Institute *for* Healthcare Improvement

MDHHS
Michigan Department of Health & Human Services

MI PCMH Initiative Practice Transformation Collaborative

September 14, 2017

The IHI Support Team

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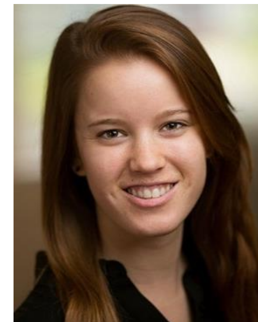
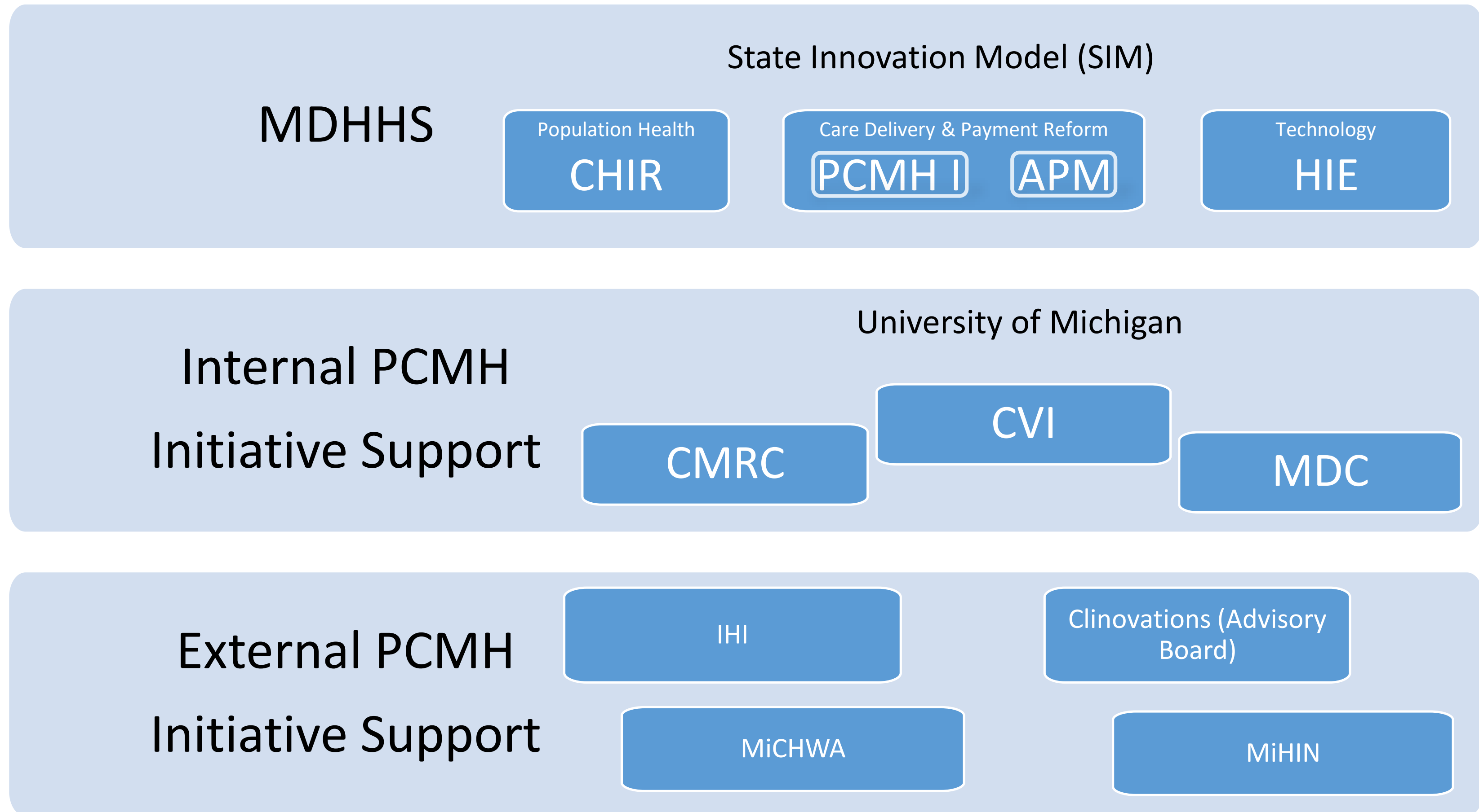


