

Preparing for PIP QI

Topic: Meaningful use of data for QI

Presenter: Colin Frick

Go to training



An Australian Government Initiative

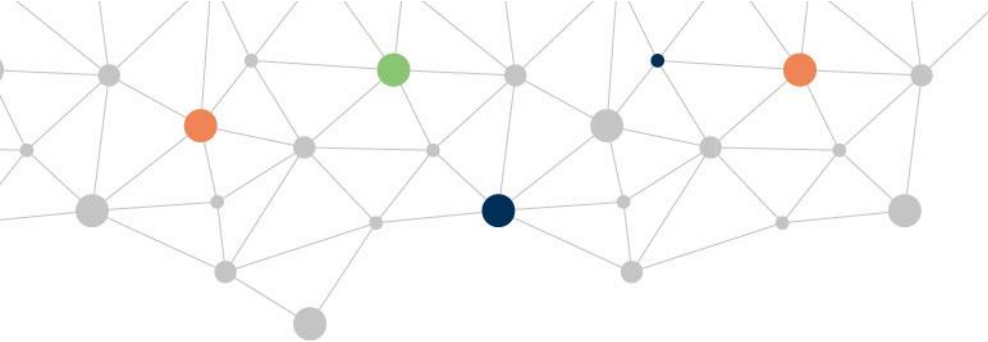
Open and hide your control panel

Join audio:

- Choose "Mic & Speakers" to use VoIP or you can
- Choose "Telephone" and dial using the information provided

Raise your hand to ask a question
or

Submit questions and comments via the Chat panel



We acknowledge the traditional custodians of the land that we work on and are meeting on today. We pay our respects to Elders past, present and emerging and extend that respect to any Aboriginal peoples that may be meeting with us here today.

Learning Objectives

1. Describe the role of data for quality improvement
2. Explain the benefits of measurement over time
3. Discuss some strategies to improve data quality

A successful quality improvement program will always incorporate the following :

QI work as systems and processes -

- Focus on patients
- Focus on team work
- **Focus on use of the data**



Data for QI

- Cornerstone of QI
- Provides motivation
- Identify if a change is leading to an improvement
- Understand unintended consequences
- Improve efficiency and reduce waste
- Improve patient safety
- Identify and spread innovations
- Supports sustainability



Benefits of measurement

- Common frame of reference; objective
- Understand patterns and trends
- Identify performance gaps, safety issues – opportunities for improvement
- Supports decision making & planning
- Allows for benchmarking



Selecting Measures

Measure

p

- **PROCESS MEASURE:** Are we doing what we must to get the improvement we seek?

O

- **OUTCOME MEASURE:** Are we getting what we expect?

b

- **BALANCING MEASURE:** Are we causing new problems in other parts of the system?

Assessing the measures

Aim to have a suite of measures covering the different types

Each measure should be:

- Reliable
- Valid
- Responsive

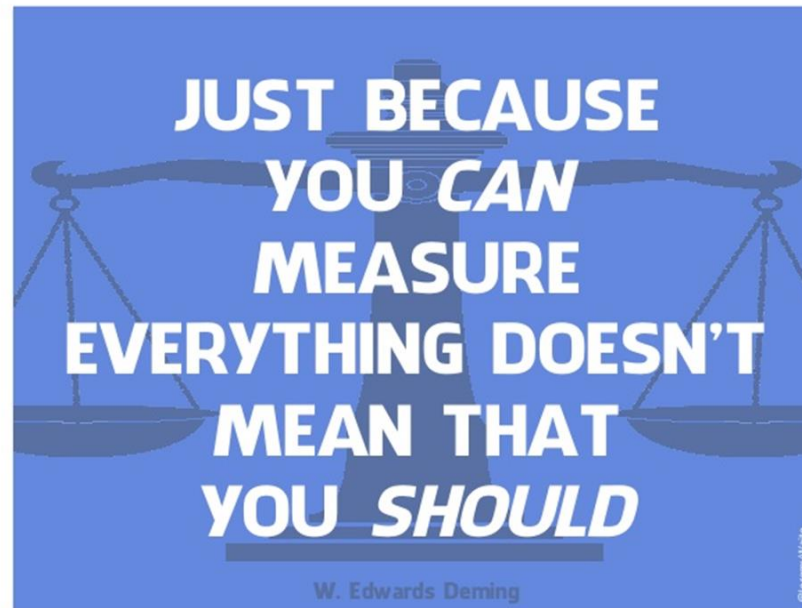


Effective measures

- Relevant to the goal
- Readily available so data can be analyzed over time
- Capture a key process or outcome



Seek usefulness, not perfection



Important considerations

Q: Is the data already being collected for another purpose?

Q: Can the data be collected easily? How?

Q: When will the measures be collected?

- Baseline
- Regularly e.g. monthly / weekly
- Pre and post changes

Q: Who will collect the measures?



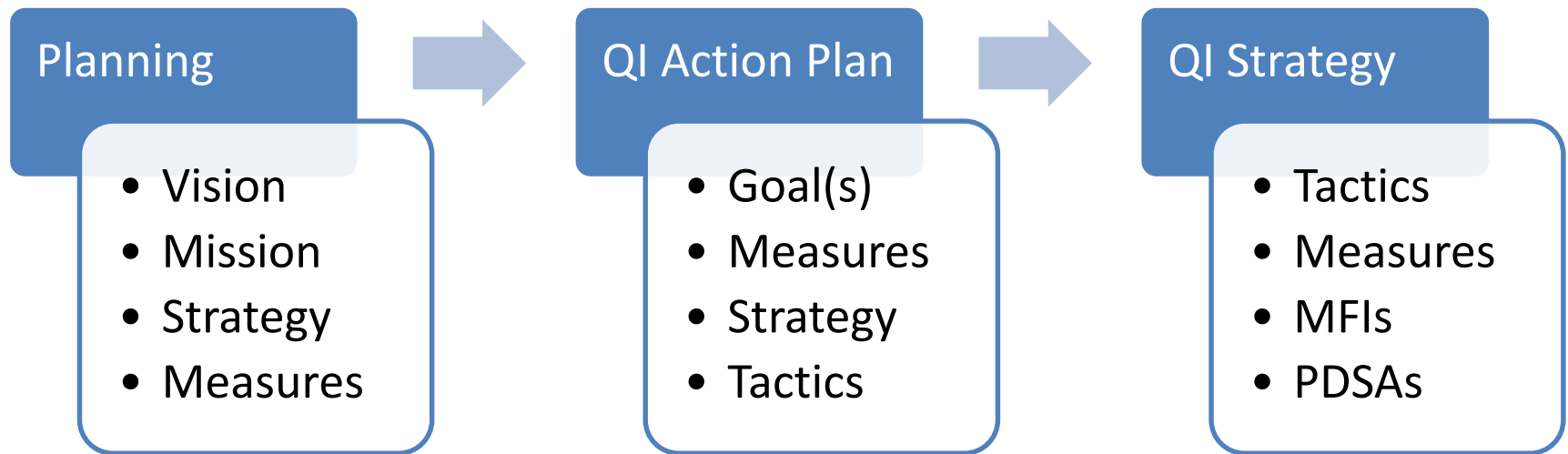
Data to improve vs data to judge

Judgement-based approaches ask:

- Who?

