QUALITY HEALTH STRATEGIES

Moderator: Caroline Jackson
March 19, 2014
12:00 pm CT

Operator: Ladies and gentlemen, thank you for standing by and welcome to the CDI conference call.

During the presentation all participants will be in a listen only mode.

Afterwards we will conduct a question and answer session. At that time if you have a question press the 1 followed by the 4 on your telephone.

If at any time during the conference you need to reach an operator, press the star followed by the 0.

As a reminder today's call is being recorded Wednesday, March 19, 2014.

I would now like to turn the conference over to Ms. Caroline Jackson, Project Manager. Please go right ahead ma'am.

Caroline Jackson: Thank you very much.

Good afternoon everyone and thank you for joining our monthly CDI webinar series. Today we will focus on sustaining and spreading your reduction efforts towards CDI within your hospital.

We are so fortunate to have (Maria Shaw) from the Institute for Healthcare Improvement as our featured speaker. (Maria) directs improvement and innovation projects focused on outpatient based care, and is responsible for IHI programming in this area.

In addition she directs and is senior faculty for IHI's breakthrough series college and is also responsible for the ongoing development of IHI's spread methodology and programming. Prior to joining IHI in 1995, Ms. (Shaw) designed and led improvement projects for Pro New Jersey, the New Jersey Quality Improvement Organization.

This area as you know - this area of practice will require increased momentum as we move forward in this collaborative. And we are so fortunate to be able to have (Maria) to join us.

Keep in mind that your Chat room is open so we invite you to Chat in. And (Maria), thank you again for joining us and you can take it away.

(Maria Shaw): Okay. Well thank you very much Caroline. And I'm very happy to be here with you this afternoon. And I'd like to just support and encourage you to use the Chat. I would like to be as interactive as possible with this conversation with you and look forward to seeing your comments in the Chat.

So there I am. And those of you that I haven't met in person, I'm glad to be meeting you this afternoon. What we are going to be doing is I'm going to be

sharing with you strategies for sustaining improvements. Another way to say that is holding the games.

In order to do that well, it's helpful to have an understanding of reliability science - how to - and that's going to enable us to strengthen the implementation and the ability to sustain improvements. So I'm going to be introducing some of those concepts and some of the activities that you can do to strengthen your reliability and to insure that your - the systems that you're building - the processes that you're building are reliable and sustainable.

And then I'm also going to talk about how to utilize effective message for a spread and scale up. Now certainly sustaining implementation, sustaining building reliability and spread and scale up are all related. And we're going to be talking about that relationship.

What does sustaining improvements looks like? It looks like when staff or leaders can say that we started a new process with one care team and now everybody does it - that our information systems may support us to make it easy to do what we want to do regularly.

And when you have a sustained system you have a reliable system when the process is the same for each patient every time. So that's what you want to be working towards. And some of you, you know, may have, you know, taken some steps along that path to get there and certainly would like to hear about anything that you've learned about this process in the Chat as we go through the discussion this afternoon.

I want to set the context for the sort of the understanding of sustainability spread and scale. And that's to view it as what we're all doing as we're making improvements is really creating a new system. And that creation of a

new system really has three parts - making the initial improvement, sustaining that, and then spreading or scaling it up.

And it's important to see the relationship between those three parts of the system. And this is one way that we at IHI visualize this. So you're starting with developing a change, testing, implementing that change and then scaling up and spreading, all supported by the model for improvement - some method for being able to test and further refine your changes.

What's embedded in that previous slide is several what we call methods to achieve results at scale. And I just want to introduce these so that we all have a common language for what I'll be talking about and what you are doing in your work.

So when we talk about testing we're talking about trying and adapting ideas that work in your system. And often you want to start doing that in a very small scale in a pilot or with a small number of providers or care team members.

Implementation means that you're making those changes a permanent part of the day to day operation of the system. Oftentimes implementation starts at a small level - might start at your pilot level. But really when we talk about spread and taking things to scale, that's just a wider application of the key aspects of making the changes permanent. You're just making them permanent in a larger part of your system.

Spread means that you have individuals outside the pilot that adopt and adapt the changes. So they're making the decision supported by the infrastructure, supported by the policies and procedures that you've developed that enable them to make those decisions to adopt and adapt the changes.

