Quality Improvement for Frontline Staff

It Takes a Village

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TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

ACCREDITED CONTINUING EDUCATION

Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by AXIS Medical Education and Texas Hospital Association. AXIS Medical Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Learning Objectives

Describe basics of quality improvement

Describe use of data for quality improvement activities

Describe role of frontline staff in quality improvement processes

Critical Access Hospital Quality Improvement – FLEX Program

- Work with partners to improve quality across the state of Texas
  - State Office of Rural Health, Texas A&M RCHI, Texas Hospital Association

- Core Measures Domains
  - Patient Safety / Inpatient
  - Patient Engagement
  - Care Transitions
  - Outpatient

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Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

MBQIP measures are divided into two categories:

- **Core MBQIP Measures** are those that all state Flex Programs are expected to support. Reporting on these measures contributes towards a CAH's Flex eligibility requirements.
- **Additional MBQIP Measures** are those that state Flex Programs can elect to support in addition to the Core measures, particularly in alignment with other partners or initiatives. While these measures are also rural relevant, they may not be as widely applicable across all CAHs. The MBQIP Measures resource includes a list of potential additional measures, but that list is not meant to be exhaustive. Flex programs can propose to work on other quality improvement topics within the four MBQIP domains. If there is not a nationally standardized or standardly reported measure currently available, Flex programs can propose a data collection mechanism.

Core MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
HCP/IMM-3 (formerly OP-27): Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment	**Emergency Department Transfer Communication (EDTC)** *1 composite; 8 elements* • **All EDTC Composite** • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care	**AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

Additional MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
Healthcare-Associated Infections (HAI) • **CLABSI:** Central Line-Associated Bloodstream Infection • **CAUTI:** Catheter-Associated Urinary Tract Infection • **CDI:** *Clostridioides difficile* (*C.diff*) Infection • **MRSA:** Methicillin-resistant *Staphylococcus aureus* • **SSIs:** Surgical Site Infections Colon or Hysterectomy **Perinatal Care** • **PC-01:** Elective Delivery • **PC-05**: Exclusive Breast Milk Feeding (eCQM) **Falls** • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** • Opioids • Glycemic Control • Anticoagulant Therapy	**Emergency Department Patient Experience**	**Discharge Planning** **Medication Reconciliation** **Swing Bed Care** **Claims-Based Measures** *Measures are automatically calculated for hospitals using Medicare Administrative Claims Data* • **Readmissions** • **Complications** • **Hospital Return Days**	**Chest Pain/AMI** • Aspirin at Arrival • Median Time to ECG **ED Throughput** • Door to Diagnostic Evaluation by a Qualified Medical Professional

Quality Improvement

Quality Improvement

- **Quality improvement strives to make a difference to patients by improving safety, effectiveness, and delivery of care by:**
  - **Using understanding of our complex healthcare environment**
  - **Applying a systematic approach**
  - **Designing, testing, and implementing changes using real time measurement for improvement**

Why is Quality Important?

