Podcast 23 - Quality Improvement in Clinical Practice: How to Tell Your Story

Transcript

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular and Diabetes Health Collaborative, also known as Cardi-OH. This is Dr. Michael Conston from the Case Western Reserve University School of Medicine, and I serve as the principal investigator for Cardi-OH, a statewide network of Ohio 7 Medical Schools. Cardi-OH is funded by the Ohio Department of Medicaid, and shares best practices to improve cardiovascular health, diabetes outcomes, and to eliminate health disparities in Ohio's Medicaid population. The opinions and recommendations in this podcast are those of the presenters and not those of Cardi-OH and its sponsors and are not intended to be a substitute for medical advice. I hope you enjoy today's podcast.

Chris Bernheisel: I'm Chris Bernheisel. I'm an associate professor in family medicine at the University of Cincinnati. I'm a family physician and a member of Cardi-OH's team best practices. In this podcast, we will discuss the power of storytelling in quality improvement and the elements of a strong performance story. We will then hear a performance story from one of our guests. With me today to talk about performance storytelling are Dr. Aleece Caron and Dr. Joe Daprano. Dr. Caron is associate professor at medicine at Case Western Reserve University, co-director of education for the population health research institute in the Metro Health System in Cleveland, Ohio, and a member of Cardi-OH's team best practices. Dr. Caron's research focuses on quality improvement and primary care transformation. She has worked extensively with clinicians and students on quality improvement initiatives. Dr. Daprano is a primary care physician in internal medicine pediatrics, assistant professor of medicine at Case Western Reserve University, and a subject matter expert for Cardi-OH. His career has focused on providing high quality care to patients in the inner city of Cleveland and he currently serves as associate director of quality improvement from Metro Health Adult Wellness Service Line. Thank you so much for being here today.

Aleece Caron: Thank you for having us.

Bernheisel: One of the things I thought of when I heard this initially, this podcast coming up was what does it exactly mean to say performance story? I was hoping you could share a little more information for me and also for our listeners. What do you mean when you say perform a story?

Caron: Sure, Chris. So, we can all learn from others experiences with testing and implementing changes in real settings and which changes work best, which didn't work at all, and what lessons were learned. I kind of want to emphasize that sometimes it's okay to tell a performance story that doesn't work because we all want to know what doesn't work, so we don't try it. We tell these stories to really accelerate our collective learning and describe the improvement journeys and experiences of individuals, teams and organizations and importantly their patients and their families. So we share lessons learned, bright spots, possibly a promising practice. No matter what

the result is, these stories are about making changes. And there's a variety of mediums you can use to reach your audiences. You could use a webinar, you could use a storyboard, or you can just talk about what you did and how well it worked. And you'll highlight certain aspects of the story depending on the audience. We'll talk about that a little bit later. Sometimes the performance story is not complete or the project is still in process. It's important to share these incomplete stories to demonstrate what's going well and what might not be going as well. And these stories are great learning opportunities for practices working on similar interventions or practices thinking about getting started in quality improvement. For another initiative I co-lead, we use quarterly webinars for teams to share their works in progress. It's very informal and they often don't use slides, but it allows them to share their successes and challenges and get input from other teams working on similar projects and learn what other teams are working on and ask questions about their projects. It's a really safe environment where they can share things that may not be working so well and get advice. And this can also be really powerful information for leadership if they're considering how to expand quality improvement efforts and where they want to put their resources.

Bernheisel: Thanks, Aleece. I think I want to kind of follow up on that last part there. Why is it important to share your performance story?

Caron: So, One of the most important reasons is acknowledging the hard work that the team does and celebrating that work. That really helps add to joy in work and job satisfaction. And there's a lot of evidence that shows that participating in quality improvement can really reduce burnout. It's also a really great opportunity to convince leaders and motivate leadership and peers to participate and make resources available to do quality improvement. And stakeholder buyin is important, but you can't get the buyin if they don't know what's going on. And communicating important information in an engaging way to your audience is also really important. It can serve as a sales pitch to your potential partners or your stakeholders. And it really also helps provide a record of the work.

