

WELCOME!

While we wait...

- Have your improvement cycle documentation ready to share.

Be ready to share...

- How you determined your SMART goal.
- Any progress you have made on implementing your project.



NATIONAL ASSOCIATION OF
Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

QI TRAINING, POWERED BY



REGLANTERN



QI TRAINING: COHORT C - LIVE SESSION 3

OCTOBER 12, 2023

2:00 – 3:30 PM ET





QI Training: Course Timeline

Pre-Work

Course: September 5, 2023 – December 12, 2023

- ✓ Register for Elevate
- ✓ Block calendar for sessions

Sep 5th
Webinar 1

Session 1
(with your Cohort)

Session 2
(with your Cohort)

Session 3
(with your Cohort)

Oct 19th
Webinar 2

Session 4
(with your Cohort)

Session 5
(with your Cohort)

Session 6
(with your Cohort)

Dec 12th
Closing Webinar

You are here!



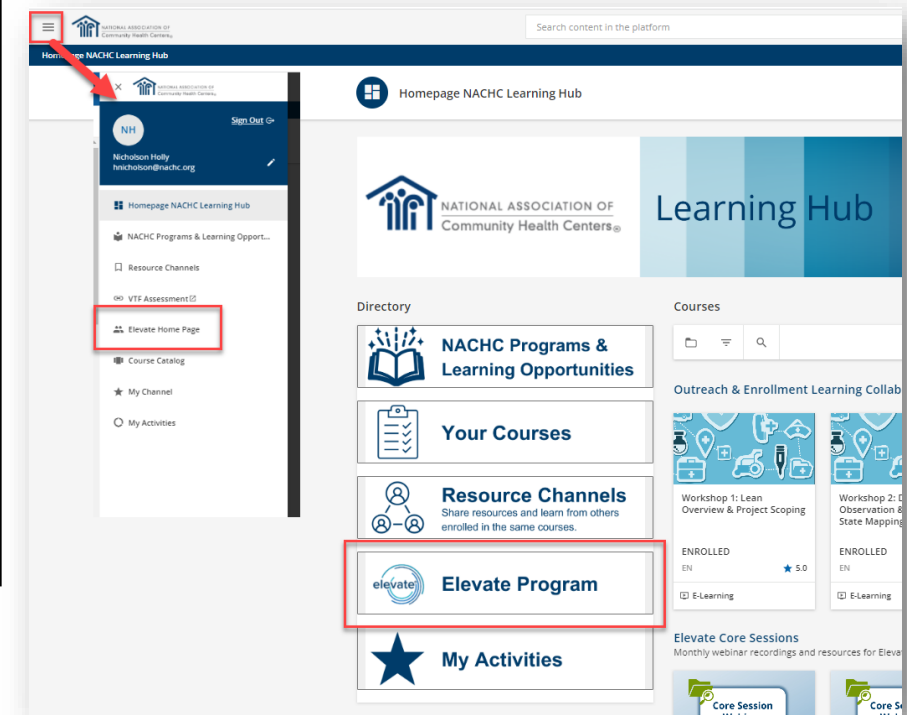
NACHC's Online Learning Hub

Session will be recorded and available in the Learning Hub



If you already have a 'NACHC One' login (the login used for NACHC conferences), use this to sign in.

*If you do not yet have a 'NACHC One' login, **register for free!***



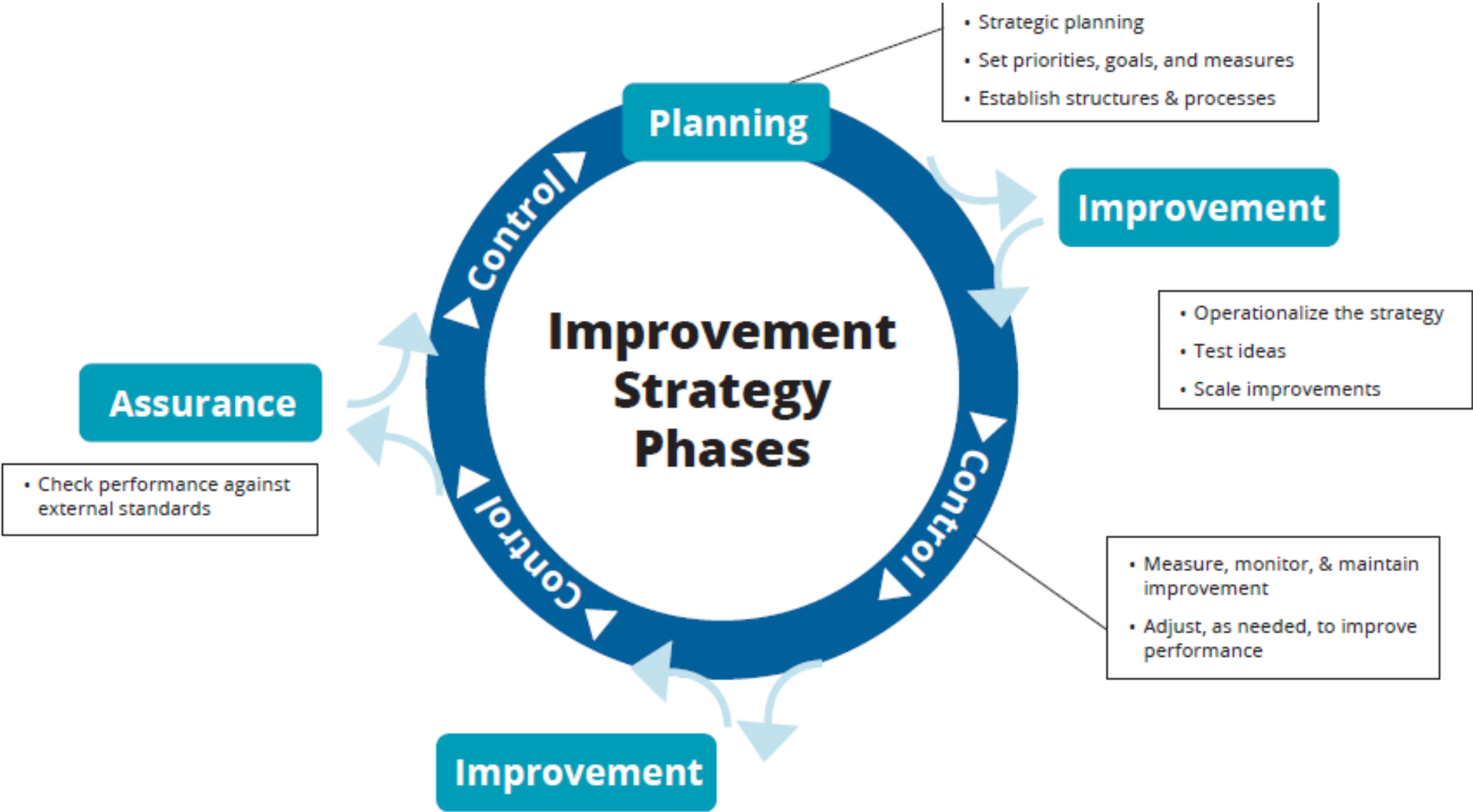
Access NACHC's Learning Hub at <https://nachc.docebosaaS.com/learn/signin>

Quick Break Out!

In small groups of 2-3, share the following:

- Your SMART goal for your improvement cycle.
- The steps in the plan section of your improvement cycle.
- Any progress you have made in the implementation of the improvement cycle.
- Provide any feedback about the ideas to your group members.

10 Minutes



Today's Focus



A Case Study in Quality Control

9:41

Medical Consent Form

I, *Michelle Robinson*, do hereby agree and give my consent to the physician to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize a nurse to assist with my plan of care.

Patient Name Required

Michelle

Robinson

Patient Signature

Michelle

HIPAA COMPLIANT FORMS SUBMIT FORM

Quality Control



- **Measuring** improvement
- **Maintaining** over time
- **Occurs daily** within teams
- **Adjust** as needed



PLANNING (QP)



IMPROVEMENT
(QI)



CONTROL (QC)



