

Learning Session One

23 May 2017

Whakakotahi

Primary care quality improvement challenge 2017

Find out more at www.hqsc.govt.nz

Who We Are . . .

Pauline

Kim

John
K.

Jennell

Marty

Sally

Sue C.

Michelle

Leanne T

Sandy

Valerie

Rachel

Jane

Megan

Kerryanne

Nita

Muriel

Annie

Leanne

Sue W.

John W.

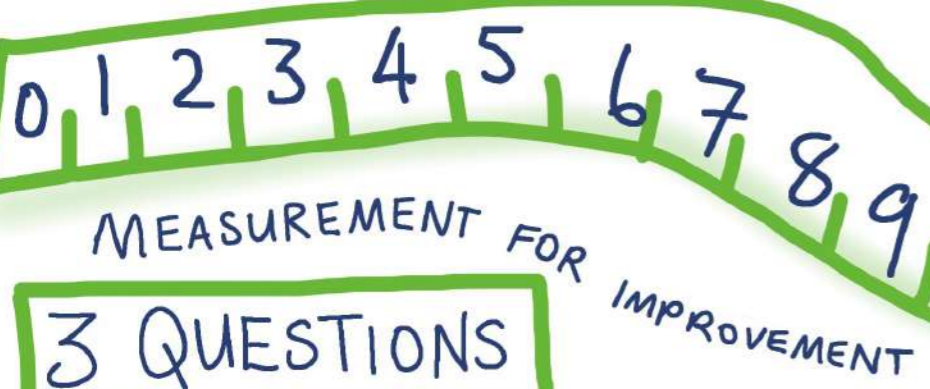
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SUE WELLS

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P R I M A R Y
H E A L T H
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ANALYSING IMPROVEMENT DATA



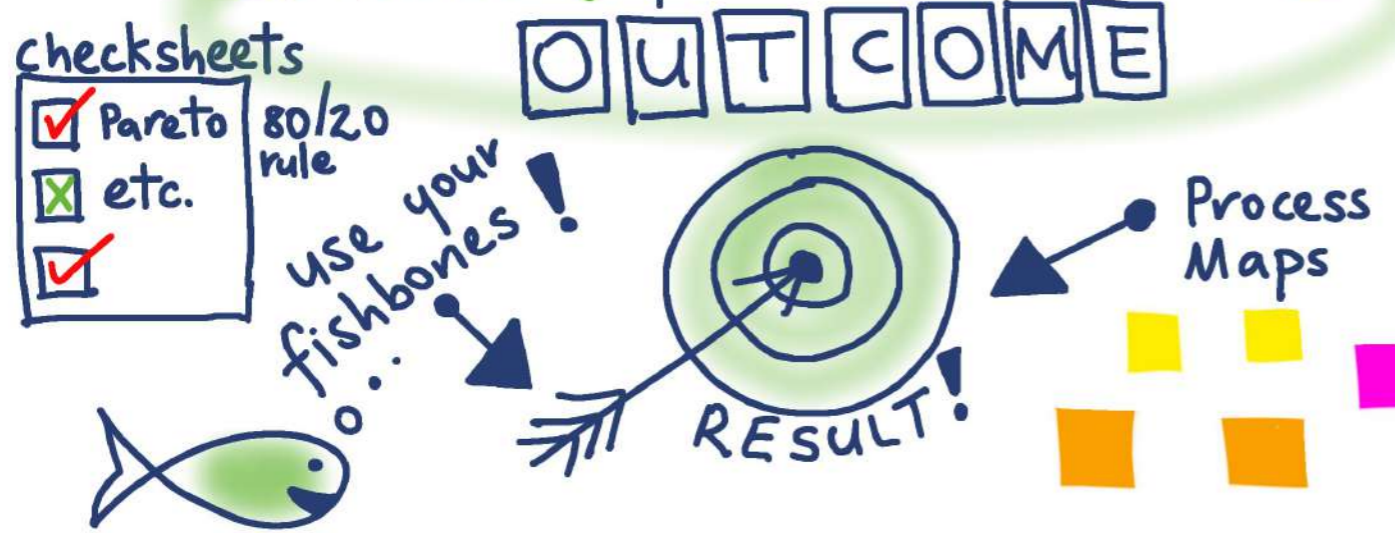
WHAT MEASURES WILL BE USED?

3 QUESTIONS

- 1 What do we want to accomplish?
- 2 How will we know that the changes we make = improvement?
- 3 What change can we make that = improvement?

