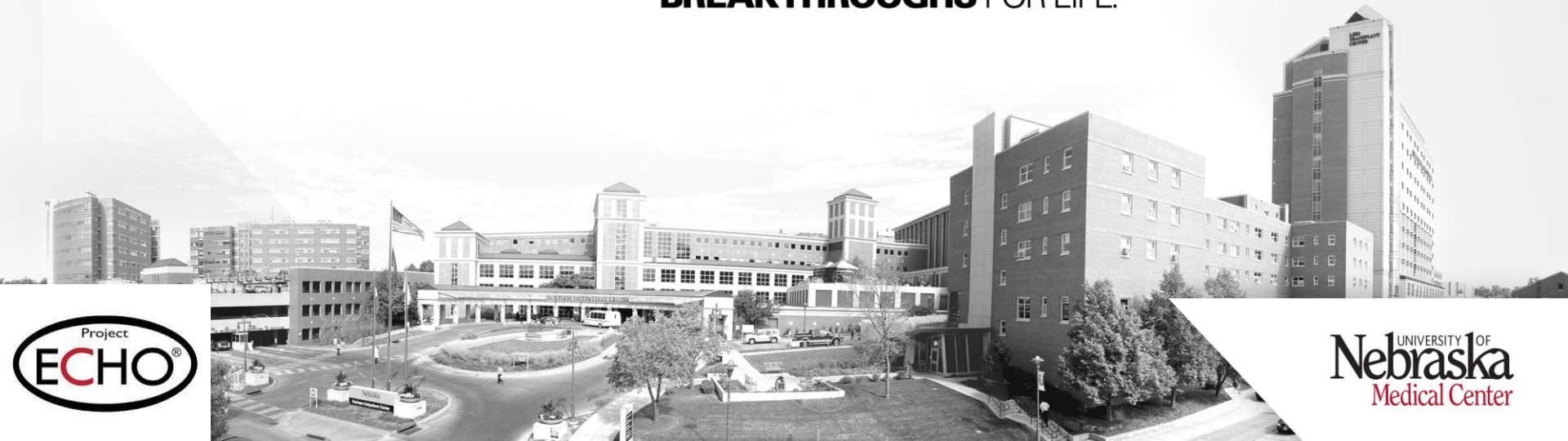
UNMC[SM]

BREAKTHROUGHS FOR LIFE.®



Project ECHO®

University of Nebraska Medical Center

UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 16

Project Funded by Nebraska DHHS through a CDC grant

Housekeeping Reminders

- Discussion makes sessions work best!
- Please stay muted unless you are speaking
- We love to see your face!
- Enter your full name: More ⇨ Rename
- Sessions will be recorded and available upon request
- Attendance is taken by filling the survey in the chat

- Reminder: Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. This data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to create new initiatives.

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Erica Stohs, MD, MPH
- Anum Abbas, MD
- Kelly Cawcutt, MD, MS

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD

Health Equity & Cultural Sensitivity Team

- Nada Fadul, MD
- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Andrea Jones, MD
- Precious Davis, Case Manager
- Samantha Jones, Program Manager

CE Disclosures

Project ECHO

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UNMC ID Health Equity and Quality Improvement ECHO Project

Topics: CS: Implicit Bias. QI: Change Management (part 2-2) Securing Buy-in and "Selling" Your Improvements.

Free Live ECHO Project
June 15, 2022
CID 53868

University of Nebraska Medical Center

TARGET AUDIENCE

This accredited continuing education activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.
The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- Differentiate between explicit and implicit bias
- Articulate effective strategies for securing buy-in from leadership and key stakeholders.
- Discuss strategies for aligning your QI project with institutional priorities.

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
    a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
    b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hours. Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Nebraska Medical Center maintains responsibility for this course. Social workers completing this live activity receive 1.5 interactive continuing education credits.
Social work level of content: Advanced.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hours.
Activity code: I00050850 Approval Number: 220001695
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE INFORMATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

The below faculty have nothing to disclose:

- Gale Etherton, MD, FACP
- Nada Fadul, MD*
- Mahelet Kebede, MPH*
- Mahliqha Qasimyar, MD
- Jeff Wetherhold, M. Ed*

**Indicates on the planning committee*

Disclosures

PLANNING COMMITTEE

M. Salman Ashraf, MBBS
Merck & Co, Inc: Industry funded research/investigator

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

- Valeta Creason-Wahl, HMCC
- Precious Davis, MSN, BSN, RN
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Bailey Wrenn, MA

www.unmc.edu/cce

POLL

QI Projects

Benefits

1. **Coaching:** Organizations will receive 1:1 coaching on quality improvement and health equity to develop and implement approved QI projects.
2. **Reimbursement:** Organizations are eligible to apply for up to $2,000 in expense reimbursement related to an approved QI project.

Coaching is available for:

1. Implementing an approved QI project
2. Designing a project based on a topic of interest
3. Choosing a relevant topic from multiple ideas or from within an existing project
4. Brainstorming ideas for a project

Project Information

1. What problem are you trying to address?
2. What leads you to believe this is a problem?
3. What change can you make?
4. What can you measure to know if you are successful?
5. How does this impact COVID-19 management?
6. How does this impact health equity or cultural sensitivity?
7. Are you open to sharing your project with another team?

Next Session

- QI Focus: How to scope an improvement project to ensure that QI tools can be applied effectively

- Resource: Quality Improvement Knowledge Application Tool Revised (QIKAT-R)

Research Report

The Quality Improvement Knowledge Application Tool Revised (QIKAT-R)

Mamta K. Singh, MD, MS, Greg Ogrinc, MD, MS, Karen R. Cox, RN, PhD, Mary Dolansky, RN, PhD, Julie Brandt, PhD, Laura J. Morrison, MD, Beth Harwood, MEd, Greg Petroski, PhD, Al West, PhD, and Linda A. Headrick, MD, MS

Abstract

Purpose
Quality improvement (QI) has been part of medical education for over a decade. Assessment of QI learning remains challenging. The Quality Improvement Knowledge Application Tool (QIKAT), developed a decade ago, is widely used despite its subjective nature and inconsistent reliability. From 2009 to 2012, the authors developed and assessed the validation of a revised QIKAT, the "QIKAT-R."

Method
Phase 1: Using an iterative, consensus-building process, a national group of QI educators developed a scoring rubric with defined language and elements. *Phase 2:* Five scorers pilot tested the QIKAT-R to assess validity and inter- and intrarater reliability using responses to four scenarios, each with three different levels of response quality: "excellent," "fair," and "poor." *Phase 3:* Eighteen scorers from three countries used the QIKAT-R to assess the same sets of student responses.

Results
Phase 1: The QI educators developed a nine-point scale that uses dichotomous answers (yes/no) for each of three QIKAT-R subsections: Aim, Measure, and Change. *Phase 2:* The QIKAT-R showed strong discrimination between "poor" and "excellent" responses, and the intra- and interrater reliability were strong. *Phase 3:* The discriminative validity of the instrument remained strong between excellent and poor responses. The intraclass correlation was 0.66 for the total nine-point scale.

