The Public Health Quality Improvement Handbook

A substantial amount of research exists demonstrating that health care frequently fails to meet the current standards of quality care. Errors, suboptimal management or control of disease, and overutilization or underutilization of services are more likely to occur when high quality evidence-based health care is not provided. In a quality improvement framework that includes measuring, influencing, and improving quality, public reporting (making quality, safety, or performance data publicly available) is categorized as a means of influencing quality by providing incentives for change. This report focuses on how the public reporting of health care quality information may provide incentives for quality improvement that ultimately produce higher quality care. It is part of the Closing the Quality Gap: Revisiting the State of the Science series, which examines the role of several interventions in promoting quality health care. Quality might be influenced by the different incentives public reports create for different people and organizations. The incentives may be for the consumers of health care, including patients, families, or advocates who act on the behalf of patients, or for other purchasers of health care services, such as employers, who select the options available to their employees. Public reporting can also provide incentives for the individuals and organizations that provide or arrange care, including individual clinicians, hospitals, long-term facilities or services, and health plans. Patients are motivated by the desire to maximize the benefits they derive from health care by obtaining the highest quality of care available. Individual clinicians, hospitals, and other organizations that provide or arrange health care want to attract new patients or members and avoid losing existing ones. They may also be motivated by concern about their reputation among their peers or by professional and organizational commitments to providing high-quality care. This report was designed to update the last published systematic review, given the significant changes that have occurred in the scope and nature of public reporting. Medicare has substantially expanded its public reporting program, health data from many more sources are now available with minimal restrictions, new technologies allow aggregating data from consumer feedback sites, and applications have been built to help customize and simplify the combination of data from multiple sources. These trends and continuing commitments to transparency and patient-centered health care are likely to contribute to substantial increases in the amount of publicly available data on health care quality. The scope of this review was determined by a definition designed to situate public reporting in the context of quality improvement, the theme of the Closing the Quality Gap: Revisiting the State of the Science series. Given the resources devoted to public reporting and the desire to synthesize existing research knowledge to inform future public reporting efforts, the objectives of this systematic review were: To determine the effectiveness of public reporting as a quality improvement strategy by evaluating the evidence available about whether public reporting results in improvements in health care delivery and patient outcomes (Key Question 1) and evidence of harms resulting from public reporting (Key Question 2); To determine whether public reporting leads to changes in health care delivery or changes in patients' or purchasers' behaviors (intermediate outcomes) that may contribute to improved quality of care (Key Questions 3 and 4); To identify characteristics of public reports and contextual factors that can increase or decrease the impact of public

reporting (Key Questions 5 and 6).

This text will act as a quick quality improvement reference and resource for every role within the healthcare system including physicians, nurses, support staff, security, fellows, residents, therapists, managers, directors, chiefs, and board members. It aims to provide a broad overview of quality improvement concepts and how they can be immediately pertinent to one's role. The editors have used a tiered approach, outlining what each role needs to lead a QI project, participate as a team member, set goals and identify resources to drive improvements in care delivery. Each section of the book targets a specific group within the healthcare organization. Pocket Guide to Quality Improvement in Healthcare will guide the individual, as well as the organization to fully engage all staff in QI, creating a safety culture, and ultimately strengthening care delivery.

Healthcare Organizations offer significant opportunities for change and improvement in their overall performance. Hospitals and clinics are generally large, complex, and inefficient, and need serious development in process workflow and management systems, which will ultimately lead to better patient and financial outcomes. The National Academy of Medicine has stated that hospital systems are broken, and that they must begin by "... improving hospital efficiency and patient flow, and using operational management methods and information technologies." In fact, costs and quality are two of the important aspects of the "triple aim" in healthcare. One area that offers significant potential for improvement is through the application of performance improvement methods to patient and process flows. Performance improvement has a significant impact on a hospital's over financial and strategic performance. Performance improvement involves the deployment of quantitative and scientific methods to model and influence the functioning of organizations. Performance improvement professionals are tasked with managing a variety of activities, such as deploying new information technologies, serving as project managers for construction events, re-engineering departmental process workflow, eliminating bottlenecks, and improving the flow and movement of patients between resource-intensive clinical areas. All of these are high risk, and require use of advanced, sophisticated methods to improve efficiency and quality, while minimizing disruptions from change. This updated edition is a comprehensive and concise guide to performance improvement in healthcare. It describes the management engineering principles focused on designing optimal management and information systems and processes. Case studies and examples are integrated throughout all chapters.

