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Integrated Care Wave Aims and Measures

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Principal Clinical Advisor
Townsville 2 December 2014

HOW DO WE KNOW IF A CHANGE IS AN IMPROVEMENT?

MEASURE IT!

Integrated Care Wave Topic

The Integrated Care wave will bring together general practices, hospital and community clinicians to build integrated care teams around patients with high care needs

Wave Aim

Improve outcomes and decrease hospitalisations for patients with high care needs

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Topic Aims

- Decrease ED presentations to hospital by 50% over the period of the Collaborative
- That **xx** people with high care needs are managed by a fully-functioning Integrated Care Team (About 5 per participating practice)

xx *number of people in measure variable dependant on number of participating health services and size of health service*

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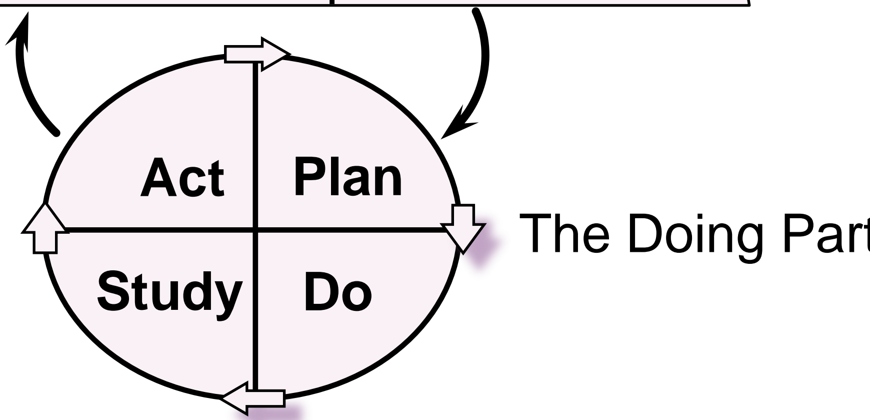
The Model For Improvement (MFI)

The Thinking Part

What are we trying to accomplish?

How will we know that a change is an improvement?

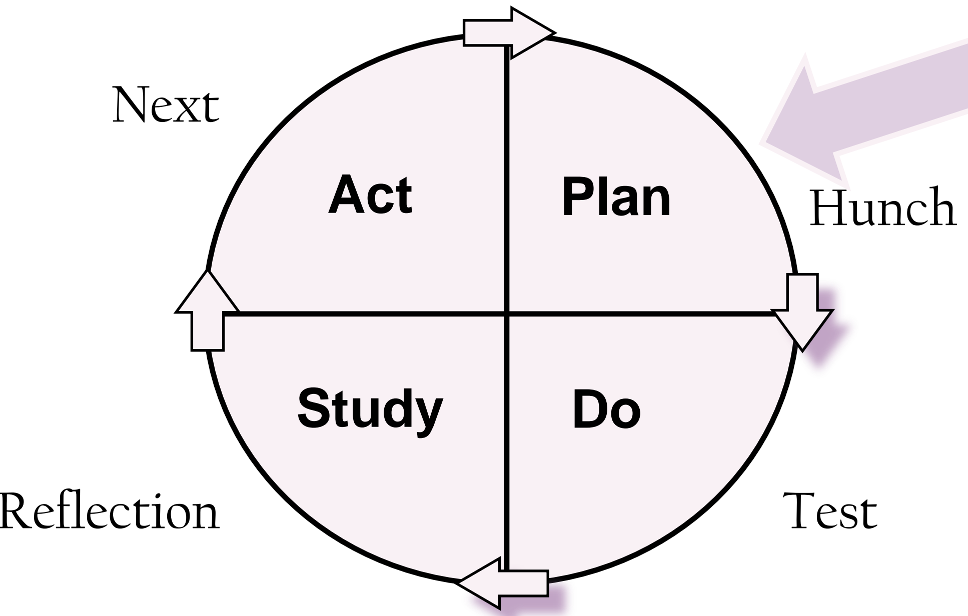
What change can we make that will result in an improvement?



