Leadership in Quality Improvement
Dallas County CQM Team

Oscar R. Salinas MD
Clinical Quality Management Supervisor-Medical
Dallas County Health and Human Services

About DCHHS 2018

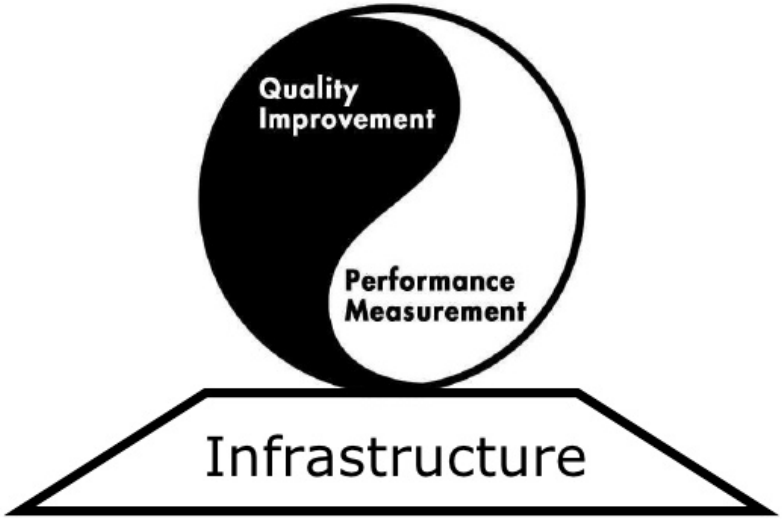
- DCHHS 2018 HRSA Visit

As we mentioned on the “Bringing the Ball and Pedestal to Life,” presentation, we had findings on all components of a CQM Program

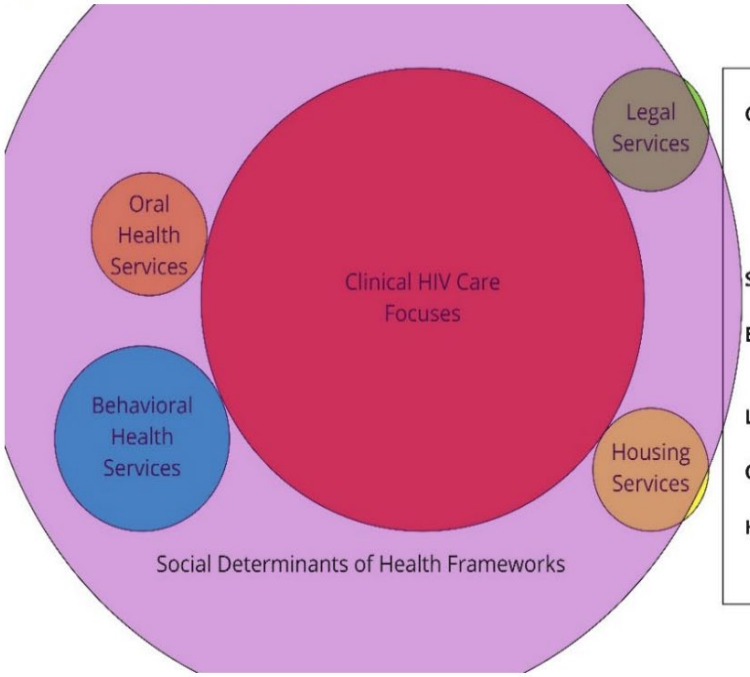
✓Infrastructure

✓Quality Improvement

✓Performance Measurement



Dallas County Subrecipients



Clinical HIV Care Focuses
- Health Services of North Texas
- Callie Clinic
- AIDS Healthcare Foundation
- Prism Health of North Texas
- Resource Center of Dallas

Social Determinants of Health Identification
- Bryans House

Behavioral Health Services
- Legacy Counseling Center
- Parkland Hospitals

Legal Services
- Legal Hospice of Texas

Oral Health Services
- Community Dental

Housing Services
- AIDS Services of Dallas

About the CQM Team and Consultant Support

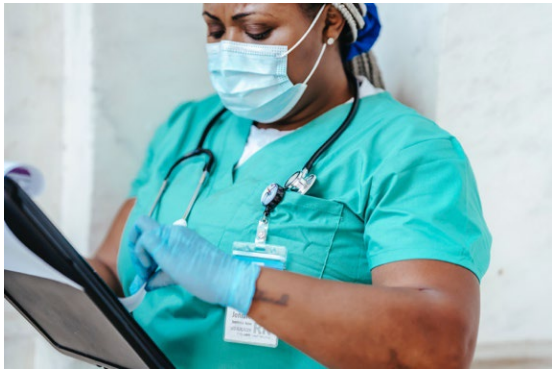
About the QI Project

Return to Care (R2C): a 24-month project (February 1, 2021 through February 28, 2023

