Advancing Behavioral Health Equity in Primary Care

Strengthening Your Foundation of Integration

May 18, 2022 | 9am-1pm (PDT)

While you are waiting…

**********************

Please rename yourself by adding your organization’s name.

How: Right-click on your name in the Participant list, and click, “Rename”
Minimize Interruptions
Please make sure to mute yourself when you aren’t speaking.

Go Ahead, Speak Up!
Use the Zoom chat to ask questions and participate in activities.

Where Are You From?
Please rename yourself and add your organization’s name.

Here to Help
Chat Brianna Harris privately if are having issues and need tech assistance.
Change Your Zoom Name

1. After launching the Zoom meeting, click on the "Participants" icon at the bottom of the window.

2. In the "Participants" list on the right side of the Zoom window, hover over your name and click on the "Rename" button.

3. Type in the display name you’d like to appear in the meeting and click on "OK".
Deepening Connections
Welcome ABHE Teams!
Instructions

1. Unmute yourselves, turn your cameras on and wave!
2. We will be taking three group photos.
3. We will take screen shots of everyone in gallery view.
Instructions

1. You will be randomly assigned to groups of 4 people.
2. You will have 14-minutes together.
3. Introduce yourself by sharing your name, where you work, your role on your ABHE team, and then answer one of the following prompts.

Prompts

- What’s one of your most memorable vacation destination and why?
- If you could pick one job for a year, which one would it be and why?
- What’s one win you are proud of in your ABHE project?
Setting the Stage
I Agenda

1. Reflecting on Your ABHE Journey
2. Belonging, Dignity, & Justice in Action: Dignity
3. Back to Basics: Why Behavioral Health Integration Matters
4. Best Practices: Key Elements for Behavioral Health Integration
5. Developing a PDSA to Drive Change
6. Review Upcoming Date and Key Activities
Today's Objectives

By the end of our session today, you will ...

1. Made connections with and learned from fellow ABHE teams.
2. Cultivated a vision for dignity as a core value in the ABHE program.
3. Selected best practices and key elements of behavioral health and primary care integration to strengthen in your clinic to achieve your project goals.
4. Developed a plan-do-study-act (PDSA) on one change idea to test in your organization.
Understanding Where You Are

Current State

Your Data Toolbox

Ideal State
What You'll Need

For today's learning session, your team will be asked to...

Identify the change idea that your team posted in the ABHE program club.

Develop a PDSA using a template that the CCI team will share.
Introductions
Joining us today…

Parinda Khatri, PhD (she/her)
ABHE Clinical Director & Chief Clinical Officer
Cherokee Health Systems

Kristene Cristobal, MS, MA (she/her)
Equity, Leadership, & Improvement Consulting
Cristobal Consulting
Reflecting on Your ABHE Journey
## Moving from Phase 1 to Phase 2

<table>
<thead>
<tr>
<th>Phase</th>
<th>COMMIT, COLLECT, CHOOSE</th>
<th>COLLABORATE &amp; LEARN</th>
<th>HARVEST, INTEGRATE, IMPLEMENT</th>
<th>RE-COMMIT, SPREAD, SUSTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events</td>
<td>Kick-off (11/3)</td>
<td>Learning Session 1 (12/2)</td>
<td>Topical Webinar 1 (3/3)</td>
<td>Learning Session 2 (5/18)</td>
</tr>
<tr>
<td>Deliverable (Data)</td>
<td>CAT Baseline</td>
<td>Data Abstraction</td>
<td>Patient Interviews</td>
<td>UMS Data Submission</td>
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<td></td>
<td>Patient Surveys</td>
<td></td>
<td>Project Roadmaps</td>
<td>Revise Roadmaps</td>
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<tr>
<td>Activities</td>
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</tbody>
</table>
Your ABHE data journey is a learning process, NOT an assessment on the status or contributions of your clinic.

