

WELCOME!

While we wait...

- Have your improvement cycle documentation ready to share.
- Have your data visualization ready to share.
- Dust off your memorable comparison from Webinar #2.

Be ready to share...

- Review PDSAs from Quality Improvement Part I.
- Review data visualization tool assigned in Session 3.
- Discuss the outcomes of attempts to share information in a more accessible context.
- Review differences between outcome improvements and process improvements.



NATIONAL ASSOCIATION OF
Community Health Centers®

HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

QI TRAINING, POWERED BY



REGLANTERN

QI TRAINING: COHORT A - LIVE SESSION 4

OCTOBER 26, 2023

2:00 – 3:30 PM ET

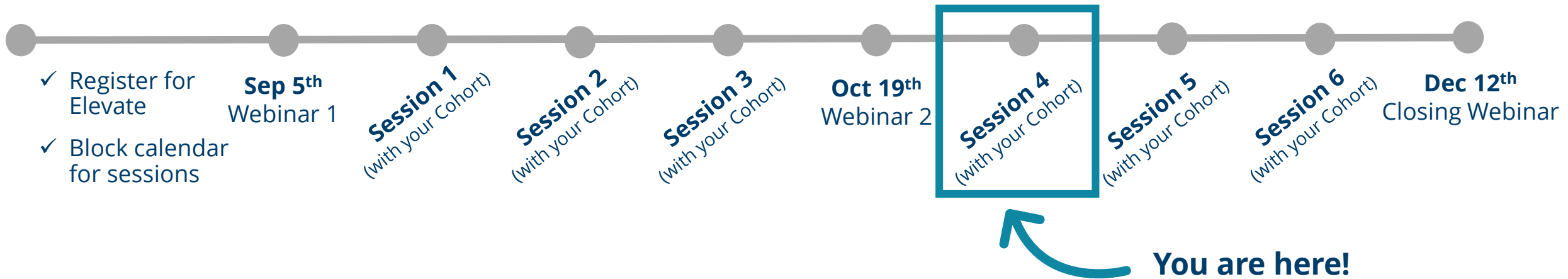




QI Training: Course Timeline

Pre-Work

Course: September 5, 2023 – December 12, 2023



Quick Breakout!

In your breakouts, share the following (10 minutes):

- Review data visualization tool assigned in Session #3.
- Discuss memorable comparison of data.



- Strategic planning
- Set priorities, goals, and measures
- Establish structures & processes