Conclusions
The QIKAT-R is a user-friendly instrument that maintains the content and construct validity of the original QIKAT but provides greatly improved interrater reliability. The clarity within the key subsections aligns the assessment closely with QI knowledge application for students and residents.

Since 2003, the Accreditation Council for Graduate Medical Education[1,2] has required practice-based learning and improvement (PBLI) and systems-based practice as two of six core competencies for resident physicians. The American Board of Medical Specialties also requires these two competencies for board certification in all specialties.[3] Additionally, the Robert Wood Johnson Foundation[4] and the QSEN (Quality and Safety Education in Nursing) Institute[5] have each published recommendations and curricula to teach quality improvement (QI) to health professional learners, and in 2012, the Association of American Medical Colleges recommended a set of competencies for faculty educators in QI and patient safety.[6] These competencies, recommendations, and guidelines highlight the increasing importance of QI education. They have also generated substantial interest in designing, implementing, and evaluating curricula for QI. Review articles about teaching QI have described medical training programs and curricula, identified common elements across these programs and curricula, and recommended important next steps.[7–9] Each review's authors have underscored current challenges with evaluating learner QI competence and argued for better instruments to assess learner achievement in QI.

Over the last decade, various QI assessment tools have surfaced, each measuring specific components of QI education. For instance, the Quality Improvement Project Assessment Tool assesses the structure, content, and strength of an initial QI proposal.[10,11] The Systems Quality Improvement and Assessment Tool evaluates PBLI self-efficacy, knowledge, and application skills in resident learners[12] and can help guide PBLI residency curricula.[13] Surveys measuring resident self-reported attitudes about PBLI and QI project implementation have proven to be a useful way for educators to measure achievement of curricular objectives.[14] The Systems Thinking Scale measures systems thinking in the context of QI, whereas the Team Check-up Tool measures the QI intervention context itself.[15,16] The Quality Improvement Knowledge Application Tool (QIKAT), originally described in 2003 and 2004, has been used to assess the results of an internal medicine elective rotation for residents in QI.[17,18]

The QIKAT consists of three short descriptions of scenarios. Each depicts a system-level quality problem. The respondent is required to read the scenario and supply a free-text response consisting of an aim, a measure, and one focused change for a QI effort that addresses the system-level issue raised in the scenario. The QIKAT thus assesses an individual's ability to decipher a quality problem within a complex system and propose an initiative for improvement. This capacity of QIKAT, coupled with its straightforward administration and its ability to measure QI knowledge application close to curricular interventions, resulted in the widespread use of the QIKAT across disciplines and developmental learning stages. It has been used to assess QI learning in medical school curricula[19,20]; in interprofessional education[21]; in internal medicine,[22] psychiatry,[23,24] and family medicine residencies[25]; and in a preventive

Please see the end of this article for information about the authors.

Correspondence should be addressed to Dr. Singh, Louis Stokes VA Medical Center, Case Western Reserve University, EUL, ZM680, 10701 East Blvd., Cleveland, OH 44018; telephone: (216) 791-2300 ext. 2328; e-mail: Mamta.singh@case.edu.

Acad Med. 2014;89:1386–1391.
First published online August 12, 2014
doi: 10.1097/ACM.0000000000000456

Poll Results

Quality Improvement: Securing Buy-in and "Selling" Your Improvements

Presenters: Gale Etherton, MD; Mahliqha Qasimyar, MD; Jeff Wetherhold

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Objectives

1. Articulate effective strategies for securing buy-in from leadership and key stakeholders.
2. Discuss strategies for aligning your QI project with institutional priorities.

Steps for Change Leadership

1. Establish a sense of urgency
2. Form a guiding coalition
3. Create a vision

When Starting Out

4. Communicate the vision
5. Empower others to act
6. Create short-term wins

When Building Momentum

7. Consolidate; create more change
8. Internalize new approaches

When Spreading Success

John Kotter's 8 Steps from "Why Transformation Efforts Fail," Harvard Business Review, 2006.

“Analysis rarely changes how people think and it does not send people running out the door to act in a new way….When individuals are motivated it is something they feel in their hearts and not in their heads that impel them into action.”

- *Change Management in Health Care*, 2008

Discussion

What tools or tactics do you use to secure buy-in for your changes?

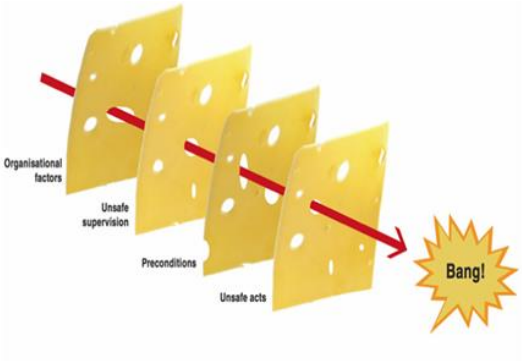
Kotter's Change Management

- "See-Feel-Change" Approach
    - When behavior is fueled by emotion, it is more likely to last longer than when fueled by analysis because it will be resistant to negative emotions
- Leaders need a burning platform to make real changes
- You need to provide that burning platform by telling them the story

Connecting the Dots

- The patient's story creates the burning platform

- Your job is to make the leaders
  - Understand how the holes in the Swiss cheese line up to create the risk
  - See how fixing the problem with process change aligns with the goals of the institution
  - Understand their contribution as leaders to the process
  - Understand what it is that you need them to do (the vision)



Importance of Buy-in

Link to video

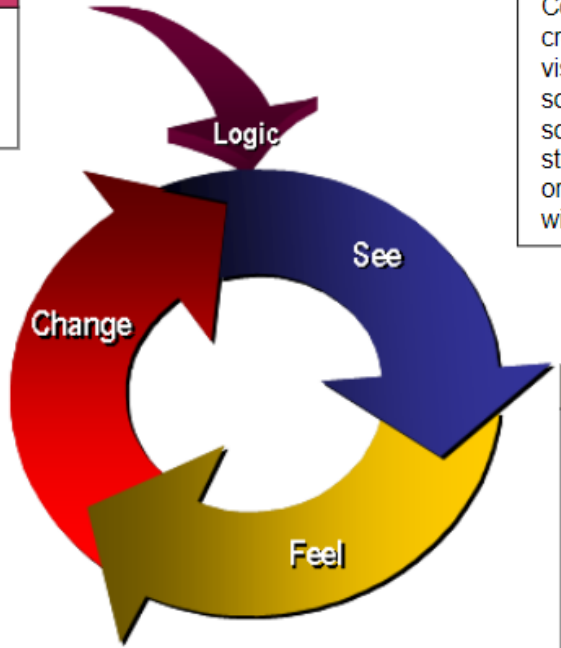
Change is Not an Event...it is a Process

Understand the Logic

The logic from the analysis feeds into the creation of the compelling situations

Help People See

Compelling situations are created to help others visualize problems, solutions, or progress in solving complacency, strategy, empowerment or other key problems within the eight steps



Change Behavior

Emotionally charged ideas change behavior or reinforce changed behavior

Hit the Emotions

The visualizations provide useful ideas that hit people at a deeper level than surface thinking. They evoke a visceral response which reduces emotions that block change and enhances those that support it.

