Sequence to Achieve Change Workbook

Clinic Team: __*Blue Meadows Clinic*_____ **Change Package**: _*Financial Strain*__

Elevator Speech

When you approach a team to consider quality improvement work, you'll want to be prepared with an "elevator speech." Use the tool below to help develop it.

Who You Are: *A Practice Facilitator from XYZ PCN.*	What You Do (short explanation): *Work with XYZ PCN member clinics on quality improvement initiatives that support the Patient's Medical Home. Am able to aid teams with implementation of and measurement of changes and build capacity for change within the clinic.*
Features: *The financial strain change package supports teams to:* - *identify patients experiencing financial strain within their practice and respond to their determined needs,* - *improve the experience for those patients and others,* - *standardize documentation in the EMR,* - *optimize care management, and* - *better coordinate care within the medical home and health neighborhood.*	Benefits: *The benefits of implementing potentially better practice within the financial strain change package include:* - *A better understanding of the social determinant of health impacting paneled patients* - *More satisfied patients who feel comfortable discussing their needs with their care team* - *Better use of team members and optimization of each role in the clinic* - *Better hand offs to community resources* - *More efficient clinic processes such as EMR point of care reminders that enable identification of who is due for screening or requires follow up*
Key Messages for Your "Elevator Speech": *I know you really care about your patients and their well-being. Financial strain is currently affecting the health of many Albertans and income is one of the most important determinants of health. I often hear from doctors that it can feel overwhelming to try to address social issues such as financial strain but there are evidenced-based actions that primary care teams can do to help these patients. In 2015, 15% of Albertan children were living in poverty and there are other vulnerable groups such as single people age 45-64, new immigrants, Indigenous*	

people, people with disabilities and single parents. Efforts that address financial strain align with the implementation of the Patient's Medical Home. Do you think we could set up a meeting to discuss how we can best use the clinic and PCN team to support you in this work?	
Anticipated Barriers: - *Too busy / I don't have enough time to take this work on* - *I don't have any patients experiencing financial strain in my practice* - *We don't have the resources to address this*	Plan for Managing Barriers: - *Process improvements can help to streamline work and reduce redundancies/re-work; they also support team members to work to full capacity to everything doesn't fall on the physician* - *We recognize that for many patients talking about financial challenges is a very private and difficult thing to do. Unless patients are specifically asked, they often won't discuss their difficulties making ends meet as they feel shame admitting they are struggling. The screening tool is just 1 question and resources are available within the health neighborhood from places like the PCN, AHS and community*

1. Form an Improvement Team

Next, assemble a team that represents all areas and roles of the clinic; consider including a patient on your team. Indicate below who is on your improvement team. It is recommended that you include someone with training in quality improvement facilitation (likely this will be you!) and someone with decision making authority (a physician champion or office manager).

Team Member Name	Role in Clinic
Dr. Green	*Physician champion*
Hailey	*MOA/Receptionist*
Elaine	*Office Manager*
Jeff	*PCN Nurse (or social worker if clinic has access to this team member)*
Charlotte	*Practice Facilitator*
Sally	*Patient with Lived Experience*

2. Clarify the Problem/Opportunity

Articulate the problem you want to solve. Use evidence and data to strengthen your rationale (consider reviewing the physician's HQCA Primary Health Care Panel Report with them and the team). Discuss with your improvement team what aspects of the area you're focusing on most need improvement. You may also want to use some QI tools like the Fishbone Diagram, 5 Why's, or Pareto Chart.

Data that may support my change package:

- *Statistics for people experiencing poverty or financial strain in Alberta and Canada from ACTT website*
- *Dr. Green's HQCA report for social deprivation data*

When writing your problem or opportunity statement, consider the following questions:

Question	Answer
What is the problem?	*We don't have an accurate list of patients in the practice who are experiencing financial strain.*
Who does the problem affect?	*MOA/receptionist, nurse, physician, patient*
When is it a problem?	*When scheduling appointments, during appointments*
Why should we care?	*If the patient is experiencing financial strain they might:* *-have transportation challenges and no show for appointments;* *-not take their medications regularly because they can't afford them which can make their chronic conditions more challenging to manage;* *-be experiencing physical harm if they don't have safe housing* *-be experiencing weight changes if they are struggling to buy food* *-be observed to have challenging behaviors if the stress of financial strain is impacting their sleep and mental health* *Managing the patient's physical conditions may be more challenging because the underlying social and psychological issues aren't being addressed. This may result in additional appointments being booked but the patient may still struggle if the root causes aren't explored.*
How does it affect patients?	*Patient may not be receiving all supports that they need and the patient's health may further deteriorate*

Problem Statement: The team at Blue Meadows Clinic is frustrated because they know that financial strain can impact the physical health of their patients but they don't have a process to document or identify a list of patients who are experiencing financial strain. This requires additional work for the team and requires the patient to book multiple appointments.

