

The Continual Improvement of Health Care: An Overview

ECS 117

Fall 2007

**** Assignment for September 25, 2007, the first day of class ****

Before the 1st class:

- Complete the readings assigned for Session 1
- Begin journaling (see page 3)

The Continual Improvement of Health Care: An Overview

Fall 2007 Course Syllabus
Tuesdays, 8:00 am – 4:00 pm

8:00a-12:30p: Class
12:30-1:30p: Lunch
1:30-2:00p: Summary & Closing
2:00-2:30p: TA session with Teams
2:30-4:00p: Team meetings/Consultations/Work Sessions

September 25 – November 27

Professor:

Paul B. Batalden, MD

Associate Professor:

Tina Foster, MD, MPH, MS

Offices:

Novell Building, 3rd Floor

Contact Joy McAvoy (joy.mcavoy@dartmouth.edu)

603-653-3229

Office hours by appointment

Teaching Assistants:

Mao Fontanilla, MD

Auden McClure, MD

Craig Melin, MBA, MS

Brant J. Oliver, NP, MPH, MS

Class Aim:

Offer participants an opportunity to discover and preview the knowledge, methods and skills necessary to participate in, and help make sense of, the continual improvement and innovation of health care.

Learning Objectives for the Participants:

- 1. Explore the basic ingredients necessary for the continual improvement of health care.** By a wide variety of means, including reading, discussion, practice, simulation and integration exercises, participants will be invited to discover the intellectual underpinnings and connections of the fundamental theories, knowledge, methods and skills that have been found to be helpful in the continual improvement of health care.
- 2. Connect this understanding to personal work.** By classroom and course exercises, participants will be invited to reflect on and connect these ideas to what they have done, currently do, and plan to do in the future.

Course Materials:

1. Batalden PB and Stoltz P. *A Framework for the Continual Improvement of Health Care: Building and Applying Professional and Improvement Knowledge to Test Changes in Daily Work*. The Joint Commission Journal on Quality Improvement. 19(10): 425-452. October 1993. **(Posted on Blackboard under Documents)**
2. Scholtes PR, Joiner BL, Streibel BJ. The Team Handbook 3rd Edition Madison (Oriel) 2003.
3. George ML, et al. The Lean Six Sigma Pocket Toolbook: A Quick Reference Guide to 100 Tools for Improving Quality and Speed. New York (McGraw Hill) 2005.
4. Coursepack
5. Optional: Deming W Edwards. The New Economics, 2nd Ed. 1994

Five Basic Expectations of Participants:

1. Complete the Pre-Readings for Each Class. The literature in this field spans nearly a century and is drawn from multiple disciplines and all sectors of economic activity. It is important to be able to learn from all of them, without being put off by the specialized language that may be found in one setting or application. The readings have been chosen because they are either classic papers and/or authored by an expert in the field or because they get to the salient points with a wonderful parsimony of words. A few readings related to health care applications have also been included. Your completion of the readings before we discuss the issues in class will make your participation more valuable to the others in the class and will make it possible for all of us to learn more in the time we have together. Recognizing that the volume of recommended reading exceeds the capacity of some students to assimilate it all, we will offer our priorities for each week's reading, even though we also believe that all of the readings are germane to a serious effort to acquire proficiency in this subject area.

2. Attend and Participate Thoughtfully in the Class Conversations and Discussions. The art of conversation is built on careful listening and insightful questioning. Building on each other's ideas and insights is generative work. Using precious air time to re-state or advocate one more time for your point of view is generally not informative. Our work to master these ways of interacting and learning together will be an important take-away from this class. To do this well, we will need to have people who attend each session of the course, the TA sessions and who will help manage our "common" time to maximize shared inquiry and learning.

Experience has taught us that use of laptops during class disengages users and distracts other students and presenters. As a courtesy to all parties, we strongly request that no one use laptop computers during class. If you must use your computer during class to access the internet or your mail, please step out of the room.

3. Develop and Keep an Ideas/Thinking Journal.

Many ideas, and connections between those ideas, will be introduced in the readings. Capturing these thoughts a journal of ideas will help to focus what can be taken as new and potentially usable from the time spent in your reading and reflection on that reading. Each week you will be asked to write a one page comment on the ideas and questions raised for you in one or more of the readings.

This is a regular opportunity to reflect on the question, "What does _____ mean to me?" and to explore how your own life experiences, assumptions, and sensibilities inform and connect to the readings. The journal is the place where the diversity of our learning is made explicit.

Try to be comfortable with your own confusions and what you may not yet have been able to figure out. Use the journal to probe your thinking, not to prove anything.

Some helpful starters for your journals might be:

“I really don’t understand _____ because...” or

“I think the relationship between _____ and _____ is interesting because...” or

“These ideas remind me of the ideas in (*another reading*) because...”

Journals are not reports or summaries of the readings. Instead, they:

- Ask questions
- Make connections
- Begin a worthwhile dialogue

One gains a great deal from the exchange of ideas and sharing of our thoughts. Therefore, journals are exchanged on each class day with colleagues for signed review and comment. The purpose is threefold: 1) to learn from your colleagues, 2) to gain experience critically reflecting on another’s thoughts and thought processes, 3) to offer your insights, experience, and thought processes to fellow classmates and 4) to make connections between readings, projects, classroom discussions, etc.

Comments for journals should:

- Go beyond simply writing “agree/disagree”
- Ask questions and/or offer possible answers
- Expound on current thoughts
- Point out / clarify confusions
- Promote dialogue, not grading or spell-checking

After peer review during class, the journals will be reviewed and commented on by the teaching assistants between class sessions. The journals will be returned at the beginning of the next class session.

Journal-writing instructions:

1. Make your journal entries for the assigned readings on **one** typewritten page with a wide (3”) left margin. *Please use the following guidelines for journal writing: 12 point Times font, 1.5 line spacing, 3” left margin.* Consider including a header with the date and your ID number (see below).
2. Identify yourself using the last four digits of your social security number or another 4 digits of your choice-- this should be in the header of the template. We need to know what 4 numbers will be used to identify you.
3. **Before each class begins**, place your journal entry in the box marked, “Current Journal -- Uncommented.” Please check off on the sheet that you have handed in a journal entry.
4. After handing in your journal, take a colleague’s journal entry from the box. (“Current Journal – Uncommented”) Take a colleague’s journal entry **only** if you handed one in. (If you have to miss a class, please give your journal entry to one of the teaching assistants at the next class session.)
5. **Before 2:30 pm**, read and write constructive comments and questions stimulating further reflection in the margin of your colleague’s paper. Return that journal entry to the box marked, “Current Journal -- Completed Comments.” These pages will be collected and distributed among the TA’s before the end of class. They will be commented on by the TAs and returned to you the following week.
6. Journal pages with colleague and TA comments can be picked up from the box marked, “Last Week’s Journals”.
7. Keep all your own pages together (Sessions 1 - 9) and **hand in the originals with the comments** on them at the last class session (November 27). *Please be sure to put*

your name (not ID number) on the top sheet of the packet of your journals. A journal is not required for Session 10 on November 27.

Dr. Batalden will read the final packet of journal pages to gain further insight into your reading and thinking and the progression of our collective ability to thoughtfully inquire of each other throughout the term. Upon completion of Dr. Batalden's reading of your journals, your journal packet will be returned to you.

At the end of the term, Journals will be evaluated in the following areas:

- Timely completion of an entry for each session
- Demonstrated progression of thinking
- Integration of readings with class and other readings
- Relating readings to own work

****Some illustrative journals from last year's class are on Blackboard.com.**

4. Report of a Personal Improvement Effort.

At the heart of modern efforts to improve quality has been the recognition that everyone's job is to do their job and to improve their job. The Personal Improvement Project (PIP) is designed to offer class members an opportunity to experiment with an effort in personal improvement.

