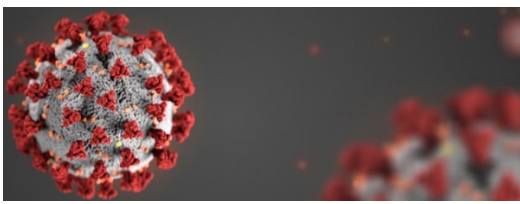




A newsletter brought to you by the Office of Research, PCS

October 2, 2020

Meet the Expert



Blurb: In this issue of Discovery, various leaders from Nursing and Patient Care Services were interviewed to gain insight on the critical role their teams played in the first response and initial surge planning of the COVID-19 Pandemic. **Click here for the full article.**

Web Article: Preparation for Care Delivery During the COVID-19 Pandemic

Amid the first, major *pandemic* in our lifetime, industries across the globe are modifying their daily operations to respond to seemingly untenable challenges, which have been brought on by the Coronavirus! From non-essential business closures and traditional schools becoming virtual, to homemakers manufacturing patient protective equipment (PPE) and healthcare organizations innovating with predictive modeling for staffing needs; we bring awareness to innovations across Stanford Health Care that are meeting the everchanging operational and patient care needs during this pandemic!

In this **Spotlight** article, you will hear from Nursing and Patient Care Services leaders across Stanford Health Care regarding the role of their respective departments in preparing for the COVID-19 Pandemic. As you can imagine, with a shared goal of delivering safe, quality patient care throughout the organization, coordination of efforts is paramount. To tell their COVID-19 response stories, each leader has answered several questions about the role of their teams; collaborations with other departments; challenges they have encountered; and, their next steps.

Key Resources

Authors: Rudy Arthofer RN, BSN, MHA, ACNO Inpatient Access, Capacity, Throughput & Efficiency, Jacob Shepherd, RN, Director, Clinical Inpatient Access and Throughput



QUESTION: What is your role/your team's role in the COVID-19 Pandemic response at Stanford Health Care?

We had two primary roles related to planning the COVID-19 Pandemic response. The first role was the Planning Chief for the Incident Command Center, which involved representing Nursing and Patient Care Services with the larger executive leadership team to address COVID-19 related incidents across Stanford Health Care (SHC). The second role involved managing the COVID-19 Surge Capacity Committee, to plan for resource needs for the anticipated increases in hospital census. Jacob Shepherd, Director of Clinical Inpatient Access and Throughput, led the development of the EPIC COVID-19 dashboard, which automatically pulled hospital data to reflect both COVID-19 positive patients and Persons Under Investigation (PUI) of having COVID-19 admitted at SHC.

QUESTION: What departments do you collaborate with to prepare for the COVID-19 Pandemic across the Stanford enterprise?

We were able to work with almost all the direct patient care areas and support teams. For example, we worked very closely with the Intensive Care Unit (ICU) and Acuity-Adaptable Unit (AAU) Nursing teams, Interventional Platform, Physician teams, Pharmacy, Supply Chain, and Respiratory, among other departments. The Clinical and Business Analytics and Information Technology partners played a huge role supporting data analysis and ongoing monitoring. Overall, too many groups to list and the cooperative efforts and collaboration excelled beyond expectations. The COVID19 Surge Capacity Committee was made up of 30+ people, with members from each of these department that met 7 days a week for multiple weeks.

It focused on assessing these three items:

1. What key resources need to be tracked?
2. What is the method for tracking the resource?
3. Developing countermeasures to prepare if the demand for the resource exceeded availability.

The process followed these steps:

1. Use models to establish demand.

2. Develop a database of the available resource in house or within the system (sometimes in the county).
3. Develop countermeasures to meet the expected demand.
4. Create real time monitoring systems to alert operations when to activate the countermeasures.

