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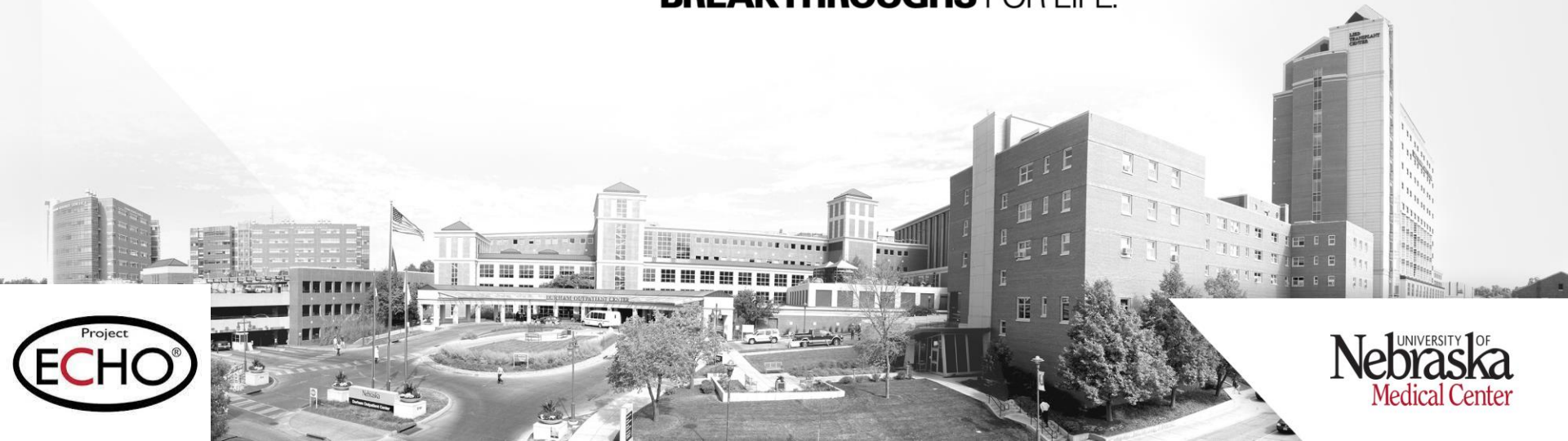

Project ECHO®

University of Nebraska Medical Center

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

Welcome to Session 17

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!
- 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: IPC Outbreak Identification & Response; QI: Applying QI Tools to Root Cause Identification and Management

Free Live ECHO Project
July 6, 2022
CID 53869

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:

- Describe the critical elements of an effective approach to COVID-19 surveillance.
- Articulate the principles of an effective outbreak response strategy for COVID-19.
- Apply QI tools to the identification of the root causes of error in improvement projects relevant to COVID-19.

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 Credit(s)*™. 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 hour(s). 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 hour(s).

Activity code: I00051296 Approval Number: 220002141

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:

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

The below faculty have nothing to disclose:

Jeff Wetherhold, M. Ed*

**Indicates on the planning committee*

Disclosures

PLANNING COMMITTEE

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
- Nada Fadul, MD
- Samantha Jones, CSW
- Mahelet Kebede, MPH
- 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?

What is the problem statement you are trying to address?	Our facility needs a revised plan for outbreak management that is informed by current knowledge of COVID-19
What data or information leads you to believe that this is a problem?	Staff-reported confidence in currency of outbreak plan, staff reported confidence in implementing outbreak plan
What change can you make to address this problem?	Develop a revised outbreak management plan and resources that reflect the language preferences and literacy levels of our staff
What can you measure to know if you are successful?	Staff-reported confidence in currency of outbreak plan, staff reported confidence in implementing outbreak plan, staff reported comprehension of information
What elements of COVID-19 management are relevant to this project?	Plans for countermeasures and adaption services Evidence-based policies or system
In what ways will this project address cultural sensitivity and/or the health equity factors of the community members you work with?	Education access, quality, and literacy level Health care access, quality, and health literacy level

Poll Results

Infection Prevention and Control: Outbreak Identification & Response

Presenter: Salman, Ashraf, MD

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Objectives

- Describe the critical elements of an effective approach to COVID-19 surveillance.
- Articulate the principles of an effective outbreak response strategy for COVID-19.

