# Quality Improvement (QI) Learning Academy

June 18, 2021

HEALTHY start TA & SUPPORT CENTER

NICHQ National Institute for Children's Health Quality

# Agenda

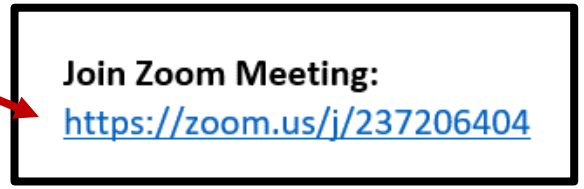
| | |
|---|---|
| Housekeeping | Lisa Hong, NICHQ |
| Welcome | Olivia Giordano, NICHQ |
| Review: From Holding Gains to Spread | Jane Taylor, EdD |
| Next Steps | Danisha Charles, NICHQ |

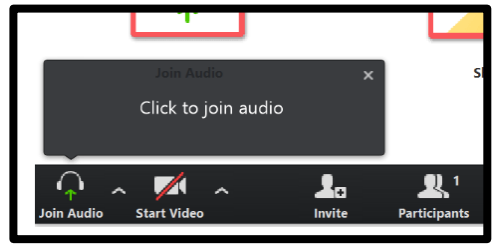
# Meeting Logistics

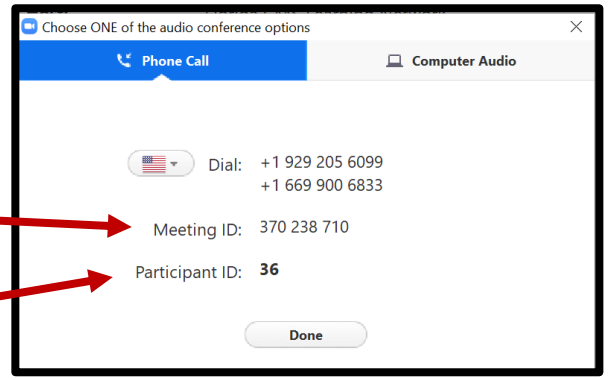
- This session is being recorded.
- All participants are muted upon entry. We ask that you remain muted to limit background noise.
- Members are encouraged to participate in the discussion by typing your comments or asking questions using the chat box.

# Connecting to the Audio Conference

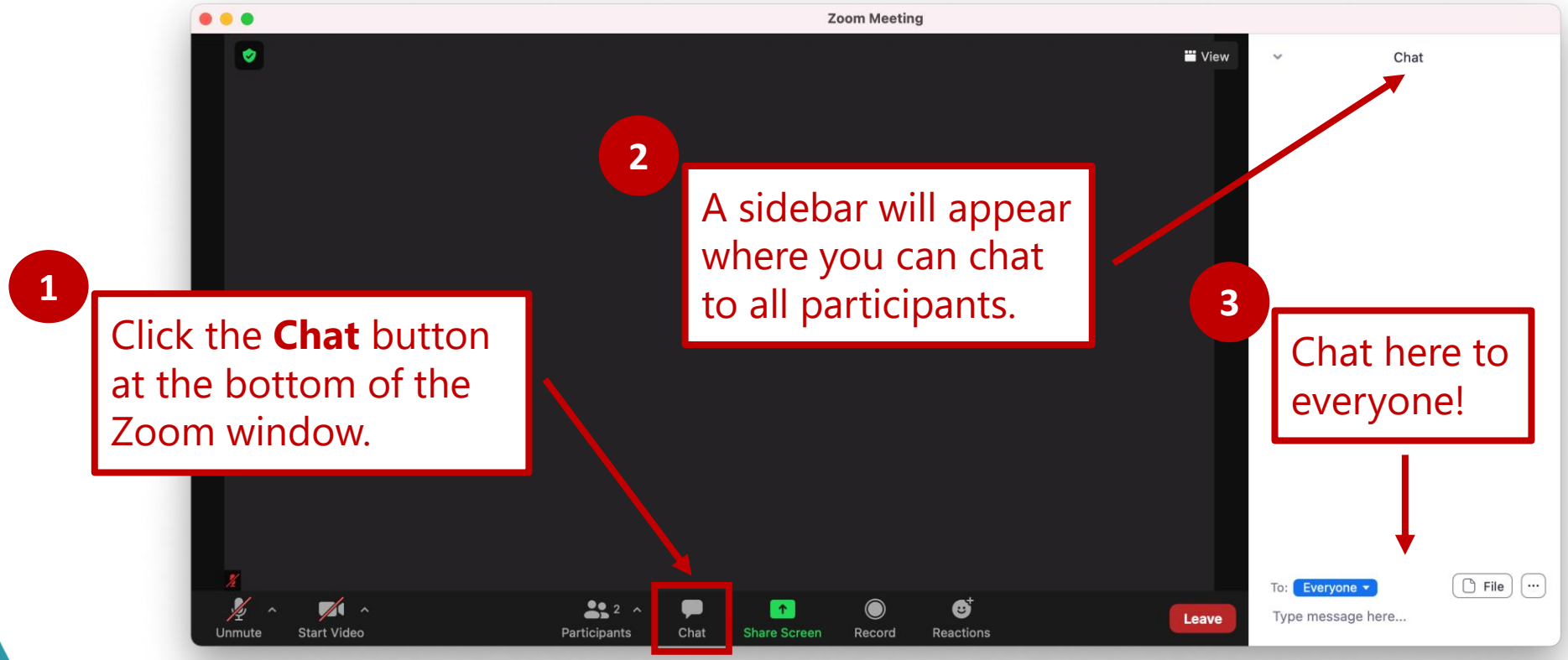
- Join the Zoom Meeting by **clicking the Zoom Meeting link** & launching the Zoom application
- An audio conference box will appear
  - If you do not see the box, click '**Join Audio**'
- From the audio conference box, select '**Phone Call**' or '**Computer Audio**'
  - If using the phone:
    - Dial one of the given numbers next to "**Dial**"
    - You will be prompted to enter the **Meeting ID**
    - Then you will be prompted to enter the **Participant ID**