The team identified seven key resources: Medical Doctor (MD) Teams, ICU & AAU bed availability, ventilators, dialysis machines, Extracorporeal membrane oxygenation (ECMO), beds, and intravenous (IV) pumps. The Patient Care Services (PCS) clinical staff (Registered Nurses, Respiratory Therapist, Physical Therapist/Occupational Therapist, etc.) were all managed via the Unit Activation (led by Gretchen Brown) and Labor Pool (Salem Paschal). Ventilators were a concern from the beginning and are a great example of the work the committee executed on. First Dr. Kristan Staudenmayer, a trauma surgeon, was a member of the committee and she worked directly with Dr. Nigam Shah's team who developed the COVID predictive models. Those models were used to make the critical decisions about the number of ventilators needed. Then Kristen Merriman, the Director of Respiratory Therapy, and her team, did an assessment of all the possible devices around Stanford that could be used as a ventilator. There were several types, and each was put in a category indicating the type of situation they would be used and the trigger to move from one category to another was developed. This indicated the gap in ventilators for which the organization then purchased more and put a request into the county. This entire plan was put together then approved at Clinical Oversight Resource Team (CORT). Then the EPIC COVID-19 dashboard had a component added showing the total number of ventilators in use by COVID-19 positive patients. This allowed ongoing monitoring to see if the "trigger" was hit when the next type of ventilator would be used. Each of the key resources had similar plans developed. Another extensive example of this work was the development of the physician surge teams and coverage plan lead by Dr. Ahuja (AAU), Dr. Staudenmayer, Dr. Sung and Dr. Rogers (ICU).

QUESTION: What is your biggest challenge in improving SHC systems and services, in preparation for the COVID-19 Pandemic?

The biggest challenge we faced was identifying the critical resource needs, such as ventilators, monitors and other biomedical equipment and staffing resources, and subsequently allocating and managing the resources across SHC clinical practice areas.

QUESTION: Can you tell us about your next steps in response to the COVID-19 Pandemic at Stanford Health Care?

The next step in the COVID-19 Pandemic response will be preparing for the winter surge, which is the expected increase in the SHC census due to the flu season. Taken together, the winter surge plus the possibility of an increase in admissions of COVID-19 positive patients, will require our steady attention to address what we expect to be a hospital already full of patients. The winter surge preparation is a very similar process to the COVID-19 response, as it requires using models to set parameters of what the census volumes could look like and subsequently developing a plan to manage that increased volume.

Staffing: Labor Pool

Authors: Salem Paschal, MSN, RN, Director, Clinical Support, Clinical Inpatient Access and Clinical Support; Austin Wilson, Program Manager; and Patrice Duhon, MSN, RN, Director, EPIC Optimization and Reporting



QUESTION: What is your role/your team's role in the COVID-19 Pandemic response at Stanford Health Care?

My department's role in the COVID-19 Pandemic response was to stand up the Contingency Staffing Operation Center (CSOC), also known as The Labor Pool Department, which was developed to provide staffing support throughout the organization and to optimize labor resources. The CSOC's goal was to help fill the staffing needs throughout SHC departments where there may have been staffing shortages and to provide to those areas with staff from units/departments that had a staffing surplus. The Labor Pool evaluated the skills and experience of surplus staff, to determine how best and where to redeploy them to units where they could be best utilized to fulfill staffing needs. In addition, staff deployed to the CSOC also had the option to volunteer to work in other areas where they were qualified and had competency. Our team's accomplishments included:

- Creating 70-90 jobs daily.
- Negotiating Collaborative Space for nurses to congregate until assigned to jobs- with social distancing in mind.
- Developing the Patient companionship program.
- Identifying and training ICU and AAU skills for COVID-19 Pandemic surge staffing.
- Expedited hiring Travel Nurses and Respiratory Therapists to support staffing needs.
- Collaborating with the Finance department to create a cost center to enable recharging Labor Pool staffing time.
- Completing a department assessment plan for all inpatient units, which identified staff competency needs.
- Collaborating with the CEDP in the creation of a manual for training plan for the Labor Pool processing center.

QUESTION: What departments do you collaborate with to prepare for the COVID-19 Pandemic across the Stanford enterprise?

Salem Paschal served as the Staffing Lead of the CSOC, Austin Wilson served as the Program Manager, and Patrice Duhon served as the Clinical Lead. Several departments collaborated, including Nursing and Patient Care Services, Ambulatory Services, Human Resources, and the Center for Education and Professional Development, among others, to support facilitation of daily and shift staff deployment across the SHC enterprise.

