

# MI PCMH Initiative Practice Transformation Collaborative

*Webinar #6*



August 10, 2017

# 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

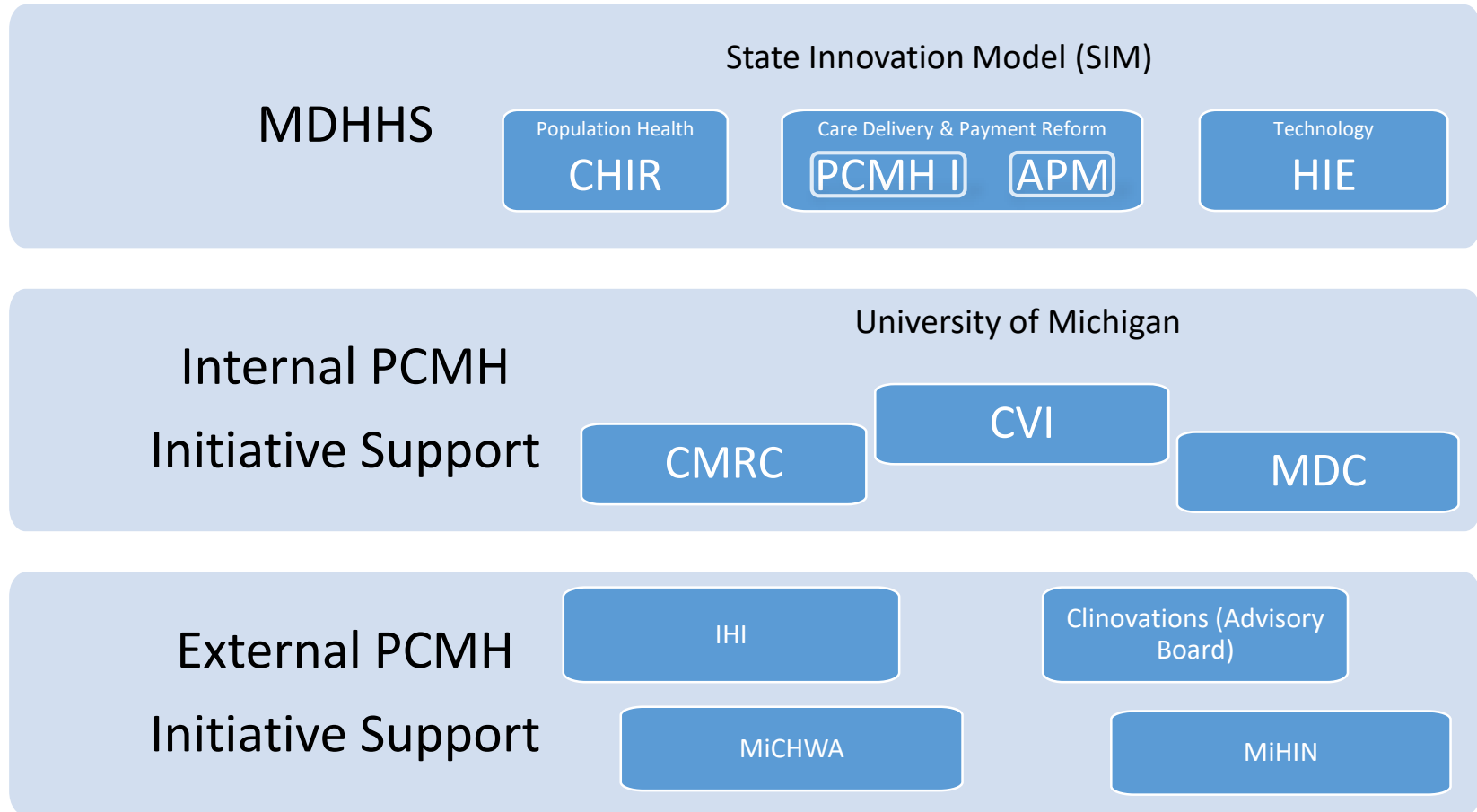


**Tam Duong, MS**  
Project Manager



**Julia Nagy**  
Project Coordinator

# SIM PCMH Initiative Team Structure



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

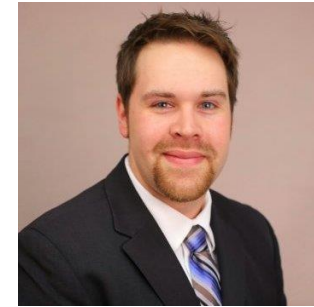
# The MDHHS PCMH Initiative Team



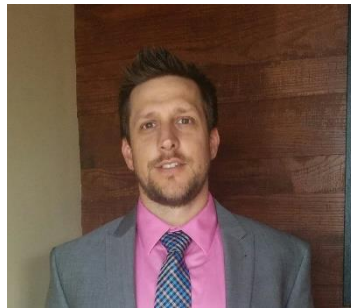
**Kathy Stiffler**  
MSA, Deputy Director



**Katie Commey**  
PCMH Initiative Coordinator



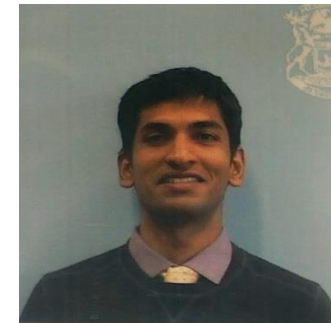
**Phillip Bergquist**  
Policy & Strategic Initiatives Manager



**Justin Meese**  
Sr. Business Analyst



**Linda Pappas**  
Project Assistant



**Yagna Talakola**  
Project Manager

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

# The PCMH Initiative Internal Support Team



**Amanda First**  
Analyst - CVI



**Diane Marriott**  
Director - CVI



**Veralyn Klink**  
Administrator - CVI



**Yi Mao**  
Analyst - CVI



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



**Lauren Yaroch, RN**  
Project Manager - CMRC



**Susan Stephan**  
Sr. System Analyst - MDC

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



# MI PCMH Initiative Practice Transformation Collaborative

Webinar #6

August 10, 2017

Participants (2)

Speaker

Rowan T

View Meeting Info

Join My Meeting

Join Meeting

Screen Share

Send Chat

Send File

Send Video

Send Audio

Member List (Hidden)

Chat

From: Rowan T (Moderator)

I am the Initiative's coordinator and am attending today as a representative. Looking forward to having additional members of our care team attend in another meeting and get share their insights. Feel free to reach out to me if needed.

Interested to have us all as partners to participate and share collaboratively, how about?

