Quality Improvement Program

University of South Alabama Health
Department of Family Medicine

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CONTENTS

PROGRAM GOALS

The Family Medicine Department at the University of South Alabama aims to create and maintain a culture of quality improvement in its clinical practice. This goal comprises both educational—primarily residency and fellowship programs and to a lesser degree undergraduate medical education—and professional components, through faculty and staff engaged in providing patient care.

This educational and operational framework is designed to work in conjunction with the three-year postgraduate curriculum and the three-team (also known as "pods") structure of the clinic itself. As such, quality improvement (QI) initiatives involve the entire clinical and support staff of the pod as well as other operational and administrative personnel as needed for the specific initiative.

Quality improvement initiatives at USA Health support the educational requirements stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as well as additional scholarship, publication, and presentation requirements. Among the ACGME requirements are:

- Practice-based Learning & Improvement:
  - Setting learning and improvement goals
  - Systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement
- Systems-based Practice:
  - Advocating for quality patient care and optimal patient care systems
  - Working in interprofessional teams to enhance patient safety and improve patient care quality
  - Participating in identifying system errors and implementing potential systems solutions
  - Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate
- Scholarship:
  - The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities

The department's clinical practice faces similar requirements for its certification as a Patient Centered Medical Home (PCMH). Additionally, PCMH competencies themselves are excellent sources of quality improvement opportunities as the standards strive to improve healthcare delivery. The following are examples of specific QI-based PCMH requirements which, in turn, support the attainment of other competencies:

- Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.
- Setting Goals and Acting to Improve. The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

In terms of deciding what warrants improvement across a very complex healthcare landscape, it is often useful to return to the National Academy of Medicine (NAM) six aims for the U.S. healthcare system:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Almost anything we can conceive of improving would fall within one or more of these categories. As such, it is useful to return to these domains as we explore QI opportunities.

QI FRAMEWORK & TIMING

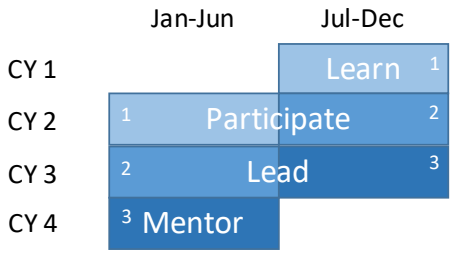
Quality improvement at USA Health can be broken down into three main categories of efforts: those by residents and fellows, by nursing and medical assistant (MA) staff, and by faculty and administrative / operational staff. The processes and timing of each varies due to the differing goals discussed above.

- Residents – coordinated three-year schedule
- Nursing / MA – continuous improvement by rapid-cycle process
- Faculty – for scholarly activity or necessary interventions

This document focuses primary on the first two of these, although planning, tracking, and execution of QI projects using these tools is applicable across all participant and project types.

RESIDENTS

Residents are responsible for participating in two full QI projects during their three-year education—first as a participant and then as a leader. Each of these QI projects should result in a poster and could be potentially used as a publication or presentation opportunity. The timing of these efforts across the three-year period is highlighted below (PGY numbers are indicated separate from calendar years).



For the new resident's first partial year, they will be responsible for observing and learning about the QI process while assisting with their pod's ongoing project—which is already halfway completed. Starting the beginning of the next calendar year, they will participate as a full member on a third-year's project (as a PGY1 and PGY2). Toward the end of that year, they will formulate their own project, for which they will obtain approval and execute the following year (as a PGY2 and PGY3). Their final spring as a PGY3 will allow them to serve as a mentor to a PGY2-led project.

So for any given calendar year, there is a complete project being proposed, approved, executed, tracked, and documented within each pod. In the spring and early summer, there will be a first- and second-year proposing and kicking off the project as well as a graduating third-year mentoring them. In the late summer and fall, the same two (now a second- and third-year) will be wrapping up the project, and an incoming first-year will be learning and helping out where possible.

When there are multiple same-year residents on the same pod, efforts should be made to distribute work between the available projects on that pod. Each resident should lead their own project for the second half of PGY2 and first half of PGY3.

