Sequence to Achieve Change Workbook

Clinic Team: __*Blue Meadows Clinic*_____ **Change Package**: _*H2H2H*__

1. Elevator Speech

When you approach a team to consider quality improvement work, you'll want to be prepared with an "elevator speech." Use the tool below to help develop it.

<table>
<tr><td>Who You Are:
A Practice Facilitator from XYZ PCN.</td><td>What You Do (short explanation):
I work with XYZ PCN member clinics on quality improvement initiatives that support the Patient's Medical Home. I help teams with implementation and measurement of changes and aim to build capacity for change within the clinic.</td></tr>
<tr><td>Features:
The H2H2H change package supports teams to:
- identify patients admitted to and discharged from hospital,
- engage in 2-way communication with acute care
- creating a plan for post-discharge follow-up visits
- using assessment for readmission and follow-up appointments as necessary</td><td>Benefits:
The benefits of implementing potentially better practices within the H2H2H change package include:
- the ability to better support your patients during transitions in care
- ability for the ability to contribute to transition planning and the transition care plan
- improved experience for patients
- optimized use of post-discharge follow-up appointments</td></tr>
<tr><td colspan="2">Key Messages for Your "Elevator Speech":
How often are you unaware that a patient has been admitted to or discharged from hospital? What challenges does that create for you? And for your patients? Transitions in care between care teams and care settings is a particularly vulnerable time for our patients. I know it can be frustrating when you are unaware that a patient of yours has been in hospital. Unfortunately, x% of patients discharged will be readmitted with in 30 days. Supporting patients with transitions aligns with the Patient's Medical Home by supporting implementation elements such as care coordination, continuity and access, among others. Would you be interested in setting up a meeting to discuss how we could make some improvements using the clinic and PCN staff to support patients in transitions of care?</td></tr>
<tr><td>Anticipated Barriers:
- Too busy / I don't have enough time (or resources) to take this work on
- This isn't a problem for us ; this is something hospitals need to do</td><td>Plan for Managing Barriers:
- Process improvements can help to streamline; they also support team members to work to full scope, so everything doesn't fall on the physician
- CII/CPAR is a technological enabler that may allow your PCN to free up resources who are currently supporting transitions in care</td></tr>
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	- *Better transitions require 2-way communication between acute and primary care. Engaging with acute care for admitted patients will enable more effective management of those patients at discharge*

2. Form an Improvement Team

Next, assemble a team that represents all areas and roles of the clinic; consider including a patient on your team. Indicate below who is on your improvement team. It is recommended that you include someone with training in quality improvement facilitation (likely this will be you!) and someone with decision making authority (a physician champion or office manager).

Team Member Name	Role in Clinic
Dr. Green	*Physician champion*
Hailey	*MOA/Receptionist*
Elaine	*Office Manager*
Jeff	*PCN Nurse*
Charlotte	*Practice Facilitator*
Sally	*Patient with Lived Experience*

3. Clarify the Problem/Opportunity

Articulate the problem you want to solve. Use evidence and data to strengthen your rationale (consider reviewing the physician's HQCA Primary Health Care Panel Report with them and the team). Discuss with your improvement team what aspects most need improvement. You may also want to use some QI tools like the Fishbone Diagram, 5 Whys, or Pareto Chart.

Data that may support my change package:

- *Consider a story of a patient from the clinic or from another clinic that you should share*
- *Dr. Green's HQCA panel report "30-day hospital readmission" rate*
- *CII/CPAR : e-notifications, conflict reports, confirmed panel reports*

When writing your problem or opportunity statement, consider the following questions:

Question	Answer
What is the problem?	*There is no process for supporting patients in transition to or from hospitals.*

Who does the problem affect?	*MOA/receptionist, nurse, physician, patient*
When is it a problem?	*When patients transition between care teams/settings.*
Why should we care?	*You may be frustrated with not knowing what happened to a patient in hospital, and an inability to influence what happens at the hospital and after discharge. If the patient has a poor transition in care or is unable to see their primary care physician post-discharge, managing the patient's conditions may be more difficult.*
How does it affect patients?	*When discharged, patients often need additional follow-up tests and supports. Follow-up in primary care can ensure patients have the supports they need and that patients understand any expectations. Patient's don't want to end up back in hospital. Follow-up in primary care post-discharge can help to prevent readmission.*

Problem Statement: At Blue Meadows Clinic we are frustrated because we know that admission to and discharge from hospital is a vulnerable time for their patients and we don't have a process to support these patients the best we can. Without this process patients are a greater risk of readmission.

