# Quality Based Procedures: An Integrated, Collaborative Approach

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BLUEWATER HEALTH

## Our Strategic Themes

**Vision:** Exceptional Care - Exceptional People - Exceptional Relationships
**Values:** Compassion, Accountability, Respect, Excellence (CARE)

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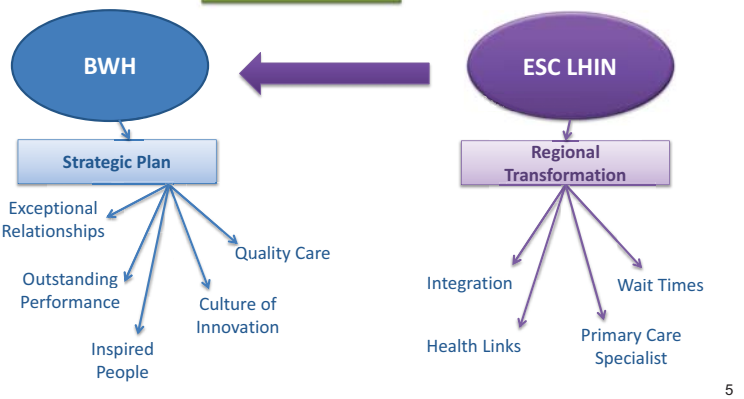
## What is a Quality Based Procedure or QBP?

- **Quality Based Procedures** involve clusters of patients with diagnoses and treatments that are clinically related (i.e. CHF, COPD, Stroke, Pneumonia etc.)
- **QBPs** are a compilation of evidence-based best practices and recommendations for clinical redesign, improved patient outcomes, enhanced patient experiences and potential cost savings, outlined by expert panels

## Health System Transformation

The paradigm shift to quality, integration and the long-term sustainability of our healthcare system…



## Standardizing Processes for QBPs

- Disease/QBP Specific Order Set
- Electronic Clinical Pathway
- Targeted, Consistent Patient Education
- Enhanced Discharge Processes
- Community Hand-off

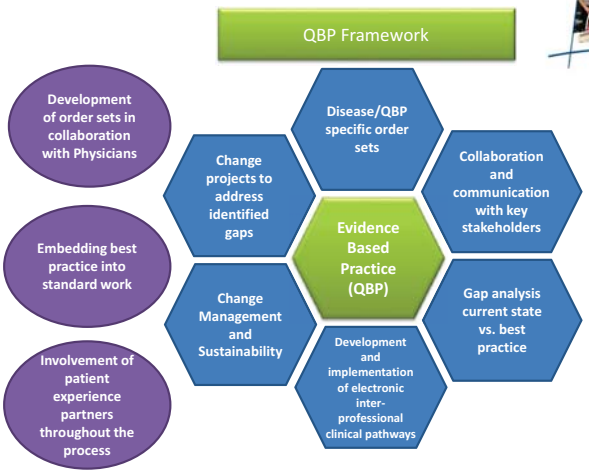
## How our Journey Began

- Commitment from Bluewater Health Executive Team to focus on completion of key Quality Based Procedures
- Key QBPs identified for 2013-2014:
  - COPD
  - CHF
  - Stroke
  - Unilateral Hip and Knee Replacement

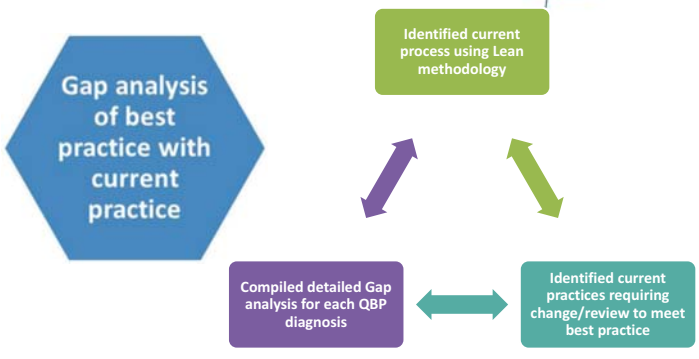
## Key Initial Steps

- Project Manager and Lead Physician Secured
- Project Leads Identified for Specific QBPs
- Project Teams Established

