Workshop: Welcome, Overview & Introductions

State Innovation Model
Patient Centered Medical Home Initiative
Practice Transformation Collaborative: Learning Session 2

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.
Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test care delivery and payment system changes.

• Strategies focus on moving towards cost-effective use of healthcare dollars overall in terms of patient experience and quality outcomes.
• System that coordinates care within the medical system to improve disease management and utilization; and out into the community to address social determinants of health.

Vision: A person-centered system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, improve health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes.
Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.
Population Health Goals

• Better population health and health care delivery at lower costs

• Align priorities across health and community organizations, and support the broad membership of the CHIR in executing improvement strategies.

• Initiatives focused on both: (1) primary prevention, as well as (2) addressing the social determinants of health that impact residents’ ability to stay healthy and/or manage disease through linkages between health care and social services.

• Enhancement of local policy, identification of cross-organization programmatic and procedural improvements, and development of a built environment that encourages health and wellness.

• Further development of capacity and sophistication for effective and efficient governance, partnership, data collection and information sharing, and integrated service delivery.

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.
The overall goal of the Community Health Innovation Region (CHIR) is to **develop community capacity** to improve population health. The objectives of the CHIR are to:

- Leverage the existing, well-developed capacity in communities to bring regional partners together to identify and address community health needs.

- Develop and implement linkages between Accountable Systems of Care, payers, and community-based agencies to address social determinants of health.

- Enhance local policy, identify cross-organization programmatic and procedural enhancements, and advance built environment efforts to encourage health and wellness.

- Further develop a high level of organization and sophistication in terms of governance, partnership, data collection and information sharing, and integrated service delivery.

---

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

<table>
<thead>
<tr>
<th>Support Scale for What’s Working</th>
<th>Encourage the “Next Step” for Advancement</th>
<th>Test Promising Practices Where Opportunities Exist</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH Recognition as a Foundation</td>
<td>Team-Based Care Practices</td>
<td>Clinical-Community Linkages</td>
</tr>
<tr>
<td><strong>Advanced Access</strong> (24/7, Open Access, Non-Traditional Hours)</td>
<td><strong>Integrative Treatment Planning</strong></td>
<td><strong>Health Literacy and Social Determinants Perspectives</strong></td>
</tr>
<tr>
<td><strong>Electronic Health Record and Registry Base Technology</strong></td>
<td>Provider Collaboration and Integration</td>
<td>Patient-Reported Outcomes</td>
</tr>
<tr>
<td>Structured Quality Improvement Processes</td>
<td><strong>Robust Care Management and Coordination</strong></td>
<td>Referral Decision Supports</td>
</tr>
<tr>
<td></td>
<td>Patient Education and Self-Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caregiver Engagement</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Transitions of Care</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managing Total Cost of Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Health Information Exchange Use Cases</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Patient Experience Perspectives</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Population Health Strategies</strong></td>
<td></td>
</tr>
</tbody>
</table>

Bolded items represent current areas of direct focus.

*Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.*
“Practice Transformation” or “PCMH Transformation” refers to the result of enabling a primary care Practice to use both educational and financial support to develop the following characteristics of the Patient Centered Medical Home:

1) infrastructure,
2) organizational, and
3) cultural changes

i.e., primary care provider-led; prepared and proactive care teams providing comprehensive, whole person care; coordination of care across healthcare settings; enhanced patient access; use of electronic technology; and development of a culture that encourages striving for continual improvement in patients’ experience of care and health outcomes for the entire Practice panel, while reducing preventable costs.
Refresher- PCMH Initiative Participation Agreement

• Practice Requirement, By November 1, 2017: “Complete the PCMH Initiative’s required Practice Transformation Objective (clinical-community linkage), including submitting practice transformation progress reporting on a semi-annual basis.”

• Practice Requirement, During the Initiative: “Complete the required Practice Transformation Objective (as defined in the Participation Agreement), demonstrate progress toward completing the Practice Transformation Objective selected from the Initiative’s menu of objectives, and report progress in a manner defined by the Initiative on a semi-annual basis.”

• PO Requirement (As Applicable): “Submit practice transformation progress reporting on a semi-annual basis for participating Practices which choose to pursue Practice Transformation Objectives in partnership with the PO.”

