Certificate Training Program
Session 18

Welcome! Before We Begin:

Sign-in at the back
Pick up agenda
Put on your name tag
Sit with your CTP team at your assigned table

Institute for Healthcare Quality, Safety and Efficiency
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

KEY
Team Check-in
Inspiration
Background
Process Improvement
Leadership
Quality/Safety
Coaching
EMR

1/28	#12	UCH Sleep	Overcoming Resistance	Feedback to Improve Performance	Mid-year Report Practice Session	EMR Build
2/4		Coaching				
2/11	#13	Report Outs			Leading Change: Removing Barriers	EMR Build
2/18		Coaching				
2/25	#14	Report Outs			Running Effective Meetings	EMR Build
3/4		Coaching				
3/11	#15	Using AI for QI		Leadership Journey: Jena Hausmann	Second Victim	EMR Build
3/18		Coaching				
3/25		Coaching				
4/1	#16	DHA Antimicrobial Stewardship	Data to Understand Impact	Positive Organizational Design	Leading Change: Short-term Wins	Production
4/8	#17	CU Medicine Dermatology	Impact of Quality and Safety on Healthcare Finance	Leading through Complexity	Biases & Leadership	Refinement
4/15		Coaching				
4/22	#18	UCH Nursery	Strategic Planning		QI Spread / Power & Influence	Refinement
4/29		Coaching				
5/13	#19	UCH Infectious Diseases	Burnout & Resilience	Innovation in Healthcare	Embed the Change	Data Extraction
5/20		Coaching				
5/27	#20	Leadership Journey: Dean Sampson	Report Outs			Data Extraction
6/3		Coaching				
6/10	#21	Report Outs				Data Extraction
6/17		Coaching				
6/24	#22	Reflecting on Why		Certificates	Closing Time	Data Extraction

KEY	Team Check-in	Inspiration	Background	Process Improvement	Leadership	Quality/Safety	Coaching

#17 Apr. 8	Team Check-in: CU Medicine Dermatology	Who are my colleagues?		
	Impact of Quality and Safety on Healthcare Finance	How does quality and safety impact clinical revenue?		
	Leading Through Complexity	How do we develop goals, tactics and plans to meet long-term strategic needs?		
	Biases & Leadership	How can we best address personal biases in medicine?		
Coaching	**Create series of short-term wins to support project, intervention implementation**			
#18 Apr. 22	Team Check-in: UCH Nursery	Who are my colleagues?	❑ **Develop plan for sharing/spreading your work** *Due June 10*	✓ **Create a series of short-term wins to support project** ✓ **Update data plan to include current state data**
	Strategic Planning	How do we develop goals, tactics and plans to meet long-term strategic needs?		
	QI Spread	How do I share/spread my project work and outcomes?		
	Power and Influence	What are the sources of power and influence and when do I use these tools?		
Coaching	**Develop plan for sharing and spreading your work**			
#19 May 13	Team Check-in: UCH Infectious Diseases	Who are my colleagues?	❑ **Plan for putting project into embed phase, Develop final report** *Due May 27 / June 10*	
	Burnout and Resilience	How do I support personal and organizational resilience while reducing burnout?		
	Innovation in Healthcare	What is the role of innovation in healthcare?		
	Embed the Change	How do I embed by intervention and ensure its sustainability?		

Today's Learning Objectives

1. Start to create a strategic plan for your care area
2. Understand the sources of power and influence and when to use each tool
3. Understand how to spread your interventions locally and nationally

Final Report-out Schedule

May 27, 2025	
1:05 – 1:10	Welcome/Opening
1:10 – 2:00	Leadership Journey: Dean Sampson
2:00 – 2:15	Break
2:15 – 2:45	DHA Clinical Informatics
2:45 – 3:15	DHA Antimicrobial Stewardship
3:15 – 3:30	Break
3:30 – 4:00	UCH Nursery
4:00 – 4:30	UCH Neurosciences

June 10, 2025	
1:05 – 1:10	Welcome/Opening
1:10 – 1:40	UCH HOPE Oncology Clinic
1:40 – 2:10	UCH Sleep
2:10 – 2:25	Break
2:25 – 2:55	CU Medicine Dermatology
2:55 – 3:25	UCH Infectious Diseases
3:25 – 3:40	Break
3:40 – 4:10	CHCO ICU Delirium
4:10 – 4:40	CHCO Secure Chat

Let Anne know any conflicts ASAP!

Strategic Planning

Jeff Glasheen, MD

Institute for Healthcare Quality,
Safety and Efficiency
SCHOOL OF MEDICINE
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Breakout

15 minutes

As a leadership team for your unit/program...what issues/efforts/work have you spent your time on over the past few months.

Make a list of these.

MB
Key to Fun

stratego®

fascinating two-handed strategy game

Ages 10-Adult

Move hidden value pieces to outwit your opponent and capture his flag.

2 Players

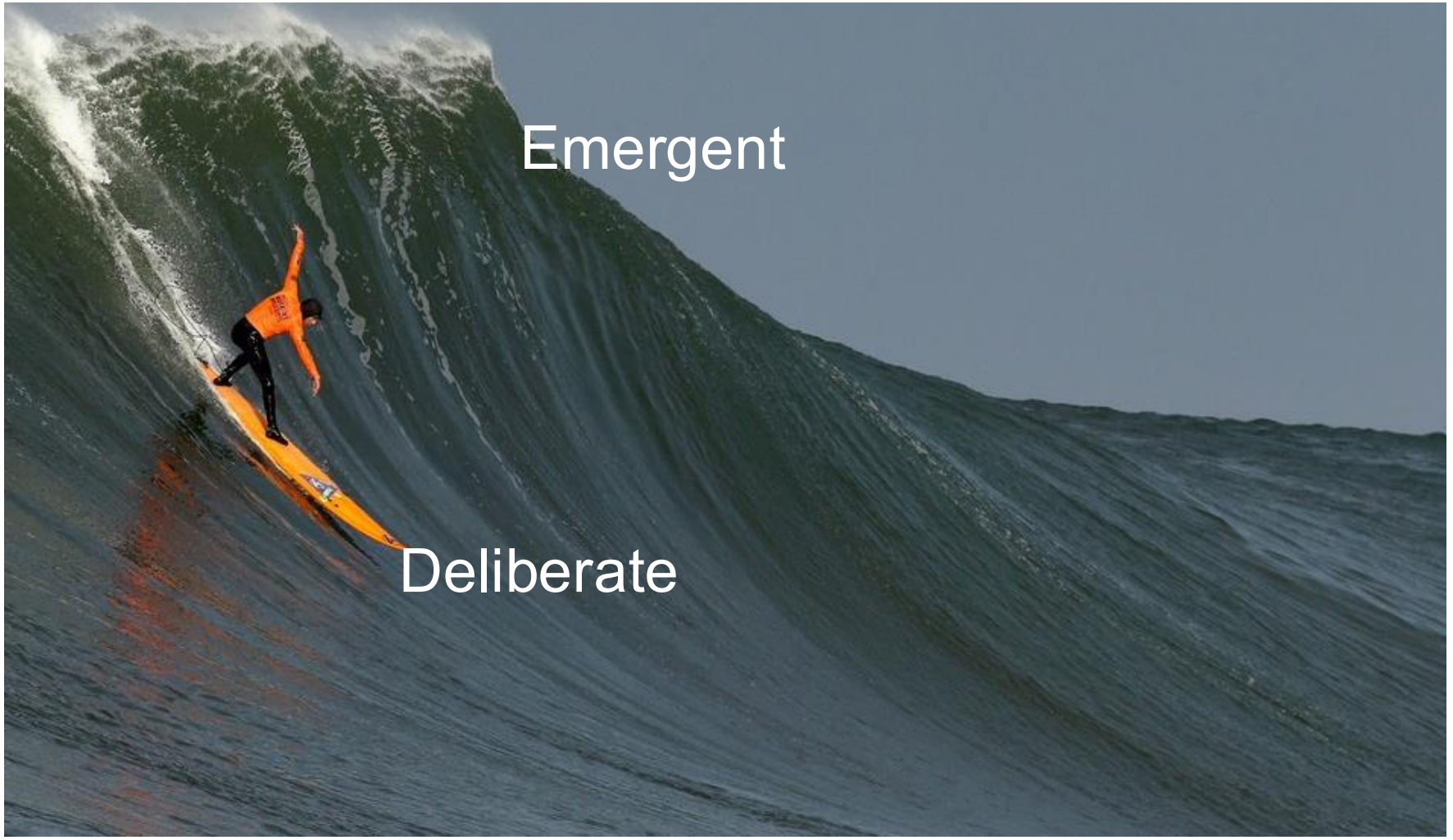
SEE BOX BOTTOM FOR DESCRIPTION OF GAME

MILTON BRADLEY Company
SPRINGFIELD, MA 01101
Made in U.S.A.
4916

A plan of action designed to achieve a major aim

Strategy: Moving with Purpose

Strategy in Action



A process that starts with deciding where you want to go,
recognizing where you are today,
and then closing that gap through plans and actions

Key Terms

Vision	aspirational future state
Strategies	what you are going to do
Tactics	how you are going to do it
Goal	specific, measurable target

Example - Personal

Vision (future state): Be a great marathon runner

Goal (specific, measurable target): 4 hr marathon

Strategies (what to do):

Exercise	Eat Well	Exercise Community

Tactics (how to do it):

M/W/F: Speed workout	Breakfast: Smoothie	Join running club
T/Th: Recovery run	Lunch: Salad	Share stats w/ peers
Sat: Long Run	Dinner: Blue Apron	
Sun: Off		

Example: Made My Goal! – Now What?

Vision (future state): Be a great marathon runner

Goal (specific, measurable target): 3.5 hr marathon

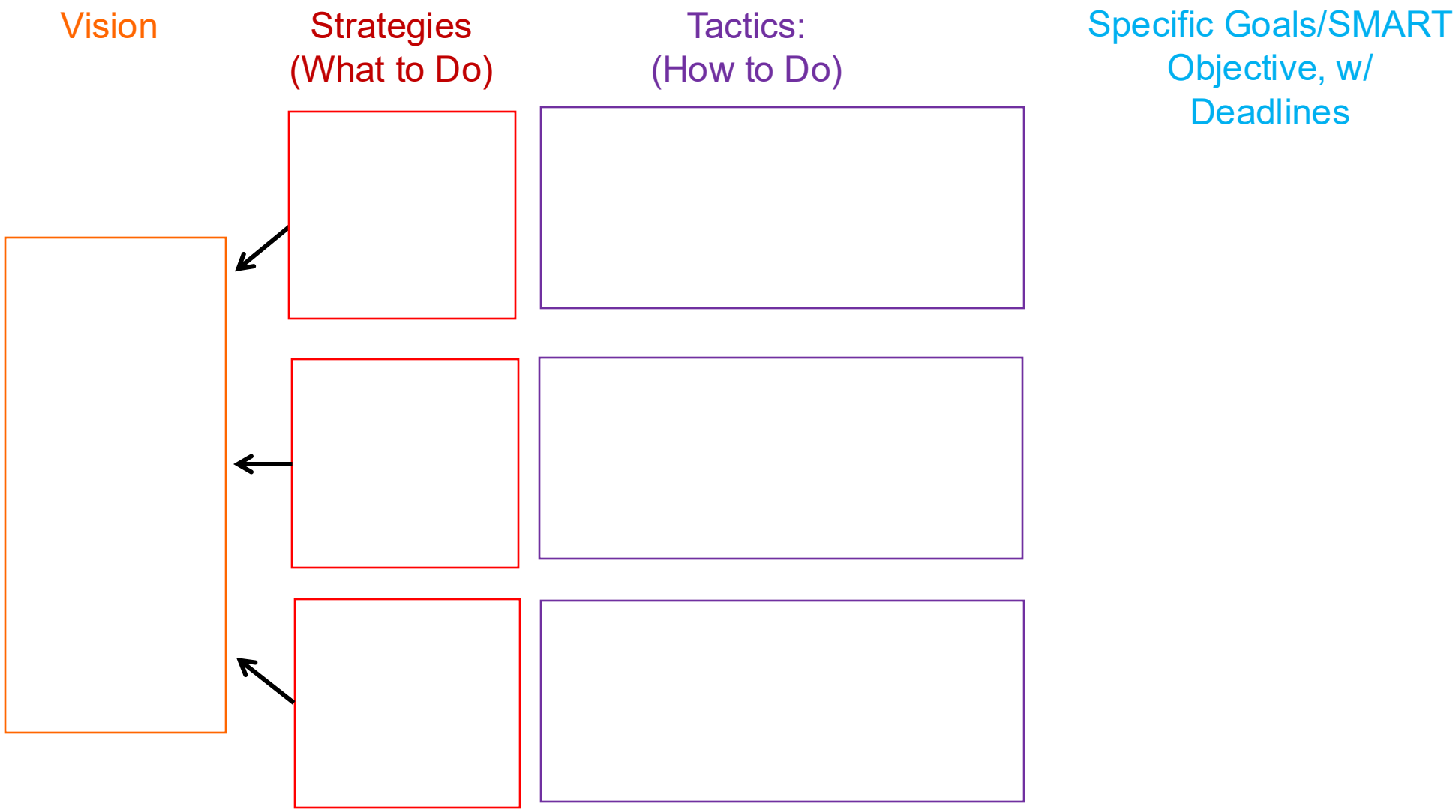
Strategies (what to do):

