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Learning Session One

23 May 2017

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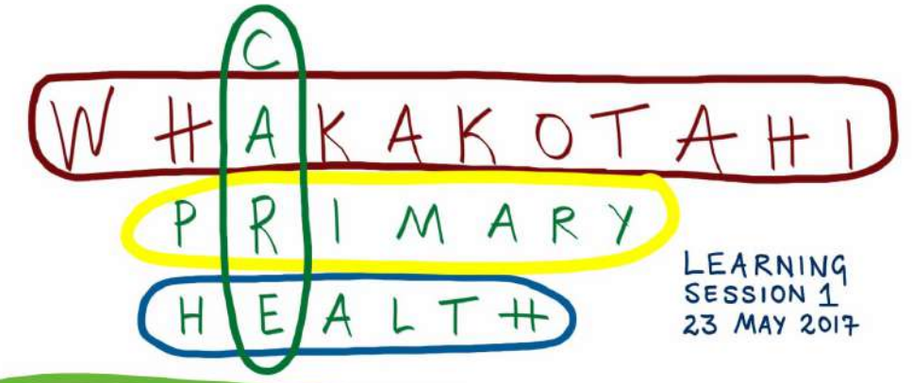
ANALYSING IMPROVEMENT DATA

SUE WELLS



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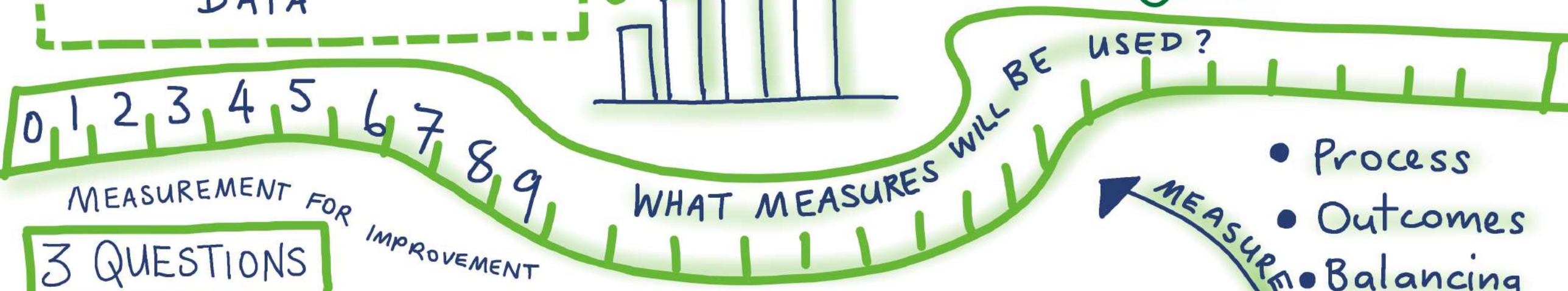
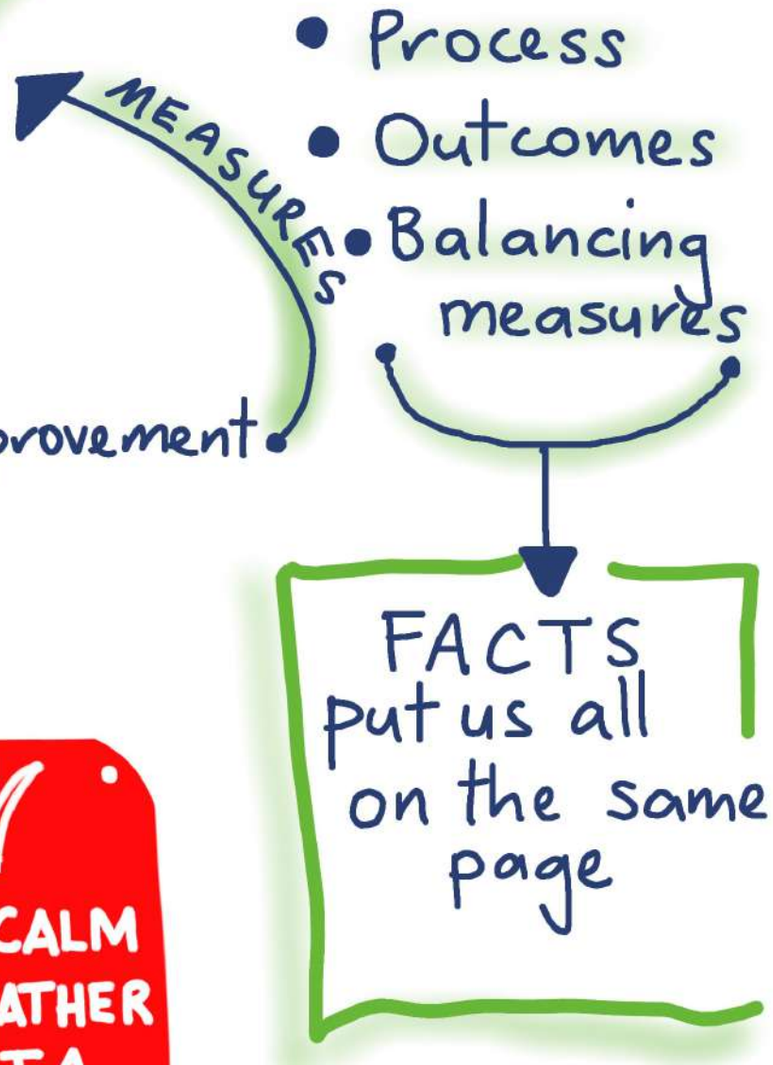
