Institute for Healthcare Improvement

Welcome Back

Day 2

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

Yesterday, we…

- Had an **orientation** workshop for new participants, including a review of QI 101
- Had time to connect with **CHIRs**
- Learned from our peers and expanded our learning network through **Storyboard Rounds**
- Talked about different **models to support change**
- Learned about a **patient case**

Today, we will…

- Hear about **best practices** to link patients and achieve health
- Network in "**open space**" conversations
- Attend **breakouts**
  - **Building will**: Engaging patients as the core stakeholders in the PCMH transformation
  - **Measurement**: Developing a Measurement Strategy
  - **Journey to test and implement a SDoH assessment** screening tool
- Learn about **population health management**
- Learn how to use Driver Diagrams to organize learnings
- Participate in **team time** to work on storyboards and plan for the action period

Institute *for* Healthcare Improvement

Sites and Their Clinical Community Partners

Facilitator:

- Trissa Torres, Institute for Healthcare Improvement

Panelists:

- Beth St. John, Michigan Association of United Ways (MiCHAP)
- Laura Kilfoyle, Michigan Association of United Ways
- Lori Noyer, Ingham CHAP and Pathways

Michigan Children's Health Access Program (MI-CHAP)

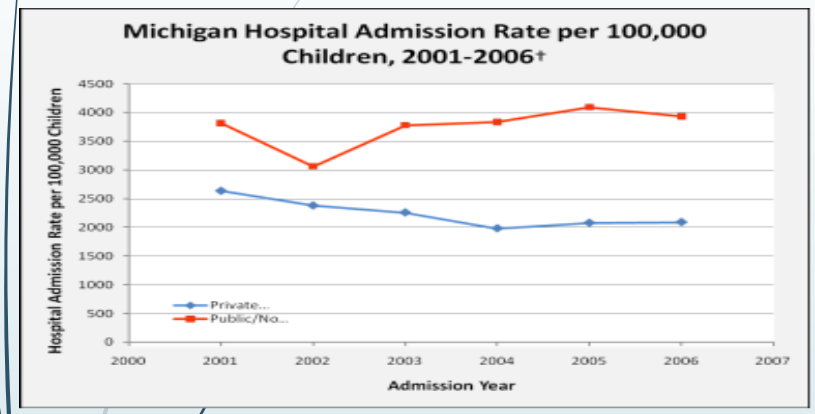
Laura Kilfoyle, MPA
MI-CHAP Director

Beth St. John, MEd, MLIS
MI-CHAP Coordinator

Michigan Association of United Ways (MAUW)
330 Marshall St, Suite 211
Lansing, MI 48912

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

The Need for MI-CHAP



*If the hospitalization rate for children on Medicaid was the same as for those with private insurance, the estimated savings **for one year** would be $300-$400 million.*

CHAP's Triple Aim Outcomes

- Better Care
- Improved Health
- Cost Reduction

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

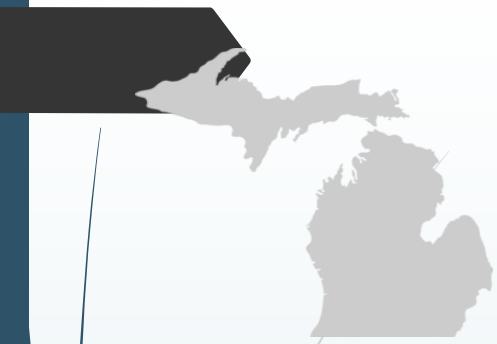
MI-CHAP Model

A local CHAP team is comprised of staff who have varying expertise. This integrated model provides an approach to the work which allows them to address not only health-related issues but broader issues such as Social Determinants of Health (SDoH). The CHAP interdisciplinary team works collectively to address each client's barriers and provide a path to health equity.

Kent CHAP's team:

- 1 - CHAP Manager (LMSW)
- 3 - LMSW/MSW Interns
- 2 - BSW/BSW Interns
- 1 - Behavioral Health Navigator
- 3 - CHWs
- 1 - RN
- 1 - Practice Engagement Specialist
- 1 - Program Assistant

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND



MI-CHAP Michigan Health Endowment Fund Proposal

MiCHAP

United Way
Michigan Association of United Ways

What we proposed doing:

- Improve health outcomes of Medicaid-eligible children
- Improve quality and access to medical homes
- Reduce emergency room visits and hospital admissions
- Expand Kent and Wayne CHAPs, Launch 7 new local CHAPs
- Innovate efficiencies and scalability by delivering components of the CHAP model though a new virtual strategy

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

What is Virtual CHAP?

- A cost-effective way to expand MI-CHAP services to counties that do not have a local, on-the-ground CHAP

What does Virtual CHAP do?

- Screens callers for CHAP services—either for a Virtual CHAP or a Local CHAP
- Connects families with CHAP services to address social determinants of health and/or health services navigation
- Follows-up with one in five CHAP referrals to: assess whether the child received services, record any barriers to success, and work toward solutions
- Partners with Michigan Chapter of the American Academy of Pediatrics (MIAAP) to engage pediatric practices in areas that do not have a local CHAP
  - Outreach Goal: Educate practices about the social determinants of health referrals 2-1-1 provides and the expanded role of Virtual CHAP staff

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

What are the current V-CHAP outcomes?

MiCHAP

United Way

Michigan Association of United Ways

MI-CHAP Screening & Referral Data January 2016 – May 2017

Total Clients Screened	48,189
Total Referrals to Local CHAPs	1,180
Total Client Interactions with V-CHAP Staff	1,700

Follow-Ups Initial Results (From Feb. - June 9, 2017)

Connection Rate	Approximately 50%
Percent connected with at least 1 referral	Approximately 70%

MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

How can clients connect with MI-CHAP?

MiCHAP

United Way
Michigan Association of United Ways

Local CHAPs

- Visit our web site: www.michildrenshealth.org
- Click Local CHAP for a complete list of contact information

V-CHAP

- Call 2-1-1 from any phone
- Ask to speak to a CHAP Specialist

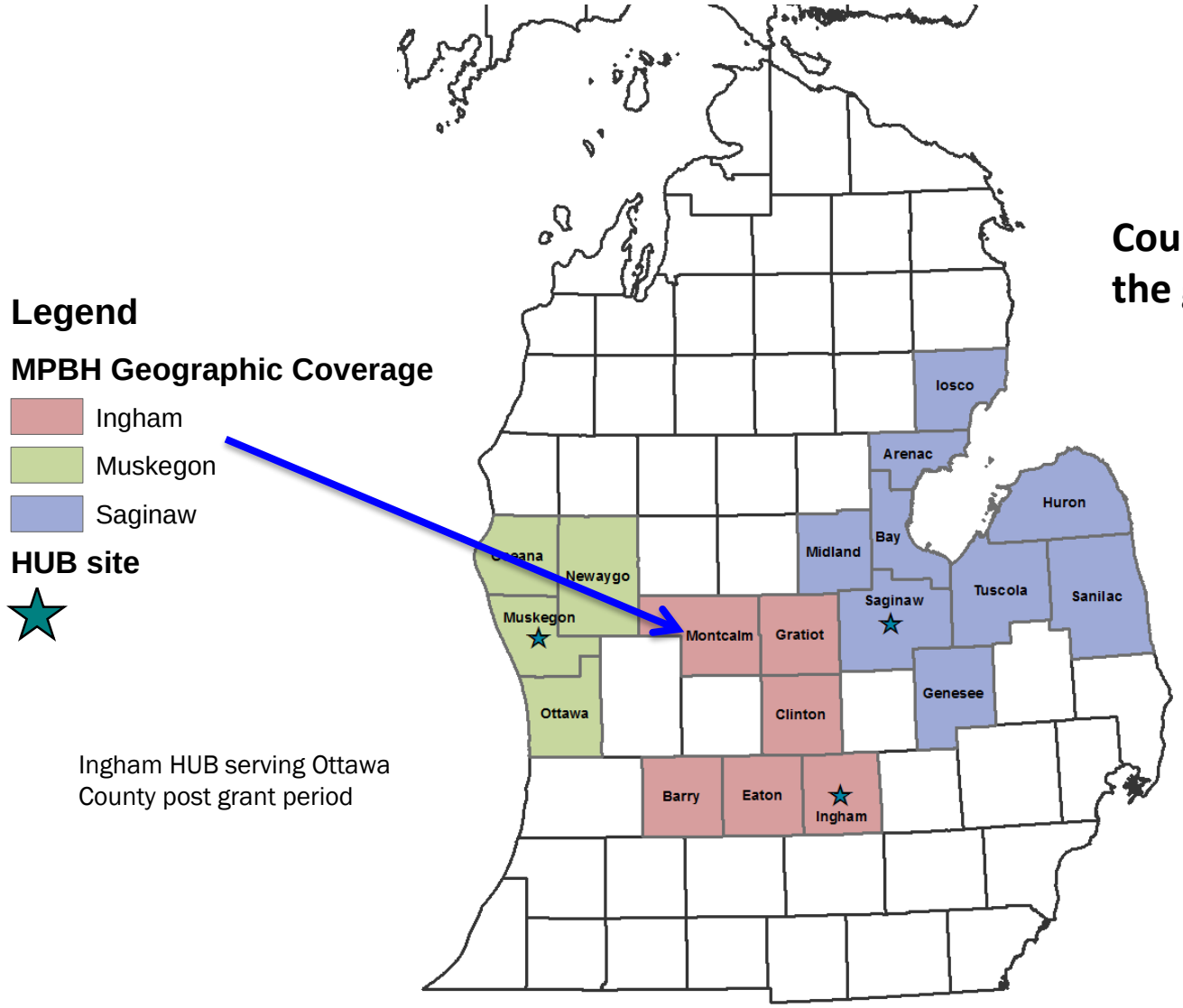
MI-CHAP is generously funded by the MICHIGAN HEALTH ENDOWMENT FUND

PATHWAYS TO BETTER HEALTH OVERVIEW

A PATHWAYS COMMUNITY HUB MODEL

Lori Noyer, MA
CareHub Programs Manager
lnoyer@ihpmi.org
517-336-3778

COUNTIES SERVED BY 3 HUBS



PROGRAM GOALS

- Pathways to Better Health focuses on
  - Decreasing primary sensitive ED visits & inpatient admissions
  - Increasing utilization of primary care
  - Addressing social determinants of health
  - Integration of health care and social services
- Targets at-risk population

WHAT IS A COMMUNITY HUB?

- Centralized ***access point*** assures efficient and effective service delivery in a community
- Hub ***contracts*** with Care Coordination Agencies (CCA) to hire, manage & deploy Community Health Workers
- Hub ***assigns*** referrals to Community Health Workers (CHWs) to connect individuals to needed social and healthcare resources.

COMMUNITY HUB ROLE

Acting as an information clearinghouse with a centralized client registry to avoid duplication of services

- Receives referrals, screens for eligibility and assigns to trained community health workers; Provides the vehicle for bi-directional communication with referral entities

Provides a single point of entry or the no wrong door approach to patients, ensuring the referral will best meet their needs

Performance monitoring and QA functions for **all** aspects of the program.

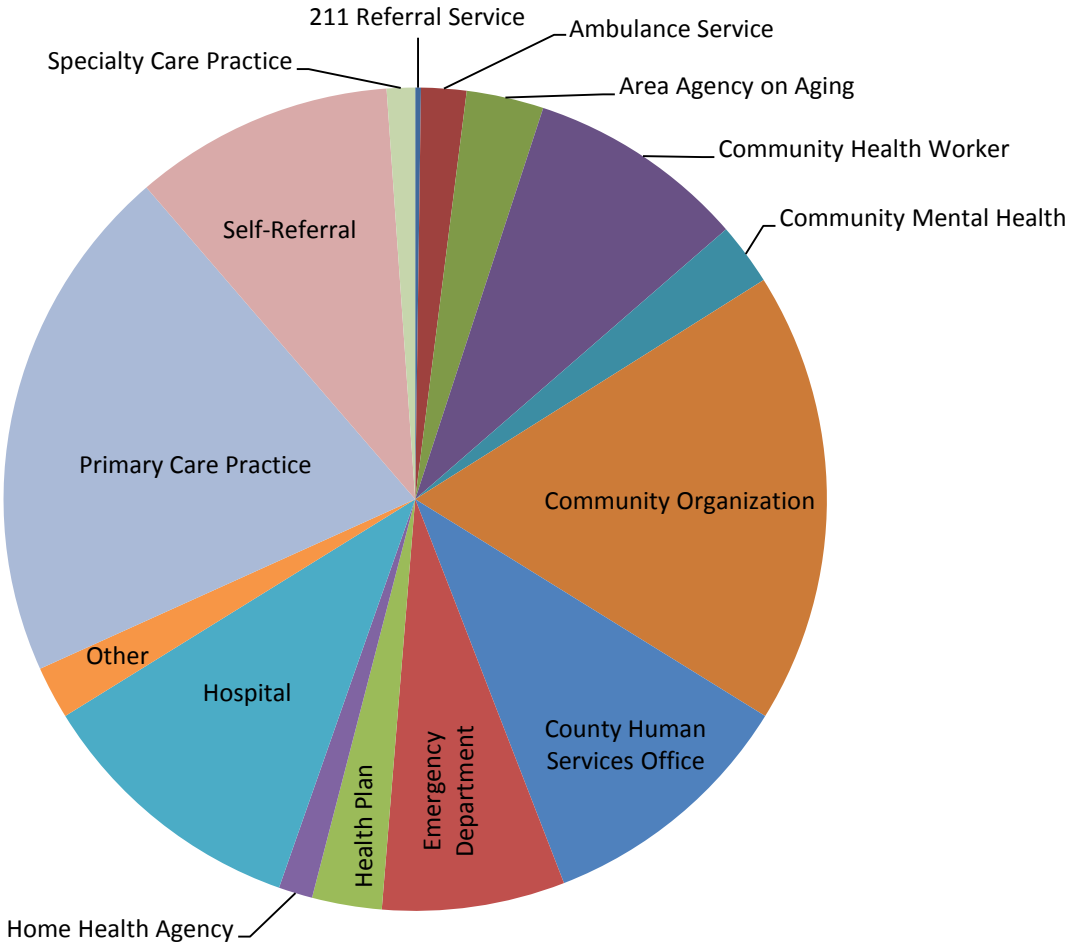
- Delivers consistency – responsible for training, monitors activity for quality and productivity and provides program oversight
- National standards from Pathways Community HUB Certification Program promotes accountability for quality care coordination services

Provides a single point for contracting arrangements to reduce administrative costs.

