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Integrating shared measures into project planning

Thursday, January 20, 2022

BRITISH COLUMBIA

doctors of bc

Agenda

- Introductions & Land Acknowledgement
- Housekeeping:
  - Go on mute when not asking a question
  - Questions can be asked by raising a hand or typing in chat
  - 2 reference documents *(Evaluation Plan & Shared Measures Quick Reference Guide)* and 1 worksheet are attached to meeting invite
- Overview of *Process & Requirements*
- Activity – selecting shared measures
- Session evaluation

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Objectives: Session 1

- Why Shared Care Committee has adopted shared measurement
- To describe the process and requirements of integrating shared measures into the project intake form and evaluation plan
- To select shared measures for a Shared Care project (case study)

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Objectives: Session 2

Feb. 3, 2022

- How to create a data collection tool with selected shared measures
- How to submit survey data to Shared Care
- How to report data at the project level
- How Shared Care will report data at the provincial level

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Shared Care Values & Principles

Effective Engagement

Innovation

Collaborative Culture Change

Measurable Improvement

What are Shared Care's shared measures?

A list of **31 measures** created from previous Shared Care projects

The measures align with **8 Shared Care Outcomes**

At the **local project level**, data can illustrate the impact of a single project

At the **provincial level**, data is aggregated to show impact in key areas across projects

Process Overview:
Selecting, Integrating & Reporting shared measures data

Phase	Task
1. Project proposal	• Identify which Shared Care Outcomes align with your project
2. Evaluation / Measurement Planning	Integrate shared measures into the evaluation plan: • Identify which shared measures corresponds to the Shared Care Outcomes • Determine the data collection method for each measure • Submit Evaluation Plan
3. Instrument development & data collection	• Create data collection tool • Collect data using appropriate platform (i.e. paper, online platform)
4. Data submission	• Submit data from survey platform with quarterly report
5. Reporting	• Analyze and summarize results in Final Project Report

Today's session

Case Study: Geri-Psychiatry Improvement Project

Project Objectives:

1. Develop a process for FPs to access a quick phone consult from a local Geriatric Psychiatrist

2. Develop a geriatric psychiatry referral algorithm so FPs are better aware of, and understand how to navigate geriatric MHSU services

3. Organize engagement event(s) to spread the project and gather feedback for continuous PDSA cycles

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Step 1:

Identify relevant Shared Care Outcomes

Project Funding Request

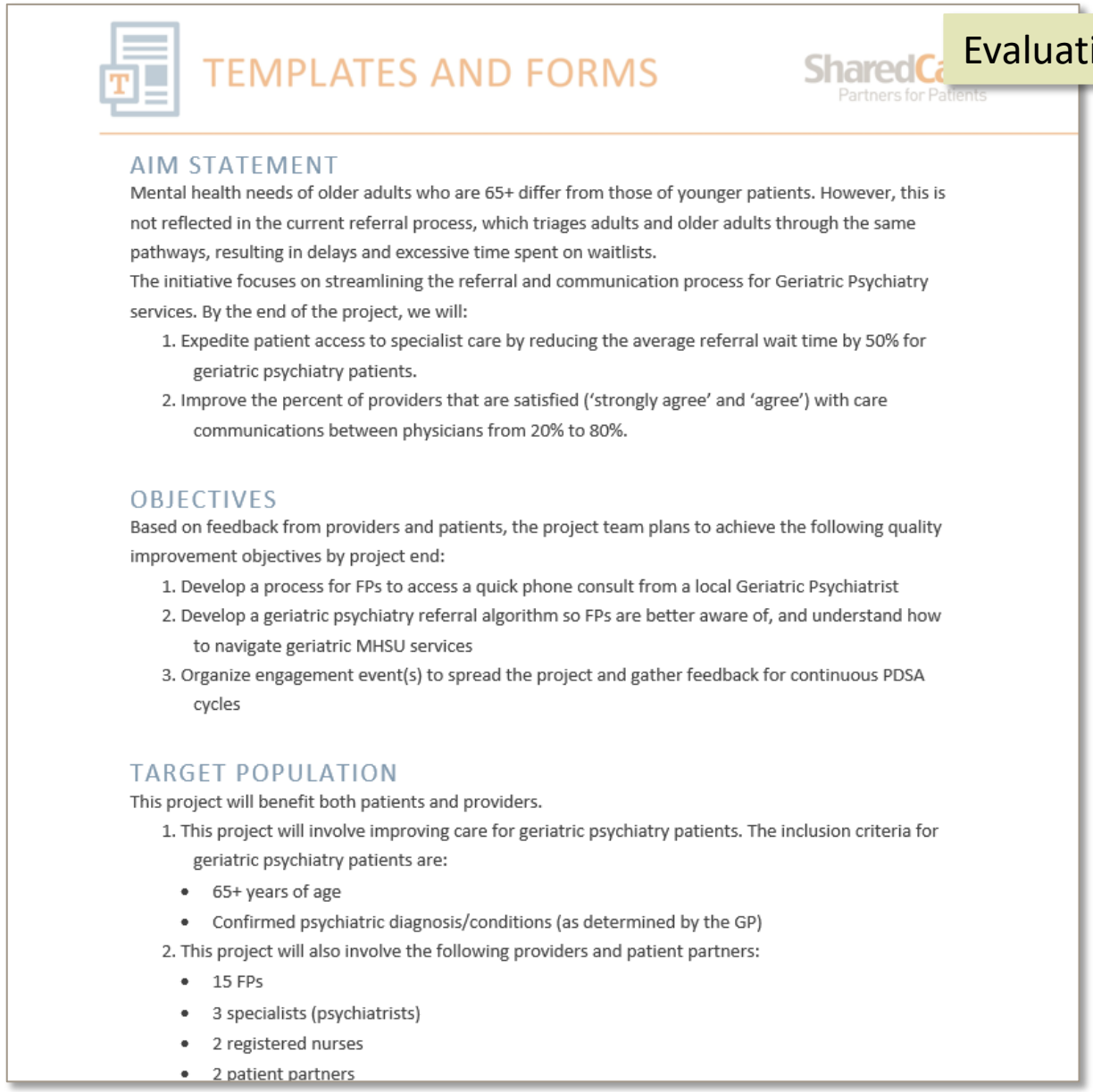
Project Funding Request (Proposal)

4. Using the boxes below, identify which outcomes will be addressed by the project (**suggestion of 3-4**). This information will assist in identifying the relevant Shared Measures for your project:

- ☐ SCC1 - Improved patient care and health outcomes
- ☐ SCC2 - Improved patient ability to self-manage care
- ☑ SCC3 - Improvements in physician and other health provider coordination, flow of care and communication
- ☐ SCC4 - Improved patient transitions between provider and care environments
- ☑ SCC5 - Improvements in GP access to specialist consultations
- ☑ SCC6 - Improve timeliness of patient access to physician care
- ☑ SCC7 - Improvements in appropriateness of GP referrals to specialist physicians
- ☐ SCC8 - Improved per capita cost of care or improved sustainability

Step 2: Integrate shared measures into evaluation plan

Evaluation Plan



TEMPLATES AND FORMS

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AIM STATEMENT

Mental health needs of older adults who are 65+ differ from those of younger patients. However, this is not reflected in the current referral process, which triages adults and older adults through the same pathways, resulting in delays and excessive time spent on waitlists.

The initiative focuses on streamlining the referral and communication process for Geriatric Psychiatry services. By the end of the project, we will:

1. Expedite patient access to specialist care by reducing the average referral wait time by 50% for geriatric psychiatry patients.
2. Improve the percent of providers that are satisfied ('strongly agree' and 'agree') with care communications between physicians from 20% to 80%.

