Using the Model for Improvement: Fundamental Questions

CCC – Care Coordination Collaborative

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FUNDAMENTAL PRINCIPLE OF IMPROVEMENT

Every system is perfectly designed to produce the results that it produces

Where Does Improvement Come From?

1. **What is a change, or more specifically, what is a change that will result in improvement, and**

2. **What are the fundamental principles of improvement?**

Changes That Result In Improvement

- **Alter how work or activity is done or the makeup of a product,**
- **Produce visible, positive differences in results relative to historical norms, and**
- **Have a lasting impact.**

Material is from The Improvement Guide, Second Edition, Jossey-Bass, March, 2009

Requirements for Successful Improvement Effort

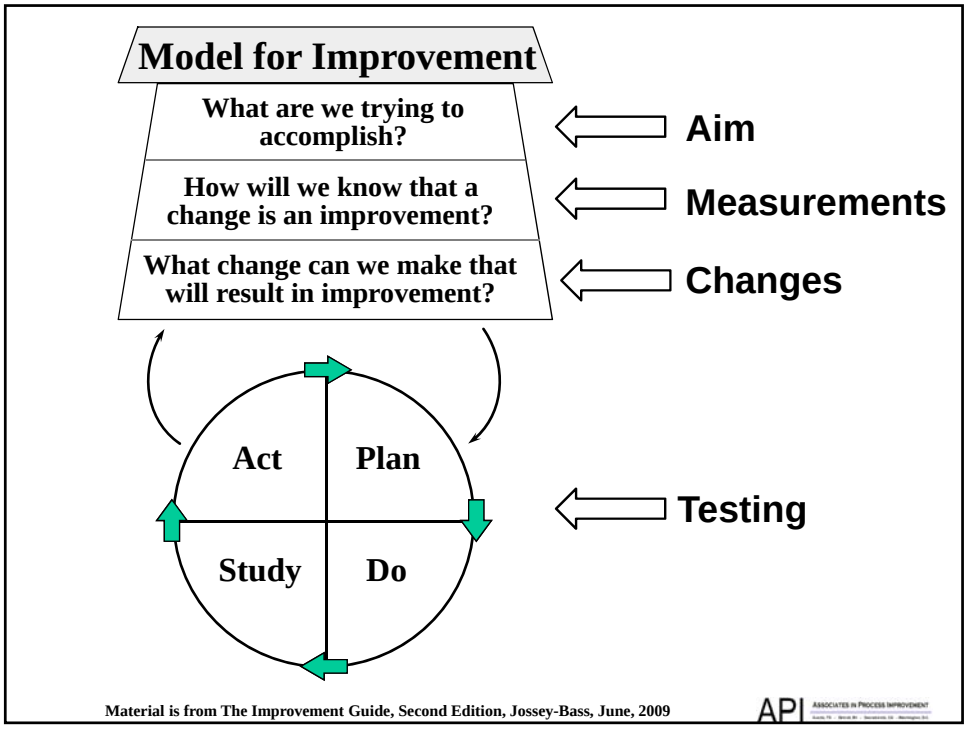
- Will
- Ideas
- Execution

Principles of Improvement

1. Knowing why you need to improve
2. Having a feedback mechanism to tell you if the improvement is happening
3. Developing an effective change that will result in improvement
4. Testing a change before attempting to implement, and
5. Knowing when and how to make the change permanent (implement the change).

Material is from The Improvement Guide, Second Edition, Jossey-Bass, 2009

API ASSOCIATES IN PROCESS IMPROVEMENT



Fundamental Questions 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 ?

Material is from The Improvement Guide, Second Edition, Jossey-Bass, 2009

API

Aim Development….

- **What are we trying to accomplish?**
  - **System to be improved**
  - **Subpopulation of clients**
  - **Timeframe**
  - **Focus on issues that matter to the organization and issues that might have been recognized as needing improvement in the any assessments done in the Prework period.**
- **Why is it important to do this?**
  - **Why is this important to the organization? (mesh with strategic plan, goals, business plan, etc.)**
  - **Do you have data/analysis to support the choice of this work?**
- **What does the team want to accomplish?**
  - **Anticipated outcomes**
  - **Goals you hope to attain**

CCC Aim Statement

Over a period of fifteen (15) months, Care Coordination Collaborative Partnership Teams consisting of primary care, mental health, substance use disorders, and other safety net providers, working with local public safety net health plans, will make changes to improve the health status of individuals who have complex, co-occurring conditions and require coordinated services.

