



INFORMATION PACKAGE

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INTRODUCTION

The Alberta AIM learning process involves a set of recommended practice changes to create a clinic environment that removes unnecessary waits and delays for patients, and redesigns the delivery of clinical care to maximize health outcomes. Experience in similar health system settings has shown that achieving these goals requires a clinic to learn quality improvement techniques and build a foundation that will support quality improvement over time.

WHY PRACTICE IMPROVEMENT?

Our health care system is burdened by delays – the inability to get an appointment with a primary care physician or a specialist, extended telephone waits, and repeated telephone calls to get test results or have a question answered by a provider.

These delays adversely affect clinical outcomes, patient satisfaction and cost. People often assume that reducing delays and increasing access to physicians will increase costs. In fact the opposite is true - delays and restricted access result from poorly designed systems that are costly. Using system design principles and queuing methods, organizations can develop and implement changes that reduce delays without increasing costs.

Delays prevent physicians and other clinic staff from being able to provide care in an optimal fashion, and from determining the right team or group of people to deliver the care. So eliminating waits and delays is essential in order to optimize system performance.

I have learned to look at my practice as a business as well - and to look at ways of improving the access to my business.

*Dr. Dave Stewart
Family Medical Clinic
Lethbridge, AB*

APPROACH AND STRATEGY

AIM is based on a proven process and a set of principles designed to assist physicians and others in their practices by eliminating the need for a patient to wait to get an appointment, and minimizing the amount of time a patient spends at an appointment. Reduction of waits can be achieved by predicting and managing patient demands.

Recent studies and work in this field have shown that successful use of strategies to reduce delays leads to improved compliance with prevention guidelines, improved care for patients with chronic illness, and enhanced early detection of serious illness. These strategies are based on a fundamental understanding of patient and provider desire for continuity of care, the need to balance the demand for service with the supply of service, and the importance of measurement to clarify the current state and move toward an improved model of practice.

Health care is a large and complex system and change may often seem overwhelming. AIM provides the family physician office team with a step-by-step approach that can result in significant change for the health care team and system, but most importantly improves the health of our patients.

*Sheri Fielding
Nurse Practitioner
Heritage Medical Clinic
Edmonton, AB*

The framework for AIM is based on the *Learning Model* and *Model for Improvement* used in the Institute for Healthcare Improvement (www.ihl.org) Breakthrough Series. It involves learning and applying methodologies for reducing delays, increasing continuity, building and strengthening teams, effectively implementing decision support tools and improving quality outcomes.

Working collaboratively with experts and other practitioners, sharing ideas and knowledge, learning a new methodology for change, and measuring progress results in opportunities to offer patients the best possible solutions to their health care needs.

Improvement teams, made up of members from each clinic, will work together for approximately 14 months to design, test, and deploy new models of clinic practice and practice management and apply them in their own environments. These changes will lead to fundamentally improved performance levels, including improved access, improved office flow and efficiency, increased patient, provider and staff satisfaction, improved clinical outcomes, improved financial outcomes and more effective interdisciplinary care teams.

Some of the work that physicians are currently doing could be done by someone else. When teams involving physicians, nurses, pharmacists, and other medical professionals work together and people can see their doctor sooner, they receive better comprehensive care and delays for and during appointments are reduced.

*Dr. Janet Craig
Glenora Medical Clinic
Edmonton, AB*

PROCESS

Each participating clinic will be asked to confirm its commitment to having an improvement team (three to seven people) attend all learning sessions (typically totalling 11 days), participate in monthly one-hour teleconferences, and be willing to test and implement change as it relates to making practice improvements.

Our clinic is more efficient than it has ever been thanks to the great measurement tools and support, but the big winner is that we are truly a "team" now. Morale is at an all time high.

*Roxanne Bergheim
Clinic Manager
St. Paul Medical Clinic
St. Paul, AB*

Orientation Phase

The orientation phase is designed to promote awareness of AIM and to help clinics assess their desire to participate.

Readiness Phase

The readiness phase will provide an opportunity for clinics to complete a clinic profile and answer some questions about their practices. The goal is to assemble a group of 12 to 17 clinics that can be grouped as a single collaborative and participate together in the AIM process.

Clinics must first self-evaluate their readiness for participation by filling in a *Clinic Profile Form*. It is important that all members of each clinic team be made aware of the intention to participate in AIM, and ideally, all physicians and staff should have an opportunity to provide input to the completion of the clinic profile.

TEAM, AIM, CHANGE, MAP AND MEASURE

The Alberta AIM learning process includes four fundamental success factors: **Team, Aim, Change, Map** and **Measure**.

