MI PCMH Initiative Practice Transformation Collaborative

Webinar #5

July 13, 2017

The IHI Support Team

Sue Butts-Dion
Improvement Advisor

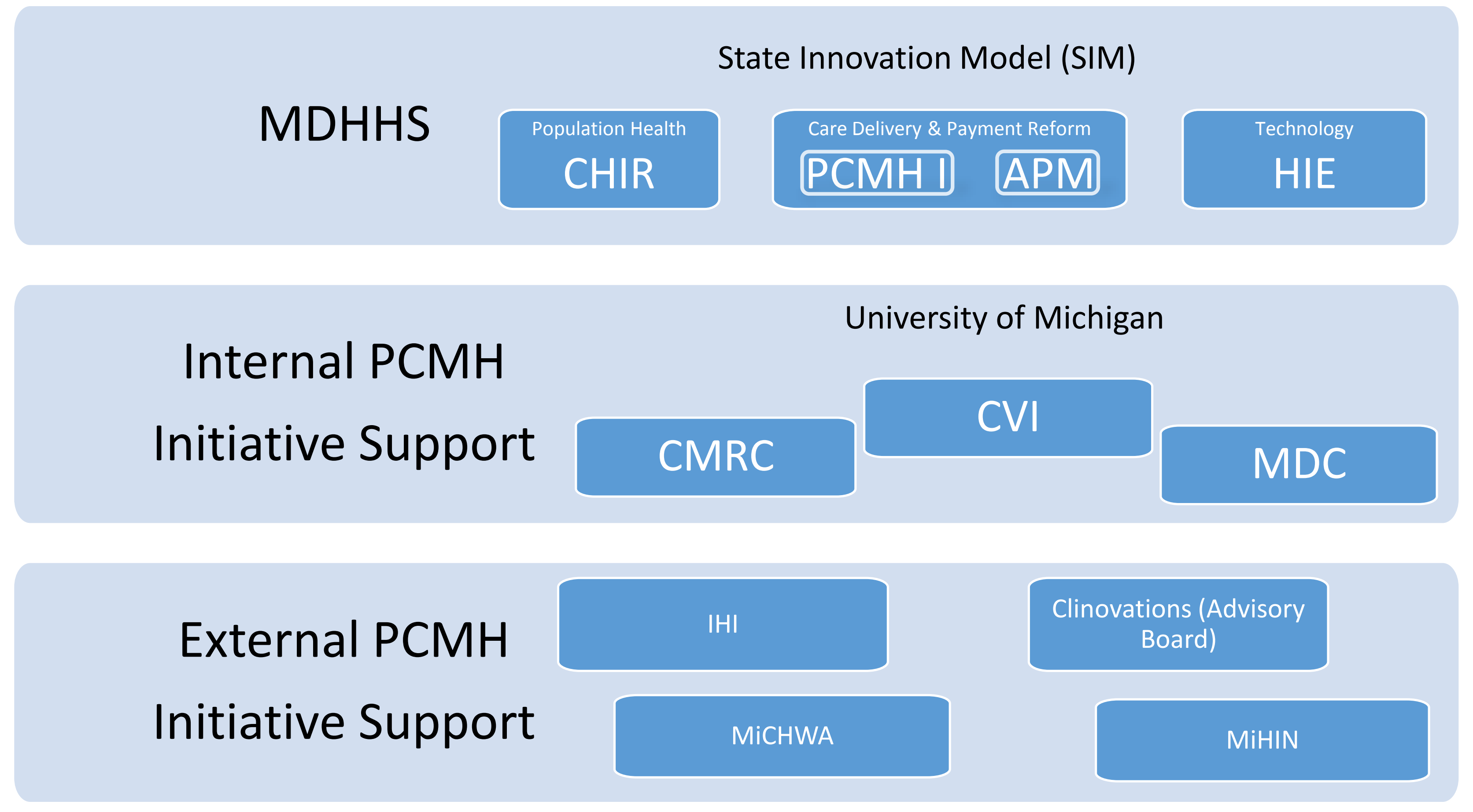
Sue Gullo, RN, BSN, MS
Director

Trissa Torres, MD, MSPH, FACPM
Chief Operations and North America Programs Officer

