

Improving Colorectal Cancer Screening Rates in North Dakota



# **Measuring Practice Progress**

### Back to Data: Using Data to Maintain a Quality Intervention

- Data (noun)
  - Factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation

#### Information (noun)

• Knowledge obtained from investigation, study, or instruction



*Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary

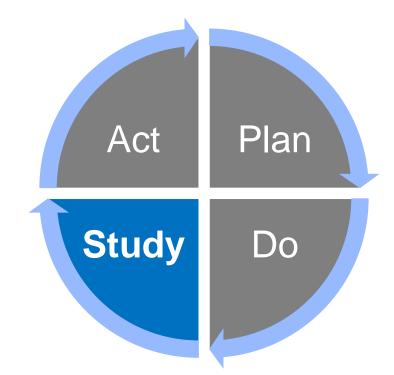
# Using Data to Maintain a Quality Intervention

- Collecting Data
  - How is data being collected?
  - How will the data be reported?
- Data Quality Checks
  - Chart review
  - Monitoring data tools
- Data Monitoring
- <u>Use</u> your data for Continuous Quality Improvement



### **Use Your Data with PDSA Cycles**

- Plan for small changes or interventions
- **Do** implement changes
- Study the results
- Act on the results make any adjustments and start the cycle again



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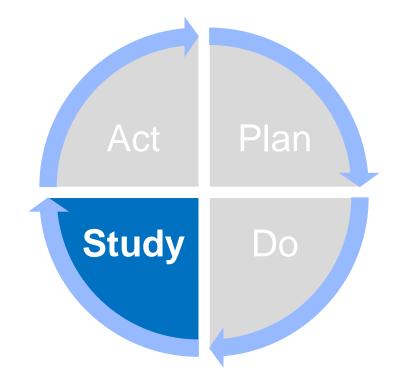


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### **Use Your Data with PDSA Cycles**

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What can you measure?

#### Process Measures measure Implementation

#### Population Reach

*Numerator:* # of patients for which [intervention] was completed meeting priority population definition *Denominator:* Number of patients meeting the priority population definition.

#### Protocol fidelity

*Numerator:* # of patients who received all 6 topics in navigation protocol *Denominator:* # of patients who were assigned to a navigator

#### Time for Intervention

*Numerator:* Total # of minutes delivering intervention *Denominator:* number of patients who received the intervention

#### <u>Outcome Measures</u> measure <u>Outcomes or</u> <u>Results</u>

Screening Tests Completed

*Numerator:* Number of patients with completed screening *Denominator:* Number of patients scheduled for screening or received a stool test

Adequate Bowel Prep Quality

*Numerator:* Number of patients with adequate bowel prep *Denominator:* Number of patients with a performed colonoscopy

#### Results Communicated to Patient

*Numerator:* Number of patients who received screening results

*Denominator:* Number of patients with a completed colonoscopy

What can you measure?



## Calculating Your Relative Improvement It was my

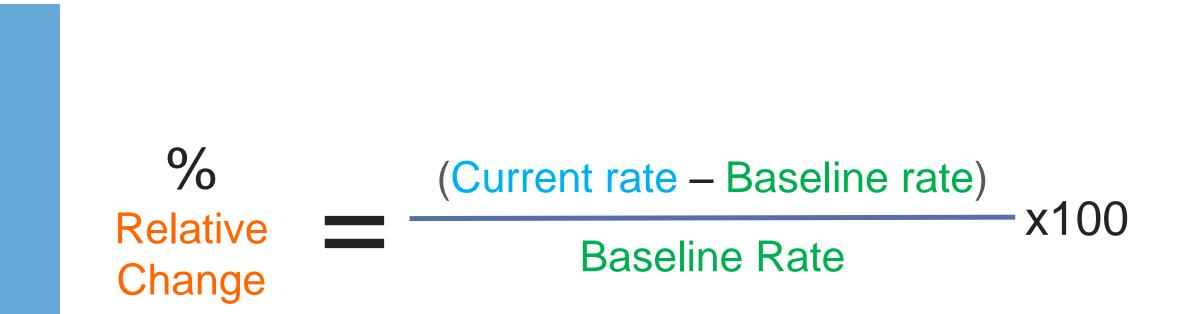
# understanding that there would be no math. (Current rate – Baseline rate)

