Institute for Healthcare Improvement

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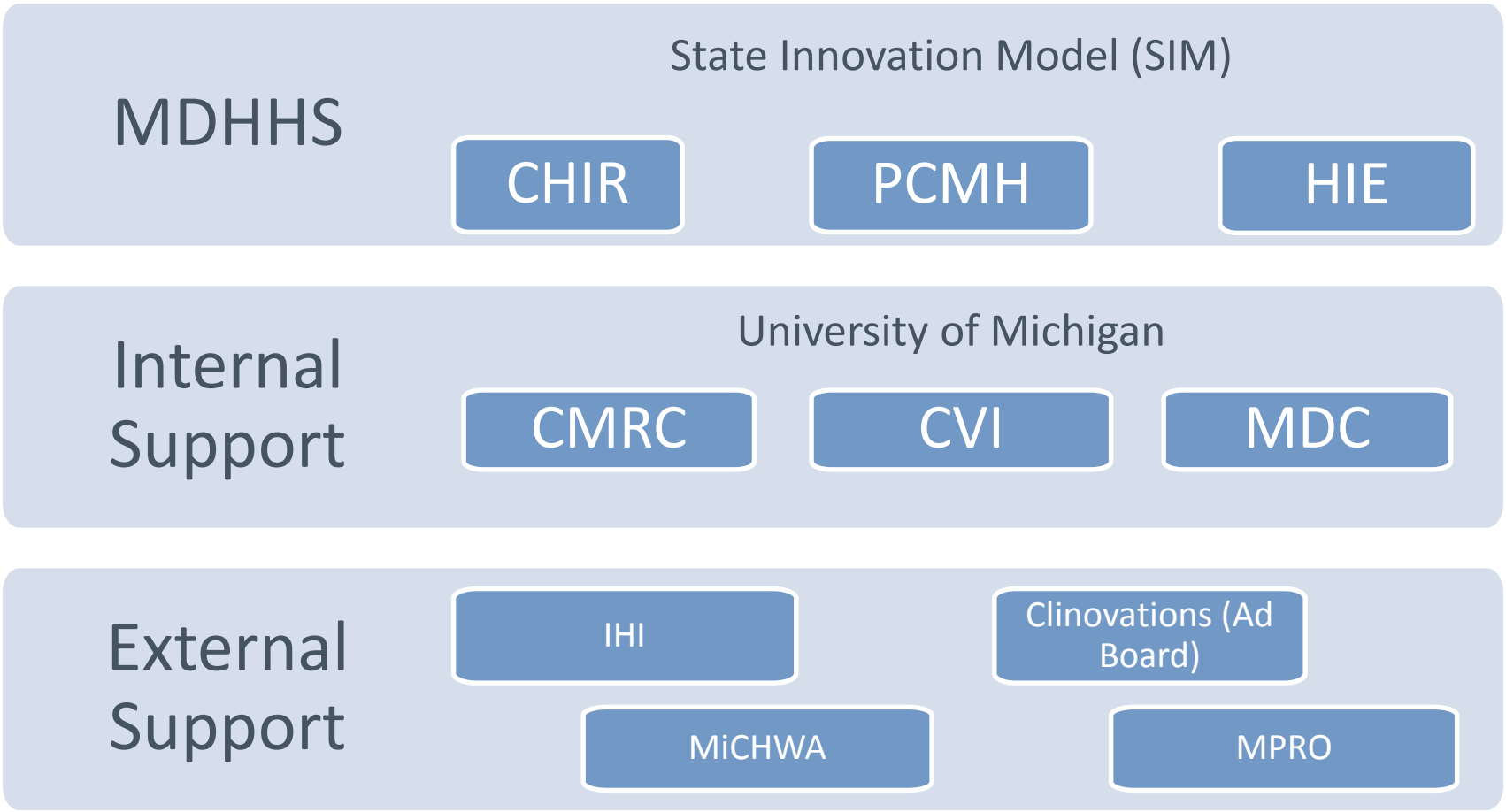
Michigan Department of Health & Human Services

