



Using Quality Improvement tools for Spreading Good Practice

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Objectives

- Describe how and why spread does or doesn't happen
- Explore some strategies for successful spread
- Introduce some practical tools for spread planning and implementation:
 - Spread Potential Worksheet
 - Spread Planner
 - Spread Checklist
 - Spread Matrix



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What is Spread?

- The science of taking a local improvement (intervention, idea, process) and *actively* disseminating it across a system (e.g. within a hospital, a group of hospitals, a region, a country)



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Spread and Adoption

Spread

- Push ideas outward to others
- My agenda at the centre of a larger organization
- Use of organizational structure and hierarchy to communicate about change
- A focus on tools, techniques and processes

Adoption

- Pull ideas into myself
- My agenda at the sharp end of care
- Use of social systems to communicate about change
- A focus on relationships and facilitation

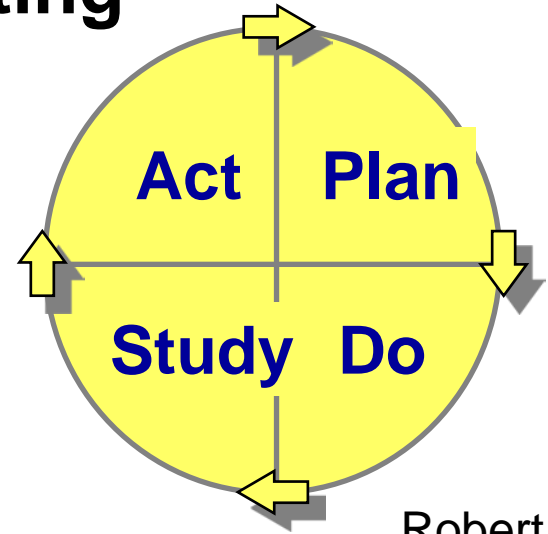
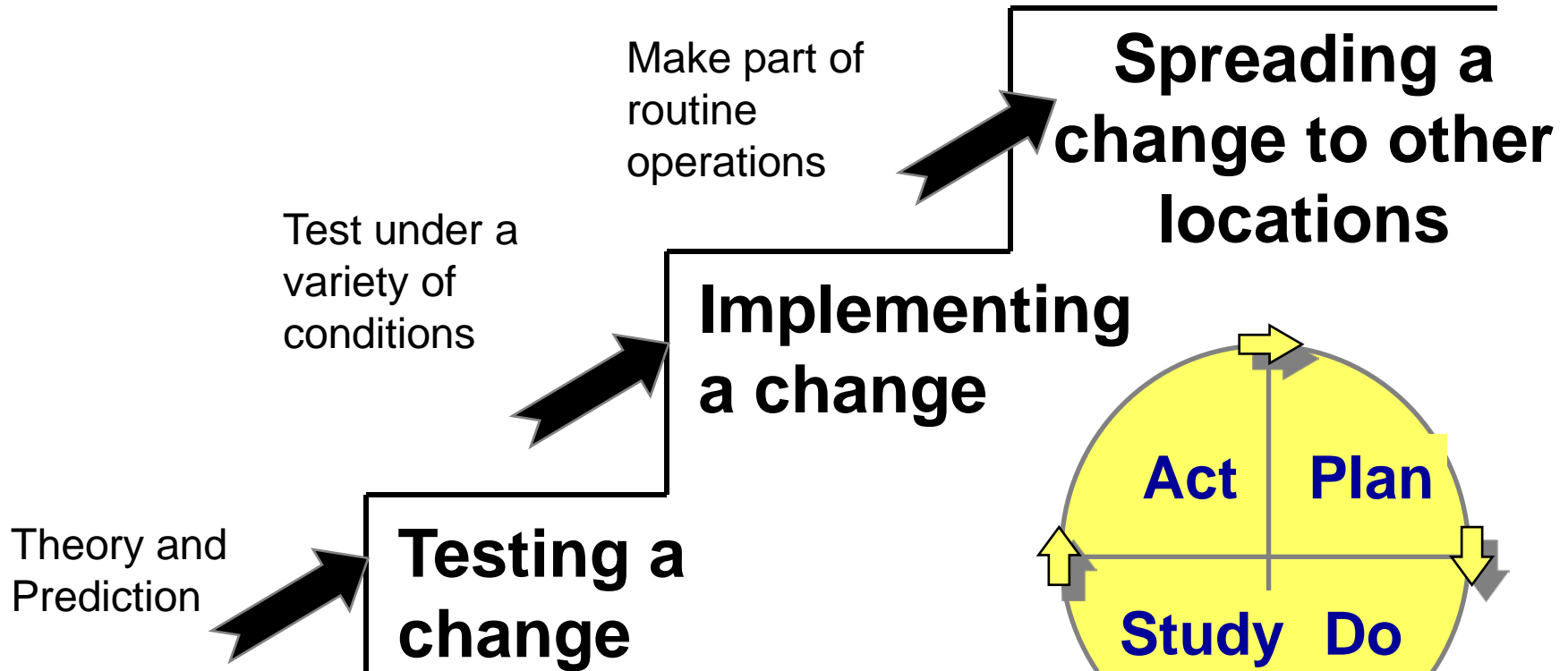
Fraser and Plsek, 2003



