Tuesday, April 16, 2024

RQITA
RESOURCE CENTER

Embedding Quality Improvement in Organizational Culture

Outline of the Multi-State Collaborative Learning Series

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- 1/12/23: Current Status MBQIP and Beyond – Meet the RQITA Team
- 2/13/24: Learn about the MBQIP 2025 Measures
- 4/16/24: Embedding QI in Organizational Culture
- 6/11/24: How to leverage MBQIP Data for Improvements
  - SDOH and Health Equity
- 8/13/24: CAH Quality Infrastructure Implementation

CLICK HERE TO CONNECT WITH YOU STATE FLEX PROGRAM

Role of Rural Quality Improvement Technical Assistance Center (RQITA)

RQITA RESOURCE CENTER

The goal of RQITA is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of Federal Office of Rural Health Policy (FORHP) quality initiatives, which are focused on quality measure reporting and improvement.

RQITA is intended to add expertise related to quality reporting and quality improvement, not to replace technical assistance support already in place.

Resources and Services

- Monthly Newsletter
- Up-to-date resources, guides and tools
- 1:1 technical assistance
- Learning and action webinar events
- Recorded trainings
- **Telligen RQITA website for quality improvement resources**
- **TASC Rural Center website**

The RQITA Team

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Objectives

- Define Quality Improvement (QI)
- Discuss Foundational Leadership for QI
- Identify Ways to Create a Culture of QI
- Review an Example of leveraging MBQIP data for the purposes of QI
- Learn about Available RQITA Resources to Support QI

Before We Begin…..

Think about a QI project you are currently working on. During today's presentation, jot down what kind of support would be helpful to make this project successful.

OR

Think about a QI opportunity that you would like to develop a project for. During today's presentation, jot down what kind of support would be helpful to make this project successful.

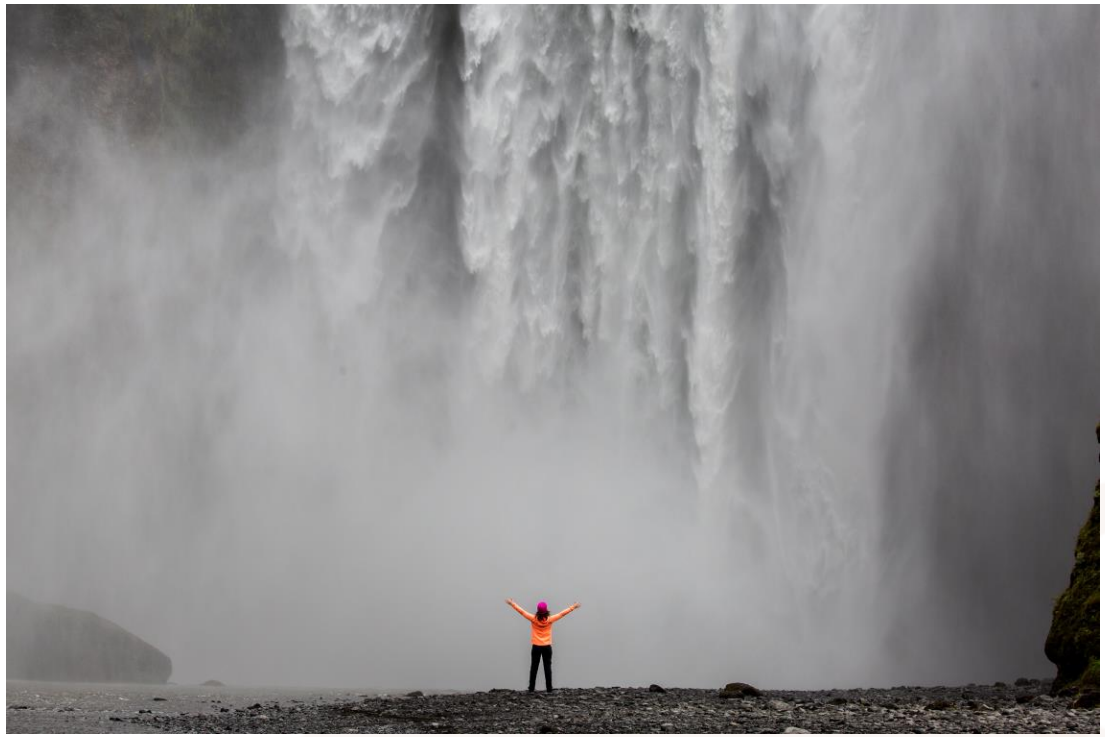
OR

Perhaps you need help identifying a project to work on?

Chat Waterfall Exercise

1. Facilitator will pose a question.
2. Type your state, and response into chat BUT DO NOT HIT SEND until prompted.

Watch the waterfall of responses come in!



What is Quality Improvement and Why Does it Matter?

What is Quality Improvement?

Systematic approach to improve the quality of service and quality of outcomes through analysis, standardization, reduction of variability, and ability to adapt and implement change to reach desired results.

Science of Improvement:

- Walter Shewhart
- W. Edwards Deming

Driven by a need to reduce errors with a focus on systems

- Every system is perfectly designed to get the results it gets

National Quality Strategy

Provide better care to individuals:

- Improve patient's ability to talk to their doctor, improve safety of care, encourage patients to engage in their healthcare plan

Improve our population's health:

- Address determinants of health and identify solutions to build healthier communities

Reduce cost:

- Lower the costs for individuals as well as organizations

Six Aims: Changing the Healthcare System

Safe

- Avoid injuries to patients form the care that is intended to help
- Noticing and learning form mistakes should not only be acceptable by expected and encouraged
- **Examples:** simplifying forms, standardizing processes, reorganizing medication storage, using electronic documentation vs. paper

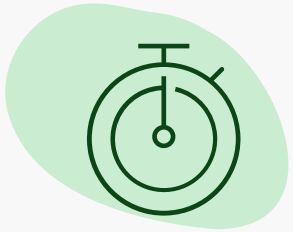
Effective

- Providing evidence-based care to those who can benefit and refraining from providing to those who will not benefit
- **Examples:** Antibiotic stewardship, following evidence-based guidelines, providing appropriate screening as part of preventative care

Patient-Centered

- Providing care that is respectful or and responsive to: needs and values and drives clinical decision-making
- **Examples:** Culturally sensitive practices, lifestyle considerations, provide patients easy access to their health information

Six Aims Cont.