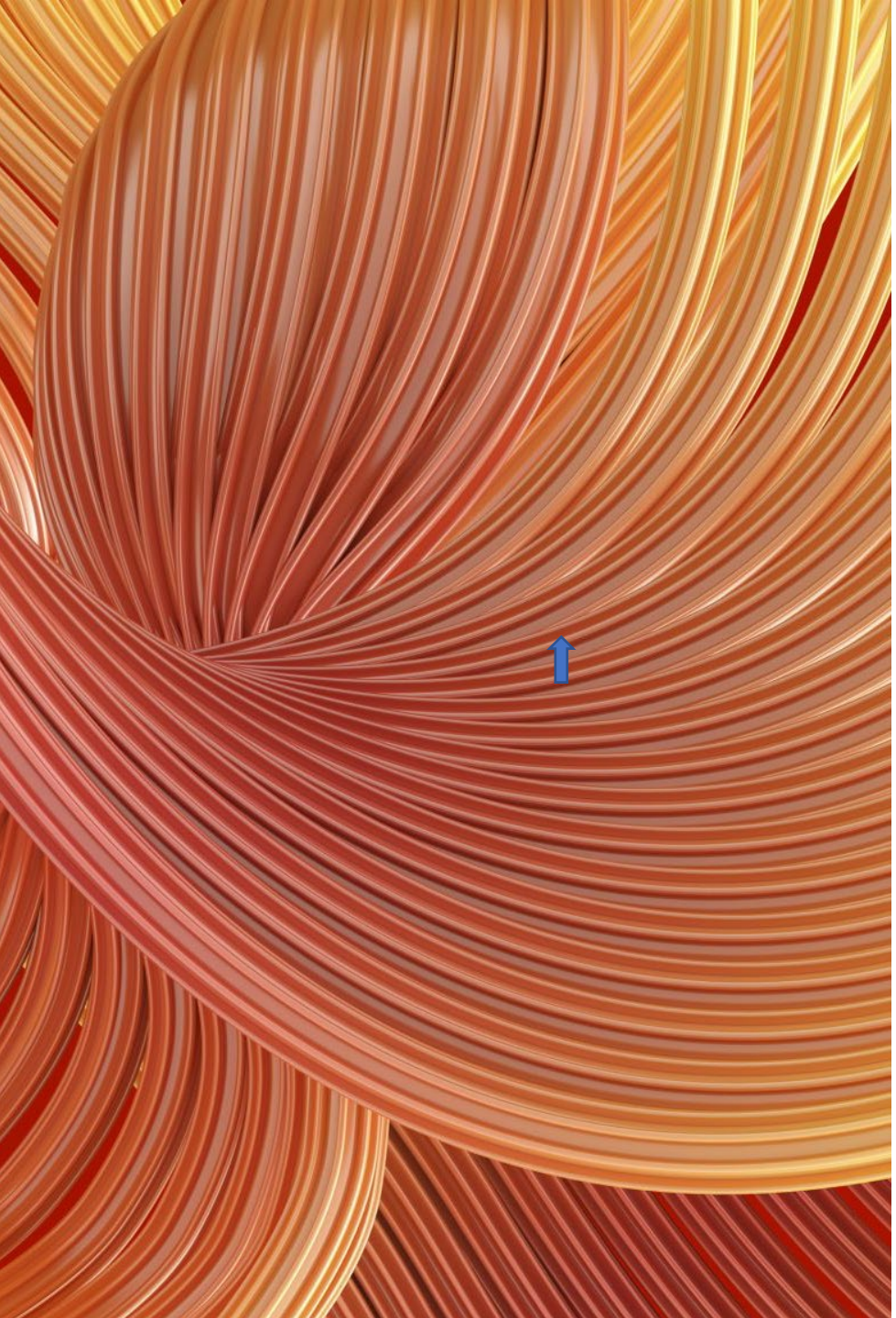
- Approximately 250,000 people die each year from medical errors – 3rd leading cause of death behind cancer and heart disease
- Medical errors cost approximately $20 billion each year
- One CAUTI can result in over $10,000 cost to facility
- Average cost of patient fall with injury is around $30,000

Importance to Critical Access Hospitals

- Smaller in size
- Lower acute care inpatient volumes
- Operate with the least amount of resources
- Can’t absorb costs associated with patient harm events
- At greatest risk for closure

Specific to Texas

- Second largest state
- 268,597 square miles
- Approximately 29 million people
- 51 counties (roughly 15% population) considered rural
- **3,014,819 people live in rural Texas**
- **88 Critical access hospitals in Texas**



How improved quality helps

Quality = efficiency	Efficiency = reduction in cost	Both lead to patient satisfaction
patient satisfaction leads to increased patient volume	Happy patients lead to happy staff!!	Less turnover

Parts to Quality Improvement

- Data collection and analysis
- Development of action plans
- Implementation of change
- Continuous monitoring through data collection and analysis
- Sustained improvement