Improve patient outcomes, lower costs, reduce fraud—allwith healthcare analytics Healthcare Analytics for Quality and PerformanceImprovement walks your healthcare organization from relying ongeneric reports and dashboards to developing powerful analyticapplications that drive effective decision-making throughout yourorganization. Renowned healthcare analytics leader Trevor Stromereveals in this groundbreaking volume the true potential ofanalytics to harness the vast amounts of data being generated inorder to improve the decision-making ability of healthcare managersand improvement teams. Examines how technology has impacted healthcare delivery Discusses the challenge facing healthcare organizations: toleverage advances in both clinical and information technology toimprove quality and performance while containing costs Explores the tools and techniques to analyze and extract valuefrom healthcare

data Demonstrates how the clinical, business, and technologycomponents of healthcare organizations (HCOs) must work together toleverage analytics Other industries are already taking advantage of big data.Healthcare Analytics for Quality and Performance Improvementhelps the healthcare industry make the most of the precious dataalready at its fingertips for long-overdue quality and performanceimprovement.

Characteristics, Effectiveness and Implementation of Different Strategies

Registries for Evaluating Patient Outcomes

Public Health Quality Improvement Encyclopedia

Improving Outcomes in Public Health Practice

Achieving STEEEP Health Care

Building a Safer Health System

Knowledge Translation in Health Care

Performance management can be an uncomfortable topic within the discipline of public health. Written by leaders in public health performance management and quality improvement, this book carefully explains what public health performance management is – and makes a strong case for why it is needed to tackle successfully the long-standing health issues plaguing communities and states. Notably, the book eschews the need to invest in technology or to learn a new performance management vocabulary. Rather the authors advocate for more thoughtful use of the resources already available in the organization, relying on public health leadership working in conjunction with well trained staff to manage their own organizational performance. To be broadly accepted within public health, performance management concepts and models have to be framed and populated with public health examples, and this book offers a wealth of practical insights and case studies that may be immediately applied to public health organizations, from assessing an organization's needs, introducing a performance management system to the organization, developing an agency's goals and targets, to implementation of sound performance management systems and plans. Collaborative Performance Management for Public Health is required reading for all public health leaders and employees concerned with maximizing the health impact of scarce resources.

Little in the current world is simple. Nothing comes in a box for us to add water and stir. There are those, however, who have been successful and who are willing to share their success. The messages in The Public Health Quality Improvement Handbook are from leaders, physicians, practitioners, academics, consultants, and researchers who are successfully applying the tools and techniques they share. The chapters are written to support the leaders and workforce of our public health community. This book, a collaboration between ASQ and the Public Health Foundation, is an anthology of chapters written by subject matter experts in public health who are successfully meeting client needs, working together to maximize outcomes, and expanding their collaboration with community partners to encourage better health within neighborhoods, counties, and states. There has never been a better time or a more needed one for us to harness the energy, enthusiasm, hard work, and dedication of our public health workforce to make a lasting difference. By effectively using quality improvement tools and techniques, we can and will improve our nation's health.

This innovative volume presents a cogent case for quality improvement (QI) in behavioral healthcare as ethical practice, solid science, and good business. Divided between foundational concepts, key QI tools and methods, and emerging applications, it offers guidelines for raising care standards while addressing ongoing issues of treatment validity, staffing and training, costs and funding, and integration with medical systems. Expert contributors review the implications and potential of QI in diverse areas such as treatment

of entrenched mental disorders, in correctional facilities, and within the professional context of the American Psychological Association. The insights, examples, and strategies featured will increase in value as behavioral health becomes more prominent in integrated care and vital to large-scale health goals. Included in the coverage: Behavioral health conditions: direct treatment costs and indirect social costs. /liliQuality improvement and clinical psychological science. · Process mapping to improve quality in behavioral health service delivery. · Checklists for quality improvement and evaluation in behavioral health. · Creating a quality improvement system for an integrated care program: the why, what, and how to measure. · Feedback Informed Treatment (FIT): improving the outcome of psychotherapy one person at a time. Quality Improvement i n Behavioral Healthcare gives health psychologists, public health professionals, and health administrators a real-world framework for maintaining quality services in a rapidly evolving health landscape.