Timely

- Reducing wait times and delays for those that receive care and those who provide care
- **Examples:** Prompt test result delivery, reduced appointment waiting times, improved patient flow in clinics

Efficient

- Avoiding waste of equipment, supplies, ideas, and energy. Sometimes boosting efficiency is a matter of using existing resources in a more efficient way; work smarter, not harder.
- **Examples:** promoting open and easy communication, assessing space/layout design, secure messaging for patients using a portal

Equitable

Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geography, socioeconomic status

Examples: raise awareness of disparities using research and data, train staff to deliver equitable care

Polling Question

What Does QI Look Like in Your Hospital?

Leadership, Relationships, and Culture – It all Starts Here!

A Call to Action

“Take action to accomplish the transformation” Edward Deming

Group Activity

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Let’s Create a Chat Waterfall!

Think about **one** positive experience participating in a QI project and **one** negative experience participating in a QI project.

Think about how what made those experiences positive or negative, jot this down.

1. When facilitator prompts, type in your state, type your response into chat **BUT DO NOT HIT SEND!**
2. Hit send when prompted

Watch the waterfall of responses come in!

Quality Improvement Requires a Unity of Purpose - Frames Your Culture

What matters to your patients and their families?

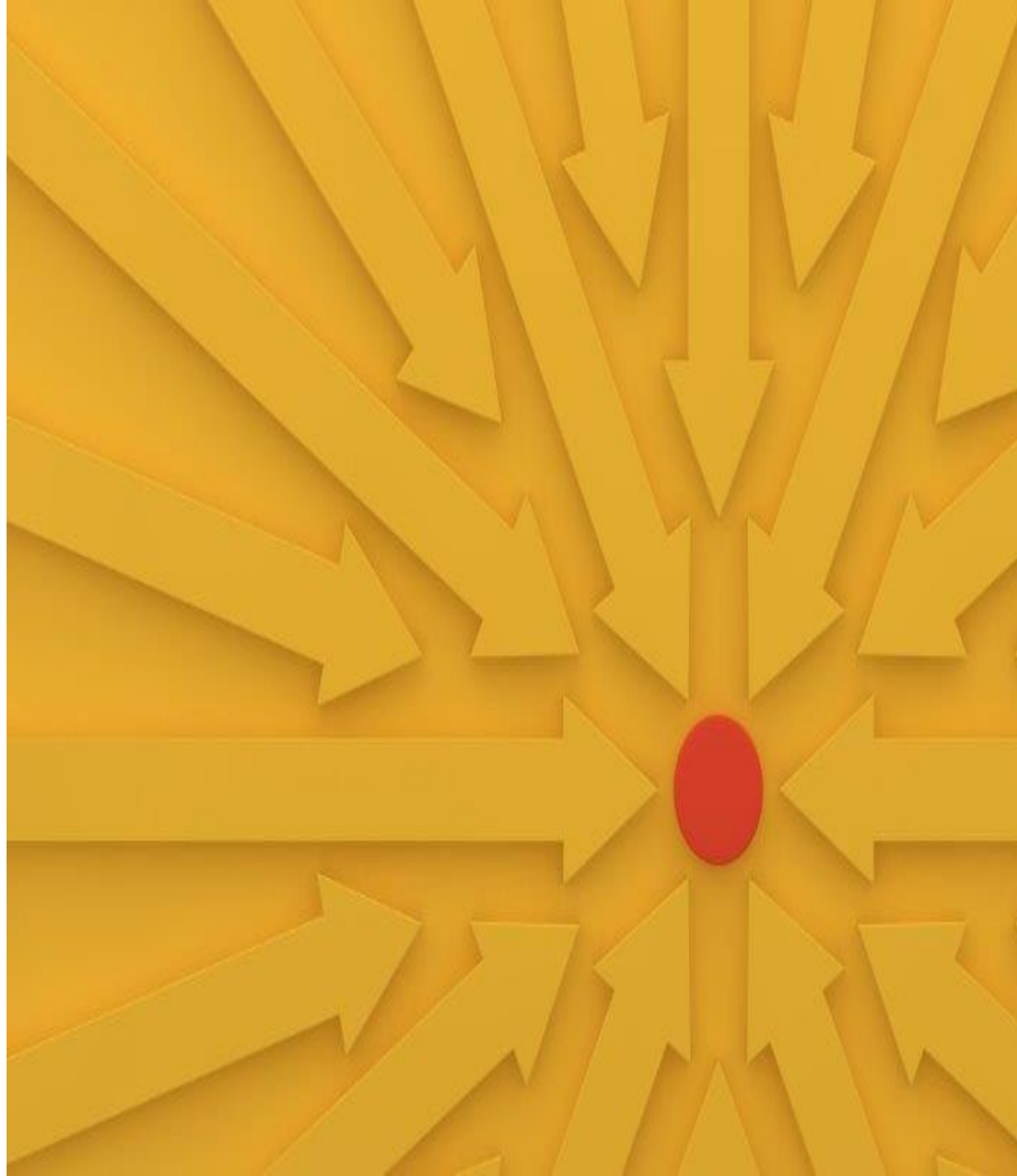
Reflects what is important from care givers representing all roles, services and disciplines in your hospital

It is based on understanding your patient population to determine skills and competencies staff must possess to provide high quality care

Guides your performance improvement efforts

Leadership Impacts Quality Improvement

- Patient and Family Satisfaction
- Quality of patient outcomes increases
- Positive work culture
- Staff satisfaction and empowerment
- Support staff in overcoming burnout
- Community Perception



Building a QI Framework

CREATE a safe, supportive and challenging environment

TRY to work within your teams agenda

FACILITATE and congratulate

ADVOCATE self-awareness

PROMOTE learning from experience

MODEL what you coach

Communication

When

- Rounding/Huddles
- Vision Boards
- Newsletters
- Staff meetings

How

- Verbal, paraverbal and non-verbal communication
- Positive reinforcement and feedback
- Individualized praise and gratitude
- Motivate and inspire

Who

- Leadership
- Staff – including all departments/units
- Patients, families, caregivers
- Community

What

- Staff – including all departments/units
- Patients, families, caregivers
- Community

What Matters?