Tam Duong, MS
Project Manager

Julia Nagy
Project Coordinator

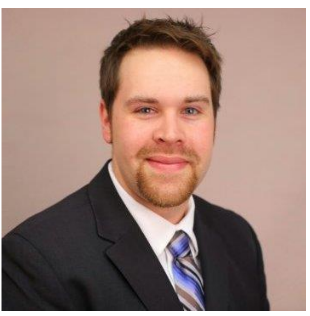
SIM PCMH Initiative Team Structure



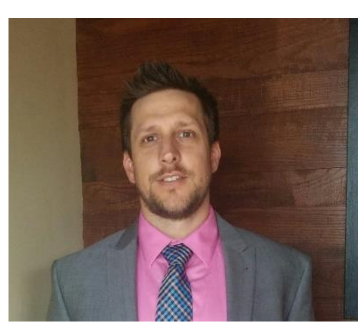
The MDHHS PCMH Initiative Team

Kathy Stiffler
MSA, Deputy Director

Katie Commey
SIM Care Delivery Lead

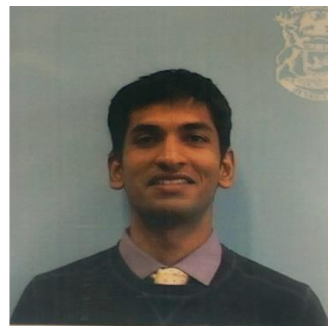


Phillip Bergquist
Policy & Strategic Initiatives Manager



Justin Meese
Sr. Business Analyst

Linda Pappas
Project Assistant



Yagna Talakola
Project Manager

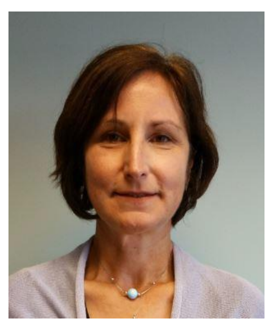
The PCMH Initiative Internal Support Team

Amanda First
Analyst - CVI

Diane Marriott
Director - CVI

Veralyn Klink
Administrator - CVI

Yi Mao
Analyst - CVI



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

Lauren Yaroch, RN
Project Manager - CMRC

Susan Stephan
Sr. System Analyst - MDC

Cisco WebEx Event Center

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Quick Start | Event Info | MI PCMH Pee... | Compiled To... | pdsa workshe...

01

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 | Chat

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

Unmute

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...