Bernheisel: Gosh, with so much burnout that we see, especially with COVID over these past couple years, it sounds like this pretty powerful tool not only for helping burnout but also motivating. Thanks so much for sharing about that. What are some challenges practices face when telling their performance stories?

Caron: In many cases, it's often difficult for them to get started because there's so much going on in their performance story. So, they're challenged in describing the impact of their quality improvement work and demonstrating how their work is impactful. This is often difficult because in many cases, the audience is only really interested in the results. So, if you're presenting to a CEO or leadership, they just really want to know what you did. Really, the process of how the practice achieved the results is also important. And practices sometimes struggle to showcase the outcomes of their work to a variety of audiences and may want to work with a practice coach or a practice facilitator to support them in developing their performance stories for different audiences.

Bernheisel: Tell me a little more about that. Why is it important or is it important to consider the audience for this story?

Caron: Yeah, it's very important to determine the audience for your performance story prior to developing it. You'll highlight different aspects of a story depending on the audience and the audience may be a clinic leader, a funding organization, a community partner, a payer, another clinic working on the same intervention or another clinic facing challenges implementing the intervention and this will affect the details you put in your performance story and also the length of your performance story. So for example, if I'm speaking to the CEO at my hospital, I really only want

to provide the pertinent details and tie the work into the financial success of the health system in about the amount of time it would take for us to ride together in an elevator. So it'd be about 90 seconds. So by way of contrast, if I'm sharing my performance story on a webinar or with other clinical teams trying to do similar work, or my stakeholders, I would go into more detail about my team, what kind of team building we did, how often we met, who my stakeholders are, and why they were selected, planning and implementing the tests of change, and how I selected measures.

Bernheisel: That makes total sense. Thanks. That that is really helpful. What are the elements or what elements should you include in your performance story?

Caron: I'd like to say you should include the who, the what, the how, the why, and the impact. You want to include demographics about your population, who you're serving, and you want to start with the entire population being served and break it out into the segments being managed, and maybe include your organization's clinical focus and your organizational mission if you think that's appropriate. So, for example, I work at the Metro Health System in Cleveland, so I might say it's an urban underserved safety net hospital. It's a level one trauma facility. 75% of the patients are uninsured or covered by Medicare or Medicaid. And we're a principal teaching hospital of Case Western Reserve University School of Medicine since 1914. And then within the organization, I would say the quality improvement effort is focused in a pediatric clinic or a geriatric clinic or a federally qualified health center and say something specific about the details and the demographics of that population. And then you want to identify the goals and what you hope to achieve. You want to be specific. Instead of saying we're working to improve diabetes, you want to say we want to increase the percentage of patients with hemoglobin A1C less than eight from 50% to 60% by the end of 2021. You want to describe the intervention, what changes were put in place. So, we designed and implemented a patient education tool to help patients manage their diabetes. You want to discuss the components of the tool, how many cycles of change you did. It's not just important to share what you did, but how you did it. So, a diabetes educator developed the tool. He did this by searching the literature and finding existing tools. He found elements that were relevant and he took it to the team and they decided whether or not they were going to use a validated tool or tweak these validated tools to meet their needs. Then he would test it with a couple patients and you know come back to the team with results and how many iterative tests of change you did and how long it took. You want to talk about the importance of team building and defining their roles. This really helps with communication. So who's responsible for getting baseline data? Who's responsible for training patients and staff on educational tools? When do these tasks need to be completed? Discuss what went well and not only if you achieved your goals, but what was effective. Was it the patient feedback that was effective? Was it, you know, how you rolled it out that was effective? Talk about those things. As I mentioned before, also important to share challenges and barriers because this will really inform others who are trying to do similar interventions. So, one of the things we've all been affected by is the COVID-19 pandemic. So, how did this affect your quality improvement project? Was there turnover? Were there staffing shortages that affected your ability to complete your quality improvement project? Name your partners and your team members and who's responsible for what on the team. And talk about the roles of the team members and finally talk about the results. Did you meet your goal? Did you need to adapt or enhance your intervention? And were there unanticipated consequences? And why is this intervention important? And how was it evaluable? And then finally, talk about lessons learned. What did you learn from doing your quality improvement project?