Send to: All Participants

Send

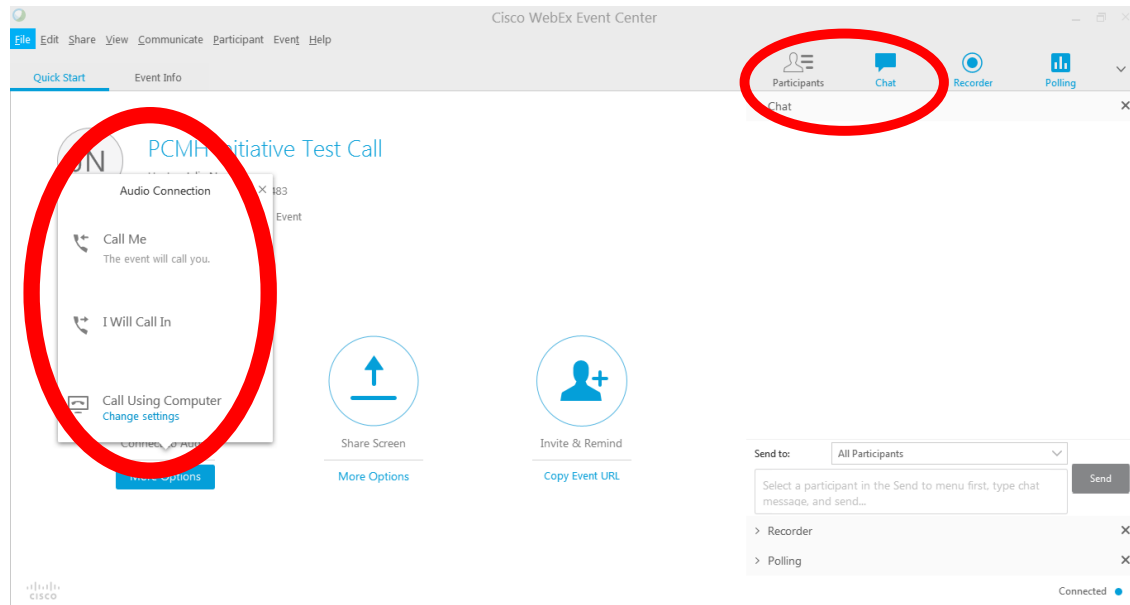
Connected



# Phone Connection (Preferred)

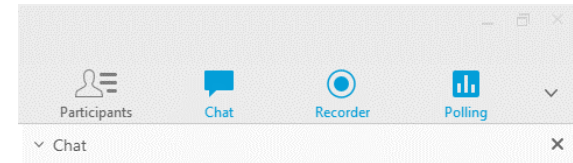
To join by **phone**:

- 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.



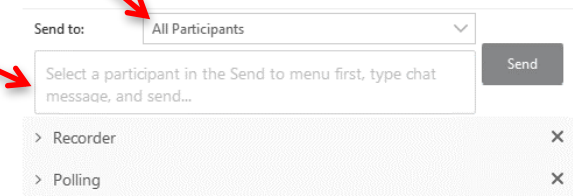
# WebEx Quick Reference

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



Select Chat recipient

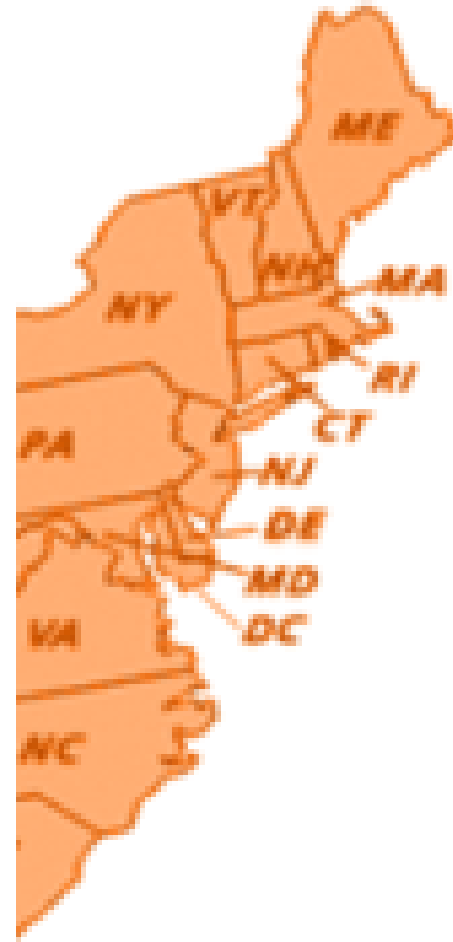
Enter Text



Connected ●



# Where are you joining from?



# Agenda

---

- Welcome, Introductions, Setting the Stage
- Using Data to Inform Interventions and Linkages
- Team Report Outs and Sharing
- Looking Ahead
  - Peer Coaching Calls
  - Semi-Annual Reporting
  - Q & A

## 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

**\* Clinical-Community Linkages**

**Access**

**Activated Patients and Care Teams**

**Continuity/Continuum of Care**

**\*\* Population Health Management-Knowing & Co-Managing Patients**

## Secondary Drivers

Reliable processes to link patients to supports

Assess Social Determinants of Health

Use Care Coordinators & Managers

**\*\* Telehealth Adoption**

**\*\* Group Visits**

**\*\* Patient Portal**

**\*\* Improvement Plans from Patient Feedback**

**\*\* Self Management Monitoring & Support**

**\*\* Integrated Peer Support**

**\*\* Medication Management**

**\*\* Integrated Clinical Decision Making**

**\*\* 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.



## Assessing Patients' Social Determinants of Health

Domain	Question	Response	
<b>Healthcare</b>	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?	Yes	No
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No
<b>Food</b>	Do you ever eat less than you feel you should because there is not enough food?	Yes	No
<b>Employment &amp; Income</b>	Do you have a job or other steady source of income?	Yes	No
<b>Housing &amp; Shelter</b>	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	Yes	No
<b>Utilities</b>	In the past year, have you had a hard time paying your utility company bills?	Yes	No
<b>Childcare</b>	Does getting child care make it hard for you to work, go to school or study?	Yes	No
<b>Education</b>	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	Yes	No
<b>Transportation</b>	Do you have a dependable way to get to work or school and your appointments?	Yes	No
<b>Clothing &amp; Household</b>	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
<b>General</b>	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No