4. Map Processes

Visually depict the sequence/steps of events in the process that you are trying to improve. Start by naming your process so that all team members are focusing on the same thing. Next, determine the start and ends points in the process. Use your team to brainstorm all of the steps that happen in between. Finally, arrange your steps in order.

Once you have your current state mapped, review it as a team. Consider the following questions:

Question	Answer
Where are the bottlenecks?	*-poor access may make it difficult to book post-discharge appointments* *-process needed to review transition plans*
Where is work being duplicated?	*-process needed to ensure tests, assessments aren't duplicated in acute care and primary care* *-some low-risk patients may be booked for post-discharge appointments*

Are their inconsistencies?	*-Some patients are asked for to have a follow-up appointment while others are not. No one is sure what the criteria is, if any.*
What can be standardized?	*-Roles and responsibilities around transitions in care including:* *○ Communication back to the hospital when an admit notification is received* *○ Review of discharge summaries.* *-Process could be developed for when physicians are away*
Does each step add value? If not, can it be eliminated?	*-ensure work in primary care is not duplicating what has been done in acute*

Use the Process Mapping Guide in your Practice Facilitator Core Training as support.

5. Use the Model for Improvement

When making a change, the Institute for Healthcare's Improvement Model for Improvement asks three questions:

1. What are you trying to accomplish? – *This is your aim statement.*
2. How will you know that a change is an improvement? – *These are your measures.*
3. What change can be made that will result in an improvement? – *These are your PBPs.*

These three questions are followed by small tests of change called Plan-Do-Study-Act (PDSA) cycles.

Set an Aim Statement

Question	Answer
What are we trying to improve?	*To know which patients require follow-up appointment after hospital discharge and to offer the appointment in a timely fashion.*
By how much? (Try a stretch goal!)	*80% of high-risk patients will have a follow-up appointment within 7 days of hospital discharge*
By when?	*August 2021*
Aim Statement:	*We aim to offer at least 80% of our high-risk patients a follow-up appointment within 7 days post-discharge, by August 2021.*

Identify Measures

Measurement is a key component of good quality improvement. Measurement allows you to track the changes that are occurring and assess their impact. There are three types of measures that can be collected:

- A **process measure** measures of whether an activity has been accomplished. Often used to determine if a PDSA cycle was carried out as planned.
- An **outcome measure** measures the performance of the system under study. Often relates directly to the aim of the project and offers evidence that changes are actually having an impact.
- A **balancing measure** determines the impact of a change on separate parts of the system.

QI Measure	Method of Collection	Frequency
# of patients discharged from hospital (process)	*EMR report*	*Weekly*
% of patients with risk assessment completed (process)	*EMR report*	*Weekly*
% of high-risk patients with follow-up appointment within 7 days post discharge (outcome)	*EMR report*	*Weekly*
#/% of patients readmitted to hospital with 30 days of discharge (outcome)	*HQCA report*	*Annually*
TNA (balancing)	*Manual count from EMR schedule done by Hailey on Tuesday mornings*	*Weekly*

