Kootenay Boundary Division of Family Practice
A GPSC initiative

Interior Health
Every person matters

PMH/PCH QI Framework - Draft

November 17, 2016

What is Quality Improvement (QI)?

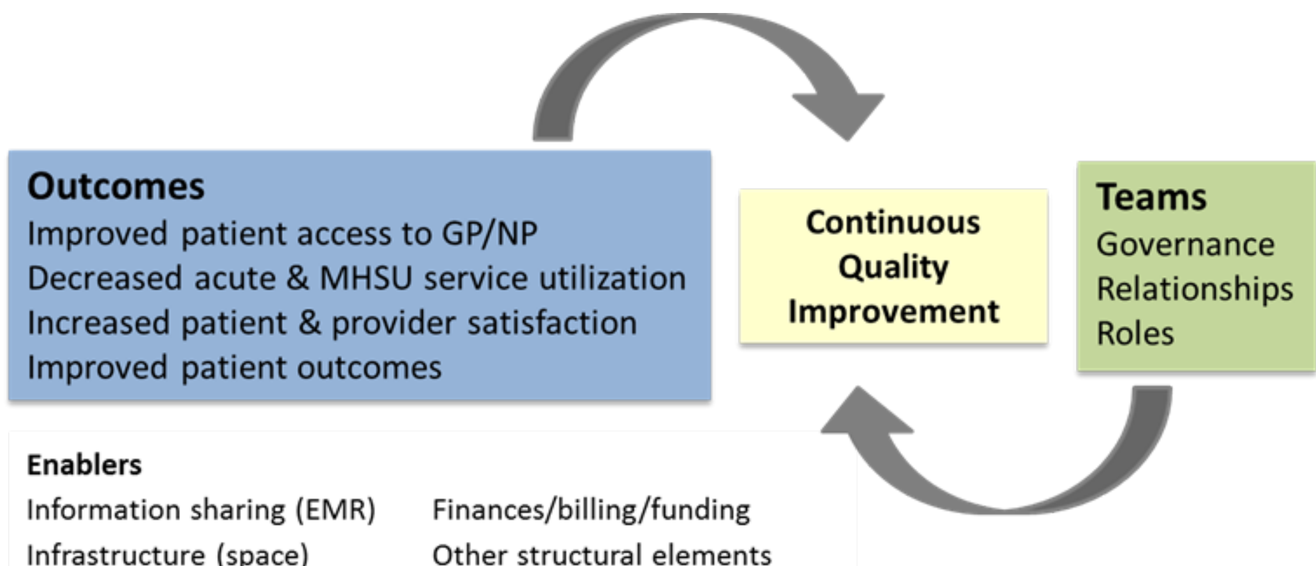
Quality improvement (QI) is a systematic process to use data and teamwork to identify and implement change and improve organizational quality. In simple terms, it's about trying to figure out where your organization is and make things better. In a clinic setting, it's about identifying clinical practices or processes that could be changed to improve patient outcomes, reduce system costs, and/or increase provider and patient satisfaction.

Why do QI?

Will changing your practices to incorporate more team-based care and increase same-day access in your practice reduce the number of CTAS 4 and 5 visits at your local ED, thereby reducing system costs, and at the same time increasing your satisfaction as a provider? Does having a social worker in your practice reduce your workload while at the same time reducing the ALC rate and improving patient satisfaction? QI aims to use data to answer these questions, so you know that your efforts are helping you to achieve the results that you want. Primary care is starting to undergo changes. QI is key to ensuring those changes are improvements. QI is one of the GPSC's twelve attributes of a Patient Medical Home (PMH), and is critical to ensuring that the PMH iniative is a success.

QI and Patient Medical Homes

For Patient Medical Homes in the Boundary to achieve desired outcomes, they must be successful in two key areas: 1) establishing appropriate governance structures, roles and relationships and 2) achieving clinical outcomes. Continuous quality improvement as PMHs are implemented will be essential to ensuring success in both of these areas.