## Our Planned Approach




## Milestone 1




## Value Stream Mapping - CHF

CHF QBP – Gap Analysis Template:

Gaps identified from reviewing handbook and current practice:

| Recommended | Available | Mitigation/Plans |
|---|---|---|
| Clinical Assessment Node: ED Risk Stratification and Responsiveness to Diuresis | | |
| | | |
| | | |
| Care Module: Acute Stabilization Phase: Low Intensity Patient (0-24hrs) | | |
| | | |
| | | |
| Clinical Assessment Node : Reassessment and Re-evaluation: | | |
| | | |
| Care Module: Sub-acute stabilization Phase | | |
| | | |
| Care Module: Advanced Heart Failure | | |
| | | |
| Care Module: Discharge Phase | | |
| | | |
| | | |
| | | |
| | | |

## Milestone 2

**Four Working Group Teams Created:**

**Change Projects to address gaps**

- Best Practice – Assessment in ER
- Best Practice – Order Set and Clinical Pathway Creation
- Best Practice – Discharge Practices
- Best Practice – Advanced Care Planning

## Milestone 3:

**Disease specific order sets**

| | |
|---|---|
| **Lead Physician and Project Team** | •Created order sets |
| **Lead Physician** | • Responsible for communication with Physicians<br>• Assisted with approval process |
| **Project Manager** | • Collaborated with LHIN Chronic Disease Leads on QBP education for Physicians<br>• Assisted in creation and approval of order sets |

## Milestone 4

**Electronic Clinical Pathways**

- Internal and External Stakeholders
- Super-user approach to development and testing
- Super-user expert group facilitated education and became key resources during roll out

## Milestone 5

**Communication to Key Stakeholders**

- Project Manager – communication to key stakeholders
- Weekly meetings – risk identification, strategy
- Communication to staff (Lean Huddles, face-to-face, LIFE newsletter

## Milestone 6

**Change and Sustainability**

- Organizational Development
- Physician Leads and Leadership Team
- Clinical Education and Professional Practice
- Performance and Transformation (Lean Process)

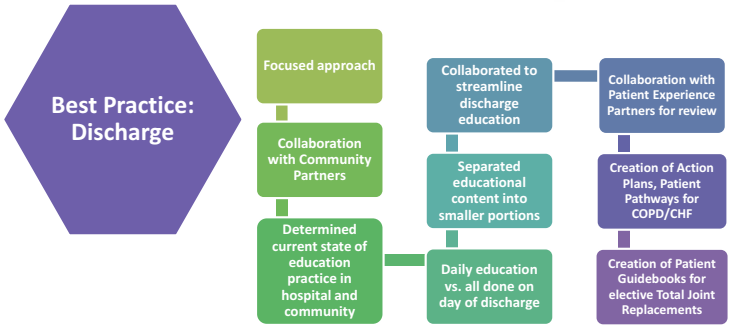
## Lean Huddle: Communication

## Working Group 1

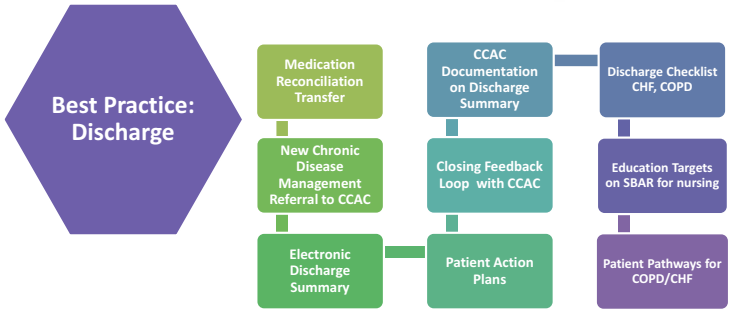
**Best Practice: Assessment in ER**

- Review of current practice in ER
- Standardized ER discharge education with Community Partners
- Electronic solution created for capture of key QBP activities

