

Introduction to this writing sample – “Adopting the CDM Toolkit” Participant Guide for one module of a training program

The Chronic Disease Management (CDM) Toolkit is a web-based application that supports doctors and health-care teams in caring for patients with chronic diseases. This training manual is part of a series. The goal of the module is to manage the integration of the tool into physician practices, in reference to a separate software user guide.

I started with a very sparse BCMA directive for what this module should cover, along with a report summarizing doctors’ concerns with the health-care system. I had no additional start-up guidance from the Ministry or other client agencies, so I used my own discretion to develop the first draft. First I developed the instructional objectives. Then I learned how to use the tool by working with it. Next I interviewed, by telephone, several designated Subject Matter Experts across BC to obtain practical tips for adopting the tool, hear their concerns, and gather testimonial quotes and photographs. SMEs were family doctors and Health Authority personnel who were extremely busy and overworked, so I had to get maximum information in minimal time. I also drew from a small selection of existing internal bulletins and published communications. I developed an outline that was then approved by the Ministry lead person, whose company had also developed the software. Only minor revisions were made to what I had selected and organized.

Format and overall structure of the document conforms to the basic template developed by Healthy Heart for all training guides, with some suggestions for minor revisions. All guides in the training program are organized around the *Plan-Do-Study-Act* cycle used as a quality-improvement strategy for managing change of office practices. The document was initially composed in Microsoft Word, including quote boxes, photos, and headers.

Substantive and editorial revisions were made after internal and external reviews by designated committee members from various agencies. Changes were not extensive. Support materials in the appendix were expanded and edited by me.

A designer then performed reformatting for desktop publishing. Tip boxes have been repositioned by the desktop publisher, and are no longer always in the optimal spot. Finally, copy editing was performed by Frank Chow, which was minimal for this guide.

—Stephen Arthur www.sxa-portfolio.com sxarthur@shaw.ca

Practice Support Program



Adopting the CDM Toolkit Practice Guide



Acknowledgements

The preparation of this guide has been a truly collaborative process. Many people have given freely of their time to contribute their experience of adopting the CDM Toolkit. We are really grateful to them. If we have omitted your name from the list below, please accept our apologies. Your help was appreciated and influential.

Dr. Paul Murray, Dr. Tom Bailey, Dr. Andrew Sear, Dr. Paul Mackey, Margie Wiebe, Rosemary Gray, Liza Kallstrom, Stephen Arthur, Frank Chow, Robert Wall, Diana Cikes, Jaye Routledge

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Adopting the CDM Toolkit

The CDM Toolkit is a secure, web-based clinical quality improvement application that supports doctors and health care teams in using practices in caring for patients with chronic diseases.

The CDM Toolkit enables you to monitor patient and population outcomes for specified chronic conditions so that you can plan and manage care for all your patients in a timely way.

This Practice Guide has been developed for the Practice Support Program, an initiative sponsored by the BC Ministry of Health and the BC Medical Association through the General Practice Services Committee.

For more information on the Practice Support Program, visit

www.practicesupport.bc.ca

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Step-by-Step Guide



Each step outlined below is described in more detail in the module.

Click the video icon to hear what other BC physicians have to say about adopting the CDM Toolkit. The video can also be downloaded from www.practicesupport.bc.ca.

Stage 1 Plan

Assess whether the CDM Toolkit will help you improve patient care.

- Complete the Practice Profile section in the [In-Depth Practice Self-Assessment Questionnaire](#).

Assess your system capabilities and computer skills.

- See the completed [Sample Action Plan](#) in the [Resources](#) section of this guide.
- Decide on team member roles and responsibilities.
- Identify and overcome barriers.
- For detailed steps, see the [Create an Action Plan Tips](#) on the Adopting the CDM Toolkit page at www.practicesupport.bc.ca. Blank action plan forms are also available there.

Stage 2 Do

Register for the Toolkit and log on.

- Apply for a digital certificate.
- Install the digital certificate.
- Register additional users.
- Become familiar with the log-on process.

Set up a patient registry.

- To learn how to select a population, identify patients, and create and use flowsheets, see the [Developing Patient Registries](#) Practice Guide.
- If you have an Electronic Medical Records (EMR) system with a secure interface, export patient data directly to the Toolkit.

Train MOAs in Toolkit data entry and workflow.

- Dedicate a block of time to pull charts and gather baseline data.
- Follow the recommended workflow.
- To learn how to create and update patient records, see the online help or the [CDM Toolkit User Guide](#).

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Stage 2 Do

... continued

Use monthly Recall Reports to start recalling patients.

- Target one condition or one type of recall at a time (e.g., foot exams).
- With each patient's initial appointment, consult with them about having their records on the Toolkit, and explain the confidentiality and security of the information.
- Pass lab requisitions to the MOA to notify patients to go to the lab before coming for their next appointment.
- For more instructions, see the [Implementing Planned Recall](#) and [Introducing Group Visits](#) Practice Guides.

Support patient self-management.

- Give patients copies of their flowsheets and Patient Education Reports.

Share data with team members.

Use Data Extremes Reports.

- After six months or so, start recalling patients who still fit data extremes.
- Screen these patients for depression.

Use Key Measures Reports.

- Once completion rates are high (after doing recalls for six months to a year), use Key Measures Reports to target remaining patients with poor outcomes.

Use Advanced Search to identify special subpopulations for prevention interventions, group visits, and so on.

- Run a Recall Report or Run Chart for that search population, or access patient files directly.

Use Run Charts to measure the process and outcomes of care.

- Compare your two specified populations over a period of time, in terms of percentages of patients receiving guideline-recommended care. For example, compare your patient population with the average outcome trend for BC.

Stage 3 Study

Assess the effects on workflow, staff time, billing, and office redesign.

Assess the impact on patient care and outcomes.

Assess staff and patient satisfaction with the Toolkit.

- See the [Patient Satisfaction Survey](#) and [Clinical Practice Satisfaction Survey](#) in the [Resources](#) section of this guide.

Complete self-evaluation sheet.

- See the [CDM Toolkit Self-Evaluation Form](#) in the Resources section.

... continued

Stage 4 **Act**

... continued

Report and share your results with your team, colleagues, the Ministry of Health, and your health authority.

Rerun the Toolkit tests to refine your processes and routines.

Establish a routine for entering data and customizing reports.

Start managing planned care.

- See the [Implementing Planned Recall](#), [Introducing Group Visits](#), and [Enabling Patient Self-Management Practice Guides](#).

Expand to other conditions.

Sustain use of the Toolkit.

Introduction



**Dr. Paul Murray,
Prince George**

The Toolkit is wonderful for all paper-based practices. It really shows the huge potential of using software.

It's very useful for doctors to be able to manage their outcomes and compare themselves to colleagues.

Do you want a quick, straightforward tool for getting feedback about applying best practices? The Chronic Disease Management (CDM) Toolkit is a web-based system that provides decision support based on clinical guidelines to help health care providers give optimal care to high-risk populations such as patients with chronic conditions – including diabetes, congestive heart failure (CHF), depression, kidney disease, hypertension, and chronic obstructive pulmonary disease (COPD).

