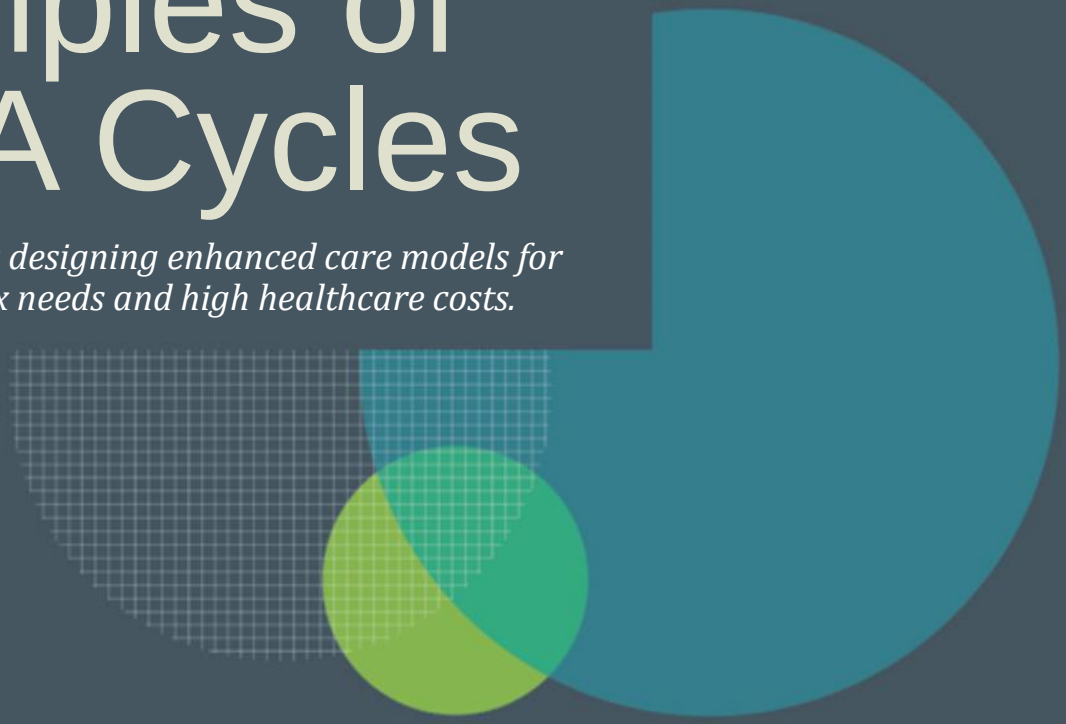
Institute *for* Healthcare Improvement

Examples of PDSA Cycles

Examples from teams designing enhanced care models for patients with complex needs and high healthcare costs.



