QUALITY CONNECTION

NEWS FROM THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

VOLUME 2, NUMBER 4 FALL, 1993

IN THIS ISSUE

BUILDING COMMUNITY COLLABORATIONS

BEYOND THE HOSPITAL WALLS

BY LISA BOISVERT

Representatives from ten communities across the U.S. and Canada recently gathered in Boston, MA for an innovative event in health improvement. What brings these communities together? It is the common aim of improving the health of their communities, and the common conviction that only by working together and breaking down traditional barriers between organizations and constituencies can that goal be achieved.

The conference launched the two-year Community-wide Health Improvement Learning Collaborative, sponsored by GOAL/QPC and the Institute for Healthcare Improvement, designed to advance the knowledge and application of continuous improvement principles to the improvement of community health. The strategy of the Collaborative is to convene leaders in community-wide health improvement at regular intervals to share experiences, learn together, and design and report on projects to improve a particular aspect of the community's health using the techniques of quality improvement.

Each community identified a particular health status issue on which to focus (see box below) and assembled a team that broadly represented the community. The goal was to choose a limited number of health status areas, based on matching interests among communities and the ability of the Collaborative to provide mentoring support from subject matter experts.

PARTICIPATING COMMUNITIES AND THEIR CHOSEN TOPICS

Infant Mortality/Morbidity
Anchorage, Alaska
Camden, New Jersey

Preventable Injuries in Children
Edmonton, Alberta
Twin Falls, Idaho
Baton Rouge, Louisiana
Kingsport, Tennessee

Prevention Issues in the Elderly
Kent County, Rhode Island
London, Ontario

Cardiovascular Health
Monroe, Louisiana
Rochester, New York

(Continued on Page 6)

(Beyond the Hospital Walls, ***continued from Page 1*****)**

Communities in the Collaborative are supported by subject mentors—experts in particular health status issues—as well as method mentors—experts in the theory and techniques of continuous improvement.

With guidance from the subject and method mentors, communities used the initial conference to plan their improvement projects. Teams returned to their communities to pursue their projects, supported by regular contact with their "sister communities," subject and method mentors, and the Planning Committee.

Perhaps the most compelling part of this project is the enthusiasm and commitment the project mentors and community representatives share in pursuing this effort. Participating experts are donating much of their time; members of the community teams will be conducting their Collaborative work above and beyond their regular full-time jobs. The effort is fueled by a spirit of cooperation, and the distinct feeling that we are participating in the making of health care history.

Lisa Boisvert is Director of TQM Research at GOAL/QPC in Methuen, MA and a method mentor for the Community Collaborative. Questions about the Community-wide Health Improvement Learning Collaborative may be directed to Marian Knapp of IHI at (617) 424-4800, or to Lisa Boisvert at (508) 685-3900.

INITIATIVE IN HEALTH PROFESSIONAL EDUCATION

BY LINDA HEADRICK, MD

The IHI's Interdisciplinary Initiative in Health Professional Education is a catalyst for change in health professional education. The goal is to stimulate educators in health administration, medicine and nursing to work together to increase the capacity for the continual improvement of health care.

The project seeks to equip new health administrators, physicians and nurses with 1) knowledge that will drive continuous improvement in the daily work of health service delivery; 2) skills in the application of that knowledge; 3) a professional ethic that supports integrated work; and 4) competency for integrated health professional work to meet individual and community health needs.

The project is coordinated by Linda Headrick, MD and Duncan Neuhauser, PhD (Case Western Reserve University School of Medicine); Colleen Conway-Welch, PhD (Vanderbilt University School of Nursing); Sherril Gelmon, DrPH (Association of University Professors of Health Administration); and Marian Knapp (IHI). Paul Batalden, MD, advises the group as liaison to the IHI Board.

Pilot projects already exist across the country, among and within all three disciplines. At CWRU, for example, medical students and faculty have initiated QI projects both in the classroom (to improve lectures and increase the use of problem-based learning) and in the clinical setting (to tailor ward rounds and clinical clerkships to better reflect the needs of the learners). Medical students and residents have also begun to work on QI teams. A team at MetroHealth Medical Center, a major teaching affiliate of CWRU, is working to improve communication among physicians, nurses and other personnel, to increase the efficiency of work on the inpatient service, and to improve its value to patients and learners. The Schools of Medicine and Nursing plan to have students work together on such teams for course credit.

