Institute for Healthcare Improvement

MDHHS
Michigan Department of Health & Human Services

MI PCMH Initiative Practice Transformation Collaborative

Webinar #3

May 11, 2017

SIM PCMH Initiative Team Structure

MDHHS

State Innovation Model (SIM)

- CHIR
- PCMH
- HIE

Internal Support

University of Michigan

- CMRC
- CVI
- MDC

External Support

- IHI
- Clinovations (Ad Board)
- MiCHWA
- MPRO

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

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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

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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

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Instructions for Using WebEx

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

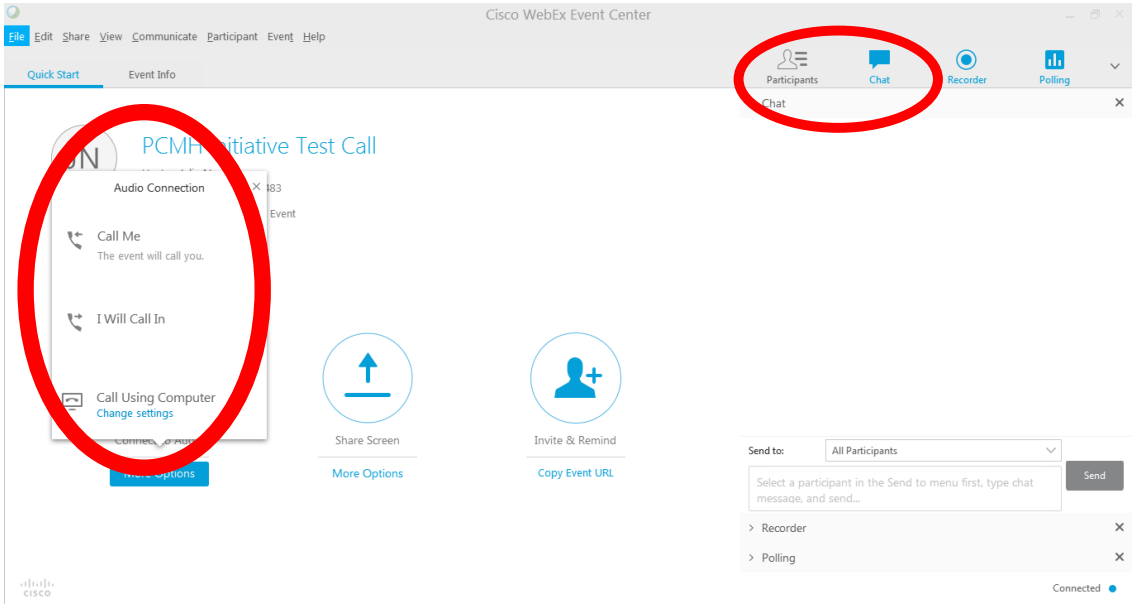
1. Go to **http://ihi.webex.com** (Note: There is no “www” in the address)
2. On the navigation bar, select **Event Center> Attend a Session > Live Sessions** to view a list of links.
3. Click “Join” or “Register” next to the event titled the topic listed above.
4. Enter your name and email address in 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**:

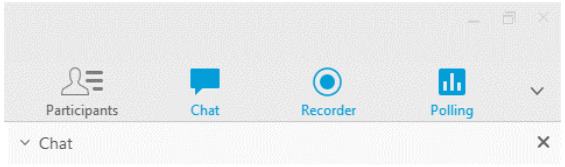
1) Click on the “Participants” and “Chat” icon in the top, right hand side of your screen to open the necessary panels

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.