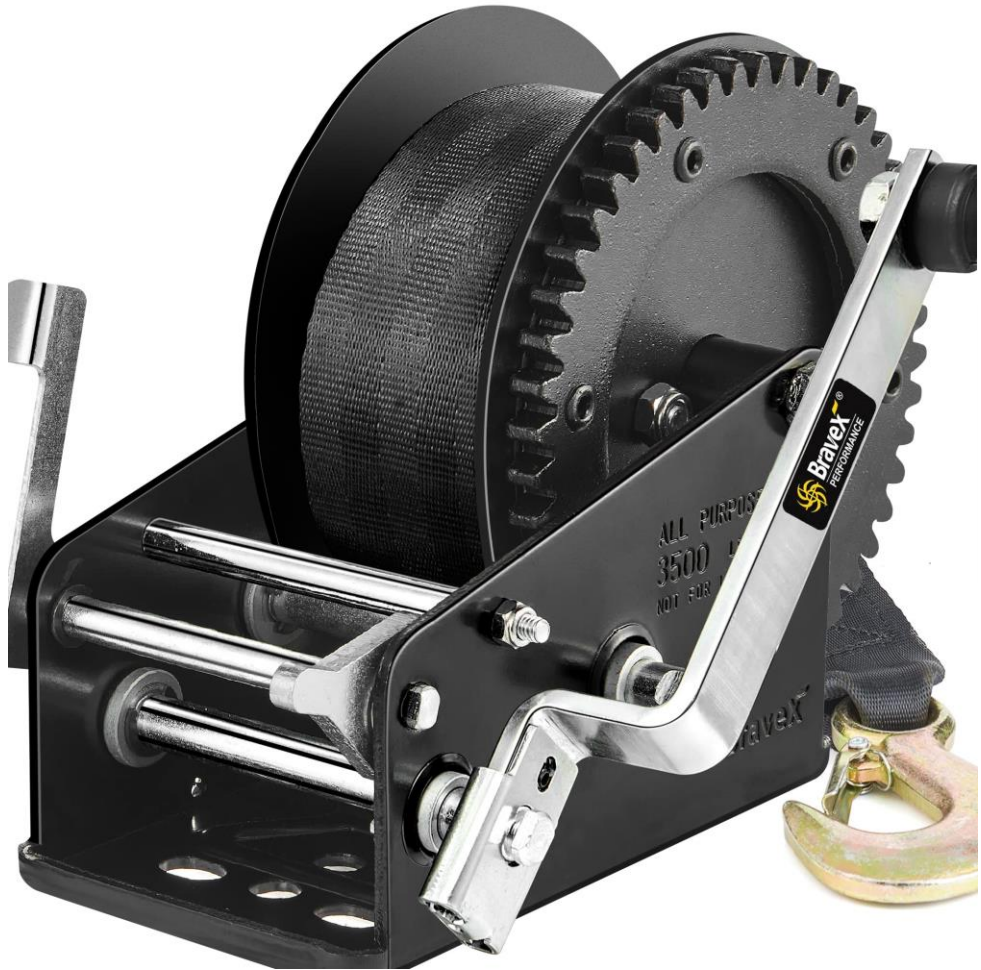
ASSURANCE
(QA)

Session Objectives

1. Differentiate between Quality Control (QC) and Quality Improvement (QI).
2. Clarify who conducts QC and for what audience.
3. Learn how to conduct QC audit to validate data and detect changes.
4. Learn to make and use Run Charts according to statistical rules.
5. Use Root Cause Analysis to answer the 5 Why's for a specific measure.

Quality Control - Overview

Quality Control – Back Stops in Place



Quality Improvement vs. Quality Control

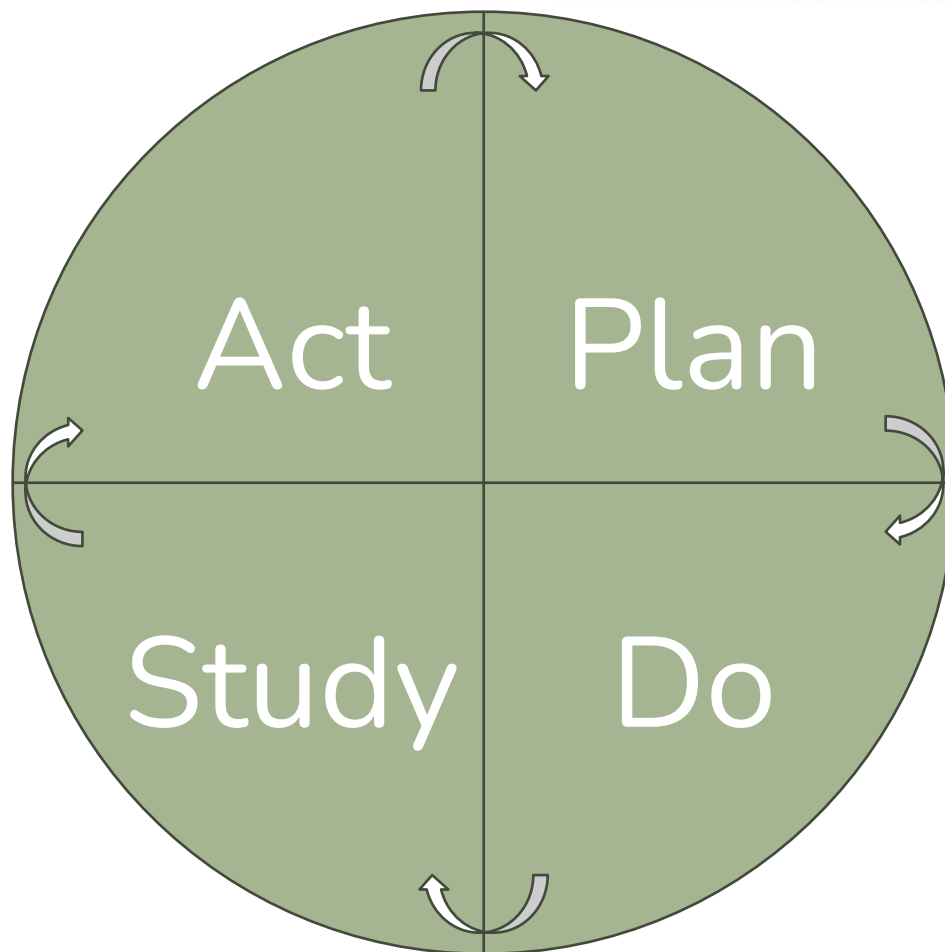
Quality Improvement

- Let's make this better.
- Achieving new levels of performance.
- Identify opportunities for improvement through new features or removing problems.
- Improving.

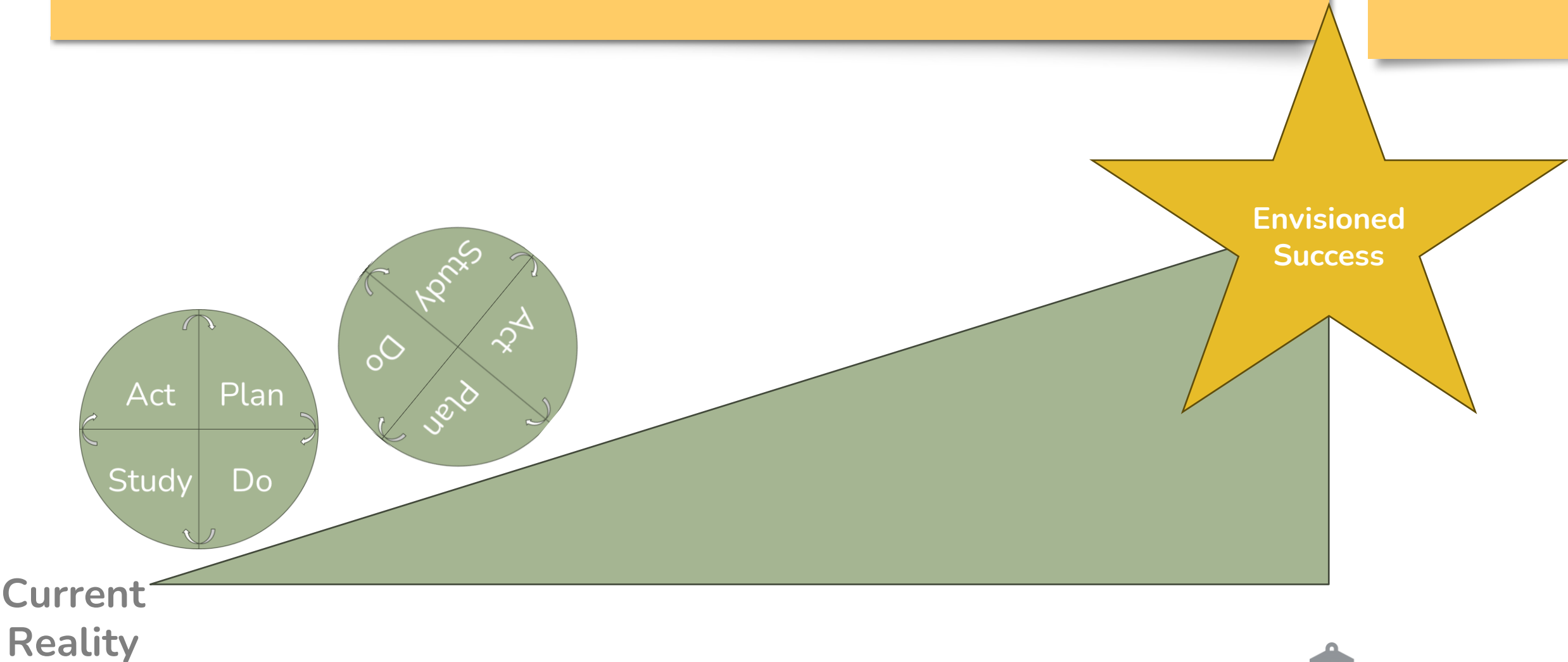
Quality Control

- Inspect what you Expect
- Ensure our services meet benchmarks.
- Identify exceptions to the process that need to be addressed.
- Maintaining.

