

A close-up photograph of a person's hands pulling a thick, white rope with blue markings through a shiny, metallic winch on the deck of a boat. The background shows the blue ocean and a clear sky with some clouds. The person is wearing a dark jacket. The text "Quality Improvement for Frontline Staff" is overlaid in white, and "All hands on deck!" is overlaid in white below it.

# Quality Improvement for Frontline Staff

**All hands on deck!**

This educational opportunity is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of the Medicare Rural Hospital Flexibility Grant. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.



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.

Each webinar is approved for 1 Continuing Nursing Education credit

The evaluation link will be sent out via email at the completion of the series

For those watching in groups:

- Only one email will be sent with evaluation if only one person is registered
- Make sure you each go in and actually register for the series

# Learning Objectives

- **Describe basics of quality improvement**
- 
- **Describe use of data for quality improvement activities**
- 
- **Describe role of frontline staff in quality improvement processes**





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





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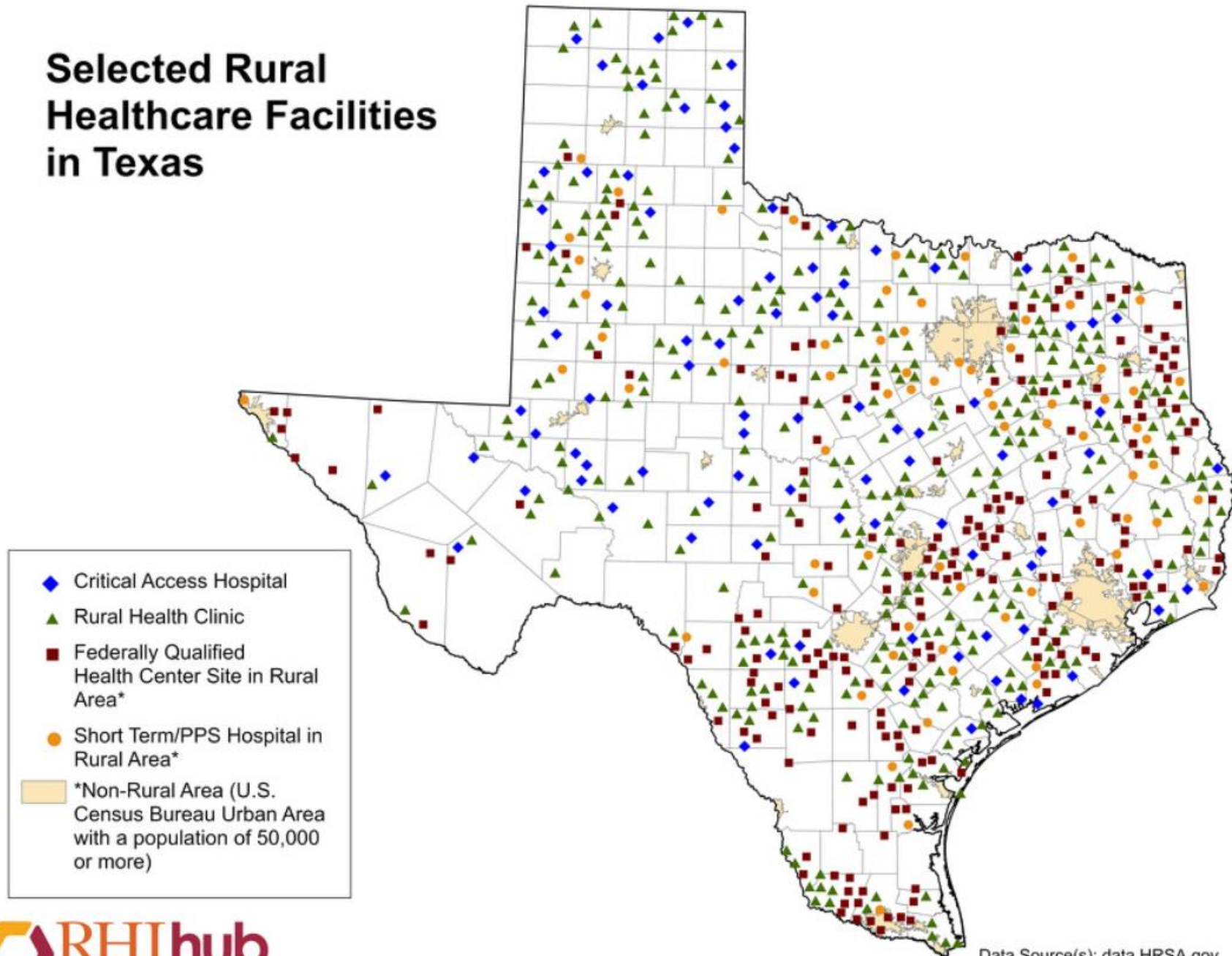
# Specific to Texas

