

# Using Data to Inform Improvement of Clinical- Community Linkages

*Peer Coaching Call*



September 28, 2017

# Peer Coaching Calls (See website)

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- ~~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 Identifying and Exploring New Ones
- **Thursday, September 28, 2017**
  - **Using Data to Inform Improvement of Clinical-Community Linkages**
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  - Time reserved for unique Physician Organization Topics



**Institute for Healthcare Improvement**

**MDHHS**  
Michigan Department of Health & Human Services

# MI PCMH Initiative Practice Transformation Collaborative

*Peer Coaching Call*



July 18-21, 2017

These presenters have nothing to disclose

Participants (7)

Speaker:

Panelist: 7

- TD Tam Duong (me)  
- JN Julia Nagy (Host)
- CD coleen dewey
- SK Shawn Kintigh
- SB Sue Butts-Dion
- SG Sue Gullo
- TL Teri Lamia

Attendee: 0 (0 displayed)

Chat

from missy davison to all participants:  
I am the incentives coordinator and am attending today as a representative. Looking forward to having additional members of our care team attend in another meeting and can share their insights.

from dave stetson to All Panelists:  
awesome to have us all as panelists to participate and share collaboratively, nice touch!!

Send to: All Participants

Send

Connected



# Peer Coaching Call/Webinar Aims

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- Share successes
- Share challenges
- Share learning
- Get support from others
- Hear new ideas
- Share documents, products, or develop together (can facilitate this if know in advance!)
- Time and space dedicated to you!

# Welcome

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- Your Role

- Attend with a spirit of transparency, curiosity and willingness to share
- Who is on? A trip around the virtual room 😊

# Tell us about your data...

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- What do you collect related to Clinical Community Linkages?
- How do you collect and report data?
- How do you share the data?
- Can snap a picture of your data and send it to Julia Nagy ([jnagy@IHI.org](mailto:jnagy@IHI.org))?



Week of:  
9/18-9/22

# Huddle Info

Kitchen Duty:

Veronica

Schedule

Staffing

Updates

Concerns

Monday

openings

Provider meeting at 9:00

OK

Kelly leaving at 11:45 meeting

-

walk ins to schedule  
encourage MyHealth

Tuesday

openings

No nurse  
MA's to cover

Chris - mgr meeting  
in breakroom at  
2:30

DO SHLI's!!  
CPE Labs not getting  
Completed

Wednesday

Thursday

Friday

Tobacco Use

mm47-KIND???

Opport?

Cher?

Opport?

Working? Thinking to do...

PROL: Stop anyone in the hallway from...

# Data for Improvement, Accountability and Research in Health Care

Aspect	Improvement	Accountability or Judgment	Research
<u>Aim:</u>	Improvement of care processes, systems and outcomes	Comparison for judgment, choice, reassurance, spur for change	New generalizable knowledge
<u>Methods:</u>	Test observable	No test, evaluate current performance	Test blinded
<u>Bias:</u>	Accept consistent bias	Measure and adjust to reduce bias	Design to eliminate bias
<u>Sample Size:</u>	“Just enough” data, small sequential samples	Obtain 100% of available, relevant data	“Just in case” data
<u>Flexibility of Hypothesis:</u>	Hypothesis flexible, changes as learning takes place	No hypothesis	Fixed hypothesis
<u>Testing Strategy:</u>	Sequential tests	No tests	One large test
<u>Determining if a Change is an Improvement:</u>	Run charts or Shewhart control charts	No focus on change	Hypothesis, statistical tests (t-test, F-test, chi square, p-values)
<u>Confidentiality of the Data:</u>	Data used only by those involved with improvement	Data available for public consumption	Research subjects’ identities protected
<u>Frequency of Use:</u>	<b>Daily, weekly, monthly</b>	<b>Quarterly, annually</b>	<b>At end of project</b>

Source: The Health Care Data Guide: Provost and Murray, 2011. Developed from Solberg, Leif I., Mosser, Gordon and McDonald, Susan. “The Three Faces of Performance Measurement: Improvement, Accountability and Research.” Journal on Quality Improvement. March 1997, Vol.23, No. 3.





