Engaging Primary Care Providers in Quality Improvement

November 25, 2014
Sandra Pelchat
Introduction

Edmonton Southside PCN

Situation

Collaborations

Journey
- Grasping
- Implementing
- Sustaining
- Developing

Barriers

Successes

Key Messages

Closing

Dolores Paul    Robin Anderson    Sandra Pelchat

Clinical Improvement Facilitators
Edmonton Southside Primary Care Network

- **66** family practice clinics
- **211** family physicians
- **225,000** funded patients
- **100** Multidisciplinary Staff (RN, NP, BHC, RD, RT, ES)
- **6,000** patients per month
- **10,000** patient encounters per month
Edmonton Southside Primary Care Network

**Vision**
- The trusted cornerstone of a healthy community

**Mission**
- To provide team-based primary care and work with our community to achieve the best health for all

**Values**
- Respect, passion, commitment, collaboration, innovation

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Organizational Chart 2013
Edmonton Southside PCN Growth

- **# of Staff**
- **# of Clinics**
- **# of Physicians**

<table>
<thead>
<tr>
<th>Year</th>
<th># of Staff</th>
<th># of Clinics</th>
<th># of Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>28</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>2008</td>
<td>67</td>
<td>32</td>
<td>39</td>
</tr>
<tr>
<td>2009</td>
<td>104</td>
<td>68</td>
<td>18</td>
</tr>
<tr>
<td>2010</td>
<td>128</td>
<td>25</td>
<td>44.3</td>
</tr>
<tr>
<td>2011</td>
<td>145</td>
<td>33</td>
<td>54</td>
</tr>
<tr>
<td>2012</td>
<td>162</td>
<td>45</td>
<td>73</td>
</tr>
<tr>
<td>2013</td>
<td>183</td>
<td>53</td>
<td>94</td>
</tr>
<tr>
<td>2014</td>
<td>211</td>
<td>66</td>
<td>100</td>
</tr>
</tbody>
</table>
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Closing
Journey

- Grasping • Oct-Dec 2013
- Implementing • Jan-May 2014
- Sustaining • Jun-Aug 2014
- Developing • Sep-Nov 2014
Journey

Grasping • Oct- Dec 2013

- Attended “The Art and Science of Improvement and Innovation” through the Institute for Healthcare Improvement

- Attended Improvement Facilitator Training through TOP’s Alberta Screening and Prevention Program

- Developed a menu of improvement Projects to choose from

- Developed a communication plan
Journey

• Grasping

• Implementing
• Sustaining
• Developing

Deming’s System of Profound Knowledge

Source: McKeen S, Ross JJ, Dressler DD, Brotman DJ, Ginsberg JS: Principles and Practice of Hospital Medicine: www.accessmedicine.com

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Journey

Grasping  •  Oct- Dec 2013

Model for Improvement

- 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?

Act  Plan  Study  Do
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**Journey**

**Grasping** • Oct- Dec 2013

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Advanced Health Care Planning and Goals of Care Designation (ACP/GCD)
ACP can help guide healthcare decisions with your patients while Goals of Care designations will help to identify your patient’s general aims of health care and the preferred location of that care.

Alberta Screening and Prevention
Supported through the AMA, ASaP offers primary care providers customized processes and tools to improve patient screening and early detection for significant health issues. ASaP also includes an outreach process for targeting patients who don’t present for routine screening.

Better 2 Project
Better 2 is designed to improve chronic disease prevention screening for cardiovascular disease, diabetes and cancer in family practice settings. The Better project provides patient and practice level tools as well as an EMR audit tool.

COPD Pathway
A novel approach for COPD diagnosis and management in a primary care setting using a multidisciplinary team.

Depression Pathway
The Clinical Depression Pathway is a collection of best practice evidence for the identification, assessment, treatment and follow-up of adults with suspected depression in primary care settings. The pathway algorithm can be incorporated into the EMR to track the care and follow-up of these patients.

Health Care Team Effectiveness
A program designed for today’s healthcare leaders. Quick, effective, and targeted solutions to develop and maintain team performance, communication and continuity of care.

Heart Failure Remote Monitoring
Alberta Health Services, GE and Edmonton PCNs have partnered on a Pilot Project to offer virtual care devices to patients with congestive heart failure under the care of PCN primary care providers and their teams.