OBJECTIVES

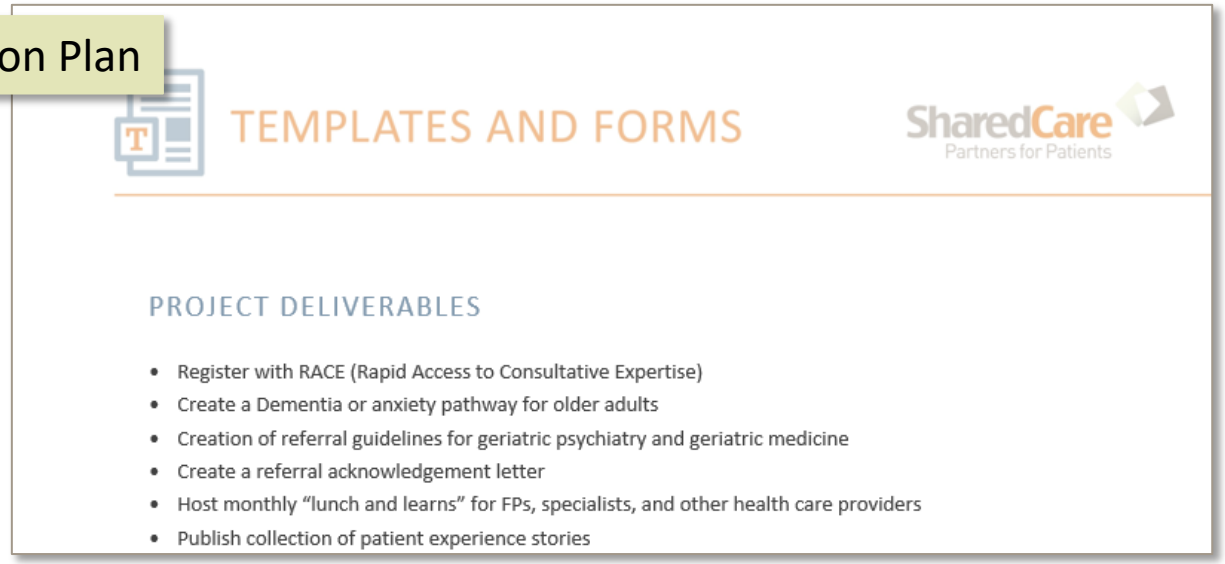
Based on feedback from providers and patients, the project team plans to achieve the following quality improvement objectives by project end:

1. Develop a process for FPs to access a quick phone consult from a local Geriatric Psychiatrist
2. Develop a geriatric psychiatry referral algorithm so FPs are better aware of, and understand how to navigate geriatric MHSU services
3. Organize engagement event(s) to spread the project and gather feedback for continuous PDSA cycles

TARGET POPULATION

This project will benefit both patients and providers.

1. This project will involve improving care for geriatric psychiatry patients. The inclusion criteria for geriatric psychiatry patients are:
   - 65+ years of age
   - Confirmed psychiatric diagnosis/conditions (as determined by the GP)
2. This project will also involve the following providers and patient partners:
   - 15 FPs
   - 3 specialists (psychiatrists)
   - 2 registered nurses
   - 2 patient partners



TEMPLATES AND FORMS

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PROJECT DELIVERABLES

- Register with RACE (Rapid Access to Consultative Expertise)
- Create a Dementia or anxiety pathway for older adults
- Creation of referral guidelines for geriatric psychiatry and geriatric medicine
- Create a referral acknowledgement letter
- Host monthly "lunch and learns" for FPs, specialists, and other health care providers
- Publish collection of patient experience stories

An Evaluation Plan also includes the Evaluation Framework:

- Evaluation questions
- Methods and approaches
- Table of measures used to monitor the outcomes (impact)

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Step 2a: Identify relevant measures corresponding with SCC outcomes of the project

Shared Measures Quick Reference Guide

SCC Outcome	Shared Measure	IHI Triple Aim: Pop. Health	Experience	Cost
SCC1 – Improved patient care and health outcomes	M0002 – Improved patient overall satisfaction		✓	
	M0016 – Improved access to physician care		✓	✓
	M0021 – Decreased average wait time for family physician to specialist physician consult		✓	✓
	M0022 – Decreased average patient wait time from family physician referral to related specialist visit		✓	✓
	M0027 – Improved family and/or caregiver overall satisfaction		✓	
	M0029 – Improved communication between providers and patients and family caregivers			
	M0030 – Improved patient and family caregiver awareness of community supports and resources			
SCC2 – Improved patient ability to self-manage care	M0002 – Improved patient overall satisfaction		✓	
	M0028 – Improved patient ability to self-manage condition		✓	✓
	M0030 – Improved patient and family caregiver awareness of community supports and resources		✓	
SCC3 – Improvements in physician and other health provider coordination, flow of care and communication	M0001 – Improved provider overall satisfaction		✓	
	M0002 – Improved patient overall satisfaction		✓	
	M0005 – Improved coordination of care between physicians		✓	
	M0006 – Improved flow of care between physicians		✓	
	M0007 – Improved care communication between physicians		✓	
	M0008 – Improved coordination of care between physicians and other health care providers		✓	
	M0009 – Improved flow of care between physicians and other health care providers		✓	
	M0010 – Improved care communication between physicians and other healthcare providers		✓	
	M0011 – Increased collegiality between family physicians and specialist physicians		✓	