Abigayle Blake: Organization Change Management Presentation; 2016

Communicating Change

When addressing complex issues:

- Identify audiences and how the proposed solution will impact them.
- Consider how audiences interact. Where do needs align or conflict?
- Balance the needs and interactions of your audiences to get to a systems-level view

Systems Communication Plan

	Audience 1	Audience 2	Audience 3
Who do you need to communicate with?			
How will you reach them?			
What will they be most worried about?			
What do you need them to understand?			
What do you need them to do next?			
How can they communicate back with you?			

Getting Team Buy-in

[Link to video]

Advancing the Change

- Getting Team Buy-in
- Empower Individuals
- Remove Obstacles
- Go for short term wins
    - Achieve visible, meaningful and unambiguous progress quickly

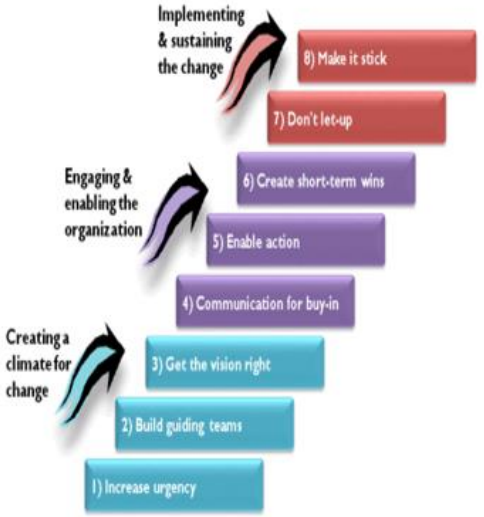
Sustaining the Change

- Tenacity
  - Change is difficult
  - Change takes time
  - Do not let up!

- Keep up the momentum
  - Select out front line workers to problem solve in small groups and continue the momentum of change

Kotter's 8 Steps for Change

1. Establish a sense of urgency
2. Form a powerful guiding coalition
3. Create a vision
4. Communicate the vision
5. Empower others to act on the vision
6. Plan for and create short-term wins
7. Consolidate improvement; produce more change
8. Institutionalize new approaches



John Kotter's 8 Steps from "Why Transformation Efforts Fail," Harvard Business Review, 2006.

Cultural Sensitivity: Implicit Bias

Presenters: Nada Fadul, MD and Mahelet Kebede, MPH

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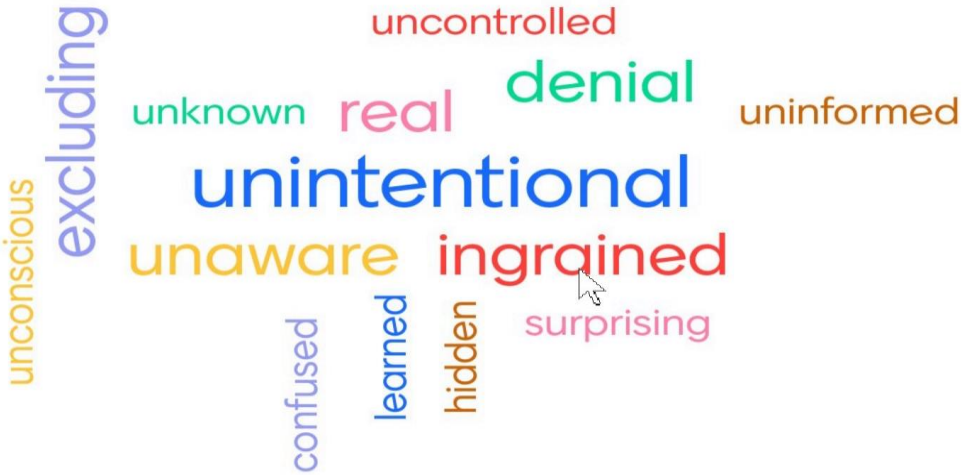
Objectives

1. Describe an example of implicit bias.
2. Differentiate between explicit and implicit bias.

Word Cloud Activity

What word do you think of when you hear the term "implicit/unconscious bias?"