Surveillance

"*Process of systematic collection, collation and analysis of data with prompt dissemination to those who need to know for relevant action to be taken*"

Ogboghodo EO at al. Am. J. Trop. Med. Hyg., 104(3), 2021, pp. 1034–1040
Clinical Medicine 2019 Vol 19, No 2: 140–4

Essential Elements of Surveillance

- Assess the population and identify those at greatest risk for the outcome or process of interest
- Select the outcome or process for surveillance
- Determine observation time period
- Choose the surveillance methodology
- Monitor for the outcome or process using standardized definitions for all data collected
- Collect appropriate denominator data, if rates are to be calculated
- Analyze surveillance data
- Report and use surveillance information in a timely manner

https://www.cdc.gov/nhsn/pdfs/outlineforhaisurveillance.pdf

Surveillance Methodology

- **Active**
  - trained staff (IP) using various data sources
- **Patient-Based**
  - requires rounding, reviewing cases
- **Prospective**
  - monitor while inpatient or f/u post-discharge
- **Priority-directed**
  - focused on specific objectives
- **Risk-adjusted rates**
  - accounts for variations in risk factor distribution
- **Incidence**
  - counts only new events

- **Passive**
  - frontline staff (e.g., nurses) identifying & reporting
- **Laboratory-based**
  - solely based on lab results
- **Retrospective**
  - identify cases via chart reviews post-discharge
- **Comprehensive**
  - continuous monitoring for all events/ processes
- **Crude rates**
  - assume equal distribution of risk factors
- **Prevalence**
  - count all events

https://www.cdc.gov/nhsn/pdfs/outlineforhaisurveillance.pdf

Discussion

For what infections do you conduct surveillance in your facility?

What methods are you using for surveillance?

Outbreak

"More cases of a disease than expected in a specific location over a specific time period"

Also defined as "increase in incidence above the baseline"

Ogboghodo EO at al. Am. J. Trop. Med. Hyg., 104(3), 2021, pp. 1034–1040
Clinical Medicine 2019 Vol 19, No 2: 140–4

Outbreak Investigation – Public Health Perspective

Box 5.3 Steps of an Outbreak Investigation

1. Perform an initial assessment
2. Verify the diagnosis
3. Assemble and brief the outbreak response team
4. Establish a plan and prepare for fieldwork
5. Confirm the presence of an outbreak
6. Establish case definition and classification criteria
7. Identify and count cases
8. Collect, organize, and analyze data
9. Perform an infection control assessment
10. Consider an environmental assessment
11. Recommend control measures
12. Interpret results
13. Monitor the outbreak until completion

Not all steps might be performed in every outbreak response. Steps might not be performed in order, and some steps might occur concurrently.

https://www.corha.org/wp-content/uploads/2021/01/CORHA-HLG-Chapter-5.pdf

Stages of an Outbreak Investigation

Initial Investigation

- Literature review
- Case Definition
- Case finding
- Chart review and line list
- Implement interim infection control measures