Learning based approaches ask:

- Why?
- How?
- What?



Approx 3 measures over the course of a year.

Strategies or tactics may be actions.
MFIs are likely to have different measurement.
Measurement will vary depending on the strategy or tactic

Annual Diabetes Measure Example

- The proportion of Active clients living with type II diabetes, whose most recent HbA1c measurement result that was recorded within the previous 12 months was categorised as less than or equal to 7%
- The proportion of Active clients with Type II diabetes who have had two HbA1c measurement result recorded within the previous 12 months
- The proportion of Active clients with Type II diabetes who have had GPMP claimed within the past 12 months or a GPMP review within the past 6 months.

Model for Improvement Example

- Goal: Within 6 weeks, 90% of all Active clients living with diabetes will have at least one HbA1c test recorded within the past year.
- Measure: The proportion of Active clients coded with diabetes who have one of more HbA1c test(s) recorded in the past year.

PDSA Example

- Plan: Next week, identify Active clients coded with diabetes and recall (SMS) 20 clients who have not had at least one HbA1c test recorded within the past year.
- Data and Measurement:
 - Number of Active clients coded with diabetes who have not had at least one HbA1c test within the past year
 - The number of these clients who respond to the SMS
 - The number of these clients who receive a HbA1c test within the next week

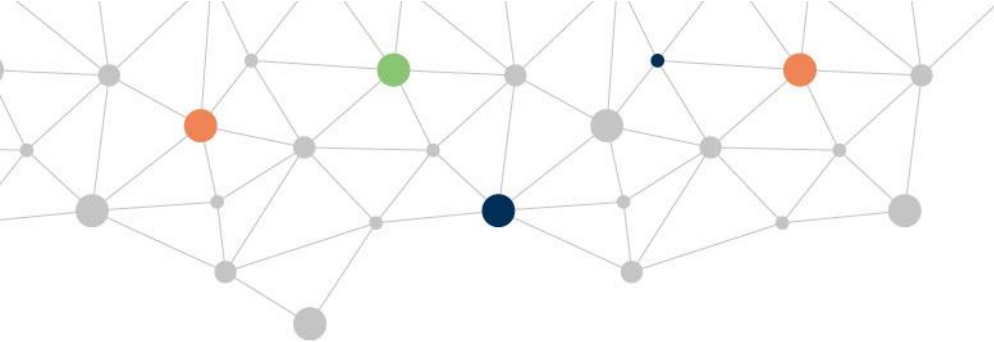
Measurement layers

- National
- Regional
- Program or initiative
- Single organisation
 - QI plan
 - Model for Improvement
 - PDSA

A network diagram in the top left corner consisting of a grid of grey nodes connected by thin grey lines. Several nodes are highlighted with colored circles: one orange, one green, one dark blue, and one red.

PIP QI Improvement Measures

1. Proportion of patients with diabetes with a current HbA1c result.
2. Proportion of patients with a smoking status.
3. Proportion of patients with a weight classification.
4. Proportion of patients aged 65 and over who were immunised against influenza.
5. Proportion of patients with diabetes who were immunised against influenza.
6. Proportion of patients with COPD who were immunised against influenza.
7. Proportion of patients with an alcohol consumption status.
8. Proportion of patients with the necessary risk factors assessed to enable CVD assessment.
9. Proportion of female patients with an up-to-date cervical screening.
10. Proportion of patients with diabetes with a blood pressure result.



Displaying and Analyzing Data

How to display data – an example

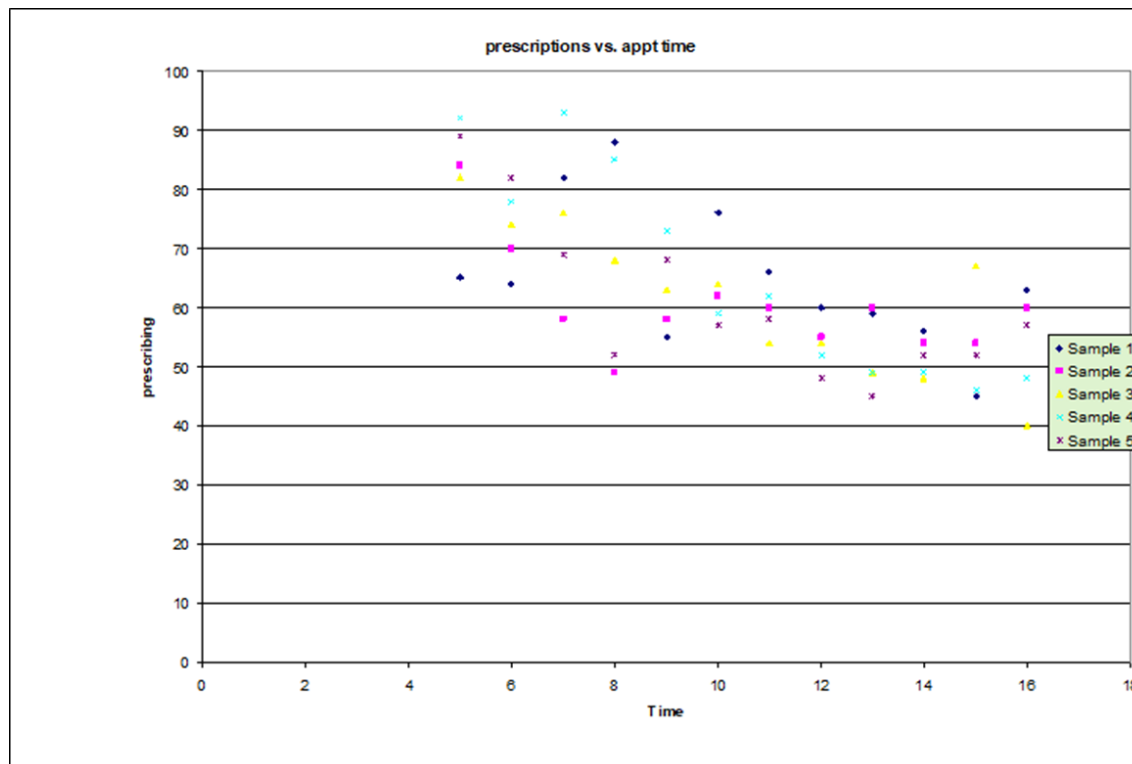
- A general practice wished to analyse whether their prescribing habits were above or below the national average.
- They decided to gather data to see how often they were prescribing medications in their consultations.
- Once they had collected the data, they had to decide how to display the data to the team.