This book provides a set of detailed instructions to help you construct your departmental, divisional, or organizational functional tree structure (FTS) and work towards world-class service. Preparing for Continuous Quality Improvement for Healthcare: Sustainability through Functional Tree Structures outlines a method that will enable your organization to set a stable base for future improvements that are sustainable and create breakthrough improvements in service, quality, and costs. More importantly, the FTS method outlined in the book will provide you with the tools to build processes tailored to your customers' specifications and standards. It will enable you to improve your department, division, and entire organization and edge ahead of your competition. The book explains why organizations steeped in process improvement need to re-evaluate and re-establish their procedures—especially if initial outcomes have not met expectations. Illustrating key concepts with examples, case studies, and flow charts, it provides you with a clear understanding of organizational functional structure and how to document current organizational and departmental functional tree structures. Describing how to identify a department's functional deficits, shortcomings, and waste, it explains how to select the best course of action for your organization. After reading this book, you will be able to create a pictorial representation of your organization's current functional structure and select the best course of action for achieving sustainable advancements in service, quality, and costs. The book will help to convert your managers from a people-management mentality to one of process management—transforming leaders to educators and not guards.

Healthcare Analytics for Quality and Performance Improvement
Pocket Guide to Quality Improvement in Healthcare
Measuring the Quality of Health Care
Implementing Continuous Quality Improvement in Health Care
The Quality Improvement Challenge
New Strategies for Quality Improvement
A New Health System for the 21st Century

. Through a unique interdisciplinary perspective on quality management in health care, this text covers the subjects of operations management, organizational behavior, and health services research. With a particular focus on Total Quality Management and Continuous Quality Improvement, the challenges of implementation and institutionalization are addressed using examples from a variety of health care organizations, including primary care clinics, hospital laboratories, public health departments, and academic health centers. Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition

Quality improvement (QI) is embedded in the fabric of successful healthcare organisations across the world, with healthcare professionals increasingly expected to develop and lead improvement as a core part of their clinical responsibilities. As a result, QI is rapidly becoming a feature of the education and training programmes of all healthcare professionals. Written and edited by some of the leading clinicians and managers in the field, ABC of Quality Improvement is designed for clinicians new to the discipline, as well as experienced leaders of change and improvement. Providing comprehensive coverage and clear, succinct descriptions of the major tools, techniques and approaches, this new addition to the ABC series demystifies quality improvement and develops a broader understanding of what constitutes quality in healthcare. With practical examples of improvement interventions and the common pitfalls that can befall them, this book will support and enable readers to manage change projects within their own organisations. Relevant to doctors, dentists, nurses, health service managers and support staff, medical students and doctors in training, their tutors and trainers, and other healthcare professionals at various levels, ABC of Quality Improvement will give readers the confidence to embark on their own improvement projects, whoever, and wherever they may be.

The Public Health Quality Improvement HandbookAsq Press

Concise, portable, and user-friendly, The Washington Manual® of Patient Safety and Quality Improvement covers essential information in every area of this complex field. With a focus on improving systems and processes, preventing errors, and promoting transparency, this practical reference provides an overview of PS/QI fundamentals, as well as insight into how these principles apply to a variety of clinical settings. Part of the popular Washington Manual® series, this unique volume provides the knowledge and skills necessary for an effective, proactive approach to patient safety and quality improvement.

Strategy and Methods

A Practical Guide for Physicians

Learning from Data for Improvement

Transforming Health Care Quality

Collaborative Performance Management for Public Health

A Case-Based Approach

Improving Quality in Outpatient Services

In the realm of health care, privacy protections are needed to preserve patients' dignity and prevent possible harms. Ten years ago, to address these concerns as well as set guidelines for ethical health research, Congress called for a set of federal standards now known as the HIPAA Privacy Rule. In its 2009 report, Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research, the Institute of Medicine's Committee on Health Research and the Privacy of Health Information concludes that the HIPAA Privacy Rule does not protect privacy as well as it should, and that it impedes important health research.

This ground-breaking book addresses the critical, growing need among health care administrators and practitioners to measure the effectiveness of quality

improvement efforts. Written by respected healthcare quality professionals, Measuring Quality Improvement in Healthcare covers practical applications of the tools and techniques of statistical process control (SPC), including control charts, in healthcare settings. The authors' straightforward discussions of data collection, variation, and process improvement set the context for the use and interpretation of control charts. Their approach incorporates "the voice of the customer" as a key element driving the improvement processes and outcomes. The core of the book is a set of 12 case studies that show how to apply statistical thinking to health care process, and when and how to use different types of control charts. The practical, down-to-earth orientation of the book makes it accessible to a wide readership.

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequence--but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda--with state and local implications--for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors--which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient

advocates--as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

This User's Guide is intended to support the design, implementation, analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User's Guide was created by researchers affiliated with AHRQ's Effective Health Care Program, particularly those who participated in AHRQ's DEcIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.

