Institute for Healthcare Improvement

MDHHS
Michigan Department of Health & Human Services

Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

June 13-14, 2017

Michigan Department of Health & Human Services

Workshop: Welcome, Overview & Introductions

State Innovation Model

Patient Centered Medical Home Initiative

Practice Transformation Collaborative: Learning Session 2

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Background: A look at the State Innovation Model

Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test care delivery and payment system changes.

- Strategies focus on moving towards cost-effective use of healthcare dollars overall in terms of patient experience and quality outcomes.
- System that coordinates care within the medical system to improve disease management and utilization; and out into the community to address social determinants of health.

Vision: A person-centered system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, improve health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes.

The State Innovation Model

Care Delivery

Population Health

Payment Reform

Health Information Technology

Evaluation

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Population Health Goals

- Better population health and health care delivery at lower costs
- Align priorities across health and community organizations, and support the broad membership of the CHIR in executing improvement strategies.
- Initiatives focused on both: (1) primary prevention, as well as (2) addressing the social determinants of health that impact residents' ability to stay healthy and/or manage disease through linkages between health care and social services.
- Enhancement of local policy, identification of cross-organization programmatic and procedural improvements, and development of a built environment that encourages health and wellness.
- Further development of capacity and sophistication for effective and efficient governance, partnership, data collection and information sharing, and integrated service delivery.

CHIR Goals and Objectives

The overall goal of the Community Health Innovation Region (CHIR) is to **develop community capacity** to improve population health. The objectives of the CHIR are to:

- Leverage the existing, well-developed capacity in communities to bring regional partners together to identify and address community health needs.

- Develop and implement linkages between Accountable Systems of Care, payers, and community-based agencies to address social determinants of health.

- Enhance local policy, identify cross-organization programmatic and procedural enhancements, and advance built environment efforts to encourage health and wellness.

- Further develop a high level of organization and sophistication in terms of governance, partnership, data collection and information sharing, and integrated service delivery.

Where are the CHIRs?

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Future of Care Delivery?

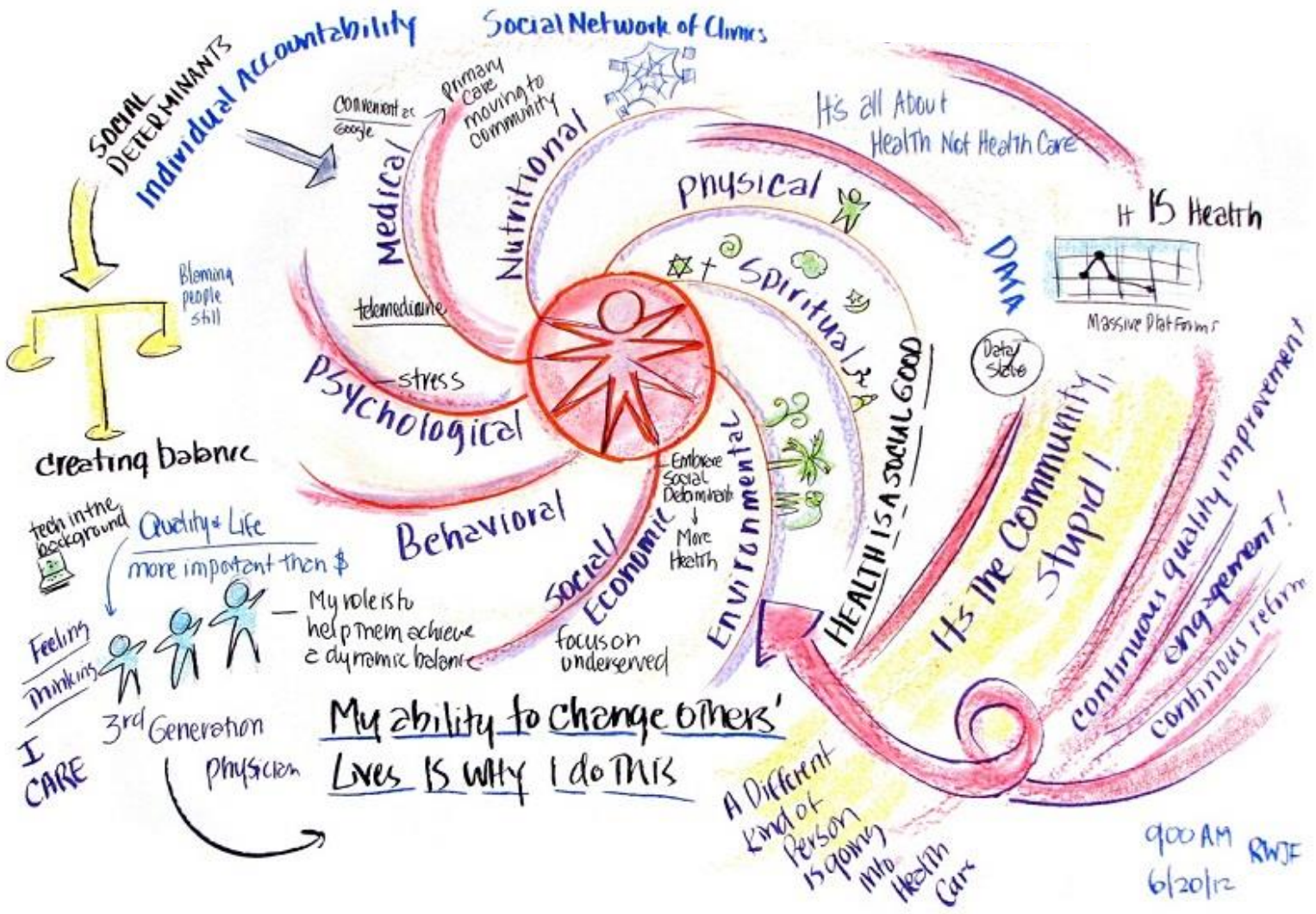

Image Credit: Eileen Clegg, Visual Insight

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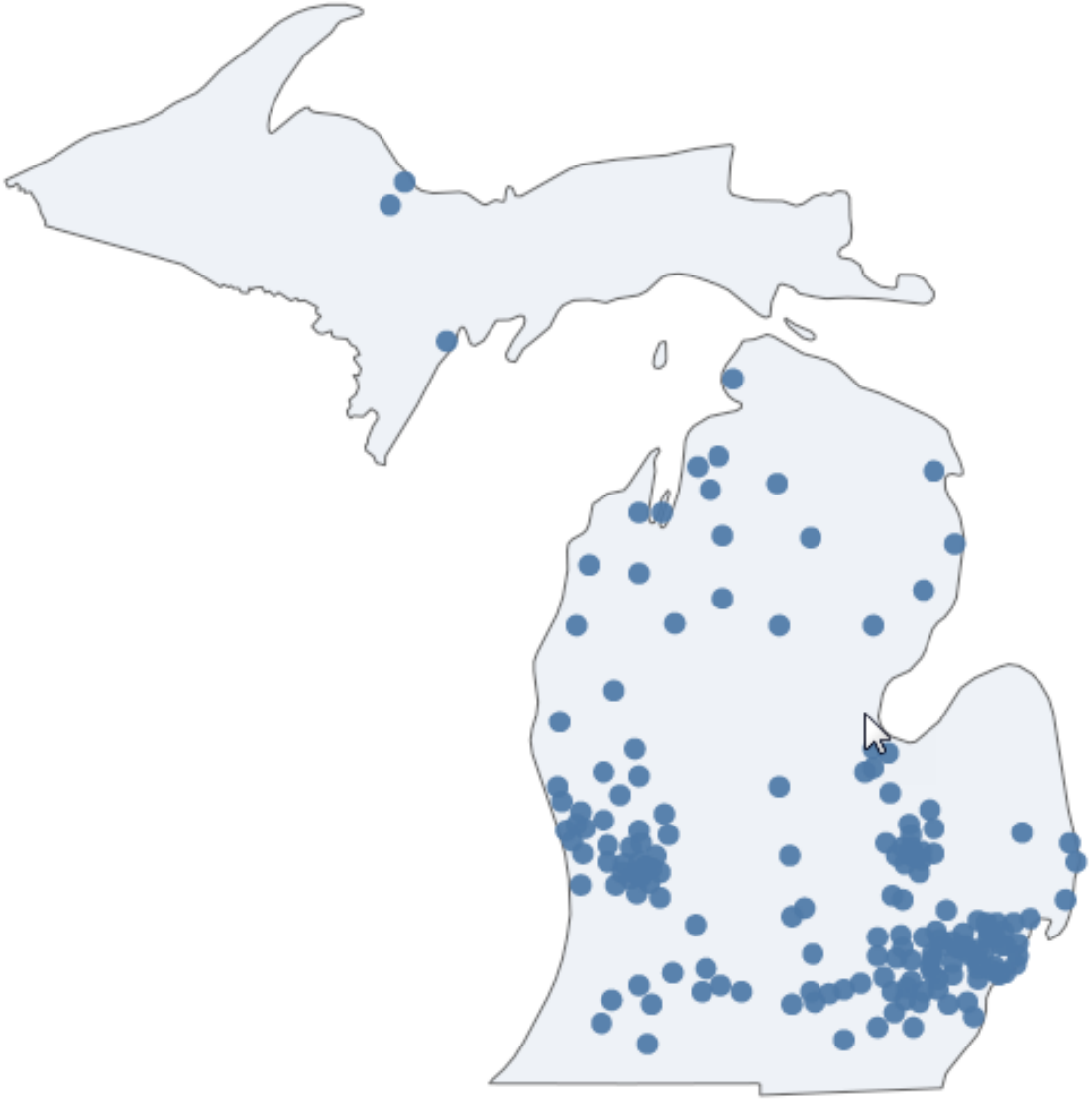
The PCMH Initiative Focus