Let's have a look.....

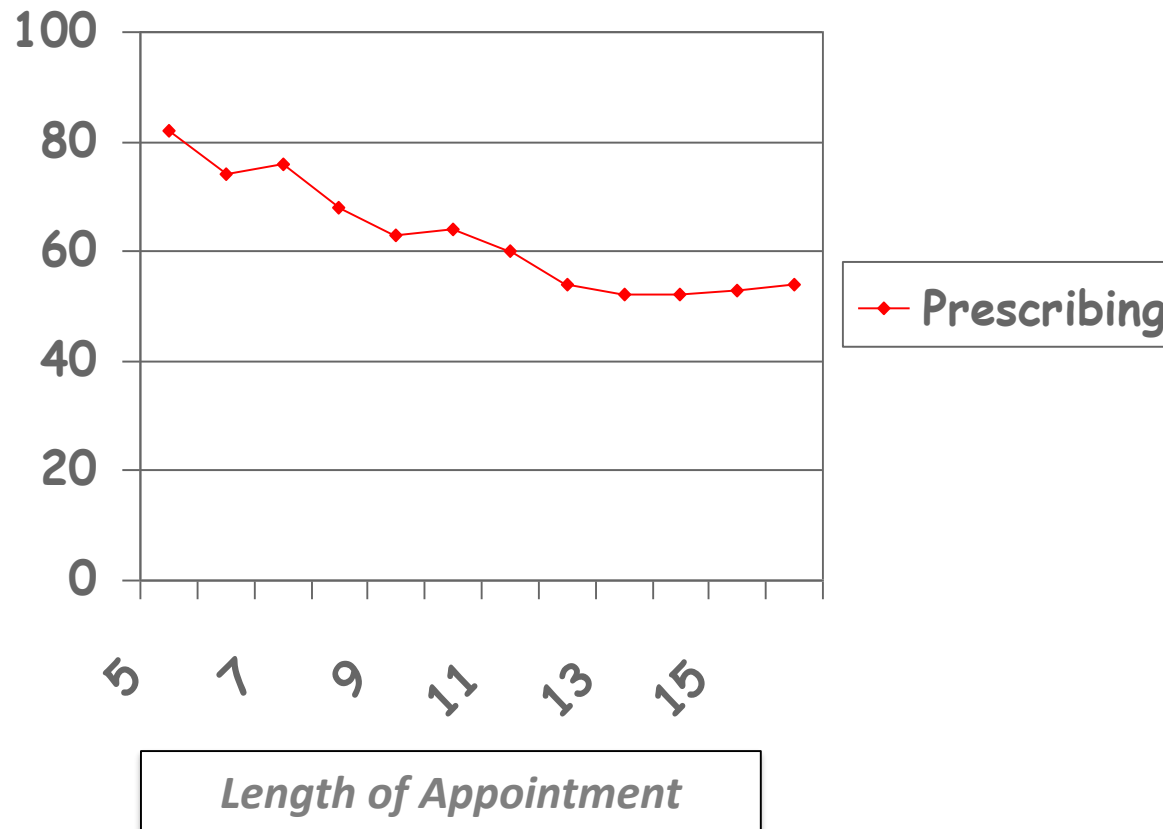
Table

| What happens to the number of prescriptions when you alter appointment times? | | | | | | | | | | | | |
|---|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Appt .time | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| Sample 1 | 65 | 64 | 82 | 88 | 55 | 76 | 66 | 60 | 59 | 56 | 45 | 63 |
| Sample 2 | 84 | 70 | 58 | 49 | 58 | 62 | 60 | 55 | 60 | 54 | 54 | 60 |
| Sample 3 | 82 | 74 | 76 | 68 | 63 | 64 | 54 | 54 | 49 | 48 | 67 | 40 |
| Sample 4 | 92 | 78 | 93 | 85 | 73 | 59 | 62 | 52 | 49 | 49 | 46 | 48 |
| Sample 5 | 89 | 82 | 69 | 52 | 68 | 57 | 58 | 48 | 45 | 52 | 52 | 57 |
| Average | 82 | 74 | 76 | 68 | 63 | 64 | 60 | 54 | 52 | 52 | 53 | 54 |

Scatter Chart

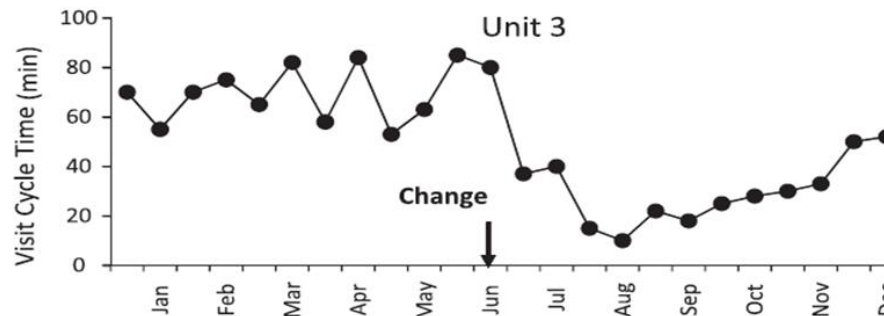
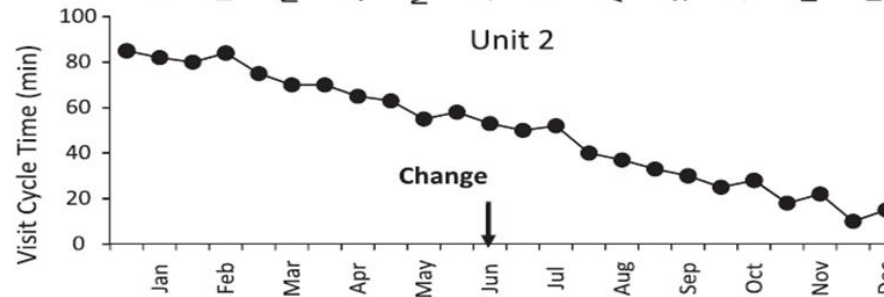
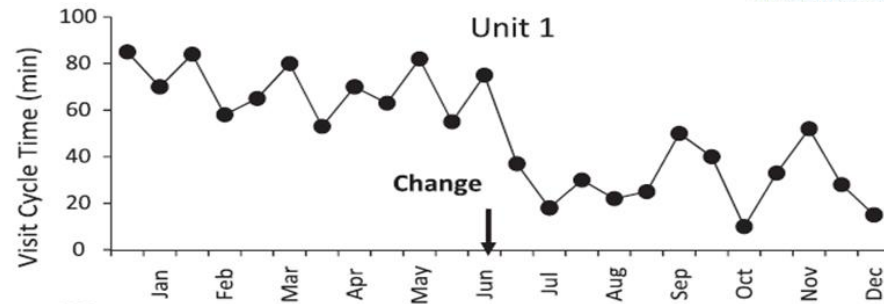
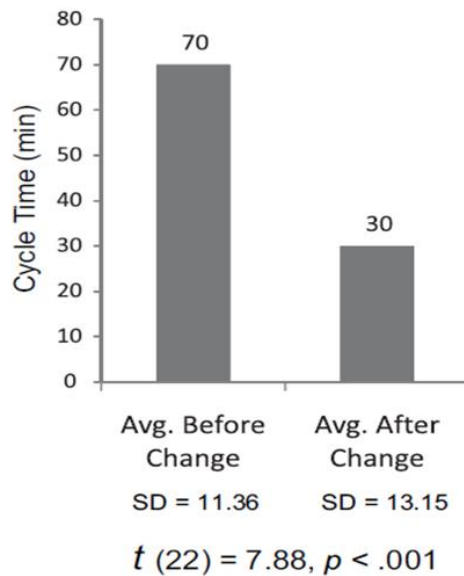