- Process
- Outcomes
- Balancing measures

structure + process + culture =



KEEP CALM AND GATHER DATA

FACTS put us all on the same page

ANALYSING Q.I. DATA

= RUN CHARTS =

Y

The X axis always time
The Y axis is the description of whatever you are measuring

FIRST

Count the number of useful observations made (ignore those that fall on the median) and the number of runs (data points on the same side as the median)

THEN

Apply the Run Rules

- ① Shift in the process
- ② Trend
- ③ Too many, or too few runs
- ④ Astronomical point (way off scale)

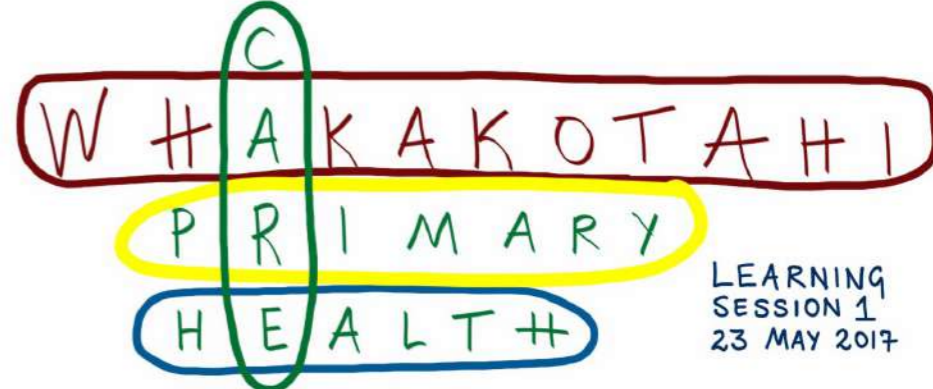
Analyse + Report on the IMPACT of the changes

X

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ANALYSING Q.I. DATA

HOW?

- Blocks - consec.
- Random
- Systemic or Purposive (every eg. 10th patient)

VARIATION ↑

- we all vary
- Special or (unusual, out of control etc.)
Common cause (usual, random inherent)

eg. a snowflake is

common



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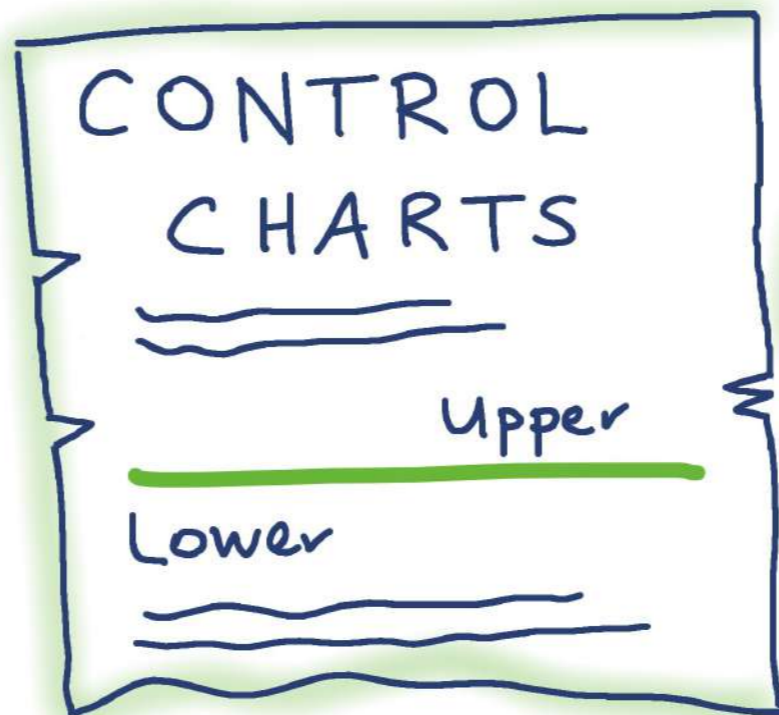
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ANALYSING Q.I. DATA

- rules different
- choice of chart depends on which data you've got (Jane C. will help)

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Like Run Charts
on steroids!