The CDM Toolkit is especially useful to practices not equipped with electronic medical record (EMR) systems. For some practices, the Toolkit can be used as an interim measure before investing in an EMR system.

The Toolkit is available for free to all BC physicians and their staff. It's hosted at the BC Ministry of Health, on the Secure Website for Practitioners.

Benefits

Benefits of the CDM Toolkit

FOR PATIENTS

- Improves health and lifestyle
- Helps patients self-manage their care
- Increases patient satisfaction
- Increases likelihood that patients who need follow-up will get it
- Prevents complications and provides early treatment because of proactive (not reactive) care

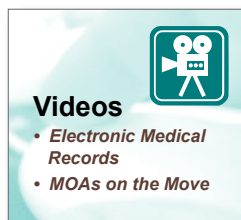
FOR PHYSICIANS

- Facilitates managing chronic disease patients in a more proactive way, leading to fewer patients visiting for acute or crisis conditions
- Provides feedback on patient outcomes by measuring the impact of changes
- Enables you to easily monitor how well your practice is meeting the clinical guidelines for your patients
- Makes managing patient registries easier
- Provides summary data at a glance and reduces charting time
- Supports individual care planning and reminders
- Enables you to securely share patient data with other members of a patient's care team, even when not co-located
- Enables you to identify high-risk patients

Objectives

After completing this module, clinical practices will be able to:

- Identify the functions and benefits of the Toolkit for clinical practices
- Assess their system capabilities for implementing the Toolkit
- Put together an action plan and a working team to implement the Toolkit
- Import patient data from electronic medical records (EMR) software
- Use flowsheets to provide evidence-based, guideline-directed care for their chronic disease patients
- Use practice-based analysis tools to identify and monitor gaps in care
- Share secure patient data with other members of the patient care team
- Generate reports to profile the practice and compare patient outcomes with other populations
- Integrate the Toolkit with practice workflow
- Maximize the clinical value of Toolkit reports and tools
- Measure how the Toolkit is improving care management
- Contact the appropriate resources for help in using the Toolkit



Key Services

The CDM Toolkit provides three key services:

1. Flowsheets
2. Data sharing
3. Reports for both patients and populations

These services make it easy to:

- **Manage patient registries** – Find patients with particular conditions, determine appropriate recall and alert processes, and generate reports showing how patient health outcomes change over time after receiving guideline-directed care.
- **Monitor your practice** – Print or view reports showing how your patterns of practice – following recommendations in the clinical guidelines – have affected treatment of your patient populations. Based on the data, the reports indicate areas for improvement. For example, how many diabetes patients have had an A1c test and a blood pressure measurement within the past six months?

An electronic registry system

At a busy practice, the needs of individual patients might not be fully met and their progress not systematically tracked. This is because many patients will not make regular appointments on their own, showing up only when they have an acute problem that could have been prevented with a check-up. The CDM Toolkit helps ensure that no patient falls through the cracks, and that all patients have the opportunity to receive proactive ongoing care.

Effective patient health care cannot be delivered without knowing your patient population. The CDM Toolkit starts with a list of all of the patients of a physician or group practice with a particular condition (e.g., diabetes mellitus).

ADVANTAGES OVER PAPER-BASED REGISTRIES

Although paper-based registries for chronic conditions permit identification and tracking of patients in simple ways, they don't provide the means to easily identify recurring patterns of care – or gaps in care – or a means to look at trends in your patient population groups. For example, you might be unaware that only a few of your diabetes patients have had a foot exam in the past year.

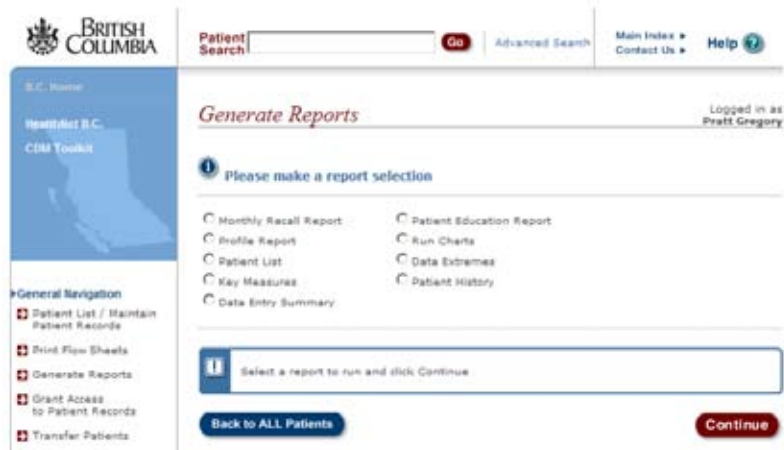
Paper registries also make it difficult to maintain a comprehensive "chart" for all clinical data pertaining to a patient's condition if there are several health care providers participating in the patient's care.

As an electronic patient registry system, the CDM Toolkit has advanced reporting capabilities that make it easy to track both the process of care and patient health outcomes, regardless of whether the patient's care providers share an office or charting system, or even the same building or community. The Toolkit also lets providers compare their progress with larger groups, e.g., how are your diabetes patients doing compared with the province as a whole?

Reports

Several reports are built into the CDM Toolkit. The four most commonly used reports are:

- **Recall Report** – lists patients who need to be recalled and the measures for which they require recall.
- **Run Chart** – shows guideline-based performance, used to track progress toward goals.
- **Key Measures** – lists patients who have key measures that are not on target.
- **Data Extremes** – highlights patients who are at the far extremes of clinical measurements.



Confidentiality

In most cases, physicians are the “primary users” for their practice. They must request additional user IDs for their staff to use the Toolkit. This puts a responsibility on the physician to ensure that all individuals with user IDs use the system appropriately to protect patient privacy.

The Ministry of Health’s physician user agreement requires that the physician, and all individuals for whom the physician requests IDs, sign a *Confidentiality Undertaking*. The undertaking states that they will use the data for purposes authorized in their user agreement only and will not permit the disclosure of this information for unauthorized purposes. A sample confidentiality undertaking is included in the introductory documentation received along with the user’s ID (see *How to Install Digital Certificates Using Internet Explorer (IE) 6.0*).

Security

The Toolkit uses encryption like an online banking system; it can’t be hacked into, and it can’t be used from a public computer. In order to use the CDM Toolkit online, validated users must install a forgery-resistant computer file called a *digital certificate*.

For more information on security and what information the government can see, as well as how to let other people access the data, see the Ministry of Health’s *CDM Toolkit Frequently Asked Questions (FAQ)* document.

Before You Begin

It’s recommended that you complete the [In-Depth Practice Self-Assessment Questionnaire](#) before you begin this Practice Guide. It guides you through various methods for assessing your practice to determine where there might be gaps in patient care management or administrative inefficiencies.

Training in the CDM Toolkit Education Environment

The CDM Toolkit Education Environment is a fully functioning replica of the actual CDM Toolkit. It can be used for demonstration, troubleshooting, and training. The data contained within the Education Environment are fictitious. The data are periodically deleted and reloaded as part of routine housekeeping.