# MI PCMH Initiative Practice Transformation Collaborative

*Webinar #4*

**June 8, 2017**

# SIM PCMH Initiative Team Structure



# 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

**Amanda First**
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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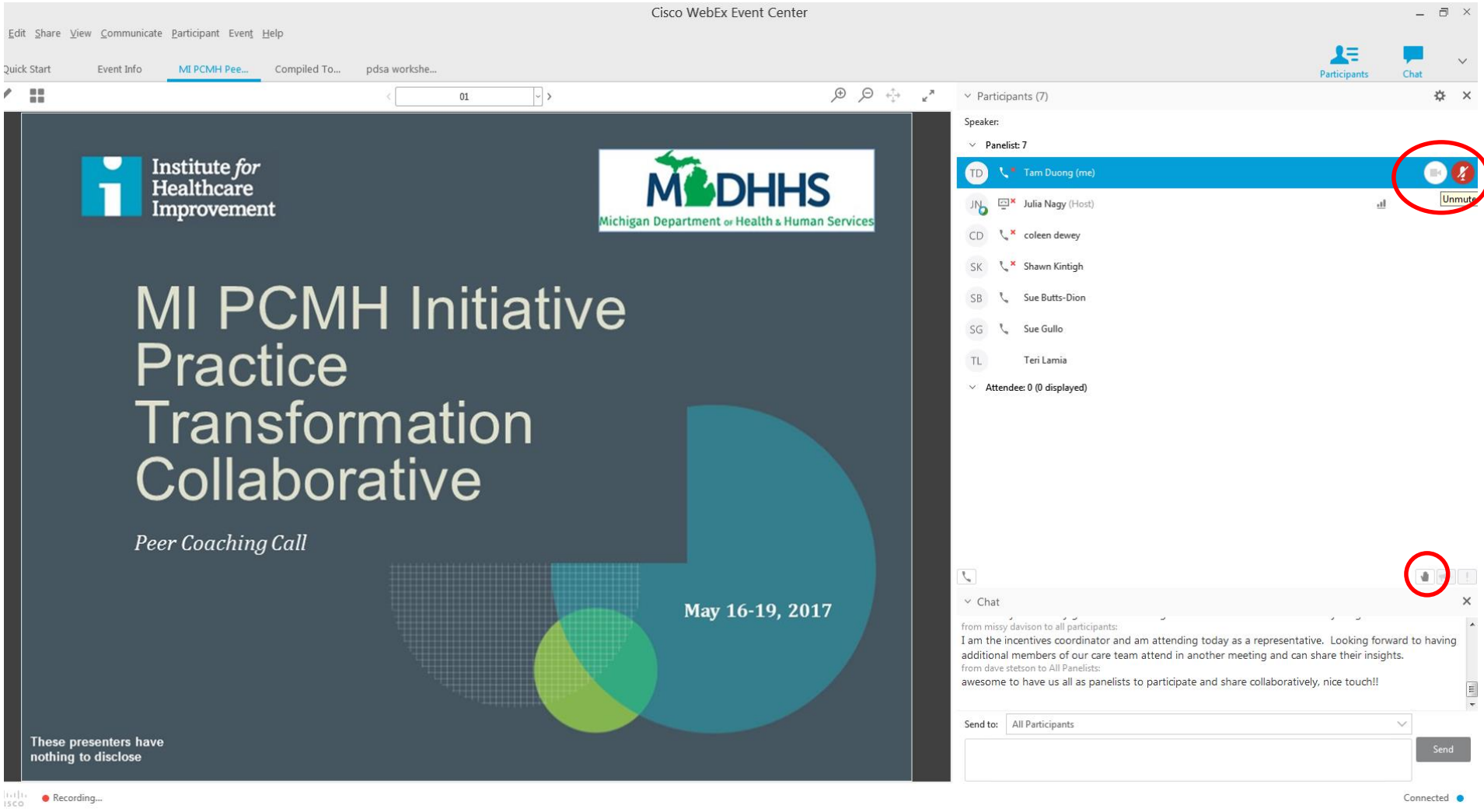
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Event Info
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Participants
