

## The ABCs of QI:



# How Do We Know That a Change is an Improvement









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## **Webinar Instructions**

To avoid echoes and feedback, we request that you use the telephone audio instead of your computer audio for listening and speaking during the webinar.







## **Webinar Instructions**

- All attendees have been muted to eliminate any possible noise/ interference/distraction.
- Please take a moment and open your chat box by clicking the chat icon found at the bottom righthand corner of your screen and as shown in Figure 1.
- If you have any questions, please type your questions into the chat box, and they will be answered throughout the presentation.
- Be sure to select "Everyone" when sending a message.

### Figure 1





## **Conflict of Interest**

All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.





## **Learning Objectives**





## **Review Session II - Data for QI**

Understand	<ul> <li>How does the current system perform?</li> </ul>
Predict	What interventions might improve the performance of the current system?
Evaluate	<ul> <li>Did our interventions result in improvement?</li> </ul>
Monitor	<ul> <li>Are our improvements sustained over time?</li> </ul>
Engage	<ul> <li>What do stakeholders need to know?</li> </ul>



# Understanding the context of data helps with interpreting the data

# All data exhibit variation, either common cause or special cause







## **Review Session II - Data for QI**

Rule	Definition								
Astronomical point	<ul> <li>One value that is <u>clearly different from the rest</u> Example: When the Medical Provider is on vacation</li> </ul>								
Shift	<ul> <li>An indication of <i>movement</i>, where <u>6 consecutive</u> <u>points</u> have 'shifted' to the other side of the median</li> <li>If 1 point is on the median, skip it and keep counting</li> </ul>								
Trend	<ul> <li>5 or more points in a row, each one consecutively higher or lower in value than the previous data point</li> <li>If 2 or more consecutive points have the same value, skip all but one of the matching points when counting</li> </ul>								







## "Measurement" within Model for Improvement



## **Measurement for Improvement**

- **Purpose**: To track progress over time and to engage practice staff and leaders
  - Not for scientific research or provider feedback
- Character:
  - Simple (small samples)
  - Rapid (frequent sampling)
  - Motivating (immediate response)
- Audience: QI Team, front-line staff and providers, senior sponsor, and leadership





## **Set of Measures**





# Selecting an Outcome Measure

- Answers the questions:
  - Did we achieve our aim?
  - Is anybody better off?





## **Process Measures**

- Measures whether a change has been accomplished
- Helps us understand why we did or did not achieve our aim
- Should be sensitive to changes







## Driver Diagram to Guide Measure Development







## **Arrival Time Measures Set**

**Aim**: I will improve my arrival time to work from 70% to 95% by December 31, 20XX.







## **CRC Measures Set**

**Aim**: Center #1 will improve early detection of colorectal cancer for patients 50-75 years of age by increasing colon cancer screening from 23% to 56.6% by June 30, 20XX.







## Well-Child Visit Measure Set

**Aim**: We will increase the percentage of well-child visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> years of life, from 56% to 75% by December 31, 20XX.







## Considerations When You Are Selecting Measures

- Improvement Topic
  - Manageable number of measures
  - Define patient population
- Methodology
  - Sample size
  - Frequency
  - Sources

- Key Players: data selection/data collection
  - QI team
  - Involve "front line" in the selection of measures
  - Involve the data collectors in planning collection
  - Get senior leader support for your measures





## Exercise

Here is an aim statement and a list of measures for each. At your table, categorize each measure as an outcome (O), process (P), or balance (B) measure.

**Aim statement**: We will improve the cervical cancer screening rate for women ages 24-64 from 45% to 65% by September 30, 20XX.

### Measures:

- Third next available appointment
- % of women with cervical cancer screening ordered
- % of women with cervical cancer screening completed
- % of women due who received a CCS reminder





## Once You Have Selected Your Measures







## How Big is this Elephant?







# **Defining Your Measures**

- Conceptual definition or the measure "name"
  - Tells what will be measured
  - For example: Patient wait time
- Operational definition "Specify and Quantify"
  - Tells how it will be measured
  - For example: Time elapsed from the patient appointment time until time patient enters exam room, in minutes

Adopted from the Dartmouth Institute for Health Policy & Clinical Practice





# **Defining Your Measures**

- Be specific. The more specific your measure definitions, the better!
- For proportions and percentages: Define numerator and denominator criteria
- Create operational definitions (common language definitions) for all "lingo":
  - No-show rate
  - Wait time, cycle time, etc.
  - Patient satisfaction





## How to Measure a Banana?

## Measure the banana from top to bottom.







## How to Measure a Banana?







## How to Measure a Banana?

# Measure the banana curve side out from top of the stem to the black tip.





# **Defining Measures – Example**

**Measure:** Percentage of patients 50-75 with colorectal cancer screening.

- Numerator: Include any of the following
  - Fecal occult blood test during the measurement year.
  - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
  - Colonoscopy during the measurement year or the nine years prior to the measurement year.
- Denominator: Patients 51–75 years of age at end of measurement year.
- Exclusions: Patients with a diagnosis of colorectal cancer or total colectomy.



From National Quality Forum: <u>www.qualityforum.org</u>



## **Data Collection Plan**

- Who is responsible for getting the data (measurement)?
- Sample size
  - Will data be collected on the entire eligible population? Or will you sample?
- Sources
  - EHR or registry report
  - Chart review
- Frequency
  - How often will the data be collected?