Improvement

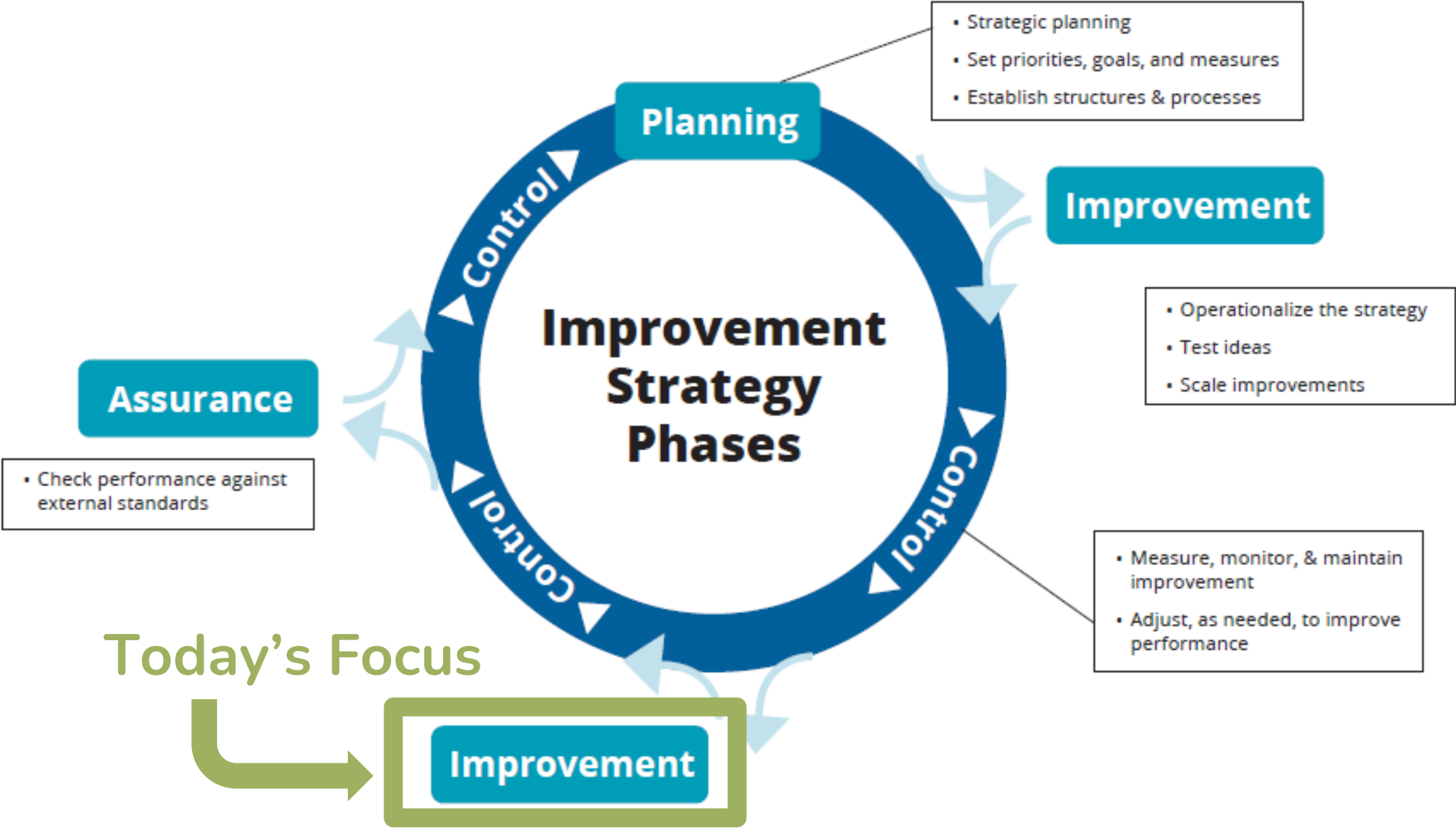
- Operationalize the strategy
- Test ideas
- Scale improvements

- Measure, monitor, & maintain improvement
- Adjust, as needed, to improve performance

Assurance

- Check performance against external standards

Improvement



Quality Improvement



- **Testing** ideas
- **Identifying** what works
- **Scaling** (replicating and expanding)
- Done by those **closest** to the work
- Should occur in **intervals** over time



PLANNING (QP)



IMPROVEMENT
(QI)



CONTROL (QC)



ASSURANCE
(QA)

Session Objectives

- Discuss the "Act" stage of the PDSA process.
- Discuss the different types of processes and measures.
- Talk about each health center's potential processes that could be improved (C/P process, Quarterly RM Assessment processes, peer review processes, incident report process, etc.)
- Share how to complete an FMEA.
- Discuss possible ways to communicate improvement efforts, next steps, results, successes with staff, leadership, and the Board.

Completing a PDSA

PLAN: *Plan the test, including a plan for collecting data.*

Objective: Improve uncontrolled diabetes (A1c) control from 32.6% to 25%.

Baseline Data (Time frame, numerator, denominator, percentage):

2022, 32.6% uncontrolled, 141/432 patients with diabetes

Questions & Predictions:

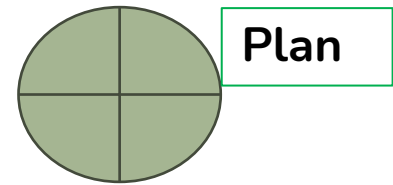
We predict that quarterly appointment reminder calls will improve patient engagement and A1c control.

Who, What, Where, When:

Find one patient with diabetes who has not been in for an appointment in three months, have Nurse Kyle call them, and schedule an appointment in the next two weeks.

Plan for collecting data:

Review appointment records and see if appointment was kept.

