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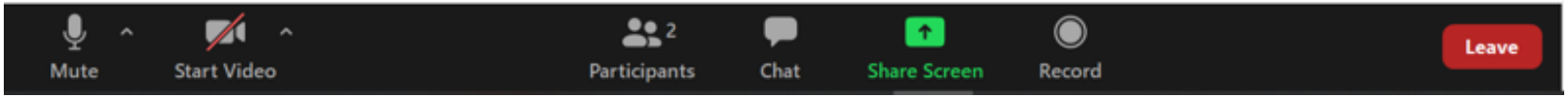
Health Quality Innovation Network

HQIC Office Hours

March 9, 2023

Logistics – Zoom Meeting



To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

You may adjust your audio by clicking the caret next to the **Mute** icon.

Resources from today's session will be shared after the call.

Health Quality Innovation Network

Today's Presenter

Tiffany Wilson
BSN, RN, CPHQ
Consultant

Health Quality Innovation Network

Using Data to Drive Quality Improvement

Agenda

1. **Importance of Data**
2. **Identifying Improvement Opportunities**
3. **Engaging Staff in Improvement**
4. **Tools Available to Assist in Quality Improvement**

Why is data so important?

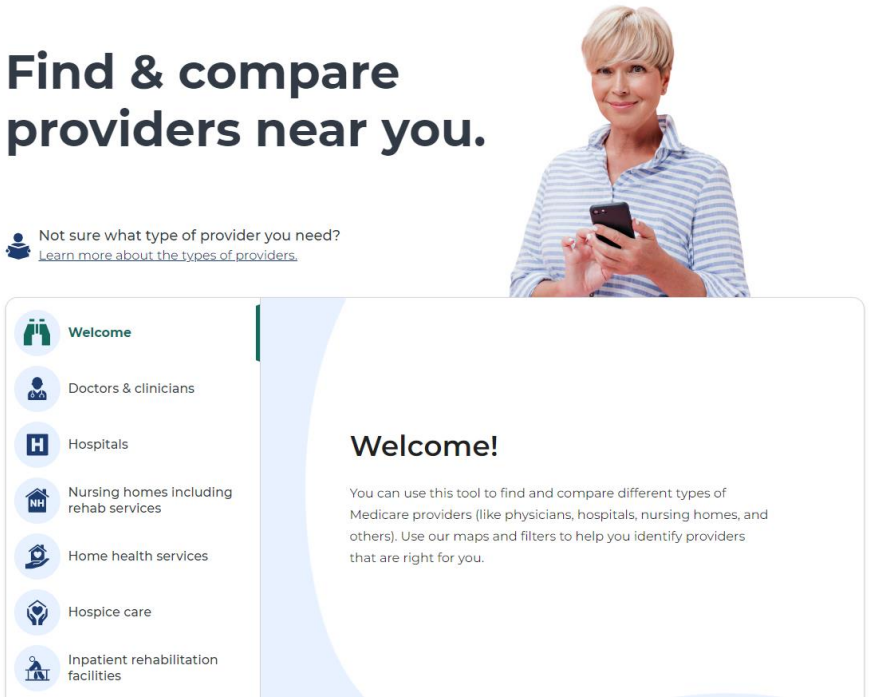
- Make informed decisions
- Can help save time
- Planning for the future
- Find solutions to problems
- Help with cost savings
- Customer satisfaction

Data in Healthcare

- CMS National Quality Strategy
- Care Compare
- Hospital ratings
- Pay for Performance programs