This interwoven schedule provides consistency and overlap between projects and allows residents to learn the process as a participant prior to leading their own project. This cycle also allows for findings and observations from earlier projects to spawn subsequent initiatives, creating a culture of continuous improvement. Specific timing of activities and milestones within each project year is provided later in this document.

NURSING / MA STAFF

For nursing and MA staff, quality improvement is continuous in nature since there is no fixed schedule tied to an educational curriculum. The PDSA (Plan-Do-Study-Act) tool is the primary approach for achieving these improvements, and often multiple PDSAs are cascaded to focus on a single topic—such that the findings from one PDSA inform the next PDSA.

PDSA cycles in this approach are typically 4-8 weeks in duration, keeping them short enough to define and measure outcomes and then adapt as necessary to

achieve the desired results. Topics chosen for nursing QI projects should include those items mostly under the direct control of nursing staff and often include areas such as patient intake process, collection of vitals, execution of standing orders, completion of other documentation, care transitions, and refining workflow.

Since there are usually several PDSA cycles run back-to-back on a given improvement topic, the number of actual improvement initiatives per year is probably three or four. Improvement areas can be coordinated with an ongoing resident-led project in that pod, if appropriate and useful, or can be completely separate and independent. Each pod is responsible for maintaining its continuous improvement process.

IMPROVEMENT AREAS

As we reviewed in the program goals section, there are a number of high level aims for which we would like to affect positive change. The National Academy of Medicine recommends six domains: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. We can think about individual improvements addressing one or more of these categories, and the review and approval process for each project will ensure that linkages to quality outcomes are a key consideration in formulating each project.

The other goal of our QI program is to ensure that project leads, where feasible, get to work on projects of personal interest. Examples could include management of a particular chronic condition, targeting a specific transition of care, enhancing an interprofessional care delivery method, leveraging population health research to fill a gap, or enhancing community partnerships to address a need.

If we go a step deeper into potential improvement areas, we can think about the types of things experienced every day in the clinic that might target a better outcome, an improved patient experience, a more efficient process, etc. Examples of these areas are:

- Quality measures (CMS or other payers, HRSA, PCMH)
- Practice workflow and process – efficiency, team-based care, safety
- Standards of care / medications / protocols
- Patient experience and outcomes
- Panel performance (severity, control rates, membership)
- Patient engagement / activation (chronic condition management, regular appointments, medication adherence)
- Access to and use of community resources; filling unmet needs
- Cost effectiveness (vs. reimbursement)
- Reducing health disparities
- Transitions of care (streamlining, outcome effectiveness)
- Addressing social determinants of health (SDOH)
- Adverse event avoidance (ER visits, readmissions, HACs, mortality)
- Employee / team satisfaction

These are just a few of the potential areas of exploration. It is worth emphasizing that almost any part of the clinical or patient experience that could be improved from an efficiency, outcome, efficacy, safety, or equity standpoint could serve as an important QI project.

OVERLAP WITH QUALITY MANAGEMENT

It is a common misconception that quality improvement should focus solely on quality measures. While addressing quality measures can be a potential area for a QI project, they are only a small subset of topics as evident from the list above.

The federal government—via Health and Human Services (HHS) and its Centers for Medicare & Medicaid Services (CMS)—mandate a wide variety of quality measures. The Health Resources & Services Administration (HRSA) similarly maintains quality reporting requirements for its health centers and grant recipients, of which Family Medicine is one. Similarly, our PCMH certification requires monitoring and reporting of quality metrics, and many commercial payers are following the national leads.

