Quality Improvement: Pulling It All Together

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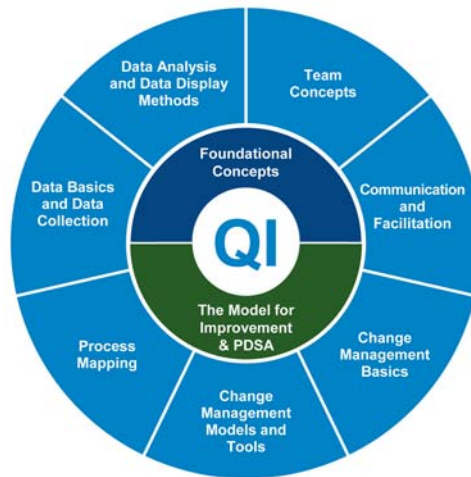
Topics

- Brief review of all the quality improvement (QI) components
- Example: A QI Story
- Conclusion of the QI Basics Course and tips for going forward

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A QI Improvement Story

Starting Your QI Work

- List of possible projects
- Leadership involvement and support
- PICK Prioritization Matrix
- Organizational mission and strategy
- Quality reporting requirements (national and state)
- Patient population and current improvement efforts at the community, state, and national level
- Create the project charter
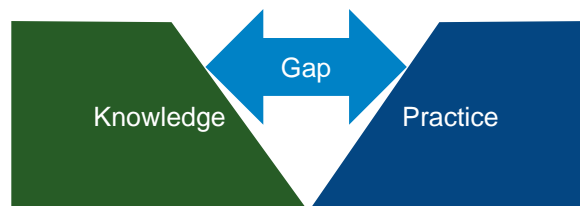
Selecting a Project

- Low performance based on data
- Potential harm to patients
- The number of patients impacted
- Multiple/broad priorities
- Alignment with national, state, or regional level quality initiatives
- Alignment with the mission at your facility
- Enthusiasm among staff for the topic

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QI Story: Hypertension Improvement

Gap

Knowledge

Practice

Opportunities to improve are identified where there is a gap between what we know and how we practice

National Quality Foundation 0018 measure: **Controlling High Blood pressure**. Increase the percent of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
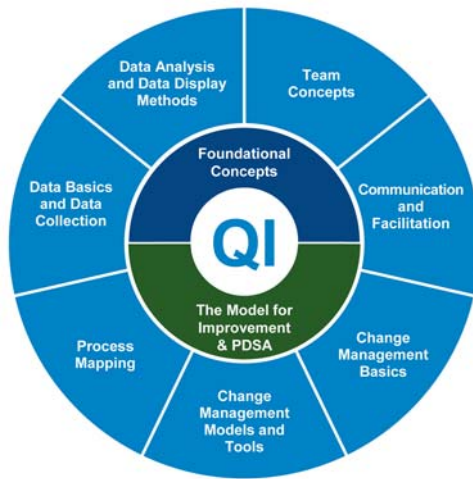
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QI Tools and Templates

- Project Charter
- Project Work Plan
- PICK Prioritization Matrix
- Team Roles and Responsibilities
- Communication Plan
- Force Field Analysis
- 5 Whys Tool
- PDSA Worksheet
- Measures Collection and Monitoring Plan
- Data Collection Plan

Quality Improvement Success

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Teams and Facilitation

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Teams and Facilitation

- Build your QI Team
- Ensure roles are filled
- Team communication
- Facilitation challenges and solutions

Teams and Facilitation: Common Group Roles

Remember:
- Not all roles are always present or necessary
- Some roles are filled by the same person
- Consider rotating roles and responsibilities

- Project sponsor
- Team leader
- Meeting facilitator
- Group contributor
- Data specialist
- Systems specialist
- Scribe/Note taker

Teams Roles and Responsibilities

QI Team Roles and Responsibilities Checklist

Role	Responsibilities	Name(s)	Notes / Comments
Project Sponsor	(See template...text removed)	Dr. Jane Polinski	She is a member of clinic leadership
Team Leader	(See template...text removed)	Juan Melendez	
Meeting Facilitator	(See template...text removed)	Juan Melendez (but this role may be delegated)	
Team Contributor (or SME)	(See template...text removed)	Dr. Jane Polinski (as needed for clinical expertise) Gale Vasquez (MA) (special training at AHA conferences) Kenji Omada (MA)	
Data Specialist	(See template...text removed)	Brenda Wilson	
Systems Specialist (EHR/IT)	(See template...text removed)	Brenda Wilson	
Scribe / Note Taker	(See template...text removed)	This role will be rotated at each meeting.	

