

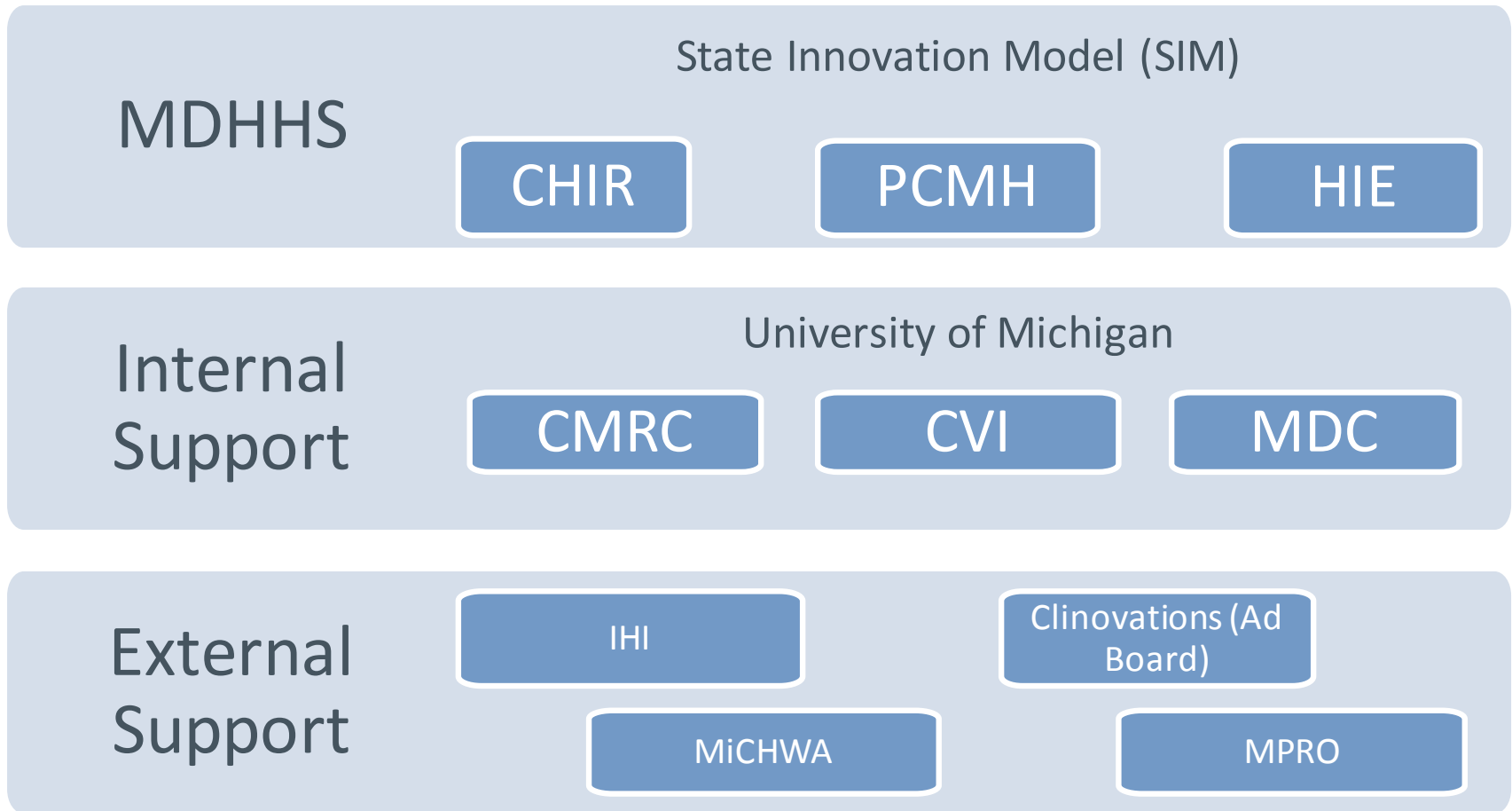
MI PCMH Initiative Practice Transformation Collaborative

Webinar #1: Kick Off



March 9, 2017

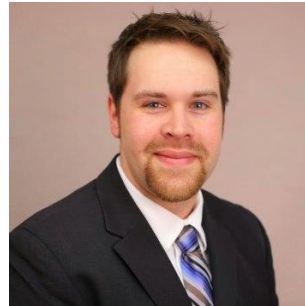
SIM PCMH Initiative Team Structure



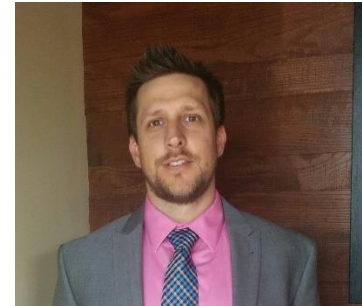
The MDHHS PCMH Initiative Team



Katie Commey, MPH
PCMH Initiative Coordinator



Phillip Bergquist
Policy & Strategic Initiatives Manager



Justin Meese
Sr. Business Analyst



The PCMH Initiative Internal Support Team



Amanda First
CVI Analyst



Diane Marriott
CVI Director



Veralyn Klink
CVI Administrator



Marie Beisel, MSN, RN, CPHQ
Sr. Project Manager - CMRC



Lauren Yaroch, RN
Project Manager - CMRC



Susan Stephan
Sr. System Analyst - MDC



The IHI Support Team



Sue Butts-Dion
Improvement Advisor



Sue Gullo, RN, BSN, MS
Director



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



Tam Duong, MS
Project Manager



Julia Nagy
Project Coordinator



Instructions for Using WebEx

To log-in, dial-in, and view materials:

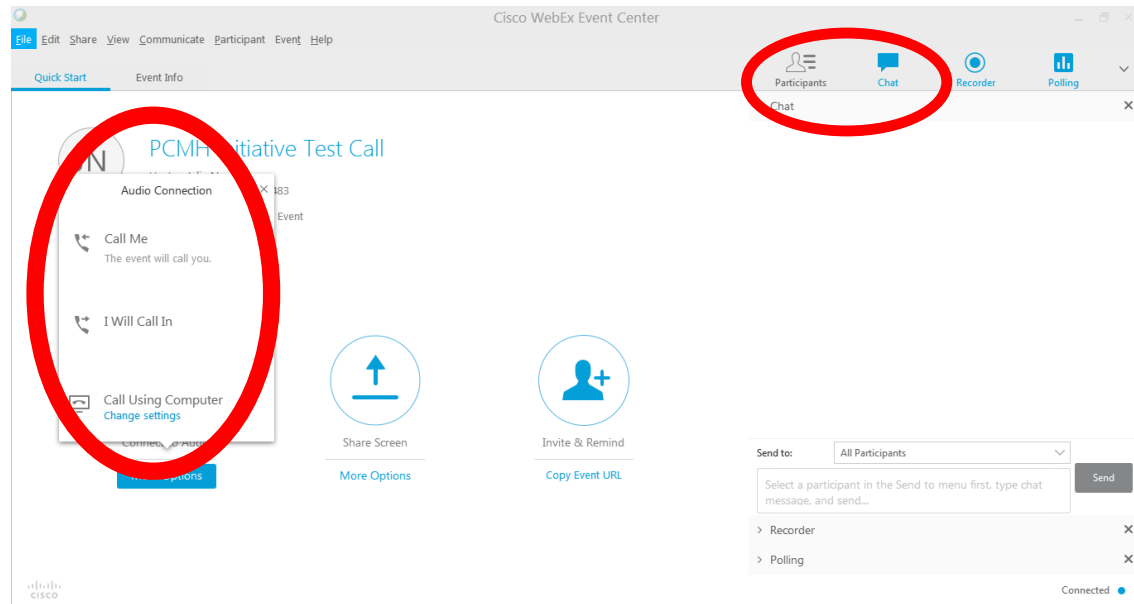
1. Go to <http://ihi.webex.com> (Note: There is no “www” in the address)
2. On the navigation bar, select **Event Center > Attend a Session > Live Sessions** to view a list of links.
3. Click “Join” or “Register” next to the event titled the topic listed above.
4. Enter your name and email address in the boxes on the right, then click “**Join Now.**”
5. After the WebEx loads, a pop-up box that says “**Audio Conference**” will appear.
6. Please call in using the dial-in provided. **Use both the access code and attendee ID to dial in.**
7. Upon sign-in, please type your full name and organization into the chat box.



Phone Connection (Preferred)

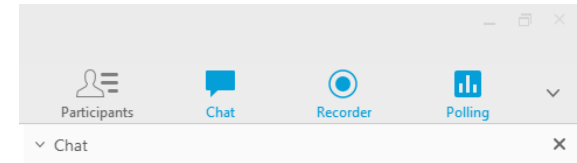
To join by **phone**:

- 1) Click on the “Participants” and “Chat” icon in the top, right hand side of your screen to open the necessary panels
- 2) You can select to call in to the session, or to be called. If you choose to call in yourself, please dial the **phone number**, the **event number** and your **attendee ID** to connect correctly.



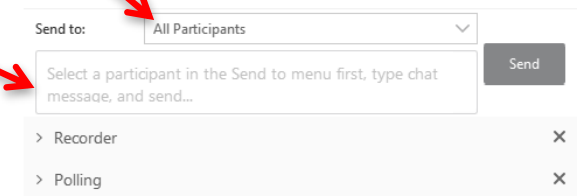
WebEx Quick Reference

- Please use chat to “**All Participants**” for questions
- For technology issues only, please chat to “**Host**”