Key Points

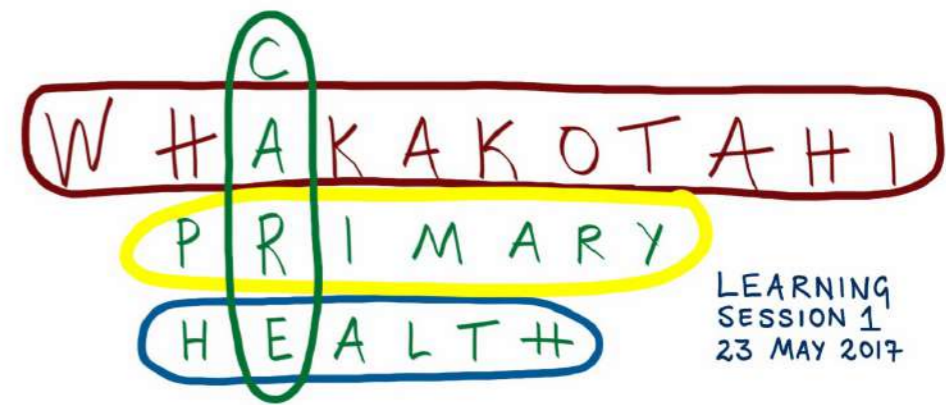


- Q.I. not accountability
learning not judging
- Be aware of measurement limitations
- Balanced set - process / outcome /
balancing measures
- Report regularly
- link measures to your aim
- Focus on vital few

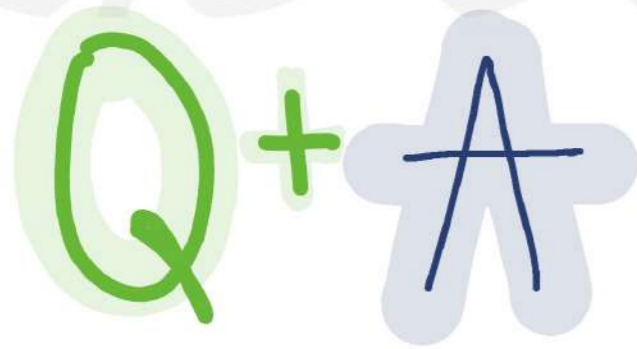
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Fishbone diagram?

What are the possible changes you can put in for each identified barrier?

The 80/20 Pareto rule helps here + the fishbone helps to prioritise



K.I.S.S. 
Complexity should lead us to simplicity eg. $E=MC^2$

"All improvement is change, but not all change is improvement"
Don Berwick, IHI.



EQUITY

SUE CRENGLE

Associate Professor

WHO Definition...

- Remedying differences between people
- more than inequality
- breaches of our human rights

What is equity

how to assess

Doing it Well

Boston Public Health

Commission

definition is **GOOD**

fair opportunities
= equity

unfair - avoidable - unjust
= inequities

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This definition is ok, but have a look at:
bphc.org

check it out
Not always just up to health services - others involved, eg. housing, welfare etc.

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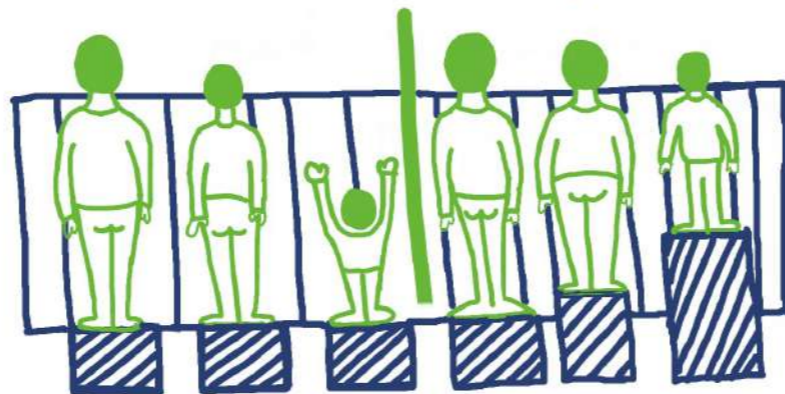
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EQUITY

SUE CRENGLE

Assoc. Professor



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we need the boxes to be appropriate - so we can all see what's over the fence

Equity is not the same as equal

DATA

must be high quality
care over ethnicity data

Gold standard is Census (self reported)

- assess early
- use DATA
- keep eyes open for unintended consequences (e.g. SIDs did not work for Māori)

mortality set OK, but beware of some others as misclassified

numerator - denominator

make it from same dataset

Impact of misclass. = Māori could be under-represented +/or over-represented

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- ③ Ethnicity classificⁿ -
eg. re-registration changes → 8.5%!
from Sue's practice 173/2023 misclassified as Non-Māori. Trained all admin staff on better data collection methodology.
- ③ Careful with stats if re-registering + re-classifying. Too few = can miss vital statistical data. There is approx. 8-9% error rate in private practice
- ③ Inequities + class. errors can also occur across other ethnicities, so beware
- ③ Link-tech can create errors -
↓
Med-tech they drop 2nd + 3rd options off
- ③ Good to run ethnicity checks + teach admin staff

- ③ Think about age structures
60% Euro's have X
50% Māori have X
make sure denominator is relevant - choose well so it's appropriate to your patient cohort. Look for complete + high quality datasets.