Teams will work to establish multiagency communication, create workflows for coordinated care, promote self-management, and use clinical information systems. These changes will build a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness.

CCC Goals

CCC will support teams to:

1. **Increase the screening of individuals for mental health/substance abuse and chronic medical conditions within each care setting (Mental Health Agencies, Substance Use Disorder Agencies, and Primary Care Providers)**
2. **Increase the percentage of individuals with shared care objectives that address physical health and specialty mental health and/or substance use disorder conditions**
3. **Increase the percentage of individuals with a care coordinator assigned by any partner and with whom your staff work to coordinate care**
4. **Improve medication reconciliation across 2 (or more) provider agencies**
5. **Improve access to appropriate care for people with unmet needs**
6. **Improve satisfaction with experience of care**
7. **Reduce emergency room utilization**
8. **Reduce hospital utilization**

CCC Objectives

To achieve these goals, teams will pursue the following objectives:

1. **Within the Collaborative timeframe, 75% of individuals in a care setting have been evaluated for a second condition requiring care from another provider**
2. **75% of individuals in target population will have shared care objectives that include physical health, mental health and substance use concerns**
3. **90% of target population individuals will have an identified care coordinator assigned by one of the participating partners and acknowledged by provider partners and the individual receiving services as accountable for coordinating care**
4. **60% of target population individuals will have documentation of medication reconciliation across all providers in the last 6 months or 2 weeks following a medication change.**
5. **90% of target population will have seen a primary care provider and any of their needed specialty care providers in the last 6 months**
6. **80% of target population will report that their satisfaction/experience with care is good/excellent**
7. **Reduce by 25% the use of emergency rooms**
8. **Reduce by 25% hospitalizations**

CCC Guidance

Achievement of this aim and associated goals and objectives will require focus in some specific areas. These areas of focus include:

a. Each Partnership Team will be identifying the initial target population members that will be served by the Care Coordination Collaborative during the Pre-Work Phase

b. Suggested screenings to be completed or documented by agencies in the Collaborative Team include: Blood Pressure, BMI, A1c, LDL, PHQ2 or PHQ9, GAD 2, Single Item for Alcohol and Drug Use

c. Teams can be co-located, virtual, or a combination

d. A peer provider or peer run organization and a family member provider or family provider organization is highly recommended as a participating member/agency of the team.

e. Although each collaborative team will consist of multiple agencies, it is expected that each agency will collect the collaborative measures and work together to track and improve care

f. Testing a clinical information system that promotes improvement in the following areas is a requirement of all participating teams

Subpopulation of Clients

- Natural grouping by provider/clinician/care team and site
- Not a fixed number (changes from month to month)

Determining the Target Population

Subpopulation of clients with whom the changes will be first tested and implemented

- The target population is the collection of individuals who have serious mental health and/or substance use disorders with co-occurring diabetes or cardiovascular disease, and require services from two or more service-provider organizations.
- Natural grouping by provider/care team and site
- Not a fixed number (changes from month to month)