Select Chat recipient

Enter Text



Connected ●

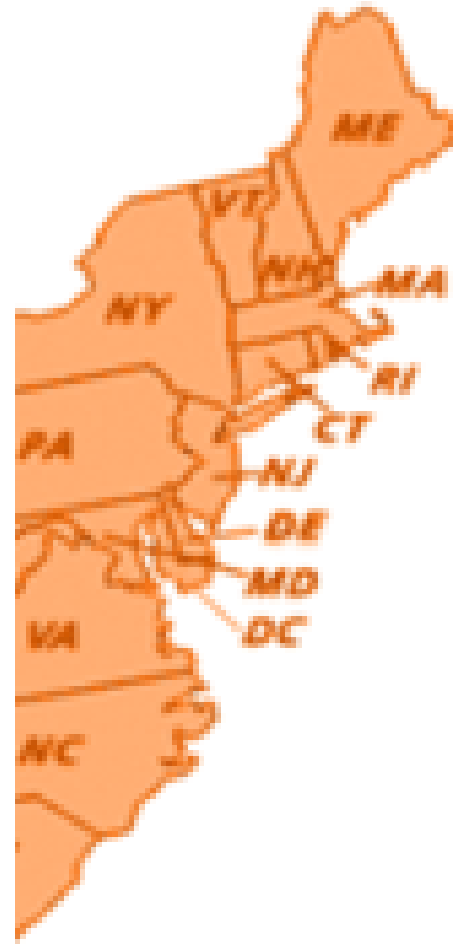


Agenda

- Welcome & Introductions
- The Michigan Patient Centered Medical Home (PCMH) Practice Transformation Collaborative
 - Why
 - Who
 - What
 - How
- Preparing for Learning Session 1
- Q & A



Where are you joining from? ¹⁰



About IHI

Our Mission

To improve health and health care worldwide.

Our Vision

Everyone has the best care and health possible.

Who We Are

IHI is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide.



IHI Strategy

Mission

Improve health and health care worldwide

Vision

Everyone has the best care and health possible

Strategic Approach

IHI applies practical improvement science and methods to improve and sustain performance in health and health systems across the world. We generate optimism, spark and harvest fresh ideas, and strengthen local capabilities.

