ADCES Quality Improvement Action Plan

An Overview

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Purpose

The purpose of this document is to provide an overview of the components of a Quality Improvement (QI) Action Plan. This document will help you:

- define a QI Action Plan
- identify metrics for quality improvement activities
- develop a QI team
- understand common QI tools
- implement strategies and best practices for assessment and sustainment of your QI initiatives

This QI Action Plan uses the ideas, models, and best practices identified by many groups, such as the Centers for Medicare & Medicaid Services (CMS), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ). There are hyperlinks throughout this document to original source material should you be interested in further reading.

An Overview of Quality Improvement in Healthcare

It is important for all healthcare organizations to understand *what* quality improvement is, and *how* to conduct QI activities. According to the Centers for Medicare & Medicaid Services (CMS), Quality Improvement in healthcare is:

> ***"The framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations."***

In order to conduct effective QI activities, your organization needs to understand its own systems and processes:

- What are your current resources and infrastructure?
- Which staff are responsible for which services?
- How are services provided (e.g., your workflows)?
- Are your patients' clinical outcomes where they should be or what you want them to be?[1]

Why is QI in healthcare important? QI provides a venue to consistently provide evidence-based, high-quality care to patients in order to achieve optimal outcomes. Evaluating and changing workflows can create systematic efficiencies and improve communication techniques. Overall, QI guides your

[1] Your organization's QI efforts should include and evaluate all of these components.

organization in working upstream to identifying and resolve barriers to providing care prior to them becoming a systemic challenge.

One important measure of quality is to ensure **you are meeting the needs and expectations of your patients**. There are many ways to evaluate whether or not your patients are receiving the care they need, such as: (i) looking at how easy it is for your patients to access care;[2] (ii) making sure your organization is following evidence-based practices in delivering care; and (iii) offering comprehensive care coordination and engagement services.

Effective quality improvement work tends to involve multiple departments across a health center, it is most effective by using a team approach. Your QI team should be interdisciplinary and include members with varying skillsets, knowledge, perspectives, and experiences. All team members need to be engaged and active participants. Your organization's leadership will be a key stakeholder for being successful with developing and implementing any QI Action Plan. Forming and managing your QI team will be an integral part of completing this QI Action plan.

Action plans and QI require the use and evaluation of data. Data describe the current state, and show what happens when you implement interventions. Data alleviate the use of assumptions, validate or invalidate implemented strategies, and serve as an evaluative tool when monitoring success.

QI Plan versus QI Project

Many organizations use the phrases "QI Plan" and "QI Project" interchangeably. However, it is important to understand how they are different.

A QI Plan is a strategy for monitoring and evaluating your organization. It outlines S.M.A.R.T. goals and performance measures that relate to the component of your organization you are using the plan to evaluate.

A QI Project is a component of the QI Plan, and outlines a specific intervention you are testing the effectiveness of.

For example: If you are looking to evaluate the effectiveness of your organization's diabetes programs:

- Your QI Plan is the overarching strategy your organization will implement to successfully prevent persons at-risk for type 2 diabetes from progressing to a diabetes diagnosis
- Examples of potential QI Projects include:

[2] For more information on ways to increase access to your National Diabetes Prevention Program by supporting participant engagement through telehealth, see *TELEHEALTH AND THE NATIONAL DPP: INCREASING PARTICIPANT ENGAGEMENT*.

- referring persons with a high-risk of developing type 2 diabetes or with a prediabetes diagnosis to your health center's National Diabetes Prevention Program lifestyle change program; or
- scheduling a visit with a Certified Diabetes Care and Education Specialist (CDCES) [3] for persons with a diabetes diagnosis.

Performance metrics are included in both a QI Plan and QI Project and monitor the success of each. The baseline data of the various metrics will assist QI teams in determining which efforts take priority. For example, a QI Action Plan for the National Diabetes Prevention Program (National DPP) may include performance metrics to increase participant activities in the program, improve the number of participants with reduced weight, reduce participant HbA1c levels, and retain participants in the program. If the organization has a high engagement rate and a low retention rate, it would make sense to initially prioritize projects related to participant retention.