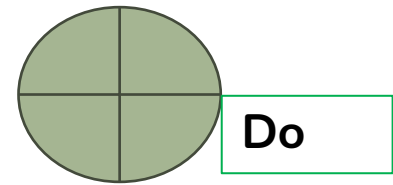


Completing a PDSA

DO: *Run the test on a small scale.*

Describe what happened. What data did you collect? What observations did you make?

Nurse Kyle called Patient C.R., scheduled an appointment for MM/DD/YYYY (had not been in for last year). The day after, pulled patient record, saw that patient kept appointment.



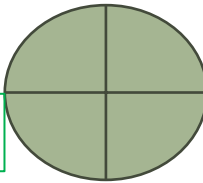
Completing a PDSA

STUDY: *Analyze the results and compare them to your predictions.*

Summarize and reflect on what you learned:

The patient came in for the appointment. The patient record noted that the provider discussed importance of A1c labs every quarter and keeping appointments. Provider had Nurse Kyle schedule next appointment with patient while patient was in the room.

Study



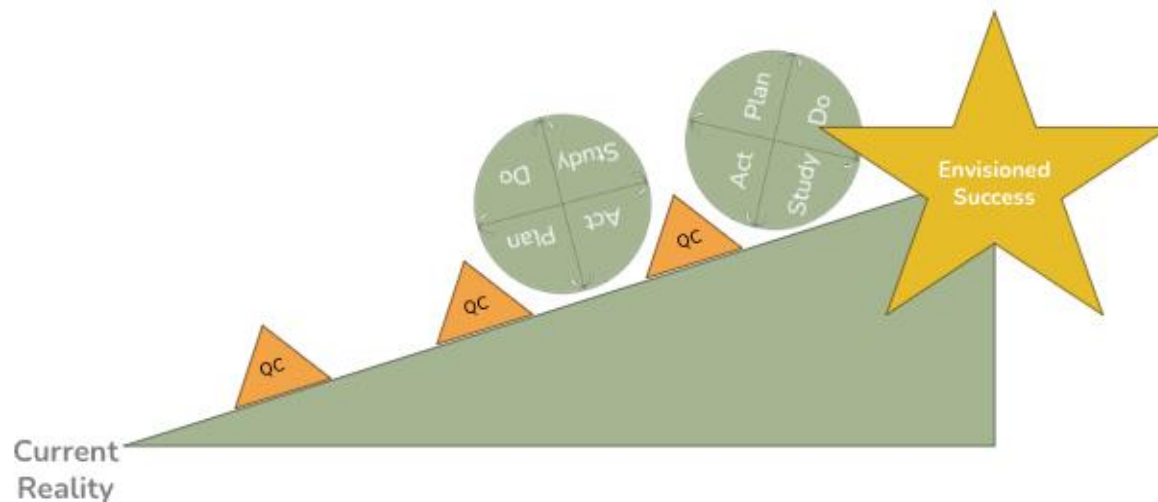
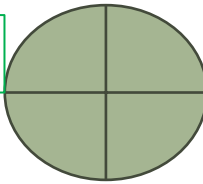
Completing a PDSA

ACT: *Based on what you learned, make a plan for your next step.*

Determine what modifications you should make – adapt, adopt, or abandon:

Adopt and Scale: Next step would be for Nurse Kyle to run a report all of Dr. Doe's patients with diabetes and see how many have not been in for an appointment/A1c in last quarter and had an A1c above 9%, and call them to schedule an appointment.

