TURNING #DATA INTO ACTION

Lessons Learned from TQIP-Driven Performance Improvement

(...and Surviving the Process)

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Objectives

Share a practical framework for reviewing TQIP data and prioritizing improvement opportunities.

Demonstrate a practical approach to data drill-downs and root cause analysis.

Describe how we used TQIP findings to investigate unplanned ICU events and identify target populations.

Highlight the role of multidisciplinary collaboration in developing actionable improvement strategies.

Provide lessons learned and best practices that can be replicated at other trauma centers.

Why TQIP Benchmark Reports Matter

(Because guessing is not a performance improvement strategy)

IDENTIFY

Highlight what matters

- Highlight outcomes and processes that differ from expected performance
- Help us focus on the areas that deserve a closer look
- Prevent us from chasing every red box (or losing sleep over all of them)

INVESTIGATE

Ask better questions

- Turn assumptions into investigations
- Help uncover the story behind the numbers

COLLABORATE

Bring people to the table

- Provide objective data that brings stakeholders to the table
- Create shared ownership of improvement initiatives

MANAGE PROGRESS

Measure what matters

- Evaluate whether interventions are making a difference
- Demonstrate improvement over time

IMPROVE PATIENT CARE

Drive meaningful change

- Transform data into actionable change
- Support safer, more reliable trauma care

Key Takeaway:

TQIP reports don't improve outcomes. People do. TQIP just tells us where to start looking.

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The Problem/Challenge

We all have access to performance data…

The challenge isn't getting data.

The challenge is:

-Prioritizing opportunities

-Getting physician engagement

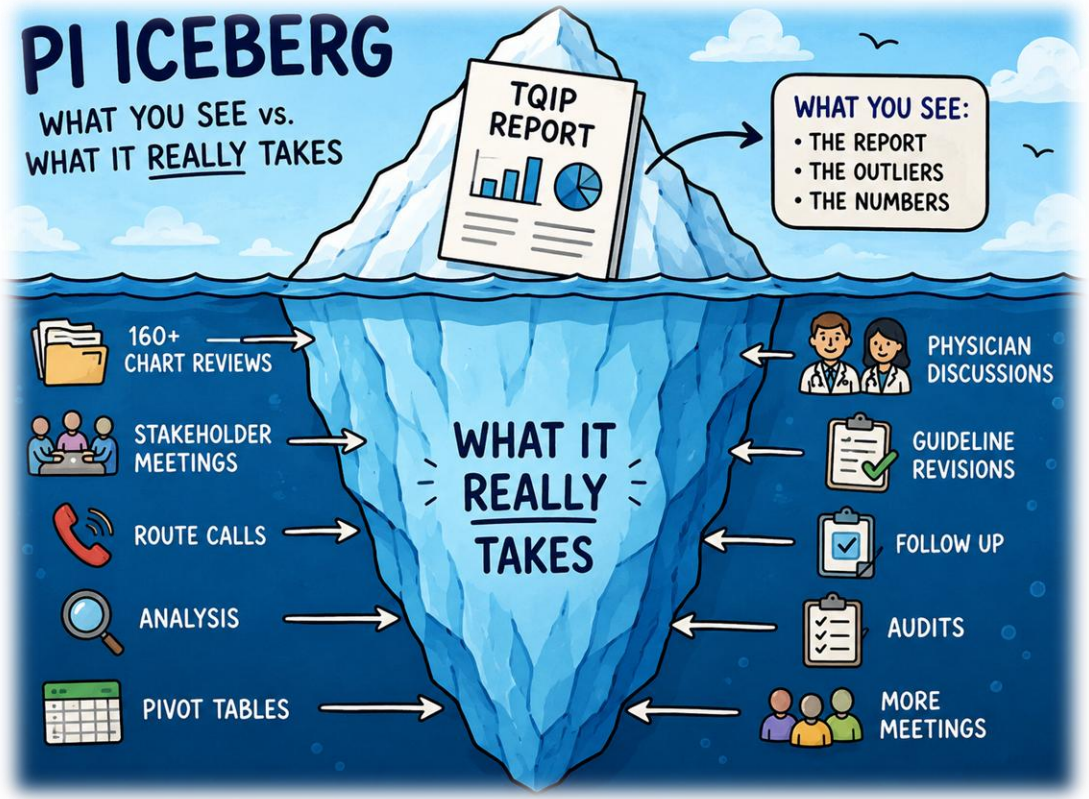
-Identifying root causes

-Implementing change

-Demonstrating improvement

-Surviving multiple meetings

"Having data is not the same thing as having a performance improvement plan."