• “Practice Transformation Objective” or “Transformation Objective” refers to the care delivery enhancements and/or quality improvement activities defined by the Initiative that a Practice undertakes as to improve quality, improve health outcomes (including patient experience), improve access to care, and/or reduce health care costs. A list of Transformation Objectives is provided in Appendix F of the Participation Agreement and on the SIM Care Delivery webpage.
Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Practice Transformation Objectives

- Clinical-Community Linkages
- Telehealth Adoption
- Improvement Plans from Patient Feedback
- Medication Management
- Population Health Management
- Self-Management and Support
- Care Team Review of Patient Reported Outcomes
- Group Visit Implementation
- Integrated Peer Support
- Patient Portal Access
- Cost of Care Analysis
- Integrated Clinical Decision Making
Participant Requirements: Testing Promising Practices

Clinical Community Linkages:
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:

- Assess patients’ social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
- 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.
- 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.”
What is Bringing Us Together: Practice Transformation

The objective of the PCMH Initiative’s practice transformation objectives and payment model is to support the advancement of infrastructure within (or accessible to) PCMH practice environments.

Practice transformation in this context is not focused on (or funded to support) the act of delivering a service to an individual patient.

Rather, practice transformation support in the PCMH Initiative is geared toward building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.
More Than a Flip of a Switch

Transformation requires:

• Changes in:
  o Scheduling
  o Access requirements
  o Coordination
  o Types of visits (i.e. group visits)
  o Provision of services (e.g. telehealth)
  o Practice management
  o Staff roles

• Incorporating population medicine
• Evidence based care
• Redefining patient visit
• Response to patient needs and events outside of the clinical setting

• New coordination points:
  o With other parts of the healthcare system
  o With partners outside of the healthcare system

• Team based care
• New strategies for patient engagement
• Use of Information Systems including leveraging Health Information Exchange
• Outcomes based staffing
• Quality Improvement at the point of care

Adapted from Initial Lessons Learned from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home ANNALS OF FAMILY MEDICINE MAY/JUNE 2009
In This Together

• The Practice Transformation Collaborative supports:
  o “Going beyond” Patient Centered Medical Home,
  o Sustaining change, and
  o Continuous quality improvement

• Provides participants the opportunity to work together to support successful practice transformation

• Key Partner: Institute for Healthcare Improvement (IHI)
  • IHI is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide

• How to Engage in this opportunity:
  o Action Period Calls
  o Learning Sessions
  o Peer Coaching Calls
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

<table>
<thead>
<tr>
<th>Learning Session 1</th>
<th>Learning Session 2</th>
<th>Future Learning Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 3-4, 2017</td>
<td>June 13-14, 2017</td>
<td>TBD</td>
</tr>
<tr>
<td>Clinical-Community Linkages</td>
<td>Population Health Management &amp; Clinical-Community Linkages</td>
<td>TBD</td>
</tr>
</tbody>
</table>

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.

**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.

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

Quality Improvement 101: Theory & Tools

Sue Butts-Dion
Improvement Advisor
Bad people??

NO!!
All Improvement Requires Change
The Primary Drivers of Improvement

Having the **Will** (desire) to change the current state to one that is better

Developing **Ideas** that will contribute to making processes and outcomes better

Having the capacity and capability to apply CQI theories, tools and techniques that enable the **Execution** of the ideas
How prepared are you?  
(your work group, unit, department, team or facility?)

<table>
<thead>
<tr>
<th>Key Components*</th>
<th>Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will (to change)</td>
<td>Low  Medium  High</td>
</tr>
<tr>
<td>Ideas</td>
<td>Low  Medium  High</td>
</tr>
<tr>
<td>Execution</td>
<td>Low  Medium  High</td>
</tr>
</tbody>
</table>

*All three components **MUST** be viewed together. Focusing on one or even two of the components will guarantee suboptimal performance.
Accelerating change and improvement

When you combine the 3 questions with the... PDSA cycle, you get... …the Model for Improvement.
A Model for Learning and Change

Let’s start with the three questions

Question 1: What are we trying to accomplish?

Developing the team’s Aim Statement

For fun…

- Think of something that you are currently trying to improve (can be personal or professional just be sure that you won’t mind sharing at your table and possibly with the group).
- What is it you are trying to accomplish? Jot it down on a piece of paper.
Key Components of Aim

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

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

“Hope” is not a plan

“Soon” is not a time

“Some” is not a number

Donald Berwick, MD
How did you do?