# Measures for Accountability

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- SIM PCMH Initiative Semi-Annual Practice Transformation Report
  - Social Determinants of Health
    - Screening Plan, Procedure, and Tool
  - Clinical Community Linkage Methodology
    - Roles and Responsibilities, Information Sharing, Training Approach, Partnerships, Documentation
  - Quality Improvement Activities
    - Process Reviews, Documentation Reviews, Addressing Gaps



# Reporting requirements and improvement...not mutually exclusive!

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## ● Reporting requirements

### **CCL Part I: ASSESSING PATIENTS' SOCIAL DETERMINANTS OF HEALTH**

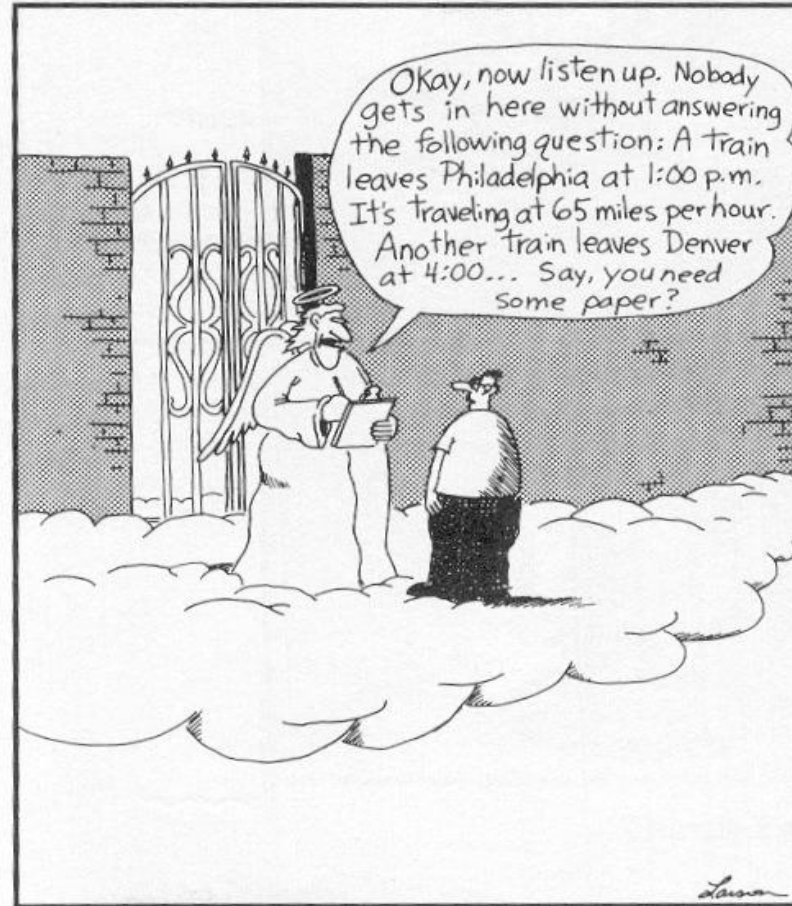
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Provide a copy of your organization's Social Determinants of Health screening plan, include the following information within the plan:

- The circumstances/visits during which PCMHs will administer screening
  - Anticipated time it will take to complete the first screening across the attributed population
  - The timing and process for ongoing patient screening
  - The approach to monitoring screening completion and closing screening gaps
- 



