Welcome to today’s session!
Please use chat to “All Participants” for questions
For technology issues only, please chat to “Host”
Follow the instructions in the pop-up box to connect your audio (either by phone, or through your computer)
Objectives

- Revisit the key elements of measurement and aim statements
- Learn about one Chapter’s measurement strategy and results
- Reconnect as change agents leading work in the Recover Hope Campaign and build community across the Chapter Network
Today’s Agenda

- Welcome and Introductions
- IHI Open School Overview
- Measurement Refresher
- Chapter Example from the University of Texas – Southwestern Medical Center
- Discussion
- Next Steps
Help us get to know you!

In the chat box, select “All Participants” as the recipients and share:
- Your Name
- Chapter Name (University/Organization)
- What motivated you to join or start your Open School Chapter?
- What would you like to learn from today’s call?
IHI Open School Team

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Global Chapter Leaders

Global Chapter Leaders Team
Support Chapter development and create sense of identity and belonging to IHI Open School Chapter Network.

Group 1: New Chapter Coaches
Welcome, guide, and support new Chapters, including those participating in the campaign.

Group 2: Global Chapter Coaches
Support, coach, and strengthen established Chapters, including those participating in the campaign.

Group 3: Chapter Network Coaches
Build capacity and opportunities for collaboration and learning across Chapter Network.
Call Faculty

Ross Hilliard, MD, FACP
Associate Residency Director,
Brown University
Director of Medical Informatics
Our Mission

“Advance quality improvement, patient safety, and leadership competencies of health and health care professionals worldwide.”
Our Strategy

Online Courses
Educational modules and activities

Community
Interprofessional Chapters and networks

IHI OPEN SCHOOL

Project-Based Learning
Guided experiential training
Online Courses

- **30+** online courses in Improvement Capability, Patient Safety, Person- and Family-Centered Care, Triple Aim for Populations, Leadership – all free to students, residents, and faculty
- **Almost 800,000** students and residents registered on IHI.org and taking courses
- **More than 4 million** course completions
- **More than 1,500** institutions use the courses as a core part of their training programs or curriculum
Online Courses on Measurement

The following Open School courses may be helpful as you continue to strengthen your measurement strategy...

**Improvement Capability**
QI 101: Introduction to Health Care Improvement  
QI 102: How to Improve with the Model for Improvement  
QI 103: Testing and Measuring Changes with PDSA Cycles  
QI 104: Interpreting Data: Run Charts, Control Charts, and other Measurement Tools

**Patient Safety**
PS 101: Introduction to Patient Safety  
PS 201: Root Cause Analyses and Actions

**Leadership**
L 101: Introduction to Health Care Leadership
Project-Based Learning

Leadership & Organizing for Change

- Improvement Science
- Organizing & Leadership Training
- Subject Matter Knowledge

Change
IHI Open School Community

- Nearly **800,000** students and residents registered
- Over **950** Chapters started in over **95** countries
- Over **50%** of our Chapters are interprofessional
What are your measurement questions?

• **Share in the chat:**
  – What questions do you have about how to measure your project efforts?
  – Did you consider your measurement strategy in the design of your project?
  – If you’re already tracking measures in your project, GREAT! Tell us about your experience so far!
Why Measurement?

- If you don’t measure, you don’t know where you are going
- Measurement allows for rapid feedback on strategies being taken
- Measurement can allow for rapid cycles of change
- Can’t assume success, have to ensure success is measured
Anatomy of an Aim Statement

• A good aim statement should answer the following questions:
  – **What outcome** are you trying to improve?
    – Will often link to a specific metric developed when answering the question, How will we know that a change is an improvement?
  – **How good**
    – Should be specific and measureable
    – Requires some understanding of baseline performance
  – **For and with whom**
    – Should describe the setting or population of focus
  – **By when**
    – Should include a specific date
Person-Centered Aim Statements!

We ________ (WHO – our leaders) ________ (Who will lead this?)

are co-designing with (WHOM – our people) ________ (Who will be affected?)

to improve ____ (WHAT – measurable aim) ________ (How good?)

by ________ (HOW – tests of change) ________ (Tactics to PDSA?)

in order to ____ (WHY – why it matters) ________ (Narrative?)

by ________ (WHEN - timeline) _________. (By when?)
Anatomy of an Aim Statement: Example

- **What outcome are you trying to improve?**
  - Decrease the number of people dying from drug overdoses in Montgomery County.