And then scale up, which is often used synonymously with spread, but we think it's important to differentiate that method. Scale up being identifying and overcome the structural - overcoming the structural issues that arise during spread.

So spread and scale up - they're related. But the emphasis when you're talking about taking things to scale, scaling up really is focusing on the structural issues that often get in the way of spread. And this is - we'll be going into this in some detail as we move through the presentation.

But just to introduce those terms so that we're all clearer on what it is that I'll be talking about as we talk about each one of those.

So we're going to start out talking about sustaining - holding the gains and what that means. And I think it's important to understand that you begin working on holding the gains from the very beginning of your improvement work.

So oftentimes I think people think about okay, you're going to do improvement, you're going to test some things and then oh, you know, in a few months we'll think about how we're going to hold those gains. But really the time to think about holding the gains is when you're just beginning your testing.

So I'm going to be talking about how you - what kinds of things to do to hold - to set yourself up well to make sure that the processes, the improvements that you're introducing into your systems stick in each part of the diagram that's here.

So the first area to think about is how - what kinds of things you can do during the initial testing of a change. And so here's some things to think about and perhaps you've done these. And I'm going to ask you actually to Chat these in just a moment.

So when you're initially begun your CDI work and you've begun to make some changes, some tests in your pilot unit, you may have thought about purposefully testing the changes under a wide range of conditions. So in other words you're developing what we call a robust design.

So you may think about - you may have done testing - a particular change on different shifts or with experienced or inexperienced staff or different types of units - Med-Surg or other kinds of units. So purposefully testing the changes is one thing you can do.

Another is doing things that we call fool proofing the process or the procedure. So you want to - you perhaps have been looking for ways to make it easy to do the right thing. So you might use constraints or affordances or reminders or differentiation.

And just to give an example of a couple of these that might not be that familiar to you, I think reminders are pretty familiar. Differentiation just means being able to visually see the difference in say a medication bottle or a prescription bottle for example.

Constraints means that it's - you put a process in place where it makes it hard to do the wrong thing and easy to do the right thing. And I think the example that I like to think of is, you know, when you're at an ATM machine and they always have those little diagrams that are not intuitive to me about you insert

your ATM card in there. But basically you can only put it in one way. So that's a constraint in terms of it's not going to let you do it the wrong way.

An affordance means that it's something that's part of the system that really enables you to have the best outcome. And again the ATM example is when you put your ATM card in and then it immediately comes back out which makes it harder to forget to take your card.

And I know we've all had the experience of not having a machine like that where it keeps your card the whole time, gives you the money and then it gives you your card. And I've had the experience of walking away with the money without my card.

And so an affordance is - would be the situation where it actually gives you your card back right away and makes it easy for you to not to forget it. So fool proofing and then finally using technology wherever we can. And I think that's something that we all look for.

So these are all things that you can do when you're doing your initial testing. So as I mentioned, I was going to ask you to Chat in how you may have utilized some of these methods in some of the work that you've done even if you've only begun to do your testing.

But I think you're probably further along than that in your work. But please Chat in what you may have done to test under a wide range of conditions in relation to the CDI work and what methods you may have used for fool proofing. And then if you've used any particular types of technology.

So go ahead and Chat that in and I'll keep talking but I'll be watching and would love to see what kind of examples - how you have integrated these concepts into your work.

The next area where you want to be thinking about what kinds of things to do in order to assure that you will be able to hold the gains is during the implementation itself. Okay, so there's a period following the initial testing on a very small scale - say with one or two staff members or one or two providers, one or two patients.

But then you're going to move to implementation where you're gaining some confidence in those tests - in those changes. And so you'll be doing it with say perhaps in your whole unit. And so what kinds of things do we think about during implementation and what does implementation mean?

So implementation means that a change is a specified part of daily work. So it's not just something that you're testing now, but it's something that people are going to recognize as okay, this is the way that we do things. And you need to develop, you know, infrastructure to support that to maintain that change, and I'll be talking about that in a moment.

This is the period where there's a high expectation to see improvement. So at this point you've refined the changes. And so hopefully you're not seeing "failures". You're not seeing things work the way that you don't want them to work. But you're still out on - certainly on the lookout for that. And if you see some things that aren't working the way that they should, you know that you need some continued testing.