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A Completely Normal Reaction to Receiving a TQIP Report

(Based on several true stories)

We all know the feeling….The TQIP report hits your inbox, your heart rate goes up a little, and you start wondering

"What red box is about to become my entire personality for the next six months?"

Here's my 3-step approach for reviewing a TQIP report and identifying meaningful opportunities for improvement.

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The Real Work Begins

(The Team Behind the Data)

Performance Improvement is a Team Sport

Under the leadership of our Trauma Medical Director and with dedicated Performance Improvement Coordinators leading each initiative, the data drill-down is anything but a solo project.

It takes a committed multidisciplinary team to understand the story behind the numbers and turn findings into meaningful performance improvement.

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Case Study

(A single red box that changed our entire approach)

After being identified as an outlier for unplanned ICU events in our TQIP report, we undertook a large retrospective review to move beyond the benchmark data, identify recurring themes, uncover root causes, and develop targeted improvement strategies.

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Looking Beyond the Red Box

(The journey from "that's concerning" to "that's actionable")

The answer wasn't in the TQIP report.

We began with a broad review of more than 160 unplanned ICU events spanning one year, allowing us to identify trends and determine where to focus our efforts.

Together, we reviewed cases, explored different patient cohorts, challenged our assumptions, and looked for patterns that could explain why these ICU upgrades were occurring.

Several recurring themes emerged, helping us identify high-impact patient cohorts and guiding a focused six-month retrospective review

But the journey to get there looked something like this….

