

Practice Support Program

Goals and Measurements



Practice Support Program - Goals and Measurements for Improvement

Goals

The main goals of all physicians and staff who work in healthcare are to provide outstanding care to every single patient every single time, while simultaneously maintaining and increasing their own satisfaction of practicing medicine.

Over the last 20 years, a wealth of data and experience has shown that, in our increasingly complex environment, these goals can be hard to attain and sustain unless physicians improve the day-to-day organization of their office practice.

After consultations with physicians across the province to determine how best to accomplish these goals, the Practice Support Program (PSP) was created. PSP was developed as a teaching tool to help family physicians and their staff learn how to integrate well-tested, proven new methods of office management into their own practice to improve efficiency and reduce stress.

This document is about you and your practice. Deciding to make a change and then implementing the necessary methods sometimes requires a willingness to move out of your comfort zone in order to tackle something new. When making a change from procedures you may have used for years to those that are new and unfamiliar, you may not always get the results you had hoped, however the methodology used in the PSP is designed to support you every step of the way in order to get those anticipated results.

Measurement

This document includes measurement tools for four clinical and practice management “change concepts”, or PSP modules: Advanced Access, Chronic Disease Management, Group Visits, and Patient Self Management. Because of the diverse natures of different physician practices, we know that not every change implemented will always result in improvement. **Therefore, personal goal setting and measurement are a critical component to help you to assess your own progress toward your goals** and to make course corrections if the outcomes resulting from a change are not in the desired direction.

To support physicians and their staff, the PSP has developed a work plan to **guide you in creating your own goal statements** and implementing measurement strategies. Setting goals is fundamental to improving quality in health care. The following methods and accompanying measurement tools have been developed and tested by physicians for physicians.

Goal Statements:

Clearly stated overall practice goals for PSP module chosen.

Practice Targets:

Generate practice targets for your unique practice setting.

Measurements for Improvement:

Clear definitions of the practice targets to be measured. This will indicate if change in the desired direction is occurring.

Sample “stretch” targets:

Meant as a guide these are purposely set high because they represent an ideal target. Reaching for “stretch goals” often leads to results beyond what we thought possible, even if short of the sample target level. If we set average goals, we will get average results.

Practice Support Program - Goals and Measurements for Improvement

The Practice Support Program (PSP) is the result of a team effort involving family physicians, the BCMA, the Society of General Practice, the Ministry of Health, and health authorities. It was developed after extensive consultations with family physicians to find better organizational methods that can be used in the management of a physician's practice so that the practice itself becomes more efficient. The PSP is delivered through BC's five regional health authority Practice Support Teams.

The two overarching goals of the PSP are:

Improve physician professional satisfaction

- Increase retention of family physicians
- Increase recruitment of family physicians
- Strengthen the primary care system

Improve patient access to and quality of care:

- Improve patient health outcomes
- Improve patient satisfaction
- Reduce patient complications

This requires a whole-system approach -- Achieving these goals does not result from a linear, one-time effort. Success is achieved through a continual, repeating process which we call the "Quality Loop". In this "loop" of activities, professional satisfaction is enhanced and sustained through achieving quality care. In turn, this is accomplished through ongoing measurement, feedback, and professional development. The latter should provide a collegial, satisfying sense of community. Sustaining such a whole-system approach is challenging.

Specifically, it requires:

Relationships built on mutual trust that recognize the needs of both sides.

Incentives that recognize the time required by FPs to provide comprehensive care are essential, but not sufficient on their own.

Supports for FPs to make practice changes and to coach their office staff through the processes of change

Quality improvement as the common foundation for all change designed to improve the quality of health care services around patient needs

The Quality Loop, as the "engine" for change, is continually moving forward and includes three elements:

- **Leadership** - we make a commitment to the energy and focus needed to sustain the ongoing process of improvement
- **Methods/tools** - the means of learning about our practices and then, to begin with, testing changes on a small scale to determine if they are, in fact, beneficial
- **Culture** - the supportive and mutually inspirational feeling of our community

The Quality Care Loop



Measurement and feedback

- Continues the cycle of ongoing education and excellence that led doctors into medicine in the first place

Professional development component of quality improvement

- Restores collegiality and a sense of professional community
- Results in professional fulfillment and satisfaction

Success is achieved not from a one-time effort, but through a progressive, continuous process. In this Loop of activities, professional satisfaction is increased and sustained by providing quality care to patients. This is achieved by ongoing measurement, feedback, and professional development.