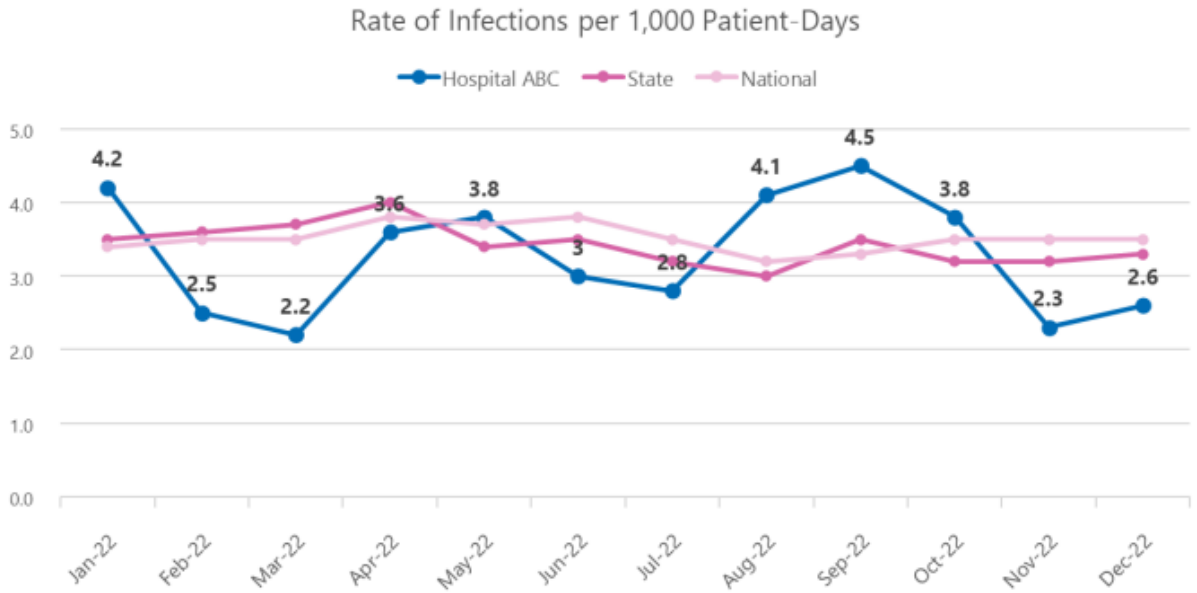
https://www.medicare.gov/care-compare/

Care Compare



https://www.medicare.gov/care-compare/

Identifying Areas of Opportunity



- **Internal reports**
- **HQIC monthly and quarterly reports**
- **Hospital Ratings or Pay for Performance programs**
- **Patient or staff feedback**
- **Comparison to national or state benchmarks**

Types of Measures

Measure	Definition	Example
Outcome	An outcome measure is a measure that focuses on the health status of a patient (or change in health status) resulting from health care—desirable or adverse.	Length of stay
Process	A process measure is a measure that focuses on steps that should be followed to provide good care.	Measure the length of time from physician order written until patient is discharged
Balancing	Balancing measures must be tracked to ensure that improvement work in one area does not negatively impact another.	30-day readmissions Patient satisfaction

https://mmshub.cms.gov/about-quality/new-to-measures/types

Test Your Knowledge

Choose whether the measure is an outcome, process, or balancing measure.

1. Total number of catheter-associated urinary tract infections.
    a. Outcome measure
    b. Process measure
    c. Balancing measure

2. Patients with indwelling urinary catheters without daily necessity documentation.
    a. Outcome measure
    b. Process measure
    c. Balancing measure