What will QI look like in the Boundary?

QI in PMHs in the Boundary must be driven by grass roots decision making by local teams. Each PMH team will be invited to choose their own areas of focus for QI from a wide range of potential indicators relating to access to care, quality of care, team relationships and patient and provider satisfaction. In addition, there will be desired Boundary-wide outcomes that will be determined by consensus by a Boundary change design working group made up of representatives from IH, the Division, and all Boundary clinics. These Boundary-wide outcomes will include targets such as a desired reduction in ED CTAS 4 and 5 visits or the number of MHSU clients and visits. Once these Boundary-wide outcomes have been set, Boundary clinics will be asked to work toward them via clinic-specific QI activities. However not all clinic-specific QI activities need to be directed toward achieving the Boundary-wide outcomes. Different clinic teams may decide on different areas of QI focus that reflect their own team needs and goals.

To engage in QI, Boundary clinicians will need to commit time (suggested minimum 4 hours/month) to engage in QI activities including:

- considering Boundary GSA-level data that tracks progress with regard to the desired Boundary-wide outcomes, such as ED visits and hospitalization rates;
- selecting a few indicators of clinical success important to your clinic and drawing data from your own EMR to measure them;
- participating in Division or PSP-supported clinic assessments to measure indicators identified as important by your team, including team functioning, patient satisfaction or provider burnout; and
- developing improvement strategies with your team based on the results of the above activities.

A range of supports will be provided to PMHs to undertake QI, including some sessional assistance for training and planning, quarterly GSA-level data, tools such as surveys and EMR queries, implementation support for desired assessments, information sharing agreements allowing you to share patient information with everyone on your team, assistance with data analysis and coaching with regard to identifying and undertaking strategies for improvement. These supports will enable clinics to undertake this work in a safe and coached way. Clinics will determine their areas of focus for improvement and the level of support that they require.

Although GSA-level utilization data, the Boundary-wide outcomes, and some regional QI meetings may be part of the process, much of your QI effort will internal to your clinic. You will decide the amount of time you wish to devote to QI, what indicators you wish to measure, what improvements you want to make, and what, if any, data you wish to share.

Ten Essentials for Successful PMH QI

1. A QI plan
2. A commitment to a QI culture
3. A QI leader or champion
4. A team approach
5. Protected time for team members to do QI
6. A clean EMR panel
7. Input from patients, family members and caregivers
8. Agreed-upon QI indicators/measures of success
9. Tools to gather data
10. A realistic timeline

QI 101 - What is essential to successful QI?

There are ten essentials to successful QI at the PMH level. These include:

1. A QI Plan

The plan does not have to be detailed, but it must spell out your QI goals and who is doing what, when, and how (e.g. who is collecting and analyzing data for which indicators, how often does the team have QI meetings, does the team have daily huddles, or monthly data dinners). It could also contain a proposed initial set of QI indicators and an approach for ensuring everyone who should be included is included in QI.

➔ ***How we can help:*** Plan templates will be provided, and a QI coordinator will be available to review plans and provide tips.

2. A QI Culture

Continuous QI can be challenging and requires establishing somewhat of a QI culture and understanding how change works. When trying to change complex systems, some changes will result in improvements, but others might result in negative unintended consequences. Some changes will result in improvements in one area of the system, but negative impacts in other areas. Change can also be uncomfortable and may give some team members the impression that they have been doing it "wrong", but no improvements are possible without change. It takes practice to become more effective in using QI processes and shift attention from "what is" to "what can be" or what the team wants to achieve. Understanding these challenges, being committed to the process, celebrating wins, taking time to reflect on how work is done, establishing a blame-free culture, and sticking with it are all critical to the success of QI.

➔ ***How we can help:*** PSP will be offering sessional supported small group learning sessions regarding QI. These will help you to understand the philosophy of QI and the importance of QI culture. Coaching from PSP and Division staff will be available on an ongoing basis.

