Incorporating Quality Improvement & Patient Safety in Your Practice: Introduction to Methodology in Academia and Private Practice

Part I
Why QI?

“If you can't describe what you are doing as a process, you don't know what you're doing” -

Edward Deming

• US Healthcare economics
• Patient Safety
• Systems Improvement
• ACGME/CLER
• You
HEALTH CARE COSTS: WE’RE NUMBER ONE!

Not only does the U.S. have the highest per-capita health costs in the world, but they’ve been going up faster than in other rich countries for the past three decades - yet we haven’t gotten more or better care for our money.
US Healthcare Costs

• Healthcare costs in US -
  • $253 billion in 1980
  • $714 billion in 1990
  • to nearly $2.7 trillion in 2014

• ~ 30% of healthcare costs (> $750 billion annually) [2]
  • are wasted care,
  • potentially avoidable
  • would not negatively affect the quality of care if eliminated
Quality and Patient Safety

More Efficient Cost of Care

Enhance the Patient Experience

Triple Aim
Patient Safety – Subset of Quality

• Mid 1800s – “Even admitting to the full extent the great value of the hospital improvements of recent years, a vast deal of suffering, and some at least of the mortality, in these establishments is avoidable”

Florence Nightingale
Patient safety

- Institute of Medicine (IOM) defined safety as “freedom from accidental injury”

- AHRQ definition - “Patient safety is a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

- 1999 IOM report - 44,000-98,000 deaths/year due to medical errors
Types of Errors

• **Error or delay in diagnosis** - Failure to employ indicated tests
  Use of outmoded tests or therapy
  Failure to act on results of monitoring or testing

• **Treatment** - Error in the performance of an operation, procedure, or test
  Error in administering the treatment
  Error in the dose or method of using a drug
  Avoidable delay in treatment or in responding to an abnormal test
  Inappropriate (not indicated) care

• **Preventive** - Failure to provide prophylactic treatment
  Inadequate monitoring or follow-up of treatment

• **Others** - Failure of communication, Equipment failure or other system failure
Types of Patient Safety Events

1. Adverse event- Any variation in the process leading to unsafe situations in everyday working life

2. Near Miss- An event that could have resulted in patient harm but did not, either by chance or timely intervention

3. Sentinel Event- Unexpected incident involving death or serious physical or psychological injury or the risk thereof
Patient Safety Tools

- Healthcare Failure Modes and Effects Analysis (HFMEA) or Prospective Risk Assessment
- Root Cause Analysis (RCA) - Retrospective
Root Cause Analysis (RCA)

- The goal of a RCA is to find out
  - What happened
  - Why did it happen
  - What to do to prevent it from happening again
- Tool for identifying prevention strategies
- An effort to build a culture of safety and move beyond the culture of blame
- Basic and contributing causes are discovered in a process similar to diagnosis of disease – 5 WHY’s
Patient Safety – Subset of Quality

• Patient Safety is related to ‘quality of care,’ but the two concepts are not synonymous

• Two dimensions of patient safety-
  • 1st External environment- regulatory/legislative activities and economic incentives
  • 2nd Three domains of quality- safe care, practice consistent with current knowledge, customization

• Patient safety can be due to overuse, underuse and misuse
Quality in Healthcare

• In 1998, the IOM - National Roundtable on Health Care Quality defined as –

• “Quality of care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”
Academic QI- CLER/ACGME

• Late 1990s, IOM conducted a multi-year project to examine pt healthcare quality in the US
• American Hospital Association survey found that newly trained physicians are deficient in communication, system based practice, interprofessional team work
• Need to educate the US trained physicians, residents and fellows to address quality improvement
Aspects of Quality

- Safe - without harm
- Effective - evidence based
- Timely - when needed
- Efficient - avoids waste
- Equitable
- People centered - cultural sensitivity and preferences
QI Work as Systems and Processes
(Donabedian, 1988)

1) What is done (what care is provided)
2) How it is done (when, where, and by whom care is delivered)
Steps for QI

• Identify opportunity and assemble team
• Review literature and best practices
• Identify current practice
• Collect baseline data
• Develop Strategy for improvement using the “Model for Improvement” tool
Idea for developing change