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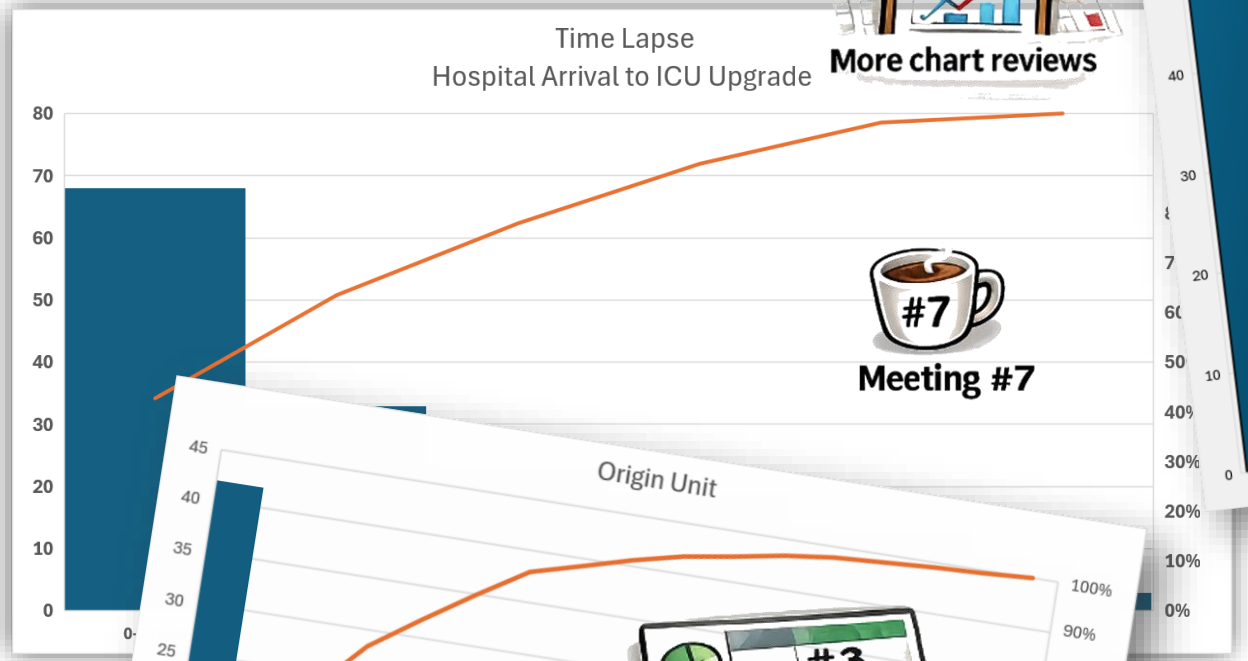
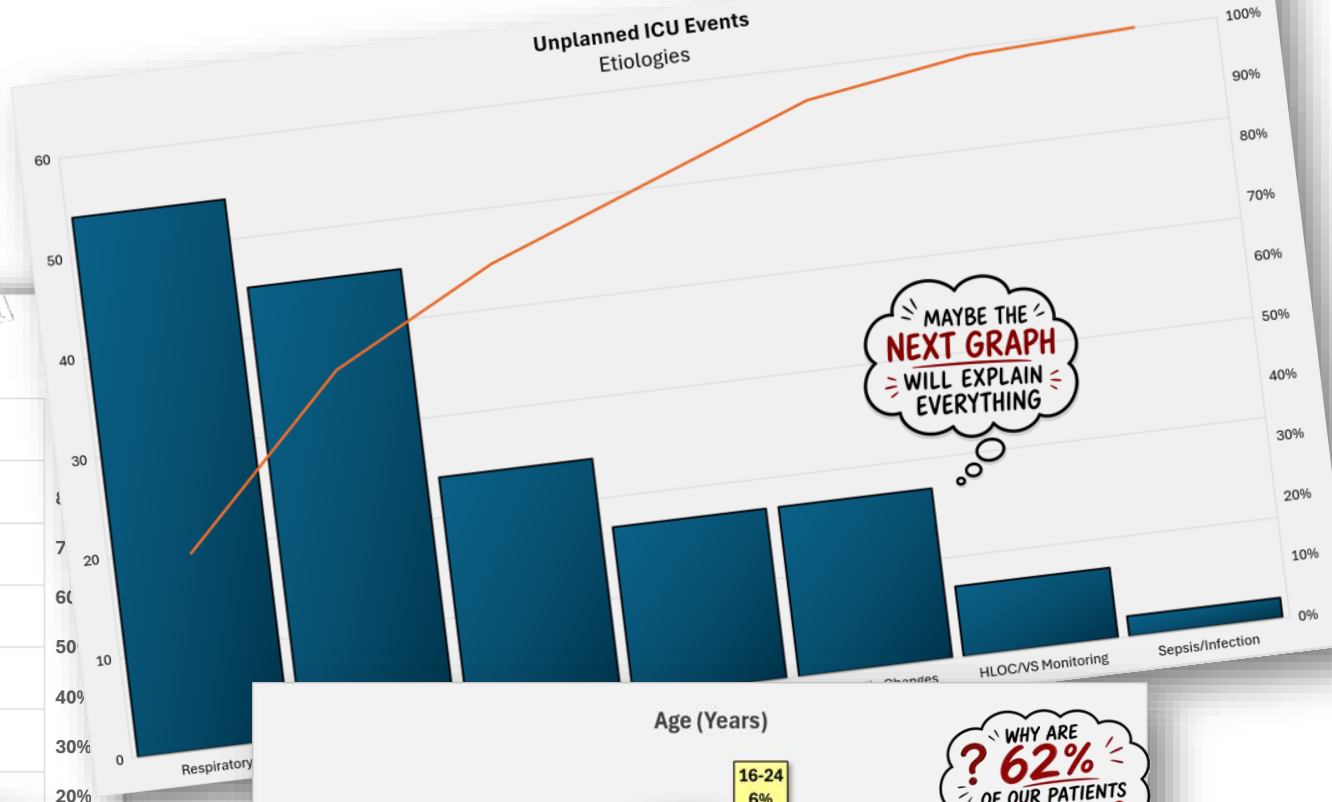
The Detective Phase

