Cyberseminar Transcript

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Series: Timely Topics of Interest

Session: Facilitating Quality Improvement at the Frontlines: Lessons Learned from a National Program

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Molly: And once again, we are at the top of the hour so I am going just going to do another brief introduction real quick for our speakers. Joining us we have Dr. Christine Hartmann, supervisory research health scientist for the VA Center for Healthcare Organization and Implementation Research, known as CHOIR, and the co-director for the VA Community Living Centers Ongoing National Center for Enhancing Resources and Training, known as CONCERT, and she’s also a research associate professor at the Boston University School of Health. Joining her today is Dr. Lynn Snow, the co-director for the CLC CONCERT center, and also at CHOIR, which is located at VA Boston Healthcare System. So at this time I would like to turn it over to Dr. Hartmann.

Dr. Christine Hartmann: Molly, thank you so much. And I will just note that Lynn is actually at the Tuscaloosa VA Medical Center, not at Boston. But also when you were going through our introductions was the first time I heard CHOIR and CONCERT together in close proximity and it does sound like there is a musical theme to my life. But I otherwise don’t notice that because I am not very good musically. But thank you very much for the introduction and welcome to everybody listening to this Cyberseminar. We are going to try to make this as interactive as possible in this type of environment. This is actually the second in a two-series Cyberseminar about research and quality improvement in the VA CLCs, or the nursing home system within the VA, known as Community Living Centers, or as I will be calling them throughout this presentation, CLCs.

And I wanted to start with a statement and asking all of you in the audience what you think about the statement that is up on the screen right now. Do you have a firm opinion about the answer or are you not committed to your opinion on the answer for this? Because this is something that we are going to be addressing in the presentation today, so I am just curious in asking you to assess your stance on all of this.

So today, the title of the talk is Facilitating Quality Improvement at the Frontlines of Care, and we are going to be talking about that in the CLCs in particular. And as Molly said, I am at the Bedford Massachusetts VA, and Lynn Snow as at the Tuscaloosa VA, and Lynn and I have had a partnership for around a decade doing this work in CLC quality improvement together. And one of the ways that we do that work in partnership is that we sometimes split our roles. And my role today is to do the talking for most of this Cyberseminar, but I am going to draw both Lynn and Lisa Minor, who is with the VA’s Office of Geriatrics and Extended Care. She is on the phone as well. And I am going to draw both of them into the conversation, particularly around the poll questions that we will have a little bit later, where we are going to try to make this a little bit more interactive. But I will say that this entire talk has been approved by Lynn Snow, and Lynn, I am just going to ask you to say hello to everybody.

Dr. Lynn Snow: Hello, everyone. So glad that we could be with you today. Thank you, and thanks to Tina for doing all the heavy lifting and talking today.

Dr. Christine Hartmann: Well, you do heavy lifting in other areas, and that is why it’s such a great partnership because sometimes I wonder how people who don’t have a wonderful partner can do all this work. So as I said, on the line we also have Lisa Minor. So Lisa is the Director of the CLC system within VA, and she works at Central Office. So Lisa, I know you’re on, can you just say hello as well?

Lisa Minor: Yes. Hi, this is Lisa. Thank you all for joining us today for the second series, and I appreciate you listening.

Dr. Christine Hartmann: Great. Thanks Lisa. And I will pull you in, as I said, later when I run through some of these poll questions with the audience. We may or may not have some other people. I actually know we have Sheryl Terkildsen from the Office of Geriatrics and Extended Care, and we might have some other folks on as well, and we probably also have some folks on from the CONCERT team. The CONCERT team, as you heard Molly say, Lynn and I co-direct that. But that is the team that is, one of the teams that is really facilitating quality improvement at the frontlines in CLCs, and so we are thrilled to have them listening in as well.

We all share a vison; Lynn, Lisa and I, the CONCERT team, the folks at Geriatrics and Extended Care, and probably many of you, in terms of improving the quality of care within the VA system and working with staff to do that. And if you heard that previous Cyberseminar, which was just last week on January 23, 2019, if you want to go back in the archives and listen, that conversation was really between Central Office and researchers, so myself and Lisa and Lynn, about the importance of partnership and the importance of having a shared vision. And for us, I’d just like to give you a little example of what that shared vision could look like.

In some of the work that I will describe a little bit later in the slides, we did an intervention in CLCs. And that intervention was around having CLC staff conduct observations, so these were structured observations where they just took five minutes to step back from their usual routines and observe what was going on in the CLC and learning from those observations by focusing on what they were doing well. And through that intervention the atmosphere in the CLC changed.

And they had a Veteran that they talked about in one of the CLCs, and he had ALS and he was somewhat new to the CLC and spent a lot of time in his room. He just didn’t feel comfortable coming out. He was new, but it wasn’t just that he was new, he just didn’t feel comfortable leaving his room. He spent a lot of time watching TV and movies in his room. And what staff talked about was that as that intervention proceeded, and this intervention was really focused on resident/staff interactions and improving those interactions and improving resident engagement in their lives in a CLC and how staff could help facilitate that. And as this intervention proceeded, what they noticed was that he was coming out of his room and he was watching movies with other Veterans in the common areas and he was laughing. And his family was more relieved and relaxed, and they stopped feeling as though they needed to visit so often because he was actually interacting with folks in the CLC. And they talked about this story and the amazing potential that this intervention has because of the improvement in his interactions and in his feeling that the atmosphere in that CLC had changed.