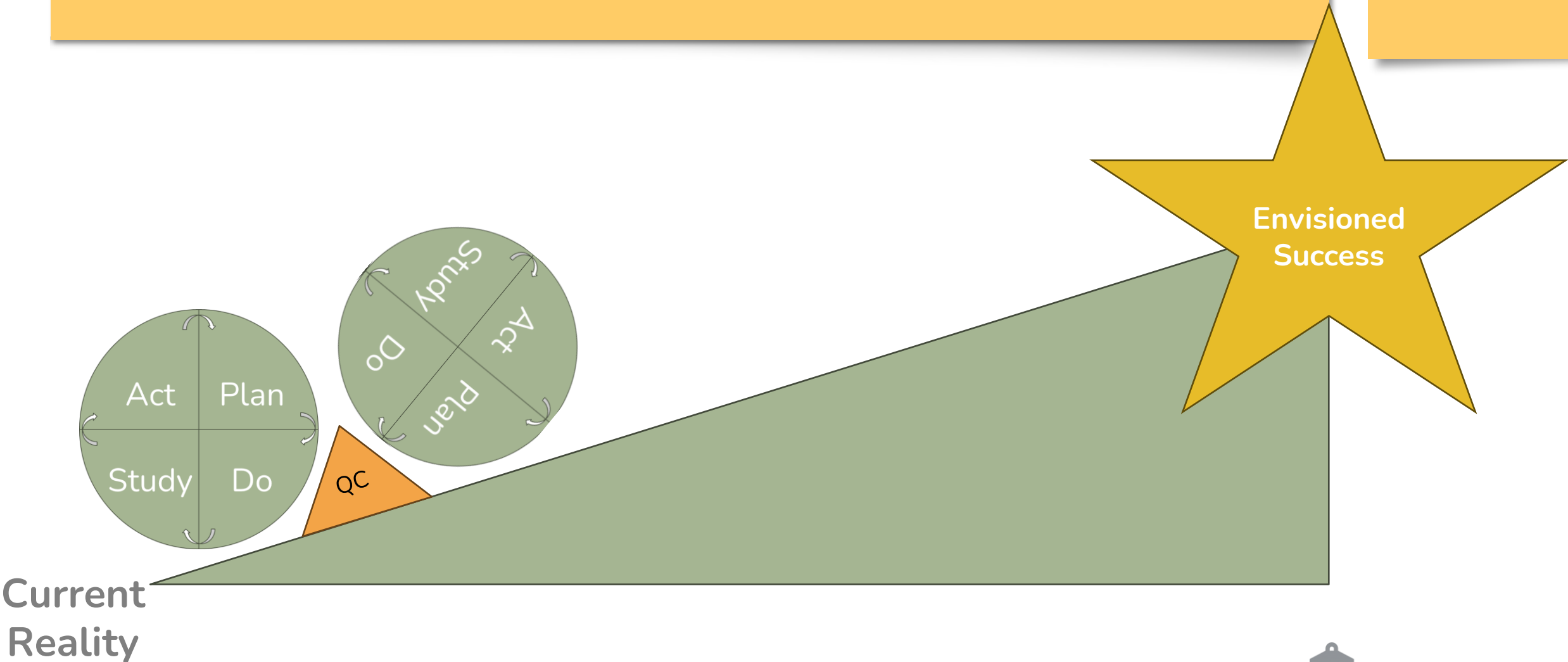
Quality Improvement Cycle



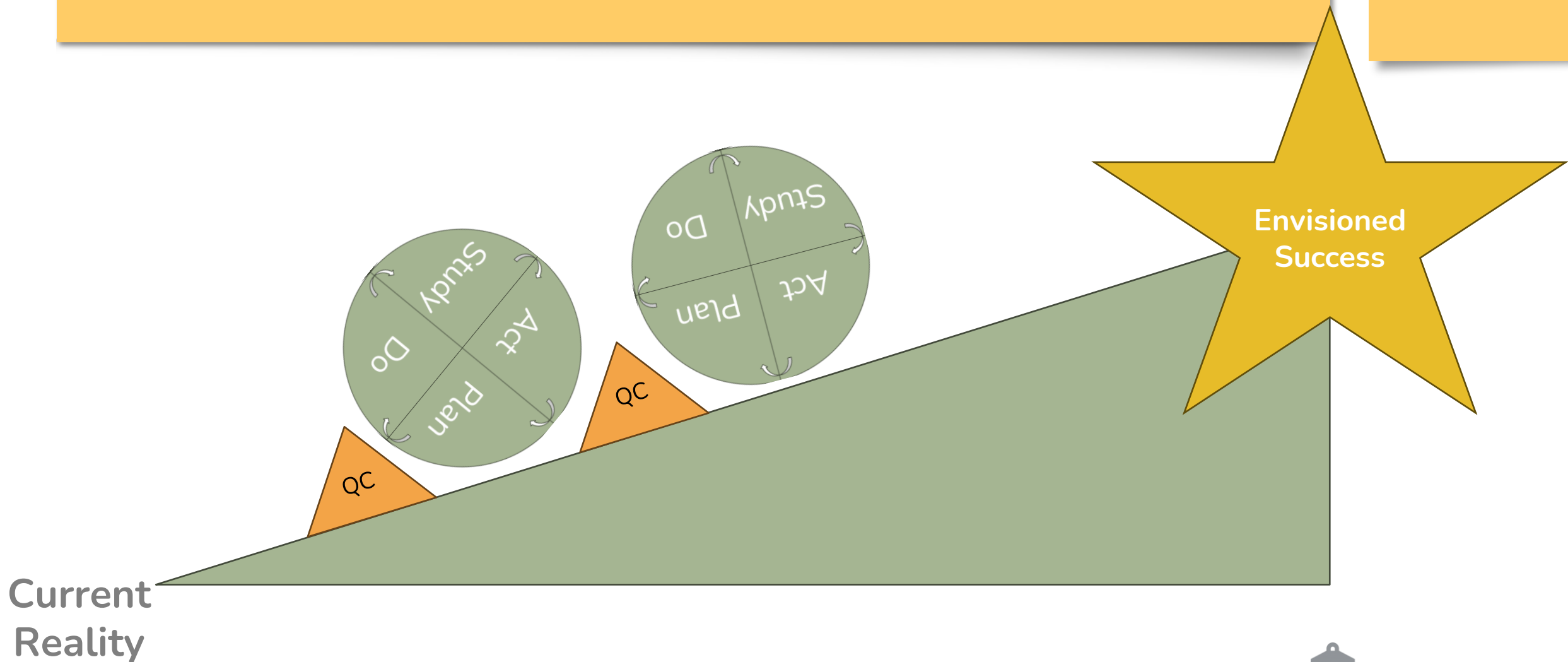
Quality Improvement - ONLY



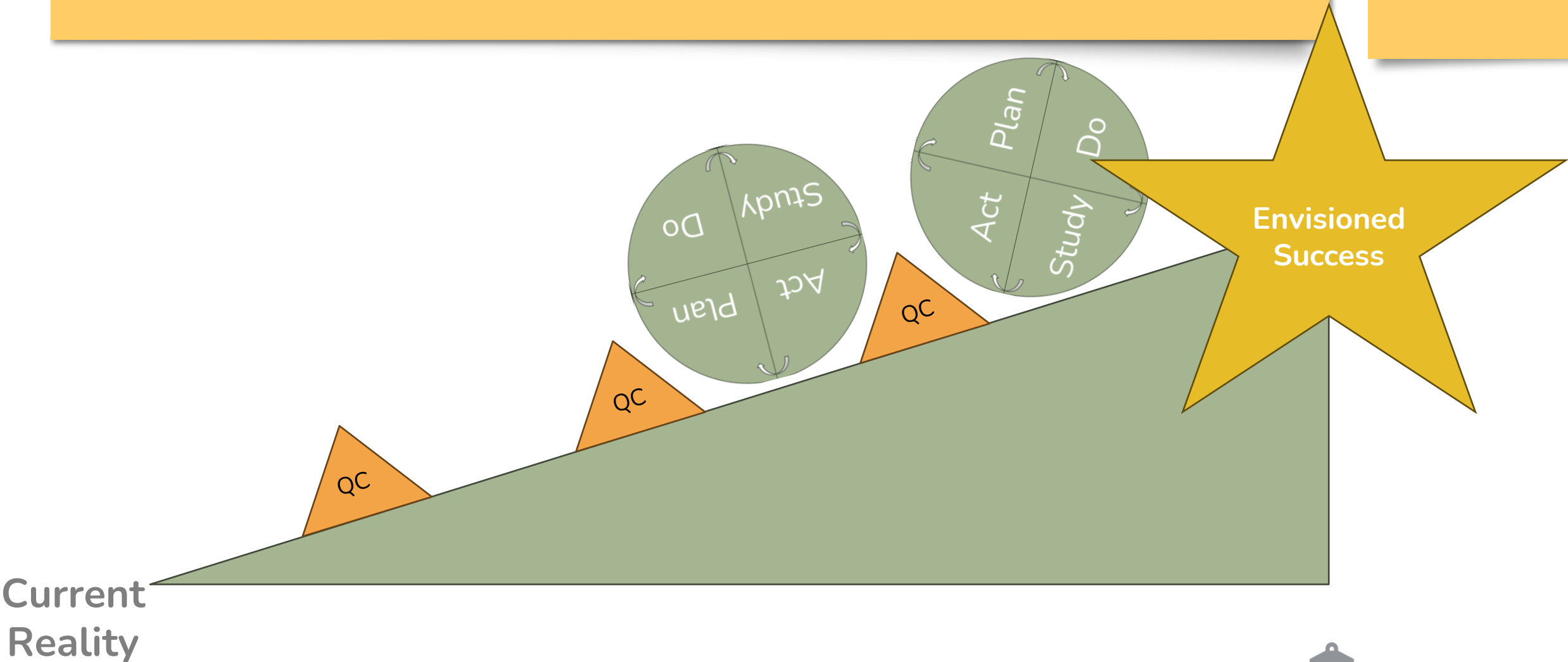
Quality Improvement with Quality Control



Repeated Improvement with Control



Culture of Learning with Control



Current
Reality

What is the purpose Quality Control?