- What do you envision your culture to look like? What do others on your team?
- Checking-in versus checking-up
- Creating connections – supporting a ‘permission to correct’ environment
- Peer to Peer Mentorship
- Being mindful of staff and peer workload
- Recognition
- Encouraging boundaries and work-life balance

Self-awareness

- What do you need to increase confidence in your ability to perform well?
  - Develop skills in quality improvement methodologies (Root Cause Analysis, PDSA, Process Mapping, etc.)
  - Designing effective and efficient performance improvement projects
  - Time management
  - Guidance on implementing interventions and process improvement
  - Education
  - Practice
  - Feedback
  - Trust from leadership, your peers

Promote Teamwork

- *All-Hands-On-Deck* approach to reduce stress and strengthen teamwork
- Why is teamwork so important?
  - Patient needs are better met
  - Staff stress is reduced
  - Managers receive firsthand knowledge of the workload and hospital dynamics
  - Managers model teamwork
  - Develops improved relationships with staff – peer to peer mentorship
  - Helps to reduce the cycle of staff instability

Quality Improvement – It’s What We Do!

First Things First….
Conditions of Participation

State Survey

or

CMS Approved Accrediting Organizations for CAHs

- Accreditation Commission for Health Care(ACHC)
- Center for Improvement in Healthcare Quality (CIHQ)
- DNV - Healthcare (DNV)
- The Joint Commission (TJC)

Next… Utilize Your Data

- What data do you currently review?
- What is the structure and cadence for how data is shared. Who will share it, when and how.
- How are opportunities for improvement identified?
- Who/what determines how quality improvement projects are designed and executed?

Do you need to put these processes into place?

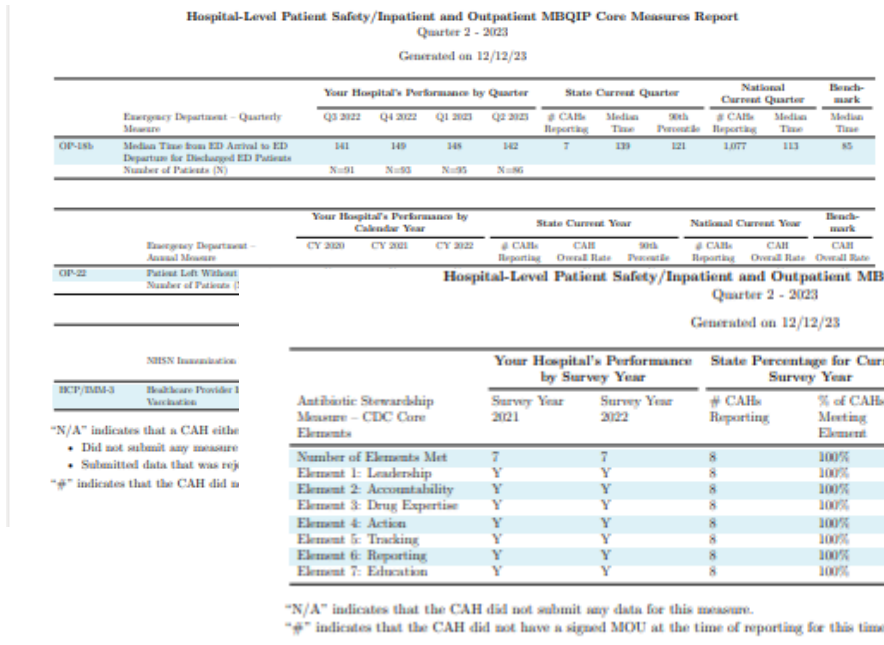
Ex. FMT Report – MBQIP Core Measures

- ❑ OP-18 – Median time from ED arrival to ED departure for discharged ED Patients
- ❑ OP-22 – Left without being seen
- ❑ HCP/IMM3 – Healthcare provider influenza vaccination
- ❑ Antibiotic Stewardship

Flex Monitoring Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Hospital-Level
Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report



Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 2 - 2023

Generated on 12/12/23

	Emergency Department – Quarterly Measure	Your Hospital's Performance by Quarter: Q3 2022	Q4 2022	Q1 2023	Q2 2023	State Current Quarter: # CAHs Reporting	Median Time	90th Percentile	National Current Quarter: # CAHs Reporting	Median Time	Benchmark: Median Time
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	141	149	148	142	7	139	121	1,077	113	85
	Number of Patients (N)	N=91	N=93	N=95	N=86						

	Emergency Department – Annual Measure	Your Hospital's Performance by Calendar Year: CY 2020	CY 2021	CY 2022	State Current Year: # CAHs Reporting	CAH Overall Rate	90th Percentile	National Current Year: # CAHs Reporting	CAH Overall Rate	Benchmark: CAH Overall Rate
OP-22	Patient Left Without									
	Number of Patients									

NHSN Immunization

HCP/IMM-3	Healthcare Provider I Vaccination	

"N/A" indicates that a CAH eithe
- Did not submit any measure
- Submitted data that was rej

"#" indicates that the CAH did n

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 2 - 2023

Generated on 12/12/23

Antibiotic Stewardship Measure – CDC Core Elements	Your Hospital's Performance by Survey Year: Survey Year 2021	Survey Year 2022	State Percentage for Current Survey Year: # CAHs Reporting	% of CAHs Meeting Element	National Percentage for Current Survey Year: # CAHs Reporting	% of CAHs Meeting Element	Benchmark: % of CAHs Meeting Element
Number of Elements Met	7	7	8	100%	1,232	91%	100%
Element 1: Leadership	Y	Y	8	100%	1,232	99%	100%
Element 2: Accountability	Y	Y	8	100%	1,232	97%	100%
Element 3: Drug Expertise	Y	Y	8	100%	1,232	95%	100%
Element 4: Action	Y	Y	8	100%	1,232	98%	100%
Element 5: Tracking	Y	Y	8	100%	1,232	96%	100%
Element 6: Reporting	Y	Y	8	100%	1,232	98%	100%
Element 7: Education	Y	Y	8	100%	1,232	99%	100%

"N/A" indicates that the CAH did not submit any data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

Identifying Opportunities for Improvement – What Do You See?

		Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
	Emergency Department – Quarterly Measure	Q3 2022	Q4 2022	Q1 2023	Q2 2023	# CAHs Reporting	Median Time	90th Percentile	# CAHs Reporting	Median Time	Median Time
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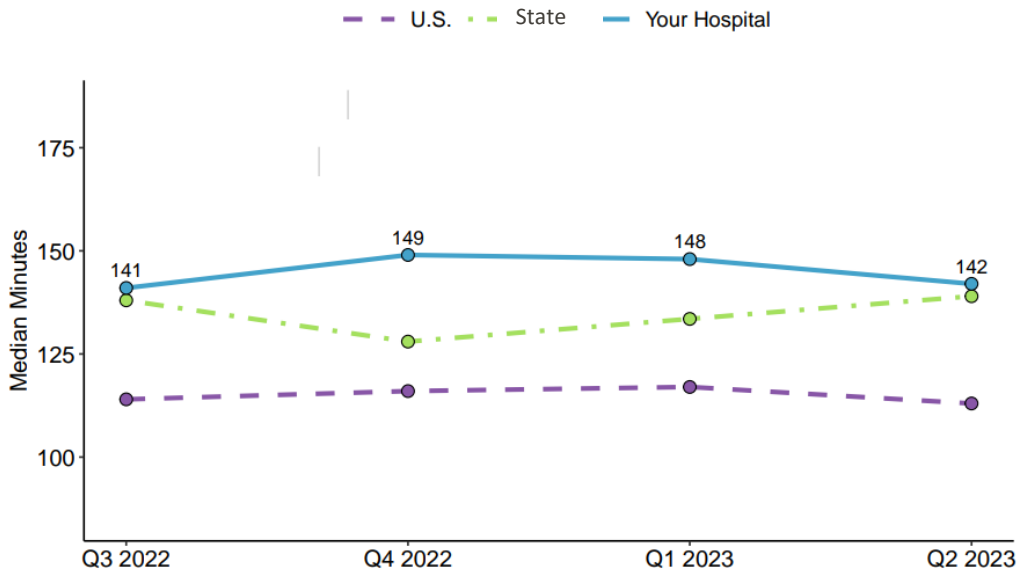
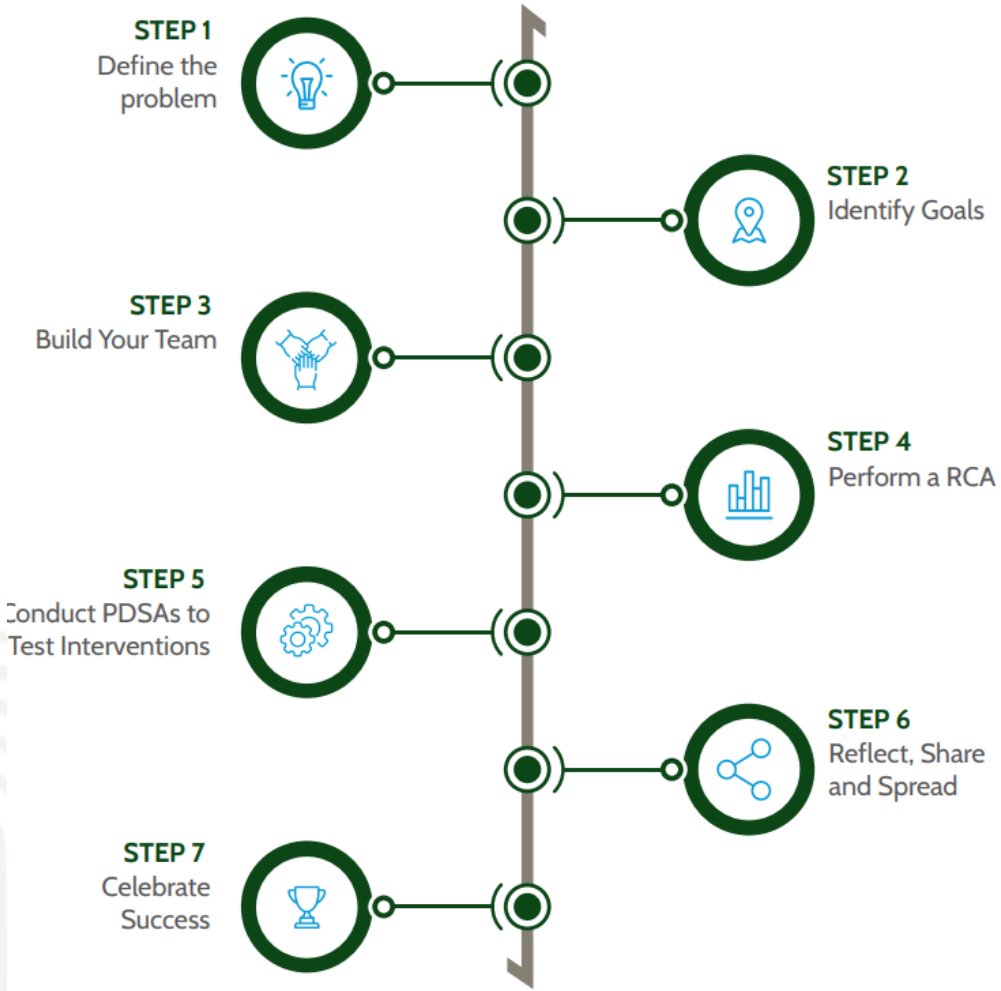
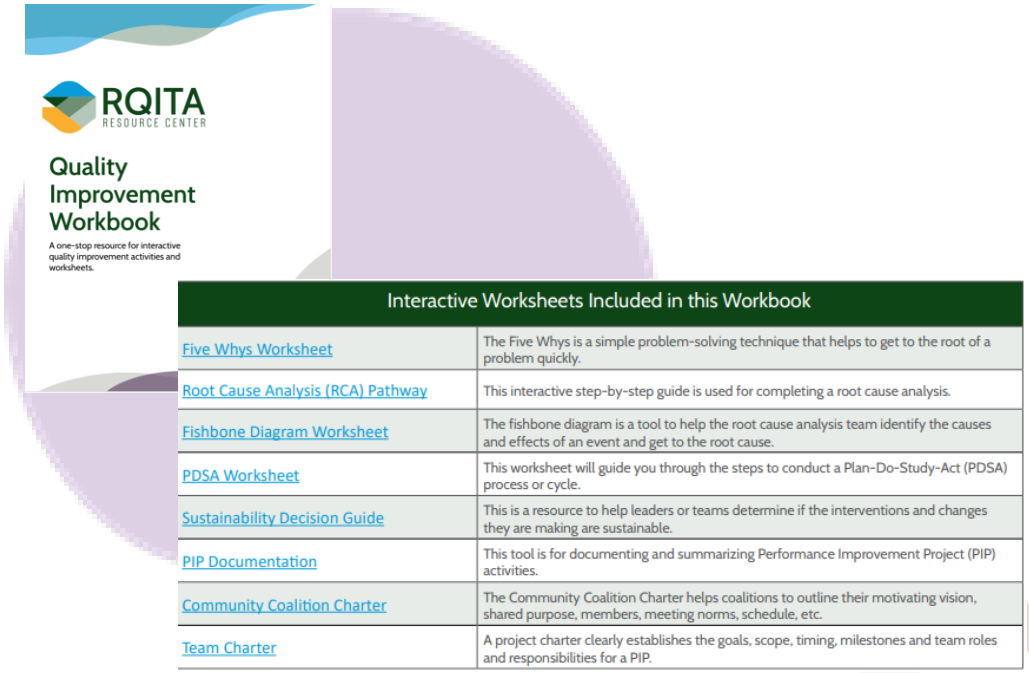