Quality Improvement Action Plan

According to the Health Resources and Services Administration (HRSA), the QI Action Plan serves as a main work plan for your healthcare organization's identified process for improvement. Your organization should use a multidisciplinary team of internal stakeholders to develop your QI Action Plan. HRSA also recommends that your organization have a member of your senior or executive leadership team be a sponsor, or champion, for the QI Action Plan. The Plan serves as a road map for all related quality activities, both operational and clinical, and should have the following characteristics:

Develop a Team	Organize the right people to implement your process improvement strategy.
Define an Aim Statement	The aim statement should be time-specific and measurable, and define the specific population of patients or other system that will be affected.
Determine Metrics for Evaluation	Use quantitative measures to determine if a specific change actually leads to an improvement in outcomes.
Select a Quality Improvement Tool	A scientific method adapted for action-oriented learning that includes identifying a change, testing the change, and evaluating how effective the change is.
Develop an Implementation Plan	This plan provides guidance for how to implement a change on a small scale in order to evaluate, or test, its effectiveness.
Plan for Analysis and Sustainment	Once you have found a change to be effective, you must plan for how to sustain the change across your organization, and how to continually evaluate its effectiveness.

[3] For more information on ways to integrate a CDCES into your team, see *INTEGRATING A LCSW CDCES INTO THE NATIONAL DPP*.

Develop a Team

Effective teams include senior leadership and multidisciplinary members representing varying areas within your organization. The member list can be expansive or smaller based on the resources and infrastructure of your organization.

When developing your team, review IHI's Model for Improvement to help specify exactly what your organization is trying to accomplish. Your organization needs to clearly define its aim and determine what departments, systems, and resources will affect the aim.

You should develop your QI Action Plan team to include staff who are familiar with these QI concepts.

Define an Aim Statement

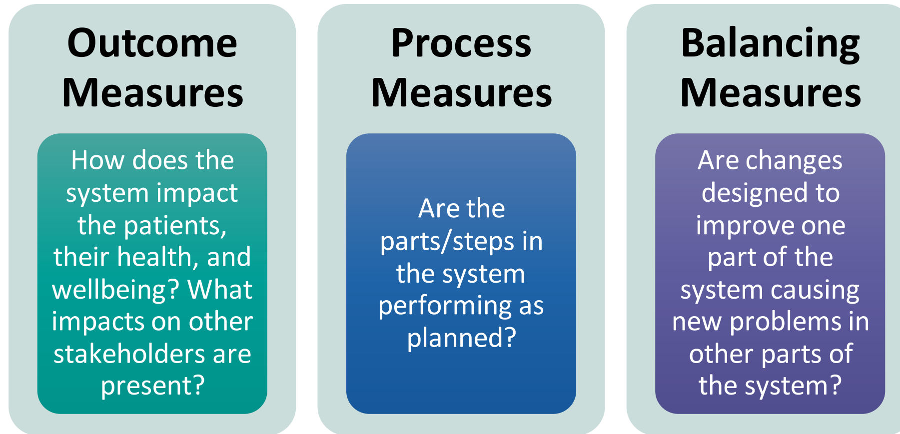
An aim statement is the answer to the first question in QI process: "*What are we trying to accomplish?*" You need to write your aim statement clearly as it presents a summary of what your team hopes to achieve over a specific amount of time, including the magnitude of change you are looking to achieve.

You should ground your aim statement in the mission of your organization. Use the aim statement as a framework for the QI Action Plan, which serves as a guide for the entire QI process, including the metrics you identify to measure. A clearly written aim statement aligns the varying expertise of the stakeholders and assists the team remain attentive to the plan at hand.

Determine Metrics for Evaluation

In order to determine if the change you have chosen is effective, you must understand your current performance (also known as your "baseline"). Your organization needs to identify those metrics that help inform what is happening, and how effective the current state is at delivering high-quality care to your patients.

There are three types of measures to consider for evaluation: **Outcome**, **Process**, and **Balancing**. Successful organizations use a mix of all three measures for improvement efforts.