- Evaluate current system
  - Process mapping and RCA
- Best practices and current evidence
- Creative thinking
- Novel ideas
- Use of technology
Principles of QI

• The **current system** is defined as how things are done now

• **Health care performance** is defined by an organization's efficiency and outcome of care, and level of patient satisfaction

• Successful program always incorporates the following **four key principles**:
  • QI work as systems and processes
  • Focus on patients
  • Focus on being part of the team
  • Focus on use of the data
IHI Model for Improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act  Plan

Study  Do

http://www.apiweb.org/images/model.png
Model for Improvement

- A clear AIM
- Run chart/control chart?
- Process/ Systems
Set your AIM (SMART-ly)

• Aim needs to have the following characteristics - “SMART”
  • S- Specific
    • Is the statement precise about what the team hopes to achieve?
  • M- Measurable
    • Are the objectives measureable? Will you know if the changes resulted in improvement?
  • A- Attainable/Actionable/Achievable
    • Is this doable in the time you have? Are you attempting too much? Could you do more?
  • R- Relevant/Reliable/Realistic
    • Do you have the resources needed (people, time, support?)
  • T- Timely/Time bound/Time frame
    • Do you identify the timeline for the project - when will you accomplish each part?

• Example- We aim to reduce CAUTI in post-op patients by 25% from our baseline by June 30, 2018.
Project Metrics

Measure success of pilot - Well defined and can be measured

Examples of processes that can be measured:

• Work in Progress (WIP)
  • How many EKGs are waiting to be read?
• Throughput
  • How many patients are seen in an eight hour period?
• Distance Traveled
  • Total route traveled when putting together a surgery case cart
• Time
  • Time to transport patients to & from rehab
  • Time waiting for results
  • Time to be seen by a doctor
Project Metrics

Examples of Primary & Secondary Metrics

- **Process: Inpatient Stay**
  - Primary metrics
    - LOS
  - Secondary Metric
    - Readmission rate

- **Process: Cleaning a patient room**
  - Primary metric
    - Cycle time
  - Secondary metric
    - Hospital acquired infection rate
    - Patient satisfaction scores
PDSA/PDCA – Edward Deming

- **Plan**
  - Objective
  - Questions and predictions (Why?)
  - Plan to carry out the cycle (who, what, where, when)

- **Act**
  - What changes are to be made?
  - Next cycle?

- **Do**
  - Carry out the plan
  - Document problems and unexpected observations

- **Study**
  - Complete the analysis of the data
  - Compare data to predictions
  - Summarize what was learned

- **Plan**
  - Objective
  - Questions and predictions (Why?)
  - Plan to carry out the cycle (who, what, where, when)
Seven QI tools

- **Cause-and-effect** diagram (also known as the "fishbone" or Ishikawa diagram)
- Check sheet
- Control chart
- Histogram
- Pareto chart
- Scatter diagram
- Stratification (alternately, flow chart or run chart)

Pareto Chart of HHC Patient Concerns

- Long Wait: 73 responses (35.1%)
- Old/Few Magazines: 37 responses (52.9%)
- Crowded Waiting Room: 35 responses (81.7%)
- Provider Continuity: 25 responses (91.3%)
- Not Enough Time w/ Physician: 20 responses (100%)

Response Categories (N = 208 Total Responses)
Run Chart

CVL-BSI Events
Infection = ALL
119 Days since last reported event

Days since last event

Days Between Events

Date

Apr 24, 2008 14:53:23
Control chart

Figure 2: Control Chart of IV Waste

% of IV Waste

Week

UCL - 20.9

Avg. - 11.4

LCL - 1.9
Normal distribution and Control chart

Figure 5.6. The relationship between a normal distribution and a control chart.
“Success is the ability to go from one failure to another with no loss of enthusiasm”

Sir Winston Churchill
Repeated Use of the Cycle

Hunches Theories Ideas

DATA

Changes That Result in Improvement
“I didn't fail the test, I just found 100 ways to do it wrong”

Benjamin Franklin
### Background

Challenges identified in process mapping: low evaluation completion percentages, the programs resident scheduling cadence was not in alignment with evaluations being delivered, the assessment system was not in alignment with accreditation milestone standards, resident evaluations were identified as not reliable when used by multiple evaluators, evaluations were too complex and had too many questions, anecdotal feedback was minimal and aggregate reporting data did not assist in identifying root causes.

