" can address conduct disorder issues in children – relies on early identification and intervention.

Dr. Wills has studied child health and successful interventions (including from outside health) over many years. The collaborative and coordinated hospital, community, NGOs, social services, and education model provides a framework for others to follow.

Dr. Trenholme acknowledged the work that Dr. Wills and Hawke's Bay DHB has done, noting that Counties Manukau DHB is around 8-10 years behind. We need to follow Dr. Wills' lead - get out and work with our communities.

Progress has been made in South Auckland – more paediatricians, a successful new KidzFirst hospital, and Centre for Youth Health. The result has been improved outcomes in some areas, e.g immunisation rates increasing to 96%. But we still have challenges with preventable conditions such as rheumatic fever, lower respiratory infections.

Hospital-based medical services have failed children in South Auckland – there are gaps with primary care that need resolving. The health system "does not work" for under-5s in high deprivation areas.

The "Healthy Housing" programme (for 6,000 families) is an evidence-based intervention that is an excellent example of a successful intersectoral approach.

Pneumonia rates have fallen for under-2s in the last decade (even before new vaccine was introduced) - but we are not sure why.

Dr. Wills summarised by saying that making inroads to future-proofing child health relies on shared values, leadership, evidence-based solutions, stringent fidelity requirements (culturally appropriate) and intersectoral collaboration.

D1: The Science of Allocative Decision Making – Investment and Disinvestment (P)

Gloria Johnson, Chief Medical officer, Counties Manukau DHB, New Zealand; **Stephen Streat,** Medical Director and Intensive Care Specialist, New Zealand; **Emma Parry,** Clinical Director, Maternal Fetal Medicine, Department of Obstetrics and Gynaecology, Auckland DHB, New Zealand; **Anita Fitzgerald,** Clinical Practice Committee Manager, Auckland DHB, New Zealand

- Anna Fitzgerald (Coordinator) outlined the establishment of Auckland DHB's Clinical Practice Committee (CPC), which has been in place since 2005 (Chaired by Dr. Stephen Munn).
- The CPC consists of 12 DHB representatives (mainly doctors) who use an impartial evidence-based review process related to Health Technology Assessments (HTAs).
- There is a toolkit to guide staff through the submissions process – criteria include a range of factors e.g cost, quality of life, discussion with regional colleagues.
- In the past 7 years the CPC has met 107 times and evaluated 62 submissions.
- Dr. Stephen Streat (Deputy Chair of CPC) noted that CPC members aren't representative, they are selected.
- He outlined several examples of CPC submissions – one that scored 115 points was "Sacral Nerve Stimulation for Faecal Incontinence" (2008). It was recommended for implementation and a review that occurred in 2012 showed positive quality of life outcomes and lower costs than estimated.
- Some submissions may score low, yet still be implemented. One example was "Pre-filled pre-labelled Midazolam syringes for Anaesthesia" which scored 15, yet was still implemented by management.
- Dr. Emma Parry presented some of her work – she has been both a submitter and subsequently became a CPC member. Her initiative looking at an innovative way to treat Twin-to-Twin Transfusion Syndrome was successfully submitted and implemented. It has subsequently become a national service.
- A regional approach to the CPC has recently been endorsed by CEOs. There is also national interest in the approach.
- Examples of disinvestment are much rarer than new investment – disinvestment decisions are challenging but necessary.
- The key strengths of the CPC approach are that it is free from political bias and that the scoring system effectively allows "apples vs oranges" comparisons to be made.

D2: Research and Evidence in Primary Care

Tony Dowell, Professor of Primary Health Care and General Practice, Deputy Dean, University of Otago, Wellington, New Zealand; **Dee Mangin,** Associate Professor and Director, Primary Care Research Unit, University of Otago, New Zealand

Professor Dowell and Assoc. Professor Mangin used a range of examples from general practice and primary care to explore how research evidence can be translated into quality practice.

Specifically, they addressed the evidence surrounding immunisation which has conclusively shown a reduction in risk and increased quality of care. This was contrasted against the Prostate-Specific Antigen (PSA) screening test for prostate cancer, where there is less evidence indicating benefit, however the clinical need cannot be argued with.

Lively debate followed from the floor, particularly from general practitioners present. Commentary followed regarding the need to conduct research as an integral part of the quality improvement cycle.

The role of general practitioners and primary care was highlighted during discussions relating to obesity. There was split opinion; those who felt they should work directly with their patients on interventions, and those who felt it was the role of primary care to provide support and intervention. Regardless, applying and implementing the evidence surrounding obesity intervention was deemed to be challenging by many.

