



# Creating and Implementing a Performance Improvement System

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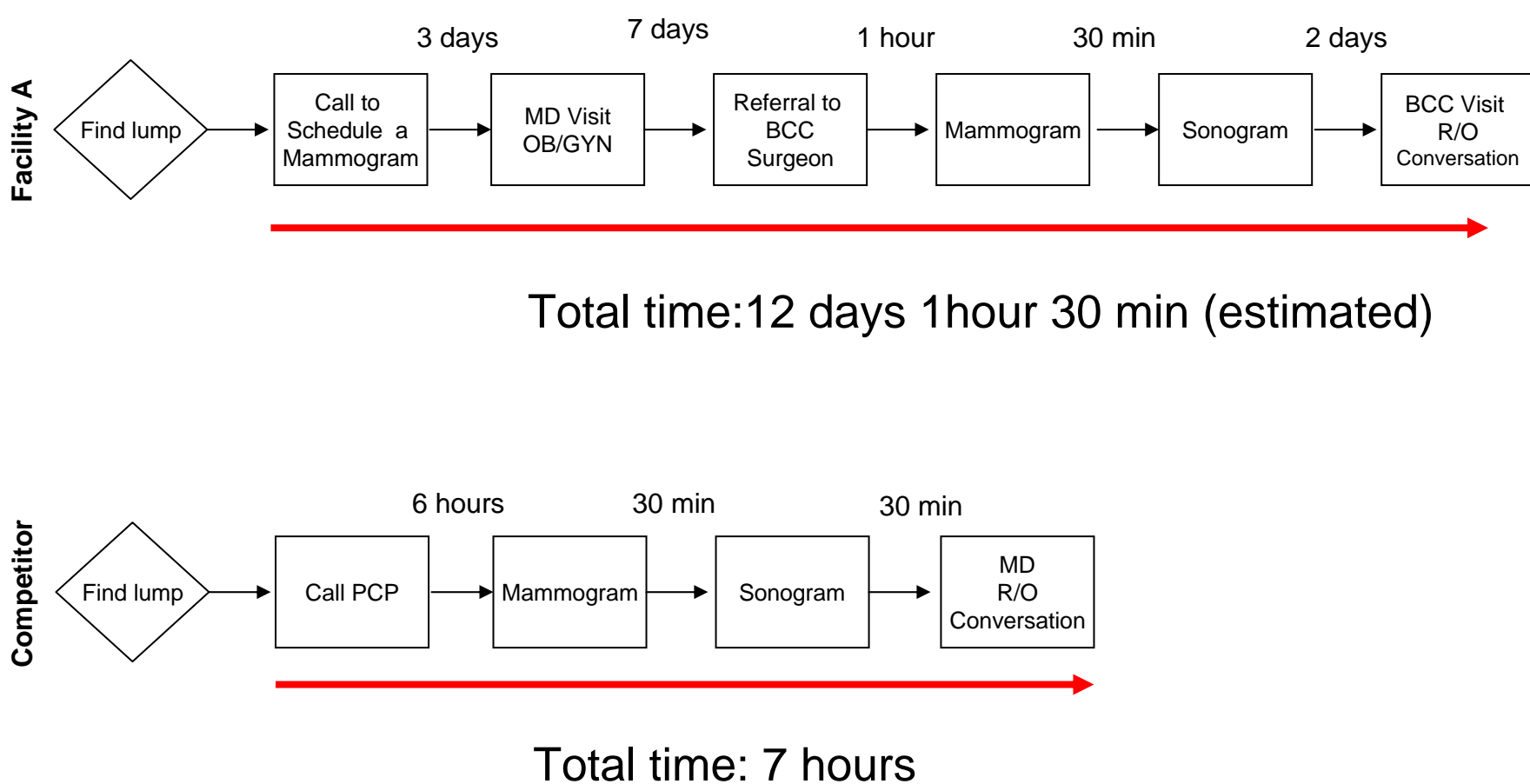
March 5, 2010

# Objectives

- ❑ Share Kaiser Permanente's Performance Improvement IA execution strategy to include:
  - ▶ Program infrastructure
  - ▶ Wave approach
  - ▶ Capacity building
  - ▶ Strategic alignment of initiatives
  - ▶ Roles & responsibilities
- ❑ Facilitative discussion on how participants intent on using the knowledge gained