# What are you learning?

---

- *...we must not let the research process interfere with common sense or delay action. For example, housing is critical to health, for it provides shelter, freedom from violence, a safe place to store food and medicine, a place to care for personal hygiene, and an address when applying for jobs. We do not need more research studies that indicate housing is integral to health, for we intuitively know this already. Rather, we must be intentional and proactive in what research questions we choose to ask and answer and in what interventions we pursue to affect the health of our patients, families, and communities.*
  - <http://www.jabfm.org/content/29/3/297.full#fn-group-1>
  - **Social Determinants of Health and Primary Care: Intentionality is Key to the Data we Collect and the Interventions We Pursue**  
Lauren S. Hughes MD, MPH 2016



# How much data do we need?

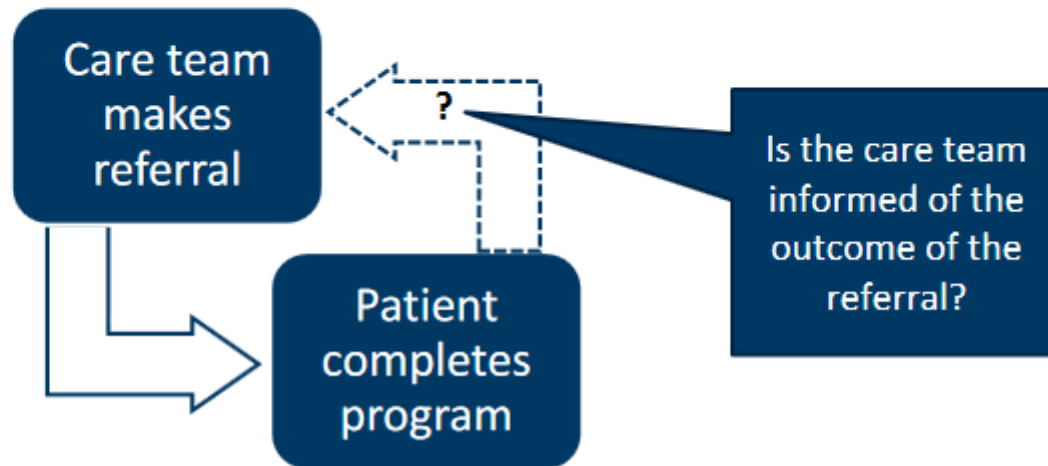
---

- Just enough. It's the condition of the experiment that matters the most.
  - Rapid Cycle Change QHR



# How are you using the data to inform design of reliable processes to link patients to supports and to close the loop?

- **Understand** the health care setting work flow and the roles represented.
  - What and how does the health care setting:
    - Screen
    - Counsel
    - Refer
    - Follow – up (closing the loop, aka bi-directional communication)



Source: <http://www.health.state.mn.us/healthreform/ship/docs/ship4/health-care.pdf>