And then finally during the implementation period there's an increase in scope which you may anticipate might lead to some resistance. So if you've had one

or two staff members making some of the changes in your CDIF work, and now you're going to be introducing it to the whole unit, there may be some lack of understanding or some push back for that.

And so one way to counteract that is to share the value of the evidence from the successful test to show other folks that - how the process works and how it can be easy for them to do.

So in order to implement, here's some things that you might have in your toolbox. So you certainly want to be using plan-do-study-act cycles. So you certainly want to be learning from your actions. It's the period when you want to establish, buy in and build consensus amongst a slightly larger group that may have been involved in your initial tests.

Importantly you want to create an infrastructure and a support that is going to enable people to do the right things. And I'll show you a little worksheet that you can use in just a moment.

Some of the ways you do that, by building what we call communication channels so that you want to make sure that there's information out there. And I know that there's, you know, there's a lot of information and educational materials that have been developed as part of the CDIF work.

And understanding how to - what methods of communication that you can use for that, so taking advantage of everything that you have whether it's staff meetings or, you know, newsletters or, you know, online, you know, kind of prompts or videos or whatever it might be - doing that in as many ways as you can - creating education and training, reviewing policies and procedures - importantly to assign accountability and to cultivate leadership and build will.

I can see that we have a little bit of Chat coming in and that's great. There's a lab alert that (Joell) uses. Thanks (Joell). (Terry) says progression rounds tools which identifies these patients having diarrhea. And (Christine) is looking for reminders or EMI heart stops. Well that's great. Keep the conversation going. I'll keep talking. And please share what you're doing.

And (Karen), let me know if there's any particular question that might come up that I can help address in terms of perhaps what I might be saying.

Some things to keep in mind about testing versus implementation or the initial testing is to understand that during implementation you're also testing. It's just a slightly different kind of testing. So if you look on the left hand side of this slide, when you're doing your initial testing you can see that the scale is really small. You might be recruiting one volunteer for one shift.

And then as you move to the right hand side of this slide, you can see that during implementation you're testing different things. You're testing what job descriptions may be like, how to conduct market salary studies or what information are you learning from those - how to describe and post the hiring positions, that kind of thing.

So let me show you this worksheet that includes some of the categories of things that you want to make sure are part of your implementation planning. So these are some of the things that I've been mentioning - policies, documentation, hiring procedures, staff education and training, etc.

And this might be a useful tool for you to use to outline, you know, how exactly you're going to be testing these things and putting these things into place over what period of time. So it's a handy checklist to use.

So if you're finding that, you know, you're having trouble with some of the changes that you've tested and having those stick, then making some of these infrastructure and structural changes can certainly help in that process. So use this as a little bit of a checklist.

So as I mentioned, having an understanding of reliability science and how that contributes to implementation can be helpful in this. I see that we're still getting some Chat in about different ways that you've integrated some of these principals into your work. Education documentation as a tab in the AMR patient isolation lists - terrific. These are all - these all look like really great examples of the way to build in ways to make your processes more reliable.

So what is reliability? What does it mean when your processes are reliable and how do you know? So here's just some comments that staff might be making. So we all know how to use the CDC environmental checklist. So a checklist is a great example of a method to insure reliability.

The use of the checklist is reviewed regularly at our unit staff meeting. So not only is the checklist used, but it's used to identify issues that may come up that need to be addressed in order to make the processes more reliable.

And you also need a way to use data to check for failures. So in this case - I'm going to be talking about failures more in a moment. But failures are something obviously that you want to watch for. But they're both indications of a process that is not perhaps as reliable as you'd like it. But also they're a great indicator of things to address in order to make the processes more reliable.

So just a little bit of background on levels of reliability and reliability science, and, you know, you may be familiar with this but I think it's helpful to keep this in mind as you're developing your work.

So when we talk about reliability, it's important to know that there's different levels of it. And it's important to know where you are in these different levels because you will be doing different things based on the level of reliability that you have in order to improve the reliability.

So a chaotic process means that you have failure in greater than 20% of the opportunities which means that, you know, one out of five times the process doesn't work the way that it should. Another way to determine this is to ask five front line users if they can describe the process. And if they can't or if they all describe it differently, you know that you have a chaotic process.