3. Map Processes

Visually depict the sequence/steps of events in the process that you are trying to improve. Start by naming your process so that all team members are focusing on the same thing. Next, determine the start and ends points in the process. Use your team to brainstorm all of the steps that happen in between. Finally, arrange your steps in order.

Once you have your current state mapped, review it as a team. Consider the following questions:

Question	Answer
Where are the bottlenecks?	*-The physician does not have time to complete multiple referrals to community agencies and the resources are always changing so it's challenging to stay current*
Where is work being duplicated?	*-The nurse asks about the social determinants of health in their assessment but the physician often can't find that information in the EMR so they'll ask the question again if it comes up*
Are their inconsistencies?	*-Not all patients are asked about financial strain unless the patient brings it up or the team member has a "gut-feeling"*
What can be standardized?	*-EMR reminders for screening and follow-up, documentation of social history into EMR*
Does each step add value? If not, can it be eliminated?	*-Redundancies in appointment time between nurse/physician* *-Manual review of chart rather than using point of care reminders*

Use the Process Mapping Guide in your Practice Facilitator Core Training as support.

4. Use the Model for Improvement

When making a change, the Institute for Healthcare Improvement Model for Improvement asks three questions:

1. What are you trying to accomplish? – *This is your aim statement.*
2. How will you know that a change is an improvement? – *These are your measures.*
3. What change can be made that will result in an improvement? – *These are your PBPs.*

These three questions are followed by small tests of change called Plan-Do-Study-Act (PDSA) cycles.

Set an Aim Statement

Question	Answer
What are we trying to improve?	*To know which patients on our panel are experiencing financial strain* *A screening process needs to be implemented*
By how much? (Try a stretch goal!)	*20% of female patients, age of 18-39* *(trying to focus in on single parent families but that that isn't currently documented in the EMR in a standardized way)*
By when?	*August 2021*
Aim Statement:	*The Blue Meadows clinic aims to implement a financial strain screening process and screen 20% of female patients aged 18-39 by August 2021.*

Identify Measures

Measurement is a key component of good quality improvement. Measurement allows you to track the changes that are occurring and assess their impact. There are three types of measures that can be collected:

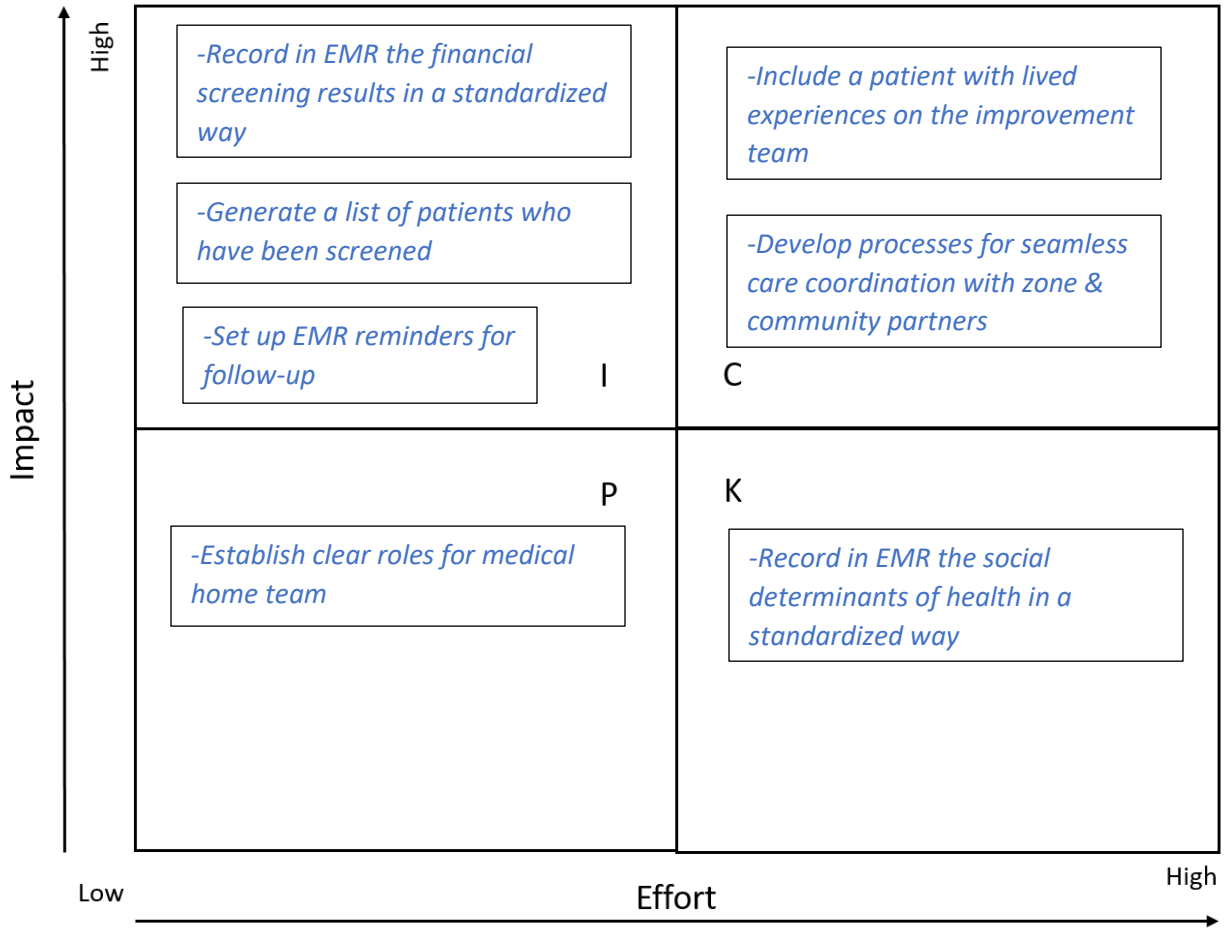
- A **process measure** measures of whether an activity has been accomplished. Often used to determine if a PDSA cycle was carried out as planned.
- An **outcome measure** measures the performance of the system under study. Often relates directly to the aim of the project and offers evidence that changes are actually having an impact.
- A **balancing measure** determines the impact of a change on separate parts of the system.

QI Measure	Method of Collection	Frequency
# of patients assessed for financial strain	*EMR report*	*Monthly*
# of patients refusing screen	*EMR report*	*Monthly*
# of patients referred to PCN resource or community agency	*EMR report*	*Monthly*

EMR access varies by clinic and PCN so have a discussion with the team about which person or role is responsible for running the EMR report and what frequency makes the most sense for your circumstances.

Select Changes or Potentially Better Practices (PBPs) to Test

Use your change package table to select PBPs. Based on what you know about the impact they'd have and the effort they'd take, slot them into the PICK Chart below. Indicate which ones the team will try first: Impact/Effort Grid or PICK Chart



Test Changes

After a change idea is selected, use PDSA cycles to test changes in a real world setting. Consider starting with just one patient and one provider. Document each PDSA Cycle. Use the PDSA template in the QI Guide as support.

5. Sustain the Gains

Congratulations on making an improvement! However, now you've got to hold the gains. Some strategies to consider for maintaining improvements are:

- Standardization
- Accountability
- A visual management system
- Daily communication

Use the Five Strategies for Sustaining the Gains handout to learn more.

Additionally, measurement does not stop once you have improved your outcomes. Continue to periodically measure your results to ensure that improvements are sustained over time. Consider creating a quality improvement board and displaying results for both clinical staff and patients to see.

6. Spread the Successful Changes

After successful implementation with the initial site, the improvement team can work to spread learning and changes to other parts of the clinic or to other clinics within the Primary Care Network. While actual spread occurs at the end of a successful improvement initiative, improvement teams should develop strategies for spreading improvements from the beginning of the project.

Thinking of the work your currently doing with your team, how can it be spread (to other patient populations/to other physicians or clinics)?:

- *To another physician in the clinic*

Be aware of the Seven Spreadly Sins. Reference the Seven Spreadly Sins handout to learn more.

7. Celebrate!

Plan to celebrate at milestones along the improvement journey, as well as when you achieve your aim. Recognize and highlight the efforts and accomplishments of the team.

Brainstorm ways in which you might celebrate with a team:

- Team lunch