Reports outcomes to the community

IT Infrastructure

2016 Referral sources BY TYPE



COMMUNITY HEALTH WORKER ROLES

- Engage eligible clients in the Pathways to Better Health Program

- Assess eligible clients' health and social needs as identified by client priorities (using a person-centered planning approach). Assess client's stage of change and educate appropriate to that stage in order to promote healthy behaviors

- Connect clients to needed medical and social services; assist in making appointments and assuring client participation; follow up to assure that services are available and meeting the client's needs

- Document services provided to eligible clients and collect client data using standardized Checklists and evidence-based Pathways and Tools

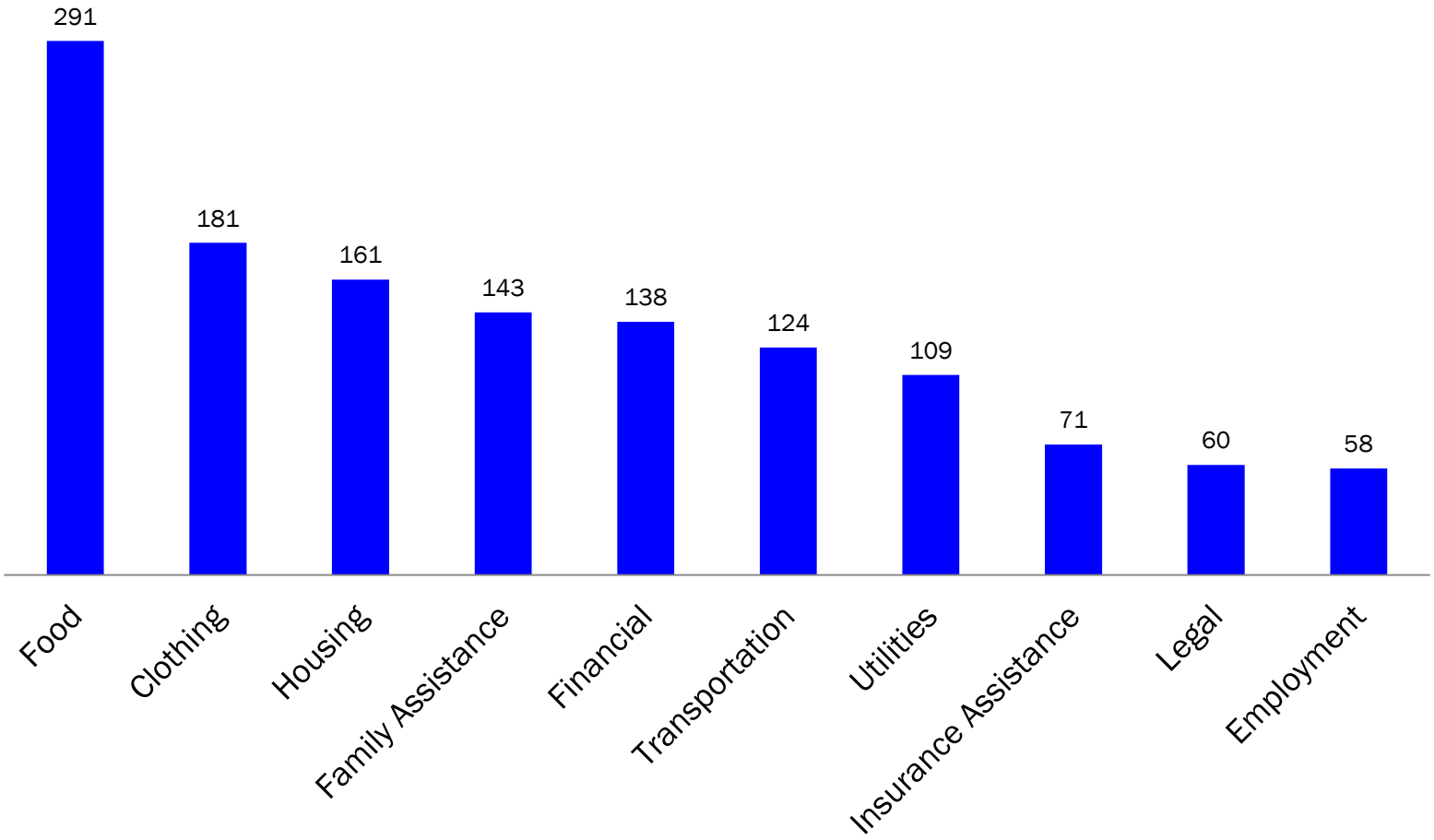
- Communicate and serve as a liaison between providers, community agencies and health plan and the client
- Coordinate client care with a team of health care and social service provide

- Provide peer support to clients and reinforce health education and preventive measures
- Help clients navigate care transitions through all systems of services and foster independence
- Advocate for clients within the health and social service systems

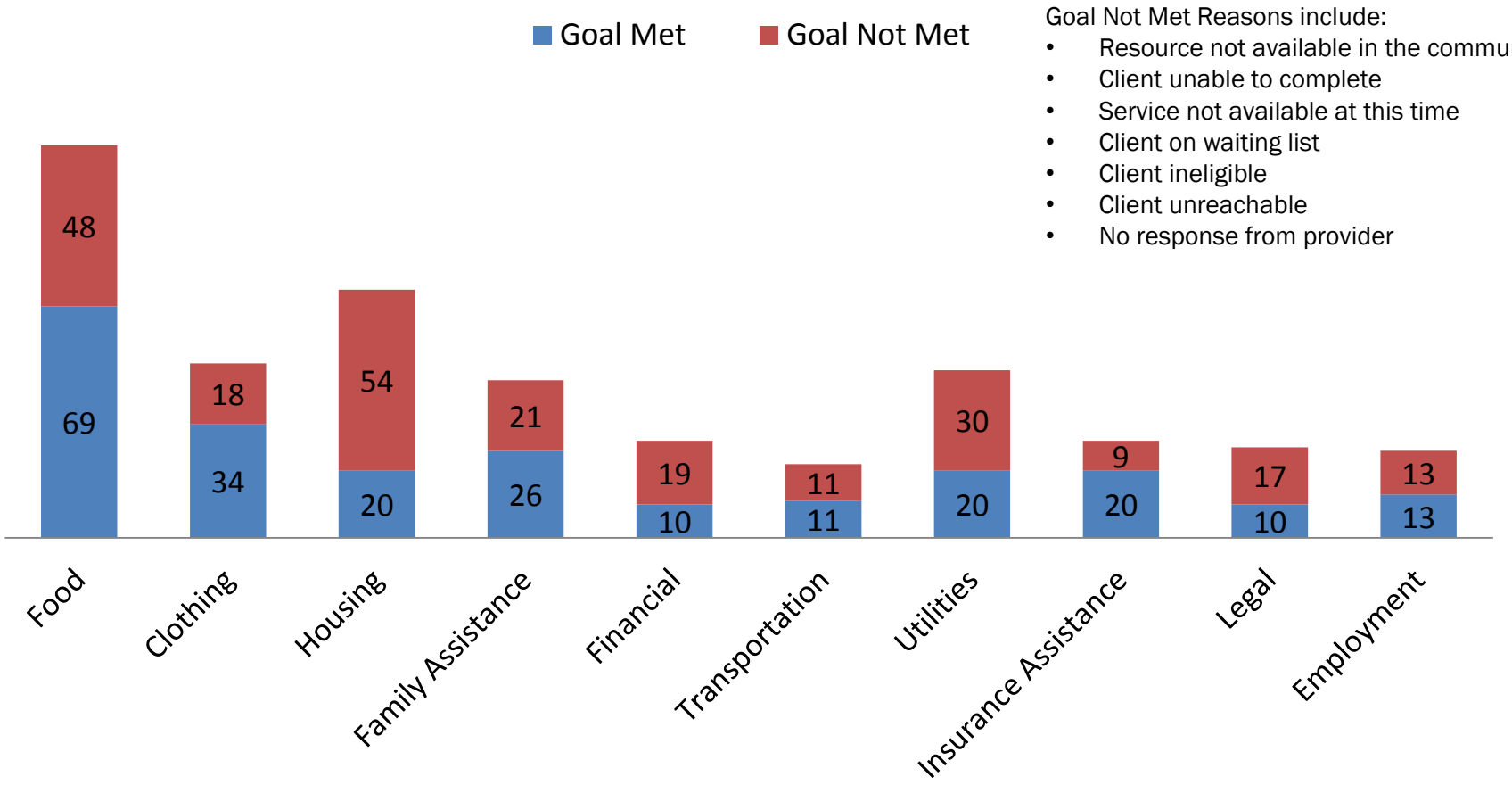
CORE PATHWAYS AND TOOLS

- Social Service Referral
- Medical Referral
- Tobacco Cessation
- Medication Assessment
- Medication Management
- Medical Home
- Health Insurance
- Chronic Disease Education
- Lead
- Healthy Changes Plan
- Healthy Homes Checklist
- PHQ-9 Screening
- Fall Prevention
- CAGE-AID
- Pregnancy, Postpartum, Family Planning
- Healthy Michigan Plan – Health Risk Assessment
- Care Transitions
- Emergency Dept Reduction

2016 TOP 10 SOCIAL SERVICES REFERRALS BY TYPE



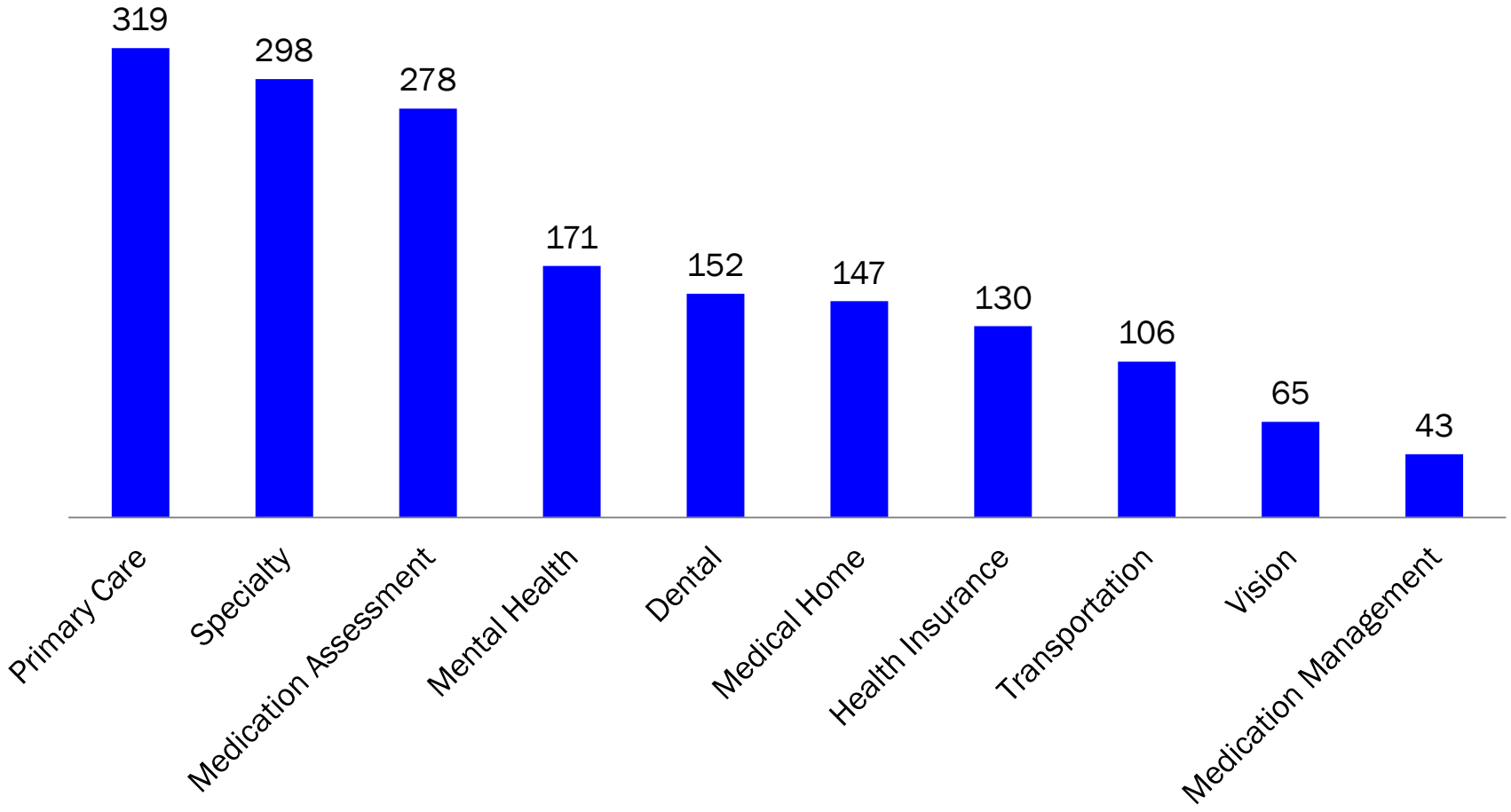
Social Services Referral Pathway Outcomes
Mar - Dec 2016 only



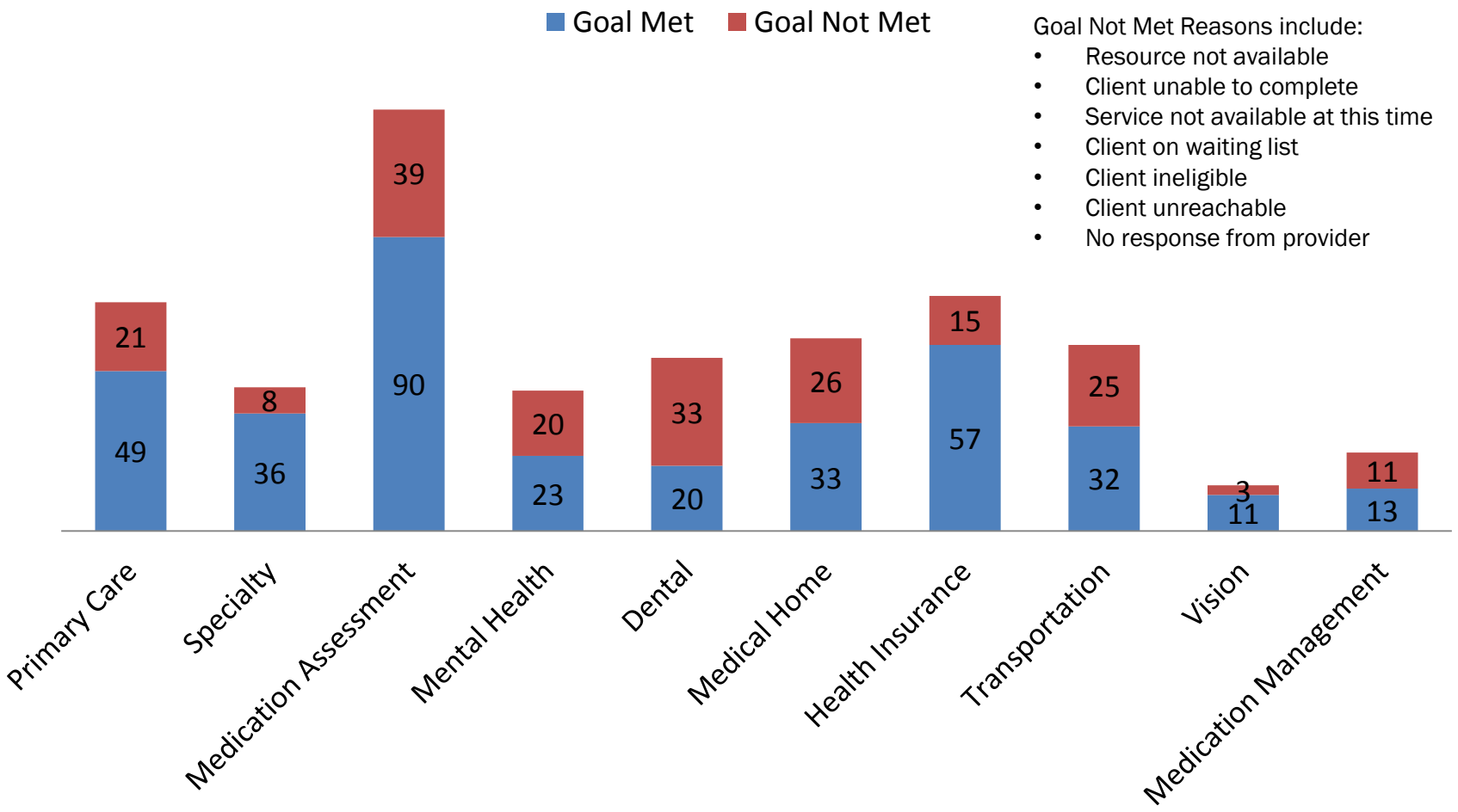
Goal Not Met Reasons include:

- Resource not available in the community
- Client unable to complete
- Service not available at this time
- Client on waiting list
- Client ineligible
- Client unreachable
- No response from provider

2016 TOP TEN MEDICAL SERVICES REFERRALS BY TYPE



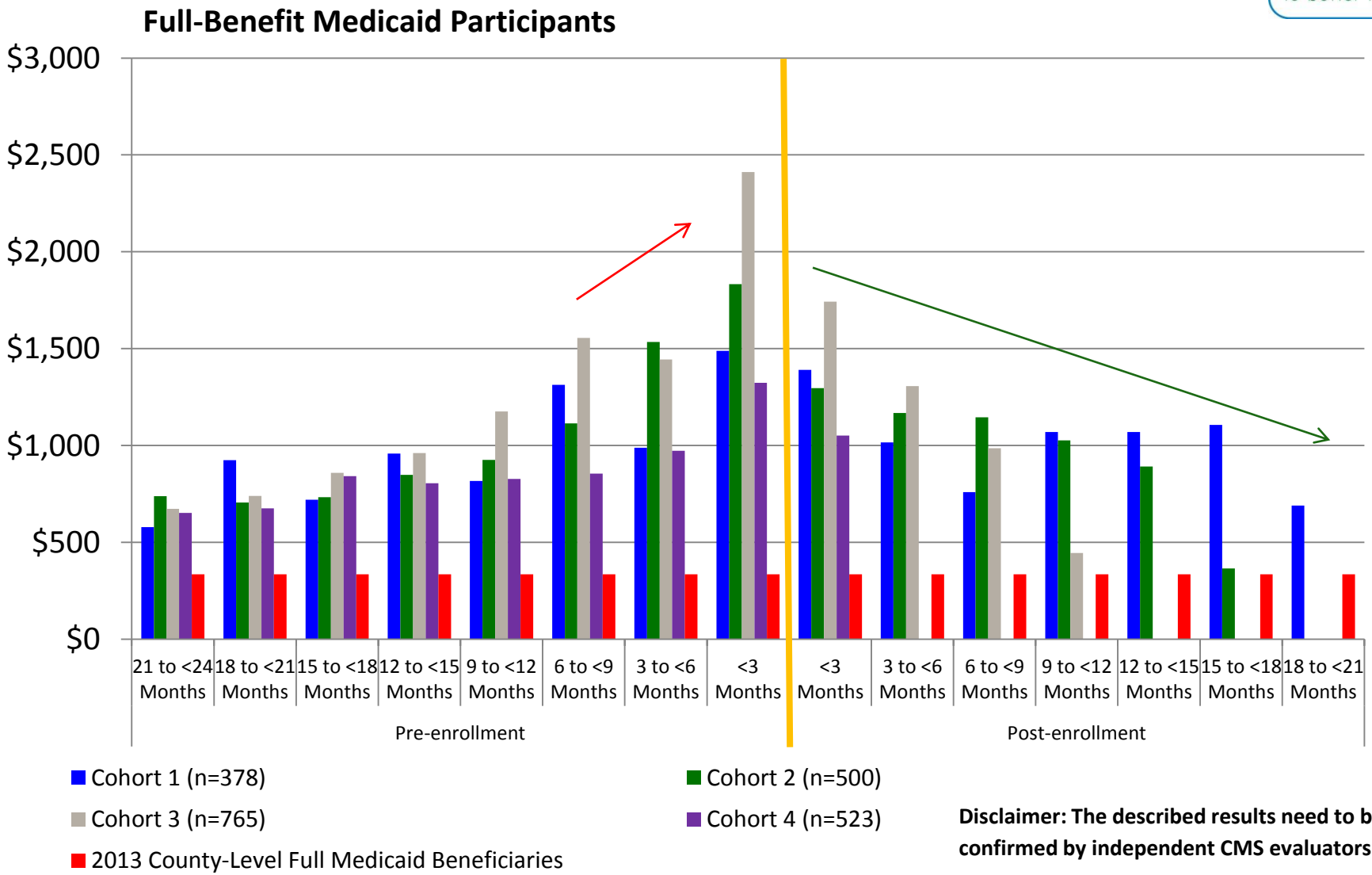
Medical Referral Pathway Outcomes- March - Dec 2016