Act

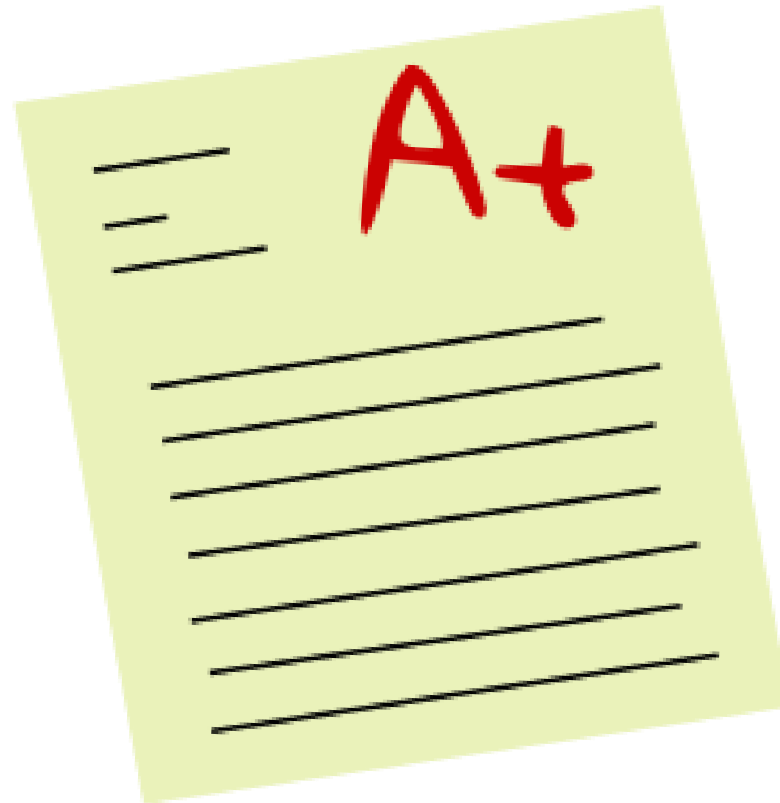


“Act” in PDSA

Adapt



Adopt



Abandon



Action Guide Steps (5, 6, 7)

5: Train staff in improvement tools and processes

Organization transformation requires that leaders invest in training health center staff to implement a formal model of quality improvement and use tools to drive practice transformation and manage change.

6: Select a manageable number of improvement initiatives; Test

Define a limited set of measures that will be the focus of active improvement efforts based upon your health center's priorities. This manageable set of measures can be assigned by service line, staff role, or health center site.

7: Develop mechanisms to communicate improvement ideas/activities

Establish processes to foster open communication, share and spread of ideas, and to allow for innovation. Strategies for communication and sharing include: Care team huddles, Staff meetings, Dedicated QI meetings.

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

UDS Quality of Care Measures

Screening and Preventive Care

- 6B-11: Cervical Cancer Screening
- 6B-11a: Breast Cancer Screening
- 6B-13: Adult BMI Screening and Follow-Up
- 6B-14a: Tobacco Screening and Cessation Counseling
- 6B-19: Colorectal Cancer Screening
- 6B-20a: HIV Screening
- 6B-21: Depression Screening and Treatment

Maternal Care and Children's Health

- 6B-B: Early Entry Into Prenatal Care
- 6B-10: Childhood Immunization
- 6B-12: Pediatric Weight Assessment and Nutrition and Physical Activity Counseling
- 6B-22: Dental Sealants
- 7A: Low Birth Weight* (inverse measure)

Disease Management

- 6B-17a: Statin Therapy to Prevent CVD
- 6B-18: IVD: Use of Aspirin or Antiplatelet
- 6B-20: HIV Linkage to Care
- 7B: Hypertension Control*
- 7C: Diabetes Poor Control* (inverse measure)
- 6B-21a: Depression Remission

Health Center Processes

Administrative Processes

- Credentialing/Privileging
- Peer Review
- Risk Management Assessments
- Incident Reports
- HRSA compliance efforts
- FTCA Risk/Claims Management
- QI/QA/QC
- Patient empanelment
- Patient access

Clinical Processes

- Check-in/Check-out
- Rooming Patients
- EMR Documentation
- Front desk operations (SFD, questions, etc.)
- Scheduling
- After-Hours Call Process
- Financial/Billing
- Patient grievance
- Patient satisfaction surveys

Three Types of Measures

Outcome Measures

- How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as payers, employees, or the community?

Process Measures

- Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

Balancing Measures

- Are changes designed to improve one part of the system causing new problems in other parts of the system?

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?

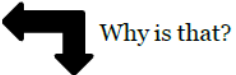
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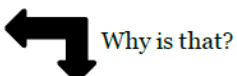
2. Several patients had the mammogram just beyond the required time frame in the past.



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



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Outcome Measures

- Percentage of women 52–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

Process Measures

- Number of days the Mammography mobile van is scheduled at our health center.
- Number of patients scheduled for mammograms on mobile van days.