3. A QI Leader or Champion

The QI leader (or leaders) must be engaged and interested, with enough time to ensure that barriers are overcome and the QI process stays on track. The QI leader can be anyone on the team, and the role can be rotated through team members. The QI leader does not have to do all of the QI work in terms of selecting indicators, collecting data, and calling meetings—some of these tasks can be delegated to team members and PSP and Division support people—but the leader must be able to remind everyone why QI is important, explain how indicators will be utilized to improve practice, and bring the team along in the QI journey.

➔ ***How we can help:*** Coaching from PSP and Division staff will be available on an ongoing basis for PMH QI leaders. In addition, tools and analysis support will be available from PSP and a Division QI coordinator.

4. Team Approach

The work of change and improvement is best accomplished when everyone involved in doing the work is involved in assessing and changing the work, because they know the work the best. Building an effective team is critical to the success of a PMH and empowering all PMH team members and ensuring that everyone's voice is heard and valued is essential to effective QI. Implementing changes without allowing everyone to have input often does not result in improvement because some key piece of data was missed or buy-in from the team is low. Including all team members in QI can be done in a variety of ways, such as monthly staff meetings, morning huddles to review the day ahead, or data dinners. Being connected on a personal level also matters and taking the time to check in and see what is happening in each other's lives as well as in the practice is critical to an effectively functioning team.

➔ ***How we can help:*** Coaching from PSP and Division staff will be available on an ongoing basis for teams. Team assessments can be undertaken by PSP or Division staff to help identify areas of team functioning that teams need to work on.

5. Protected Time for Team Members to do QI

Doing QI will take some time. Everyone in the clinic will have to participate in some assessments, such as analyses of team functioning. They will also have to participate in team discussions with regard to the selection of indicators, the data collected, and the improvements to be made. Some team members may

have to assist in the collection of data or the implementation of changes. It does not have to be a lot of time, and it is important that QI not take away from clinical practice—but it is important to remember that successful QI can dramatically increase clinical efficiency, improve clinical outcomes, and create more time for everyone. Two-hour monthly staff meetings, or five-minute morning huddles may be enough time to consider the data. Data collection could require an hour a month running EMR queries. The QI leader may require an hour or two a week to do their work. QI may take a bit more time in the beginning to understand and establish processes, but eventually it should become a seamless and enjoyable part of the practice.

> ➔ ***How we can help:*** PSP and Division staff will be available to analyze data, suggest tools and indicators, and in the beginning facilitate meetings. Some sessional support will be available to physicians to support their time investment at the outset of the process.

6. A Clean EMR Panel

Much of the data for QI will be drawn from your own EMR. As such, it is important that the data in your EMR is as clean as possible. This means that you and your colleagues must be coding diseases, reasons for visits, and treatments in a consistent manner, such that if you want to do a query to determine, for example, how many patients you have with diabetes and who they are, or how many women over the age of 50 have had a mammogram, you can. It also means having someone in your office who knows how to work with your EMR, by for example, flagging patients who are no longer with the practice, analyzing query results to ensure the data reflects what is expected. Having a clean EMR panel will benefit you in your clinical practice in multiple ways. It will help you understand what your panel looks like, the specific challenges you might face in serving your panel, and how to better provide care for your patients.

> ➔ ***How we can help:*** PSP, GP and MOA champions will be available to your clinics to facilitate panel assessments and cleaning. Sessional support will be available for some of this work, as will MOA supports.

7. Input from Patients, Families and Caregivers

Patients, families and caregivers are an essential part of the PMH team and their opinions and experiences are essential data that can help you improve your processes and clinical outcomes. In a patient-centred PMH, their voice matters. Getting input from patients, families and caregivers can happen via patient surveys, patient focus groups, interviews with patients or a patient voice member on your QI team. Input from patients, families and caregivers does not have to happen every month or be too onerous, but it should be considered as part of your QI process.