Choosing the most useful metrics is a critical step toward success. Your organization should consider using fewer rather than more measures at the onset; you can always expand the number of measures at a later point in time. Starting with a smaller number of metrics allows your team to observe the feasibility and usefulness of any QI activity without overly taxing the resources of all parties involved.

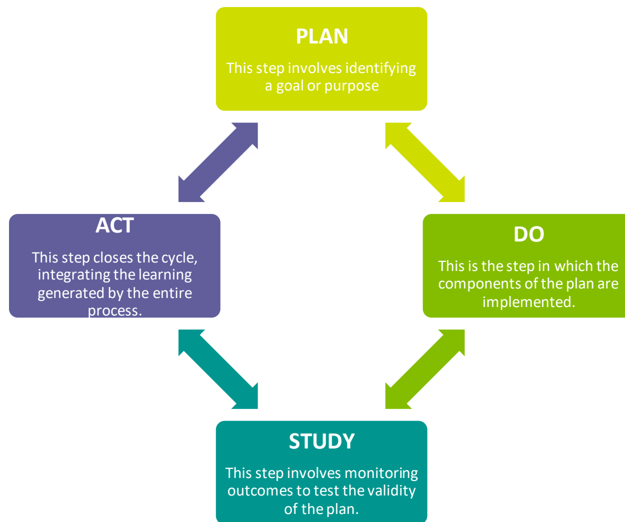
As discussed earlier, the QI Plan generally outlines S.M.A.R.T. goals and identifies performance measures based on the needs of your identified strategy.

Select a Quality Improvement Tool

AHRQ concluded that although QI models vary in approach and methods, a basic underlying principle is that QI is a continuous activity, not a one-time thing; as you implement changes, you will identify new challenges. An organization's analysis and understanding of its data (based on its identified Performance Metrics) drives future actions on performance. Once an organization has completed the analysis of the data, they may determine a specific measure requires attention. Once you have identified the measure, leadership will make this measure a priority. The team will then focus on the improvement of this metric through a QI project based on the aim statement within the QI Plan.

The approach that serves as the basis for most QI models is the PDSA cycle, which stands for Plan-Do-Study-Act.[4] This cycle is a series of steps for acquiring knowledge based on the outcomes of the cycle. A team would use this knowledge to continually improve a process. The primary concept of the PDSA cycle is the idea that small changes can have large effects on the process.

[4] For more information on the PDSA cycle and other QI tools, see *CREATING A PDSA*.



The PDSA cycle is integral to rapid-cycle change methodology with emphasis on the "S", or Study, part of the cycle. Once data is collected, Study is the analysis and interpretation phase. Once this phase is completed, an organization can proceed to "A", or acting on the data.

The PDSA cycle involves all stakeholders in assessing problems and suggesting and testing potential solutions. This bottom-up approach increases the likelihood that those in the organization will embrace the changes. In this approach, the leaders of the organization welcome the input and ideas of staff. In turn, the staff accepts the change as being part of the decision-making process.

When the QI team is ready to apply the PDSA cycle to improve performance, the team will need to define goals, identify and implement interventions, and evaluate outcomes. Your organization will repeat this cycle several times through implementing varying strategies. Once those strategies prove to be successful, your team organization will focus on expanding the intervention, or change, on a broader scale across your organization.

Develop an Implementation Plan

Prior to implementing any change, no matter how big or small, your team must conduct a readiness assessment. According to HRSA, the purpose of a readiness assessment is to determine if there are potential barriers within your organization to success, and provide your QI team the ability to overcome such barriers before beginning or spreading the QI project.

Many factors predicate an organization's readiness, including:

- Commitment from executive leadership;
- An understanding of the time commitment and possible financial commitment to the QI Plan;
- Consensus of alignment of organizational goals and the vision of the QI Plan; and

- Stakeholder buy-in.

Once you have assessed your organization's readiness any you have mitigated any identified barriers, the QI team can move forward with implementing change.

IHI concluded that QI teams should use change concepts when deciding on strategies for change. This is due in part to the notion that not all change will improve the process, but that change is necessary for the process to improve.