Bernheisel: When sharing this performance story, are you also including measures in that story? The practice measures?

Caron: Absolutely. So you talk about short-term goals, long-term goals and stretch goals. Maybe your short-term goal is to increase patient knowledge on how to take medications to control their diabetes and your long-term goals is looking at hemoglobin A1C changes. You want to think about process versus outcome measures. And you want to talk about non-numerical goals like team engagement, like we were really successful because the team was really excited to meet. You want to talk about what data was collected and how it was collected, how you use the data to inform your process and refine it. You want to make sure you have the data piece right up front. Because sharing the outcomes will help demonstrate the value of the project. And if you can use population targets to set benchmarks, you might want to consider using annotated run charts to show special cause variation. This shows overall positive performance and offers an explanation for a dip in performance. So, as I mentioned before, lots of clinics saw dips in performance due to COVID. So, showing that on a run chart is going to be really helpful when you're going back to look at the history of the performance of your quality improvement measures.

Bernheisel: Yeah, all of this is really helpful, but how should a practice develop or perform a story?

Caron: So, I know I said a whole lot in all of that detail, but it should really be a fairly short verbal presentation with a beginning, middle, and end. You want to focus on three to five takeaways. So, what I talked about were all the possible takeaways, and you're going to take those in consideration when you're developing your performance story. You don't want to focus on too many elements. Handouts or visuals are often useful. And they may include things like team photos, photo of the clinic and patient photos, obviously with permission from the patient.

Bernheisel: Can you provide some tips on how to develop a performance story?

Caron: Sure, Chris. So, you want to develop your story using the first person voice and you want to make it compelling and exciting to read. In case you can't tell, like I'm excited to share tips on how to develop performance stories. So, you want that enthusiasm to come through when you're telling your own performance story. You want to share stories with others in your practice and outside your practice for feedback. And you want to consider working with an external thought partner. This could be a practice coach, but somebody who brings outside expertise or a different perspective to develop your story. In a minute, we're going to hear a performance story from one of my colleagues, Joe Daprano. Chris, you don't work within our organization, so you might be somebody who could offer that outside perspective because you're a primary care provider. You work in a similar environment, but not the exact same one. It's really powerful to share patient stories and share the patient perspectives. Often I tell practices to include patient quotes to demonstrate the value that patients saw. Also, staff perspective is really, really important and powerful as well.

Bernheisel: Thanks so much, Aleece. This has really been helpful and I'm right with you. I'm really excited to actually hear a performance story and hear it in action. I'm so glad to have Dr. Daprano, Joe, with us today. I understand Joe, you're going to be sharing your performance story from Cardi-OH's diabetes quality improvement project.

Joe Daprano: Oh, thank you so much for this opportunity to share our Glenville Health Center quality improvement project story. First, I'd like to provide a little bit of context about our site. So, Metro Health Glennville Health Center is a federally qualified health center. Technically, we're a lookalike, but we are a federally qualified health center. And we're located in the urban core of Cleveland, Ohio. And our small practice of three primary care providers enjoys the benefit of being

a part of Metro Health Center, which is the tertiary care academic safety net hospital for Cuyahoga County. Our patients at Glenville Health Center are 75% African-American, 61% are female, 62% are older than 18 years of age, and 80% are either on the Metro Health Financial Assistance Program, Medicare or Medicaid. I would start out by saying that our project goal actually changed during the three years of this project. We actually had begun a quality improvement project with the goal of reducing our percent of uncontrolled diabetic patients from 40% to 35% over one year. So we had about a 5% reduction as our goal in one year. We subsequently became involved with the Cardi-OH quality improvement initiative and our timeline therefore was extended to three years and our goal set at achieving a 15% reduction in uncontrolled diabetic patients. So going from our baseline of 40% down to 25% of patients with uncontrolled diabetes. And of course, just as the Cardi-OH project got underway, the pandemic started and our number of uncontrolled diabetic patients soared to 48%.

