Ten Steps to Leading Quality Improvement Topics

Once a decision has been made to focus on a particular topic for quality improvement, or initiate a "spoke" in the hub and spoke model, it is helpful to follow a consistent series of steps to guide the work. Following are suggested steps to conducting a quality improvement project. Depending on the type of quality improvement effort, steps might be combined or eliminated. For example, measure selection is pre-defined for MBQIP, so that step is not necessary. **A template to document completion of project steps can be found in the CAH QI Toolkit.**

1) **Research the topic or measure**
   It is important to understand the background and rationale behind changes being made to improve patient safety or quality to gain buy in and enthusiasm on the part of the staff and providers being asked to change. For each of the required MBQIP measures, summary information and best practices are provided in the appendices to this document.

   For other quality and patient safety topics, a quick google search often will garner a wealth of resources. Keep an eye out for credible national sources such as the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), the Center for Disease Control (CDC), Health Research & Educational Trust (HRET), Technical Assistance Service Center (TASC), and others. Research will also help in developing a list of potential best practice ideas for implementation consideration, and potential measures to track in order to determine whether the work being done is successful.

   Consider involving a provider early in the process. If there is a willing and enthusiastic provider that will assist with or review the research, and contribute throughout the project, the effort will be a worthy investment towards ease of implementation.

2) **Set a broad goal and draft a timeline**
   Having researched the topic or measure being implemented, it is helpful to articulate a broad goal and come up with a draft timeline to present to the group of people that will participate in the improvement efforts. Don't be afraid to be ambitious in terms of timelines. With creative meeting alternatives, and a commitment to keeping work flowing, it is entirely possible to bring a change to full implementation in two or three months, especially for pre-identified measures such as MBQIP that have readily available research and national alignment in terms of prioritization.

3) **Build the team/ad hoc group**
   In deciding who will be needed to bring about a particular change in improvement, it is helpful to start by drawing a rough flowchart of the processes involved and include a representative from every point in the process. As representatives are being invited, it is a good idea to check with them to make sure all stakeholders are represented.

   It is important to find a way to obtain input from patients on changes that will impact their care. It may not be realistic to include a patient or family member on every quality improvement activity, but there are other ways to include the patient voice, such as presenting project plans to a patient/family council if one exists, or simply asking several patients for input as projects unfold.

4) **Design the strategy**

Ask the team or ad hoc group to think through what must be done to achieve the general goal. Drawing a rough flow chart of the process in question with the group, and identifying points in the process where changes need to be made helps structure the discussion. Brainstorming activities to gather implementation ideas are also helpful. Ideas can be categorized into themes and prioritized by the group. **A brainstorming tool has been included in the CAH QI Toolkit.** Implementation ideas and best practices identified in this guide, or identified in your research can also be reviewed for applicability to your setting. Encourage participants to gather co-worker input frequently throughout the project so that potential challenges can be detected early. Once an implementation strategy has been identified, a plan of action can be established. **A project action plan template is included in the CAH QI Toolkit.**

Policies, order sets, implementation bundles, staff education, and patient education might need to be created, adopted, or adapted. Take time to assess whether your implementation strategies are "weak" or "strong", and consider the balance between strength of the intervention and the resources needed to support implementation. A sampling of strategies follows:

- EHR templates can be a powerful way to "hardwire" adherence to assessment or practice changes. Such templates make it difficult to do or document the wrong thing, thus, EHR template changes would be qualified as a strong strategy.
- Staff education, although important, might be qualified as a weak strategy if it is the only support for implementation. In rural hospitals, where staff do not typically work in the same area every day, and low volumes are not conducive to repetition, information is likely to be forgotten.
- Checklists are very helpful in driving consistency of care, but are only as strong as the frequency with which they are utilized. Discharge checklists, surgical checklists, shift to shift report templates, and charge nurse duty checklists are examples of situations where checklists can help staff to deliver consistent care.

Strive to keep implementation strategies as simple as possible to help staff navigate changes coming from various simultaneous improvement efforts. Simplicity is the driving force behind bundling, where several key changes to accomplish a goal are promoted, rather than a long list of changes. For example, the Institute for Healthcare Improvement (IHI) Central line associated blood stream infection (CLABSI) bundle is comprised of five best practices projected to be the most impactful in preventing central line associated blood stream infections.

5) **Select specific measures, and define the goal**

Measure selection

Measures for quality improvement projects such as those related to MBQIP are predetermined, eliminating the need for this step. Standardized measures have been established for many quality and patient safety topics, and it is wise to align with them to be consistent with state and national efforts, and allow for comparison with other hospitals. The National Quality Forum (NQF) maintains an inventory of current measures and is a great place to start looking for established measures on various hospital quality and patient safety topics.