The National Forum on Quality Improvement in Health Care (December 6-8 in Orlando, Florida) will provide the opportunity for sharing and peer consultation among professionals in this area, and will offer a Minicourse to discuss how teaching methods and models may be applied within and across disciplines.

Part of the Initiative's strategy is to recruit health care systems doing excellent work in QI to become teaching sites. An example is the relationship between the medical community in Twin Falls, Idaho and CWRU School of Medicine. Several CWRU medical students and residents have traveled to Twin Falls to learn about the community-based quality improvement there. We would like to hear from others who are working to include knowledge for improvement in the education of health professionals. Please take a moment to complete the attached questionnaire.

Linda Headrick, MD is Associate Professor of Medicine at CWRU, MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, OH 44109. Telephone (216) 459-3901. Fax (216) 459-3945.

IMPROVING COMMUNITY HEALTH: STAYING ON THE PATH

A REPORT ON THE COMMUNITY-WIDE HEALTH IMPROVEMENT LEARNING COLLABORATIVE

BY LISA BOISVERT, MANAGER OF INSTRUCTIONAL SERVICES, GOAL/QPC, METHUEN, MA

"I should see the garden far better," said Alice to herself, "if I could get to the top of that hill; and here's a path that leads straight to it—at least, no... how curiously it twists! It's more like a corkscrew than a path!"

—from Lewis Carroll,
"The Garden of Living Flowers"
Through the Looking Glass

In September, 1993, nine communities from across the U.S. and Canada joined together, at the invitation of the Institute for Healthcare Improvement and GOAL/QPC, and the Community-wide Health Improvement Learning Collaborative's journey began. The Collaborative's aim was to use the theory and methods of quality improvement to improve key health indicators in the communities (see chart) and share the learning as broadly and effectively as possible. Two years later, in September, 1995, these nine communities reconvened, accompanied by their team of committed mentors and content-knowledgeable coaches and joined by a team of independent observers, to bring a close to this phase of the two-year project. As David Luther, an observer from ASQC, summed it up, "This is one of the greatest applied learning machines I have ever seen."

FLEXIBLE BUT FOCUSED

Like Alice on her journey through Wonderland, these communities followed paths that proved at times to be "more like a corkscrew than a path." Community team members, with counsel from a team of mentors, recognized the value of incremental change, trying out small tests of change and modifying their original aim based on learning along the way. Although small cycles will likely unstraighten an improvement path, they can keep a project on target in the long run by surfacing challenges and changes early on so that team members can adjust plans and stay on course. Engaging the broader community in these small improvement cycles will build trust among the skeptics. "One PDCA cycle at a time," as one community leader said.

Community leaders shared key lessons learned about the need for adaptability in communities taking on similar challenges. Among their suggestions:

- Don't be afraid to learn as you go.
- Most important, keep your eye on the purpose of your work together.
- Expect change.
- Be tenacious in the commitment to being flexible. In an often rigid and fearful health care environment, those who are willing to move and adapt are often mistrusted or discredited.

"MANAGING THE COMMONS"

One concept that emerged in relation to capturing learning from this project is based on the traditional notion of "the Commons:" land from which the entire community can reap, but also into which it must sow. All nine communities learned the importance of reminding members of the community that it is in everyone's best interest to make community health improvement a priority.

The nine communities and the coaching leadership of the Collaborative suggest these lessons learned to other communities:

- Make sure the people who will benefit from improvement are invested in the early stages of the improvement project.
- Provide legitimate processes for an individual or organization to gracefully enter and exit from a community improvement team. Tenure on the team should be determined by the particular role that a person or organization serves.
- Insist that everyone who is present contributes using his or her skills and knowledge.
- Expand partnerships with community leaders, and carefully orient new partners to the project's goals and process.
- Understand that individual support and organizational support are different. Mistaking one for the other can lead to unreasonable expectations and broken promises.