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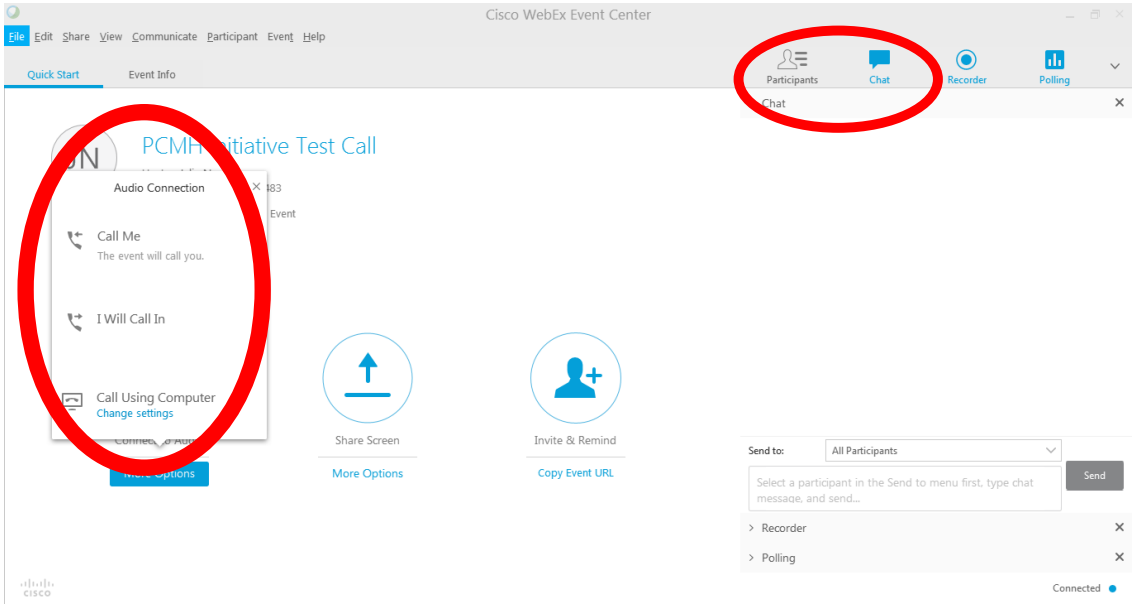
Institute for Healthcare Improvement
MDHHS
Michigan Department of Health & Human Services
MI PCMH Initiative
Practice
Transformation
Collaborative
Peer Coaching Call
May 16-19, 2017
These presenters have nothing to disclose
Participants (7)
Speaker:
Panelist: 7
TD Tam Duong (me)
Unmute
JN Julia Nagy (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
Recording...
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