Coordinating Government Roles in Improving Health Care Quality

Preparing for Continuous Quality Improvement for Healthcare

Sustainability through Functional Tree Structures

ABC of Quality Improvement in Healthcare

Modular Kaizen

A Case Book

The Health Care Data Guide

The anthrax incidents following the 9/11 terrorist attacks put the spotlight on the nation's public health agencies, placing it under an unprecedented scrutiny that added new dimensions to the complex issues considered in this report. The Future of the Public's Health in the 21st Century reaffirms the vision of Healthy People 2010, and outlines a systems approach to assuring the nation's health in practice, research, and policy. This approach focuses on joining the unique resources and perspectives of diverse sectors and entities and challenges these groups to work in a concerted, strategic way to promote and protect the public's health. Focusing on diverse partnerships as the framework for public health, the book

discusses: The need for a shift from an individual to a population-based approach in practice, research, policy, and community engagement. The status of the governmental public health infrastructure and what needs to be improved, including its interface with the health care delivery system. The roles nongovernment actors, such as academia, business, local communities and the media can play in creating a healthy nation. Providing an accessible analysis, this book will be important to public health policy-makers and practitioners, business and community leaders, health advocates, educators and journalists.
*Developed by the Public Health Foundation (PHF) and written by PHF Senior Quality Advisor John Moran and Quality Expert Grace Duffy, this resource includes 75 Quality Improvement (QI) tools, defines the purpose of each tool, and provides guidance on when and how to use each one. It is essential for health departments and others to use QI tools to fulfill their missions, apply for accreditation, improve the health of their communities, and become more efficient and effective. This Encyclopedia includes basic and advanced tools - many that aren't available elsewhere in print, including: * Continuum of Quality* Five Whys* Gantt Chart* Purpose Principe* Stakeholder Analysis "The Public Health Quality Improvement Encyclopedia is a great tool that I use at work, in our QI Council, and for my personal use. I love the way it is set up - very simple and easy to follow. I find the examples, the description of what each tool does, and the next steps particularly useful." Renee S. Frauendienst, RN, PHN, BSN, Public Health Division Director, CHS Administrator, Stearns County Human Services, MN "Our LHJ adopted the Public Health Quality Improvement Encyclopedia as a key QI tool last year, and it has been extremely helpful as a resource. I especially like the format of having an explanation of the tool AND a public health example. Besides being really portable, the Encyclopedia makes it easy to highlight one tool at our team meetings, so everyone can focus on a tool that is particularly relevant at the moment." Susan Sloan, Performance Management Specialist, Whatcom County Health Department, WAUse the tools to help your organization improve the public's health.*
A valuable reference for those involved in the field of ambulatory patient care, Improving Quality in Outpatient Services offers time-tested instruction on how to create a world-class outpatient program. It supplies a high-level overview of current opportunities, national quality programs, and challenges—outlining the policies, procedures, and plans required for success. Stimulating readers with a wealth of practical applications, stories, and examples, the book details the governance, medical staff, and quality structures required

to create, implement, and maintain a safe and efficient outpatient program. It introduces powerful techniques for infection control, medication management, risk prevention, and the elimination of medication errors. It also: Lists mandatory policies and procedures Contains practice drills to prepare you for real-world scenarios Explains how to create a report card to measure quality at all levels Includes a sample curriculum that outlines the courseware required by OSHA and other licensing and regulatory agencies The authors address documentation and human resources factors and supply an abundance of information and resources in the appendices, including how and where to apply for certification, medical record review tools, policy and procedure checklists, and a state-by-state listing of resources available for outpatient and ambulatory programs. Explaining how to involve patients in the decision making process, the text details a proven system for evaluating quality at all levels of your organization.

This text uses a case-based approach to share knowledge and techniques on how to operationalize much of the theoretical underpinnings of hospital quality and safety. Written and edited by leaders in healthcare, education, and engineering, these 22 chapters provide insights as to where the field of improvement and safety science is with regards to the views and aspirations of healthcare advocates and patients. Each chapter also includes vignettes to further solidify the theoretical underpinnings and drive home learning. End of chapter commentary by the editors highlight important concepts and connections between various chapters in the text. Patient Safety and Quality Improvement in Healthcare: A Case-Based Approach presents a novel approach towards hospital safety and quality with the goal to help healthcare providers reach zero harm within their organizations.

