A Strong Foundation for Change

- QI Capacity
- Engaged Leadership
- Empaneled Population
- Person and Family Centered Care and Approaches
- Care Coordination

Framework for Quality Improvement

The Model for Improvement
Requirements for Successful Improvement Effort

- Will
- Ideas
- Execution

Principles of Improvement
1. Knowing why you need to improve and what you want to accomplish
2. Having a feedback mechanism to tell you if the improvement is happening
3. Developing an effective change that will result in improvement
4. Testing a change before attempting to implement, and
5. Knowing when and how to make the change permanent (implement the change).

What are we trying to accomplish?
- System to be improved
- Subpopulation of clients
- Timeframe
  - Focus on issues that matter to the organization and issues that might have been recognized as needing improvement in the any assessments done in the Prework period.

Why is it important to do this?
- Why is this important to the organization? (mesh with strategic plan, goals, business plan, etc.)
- Do you have data/analysis to support the choice of this work?

What does the team want to accomplish?
- Anticipated outcomes
- Goals you hope to attain
Example: Aim Statement

In one year the Wannabethebest Health Center will develop a sustainable model for integrated care that will result in patients being treated holistically, improved clinical outcomes, better access to care, improved support for complex patients, and reduced burnout for staff.

- Dr. High Achiever’s panel of around 1,800 patients at the Wannabethebest Health Center will be the initial population of focus, and we will develop a sustainable model for integrated care so that this system can be integrated into all care teams at the health center within one year.
- Integrated care is important for our organization and the community to align us with our organizational mission, which is to raise the physical, mental, social and spiritual health of the population we serve to the highest level in partnership with the community.
- By serving patients holistically patients will be better advocates for themselves and take control of their health.

Review of Goals

Goals should be specific achievement of outcomes

The following goals were specific and not small:

- Demonstrate a 20% reduction in the cost of care for patients with Diabetes engaged in behavioral health
- Increase of 30% for behavioral health access for abnormal PHQs
- 50% decrease in wait lists in the clinics
- 95% patients screened with PHQ
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

### Three Different Purposes for Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim:</strong></td>
<td>Improvement of care</td>
<td>Comparison, choice, reassurance</td>
<td>New knowledge</td>
</tr>
<tr>
<td><strong>Methods:</strong></td>
<td>Test observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
</tr>
<tr>
<td><strong>Bias:</strong></td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td><strong>Sample Size:</strong></td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td><strong>Flexibility of Hypothesis:</strong></td>
<td>Hypothesis flexible, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis</td>
</tr>
<tr>
<td><strong>Testing Strategy:</strong></td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td><strong>Determining if a Change is an Improvement:</strong></td>
<td>Run charts or Shewhart control charts</td>
<td>No change focus</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square, p-values)</td>
</tr>
<tr>
<td><strong>Confidentiality of the Data:</strong></td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
</tr>
<tr>
<td><strong>Frequency of Use:</strong></td>
<td>Daily, weekly, monthly</td>
<td>Quarterly, annually</td>
<td>At end of project</td>
</tr>
</tbody>
</table>
How will we know that a change is an improvement?

Improvement work is about changing your organization’s approach to caring for patients. 
It is not about measurement. But ……

- Specific measures are required for learning about the impact of changes
- Key outcome measures are required to assess progress on your team’s aim.


How Should We Look at Data?

Before and After Test
Change made between week 7 and week 8

Delay Time (hrs)

0 1 2 3 4 5 6 7 8 9 10

Before Change (measure on Week 4)
After Change (measure on week 11)

Case 1

Delay Time (hrs)

0 2 4 6 8 10 12

1 2 3 4 5 6 7 8 9 10 11 12 13 14
Evidence that change tested resulted in an improvement?