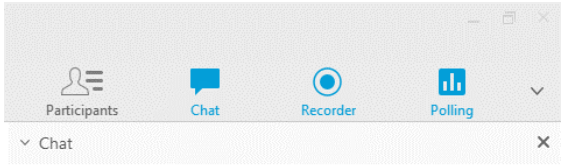
2) You can select to call in to the session, or to be called. If you choose to call in yourself, please dial the **phone number**, the **event number** and your **attendee ID** to connect correctly.



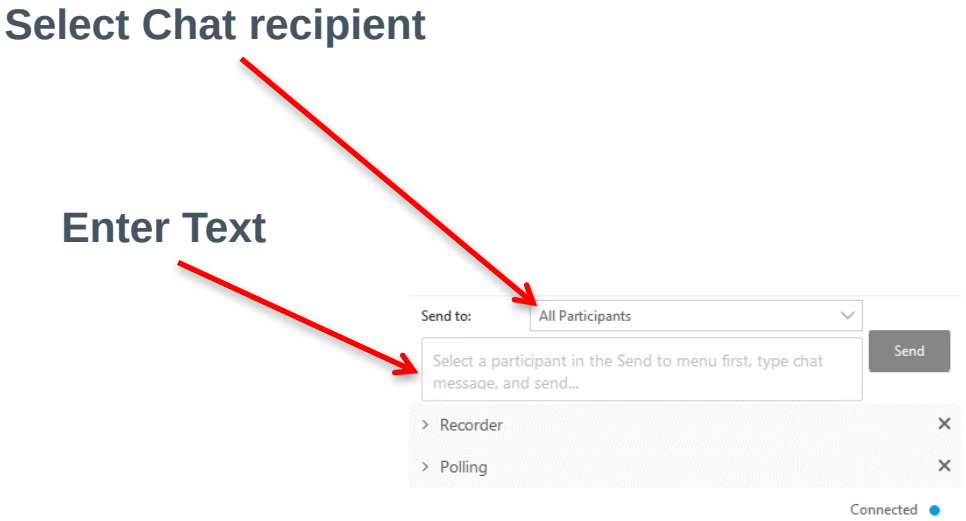
# WebEx Quick Reference



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

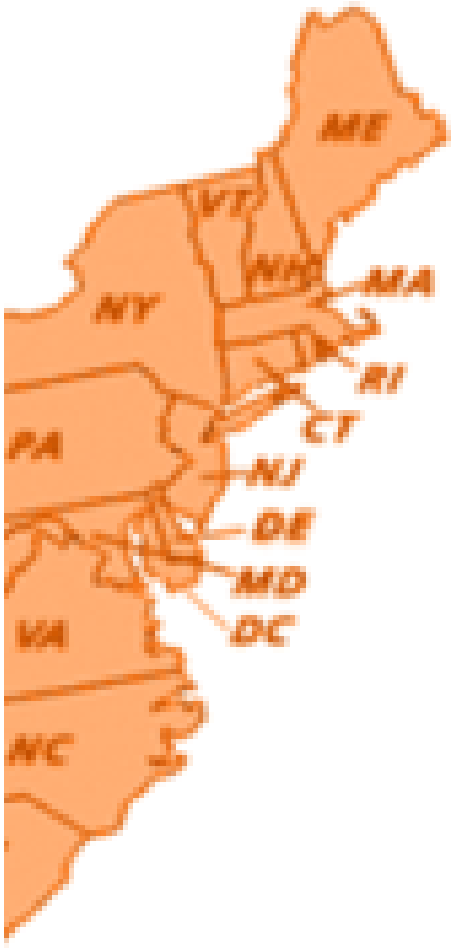



- For technology issues only, please chat to "***Host***"



# 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<br>April 3-4, 2017 | Learning Session 2<br>June 13-14, 2017 | Future Learning Sessions<br>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

- Looking Forward
  - Prep for Learning Session 2
- Q&A

# Looking Forward

## Preparing for Learning Session 2

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# Learning Session 2: Day One

**Day One · Tuesday, June 13, 2017**

| Time | Topic | |
|---|---|---|
| 8:00 – 9:00 AM<br>*Ballroom Foyer* | **Registration and Continental Breakfast**<br>**For participants who were not at Learning Session 1 or who want to attend for a refresher** | |
| 9:00 – 11:30 AM | **Concurrent Sessions** | |
| 9:00 – 10:00 AM<br>*University Ballroom* | **Workshop: Welcome, Overview & Introductions**<br>** For participants who were not at Learning Session 1 or who want to attend for a refresher ** | **Workshop: Putting the Puzzle Pieces Together**<br>**For CHIR Representatives** |
| 10:00 - 11:30 AM<br>*University Ballroom* | **Learning Lab: Quality Improvement 101 – Theory and Tools**<br>** For participants who were not at Learning Session 1 or who want to attend for a refresher ** | |
| 11:30 – 12:30 PM<br>*Ballroom Foyer* | **Registration and Lunch**<br>**For all returning participants** | |
| 12:30 – 1:00 PM<br>*University Ballroom* | **Launch of Learning Session 2** | |
| 1:00 – 1:15 PM | **Transition to groups** | |
| 1:15 – 2:15 PM<br>*University Ballroom* | **Connecting with CHIRs** | |
| 2:15 - 2:30 PM | **Transition to large group** | |
| 2:30 - 3:00 PM<br>*University Ballroom* | **Learning from Our Peers** | |
| 3:00 – 4:00 PM<br>*University Ballroom* | **Team Time & Storyboard Rounds**<br>• | |
| 4:00 – 4:30 PM<br>*University Ballroom* | **Debriet Team Time & Ideas of Models to Support Change** | |
| 4:30 – 5:00 PM<br>*University Ballroom* | **Patient Case Study, Close and Prep for Day 2** | |
| 5:00 PM | **ADJOURN** | |

