Quality Improvement in Family Practice: “El Camino se hace al andar”

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Faculty/Presenter Disclosure

• Faculty/Presenter: Rob Wedel

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Objectives:

• Discuss the conditions that contribute to successful improvement initiatives in our clinics, and our role as physicians in those initiatives
• Discuss Improvement techniques and supports that can be applied within our family practice clinic
• Discuss the elements of the PMH, and the role they can play in guiding Improvement activities in our clinics
• Describe practical examples of QI initiatives that have made a measurable difference in quality of care of a family practice clinic.
New approach to primary medical care
Nine-point plan for a family practice service

JOHN FORSTER, MD, CCFP
WALTER ROSSER, MD, CCFP
BRIAN HENNEN, MD, CCFP
RON MCAULEY, MD, CCFP
RUTH WILSON, MD, CCFP
MAGGIE GROGAN

Since its creation almost 20 years ago, our national health care medicare legislation: accessibility, universality, comprehensiveness, portability, and public administration? Is it effective and efficient? Is it affordable? Are the originally enunciated principles out of date? Do we need to add new ones?

This paper is about primary medical care: the level of care at which people initially come into contact with physicians and, in most cases, with the health care system. In a recent survey of Ontario residents, 98% of people claimed to have a family doctor. Family physicians have extensive training as generalists. They are often called upon to

New Approach to primary medical care: Nine Point Plan for family practice

1. Practice registration (patient enrollment)
2. A system of blended funding (salary, Capitation, incentives)
3. Primary care through interprofessional teams
4. A balance between preventative, curative, and palliative services
5. Central health records
6. Computerized databases
7. Use of health targets
8. Local authority with fiscal responsibility for coordinating care
9. A managed system

Forster et al, “New Approach to Primary Medical Care”, Canadian Family Physician, Sept 1994
http://www.researchgate.net/publication/15279277
Framework for Surveillance of Chronic Disease

A. Identify Patient Population
B. Multidimensional Assessment
C. Systematic, proactive Monitoring
D. Consistent assessment tools
E. Patient Education in Self and Family Care
F. Integration of Evidence based care/practice guidelines
G. Coordination of care
H. Rapid Response in Crisis

Dr. Ed Wagner. Chronic Care Model. 1985
“New Script, same old Play?”

- Saskatchewan Commission on Medicare. Caring for Medicare, Sustaining a Quality System (Fyke, Saskatoon: 2001)
- Quebec Study Commission on Health Services and Social Services. Emerging Solutions, Report and Recommendations (Quebec: 2000)
- Health Services Review Committee. Fredericton: 1999

Jeffery Simpson, Globe and Mail editorial, Jan 8, 2004

“New script, same old play? Reform primary health care.
(pick a model, any model)”
“New Script, same old Play?”

- Standing Senate Committee on Social Affairs, Science and Technology. Kirby, Ottawa: 2003
- Saskatchewan Commission on Medicare. Fyke, Saskatoon: 2001
- Quebec Study Commission on Health Services and Social Services. 2000
- Health Services Review Committee. Fredericton: 1999


- Office of the Auditor General of Alberta 2012
- CFPC. A Vision for Family Practice. The Patients Medical Home. 2011
- PCN Evolution. VISION AND FRAMEWORK. Report to the Minister of Health. AMA Primary Care Alliance Board. 2013
“The Evidentiary Vacuum”

“Discussions of innovations in primary care invariably take place in an **evidentiary vacuum.** Strong evidence is lacking to support the superiority of any one model...”

Hutchison B et al. Primary care in Canada: so much innovation, so little change. *Health Affairs* 2001

Evidence from recent Canadian experience is that primary health care can be transformed through a process that is **voluntary and incremental.** This emerging vision (Patients Medical Home) offers opportunities to those ready to embrace innovation without imposing changes on the remainder.

Hutchison B et al. Primary Care in Canada: Systems in Motion. *The Milbank Quarterly.* 2011
The Science of Improvement

The Evidentiary Vacuum...?