> ➔ ***How we can help:*** There are many patient surveys you can utilize—PSP is piloting one and the Division has developed one as well. PSP and Division staff will be available to help implement and analyze results from patient surveys. They may also be able to facilitate patient focus groups or undertake patient interviews depending on what approach you think is best for gathering input.

8. Agreed Upon QI Indicators/Measures of Success

What are you going to measure to determine how you are doing and what changes you might need to make? Indicators are quantitative or qualitative measures, such as number of CTAS 4 and 5 visits at the ED per year, or number of patients over 70 in your practice who have had a FIT colon cancer screening, that help tell you how you are doing. They can be divided into many categories, such as access and attachment, utilization rates, quality of care, patient outcomes, patient satisfaction, provider satisfaction and team functioning. Please see Appendix A for a list of sample indicators.

As part of the Boundary change design process, a change design working group will determine Boundary-wide outcomes, such as a reductions in CTAS 4 and 5 ED visits, hospitalizations of clients 75+, or MHSU

clients and visits. Utilization data measuring progress towards these outcomes will be provided to you quarterly for your consideration. Your main job with respect to the Boundary-wide outcomes will be to consider the utilization data and identify ways your clinic can contribute to achieving the outcomes.
At an individual PMH level, it will be important to pick only a few indicators. At least some of these indicators should reflect the Boundary-wide outcomes (e.g. if we increase same-day access, we could help decrease CTAS 4 and 5 ED visits, so third next available appointment is an important indicator for our clinic), but some should also focus on clinic-specific goals (e.g. we have a lot of chronic pain patients in our practice, how can we help them reduce their dependence on medication and improve their quality of life). Often indicators that reflect clinic-specific goals will also contribute to achieving the Boundary-wide outcomes, but not always in as direct a manner. You may focus on certain indicators, such as screening rates for specific diseases, only for a few months until you have changed your processes. Other indicators, such as third next available appointment, may be important to check in on for many years.

> ➔ ***How we can help:*** The change design working group will collaboratively determine the Boundary-wide desired outcomes. For clinic-specific outcomes, an appendix of sample indicators is provided as a start. Assistance from PSP and a Division QI coordinator in selecting indicators and determining how to measure them is available. If there is something you want to measure that isn't on the list, the Division QI coordinator can help you find the right indicator.

9. Tools to Gather Data

Depending on the indicators you choose, you will need tools to gather data, such as EMR queries, team assessments, or patient satisfaction surveys. Some of these tools have already been developed. Others will be developed on an as need basis as Boundary clinics identify what they want to focus on. You may also wish to develop your own tools based on specific indicators you wish to measure.

> ➔ ***How we can help:*** PSP and a Division QI coordinator will work to develop the tools that you need as you need them.

10. A Realistic Timeline

Continuous QI is critical to PMH implementation. It will be helpful in establishing appropriate governance structures and roles, building relationships within the PMH team, and achieving desired clinical outcomes. But is is important to be realistic about timelines. Changing practice takes time. It is not reasonable to expect team members to stop behaviours that they believe serve patients well or add value and start performing a completely new set of behaviours. Everyone needs time and support to change. Start small, keep reassessing, be patient and flexible, abandon the notion of perfection and keep focusing on improvement.

What's Next?

The next phase of the process is the change design phase. Representatives from your clinic will be asked to participate in a change design working group to determine desired Boundary-wide outcomes and how the Boundary PMH proof-of-concept project will unfold. How practices will undertake QI will be a key part of that discussion. In the meantime, panel assessments to clean up your EMR and PSP small group learning sessions will be starting in the Boundary. Taking advantage of those opportunities will greatly assist you in being able to undertake robust QI, team building and achieve desired clinical outcomes during implementation.

QI in Practice

November 17, 2016

What might QI look like in a busy practice? Read this and find out.

The Team

As part of the Boundary PMH proof-of-concept funding, the Green Forks clinic, owned by Dr. John Green and staffed by Sandra, his MOA, will now include Ryan, a nurse who works in the practice three days a week, and Marie, a nurse practitioner who will be available to the practice twice a week.