Support Scale for What's Working	Encourage the "Next Step" for Advancement	Test Promising Practices Where Opportunities Exist
PCMH Recognition as a Foundation	**Team-Based Care Practices**	**Clinical-Community Linkages**
Advanced Access (24/7, Open Access, Non-Traditional Hours)	**Integrative Treatment Planning**	**Health Literacy and Social Determinants Perspectives**
Electronic Health Record and Registry Base Technology	Provider Collaboration and Integration	Patient-Reported Outcomes
Structured Quality Improvement Processes	**Robust Care Management and Coordination**	Referral Decision Supports
	Patient Education and Self-Care	
	Caregiver Engagement	
	Transitions of Care	
	Managing Total Cost of Care	
	Health Information Exchange Use Cases	
	Patient Experience Perspectives	
	Population Health Strategies	

Bolded items represent current areas of direct focus.

Where are the PCMH Initiative Participants?



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What is Bringing Us Together: Practice Transformation

"Practice Transformation" or "PCMH Transformation" refers to the result of enabling a primary care Practice to use both educational and financial support to develop the following characteristics of the Patient Centered Medical Home:

1) infrastructure,
2) organizational, and
3) cultural changes

i.e., primary care provider-led; prepared and proactive care teams providing comprehensive, whole person care; coordination of care across healthcare settings; enhanced patient access; use of electronic technology; and development of a culture that encourages striving for continual improvement in patients' experience of care and health outcomes for the entire Practice panel, while reducing preventable costs.

Refresher- PCMH Initiative Participation Agreement

- Practice Requirement, By *November 1, 2017*: "Complete the PCMH Initiative's required Practice Transformation Objective (clinical-community linkage), including submitting practice transformation progress reporting on a semi-annual basis."

- Practice Requirement, *During the Initiative*: "Complete the required Practice Transformation Objective (as defined in the Participation Agreement), demonstrate progress toward completing the Practice Transformation Objective selected from the Initiative's menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis."

- PO Requirement (As Applicable): "Submit practice transformation progress reporting on a semi-annual basis for participating Practices which choose to pursue Practice Transformation Objectives in partnership with the PO."

- "Practice Transformation Objective" or "Transformation Objective" refers to the care delivery enhancements and/or quality improvement activities defined by the Initiative that a Practice undertakes as to improve quality, improve health outcomes (including patient experience), improve access to care, and/or reduce health care costs. A list of Transformation Objectives is provided in Appendix F of the Participation Agreement and on the SIM Care Delivery webpage.

Practice Transformation Objectives

★ Clinical-Community Linkages	Telehealth Adoption	Improvement Plans from Patient Feedback	Medication Management
Population Health Management	Self-Management and Support	Care Team Review of Patient Reported Outcomes	Group Visit Implementation
Integrated Peer Support	Patient Portal Access	Cost of Care Analysis	Integrated Clinical Decision Making

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Participant Requirements: Testing Promising Practices

Clinical Community Linkages:
Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below:

- Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
- Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made.
- As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion."

What is Bringing Us Together: Practice Transformation

The objective of the PCMH Initiative's practice transformation objectives and payment model is to support the advancement of infrastructure within (or accessible to) PCMH practice environments.

Practice transformation in this context is not focused on (or funded to support) the act of delivering a service to an individual patient.

Rather, practice transformation support in the PCMH Initiative is geared toward building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

More Than a Flip of a Switch

Transformation requires:

- Changes in:
  - Scheduling
  - Access requirements
  - Coordination
  - Types of visits (i.e. group visits)
  - Provision of services (e.g. telehealth)
  - Practice management
  - Staff roles
- Incorporating population medicine
- Evidence based care
- Redefining patient visit
- Response to patient needs and events outside of the clinical setting
- New coordination points:
  - With other parts of the healthcare system
  - With partners outside of the healthcare system
- Team based care
- New strategies for patient engagement
- Use of Information Systems including leveraging Health Information Exchange
- Outcomes based staffing
- Quality Improvement at the point of care

Adapted from Initial Lessons Learned from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home ANNALS OF FAMILY MEDICINE MAY/JUNE 2009

In This Together

- The Practice Transformation Collaborative supports:
  - "Going beyond" Patient Centered Medical Home,
  - Sustaining change, and
  - Continuous quality improvement

- Provides participants the opportunity to work **together** to support successful practice transformation

- Key Partner: Institute for Healthcare Improvement (IHI)
  - IHI is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide

- How to Engage in this opportunity:
  - Action Period Calls
  - Learning Sessions
  - Peer Coaching Calls

Michigan PCMH Initiative Practice Transformation Collaborative

TRANSFORMATION OBJECTIVES DEVELOPED

COLLABORATIVE ORIENTATION CALL
March 9, 2017
Pre-Work:
- Draft Aim for Clinical Community Linkages
- Vulnerable patient story

Learning Session 1 April 3-4, 2017	Learning Session 2 June 13-14, 2017	Future Learning Sessions TBD
Clinical-Community Linkages	**Population Health Management & Clinical-Community Linkages**	**TBD**

Learning Sessions are face-to-face sessions that include the following:
- Plenary and breakout sessions focused on the PCMH Transformation Objectives combined with Quality Improvement tools and methods to advance the work.
- Dedicated team meeting time.
- Poster sessions.
- Opportunities to meeting informally with peers and communities of practice from around the State.

Learning Session Guiding Principles:
- Incorporate interaction and mixture of formats for participants—honor adult learning principles.
- Minimize didactic (talking head) sessions.
- Engage participants as the teachers/faculty as soon as possible.
- Provide sufficient time for teams to plan together.
- Set a pace—urgency and excitement.

All teach, all learn

Action Period (AP) Supports

Monthly AP Teaching Webinars (April 13, May 11, June 8, July 13) :
The aim of these webinars are to accelerate testing of changes between face-to-face sessions. Teams come together for continued learning around the Transformation Objectives, the Model for Improvement, changes teams are making and helpful quality improvement tools & methods.

Bi-Monthly Peer Coaching Webinars (May 16-19; July 18-21—Select One Bi-Monthly):
Also aimed at accelerating change and improvement, these bi-monthly webinars offer dedicated space for teams to engage in facilitated conversations and coaching with one another. Participants will create their own agenda of things that they need to talk about to advance the work.