And so that just highlights some of the possibilities and really what we are shooting for and the shared vision that we have that if staff and all of us observe and communicate about what we are doing well that those strengths that one learns from observing where one does well can be applied to other situations and used to improve the quality of care.

So these photos just illustrate that. And our journey is really all about that. As you can see from this picture--I like this picture, and Lynn is probably laughing, and probably Lisa, too, because our journey has not been a straight line, I would call it a curvy and exciting, as many curvy roads are, very exciting, sometimes stressful, but very picturesque journey that we have taken. And we are still on that journey. I think despite its not having been a straight line, I know for myself, I wouldn’t have had it be any other way. I think Lynn and Lisa probably you feel the same. It is curvy and that makes it more interesting. I will, at some points in this presentation present it as though it is a little straighter than it is, but you know the truth now. It has been a curvy line.

So I am going to ask actually Molly to take back control and ask the first poll question so we can get a little bit of the sense of the audience for today and who all of you are.

Molly: Thank you. So for our attendees, as you can see up on your screen, you do have the first poll question. So go ahead and click the circle right there next to your response and you can select all that apply. What experience have you had with frontline healthcare? Are you a clinician, you are not a clinician but worked with frontline staff, you have visited frontlines for research or other reasons, have worked with people who work on the frontline, or have no contact with frontline? And again, just go ahead and select all that apply, so you can just click the squares right next to your response. We’ve got a very responsive audience. That’s great. About 70% have replied so far, so we will give people a few more seconds. And with that, I am going to close the poll out and share those results. So as you can see on your screen, 28% of our respondents are clinicians, 36% are not clinicians but work with frontline staff, 38% of respondents have visited frontlines for research or other reasons, 50% of respondents work with people who work on the frontline, and 11% have no contact with the frontline. So thank you to those respondents. Dr. Hartmann, did you want to give any commentary before we move on?

Dr. Christine Hartmann: Oh, no, just that that was super helpful. So this is really great to know. So a lot of you are actually clinicians and at least if you are not, then you have worked with frontline staff or have been to the frontlines of care. So when we talk about what is happening at the frontlines, this will really speak to your own experience. And for those of you who don’t have any contact, it will also, I think, be pretty intuitive, so you don’t need to worry that if that's not your own experience that will preclude you from being able to understand what we are going through today.

So I did allude to the previous Cyberseminar and in that Cyberseminar that we talked about the importance of partnership and partnering, particularly with, so researcher and operations. So those folks in Central Office who run what is happening in the VHA and I would say “we”, meaning people like Lynn and myself, who are predominantly health services researchers. I'm not going to recap that presentation in any detail except I will go through some of the lessons that came out of the conversation that we had. So we had some interactive polling happening during that Cyberseminar, so I encourage you to go back and listen to it.

But to summarize mainly what Lisa was talking about is that when one partners, it is all about the relationships, and I am saying this in reference to the talk about the operations and researcher partnerships, but I can extrapolate from that, it is all about the relationships at the frontlines of care. It is all about the relationships between the researchers and the people at the frontline of care, quality improvement people and the frontlines of care. So remembering that everything really has to do with the relationship and that building of relationship, as you know in your own personal lives, takes time. It can’t happen overnight.

Another point that Lisa made was that it’s really important to have agendas that both parties or all parties agree on and that those aren’t static but that they change over time and it is important to remember to re-evaluate them. She also talked about the importance of being patient and flexible. I think sometimes changes in the operations world work a lot faster than changes in the research world. And there are things that happen in the outside world, so in the national media or with Congress, that can really impact Central Office and have an impact that happens very quickly, and we on the research side aren’t always used to that.

And then another message was to partner broadly and I think that refers to not just partnering with multiple offices at Central Office but knowing the whole office, knowing a lot of people within that office, not just one person, and expanding your contact base.

So with that said, I told you we have some folks in addition to Lisa on the phone today, so we have Lisa, who is the Director of CLCs, Dr. Scotte Hartronft may be on the phone as well. I know we have Sheryl Terkildsen and then Janet Barber. And this is just a snapshot of part of the Office of Geriatrics and Extended Care, but it is the part with whom we on the CONCERT team work most closely.

I am going to go through now some of the projects that we’ve had. Now you know the secret, that this is not a straight line but a curvy line. But we, for the sake of the presentation, had to make it look a little bit more straight than it actually was. So what I am going to focus on is giving you some of the background for the national work that we are doing because the background will help you understand what we are doing right now to facilitate quality improvement at the frontlines of care.

So we began in 2010 with an HSR&D pilot grant, Lynn and I, and then in 2013 had an HSR&D larger grant called an IIR. And at the same time we also had an Office of Patient-Centered Care and Cultural Transformation funded innovation project that we worked on, and in 2016 began what became in 2017, 2018 and beyond the CONCERT work, the national rollout, the national work with the Office of Geriatrics and Extended Care. But if you heard the previous Cyberseminar, you heard us talk about the partnership with the Office of Geriatrics and Extended Care predates even the pilot. My relationship began in 2008. Lynn’s relationship with the office began even earlier than that. So this entire trajectory is really hand in hand with the Office of Geriatrics and Extended Care.