To conclude the session, an example was presented where objective data collected by a pharmaceutical company was conveniently manipulated, resulting in some subjective bias. Conference delegates were urged to be cautious when considering research evidence and quality.

*Very thought provoking and finished on a positive note. Quality is being improved by reduction in variation and shared experience through more GP continuing medical education (peer review groups) and the ability to compare data, processes and outcomes. –**Harry Rae***

D3: The Business Case: Investing in Quality (P/V)

Geraint Martin, BA, MSc, CEO Counties Manukau DHB, New Zealand; **Ron Pearson,** Deputy Chief Executive, Counties Manukau DHB, New Zealand; **Chien Earn Lee, MBBS, M.Med, FAMS,** CEO, Changi General Hospital, Singapore; **J.A. Muir Gray, CBE, DSc, MD, FCLIP,** Director, National Knowledge Service and Chief Knowledge Officer, NHS, United Kingdom

Healthcare organisations worldwide are faced with a challenge of an ever increasing demand for healthcare whilst trying to prepare for the future needs of a growing population. To add to their woes, the global financial crisis has now made it critical for the organisations to re-evaluate their strategy around capacity and resource management. Changing the way we do things and improving quality through elimination of defects has been the mantra for achieving this feat in certain health care organisations.

Some key points:

- More money cannot solve the problem of poor quality.
- A change needs to happen at both individual and systemic level.
- Robust quality improvement methodology, brave leadership, committed frontline staff, clinical engagement, and continuous investment in innovation are the key ingredients in the recipe for achieving successful transformation.
- Clear expectations and goals need to be set at all levels of the organisation.
- You need the right people with the right mindset in order to establish a culture which accepts change, trusts in the processes, and works towards achieving the organisational goals.

D4: Building Capacity for Middle Managers (V)

Maxine Power, PhD, MPH, National Improvement Advisor and Safe care National Work Stream Lead, QIPP, Department of Health, United Kingdom

Middle managers are often the 'key' to the execution of quality improvement; the critical bridge between leadership and the front-line – the 'meat in the sandwich'. They are translators of strategy into delivery of care and who they are depends on the size of the system.

The core purpose of middle managers is to keep the doors open for patients coming in and to deliver high quality care safely, efficiently and on time.

They act as a catalyst for de-stabilisation in order to bring about change. Middle managers have an extensive skills inventory; they are team players and their focus is on the cause, rather than personal ambition.

Essential qualities of a middle manager – the ability to establish clear safety and improvement goals by taking strategic goals and changing them into focus goals and to create a set of project measures. They need to be self-aware – skilled managers know what they are not good at and surround themselves with others who can fill those gaps.

They have a role driving change. Through feedback, action informs strategy. Connecting with values.

Calling people to action is a key skill. The medium needs to be appropriate to 'where they are', and you may need to convince them of both problem and solution, or foster their creation of the solution.

To assess assets, capabilities and capacities in teams you need to understand each other and your strengths and weaknesses. Managers need to foster an environment characterised by a culture of teamwork.

As implementers, managers set the tempo for change – what we can achieve by when. Timetables have the power to motivate and de-motivate. Managers need to experience how to use change methods, improvements models. Measurement is key.

The IHI Breakthrough Series was highlighted as being very useful to middle managers. (http://www.ihi.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx)

*I particularly liked this introductory quotation– "Improvement happens when you have the will to change; the ideas to change; and when you execute the will and the ideas towards delivery".–**Linda McIsaac***

D5: Building an Integrated Approach to Improvement with Lean, Six Sigma, and the Model for Improvement (P)

Robert Lloyd, PhD, Executive Director, Performance Improvement, IHI, USA; **Greg Balla, BE,** Director, Performance and Provider Development, Auckland DHB, New Zealand

The better you understand improvement frameworks, the better you will be equipped to choose and utilise them – either individually or in combinations – and to organise your overall quality improvement strategy.

Scientific method provides the foundation for all improvement and the history of improvement shows how the ideas behind current frameworks grew out of general science, inductive learning, pragmatism, empiricism, and through to Shewhart's Cycle, Deming's Wheel, and the breadth of Japanese quality control. The frameworks are intertwined variations on a consistent theme.

Of six key frameworks: Baldrige Performance Excellence Program, European Foundation for Quality Management (EFQM), International Organization for Standardization (ISO), Lean, Six Sigma, and the Model for Improvement (MFI), the first three are suited to organisation-wide process improvement, with the last three more appropriate for personal problem solving.