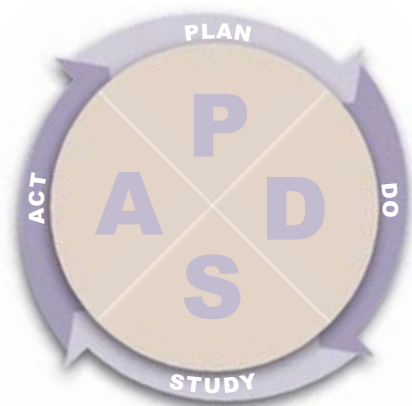
Access to the Education Environment is only for persons using or planning to use the CDM Toolkit.

Contact your Practice Support Team to gain access to the education site at <https://cdme1.moh.hnet.bc.ca/>

Software User Guide Documents

The Toolkit software is simple and easy to use. The way to use it is largely self-evident, but in some cases you might want to consult the online help. You can also obtain a user guide and more detailed supplementary user documentation. Go to the website or ask your Practice Support Team. All of the supporting user guide documents are listed in the [Resources](#) section.

NOTE *In this Practice Guide, whenever more information is needed about how to use the Toolkit software, refer to the online help or the user guide materials listed in the [Resources](#) section.*



Plan-Do-Study-Act

The main steps for adopting the CDM Toolkit are grouped according to the four stages of the **Plan-Do-Study-Act (PDSA) Cycle**, a change management strategy that has been used successfully by many BC primary care practices to adopt practice improvements. The Plan-Do-Study-Act Cycle is an evidence-based “trial-and-learning” method to test changes quickly to see how they work.

The clinical practice team selects a small change and implements it quickly. Then they use the PDSA Cycle to measure and refine the change as required. When it is working, they implement the change on a wide scale. This process results in effective changes that are implemented more rapidly than ones that are broad but take longer to adopt. Since each PDSA Cycle is only a small investment in time and resources, there is less risk to the practice associated with trying new things.

Stage 1 Plan



**Dr. Tom Bailey,
Victoria**

Being able to compare your own data to that of your practice partners and others that participate in the Toolkit provides a dimension to quality improvement and self-reflective practice that would otherwise be unavailable to you.

A little competition can drive each of us to improve the care we provide for our patients!

The purpose of this stage in the PDSA Cycle is to help you assess your current situation and identify the goals and outcomes you want to achieve. For detailed guidance on planning, consult the [Create an Action Plan Tips](#).

Assess Your Needs

What actual improvement do you want to achieve in your practice by adopting the CDM Toolkit? Are there any gaps in care that should be addressed? To find out, consult the Practice Profile section of the [In-Depth Practice Self-Assessment Questionnaire](#).

Assess Your System Capabilities and Computer Skills

All that's needed to use the Toolkit is Internet access – preferably high-speed – and a basic modern computer running the software that comes with it.

Make an adequate IT investment. A computer that's shared for dictation and Toolkit data entry makes for inefficient data entry. Having only one computer station might not be enough.

Also consider the potential impact the Toolkit might have on other areas of your practice. Ensure that your communication protocols, facilities, equipment, policies, and procedures are appropriate for implementing and sustaining the Toolkit.

Create an Action Plan

Create an action plan that lays out the tasks to be completed, including planning the time and resources required, selecting team members, assigning roles, and setting a timeline and data to be measured. A completed [Sample Action Plan](#) is included in the [Resources](#) section. Blank copies that can be modified can be downloaded from www.practicesupport.bc.ca.



TIP

A single computer might be enough if good sharing routines are established between the users. Allot specific time intervals, for example, one hour a week on Thursdays, before patients start to arrive for the day.



TIPS

Discuss who's responsible and who will inform locums and get them user IDs.

As you get closer to meeting your completion targets, it takes a different kind of work (Key Measures and Data Extremes).

Measure what's most important for you, and choose one measurement at a time – many PDSA cycles will come out of each measurement.

Document the changes you make so they're reproducible and to avoid repeating mistakes.

Team Member Roles

Team member	Possible roles
Medical office assistant (MOA) or data entry staff	<ul style="list-style-type: none"> • Transfer paper data to CDM Toolkit • Enter flowsheet data and maintain patient records • Train other staff on use of Toolkit • Run monthly recall reports • Run other reports routinely or on request • Participate in goal setting and testing of ways to improve
Physician	<ul style="list-style-type: none"> • Arrange training for staff • Select condition and patients • Enter data directly via EMR software • Request and evaluate reports • Take advantage of remote access • Participate in goal setting and testing of ways to improve
Administrative staff <i>(This could be the physician or MOA if there isn't a separate individual in this role)</i>	<ul style="list-style-type: none"> • Run reports • Track progress, issues, barriers, and work to assess progress • Help with registration and removing any barriers to using the Toolkit
All	<ul style="list-style-type: none"> • Participate in goal setting • Participate in identifying and testing ways to improve • Share results and feedback on changes (both positive and negative)

NOTE *Your Practice Support Team can also help in various ways, such as working with your practice team members to help identify roles, potential gaps in care, or priority populations for your practice; troubleshooting issues and solutions; and helping with registration, training, and technical support for the Toolkit.*



TIP

The key is to work smarter, not harder. If new things like the Toolkit are being added to the office workflow, then there are also likely things that can stop being done. Focus on the benefits that having a better-managed patient population provides; it frees up time for the practice staff because they're not always trying to fit in panicked, acute-suffering patients, or playing catch-up when they find out that the patient has been taken to emergency.

Identify and Overcome Barriers

What other changes do you need to make in your practice to successfully implement and sustain the Toolkit? Small offices can experience a big impact if just three more steps are added. What is it that needs to change so there's less burden on data entry?

Office routine is the biggest obstacle. Keep your eyes open going in, realizing this will eat up time. Consider workload and workflow. Expect to pay MOAs overtime while getting started with chart reviews and entering baseline data.

Get help with registering for the Toolkit. Make use of your Practice Support Team to help streamline this process.

MOAs

MOAs are key to success in office redesign. Choose MOAs who are *keen*.

Hold a staff meeting to explain office redesign and decide on roles. Have the whole office team participate in meetings. Keep it interactive and fun so everyone stays engaged. Supply food and beverage.

Make sure more than one person is trained to do data entry and provide cross-coverage for sick leave and staff turnover. MOA fatigue can occur when only one MOA is performing expanded roles in a group practice.

Stage 2 Do



**Dr. Tom Bailey,
Victoria**

One of the initial barriers to using the Toolkit is learning how to register and sign on efficiently. The process may initially seem rather cumbersome, but it can be quickly learned and become second nature.

Remember that the apparent awkwardness is related to ensuring that the system remains secure and private.

Ask for help from others, including the Ministry, to get over this barrier at the beginning.

Once you've made a plan to use the CDM Toolkit, the next stage is to implement the CDM Toolkit on a trial basis, using a select group of patients.

It's important to document any problems as you go along. You can also begin analyzing data during the Do stage, rather than wait until the end. The PDSA Cycle is designed to be flexible, so you should engage in continual planning, study, and refinements at every stage.

Register for the Toolkit

Whether or not you have an EMR system, the first step is to register for access to the CDM Toolkit. This section provides an overview of the registration process. For more details, see the *CDM Toolkit User Guide* and *CDM Toolkit Frequently Asked Questions (FAQ)*.