TOP 10 CHRONIC CONDITIONS SELF-REPORTED BY CLIENT

1. Depression
2. Anxiety
3. Hypertension
4. Arthritis
5. Tobacco Use
6. Back Pain
7. Chronic Pain
8. Vision Loss
9. Diabetes
10. Asthma

MEDICAID COSTS: PER MEMBER PER MONTH

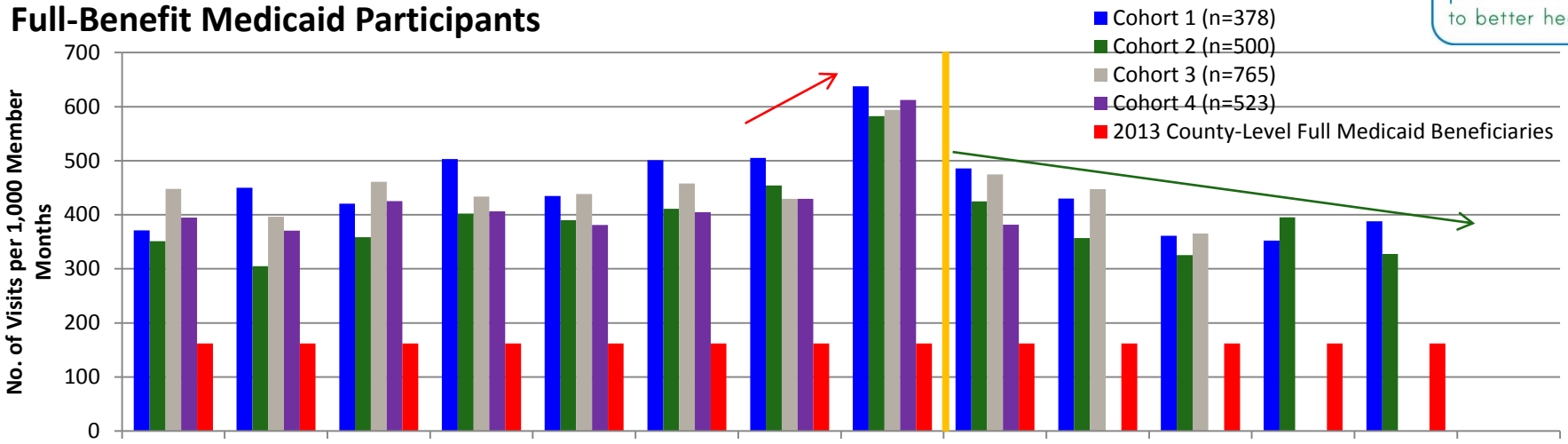


Disclaimer: The described results need to be confirmed by independent CMS evaluators.

EMERGENCY DEPARTMENT UTILIZATION: NUMBER OF VISITS PER 1,000 MEMBER MONTHS

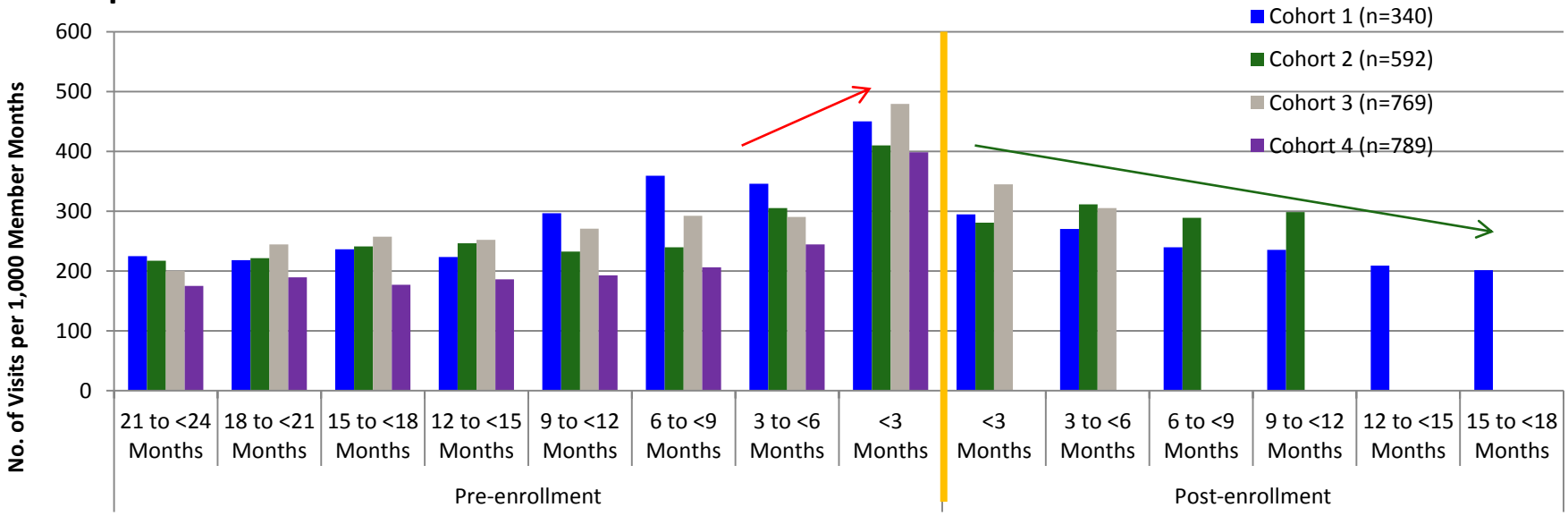
pathways to better health

Full-Benefit Medicaid Participants



Disclaimer: The described results need to be confirmed by independent CMS evaluators.

Participants with Medicare FFS Claims



SUCCESSES

- Client's health and quality of life improved
- CHWs are making healthy changes
- Support for the model is growing
- HUB certification attained April 2016

CHALLENGES/BARRIERS

- SUSTAINABILITY

Institute *for* Healthcare Improvement

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

Topics

1. Care managers/coordinators
2. Billing and coding
3. Quality Improvement - PDSAs
4. Storyboards
5.
6.

Break and Transition to Breakouts

- **University Ballroom (Red Dots):**
  - Building Will: Engaging Patients as the Core Stakeholders in the PCMH Transformation
- **Beaumont Room (Green Dots):**
  - Measurement: Developing a Measurement Strategy
- **Campus Room (Yellow Dots):**
  - Journey to Test and Implement a SDoH Assessment Screening Tool

Institute *for* Healthcare Improvement

Breakout 1
Engaging Patients in Care and Care Redesign

June, 2017

5000
hours

Trevor

"THERE ARE NO GOOD OR BAD NUMBERS."

- TREVOR TORRES
THE DIABETES EVANGELIST

A SHOW ABOUT PEOPLE LIVING WITH TYPE 1 DIABETES
BETACELLPODCAST.COM

CEO

https://www.youtube.com/watch?v=cMGgoInt1Mo

Your Turn

Think of specific experience where you were a patient or family member of a patient. Share with your neighbor:

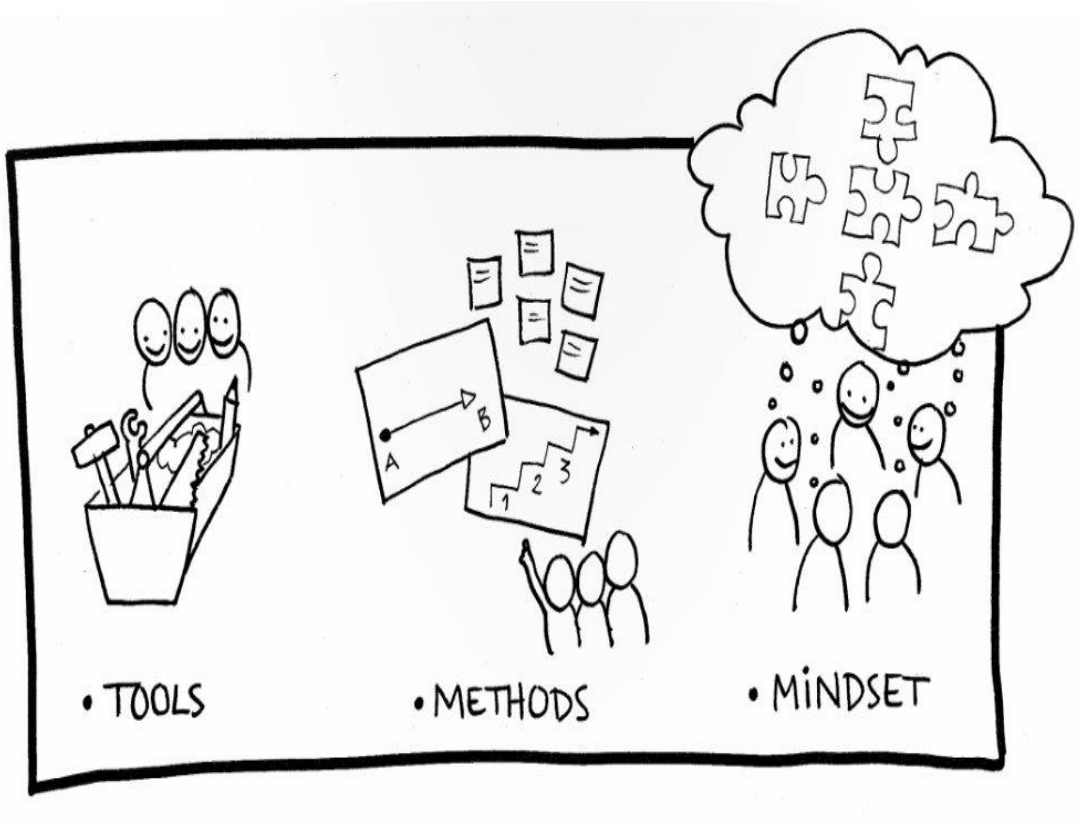
- Good parts of your experience
- Things you would change about your experience


PATIENT
CODESIGN
COCREATION
ADVISERS
PARTNERSHIP
TEAM
COPRODUCTION
COUNCILS
MEMBER
PATIENTS
FAMILY

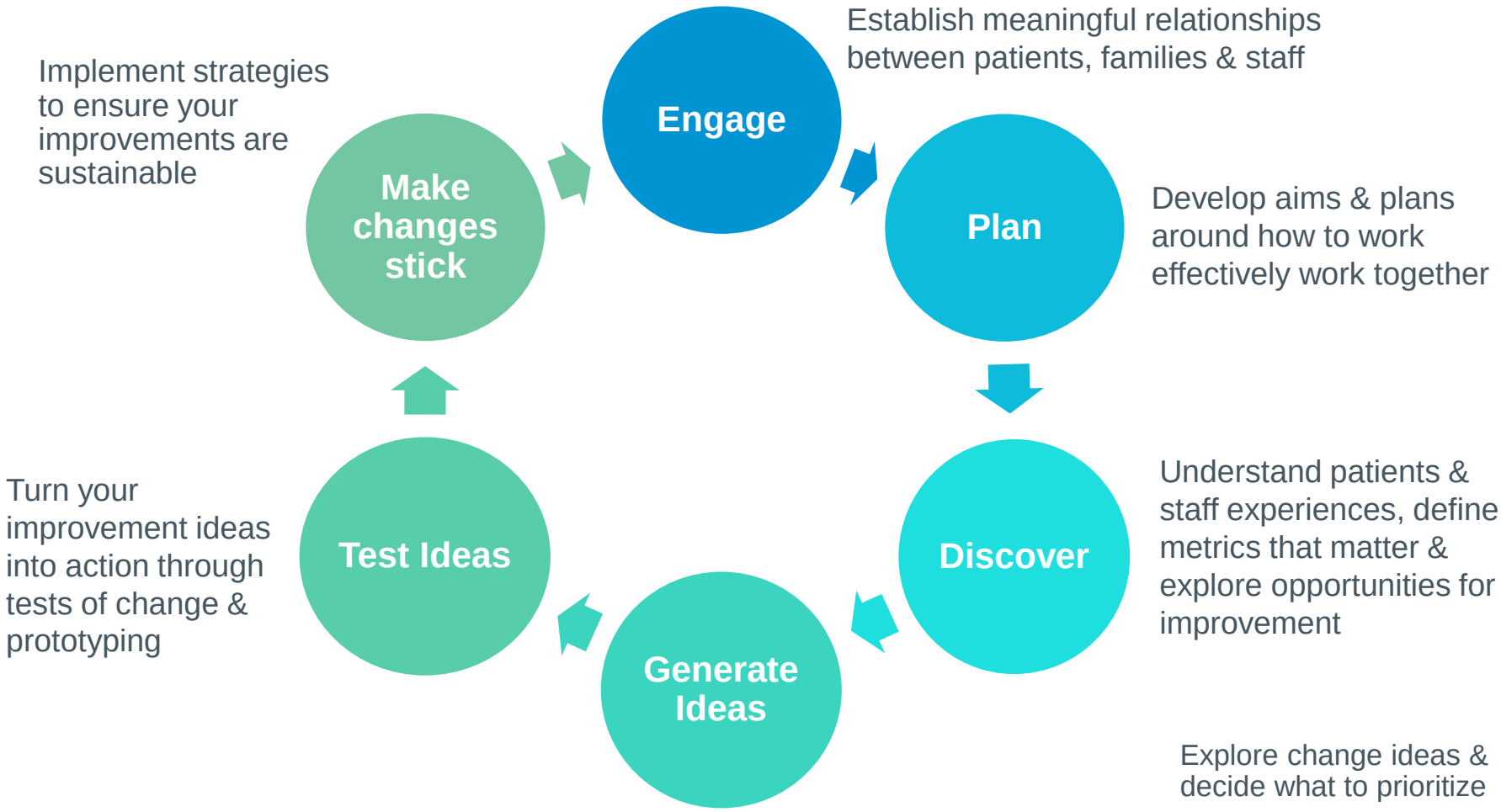
What is Co-design in healthcare?