On the first day of class, we will explore a process for personal assessment and improvement that can offer insight into improving our own work. We will be working with four models for personal change: 1) A primer based on Dr. Harry Roberts' book Quality is Personal, is included in the Coursepack of readings. 2) The Prochaska and DiClemente model outlined in the article "In Search of How People Change: Applications to Addictive Behavior," also included in your Coursepack. (3) The Kegan and Lahey model of competing commitments which has been helpful to many. (4) The Toyota leadership development process described by Spear.

In developing your personal improvement project, you can use any or all of these models. A Personal Improvement Worksheet is also available. The aim of the assignment is to experiment with a small change that is under your personal control, using data and your own creativity—and then to reflect on what you have learned from your project about the general challenge of changing something. The outline submitted on October 2 (Session 2) will allow the TAs to help you refine your proposal.

The completed personal improvement project is due October 23rd. Please use 12 point Times font, 1.5 line spacing and limit the report to five pages (graphics may be added as supplemental material.) In a later class, we will devote some of the class time to hear selected reports and to explore lessons learned. Our focus will be on those observations and lessons learned that may offer insight into leading improvement elsewhere.

Reports will be evaluated in the following areas:

- Aim (Background, Clarity)
- Description of Process with clear definition of boundaries (where process begins and ends)
- Operationally defined measures; defined method for obtaining measures
- Data display, including display of data over time
- Balanced "time expanders" and "time contractors"
- Evidence of thoughtful reflection on your experience with Personal Improvement

PIP Outline Due: October 2nd. One of the TAs will comment on them.

PIP Due: October 23rd. Please send electronically to your TA.

Selected PIP Presentations: October 30th

5. Report of a Team Improvement Project

The AIM of this project is to provide students with a guided, critiqued experience of working in teams to connect an evidence-based synthesis of currently available knowledge about a particular condition to a particular setting with the aim of improving the care provided in that setting. This project will allow you to explore and rehearse how the domains of improvement knowledge that form the basis of this course (see below) would inform efforts to change and improve care for people with a particular need condition in a defined health care setting. Good practice is based on connecting the knowledge found in evidence-based syntheses to the actual delivery of health care. This project focuses on a practical consideration of how this might happen in a real-world setting. You will work in self-selected teams which will be facilitated by a sign-up sheet on the first class day. Each team should include a member with clinical preparation. Final team composition and condition assignments will be firm by noon of the second class day.

Successful projects:

- Integrate the whole course
- Provide a structured analysis of a worthwhile problem
- Are useful and practical
- Are interesting to readers
- Reflect thoughtful collaboration among team members

Conditions:

The following list of conditions is based on findings of the IOM regarding priority areas for improvement in health care and the IHI campaign to save 100,000 lives. Most are very broad, requiring the team to narrow the scope appropriately. Your TA and clinically-prepared member(s) of your team will be helpful here. You or someone on your team may currently work in or have worked in a clinical setting where care for that condition is delivered. It is very helpful to identify or imagine a particular setting and specific audience as you do the work of this project.

If you strongly wish to work with a condition not listed here, please contact Dr. Batalden.

Conditions:

1. Asthma
2. Care Coordination (chronic conditions)
3. Heart Failure
4. Diabetes
5. End of life with advanced organ system failure
6. Evidence-based cancer screening
7. Frailty associated with old age
8. Hypertension
9. Immunization
10. Ischemic Heart Disease (including Acute Myocardial Infarction)
11. Major Depression
12. Medication Management (including prevention of adverse drug events)
13. Nosocomial (including surgical site and Methicillin-resistant Staph (MRSA)) Infections
14. Obesity
15. Pain Management
16. Pregnancy and Childbirth
17. Self-Management and Health Literacy
18. Severe and Persistent Mental Illness
19. Stroke
20. Tobacco-dependence Treatment in Adults
21. Ventilator associated pneumonia
22. Central line sepsis
23. Rapid Response Teams
24. Community acquired pneumonia
25. Prevention of pressure ulcers

Evidence-Based Syntheses:

Richard Smith, formerly editor of the *British Medical Journal*, suggested that there has been a progression of clinically-useful information, from case studies to automated, embedded information in clinical practice. ((Smith, Richard. *What clinical information do doctors need?* *BMJ* 1996; 313: 1062-1068)

Good practice is based on scientific **studies** which can form the basis for systematic **reviews** and meta-analyses. This knowledge can then be collected in **syntheses** which describe optimal care for a given condition. When these syntheses are developed, the possibility then exists for **automation** as a way to incorporate these best practices into health care.

Consider the specific setting where you envision the improvement occurring. What evidence is relevant to patients in that setting with the condition of interest? What evidence would be important to use in providing the best possible care for patients with this condition? With this in mind, identify relevant evidence-based syntheses that would be useful to people working to improve care in that setting. These syntheses can be identified from a survey of standard references as well as resources that complement them. There are a number of excellent electronic resources, such as the Cochrane Database, BMJ Clinical Evidence, AHRQ's Guidelines Clearinghouse, NHS Performance Frameworks, and websites from pertinent professional organizations. It can be challenging to deal with the large number of resources, electronic and otherwise, and of high-quality and otherwise, so a thoughtful approach is important. Tom Mead, from the Biomedical Libraries, will address the class and is available for advice on how to undertake this task throughout the term. Remember that your focus in this project is NOT the assembly of such a synthesis—rather it is the rehearsal of the USE of such a synthesis in a particular clinical setting.

Your discussion of your evidence synthesis should include an overview of the resources and a discussion of their limitations in the context of the condition in question and the setting you have in mind. Bear in mind that you are NOT being asked to develop the syntheses; you are being asked to FIND them and to assess their utility for introducing scientifically grounded change in the setting you have chosen. Remember that finding evidence syntheses is just the first step in this project. You will need plenty of time to complete the heart of this project: "Advice for Improvers." Some teams have found it helpful to set a date by which the Portfolio of Evidence should be considered "complete," avoiding the temptation to spend the entire term revising and refining it.

Advice for Improvers:

This class is based on the premise that there are eight "Domains of Knowledge" helpful for those seeking to change and continually improve the care for patients, families and communities:

1. Health care as process, system. The interdependent people (patients, families, eligible populations, caregivers), procedures, activities, and technologies of health care-giving that come together to meet the need(s) of individuals and communities and the activities in which that occurs.

2. Variation and measurement. The use of measurement to understand the variation across and within systems to improve the design and redesign of health care.

3. Customer / Beneficiary knowledge. Identification of the person, persons, or groups of persons for whom health care is provided or may be provided in the future, an understanding of their needs & preferences, the roles they may play in their own health care and the relationship of health care to their needs and preferences.

4. Leading, following and making changes in health care. The methods and skills for designing and testing change in complex organizational care-giving arrangements, including the general and strategic management of people and the health care work they do in organizations.

5. Collaboration. The knowledge, methods and skills needed to work effectively in groups, to understand and value the perspectives and responsibilities of others and the capacity to foster the same in others, including an understanding of the implications of such work.

6. Social context & accountability. An understanding of the social contexts (local, regional, national, global) of health care-giving and the way that expectations arising from those social contexts are made explicit. This specifically includes an understanding of the financial impact and costs of health care.

7. Developing new locally useful knowledge. The recognition of the need for new knowledge in personal daily health professional practice and the skill to develop new knowledge through empiric testing and reflection on daily work experiences.