Graph



Benefits of Measurement Over Time

Cycle Time Results for Units 1, 2 and 3

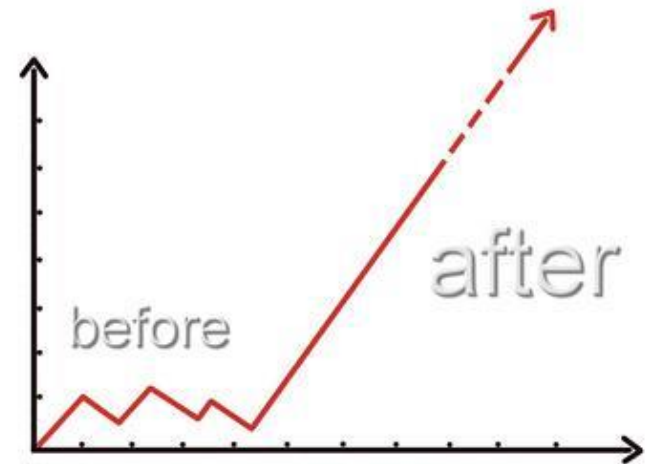


<http://qualitysafety.bmj.com/content/20/1/46>

Measuring Over Time

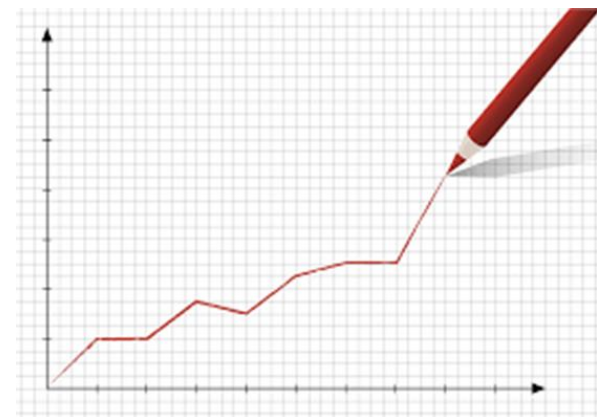
For improvement:

- Establish baseline (plan)
- Study for changes
- Assess the significance and magnitude of the change required
- Use as a guide and motivator for action
- Observe variation



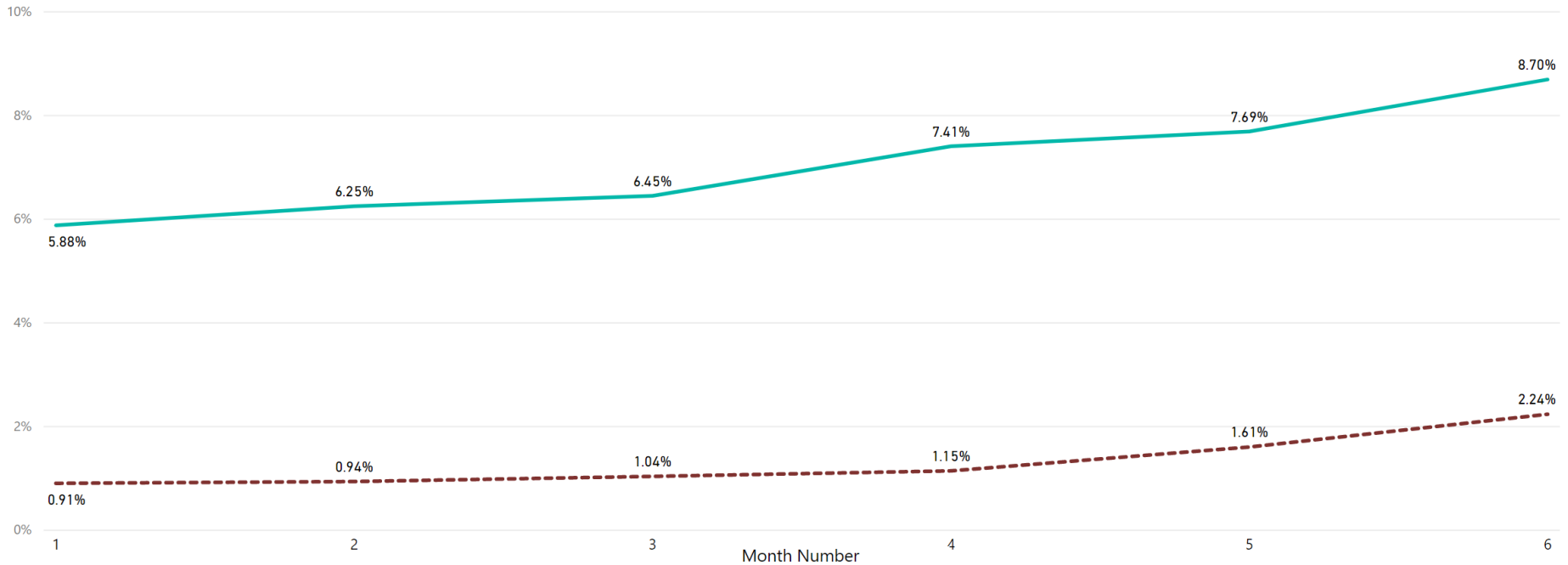
Presenting data

- Keep it simple
- One graph, one message
- Use run charts or control charts
- Charts are easier to assimilate than tables

