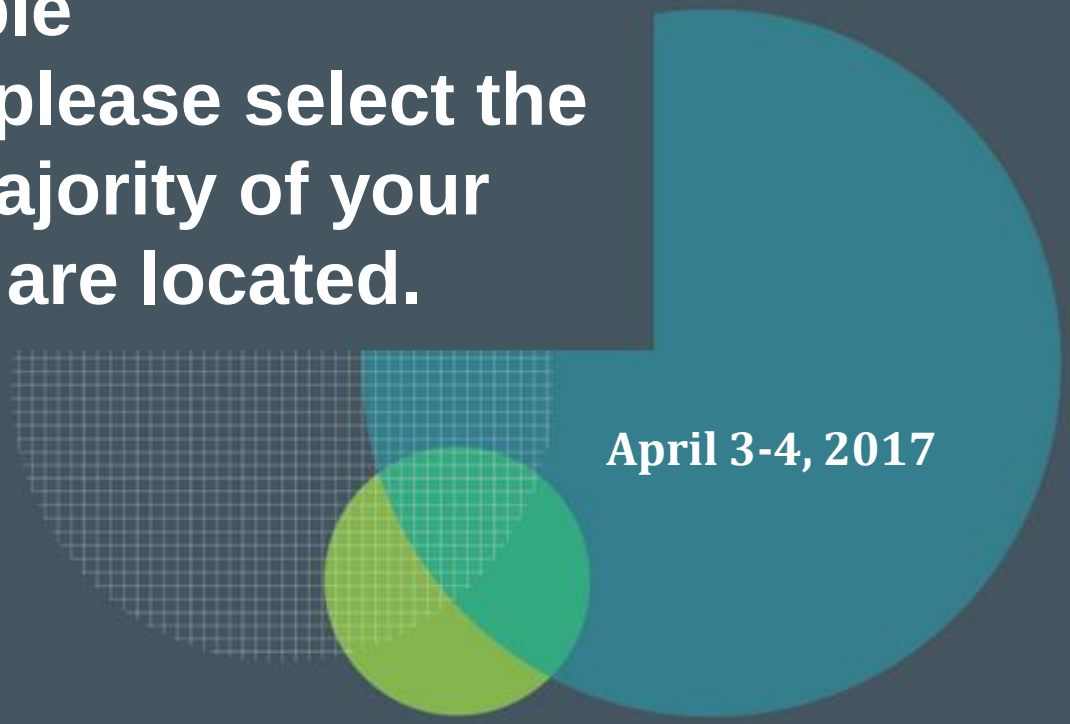
Institute *for* Healthcare Improvement

MDHHS
Michigan Department of Health & Human Services

Please find the county/region your practice/organization is located in and sit at that table. If you represent practices in multiple counties/regions, please select the table in which a majority of your practices/patients are located.



April 3-4, 2017

Institute for Healthcare Improvement

Welcome Back

Sue Gullo, Director, IHI

Day 2

1. Welcome
2. Lingering Questions and Reflect
3. Review Today's Agenda

Institute for Healthcare Improvement

Building a PCMH: The Journey After Designation

Panel
Sue Gullo, Director, IHI
Sue Butts-Dion, Improvement Advisor, IHI

Objectives

- By the end of this session, participants will:
  - Critically reflect on their own practice's transformation journey regardless of where they are in that journey
  - Formulate questions for the presenters as they think about their own struggles and improvement opportunities

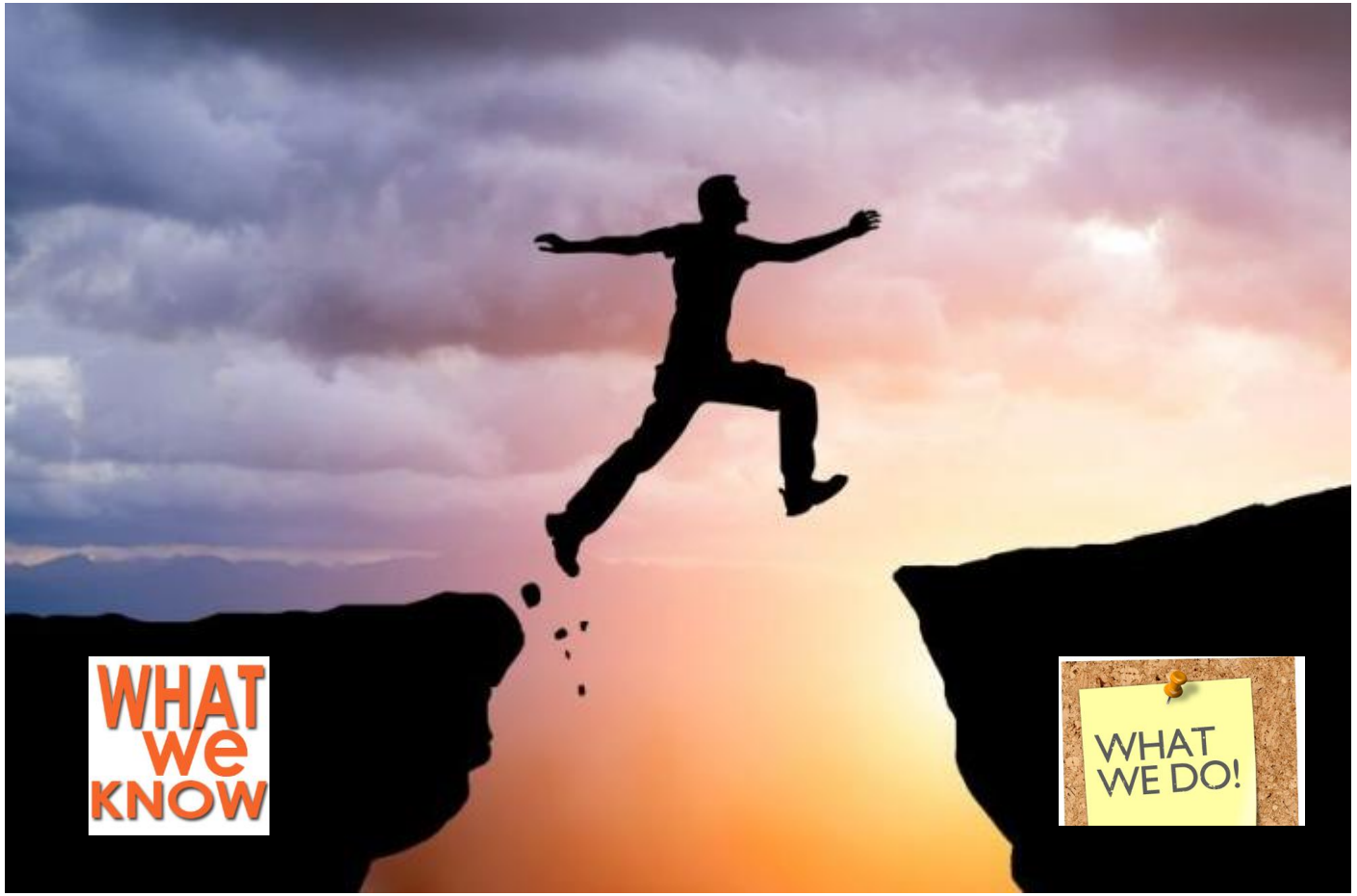
BREAK

Institute *for* Healthcare Improvement

The Model for Improvement

Using QI Science to Help Close the Gap Between What we Know and What We do With What we Know

Sue Butts-Dion
Improvement Advisor


WHAT
We
KNOW
WHAT
WE DO!

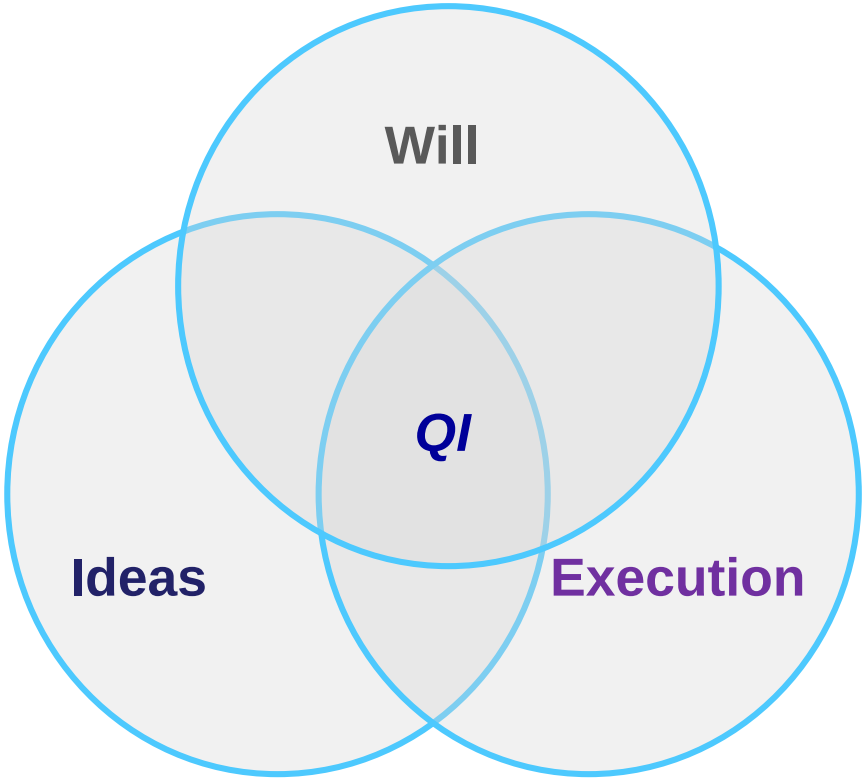
Bad people??

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, unite, 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.

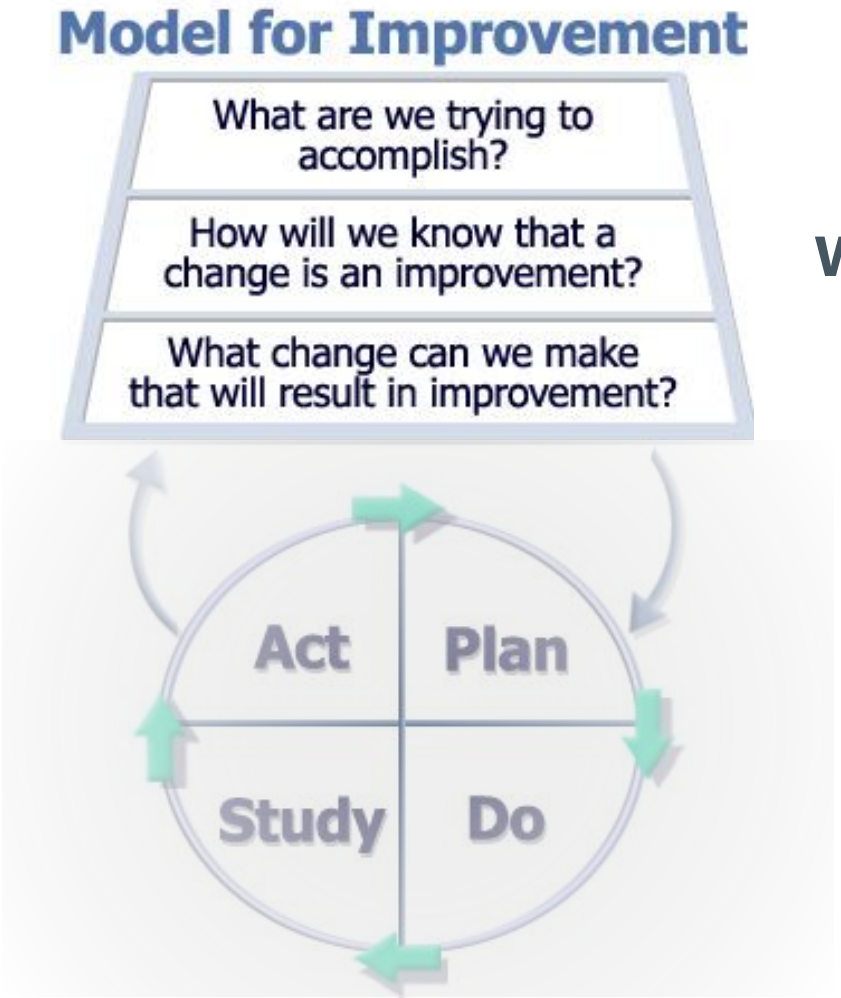
A Model for Learning and Change

When you combine the 3 questions with the…

PDSA cycle, you get…

…the Model for Improvement.