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From Improvement to Spread



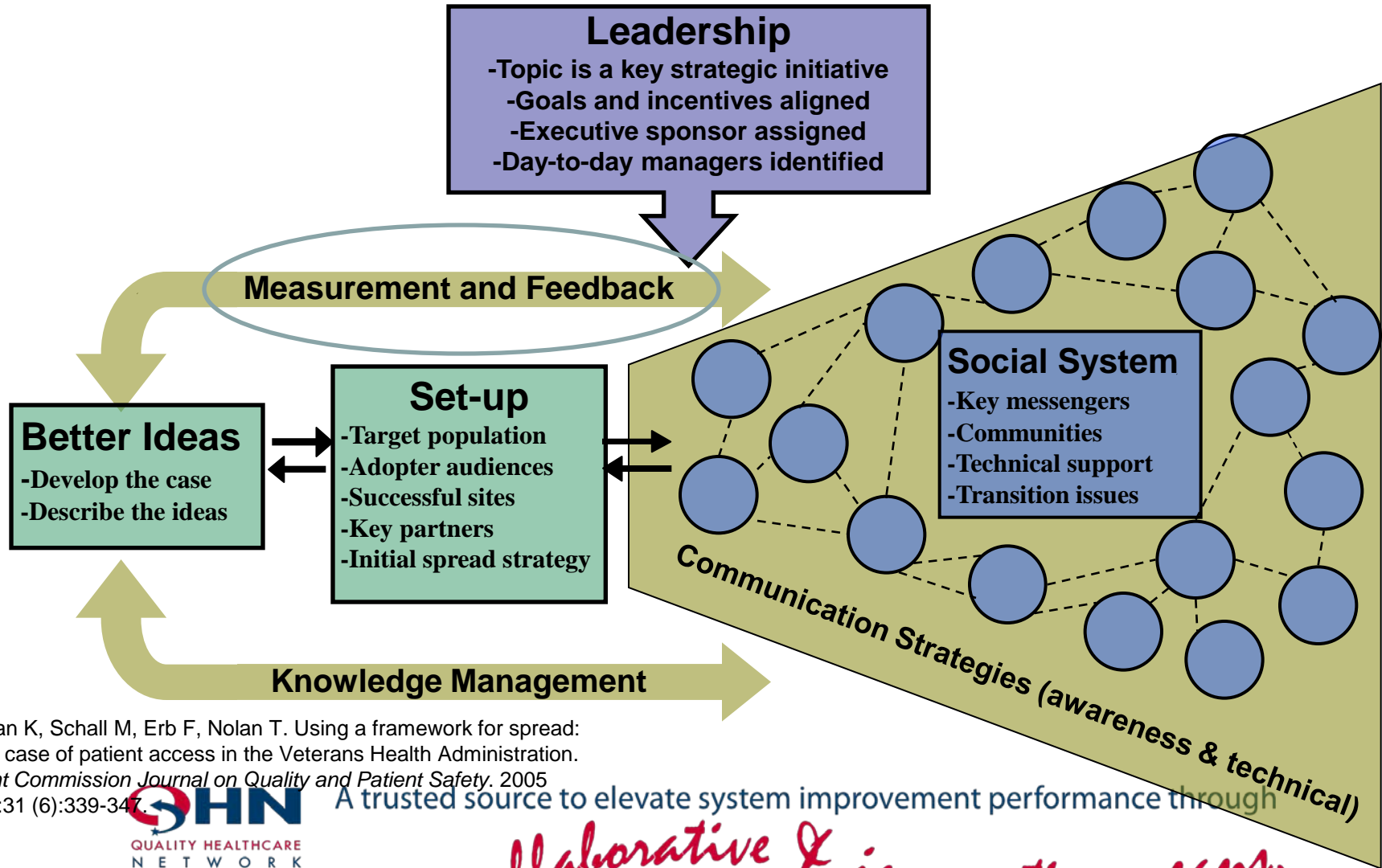
Robert Lloyd



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A Framework for Spread



Nolan K, Schall M, Erb F, Nolan T. Using a framework for spread: The case of patient access in the Veterans Health Administration. *Joint Commission Journal on Quality and Patient Safety*. 2005 Jun;31 (6):339-347.



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Tool #1: Spread Potential Worksheet

Exercise: Testing attributes

Understanding the “spreadability” of your change

Ideas that spread naturally share these attributes:

- ✓ Strength of evidence
- ✓ Relative advantage
- ✓ Simplicity
- ✓ Compatibility
- ✓ Trialability
- ✓ Observability



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Spread Potential Worksheet

Attribute	Score	Plan to Increase
Strength of evidence	○ ○ ○ ○ ○ 1 2 3 4 5	
Relative advantage	○ ○ ○ ○ ○ 1 2 3 4 5	
Simplicity	○ ○ ○ ○ ○ 1 2 3 4 5	
Compatibility	○ ○ ○ ○ ○ 1 2 3 4 5	
Trialability	○ ○ ○ ○ ○ 1 2 3 4 5	
Observability	○ ○ ○ ○ ○ 1 2 3 4 5	

Score: 1=Low 5=High

From Paul Plsek, VHA 2000 Research Series
 (Based on an idea from Jim Roberts, MD and the work of Everett Rogers)



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Ready to Spread?

- There are demonstrated **results**
- There is **will** to spread the idea within the organization
- The strategy is a **key initiative** for the organization
- A **senior leader** is responsible for spread of the changes
- There is an agreed upon **Plan** documented



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Three Key Questions for Spread

- What do we want to spread?
- To whom do we want to spread?
- How are we going to spread?



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Plan for Spread

- Develop a Spread AIM
- Leadership
- Set-up/ infrastructure
- Communication
- Social System
- Measurement and Feedback

Tool #2: Spread Planner

- Addresses all the components of Spread as identified in the Framework for Spread



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Tool #3: Spread Checklist

- Condenses the planner to a tool that spread planners and teams can use

Exercise: Where are we now with our spread planning?

What still needs to be done?