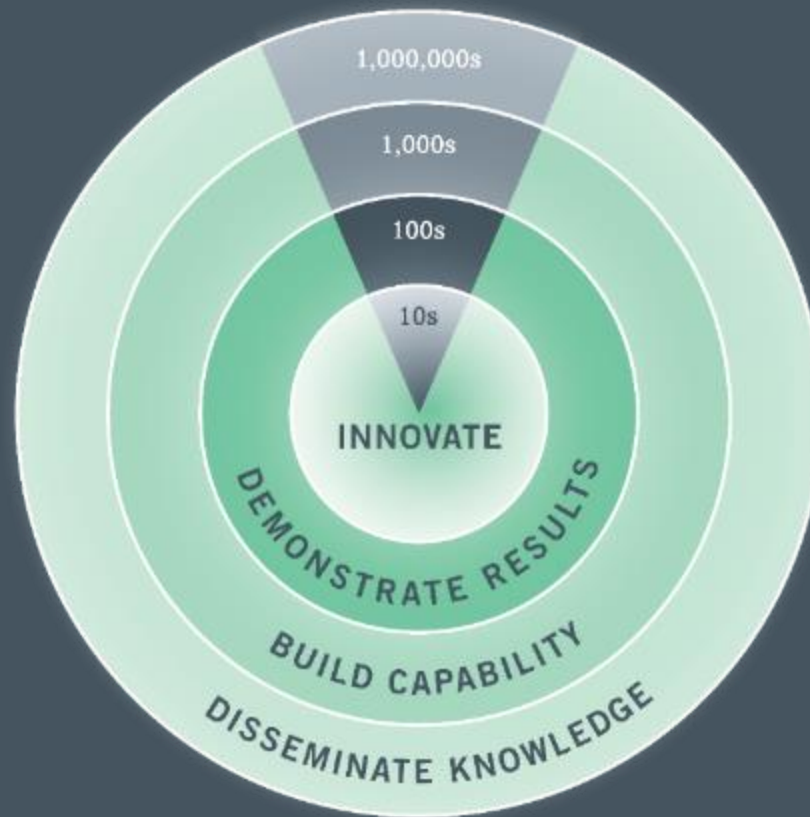


How We Work

- Convene
- Innovate
- Partner for Results



The Way We Work: A Leverage Strategy



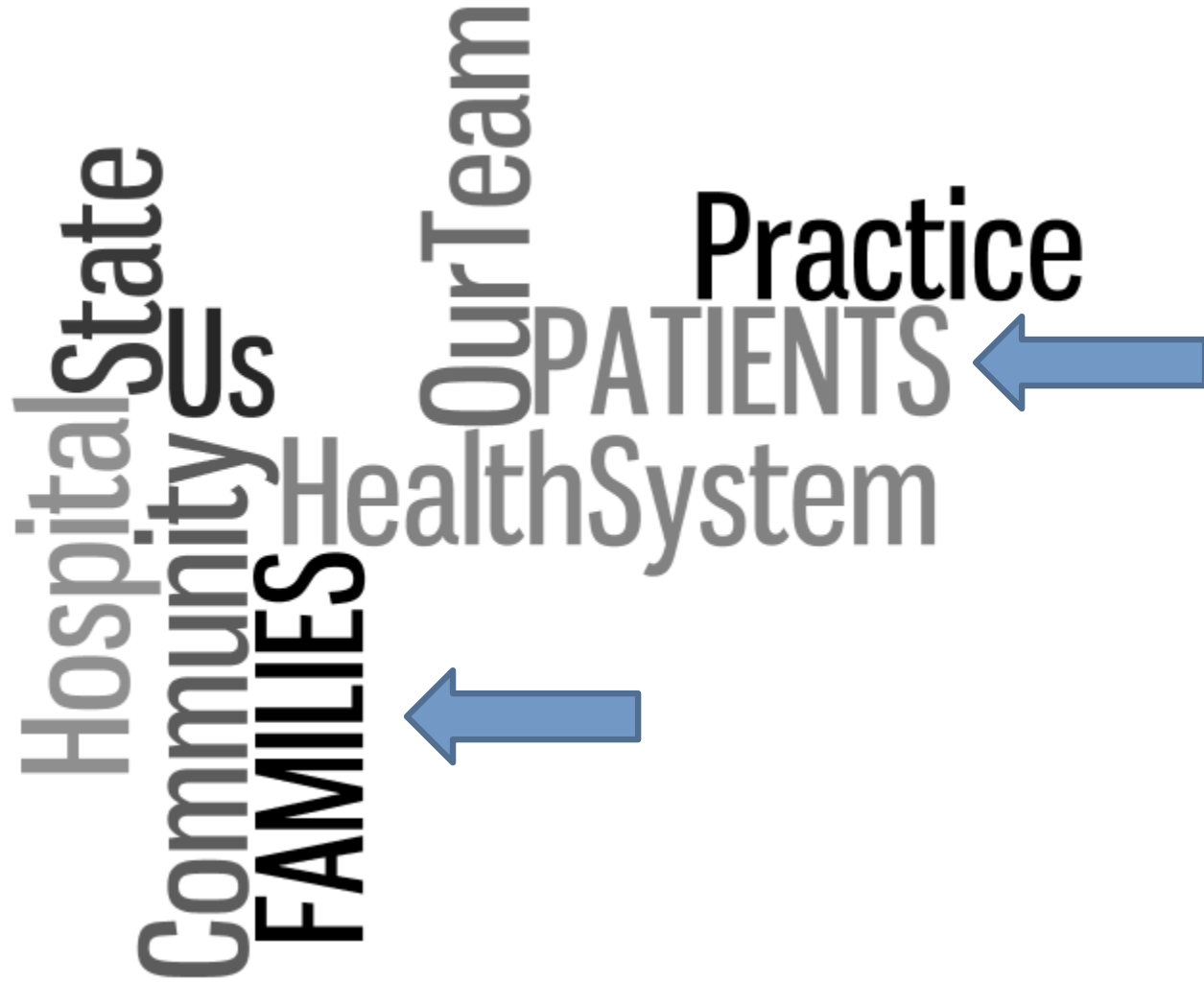
So, let's get started...

The secret
to getting
ahead is
getting
started

Using the chat box, chat in one improvement your team has made in the last year that you are most proud of. Who benefited most from the improvement?



Many Benefit...





The Ultimate “Why”

- Integrate the experiences of those for whom we care.
- Measure widely so we can learn to get better.
- Teach one another.
- Reduce the costs of the whole, not its parts.
- Compete against disease and cooperate in doing so.



“Why” a Collaborative Learning Network?

Working together to improve and spread knowledge and to accomplish a common aim.

If you want to go fast,
go alone.

If you want to go far,
go together.

- African Proverb -



Who ?



Poll: Tell us about yourself

Are you a...

- a) PO Representative / Practice Consultant?
- b) Clinical Provider?
- c) Care Manager/Coordinator?
- d) Practice Manager?
- e) CHIR Representative?
- f) Other (please chat in your role)

Where are you located?

- a) Genesee CHIR
- b) Jackson CHIR
- c) Muskegon CHIR
- d) Northern CHIR
- e) Washtenaw/Livingston CHIR
- f) Outside of a CHIR
- g) Other (please chat in location)



What?



Aim

The purposes of the PCMH Initiative are:

1. To foster the transformation of participating PCMH primary care practices to enable interventions that impact all persons served by the Practice in a cost-effective manner using evidence-based guidelines and practices
2. To support a premier model for advanced primary care in Michigan leveraging experience gained from the MiPCT demonstration, and
3. To improve health outcomes, improve patient experience of care, and reduce preventable healthcare costs.



Categories

- Community-Clinical Linkages
- Population Health Management-Knowing & Co-Managing Patients
- Telehealth Adoption
- Group Visits
- Patient Portal
- Improvement Plans from Patient Feedback
- Self Management Monitoring & Support
- Integrate Peer Support
- Medication Management
- Integrated Clinical Decision Making
- Care Team Review of Patient Reported Outcomes
- Cost of Care Analysis




Who? It takes everyone....

A Patient
Centered Medical
Home (PCMH)
without a
neighborhood.