8. Professional subject matter. The health professional knowledge appropriate for a specific discipline and the ability to apply and connect it to all of the above.

With your evidence in hand, you are now asked to consider HOW that evidence could be applied in a given setting. Syntheses comprise generalizable evidence, but the work of health care occurs in specific contexts. Thus, it is important to think about how knowledge of the specific context can be gained, and how it might affect the implementation of the evidence. Measurement is fundamental to improvement – without it, how can we know improvement has occurred? You will be asked to think about what measures would be needed for your effort, and how knowledge of outcomes in that setting can be gained. Change does not occur spontaneously – what is needed to lead change in that setting? How will collaboration be fostered?

If it were possible to simply “install” the evidence, health care would already look very different. Well-intentioned, hard-working people are trying hard to do the right thing, but are often not successful. How does what you learn in this course help to you understand about this, and what does it suggest about ways to incorporate best practices into care?

We ask that you address each domain individually (note that domain 8, Professional Subject Matter, is largely covered by the evidence you assemble and comment upon). Some domains will be especially relevant to particular aspects of the challenges you describe; take advantage of this to make your report specific and actionable. A very general, “high-level” restatement of the basic content of this course is NOT what is desired. Your ability to apply that knowledge in your project is what we hope to see demonstrated in your project. In essence, you are “rehearsing” how you would go about taking the evidence into practice in a setting such as the one you have selected.

Teams

Each student will work with three others. Each team should include at least one person who is clinically prepared. *Since there are a limited number of clinicians in the class, this often means that multiple clinicians are not able to be on the same team.* During the first class session (September 25th), you will have an opportunity to sign up for a condition you have an interest in, meet and talk with others that have a similar interest. By noon, Session two (October 2nd), your team should be formed and a condition chosen and submitted to Dr. Batalden for

approval. You are welcome to submit the names of your proposed team members and condition earlier.

Class Sections

The class will be divided into sections of teams. Each section is led by a TA and will meet during class time for 30-45 minutes. This time will be spent in shared conversation about the readings, projects, and other topics. Your TA will review the readings and can help your team approach the project. You should plan to check in with him or her regularly about your project. The TA's have wrestled with this project themselves, so they can be very helpful! The afternoon consultation time (2:30 – 4:00) allows an opportunity for the TAs to spend time with individual teams as needed.

Library Resources

The Biomedical Libraries (Dana Library in Hanover & the Matthews-Fuller Health Sciences Library at DHMC) will be helpful to you. Go to the Reference Desk, or call 650-1660 (Dana) or 650-7660 (MFHSL). Or send email to “biomedical.reference@dartmouth.edu”. Feel free to contact Tom Mead (tom.mead@dartmouth.edu) or 650-1741. Tom is the Libraries' liaison to the TDIHPCP program. You can make an appointment with him or any Reference Librarian. The Biomedical Libraries web presence is at <http://www.dartmouth.edu/~biomed>.

Format

Use 12-point Times font with 1.5 spacing and 1-inch left margins. Begin the report with a summary that is not more than one page long. The total length of the report should not exceed 25 pages. It should be comprehensive enough to be authoritative and short enough to be digestible. Longer is not necessarily better.

Due Dates

Success in this project requires that you start early and keep on task throughout the term. We ask for regular progress reports to be sure you are about where you should be and to give you an opportunity to reflect on your progress and any concerns you may have. Status reports must be turned in, but are not graded.

Week 2: *Identify teams and select conditions*

Week 3: *Status Report 1 – a brief (no more than one page) summary of the condition you have selected, the clinical setting you will consider, the patient population of interest, and the proposed aim/scope of the project.*

Week 5: *Status Report 2 – Update on progress. Search for evidence should be complete; discuss thoughts on beginning to connect evidence to practice.*

Week 7: *Status Report 3 – Update on progress. Discuss work on the eight domains of knowledge and how they relate to your condition, evidence, setting.*

Week 10: *Final Report due. **November 27th. NO EXTENSIONS.***

Team Function

Working together is a major part of this project. You will be asked periodically to assess your own skills at working as part of a group, and to assess the function of your team as a whole. These assessments will contribute to your grade in the course. Your TAs and faculty are happy to serve as resources if help is needed. The fishbone diagram on p. 11 depicts previous students' experiences and thoughts on completing this project.

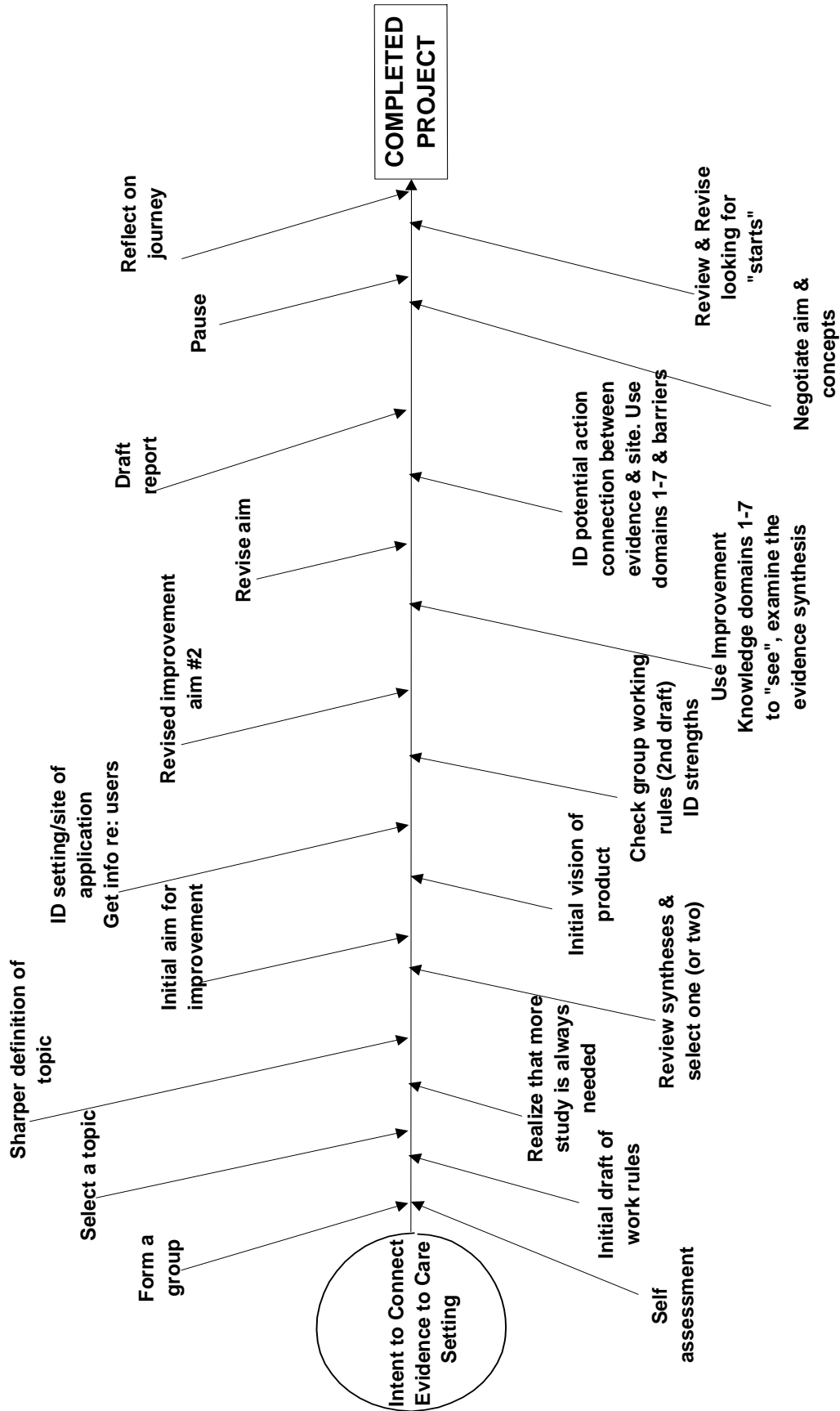
Projects will be evaluated using these criteria:

- **AIM.** Is the aim explicitly stated? If a particular perspective was chosen, is it explicit and clear? Is the population for whom care is to be improved clearly defined? If a subset of a

larger class was chosen, is it appropriately broad / narrow (big enough to be meaningful, but not so broad that only generalities are invoked)? How was the population narrowed?