A User's Guide

Baylor Health Care System's Quality Improvement Journey

McLaughlin and Kaluzny's Continuous Quality Improvement In Health Care

Continuous and Breakthrough Improvement

Return on Investment for Healthcare Quality Improvement

Washington Manual of Patient Safety and Quality Improvement

McLaughlin & Kaluzny's Continuous Quality Improvement in Health Care

Health care systems worldwide are faced with the challenge of improving the quality of care. Providing evidence from health research is necessary but not sufficient for the provision of optimal care and so knowledge translation (KT), the scientific study of methods for closing the knowledge-to-action gap and of the barriers and facilitators inherent in the process, is gaining significance. Knowledge Translation in Health Care explains how to use research findings to improve health care in real life, everyday situations. The authors define and describe knowledge

translation, and outline strategies for successful knowledge translation in practice and policy making. The book is full of examples of how knowledge translation models work in closing the gap between evidence and action. Written by a team of authors closely involved in the development of knowledge translation this unique book aims to extend understanding and implementation worldwide. It is an introductory guide to an emerging hot topic in evidence-based care and essential for health policy makers, researchers, managers, clinicians and trainees.

*This open access book is a collection of 12 case studies capturing decades of experience improving health care and outcomes in low- and middle-income countries. Each case study is written by healthcare managers and providers who have implemented health improvement projects using quality improvement methodology, with analysis from global health experts on the practical application of improvement methods. The book shows how frontline providers in health and social services can identify gaps in care, propose changes to address those gaps, and test the effectiveness of their changes in order to improve health processes and outcomes. The chapters feature cases that provide real-life examples of the challenges, solutions, and benefits of improving healthcare quality and clearly demonstrate for readers what quality improvement looks like in practice:Addressing Behavior Change in Maternal, Neonatal, and Child Health with Quality Improvement and Collaborative Learning Methods in GuatemalaHaiti's National HIV Quality Management Program and the Implementation of an Electronic Medical Record to Drive Improvement in Patient CareScaling Up a Quality Improvement Initiative: Lessons from Chamba District, IndiaPromoting Rational Use of Antibiotics in the Kyrgyz RepublicStrengthening Services for Most Vulnerable Children through Quality Improvement Approaches in a Community Setting: The Case of Bagamoyo District, TanzaniaImproving HIV Counselling and Testing in Tuberculosis Service Delivery in Ukraine: Profile of a Pilot Quality Improvement Team and Its Scale?Up JourneyImproving Health Care in Low- and Middle-Income Countries: A Case Book will find an engaged audience among healthcare providers and administrators implementing and managing improvement projects at Ministries of Health in low- to middle-income countries. The book also aims to be a useful reference for government donor agencies, their implementing partners, and other high-level decision makers, and can be used as a course text in schools of public health, public policy, medicine, and development. ACKNOWLEDGMENT:This work was conducted under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, USAID Award No. AID-OAA-A-12-00101, which is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). DISCLAIMER:The contents of this book are the sole responsibility of the Editor(s) and do not necessarily reflect the views of USAID or the United States Government. div=""^*

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Despite having the costliest medical care delivery system in the world, Americans are not particularly healthy. Recent international comparisons show that life expectancy in the U.S. ranks 49th among all nations, and infant mortality rates are higher in the U.S. than in many far less affluent nations. While these statistics are alarming, the bigger problem is that we do not

know how to reverse this trend. Our lack of knowledge is due in large part to significant inadequacies in the health system for gathering, analyzing, and communicating health information about the population. To inform the public health community and all other sectors that contribute to population health, For the Public's Health: The Role of Measurement in Action and Accountability reviews current approaches for measuring the health of individuals and communities and creates a roadmap for future development. This book, the first of three in a series, focuses on data and measurement-not as ends in themselves, but rather tools to inform the myriad programs, policies, and processes developed or undertaken by governmental public health agencies and their many partners in the health system. For the Public's Health seeks to reinstate the proper and evidence-based understanding of health as not merely the result of medical or clinical care but the result of the sum of what we do as a society to create the conditions in which people can be healthy. To achieve this goal, the book suggests changes in the processes, tools, and approaches used to gather information about health outcomes and their determinants. The book also recommends developing an integrated and coordinated system in which all parties-including governmental and private sector partners at all levels-have access to timely and meaningful data to help foster individual and community awareness and action.

A Practical Approach to Enhancing Organizational Performance

To Err Is Human

Enhancing Privacy, Improving Health Through Research

Performance Improvement in Hospitals and Health Systems

Moving from Evidence to Practice

The Public Health Quality Improvement Handbook

Crossing the Quality Chasm

This new edition of this bestselling guide offers an integrated approach to process improvement that delivers quick and substantial results in quality and productivity in diverse settings. The authors explore their Model for Improvement that worked with international improvement efforts at multinational companies as well as in different industries such as healthcare and public agencies. This edition includes new information that shows how to accelerate improvement by spreading changes across multiple sites. The book presents a practical tool kit of ideas, examples, and applications.