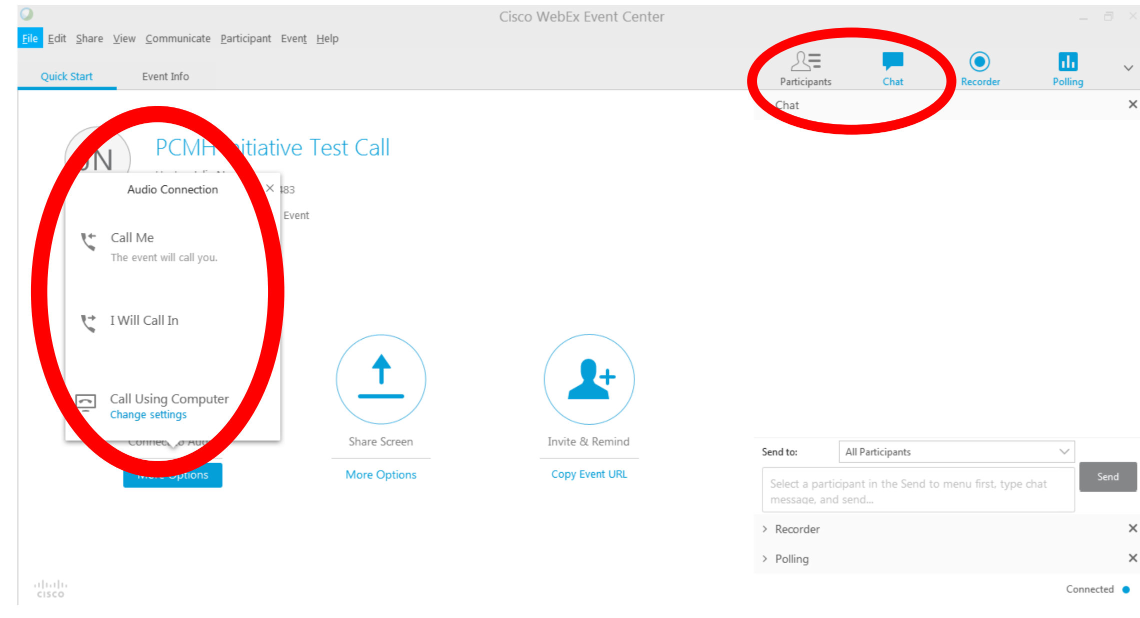
Connected

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

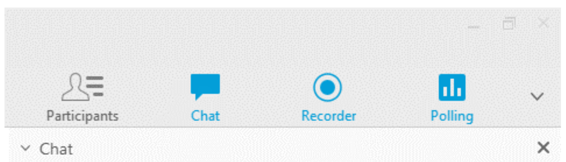
2) You can select to call in to the session, or to be called. If you choose to call in yourself, please dial the **phone number**, the **event number** and your **attendee ID** to connect correctly.



WebEx Quick Reference

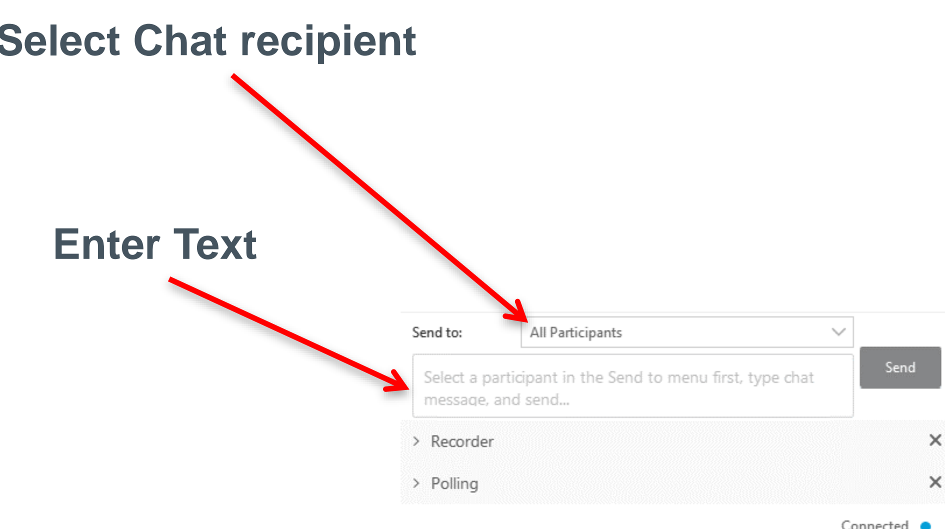
- Please use chat to "***All Participants***" for questions

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

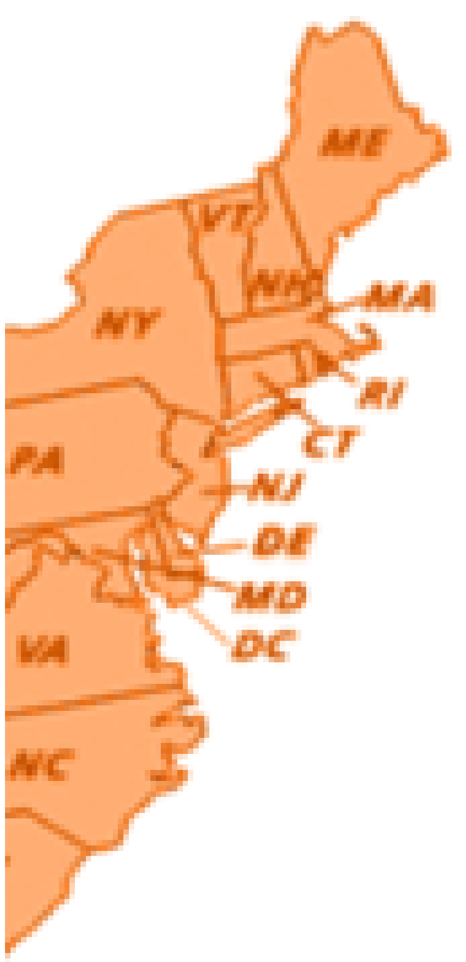


Select Chat recipient

Enter Text



Where are you joining from?



Agenda

- Welcome, Introductions, Setting the Stage
- Team Report Out
  - Testing Since Learning Session 2
- Using Quality Improvement to Take Action on What We Know
- Team Report Outs, cont.
- Looking Ahead
  - Peer Coaching Calls
  - Semi-Annual Reporting
  - Q & A

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 April 3-4, 2017	Learning Session 2 June 13-14, 2017	Future Learning Sessions 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.

