

AHEAD Podcast 14 – Planning for Sustainability in Quality Improvement

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to the AHEAD Initiative podcast series focused on sharing evidence-based practical strategies to improve diabetes outcomes and advance diabetes health equity. I'm Dr. Michael Konstan from Case Western Reserve University School of Medicine and I serve as the principal investigator for the Northeast Ohio Quality Improvement Hub, a collaboration of Western Reserve University with Northeast Ohio Medical University. The Northeast Ohio QI Hub is funded by the Ohio Department of Medicaid and provides quality improvement infrastructure for primary care clinics in our region. We hope you enjoy today's ahead initiative podcast.

Aleece Caron: Welcome to our Achieving Health Equity and Diabetes Ahead podcast series for the Northeast Ohio Quality Improvement Hub. My name is Dr. Aleece Caron and I am the co-lead of the quality improvement and implementation team for the Northeast Ohio Quality Improvement Hub, and I am a professor of medicine at Case Western Reserve University and the Metro Health System. Today I am chatting with Dr. Jim Campbell about sustainability and quality improvement. Dr. Campbell is a practicing geriatrician and health equity researcher and is a professor of family medicine at Case Western Reserve University and the Metro Health System. He also serves as the chair of geriatrics. Thanks so much for talking with me today, Jim. I'm really excited to get started.

Jim Campbell: Thank you so much for bringing me on.

Aleece: How exactly would you define sustainability when we're talking about quality improvement?

Jim: So, sustainability is really how do you take quality improvement from a brief project intervention to an actual change in clinical practice. ICE team practice where you really work to make sure that the culture of the institution you're working with adopts the change where the change has financial sustainability, operational sustainability so that you go through the hard work of figuring out what needs to change, how you want to change it. This is how do you make sure that that change will still be there six months later, two years later as opposed to sort of you succeed during the change phase and then once you're done actually looking closely things fade back to normal.

Aleece: Thanks Jim. And why should we really care about sustaining our quality improvement efforts?

Jim: Well, it really comes down to trying to figure out how do you make it so that you can actually make the process and the practice of clinical medicine better. We know that quality improvement is very good at diagnosing the problem, figuring out where the barriers are to getting the outcome you want. Say for example, you're trying to improve your blood pressure control. We're very good at figuring out, well, this is the reason that, you know, patients are not coming in. We're not measuring their blood pressure two or three times. We're not following up quickly. We're not doing this. We're not doing that. And what you try to do is you try to put an implemented change in their practice. The quality improvement part measures whether that implemented change was effective.

So, you say, okay, we're going to try to see everybody who's had an abnormal blood pressure back within two weeks. That's going to be helpful. That's going to work. But that's a change in the way the team is processing a patient. That's a change in the way the person is checked out of the clinic in the way the person is contacted for follow-up, how you do the follow-up. So, what you do with a sustainability practice is that you basically figure out not only okay, we know what we need to fix, but we need to understand how do we make that work? How does that fit into the flow of the clinic? How does that fit into the flow of the provider? How does that work in terms of did we create a situation where now they need a new employee in order to be able to accomplish the change, or did we get it in such a way that it actually works pretty well without a whole lot of changes in the background so that it's financially sustainable. The problem is that we all believe in quality but we're also all desperately trying to figure out how do we do things with a very narrow margin particularly in primary care. Primary care is not a high-income sort of operation. So, we want to do things in a way that is not overly costly and still achieves a sustainable change.

Aleece: So, it sounds like you know just to paraphrase a little bit Jim, and you can add on to this. It sounds like it's a lot of work and a lot of resources to do some of these projects.

Jim: It is a lot of resources and it's a lot of work to put the project together. And normally what you do is you do the project in bites and chunks. Okay? So, you figure out, okay, well, we we're not having a good outcome with blood pressure. And I'll come back to that because that's just an easy one to work with. So, your first chunk is saying, okay, are we measuring their blood pressure correctly? And then you sort of work with that process and you train the staff and you train the providers on how to do repeat blood pressures, how to have the person in the right position, right size cuff, whatever it is. But if you don't actually make that a part of the culture, the way you're going to do business. We know that providers turn over. We know that staff turns over. We know that sort of the way clinics are working turns over.