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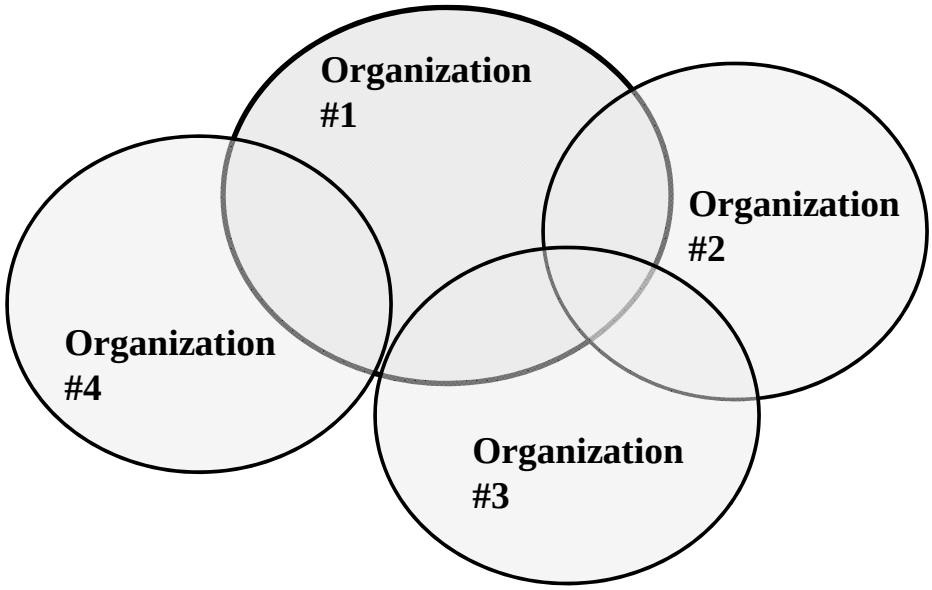
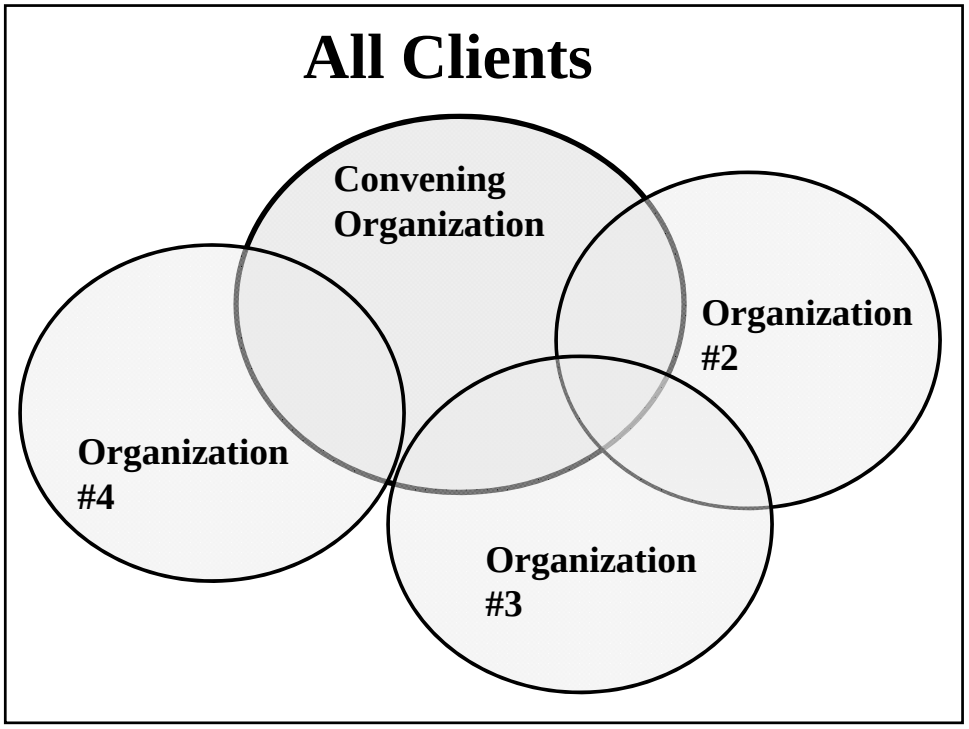
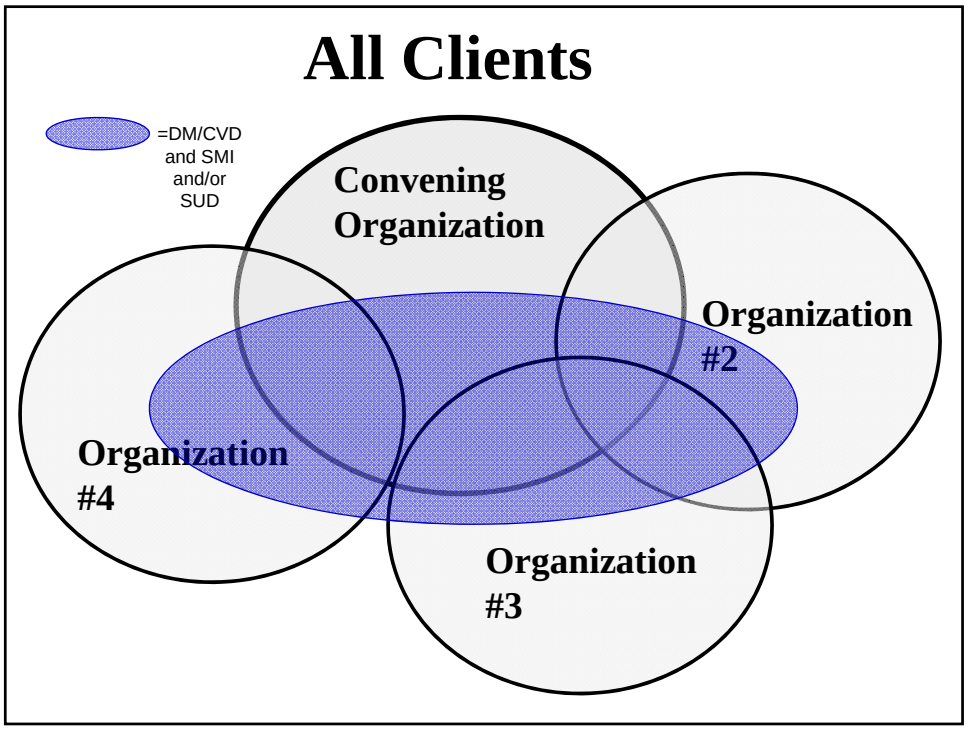