# How to Chat


1
Click the **Chat** button at the bottom of the Zoom window.
2
A sidebar will appear where you can chat to all participants.
3
Chat here to everyone!
Zoom Meeting
View
Chat
Unmute
Start Video
Participants
Chat
Share Screen
Record
Reactions
Leave
To: Everyone
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Type message here...

# Welcome Back to the Healthy Start QI Learning Academy!

# Quality Improvement Learning Academy

**Goal:**

Build grantee knowledge and develop grantee skills around Quality Improvement (QI), to support them in executing a QI project with an equity lens, achieving their programmatic goals, and meeting the Healthy Start benchmarks

# QI Learning Academy Schedule

| | |
|---|---|
| Session #1: Power, Philosophy and Culture: Introduction to Quality Improvement | February 18, 2-4 p.m. ET |
| Session #2: Using Power-Leveling Tools | March 18, 2-4 p.m. ET |
| Session #3: Using Data that Grows Equity | April 16, 2-4 p.m. ET |
| Session #4: Testing Changes with an Equity Focus | May 20, 2-4 p.m. ET |
| Session #5: Holding the Gains and Spreading Change | June 18, 2-4 p.m. ET |

# QI Learning Academy Session #5

**Learning Objective:**

Develop the facility to answer the first two questions in the *Model for Improvement* with an equity focus

**Today's Focus:**

Review of key points and emerging trends in equity measurement from Implementation to scale up and spread

Jane Taylor, EdD
Improvement Advisor and Healthy Start Faculty

**Child's floral jacket** Made by a Dakota artist Late 1800s

# Acknowledgement of Land and Country

# Review Overall

- ✓ Introduction to Model for Improvement
- ✓ Power mapping: data, influence, funding
- ✓ Historical context of improvement
- ✓ No blame, no shame data
- ✓ Testing to move things in the right direction
- ✓ Learning the way to implementation before you finalize how to do things differently

# WS-1: What are we trying to accomplish?
## Equity Lens – Key points

HEALTHY start

### Aim Statements for Improvement Projects

- **What?**
  - Discover what the community needs.
    - Uncover lived experience within that need.
    - Talk to community members and clients about their personal and collective history with the service you want to improve.
    - Find ways to do both!
- **By when?**
  - It's not a race, but when we know a better way, we have an obligation.
- **How much improvement (goals in concrete measurable terms)?**
  - Rely on the community to inform what they want.
- **For whom?**
  - Be very specific!