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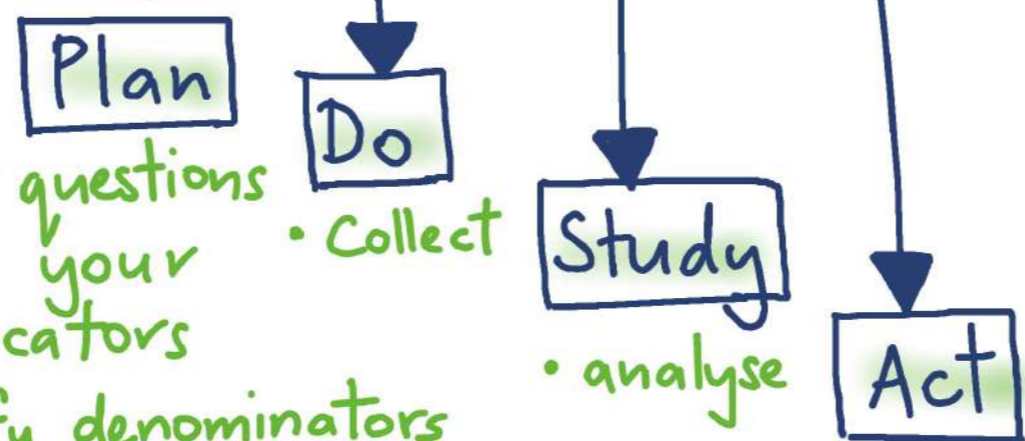
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P D S A



- What questions
- choose your indicators
- Identify denominators
- Collect
- analyse
- decide Actions

Let's remove fences so we can all see that even playing field!

See IMC Māori Health = Plan =

- ⊙ Concrete Indicators
- ⊙ 😊 news — 😞 news
eg. • Immunisations • cardio

no diffs in no. of consults for Māori says utilisation rate by age group for 12 months

Māori patients scored 2mins less per consult



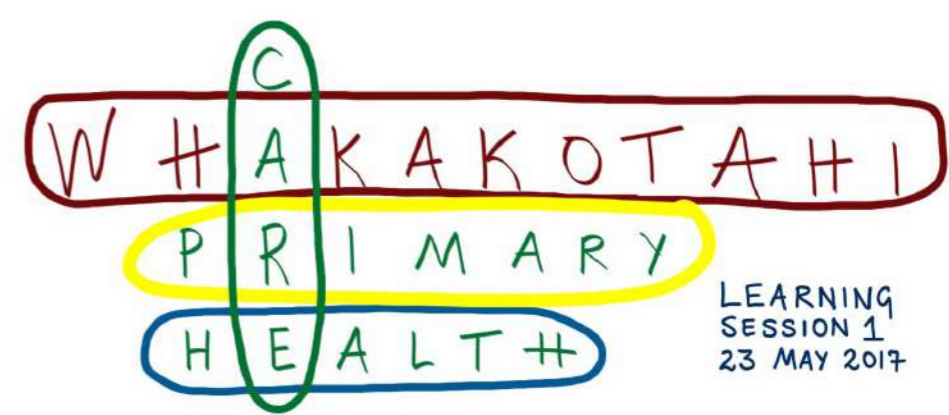
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SUE
CRENGLE
Assoc. Professor



Training
for staff
+ repeat

Audit Tool
(Mott www)

Check
Māori in
Ethnicity₂
+ Ethnicity₃
fields



Prioritisation → Māori, Pacific, etc.
See Mott ethnicity protocols

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Hutt Union + Community Health Service

HUTT UNION & COMMUNITY HEALTH SERVICE

DIABETES IMPROVEMENT PROJECT

May 2017

Problem Analysis

- Hutt Union & Community Health Service has 5000 patients with diabetes. Almost 50% of patients have an HbA1c greater than 65mmol/mol, which indicates poor glycaemic control.
- The target HbA1c level for people with diabetes is between 50-55mmol/mol.
- Evidence shows that for every 10mmol/mol reduction in HbA1c there is a 25% decrease in diabetes related death and significant decreases in other complications.

Our aim is to reduce the average HbA1c by 10% in HUCHS patients with diabetes who have an HbA1c >64mmol/mol by 31 December 2017

Theory of Change

Diagram showing the flow from 'Problem Analysis' to 'Measures' and 'Outcomes'.

Measures

Description	Measure	Current Performance	Target Performance	
Outcome Measure	Reduce Average HbA1c in patients with HbA1c more than 64mmol/mol	Reduce by 20% by 31 December 2017	62mmol/mol	71.8mmol/mol
Process Measure	Increase percentage of diabetes annual reviews in the population (currently 53% patients with diabetes)	Percentage of diabetes annual reviews completed	52%	75%
Balance Measure	Number of annual appointments	Time spent on the project	100000	100000

Process Mapping – New diagnosis of diabetes

Flowchart showing the process from patient identification to care plan development.