Balancing Measures

- Patient experience survey.

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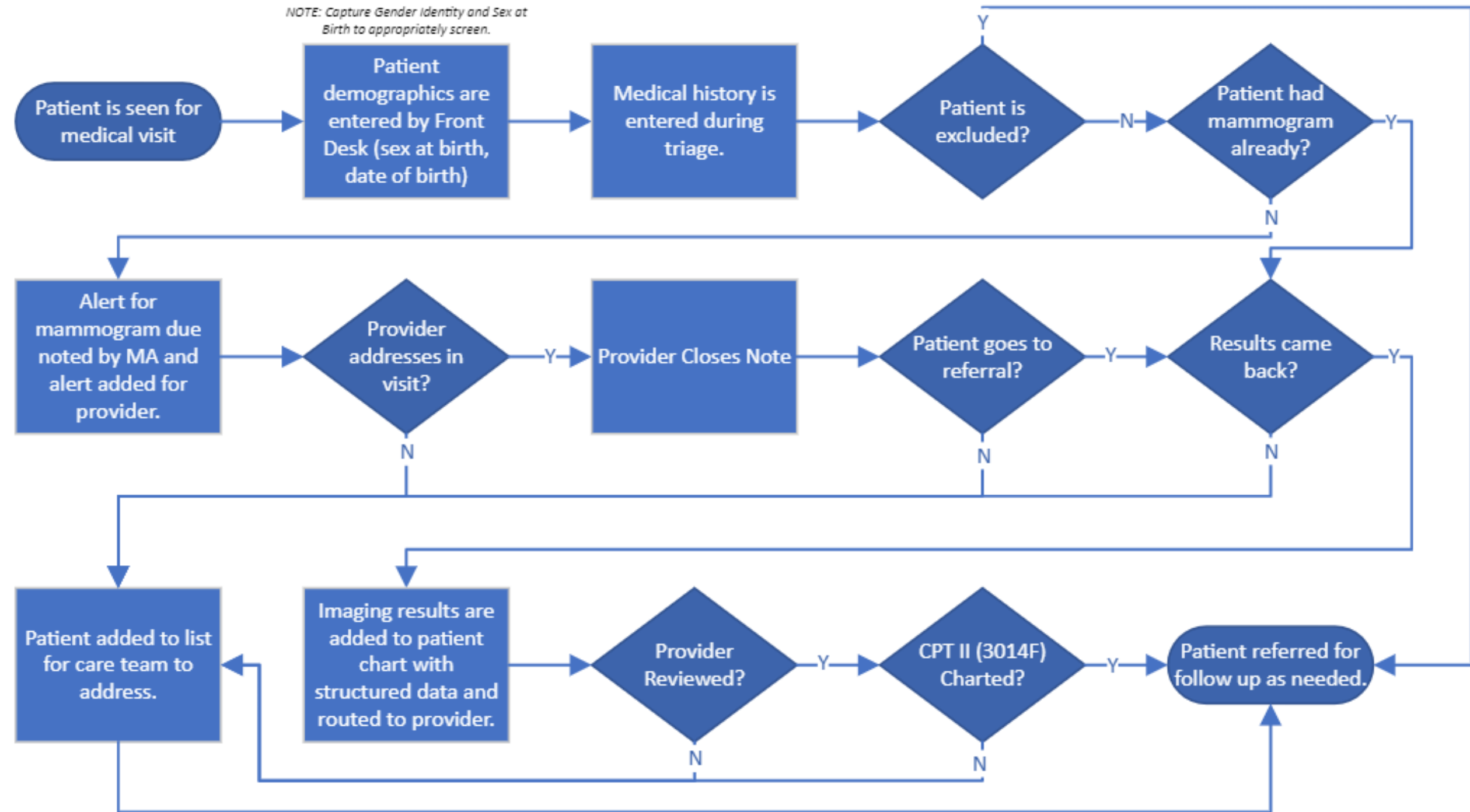
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- Patient experience survey.