So, we have to make sure that we have internal champions who are keeping that going. And then you go to the next step. You say, "Oh, okay. Well, now we want to make sure that everybody comes back in two weeks." So, then we put in a new change that says, "Oh, we're going to put an order in for them to come back in two weeks." Well, you got to figure out who's

going to put that order in. How's that order going to be put in? And how's that follow-up going to be made? Do you have access for that person to get back, or can you make it so that that follow-up visit is done by a nurse? So, it doesn't have to be the primary care who we know is sort of booked three months out. So, you look at those barriers and then you sort of fix that piece because if you try to do it all at once, you're going to get into trouble.

But the other things that are very important is to make sure that you have champions on the team and that's not you. That's not the person who's coming in to help diagnose and implement the change. That's somebody usually from every level of the workforce. So, you need somebody who's front desk, check in, check out. You need somebody who's the MTA who's doing the actual putting them in a room and checking their blood pressure and asking about polls and all those other things. You need the person who's actually doing the nursing and doing the blood draw. You need the provider and you know the A or the physician who's actually putting in the medication changes. And it's good to have a champion in each of those levels. One of the other pieces that's critically important is that you have a member of the actual patient population because the patient population will tell you what—well, you all have this belief about how things are working. This is how they're really working and you suddenly have a whole lot of additional information, and they will actually also help to advocate to make that change more sustainable over time.

Aleece: Thanks Jim. That was a really thorough answer. I think you know that will really help our listeners understand what they need to do to ensure sustainability at least part of it anyway. I think we'll get into it a little bit more later on. So ideally when would you start planning for sustainability?

Jim: You really need to plan for sustainability day one. Because if you do it all for a while and then you say, "Well, this was so great." And then you sort of quote unquote try to sell it and you say, "Look at our great results. Now y'all should just buy into this." That's not nearly as powerful as having, oh well, the nurse who was your champion who worked with the other nurses in the clinic were there at the point that you developed the change and the flow in the change. She's made sure that fits into her day-to-day world. You have the MTA who's the champion who works with all the other MTAs who buys into saying, "I was part of putting this together." You have the patients who are telling you reality and helping you understand and they, you know, will help get you buy in. And then you got to have the providers on board and the front desk on board. But Everybody who feels like they were part of the change is going to be far more invested in making sure that that change is sustained as opposed to feeling like, well, okay, a bunch of, you know, people from down the street came in and decided we should do something better. And then all of a sudden, you tell them, well, here's how we proved you can do it better. Why don't you just do it better? That's just not the way people work. People like to feel involved and then they'll feel more invested long term.

Aleece: Thanks, Jim. One follow-up question around that. As an organizational or a department leader, we're talking about planning early for sustainability. How important is it for the team to get somebody like you as the department chair their buy in or, you know, a clinic director or something like that?

Jim: You have to have buy-in at all levels. You know, I've talked a little bit about how important it is to have buy-in at what you think of as the frontline level. The people who are actually doing the work and doing the change but you have to have buy-in of the clinic director the department chair and whoever is in charge whether it's sort of you know if you're in an FQC having the leadership of that FQC if you're in a health system having the leadership of that health system if you've got a business person who's helping to sort of manage the business side of your clinic you got to have that person involved because if they think that what you're doing is financially unsustainable, I can almost guarantee that you're going to have a great problem keeping that change in place.

So, you really got to go from the patient through the frontline staff as high as you can possibly get it. What I do sometimes as a trick is I sort of say, you know, oh well, we're going to institute this change and you know, I talk to the business people and I say, you know, as we're putting this together, I want to make sure that I'm not doing anything wrong. So, will you please review this with me and, you know, get them sort of involved and again, just as you asked with the last question at least day one, don't bring the businesspeople in after the fact and then try to sell it to them. They're human just like the rest of us. Although sometimes you don't think so, but they will actually, you know, if they feel like, oh, I was a part of putting this together. I looked at the financials, and you know they also might even help you. They might say you know did you realize that if your blood pressure control is better time over time you're going to get more money based on your acco or direct contracting entity or any of the value-based products have quality measures and if you do better on the quality measures it actually brings in physical dollar real money. And you know, at a big health system, we're talking millions of dollars. So, you want to have them on board and say, you know, hey, if I can get our, you know, blood pressure control from, you know, 70% to 80%. That's going to bump us up and that's going to improve our overall financial outcome. So, it's, you know, even though maybe we do need another half of an FTE in the clinic, it's more than going to pay off downstream.