### Action Plans

<table>
<thead>
<tr>
<th>Initiatives/ Goals</th>
<th>Actions/Specific Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Revision/Creation</strong></td>
<td>Meet with all SEC’s / Content Experts across enterprise</td>
</tr>
<tr>
<td></td>
<td>Revise all Evaluations and break down by Sub-Competency most relevant to Sub Specialty</td>
</tr>
<tr>
<td></td>
<td>Draft all new Evaluations in MedHub and Simulate</td>
</tr>
<tr>
<td></td>
<td>Go Live</td>
</tr>
<tr>
<td></td>
<td>Monitor Return Rate</td>
</tr>
<tr>
<td><strong>Messaging and Education</strong></td>
<td>Pre and Post Go-Live Messaging to Subspecialties</td>
</tr>
<tr>
<td></td>
<td>Ongoing data delivered to institute chairs</td>
</tr>
<tr>
<td></td>
<td>SEC’s provides quarterly evaluation data SEC Meetings</td>
</tr>
<tr>
<td></td>
<td>IMRP Advisors to monitor completion rate</td>
</tr>
<tr>
<td><strong>Sustainment Plan</strong></td>
<td>Educate Residency Coordinators Sub Spec Programs</td>
</tr>
<tr>
<td></td>
<td>Ongoing data delivered to institute chairs</td>
</tr>
<tr>
<td></td>
<td>Monitor Evaluation Completion CCC</td>
</tr>
<tr>
<td></td>
<td>Assess Evaluation Completion Rate at 6 Months</td>
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</tbody>
</table>

Lean A3 to problem solving for root causes and create action plans. ACGME 1/4 Accreditation Council for Graduate Medical Education; CCC 1/4 clinical competency committee; SEC 1/4 subspecialty education coor
We appreciate your participation...

Thank you!

Please stay tuned for Part II of the session this afternoon!
• Giri Andukuri, MD, MPH
  Assistant Professor
  GME Physician Lead QI &PS
  IM Faculty QI Champion
  Creighton University School of Medicine
  Academic Hospitalist
  CHI Health Clinic

• Ann Polich, MD, MPH
  Vice President of Quality and Safety
  Nebraska Methodist Health System
Incorporating Quality Improvement & Patient Safety in Your Practice: Introduction to Methodology in Academia and Private Practice

Part II
Current State of Healthcare

- Uncertainty
- Volume over Value
- Over Utilization
- Silos of Care
- Variation in Care
- Unsustainable High Cost
- Increased Patient Financial Responsibility
HEALTH CARE COSTS: WE’RE NUMBER ONE!

Not only does the U.S. have the highest per-capita health costs in the world, but they’ve been going up faster than in other rich countries for the past three decades - yet we haven’t gotten more or better care for our money.

Source: The Commonwealth Fund
And hospital visits for chronic conditions are common.

**Congestive heart failure**
- United States: 441
- Canada: 146
- United Kingdom: 117

**Asthma**
- United States: 120
- Canada: 18
- United Kingdom: 76

**Diabetes acute complications**
- United States: 57
- Canada: 23
- United Kingdom: 32

*Hospital admissions per 100,000 people age 15 and older, 2007*

Notes: United States does not fully exclude day cases.
Data is from 2007 or nearest year.
Source: OECD Health Care Quality Indicators Data 2009,
The Commonwealth Fund
Americans don’t live longer than people in countries that spend much less on health care.