Initial Preparations

During the PMH design phase, Dr. Green took advantage of the PSP panel assessment process and he and Sandra worked to ensure that his panel is as clean as possible. They were also able to determine the number of high risk and complex chronic disease patients Dr. Green has on his panel. He knows that he has a large number of patients with mental health issues and chronic pain relative to practitioners in the KB region. The team was introduced to each other during the PMH design process and had some preliminary discussions regarding scope of practice. They also set some agreements regarding roles and responsibilities. A critical agreement was the ability to share an EMR. Dr. Green took the opportunity to review his coding protocols for the EMR with the entire team to ensure that everyone is coding as consistently as possible.

The First Team QI Meeting

At their first team QI meeting, after doing an exercise to get to know each other better and checking in on how everyone is doing on a personal level, the team decides that Ryan will spearhead QI for the practice as he's very interested in QI and has a bit more time to devote to it than Dr. Green.

Considering Boundary-wide indicators

They also consider the GSA-level data for the Boundary region and realize that CTAS 4 and 5 visits to the ED are very high in the Boundary region. They know that reducing CTAS 4 and 5 visits to the ED is a desired outcome for the Boundary PMH proof-of-concept funding. Sandra points out that it often takes patients two weeks to get an appointment with Dr. Green. They decide that tracking the third next available appointment would be a useful indicator, and discuss ways to ensure they can offer same day appointments. They agree that Sandra should start asking patients to indicate their main concern when booking appointments and, with the patients' permission, start triaging some appropriate appointments to Ryan, the nurse, and Marie, the nurse practitioner. They also give Sandra permission to tell patients who have symptoms of a cold that they might not need an appointment. Dr. Green will also start doing warm hand-offs of patients to Ryan and Marie to help the patient population get to know the new members of the team better and develop a sense of trust in their abilities. They also decide to allow patients to present more than one issue per visit.

Determining PMH-specific goals

Ryan asks the team what other types of indicators might be important to them based on where they want to be in a year's time. Dr. Green indicates that he wants to concentrate on his chronic pain patients, and implementing the new narcotic guidelines and ensuring that all of their patient screenings for diseases such as breast and colon cancer are up-to-date. Marie indicates that she's interested in focusing on polypharmacy and ensuring that they gel as a team, while Sandra wants to concentrate on patient satisfaction because she's the one who hears from patients when they aren't happy. Dr. Green adds that he'd really like to be able to go for a run at lunch at least twice a week.

Deciding on the QI process

Before they conclude the first meeting, they agree to meet again in two weeks to discuss some proposed indicators based on their interests. They agree that they will meet every two weeks for the first few months,

and then shift to monthly meetings once they feel that they have a team established. They decide to meet on Fridays at lunch when both Ryan and Marie are in the office.

Initial Data Analysis

With some coaching from PSP, Ryan does some initial analysis on the practice EMR. He discovers that 27% of chronic pain patients' narcotic use still exceeds the guidelines, and only 60% of patients over 65 have had a FIT colon cancer screening. He talks to Marie in passing and discovers that she has a lot of experience with chronic pain agreements. He checks in with the PSP and Division QI coordinators and accesses a plan template, a patient satisfaction survey, and a team assessment. Meanwhile, the plan to increase same day appointments is going well in some ways—some patients are happy to see Marie and Ryan, but Sandra isn't feeling a hundred percent sure that she knows what she's doing when she tells patients with a cold that they do not need to see a practitioner, and Dr. Green is finding that when he goes to do the warm hand-offs to Marie and Ryan, they are sometimes already seeing other patients. Ryan offers some encouraging words and encourages them to stick with their efforts even though it is sometimes hard.