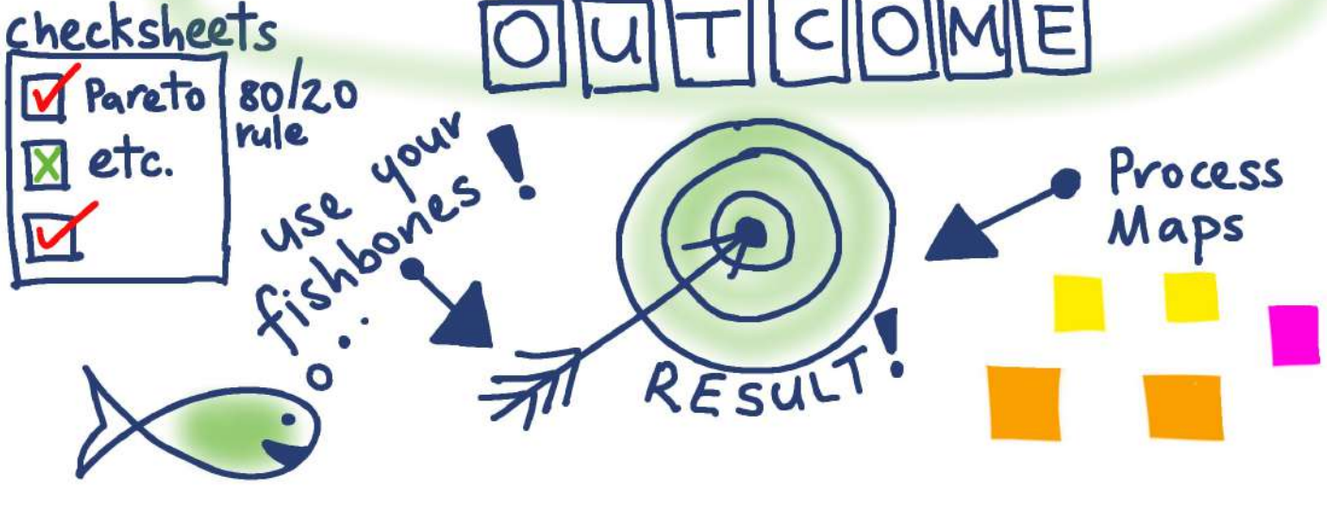


3 QUESTIONS

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?



structure + process + culture = OUTCOME



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ANALYSING Q.I. DATA

= RUN CHARTS =

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

Y

X

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ANALYSING Q.I. DATA

HOW?