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# Aim Statement:
## *Selecting how much improvement and for whom*

- **How much improvement?**
  - Rely on the community to inform what they want.
  - What matters to the community?
- **How should it be measured?**
- **For whom?**
  - Be very specific. Select a group who stands to benefit most.
- **Take learning from those to all you serve.**

# Tips

- Avoid deficit language: From inequity and disparity to those who stand to benefit the most
- Avoid letting measurement drive improvement
- Avoid pathologizing measures
- Instead let the community pull improvement and measurement

# Tips

One more time…

- **Be specific** about who will benefit the most – use data to help understand. **Talk to the community**.
- **Avoid jargon and white supremacy** – make things understandable to clients and community. **Avoid worship of written word**. **Honor cultural traditions** and ways of clients and the community.
- **Interrogate** all your policies, structures, norms, and processes
  - Whose interest is served? Is it informed by white supremacy or racist history?

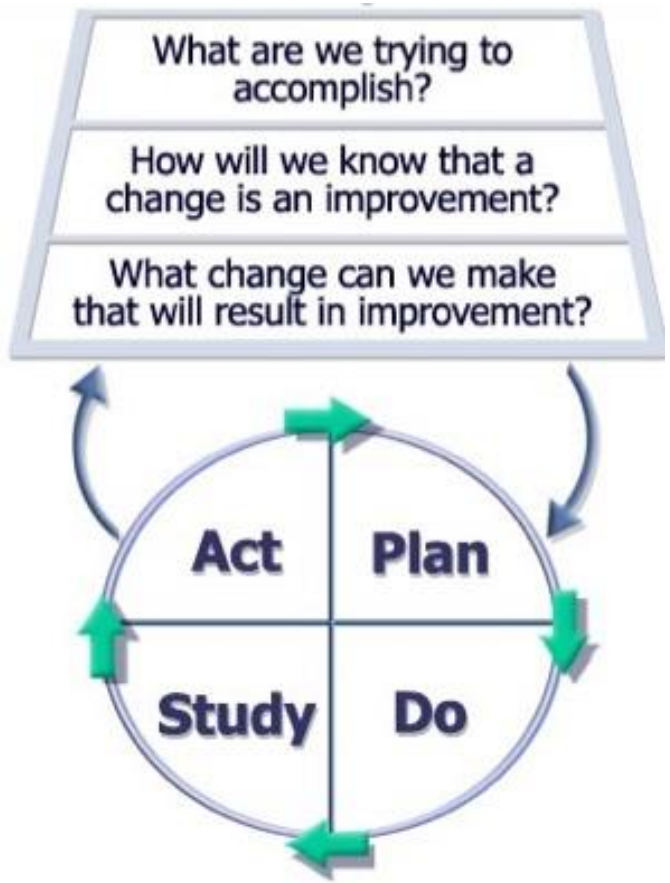
# Data and Data Display
# Family of Measures in an Improvement Project