3. Costs of supplies and patient satisfaction.
    a. Outcome measure
    b. Process measure
    c. Balancing measure

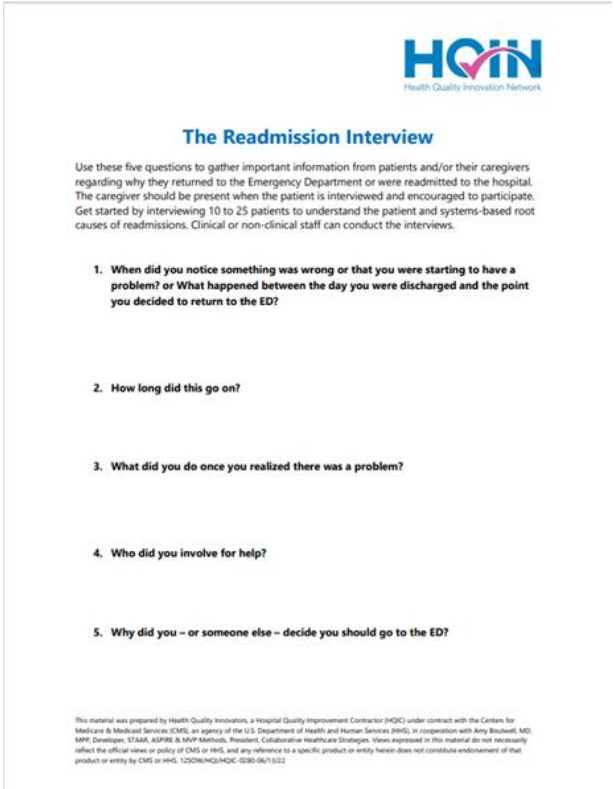
Quantitative vs Qualitative Data

Hand Hygiene Competency Validation
Soap & Water
Alcohol Based Hand Rub (ABHR) (60% - 95% alcohol content)

Type of validation: Return demonstration	☐ Orientation ☐ Annual ☐ Other

Employee Name: _____ Job Title: _____

Hand Hygiene with Soap & Water	Competent	
	YES	NO
1. Checks that sink areas are supplied with soap and paper towels		
2. Turns on faucet and regulates water temperature		
3. Wets hands and applies enough soap to cover all surfaces of hands		
4. Vigorously rubs hands for at least ***20 seconds*** including palms, back of hands, between fingers, and wrists		
5. Rinses thoroughly keeping fingertips pointed down		
6. Dries hands and wrists thoroughly with paper towels		
7. Discards paper towel in wastebasket		
8. Uses paper towel to turn off faucet to prevent contamination to clean hands		
Hand Hygiene with ABHR		
9. Applies enough product to adequately cover all surfaces of hands		
10. Rubs hands including palms, back of hands, between fingers until all surfaces dry		
General Observations		
11. Direct care providers—no artificial nails or enhancements		
12. Natural nails are clean, well groomed, and tips less than ¼ inch long		
13. Skin is intact without open wounds or rashes		



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The Readmission Interview

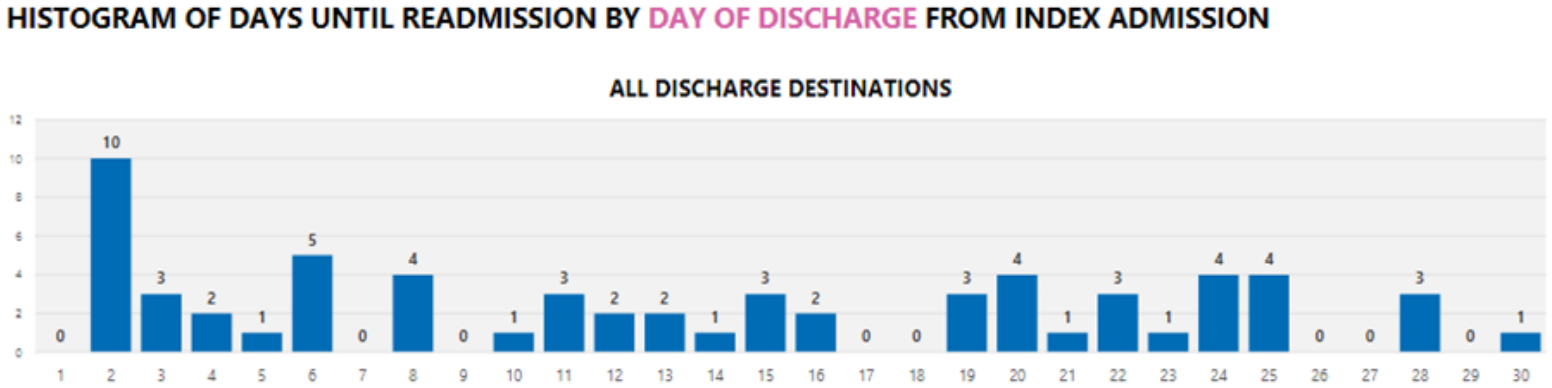
Use these five questions to gather important information from patients and/or their caregivers regarding why they returned to the Emergency Department or were readmitted to the hospital. The caregiver should be present when the patient is interviewed and encouraged to participate. Get started by interviewing 10 to 25 patients to understand the patient and systems-based root causes of readmissions. Clinical or non-clinical staff can conduct the interviews.