Exercise	Eat Well	Exercise Community

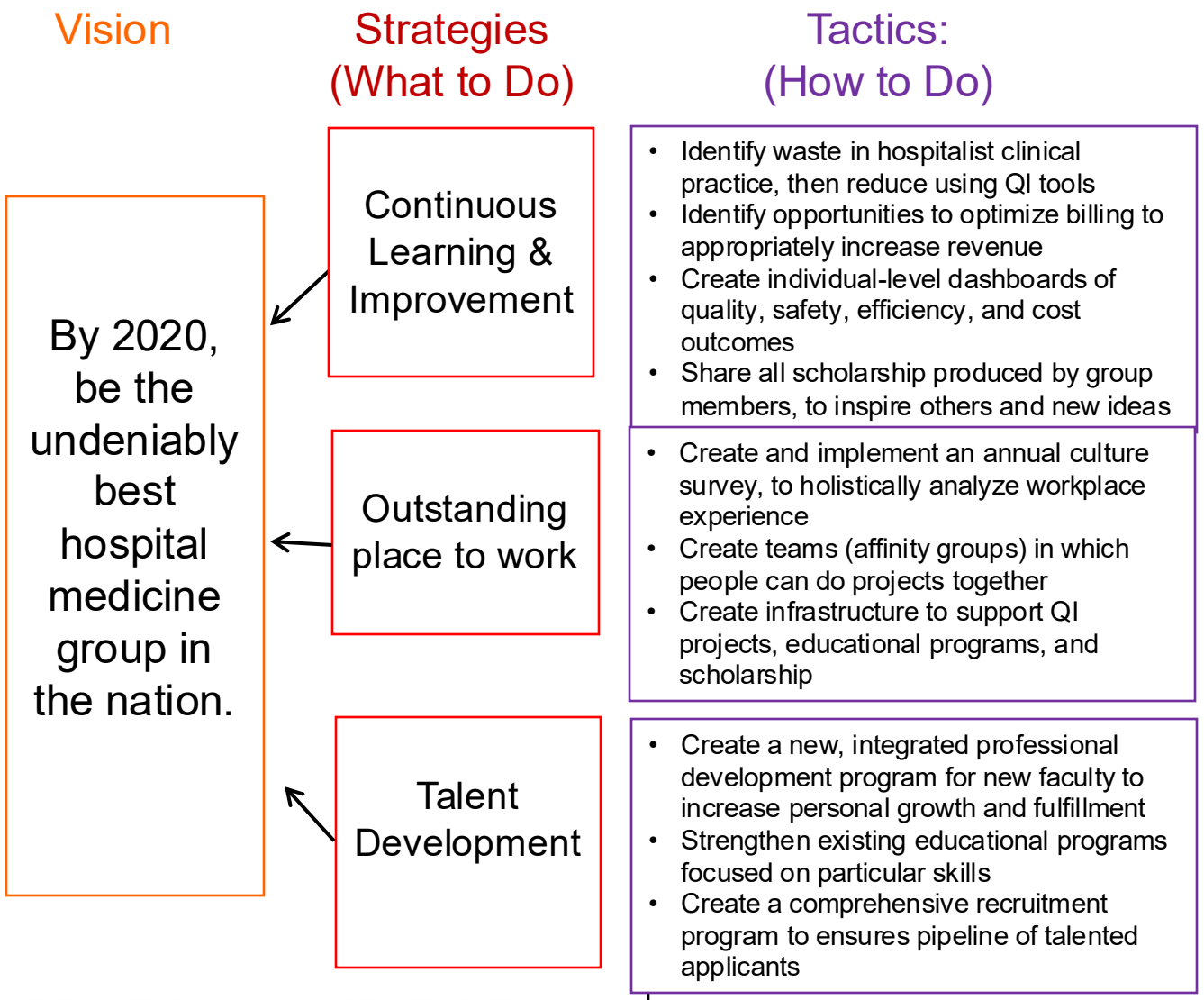
Tactics (how to do it):

M/W/F: Speed workout	Breakfast: Smoothie	Running club
T/Th: Recovery run **& weights**	Lunch: Salad	Share stats w/ peers
Sat: Long Run	Dinner: Blue Apron	**Training partner who already runs <3.5 hr marathon**
Sun: **Yoga**	Snack: **Protein shakes**	

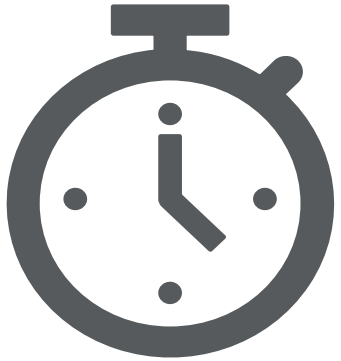
Strategic Planning Tool: Driver Diagram



Ex. Strategic Plan – Hospital Medicine Group



Breakout



10 minutes

What is your vision for your care area?

Vision: Background

- A vision is an ideal future state. What your group is aspiring to become.
- There should be near-unanimous agreement with the vision.
- It should:
  - Inspire people to join you.
  - Allow people to follow plans they don't like because they get us closer to the vision
- Plans that don't tie back to a vision are destined to fail.
- A vision is not a goal, and technically, cannot be achieved.
- Rather, you undertake initiatives & projects to get ever closer to the vision.
- If you don't have a vision for your group, then you must create one.

Vision: Components

- Ambitious — Set a high bar for level of performance
  - “We deliver the best outcomes, every time, to every patient.”
- Future-oriented — Long-term aspirations of what you want to achieve
  - “We will remove all avoidable patient harm by 2030.”
- Clear — Avoid ambiguity; use language everyone understands
  - “We strive to rid the world of all forms of glomerular membrane disease.”
- Concise — Short and to the point
  - “A world without patient harm.”
- Inspirational — Evoke positive emotions that motivates people
  - “We will provide the highest quality, safest, lowest cost care in the country.”

Vision: Examples

- UCHealth:

  We improve lives. In big ways through learning, healing and discovery. In small, personal ways through human connection. But in all ways, we improve lives.

- CHCO

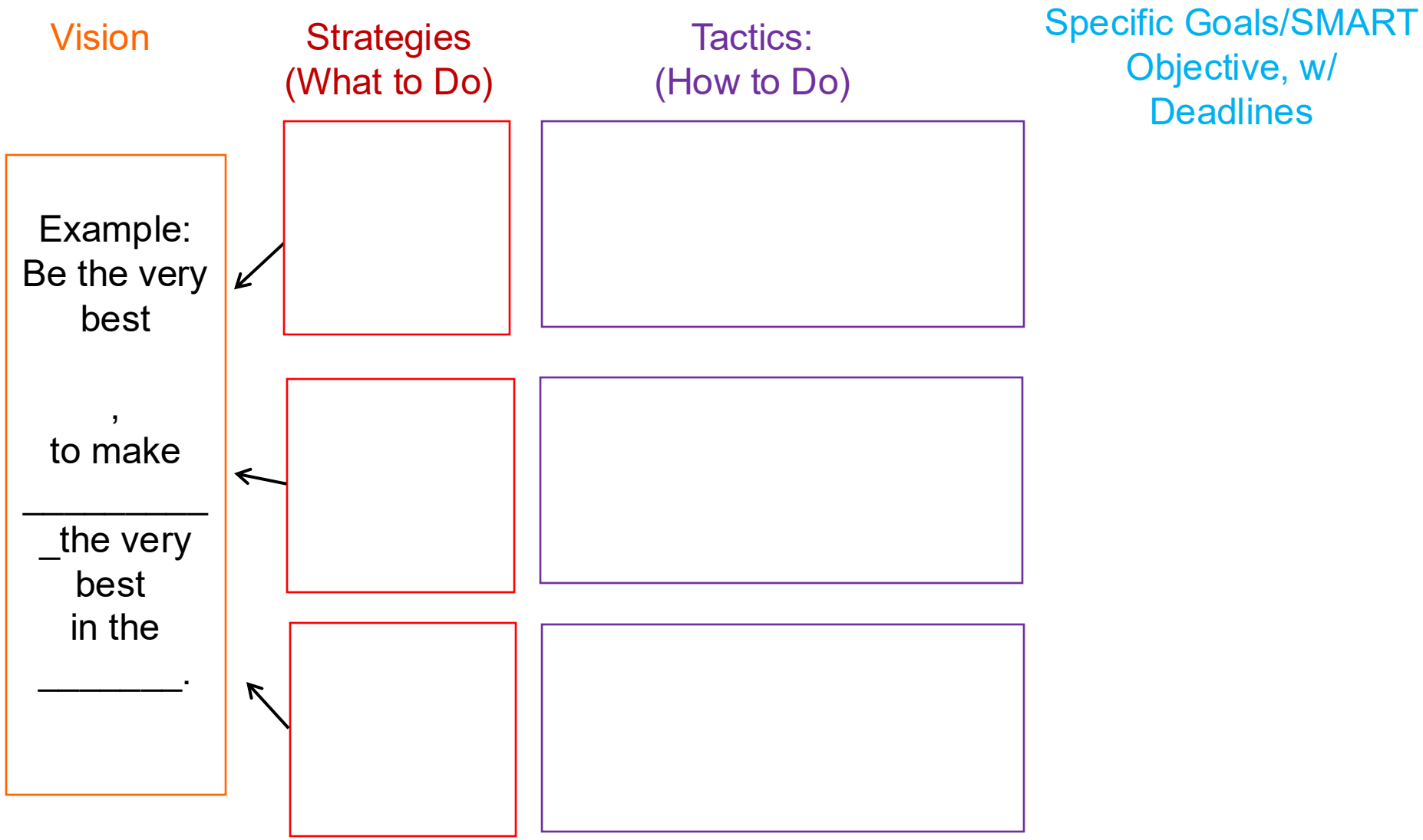
  Child Health. Reimagined. Realized.

- Other Examples:
  - We aspire to be the best ICU in the country.
  - We will be the standard against which other primary clinics are measured.

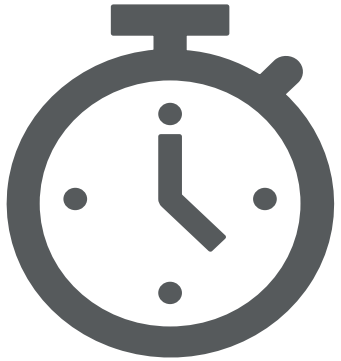
Vision: Breakout

- What vision will you tie your project back to?
  - Start with a group, department, organizational vision if it resonates.
  - If you don't have one, then create one.
    - Preferably something you could use for other projects as well.
    - I.e., not specific to vancomycin but rather something we as an ICU aspire to be.
  - Always start your discussions about the project with the vision…
    - …then tie your project work back to the vision
    - "We all want to be the highest performing ICU in the country, right? (Vision)
    - "Wouldn't the highest performing ICU in the country appropriately dose vancomycin in critically ill patients 100% of the time?" (Goal)
    - "Then let's do that by using the nomogram." (Project/Tactic)

Strategic Planning: Your Turn



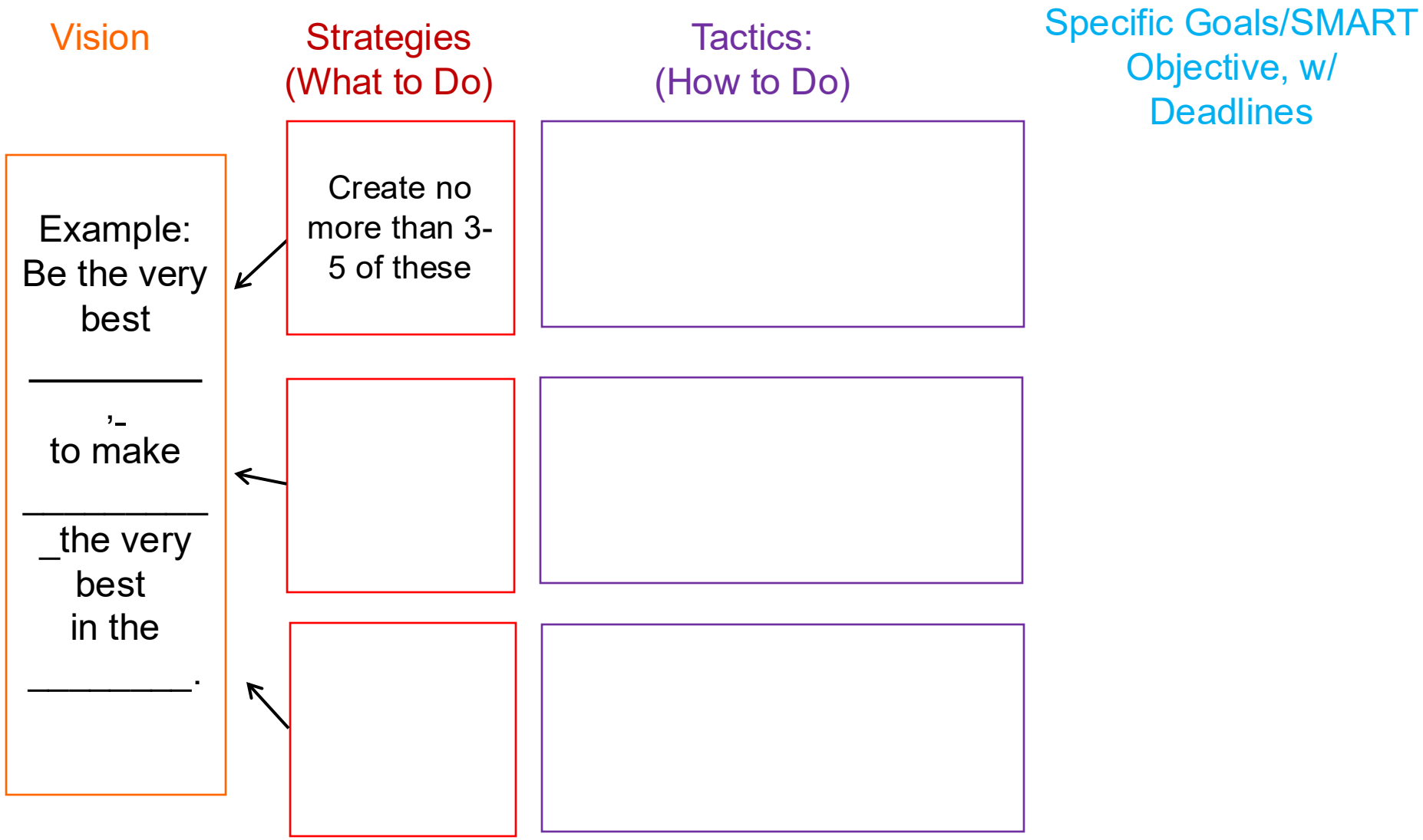
Breakout



20 minutes

What core strategies (what you will do) will allow you to achieve your vision?