Next….Quality Improvement Project Design





Interactive Worksheets Included in this Workbook	
Five Whys Worksheet	The Five Whys is a simple problem-solving technique that helps to get to the root of a problem quickly.
Root Cause Analysis (RCA) Pathway	This interactive step-by-step guide is used for completing a root cause analysis.
Fishbone Diagram Worksheet	The fishbone diagram is a tool to help the root cause analysis team identify the causes and effects of an event and get to the root cause.
PDSA Worksheet	This worksheet will guide you through the steps to conduct a Plan-Do-Study-Act (PDSA) process or cycle.
Sustainability Decision Guide	This is a resource to help leaders or teams determine if the interventions and changes they are making are sustainable.
PIP Documentation	This tool is for documenting and summarizing Performance Improvement Project (PIP) activities.
Community Coalition Charter	The Community Coalition Charter helps coalitions to outline their motivating vision, shared purpose, members, meeting norms, schedule, etc.
Team Charter	A project charter clearly establishes the goals, scope, timing, milestones and team roles and responsibilities for a PIP.

QI Project Design – Performance Improvement Project (PIP)

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Performance Improvement Project (PIP) Documentation

Facility Name	State	CCN
CAH Memorial Hospial	State	12345

Team Charter

PIP Team Name	PIP Start Date
ED Qualtiy Project Team	May 1, 2024

PIP Team Project

Quality Measure (QM or Area of Focus)	Baseline Data (include time period)
OP-18 ED Time from Arrival to Departure	145 minutes (last 4 quarters)

SMART (Specific, Measurable, Attainable, Relevant and Time-Bound) Goal

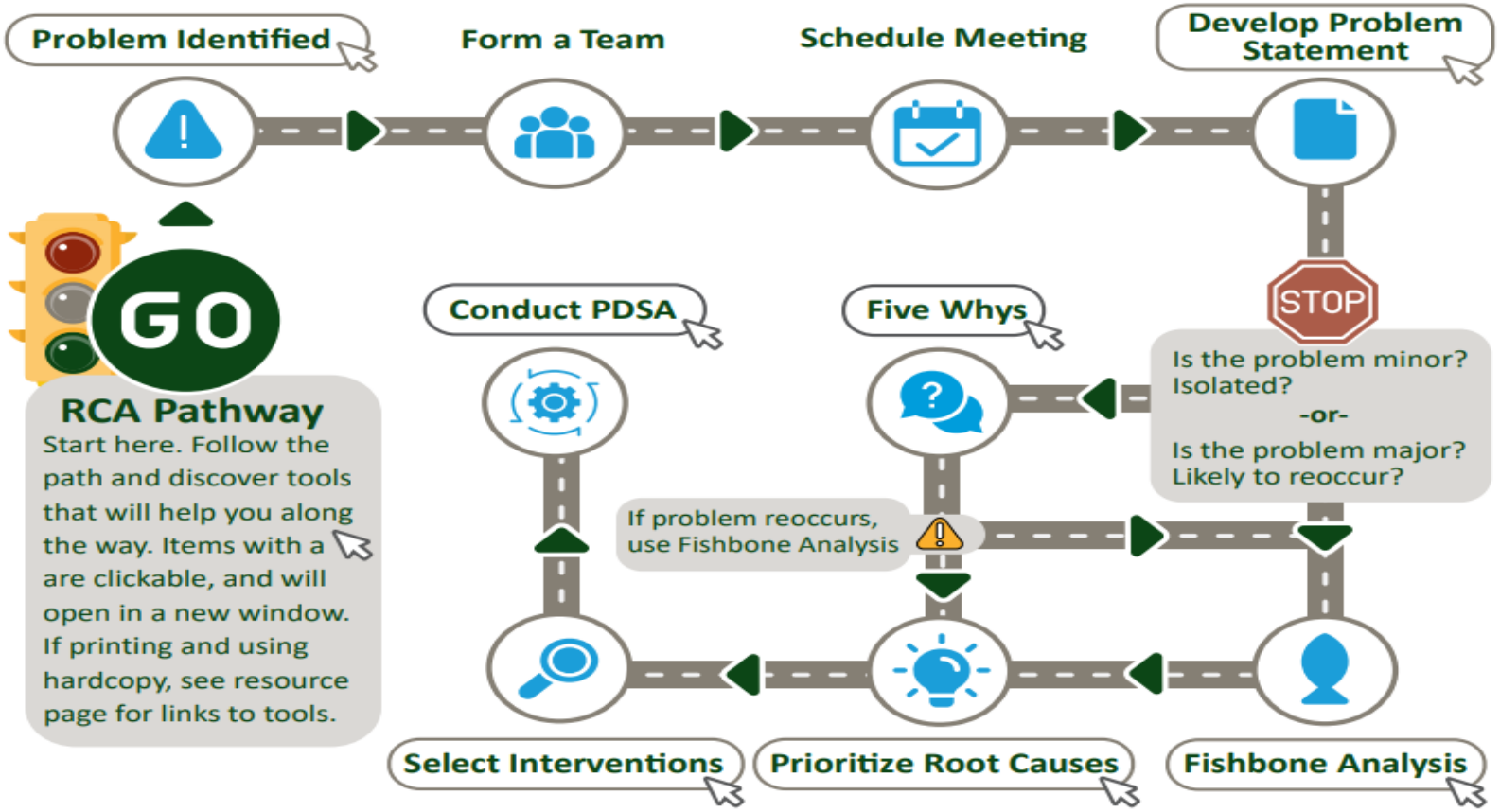
Example: Reduce the long-stay quality measure rate for UTI from 4.2% to 2.5% (the national average on Care Compare) by December 31, 2022.
In order to prevent delay of care for time sensitive diseases, the CAH Memorial will reduce the average median time from ED arrival to ED departure by 20% (116 min) by May 1st, 2025 (four quarters)

PIP Team Members

Identify team members to support the improvement project; select those who are closest to the area of focus identified

Staff Name	Title
Leader:	ED Medical Director
	Patient Representative
	ED Manager
	CAH Quality Director
	EMT/Ambulance Service
	LAB Personnel
	Radiology Personnel

Conduct a Root Cause Analysis (RCA)