**Traditional**

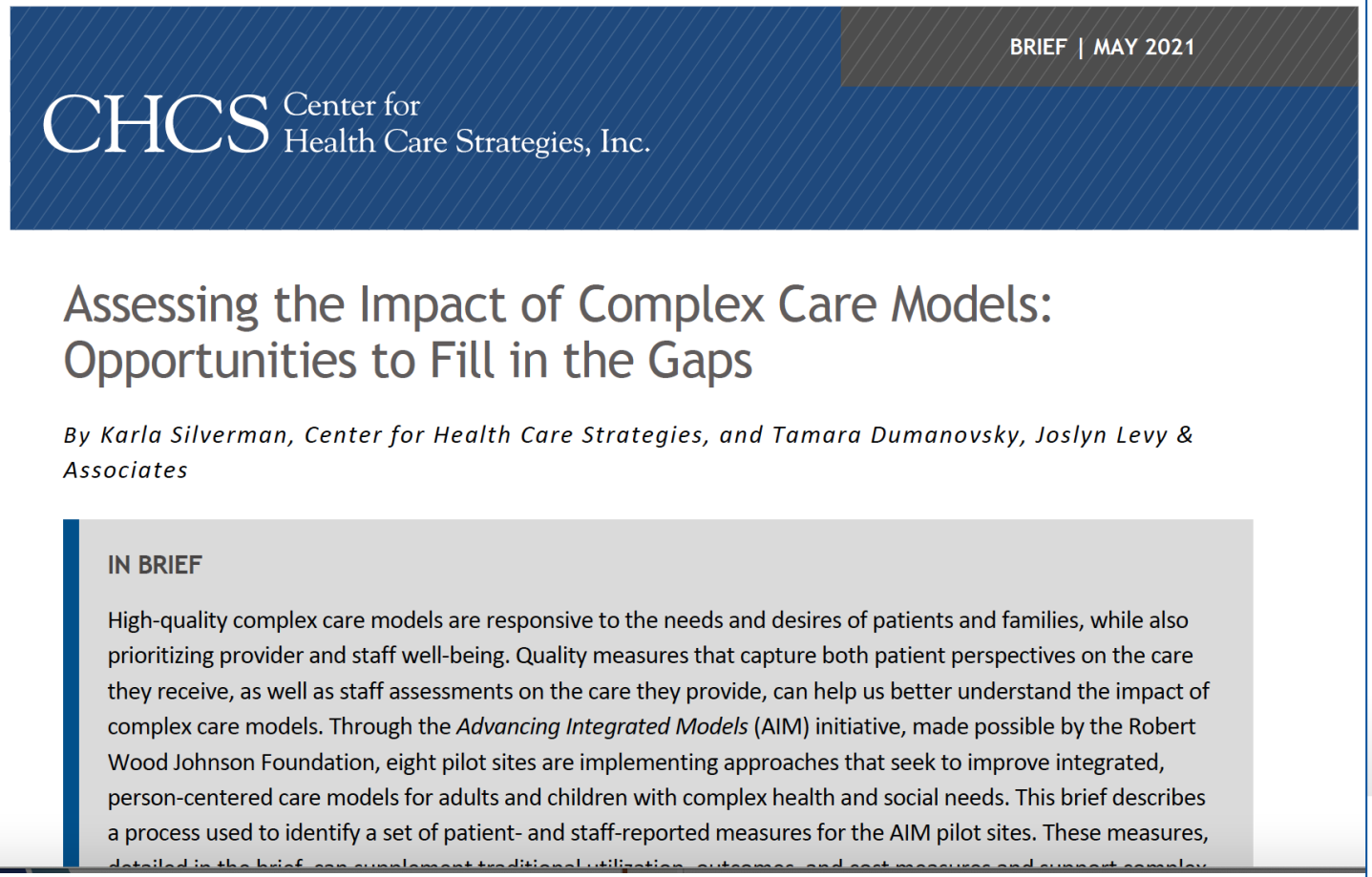
- Outcome
- Process
- Balancing

**Reframing**

- What we value
- What we value about how we do it, make it happen
- How we make sure no one else is harmed as we make these changes



# Promising Updates in Measurement



CHCS Center for Health Care Strategies, Inc.