# What it takes to get to best in class: Breast Cancer Suspicion Example

5 miles apart

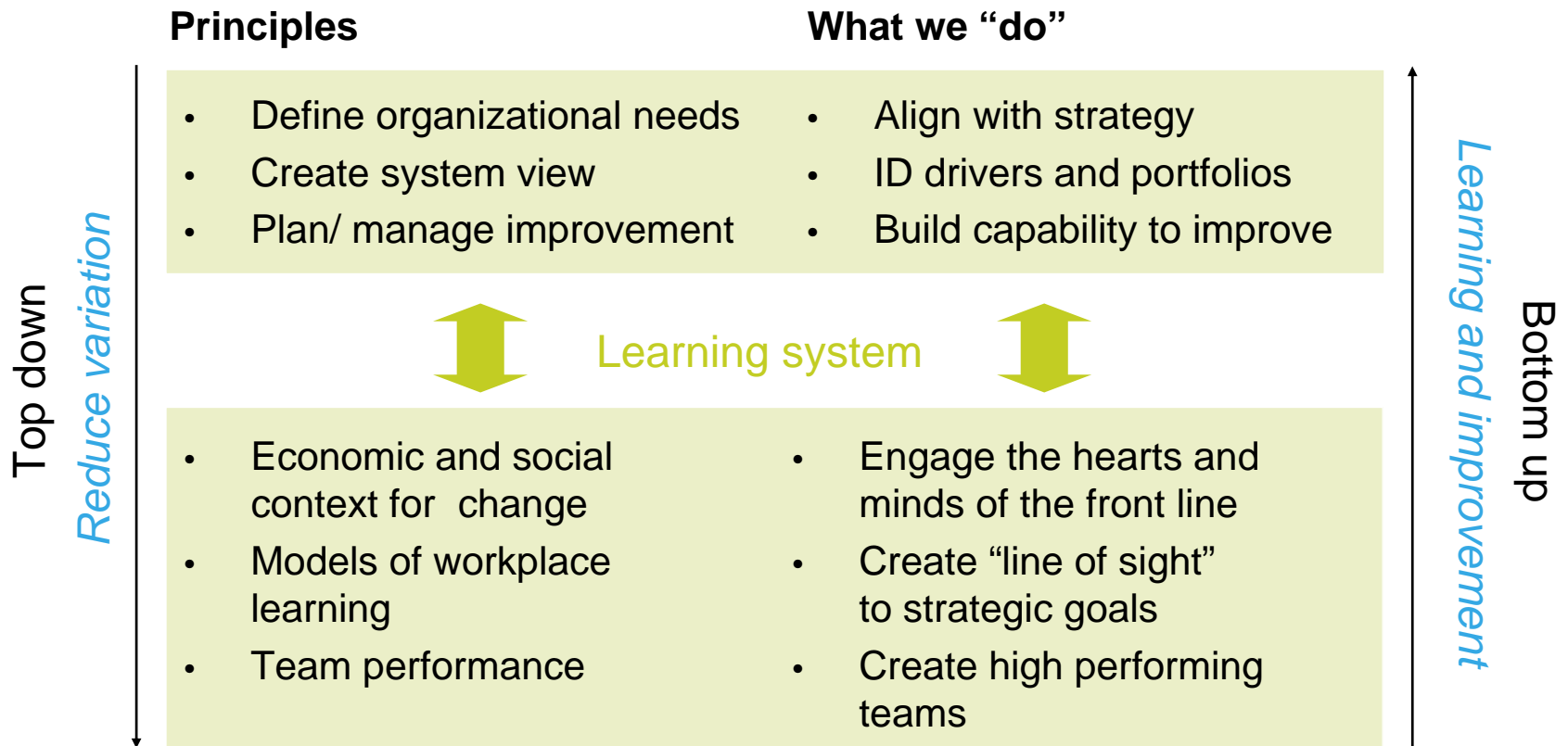


# KP's system is based on the attributes of high performing organizations

***KP needs to build capability in these six areas in order to achieve breakthrough performance***



# High Performing Organizations Build Culture and Capability



# Key Levers to Achieve Results

Key Area	Levers
Aligning with the strategy	Building will
	Use of transparency and measurement
	Focus on quality, safety, service and efficiency together
Executing on strategic priorities	Develop organizational capabilities
	Understand drivers of performance
	Oversight and management of improvement
	System roles in reducing variation
Building improvement capability	Build Skills to improve by audience
	Getting to scale
	Evaluating effectiveness

***Supporting Organizational culture and capability  
to achieve world class performance***

# KP's Improvement Framework

# Are we Lean or Six Sigma? Considering Language

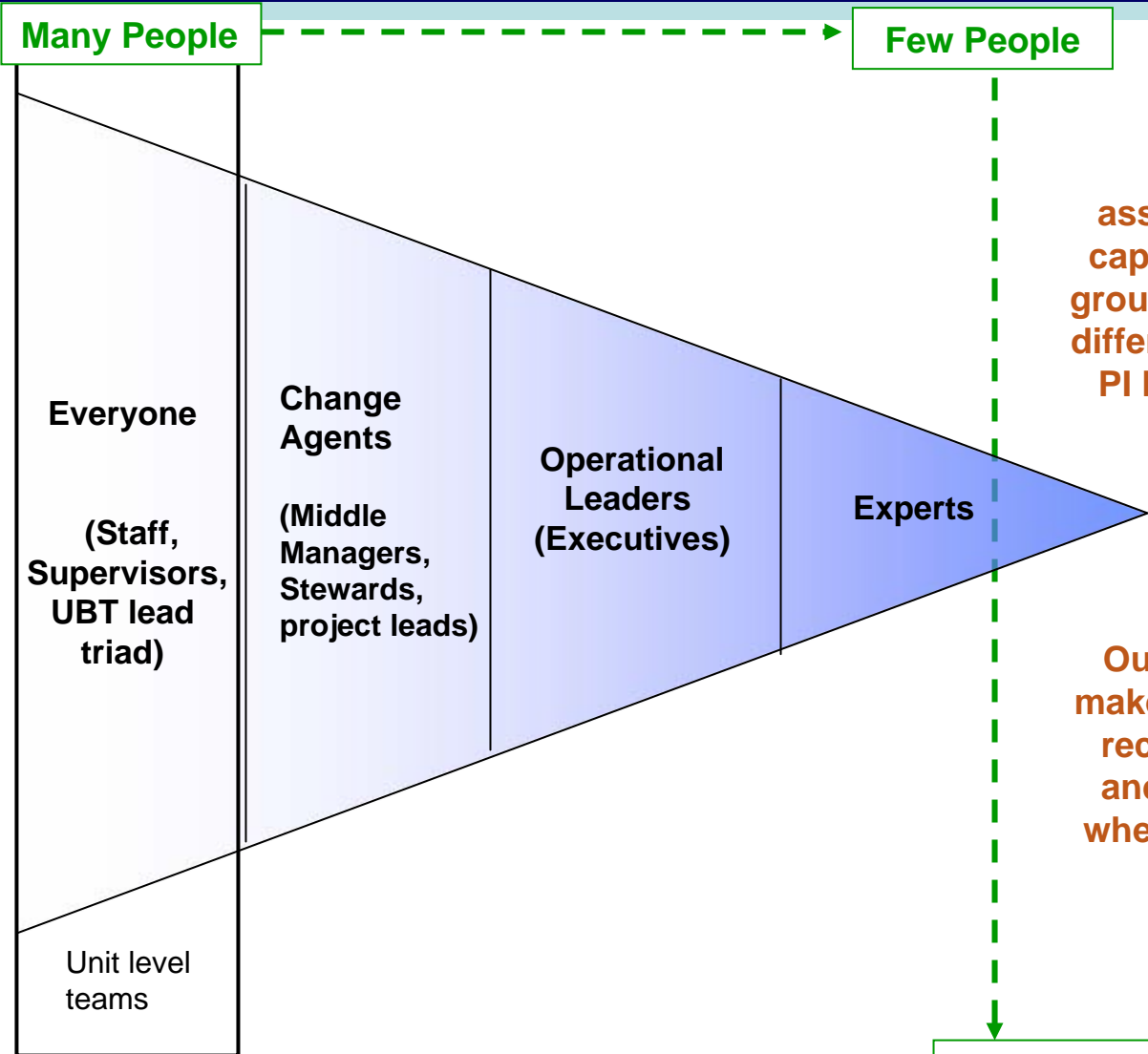
“YES, but we are really what we strive to achieve, a world class organization”