Winner of a 2014 Shingo Research and Professional Publication Award! Reaching America's true potential to deliver and receive exceptional health care will require not only an immense and concerted effort, but a fundamental change of perspective from medical providers, government officials, industry leaders, and patients alike. The Institute of Medicine set forth six primary "aims" to which every participant in the American healthcare system must contribute: health care must be safe, timely, effective, efficient, equitable, and patient-centered. Presented as the acronym STEEEP, the collective realization of these goals is to reduce the burden of illness, injury, and disability in our nation. Baylor Health Care System is committed to doing its part and has adopted these six aims as its own. Achieving STEEEP Health Care tells the story of Baylor Health Care

System's continuing quality journey, offering practical strategies and lessons in the areas of people, culture, and processes that have contributed to dramatic improvements in patient and operational outcomes. This book also discusses newer approaches to accountable care that strive to simultaneously improve the patient experience of care, improve population health, and reduce per capita costs of health care. Provides the perspectives of senior leaders in the areas of corporate governance, finance, and physician and nurse leadership Supplies strategies for developing and supporting a culture of quality, including systems and tools for data collection, performance measurement and reporting Includes service-line examples of successful quality improvement initiatives from reducing heart failure readmissions to coordinating cancer care Outlines approaches to accountable care and improved population health and well-being

Applying Quality-Assurance Methods A Report on the National Demonstration Project on Quality Improvement in Health Care This book is recommAnded for managers wanting to enhance service quality and productivity. By avoiding mistakes and useless units of activity, gains in productivity occur as quality improves. --Healthcare Financial Management

Learn how health care organizations can use the quality improvement process to help regain control and hope in a time of frustration and skyrocketing costs. In ten key lessons, the authors demonstrate what works and does not work in actual practice. They present case examples of specific health care improvement projects ranging from transport of critically ill infants to quick turnaround of emergency lab specimens and to the generation of accurate Medicare bills.

With this text, students learn how to explicitly apply the quantitative, analytical methods of quality measurement and improvement to the public health setting. Truly "hands on" this practical textbook provides the public health student with the basic analytical skills essential for implementing a CQI program.

Patient Safety and Quality Improvement in Healthcare

Measuring Quality Improvement in Healthcare

A Practical Guide

Toward Quality Measures for Population Health and the Leading Health Indicators

Quality Improvement in Behavioral Health

Beyond the HIPAA Privacy Rule

Closing the Quality Gap: Revisiting the State of the Science (Evidence Report/Technology Assessment Number 208)

This collection of 18 case studies covers a broad range of subjects related to health care quality improvement efforts. Ideal as complement to the new Fourth Edition of Continuous Quality Improvement in Health Care, these

case studies explore themes such as CQI in Ghana Malaria Control, CQI to reduce central line infections in pediatric hospital, a mother's advocacy group against medical errors, WHO Safe Surgery Saves Lives Campaign, The Malcolm Baldrige Award Process in Health Care, Comparison of NICE and similar agencies for comparative effectiveness research, and much more.

The National Roundtable on Health Care Quality was established in 1995 by the Institute of Medicine. The Roundtable consists of experts formally appointed through procedures of the National Research Council (NRC) who represent both public and private-sector perspectives and appropriate areas of substantive expertise (not organizations). From the public sector, heads of appropriate Federal agencies serve. It offers a unique, nonadversarial environment to explore ongoing rapid changes in the medical marketplace and the implications of these changes for the quality of health and health care in this nation. The Roundtable has a liaison panel focused on quality of care in managed care organizations. The Roundtable convenes nationally prominent representatives of the private and public sector (regional, state and federal), academia, patients, and the health media to analyze unfolding issues concerning quality, to hold workshops and commission papers on significant topics, and when appropriate, to produce periodic statements for the nation on quality of care matters. By providing a structured opportunity for regular communication and interaction, the Roundtable fosters candid discussion among individuals who represent various sides of a given issue.