All Clients
Convening Organization
Organization #2
Organization #4
Organization #3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=DM/CVD and SMI and/or SUD
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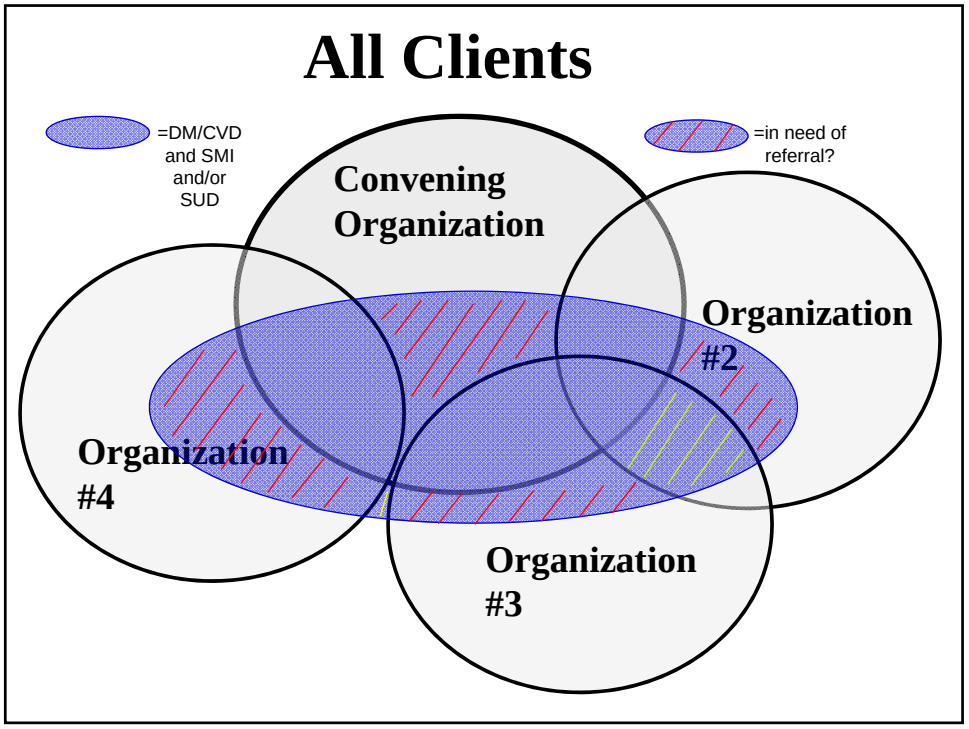
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=DM/CVD and SMI and/or SUD
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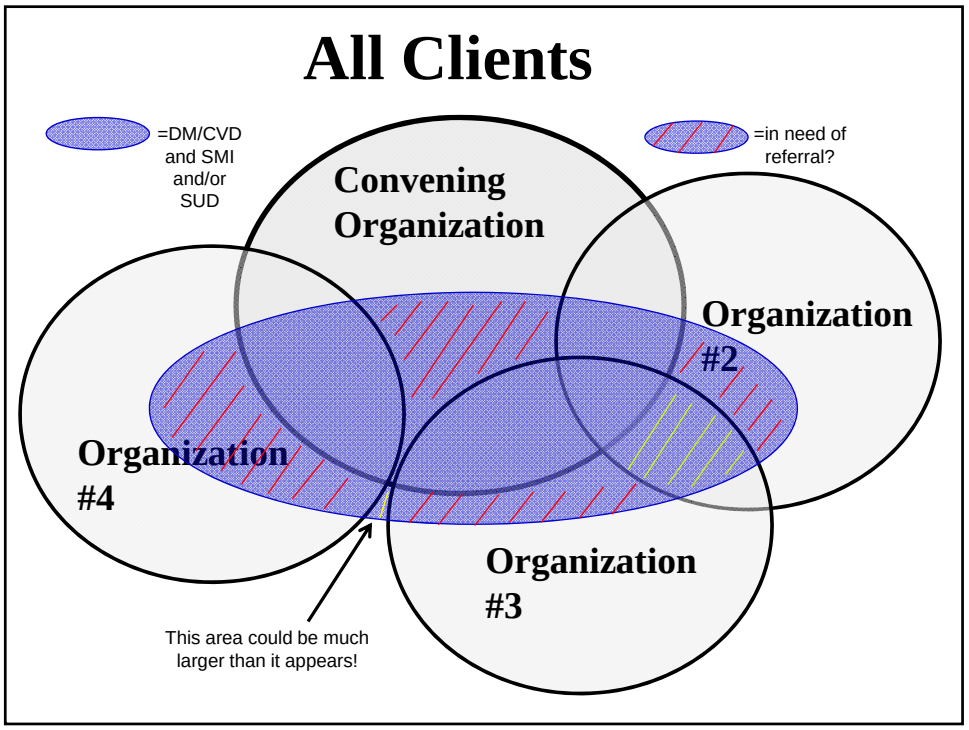
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This area could be much larger than it appears!