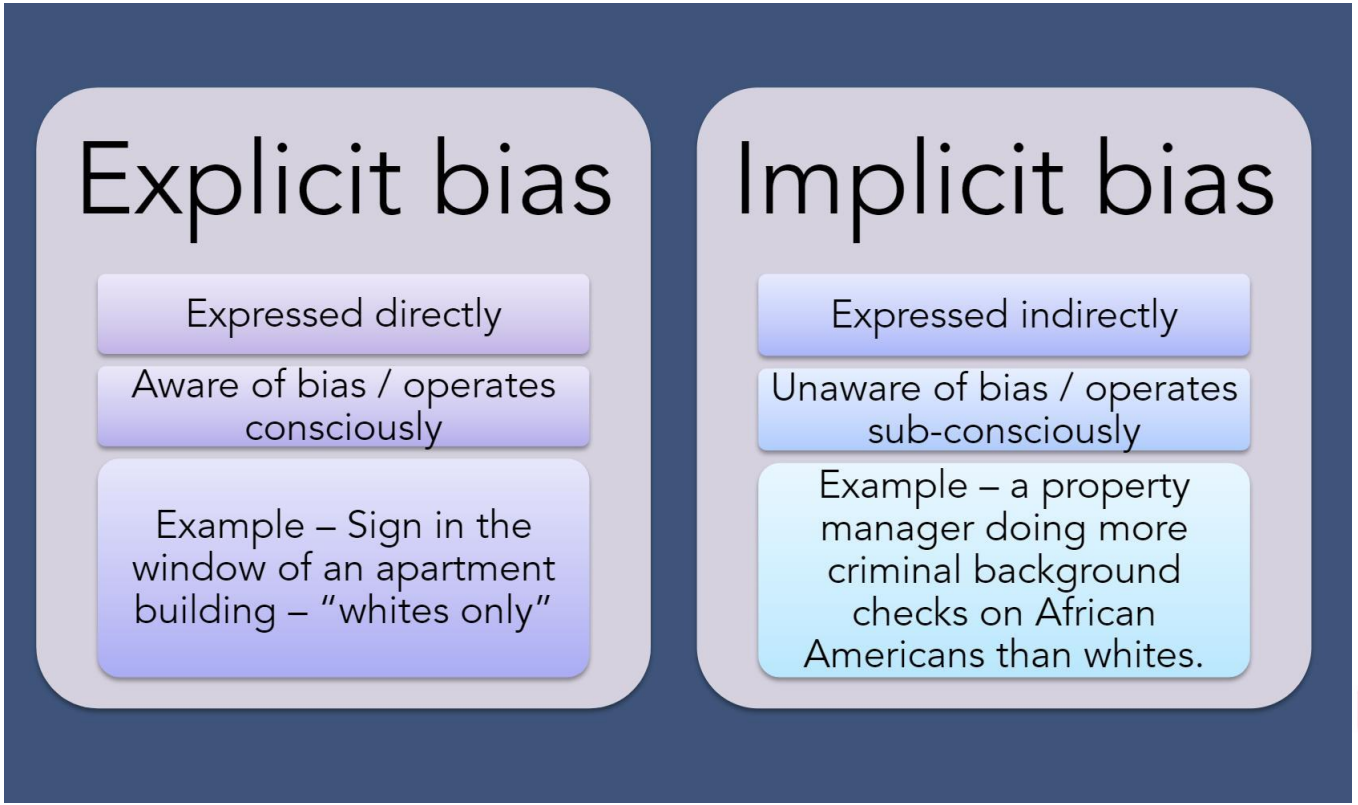
Implicit Bias

(AKA Unconscious Bias)

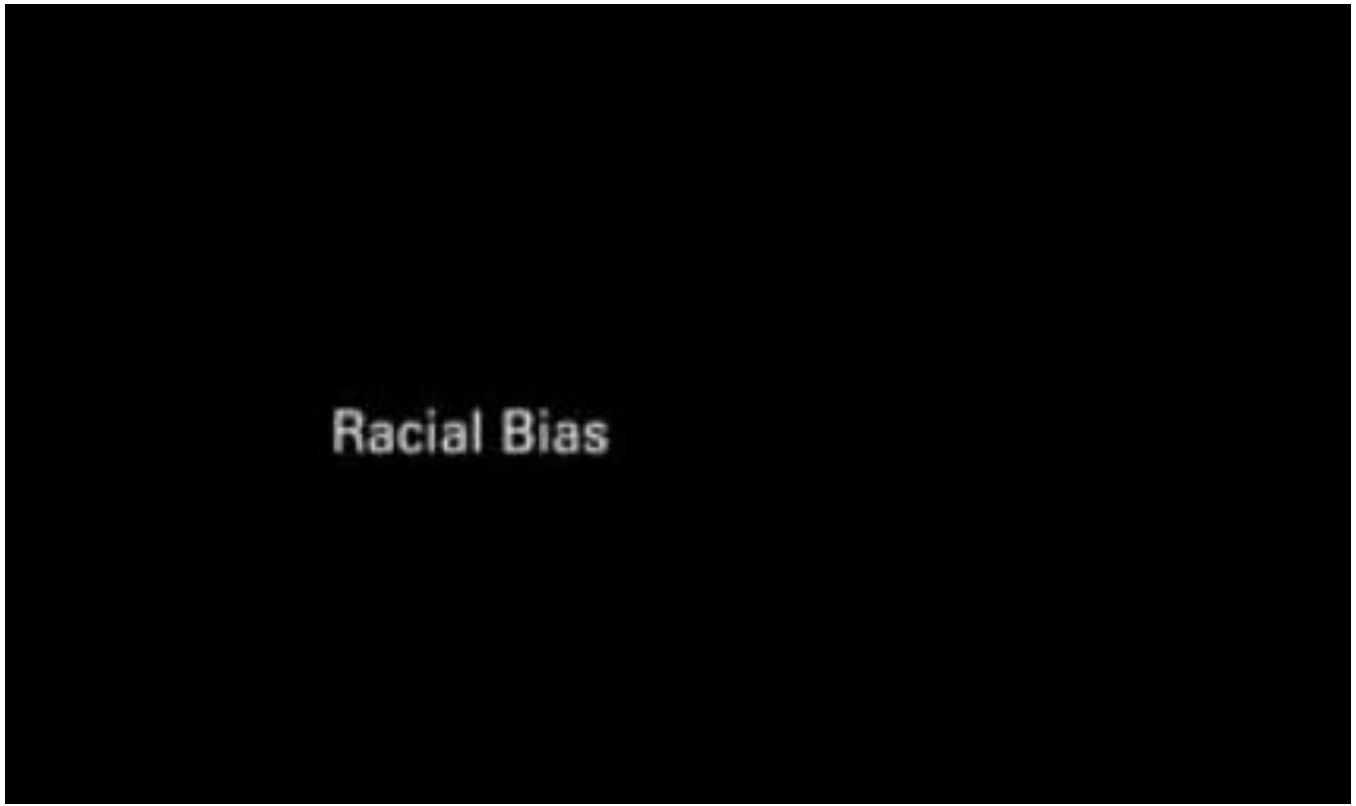
Definition

When we have attitudes towards people or associate stereotypes with them without our conscious knowledge.