- **The RCT** - The ‘gold standard’ of Best Evidence in clinical practice
- **Quality Assurance** - The establishment of Best Standards in care
- **Quality Improvement** - A focus on the Best Quality of care

- A ‘new’ science...
  - Interventions (process, idea) made within a unique social context (clinics, teams, systems) to produce the multidimensional changes required for improvement
    - Implementation of guideline based medicine – CPGs
    - Processes of care - timely access, efficiency, patient safety
    - Integration of care - teams/systems that work

- Multiple models – LEAN, Six Sigma, etc – alone or combined (AlbertaAIM) - all intended to provide us easier and better ways of getting improvement faster.

Donald Berwick. The Science of Improvement. JAMA. 2008
The Science of Improvement

- **AIM**
  - SMART-Specific, Measurable, Achievable, Realistic, Timely

- **TEAM**
  - “The people that do the work have to change the work”

- **MAP**
  - Access (TNA), Continuity/Panel, Quality of Care

- **CHANGE**
  - PDSAs

- **SUSTAIN**

Donald Berwick. The Science of Improvement. JAMA. 2008
The Science of Improvement: Quality Improvement is not Quality Assurance

Quality Improvement
- Proactive
- Focuses on all aspects of care
- Improves processes to improve outcomes
  - Focuses on system performance; non-judgmental culture; developing best practices

Quality Assurance
- Reactive
- Focuses on defects and activities below target
- Accreditation = pass/fail of minimum standard
No one wants to talk M%@#$~#*$!*^&

(Measurement)

Measurement is about improving patient experience and outcomes by changing and refining the health care system rather than judging it.

– At the clinic level, measurement is about identifying problems, and recognizing opportunities for improvement.
– At the PCN level, aggregated data can inform the sharing of successful improvement strategies across clinics within the network.
– At the provincial level, aggregate data monitors the performance of the health system and ensures transparency and accountability to Albertans.

• Multiple supports available to us in our province.
  – PCNs, PMO, HQCA, AIM, etc

*Primary Care News*. PCN PMO. Dec 2015
The Concern...

- While once Canada was seen in middle of the pack in primary care (Starfield 2002), other countries of similar wealth and health systems have advanced and left us behind.
  - 2015 Commonwealth Fund Survey

“Canada seems to have stalled in its commitment to strengthening primary care...In this regard, Canada is probably at least 10 years behind.”

Barbara Starfield, 2008
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<td>Dimension of Care</td>
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<td>Timeliness of Care</td>
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<td>Cost as a barrier to health care access</td>
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<td>Coordination of care</td>
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<td>With specialists and hospitals</td>
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<td>Between primary care visits</td>
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<td>With home care and social services</td>
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<td>IT adoption</td>
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<td>Computerized care decision support</td>
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<td>Electronic communication with patients</td>
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<td>Performance Measurement</td>
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<td>Measuring patient outcomes and experience</td>
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<td>Monitoring preventive care</td>
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How Canada Compares

• **Timely access** remains the lowest of the OECD countries.
• **ER visits** per capita are the highest of any other country.
• **Coordination of care** between primary care doctors and other home care and social services is lower.
• **Use of EMRs** to support decisions of care is not standard practice in Canada.
  – To assess/measure performance, and to track progress (17% versus 37%).
  – To routinely review surveys on patient satisfaction and experiences (17% versus 47%)
• However, Canadian physicians working in primary care models (PCNs, FHNs, FHTs) had better overall results than their Canadian peers.

How Canada Compares: Results from the 2015 Commonwealth Fund Survey. CIHR. CIHI. Jan 2016
How do the provinces compare?

Most provinces are below the international average in use of performance measurement.

