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myPI Summary Report

Step One: Finding an actionable opportunity

This report contains the answers you submitted during Step One of your activity (Updating and connecting with my diabetic population post pandemic) on the my Practice Improvement environment.

Date

10/18/2022

1. How do you approach this assessment activity?

I didn't participate in a QI project

2. Have you and/or your practice group identified an area of practice to assess?

Yes

2a. What may be your data sources?

HQCA Panel Report, EMR generated lists, Netcare

3. What is the specific aspect of your/your group clinical practice you would like to assess?

Optimizing CVD risk and detecting unrecognized CKD in my diabetic population and assess whether suitable interventions are in place.
Ensuring my diabetic populations have had relevant lab testing, medication review, and follow-up in the last 12 months

4. What performance measures will you use to track how you are doing?

% of diabetic patients that had lab test (A1C, eGFR, ACR, lipids) in the last year
% of diabetic patients with blood pressure recording in the last year
Ensuring appropriate prescribing of Statins, ACE/ARB, SGTL2i to support CVD risk reduction and CKD progression in this population

5. How will you access your data?

I will use my HQCA panel report (when metrics are available), EMR generated lists, and NetCare.

6. How did you review and reflect on your data?

- I discussed with my team/a colleague/a peer coach/the improvement facilitator
- I reflected on the data by myself

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7. How would you summarize your/your group performance? (Describe such as did/did not perform a task or the percent of patients who meet established targets)

Through the peer comparator metrics on the HQCA panel report, I note that fewer my of my diabetic patients are prescribed statins.
From my EMR data I identify that 45% of my diabetics had not had labs or been reviewed in the last 12 months.

8. The more certain we are in the evidence for a clinical decision, the more likely we are to incorporate a change into our practice. During the review and reflection on the data, what additional sources did you access to appraise the best available evidence?

- Current/Recent released practice guidelines
- Clinical decision support sources such as DynaMed, UptoDate, Cochrane Library

9. After reviewing and reflecting on the data, you might think of or brainstorm with others some ideas, such as "now I understand …", "it seems I need to …", 'there are some possible ideas for improvement …'. With all these ideas, it's a matter of prioritizing them. With all these ideas, it's a matter of prioritizing them. What have you prioritized as a change to make? Briefly describe.

Setting up a robust reminder system to ensure ongoing prompts for follow-up and lab tests to patients.
Easy access to patient support materials, to help engagement with prescribing (e.g., my kidney my health, my health Alberta)

10. Now let's specify a title for this project. It doesn't have to be perfectly worded; this is for your own reference. Being able to explain your project in a title or a few words will help you solidify what you intend to do.

Updating and connecting with my diabetic population post pandemic

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Step Two: An action plan

This report contains the answers you submitted during Step Two of your activity (Updating and connecting with my diabetic population post pandemic) on the my Practice Improvement environment.

1. According to the prioritized change to make, what is your achievable goal?
I want to set up a reminder system, to ensure that this high risk population of patients gets appropriate and timely intervention. Prioritize diabetics that have not connected in the last year/have not had appropriate labs done.

2. Think about the people that will need to be involved in this action...

Connect with my Improvement Facilitator to generate an updated report of my diabetics: last visit, last A1C, eGFR, ACR, lipids.

Work with my MOA to create an action plan to reach out to patients to either book a follow-up or get updated labs and then follow-up.

Work with PCN multidisciplinary team to connect and engage patients in updating their knowledge and awareness of CVD risk, using patient facing materials.

3. Think about the resources to be involved in this action…

What resources will you need?

Connection with my improvement facilitator to generate reports and development of reminders.
Support of clinic management, to account for MOA time.

Easy access to patient support materials (might need help from IF/clinic manager).

Set-up EMR link to CKD/DKD-pathways for point of care reference, share pathways with team.

4. It is also important to identify potential obstacles to prepare some backup plans.

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What could get in the way of achieving the goal?	How would you overcome the challenge?
Dedicated time to connect with IF and follow-through with the steps.	Make sure to plan ahead and schedule in a time with IF
Appointment availability (both for patient to access lab, and to follow-up in clinic in a timely fashion)	Ability to tag on to existing appointments.
Patient engagement (both in getting lab done, and medication/intervention compliance).	
HQCA metrics are not yet populated.	If HQCA metrics are delayed, rely more on EMR generated lists. Focus on personal progress rather then peer comparison.

5. What are your timelines?

When will you begin?

I plan to book a meeting with my IF in the next 2-4 weeks.

Put proposal past clinic manager to ensure MOA time in the next week.

Opportunistic interventions with those already book starting immediately, MOA to book follow-up visits starting in about 4 weeks.

When do you hope to see results?

Plan to reach all diabetics in the next 6 months.

I want to see an increase at 6 months, and at 12 months all of my diabetic population are within the reminder system and have had an offer of connection.

6. Ensure your plan is on track by measuring progress and success.

How to measure Progress?	How will you determine success? Or, what would tell you that you have achieved your goal?
Repeat EMR generated lists at 6 months and again at 12 months	Observe a higher rate of % of diabetic that had appropriate lab tests and review

7. You've reached the end of Step Two.

I should recognize that this is an ongoing process, and not all patients will be able to be seen within the allocated time frame.

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Step Three: Accomplishment

This report contains the answers you submitted during Step Three of your activity (Updating and connecting with my diabetic population post pandemic) on the my Practice Improvement environment.

1. How did you review and reflect on the measurement of progress and success?

- I discussed with my team / a colleague / a peer coach / the improvement facilitator
- I reflected on the measurement by myself

2. Recall the previous review and reflection on your data report, did you notice the change in your practice?

Yes, I have seen more of my diabetic population since I initiated the reminder system.

More of my complex diabetics are connected with the multidisciplinary team.

Some of my diabetics have been initiated on statins, ACE/ARB, SGTL2i as appropriate.

3. Let's revisit the strategies you identified in Step Two about getting people and resources involved, and overcoming barriers… What worked? What did not work?

What worked was close connection with IF, to generate reports and help with setting up reminder system. Getting support from clinic management for MOA time and connecting with MDT.

Staff turnover and absence delayed progress (MOA). Health management nurse went on mat leave. Delay in metrics from HQCA reports (meaningful comparators were not available).

4. To be sustainable is crucial once a practice improvement goal is achieved. If you have made some change since this MyPI activity, do you think the newly established pattern in your practice is sustainable? Is there any area would you struggle to be consistent? What strategies could you implement to address it?

Now that the reminder system is set-up, I am confident that this would be useful.
Other physician have set-up the same system, having seen the impact.

With staff turnover it is hard to ensure new MOAs are aware and invested in this work.