- Lean: production and flow (waste and time reduction)
- Six sigma: decision making and defects (reducing failures)
- Tests of change: applying theory to real work

# KP's Program is designed to grow with us

- ▶ Benchmarked with large complex organizations that have a similar goal to ours
- ▶ Leverages UBT and Quality language for the front line
- ▶ Uses integrated methods to be used for specific issues
- ▶ Uses top -down and bottom –up approach taking advantage of our robust expert resources
- ▶ Avoids “flavor of the month” by integrating methods in KP language to evolve tools as we enhance our skills throughout the care delivery system

# What skills do we need?

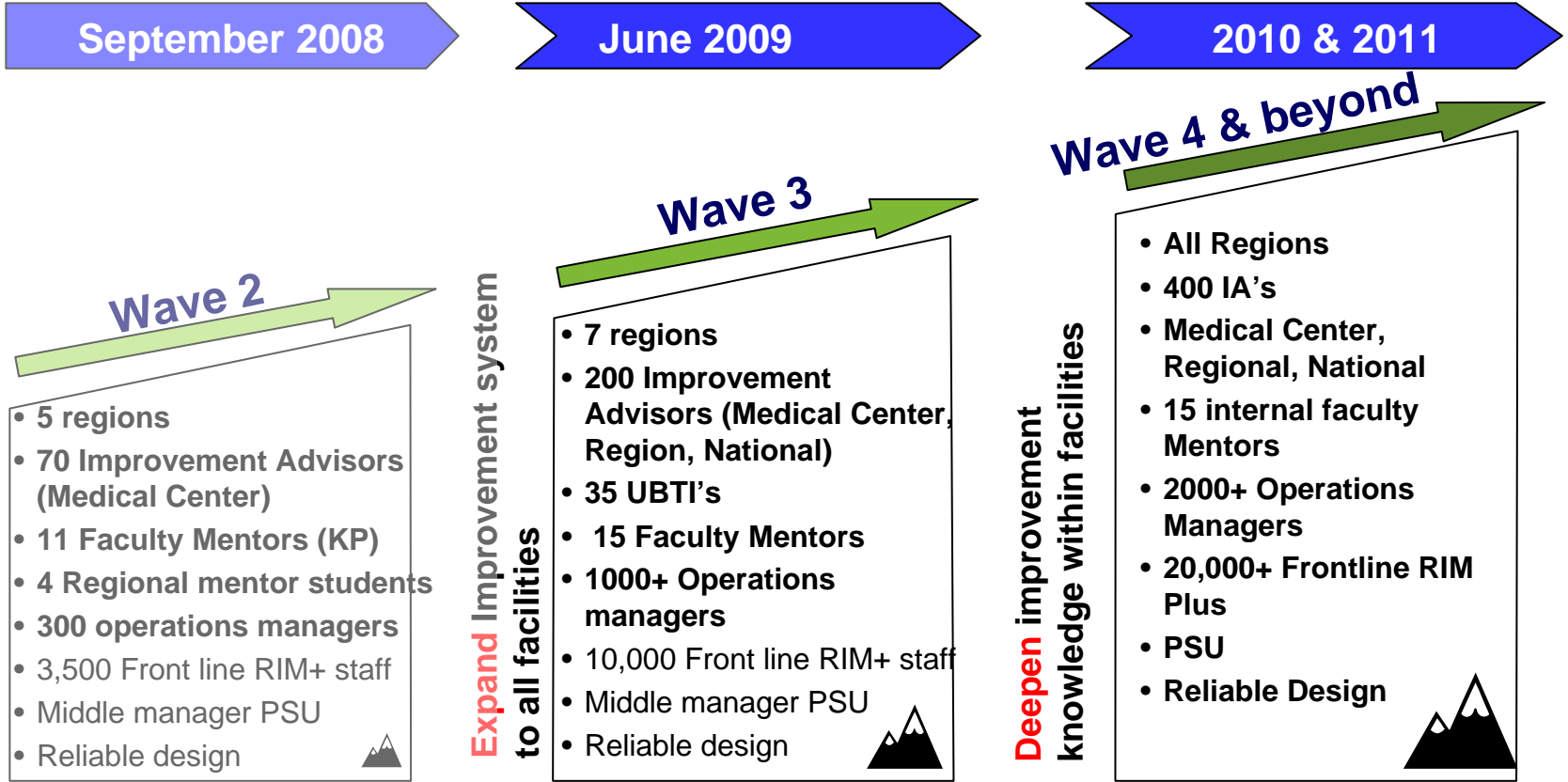


A key operating assumption of building capacity is that different groups of people will have different levels of need for PI knowledge and skill.

Our approach will be to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts.