Strategic Planning: Your Turn



Breakout

20 minutes

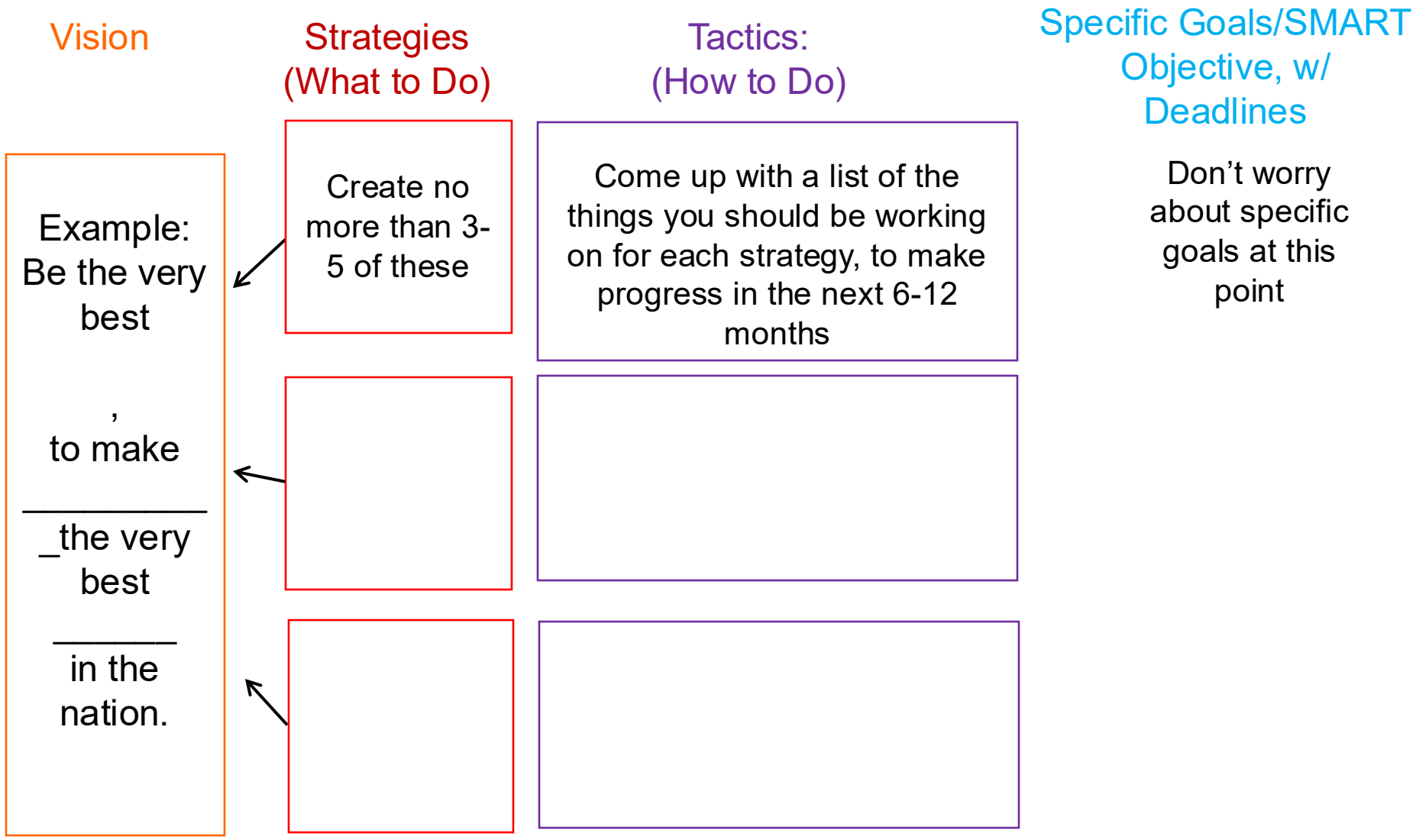
For each strategy (what you will do) what are a few tactics (how you will do it) to achieve success?

Alternatively, you can think of this as:

Strategy → General (reduce waste)

Tactic → Specific (decrease lab use)

Strategic Planning: Your Turn



Breakout

5 minutes

As a leadership team for your unit/program...what issues/efforts/work have you spent your time on over the past few months.

Reflecting on how you spend your time…how much time do you spend on strategy?

Evaluation

Evaluation

BREAK-TIME
Come back at 2:50!

Power & Influence

(Or, How to Get What you Want)

Emily Gottenborg, MD

Institute for Healthcare Quality, Safety and Efficiency
SCHOOL OF MEDICINE
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Feedback notes

- Get rid of personal sources
- Move alive tree to influence
- Highlight that power can be good when used sparingly
  - Example of lactation time / space
- Tell us people upfront with power / influence, its fun and helps make point that some people have both

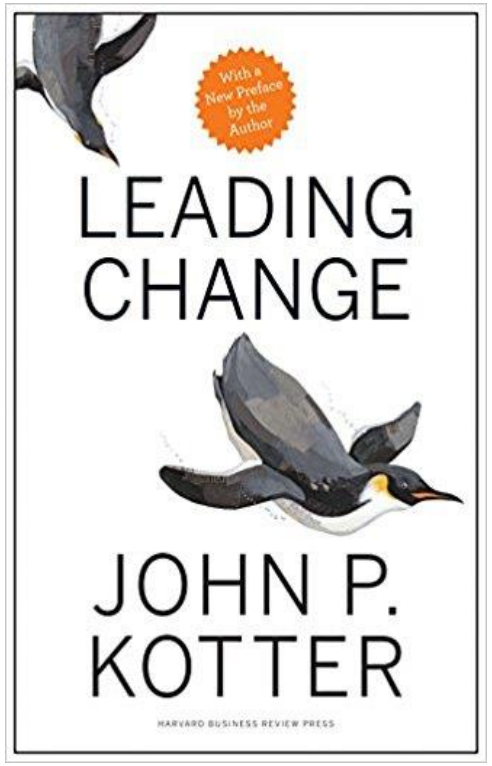
Goals

Understand the difference between power and influence, and where it fits in the leadership competency landscape

Learn your preferences for power bases, influence domains

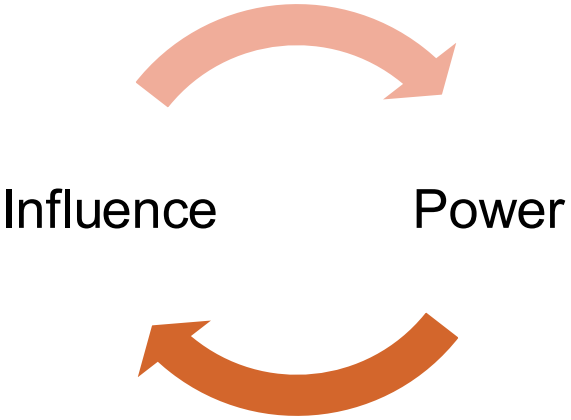
Apply power and influence modes to your current project work

The Leadership Landscape



Motivate People to Change

Manage Inevitable Resistance



Gain Followers

Break-out 1:

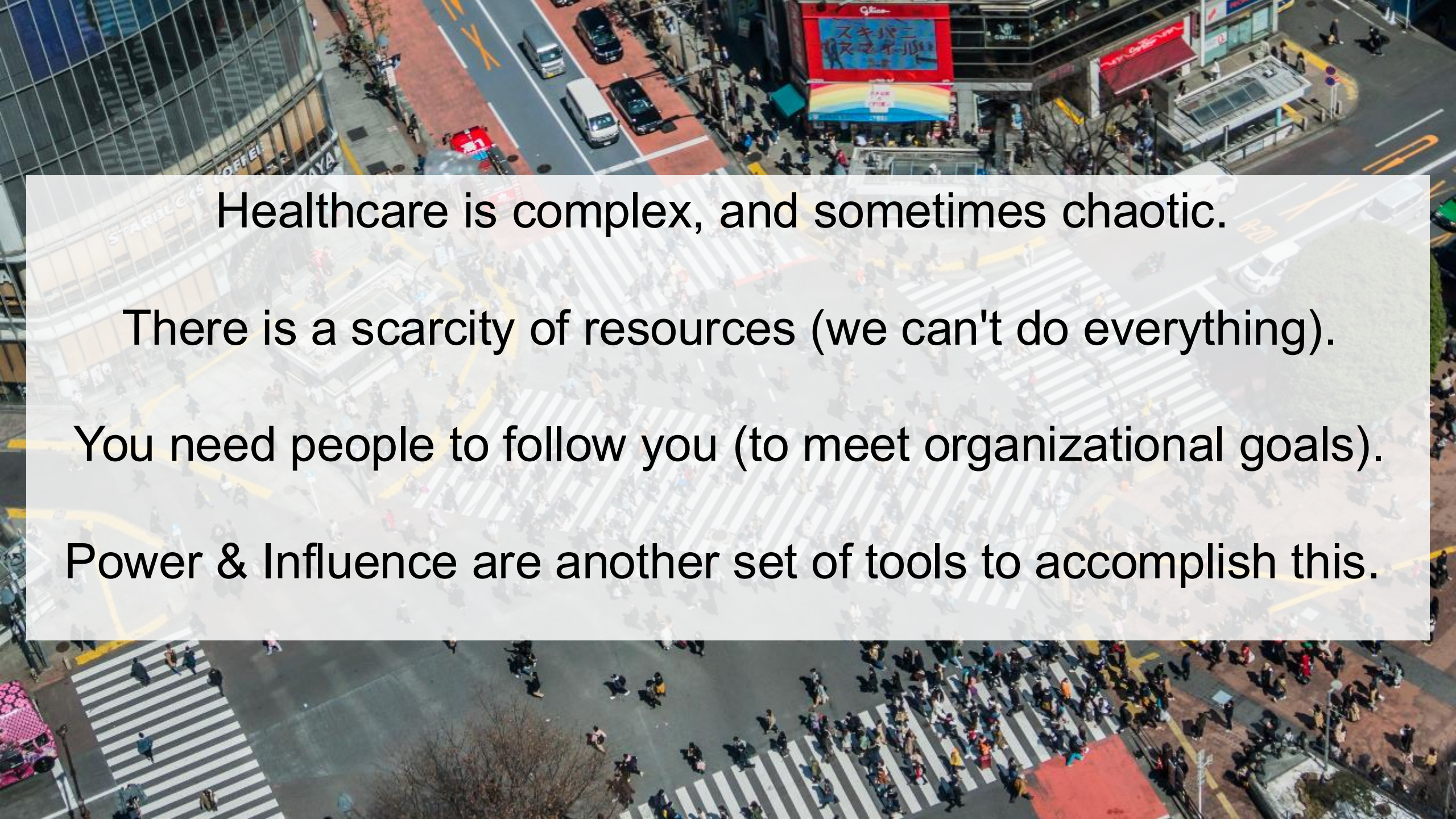
Think about someone in Power.

Think about someone who has influence.

- How did you define each?
- How do you know that person has Power or Influence?
- How did each show up in their ability to lead?

"It is better to be feared than loved."

- Niccolo Machiavelli, 1532



Healthcare is complex, and sometimes chaotic.

There is a scarcity of resources (we can't do everything).

You need people to follow you (to meet organizational goals).

Power & Influence are another set of tools to accomplish this.

Definitions

Power is the potential to change behaviors, attitudes, values, actions.

Power is determined by personal and positional characteristics. It is context specific.

As a leader, how do you handle this?

Due to the high census of patients admitted with COVID-19, you, as the Director of Operations, must call in providers to work additional shifts.

Power Bases

Positional Sources

- Authority
- Reward
- Discipline

Personal Sources

- Information
- Expertise
- Goodwill

Positional Power in Action

Authority: You have to cover the shift, because it is in your contract. (I'm the boss and I said so)

Reward: You have to cover the shift, and you will receive additional compensation for the shift.

Discipline: You have to cover the shift, and you'll get fired if you don't show up.

Result?

Compliance, Resistance

Positional Power
+
Relationships

Personal Power in Action

Information: Due to COVID, our OR's are closed, our profit stream is dwindling, and our hospital is struggling. As hospitalists we have offered to step up and help cover the extra patients. (Transparency)

Expertise: Based on my conversations with the CMO, I believe this will lead to additional hiring capability next year, and possibly even higher salaries. I'd really like to have that leverage to help support our team.

Goodwill: I'd like to offer to cover your shift next weekend in exchange.

Result?

Commitment

Personal Power
+
Relationships

Break-out 2: Reflection

Reflect on your preferred power bases.

Pick a situation at work that required you to use your power bases. Consider a recent situation -

- What power bases did you use?
- Was it successful?
- If not, which ones may have been more preferred?

Power Bases

Positional Sources

- Authority
- Reward
- Discipline

Personal Sources

- Information
- Expertise
- Goodwill

Considerations

Power structures exist in organizations and can be necessary.