Your ABHE data journey should uncover your opportunity areas NOT discourage your motivation to make change.
Where We Are Focusing

Advancing Behavioral Health Equity in Primary Care

- Health Equity
- Patient & Family Engagement
- Culture of Improvement

- Senior Leadership & Organizational Commitment
- Data Driven Systems
- Access to Care
- Integrated Care Team & Care Delivery
- Patient Activation & Self-Management
- Community Partnerships
Belonging, Dignity, and Justice in Action

DIGNITY
Belonging

Dignity

Justice

Equity
Dignity & Respect

Some Definitions...

The state or quality of being worthy of honor or respect

- Oxford English Dictionary

The intrinsic, unconditional value of all persons; respect is the sum of the actions that honor or acknowledge a person’s dignity.

Emergence of “dignity” as we know it today:

Universal Declaration of Human Rights (1948) – United Nations

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
• Self-determination
• Humanity
• Nobility

Liston, M. Ubuntu Research and Evaluation
10 Essential Elements of Dignity

- Acceptance of Identity
- Recognition
- Acknowledgement
- Inclusion
- Safety
- Fairness
- Independence
- Understanding
- Benefit of the Doubt
- Accountability

Hicks, D, Dignity, *Its Essential Role in Resolving Conflict*
Lack of Dignity – Consequences

- Domination
  - Loss of Independence
  - Poor Relationships
  - Resentment
  - Dignity Violated

Hicks, D, Dignity, *Its Essential Role in Resolving Conflict*
A sense of dignity for individuals, families and communities.

Equity Approach

• Respect
• Protect
• Fulfill

Liston M. Dignity for Boys and Men of Color
Cobb and Krownapple. Belonging through a Culture of Dignity
Breakout Groups (15 min)

Instructions

• Reflect on your own clinic and the patients who are part of your subpopulation of focus. Which of the 10 elements of dignity do you think drive their experienced indignities most? *(2 minutes individually)*

• In pairs, share your insights (10 min)
  • Each partner will have up to 5 minutes, uninterrupted
  • Feel free to share examples that you have seen.
  • Please protect patient confidentiality.

• Reflect together (5 min)
  • What are some of the practices your clinic might try to repair these indignities?
Reflection

Instructions:

• Type into the chat or take yourselves off mute to share your voice.
  • What insights did you have in your discussion?
  • Where do you see this framework being helpful for your efforts to advance equity for your patients?
“We are guests in our patients’ lives.”

- Don Berwick
“What do I need to know about you as a person to give you the best care possible?”

**Attitude**
- How do our preconceived ideas affect our actions?

**Behavior**
- Kindness & respect must be the basis

**Compassion**
- Awareness of the suffering of another, paired with a wish to relieve it.

**Dialogue**
- Communication is the first step toward understanding

---

**Toolkit**
Practical tools have been developed to support people working in health care as they address people's emotional needs. Some of these tools, such as the PDQ, can be adapted to any health care situation and setting. Others are designed for specific situations where patient dignity may be at risk.

This section introduces:

- **The Patient Dignity Question (PDQ)**: The key question everyone working in health care should consider when interacting with patients
- **The Patient Dignity Inventory (PDI)**: 25 potential concerns that should be regularly evaluated by health care providers
- **Therapeutic Interventions**: Practices to address the 20 most common concerns identified in dignity research
- **Dignity Therapy for dying patients**: A model for individualized psychotherapy, developed and piloted by the team and funded by a grant from the [Alberta Heritage Foundation for Medical Research](https://www.albertahealthservices.ca/aboutaahas/aboutaahas.html#)
An Invitation:

How can you be an AGENT of dignity in the lives of your colleagues, your patients, and your community?

PEOPLE WILL FORGET WHAT YOU SAID, PEOPLE WILL FORGET WHAT YOU DID, BUT PEOPLE WILL NEVER FORGET HOW YOU MADE THEM FEEL

MAYA ANGELOU
Our Values in Practice

Belonging

Dignity

Justice

Speak my truth and think about impact

Value & acknowledge vulnerability

Listen without judgment and assume positive and kind intent

Provide feedback in a timely manner

Query silence for meaning

Embrace different points of view
5-min Stretch/Rest Break
Back to Basics:
Why Behavioral Health & Primary Care Integration Matters
ABHE: Learning Session 2

Parinda Khatri, PhD
Clinical Director, ABHE
Chief Executive Officer
Cherokee Health Systems
May 18, 2022
Status Check:

What's going on?