- Second largest state
- 268,597 square miles
- Approximately 30 million people
- 51 counties (roughly 16% population) considered rural
- **4.8 million people live in rural Texas**
- **91 Critical access hospitals in Texas**





## Selected Rural Healthcare Facilities in Texas



# Critical Access Hospital Designation

- Eligible hospitals must meet the following conditions to obtain CAH designation:
- Have 25 or fewer acute care inpatient beds
- Be located more than 35 miles from another hospital (exceptions may apply)
- Maintain an annual average length of stay of 96 hours or less for acute care patients
- Provide 24/7 emergency care services



# What does the data tell us

The not so good news

# The Statistics

- Approximately 250,000 people die each year from medical errors – 3<sup>rd</sup> leading cause of death behind cancer and heart disease
- Medical errors cost approximately \$20 billion each year
  - Some say \$35 – 45 Billion for healthcare associated infections alone
- 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

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Smaller in size

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Lower acute care inpatient volumes

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Operate with the least amount of  
resources

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Can't absorb costs associated with  
patient harm events

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At greatest risk for closure





# How improved quality helps

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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





# Federal Quality Improvement Programs

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Benefits to participation



# Critical Access Hospital Quality Improvement – FLEX Program

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- 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







# Benefits of Participation



Technical assistance in Quality Improvement



Technical assistance in Finance



Free education for quality leaders, frontline staff



Advocacy for critical access hospital at the state / federal level



Ability to qualify / participate in other programs / funding sources



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# New Core Measure Set

Removed

Proposed New MBQIP Core Measure Set				
Global Measures	Patient Safety	Patient Experience	Care Coordination	Emergency Department
<ul style="list-style-type: none"> <li>CAH Quality Infrastructure Implementation (annual submission)</li> <li>Hospital Commitment to Health Equity (required CY 2025) (annual submission)</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare Personnel Influenza Immunization (annual submission)</li> <li>Antibiotic Stewardship Implementation (annual submission)</li> <li>Safe Use of Opioids (eCQM) (annual submission)</li> </ul>	<ul style="list-style-type: none"> <li>Hospital Consumer Assessment of Healthcare Providers &amp; Systems (HCAHPS) (quarterly submission)</li> </ul>	<ul style="list-style-type: none"> <li>Hybrid All-Cause Readmissions (required starting in 2025) (annual submission)</li> <li>SDOH Screening (required CY 2025) (annual submission)</li> <li>SDOH Screening Positive (required CY 2025) (annual submission)</li> </ul>	<ul style="list-style-type: none"> <li>Emergency Department Transfer Communication (EDTC) (quarterly submission)</li> <li>OP-18 Time from Arrival to Departure (quarterly submission)</li> <li>OP-22 Left without Being Seen (annual submission)</li> </ul>



