Welcome to…..

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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.

Credit Designation for Nursing

AXIS Medical Education designates this continuing nursing education activity for 12.75 contact hours. *Learners are advised that accredited status does not imply endorsement by the provider or ANCC of any commercial products displayed in conjunction with an activity.*

FLEX Program Quality Improvement

DAY 1	
8 a.m. - 8:15 a.m.	Check-In
8:15 a.m. – 8:45 a.m.	Welcome / Introductions
8:45 a.m. – 9:45 a.m.	Basics of Quality Improvement
9:45 a.m. – 10:45 a.m.	Define it, Collect it, Analyze it, Use it
10:45 a.m. – 10:55 a.m.	Break
10:55 a.m. – 11:45 a.m.	Teams for Improvement
11:45 a.m. – 12:30 p.m.	Lunch
12:30 a.m. – 1:30 p.m.	Adult Learning Styles
1:30 p.m. – 2:30 p.m.	Educational Development
2:30 p.m. – 2:40 p.m.	Break
2:40 p.m. – 3:40 p.m.	Teaching Strategies – Part 1
3:40 p.m. – 4:45 p.m.	Business Plan Development
4:45 p.m. – 5:00 p.m.	Wrap Up / Questions

DAY 2	
8:15 a.m. – 8:30 a.m.	Check-in / Questions
8:30 a.m. – 9:00 a.m.	The STATE of Texas
9:00 a.m. – 9:45 a.m.	Healthcare Disparities
9:45 a.m. – 10:45 a.m.	Selling Your Story to Leadership
10:45 a.m. -10:55 a.m.	Break
10:55 a.m. – 12:00 p.m.	Teaching Strategies part 2
12:00 p.m. – 12:45 p.m.	Lunch
12:45 p.m. – 1:30 p.m.	Staff Engagement
1:30 p.m. – 2:15 p.m.	Workplace Violence
2:15 p.m. – 2:30 p.m.	Break
2:30 p.m. – 3:30 p.m.	Root Cause Analysis - Interview
3:30 p.m. – 4:15 p.m.	Building a Debriefing Team
4:15 p.m. – 4:30 p.m.	Wrap up / Questions

Texas Hospital Association Foundation

Basics for Quality Improvement

Critical Access Hospital Quality Improvement Bootcamp

2023

TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Texas Hospital Association Foundation