QUESTION: What is your biggest challenge in improving SHC systems and services, in preparation for the COVID-19 Pandemic?

Our biggest challenge was standing up the Labor Pool in a very short timeframe, which was imperative, to provide immediate staffing support across the Hospital and Ambulatory Services. The Labor Pool was launched on March 16, 2020 and concluded on May 13, 2020. William Wu, Assistant Patient Care Manager, Float Pool, was asked to lead the Labor Pool, which was followed by adding patient care managers, assistant patient care managers, human resources, members of the Nursing Quality and the Center for Education and Professional Development.

QUESTION: Can you tell us about your next steps in response to the COVID-19 Pandemic at Stanford Health Care?

Our next steps include continuing to build the Labor Pool capabilities to support staffing needs of the COVID-19 Pandemic, winter surge and other situations that require immediate staffing deployment to meet operational needs.

Unit Activation

Gretchen Brown, MSN, RN, NEA-BC, EDAC Associate Chief Nursing Informatics Officer (ACNIO), Interim Associate Chief Nursing Officer (ACNO) Inpatient Services



QUESTION: What is/was your role/your team's role in the COVID-19 Pandemic response at Stanford Health Care?

I had a few leadership roles in the COVID-19 Pandemic response at Stanford Health Care. First, I was part of the multi-department team that was tasked with evaluating our decommissioned and current areas of patient care that could be utilized as dedicated COVID-19 units, both ICU and AAU. After rigorous evaluation, the team recommended and reactivated the D1 and D2 Patient Care Units from shell to shiny floors providing all current functionality for patient care in 14 days. I attribute this speedy turn around to the team, as previously we had worked together to activate the Patient Care Services areas in 500P in similar fashion. Second, as the Associate Chief Nursing Informatics Officer (ACNIO), I partnered with Technology and Digital Solutions (TDS) to rapidly deploy, implement and educate around strategies for communication with patients in the Hospital to decrease exposure for staff as well, preserve personal protective equipment (PPE) and ensure the patient experience was as optimal as possible. Two strategies that the team implemented were Teleconferencing via Zoom on iPads in the patient's room as well as expansion of our Remote sitting application for ICU workflows. Lastly, I was asked to fill the open Associate Chief Nursing Officer (ACNO) for Inpatient in an interim position. With the rapid changing planning and information, it was important to have this role filled for coordination in Patient Care Services for all COVID activities.

QUESTION: What departments do you collaborate with to prepare for the COVID-19 Pandemic across the Stanford enterprise?

As the ACNIO, all work that my team and I engage in is always done in partnerships with clinicians, Technology and Digital Solutions (TDS), and others. During the COVID-19 response, it was important that we were rounding, listening to our clinicians on what workflows needed enhancement for safety and efficiency. Our work was to respond quickly with a solution. Some of the brainstorming that came out of that time listening helped us leverage our Teleconferencing strategy utilizing Zoom in the Inpatient areas of the hospital for example. We collaborated with physicians, Interpreter Services, Guest Services, Nursing and all Support Services along with TDS.

QUESTION: What is your biggest challenge in improving SHC systems and services, in preparation for the COVID-19 Pandemic?

While we were prepping for the COVID-19 Pandemic, the team very much felt the pressure of time. We were all watching events unfold in New York and this feeling of timeliness shaped our decisions to leverage technology that was on our network or somewhere in our environment. We knew we would not be nimble if implementation required an execution of a new contract, development of a new business relationship, or leveraging a technology that was not already proven to be user friendly for our clinicians. The team accomplished a lot moving very quickly, and ensuring we were not breaking another system was always top of mind during implementation.

QUESTION: Can you tell us about your next steps in response to the COVID-19 Pandemic at Stanford Health Care?

I believe we all are looking at COVID-19 Pandemic response as something that is here to stay and should be part of our “disaster” or “seasonal” planning to manage. The Office of ACNIO and Technology and Digital Solutions meet regularly to ensure our technology is ready for any surge so that we can pivot easily to bring back seasonal strategies more seamlessly. Some strategies that could ramp up easily include: use of semi-private beds in some areas of the facility and maintaining the Phillips® and EPIC® interfaces in these virtual beds needs to remain on the cross walk. Also, our Zoom Teleconferencing in the Inpatient areas is maturing and can be ramped up to meet increased volume. Our team did learn what our clinicians wanted long term as well. As a result, we are looking to enhance accessibility to patient’s real time data and notifications, regardless of where the clinicians may be working. We have a few projects on the roadmap to bring this capability to our clinicians soon.