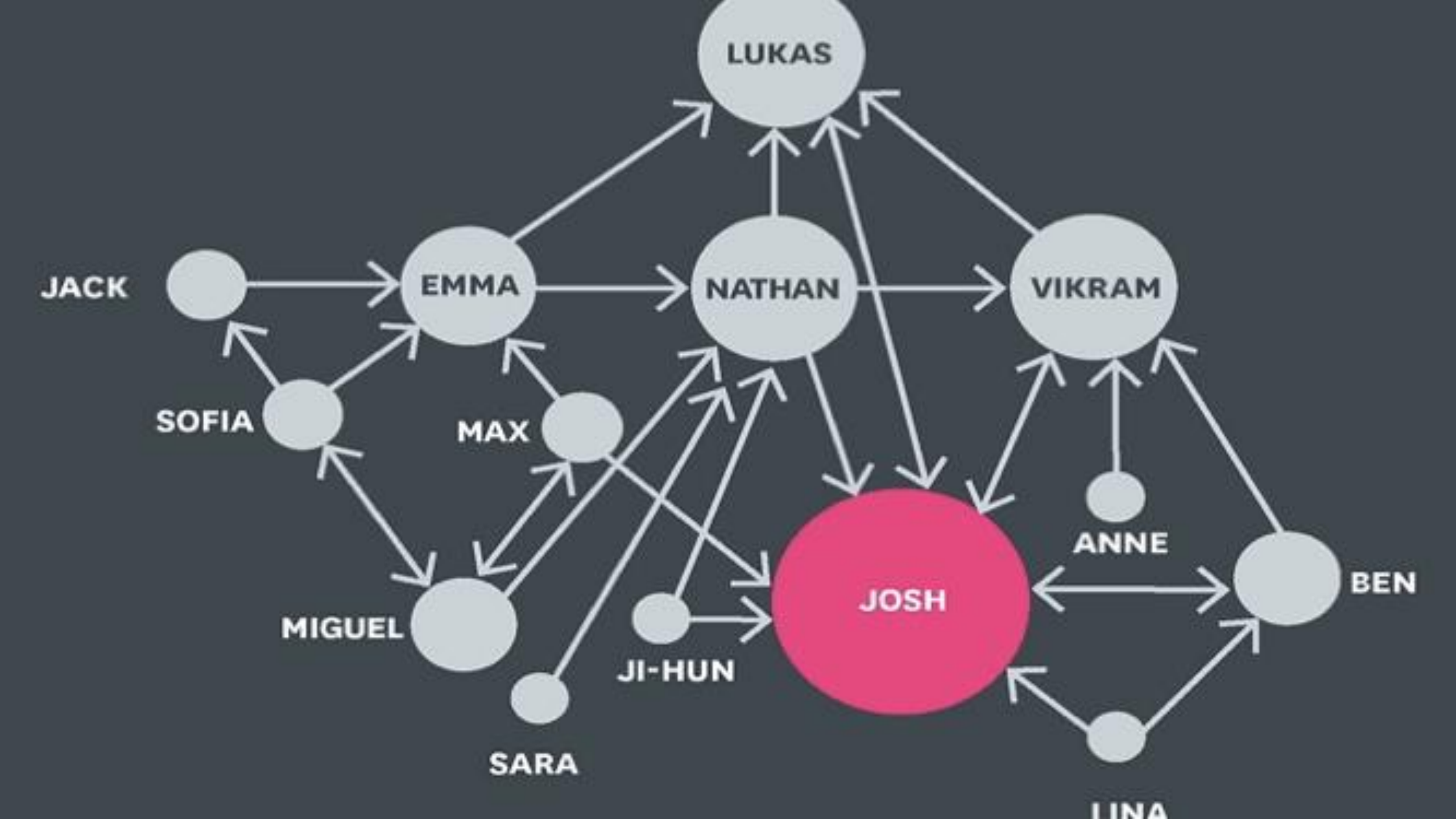
But, should be used *sparingly* and in *short-lived* situations – frequent use will upset people.

The more positional power you gain, the less you should be using it.

Use of power needs to be tampered with influence tactics...

Influence


LUKAS
EMMA
NATHAN
VIKR
JACK
SOFIA
MAX
MIGUEL
SARA
JI-HUN
JOSH
ANNE
BEN


LUKAS
JACK
EMMA
NATHAN
VIKRAM
SOFIA
MAX
ANNE
BEN
JOSH
MIGUEL
JI-HUN
SARA
LUNA

Key Sources of Influence

Formal Authority
(Positional Power)

Relevance
Centrality
Autonomy
Visibility
Track Record
Expertise
Effort
Attractiveness

Sources of Influence

Relevance – relationship between task and organizational objectives
Centrality - position in key networks
Autonomy - amount of discretion in position
Visibility - degree to which performance can be seen by others
Expertise – relevant knowledge, skills
Track record – relevant experiences
Effort – expenditure of energy
Attractiveness – attractive qualities

Building Project Based Influence

Emily, 2014 - I want parental leave.

Emily, 2018 –

Step 1: Effort, Track Record

Journal of Hospital Medicine

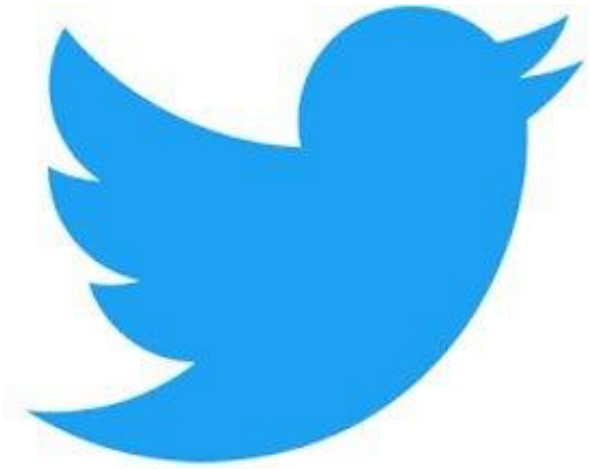
shm Society of Hospital Medicine

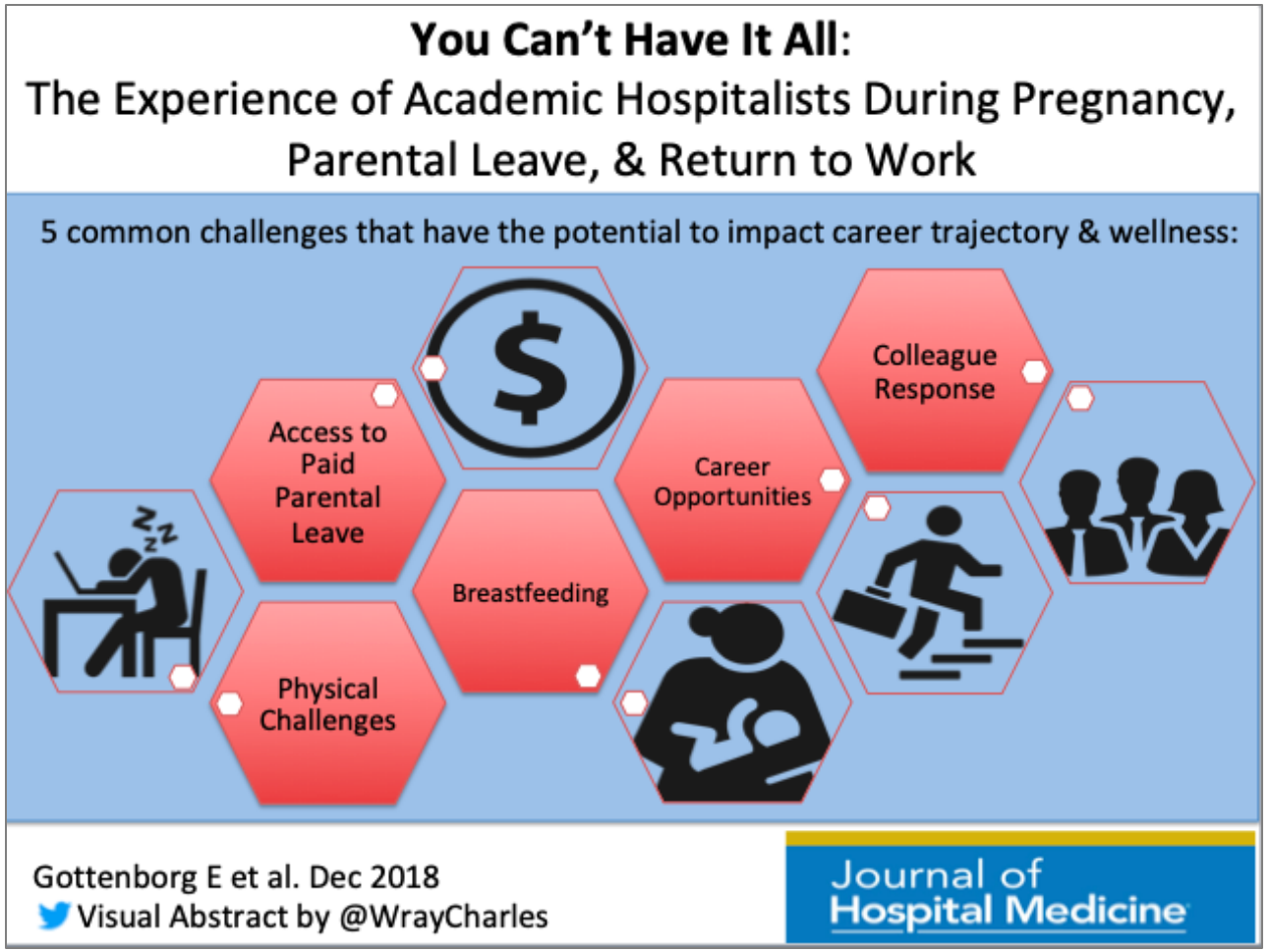
Brief Report

You Can't Have It All: The Experience of Academic Hospitalists During Pregnancy, Parental Leave, and Return to Work

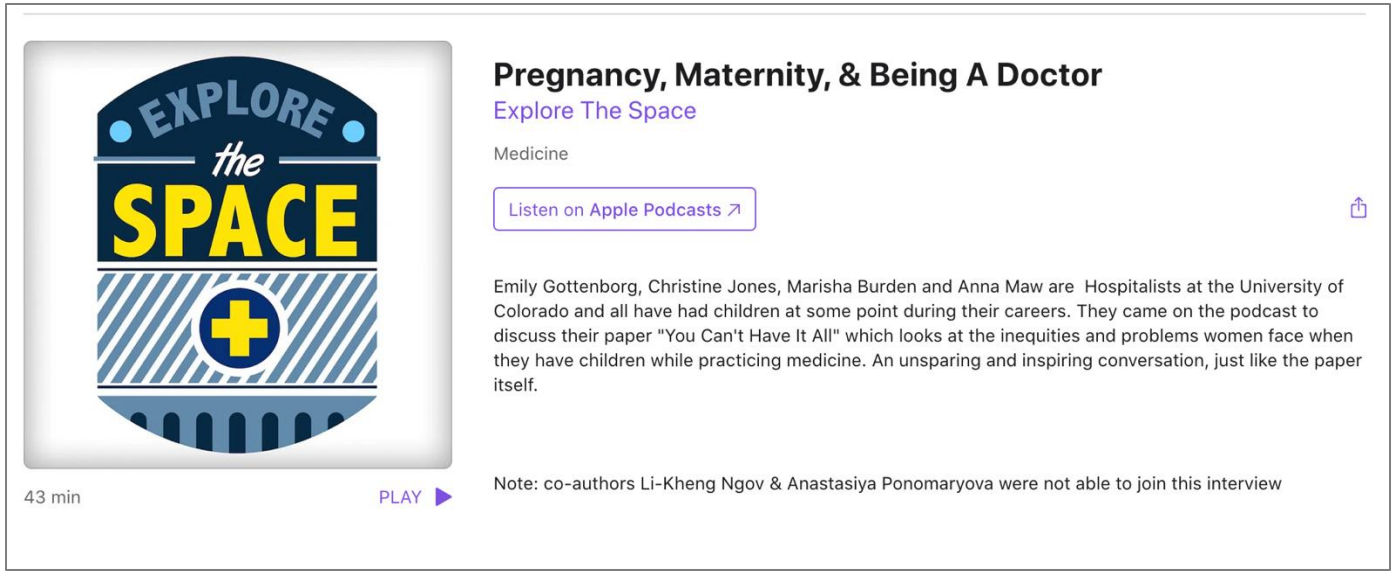
Emily Gottenborg MD, Anna Maw MD, Li-Kheng Ngov MD, Marisha Burden MD, Anastasiya Ponomaryova BS, Christine D. Jones MD, MS

Step 2: Expertise





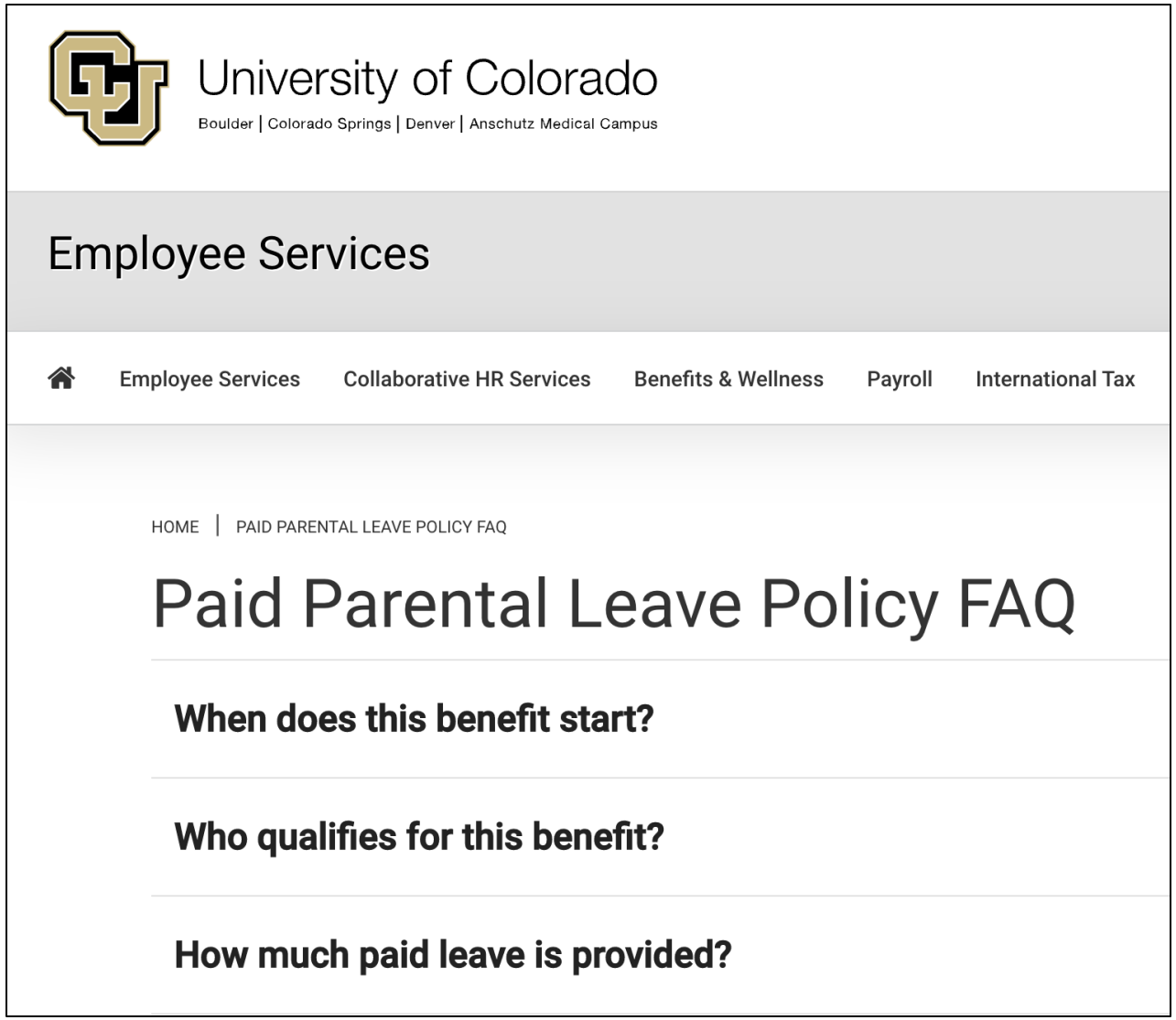
Step 3: Enhance Visibility



Step 4: Become Relevant, Central to organizational initiatives

Step 5: Attractiveness (to my boss – involved, a doer, GSD)

Fastforward, 2023



Break-out 3: Application

Consider the influence you have in your leadership role - assess yourself in each of the domains.