# 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**





# 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

MBQIP Quality Program  
HIIN  
HQIC



Regulatory agencies

CMS  
State Agencies

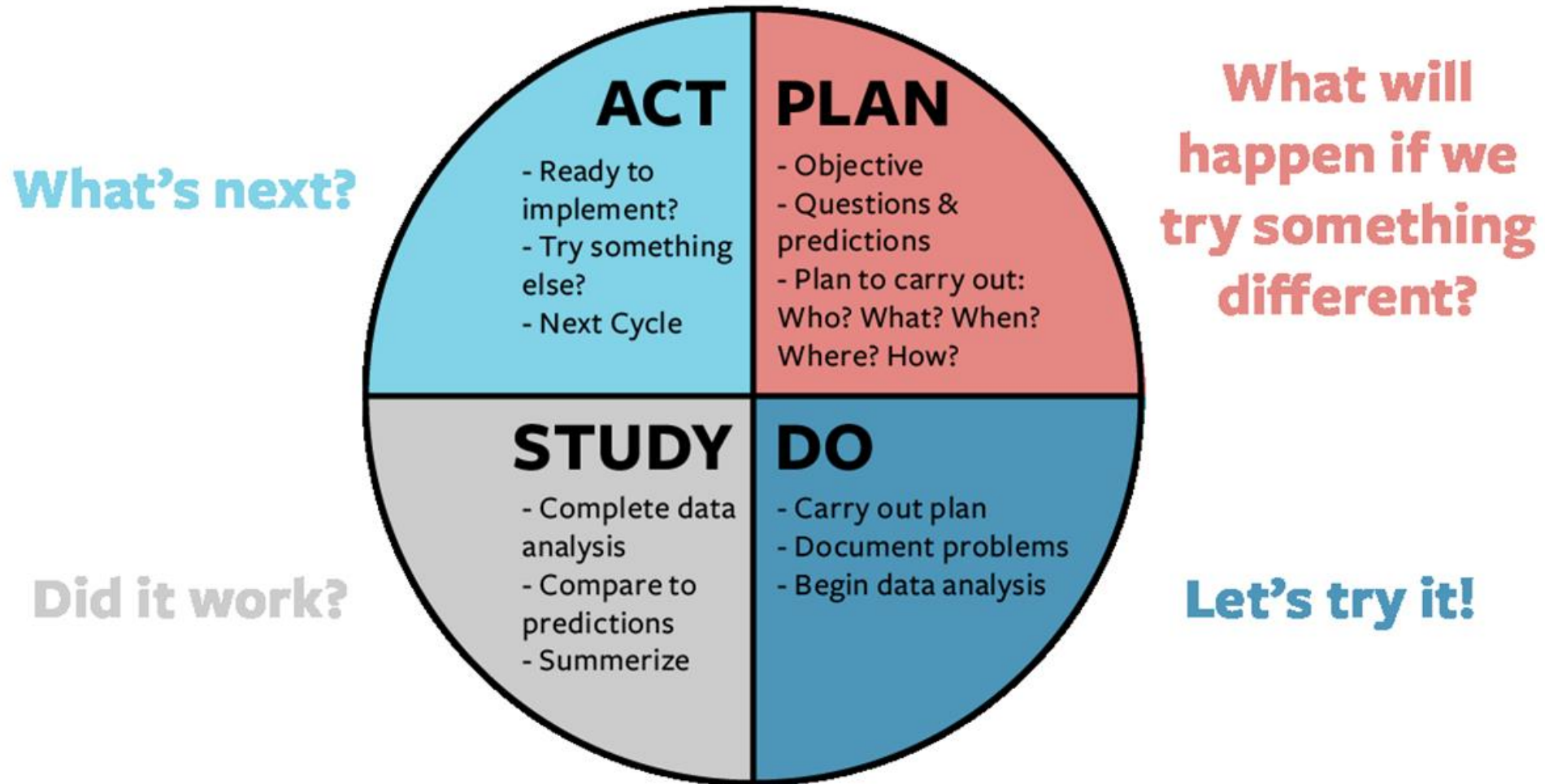


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# How does the process work?



# The PDSA Cycle for Learning and Improvement





# Everyone has a role to play

## 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
- Identify ways in which change can be made even better
- Share ideas on best strategies based on work they do
- Ensure success of improvement projects