Julia Nagy
Project Coordinator

SIM PCMH Initiative Team Structure



The MDHHS PCMH Initiative Team

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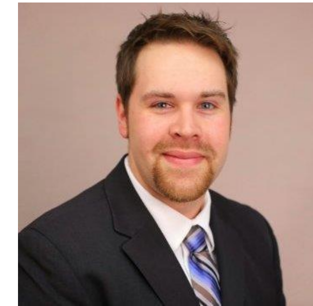
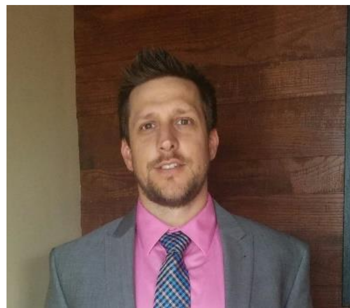
PCMH Initiative Coordinator



Phillip Bergquist
Policy & Strategic Initiatives Manager



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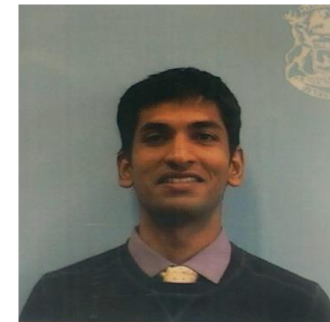
Sr. Business Analyst

Linda Pappas
Project Assistant



Yagna Talakola
Project Manager

The PCMH Initiative Internal Support Team

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Susan Stephan
Sr. System Analyst - MDC