Notes: Data is from 2011 or nearest year. New Zealand numbers exclude investments. Not all OECD countries are included.
Source: OECD Health Data 2013
U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

### Overall Health Care Ranking

<table>
<thead>
<tr>
<th>Country</th>
<th>Rank</th>
<th>Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.K.</td>
<td>Low</td>
<td>🇬🇧</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Low</td>
<td>🇨🇭</td>
</tr>
<tr>
<td>Sweden</td>
<td>Medium</td>
<td>🇸🇪</td>
</tr>
<tr>
<td>Australia</td>
<td>Medium</td>
<td>🇦🇺</td>
</tr>
<tr>
<td>Germany</td>
<td>Medium</td>
<td>🇩🇪</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>Medium</td>
<td>🇳🇱</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Medium</td>
<td>🇳🇿</td>
</tr>
<tr>
<td>Norway</td>
<td>Medium</td>
<td>🇳🇴</td>
</tr>
<tr>
<td>France</td>
<td>Medium</td>
<td>🇫🇷</td>
</tr>
<tr>
<td>Canada</td>
<td>Medium</td>
<td>🇨🇦</td>
</tr>
<tr>
<td>U.S.</td>
<td>Low</td>
<td>🇺🇸</td>
</tr>
</tbody>
</table>

High U.S. Health Care Spending Is Largely Driven by Technology Use, Prices

Despite spending more on health care, the United States generally has worse health outcomes than other high-income nations, including higher rates of chronic conditions and infant mortality and lower life expectancy.

High spending in the U.S. is largely the result of greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions.

### MRI exams per 1,000 people (2013)

- Canada: 53
- U.S.: 107

### Bypass surgery (2013)

- Netherlands: $15,742
- U.S.: $75,345

### Annual physician visits per person (2013 or nearest year available)

- U.S.: 4.0
- Median of 34 high-income countries*: 6.5

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*Includes 34 member countries of the Organization for Economic Cooperation and Development (http://www.oecd.org/about/membersandpartners/)

Mandatory Spending in 2016

Billions of Dollars

- Major Health Care Programs: $1,116 Billion
  - Medicare: $662 Billion
  - Medicaid: $368 Billion
  - Other: $36 Billion

- Social Security: $910 Billion
  - Old-age and Survivors Insurance: $767 Billion
  - Disability Insurance: $144 Billion

- Income Security Programs: $304 Billion
  - Earned Income Tax Credit: $85 Billion
  - Supplemental Security Income: $59 Billion
  - General Assistance Programs: $54 Billion
  - Other: $33 Billion

- Federal Civilian and Military Retirement: $164 Billion
  - Civilian: $99 Billion
  - Military: $62 Billion
  - Other: $3 Billion

- Veterans’ Benefits: $107 Billion
  - Income Security: $87 Billion
  - Other: $20 Billion

- Other Programs: $66 Billion
U.S. Demographic Projections

Changing shares of the total U.S. population in different age cohorts, 2000-2050

U.S. Demographic Projections

Changing shares of the total U.S. population in different age cohorts, 2000-2050

- 85 and older
- 65 to 84
- 45 to 64
- 20 to 44
- 5 to 19
- 0 to 4

<table>
<thead>
<tr>
<th>Year</th>
<th>0 to 4</th>
<th>5 to 19</th>
<th>20 to 44</th>
<th>45 to 64</th>
<th>65 to 84</th>
<th>85 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>6.8</td>
<td>21.7</td>
<td>36.9</td>
<td>24.9</td>
<td>14.1</td>
<td>10.9</td>
</tr>
<tr>
<td>2010</td>
<td>6.9</td>
<td>20.0</td>
<td>33.8</td>
<td>26.2</td>
<td>22.6</td>
<td>11.0</td>
</tr>
<tr>
<td>2020</td>
<td>6.8</td>
<td>19.6</td>
<td>32.3</td>
<td>24.9</td>
<td>22.6</td>
<td>14.1</td>
</tr>
<tr>
<td>2030</td>
<td>6.7</td>
<td>19.5</td>
<td>31.6</td>
<td>22.6</td>
<td>17.0</td>
<td>2.6</td>
</tr>
<tr>
<td>2040</td>
<td>6.7</td>
<td>19.2</td>
<td>31.0</td>
<td>22.6</td>
<td>16.5</td>
<td>3.9</td>
</tr>
<tr>
<td>2050</td>
<td>6.7</td>
<td>19.3</td>
<td>31.2</td>
<td>22.2</td>
<td>15.7</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Exhibit 1.1

People ages 80 and older accounted for 24 percent of the Medicare population and 33 percent of Medicare spending in 2011.