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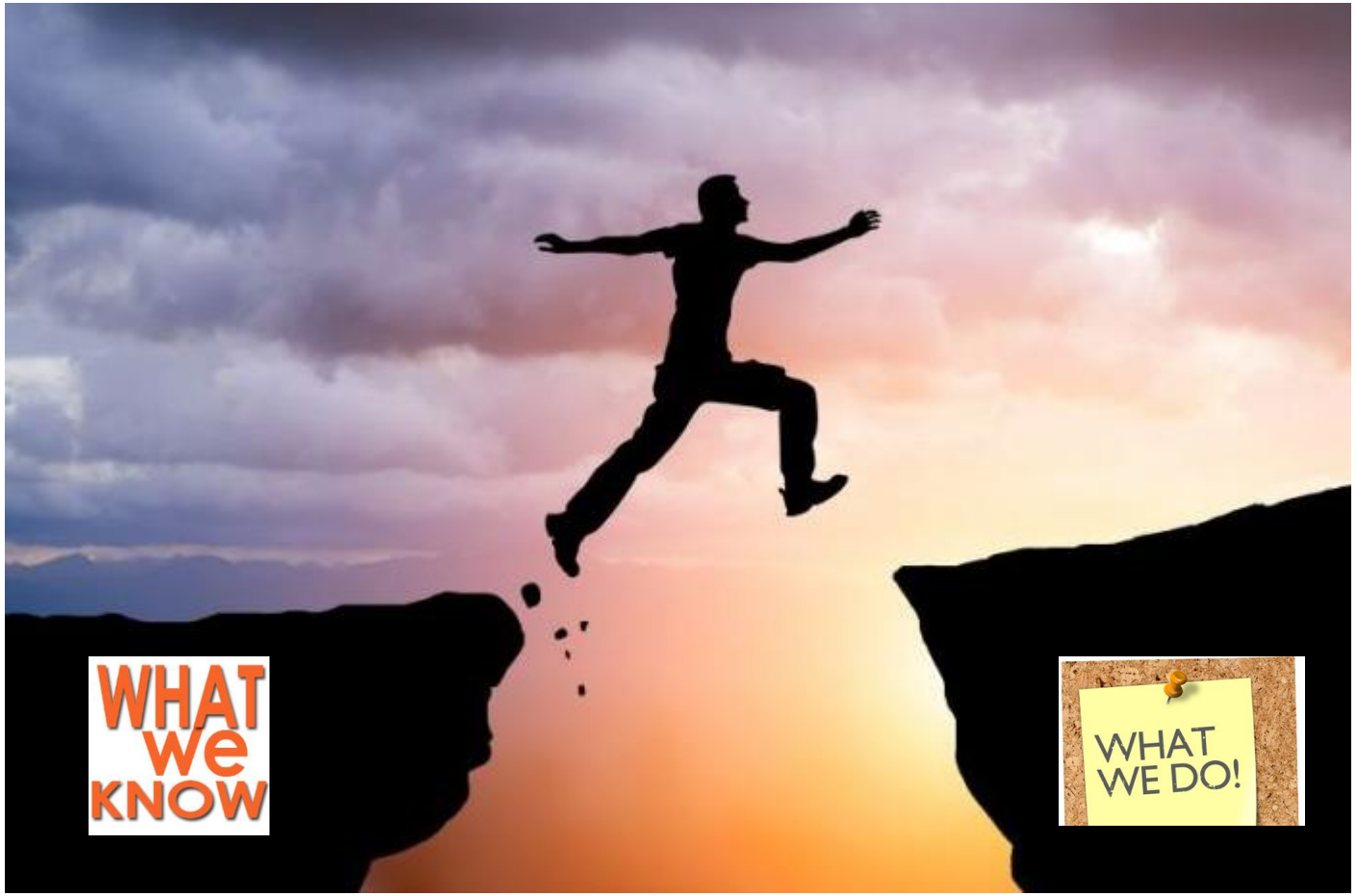
Institute for Healthcare Improvement

Learning Lab

Quality Improvement 101: Theory & Tools

Sue Butts-Dion
Improvement Advisor

Closing the Gap



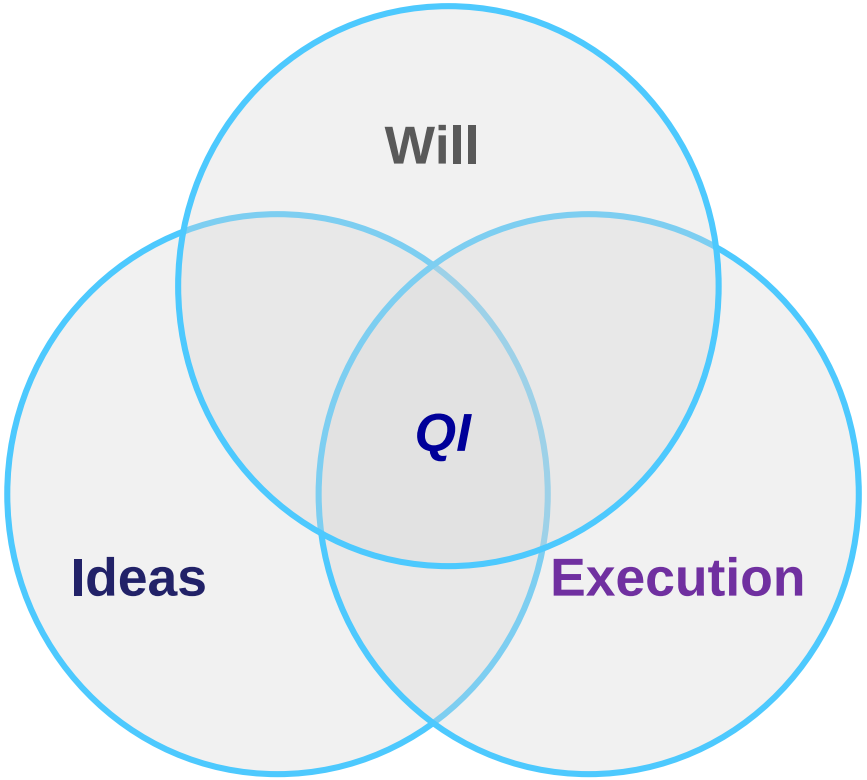
Bad people??

NO!!

All Improvement Requires Change

The Primary Drivers of Improvement

Having the ***Will*** (desire) to change the current state to one that is better



Developing ***Ideas*** that will contribute to making processes and outcomes better

Having the capacity and capability to apply CQI theories, tools and techniques that enable the ***Execution*** of the ideas

How prepared are you?
(your work group, unit, department, team or facility?)

Key Components*	Self-Assessment
Will (to change)	Low Medium High
Ideas	Low Medium High
Execution	Low Medium High

*All three components **MUST** be viewed together. Focusing on one or even two of the components will guarantee suboptimal performance.

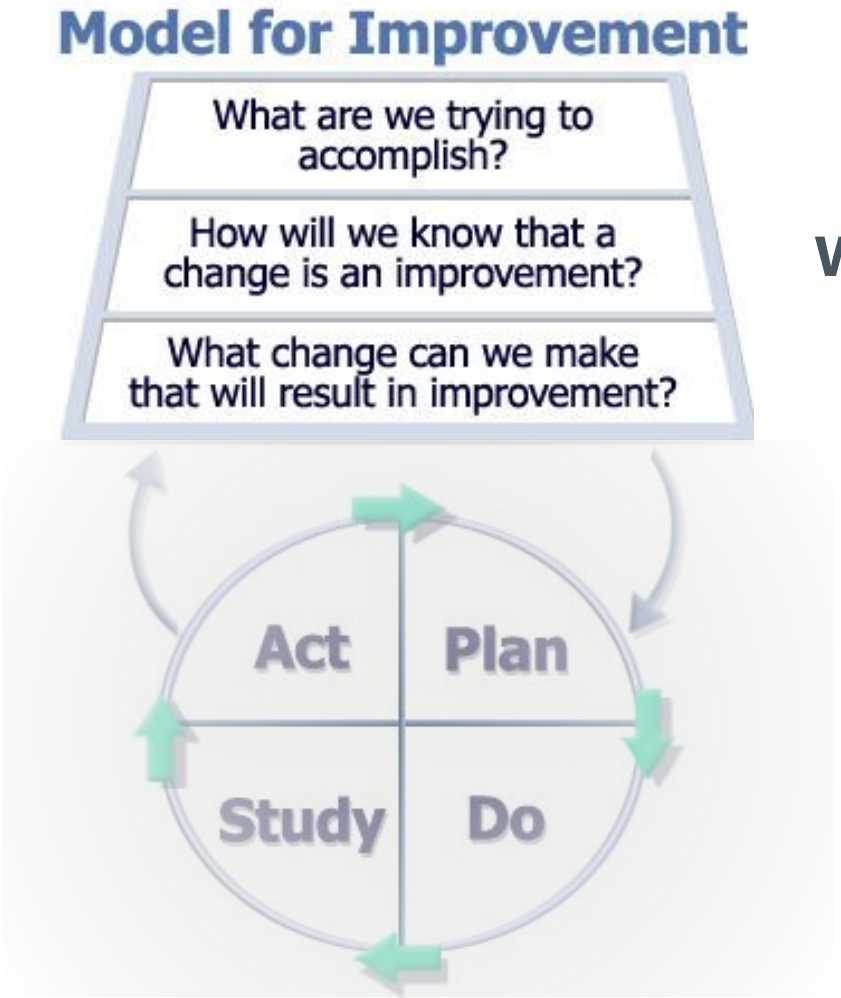
Accelerating change and improvement

When you combine the 3 questions with the…

PDSA cycle, you get…

…the Model for Improvement.

