Performance Improvement Basics

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- Utilize Performance Improvement as a managerial tool
- Consider various Performance Improvement models
- Identify the greatest opportunities to make a difference
- Select a plan and design for specific processes
- Effectively use measurement and monitoring tools
- Increase awareness of communication pitfalls

What are we trying to accomplish?

Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected. Agreeing on the aim is crucial; so is allocating the people and resources necessary to accomplish the aim.

What is quality?

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Institute of Medicine (IOM)

Two major reports published by IOM in 1999 and 2001: To Err is Human and Crossing the Quality Chasm.
The latter uses mnemonic STEEEP: Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered.
PI as a management tool

- Your role as a manager
- History of PI in Healthcare delivery
- Public disclosure of quality data
  - Medicare web site
  - Leapfrog Group
  - JCAHO web site
  - National Patient Safety Goals

Hospice CoPs

§418.58 Condition of participation: Quality assessment and performance improvement

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance.

§418.58 (a) Standard: Program scope.

(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

§418.58 (b) Standard: Program data.

(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.

(2) The hospice must use the data collected to do the following:

(i) Monitor the effectiveness and safety of services and quality of care.

(ii) Identify opportunities and priorities for improvement.
§418.58 (c) Standard: Program activities.

(1) The hospice's performance improvement activities must:
   (i) Focus on high risk, high volume, or problem-prone areas.
   (ii) Consider incidence, prevalence, and severity of problems in those areas.
   (iii) Affect palliative outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.

§418.58 (d)

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

§418.58 (e)

(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

Planning for Data Collection

1. What questions need to be answered?
2. What data analysis tools do we expect to use?
3. Where in the process can we get this data?
4. Who in the process can give us this data?
5. How can we collect this data with minimum effort and chance of error?

Florence Nightengale
Deming - System of profound knowledge

“The prevailing style of management must undergo transformation. A system can not understand itself. The transformation requires a view from outside.”

The first step is transformation of the individual. This transformation is discontinuous. It comes from understanding of the system of profound knowledge. The individual, transformed, will perceive new meaning to his life, to events, to numbers, to interactions between people.

Once the individual understands the system of profound knowledge, he will apply its principles in every kind of relationship with other people. He will have a basis for judgment of his own decisions and for transformation of the organizations that he belongs to. The individual, once transformed, will:

Set an example
Be a good listener, but will not compromise
Continually teach other people
Help people to pull away from their current practice and beliefs and move into the new philosophy without a feeling of guilt about the past

The layout of profound knowledge appears here in four parts, all related to each other:

- Appreciation for a system
- Knowledge about variation
- Theory of knowledge
- Psychology

Deming’s 14 point

- Create consistency of purpose for service improvement
- Adopt the new philosophy
- Cease dependence on inspection to achieve quality
- End the practice of awarding business on price along-make partners out of vendors.
- Consistently improve every process for planning production and service.
- Institute training and retraining on the job.
- Institute leadership for system improvement
- Drive out fear
- Break down barriers between staff areas
- Eliminate slogan, exhortations, and targets for the work force.
- Eliminate numerical quotas for the work force and numerical goals for management.
- Remove barriers to pride of workmanship
- Institute a vigorous program of education and self-improvement for everyone.
- Put everyone to work on transformation
Quality in Business

- Crosby – emphasizes the need to do things right the first time
- Juran – 3 part approach to quality –
  - Quality planning
  - Quality control
  - Quality improvement

Crosby’s 14 Steps

- Management commitment
- The QI team
- Quality measurement
- The cost of quality
- Quality awareness
- Corrective action
- Zero defects day
- Goal setting
- Zero deficit planning
- Supervisor training
- Error-cause removal
- Recognition
- Quality Councils
- Do it over again

Kaizen

A continual improvement process involving everyone in a personal quest for excellence.

iSixSigma

iSixSigma LLC is an independent company, privately owned, funded and operated by quality improvement professionals. Their mission is to provide a free information resource to help business professionals successfully implement quality within their organizations. This information includes tools, checklists, calculators, editorial and personalized advice to assist with the implementation of Six Sigma.
Baldridge Quality Program

The Baldrige National Quality Program promotes performance excellence among U.S. manufacturers, service companies, educational institutions, and health care providers. Baldrige also conducts outreach programs and manages the annual Malcolm Baldrige National Quality Awards.

5S

5S is a philosophy and a way of organizing and managing the workspace. The key impacts of 5S is upon workplace morale and efficiency. By ensuring everything has a place and everything is in its place then time is not wasted looking for things and it can be made immediately obvious when something missing.