Distribution of traditional Medicare beneficiaries and Medicare spending, 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Share of beneficiaries</th>
<th>Share of spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 80+</td>
<td>24%</td>
<td>$375 billion</td>
</tr>
<tr>
<td>Age 70-79</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Age 65-69</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Under age 65</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Analysis excludes beneficiaries with Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of a 5 percent sample of Medicare claims from the Chronic Conditions Data Warehouse, 2011.
Exhibit 1.2

Traditional Medicare per capita spending increased with age in 2011 and peaked at age 96 before declining; the pattern is similar when decedents are excluded.

Medicare per capita spending for traditional Medicare beneficiaries over age 65, including and excluding decedents, by age, 2011

All traditional Medicare beneficiaries age 66+ (average = $9,839)

Full-year survivors in traditional Medicare age 66+ (average = $8,647)

NOTE: Analysis excludes beneficiaries with Medicare Advantage. *Analysis excludes people age 65 because some of these beneficiaries are enrolled for less than a full year; therefore, a full year of Medicare spending data is not available for all people at this year of age.

SOURCE: Kaiser Family Foundation analysis of a 5 percent sample of Medicare claims from the Chronic Conditions Data Warehouse, 2011.
Percent Distribution of National Health Expenditures, by Type of Sponsor, 1987, 2000, 2010

Notes: Starting with the 2009 NHE data, CMS expanded their focus on spending by Type of Sponsor, which provides estimates of the individual, business, or tax source that is behind each Source of Funds category and is responsible for financing or sponsoring the payments. "Federal" and "State & Local" includes government contributions to private health insurance premiums and to the Medicare Hospital Insurance Trust Fund through payroll taxes. Medicaid program expenditures including buy-in premiums for Medicare, and other state & local government programs. "Private Business" includes employer contributions to private health insurance, the Medicare Hospital Insurance Trust Fund through payroll taxes, workers' compensation insurance, temporary disability insurance, workplace health care. "Household" includes contributions to health insurance premiums for private health insurance, Medicare Part A or Part B, out-of-pocket costs. "Other Private Revenues" includes philanthropy, structure & equipment, non-patient revenues.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group at https://www.cms.gov/NationalHealthExpendData/ (see Historical: NHE Web tables, Table 5).
Our Existing Business Model

Staying Afloat Through Cross-Subsidization

Traditional Hospital Cross-Subsidy

Commercial Insurance  
- Above-cost pricing  
- Robust fee-for-service volume growth  

Public Payers  
- Steady price growth  
- Only one component of our total business

Above Cost  

149%  
Hospital Payment-to-Cost Ratio, Private Payer, 2012

Below Cost  

86%  
Hospital Payment-to-Cost Ratio, Medicare, 2012
Health Care Expenditures

National Health Expenditures and Projections, 2006 - 2022

Payment Reform - Why It Matters

• Fee For Service unsustainable as cost escalating

• Quality measures relate to OUTCOMES so can be directed to efficiency and effectiveness of care
Change In Healthcare

• Data management and care delivery is key to high performance

• Can’t cut your way to financial competitiveness, have to improve efficiency and effectiveness of your healthcare delivery system
Mark Twain

“What's the use you learning to do right when it's troublesome to do right and ain't no trouble to do wrong, and the wages is just the same?”
Current Physician Compensation Plans

• Largely based on production
• Measured by RVUs, clinic visits, panel size
• Going forward will need to be revised to encourage practice habits that drive quality and reduce cost
REFOCUSBING CLINICIAN INCENTIVES FOR THE AGE OF MACRA

Focus for Rewards

2015, MOVING TOWARD PAY FOR VALUE

2017, FINE-TUNING PAY FOR VALUE

2019+

Measurement weighting, illustrative example

Source: Oliver Wyman, Mercer

#OWHealth
health.oliverwyman.com
MACRA

- Medicare Access and CHIP Reauthorization Act
- Bipartisan support of MACRA Quality Payment Program
- Zero Sum equation
- Places Medicare Part B revenue at risk of downward adjustment
Medicare B- Payments to Physicians