Follow-up Investigation

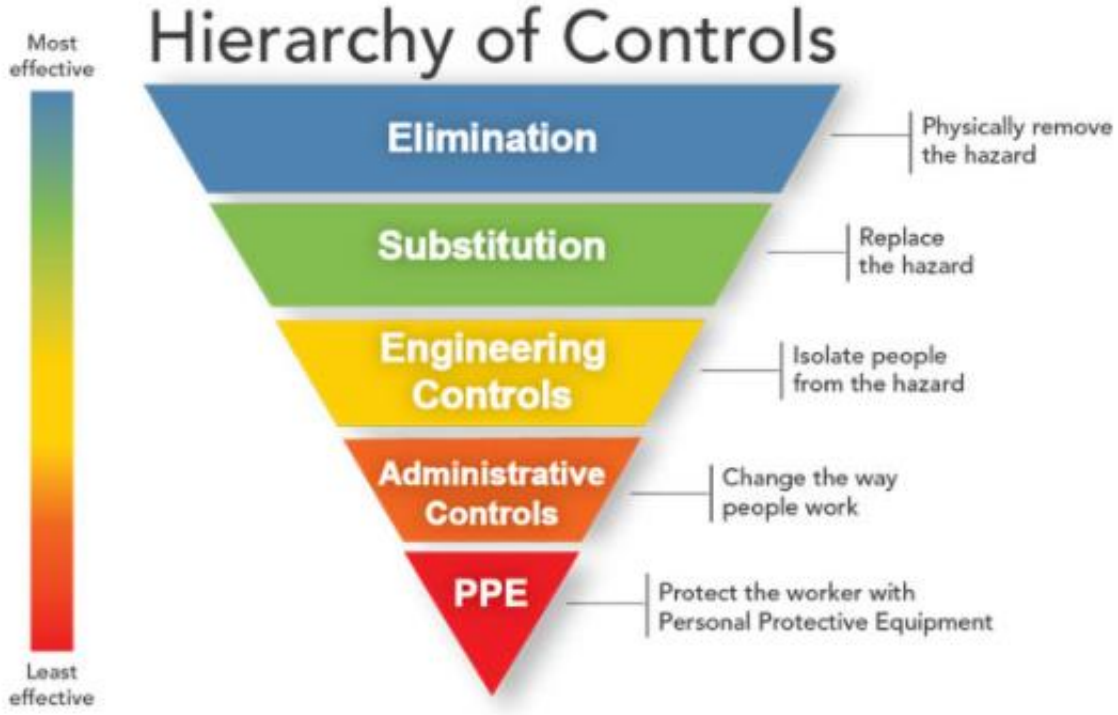
- Refine the case definition
- On-going case finding surveillance
- Review of control measures
- +/- Analytic studies (case-control, cohort, etc.)

Slide source: Dr. Arjun Srinivasan SHEA 2012 presentation

Outbreak Containment – Points to consider

- Increase in incidence of infection from baseline (i.e., outbreak) is reportable in Nebraska so health department should be notified.
    - Health department usually support healthcare facilities in their outbreak response
- Specific steps will depend on the nature/cause of the outbreak
- "Identify, isolate and inform" strategy is an important tool to evaluate patient under investigation for highly communicable disease
- Hierarchy of controls approach can be used during a communicable disease outbreak to prevent transmission within healthcare facilities

https://www.cdc.gov/vhf/ebola/clinicians/emergency-services/emergency-departments.html
https://www.cdc.gov/niosh/topics/hierarchy/default.html
https://www.cdc.gov/niosh/topics/hierarchy/default.html



https://www.cdc.gov/niosh/topics/hierarchy/default.html

Steps to prevent COVID-19 Outbreaks in Healthcare Settings

- Remain up to date with COVID-19 Vaccination
- Establish a Process to identify and manage individuals with suspected or confirmed COVID-19
- Implement source control measures
- Appropriate use of personal protective equipment for HCP based on the risks
- Encourage physical distancing
- Optimize the use of engineering controls and indoor air quality
- Implement SARS-CoV-2 viral testing policy/protocol to identify COVID-19 cases quickly
- Create a process to respond to SARS-CoV-2 exposures among HCP and others
- Follow all infection prevention and control policies and procedures

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

COVID-19 outbreak containment in Healthcare Settings

- Appropriate patient placement for isolation when COVID-19 is diagnosed or suspected
- Consider contact tracing and monitoring to identify additional cases based on exposures within the facility
- Implement quarantine protocols for those who meet the criteria for quarantine
- Staff should also follow isolation and quarantine guidelines for healthcare facilities
- Expanded testing protocols for staff and patients during outbreaks
- Donning recommended PPE (NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection)
- Taking appropriate precautions for aerosol generating procedures
- Ensuring safe visitation practices
- Discontinuation of isolation and quarantine within healthcare settings should be based on CDC recommendations for healthcare settings

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Upcoming Event – Register now to secure your spot

Friday, Aug. 12 • Embassy Suites Downtown/Old Market

About the Summit

With workload increases and staffing limitations due to COVID-19, the focus has been shifted away from antimicrobial stewardship in many facilities across diverse healthcare settings. Unfortunately, inappropriate antibiotic prescribing is common and can result in sub-optimal patient outcomes, development of antimicrobial resistance, and serious adverse reactions such as *Clostridioides difficile* infection. This summit is designed to highlight the importance of antimicrobial stewardship and focus on implementation strategies to promote facility-wide incorporation and improved antimicrobial use and patient outcomes.