x100

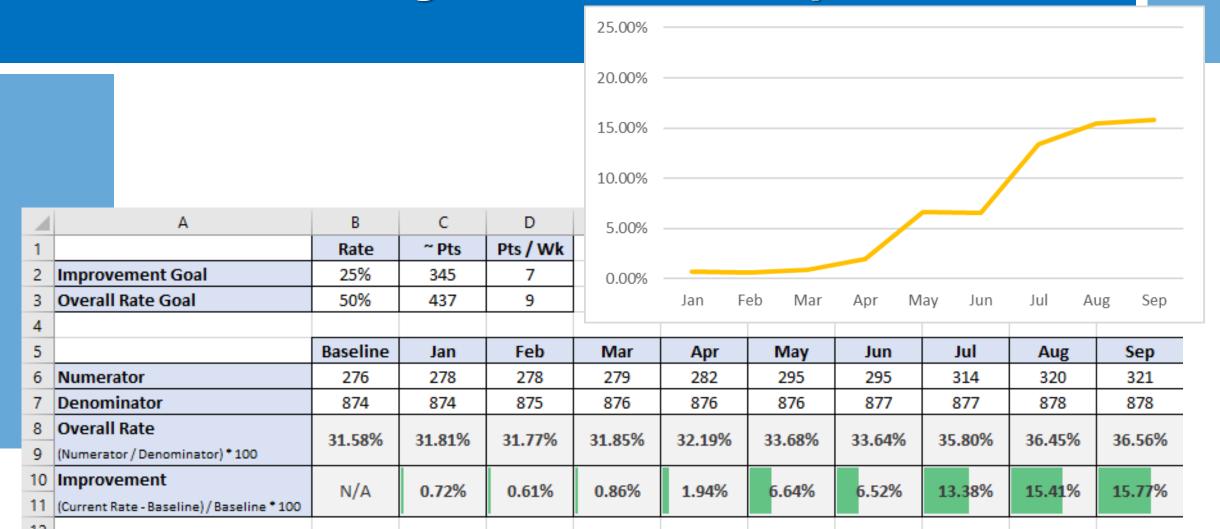
Change

# - Chevy Chase, ine Rate Saturday Night Live

#### **Calculating Your Relative Improvement**



#### **Calculating Your Relative Improvement**

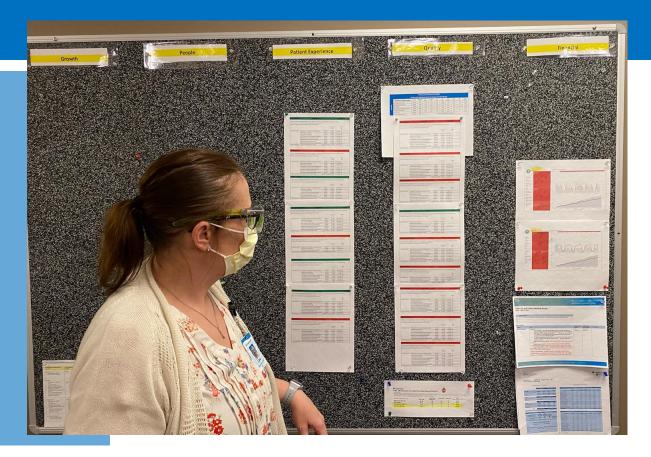


### **Produce and Review Reports**

- Meet as a team troubleshoot/reflect
  - All perspectives needed for accurate interpretation of data
  - Determine what interventions works and what didn't
  - Share the data with staff, leadership, the governing board