The Doing Part

PDSA Cycle(s)

IDEAS



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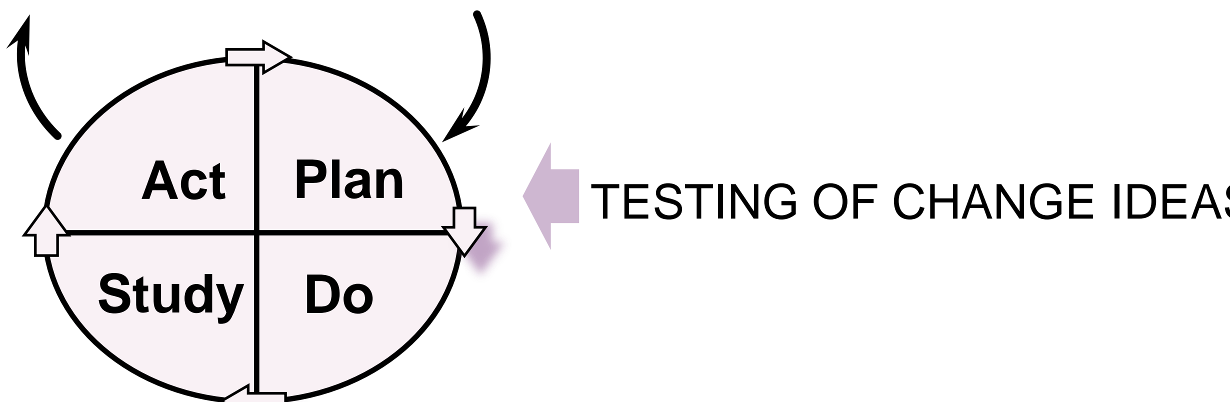
GOAL

MEASURE

CHANGE IDEAS



The Model For Improvement (MFI)

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Definitions – High care needs patient

For the purposes of the APCC Integrated Care Wave, the following may be defined as a high care needs patient:

- Patients with multimorbidities (2 or more chronic illnesses)
- Do not have a carer
- Frequent emergency presentations or hospital admissions
- Social Isolation

Health Services in collaboration with Townsville Hospital Health Service and other local services will identify 5 patients that they will put on the register, ideally focusing on those who meet the above criteria.

- http://www.savevid.com/video/model-for-improvement-clip-2.html

YT Links

- https://www.youtube.com/watch?v=SCYghxtioIY

- https://www.youtube.com/watch?v=xzAp6ZV5ml4

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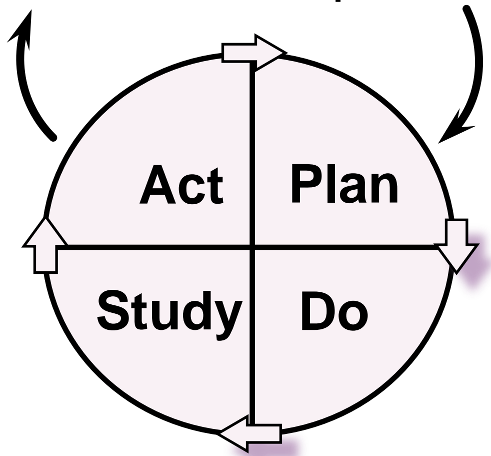

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Questions about the new topic …..

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The Measures in Brief

Integrated Care Measures

- Number of people on the register with high care needs being managed by an integrated care team
- Number of hospital ED presentations per person on register since the start of the collaborative
- % of people on register with a Shared Health Summary loaded or updated in the last 6 months

Measures in Brief cont…

- % on register whose ‘Overall Health’ self-rating has increased
- % on register whose ‘Overall Confidence’ self-rating has increased
- % on register who have an Advance Care Directive in place
- % on register who have had a GPMP created or reviewed in previous 6 months

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Measure 1

Numbers of people on the register with high care needs being managed by an integrated care team

This number will be dependent on:

- Number of participating health services
- Number of patients identified with high care needs per participating health service (5-10 per health service)

Measure 2

Number of hospital ED presentations per person on register since the start of the collaborative

- Ongoing monthly measure (culmulative)
- Collect at baseline how many admissions patients on register have had in the previous 12 months
- THHS can identify subgroup of patients to extract this data as per GP participant

Measure 3

- **% of people on register with a Shared Health Summary loaded or updated in the last 6 months**

Measure 4

% on register whose 'Overall Health' self-rating has increased

- Collect data at start of collaborative and at end
- Patient survey/tool rating system to be used to collect this measurement

Measure 5

% on register whose 'Overall Confidence' self-rating has increased

- Collect data at start of collaborative and at end as per Measure 4
- Patient survey/tool rating system to be used to collect this measurement

Measure 6

% on register who have an Advance Care Directive in place

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- How many prescription medications are you taking more than three days a week?
- In the past year have you been in the hospital or visited an emergency room because of a chronic problem?
- Do you have one person you think of as your personal doctor or nurse?
- Are there things about your medical care that could be better?
- How easy is it for you to get medical care when you need it?
- How confident are you that you can control and manage most of your health problems?
- When you visit your doctor's office, how often is it well organized, efficient and not a waste of your time?
- When you think about your health care, how much do you agree or disagree with this statement: “I receive exactly what I want and need exactly when and how I want and need it

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Measure 7

% on register who have had a GPMP created or reviewed in previous 6 months

- Ref to case conferencing item number for discharge from hospital for measuring
- Driven by practice nurse