- **How good?**
  - 10% reduction

- **With whom?**
  - IHI Open School Chapter / Student Opioid Coalition
  - Patients affected by opioid use disorder

- **By when?**
  - December 1, 2019

**Aim statement:** Our five-person leadership team will reduce the drug overdose mortality rate by 10% in Montgomery County by building the capacity of interprofessional members of the Student Opioid Coalition in partnership with patients affected by opioid use disorder by December 1, 2019.
Measurement and Key Drivers

• In leading improvement, it's important that you understand the **actions and steps** that will lead to improvement
  - Weight loss will happen if I exercise more
  - My time commuting to work will improve if I leave an hour earlier
  - The score I receive on the next exam will be better if I study differently/more/earlier.

• The above each speak to a specific driver of the improvement desired
  - Exercise is the driver of weight loss
  - Time of day of commute is also a driver of commute time, so is method of commuting (walking, biking, car, bus, train, etc.)
  - The amount and quality of studying is a driver of exam success
Three Types of Measures

1. Outcome Measure
2. Process Measure
3. Balancing Measure
Outcome Measures
(where are we ultimately trying to go?)

• Tell you whether changes you are making are actually leading to improvement.
  - These are the measures you ultimately want to move. They tell you how the system is performing—what is the ultimate result?

• Examples
  - For diabetes: Average hemoglobin A1c level for population of patients with diabetes
  - For access: Number of days before an available appointment
  - For population health: 6-month hospitalization rate of Asthma patients
  - For organizing in health care: 6-month relapse rate for patients with SUD

• In your projects:
  - Number of naloxone kits distributed
  - Number of patients provided alternative pain management therapies
  - Percent of patients seen at a health care system for chronic pain who have documented evidence in their medical charts of receiving best practice treatment (i.e. a pain plan, appropriate volume of opioid prescriptions)
  - Percent of patients who were treated by students who used validated instrument to screen for substance use disorder and referred to further treatment
Process Measures
(are we doing the right things to get there?)

• To affect the outcome measure, you have to improve your processes that impact the ‘outcome’ measures of interest
  – Measuring the results of these process changes will tell you if they’re leading to improvement. Are the parts/steps in the system performing as planned?

• Examples
  – For diabetes: Percentage of patients with hemoglobin A1c level measured at some point in the past year
  – For access: Average daily clinician hours available for appointments
  – For population health: % of asthma patients seen in clinic on controller medication
  – For organizing in health care: % of established SUD patients in active treatment

In your projects:
  – Number of attendees at an educational event or training
  – Number of sites that receive naloxone kits to be distributed
  – Percent of students who report greater awareness of substance use disorders and how to prevent and treat them
  – Percent of students who report confidence knowing when and how to administer naloxone
  – Number of courses that integrate education on the opioid epidemic
Balancing Measures

- Balancing measures tell you if changes designed to improve one part of the system are causing new problems in other parts of the system.

- **Examples**
  - They are often not directly related to the aim.
  - For reducing patients' length of stay in the hospital: Make sure readmission rates are not increasing.
  - For population health: Track the out of pocket money spent by asthma patients on controller medications.
  - For organizing in health care: Track patient satisfaction with active SUD treatment.

- **Consider equity as a balancing measure for your own work:**
  - Which demographics benefit from this project, and who may be negatively affected? Why?
  - What are the equity barriers (think about race, class, education, sexual orientation, gender, etc.) for this project to be implemented?
Integrating Equity into your Measurement Plan

- Identify and track equity measures
- Work with people with lived experience of substance use disorders
- Use the language of recovery
- Understand that communities have been working on this for a long time and we don’t always have the solutions
- Translate materials into other languages
- Research health disparities in your local area on basis of race, education-level, socio-economic status
- Be mindful of what technologies people have access to
- Be mindful of child care needs, transportation needs, time of day of meetings, central location
- Be mindful of local cultural stigmas and histories with other stakeholders (police, etc.)
Equity Measures in Your Project

• Check in: Click the green check mark if you have designed an equity measure for your campaign project.
• If not, what’s holding you back? Share in the chat.
Final thoughts: Measurement isn’t easy, but you just have to get started!