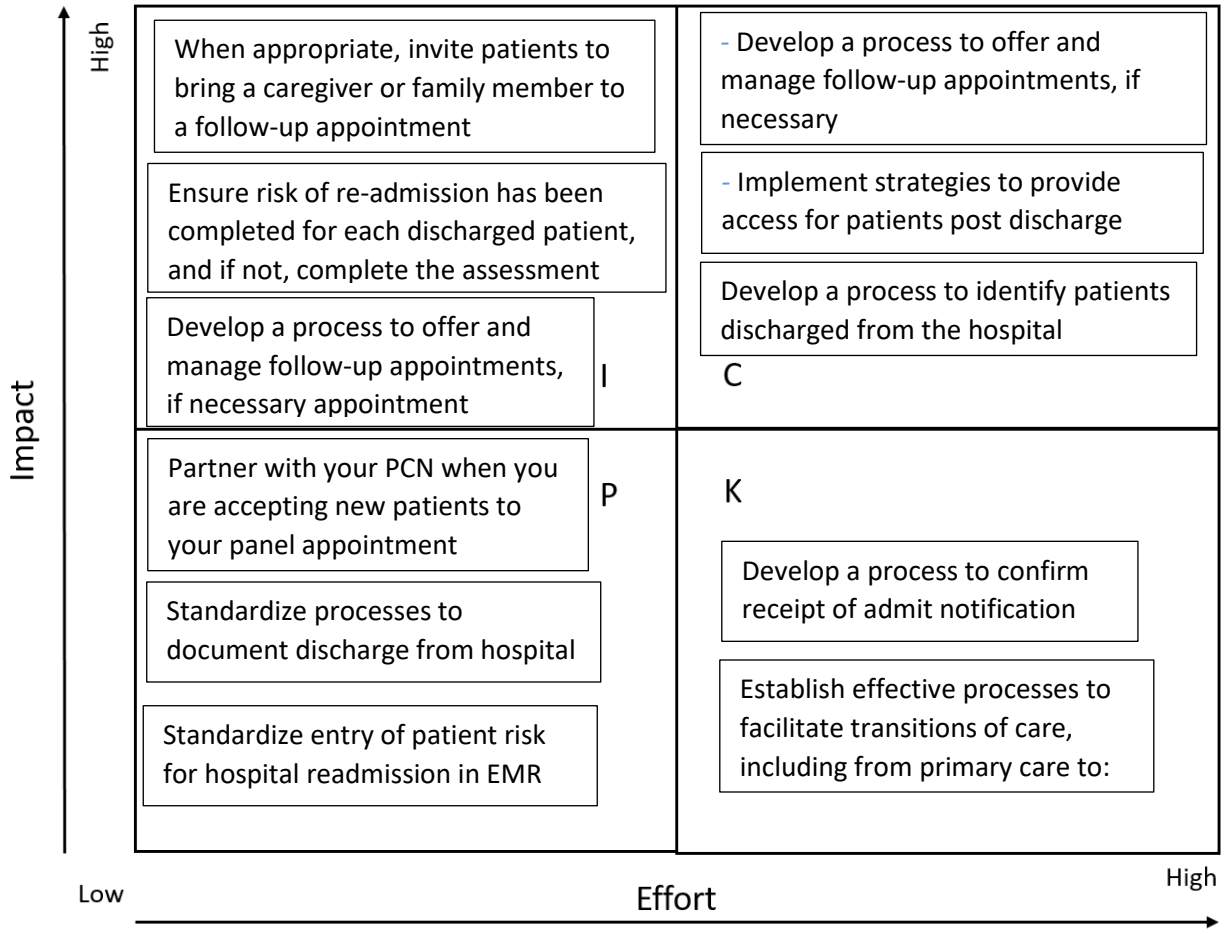
EMR access varies by clinic and PCN so have a discussion with the team about which person or role is responsible for running the EMR report and what frequency makes the most sense for your circumstances.

When you are actively working on a process change, measure it often. As they become established, move to less frequent monitoring.

Select Changes or Potentially Better Practices (PBPs) to Test

Use your change package table to select PBPs. Based on what you know about the impact they'd have and the effort they'd take, slot them into the PICK Chart below. Indicate which ones the team will try first: Impact/Effort Grid or PICK (Possible, Implement, Challenge, Kill) Chart

Note: this is just a sample PICK chart. Some PBPs that may be very difficult for one team to implement may be easy for another team to implement because of the other processes they have already put in place. The critical activity is having a team discussion about the PBPs & how they apply to your team to determine which ones would be the most beneficial to try implementing.



Test Changes

After a change idea is selected, use PDSA cycles to test changes in a real-world setting. Consider starting with just one patient and one provider. Document each PDSA Cycle. Use the PDSA template in the QI Guide as support.

6. Sustain the Gains

Congratulations on making an improvement! However, now you've got to hold the gains. Some strategies to consider for maintaining improvements are:

- Standardization
- Accountability
- A visual management system
- Daily communication

Use the Five Strategies for Sustaining the Gains handout to learn more.