“I'm afraid you've had a paradigm shift.”
Time for Back to Basics

- Primary Care
- Integration
- Implementation
# Top 10 Health Problems in 2021

1. COVID-19
2. Mental Health Conditions
3. Unhealthy Alcohol and Substance Use
4. Food Safety
5. Healthcare Associated Infections
6. Heart Disease and Stroke
7. Human Immunodeficiency Virus (HIV)
8. Motor Vehicle Injuries
9. Nutrition, Physical Activity, & Obesity
10. Prescription Drug Overdose

*Centers for Disease Control (cdc.gov) and World Health Organization (who.org), 2021*
Health Outcomes

Health Factors
- Health Outcomes
  - Length of Life (50%)
  - Quality of Life (50%)
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Policies & Programs

County Health Rankings model © 2014 UWPHII
Where do people go for help? Watch the Design Path...
Levels of Care

- Quaternary Care
- Tertiary Care
- Secondary Care
- Primary Care
Welcome to Primary Care

1. Main point of access to care for all healthcare, including behavioral health conditions

2. Principal setting for treatment of behavioral health conditions

3. Central stage for the complex and bidirectional interplay between medical and mental health disorders, health behaviors, and social determinants of health
### By the numbers…

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Of people with a behavioral health disorder will visit a primary care provider at least once a year</td>
</tr>
<tr>
<td>50%</td>
<td>Of all behavioral health disorders are treated in primary care</td>
</tr>
<tr>
<td>48%</td>
<td>Of appointments for all psychotropic agents are with a non-psychiatric primary care provider</td>
</tr>
<tr>
<td>67%</td>
<td>Of people with a behavioral health disorder do not get behavioral health treatment</td>
</tr>
<tr>
<td>30-50%</td>
<td>Of patient referrals from primary care to an outpatient behavioral health clinic do not make the first appointment</td>
</tr>
<tr>
<td>67%</td>
<td>Of primary care physicians report not being able to access outpatient behavioral health for their patients</td>
</tr>
<tr>
<td>70%</td>
<td>Of resources are utilized by 10% of patient population – those with comorbid behavioral health and medical conditions</td>
</tr>
</tbody>
</table>
How much have behavioral health services increased in community health centers over the past decade? (Choose a %)

Instructions
• Take a moment to reflect on the poll question.
• Respond to the question.
Health Centers Have Expanded Their Capacity to Provide More Services Onsite

Number of Health Centers Employing Staff for Selected Services

- **30% Growth**
  - 2010: 1,053
  - 2019: 1,368
  - Service: Enabling Services*

- **62% Growth**
  - 2010: 828
  - 2019: 1,343
  - Service: Behavioral Health

- **32% Growth**
  - 2010: 857
  - 2019: 1,128
  - Service: Dental

- **50% Growth**
  - 2010: 442
  - 2019: 663
  - Service: Pharmacy**

- **81% Growth**
  - 2010: 199
  - 2019: 360
  - Service: Vision

- **72% Growth**
  - 2010: 402
  - 2019: 693
  - Service: Four or More Services***
Leading Determinants of Overall Health & Behavior

- Behavioral: 40%
- Genetic: 30%
- Socioeconomic: 15%
- Environment: 10%
- Health Care: 5%
Moving the Needle in Health Equity

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

- Childhood experiences
- Housing
- Education
- Social support
- Family income
- Employment
- Our communities
- Access to health services

Source: NHS Health Scotland
Levels of Care

- Quaternary
- Tertiary Care
- Secondary Care
- Primary Care
The Case for Integration

High prevalence and cost of unmet behavioral health needs in primary care

Improved Quality, Value, Experience with integration of behavioral health in primary care
Integrated Behavioral Health MUST Fulfill Functions of PRIMARY Care

**Contact**
*First line of access*

**Coordinated**
*Organizes and synchronizes all elements of care*

**Comprehensive**
*Anything that walks through the door*

**Continuous**
*Episodes of care within context of longitudinal partnership*
Poll Question

Which one of the 4 C’s do you feel your organization is the strongest in?

