Quality Improvement Guided by the Patient Experience in Primary Health Care – The Patient Journey Project

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NATIONAL SYMPOSIUM ON PATIENT ENGAGEMENT

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Learning Objectives

• Describe a quality improvement approach that focuses on measuring the patient experience, as well as provider/care team experience.

• Identify 2-3 tools and resources that are used to integrate patient and family centeredness within a quality improvement approach.

• Define the spread potential of this patient centered quality improvement approach to other healthcare system areas of focus.
What is the experience of care?
TILLY GOES TO THE CLINIC
PART 1
Is that really the experience of care?
Canada trails all or most other countries in information technology, care coordination, use of teams, performance monitoring and participation in quality improvement initiatives (Schoen et al. 2006, Schoen et al. 2007, Schoen et al. 2008, Schoen et al. 2009, Schoen et al. 2010).
The Commonwealth Fund’s ranking of health system performance among seven developed countries placed Canada last in quality of care, second to last (ahead of the United States) in overall ranking and efficiency, and fifth in access and equity (Davis et al. 2010).
Seventy-five percent of Ontarians who have a regular doctor or place of care rate the overall quality of medical care they receive as excellent or very good.
“Every system is designed perfectly to get the results it gets.”

- Paul Batalden
The Patient Journey Project, 2009-10

• Mapping the Patient Journey - Patients Engaged

1. Patient focus groups.
2. The patient experience mapped.
3. Interdisciplinary team focus groups.
4. Opportunities for improvement.
5. Strategies to improve the patient experience.
The Patient Journey Project, 2009-10

• Patient Focus Groups

1. Patient focus groups to identify typical health care experiences, over time, for Ontarians with health care needs ranging from preventive and episodic care to care for multiple co-existing chronic conditions.
The Patient Journey Project, 2009-10

• The Patient Experience Mapped

2. Mapping the patient journey across a spectrum of health care needs based on focus group findings.
**Patient Journey Map for Complex Care**

**Patient**
- Books follow-up/return visit at intervals set by physician if schedule available or calls back to book.
- Attends return visit – medications adjusted/reordered.
- Patient books return visit before leaving office if schedule available. If schedule not available, calls back.
- May be referred to specialist.
- If calls back may face wait for appointment beyond provider requested return visit date.
- Needs additional assistance at home.
- Specialist requests more tests and/or return visit as per patient condition.

**Family Doctor**
- Physician directs care, sets return intervals based on patient needs and condition.
- Informs and encourages patients. Gives clear choices for patient decision making and setting priorities.
- Receptionist is gatekeeper to schedule.
- Where available, nurse triages patient.
- Physician resets return visit interval based on patient condition.

**Family Health Team/other health care providers**
- Depending on services available, patients may be referred to other providers, e.g., FHT pharmacist, dietitian, social worker, etc.

**Ontario Telemedicine Network**, in conjunction with FHTs, is running pilot projects to educate specific patient groups regarding management of their chronic disease, e.g., COPD and CHF.

**Specialist**
- Requests to speak to nurse to access faster appointment.
- Patient attends episodic visit.
- Booked for appointment, may have to wait 4-6 wks.
- Go to walk-in clinic.
- Go to emergency department.
- Assessed for eligibility for home-based services.
- May travel out of town for specialist visit with added cost.

**Managing day to day care; then has episodic need**
- Calls to book episodic appointment.
- Sees in clinic and referred back to family physician.
- Sees in emergency department and referred back to family physician.

**Waits for referral**
- Sees in clinic and referred back to family physician.

**Waits for 4-6 weeks or more**
- Sees in emergency department and referred back to family physician.

**Attends visit and follow-up as needed**
- Sees in clinic and referred back to family physician.

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The Patient Journey Project, 2009-10

- Interdisciplinary Team Focus Groups

3. Focus groups of interdisciplinary health care providers in several primary health care locations to validate the patient journey maps.
The Patient Journey Project, 2009-10

• Opportunities for Improvement & Strategies for Change

4. Identification of opportunities for improvement in system design that could improve the patient experience, quality of care and efficiency.

5. Describing the expected impacts of those changes on the patient/provider experience, health outcomes and health care costs.
Improvement Ideas

**Episodic & Preventative Care:**
- Greater use IHP to carry out the prevention programs.
- Education of patients regarding prevention and self-management.
- EMR with capacity and capability to maintain preventative care.
- Access to care and continuity.
- Community awareness and partnerships.

