The Provincial BOOST Collaborative: Guide to Measurement

February 2019

OVERVIEW

Measurement for improvement is an important part of participation in the Best Practices in Oral Opioid AgnoiSt Therapy (BOOST) Collaborative. Measurement tells us if we are improving, reaching our aims, and helps teams communicate about their improvement efforts. Measurement for improvement should be useful, but need not be perfect. The goal is to obtain just enough "good enough" data to take action.

Each team will collect four quality improvement (QI) measures, accompanied by a qualitative narrative summary on a monthly basis. Reports are due the last Wednesday of each month. The first reporting date is scheduled for February 27th, 2019.

WHY DO WE MEASURE FOR IMPROVEMENT?

Measurement is an important part of improvement. How will you know if the changes you are making are improving outcomes? How will you demonstrate to clients, leaders, and peers that your efforts are contributing to better care?

As we begin to make changes in the care and services we deliver, measurement helps us:

- Understand current performance
- Observe if the changes we are making are having a desired impact on the outcomes
- Compare our performance with similar sites to foster learning
- Communicate clearly about our improvement effort and outcomes
- Identify negative or unexpected outcomes related to changes we are making
- Know if we have reached our aims

HOW DO WE MEASURE FOR IMPROVEMENT?

Step 1 – DEVELOP AN AIM STATEMENT

An Aim Statement is a description of the current status and what you intend to accomplish at the end of your improvement work. Your aim should align well with the overarching Collaborative aims and include all the characteristics of a good aim **(SMART):**

- **S**pecific: target a specific area for improvement
- **M**easurable: quantify or at least suggest an indicator of progress
- **A**ssignable: specify who will do it
- **R**ealistic: state what results can realistically be achieved, given available resources
- **T**ime-related: specify when the result(s) can be achieved

The BOOST Collaborative aims:

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 opioid use disorder (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

Examples of SMART aims aligned with the BOOST aims:

A) By November 1st,2019 the team will decrease the number of 'no-shows' in both counselling and addiction medicine appointments to 1.9 per day (from 2.9 per day).

B) By July 2019, 75% of clients who have been on oral opioid agonist treatment will be assessed by a Mental Health provider..

C) By June 2019, 80% of the population of focus will be receiving an optimal therapeutic dose of OAT.

D) By October 2019, we aim to achieve a 50% average increase in quality of life as scored using the 10 question PROMIS scale for clients with OUD.

Step 2: DEFINE YOUR POPULATION OF FOCUS

Population of Focus refers to the clients diagnosed with opioid use disorder and receiving OUD care from the participating team. Here we want to have a list of who your patients are.

If we measure people we are NOT actually seeing, then we dilute any changes and If we miss measuring people we ARE seeing, we miss detecting any improvements from their cases. Figuring out this list of clients is called **Empanelment**:

A) Identify your patients with opioid use disorder by generating/creating a list
B) Remove patients who have an external provider for OUD/OAT
C) Remove patients not found after adequate follow-up/outreach efforts, or they have moved, are seeking care elsewhere or are deceased.

Step 3: IDENTIFY YOUR DATA COLLECTION PLAN

What data will you need and where will it come from? The easiest way to ensure you are consistently tracking the same measure is to use the definition of core measures used in this document. Data can be collected using an Electronic Medical Record (EMR) or paper charts and spread sheets.

In quality improvement we do not need "perfect" data in order to get started, and we can make changes to improve our data quality as we go along but you may need to standardize how the data is collected and recorded in order to maximize the utility of the data.

If you are on Profile EMR please visit http://stophivaids.ca/vancouver-boost-presentations/#vancouver-boost-webinar-slides to view tutorials on Profile EMR queries and how to easily pull the data required.

Step 4: REPORT YOUR DATA

A reporting template has been developed to visualize your data in run charts. A copy of the template is available here: http://stophivaids.ca/provincial-boost-tools resources/#1501613412073-d0a71d70-d02d

Reporting of quantitative data and qualitative will occur monthly. Reports are due on the ***last Wednesday of each month***. The first reporting date is February 27th, 2019.

Step 5: ANALYZE YOUR DATA

Your team should dedicate regular weekly/bi-weekly team meetings to review your data. Reviewing the data from the reporting template is also useful as this tool will automatically calculate and present your data in run chart; a very common way to present improvement data.

Measurement should help you decide if you are getting closer to your aims and it can also inform your next steps.

WHAT DO WE MEASURE FOR IMPROVEMENT?

There are two levels of measurement:

1. The Collaborative Core Measure

These measures monitor your progress towards the overall Collaborative aims and goals. Your team will track these throughout the Collaborative and they are strictly ***Quantitative***.