• ‘What’ to measure has been the focus of today’s talk

• Important to operationalize ‘how’ to measure
  – Trackers/checklists that allow for easy quantification
  – Keep it simple!

• Create frequent moments of looking at objective information → Anxiety of Improvement
  – # of community members who take pledge to action
  – # of community members who actually take action defined as…
  – # of patients engaged by community members taking action

• If any of the above is poorly performing, don’t you want to know right away? (so that you can consider a change)
Chapter Example:
University of Texas – Southwestern Medical Center
Our Team

Enas Kandil, MD, MSc - Department of Anesthesiology and Pain Management

Sonal Gagrani MS3
Aemen Zamir MS3
Madhav Shukla
Harsh Patel

UTSW Opioid Prescription Policy and Workflow Group
University of Texas Southwestern Medical Center

- UT Southwestern physicians provide medical care in about 70 specialties
- Faculty and residents provide care to more than 105,000 hospitalized patients, almost 370,000 emergency room cases, and oversee approximately 3 million outpatient visits annually
- 17 different hospital and outpatient buildings with over 150 clinics
- Mission statement focuses on dedication to educating, discovering, and healing.
- The schools train nearly 3,600 medical, graduate, and health profession students, residents, and postdoctoral fellows each year.
The CDC has developed a set of guidelines for safe chronic opioid prescribing for chronic pain management including:

- Nonpharmacologic interventions tried first
- Treatment plan and goals
- Annual urine drug testing
- Review of PDMP
- Pain management agreement
- Periodic review of pain control
- Evaluation and discussion of risks and benefits

Aims

• In order to improve safe prescribing practices at UT Southwestern Medical Center, a multidisciplinary task force is in the process of implementing an EMR accessibility tool for chronic opioid management.
• This will assist in adherence to the CDC guidelines in accordance with best practices. Preliminary studies by our group at UTSW have shown low physician adherence to several of the policy components. There is little data regarding current physician practices.
• Understand the current physician practices and adherence to the TMB policy
  – Subjective approach (survey)
  – Objective approach (chart review)
• Guide implementation strategies for the opioid navigator tool built in the electronic medical record (EMR)
Understanding the Problem

- Christopher Bender (PGY-1) looked at Texas Medical Board (TMB) rule 170.3 regarding the guidelines for prescribing opioids for chronic, non-cancer related pain. He identified eight elements required to be completed and documented in electronic medical records.
  - History and physical exam
  - Use of the state prescription drug monitoring program
  - Baseline drug screening
  - Discussion of risks and benefits
  - Treatment plan that outlines goals of care
  - Written pain management agreement
  - List of patient medications
  - Periodic Review
• Convenience sample of 100 taken from previously compiled dataset with patients seen in pain management clinic

• The lowest compliance rates were seen in baseline drug screening, signed pain management agreement, and the use of the state prescription database.
The Opioid Task Force, a multidisciplinary team led by several UTSW physicians, is in the process of developing many electronic health record tools that will facilitate the process of fulfilling and completing the CDC guidelines.

- The first component is a registry housed directly on EPIC.
- The registry will flag patients who are on chronic opioid therapy, help track compliance of the CDC guidelines, and turn on best practice alerts for those patients so physicians are notified during office visits.
1) **Signed pain management agreement:** Completion of requirement required an uploaded agreement under “Media” in the patient’s chart.

2) **Urine Drug Screen:** Completion of a drug screen within the past year or documentation of exemption satisfied the requirement.

3) **Review of Prescription Monitoring Database:** Any referencing to review of PDMP in a patient chart within the past three months satisfied the requirement.
Results

Overall, 6% of patients on the registry had all three elements in their chart.