Teams and Facilitation: Communication Plan

Communication Plan

Key Message	Medium	To Whom	From Whom	When	Date
Intention to form a QI project team around hypertension improvement for NQF0018	email	Leadership	Project Champion	At outset of project	TBD
Staff recruitment for roles on project team (including questions on prior HTN work)	Bulletin board and email	All staff	Project Champion	At outset of project	TBD
Announce team formation	Bulletin board and email	All staff	Project Champion & Team lead	At outset of project	TBD
Intent to analyze aggregate and provider specific NQF0018 data	email	Providers	Team lead	At outset of project	TBD
Monthly project updates	email and All staff meetings	All staff	Team lead	Monthly	TBD
Advisories and guidance to specific providers		Providers as identified	Project Champion & Team lead	As needed and after monthly data pulls	TBD
Project data results and findings	All staff meeting	All staff	Project Champion & Team lead	At completion of PDSA work and data analysis	TBD
					TBD
					TBD

QI Work Plan

Example QI Work Plan
Insert standard verbiage about this being an example, delete if not needed, etc…

Task / Objective	Detailed description	Assigned To	Due Date	Completion Date	Status	Notes / Comments
Hold initial project kickoff meeting	Gather initial 5 QI team members together	Juan Melendez, Team Leader	Date to be set	TBD	Not started	
Create communication plan	To be done as a QI team together. Template started by team leader	QI Team	Date to be set	TBD	Not started	
Hold Process Mapping exercise to document hypertension encounters. Utilize 5 whys tool	To be done as a QI team.	QI Team	Date to be set	TBD	Not started	Determine any additional staff that need to be included
Create PDSA document based on process mapping and 5 whys analyis	To be done as a QI team	QI Team	Date to be set	TBD	Not started	
Report back to leadership on QI team progress after 2nd week of work	Leadership has requested a bi-weekly update for the first month of our QI team project	Juan Melendez, Team Leader	Date to be set	TBD	Not started	5-10 minute project summary to be given at leadership meeting. Need to prepare remarks. Add this task to communication plan

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Change Management

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Change Management

- Leadership commitment
- Focus on the path to your goals
- Attend to the technical and personal aspects of change
- Recognize individual adaptation approaches

Force Field Analysis

- Identify driving forces that support the specific change
- Identify restraining forces that resist the specific change
- Develop strategies and gain consensus to move to new point of equilibrium

Lewin, K. (1951). Field theory in social science. London: Tavistock Publications Ltd.

Force Field Analysis

Example Force Field Driving and Restraining Factors Tables

Driving Factors	Impact (High/Med/Low)	Assigned To	Notes / Comments
Peer clinics that are performing higher than ours	Med	Brenda Wilson (Data Specialist)	Keep abreast of published NQF0018 peer performance
Project sponsor who is motivated to improve our measure	High	Juan Melendez (Team Leader)	Tap into the project sponsor skills and knowledge as needed to keep things moving forward
Improved analytics capability in our EHR	Med	Brenda Wilson (Systems Specialist)	Pull our measure numbers for frequently
Clinic has also chosen this measure for the CMS QPP/MIPS reporting program	High	Entire Team	Clinic leadership is looking at this measure more closely

Restraining Factors	Impact (High/Med/Low)	Assigned To	Notes / Comments
Clinic has been slow to make QI changes in the past	Med	Juan Melendez (Team Leader)	Keep in mind when developing PDSA plans and be strategic about engaging frontline staff
Although we have improved EHR analytics, not all staff know how to use them	High	Brenda Wilson (Data Specialist)	Confirm training and ability to analyze and display data meaningfully
Lack of time for QI team meetings and taking staff away from patient care	High	Juan Melendez (Team Leader)	Need to have conversations with clinic leadership
Some clinicians have negative attitude toward measures or distrust the data (believe they do high quality work so the measure or data must be wrong)	Med	Dr. Jane Polinski (Project Sponsor) and Juan Melendez (Team Leader)	Discuss project at provider meetings ongoing to enhance buy-in

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18

Eight Steps to Change

1. Create a sense of urgency
2. Pull together a guiding coalition
3. Develop a vision and strategy
4. Communicate the "change vision"
5. Empower action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture

Source: https://www.kotterinc.com/8-steps-process-for-leading-change/

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19

The Model for Improvement and PDSA

The Model for Improvement and Plan Do Study Act (PDSA)

The Model for Improvement Three Questions

Example Plan-Do-Study-Act Worksheet
The example below is based on a clinic that is seeking to improve the identification and treatment of its patients that are hypertensive. The clinic will attempt several small-scale interventions/improvements to raise their performance on this measure.