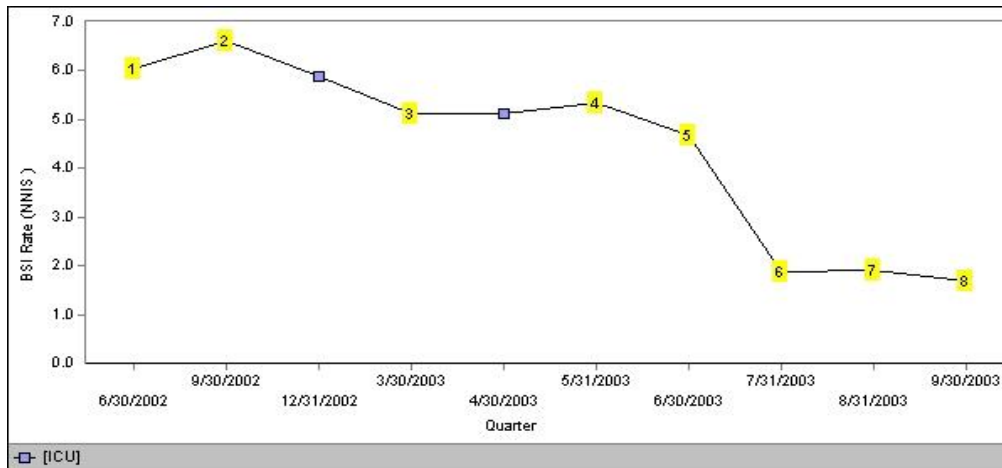
# Data Display & Analysis



Math phobic's nightmare

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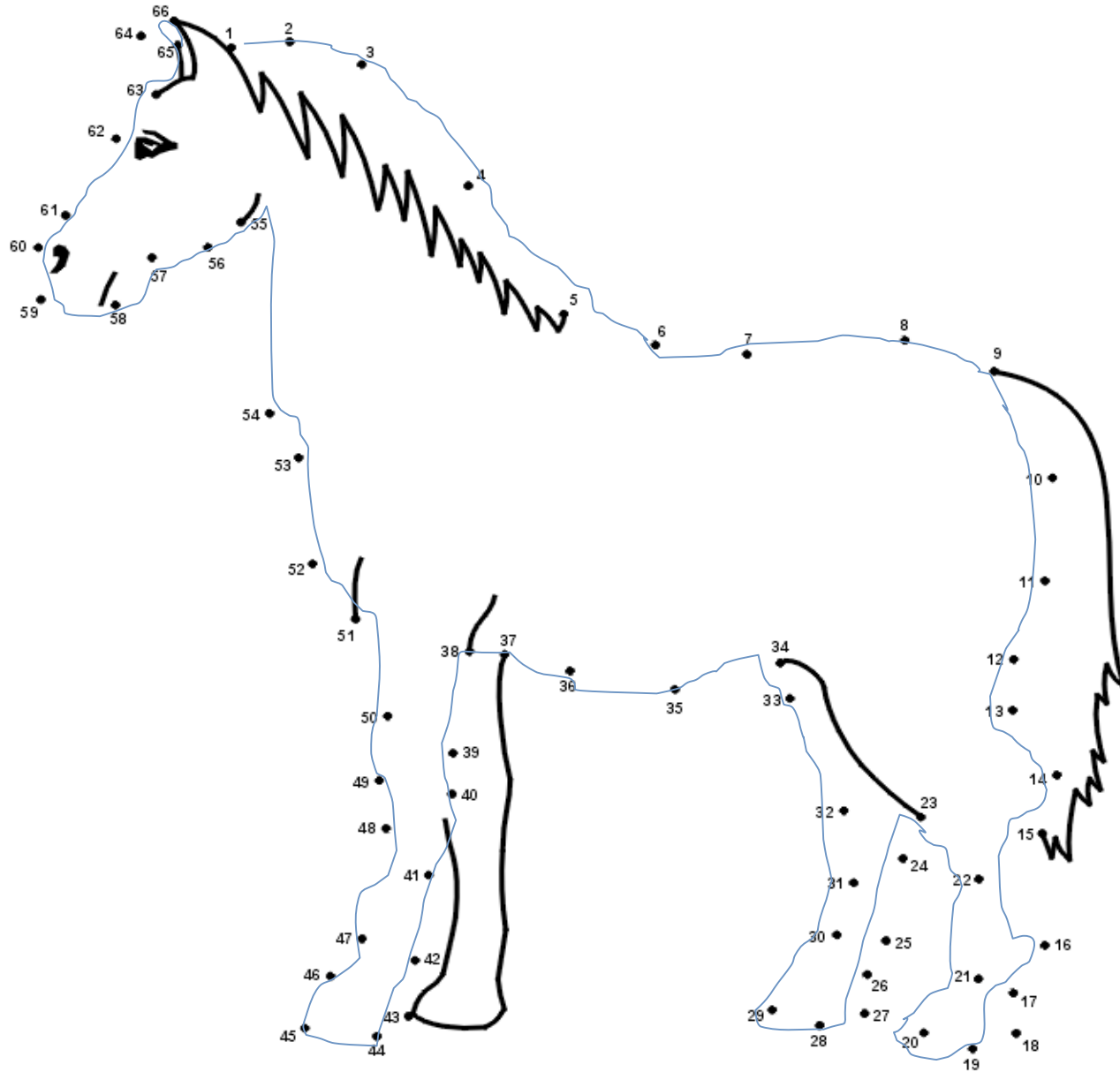
**Plot data over time:** “Tracking a few key measures over time is the single most powerful tool a team can use.”