Instructions
• Take a moment to reflect on the poll question.
• Respond to the question.

4 Cs of Primary Care
• Contact
• Comprehensive
• Coordinated
• Continuous
Poll Question

Which one of the 4 C’s do you want to strengthen in service of your ABHE project aims?

Instructions

• Take a moment to reflect on the poll question.
• Respond to the question.

4 Cs of Primary Care

• Contact
• Comprehensive
• Coordinated
• Continuous
Integration Is A Means To An End

- Improve the health of a population
- Achieve health equity
- Improve access
- Focus on wellness and prevention
- Patient centered care
- Evidence based clinical & program decision making
Paradigm Shift

Strong primary care is critical for a strong healthcare system.

Behavioral health is a necessary and unavoidable part of strong primary care.

Effective integrated behavioral healthcare is a qualitatively different clinical process than specialty mental health.

Advancing equity in behavioral health requires expansion of scope, roles, practice.
Questions & Comments
Breakout Groups

Which one of the 4 C’s is the biggest opportunity area for your clinic?

******************************************

Instructions

1. You will be randomly assigned to groups of 4 people.
2. You will be in your breakout groups for 13-minutes.
3. In your group, respond to the prompt.

4 Cs of Primary Care

• Contact
• Comprehensive
• Coordinated
• Continuous
Best Practices:
Key Elements for Integration
Implementation
The Reality of Primary Care

- Patient Panel Size
- Health Complexity
- Social Complexity
- Coordination Demands
- Insurance Requirements
- Documentation Demands
- Accountability

Time
Resources
Reimbursement
ABHE Pathways As Key Drivers

Advancing Behavioral Health Equity in Primary Care

Health Equity

Patient & Family Engagement

Culture of Improvement

Senior Leadership & Organizational Commitment

Data Driven Systems

Access to Care

Integrated Care Team & Care Delivery

Patient Activation & Self-Management

Community Partnerships
Sample Areas of Focus: They are Interconnected

- Screening, Referral, Follow Up
- Adapted Self Management
- Multi-disciplinary Team
- Systematic Quality Improvement

Together... ENHANCING LIFE
Example 1: Screening, Referral, & Follow Up Strategies

- BH Screening Tools
- Schedule Review
- Chart Review
- Reporting
- Patient Self-Referral
- Team Huddle
- Real-time Provider/Staff Referral
Example 1: Possible Design Path

Identification

Patient with depression & scheduled visit identified by PCP during team huddle

Depression screening completed by LPN during triage and score is positive

Coordination

PCP discusses screening results with patient & facilitates BHC warm-handoff at point of care

Collaboration

BHC meets with patient for brief intervention at point of care

BHC provides real-time verbal feedback to PCP about BH intervention target & past med efficacy

PCP reinforces BHC intervention with patient, initiates SSRI at point of care & schedules concurrent PCP & BHC visit in 4 weeks
Tips for Success

- Primary Care Frame
- Logistics
- Interconnection
- Discipline
- Continuous Alpha/Beta
Screening, Referral, and Follow-up

Lorin M. Scher, MD, FACLP
Clinical Professor of Psychiatry & Behavioral Sciences

Gina Rossetti, M.D.
Medical Director of Population Health Quality
Robert B. Gross (he/him)
Equity, Leadership, & Improvement Consulting
Cristobal Consulting
Systematic Quality Improvement
Systematic Quality Improvement

Aim: Improve depression response rate within gender minority patients by 5% by May 2023.

**Element 1: Screening & referral** Distribute outreach brochures to primary care clinic A that are tailored for patients who identify as gender minority, promoting mental health our depression treatment services.

**Element 2: Self-management support that is adapted to culture** Deliver training to staff at primary care clinic A about patients who identify as gender minority: culture, values, stigma, disparate outcomes.

