CRaNHR – LEG Evaluation Project (J. Sherman)

Objectives

- *Improve the collection and reporting of information on scholarly and professional development activities*
- *Contribute to the refinement of the LEGs annual report form*

Continue development and application of the LEGs evaluation framework

- Consultations with LEG Leads & Administrators (five LEGs participated)
- Review of annual reports (2014-15)
- Revise framework, next steps

Summary of Consultations

- Goals, activities in evaluation framework were relevant to participating LEGs
- Different priorities for LEG development, evaluation
- Each LEG has developed its internal reporting/accounting system
- Common Challenge: Annual Report (Enhanced scholarly activity)
  - Not sure what to report
  - No feedback on reports submitted

Review of Scholarly Activities Reported

- Report format – first attempt by NOAMA to apply framework
- 31 LEGs submitted reports (2014-15)
- Focus on Scholarly Activity Report
  - Great variability in quantity and quality of information reported
  - “Free form” information – Format makes it difficult to collate, summarize information

Conclusion

- Need to improve reporting tools
  - Report categories are too broad – “boxes” need to be more focused and well defined
  - Need more clarity/agreement on some terms, e.g. “community-engaged scholarship.”

For Discussion

- What are your recommendations for improving the reporting mechanism?
  - Do the more focused categories in the handout aid/clarify what can or should be reported?
  - Are examples, definitions be useful?
  - Format
    - Fillable PDF; Excel file, Online “survey”, other software?

LEG LEADS & ADMINISTRATORS MEETING

Friday, November 4, 2016

Faculty Engagement (Dr Barb Zelek)

- Faculty engagement is very much a relationship between an organization and people.

Enablers of Employee Engagement

1. Define employee role
2. Passionate and capable
3. Support and value
4. Create sustainable support system
5. Develop feedback and reinforcement mechanisms

- Interest in faculty engagement is mainly in hospitals based in the U.S.
- Physicians that are engaged improve the financial bottom line.
- Found lower patient mortality and improved patient satisfaction with physicians who are engaged in hospital-type settings.
- There is a strong link between faculty engagement and retention in an organizational performance.
- Highly engaged faculty are interested in their work and invested in their institution.

Drivers of Physician Engagement

1. Having confidence in the institutions' success
2. That the school cares about its' students
3. Being satisfied with the teamwork demonstrated among faculty/administrators.
4. Being satisfied with the overall performance of the school.
5. Feeling students are satisfied with the quality of medical education they receive.
6. Perceived usefulness of the supports offered to faculty.
7. Being satisfied with the performance of staff within the immediate work environment.
8. Feeling school cares about quality improvement
9. Believing that the school treats faculty with respect

Motivation Theory
- Extrinsic motivators
- Intrinsic motivators
  - Autonomy
  - Purpose
  - Mastery

Intrinsic Motivators

- Good elements
- A natural state
- Produces something transcendent or meaningful
- A Greater sense of purpose

Purpose: The sense that what we do produces something transcendent or serves something meaningful beyond ourselves.

Mastery: To keep improving at something that is important to us. Must be engaged and has a sense of "flow".

Autonomy: The desire to be self-directed and linked to overall well-being

Find out ways to incorporate these into your LEG. (Table Work)

Barriers to Change

- Organizational
- Attitudinal

Next Steps

- Definition of faculty engagement in DME
- AFMC National Working Group – Dr George Kim research study
- LEG Faculty

Engaging Physicians with Quality Improvement (Dr Andrew Webb)

Learning Objectives

1. Describe why a physician should be involved in quality improvement and how to overcome barriers to participation.
2. Describe the role of physician leadership in delivering quality improvement.
3. Recognize reduced cost as a by-product of quality improvement.