- Aim Statement:
  - What?
  - For whom?
  - By when?
  - How much?
Alignment...
Sue’s example

What Sue said…
I want my back yard to be a beautiful, lush sanctuary.

What Sue’s husband heard: $$$$$$$$

Sue’s revised aim…
- By July 4th, 2017, I want to have grass in my back yard. Specifically, I want at least 95% of my yard to be covered in grass (currently 10%).
Sue’s example

What Sue said…
I want my back yard to be a beautiful, lush sanctuary.

What Sue’s husband heard:
$$$$$$$$$$

Sue’s revised aim…
- By July 4th, 2017, I want to have grass in my back yard. Specifically, I want at least 95% of my yard to be covered in grass (currently 10%).
Example

By November 1, 2017, our practice will have a reliable system in place for identifying potential community clinical linkages and nurturing those relationships in support of what matters to patients. We will focus specifically on:

- Increasing % of attributed patients assessed using SDoH brief assessment from 0-??%
- Developing and carrying out a communication plan with at least 2 community partners (informed by results of assessment and on our experience and knowledge)
- Increasing the % of closed-loop communications with community partners on behalf of patients referred to them (from X to Y)
Tools to explore systems…
Ecomaps & Sociograms

Our Organization

--- = A Strong Relationship

- - = A Weak/Vulnerable Relationship

\-/-/-\ = A Stressful/Adverse Relationship

← = Flow of Resources
CCL Questions for Consideration

- Linkages to strengthen on behalf of patient?
- Linkages to create?
- How could your practice/organization support this patient in a manner that is responsive, respectful of the patients and family’s goals and ensures that feedback loops are closed?
Ecomaps: through the patient’s eyes…

- Used case studies to map out the clinical-community relationships you may have or may need to strengthen or create on their behalf
Emphasis on “What are we trying to accomplish” WITH a focus on what matters to the patient!
During Learning Session 2…

- A next step for teams leaving LS1 was to go back to their organizational teams and refine aim statement
- Learning Session 2’s story boards will feature revised aims-look for presence of key components
- Look for presence of the patient voice
Question 2: How will we know that a change is an improvement?

Developing a set of measures for your project

Family of Measures

- Outcome measures
- Process measures
- Balancing measures (if useful)
Sue’s Measures

Grass in my back yard:

- **Outcome**
  - % of yard where grass is growing in back yard
  - Health of grass

- **Process**
  - Minutes of watering
  - Time spent planting
  - Time spent treating/ fertilizing
  - # times empty the lawn mower bag

**Balancing**

- **Cost**
  - Beach time missed working on lawn 😊
- **My front yard**
Clinical Community Linkages (example)

**Outcome**
- Clinical Outcomes

**Process**
- % of patients reporting that they were linked to exactly the care they needed when and where they needed it
- % of patients referred with closed loop communication with PCMH documented
- % of patients assessed using SDoH assessment
- % patients with co-created care plan
- % of patients with ecomaps completed

**Balancing**
- Time required to f/u on linkage
- Cost to f/u
- Time spent in office visit
<table>
<thead>
<tr>
<th>First Release</th>
<th>Second Release</th>
<th>Third Release</th>
<th>Fourth Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC: A1c Testing</td>
<td>Chlamydia Screening</td>
<td>Anti-Depressant Medication Management</td>
<td>CDC: A1c Control</td>
</tr>
<tr>
<td>CDC: Eye Exam</td>
<td>Childhood Immunization</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>CDC: Blood Pressure Control</td>
</tr>
<tr>
<td>CDC: Attention for Nephropathy</td>
<td>Adolescent Immunization</td>
<td></td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Well Child Visits (15 Months)</td>
<td></td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Well Child Visits (3-6 Years)</td>
<td></td>
<td>Adult BMI Assessment</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Well Child Visits (Adolescent)</td>
<td></td>
<td>Tobacco Use Screening and Cessation</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Use of High Risk Medications in the Elderly</td>
<td></td>
<td>Screening for Depression and Follow-Up</td>
</tr>
<tr>
<td>Hypertension Prevalence</td>
<td>Lead Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Prevalence</td>
<td>Diabetes Prevalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity Prevalence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Utilization, Cost, and Care Management Metrics