The Institute of Medicine (IOM) Committee on Quality Measures for the Healthy People Leading Health Indicators was charged by the Office of the Assistant Secretary for Health to identify measures of quality for the 12 Leading Health Indicator (LHI) topics and 26 Leading Health Indicators in Healthy People 2020 (HP2020), the current version of the Department of Health and Human Services (HHS) 10-year agenda for improving the nation's health. The scope of work for this project is to use the nine aims for improvement of quality in public health (population-centered, equitable, proactive, health promoting, risk reducing, vigilant, transparent, effective, and efficient) as a framework to identify quality measures for the Healthy People Leading Health Indicators (LHIs). The committee reviewed existing literature on the 12 LHI topics and the 26 Leading Health Indicators. Quality measures for the LHIs that are aligned with the nine aims for improvement of quality in public health will be identified. When appropriate, alignments with the six Priority Areas for Improvement of Quality in Public Health will be noted in the Committee's report. Toward Quality Measures for Population Health and the Leading Health Indicators also address data reporting and analytical capacities that must be available to capture the measures and for demonstrating the value of the measures to improving

population health. Toward Quality Measures for Population Health and the Leading Health Indicators provides recommendations for how the measures can be used across sectors of the public health and health care systems. The six priority areas (also known as drivers) are population health metrics and information technology; evidence-based practices, research, and evaluation; systems thinking; sustainability and stewardship; policy; and workforce and education.

A new release in the Quality Chasm Series, Priority Areas for National Action recommends a set of 20 priority areas that the U.S. Department of Health and Human Services and other groups in the public and private sectors should focus on to improve the quality of health care delivered to all Americans. The priority areas selected represent the entire spectrum of health care from preventive care to end of life care. They also touch on all age groups, health care settings and health care providers. Collective action in these areas could help transform the entire health care system. In addition, the report identifies criteria and delineates a process that DHHS may adopt to determine future priority areas.

The Role of Measurement in Action and Accountability

Priority Areas for National Action

A Guide to Statistical Process Control Applications

The Future of the Public's Health in the 21st Century

Managing the Quality of Health Care in Developing Countries

The Improvement Guide

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

World Bank Technical Paper No. 258. Quality of health care is a complex concept interwoven with value judgments about what constitutes good quality. This lack of linearity partly explains the large number of definitions of the concept of quality an

The federal government operates six major health care programs that serve nearly 100 million Americans. Collectively, these programs significantly influence how health care is provided by the private sector. Leadership by Example explores how the federal

government can leverage its unique position as regulator, purchaser, provider, and research sponsor to improve care - not only in these six programs but also throughout the nationâ€™s health care system. The book describes the federal programs and the populations they serve: Medicare (elderly), Medicaid (low income), SCHIP (children), VHA (veterans), TRICARE (individuals in the military and their dependents), and IHS (native Americans). It then examines the steps each program takes to assure and improve safety and quality of care. The Institute of Medicine proposes a national quality enhancement strategy focused on performance measurement of clinical quality and patient perceptions of care. The discussion on which this book focuses includes recommendations for developing and pilot-testing performance measures, creating an information infrastructure for comparing performance and disseminating results, and more. Leadership by Example also includes a proposed research agenda to support quality enhancement. The third in the series of books from the Quality of Health Care in America project, this well-targeted volume will be important to all readers of To Err Is Human and Crossing the Quality Chasm - as well as new readers interested in the federal governmentâ€™s role in health care.

This book offers a comprehensive overview of performing return-on-investment (ROI) analyses for healthcare quality improvement (QI). In the United States, healthcare policy regarding physician and facility payment/reimbursement is steadily trending towards the use of "value-based" systems and away from the traditional "fee-for-service" (FFS) payment mechanisms. Healthcare professionals and organizations who have previously focused on quality metrics are now finding themselves burdened with having to define and assess value metrics, without much guidance or assistance. This volume aims to be a guide and a reference for healthcare professionals tasked with estimating and establishing ROI for QI. Chapters describe the general framework for how to perform QI; establish standard definitions of important terms, concepts, and calculations; and provide specific instructions for how to complete each step of an ROI analysis. These include: selecting a QI initiative and identifying the associated metrics, establishing measurable, monetizable, and attributable costs and benefits, determining the appropriate scope and perspective, calculating ROI and related metrics (payback period, benefit-to-cost ratio, etc.), comparing with established benchmarks or previously published results, and interpreting the results for the intended audience. In addition, chapters offer examples of real studies (or hypothetical studies of real situations), as well as templates for several of the necessary activities that readers can leverage for their own use. Return on Investment for Healthcare Quality Improvement is a must-have resource for healthcare providers, administrators, and other professionals who work in healthcare organizations, hospitals and other healthcare settings, health systems, and residency programs seeking to obtain outside funding, as well as policy makers and administrators of federal programs.