**Element 3: Multidisciplinary team** The integrated BH/PC team conducts monthly case conferences that are focused on our patients who identify as gender minority.
Adaptive Self-Management

ABHE Learning Collaborative Teams
Questions & Comments
15-min Stretch/Rest Break
Improving Equity in Behavioral Health One PDSA at a Time
Of all the ideas, approaches, and models you've learned about to help your clinic improve mental health outcomes for your patients who experience the most disparities, **what feels like the biggest challenge you'll face?**

-----------------------------------------------------

**Instructions**

- Take a moment to reflect on what’s been shared.
- In the chat box, respond to the prompt.
How Is This All Connected?

- Screening, referral, follow-up
- Adapted self-management
- Multidisciplinary Teams
- Systematic quality improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Act

Plan

Study

Do

From Associates in Process Improvement

Testing Changes
Model for Improvement

Aim Statement (by May 2023)
What’s your overall goal and by when? Remember SMARTIE
Resource: Developing an Aim Statement

Model for Improvement

What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can we make that will result in improvement?

Act
Plan
Study
Do

Testing Changes

From Associates in Process Improvement
Model For Improvement

From Associates in Process Improvement

Testing Changes

<table>
<thead>
<tr>
<th>Driver or Change Idea</th>
<th>Measure</th>
<th>Operational Definition</th>
<th>Baseline</th>
<th>Target</th>
<th>Benchmark</th>
<th>Who will collect data? How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Management: All</td>
<td>Substance Use Screening and Intervention</td>
<td>Number of patients 18 years of age and older who received substance use screening once during an office visit AND who received an intervention for all positive screening results during the measurement period:  - Tobacco use  - Unhealthy alcohol use  - Drug use</td>
<td>12% screening</td>
<td>30%</td>
<td>N/A</td>
<td>Who will collect:  - Office of Population Health  - Quarterly</td>
</tr>
<tr>
<td>Screening and Management: Depression Utilization of the PHQ-9 Tool (PHQ-9)</td>
<td>Depression Utilization</td>
<td>Number of patients 18 years of age and older with an office visit and the diagnosis of major depression or dysthymia during the measurement period who also completed the PHQ-9</td>
<td>Raw metric – baseline data to be submitted March 2022</td>
<td>Under consideration</td>
<td>N/A</td>
<td>Who will collect:  - Office of Population Health  - Quarterly</td>
</tr>
</tbody>
</table>
Model For Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Act

Plan

Study

Do

Associates in Process Improvement

Testing Changes
Model For Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Act
Plan
Study
Do

Testing Changes

From Associates in Process Improvement
Anatomy of a PDSA - Plan

Plan

- Questions & predictions
- Plan to carry out the cycle
Anatomy of a PDSA - Do

Do
- Carry out the plan
- Document problems, observations
Anatomy of a PDSA - Study

Study
- Data analysis
- Compare data to predictions
- Summarize learnings
Anatomy of a PDSA - Act

**Act**
- What changes to make?
- Adapt, adopt, or abandon
Ramp Up – Rapid Iterative Cycles

Hunches  Theories Ideas

Very Small-Scale Tests

Follow-up Tests

Wide-Scale Tests of Change

Implementation of Change

Changes That Result in Improvement

DATA

Rapid = Frequent

Center for Care Innovations

Armstorff Consulting
Connecting Quality to Care
**Example 1: Using PDSAs To Read More Books**

**Aim statement:** Lydia would like to increase her reading to one non-fiction book focused on health equity per month.

- **Increase Access to Books**
  - Going to public library
  - Book club
  - Book recommendation list

- **Increase Time for Reading**
  - Start bedtime routine earlier
  - Read on public transport
  - ??

- **Creating a Practice**
  - Set calendar reminders
  - Carry book with her
  - ??
Example 1: Create earlier bedtime routine (Lydia’s PDSA)

**Describe the test**
- Now going to bed at 11pm but want to create a routine getting in bed by 10pm so have almost an hour to read

**Objectives**
- Increase time spent reading, increase health knowledge, deepen knowledge of specific health equity issues

**Questions this test answers**
- Will an earlier bedtime routine lead to more reading time?
- Is 1 hour enough time?

**What/Where**
- In bed by 10pm

**When**
- 3x/week for 1st week; increase to 5x/week afterwards

**Prediction:**
- I will have less screen time before bed
- I might want some nights w/o reading
- Sticking to a routine might be a challenge
- I may have unexpected invitations or life events that will disrupt this routine
Example 2: Improve depression among gender nonconforming patients

Aim: Improve depression response rate within gender minority patients by 5% by May 2023.

