Help for Quality Improvement Overload

What really works in primary care from a decade of ORPRN experience

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Oregon Rural Practice-based Research Network (ORPRN)
Oregon Health & Science University (OHSU)
Today’s Outline

1. Setting the stage – Introductions & Ground Rules
2. Take home message!
3. Providing context – ORPRN, Practice Facilitation, & Quality Improvement
4. Sharing how ORPRN PFs work with clinics on QI activities
   • How has this changed over time?
   • How has this changed due to COVID-19?
5. Reflections and answering questions!
Setting the Stage

Thanks for being here today!

We will be sharing our experiences and understanding of the field.

To get the most out of this session, please:
- Use the chat box!
- Stick around for the Q&A session.
- Be open.
Take Home Message:
Core Components for Successful QI

1. Engaged Leadership
2. QI Space
3. HIT Capabilities
4. QI Processes
Oregon Rural Practice-Based Research Network (ORPRN)

Regional facilitation model for research, transformation, and technical assistance.

Statewide network of primary care clinics and partners to study healthcare delivery, improve outcomes, and reduce disparities.

Wide range of ongoing studies and projects.
ORPRN’s mission is to improve health outcomes and equity for all Oregonians through community partnered dialogue, research, coaching, and education.

https://www.ohsu.edu/oregon-rural-practice-based-research-network
ORPRN Advisory Board

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ACTION IV — Accelerating Change and Transformation in Organizations and Networks
Topic: Task orders focus on practical, applied topics of high interest to AHRQ, those on the front lines of care delivery, and the patients they serve.
Funder: Agency for Healthcare Research and Quality (AHRQ)
ORPRN Contact: LeAnn Michaels, B.A., michaelj@ohsu.edu

AHCH — Accountable Health Communities
Topic: ORPRN acts as the bridge of a consortium to screen Medicaid and Medicare beneficiaries for health-related social needs and connect them to community services.
Ft: Bruce Goldberg, M.D.
Funder: Centers for Medicaid and Medicare Services
Term: 2017-2021
ORPRN Contact: Anne King, M.B.A., kinga@ohsu.edu

ANTECEDENT — Partnerships to Enhance Alcohol Screening, Treatment, and Intervention
Goal: To increase screening, brief intervention and referral to treatment (SBIRT) and medication-assisted treatment (MAT) for unhealthy alcohol use.
Ft: Melinda Davis, Ph.D.
Funder: Agency for Healthcare Research and Quality (AHRQ)
Term: 2019-2022
Eligibility: Family medicine clinics in Oregon, Idaho, and Washington
ORPRN Contact: Melinda Davis, Ph.D., davismd@ohsu.edu

CAPTURE — COPD Assessment in Primary Care to Identify
Undiagnosed Respiratory Disease and Exacerbation Risk
Goal: To assess the ability of a 9-question screener to identify people at risk of COPD and assess the best methods to implement CAPTURE screening within primary care.
Ft: Fernando Martinez, M.D.; Mel-Lan Han, M.D.; Nancy Elder, M.D., M.S.P.H.
Funder: Joan & Sanford I. Weill Medical College of Cornell/DHHS
Term: 2017-2021
ORPRN Contact: Nancy Elder, M.D., M.S.P.H., eldern@ohsu.edu

CARAVAN — The MISSION Act’s Impact on Rural Veteran Access to and Experience of Care
Goal: A qualitative and quantitative examination of the impact of Congress’ VA MISSION Act in rural Western states, assessing views of rural veterans and non-VA primary care clinics plus VA clinics and community service organizations.
Ft: Malinda Davis, Ph.D.
Funder: Agency for Healthcare Research and Quality (AHRQ)
Term: 2019-2022
ORPRN Contact: Mary Patzel, M.R.A., patzelm@ohsu.edu

CASCADE — A Community-based Assessment of Skin Care, Allergies and Eczema
Goal: A pragmatic, community-based randomized trial to determine the effect of skin care education on the development of atopic dermatitis.
Ft: Eric Simpson, M.D.; M.C.R.; Nancy Elder, M.D., M.S.P.H.
Funder: National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
Term: 2018-2021

CPC+ — Comprehensive Primary Care Plus
Goal: To achieve Triple Aim through five comprehensive primary care functions of access, care management, comprehensiveness and coordination, patient engagement and population health.
Ft: David Dorr, M.D.
Funder: Centers for Medicaid and Medicare Services
Term: 2017-2020
ORPRN Contact: Martha Snow, M.D., snowm@ohsu.edu