Explicit vs Implicit Bias



Example, part 1

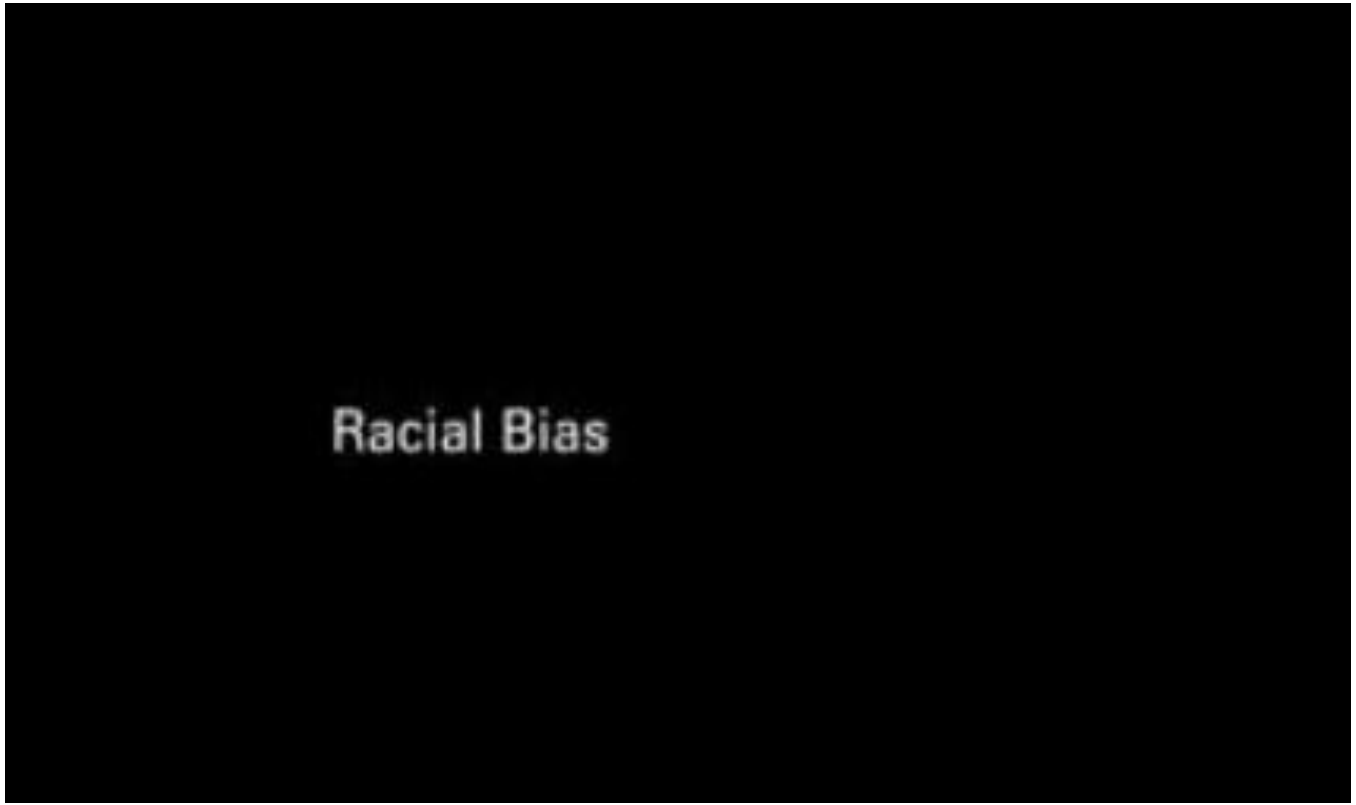


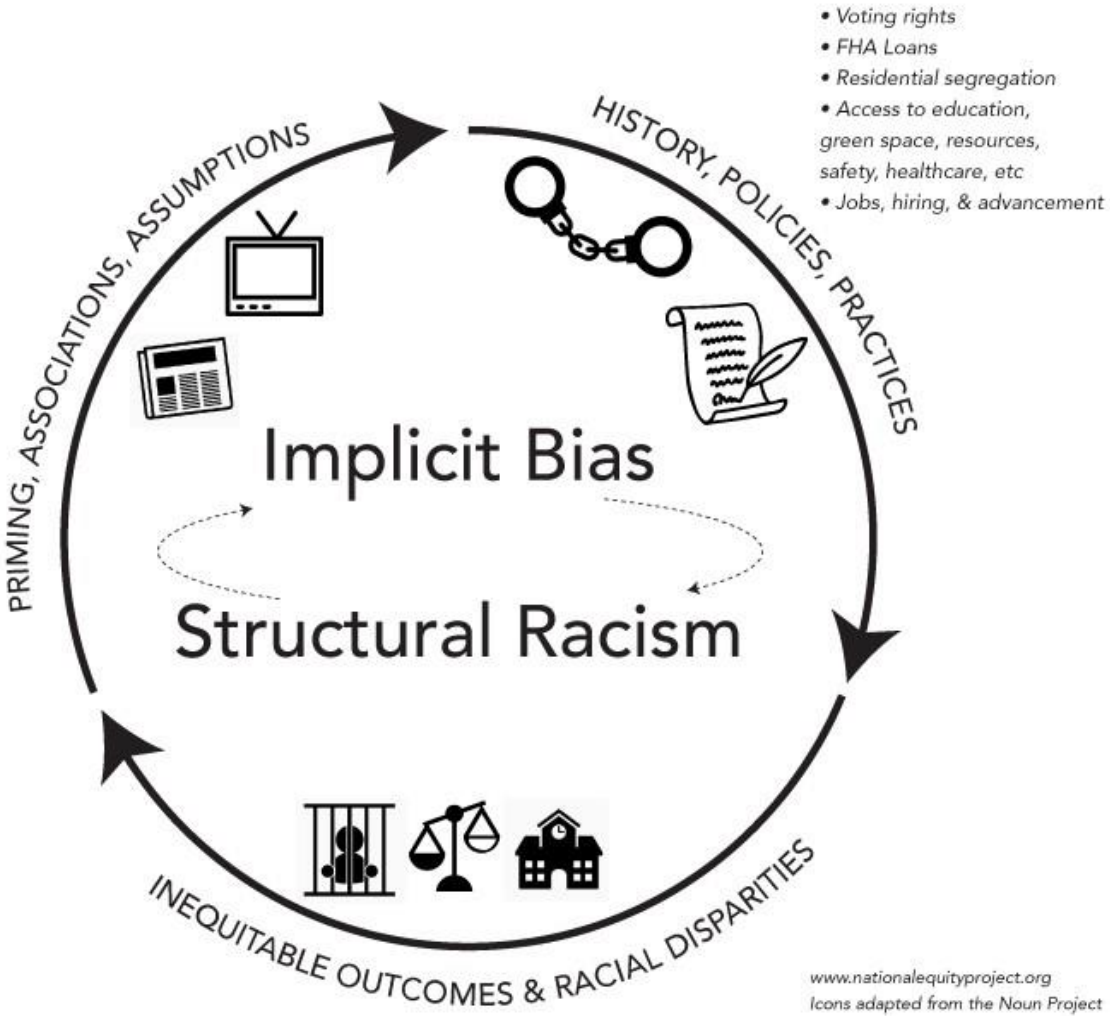
Reflection

How do you think the second shift nurse did with their response/reaction to the implicit bias expressed by the first nurse?

- What would you have done differently? Or the same?