# Kind of Like Connecting the Dots...

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# The Headlines Scream - Great News!

## Tennessee highway fatalities drop for third straight year

Associated Press

NASHVILLE — Traffic fatalities in Tennessee are dropping for the third straight year, the state Department of Safety says.

So far this year, Tennessee has recorded 962 traffic fatalities and likely will finish 50 to 75 below last year's 1,223, state Department of Safety spokesman Anthony Kimbrough said.

Tennessee recorded 1,239 traffic deaths in 1996 and 1,259 in 1995.

"We like to think that more active law enforcement has been a factor," Kimbrough told the state House highway safety subcommittee.

Other contributors to the lower number of traffic deaths

Safety administration representative told legislators on Monday that Tennessee needs a mandatory seat belt law. Fourteen other states have such a law.

It's too early to say whether the subcommittee will recommend a primary seat belt law, said chairman Don Ridgeway, a Democratic representative from Paris.

Subcommittee members also are investigating safety at railroad crossings.

Tennessee has about \$3.5 million for railroad safety. Subcommittee members are looking at safer crossing devices including longer, but more expensive, crossing arms and video monitors to record gate-runners.

Kimbrough also reported

### Highway Deaths

Associated Press

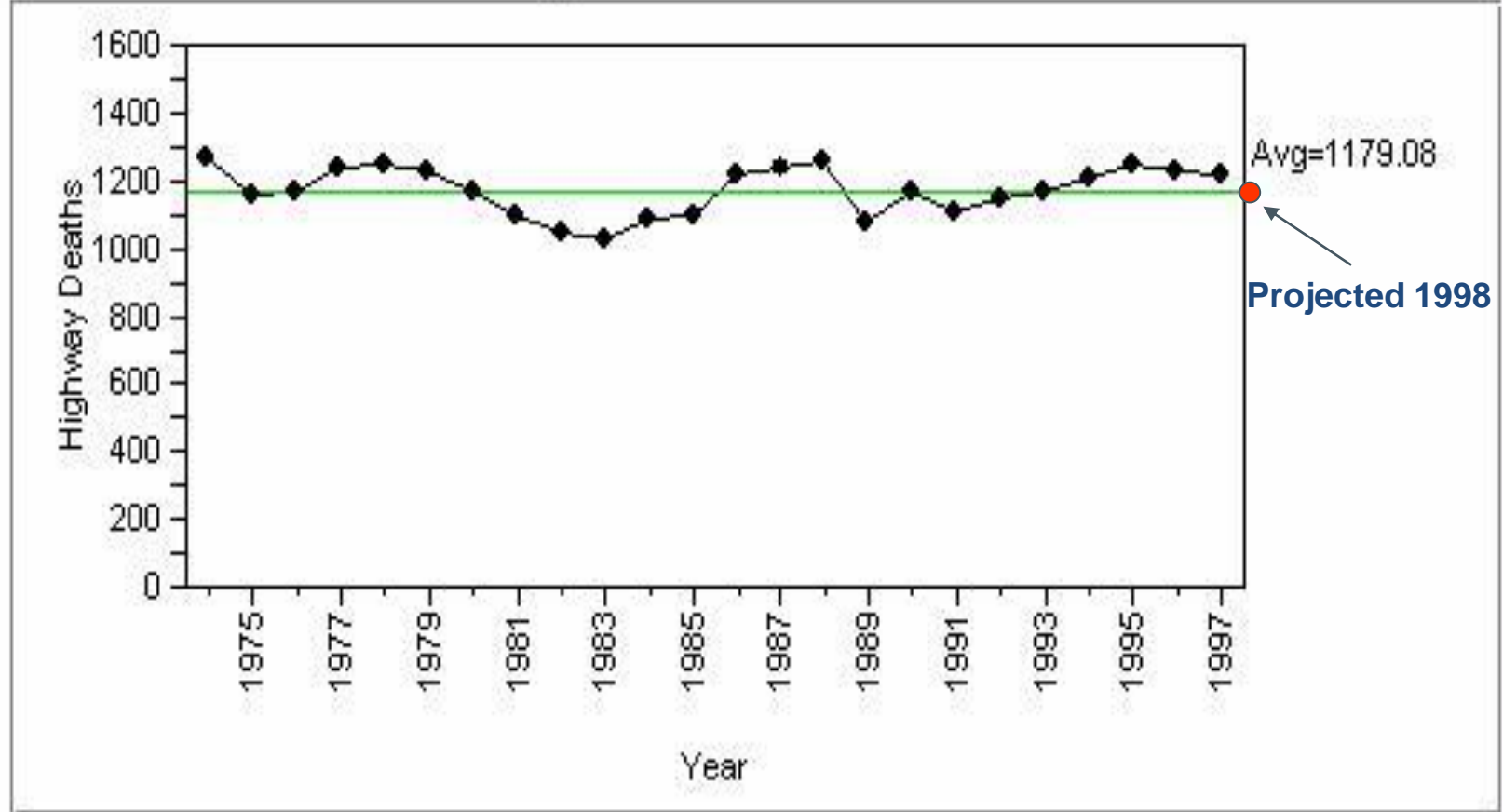
NASHVILLE — Traffic fatalities in Tennessee year-by-year since 1972:

1997:1,223	1984:1,095
1996:1,239	1983:1,037
1995:1,259	1982:1,055
1994:1,214	1981:1,104
1993:1,177	1980:1,171
1992:1,158	1979:1,236
1991:1,113	1978:1,256
1990:1,177	1977:1,244
1989:1,080	1976:1,172
1988:1,266	1975:1,162
1987:1,247	1974:1,274
1986:1,200	1973:1,441
1985:1,101	1972:1,431