Obstacles and Barriers to Participation

- Health system incentivizes quantity over quality
- Health system does not reward professionalism
- Health system does not reward physician leadership
- If it is not counted, if it's not measured, then it may not get done

There are four pillars of professionalism

- Excellence
- Humanism
- Accountability, and
- Altruism

- We have to find ways of encouraging or motivating physicians to get involved

Physician Leadership

- Medical leadership is both a need and a void
- Independent practice
  - Ambition for a small part of the system
  - Not the balcony view of the system
- Physician Culture
  - Team vs. Individual
  - Medical vs. Interprofessional
  - Crossing to the "dark side."
- Reduction in financial reward

Creating Physician Leaders

"Competency in healthcare leadership cannot be assumed because a physician has achieved academic and clinical success."

- Prepare for leadership during training
- Service redesign must be part of undergraduate curricula
- Leadership should be considered as an essential medical service

Engaging Physicians in Quality Improvement Activity

Physician Compact: A statement of commitment to behaviours on both sides

A process that takes multiple meetings on both sides to develop this commitment. Physicians have to take the time to think about what they would like to say and have to make physicians feel safe.

Physician Led Clinical Audit Program

"For medical quality improvement to be successful physicians must believe in the benefits of engaging in the activity, have trust the outcome will be used for the improvement of medical practice and patient care, and be involved in selecting the activity."

- Infection Prevention and Control

Hospital Congestion

- Patients stuck in the emergency department that cannot get the right assistance
- The traditional way to persuade people to do things is "patience".
- 90% of people choose death
- Fear, facts and force do not work.
- Ornish's approach to reversing heart disease giving them new hope, new skills and new thinking
- Small group discussions (team building).
- Provision of data in activity reports and repeated data reframing the issue as their own.
- Physician-initiated length of stay review
- Focus on engagement – team development sessions and strategies to improve physician communication.

4 Steps to Seamless Care Philosophy

1. Standardized care – data processes and workflows
2. Integrate information – accessible and shared
3. Coordinate Care – seamless patient experience
4. Personalized care – tailor standards

Conclusion

For physicians to engage with system-wide Quality Improvement

- Data must be relevant and meaningful
- As contractors physicians must feel safe
- FFS creates a piecework culture that must be respected and negotiated
- Leadership must be accepted and rewarded as necessary
- Teaching social accountability and professionalism are necessary and fundamental changes required in medical school.

LEG Lead Meeting – Health Quality Ontario (R. Dhatt, J. Johnsen)

Objective

- *Discuss ways that Health Quality Ontario can support your LEG*

The Six Domains of Quality:

- Safe
- Effective
- Patient Centered
- Timely
- Efficient
- Equitable

Health Quality Ontario is:

- Provincially driven
- Locally Focused

What we've heard:

- Engagement is difficult – Intrinsic motivators are necessary
- Physician leadership is key
- Need to develop "safe spaces" for Quality Improvement
- Safety receiving data
- Safety in failure
- Data availability
- Patient engagement
- Shared purpose
- Often things we know we could do better
- Technical support is important

Staying True to These Principles:

- Commits to ongoing quality improvement
- Achieves healthy populations
- Ensures accessibility for all
- Partners with patients
- Balances priorities
- Uses resources wisely

All of these principles can only happen when we:

- Engage patients and the public
- Redesign the system to support quality care
- Help professionals and caregivers thrive
- Ensure technology works for all
- Support innovation and spread knowledge
- Monitor performance with quality in mind

- Build a quality-driven culture

“**Better has no limit.”**
Begin with an idea, and then it becomes something else – Reform

LEG LEADS & ADMINISTRATORS MEETING

Saturday, November 5, 2016

Breakfast Meeting – LEG Administrators (Michelle Labate)

LEG Website

- Create an account (see handouts for detailed instructions)
- Edit profile
- You are now able to create and edit your topics and replies under the Forums. Please note that all Forums are created by NOAMA, users can create their topics.
- Anyone comments or replies, you will get a notification.