Family Medicine maintains a rigorous quality management process through which a wide variety of quality measures are tracked and reported. Some of these include:

- Screening Rates
  - SBIRT Screening
  - Tobacco Use
  - Alcohol Use
  - Drug Use
- Evaluation & Test Rates (within target populations, typically by age/sex or chronic condition)
  - DEXA Scan
  - Eye Exam
  - Monofilament Exam
  - Serum Creatinine
  - Micro-albumin
  - Mammogram
  - Pap Smear
  - Colorectal Cancer Screening
- Chronic Condition Control Rates
  - Diabetes – HgA1c
  - Hypertension – blood pressure below target
- Vaccination Rates
  - Influenza
  - Pneumococcal
  - HPV
  - Hepatitis C
- Other Treatments & Services
  - Asthma Long-Term Prescription
  - Smoking Cessation Counseling
  - Obesity Counseling
  - Drug / Alcohol Use Counseling

Beyond the current reporting system, a new analytics and reporting approach is being finalized for these measures—one that will allow calculation of rates at both the team and individual Primary Care Physician (PCP) level. New reporting will also allow for breakdown of results by demographic factor (race, gender, age, language, etc.) as well as by financial class (Medicare, Medicaid, Blue Cross Blue Shield, Tricare, commercial payers, or self-pay) and at a zip code geographically.

While the ongoing management and focus on particular metrics will remain the responsibility of each team, these will not be the default QI topics as they were in the past. It is still appropriate to consider improvement of a particular metric, especially if a larger-scale intervention is warranted or if a disparity has been identified through further analysis of demographic and operational data. One could also consider the creation and implementation of a new quality metric to track a specific condition, situation, or population.

PROJECT DEFINITION

Residents' projects will go through an approval process (discussed later in this document) and must meet a number of criteria to be accepted. The following sections provide information on primary components of the project proposal and the criteria by which each will be reviewed and scored.

Each project proposal is submitted using the Family Medicine Project Proposal Form, which includes all of the required information. The following sections should assist in filling out that form and provide context to key decisions that need to be made when framing out a new project.

AIM STATEMENT

The project must have a strong aim statement that satisfies the complete SMART criteria. SMART is an acronym that specifies several important aspects of an effective aim statement:

- **Specific**: precisely what the team aims to achieve (especially the what, how, and who questions)
- **Measurable**: how will success be measured; target quantitative metrics (percentage, number, percent increase/decrease)
- **Achievable**: is the improvement initiative feasible within the time frame allotted
- **Realistic**: does the team have the available resources and commitments to execute the project
- **Timely**: is the project time-bound with a stated end date (and start date if not immediate)

An example of an effective aim statement that meets the SMART criteria is:

> *"Increase the rate of hypertension control (≤140/90) within the C-pod Medicaid patient population aged 18-59 from 60% to 65% by August 2020 through a targeted intervention involving handoff to the clinical pharmacy team."*

Note that this example fully meets the SMART criteria. It is specific in that it says what we're aiming to change (hypertension control rate), for whom (C-pod, Medicaid, age 18-59), and how (by handoff to clinical pharmacy team). It is measurable since both baseline and target percent control rates are provided. It is achievable and realistic since it doesn't rely on significant resources outside of those already available to the pod (note that if we had targeted an increase from 60% to 90%, that would not be realistic in under a year, or likely ever for that matter). This statement is also timely since it specifies an end date—and the start date in this case is assumed to be imminent.

The "how" part of the specific criteria needs to be defined at a slightly higher level to leave some flexibility for definition of multiple PDSAs that comprise the project. In our example above, we could have stipulated "through a targeted intervention involving an interprofessional care team" if we wanted to give ourselves the flexibility to pull in nutrition or behavioral health. Or it could be "involving an interprofessional care team and ensuring accurate resting blood pressure readings" if we suspect that inaccurate readings might be part of the problem. We want to frame the scope of the potential solutions without locking in on a single idea.

One of the more complex definitions involved in setting the aim statement is actually "who is a patient?" There are several possibilities, and it is important to consider these and specify accurately in the aim statement—or ensure that expectations for measureable change are set accordingly.

As a default definition, a patient of the Family Medicine Department is someone we have seen in the past two years who we do not have otherwise documented as having moved (physically out of town, or to a different primary care setting). The difficulty with this definition, especially as it relates to short-term improvement efforts, is that many of these "patients" will not be seen within a several-month project execution phase and therefore limit the percent change from baseline. With our example aim statement, it would be virtually impossible to increase hypertension control from 60% to even 75% during a given project if we only see 20% of the patients during that time.