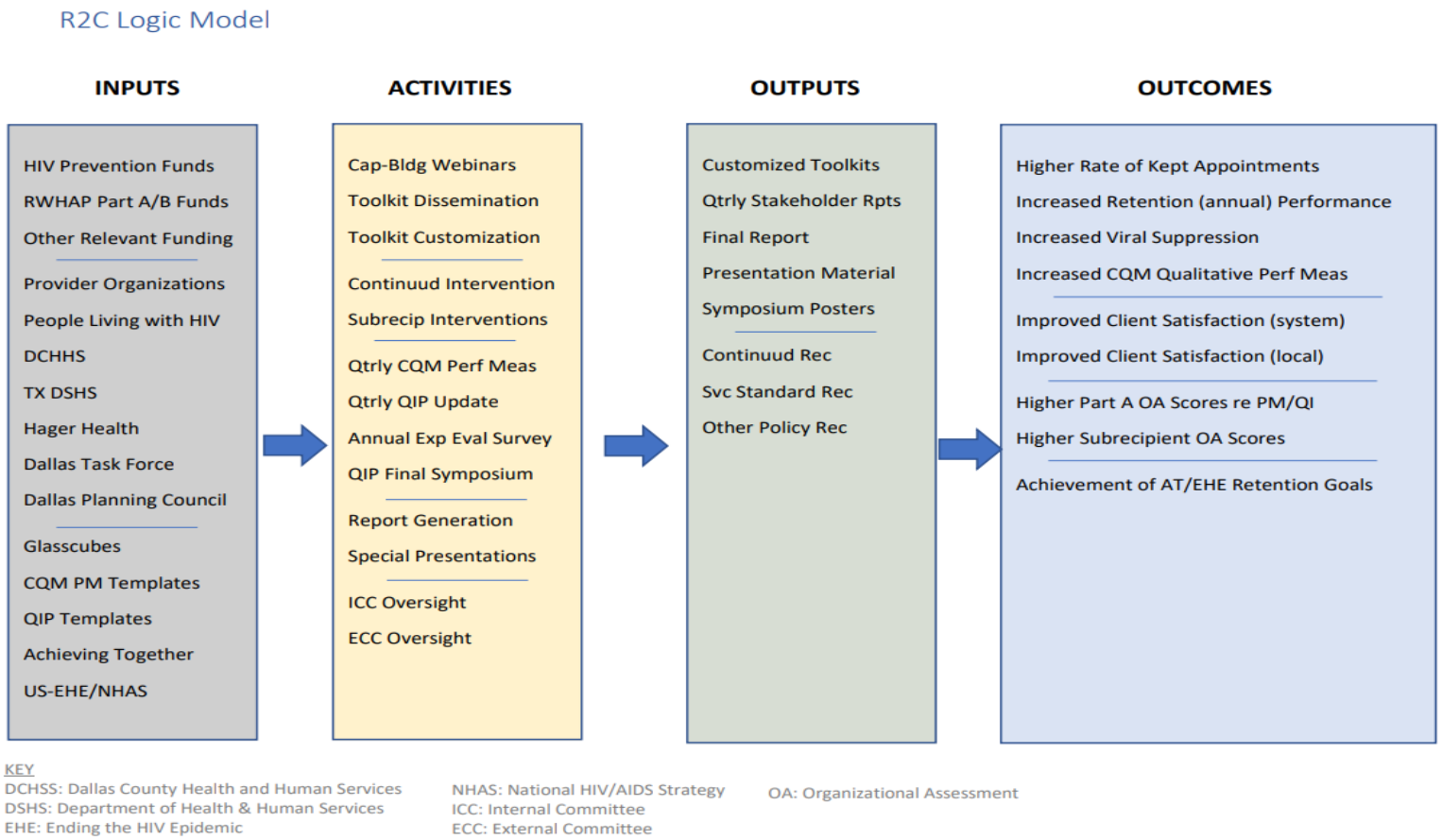
Primary purpose = Improve Retention in HIV Care

Facilitated a 4-part webinar series each grant year to provide TA and capacity building on implementing a QIP Project, using the Model for Improvement Methodology and more!

This was the FIRST EVER regional QI Project in Dallas!



Return 2 Care QIP Dallas County 2022



KEY
DCHSS: Dallas County Health and Human Services
DSHS: Department of Health & Human Services
EHE: Ending the HIV Epidemic
NHAS: National HIV/AIDS Strategy
ICC: Internal Committee
ECC: External Committee
OA: Organizational Assessment

Dallas EMA/HSDA Interventions to Improve Access to Care

AGENCY	INTERVENTION TYPE	SPECIFIC INTERVENTION
AHF/AIN	Continuud Tablets	Tablets for all based on need
Prism	Continuud Tablets	Tablets for trans patients
RCD	Continuud Tablets	Tablets for ESL patients
Callie Clinic	Access to Care	Finalizing approach
HSNT	Access to Care	Streamlined care coordination / case management
Parkland	Access to Care	Streamlined eligibility and enrollment
ASD	Housing Access	housing plan completion
Bryan's House	Addressing SDOH	Improved screening and addressing SDOH
Community Dental	Prevention	Improving dental plan completion
Legacy Counseling	Addressing SDOH	Streamlined eligibility and enrollment
Legal Hospice Texas	Expanded Outreach	Enrolling Hispanic and youth

Return to Care [R2C]

Parkland HIV Services

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Parkland

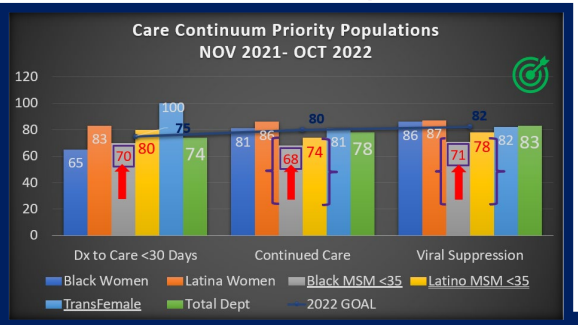
Launched March 2022:
Our Outreach & Retention Team
Lorna, Bridgette, Alex, Jana & Jonathan

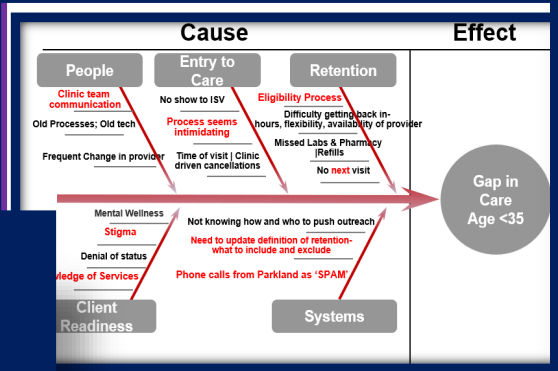
Aim Statement and Goals:

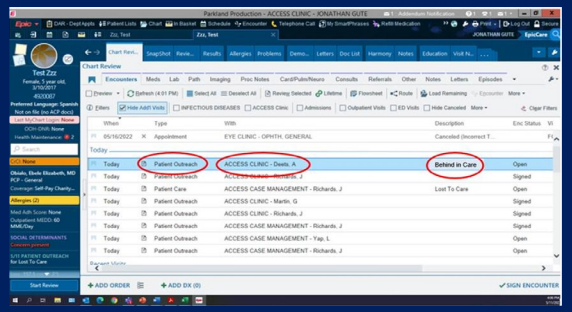
Parkland HIV Services aims to build a culturally responsive team & process to

GOAL: Improve retention of clients <35 who identify as MSM from 62% to 75%

SYSTEM GOAL: Imbed Outreach & Retention into clinic team for better clinic communication on clients' behalf







Performance Measure	Quarter 1 Results 03/01/2021-2/28/2022 (baseline)	
Annual Retention	Overall: 75% [N 4712 D 6304]	
	Black MSM <35: 62% [N 245 D 394]	
	Latino MSM <35: 62% [N 152 D 246]	
VL Suppression	Overall: 81% [N4915D 6085]	
	Black MSM <35: 72% [N 261 D 365]	
	Latino MSM <35: 78% [N 183 D 235]	
Show Rate by clinic	ACCESS	68% [N 13144 D 19207]
	BLUITT FLOWERS	79% [N 2363 D 3002]
	SOUTHEAST 350	63% [N 1828 D 2899]
	WOMENS SPECIALTY	72% [N 1231 D 1711]

icated O&R Team worked a daily census to
end a huddle retention note to providers
cussing the client's scheduling needs for next appt
all client to 3) directly assess barriers to care and
mmediately reschedule their appointment plus 5)
a personal touch to the process 😉

- 3,651 clients contacted
- 105 clients returned to care
- 365 clients prevented from falling out of care
- Impacted *multiple priority populations* through this client centered work* see care continuum work

Next Steps/Adaptations:

- dedicated Financial Counselor appointment for R2C
- Increase % of clients returning to care through dedicated clinic visit & overbook advocacy

Return to Care

Legacy Counseling Center Inc, dba Legacy Cares

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Team

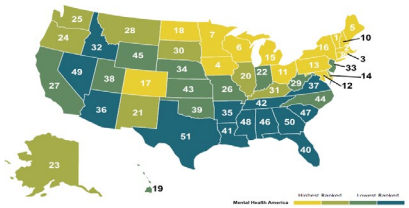
Melissa Grove, Former Executive Director & Clinical Director
Brooke Henderson, Present Executive Director
Tammy McCormack, Office Manager
Parris Greer, Counseling Intern

legacy cares
positive starts here.

ttt

Data

Access To Care Ranking 2020



Data Trends: Texas ranked the last in mental health services. As the largest MH provider in the South, we aim to provide a haven for individuals impacted with HIV/AIDS.

Aim Statement and Goals

Legacy Cares aims to provide affordable high-quality mental healthcare and substance abuse counseling to Texans impacted by HIV/AIDS.
Goal/Reach: Reduce the number of no shows for clients seeking behavioral health care. The last year, we sought to improve sessions by 20%.

Root Cause Analysis

5 WHY'S:

Problem: Reduce MH No Show rate

Test(s) of Change

Test of Change: We tracked clients who had <4 counseling sessions and did not return to care. We utilized a counseling intern to send out a Survey Monkey and/or conduct a phone survey with client's. If we connected with a client, we provided education on alternative treatment options (change of therapist and/or being referred out), and inquire about barriers to care.

Results

1) How did your test of change go? Limited to success due to not always being able to connect with clients (technology, communication, and lack of contact)

2) How did you evaluate it? Survey Monkey & Phone Calls

3) Did you pivot? During this season of transition we are re-evaluating a need to pivot

4) What's next? We are assessing new performance measures (linkage timeframe, supportive services accessed, etc)

Lessons Learned

- **1. There is still a stigma associated to behavioral healthcare.**
- **2. Lack of qualified licensed professionals**
- **3. Non-profit rate of pay to licensed therapist; especially Licensed Clinical Social Workers (LCSWs).**

Celebration Corner

★ **Thank you to DCHD CQM Team and consultants for their support, TA sessions, and workgroups. Also to all the ASO's involved, thank you for sharing your successes and challenges during this process. We learned so much from one another.**

Return to Care

YOUR HEALTH CLINIC DBA

Callie Clinic

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Team

- CQM Committee – Overall oversight. Staff & Consumer members.
- Glenn Moreland, HIV Program Director
- Kelly Fretwell, Office Manager
- Clinical Staff (APRN, PA, RN, and Medical Asst.)
- Norma Piel-Brown, CQM Coordinator
- Dr. Minaxi Rathod, ID Provider/Medical Director

Root Cause Analysis

Asking Powerful Questions - 5 Whys Worksheet

Define the Problem: Historically, STD screening rates (Chlamydia & Gonorrhea) are and have been very low (55% or less) at our clinic.

Why is it happening?