CMS Shift to Value Based Payments

**MACRA**
(Medicare Access & CHIP Reauthorization Act)

**MIPS**
(Merit-Based Incentive Payment System (>+/-.4%)
- **0% Cost** (deferred until 2018) (replaces Value-Based Modifier)
- **60% Quality** (Physician Quality Reporting System: PQRS and 6 VBM quality measures)
- **15% Clinical Practice Improvement** (i.e., PCMH)
- **25% Advancing Care Information** (Replaces Meaningful Use – interoperability, EHR Utilization, etc.)

2017 Measure Only

2019 Implement

Publicly Reported

**APM**
(Alternate Payment Models (>+/-.5%)
- PCMH
- MSSP ACOs
- Next Generation ACO
- CPCII+

- Requirements:
  - Notify CMS by 2017
  - Shared Savings
  - Use EHR
  - Submit Quality Measures
PICK YOUR PACE FOR MIPS REPORTING IN 2017

DON'T PARTICIPATE
Not participating in QPP:
If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

SUBMIT SOMETHING
Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

SUBMIT A PARTIAL YEAR
Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

SUBMIT A FULL YEAR
Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.
MACRA Models

Advanced Alternative Payment Models (APMs)
- Higher risk model
- Risk is shared throughout APM
- Limited number of acceptable models
- Rules to being considered a qualified provider (QP)

Note: APM = Risk

Merit Based Incentive Program (MIPS)
- Designed for individuals and small group practices
- Not all or nothing. Can receive partial credit. Incentive based on sliding scale.
- Replaces all current incentive programs
- Fee for service with adjustments based on performance

Most Providers are expected to choose MIPS
MACRA Progression

- Advanced APM
  - Global Payments
  - Shared Risk
  - Shared Savings
  - Bundled Payments
- APM
- MIPS
  - Performance-Based Contracts
  - Fee for Service

Advanced APMs:
- CPC+
- MSSP Tracks 2 & 3
- Next Gen ACO
- Oncology Care 2 Side Risk
- Comprehensive ESRD Care Model

Barnett 2016: MACRA Overview
2018: 90% of Medicare payments tied to quality.

2020: 75% of commercial plans will be value-based.

Local Assistance

• [https://www.nehii.org/](https://www.nehii.org/)
• Health Information Initiative (NeHII) has partnered with the Compass Practice Transformation Network
• TCPI was introduced by the Centers for Medicare and Medicaid Services (CMS) in 2015 to help clinicians achieve large-scale clinical transformation.
• TCPI provides technical assistance for eligible providers to succeed in value-based care environments, as defined by MACRA
NeHII and TCPI

• Technical assistance to more than 750 clinicians in Nebraska over the next two years of TCPI,

• by using its data infrastructure and quality improvement staff to move the clinicians through five stages of transformation:

  1. Setting aims with clinical and process measures
  2. Using clinical data to drive care decisions in areas (such as HbA1C control, breast cancer and colorectal cancer screening rates and reducing hospital readmissions)
  3. Achieving progress on aims
  4. Achieving benchmark status in local, regional and national clinical data sets
  5. Thriving as a business via pay-for-value approaches (private and commercial value-based contracts)
Five steps to approach organizational development

- Perform a practice assessment
- Develop and share a vision for your practice
- Designate and train your change team
- Document your progress with a project management approach
- Design systematic and sustainable changes
- www.stepsforward.org
Final Thoughts

- Start improvement where you have control
- Need “small wins so you can stay alive to fight the war”
- Exert your leadership and influence where you don’t have direct control
Questions?

Thank you!
• Giri Andukuri, MD, MPH
  Assistant Professor
  GME Physician Lead QI & PS
  IM Faculty QI Champion
  Creighton University School of Medicine
  Academic Hospitalist
  CHI Health Clinic

• Ann Polich, MD, MPH
  Vice President of Quality and Safety
  Nebraska Methodist Health System