The Model for Improvement: Three Questions

1. **What are we trying to accomplish (aim)?**
   We are trying to improve our NQF 0018 measure and improve our clinic's ability to properly identify and diagnose patients with hypertension. Our goal will be to improve our facilities current performance rate from 45% to 55% within 1 months starting the first day next month. We believe that we are doing well with the treatment portion of our measure and we will not focus on this as part of our PDSA cycle of improvements.

2. **How will we know that change is an improvement (measures)?**
   Here is the chosen measure for our work:
   National Quality Foundation 0018 measure: Controlling High Blood pressure: Increase the % of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

3. **What change can we make that will result in an improvement?**

   We made updates to our workflow based on our process mapping and we will start to test the new workflow with one provider/nurse team for one week. Changes will include a higher level of accuracy when taking BPs based on American Heart Association guidelines and best practices, along with a focus on improving the accuracy of documenting them in the EHR (getting hypertension on the problem list and entering BPs consistently in the same fields (not in the notes field, for example).

22

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5 Whys Worksheet

Example Five Whys Worksheet

Team Members: All QI team members that are part of the NQF0018 improvement project.

Date: XX/XX/2019

Problem statement	We are trying to improve our NQF 0018 metric and improve our clinic's ability to properly identify and diagnose hypertensive patients. Our goal will be to improve our facilities current performance rate from 45% to 55% within 1 month starting the first day next month. We think we may have issues with the overall BP check process. Why isn't our hypertension process working to produce an optimal result or high performance on the hypertension 0018 measure?
Why? ➡	We don't have regular training as well as policies and procedures around BP checks and documentation.
Why? ➡	We don't have consistency around how we document and implement our policies and procedures.
Why? ➡	We have a culture of letting all providers practice independently and they instruct the nurses and medical assistants to adapt to their individual practice approaches.
Why? ➡	Our clinic manager doesn't have the time or attention to create these policies and procedures and have clinicians confirm and utilized them
Why? ➡	
Root Cause(s)	1. Blood pressures may not be documented correctly in the electronic health record 2. There may be inconsistencies in how BP is documented from clinician to clinician To validate root causes, ask the following: "If you removed this root cause, would this event or problem have been prevented?"

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23

Process Mapping

Process Mapping

- Current state – document and review existing process
- Determine changes needed
- Future state – map out desired process
- Test future state process
- Optimize the new process

Framing (Defining) the Process

- Boundaries – process input/trigger and output
- Major steps in the process, from trigger event to the end result
- Scope – What is included and what is not?
- Who are the stakeholders and customers?
- What are the process inputs (reports, data, forms, etc.)?
- Keep thinking "Who/ Does/ What/ When?" as you visually build your process
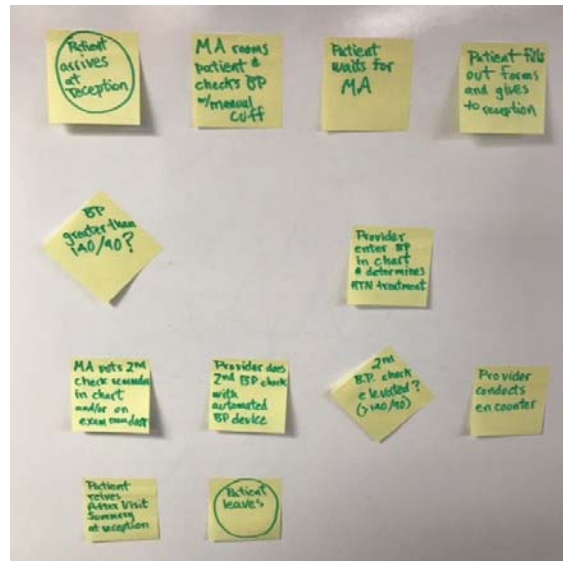- Consider interdepartmental handoffs