How can you diversify your influence portfolio?

Hint – this will help people follow you when you ask them to do the next hard thing..

Pick 2 – 3 influence domains - make a goal to enhance them.

Key Sources of Influence

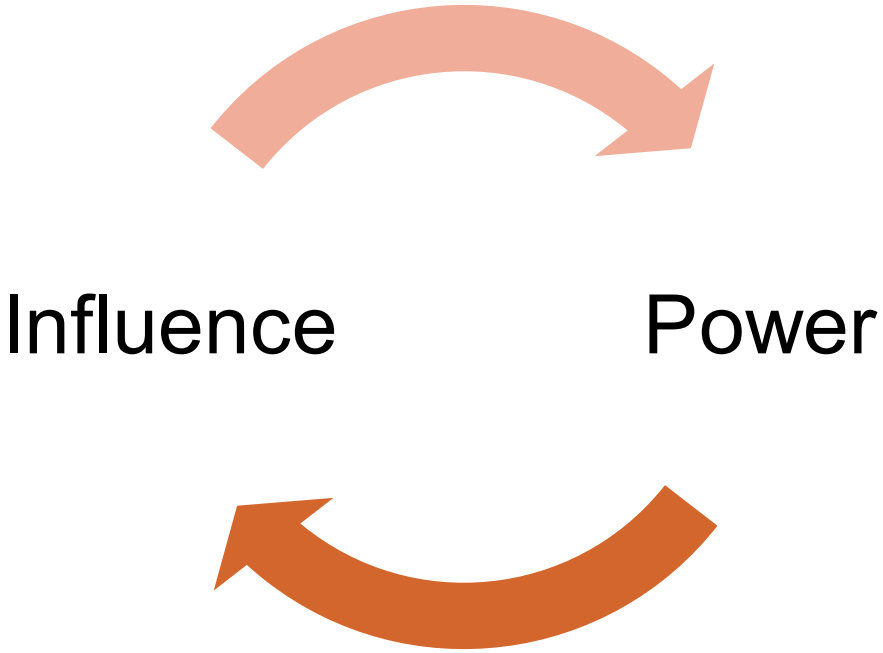
Formal Authority
(Positional Power)

Relevance
Centrality
Autonomy
Visibility
Track Record
Expertise
Effort
Attractiveness

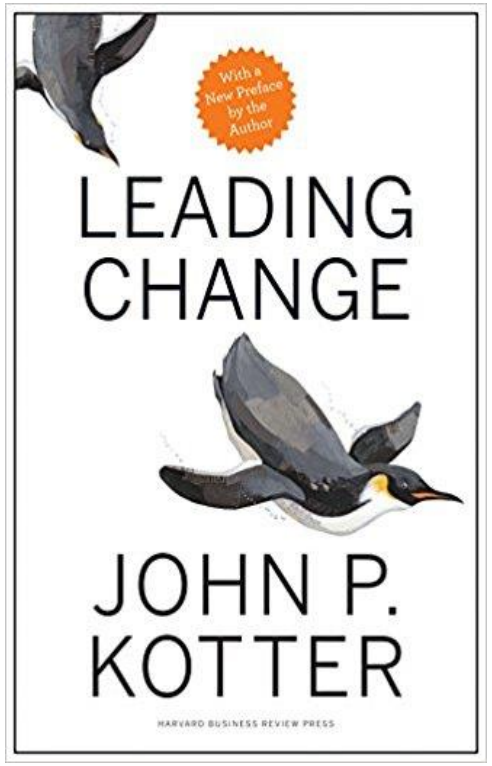
Considerations

Even / When you are THE BOSS, you need to build and use your influence:

- to get others to follow you
- to earn commitment
- to lead effectively
- to meet organizational goals



Putting it all Together



Motivate People to Change

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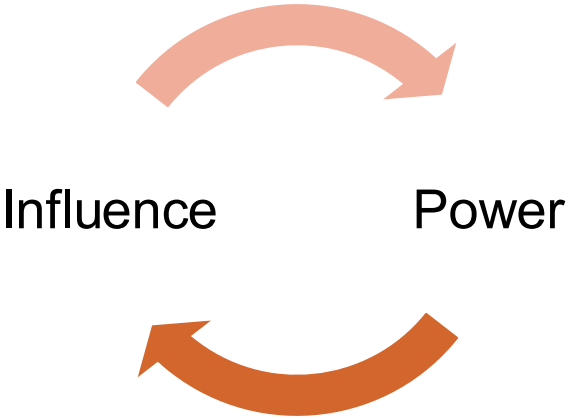


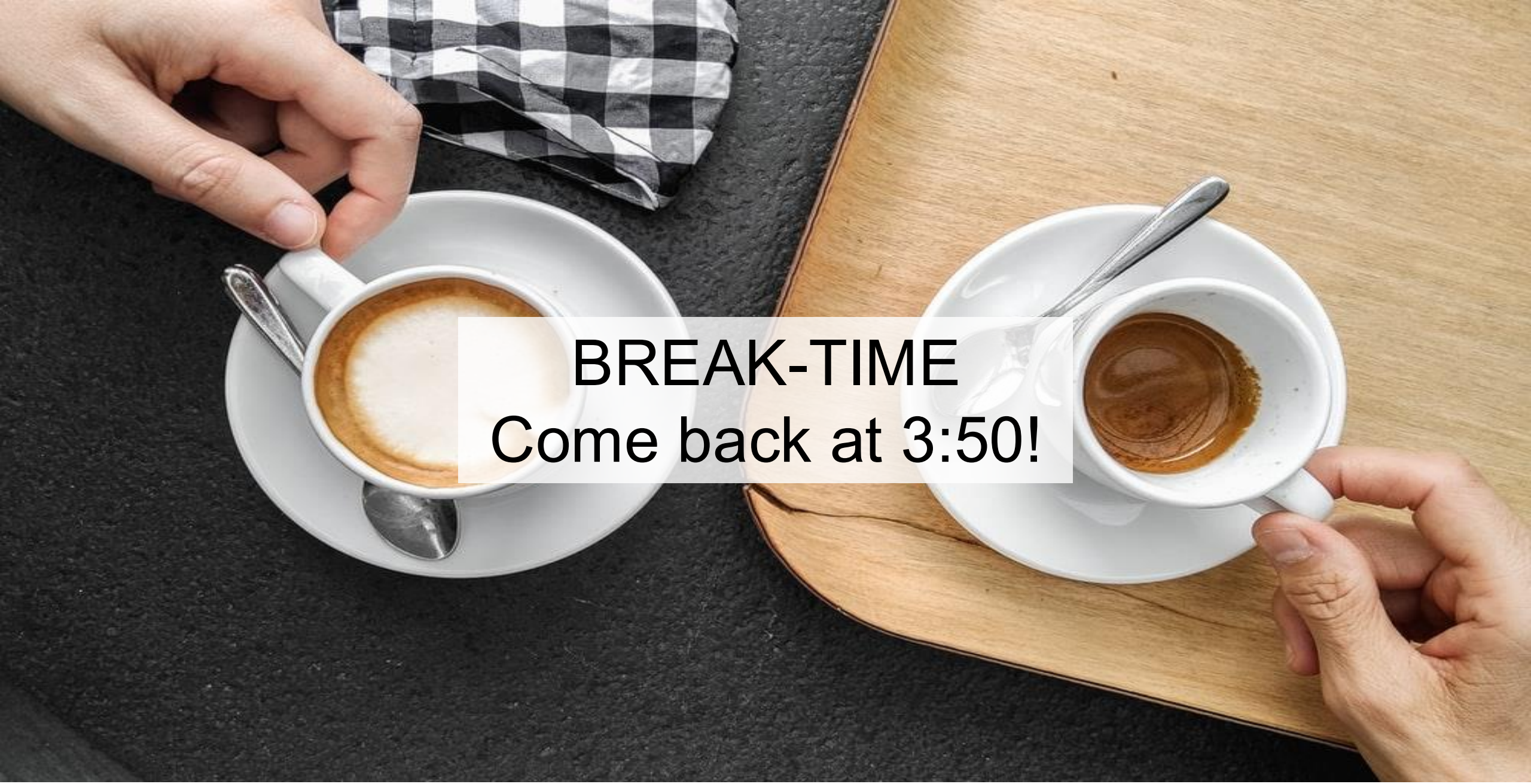
Gain Followers

Summary

Power and influence are related, but not the same. Both are necessary to bring about productive and creative resolutions to organizational problems.

Power comes from building influence - the more positional power you have, the less you may use it.

Building your influence modes is critical as a leader.


BREAK-TIME
Come back at 3:50!

QI Spread

Ethan Cumbler, MD

Institute for Healthcare Quality,
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UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Dissemination of QI

Spread and Scholarship

Ethan Cumbler MD, FHM, FACP

Institute for Healthcare Quality, Safety, and Efficiency

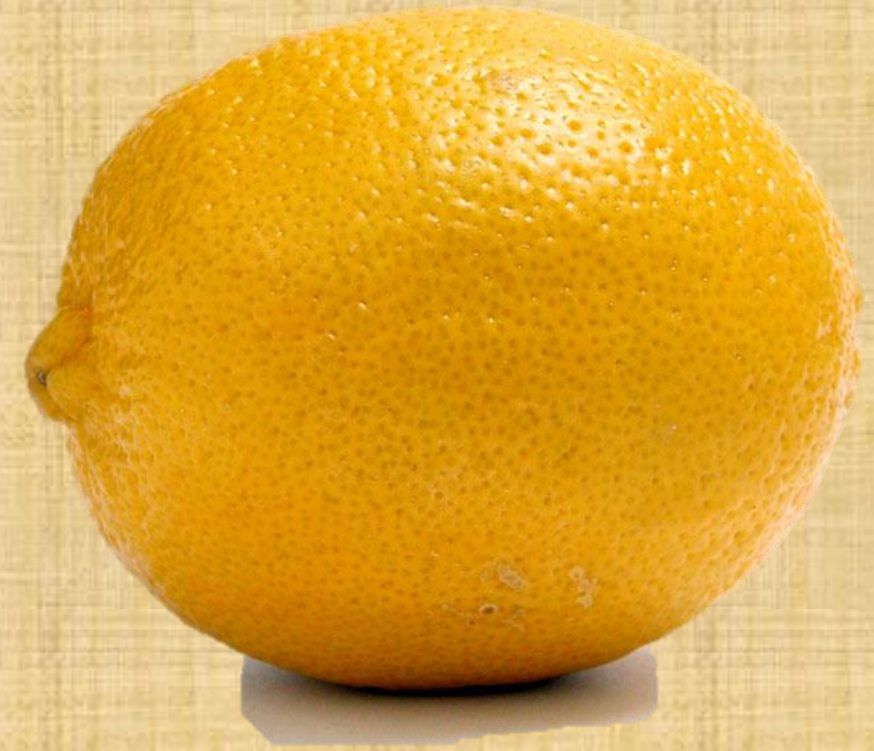
Professor University of Colorado

Departments of Medicine and Surgery

1480-1521


MARIS PACIFICI,
(quod vulgò Mar del Zur)
cum regionibus circumiacentibus, insulisque in eodem passim sparsis, novissima descriptio.
MARIS ATLANTICI,
SIVE MAR DEL NORT
MARE PACIFICVM,
CVM, QVOD VVLGO
NOMINANT
MAR DEL ZVR.
AMERICAE SEPTEM-
TRIONALIOR PARS.
AMERICAE
MERIDIONA
LIOR PARS.
Nova Guinea, quibusdam
Terra de Piccinacoli.
TERRA AVSTRALIS,
SIVE MAGELLANICA, NON-
DVM DETECTA.
Nova Hispania.
Caribana.
Quito.
Peru.
Charcas.
Chili.
Patagones.
Tierra del Fuego.
Mar del Norte
Archipelagus in-
sularum.
Insulae Sa-
lomonis.
Circulus Cancri.
Circulus Capricorni.
Circulus Aequinoctialis.
MERIDIES.
SEPTENTRIO.
ASIAE PARS ORIEN.
Tartariae li-
mites.
Isla de Plata.
Japan Ins.
Cequij.
Fogniem
Islas de Ladrones.
Philippinas.
Malucho
SPE ET
METV.
GENIO ET INGENIO NO-
BILI DN. NICOLAO ROCCOXIO,
PATRICIO ANTVERPIENSI,
EIVSDEMQVE VRBIS SENATORI,
Abrahamus Ortelius Regiae Mtis geographus
hoc suorum
dedicavit.

Important Medical Innovations Spread Slowly



ACE services

Effectiveness of Acute Geriatric Unit Care Using Acute Care for Elders Components: A Systematic Review and Meta-Analysis

Mary T. Fox, PhD, Malini Persaud, PhD,* Ilo Maimets, MSc, MISt,† Kelly O'Brien, PhD,‡ Dina Brooks, PhD,‡ Deborah Tregunno, PhD,* and Ellen Schraa, PhD§*

OBJECTIVES: To compare the effectiveness of acute geriatric unit care, based on all or part of the Acute Care for Elders (ACE) model and introduced in the acute phase of illness or injury, with that of usual care.

DESIGN: Systematic review and meta-analysis of 13 randomized controlled and quasi-experimental trials with parallel comparison groups retrieved from multiple sources.