The **similarities** between Lean, Six Sigma and MFI are: Disciplined processes and approaches; rely on measurement; specific language (with many common terms); long history and Japanese connection; don't have fixed 'rules'.

It is important to start with the problem, then choose the appropriate framework and tools to help you to address the problem, not the other way round.

The focus strengths of each were described as:

Lean: Elimination of waste, improvement of flow, simplifying and mistake proofing processes
Six Sigma: Minimises variation, based on facts and data, robust sustain controls
Model for Improvement: Aim, tests, multiple cycles, learning; works in multiple situations – including large and small scale projects

Integration of the various frameworks is increasingly common and two case studies were provided, Kaiser Permanente and Auckland DHB. KP use MFI for the overarching framework and Lean and Six Sigma as tools. ADHB's key learnings have been:

- Ensure you are working on something important
- Develop a common language for improvement
- Skill development is required
- Expert help in partnership with Clinical Champions
- Quality improvement skills are not enough
- No problem is pure lean, six sigma or MFI

Bob and Greg ended with a salient quote: “It should be fairly obvious that no single quality system, set of quality criteria or even quality philosophy is ever going to be the solution by itself to a firm’s quality problems.” H. Scott Tonk. “Integrating ISO 9001:2000 and Baldrige Criteria” Quality Progress August, 2000.

E1: Creating Resilience in an Organisation: Preparing for an Unimaginable Disaster (V)

Roger Dennis, Consultant, Innovation Matters, New Zealand

Narration of the story is key to change (see www.rogerdennis.com).

Work performed at the Canterbury District Health Board (CDHB) in the five or so years prior to the Canterbury earthquake enabled this health system to not only survive, but thrive in aftermath of a disaster. Rather than hold them back, they brought their vision for 2020 into 2011 after earthquake.

This work was around:

- Investment in measurement of acute demand
- Interrogation of that demand
- Decrease variability in demand (production/engineering Queue theory)
- Next, looked at whole patient journey, identified constraint and waste, improved patient flow
- Next, started to invest in engagement programs with staff

Changes in health care delivery models were needed. Rather than impose a solution, set a direction and get everyone around the table.

Three threads: partnership, empowerment, leadership.

Workshops held in Canterbury DHB – permission to change the health care system at all levels.

Needed a large scale to create change. Developed ‘Our Health System Showcase (09)’ built an environment in warehouse – what would it look like in 2020.

For radical change need a tolerance of risk and tolerance of failure.

Never ever design a solution – we forget to ask for input. Need to have everyone around the table/in process. Allowing experts to inform solutions.

Why some ideas survive and others die. Recommend “Made to stick” by Chip Heath & Dan Heath.

E2: Right People, Right Skills: The Role of the Health Care Workforce (P)

Gregor Coster, CNZM, MB ChB, MSc, PhD, Chairman, CMDHB, New Zealand**; Jo Scott-Jones, MB ChB, FRNZCGP**, Chairperson, Rural General Practice Network, New Zealand; **Shelley Frost, RN**, Director of Nursing, Pegasus Health and Deputy Chair, General Practice New Zealand

Professor Coster spoke of workforce challenges, like a 50,000 nurse shortage in Australia by 2020 – that's equivalent to the entire current New Zealand workforce.

He spoke of the cost of healthcare rising while budgets are decreasing, and yet we have an ageing population and growth in chronic conditions. The status quo is not an option. The only options are: reduce demand for services and/or reduce the cost of the meeting demand.

Improve quality – utilisation of current health professionals' skills working at the top of their range. Explore workforce flexibility and retraining. Strengthen workforce relationships between education and health. Reference was made to healthworkforce.govt.nz.

Dr Jo Scott spoke of 'just doing it'. Taking advantage of a permissive culture working "under the radar." People embedded in their community taking charge. Enterprise, and engaging the local community

Shelly Frost's presentation focussed on the development of a Community Pharmacist Role and other Canterbury initiatives around medicine user reviews, medication management services, and the Canterbury Clinical Network.

The aim of the Community Pharmacist Role is to improve patient outcomes through a shift from a traditional dispensing/counselling role to medication management and increasing patients' health literacy.

The Medication Management Service is a new, free pharmacist-led service where accredited pharmacists discuss and assess a patient's medication knowledge, adherence and use. The service improves outcomes for the patient and reduces problems and costs for the health system.

