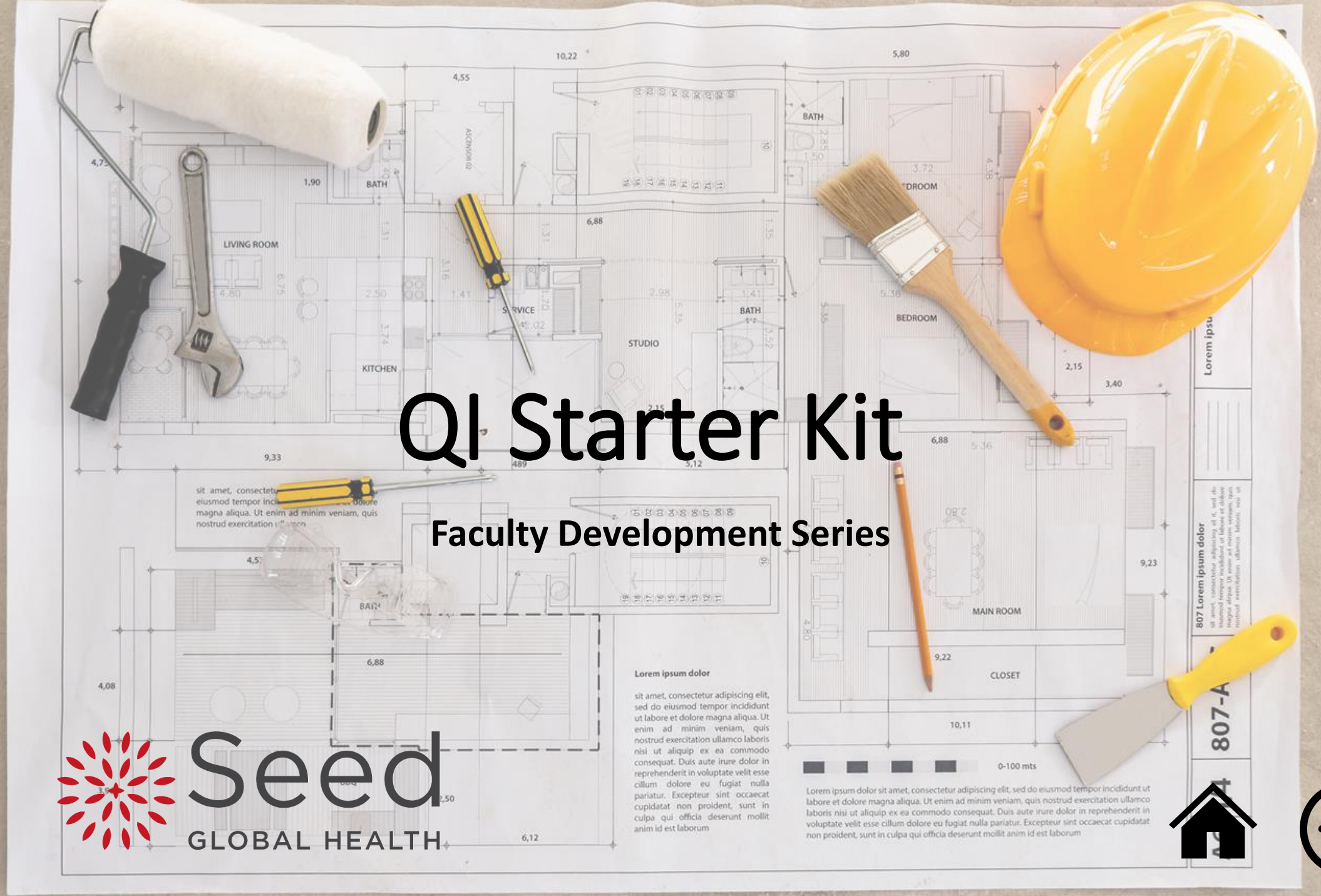


QI Starter Kit

Faculty Development Series

Seed
GLOBAL HEALTH

Next slide

Back to main steps

Examples

Google form

Think of a QI topic prior to starting and at each step of the QI process decide what your QI project would entail. Once finished fill in the google form and submit.

Objectives

Recognize	Recognize the components of a needs assessment and draft steps to performing a needs assessment on the QI topic of choice.
Design	Design an intervention based on a SMART goal to the QI topic of choice.
Develop	Develop an implementation plan for the intervention to the QI topic of choice.
Create	Create an evaluation process for the QI topic of choice.
Understand	Understand the key concepts behind what rapid cycle continuous quality improvement is and draft anticipated PDSA cycle iterations for the QI topic of choice.
Pivot	Recognize when to transition between the different steps of a QI project eventually leading to a maintenance phase/consolidation.