<table>
<thead>
<tr>
<th></th>
<th>First Release</th>
<th>Second Release</th>
<th>Third Release</th>
<th>Fourth Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cause Acute</td>
<td>Percent of Attributed Patients</td>
<td>Total PMPM Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization Rate</td>
<td>Receiving Care Management*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit Rate</td>
<td>Timely Follow-Up with a PCP After Inpatient Discharge*</td>
<td>Preventable Emergency Room Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Day Re-Admission Rate</td>
<td></td>
<td>Ambulatory Care Sensitive Hospitalizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Three Faces of Performance Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
<td>Improvement of care (efficiency &amp; effectiveness)</td>
<td>Comparison, choice, reassurance, motivation for change</td>
<td>New knowledge (efficacy)</td>
</tr>
<tr>
<td><strong>Methods:</strong></td>
<td><strong>Test Observability</strong>*</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
</tr>
<tr>
<td><strong>Bias</strong></td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td><strong>Sample Size</strong></td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td><strong>Flexibility of Hypothesis</strong></td>
<td>Flexible hypotheses, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis (null hypothesis)</td>
</tr>
<tr>
<td><strong>Testing Strategy</strong></td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td><strong>Determining if a change is an improvement</strong></td>
<td>Run charts or Shewhart control charts (statistical process control)</td>
<td>No change focus (maybe compute a percent change or rank order the results)</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square), p-values</td>
</tr>
<tr>
<td><strong>Confidentiality of the data</strong></td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
</tr>
</tbody>
</table>

Frequent, ongoing measurement for learning and data driven decision making
During Learning Session 2…

- Storyboards should include measures—look for the various categories of measures (outcome, process, balancing, when useful)
- More on measures during Day 2 breakout session
  - Reporting requirements
  - Difference between measures for improvement and measures for accountability & judgement
Take 15, but before you go...

Thank You
Question 3: What changes can we make that will result in an improvement?

Developing and testing changes to achieve your aim
Your Improvement Project

- Where might you turn for some change ideas related to the personal/professional improvement project you identified?
Where we find changes…

- Research
- Evidence/Literature
- Experience
- Hunches/Ideas/Theories—Asking “Why”
- From Others
- Results of Assessments
Learning Session 1
The 5 Why’s of the Washington Monument

Why was the Washington monument deteriorating?

Why?
- Because of the strong chemicals needed to clean it

Why?
- Because there was lots of pigeon poo on the monument

Why?
- Because there were lots of spiders at the monument

Why?
- Because there were lots of flies and moths at the monument

Why?
- Because the lights were turned on at dusk.

Turned the lights on later and stopped the chain of causes

Some of the ideas from LS1...

<table>
<thead>
<tr>
<th>Triggering Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Annual Preventive Visits</td>
</tr>
<tr>
<td>- New Patient Visits</td>
</tr>
<tr>
<td>- Changes in Patient Health Status</td>
</tr>
<tr>
<td>- As Part of Chronic Disease Program</td>
</tr>
<tr>
<td>- Changes in Family or Caregiver Support</td>
</tr>
<tr>
<td>- Transitions of Care</td>
</tr>
<tr>
<td>- Changes in Service Utilization (e.g. ED)</td>
</tr>
<tr>
<td>- After Risk Score Stratification</td>
</tr>
<tr>
<td>- Sick or Preventive Visit on Rolling Annual Basis</td>
</tr>
<tr>
<td>- Alter Frequency Based on Severity of Need</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Saving &amp; Monitoring Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Build Screening Tool as an EHR Template</td>
</tr>
<tr>
<td>- Input Screening “Score” as Discrete Data and Scan Into EHR or Registry</td>
</tr>
<tr>
<td>- Use an Internal Tracking Code for SDoH Screening</td>
</tr>
<tr>
<td>- Use a One Question Screener Between Screening Occurrences</td>
</tr>
<tr>
<td>- Create a Report or Alert Similar to Gaps in Care for Monitoring</td>
</tr>
<tr>
<td>- Create a Report for Panel Level Completion and Timing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next Steps After Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Introduce Care Coordinator During Appointment</td>
</tr>
<tr>
<td>- Create a Trackable Internal “Referral”</td>
</tr>
<tr>
<td>- Conduct a Deeper Assessment of Social Needs</td>
</tr>
<tr>
<td>- Address Urgent Needs and Coordinate Access</td>
</tr>
<tr>
<td>- Commit to an Ongoing Coordination Plan</td>
</tr>
<tr>
<td>- Follow-Up on Urgent Linkages</td>
</tr>
</tbody>
</table>

See handouts posted

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.
You actually do PDSAs every day
In fact, you just did one…

Plan:

• Question: I’m wondering if I start to show more appreciation toward the people I work with, if I can create more joy in work.