# Wave II Impact Realized, Wave III and IV focus on Expansion and Spread

## Waves of Improvement Institute



Learning and sharing systems regionally and program-wide Improvement Institute



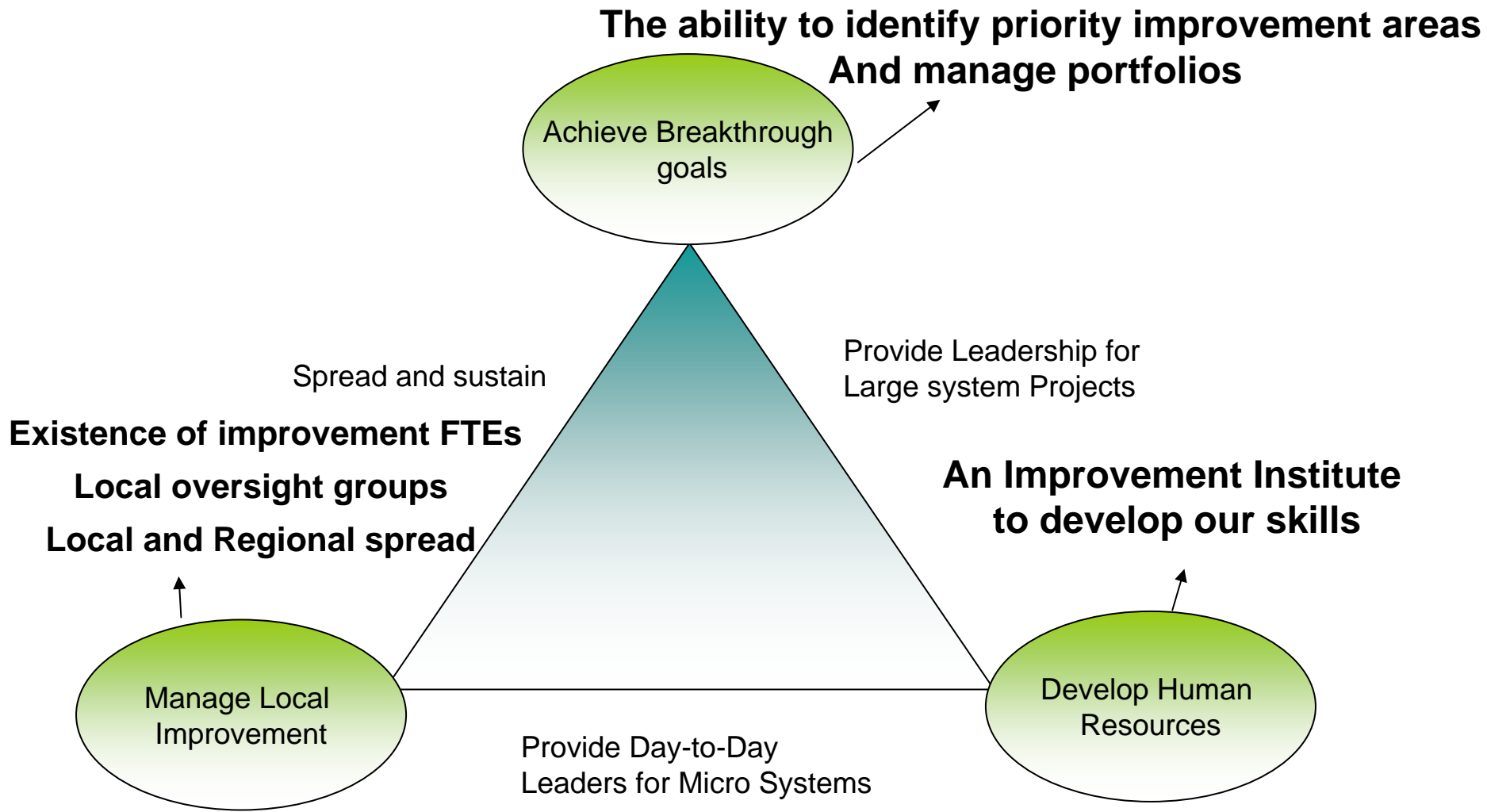
NATIONAL Performance Improvement

We are here



# Basics of Execution

# KP's Improvement System Addresses Three Critical Needs



# Establishing A Medical Center Improvement System

- ❑ Set goals (consider clinical quality and safety; member / patient satisfaction and delight; and cost)
- ❑ Be bold – answer: “How Good?” and “By When?” and communicate to all
- ❑ Work with senior team and improvement expert to scope effort
- ❑ Lay out the system drivers and then the portfolio of projects
  - ▶ Use cascading charters
- ❑ Monitor the portfolio to understand progress, maintain pace
- ❑ Consider how your organization will share learning and the culture that exists

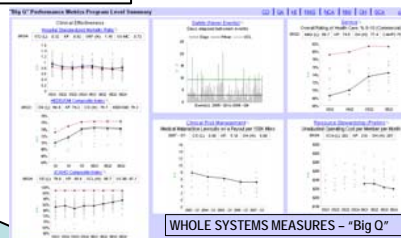
# From Strategy to Execution

We will be recognized by our members, payers, and employees as the safest, most effective and personal health care delivery system in the country.

**Big Goal**



**Strategy**



- Member Gap to US Medicare exp. increased since 2007 data
- HEDIS KP is just below US 50th percentile
- ICARDI KP is just below US 50th percentile but rising
- Safety: 21 severe events in Q4 06, 4 quarter downward trend
- Risk Management: downward trend since 2003, but level in 06-07
- Service: upward trend but KP below CARRS 25th percentile (not shown)
- Cost: all preliminary data

**Dashboard**

Domain	2008	2009	2010
<b>Inpatient Mortality Ratio</b>	Reduce HSMR %	Reduce HSMR %	Reduce HSMR %
<b>TJC Composite Index</b>	Halfway between national average and 90th percentile	Three-quarters of way between national average and 90th percentile	National 90th percentile
<b>Ambulatory Care HEDIS</b>	30th percentile	90th percentile	90th percentile
<b>Safety (Never Events)</b>	Zero	Zero	Zero
<b>Clinical Risk Management</b>	5% reduction in claims from 2007	5% reduction in claims from 2008	5% reduction in claims from 2009
<b>Service</b>	Proposed: At or above 75th local or National Market	Long term goal under development	TBD
<b>Resource Stewardship</b>	TBD	TBD	TBD
<b>Equitable Care</b>	NA	TBD	TBD