The other alternative is to focus on in-stream patients for an intervention—essentially those we would have been seen anyway, through our normal course of clinic operations. If using this definition, the aim statement could be worded to say that we want to establish hypertension control by September for 50% of out-of-control patients seen during the period February through June. This creates a discreet sub-population to measure and track. One down side, however, is that global reporting will not separate out these patients, and some amount of manual tracking would be necessary.

Another alternative would be to shorten the time window to say six months instead of two years. In this case, we would have fewer patients who have moved or otherwise will not come back to the clinic included in our denominator—

meaning that we're more likely to improve a percentage during the project window. Again, reporting and tracking is the consideration.

The specific time window needs to be reasonable for the given project and the base of patients who might be included in the target population and who could be meaningfully impacted by the intervention. In the end, however, these timing definitions do not change the intervention itself, but rather factor in to setting a reasonable, measureable goal. As such, they need to be specified clearly unless relying on the standard two-year look-back as our example aim statement assumed.

BACKGROUND & POTENTIAL IMPACT

This section should describe the project's background, whether clinical or operational, and indicate the types and scope of potential impacts from the quality improvement initiative. This section should indicate the areas of impact from the NAM six healthcare domains:

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

The background should also provide context for the clinical areas to be impacted. References to external publications in support of the problem definition, potential impacts, challenges, etc. are also recommended.

The team should use available toolkit resources such as Root Cause Analysis (RCA) (a.k.a., "cause-and-effect diagram"), Driver Diagram, and Failure Modes & Effects Analysis (FMEA) to help define the problem, and additional tools and depictions such as the flowchart, histogram, Pareto chart, and scatter diagram can be used to help visualize the prioritize these efforts.

TEAM & RESOURCES

The project definition also needs to include the key team members, supporting pod, interprofessional care teams, and any other resources necessary to execute the project. Specific details include:

- Project Lead [Resident]
- Supporting Resident(s)
- Pod or Other Team
- Ancillary Providers: Behavioral, Dietary, Pharmacy, Care Coordination
- Community Resources
- Front Office Staff Impacts
- Back Office (Billing) Staff Impacts
- Phone / Email / Portal Communications
- Other Resources

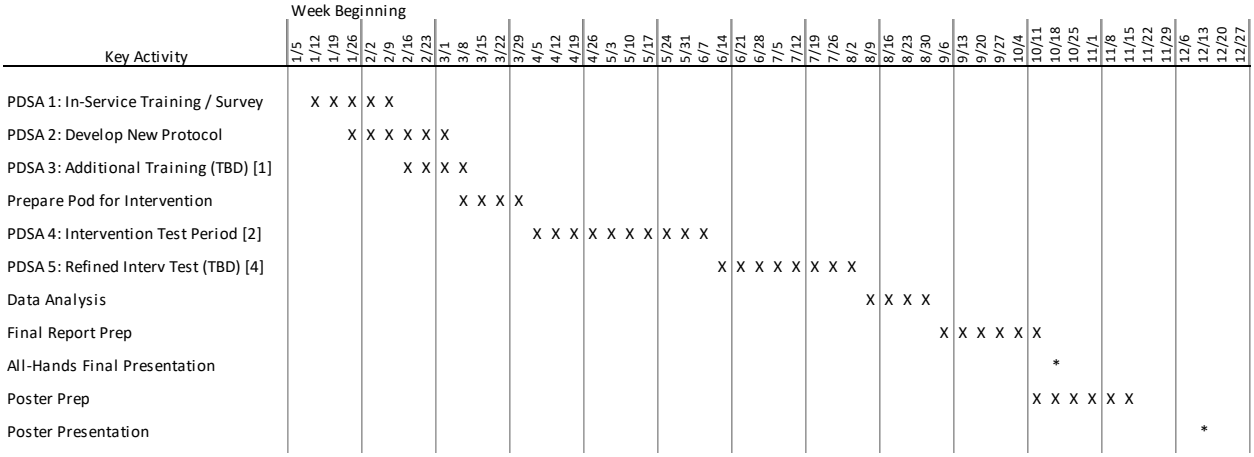
For the first two, the project definition needs to specify the individuals by name, and for the others, the project should describe the support team's role and estimated level of commitment (hours per week or number of discreet activities, for example). The goal of this section is to accurately describe—again based on the aim statement and any draft PDSAs—the scope of the project and the commitments it is bringing to the clinic as a whole.