Process Mapping – HbA1c above 64mmol/mol

Flowchart showing the process from patient identification to care plan development.

Successes and Challenges

Successes:

- 5.3mmol/mol reduction in average HbA1c
- 24% increase in number of Diabetes Annual Reviews completed
- 97 patients reduced their HbA1c

Challenges:

- Time/Staff/Time for patient consultations, planning, follow up, project planning, leadership, quality improvement activities
- Patient non-engagement
- Discontinuing PDSA cycles rather than just trying the new idea
- Baseline data collection given the dynamic nature of glycaemic control

With Thanks To

- Project Lead – Sarah Shotton
- Project Team – Rosaline Scott & Ann Baker (GPs), Mia Mathias & Louise Long (Nurses), Pia Parnell & Tina Tomkins (Patient Representatives), Rhona Taylor (Community Health Worker), Murali Tejasvi (Community Health Worker), Sita Tejasvi (Manager)
- HUCHS patients, staff and board
- Te Kaitiaki Health Network
- Health Quality & Safety Commission – Jane Cohen & John Wilkinson

Nelson Marlborough Health

Health

Whakakotahi living longer and feeling better following a heart attack

Nelson Marlborough Health
Elizabeth Wood and Fran Mitchell

Problem statement

Only 62% of post-stent patients take appropriate medication after their heart attack

Aim

100% medication adherence at 3 and 12 months post-stent across three GP Practices in the Nelson Marlborough region by December 2017

Project Team

Role	Person
Consumer	Ursula Davis
Community Care	Ben Williamson (Coordinator Health Program), Sarah Ross (Nurse Practitioner), Angela Peters (Community Pharmacist)
Primary Care	Marlene Edwards (2 GP), Debra Shaw (Nurse), Dr. Elizabeth Wood (GP), Dr. Fran Mitchell (GP), Dr. Pauline Taylor (GP), Dr. Sue Taylor (GP)
Secondary Care	Annelle Egan (Pharmacist), Jane Tomkins (Nurse Practitioner), Dr. Marlene Johnson (Cardiologist), Fran Mitchell (Quality Improvement Coordinator), Sita Tejasvi (GP)

Problem analysis

Diagram showing the flow from 'Problem Statement' to 'Measures' and 'Outcomes'.

Theory of Change

Diagram showing the flow from 'Problem Statement' to 'Measures' and 'Outcomes'.

Measures

Outcome Measure	Process Measure	Balance Measure
90% of post-stent patients are discharged with Pharmacy input	90% of patients consult with their GP 3-5 weeks post-stent	Number of post-stent ED presentations within a year of discharge (Carbimab)
90% patient medication adherence at 3 and 12 months post-stent	90% of post-stent patients attend Carbimab	Number of post-stent ED presentations within a year of discharge (Carbimab)
100% adhere to medication when notified that post-stent patients are prescribed the right medications, at 3 months and at 12 months		Number of post-stent ED presentations within a year of discharge

Change Ideas

List of ideas for improving medication adherence.

PDSA Cycle

Plan-Do-Study-Act cycle for the project.

Successes & Challenges

Successes:

- Diversity of our team
- Enthusiasm
- Team and engaging others
- Driver Diagram
- Process Map
- Measures

Challenges:

- Hard to get us all together
- Good to refer back to
- Each group explained their version for the others
- A bit of a challenge

Cool Storyboards!

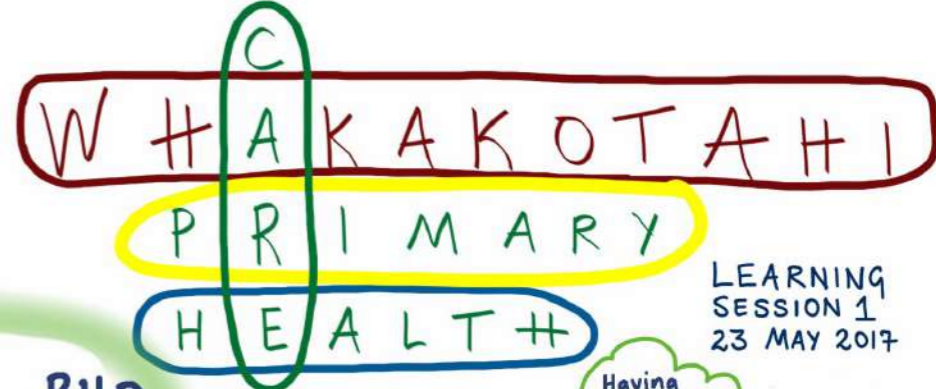
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- we have an enrolled popⁿ = 3200
- We are a team of 5

ORANGA
RONGOA

Papakura Marae
National Hauora Coalition PHO



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Having
goutⁿ is
a pain



Patient literacy
is an important
aspect



Our project is about

GOUT

Our Drivers are

Whanau ownership + best practice

The platform we use to collect + measure data is

MOHIO

Great
dashboard

We are collecting measures:

- Outcomes
- Process
- Balancing

147
124

= gout classification
= no gout classⁿ
but on Allopurinol
or Colchicine



who is missing?