# Team Report Out—Teeing us Up

Muskegon Family Care  
Muskegon Heights, MI



**Ros Berry**  
Quality Manager



**Marsha DeBoer**  
CFO



**Lisa Santos**  
Clinic Administrator



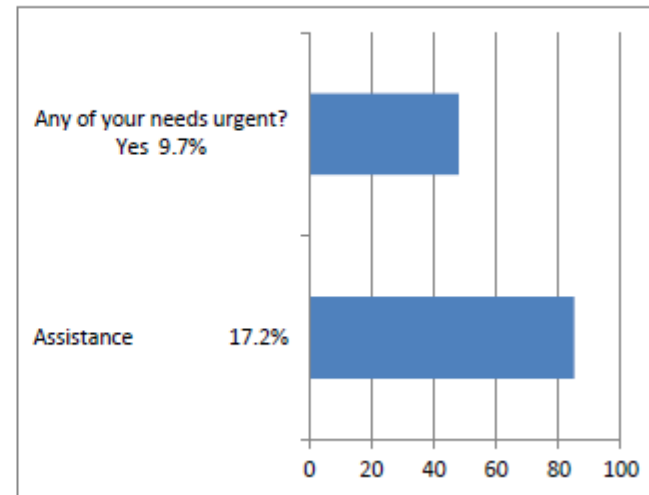
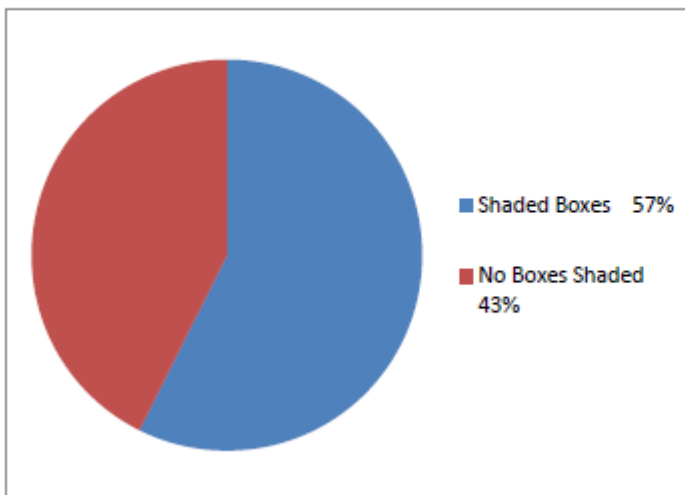
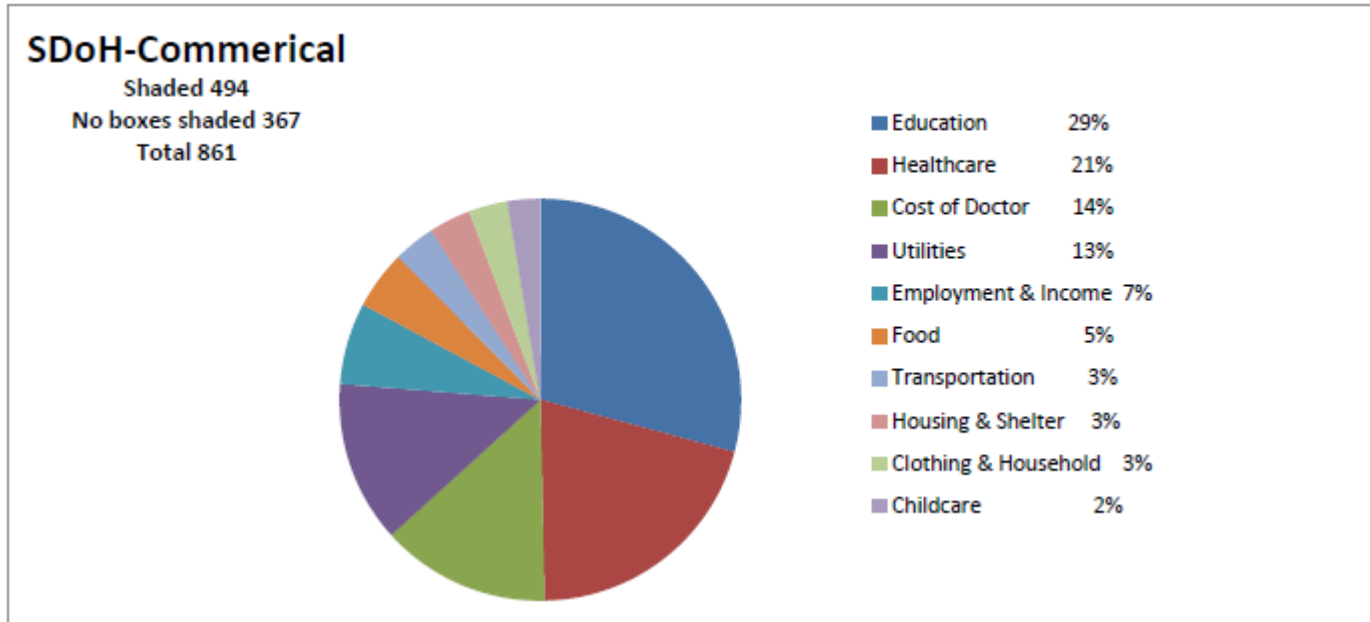
**Dr. Ramona Wallace**  
Chief Medical Officer

**Mission: "To promote the physical, emotional, and spiritual health of families through our healthcare and other supportive services."**