# Reality

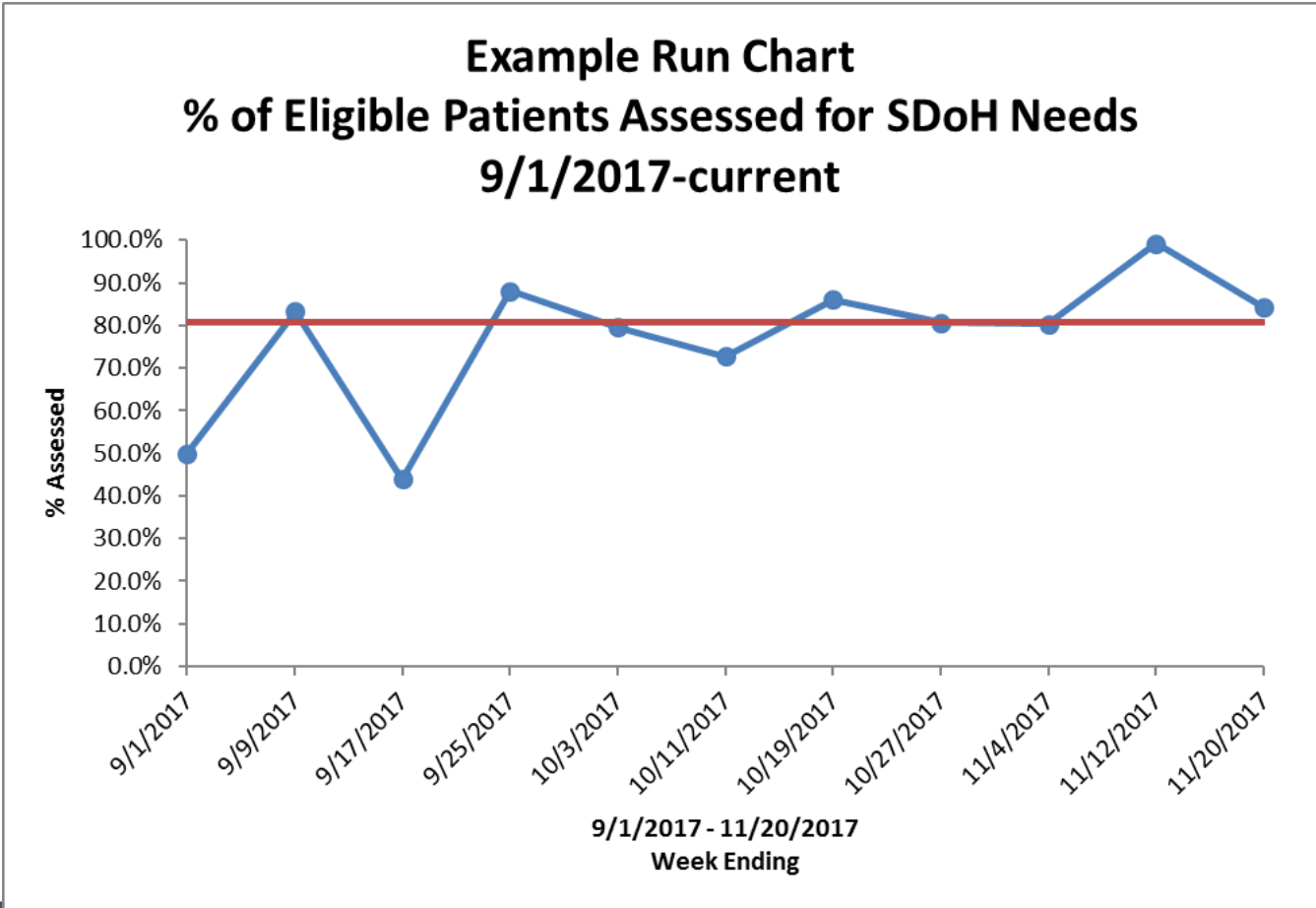
## Traffic Fatalities

### State of Tennessee 1974 through 1997





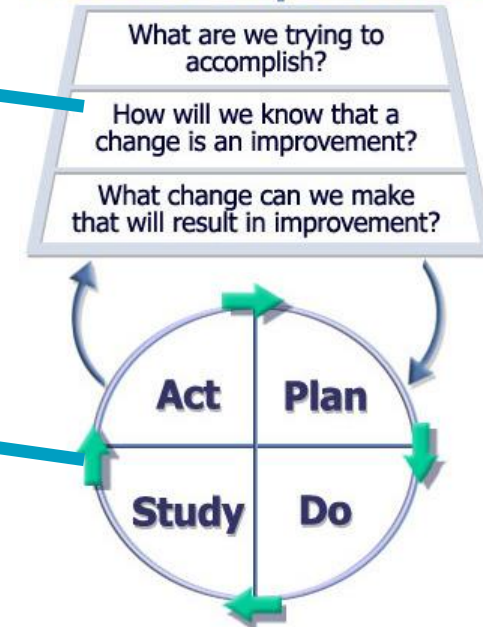
# Run Charts—Best way to display data to inform improvement