**Targets**

# Elements of Effective Alignment: Balanced Scorecards

Performance Measure	South Bay Ranking				Current Comparison		Performance				Accountability				
	Jan	Feb	Mar	Apr	Rank #1	Rank #3	Target performance	YTD	Regional Target	Accountable Partner Pair	Accountable Physician	Accountable Ops Leader			
<b>Quality</b>															
CSG Composite (BigQ)				3	77.3% OC	76.9% SB	-	76.9% YE 08	N/A P1 09	P2 09	-	-	-	-	
Breast Cancer Screening				10	91.1% RIV	90.0% BPK	87.0 P5 08	86.8 YE 08	N/A P1 09	N/A P2 09	-	90%	Clarice Crossley Dr. Joseph Colli		
Cervical Cancer Screening				12	89.4% BPK	87.7% OC & RIV	84.9 P5 08	85.0 YE 08	N/A P1 09	N/A P2 09	-	88%	Sin Young Calantoni Dr. Ronald Navarro	Vanessa Gavin-Headen Dr. Jake Rofman	Candy Soutar Dotty Carmichael
Colorectal Cancer Screening	8	8	8	8	71.7% WH	68.8% OC	67.4 P5 08	68.8 YE 08	N/A P1 09	N/A P2 09	-	68%	Jeff Moses Dr. Barbara Carnes	Dr. Verna Guo	Fran Alexander Barbara Tiedemann
Glycohemoglobin Control in Diabetics: - A1c < 9.0 **	11	11	9	9	79.8% KERN	77.8% RIV	76.2 P5 08	76.8 YE 08	N/A P1 09	N/A P2 09	-	81%	Jeff Moses Dr. Barbara Carnes	Dr. Shelley Pickering	Shelly Fisher
Glycohemoglobin Control in Diabetics: A1c < 8.0 **	11	11	9	9	70.8% KERN	67.9% RIV	64.5 P5 08	65.3 YE 08	N/A P1 09	N/A P2 09	-		Jeff Moses Dr. Barbara Carnes	Dr. Shelley Pickering	Shelly Fisher
Lipid Control (Diab)				2	60.5% OC	58.7% RIV	60.6 P5 08	61.7 YE 08	N/A P1 09	N/A P2 09	-		Jeff Moses Dr. Barbara Carnes	Dr. Shelley Pickering	Shelly Fisher
Lipid Control (Card)				7	75.2% OC & PC	74.6% AV	73.0 P5 08	74.3 YE 08	N/A P1 09	N/A P2 09	-	77%	Jeff Moses Dr. Barbara Carnes	Dr. Jake Rofman	Karen Sielbeck Shelly Fisher
Controlling High Blood Pressure (Age 18-85)	10	10	10	10	83.5% OC	82.7% RIV	79.7 P5 08	79.4 YE 08	N/A P1 09	N/A P2 09	-	80%	Jeff Moses Dr. Barbara Carnes	Dr. Radha Pema	Dotty Carmichael
Childhood Immunization	11	11	11	11	84.5% PC	82.7% BPK	76.2 P5 08	76.3 YE 08	N/A P1 09	N/A P2 09	-	91%	Sin Young Calantoni Dr. Ronald Navarro	Dr. Nancy Wiedlan	Sue Dao Anett Scognamillo
Smoking Cessation (ASQ) ** % of Smokers Advised to Quit	5	8	7	12	73.0% RIV	70% BPK & OC	70.0 Jan-09	67.0 Feb-09	66.0 Mar-09	64.0	65.7	83%	Clarice Crossley Dr. Joseph Colli	Dr. Angie Sung	Deme Flores
Smoking Cessation (ASQ) ** % of Smokers Offered Strategies	5	8	7	12	54% BPK & WLA					52.0 Mar-09	51.7	60%	Clarice Crossley Dr. Joseph Colli	Dr. Angie Sung	Deme Flores
SCIP Composite	4	4	2	2	98% WH					N/A 1Q09	-	98%	Bonnie Tann Dr. Kevin Pusavat	Dr. Edward Yang	Phillip Butt

Sponsors

Measures related to priorities

Target performance

Champions

Rank over time

Performance over time

Comparison info for learning

# Establishing A Medical Center Improvement System

- ❑ Set goals (consider clinical quality and safety; member / patient satisfaction and delight; and cost)
- ❑ Be bold – answer: “How Good?” and “By When?” and communicate to all
- ❑ **Work with senior team and improvement advisor to scope effort**
- ❑ Lay out the system drivers and then the portfolio of projects
  - ▶ Use cascading charters
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- ❑ Consider how your organization will share learning and the culture that exists

# Checklist for Selecting Improvement Portfolios

- ❑ Set your big goals
- ❑ Get a senior group together to analyze data, develop a driver diagram, prioritize opportunities and map the process
- ❑ Develop the portfolio of projects needed to move the dot
- ❑ Define and assign the resource / technical support
- ❑ Identify the sponsor and champions
- ❑ Agree to oversight review process and frequency

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# Approaches to Identify Opportunities

<b>Name</b>	<b>Approach</b>
<b>Driver Diagrams</b>	Cross-functional leadership engagement in identifying primary levers that affect performance
<b>End-to-End Process</b>	Assess the end-to-end processes to improve flow or identify defects leading to poor outcomes
<b>Customer Process</b>	Evaluate customer facing processes & services and identify performance improvement opportunities
<b>Performance to Plan</b>	Identify performance gaps and weaknesses in forecasting and execution of budgets, schedules and/ or service level agreements
<b>Financial Analysis</b>	Evaluate detailed financial indicators within business and identify project themes for performance improvement

# Example: Drivers of Efficiency

Goals

Drivers

Focus Areas & Initiatives

**Right Venue of Care**

High-risk population management  
Anticipating end of life: Palliative care, advance directives  
Admission alternatives

**Optimize Hospital Throughput**

Patient flow: Well-sequenced care, no delays  
Evidence-based care, no needless harm