A Model for Learning and Change

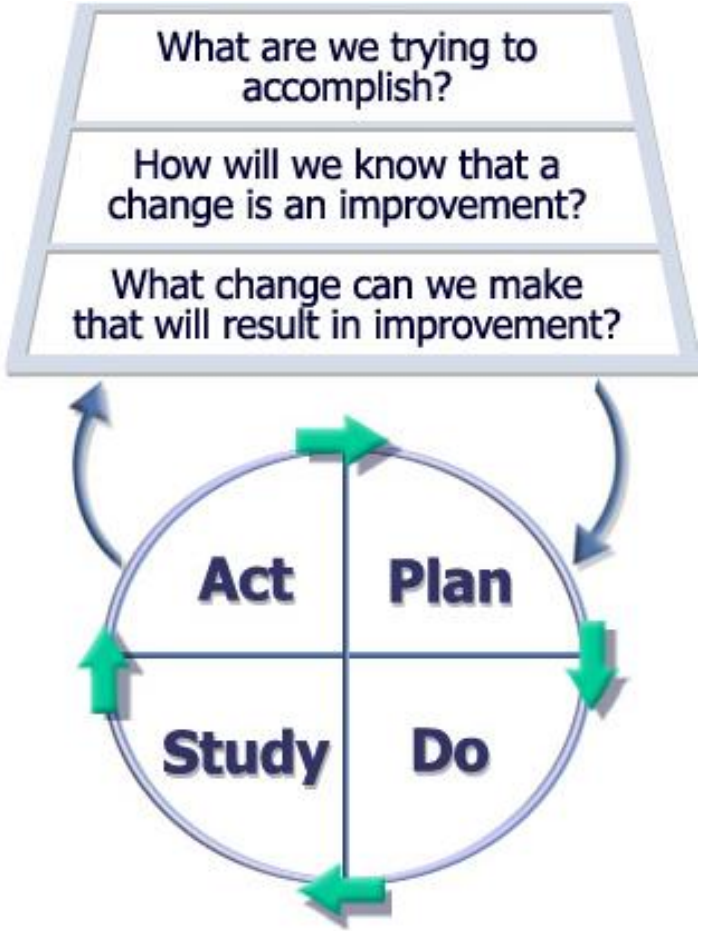


Let's start with the three questions

Langley, et al, *The Improvement Guide*, 2009

Question 1: What are we trying to accomplish?

Developing the team's *Aim Statement*



Langley, et al, *The Improvement Guide*, 2009


SPEED LIMIT
40
ONE WAY
ONE WAY
ONE WAY
ONE WAY
ONE WAY

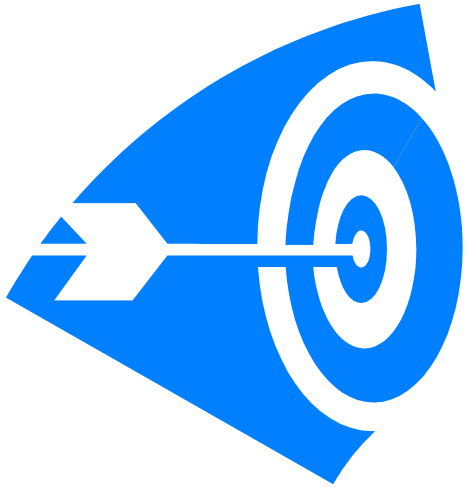
For fun…

- Think of something that you are currently trying to improve (can be personal or professional just be sure that you won't mind sharing at your table and possibly with the group).
- What is it you are trying to accomplish? Jot it down on a piece of paper.

Key Components of Aim

Aim statement:

- What?
- For whom?
- By when?
- How much?



What are We Trying To Accomplish?

The AIM is

- Not just a vague desire to do better
- A commitment to achieve measured improvement
  - In a specific *system*
  - With a definite *timeline*
  - And numeric *goals*

What are We Trying To Accomplish?

The AIM is

- to do better
- ve measured
  - In a specific *system*
  - With a definite *timeline*

"Soon" is *not* a time

"Some" is *not* a number

Donald Berwick, MD

"Hope" is *not* a plan

How did you do?

- Aim Statement:
  - What?
  - For whom?
  - By when?
  - How much?

Alignment…

Sue's example

What Sue said…

I want my back yard to be a beautiful, lush sanctuary.

What Sue's husband heard: $$$$$$$$

Sue's revised aim…

- By July 4th, 2017, I want to have grass in my back yard. Specifically, I want at least 95% of my yard to be covered in grass (currently 10%).

Sue's example

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I want my back yard to be a beautiful, lush sanctuary.

What Sue's husband heard: $$$$$$$$

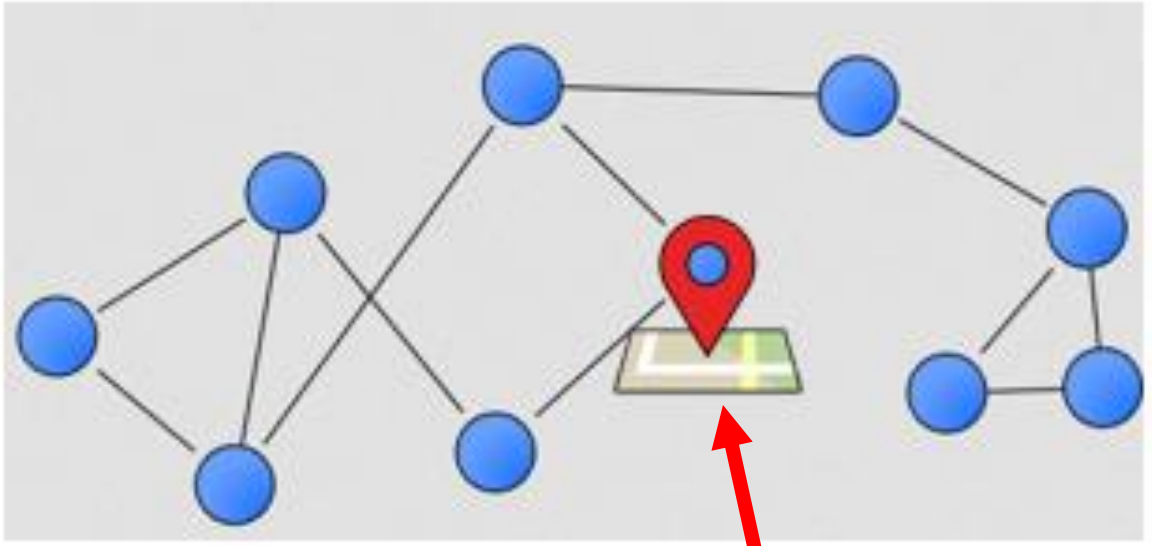
Sue's revised aim…

- By July 4th, 2017, I want to have grass in my back yard. Specifically, I want at least 95% of my yard to be covered in grass (currently 10%).

Example

- By November 1, 2017, our practice will have a reliable system in place for identifying potential community clinical linkages and nurturing those relationships in support of what matters to patients. We will focus specifically on:
  - Increasing % of attributed patients assessed using SDoH brief assessment from 0-??%
  - Developing and carrying out a communication plan with at least 2 community partners (informed by results of assessment and on our experience and knowledge)
  - Increasing the % of closed-loop communications with community partners on behalf of patients referred to them (from X to Y)