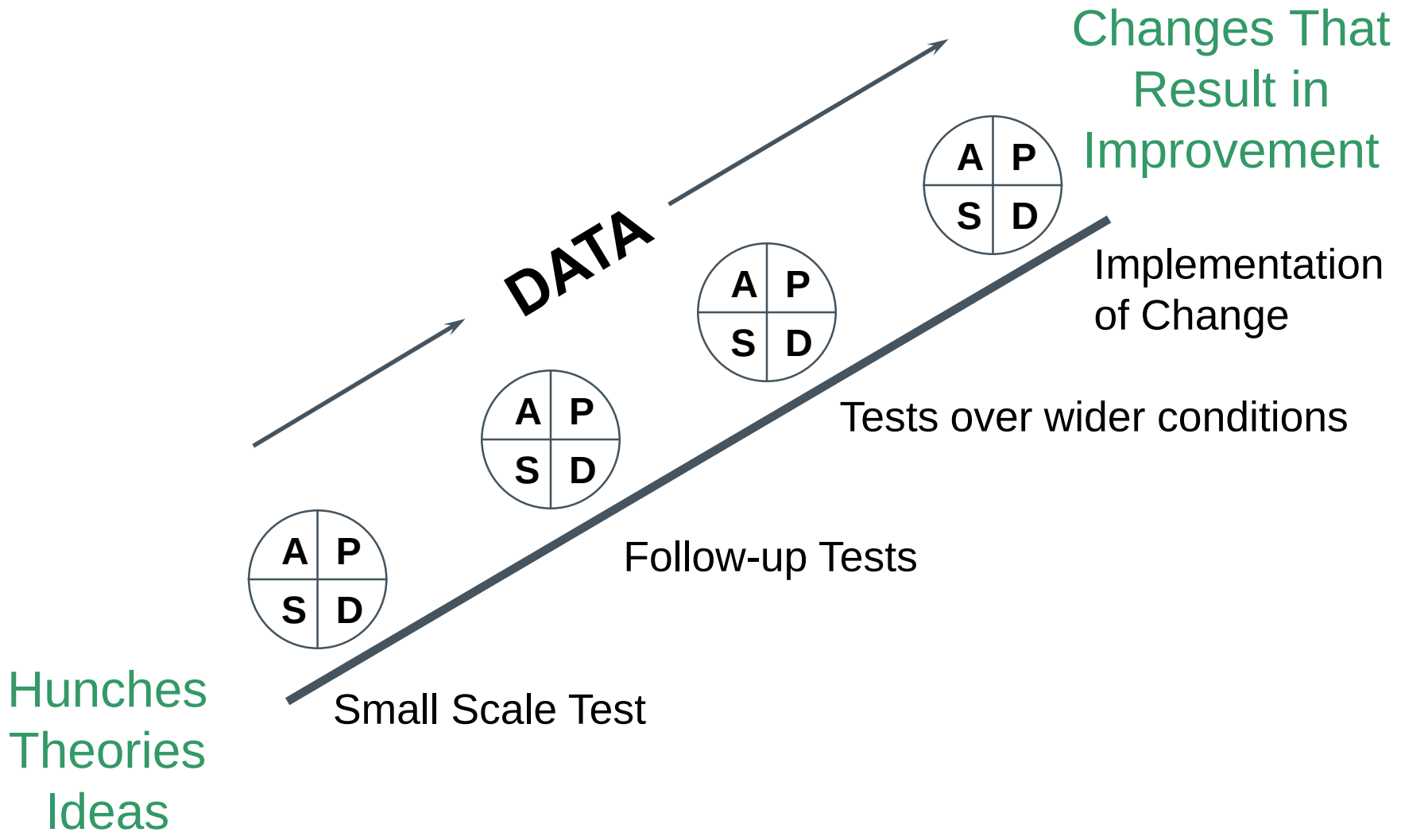
A Basic Concept of Improvement

Every system is perfectly designed to achieve the results it achieves

A Basic Concept of Improvement

Improvement of processes requires change, but all change is not improvement.

Execution Using Sequential Plan-Do-Study-Act (PDSA) Cycles



Describing a Test

- What are we testing?
- How will the test be organized? (What is our plan?)
- What did we learn?
- What revisions will we make to the current process based on the learning?
- What will be our next test?

Identification of Individuals who would benefit from an enhanced model of care

- **PDSA Cycles:**
  Patient Identification
  - #1 Review of Triage Lists
  - #2 Joint Physician Triage
  - #3 Development & Testing of an Identification Algorithm
  - #4 Refinement of an Identification Algorithm
  - #5 Analysis of 37 clinician identified children out of the 120 children screened during PDSA cycle 4 to further refine the identification algorithm

Name:
DOB:
MRN:

