Session 1: Intro to Quality Improvement
Small Group Exercise

Assignment:

- Each team will be assigned to an ongoing and relevant health care problem
- Review the Reference Article for your team's assigned problem (please see reference articles listed below)
- Discuss the Health Care Problem with your Team
- Complete the Health Care Problem Template on Power point
- Regroup with entire large group. Each team will present their PPT presentation to report out their findings/ideas. Each team will have 7-8 minutes to present and 2-3 minutes for questions/feedback.

Team Assignments:

A reference article for each problem is provided for you. Use the article to help get your team's discussion started.

Team Assignments	1	2	3	4
Business Driver	Compendium of Strategies to Reduce HAIs in Acute Care Hospitals (SHEA – Joint Commission Initiative)[1]		Joint Commission 2006 National Patient Safety Goal: " Implement a standardized approach to 'hand off' communications." [2]	
Health Care Problem	Handwashing rates among physicians in the inpatient setting are low.	Rates of unnecessary or inappropriate urinary catheters in hospitalized patients are high.	Handoffs between providers during patient transfers from MICU to floors can lead to patient harm and there is currently no standard approach.	Transitions of care between inpatient physicians and outpatient primary care providers are poor.
Reference article	Boyce JM and Pittet, D. Hand Hygiene in Healthcare Settings: Recommendations of the Healthcare Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *Infect Control Hosp Epidemiol:* 2002. 23[suppl]:S3-S40.	Apisarnthanarak A, et al. Effectiveness of Multifaceted Hospitalwide Quality Improvement Programs Featuring an Intervention to Remove Unnecessary Urinary Catheters at a Tertiary Care Center in Thailand. *Infect Control Hosp Epidemiol:* 2007; 28, 791-798.	Arora VM et al. Hospitalist Handoffs: A Systematic Review and Task Force Recommendations. *JHM:* 2009; 7(4).	Kripilani S et al. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians Implications for Patient Safety and Continuity of Care. *JAMA:* 2007; 297 (8).

[1] http://www.jointcommission.org/patientsafety/infectioncontrol/

[2] http://psnet.ahrq.gov/primer.aspx?primerID=9

Steps in the QI Process:

Step 1: Understanding The Problem

- Your team will likely not know the data about your instituction's performance. You may be able to find this information on your institution's website. This information is important for the 1st step of "understanding your problem."
- Choose either a Fishbone diagram or Process map to help characterize your problem. Spend time with your team to brainstorm and flesh this out as much as possible.

Step 2: Identifying Areas for Improvement

- Try to identify areas in which you could make a large impact with the least amount of effort

Step 3: Measuring Progress

- Choose metrics that can be measured that are relevant to your problem.

Step 4: Objectives and Goals

- Create SMART goals for your project – how much improvement in which areas over what period of time?

Step 5: Effective Solutions

- Propose some interventions that can be undertaken to move your institution from its current performance to its ideal performance (this should take into consideration steps 3 and 4)

Step 6: Building and Sustaining success

- How can lasting change be made?