# Learning Session 2: Day Two

**Day Two · Wednesday, June 14, 2017**

| Time | Topic |
|---|---|
| 7:30 – 8:30 AM<br>*Ballroom Foyer* | Continental Breakfast |
| 8:30 – 8:45 AM<br>*University Ballroom* | Welcome Back & Review of the Day's Agenda |
| 8:45 – 10:00 AM<br>*University Ballroom* | Panel: Best Practices to Link Patients and Achieve Health |
| 10:00 – 10:45 AM<br>*University Ballroom* | Open Space: Communities of Practices |
| 10:45 – 11:00 AM | BREAK |
| 11:00 – 12:00 PM<br>*University Ballroom*<br>*Beaumont Room*<br>*Campus Room* | Concurrent Breakout Sessions<br>A. Building Will: Engaging Patients as the Core Stakeholders in the PCMH Transformation.<br>B. Measurement: Developing a Measurement Strategy<br>C. Journey to test and implement a SDoH screening tool |
| 12:00 – 1:00 PM<br>*Ballroom Foyer* | Lunch |
| 1:00 – 1:45 PM<br>*University Ballroom* | Moving Towards Population Health Management |
| 1:45 – 2:30 PM<br>*University Ballroom* | Identity and Understand Your Population: What Do You Know? |
| 2:30 - 2:45 PM | BREAK |
| 2:45 - 3:30 PM<br>*University Ballroom* | Organizing Our Learning and Theories & Refresher on PDSA |
| 3:30 - 4:00 PM<br>*University Ballroom* | Team Time |
| 4:00 - 4:30 PM<br>*University Ballroom* | Close, Q & A, Evaluate |
| 4:30 PM | ADJOURN |

# Learning Session 2
# Pre-work

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# Pre-work #1: The Power of Learning from One



1. Identify **one patient** your team "worries" and wonders about often.
   - This patient comes to mind quickly and may have multiple chronic conditions, mental 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.
2. Write a brief profile of this patient, including their readmissions history and any other information pertinent to why your team worries about them (no patient identifiers, please).

# Architecting Clinical-Community Linkages

3. 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: Use the Ecomap template from Learning Session 1 to map out the relationships and the type and strength of the relationships.
4. Reflect on the following questions:
   - 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?

# 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.

**“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**

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# Pre-work #2
# Storyboard Template

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# Instructions to prepare a storyboard about your work to improve Clinical-Community Linkages

- Fill out this template, print it, and bring it to Learning Session 2 (June 13-14). There should be one storyboard per team.
  - Be ready to attach it to a flip chart paper. We will supply paper, tape, and pins.
- 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.

**Organization** _____

**Name(s) and Role(s):**

- _____
- _____
- _____

*(Please insert your organization, your name and role / your team members' name and role.)*

*(Insert an interesting picture of you, your team, your project, and /or your organization)*

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# Aim Statement for Improving Clinical-Community Linkages *(Insert your aim statement at what ever stage it is in)*

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?

  _____

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# Clarifying Knowledge of the Current Processes & Systems

- *What do you know about the problem you want to solve? What is working well?*

*Insert answer here:*

*In this box or on another slide, insert picture(s) 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.)*

*Insert answer here:*

- *What are patients saying about their experience?*

*Insert answer here:*

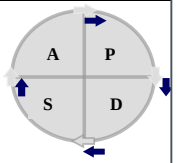
# First PDSA....