Apply for a digital certificate

The CDM Toolkit exists on a secure computer in Victoria, and is accessible from any computer with Internet access, as long as that computer has a digital certificate. To apply for a certificate:

- Designate an Access Administrator. Likely this will be the physician, or his/her MOA. The certificate will later be sent to the Access Administrator by email.
- Read the *Provider Registration Agreement* at <http://healthnet.hnet.bc.ca/has/regagree/4614fil.pdf>. Fill out the form and submit it online.

NOTE If you already have a user ID and password for the secure website, you can use these to log on to the CDM Toolkit.

Once approved for access, which can take a few days, the Access Administrator will receive an email with the following items:

- Digital certificate
- *Confidentiality Undertaking* agreement
- User ID for the physician
- Temporary log-on password for the physician
- User ID and temporary log-on password for the Access Administrator (if different)
- Detailed instructions on how to install the certificate

Install the digital certificate

Steps

1. Check the encryption strength of your browser and upgrade if necessary. The Ministry of Health can help you with this.
2. Call the Ministry of Health's Helpdesk to get a permanent password for installing the digital certificate (this is not the same as the log-on password).
3. Install the digital certificate into your browser, entering the certificate password. *Repeat the installation process on every computer that will be used to access the Toolkit.*
4. Save the digital certificate and its password to a safe location so you can install it on new computers if required.
5. Have each user sign the confidentiality agreement.
6. Log on to the secure website. You'll be prompted to change your temporary log-on password.



TIP

For problems installing the certificate, call the Helpdesk, or see the troubleshooting sections of the *CDM User Guide* or *FAQ*.

Register additional users

Request additional user IDs from the Helpdesk by email.

DATA ACCESS

The Ministry recognizes different types of users, with different access privileges for patient data. When the Helpdesk sets up and manages user accounts, they assign broad user roles that help with the administration of the application.

Full access – Nurses, nutritionists, MOAs, data entry clerks, and other physicians usually have full access to clinical data for the physicians' own patients. They can add and remove patients from that list but cannot transfer or grant access to patients.

Aggregate data only – Other non-clinical staff who don't need access to clinical data (e.g., clinic managers, collaborative administrators and data analysts, Ministry representatives, and

health authority support persons like a Practice Support Team) would see only the aggregate data given in reports, such as Run Charts and Practice Profile Reports. These external users do not have access to data at the individual patient level.

No access – Ministry Helpdesk staff cannot see patient-level data. Although support staff or other interested individuals may have access to the Education Environment to train users or to learn about the CDM Toolkit, the Education Environment contains only fictitious data.

Authorized users can view confidential patient information in the “Shared Patients” tab on the Patient List screen.

See your Practice Support Team for more information.

Log On

Logging on is straightforward and simple. However, because of the enhanced security of this website, the following log-on events will be encountered:

- If more than one digital certificate is installed on a computer, you’ll be prompted to choose the correct certificate prior to logging on. Choose the one that matches your user ID.
- You’ll be *automatically logged off after 20 minutes of inactivity*.
- Your *password will expire every 40 days*, and therefore you’ll be prompted to change your password at that time.

Establish a routine for dealing with these ongoing issues effectively.

Set Up a Patient Registry

To learn how to select a population, identify patients, and create and use flowsheets, see the [Developing Patient Registries](#) Practice Guide.

Import from an EMR System

If you have an EMR system, talk to your EMR vendor to determine whether they have implemented the secure interface (an *XML schema standard*), to send data from your EMR system to the CDM Toolkit. Several vendors have implemented one or more flowsheets in their software. This may permit you to enter data through the EMR system, and then send it securely to the Toolkit without repeating the data entry.

Using the EMR system in this way enables you to take advantage of the CDM Toolkit reports for recalls, alerts, and comparisons of your patient populations with larger population groups.



**Dr. Paul Murray and
MOA Tasha Botelho,
Prince George**

I find the section where you can generate reports and get the “data extremes” and “monthly recall” are very useful for ensuring good continuity of care – especially for patients who don’t come in on a regular basis for diabetic visits.

Our MOAs run this report monthly and we’re working to ensure more timely attendance for regular chronic disease care.



**Dr. Andrew Sear,
Quesnel**

“Recall” is like playing “Battleship” – you just blow the X’s out of there.

Train MOAs in Toolkit Data Entry and Workflow

Giving clear direction to MOAs is important so that MOAs understand expectations from the physician. The physician leads the team and works with the MOAs to determine what the new MOA roles will be.

To create the initial patient registry for the Toolkit, dedicate a block of time daily or on a weekend to pull charts and gather *baseline* data. You can do this on paper flowsheets before the Toolkit certificate arrives. It should take no more than 10 minutes per patient chart. For more instruction, see the [Developing Patient Registries](#) Practice Guide.

Your Practice Support Team can help to arrange training for your practice team (physicians, MOAs, and other staff).

Recommended workflow

After all recall visits, put the CDM charts into one spot for the “data entry MOA” to enter new data into Toolkit on a weekly basis.

Print each patient’s flowsheet once it’s updated, and file it in the patient’s chart.

Have MOAs print Recall Reports monthly, and Key Measures Reports quarterly.

Have two MOAs doing data entry daily for five doctors to get the smoothest transition, the best work environment, and the best Toolkit results. It takes less than 90 seconds per patient for ongoing data entry.

Create and Update Patient Records

If detailed instructions are needed, see the online help or the *CDM Toolkit User Guide*.

Run Recall Reports

This report is useful to the person in charge of booking appointments. Its primary purpose is to help give CDM guideline care.

Congestive Heart Failure

Patient	6MON	BP	ACE	BBLG	ARB	EF	SMHF	SMD	FLUV
ALEXANDER, GLORIA 250535529			X	X	X	X	X	1	X
ATEST, BP			X	X	X	X	X	2	X
BEAUPRES, JACQUELINE 250538149							X	2	X
BML TEST	X	X	X	X	X	X	X	X	X
BRUCE, PETER 250538121	X	X	X	X	X	X	X	1	X
BUDDEN, CLINTON 250535430	X	X	X	X	X	X	X	1	X
BUFFAS, GEORGE 250535271	X	X	X	X	X	X	X	0	X
BURSH, BOB (250) 123-4560	X	X	X	X	X				
BURSH, MIKE (250) 123-4560	X	X	X	X	X				
Bursh, Moonbeam (250) 123-4564	X	X	X	X	X		X	X	
Byrd, Woodstock 250-555-5555	X	X	X	X	X	X	X	X	X
COURTNEY, LOREN 250538727	X	X	X	X	X	X	X	1	X
Canning, Susan	X	X	X	X	X	X	X	X	X
DOERFNESS, LEO 250535000	X	X	X	X	X	X	X	X	X
DOELL, MARY 250535512	X	X	X	X	X	X	X	2	X
FRIESEN, MINNIE 250515008	X	X	X	X	X	X	X	X	X
GOMES, MANUEL 250538108	X	X	X	X	X		X	1	1
Gazette, Francine (250) 123-4501	X	X	X	X	X	X	X	X	X
Gazette, Mary (250) 123-4571	X	X	X	X	X	X	X	X	X

This Recall Report shows a list of all patients who should be recalled for one or more items. The column codes indicate a flowsheet observation type (an "X" indicates that the patient is overdue for that observation; a number in the column indicates the number of months until the patient is to be recalled).