Learning Objectives

Discuss basics of Quality Improvement

Describe the Quality Improvement Process

Identify role of quality managers in leading change

Quality Improvement

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

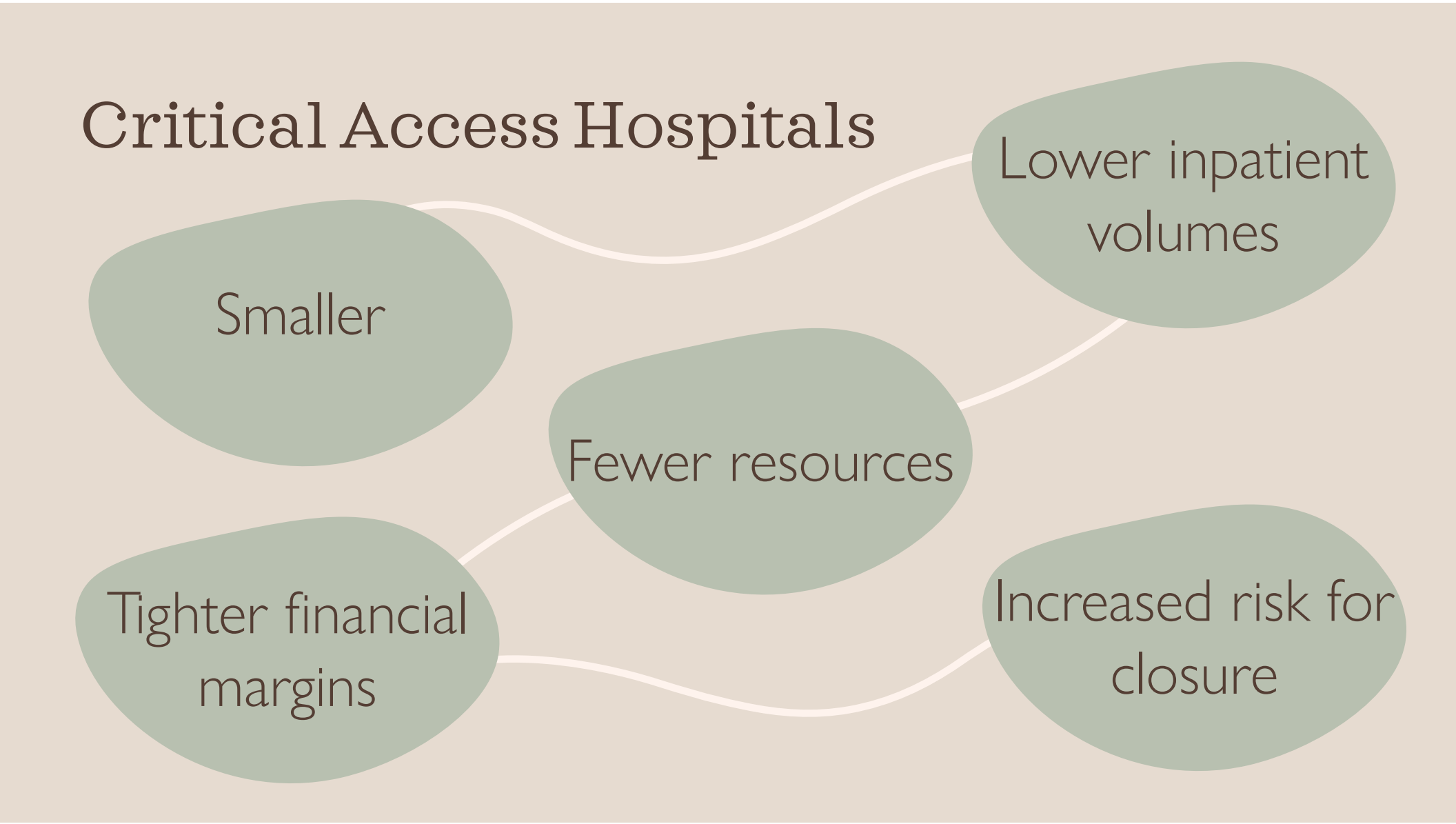
What does it mean to improve?

- You want to do something better.
- Implies that something needs to change.
- Will that change result in 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

Critical Access Hospitals



Foundation for Successful Improvement

- Plan, Do, Study, Act (PDSA)
- *Why* do you need to improve? – AIM statement
- Develop change intended to improve
  - Action Plans
- Test change
- Implement change
- Process for feedback/data collection
  - Continuous monitoring and analysis

AIM Statement

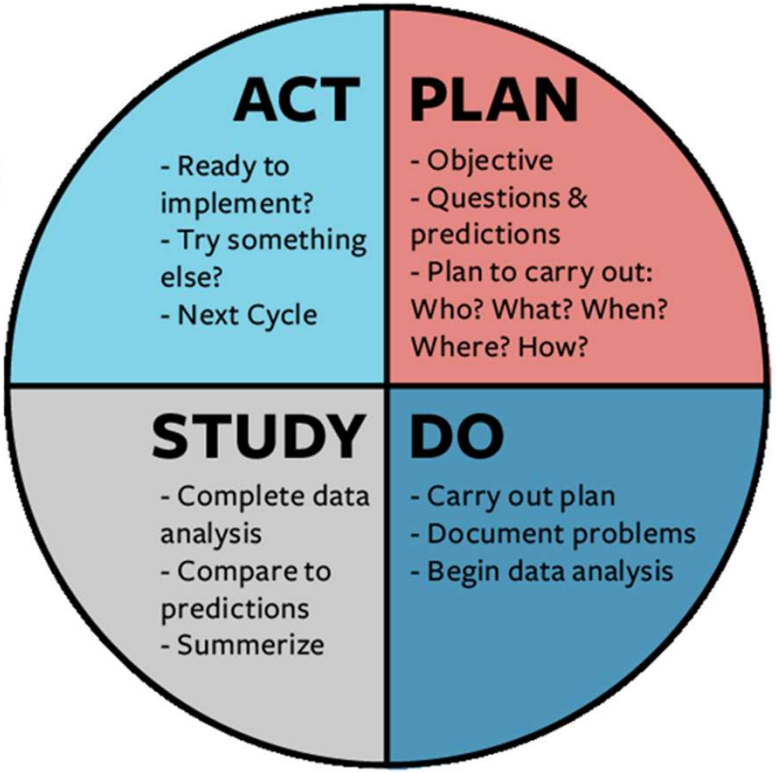
- Clear, explicit statement of what will be accomplished, includes the timeframe and the magnitude of the change
- Guides your work
- Establishes what success will look like

Team Aim Graphic. Digital Image. n.d. https://www.freepik.com/premium-vector/team-business-goal-teamwork-collaboration-achieve-target_13533256.htm#&position=44.