1. **When did you notice something was wrong or that you were starting to have a problem? or What happened between the day you were discharged and the point you decided to return to the ED?**
2. **How long did this go on?**
3. **What did you do once you realized there was a problem?**
4. **Who did you involve for help?**
5. **Why did you – or someone else – decide you should go to the ED?**

This material was prepared by Health Quality Innovators, a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS), in cooperation with Amy Boutwell, MD, MPP, Developer, STAAR, ASPIRE & MVP Methods, President, Collaborative Healthcare Strategies. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW6/MQI/MQIC-0280-06/1/22

Ideas That Work - Circle Back (hqin.org)

Readmissions



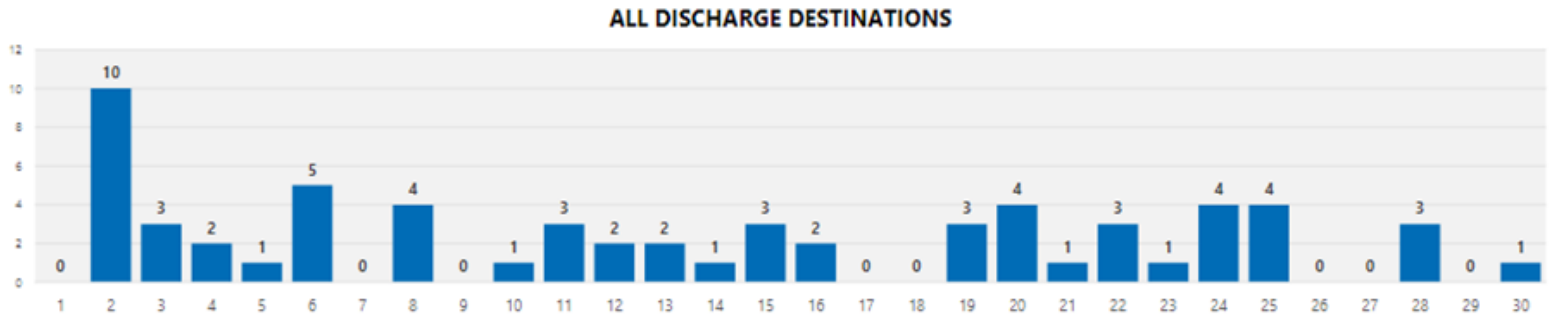
Poll

What additional measures and processes would you review if you noted increased readmissions within the first 7 days after discharge? Check all that apply.

a) Discharge education process
b) Follow-up phone call scripting
c) Readmission interviews
d) Patient satisfaction comments
e) Discharge destination associated
f) Patient compliance with medications