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9 Years of Collaborative Experience

- Its the patient
- Consider who the team are and invest in the team
- Spend time agreeing on aims
- Protect some time
- Agree on some measurements which provide guideposts towards the aims
- Use the measurements in decision making, and motivation

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9 years of Collaboratives

- Regard the Medical Record as an asset which needs investment
- Understand organisational and change psychology
- Incentives and KPIs are marginal at creating improvement, but culture is central
- Consider the practice population
- Look at this as a long term journey

6 years of Collaboratives

- Consider GP / Primary Care career development
- Its the Practice Systems
- Redesign part of the system
- share
- Don't forget to do small tests
- Get patients involved in the redesign

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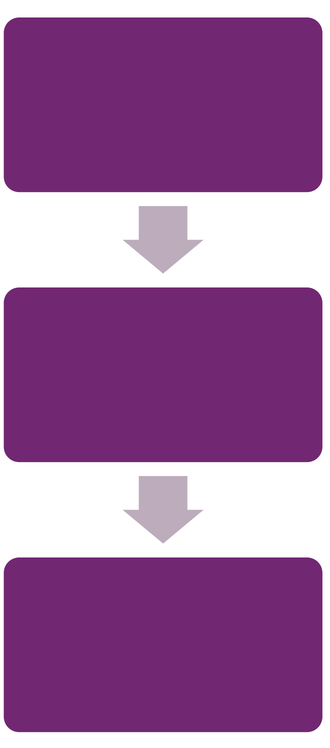
Practice Performance

- Consultation Quality
- Clear Process Plans
- Team morale
- Waiting times
- Delays
- Prevention Goal
- Chronic Disease Care and outcomes
- Safety and Error prevention

Collection and Submission of Manual Measures

Submission of manual measures process map to be inserted here – TBC as per David M/Nicole



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Manual Measures Spreadsheet

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APCC Australian Primary Care Collaboratives Pioneering Change

APCC Intergrative Care Wave

HS name **Submission Date:**

	Name / reference of patient with high care needs being managed by an integrated care team (there must be an entry in this field for the patient to be counted)	How many hospital ED presentations has the patient had since the start of the collaborative (date#)?	Does the patient have an Advance Care Directive in place?	Has a Shared Health Summary been uploaded or re-uploaded (updated) for the patient in the previous 6 months?	Has a GP Management Plan been created or reviewed for the patient in the previous 6 months?
Patient 1					
Patient 2					
Patient 3					
Patient 4					
Patient 5					
Patient 6					
Patient 7					
Patient 8					
Patient 9					
Patient 10					
Patient 11					
Patient 12					
Patient 13					
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Patient 17					
Patient 18					
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Patient 22					
Patient 23					
Patient 24					
Patient 25					

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Email Submission of Manual Measures

Once your spreadsheet has been populated, please email this information to

Insert email here

For any support

- Contact your TMML support person
- Call IF help desk **08 8422 7450**

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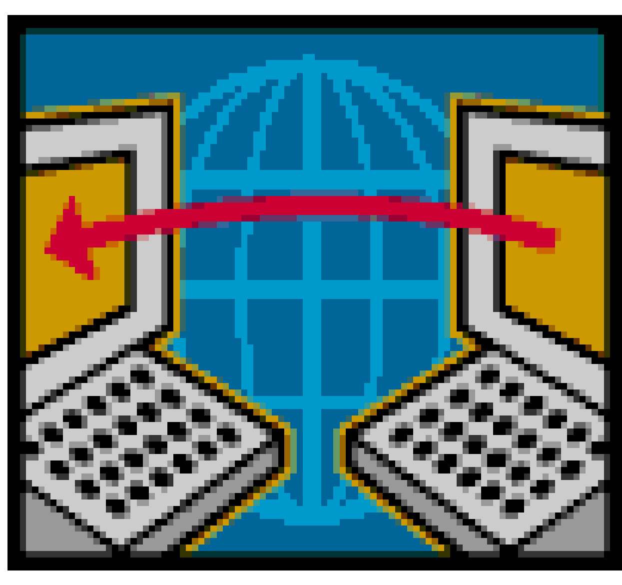
ICW Data Submission Dates



Data submission requirements:

- Baseline data manual measures to be submitted by **Monday 15th December**
- Ongoing monthly data submission by **23rd** of each month
- Do not submit on last day of month as manual measures need to be processed and uploaded onto qiConnect
- Submit practice data in the background each month

Townsville Mackay Medicare Local support staff play an important role in assisting health services successfully fulfil these manual data submission requirements and **timeliness**

Any Questions?

Acknowledgements

This program is funded by the Australian Government Department of Health