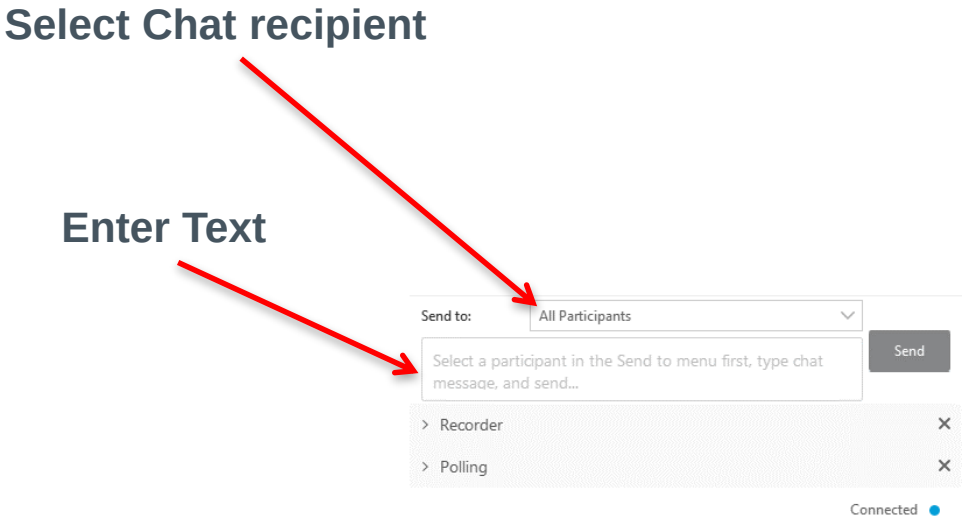


WebEx Quick Reference

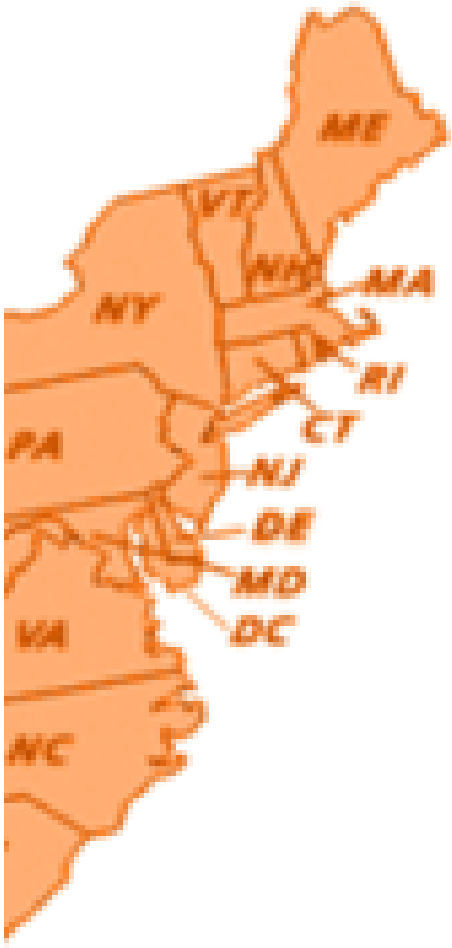
- Please use chat to "***All Participants***" for questions



- For technology issues only, please chat to "***Host***"



Where are you joining from?



Michigan PCMH Initiative Practice Transformation Collaborative

TRANSFORMATION OBJECTIVES DEVELOPED

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

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

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

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

All teach, all learn

Action Period (AP) Supports

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

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

Agenda

- Reflecting
  - All teach, all learn
- Looking Forward
  - Prep for Learning Session 2

Reflecting

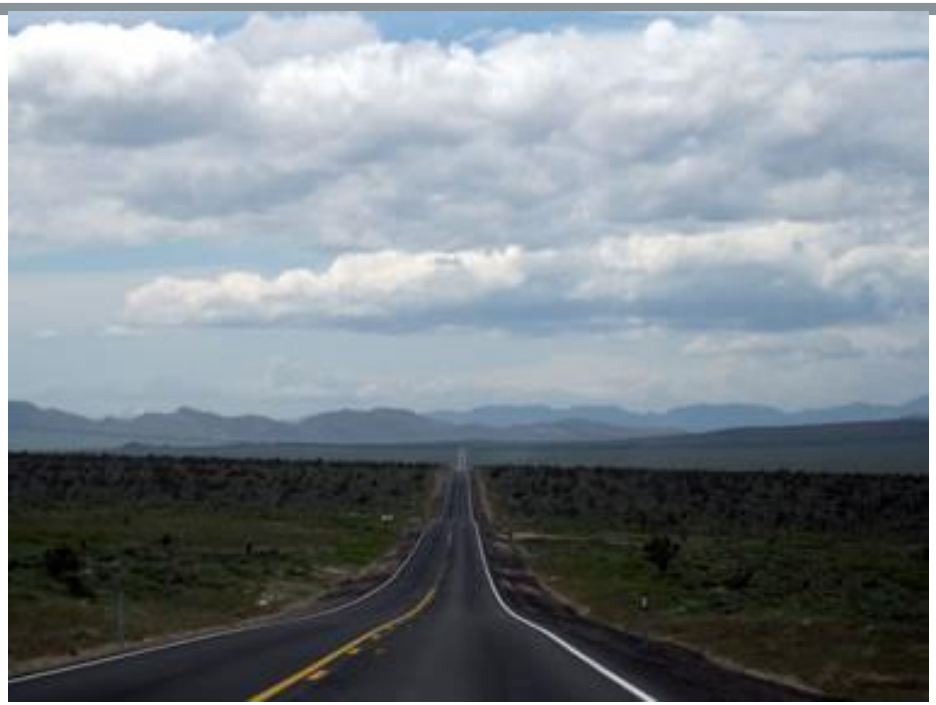
Actions since LS1 and

All teach, all learn

- Aim Statement
  - How have you refined your aim? Shared your aim?
- Team Formation—What is needed for your work related to:
  - *processes owners/knowledge*
  - *stakeholders*
  - *political support*
  - *organizational and structural support*
  - *patient voice*
  - *team members*