Creating a Team

Creating and working with an appropriate, engaged and effective improvement team is a key component of a successful improvement effort. Members of the improvement team should be chosen for their knowledge of, and involvement in, office processes and their willingness to change. The team is comprised of two essential components: the **core improvement team** (who will attend learning sessions and lead the improvement effort) and **additional clinic team members** (the rest of the team at the office practice site). Core improvement team membership will vary depending on clinic size and composition. However, every improvement team should include the following members where available:

- Clinic manager
- Physician representative(s)
- Nursing representative(s)
- Allied health provider representative(s)
- Reception representative(s)
- Medical office assistant representative(s)

The core improvement leadership team will normally consist of three to five team members (depending on clinic size) that are intimately involved in the changes. In addition, there may be a number of additional clinic team members who attend meetings when changes are relevant to their area of expertise. Core improvement team members are expected to attend all AIM Learning Sessions and teleconferences.

There may be one or more individuals on the team, who fit each dimension, and one individual may fill more than one role, but each component should be represented to successfully drive change in the clinic. It is critical to have at least one physician champion on the team. This champion should have a good working relationship with colleagues and the day-to-day leader, and be interested in driving change in the system. The

physician champion is an opinion leader in the office practice (an individual who is sought out for advice and who is not afraid to test change).

Defining Aims

Improvement requires setting aims, which are explicit statements of what the team hopes to achieve through the improvement process. Aim statements are the response to the first question in the Model for Improvement: *What are we trying to accomplish?*

Teams are required to develop two primary aims, one specific to access and one specific to office efficiency. Teams may also choose to develop additional aims in the areas of clinical improvement that fit their unique patient population and/or other initiatives they wish to undertake.

Making Changes

Improvement efforts require that changes be made to narrow the gap between current performance and possibility. However, not all changes result in improvement. Once a team has defined its aims and measures, it needs to develop, test and implement changes to move toward improved outcomes. Once ideas for changes have been generated, teams use Plan-Do-Study-Act (PDSA) cycles to test these changes and determine whether they resulted in an improvement. Teams can then expand the tests to the point that there is confidence that the change can be applied broadly within their context, and eventually adopted by others. If changes do not result in improvement, they can be adapted and retested, or discontinued.

Determining and Collecting Measures

Measurement is a critical part of testing and implementing change. Measures provide the means to determine the starting state, assess progress toward an aim, and determine whether the changes are actually leading to improvements. Teams are expected to continuously monitor a core set of measures related to access and office efficiency. Measures include:

- Third next available appointment (delay)
- Patient flow and cycle time
- Continuity
- Supply
- Demand
- Activity
- No-shows
- Revisit rate
- Panel size
- Teamwork

ACTION PERIOD (Time between Learning Sessions)

Team members work in their own clinic settings to implement and test multiple changes in their clinics and collect data to measure the impact of the changes. Although participants focus on their own clinics, they remain in continuous contact with other teams, facilitators and faculty through conference calls and group email and by submitting monthly reports on their progress. Faculty members provide written feedback and coaching on these monthly reports. During the action period, it is encouraged and expected that all clinic team members (not just the improvement team) participate in implementing, testing and measuring the changes.

Commitment

It is also important that physicians and clinic staff are aware of the commitment they are making by participating in AIM, specifically:

Committing a quality improvement team of three to seven participants to full participation in 11 days of learning sessions over approximately fourteen months.

- Participating in monthly (or as scheduled) teleconferences.
- Preparing and submitting monthly reports on the team's progress, and presenting at learning sessions.
- Committing resources (time, funding, etc.) to support participation in AIM.
- Holding weekly/regular improvement team meetings to discuss changes and improvements, and plan activities relating to improvement aims.
- Allocating adequate resources from within the clinic to gather and enter data on a regular and ongoing basis to measure and support the improvements.
- Transferring learnings to and including all members of the clinic team in the improvement initiative.

Available Support

Through participation in the AIM collaborative, clinics will have access to a variety of supporting resources, specifically:

- Six learning sessions (total of 11 days), most in-person; some may be by videoconference.
- Access to a variety of articles and papers on subjects related to the concepts learned at the learning sessions.
- Access to a facilitator to assist with setting aims, measurement, reporting, holding meetings, and team development.
- Access to faculty and other participants for information sharing and problem solving during action periods
- Access to resources for assistance with spreadsheets, data collection and panel/caseload identification.
- Access to secondary resources such as support for situations where team issues are a barrier to success.
- Monthly teleconferences with faculty and other participating clinics to share learnings and ideas.

- Access to group email for posing questions and sharing information.

My patients now have better access to see me; my delay measures have been cut in half and that is the same as the general clinic trend since we've been implementing these strategies.

*Dr. Rob Wedel
Associate Medical Centre
Taber, AB*

ONGOING

At the conclusion of the collaborative process, clinics will be encouraged to participate in ongoing networking activities to maintain and strengthen the improvements they have made and the gains they have achieved.

I came in as a sceptic and now I recommend this process to other sceptics.

*Dr. Wes Steed
Associate Medical Centre
Taber, AB*

FURTHER INFORMATION

For further information, please contact:

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