Aleece: So, getting by in early for sustainability is really, really important and at all levels of the organization. What are some barriers to sustainability?

Jim: Time and space. Okay, it sounds silly, but that's really what it's all about. And in this case, you know, it's the old-fashioned time, but time is money. So, you know, anything that takes time is dollars, you know. The example I like to give is sort of we wanted to do alcohol screening in the emergency room, and we wanted to do a four-question test, and the four-question test takes yeah whatever you know a minute and a half to deliver and get the answers to. Well, somebody in the background said okay so you're spending a minute and a half on every patient We see 300 patients a day. That's six, you know, 450 minutes a day divided by 60, that's more than eight hours a day. You've just forced me to buy one new FTE because I have eight hours of additional work per day for that department. That's what I mean when I say time is money.

And it's also a matter of sort of space, particularly like when you're in a clinic where you're trying to do a lot of volume and turnover, which unfortunately we're all in that business. If you're sort of saying, well, we need to check their blood pressure three times. Are you going to do that in the exam room, which is sort of the most costly space because that's the space that the patient

goes into, the provider goes into, you know, or can you move that down to a, you know, an alternative location so that you can keep that exam room turning over. You really got to be very careful to make sure that your change does not impede flow. It doesn't impede productivity and so that it's able to be sustained without people saying, "Boy, I really hate this."

Aleece: And you already talked about how important it is to try and embed some of these changes into existing workflows and to get, you know, the buy in of staff, get staff and leadership engaged early on. And we know that there are always competing demands especially in primary care when we're talking about these things. They've talked about blood pressure control and alcohol you know uh screening and things like that but it's all you know primary care providers have so many other things that they need to think about and when we say to them let's talk about this quality improvement initiative it's really important as you mentioned to get their engagement early on and like what's the carrot in it for them why are they incentivized and I don't want to say monetarily but you know It's that whole adaptive leadership model of meeting them where they are, which you're really good at.

Jim: I want to say one thing that's sort of a side answer and then I'll get to the real question, but I want to make the point that it's not just about getting buy in. It's also about the front line will give you the best idea. Okay. As you talked about, the primary care provider has, you know, all these different aspects they're trying to get to. Right. So, when we did one of these blood pressure interventions and thought the person needed potentially extra attention to their blood pressure, one of the frontline staff members said, "Well, just, you know, laminate some index cards that are bright red that say stop on them and actually post them to the door so that the provider says, "Oh, this person has a blood pressure issue." Okay? As opposed to having to look at a large epic EMR screen that's got, you know, it looks like CNN. It's got things running all over the place and you're like, "Oh, well, I did—I missed that piece of the puzzle."

Aleece: I also know one of the things that you're really good at is acknowledging the work that people put into these projects and celebrating them when they're successful. You've got a lot of experience with this, and you tend to understand that these projects take time. So, often you really are successful in your in your QI initiatives and when you're not you know it's one of those let's learn from our failures.

Jim: Well, I think the other question was really sort of getting to the point of what's in it for them and the reality is they want the patients to get better too. So, you got to make sure that sort of if you achieve better blood pressure control which you will that you give them regular feedback. You say you know do you realize that we have improved our blood pressure control by 10% And that means we have just prevented people from having a stroke, a heart attack, going on dialysis. You know, nobody in healthcare, you know, they all I mean, understand we're all here because we have to make a living as well. But primarily, we're here because we want to help people. And if you can show them results that show, hey, what we have done has made us better able to help people, that's a huge satisfier. People quickly say, "Oh, that's great. Let's see

if we can't get to 78% instead of 75." You know, they they really will say, "Oh, that's wonderful. Let's do more."