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For more information, contact Dia Campbell at dia.campbell@edmontonsouthsidepcn.ca or 780.390.2648.
Journey

Implementing • Jan-May 2014

- Strong focus on our most tangible tool; the ASaP initiative
- Building a culture of improvement through activities and presentations at staff meetings
- Facilitation of a discussion around improvement at our AGM
- Face to face meetings with physicians and clinics
- Established a presence in the monthly PCN Newsletter
# Journey

**Implementing** • Jan-May 2014

## Screening Maneuvers Menu for Adults

### Alberta Screening & Prevention Initiative (ASaP)

<table>
<thead>
<tr>
<th>Maneuver</th>
<th>Age (years)</th>
<th>General Population Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Weight</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Height</td>
<td>18+</td>
<td>At least once</td>
</tr>
<tr>
<td>Exercise Assessment</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Tobacco Use Assessment</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Alcohol Use Assessment</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Influenza Vaccination/Screen</td>
<td>18+</td>
<td>Annual</td>
</tr>
<tr>
<td>Pap Test</td>
<td>Females 21–69</td>
<td>3 years</td>
</tr>
<tr>
<td>Plasma Lipid Profile - Fasting</td>
<td>Males 40–74</td>
<td>Females 50–74</td>
</tr>
<tr>
<td>CV Risk Calculation</td>
<td>Males 40–74</td>
<td>Females 50–74</td>
</tr>
<tr>
<td>Diabetes Screen</td>
<td>40+</td>
<td>3 years</td>
</tr>
<tr>
<td>One of: Fasting Glucose</td>
<td>50–74</td>
<td>2 years</td>
</tr>
<tr>
<td>Hgb A1c</td>
<td>50–74</td>
<td>5 years</td>
</tr>
<tr>
<td>Diabetes Risk Calculator</td>
<td></td>
<td>10 years</td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One of: FOBT/FIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flex Sigmoidoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Females 50–69 (74)</td>
<td>2 years</td>
</tr>
</tbody>
</table>
Journey

**Implementing** • Jan-May 2014

Comparison to Provincial Data

Provider Average Score

- Provincial Data (n = 167)
- Edmonton South Side PCN (n = 16)

Provincial Average of 47%
Sustaining  •  Jun-Aug 2014

• Performed “post reviews” on several clinics implementing ASaP

• Focused on maintaining relationships

• EMR development created a halt in some projects

• Developed a deeper focus on panelling

• Started discussions on a need for additional administrative support in the clinics
Journey

Sustaining • Jun-Aug 2014

Average improvement of 33%

24 Initial Review Average of 40%

8 Post Review Average of 54%

Key Messages

ASaP
Alberta Screening and Prevention
Journey

Sustaining • Jun-Aug 2014

You Know Your Panel is Clean When...

1. You can generate a list of patients that identify you as their primary care provider.
2. Your list is current for the preceding 3 years.
3. You have a process in place to maintain currency of your panel.

The Benefits to Your Practice Include:

- Identification of clear patient demographics
- Optimized ability to routinely screen your patients
- Meaningful use of EMR to identify clinical subgroups
- Better match of resources to patient needs
• Received supporting documentation from several key players in the development of Primary Care in the province

• Hired 5 Panel Management Assistants for 5 clinics
Journey

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Developing • Sep- Nov 2014

PCN Evolution Panel Goal for 2014-15;
Each PCN will have 80% of their physicians
with panel identification processes in use.
Journey

Suggested Reporting AH Measures

- % of patients returning to same provider
- % of patients returning to same clinic
- Median TNA for primary care provider
- % patients satisfied with PCN care
- % Screening for ASaP maneuvers
- % patients with chronic condition offered self-management
- % patients with chronic condition self reporting improved QOL
- % of multidisciplinary team members responding to team effectiveness survey
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Panel Management Assistants

- In clinic staff designated to support
  1. Panel Identification
  2. Panel Maintenance
  3. Panel Management

- 5 people (3.5 FTE) hired into 5 clinics

- Starting date October 14, 2014
Journey

Physician Engagement in Improvement

- PMA & ASaP 7%
- ASaP 9%
- Other 2%
- AMA PMP 2%
- Conversation Initiated 10%
- Untapped Potential 70%

* As of October 2014
Barriers

- Time
- Buy in
- Standardized processes
- Complex reporting and communication structures
- EMRs-
  - Still developing capabilities to support improvement
  - Some clinics are still paper based
- Changing a culture takes constant effort and time
Successes

- 30% physician engagement in 1 year
- Excitement that is visible from physicians
- A budding culture of improvement stemming from PCN staff
- Enhanced comfort around improvement for PCN frontline management
- A strong and engaged improvement team
Key Messages

- Regular meetings around improvement are necessary to change the culture
- Implementing small measurable changes are key to sustainability
- EMR support and efficient utilization is paramount
- Engaged leadership is the first building block
thank you!
Appendix

ESPCN Physician Numbers from: December 2004 to October 2014

Number of Physicians

Linear (Number of Physicians)

Primary Care Network
EDMONTON SOUTHSIDE