AIM Statement Examples

- There will be a 50% reduction in adverse drug events in Labor and Delivery in six months.
- Achieve > 95 percent compliance with on-time prophylactic antibiotic administration within one year.
- By December 2021, we will transfer every patient from the Emergency Department to an inpatient bed within one hour of the decision to admit.

The PDSA Cycle for Learning and Improvement

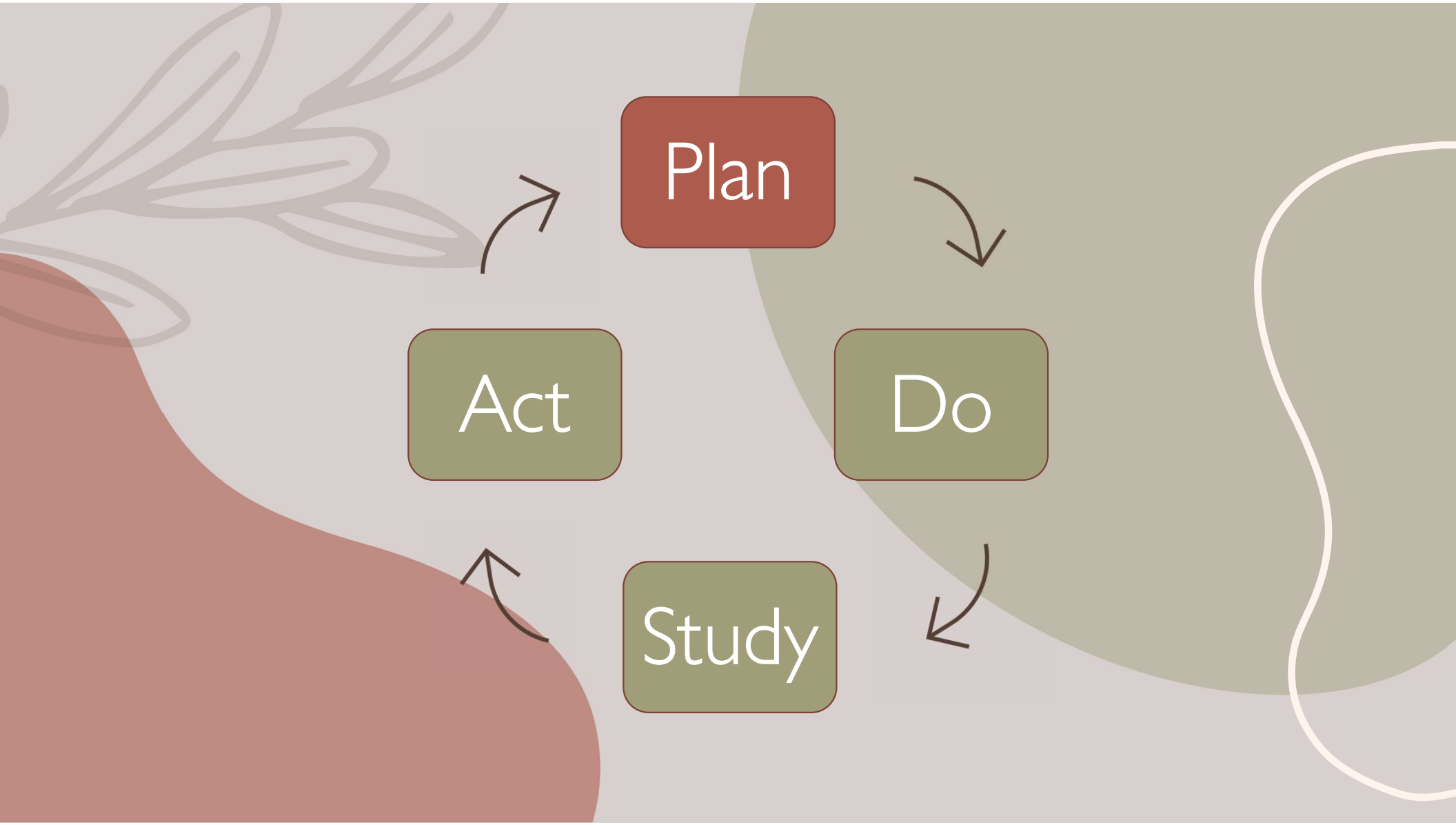


What's next?

What will happen if we try something different?

Did it work?

Let's try it!


Plan
Do
Study
Act

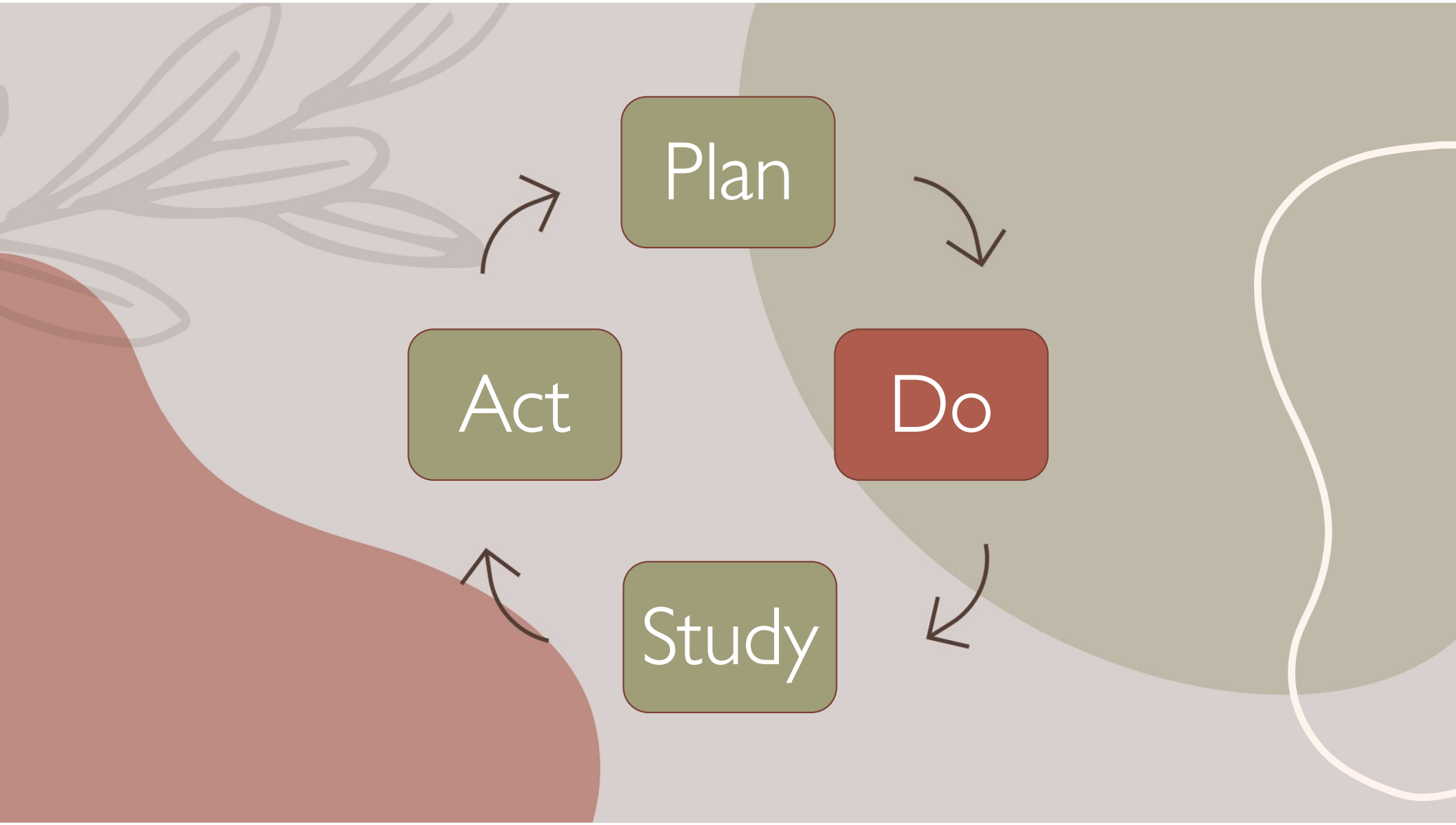
Develop Change

What possible change, if implemented, could result in improvement?