Aleece: So, you bring up what I was really wanted to delve into next, Jim, which is data. You can't improve what you can't measure. And you just cited an example of, you know, a 10% improvement in blood pressure control. So, how difficult is it to obtain data for your QI project? And how do you do it? And what would you recommend to others?

Jim: It's another one where you go back to day one, okay? And when you're on day one, you start asking the question, what data exists? And can I use existing data? 99 times out of a hundred, the data is there. It's a matter of figuring out how to harvest it and then how to get it so that you're harvesting it without anybody having to do any work. So that it becomes a routine rotating report. It's a little challenging oftentimes to get that routine renewing report put together, but once it's together, you can get a report that you just clump out, and it comes to you either once a month or it comes to you whenever you ask for it. So that you can say, "Okay, I've got, you know, 3,800 patients in my clinic. Here's their blood pressure. Here's how many of them are in control. How many of them are out of control?" And I run that at the end of September, the end of October, the end of November. And I can say, Oh, well, you know, we had 68%, now we're at 72, now we're at 77.

Don't try to say, I need the perfect data. You need good enough data. And if good enough data means you can use a data source that already exists, you've taken away one of those barriers to sustainability. And you got to make sure that your data processing by the time you're really good to go is automated because if you're dependent on a person to pull data out for you once a month, that's going to be very hard to get that to be lasting. You've got to be able to push a couple of keys and have the computer do it for you as opposed to having to say, "Well, I need a data analyst to be on board for the rest of my time."

Aleece: Jim, you're in a different position than I think some of our listeners might be and that you're in a leadership role, so you might be able to direct some of those resources for somebody who's just getting started in QI or isn't in a leadership role like you are. How would you recommend that they get started in pulling data from the EHR to support their quality improvement efforts?

Jim: It really is you got to get some friends in EHR. You get a couple of people who can work with you and learn, you know, whether it's slice or dicer, which is what's in Epic, or it's this or it's that. You know, you got to sort of become familiar with the system. But make some friends, you know, and have them help you understand. If you get them to say, "Hey, you're sitting there working in a back office on a computer program, but I can have you feel like you've improved the control of patients blood pressure." They're going to say, you know, that sounds like something I'd like to do. That's like something worthwhile. And they will they will help you. And then once you've done it once, then it's the Same thing. Then you give them feedback. You say, "Oh, did you know what you did for me last six months ago? We've improved their blood pressure control month over month. Thank you very much." And they'll say, "Oh, okay. Sure. No problem."

And then when you go back to them to say, "Now I want to improve their hemoglobin A1C and improve their diabetic control." They'll say, "Oh, how can I help?" Okay. You know, it's it's that same, you know, they are a part of the puzzle. And so, you know, because you're not going to be you're not going to be a master at the EHR. I mean, I've been here for 31 years, and I still am not a master at the EHR. Okay. That that I need a I need a lot of professional help with that.

Aleece: Sounds like the themes that I'm hearing is that, you know, you you want to find somebody who can really support the work and understands EHR, but as I pointed out before, you you go back and you recognize them for their hard work. That's really key. Recognizing them for their hard work, celebrating the successes and sharing those successes are really, really important too. Thank you, Jim. This has been a great conversation.

Jim: I appreciate your time and I appreciate everyone who's, you know, working on the good work to try to make this a better environment, improve patient care, and make the quality improvement that will change the culture and improve the care of patients for months to years to come.

Aleece: And thank you for listening to the AHEAD podcast. As always, please find more resources on NEOQIHub.org. Subscribe on your favorite podcast platform so you never miss an episode.

[Voiceover] Michael: This concludes today's Ahead Initiative podcast. To learn more about the Northeast Ohio QI Hub, visit NEOQIHub.org. The Northeast Ohio QI Hub is part of the regional quality improvement hub project funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. Views stated in this podcast are those of the presenters only and are not to be attributed to the Ohio Department of Medicaid or to the federal Medicaid program.

[Jazzy instrumental outro music]

The Northeast Ohio Quality Improvement Hub is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this podcast are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.