SETTING: Acute care geriatric and nongeriatric hospital units.

toward fewer pressure ulcers was observed. No differences were found in functional decline between baseline hospital admission status and discharge, mortality, or hospital readmissions.

CONCLUSION: Acute geriatric unit care, based on all or part of the ACE model and introduced during the acute phase of older adults' illness or injury, improves patient- and system-level outcomes. J Am Geriatr Soc 60:2237–2245, 2012.

Reduced Delirium RR 0.73
Less Functional Decline from baseline to discharge RR 0.87
Fewer discharges to NH RR 0.82
Reduced Falls RR 0.51
Shorter LOS by 0.61 days

“If these concentrated efforts are so amazingly effective, why are there only about 200 in the country?”

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Press Releases

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Staff

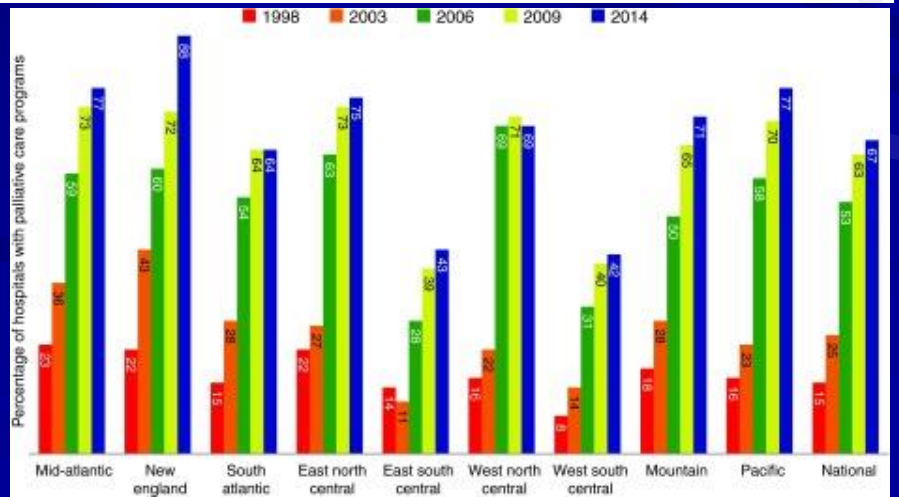
Palliative Care Continues Its Annual Growth Trend, According to Latest Center to Advance Palliative Care Analysis

NEW YORK, NY (May 27, 2015)—Palliative care in U.S. hospitals has increased yet again this year, according to a new analysis released today by the Center to Advance Palliative Care (CAPC). The prevalence of hospitals (50 or more beds) with a palliative care team increased from 658 to 1,744 – a 165% increase from 2000 to 2013.

The rise in prevalence of palliative care in U.S. hospitals has been steady over the last 13 years. In 2000, less than one-quarter of U.S. hospitals (658) had a palliative care program, compared with nearly three-quarters (1,744) in 2013. If current trends continue, by 2017, eight in ten U.S. hospitals with 50 or more beds will have a palliative care program.

"The continued growth of palliative care in U.S. hospitals shows that patients with serious illness and their families are receiving the quality care they need," said CAPC Director Diane E. Meier, MD. "We are well on our way to ensuring that our most vulnerable patients have full access to palliative care."

"In 2000, just 24.5% (658) of hospitals with more than 50 beds reported palliative care programs; in 2013, 72.3% (1,744) of such hospitals reported a program."




What makes some ideas, improvements, or innovations spread and stick?
iPhone

Attributes of ideas which spread

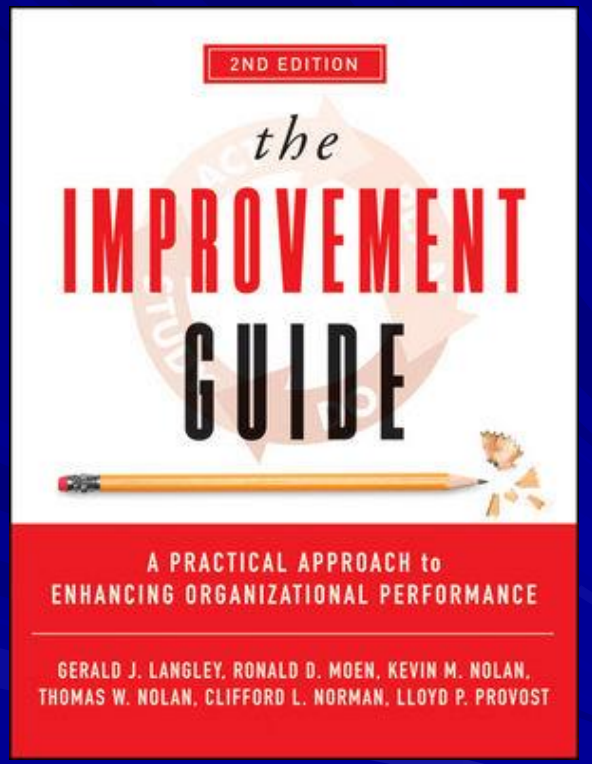
– Relative Advantage (over current state)

– Simplicity (Complexity = Idea death)

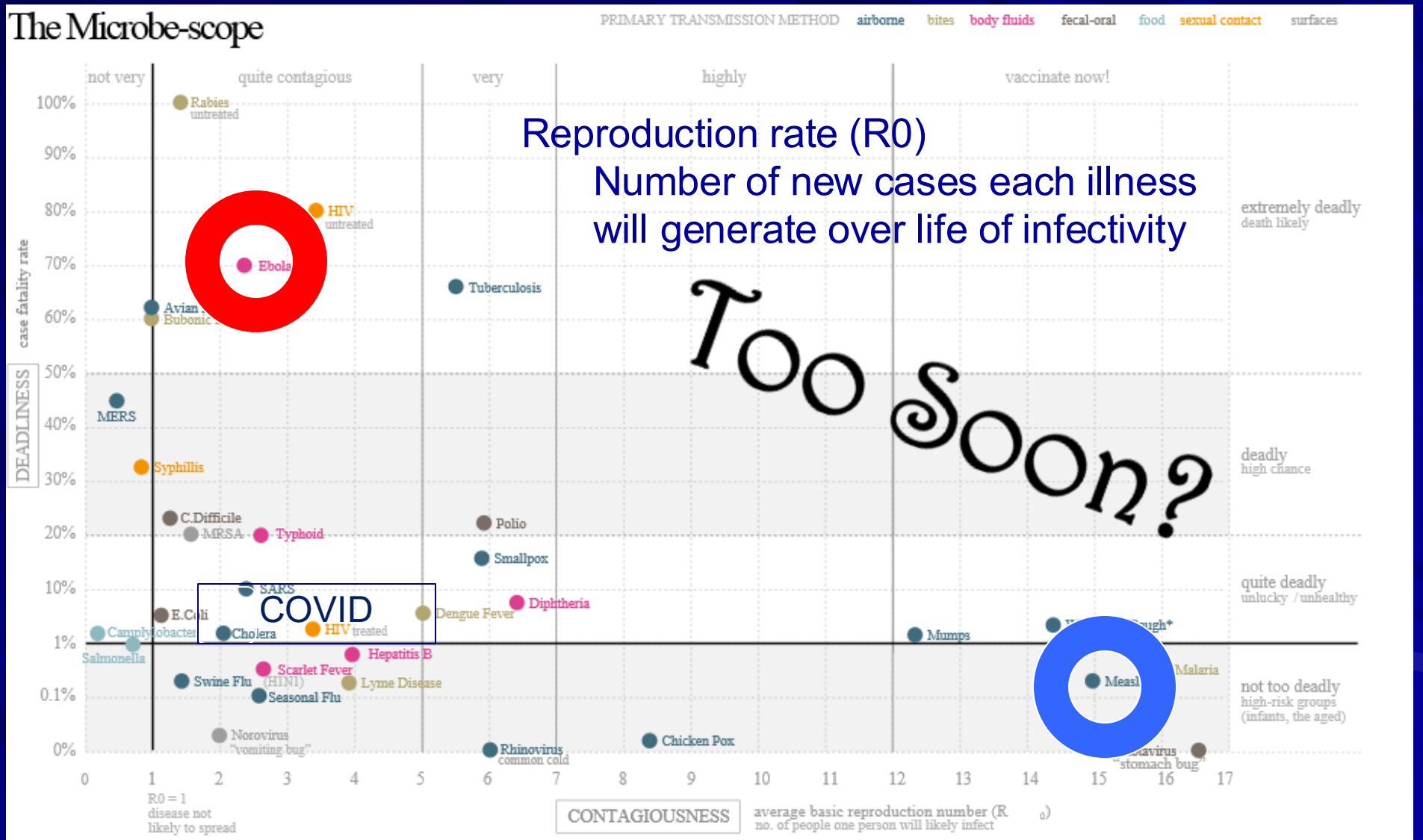
– Compatibility (with existing values)

– Observability (Can I see how it worked)

– Trialability (Is it easy to test out in my environment)



Epidemic Model



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

Office of Public Health Preparedness and Response

- Office of Public Health Preparedness and Response
- Overview +
- Are We Prepared? −
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  - **Zombie Preparedness** −
    - Zombie Novella
- Blog: Public Health Matters +
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- Funding, Guidance, and Technical Assistance to States, Localities, and

Office of Public Health Preparedness and Response > Are We Prepared? > Zombie Preparedness

Zombie Preparedness

Wonder why Zombies, Zombie Apocalypse, and Zombie Preparedness continue to live or walk dead on a CDC web site? As it turns out what first began as a tongue in cheek campaign to engage new audiences with preparedness messages has proven to be a very effective platform. We continue to reach and engage a wide variety of audiences on all hazards preparedness via Zombie Preparedness.

Zombie Products

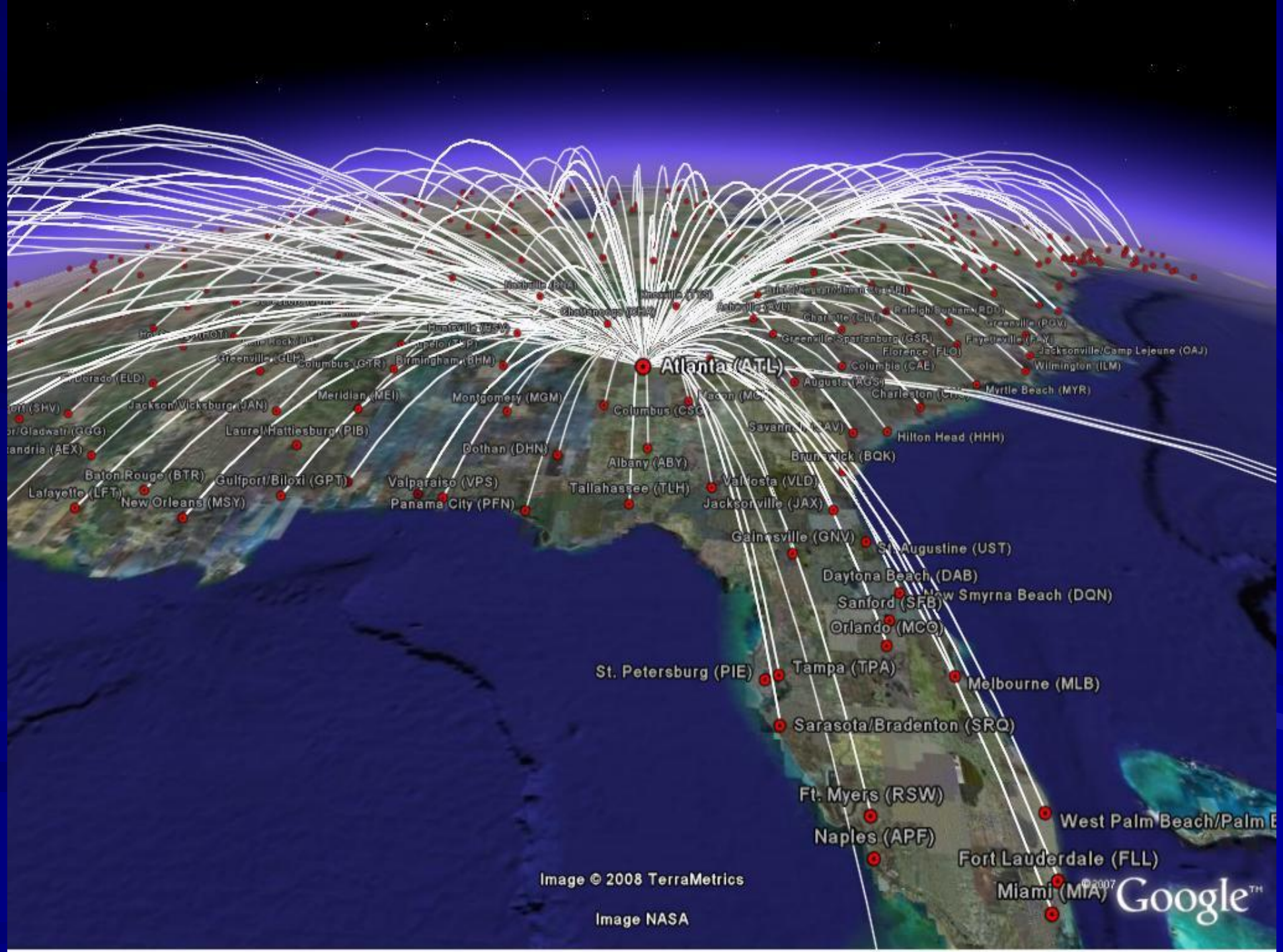
How vulnerable is your state to the Zombie Apocalypse?

Source: Estately Inc.