1. STD screenings are offered; clients are opting not to get these tests.
   Why is that?
2. They are in monogamous relationships and/or use condoms for protection.
   Why is that?
3. A false sense of security comes from being in a monogamous relationship and/or not using condoms 100% of the time or using them incorrectly.
   Why is that?
4. Clients don't consider themselves at risk or that monogamy and condom use is less than 100% effective; routine testing not needed for healthy lifestyle.
   Why is that?
5. Clinic's policy was to allow opt-out for monogamous relationships; annual STD screenings not part of standard practice.

Action: Last Quality Improvement Project (QIP) focused on increasing VLS & Retention rates. This phase incorporates STD screening rates with VLS & Retention rates. High-risk behaviors impact overall health for both groups. Same interventions will be used for both to test if an increase to STD rates will impact VLS & Retention rates.

Aim Statement and Goals

By January 2023, STD screening rates (Chlamydia & Gonorrhea) will increase from above baseline by ~5% and the retention and viral load suppression (VLS) rates will be impacted (improved) by ~ 1 – 4%.

Test(s) of Change

To test if improvement to STD performance measure rates affect (improve) VLS and Retention rates, we will:

- Use data driven quality improvement techniques to identify clients who have and have not met Performance Measure (PM) indicators:

- Monthly CAREWare PM Reports to identify clients who met performance indicators.
- Monthly CAREWare PM Exclusion Reports to identify clients who did not meet the performance indicators.
- Validation of above reports against clinic EMR to assure accuracy.
- Collection/evaluation of validated data to set baseline, determine goals and complete tracking forms.

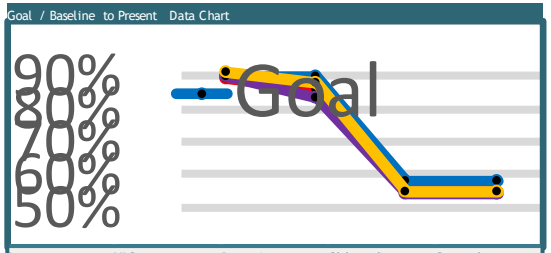
Interventions:

- Weekly Huddle Policy & Checklist Development. Utilize weekly Huddle Checklist to identify clients in need of STD screenings prior to actual appointment.

Communication (meetings) with CQM team, staff, consumers and funders:

- Posted info on clinic bulletin board on QIP status.
- Monthly CQM team meetings to provide updates.

Data



Dates	VLS	Retention	Chlamydia	Gonorrhea
Target	90%	90%	58%	58%
June 2022 (Baseline)	89%	86%	55%	55%
August 2022	90%	83%	54%	54%
October 2022	91%	88%	55%	55%
December 2022	TBD	TBD	TBD	TBD

Results/Lessons Learned

Results: We test for change on a monthly basis by collecting performance measures. The CQM team reviews results once data validated. No changes yet to the project. We anticipate this project will be ongoing.

Lessons Learned:

- At the onset, during a CQM meeting we discovered that "monogamous relationships" should not be "excluded/exempted" for STD PMs. Screenings should be annual unless <18 years with no prior history of sexual relationships. This should affect our numbers in the long term.
- By conducting deep dives into the data, we discovered that the formula used by CAREWare for Gonorrhea and Chlamydia PMs did not capture all of the labs associated with these STDs. We revised the formulas.
- The clinical staff as a whole is on the alert to obtain screenings. We are all on the same page.

QIP Return to Care – Callie Clinic

Bulletin Board:

Return to Care

RESOURCE CENTER

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Team

Del Wilson, Ryan White Program Director
Gary Benecke, Eligibility Manager
Daniel Sanchez, Nutrition Manager
Eddie Marez, Health Campus Coordinator

resourcecenter®

Data

LGBTQ Health was established in 2019 to provide outpatient medical services to the LGBTQ community and allies in a neighborhood clinic located in the Oak Lawn area of the City of Dallas. Resource Center received Ryan White Ambulatory Outpatient Health Services funding effective 7/1/20 that made it possible for the clinic to begin serving low income, non-insured patients living with HIV. We are tracking Retention in Care and Viral Load Suppression for our Ryan White performance measures.

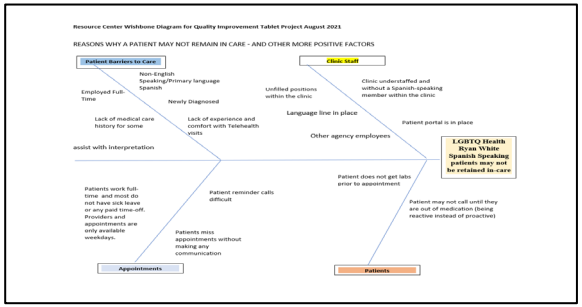
Aim Statement and Goals

Resource Center will increase the percentage of Ryan White funded Latinx patients retained in clinic care to 70% for Calendar Year 2022.

Actuals 9/1/20 - 8/31/21 (Baseline)
23.7% for Hispanic Ryan White patients (56.3% if not including patients who entered medical care less than 90 days before the end of the reporting period - which did not allow sufficient time to possibly meet the standard).

Actuals 9/1/21 - 8/31/22
58.51% for Hispanic Ryan White patients (74.3% if not including patients who entered medical care less than 90 days before the end of the reporting period - which did not allow sufficient time to possibly meet the standard).)

Root Cause Analysis



Test(s) of Change

Tablet project – we requested 2 tablets and provided them to patients with limited English-speaking ability. If the tablets were later determined to no longer be needed by the assigned patient, the tablet was re-assigned to another patient. We tracked appointment adherence for medical visits and labs for these patients.

For all Latinix patients - we discussed with the patient language of choice and any need for a Spanish-speaking provider or interpretation services.

Results

We were satisfied with the results that showed the tablets did help patients in adherence to medical and lab appointments. It is not really possible to propose any useful statistics over such a small sample. We will definitely continue to give patients with limited English-speaking ability extra support in the language area as needed. At the end of the next quarter we will determine whether or not to continue our participation in the tablet project. We may decide to use tablets with non-medical case management clients to support their engagement in care services.