Prepayments and Reconciliations

Prepayments

- Sent to LEGs quarterly for Clinical Teaching (Jan-Mar, Apr-June, July-Sept, Oct-Dec)
- Data is received from NOSM which is taken from their database
- Data is extracted from their database month before beginning of the quarter
- Two documents will be sent to the LEG
  - Summary and Details (pdf)
  - Confirmation Tracking Sheet (Excel)

Reconciliation

- Data is received from NOSM which is taken from their database
- NOAMA receives reconciliation data 2 quarters after prepayment
- Updated teaching list vs. prepaid teaching in each LEG
- Changes are caught and paid to (clawed back from) each LEG
- One pdf document sent to each LEG with:
  - Summary of Reconciliation
  - Prepayment details
  - Reconciliation details
- Confirmation needed from the LEG administrator/lead
- Reconciliation details=changes you have made to your Confirmation Tracking Sheet
- Reconciliation sent to LEGs quarterly

Prepayment and Reconciliation Document

- NOAMA **does not** need a response after prepayment documents are sent

- NOAMA **does need** a confirmation from the LEG after reconciliation documents are sent, stating whether or not we caught all the changes in the planned clinical teaching.
  - This is done by comparing the changes you have tracked on the “Confirmation Tracking Sheet” to the “Reconciliation Details” tab in the reconciliation document we send out.
- If you see any mistakes, please bring it to our attention and in turn, we will contact NOSM

<u>Income Distribution</u>

LEG Income Distribution

- It is dependent on the Governance Agreement
- The LEG has the freedom to use their money as they see fit

Sudbury Psychiatry LEG (Lisa Allen)

Point System

- As jobs are completed, they are taken off the list
- Points are evaluated once per year
- In one year points were $50
- Given a lot of points for research
- No points are given for lectures
- At year end points are added up and divide total points by what you want to keep in the bank
- No points are given until an evaluation is done. Tracking of evaluations is done by reminding that they haven’t been done

<u>Residency Programs (Catherine Cervin)</u>

- Residency programs are hard to get
- Objectives
  - Describe aspects of site level administrative support needed for residency education
  - Give feedback

1st Working Group

- Time limited
- Representation for LEG Lead, Section Chair, HSN, TBRHSC and NOSM Postgrad
- NOSM decides the “what” of clinical and academic teaching
- The site or AHSC describes the “how” for experience and teaching at that site
- Clear need for seamless communication, integration and support
- Macro level scheduling

- At site level, there is orientation to rotation
- Evaluation of site
- Recruitment of faculty
- Local faculty meetings

Recommendations from Working Group
- Create an ongoing multi-representational group
- Communicate among the groups what is working
- All rotations will have an effective orientation

QUALITY IMPROVEMENT - PRESENTATIONS

Thunder Bay Pediatric – "Integrating Child and Youth Mental Healthcare in Office Setting to Reduce Health Disparities" (Dr Baboolal)

Objectives
At the end of this talk you will be able to:

- *Identify tasks associated with competencies of system based and practice-based learning and improvement*
- *Identify enablers and barriers to collaborative engagement in SBP & PBLI (CANMEDS Leader)*
- *Develop a conceptual framework that informs strategies to enable and overcome barriers to the application of these competencies, based on an understanding of adult learning theory.*
- *Determine if care is consistent applying principles*

Tasks Associated with Competencies of PBLI and SBP

Guided Knowledge Management:

- Uses scientific methods for making decisions
- Requires ability to incorporate EBM into daily practice
- Transmits learned knowledge through practice (explicit and tacit knowledge)
- Uses measurement of performance as a source of information to drive learning in the workplace and change the process that delivers care
- Captures insight from daily practice, exceptions to protocols, etc.