# Working Group 2




# Working Group 2 cont.

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## Patient Action Plan for Chronic Obstructive Pulmonary Disease (COPD): Signs & Symptoms

Use this guide to help you report changes in your symptoms to your doctor or nurse. When you report symptoms early, you are less likely to have to go to the hospital for treatment.

Family Doctor or Nurse Practitioner: _____

Phone Number: _____

** If you do not have a family doctor or nurse practitioner, CCAC can help you find one. Call 1-888-647-4468 **

**Green Zone: I Feel Well**

**Remember at all times to avoid cigarette smoke, inhaled irritants and your triggers**

- I can continue my usual activity and exercise level
- My cough has not changed
- My sputum has not changed
- My appetite is good and I continue to eat healthily
- I sleep well at night. I do not wake up because of cough or shortness of breath
- I continue to work with my healthcare team to stay on track

**Yellow Zone: I Feel Different**

**Call your family doctor or nurse practitioner or go to the nearest walk-in clinic if you experience any of the following symptoms:**

- I am experiencing an increase in symptoms, such as tightness in my chest, breathlessness or cough
- I have an increase in the amount or thickness of my sputum
- My sputum may be more yellow, green or brown in color than usual

**Other symptoms that may suggest a COPD flare-up:**

- I have a fever
- I feel like I have a chest cold
- I have swollen ankles
- I feel fatigued and generally unwell

**Remember when feeling unwell to:**

- Continue daily medications
- Use your quick-relief inhaler as prescribed
- Get plenty of rest
- Use your breathing techniques
- Pace yourself to conserve energy

**Red Zone: I Need Help**

**Call 911 for an ambulance if you experience any of the following symptoms:**

- Chest pain
- Blue lips or fingers
- Extremely short of breath
- Drowsy
- Confusion, can't think clearly or very agitated (upset)

PIB1-002 2014 10

Adapted from Canadian Respiratory Guidelines and in collaboration with *COPD & Asthma of Alberta* (CANA).

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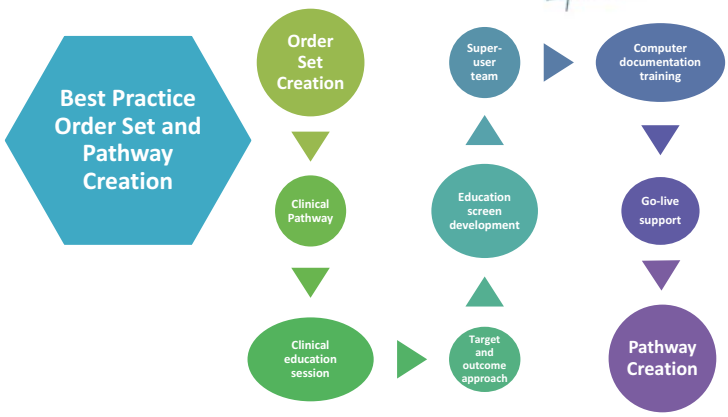
## Chronic Obstructive Pulmonary Disease (COPD) Patient Pathway