The principles of the Canterbury Initiative are: Strong Focus on Partnership – whole of system; Clinician led, Management enabled redesign; Solutions focused – local solutions for local problems; Underpinned by evidence based pathways & quality frameworks; Efficient use of current resources – people, facilities, funds; Reduced reliance on hospital – prevention, earlier intervention,better access in community.

*A good overview of different systems and workforces from CMDHB to rural to Canterbury initiatives. Good discussion in questioning working inside and outside scope of practice and working at top of scope. –**Sarah Candy***

E3: The Right Technology: Why Is It All So Hard? (V)

J.A. Muir Gray, CBE, DSc, MD, FCLIP, Director, National Knowledge Service and Chief Knowledge Officer, National Health Service, United Kingdom; **Ian McCrae,** CE and Founder, Orion Health, New Zealand

The key knowledge shared in this workshop was that increasing technology has the potential to add value to the healthcare delivered but the difficulty lies in the varying health IT operating systems currently in place and how they can be linked.

In an ideal world we should look at starting with the patient and build an IT system around that patient and their family. The current system does not allow the patient to have easy ready and open access to their own health data on line. Open access to their own health records would have a positive impact on the overall health status/condition of a country's population with the patient taking responsibility for partnering in their own care.

There is recognised mismatch between the varying clinical management systems for hospitals, the practice and clinical management systems for GPs and other health providers which can prevent a streamlined delivery of services for the patient.

It is clear that growing electronic connectivity is making possible new kinds of IT-driven advances. In an ever-increasing information technology world, sharing of clinical medical information is proving to be the best means of ensuring continuity where it matters most: population healthcare. Every country has a stake in protecting and improving its populations' health, and many are seeking and finding ways to leverage IT for this purpose.

An increasing proportion of clinicians are using the internet to communicate with patients and there is a rapid uptake across the sector of shared electronic records. There are missed opportunities utilising technology however in that there should be a standard principle of referencing patients to approved websites where they can access further information regarding their condition.

Leaving us with the question: what is the future function of the human being in the healthcare equation?

E4: Patients First: Building a Lighthouse in a Sea of Data (P)

Andrew Terris, Programme Director, Patients First, New Zealand; **Richard Hamblin**, Director, Health Quality Evaluation, Health Quality and Safety Commission, New Zealand

This workshop set out to provide a roadmap, a set of principles and some practical examples of achieving the right balance when implementing measures. It provided a discussion on how to create measures that matter and are balanced; provided road-tested measures to ensure a baseline and the ability to collect data.

Take home messages:

- "We can only be sure to improve what we can actually measure." – Raleigh and Foot 2010.
- Measurement of itself is not improvement.
- Don't make assumptions.
- What we need – a common language for measurement in NZ.
- Why does it go wrong? – wrong approach/framing/system incentives/measure/construction. Get the rest wrong and perfect data will still not work – get the rest right and imperfect data will still be useful.
- Data quality - the more you exercise your data, the fitter it gets. Reluctant to use your data until it's "clean"? Use your data and it will "clean" itself.
- Get your framing right before you start designing measures – what questions do you want to ask?
- Framing systems help avoid the wrong approach – Donabedian (structure, process, outcome) and Carter & Klein (Tin openers and dials)
- Most of the time you need to ask the right questions as much as you need to get the right answers
- Frames of measurement – aggregation/aggroupation/synecdoche.
- Wrong measure – doesn't measure what it sets out to measure/impossibility of measurement.
- Road test your measures.
- Use of a specific electronic system is not a process.
- Clinical actions are not outcomes.
- Process is not a proxy of outcome – doing the right thing may not lead to a desired outcome.

Useful websites:

- Health Quality Measures NZ www.hqmnz.org.nz – Health Quality Safety Indicators
- www.patientsfirst.org.nz/hqmnz.org.nz
- www.ihi.org

E5: Effecting Change to Promote the Rational Use of Medicines—A Whole System Approach (P)

Les Toop, MD, MRCGP, Professor of General Practice, University of Otago Christchurch, New Zealand

There are differences between what influences parents and presciber behaviour. For example, parents are influenced by family members, peers, friends, media, self help groups, health professionals and the internet. Prescriber behaviour is influenced by patient demand, training, experience, reading, peers and local fashion, etc

There are two complimentary approaches to guidance and influence. Clinical variation is important as it provides the setting both for innovation and for patients and clinicians to make a variety of decisions, however it exists in most parts of the health system to a degree that defies rational explanation.

Knowing the cause of variation is only the first battle, the second is to convert that knowledge into action – BMJ 2009,339

The Canterbury initiative in mid 2000s was instrumental in developing consensus referral pathways between primary and secondary care.