Patients will not appear on the report if they are not due for recall for any of the selected diseases or observations.

Note that the patient's phone number appears on this report to make it easy to plan and schedule recall.

Start Recalling Patients

A recall system enables you to proactively ensure that all patients in the CDM Toolkit are given the opportunity to have their condition managed to clinical guidelines, with their active participation.

At the beginning of each month, have staff pull up all recalls due that month and set up an appointment. Start small; target one condition or one type of recall at a time (e.g., foot exams). For more instruction, see the [Implementing Planned Recall](#) and [Introducing Group Visits](#) Practice Guides.



TIP

Printed versions of the flowsheets show checkmarks on clinical indicators due for recall (e.g., indicating that a blood pressure measurement or A1c test is due based on guidelines).

Lab tests

The patient does not have to come in twice when due for lab tests. Efficient appointments increase the capacity to be proactive and address other issues.

After printing the Recall Report, the doctor can check the correct boxes on printed lab requisitions, then pass them on to an MOA with instructions to notify the patient that he or she must go to the lab for testing before coming for the next appointment.

Patient agreement

With each patient's initial appointment, discuss having their records on the Toolkit and explain the confidentiality of the information. Let patients know that the system is more secure than a bank.

Patients will be comfortable with the Toolkit records when they understand that it helps organize their care. This approach has proven very successful; it's a rare patient who declines. This step also ensures that doctors are confident in using the Toolkit.

Ensure that a patient notification poster is displayed prominently in the waiting room and exam rooms.



TIP

Providing patients with copies of their flowsheets helps to improve their understanding of their condition.



TIP

It's usually better to work on what a patient wants to work on. You can lose a patient if the process is too data-driven. Ensure that they set their own goals.



TIP

If a Run Chart has a data point that appears to be incorrect, it can be checked by running the Data Extremes Report for that observation or measure and that month. It can also be used as a general check to pick up any data entry errors.



TIP

Don't screen for depression unless you intend to treat it.

Support Patient Self-Management

See the [Enabling Patient Self-Management](#) Practice Guide.

Patient Education Reports

Give patients their Patient Education Reports showing trends in key clinical indicators over time, such as personalized graphs of systolic blood pressure and A1c values for the past year.

Share Data with Team Members

To support coordinated, interdisciplinary care, the provider most responsible for a patient – usually the family physician – can grant access to the patient data to any other provider who needs to participate in the patient's care. This means that all members of the care team, whether co-located or not, can securely review and update the patient's chronic care record as required, including GPs in other clinics.

NOTE *When patients leave your practice, you can also transfer patient data electronically to their new provider.*

Target Patients Needing Special Care

Use Data Extremes Reports

The Data Extremes Report shows a patient list for a selected disease parameter during a specified time period. The report lists all observation values sorted from high to low, with the top and bottom 10% highlighted.

After six months or so, start to recall those patients that still fit data extremes.

DEPRESSION SCREENING

According to data from the Northern Health Authority, about 90% of patients in the extreme range are depressed. Patients recalled on the basis of Data Extremes Reports should be screened with the depression questionnaire (PHQ9).

For better results, treat their depression *first*, by private counselling or by referral. Statistics show that about 60% of chronic disease patients are depressed, and some will stop complying due to "disease fatigue."

Use Key Measures Reports

Once completion rates are high after doing recalls for six months to a year, use Key Measures to target the remaining patients with poor outcomes. Only patients who have key measures that are not on target appear on this report.

NOTE *So far this report has been implemented only for CHF and diabetes.*

Identify special subpopulations (Advanced Search)

To find a specific patient population – such as all female diabetes patients with A1c values over 8 – use the Advanced Search function. From the resulting search population, you can then run a report like a Recall Report or Run Chart for that search population.

Advanced Search can be very helpful for selecting patients for group visits or for prevention interventions, such as for hypertension. You can search by age or by co-morbid conditions.

In the resulting patient list, you can click the patient entry to open the patient's file (unlike the reports, which produce PDF files).

With Advanced Search you can also see the range and extremes.

Measure Outcomes of Care (Run Charts)

The CDM Toolkit supports simple population “trending” to enable comparison of two populations over a period of time. For instance, you might compare your own practice with a collaborative group to show the proportion of a patient population that's on target for guideline-based care.

A Run Chart allows you to compare your two specified populations in terms of percentages of patients receiving guideline-recommended care. The graphs that are displayed depend on the data type of the measures selected.



TIP

Start with one indicator, such as all patients missing a particular test. Those patients are likely missing other tests as well. Generate a Key Measures Report for those patients.

There are two main types of graphs:

1. **Completion rate graphs** show the percentage of the selected population that had an observation recorded within the guideline time period.
2. **Detail graphs** show the percentage of patients meeting particular targets or outcomes based on the clinical guidelines.
 - For *value* observations, most graphs show the percentage of the selected population that had an observation above or below a specified target threshold. Some graphs give the percentage of patients in specified categories.
 - *Drug* observation graphs are a little more complicated, showing the drug status distribution of the population.



TIP

Once completion rates stabilize and patients are self-managing, look more for change in clinical data rather than completion rates.

Interpreting Run Charts is the perhaps the most complex procedure in the Toolkit. We recommend referring to the online help, the *CDM Toolkit User Guide*, or *CDM Toolkit – Reading Run Charts*.

Stage 3 Study



*Dr. Andrew Sear,
Quesnel*

I was surprised. I thought I provided better care than I actually did.



TIP

A member of your Practice Support Team or a coordinator at your regional health authority may be able to run reports from the CDM Toolkit on your behalf, or train your staff how to do so.

An essential part of implementing the CDM Toolkit is establishing an evaluation method to see whether changes are effective and goals have been achieved.

Once you've used the CDM Toolkit for a period of time, you should track progress to see whether you have measurably improved outcomes for patient care and clinical outcomes. Use the quantitative and qualitative measurements and tools you selected during the Plan stage, such as patient surveys and data sampling.

Assess Workflow and Staff Time

Steps

1. Identify any lessons learned about the implementation process or about the CDM Toolkit itself.
2. Consider ways to refine the process to address any weak areas or further improve clinical outcomes.

Assess Clinical Impact

Assess the impact on patient care and outcomes.

Assess the ability of your practice to monitor how well it is able to embed evidence-based care into the practice for patients registered on the Toolkit.

Assess Staff and Patient Satisfaction

Steps

1. Distribute blank patient and staff surveys.
2. Compare the previous responses with the current responses.
3. As far as possible, quantify the degree of improvement in staff and patient satisfaction.



TIP

Normally you can't compare Run Charts directly between individual doctors. If all physicians agree, they can form a group for reporting purposes in the Toolkit, or more formally take part in collaborative learning sessions offered regionally or provincially. They can then make customized reports so that each practice can compare directly with each other and see results compared with the entire group. Discuss collaborative opportunities with your Practice Support Team.