Your team will track four quality improvement measures that are aligned with your aims.

Quality Improvement Measure 1: Population of Focus

Your team can measure its population of focus as often as needed and will report back to the BOOST team monthly.

To identify your population of focus, follow the following steps:

A) Identify your patients with opioid use disorder by generating/creating a list
B) Remove patients who have an external provider for OUD/OAT
C) Remove patients not found after adequate follow-up/outreach efforts, or they have moved, are seeking care elsewhere or have died.

Population of Focus means patients diagnosed with an opioid use disorder and receiving OUD care from the participating team.

Example:

You have 200 patients on your list diagnosed with OUD and 25 receives OAT from an external provider, 10 moved somewhere else, 5 died and 10 patients you were not able to outreach.

In that case, your population of Focus = 200 - (25+10+5+10) = 150

Quality Improvement Measure 2: Active OAT Prescription

This is defined as the number of patients with a current OAT prescription that has an end date on the same day or at a later date regardless of dose.

To calculate the percentage of patients with an active OAT prescription use the following formula:

$$\text{\% Active OAT Prescription} = \frac{\text{Number of clients with an active OAT prescription}}{\text{Population of Focus}} * 100$$

Example:

If your population of focus is 150 patients and out of these patients 70 had a prescription date of today or at a later date (Active Prescription) then the percentage will be: $\frac{90}{150} * 100 = 81.8\%$

Quality Improvement Measure 3: Retention on OAT for greater than 3 months

This is defined as the number of patients with an OAT prescription for an un-interrupted period of 3 months or greater.

Not all clients with an active prescription are eligible for retention on OAT for 3 months since some might not have been on OAT long enough.
To calculate the percentage of patients retained on OAT for 3 months or greater you first need to identify your clients with an active prescription whose prescription's most recent start date is equal to or greater than 3 months.

Example:

Your Population of focus is 150 patients,
90 have an active prescription and out of the 90 patients,

- 30 patients started OAT 6 months ago,
- 20 started OAT 4 months ago,
- 15 started OAT 3 months ago,
- 10 started OAT 2 months ago
- 15 patients started OAT 1 month ago.

A) Identify the patients with an active prescription with a most recent start date that is equal to or greater than 3 months.

In this example, it is 30+20+15 = 65 patients
Even though all 90 patients have an active prescription, to calculate retention, only 65 patients are eligible.

B) Now Identify how many patients out of the 65 have been on OAT for an uninterrupted period of 3 months or greater.

To calculate the percentage of patients retained on OAT for 3 months or greater you can use the following formula:

% Retention on OAT 3 months or greater =

$$\frac{\textbf{Number of patients on OAT for an uninterrupted period of 3 months or greater}}{\textbf{Number of patients with an active OAT prescription with a most recent start date >=3 months}} \times 100$$

Example:

You have 65 patients with an active prescription with a most recent start date equal to or greater than 3 months, and out of the 65 patients 50 have been on OAT for equal to or greater than 3 months.

% patients retained on OAT for >=3 months = $\frac{50}{65} * 100 = 76.9\%$

Quality Improvement Measures 4: A Process to monitor and incorporate the Patient Voice

This is defined as a process to capture the patient voice that is embedded in the workflow of your clinical setting. You are encouraged to develop your own process to capture the patient voice. This can be through various means, such as: including a patient in your quality improvement team, collecting patient feedback through periodic satisfaction surveys or using quality of life assessment tools, such as the PROMIS scale.

There is no formula to calculate this QI measure. You should aim to have a process in place to be able to report on monthly.

2. Plan-Do-Check-Act (PDSA) Cycle Measure

These measures monitor the results of specific tests of change. They are done on an as needed basis for the assessment of the changes tested. These measures are **always Qualitative** and **Quantitative as needed.**

The PDSA cycle has three types of measures:

A) **Outcome Measures:** These measures are usually based on your Aim Statement. What is better for the patient/customer? What is the result of the new process/procedure? What, ultimately will be better? (not what are you trying to "do")

B) **Process Measures:** These are the voice of the system. What is being done differently that we want to capture? What is now being done consistently?

C) **Balancing Measures:** What unintended consequences might occur? What are we worried about-that we can do something about?

Example:

Your aim is: By November 1st,2019 the team will decrease the number of 'no-shows' in both counselling and addiction medicine appointments to 1.9 per day (from 2.9 per day).

Outcome Measure: number of "no-show" in both counselling and addiction medicine by the end of the week, month or year.

Process Measure: number of patients who received an appointment reminder call.

Balancing Measure: 1) amount of time it takes staff each day to do reminder calls.
2) percent of clients who are seen on time for their appointment (less no shows means there may be a busier clinic and clinicians may not be able to keep up).