Categories

- Community-Clinical Linkages 
- Population Health Management-Knowing & Co-Managing Patients
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- Integrate Peer Support
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- Integrated Clinical Decision Making
- Care Team Review of Patient Reported Outcomes
- Cost of Care Analysis



Chosen Practice Objectives

Objective	# of Practices that Selected
Telehealth Adoption	4
Improvement Plans from Patient Feedback	26
Medication Management	8
Population Health Management	215
Self-Management Monitoring and Support	25
Care Team Review of Patient Reported Outcomes	0
Integrated Peer Support	6
Group Visit Implementation	11
Patient Portal Access	18
Cost of Care Analysis	11
Integrated Clinical Decision Making	19



All Improvement Requires Change



Going Together...

- ***Change is hard enough; transformation to PCMH requires epic whole practice reimagination and redesign. It is much more than a series of incremental changes.”***
 - *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient Centered Medical Home, Annals of Family Medicine, VOL. 7, NO. 2 May/June 2009*



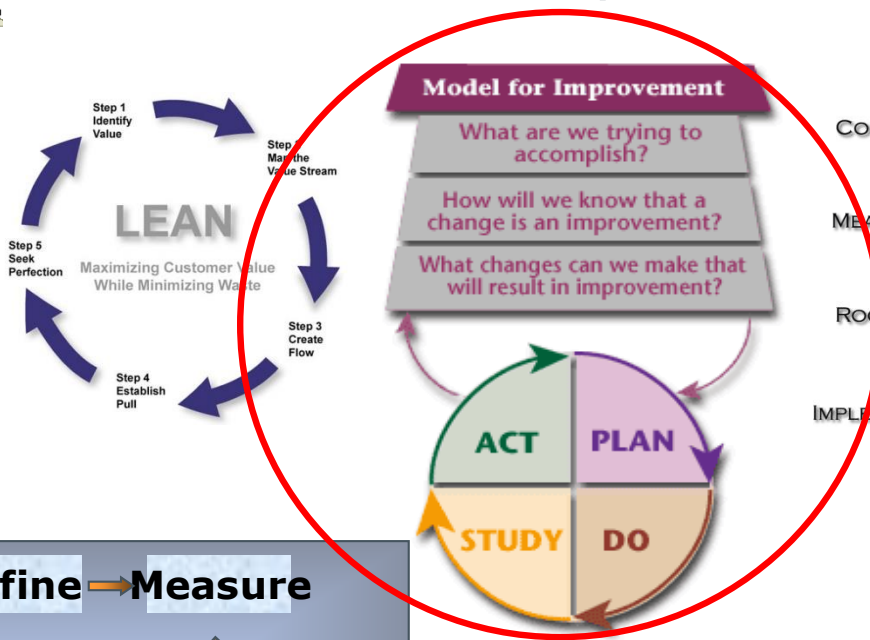
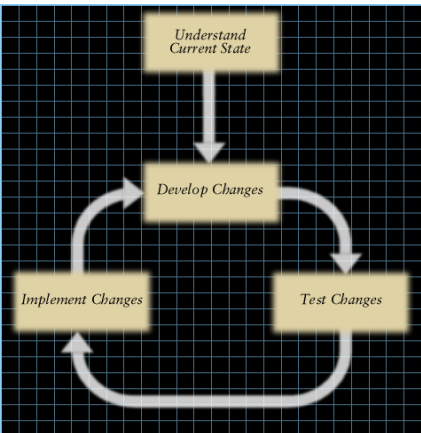
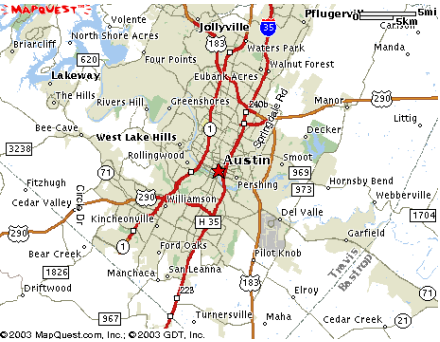
Improvement Takes...

- **Will** – Motivation comes from learning that it is possible and from bonding with colleagues working on the same problem.
- **Ideas** – Acquire great ideas for change from the evidence, one another, etc.
- **Execution** – Learn a method for making lasting changes and begin using it.

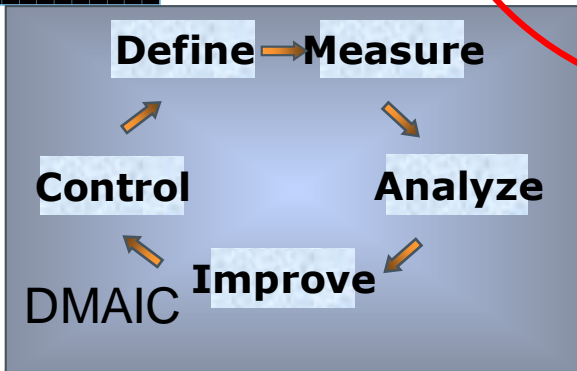


Road Maps for Improvement

Everyone involved in improvement is searching for a “perfect road map” to accomplish an improvement project