1st 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.

Team Report Out—Activity Since LS2

Kimberly M. Ross

PCMH-N Specialist

Covenant HealthCare Partners, Inc.

Saginaw, MI

Consideration: November 1st is just over 4 months away so do consider that. Perhaps staged goals that include November 1st and beyond?

Working to get consensus around aim:

- By November 1, 2017, the participating SIM practices will have a process in place to identify patients with possible support needs where community clinical linkages can be put into place. The focus will be on:
  - Developing and distributing an updated list of community partners. Include contact name (if available), telephone number, and hours of availability
  - Increasing community linkage referrals of attributed patients from 0 % - ?? (Working to determine realistic goal.)

PDSA….

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)

Team Report Out (**PLAN**-D-S-A)

- We are wondering if we have the MA administer the assessment (modified assessment) process with the patient followed by the provider review, referral to care management as needed and results scanned to the encounter if it will result in the most efficient and effective means for completing the SDoH assessment process.
- What: Test out this process flow for administering the SDoH assessment.
- When? Between LS2 and July 13th, 2017
- Who: Each practice will test this process flow on a minimum of ten patients in the managed care Medicaid population.
- Where: In their practice.
- Predictions: These tests will reveal where the vulnerabilities are. Pediatrician predicts that the staff will need scripting to assist them. There will be variability in the process of scanning it to the record based on the EHR. In offices using EPIC, family comments in Snapshot will be updated to reflect SDoH data completed but will need to address variation.
- PDSA Data: Assessment completed. Staff feedback (MA, provider, etc.) on how the process worked, need for scripting, etc.

Testing Using P-**Do-Study-Act**

- Do: Was the test carried out as planned? What happened that was different than planned?
- Study: How did your predictions compare to what happened?
- Action: What will you do next? Adapt? Adopt? Abandon?

Offer: Revised SDoH Assess. for Peds (Children's Medical Group)

1. Do you have difficulty understanding the English language? Do you need help completing this form?
2. Do you ever have a time during the month when you don't have enough food?
3. Do you have trouble paying for housing or your electric/heating bills? Is your family currently or at risk of becoming homeless?
4. Is there a problem with your health insurance covering your child's medical costs? Do you need help with transportation to attend medical appointments? Do you need help paying for medications?
5. Are you concerned about your child's educational plan? Are you concerned about your child's success or behaviors in school?
6. Has your child experienced or observed any form of abuse, including physical, emotional, verbal, sexual, or neglect? Do you or your children feel unsafe at home or school now?
7. Is anyone close to your child having problems with depression or other mental illness, problem drinking, alcoholism, or drug use?
8. Do you need help with child care items such as a car seat, crib, diapers, formula, or other needs?
9. Has anyone close to your child gone to prison or jail?
10. Has your child experienced separation, divorce, or abandonment by one of their parents?
11. Does your child repeatedly verbalize feelings of not being loved, not feeling special, or not being supported?

WHAT we KNOW

A lot and learning more all of the time!!

PCMHRegionalSummits MichiganDataCollaborative
SelfManagementSupportCourses
SocialDeterminantsofHealthOnlineTraining
MiCMRCComplexCareManagementCourses AffinityGroups
CareManagementEducationWebinars Billing
MIPatientExperienceofCareInitiative
CodingCollaborativeMIPEC

WHAT
WE DO!

Celebrate!!

PCMH Initiative Quarterly Update Call Responses
Percent of Sites Testing Since Learning Session 2 (N=42)
June 22, 2017

	Percent
Testing	26%
Not Yet Testing	74%

A lot and learning more all of the time!!

Where to begin?!?

Collaborative
AffinityGroups
CareManagementEducationWebinars
Billing
MIPatientExperienceofCareInitiative
CodingCollaborative
MIPEC

Quality Improvement Tools & Methods…

WHAT we KNOW

WHAT WE DO!