6 IOM aims

- **Safe**: Avoid injuries to patients from the care that is intended to help them.
- **Effective**: Match care to science; avoid overuse of ineffective care and underuse of effective care.
- **Patient-Centered**: Honor the individual and respect choice.
- **Timely**: Reduce waiting for both patients and those who give care.
- **Efficient**: Reduce waste.
- **Equitable**: Close racial and ethnic gaps in health status.

Dimensions of performance

- **Customer perspective**: at least 90 % of patients rate our nurses “very good.”
- **Accessibility**: Patients are seen within 24 hours of referral.
- **Continuity**: Every patient has a list of current medications and instructions.
- **Efficiency**: Costs are at or below the median for the community.
- **Timeliness**: Calls are responded to within 30 minutes.
Similarities of all theories in relation to health care
1. Quality can be defined and measured
2. Quality is dynamic
3. Quality involves a competitive edge
4. Quality has to do with doing the “right” things right
5. Quality relates to outcomes
6. Quality is everyone’s responsibility
7. Quality and costs are linked.
8. Quality and performance are synonymous

PI Importance

Mission, Strategy, Leaders, and Customers

Performance always occurs in a context.
No program can be all things to all people.
Need to know who you are serving and with what goal.

Where do you start?
1. Know your organization’s mission and goals.
2. Know your customers – internal and external
3. Team work and communication are essential
4. One time successes aren’t enough.
5. Performance improvement is ongoing.
Mission Statement

• Identifies what an organization is about
  – Articulated
  – Understood by all members of organization
  – Valued
  – Visible
  – Used consistently to guide all plans, goals, and actions

3 Mission Statements

Visiting Nurse Association, a nonprofit agency serving the community since 1888, is committed to the belief that every individual deserves care and support to preserve independence, dignity, and quality of life. Visiting Nurse Association dedicates itself to this belief by providing professional and compassionate health care solutions to people touched by disease, disability or death.

Mission: Continuing Christ's ministry in our Franciscan tradition.

We are committed to providing the highest quality home health and hospice care to the people of the Wabash Valley.

Organization goals

Goals are statements describing what your organization wishes to accomplish, stemming from your purpose or mission. Goals are the ends toward which your efforts will be directed and often change from term to term or year to year, depending on the nature of the group.

Specific Agency Performance Improvement Goals

Increase qualitative review of OASIS assessments in comparison to patient clinical status in response to new OASIS-C data set.

Review the current Hospice Performance Improvement project and determine direction for 2010.

Goal is to have re-hospitalization rates to be at or below the state average.

To reward and retain employees as measured by:
  a. Turnover rate compared to quarterly results and state and national benchmarks.
  b. Employee satisfaction survey results.
To improve customer satisfaction and community awareness of our agency.
Self Assessment Checklist

- What is the mission & strategy of your organization & can you draw a clear line from that mission to your department?
- Describe the specific scope of care
- Do you have a standard format for documenting a quality plan?
- Who are your customers, what do they want, & how do you know it?
- What are the elements of performance you deliver?
- What QI model is in use?

Next Step

- Document all information you have collected. Include:
  - Leadership of department
  - Customers & what they need/want
  - Scope of care & service provided
  - Elements of quality process & outcomes, evaluated to identify those that are high risk, high volume, and problem prone
  - Specific performance levels that the department aspire to meet. (Model)

Standards Define Quality Performance

- A standard is a written value statement of rules, conditions, and actions in a patient, staff member, or the system that are sanctioned
  - Written
  - Define rules, action, or outcomes*
  - Process standards – define how service is to be carried out**
  - Outcome standards – results to be achieved

Consider various performance improvement models
Select a plan and design for the specific processes

The QI or PI Model

- Variety of approaches
  - Shewhart?deming cycle
  - Plan-DO-Check-Act or modified FOCUS-PDCA
  - Six Sigma’s define, measure, analyze, improve, control
  - JCAHO: Plan, design, measure, assess, improve
  - OBQI – Outcome-based quality improvement

PDSA steps

Select a high-risk process
Describe the process
Identify the process breakdown
Discuss how the breakdown affects the patient and or organization
Identify if it is a priority for the organization
Investigate the reason why it is occurring
Redesign a process to correct the breakdown
Test and implement
Monitor the effectiveness of the redesign
Identify the greatest opportunities for improvement.