| 5  | <u>S</u>  |  |                        |                          | Q                | Quality             |   |                               |   |                      |                  |                    | S.   |  |
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|  |   |  |                        |                          |                  |                     |   |                               |   |                      |                  |                    | 1    |  |
|  |   |  |                        | Primar                   | / Care Das       | hboard:             | 3/27/2021                               |                               |   |                      |                  |                    |      |  |
|  | Primary Care Dashboard: 3/27/2021 Primary Care Dashboard Metric by Category for West Market     |  |                        |                          |                  |                     |   |                               |   |                      |                  |                    |      |  |
|  | Jamestown Fami  | ly Practice  | Metric Date            | All Essentia<br>Target % | West<br>Region N | Jamestown<br>Clinic | Tania<br>Busch                          | Teresa<br>Forme               | Carmen<br>Mittleider                          | Dr. James<br>Tomance | Johnn<br>Trader  | Dr. Glenn<br>Wiens |      |  |
|  | Asthma Optimal Care (Adult 18-50<br>Asthma Optimal Care (Children 5-1                           |  | 3/27/2021              | 57.79%<br>52.48%         | SS.RTN<br>40.7TN | 70.55%<br>62.75%    | 81.67%<br>61.23%                        | 0.00%<br>100.00%              | 51.56N<br>66.67%                              | 65.22%<br>62.50%     | 96.67%<br>11.11% | 64.29%<br>25.00%   | A.   |  |
| quality  | Asthma Optimal Care (Children 5-<br>BMI Documented  |  | 1/27/2021              | C.00%                    | 98.67X           | \$7.42%             | 98.22%                                  | 83.06N                        | 97.78%  | 96.38%               | 94.605           | 91.71%             |      |  |
| 3  | Childhood imminization Compliant<br>Chiamydia Screening Compliance                              | ce (Combo 30)  | 3/27/2021<br>3/27/2021 | 66.00%<br>41.00%         | SLAIN<br>MARK    | 71.31%              | 76.92%<br>15.38%                        | 0.00%<br>20.00%               | 31.11%<br>34.00%                              | 78.35%<br>13.37%     | ILLIN            | 100.00%<br>15.71%  |      |  |
|  | Tobacco Treatment   |  | 3/27/2021              | 12.20%<br>62.41%         | 11.52%           | 19.69%              | 0.00%                                   | 34,29%<br>ar did not tabulate | 66.67%  | 1.67%                | 421%             | 38.46N             |      |  |
|  | Vascular Pts Receiving Optimal Care   |  | 3/23/2021              | BZAIN                    |                  |                     |   |                               |   |                      |                  | -                  | -    |  |
|  | Q   |  |                        |                          |                  |                     |   |                               |   |                      | 1                | 5                  |      |  |
|  | Jamest  | Jamestown QUALITY  |                        |                          |                  |                     |   | 4/3/2021                      |   |                      |                  |                    |      |  |
|  | Clinical Quality Dashboard Metrics by Category for MHEAN/LocDH-JAMESTOWN CLINIC/Dept-AN/Prov-AN |  |                        |                          |                  |                     |   |                               |   |                      |                  |                    |      |  |
| (cicci an a metric to inter-clashoard then nover for business glossery or report link)<br>Each metric displays Metric Value (# Patients above or below Target) |   |  |                        |                          |                  |                     |   |                               |   |                      |                  |                    |      |  |
|  |   |  |                        |                          |                  |                     |   | All Essentio<br>Target        |   | West<br>8/9          |                  |                    |      |  |
|  |   |  |                        |                          |                  |                     | 4/3/2021                                |                               | 1 10 00                                       |                      | 1836             |                    |      |  |
|  | Ambulatory Care Adolescent<br>Breast Can  |  |                        | nization Com<br>eening   | phance (Co       |                     |   |                               | √ 49.09% (+6)<br>√ 80.57% (+1)                |                      |                  |                    |      |  |
|  | Cervical Cancer Screening   |  |                        |                          |                  |                     | 4/3/2021                                |                               | √ 79.91% (+58)                                |                      |                  |                    |      |  |
|  | COAT Patients w/ Active Treatment Agreement<br>Colorectal Cancer Screening Rate (MNCM)          |  |                        |                          |                  |                     | 4/3/2021<br>4/3/2021                    |                               | √ 100.00% (+3)<br>√ 75.92% (+7)               |                      |                  |                    |      |  |
|  | Depression Remission Rate at Six Mor<br>Diabetic Pts Receiving Optimal Care                     |  |                        |                          |                  |                     | 4/3/2021                                | 22.50%                        | 18.4  | 296 (-4)             |                  |                    |      |  |
|  |   |  |                        |                          |                  | Care                | 4/3/2021<br>4/3/2021                    |                               | 47.82% √ 50.56% (+9)<br>81.09% √ 84.72% (+36) |                      |                  |                    |      |  |
|  |   | Hypertensive Patients Receiving Optimal Care<br>Patient Experience CGCAHPS Recommend This Provider |                        |                          |                  |                     |   | 2021 91.80% 		94.90% (+3)     |   |                      |                  |                    |      |  |
|  | Patient Experie   | nce CGCAH  | PS Recomm              | end inis Pri             | DAIMEL           |                     | 201000000000000000000000000000000000000 |                               |   |                      |                  |                    |      |  |

#### **Produce and Review Reports**



#### Benefits

- Set new goals
- Create cohesive team everyone's contribution matters
- Motivational/Hold each other accountable

#### **Data Feedback and Benchmarking**

- Use feedback to provide your clinic and teams information about both Processes and Outcomes
- Incorporate historical or timeline tracking to assess improvement
- Include benchmarks or goals to allow your providers or teams to compare their performance on select measures with each other, or with national targets.

#### **Provider Feedback**

- Report performance measures to each HCP
  - # of patients with completed screening / # of patients empaneled to the provider who meet eligibility criteria
- Could also report by team/facility within a system

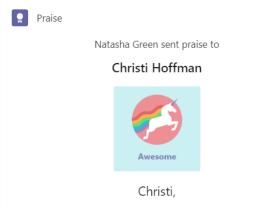
Patient performance can not improve until provider performance does. Keys to making feedback actionable: (Hyson, Best, & Pugh, 2006)

- ✓ Timeliness MONTHLY (not quarterly)
- ✓ Individualization
- Non-punitive approach offer suggestions for improvement, case review for those that are outside the norm.
- ✓ Customizability



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I just wanted to say THANK YOU for your speediness with all requests!!! You have many roles and do such a great job. THANK YOU for being AWESOME!!!!!



### Celebrating the LIFE Saved

### **Sharing Innovation**

# How does your organization share progress across QI initiatives with staff, administration, board members, or the community?

- Do you have a dashboard or other mechanism to share your progress on QI initiatives?
- Who is it shared with?
- How does it get to the staff level?
- Do you share QI info with patients or the public? How?

#### How do you celebrate successes?

- Do you celebrate small successes along the way to your goal?
- What do you find the best way to celebrate with staff?

#### **Resources for the Journey Ahead**

#### Resources

- Book: Hitchhikers Guide to the Galaxy
- Crush It Call Example: <u>https://youtu.be/0Hau4C00Jd0</u>
- QI Project Sustainability Checklist (ASTHO)

### **Next Steps**

#### TA Calls

Evaluation (required for CEUs)

Thank you for participating in the Rapid Action Collaborative! Please watch for upcoming learning opportunities!

# **ScreeND Contact Information**

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