- **SYNTHESES.** Is the concept of “evidence synthesis” understood? Are appropriate syntheses included? Are they understood? What is excluded? Why?
- **ADVICE FOR IMPROVERS.** Are the linkages between syntheses and domains of improvement knowledge “real”, not just a rehash of general principles? Is there evidence that the authors have given serious thought to actual application? Have the authors anticipated barriers to implementation of improvements suggested by evidence syntheses? Does the advice to improvers reflect the aim, the population and the perspective selected? Does it reflect the reality that health care is interdisciplinary? Are the beneficiaries of care adequately considered?
- **PRESENTATION.** Has the reader been considered? Is the body of the report of reasonable length, well organized, logical? Are there unique or creative aspects of the design of the report? Is the report appropriately professional, with evidence of pride in the work?

All completed projects are read by Dr. Batalden and at least one other reader, allowing you the benefit of several sets of eyes and comments. Final grades are determined by Dr. Batalden. The project will receive its own grade, which will influence the course grade, but may not be identical to it. Assessment of individual contributions to the project by fellow team members will also influence grade.



Using an Evidence Synthesis

Summary of Due Dates for Class “Deliverables”:

Sessions 1-9	Journals Due
October 2	Personal Improvement Project Outline Due
October 2	Team Improvement Project members and topic
October 9	Team Improvement Project status report 1
October 23	Personal Improvement Report Due
October 30	Team Improvement Project status report 2
November 13	Team Improvement Project status report 3
November 27	Team Improvement Project Due and final packet of original Journal Pages (with comments) are due on the last day of class.

Grading Policy:

Grades are determined primarily by the Personal Improvement Project and the final Project. Taken into consideration are the journal writings, participation in class and feedback from teammates, TAs and instructors.

Students who complete the assignments and who demonstrate evidence of the integration of the materials and applications in their own work and who manifest critical thinking in their written assignments will receive a grade of “High Pass” Students who attend the class, meet the above stated expectations and complete the assignments on time will receive a grade of “Pass.” Not completing the assignments will mean a grade of “Fail.”

The Continual Improvement of Health Care: An Overview

A Session-by-Session Outline

1. 9/25/07 Personal Learning and Change

****SELECT CONDITION AND ASSEMBLE TEAM IMPROVEMENT PROJECT TEAM****

Aim:

- Review the basic beginning point for the improvement of quality: yourself and your ability to learn from reflecting on your own ways
- Review the data on the quality of medical care and the opportunity for improvement
- Create a means by which personal insight can be translated into specific improvement opportunities
- Discuss the importance of reflection-in-action, intrinsic motivation, personal mastery and the psychology of optimal experience

Pre-readings: The Team Handbook: Introduction and Chapter 1

Pre-readings (from the Coursepack):

Argyris C. *Teaching Smart People to Learn*. Harvard Business Review. May-June 1991. pp. 99 - 109.

Roberts HV. *A Primer on Personal Quality*. Graduate School of Business, University of Chicago. August 1995. pp. 1-62

Prochaska JO, DiClemente CC, Norcross JC. *In Search of How People Change: Applications to Addictive Behavior*. American Psychologist. 47(9): September 1992. pp. 1102-1114.

Herzberg FM. *One More Time: How do you Motivate Employees?* Harvard Business Review. 65(5): September-October 1987. Pp.109-120.

Kohn, A. *Why Incentive Plans Cannot Work*. Harvard Business Review. September-October 1993. pp. 2 - 7.

Mohr J, Batalden PB. Flow Handout. Unpublished.

Norman, DA. The Psychology of Everyday Things. New York: Basic Books, 1988. *Chap. 5 To Err is Human*, pp. 105-140.

Spear SJ. "Learning to Lead at Toyota." *Harvard Business Review*. May 2004. pp. 78-86.

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under "Resources"):

McGlynn EA, Asch SM, Adams J et al. *The quality of health care delivered to adults in the United States*. New England Journal of Medicine 2003; 348 (26):2635-45.

Chassin M., Galvin RW and the National Roundtable on Health Care Quality. *The Urgent Need to Improve Health Care Quality*. Journal of the American Medical Association. 280(11): 1998. Pp.1000-1005.

Galvin, R. A Deficiency of Will and Ambition: A Conversation with Donald Berwick. *Health Affairs*, **Web Exclusive**, January 12, 2005.

Batalden PB, Davidoff F. "What is "quality improvement" and how can it transform healthcare?" Editorial in *Quality and Safety in Health Care*, 16, 2-3, February 2007.

Optional readings: (Ask Liz in the OEP office)

Harvard Business School Colloquium. Teaching by the Case Method. Cambridge, MA: Harvard Business School Publishing, 1984. *The Crisis of Professional Knowledge and the Pursuit of an Epistemology of Practice* by Donald A. Schon, pp. 241-253.

Dreyfus H, Dreyfus S. Mind Over Machine. New York: Free Press, 1986. *Chapter 1: Five Steps from Novice to Expert*. pp. 16-51.

Csikszentmihalyi M. Finding Flow: The Psychology of Engagement with Everyday Life. New York: HarperCollins, 1997. *Chapter 7: Changing the Patterns of Life*. pp. 97-115.

Greenleaf RK. On Becoming a Servant Leader. San Francisco: Jossey-Bass, Inc., 1996.

Stewart, G. Bennett. Rethinking Rewards. Harvard Business Review. November-December 1993, pp. 37 - 49.

2. 10/2/07 Context for the Continual Improvement of Health and Health Care

**** TEAM IMPROVEMENT PROJECT TEAM MEMBERS AND TOPIC DUE****
****PERSONAL IMPROVEMENT PROJECT OUTLINE DUE****

Aim:

- Describe the thinking, and some of the important contributions, of leaders of quality improvement of health care
- Review and further characterize the underlying knowledge
- Create insight into the context of the delivery of health care to patients

To prepare for this session, we've selected a set of "core" readings to give you a sense of the accomplishments of leaders of quality improvement of health care. Beyond the core readings, it is only necessary to complete the readings for one person. **These additional readings are on reserve in the library.**

In the readings for your person, please look for:

- a sense of the person—some story, symbol, signature event
- the historical context of the person and their contributions
- basic biographical facts
- evidences of the evolution of their thought
- key accomplishments and ingredients of their thinking

During class, students will be divided into "persona" teams to prepare responses to a series of discussion questions. Some candidate questions might include:

- We have no illusions that we can move forward with any sense of security about the future if we don't have our staff with us. Do you have any advice for us?