"***Co-design*** *is a process and mindset that brings together patients & families, staff & clinicians, performance improvement experts & other improvement stakeholders to design new care and service offerings or improve existing ones."*

Reference: Kaiser Permanente



Co-design Method



MiPCT: Building the Patient Voice "In"

1. Program-Level Patient Advisory Council
2. Patient and Caregiver Presentations at MiPCT Events
   - Summit Keynote
   - Medicaid Health Plan/MiPCT Care Manager Synergy Sessions
3. Practice-Level Patient and Family Council (PFAC) Support and Training
4. Other Aspects
   - "E-Councils"
   - "Michigan Pathways" (Stanford Self Management) Awareness/Training

Advisor Roles

Role of patient and family advisors:

- Serve as sounding board for initiatives to establish balance with priorities of patients and families
- Generate new ideas to drive initiatives at all levels
- Decrease barriers to patient engagement
- Share best practices across regions
- Participate in program planning and evaluation
- Provide input on policies, programs, and practices
- Evaluate and give input on PCMH transformation and QI activities

Advisor Selection

Characteristics of Great Patient/Family Advisors:

- Comfortable speaking publicly with candor
- Able to use their own experience constructively
- Able to see beyond their own experience; concerned about more than one issue or agenda
- Able to listen and hear differing opinions

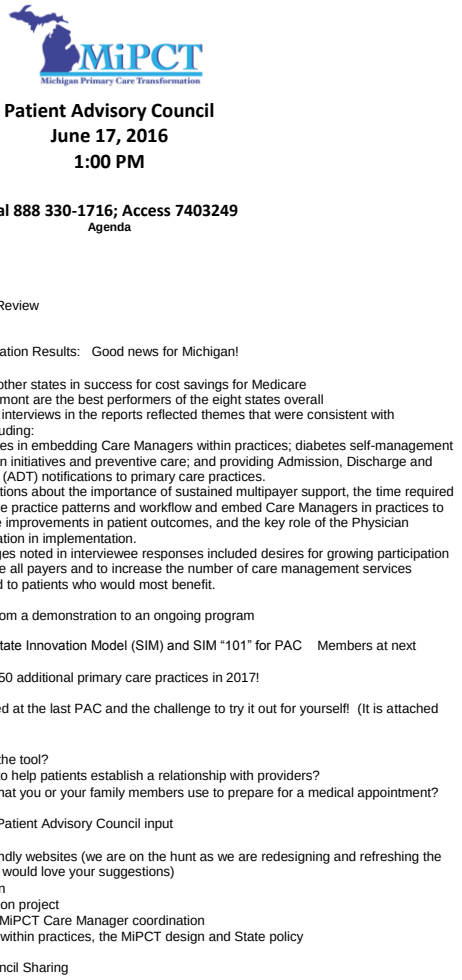
Best Practices to Support Members

- Convene in-person meetings where possible to build relationships
- Use social networking web-based applications
- Train advisors and “train the trainer” partners
- Provide committee members with a contact list
- Provide committee members with advisor to orient them

Remember, this type of collaboration is new for many people so preparation and orientation is important for care teams, as well as patients and family members.

Program-Wide Patient and Family Council

- Provided patient and family input into program design and operations during the MiPCT Demonstration
- Examples of issues taken to the PAC:
  - Patient experience survey question review
  - CAHPS-CG aggregate findings review
  - Community Health Worker integration
- All patients and family members had experience with MiPCT practices and care management servicing



MiPCT
Michigan Primary Care Transformation

Patient Advisory Council
June 17, 2016
1:00 PM

Dial 888 330-1716; Access 7403249
Agenda

1:00-1:05 Welcome

1:05-1:10 Minutes and Agenda Review

1:10-1:20 MiPCT National Evaluation Results: Good news for Michigan!

a. Michigan led the other states in success for cost savings for Medicare
b. Michigan and Vermont are the best performers of the eight states overall
c. Key stakeholders interviews in the reports reflected themes that were consistent with expectations, including:
   - Successes in embedding Care Managers within practices; diabetes self-management education initiatives and preventive care; and providing Admission, Discharge and Transfer (ADT) notifications to primary care practices.
   - Observations about the importance of sustained multipayer support, the time required to change practice patterns and workflow and embed Care Managers in practices to generate improvements in patient outcomes, and the key role of the Physician Organization in implementation.
   - Challenges noted in interviewee responses included desires for growing participation to include all payers and to increase the number of care management services delivered to patients who would most benefit.

1:20-1:30 Transition of MiPCT from a demonstration to an ongoing program

- Partnership with the State Innovation Model (SIM) and SIM "101" for PAC Members at next meeting
- Expansion to 100 to 150 additional primary care practices in 2017!

1:30-1: 40 ICAN Tool (I Can!) reviewed at the last PAC and the challenge to try it out for yourself! (It is attached below for easy reference)

- What did you think of the tool?
- How could it be used to help patients establish a relationship with providers?
- Are there other tools that you or your family members use to prepare for a medical appointment?

1:40-1:50 Upcoming Opportunities for Patient Advisory Council input

- Your favorite user-friendly websites (we are on the hunt as we are redesigning and refreshing the mipct.org website and would love your suggestions)
- Summit agenda design
- Medication reconciliation project
- Medicaid Health Plan/MiPCT Care Manager coordination
- Growing Patient input within practices, the MiPCT design and State policy

1:50-2:00 Other Patient Advisory Council Sharing

The "Voice of the Patient" MiPCT/GDAHC/IPFCC Partnership

A "Train the Trainer" Approach to Supporting PFAC Development in Michigan Practices

- Step One - Engage and Identify "Voice" Practices
  - Develop and host a joint webinar, explain options and offerings, benefits and expectations
  - Request interested practices to submit a response form for practices that wish to participate in the initiative

- Step Two – Train the Trainers
  - Train MiPCT and GDAHC staff
  - Offer trainings to responding practices

- Step Three – Initiate Program Implementation at the Practice Level

- Step Four – Collect outcomes and robustly share lessons through a learning network (MiPCT Practice Learning Credits awarded for participation)

"Voice of the Patient" (VOP) Initiative

Celebrating Our Practice Partners for Their Achievements in Starting Patient and Family Advisor Programs

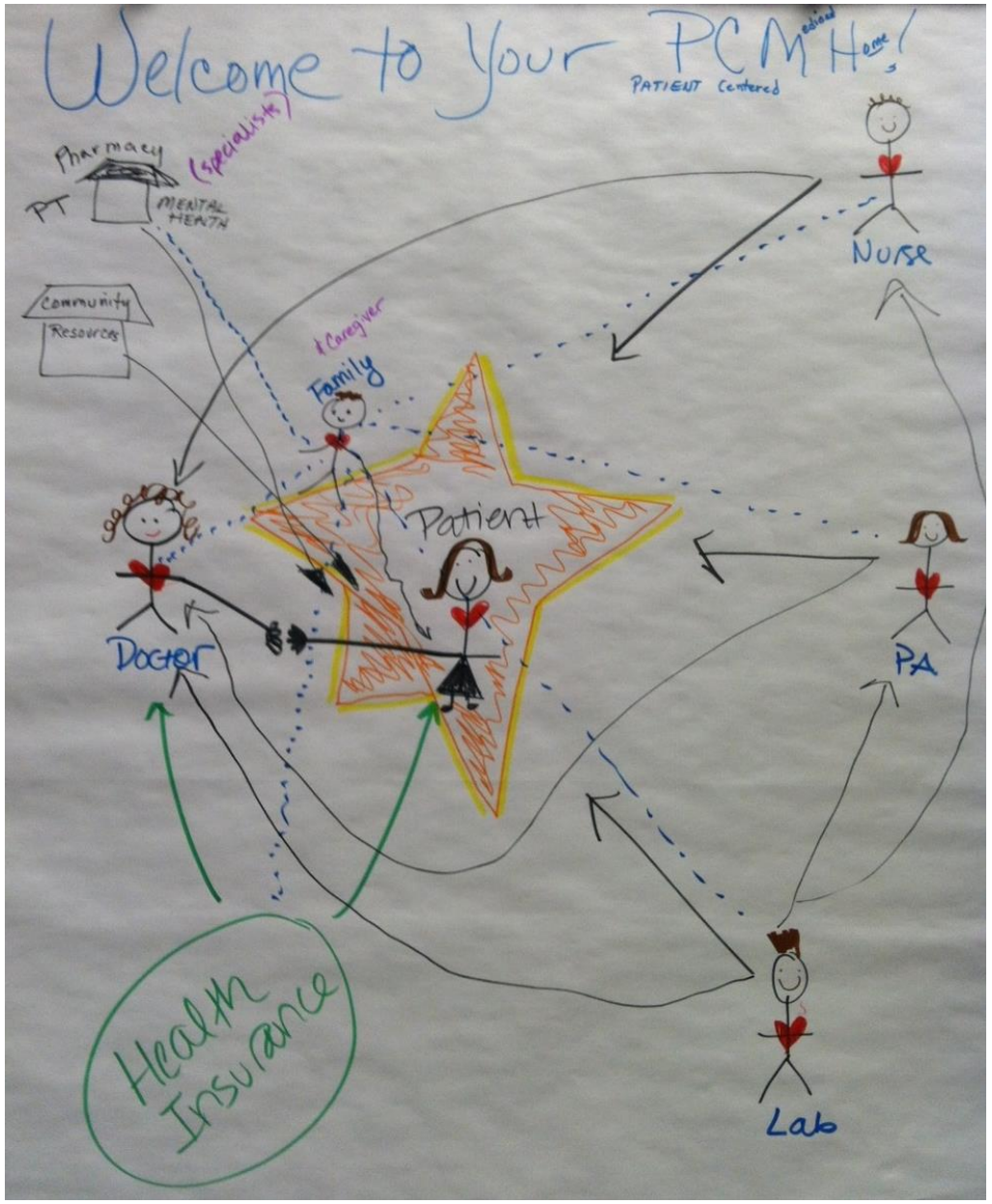
March 17, 2015

MiPCT/GDAHC/IPFCC

Practice “Celebration” Report Out -Example

What We Learned

- Starting a Patient and Family Advisory Council requires some work – and a continued commitment. If you give up too soon, you “throw the baby out with the bathwater”. The value that a council can return value to the practice builds over time.
- Use your advisors to get a sense from a patient’s perspective when your practice struggles with an area of patient engagement, or with a pattern of feedback/complaints from patients
- Tools provided to practices should be sculpted to the beginning small practice. Often many tools are geared toward large systems or inpatient environments.


Welcome to Your PCMH!
PATIENT Centered
Pharmacy
(specialists)
PT
MENTAL HEALTH
Community Resources
Caregiver
Family
Patient
Doctor
Nurse
PA
Lab
Health Insurance

Supporting Practices for PFAC Success

- Are you also a CPC+ practice? PFACS are a CPC+ requirement

- Prepare and position for success
  - Collect patient/practice interaction “frustration points” for a week or two
    - From the practice perspective (“I don’t know why patients can’t….”; “We have done all we can”; “ patient won’t comply”; etc.)
    - From the patient perspective (what do you hear the most concern about from patients? What annoys them? Catch yourself saying “that is just the way we do it”, etc.)
  - Talk about the big “why”, “what” and “how”
  - Recruit (staff, prospective patient reps)
  - Plan the agenda and logistics for the first meeting
  - Incorporate things that advisors want to discuss
  - Repeat again, review and improve, adjust if necessary

- Find early “quick win” areas that allow practices to reap benefit from patient and family input as a hook for expansion and greater adoption and let members see how their input becomes action that benefits other patients

Your Turn: Turning Pain Points into Progress!

Part One: From the Practice/PO/CHIR Perspective

- Do you ever think or hear “I don’t know why patients can’t….”; “We have done all we can, but they won’t comply”….
  - When?
  - What did that look like?

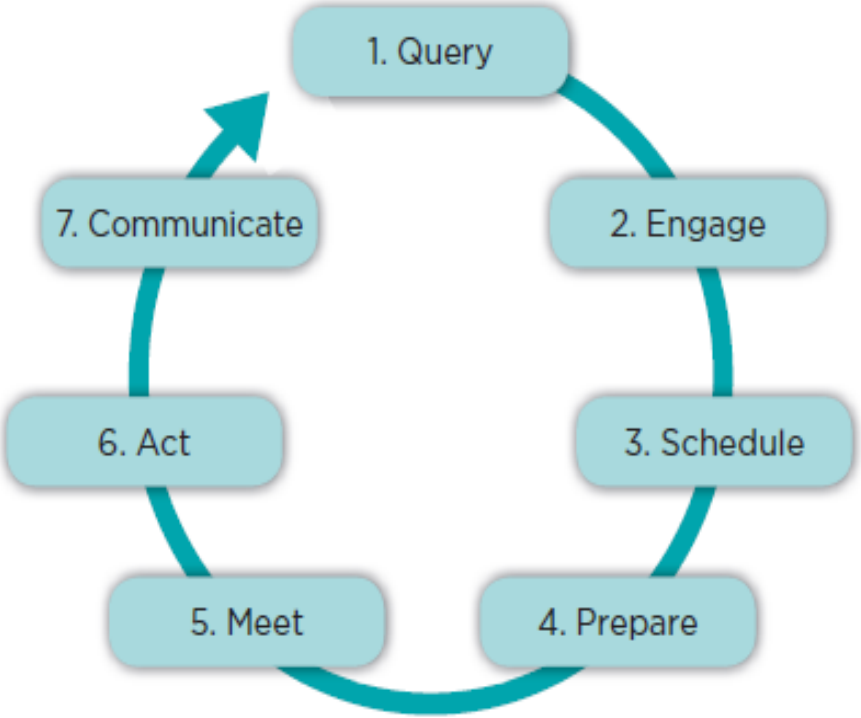
Part Two: From the Patient Perspective

- What do you hear the most concern about from patients? What annoys them? Catch yourself saying “that is just the way we do it”, etc.)

Share your thoughts with your neighbor!

Explore your aspirations!

Brainstorm 1-2 new ideas to try!



1. Query: Patient presents health question
- Patient can access system 24/7; system responds immediately
- Patient's concerns are respected

2. Engage: There is a collaborative process to answer question
- Communication is provided in an understandable and convenient way

3. Schedule: Patient can easily/quickly schedule consultation
- Patient can schedule care 24/7 and can do so online
- Rescheduling is easy and readily available
- New appointments can be synchronized with existing ones

4. Prepare: Patient can make preparations in the interim
- Needed prior approvals and forms are obtained automatically
- Needed lab tests are arranged and scheduled automatically
- New appointments can be synchronized with existing ones

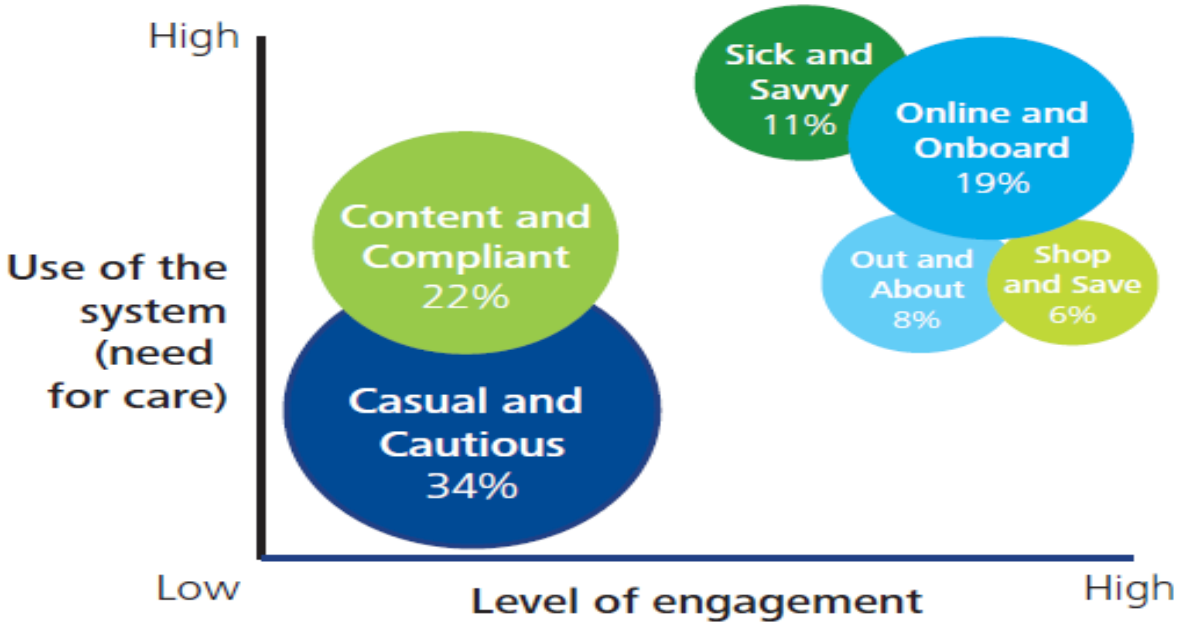
5. Meet: Patient has encounter with health care provider
- Encounter takes place in person, online or by telemedicine
- Encounter takes place on time; patient is given alternatives to waiting (when delays occur)
- Staff is respectful and courteous; exam space private and comfortable
- Team goes to patient

6. Act: The patient and provider take follow-up action
- Understandable visit summary is provided on patient portal and hard copy
- Team uses teach-back to insure patient understands critical information
- Rest of care team fully informed about visit
- Prescriptions are e-prescribed

7. Communicate: Patient has ongoing care from care team
- Any follow-up appointments are scheduled
- Care team checks in to answer questions or ensure follow-up care

Source: Institute of Medicine (IOM) Framework for Patient and Family Engagement: Care, Scheduling, Delivery, and Follow-Up
(Released July 13 2015 in "Transforming Health Care Scheduling and Access: Getting to Now)

Consumers' Use of the Healthcare System and Level of Engagement by Segment



Source: Deloitte Center for Health Solutions Survey of US Health Care Consumers, 2015

LUNCH

Institute *for* Healthcare Improvement

Population Health Management

Trissa Torres, MD, MSPH
Chief Operations and North America Programs Officer

Agenda

Definitions

Approach

Segmenting your population

Understanding your population segment

Next step… redesigning care

What Matters

Population Management

The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and health outcomes for that group of people.