So our baseline over the first six months of the Cardi-OH quality improvement project actually increased primarily because patients were not able to come in to get their diabetes care. So we had our work cut out for us and of course teamwork was the reason we were able to achieve our goal which we did achieve our goal. So our team members included all three primary care providers, our medical team assistants, our nurse, our registered dietician, our community health worker who joined us in the second year of the quality improvement program, and of course our lab who arranged our point of care testing and our information services who maintained our dashboard of patients. We ran a series of three major PDSA cycles and I'll give you a little description of each one of those. The PDSA is a plan, do, study, act cycle. So, You plan what your intervention is going to be, you do it and then you study the outcome of your intervention and then you act to make changes in your next intervention taking into account what you learn from the initial one. But within each one of those we had both process and outcome metrics that we were following. And I'm not going to go into all the details because we don't have time to discuss all of those. But I will say that initially not all team members were enthusiastic. But as we started to see patients gaining control of their diabetes, each team member really felt that they wanted to be a part of that improvement. So, pretty much everybody got on board.

Our first iteration of our PDSA cycle was using a three-ring binder titled "Seekers of Excellent Diabetes Control." So, you can do quality improvement without a whole lot of high-tech. That's how we started. We created a list of patients that had been seen in any given day. At the end of the day, we listed them as participants in this 222 we called it frequent return paradigm. So we gave a two-week follow-up appointment with nursing for education on various topics but primarily making sure a patient was able to use their glucometer and were able to understand how to acquire the 7, 14, and 28 day averages from their glucometer so they could report those out to us. Two weeks later the patient had a visit with a dietitian who went over the diabetes meal plan and two weeks after that a return to their primary care physician or provider to see what changes had been achieved over that six-month time period. So, we had process measures of how many patients actually went through this 222 setup. And I will say that it took a little while to get patients and the rest of us staff and providers used to this, but it actually was able to be recorded in that spiral notebook I had mentioned earlier. Later, we were able to make this all an electronic follow-up. But our major outcome measure at that time of course was how many patients had seen an improvement in their hemoglobin A1C and we didn't pick this recurrent follow-up out of the blue. It is supported in the literature that more frequent followup results in more quickly attaining control of diabetes for patients.

Our second PDSA cycle centered around obtaining a point of care hemoglobin A1C if a patient had not had one in the previous one year or the last hemoglobin A1C was greater than 9.0. So this did take a whole lot of process change to occur because we had to get a point of care testing machine which required quite a bit of time. I'm not going to go into all the details but we had to make a case for it and also then once we started collecting hemoglobin's recording and making sure that we were seeing improvements and I think the biggest unexpected outcome of this was that really it resulted in a tremendous amount of positive reinforcement given to the patient. Because all of us staff and providers included were on board with identifying who in the morning huddle which patients needed a point of care test for hemoglobin A1C and then once the patient had their point of care test done by the medical team assistant and medical team assistant saw that they had achieved significant improvement the patient received a whole lot of positive reinforcement from the medical team assistant who would pass that information on to the nurse who would also congratulate the patient and so by the time the patient was talking with the primary care provider also receiving positive reinforcement for the changes that occurred. The patient was just glowing and really this had a tremendous impact on changes in behaviors. Um there's no question in my mind. It also cut down on the telephone tag that you had to play prior to having the point of care testing at our site with the provider seeing the next day what the hemoglobin A1C was, trying to get a hold of the patient. If he wasn't able, if she wasn't able to get a hold of the patient, then the nurse had to try back and forth, back and forth, that kind of stuff. So all that was cut out, which lightened the load on all providers and nursing staff involved. So there were a whole lot of unintended unexpected benefits but definite benefits both for the patient and for the provider. And we actually saw a drop in hemoglobin A1C's using the point of care testing of about 0.6 which if you look at the various medications that are out there some of them dropped the hemoglobin A1C by 0.6 to 1.2. So we were actually achieving just with a process of using point of care hemoglobin A1C almost the equivalent of what some introductions of new medicines could have achieved. So that's a pretty interesting outcome as well.