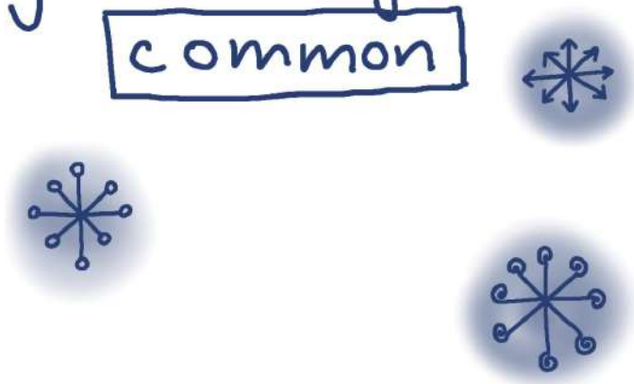
- Blocks - consec.
- Random
- Systemic or Purposive (every eg. 10th patient)

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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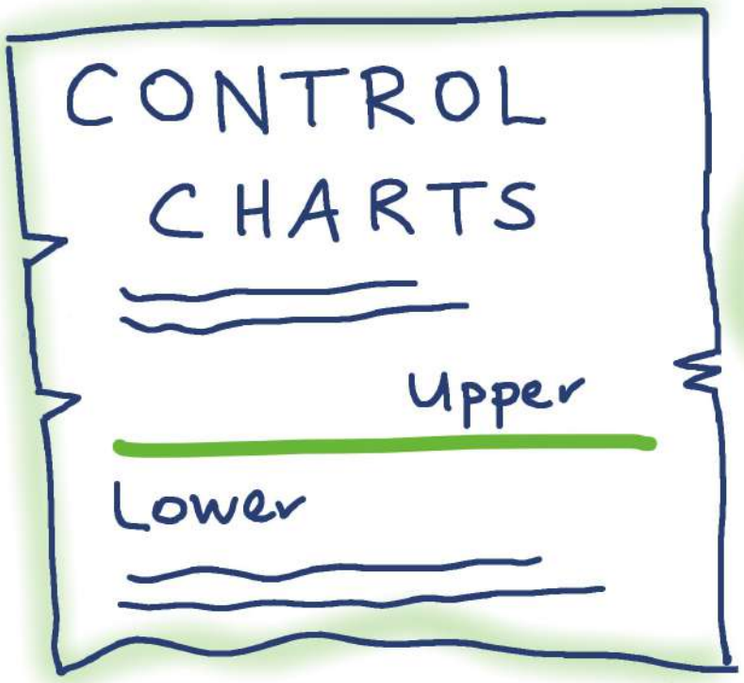
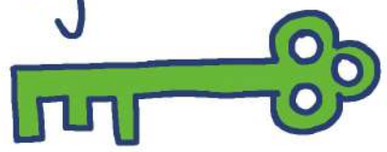
ANALYSING Q.I. DATA

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



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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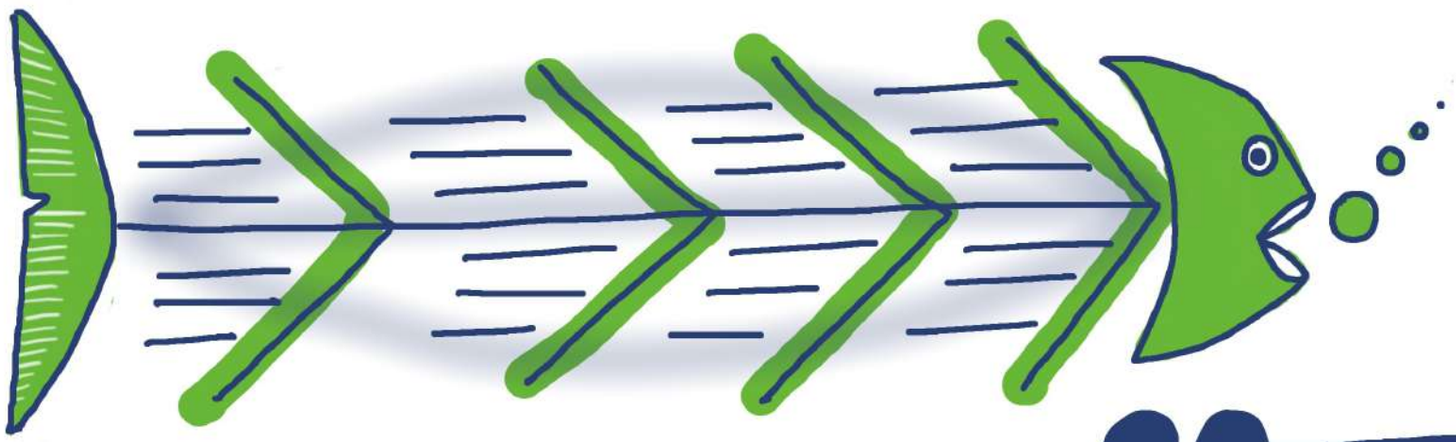
Q + A

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. $E=MC^2$

REMEMBER

"All improvement is change, but not all change is improvement"

Don Berwick, IHI.