**What to Expect on the Day of Admission (Day 1)**

| | |
|---|---|
| Patient Outcomes | This booklet will help you understand what will happen during your stay and why you were admitted to the hospital. If you do not understand, please ask your nurse. |
| Assessment | Your temperature, pulse, breathing, and blood pressure will be checked frequently. A nurse will listen to your chest and assess your breathing as required.<br><br>Your weight and height will be measured.<br><br>A nurse will ask if you smoke. If you do, and you are interested in quitting, education will be provided. You will be encouraged not to smoke during your hospital stay. We can offer you a nicotine patch while in hospital. |
| Tests | You will have blood tests and a chest x-ray done. If necessary, they may be repeated throughout your stay. |
| Medications | You will be asked about all the medications you take at home, so your doctor has a current and accurate list. This includes prescription medications, over-the-counter medications, and herbal and vitamin supplements.<br><br>Medications will be given to you as ordered by the doctor. These may include antibiotics and medication to help with your breathing. If you have any concerns or questions about your medications, please speak to your nurse. |
| Treatment | You will be given oxygen through small prongs in your nose or through a face mask if necessary. |
| Nutrition | You may eat or drink as you like, unless you require a special diet ordered by your doctor. It is important that you drink a lot of fluids. |
| Consult | A team of people, including a pharmacist, dietitian, physiotherapist, occupational therapist, social worker, respiratory therapist and Community Care Access Centre (CCAC) care coordinator, are already working on getting you home. They will explain who they are and what they do when they come to see you. |
| Activity | You will be encouraged to move as much as possible. We want to get you up moving at least once every six hours. This includes getting up in a chair, getting to a commode or walking to the bathroom if possible. Staff is available to assist you if needed. |
| Education | Your nurse will orientate you to your room and the unit you are on. Today, we will help you understand what Chronic Pulmonary Obstructive Disease (COPD) is, and give you an education package for you and your family. This package will be used throughout your stay to help you manage your disease when you return home. Please review this package with your family. We will work with you and your family to help prepare you for going home. |
| Discharge Planning | What are your goals and/or concerns for returning home safely? Please share any concerns and goals with your healthcare team. |

# Working Group 3



## FIRST PHASE OF QBPS ROLLED OUT

In October's LIFE, we learned that Quality Based Procedures (QBPs) are evidence-based best-practices that involve clusters of patients with diagnoses and treatments that are clinically related. The goal is to standardize care across Ontario and provide quality outcomes for patients.

President/CEO Sue Denomy says, "QBPs are a significant priority for the Ministry of Health and Long-Term Care, and indeed for Bluewater Health. These evidence-based frameworks provide opportunities for process improvements, clinical redesign, potential cost savings, improved patient outcomes and enhanced patient experience. Every one of those opportunities helps Bluewater Health deliver on our strategic plan and our promise to our community ultimately creating exemplary experiences for our patients and families every time."

As part of the QBP rollout, electronic clinical pathways for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Total Hip Replacement and Total Knee Replacement went live in our computer documentation system. These pathways, used by the interdisciplinary team, include guidelines for daily practice, such as activities, education, tests, treatments and medication, and are linked to physician orders sets.

Thank you to the following staff members who were instrumental in the development, testing, training and implementation of the pathways.

**Jennifer Moore** **Lindsay Mclean** **Elizabeth Anthony**
**Cindy Wilson** **Heather Reid** **Milly Helps**
**Sandy Maxfield** **Marcel Blais** **Dan Maure**
**Carol Columbus** **Joe Blythe** **Harry Rianto**

We would also like to extend appreciation to our super users who immersed themselves in learning the electronic QBP pathways, medication reconciliation transfer and the Learns model, and trained their colleagues throughout the organization.

**Jennifer Moore** **Lindsay Mclean** **Elizabeth Anthony**
**Cindy Wilson** **Milly Helps** **Joe Blythe**
**Elizabeth Hart** **Karla Moffatt** **Darren Henderson**
**Helen Rummery** **Joanne Bartley** **Mary Bradburn**
**Anne Gilmore** **Margie Hull** **Brian Anthony**
**Vicky Fletcher** **Danielle Szaefer**