There are several change concepts for your QI team to keep in mind. The following concepts are a subset of common ones that may be useful for the organization's QI Plan:

- **Elimination of Waste**
  Look for ways to eliminate any activity or resource in the organization that does not add value to the process. Ask, "Are there any processes in place that are not creating an impact on the desired outcome?"
- **Improve Work Flow**
  Improving the flow of work in processes is an important way to improve the quality of services provided. Ask, "Is my current workflow suitable to obtain the desired outcome?"
- **Patient Engagement**
  To benefit from improvements in the quality of services, the patient must recognize and appreciate the improvements. Ask, "How does the patient view the process, and is there a need for change?"
- **Focus on Variation**
  Implementing small, focused change strategies instead of a variety of changes increases the likelihood of improved outcomes and helps reduce the frequency of negative outcomes. Ask, "Has the organization planned to create (too) many changes at once?"

Learning and using these change concepts to understand your organization's current state will generate useful ideas for tests of change. Once your QI team has selected the appropriate change concepts, you should decide which change you will implement and then pilot the change on a small scale.

While a pilot may seem to delay the change process, it gives an opportunity to observe the process on a small scale. Challenges and issues can be mitigated prior to implementing on a broader scale. Before instituting the pilot, your QI team should consider the following questions according to AHRQ:

- Where would you like to pilot test the process?
- Are the areas chosen for the pilot already engaged and bought into the process?

- What mechanism will be in place to give and receive feedback from frontline staff during the pilot?
- What structure will be put in place to support staff during the pilot period?
- What roles can the leadership team play in the pilot?
- Are the stakeholders engaged, and have roadblocks been identified and removed prior to piloting in those practice settings?
- What are the process measures to determine compliance during the pilot?

Planning for Analysis and Sustainment Activities

According to HRSA, analyzing the effect of any change is vital in determining if the change resulted in the desired outcome. Analysis of data from your pilot will determine whether the change was a success, or if modifications or an alternate change is necessary to improve outcomes in alignment with your QI Action Plan. In addition to determining how the pilot impacted outcomes, your QI team also needs to determine how the change affected the entire organization. Any single change can have a systemic effect. You may need to implement other strategies if the pilot resulted in a negative impact on other workflows and processes within the organization.

In the event the change has a favorable effect, your organization can implement the change as a permanent process or workflow. Implementation has several factors involved:

- document the change through policies and procedures;
- educate and train staff on the change;
- prepare to add or realign resources; and
- refine the change for varying departments since areas may have disparate ways of doing things.

Once you have implemented the change across your organization, how do you commit to these changes? Analysis does not stop when initially evaluating the change. **QI is a continuous process.** Using the identified metrics, an organization will need to periodically review the effect of the implemented change to ensure it still produces the desired outcomes. The constant evaluation of change should be part of your organization's QI Action Plan.

Conclusion

Understanding and properly implementing QI is essential to a well-functioning organization, and is necessary for any organization interested in improving efficiency, patient safety, or clinical outcomes. Creating a culture of quality improvement and supporting it through active engagement and continual evaluation strengthens your organization's ability to promote change.

Appendix I

Increasing Enrollment in the National Diabetes Prevention Program

A Quality Improvement High Level Action Plan for ACME Health Center

(For demonstrative purposes only)

Introduction

The National Institutes of Health states that more than 10% of US adults are living with Type 2 Diabetes. The Centers for Disease Control and Prevention established the National Diabetes Prevention Program (National DPP) in 2010 in an effort to delay or prevent this disease among individuals at high risk. Unfortunately, enrollment and retention rates into the program are low across the country.

The mission of ACME Health Center is to improve the health status of the members of its community. The organization has seen an increase in the number of persons progressing to a diagnosis of Type 2 Diabetes. ACME Health Center became a CDC-recognized Diabetes Prevention Program offering the lifestyle change program in an attempt to reduce the number of persons progressing to a Type 2 Diabetes diagnosis. The organization has concluded that enrollment rates for the program are low. The organization seeks to improve enrollment into the National DPP lifestyle change program to alleviate the progression of type 2 diabetes within the community.