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



Improvement Measures

Measure/Type	Measure Definition	Data Collection Plan
Outcome Measure: <i>Percent of Mammograms completed.</i>	Percentage of women 52–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	Run EMR report monthly.
Process Measure: <i>Number of scheduled Mammogram van days.</i>	Number of days the Mammography mobile van is scheduled.	Count number of days scheduled on center calendar for calendar year.
Process Measure: <i>Number of patients scheduled.</i>	Number of patients scheduled for mammograms on mobile van days.	Count number of patients scheduled for each day van is present.
Balancing Measure: <i>Patient satisfaction.</i>	Patient satisfaction with visit.	Have tablet/kiosk satisfaction survey at check-out.

Consideration for Selecting Processes

Priority

- What are the areas your health center has most trouble with?

Power

- Which measure(s) could you make an impact on in the next 4-6 weeks?
- How can you align with other initiatives that are already underway?

Proximity

- Who will you be able to involve?
- How available is the necessary data?

Personal

- Who among leadership will communicate the value and importance of this project?

Quick Breakout!

In your breakouts, share the following (10 minutes):

- Look at your rapid cycle improvement project and find at least one
 - Outcome measure
 - Process measure
 - Balancing measure

Failure Modes and Effects Analysis (FMEA)

Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change.

Failure Modes and Effects Analysis (FMEA)

Steps in the Process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN) O x D x S	Actions to Reduce Occurrence of Failure

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Risk Identification

Risk Analysis

Risk Mitigation



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Analysis (FMEA)

Good Performance (0)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN) O x D x S	Actions to Reduce Occurrence of Failure

Risk Analysis

Risk Mitigation



Failure Modes and Effects Analysis (FMEA)

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Nurse Manager contacts Mammogram Bus Inc. and schedules dates for visit for next 6 months.	Nurse Manager forgets to schedule dates.	Nurse Manager has no reminder system for reminding to schedule.	Bus is not scheduled and pts are not screened for breast cancer.	5 - Frequent	4 - Moderate	5 - Critical	100	Create a Quality Work Plan noting times where NM schedules bus. Reviewed by Quality Team quarterly.

Risk Identification

Risk Analysis

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Ranking	Qualitative	Quantitative
1	Extremely Unlikely	Less than 1 in 1M
2	Remote	Between 1 in 1M and 1 in 100k
3	Unlikely	Between 1 in 100k and 1 in 10k
4	Occasional	Between 1 in 10k and 1 in 1k
5	Frequent	Between 1 in 1k and 1 in 100
6	Often	Greater than 1 in 100

Risk Identification

Risk Mitigation



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Ranking	Qualitative	Quantitative
1	Certain	100% Detection
2	Almost Certain	95% Detection
3	High	75% Detection
4	Moderate	50% Detection
5	Low	25% Detection
6	Undetectable	<10% Detection

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Risk Mitigation



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Ranking	Qualitative	Definition
1	None	No relevant effect on reliability or safety.
2	Very Minor	No damage, injuries; only maintenance action.
3	Minor	Low damage, light injuries.
4	Moderate	Moderate damage, injuries possible.
5	Critical	Causes loss of primary function, safety margin, severe damage, death.
6	Catastrophic	Product/service inoperative, possible multiple deaths.

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Mammogram Bus Inc. sends email to Nurse Manager confirming planned dates.	Bus organization never confirms email and nurse manager forgets to follow-up.	Nurse manager has no reminder system for reminding to schedule.	Nurse Manager schedules patients, bus does not show up.	5 - Frequent	5 - Low	5- Critical	125	Design the process so that pts are not scheduled until confirmation received.
Nurse Manager creates encounters in PM software.	Bus is scheduled but NM never creates encounters.	NM did not follow written process.	Bus is scheduled but no pts are scheduled, bus leaves.	4 - Occasional	3 – High	2 – Minor	23	Quality Committee verifies bus scheduled, pt encounters created.
Nurse Manager runs EMR report of pts with no Mammogram in last 24 mo.	Report is run incorrectly.	Saved reports are not set-up correctly.	Pts are scheduled who are not eligible for screening.	3 – Unlikely	3 – High	2 – Minor	18	Have the Quality Director verify correct report set-up.