Tools to explore systems… Ecomaps & Sociograms



Our Organization

= A Strong Relationship

= A Weak/Vulnerable Relationship

= A Stressful/Adverse Relationship

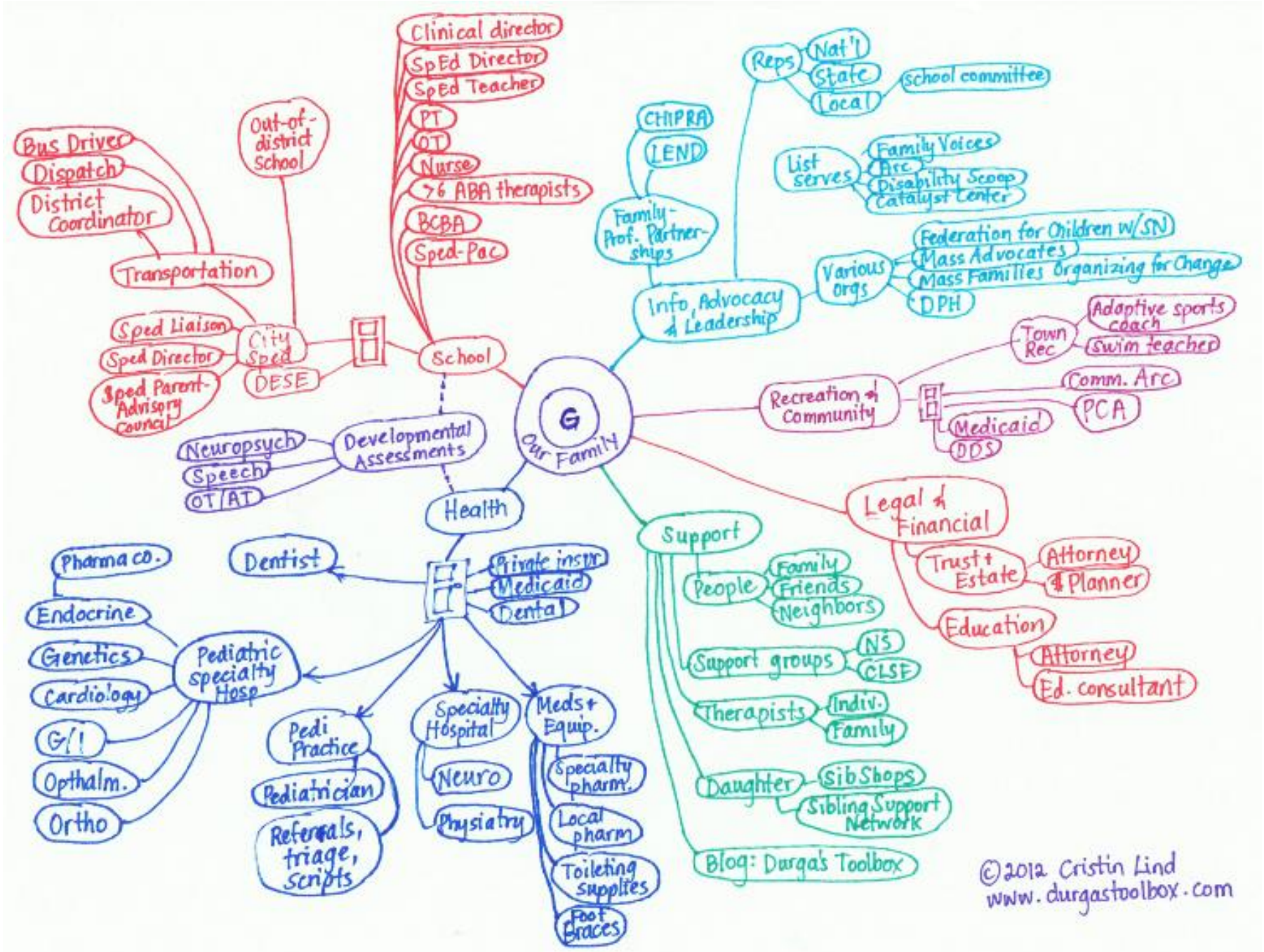
= Flow of Resources

CCL Questions for Consideration

- Linkages to strengthen on behalf of patient?
- Linkages to create?
- How could your practice/organization support this patient in a manner that is responsive, respectful of the patients and family's goals and ensures that feedback loops are closed?

Ecomaps: through the patient's eyes…

- Used case studies to map out the clinical-community relationships you may have or may need to strengthen or create on their behalf



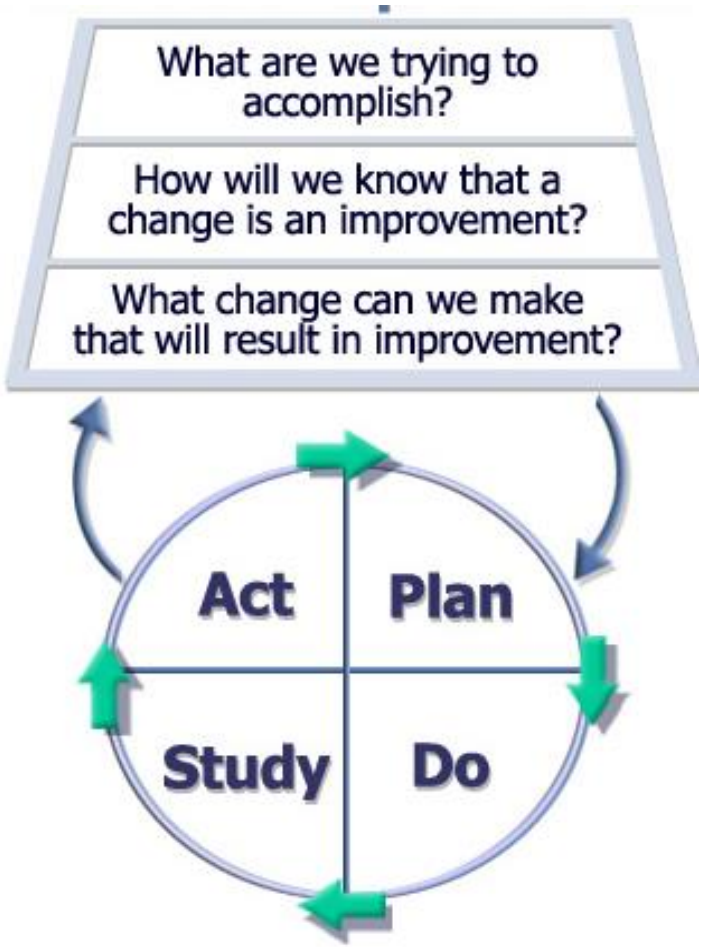
Emphasis on “What are we trying to accomplish” WITH a focus on what matters to the patient!

During Learning Session 2…

- A next step for teams leaving LS1 was to go back to their organizational teams and refine aim statement
- Learning Session 2's story boards will feature revised aims-look for presence of key components
- Look for presence of the patient voice

Question 2: How will we know that a change is an improvement?

Developing a set of measures for your project



Langley, et al, *The Improvement Guide*, 2009

Family of Measures

- Outcome measures
- Process measures
- Balancing measures (if useful)

Sue's Measures

Grass in my back yard:

- Outcome
  - % of yard where grass is growing in back yard
  - Health of grass
- Process
  - Minutes of watering
  - Time spent planting
  - Time spent treating/ fertilizing
  - # times empty the lawn mower bag
- Balancing
  - Cost
  - Beach time missed working on lawn☺
  - My front yard

Clinical Community Linkages (example)

Outcome

- Clinical Outcomes

Process

- % of patients reporting that they were linked to exactly the care they needed when and where they needed it
- % of patients referred w/ closed loop communication with PCMH documented
- % of patients assessed using SDoH assessment
- % patients with co-created care plan
- % of patients with ecomaps completed

Balancing

- Time required to f/u on linkage
- Cost to f/u
- Time spent in office visit

Table 1: Quality of Care and Health Outcome Measures

First Release	Second Release	Third Release	Fourth Release
CDC: A1c Testing	Chlamydia Screening	Anti-Depressant Medication Management	CDC: A1c Control
CDC: Eye Exam	Childhood Immunization	Follow-Up Care for Children Prescribed ADHD Medication	CDC: Blood Pressure Control
CDC: Attention for Nephropathy	Adolescent Immunization		Controlling High Blood Pressure
Colorectal Cancer Screening	Well Child Visits (15 Months)		Weight Assessment and Counseling for Nutrition and Physical Activity
Cervical Cancer Screening	Well Child Visits (3-6 Years)		Adult BMI Assessment
Breast Cancer Screening	Well Child Visits (Adolescent)		Tobacco Use Screening and Cessation
Use of Imaging Studies for Low Back Pain	Use of High Risk Medications in the Elderly		Screening for Depression and Follow-Up
Hypertension Prevalence	Lead Screening		
Asthma Prevalence	*Diabetes Prevalence*		
Obesity Prevalence			