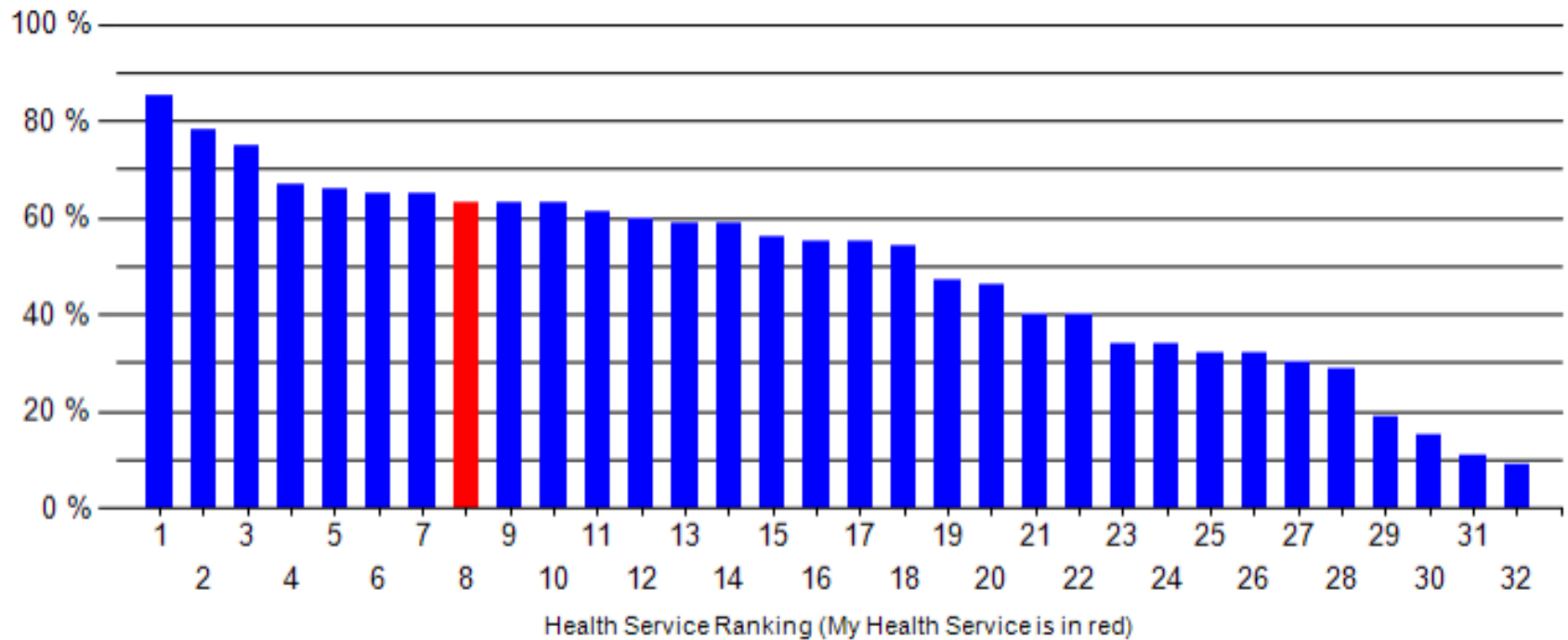


Health Assessment Quality - All Elements Completed for a Client

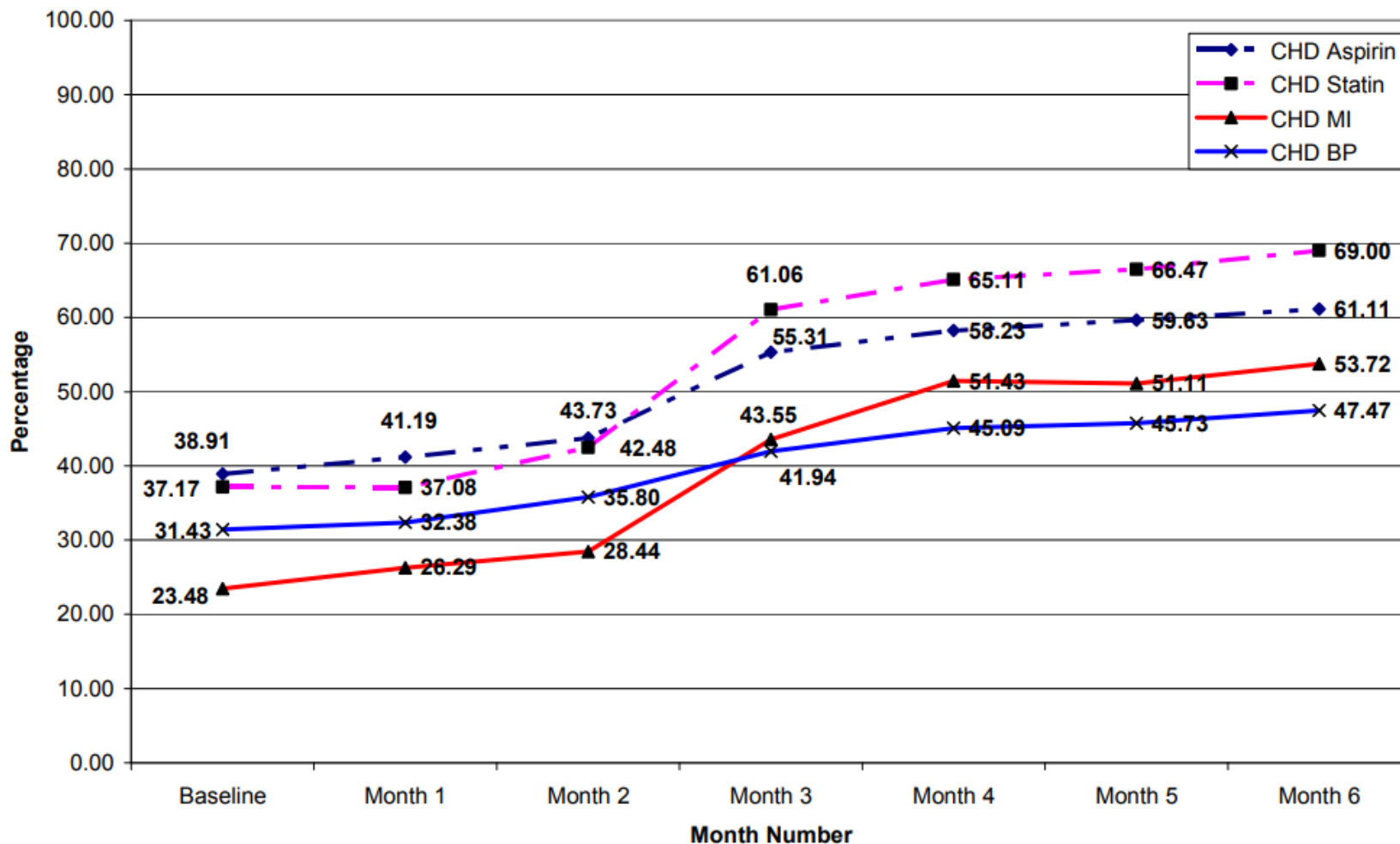
● Organisation Result ● Wave Average Result