All teach, all learn

- Clarifying Knowledge of Your Current System
  - Have you used a Ecomap, high level or detailed flow chart to look at your current system and/or flow?
- Social Determinants of Health Brief Assessment
  - What are you learning?
- Tests of Change using PDSA Cycles
  - What improvements are you testing related to developing community linkages? Related to approaching patients with “What matters to you?” vs. “What’s the matter with you?”



Looking Forward

Preparing for LS2

LS 2: Day One

Day One · Tuesday, June 13, 2017

Time	Topic
7:30 – 8:30 AM *Ballroom Foyer*	**Registration and Continental Breakfast** **For participants who were not at Learning Session 1 or who want to attend for a refresher**
8:30 – 9:30 AM *University Ballroom*	**Workshop: Welcome, Overview & Introductions** ***For New Participants***
9:30 - 11:00 AM *University Ballroom*	**Learning Lab: Quality Improvement 101 – Theory and Tools** ***For New Participants*** *Sue Butts-Dion, Faculty, IHI*
11:00 – 11:30 AM	**Break**
11:30 – 12:30 PM *Ballroom Foyer*	**Registration and Lunch** **For all returning participants**
12:30 – 1:00 PM *University Ballroom*	**Launch of Learning Session 2** *MI SIM PCMH team*
1:00 - 1:45 PM *University Ballroom*	**CCLs: Models to Support Change** *Trissa Torres, Chief Operations and North America Programs Officer, IHI*
1:45 - 2:45 PM *University Ballroom*	**Learning from Our Peers** *Facilitators: Sue Butts-Dion, Faculty, IHI and Sue Gullo, Director, IHI*
2:45 – 3:00 PM	**Break**
3:00 – 3:45 PM	**Developing a CCL Measurement Strategy: How will we know that a change is an improvement?** *Katie Commey, SIM PCMH Initiative Coordinator, MDHHS* *Sue Butts Dion, IA*
3:45 – 4:30 PM *University Ballroom*	**Team Time** *Facilitators: Sue Butts-Dion, Faculty, IHI and Sue Gullo, Director, IHI*
4:30 – 4:45 PM *University Ballroom*	**Patient Case Study, Close and Prep for Day 2**

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LS 2: Day Two

Day Two · Wednesday, June 14, 2017

Time	Topic
7:30 – 8:30 AM *Ballroom Foyer*	Continental Breakfast
8:30 –9:30 AM *University Ballroom*	Panel: Best Practices to Link Patients and Achieve Health Identifying local models that are promising or showing results
9:30 – 10:15 AM *University Ballroom*	Storyboard Rounds
10:15 - 10:30 AM	BREAK
10:30 - 11:30 AM *University Ballroom*	Concurrent Breakout Sessions (Draft) A. Building Will: Engaging Stakeholders in the PCMH Transformation. B. Measurement: Using Data to Drive Your Improvement C. Journey to test and implement a SDoH assessment screening tool
11:30 - 12:30 PM	Lunch
12:30 – 1:40 PM	Moving Towards Population Health Management *Trissa Torres*
1:40 – 2:30 PM	Identify Your Population: What Do You Know?
2:30 - 2:45 PM	BREAK
2:45 - 3:15 PM	Organizing Our Learning and Theories & Refresher on PDSA
3:15 - 4:00 PM	Team Time/Open Space
4:00 - 4:30 PM	Close, Q & A, Evaluate *Katie Commey, SIM PCMH Initiative Coordinator, MDHHS*

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LS2 Pre-work

1. The Power of Learning from One

- Identify **one patient** your team “worries” and wonders about often.
- They come to mind quickly and may have multiple chronic conditions, behavioral health challenges, a complex medication regimen, and/or challenging social conditions. Perhaps they are frequent users of the ED and/or admitted to the hospital often. Perhaps they have been patients in your practice for many years and have not been able to meet their goals.
- Write a brief profile of the patient including their readmissions history and any other information pertinent to why your team worries/wonders about them (no patient identifiers, please).