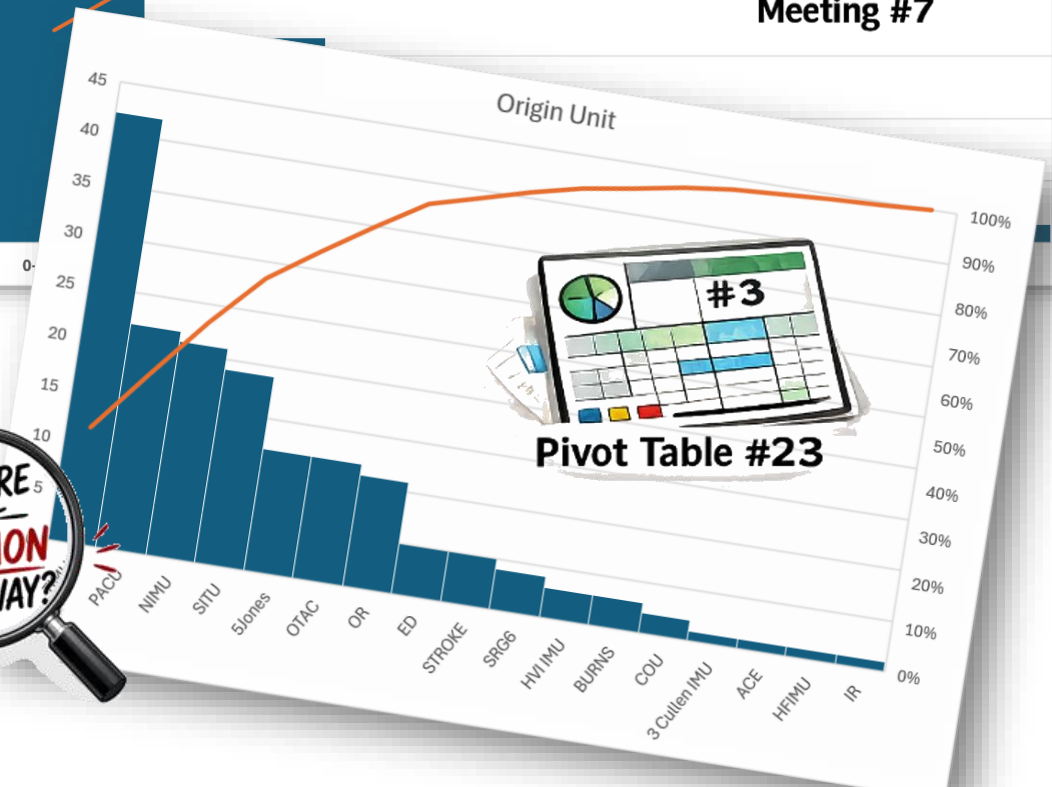
(Making Sense of the Madness...)

More chart reviews

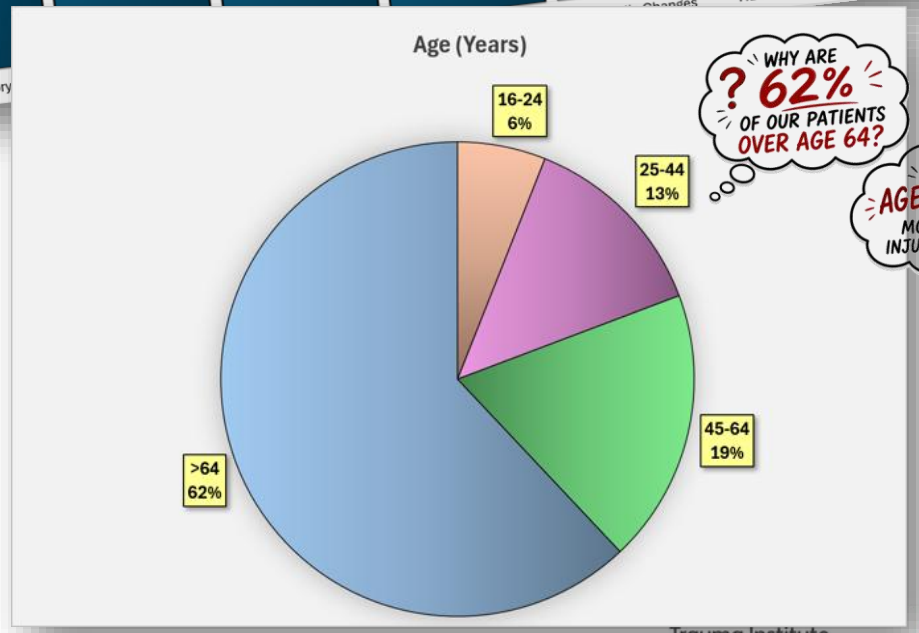


Meeting #7





Pivot Table #23



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DATA REVIEW MELTDOWN
FILTERS
OUTLIERS
MORE CHARTS
PIVOT TABLE #23
NEW HYPOTHESIS
CORRELATION OR COINCIDENCE?
"LET'S ASK DR. WANDLING."
Texas Children's Hospital
Methodist HOSPITAL
MEMORIAL HERMANN
St. Luke's HEALTH
Ben Taub HOSPITAL
Houston
TEXAS
THIS REALLY HAPPENED.
#TRUESTORY

Digging Deeper

(Understanding the Story Behind the Data)

The majority of unplanned ICU events occurred in:

Geriatric patients with isolated hip fractures

Geriatric patients with lower-acuity polytrauma injuries

The immediate postoperative period, with many unplanned ICU admissions occurring within the first several hours after surgery

Recurring Themes Identified

Hemodynamic instability

Respiratory deterioration

Variability in GTS guideline adherence

Missed opportunities for preoperative optimization

Need for enhanced perioperative planning and communication

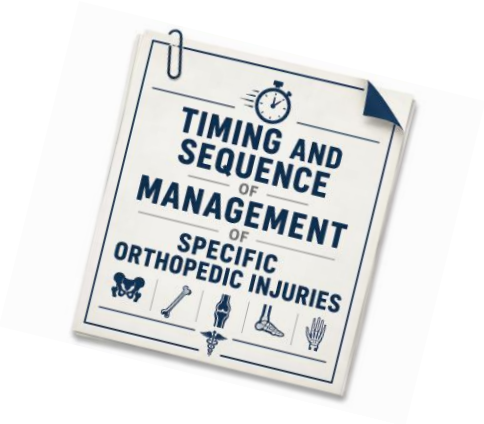
What initially appeared to be a broad ICU utilization issue was ***actually*** being driven by a very specific patient population.

We already had a guideline…so what was missing?

(Sometimes the answer isn't a new process)

Questions We Asked

- ❓ Was the guideline being followed?
- ❓ Were we capturing the right patients?
- ❓ Were our admission criteria still appropriate?
- ❓ Was this a compliance issue or a guideline issue?



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Building on what works..

Rather than creating an entirely new process, our goal is to build on the strong foundation already established by our GTS program and expand optimization efforts beyond admission through the intraoperative and postoperative phases, where we identified the greatest opportunity for improvement.

- Reevaluat… assessme…
- Expand c… broader g…
- Refine ap… hemodyna…
- Explore th… clinically i…

- Enhance c… nursing tea…
- Explore develop… for high-risk geriatric trauma patients
- Improve escalation pathways for postoperative clinical changes and critical results

- documentation tools
- Align workflows and documentation with existing Epic functionality

Key Takeaways

- One of our biggest takeaways was the importance of **not** stopping at the data.
- While TQIP helped us identify the opportunity, the real value came from drilling down into the underlying causes.
- Through our review, we discovered that there wasn't a single root cause, but rather several contributing factors that collectively increased the risk of unplanned ICU admission.
- Identifying those factors allowed us to develop targeted interventions focused on the areas most likely to improve patient outcomes.

✅ TQIP identified the opportunity.
✅ Detailed case review revealed the "why."
✅ Multiple contributing factors were identified.
✅ Understanding the root causes guided targeted interventions.
✅ Data alone doesn't drive improvement—action does.

Best Practice Tip #1

Don't Chase Every Red Box

"Trying to fix everything usually results in fixing nothing."

Many trauma centers receive a report and immediately focus on every outcome outside expected performance.

What we've learned:

- ✅ Focus on high-impact opportunities
- ✅ Look for recurring trends
- ✅ Consider volume and clinical significance
- ✅ Prioritize projects aligned with organizational goals

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Best Practice Tip #2

Validate the Data Before Building the Project

Questions:

- ❓ Are registry abstractions accurate?
- ❓ Is documentation affecting outcomes?
- ❓ Are there coding inconsistencies?
- ❓ Is the sample size meaningful?

Lesson Learned from past data drilldowns:

"The first root cause analysis should be on the data itself."

Best Practice Tip #3

Stop Owning the Entire Problem Yourself!

When a TQIP opportunity is identified, the trauma program often becomes responsible for:

- ✅ Identifying the issue
- ✅ Investigating cases
- ✅ Gathering data
- ✅ Educating staff
- ✅ Facilitating improvement initiatives
- ✅ Monitoring outcomes

The result?

The trauma program becomes the owner of problems it can't solve alone

Best Practice Tip #4

Make PI **Multidisciplinary** from the Beginning

Successful PI efforts require shared ownership across the trauma program and key stakeholders

Include:

✅Trauma Medical Director
✅Trauma surgeons
✅Physician Liaisons
✅Nursing leadership
✅Registry staff
✅Quality department
✅Your favorite Starbucks barista

Remember this phrase…

"The trauma program owns the process, but not every solution."

Bringing it All Together

(The Journey from Data to Action)

Performance Improvement begins when you ask why

Meaningful change happens when you turn those answers into action

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Questions?

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