CVD Risk factor screening - Baseline data



CHD Percentage Measures: Trend of Mean Percentage by Month Number Wave One Month Six (2005)



Comments: Continued improvement in all CHD measures between Month 5 and Month 6.

Data analysis – what are we looking for?

- To describe what is happening in the cohort
- To identify whether improvements have occurred
- To monitor improvements over time
- To identify relationships between variables
- To determine the significance of the results
- To communicate conclusions effectively



Barriers to measurement

- Lack of purpose
- Data not used
- Threatening
- Too many measures
- Manual measures
- It creates additional work



Overcoming barriers

- Focus on a few relevant measures
- Use automated processes
- Use the data you already collect
- Provide protected time
- Display data in graphs to aid understanding
- Discuss measurement with the team:
 - Purpose, goal
 - Ongoing review

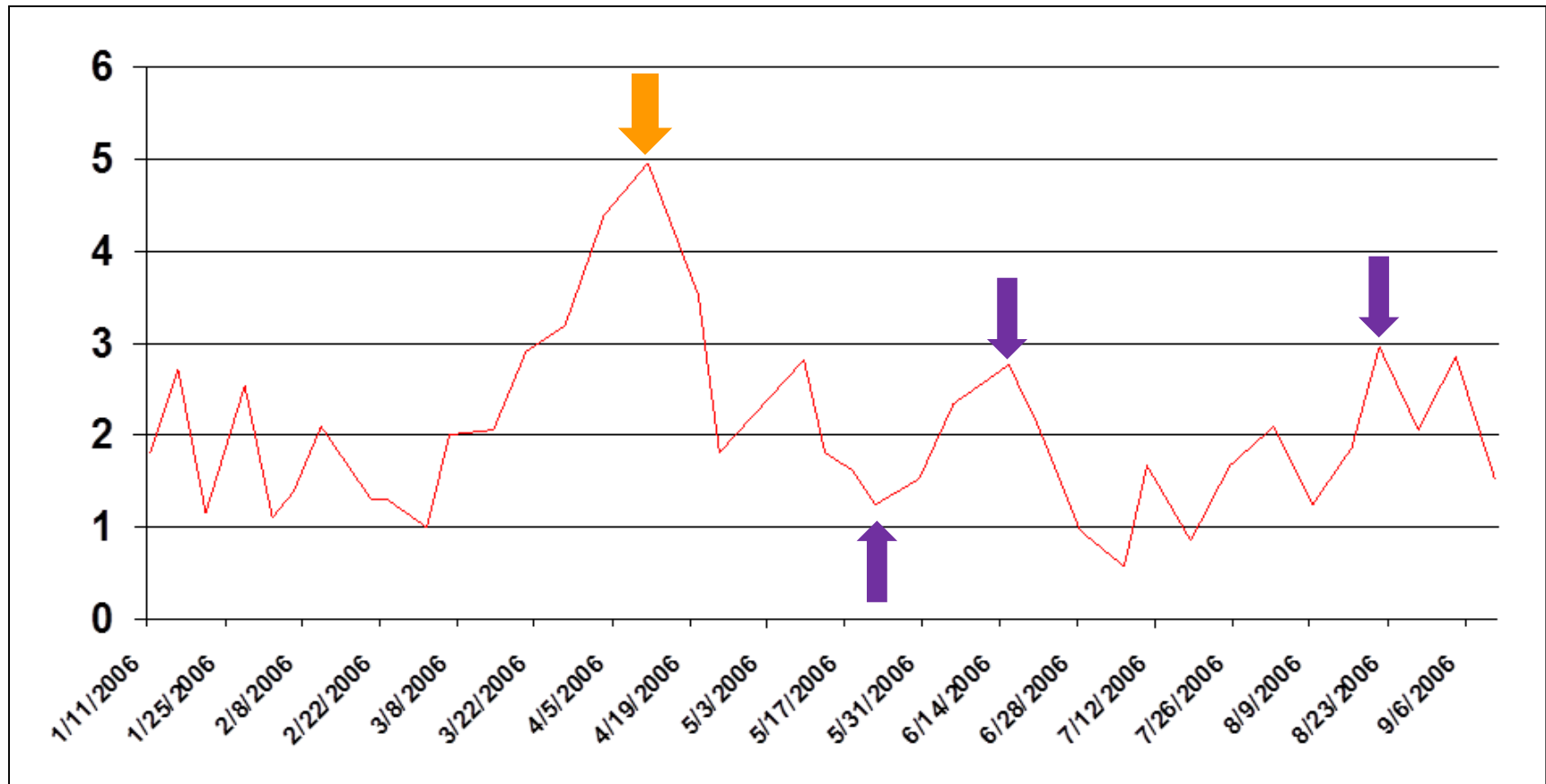


Team Engagement in Measurement

- Participating in decision making and planning
- Acknowledging improvements and celebrate small wins
- Rewarding staff
- Reinforcing improvement efforts
- Maintaining momentum and motivation
- Helps team learning and understanding



Variation



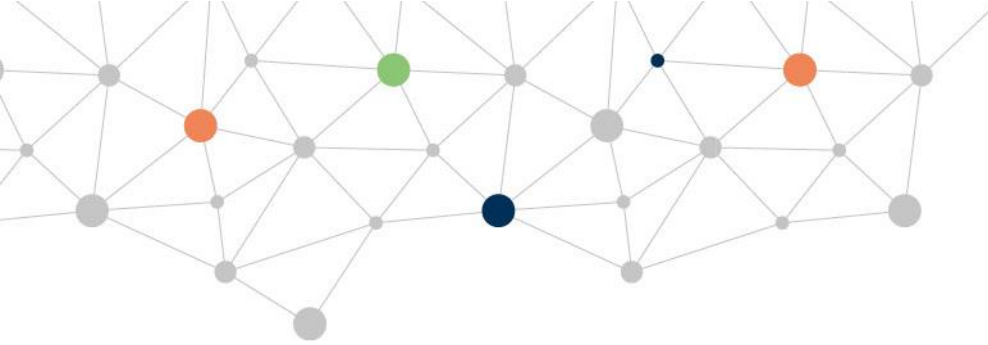
Two general types of variation

“Common Cause” or “Routine” Variation

- Inherent in a process

“Special Cause” or “Exceptional” Variation

- Something that is not part of a process



Data Quality

Data quality

- Essential for reliable and safe service delivery
- Accurate, timely, recorded correctly and complete
- RIRO
- Retrospective cleaning vs line in the sand