PROJECT PLAN

The project plan consists of the major components of the project and their estimated schedule and interdependencies. The timing of several PDSAs that make up a project comprise the majority of the work effort. Overall requirements for a project to be approved are:

- At least four PDSAs (recommend no more than six PDSAs)
- At least two scheduled concurrently or partially concurrently, which requires that these don't have a strict dependency
- At least two scheduled sequentially, preferably with a dependency between them
- At least two PDSAs should be in draft format, meaning that the team has decided the specifics of what they are going to test, at least for the outset of the project
- Subsequent PDSAs can be follow-on cycles to the initial ones, meaning that the team does not yet know the specifics of what will be tested, since those should be informed by the learnings from the first round of PDSAs

The project schedule should be developed using the Excel template provided, and output from that tool should look similar to the following:



This is a very simple Gantt chart view of the project. It highlights the major components and milestones as well as interdependencies between items. In this example, the project kicks off in early January with PDSA 1—some type of training and follow-up survey / evaluation. Concurrently, PDSA 2 starts with the development of some form of new treatment protocol. PDSA 3, listed as TBD, assumes a follow-up round to the initial training, assuming incorporation of learnings from PDSA 1.

Then we approach the intervention phase with rollout planning within the pod, then a 10-week patient intervention PDSA. Next comes refinement of the intervention, again based on learnings from PDSA 4, and a shorter 6-week alternate intervention PDSA.

The project enters the wrap-up phase with additional data analysis, final report preparation, a final presentation in the department All-Hands meeting, poster preparation, and poster presentation toward the end of the year.

Note that this example projects meets the PDSA requirements in that it has concurrent PDSAs (1+2 and 2+3), sequential / dependent PDSAs (1+3 and 2+4+5), more than four and less than six PDSAs, and two or more PDSAs that are already well defined (1, 2, and 4).

MEASUREMENT APPROACH

A critical consideration of any project, at least one that meets the SMART criteria, is the ability to measure outcomes. The project description must describe the way that data will be collected and analyzed to support the aim statement. In some cases, existing Family Medicine reports may have all of the required data and these can be run as needed to track progress. The primary responsibility for data collection and analysis is with the project team, with the Pop Health staff assisting, where possible, with guidance and use of Cerner default reports.

More likely, however, is that existing reports will not be fully sufficient to support the project. In that case, the project team must work with reporting resources to determine whether data can be collected systematically or whether separate tracking—possibly based on chart reviews and manual spreadsheet-based patient registers—will be required.

Measurement plans must support the details provided in the aim statement. Typically, this involves coverage of the following areas:

- Quality measure or outcome metric
- Patient subset classification (and how many, estimated)
- Intervention tracking (and how many, estimated)
- Baseline determination or control group tracking

The first three of these categories are fairly straightforward. We have to know what we're tracking (e.g., hypertension control rates), within what population (e.g., C-pod, Medicaid, aged 18-59), and which specific patients have received the intervention (unless globally deployed).

The final category is important as it serves as the starting point for the PDSA / intervention. Many interventions, as with the hypertension example, have an established baseline performance (in that case, 60%) for the target patient group. These types of projects typically rely on a run chart, basically a time series, to identify the trend before and after the intervention. Simple statistics can be used to quantify the change—a straight average plus standard deviation or potentially before and after trend lines—and the results are intuitive to a casual viewer.