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Process Mapping
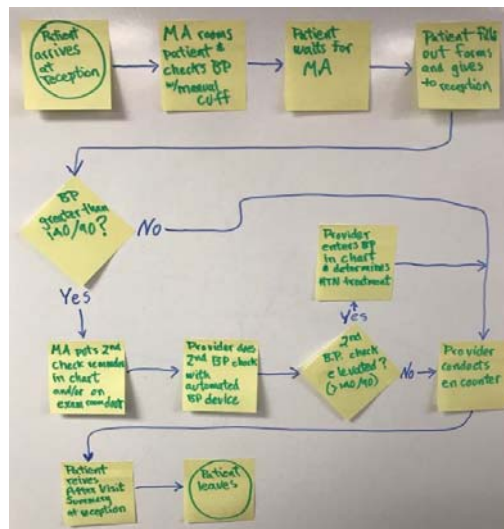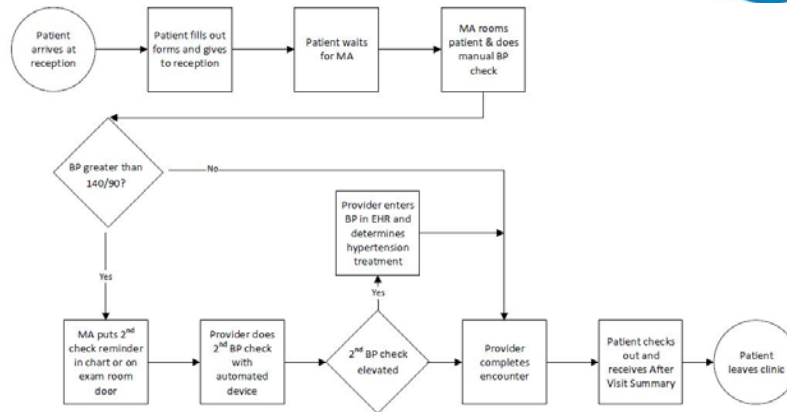

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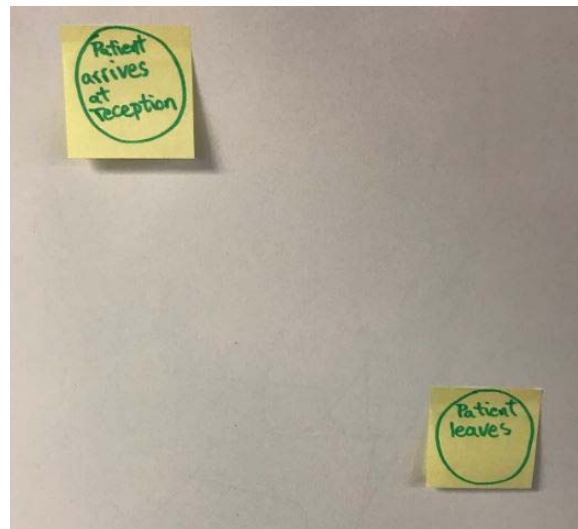
Process Mapping (cont.)

Process Mapping (cont.)

Process Mapping (cont.)

Identify Opportunities to Improve the Process

- Bottlenecks
- Rework due to errors
- Role ambiguity
- Unnecessary duplications
- Long cycle time

- Lack of adherence to standards
- Lack of information
- Lack of quality controls

Plan Do Study Act (PDSA)

PDSA Document: Plan

Plan – What exactly are we going to do? (Add rows to table below as needed.)

Describe test of change	Person responsible	When to be done	Where to be done	Other notes
QI Team leader to present and will emphasize importance of proper BP checks and documentation	Team Leader	At next provider meeting	Provider meeting at the clinic	
Dr. X and Nurse Y will utilize the updated blood pressure workflow which will include a higher level of accuracy and documenting BPs in the EHR	Dr. X and Nurse Y	Monday-Friday MM/DD/YYYY-MM/DD/YYYY	Clinic with all patients seen by Dr. X	Nurse Y will be responsible for double-checking that the process was followed and noting any deviations from workflow

Plan – What exactly are we going to measure to evaluate the test of change? (Add rows to table below as needed.)

Measurement	Baseline (if known)	Prediction	Outcome/Result (to be populated after the 'Do' phase)
NQF 0018 Hypertension	45%	55%	62%
Number of patients with two or more BP values of greater than 140/90 who don't have hypertension as a diagnosis in the problem list in the EHR	Unknown	Unknown, but should be close to 0% (inverse measure, lower is better)	To be determined

PDSA Document: Do

Do – When and how did we do it?

Was the change implemented as expected? Note any deviations from Plan.	What happened? Surprises? Challenges?
There were some hiccups the first few days in remembering the standardized process to document BPs in the EHR (challenge in altering documentation behavior) and finding the correct spots in the EHR, but once the team were on the same page and the EHR bugs were worked out, the process went smoothly	Over the initial test cycle, BPs were getting documented correctly and there were fewer questions after the first few days.

PDSA Document: Study

Study – What were the results?

Populate the outcome column in the Plan section above and analyze the results. Summarize and reflect on what you learned, particularly as it can be help you determine next steps.