Elicit feedback from subject matter experts.

Process Mapping

Not just about having an idea, but ideas that can be broadly implemented and sustained.


Plan
Do
Study
Act

Test Change

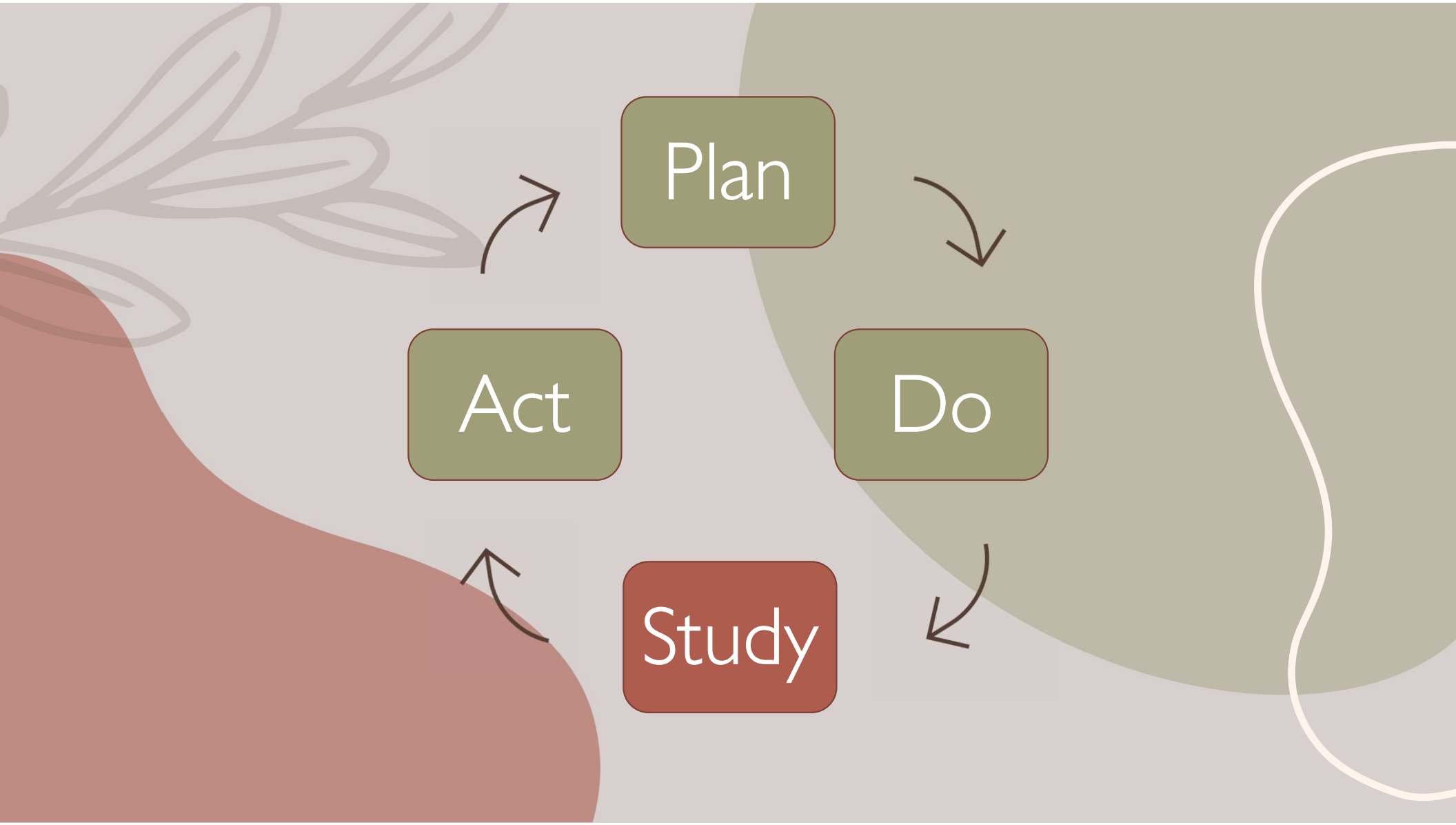
Plan the test

- What will it look like?
- Who will be involved?
- When and for how long?
- How will the test be reviewed/examined?