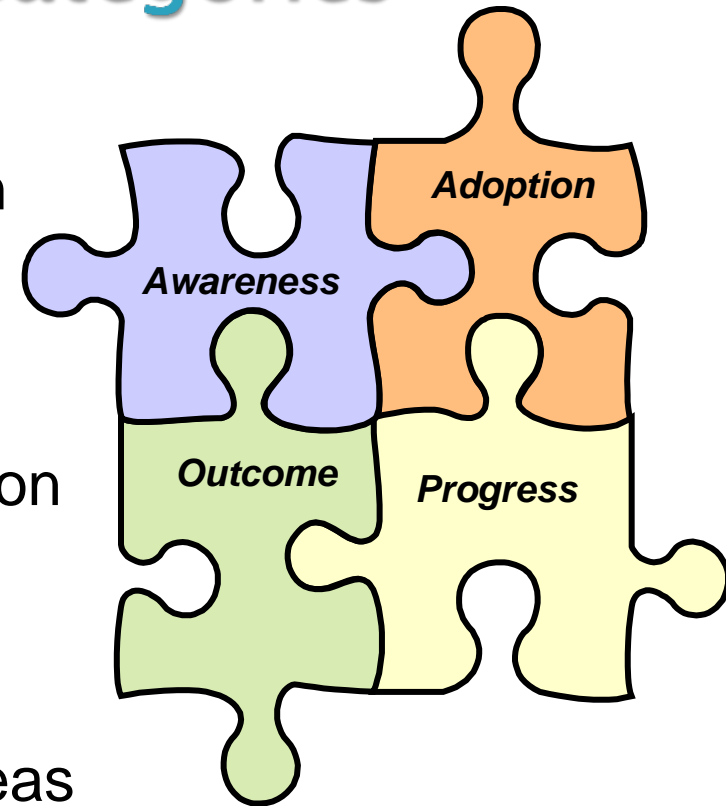


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Develop Measures in 4 Categories

1. Awareness of the change
 - Reflects spread of communication
2. Adoption of the Change
 - Reflects the integrity of the adoption
3. Outcome of the Change
 - Reflects the evidence of better ideas
4. Progress of the Change
 - Reflects the places and stage of the adoption



Tool #4: Spread Matrix

Tracking and reporting your spread progress

Spread Matrix Example: Spreading innovations to reduce C-Section rates

Spread Site	July 1999	September 1999	October 1999	November 1999	December 1999
Childbirth Ed Program	A,B,C,D	E		F	
		1 week pilot			
Great Beginnings		A,C,D,E			
Healthy Pregnancy Program			A,C,D		
Physician Clinic, OBGYN Ltd.				A,C	A,B,C,D,F
				50%	

From Sioux Valley Hospital, USD Medical Centre



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The 7 Spreadly Sins

#1

Myths and Don'ts

- **Start with Large Pilots vs Testing**
- Gives front line staff, who do not necessarily know the science, too much opportunity for input to a process
- All this testing just takes too long
- Getting too many other opinions just confuses the team since most of the time they already know what to do

Reality and Dos

- **Local Small Scale Testing, Local Implementation under multiple conditions, Spread**
- Small scale testing is crucial to learning how to neutralise or overcome barriers
- Front line staff opinions generated from small scale testing are essential in creating a clearly defined process
- Most processes can be “firmed up” in 3 or 4 cycles of testing and in the long run will be faster and have more chance of success than larger scale implementation

From: The Seven “Spreadly” Sins
Roger Resar and Carol Haranden
October 18, 2006



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The 7 Spreadly Sins

#2

Myths and Don'ts

- **Find One Person Willing to Do It All**
- A willing team member able to take the entire burden makes it easier on all other team members
- One person can then be held responsible for the process
- Commonly, we can make a lot of progress using the enthusiasm and charisma of one person

Reality and Dos

- **Spread is a TEAM effort**
- A process dependent on a single individual is basically not a sustainable process
- When key individuals are absent, the reliability of the process will deteriorate within days



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The 7 Spreadly Sins

#3

Myths and Don'ts

- **Vigilance & Hard Work**
- Just being more careful and working harder will accomplish the task. This is what I do in my clinical work.
- If only every one else worked as diligently as I do there would be no problem

Reality and Dos

- **Hold the Gains with infrastructure support**
- Hard work and vigilance cannot be maintained over the long term
- A process that succeeds using hard work and vigilance is hard to teach to new employees
- A process dependent on hard work is difficult to test for competency



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The 7 Spreadly Sins

#4

Myths and Don'ts

- If the pilot works then spread the idea unchanged
- Any customization will ruin the hard work we put into the design.
- If it works well in one area all other units should be able to do the same.
- We were taught that variation is not desirable so why should we allow it in our designs?