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<td>Review clinical performance annually</td>
<td>45%</td>
<td>29%</td>
<td>42%</td>
<td>43%</td>
<td>65%</td>
<td>13%</td>
<td>38%</td>
<td>38%</td>
<td>33%</td>
<td>41%</td>
<td>52%</td>
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<td>Routinely receive information on how practice compares with other practices</td>
<td>24%</td>
<td>8%</td>
<td>15%</td>
<td>20%</td>
<td>31%</td>
<td>1%</td>
<td>8%</td>
<td>17%</td>
<td>6%</td>
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Quality Improvement in “small office settings”

• Benefits identified-
  – More appropriate, effective patient care
  – Greater practice efficiency and safety
  – Improved timeliness of care
  – Improved patient outcomes
  – Improved revenue
  – Clinic staff and patient satisfaction/retention
  – Improved practice reputation with patients and community

Quality Improvement in “small office settings”

• **Internal Facilitators**
  
  – Intrinsic professional motivation to provide better care
    
  – An “Physician champion” – an Idea and Improvement champion
  
  – “teamness’ of the practice
    
  – A sense of empowerment within the team
  
  – “Success breeds success- QI gains momentum with each new effort”

The “Physician Champion”

• The physician champion:
  – is committed to improving care they provide to their patients
  – willing to change personally in order to do so
  – Actively supports the team, through encouragement, empowerment to suggest and make improvements, visibility, participation
  – Is a respected physician, a strong listener and negotiator, able and willing to take initiative as needed.
  – has the networks necessary to identify experts and consultants with experience in QI to help facilitate the changes.
  – acts as a liaison between their practice and the health care system
Quality Improvement in “small office settings”

• Internal Facilitators
  – Intrinsic professional motivation to provide better care
  – “teamness” of the practice
    • collective values and shared vision
    • office culture that values and supports improvement work
    • generates a sense of empowerment within the team
    • clear delineation of shared responsibilities
    • routine interaction between doctors and staff.
  • Cooperation/commitment of physicians and other clinical/support staff

Outcomes: Access (Time to Next Available Appt.)
Patient Label

Doctor_____________

Date_____________

Risk Factors:_________________________Target BP:_____

**HTN Pathway: Not Yet Diagnosed**

Elevated BP: [ ]

Follow up appt with LPN/ RN (one week) Date: __________

**NURSE VISIT ONE: BP** [ ]

* If BP >180/110 notify physician for possible diagnosis of HTN

☐ Order lab work

☐ Initiate lifestyle teaching

☐ Complete cardio view data sheet

Follow up appt with nurse (one week) Date: __________

**NURSE VISIT TWO: BP** [ ]

*If BP> 160/100 notify physician for possible diagnosis of HTN

☐ Consider initiating 24hr BP or home monitoring

☐ Review cardio view results and overall risk factors

☐ Review lab results

☐ Reinforce lifestyle modifications

☐ Offer BHL classes for risk factors

Follow up appt with nurse (one week) Date: __________

**NURSE VISIT THREE: BP** [ ]

*If pt has target organ damage and BP >140/100 notify physician for diagnosis or
if pt has no target organ damage and BP >160/100 notify physician for diagnosis of HTN

☐ Refer to physician for diagnosis of HTN (one week)

☐ Complete an ECG

**Positive Diagnosis:** Initiate HTN pathway

**NOTE:**

At least two BP should be done.

If BP <140/90 and no target organ damage then review BP yearly

24hr BP monitoring may be done at any time per physician request
Quality Improvement in “small office settings”

- External Facilitators
  - Available external resources, like Learning Collaboratives, facilitators
  - Committed internal resources, including the staff time needed to engineer new office practices
  - Decision support, including systems to initiate performance assessment and track progress
  - Support from national and provincial professional organizations

Quality Improvement in “small office settings”

• Barriers
  – Time constraints
  – Internal cost (staff time, equipment)
  – Resistance of clinical staff
  – External pressure
    • loss of autonomy
    • increasing responsibility with heightened expectations from patients, payers, insurers, and regulators.
    • changing remuneration arrangements

Time Constraints

• Most physicians report overall career satisfaction, but perceive themselves on a treadmill, with increased expectations and erosion of autonomy.