Note the key components for the foundation of the Action Plan for ACME Health Center:

Organizational Mission	Identified Problem	Desired Outcome
Improve the health status of the members of the community.	Increase in patients developing Type II Diabetes.	Increase the enrollment of individuals at risk for diabetes in the National DPP lifestyle change program.

Development of the Team

The quality improvement team for the QI Action Plan needs to be multidisciplinary. When reviewing the identified problem and the desired outcome, all applicable areas need to be represented on the team as a stakeholder.

Example of stakeholders for the QI Action Plan for ACME Health Center (Note: This list is not all inclusive):

- Executive Sponsor
- Medical Provider

- National DPP Coordinator
- Quality Improvement Coordinator
- Data Analyst

Define the Aim

An aim statement is a summary of what the organization hopes to achieve with specific quantitative components. The aim statement guides the work by establishing what success looks like.

What?	Improve the enrollment rate for the National DPP.
For Whom?	Persons at risk for diabetes in the community and health center that are eligible for the National DPP.
By When?	December 2022
How Much?	Increase enrollment rates by 10%
Full Statement	By December 2022, the ACME Health Center will increase the enrollment rate by 10% of eligible Health Center participants for the National DPP.

Determine Metrics

The first step in determining metrics is to determine the type of metric you are evaluating: Outcome, Process, or Balancing. In this instance, the metric is an Outcome metric. As previously mentioned, Outcome metrics asks how system impacts the patients, their health, and wellbeing? What impacts on other stakeholders are present?

Next, the organization will create Specific, Measurable, Attainable, Realistic, and Timely (S.M.A.R.T.) goals to evaluate an implemented change.

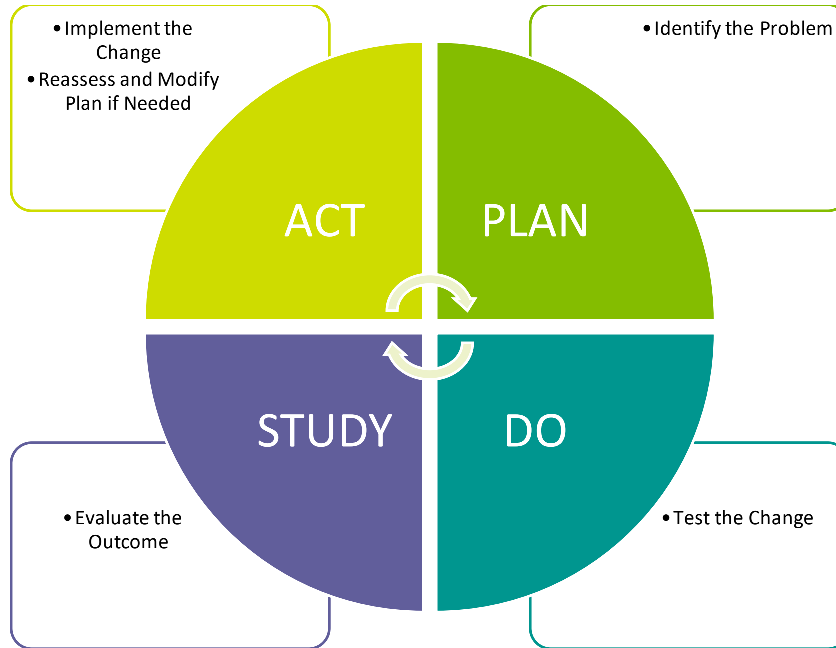
Example of SMART Goal for QI Action Plan

Name	Description	Denominator	Numerator	Benchmark	Goal
Enrollment Rate for the National DPP	Percentage of patients enrolled in the National DPP.	The number of patients of ACME Health Center whom are eligible for the National DPP.	The number of patients of ACME Health Center that are currently enrolled in the National DPP.	30%	40%

Timeline: January 2022-December 2022

Select Quality Improvement Tool

The PDSA cycle, which stands for Plan-Do-Study-Act, is one of the most common quality improvement tools to evaluate change. Small scale changes are encouraged for testing. ACME Health Center decides to initially implement the change at only one practice location, *not* across the entire health center.



Example of a PDSA Cycle for ACME Health Center

PLAN

- Develop tools to support Care Team development & utilization.