Cisco WebEx Event Center

MI PCMH Initiative Practice Transformation Collaborative

Webinar #6

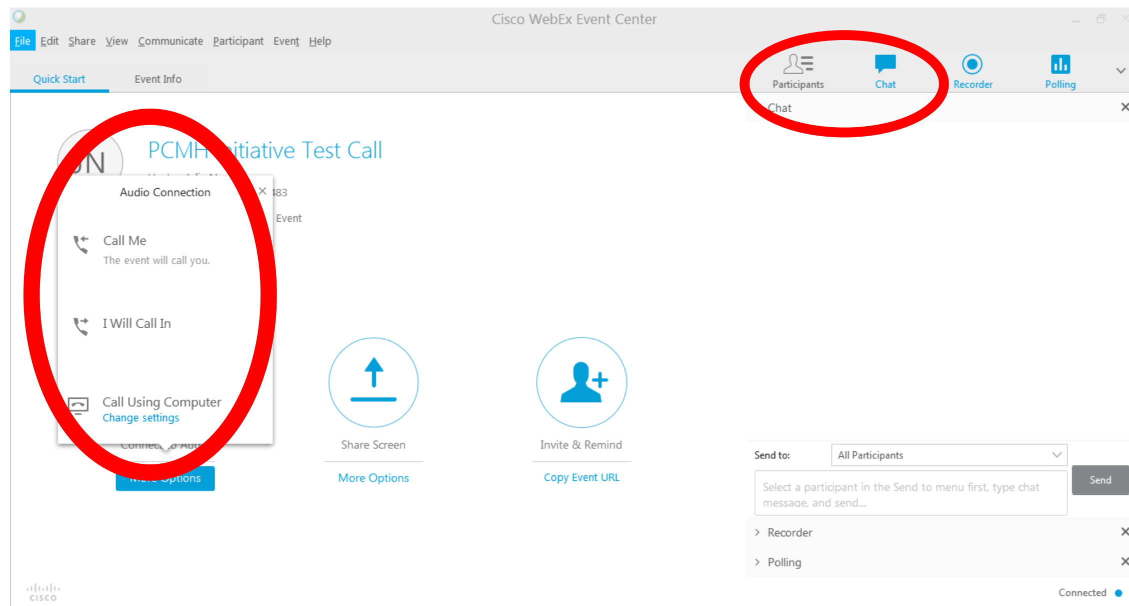
August 10, 2017

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

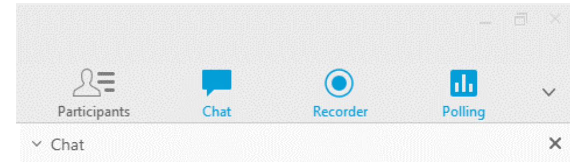
2) You can select to call in to the session, or to be called. If you choose to call in yourself, please dial the **phone number**, the **event number** and your **attendee ID** to connect correctly.



WebEx Quick Reference

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

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



Select Chat recipient

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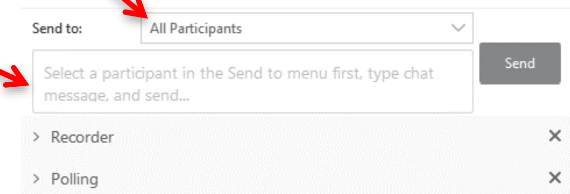
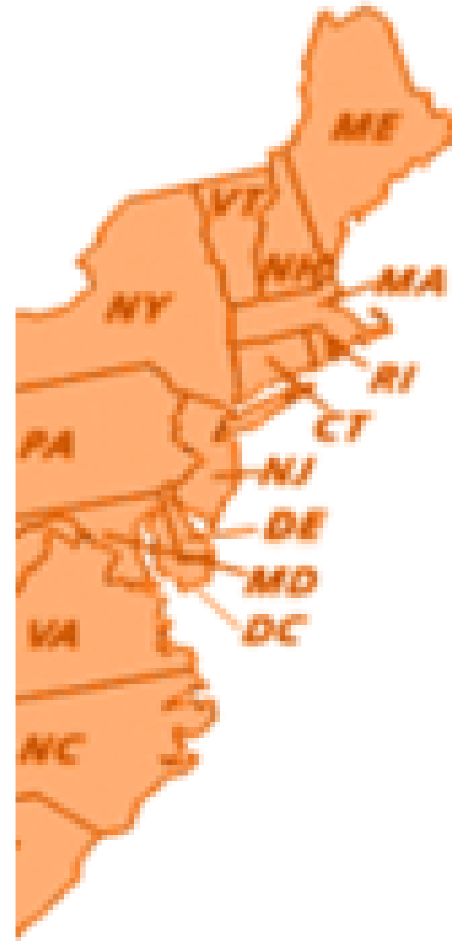


Where are you joining from?



Agenda

- Welcome, Introductions, Setting the Stage
- Learnings from Michigan SIM PCMH Semi-Annual Practice Transformation Survey
- Looking Ahead
  - Peer Coaching Calls
  - Summits
  - Learning Collaborative
  - Q & A

But, before we start, if you missed last month’s call, don’t miss listening to the recording!

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.*"