Santa Marta County Behavioral Health
### PCC Core Measures (150424)

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>Screening and F/U</th>
<th>Health</th>
<th>Team Functionality</th>
<th>Health Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONFIDENCE:</strong></td>
<td></td>
<td></td>
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<tr>
<td>&quot;How confident are you that you can control and manage most of your health problems?&quot; (promote early in visit so that it can be addressed)</td>
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<tr>
<td><strong>SATISFACTION:</strong></td>
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<tr>
<td>&quot;Were you able to get all of your health needs met by your healthcare team?&quot; (end of visit summary process)</td>
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<tr>
<td><strong>DEPRESSION:</strong></td>
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<tr>
<td>a. Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool</td>
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<tr>
<td>b. Percentage of patients screened positive with documented follow-up plan</td>
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<tr>
<td>c. Percentage of patients diagnosed with major depression and were treated with antidepressant medication and remained on an antidepressant medication treatment for 180 days</td>
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<tr>
<td><strong>FUNCTIONAL STATUS:</strong></td>
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</tr>
<tr>
<td>SF-1: Overall patient perception of health - &quot;In general, would you say your health is: Excellent, Very Good, Good, Fair, or Poor?&quot; (assess early in visit so that it can be addressed and check wording of question for accuracy)</td>
<td></td>
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<tr>
<td><strong>IMPROVEMENT IN DEPRESSION:</strong></td>
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</tr>
<tr>
<td>Percentage of patients with &gt;50% reduction in depression score (PHQ recommended) from baseline</td>
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<tr>
<td><strong>IMPROVEMENT IN BLOOD PRESSURE CONTROL:</strong></td>
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<tr>
<td>Percentage of patients 18 to 79 years of age with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year</td>
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<tr>
<td><strong>PRIMARY CARE ASSESSMENT:</strong></td>
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<tr>
<td>This assessment was developed by the MacColl Center for Health Care Innovation at Group Health Research Institute. To be done q 6 mo. (pre, mid, and end)</td>
<td></td>
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<tr>
<td><strong>PATIENT EXPERIENCE:</strong></td>
<td></td>
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<tr>
<td>&quot;For today’s visit, your care team was well organized, efficient, and did not waste your time?&quot; (end of visit summary process)</td>
<td></td>
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<tr>
<td><strong>STAFF SURVEY:</strong></td>
<td></td>
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<tr>
<td>Team Experience/Satisfaction Assessment to be done q 6 mo (pre, mid, and end)</td>
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<tr>
<td><strong>LEVEL OF INTEGRATION:</strong></td>
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</tr>
<tr>
<td>Reflect integration of PC and BH as defined by Center for Integrated Health Solutions, March 2013 (adaptation in process) to be done q 6 mo (pre, mid, and end)</td>
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<td></td>
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<tr>
<td><strong>EMERGENCY ROOM VISITS:</strong></td>
<td></td>
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<tr>
<td>Rate of ED visits by patients 18 and older</td>
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</tr>
</tbody>
</table>

### Model for Improvement

1. **Act Plan Study Do**
2. **What are we trying to accomplish?**
3. **How will we know that a change is an improvement?**
4. **What change can we make that will result in improvement?**

**Aim**

**Measurement**

**Changes**

**Testing**

Fundamental Law of Improvement

“Improvement only comes from changes, but not all changes result in improvement”

Fundamental Changes

- They result from design or redesign of some aspect of the system.
- They are necessary for the improvement of a system that is not plagued by special circumstances and problems.
- They fundamentally alter how the system works and what people do.
- They often result in improvement of several measures simultaneously (e.g., quality and cost; time to ship and errors).
- Their impact is felt far into the future
## Change Package

<table>
<thead>
<tr>
<th>Component</th>
<th>Change Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Based Relationships</td>
<td>Develop clear roles and responsibilities for every member of the team so that</td>
</tr>
<tr>
<td></td>
<td>they function at the top of their skill sets.</td>
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<td></td>
<td>Encourage and enable staff to work independently.</td>
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<td></td>
<td>Provide training so that staff members learn new tasks and how to coordinate</td>
</tr>
<tr>
<td></td>
<td>with team members.</td>
</tr>
<tr>
<td></td>
<td>Help patients understand what they can expect in a team-based model of care</td>
</tr>
<tr>
<td>Integrated Behavioral Health and</td>
<td>Define the behavioral health needs you need and want to address</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Choose BH integration strategy</td>
</tr>
<tr>
<td></td>
<td>Select behavioral health providers and organizations with whom to collaborate</td>
</tr>
<tr>
<td></td>
<td>Develop and Train the Workforce</td>
</tr>
<tr>
<td></td>
<td>Develop a process for how patients will access behavioral health care</td>
</tr>
<tr>
<td></td>
<td>Redesign clinical and operational workflows</td>
</tr>
<tr>
<td></td>
<td>Enhance capacity to provide evidence based, collaborative care</td>
</tr>
</tbody>
</table>