*Insert a description of the first thing you tested after Learning Session 1.*

- *What did you predict would happen?*
- *What did happen?*
- *How was 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)

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# Sequence of Improvement

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

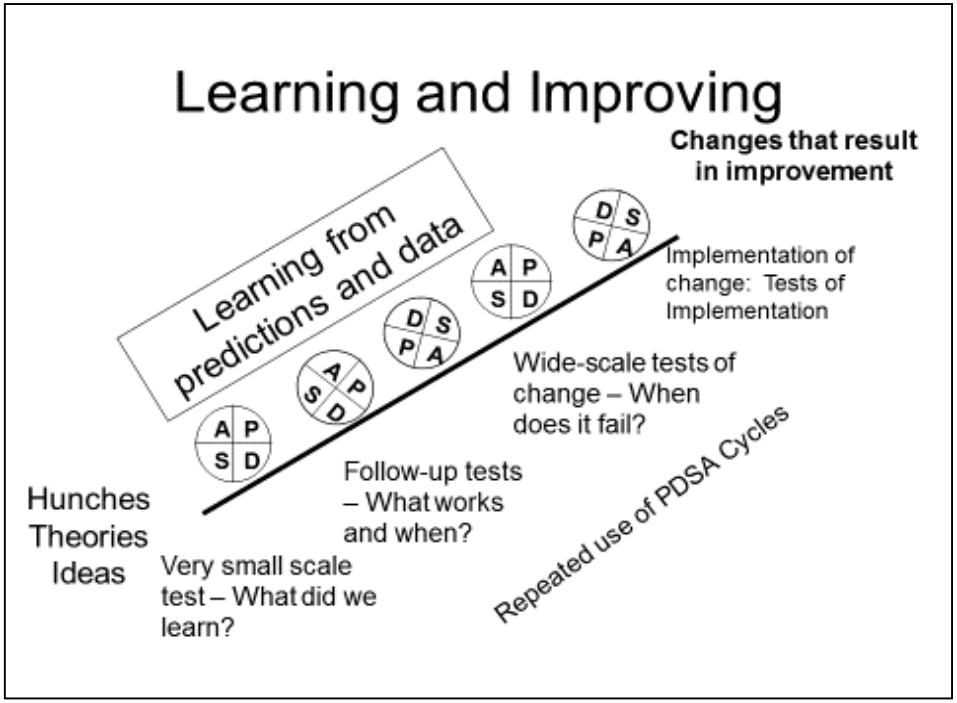
- _____
- _____

*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?*

- _____
- _____



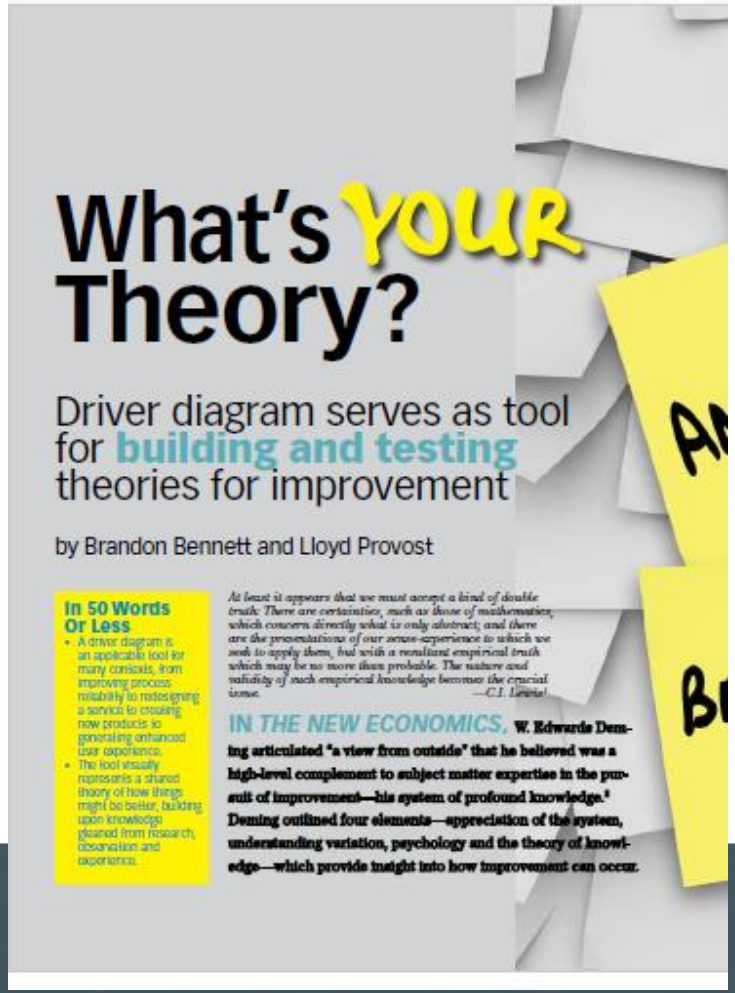
# Reflection... *(Insert your answers to the questions below)*