Group Visits

Physician Name / MOA Name: _____ Date: _____

Please complete the following based on discussion with your peers and PSP Support Team at the module learning sessions:

Our PSP Group Goal

As a group, we have set the following stretch goals for integrating Group Visits into our practices on an ongoing basis:

- 1) ___ % of participating practices will each hold at least _____ group visits/group medical appointments between now and the end of the module learning sessions.
- 2) ___ % (e.g., 80%) of participating practices should have a confidence level of at least 7 out of 10 that they can sustain their achievements.
- 3) ___% of participating practices will organize group visits/group medical appointments at least once per month on an ongoing basis.
- 4) ___% (e.g., 80%) of FPs and practice staff should also experience greater professional satisfaction.

Please complete the following with your practice team, as part of developing your action plan.

My Practice Goal

My practice can plan and hold group visits so that:

- 1) _____
- 2) _____
- 3) _____

Targets and Measurements for Improvement

My Practice Targets	Sample Stretch Targets	Measurements
	>3	Group visits/group medical appointments (GV/GMA) held in my practice between now and the end of the module learning sessions.
	1	Plan for GV/GMA to be held at least monthly, on an ongoing basis
	1	GV/GMA held at least monthly, on an ongoing basis
	>10	Patients attending each GV/GMA
	50%	Of GV/GMA will include another health care provider such as a nurse or dietitian to help with patient education and improving patient self-management
	>7 out of 10	Confidence that positive changes we implement can be sustained in my practice

PSP Modules - Goals and Measurement for Improvement

Advanced Access	<p>Advanced Access is designed to improve the flow of patients through the practice so that family physicians can feel less hurried, increase their revenue, and enhance their quality of work life. PSP will support participants during this module to reach their targeted goals as they learn to integrate improvements in scheduling and related office workflow.</p> <ul style="list-style-type: none">• Patients can get an appointment the same day.• Starting and ending your practice day on time.• Patients wait ≤10 minutes beyond their scheduled appointment time until seen in the exam room.• Increasing your panel size. (Potentially resulting in higher practice revenues.)
CDM	<p>Family physicians can feel comfortable managing their entire patient population with chronic conditions, avail themselves of the new incentive fees, and work effectively and collaboratively with their patients, staff, and local community and health authority services. PSP will support participants during this module to reach their targeted goals as they learn to integrate evidence-based CDM guidelines.</p> <ul style="list-style-type: none">• Patients with an identified chronic condition will receive the guideline-based care, as appropriate.• Patients with an identified chronic condition will have improved outcomes based on the measures identified for the condition.
Group Visits	<p>Through group settings, family physicians can provide more efficient care for patients with specific conditions and offer education and advice that is both efficient for them and beneficial for their patients who can also share their experiences with others. PSP will support participants during this module to reach their targeted goals as they learn to plan and implement group visits/group medical appointments.</p> <ul style="list-style-type: none">• Hold group visits/group medical appointments at least once per month on an ongoing basis.• For some group visits, another health care provider will be included such as a nurse or dietician.
Patient Self-Management	<p>For patients with a chronic disease, family physicians can introduce patient self-management to help their patients set their own health goals and support them in a way that is meaningful. PSP will support participants during this module to reach their targeted goals as they learn to jointly develop and document self-management goals and personal action plans with their patients.</p> <ul style="list-style-type: none">• Patients will have documented self-management goals and action plans with regular follow-up• Achieve a confidence level that the patient self-management plans can be sustained over the long term

Roles and Responsibilities

FP Practices participating in PSP Modules

My MOA and I can access our local PSP Support Team at any time to help us to identify areas where we may want to focus, talk through any issues or concerns we have or barriers we have encountered, and draw on the Team for support to help identify solutions relevant to our unique practice situation. We can contact our PSP Team with questions, or just to bounce around ideas, even if we are not going to proceed with a PSP module at this time.

If we decide to participate in a module, we will set a goal statement for my practice related to the module in which I'm participating. The goal statement will help clearly define what I am trying to accomplish and keep our improvement work on track. To do this, I will work with my MOA and assess areas where we think there may be room for improvement, and areas where we may be able to make a difference by applying the principles, tools and methods we'll learn through the module.

We will then choose one or more of the measures identified for the module and/or we can add other measures of our own choosing. We know that being able to measure our own progress is essential to determining whether we're making a difference or not as a result of the changes we're testing, so we'll commit to tracking data to help monitor our progress toward our stretch goals.

We'll then look at the sample stretch targets set for the measures identified for each module to determine the ones we'd like to tackle, and set our own stretch targets for them. These will help us keep in mind what we think is optimal for our patients and our practice.

To learn from others and to share with others what we have learned, we'll share our experiences and lessons learned, both good and bad, with our peers at the module Learning Sessions, and remember that our Team is there to help if and when we need it.