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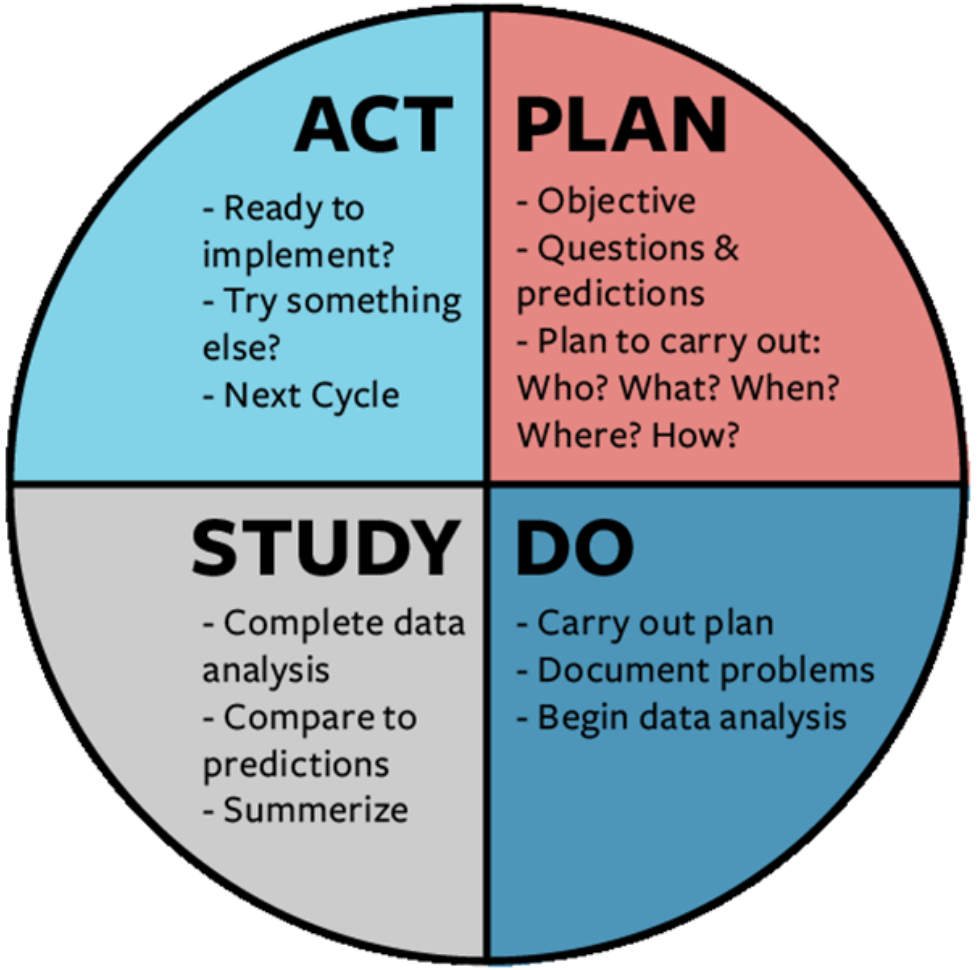
Who decides what we measure?

Issues reported through hospital reporting mechanism	Staff reports Patient complaints Surveys
Quality improvement project participation	CAHQI Project HIIN HQIC
Regulatory agencies	CMS

How does the process work?

The PDSA Cycle for Learning and Improvement



What's next?

What will happen if we try something different?

Did it work?

Let's try it!

Who is responsible for what?

Hospital Boards

- Community leaders
- Invested in success of facility
- Have responsibility to their community

C-Suite

- Make or break change
- Must recognize importance of quality to overall success

Department leaders

- Provide guidance to frontline staff
- Help facilitate change

Frontline staff

- Help identify need for change
- Enact and comply with change to ensure success

Do you know what your quality structure is?

- Who is responsible for Quality Improvement?
- Who reports quality information?
- What is reported?
- What is done with the information?

Who is responsible for all of this?

EVERYONE!!!!

Reporting is key!

- In a typical hospital, approximately what percentage of errors is reported?
  - A. less than 5
  - B. between 25 and 50
  - C. 75
  - D. between 80 and 90

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Barriers to reporting

FEAR OF DISCIPLINARY ACTION

EMBARRASSMENT

PRIDE

How do we increase reporting?

Culture of Safety

Culture of Safety

Agency for Healthcare Research and Quality (AHRQ) defines a culture of safety as one "in which healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near misses and prevent recurrence" (AHRQ PSNet Safety Culture 2014)

Culture of Safety and Quality Improvement

- Encourages reporting – NEAR MISSES
- Heightens awareness of safety
- Uses near misses to avoid bigger events
- Culture of Safety understands the involvement of the system on potential safety issues

High Reliability

Operating in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures

- **Determine areas of high risk**
- **Learn from errors and near misses**
- **Evaluate culture of safety**
- **Enhance the concept of teamwork**
- **Speak up!!**

How does high reliability work?

- Fosters reporting of events
- Empowers staff on all levels to lead the way
- Encourages participation at all levels
- Makes quality a TEAM effort!!

What does this mean for you?

YOU HAVE POWER!!

- First to recognize potential issues
- Knowledge and expertise in your area
- Ability to bring ideas to the table
- Ability to help lead change

What you can do……..

- Report!!!!!
  - Don’t wait for significant patient harm event
  - Near misses can prevent bigger problems
  - Stand up, speak up
  - Take ownership

Get Involved…….

- Learn what your hospital reports
- Assist with data collection
- Follow the data

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Quality Improvement Committee / Teams

1. Participate in a Quality Improvement Team
2. Bring ideas to the table
3. Develop change strategies
4. Lead change on your unit
5. Be the voice for your department!


Any
Questions

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THANK
YOU!