Table 2: Utilization, Cost, and Care Management Metrics

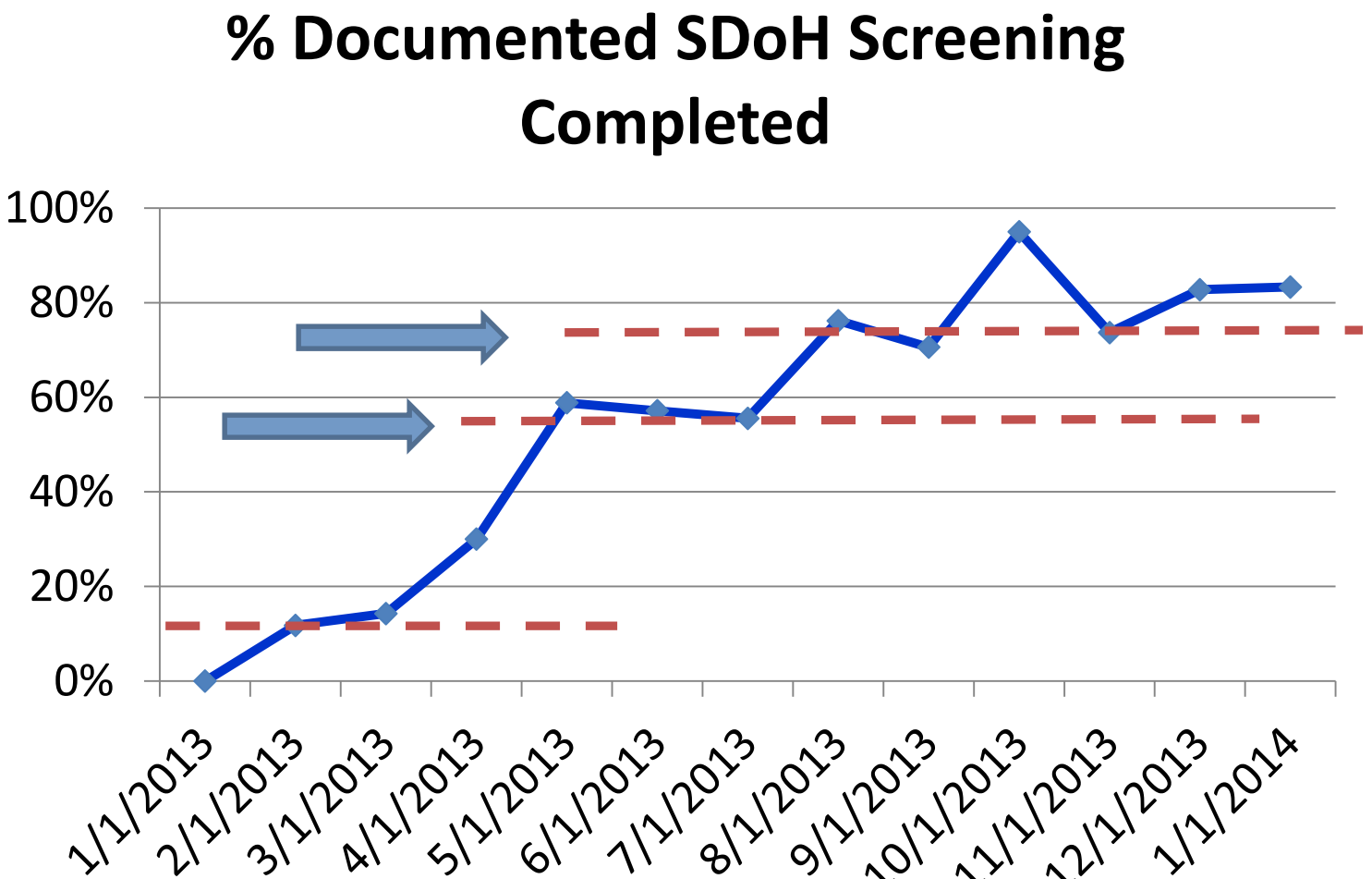
First Release	Second Release	Third Release	Fourth Release
All Cause Acute Inpatient Hospitalization Rate	Percent of Attributed Patients Receiving Care Management*	Total PMPM Cost	
Emergency Room Visit Rate	Timely Follow-Up with a PCP After Inpatient Discharge*	Preventable Emergency Room Visits	
30 Day Re-Admission Rate		Ambulatory Care Sensitive Hospitalizations	

The Three Faces of Performance Measurement

Aspect	Improvement	Accountability	Research
Aim	Improvement of care (efficiency & effectiveness)	Comparison, choice, reassurance, motivation for change	New knowledge (efficacy)
Methods: • Test Observability	Test observable	No test, evaluate current performance	Test blinded or controlled
• Bias	Accept consistent bias	Measure and adjust to reduce bias	Design to eliminate bias
• Sample Size	"Just enough" data, small sequential samples	Obtain 100% of available, relevant data	"Just in case" data
• Flexibility of Hypothesis	Flexible hypotheses, changes as learning takes place	No hypothesis	Fixed hypothesis (null hypothesis)
• Testing Strategy	Sequential tests	No tests	One large test
• Determining if a change is an improvement	Run charts or Shewhart control charts (statistical process control)	No change focus (maybe compute a percent change or rank order the results)	Hypothesis, statistical tests (t-test, F-test, chi square), p-values
• Confidentiality of the data	Data used only by those involved with improvement	Data available for public consumption and review	Research subjects' identities protected

Lief Solberg, Gordon Mosser and Sharon McDonald. **The Three Faces of Performance Measurement: Improvement, Accountability and Research**. *Journal on Quality Improvement* vol. 23, no. 3, (March 1997), 135-147.

Frequent, ongoing **measurement** for learning and data driven decision making



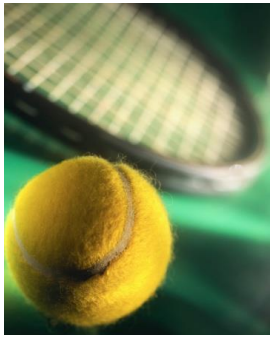
During Learning Session 2…

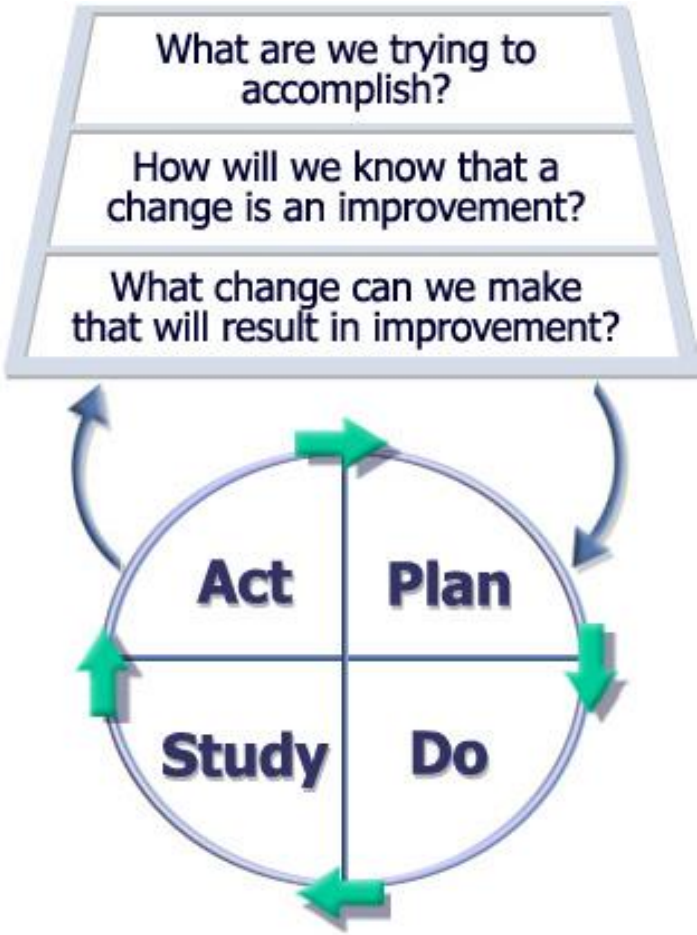
- Storyboards should include measures—look for the various categories of measures (outcome, process, balancing, when useful)
- More on measures during Day 2 breakout session
  - Reporting requirements
  - Difference between measures for improvement and measures for accountability & judgement

Take 15, but before you go…

Question 3: What changes can we make that will result in an improvement?

Developing and testing changes to achieve your aim





Langley, et al, *The Improvement Guide*, 2009

Your Improvement Project

- Where might you turn for some change ideas related to the personal/professional improvement project you identified?

Where we find changes…

- Research
- Evidence/Literature
- Experience
- Hunches/Ideas/Theories—Asking “Why”
- From Others
- Results of Assessments
- Generic Change Concepts (The Improvement Guide 2nd Edition, pgs 357-408)

Learning Session 1

The 5 Why's of the Washington Monument

Why was the Washington monument deteriorating?

Why?

- Because of the strong chemicals needed to clean it

Why?

- Because there was lots of pidgeon poo on the monument

Why?

- Because there were lots of spiders at the monument

Why?

- Because there were lots of flies and moths at the monument

Why?

- Because the lights were turned on at dusk.

Turned the lights on later and stopped the chain of causes

Source: http://www.rch.org.au/uploadedImages/Main/Content/quality/Washington%20Monument.jpg

Some of the ideas from LS1…

Triggering Screening

- Annual Preventive Visits
- New Patient Visits
- Changes in Patient Health Status
- As Part of Chronic Disease Program
- Changes in Family or Caregiver Support
- Transitions of Care
- Changes in Service Utilization (e.g. ED)
- After Risk Score Stratification
- Sick or Preventive Visit on Rolling Annual Basis
- Alter Frequency Based on Severity of Need