Methods of problem identification:
- Brainstorming
- Flowcharts
- Cause and effect diagrams
- Check sheets
- Pareto charts
- Histograms
- Stratification scatter diagrams
- Run charts
- Control charts
- Focus groups
Performance Measures

Indicators

- Ubiquitous – positive or negative signs of change
- Alerts you
- Part of daily life
- Valid and reliable quantitative measure
  - # of patients with Stage IV pressure ulcers
  - # of patients with pressure ulcers

Three Types of Measures

Process Measures (voice of the workings of the system):

Outcome Measures (voice of the customer or patient):

Balancing Measures (looking at a system from different directions/dimensions):

Indicators

- 1. reliable – accuracy over time – consistent
- 2. accurate and valid – measure what it is designed to measure
- Measurable
- Specific and definite
- Relevant to service, practice, or governance

Examples of Quality Measures

<table>
<thead>
<tr>
<th>Patient/Family Outcomes</th>
<th>Processes of Care</th>
<th>Hospice Services</th>
<th>Operations (non-clinical)</th>
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<td>- Patient comfort</td>
<td>- Staffing</td>
<td>- After hours care and support</td>
<td>- Human resources</td>
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<td>- Patient safety</td>
<td>- Admission assessment/ reassessment</td>
<td>- DME</td>
<td>- Referral management</td>
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<td>- Autonomy/self-determined life closure</td>
<td>- Care planning</td>
<td>- Pharmacy</td>
<td>- Accounting/billing</td>
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<tr>
<td>- FE/HC</td>
<td>- Interventions</td>
<td>- Supplies</td>
<td>- Finance</td>
</tr>
<tr>
<td>- Visits/calls</td>
<td>- Volunteer services</td>
<td>- Volunteer services</td>
<td>- Development</td>
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The QAPI Requirement: Resources for Hospice Programs
Handout 3
Interpreting Outcomes and Case Mix Reports and Selecting Target Outcomes

See POA Handout

Effectively use measurement and monitoring tools
What changes can we see that will result in improvement?

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement.

Tools and techniques

• Logs
• Check sheets
• Surveys/questionnaires
• Interviews
• Focus groups
• Brainstorming
• Nominal group process

Tips for small test of change

More tools and techniques

• Multivoting
• Run charts
• Control charts
• Histograms
• Pareto chart
• Fishbone diagram
• Flowchart
• Benchmarking
• Force Field analysis
SCAMPER
• S – substitute
• C – combine
• A – adapt
• M – magnify/miniaturize/multiply
• P – put to another use
• E – who/what/where else
• R – rearrange or reverse
**Force Field Analysis**

- **Restoring Forces**
  - Driving forces (induced change)
  - Restoring forces (towards equilibrium)

- **Present Productivity**

**Examples of Annotated Run Chart of PDSA Cycles**

Run Charts are used to plot the progress of PDSA cycles over time. Each data point is annotated to understand the effect of each small change on the desired change measure.

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**Cause and Effect Diagram**

- **Causes**
  - Equipment
  - Process
  - People
- **Effects**
  - Problem

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Related Concepts

1. Sentinel Event
2. Root Cause Analysis
3. Never Events
4. Peer Review
5. Adverse Events

See data collection handout

Questions???

Thank you !!!
Root Cause Analysis

- Root cause analysis (RCA) is a class of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized.

Confidentiality & protection

- Sensitive data – need to consider
  - Privacy of patients
  - Privacy of staff members & physicians
  - Discoverability
  - Risk management
  - Corporate/organizational public relations & potential embarrassment

How to protect information appropriately

- A quality orientation session for all new quality department staff members or those collecting relevant data
- A confidentiality statement signed by all employees, physicians, volunteers, and students
- A quality committee request for information
- A notation documenting all information, such as privileged & confidential
- Quality information that is kept physically secure

Employee Orientation to Quality

- Each employee needs to be able to identify his customers for each aspect of work.
- Need to know basic quality goals and measures of work & describe how he can contribute to the success of those goals. Need to know that their own ideas and contributions are desired & welcome.
- Opportunity to become acquainted with key performance measures, or indicators that have been selected by the department.
- Orientation should focus on how the employee’s responsibilities contribute to achievement of overall objectives & how key performance measures have been developed to meet patients’ needs.
- Realize they are someone’s customers too.
Conduct & Document meeting

• Need for a monthly staff meeting?
• Pitfalls: time & logistics
• Meetings of value:
  – Substantive agenda
  – Conduct meetings efficiently
  – Plan ahead with proper notice
  – Include the right people & start & end on time
  – Provide food
  – Include quality components

Quality meeting Prep

1. Prepare agenda
2. Prepare data & materials for meeting
   1. Monitoring/performance data for discussion, such as quality metrics & satisfaction
   2. Collect reports from intra-departmental teams
   3. Identify sentinel, critical, or other special events requiring discussion
   4. Collect risk, employee safety, infection control
3. Hold the meeting & document attendance
4. Document group’s conclusions & recommendations & planned follow-up

The Quality Meeting

• Call to order – take attendance & review agenda. Provide confidentiality reminder
• Findings & Conclusions – 4 basic questions
  – 1. Did our interventions last month have the desired effect?
  – 2. Are we meeting our target/goal/threshold?
  – 3. If we are meeting our goal, does this performance appear to be solid, consistent, & reliable? If we are not meeting our goal, why not?
  – 4. Are there other possible improvement opportunities we should consider pursuing later?