Risk Identification

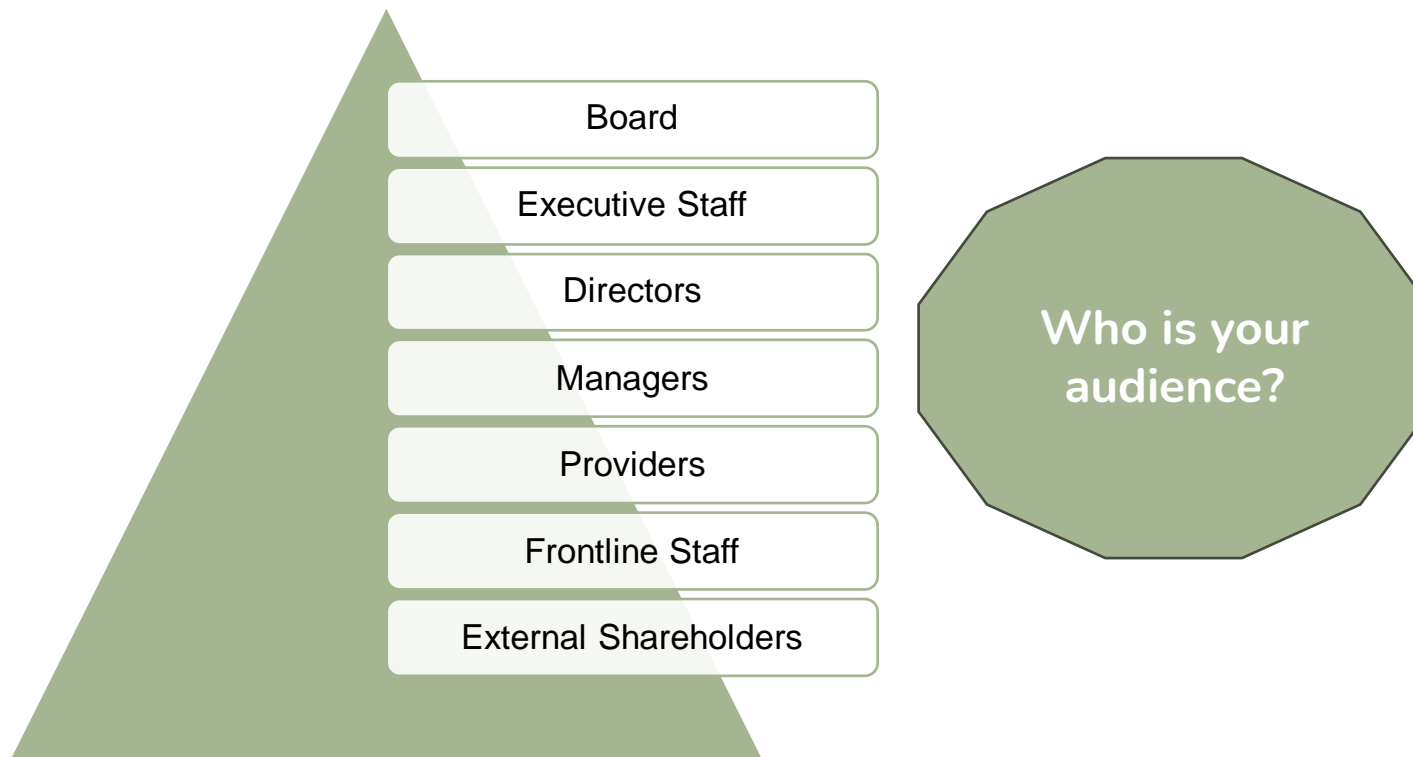
Risk Analysis

Risk Mitigation



Communicating

Communicating



Communicating

Responsible

- The people actually tasked to do the work.

Accountable (only 1 per task)

- The people ultimately accountable for making sure others get the job done.