Lessons Learned

A technology-naïve patient can learn, in a fairly short period of time, to use an electronic tablet as a communication tool to strengthen their engagement in medical care and improve their appointment adherence.

English as a second language patients require more support to fully engage in medical care including the availability of staff who speak that language if possible or interpretation services.

Cultural humility promotes retention in medical care and appointment adherence which are key components in a patient's journey to their best possible health.

Celebration Corner

A shout out to the Dallas County CQM team for bringing this innovative tablet program to the Dallas area.

A hooray to the technology-naïve patients who participated in the tablet project.

A salute to the other Ryan White ambulatory outpatient health services providers who freely shared their project successes and difficulties.

Return to Care

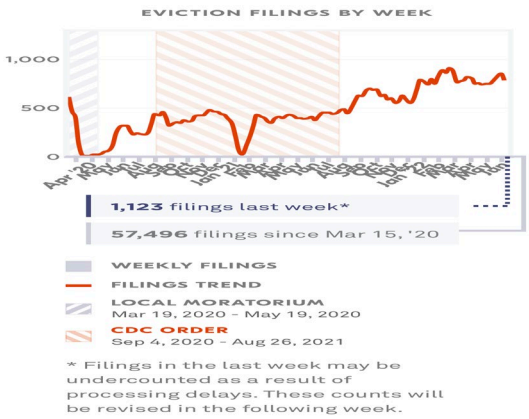
Legal Hospice of Texas

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Team

Jasmin Alvarez – Client Services Coordinator
Nisa Ortiz - Director of Client Services
Joel Lazarine – Legal Director
Jennifer Longfellow – Staff Attorney
Michelle Moos – Executive Director

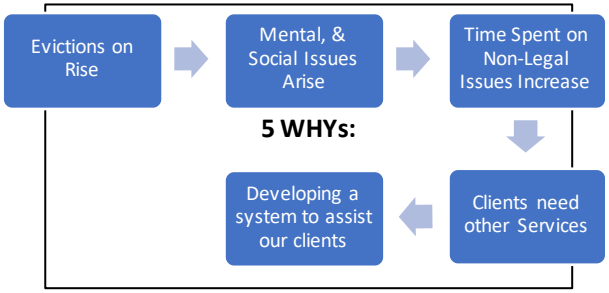
Data



Aim Statement and Goals

The LHT staff will work to decrease the amount of time attorney's work on social issues for client's by referring them within our network to the appropriate services and allowing our staff to stay focused on the legal issues at hand. In doing so, we will work to refer individuals who need case management services back to care. We will increase reporting by 100% by creating a formal system to keep track of client's in case management and related services.

Root Cause Analysis



Test(s) of Change

We began an informal referral process, sending the client to Housing resources, income resources, case management and medical resources as needed. As our new data base goes live Jan. 2022, this process will become formalized.

Results

The test changed proved to be effective. In cases where referrals were made, the time spent discussing non-legal issues decreased and Housing cases were closed at normal rates as client's seek other resources for their issues. We've pivoted in not having a formalized way of keeping track after a case is closed but are working to change this.

Lessons Learned

- Attorney's need constant developing resources for their client's to refer out
- Every need for a client is different
- The Pandemic had a lasting effect on many different aspects of one's life (one shoe does not fit all)
- Developing a formalized process for Referrals is necessary

Celebration Corner

Always proud of our Amazing Attorney's, Jennifer and Joel!
Our Client Services Coordinator, Jasmin, takes on a huge role daily as our intake person and we are very proud of her! & ECQM!!! <3

Return to Care

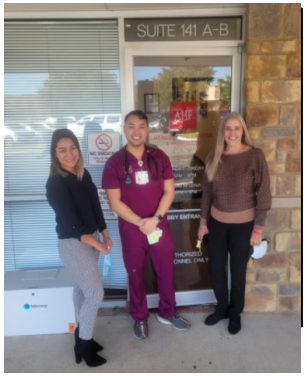
AIDS Healthcare Foundation

Poster Symposium | December 1, 2022 | Dallas EMA/HSDA

AHF

Team

Sandra Najuna- Quality Lead
Astrid Edison- Contract Manager
Joni Wysocki- COO AIN
Shonda McGraw- Practice Manager
Teddy Luong- Medical Director
Dan Nguyen- Medical Director



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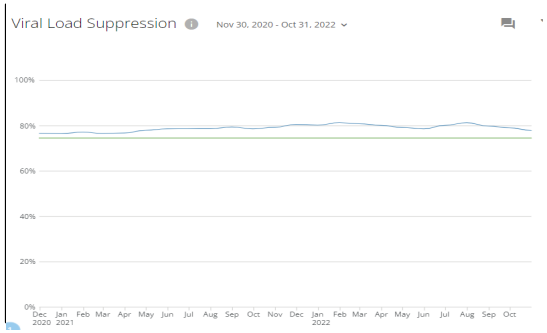
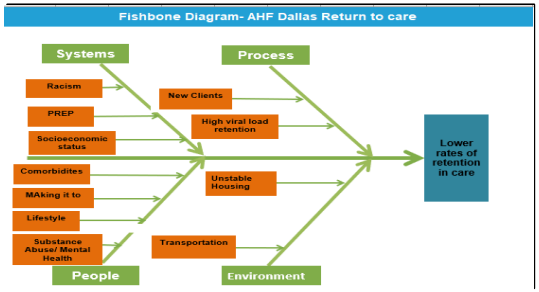


Aim Statement and Goals

To increase viral load suppression rate from 80% to 83% by December 2022.

