Agenda Breakout #1

- **9:10-9:15** Dick Colletti – Welcome & Introductions
- **9:15-9:35** Beth Williams
  - Chronic Care Model
- **9:35-9:40** Jon Moses
  - Communication as a team to achieve >75% registerable population registered
- **9:40-9:45** Mallory McFarren
  - Coordinator role in achieving >75% registerable population registered
- **9:45-10:05** Role Specific breakouts
  - Physicians – led by Jon, Dan, Sandy
  - Coordinators - led by Theresa, Mallory, Roger
  - RNs, RDs, Psychosocial – led by Sharon, Kim, Beth
- **10:05-10:20**
  - Tables report discussion highlights
  - Take this back to team time in Session #2 to incorporate into PDSAs/interventions activity
Welcome!
Beth Williams
The Chronic Care Model and ICN

Beth Williams
9/20/2019
A few facts...

- Created in 1998 by Ed Wagner (MacColl Institute, Group Health Center for Health Studies) and Improving Chronic Illness Care

- Summarizes basic elements for improving care in health systems at the community, organization, practice and patient levels

- Changes focus from responding mainly when a person is sick to one that is proactive and focused on keeping a person as healthy as possible

aim of the CCM

- Transform the daily care for patients with chronic illnesses from acute and reactive to proactive, planned, and population-based.

- Combine effective team care and planned interactions.

- Bolster self-management support by more effective use of community resources.

- Integrate decision support, patient registries, and other supportive information technology (IT).

CCM interventions

Multicomponent practice changes in four categories led to the greatest improvements in health outcomes:

- increasing providers’ expertise and skill
- educating and supporting patients
- making care delivery more team-based and planned
- making better use of registry-based information systems

**Pre-PTM Key Driver Diagram**

**Global Aim:**
Improve the care and health of all children and adolescents with Crohn’s disease and ulcerative colitis.

**Outcomes**

**KEY DRIVERS**

- Optimal access and communication
- Accurate diagnosis and disease classification
- Appropriate drug selection and dosage
- Optimal nutritional intake
- Optimal psychosocial health
- Optimal Self-Management/Adherence

**Change Concepts + Interventions**

**Registration and Data Quality**
- Identify and register all eligible patients
- Develop standardized template for data elements
- Collect and enter visit data for all patients on a timely basis
- Develop and implement a data quality plan

**Consistent Reliable Care**
- Implement Model IBD Care with reliability of >90%
- Implement Pediatric IBD Nutrition Algorithm with reliability of >90%

**Population Management (PM)**
- Insure patients are being seen regularly
- Contact those who have not been seen in past 6 months
- Score patients using risk stratification scale
- Identify patients/subgroups for proactive care
- Design, coordinate and manage care for specific segments of the practice population
- Regularly review automated PM reports

**Pre-Visit Planning (PVP)**
- Review important data via automated PVP reports or other format
- Obtain or provide additional information to the patient
- Identify and arrange for needed resources
- Identify and “flag” variables that fall outside of protocol guidelines
- When feasible, meet as a team to review patients and determine

**Self-Management Support (SMS)**
- Provide patient education
- Define team roles and responsibilities for SMS
- Elicit patient and family priorities for visits
- Confirm patient understanding of new information
- Set patient goals collaboratively
- Monitor & document progress toward SMS goals at each visit
Relationship between interventions and CCM

Sequencing of interventions

Registration and Data Quality
- Identify and enroll all of the enrollable population
- Develop standardized template for data elements
- Collect visit data for all enrolled patients on a timely basis
- Develop and implement a data quality plan

Consistent, Reliable Care
- Implement Model IBD Care with reliability of >90%
- Implement Pediatric IBD Nutrition Algorithm with reliability of >90%

Pre Visit Planning
- Prior to routine visits:
  - Review important data
  - Obtain or provide additional information to the patient
  - Identify and arrange for needed resources
  - Identify and “flag” variables that fall outside of protocol guidelines
  - When feasible, meet as a team to review patients and determine recommendations

Population Management
- Insure patients are being seen regularly (using PM Report)
- Contact those who have not been seen in past 6 months
- Score patients using risk stratification scale
- Identify patients/subgroups for proactive care
- Design, coordinate and manage care for specific segments of the practice population
- Generate reports of overall patient health across the practice

Self-Management Support
- Provide patient education
- Define team roles and responsibilities for SMS
- Elicit patient and family priorities for visits
- Confirm patient understanding of new information
- Set patient goals collaboratively
- Monitor & document progress toward SMS goals at each visit
PTM key driver diagram (center level)

Center Level KDD – ICN
Revised: 8/28/2019 (v4)

SMART Aim

80% of teams in the network achieve the following by xx years:
- IRB activation
- 75% of population registered
- >= 83% remission
- >= 60% sustained remission

Drivers
- Prepared, proactive, multidisciplinary team
- Clear team roles and responsibilities
- Accurate patient identification and classification
- Robust and flexible data management and reporting systems
- Evidence based model care guidelines
- Proactive, timely reliable care
- Optimal psychosocial health
- Optimal self-management/adherence
- Robust patient/family activation and participation in co-production opportunities
- Active participation in research community

Pathway Interventions
- Foundations Pathway
- Achieving Remission Pathway
- Achieving Sustained Remission Pathway
- Trailblazers Pathway
Relationship between drivers and CCM

Relationship between pathway learning labs and CCM

Which pathway addresses the current model care guidelines?