Second Team Meeting

At the second team meeting, the team does their usual check-in and talks about Marie's three-year-old son and Dr. Green's ailing mother. Ryan presents his proposed plan and indicators for the team. He suggests doing an initial team functioning assessment, burnout assessment, and patient satisfaction survey to get baseline data and identify potential improvement goals, and so that they can do them again in the future and determine whether there has been any improvement and identify areas of further work. He indicates that the patient survey and team assessment will be largely implemented by the Division QI coordinator and the results will be made available to everyone on the team. The team agrees that this is a great idea. Ryan also suggests focusing on chronic pain patients for the first two months and invites Marie to talk about her expertise in chronic pain agreements. Sandra agrees to spend some time recalling all the chronic pain patients on Dr. Green's panel. Dr. Green will offer them a taper of their narcotics or naloxone and refer them to Marie to talk about their agreements. Marie and Dr. Green are happy to see that focusing on polypharmacy and disease screening are in the plan for months three and four. They also agree to set aside some training time for Sandra to talk to an MOA champion about triaging, and decide to do a morning huddle on the days that Ryan and Marie are in the office to talk quickly about the patients scheduled for the day to determine who Dr. Green might want to introduce to Ryan and Marie, to ensure that they are going to be available at that time. Ryan concludes the meeting by indicating that even though it has not gone perfectly, they've already shortened the time to the third next available appointment by a day and a half. The team has a quick celebratory chocolate and then goes back to work.

Ongoing QI

The team assessment shows that they need to work on understanding what each other can do, so they add that as an agenda item to their now monthly meetings. The morning huddles are going great, and they use the opportunity to quickly discuss and modify any new QI approaches that they are taking as well. The patient satisfaction survey indicated a high level of satisfaction overall, but that patients are sometimes confused about their prescription directions and that they'd really like the option of being able to get advice over the phone when they have a question. They decide to set aside one appointment slot per day for Dr. Green to provide phone advice and find that once they implement phone advice, the number of patients requesting same day appointments drops by 50 percent. Ryan has started tracking the stats for the "indicator of the month" on the whiteboard in the staff room where the group has their huddles. The polypharmacy recall is in full swing, and Dr. Green is thrilled that they've been able to reduce the number of seniors on five or more medications by 40 percent and believes it is reducing hospitalization rates within the practice. Even better, he's been able to get out for a run three times a week for the last four weeks.

Appendix A: PMH/PCH Indicator Examples – Draft

This table provides examples of indicators commonly utilized in doing QI in PMHs.

Indicators	Data Sources
PMH Services/ Implementation	
• Existence of patient registry that identifies patients with specific conditions	Practice Survey
• Existence of patient registry that identifies patients on specific medications	Practice Survey
• Use of registry to identify patients overdue for screening services	Practice Survey
• Use of registry to identify patients overdue for chronic disease services	Practice Survey
• Use of registry to identify patients out of target range for chronic disease laboratory values	Practice Survey
• Care management for patients at high risk of disease complications or hospitalization	Practice Survey
• Referral system for linking to community programs	Practice Survey
• Weekend care offered regularly	Practice Survey
• Evening care offered ≥2 nights per week	Practice Survey
• Phone and electronic communication with patients during and after office hours	Practice Survey
• Patient access to their own medical record	Practice Survey
Quality of Care/Preventative Service Delivery Rates	
• % of patients with specific conditions who have been prescribed particular drugs (e.g. asthma, antidepressants)	EMR
• % of patients with specific conditions who have been prescribed particular drugs and continue using those drugs appropriately	EMR
• % of patients who received annual monitoring for persistent medications (e.g. digoxin, diuretics, anticonvulsants)	EMR
• Polypharmacy rates	EMR
• % of patients with specific conditions (e.g. diabetes, COPD, Asthma, coronary conditions) who have received specific tests, examinations, health behaviour discussions, or follow-up visits within a specific time frame	EMR
o Diabetes (e.g. A1C testing, LDL-C testing, Nephropathy, eye exams, foot exams)	EMR
o Asthma (e.g. spirometry test, influenza vaccination)	EMR
• % of eligible patients who received mental health counselling	EMR
• % of eligible patients receiving disease screenings over a specific time frame (e.g. breast cancer, cervical cancer, prostate cancer, colorectal cancer)	EMR
• % of patients who report receiving self-management support	Patient Survey
• % of patients taking responsibility for their own health/confidence in self-care (level 1: starting to take a role but not confident enough to play an active role; level 2: building confidence and knowledge; level 3: taking action; level 4: maintaining behaviors)	Patient Survey
• % of patients with a calculated BMI in the past six months documented in the EMR and for those with a BMI outside of parameters a documented follow up plan	EMR
• % of patients age 18 and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months	EMR
• % of patients with a primary diagnosis of low back pain who did not have an imaging study (x-ray, MRI, CT scan) within 28 days of diagnosis	EMR
Patient Outcomes	
• % of patients with specific conditions with readings above/below certain levels	EMR
o % of hypertensive patients with a blood pressure <140/90	EMR
o % of patients with diabetes with HbA1C <7%, <8%, <9%	EMR
• % of patients with specific conditions reporting having symptoms under control	Patient Survey
o % of individuals with asthma using asthma inhaler <2 days per week	Patient Survey
• % of patients who have certain characteristics	EMR
o % of patients who smoke	EMR
o % of patients report being physically inactive	EMR