Two Main criteria for selecting Subpopulation of Clients

- The total size of the population should be between 100 and 300 Clients
- The clients should be selected based on either clinic or provider/care team, or both

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Subpopulation of Clients Should NOT Be Selected By

- Risk level
- Sampling (the first 100 or those Clients who come in during March or just the new Clients each month)
- Eliminating those with certain demographics or complications (e.g homeless, those with Hep C, etc.)

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Charter from Mendocino County

Aim:

Over a period of 15 months, the Mendocino County Care Coordination Collaborative Team, consisting of Mendocino County Behavioral Health & Recovery Services (Mental Health and Alcohol & Other Drug Programs), Ortner Management Group, Mendocino County Public Health, Ford Street Project (substance use disorder treatment), Manzanita Services (Mental Health Wellness Center, Care management, and outreach & engagement services), Ukiah Valley Rural Health Center (Primary Care), Mendocino Community Health Clinic, Hillside Clinic (Primary Care), and Partnership Health Plan will make changes to:

Charter from Mendocino County

Aim:

improve the health status of individuals who have complex, co-occurring conditions and require coordinated services. Teams will work to establish multiagency communication, create workflows for coordinated care, promote self management by clients, and use shared clinical information systems. These changes will build a seamless experience of care that is person-centered, cost effective, and results in improved health & wellness.

Charter from Mendocino County

Goals:

1. Increase screening in the primary care setting for mental health and substance use issues.
2. Increase communication between primary care, mental health treatment & substance use treatment services.
3. Increase the number of target population clients served by the Patient Navigation system.
4. Decrease the percentage of clients using emergency care for preventative services.
5. Increase the number of preventative services utilized by target population clients.
6. Improve target population's markers of cardiovascular & diabetes health by the end of the collaborative time frame.
7. Improve overall satisfaction with health and health services by the end of the collaborative time frame.
8. Spread care collaboration to other areas of the county

Charter from Mendocino County

Target Population:

Our target population will be a "no wrong door" referral system of any consumer working with more than one of our collaboration partner teams. A client that is identified by one of the partner agencies by using a shared screening tool as having both a chronic medical issue related to cardiovascular disease or diabetes and either a substance use disorder or mental illness, the client will be considered part of the target population and will be referred to a patient navigator for linkage and support services. Patient Navigators will help complete shared release of information, and link the client to needed services, and will aid clients in connecting to preventative services, as well as assist and inspire client to participate more fully in his or her health care needs.

Establishing the Team's Aim

- Involve senior leaders **- align aim with strategic goals of the organization.**
- Focus on issues that are important to your organization **- choose appropriate goals.**
- Write a clear statement of aim with goals/objectives**- make the target for improvement unambiguous.**
- Guidance **- include anything and everything to keep the team focused (strategies, client populations, office systems, etc.)**

Material is from The Improvement Guide, Second Edition, Jossey-Bass, 2009

API Associates in Process Improvement

Fundamental Questions 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 ?**

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API Associates in Process Improvement

How will we know that a change is an improvement?

This collaborative is about changing your organization's approach to caring for clients.

It is <u>not</u> about measurement. But ……

- Specific measures are required for learning about the impact of changes
- Key outcome measures are required to assess progress on your team's aim.