A Model for Learning and Change

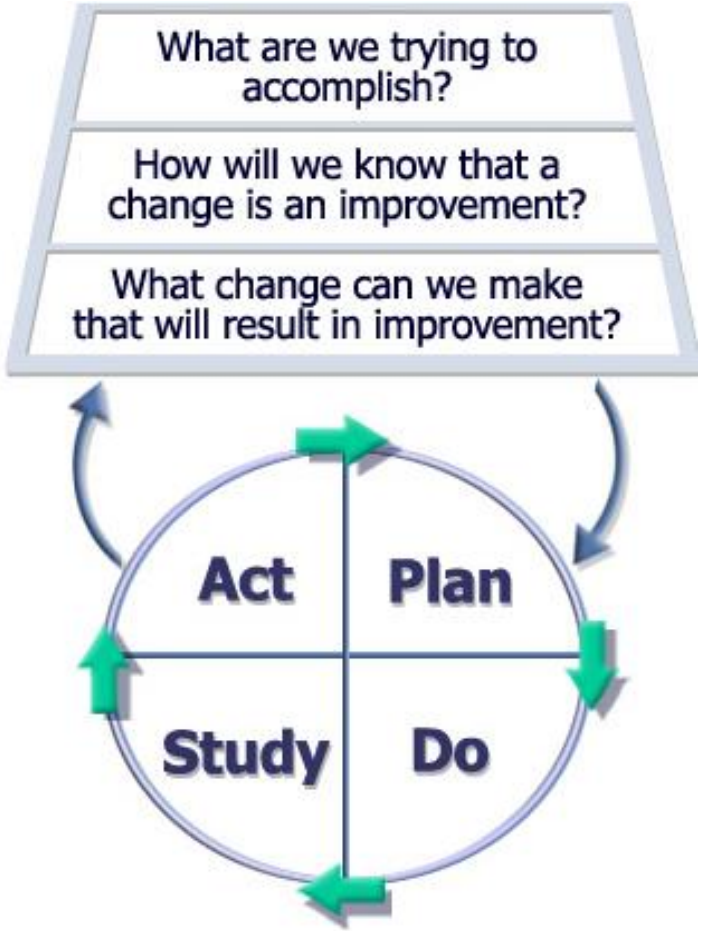


Let's start with the three questions

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

Alignment…

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 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)

Sue's example

What I want to improve

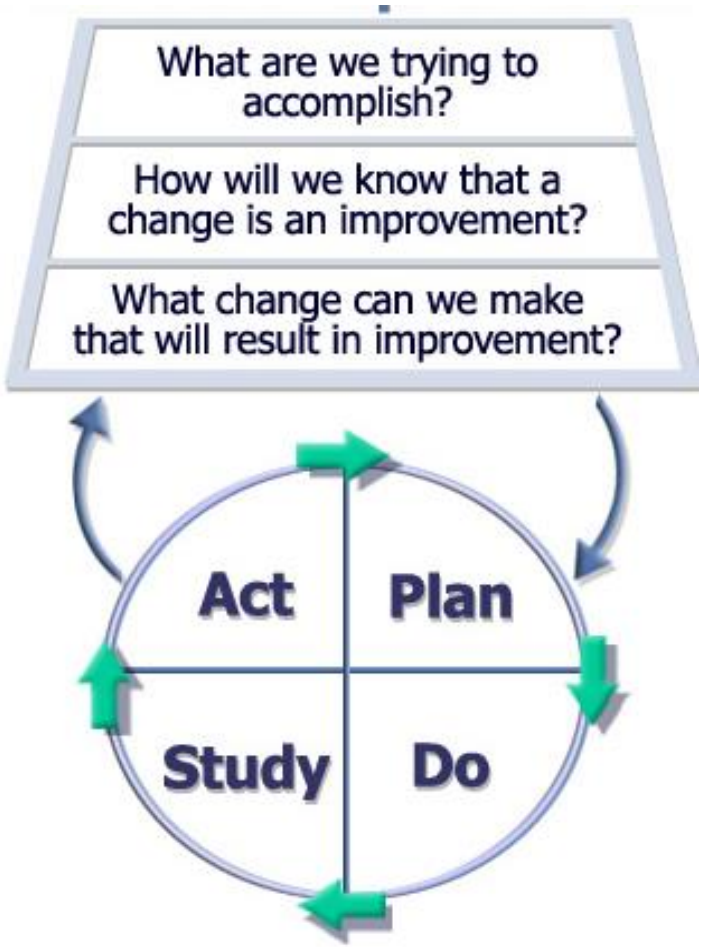
I want my back yard to be a beautiful, lush sanctuary.

Sue's 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%).

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)

Example

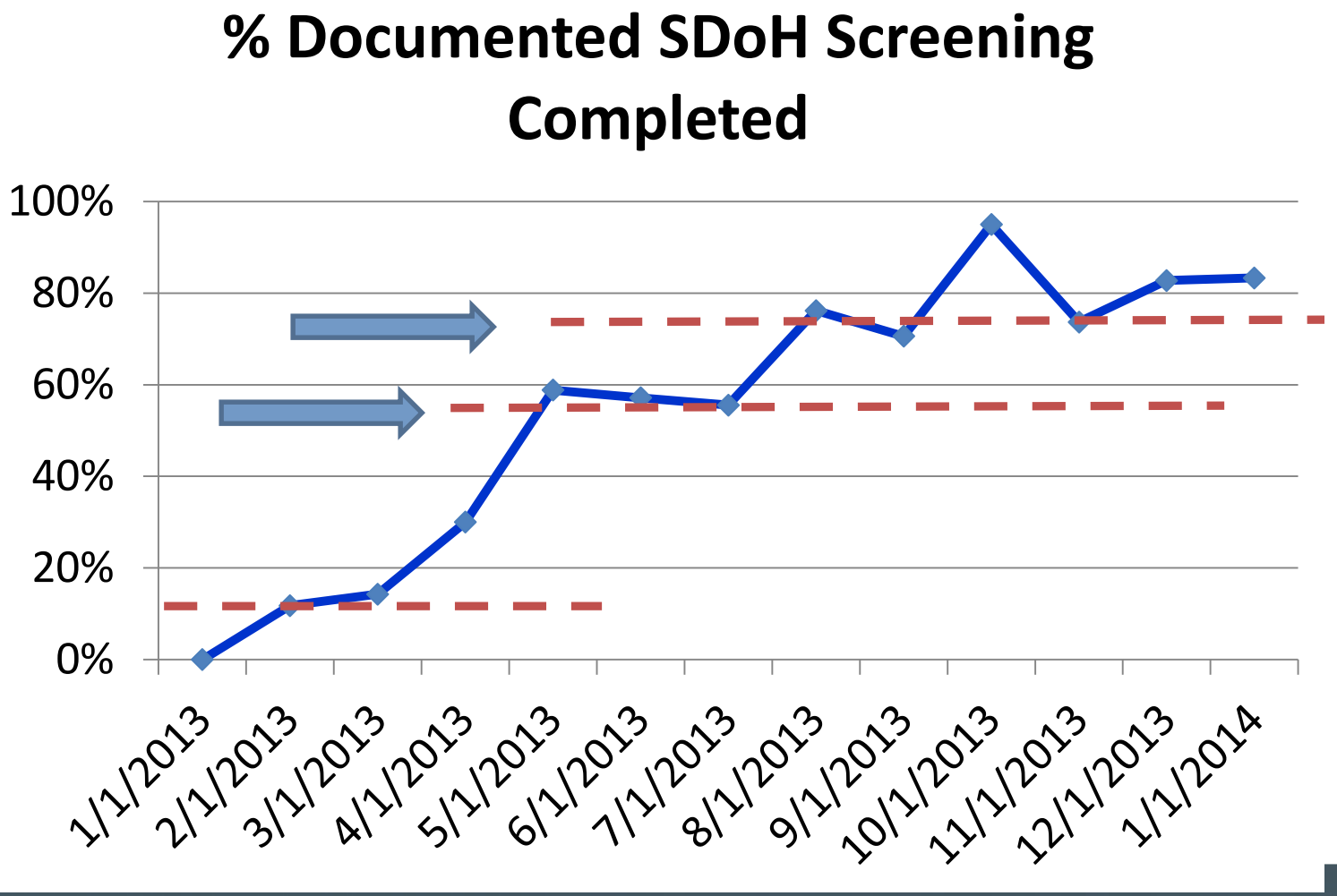
- Outcome measures
  - Patient Clinical Outcomes
- Process measures
  - # meetings with partners
  - % linkages where feedback loop is closed
  - % of patients with ecomaps documented
  - % of patients with co-created care plans
- Balancing measures (if useful)
  - Time for office visit
  - Time spent communicating with partners

Sue's Measures

Grass in my back yard:

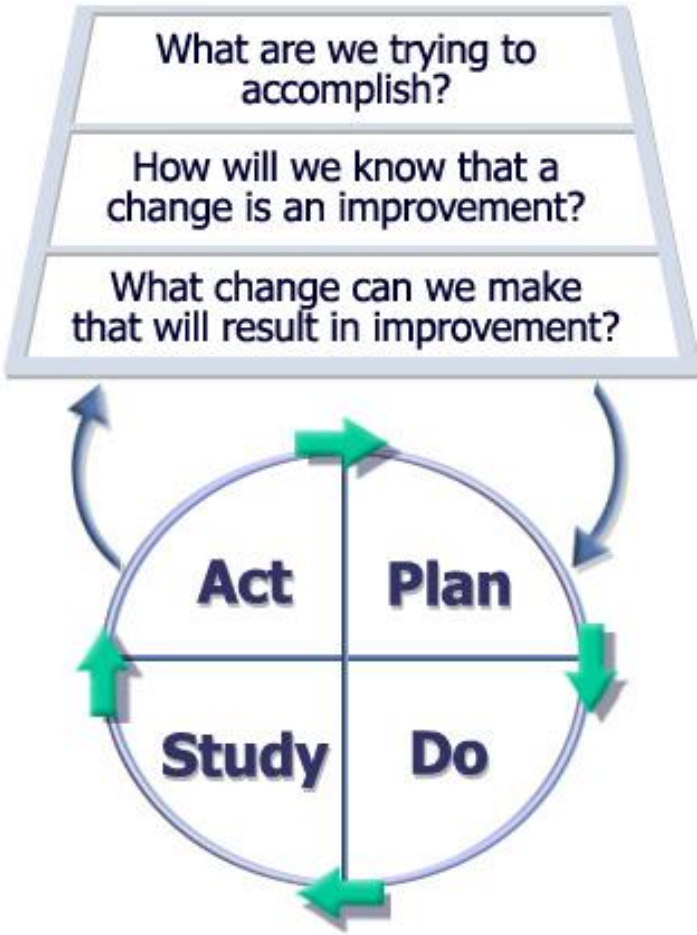
- Outcome
  - % of yard where grass is growing in back yard
  - Health of grass
- Process
  - Minutes of watering
  - Time spent planting
  - Time spent treating/ fertilizing
  - # times empty the lawn mower bag
- Balancing
  - Cost
  - Beach time missed working on lawn☺
  - My front yard

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



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

Developing and testing changes to achieve your aim

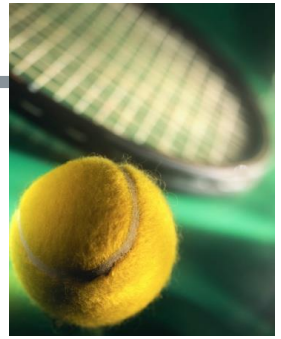


Langley, et al, *The Improvement Guide*, 2009

You actually do PDSAs every day


Life is
SHORT,
Enjoy ur
coffee

Experiential Learning - Tennis Ball Simulation

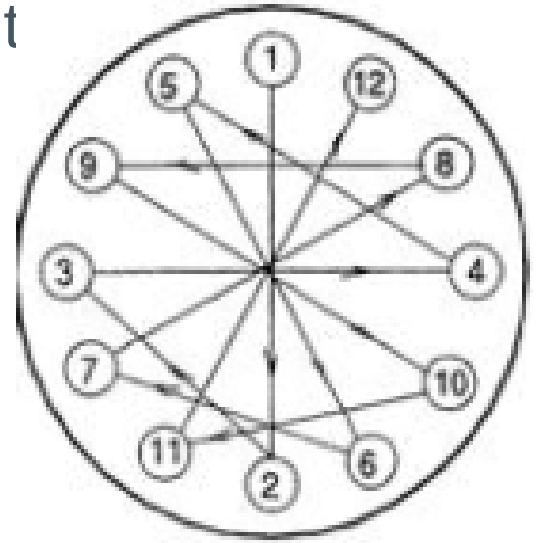


- **Organization**
  - 8ish-10ish people form a semi-circle representing the steps in the process
  - 1 stand aside and observes/ and records data
    - Quality Manager/Data Collector
- **Team Equipment**
  - 1 Tennis Ball
- **Quality Manager/Data Collector Equipment**
  - Smart phone with a stop watch or watch with a second hand
  - Piece of paper on which to write the times & pen/pencil

Instructions

- One person will start the process by tossing the ball to the person across from him/her in the semi-circle.
- Receiver, in turn, will throw it to a different person across from him/her, and repeat this until everyone in the group has touched the ball in sequence and it is back in the hands of the person who started the process (last person passes it back to the person who started).
- Remember the sequence—who threw t

Example --------→

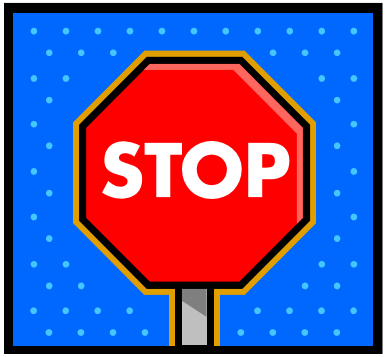


Quality Manager Will

1. Record time from beginning to end (with phone or watch)
2. **Enforce all rules**
   - Start and stop wrong person→ start over
   - Sequence violated→ start over
   - Ball dropped→ start over
3. **Judgment Call**
   - Execution done incorrectly in any other manner → start over

NOTE:
When team starts over, **DO NOT stop the clock**—the clock keeps ticking!

Right now, please complete ONE round and get your baseline time. Remember to start over if ball dropped but the clock does not stop!
After you get your baseline STOP for further instructions before continuing!



- What changes can you make that will result in improvement?
- You have 2 minutes to try to improve your time.

- “Not good enough. Need to improve the time and don’t drop the ball.
- Aim: In the cycles, reduce your lowest time by 50% with no errors (don’t drop the ball)—cut it in half.
- What changes can you make that will result in improvement?
- You have 2 minutes to reduce your lowest time by 50%.

St. Elsewhere does it better!

- Striving for excellence!
- Aim: In the next minute, we aim to decrease our lowest time by 50% more with zero errors. We intend to do this by using “gravity” as our change concept.
- You have 1 minute to test the using “gravity”?

Debrief: What did we learn?

Goals?

Measures?

Teams and motivation?

PDSA Cycles—Small Tests of Change

Debrief: What did we learn?

Goals?

Measures?

Teams and motivation?

PDSA Cycles—Small Tests of Change

Debrief: What did we learn?

Goals?

Measures?

Teams and motivation?

PDSA Cycles—Small Tests of Change

We don't need to motivate; we need to stop demotivating.

W.E.Deming (attributed)

Debrief: What did we learn?

Goals?

Measures?

Teams and motivation?

PDSA Cycles—Small Tests of Change

The PDSA Cycle for Learning and Improvement

What's next?

What will happen if we try something different?

Did it work?