Example, part 2

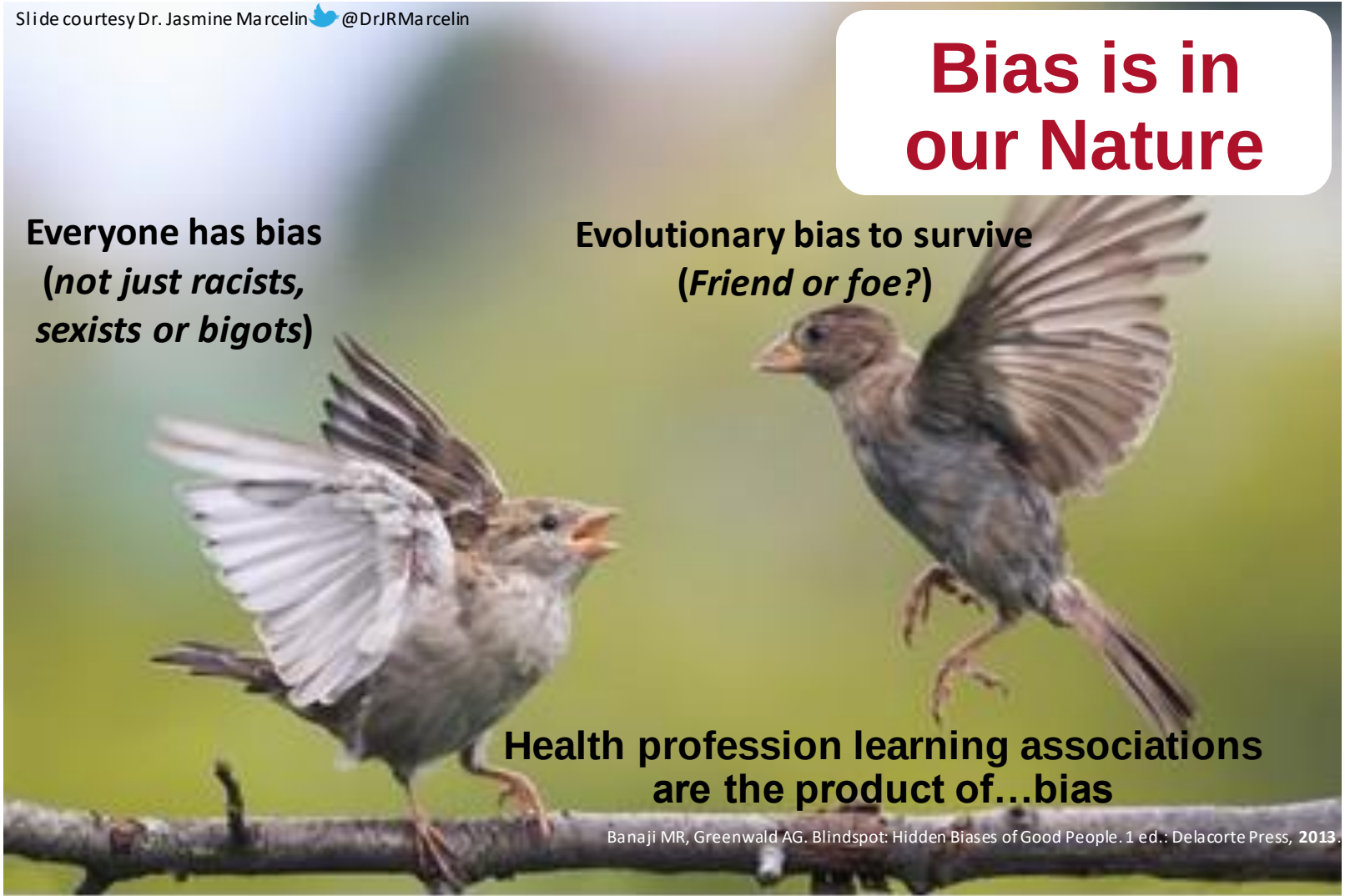




https://medium.com/national-equity-project/implicit-bias-structural-racism-6c52cf0f4a92

Slide courtesy Dr. Jasmine Marcelin @DrJRMarcelin

Bias is in our Nature



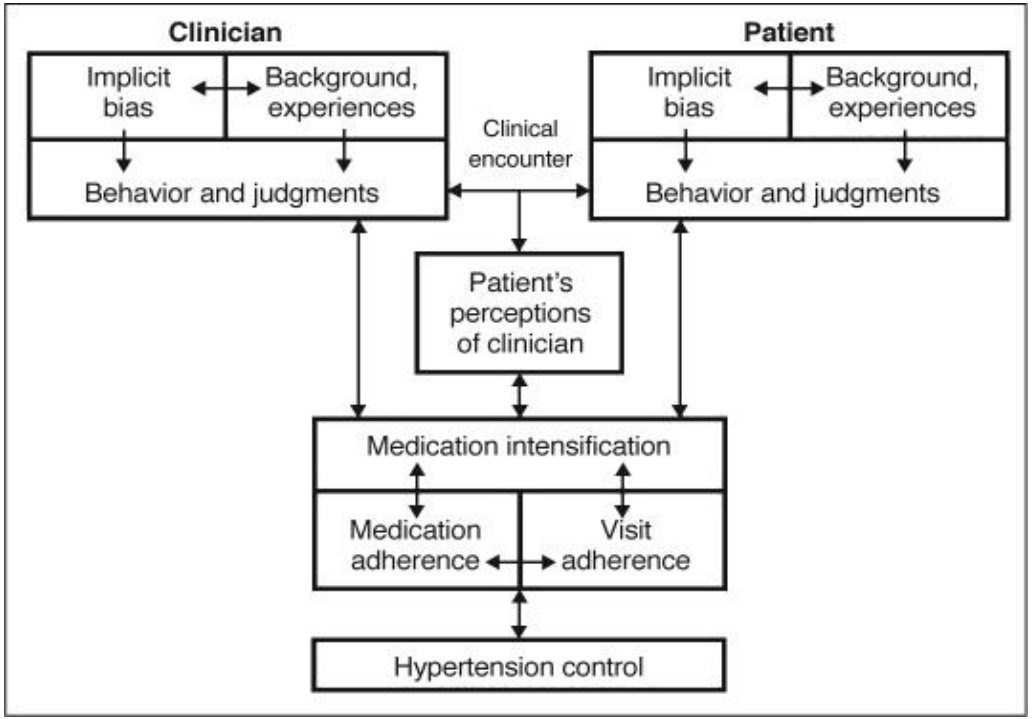
Everyone has bias
(*not just racists, sexists or bigots*)

Evolutionary bias to survive
(*Friend or foe?*)

Health profession learning associations are the product of…bias

Banaji MR, Greenwald AG. Blindspot: Hidden Biases of Good People. 1 ed.: Delacorte Press, **2013**.

Bias is a 2-way Street in Patient Interactions



Blair, Irene V et al. "Unconscious (implicit) bias and health disparities: where do we go from here?." The Permanente journal vol. 15,2 (2011): 71-8.