The next level is one where you have what's called 80 or 90% level of reliability or success. And this means that there are only one or two failures out of ten opportunities. But again you might not have the same answers if you ask five front line users to describe the process. So you know that you're still not at an optimal level of reliability.

Where you want to get towards is what we call 95% success. So there's five failures or less out of a total of 100. And here you would expect that if you ask five front line users, they could all describe the process in the same way.

There's a three step model that IHI uses when we help people to strengthen their levels of reliability. This is a free download on ihi.org. It's the reference at the bottom of the slide. But basically you're doing three things.

First of all you want to prevent failures. So design the system to prevent a breakdown in operations and functions. That's sort of the first step. That's the baseline.

Then you want to identify and do what we call mitigate failures or put things in place that are going to reduce the likelihood that a failure will occur. And when you're working on this aspect of reliability, it means you want to identify the failure when it occurs and intercede before harm is caused, or if you anticipate the harm causes and put things in place that it doesn't happen, and then finally redesigning, so taking steps to reduce the process - to redesign the process on the critical failures that are identified. So those are three sort of steps in building a higher reliability.

So when I mentioned before that it's important to know where you are in terms of your reliability process because you can work - put different things in place that can help you move to the next level. So if you have a chaotic process or one where you only have 80 or 90% reliability, then you can think about doing things like these.

And these are some of things that you've been Chatting in about. So having common equipment or standard orders in place, having checklists - personal checklists - vigilance or sort of encouragement to work harder the next time, feedback or information on how well folks are doing in complying with the standard process, and finally awareness and training. So these are all things that are sort of at the baseline of what you - some of the first things that you can do to help build your reliability.

So this is an example and just a visual reminder in terms of hand hygiene. I'm sure you've all developed these or have examples of those. But then there's another level of things that you can do. If you already have 80 or 90%

reliability - so things are working pretty well - then how can you even get to that higher level where you're having what we call greater than 95% of reliability? So remember that's only one or two failures out of 100.

So here's where you do things such as standardizing the work processes or building job aides. You take advantage of preexisting work and habits. So these are things that we call building on or using human factors. So what do we as humans do and what can we build into our processes that can build on those natural ways that we work together?

So taking advantage of preexisting work and habits makes it easier for people to adapt and to do something different - makes the desire the default rather than the exception. So again going back to the affordances that I was talking about, so making it so that, you know, putting the card in the ATM machine the right way.

Or I think the example that we're probably all familiar with in terms of prescribing that, you know, having in the AMR a certain set of medications that can be prescribed. And then if the physician wants to use something other than the standard, he or she has to take another step to get there to another type of medication.

Creating redundancy - and people off ask about this. They say well, you know, isn't that inefficient? But the fact is that at least in the beginning building in a redundant step - so that means sort of a double check on making sure that things work right - is some, you know, is oftentimes a good idea. And then once the process gets working well, then you can perhaps reduce the redundancy.

Bundling related tasks is a good example. And I think we're all familiar with the bundles related to a number of the improvement areas that you've all been working on.

So these are some of the things that we call based on human factors that are a little bit higher level in terms of the types of things that you can do to build reliability. So just a few things about - to say a little bit more about some of those things that were on that list.

So it's always helpful to ask yourself how standard is your work? So I mentioned before, you know, you can ask, you know, five folks and see whether they all say the same thing. But this is a useful exercise for your team to do, and so I'm going to ask you to do this as we're on the call the afternoon. It's also something you can do, you know, outside of the call.

But to select a process from your work - so think about one of the, you know, the parts of the several changes that you've been making. And on a scale of one to five with five being the highest level of confidence, how confident are you that the process occurs the same way every time? So think about that. Think about a particular process. Think about that scale of one to five. And how confident are you that the process occurs the same way every time?

So you may think about that maybe, you know, there may be differences because you're working on a number of different processes. So if you want to think about one perhaps that has a high level - where you have a high level of confidence. And then maybe another one where there's a low level.

And then you can think about okay, what's the difference between those two things? Why is one at a higher level of reliability than the other? So Chat in the process that you selected or more than one, and your score, and then you

might want to Chat in or at least think about how you might make your work with these processes more reliable.