- Everyone seems to want to measure quality differently, what advice do you have for us?
- Limiting social expenditures for health care is a pressing issue for many in our society today. How should this be done?
- We're trying to become a more integrated system of care for patients and their communities, what advice do you have for us?
- As you look out on the challenges being faced by contemporary leaders in health care in the United States, how are they alike and different from those that you faced?
- Are there some threads that connect your thinking to the others we've invited here today?

There will also be time for an open question and answer session where the persona groups will field questions from the class.

Pre-Readings (from the Coursepack):

Brennan TA, Berwick DM. New Rules: Regulation, Markets, and the Quality of American Health Care. San Francisco: Jossey-Bass, Inc., 1996. *Chapter 3: The History of Research on Health Care Quality*. pp. 93-147.

Mohr J & Batalden PB. *Timeline of Some of the Evolutionary Context of Quality in Health Care*. Unpublished.

Codman EA. A Study in Hospital Efficiency [reprinted]. Chicago: Joint Commission on Accreditation of Healthcare Organizations, 1996. *Introduction: Ernest Amory Codman and the End Results of Medical Care* by Duncan Neuhauser. pp. 7-47.

Neuhauser D. Florence Nightingale: Measuring Hospital Care Outcomes. Chicago: Joint Commission on Accreditation of Healthcare Organizations. 1999. *Foreword: Florence Nightingale* by Mary Munding. pp. vii-ix.

Donabedian A. *Biographical Sketch. Personal communication to PB Batalden*. October 18, 1994.

Donabedian A. Citation Classic. February 1983, p. 304. *Evaluating the Quality of Medical Care in Milbank Memorial Fund Quarterly*. 44: 1966. pp. 166-206.

Donabedian A. *Acceptance Speech Upon Induction to Honorary Membership of the National Academy of Medicine of Mexico*. 1992. Unpublished.

Kilian CS. The World of W. Edwards Deming. Knoxville: SPC Press, Inc., 1992. *Dedication: Economic Control of Quality of Manufactured Product by W. A. Shewhart, PhD* by W. Edwards Deming, pp. 94-101.

Walton M. The Deming Management Method. New York: Putnam Publishing Group, 1986. *Chapter 1: W. Edwards Deming: A Biographical Note*. pp. 3-21.

Butman J. Juran: A Lifetime of Influence. New York: John Wiley & Sons, 1997. *Chapter 2: The Big Ship Hawthorne (1920-1941)*. pp 19 - 51.

Reason JT. [Vincent C, editor] Clinical Risk Management. London: BMJ Books, 1999. Chapter 1, "Understanding adverse events: the human factor," pp.9-30.

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under "Resources"):

Best M, Neuhauser D. *Walter A. Shewhart, 1924, and the Hawthorne Factory. Quality and Safety in Health Care*. April 2006; 15(2); pp 142-143.

Additional Readings (Ask Liz in OEP Office)

CODMAN

Codman EA. A Study in Hospital Efficiency: As Demonstrated by the Case Report of the First Five Years of a Private Hospital [reprinted]. Chicago: Joint Commission on Accreditation of Healthcare Organizations, 1996.

Codman EA. A Study in Hospital Efficiency: As Demonstrated by the Case Report of the First Five Years of a Private Hospital [reprinted]. Chicago: Joint Commission on Accreditation of Healthcare Organizations, 1996. *Recollections of Grouse Hunting with Amory Codman* by W.C. Quinby.

Donabedian A. *The End Results of Health Care: Ernest Codman's Contribution to Quality Assessment and Beyond*. Milbank Quarterly. 67: 1989. pp. 233-256.

Berwick D. *E.A.Codman and the Rhetoric of Battle: A Commentary*. Milbank Quarterly. 67:1989. pp. 262-267.

Mulley AG. *E.A.Codman and the End Results Idea: A Commentary*. Milbank Quarterly. 67:1989. pp. 257-261.

Codman EA. The shoulder: rupture of the supraspinatus tendon and other lesions in or about the subacromial bursa. Malabar, Fla.: R.E. Kreiger; 1984. [Reprint]

Mallon B. Ernest Amory Codman: the end result of a life in medicine. Philadelphia: Saunders. 2000.

DEMING

Neave H. The Deming dimension. Knoxville: SPC Press, 1990. pp. 13-27.

Killian CS. The world of W. Edwards Deming. Knoxville: SPC Press, 1992. pp. 103-127, 129-142, 173-178.

Deming WE. Out of the crisis. Cambridge, Mass.: Massachusetts Institute of Technology Center for Advanced Engineering Study; 1986.

Voehl F, Deming WE. Deming: the way we knew him. Delray Beach, Fla.: St. Lucie Press; 1995.

DONABEDIAN

Donabedian A. *Quality in Health Care: Whose Responsibility is it?* American Journal of Medical Quality. 8: Summer 1993. pp. 32-36.

Baker R. *Avedis Donabedian: An Interview*. Quality in Health Care. 2: 1993. pp. 40-46.

Mullen F. *A Founder of Quality Assessment Encounters a Troubled System Firsthand*. Health Affairs. 20(1): January-February 2001. Pp.137-141.

Donabedian A. An introduction to quality assurance in health care. New York: Oxford University Press; 2003.

JURAN

Juran JM. *Abbreviated Curriculum Vitae*. Unpublished.

Juran JM. *Address to Business Roundtable April 7, 1993*. Wilton: Juran Institute, 1993.

Godfrey AB. *Preface to Last Word Speaking Tour of J. M. Juran*. Wilton: Juran Institute, 1994.

Juran JM. *The Quality Trilogy: A Universal Approach to Managing for Quality*. Quality Progress. August 1986. pp. 19-24.

Juran JM. *A Tale of the Twentieth Century*. The Quality Scrapbook. The Juran Institute, 1993.

NIGHTINGALE

Cohen B. *Florence Nightingale*. Scientific American. 250(3): March. pp. 128-137.

Nightingale F [Stretkowitz V - ed.]. Notes on Nursing. London: Scutari Press, 1992. Selected excerpts: pp. 3, 17, 18, 50, 51, 57-65, 67-79, 127-135, 137-156.

Ulrich BT. Leadership and Management According to Florence Nightingale. Norwalk: Appleton & Lange, 1992. pp. 2-6, 10-58.

Nightingale F. Florence Nightingale: measuring hospital care outcomes: excerpts from the books Notes on matters affecting the health, efficiency, and hospital administration of the British Army founded chiefly on the experience of the late war, and Notes on hospitals. Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations; 1999.

Dossey BM. Florence Nightingale: Mystic, Visionary, Healer. Springhouse: Springhouse, 1999.

REASON

Reason JT. Human error. Cambridge England; New York: Cambridge University Press; 1990. Chapters 1 & 3

Reason JT. Managing the risks of organizational accidents. Aldershot, Hants, England; Brookfield, Vt.: Ashgate; 1997. Chapters 1, 4, 8 & 10.

Reason J, Parker D, Lawton R. *Organizational controls and safety: The varieties of rule-related behaviour*. Journal of Occupational & Organizational Psychology 1998; 71 (4):289-304.

Reason JT. *Achieving a safe culture: theory and practice*. Work and Stress, 1998; 12, 293-306.

Reason JT. [Vincent C, editor] Clinical Risk Management. London: BMJ Books; 1999. Chap. 1, "Understanding adverse events: the human factor," 9-30.

SHEWHART

Deming EW. Economic Control of Quality of Manufactured Product [republication of D. van Nostrand edition, 1931]. Milwaukee: American Society of Quality Control, 1980. *Dedication for Shewhart, WA*.

Bell Telephone Laboratories. *W.A. Shewhart, Obituary*. June, 1969.

Shewhart WA. *Nature and Origin of Standards of Quality*. Bell System Technical Journal. 37 (1): January 1958. pp. 1-22.