So using that same trajectory and talking about that partnership with Geriatrics and Extended Care, in the previous Cyberseminar I talked about how this was really maybe an analogy to what a relationship can look like, that we started off as pen pals and we moved to Facebook friends and then we maybe moved to Facebook instant messaging and then we became lunch buddies and then by now we are In Case of Emergency contacts with each other. So as I said, you can hear more about that on the January 23, 2019, Cyberseminar.

This trajectory also applies to Lynn and myself and our growth of our understanding of this work. And this is a journey that is also still continuing. In 2010, we began with that pilot grant with the mantra basically you can’t improve what you can’t measure. And we designed a measure for measuring one small aspect, a necessary but not sufficient aspect, for culture and for improving the culture or the person-centeredness of care within CLCs. Then we really began involving CLC staff a lot more in our research. In 2014 there was this shift, and Lynn, I don’t know if this was the same for you, but if I had to pick out any moment in our whole research decade-long collaboration and trajectory, I would pick out that moment where we shifted from a deficit perspective to a strengths-based perspective.

Dr. Lynn Snow: Absolutely.

Dr. Christine Hartmann: Yeah, I was just going to ask you, go ahead, jump in.

Dr. Lynn Snow: That was just such a huge “ah-ha” moment when we realized that we had been always focusing on what was going wrong and that there was so much more power for the learning and for action when you focus on the strengths. And I just remember us both in a car together driving from a nursing home in Maine back to Boston and having that epiphany and it was a huge turning point.

Dr. Christine Hartmann: Ha, that’s so great, that’s exactly the moment I remember. As we said recently, if you took Lynn and me into separate interrogation rooms, we would probably give you the same story, so we have worked together that long. So that is great to know, Lynn, and that was a pivotal moment. And I will explain a little bit more about what this focus on strengths means a little bit later, if Lynn’s summary there didn’t quite do it for you.

In 2017, we had been doing this, but it really hit us on the head, and this was through working with frontline staff, that we had to prioritize frontline huddling. In 2018, I think our lesson is to be nimble and to constantly refine and respond to what is happening in the outside environment.

All of this work is grounded in a conceptual framework. And I have never lived, breathed, eaten a conceptual framework the way I have relational coordination. So this is not only the conceptual framework for the research that we do, but it is actually the conceptual framework for the quality improvement work and for our own personal work within our teams. And when I say team, I really mean the Office of Geriatrics and extended care partners and our CONCERT team together.

Relational coordination. I am not going to get into a lot of details about this either, but really the premise is that high-quality relationships and high-quality interactions then result in higher quality outcomes. So this frequent, timely, accurate, problem-solving communication that takes place in an atmosphere of shared knowledge, shared goals, and mutual respect is what results in the improved outcomes. As you may be able to see, if you are not familiar with relational coordination, you might be able to see how this can apply to interpersonal relationships, to group relationships, and how it can, how we can say that this conceptual framework not only applies at the frontlines of care, but it also applies within our team.

The other principles, I think I have touched on here the first there at least, and the pilot, everything, is something that we, again, try to build into both our teams and our work in the CLCs. If you are familiar with the PDSA cycle, the Plan-Do-Study-Act cycle, this rapid cycle quality improvement, that is really what we focus on. We are trying to use that internally. And the more we use that internally by piloting processes within our teams and then evaluating them, tweaking them when necessary, spreading them if they are good, it actually becomes easier to then teach them and apply them externally. So the lessons we are learning as a team actually apply often to what we are doing on the frontlines of care.

You know this slide by now, so this is the growth of the project. I am going to walk you through this timeline in a little bit more detail because this timeline from the pilot work on actually forms the basis for what we are doing now. And then after we do this I am going to guide us in a little discussion through some poll questions.

So as I said, we began by measuring because you can’t improve what you can’t measure. So we began by measuring, and we were measuring this necessary but not sufficient aspect of person-centered care, basically the engagement of residents in their lives in the CLC and the interactions between residents and staff. And there is no intent for you to be able to read this slide, this slide is actually this small on purpose because what we constructed was this tool. So this is a researcher-based structured observation tool. There are nine columns. Some of those columns have 30 or more variables. And it is called the RAISE tool. This took a lot of work, and we published on it if you’re interested to see more about the RAISE tool. But as you can tell from that tool, that is not a tool that is easy for someone to use. That takes 40 or more hours to train a researcher on using.

So we also, after we had developed this tool, put in for a grant and were funded for a larger VA grant called an IIR, and that is, in our nomenclature, known as Project DIRECT. What we did in DIRECT was take that huge tool that was just on the screen, and if you focus on the bottom lines on this slide, you can see Line 1, Line 2, that continues on. This is a structured observation tool that requires only one checkbox. So it is the same information about resident engagement now slimmed down. How were we able to do this? Because this is where we really worked with frontline staff. So we went to CLCs, we talked with frontline staff, we brought them our own researcher versions of slimmed down versions of that RAISE tool that you saw. And boy were they still way too complex. So it was though multiple conversations and having people use them, discussions with frontline staff, that we were then able to create an instrument that you can now teach in five minutes, so literally we can go into a CLC, teach somebody in five minutes to use this tool, and then they can do their own five-minute structured observations about resident engagement.