It is also important to consider what type of measure(s) to utilize to support implementation and measure improvement:

- Process measures are measures that reflect consistency in staff adherence to tasks, assessments, or treatments associated with providing care. Process measures are often more effective as a feedback tool for staff because improvements will be reflected sooner than in outcome measures, especially in low volume settings. All required MBQIP measures other than HCAHPS survey scores are process measures.
- Outcome measures reflect patient outcomes, such as morbidity, mortality, or readmission rates. In rural hospitals, low volumes can diminish the usefulness of outcome measures, since the occurrences measured, such as death or readmissions, can be rare in any specific subset of the population.
- HCAHPS surveys are a measure of patient perception, which do not tidily fit into either the process or outcome measure category, but provide a valuable view of quality from the patient perspective.

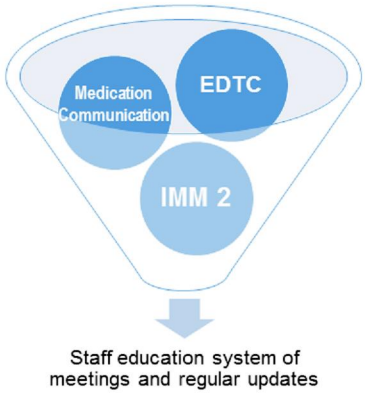
Setting Goals

Broadly speaking, goals should ultimately be "the right care for every patient, every time", which for process measures translates into 100% or below benchmark time medians for every measure. It is helpful to have this in mind for a general long term goal, but to initially focus on measureable improvement. Any improvement translates into one more patient that received high quality care, and that is an encouraging message for staff.

6) Educate widely and creatively

Staff education is a challenge given the pace of change and the amount of information that must be shared to keep staff current in terms of quality and patient safety.

To support the mindset and expectation of "continuous improvement", it is a fruitful investment to develop a consistent system of staff education that combines periodic in-person education sessions that are recorded for those unable to attend, with monthly electronic updates (written or short video recordings) that include a feedback mechanism to communicate receipt and review. All quality improvement education can be funneled into this ongoing education system.



Determine whether there are other groups that can influence the success of the project or topic implementation as education is being planned. Other departments, healthcare

settings, hospital leadership and boards, and community members are potential considerations, as well as patients and family members.
However staff education is delivered, there are some concepts that are important to keep in mind:

- Enthusiasm is an insightful prediction of change success, and can be generated early in the quality improvement process by soliciting stakeholder input formally or informally, and continued throughout the course of the project.
- The inclusion of pertinent compelling patient stories or sharing goals and progress using real numbers of lives saved or harm averted helps to generate enthusiasm.
- Sharing baseline hospital performance metrics with national and state comparisons and benchmarks provides a sense of direction for the project.
- Simplicity in the design and delivery of staff education will help them to learn and remember the information. Consider what staff absolutely need to know to support the change, and design education around that core.
- Critical project implementation steps should be hardwired into paper or electronic documentation systems to provide "just in time" guidance.

7) **The kick off**
Timelines should be arranged so that the launch of the project, sometimes termed "kick off" or "go-live" begins shortly after staff education has been completed, when the information and inclination are fresh. Project leaders should review the new process beforehand to make sure that staff have everything they need to ensure success. A fun kick off mini-event, such as a treat in the cafeteria or a name draw for a gift basket or tickets to a sports event can be an inexpensive and positive way to bring attention to the project.

8) **Rapid tests of change**
It is important to evaluate the changes being made using a rapid tests of change tool, which aids in guiding the documentation, communication, and correction of unforeseen technical or process errors. **A sample rapid tests of change tool is included in the CAH QI Toolkit.**

It is helpful for members of the project team or ad hoc group to be available to answer questions, document issues, and communicate frequently to respond to complications during initial implementation. Daily or weekly huddles can be held to communicate with staff about the new processes. Rapid tests of change continue until it appears that the new process is running smoothly and implementation can be considered complete.

9) **Evaluation**
The best way to build momentum on quality improvement efforts is to actively monitor staff adherence to process measures as close to real time as possible, and provide feedback to staff and providers individually or during regular communications. As audits or observations are being done, "catching people doing right" and thanking them personally and/or publicly builds morale and encourages a continuation of the behavior. When interventions are missed, a timely and friendly conversation to learn more about potential barriers and elicit suggestions can lend valuable insight into process improvement. Staff and provider performance feedback at least monthly is extremely

important in the beginning stages of project implementation. Once improvement has plateaued, a decision has to be made whether to move the project into sustain mode and monitor less frequently, or to reconvene the group for a discussion on how to improve further.