Shewhart WA, Deming WE. Statistical method from the viewpoint of quality control. New York: Dover; 1986.

3. 10/9/07 Understanding Health Care as a System

****TEAM IMPROVEMENT PROJECT STATUS REPORT #1 DUE****

Aim

- Discuss an overview of systems thinking for patient care which integrates underlying need and the work involved in producing care and health services.

- Identify ways of using systems and process knowledge to undertake tests of process change.

Pre-readings: The Team Handbook: Chapters 2 - 4

Pre-readings (from the Coursepack):

Ackoff RL. The Democratic Corporation. New York: Oxford University Press, 1994. *Chapter 1: The Emerging Concept of an Enterprise*. Pp.3-25.

Batalden PB, Mohr J. *Building Knowledge of Healthcare as a System*. Quality Management in Health Care. 5(3): Spring 1997. pp. 1 - 9.

Reason JT. Managing the Risks of Organizational Accidents. Brookfield, Vt., Ashgate, 1997. Chapter 1, pp. 1-20.

Gawande A. Complications: a Surgeon's Notes on an Imperfect Science. New York, Metropolitan Books, 2002, pp. 47-74.

Glouberman S, Zimmerman B. "Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?" York University, July 2002.

Optional readings: (Ask Liz in the OEP office)

Checkland P. Systems Thinking, Systems Practice. Chichester: John Wiley and Sons, 1981. *Tables 1a, 1b, Chapter 3: Science and the Systems Movement*, pp. 32-33, 48-49, 59-98.

Ackoff RL. The Second Industrial Revolution. Cincinnati: Forward Movement Publication.

Gharajedaghi J, Ackoff RL. *Mechanisms, Organisms, and Social Systems*. Strategic Management Journal. 5: 1984. pp. 289-300.

4. 10/16/07 Building Knowledge of Patients

Guest Speaker: Eugene C. Nelson, DSc, MPH, Director, Quality Administration, DHMC

Aim:

- Create an appreciation for what is yet to be known about patients and their needs as a means for the design of services, and to explore ways of learning about patients needs and preferences
- Discuss the importance and limits of customer satisfaction measurement
- Describe the concepts of "need" for health care in relation to patient preferences
- Define the value of patient functioning and human-centered development as a clue to the design of services and improvement
- Illustrate the connection between the measurement of satisfaction and the design of change for the improvement of health care

Pre-readings (from the Coursepack):

Gerteis M, Edgman-Levitan S, Daley J & Delbanco TL. Through the Patient's Eyes: Understanding and Promoting Patient Centered Care. San Francisco: Jossey-Bass, Inc., 1993. *Chapter 1: Introduction: Medicine and Health from the Patient's Perspective*. pp. 1-15.

Nelson EC & Batalden PB. *Patient-Based Quality Measurement Systems*. Quality Management in Health Care. 2(1):18-30. 1993.

Gawande A. *The Bell Curve: What happens when patients find out how good their doctors really are?* The New Yorker, 82-91, December 6, 2004. – **Go to Newyorker.com and do a search for Bell Curve**

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under “Resources”):

Pope C, van Royen P, Baker, R. *Qualitative Methods in Research of Healthcare Quality*. Quality Safety Health Care 2002; 11(2):148-152.

Amalberti R, Auroy Y, Berwick D, Barach P. *Five System Barriers to Achieving Ultrasafe Health Care*. Annals of Internal Medicine. 142(9):756-64. May 3, 2005.

Kiefe CI, Allison JJ, Williams OD, Person SD, Weaver MT, Weissman NW. *Improving quality improvement using achievable benchmarks for physician feedback: a randomized controlled trial*. JAMA. 285(22):2871-9, 2001.

Espinosa J, Nolan T. *Reducing Errors Made by Emergency Physicians in Interpreting Radiographs: Longitudinal Study*. British Medical Journal. 320(7237):737-740, 2000.

Jaipaul CK, Rosenthal GE. *Do hospitals with lower mortality have higher patient satisfaction? A regional analysis of patients with medical diagnoses*. American Journal of Medical Quality. 18(2):59-65, 2003.

Optional Readings: (Ask Liz in the OEP office)

Norman DA. The Invisible Computer. Cambridge, MA: The MIT Press, 1998. *Chapter 9 Human-centered Development*, pp. 185-201.

Batalden PB & Nelson EC. *Hospital Quality: Patient, Physician and Employee Judgments*. International Journal of Health Care Quality Assurance. 3(4): November 1990. pp. 7-17.

Caldwell C. The Handbook for Managing Change in Health Care. Milwaukee: ASQC Press, 1998. Chapter 9: *Measuring Clinical Outcomes at the Front Line*, by EC Nelson, ME Splaine, PB Batalden & SK Plume.

Meyer JA, Wicks EK, Rybowski LS & Perry MJ. Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use Financial Incentives. Economic and Social Research Institute. March 1998. pp. 1-48

Stewart M, Tudiver F, Bass MJ, Dunn EV & Norton PG. Tools for Primary Care Research. Portland: Sage Publications, 1992. *Chapter 13: COOP Measures of Functional Status* by DW Beaufait, EC Nelson, JM Landgraf, RD Hays, JW Kirk, JH Wasson, & A Keller. pp. 151-167.

Stewart AL & Ware JE. Measuring Functioning and Well-Being. Durham: Duke University Press, 1992. *Chapter 2: The Medical Outcomes Study Framework of Health Indicators* by AL Stewart, 12-24.

Denzin NK, Lincoln YS. Handbook of qualitative research. 2nd ed. Thousand Oaks, Calif.: Sage Publications; 2000.

5. 10/23/07 Health Care as Process

****PERSONAL IMPROVEMENT PROJECT DUE****

Aim:

- Describe an approach to the graphic depiction of a process
- Describe an approach to applying that knowledge to the design of improvements
- Connect knowledge of health care as a process to safety, system/process failure

Pre-readings (from the Coursepack):

Nelson EC, Batalden PB, Plume SK & Mohr JJ. *Improving Health Care, Part 2: A Clinical Improvement Worksheet and Users' Manual*. The Joint Commission Journal on Quality Improvement. 22(8): August 1996. pp. 531-548.

Mohr JJ, Mahoney CC, Nelson EC, Batalden PB & Plume SK. *Improving Health Care, Part 3: Clinical Benchmarking for Best Patient Care*. The Joint Commission Journal on Quality Improvement. 22(9): September 1996. pp. 599-616.

Mohr JM, Batalden PB & Nelson EC. *Flowcharting: A Guide for Depicting a Process*. December 1994. Unpublished.

ICSI *Guideline Development Process*.

IOM Report: To Err is Human. Washington, DC: National Academy Press. 1999. Chapters 2 & 3. Pp.22-58.

Guideline Examples (ICSI Uncomplicated Urinary Tract Infection in Women, Nashua Acute Uncomplicated Cystitis in Non-pregnant Women).

Dekker SW. *Reconstructing human contributions to accidents: the new view on error and performance*. J Safety Res 2002; 33(3): 371-385.

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under "Resources"):

Vincent, C., S. Taylor-Adams, et al. (2000). "How to investigate and analyse clinical incidents: clinical risk unit and association of litigation and risk management protocol." British Medical Journal; 320(7237): 777-81.

Leape LL, Berwick DM & Bates DW. *What Practices Will Most Improve Safety? Evidence-Based Medicine Meets Patient Safety*. JAMA. 288(4): 2002. pp. 501-507.