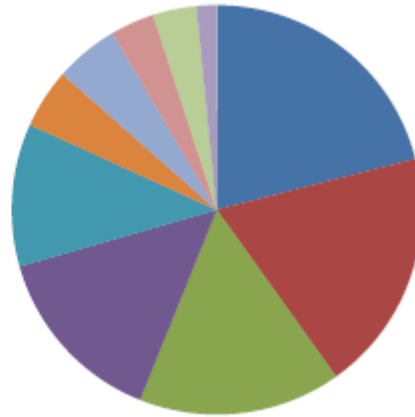


# Using Data to Inform Improvement—Breaking Down and Using the Assessment Data

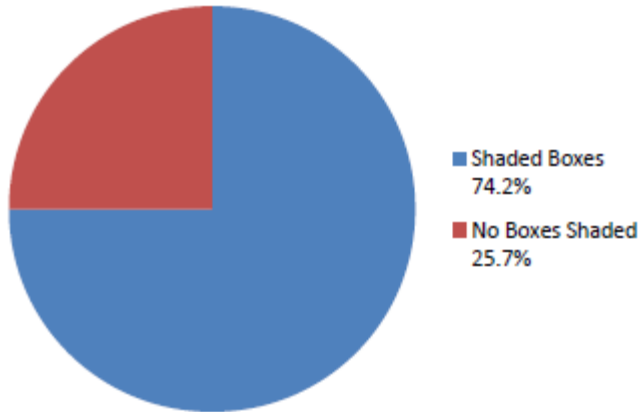


## SDoH-Uninsured

Shaded 123  
 No boxes shaded 41  
 Total 164

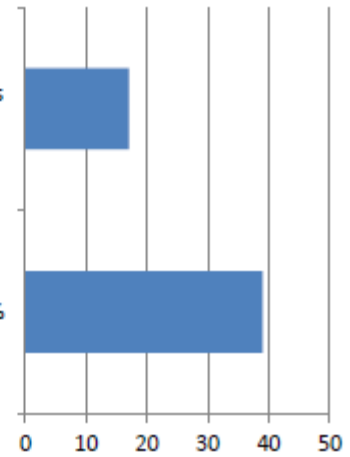


Education	20%
Cost of Doctor	18%
Healthcare	17%
Utilities	15%
Employment & Income	13%
Food	4%
Housing & Shelter	4%
Clothing & Household	4%
Transportation	3%
Childcare	2%



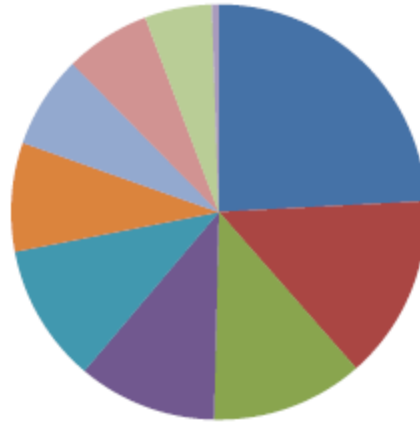
Any of your needs urgent? Yes  
 13.8%

Assistance 31.7%

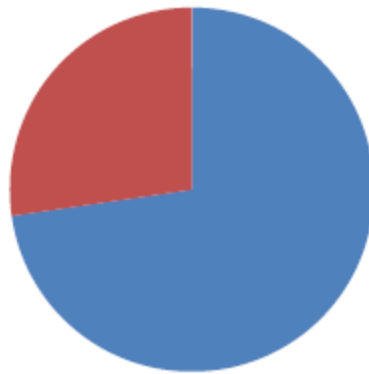


## SDoH-Medicare

Shaded 775  
No boxes shaded 291  
Total 1066



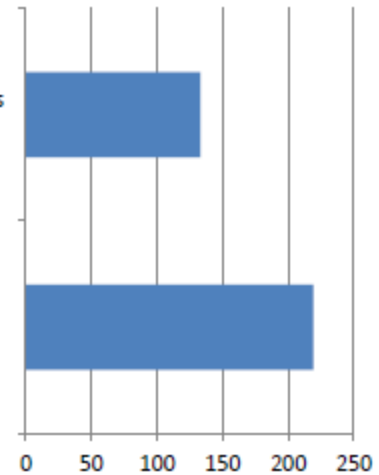
Healthcare	24%
Utilities	14%
Employment & Income	12%
Education	11%
Transportation	11%
Cost of Doctor	8%
Food	7%
Clothing & Household	7%
Housing & Shelter	5%
Childcare	1%