Again, if you want some more information about how all that was done, you can see a publication that we have on this. But the main point is that we learned to involve CLC staff more in what we were doing.

And at the same time as we were doing that work, we had this Innovation Project funded by, as I said, the Office of Patient Centered Care and Cultural Transformation. And we had the opportunity to work with these national nursing home consultants. These are the people who actually taught us about the strengths-based approach, and their names are Barbara Frank and Cathie Brady. They are, I would say, the premier national nursing home quality improvement/performance improvement consultants. And we are privileged to have had and continue to have the opportunity to work with them.

They went with us six times to one CLC where they taught us really how to implement relational coordination principles. They helped the CLC staff pilot small changes to improve Veteran care and see how those small changes, using PDSA cycles, could be adapted over time and spread. So it was an intense time for us learning about how to facilitate change in one area. And I would say that that opportunity to dive in deeply before we went more broadly was really invaluable.

In the IIR Phase 2, we therefore developed a bundle of practices. So these are all evidence-based practices that we bundled together in something we call LOCK. And LOCK is, I am going to spend some time talking about that because LOCK is really the main point of this presentation. So how do we, meaning our group of operations and researchers, this team of ours, how do we facilitate quality improvement at the frontlines of care? We do it using this LOCK bundle. This LOCK bundle comprises these four elements, learning from the Bright Spots. So this is learning from your strengths. Observations by everyone, so everyone conducting some sort of observation, whether it be a small step back in your mind from your usual routine or using some sort of structured tool, so a formal or an informal observation. And then the linchpin for all of this is collaborating in huddles, so getting together and discussing the bright spots that you learned through the observations and having a discussion about that and keeping all aspects of this very efficient by keeping it down to five to 15 minutes. So everything that is done in service of this LOCK bundle is done in quick increments so that habits can be formed and that this can be incorporated into changes at the very busy frontlines of care.

So I am going to spend a little bit more time talking about these LOCK principles because they are, as I said, the real key for us for how to facilitate quality improvement at the frontlines of care. And the first is the L, the Learning from the Bright Spots. So what Lynn talked about a little bit earlier was this focus on positive deviants. I am going to have you all walk through a thought exercise with me, just so you can feel a little bit what this is like.

So all of us have something we are interested in doing outside of work. So whether it is a hobby or just an interest, just think for a second, what is it that you like to do outside of work? Okay, so I’m hoping you have something in mind, and if you don’t then you should really think of things that you like to do outside of work. But let’s say we all have something in mind outside of work, right? So imagine that you had the opportunity to build that into a business and you had the time and the space and the money in your life to build that thing that you really love to do into a business. And then you had one day, you had one day where you could visit a business that was really similar to yours and you could learn from that business, and you had one day only to do that, and you could choose between a business that had won a national award for being the best in the nation for that thing that you want to do, or you could visit a business that was similar to yours but had done really poorly, was going bankrupt, and was closing its doors the day after you were going to visit them. So which one would you like to go visit?

So I don’t think that is a difficult question. Most of us would say we want to spend the day with the business that won the national award, and that makes sense. But why would you want to go there? Think about that for a second. You want to go there because they did it, right? They know what they did and you want to figure out what they did and how they got there. You want to figure out what facilitated their success and you probably anticipate that they had some hurdles that they had to overcome. How did they overcome those hurdles? So this is what we are talking about. When one focuses on the bright spots, when one focuses on the positive deviants, one has the opportunity to learn lessons and the solutions are inherent in the digging down process. So that is not necessarily, however, what we are used to doing, so I am going to give you an example in CLCs.

So let’s say Mr. Jones is at high risk for falling and you look at Mr. Jones’ data and he has fallen eight times in the past month. Oh my gosh! And seven of those eight times were right before he took a shower. So your tendency, and all of our tendencies, if we are not geared to this positive deviants Bright Spots approach is to look at those seven times he fell. Oh my gosh! What went wrong those seven times? What that is not going to teach you is what to do to prevent a fall, except to perhaps remove some obstacles. But it won’t give you the big picture of what happens when he is at high risk for falling. But there was one time last month where he was going to take a shower and he was at high risk, just like all those other times, and he didn’t fall. It behooves us to look at that one time when he didn’t fall and see what was in place because that can teach us what to put in place next time to help prevent a fall.

So just like with your business example, if we focus on what is going well, we can find the solutions inherent in the bright spot, and then we can learn from that and spread it, what we call spread the bright spots. So I spent a lot of time on Learning from the Bright Spots, because that is a counterintuitive thing for us to do and it is something we continually have to remind ourselves to do. And we help staff keep that in mind because as human beings we are primed to look for the negative because that is what helped us survive in the past. We couldn’t be spending time looking at the flowers. We had to be looking for the saber-toothed tigers. We are primed to look for negative things, but it actually helps us to look for positive things when we are looking for solutions. So enough on that.

The O is Observations, and I think for all of us, if you are clinicians or researchers, observation comes a lot more easily. We are used to stepping back from a regular routine perhaps, even though that requires some effort in our minds, to step back and do some critical observation of what is actually happening. Now critical doesn’t mean looking for the negative. Critical just means trying to be more objective in what you are looking for.