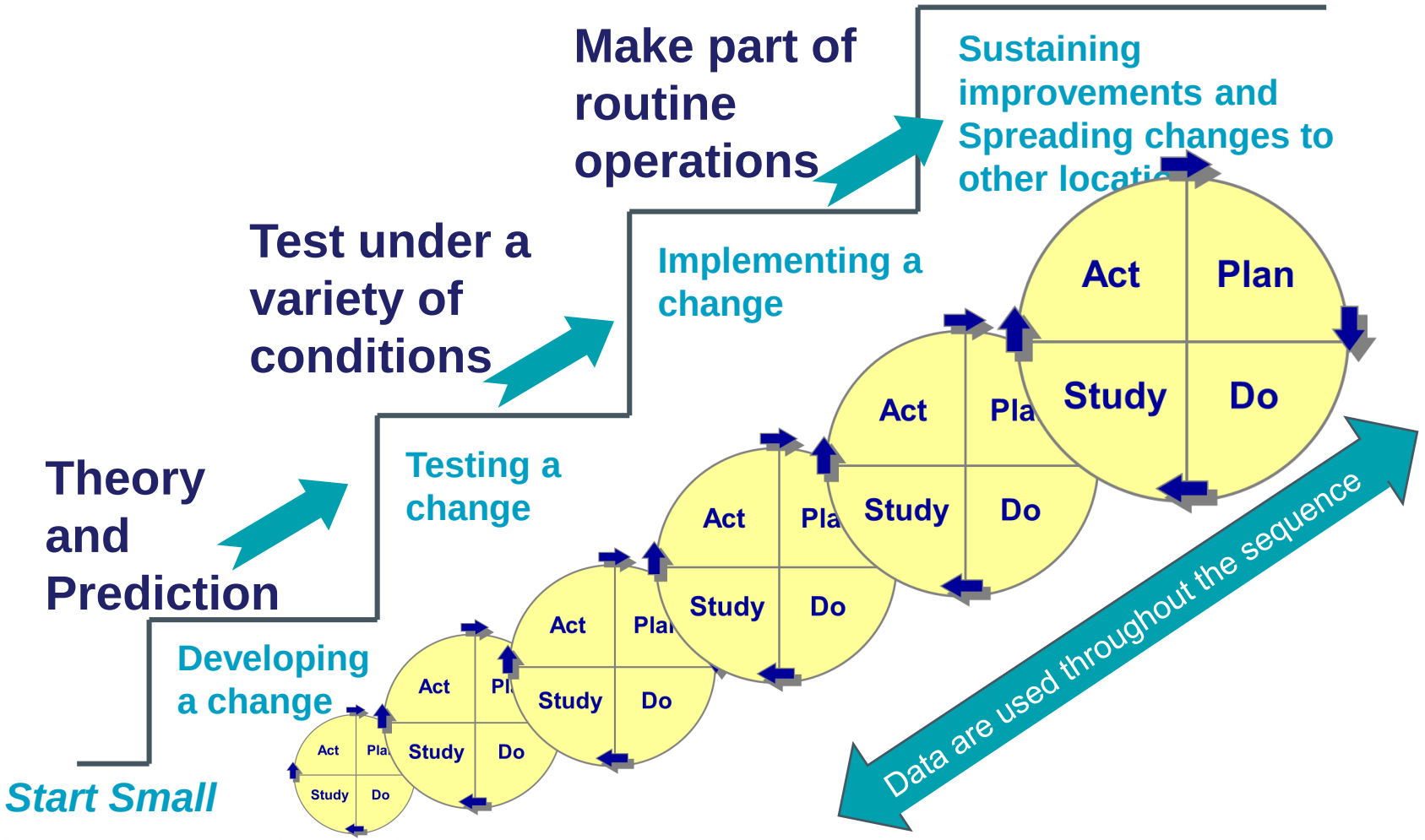
Let's try it!

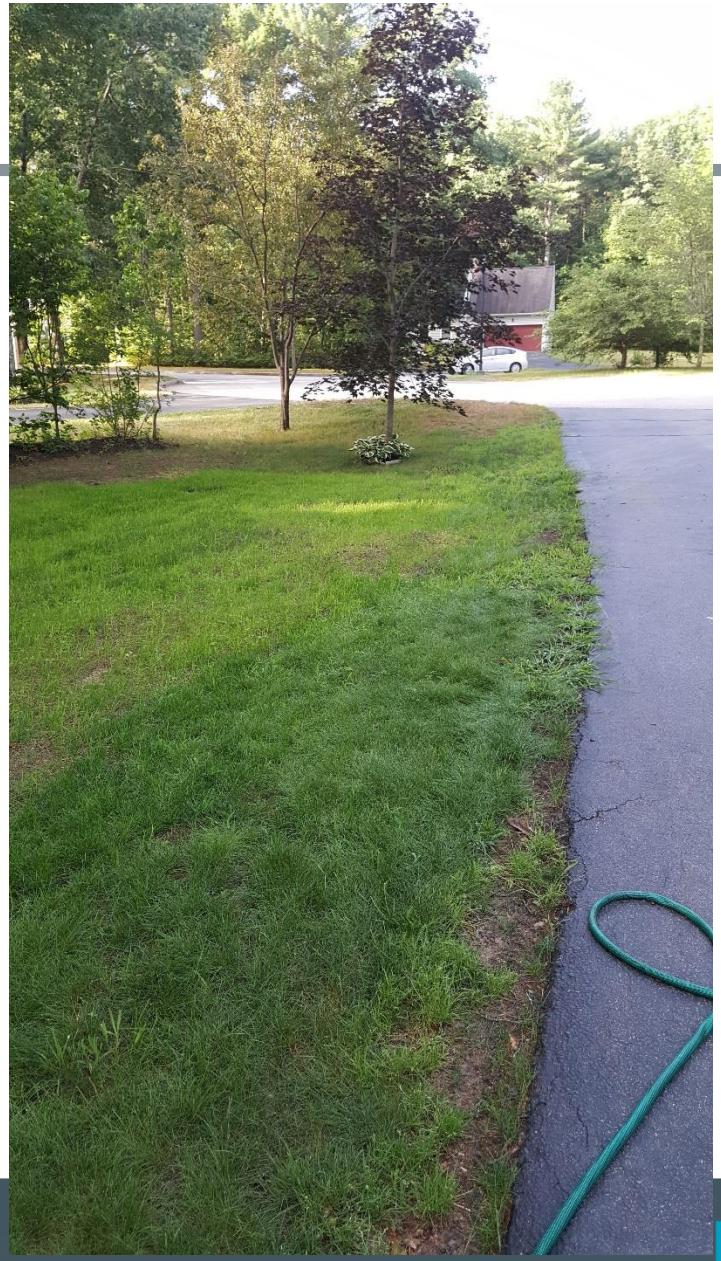
Langley, et al, *The Improvement Guide*, 2009

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

The Sequence of Improvement





http://www.ihi.org/communities/blogs

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.

Michigan Department of Health & Human Services

Digging Deep: Unearthing Promising Practices in Developing Clinical-Community Linkages

SIM PCMH Initiative Practice Transformation Collaborative

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Why We're Here

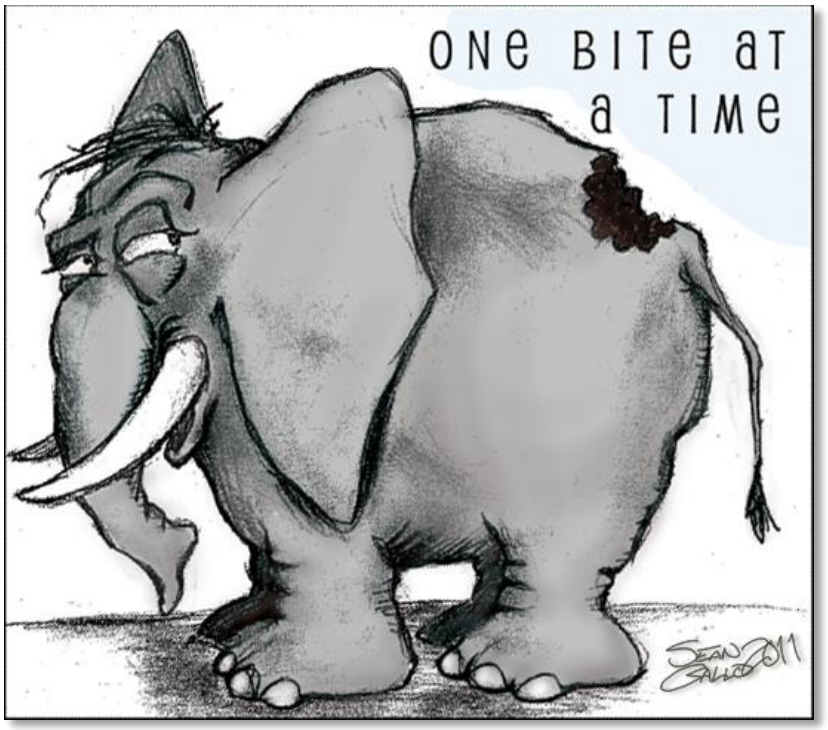
Clinicians have long recognized the connection between unmet basic resource needs – e.g. food, housing, and transportation – and the health of their patients. More than 70% of health outcomes are attributable to the social and environmental factors that patients face outside of their PCMH.

If healthy behaviors are not reinforced or social service needs are not supported outside of clinical and care management services, it's very difficult to change underlying risk factors that lead to poor health.

Clinical-Community Linkages can deliver more support to patients focused on those underlying social and environmental needs, as well as help clinicians offer services to patients that they cannot provide themselves.

Before We Jump In

- The transformation you're undertaking is bigger than any one change
- There's a community of committed peers and partners to lend a hand
- The end state can be daunting, we have time to start small and scale up
- So, let's take a bite…



PCMH Initiative CCL Objective

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:

1. Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.

2. 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.

3. 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.

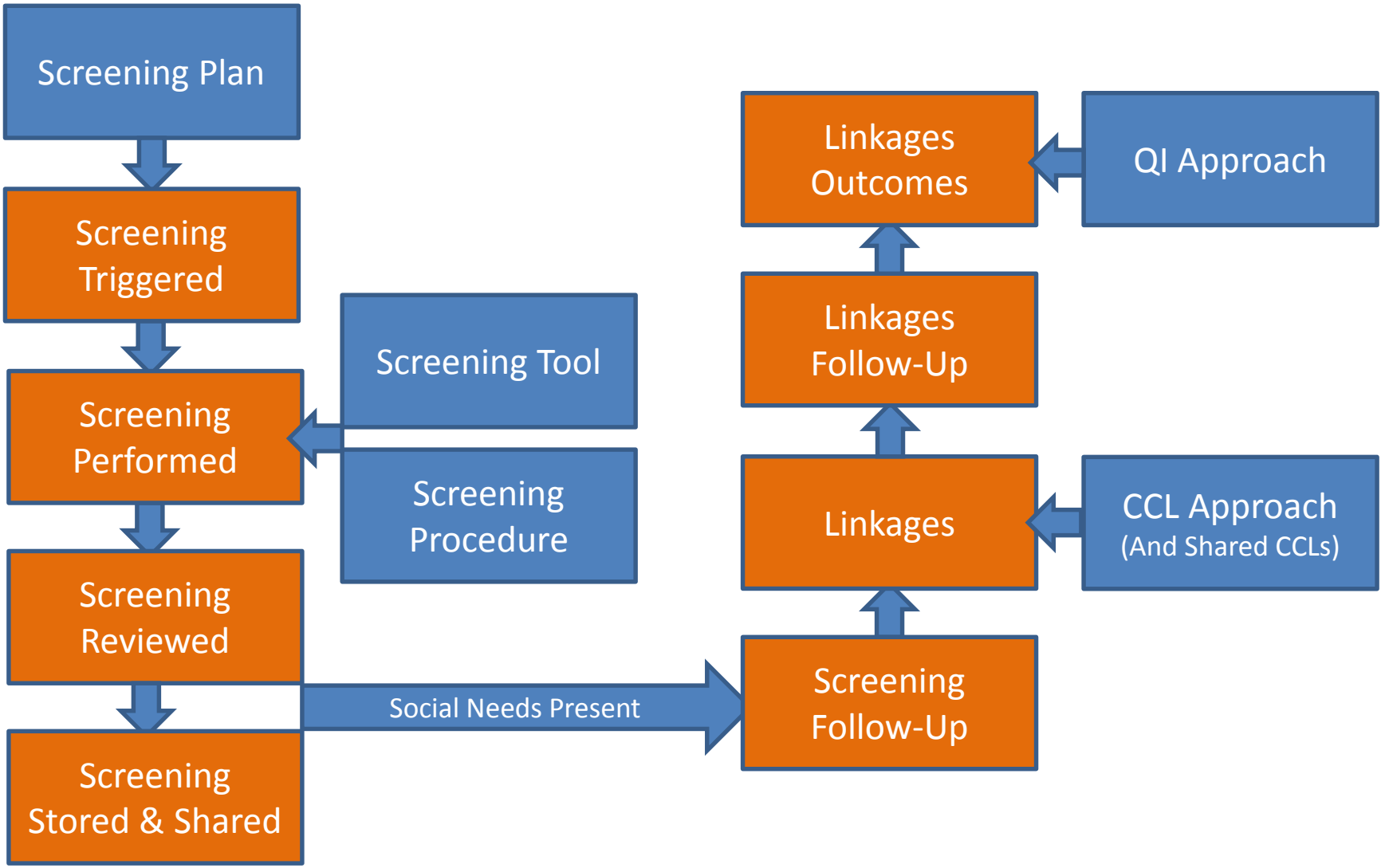
Why We Say Linkage

- Made possible by a trusting relationship
- Initiated based not only on need, but on patient goals
- Referral is only one part of the experience
- Can't be isolated to one part of the practice team
- Relies on a much wide array of partners, requires new affiliations
- Supports are provided in clearing barriers to accessing a resource
- Follow-up is oriented around both accessing a resource and the effectiveness of it

Inputs to Your Framework for Clinical Community Linkages

Screening Plan	• When to Screen • Initial Screening Timeline • Maintaining Screening • Monitoring Screening Completion
Screening Procedure	• Who Performs Screening • Who Reviews Results • Where Are Results Stored and How Are They Shared • Screening Follow-Up
Screening Tool	• Broad Social and Environmental Need Focus • Designed to Open a Conversation • Brief, Easy to Complete, Appropriate for Language/Literacy
CCL Approach	• Defined Roles, Responsibilities and Training • Internal and External Communications • Partner Relationships • Linkage Components (including Monitoring) • Documentation Approach
QI Approach	• Screening Gaps and More/Less Effective Screening Triggers • Linkage Outcomes • Partnership and Resource Effectiveness