Element 1: Screening & referral Distribute outreach brochures to primary care clinic A that are tailored for patients who identify as gender minority, promoting mental health and depression treatment services.

Element 2: Self-management support that is adapted to culture. Deliver training to staff at primary care clinic A about patients who identify as gender minority; culture, values, stigma, disparate outcomes.

Element 3: Multidisciplinary team The integrated BH/PC team conducts monthly case conferences that are focused on our patients who identify as gender minority.

Change ideas
1. Normalize mental health
2. Education about gender minority population
3. Work together better

Describe the test
• BH/PC team hold case conferences about pts identified as gender minority

Objectives
• Raise awareness, learn, strategize, coordinate

Questions this test answers
• Will case conferences be doable? Will they help us focus well on this population?

What/Where
• Zoom huddles

When
• Monthly on Monday mornings

Prediction:
Our team's care will be more:
• Informed
• Timely
• Comprehensive
• Coordinated
Example 3: How We Might Honor Our Patient’s Dignity?

10 Essential Elements of Dignity

- Acceptance of Identity
- Recognition
- Acknowledgement
- Inclusion
- Safety
- Fairness
- Independence
- Understanding
- Benefit of the Doubt
- Accountability

Prediction:
Our team’s care will be more:
- Informed
- Kind
- Respectful
- Inclusive

Change ideas
1. Clinic better represents & includes how our patients identify
2. Each team member feels well prepared to support our patients in however they identify

Describe the test
- Develop gender identity affirming staff education

Objectives
- Raise awareness & knowledge; teach affirming language and skillsets

Questions this test answers
- How can we be more respectful, inclusive, and caring of our pts?

What/Where
- Education=brochures, staff training, 1:1 coaching

When
- Starting next month
PDSA Worksheet

**DO**

Carry out the planned test; collect the data and place the results here. (Include comments about what happened and what was observed)

**STUDY**

Describe the measured results and how they compared to the predictions (What did you learn? What do you wonder about?)

What did we learn:

<table>
<thead>
<tr>
<th>Predictions vs. Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prediction</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
</tbody>
</table>

What else did we learn about the process? What worked and what could be different in the next test iteration?

Our learnings caused us to wonder about:

<table>
<thead>
<tr>
<th>Wandering</th>
<th>What Will We Do About It?</th>
<th>Who Will Do It?</th>
<th>By What Date?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**PLAN**

What is your plan (process, people, etc.) for what we need to do?

What are the high-level process steps for this test?

List the detailed tasks needed to conduct this test of change (What/Where)

<table>
<thead>
<tr>
<th>#</th>
<th>What/Where</th>
<th>Person(s) responsible</th>
<th>When will it be done?</th>
</tr>
</thead>
<tbody>
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</table>

Predict what you believe will happen when the test is carried out

What data will be collected to determine whether your test is successful?

Create the data collection tool (provide a copy if it helps); what are the column headings of the data you need to collect? What do you want to know?
Build Part 1 of Your PDSA

Instructions

1. **PDSA Worksheet**: Locate your PDSA worksheet.
2. **Build**: 1st section of your PDSA (15-min).
3. **Reconvene**: Share your examples w/group (5-min).
Build Part 1 of Your PDISA

**PDSA WORKSHEET**

Date:
Name of Test:

Describe briefly, at a high-level, the test of change you are planning (What are the objectives of this test/why are you doing it? What questions do we want answered with this test?):

<table>
<thead>
<tr>
<th>Test description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
</tr>
</tbody>
</table>

Questions this test should answer:

**Spend 15 minutes on these three items**
Build Part 1 of Your PDSA

PDSA WORKSHEET - EXAMPLE

Date: March 18, 2020
Name of Test: Hypertension Check-in call between scheduled appointments

Describe briefly, at a high-level, the test of change you are planning (What is the objective? What questions do we want answered with this test?):

Test Description: Provide a mid-point check-in call to patients with uncontrolled hypertension who are scheduled for a f/up appointment.