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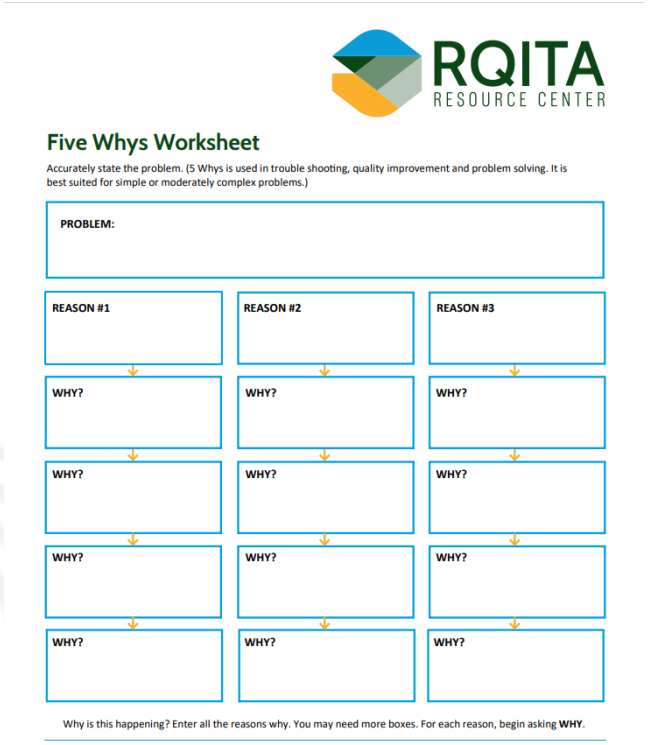
This resource was designed for screen

Types of RCAs

Five Whys



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Five Whys Worksheet

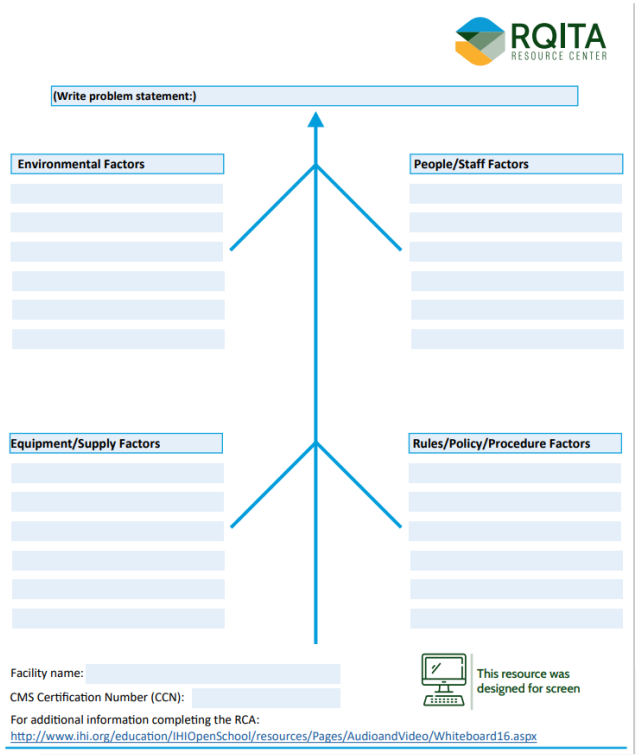
Accurately state the problem. (5 Whys is used in trouble shooting, quality improvement and problem solving. It is best suited for simple or moderately complex problems.)

PROBLEM:

REASON #1	REASON #2	REASON #3
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?
WHY?	WHY?	WHY?

Why is this happening? Enter all the reasons why. You may need more boxes. For each reason, begin asking **WHY**.

Fishbone Diagram



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(Write problem statement:)

Environmental Factors

People/Staff Factors

Equipment/Supply Factors

Rules/Policy/Procedure Factors

Facility name:

CMS Certification Number (CCN):

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For additional information completing the RCA:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx

QI Project Design- Performance Improvement Project (PIP)

Executive Sponsor: (Name and Title) ED Medical Director

List of Root Causes

List top root causes in order of priority

Long wait times for radology interpretation and lab results- slows diagnosis and treatment times
When transfer to higher level of care is needed, excessive time finding an accepting faclity and accepting provider
Delayed access to medications
Not all staff working at the top of their skill set / licensure to maximize timeliness and effectiveness of triage and treatment
Long wait times for transfering to inpaitnet mental health facilities
Excessive time to complete Admission and Discharge paperwork and EHR processes
Waiting for bed availablity inhouse when patients are admitted to accute care

Goal Monitoring

Use the table to routinely track outcomes measures to determine progress in reaching your goal