Ambulatory Activation

Blake Herring, BSN, RN, OCN, NE-BC, Director, Clinical Services Cancer Center; and Donna Healy, RN PHN MSN, Administrative Director Cancer Network Infusion & Apheresis



QUESTION: What is your role/your team’s role in the COVID-19 Pandemic response at Stanford Health Care?

Donna Healy and I led the assessment and coordination of entrance to the Hospital screening, including the daily staffing of the COVID-19 screeners at the Stanford Advanced Medical Centers at 875 and 900 Blake Wilber (BW). We established a COVID-19 Assessment and Testing (CAT) clinic at 900 BW to isolate and expedite evaluation of symptomatic patients and perform COVID-19 diagnostic testing. We coordinated staffing for patient, visitor and staff COVID-19 symptom screening and the CAT clinic for the entire Stanford Advanced Medical Center (875 and 900 BW). We established a daily staffing huddle for the entire cancer care network, including Cancer Center Palo Alto, South Bay and Redwood City (CCPA, CCSB, CCRWC), to formalize regular discussions regarding sick calls, coordination of Temporary Work Agreement (TWA) time off and supply availability. We also established two daily workgroup meetings, including a one-hour Cancer COVID-19 response workgroup meeting, and a one-

hour meeting to discuss updates and changes to operations and communication plans. To ensure that frontline staff had sufficient leadership support, we developed an escalation algorithm to address symptomatic patients and caregiver requirements. We also facilitated transition of the in-person clinic to video visits, which resulted in converting over 70% of the in-person visits to video visits. We did this in the first few weeks, after the onset of the COVID-19 Pandemic. To support remote work success, we created standard work processes.

QUESTION: What departments do you collaborate with to prepare for the COVID-19 Pandemic across the Stanford enterprise?

The Clinical Cancer Services Center forged ahead with seeing and providing patient care to the cancer patient population, despite the COVID-19 Pandemic. While many other health care systems were slowing down, the cancer care program continued to see and treat patients daily. The daily cancer COVID-19 Pandemic response workgroup was available to the frontline teams, which allowed the teams to seamlessly escalate issues, provide updates on assigned tasks and address issues in real time. The ability of the cancer care team to pivot and quickly adapt to the changing landscape would not have been possible without the ability to collaborate with departments across the Stanford Health Care enterprise. The collaboration across departments enabled the cancer center to treat patients while maintaining continuity of care, quality, and safety for patients, caregivers, staff and faculty.

QUESTION: What is your biggest challenge in improving SHC systems and services, in preparation for the COVID-19 Pandemic?

The biggest challenge at the beginning of the COVID-19 Pandemic was how quickly things changed, and, the fact that the changes occurred on the same day. Our team adjusted to the frequent changes by addressing the challenges that drove the changes, such as, the need for physical space to support patients and families, accommodating visitors, and ensuring social distancing restrictions were established.

QUESTION: Can you tell us about your next steps in response to the COVID-19 Pandemic at Stanford Health Care?

Knowing that this is our new normal and maybe our normal for some time to come, our focus has now shifted to optimizing the COVID-19 Pandemic response workflows that have been developed over the last five months. Therefore, our next steps involve:

- Exploring ways in which we can align the two patient visit experiences to ensure the video visits are as positive and impactful to our patients as our in-person visits are.
- Ensuring safety of the patient, caregivers, staff and faculty, while maintaining the highest quality of care. Working on developing workflows for treating COVID-19 positive patients in the Infusion Centers and in Radiation Therapy.
- Developing standard work for virtual rooming for video visits that will follow the same workflow as in person visits. We are also looking at optimizing space in the cancer centers to provide social distancing when possible and places for staff breaks and lunches that keep the staff safe. We are also working with the specialty pharmacy team to prepare for the upcoming flu season.