Target Audience

This summit is intended for:

- **Post-acute and long-term facilities:** Long-term care providers, medical directors, infection preventionists, nurses, consultant pharmacists, pharmacy technicians, directors of nursing, quality program leaders, and all other health care workers interested in improving the management of common infections through the incorporation of antimicrobial stewardship principles.
- **Outpatient facilities and acute care hospitals:** family medicine providers, internal medicine providers, ambulatory care providers, pharmacists, pharmacy technicians, nurses, medical directors, quality program leaders, and all other health care workers interested in improving the management of common infections through the incorporation of antimicrobial stewardship principles.

https://www.unmc.edu/cce/catalog/clinicmed/neb-asap-summit/index.html

Quality Improvement: Applying QI Tools

Presenter: Jeff Wetherhold

Project ECHO®

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Objectives

- Apply QI tools to the identification of the root causes of error in improvement projects relevant to COVID-19.

Your QI Toolkit So Far

Key questions	QI tools	Sessions
What are we trying to accomplish?	• Problem statements	• Session 7
How will we implement our changes?	• Process maps (basic and complex) • Plan-Do-Study-Act (PDSA) cycles	• Session 8 • Session 11
How can we effectively ID and classify errors?	• Human factors approach • Swiss cheese model for risk management	• Session 9
Where are the known or potential points of failure?	• Fishbone diagrams	• Session 9
How will you know that your process is reliable?	• Observation techniques and pitfalls • 5+1 Framework (who, what, where, when, and how)	• Session 10
Why are these parts of the process unreliable?	• Root cause analysis	• Session 11
What changes are most likely to have an impact?	• Hierarchy of actions	• Session 12
How realistic is it to implement a change?	• Impact/effort matrix	• Session 12
What will success look like?	• SMART aim statements	• Session 12
How can I support my team when failures happen?	• Strategies for preserving motivation and morale	• Session 15
How can I get buy-in to implement my change?	• Change management frameworks • Systems communication plan	• Session 16

Our Goal

Participants who complete all requirements will receive a 'Health Equity and Quality Improvement Champion' certificate by the end of the project.

Requirements:

- Submit your project proposal
- Complete attendance surveys
- View recordings and let us know if you miss a session

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[18,24]; in interprofessional education[23]; in internal medicine,[25] psychiatry,[21,24] and family medicine residencies[26]; 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, 2M680, 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.0000000000000436

QIKAT-R Tool

- Initially developed in 2003 to provide a framework for assessing the quality of QI projects
- Five-point scoring system allowed for subjectivity in evaluations
- Revised in 2014 to include binary scoring across a set of nine key criteria focused on:
    - Aim
    - Measure
    - Change

QIKAT-R Tool

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

Singh, Mamta K.; Ogrinc, Greg; Cox, Karen R.; Dolansky, Mary; Brandt, Julie; Morrison, Laura J.; Harwood, Beth; Petroski, Greg; West, Al; Headrick, Linda A.
Academic Medicine89(10):1386-1391, October 2014.
doi: 10.1097/ACM.0000000000000456

Three possible points for the Aim. The Aim …	
A1	is focused on the system level of the problem presented.
A2	includes the direction of change (increase or decrease).
A3	includes at least one specific characteristic such as magnitude (% change) or time frame.
Three possible points for the Measure. The Measure …	
M1	is relevant to the Aim.
M2	is readily available so data can be analyzed over time.
M3	captures a key process or outcome.
Three possible points for the Change. The Change …	
C1	is linked directly with the Aim.
C2	proposes to use existing resources.
C3	provides sufficient details to initiate a test of change.

[a]Scoring is dichotomous (1 = yes; 0 = no); responders may receive one point for each item.