- STEP 1.** DEFINE & CONTAIN THE PROBLEM
- STEP 2.** MEASURE THE PROBLEM
- STEP 3.** PERFORM ROOT CAUSE ANALYSIS
- STEP 4.** PLAN & IMPLEMENT IMPROVEMENT
- STEP 5.** ASSESS EFFECTIVENESS OF IMPROVEMENT
- STEP 6.** STANDARDIZE & CONTROL
- STEP 7.** REALIZE & REFLECT

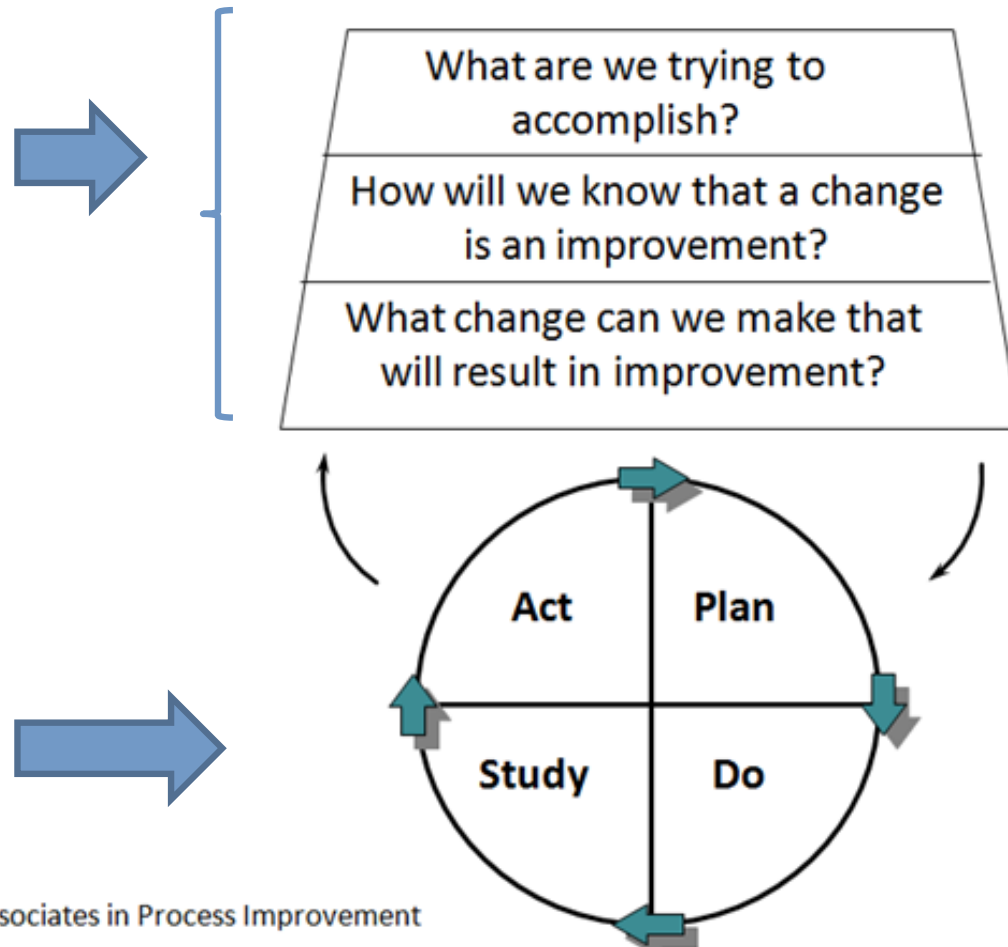


FOCUS PDCA



“All improvement requires change, but not all change is an improvement...”

Model for Improvement



We use the Model for Improvement to increase the odds that changes will lead to improvement and to accelerate change!



Poll

Indicate below your level of knowledge with the Model for Improvement.

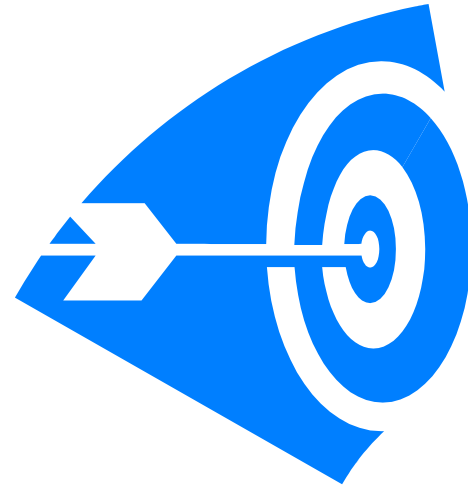
- a) No knowledge
- b) Know what it is—can give you facts
- c) Know what it is and apply sporadically
- d) Know what it is and apply consistently
- e) Expert knowledge—can teach and coach others how to apply



Question 1: What Are We Trying to Accomplish?

Aim statement:

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



What Are We Trying To Accomplish?

The AIM is

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



What Are We Trying To Accomplish?