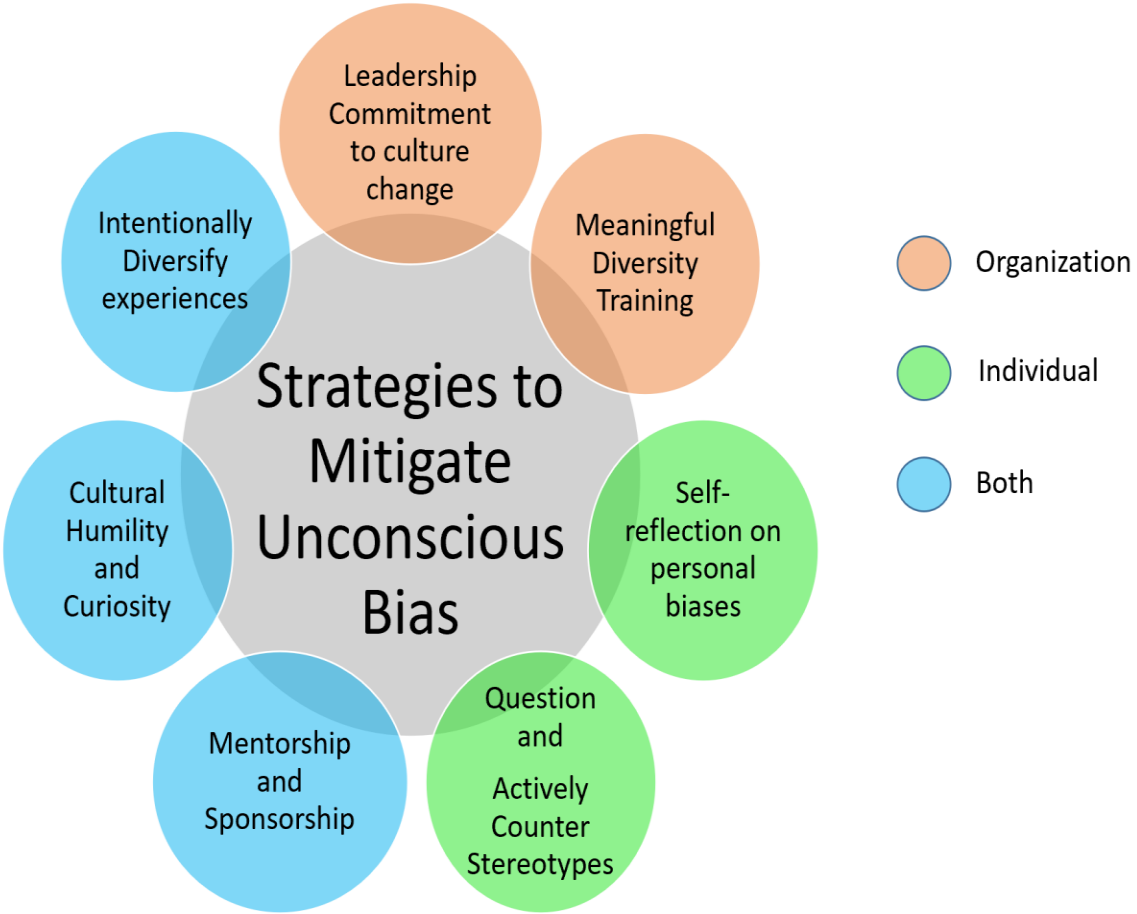
	How race is used	Rationale for race-based management	Potential harm
eGFR[6]	eGFR for Black patients is multiplied by 1·16–1·21 the eGFR for White patients, depending on the equation used	Black patients are presumed to have higher muscle mass and creatinine generation rate than patients of other races	Black patients might experience delayed dialysis and transplant referral[8,9]
BMI risk for diabetes[7]	Asian patients considered at risk for diabetes at BMI ≥23 *vs* 25 for patients of other races	Asian patients are presumed to develop more visceral than peripheral adiposity than patients of other races at similar BMI levels, increasing risk for insulin resistance[7]	Asian patients screened for diabetes despite absence of other risk factors might experience increased stigma and distrust of medical providers[11]
FRAX[13]	Probability of fracture is adjusted according to geography or minority status, or both	Different geographical and ethnic minority populations are presumed to have varied relative risks for fracture on the basis of epidemiological data	Some populations, including Black women, might be less likely to be screened for osteoporosis than other populations[14]
PFT[16]	Reference values for pulmonary function are adjusted for race and ethnicity	Racial and ethnic minority groups are presumed to have varied lung function on the basis of epidemiological data	Black patients might experience increased difficulty obtaining disability support for pulmonary disease[17]
JNC 8 Hypertension Guidelines[19]	Treatment algorithm provides alternate pathways for Black and non-Black patients	ACE-inhibitor use associated with higher risk of stroke and poorer control of blood pressure in Black patients than in patients of other races	Black patients might be less likely to achieve hypertension control and require multiple antihypertensive agents[20]

The problem with race-based medicine

Cerdeña, Jessica P., et al. **From race-based to race-conscious medicine: how anti-racist uprisings call us to act.** The Lancet, Volume 396, Issue 10257, 1125 - 1128

Slide courtesy Dr. Jasmine Marcelin @DrJRMarcelin

Organization-level and Personal-level Strategies to Mitigate Unconscious Bias



Slide courtesy Dr. Jasmine Marcelin @DrJRMarcelin

Marcelin JR et. al. The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It. *Journal of Infectious Diseases*. 2019

Slide courtesy Dr. Jasmine Marcelin @DrJRMarcelin

Going from Bystander to Upstander

Step 1: Acknowledge the bias in the interaction

Step 2: Make a conscious decision to address the bias

Step 3: Strategies to counter the bias { *Humor; Reject the stereotype outright; Ask questions; Acknowledge discomfort; Be direct* }

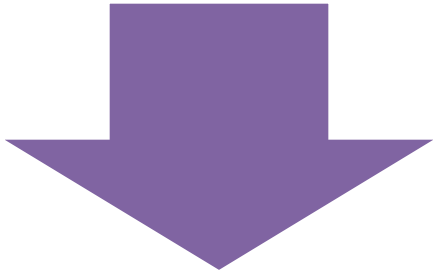
Step 4: Continue the conversation beyond the interaction

Adapted from Lena Teney: *http://kirwaninstitute.osu.edu/active-bystander-training/*

Marcelin JR et. al. The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It. *Journal of Infectious Diseases*. 2019

Discussion

Balancing Goals



Maintaining the quality of care (which includes cultural sensitivity)

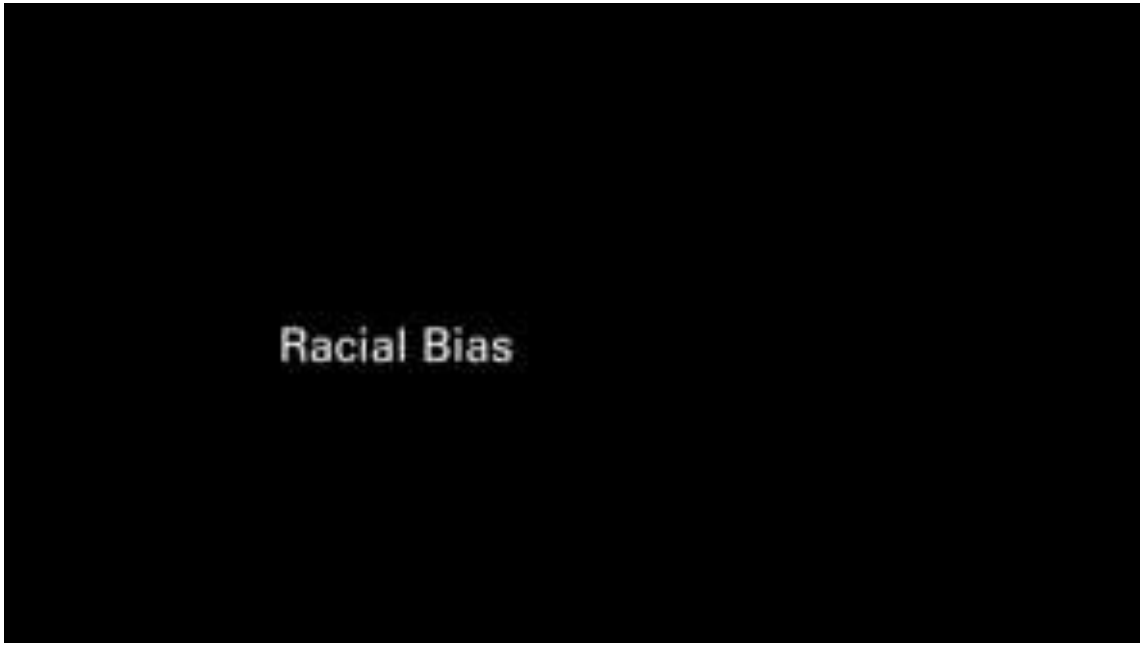
Preserving your relationship with the team

Discussion

Reflect on the patient encounters that you saw:

If you were the physician, how would you balance these two goals in your conversation with the team?