Saving & Monitoring Screening

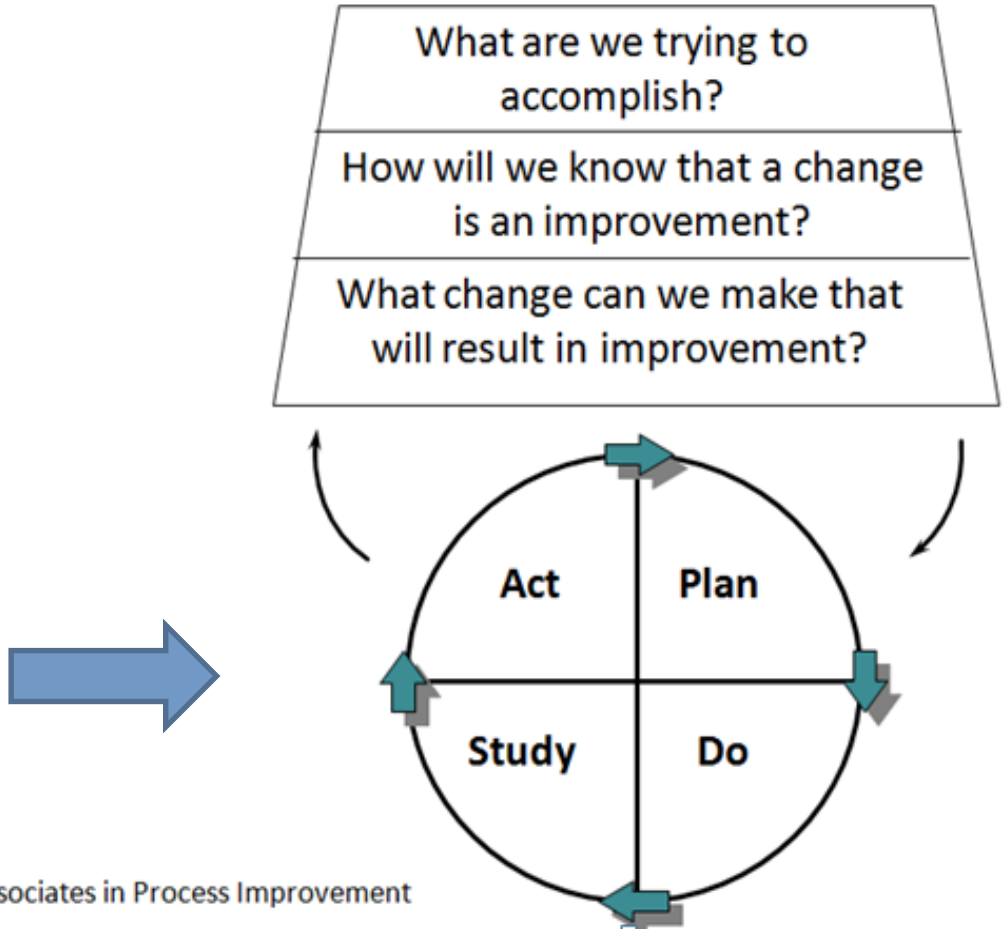
- Build Screening Tool as an EHR Template
- Input Screening "Score" as Discrete Data and Scan Into EHR or Registry
- Use an Internal Tracking Code for SDoH Screening
- Use a One Question Screener Between Screening Occurrences
- Create a Report or Alert Similar to Gaps in Care for Monitoring
- Create a Report for Panel Level Completion and Timing

Next Steps After Screening

- Introduce Care Coordinator During Appointment
- Create a Trackable Internal "Referral"
- Conduct a Deeper Assessment of Social Needs
- Address Urgent Needs and Coordinate Access
- Commit to an Ongoing Coordination Plan
- Follow-Up on Urgent Linkages

See handouts posted

Model for Improvement



From: Associates in Process Improvement

You actually do PDSAs every day

In fact, you just did one…

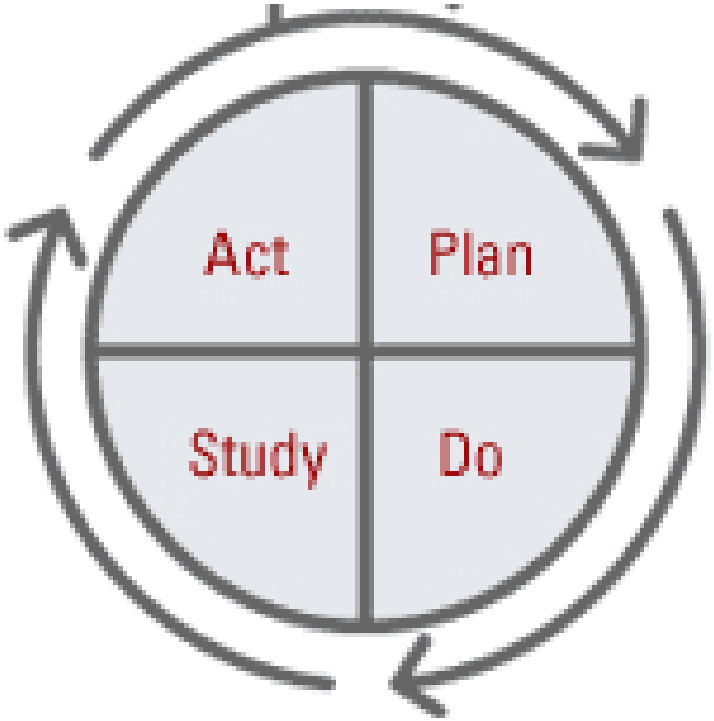
Plan:

- Question: I'm wondering if I start to show more appreciation toward the people I work with, if I can create more joy in work.
- Test: I am going to send a text message right now to one person today thanking them for pitching in for me today so that I could be at this meeting.
- Things needed: Cell phone and 15-30 seconds.
- Prediction: They will respond and may even pay it forward. They won't see it until later. They will think I'm crazy because I don't usually do this☺.
- Data I will collect to measure PDSA. Reaction (e.g., response). Any feedback. If possible, measure if paid forward. My reactions.

Small Test of Change

PDSA Cycle

A structured trial for a change.



Source: W. Edwards Deming

The PDSA Cycle for Learning and Improvement

What's next?

What will happen if we try something different?

Did it work?

Let's try it!

Langley, et al, *The Improvement Guide*, 2009

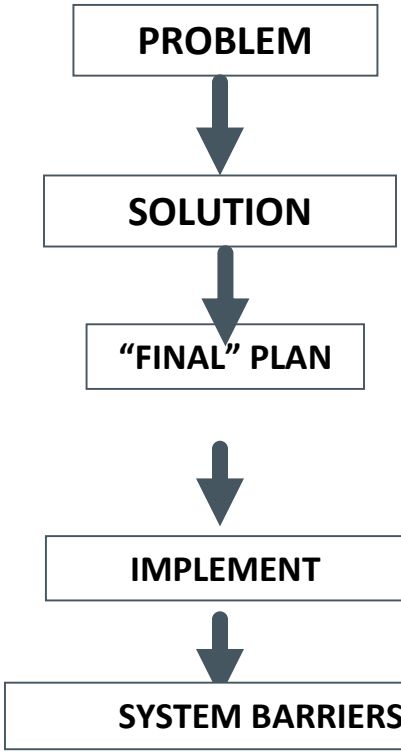
Benefits to Small-Scale Testing

- Learn how to adapt the change to conditions in the local environment
- Increase belief that change will result in improvement
- Opportunity for “failures” without impacting performance
- Identify how much improvement can be expected from the change
- Minimize resistance upon implementation
- Evaluate costs and side-effects of the change

Test on a Small Scale

- Conduct the test for one patient, one provider, one time, one hour, the next time it happens—”Rule of 1”
- Decrease the time frame (move from thinking years to quarters to months to days to hours to minutes)
- Test the change with volunteers
- Simulate the change in some way (when feasible)