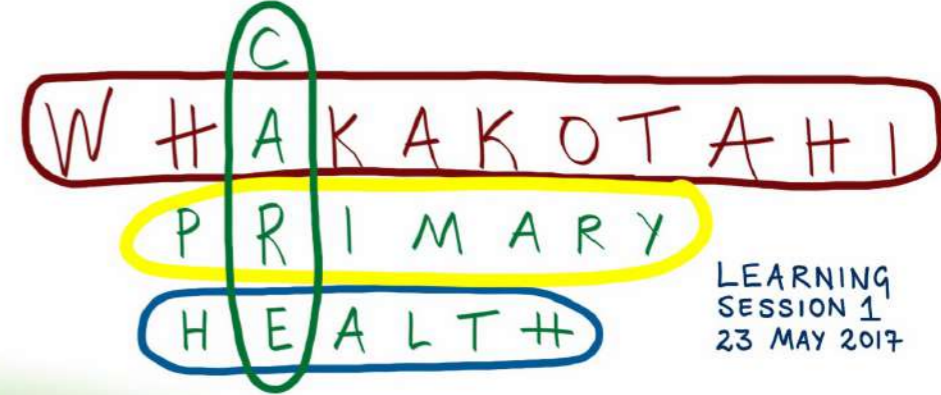
We know the overall statistics,
but not the specific no. for
our own practice - yet.

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RONGOA

The **CULTURE** is what matters



Gout is hereditary
+ This helps people
to accept it - not
being judged as
alcoholic or eating
too much kai moana

We are on the marae
+ engage whole whanau
in their health journey

+ like
We know these
people - we accept
it's the health system
that is hard to reach, not vice versa
we awahi them - we honour them

We are also working
with patients with
diabetes + other
long term conditions

We bought
a bike + shoes
for a patient in
our
'hurdie club'
100 HBA1C → 86 HBA1C

Now she
has her own
vege garden

+ her
levels
have
dropped!

We are
Thinking outside the
box to address
inequities, e.g. use a
co. car to
collect
patients

We are a
bit different
- we are putting
more effort into
building boxes
for people to
stand on 😊

PARTNERS IN CARE

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Consumer Engagement

We expect you to describe how you worked with consumers in this project

our **CORE** principles

- Partnership
- emphasis on experience
- storytelling
- co-design
- evaluations of improvement + benefits

We work in partnership with consumers * + clinicians

'CO-DESIGN' is how Māori do it, naturally we don't use that term

* 'consumers' can mean so many things - our definition is just a stake in the ground



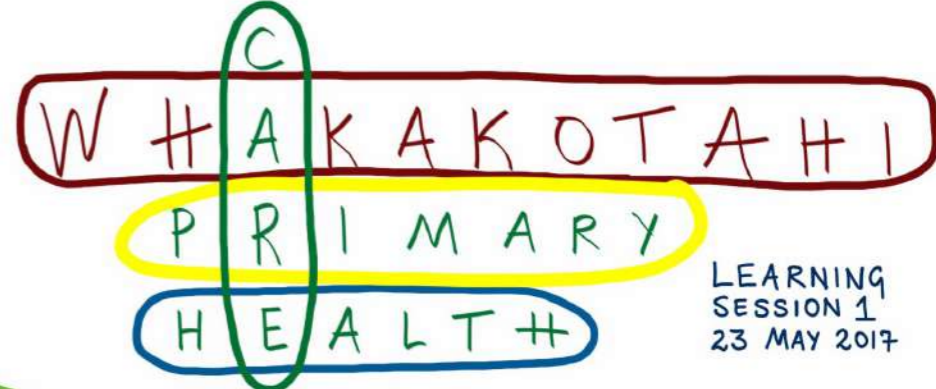
CONSUMERS = largest untapped resource in health

We need to see more medical staff on board with the idea

BUT

evidence base shows benefits from actively involving consumers

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Don't forget
to get your
consumers in
at the beginning
of your project

"Blood-letting
in
children"
nobody liked
this term + the
consumers told
them + changed
it



Often its just
small changes that
can make a

M A S S I V E

difference to people
+
save the health \$'s
too

check out
our co-designed
resources - health literacy,
P.L.A.N. etc.
www.hqsc.govt.nz



Valerie has
brought her
copy of the
paper today!