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API Associates in Process Improvement

CCC Measurement

How will we know that a change is an improvement?

More on this tomorrow

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API Associates in Process Improvement

Fundamental Law of Improvement

"Improvement only comes from changes, but not all changes result in improvement"

API Associates in Process Improvement

What is a Change?

- Not an attempt at perfection
- Not more of the same
- Something that alters the current system in some fundamental way
- Fundamental does not mean big and expensive!

Fundamental Changes

- They result from design or redesign of some aspect of the system.
- They are necessary for the improvement of a system that is not plagued by special circumstances and problems.
- They fundamentally alter how the system works and what people do.
- They often result in improvement of several measures simultaneously (e.g., quality and cost; time to ship and errors).
- Their impact is felt far into the future

Care Coordination Collaborative Change Package

I. **Develop effective collaborative care relationships**

II. **Engage clients/patients in their whole health**

III. **Deliver Coordinated Services**

IV. **Care Coordination Infrastructure**

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Care Coordination Collaborative Change Package

III. Deliver Coordinated Services

a. Assign Care Coordinator to identified clients/patients with complex co-occurring conditions, preferably culturally matched. Consider assigning more than one individual to Care Coordination function
b. Make Care Managers (individuals assigned to clients/patients who are extremely high utilizers of care to assist them in managing their medical and psychosocial problems more effectively) available for those clients/patients who are identified by Care Team as needing clinical coordination of their care
c. Develop and use standard referral processes and protocol, including referral and access standards specifically defined by partners for the target population
d. Create processes and workflows to achieve coordinated care
e. Conduct regular multi-disciplinary meetings, face to face or virtual, to facilitate service coordination
f. Require multidisciplinary team meetings:
g. Promote health literacy using a wide array of educational resources, such as classes, online and printed materials (this can be done by a variety of workers, including a peer provider, a family member provider, a clinician, a care coordinator, etc.)
h. Perform Monthly Medication Reconciliation:
i. Care Coordinator insures clients/patients have a single medication list that is reconciled across primary care and specialty mental health and substance use disorders providers

Care Coordination Collaborative Change Package

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Care Coordination Collaborative Change Package

c. **Develop and use standard referral processes and protocol, including referral and access standards specifically defined by partners for the target population**

i. Prepare individual being referred; for example, role play the visit and clarify expectations and the questions to ask

ii. Determine the type of approach to referrals that works best in your environment and formalize the role, for example: warm hand offs, access to appointments, direct phone numbers, etc.

iii. Send data needed by the receiving referral organization

iv. Verify referral was completed

v. Complete the loop and obtain data/feedback from the individual who was referred as well as from the organization to where they were referred

vi. Share data with payer and inform them of referral status and results

Change Concepts vs. Ideas

General, strategic, creative

↓

Specific, actionable, change

Increase sharing of clinical information

↓

Share medications and vital/lab results between PCP and MH

↓

With consent share build Med list and prepare to receive specific vitals and lab results from PCP

↓

With one common client (with consent) share and compare med lists (from MH and from PCP) and receive 6 key vitals and labs next Tuesday

Ideas are testable – Concepts are not

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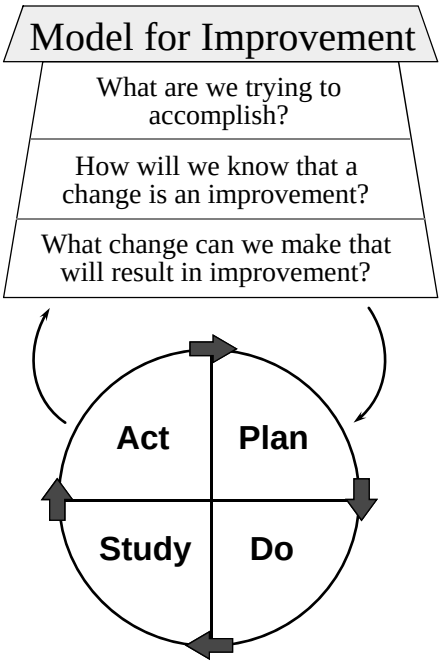

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API Associates in Process Improvement

Tomorrow

- **Accelerating Improvement**
  - **Model for Improvement**
  - **PDSA Cycle and Testing of Changes**
- **Measurement**

Next Session

An opportunity to do some work answering the 3 questions for your organization:

1. **What are we trying to accomplish?**
2. **How will we know that a change is an improvement?**
3. **What change can we make that will result in improvement ?**