Evaluation Plan

IHI Modified Triple Aim / SCC Outcome	Expected Outcome	Data Source	Measure(s)
Improved provider experience	FP improved satisfaction with access to geriatric psychiatry	• Provider satisfaction surveys • Engagement event data	**PLEASE LIST HERE THE SHARED MEASURES RELEVANT TO THESE OUTCOMES:** • Shared Measure 1 • Shared Measure 2 • Shared Measure 3
SCC3: Improvements in physician and other health provider coordination, flow of care, and communication	Increased number of geriatric psychiatrists accessed by RACE platform		
SCC5: Improvements in GP access to specialist consultations	FP improved understanding of geriatric MHSU services and tools available		**QUESTIONS / NOTES:**

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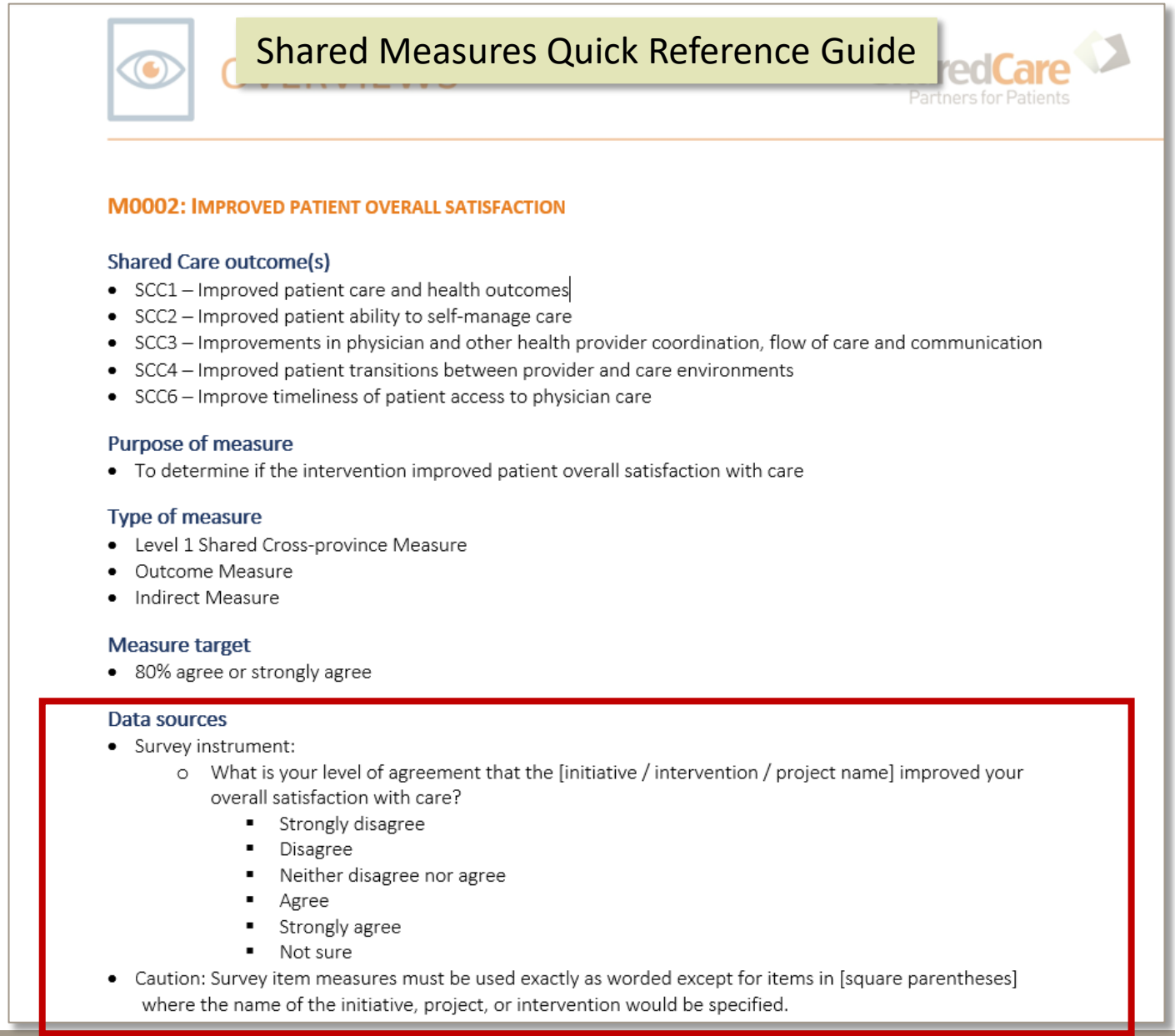
Step 2b: Identify data source & add to Evaluation Framework