PSP Support Teams

The PSP Support Team will work with family physicians and practice staff to help you assess your own needs and determine how best to meet them. We will support you and your staff in your choice to proceed (or not proceed) and participate in different PSP modules. We can help you assess your practice, identify your needs, goals and which module or modules may be of interest to you. If you decide you're not interested, you have the option of keeping in touch so we can update you on new supports and services, or at a later date you can sign up for the program if you become interested. Once you decide to proceed, we'll be there to help you get started, and to provide as much or as little support as you need to test and implement changes in your practice.

We will arrange peer learning opportunities for you and your colleagues who have similar interests, and support you in sharing your learning experiences with your peers. We commit to providing you with confidential data and feedback on your quality improvement efforts, help you to celebrate the successes you achieve, and learn from any unsuccessful changes.

We will help you to integrate the changes you are testing into your new day-to-day practice management, and help you develop the confidence needed to sustain the positive changes you have made as part of the module's structured quality improvement process.

We will also participate in the provincial planning and evaluation of the PSP to be sure the program can grow and evolve to best meet BC FPs needs.

GPSC and the PSP Coordinating Office

Provincially, through the GPSC and the joint BCMA/MOH PSP Coordinating Office, with input from BC physicians and the health authorities, we will continue to examine both physician needs and health system needs to identify new content areas or other areas of support. We will make course corrections to ensure that the services and support available to BC FPs are helping to accomplish the overall program goals:

- To improve patient access and quality of care; and
- To improve family physicians' professional satisfaction.

As an ongoing part of this process we will examine the evidence from the literature and from participants in the many quality improvement initiatives across BC, to validate the existing program goals, set and revise stretch goals, and assess and report on BC's progress toward those long term targets and goals over time.

The overall stretch goals set for the program are numerical targets for each measure and module that are set very high because they represent the ideal of what we hope to achieve. They've been set in consultation with physicians across BC. Reaching for such "stretch" goals leads to results beyond what we considered possible even if short of the exact target level. Their intent is never punitive. Overall stretch goals, the long term "ideal targets" for the program and each module are outlined below:

Sustainability	<ul style="list-style-type: none">• We hope that for all participants, by the end of their participation in each module, changes implemented are sustainable in > 80% of participating FP practices.• Sustainability can be reflected by GP practices having a confidence level of at least 7 out of 10 that they can sustain their achievements.
Improvements in Professional Satisfaction	<ul style="list-style-type: none">• We hope that > 80% of participating GPs and practice staff can experience greater professional satisfaction as a result of having support to test changes through the modules, and "transforming" their practices to new ways of working that will become their new day-to-day practice routines.
Advanced Access	<ul style="list-style-type: none">• We hope that 80% of participating practices have their 3rd next available appointment on the same day.• 80% of patients wait ≤10 minutes beyond their scheduled appointment time until seen in the exam room.• 60% of participating practices start and end their day on time.
CDM	<ul style="list-style-type: none">• We hope that 80% of practice patients with a particular chronic condition can receive guidelines-based care, as appropriate, for the measures identified for each condition and the specific goals selected by each practice.• 60% of practice patients with a particular chronic condition can have improved outcomes based on the measures identified for each condition and the specific

<p>Group Visits</p>	<ul style="list-style-type: none"> • We hope that 95% of participating practices will each hold at least 3 group visits/group medical appointments during the module. • 80% of participating practices will organize group visits/group medical appointments at least once per month on an ongoing basis.
<p>Patient Self-Management</p>	<ul style="list-style-type: none"> • We hope that 90% of participating practices will jointly develop and document personal action plans and goals with at least 30 patients during the module. • 95% of patients with documented action plans and goals will have a level of confidence of at least 7 out of 10 that they can meet their goals. • 90% of patients with documented action plans and goals will have had a followup

The GPSC and PSP Coordinating Office are working in an environment of continuous quality improvement, and are continually refining the content and support processes of the PSP to better meet your needs. Your feedback, and the data associated with the changes you are implementing in your practices, will validate the approach and content, or let us know what changes are necessary.

The purpose of measurement and goal setting through the PSP is to encourage a health-system-wide culture of ongoing quality improvement. The GPSC, in collaboration with the health authorities, has implemented the PSP as a means to encourage and support transformational change in family practice, by providing a variety of practice based supports that physicians, with their office staff, can choose to access based on the relevance to their own unique practice needs. We hope you will take advantage of the new opportunities for strengthening relationships with your health authority, for the support and encouragement of learning from and sharing your experiences with your peers, and for putting the joy back into family practice.

“Data backs up our story”

Dr Neil Baker

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