Questions?

Thank you!!
Strategies & Action Plans

1. Should we revise an action plan we previously developed?
2. Who is responsible, and when, for each action?

Follow up

1. How can we share all this information with staff members not present today?
2. When are the data shared with the chain of command?
3. When are the data shared with pertinent medical leadership?
4. When can we obtain feedback on our recommendations to other areas?
5. Do we need consultation regarding matters such as data analysis, HR issues, and information systems?
6. Should we share these data with some of our customer groups?
7. Should we share these data with colleagues who provide a similar service and solicit or offer advice?
8. When will we review the data again?

Quality Reporting & Communication

• Quality is the result of staff members’ comprehensive understanding of what is expected, why it is appropriate to expect it, how they will be supported to deliver that performance, and how they will be evaluated according to defined criteria.

Performance Opportunities

1. Indiana State Department of Health and University of Indianapolis Pressure Ulcer Collaborative
2. Indiana Healthcare Associated Infection Initiative
3. Partner with local hospitals or skilled nursing facilities to work on common concerns, such as CHF or diabetes management.
4. www.medqic.org
Home Health Quality Improvement

The Home Health Quality Improvement (HHQI) National Campaign is a grassroots movement designed to unite home health stakeholders and multiple health care settings under the shared vision of reducing avoidable hospitalizations and improving medication management.

Best Practice Intervention Packages

- January 2010 - Introduction and Fundamentals of Reducing Avoidable Hospitalizations
- April 2010 - Medication Management
- July 2010 - Fall Prevention
- October 2010 - Cross Settings Part I
- January 2011 - Cross Settings Part II
- April 2011 - Cross Settings Part III

Associated Resources

- M2020 Quick Guide - Stratis Health
- Potentially Inappropriate Medications in Older Adults - HSQI, NJDSI
- Medication Management Tips for Staff - Lakeland Hospice and Home Care
- Patient Medication Review Questionnaire
- Taking Charge of My Warfarin - HSQI, NJDSI
- Home Health Medication Discrepancy Tool - GMCF
- Warfarin Drug-to-Drug Interaction Guidelines - HSQI, NJDSI
- Fax Form: Potential Medication Interactions - Dominican Sisters
- Family Health Service
  - Guidelines for Fax Form to Physician with Potential Medication Interaction
- Beers Criteria: Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions (2002 Criteria)
- Medication Nonadherence: A Staff Education Tool
- Medication Management Care Planning Tool
- Medication Compliance Aids-Selection Criteria
- Patient INR Test - Dominican Sisters Family Health Service
- Medication Tips: Simple Steps for Medication Safety - HSQI, NJDSI
- Personal Health Record - GMCF
- Medication Safety and You (Understanding Dietary Supplements) - HSQI, NJDSI
- Medication Safety and You (Are you taking a blood thinner?) - HSQI, NJDSI
- High-Alert Medication Education - Piedmont Home Care (Medical Services of America)
- Medication Cards - VNA of Middlesex-East & VN Hospice
- Channel Blocker
- Insulin
- Vasodilator
- Anticoagulation Patient Teaching Booklet - Dominican Sisters Family Health Service
- Case Study #1
- Case Study #2
QUICK START GUIDE

QUICK START GUIDE: A brief guide and introduction to the Best Practice Intervention Package (BPIP) contents.

INTRODUCTION: A brief introduction to the topic of this BPIP, Oral Medication Management.

LEADERSHIP TRACK (PAGE 9): Designed for agency leadership and the quality or implementation team. Although this section is designed for leadership and the implementation team, it is divided in sections so that it can be printed and shared with other staff. You will see similar features in each BPIP such as the Guide for using the BPIPs.

You’ll also see new features specific for this educational package.

Contents include:
- A Guide for using the BPIPs
- Best Practice Intervention Schedule and Suggested Timeline
- Focus: Importance of Medication Management
- Checklist for Agency Leadership (Select interventions)
- Tools and Resources
- Links to Success Stories
- Organizational Culture
- Physician Perspective

DISCIPLINE TRACKS: These 2-page guides are designed for the following disciplines:
- Skilled nurse (page 43)
- Therapist (page 45)
- Medical social worker (page 48)
- Home health aide (page 49)
Questions ??

Thank you!!