Run Test

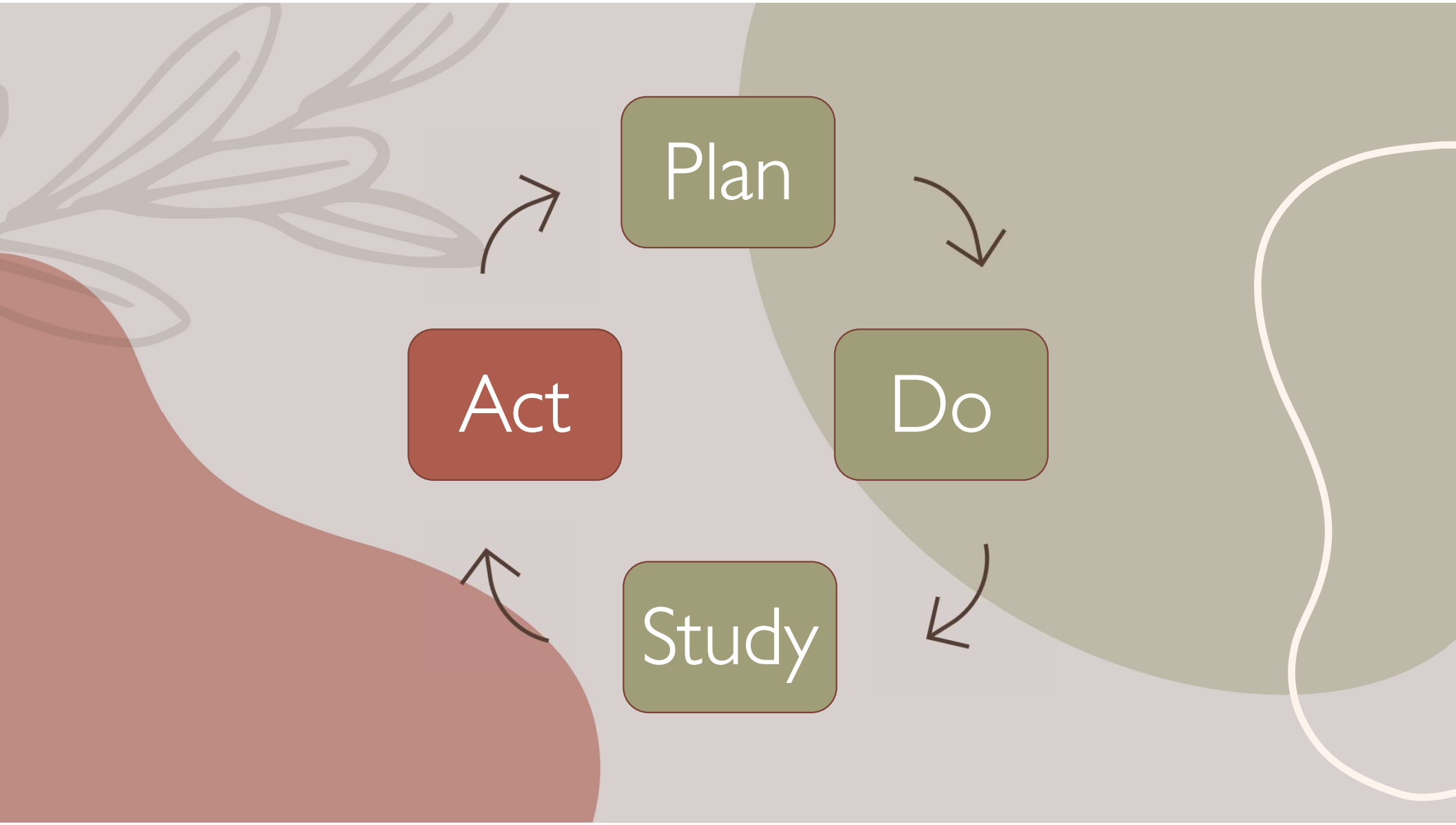
Review test and elicit end user feedback

What adjustments need to be made?