Our final PDSA cycle centered around using our community health worker and as I said she joined our team about the second year maybe towards the end of the second year actually of our quality improvement project. Our community health worker took a lead role in using our dashboard which she could then find out which patients were out of care, had not been seen within a year, or who had been no-showing by looking at the schedule. If a diabetes patient no-showed for a recent appointment, she would get on the phone and call that patient and make sure that the patient had the ability to reschedule and try and troubleshoot. Were there some social determinants of health that prevented the patient from showing up for their appointment or were there problems with insurance that prevented the patient from being seen within the last year? And then troubleshooting those issues so that the patient could actually show up for an appointment was a large part of what the work that the community health worker did. And unfortunately, our community health worker left our site about four weeks ago. And I was unable to really get all of the the data from our community health worker regarding how many patients she called, how many times that a phone call was made to actually be able to talk with a patient, and then what number or what kinds of social determinants of health issues was she able to help mitigate so that a patient could get in. But there was a tremendous amount of collateral benefit from her involvement because not only does a patient have diabetes obviously, but they may have hypertension that was out of control or hadn't been treated, hadn't been dealt with in over a year. If they were out of care for their diabetes and hadn't been seen for a year, they were probably out of care for other issues as well. So we had all kinds of collateral benefit from that involvement of the community health worker and over the last year we saw a steep decline in our rate of uncontrolled diabetic patients.

So we actually achieved our goal of reducing almost—we got down to 26% uncontrolled diabetics at the end of 2021 and we've been able to maintain that through the beginning quarter of 2022. So those were our PDSA cycles. Um there were a whole lot of process outcomes and other stories that I could tell you with embedded within each one of those things and bear in mind that this occurred over three years.

Bernheisel: Gosh, thanks so much for sharing such an outstanding performance story and all the impact you all have had in that community. Pretty inspiring. Aleece, do you have questions?

Caron: I just have a couple questions, Joe. Um, did anyone on your team have quality improvement training?

Daprano: Yes, I did have training through a faculty development program at Metro Health that was funded by the health resources and services administration about three two or three years before this Cardi-OH quality improvement project occurred. I definitely had some training in obtaining metrics particularly—I had interest prior to that but I definitely had a lot of training and actually did a sample project through that faculty development program that really solidified a lot of the techniques involved in quality improvement and leading quality improvement projects.

Caron: So one more question And Joe, we talked a little bit earlier about the benefits of a practice coach. Did you have a practice coach involved in this quality improvement effort?

Daprano: So, yes, we actually had a coach assisting us through this process through the Institute of Healthcare Improvement. That person did not come to our site quality improvement meetings and did not participate in our huddles, but they definitely provided advice and suggestions. I think the biggest component of what I learned from that person was that really trying to do small PDSA cycles and lots of them as opposed to focusing on one for an entire year. So that was quite a novel insight for me and I talk with our staff about quality improvement because we've been engaged in quality improvement here for a long time. But our nurses as a part of their expected work are involved in program improvement projects as well. I think that if a practice has never had any one trained in quality improvement, the coach would definitely be very beneficial to walk them through the process because it certainly is very helpful to have a coach if you have not had much training and quality improvement.

Bernheisel: Thanks so much, Joe. I also have a couple questions for you. You mentioned that you had a setback with COVID-19. You went up to 48% and you had been down already at that point. I'd love to hear a little bit more about that impact by COVID on your improvement story?