EOCO Transformation Community Benefit Initiative
Reimbursements Program
Goal: ORPRN administers the TCBIP which provides funding and technical assistance to health systems, clinics, public health, social service agencies and community advisory councils aimed at improving health care and population health in Eastern Oregon.
Funder: Moda Health
ORPRN Contact: Anne King, M.B.A., kinga@ohsu.edu

INTEGRATE-D — A Pilot-test of Implementation Strategies to Support Integration of Medical and Psychosocial Care for People with Type II Diabetes
Goal: To refine and pilot test a practical, feasible and acceptable step-by-step blueprint to assist with implementation of the AHA recommendations for integrating medical and psychosocial care for patients with DMII.
Ft: Deborah Cohen, Ph.D.; Nancy Elder, M.D., M.S.P.H.
Funder: NIH National Institute of...
What does ORPRN actually do?

“Daddy works in a magical, faraway land called Academia.”
“Doing primary care research in an academic medical center is like doing forestry research in a lumber yard.”

- LJ Fagnan, ORPRN Founder
Practice-Based Research—“Blue Highways” on the NIH Roadmap

John M. Westfall, MD, MPH
James Mold, MD, MPH
Lyle Fagnan, MD

On the old highway maps of America, the main routes were red and the back roads blue. Now even the colors are changing. But in those brevities just before dawn and a little after dusk—times neither day nor night—the old roads return to the sky some of its color. Then, in truth, they carry a mysterious cast of blue, and it’s that time when the pull of the blue highway is strongest, when the open road is a beckoning, a strangeness, a place where a man can lose himself.

William Least Heat-Moon, Blue Highways

U S Route 34 drops out of the Rockies like so many spring-fed creeks. Passing through the front-range sprawl of bedroom communities and suburbs, it narrows to 2 lanes and begins its trek across the Great Plains. In its heyday it was a bustling highway with countless travelers on their way to vacation in the cool Colorado Mountains. Now it lies still, a “blue highway,” heat rising in waves of the pavement, dotted with small, dusty farming communities. A brochure for a nearby town boasts, “Just an hour from I-70.”

But do not be fooled. The communities through which it runs are active, vital centers of business and agriculture. A lot of life happens in these communities, and a lot of health care is delivered. This blue highway connects hundreds of small, vital communities to the roaring interstate system, to the academic research enterprise, to the physicians and patients in primary care offices across the United States.

Inventing a new medicine or treatment is only the starting point for improving the health of an individual patient. The magnitude and nature of the work required to translate findings from human medical research into valid and effective clinical practice, as depicted in the current NIH research pipeline diagrams, have been underestimated. Frequently, years or even decades are required for laboratory discoveries to reach clinical practice. It takes an estimated average of 17 years for only 14% of new scientific discoveries to enter day-to-day clinical practice. McGlynn et al reported that Americans only receive 50% of the recommended preventive, acute, and long-term health care. For example, just over 50% of eligible Americans have received appropriate colorectal cancer screening. While the beneficial effect of β-blockers in acute myocardial infarction was established 25 years ago, β-blockers are widely underused and there is still wide variation in their use.

Myriad detours, speed traps, roadblocks, and potholes limit the movement of treatments from bench to practice. They include the limited external validity of randomized controlled trials, the diverse nature of ambulatory primary care practice, the difference between efficacy and effectiveness, the paucity of successful collaborative efforts between academic researchers and community physicians and patients, and the failure of the academic research enterprise to address needs identified by the community.
Practice-based Research

The “blue highway” between the academic interstate of basic and clinical research and the streets where the majority of Americans live and obtain medical care.
Practice Facilitation

Who Are ORPRN Facilitators?
Why Is Their Role Important?
ORPRN’s Practice Facilitators
What is a practice facilitator?

A trained individual that:

• Provides a supportive service to a primary care practice

• Uses a range of organizational development, project management, QI, and practice improvement approaches

• Builds the internal capacity of a practice over time and supports it in reaching incremental and transformative improvement goals

The Powers of the PERC

Facilitation – bringing about change
Listening – looking for barriers and solutions behind those barriers
Framing and reframing – gaining understanding
Develop skills and create capacity – focusing on sustainability
I appreciate the nuts and bolts, how-to of the toolkit. The harder part is the practical. Who do you have do this and with what resources? Having instructions is different than having someone knowledgeable to help make the change. Toolkits can be helpful, but also intimidating...they’re different than working with a practice facilitator or other another clinic that’s done it. It’s different than having a cheerleader in the practice to actually help you make the change.”
Practice Facilitation is Effective

Primary care practices are 2.76 (95% CI, 2.18-3.43) times more likely to adopt evidence-based guidelines through practice facilitation.