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SUE CRENGLE

Associate Professor

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WHO Definition...

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

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

What is equity — how to assess — Doing it Well

Boston Public Health Commission definition is GOOD ← check it out

fair opportunities = equity

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

unfair - avoidable - unjust = inequities

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Assoc. Professor

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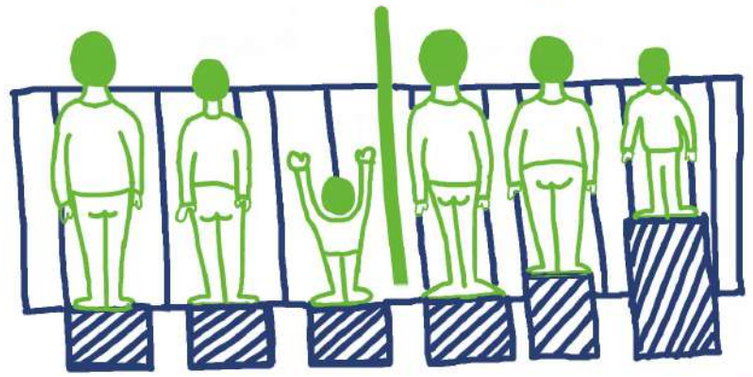

we need the boxes to be appropriate - so we can all see what's over the fence

Equity is not the same as equal

DATA

- must be high quality
  - care over ethnicity data
  - Gold standard is Census (self reported)
- 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

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

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SUE CRENGLE

Assoc. Professor

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- Ethnicity classific^{n} -
  eg. re-registration changes from Sue's practice 173/2023 misclassified as Non-Māori. Trained all admin staff on better data collection methodology. → 8.5%!
- 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
- 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.
- Inequities + class. errors can also occur across other ethnicities, so beware
- Link-tech ↓ Med-tech can create errors - they drop 2nd + 3rd options off
- Good to run ethnicity checks + teach admin staff

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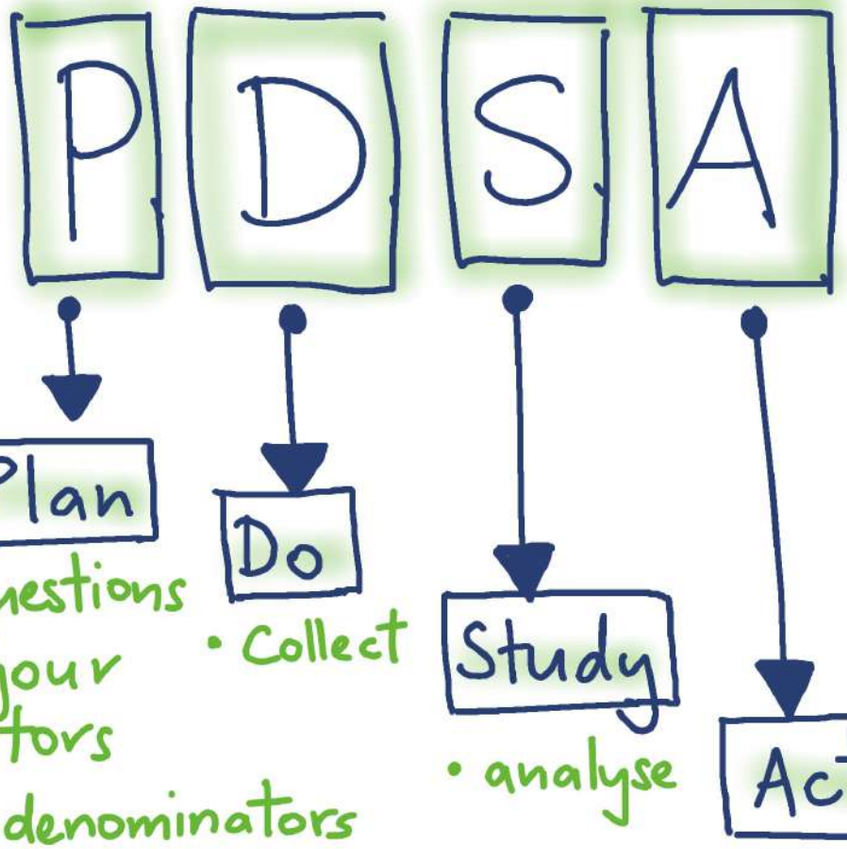