So another way to build your reliability or something you can do, you know, after you've done that sort of scale exercise. So a couple of techniques you can use to build reliability. First one is to go ask five. So I've been describing that.

You pick a process, you, you know, you teach the front line folks. You teach the people that are going to be doing the process. So they've been developing it so they're familiar with it. And then ask five people to describe it. And how many of the five got it right? So that's just what I've been saying in terms of, you know, asking five. And that's a good indication.

Because oftentimes people will say well, we usually do it like this. But, you know, sometimes this happens. Or, you know, so if you're getting words like usually or most of the time or some of the time or it depends, then you know that your - you don't have a reliable process.

Another thing that you can do is to observe the process. So go actually - don't just sit in a meeting and talk about it - but go out and observe it. This is often done with hand hygiene, to learn what really happens compared to what's described.

Because you might ask in a - as you're having your team meeting and everyone will say oh yes, we have a high level of confidence. Yes, we all do it the same way. But then if you go observe each other, then the variation often is - becomes more apparent. And then you can have further discussion about it.

Identifying ways to - identifying what gets in the way of reliability and then being able to address those, and then identifying tests that you could do to further strengthen that reliability.

So to specify improvements to tackle as you've done some of that diagnostic work is - to develop standard work means that you specify the changes that are documented. So you want to say who - who's going to do it - what they do, when do they do it, where do they do it and how do they do it? That's all part of what we mean by standard work.

Then you can use PDSA cycles - tests of change - to try the changes, and to identify the best way to do the particular process, and then using process measure to assess the progress over time. So you can't - I mean some of this you can do qualitatively. But you want to make sure that you're using, you know, process and outcome measures to be a check on your work - to be an indicator of how well you're actually doing.

One of the things that we've found to be really important as you're moving from, you know, doing some initial testing to actually embedding changes in the day to day work in the way that work, is done is to pay attention to mid-level managers and to help them coach and be aware of the kinds of things they can do to help, not only encourage the recommended behavior, but to put things in place that are going to reinforce those changes.

So some of the things that we've found in terms of helping those mid-level managers be able to coach - one thing is to honor the current work. So that means to be aware of why people are doing things the way that they're doing them. And what - and asking them what can help them do things in a different way, understanding that the change is hard and uncomfortable - acknowledging that.

Resisting - acknowledging that resistance to change is natural and it comes from fear of change. Building new skill development amongst the mid-level managers, so helping them become better coaches so that they have building confidence to integrate the new habit into work patterns and then having a way as we're talking about, building reliabilities - yes, building reliability and managing relapses.

So this comes from the work that Iowa Health System has done to help implement teach back. So there's just a little reference there to teach back training in a video series.

This is another slide from (Gail Neilson) at Iowa Health System who has taught us about the difference in how we teach. So teaching - education - is part of helping to make your systems reliable. But we want to be aware that there's different optimal methods for teaching.

So the old way is what we call teach and leave. So you do a session, everybody leaves and you figure okay, we did our education. Or, you know, death by slides which, you know, is perhaps a little bit of what we're doing this afternoon. But hopefully it's not too painful for you.

The old way might be, you know, trying to squeeze some training in during busy staff meetings or teaching in remote conference rooms where folks are isolated and by themselves.

But a new way which is based on what (Gail) has shared with us which is called training within industry, means that you test to reliable process. You tailor your training and your teaching around particular processes. You specify the process, you design the education in a way that's going to meet the

needs of those that you're engaging with including help aides or teaching the test group in the workplace itself so that you can - they can, you know, see, hear what is the best way to do it and then go out and try it.

Stick around to see if they can do it is taught. If needed, redesign the education. Mentoring is often a good way to do teaching so that there's a one on one aspect to it at least in the beginning. So those are some things to keep in mind in terms of how we might teach in different ways so as to help increase - improve the reliability.

And I mentioned before about using process measures to evaluate the reliability of processes. So process measures tell us whether the specific changes we're making are working as planned. And using run charts - so tracking data over time which hopefully you're all familiar with and doing - gives us feedback on the relationship between our theory about the changes that we're making and the outcomes for our patients - oh, this didn't come out very well. Sorry about that.