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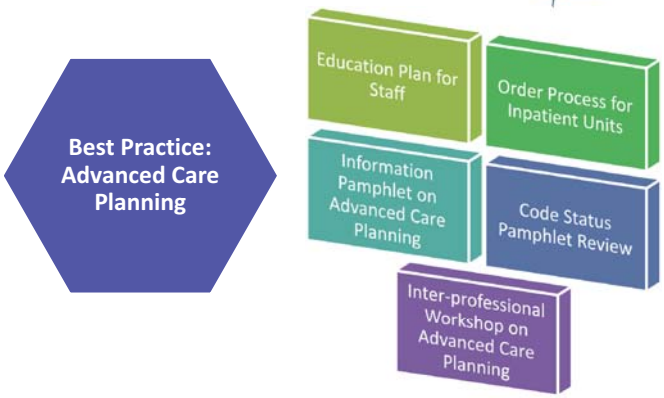
**CLINICAL PATHWAY - COPD**
**TARGET LOS – 5 Days**
**EARLY DISCHARGE OPPORTUNITY – DAY 4**
*(*Numerous variables can further impact ELOS, including age, comorbidities and flagged interventions.)*

**Clinical Pathways are not considered a substitute for professional judgment.**

| DATE | Day of Admission (0-24hrs) | Day 1 and 2 (24-48hrs) |
|---|---|---|
| Assessments and Monitoring: | • Vital signs on admission, then q4hr and prn<br>• Respiratory assessment on admission, then q4h and prn<br>• Neurological assessment (L.O.C) on admission, then q4hr and prn<br>• Weight and height (T)<br>• Assess need for nicotine replacement therapy | • Vital signs q 12hr and prn, or as per physician order<br>• Respiratory assessment q12hr and prn, or as per physician order<br>• Neurological assessment (L.O.C) q12hr and prn or as per physician order |
| Tests / Treatments / Interventions: | • CBC, Electrolytes, Creatinine, Random blood sugar<br>• Other blood work/tests as ordered<br>• Blood cultures for temp >38.5C, and as ordered<br>• Maintain O2 sat 88-92 % or as per physician order<br>• Blood gases as per physician order or per RRT assessment | • Review test results<br>• Bloodwork as ordered<br>• CXR as ordered<br>• Maintain O2 sat 88-92%<br>• Confirm patient has a PCP in readiness for discharge (T) |
| Medication / Pharmacy: | • Complete Medication Reconciliation (T)<br>• Assessment for DVT prophylaxis<br>• Discussion with patient re: smoking cessation (if smoker) (T)<br>• Ensure prescribed medications given and document effectiveness | • Assessment for DVT prophylaxis<br>• Review medication reconciliation<br>• Teaching of new medications |
| Nutrition and Elimination: | • Diet as ordered<br>• Assess nutritional status with meals<br>• Bowel management as ordered<br>• Assess bowel function q12hr | • Assess nutritional status with meals<br>• Assess bowel function q12hr |
| DATE | Day of Admission (0-24hrs) | Day 1 and 2 (24-48hrs) |