Categories	Medical Condition Neuro or Genetic /Metabolic Disorder with known behavioral phenotype	Developmental	Mental Health
Health Condition: Diagnoses/Symptoms	☐ Epilepsy Ie. Intractability, multiple medications	☐ Autism – or - Autism like symptoms	☐ Self-Injurious Behavior: ☐ 2-6 yr old ☐ Tissue Injury
	☐ Brain Injury or Anomaly Eg.Inflammatory, Traumatic (Frontal, Temporal), Cerebral Palsy	☐ Global Developmental Delay < 5 years old or Intellectual Disability > 5 years old	☐ Aggression – Physical at least 1x/ week
	☐ Behavioral/Cognitive Regression		☐ Severe Anxiety
	☐ Neuro-degenerative Disorder		☐ Pervasive hyperactivity or restlessness
	☐ Pain or unexplained somatic symptoms with significant impact		☐ Severe irritability and/or agitation
	☐ Genetic Conditions Examples: Angelmans IDIC15 Fragile X Smith Magenis 22q11 microdeletion Cornelia de Lange Prader Willi		☐ Psychosis
	☐ Metabolic Conditions examples: Lesch Nyhan		

Severity Factors

Severe impact on daily function ☐ Yes ☐ No ☐ Unknown
☐ Family perception ☐ Clinician perception
☐ Severely restricted participation in school/preschool/daycare
☐ Unable to participate in community activity
☐ Multiple ED visits (≥ 2) for behaviour and/or undiagnosed medical symptoms/conditions
☐ Other ______________________

Service Need

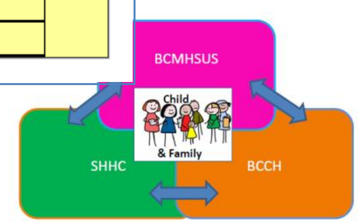
Identified Service Gap: ☐ No ☐ Unknown ☐ Yes – please explain

Do you feel this child requires the services that may be offered within an enhanced integrated Neurology/Developmental/ Mental Health Service Program? ☐ YES ☐ NO

What impact has the family's psychosocial circumstances had on your decision to recommend this child to C4?
☐ No Impact ☐ Some Impact ☐ Moderate Impact ☐ High Impact

Identified Circumstance

Parental Mental Health ☐	Low Socioeconomic Status ☐
Geographic Isolation ☐	Cultural Isolation ☐
Other – Please Explain	



Spectrum Health: Live Well Newaygo County

- What was tested?

  Recruitment approaches

- How was the test organized?

  Community worker at regular in person meeting asked 10 human service recipients if they would like to participate in a complex care program. Recipients were given an overview of the program verbally.

- What was learned?

  Participants didn’t understand program or why they should join. Only 4 agreed.

Spectrum Health: Live Well Newaygo County

- What revisions were made to the current process based on the learning?

  Created program name and introduction packet: letter in simple language, brochure, consent form, created script for community worker

- What will be the next test?

  Test new name and introduction packet, determine if further clarification is needed and/or any new approaches

Kaiser Permanente
Santa Clara Medical Center

What was tested?

- Putting together a community connector and RNP to focus on a group of 12 BHLC to complete patient centered goals of care
- Harms8 survey completed on each patient
- What to use for patient centered goals and what to do with them once completed

How was the test organized?

- We had a community connector that has the skill set and a RNP that had some time, both with the background to work with this patient population.
- We decided to pilot in our chronic conditions management team area
- We utilized staff already employed in that area that had some time to work with these patients

What was learned?

- We had to give more guidance and empowerment to the team and push for faster engagement.
- Engaging the whole team including the primary care provider was very important
- Encouraged them to learn, develop scripts that worked and how much and when to outreach for engagement.
- Helping the patients with at least 1 item, right in the beginning could help build trust in us and engagement.

What revisions were made to the current process based on the learning?

- We started to develop scripts for outreach, setting expectations, no longer was it “business as usual”, Randy started to do home visits without being prompted and the NP started coming up with patient solutions
- We asked them to “do what they had to do” to engage these patients, not just phone calls.
- We had to make a free visit, people did not want, nor should they have to pay for these visits

What will be the next test?

- Better scripts for outreach to more quickly build trust and engagement

Questions to answer

- Should the navigator be in primary care?
- How do we decide who the right person is to do this work, team based etc.
- What happens when patients refuse to engage?
- How to utilize the PAM tool for improved engagement and coaching