This is just an example of a slide that's showing - it's an example - a sample of how you might be tracking the number of missed opportunities if you're observing hand washing. So you would, you know, be tracking over - either this might be daily. Or in this case this is monthly. But it would probably be more helpful be daily.

And then to annotate this with the things - with the changes that you may be testing. So you can sort of see them in there at the bottom of the slide. You might have introduced education or posters. Or you might have, you know, done some work with the care team. And then see the results of that as you are doing your auditing of hand washing.

So that's - so these are data that are close to the process. So you can see whether the process that you're doing and the changes that you're making - what kind of affect it has on the process.

And I mean ultimately your theory is that those processes that you're doing are going to result in your outcome measures. So you all have the outcome measures in terms of CDIF and the rate. And this is just an example of tracking the improvements over time from an organization that has worked with us in seeing the reduction in the rates. So hopefully you have some graphs that look like this. But that's where we're all heading towards.

Okay. So I've been talking about the actions that you can take to improve reliability to increase the likelihood that you're able to hold the gains from your work. We've talked about it during testing here. We've talked about it during - what you do during implementation.

And then there are a set of things that you can do that are in the sort of the phase of work that we call after implementation. So after you've had - you've put in place, you've developed your reliability. It's the way - it's a standard way that things are done. But you don't want to forget about it then.

So you want to make sure that you continue to do communication around the changes, continue to publicize or document key contacts with the initial team or with the teams that are making the changes. You want to continue to build infrastructure. So these are things that, you know, could slip back. You know they could deteriorate. And so you want to keep your eye on them.

And this is a role that leaders in efforts need to play a major role in - so not just the person who's been leading the improvement work. I think one of the most important sort of insights about moving or having a high reliability

process or having systems that are sustainable is that something moves from being a project to being a part of the infrastructure and part of the way that work is done day to day.

So it also means sort of in a sense the transfer of responsibility. So there needs to be, you know, operational responsibility and accountability. So you're continuing to build infrastructure, hiring and policies - ownership is what I was mentioning and maintenance of the work to make sure that the processes are holding in place.

And then designing effective control systems - so making sure that you're continuing to track data and to be able to take some steps if you see that the data is deteriorating and going in the wrong way.

So when we're talking about reliability and sustainability and sometimes people say well, are they interchangeable? And certainly they're related but they're slightly different in their definition. So when we talk about reliability we're talking about the process provides the best care for every patient every time. That's the description of what we mean by reliable.

Sustainable means that the process never deteriorates over time regardless of the participants. So there's a, you know, sort of more of a temporal component to sustainability. It implies that the reliable process is going to continue over time.

So hopefully the discussion that we've been having so far in terms of how you build sustainability into your work as you develop and test your initial changes and then embed them in your systems in order to have systems that you consider reliable and sustainable.

So here's just a little graphic about holding the gains. We want to continue to do that. And hopefully some of the things that I've mentioned can help you as a little checklist for if your reliability is not as high as you'd like - some things that you can do that can contribute to your being able to sustain the work that you've done so far.

All right. Now what do you do when you're at the point where you have confidence in your system, you've built a reliable system? You've been implementing perhaps at a pilot level on a unit. But now you want to take the changes that you've made to all the other units in your hospital or perhaps to other hospitals in your system.

So this is where we get into the issues around spread and what we call scale up. So I'm going to transition to that. Please Chat in if there's anything that I've been saying that is confusing or that you'd like a little bit more explanation about.

And I see that a lot of the Chat is around some of the specific things - around CDIF and that's great. So I hope this is provoking some thinking on your part about your work. But if there are any particular questions about any of the content that I've been covering, please go ahead and Chat that in too.

So as we begin to talk about spread and scale, again just a reminder about that these are what we call methods for achieving results of scale. So you need to do initial testing. We've been talking about implementation.

So now we're moving into spread and scale, spread being having individuals outside the pilot adopt and adapt the changes. And scale up being identifying the structural issues that arise during spread.

So those two things are as I said before related. But they're slightly different. I like to call them sort of a different lens. So here I'm going to ask you to Chat in your sort of thinking about this.

So I'm going to tell you - give you this example. And I want you to think about whether this is the problem that these folks are having with the implementation of malaria control intervention are mainly a spread issue or a scale up issue, and again going back to the definitions.