Consult

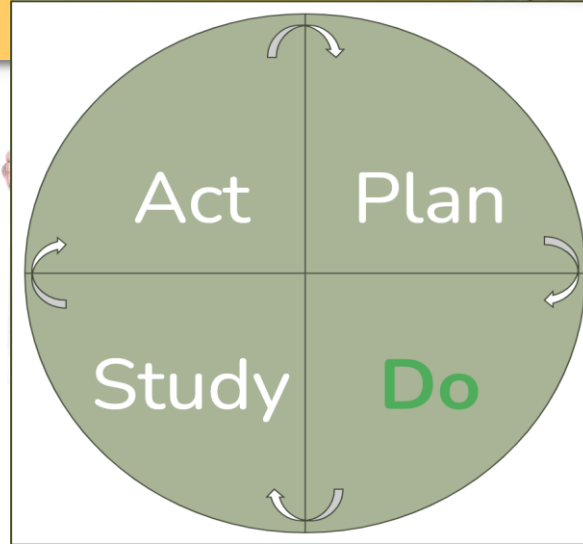
- The people who contribute information or expertise to the work that others do.

Inform

- The people who are informed to when the work is complete.

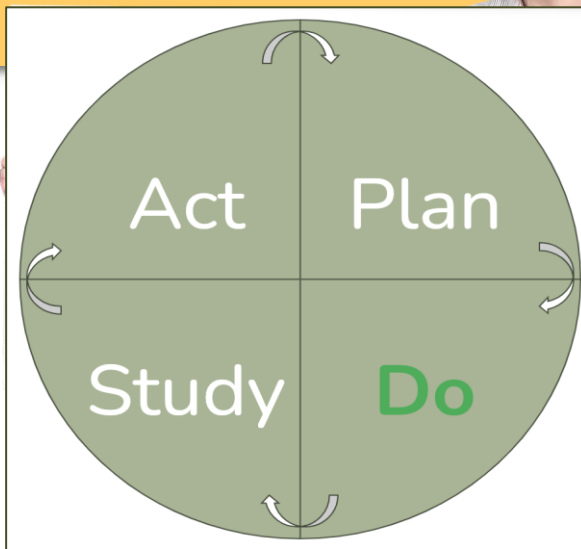
Communicating

PDSA Activity



Communicating

PDSA Activity



Responsible

Accountable

Consult

Inform

Communicating – Bylaws Updates



Communicating – Bylaws Updates



Consult



Accountable

Responsible

Conclusion

RECAP

- Discussed the "Act" stage of the PDSA process.
- Discussed the different types of processes and measures.
- Talked about each health center's potential processes that could be improved (C/P process, Quarterly RM Assessment processes, peer review processes, incident report process, etc.)
- Shared how to complete an FMEA.
- Discussed possible ways to communicate improvement efforts, next steps, results, successes with staff, leadership, and the Board.

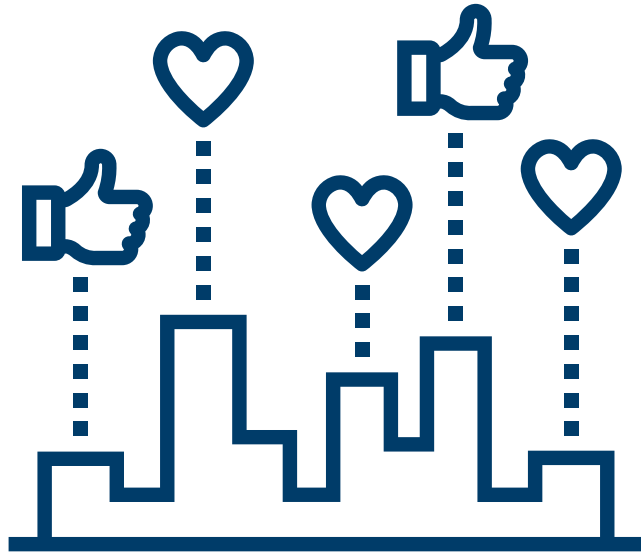
Next Steps

- Complete the "Action" step for the PDSA/Improvement Cycle
- Complete a line of FMEA for a step in a process that impacts your chosen metric.
- Begin to prepare for presenting your PDSA/Improvement Cycle and Lessons Learned during Session 6.

Session #5 Dates

All times are 2PM Eastern / 11AM Pacific

- **Cohort A:** November 9
- **Cohort B:** November 14
- **Cohort C:** November 16
- **Cohort D:** November 7



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