**Manage Hospital Output**

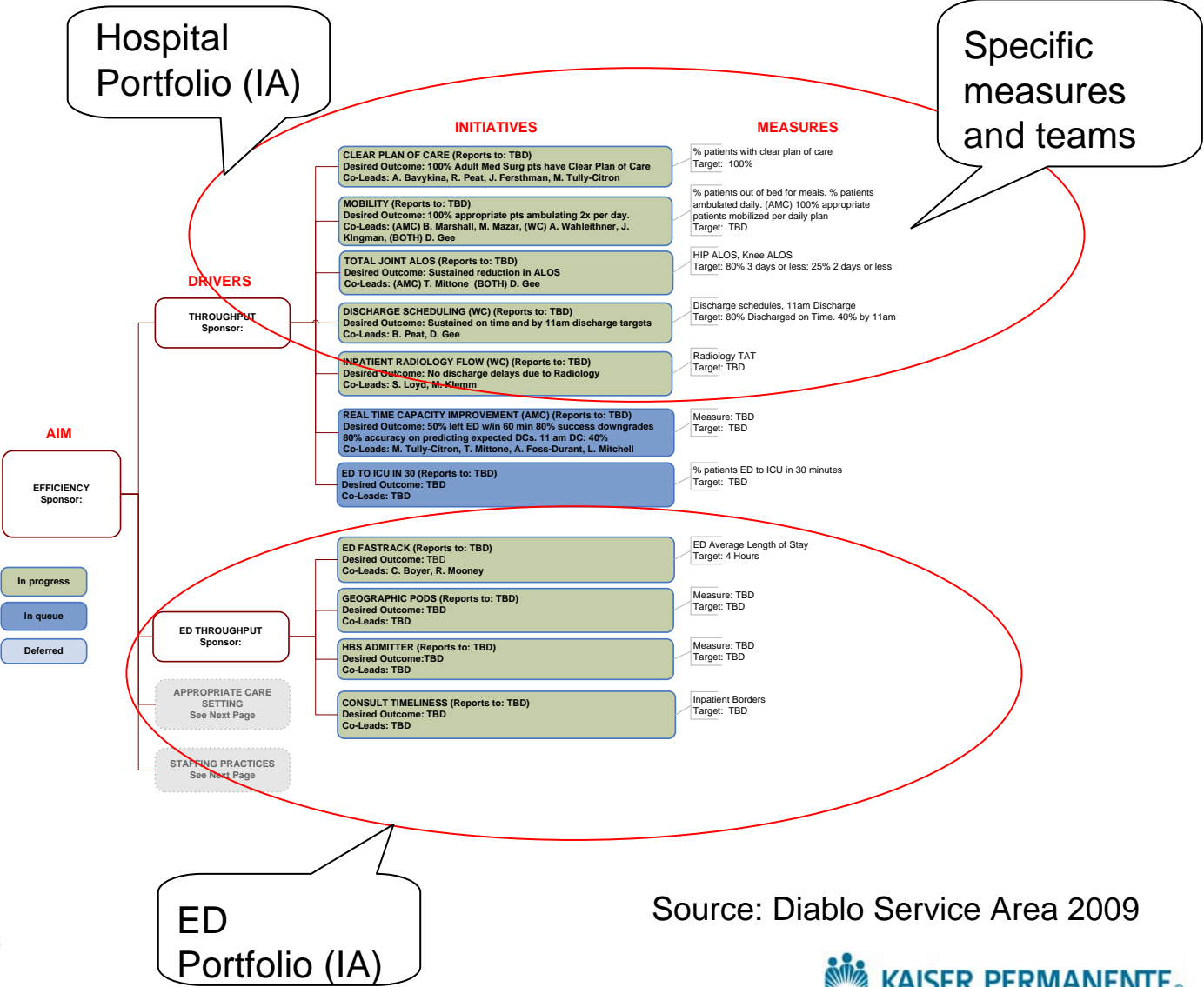
Discharge Processes  
Access to and management in alternative care settings: SNF, HH, rehab, sub-acute, in-patient psych

**Manage Cost Structure**

Direct patient care expenses: HPPD, OT, Registry, attendance  
Other hospital expenses: Supplies, materials, non-patient care staff, attendance  
Workplace Safety: Patient and non-patient care