Examples topics for QI projects

- Diabetes
- Hypertension
- CCF
- Sepsis
- Stroke
- ACS
- TB
- HIV
- Malaria
- Sickle cell
- Medical knowledge
- Medical skills
- BP measurements
- Nursing orders followed
- Number of patients seen
- Documentation
- Medication adherence
- Patient education
- Cancer screenings
- Vaccines

Examples of data for diabetes

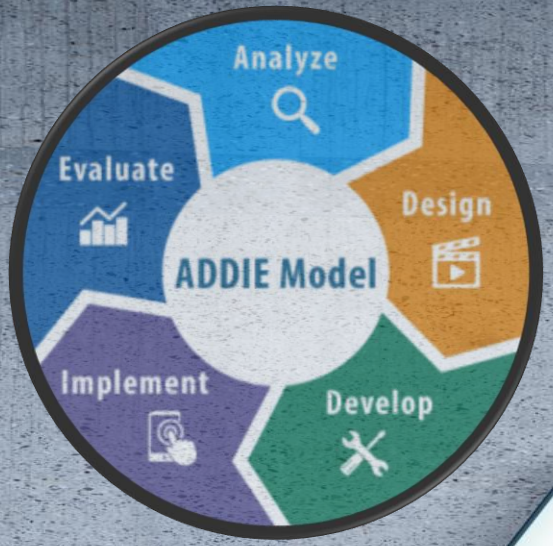
Process/implementation data
% A1c measured
% BP measured/recorded
% Calculated ASCVD
% Counseled on diet/exercise
% Referred for eye exam
% Foot exam documented
% Kidney function tests ordered

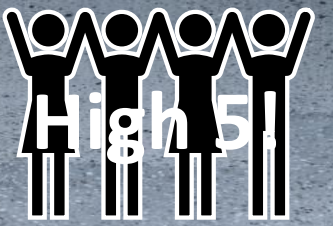
Clinical/Outcome data
% A1c controlled
% BP controlled
% of ASCVD ≥ 10% on statin
% At goal with lifestyle changes
% Completed eye exam
% Kidney tests up to date

Normal vs Abnormal

Normal vs Abnormal

STEPS





Needs assessment

Design an intervention

Develop tools

Implement the intervention

Evaluate

Repeat

Maintenance

Click the topic to begin

Needs Assessment

- Must occur prior to any other step
- Identify the area for improvement
  - Initial/baseline data
  - Justify need for improvement
- Find/Make an expert
  - Literature review
    - General on the topic
    - Guidelines/review article
  - Best practices
- Identify current strengths
- Identify current weakness

Diabetes needs assessment

- ADA Standards of care
- Survey staff
- Patient review
- Stakeholder input
- Baseline data
  - Patient
  - Provider
  - Clinic

Design

- This step should only begin once enough information has been gained from the needs assessment
- Create a measurable goal(s)
  - Quantitative method for measuring
  - Short term and long term
  - S.M.A.R.T.
- Refine literature review
  - Specific to your S.M.A.R.T. goal
- Identify strengths
- Identify weaknesses
- Identify barriers to implementation
- Develop standardized simple procedures/guidelines
  - Leads to a required minimal process

Diabetes SMART goals

- There will be an increase from 56% to 80% of patients who will have an A1c < 8.5 in 6 months who were seen in the previous 3 months.
- There will be an increase from 52% to 80% of patients who will have a blood pressure <140/90 on their last clinical visit in 3 months.
- There will be an increase from 25% to 75% of patients who have an ASCVD of >10% who will be on an appropriate dose statin.
- There will be a decrease from 56% to 20% of the patients not taking insulin who will not check their blood sugars in 3 months.
- There will be an increase from 65% to 90% of patients on basal insulin who will be on twice daily injections in 1 month.

Decrease A1c clinic procedures

- Check A1c if > 8.5/unknown and ≥3 months since last check
  - Need lab/patient needs money/requires another visit
- If A1c > 8.5 will need medication adjustment based on level of control and desired drop
  - Provider knowledge gap on how to adjust medication
  - Patient knowledge gap on how to follow complex instructions
- Will need to return in 3 months for an A1c if oral medication change
- Will need to return in 1-2 weeks if insulin change and 3 months after last change.
  - Issues with continuity and double visits if they do not get A1c prior to visit

Develop tools

- Leverage the strengths previously identified
- Create work arounds/fill in gaps for previously identified weaknesses
- Develop a plan for anticipated barriers
- Obtain materials needed
- Buy necessary equipment
- Identify champions

