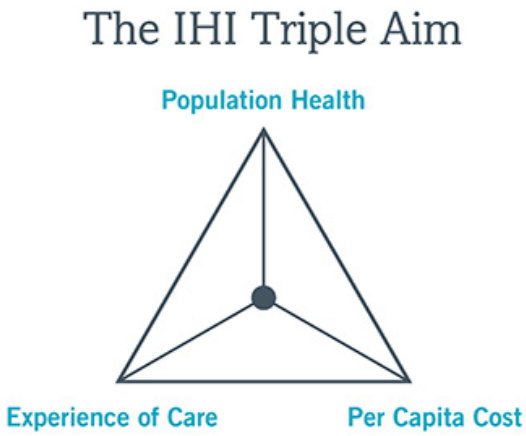
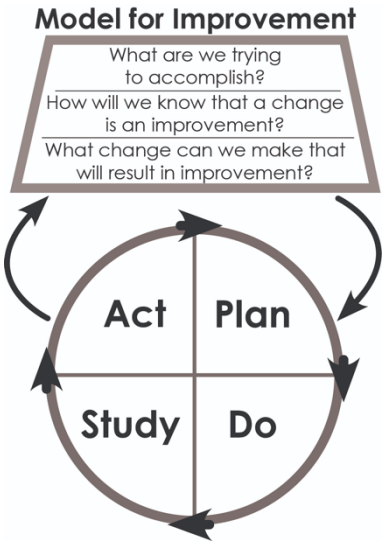
Quality Improvement (QI) Foundations and Collaborative

- Quality Improvement provides a framework for frontline workers to make meaningful changes to the system in which they work.
    - Allows for creativity
    - Allows for "rule breaking"
    - Values patient outcomes, and joy at work
    - Values regular thoughtful assessment of processes
    - Bottom-up approach
- Dimensions of healthcare quality (from 2001 *Crossing the Quality Chasm*, Institute of Medicine report, also refer to BCPSQ's Quality Matrix)
    - Safe
    - Timely
    - Efficient
    - Effective
    - Equitable
    - Patient-centred
    - + Provider experience
- The IHI Triple Aim



And don't forget provider experience!

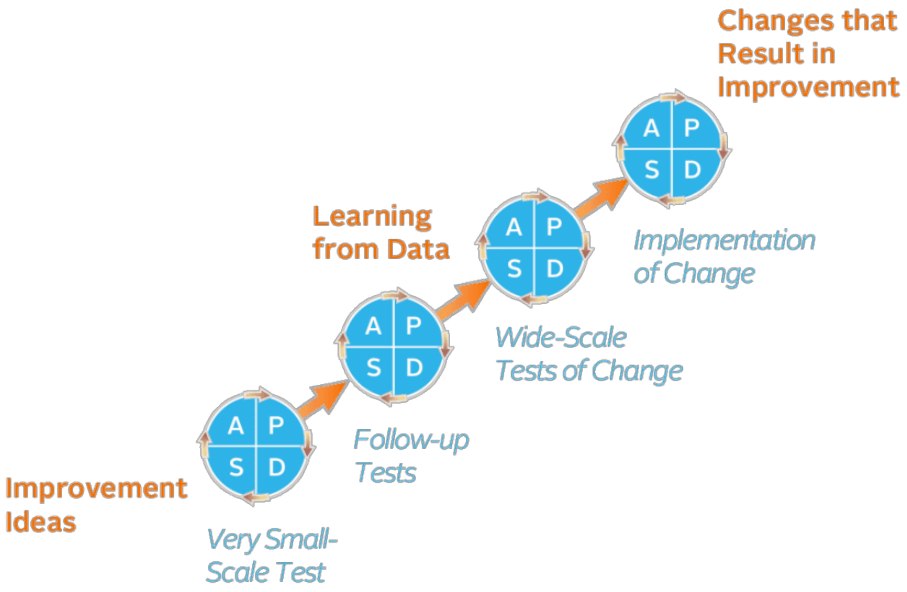
- Model for Improvement is most commonly used model in healthcare QI
- *The Improvement Guide* is the bible for QI



- Ensures that we know what we are aiming for, have some ideas for change to test, and have measures for knowing when our changes cause improvement.
- Healthcare is a complex adaptive system – changes to one part of the system may affect many other parts
    - "Every system is perfectly designed to get the results that it gets"
    - We need to anticipate changes and have measurement strategy for these
- **Example**
    - Aim statement: By March 15, 2019, I aim to shed the roughly 10lbs of weight gained over Xmas holidays.
    - Change idea: use an app to track net daily caloric intake
    - Measures:
        - Outcome measure: usually in our aim statement – in this case it will be weight
        - Process measures: "the voice of the workings of the system", or measures that capture effects on the inputs or steps in the process we are trying to improve – net caloric intake and the number of days we record it could be two process measures in our example
        - Process measures are sometimes analogous to the data on a scoreboard in a sports game, where the outcome is winning or losing the game.
        - Balancing measures: these determine whether changes in one part of our system are causing problems in other parts. In our example, we may want to measure how calorie counting is affecting our mood, and how much time it is taking to do the counting.
- We measure to overcome human bias. As humans, we are prone to cognitive errors such as recency bias, the peak-end rule, the halo effect, etc. Basically, our assessments are biased and we will often come to

different conclusions without being able to see the data. Daniel Kahneman's book *Thinking, Fast and Slow,* is a good reference for this.

- In PDSA cycles, we test on a small scale with a rapid cycle, study results, then either adapt, adopt, or abandon our change idea.



- Highly adoptable change (highlyadopatableqi.com)
    - The changes that are most likely to be adopted are the ones that reduce overall workload

Characteristic	Judgement	Research	Improvement
Aim	Achievement of target	New knowledge	Improvement of service
Testing strategy	No tests	One large, blind test	Sequential, observable tests
Sample size	Obtain 100% of available, relevant data	'Just in case' data	'Just enough' data small, sequential samples
Hypothesis	No hypothesis	Fixed hypothesis	Hypothesis flexible; changes as learning takes place
Variation	Adjust measures to reduce variation	Design to eliminate unwanted variation	Accept consistent variation
Determining if change is an improvement	No change focus	Statistical tests (t-test, F-test, chi-square, p-values)	Run chart or statistical process control (SPC) charts

- BOOST Collaborative Aim Statement: By the end of the 12 months, the aim of the *Provincial BOOST Collaborative* is to provide equitable access to integrated, evidence-based care to help our population of clients with OUD achieve:
    - 95% of clients have an active OAT prescription
    - 95% of those clients with an active OAT prescription will be retained on therapy for greater than 3 months
    - 100% of teams have a process to monitor and incorporate the patient voice
- We need to figure out who our patients with OUD are, give them OAT, and then help them stay on the therapy until their OUD is in remission.
- By measuring who has an active prescription, we are keeping score, knowing that we need this to be high in order to reach our retention goals.
- Retention >3mos is our main outcome measure. We can also look at 1mos, 2mos, etc. to gain further insights.
- A key component of our improvement efforts needs to be inclusion of the client voice
    - Ideally there are empowered patients and peers contributing to your team's QI work
- Team aims will align with Collaborative aims, but there is room for tailoring these to the specific circumstances of your team.
- See the BOOST Preparation Manual and Change Package for further information