- what questions
- choose your indicators
- Identify denominators

- Collect

- analyse

- decide Actions

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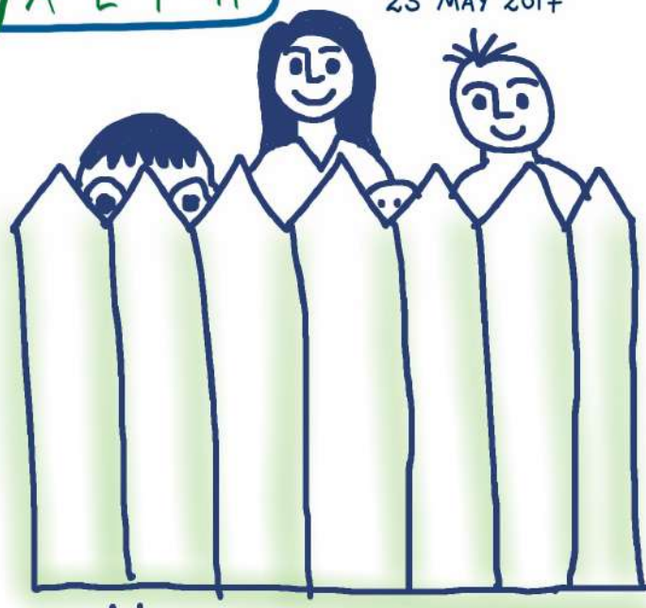

Let's remove fences so we can all see that even playing field!

See IMC Māori Health

= Plan =

Concrete Indicators

eg. news — Immunisations; news — 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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Training – for staff + repeat

Audit Tool (Mott www)