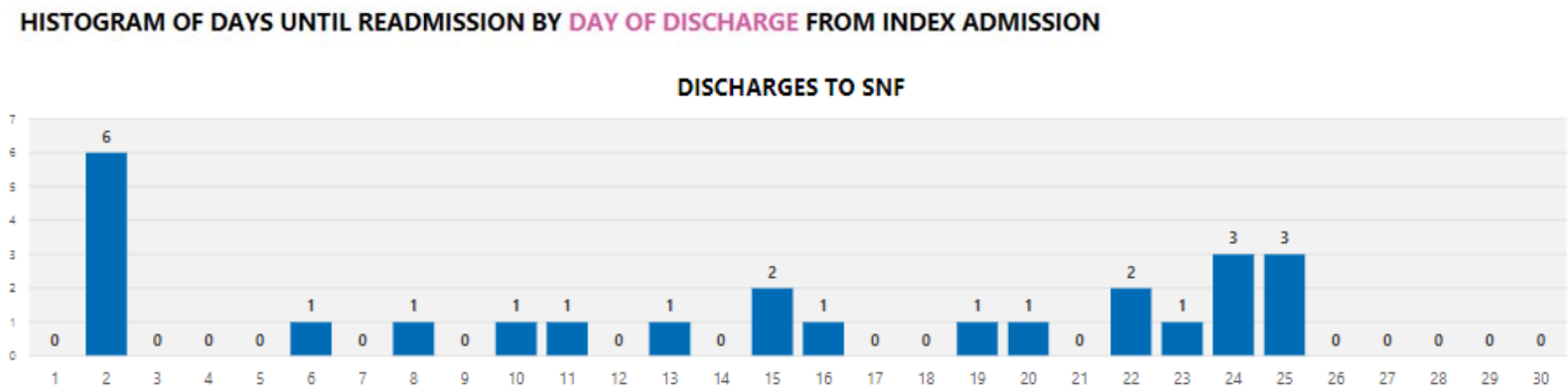
Readmissions

HISTOGRAM OF DAYS UNTIL READMISSION BY DAY OF DISCHARGE FROM INDEX ADMISSION



- Discharge education
- Follow up phone calls
- Discharge medications
- Readmission interviews
- Discharge destination
- Patient satisfaction comments

Readmissions



- Handoff process
- Specific SNF location contributing?
- Missing information
- Discharge diagnosis
- Was the patient suitable for discharge?
- Need for collaboration

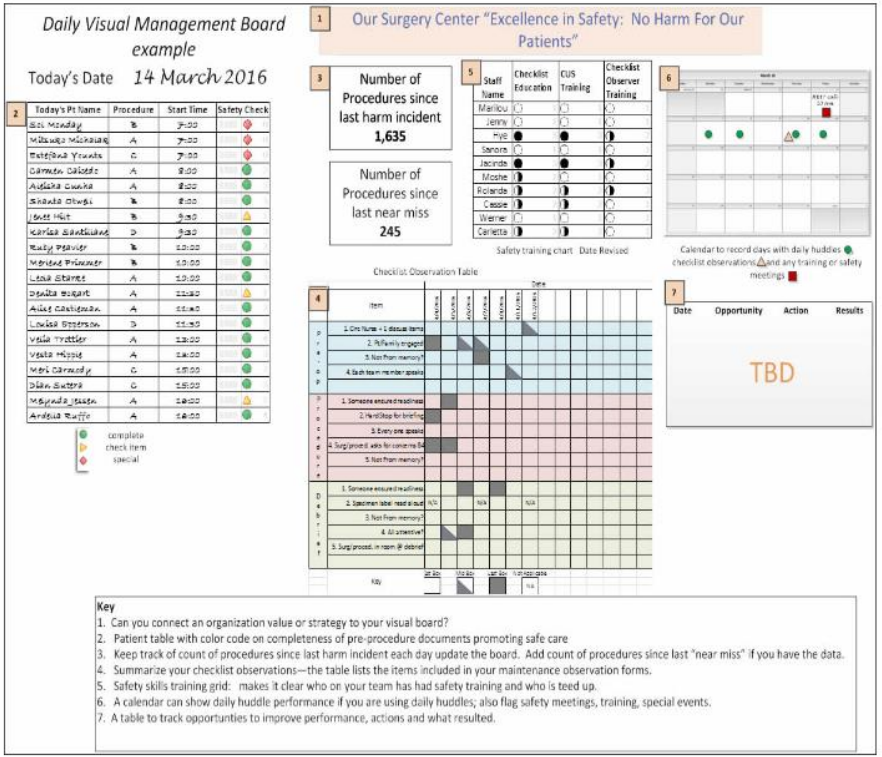
Poll

How do you most commonly share data with your staff? Check all that apply.

a) E-mail
b) Staff meetings
c) Visual management board/Huddle board
d) Dashboard/Scorecard
e) Other (please share details in chat)