– Suggested Strategies to ease practice burdens and empower physicians include
  • increased use and enhanced scope of non-physician clinicians,
  • adoption of IT and disease management programs to safety and effectiveness
  • thoughtful practice design to improve efficiency and quality.

Resistance and Cooperation of physicians and other clinical staff

Taber - Phase 1 Clinic with AVG TTTN data by quarter for 10 physicians

2005 to end of 2008
What we Know Works...

“The Medical Home”

• The greater the range of services provided by primary care clinic, along with a family physician providing a **continuous care relationship to a defined patient population** had one third lower overall costs and were 19% less likely to die.

• “Attachment to a practice” was more significant than all other variables, such as age.

• For most aspects of care and health outcomes, identification of a **particular practitioner** provides even better services than mere identification of a **particular place**.


The Patients Medical Home

Patients receive care that is centered on their needs from a team that knows their story

http://www.patientsmedicalhome.ca
The Patients Medical Home

Patients receive care that is centered on their needs from a team that knows their story

Clinical Supports provided by the Medical Home
- Timely Access to care and information
- Continuity to personal family doctor
- Comprehensive, Coordinated care
- Team based Care
The Patients Medical Home
Patients receive care that is centered on their needs from a team that knows their story

System Supports for the Medical Home
- Provincial Support Programs
- Supportive Payment Structures
- Integrated Information Systems/Evaluation
- Workforce Development
Patient Centered Medical Home: Impact on Cost and Quality

Aggregated outcomes from 28 Peer reviewed articles and government program evaluations

Statistically significant improvements in:
- Satisfaction
- Access
- Quality
- Cost
- Utilization
What do we know works in Canada...

Practices that provide the best, most effective care...

- Enhance **capacity** through effective patient flow processes, focusing on eliminating delays for appointments and at appointments.

- have a sound knowledge of **patient population**, and of their **community resources**. (Four Principles of Family Medicine)

- Have **pre-planned and prepared for patient encounters**, using protocols and guidelines to support collaborative **team-based care**, whether co-located or not

- Have a strong emphasis on **self management**

- Use and share sophisticated **electronic medical records** that include clinical decision support, prompts, registries, communication tools for other providers, etc

- **Use continuous measurement and evaluation** to inform change

What do our patients value?

• The single most important issue for Canadians is poor access to health services. (p>0.01)
  – Access to primary care (for appts)
  – Timeliness at the appointment
  – Respect and empathy
  – Time available in the consultation
  – Medication and Treatment costs

• Delay in seeing a doctor and getting treatment is the longest among the seven developed countries. (2015 Commonwealth Fund Survey)

• Physicians prioritize:
  – ER visits
  – Self efficacy
  – Multidisciplinary teams
  – Collaboration between healthcare organizations
  – Self care support
  – Technical quality of Chronic disease management
  – Physical activity counselling

Patients Medical Home - Links to Resources:

- **CFPC ‘Best Advice’:** [www.patientsmedicalhome.ca](http://www.patientsmedicalhome.ca)
- **Compilation of Resource Tools:**
  - [http://www.topalbertadoctors.org/file/pmh-implementation-field-kit.docx](http://www.topalbertadoctors.org/file/pmh-implementation-field-kit.docx)
- **Compilation of PMH Evidence:**
- **Advanced Access, Measurement Tools:**
  - [www.albertaaim.ca/index.php/resources](http://www.albertaaim.ca/index.php/resources)
  - [http://www.topalbertadoctors.org/file/pmh-implementation-field-kit.docx](http://www.topalbertadoctors.org/file/pmh-implementation-field-kit.docx)
  - [https://www.youtube.com/watch?v=cqGsHB3vvj0&feature=youtu.be](https://www.youtube.com/watch?v=cqGsHB3vvj0&feature=youtu.be)
- **McMaster U: Quality Book of Tools. 2010**
Take the leap... we will build our wings on the way down.

Donald Berwick

“El Camino Se hace al andar”

“wanderer, there is no path, the path is made by walking.”

Antonio Machoda 1939