Case Example



https://vimeo.com/691129770/6410d11479

Discussion

Reflect on the conversation you just saw between the physician and the nurse:

What did you find most effective?

What would you borrow from her?

Current State of COVID-19 in Nebraska

Project ECHO®

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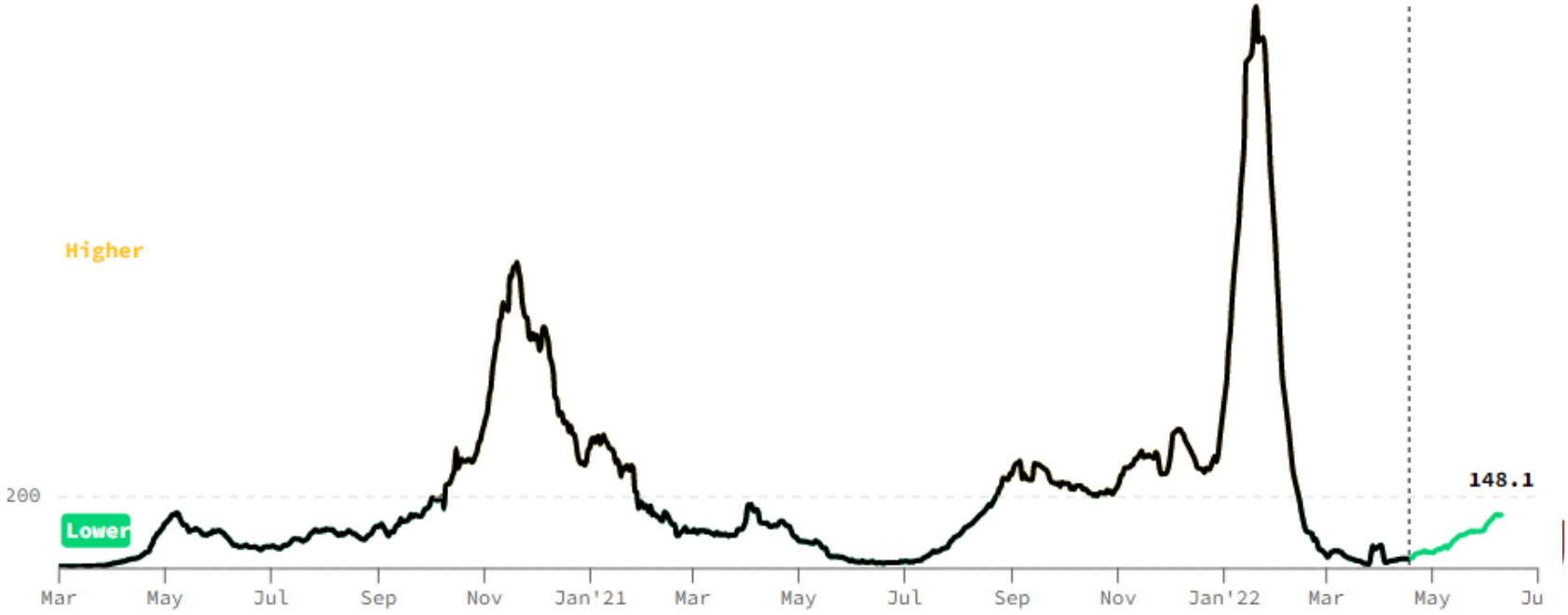
NE COVID-19 Updates

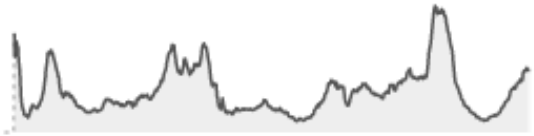
WEEKLY NEW REPORTED CASES	WEEKLY COVID ADMISSIONS	PATIENTS W/ COVID
148.1 PER 100K	6.3 PER 100K	3.1% OF ALL BEDS



https://covidactnow.org/us/nebraska-ne/?s=35202311

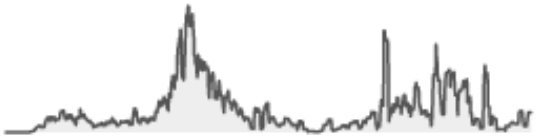
Nebraska COVID-19 Statistics

Test positivity rate



Hospitalized

Deaths



	DAILY AVG. ON JUN. 13	14-DAY CHANGE	TOTAL REPORTED
Cases	405	+44%	491,350
Test positivity	19%	—	—
Hospitalized	139	+37%	—
In I.C.U.s	13	+42%	—
Deaths	5	-6%	4,323

Nebraska COVID-19 Statistics

Week	Weekly Cases/ 100K	Weekly Admits	Number of Hospitalizations	Hospitalizations with COVID	Vaccinated[1] 1+	Fully Vaccinated
4/20/22	22.2	2.5	54	1%	70%	68.3%
5/4/22	41.8	2.1	50	1%	70%	68.5%
5/18/22	71.1	2.9	92	2%	70%	N/A
6/1/22	102	5.3	113	2.3%	70.5%	N/A
6/15/22	148	6.3	139	3.1%	70.6%	69%[2]; 64%[3]

[1]Percent of the entire state population vaccinated, regardless of eligibility/age. [2]If eligible (5y+) and [3]all ages.

https://covidactnow.org/us/nebraska-ne/?s=24951410
https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y
https://www.nytimes.com/interactive/2021/us/nebraska-covid-cases.html

COVID-19 Vaccine Updates

FDA reviewing vaccine data for ages 6 months to up to 5 years

Coming soon….

- Preliminary data under review: safety and effectiveness in preventing symptomatic COVID-19
    - Pfizer-BioNTech (3-part series)
    - Moderna (2-part series)
- May be available as soon as next week!

POLL

Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email.

2. Next session will be on **July 6th** on:

- Infection Prevention and Control: ***Outbreak Identification & Response***
- Quality Improvement: ***Applying QI Tools to Root Cause Identification and Management***

Poll Results

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Thank You!