Everyday Assurance

Daily reviews to ensure we deliver services according to our standards.



Control Variation

Reduce variation in the process that could affect our service.



Maintain Improvements

Sustain improvements made during the Quality Improvement phase.

| Stage | Step |
|-------|------|
| QP | 1 |
| | 2 |
| | 3 |
| | 4 |
| QI | 5 |
| | 6 |
| | 7 |
| QC | 8 |
| QA | 9 |

Who performs Quality Control?

- Initially performed by Quality Leader or staff in charge of reviewing the process (e.g. *Nurse Manager, Front Desk Manager, etc.*)
- As the process matures, QC should be assigned to the person accountable for maintaining the quality of the process or service.



Who is Quality Control for?

- Quality Control is ultimately for the patients.
- The results of the Quality Control process are designed for the staff members who can address the issues at the patient level.
- Examples:
 - Produce a list of patients seen this past week who are due for their mammogram.
 - Produce a list of patients next week who have outstanding referrals.
 - Review the list of patients listed on the schedule to ensure insurance was captured and the data matches the insurance eligibility log.



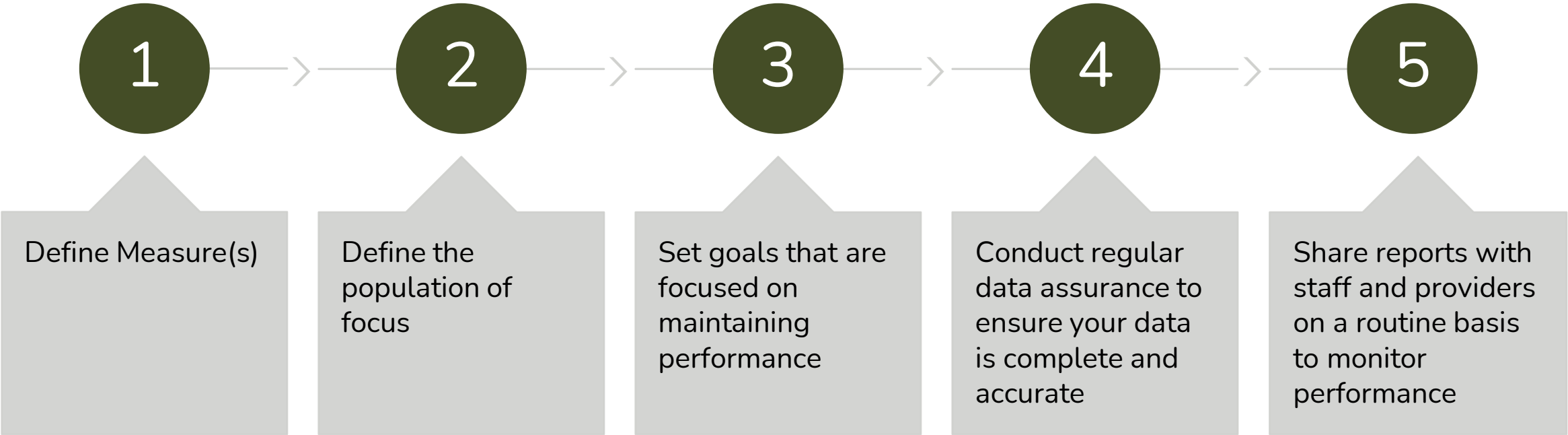
Quality Control - Process



Imperfect action
beats
perfect inaction
every time

Harry S. Truman
33rd U.S. President

QC Process



QC Process – Define Measure(s)

- Use UDS, HEDIS or CQM definitions for clarity, consistency, and comparison.
- **Numerator** – patients who meet the measure (e.g. patients with a mammogram in the past 27 months)
- **Clarify How the Measure is Met** – is this claims data (i.e. ICD/CPT codes) or is this clinical data from the EMR? Does placing the order satisfy or must the result be returned?

46 mammos

 92 patients



Breast Cancer Screening (Line 11a), [CMS125v11](#)

Measure Description

Percentage of women 50*–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

*Use 52 on or after December 31 as the initial age to include in assessment. See UDS Reporting Considerations for further detail.

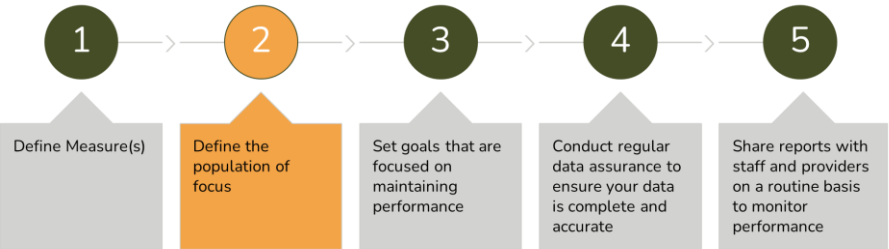
QC Process – Define the population

46 mammos

92 patients



- **Denominator** – which patients are included?
 - Patients seen or patients assigned (e.g. UDS = patients seen, Quality Performance = assigned)
 - Age range (e.g. women between 52 and 74)
 - Date of service range (e.g. calendar year 2023)
 - A particular site
 - A particular provider
 - A particular day
 - A particular patient
- **Exclusions** – patients who are removed from the denominator (e.g. patients with a bilateral mastectomy)



Breast Cancer Screening (Line 11a), [CMS125v11](#)

Measure Description

Percentage of women 50*–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

*Use 52 on or after December 31 as the initial age to include in assessment. See UDS Reporting Considerations for further detail.

QC Process – Set Goals

- Set goals focused on **maintaining** performance
 - Think about the threshold that is the minimal acceptable performance given your current reality.
 - Set those as thresholds that would trigger an improvement cycle if they were breached.
- **Example:** Current performance for Breast Cancer Screening is 50%. If it falls below 47.5% (25th percentile), we will initiate improvement activities.