- We have been most engaged when...
- What surprised or puzzled us...
- Our advice to ourselves about improvement work is...
- Our advice to others about improvement work is...

# Pre-work #3: "What's Your Theory" Reading



- 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.**

DRAFT

## 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 | Secondary Drivers |
|---|---|
| * Clinical-Community Linkages | Reliable processes to link patients to supports |
| | Assess Social Determinants of Health |
| | Use Care Coordinators & Managers |
| Access | ** Telehealth Adoption |
| | ** Group Visits |
| | ** Patient Portal |
| Activated Patients and Care Teams | ** Improvement Plans from Patient Feedback |
| | **Self Management Monitoring & Support |
| | ** Integrated Peer Support |
| Continuity/ Continuum of Care | ** Medication Management |
| | ** Integrated Clinical Decision Making |
| ** Population Health Management-Knowing & Co-Managing Patients | ** 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.

# Questions?

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

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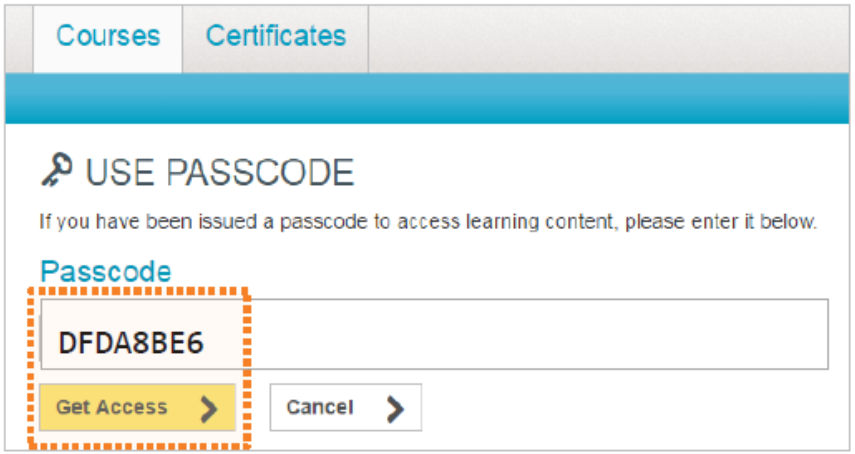
# Michigan Patient Centered Medical Home (PCMH) Initiative Practice Transformation Collaborative

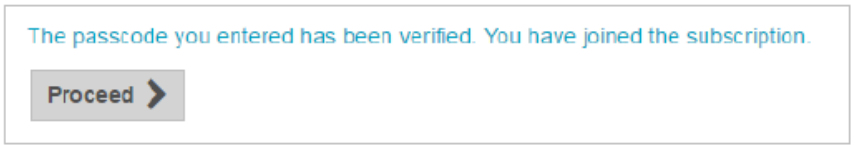
**Step 2: Enter your group's passcode.**

- 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.

# 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

**Learning Session**

- June 13-14, 2017

**Action Period Calls**

- July 13, 2017 from 4:00 – 5:00 PM ET

**Peer Coaching Calls** *(pick one)*

- July 18-21, 2017 from 12:00 – 1:30 PM ET