Your Aim Should Be

- System-focused
- Narrow in scope (addressing one problem only)
- Specific on:
    - Magnitude of the change
    - Direction of the change
    - Time frame for results

Hierarchy of Actions

Stronger Actions	• Architectural/physical plant changes • New devices with usability testing before purchasing • Engineering control or interlock (forcing functions) • Simplify the process & remove unnecessary steps • Standardize equipment or process • Tangible involvement & action by leadership in support of patient safety
Intermediate Actions	• Redundancy • Increase in staffing/decrease in workload • Software enhancements/modifications • Eliminate/reduce distractions • Checklist/cognitive aid • Eliminate look and sound-alikes • Readback/repeat back • Enhanced documentation/communication
Weaker Actions	• Double checks • Warnings & labels • New procedure/policy/memorandum • (Re)training • Additional study/analysis

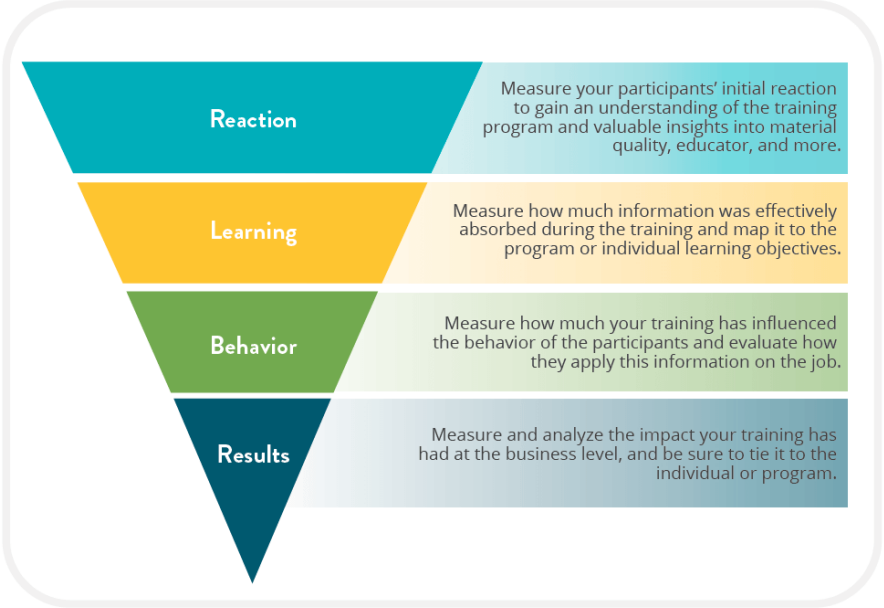
SMART Aim Statement

Your Measure(s) Should Be

- Clear from your aim statement
- Based on available data
- Within your control

What Can You Control?

1. Experience and meaning
2. Learning and knowledge
3. Process and behavior change
4. Outcomes



Based on a model developed by Donald Kirkpatrick.
Source: Kirkpatrick Partners website.

Drucker Never Said

"What gets measured, gets managed."

Drucker Did Say

"Unless we determine what shall be measured and what the yardstick of measurement in an area will be, the area itself will not be seen."

Source: Drucker. *People and Performance* (1959), p. 120
Source: "Did Peter Drucker Say That?" Drucker Institute Website

Your Change Should Be

- Meaningful and motivating to your team
- Clearly aligned with your aim
- Dependent on only existing resources
- Within your control (or your team's)
- Sufficiently detailed

Effective Change is Collaborative

"Your first role . . . is the personal one. It is the relationship with people, the development of mutual confidence, the identification of people, the creation of a community. This is something only you can do. It cannot be measured or easily defined. But it is not only a key function. It is one only you can perform."