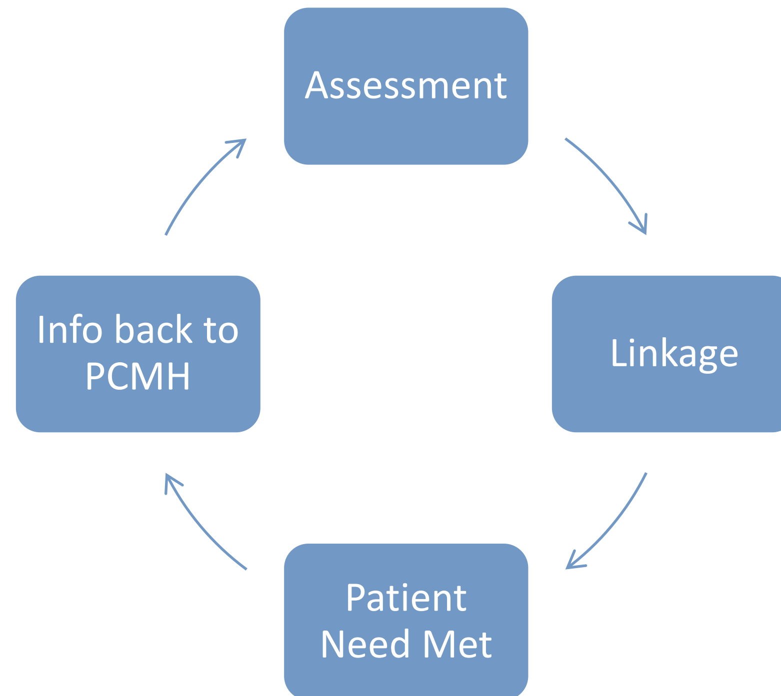
Key Learnings & Discussion

> ***"The questionnaire is what I have been waiting for in my 27 years of practice""***
> **Dr. Ramona Wallace**

- 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!!

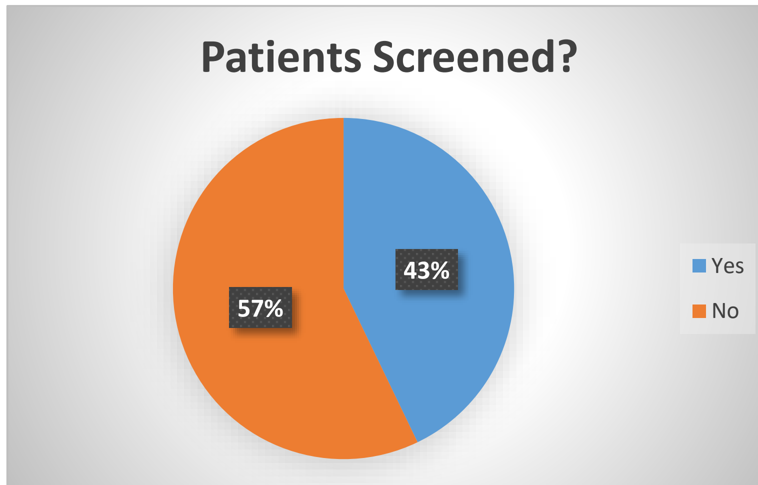
MI SIM PCMH Semi-Annual Practice Transformation Survey w/ Focus on CCL

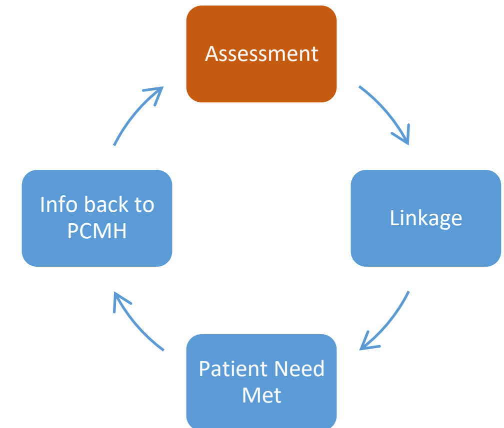
Key Learnings



Patients Screened for the First 6 Months

43% of the POs/practices have started the screening process





- 18 out of the 42 POs/practices have started the screening process
- 4 POs/practices have screened over 1,000 patients with in the first 6 months for the PCMH Initiative

Assessing Patients' Social Determinants of Health

Domain	Question	Response	
Healthcare	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
Food	Do you ever eat less than you feel you should because there is not enough food?	Yes	No
Employment & Income	Do you have a job or other steady source of income?	Yes	No
Transportation	Do you have a dependable way to get to work or school and your appointments?	Yes	No
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
General	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No

Remaining Improvement Opportunities

Assessing Patients' Social Determinants of Health

Domain	Question	Response	
Healthcare	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

But over 80% of a plan! Biggest gap identified: monitoring screening completion.