Objectives:
1) Remind patient of scheduled f/up appointment
2) Contact patient between appointments to:
   - Discuss medication adherence
   - Discuss progress regarding established shared goal
   - Encourage self-management
   - Identify any successes/challenges/needs

Questions this Test Should Answer (We wonder . . . ):
1) Will a mid-point call to the uncontrolled hypertensive patient prior to the follow-up appointment:
   - Improve appointment kept rate?
   - Provide clinic with valuable information regarding whether the patient understood the established shared goal and education/instructions given during the initial appointment?
   - Encourage/motivate the patient to engage in shared goals established during the visit?
   - Reveal other factors/needs impacting patient’s ability to self-manage hypertension?

2) Will a script be valuable in guiding dialogue with the patient?

3) Will motivational interviewing techniques be useful?
Join Your Team’s Breakout Room

Follow the steps below to choose your team's breakout room:

**Step 1:**
When breakout rooms open, a popup will show up above the Breakout Rooms icon.
Click Breakout Rooms.

**Step 2:**
A menu will pop up with a list of breakout rooms.
Hover above the breakout room you want and select “Join.”

**Step 3:** Click “Yes” to confirm, and you will be moved to that breakout room.
What did you decide to test?

Instructions

- Type into the chat what you decided to test.
- In the chat box, respond to the prompt.
Build Part 2 of Your PDSA

Instructions
1. Go back to your PDSA worksheet.
2. Build 2nd section of PDSA (15-mins).
3. Reconvene w/big group.
## Build Part 2 of Your PDSA

Spend 15 minutes on these three items

### PLAN

**What is your plan? (Answers who, what, when, and where):**

What are the high-level process steps for this test?

<table>
<thead>
<tr>
<th>List the detailed tasks needed to conduct this test of change (What/Where)</th>
<th>Person(s) responsible (Who)</th>
<th>When will it be done? (When)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
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<td>2)</td>
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<td>3)</td>
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</tbody>
</table>

**Predict what you believe will happen when the test is carried out**
### PLAN

**What is your plan? (Answers who, what, when, and where):**

**What are the high-level process steps for this test?**
- Develop a process for identifying/monitoring patients who need to be contacted regarding hypertension
- Determine “sicker” system to alert Nurse regarding mid-point call due date
- Develop a script to use with the patient
- Develop a data collection sheet

**List the detailed tasks needed to conduct this test of change**

<table>
<thead>
<tr>
<th>Task</th>
<th>Person(s) responsible</th>
<th>When will it be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with QI Data Analyst to identify method for generating a list of patients with f/up appointments for uncontrolled hypertension</td>
<td>Sally will meet with Dave (QI Analyst)</td>
<td>3/20/2020</td>
</tr>
<tr>
<td>Develop a &quot;script&quot; to use when conducting the mid-point check-in call: Identify the three most important points to cover, including medication adherence and the established shared goal</td>
<td>Ruth will design script and obtain feedback and input from team via email</td>
<td>3/20/2020</td>
</tr>
<tr>
<td>Use motivational interviewing techniques to discover patient needs for self-management encouragement/motivation</td>
<td>Sally will practice/role play with Ruth</td>
<td>03/23/2020</td>
</tr>
<tr>
<td>Remind the patient about the upcoming appointment for re-check of hypertension and confirm ability to attend</td>
<td></td>
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</tr>
<tr>
<td>Care Team A Nurse will use EHR-generated list to identify next 3 patients on that are scheduled for f/up during the week of 3/30; set alarms on Google calendar to follow-up with the patient at approximate mid-way between “seen and next apt.”</td>
<td>Sally on Care Team A will set alarms for 3 patients</td>
<td>Week of 3/23/2020</td>
</tr>
<tr>
<td>When alerted, use prepared script to dialogue with patient to populate and record identified data elements</td>
<td>Sally on Care Team A will contact 3 patients/use MI/use script/collate data on data collection sheet</td>
<td>Week of 3/30/2020</td>
</tr>
<tr>
<td>Improvement Team will huddle to discuss PDSA learning on Friday morning at 8:00 AM to determine next steps (compare outcomes to previous step, discuss learning, identify next steps and iterations)</td>
<td>Improvement Team</td>
<td>4/3/2020</td>
</tr>
</tbody>
</table>