Systematic way to…

1. Close the gap between what you know and what you do…
   - Continue to improve processes and structure and incorporate evidence based practice
2. Keep the gap closed once improved…
   - Hold the gains by making processes so reliable that it will be very hard, if not impossible, for things to go back to old practices

Execution—One Method for Creating Lasting Change

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

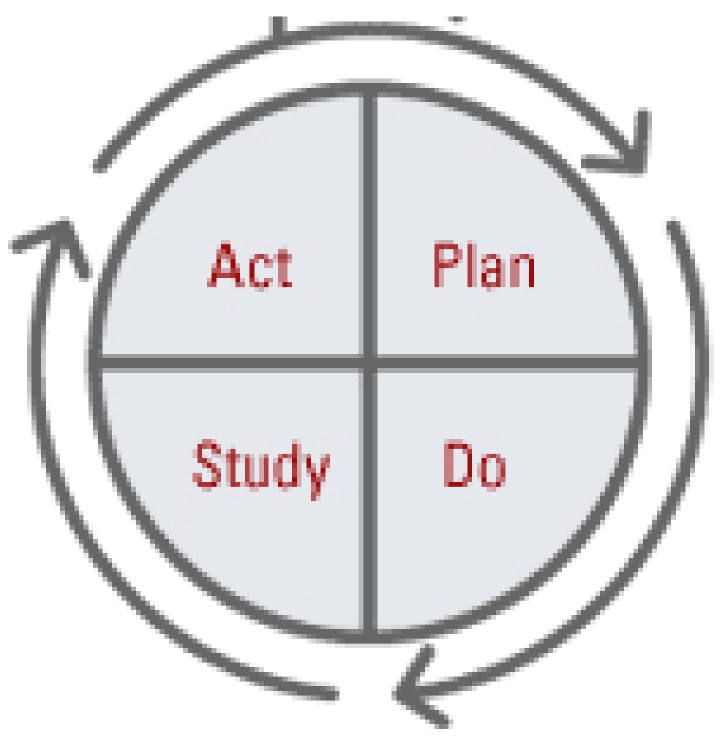
From: Associates in Process Improvement

We use the Model for Improvement to increase the odds that changes will lead to improvement and to accelerate change!