Domain	Question	Response	
	shampoo.		
General	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No

Monitoring Completion

- How are you doing this? Advice for others?
- What was easiest and why?
- What was hardest and how did you overcome?

Quality Improvement Considerations

1. Assure common aim--that staff all know and support what this is (SDoH and Community Clinical Linkages) and why you are doing this—what is at the heart of this work?

Engaging Staff

- Common Definition
  - “The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. “
- Getting to the “Why”
  - Clinicians have long recognized the connection between unmet basic resource needs – e.g. food, housing, and transportation – and the health of their patients. More than 70% of health outcomes are attributable to the social and environmental factors that patients face outside of their PCMH.

Engaging Staff

- Creating effective linkages between clinical and community settings can improve patients' access to services by developing partnerships between organizations that share common goals. These linkages have many positive outcomes:
  - Patients get more help and more broadly based support in changing unhealthy behaviors
  - Clinicians get help in offering services to patients that they cannot provide themselves
  - Community programs get help in connecting with clients for who
  - their services were designed
  - Partnerships and relationships among clinical, community, and public health organizations are strengthened to better work together in filling service gaps
  - Health care delivery, public health, and community-based activities are coordinated to maximize their impact

Engaging Staff

- Has everyone in the PCMH taken a Social Determinants of Health Assessment? Experienced it?

Quality Improvement Considerations

1. Assure that staff all know what this is and why you are doing this—what is at the heart of this work?
2. Select the population that you will be assessing and identify at what visit the screening will take place (survey revealed that most are doing it at well visits to start vs. acute visits)
3. Map out the steps in that visit including who does what
4. Identify where you might test administering the assessment

Many ways to administer

- **Patient Self Screening Followed By Staff/Clinician Review**
  - Example: A patient is handed a paper screening form during check-in to complete in the waiting room. The screening is given to a Care Coordinator for review before/during the patient's appointment.
- **Assisted Patient Self Screening Followed By Staff/Clinician Review**
  - Example: At check-in the patient is invited to take a seat in semi-private reception area to complete a paper screening form with a MA. The MA introduces the screening, why the practice is asking these types of questions, and answers questions the patient may have. The screening is given to a Care Coordinator for review before/during the patient's appointment.
- **Staff Administered Screening Followed By Staff/Clinician Review**
  - Example: As part of rooming a patient, a Medical Assistant introduces the screening, asks the patient a series of screening questions, and marks the patient's answers in the EHR. The EHR alerts a Care Manager that a screening is ready to review before/during the patient's appointment.
- **Staff Administered Screening and Review**
  - Example: Before/during/after the patient's appointment, a Care Manager introduces the screening, why the practice is asking these types of questions, and asks the patient a series of screening questions. The Care Manager marks the patient's answers in the CM system during the screening and takes action (as needed) on the results

Source: LS2 Breakout Session Slides

IHI's Innovation Team Report

Beware relying on only one person or position to carry this out. Everyone's part in this is critical!

Do not put too much burden on one role.

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Roles& Responsibilities as Reported in the Survey

Roles	Responsibilities
• Clinical Staff • CHW • BH Navigator • Care manager • Care Coordinator • Referral Specialist • Front desk • Administrative lead • Certified Application Counselors • Quality staff • Social Worker	• Perform screening procedure • Review results • Refer to community services (Meals on Wheels, Commission on Aging, Shelter, United Way, Community Mental Health service) and government-funded programs (Medicaid, Medicare, Social Security, WICC, MiChild) • Track and follow up with patients on the progress and satisfaction with the referral • Mapping the data to i2i system registry, generate reports to facilitate follow up and identify areas of highest need • Establish MOUs with community organizations and perform annual check-in to determine if community organization is still able to provide services