Conclusion - Michelle Y. Williams TBD

Article By: Rudy Arthofer, Gretchen Brown, Blake Herring, Donna Healy, Salem Pascal, Michelle Y. Williams

Research



Blurb: Amidst the Covid-19 pandemic, engagement from front-line health practitioners in evidence-based practice, research, and clinical trials is more important than ever. In this feature, we meet two Stanford clinical nurses who have taken on special assignments with the Office of Research & Patient Care Services. Learn more about their roles and objectives in this article. **Click here for the full article.**

Web Article:

Clinical Nurses Inside ORPCS

Nick Lynch, MBA, BSN, RN and Ryan Kelley, BSN, RN, CNRN, PHN are the Chair and Chair-Elect of the Shared Leadership - Research and Innovation Council (RIC). As Chairs of RIC, Nick and Ryan have partnered with the Office of Research Patient Care Services (ORPCS) to support clinical staff research involvement at Stanford Health Care. In August, they began collaborating on research activities during a temporary placement at ORPCS as clinical nurse contributors. The goals of this collaboration are to further strengthen ORPCS support of clinical staff through key projects, including managing the influx of COVID-19 clinical trials to the bedside and the impact of COVID-19 on nurse workflow and satisfaction. Also, through this experience, Nick and Ryan hope to further inform clinical staff of the resources available through ORPCS.

Supporting Clinical Trials at SHC

Stanford Health Care's participation in clinical trials has grown as treatments for COVID-19 have become the forefront of research. With this influx, ORPCS is establishing clinical trial intake guidance for researchers and clinical staff. A primary goal is to ensure clear communication and alignment of roles and responsibilities between researchers and clinical staff. As a liaison between researchers and clinical staff, ORPCS can facilitate successful execution of research protocols by providing clinical staff the education and resources to accomplish required clinical research goals. Furthermore, an intake process is being developed for researchers to align their protocol requirements with responsibilities of clinical staff prior to their patient day one. This intake process will help both researchers and clinical staff to identify appropriate resources for successful execution of the research protocol. To accomplish these goals, Ryan is assisting by identifying, curating and distributing the education and resources needed by clinical staff to perform protocol requirements, along with developing reasonable expectations of clinical staff responsibilities.

Impact of Covid-19 RN Focus Group Study

Supporting nurses in their roles and promoting emotional wellness through times of adversity is a core value at Stanford Health Care. The COVID-19 pandemic has introduced unprecedented changes and challenging dynamics to nurses everywhere who are learning how to adapt to this new environment. ORPCS, in partnership with Ali Abolfazli, PMHNP-BC, a Nursing Development Professional Specialist and Psychiatric Liaison, is facilitating a qualitative research study with a focus on the impact of COVID-19 on RN emotional wellness and patient care. Using online RN focus groups, this study intends to capture themes related to the evolving nature of the COVID-19 pandemic for inpatient nurses at SHC, with a focus on patient care, emotional wellness and social experiences. Nick is assisting with development of focus group framework, facilitation of discussion groups, Institutional Review Board (IRB) protocols, and compilation and analyzation of results. The plan is that the results of this study may provide evidence to help support nurses in the future.



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Article by: Ryan Kelly and Nick Lynch

Education



Blurb: Are A3s overrated? Seasoned improvers learn that, while helpful, following the A3 method for problem solving does not guarantee success for an improvement project. In this article, Stanford Improvement Team leader Hurley Smith explores some of the most common reasons improvement projects fail and suggests practical advice for improvers hoping to avoid those pitfalls. **Click here for the full article.**

Web Article:

When A3 Problem Solving Fails: Practical Advice for Improvers

Much has been published about the reasons why improvement projects fail. [Six Sigma Daily](#) describes the top 5 reasons for failureⁱ, the Harvard Business Review the top three reasonsⁱⁱ, and the [Juran Institute](#) sums it up into one reason: lack of management supportⁱⁱⁱ. Though the A3 method will increase your chances of success in your improvement project, it will not make it impervious to failure. This article will explore the top reasons for project failure according to the Juran Institute and suggest practical approaches to mitigate these risks.