• Test: I am going to send a text message right now to one person today thanking them for pitching in for me today so that I could be at this meeting.

• Things needed: Cell phone and 15-30 seconds.

• Prediction: They will respond and may even pay it forward. They won’t see it until later. They will think I’m crazy because I don’t usually do this😊.

• Data I will collect to measure PDSA. Reaction (e.g., response). Any feedback. If possible, measure if paid forward. My reactions.
Small Test of Change

PDSA Cycle
A structured trial for a change.

Source: W. Edwards Deming
The PDSA Cycle for Learning and Improvement

What will happen if we try something different?

Let’s try it!

What’s next?

Did it work?

Benefits to Small-Scale Testing

- Learn how to adapt the change to conditions in the local environment
- Increase belief that change will result in improvement
- Opportunity for “failures” without impacting performance
- Identify how much improvement can be expected from the change
- Minimize resistance upon implementation
- Evaluate costs and side-effects of the change
Test on a Small Scale

- Conduct the test for one patient, one provider, one time, one hour, the next time it happens—"Rule of 1"
- Decrease the time frame (move from thinking years to quarters to months to days to hours to minutes)
- Test the change with volunteers
- Simulate the change in some way (when feasible)
Traditional model for introducing change

Adapted from: Jean Vukoson’s Bright Futures Presentation
QI Approach to Change

1. **DEFINE PROBLEM**
2. **ASSESS CURRENT CONDITION**
3. **DEFINE POSSIBLE SOLUTIONS**
4. **CONDUCT Plan-Do-Study-Act cycles**

- **Act**
  - What changes are to be made
  - Next cycle

- **Plan**
  - Objective
  - Questions / Predictions
  - Plan to carry out cycle (who, what, where and when)

- **Study**
  - Compare Analysis of data
  - Compare data to predictions
  - Summarise what was learned

- **Do**
  - Carry out plan
  - Document problems and observations
  - Begin analysis

Adapted from: Jean Vukoson’s Bright Futures Presentation
PDSA Tip: Build to the More Robust Testing

1. Early tests are simple and designed to learn then succeed
2. Then test over a variety of conditions to understand scalability and identify weaknesses
3. Later tests are designed to predict and prevent failures
4. Implementation testing

Source: IHI
Some Misperceptions about PDSAs

- Because it is simple, it is “easy”
- That it can be used as a stand-alone method without a broader methodological approach to ensure that the problem is correctly understood and framed
- That a successful PDSA means improvement in the outcome
- That it is limited to only small-scale tests of 1, 2, or 5 patients, for example and can’t be adapted for larger scale problems


http://qualitysafety.bmj.com/content/25/3/147.full.pdf+html?sid=3cac1002-ab8d-4619-a741-453ca9873cbc
Although...

- Enter in a new variable...may need to go back to testing 😊
Myths (and Tips) about Creating Improvement Aim Statements

By IHI Multimedia Team | Thursday, March 30, 2017

Why It Matters
Writing an improvement aim statement can be challenging, but some common myths may be making it harder than necessary.
Story Board
Rounds & Team
Time

Sue Butts-Dion
Improvement Advisor
Storyboard Instructions

- Join up with 2 other teams (preferably 2 teams you have not yet interacted with or heard from)
- As a trio, round to each storyboard stopping at each for ~10 minutes for a presentation from that team
  - (5 minutes presentation and 5 minutes Q & A)
- Role of reporting teams
  - Share highlights & key learnings
- Role of observing teams
  - Be curious, ask questions, provide insight (leave behind any ideas on sticky notes so that the team will have them as takeaways)
Team Time Instructions

As a result of the dialogue during Storyboard Rounds, spend the last 15 minutes:

- What, about your aim, measures, changes or PDSAs, might you investigate more, change, refine?
- Update your story boards in real time!
- As a team, write down your next steps.
Models to Support Change

Trissa Torres, MD, MSPH, FACPM

June 2017
Evolution of partnering to address the social determinants of health

1. Suggesting a Resource +/- Providing Information
2. Screening within the Clinical Encounter
3. Warm Handoff with Closed Loop Follow-up
4. Co-design of Coordinated Resource Delivery
5. Partner to Change Policy
6. Putting patients in the driver’s seat
Suggest Resource/Provide Information: 211

2-1-1 is a free and confidential service that helps people across North America find the local resources they need.