Quality Improvement Considerations

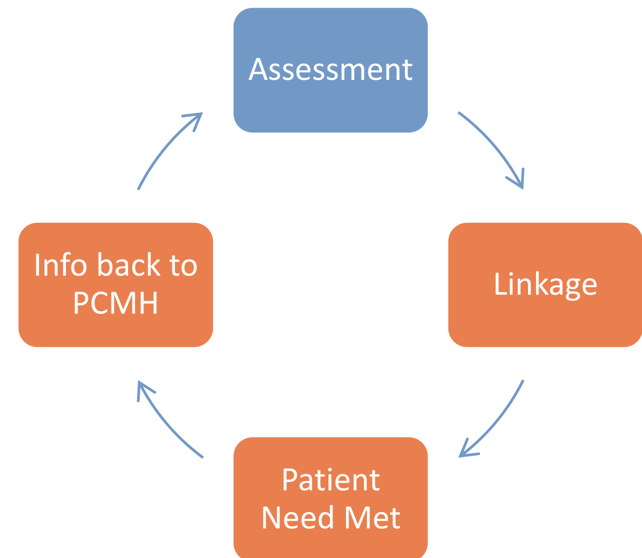
1. Assure that staff all know what this is and why you are doing this—what is at the heart of this work?
2. Select the population that you will be assessing and identify at what visit the screening will take place (survey revealed that most are doing it at well visits to start vs. acute visits)
3. Map out the steps in that visit including who does what
4. Identify where you might test administering the assessment
5. Develop a plan to test (who, what, when, where, why, predictions, measures)
6. Test it with one or two patients
7. Study what happened
8. Adapt and test again

Early PDSA findings

- During acute visits is difficult to have patients fill out assessment. It works more efficiently when the patient is here for a Health Maintenance Exam where the provider has time to address some of the patients concerns.
- More effective when there is a warm hand off between the MA and CHW when the screening is complete and a need is identified.
- Less effective when the CHW have to call the patients after the visit. Even with an up to date phone number, patients rarely call back or want to discuss needs over the phone.

Linking Patients to Supports & Closing the Loop

- The harder part—where it gets a little (okay, a lot) “messier”
- System becomes much more complex once outside the walls of the PCMH (remember the yarn??!!)
- Only 5 reported anything about their plan or process for following up with patients
- Opportunity for continued focus and improvement



Looking Forward at Opportunities to Close Remaining Gaps

Peer Coaching Calls (See website)

- Tuesday, September 19, 2017
  - Strategies for Getting Buy-in from the Care Team, Patients and Partners on Clinical-Community Linkages
- Wednesday, September 20, 2017
  - Strategies for Strengthening Relationships with Existing Partners and for Identifying and Exploring New Ones
- Thursday, September 28, 2017
  - Using Data to Inform Improvement of Clinical-Community Linkages
- Friday, September 29, 2017
  - Time reserved for unique Physician Organization Topics

All sessions 12-1 ET On-line Registration

Regional Summits

Q4 Preview: Annual Regional Summits

Taking Michigan Forward with Team-Based Care

Purpose:
Each interactive regional summit will facilitate collaboration and shared learning focused on efficient team- based care in the primary care setting. Together physicians, practice team members, Physician Organization leaders and partners will address clinical and office operations aimed at meeting the diverse needs of the Michigan patient population.

Intended Audience:
The summits are intended for Michigan State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative participants and partners including physicians, practice teams, care managers, care coordinators, Physician Organization leaders, Community Health Innovation Region (CHIR) partners, and health plans.

Contact Hours:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Michigan State Medical Society (MSMS) through the joint providership of Practice Transformation Institute and Michigan Department of Health and Human Services. Practice Transformation Institute is accredited by the MSMS to provide continuing medical education for physicians.

Practice Transformation Institute designates this live activity for a maximum of (6) *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Practice Transformation Institute is accredited by the International Association for Continuing Education and Training (IACET) and is authorized to issue the IACET CEU. Practice Transformation Institute is authorized by IACET to offer .6 CEUs for this program.