## Change Package (cont.)

<table>
<thead>
<tr>
<th>Component</th>
<th>Change Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>Link patients with community resources</td>
</tr>
<tr>
<td></td>
<td>Track and support patients when they obtain services outside the practice</td>
</tr>
<tr>
<td></td>
<td>Follow-up with patients within a few days of an ER visit or hospital discharge.</td>
</tr>
<tr>
<td></td>
<td>Communicate test results and care plans to patients/ families</td>
</tr>
<tr>
<td>Person and Family Centered Care</td>
<td>Respect individual and family values and expressed needs.</td>
</tr>
<tr>
<td></td>
<td>Embed individual and family based decision making and self-management tools into</td>
</tr>
<tr>
<td></td>
<td>team roles and interactions</td>
</tr>
<tr>
<td></td>
<td>Communicate with individuals and families in a culturally appropriate manner,</td>
</tr>
<tr>
<td></td>
<td>in a language and at a level that everyone understands.</td>
</tr>
<tr>
<td></td>
<td>Provide self-management and self-care support at every visit</td>
</tr>
<tr>
<td></td>
<td>Obtain structured feedback from individuals/family about their healthcare</td>
</tr>
<tr>
<td></td>
<td>experience</td>
</tr>
<tr>
<td></td>
<td>Involve individuals and families in the development of community wide plans of</td>
</tr>
<tr>
<td></td>
<td>care and integrated care plans.</td>
</tr>
</tbody>
</table>
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

Model for Improvement

Aim
Measurement
Changes

Act
Plan
Study
Do

Testing


The PDSA Cycle for Learning and Improvement

Act
- What changes are to be made?
- Next cycle?

Plan
- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

Study
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

Do
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

Learning from Testing
Improvement Based on New Knowledge

The PDSA Cycle

Why Test?

Act

Plan

Study

Do

2,4,6 Exercise
What is the PDSA Cycle?

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective
- Questions and predictions
- Plan to carry out the cycle (who, what, where, when)

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

From the father of inductive learning...

...humans have a proclivity to suppose the existence of more order and regularity in the world than they find. Man is little more than a pattern-seeking primate, with an unerring ability to see connections and suspect conspiracies where none exist.

Sir Francis Bacon
1561-1626

Adapted from *The Birth of Plenty—How the Prosperity of the Modern World was Created* By William J. Bernstein, p. 105
Why Test?

• Increase the belief that the change will result in improvement
• Predict how much improvement can be expected from the change
• Learn how to adapt the change to conditions in the local environment
• Build trust (in people and processes)
• Evaluate costs and side-effects of the change
• Minimize resistance upon implementation

Chapter 7

**Aim:** Improve appointment availability through reducing and standardizing appointment types

**Data**

- **Cycle 1:** Define a small number of appointment types
- **Cycle 2:** Compare requests to the types for one week
- **Cycle 3:** Test the types with 1-3 physicians
- **Cycle 4:** Standardize appointment types
- **Cycle 5:** Staff education in new standards

**Changes That Result in Improvement**

- **AP**
- **SD**

**Hunches, Theories, Ideas**

- **DATA**
- **AP**
- **SD**

**Reduction of appointment types will increase appointment availability**

**Improved access**

- **Third Next**
- **80**
- **70**
- **60**
- **50**
- **40**
- **30**
- **20**
- **10**
- **0**

**Cycle 1:** Define a small number of appointment types

**Cycle 2:** Compare requests to the types for one week

**Cycle 3:** Test the types with 1-3 physicians

**Cycle 4:** Standardize appointment types

**Cycle 5:** Staff education in new standards
Testing on a Small Scale

- Have others that have some knowledgeable about the change review and comment on its feasibility.
- Test the change on the members of the team that helped developed it before introducing the change to others.
- Incorporate redundancy in the test by making the change side-by-side with the existing system.
- Conduct the test in one facility or office in the organization, or with one client.
- Conduct the test over a short time period.
- Test the change on a small group of volunteers.
- Develop a plan to simulate the change in some way.

