The Quality Post

Monthly Quality Improvement Newsletter FOR THE **Division of Hospital Medicine**

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Greetings from Michelle & Katie
QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the third issue of the Quality Post. In this issue we'll highlight the principles of Change Management taught to us by Ed O'Neil in our most recent QI school as well as introduce you to our evolving DHM quality improvement dashboard.

Change Management

We had the pleasure of having Ed O'Neil come speak to our Division about Change for our March 10th QI School.

Ed O'Neil
Director, Center for Health Professions

Ed O'Neil is a Professor at the University of California, San Francisco and serves as the Director of the UCSF Center for the Health Professions. He is a frequent speaker on the challenges and opportunities of a health care workforce capable of improving the health and well being of people and their communities.

He writes a Monthly "Hot Topic" column on change management, with topics such as Influencing Change and Making the Case for Change. At QI School Ed focused on the critical elements of leadership: Vision, Tasks and Relationships and discussed how each of these components relate to creating change.

He reminded us that effective change happens when leaders succeed in aligning the group to a set of shared values and interests and demonstrate with data how the status quo does not serve these ends. He emphasized that that leaders must provide a compelling vision for an alternate future, but do not need all the answers for the change. Instead they succeed by engaging key stakeholders in shaping the change process.

For more information about the Center for Health Professions, their programs and their classes, check out their web site.

The 6 C's of Behavior Change

1. **Establish a Common Context**: Make sure those you are leading towards change have a view of success and share your values, culture and expectations. Make sure you provide opportunities to give and receive feedback.

2. **Clear Goals and Process:** Linking to your context above, have specific goals and process. Identify how those goals are of interest to all parties.

3. **Capability:** Make sure all involved have the capability to take on the change, both in terms of process, skills and attitudes. Establish buy in for the effort this change will take.

4. **Coaching**: Provide informal and frequent feedback, recognizing gains towards the goal. Provide instructive coaching to improve behavior towards your goal.

5. **Confrontation**: Confront the group on progress to the goal, their commitment and behavior. Provide real data on performance and behavior and its impact on the goal. Don't speculate on people's motives, use the data and commitment to the shared goal to drive change.

6. **Consequences:** Provide consequences for change, or lack there of. Be consistent with rewards or consequences. These cannot work in isolation, but can help overcome barriers to change.

Measuring Hospital Quality

Staying at the forefront of the rapidly changing world of inpatient medicine is necessary to maintain a top tier hospitalist program. Taking a rigorous, focused approach to measuring quality often means the creation of a quality dashboard to track and improve performance over time. Here's a brief synopsis of how we developed our DHM QI Dashboard:

Quality Improvement Data Selection

How to begin? We looked for metrics that would illustrate quality of patient care we provide as a Division. Due to the overabundance of both process and outcome metrics out there, we knew we couldn't track and measure *all* quality metrics. To create our final dashboard list, we took into consideration:
- Division, Medical Center, and National (CMS) goals
- Current Divisional project focus areas.
- Balancing process with outcome measures
- Indicators that are actionable & can change performance

Understanding your Data

Behind the data. Once the dashboard was created, it was important to understand the data. Important questions asked and included in our definitions page:
- Where does the data come from?
- What are the definitions (including numerator and denominator populations)?
- What are the limitations? For example: are CRI patients included in our VTE rates?

Analyze and Interpret Data

Data says what? We asked ourselves, based on these metrics, where were we doing well and where can we improve? The QI committee first selected target and stretch goals based on benchmarks and historical performance. Each champion then drills down on their data to better understand specific areas in need of improvement to elevate performance and reach their goals. **For example:** How many cases of hospital acquired VTE are appropriately on prophylaxis?

Decide What to Do with the Information

Last but not Least. The most important part of this dashboard is not to stop at abstracting and analyzing data but to use this data to create meaningful improvements. Each champion can then create action plans for improvement which includes disseminating data to stakeholders and engaging them in quick fixes or larger scale improvement projects. **For example:** High mortality for hospital acquired sepsis… how soon are antibiotics started and can we do better?

CALENDAR OF EVENTS

QI SCHOOL

APRIL: QI Methodology with Alison Stroh in Operational Excellence

DOM INNOVATION CHALLENGE

MAY 15: Project Report Due
JUNE 7: DOM Quality & Safety Symposium

RESIDENT QI LUNCHES

M&M type format for Quality Case:
MARCH 21
APRIL 18

FACULTY QI LUNCHES

MARCH 14: Divisional Incentives for Quality and the QI Committee
APRIL 11: Stories from Case Review

CENTER FOR HEALTH PROFESSIONS

APRIL 18: Managing Conflict Effectively
MAY 9: Skillfully Engaging in Difficult Conversations
MAY 9: Working Across Personality Differences