Failure to Select the Right Project

Two criteria must be met for optimal project selection. First, the benefit it will provide to the organization must outweigh the resources required to complete it. All organizations have a finite capacity to improve, therefore,

Careful stewardship of improvement resources is key. Second, those working on the project must be motivated to do so. Improvers are generally motivated to solve problems that exist locally because they experience them frequently. However, when improvers are asked to solve an organizational problem that they don't necessarily experience themselves, it can be challenging to remain motivated. Ideally, all projects would always be selected to satisfy both criteria. However, in complex organizations this does not always happen.

Remedy: Balance Local & Organizational Needs

The first criterion can be satisfied by performing data analysis on the proposed problem to understand how much opportunity exists. Next, consult a team member with improvement experience to weigh the opportunity against an estimate of the resources it will take to solve it. The second criterion is commonly compromised by an imbalance in project selection. The improvement team leader and their sponsor(s) should discuss the proposed project in the context of all projects: past, present, and future. If the portfolio of projects appears skewed towards those with significant organizational benefit but minimal local benefit, perhaps a project in the latter category would be a better choice. Alternatively, if most the projects have been of great local benefit but less impactful overall, perhaps it's time to tackle an organizational goal. There is no formula for the perfect project mix, but it is important that the balance between local and organizational priorities be considered to keep all stakeholders motivated.

Failure to Assemble a Team of the Right People

Once the problem and the reason why it needs to be solved are clear, the next step is to assemble a team. This is done by considering the various process experts that will be needed to fully understand the problem and the current state surrounding it. When teams have inadequate representation from essential stakeholders, the quality of the current state analysis may be compromised. The less thorough the current state analysis, the less likely hypothesized tests of change will achieve the predicted effect. Without a robust current state analysis to fall back on, the team may find themselves stuck without a clear path forward.

Remedy: Start Current State Mapping Early

One reason that teams fail to include the right people is because they are assembled before the discovery process begins and are not re-evaluated once the project is underway. To mitigate this risk, create a rough process map(s) for your project while considering who should be on the team. By making the problem visual, it is less likely that a key stakeholder will be omitted from future discussion. Also, take time to reflect on your team's composition throughout the project and resist the urge to proceed when it is clear a stakeholder is missing from the discussion! Often, this will create more work in the future.

Failure to Apply Improvement Methods Effectively

Though "A3 Thinking" is often described as common sense, the effective application of the methodology requires practice and experience. For example, consider the first step in A3 problem solving: Defining the Problem. How does a team develop a problem statement? How will they know when it's satisfactory? There aren't necessarily right or wrong answers to these questions, but some will serve the team better than others. If

there is no one on the team to guide them through their chosen method and offer helpful tools and techniques along the way, projects can easily go astray.

Remedy: Seek Improvement Expertise

When assembling the improvement team, consider including someone who has experience applying improvement methods. Many organizations have dedicated Improvement Teams of specialists who can assist when tackling high-complexity problems. Not all improvement projects require improvement experts, however. For many projects, it is sufficient to include someone on the team that has experience applying the chosen method for improvement. Identify someone who has done more improvement projects than anyone else on the team and invite them to join in that capacity.

Failure to Define Roles & Responsibilities

Clearly articulated roles and responsibilities for physicians, nurses, medical assistants, and other disciplines are crucial for optimal care delivery. To improve effectively, however, the necessary job functions are different. Who will decide when the team meets? Who sets the agenda? Who takes notes? Who manages time? Who knows how to work with data? The team will naturally assume that these activities are everyone's responsibility. But what's everyone's responsibility can easily become no one's responsibility, which means these crucial activities will not happen reliably.

Remedy: Match Needs with Interest & Ability

In the first few team meetings, consult the improvement-methods expert and create a list of all activities that will need to be conducted during the improvement project. Next, match the individuals on the team with the necessary activities according to their interest in and ability to perform that task. It is incumbent upon the team leader to empower team members in their respective roles by respecting their function on the team throughout the project.

Failure to Effectively Communicate Project Progress

Well-chosen projects will have several individuals who are vested in the project's success even though they are not attending team meetings on a regular basis. Consider the project's primary sponsor as an example. How often should they receive communication from the team? Which mode of communication should be used? What do they want to know? Improvement teams can easily get carried away with problem solving and fail to answer these questions satisfactorily. If an effective communication plan is not in place, teams may find themselves having to work backwards when barrier removal or course corrections are needed later in the project.