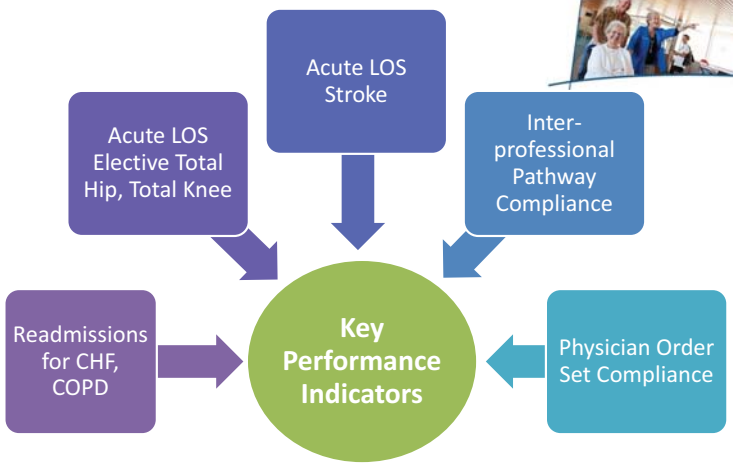
# Working Group 4



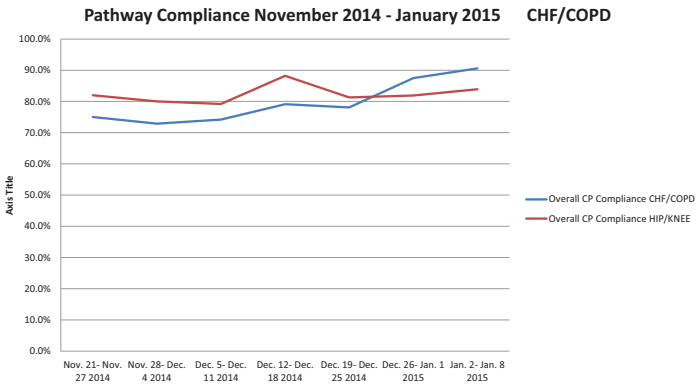
# Education and Training for Staff

- Targeted Clinical Staff Education on COPD/CHF
- Documentation Training (Med Rec, Pathway, Patient Education)
- Learns Model – Teach-back Education
- CCAC Documentation Training Sessions
- Allied Health Specific Documentation Training Sessions
- Physician Education with LHIN Chronic Disease Physician Lead

# …Pulling It All Together




## Reporting




## Readmissions: Early Findings

| Quarter | COPD | CHF |
|---|---|---|
| Q2 2013-14 | 23% | 19% |
| Q3 2013-14 | 28.43% | 18.4% |
| Q4 2013-14 | 24.5% | 17.5% |
| Q1 2014-15 | 20.3% | 16.2% |
| Q2 2014-15 | 24.3% | 14.7% |

## Successes

## Challenges – Order Sets

- Order sets – no CPOE (access issues)
- Length of Order Sets – now creating Addendums
- Physician Compliance
- Transfers out of ICU – orders associated

## Challenges

- Rural Site – Resources
- Education – Super-user coverage
- Project Leads – Competing Priorities
- Reporting Resources- Manual Audits
- Documentation – new approach(target & outcome vs. task-based)

## Lessons Learned To-date

- Inclusion of front-line staff and Physicians is critical
- RRTs carry a great deal of knowledge on COPD/CHF – leverage this
- Follow up appointments and Action Plans are a key component of discharge
- Daily approach to patient education using "Learns" teach-back model
- Comprehensive Change Management and Sustainability Plans are key to success
- Engage front-line staff in using data to drive changes in practice
- Celebrate and communicate successes back to front-line staff and key stakeholders

## LHIN Regional QBP Strategies

### Quality Based Procedures

Example Master Documents (BWH Initial roll-out)

| Hip & Knee | Example | CHF | Example |
|---|---|---|---|
| Gap Analysis | Gap Analysis - Hip & Knee | Gap Analysis | Gap Analysis - CHF |
| Pathways | Hips, Knees | Pathways | CHF |
| Order Sets | Available in citrix | Order Sets | Available in citrix |
| Scorecards | Hips & Knees Scorecard | Scorecards | CHF Scorecard |
| Education Packages / Surgical Handbook | Hip Handbook, Knee Handbook | Education / Discharge Packages | In development |

# LHIN Regional QBP Strategies

## Quality Based Procedures

Example Master Documents (BWH Initial roll-out)

| COPD | Ex. | Stroke | Ex. |
|---|---|---|---|
| Gap Analysis | Gap Analysis - COPD | Gap Analysis | Gap Analysis - Stroke |
| Pathways | COPD | Pathways | In development |
| Order Sets | Available in citrix | Order Sets | ER tPA Elig tPA Rx Acute Stroke T |
| Scorecards | Scorecard - COPD | Scorecards | Scorecard - Stroke |
| Communication Plan | QBP Comm Plan | | |
| Education / Discharge Packages | COPD Discharge | Education / Discharge Packages | In development |

# Questions?

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