Collaborating in huddles is the C of LOCK. The Collaborating in huddles, as I said before, is the linchpin to this whole bundle. You can do observations. And through those observations you can find the bright spots of care. You can find those positive deviants. If you do not have the structure and the time to discuss and learn from those observations and those bright spots, then nothing will happen because you haven’t taken that next step to have as a group a dialogue. So no data without dialogue. So it is pointless to collect the data if you don’t have dialogue about it. That is one of the little mantras that we live by, I would say.

Hearing from everyone within these huddles is very important and I will give you an example closer to the end of the importance of really involving frontline staff in these huddles and hearing from everyone. And frontline just means people who have the closest contact with the Veterans in the clinical scenario that you are working in. For us, it is in the CLCs, and so for us it often the nursing assistants, but it might be the housekeeping staff, for example, who also come into the room and really spend a lot of time with the Veterans. And then within those huddles, devising an action plan. So you have the observations. You’ve found the bright spots. You use the huddles to learn from and discuss the bright spots of care. Then the final step is come up with an action plan, make an action plan for something to use a PDSA-cycle on to pilot, and then come back in the next huddle. Discuss whether it worked. If it didn’t, tweak it or throw it out and try something else. If it worked, then figure out how to spread it. This huddling is relational coordination in action. It is a discussion. It promotes this frequent, timely, accurate problem-solving communication, and it is important to, within that huddle, create an environment that emphasizes shared knowledge, shared goals, and mutual respect, and particularly avoid blaming, but instead focus very much on problem solving.

And the Keep it bite-sized part of LOCK, I think we would all appreciate this in our lives, the efficiency and habit-forming capabilities of something that happens very quickly.

Within our study, so going back to the IIR, we did have some positive findings that I am just going to go through with you. These are some of the quantitative data we have published on this and the publications will come up in a second. But if you just focus on the yellow lines, you will see that this realized opportunity for relationship, by which we meant staff interacting with residents in the resident’s space, so when they were helping the resident eat or helping the resident get dressed or taking vitals with the resident, that they use that opportunity, instead of being quiet, but instead use that opportunity to build a relationship with that resident by having verbal or nonverbal interactions, positive interactions with that resident. We saw that go up over time, from pre to post. And the quality of staff interactions, the number of negative staff interactions decreased over time.

But really, I think that the Semi-Structured Interviews that we did provide a lot of the background information on some of the details. The overview of what came out of those, because we don’t have a lot of time to go through a whole bunch of quotes, I will go through some, but it will just give you a skimming of the surface piece of information about what we learned from the qualitative interviews. So to summarize, we really heard from staff that through this intervention, so this LOCK-based intervention, what I just went through, they were able to develop a greater awareness of the importance of identifying these types of opportunities where they were with the resident but not interacting, so capitalizing on those opportunities, or they were with the resident interacting but they could interact more. So we heard multiple stories about people who were doing the structured observation, and when they were doing the structured observation, noticing that no one was interacting with a certain resident. As soon as they were done, they dropped the paper and ran over to that resident. They hadn’t realized before how no one was interacting with that resident and that they had the opportunity to improve the quality of the interactions with the resident. So our structured observations and our implementation was focused on these resident-staff interactions and resident engagement. But this rubric of LOCK applies to any type of quality improvement work you want to do.

I will just give you some examples of some quotes that we heard. These quotes are all from registered nurses, but the first one here is about it becoming an instinct. When they--and she is referring to staff--when staff see someone, meaning a Veteran, walking around on his own, they just go over and meet that Veteran in the middle of the room and hold their hand and walk together instead of letting him wander around. You think it is just a very small thing, but those are the ones that prevent bigger things from happening.

Another nurse said, “Huddles allowed you to hear from peers about your own mostly good behaviors that you didn’t even realize about yourself, in a way that was easy to hear.”

And, “The physician was involved in the huddles. It really meant a lot when he spoke up about the different bright areas to the staff.” So this is another way that focusing on the bright spots serves to level the hierarchy because when you have conversations about where things are going well, it is easy for everyone to speak up and to feel heard.

So as I’ve said, we’ve published a number of papers on all of this work, and there are more coming out, so if you are interested in that, you can go back to this slide and look at that.

But the turning point for us was really October 28, 2015. And I won’t ask Lisa to repeat what she said in the previous Cyberseminar, but this was the day where Lynn and I went to Central Office, and this was one of--we took periodic trips to Central Office, at least once a year, often meeting multiple times a year with Central Office staff, but this was one of those meetings. We were all sitting around a big conference table; Lynn, myself, and then all the--not just Lisa, but a whole bunch of people from the Office of Geriatrics and Extended Care, really anyone who touched on CLCs. And then Lisa came up with this idea, well, because your IIR results are so promising, what would happen if we rolled this out nationally. So you can hear Lisa’s description about that fateful day on the previous Cyberseminar and I won’t go into it here or ask Lisa to repeat herself, but this is what happened. Because of these promising data that we had from the IIR, this became then, the LOCK program became a national program known as, initially, the Bright Spots Program. And CONCERT is the umbrella which runs the Bright Spots Program. It really, I think, highlights the importance of partnering and sharing information as you work through a research project with your partner.

I am going to turn it back over to Molly because I, at this point want to facilitate some dialogue. We still have about 20 minutes left until the top of the hour anyway, and we would really like to get some audience participation going here. So Molly, I am going to ask you to ask the audience a poll question.

