IHI ID 21

A COMPREHENSIVE PBM PROGRAM EMPHASIZES FOCUSED FEEDBACK TO IMPROVE PATIENT SAFETY AND DECREASE COSTS

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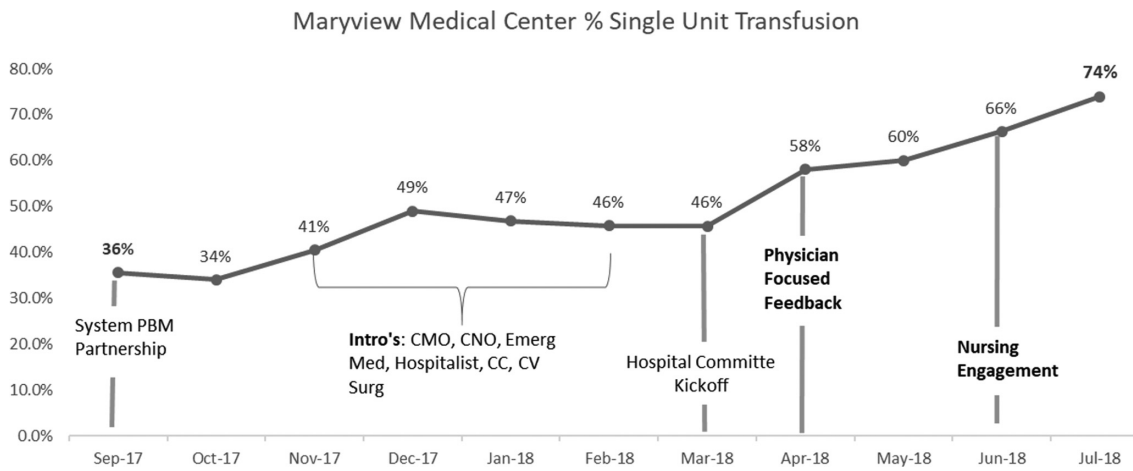
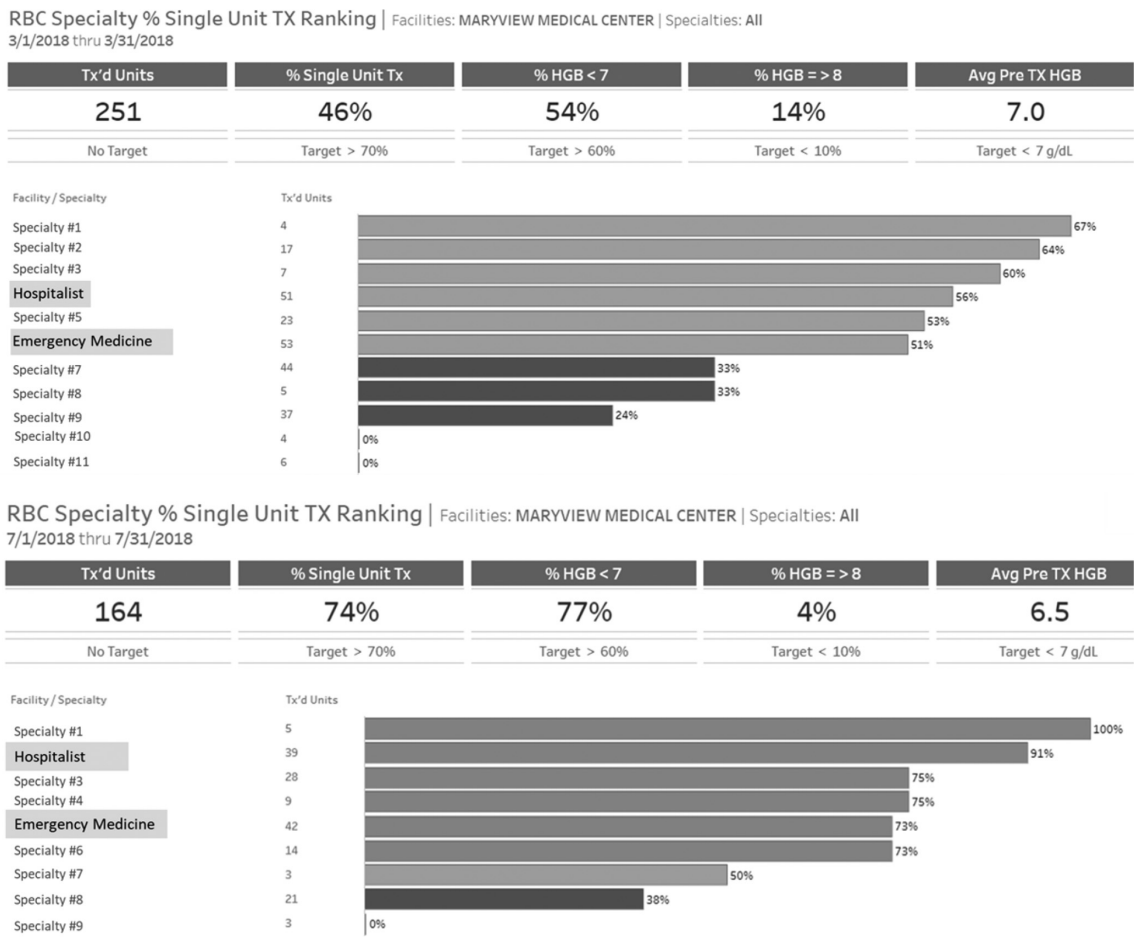
Background Patient blood management (PBM) is one of the top patient safety initiatives of the decade. A community hospital, administering over 5000 transfusion a year, evaluated their transfusion practices against a national PBM data set. High-performing comparable hospitals are delivering 64–80% of their transfusions one unit at a time. Maryview Medical had an initial performance rate of 36%. Single unit transfusions (SUT) in non-hemorrhaging patients is a practice that decreases patient exposures, improves patient outcomes, and reduces hospital costs.