Optional readings: (Ask Liz in the OEP office)

Handley, MR, Stuart, ME & Kirz, HL. *An Evidence-Based Approach to Evaluative and Improving Clinical Practice: Implementing Practice Guidelines*. HMO Practice. 8 (2): June 1994. pp. 75 - 83.

Johnson LC, Batalden PB, Corindia JT, Marrin CAS, Nelson EC & Plume SK. *Clinical Process Cost Analysis: A Promising Tool for Clinical Improvement*. Quality Management in Health Care. 5(3): Spring 1997. pp. 52 - 62.

Langely GJ, Nolan KM & Nolan TW. *The Foundation of Improvement*. Quality Progress. June 1994. pp. 80-86.

Brennan TA, Leape L. et al. *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*. New England Journal of Medicine. 324: 1991. pp. 370-376.

Leape LL, Brennan TA, et al. *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study I*. New England Journal of Medicine. 324(6): 1991. pp. 377-384.

Web site of National Patient Safety Foundation: <http://www.npsf.org/>

Wilson RM, Runciman WB, et al. *The Quality in Australian Health Care Study*. Medical Journal of Australia 163: November, 1995. pp. 458-476.

Sentinel Events: Evaluating Cause and Planning Improvement (Foreword by Troyen A. Brennan)
Chicago: Joint Commission. *Chapter 1: Sentinel Events and Errors in Health Care: In Search of a Definition and Taxonomy*. pp. 7-19.

Bates DW, Spell N, Cullen DJ, Burdick E, Laird N, Petersen LA, Small SD, Sweitzer BJ & Leape LL.
The Cost of Adverse Drug Events in Hospitalized Patients. Journal of the American Medical Association. 227 (4): January 1997. pp. 307- 311.

6. 10/30/07 Understanding Measurement and Variation *Guest Speaker: Mark Splaine, MD, MS, GIM-DHMC; Co-Director, VA Quality Scholars Fellowship*

****TEAM IMPROVEMENT PROJECT STATUS REPORT #2 DUE****

Aim:

- Discuss the study of variation over time and its relation to predictability of performance
- Explain the distinction between special and common causes of variation and their significance
- List methods that assist in the temporal display and analysis of information--run charts and control charts (XmR)
- Discuss the work of developing measures for measuring the quality of health care.
- Summarize our individual improvement efforts

Pre-readings (from the Coursepack):

Berwick DM. *Controlling Variation in Health Care: A Consultation from Walter Shewhart*. Medical Care. 29(12): December 1991. pp. 1212-1225.

Nolan TW & Provost LP. *Understanding Variation*. Quality Progress. 23(5): May 1990. pp. 70-78.

Flowchart for constructing an XmR Chart.

Nelson EC, Homa K, et al. Publicly Reporting Comprehensive Quality and Cost Data: A Health Care System's Transparency Initiative. Journal on Quality and Patient Safety. 31(10): 2005. pp. 573-584.

http://www.qualityforum.org/publications/reports/hospital_measures.asp. Click on Download Executive Summary: **National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set**.

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under "Resources"):

Shahian DM, Williamson WA, Svensson LG, Restuccia JD, D'Agostino RS. *Applications of statistical quality control to cardiac surgery*. Annals of Thoracic Surgery. 62:1351-9.

Nelson EC, Splaine ME, Batalden PB & Plume SK. *Building Measurement and Data Collection into Medical Practice*. Annals of Internal Medicine. 128(6): March 1998. pp. 460-466.

Optional readings: (Ask Liz in the OEP)

Bounds G, Yorks L, Adams M & Ranney G. Beyond Total Quality Management: Toward the Emerging Paradigm. New York: McGraw-Hill, Inc., 1994.

Hahn JH & Meeker WQ. *Assumptions for Statistical Inference*. The American Statistician. 47(1): February 1993. pp. 1-11.

Jordan JA, Jordan LM & Ranney GB. Methods for Continual Improvement with Applications to Healthcare. Detroit: Henry Ford Health Systems, 1997. pp. 215-254.

Wheeler DJ. Advanced Topics in Statistical Process Control: The Power of Shewhart's Charts. Knoxville: SPC Press, 1995.

7. 11/6/07 Collaboration

Aim:

- Discuss the natural history of work groups
- Describe the relation between conflict, diversity and learning
- Identify some common behavioral barriers to effective cooperation

Pre-readings: The Team Handbook: Chapter 6 & 7 & Appendix C

Pre-readings (from the Coursepack):

Batalden PB, Cronenwett LR, Brown LL, Moffatt C & Serrell NP. *Collaboration in Improving Care for Patients: How Can We Find Out What We Haven't Been Able to Figure Out Yet?* Journal on Quality Improvement. 24(10): 1998. pp. 609-618.

Ferguson SG, Howell WT & Batalden PB. *Knowledge and Skills Needed for Collaborative Work*. Quality Management in Health Care. 1(2): 1993. pp. 1-11.

Kohn A. No Contest: The Case Against Competition (revised edition). Boston: Houghton Mifflin, 1992. *Chapter 2: Is Competition Inevitable?: The "Human Nature" Myth*, pp.11-44.

Sasou K, Reason JT. *Team Errors: Definition and Taxonomy*. *Reliability Engineering and System Safety* 65: 1999. pp. 1-9.

Optional Readings: (Ask Liz in the OEP)

Scholtes PR. *Teams in the Age of Systems*. Quality Progress. December 1995. pp 51-59.

Mosel D & Shamp MJ. *Enhancing Quality Improvement Team Effectiveness*. Quality Management in Health Care. 1(2): 1993. pp. 47-57.

Kohn A. The Brighter Side of Human Nature: Altruism and Empathy in Everyday Life. New York: Basic Books, 1990. *Chapter 2: On the Nature of "Human Nature"*, pp. 35-59.

Arrow H., McGrath JE & Berdahl JL. Small Groups as Complex Systems. Thousand Oaks: Sage Publications, Inc, 2000, Chapter 2, pp.11-31.

8. 11/13/07 Designing Real Change and Innovation

****TEAM IMPROVEMENT PROJECT STATUS REPORT #3 DUE****

Aim:

- Contrast the difference between 1st and 2nd order change
- Describe the idea of basic concepts of change
- Discuss the role of mental models and paradigms
- Identify the role of reframing in innovation and creative thinking
- Discuss systematic thinking about barriers to innovation
- Explore the phenomena associated with resistance to change

Pre-readings (from the Coursepack):

www.ihl.org (go to 5K materials and navigate the territory)

Gustafson DH, Cats-Baril W & Alemi F. Systems to Support Health Policy Analysis: Theory, Models, and Uses. Ann Arbor: Health Administration Press, 1992. *Chapter 2: Rationality and Policymaking*. Pp.11-54.

Kotter JP. *Leading Change: Why Transformation Efforts Fail*. Harvard Business Review. March/April, 1995. Pp.59-67.

Rogers EM. *Lessons for Guidelines from the Diffusion of Innovations*. Joint Commission Journal on Quality Improvement. 21 (7): July 1995. pp. 324 - 328.

Beer M & Nohria N (eds). Breaking the Code of Change. Boston: Harvard Business Press, 1999. Chapter 11: Weick K. *Emergent vs. Planned Change*. Pp.223-241.

Weick K. "Management of Change Among Loosely Coupled Elements," in Making Sense of the Organization. Weick, K, Oxford. Blackwell, 2000. Pp.387-403.

Grimshaw JM, Shirran L, Thomas R, Mowatt G, Fraser C, Bero L, Grilli R, Harvey E, Oxman A, O'Brien MA. *Changing provider behavior: an overview of systematic reviews of interventions*. Medical Care. 39(8 Suppl 2):112-45, 2001.