Source: http://www.211.org/
Michigan Children's Health Access Program (CHAP)

Among CHAP clients (those receiving at least one CHAP support service):

- Age 1 to 5, emergency department visits declined 43%
- Age 1 to 17, ED visits declined by 35%

What is Virtual CHAP?
Expertly trained CHAP Specialists who can be reached by calling Michigan 2-1-1

http://www.uwmich.org/michap/
Within the Clinical Encounter: Upstreamists

Rishi Manchanda
TED Talk

At this time, which of the following "upstream" problems or issues do you wish your clinic could better identify in order to improve care of patients?

- Financial (insecurity, management)
- Immigration
- Fitness / Physical Activity
- Household goods
- Literacy
- Housing and/or utilities
- Health insurance
- Transportation
- Employment and/or income
- Child care
- Nutrition
- Legal (civil, criminal)
- Food insecurity
- Education (access, quality, equity)
- Intimate partner & domestic violence
- Mental health
- Social isolation
- Community violence/ safety
- Civil and political rights
- Environmental (pollutants, toxins, justice)

Source:
http://www.healthbegins.org/
Better health.
One connection at a time.

https://healthleadsusa.org/
Pathways Community Hub
Partnering with Community Services

Identifying and Decreasing Risk

Engagement of at risk client
Initial Checklist – Captures Comprehensive Risk Issues

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td></td>
<td>Do you need a primary medical provider?</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you need health Insurance?</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you smoke cigarettes</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you need food or clothing?</td>
</tr>
</tbody>
</table>

Assign Pathways

Initiation Step

Action Step

Completion Step

Reliably Track/Measure Results
(Connections to Care)
By: Care Coordinator Agency Region

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW A</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>CHW B</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHW C</td>
<td>9</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>50</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Agency B</td>
<td>64</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Agency C</td>
<td>40</td>
<td>32</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: The Pathways Community HUB Model
Pathways Community Hub

Low Birth Weight Rates in Ohio and Richland County: 2005-2008

Source: The Pathways Community HUB Model
Models

Evolution of partnering to address the social determinants of health

- Suggesting a Resource +/- Providing Information
- Screening within the Clinical Encounter
- Warm Handoff with Closed Loop Follow-up
- Co-design of Coordinated Resource Delivery
- Partner to Change Policy
- Putting patients in the driver’s seat
Partner to Change Policy: Homeless Moms

Source: http://www.homelessprenatal.org/services
Models

Evolution of partnering to address the social determinants of health

- Suggesting a Resource +/- Providing Information
- Screening within the Clinical Encounter
- Warm Handoff with Closed Loop Follow-up
- Co-design of Coordinated Resource Delivery
- Partner to Change Policy
- Putting patients in the driver’s seat
Welcome to Big White Wall. Having a tough time? Feeling down or stressed? Start feeling better now.

Source: www.bigwhitewall.com
The Big White Wall

Among Big White Wall Users:

- 73% reported sharing a mental health issue for the first time in their lives
- 95% reported an improved sense of well-being from using the service
- 80% reported an improved ability to practice self-care

- Post a Talkabout: Talk to other Big White Wall members who may be experiencing the same thing as you.
- Create a Brick: Express your feelings by creating a Brick using pictures and images.
- Assess Yourself: Take assessments to set goals and track your progress.
- Find Useful Stuff: With over 200 articles on Big White Wall, you can understand more about how you are feeling.
- Join a Program: Register for online guided support courses using recognized therapies.
- Make Friends: Connect with other Big White Wall members who feel like you so you can support each other.
Patient Case Study and Close
Video
Reflection

- What surprised you?
- What were you puzzled by?
- How does it / does not correlate with your own experience?
- Where are you in this journey?