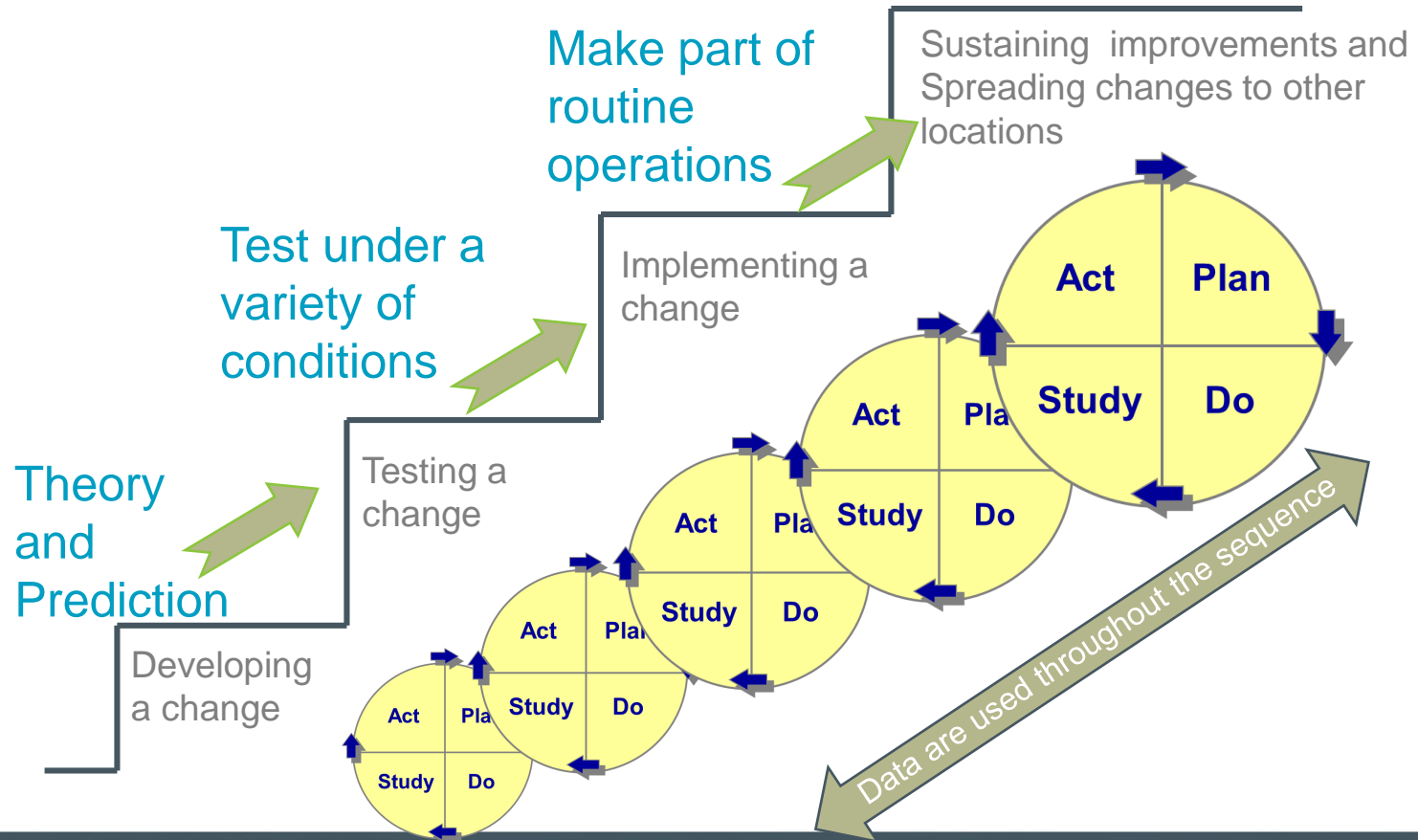
# Two Levels of Measures with the MFI

- Global: focus at the project level and are maintained throughout the life of the improvement project.
  - Quantitative Data
    - % of patients with SDoH completed
    - % of patients linked to support
    - % w/ feedback loop closed
  
- PDSA-level: Measures are done on an as needed basis for diagnosis and for assessment of the changes tested
  - Qualitative and/or quantitative
    - % patients answering f/u phone calls to check on linkage
    - Patient and staff feedback on various process things tested in pursuit of improving outcome measures

## Model for Improvement



# Measurement is used Throughout the Sequence of Improvement



# CCL-Operational Definition/Objective— What are we trying to accomplish?

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- Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below:
  1. Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
  2. Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made.
  3. As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.



**“In God we trust.  
All others must  