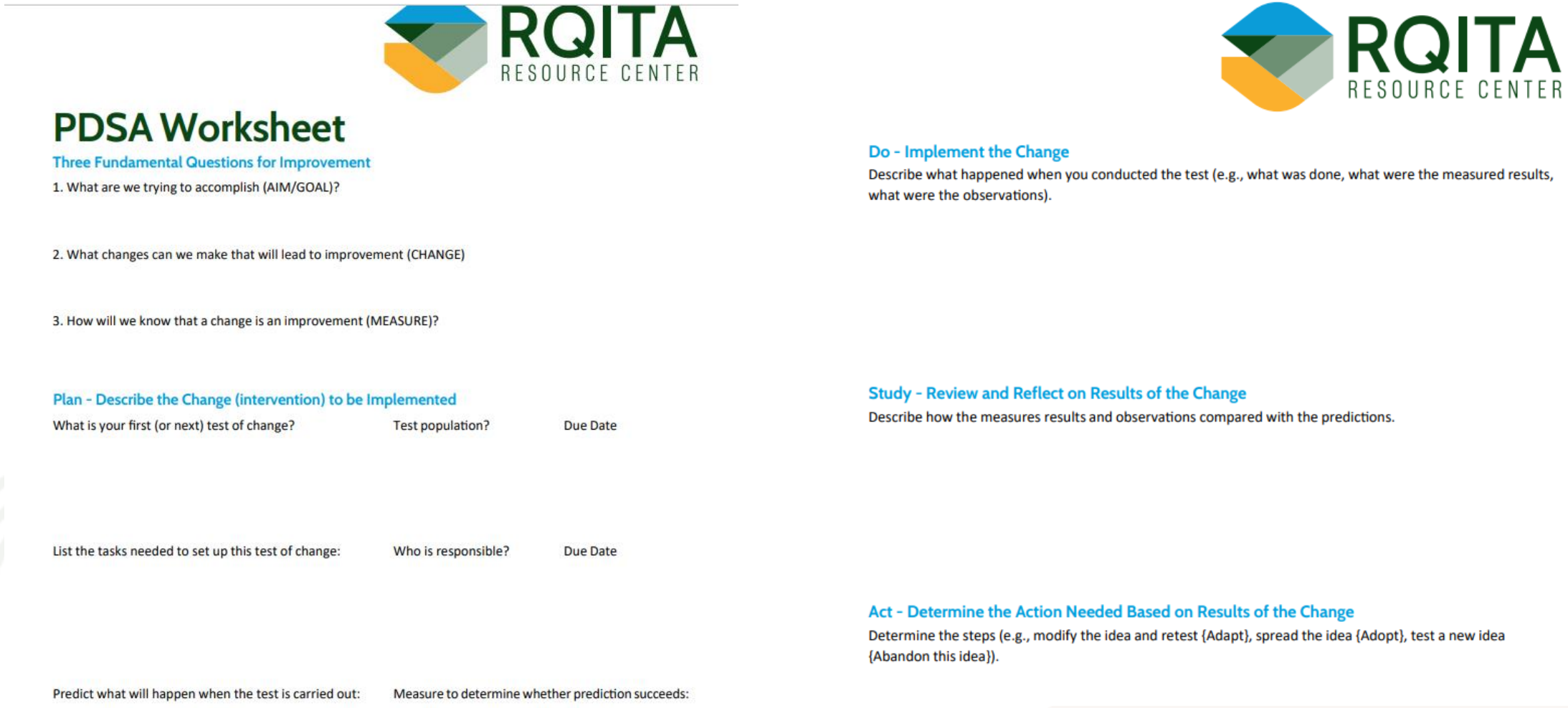
Measure of Focus	1st Measured Date	1st Measured Rate	2nd Monitoring Date	2nd Measured Rate	3rd Monitoring Date	3rd Measured Rate
Time from radiolgy order to test						
Time from test to results available						
Measure of Focus	**4th Measured Date**	**4th Measured Rate**	**5th Monitoring Date**	**5th Measured Rate**	**6th Monitoring Date**	**6th Measured Rate**
[illegible]						

Interventions

The following are interventions to eliminate root causes and are used in PDSA process completion

Selected Root Cause	Start Date	Selected Intervention	PDSA Cycle (1, 2 or 3)	Outcomes	Adapt, Adopt or Abandon
No standard for how to notifiing Rad Techs of order		Calling Tree updated and Standard process			
The EHR did not send out a notification when Radiology interpresation was availble.		IT to set up Flags for ED provider AND Rad Tech			

Plan, Do, Study, Act (PDSA)



PDSA Worksheet

Three Fundamental Questions for Improvement

1. What are we trying to accomplish (AIM/GOAL)?

2. What changes can we make that will lead to improvement (CHANGE)

3. How will we know that a change is an improvement (MEASURE)?

Plan - Describe the Change (intervention) to be Implemented

What is your first (or next) test of change? Test population? Due Date

List the tasks needed to set up this test of change: Who is responsible? Due Date

Predict what will happen when the test is carried out: Measure to determine whether prediction succeeds:

Do - Implement the Change

Describe what happened when you conducted the test (e.g., what was done, what were the measured results, what were the observations).

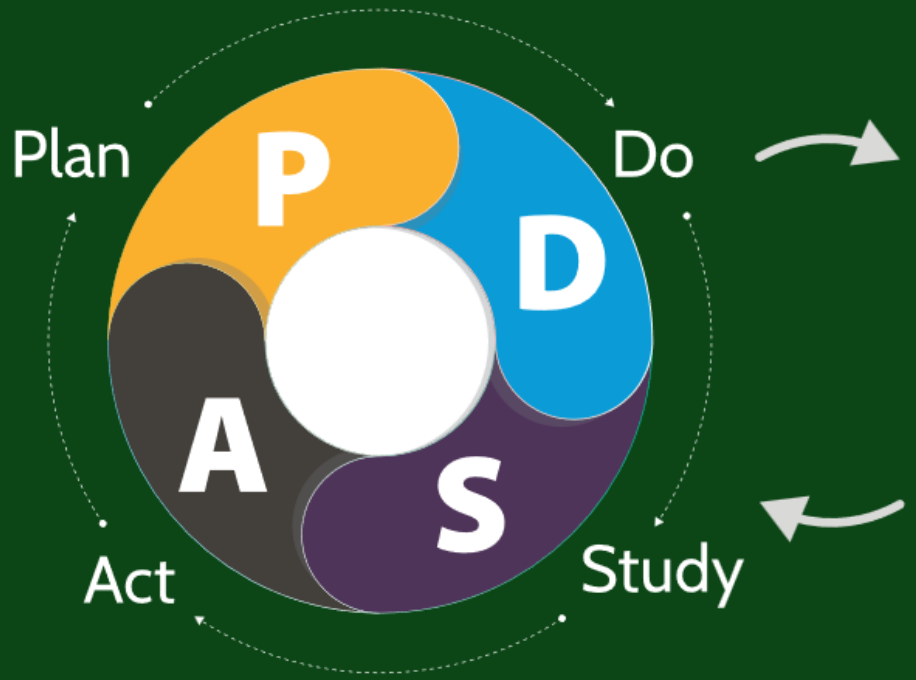
Study - Review and Reflect on Results of the Change

Describe how the measures results and observations compared with the predictions.

Act - Determine the Action Needed Based on Results of the Change

Determine the steps (e.g., modify the idea and retest {Adapt}, spread the idea {Adopt}, test a new idea {Abandon this idea}).