Diabetes tools

- Education
- Plan of care
- Workshops
- Standing orders
- Posters
- Empowerment

Diabetes

The University of Zambia
School of Public Health ○ Family Medicine MMed Program

ASSOCIATION OF FAMILY PHYSICIANS OF ZAMBIA

iabetes Standards of Care

- 4 - 7.2
- 5 Fasting 5.0 - 7.2
- 8.0 Fasting 5.0 - 8.3
- ✓ Post-prandial < 10.0
- Pre-dinner <8.3

ood Pressure
- 40/90
- HTN start 1st line med

C: Cholesterol
- ✓ Start low-moderate
- tatin if ASCVD ≥ 10%

rugs
- rmin/sitagliptin
- rmin/dapagliflozin
- azone
- limiperide
- /30, R

A1c	RBS
14	19.7
13	18.1
12	16.5
11	14.9
10	13.3
9	11.8
8	10.2
7	8.5
6	7.0

F: Foot
- ✓ Examine skin, pulses, and sensation yearly

G: Give up smoking
- ✓ Encourage cessation

H: Heart
- ✓ Start aspirin 75mg if history of MI or CVA

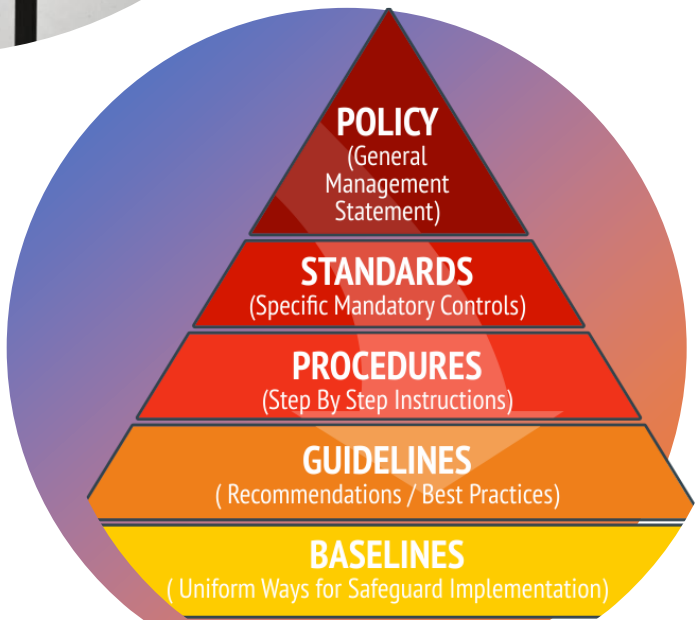
I: Immunizations
- ✓ Pneumonia, Hepatitis B, Flu and COVID vaccines

K: Kidney
- ✓ Creatinine and GFR (U/Cr) yearly
- ✓ Urine protein yearly

L: Lifestyle
- ✓ 150 min of activity/week
- ✓ Balanced diet – my plate

Implement

- Defined start date
- Start small (pilot)
- Clearly defined objectives
  - Why are we doing this?
- Well documented process to follow
- Well defined roles
- Clear timeline for evaluation
  - System for tracking change
- Create a safe environment
  - Crucial for constructive feedback



Implement

- Start with one team/provider in clinic
- Orient team to the purpose and importance of decreasing the A1c
- Formal standardized education for all team members on titration of meds and follow up
- Team is given a quick reference cheat sheet for rescheduling patients
- All tools developed are available
  - Posters, logs, etc
- Calendar for formal feedback is given
- Methods for informal feedback given
- Empowerment/team building exercises

Evaluate

- Set regular formal meetings
  - Daily, weekly, bi-weekly, monthly
  - Decided on the amount of data/feedback that can be generated by the intervention
  - Review objective and subjective data
- Encourage informal feedback/updates
  - In person
  - Email
  - WhatsApp
  - Message board/suggestion box
- Transparency in progress/lack of progress
  - Actual outcomes of what is being measured
- Involve everyone
  - Most processes are not affected by the person at the top but all the people on the ground
- Compare: perform statistical analysis to identify gains/losses towards the ultimate goal or intermediate goals
- CHANGE
  - Be flexible without egos and adjust small/large parts of the plan that can improve