Traditional model for introducing change



Adapted from: Jean Vukoson's Bright Futures Presentation

QI Approach to Change

PROBLEM

↓

ASSESS CURRENT CONDITION

↓

DEFINE *POSSIBLE* SOLUTIONS

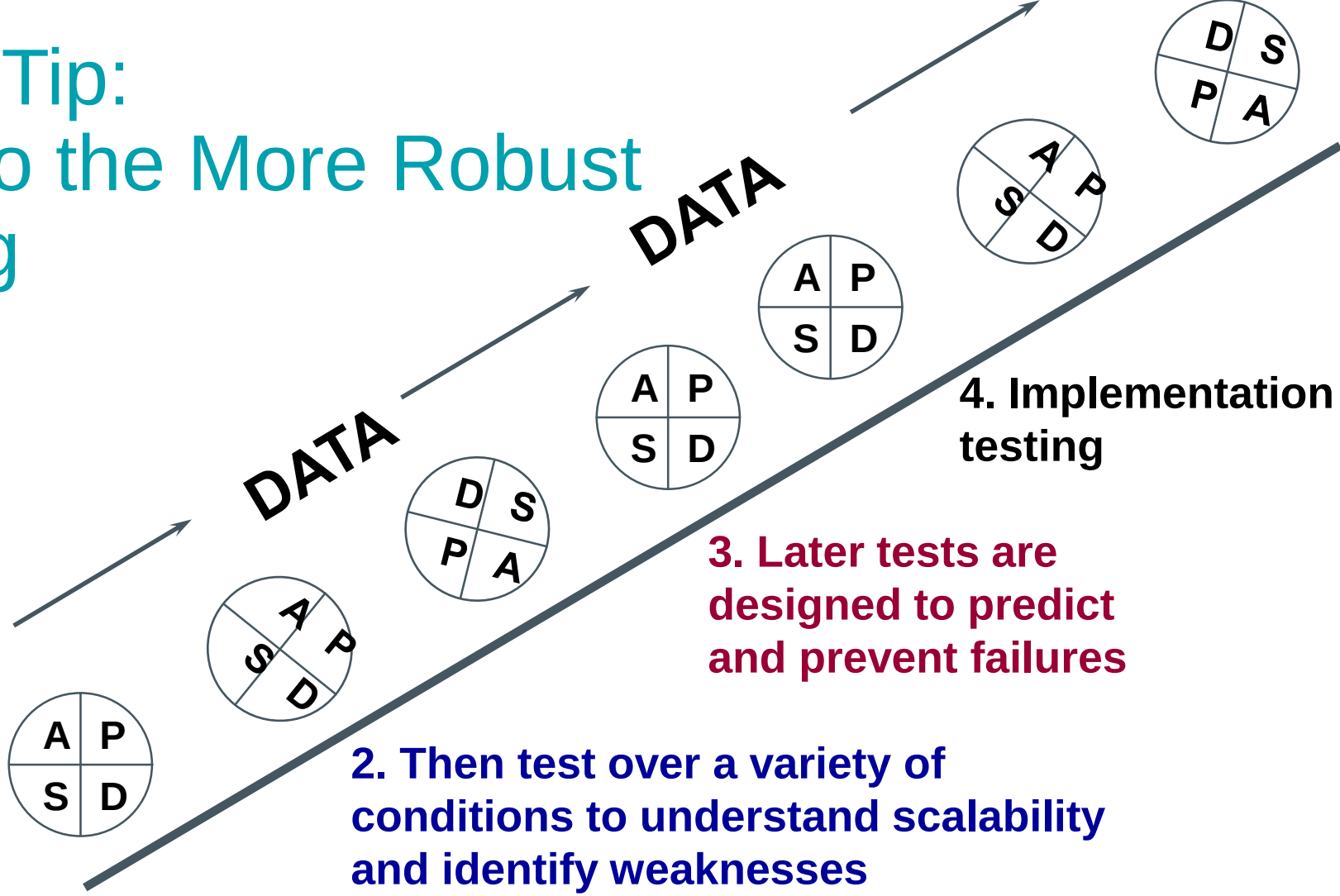
↓

CONDUCT

Plan-Do-Study-Act cycles

Adapted from: Jean Vukoson's Bright Futures Presentation

PDSA Tip: Build to the More Robust Testing

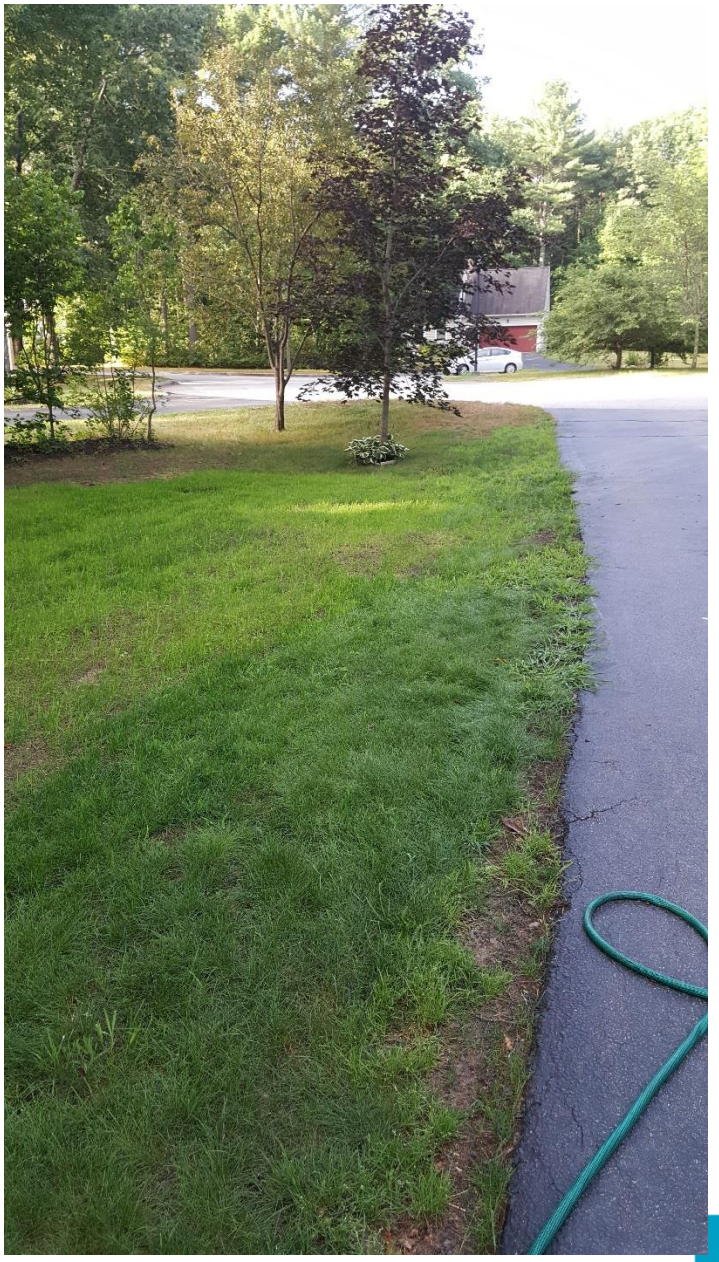


Source: IHI

Some Misperceptions about PDSAs

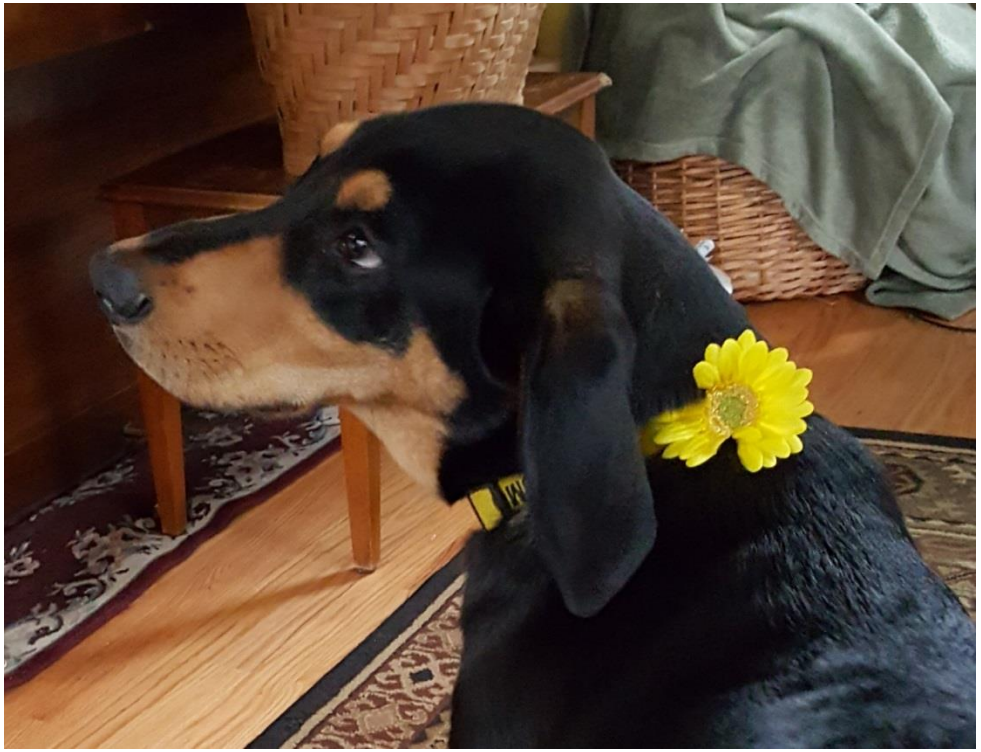
- Because it is simple, it is “easy”
- That it can be used as a stand-alone method without a broader methodological approach to ensure that the problem is correctly understood and framed
- That a successful PDSA means improvement in the outcome
- That it is limited to only small-scale tests of 1, 2, or 5 patients, for example and can’t be adapted for larger scale problems

Julie Reed, Alan Card. *The Problem with Plan-Do-Study-Act Cycles,* British Medical Journal, December 2015
http://qualitysafety.bmj.com/content/25/3/147.full.pdf+html?sid=3cac1002-ab8d-4619-a741-453ca9873cbc



Although…

- Enter in a new variable…may need to go back to testing ☺



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Myths (and Tips) about Creating Improvement Aim Statements

*By **IHI Multimedia Team** | Thursday, March 30, 2017*

Why It Matters

Writing an improvement aim statement can be challenging, but some common myths may be making it harder than necessary.