The Value of “Failed” Tests

“\textit{I did not fail one thousand times; I found one thousand ways how not to make a light bulb.}”
\textit{Thomas Edison}

---

Do \rightarrow Study

- Reasons for failed tests
  1. Change not executed well
  2. Support processes inadequate
  3. Hypothesis/hunch wrong:
     - Change executed but did not result in local improvement
     - Local improvement did not impact access or efficiency
- Collect data during the Do phase of the cycle to help differentiate these situations.
Study --- Act

• Compare data to prediction
• Summarize what was learned
• ACT - Take action on the new knowledge

Aspects All of Us Need to Emphasize and Help Build

• Culture of experimentation
  — Testing everything, testing every day
  — Power of failure
  — Use of data to support testing and learning
  — Sequential nature of learning

• Clarity on the microsystem

• Ability to tell the story with data (describe and document PDSA)
Churchill on Learning

*Making predictions slows up the “hurry”*

Men occasionally stumble over the truth, but most of them pick themselves up and hurry off as if nothing has happened.

--Winston Churchill

Principles of Testing a Change

- Principle 1: Test on a small scale and build knowledge sequentially.
- Principle 2: Collect data over time.
- Principle 3: Include a wide range of conditions in the sequence of tests.
Accelerating Learning and Improvement

*What Cycle can we complete by next Tuesday?*

Willing to compromise on scope, size, rigor, and sophistication, but the Cycle must be completed by Tuesday.

Engaged Leadership: Why?

Support from leadership, provides....

Direction, motivation, and resources, in order to....

Make and sustain key changes required for transformative change.

Engaged Leadership: High Leverage Concepts

- Provide visible and sustained leadership to lead overall culture change, as well as specific strategies to improve quality and spread sustain change.
- Ensure that the transformation effort has the time and resources needed to be successful.
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the development of an integrated care model.
- Build the practice’s values on creating a team based and holistic patient centered culture into staff hiring and training processes.

Empanelment
Why?

- The relationship between patient, provider, and care team is at the heart of the Patient-Centered Medical Home (PCMH) Model of Care and transformation of Primary Care.
- Empanelment formalizes and affirms partnerships and sets the stage for all of the other components of an effective practice.
- Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each patient.
- Stable patient and provider/care team relationships build trust and provide consistency in treatment approaches and follow-up.

What

- Empanelment is the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference.
- Empanelment is the basis for population health management. The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether he/she regularly comes in for visits or not.
- Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each patient.
Empanelment: High Leverage Concepts

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Person and Family Centered Care

“Putting the patient and the family at the heart of every decision and empowering them to be genuine partners in their care.”
**Why Person and Family Centered Approaches?**

Person and Family Centered Care

- Respect individual and family values and expressed needs.
- Embed individual and family based decision making and self-management tools into team roles and interactions.
- Communicate with individuals and families in a culturally appropriate manner, in a language and at a level that everyone understands.
- Provide self-management and self-care support at every visit.
- Obtain structured feedback from individuals/family about their healthcare experience and use this information for quality improvement.
- Involve individuals and families in the development of community wide plans of care and integrated care plans.
- Provide an integrated care plan that has been developed with the individual and is held by the individual.
Care Coordination

- Organize a practice team to support patients and families
- Link patients with community resources
- Track and support patients when they obtain services outside the practice
- Follow-up with patients within a few days of an ER visit or hospital discharge.

12:00 pm – 1:00 pm

Gone For Lunch