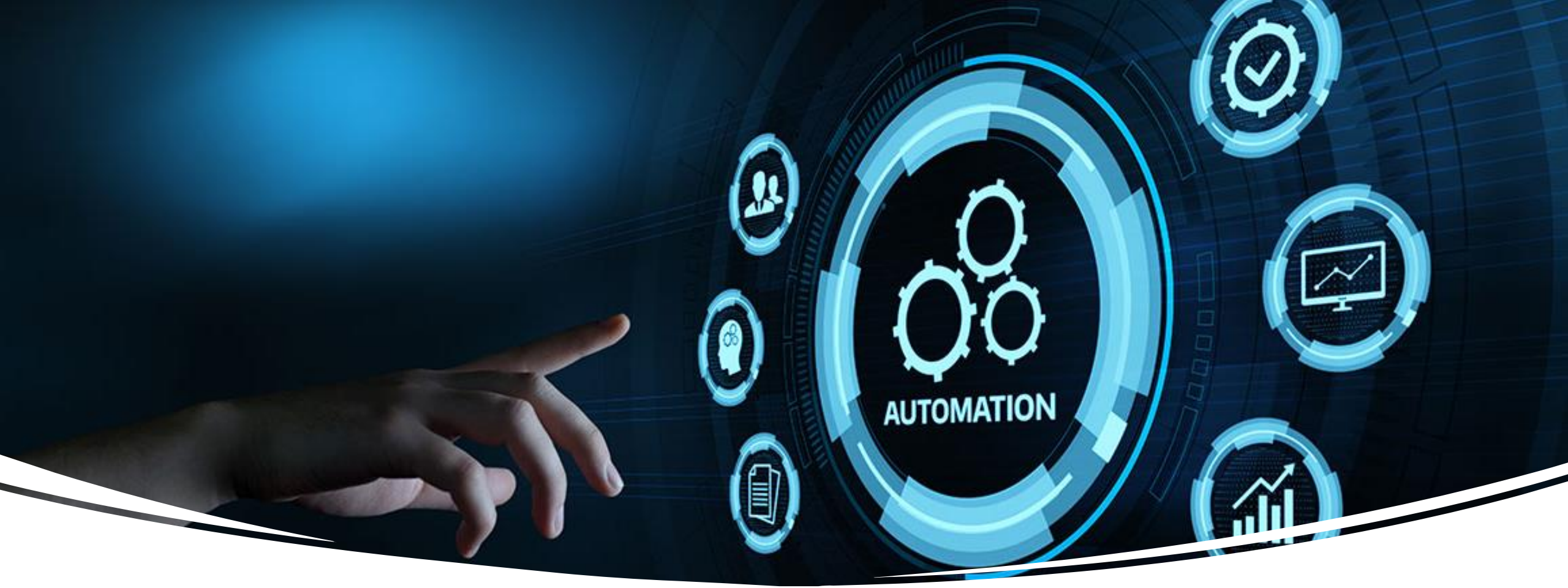
Repeat

Continuous rapid cycle improvement

- Is not linear
- Multiple changes can be occurring at any given time
- Multiple teams can be championing different changes
- Adjust and track

PDSA *Cycles*

- Observation
  - Provider X and Y are not prescribing insulin according to guidelines
- Intervention
  - Medical director speaks with provider X and Y to see why they are not following guidelines and makes changes accordingly
- Observation
  - Patients are not returning with accurate glucose logs
- Intervention
  - A standardized way to draw and report glucose log is used with all patients. Providers and staff are all trained at the next meeting
- Observation
  - Patients are not taking medications because they are too expensive
- Intervention
  - Pharmacies are visited to see which medications are affordable. Formulary is posted with prices. Preferred medications in each class are posted
- Observation
  - Patients are not having A1c done prior to follow up visit
- Intervention
  - Calendar events are created in the patient's phone for 1 week prior to the visit so they can get their A1c in time



Maintenance

- Once the goal has been achieved identify best practices and build on them
- Formal meetings can decrease/stop
- Formalize standard operating procedures
- Institutionalize the changes
- Reporting can be automated and reviewed for need to re-address
- If there is low hanging fruit, go for it
  - Different quality metric within same disease that can be addressed with similar process
  - Different disease that you can apply best practices to

Maintenance

- Weekly meetings with entire team
  - Daily briefings with core team
  - Lots of changes
- As process data improves
  - Biweekly meetings with entire team
  - Weekly meetings with core team
  - Minor changes occur
- As clinical outcomes improve
  - Monthly meetings with entire team
  - Biweekly meetings with core team
  - Tweaking processes
  - Drafting policies/procedures
- Goal attained
  - Standard operating procedures finalized
  - Reports are automated
  - Dashboard updated regularly

High 5s!

- Celebrate all victories
  - Process/Outcome
  - Big/Small
  - Moral/Actual
- Learn from all mistakes
  - Abandoning an approach after 2 weeks is better than abandoning it after 6 months
  - “All of my successes are just the sum of my failures””
  - Build on lessons learned
- Acknowledge people for their work
- Display results transparently where everyone can see

Google form

- If you have not done so already, input your skeleton plan for the:
  - Topic
  - Needs assessment
  - Design for the intervention
  - Development of the resources needed to implement
  - Implementation plan
  - Evaluation process
  - Examples of PDSA cycles
  - Transition to a maintenance phase

Google Forms