Improving Data Quality

Agree as a team on a data collection process that will ensure:

- System coding is used wherever possible
- Data in client records are complete, up to date and accurate
- Then implement and monitor data quality improvements

No selections applied

Selections

Double click to view list

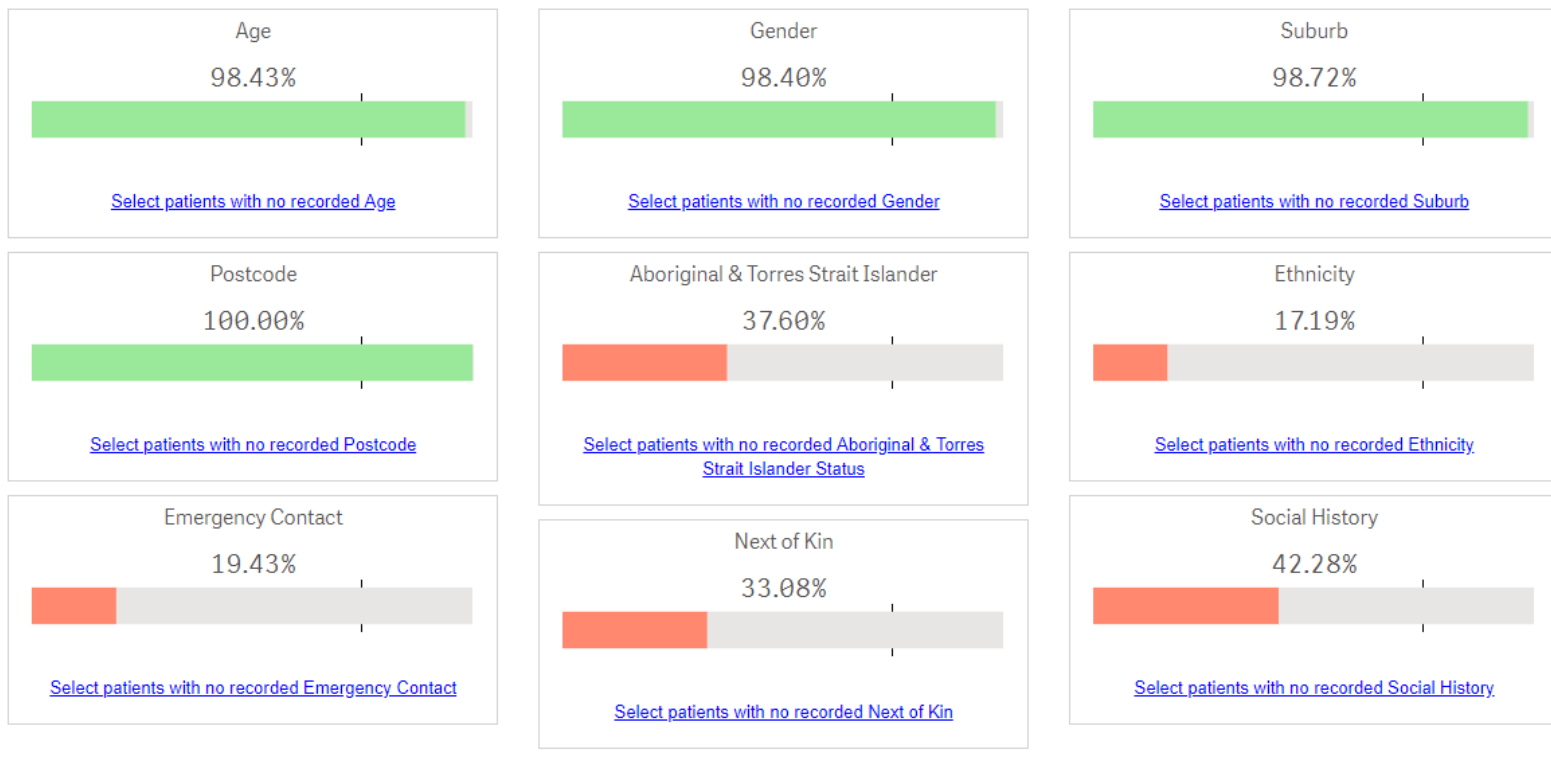
Patient Count
36,155 ^{14,468}
Active

FILTERS

- Patient ▶
- Activity ▶
- Provider ▶
- Diagnosis ▶
- Medications ▶
- Pathology ▶
- Radiology ▶
- Immunisation ▶
- Service ▶
- Cervical Screening ▶
- My Health Record ▶

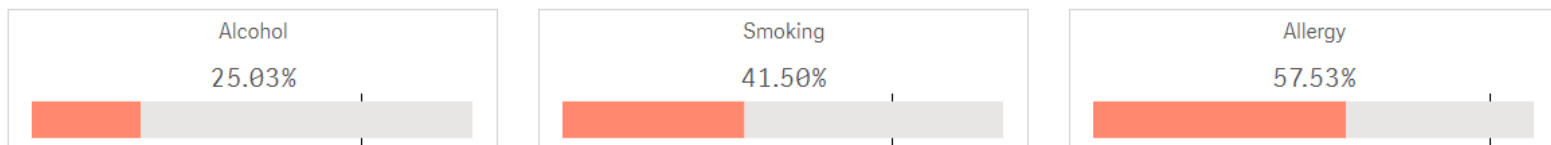
Demographics Recorded

Note on targets: RACGP Quality Standards recommend these demographic items are at a minimum of 75%.



Clinical Metrics Recorded

Note on targets: RACGP Quality Standards recommend these clinical items are at a minimum of 75%, except for Allergy, which is a minimum of 90%.