Some
are translated

There is a
learning curve by
medical staff +
consumers about
how best to work
together - we
need to do
it to
learn

JUST DO IT!

Evaluations
of co-design
programs - see
www.hqsc.govt.nz
+ recently published
paper



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GROUP 1

Mens B project...
where to put everyone
for their 20 min. wait
after vaccine. Our
Board (Community based)
came up with the
solution... bouncy
castle etc + fun days



these learnings
may be
able to be
applied to our
Diabetes project

PARTNERS IN CARE

GROUP 2



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GROUP 3

We have
a consumer
representative
on our
team

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NELSON MARLBOROUGH HEALTH

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OUR TOPIC

feeling better after a heart attack

data goes into Antics Q.I. pipes + pumps but adherence to meds. v. impt

only 61% patients taking their meds needs to be 100%

why? 10% lower for Māori patients

2015 report kicked our project off

we have our own consumer member - Valerie Steele!

We're a big Team

The info. for GPs isn't really adequate

We realised our hospital discharge process was not ideal

PDSA cycle around the info we put out

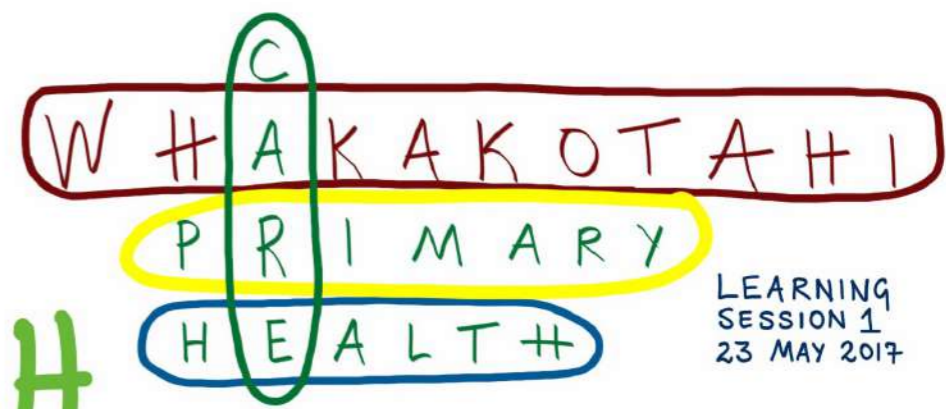
Info. for patients
Info. for pharmacists
value of yellow cards?



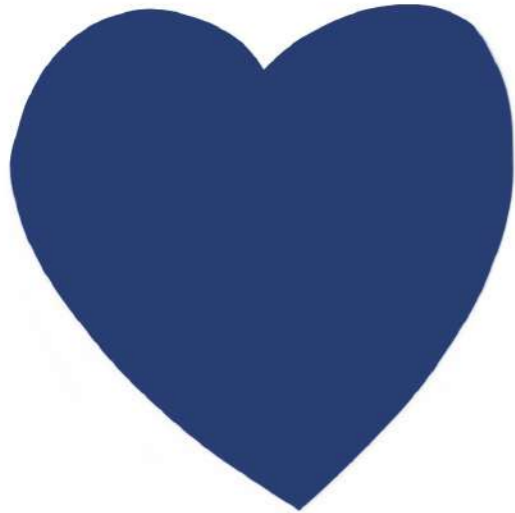
Discharge Summary is for 3 diff. audiences makes it hard for patients



NELSON MARLBOROUGH



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The Heart Foundation
website
has 81 stories -
very revealing about
people with stents +
their meds + also learnings
about those who have
heart failure + don't present

Nurse, Doctor +
Pharmacist
to go out to the
Community...
On tour!



Sue C. says don't
assume its always
patients who fail to
adhere - sometimes
GPI's take their
patients off them