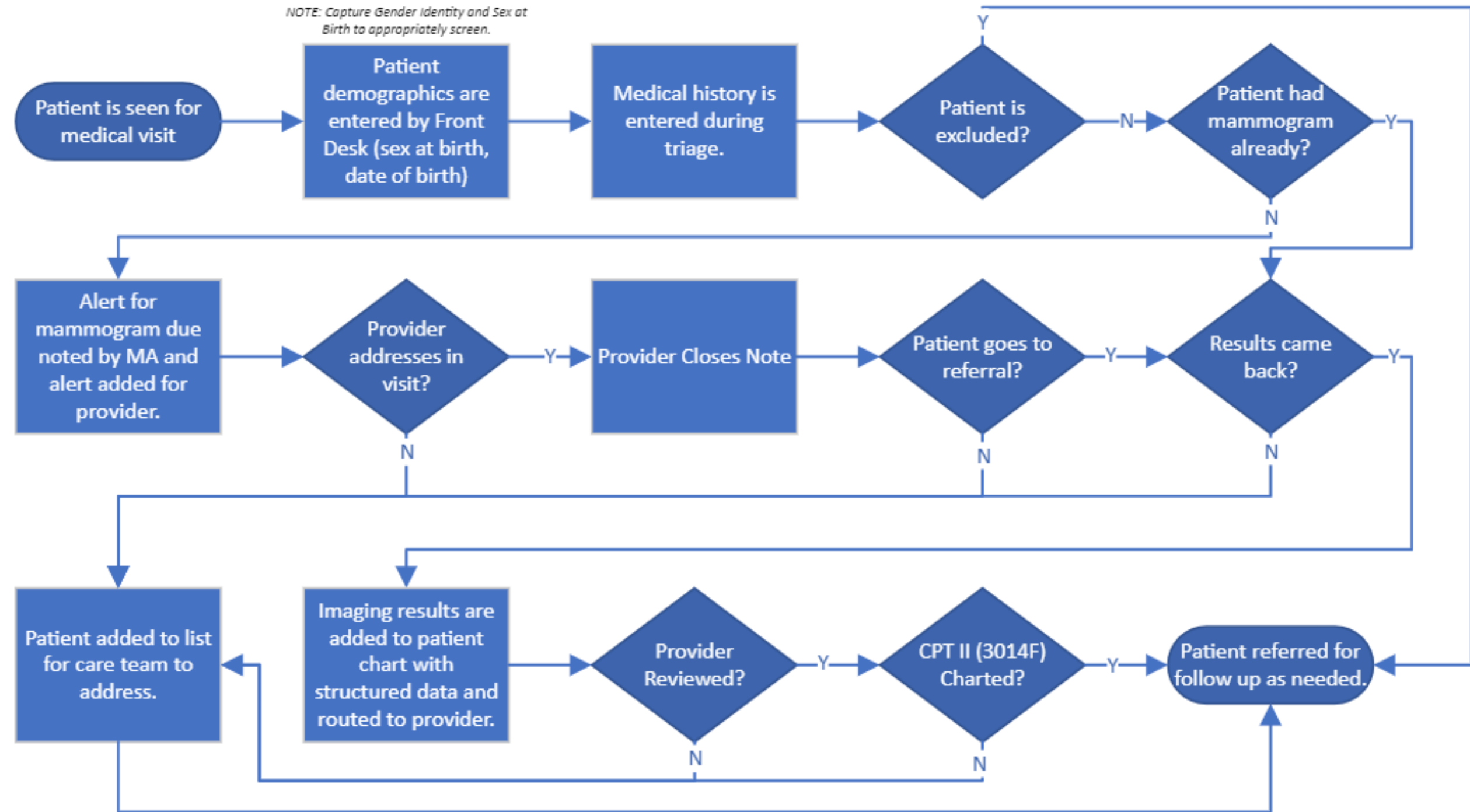


QC Process – Data Assurance

- Map the process for how a patient:
 - Is included in the denominator
 - Excluded from the denominator
 - Satisfy the numerator
- Validate reports with a manual review of the data to determine if the patient truly needs the service, if there is a data issue or if there is a need for staff education.



NOTE: Capture Gender Identity and Sex at Birth to appropriately screen.



QC Process – Data Visualization

- Use Run Charts.
- Share Root Cause Analysis.
- Displaying Monitoring Measures – (we will address this in more detail in Webinar #2).



Quality Control - Tools

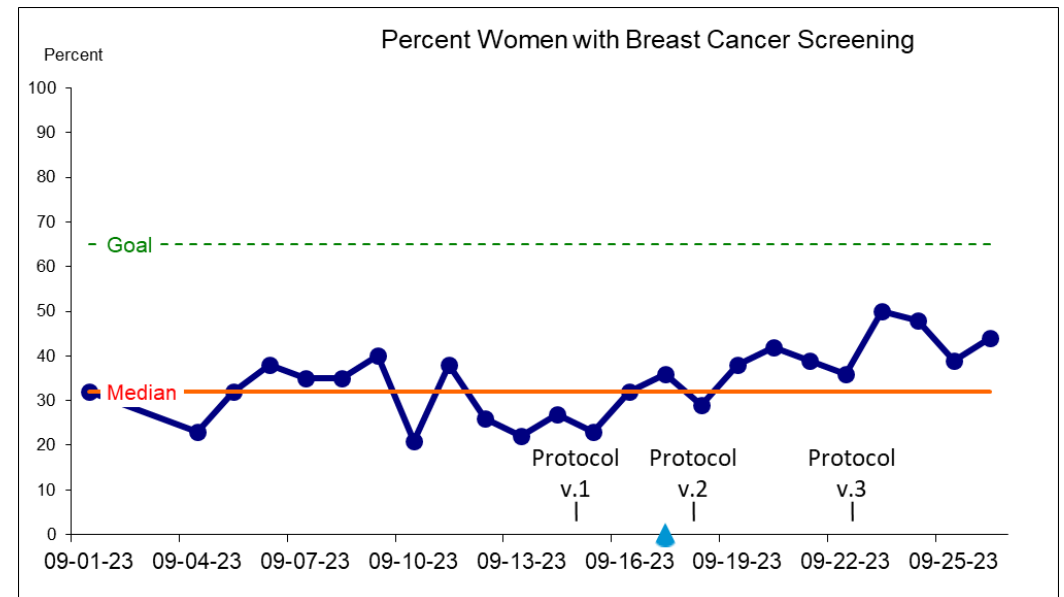
Sampling Data

- Plan for the time needed to perform the review. -> 4:30PM on Thursday
- Use a standard template for collecting the data. -> Provided Template
- Pick a time frame to find a list of patients. -> 1st week of Sep
- Filter for patients in the population of focus. -> Dr. D's Eligible Patients
- Randomize the list OR sample all results
 - Accurate percentage samples require 30 samples or the whole population if less than 30
 - Consider using the =RAND() function in Excel to sort the list or online list randomizers for selection

| Instructions | | | | Performance | Numerator |
|---|----------------------|-----------------|-------------------------|---------------------------------|---|
| 1. Clarify the population CQM of focus | | | | | 15 |
| 2. Review the charts and record the findings in "Audit Findings" | | | | 53.6% | Denominator (without exclusions) |
| 3. When complete, navigate to the Pivot Table tab, Refresh data and add results to a Run Chart for trending | | | | | 28 |
| | | | | | Excluded |
| | | | | | 2 |
| # | Population of Focus | Date of Service | CQM of Focus | Audit Findings | Other Notes |
| 1 | Dr. Dixon's Patients | 9/4/2023 | Breast Cancer Screening | Met | |
| 2 | Dr. Dixon's Patients | 9/4/2023 | Breast Cancer Screening | Excluded | History of mastectomy |
| 3 | Dr. Dixon's Patients | 9/4/2023 | Breast Cancer Screening | Missed opportunity during visit | No documentation in Med Hx or reminder to patient |
| 4 | Dr. Dixon's Patients | 9/4/2023 | Breast Cancer Screening | Documentation issues | Medical history free texted in note by MA |
| 5 | Dr. Dixon's Patients | 9/4/2023 | Breast Cancer Screening | Met | |
| 6 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Documentation issues | Previous mammogram screening noted, but date not entered |
| 7 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Met | |
| 8 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Documentation issues | Previous mammogram screening noted, but date not entered |
| 9 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Met | |
| 10 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Referral issues | Referral placed in January, no results in chart |
| 11 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Referral issues | Referral placed in March, no results in chart |
| 12 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Met | |
| 13 | Dr. Dixon's Patients | 9/5/2023 | Breast Cancer Screening | Met | |
| 14 | Dr. Dixon's Patients | 9/6/2023 | Breast Cancer Screening | Met | |
| 15 | Dr. Dixon's Patients | 9/6/2023 | Breast Cancer Screening | Referral issues | Referral placed in July, results back in August, not reviewed |
| 16 | Dr. Dixon's Patients | 9/6/2023 | Breast Cancer Screening | Met | |
| 17 | Dr. Dixon's Patients | 9/6/2023 | Breast Cancer Screening | Referral issues | Referral placed in May, patient did not show |
| 18 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Met | |
| 19 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Referral issues | Referral ordered as "referral" instead of diagnostic imaging. |
| 20 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Met | |
| 21 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Met | |
| 22 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Reporting issues | Patient shows as met on report, but mammogram not in chart. |
| 23 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Met | |
| 24 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Missed opportunity during visit | No documentation in Med Hx or reminder to patient |
| 25 | Dr. Dixon's Patients | 9/7/2023 | Breast Cancer Screening | Met | |
| 26 | Dr. Dixon's Patients | 9/8/2023 | Breast Cancer Screening | Excluded | History of mastectomy |
| 27 | Dr. Dixon's Patients | 9/8/2023 | Breast Cancer Screening | Met | |
| 28 | Dr. Dixon's Patients | 9/8/2023 | Breast Cancer Screening | Met | |
| 29 | Dr. Dixon's Patients | 9/8/2023 | Breast Cancer Screening | Missed opportunity during visit | No documentation in Med Hx or reminder to patient |
| 30 | Dr. Dixon's Patients | 9/8/2023 | Breast Cancer Screening | Missed opportunity during visit | No documentation in Med Hx or reminder to patient |

Run Charts - Definition

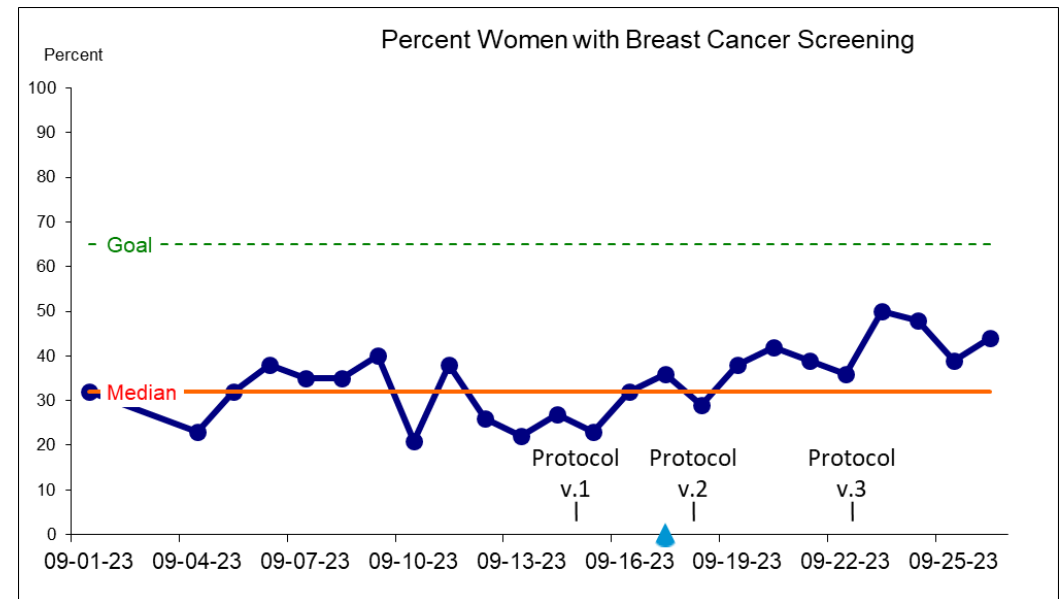
- A graph of a measure of performance over time.
- Used to depict how well (or poorly) a process is performing.
- Determine when a change is truly an improvement.
- Provide direction to initiate improvement activities.