THE HARDEST PART ABOUT A

ZOMBIE APOCALYPSE

IS PRETENDING I'M NOT EXCITED


Atlanta (ATL)
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Birmingham (BHM)
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Dothan (DHN)
Albany (ABY)
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Panama City (PFN)
Tallahassee (TLH)
Baton Rouge (BTR)
Gulfport/Biloxi (GPT)
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Jacksonville (JAX)
Columbia (CAE)
Augusta (AGS)
Charleston (CHS)
Myrtle Beach (MYR)
Florence (FLO)
Jacksonville/Camp Lejeune (OAJ)
Wilmington (ILM)
Savannah (SAV)
Hilton Head (HHH)
Brunswick (BQK)
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Ft. Myers (RSW)
Naples (APF)
West Palm Beach/Palm B
Fort Lauderdale (FLL)
Miami (MIA)
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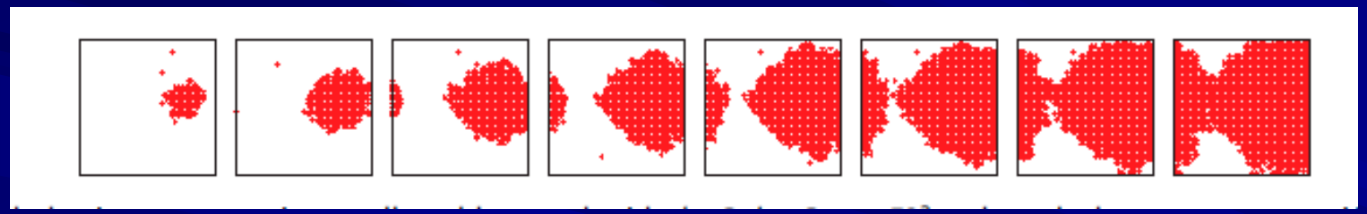
Short Connections

Direct Influence

- Ask first “who is your target audience”?
  - Who will benefit from the knowledge you have?
  - Who are you trying to reach and where are they found?



- Think about direct spread first
  - Within your institution
    - Grand rounds, research conferences, champion groups, presentations to key committees

Long Connections

Regional Conferences
Local society chapter meetings

National Conferences

Publications

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 28, 2006 VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

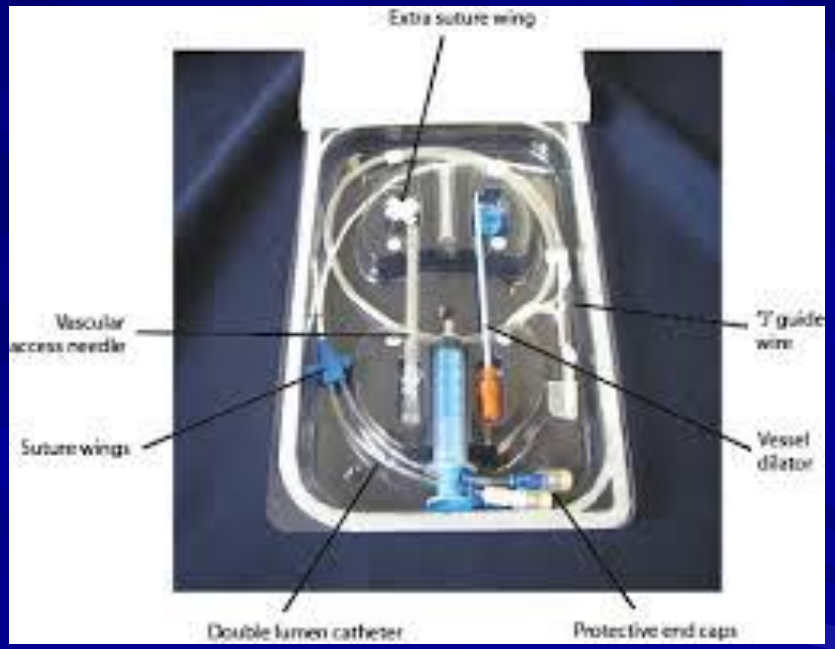
Table 3. Rates of Catheter-Related Bloodstream Infection from Baseline (before Implementation of the Study Intervention) to 18 Months of Follow-up.*

Study Period	No. of ICUs	No. of Bloodstream Infections per 1000 Catheter-Days				
		Overall	Teaching Hospital	Nonteaching Hospital	<200 Beds	≥200 Beds
		median (interquartile range)				
Baseline	55	2.7 (0.6–4.8)	2.7 (1.3–4.7)	2.6 (0–4.9)	2.1 (0–3.0)	2.7 (1.3–4.8)
During implementation	96	1.6 (0–4.4)†	1.7 (0–4.5)	0 (0–3.5)	0 (0–5.8)	1.7 (0–4.3)†
After implementation						
0– 3 mo	96	0 (0–3.0)‡	1.3 (0–3.1)†	0 (0–1.6)†	0 (0–2.7)	1.1 (0–3.1)‡
4–6 mo	96	0 (0–2.7)‡	1.1 (0–3.6)†	0 (0–0)‡	0 (0–0)†	0 (0–3.2)‡
7–9 mo	95	0 (0–2.1)‡	0.8 (0–2.4)‡	0 (0–0)‡	0 (0–0)†	0 (0–2.2)‡
10–12 mo	90	0 (0–1.9)‡	0 (0–2.3)‡	0 (0–1.5)‡	0 (0–0)†	0.2 (0–2.3)‡
13–15 mo	85	0 (0–1.6)‡	0 (0–2.2)‡	0 (0–0)‡	0 (0–0)†	0 (0–2.0)‡
16–18 mo	70	0 (0–2.4)‡	0 (0–2.7)‡	0 (0–1.2)†	0 (0–0)†	0 (0–2.6)‡

* Because the ICUs implemented the study intervention at different times, the total number of ICUs contributing data for each period varies. Of the 103 participating ICUs, 48 did not contribute baseline data. P values were calculated by the two-sample Wilcoxon rank-sum test.
† $P \leq 0.05$ for the comparison with the baseline (preimplementation) period.
‡ $P \leq 0.002$ for the comparison with the baseline (preimplementation) period.

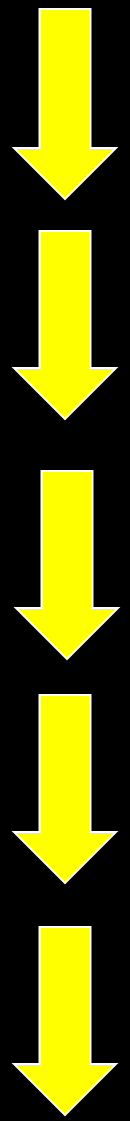
So…what actually happened?

Why?



Sometimes the results of your QI project are NOT the most critical thing to disseminate

Bad QI Project Dissemination Plan



Failure to publish
=
Total Failure to disseminate

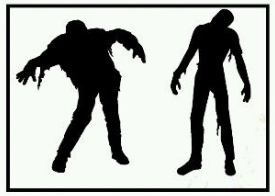
Results Dissemination via Article in Peer Reviewed Publication

Break…

ZOMBIE APOCALYPSE

Are you prepared?
have you got:

1. Supplies?
2. Adequate weaponry?
3. Fortified shelter?
4. An escape plan?



It is important to remain calm in the event of an outbreak, be alert but not alarmed. Survivors should proceed towards the nearest shelter and wait for emergency service. It is advised to limit contact with the infected doing so will reduce the chance of contamination. Those infected should be quarantined and brought to the attention of the officials in charge so they may receive appropriate treatment.

Ask yourself:

ARE YOU READY?

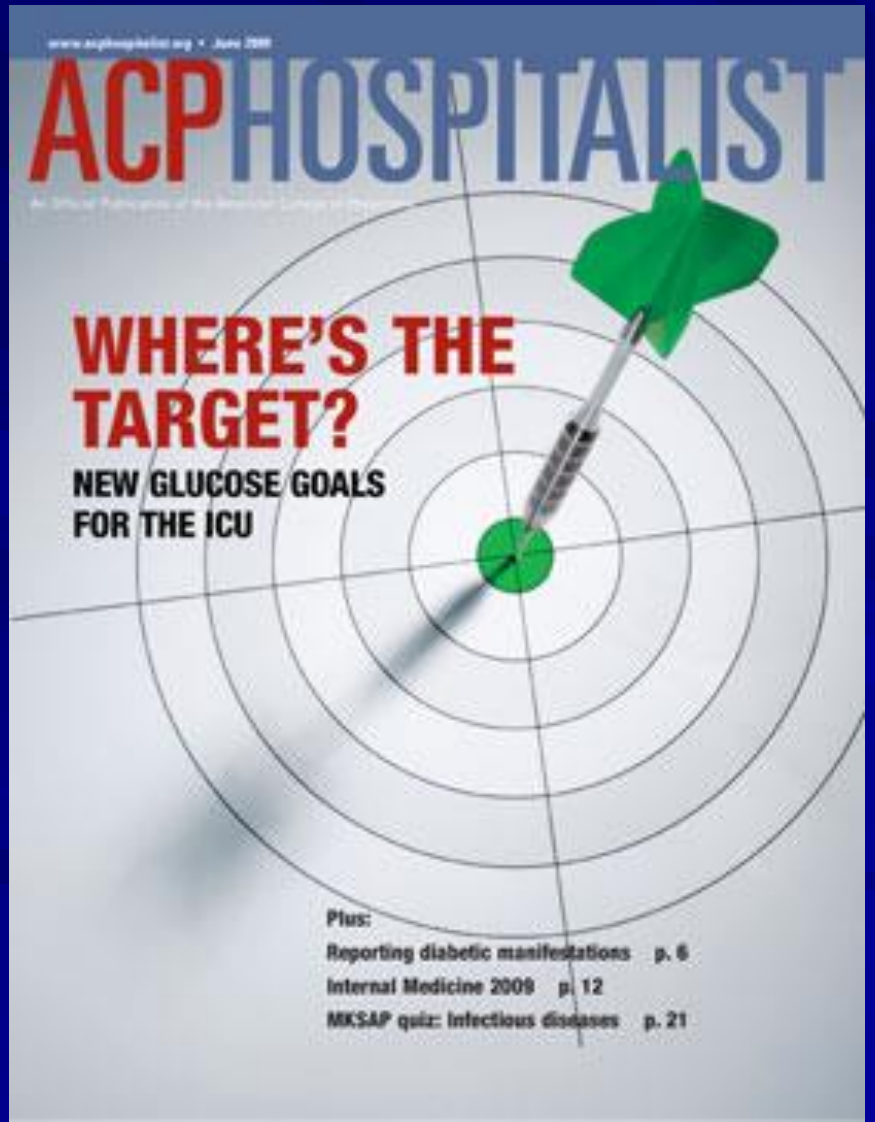
Indirect Influence

- It is more than just peer reviewed publications

Want to Hear More about Our Quality Improvement Project …

Hit us up on:
twitter

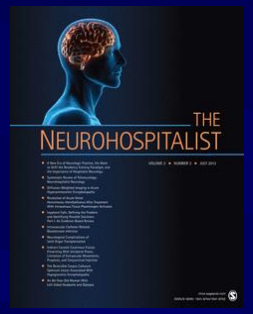
Non-Peer Reviewed Publications

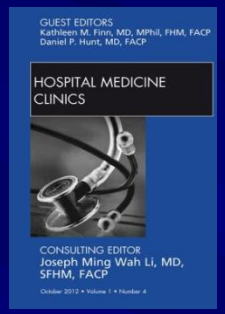


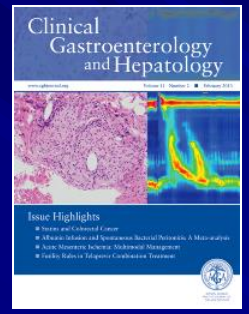
The Golden Age

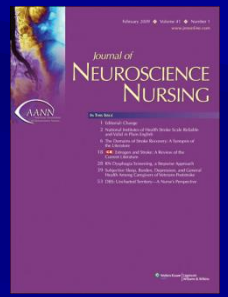
Pietro da Cortona
1637

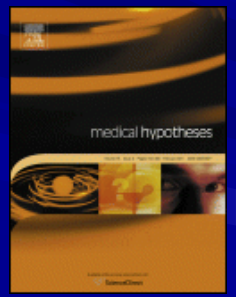
Peer Reviewed Publications











What Is Worth Disseminating?

Finding your Angle

Facet #1

Proving Efficacy of a New QI Intervention

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 28, 2006 VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pron ... M.B.A., Haitac ... M.D.,

THIS IS WHAT TO DO AND THESE ARE THE RESULTS TO EXPECT

BACKGROU

Catheter-r ... are comm ...

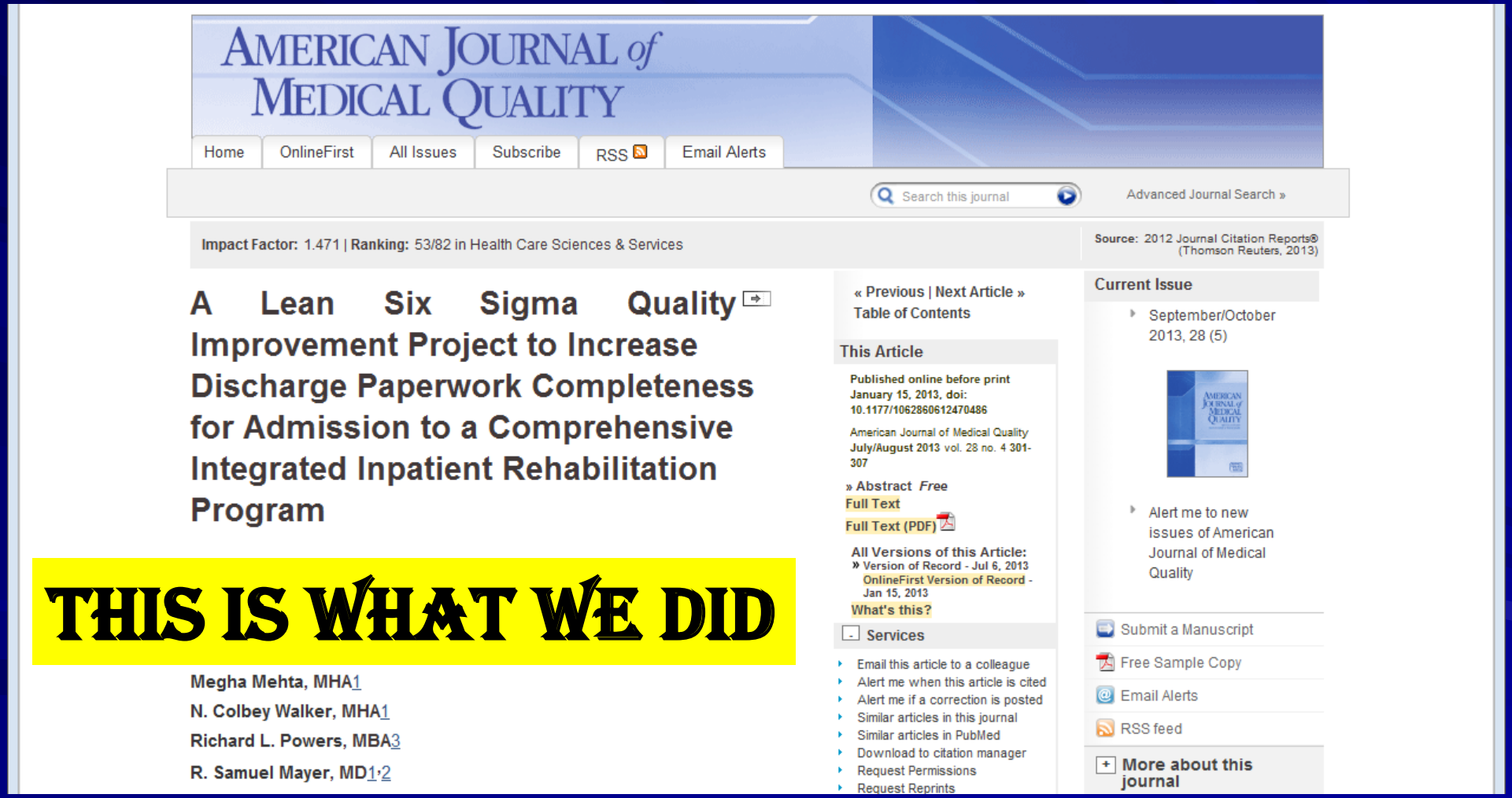
METHODS

We conducted a collaborative cohort study predominantly in ICUs in Michigan. An evidence-based intervention was used to reduce the incidence of catheter-related bloodstream infections. Multilevel Poisson regression modeling was used to compare infection rates before, during, and up to 18 months after implementation of