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NELSON MARLBOROUGH HEALTH

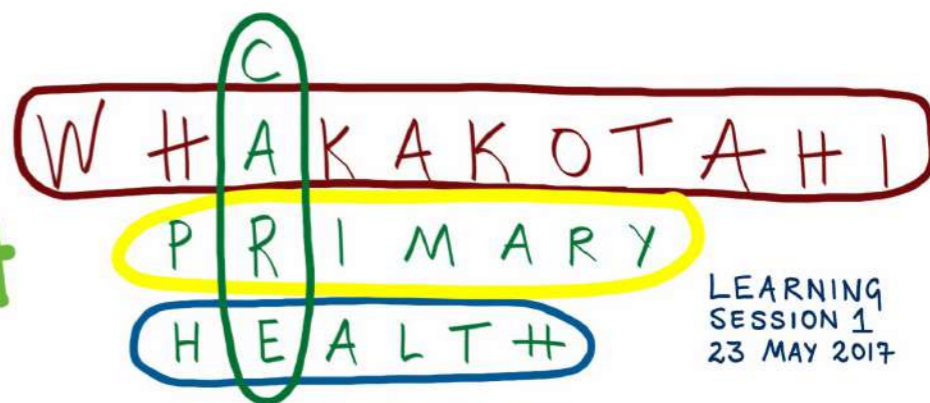
One of our
PDSA

cycles - a patient was discharged on Good Friday... Pharmacists don't want to spend all day counting - we want to be out there engaging with Patients

" Pharmacists - the health professional you see most often " *Let's bring this back!*

Discharge summary to be taken to Pharmacy

We aim to Break down silos + work in an integrated care way



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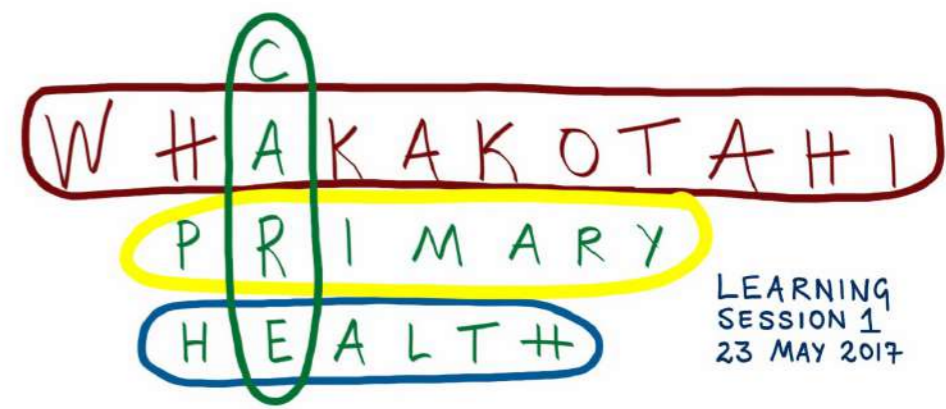
GPI's experience - designing a process map to ensure adherence - incl. Pharmacist to Counsel patients on how/why/when to take their meds

Valerie - Consumer

Rep: → has anyone asked patients why they're not taking their meds? 38% identified who don't engage, so

now we're doing a PDSA on this to connect with a sample - find out from them + their stories about improving.

Angela Boswell
● Synergia ●



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Evaluation - we evaluated the Opioids Collaborative. We're here to
We are a Team of 4 doing this project **SUPPORT**
your projects

Formative Evaluation

+ Summative Evaluation

Support HQSC
understand how this is
working

After 3 years we'll do an
evaluation of implementation
+ achievement

We will walk alongside
you for 3 years

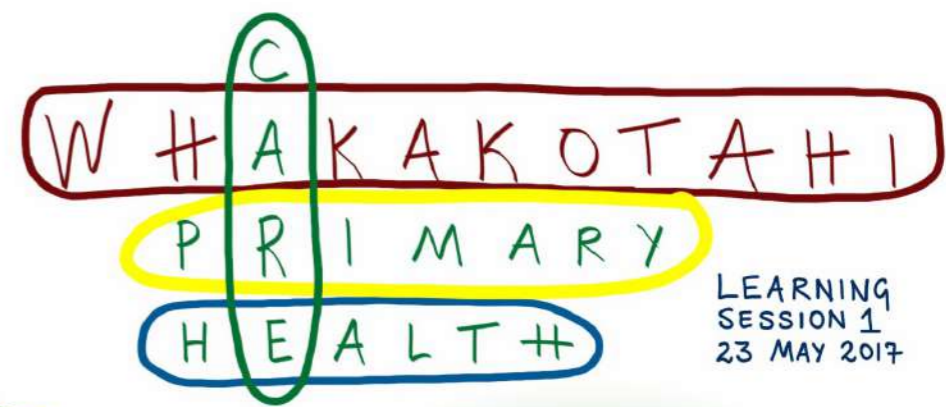
How we will
do this:

- An evaluation survey at end of each Learning Session
- Site visits
- Reviewing / evaluating your data

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Jane Cullen 'Life Qi'



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We want you to evaluate as part of this Whakakotahi Journey



Go to the **LINK** we sent you to access your license (do not Google it!)

Then give us your feedback so we can assess it

Please encourage your team to use it

You can't break it so click + play - we need your feedback

You can see others projects but detail only if it is shared

e-learning for quality improvement