Root Cause Analysis



Test(s) of Change

Distribution of Continuud tablets to qualifying consumers who have missed medical appointments for 13+ months.

Results

- Distributed four tablets to consumers.
- All four consumers were trained on tablet use.
- Attempts to contact consumers for feedback on tablet use were futile.
- Providers offered telehealth as an option for consumers' medical appointments.
- AHF reaches out to all consumers that have missed medical appointments for 3+ months.

Lessons Learned

- Re-building quality management teams during the pandemic.
- Need for continued Quality Improvement trainings.
- Provide telehealth alternative for all consumers.

Celebration Corner

ALL Staff for continued hard work throughout the COVID-19 pandemic and through the 'Great Resignation'.

Return to Care

Health Services of North Texas

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Team

HEALTH SERVICES OF NORTH TEXAS — Medical Care for You

R2C Team

Merline Wilson – Senior Manager of Programs

Sylvester Mayes – Manager of Programs

Karishma Patel – Informatics Consultant

Kim Alambar – Quality Coordinator

Infectious Disease Providers:

Dr. Arlene Hudson, Dr. Parul Kaushik, Laurie Mottl PA

Case Management Team:

Erika Washington, Veronica Fletcher, Ashlynn Stegall, Bryan Garcia, Khadeem Campbell, Pierre Kabeya

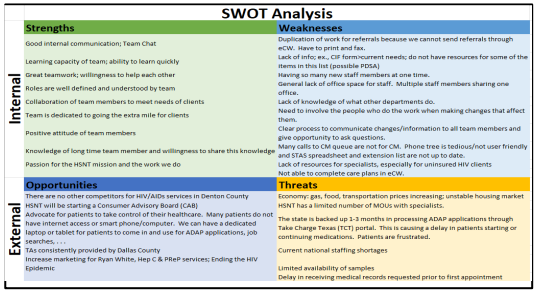
Data

HSNT	Retention in Care	Viral Load
Q4 2021	81.18%	80.21%
Q1 2022	84.03%	82.01%
Q2 2022	82.85%	87.85%
Q3 2022	86.07%	83.68%
Q4 2022		

Aim Statement and Goals

HSNT will continue to review MCM, RFHC and provider panels to identify patients who are out of care or behind on care. These patients will be contacted to identify barriers and relink to care. HSNT hopes this will increase the number of patients who return to care by 5% by December 31, 2022.

Root Cause Analysis



Test(s) of Change

HSNT started reviewing patient panels for all Infectious Disease providers in 2021. This has become a standing monthly meeting.

In 2022, HSNT added a weekly team meeting for the care management staff.

We started analyzing the MCM call queue stats.

Results

The provider panel reviews identified clients who fell out of care and CMs reached out to bring them back into care.

Weekly CM meetings have allowed staff to identify patients with barriers to care, discuss a plan to address client needs and relink clients to care.

A deep dive into the call queue stats identified issues that decreased the answer rate. Adding additional staff, changing the start time and revising call routing led to an increase in calls answered.

Lessons Learned

- **Need to be proactive in analysis of data.**
- **Weekly meetings have improved communication between staff and providers.**
- **Once a problem is identified, staff and providers need to be receptive to changes.**

Celebration Corner

The MCM call queue answer rate increased by almost 30% from July to October.

Return to Care

PRISM HEALTH NORTH TEXAS

Poster Symposium| December 1, 2022 | Dallas EMA/HSDA

Team

Deborah Morris-Harris MD
Chief Medical Officer

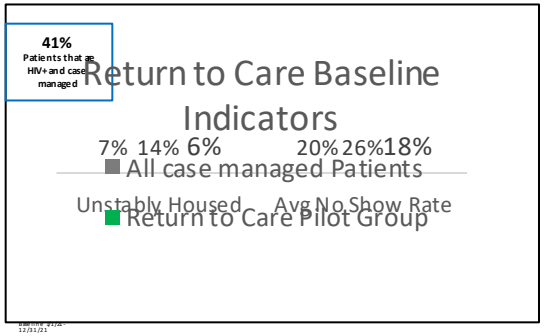
Cathy Bryan
EVP Patient Services and Operations

Javoszia Sterling-Lewis, MPH
Quality Manager

Victoria Langston, RN
Director of Clinical Compliance

PrismHealth NORTH TEXAS

Data

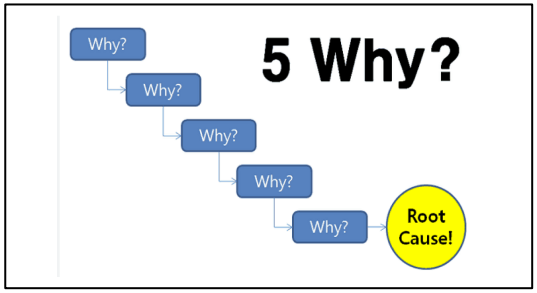


Case managed patients are typically of higher risk, hence the need for case management. As shown on the graphs, no show and unstable housing rates are higher in the case managed group compared to the main Prism patient population. Furthermore, the Return to Care pilot group has even higher rates of being unstably housed and no shows. Demonstrating a need for this intervention.

Aim Statement and Goals

Prism Health North Texas will utilize 9 tablets provided by Dallas County to improve access to care and reduce gaps in appointments for case managed patients that are HIV+ and that may be experiencing transportation issues, unstable housing, or have low no show rates.

Root Cause Analysis



Test(s) of Change

After exploring other methods of tablet distribution and completing a Root Cause Analysis (RCA), we found that a major barrier to this project is getting the tablets into the hands of patients in need. Due to the many and continuous barriers with tablet distribution, and Rapid Cycle Improvement (RCI) plan was initiated. The RCI resulted in a change in the distribution and management of the tablets. The tablets will be kept by non-medical case managers to not only address our most in-need patients but also all patients across the 9 caseworker's caseloads.