Check Māori in Ethnicity2 + Ethnicity3 fields

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

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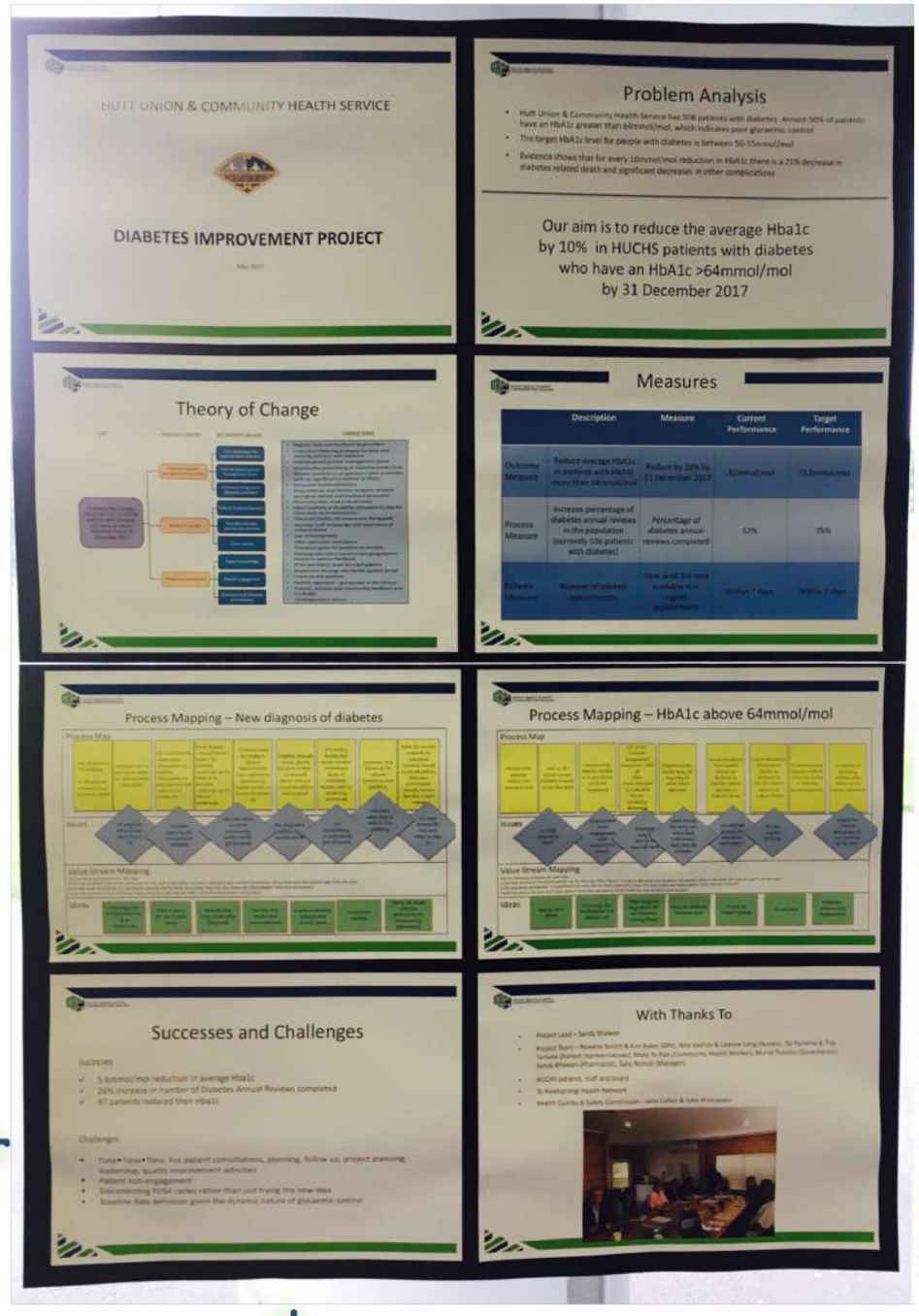
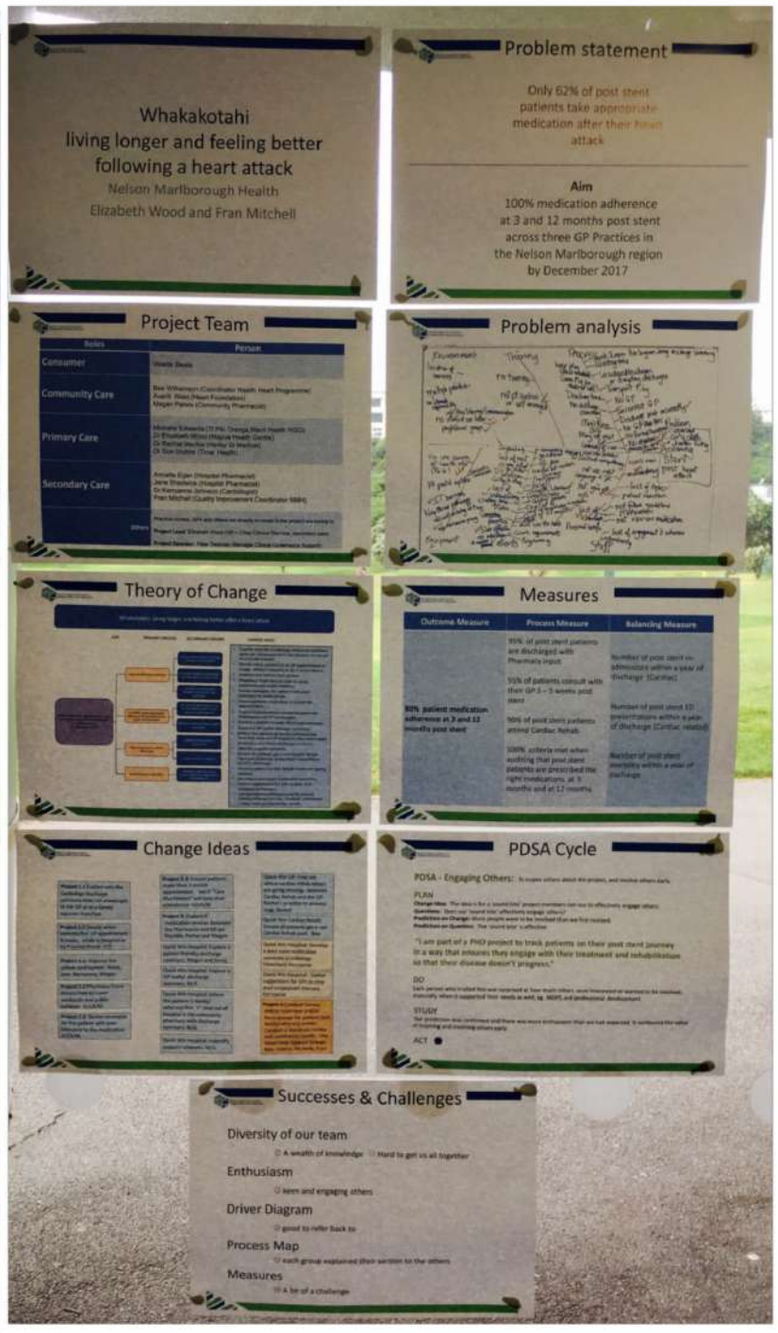
Hutt Union + Community Health Service