# Who is responsible for all of this?

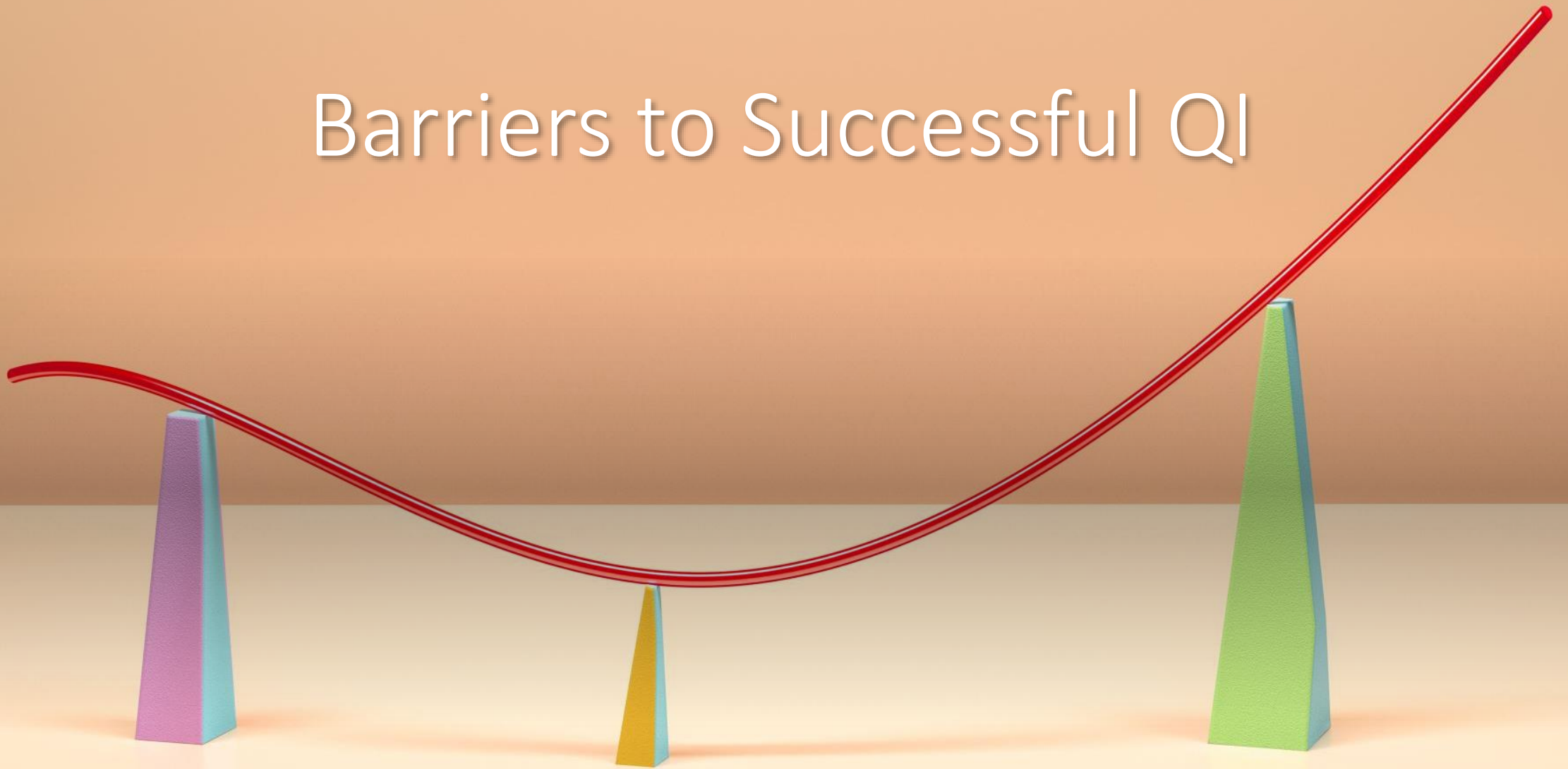
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**EVERYONE!!!!**


**Reporting is key!**



# Barriers to Successful QI







Quality  
Improvement  
relies on.....

- Engagement
- Reporting
- Identification of issues
- Changing organizational culture





# Barriers to reporting

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FEAR OF  
DISCIPLINARY  
ACTION

EMBARRASSMENT

PRIDE



# How do we overcome barriers?

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Culture of Safety



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# 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?