<https://www.ihl.org/resources/Pages/Tools/RunChart.aspx>

Run Charts - Process

- Plot points with time on the x-axis and performance on the y-axis.
- If more than 10 points, identify the median and plot.
- Title and annotate important points.

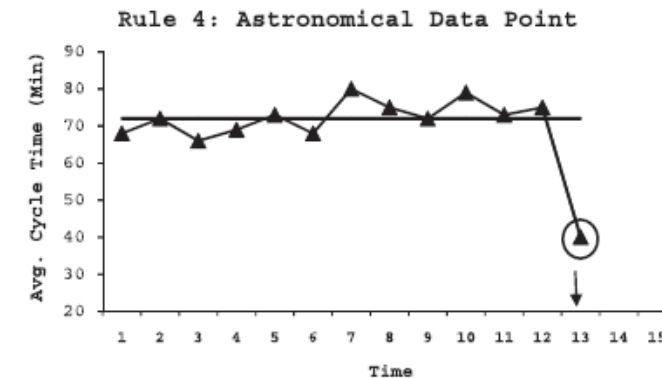
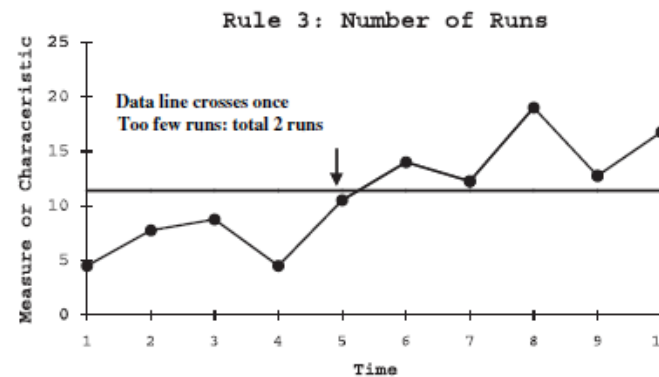
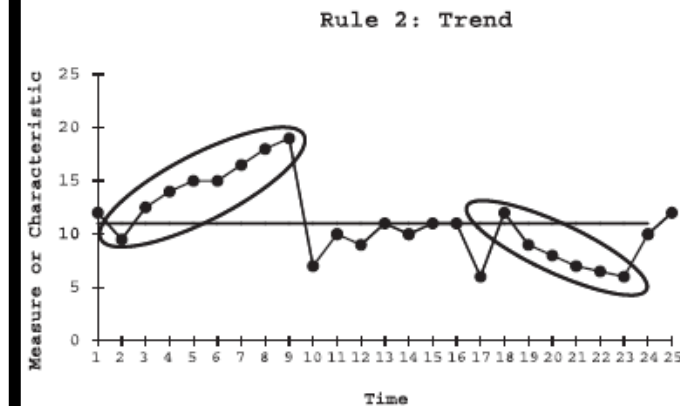
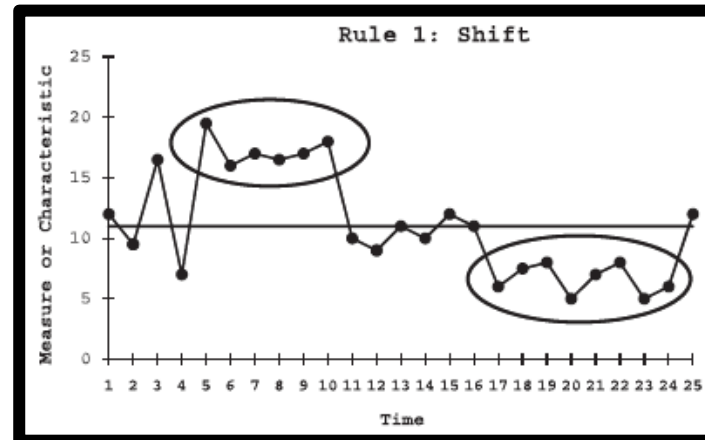


Run Chart Rules

Rule #1

You can detect a change if there is a **shift**.

6 or more consecutive points *either* all above or all below the median.

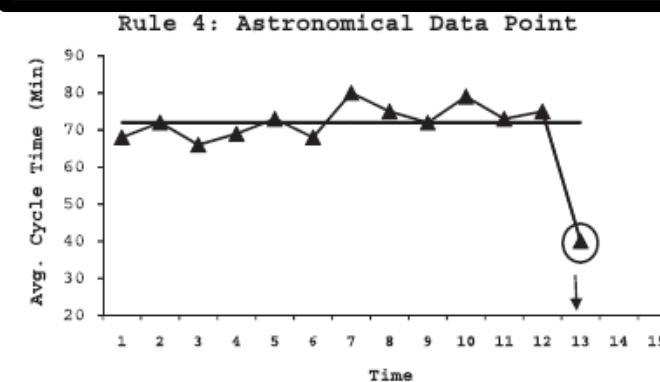
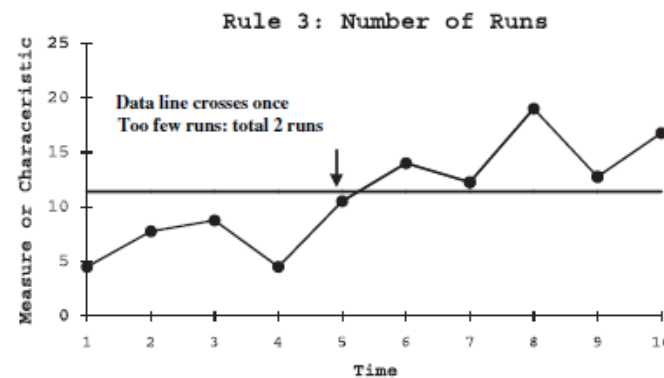
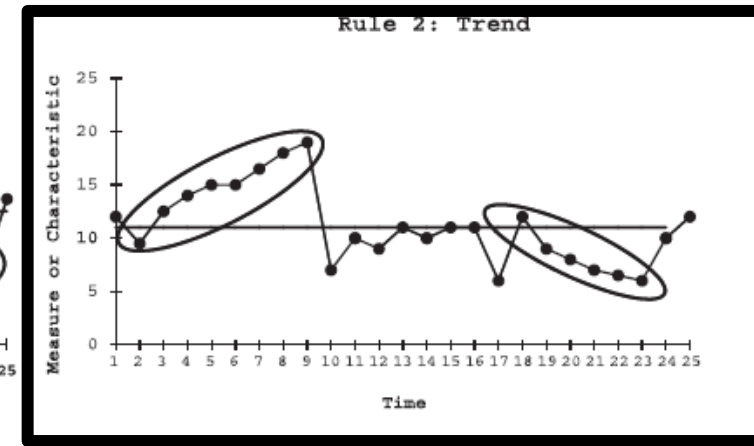
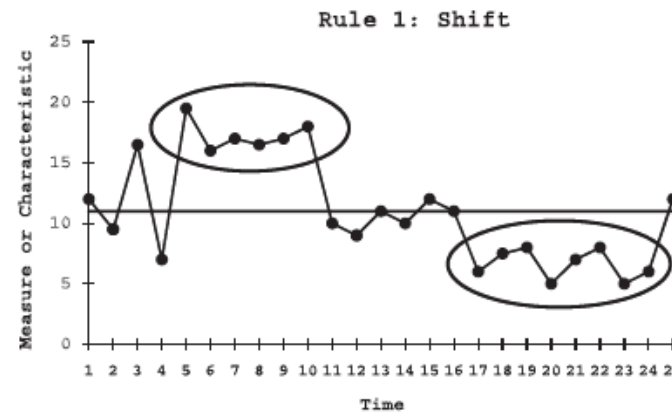


Run Chart Rules

Rule #2

You can detect a change if there is a **trend**.

6 or more consecutive points *either* all increasing or decreasing. Ignore repeated values.



Run Chart Rules

Rule #3

You can detect a change if there are too many or too few runs.

The number of times the data crosses the median.