So is the problem here the fact that the individuals either don't want to or are having trouble adopting the changes? Or is there some kind of structural issue that's going on that needs to be addressed in order for the spread to happen?

So here's the example. And this comes from a real study that was done or a real case that was written up. And this is around malaria control, you know, the use of nets. So malaria control interventions are still inadequate to reach the national and international targets to improve population health.

A key reason for this is that individuals - the target population - will not seek preventive treatment when they're pregnant, nor treatment for children with malaria. So here the situation is being described as the individuals not be willing either because of cultural differences or ingrained habits or, you know, fear of perhaps, you know, the healthcare workers or whatever it might be.

The reason here is that the individuals won't seek the treatment. So do you think this is a spread issue - one where the issue is around adoption? Or is it more a structural issue? So think about that. Chat in if you would.

In our thinking that we think this is an illustration of a spread problem because the individuals here are reluctant to adopt the treatment, all right? So it's individuals are willing - aren't willing to do something different.

But here's another way to look at that situation - perhaps a deeper understanding of what's going on here. In this case a key reason for the lack of uptake of the prevention methods is that there's inadequate systems to deliver the preventive treatment to the pregnant women or treatment itself of children with malaria.

So here I think you're getting the idea. Here we're talking about inadequate systems to deliver the treatment. So in other words people could be as willing as you want. They could be saying yes, we want to use these nets. We want to, you know, we want to use these treatments for our kids.

But if you can't get that stuff to the villages - in this case this is a lower-middle income country - if you can't get the supplies to these folks, then if they're willing to, they're not going to be able to do it. So this is the other side of the issue which is what we mean by structural or infrastructure issues.

And this was actually the case in this study that was written up. And that was the point of the study - to show that in order to do effective scaling up or spreading of these interventions, that not only do people have to pay attention to convincing people to use them, but they had to pay attention to how are they going to get these supplies as in nets to people as they become willing to use them?

So first I want to say - I want to talk a little bit about spread and some of the things to think about there. And then I'm going to talk a little bit more about

we mean by structural issues and some ways for you to think about that in your own work.

So when we talk about actions to spread improvements, we're talking about things like communication plans. So what methods are you going to use? How are you going to reach people? What is your message going to be and who's going to be the messenger? So these are things to consider in terms of communication plans to help with your spread efforts.

A useful thing is to identify earlier doctors or opinion leaders because then they can become your messengers, certainly identifying what barriers to adoption there might be. And here, you know, these can be structural issues such as the ones we're talking about.

But they can also be, you know, just things like, you know, attitudes or beliefs. If your messages don't match the concerns that people might have, then they're not going to be effective in taking people closer to adopting the changes that you'd like them to make.

And the other - another thing you can consider in terms of your actions to spread improvements is planning to track the number of doctors over time so you can see how many people in your target population, how many units in your hospital have adopted the recommended changes.

All right. So that's a really quick overview of spread. So this certainly - a lot can be said about that. Perhaps you'll have an opportunity at your upcoming meeting to delve into spread in a lot more depth. But I do want to talk a little bit more about the scale up issues - so again the method - the last method there where we want to identify and overcome the structural issues.

So some things to think about when the issue is one of the structural components, and certainly I think, you know, in any improvement process that you're undertaking in any effort to spread improvements, there's a little bit of both.

I mean there's always - you always want to consider what people's attitudes are. You're always going to need to communicate with folks so that you attract them towards the changes. The most powerful changes that can be made are those where people understand and are motivated to change and are supported in the change.

But if you don't deal with the infrastructure issues as I said before, then you're only half way there. And so what do we mean by documenting the initial structural issues and how is a good way to do that?

One way to think about it is doing what we call five times thinking. And this is something you can do as you're planning your changes. But it's also I think important because it means that you're in a sense learning your way - testing your way to scale.

So oftentimes when we start out testing something on a small scale, we might think okay, if we can do it with five people or with five providers or with five patients, then we can do it the same way if we're going to move to 25 or if we're going to move to 125.

But I think the trick to this is understanding that as you're moving up the scale to include more and more individuals in your process, that there are perhaps different structural issues that you need to have in place in order to enable that larger scale to be activated. So these are just some examples that perhaps relate to your work.