We will also add applications and tools onto the tablets as needed and identified by case managers. For example, we added visual signature to the tablets to help patients sign documentation without paper waste.

Results

Nine Non-Medical Case Mangers (NMCM) have been assigned tablets to help assist them with their caseloads. Non-medical case managers are utilizing the tablets with patients to provide a medium for telehealth appointments, sign and upload documentation, and other services that may be utilized to provide access to care or streamline patient care. For patients that have transportation concerns or unstable housing, the tablets can be used for telehealth at point of contact with the case manager. For patients that are unstably housed, the tablets will be used to assist in documentation signing.

Lessons Learned

We engaged the Patient Advisory Committee and the case manager supervisors to re-work the plan after barriers with tablet distribution to patients. From the PAC, we learned that patient privacy during telehealth appointments could be a concern so the NMCM will be working on a process to ensure patients can have their telehealth appointments privately. We also discussed barriers to language accessibility on the tablets.

Celebration Corner

We are proud of our 9 engaged Non-Medical Case Managers who provided feedback and agreed to participate in the pilot for this new project.

Organizational Assessment (OA) & CQM Evaluation

The Organizational Assessment (OA)

OA Basics

- Validated tool to assess Operational Quality of RWHAP CQM Programs
  - Rooted in the Baldridge Award methodology, created by HAB and NQC/CQII
  - Validated by JSI through NQC/CQII
  - Helps to frame the components of CQM excellence in a domains format
  - Domains cannot be clustered statistically, but may be grouped
- Standard next steps for RWHAP CQM program sophistication
  - Helps to drive the CQM Plan workplan
- Various formats for different Parts funding
  - Assesses provider-level vs system-level CQM programs and their sophistication

OA Domains

Recipient-Level OA	
A.1	Leadership Support for CQM
A.2	CQM Committee Functions
A.3	CQM Planning
B.1	Workforce Training/Engagement in CQM
C.1	CQM Performance Measurement Basics
C.2	Performance Measurement to Drive QI
D.1	QI Project Processes
E.1	Consumer Involvement in CQM
F.1	Evaluation of CQM Program
G.1	Performance Comparison/Benchmarking
G.2	Disparities Analysis
H.1	HIV Care Continuum Creation and Utility

Subrecipient-Level OA	
A.1	Leadership Support for CQM
A.2	CQM Committee Functions
A.3	CQM Planning
B.1	Workforce Training/Engagement in CQM
C.1	CQM Performance Measures and Data Use
D.1	QI Project Processes
E.1	Consumer Involvement in CQM
F.1	Evaluation of CQM Program
G.1	Performance Comparison/Benchmarking
G.2	Disparities Analysis
H.1	HIV Care Continuum Creation and Utility
I.1	Care Integration (clinical/supportive/other)

Dallas EMA/HSDA OA Results

Subrecipient-Level OA	
A.1	Leadership Support for CQM
A.2	CQM Committee Functions
A.3	CQM Planning
B.1	Workforce Training/Engagement in CQM
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E.1	Consumer Involvement in CQM
F.1	Evaluation of CQM Program
G.1	Performance Comparison/Benchmarking
G.2	Disparities Analysis
H.1	HIV Care Continuum Creation and Utility
I.1	Care Integration (clinical/supportive/other)

	2020	2021	2022
A.1	1	2	3
A.2	0	2	3
A.3	1	3	2
B.1	0	2	3
C.1	0	1	2
C.2	0	1	2
D.1	0	2	2
E.1	1	2	2
F.1	0	2	3
G.1	0	0	1
G.2	1	1	1
H.1	0	1	2
TOTAL	***4***	***19***	***26***
Version	*CQII 2017*	*CQII 2017*	*DSHS 2020*

2022 Subrecipient OA Score Quartiles

Quartiles	A1	A2	A3	B1	C1	D1	E1	F1	G1	G2	H1	I1
MIN Value	1	1	2	2	2	1	2	1	2	1	0	0
FIRST Q	3	3	2	3	3	4	3	2	3	3	2	2
MEDIAN	3	3	3	3	4	4	3	4	3	3	2	4
THIRD Q	4	4	4	3	4	4	4	4	3	4	4	4
MAX Value	4	5	5	4	5	5	5	4	5	5	4	5
AVERAGE	3.111111	3.111111	3.111111	3	3.555556	3.666667	3.444444	3.111111	3.111111	3.222222	2.444444	3.111111
VAR 21-22	0.474747	0.747475	0.383838	0.545455	0.373737	1.030303	0.444444	1.020202	0.565657	0.822222	0.444444	0.747475

Quantitative & Qualitative CQM Performance Measures in the Dallas EMA/HSDA

What we considered in our overall approach to CQM performance measure specification for our region

Performance Measures

Quantitative

OAHS Retained in Care 79.18 %
VLS- 83.49 %

APA - VLS 81.71 %
Ret in Care- 77.91 %

Qualitative

MCM (x8)- Prescriptions, housing, mental health, transportation, food and public benefit

Non-MCM- Paperwork Assist, care plan review, dental, housing

Outreach- Food, housing, utilities, public benefits, transportation

Oral Health- knowledge and tools to take care of oral health very close to each other

Medical Transportation (x3)- Bus pass the most common utilized, and the service utilization most common for medical care, shopping, friends and family, religious and other

Lessons Learned - QI Leadership

Successes/facilitating factors

- Incorporating Continued
- Speakers from outside
- Scheduled webinars
- New forms for tracking/reporting progress
- TA
- Opportunities to incorporate non RW providers