**Diabetes Care:**
- Greater coordination of work.
- Greater interdisciplinary team work including an understanding of roles and responsibilities.
- Planned and prepared visit approach for regular diabetes management visits.
- Increased EMR capability, coordination and continuity.
- Promotion of patient self-management of his/her diabetes by all involved.
- Access to care.
- Navigation or case management services.

**Complex Chronic Disease:**
- Access to care and continuity of care.
- Orientation of patients to the Family Health Team.
- Education and coaching for patients in how to manage their disease.
- Support for patients to be self-managers of their own disease.
- Staff playing the navigator role.
- Resources to enable chronic disease management clinics.
- Use of alternate visit methods.
- Bring specialists to communities either in person or via OTN.
- Link to community agencies.
- Creating partnerships.
Strategies to Improve the Patient Experience

Seven Key Themes

- Care coordination and effective communication
- Team based care and optimization of the care team
- Access to care and efficiency in care design
- Planned and proactive care of the patient
- Self management support
- Optimization of the electronic medical record
- Resource support
Mapping the Patient Journey & Improvement Strategies Applied
-The Family Health Team Experience
The DM Journey...
The NEW DM Journey

TFHT & VONDEC Patient Algorithm

- MD or NP Visit = Newly Diagnosed Diabetic Patient
- Referral to VONDEC
- 1st Appointment (VONDEC) RN + RD
- Follow-up Appointments (VONDEC + TFHT) Q 6wks until target or plateau
- Chronic Maintenance Program Diabetic Patient
  - Yearly Review (Patient, MD, RN + VONDEC)
  - Diabetic Group Appointments Q 3months
  - TFHT + VONDEC
  - If patient becomes destabilized…

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MEASURES

Percent of DM pts with A1c test in past six months

Percent of DM pts with BP<= 130/80

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MEASURES
GMA Outcome Measures

Dr. Judy Gillies Group vs. Non-Group Diabetic Outcome Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Non-Group Diabetes Visits</th>
<th>Group Diabetes Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C &lt;= 7 in last 6 months</td>
<td>61%</td>
<td>66%</td>
</tr>
<tr>
<td>A1C Self-Management</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage BP</td>
<td>64%</td>
<td>83%</td>
</tr>
<tr>
<td>Percentage ACEI or AARB</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>Percentage LDL</td>
<td>71%</td>
<td>82%</td>
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<tr>
<td></td>
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<td>32%</td>
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Planned, Proactive, Patient-Centered Diabetes Care

“In the past I was always at Dr. Gillies office not feeling 100% and never knowing why… once we started this program I became aware that only I can control my health, and I was ready at that point to grab on to anything just to know I was feeling better and doing the right thing, but I didn’t know how to do the right thing. So through Dr. Gillies and the diabetes team I learned how to, finally at the age of 62, take care of myself. Now I see Dr. Gillies once a year, under control, and I have never felt better in my whole entire life.”

Rita Garito – Patient Lead Diabetes Team
The Provider Experience…

“You have a rare condition called ‘good health’. Frankly, I’m not sure how to treat it.”
Small Group Discussion Questions

• Where do you currently engage patients within your organizations?
• How are patients engaged for improvement?
• Do you have patients as members of your improvement teams?
• Are there current opportunities for improvement within your organization?
• Describe one area of opportunity?
  – What would you like to accomplish? How will you know it is an improvement? What changes can you make that will result in an improvement?
  – What will be your strategy to engage patients in this improvement opportunity?
  – What can you do by next Monday?
What is patient-centered care?

• “... an innovative approach to planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, their families and health care providers.” (Institute for Family Centered Care, 1992)

• “…a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support that they need to make decisions and participate in their own care.” (Institute of Medicine, 2001)
What is Patient Engagement?

• “Actions individuals must take to obtain the greatest benefit from the health care services available to them.” (Centre for Advancing Health, 2010)
The shift in focus…

• A key shift in focus in defining patient-centered care is apparent.
  
  – The integration of, and partnership with, the patient in the design, delivery and evaluation of care.
  
  – Reflects more than the traditional thoughts of patient engagement in direct care via strategies such as self management.
  
  – Patient engagement is broader.
“The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.”

IOM Report: Crossing the Quality Chasm (2001)
The Patient Engagement Pilot

• Partnership to train/import PFCC methodology from UPMC innovation Centre.
• Pilot the application of the methodology within Timmins FHT practice setting for COPD program re-design.
• Align with QIIP COPD Action Group Charter/Measures to evaluate ability to integrate this methodology into current improvement methodologies.
TILLY GOES TO THE CLINIC
PART 2
Summary

• Be intentional and engage patients in a meaningful way.
• Utilize the patient experience to optimize quality improvement initiatives.
• Have patients as active members on your improvement teams.