PIP-QI

Overview

| KPI_Group | KPI_Name | Patient Counts | Current Proportion | Trend |
|-----------|----------|----------------|--------------------|-------|
| Diabetes | QIM_1.1 | 31 / 64 | 48.44% | |
| | QIM_1.2 | 407 / 545 | 74.68% | |
| | QIM_1.3 | 227 / 329 | 69.00% | |
| | QIM_10 | 399 / 606 | 65.84% | |
| Smoking | QIM_2.1 | 1346 / 13382 | 10.06% | |
| | QIM_2.2 | 1914 / 13382 | 14.30% | |
| | QIM_2.3 | 4976 / 13382 | 37.18% | |
| BMI | QIM_3.1 | 1015 / 13370 | 7.59% | |
| | QIM_3.2 | 804 / 13370 | 6.01% | |
| | QIM_3.3 | 503 / 13370 | 3.76% | |
| | QIM_3.4 | 54 / 13370 | 0.40% | |
| Influenza | QIM_4 | 2343 / 3320 | 70.57% | |
| | QIM_5 | 378 / 566 | 66.78% | |
| CVD | QIM_6 | 214 / 300 | 71.33% | |
| | QIM_8 | 1582 / 6509 | 24.30% | |

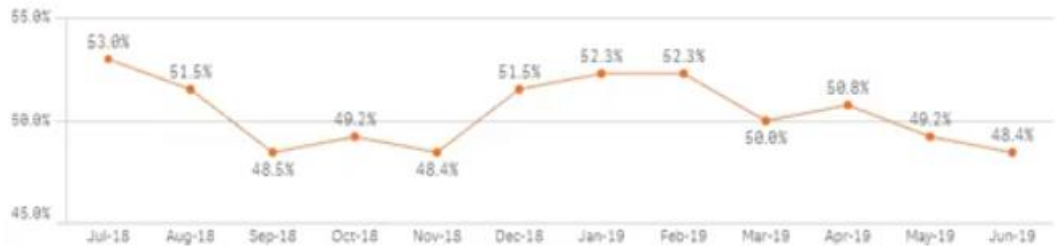
Diabetes Smoking BMI Influenza CVD Screening

QIM_1.1 - Type 1 QIM_1.2 - Type 2 QIM_1.3 - Unknown QIM_10 - BP 6/12

QIM_1.1 - Proportion of regular clients who have Type 1 diabetes and who have had a HbA1c measurement result recorded within the previous 12 months.

Use this button to select the patients that did not satisfy this Quality Improvement Measure (QIM)

Not Included



QIM_1.1
Numerator:
 RACGP active patients
 Have an ACTIVE type 1 diabetes diagnosis
 SNOMED codes: 46635009
 Have had a HbA1c recorded in the past 12 months
 LOINC codes: 17856-6, 4548-4, 59261-8

Denominator:
 RACGP active patients
 Have an ACTIVE type 1 diabetes diagnosis
 SNOMED codes: 46635009

PIP QI Report in POLAR

Please note that no practice staff will have access to the report until the check box has been selected against the practice staff member:

| PIPQI Clinic |
|-------------------------------------|
| <input checked="" type="checkbox"/> |
| <input type="checkbox"/> |

PIP-QI support material:

PIP-QI PIP QI info page -

<https://conf.outcomehealth.org.au:8443/display/CON/PIP+QI+Report+for+practices>

PIP QI mapping - <https://conf.outcomehealth.org.au:8443/display/PM/PIP+QI+report+hub>

PIP QI walkthroughs - <https://conf.outcomehealth.org.au:8443/display/CON/PIP-QI+walkthroughs>

Improvements in clinical systems

- ePrescribing
- eHealth reform
- Interoperability
- Communication
- Electronic processing

Sophisticated D

Any examples?



Summary

- Measurement is critical in quality improvement activities
- Select the right measures to support your work
- Understand that measurement will be required at various levels
- Engage your team in measurement and QI
- Display your results and monitor regularly
- Data quality – it's critical so ensure you have a team process in place

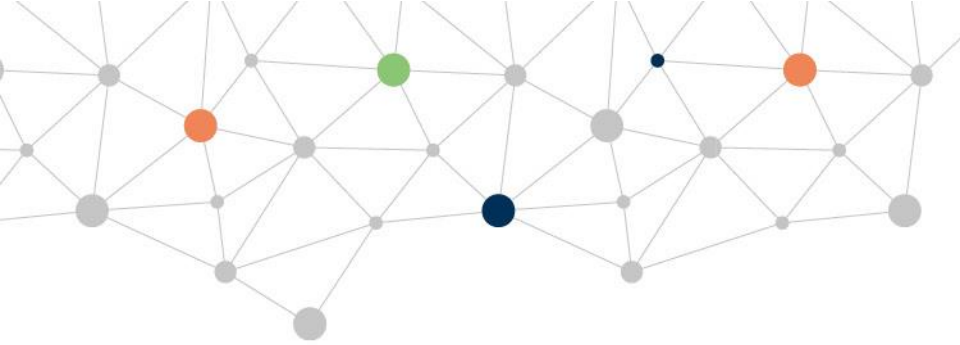
Support Resources

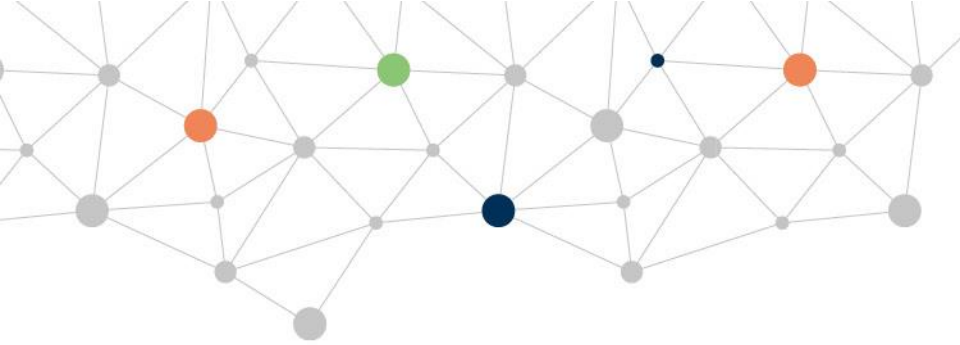
Visit <https://www.gphn.org.au/programs/practice-support/practice-incentive-program/> for:

- Most recent PIP QI information
- (Resource TBC)
- Webinar Recording
- PHN Friday Practice Support Email
- POLAR training
- For further support contact:
 - Daniel Webster, Daniel.Webster@gphn.org.au

Next Steps

- Revisit your CQI Action Plan Template and identify appropriate Measures and Change Ideas
- Next, and final, webinar is 'PIP QI Update and Team Roles & Responsibilities'
 - Wed 25 Sept, 12:30-1:30pm AEST
 - Thurs 26 Sept, 5:30-6:30pm AEST





*Thank
you*