Challenges/limiting factors

- First time QIP on the EMA and Sherman-Denison HIV Service Delivery Areas (HSDA)
- Contracts and agreements
- Subs engagement
- HIPPA Concerns
- The level of CQM not being part of the contractual obligations described on the document
- Inconsistency on reporting
- Staff changing at subs level

Best Practices - QI Leadership

- Find the right guide and coaching
- Change contract language
- Health department officials' involvement
- Education of the subs on CQM culture
- Creating new templates and coaching one on one
- TA open and encouraged
- Dedicated and motivated Staff
- Admit what you don’t know and be open to learn
- Separate QI from QA at the workplace
- Have the involvement of legal, admin, programmatic, operations, and any other staff involved in patient’s care
- It is a journey

Culture of Quality

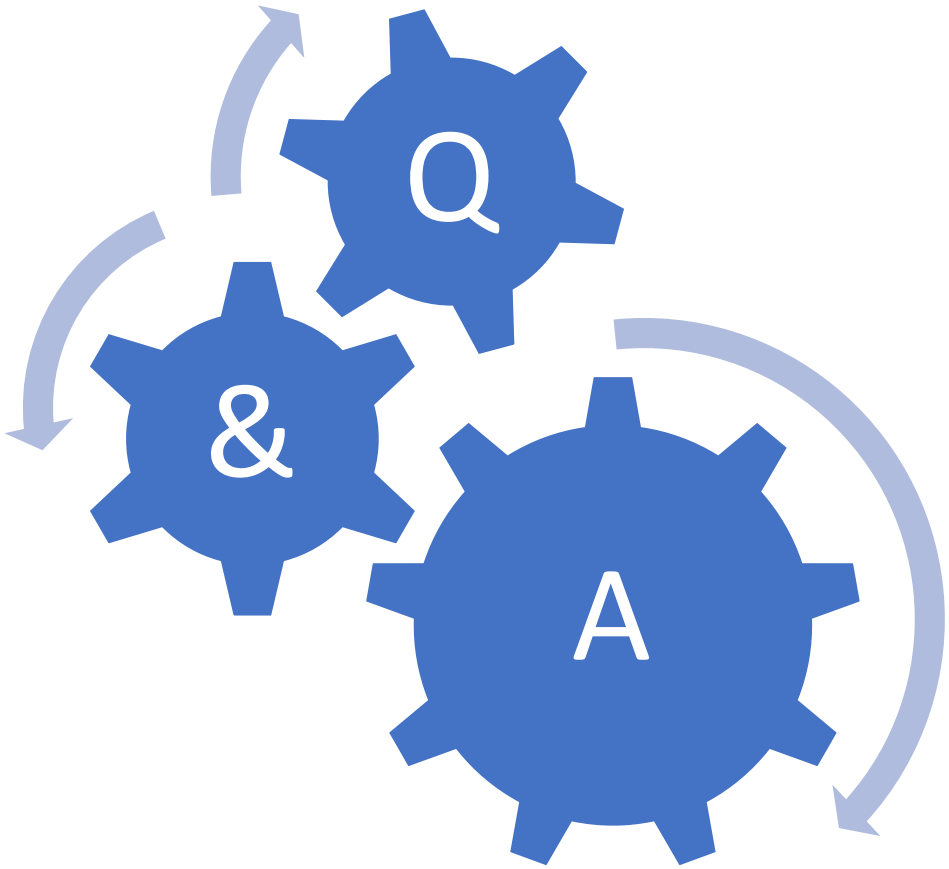
How to create

- Get educated yourself and practice at home first
- Present the concept as a way to simplify and not as “more to report”
- Be flexible for TA request
- Involve everyone from head to toe on your practice
- Be transparent

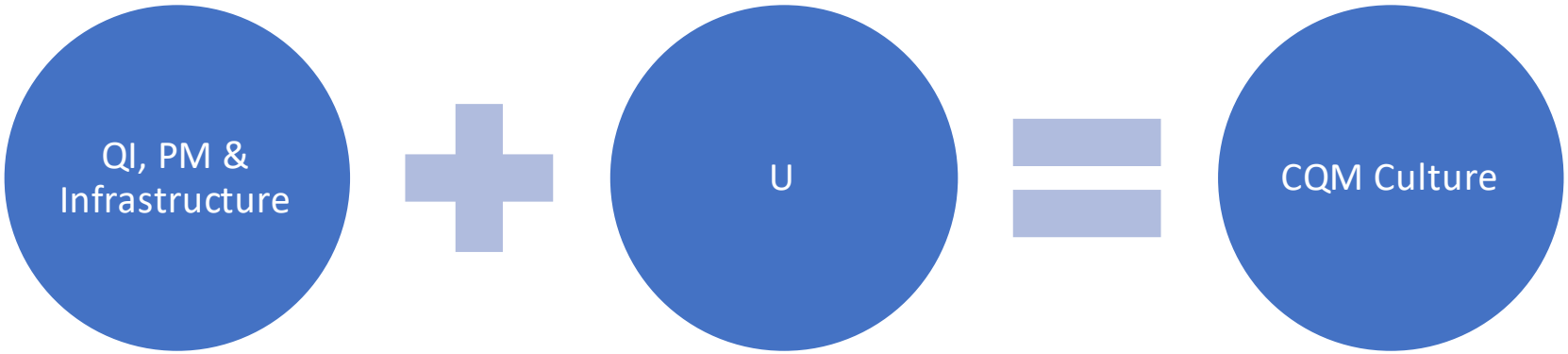
How to sustain

- Share and communicate efficiently
- Be patient and maintain the positive outcomes on validation mode
- DO NOT GIVE UP… It is not easy

Q & A



Thank you



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