DO

- Implement a provider electronic referral process from health center care team to the National DPP.

STUDY

- The referral process resulted in a 7% increase of eligible participants in the diabetes prevention program. The desired goal was not achieved within 7 months of the initial implementation. Continuing the process through the remaining months may achieve the goal.

ACT

- Continue with the current plan, periodically reassessing its impact and modifying the plan as necessary.

Develop an Implementation Plan

Once ACME Health Center has tested the change on a small scale, the organization will scale the change across all locations. ACME Health Center will consider the following prior to scaling to the entire organization:

- ✓ Completion of a readiness assessment.
- ✓ Commitment from executive leadership.
- ✓ An understanding of the time commitment and possible financial commitment to the QI Plan.
- ✓ Consensus of alignment of organizational goals and the vision of the QI Plan.
- ✓ Stakeholder buy-in.
- ✓ Production of policies and procedures to sustain the change.

Plan for Analysis and Sustainment

Implementation is the beginning steps of analysis and sustainment activities. Scaling the change to the entire organization creates another opportunity for a PDSA cycle. Now that the entire organization has been affected, the change needs to be evaluated once again to determine if other systems have been affected.

Continued efforts should be made to evaluate the success based on the identified metric. Perhaps the organization will maintain the enrollment rate goal of 10% goal year after year. This may result in the need of an analysis every quarter. Adding this initiative to the overall organizational quality strategy aligns with the mission of ACME Health Center which has resulted in the creation of a QI Action Plan.

Appendix II

Quality Improvement Action Plan Template

(For Educational Purposes Only)

Introduction

The introduction of your Quality Improvement (QI) Action Plan should provide a background for the reader. The background needs to include the "why" behind the action plan. In defining the "why" consider and document the organization's mission, the identified problem, and the desired outcome. This

[Insert Text]

should be a high-level overview, as your Aim Statement will provide details.

Organizational Mission	Identified Problem	Desired Outcome
[Insert Text]	*[Insert Text]*	*[Insert Text]*

Development of the Team

The quality improvement team for the QI Action Plan needs to be multidisciplinary. The team overseeing the QI Action Plan should include a representative from all departments impacted by the QI Action Plan.

Department	Staff Member Title	Staff Member Name	Staff Member Role
[Insert Text]	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*

Define the Aim

An aim statement is a summary of what the organization hopes to achieve with specific quantitative components. The aim statement guides the work by establishing what success looks like.

What?	***[Insert Text]***
For Whom?	*[Insert Text]*
By When?	*[Insert Text]*
How Much?	*[Insert Text]*
Full Statement	*[Insert Text]*

Determine Metrics

The first step in determining metrics is to determine the type of metric you are evaluating: Outcome, Process, or Balancing.

Next, the organization will create Specific, Measurable, Attainable, Realistic, and Timely (S.M.A.R.T.) goals to evaluate an implemented change.

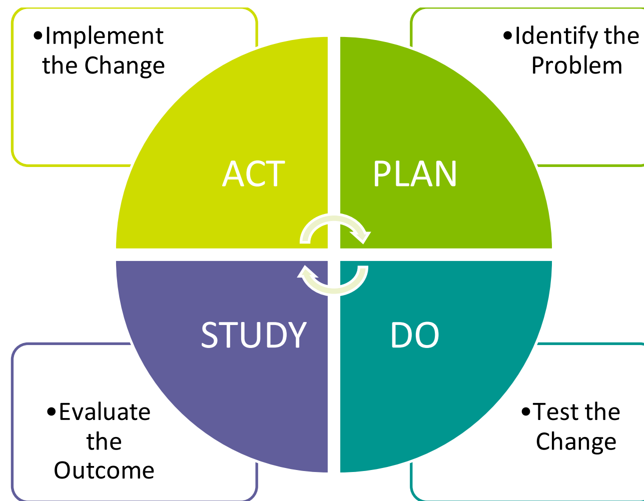
Example of SMART Goal for QI Action Plan

Name	Description	Denominator	Numerator	Benchmark	Goal
[Insert Text]	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*	*[Insert Text]*

Timeline:

Select Quality Improvement Tool

As aforementioned, the PDSA cycle, which stands for Plan-Do-Study-Act, is one of the most common quality improvement tools to evaluate change. Small scale changes are encouraged for testing.