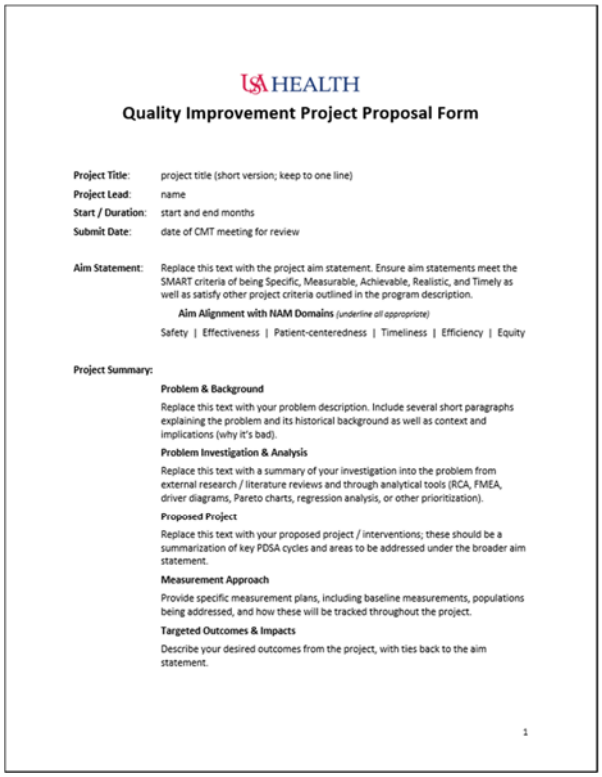
Other interventions may not have the benefit of an established baseline performance. If creating a new metric, looking at patient outcomes that are not readily summarized historically, or targeting a seasonal effort such as flu vaccination, a run rate may not make sense. In these cases, we have the

opportunity to benchmark go-forward performance against another pod (or most likely both other pods). Since the other pods operate nearly the same as the one performing the PSDA, they can serve as the control group. The only downside of this approach is that any manual tracking needed for the intervention is often required of similar patient populations across other pods, increasing the amount of manual effort.

In still other cases, results may be measured by patient survey, although it is still important to establish a pre-intervention baseline or to survey a control group in conjunction with the intervention group. In very limited cases, establishment of an entirely new process or therapy could be measured against a published study so long as the metrics and population groups were identical or very similar. Such an approach could directionally indicate the effectiveness of the rollout; however, it would be better to measure an actual outcome metric instead, or at least in conjunction with a published study.

PROJECT APPROVAL PROCESS

Projects must be approved prior to commencement and no later than the end of January of the project year. To receive approval, the project lead must complete the QI Project Proposal Form and submit to the Clinical Management Team (CMT) at least one week prior to its monthly meeting. Teams can get an early start on the process by formulating a potential project as early as October of the prior year in preparation for a January start.



USA HEALTH

Quality Improvement Project Proposal Form

Project Title: project title (short version; keep to one line)
Project Lead: name
Start / Duration: start and end months
Submit Date: date of CMT meeting for review

Aim Statement: Replace this text with the project aim statement. Ensure aim statements meet the SMART criteria of being Specific, Measurable, Achievable, Realistic, and Timely as well as satisfy other project criteria outlined in the program description.

Aim Alignment with NAM Domains *(underline all appropriate)*

Safety | Effectiveness | Patient-centeredness | Timeliness | Efficiency | Equity

Project Summary:

Problem & Background

Replace this text with your problem description. Include several short paragraphs explaining the problem and its historical background as well as context and implications (why it's bad).

Problem Investigation & Analysis

Replace this text with a summary of your investigation into the problem from external research / literature reviews and through analytical tools (RCA, FMEA, driver diagrams, Pareto charts, regression analysis, or other prioritization).

Proposed Project

Replace this text with your proposed project / interventions; these should be a summarization of key PDSA cycles and areas to be addressed under the broader aim statement.