Overall, the test was very successful. We saw an 15% increase in patients diagnosed with hypertension (NQF 0018) who also had their diagnosis under control and the team was able to follow the updated workflow consistently.

- Week 1: 47% at end of week
- Week 2: 54% at end of week (*close to 55% goal after 2 weeks)
- Week 3: 58% at end of week
- Week 4: 62% at end of month (& 1 month test period) (*exceeded 55% goal at end of test period)

- The biggest issue with the EHR was addressed during this test, which was staff and provider knowledge about how are where to document BP readings and confirming the diagnosis in the problem list, and we expect that this success can be spread throughout the clinic.
- The clinic data analyst and super user was able to determine that our clinic had 24% of our population with elevated BPs (greater than 140/90) without a hypertension diagnosis in their problem list. Clean up work was done with providers and we got this down to 7% (fewer is better) after the 1 month test. We expect that this will go below 2 or 3% now that providers are getting the documentation done correctly

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PDSA Document: Act

Act – Should we adapt, adopt, or abandon the change? Prepare a 'Plan' for the next PDSA.

☐ Adapt – modify the changes and conduct another PDSA cycle. What will change in the next test?

☒ Adopt – expand changes in the organization to additional patients, staff, units, etc. How will the test be expanded in the next cycle?
  • Continue testing next week with additional MD/MA teams, to keep learning and testing under different conditions

☐ Abandon – don't do another test on this change idea. Consider other approaches and start a new cycle

Describe what modifications to the plan will be made for the next cycle from what you learned:

We expect that we can improve the NQF0018 metric by continuing education and ongoing training, making the new procedures part of our new hire process and recurrent annual training.

Given that we have experienced success in our first round of PDSA testing, we will discuss spreading these successes to other locations beyond our initial set of MDs and MAs. We will do additional PDSA test cycles and NQF0018 data pulls to confirm effectiveness.

Using Data

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Using Data Objectives

- What story do we want to tell with our data about NQF0018?
- Include measure description
- Do we have historic data?
- What level of detail do we need?
- What data visualization tool is appropriate?

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38

Focus on the Use of Data

- Separates what is thought to be happening from what is really happening
- Establishes a baseline for improvement
- Indicates whether changes lead to improvements
- Identifies ineffective solutions
- Allows monitoring of system changes to ensure improvements are sustained
- Allows comparison of performance across sites/groups/providers

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Source: https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf
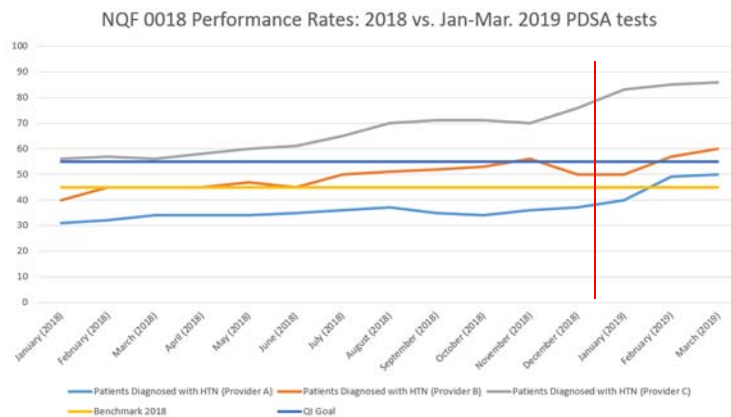
39

When to Stratify

When you suspect that whatever you are measuring may differ based on some characteristic of the data

- The data may differ by age groups
- The overall quality measure might be skewed depending on individual clinician performance
- The underlying data may vary seasonally, monthly, or by some time factor

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NQF0018 Data:
Line Chart

NQF 0018 Performance Rates: 2018 vs. Jan-Mar. 2019 PDSA tests

— Patients Diagnosed with HTN (Provider A)   — Patients Diagnosed with HTN (Provider B)   — Patients Diagnosed with HTN (Provider C)
— Benchmark 2018   — QI Goal

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QI in Practice: A Few Tips

- If you can't measure it, you can't improve it
- Manage the processes, not the health care providers
- The right data in the right hands at the right time
- Engage the people who do and understand the work

What Supports Effective QI?

- Leadership that supports learning, and drives and reinforces processes for organizational change
- Systems and process thinking
- Balancing safety and choice
- Fairness and accountability
- Engaging customers/patients and staff in quality work
- Structured method to make improvements

Words of Wisdom for Your QI Journey

"Start were you are, use what you have, do what you can."

– Arthur Ashe

"A good plan today is better than a perfect plan tomorrow."

– General George S. Patton

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46

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47