Reality and Dos

- **Choose the Non-negotiables but allow local customization**
- Without allowing some key elements of customization, successful spread will be very unlikely.
- Customization should be allowed, but controlled.
- Customization should be based on understanding defects. Study small samples and customize based on the learning.



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The 7 Spreadly Sins

#5

Myths - Don'ts

- **Require The Person and Team Who Drove the Pilot to be Responsible for Hospital Wide Spread**
- Since the leader of the pilot was successful who better to spread the process through the hospital
- A different leader might change the process
- The team is a multidisciplinary team already and represents the whole hospital

Reality - Dos

- **Choose the Spread Team based on the scope of the spread**
- Using the successful leader in one unit to be responsible for spread will burn out this person unless they have been specifically given the job of champion
- Allowing others to assume the responsibility helps build the infrastructure to sustain the process
- Spread requires local leaders with a common goal set by leadership



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The 7 Spreadly Sins

#6

Myths and Don'ts

- **Look at Defects on a Quarterly Basis**
- Prioritizing the defects will allow us to fix any problems as spread occurs, but we need a lot of data
- Do not get too wrapped up in the details of the defects, but rather the general themes

Reality and Dos

- **Frequently look at the spread measures to “tailor” the work of spread**
- Look at defects as they occur both when initially testing and when spreading
- Use the “10 Chart Strategy”
- Look at small samples on a daily or every other day basis



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The 7 Spreadly Sins

#7

Myths – Don'ts

- **Early on Expect Marked Improvement in Outcomes Without Attention to Process Reliability**
- Outcomes are the real focus of our work, correct?
- Even when we are still piloting on only one unit, we should monitor hospital-wide outcomes and expect improved outcomes.

Reality – Dos

- **Outcome improvement needs widespread reliable processes & implementation**
- Outcomes can not be expected to change unless processes change. Staff can be responsible for process improvement.
- If processes becomes highly reliable the outcome will follow as long as it is connected to science.
- Outcomes will change on the pilot unit *only after processes become more reliable.*



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The Human Face of Change

- Social Marketing theory
- Let's see how it really happens....
 - Example: Spread of hand washing

<http://www.crucialskills.com/2009/09/all-washed-up/>



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6 Sources of Influence

- Make the undesirable, desirable
- Surpass your limits
- Harness peer pressure
- Find strength in numbers
- Design rewards and demand accountability
- Change the environment



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The Model

Individual → Context ↓	Motivation	Ability
Personal	Make the Undesirable Desirable	Surpass Your Limits
Social	Harness Peer pressure	Find Strength in Numbers
Structural	Design Rewards and Demand Accountability	Change the Environment

In Summary

May all your spread efforts go like this...

[http://www.youtube.com/watch?v=WkBepgH00GM
&feature=related](http://www.youtube.com/watch?v=WkBepgH00GM&feature=related)



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Resources

- www.ihl.org
 - 7 Deadly Sins Of Spread, Resar. R and Haraden, C
 - A Framework for Spread, Innovation Series 2006 White Paper
 - Spread Checklist
- Spreading Good Ideas for Better Health Care: A practical toolkit, Paul Plsek, VHA 2000 Research Series, Volume 2
- OHQI:
<http://www.chqi.ca/Resources/SustainabilityandSpread.aspx>



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More Resources

- Accelerating the Spread of Good Practice: A workbook for health care. Sarah W. Fraser, 2002
- Undressing the Elephant: Why good practice doesn't spread in healthcare. Sarah W. Fraser, 2007
- www.sfassociates.biz
- The Influencer: The power to change anything. Kerry Patterson, Joseph Grenny et al



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Still More Resources

- Hand washing:

<http://www.crucialskills.com/2009/09/all-washed-up/>

- Trafalger Square:

<http://www.youtube.com/watch?v=orukqxeWmM0>

- Antwerp Train Station:

<http://www.youtube.com/watch?v=7EYAUazLI9k>



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