*Ann Fam Med. 2012;10(1):63-74*

Tailored practice facilitation in pediatric practices significantly improved screening and counseling for obesity, screening for lead toxicity, and fluoride varnish application.

*Meropol SB. *Pediatrics. 2014;133:e1664-e1675*
Practice facilitators create a space for clinics to ask, “Why are we doing it this way?”
Quality Improvement

WHAT IT IS

HOW WE DO IT
What is QI?

Quality Improvement (QI): The “combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). QI implies that change making is an intrinsic part of everyone’s job, every day, in all parts of the system.”^29 QI efforts are often driven by specific problems in specific healthcare systems.^31,32 The knowledge systems for QI (scientific evidence, context awareness, performance measurement, plans for change, execution of planned changes) require both scientific and experiential learning.^29 Historically in QI, the outcomes of interest were changes in indicators of clinical care process or quality with more limited explorations of why or how an intervention worked.^30
How we do it:
The Model for Improvement

“Simple, yet powerful tool for accelerating improvement.” (IHI)

1. What are we trying to accomplish?
   • Articulate and set aims

2. How will we know that a change is an improvement?
   • Establish clear and relevant measures

3. What changes can we make that will result in improvement?
   • Develop and test changes
Step 1: Create an AIM

**S**pecific – Target a specific area of improvement

**M**easurable – Quantify an indicator of progress

**A**ttainable – Make sure it is achievable, assign a responsible person

**R**elevant – Will this help you achieve your vision?

**T**imebound – Specify when the result(s) will be achieved
Step 2: Use the 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
  - What changes are to be made?
  - Next cycle?

- Plan
  - Objective.
  - Questions and predictions.
  - Plan to carry out the cycle (who, what, where, when).

- Study
  - Complete the data analysis.
  - Compare data to predictions.
  - Summarize what was learned.

- Do
  - Carry out the plan.
  - Document problems and unexpected observations.
  - Begin data analysis.
Focus on Measurement

1. Outcome Measures
   • Where are we ultimately trying to go?
   • e.g., Losing 10 pounds

2. Process Measures
   • Are we improving our processes? (to get to our outcome?)
   • e.g., Reviewing number of calories consumed

3. Balancing Measures
   • Are the changes we are making in one aspect of the process causing impacts on another?
   • e.g., Mood changes given you are eating less
Tools Used During the Process

Cause & Effect

MEAL
- Breakfast
- Lunch
- Dinner
- Snacks

CONTROL
- Interval between Shopping
- Food In House
- Who Shops
- Boyfriend
- Me

Irregular Schedule
- Boyfriend
- Me

Stress Level
- Exercise Routine
- Energy Level

Work
- School

Volunteer
- House
- Gym

DESIRE
- Eating Schedule
- Mood

EATING VEGETABLES & FRUIT DAILY
- FAMILY

O’Connor
- Early & accurate identification of AKI
- Effective intervention
- Effective monitoring and handover
- Staff & patient engagement

AUR/1000

Run Chart of antibiotic usage rates (AUR) n=523

Goal
- Median
- Web 1
- Web 2
- Web 3
- PDSA 3
- PDSA 4
- PDSA 5
- New Staff
- Training

PDSA 3
- PDSA 4
- PDSA 5
- New Staff
- Training

ABM
- PRIMARY DRIVERS
- SECONDARY DRIVERS

- Identifying patients at risk
- e-alert automated diagnosis prompt
- Accurate coding
- Straightforward care AKI bundle
- Timely nephrology input
- Identification & treatment of cause
- Daily U&E with tracking results
- Streamlined handover process
- Medication/Pharmacy alert
- Staff awareness of AKI
- Patient & Family empowerment
ORPRRN Projects

3 RECENT PROJECTS WITH QI INTERVENTIONS
Healthy Hearts Northwest (H2N)

**Objective:** To study strategies to build QI capacity with a focus on improving cardiovascular health of individual patients and populations
  - Aligned with CCO metrics for tobacco cessation and hypertension

**Intervention:** Practice facilitation, academic detailing, and learning collaboratives

**Population:** 250 primary care clinics in the Pacific NW

**Timeline:** 2015-2018

**Funder:** AHRQ
Rural Adolescent Vaccine Enterprise (RAVE)

- **Objective**: To test novel interventions for increasing HPV vaccination completion in both males and females aged 11-17 years
  - Aligned with CCO incentive metrics for adolescent vaccinations