Architecting Clinical-Community Linkages

- Using the results of the Social Determinants of Health Brief Assessment, the patient's response to "what matters to you", and your knowledge of the patient, list at least 5 clinical community linkages the patient would benefit from. (Note: Feel free to use the Ecomap template from LS1 to map out the relationships and the type and strength of the relationships.)
- Where does the clinical community linkage typically fall through—what are the contributing factors to a patient not getting connected to support that matters to them and that they need?

“At the heart of a learning organization is a shift of mind from seeing ourselves as separate from the world to connected to the world, from seeing problems as caused by someone else or something “out there” to seeing how our own actions create the problems we experience”

Peter Senge
The Fifth Discipline

Improvement Opportunities

What, from the list of factors contributing to failed linkages, can you work on as part of this improvement collaborative?

1.
2.
3.
4.
5.
Etc.

2. Prepare a story board about your work to improve Clinical-Community Linkages

- Use Story Board Template.
- Print it, bring it and be ready to attach it to a flip chart (we will supply tape, staples, etc.)
- You will present your storyboard two times to a small interactive group of your colleagues and faculty.
- Participants listening to the presentations will be asking you questions, giving feedback and identifying and suggesting change ideas.

Story Board Template

Name

Please insert your name, Organization and Role (Include interesting picture of you, your team, your project, and /or your organization to the right ☺)

Aim Statement for Improving Clinical-Community Linkages

Insert your aim statement
(at what ever stage it is in ☺)

Template Slide 25

Organization Name: _____
Location: _____

- **Brief description of your organization:**

  _____

  _____

- **With regard to Clinical-Community Linkages:**
  What do you hope to accomplish related to this objective?

  _____

  By how much do you hope to improve?

  _____

  And by when do you want to improve?

  _____

Organization Name: _____
Location: _____

- **Brief description of your organization:**

  _____

  _____

- **With regard to Clinical-Community Linkages:**

  What do you hope to accomplish related to this objective?

  _____

  By how much do you hope to improve?

  _____

  And by when do you want to improve?

  _____

Clarifying Knowledge of the Current Processes & Systems

- *What do you know about the problem you want to solve? What is working well right now?*
- *Insert pictures of any flow charts (Ecomaps, high level, detailed, etc.) you used to help you review your current process.*
- *What is known about the common "failures" in linking patients to clinical and community resources? (Note: Use information from your review of one patient.)*
- *What are patients saying about their experience?*

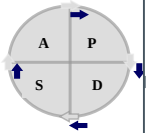
First PDSA....

Insert your description of the first thing you tested after LS1, what you predicted would happen, what did happen and how your next action was directed by your learning?

PDSA Planning Worksheet	**Team Name:**_____ **Cycle start date:**_____ **Cycle end date:**_____

PLAN:

Describe the change you are testing and state the question you want this test to answer:



What do you predict the result will be?

What measure will you use to learn if this test is successful or has promise?

Plan for change or test: who, what, when, where

Data collection plan: who, what, when, where

DO: Report what happened after you carried out the test. Describe observations, findings, problems encountered, and special circumstances.

STUDY: Compare results from this completed test to your predictions. What did you learn? Any surprises?

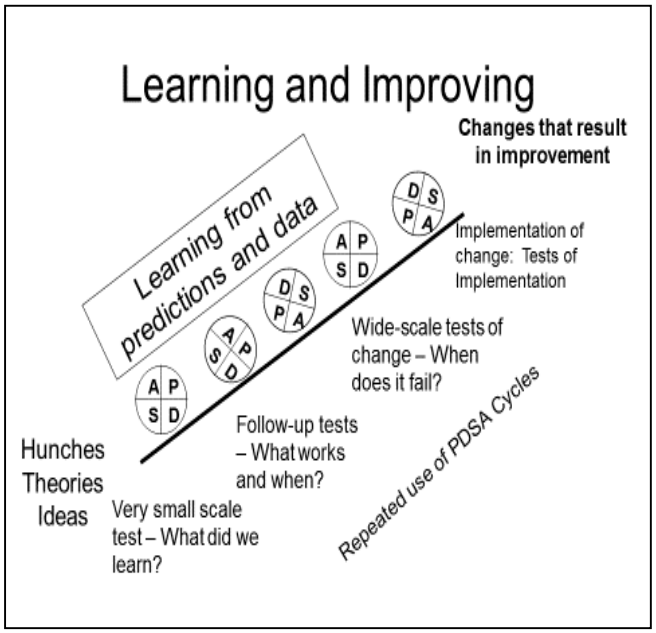
ACT: Modifications or refinements for the next cycle; what will you do next? (Adapt Adopt Abandon)

Sequence of Improvement

What follow up tests did you do? What did you learn?