Complete Self-Evaluation Sheets

The [Resources](#) section contains the [CDM Toolkit Self-Evaluation Form](#), which has a "Lessons Learned" section. Completing these will help you summarize what you did and determine the success of the CDM Toolkit and its implementation.

Report Your Results

Work with your practice team to monitor and share feedback on any issues, improvements, and progress with the CDM Toolkit.

Share your data, improvements, tools, success stories, and lessons learned with your patients, the Ministry of Health, your health authority, and other doctors and practices.

Stage 4 Act



**Dr. Tom Bailey,
Victoria**

Using the Toolkit has allowed me to better rationalize appointments. I can confidently see some patients less frequently, which creates the capacity to recall others who should be seen more frequently.

You may choose to move forward in a number of ways, depending on the results of the CDM Toolkit implementation.

Rerun the Cycle

If problems occurred during the PDSA Cycle, you should determine what went wrong and how it can be fixed to get the results you want. In this case, you can simply repeat the implementation process again, incorporating the new changes.

If the test was a success, or a partial success, you may also want to rerun the cycle to add some complexity to your use of the CDM Toolkit. For example, doing another PDSA Cycle is an opportunity to use the Toolkit on more complicated cases, make your flowsheets more comprehensive, or add new flowsheets for patients with more than one condition.

You may also want to obtain Toolkit user IDs for other members of your practice, to begin to expand its use.

Establish a Routine

It's a good idea to establish a routine for entering data and customizing reports. You'll likely find it easiest to have each flowsheet printed in advance, enter data on the paper, then give the printed flowsheet back to the MOA to enter into the CDM Toolkit.

Alternatively, doctors can enter data directly in computers at the point of care.

NOTE When you use the CDM Toolkit to create a second or third flowsheet for a patient with more than one chronic disease, you need to enter some data only once, such as demographic data, co-morbid conditions, and clinical observations that are common to each flowsheet (e.g., blood pressure). The Toolkit can pick up certain data from the first flowsheet and populate subsequent flowsheets as they are created.

**TIP**

You can use the flowsheets as is, or you can choose to include more or less information. For example, one Vancouver doctor used the flowsheet for congestive heart failure to include his patient's self-management goals, as well as progress notes on assessment, planning, and follow-up.

**TIP**

Your practice can define its own standard observation comments, which can then be used as search terms to generate a "customized" patient list for reports.

**TIP**

Use the Key Measures Report and the Profile Report to help manage group visits.

For an example of a PDSA Cycle for establishing a routine for data entry, see *Sample PDSA Cycle for Entering Information*, available in the [Resources](#) section.

“Customized” reports

Run an Advanced Search to find a specific patient population, then run a report for that search population.

Run Charts can be used to compare the selected search population with your entire patient population.

Start Managing Planned Care

For detailed information on managing planned care, see the following Practice Guides:

- [Implementing Planned Recall](#)
- [Introducing Group Visits](#)
- [Enabling Patient Self-Management](#)

Expand to Other Conditions

Consider other conditions or groups of patients where it would be beneficial to use the CDM Toolkit, then simply repeat the PDSA Cycle you carried out for the first set of patients.

You can also share your success with other physicians in your practice and work with them to adopt the CDM Toolkit.

Sustain Use of the Toolkit

See the [Understanding Quality Improvement](#) Practice Guide. Adopt methods that will help your practice continue using the CDM Toolkit. Here are some examples:

- Ensure that your staff maintains its expertise. Look for opportunities to continue their training, such as workshops and conferences.
- When a new staff member comes on board, arrange for training through your health authority, or have one of your other staff train the new person.
- Use incentives to keep every staff member involved and motivated. Celebrate successes, use teamwork to overcome obstacles and failures, and offer perks such as overtime pay, more holidays for extra work done to develop the CDM Toolkit, or “employee of the month” awards.
- Hold team meetings to discuss progress and problems and to brainstorm solutions and ideas for future changes. Make them informal and interactive so that all staff are engaged, and provide food and beverage.
- Change the formal job descriptions of your MOA and other staff to encompass the job changes needed to operate the CDM Toolkit on a permanent basis.
- Make the PDSA Cycle a habit by using it for any change you implement in the office.
- Make it part of normal office practice to identify and remove barriers to positive change and sustainability.

Practice Profile



**Dr. Tom Bailey,
Victoria**

The central hub of the Toolkit is the Monthly Recall Report. This tool allows you to quickly and efficiently see what you are and what you are not doing.

This report drives the PDSA cycles that will streamline your practice flow and improve the care you provide to your patients as a whole.

Dr. Tom Bailey, Group Practice

Dr. Bailey's group practice started using the CDM Toolkit in 2003 in the Vancouver Island Health Authority Collaborative, while the software was still in development. They already had an EMR system. Because it was the beginning of the Toolkit, they ran into lots of bugs and challenges, but they got through it without a lot of difficulty. It didn't take long to enter data, and they had good dialogues with the Toolkit developers, who understood what they needed and adapted the software. Dr. Bailey was especially pleased with the security features of the Toolkit.

The amount of demographic data needed to select populations was relatively small. Paper-based practices can request an initial patient register, listed by disease, from the Ministry of Health. However, that register is created from billing codes and other administrative data so you have to check for discrepancies. Bailey's group referred to the Ministry's list, but found it easier to simply use their in-house EMR system to identify patients with chronic diseases. They chose to manage CHF, diabetes, and depression. When patients were informed that they could choose not to be involved, none declined.

Bailey was glad to have someone step them through using the Toolkit because there's a learning curve to get into it. But he says that once you're there, it's easy. A huge advantage is that common elements automatically go into all flowsheets where tests are required.

The group started out by setting completion targets for the percentage of patients treated to guidelines; for example, A1c testing rates were to reach 90% within three months. Baseline completion rate was around 40-50%. Without any other efforts, the group met their targets. It seems that just comparing their outcomes with others – instead of working in isolation – motivated them to do better.

Because there's so much work to be done, Dr. Bailey says that the CDM Toolkit doesn't really give him more free time. However, it does make him far more efficient, and he can now manage his patients more effectively outside the office (5 or 10 minutes at home instead of driving to the office).

Summary



**Dr. Paul Mackey,
Fort St. John**

The CDM Toolkit enables you monitor patient and population outcomes for specified chronic conditions so you can plan and manage necessary care for all patients in a timely way.

The Plan-Do-Study-Act Cycle is designed to introduce the CDM Toolkit into your practice gradually, one step at a time. You can expect greater overall success when the CDM Toolkit is integrated with other practice improvements such as [Introducing Group Visits](#) and [Enabling Patient Self-Management](#).

The result is greater patient satisfaction. Dr. Paul Mackey of Fort St. John tells one story about a former diabetes patient whom he had just enrolled in the CDM Toolkit. The patient was accustomed to the doctor's directing his care. The next time the patient asked Dr. Mackey, "What should I do?" the doctor replied, "Well, it's your blood pressure, it's your sugar levels, it's your insulin. You're the one who has to live with your condition. So what do *you* want to do?" This caused a major change in perspective for the patient.