Shared Measures Quick Reference Guide

M0002: IMPROVED PATIENT OVERALL SATISFACTION

Shared Care outcome(s)

- SCC1 – Improved patient care and health outcomes
- SCC2 – Improved patient ability to self-manage care
- SCC3 – Improvements in physician and other health provider coordination, flow of care and communication
- SCC4 – Improved patient transitions between provider and care environments
- SCC6 – Improve timeliness of patient access to physician care

Purpose of measure

- To determine if the intervention improved patient overall satisfaction with care

Type of measure

- Level 1 Shared Cross-province Measure
- Outcome Measure
- Indirect Measure

Measure target

- 80% agree or strongly agree

Data sources

- Survey instrument:
  - What is your level of agreement that the [initiative / intervention / project name] improved your overall satisfaction with care?
    - Strongly disagree
    - Disagree
    - Neither disagree nor agree
    - Agree
    - Strongly agree
    - Not sure
- Caution: Survey item measures must be used exactly as worded except for items in [square parentheses] where the name of the initiative, project, or intervention would be specified.

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Evaluation Plan (Worksheet)

TEMPLATES AND FORMS

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EVALUATION FRAMEWORK

IHI Modified Triple Aim / SCC Outcome	Expected Outcome	Data Source	Measure(s)
Improved patient experience of care **SCC3**: Improvements in physician and other health provider coordination, flow of care and communication **SCC6**: Improved timeliness of patient access to physician care	Improved patient/family satisfaction Improve collaboration and communication between providers	• Patient journey mapping by FPs, specialists, nurses, patients • Patient satisfaction surveys	• M0002 – Improved patient overall satisfaction • M0012 – Increased collaboration between family physicians and specialist physicians • M0010 – Improved care communication between physicians and other health care providers