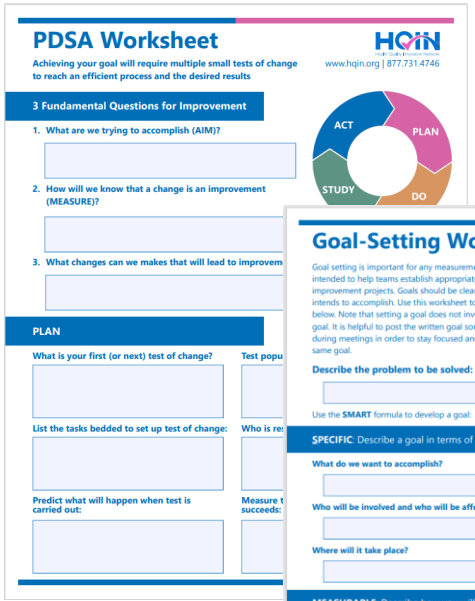
Sharing Data

- Display unit level data for staff awareness
- Connect unit level data with organizational goals
- Share numerators and actual patient numbers versus rates.



https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/sustainability/management/visual-comp-kit.html

Tools



PDSA Worksheet

Achieving your goal will require multiple small tests of change to reach an efficient process and the desired results

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3 Fundamental Questions for Improvement

1. What are we trying to accomplish (AIM)?
2. How will we know that a change is an improvement (MEASURE)?
3. What changes can we makes that will lead to improvem

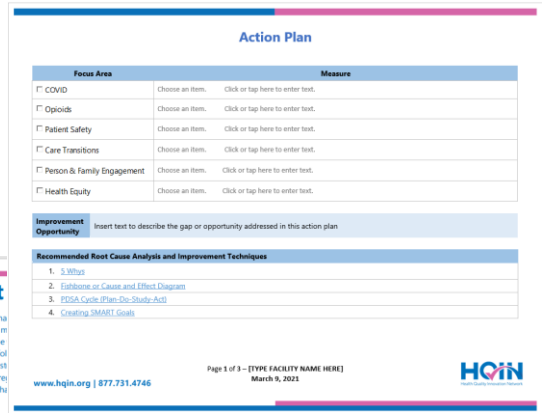
ACT PLAN DO STUDY

PLAN

What is your first (or next) test of change? Test popu

List the tasks bedded to set up test of change: Who is re

Predict what will happen when test is carried out: Measure t succeeds:



Action Plan

Focus Area	Measure
COVID	Choose an item. Click or tap here to enter text.
Opioids	Choose an item. Click or tap here to enter text.
Patient Safety	Choose an item. Click or tap here to enter text.
Care Transitions	Choose an item. Click or tap here to enter text.
Person & Family Engagement	Choose an item. Click or tap here to enter text.
Health Equity	Choose an item. Click or tap here to enter text.

Improvement Opportunity: Insert text to describe the gap or opportunity addressed in this action plan

Recommended Root Cause Analysis and Improvement Techniques

1. 5 Whys
2. Fishbone or Cause and Effect Diagram
3. PDSA Cycle (Plan-Do-Study-Act)
4. Creating SMART Goals

Page 1 of 3 – [TYPE FACILITY NAME HERE] March 9, 2021

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Goal-Setting Worksheet

Goal setting is important for any measurement related to performa intended to help teams establish appropriate goals for individual m improvement projects. Goals should be clearly stated and describe intends to accomplish. Use this worksheet to establish a goal by fol below. Note that setting a goal does not involve describing what st goal. It is helpful to post the written goal somewhere visible and re during meetings in order to stay focused and remind caregivers thi same goal.

Describe the problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC: Describe a goal in terms of three "W" questions.

What do we want to accomplish?

Who will be involved and who will be affected?