Within three months, the patient's A1c level went from 11 to 5. Dr. Mackey remarks: "When some patients are given the opportunity to self-manage their condition, they'll embrace it. Adopting the CDM Toolkit is an important first step in motivating individuals to commit to improving their condition."



Resources

Website

Go to www.practicesupport.bc.ca for more Practice Guides, as well as videos and other quality improvement resources.

Ministry of Health

Register at: <http://healthnet.hnet.bc.ca/has/regagree/4614fil.pdf>

Helpdesk at: 250-952-1234

IT Support for the CDM Toolkit

Support for using the CDM Toolkit is available at three levels:

- Level 1 – Ministry of Health (MOH) Helpdesk handles password resets, user ID management, and issuing of digital certificates. The Helpdesk refers business and clinical questions to the Primary Health Care Branch.
- Level 2 – MOH Connections/Data Access Services. Questions about detailed application use are answered at this level. For example: “How do I run a report for Dr. X’s diabetes patients to find out how many there are and how many have an A1c <7%?” They will refer you to the Primary Health Care Branch for business and clinical questions, and to the software development team for technical issues.
- Level 3 – The Primary Health Care Branch handles business and clinical questions while the software development team handles technical issues such as software bugs.

CDM Toolkit User Guide Materials

- *How to Install Digital Certificates Using Internet Explorer (IE) 6.0*
- *CDM Toolkit User Guide (long or short versions)*
- *CDM Toolkit – Introduction to Reports*
- *CDM Toolkit – Reading Run Charts*
- *CDM Toolkit Training Exercises*
- *CDM Toolkit Frequently Asked Questions (FAQ)*
- *Patient Notification Poster*



Videos

- *Fresh Ideas: Enhancing Health Care*
- *Revitalizing Family Practice*
- *The Leading Edge: Chronic Disease Management in Masset*
- *Personal Health File*
- *Advanced Access: Taming of the Queue*
- *Electronic Medical Records*
- *MOAs on the Move*
- *Moving to Group Practice*



Practice Guides

Other Practice Guides developed by IMPACT BC include:

Introductory
Understanding Quality Improvement
Clinical
Developing Patient Registries
Implementing Planned Recall
Practice Management
Adopting Advanced Access
Introducing Group Visits
Information Technology
Adopting the CDM Toolkit



Useful Worksheets and Forms

Worksheets and forms included in this guide:

1. [Quick Reference User Guide](#)
2. [Sample Action Plan](#)
3. [Sample PDSA Cycle for Entering Information](#)
4. [CDM Toolkit Patient Registry Development – INVOICE](#)
5. [BCMA CDM Toolkit Incentive – Payment Criteria](#)
6. [Clinical Practice Satisfaction Survey](#)
7. [Patient Satisfaction Survey](#)
8. [CDM Toolkit Self-Evaluation Form](#)

Additional worksheets and forms can be downloaded from the Adopting the CDM Toolkit page at www.practicesupport.bc.ca:

1. [Create an Action Plan Tips](#)
2. [Blank Action Plan](#)

Quick Reference User Guide

Log on at: <https://healthregistry.moh.hnet.bc.ca/>

Helpdesk: 250-952-1234

Logging on – To log on you will need your certificate, a username, and a password. Go to the website. If more than one certificate is installed on the computer, you'll be prompted to select a certificate. Select the one that matches your username prefix (Certificate 5567 for username 5567-Ismith). Enter your username and password, and click "Sign in."

Locating a Patient – There are various ways to locate a patient:

- Basic search – enter a patient last name or Personal Health Number (PHN)
- Advanced search – click "Advanced Search," and enter any field required
- Browse – sort the patient list to help you find a patient by browsing

Add a Patient – In "Patient List/Maintain Patient Records," click "Add New Patient," and enter the fields as required. Be sure to select the correct Primary Care Giver. Click "Save."

Select a Diagnosis for a Patient – Select the patient for whom you wish to add a chronic disease diagnosis. Click the name to view the patient record. Click "Diagnose patient with Chronic Disease." Check the appropriate diseases, and click "Continue." Enter the additional data as required and click "Save".

Add Baseline Data – Select the patient for whom you would like to add baseline data for a chronic disease. Click the name to view the patient record and the chronic disease(s). Click the disease in question, select "Add Baseline Data" from the drop-down list, and click "Go." Enter the information and date recorded. Click "Save."

Add Flowsheet Data – Select the patient for whom you wish to add flowsheet data. Click the name to view the patient record. Select the relevant disease, select "Add Data" from the drop-down list, and click "Go." Select the date you collected the data and click "Continue." Enter the data points from the flowsheet and click "Save."

Print Flowsheets – Click "Print Flowsheets." From the list on the left, select the patient whose flowsheets you wish to print. Click "Select" to move them to the right. Check the appropriate disease(s) (i.e., the one[s] you wish to print), and click "Go." A PDF document will be produced containing your flowsheets. Print paper copies of the flowsheets by clicking the printer icon.

Print Reports – Click "Generate Reports." Select the report type you wish to run and click "Go." Select the parameters you require and click "Go." A PDF document will be produced containing your report. You can then print the report by clicking the printer icon.

Remove a Patient – In "Patient List/Maintain Patient Records" click "Remove." Select the reason for removal from drop-down list, and "Save" changes. Click "Cancel" to cancel removal of the patient.

Sample Action Plan

Project Name: Adopt the CDM Toolkit

Team Members: Dr. Smith, Dr. Wang, Dr. Singh, Jane Adams

Action Plan

What are we trying to accomplish?

Purpose of project

Maximize the number of diabetes patients with current lab data

Improvement goal

Meet goal of 90% of diabetes patients with a current hemoglobin A1c recorded

How will we know that a change is an improvement?

Current measurement or baseline

Baseline data indicate that only 25% of diabetes patients have a current hemoglobin A1c

What we are going to measure on an ongoing basis?

Number of diabetes patients with current hemoglobin A1c as a percentage of total diabetes patients in Toolkit

Measurement goal

Improve to 50% within 30 days; and 70% within 60 days; and reach target of 90% within 90 days

What action can we test that will result in a small improvement towards our goal?

Change concepts and ideas to test that will improve on the item you are measuring

Run patient Recall Report in Toolkit for Diabetes patients

Identify all those who do not have current lab data

Have lab requisitions completed for each patient, to include all non-current lab data

Have flowsheets available for all diabetes patients for each visit, and screen for missing data

How will we manage the improvement project?