CONFIDENCE IN THE FACE OF SKEPTICISM

Each of the nine communities shared vivid stories of how they encountered naysayers and saboteurs along their journey toward improvement. Observers and mentors, however,

COMMUNITY / AIM	CHANGES MADE	MEASURES / RESULTS	FUTURE PLANS
Anchorage, Alaska Reduce post-neonatal mortality in the native Alaskan community in the Anchorage area	"Nutaqsiivik" (Yupik for "place of renewal") clinic initiated in June, 1994, to focus on patients of known social risk and provide a continuum of services from prenatal period through first year of life.	Days between death increased from an average 34 days to 180 days.	Efforts underway to expand program.
Baton Rouge, Louisiana Reduce injuries and deaths among adolescents due to violence in the Mid City area	Established "A Safe Season" summer program to focus on conflict resolution, personal safety and self-esteem to reduce violent behavior and keep kids in school.	Number of days absent decreased from an average 11.3 days to 5.4 days.	Collaborations with other community groups; piloting teen leadership program.
Camden, New Jersey Improve the health status of women of child-bearing age and their families in the City of Camden	Established team with broad-based community representation. Identified two pilot communities and hired community health facilitators. Projects designed based on ongoing assessment of community need. Establishing local neighborhood "Learning Collaboratives."	Tracking number of primary care visits, women receiving prenatal care, children receiving early immunizations, decreases in ER visits, neonatal infant mortality and very low birth weight babies.	Using HUD and HRET grants to develop a Community Care Network.
Edmonton, Alberta Reduce the incidence of child abuse and neglect in Edmonton	Direct Service Team working on secondary prevention and crisis intervention, as well as a variety of primary prevention activities, to break cycle of abuse.	Will compare of three months of child abuse and neglect reports from 1993 and 1995; number of families and children served by DST.	Collaborative is prototype of how services could be offered on province-wide basis; potential merger with another project with similar goals.
Kingsport, Tennessee Reduce preventable injuries to children and adolescents in the Greater Kingsport area resulting from motor vehicle accidents	Improved driver training through introduction of "Drive Smart" curriculum in five high schools; increased public awareness and involvement through public campaign.	Tracking number of students receiving improved training; eventually, number of motor vehicle injuries to children and adolescents. Various indicators of public awareness and involvement.	Implementation of curriculum in seven high schools; expansion of public awareness and involvement.
London, Ontario Reduce injuries due to falls in the elderly in the greater London area	Investigation of reasons for falls in the elderly led to testing variety of interventions, e.g., discharge elderly patients from ER with a walker rather than crutches, weekly exercise programs, curriculum development for bus drivers.	Global measures found not sensitive to project needs. Process measures on specific intervention (number of people attending education sessions, number reporting increase in physical activity).	Team will reconfigure to include key sectors within the community and serve as a catalyst for continuing efforts to reduce falls in the elderly.
Monroe, Louisiana Improve cardiovascular health in the cities of Monroe and West Monroe	Employers offered risk assessment tools to employees, implemented prevention programs, and improved care for heart attack victims in ERs.	Annual evaluation compared to baseline data on number of risk factors identified, heart attack rate, return to work after heart attack and cost. Decreased time from 60 to 27 minutes from presentation with chest pain to thrombolytic therapy.	Sponsoring agency has disbanded. Three efforts continue under their own leadership.
Rochester, New York Improve preventive cardiovascular care in Rochester	Risk assessment tool developed and piloted on hospital patients. Assessment tool used to identify interventions. HMOs have been involved to provide follow-up care.	Tracking reduction in cholesterol level, risk factors. Increase number of people with behavioral change.	Involve private practicing primary care physicians; integrate survey into admissions process, patient education and behavioral changes.
Twin Falls, Idaho Reduce the rate of teen deaths, serious injury and traffic violations due to traffic crashes in Twin Falls	Analysis of DOT data showed lack of skill and poor judgment as major factors in teen crashes. Team developed and tested driver simulator, enrolled 50 teens in pilot education on driving simulator. Data forthcoming.	Developing a community-wide integrated injury surveillance database from police department, ER, hospital and private physician data.	HRET, DOT and other grants will be used to develop a Community Care Network; if effective in preventing teen crashes, simulator will be used in statewide driver training curriculum.

noticed a different tone to how the stories were told at this conference compared to how they were told at the initial Collaborative meeting two years ago.