Nelson Marlborough Health



Cool Storyboards !

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- we have an enrolled pop^{n} = 3200
- We are a team of 5

TEAM

ORANGA RONGOA
Papakura Marae
National Hauora Coalition PHO

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Our project is about GOUT

Patient literacy is an important aspect

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 = gout classification

124 = no gout class^{n} but on Allopurinol or Colchicine

Q: who is missing?

A: we know the overall statistics, but not the specific no. for our own practice – yet.

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ORANGA RONGOA

the CULTURE is what matters

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

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

We bought a bike + shoes for a patient in our 'hundie club'

100 HBA1C → 86 HBA1C

Now she has her own vege garden

+ her levels have dropped!

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

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 awhi them - we honour them

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

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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

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

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

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 MASSIVE 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

Some are translated

Valerie has brought her copy of the paper today!

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

MensB 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

GROUP 2

(3) Whanau hui

- Barriers
- illness Perceptions
- Health belief system
  - we haven't got it formalised yet
- cohorts without a voice
  - go to their workplaces + the bush where they're

PIG HUNTING!

- going to them
  - social/sports clubs
  - we went to Te Matatini
  - identify their leaders

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've a big Team

We realised our hospital discharge process was not ideal

The info. for GP's isn't really adequate

PDSA cycle around the info we put out

Info. for patients

Info. for pharmacists

value of yellow cards?

DISCHARGE FLOW CHART developed

accessible to others

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

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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 GP's take their patients off them

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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!

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

Discharge summary to be taken to Pharmacy

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

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.

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Angela Boswell • Synergia •

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Evaluation - we evaluated the Opioids Collaborative. We're here to SUPPORT your projects

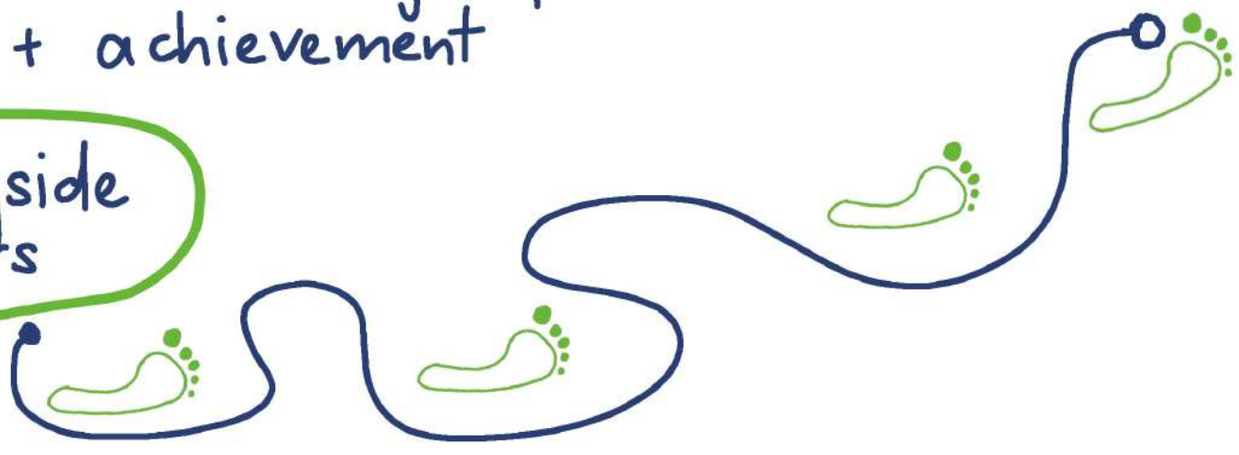
We are a Team of (4) doing this project

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

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

e-learning for quality improvement

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

Please encourage your team to use it


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