Ground rules for working through this improvement

Patient Recall Report to be printed monthly and reviewed by physician

MOA to print current flowsheets for each patient visit

... continued

Action Plan

Roles and responsibilities

Physician arranges access to CDM Toolkit

MOA calls patients proactively to have lab tests done when tests are due

MOA keeps flowsheets updated in CDM Toolkit

Realistic schedule

Expect to meet goal of 90% within 3 months of starting process

Key dates

Plan	Barriers identified and overcome	April 1-15
	Staff roles discussed and agreed upon	April 16-30
Do	Toolkit user IDs and training requested	May 1
	Charts pulled and initial flowsheet data entry complete	May 1-15
	Flowsheets available with visit for all patients	May 30
	Monthly Recall Reports created and recall method tested	June 30
Study	Interim evaluation of results	July 15
Act	Revise/refine recall methods for next test cycle and/or choose next patient group for data entry and follow-up	July 30

(Adapted from Interior Health Authority)

Sample PDSA cycle for Entering Information

- PLAN** Establish routine for entering data into Toolkit
1. MOA who is trained for entry into the Toolkit will print flowsheets for all diabetes patient charts.
 2. MOA will attach flowsheet to inside of chart.
 3. Doctor will fill out flowsheet during visit.
 4. Chart with new data will be given to MOA.
 5. MOA will enter new data into the Toolkit that same day.
 6. MOA will print a new flowsheet and place on the chart once the new data are entered.
 7. This process will be tested on Thursday with 5 diabetes patients.
- Success* = data filled out on chart; data entered same day; MOA and doctor like the process.
- DO** MOA attempted process with 5 patients on Thursday
- STUDY**
- The process was too time consuming for the part-time MOA.
 - Doctor missed seeing the flowsheet when it was inside the chart.
 - Some patients return for visits frequently for concerns other than diabetes and do not always need flowsheet filled out.
- ACT**
- Train an other part-time MOA to help with data entry process.
 - Leave flowsheet on the front of the chart for:
 - The doctor to see and fill out during the visit (the doctor will decide if the form needs filling out)
 - The MOA to see so that the data can be entered.
- PLAN** Try modified process on Friday with 6 patients who have diabetes; both MOAs will help enter data.
- Success* = data filled in by doctor if diabetic visit; data entered same day; new encounter form on front of chart; staff and doctor like the process.
- DO** Both MOAs attempted the process with 6 patients on Friday.
- STUDY** All 6 patients were scheduled for a diabetes-related visit. The flowsheet on front of chart worked. The doctor filled it out and the MOAs shared data entry. New flowsheets were printed and put on the front of the chart for the next visit.
- ACT** This worked.
- Implement the new process.
 - Write it up so that if a new MOA comes we will have it documented.

CDM Toolkit Patient Registry Development

INVOICE

To: Maria dela Cruz
BCMA
Toolkit Administration
Fax: 604.638.2939

From: Physician's Name: _____
Address: _____
Phone: _____
MSP Number: _____

Amount: \$500.00

Please submit invoice if all the following apply:

1. I am a general practitioner. ____
2. My practice has entered at least 50 qualifying patients into the Toolkit after November 1, 2004. ____
[These patients have one or more diagnoses of a chronic disease for which a CDM Toolkit flowsheet has been developed, or have been identified as part of a prevention screening age cohort.]
3. My practice has entered the patients' baseline data against the disease or prevention flowsheets. ____

Signed: _____

FOR BCMA OFFICE USE ONLY

BCMA verifies information through Toolkit team

Verified _____ Invoice Paid Date _____

See payment criteria on next page for patient qualification requirements.

BCMA CDM Toolkit Incentive – Payment Criteria

Criteria for payment:

1. Licensed general practitioner in British Columbia
2. 50 qualified patients entered into the CDM Toolkit (see below)
3. At least 3 clinical baseline observations entered for each patient
4. Has not already received payment of the BCMA CDM Toolkit Incentive

Patient qualification criteria:

In order for a patient to be included in the count of 50, the patient must meet at least one of the following criteria:

- a) A new patient entered since November 1, 2004.
- b) A new flowsheet attached to an existing patient since November 1, 2004; and baseline data entered for observation types on this new flowsheet, in addition to those pre-populated by any existing flowsheets.
- c) Observations entered since November 1, 2004, for an existing patient with existing flowsheet(s) for at least 3 observation types not used before November 1, 2004.

Patients meeting more than one of these criteria will be counted once only.

Clinical Practice Satisfaction Survey

Please circle the appropriate answer.

1. Were you able to add all your patients with the selected chronic condition to the CDM Toolkit and create flowsheets for them?

Yes No If not, what percentage ? _____

2. How would you rate your job satisfaction prior to adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

3. How would you rate your job satisfaction prior to adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

4. How would you rate your staff satisfaction prior to adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

5. How would you rate your staff satisfaction prior to adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

6. Based on your patient feedback, how would you rate your patient satisfaction prior to adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

7. Based on your patient feedback, how would you rate your patient satisfaction after adopting the CDM Toolkit?

Poor 1 2 3 4 5 6 7 Excellent

8. Are you able to easily compare your patient outcomes with those of other patient populations?

Yes No

9. Do you have fewer patients visiting for acute or crisis conditions?

Yes No

10. Is your practice better able to meet the clinical guidelines for your patients?

Yes No

Additional Comments

Patient Satisfaction Survey

Please circle the appropriate answer.

Overall, I've been getting better care since I was added to the CDM Toolkit.

Yes	No
-----	----

Overall, I've been getting more frequent care since I was added to the CDM Toolkit.

Yes	No
-----	----

The doctor's office called me to book today's appointment (I didn't book it myself).

Yes	No
-----	----

I was able to see my flowsheet when I visited the doctor today.

Yes	No
-----	----

The doctor (or other staff) explained the flowsheet to me, and I understand it.

Yes	No
-----	----

I was able to take home a copy of my flowsheet.

Yes	No
-----	----

I would recommend to others that they be added to the CDM Toolkit.

Agree	1	2	3	4	5	6	7	Disagree
-------	---	---	---	---	---	---	---	----------

Overall, I'm satisfied with the care I've been getting since being added to the CDM Toolkit.

Agree	1	2	3	4	5	6	7	Disagree
-------	---	---	---	---	---	---	---	----------

Comments

What do you like about the CDM Toolkit system?

Is there anything you would like to change?

Anything else you would like to say?

Thank you for showing us how to make this health experience better.

CDM Toolkit Self-Evaluation Form

Use this self-evaluation form to summarize and reflect on your project. You will be able to copy some of the information from your action plan. An electronic version of this form that you can modify can be downloaded from www.practicesupport.bc.ca.

When you've completed the evaluation, send it in confidence to **dcikes@healthyheart.bc.ca**. The information you send will be used to identify gaps and improvements to the Practice Support Program.

Date _____

Project name _____

Team members _____

Self-Evaluation

What did you try to accomplish?

Purpose of project

Improvement goal

Are the changes an improvement?

Baseline measurement

Current measurement

Measurement goal was?

What are you measuring on an ongoing basis?

What action did you test that resulted in a small improvement toward your goal?

What change concepts and ideas did you test?

... continued

Self-Evaluation

How did you manage the improvement project?

Roles and responsibilities?

Schedule: Did you meet your target completion dates?

Lessons learned

What lessons have you learned from this project?

What would you do differently when implementing another quality improvement in your practice?

What tips can you offer to other physicians who are interested in improving their scheduling system?

How would you rate your satisfaction with the changes you've made?

Low

1	2	3	4	5	6	7
---	---	---	---	---	---	---

 High

How would you rate patient satisfaction with the changes you've made?

Low

1	2	3	4	5	6	7
---	---	---	---	---	---	---

 High

How would you rate clinical staff satisfaction with the changes you've made?

Low

1	2	3	4	5	6	7
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 High