Molly: Thank you. So for our attendees, you can see that you have up on your screen the second poll question. Please click the circle that aligns with your response. What is your most pressing question about facilitating change at the frontlines of care? What do you think is the biggest hurdle? What do you think is the most important facilitator? Do you think changes can last? Looking back, what would you differently? How was your operational partner involved? Go ahead and just take a moment to select your response. We’ve had just about half the audience reply. I am going to give people some more time. Okay, the answers are still streaming in, so I will give people a moment to think about this one. Okay, I see a pretty clear trend, so I am going to close this out and share those results. And Christine, I will just leave them up until I hear from you otherwise.

Dr. Christine Hartmann: Great. Thank you so much. That is going to be really helpful. So thanks so much, everybody, because this is the part where we’d really like to engage in a little bit more of a conversation with all of you. I gave Lynn and Lisa a heads up that I would be turning it over to them to answer some of these questions so you don’t just hear me talking or just hear my opinion. So Lisa...

Molly: [Interposing] I am going to cut you off real quick before we turn it over to Lisa.

Dr. Christine Hartmann: Yep.

Molly: I just need to read these aloud for the recording.

Dr. Christine Hartmann: Okay.

Molly: So 21% of our respondents selected, what do you think is the biggest hurdle; 37% selected what do you think is the most important facilitator; 19% do you think the changes can last; 12% selected looking back, what would you differently; and 11% how was your operational partner involved. Thank you.

Dr. Christine Hartmann: Okay, great. Thanks so much. So I think we should take these in order, so the first two, so what do you think is the most important facilitator of facilitating change at the frontlines of care. Maybe we can go through that one first? And Lisa, do you mind just off the top of your head sharing what you think might be the most important facilitator for facilitating change at the frontlines of care, at least in CLCs?

Lisa Minor: Sure. This is Lisa. I think the most important facilitator, specifically when it came to this project, was the fact that we took it in small increments, as Tina had went over the LOCK model and it is small and small changes. When you have frontline staff who are busy and just trying to get through their shift and get through the day, making changes that they can implement and work into practice in small pieces is going to probably facilitate change more than anything.

Dr. Christine Hartmann: Thanks so much. And Lynn, I am going to ask you for your opinion also.

Dr. Lynn Snow: Sure. I think Lisa gave a great answer. I think that is a huge part of a package for successful change. I think another important part of our change bundle of practices was really working to identify areas that the CLC staffs themselves were feeling stressed about and wanted to change. And beginning this habit building process of using these new practices, focused on whatever that area was. So as an example, one of the wonderful CLC leadership teams we were working with, they were introducing the idea of frontline huddling to their CLC staff. They were themselves really excited about introducing this concept of bringing frontline staff into the quality improvement process and into that quality improvement system. But the frontline staff weren’t very excited about it. And so we really encouraged those CLC leaders and brainstormed with them about what is stressing out your staff and if they could fix this particular problem that is stressing them out, that would actually lead to an improvement of quality of care for the residents. That turned out to be a really powerful question. In the example I am thinking about, the staff came back and said we are losing so many resident possessions, and it of course makes the residents and the family members very unhappy and it is really stressful for us. If we could fix this broken system, we would be so happy. That is what they started working on as a way to introduce frontline staff huddling and then the staff were motivated and they really engaged.

Dr. Christine Hartmann: Wow. Thank you, Lynn. That’s terrific. And instead of hearing from me, because I have been doing all the talking, I would really love to move to the second most popular question and go back to Lisa and ask Lisa and Lynn again to give their perspective on this. So Lisa, if you don’t mind sharing what you think the biggest hurdle is for facilitating change at the frontlines of care.

Lisa Minor: Sure. I think the biggest hurdle is getting the buy-in and the staff excited, as Lynn alluded to. I think once you have that, the hurdle decreases or gets lower, but I think that is a huge hurdle that we have to overcome. We have to get across to them the value that this adds to the work that they do every day.

Dr. Christine Hartmann: That is a really great point, yep. That is, I think, a lesson for all of us in so many ways is when we are trying to convince somebody of something and we have to convince them of the value that is added to their own perspective on life. Lynn, do you have an answer as well?

Dr. Lynn Snow: Yes. Loved Lisa’s answer. That is very important. Then again thinking about our bundle of practices, so always multidimensional, always more than one thing. I think another hurdle that we’ve come up against over and over that is very understandable because it is part of human nature and part of our LOCK bundle of practices is that deficits-based focus. We as humans are just so drawn to focus on what isn’t working and where things are not moving smoothly. So when it comes to the change process, over and over with the CLC leadership teams, we hear, well, we decided that this thing needs to change and we are getting stuck and we can’t make this happen. And that becomes really the focus for them on trying to make the change. So then we go back to talking about a strengths-based approach and saying, well, where are you having success? Where is there movement? Let’s put the majority of your effort there instead and continue to, so for example, if the thing that is not moving very well is they’ve identified they want to make some changes in how they provide food, but they are having a lot of trouble with someone in dietary, instead of continuing to beat their heads against that brick wall, we will encourage them, continue to allocate a little bit of time to that and move that forward in the slow way that it will move forward. But this person is recreation therapy is totally excited about what you want to do and they are really an ally and willing to be a champion for you. So put more effort into moving this part of your change program forward.