Active improvement in the individual's delivery of care and improvement in the system of practice in a learning organization:

- Engage in rapid cycles of change to improve care
- Facilitate knowledge transfer amongst team to reduce redundancies in work
- Medical informatics becomes the tool for enabling KM
- Identify disparities in health
- Focuses on information as a professional asset to the individual and organization
- Acknowledge individual choice and sense of agency - Empowerment
- Identify alignment between individual goals and shared aims.
- Provide valid reasoning if goals are inconsistent
- Foster commitment rather than compliance

Sudbury Hospitalist – "Clinical Implications of the Introduction of an Alcohol Withdrawal Order Set" (Drs. Smith and Zymantas)

Objectives

- *Recognize that Alcohol Withdrawal Syndrome is a common and serious medical condition*
- *Describe a process to develop and implement a Quality Improvement (QI) project*
- *Explore strategies to overcome barriers to QI/Research*
- *Close to 80% of Canadians over the age of 15 have reported using alcohol in the last year*
- *Alcohol use has increased in the last year*
- *Of those who drink alcohol on a regular basis report alcohol withdrawal*
- *Hospitals don't have a protocol when it comes to alcohol withdrawal*

Process to Develop – Time commitment

- 1st Year – Create & Implement Order Set
- 2nd Year – Chart Review & Quality Assurance
- Mean doses of all Benzodiazepines (1 mg. Lorazepam) given to patients which by Day 7 significantly dropped in effect of withdrawal symptoms
- It was found that patient incidents dropped significantly especially patient restraints during post-implementation
- Would like to collaborate more with other institutions/hospitals

South Muskoka - "Community Medical Education Lecture Series."
(Dr. Hotson)

<u>*Objectives*</u>

- *To review the process of developing an innovative model for health care service delivery (consistent with Institute for Healthcare Improvements)*
- *Review the concept and content of the "Community Medical Education Lecture Series."*
- *Review the quantitative results of presenting medical information to the public in this way.*
- *Review the themes generated by the target audience through this model of service delivery.*
- *Consider applicability of this model of delivery in other communities, and how it may be enhanced.*
- *Consider barriers to change*

Observations & Assumptions

- Patients understand very little about the pathophysiology of their disease
- Patients tend to have little or no understanding how their medications work, why they might be helpful, or when to know if their medications are not the right choice for them
- Patients frequently are unaware of non-pharmacologic options that may positively impact their disease process
- Demands on HCP's time make it impossible to sufficiently explain disease process and management in a comprehensive way

Disclaimer

- Every person's medical history is unique, and therapy needs to be considered on a case-by-case, particularly when choosing medications.
- The information presented in these talks is not meant to be a substitution for seeking assistance from a primary care provider.

How Do We Measure Success?

- Quantitative data: The Quiz of 10 questions pre and post talk
- Quantitative themes: Anonymous feedback from attendees
- Results from the Quiz result in post-talk scores are on average increased by almost 40% better knowledge

Barriers to Change

- Organizational
- Lecture series took 100 + hours of logistics, preparation and delivery
- Not remunerated
- Attitude
- Public speaking – not for everyone
- Lack of tangible outcomes can be discouraging

- Knowledge – need to be up to date on all guidelines and recommendations

City of Lakes – "Successes and Challenges in Implementing QIP 'Nutristep'" (Dr Richardson)

Objective

- *Identify methods to engage your LEG members in QI projects*
- *List barriers to QI and strategies to overcome these barriers*
- *Consider possible QI project for your LEG*

Quality Improvement at the LEGs Members Engagement

- Quality improvement Decision Support Specialist
- Community partnership

Quality Improvement at the LEGs NutriStep Project

- Nutritional Screening Tool
- Increase Use Tool
- Track Results
- Streamline Education and RD Referral

Quality Improvement at the LEGs Barriers

- Time
- Technology
- Costs
- Implementing Process

Quality Improvement at the LEGs Strategies to Overcome Barriers

- QIDSR
- Administrative Support – Administration Processes
- Community Partnerships (Health Unit) and across the North
- Technology Support

Timmins – "Needs Assessment As Initial Step in Development of an Advanced Care Planning PDSA Cycle" (Dr Gillies)

Objectives

- *Assess need for end-of-life care planning*
- *Explore patient values that can guide decision making*
- *Understand the components of an ACP guide*
- *Improve appreciation for inter-professional collaboration for ACP conversations*

Did you know?