Lewis, Ninon. "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." *IHI Leadership Blog*. Institute for Healthcare Improvement, 19 Mar. 2014.

Population **Health** Management

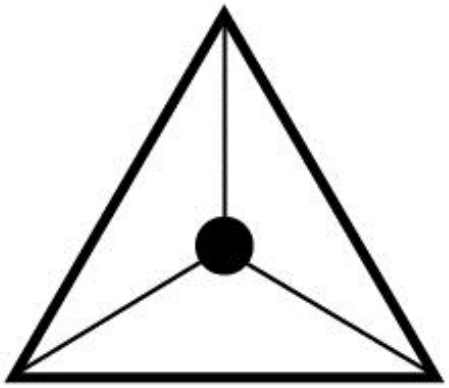
*The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and **health** outcomes for that group of people.*

Lewis, Ninon. "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today." *IHI Leadership Blog*. Institute for Healthcare Improvement, 19 Mar. 2014.

Agenda

- Definitions
- Approach
- Segmenting your population
- Understanding your population segment

Next step… redesigning care

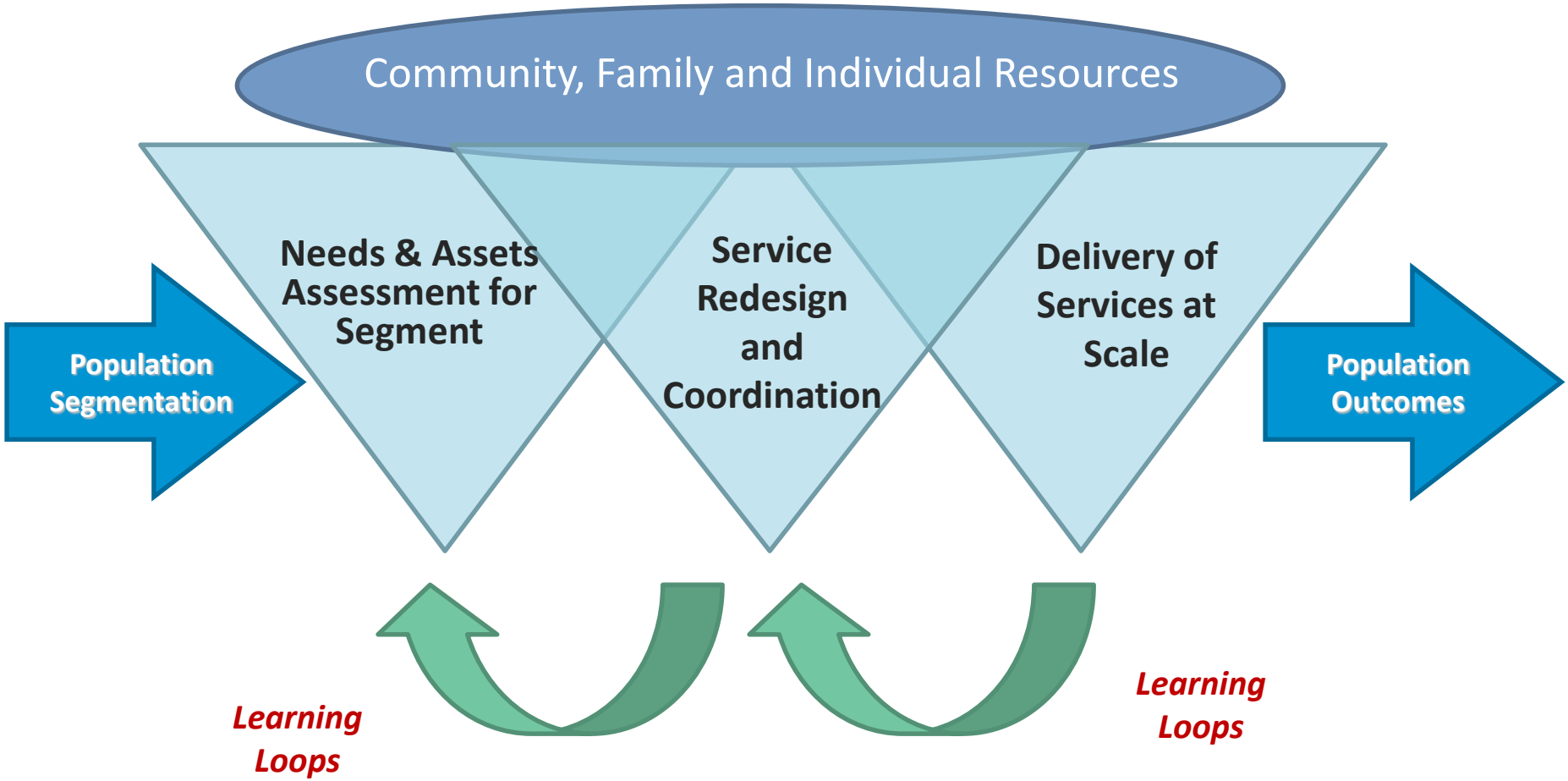


- System designs that simultaneously improve three dimensions:
  - Improving the **health** of the populations;
  - Improving the patient experience of **care** (including quality and satisfaction); and
  - Reducing the per capita **cost** of health care.

Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs. 2008 May/June;27(3):759-769

Whittington, John, Kevin Nolan, Ninon Lewis, and Trissa Torres. "Pursuing the Triple Aim: The First 7 Years." *Milbank Quarterly* 93.2 (2015): 263-300

Approach to Population Health Management



Approach to Triple Aim for Populations

- Choose a relevant ***Population*** for improved health, care and lowered cost
- Conduct a ***Needs and Assets Assessment***
- Design or ***Redesign Services*** to meet the needs of the population
- Develop a ***Portfolio*** (group) of projects that will yield Triple Aim results
- Create a ***Learning System*** and ***Measures*** that will show improvement for the population
- Build a ***Team*** of individuals who can manage this work
- Use ***Improvement Methods*** to drive results
- Develop a brisk and realistic plan for ***Execution*** and ***Scale***

Whittington, John, Kevin Nolan, Ninon Lewis, and Trissa Torres. "Pursuing the Triple Aim: The First 7 Years." *Milbank Quarterly* 93.2 (2015): 263-300.

Agenda

- Definitions
- Approach
- Segmenting your population
- Understanding your population segment

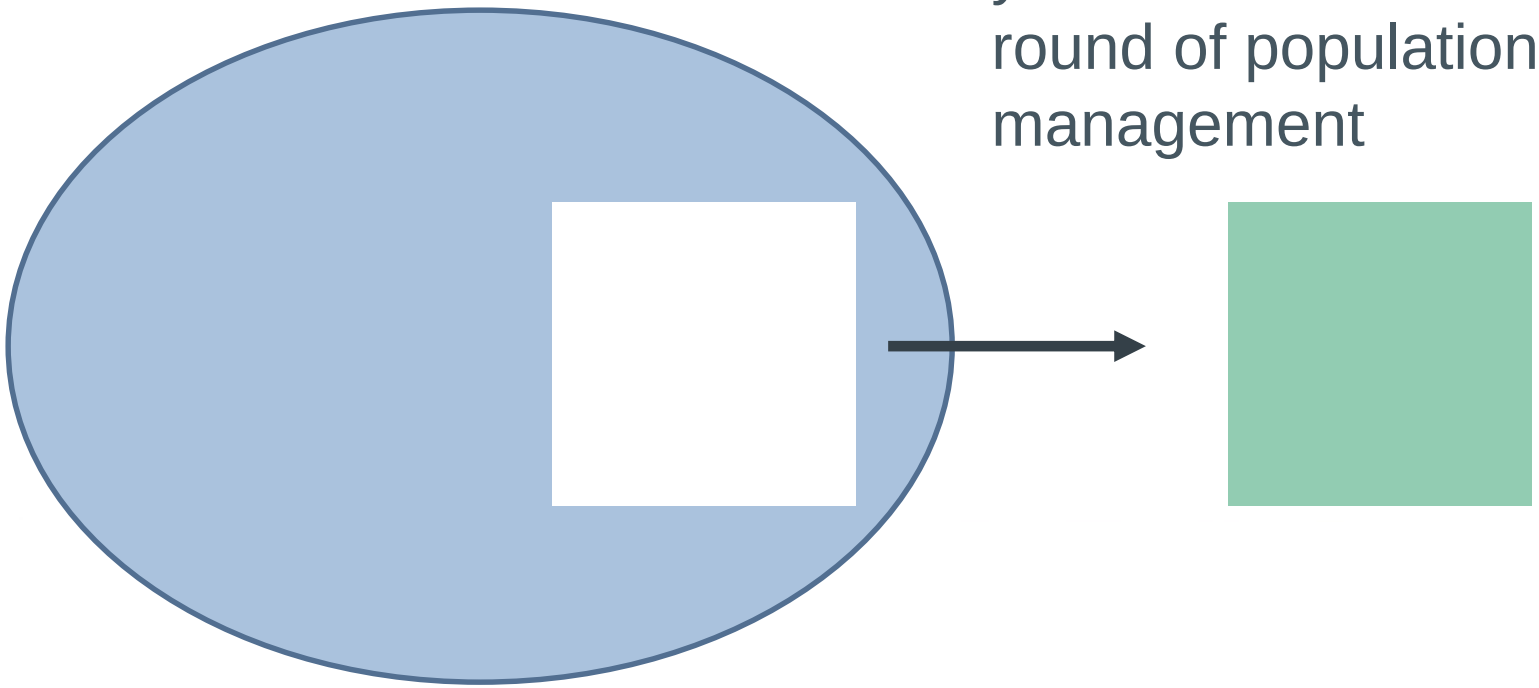
- Next step… redesigning care

Total Population to Target Population

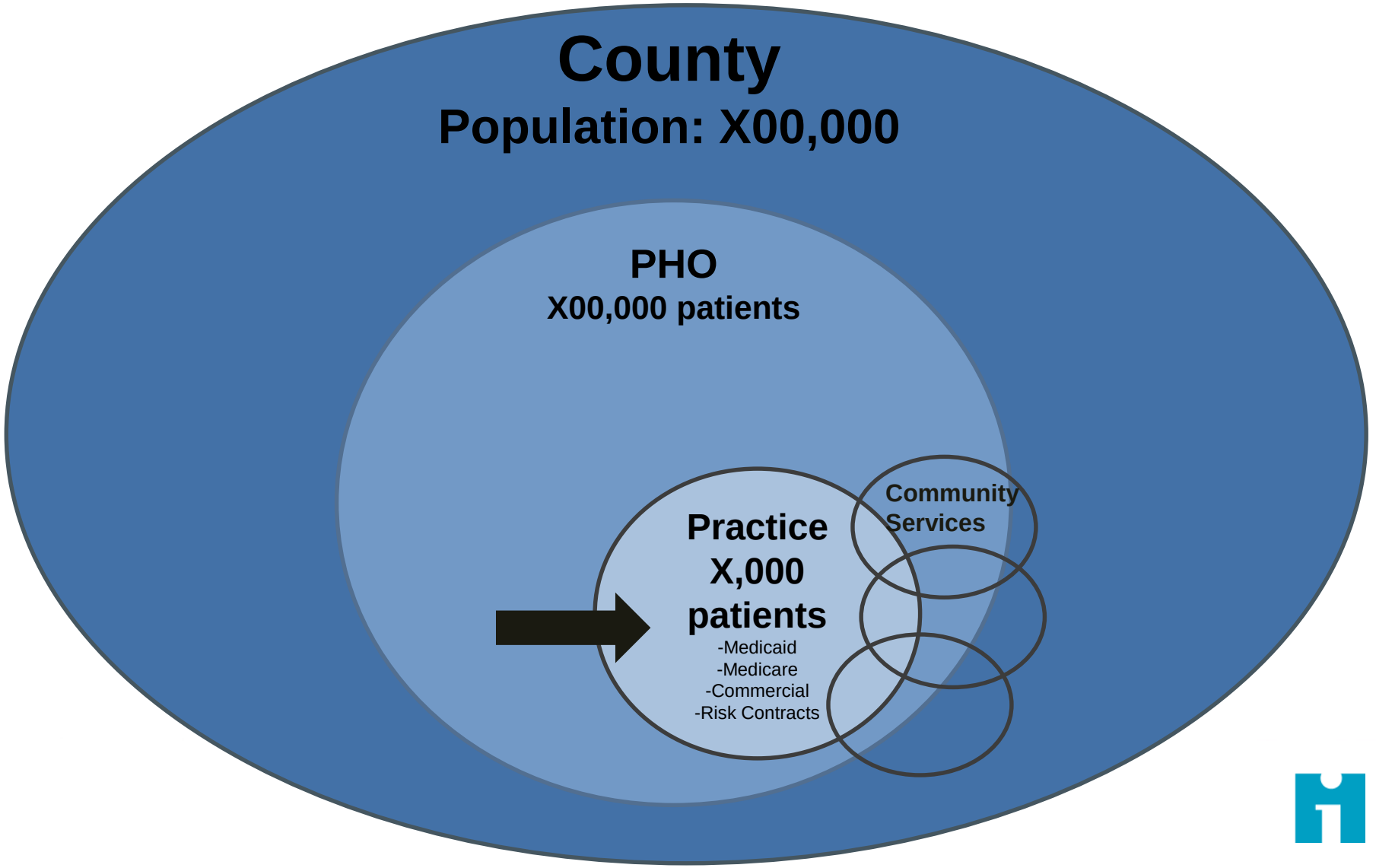
- How do you currently understand your total population?
- Choose a target population segment

Total Population
Everyone in your reach

Target Population:
People (with identified characteristics) who you will focus the next round of population management



Understand Your Total Population



Choose a Target Population Segment

Disease Burden

- Generally healthy
- Acute episode (expect full recovery)
- Behavioral risk factors and/or chronic disease(s) well managed
- High risk and/or high cost
  - Multiple chronic diseases and/or social risk factors
  - Disability
  - Frail
  - End of life

Stage of Life

- Children
- Pregnant Women
- Young Adults
- Older Adults

Lynn, Joanne et al. “Using Population Segmentation to Provide Better Health Care for All: The ‘Bridges to Health’ Model.” The Milbank Quarterly 85.2 (2007):

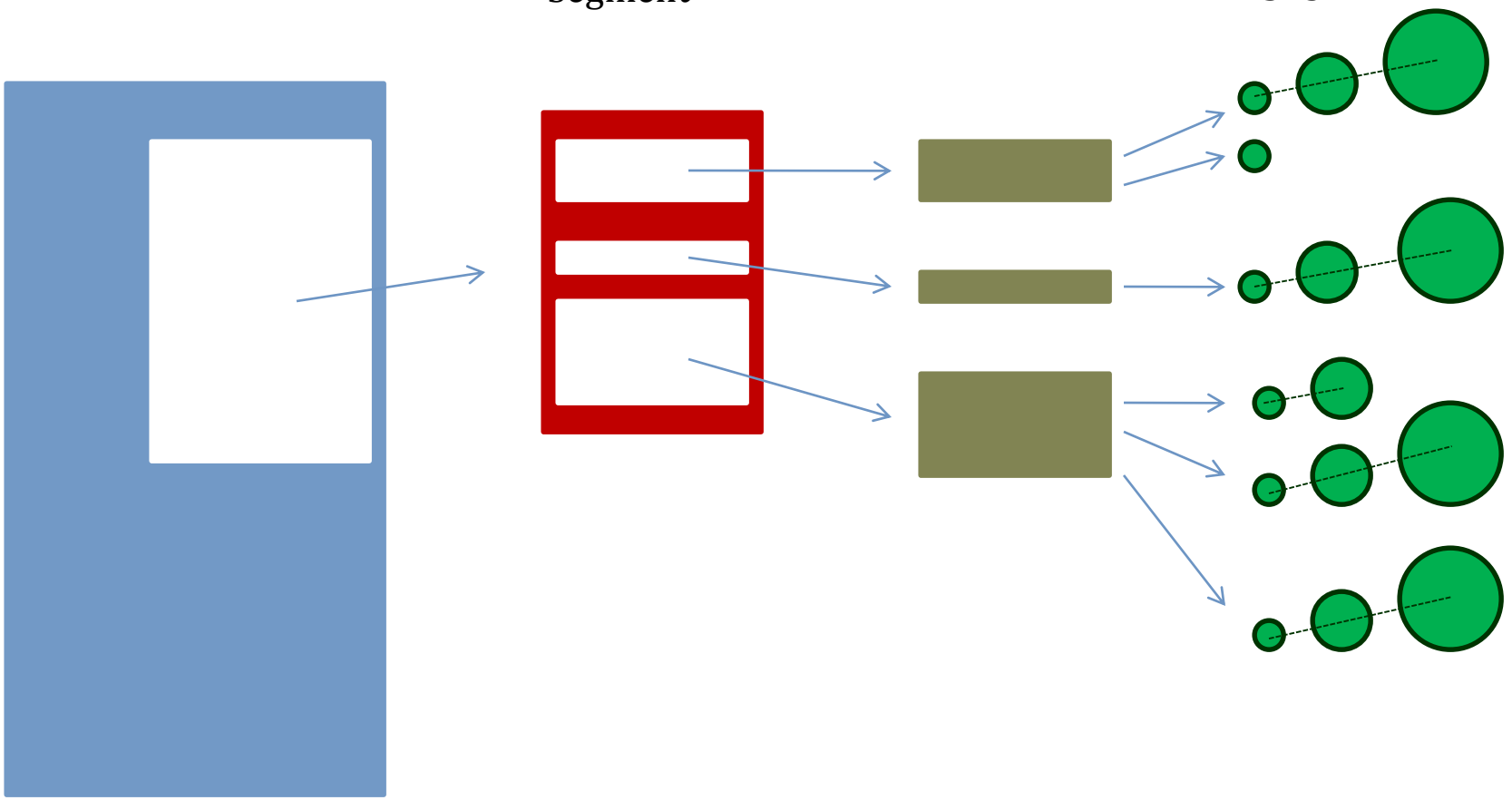
Considerations

- Prevalence
- Burden on the system
- Ability to identify and engage
- Ability to track and measure
- Ability to impact
- Partners and resources to support