PDSA Cycle Description

PLAN

- *[Insert Text]*

DO

- *[Insert Text]*

STUDY

- *[Insert Text]*

ACT

- *[Insert Text]*

Develop an Implementation Plan

Once the organization has tested the change on a small scale, the organization will scale the change to the entire organization. Prior to scaling the change, the organization should consider:

- ✓ **Completing a readiness assessment.** (See Below)
- ✓ **Commitment from executive leadership and stakeholder involvement.**
- ✓ **Stakeholder buy-in.**

Create a quality improvement project charter. (See Below)

- ✓ **An understanding of the time commitment and possible financial commitment to the QI Action Plan.**

Create a budget and consider the soft cost of staffing (if applicable).

- ✓ **Consensus of alignment of organizational goals and the vision of the QI Plan.**

QI Action Plan Vision (per Executive Sponsor)	***[Insert Text]***
Associated Organizational Goal	*[Insert Text]*

- ✓ **Production of policies and procedures. (Utilize organizational templates for new policies and/or procedures.)**

Example of Readiness Assessment

Questions	Response
Defined Need	
1. Have you clearly defined the need that is driving your health center to consider implementing the change?	○ Yes ○ No
2. Is building a stronger teamwork and improving patient outcomes an appropriate strategy to address your health center's need?	○ Yes ○ No
Readiness for Change in Culture	
3. Is now the right time for implementing a culture change (i.e., it will not compete with other major changes currently being made at your health center)?	○ Yes ○ No
4. Is a culture change that emphasizes the importance of teamwork and improving patient outcomes feasible and acceptable?	○ Yes ○ No
5. Will your health center leaders support culture change and the effort required to implement and sustain the initiative?	○ Yes ○ No
Time, Resources, Personnel	
6. Will your health center provide sufficient staff with the necessary characteristics and attitudes to serve as stakeholders?	○ Yes ○ No
Sustainment of the Change	
7. Will your health center be willing to measure and assess progress and continuously improve processes?	○ Yes ○ No
8. Will your health center be able to reinforce improvements in processes?	○ Yes ○ No

Example of Project Charter

AIM	
How good? For whom? By when? *1-2 sentences*	
PROBLEM	
What is the problem? What happens, when, how often/how much, to whom does it happen? *2-3 sentences*	
IMPORTANCE	
Why is this project important? How will the improvement benefit persons at risk for diabetes? What is the potential downside of this effort for these individuals? What background information (data/analysis/literature) supports the choice of this effort? What area or organizational goals does this project align with/support? *4-5 sentences*	
EXPECTED OUTCOMES	
Specific objectives and numerical targets. Anticipated products, tools, and deliverables (e.g., checklist, clinical pathway, etc.).	
MEASURES	
Brief measure descriptions summarized from more detailed measures table. Include Outcome (1-2), Process (2-5), and Balancing (1-2) measures.	
RISKS/BARRIERS	
What are the major challenges you anticipate? IT? Attitudes? Behaviors? Culture? Time?	
STAKEHOLDERS	
Who are the key stakeholders in the planned changes? How will you incorporate interprofessional and multidisciplinary input? How will you incorporate patients' and families' perspectives?	
SCOPE	
In Scope:	Out of Scope:
SCHEDULE	
Key dates (project kickoff, milestones, etc.) summarized from detailed project timeline.	
PROJECT TEAM	
Team Member	Project Role (sponsor, lead, SME, coordinator, etc.)

Plan for Analysis and Sustainment

Implementation is the beginning steps of analysis and sustainment activities. Scaling the change to the entire organization creates another opportunity for a PDSA cycle. Now that the entire organization has been affected, the change needs to be evaluated one again to determine if other systems have been affected.

Continued efforts should be made to evaluate the success based on the identified metric. Perhaps the organization will maintain its goal year after year. This may result in the need of an analysis every calendar year. Adding this initiative to the overall organizational quality strategy aligns with the mission of the organization.

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