Dr. Christine Hartmann: Wow. Thanks, Lynn. Your examples are terrific. I really appreciate that. And I am looking at a clock as I am saying this, so I think we still have enough time to go through Lisa and Lynn again for the last--it’s not the last question but the third in line here. I think it is such an important question. It is, do you think the changes can last?

So Molly, I see you changed things, but that is fine. It is do you think the changes can last? Lisa, I think that is something that is on a lot of peoples' minds as they try to do research work and try to improve quality of care, what about it in terms of what we have done in the CLCs? Do you think it can last and what do you think facilitates lasting change?

Lisa Minor: I am going to go back to some of the general tenets of this that we talked about a lot on the last seminar, and that is about the relationship between operations and research. If we both have the same shared vision and shared goal, we can reinforce the changes and encourage the changes from both aspects. So given that, if everyone is on the same page and to go back to Tina’s music background, singing off the same page of music, I think that we can get the changes to become part of practice and last.

Dr. Christine Hartmann: Yeah, wow, that is a really terrific thing to focus back on is this importance of the partnership between research and operations and how operations is running the day-to-day in CLCs and in other aspects of VHA care, really needs to be on the same page as this so that people can work together to facilitate lasting change. Thanks so much for that. Lynn, do you have an answer as well?

Dr. Lynn Snow: I do. I think that having that partnership and that structure building things into policy at the local VISN and Central Office levels is key to sustainability. I think we all know that. I think the twist that the LOCK package has really done a nice job of demonstrating is that that has to happen in tandem, bundled if you will, with making small changes at the frontlines and finding a place where you can make small changes, have those small successes, and then build on those. So it is like you have to get the people who are actually doing the work motivated, engaged, and moving things forward, and that happens through making those small changes and building on small changes. And at the same time, if you are not then taking what you are learning from the small change successes and writing that into policy, then when that exciting champion team who has moved those small changes along inevitably moves on, then everything will disappear. So you have to have both parts if you want to sustain.

Dr. Christine Hartmann: Great. Thank you so much, Lynn. That is perfect. So keeping an eye on the time, Molly, I will ask for control back, and we will move on ahead with the slides a little bit. Thank you very much.

So here you see the Pulse page for our national program, so this was the progression that we are now running a national program called the Bright Spots Program, under the umbrella of CONCERT, which is doing a lot of other things as well as the Bright Spots Program. There is a URL for the Pulse page on the final slide. But you can see here that there is a lot of information here on this Pulse page. If you click on any of these buttons or tiles, you can find out all you wanted to know about QI frontline huddling, about the Bright Spots Program. We have some observation tools and other things on there, so I give a shout out to our Pulse page, which you can find by searching for groups, the CLC Bright Spots Program.

I am going to review some of what we are doing in this program just briefly, really it is relational coordination in action and this focus on huddling as the linchpin of the LOCK bundle and involvement of frontline staff in quality improvement, as we’ve been talking about and as Lynn and Lisa talked about in their examples. These huddles are the realistic way to ensure that frontline staff information is heard and spread. But it is important to note that historically and in a lot of hierarchies, frontline staff, so nursing assistants, housekeeping, for example, are not included when the conversations are happening about how to improve the quality of care and that this special effort needs to be made to not just pull them into the huddle, but then within the huddle make sure their voices are heard and respected and that their opinions are acted upon.

So without frontline huddling, what does communication look like? It really looks something like this and in many of our organizations I think, whether it is clinical care or not, this is often what happens. You have the conference room on the left-hand side in that box and then you have someone come tell somebody else about what happened in the conference room, and that person tells other people. So what kind of problems are there with this type of communication? Just think about it, like if you had to name one problem for this type of communication, what would that be? I’m sorry I can’t actually hear your answers, but I am sure some of you said, well, it kind of looks like telephone, right? There’s a lot of places where the communication can change or get garbled or pieces can be missing. It takes time for things to happen and get communicated this way. And of course not everybody gets the information, because this is all one to one, basically. It is one-way, it is one to one, and it tends to be directive.

Using frontline huddling, communication can look a lot different. So here you still have the conference room conversations happening, but you have people from the huddle in that conference room conversation coming back to the huddle. You see these arrows are now bidirectional, and that they are communicating then in a huddle so that you have conversations happening more accurately, they are happening quickly, and they are happening with everyone. So if you think of that relational coordination: frequent, timely, accurate problem-solving communication, that is what huddling facilitates.

So I just have a quick example of that from a CLC that we are working with, so they run a huddle and they have CNAs and RNs and the MD. They also have housekeeping in their huddles. This huddle this one morning, the housekeeper was always--the reason the housekeeper was in the huddle is because the housekeeper was working in the morning and always in everybody’s room in the morning and had a lot of information about all the Veterans because he liked to chat to the Veterans, he knew their routines, because he was the one who really spent a lot of time in the Veterans rooms. And so he was in this huddle this morning and he said, you know, that Veteran, he didn’t get out of bed today. He gets out of bed every morning and today he is not getting out of bed. If he hadn’t spoken up, they would not have realized this for a while. But instead, because he spoke up, they went and acted on this information immediately and found out that that Veteran had pneumonia and were able to get treatment for his pneumonia very quickly because someone from housekeeping spoke up in this huddle.