bring data”.**

W. Edwards Deming



# Stages of Facing Reality: Reactions to Data

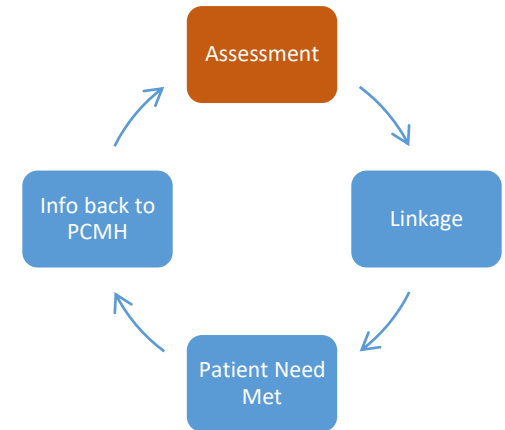
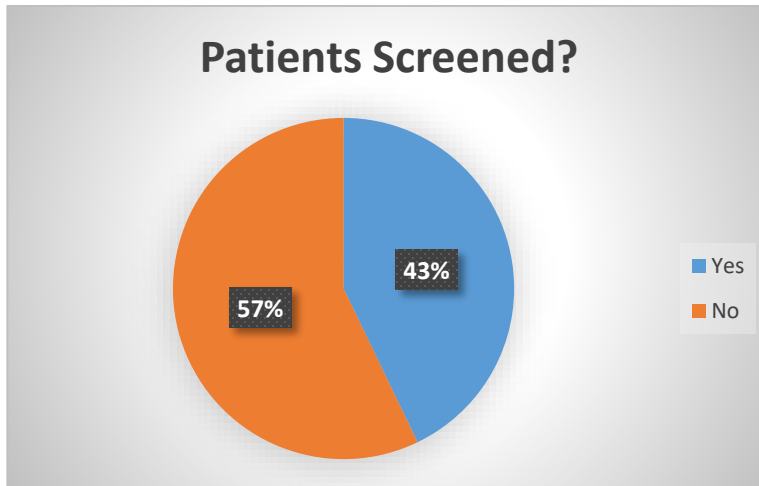
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- “The data are wrong”
- “The data are right, but it’s not a problem”
- “The data are right; it is a problem;  
but it is not my problem.”
- “I accept the burden of improvement”



# 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 within the first 6 months for the PCMH Initiative

## Assessing Patients' Social Determinants of Health

Domain	Question	Response	
<i>Healthcare</i>	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

**Biggest gap identified: monitoring screening completion.**

<i>Transportation</i>	Do you have a dependable way to get to work or school and your appointments?	Yes	No
<i>Clothing &amp; Household</i>	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
<i>General</i>	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No





# Questions?

**What is something that could help you with data collection, reporting and analysis?**



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