Additionally, measurement does not stop once you have improved your outcomes. Continue to periodically measure your results to ensure that improvements are sustained over time. Consider creating a quality improvement board and displaying results for both clinical staff and patients to see.

7. Spread the Successful Changes

After successful implementation with the initial site, the improvement team can work to spread learning and changes to other parts of the clinic or to other clinics within the Primary Care Network. While actual spread occurs at the end of a successful improvement initiative, improvement teams should develop strategies for spreading improvements from the beginning of the project.

Thinking of the work you're currently doing with your team, how can it be spread (to other patient populations/to other physicians or clinics)?:

- *To another physician in the clinic*

Be aware of the Seven Spreadly Sins. Reference the Seven Spreadly Sins handout to learn more.

8. Celebrate!

Plan to celebrate at milestones along the improvement journey, as well as when you achieve your aim. Recognize and highlight the efforts and accomplishments of the team.

Brainstorm ways in which you might celebrate with a team:

- Team lunch

H2H2H Glossary & Acronym List

8P Screening Tool: This tool identifies your patient's risk for adverse events after discharge. The 8Ps include:

- Problems with medications
- Psychological
- Principal diagnosis
- Physical limitations
- Poor health literacy
- Patient support
- Prior hospitalization
- Palliative care

ACTT: Accelerating Change Transformation Team

BRASS: The Blaylock Risk Assessment Screening Score index is an instrument used to identify patients requiring complex discharge planning.

Care Plan: Is a plan to keep everyone on the "same page" as to what matters to the patient (goals, values and preferences) It also helps keep track what has been planned or being worked on to improve the patient's health and wellbeing.

Change Package: A quality improvement framework that consists of high-impact changes that are expected to occur when the potentially better practices are implemented. Key tools and resources are often linked to support the potentially better practices and suggested measures will track progress made towards the high-impact changes.

CII: Community Information Integration is a system that transfers select patient information between community Electronic Medical Records (EMRs) and other members of the patient's care team through Alberta Netcare.

Continuity: Continuity of care is how a patient's experiences of care over time are coherent and linked. This includes relational, informational and management continuity. Relational continuity is the percentage of time a patient see's their own primary care physician vs. others. Relational continuity above 80% is the aim.

CPAR: Central Patient Attachment Registry is a provincial system that captures the confirmed relationship of a primary care provider and their paneled patients.

CPSA: College of Physicians and Surgeons of Alberta Medical Association

EMR: Electronic Medical Records; the computerized chart in the physician's office

Find A Doctor: A website designed to assist patients in finding family physicians.

H2H2H: Home to Hospital to Home

H2H2H Guideline: This guideline bridges the connections between hospitals, primary care and community services. Transitions in care require a coordinated approach as many factors may contribute to high quality care transitions. To assist providers and teams within Alberta, this guideline presents leading operational practices, change management, tools, resources, and additional information for the following elements

- o Confirmation of the Primary Care Provider
- o Admit Notification
- o Transition Planning
- o Referral and Access to Community Supports
- o Transition Care Plan
- o Follow-Up to Primary Care

HQCA: Health Quality Council of Alberta - gathers and analyzes information, monitors the healthcare system, and collaborates with **Alberta Health, Alberta** Health Services and others to help in making improvements to quality and patient safety.**Panel:** A group of patients for whom a primary provider(s) and team is responsible for providing comprehensive and longitudinal care. Paneled patients have a confirmed relationship with their primary care provider.

LACE: The Length of stay, Acuity of admission, Charlson comorbidity index, Emergency department visits in past six months (**LACE**) index was developed to predict hospital readmissions in Canada.

Patient Representatives Guide: This resource is for patients, family members and/or caregivers who have been asked to engage and partner with primary care clinics or Primary Care Networks (PCNs) to be part of the Home to Hospital to Home (H2H2H) transitions. It also helps the PCN when including a patient representative in planning new services or approaches.

PCN: Primary Care Network is a joint venture between a group of primary care physicians (who form a non-profit corporation) and Alberta Health Services to coordinate service delivery through a network of physicians and other primary health care providers—such as nurses, dieticians, pharmacists, and social workers—working together to provide primary health care to Albertans.

TNA: Third next available appointment is the number of calendar days between today and the third next available appointment in a clinician's schedule. It's the gold standard for measuring the length of time patients are waiting for an appointment.