- 8 out of 10 Canadians have never heard of Advance Care Planning; that means 50% of their families don't know their loved one's wishes and may have some very difficult decisions to make
- Advance Care Planning Process – think, learn, choose, talk, record and update

Essential Components of ACP

- Respect patient care goals, values, wishes and beliefs
- Include the substitute decision maker (SDM)
- Undertaken with a CAPABLE person, SDM and health care professional
- Recognize SDM cannot make an advance care plan on behalf of an incapable patient, timely

Role of SDM

- 70% of decisions made in the last week of a person's life are NOT made by the person him or herself
- ACP is an opportunity for the patient to share with the SDM and medical professional what is important to them
- Prepares the SDM for future decision based on patient values and beliefs
- Advocate for the patient with health care professionals

Benefits of ACP

- Improves patient and caregiver experience
- Decreases caregiver distress
- Decreases unwanted investigations, interventions and treatments
- Decreases hospitalizations and admission to critical care units
- Decreases costs
- Identifies SDM and assists with communication regarding wishes and beliefs

Challenges identified by TFHT Primary Providers

- Lack of knowledge
- Lack of tools
- Time
- Process development
- Patient comfort level in completing and ACP
- SDM comfort level

- Organization

Fitting ACP Into Practice

- Outline a process for identifying key patients
- Assess patient capacity
- Introduce topic and assess readiness
- Facilitate ACP conversation with SDM present
- Provide information
- Document
- Update

Readiness for ACP

Stage	What the person thinks about ACP
Pre-contemplation	Patient does not know about ACP or has not considered ACP
Contemplation	Patient may be aware of the pros and cons regarding ACP but does not appear ready to take an actions
Preparation	Patient prepares to engage in ACP through review of educational materials or discussions with others.
Action	Patient has discussed their wishes with others, identified their SDM and may request further information
Maintenance	Patient has consistent ACP wishes and may revisit these when health circumstances change

- Patients who retain accurate information/understanding of their illness significantly less likely to receive invasive treatment in the last 2 weeks of life
- Inaccurate illness understanding alone significantly impacts patient outcomes

Clarifying Quality of Life, Beliefs and Values

- What brings quality to your life:
- What are things you value?
- What is important in your life, and what brings it meaning?

Attitude

- Discomfort with ACP topic
- Lack of belief in one's ability to engage efficient office ACP
- Lack of motivation to change
- Commitment to Life Long Learning
- Confidence in self-directed professional behaviours
- Limited self-perception of clinical lead, organization spread

NOSM LEG Grouped Learner Evaluations QI Project (Dr James Goertzen)

Educational Scholarship (*Boyer)*

- Systematic study of teaching and learning using approaches that allow dissemination of finding, opportunities for application and evaluation by other

Faculty Development (*Rubeck & Witzke)*

- Faculty development is enhancing faculty knowledge and skills so their contributions can advance the education program rather than just teaching it

What is a Community of Practice?

- A group of people with a common interest
- A group of people with a common goal of improving
- A group of people who share experiences

- Physician consent form
- Compile and analyze learner evaluations
- Reflections and discussions – how would your LEG improve
- Commitment to change (new strategies)
- Summary of evaluations
- 3-6 months later send out follow-up email

UME Phase 2 – Strengths

- Exemplary patient care
- Preceptor approachable
- Balances learner independence with appropriate support
- Provides feedback
- Commitment to teaching
- Learner-centered
- Supporting learning

UME Phase 2 – Areas for Improvement

- Feedback
- Organization
- Students roles & responsibilities
- Balancing student clinical and personal responsibilities