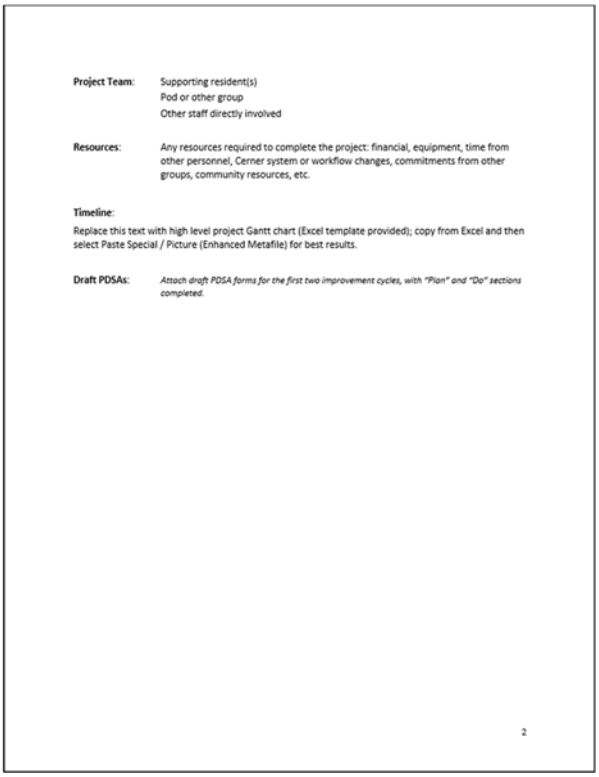
Measurement Approach

Provide specific measurement plans, including baseline measurements, populations being addressed, and how these will be tracked throughout the project.

Targeted Outcomes & Impacts

Describe your desired outcomes from the project, with ties back to the aim statement.

1



Project Team: Supporting resident(s)
Pod or other group
Other staff directly involved

Resources: Any resources required to complete the project: financial, equipment, time from other personnel, Cerner system or workflow changes, commitments from other groups, community resources, etc.

Timeline:

Replace this text with high level project Gantt chart (Excel template provided); copy from Excel and then select Paste Special / Picture (Enhanced Metafile) for best results.

Draft PDSAs: *Attach draft PDSA forms for the first two improvement cycles, with "Plan" and "Do" sections completed.*

2

The Director of Population Health Projects is available to assist with any questions, technical guidance on filling out forms, etc., and can review draft materials for accuracy and completeness prior to formal submittal. Forms and materials are updated and linked on the Family Medicine intranet site.

Additional guidance, especially for medical, workflow, or operational considerations should be sought from the team's attending physician(s), the Director of Operations, and from other interprofessional team members as needed. The goal is to work out all potential issues prior to submitting the proposal to the CMT for formal review.

A basic checklist of required materials and content is:

- Project Aim Statement
  - Specific
  - Measureable
  - Achievable
  - Realistic
  - Timely
- Background & Impact
  - Problem Identification and Definition
  - Potential Impacts – Six NAM Domains
  - External References
- Team & Resources
  - Lead and Supporting Resident(s)
  - Pod and Supporting Staff
  - Patient Communication Approach (if applicable)
  - Other Resources
- Project Plan
  - Schedule / Gantt Chart
  - PDSA Requirements
  - Two or More Completed (Draft) PDSA Forms
- Measurement Approach
  - Baseline / Control
  - Data Collection Plan
  - Reporting Plan

Based on the CMT's review of the project proposal documentation, the project can be approved, denied, or approved subject to indicated changes. If denied, the team will have a chance to rework the proposal and submit again the following month. Pre-review of submittals is strongly suggested to avoid this scenario.

PROJECT TIMELINE

As discussed previously, the QI project timeline follows a calendar year schedule, thereby spanning two academic years for each resident participant. Since it is expected that each project be approved no later than January of the project year, much of the definition and documentation work will need to be completed in the late fall of the preceding year.