Next…PDSA



What are we trying to accomplish?	**AIM:** Determine specific outcomes you are trying to change
How will we know that a change is an improvement?	**MEASURES:** Identify appropriate measures to track your success
What change can we make that will result in improvement?	**CHANGES:** Identify key changes that you will test

Multiple PDSA Cycles:
Hunches, theories and ideas for changes that result in improvement

QI Project Design- Performance Improvement Project (PIP)

Outcomes

Use the table below to document what has worked, what has not, or lessons learned

Selected Intervention	Success Identified	Barriers Identified	Lessons Learned
Radiology Tech Calling Tree updated			
Standard process for Rad Techs notified of order			
IT create flags			
ED provider respond to Flags			

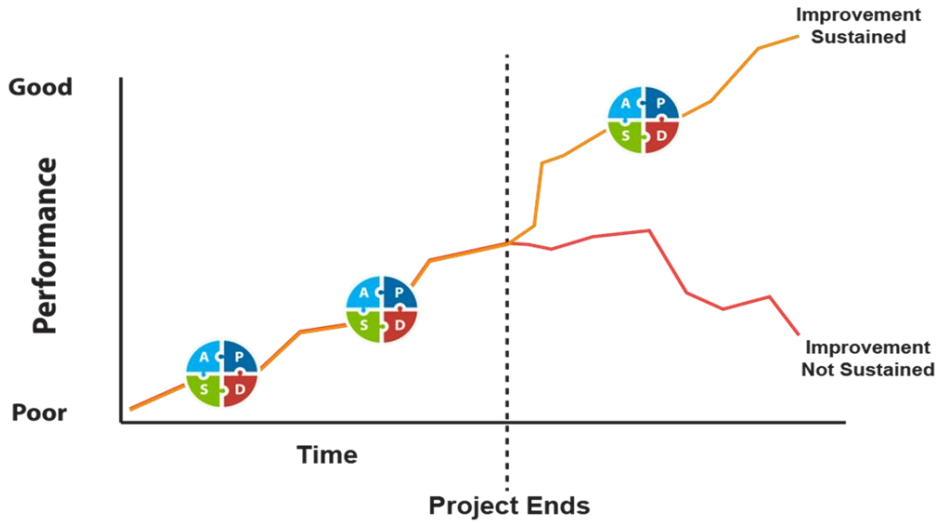
Sustainability

How are you going to sustain the improvements that were made? (Example: Update policies and procedures, educate staff, update onboarding process, identify a champion to monitor the data and interventions being carried out at routine intervals, etc.)

PIP Goal Met Date:	Sustainability Start Date:
Rad Tech calling tree updated quarterly, monitor EHR data on notifcation flags	

Then…..Build in Sustainability

"When new ways of working and improved outcomes become the norm."



Ensuring gains are maintained beyond the life of the project or integration of programs into ongoing organizational systems.

We Achieved Our Goal – Now What?

- Commit to the improvement
- Plan to update the facility's documented processes/procedures/policies
- Use your communication plan to spread the project outcome
- Educate all staff on the new interventions
- Decrease reliance and dependance on staff memory
  - Share data to show why
  - Create checklists, reminder posters, competency quizzes
- Support champion's monitoring and auditing

We Achieved Our Goal – Now What?

- Standardization
  - Specific, detailed, documented standard procedures
  - Ensure staff know what to do and when to do it provides a stable platform to work
- Accountability
  - Process in place to review implementation of standard work
  - Huddles

We Achieved Our Goal – Now What?

✓Problem Solving

- Methods are available for developing frontline improvement skills so staff can address issues as they arise
- Huddles

✓Visual Management

- Use of clear, simple data that show performance on key quality measures over time and track problems the team is currently addressing
- White board

We Achieved Our Goal – Now What?

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- ✓ Integration
  - Active communication and consistent purpose between levels of management and professional staff as well as across departments
  - Formal system for coordinating strategic intent with quality goals, prioritizing, initiating, managing improvement initiatives and building improvement capability
- ✓ Escalation
  - Involves frontline staff scoping issues and raising those that require management action to resolve
  - Becomes a part of standard work for frontline staff and managers

Reflection

- What do you need as a leader to mentor champions in your facility?
- What does your facility do well to embed quality improvement in your culture?
- What opportunities for improvement are there?
- Connect with peers for tips and best practices
- How do you keep communications open?
- How do you engage patients and families

Leave in Action:

- ❑ Pick one Quality Improvement tool and practice using in your next QI project
- ❑ Prepare to share during our next multi-state collaborative session

Let's Create a Chat Waterfall!

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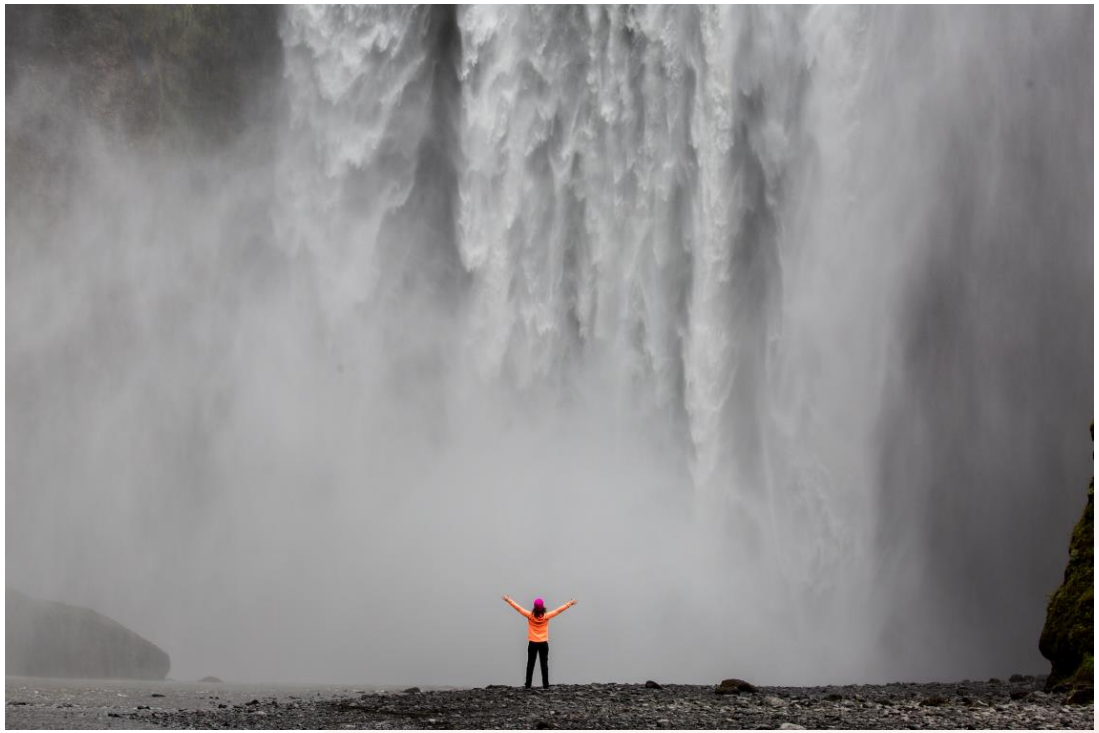

Your Quality Improvement Toolkit

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- RQITA Quality Improvement Workbook
- Root Cause Analysis Tools
- Plan Do Study Act Tools
- RQITA Performance Improvement Document


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