The difference is that these community representatives have two years of experience, progress and results behind them. They have gained competence with quality tools and content knowledge about the health indicator they are working to improve and this has built confidence. That confidence, along with cross-community support and networking, is essential to doing this type of gritty community improvement work. As Don Berwick observed, "When you create an effective alternative to the system, the system says you're crazy and irrelevant." Like Alice, community health improvement teams need the confidence to step through those big and small doors, even when no one has been there before and no one knows what's on the other side.

Among the lessons learned by the communities in the Collaborative on how to turn negative air time into positive space:

- Take success stories on the road. The more the community knows, the more it's likely to get involved.

■ Look for heroes. The enthusiastic advocates in the community can be anywhere: a police officer, a ninth-grade student, an ambulance driver, a CEO. It's through these heroes and heroines that the voices of reason will rise above the skepticism.

■ Stay focused and don't lose sight of the importance of recognizing your own successes and celebrating them. It's a long journey, made more bearable by taking pride in successes along the way.

Going Home

Finally, beneath all the tools, measuring and analyses lie the most basic things. Throughout this reflective summative event, community members told eloquent stories of what "improving the health of the community" is ultimately all about. They told of the mother who adapted to life without drugs so she could be a mother to her three children; the infant who didn't get formula because the money for it was spent on beer; and the increase in school attendance among sixth graders as a result of providing a violence-free, safe zone. As Dona Hotopp summed up, "The most significant measure of success of the Learning Collaborative is that we all kept our focus on the ultimate customer: the babies, the kids, the teenagers, and the elderly who are healthier because of our work."

These stories and many others reveal what really matters in our communities. Don Berwick, commenting on the value of the Anchorage, Alaska, project on infant mortality, said simply, "Those babies didn't die." In fact, that is what this Collaborative was all about: using quality to effect change in the world around us.

***For more information:**

For more information on the technical concepts and methods used in this project, see "The Foundation of Improvement" (Langley GJ, Nolan KM, Nolan TW. API Publishing, Silver Spring, MD. 1992. Telephone (301) 589-2974.).

For more information on specific community projects, see "The Physician's Role in Community Health Improvement," (Marian Knapp and Tom Nighswander, MD, Quality Connection, Summer, 1995, pp. 8-9) and "Applying TQM to Community Health Improvement: Nine Works in Progress" (Marian Knapp and Dona Hotopp, The Quality Letter, July-August, 1995, pp. 23-29).

Two Communities in the Learning Collaborative Receive HRET Grants

Two of the nine communities in the Community-wide Health Improvement Learning Collaborative—Camden, New Jersey, and Twin Falls, Idaho—were selected to receive three-year HRET (the American Hospital Association's Hospital Research and Educational Trust) grants averaging $225,000 to improve the health of their communities.

In a highly competitive, year-long process, 283 community partnerships applied for the grants, 49 finalists were chosen to present their qualifications in person, and 25 awards were granted. Communities were chosen on the basis of their demonstrated capability to form "community care networks"—partnerships among the various health care-related constituencies within the community to create healthier communities. Team leaders from Camden and Twin Falls attributed their involvement in the Community Collaborative, and their experience using continuous improvement methodology to improve community health, as key factors both in their decision to apply and their ultimate success in receiving grants.

Next Steps for Community Health Improvement

To continue the work and increase our learning about community health improvement, the Institute for Healthcare Improvement and the American Society for Quality Control have joined together to run a Community-based Health Improvement Breakthrough Series Collaborative. A planning committee representing both organizations will identify and select health care delivery systems that will work with local ASQC sections to improve an important community health status issue. The committee will select a topic in the areas of injury prevention or risk reduction which will require the formation of a community team. To receive more information and an application to participate in this exciting new project, call Marian Knapp at IHI at (617) 754-4817.