Framework for Clinical Community Linkages



Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

MDHHS Michigan Department of Health & Human Services

Your Ideas From Yesterday's Session

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

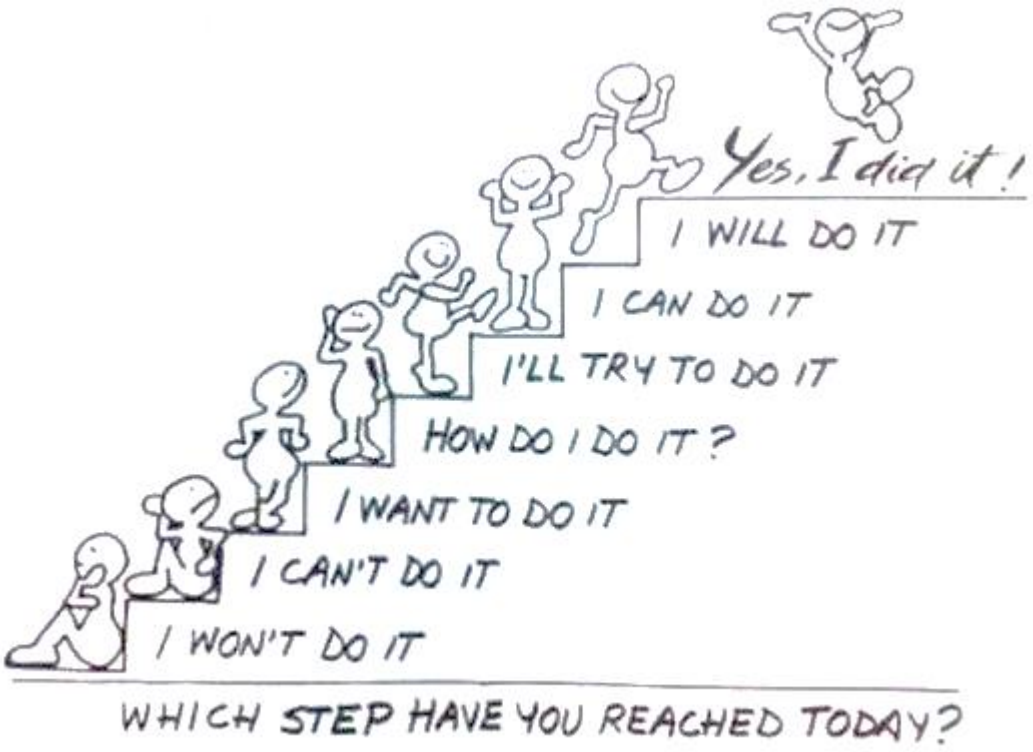
Next Steps After Screening

- 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

Small Group Brainstorming

1. How can you share the importance of SDoH screening and your CCL approach with your patients?
2. How can you use SDoH screening and/or assessment data to inform care delivery in your practice?
3. After your first SDoH screenings are complete, what strategies can you use to maintain future timely screenings?
4. What approaches can your practice use to close gaps in SDoH screening?
5. How can you train staff in your practice to support their engagement in your CCL approach?
6. Which partners in your community provide key resources for use in CCLs and how can you work to strengthen partnerships with them?
7. What types of support can you provide in clearing up barriers patients may have in accessing community resources?
8. What systems can you use to monitor the effectiveness of linkages?
9. How can you work with partners in your community to improve the effectiveness of linkages and close gaps in resources?
10. What patient populations could see the biggest impact from implementing CCLs? Do those patient shave any special needs to plan for?

Taking the Next Step



Michigan Department of Health & Human Services

Digging Deep: Unearthing Promising Practices in Developing Clinical-Community Linkages

SIM PCMH Initiative Practice Transformation Collaborative

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

BREAK

Break and Transition to Breakouts

- **University Ballroom (Yellow Dots):**
  - The Role of Care Coordinators / Managers in Developing and Maintaining Community Linkages
- **Beaumont Ballroom (Blue Dots):**
  - Quality Improvement Tool Time

The Role of Care Coordinators and Care Managers in Developing and Maintaining Community Linkages

April 3-4, 2017 State Innovation Model
Patient Centered Medical Home (PCMH) Transformation Initiative
Collaborative Learning Network (CLN) – Learning Session 1

micmrc
The Michigan Care Management Resource Center

Objectives

1. Define Clinical Community Linkages
2. Define SIM PCMH Clinical Community Linkages requirements
3. Describe 4 strategies for the Care Manager and Care Coordinator role to develop and maintain clinical community linkages

Clinical Community Linkages

DEFINITION

"Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies."

Types of clinical-community linkages include:

- Coordinating services at one location
- Coordinating services between different locations
- Developing ways to refer patients to resources

micmrc

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

Clinical Community Linkages

GOALS

The goals of clinical-community linkages include:

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services
- Promoting patient, family, and community involvement in strategic planning and improvement activities

Collaborations between clinical, community, and public health organizations offer a win-win scenario for participating organizations, clinical teams, and patients.

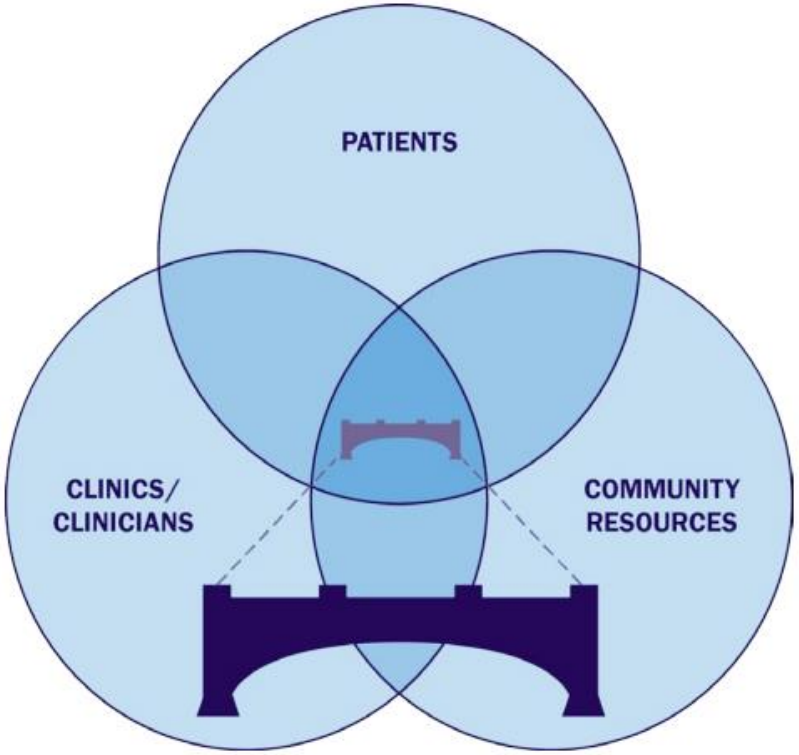
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

What do Effective Clinical-Community Linkages Offer?

- Patients get more help in changing unhealthy behaviors
- Clinicians get help in offering services to patients that they cannot provide themselves
- Community programs get help in connecting with clients for whom their services were designed

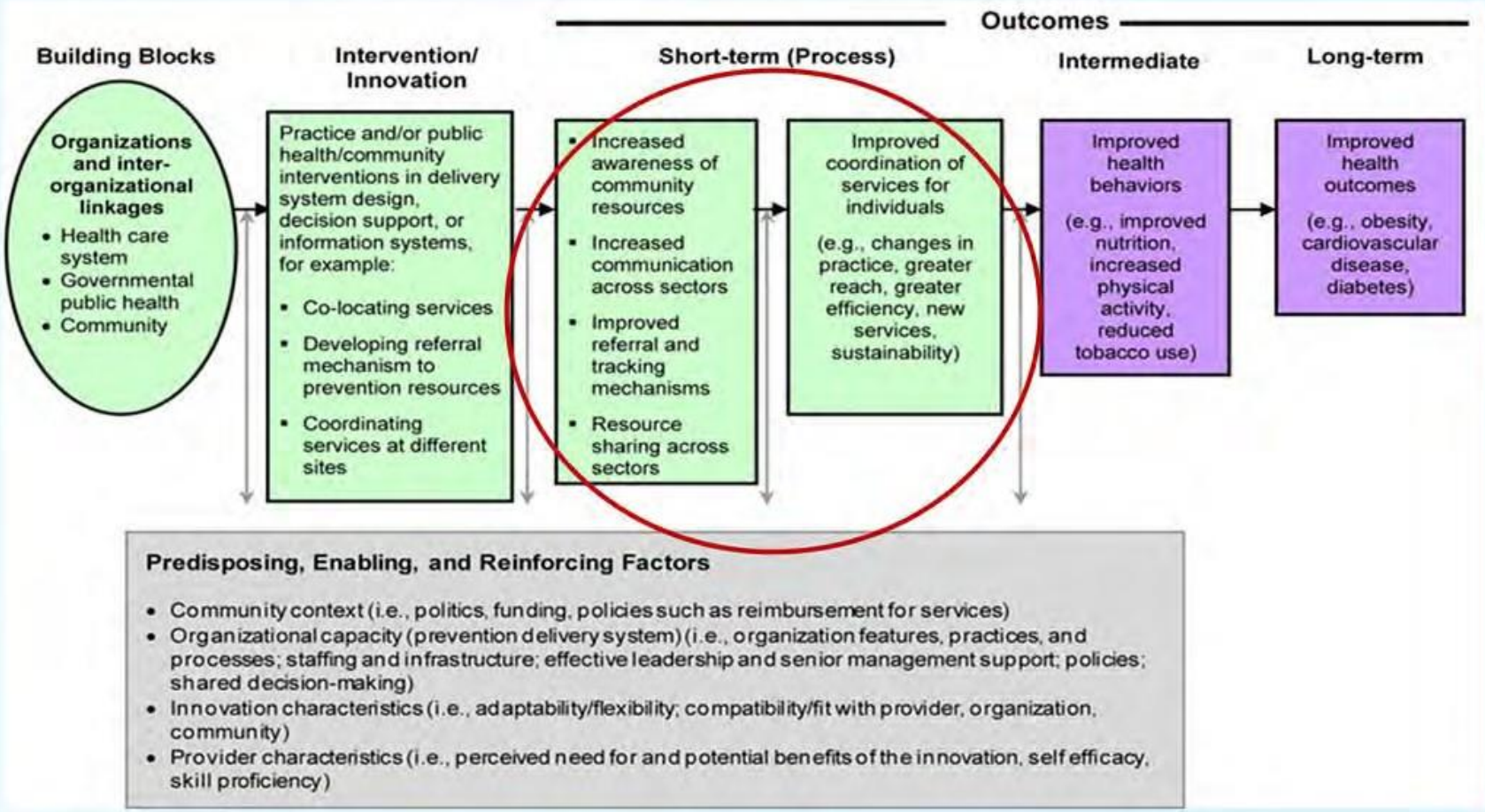
Clinical Community Linkages

Figure A-1. Conceptual framework of linkages between clinics and community resources for delivering clinical preventive services



https://www.ahrq.gov/sites/default/files/publications/files/ccreroadmap.pdf

Example Community-Clinical Linkages Framework



Source: Agency for Healthcare Research and Quality (AHRQ). (Prepared by Porterfield D, Hinnant L, Kane H, et al.). Linkages Between Clinical Practices and Community Organizations for Prevention: Final Report. 2010.

SIM-PCMH Initiative Clinical-Community Linkage Goals

- Coordinated care across not only clinical settings, but also with community organizations and resources

- Community-centered solutions to upstream factors of poor health outcomes

http://www.michigan.gov/documents/mdhhs/SIM_PCMH_Initiative_CCL_3-1-17_553205_7.pdf

SIM- PCMH Initiative Clinical-Community Linkage (CCL) Objectives

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.

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- 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.

http://www.michigan.gov/documents/mdhhs/SIM_PCMH_Initiative_CCL_3-1-17_553205_7.pdf

Care Manager and Care Coordinator Roles In CCL

CCL Job Duties	Care Coordinator	Care Manager
Complete comprehensive assessment of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team		X
Develop comprehensive, individualized care plans; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary.		X
With the care team, determine the patient's needs for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and **need for support services**.	X	
Jointly create and manage the individualized plan of care with the patient/family, care team and community based organizations, that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care.	X	
Ensure patients have timely and coordinated access to medically appropriate levels of health and support services and continuity of care.		X
Provide a range of client-centered services that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible; coordination and follow-up of medical treatments; patient-specific advocacy and/or review of utilization of services.		X
Build and maintain community linkages.	X	X
Demonstrate knowledge about community resources by providing information on the availability of and, if necessary, coordinate these services that may help support patients' health and wellness or meet their care goals.	X	
Align resources with patient and population needs.	X	

Four Strategies for CCs and CMs to Develop and Maintain Clinical Community Linkages