The AIM is

- “Soon” is not a time
 - *not a time*
- to better
measured improvement
- And numeric *goals*

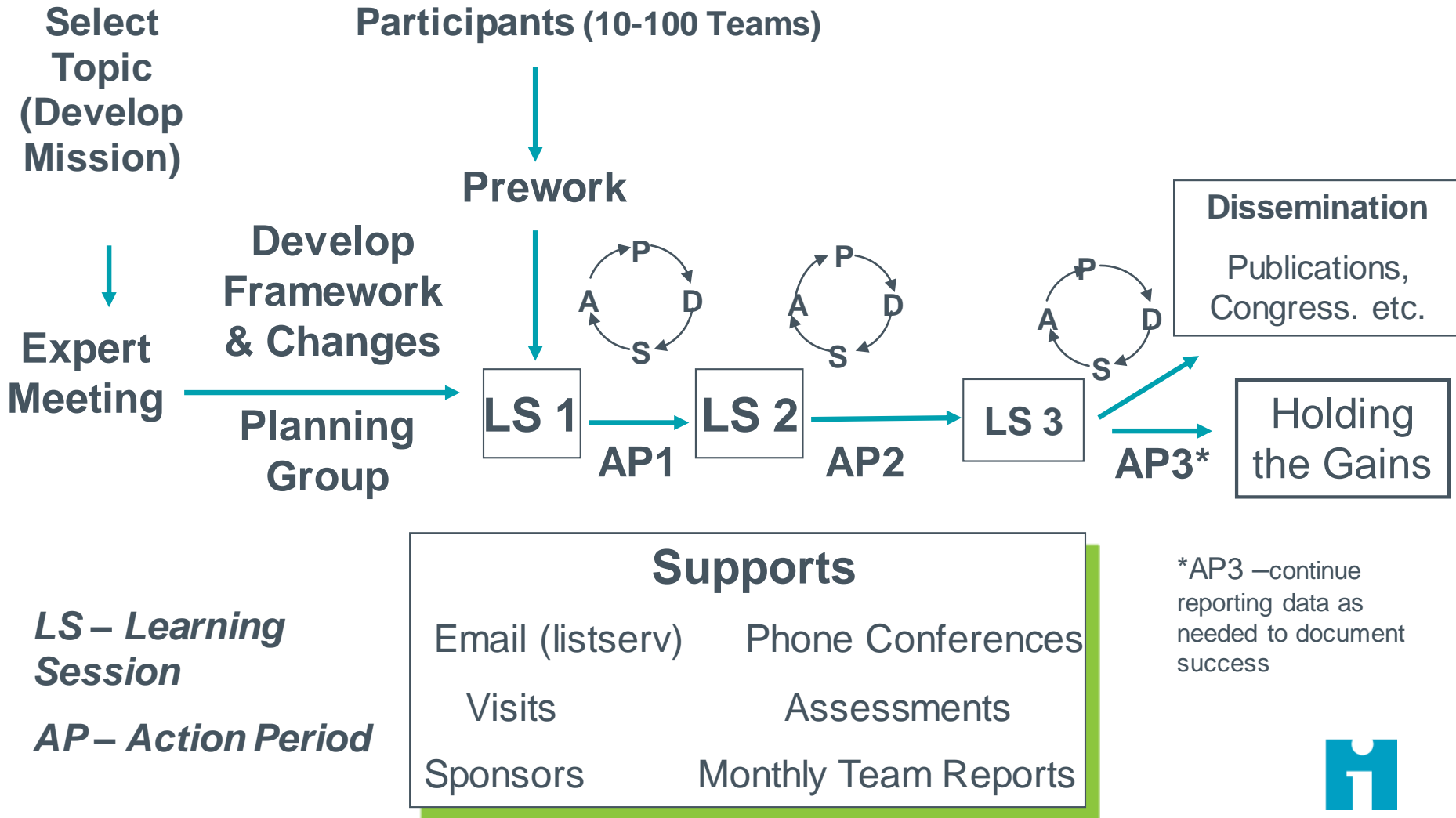
“Some” is *not*
a number

Donald Berwick, MD

“Hope” is
not a plan



“How” IHI Breakthrough Series Model



Select Topic (Develop Mission)

Expert Meeting

Develop Framework & Changes
Planning Group

Participants (10-100 Teams)

Prework

LS 1

AP1

LS 2

AP2

LS 3

AP3*

Dissemination
Publications, Congress, etc.

Holding the Gains

Supports

- Email (listserv)
- Phone Conferences
- Visits
- Assessments
- Sponsors
- Monthly Team Reports