**Predict what you believe will happen when the test is carried out**
- 2 patients will answer the initial call; 1 will need to be called back
- 2 patients will keep f/up appointment
- 2 patients will have questions regarding medication and provider instructions
- Nurse will not be able to make all calls on the exact day of the set alert
- The script will be helpful in guiding the dialogue with the patient and surfaced patient concerns
PDSA Next Steps

Instructions

1. **Discuss** logistics and other details to help you set up your PDSA (8-mins).
Preparing for your PDSAs

Prepare for what you’re testing by next Tuesday

Who needs to be looped in? [type]

What additional preparation is needed to implement the test? [type]

When will you do a follow-up to look at the data from the test and decide whether to adopt, adapt, or abandon? [type]
Question & Comments
## This Is Where We Are Going

### Phase

<table>
<thead>
<tr>
<th>2021</th>
<th>2022</th>
<th>2023</th>
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</thead>
<tbody>
<tr>
<td>OCT-NOV</td>
<td>DEC-JAN</td>
<td>FEB-MAR</td>
</tr>
<tr>
<td><strong>Phase</strong></td>
<td><strong>COMMIT, COLLECT, CHOOSE</strong></td>
<td><strong>COLLABORATE &amp; LEARN</strong></td>
</tr>
<tr>
<td><strong>Events</strong></td>
<td>Kick-off (11/3)</td>
<td>LS 1 (12/2)</td>
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<tr>
<td><strong>Deliverable (Data)</strong></td>
<td>CAT Baseline</td>
<td>Data Abstraction</td>
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<tr>
<td><strong>Activities</strong></td>
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<tr>
<td></td>
<td>• Test / Refine / Implement</td>
<td>• Collect Improvement Data</td>
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</tbody>
</table>

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Center for Care Innovations
Where Do We Go From Here?

Your ABHE Team

Your Data Toolbox

Your ABHE Coach

The ABHE Club
Connecting the Dots

Continue to develop multiple PDSAs on the change ideas you want to focus on.

Meet regularly with your coaches (multiple times a month) to iterate on your PDSAs.

Begin to collect patient stories to understand the impact it has on the communities you serve.
What ‘a-ha’ or insight are you taking with you today?

Instructions:
• Take a moment to reflect on your own experience
• Unmute yourself and speak up or share your response in the chat box
Closing & Next Steps
Poll Questions

1. Please select the number that best represents your experience with today’s session.
   - 5 – Excellent
   - 4 – Very Good
   - 3 – Good
   - 2 – Fair
   - 1 – Poor

2. Please select the number that best represents your response to the statement: Today’s session was a valuable use of my time.
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree

3. Please select the number that best represents your response to the statement: “Today’s session presented information in a way that was accessible to me”
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree

4. Please select the number that best represents your response to the statement: "I know what is expected of my team over the next few months.”
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree
I Upcoming Dates & Activities

1. **May & Beyond**: Continue testing PDSAs.
2. **June 30**: Complete midpoint check-in survey.
3. **July 27**: Submit improvement dashboard (Q1 & Q2 data)
5. **August 19**: Submit midpoint CAT.
6. **August 31**: Topical webinar 2.
Stay Connected

Email

• Reach out to the CCI team if you have questions about upcoming events, activities, or program components.

Program Club

• Log in to access public forums and get updates about program announcements, assignments, and resources.

Newsletters & Bi-monthly Buzz

• Learn about upcoming events, activities, and resources.

Meetings with Coaches

• Meet with your coach to thought partner and troubleshoot program challenges.
Juan Carlos Piña
He/Him
Program Manager
juancarlos@careinnovations.org

Lydia Zemmali
She/Her
Program Coordinator
lydia@careinnovations.org
Thank you!