This activity provides 6 Social Work Continuing Education Contact Hours. "Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative". Approved Provider Number: MICEC 1102160

West
October 10, 2017
Frederik Meijer Gardens & Sculpture Park
1000 East Beltline Ave NE
Grand Rapids, MI 49525
REGISTER HERE

Southeast
October 17, 2017
University of Michigan North Campus Research Center
2800 Plymouth Rd, Bldg. 18
Ann Arbor, MI 48105
REGISTER HERE

North
October 24, 2017
Crystal Mountain Resort & Conference Center
12500 Crystal Mountain Dr.
Thompsonville, MI 49683
REGISTER HERE

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

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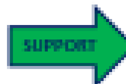
Learning Collaborative

Q4 Preview: Practice Transformation

BY NOVEMBER 1, 2017 PRACTICES MUST:
Complete the PCMH Initiative's required Practice Transformation Objective of Clinical-Community Linkage:

1) Implementing SDoH Brief Screening Plan
2) Provide Linkages to Community Based Organizations
3) Quality Improvement Activities

Semi-Annual Practice Transformation Report*
Due December 22, 2017
*will be released 6 weeks in advance



Phase Two:
PCMH Initiative Practice Transformation Collaborative

We are seeking* Patient Centered Medical Home teams interested and ready to accelerate their journey in Clinical-Community Linkages. This phase will be designed to accelerate your journey in linking patients to the support they need, when and where they need it. This collaborative will:

- Focus on working with practices to move from "Good" to "Great"—from having good linkages to having *reliable* linkages,
- Feature content on quality improvement and best practices related to Clinical-Community Linkages,
- Provide opportunities for local quality improvement coaches to support teams,
- Engage community partners and patient representatives to meaningful contribute to the design of improved linkages,
- Promote networking with and learning from colleagues and practices across Michigan.

**Interest to be captured in 2018 Intent to Continue Participation process*

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

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Questions?

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

Login Instructions

Open School

How to Access the IHI Open School Online Courses

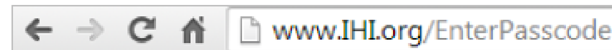
Step 1: Log in to IHI.org.

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

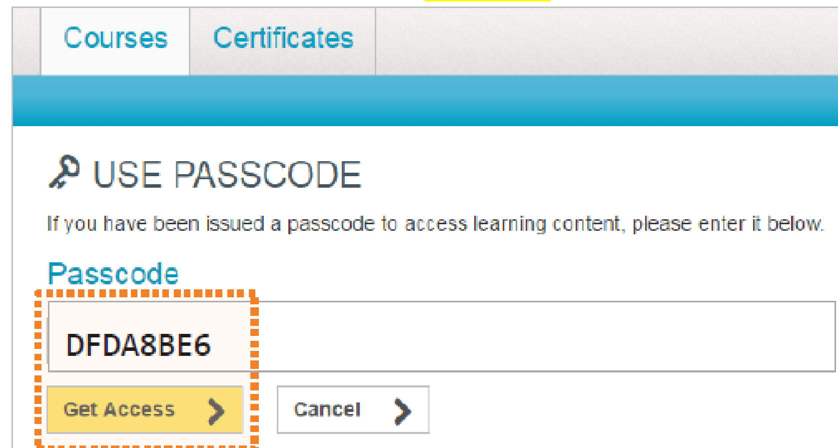
Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

Step 2: Enter your group's passcode.

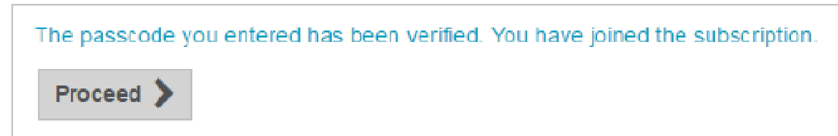
- After you have successfully logged in, go to www.IHI.org/EnterPasscode.



- 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.