- Peter Drucker

Source: "Measurement Myopia" Drucker Institute Website

Effective Change is Motivating

Extrinsic motivation means doing something to avoid punishment or earn a reward

Share some examples for your team in the chat

Effective Change is Motivating

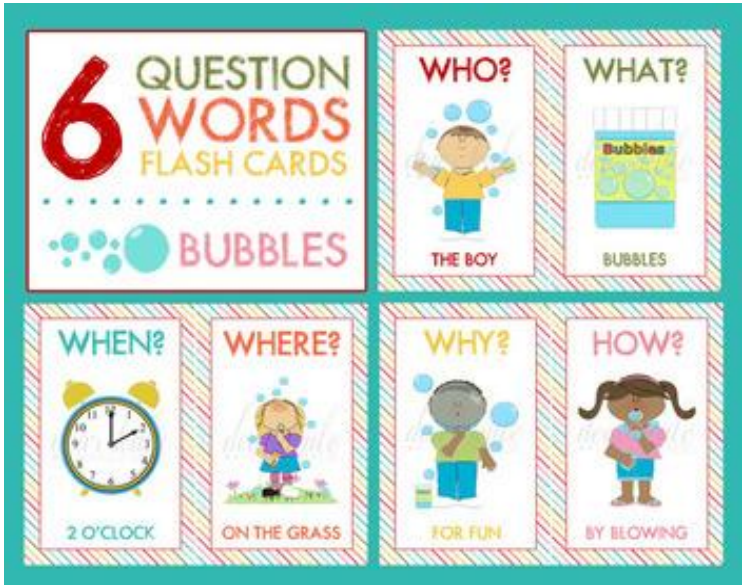
Intrinsic motivation provides satisfaction or gratification within the individual

Share some examples for your team in the chat

5+1 Framework

Intrinsic motivation addresses the "why?" From there:

- Who does it?
- When should it be done?
- Where is it done?
- How is it done?
- What is needed to do it?



Discussion

Case Study

You are a community health worker in a rural county who has noticed a higher incidence of COVID-19 cases compared to surrounding counties.

What additional data would you need to inform your next steps?

Case Study

You have learned that the CDC was alerted to COVID-19 cases among workers in several meat and poultry processing facilities in 19 states and was responding to local authorities' request for on-site and remote assistance. Your county does have a meat packing facility.

How would you focus an initial QI project?

QIKAT-R Tool

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

Singh, Mamta K.; Ogrinc, Greg; Cox, Karen R.; Dolansky, Mary; Brandt, Julie; Morrison, Laura J.; Harwood, Beth; Petroski, Greg; West, Al; Headrick, Linda A.
Academic Medicine89(10):1386-1391, October 2014.
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C2	proposes to use existing resources.
C3	provides sufficient details to initiate a test of change.

[a]Scoring is dichotomous (1 = yes; 0 = no); responders may receive one point for each item.

Case Study

Your team has proposed the following aim statement for a QI project to address this issue: "Our clinic team will implement COVID-19 symptom screening (based on CDC COVID-19 case definition) and refer those individuals for testing within next 48 hours."

What feedback would you give on this aim?