## **Example Data Collection Tool**

		Call Events					Appointment Scheduled?			Appointment Kept?		
Patient Identified as Needing Screening	Date/Time of Outreach Call Script	Left Message	Phone Disconnected	Wrong Number	Spoke with Patinet or family member	Comments	Yes	No	Date	Yes	No	Rescheduled (Date)





# **Data Collection - Sampling**

- Random
- Sample size: enough data to understand what's happening in your system
  - Baseline: Usually larger sample, e.g., 50 people
  - Re-measurement: Sample size of 20-30
- Sampling frequency depends on nature of work
  - "Complete" referrals (weekly)
  - Increasing cervical cancer screening levels (monthly)
- Start with EXISTING data sources





## Measures Definition Worksheet

Project Name: Increasing breast cancer screening											
Measure	Measure Type (Outcome, Process, Balance)	Description/Specs (include definition of numerator/denominator where appropriate)	Data Source	Measure Frequenc Y	Reporting Frequency	How will data be presented	Responsible Person(s)	Baseline	Target		
Percentage of women 50-74 who had one or more mammograms within the measurement period	Outcome	Numerator: Women in the denominator who had one or more mammograms in the last 27 months Denominator: Women 50-74 years of age Exclusions: patients with bilateral mastectomy, patients with a history of both a right and a left unilateral mastectomy	Registry	Monthly	Monthly	Run chart at team meetings and QI committee	Data collection: MA Data presentation: PCP champion and/or QI Manager	52%	65% by 6/30/19		





## **Recap of Measures**







## **Exercise 1**

**Aim:** We will increase the percentage of Dr. Seuss's diabetic patients' A1C control compliance (A1C Value < 9.0) from 62% to 70% by December 31, 20XX.

**Measure:** Percent of diabetic patients who are due for A1C screening completes their screening during their next visit to the clinic.

- a. Outcome
- b. Process
- c. Balance







**Aim:** ABC Clinic will increase asthma medication ratio compliance from 74% to 85% by November 1, 20XX.

**Measure:** # of asthma-specific appointments scheduled.

- a. Outcome
- b. Process
- c. Balance





## **Exercise 3**

**Aim:** Clinic Hope will increase Well Child Visits rates from 14.5% to 75% by April 30, 20XX.

Measure: Rate of CIS-10

- a. Outcome
- b. Process
- c. Balance





## Recap – Measurement for Improvement

**Purpose:** To track progress over time and to engage practice staff and leaders.

### Set of Measure

- Outcome relates directly to the aim
- Process measures whether a change has been accomplished
- **Balance** "unintended" impact

### When Defining your Measure

- Be Specific
- Create operational definitions (common language)





## Questions





## ABC's of QI Upcoming Sessions

**Office Hours with Improvement Coaches** 

Date: Wednesday, October 28 Time: Noon - 1 p.m.

Session 4:5 - Tips for Developing Change Ideas for Improvement Webinar

Date: Wednesday, November 4 Time: Noon - 1 p.m.

Session 5:5 - Testing and Implementing Changes via the Plan-Do-Study-Act Cycle Webinar

**Date:** Thursday, November 12 **Time:** Noon - 1 p.m.

### **Registration:**

http://www.partnershiphp.org/Providers/Quality/Pages/Quality\_Events.aspx





### Accelerated Learning Education Program

### (Recording Available)

- Well Child Visit in the First 15 Months of Life Webinar
   Date: Tuesday, September 22 Time: Noon 1 p.m.
- Childhood Immunization Measures Webinar
   Date: Tuesday, October 6 Time: Noon 1 p.m.
- Academic Detailing Webinar: Improving Asthma Care and the HEDIS Asthma Medication Ratio
   Date: Tuesday, October 20 Time: Noon – 1 p.m.

#### 2019 PCP QIP High Performers – How'd They Do That?

#### (Recording Available)

- Webinar #1 of 3 (PCP's with > 10, 000 PHC members)
   Date: Thursday, September 17 Time: Noon 1 p.m.
- Webinar #2 of 3 (PCP's between 10 20,000 PHC members)
   Date: Thursday, October 8 Time: Noon -1 p.m.
- Webinar #3 of 3 (PCP's with < 20, 000 PHC members)</li>
   Date: Thursday, November 5 Time: Noon 1 p.m.

- Tools for Prioritizing Quality Measures
   Date: Thursday, October 1 Time: Noon 1 pm (Recording Available)
- Change Management/Change Fatigue and QI Webinar
   Date: Tuesday, October 27 Time: Noon – 1 p.m.

### **Register:**

http://www.partnershiphp.org/Providers/Quality/Pages/Quality\_Events.aspx

#### **Recordings:**

http://www.partnershiphp.org/Providers/Quality /Pages/PIATopicWebinarsToolkits.aspx





## 1:1 Coaching with Improvement Advisor

Improvement Advisors Can Help:

- Additional Training & Clarification on the Model for Improvement
- Project Planning
- Advise on Quality Projects including:
  - Aim Statement
  - Project Charter
  - Driver Diagram / Process Mapping
  - PDSAs





## **Evaluations**

## Please complete your evaluation. Your feedback is important to us!







# **Continuing Education Credits**

Approved for 1.0 AAFP Elective credits.\*\*CME is for physicians and physician assistants and other healthcare professionals whose continuing educational requirements can be met with AAFP CME.

Provider approved by the California Board of Registered Nursing, Provider #CEP16728 for 1.0 hours.





## **Thank You!**

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