References

- Improving Chronic Illness Care

- Videos Explaining the CCM

- IHI Chronic Care References
  - [http://www.ihi.org/Topics/ChronicCare/Pages/default.aspx](http://www.ihi.org/Topics/ChronicCare/Pages/default.aspx)
Jon Moses
Mallory McFarren
Objectives

- Processes
- Improvement
- Outcomes
Lurie Children’s ICN Processes

- Team members
  - Providers
  - Nurses
  - Coordinator

- Weekly team meetings
- PI and Coordinator meetings
- Weekly Preparation for Clinic
  - pre visit planning
  - population management
Failures & Successes

Successes
- Modifying processes to ensure successes
  - preparing for meetings
  - open communication
  - learning from others
- application

Failures
- wide focus
- time management
- A to B, not A to Z
Achieving Outcomes

- Utilize tools in ICN
  - participate in role specific calls
  - participate in learning lab calls
- Ask for guidance
  - ICN is there to help!
- Prioritize understanding processes
Questions?
Table Time
Table Discussions:

- ICN Champion –
  - Who is your Champion?
  - What does that look like at your center?

- How are you engaging your division in ICN activities & updates?
  - How does your role contribute?

- Leveraging Resources for ICN
Discussion Highlights

Share Top Three Takeaways

Keep Your Notes & Use in Next Breakout
Applying Lean at your Care Center to Identify Opportunities and Improve Patient Enrollment

A Non-Lean Title for an Epically Lean Breakout Session

Kim Shelly, Theresa Todd, and Drew Warmin
Project Leaders: Kim Shelly and Theresa Todd
Revision Date: 6/10/2019 (v7)

**Global Aim**
Improve the care and health of all children and adolescents with Crohn’s disease and ulcerative colitis

**SMART Aim**
Fundamentals:
- Achieve activation < 90 days (IRB reliance, PDUA executed)
- Register >75% of IBD population < 9 months following activation

Reinforcing Foundations:
- Register >75% of IBD population within 9 months of joining the learning lab

**Population**
All eligible ICN center patients

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**Key Drivers**

- Effective center leadership and multidisciplinary ICN center team
- Knowledge and use of QI methods and data
- Knowledge & execution of IRB/regulatory requirements
- Accurate identification and timely maintenance of IBD patient population
- Development and use of standard ICN and center developed tools to maintain information in the ICN registry
- Effective, ongoing family education, engagement, and co-production of care

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**Interventions**

**High Performance Leadership and Management**
- Leaders build focus on outcomes and will for improvement
- Defined ICN team roles/responsibilities
- Regular review/promotion of data across care center and organization
- Leaders develop QI culture and engage care center physicians and staff in raising and solving problems
- Create ICN Elevator pitch for consent/understanding of overall purpose

**QI Methodology**
- Utilize QI resources and training available within ICN and external (e.g., IHI)
- Use of Model of Improvement (SMART aims, PDSA ramps, etc.)
- Consult with QICs for coaching/guidance

**Site Activation**
- Ensure understanding of ICN pathway /center responsibility for legal and IRB
- Create/maintain documentation binder
- Establish process for consenting patients
- Utilize available ICN resources
- Provide PI/sub-IRC education (RC education for both RCs in GI and those covering for GI)

**Defining and Managing Population**
- Connect/partner with local IT to identify patients/build reports/work with EMR
- Create and maintain Excel template of all IBD patients
- Develop process to update master list – adding and removing patients
- Create process for registering new IBD patients into ICN registry
- Develop reliable process to track IBD patient population
- Develop reliable process for updating quarterly population number

**Reliable Population and Data Capture**
- Obtain ICN registry training
- Incorporate QI approaches for reliable processes for identifying, registering and entering IBD patient outpatient and inpatient visits
- Create tool(s) for data collection (paper form, EDT, combination)
- Ensure appropriate understanding of Paris Classification and model care guidelines
- Use of QI measures report to track progress/outcomes

**Patient and Family Engagement and Coproduction**
- Connect parents and patients to ICN network, Circle, Social Media, etc.
- Develop elevator pitch to promote understanding of ICN culture/successes
- Enable culture to include patients/parents in center’s improvement work
- Foster engagement (PAC and PWG/ICN website) and education processes
- Promote research studies relevant to IBD patient population
Foundations Breakout Session #2
Agenda Breakout #2