Handout on first and second order change.

Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. *Diffusion of Innovations in Service Organizations: Systematic Reviews and Recommendations*. The Milbank Quarterly, Vol 82, Nov. 4, 2004 (pp. 581-629).

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under "Resources"):

Berwick DM, Calkins DR, McCannon CJ, Hackbarth AD. *The 100,000 Lives Campaign: Setting a Goal and a Deadline for improving HealthCare Quality*. JAMA. 295(3):324-7. January 18, 2006.

Berwick DM. *Disseminating Innovations in Health Care*. JAMA. 289(15):1969-75. April 16, 2003.

Mooney SE, Ogrinc G, Steadman W. *Improving emergency caesarean delivery response times at a rural community hospital*. Quality and Safety in Health Care. 16(1):60-66, 2007.

Optional Readings: (Ask Liz in the OEP office)

Ackoff RL. Creating the Corporate Future. New York: John Wiley and Sons, 1981. *Chapter 4: Formulating the Mess*. pp. 79-103.

Greer AL. *The Shape of Resistance...The Shapers of Change*. Joint Commission Journal on Quality Improvement. 21(7): July 1995. pp. 328 - 332.

Watzlawick P, Weakland JH & Fisch R. Change: Principles of Problem Formation and Problem Resolution. New York: Norton, 1974. *Chapter 7: Second-Order Change*. pp. 77-91.

Langley J, Nolan K, Nolan T, Norman C & Provost L. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. San Francisco: Jossey-Bass, Inc., 1996. *Appendix A*, pp. 293-359.

Nugent WC, Kilo CM, et al. Improving Outcomes and Reducing Costs in Adult Cardiac Surgery. Boston: Breakthrough Series Guide, 1999.

9. 11/20/07 Creating and Leading a Learning Environment for Work **Guest Speaker: Don Berwick, MD, President/CEO, Institute for Healthcare Improvement, Boston, MA.**

Aim:

- Review the importance of building trust and overcoming fear in the workplace
- Review the importance of fostering inquiry as a means of accelerating learning at work
- Discuss how one might assess the degree to which a given work environment fosters learning
- Describe the role of organizational and leadership policy as a means of fostering a learning environment for work
- Illustrate the role of positive affect and the psychology of optimal experience and what it might take to create such an environment for work
- Identify the linkage between values, purpose and vision as a means of creating positive personal identity with organizational aim--working toward a shared sense of vision and purpose

Pre-readings (from the Coursepack):

Ryan KD & Oestreich DK. Driving Fear Out of the Workplace. San Francisco: Jossey-Bass, Inc., 1998. *Chapter 3: Undiscussables: Secrets That Everyone Knows*. pp. 29- 40.

Woods DD, Cook RI. *Nine Steps to Move Forward from Error*. Cognition, Technology and Work. 4: 2002. Pp.137-144.

Reason JT. Managing the Risks of Organizational Accidents. Brookfield, Vt., Ashgate, 1997. Chapter 9, pp. 191-222.

Batalden, PB, Nelson, EC, Gardent, PB, Godfrey, MM. *Leading the Macrosystem and Mesosystem for Microsystem Peak Performance in From Front Office to Front Line: Essential Issues for Health Care Leaders*, ed. S. Berman. 2005 JCAHO: Chicago.

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under “Resources”):

Batalden, PB, Nelson, EC, Mohr, JJ, et al. *Microsystems in health care: Part 5 how leaders are leading*. Joint Commission Journal on Quality and Safety. 29(6): 2003. Pp.297-308.

Optional Readings: (Ask Liz in the OEP office)

Campbell A & Nash LL. A Sense of Mission: Defining Direction for the Large Corporation. Reading, MA: Addison-Wesley, 1992. *Chapter 1: What is Mission?* pp. 11-35.

Vaill, PB. Learning as a Way of Being. San Francisco: Jossey-Bass Inc., 1996. *Chapter 2*, pp. 79-100.

Watkins A & Marsick E. Sculpting the Learning Organization. San Francisco: Jossey-Bass Inc., 1993. *Chapter 12: Envisioning the Future: Portrait of a Learning Organization*. pp. 257-279.

Argyris C & Schön DA. Organizational Learning II. Reading, MA: Addison-Wesley, 1996. [BOOK]

10. 11/27/07 Leadership/Assessing Gains

****TEAM IMPROVEMENT PROJECT REPORT DUE****
****HAND IN PACKET OF ALL ORIGINAL JOURNAL PAGES****

Aim:

- Discuss some methods for the systematic assessment of efforts to continually improve the work of a health care organization
- Review the basic ingredients necessary for the continual improvement of health care
- Plan a path forward for connecting an understanding of improvement to personal work

Pre-readings (review):

Batalden PB & Stoltz P. *A Framework for the Continual Improvement of Health Care: Building and Applying Professional and Improvement Knowledge to Test Changes in Daily Work*. The Joint Commission Journal on Quality Improvement. 19(10): October 1993. pp. 425-452.

www.ihi.org (go to the measurement aspects of 100K initiative)

Pre-readings (from <http://www.dartmouth.edu/~biomed/> and go to ejournals under “Resources”):

Weeks WB, Hamby L, Stein A & Batalden PB. *Using the Baldrige Management System Framework in Health Care: The Veterans Health Administration Experience*. The Joint Commission Journal on Quality Improvement. 26(7): July 2000. pp. 379-387.

Shaughnessy PW, Hittle DF, Crisler KS, Powell MC, Richard AA, Kramer AM, Schlenker RE, Steiner JF, Donelan-McCall NS, Beaudry JM, Mulvey-Lawlor KL, Engle K. *Improving patient outcomes of home health care; findings from two demonstration trials of outcome-based quality improvement.* Journal of the American Geriatrics Society. 50(8):1354-64, 2002.

Weick KE, Sutcliffe KM. *Hospitals as cultures of entrapment: A re-analysis of the Bristol Royal Infirmary.* California Management Review. 45(2):73-84, 2003.

Greenfield S, Kaplan SH. *Creating a culture of quality: the remarkable transformation of the department of Veterans Affairs Health Care System.* Annals of Internal Medicine. 141(4):316-8, August 17, 2004.

Jha AK, Perlin JB, Kizer KAW, Dudley RA. *Effect of the transformation of the Veterans Affairs Health Care System on the quality of care.* New England Journal of Medicine. 348(22):2218-27, May 29, 2003.

Donabedian A. *Twenty years of research on the quality of medical care: 1964-1984.* Evaluation & the Health Professions. 8(3):243-65, 1985.

Reiber GE, Au D, McDonell M, Fihn SD. *Diabetes quality improvement in Department of Veterans Affairs Ambulatory Care Clinics: a group-randomized clinical trial.* Diabetes Care. 27(Suppl 2): B61-8, 2004.

O'Connor PJ, Desai J, Solberg LI, Reger LA, Crain AL, Asche SE, Pearson TL, Clark CK, Rush WA, Cherney LM, Sperl-Hillen JM, Bishop DB. *Randomized trial of quality improvement intervention to improve diabetes care in primary care settings.* Diabetes Care. 28(8):1890-7, 2005.

Goldberg H, et al. *Can Evidence Change the Rate of Back Surgery? A Randomized Trial of Community-Based Education.* Effective Clinical Practice. 4(3):95-104, May/June 2001.

Optional Readings:

Fisher, DC & Simmons, BP. The Baldrige Workbook for Healthcare. New York: Quality Resources, 1996

[Http://www.quality.nist.gov/](http://www.quality.nist.gov/)