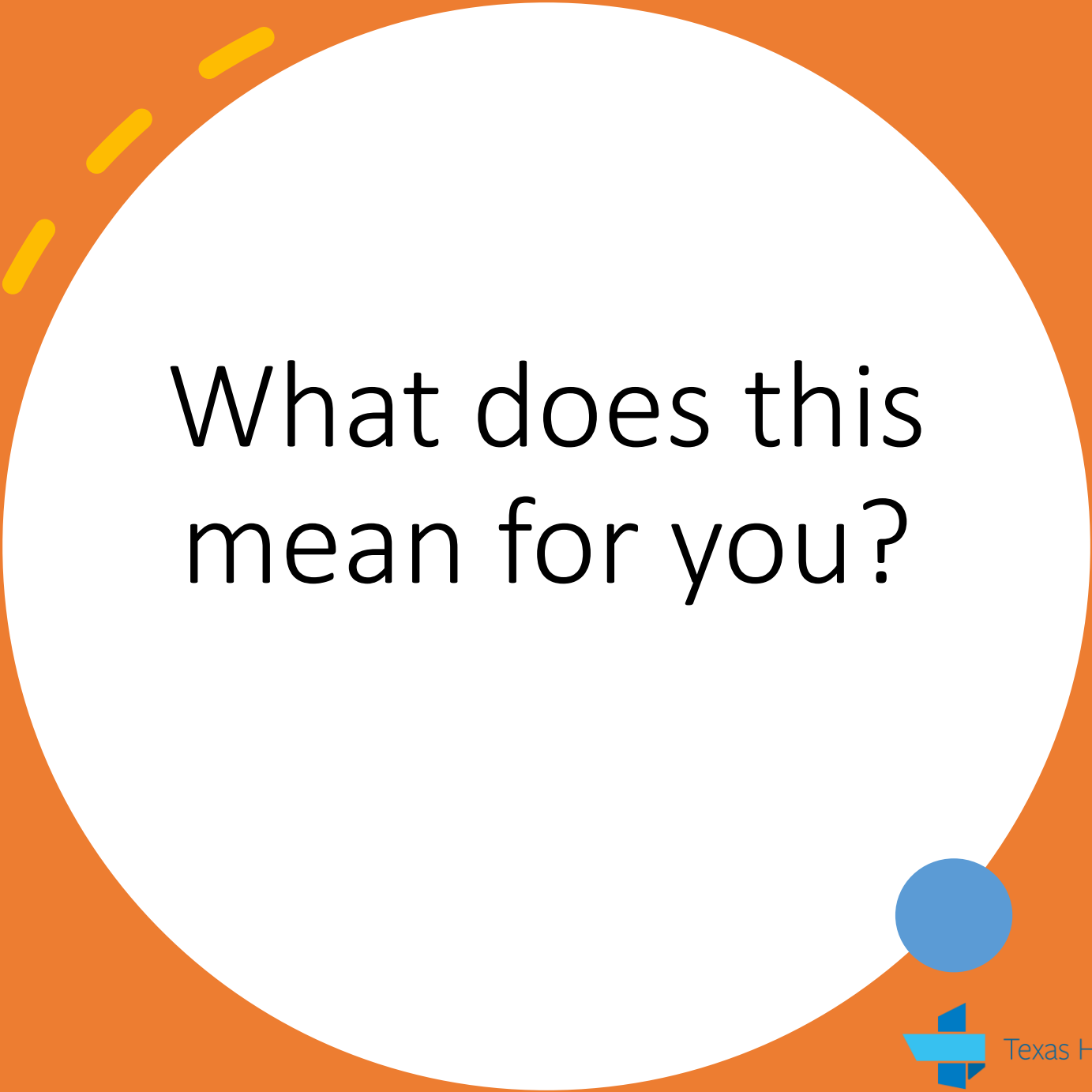
Fosters reporting of events

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?



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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



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A large orange circle on the left side of the slide.

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





Do you  
know what  
your  
quality  
structure  
is?

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Who is responsible for Quality Improvement?

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Who reports quality information?

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What is reported?

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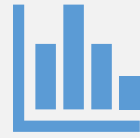
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What is done with the information?

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# 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!

# Always remember.....

**YOU** are the key

We can't do it without  
**YOU**

**YOU** have the ability to  
lead the way to success

Only **YOU** can tell us how  
you can do your job better



Questions??





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Join us for the rest of our sessions!!!

- **August 12, 2025: Ownership on the Frontline: Moving toward high reliability – Building a culture of safety and facilitating change from the frontline**
- **August 19, 2025: AI in Healthcare – taking a look at the role AI is playing in healthcare, how things are changing, and how we can be ready for the future of AI in what we do**

# Follow Up:

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A festive banner with colorful stars and swirls in blue, yellow, orange, and pink, set against a dark blue background. The banner is composed of several strings of triangular flags and small star-shaped ornaments.

THANK  
YOU!

A decorative trail of colorful stars (yellow, orange, pink, blue, and purple) and a central white star with a horizontal line and ornate flourishes, positioned below the main text.