- **Intervention**: Observation, practice facilitation, community partnership

- **Population**: 45 primary care clinics in Oregon

- **Timeline**: 2018-2023

- **Funder**: ACS
ANTECEDENT

**Objective:** To improve screening, brief intervention, and medication assisted treatment for unhealthy alcohol use

- Aligned with CCO SBIRT quality incentive metric

**Intervention:** Practice Facilitation

- Foundational Support
- Supplemental Support

**Population:** 150 primary care clinics and regional CCOs

**Timeline:** 2019-2022

**Funder:** AHRQ

*PartNerships To Enhance aLcohol scrEening, treatment, and intErveNTion*
Lessons Learned

WHAT HAVE WE DISCOVERED FROM THIS WORK?
Healthy Hearts Northwest

“EvidenceNOW offers free assistance, but making use of the assistance requires unpaid labor from physicians and staff. Unlike payers such as Medicare and health insurance companies, AHRQ cannot provide funding to practices to support their quality improvement efforts. Small primary care practices have no organizational slack to put unpaid effort into activities that are not likely to have an immediate payoff. An offer to give free swimming lessons to a drowning person – no matter how well-intentioned – may not be enthusiastically received. Just get me out of the water!”

Traditional QI Approaches

1. Prescriptive to programmatic goals
2. Linear assumptions
3. \(X \rightarrow Y\)
4. May miss complexities/interrelations
Core Components for QI

1. Engaged Leadership
2. QI Space
3. HIT Capabilities
4. QI Processes
The Quality Improvement Engine

Clinic and health outcomes

Engaged Leadership
- Admin support/resources
- Clinical champion
- Staff empowerment

QI Space
- Multi-level staff engagement
- Regular meetings
- Culture of curiosity

QI Processes
- PDSAs
- Iterative learning
- Excitement in change

HIT Capabilities
- Actionable data
- Understanding of metrics
What is QI?

**Quality Improvement (QI):** The “combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)….QI implies that change making is an intrinsic part of everyone’s job, every day, in all parts of the system.”

QI efforts are often driven by specific problems in specific healthcare systems. The knowledge systems for QI (scientific evidence, context awareness, performance measurement, plans for change, execution of planned changes) require both scientific and experiential learning. Historically in QI, the outcomes of interest were changes in indicators of clinical care process or quality with more limited explorations of why or how an intervention worked.
Case Study

RAVE PROJECT EXAMPLE: PLAN + COVID-19 ADAPTATIONS
What works for facilitating quality improvement?
The PERC perspective
QI SPACE+QI PROCESS GEARS

Strengthen Relationships
Remain Flexible
Get Creative
Leverage time
RAVE: The Plan

Monthly 60 minute meeting

Weekly huddles

Increase practice QI capacity

PDSA project work with increased adolescent HPV immunization goal

Forging community connections to partner in HPV marketing

Parent survey June 2020
RAVE: The Covid-19 Reality

Shorter check-ins, less than monthly

Diminished community partnerships, especially with schools

Less QI emphasis overall

Need to know/resources for
  ◦ Immunization rates
  ◦ Best practices in a pandemic, workflows, physical layout
  ◦ Implementing telemedicine

More support
  ◦ MOC IV deadline
  ◦ Review of student work

PDSA cycles not a priority
PDSA Example:
Patient Recalls for 2\textsuperscript{nd} or 3\textsuperscript{rd} dose

HPV series with 1 or 2 boosters

Recall systems are a challenge

Recall that relies on one part of the office (i.e. front desk)

Abandoned: Half the front desk are at home helping kids distance learn. Parked in a parking lot for later more normal times.

Adapted: Use other tools in place via EHR to set automatic recall, this system does not rely on the understaffed front desk.
• Incorporate more flexibility
• Virtual platforms for meetings
• Reconsider timelines
• Support beyond the project topic
  - COVID-19 workflows
• Sticking to routines whenever
Average Facilitation Times by Month 2020

Figure 1: Average practice facilitation time per RAVE clinic in January 2020 through May 2020.
Wrap-up

OUR TAKE HOME MESSAGE

REFLECTION QUESTIONS

THANK YOU
Take Home Message:
Core Components for Successful QI

1. Engaged Leadership
2. QI Space
3. HIT Capabilities
4. QI Processes
Reflective Questions

• Do you do QI?
  o How do you do QI? Who does it in your setting?
  o Do you get external QI support?
  o Has your process/have your procedures changed over time?

• What do you think are the most important elements for successful QI? Why?

• Have you seen changes in your processes/structure since the onset of Covid-19?
Thank you!

For more information about ORPRN, please contact: ORPRN@OHSU.EDU
https://www.ohsu.edu/oregon-rural-practice-based-research-network

For more information about this presentation, please contact: CONWAY@OHSU.EDU SUMMERCA@OHSU.EDU
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• Questions for us?