Objectives Maryview aimed to improve single-unit transfusion rate while decreasing hospital costs.



Abstract IHI ID 21 Figure 1



Abstract IHI ID 21 Figure 2

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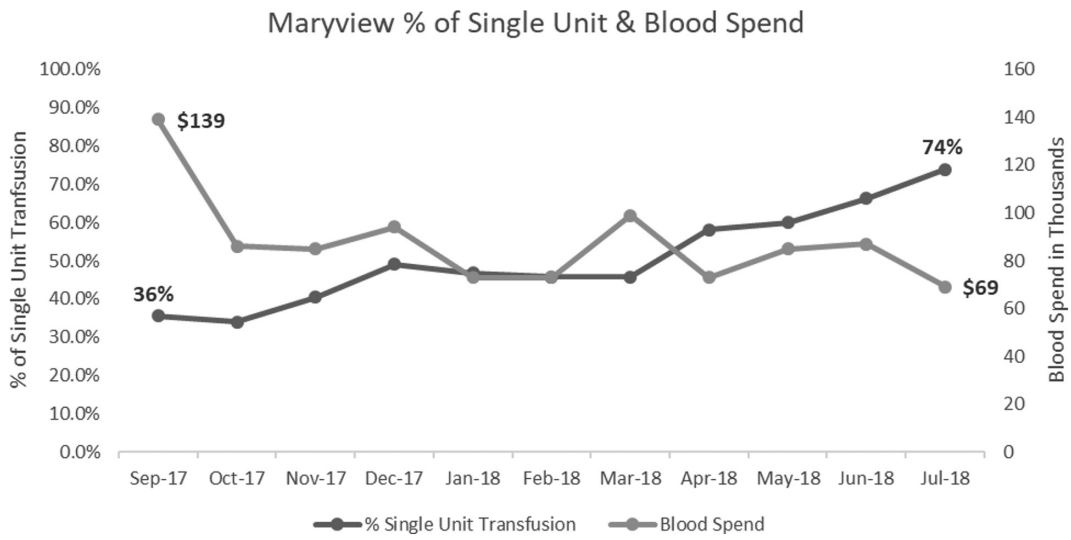
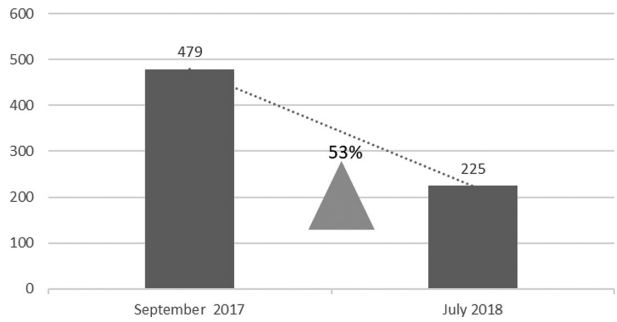


Abstract IHI ID 21 Figure 3



Abstract IHI ID 21 Figure 4 Maryview monthly RBC utilization

Methods Hospital Champions partnered with a team of PBM experts to implement a comprehensive and multidisciplinary program. Infrastructure was established and the evidence was reviewed. Validated PBM analytics were used to demonstrate organization, specialty, and physician level performance. The performance metrics guided the team toward patient service lines that had high opportunity to improve transfusion practices. A sense of urgency was created through a hospital wide awareness campaign. Physician champions used the Focus, Feedback and Fix model to begin accountable conversations. Nursing used clinical inquiry to advocate for patient centered ordering practices and the clinical team partnered with the blood bank staff to collaborate on driving out unnecessary transfusions.

Results SUT practice improved from 36% to 74% over 12 months, with Emergency Medicine and Hospitalist having the greatest improvement. Additionally, monthly red cell utilization was reduced by 53% resulting in a significant decrease in hospital blood product spend.

Conclusions Creating urgency, delivering performance feedback, and collaborating across services improves patient safety while decreasing costs.

IHI ID 22 VALIDATION OF THE QUALITY IMPROVEMENT ASSESSMENT (QIA) TOOL

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Background QI training occurs regularly in health care systems often without impact assessment. QIKAT is scenario-based, is focused on confidence not skill attainment or organizational and team contexts. A validated assessment tool grounded in QI theory, capturing organizational context, skills and growth, for frontline healthcare members is needed. The 67 item scale QIA survey used at Dartmouth measures QI skills, communication, team dynamics, and context. Response options are ordered categories measured on a 5-point scale. QIA data from 463 individuals in nine programs from 2016–2017 were used in this study.

Objectives Establish validity and reliability of Quality Improvement Assessment Survey.

Methods Content validity: Literature review/interviews Construct validity: Exploratory/confirmatory factor analysis Redundant/poor performing items: Item analysis/Rasch modeling.

Results Literature review and consultation confirmed inclusion of measures of QI skills, organizational culture, and team dynamics. EFA of QI skills items loaded on four factors measuring System, Variation, Psychology and Knowledge. EFA on organizational culture and team dynamics yielded four factors measuring Microsystem and Organizational leader(s) and Awareness of Self and Others in Team Dynamics (table 1). CFA confirmed data fit the hypothesized theoretical model for QI skills (CFI=0.954, RMSEA=0.075) Organizational culture/team dynamics (CFI=0.969, RMSEA=0.049) (table 2). Scales were reliable and moderately correlated (see table 3). Item analysis/Rasch modeling identified several items that were redundant or poor performing.

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