... D.N., ...essional ... (D.S.), ... Health (H.C.), Johns Hopkins University, Baltimore; and the University of Michigan, Ann Arbor (R.H.); William Beaumont Hospital, Royal Oak (R.W.); Ingham Regional Medical Center, Lansing (G.R.); Harper University Hospital, Detroit (J.B.); Sparrow Health System, Lansing (J.K.); and the

Facet #2

Methodology to Implement Proven Intervention



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Impact Factor: 1.471 | Ranking: 53/82 in Health Care Sciences & Services

Source: 2012 Journal Citation Reports® (Thomson Reuters, 2013)

A Lean Six Sigma Quality Improvement Project to Increase Discharge Paperwork Completeness for Admission to a Comprehensive Integrated Inpatient Rehabilitation Program

THIS IS WHAT WE DID

Megha Mehta, MHA[1]
N. Colbey Walker, MHA[1]
Richard L. Powers, MBA[3]
R. Samuel Mayer, MD[1,2]

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This Article

Published online before print January 15, 2013, doi: 10.1177/1062860612470486

American Journal of Medical Quality July/August 2013 vol. 28 no. 4 301-307

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Facet #3

Gap Analysis

HERE IS A PROBLEM

Facet #4

Attitudes of individuals touched by QI initiative

Clinician Satisfaction with a Preventive Services Implementation Trial

The IMPROVE Project

Thomas E. Kouke, MD, Leif I. Solberg, MD, Milo L. Brekke, PhD, Sanne Magnan, MD, Gail M. Amundson, MD

Object: To discover how attempts to increase the delivery of preventive services affect clinician satisfaction.

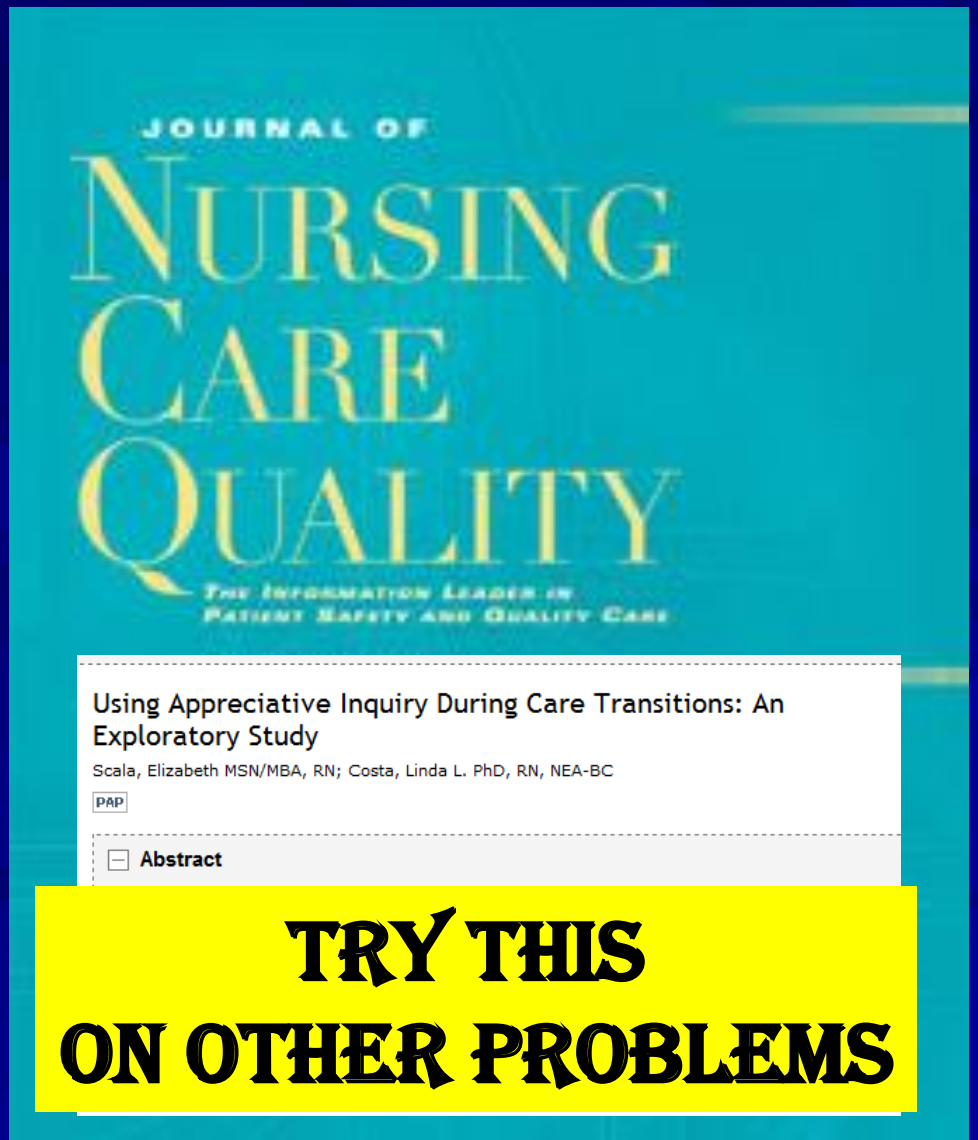
PARTICIPANT PERCEPTIONS

Facet #5

Exploration of Barriers

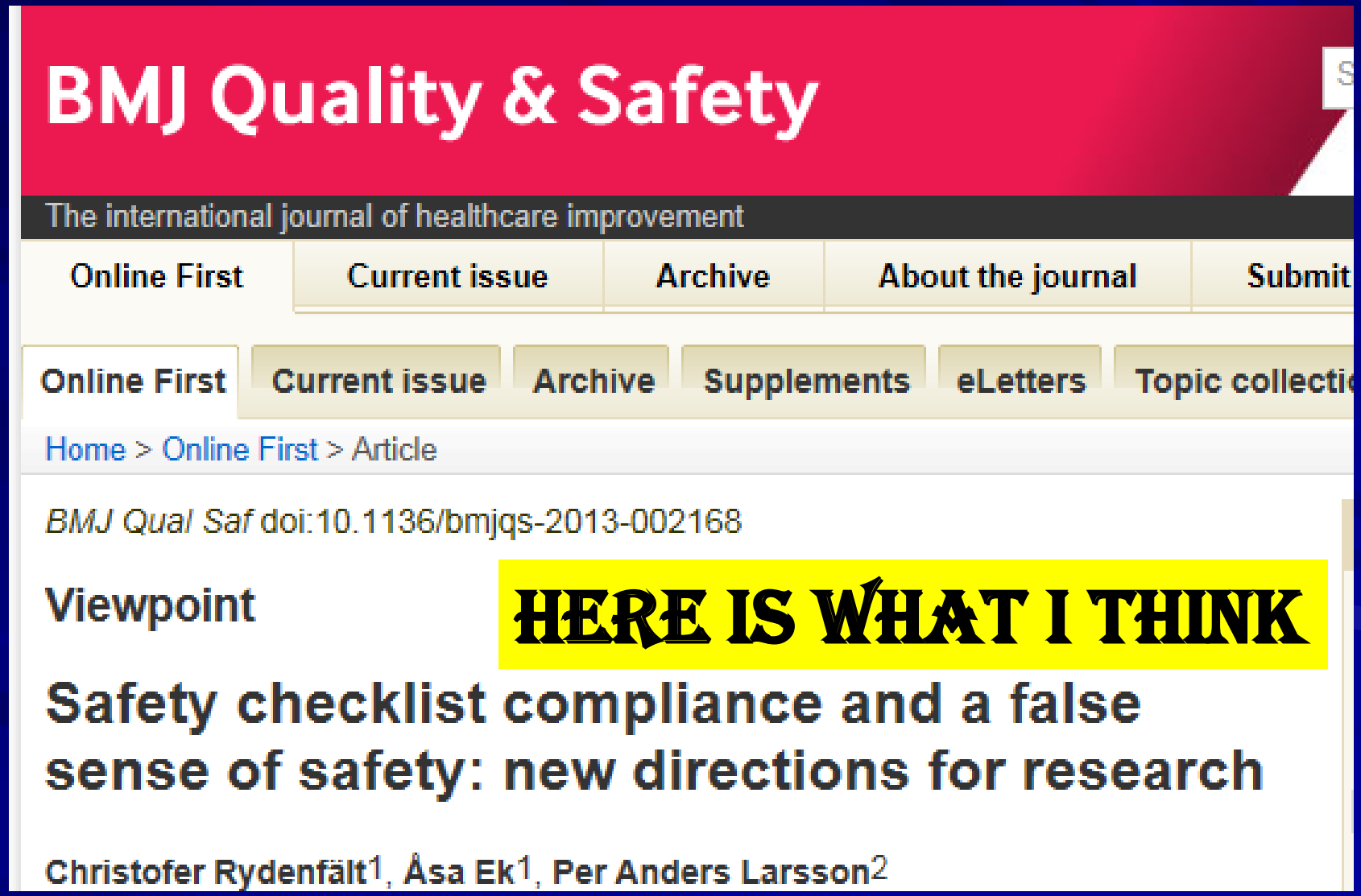
Facet #6

Demonstration of a less common QI Technique

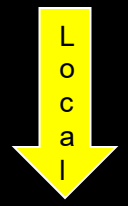


Facet #7

Commentary informed by your QI work



Good QI Project Dissemination Plan



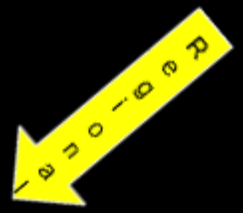
Presentation to Hospital Counsel

Grand Rounds

Presentation to Clinical Leadership Committee

Presentation to Hospital Executives

Presentation To Joint Commission

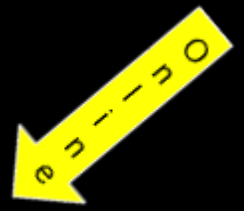


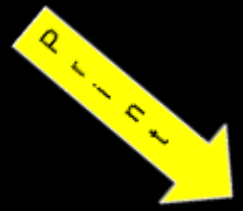
Regional Hospital Consortium

Regional Society Meeting Poster/Abstract

National Society Conference Poster/Abstract

International Conference Poster/Abstract





Methods Dissemination via online database of QI projects

Results Dissemination via Article in Peer Reviewed Journal

Information Contagion

– Ideas spread not because they are intrinsically good

– They spread because they benefit the person they are spreading to


What is your dissemination plan?

Appreciative Debrief

Share with the group one thing you found most intriguing from this session

Next Steps

- Due April 28 –
  - Send Anne list of invitees for final report out
- Due May 13 –
  - Develop a plan for sharing/spreading your work

Date Assigned	Assignment	Due Date
#13 – Feb. 11, 2025	• Create plan for removing barriers to success	#15 – Mar. 11, 2025
#14 – Feb. 25, 2025	• No new assignments	
#15 – Mar. 11, 2025	• No new assignments	
#16 – April 1, 2025	• Create series of short-term wins to support project • Update data plan to include current state data	#18 – Apr. 22, 2025
#17 – Apr. 8, 2025	No new assignments	
#18 – Apr. 22, 2025	• Develop plan for sharing/spreading your work	#21 – June 10, 2025
#19 – May 13, 2025	• Plan for putting project into embed phase • Develop final report out	#20 / #21 – May 27 / June 10, 2025
#20 – May 27, 2025	No new assignments	
#21 – June 10, 2025	No new assignments	
#22 – June 24, 2025	No new assignments	

Final Report-out Schedule

May 27, 2025	
1:05 – 1:10	Welcome/Opening
1:10 – 2:00	Leadership Journey: Dean Sampson
2:00 – 2:15	Break
2:15 – 2:45	DHA Clinical Informatics
2:45 – 3:15	DHA Antimicrobial Stewardship
3:15 – 3:30	Break
3:30 – 4:00	UCH Nursery
4:00 – 4:30	UCH Neurosciences

June 10, 2025	
1:05 – 1:10	Welcome/Opening
1:10 – 1:40	UCH HOPE Oncology Clinic
1:40 – 2:10	UCH Sleep
2:10 – 2:25	Break
2:25 – 2:55	CU Medicine Dermatology
2:55 – 3:25	UCH Infectious Diseases
3:25 – 3:40	Break
3:40 – 4:10	CHCO ICU Delirium
4:10 – 4:40	CHCO Secure Chat

Let Anne know any conflicts ASAP!

Send invite list to Anne by 4/28!

Evaluation

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