Very few patients in the hospital system are being prescribed opioids in accordance with CDC guidelines.
Survey Development Methods

- Sent out a survey to all prescribing physicians on aforementioned registry
Materials

- Inadequate resources to complete
  - Difficult to access tools in EMR
    - Takes too much time to access/complete
  - Inadequate time to complete
    - Too many policies to follow in limited time
    - Complex patients
  - Hesitancy to change existing workflow
    - Difficult to break formed habits

Process

- Few legal consequences for physicians
  - Guideline was only suggested, not required
- Policy difficult to understand
  - Vague terms with no specific definitions
- Negative impact on physician-patient relationship
  - Patient feels mistrusted
  - Checking PMP, pain contract, tax screen implies suspected abuse
- Disagreement that policy is best practice
  - Policy is not evidence based
  - Lack of research in area
- Not clinically useful in subset of patients
- Physician relies on a general impression of risk
- Lack of physician awareness of policy
  - Low priority reading
  - Infrequent patients with chronic pain
  - Forgetting components of policy

Physician Attitudes/Knowledge

Environment
Subjective Measures and Analysis

- Measures: survey questions that addressed specific barriers to adherence and physician attitudes regarding prescription practices
- Analysis: average survey responses across all parameters and organized by treatment component
  - Sub-analyses based on years of practice and number of patients treated with chronic opioids - unremarkable
Results

46% response rate after 1 initial email and 2 reminder emails

- Free responses indicated 3 primary barriers to adherence: **lack of time**, **questionable benefit to patient**, and **poor ease of accessibility**.
- Suggestions for improvement included: education, standardized policy across institution.
Next Steps

• Physician education on navigator tools – ongoing
• Develop institutional chronic opioid policy
• Integrate PMP data into EMR for easier access – ongoing
• Possibly convert into a Performance Improvement Continuing Medical Education (CME) format
• Post-implementation survey and chart review – planned for January 2020
• Incorporate patient outcome data
Other Ongoing Projects

- **Change the narrative** – participation in the Change the Narrative Challenge
- **Save lives from overdose**
  - Increasing the number of primary care physicians at UTSW who have a buprenorphine waiver, to provide MAT
  - Increasing the percentage of patients who receive naloxone after testing positive for illicit opioids
  - Using a new EMR dashboard to track chronic opioid usage and identify high-risk patients
- **Improve pain management**
  - Article published explaining some of the forces that created the opioid epidemic
  - Improving adherence to Texas Medical Board Rule 170.3 concerning the prescribing of opioids to patients for chronic non-cancer pain relief
  - Determining physician attitudes on chronic pain treatment policy for the improved implementation of newly developed EMR tools
  - Determining the effect of decision fatigue on opioid prescribing
  - Reducing the prescription of contraindicated codeine to pediatric patients in the emergency department
  - Creating opioid educational materials for surgeons performing outpatient surgeries, in order to optimize opioid stewardship and pain management
  - Developing a scoreboard for surgeons, so they can understand how their prescribing habits compare to their peers
  - Evaluating trends in opioid prescribing for outpatient surgeries, gathering consensus from surgeons regarding best-practices, and implementing measures to increase adherence to best-practices
  - Article, soon to be published, regarding compassionate care for those currently maintained on long-term opioid therapy
- **Reform university curricula**
  - Workshop on opioid stewardship for 4th year medical students in their ‘Residency Essentials’ course
  - Effort to increase number of pain management lectures given during the neuro-psych course in the preclinical portion of the medical school curriculum
  - Modification to QI education infrastructure to include a dedicated ‘Opioid Stewardship’ pathway for students who want to focus their QI efforts on combating the epidemic
Discussion
Discussion Questions for UT Southwestern

• What is your team not currently measuring that you’d like to, and how would you do it?
• How did you decide to measure these subjective and objective measures?
Discussion Questions for All

• What are you thinking about measuring?
• What road blocks are you facing?
• What don’t you know how to do?
Next Steps
Continuing the work… next steps!

• Which of the Campaign’s **four action areas** are you working on? Tell us in the chat!
  – Changing the Narrative
  – Saving Lives from Overdose
  – Improving Pain Management
  – Reforming University and Organization Curricula

• **Practice measurement skills** you’ve learned on the call today to track your Campaign project’s progress

• **Take the Fall 2019 Leadership & Organizing for Change course** to learn to more community organizing, leadership, and improvement capability skills
Global Chapter Leaders are just an email away

- **New Chapter Coaches:**
  newchaptercoach.ihi.os@gmail.com
- **Global Chapter Coaches:**
  globalchaptercoach.ihi.os@gmail.com
- **Chapter Network Coaches:**
  chapternetworkcoach.ihi.os@gmail.com
Feedback for us?

- What did you like about this call?
- What was missing?
- What would you like to see on a follow-up call?
Thank you!