Current State of COVID-19 in Nebraska

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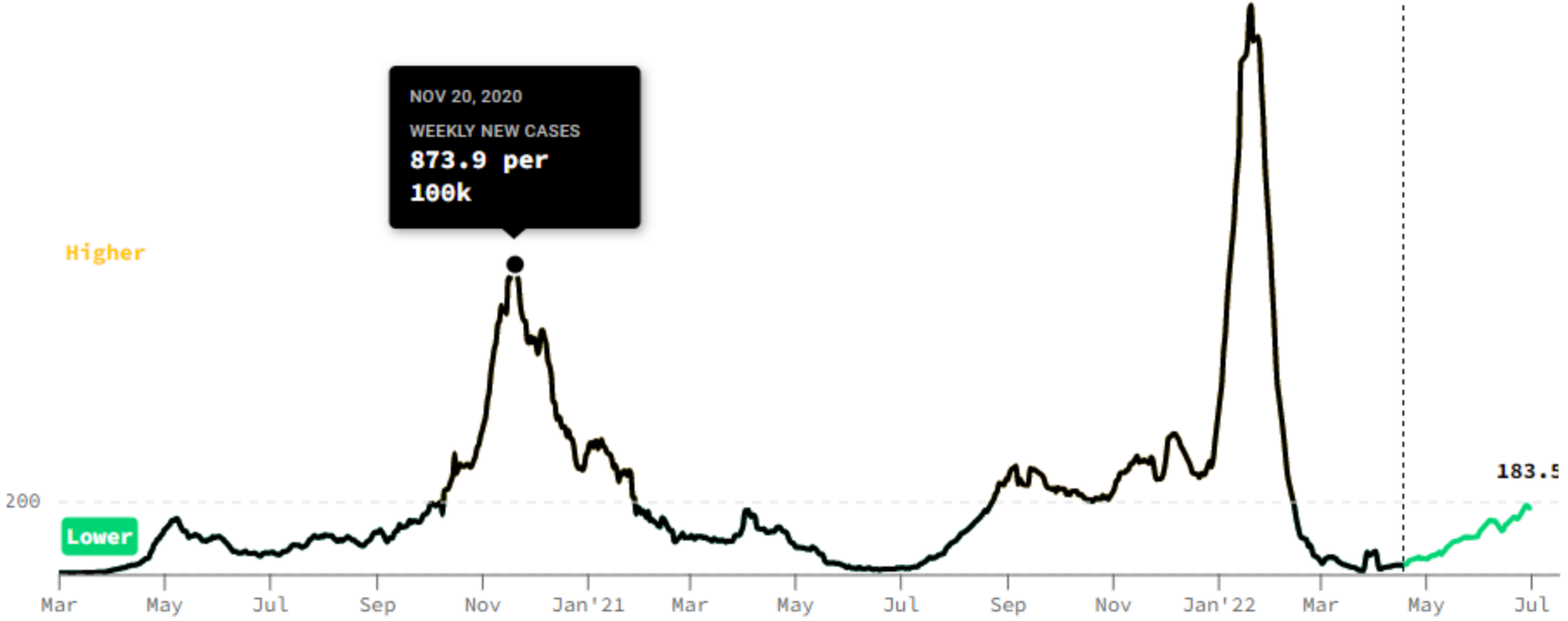
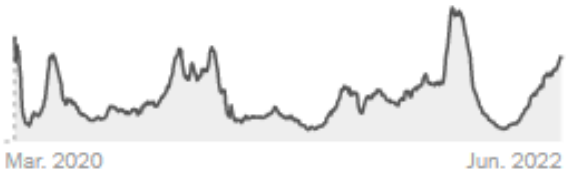
Nebraska COVID-19 Statistics

WEEKLY NEW REPORTED CASES	WEEKLY COVID ADMISSIONS	PATIENTS W/ COVID
183.5 PER 100K	8.2 PER 100K	3.8% OF ALL BEDS

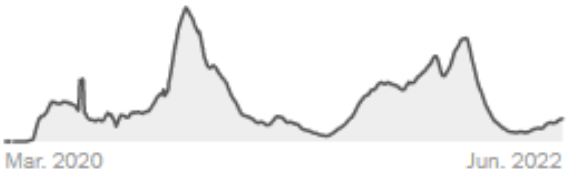


Nebraska COVID-19 Statistics

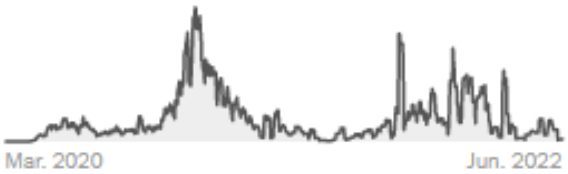
Test positivity rate



Hospitalized



Deaths



	DAILY AVG. ON JUN. 30	14-DAY CHANGE	TOTAL REPORTED
Cases	507	+35%	500,056
Test positivity	24%	—	—
Hospitalized	170	+23%	—
In I.C.U.s	19	+43%	—
Deaths	<1	-81%	4,334