Know your AIM

Moving from Population Segmentation to Care Redesign

Know your AIM

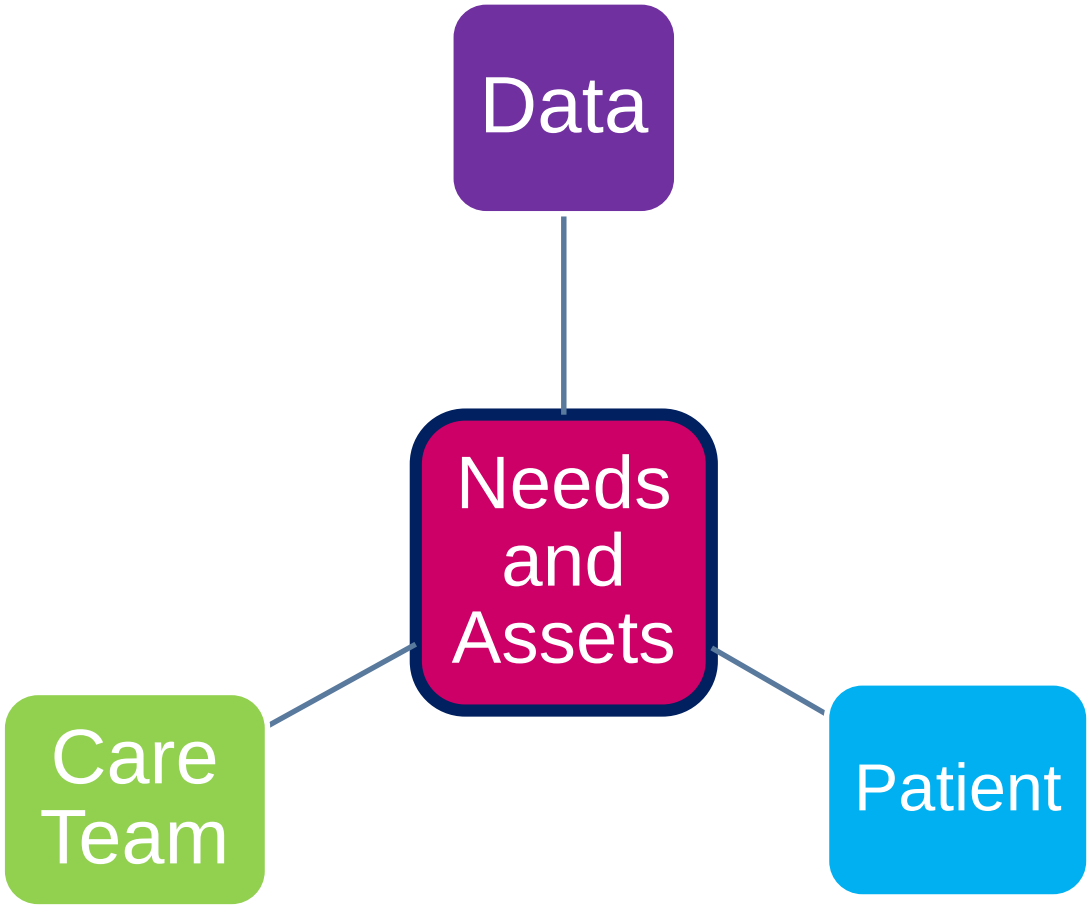


Agenda

- Definitions
- Approach
- Segmenting your population
- Understanding your population segment

Next step… redesigning care

Understanding Needs and Assets

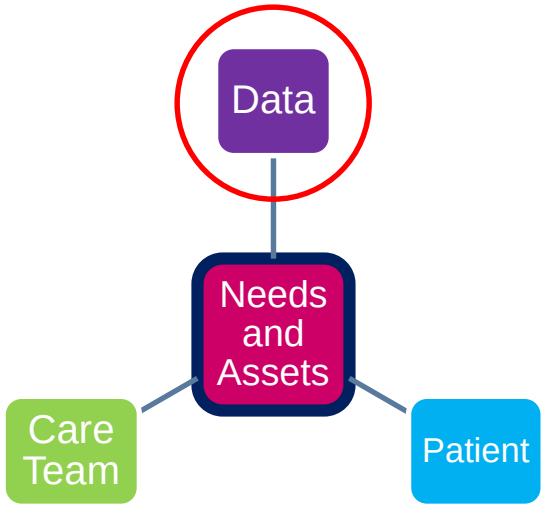


3 Part Data Review

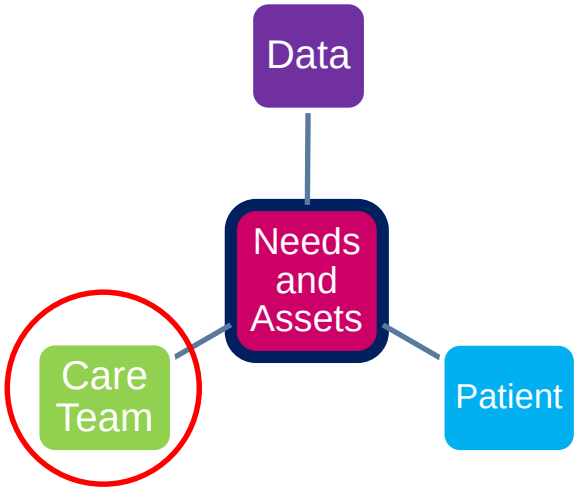
1. Review available data on your selected target population segment (and/or individuals from that segment)
2. Interview care providers to learn their perspective
3. Interview patients in the select target population to learn their perspective

Data Review: How-to

- **Review available data from HIT systems***
  - Claims/utilization data from payer or your own system (inpatient, ED, primary and specialty care visits, pharmacy)
  - Behavioral health encounter/claims data
  - EHR
  - Demographics
- **Generalized data in the literature and/or your county** (countyhealthrankings.org)



Ask the Care Team: How-to



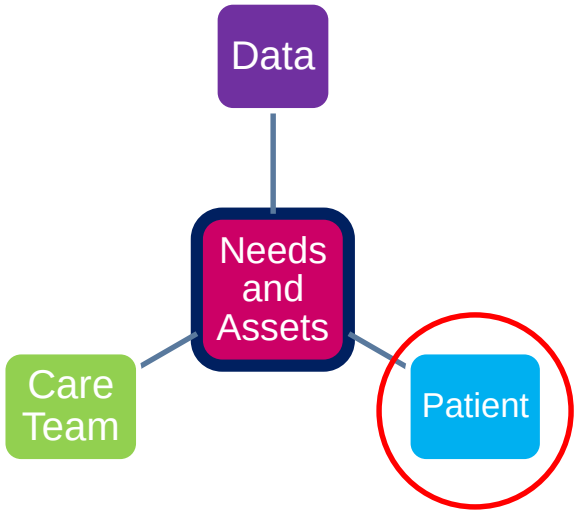
For this target population:

- What are the biggest challenges to managing these patients?
- What is working well?
- What needs do these patients have that are outside the scope of our services?
- What do you think could have the biggest impact on fostering better outcomes with these patients?

Ask the Patients: How-to

Deep listening with patients

- Use a semi-structured set of questions to gain insight into patient perspectives
  - What is working well about how you engage with us?
  - What is most helpful in managing your condition(s)?
  - What do you need that you are having trouble accessing?
  - What do you wish we could do better or differently?
- Come together as a team to discuss what was learned
- Identify similarities, differences, and common themes
- Use an ecomap to map assets and needs



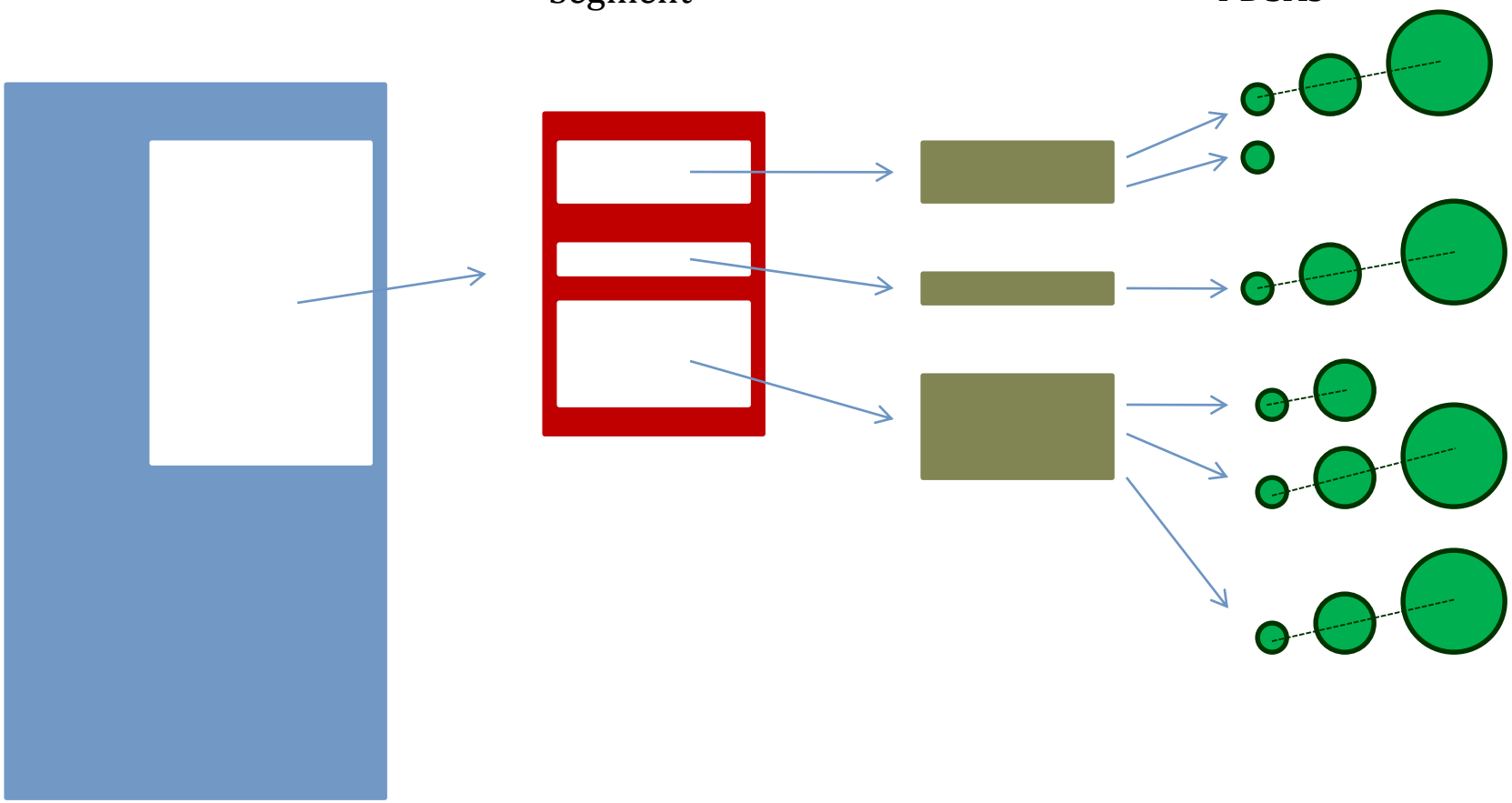
Design with the individual…
Learn for the population

Design for the population…
Adapt with the individual

From one to many

Moving from Population Segmentation to Care Redesign

Know your AIM



Agenda

- Definitions
- Approach
- Segmenting your population
- Understanding your population segment

Next step… redesigning care

MI SIM

- Implement regular reviews of targeted patient population needs including access to reports that show unique characteristics of the Practice's patient population. *(data review)*

- Identify vulnerable patients and demonstrate how clinical treatment needs are being tailored, if necessary, to address unique needs. *(interventions)*

Group Work

To Do:

- Choose a target population segment
- Understand the needs and assets of your population segment
- What possible interventions (including but not exclusive to clinical community linkages) could help improve outcomes for this population segment?

BREAK

Institute for Healthcare Improvement

Organizing Your Ideas/Theories

Building to Team Time: Leaving in Action with Your Next PDSA(s)

Objectives

- Learn how the Driver Diagram can be a way to organize theories and change ideas.
- Plan your next PDSA(s)
  - Includes a “refresher” ☺

What's YOUR Theory?

Driver diagram serves as tool for building and testing theories for improvement

by Brandon Bennett and Lloyd Provost

In 50 Words Or Less

- A driver diagram is an applicable tool for many contexts, from improving process reliability to redesigning a service to creating new products to generating enhanced user experience.
- The tool visually represents a shared theory of how things might be better, building upon knowledge gleaned from research, observation and experience.

At least it appears that we must accept a kind of double truth: There are certainties, such as those of mathematics, which concern directly what is only abstract; and there are the presentations of our sense-experience to which we seek to apply them, but with a resultant empirical truth which may be no more than probable. The nature and validity of such empirical knowledge becomes the crucial issue.
—C.I. Lewis[1]

IN *THE NEW ECONOMICS*, W. Edwards Deming articulated "a view from outside" that he believed was a high-level complement to subject matter expertise in the pursuit of improvement—his system of profound knowledge.[2] Deming outlined four elements—appreciation of the system, understanding variation, psychology and the theory of knowledge—which provide insight into how improvement can occur.

IHI Open School Short:

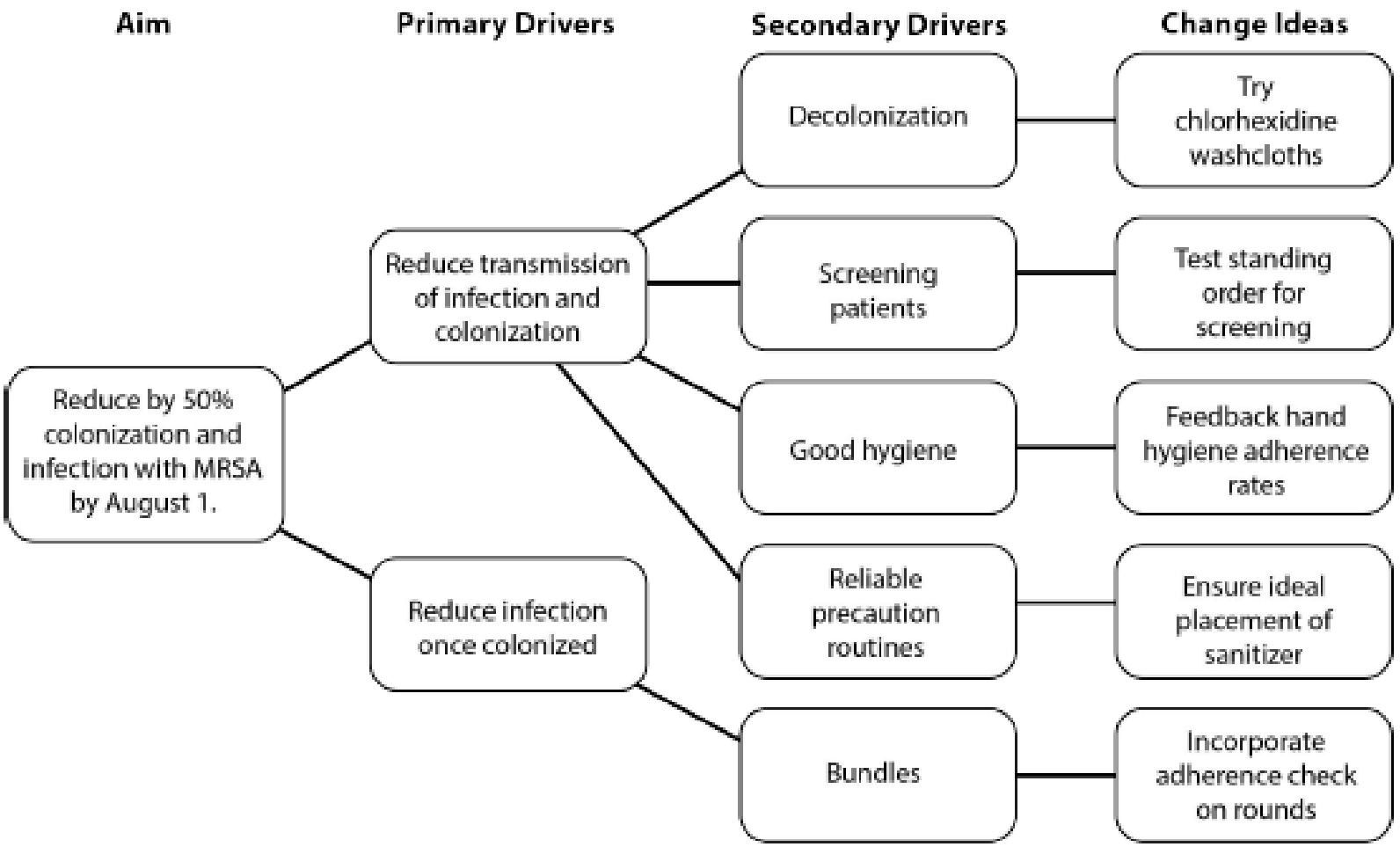
How do you use a driver diagram?