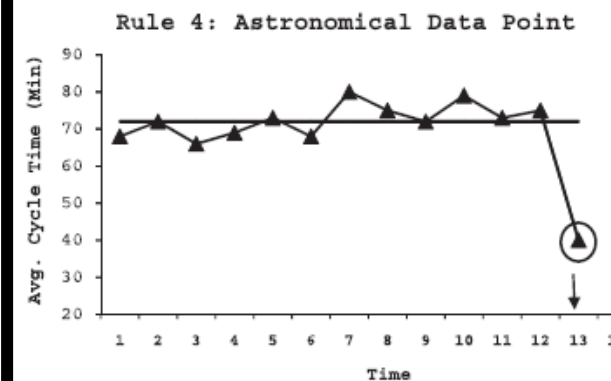
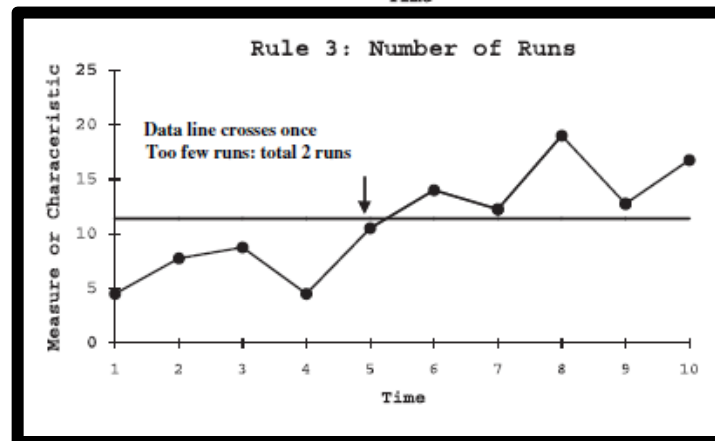
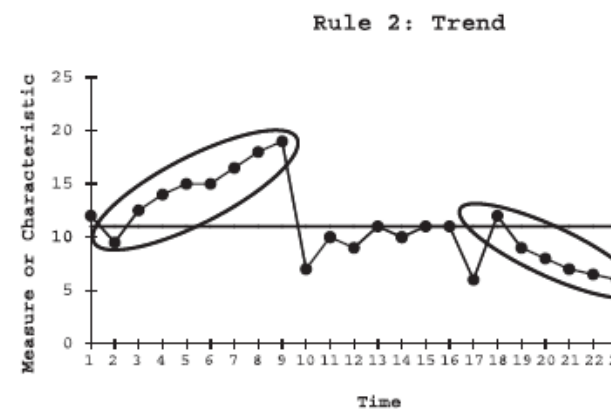
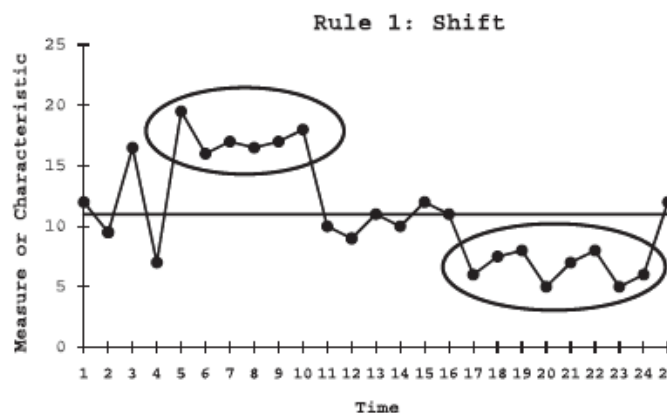


Table 1 Checking for too many or too few runs on a run chart. Table is based on about a 5% risk of falling the run test for random patterns of data

| Total number of data points on the run chart that do not fall on the median | Lower limit for the number of runs (< than this number runs is 'too few') | Upper limit for the number of runs (> than this number runs is 'too many') |
|---|---|--|
| 10 | 3 | 9 |
| 11 | 3 | 10 |
| 12 | 3 | 11 |
| 13 | 4 | 11 |
| 14 | 4 | 12 |
| 15 | 5 | 12 |
| 16 | 5 | 13 |
| 17 | 5 | 13 |
| 18 | 6 | 14 |
| 19 | 6 | 15 |
| 20 | 6 | 16 |
| 21 | 7 | 16 |
| 22 | 7 | 17 |
| 23 | 7 | 17 |
| 24 | 8 | 18 |
| 25 | 8 | 18 |
| 26 | 9 | 19 |
| 27 | 10 | 19 |
| 28 | 10 | 20 |
| 29 | 10 | 20 |
| 30 | 11 | 21 |
| 31 | 11 | 22 |
| 32 | 11 | 23 |
| 33 | 12 | 23 |
| 34 | 12 | 24 |
| 35 | 12 | 24 |
| 36 | 13 | 25 |
| 37 | 13 | 25 |
| 38 | 14 | 26 |
| 39 | 14 | 26 |
| 40 | 15 | 27 |
| 41 | 15 | 27 |
| 42 | 16 | 28 |
| 43 | 16 | 28 |
| 44 | 17 | 29 |
| 45 | 17 | 30 |
| 46 | 17 | 31 |
| 47 | 18 | 31 |
| 48 | 18 | 32 |
| 49 | 19 | 32 |
| 50 | 19 | 33 |
| 51 | 20 | 33 |
| 52 | 20 | 34 |
| 53 | 21 | 34 |
| 54 | 21 | 35 |
| 55 | 22 | 35 |
| 56 | 22 | 35 |
| 57 | 23 | 36 |
| 58 | 23 | 37 |
| 59 | 24 | 38 |
| 60 | 24 | 38 |

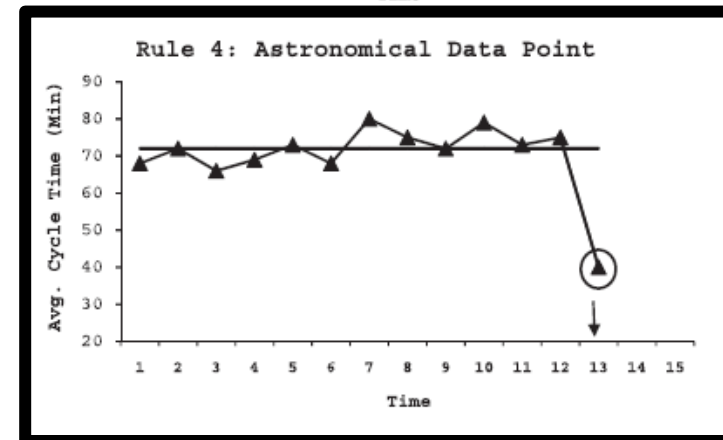
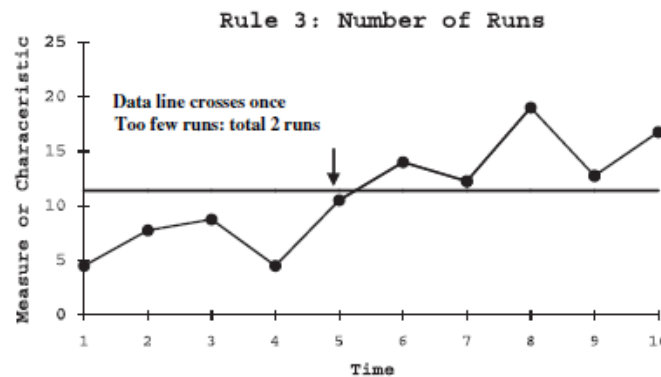
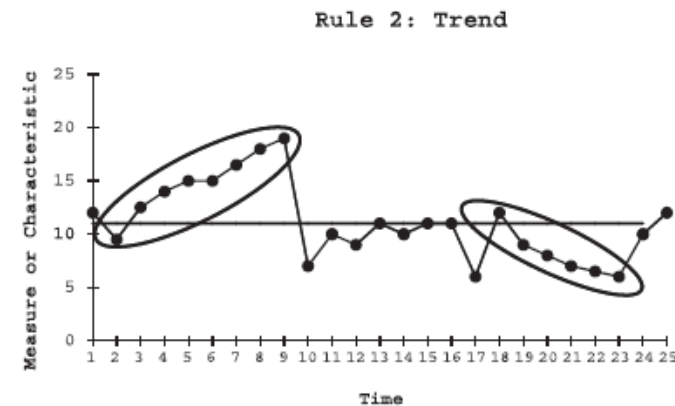
Source: Adapted from Swed and Eisenhart.¹²

Run Chart Rules

Rule #4

You can detect a change if there is an **astronomical point**.

Subjectively testing obvious outliers (not just the max or min). Annotate this point.