**Leading Patient-Centered, Efficient Care Processes**

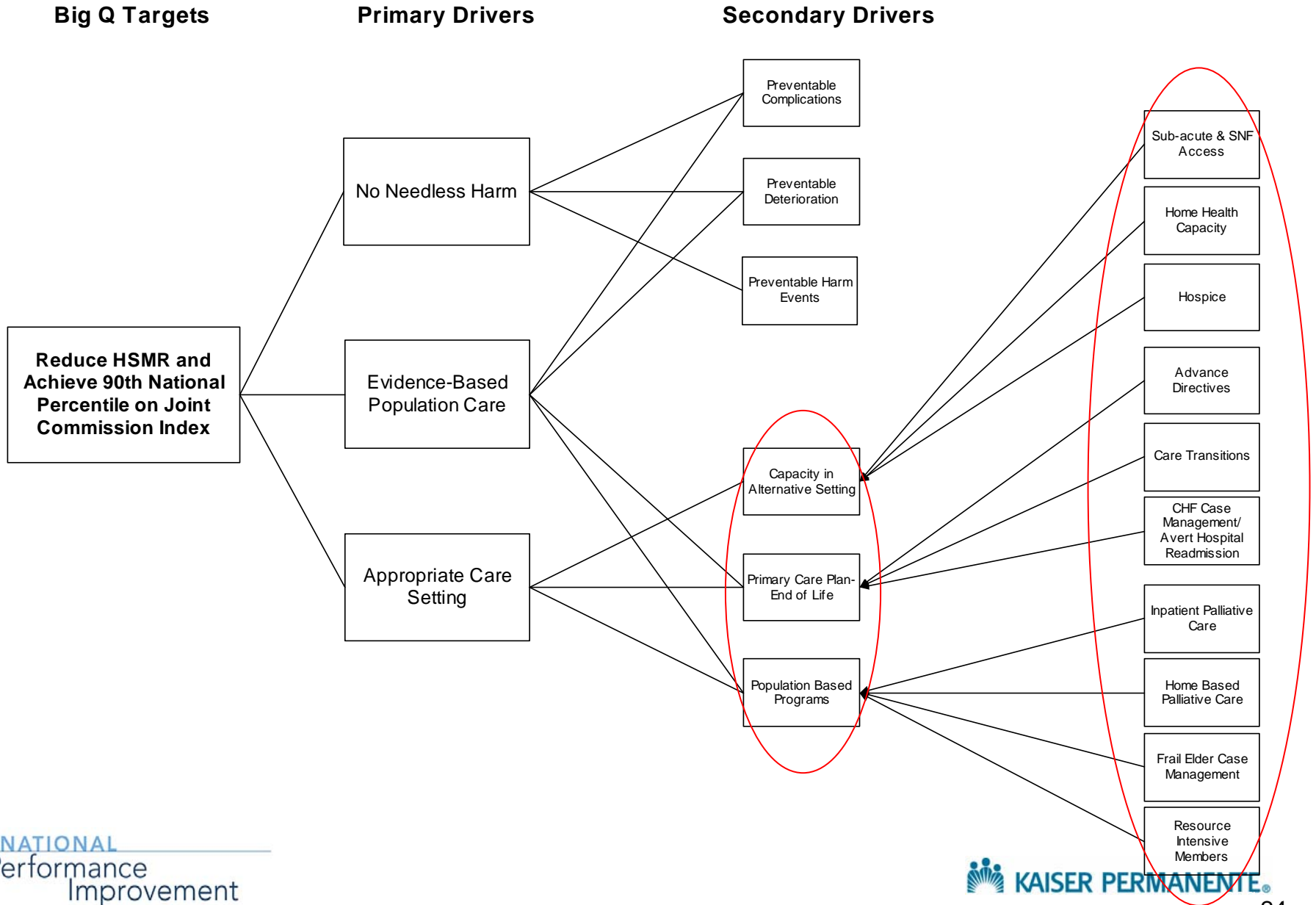
# Identifying portfolios



Source: Diablo Service Area 2009



# Framing Drivers of Performance



# Driver Diagram Template

## Secondary Drivers

### Primary Drivers

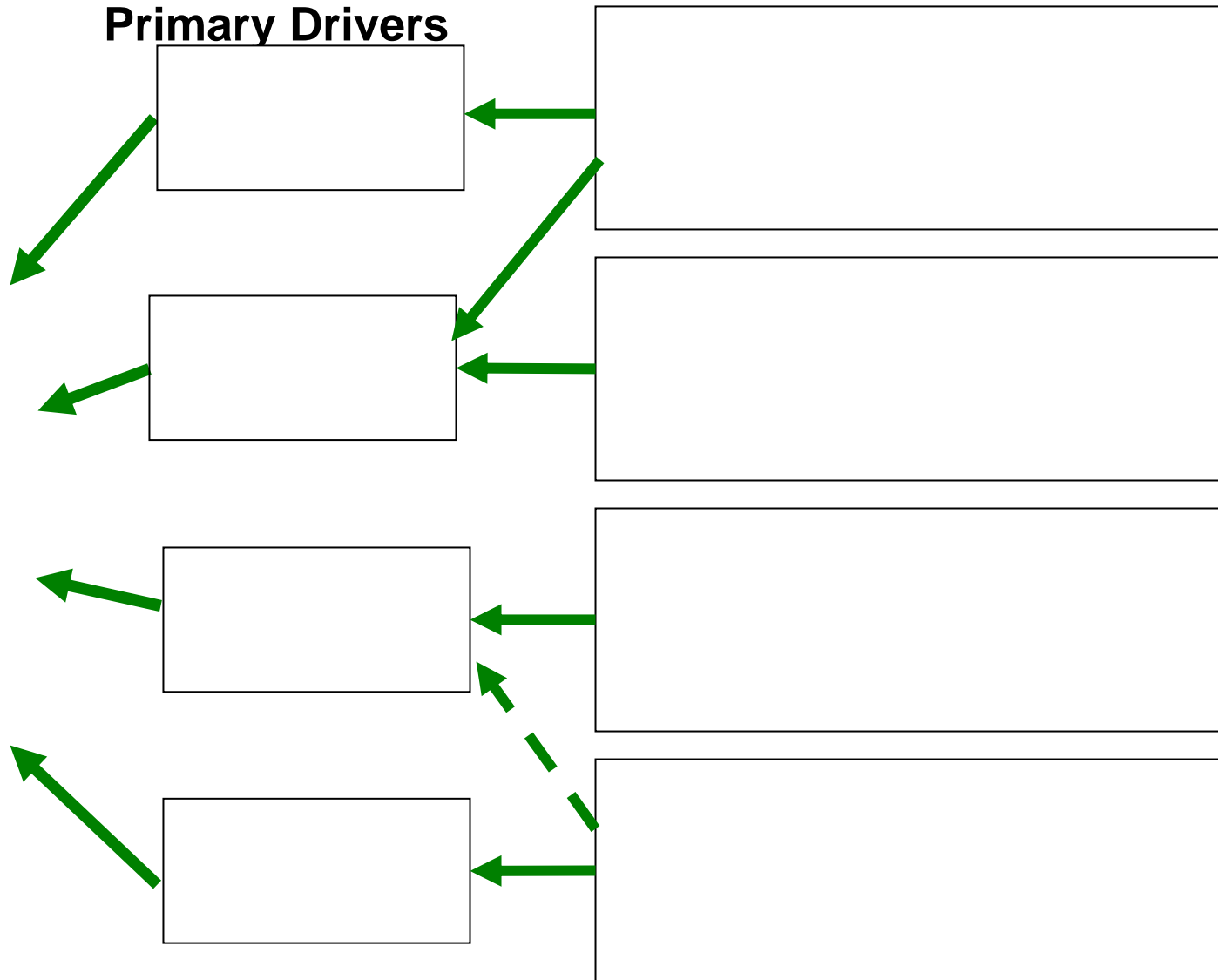
**Goal:**

**Outcome Measures:**

1.

2.

3.