Curing Health Care

Improving Health Care in Low- and Middle-Income Countries

Leadership by Example

For the Public's Health

5. Public Reporting As a Quality Improvement Strategy

Improving Healthcare Quality in Europe Characteristics, Effectiveness and Implementation of Different Strategies

Managing Analytics and Quality in Healthcare, 2nd Edition

Modular Kaizen is a development of necessity. Improvement has to happen on the fly in our rapidly changing world. This book is about using the resources, people, and schedules already in place to get things done. Modular Kaizen is the counterpoint to a kaizen blitz, in which team

members are confined in a room to hammer out an opportunity or a solution to some problem. In the hectic, interrupt-driven environment of many organizations, it is simply not possible to remove critical players from normal operations for any length of time. Grace Duffy draws on 40 years of experience to incorporate techniques, innovations, and lessons learned in pursuit of effective continuous and breakthrough improvement. Part I provides the conceptual model along with steps and tools for process and system improvement in an extremely busy and interrupt-driven workplace. Part II offers three case studies—from manufacturing, healthcare, and aerospace—to show how the techniques work in real time. If you are looking for proven approaches to integrating quality improvement into daily work, this is your book. It is written for those of us who have to “get it done,” not just talk about it. So roll up your sleeves and dig in.
Efforts to improve the quality of healthcare have failed to achieve a meaningful and sustainable improvement. Patients continue to experience fragmented, inconvenient, and unsafe care while providers are increasingly becoming overburdened with administrative tasks. The need for change is clear. Healthcare professionals need to take on new leadership roles in quality improvement (QI) projects to effect real change. The Quality Improvement Challenge in Healthcare equips readers with the skills and knowledge required to develop and implement successful operational improvement initiatives. Designed for healthcare providers seeking to apply QI in practice, this valuable resource delivers step-by-step guidance on improvement methodology, team dynamics, and organizational change management in the context of real-world healthcare environments. The text integrates the principles and practices of Lean Six Sigma, human-centered design, and neurosciences to present a field-tested framework. Detailed yet accessible chapters cover topics including identifying and prioritizing the problem, developing improvement ideas, defining the scope of the project, organizing the QI team, implementing and sustaining the improvement, and much more. Clearly explaining each step of the improvement process, this practical guide: Presents the material in a logical sequence, gradually introducing each step of the process with clearly defined workflow templates Features a wealth of examples demonstrating QI application, and case studies emphasizing key concepts to highlight successful and unsuccessful improvement initiatives Includes end-of-chapter exercises and review questions for assessing and reinforcing comprehension Offers practical tips and advice on communicating effectively, leading a team meeting, conducting a tollgate review, and motivating people to change Leading QI projects requires a specific set of skills not taught in medical school. The Quality Improvement Challenge in Healthcare bridges this gap for experienced and trainee healthcare providers, and serves as an important reference for residency program directors, physician educators, healthcare leaders, and health-related professional organizations.
The Health Care Data Guide is designed to help students and professionals build a skill set specific to using data for improvement of health care processes and systems. Even experienced data users will find valuable resources among the tools and cases that enrich The Health Care Data Guide. Practical and step-by-step, this book spotlights statistical process control (SPC) and develops a philosophy, a strategy, and a set of methods for ongoing improvement to yield better outcomes. Provost and Murray reveal how to put SPC into practice for a wide range of applications including evaluating current process performance, searching for ideas for and determining evidence of improvement, and tracking and documenting sustainability of improvement. A comprehensive overview of graphical methods in SPC includes Shewhart charts, run charts, frequency plots, Pareto analysis, and scatter diagrams. Other topics include stratification and rational sub-grouping of data and methods to help predict performance of processes. Illustrative examples and case studies encourage users to evaluate their knowledge and skills interactively and provide opportunity to develop additional skills and confidence in displaying and interpreting data. Companion Web site: www.josseybass.com/go/provost

Through a unique interdisciplinary perspective on quality management in health care, this text covers the subjects of operations management, organizational behavior, and health services research. With a particular focus on Total Quality Management (TQM) and Continuous Quality Improvement (CQI), the challenges of implementation and institutionalization are addressed using examples from a variety of health care organizations, including primary care clinics, hospital laboratories, public health departments, and academic health centers. Significantly revised throughout, the Fifth Edition offers a greater focus on application techniques, and features 14 chapters in lieu of the prior edition's 20 chapters, making it an even more effective teaching tool. New chapters have been incorporated on Implementation Science (3), Lean Six Sigma (6), and Classification and the Reduction of Medical Errors (10).