Daprano: Sure. So, it was multitudinous impacts of course from the standpoint of the staff because we had providers doing telemedicine from home during the early days of the pandemic. We weren't huddling or it was a lot more difficult to try and huddle by phone with people at various different locations. So that made it difficult to actually have the patients identified. But of course some point of that we were totally shut down doing everything by telephone. So patients couldn't come in to get a hemoglobin A1C let alone to talk about making changes and improvements. So there was a profound impact and that's certainly why during those first six months we saw such a worsening of our patient population's control of diabetes and it's inspiring to see it improved. Yes, so it was a bigger challenge I guess to work through all those things but as we were able to get patients to come in after doing a phone call by telemed, then we would just ask them to come in very briefly for a lab visit without being in the building for more than 5, 10, 15 minutes at most to get that blood drawn. So we had to figure out workarounds when we were totally shut down. We never actually closed the building every day of the week. Um, so we did have some openings for patients to come in.

Bernheisel: Thank you. Did you have patient and family involvement?

Daprano: Oh yes, definitely. I think the point of care testing gave a lot of positive reinforcements to patients because we are a federally qualified health center. 50% of our federally qualified health center board is made up of patients of our health center. And it was our board after me pitching the idea, but it was our board who recommended that we hire a community health worker. So those patients agreed that a community health worker could play a pivotal role in improving quality of care at our site. And as I pointed out earlier, our third PDSA cycle really revolved around our community health worker engaging patients directly who are out of care or who are no showing for their appointments. And also as I said earlier, patients received a tremendous amount of positive reinforcement which I think went a long way to motivating them to continue to improve when we got the point of care testing done here and they received so much positive reinforcement for improvements even if the improvement was slight and if they didn't show any improvement they got a lot of constructive reinforcement to keep on trying.

Bernheisel: How were you able to make that sustainable? Is the point of care testing sustainable?

Daprano: Yes, I feel that it is very sustainable because we have data as I pointed out earlier that shows a drop in hemoglobin A1C's in patients who we are using the point of care testing of 0.6 and that's over about a six-month time period and as I said that equals what adding another medication—depending on the medication—does for a patient's diabetes control. So we are really looking at expanding this through all of the metro health satellite offices and it's covered by insurance. So yes, I think it's definitely sustainable.

Bernheisel: That's fantastic. Thanks so much. If you were talking to another office, what's the single most important thing that you would contribute your success to?

Daprano: No doubt it's teamwork. I mean, there's no way that this could have been done by any one of the members of our team. So, I think that as I pointed out from the MTA learning how to do point of care testing and encouraging patients to our community health worker calling patients to our nurses educating patients to our primary care physicians making changes in patients diabetes medications. It's a team effort and I think the most important thing is how you approach it from the very beginning involving all the team and saying why we want to do this. We want to improve our diabetes care for our patients and getting people on board at the very beginning in a positive way I think is one of the big challenges of quality improvement but if done well and done right it really results in great buyin by the staff and the other providers which is likely to result in improvement because if you keep on doing the plan do study act cycles you're going to see change—there's just no question in my mind.

Bernheisel: Well I'm sorry to say we are near the end of our podcast. Thank you both of you for taking the time to be with us today. Aleece, thanks so much for putting the framework for how to develop a performance story, what the elements are there and why it's so important. I have to admit one of the things you said in there is it brings joy to work and just hearing Dr. Daprano's work in the FQHC and all of that I can say gosh that brings me joy. Thank you Joe so much for coming and also sharing your performance story. I really learned quite quite a bit from that performance story and came away pretty inspired. We are out of time for today's podcast, but listeners can find other podcasts and resources at Cardi-OH.org. I appreciate you both talking to me today.

Caron: Thanks, Chris.

Daprano: Thank you.

Bernheisel: And a special thank you to you, our listeners, for tuning in to Cardi-OH Radio.

[Voiceover] Konstan: This concludes today's podcast. Be sure to visit Cardi-OH.org to learn more about the Ohio Cardiovascular and Diabetes Health Collaborative.

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