- **8:45-8:55** Dan O’Connell
  - Team Engagement
- **8:55-9:00** Celebrations
  - Keys to their success or Lessons learned on this journey
  - One big break through...what was the one?
- **9:00-9:15** Beth Williams
  - QI Refresh
- **9:15-9:25** Center Assessment - Focus
- **9:25-9:50** “Team Time with Experts”
  - Experts = Beth (QI), Drew (Processes Refinement) Cassandra (IRB), Sydney (ICN PM/Encouragement), Kim (QIC) & Theresa (QIC)
  - Report out Plans
- **9:50-10:10** Team Report Outs
  - Teams share plans
  - Feedback from others who may have worked on your
- **10:10-10:15** Next Steps
Dan O’Connell
Team Engagement
Dan O’Connell, MD

American Family Children’s Hospital, UW Health
University of Wisconsin, School of Medicine and Public Health
Madison, WI
Pathway to Mastery: Foundations

- American Family Children’s Hospital – Madison WI
  - Teaching hospital for University of Wisconsin
  - Part of UW Health, a large multi-hospital regional referral system for children and adults
  - 5 Peds GI physicians, 3 NPs
  - 1 Part-time research/improvement coordinator
  - 1 nurse practitioner champion
  - About 120 IBD patients
Pathway to Mastery: Foundations

- **Time line**
  - 4/2016 – First contact with Dr Colletti
  - Multiple presentations to senior leaders regarding ICN
    - Secured commitment for funding
  - 11/2016 – Welcome email
  - **Fall 2017** - Hospital and Medical School legal approvals
  - 11/2017 – All UW and ICN/CCHMC IRB signed and approved
  - 12/2017 - ICN2 Registry training
  - 1/2018 - First patient registered
First Year
Last 3 months
Team Engagement

- ICN Team
- Clinic Team
- Hospital/System
- All care team members along with patients and families
Team Engagement

- **ICN team**
  - PI, coordinator, and nurse champion
  - Weekly scheduled meeting on everyone’s calendar
    - Scheduled for 60 mins
    - Committed to meet weekly, even when on service, one person out
  - Rallied around our goal of > 75% registered
    - Other projects placed in the parking lot
    - Seeing monthly updates in ICN2 was motivating
  - Used time to complete ICN documentation and homework
  - Participated on LL call
Team Engagement

- The whole clinic team
  - Physicians, NPs, nurses, MA, Dietician, clinic manager
- Standing agenda item on division QI monthly meeting
  - Introduced the language of QI
  - Paris classification workshop
  - Update on registration data
  - Introduction of Pre-visit planning and population management
    - Discussion of next projects/initiatives
- Celebrated milestones
Next steps

- Template for weekly meeting to create standard work
  - 1st Master list/update ICN2, 2nd pop management, 3rd data quality, 4th?
- Huddle board/visual management – clinic wide, highlight ICN
  - Selected KPIs
    - % registered population
    - Prednisone free remission
    - Clinic access
    - Patient experience data
      - Staff worked together
      - Likelihood to recommend
- Patient and family engagement
CELEBRATE!
Please share:
➢ A key to your success or
➢ Lessons learned (so far) on this journey or
➢ One big break through?
Beth Williams
Center Assessment

What are you going to Focus on?
Team Time

What are you going to Focus on?
Team Time

- Think about yesterday’s breakout session,
- Take your Focus
  - Think about your interventions
  - Use the QI Tool kit
  - **Build a PDSA ramp**

- Use the “Experts”
  - Beth Williams (QI)
  - Drew Warmin (Processes Refinement)
  - Cassandra (IRB),
  - Sydney (ICN PM/Engagement),
  - Kim (QIC) & Theresa (QIC)
SMART Aim

Key Drivers

Effective center leadership and multidisciplinary ICN center team

Knowledge and use of QI methods and data

Knowledge & execution of IRB/regulatory requirements

Accurate identification and timely maintenance of IBD patient population

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Effective, ongoing family education, engagement, and co-production of care

Interventions

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Tell us what you are going to do next...
How is your Center's Data Quality?
Co-Production of a New Tool

Cori Davis & Kelly Olano
ICN Data Management Team
QI Toolkit
High-Level Process Map Worksheet

**Process:**

Beginning Boundary:

Ending Boundary:

Customers:

Outputs/Outcomes:
Ramp Strategy Planning

*To be completed prior to beginning PDSA testing

Test Description:

Test Population (description & n=__):

Location of test:

Duration (# hours/days/shifts/etc):

<Enter Ramp Name>
List the tasks necessary to complete this test *(what)*

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<th>Person responsible <em>(who)</em></th>
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Person responsible *(who)*
*To be completed after completion of each PDSA test cycle

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Why?

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Why?

Why?

Why?

Root Cause

Caution: If your last answer is something you cannot control, go back up to previous answer.
Level 1
  Level 2
    Level 3
      Level 4
Font Colors

- XXXX  R65 G65 B66
  - XXXX  R0 G174 B239
    - XXXX  R57 G181 B74
      - XXXX  R2 G99 B51
How to remove the ImproveCareNow logo and dashed blue line

- Use New Slide dropdown
  - Select “1_Blank”

- If you want to remove the ImproveCareNow logo and dashed blue line:
  - Click the “Design” tab on the top ribbon
  - On the top right, click “Format Background”
  - Select the box to “Hide background graphics”
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