The project concludes with a final presentation in the department All-Hands Meeting in October and subsequent poster presentation in winter or early spring the following year, depending on scholarship activity requirements. A month-by-month breakdown of suggested activities and milestones is listed below:

Month	Key Activities & Milestones
Prior Oct-Dec	Project definition and documentation Team selection, roles & responsibilities Submit project plan 1 week before CMT
January	Project approval required by month-end Project kickoff for approved projects
February	At least one PDSA kicked off Group 1 – All-Hands project update
March	At least two PDSAs kicked off or completed Group 2 – All-Hands project update
April	Group 1 – All-Hands project update
May	At least three PDSAs kicked off or completed Group 2 – All-Hands project update
June	All PDSAs kicked off; 3+ completed Group 1 – All-Hands project update
July	Group 2 – All-Hands Project Update
August	All PDSAs completed
September	Data analysis & report preparation
October	Final Presentation – All-Hands Meeting
November	Poster Preparation
December	Poster Completion & Presentation

All projects will be assigned to either Group 1 or Group 2 for the purposes of staggering bimonthly updates at the department All-Hands Meetings. Group 1 will likely consist of those projects that received earlier approval or that had an earlier start of their PDSA execution—and therefore will have more progress to report during the February All-Hands Meeting. In total, each project will have three intermediate project updates plus a final presentation.

PROJECT EXECUTION

QI projects will be executed using the Individual Team QI slots scheduled at least one Thursday per month. These times will be very valuable for the team to meet and review progress against the overall project plan, review PDSA results, plan subsequent PDSAs, and continuously review outcomes for the overall project. The Thursday QI slot will also serve as the time to review nursing / MA quality improvement initiatives. A standing agenda for these meetings is provided below:

- Review project schedule and progress made against it
- Review in-progress data collection and outcomes reporting
- Review and document PDSA progress
- Plan follow-on or alternate PDSA cycles
- Ensure team alignment, roles, and responsibilities
- Plan bimonthly All-Hands status updates
- Review nursing / MA project status
- Coordinate with ongoing nursing / MA projects, as needed

Because of the complexity of these projects and the ongoing data collection / analysis and documentation requirements, additional meetings will need to be scheduled by the project lead and attended by any impacted team members. It may be possible to use some of the pop health afternoon slot to continue project planning and tracking activities so long as ongoing quality management and panel management activities are kept up during that session.

ALL-HANDS STATUS UPDATES

Each resident-led project team will be required to provide a bimonthly status update in the department All-Hands Meeting. That update should include:

- Project schedule update (versus original plan)
- Description of each PDSA's status:
    - State of completion
    - Key findings
    - Measurements
    - Challenges
- Comments on upcoming PDSAs
- Overall project results, where possible, using established metrics

These updates should be able to be delivered through five to ten PowerPoint slides and targeting a 10-minute time slot. A PowerPoint template with all slides pre-set will be available for use, and QI project admin will be available to review presentations and do dry runs the week prior to All-Hands update meetings.

FINAL REPORT / PRESENTATION

The project's final report should be a 15-30 PowerPoint slide summary of the complete project, including:

- Project definition and aim statement
- Initial and final project schedules
- PDSA summary (2-3 slides) for each
- Project results versus baseline or control group
- Key learnings and observations
- Opportunities for further research

Additional details about the final report and presentation will be provided as teams near completion of their projects. Templates will also be provided for both intermediate and final presentations so that all required areas are covered. Teams are encouraged to review update presentations with QI admin prior to delivery in the meetings to ensure that all of the topics are covered and to prepare for any questions.

HELP & RESOURCES

A variety of resources are available to help each team throughout the course of their project. Project leads should make effective use of these resources to ensure a high quality project conclusion.

- QI Admin: project planning, process, schedule, templates and other materials, approvals, measurements and reporting
- Attendings: at the pod level; use for medical or workflow questions and approvals; escalation to Medical Director as needed
- Operations: clinic workflow, Cerner use, reporting, front- and back-office personnel / process, other resources
- Interprofessional Care: other team members as needed

Access to program documentation, templates, forms, examples, and other materials is provided via the Family Medicine intranet site under the Quality Improvement link.

These projects will be the basis for enhancement of the formal QI curriculum which will be introduced during orientation each year—and maintained on the FM intranet site. For those who have not received direct education on QI techniques, extra help will be provided during project execution.