Remedy: Tailor Communication to your Audience

In a similar way that the project's necessary activities were mapped to team members, list all parties that may want to be updated somehow on the project's progress. Next, confer with each stakeholder starting with those who will be most instrumental to your success and determine the best communication process. Lastly, consult

your improvement-methods expert to ensure that the content of the communication is the most relevant for its audience.

Failure to Adequately Support Education and Training

As previously mentioned, the effective application of improvement methods requires practice and experience. In other words, it requires time spent *not* performing one's usual job functions. This author estimates that it takes an inexperienced improvement team approximately 20-30 hours to solve a medium complexity healthcare problem. If steps are not taken by leadership to ensure that each team member is afforded the time necessary to learn and do improvement work, the team will likely experience frequent absenteeism or worse, burnout.

Remedy: Protect Time for Learning by Doing

Once it is clear who needs to be on the improvement team, make sure there is a plan in place (endorsed by each member's chain of command) to accommodate their presence in team meetings and at team activities. For hourly employees, this might mean allocating non-productive hours to their schedule. For physicians, this may mean reducing RVU targets or adjusting call schedules. Whatever the chosen mechanism for protecting time for improvement activity, a plan must be in place.

Failure to Create Visibility to Leadership

Completed improvement projects must be made visible for team recognition and organizational learning. Team recognition is important because the significant number of hours of intellectually and emotionally challenging work deserve acknowledgement. For the organization, a significant portion of the return on investment for improvement work is the increased organizational knowledge about problems and how to solve them effectively. Furthermore, mature learning organizations should not only have a process to capture local knowledge, but to spread generalizable improvement knowledge to the improvement community at large in the form of publication. If plans are not set in place to ensure this recognition and knowledge sharing happens, it can easily be lost in the ebbs and flows of daily operations.

Remedy: Plan to Celebrate & Share Knowledge

At the outset of the improvement project, team leaders and sponsors should discuss how the project will be celebrated at its conclusion. Some examples include formal report-outs, poster presentations, graduation ceremonies, and organization-wide assemblies. In addition, the team should also consider where their work could be published and what the guidelines for publication are. There are many journals that publish improvement work submitted using the SQUIRE guidelines.^{iv} Whatever the chosen venue, ensure it is well attended and that it includes leaders in the same chain of command of those on the improvement team.

Conclusion

Improving complex systems is challenging. Over time, improvers have developed and continue to develop methodologies like A3 Thinking to guide teams through these challenges; however, they are not fail-proof. Consequently, it is incumbent upon all improvers to not only study the common failure modes of improvement

work, but also to share their collective knowledge of how they can be mitigated. Only by our collective efforts will we be able to expand our human improvement capability in our quest to become better at getting better.

If you have additional questions or would like to get in touch, please email hurleysmith@stanfordhealthcare.org.

Article by: Hurley Smith

Spotlight



Miss out on attending the Research Primer 2.0 course? Watch the live session recording to learn about managing clinical research studies from beginning to end.

[Watch Research Primer 2.0 Recording](#)

Web Article: Watch Research Primer 2.0

Article: None- Links directly to YouTube where recording is posted:

<https://youtu.be/QVTXif0adxc?t=18>

Article By: Sana Younus

ⁱ “What Causes Improvement Projects to Fail.” Six Sigma Daily, 21 May 2020, www.sixsigmadaily.com/what-causes-process-improvement-projects-to-fail.

ⁱⁱ “Avoiding Catastrophic Failures in Process Improvement.” Harvard Business Review, 23 July 2014, hbr.org/2011/04/avoiding-a-catastrophic-failur.

ⁱⁱⁱ Juran Global. “The No. 1 Reason Why Performance Improvement Programs Fail.” Wwww.Juran.Com, 3 Jan. 2017, www.juran.com/wp-content/uploads/2017/01/The-No.-1-Reason-Why-Performance-Improvement-Programs-Fail.pdf.

^{iv} “SQUIRE | QI Journals.” Squire-Statement.Org, 3 Jan. 2017, squires-tatement.org/index.cfm?fuseaction=Page.ViewPage&pageId=513.