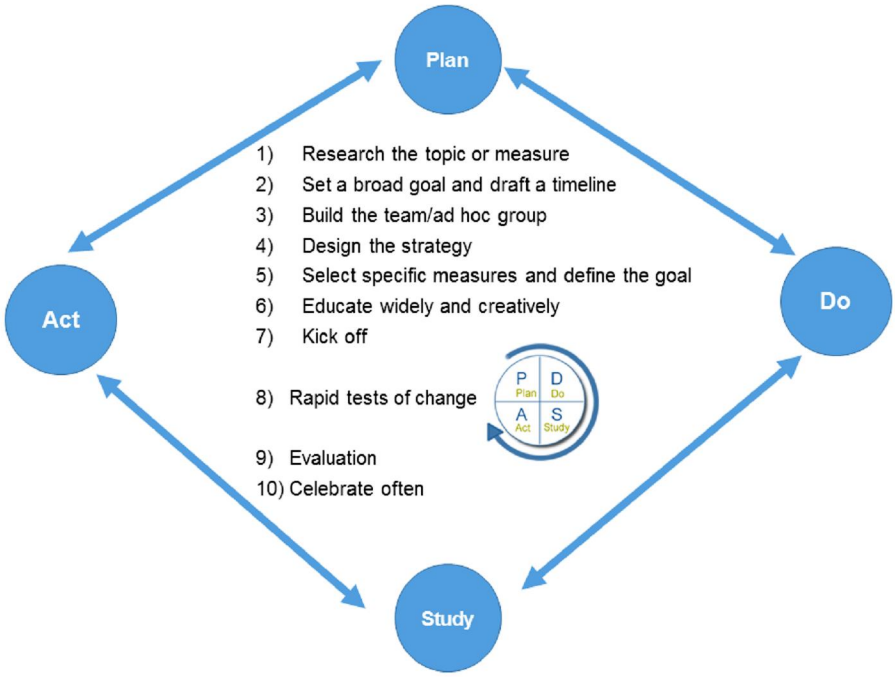
The MBQIP reports distributed by state Flex Programs can provide valuable state and national comparison data. However these reports are generated months after the delivery of the patient care they reflect, which is not helpful in providing frequent feedback during active quality improvement efforts.

A user friendly internal quality monitoring tool included in the CAH QI Toolkit has been developed to assist in tracking and reporting more frequent progress on MBQIP and other quality and patient safety measures. The tool generates run charts that can be shared with staff and leadership.

10) Celebrate often

It is very exciting when quality improvement efforts pay off and run charts begin to show an improvement in process and outcome measures! Frequent and prominent displays of run charts or graphs that acknowledge and celebrate great work foster pride and encourage staff to continue to improve. Administrative involvement in celebratory communications, staff meetings, and events reinforces the message that quality improvement is a high organizational priority.

The ten steps to leading quality improvement topics can be viewed as a project-specific Plan – Do – Study – Act (PDSA) cycle, within which intervention-specific PDSA cycles are implemented in Step 8 - "Rapid Tests of Change". The following table illustrates the connection between the Ten Steps to Quality Improvement Projects and Plan – Do – Study – Act cycles.



Key Points:

- With creative meeting alternatives, and a commitment to keeping work flowing, it is entirely possible to bring a change to full implementation in two or three months
- It is important to find a way to obtain input from patients on changes that will impact their care
- Gather staff input frequently so that potential challenges can be detected early
- Strive to keep implementation strategies as simple as possible
- Develop a consistent system of staff education that combines periodic in-person, recorded education sessions with monthly electronic updates that include a feedback mechanism to communicate receipt and review
- The best way to build momentum on quality improvement efforts is to actively monitor staff and provider adherence to process measures and provide timely feedback

Tools and Resources:

- Brainstorming Tool
- Internal Quality Monitoring Tool
- Project Action Plan Template
- Quality and Patient Safety Committee Meeting Agenda/Minute Template
- Rapid Tests of Change Tool
- Ten Step Quality Improvement Project Documentation Template

MBQIP Quality Improvement Focus Areas

Individual measures for MBQIP continue to evolve to stay aligned with other federal quality reporting programs while keeping a focus on CAH relevant services. The table in Appendix D provides a quick reference guide for all required measures reported for MBQIP as part of the FY 2015 Flex grant cycle and Appendix C provides a list of acronyms.

Currently, focus areas for MBQIP improvement fall into four quality domains:

- Patient Safety (Appendix E)
- Outpatient Care (Appendix F)
- Patient Engagement (Appendix G)
- Care Transitions (Appendix H)

The tables in Appendices E through H summarize the measures by focus area and include best practices for improvement for each area. Although for reporting purposes HCAHPS is considered a patient engagement measure, many of the individual questions and domains in the HCAHPS survey can be relevant to improvement efforts related to patient safety and care transitions and can be found in the related quality domains.