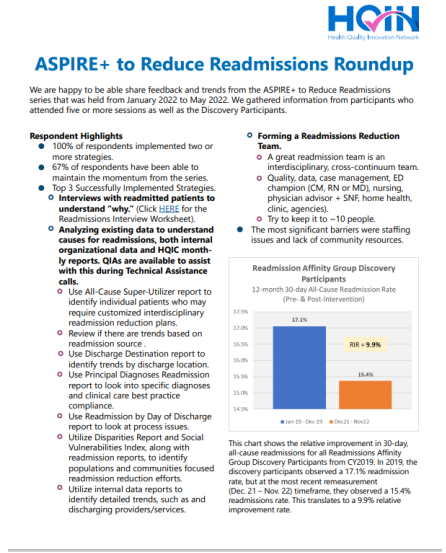
Where will it take place?

MEASURABLE: Describe how you will know if the goal is reached.

What is the measure you will use?

What is the current data figure (i.e., count, percent, rate) for the measure?

What do you want to increase/decrease that number to?



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ASPIRE+ to Reduce Readmissions Roundup

We are happy to be able share feedback and trends from the ASPIRE+ to Reduce Readmissions series that was held from January 2022 to May 2022. We gathered information from participants who attended five or more sessions as well as the Discovery Participants.

Respondent Highlights

- 100% of respondents implemented two or more strategies.
- 67% of respondents have been able to maintain the momentum from the series.
- Top 3 Successfully Implemented Strategies.
  - **Interviews with readmitted patients to understand "why."** (Click HERE for the Readmissions Interview Worksheet).
  - **Analyzing existing data to understand causes for readmissions, both internal organizational data and HQIC monthly reports. QIAs are available to assist with this during Technical Assistance calls.**
    - Use All-Cause Super-Utilizer report to identify individual patients who may require customized interdisciplinary readmission reduction plans.
    - Review if there are trends based on readmission source .
    - Use Discharge Destination report to identify trends by discharge location.
    - Use Principal Diagnoses Readmission report to look into specific diagnoses and clinical care best practice compliance.
    - Use Readmission by Day of Discharge report to look at process issues.
    - Utilize Disparities Report and Social Vulnerabilities Index, along with readmission reports, to identify populations and communities focused readmission reduction efforts.
    - Utilize internal data reports to identify detailed trends, such as and discharging providers/services.
  - **Forming a Readmissions Reduction Team.**
    - A great readmission team is an interdisciplinary, cross-continuum team.
    - Quality, data, case management, ED champion (CM, RN or MD), nursing, physician advisor + SNF, home health, clinic, agencies).
    - Try to keep it to ~10 people.
- The most significant barriers were staffing issues and lack of community resources.

Readmission Affinity Group Discovery Participants

12-month 30-day All-Cause Readmission Rate (Pre- & Post-Intervention)

This chart shows the relative improvement in 30-day, all-cause readmissions for all Readmissions Affinity Group Discovery Participants from CY2019. In 2019, the discovery participants observed a 17.1% readmission rate, but at the most recent remeasurement (Dec. 21 – Nov. 22) timeframe, they observed a 15.4% readmissions rate. This translates to a 9.9% relative improvement rate.

Demystifying Data

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References

- July 2022 Office Hours – Demystifying Data
- PDSA Worksheet (hqin.org)
- Goal-Setting Worksheet (hqin.org)
- ASPIRE Readmission Roundup
- Action Plan document
- Ideas that Work – Circle Back


Discussion
MEETING
Chat
DIALOG
TALK
BUSINESS
Answers
IDEAS
Communicate
SOCIAL
PROPOSAL
IDEAS
Discuss
Connection
Session
Group
INPUT
CONVERSATION
PARTNERSHIP
Forum
SHARE
OPERATING
QUESTIONS
EXPLORATION
Community
Group
Dialog
Business
Communication
TALK
Debate

Upcoming Events

April Office Hours
Developing a Strong Hand Hygiene Culture
April 13th
12:00 PM EST

Health Equity Workgroup
Health Equity Now!
Designing, Implementing and Maintaining Your Health Equity Program
Next Session: March 21
Exploring the Hospital Commitment to Health Equity CMS Measure
12:00 PM EST

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