Shaded Boxes	73.2%
No Boxes Shaded	26.8%

Any of your needs urgent? Yes  
17.2%

Assistance 28.2%



# Key Learnings & Discussion

- Data key
- Leadership
- Had buy-in and capacity to “go big” and continue to “test and tweak” as we go along (PDSA 😊)
- Scripting the conversation with patients (“Here’s what we can do.”)
- Relationships & Linkages (e.g., transportation, United Way, My Bridges, Healthify, community gardens, food literacy, Dental Coach)
- Engaging Care Managers
- Engaging the Patient
- And more!!

*“The questionnaire is what I have been waiting for in my 27 years of practice”*

**Dr. Ramona Wallace**



# Other stories & ideas...

---



# What is one thing you could test by next Tuesday?

---

- “That won’t harm the hair on the head of a patient.”
  - Donald Berwick, MD 1996
- Approach one local transportation agency to see if they would be willing to work with you to develop a process for linking them with patients who need assistance. (Task)
- Develop a script to use with a patient to describe the process. (Task)
- Test the process with the next patient who requests support.
- Test the script with one patient.



# Resources

---





# Looking Forward



# Peer Coaching Calls (See website)

---

- Tuesday, September 19, 2017
- Wednesday, September 20, 2017
- Thursday, September 28, 2017
- Friday, September 29, 2017

**All sessions 12-1 ET**  
**On-line Registration**



# Questions?



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

---



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](http://www.IHI.org/RegisterFull).



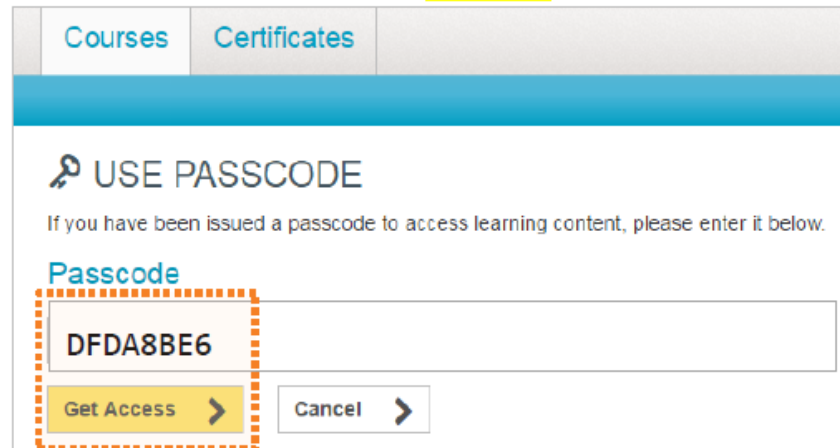
# Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

## Step 2: Enter your group's passcode.

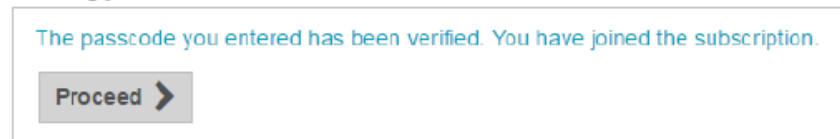
- After you have successfully logged in, go to [www.IHI.org/EnterPasscode](http://www.IHI.org/EnterPasscode).



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

A screenshot of a web form titled "USE PASSCODE". The form has two tabs: "Courses" and "Certificates". Below the tabs is a blue header bar. The main content area contains a key icon and the text "USE PASSCODE". Below that is the instruction: "If you have been issued a passcode to access learning content, please enter it below." There is a label "Passcode" above a text input field. The input field contains the text "DFDA8BE6". Below the input field are two buttons: "Get Access" with a right-pointing arrow, and "Cancel" with a right-pointing arrow. The "Get Access" button is highlighted with a yellow background and a dashed orange border.

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

A screenshot of a confirmation message box. It contains the text: "The passcode you entered has been verified. You have joined the subscription." Below the text is a button labeled "Proceed" with a right-pointing arrow.

# 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](http://www.IHI.org/OnlineCourses). Bookmark the link for easy access.