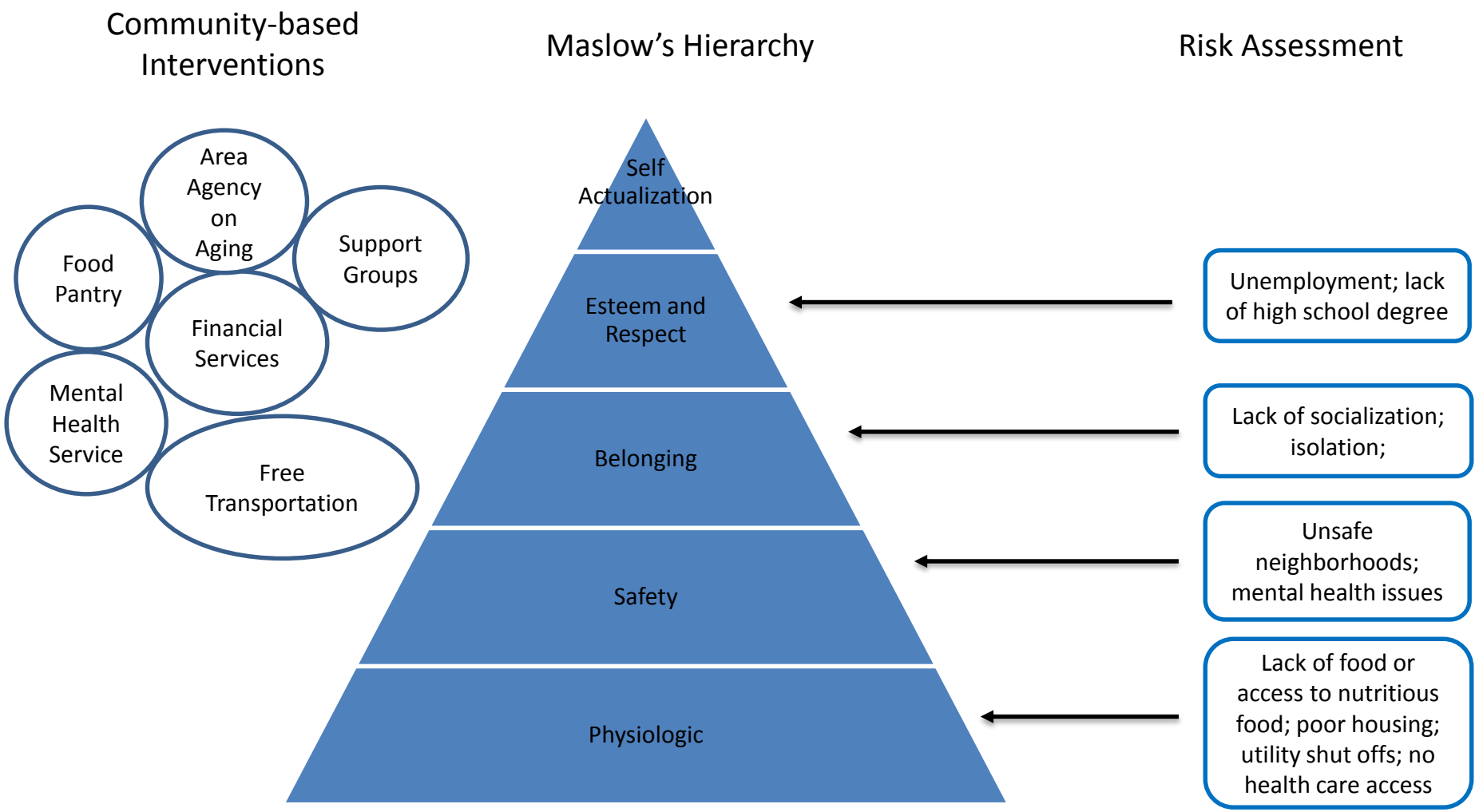
- Patient Assessment of Social Determinants of Health
- Community Assessment
- Establish defined relationships with community partners
- Referral, follow up, and outcome of the referral

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - PATIENT ASSESSMENT

Participate in the design, implementation and interpretation of patient need assessments

- Comprehensive assessment
  - Income
  - Patient-reported depression
  - Education
  - Financial resource strain
  - Intimate partner violence
  - Social connections or isolation
  - Stress
  - Eligibility for public and private benefits
- Data sources
  - Standard screening tools
    - Brief SDOH Screening Tool –*State Innovation Model*
    - ACES – *Adverse Childhood Experiences*
    - Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE) *National Association of Community Health Centers*
    - Self Sufficiency Matrix *Michigan Coalition Against Homelessness*
    - Adult Clinical Social History *Warren County Ohio Combined Health District*

Social Determinants of Health



Adapted from A road map to address the social determinants of health through community collaboration. *Pediatrics* (2015). 136(4).

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - COMMUNITY ASSESSMENT

Participate in the design, implementation and interpretation of community level assessments

- Community Asset Mapping
  - Boundaries
  - Housing
  - Signs of decay and/or pollution.
  - Parks, recreational areas
  - Transportation
  - Health and social service agencies
  - Economics
  - Protective services
  - Religious facilities
  - Schools
  - General
  - Character of the community
  - Subjective feeling
  - Community needs
  - Gaps in service
  - Community Strengths

Community Connections

QUESTIONNAIRE

Community Resource Name:	Interview By:
Questions	Responses
What evidence-based programs do you offer for patients with _____?	
Please tell me more about the program.	
Who is the main contact person for the program and how can I get hold of them?	
Do you currently work with other medical groups or practices, or have you in the past?	
Do you have a way to securely send and receive electronic fax information?	
Are there eligibility criteria for your program and if so, how do you assess it?	
Do you have some kind of financial assistance for low-income patients?	
Can you send me program information that I can share with my practice?	

On a scale of 1 to 10...	Poor				Average					Excellent
How patient-centered does this organization seem?	1	2	3	4	5	6	7	8	9	10
										Very
How confident would I feel sending my patients to organization—do I think they will receive high-quality and credible assistance?	1	2	3	4	5	6	7	8	9	10
How prepared does this organization seem to be for working closely with a medical practice like ours?	1	2	3	4	5	6	7	8	9	10

Notes:

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/obesity-toolkit/obtoolkit-tool7.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - RELATIONSHIPS

Establish relationships with community partners

- What is the perfect marriage of information the community partner needs to initiate contact and information only a clinician can provide?
- Who will fill out the referral form and at what point during the patient encounter?
- How will the referral form be entered and passed through the system; and how will this referral be documented in the patient's chart?
- What are some of the HIPAA-compliant considerations?

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages - REFERRALS

"Patients are often informed that they will be 'referred' but have little or no influence on the process or knowledge about who they will be referred to or how long the expected wait will be."

Murray M. Reducing waits and delays in the referral process. *Fam Pract Manag* 2002;9(3):39-42.

Spell out mutual expectations and responsibilities, such as:

- Which patients are appropriate to refer
- What information is needed before and after a referral
- Roles for both parties after the referral

Don't rely on patients to relay information

- Share important information directly with the other office
- Get information sent directly back to you. Make sure you get a full report prior to patient's next visit

Consider language barriers

- Include information on your patient's language assistance needs when making the referral

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

- Make sure the patient understands the reason for the referral
  - Explain why the patient needs to be seen by someone else, and what might happen if he or she is not seen
  - Ask about and address any concerns or fears

- Offer help with the referral
  - Ask patients if they would like your office to make the initial phone call
  - Ask patients about transportation and other barriers to their completing the referral. Discuss how they could overcome these barriers

- Provide clear instructions
  - Provide easy-to-understand instructions verbally and in writing
  - Explain the referral process fully

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

Follow up – patient completes referral:	Follow up - patient does not complete the referral:
Confirm and document that the patient successfully completed the referral	Reinforce that you feel the patient could benefit from the community linkage/referral
Obtain information on the result of the referral and document in the medical record	Review barriers
Make sure the patient receives the results of any tests or screenings, even normal results	Provide support as needed to facilitate completion of the referral steps
Provide patient with positive feedback for completing the referral steps	

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit.html

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

- Gather feedback
  - patients experience

- How effective was the linkage in achieving the desired outcome/service?

- Tip: Determine whether the patient needs additional referrals

https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

Strategies for CC and CM Role to Develop and Maintain Clinical Community Linkages – REFERRALS cont.

Effective Referrals and Collaboration

- Prevents fragmentation
- Reduces the likelihood of clients falling through the cracks between disparate and unconnected agencies
- Fosters a more holistic view of the client
- Helps strengthen linkages and communication among various agencies providing different services

https://www.ncbi.nlm.nih.gov/books/NBK64299/

Evaluating Community-Clinical Linkages

Focus on the linkage

- Improving coordination systems
- Improved referral and tracking mechanisms
- Resource-sharing across sectors

https://www.cdc.gov/dhdsp/pubs/docs/cb_march_2014.pdf

Clinical Community Linkages

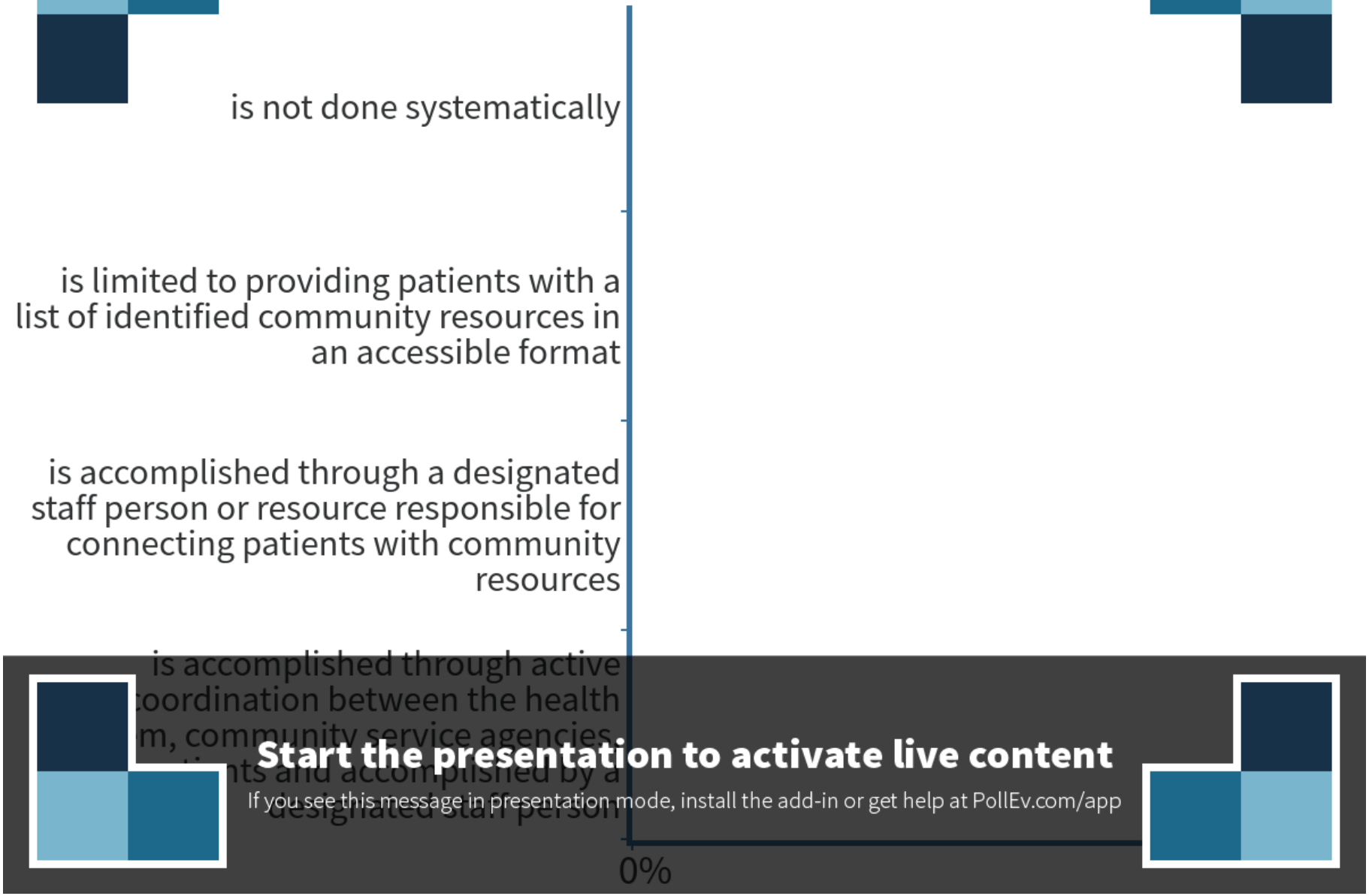
SELF-ASSESSMENT

Choose the point value that best describes the level of care that currently exists in your practice. The levels present key aspects of patient-centered care, showing various stages in development.

- The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented.

Linking patients to supportive community-based resources	...is not done systematically.			...is limited to providing patients a list of identified community resources in an accessible format.			...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.			...is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.	
	1	2	3	4	5	6	7	8	9	10	11	12

patients to supportive community based re



Start the presentation to activate live content

If you see this message in presentation mode, install the add-in or get help at PollEv.com/app

Clinical Community Linkages

GROUP ACTIVITY

Clinical Community Linkages Priority Questions – See Handout

- Report out – each table
  - One idea I would like assistance with
  - One component that is working well

SIM Patient Centered Medical Home (PCMH) Transformation Initiative - Collaborative Learning Network (CLN) – Learning Session 2

Pre-work for CLN Session 2:

Complete a Community Asset Mapping

- Windshield Activity

Next step for May…….homework (IHI)

1. Identify one organization that you currently work with and want to improve your collaboration with, or one new organization.
2. During May, can you test the following:
    1. Establish a meeting together
    2. Agenda- review the steps in the referral process from both of your perspectives and map the process steps. Discuss and share what each of your organization's goals and processes are.
    3. Identify a patient who has interacted (or may interact) and ask them to map the process steps from their perspective.
    4. Present what you learned at the June Learning Session answering the questions:
        1. What works well?
        2. What surprised you?
        3. What will you do differently (test)?

Questions?

- General State Innovation Model-PCMH Initiative questions can be sent to: SIMPCMH@mail.mihealth.org
- Visit the SIM website at: www.michigan.gov/sim
- Questions regarding Care Management and Care Coordination can be sent to: micmrc-requests@med.umich.edu
- Visit the Michigan Care Management Resource Center at www.micrmc.org

Appendix

PCMH Initiative CCL Objective

DEEP DIVE

Provide Linkages to Community-Based Organizations

- To successfully implement the CCL linkage requirement, participating PCMHs should be actively implementing a community-clinical linkage methodology on November 1, 2017 which, at a minimum, includes the following:
  - CCL roles and responsibilities within the PCMH, with a special focus on team members that are responsible for making and coordinating linkages to supportive resources
  - Communications approach for ensuring all team members, beyond those directly responsible for screening and/or linkages, are informed and engaged in the PCMH's approach to CCLs
  - Training approach (or approaches varying based on role/responsibility) for team members focused on the PCMH linkage methodology and available patient resources within a PCMH's community
  - Partnership approach to ensuring relationships are established and maintained with resource providers and programs that support patient social needs
  - Linkage process (or procedure) which conveys how linkages are initiated (information provided to patients, contact with resource providers/programs, supporting patients in access resources etc.) and how linkage monitoring (patient reminders, follow-up with patients to determine linkage outcome etc.) is conducted
  - Documentation approach for ensuring the process and outcome of the CCL methodology are appropriately stored, ensuring the information is made available to team members and for quality improvement
- During semi-annual progress reporting, the Initiative will request documentation describing the CCL methodology above (PCMHs can choose to include additional detail in their CCL methodology)

micmrc

PCMH Initiative CCL Objective
DEEP DIVE

Quality Improvement Activities

- Similar to the aim of quality improvement (QI) activities for all PCMH services, the intent of the quality component of the CCL requirement is to ensure PCMHs have the opportunity to meaningfully measure and improve the effectiveness of their CCL methodology over time
- Information collected and stored through the documentation approach defined in a PCMH's CCL methodology should be leveraged to conduct CCL QI in a data-driven manner
- The Initiative anticipates and encourages PCMHs to pursue QI activities related to CCL as part of their existing quality framework and processes, rather than creating a separate/new QI approach
- The Initiative also anticipates and encourages PCMHs to pursue some aspects of CCL QI in partnership with other organizations (PCMHs, PO, CHIR etc.)