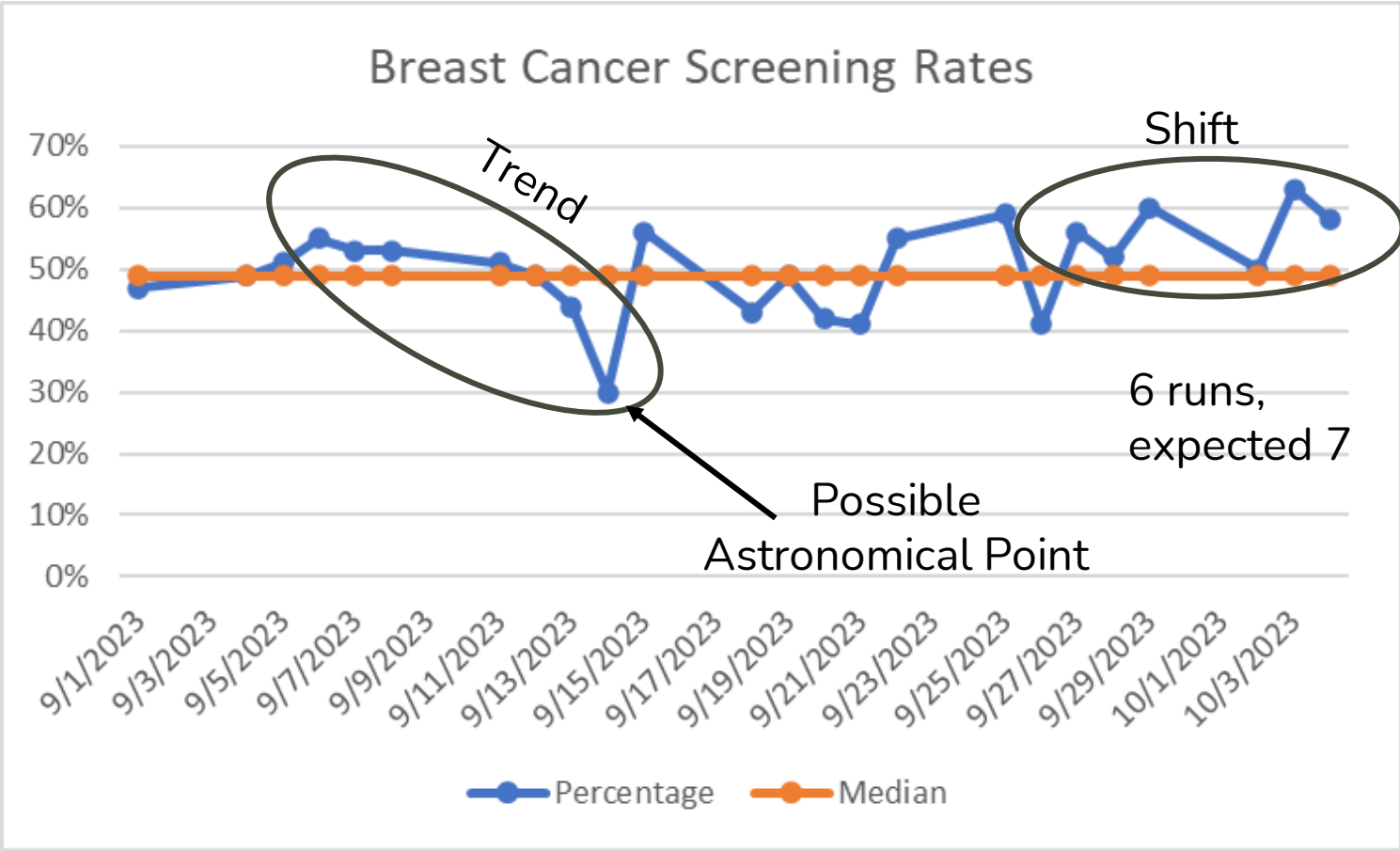


Breakouts!

- Groups of 2-3.
- View the Run Chart from the supplied data (Breast Cancer Screening).
- Answer the following questions:
 - What do the rules tell you about the data?
 - Has the overall performance shifted?
 - Is there evidence that the QI efforts are making a difference?
 - Are there any astronomical points in the data?
 - What experience have you had at your health center with data like this?

Breast Cancer Screening - KEY

| Date | Percentage |
|-----------|------------|
| 9/1/2023 | 47% |
| 9/4/2023 | 49% |
| 9/5/2023 | 51% |
| 9/6/2023 | 55% |
| 9/7/2023 | 53% |
| 9/8/2023 | 53% |
| 9/11/2023 | 51% |
| 9/12/2023 | 49% |
| 9/13/2023 | 44% |
| 9/14/2023 | 30% |
| 9/15/2023 | 56% |
| 9/18/2023 | 43% |
| 9/19/2023 | 49% |
| 9/20/2023 | 42% |
| 9/21/2023 | 41% |
| 9/22/2023 | 55% |
| 9/25/2023 | 59% |
| 9/26/2023 | 41% |
| 9/27/2023 | 56% |
| 9/28/2023 | 52% |
| 9/29/2023 | 60% |
| 10/2/2023 | 50% |
| 10/3/2023 | 63% |
| 10/4/2023 | 58% |



Reflections

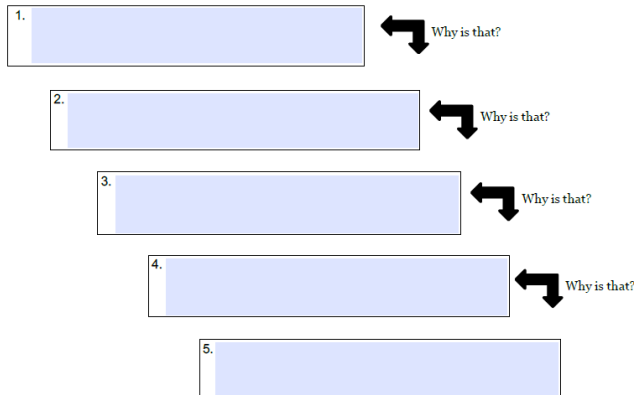
- Action required when downward trend identified
- Improvement established last week of Sep
- Find out what happened 9/14
- Fewer runs likely due to the positive shift

Root Cause Analysis – 5 Whys

EVENT. What happened? Define the problem as an *event*:

PATTERN. What's been happening? Define the problem as a *pattern* by selecting a poor performance factor:

STRUCTURE. Why is it happening? What are the tangible and intangible structures determining the results we see?



ACTION. What are the implications for action? What can you do to change the results?

1. Gather a group of interprofessional stakeholders who are familiar with the problem or event you are exploring.
2. Define the problem or event in clear, plain language.
3. Define the problem as a pattern and not just as an isolated event.
4. Ask “why” five times (at least) until you get to the root cause of the problem.
5. Explore the best way to solve the problem and make the subsequent changes to the system to ensure it doesn't happen again.

EVENT. What happened? Define the problem as an *event*:

9/14 was the lowest screening day in the past month.

PATTERN. What's been happening? Define the problem as a *pattern* by selecting a poor performance factor:

A downward trend was detected in the Breast Cancer Screening data.

STRUCTURE. Why is it happening? What are the tangible and intangible structures determining the results we see?

1. Fewer women had mammograms completed in the last 2 years.



2. Several patients had the mammogram just beyond the required time frame in the past.



3. We held a screening mammogram event for patients about this time 2 years ago, not since.



4. We have not maintained the partnership with the local hospital to have their mobile van come.



5. We have not clarified who will own this relationship and ensure this is scheduled.

ACTION. What are the implications for action? What can you do to change the results?

- Identify the team member accountable for this relationship.
- Schedule the mammography mobile van to come to the clinic.
- Send a scheduling reminder to those patients overdue and almost due for mammograms



Conclusion

RECAP

- Quality Control is about prevention of errors and detecting changes. Quality Control leads to improvement efforts and maintains improvements over time.
- Quality Control efforts are conducted close to the work and provide opportunities to correct the process.
- We can use Run Charts to detect shifts, trends, runs, and astronomical data.
- These may lead us to conduct a Root Cause Analysis.

Next Steps

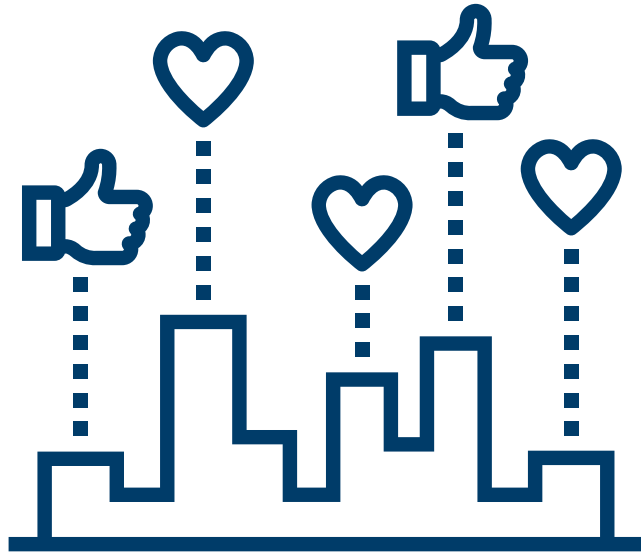
- Use the sampling template, as needed.
- Complete a Run Chart for a measure you are tracking.
- Complete a Root Cause Analysis for a patient that does not meet a measure.
- Continue with PDSA / Improvement Cycle.

Webinar #2 and Session #4 Dates

Webinar #2: October 19 @ 2PM

All times are 2PM Eastern / 11AM Pacific

- **Cohort A:** October 26
- **Cohort B:** October 24
- **Cohort C:** November 2
- **Cohort D:** October 31



Provide Us Feedback



Contact Us!

The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact QualityCenter@NACHC.org