https://www.nytimes.com/interactive/2021/us/nebraska-covid-cases.html

Nebraska COVID-19 Statistics

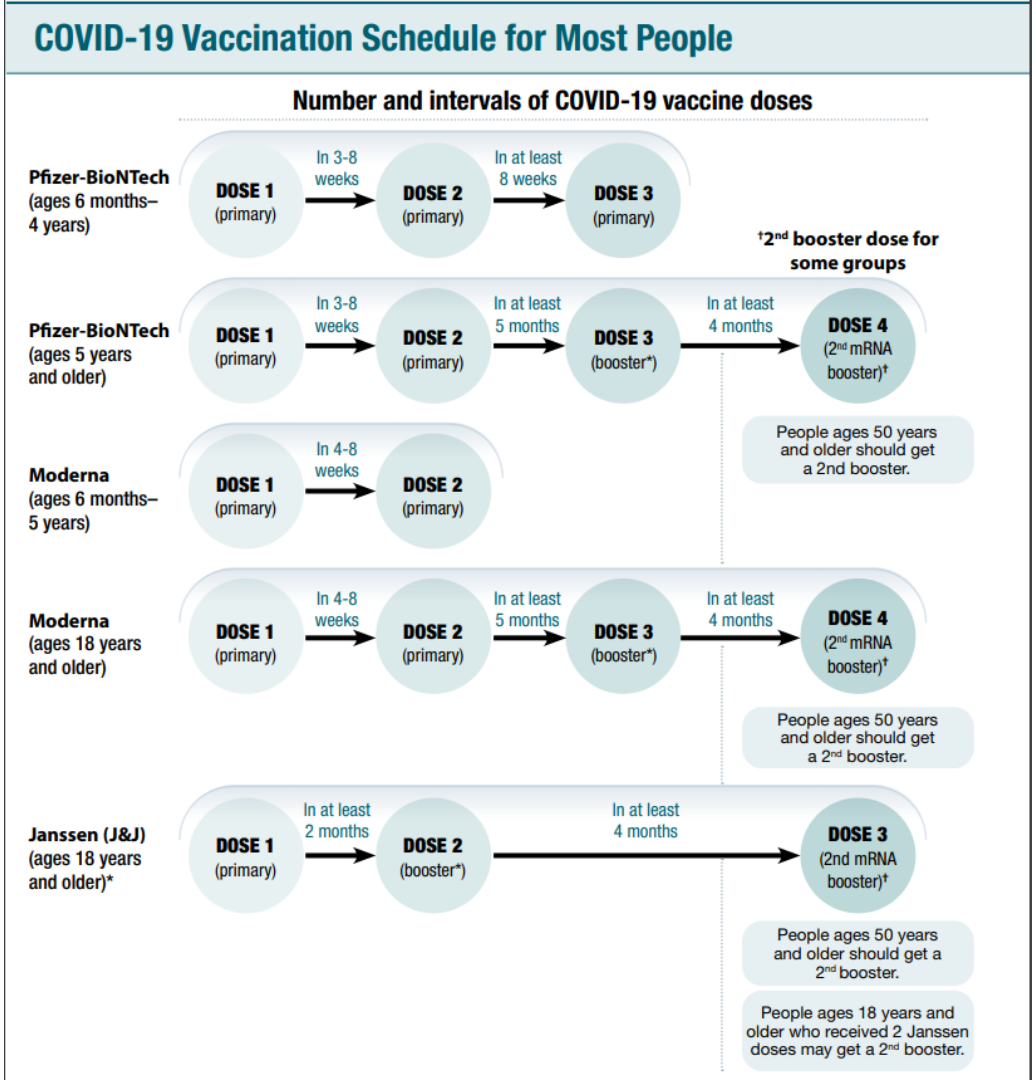
Week	Weekly Cases/ 100K	Weekly Admits	Number of Hospitalizations	Hospitalizations with COVID	Vaccinated[1] 1+	Fully Vaccinated[2,3]
4/20/22	22.2	2.5	54	1%	70%	68.3%
5/4/22	41.8	2.1	50	1%	70%	68.5%
5/18/22	71.1	2.9	92	2%	70%	N/A
6/1/22	102	5.3	282	2.3%	70.5%	N/A
6/15/22	148	6.3	139	3.1%	70.6%	64%
7/1/22	184	8.2	170	3.8%	70.8%	64%

[1]Percent of entire state population vaccinated. [2]Source prior to June 2022 was NE DHHS, % based on age 5y+. June/July
[3]Source for June 2022 -present: COVID Act Now & NYTimes based on entire state population.

https://covidactnow.org/us/nebraska-ne/?s=24951410
https://www.nytimes.com/interactive/2020/us/covid-19-vaccine-doses.html

Updated COVID-19 Vaccine Schedule

https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-vacc-schedule-at-a-glance-508.pdf



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 20th** on:

- Infection Prevention and Control: ***Antibiotic Stewardship***
- Health Equity: ***Communicating Health Equity; Emotional Intelligence***

Poll Results

Thank You!