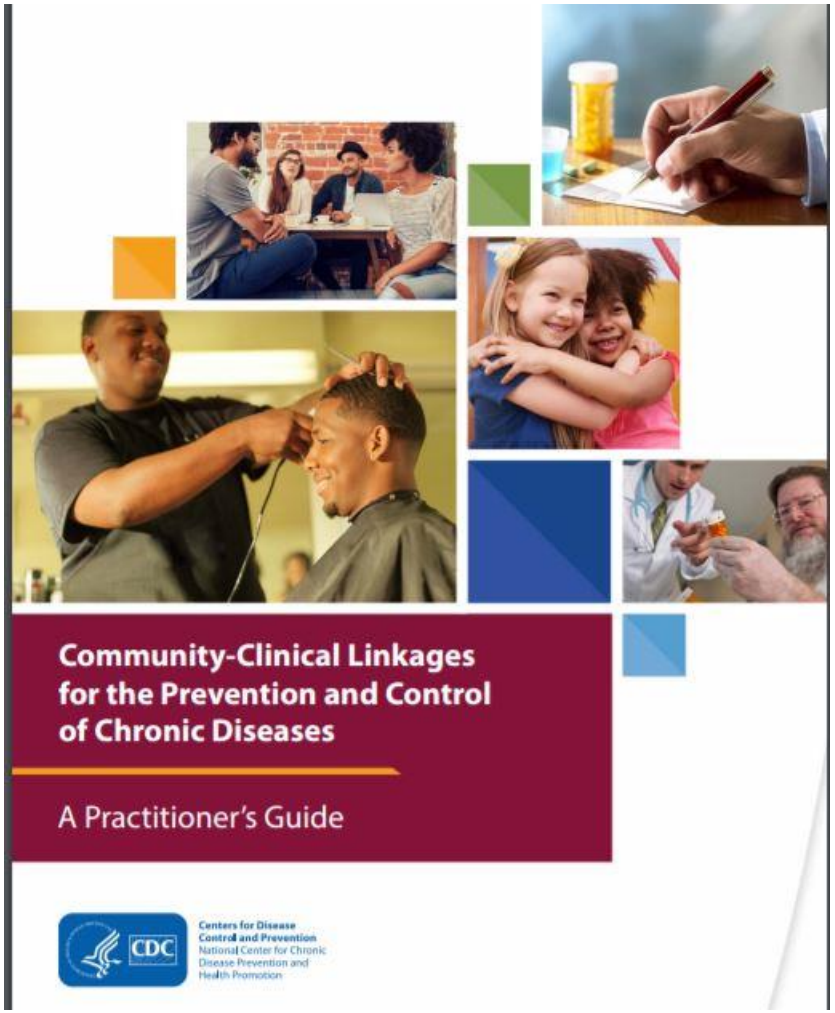
PCMH Initiative CCL Objective
DEEP DIVE

Quality Improvement Activities

- To successfully implement the CCL quality improvement requirement, participating PCMHs should be actively implementing quality improvement for their screening process and linkage methodology shortly after November 1, 2017 which, at a minimum, include:
- Review of the SDoH screening process, including monitoring screening completion, revealing screening gaps and circumstances/visits where screening is more and less effective, and ensuring the screening procedure is operationally efficient and being implemented consistently
- Review of linkages documentation, including the resources referred to and the outcome of those linkages, to determine the effectiveness of partnerships and reveal the need for additional resource partnerships or collaboration with resources providers/programs to improve patient outcomes
- During semi-annual progress reporting, the Initiative will request documentation describing the CCL quality improvement activities above (PCMHs can choose to include/pursue additional CCL QI)

Resource

- https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf



LUNCH & NETWORKING

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Open Space

Sue Gullo, Director
Sue Butts-Dion
Improvement Advisor

Objectives

- Capture energy and use it in self directed discussion
- Share learning from discussion groups
- Describe one task or test shared by a team that will aid in sustained practice changes required for practice transformation

Open Space

- Harrison Owen wondered: why is most energy in a meeting in out of meeting time (breaks, social hour)?
- How to capture that energy
- Can work small groups to 500 people
- Can replace agenda planning and even span a 2,3 day conference

Principles

- Let people decide and set breakouts
- Who ever is here are the right people
- Can “bumble bee” and cross-pollenate between groups
- Discussion group reports are the meeting notes

How to do it

- Allow people a moment to think about what they are passionate about, want to or need to talk about
- A person stands, says name, and topic of interest.
  - Writes it on a piece paper and tapes it to the wall

Repeat until all are done, wait a little longer; someone usually comes up

- Divide up into groups under area you want to discuss. Some may not be selected.

Each group

- Has a leader – person who posted topic
- Has a recorder who takes notes as well and shares those at the end of the Open Space

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What changes can we make that will result in improvement?

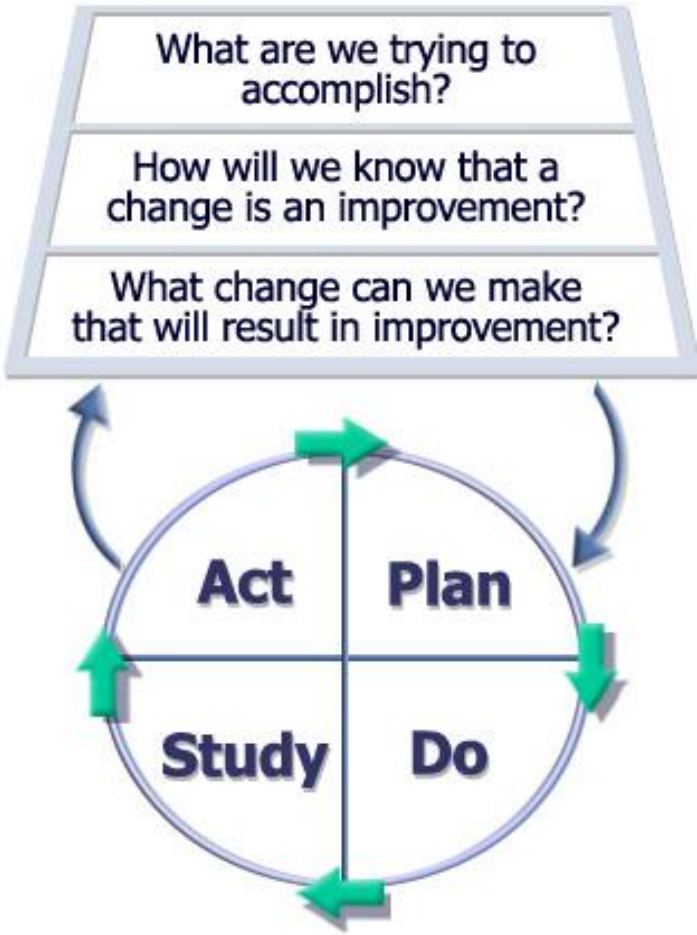
Sue Gullo, Director
Sue Butts-Dion
Improvement Advisor

Objectives

- After this session, participants will be able to:
  - Identify 3+ ideas to take and test in their organizations/systems.

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

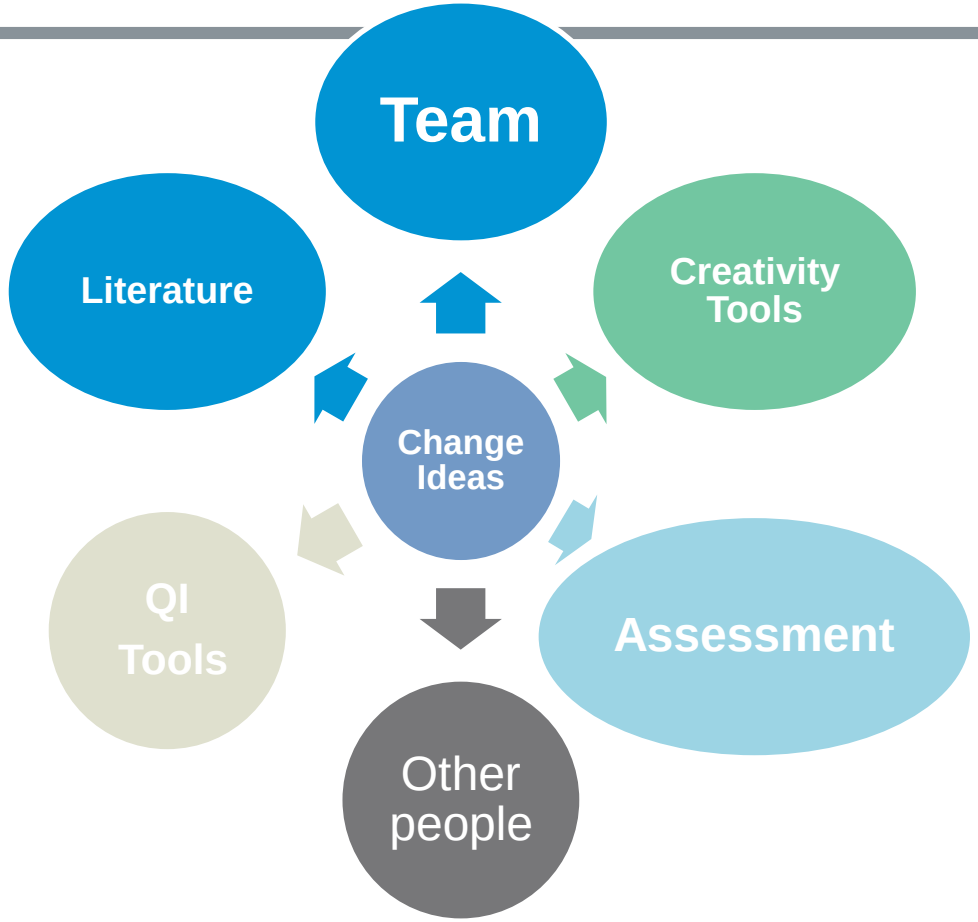
Developing and testing changes to achieve your aim



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

Where do we find changes?

Where do we find Change Ideas?



Where do we find Change Ideas?

Generic Change Concept

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement.

The "Generic" Change Concept List
The Improvement Guide (pg 295-359)1st Edition

Eliminate Waste
1. eliminate things that are not used
2. eliminate multiple entry
3. reduce or eliminate overkill
4. reduce controls on the system
5. recycle or reuse
6. use substitutions
7. reduce classifications
8. remove intermediaries
9. match the amount to the need
10. use sampling
11. change targets or set points

Improve Work Flow
12. synchronize
13. schedule into multiple processes
14. minimize hand offs
15. move steps in the process close toge
16. find and remove bottlenecks
17. use automation
18. smooth work flow
19. do tasks in parallel
20. consider people as in the same syste
21. use multiple processing units
22. adjust to peak demand

Optimize Inventory
23. match inventory to predicted demand
24. use pull systems
25. reduce choice of features
26. reduce multiple brands of same item

Change the Work Environment
27. give people access to information
28. use proper measures
29. take care of basics
30. reduce de-motivating aspects pay system
31. conduct training
32. implement cross -training
33. invest more resources in improvement
34. focus on the care process and purpose
35. share risks
36. emphasize natural and logical consequences
37. develop alliance/cooperative relationships

Enhance Product/Customer Relationship
38. listen to customers
39. coach customers to use products/service
40. focus on the outcomes to a customer
41. use a coordinator
42. reach agreement on expectations
43. outsource for "free"
44. optimize level of inspection
45. work with suppliers

Manage Time
46. reduce set-up or start-up time
47. set up timing to use discounts
48. optimize maintenance
49. extend specialists time
50. reduce wait time

Manage Variation
51. standardization (create formal process)
52. stop tampering
53. develop operational definitions
54. improve predictions
55. develop contingency plans
56. sort product into grades
57. desensitize
58. exploit variation

Design Systems to Avoid Mistakes
59. use reminders
60. use differentiation
61. use constraints
62. use affordances

Focus on the Product or Service
63. mass customize
64. offer product /service anytime
65. offer product /service anyplace
66. emphasize intangibles
67. influence/take advantage of fashion trends
68. reduce the number of components
69. disguise defects or problems
70. differentiate product -quality dimensions
71. change the order of the process
72. manage uncertainty, not tasks

Your changes…

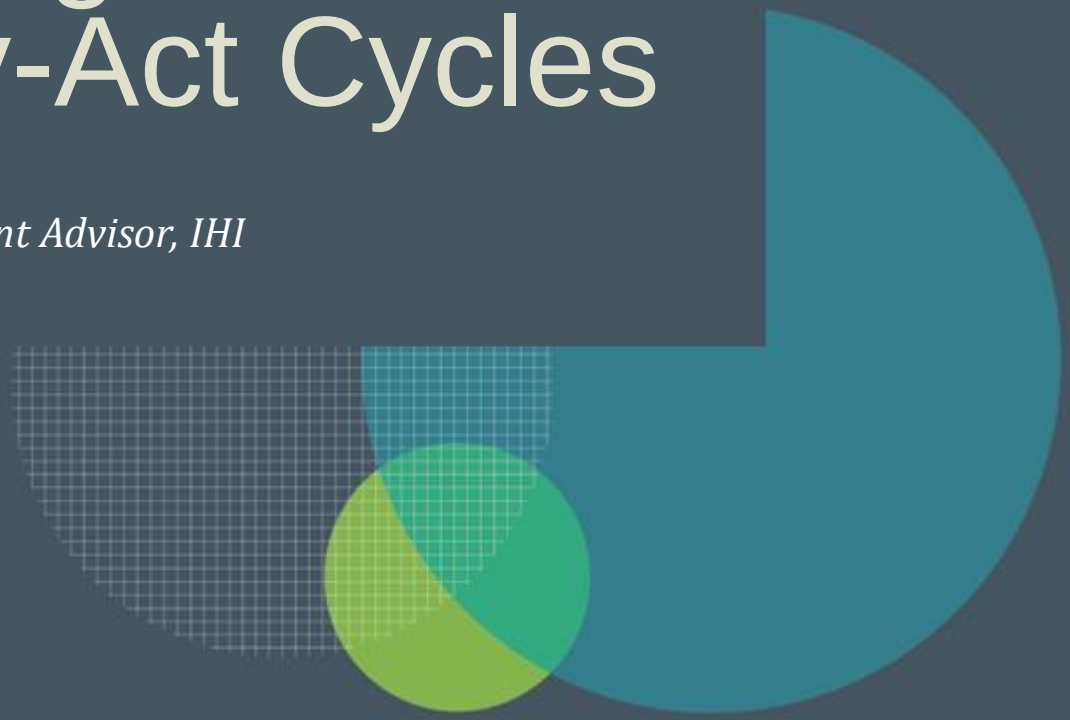
- What changes can you make that will lead to improvement?