Donald Goldmann, MD

Medical & Scientific Officer, IHI

https://www.youtube.com/watch?v=yfcE_Q-IRFg

Example: Driver Diagram



Institute for Healthcare Improvement

Perinatal Community:

Reducing Harm, Improving Care, Supporting Health

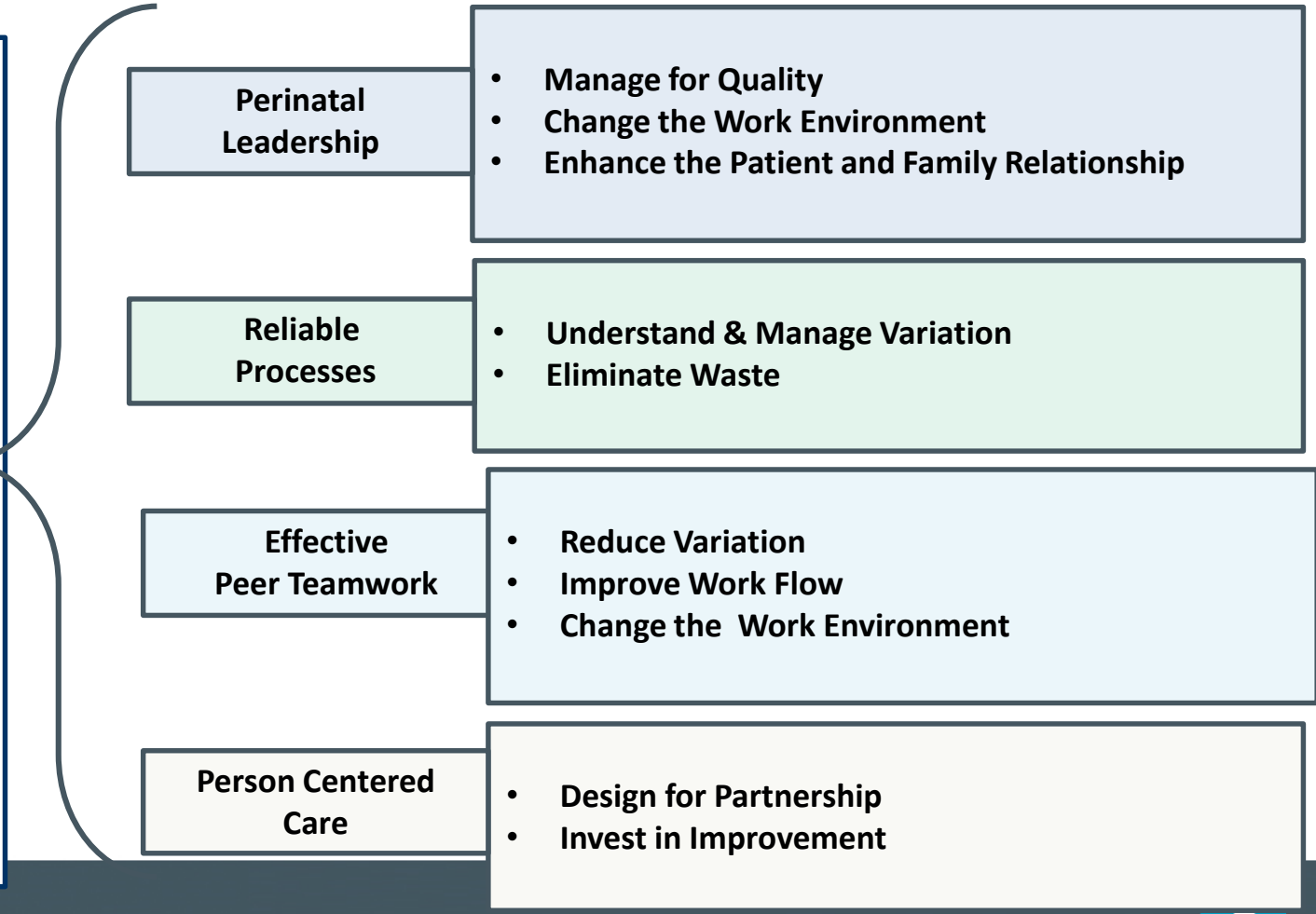
Reduce harm to 5 or less per 100 live births

Zero incidence of elective deliveries prior to 39 weeks

Augmentation Bundle(s) Composite or Compliance great than 90%

Improve organizational culture of safety survey scores in Perinatal units by 25%

100% of participating teams will have documentation of Patient & Family Centered Care



* See Perinatal Community Measurement Strategy

DRAFT

Aim

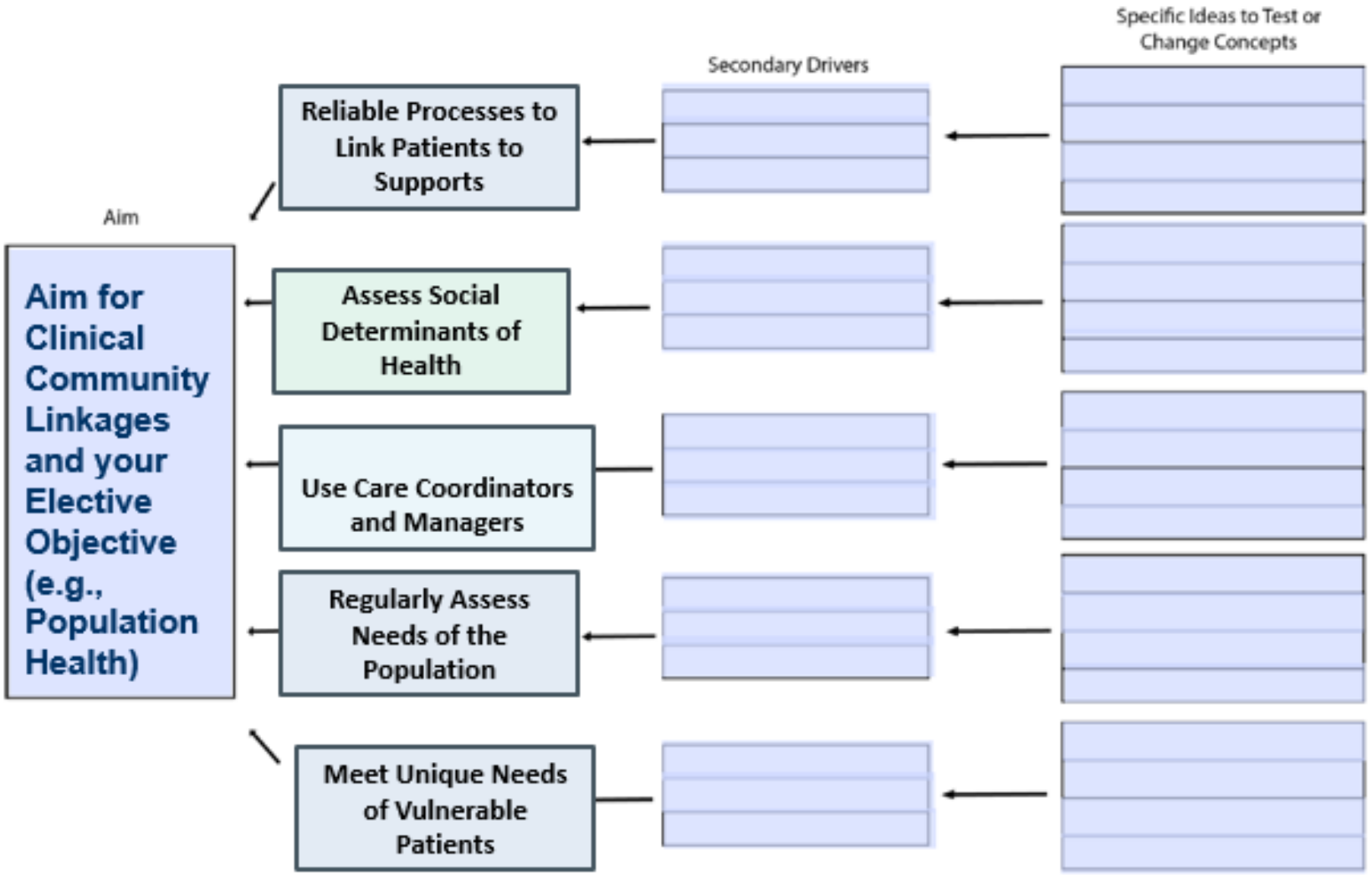
By July 31, 2019, expand the Patient Centered Medical Home Model throughout MI for up to 250 participants with a focus on an improved patient centered delivery system and a payment model that will provide and support patient-centered, safe, timely, effective, efficient, equitable, and accessible health care.

Primary Drivers	Secondary Drivers
* Clinical-Community Linkages	Reliable processes to link patients to supports
	Assess Social Determinants of Health
	Use Care Coordinators & Managers
Access	** Telehealth Adoption
	** Group Visits
	** Patient Portal
Activated Patients and Care Teams	** Improvement Plans from Patient Feedback
	**Self Management Monitoring & Support
	** Integrated Peer Support
Continuity/ Continuum of Care	** Medication Management
	** Integrated Clinical Decision Making
** Population Health Management-Knowing & Co-Managing Patients	** Care Team Review of Patient Reported Outcomes
	** Cost of Care Analysis
	Regularly assess needs of population
	Meet unique needs of vulnerable patients

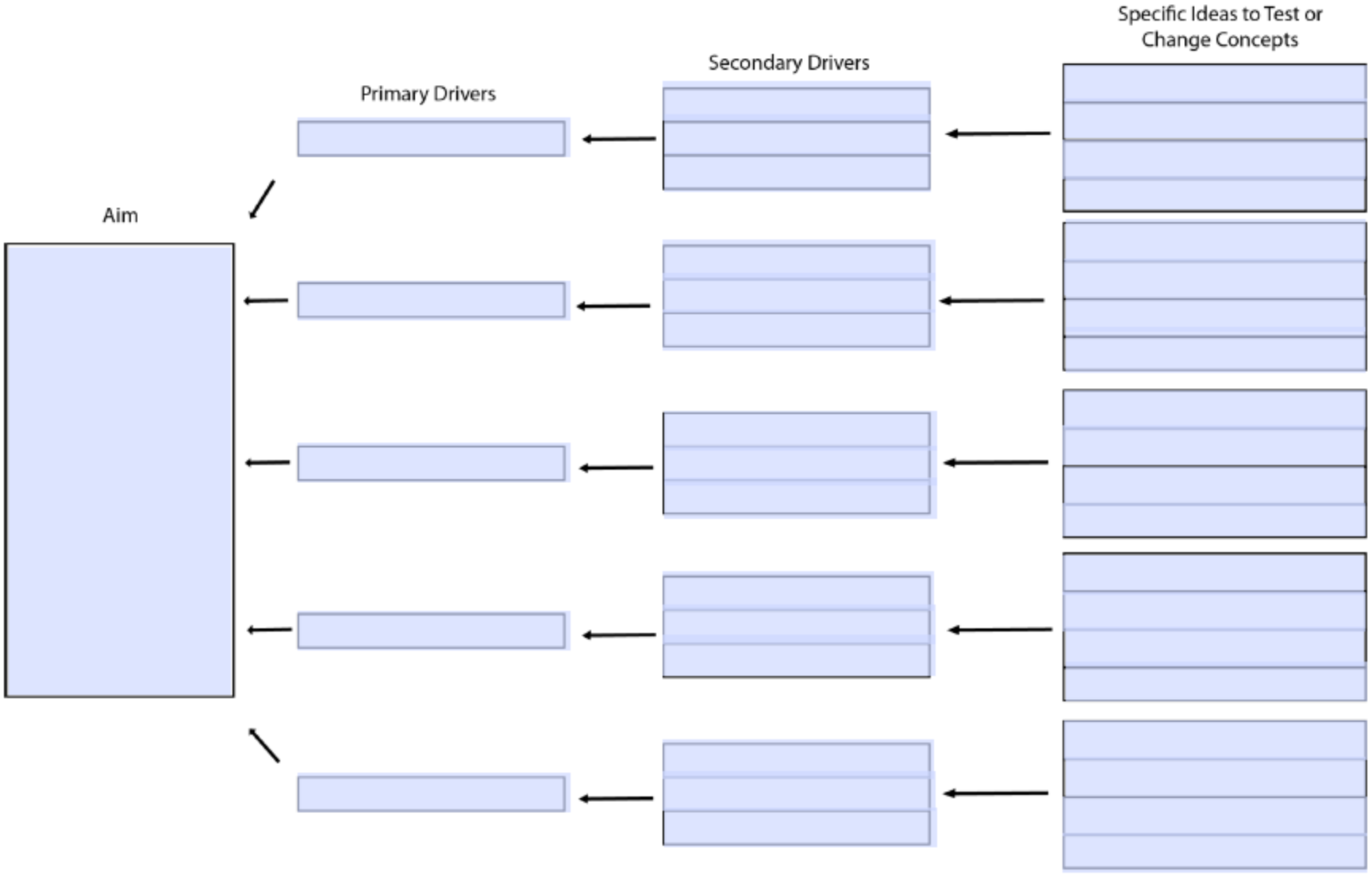
* Required objective for all participants.
** Elective objectives for participants.

How you might use…

Template: Driver Diagram

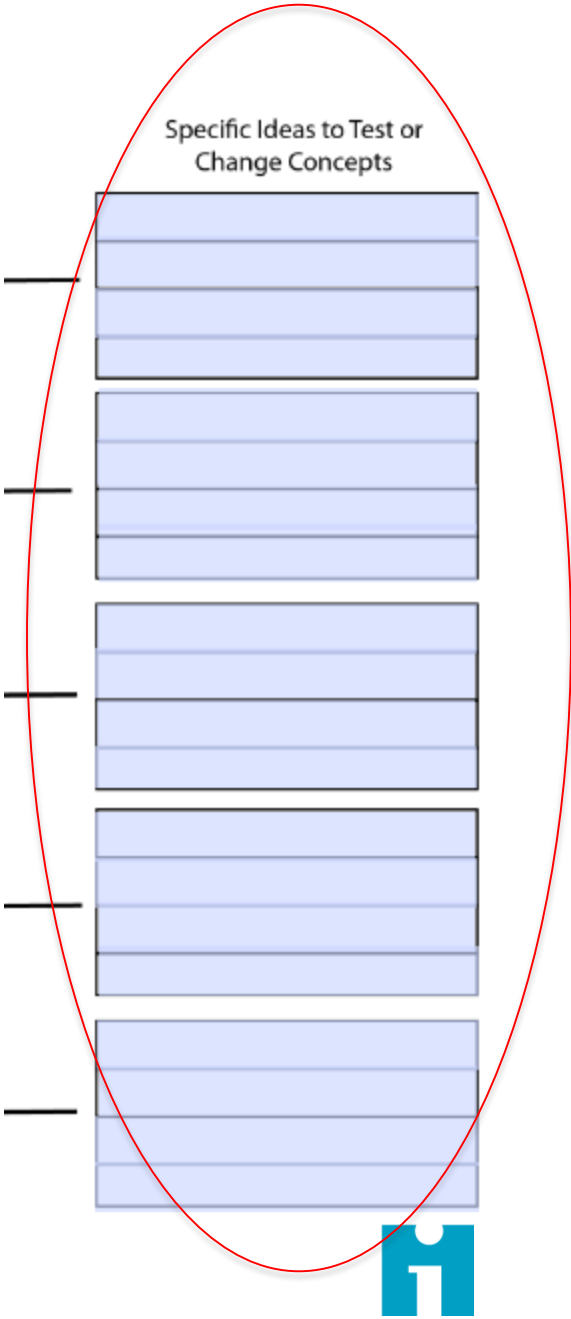


Template: Driver Diagram



Template: Driver Diagram

And we take these ideas and test using



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.