Small Test of Change

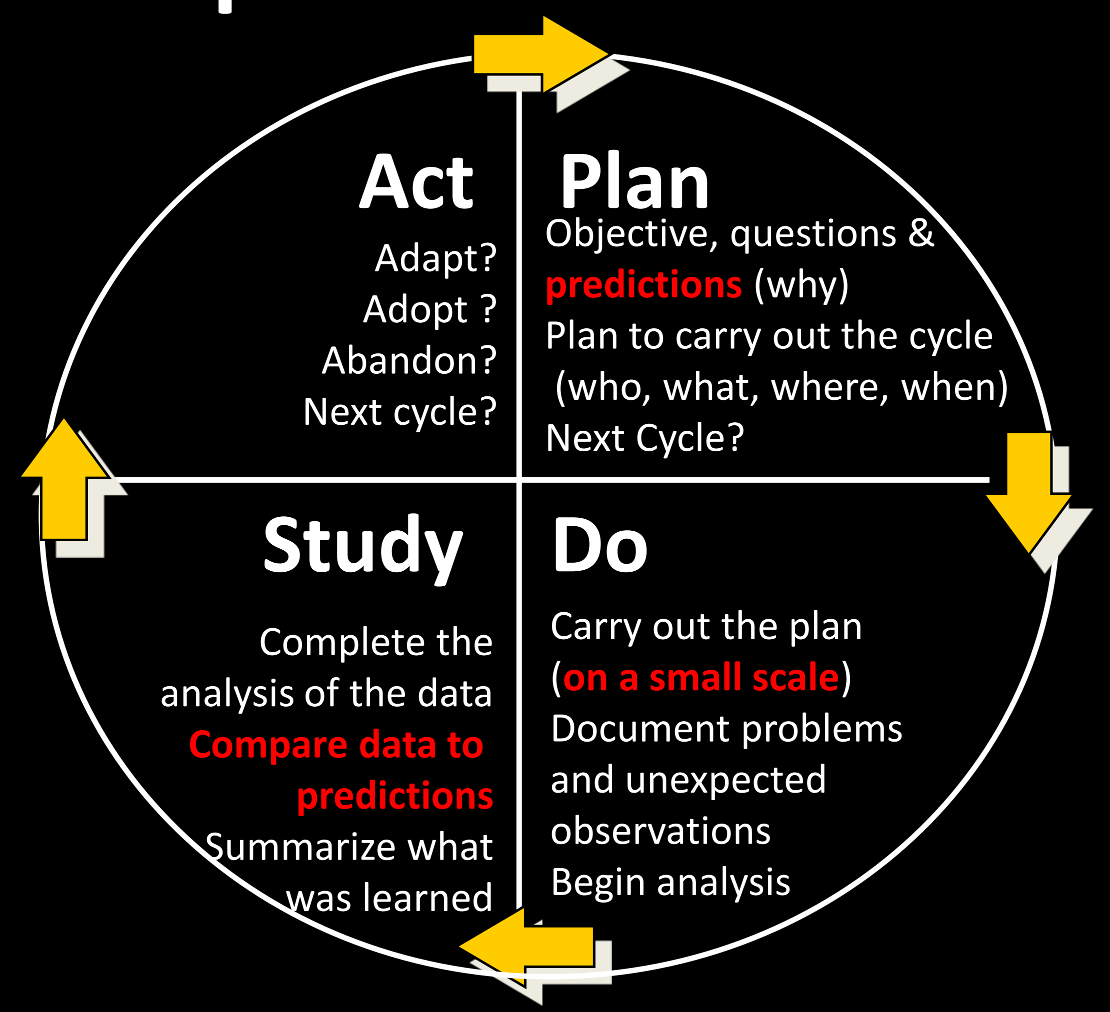
PDSA Cycle

A structured trial for a change.



Source: W. Edwards Deming

The PDSA Cycle for Learning and Improvement



More Stories from the Field!

- Hackley Community Care Center Testing and Scaling up the Scope of Tests Rapidly Since LS2!

Kristina Inthisane, Care Manager

Hackley Community Care Center

Report: SDOH screening tool built into Allscripts EHR. After LS2, did a PDSA and found a minor tweak that needed to be adjusted and added questions on: substance use, patient refusal to complete screening, and if linkages were placed. On June 21, launched SDOH to all CM and CHW to screen on patients. From June 21- to June 30 we successfully screened 95 patients (0.49% of total active patients).

More Stories from the Field!

- Cherry Health “Enlightened” by Results Screening Test

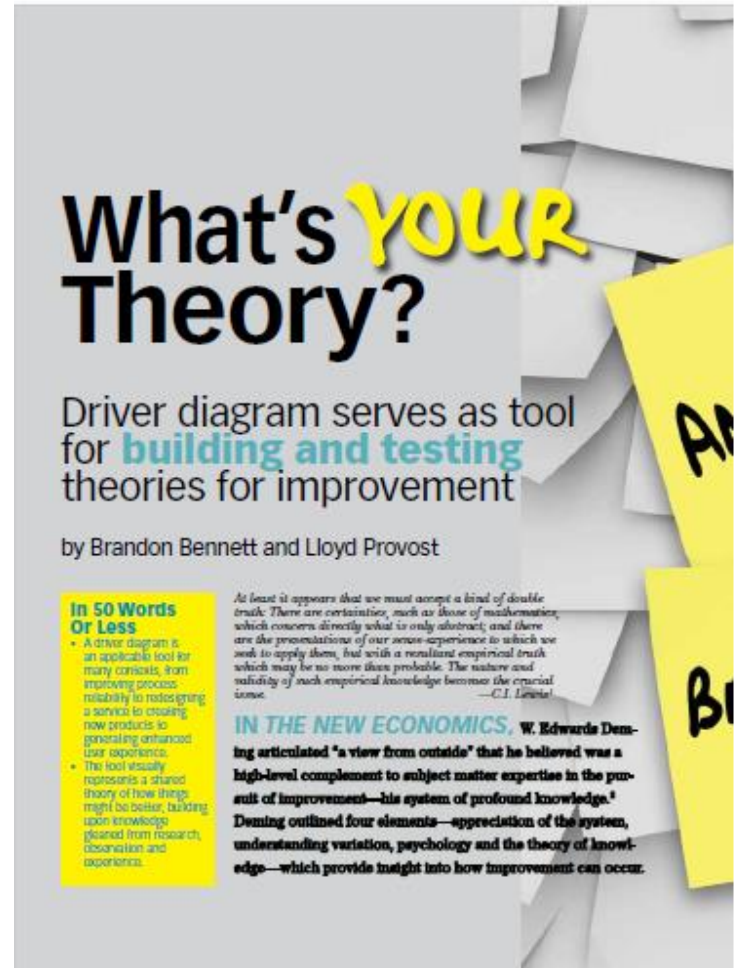
Glenda Walker, MBA, Infomatics Manager

Hackley Community Care Center

Report: Working to align screening process with another initiative and build into EHR. Tested SDoH Assessment with 9 patients to learn about receptiveness of patients, observe process flow and to gain experience. Enlightened by patient responses. Getting qualitative feedback from the staff on the test (workflow and patient engagement). Plan to test again with more patients.