BREAK

Institute for Healthcare Improvement

Leaving in Action: Developing First Plan-Do-Study-Act Cycles

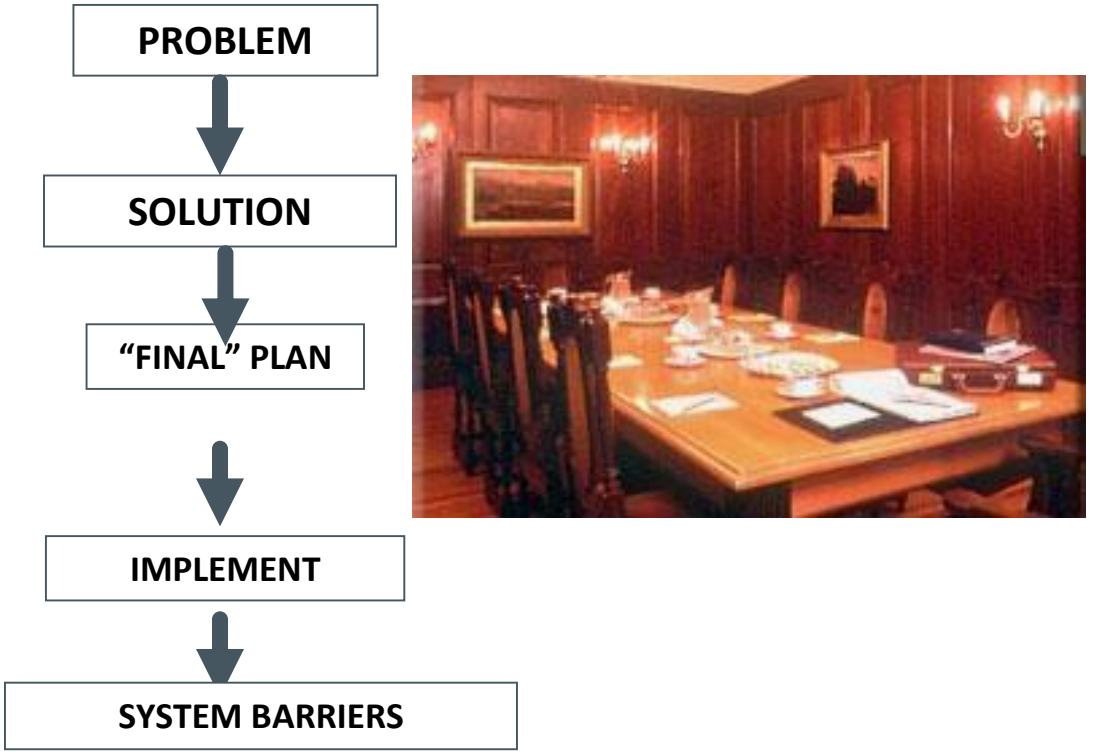
Sue Gullo, Director, IHI
Sue Butts-Dion, Improvement Advisor, IHI



Objectives

- By the end of this session, participants will:
  - Have at least one thing that they will go back and test “by next Tuesday”

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

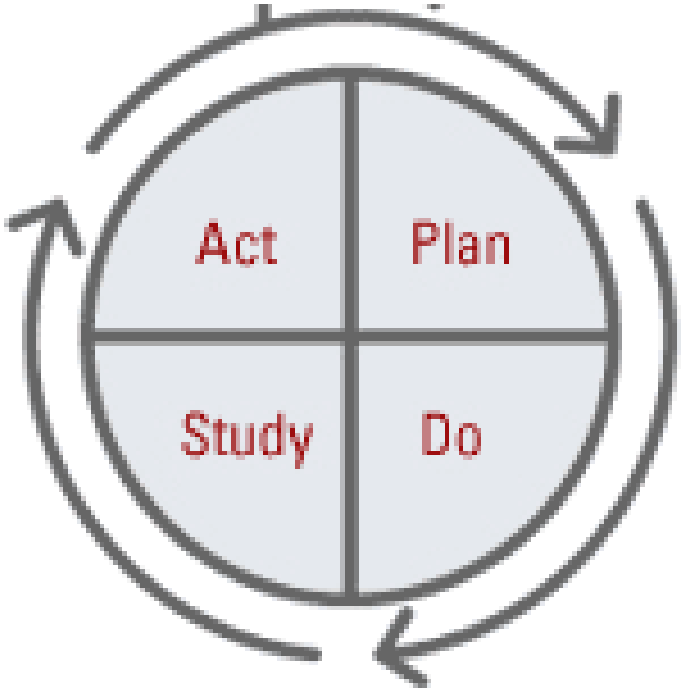
Plan-Do-Study-Act cycles

Adapted from: Jean Vukoson's Bright Futures Presentation

Small Test of Change

PDSA Cycle

A structured trial for a change.



Source: W. Edwards Deming

Plan:

Objective of this cycle (hypothesis, theory, question):

What additional information will we need to take action?

Details: (who, what, where, when, why)

WHO:

WHAT:

WHERE:

WHEN:

WHY:

What do we predict will happen?

Plan:

Objective of this cycle (hypothesis, theory, question):

What additional information will we need to take action?

Details: (who, what, where, when, why)

WHO:

WHAT:

WHERE:

WHEN:

WHY:

What do we predict will happen?

Plan (example):

Objective of this cycle (hypothesis, theory, question) Wondering if we test the SDoH assessment with one patient, will we get the information that we need or find out how we need to adapt?

What additional information will we need to take action? Need the brief assessment tool and some trained to administer.

Details: (who, what, where, when, why)

WHO: ?? (need to identify a person to test)

WHAT: the brief assessment presented at LS1

WHERE: next patient seen where applicable

WHEN: Tuesday at noon

WHY: to see how we might want to adapt

What do we predict will happen? We predict that the questions will work for now but that we will want to change them and re-test.

Plan (example):

Objective of this cycle (hypothesis, theory, question): We are wondering if we develop an Ecomap with some of our patients with multiple chronic conditions, if it will help us get them linked to the support they need and ultimately results in better health outcomes for them and fewer ED visits for them?

What additional information will we need to take action? Need to identify a patient we can test with. We will need to teach Care Manager how to use the mapping tool.

Details: (who, what, where, when, why)

WHO: 1 Care manger with one patient

WHAT: complete and ecomap

WHERE: next visit

WHEN: Tuesday at 1:20

WHY: to see if it is a viable way to connect the to potential clinical community linkages that we otherwise would not have thought of?

What do we predict will happen? We predict that it will take way too much time for the Care Manager to be able to do this and that the ROI might not be what we hoped for.

PDSA Tip: “Oneness”

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
- Can help get new team members on board

Test on a Small Scale

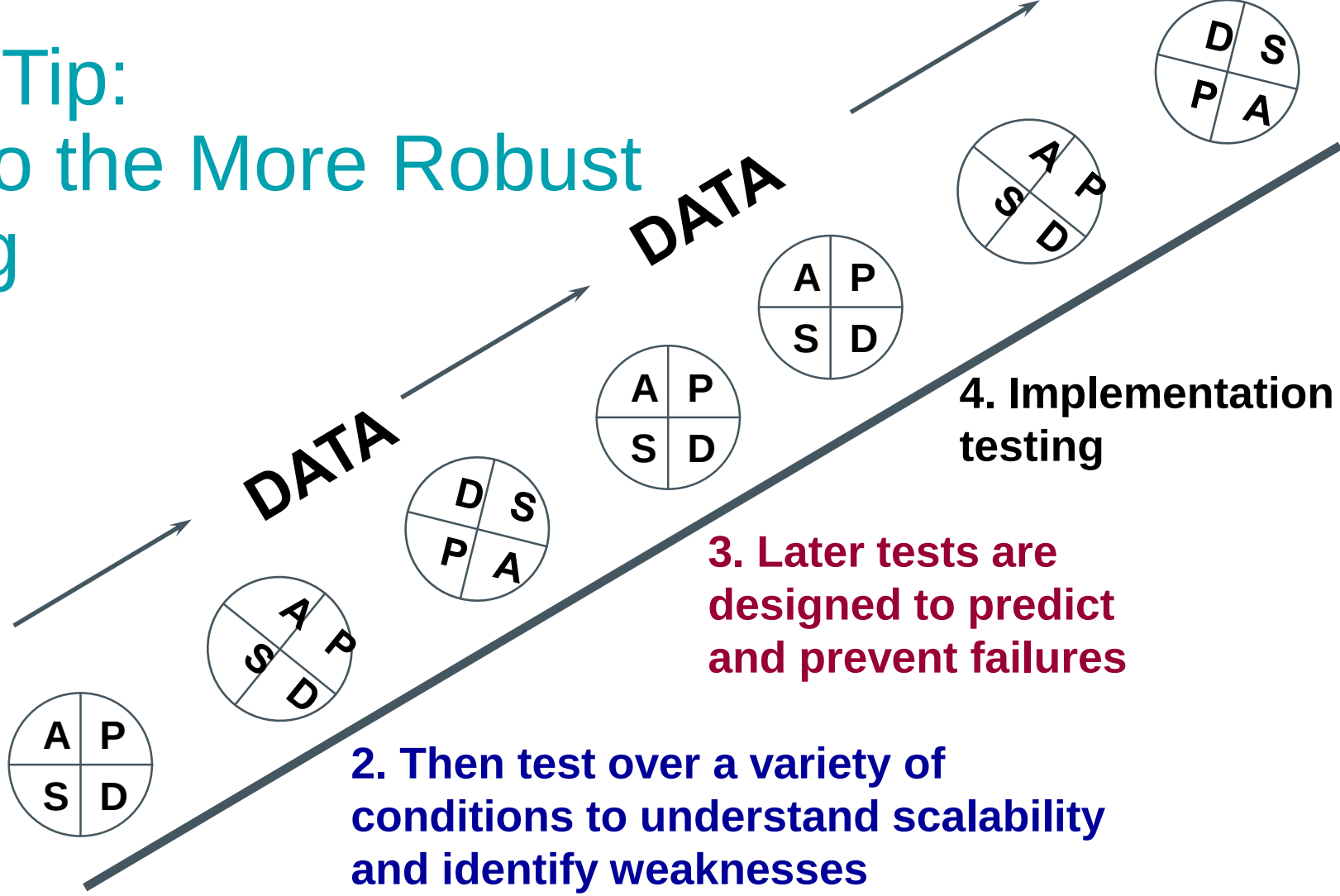
- Conduct the test for one patient, one provider, one time, one hour, the next time it happens—”Rule of 1”
- Decrease the time frame (move from thinking years to quarters to months to days to hours to minutes)
- Test the change with volunteers
- Simulate the change in some way (when feasible)

How small? Appropriate Scope for next PDSA Cycle (concept developed by Lloyd Provost)

Current Situation		Staff Readiness to Make Change: Resistant	Indifferent	Ready
Low Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

Source: Lloyd Provost, Associates in Process Improvement

PDSA Tip: Build to the More Robust Testing



Source: IHI

Do: (After you run your test per “Plan”)

Was the cycle carried out as planned?

What did we observe that was not part of our plan?

Check:

Methods of analysis:

How did or did not the results of this cycle agree with the prediction that we made earlier?

List what new knowledge we gained by this cycle:

Act:

List the actions we will take as a result of this cycle.

Are there forces in our organization that will help or hinder these changes? Explain.

Objectives of our next cycle.

What can you do by next Tuesday?