Did you test for when the process might fail? If not why? And If so what did you learn?

Are you ready to implement any changes you have tested? Why or why not?

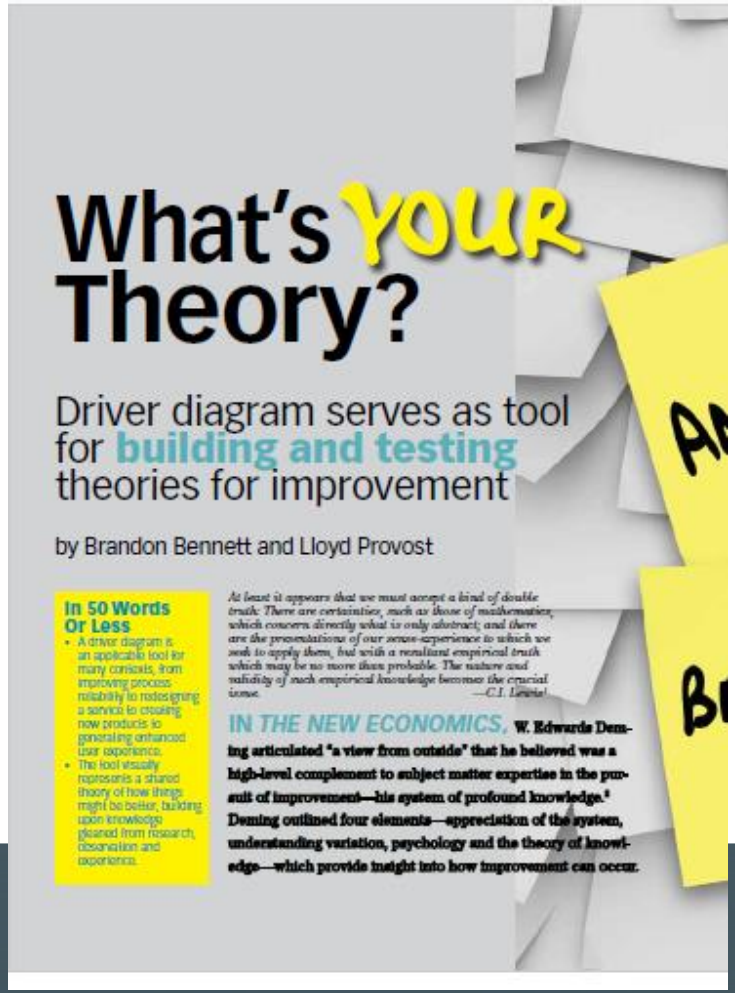


Reflection..... *Insert your answers to the questions below.*

- I have been most engaged when.....
- What surprised or puzzled me ...
- My advice to myself about improvement work is....
- My advice to others about improvement work is....

Pre-Work Reading Assignment

- http://www.apiweb.org/QP_whats-your-theory_201507.pdf



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.

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Questions

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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.

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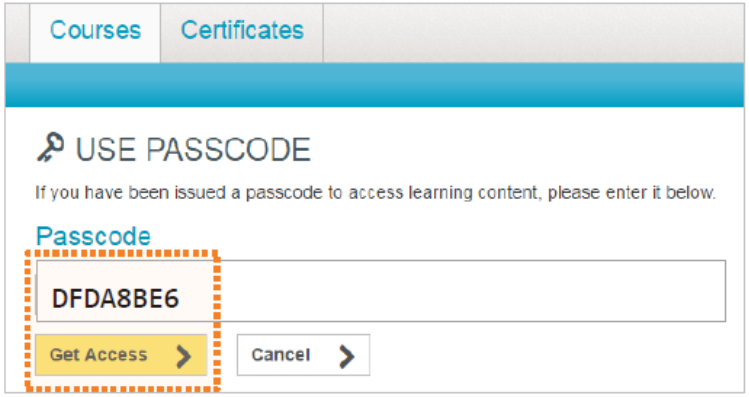
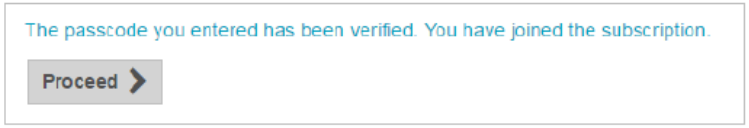
Step 2: Enter your group's passcode.

- 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.



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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.

Next Steps

Peer Coaching Calls (pick one)

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

Action Period Calls

- June 8, 2017 from 4:00 – 5:00 PM ET

Learning Session

- June 13-14, 2017