○ % of patients with a BMI <25	EMR
Patient and Provider Satisfaction	
• Provider personal and professional fulfillment and satisfaction	Provider Survey
• "Burnout" levels for GPs, NPs, health care providers and staff	Provider Survey
• Patient satisfaction (include timeliness of care, care coordination, collaboration with family)	Patient Survey
Access and Attachment	
• Patient wait times for specific treatments and procedures	EMR
• % of patients who report that they have a GP/NP	MOH
• % of patients who report being able to see GP/NP on same or next day	Patient Survey
• Availability of same day appointments/Third next available appointment	EMR
• Physician capacity/panel size	Provider Survey
Utilization Rates	
• Primary care utilization rate (apt rate for frequent users, # services/day in office)	EMR/MOH
• ED visits, all-cause	MOH/IH
• ED visits, ambulatory care-sensitive	MOH/IH
• ED visits, CTAS 4 and 5	MOH/IH
• ED visits, CTAS 2 and 3 in 75+ aged patients	MOH/IH
• Hospitalizations, all-cause	MOH/IH
• Hospitalizations, ambulatory care-sensitive	MOH/IH
• Hospitalizations, length of stay	MOH/IH
• Hospitalization of 75+ patients	MOH/IH
• ALC rate	MOH/IH
• 30-day hospital readmissions	MOH/IH
• MHSU client and service level days	MOH/IH
Cost	
• Costs per capita for unique diagnosis categories/multiple chronic diseases	MOH/IH
• Total costs of care	MOH/IH
• Proportion of cost for acute, residential, community health and primary care	MOH/IH
• Total member per month costs at a PMH level	MOH/IH
• Total member per month costs for high-risk patients at a PMH level	MOH/IH
Use of QI Feedback	
• Processes for gathering QI data on a PMH level	Practice Survey
• QI feedback from health authority to PMHs on a regular basis	Practice Survey
• Monthly or more frequent PMH meetings about QI feedback	Practice Survey
• Culture that supports improvement work	Provider Survey
Care for Marginalized Populations / Social Determinants of Health	
• Cost as a barrier to access	Patient survey
• Screening for Social Determinants of Health characteristics of patients (e.g. income level, education level, employment, ability to make ends meet at end of month)	Provider Survey
• Consideration of social determinants of health in clinical practice and care treatment plans	Provider Survey
PMH Team Collaboration and Effectiveness	
• PMH Team collaboration	Provider Survey
• Empowerment of individual PMH team members	Provider Survey
• Quality of communication and information sharing within the PMH team	Provider Survey
• Quality of PMH team relationship	Provider Survey
• Ability and willingness of PMH team members to provide coverage for each other	Provider Survey
• Patient visit patterns/patient flow	Patient Survey
• Patient experience of team care	Patient Survey