Your Turn…

- Using the PDSA handout, complete the “Plan” portion for something that you can test related to developing Clinical-Community Linkages by next Tuesday.
- Remember, think small—think one patient, one assessment, one community partner, one time…

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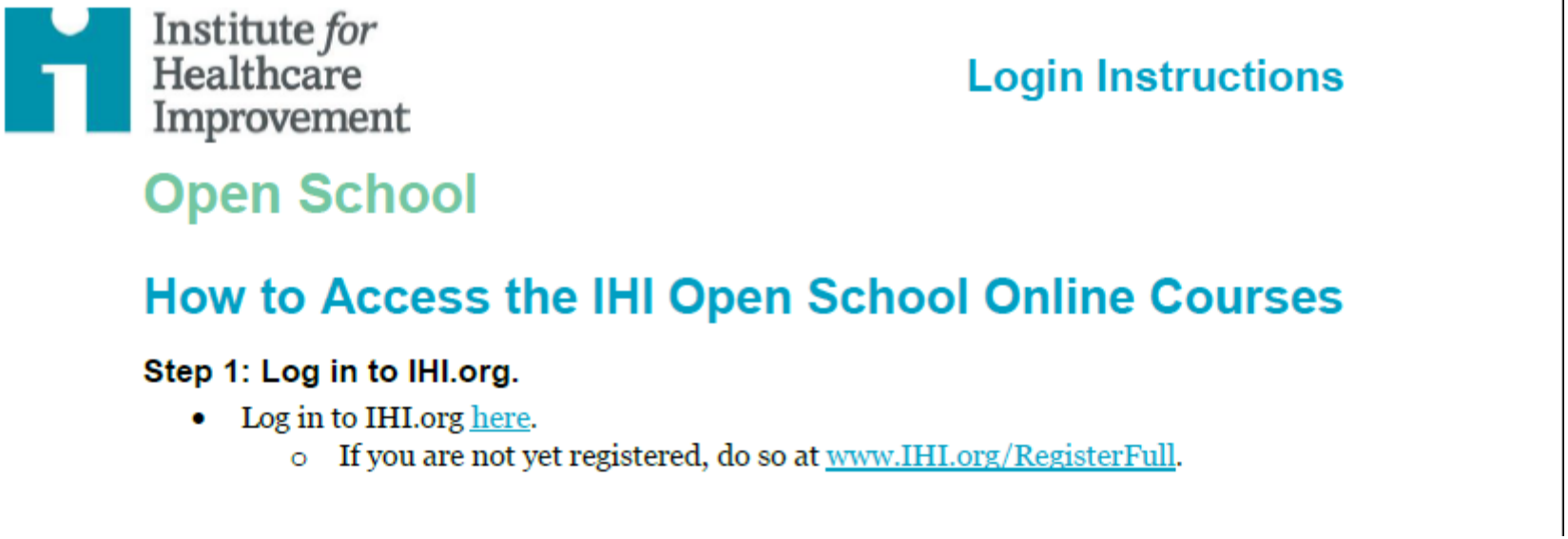
Prep for Action Period and Learning Session 2

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



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Login Instructions

Open School

How to Access the IHI Open School Online Courses

Step 1: Log in to IHI.org.

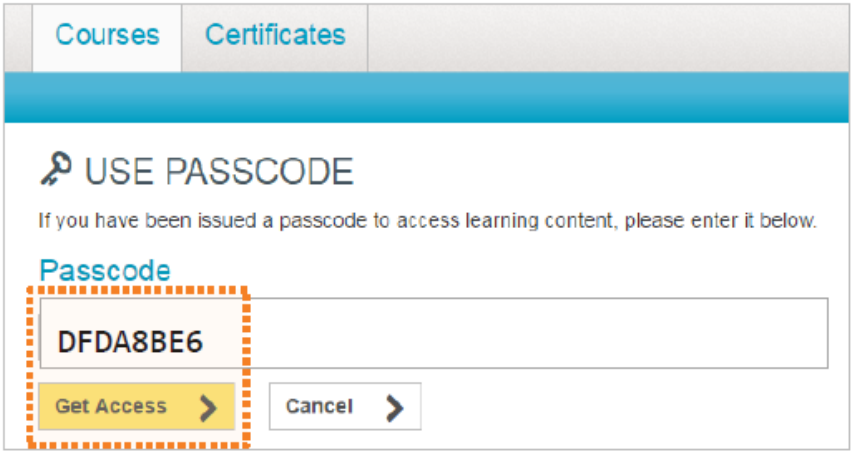
- Log in to IHI.org here.
  - If you are not yet registered, do so at www.IHI.org/RegisterFull.

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

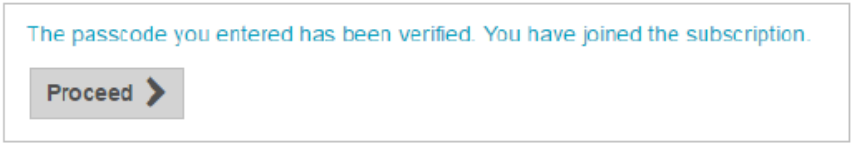
Step 2: Enter your group's passcode.

- After you have successfully logged in, go to www.IHI.org/EnterPasscode.

- Enter your group's 8-digit passcode DFDA8BE6 and click the "Get Access" button.



- A confirmation message will appear, indicating you have joined your group and inviting you into the courses.



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

Step 3: Take courses.

- Now that you are registered for the courses, return directly to your learning using the following link: www.IHI.org/OnlineCourses. Bookmark the link for easy access.

Course Examples

PFC 101: Introduction to Person- and Family-Centered Care

The relationship between patient and provider is changing. Many health care systems aim to provide not only high-quality services, but also patient-centered care that advances the unique health goals of each person and family. In this course, you'll learn about the ideal relationship to promote health — especially for underserved people who face the greatest barriers to health — as well as some practical skills to make the relationship a reality.

- Lesson 1: *Patient-Provider Partnerships for Health*
- Lesson 2: *Understanding Patients as People*
- Lesson 3: *Skills for Patient-Provider Partnerships*

After completing this course, you will be able to:

- 1. Describe the partnership model of patient-provider relationships.
- 2. Explain why the partnership model can improve health.
- 3. Discuss how social conditions, faith, culture, and trust affect the patient-provider relationship.
- 4. Identify at least four skills to improve clinical interactions with patients.

Estimated Time of Completion: 1 hours 30 minutes

Course Examples

Triple Aim for Populations

TA 101: Introduction to the Triple Aim for Populations

You might think we do a pretty good job of providing care to individuals with illnesses and diseases. But it's important to take a step back and consider the factors contributing to illness. It's important to realize that things like education, the environment, and wealth (and how it's distributed) play an enormous role in health outcomes, too.

In this course, you'll learn that to make progress against many of the most important threats to human health, it's not enough to improve clinical care for one patient at a time. We also have to focus on improving the health of entire populations.

The Triple Aim for populations is a three-part aim: better care for individuals, better health for populations, all at a lower cost. This course will explore why each dimension is an essential part of improving health and health care, and how you can promote the Triple Aim in your organization and daily work.

- Lesson 1: Improving Population Health
- Lesson 2: Providing Better Care
- Lesson 3: Lowering Costs of Care

After completing this course, you will be able to:

- 1. Describe the three components of the IHI Triple Aim for populations.
- 2. Explain the responsibilities of clinicians and health care systems in optimizing population-level outcomes with available resources.
- 3. Understand medical care as one determinant of the overall health of a population, and the relationship of health care quality and safety to population health.
- 4. Provide examples of population-level interventions designed to improve overall health and reduce costs of care.

Estimated Time of Completion: 2 hours

Course Examples

TA 102: Improving Health Equity

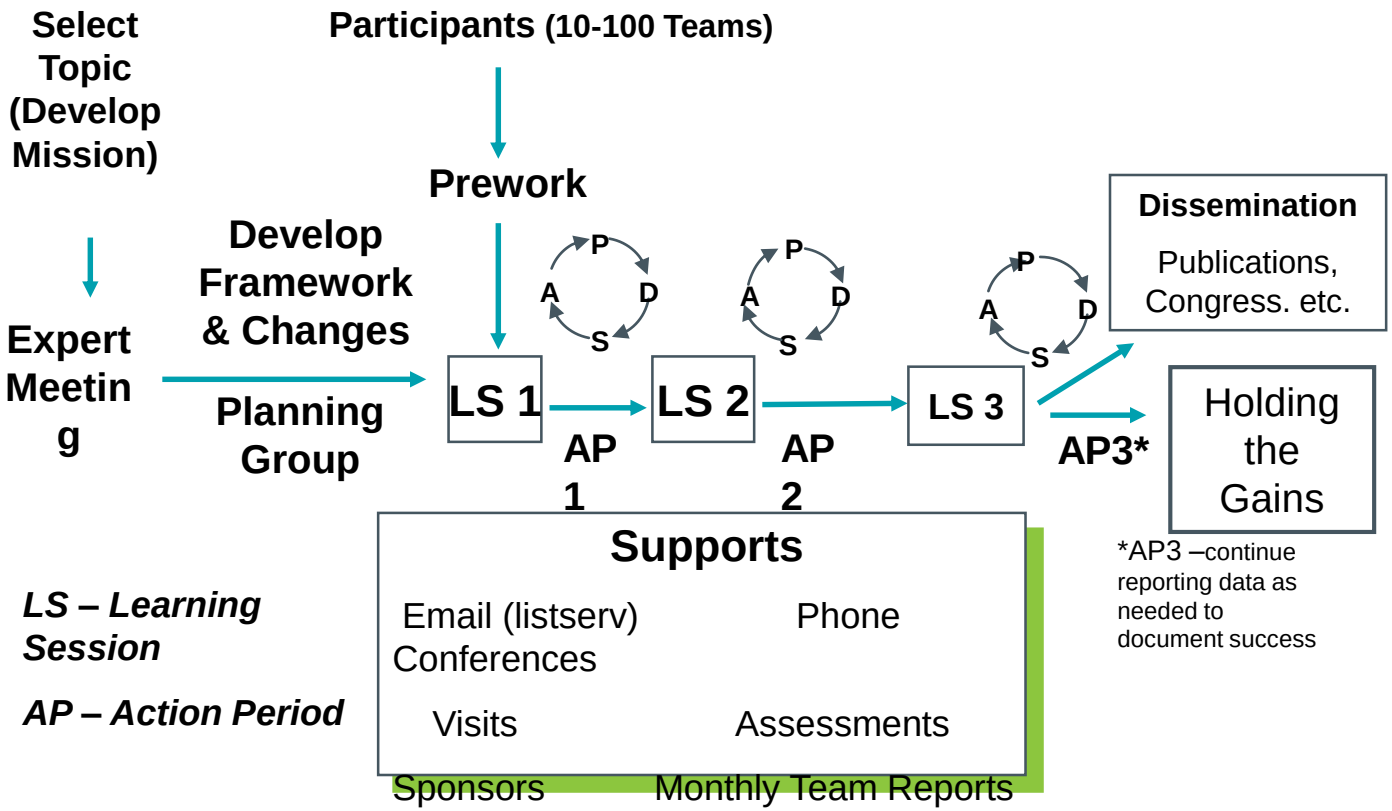
This three-lesson course will explore health disparities — what they are, why they occur, and how you can help reduce them in your local setting. After discussing the current (and alarming) picture in Lesson 1, we'll dive into Lesson 2 and learn about some of the promising work that is reducing disparities in health and health care around the world. Then, in Lesson 3, we'll suggest how you can start improving health equity in your health system and community.

- Lesson 1: Understanding Health Disparities
- Lesson 2: Initiatives to Improve Health Equity
- Lesson 3: Your Role in Improving Health Equity

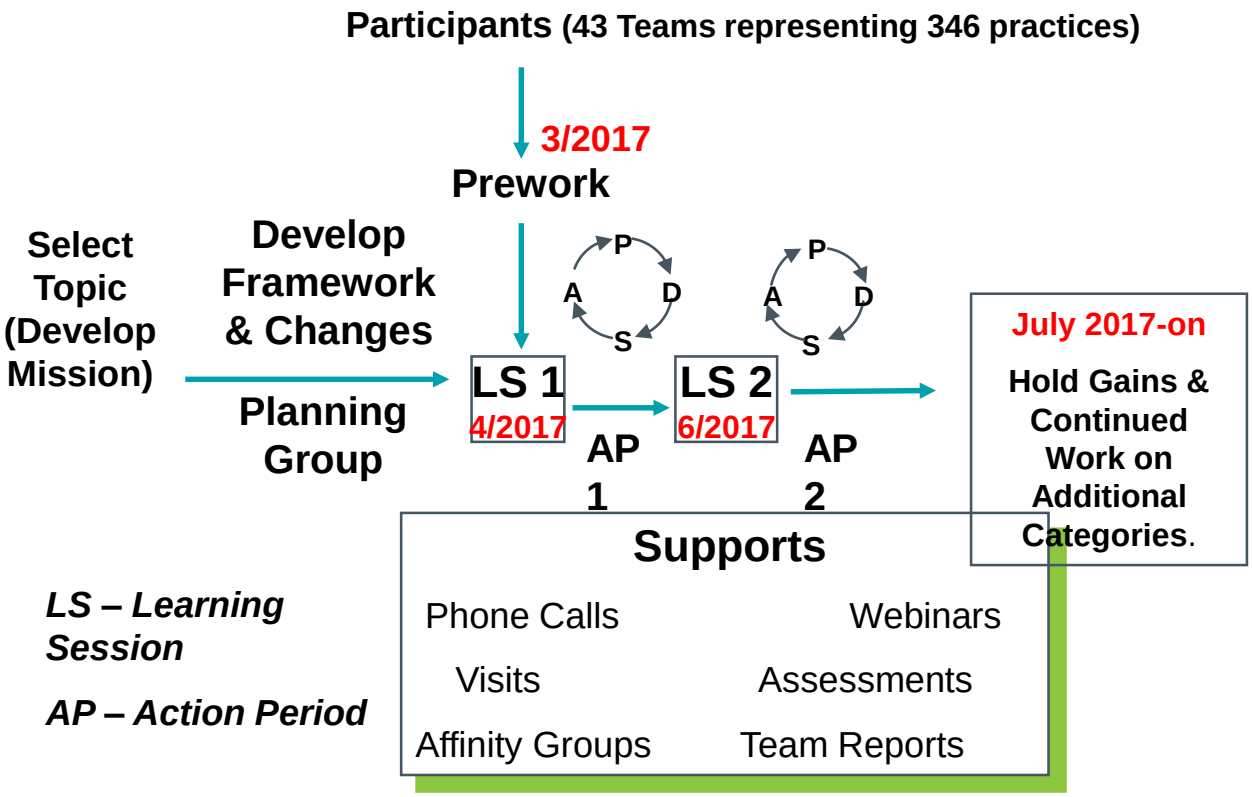
After completing this course, you will be able to:

- 1. Recognize at least two causes of health disparities in the US and around the world.
- 2. Describe at least three initiatives to reduce disparities in health and health care.
- 3. Identify several ways you can help reduce health disparities.

"How"
IHI Breakthrough Series Model



“How”—Year 1
MI PCMH Transformation Collaborative



Reminders and Next Steps

- Next Action Period Calls:
  - Thursday, April 13, 2017
  - Thursday, May 11, 2017
  - Thursday, June 8, 2017
- Next Coaching Calls:
  - May 16-19, 2017
- Next Learning Session:
  - June 13-14, 2017