# Establishing An Improvement System

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# Role of the Oversight and Learning Team

- ❑ Make clear connections to strategic direction
- ❑ Set the pace with monthly 1-2 hour reviews, expect weekly reviews at service line level
- ❑ Expect succinct and effective explanations of progress and obstacles from the team
- ❑ Rebalance as appropriate every 30-60 days
- ❑ Extract common themes among projects

# Roles in Managing Portfolios

- Sponsor
- Champion
- Project leader (process owner)
- Team member
- Improvement advisor

# New Leadership Role

Not to “solve problems” but to:

- ▶ establish direction
- ▶ identify what good looks like
- ▶ support and accelerate change
- ▶ remove barriers

## Summary and What are Your Plans (On the Ground Execution)?

- ❑ Determine PI execution strategy and objectives
- ❑ Complete the driver diagrams
- ❑ Determine data needs
- ❑ Prioritize portfolio of projects
- ❑ Execute on initial 90 day portfolios of projects
- ❑ Establish oversight group
- ❑ Monitor portfolio of projects

# Appendix

# OC Pt Transfer Time ICU to Floor Project Summary

What are we trying to accomplish?

- Improve Transfer time between units from >70 min to 60 min or less, when bed available, by May 31, 2009

What changes resulted in Improvement?

- HC Revision of transfer orders
  - Direct contact of EVS by ward clerk regarding bed clean
  - Daily transfer delay log and review by charge nurse
  - Report escalation
  - Lift team not used for transporting patients
- Process Measure—Voice of the System
- # and type of transfer delays

How do we know that change is an improvement?

- Outcome Measures—Voice of the Customer
- Average transfer time, from MD order to Pt transfer
- Balance Measures—Unintended Consequences
- Nursing Satisfaction

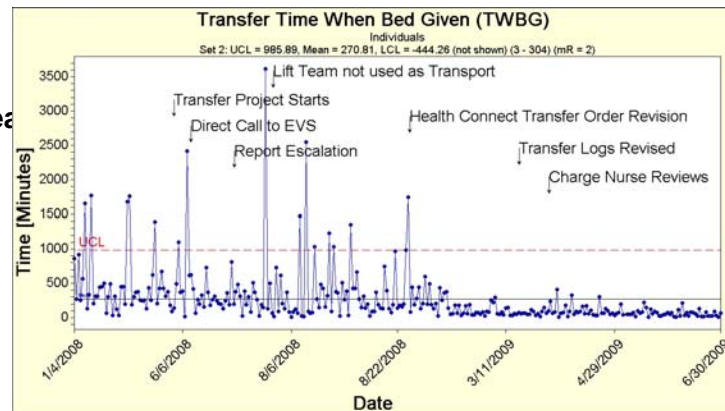
What are example tests of Change?

1. Staff nurses alert charge RN /ADA when delay >1hr
2. Do not call lift team to transfer pt unless meets weight criteria.
3. Ward clerk not to call BUN when bed to be cleaned, call EVS direct.

What is the control plan?

- Monitor Transfer Times from ICU to Floor by DA and ADA via scorecard, share at staff meetings and post within department
- Monitor EVS Bed TAT by EVS manager, share at staff meetings and post within department

Figure 1. Avg Transfer ICU to Floor 05/08 to 04/09



Baseline: 70 min  
Goal: 1 hr by 5/09  
Current Results: 61 min

**Customer Benefit:** reduced delays, wait times and excess motion

**Financial Benefit:** expected to impact overtime, LOS

**Translation/Spread Opportunities:** initial spread to IMC

# OC ED Admit Process Time Project Summary

What are we trying to accomplish?

- Improve average ED Admission Process Time from 5.5 h to 1 h or less by June 30, 2009

What changes resulted in improvement?

- No linking of beds; only assign when clean and ready
- Airmail/text ED admit pt clinical info to BUN
- Additional EVS staffing in pm
- Report escalation or roll with pt and give report bedside
- CN in ED paged along with pt ED RN when bed is ready

Process Measures—Voice of the System

- EDWC clerk response to Admit order
- Admit order to Assigned Bed Time
- Assigned Bed to Out of ED Transport Time
- Admit Process Time when bed is available

How do we know that change is an improvement?

Outcome Measures—Voice of the Customer

- Total ED Decision to Admit Process Time
- % Pts admitted within 1 hour or less
- Door-to-floor process Time, ED divert hours

Balance Measures—Unintended Consequences

- LOS, ASQ ED

What are example tests of Change?

1. Airmail/texting to BUN from ED when there is a request for Bed. BUN to respond within 15 min.
2. Report Escalation to RN buddy or ADA within 2 calls max.
3. No Linking of Beds – assigning beds based on acuity and first available.

What is the control plan?

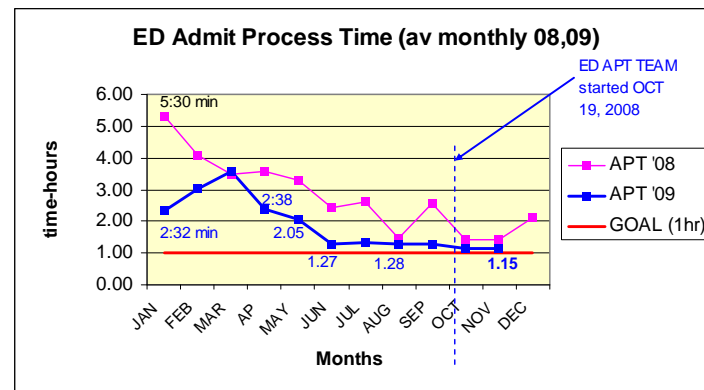
- Monitor Discharge Times by DA and ADA via scorecard, share at staff meetings and huddles and post within department

**Customer Benefit:** reduced delays, wait times and excess motion

**Financial Benefit:** expected to impact overtime, ED divert hours, LOS

**Translation/Spread Opportunities:** initial spread to IMC

Figure 1. Avg ED Admit Process Time 01/08 to 04/09



Baseline: 5.5 h  
Goal: 1 hr by 6/09  
Current Results: 2.38 min