So this shows sort of huddles in action and relational communication and coordination in action. But all of this, you don’t have to take our word for it. There are books out, and Barbara and Cathie, the national consultants with whom we work, have an amazing book out on what relational coordination can look like in a nursing home setting. And so this is an inspirational guide to transformational care. But it can be applied. They apply it in the nursing home setting. It can be applied elsewhere. Jody Gittell, who is the developer of the relational coordination theory, also has numerous books and this is just one of them. So if you are interested in pursuing this further, these are some guides for doing that.

And Molly, I know we just have a little bit of time left, but if we could just open the poll really quickly and maybe just go through the most popular answer with folks, I’d really love to give people a little bit more time to talk with us.

Molly: I’m sorry, it looks like when I opened up earlier it closed it out. So I can’t actually take the responses and we don’t have enough time for me to re-enter it. I apologize for that. People can go ahead and use the question section to write in their response and if you don’t want to type out the whole thing, you can just put 1, 2, 3, 4, 5. In the meantime, while we wait for those to come in, I will open it up to you ladies to discuss any of them that you would like to.

Dr. Christine Hartmann: All right, so let’s just, I’ll just go, since we don’t know what people are saying. What do you do when a CLC doesn’t want to participate?

Molly: Sorry to interrupt; that’s actually the one people are typing in.

Dr. Christine Hartmann: Okay, great; just so prescient. So Lisa, I am going to turn to you first and then to Lynn, and both of you if you could keep your answer somewhat brief, because we are up against a timeline here, so Lisa?

Lisa Minor: Yes. We do have some CLCs who haven’t wanted to participate and all we can do is keep encouraging them and try to stress to them the value that having the support from our CONCERT team will add to their quality improvement.

Dr. Christine Hartmann: Great, so putting out the carrot. And Lynn, what about you?

Dr. Lynn Snow: I totally agree with Lisa. The carrot is much more powerful. We have really focused on trying to understand the challenges that are facing the leadership team and the frontline staff at CLCs that are reluctant to participate and where they would like to see change. And if we can find out the places that they are frustrated with that our program could help with, then we can point those out and point out when we have a win-win, and that has been successful.

Dr. Christine Hartmann: Great. I will just add that another thing that we have done that has worked in certain situations is sort of buddying up, so within the same VISN, finding a CLC that has been making useful and for them meaningful progress and buddying them up with a CLC who is perhaps struggling with the program or not implementing the program but is willing to speak with another CLC in their VISN that has had more success, and that has also been successful.

So I am going to, I know we are right about at the top of the hour and perhaps some questions have come in, so I will turn it back over to Molly.

Molly: Thank you. There are no pending questions at this time. We did have one comment come in at the start of the session: Changing a culture quickly requires a war, a plaque, a depression, etcetera. Mindful daily cultural improvement is a very slow process and participants need to understand their general role. And that does kind of lead in a little bit to the second-most selected answer from your open-ended question here, which was how the CONCERT team is organized.

Dr. Christine Hartmann: Okay, well, I will just address that in a one-minute summary. So we organize our team into, I would say we have--our team is Geriatrics and Extended Care and the CONCERT team. So we have that over-arching sense of we are all in this together. We have a leadership group that comprises both Geriatrics and Extended Care team members and people from the CONCERT team. But I would say if I were describing our organizational structure, we have a lot of subgroups and we have opportunities for a lot of little huddles and then larger huddles happening frequently. So we really try to embrace relational coordination in what we are doing and use the huddling principle. I mean, the huddles for us are conference calls, but we do a lot of small huddlings, and then we have other huddles, larger huddles where we hear back from the smaller huddles and make decisions and go back to the smaller groups. So we are really, as I said in the beginning, trying to live, breathe, and eat relational coordination.

So Molly, I know I don’t have control, but the final slide does have our contact information on it, so if you want to share that with folks or if you want to give me the control back I will do that really quickly.

Molly: Yeah, and while you’re putting that up, a couple of people have written in saying they would like to collaborate. So I am going to go ahead and put the onus on those people writing in, go ahead and contact the presenters directly. And we have a second left, if anybody would like to give any more concluding comments.

Dr. Christine Hartmann: Well, I will just say if you do contact me, please note that my name has two N’s on the end. There is a poor Christine Hartman with just one N who gets my emails. She is also in VA HSR&D. I hope to meet her someday. But in the meantime, let’s not bother her, and do put two N’s on my name. I am in Bedford, Mass. And I would really like to thank Lisa and Lynn. Thanks so much for being on this, it is always such a pleasure to have our team be together and present nationally. I always value that opportunity, so thank you both to Lisa Minor and Lynn Snow for being on this call today.

Molly: Excellent, and I too would like to thank our presenters as well as our attendees for joining us. This has been a great session and you will receive a follow-up email two days from now with a link leading directly to the recording, so feel free to save that and pass it along to any colleagues that you feel may be interested.

Ladies, anything else, or should I go ahead and close it out?

Dr. Christine Hartmann: You can close it out. Thank you very much.

Molly: Wonderful. So for our attendees, please wait just a second while the feedback survey populates on your screen. It is just a few questions, but we do look closely at your responses and we appreciate any feedback you can provide us. So thank you once again to our presenters, and that does conclude today’s HSR&D Cyberseminar. Have a great day, everyone.

[ END OF AUDIO ]