Plan
Do
Study
Act

Feedback and Data Collection

- How do you know the change is working?
- What data points have you identified to help show quantifiable improvement?
- Make appropriate adjustments.
- Repeat cycle!


Plan
Do
Study
Act

Implement Change

Promote, Educate/Train, Buy in

- Align with organizational mission and vision
- Provide support and follow up

How will we ensure change is permanent and sustainable?

- Communication
- Empower team members
- Connect the dots

Who decides what we measure?

Issues reported through hospital reporting mechanism

- Staff reports
- Patient complaints
- Surveys

Quality improvement project participation

- CAHQI Project
- HQIC

Regulatory agencies

- CMS

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 • Transition of Care *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**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 • Tests and/or Procedures Performed • Test and/or Procedure Results	**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 **Patient Safety Culture Survey** **Inpatient Influenza Vaccination** **eCQMs** • **VTE-1:** Venous Thromboembolism Prophylaxis • **Safe Use of Opioids**: Concurrent Prescribing • **ED-2:** Median Admit Decision Time to ED Departure Time for Admitted Patients	**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

Responsibilities

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

What is one of biggest issues with Quality Improvement?

Incident reporting icon. Digital image. 2019. Bleich, C. (n.d.). Seven adult learning styles and best practices to follow. EdgePoint Learning. Retrieved from https://www.edgepointlearning.com/blog/adult-learning-styles/.

Reporting and Data Collection

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

Reporting and Data Collection

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Barriers to Reporting

Fear of disciplinary action

Embarrassment

Pride

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."

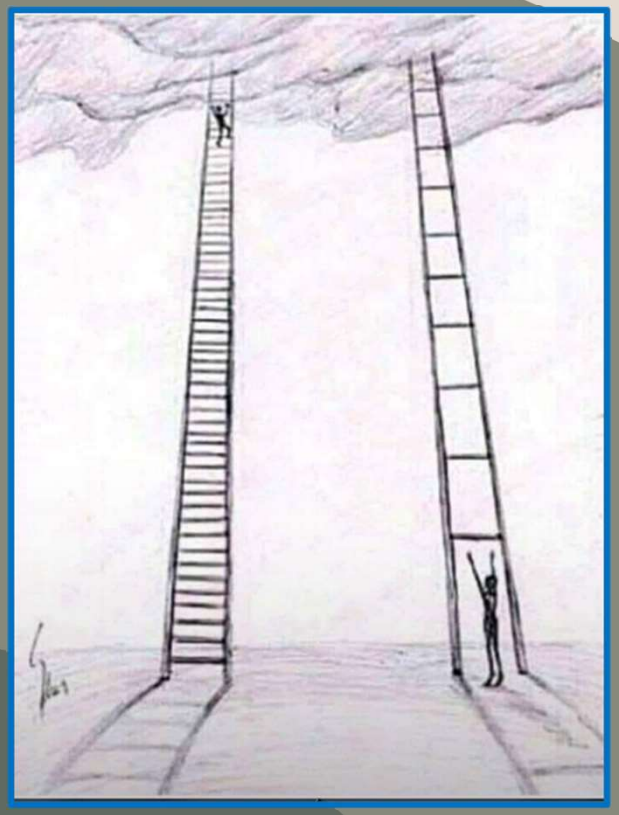
Putting it together

Culture of Safety and Quality Improvement

- Heightens awareness of safety
- Encourages reporting – near misses
- Uses near misses to avoid bigger events
- Understand the involvement of the system on potential safety issues

Remember

- Change is hard!
- Take small steps
- Patients and families should be at the center of what you do as an organization
- Employees are humans working in a high-risk, complex system



Small Steps Graphic. Digital Image. n.d. www.reddit.com/r/GetMotivated/comments/jq1h9w/image_accomplish_your_success_in_small_steps/.

Resources

- Agency for Healthcare Research and Quality
- Institute for Healthcare Improvement (IHI)
  - Patient Safety Essentials Toolkit
  - Quality Improvement Essentials Toolkit
  - Improvement Tools

Questions?

Thank you!

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