So one of the aspects of your work with CDIF is to identify the patients. So when you're dealing with five patients, there might be somebody - an individual on the unit who could look at daily lab reports. That could just be part of, you know, what they do. You could test that and that could be part of their standard work.

But if you're moving up to having more folks do that across a number of units, then certainly having some kind of daily notifications that come electronically from the lab would be a more efficient way and a more reliable way to do that.

So you might test how that would happen for 25 patients, but still in one unit, all right? So you're moving up the scale but you're not all the way up there yet. And then for a larger and larger number of patients you might have daily notifications for all the units.

So you can see there's different levels as you increase the number. There's different things that you need to think about. Another example, hand washing. When you're doing that, you know, teaching one on one might work, or, you know, sort of shadowing each other might work.

When you're moving from one to involving all the staff on a unit, then you're needing to think about you're going to do that education and how you're going to make those changes from one to many. And then if you're moving to the entire, you know, facility, then you may think about embedding the education and training into staff competencies for example.

So this is something that's done often with teach back. It starts out one to one and mentoring. But when you're really talking about scaling it up across your

facility, you need to build it into some standard way to insure that the knowledge and information is going to be imparted.

So these are the kinds of things to think about. And this is, you know, this is the kind of - you're doing testing all the way through here. So it's not just oh yes, you know, we can figure this out ahead of time. But it's part of the testing that you're doing during implementation. And then it becomes part of the testing that you're doing as you're increasing...

Operator: Please stand by just one moment.

Ms. Jackson, go right ahead.

Caroline Jackson: Okay. Thank you operator. We are trying to reconnect our speaker. I'm sorry for that inconvenience.

But while we're trying to do that, she has indicated that she can take questions in the Chat. And so I just wanted - I have a couple of reminders that I wanted to review for you at this time while we are trying to reconnect with (Maria).

We're just about at the top of our hour. But I just wanted to remind you to complete your evaluations at the end of the program. And just as a reminder, all our calls are recorded and available on line.

We got some feedback from several of you that you were trying to access some of our previous calls. And just so that you know that they're all available on Merlin, qio.org - I'm sorry, mdqio.org or dcqio.org. You can find the transcripts and the slides from all of our previous webinars there.

Also you should have received your report card for the fourth quarter 2013. And (Erica) sent out a notification email earlier this week to be sure you've received your copy. So be sure you respond to (Erica)'s email and indicate whether or not you have received your copy of your fourth quarter report card. If you haven't please let us know and we'll take every effort to make sure that you do get it.

Also...

Maria Shaw: All right, thanks.

Caroline Jackson: ...a final reminder is that we're gearing up for the Super Bowl as you know, and that there's still time to register for the April learning session. And we want to encourage you to bring your team to the big game.

Those of you have attended previous sessions know that we will have a fun packed day of learning and celebration for those of you who have been successful in achieving your CDI reduction aim.

Operator: I'm sorry, this is the operator. We do have Ms. (Shaw) reconnected.

Maria Shaw: Caroline, I am so sorry. I think I lost my WebX connection. And for some reason it does that on my phone as well. So I apologize to everybody.

But thank you everyone. I enjoyed being with you this afternoon. And just let me know if you have any questions about anything I may have said.

Caroline Jackson: Okay. Are there any questions from those of you on the line?

Operator: Ladies and gentlemen on the phones, if you have any questions you'd like to ask feel free by pressing the 1, 4 on your telephone keypad. And you'll hear a three tone prompt to acknowledge your request.

If your question has been answered, to withdraw your registration is the 1 followed by the 3.

Once again on the phone it is a 1, 4 on your telephone to ask a question. Or feel free to submit a question online using the Chat feature on your screen.

And we have no questions queued up through the phones now.

Caroline Jackson: With that I mind thank you all for participating once again today. We certainly learned a lot from (Maria). And we certainly want to thank you for providing your and sharing your expertise with us. It was great hearing from you and great learning from you as well.

Again we do apologize for the technical difficulties here at the end. The slides were pre-distributed to you prior to today's webinar session.

So thank you once again everyone for attending. Have a good rest of your day.

Operator: Thank you very much. Ladies and gentlemen, this does conclude the call for today. We thank you for your participation and ask that you disconnect your lines.

Have a great day everyone.

END