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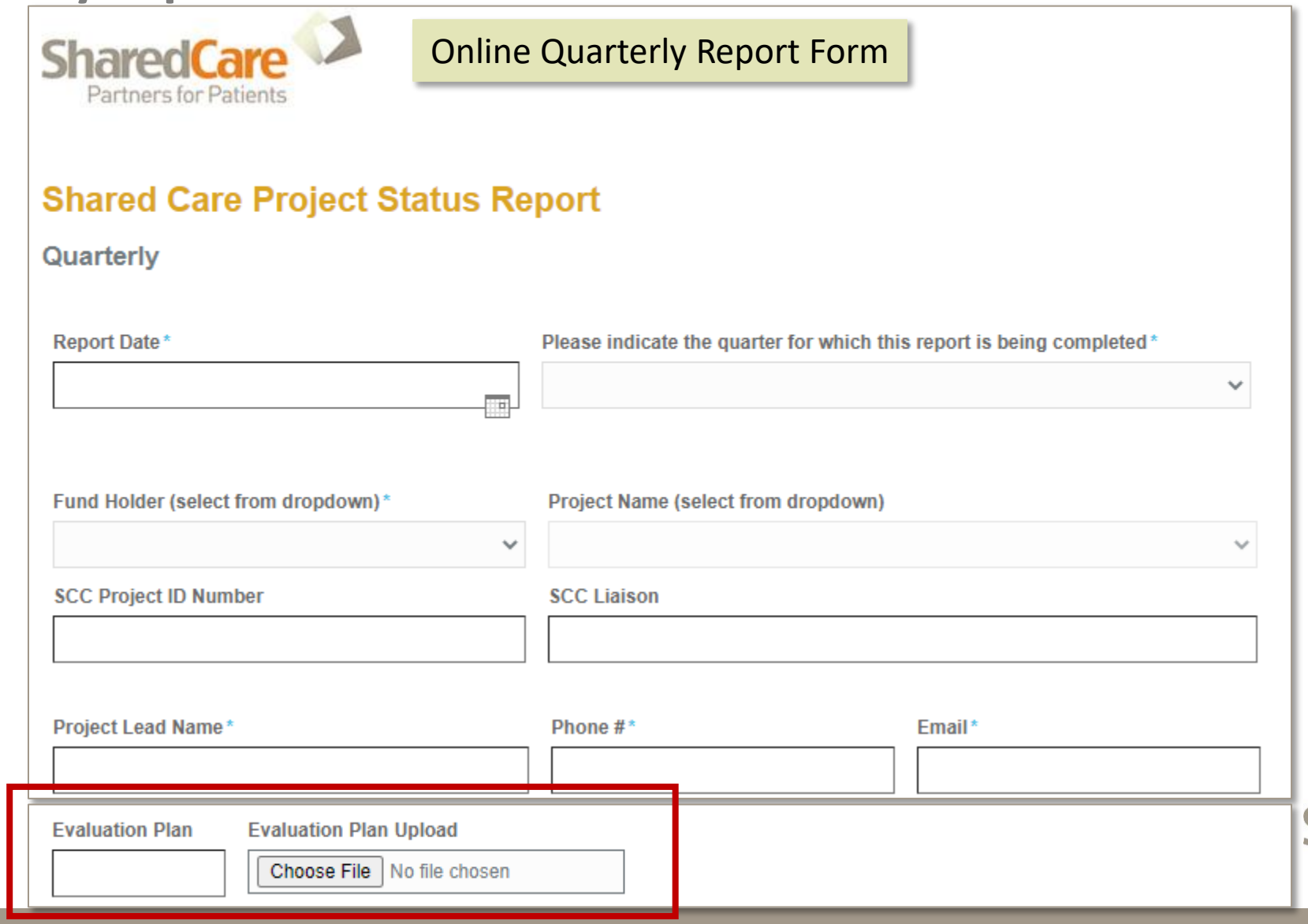
Step 2c: Submit evaluation plan to Shared Care at time of proposal or at time of quarterly report



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Selecting Shared Measures: Breakout Room Activity

Purpose:

- To go through the process of how to select shared measures that align with the project and relevant SCC Outcomes

Instructions:

- Working from the two documents in the invite (*Evaluation Plan* and *Shared Measures Quick Reference Guide*), fill out the document titled **Worksheet**
- Add the relevant shared measures that correspond with the SCC Outcomes / Expected Outcomes in the table

- 15 minutes and then report back

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Breakout Room Activity

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	M0010 – Improved care communication between physicians and other healthcare providers		✓	
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Geri-Psychiatry Case Study Worksheet

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Report Back

- Which measures did you select?
- How did the selection process go? Was it straightforward or unclear?
- Observations / questions?

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Next Steps

- Shared Measures support – how to access
- Next session on February 3rd

Session 2 Objectives:

To explain how:

1. To create data collection tool
2. To collect survey data
3. To submit survey data to Shared Care
4. To report data at the project level
5. Shared Care will report data at the provincial level

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Evaluation Poll

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Since you asked…

Q1: My project was funded in 2021 and is already underway. Do I need to implement shared measures now?

A: No. Shared Measures are required for all projects (not EOIs) funded from January 2022 onwards.

Q2: Our team usually hires an evaluation consultant to create a plan, conduct the data collection and analysis, and write a report. How will the requirement of including shared measures impact this?

A: The documents and processes provided by the SCC should be shared with the evaluation consultant, who should then be tasked with integrating them into the evaluation plan.

Q3: The types of projects that we usually do are not traditional Quality Improvement projects, nor are they formally evaluated. Are we still required to implement shared measures?

A: Yes. An evaluation plan that incorporates shared measures is a requirement for all projects. If you require assistance in how to plan and incorporate an evaluation into your project, reach out to your liaison who can connect you with the evaluation team.

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Thank You!

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