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.

PDSA Tip: “Oneness”

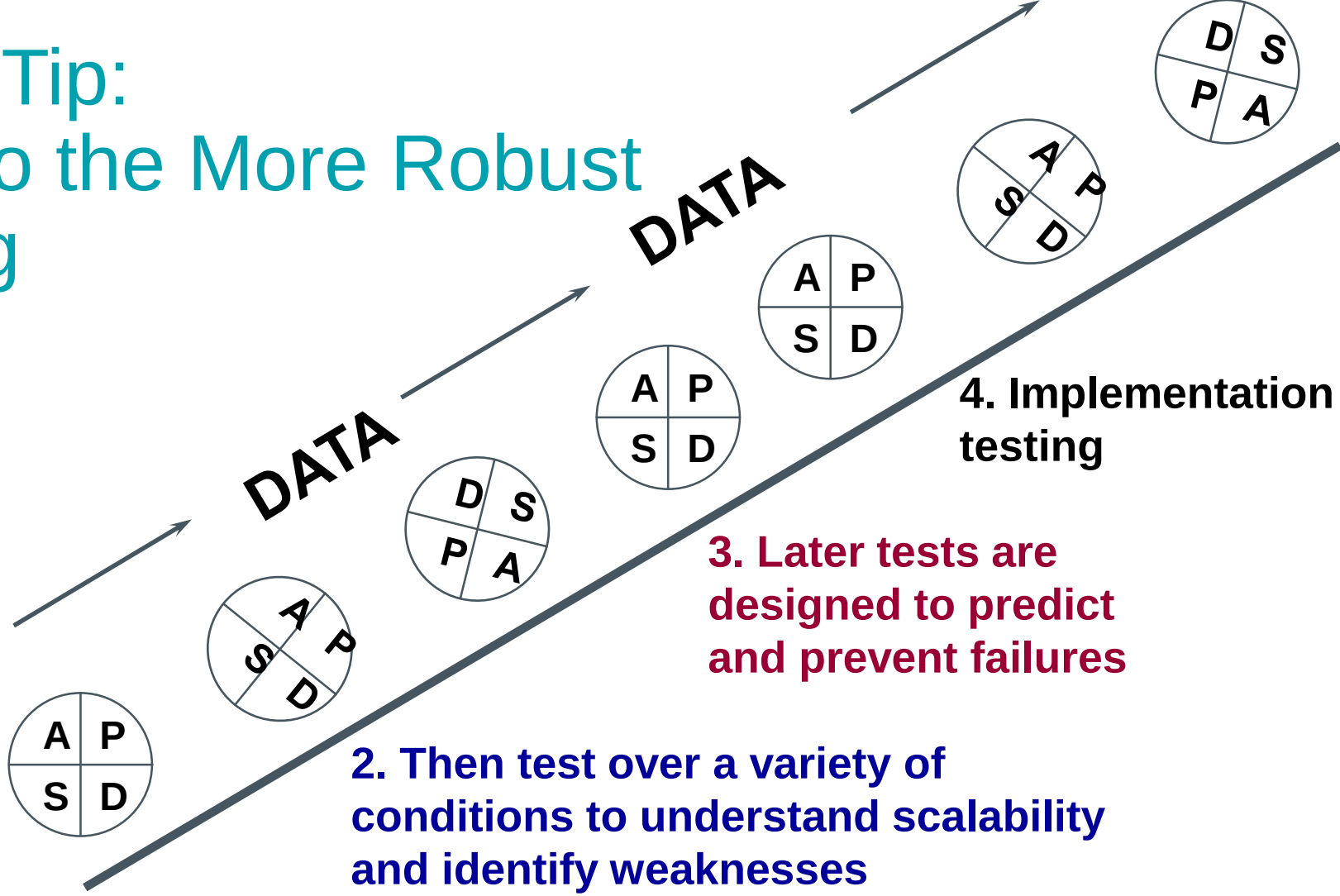
How small? Appropriate Scope for next PDSA Cycle

(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

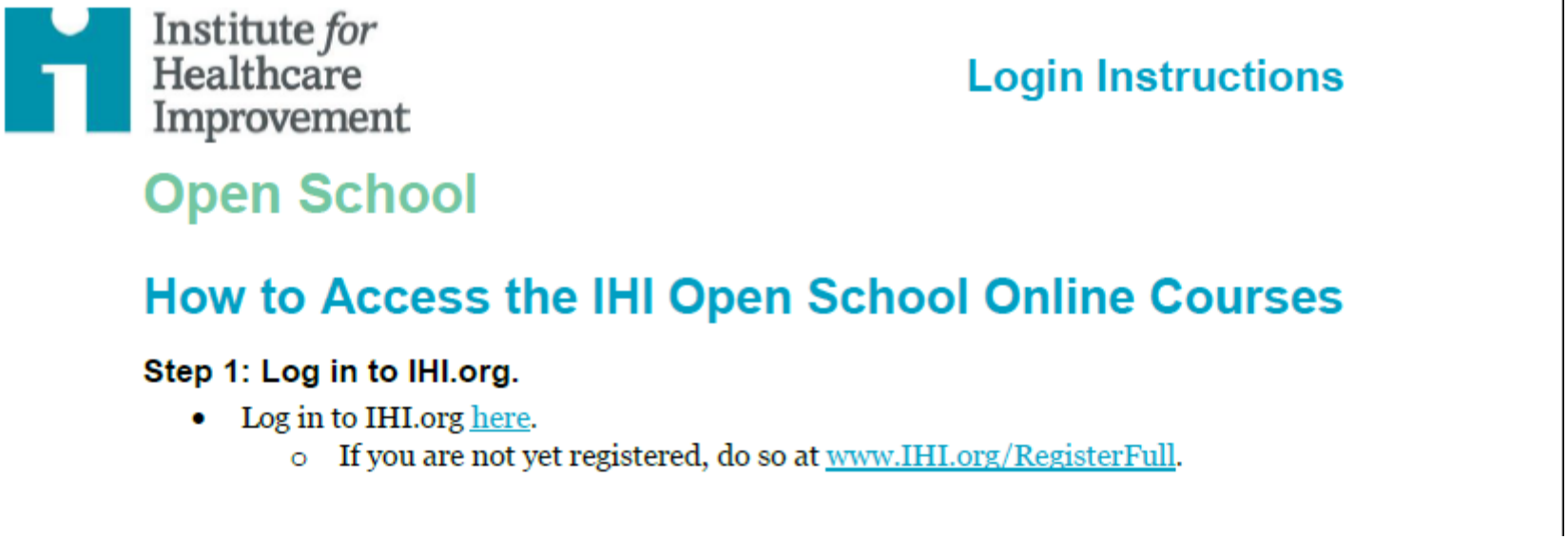
Your Turn…

- Using the PDSA handout, complete the “Plan” portion for something that you will test by next Tuesday.
- Remember, think small—think one patient, one assessment, one community partner, one time…

Institute for Healthcare Improvement

Close, Q&A, Evaluate

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



Institute for Healthcare Improvement

Login Instructions

Open School

How to Access the IHI Open School Online Courses

Step 1: Log in to IHI.org.

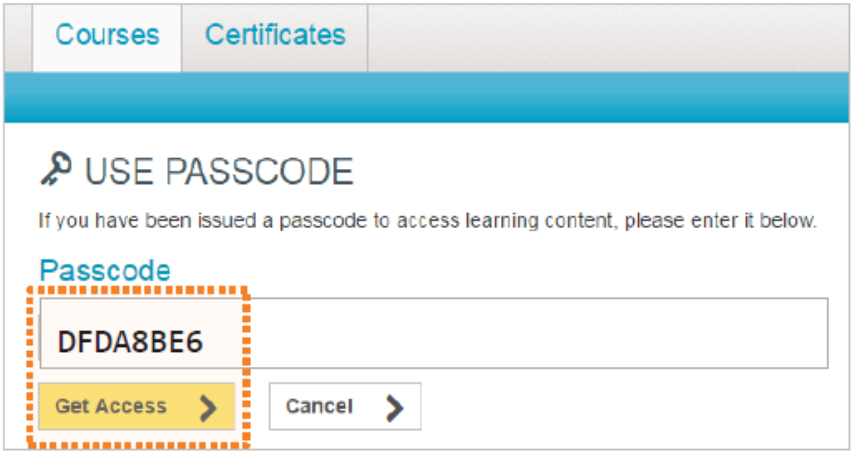
- Log in to IHI.org here.
  - If you are not yet registered, do so at www.IHI.org/RegisterFull.

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

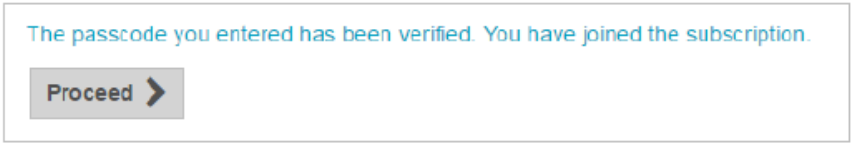
Step 2: Enter your group's passcode.

- 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

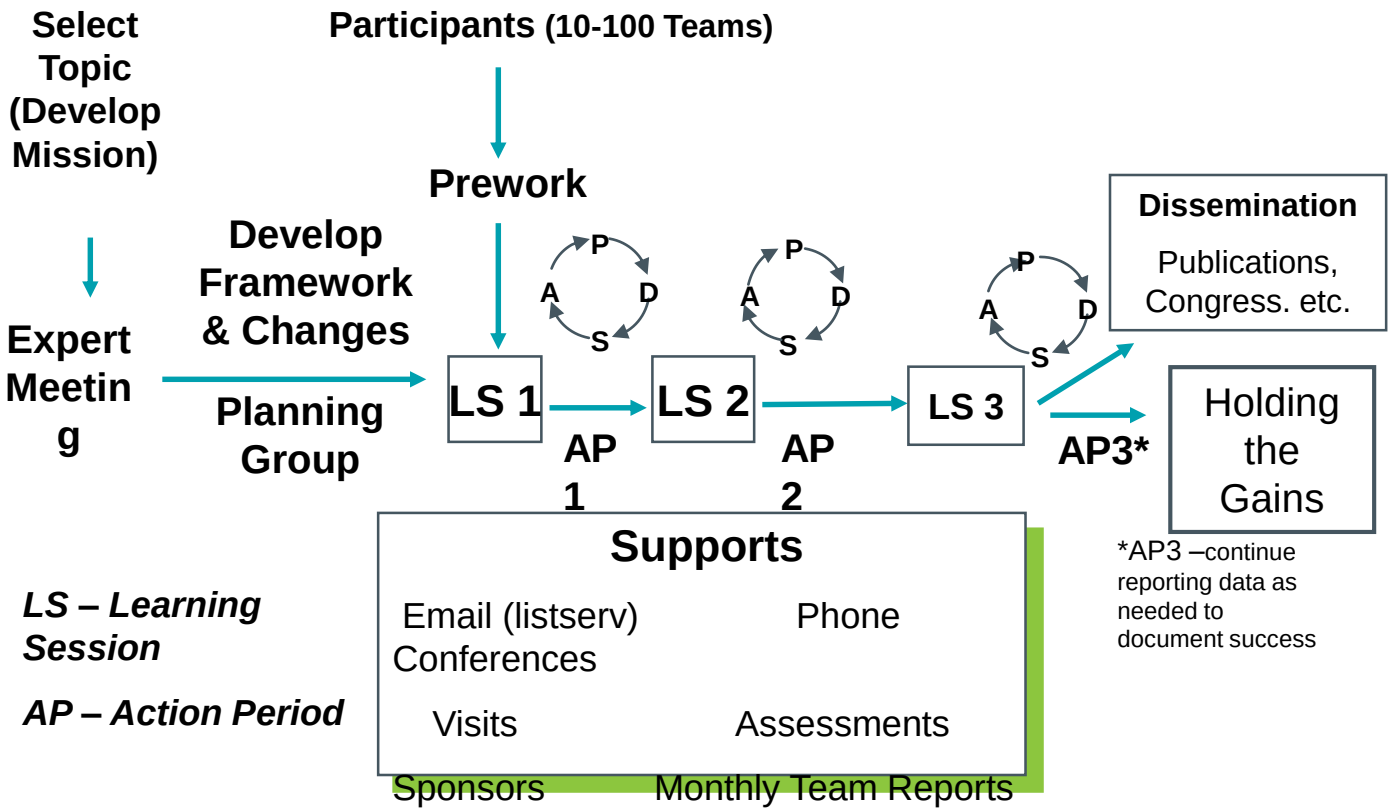
This three-lesson course will explore health disparities — what they are, why they occur, and how you can help reduce them in your local setting. After discussing the current (and alarming) picture in Lesson 1, we'll dive into Lesson 2 and learn about some of the promising work that is reducing disparities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

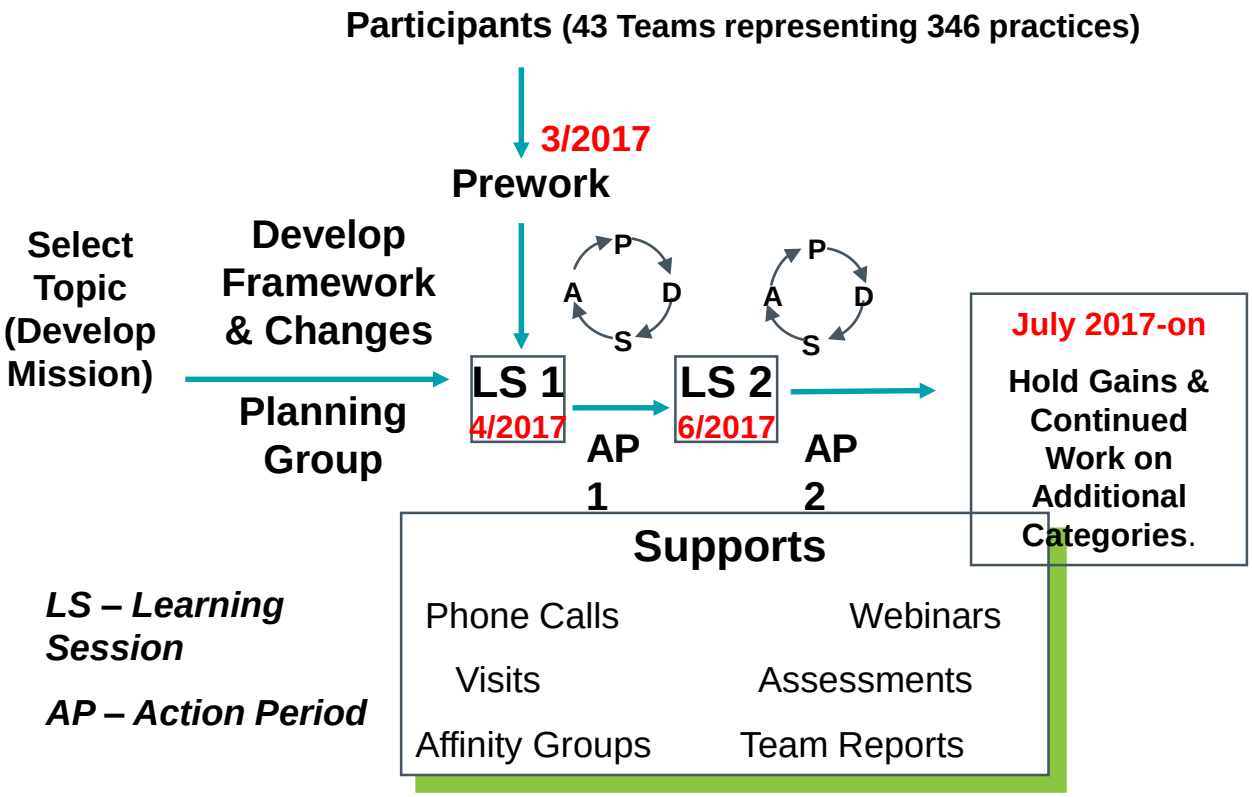
After completing this course, you will be able to:

- 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 Call:
  - Thursday, July 13, 2017
- Next Coaching Calls:
  - July 18-21, 2017