Anyone using a Driver Diagram?

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

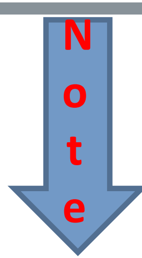
- A driver diagram is an applicable tool for many contexts, from improving process reliability to redesigning a service to creating new products to generating enhanced user experience.
- The tool visually represents a shared theory of how things might be better, building upon knowledge gleaned from research, 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.**

Looking Forward

Peer Coaching Calls (See website)



All Sessions are held from 12:00 - 1:00PM | REGISTER HERE		
Date	**Focus Area**	**Session Details**
Tuesday, July 18th	Implementing SDoH Screening	Screening tool, mapping to current screenings/processes, testing the workflow design
Wednesday, July 19th	Establishing Linkage Process	Going beyond the referral, examples from developing and testing the linkage process and documentation
Thursday, July 20th	Designing CCL QI Activities	Identifying activities to test CCL design, how will success be measured? Driving continuous improvement
Friday, July 21st	Practice/PO Leaders	Supporting a larger team, or multiple practices in CCL design, testing and implementation

Semi-annual Reporting

- **Submission deadline**: July 31st, 2017
- **Plan in action**: November 1st, 2017
- **Purpose**: Capture progress to-date in drafting the practice transformation plan and identify opportunities for the Initiative to support participants.
- **Contents**:
  - Section 1: Clinical-Community Linkages (CCL)
    - Assessing social determinants of health
    - Linkage methodology
    - Quality improvement activities
  - Section 2: Practice Transformation Objective(PTO) identified by POs
    - Goal, measurement, team member roles, progress to-date

Semi-annual Reporting

Screening plan	• When to screen • Initial screening timeline • Maintaining screening • Monitoring screening and closing gaps
Screening procedure	• Who performs screening • Who reviews and interprets results • Where are results stored and made available to the team • Screening follow-up steps
Screening tool	• Broad social and environmental need focus • Designed to open a conversation • Brief, easy to complete, appropriate for language/literacy
CCL approach	• Defined roles, responsibilities, training, and communication approach • Partner relationship • Linkage process • Documentation approach
QI approach	• Screening gaps and more/less effective screening triggers • Linkage outcomes and partnership/resource effectiveness

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.

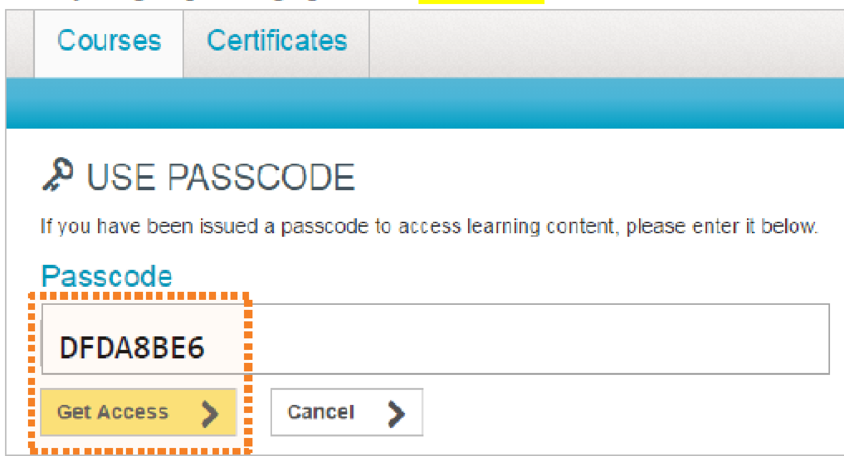
- Log in to IHI.org here.
  - If you are not yet registered, do so at www.IHI.org/RegisterFull.

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.

The passcode you entered has been verified. You have joined the subscription.

Proceed

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

<u>Triple Aim for Populations</u>

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.