LS – Learning Session

AP – Action Period

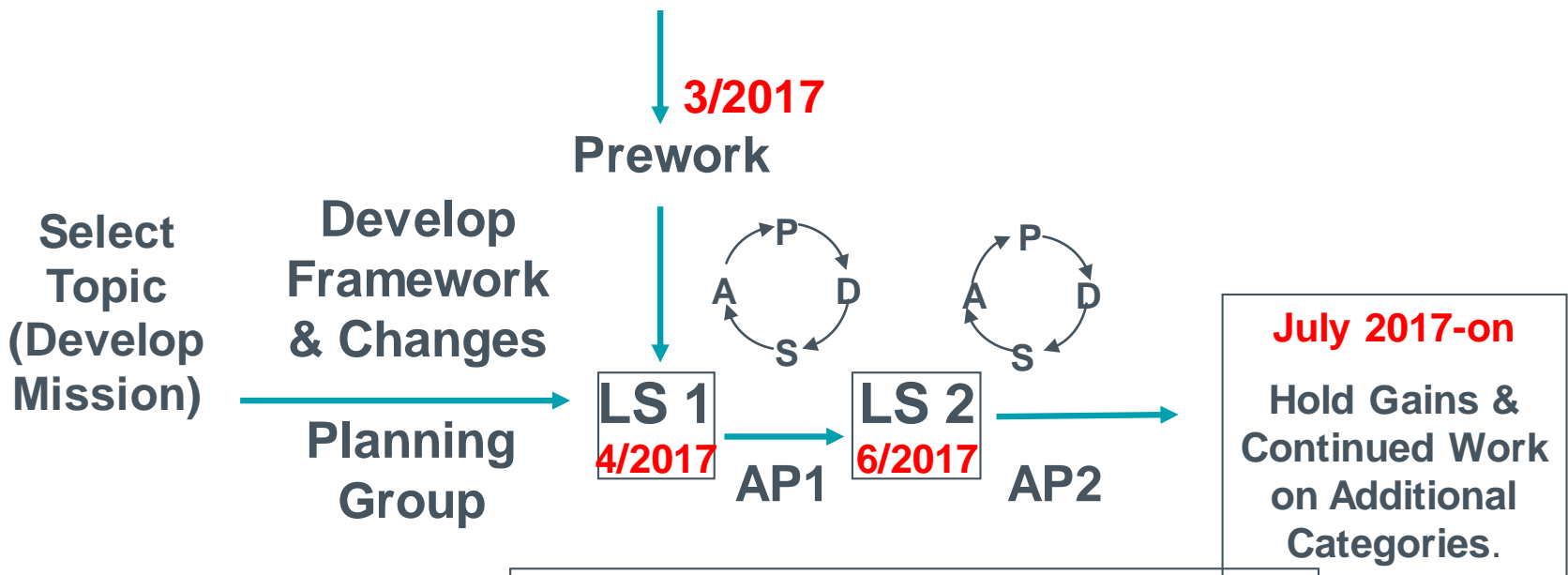
*AP3 –continue reporting data as needed to document success



“How”—Year 1

MI PCMH Transformation Collaborative

Participants (43 Teams representing 346 practices)



Supports

- Phone Calls
- Webinars
- Visits
- Assessments
- Affinity Groups
- Team Reports

LS – Learning Session

AP – Action Period



Preparing for Learning Session 1

*** Community/
Clinical
Linkages**

Link Patients to Community Supports

Assess Social Determinants of Health

Care Coordinators & Managers

April 3–4, 2017

Lansing, MI

East Lansing Marriott @ University Place



Chat...

- What is the one thing you most hope to get from our first face-to-face Learning Session?



Learning Session 1 Agenda

- **April 3, 2017- Day 1**

- **Morning session: 8:30 AM - 12:15 PM**

- What is it we are trying to accomplish? Creating the “Wall of Aims”
 - Setting the Context: Through the Patient's Eyes “What Matters to Me?”

- **Afternoon session: 1:15 PM - 4:30 PM**

- Building Clinical Community Linkages

- **April 4, 2017- Day 2**

- **Morning session: 8:30 AM - 12:15 PM**

- Building a Patient Centered Medical Home and the Team: The Journey After Designation
 - Beginning our Work with the End in Mind

- **Afternoon session: 1:15 PM - 4:30 PM**

- What changes can we make that will result in improvement ?
 - Leaving in Action: Developing First Plan-Do-Study-Act Cycles



Who should attend? *Team Members*

- Clinical leader and administrative leader
- Support staff responsible for carrying out the work (e.g. Providers, Care Managers/Coordinators)
- Practice Coaches / Consultants
- Patient representative(s)
- PO Representative(s) (e.g. medical staff leadership, QI coaches, change agents) and their Practice Representative(s)

Note: It will be important to have the same core team members attend all Learning Sessions.



Preparing for Learning Session 1



What is your aim related to building community clinical linkages?

What do you hope to improve?

By how much?

By when?

Be prepared to share this at LS1 in April.



Next Steps

- **Prepare for Learning Session 1**
 - Draft aim statement for Community Clinical Linkages work
 - If you cannot bring a patient, identify a vulnerable patient linked to your aim and bring their “story” with you
 - Bring along your self-assessment submissions to the LS



Next Steps

Action Period Calls

- April 13, 2017 from 4:00 – 5:00 PM ET
- May 11, 2017 from 4:00 – 5:00 PM ET
- June 8, 2017 from 4:00 – 5:00 PM ET

Topic: Check in call in follow-up to Learning Session & Prepare for in-person Learning Session 2 (June 2017)

Coaching Calls

- May 16-19, 2017 from 12:00 – 1:30 PM ET



Questions