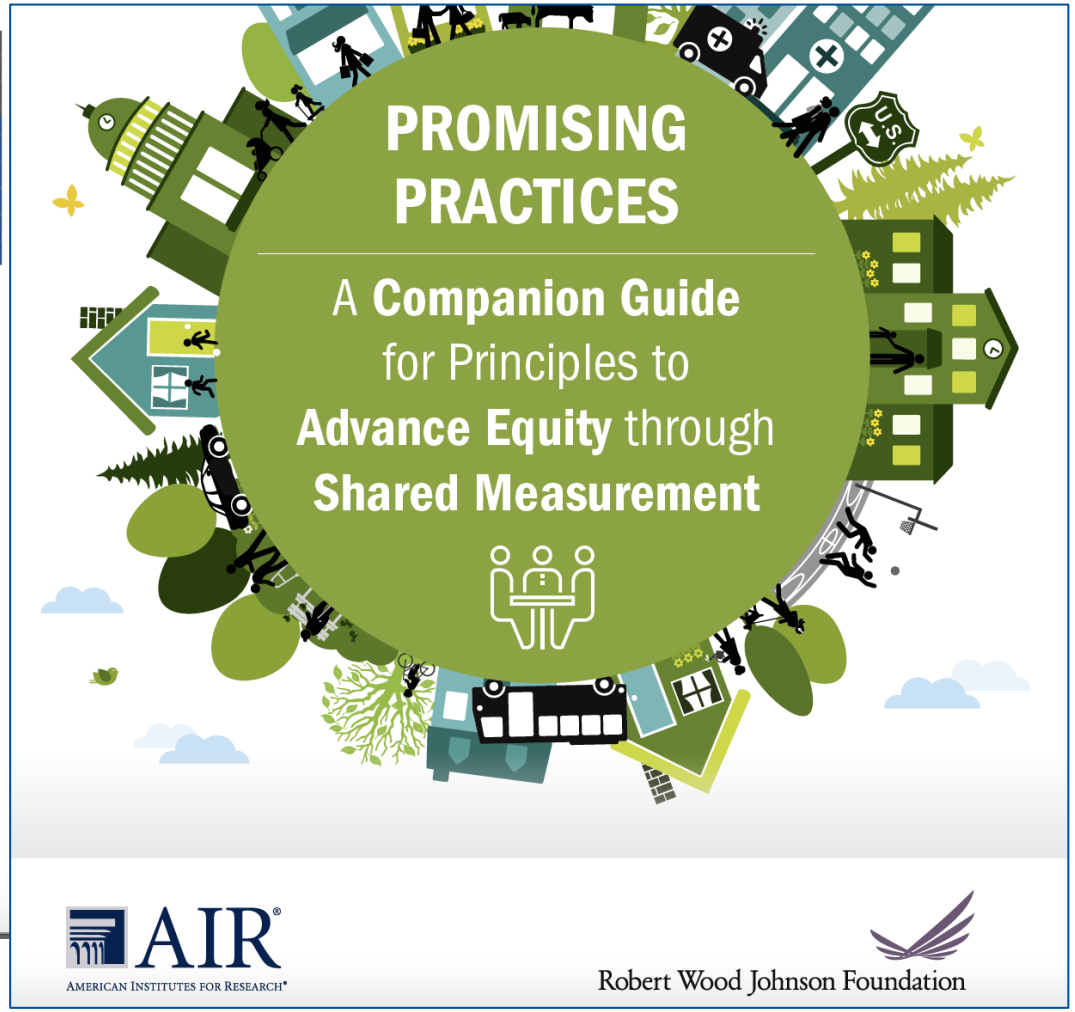
BRIEF | MAY 2021

## Assessing the Impact of Complex Care Models: Opportunities to Fill in the Gaps

*By Karla Silverman, Center for Health Care Strategies, and Tamara Dumanovsky, Joslyn Levy & Associates*

**IN BRIEF**

High-quality complex care models are responsive to the needs and desires of patients and families, while also prioritizing provider and staff well-being. Quality measures that capture both patient perspectives on the care they receive, as well as staff assessments on the care they provide, can help us better understand the impact of complex care models. Through the *Advancing Integrated Models* (AIM) initiative, made possible by the Robert Wood Johnson Foundation, eight pilot sites are implementing approaches that seek to improve integrated, person-centered care models for adults and children with complex health and social needs. This brief describes a process used to identify a set of patient- and staff-reported measures for the AIM pilot sites. These measures,



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# For Equity: Client perspective

| EQUITY |
| --- |
| I believe my care team feels comfortable around people who look like me and/or sound like me.† |
| At times I feel I am treated differently here based on my race, ethnicity and/or gender identity.† |
| When I come here I feel like they care about me as a person. |
| At times, I feel judged and criticized by the people who work in this program. |
| My care team thinks about my values and my traditions when they recommended treatments and services to me. |

# For Equity: Healthy Start Organization

| EQUITY |
| --- |
| Our organization ensures a safe and accessible environment (physical, emotional, and cultural) for all individuals, regardless of gender, sexual orientation, race, ethnicity, socioeconomic status, disability status, and language.† |
| Our organization's mission, vision and policies clearly state that equity is a high priority. |
| Our organization's leadership are committed to equity as a high priority. |
| Our organization is responsive to individual patient preferences, needs, and values. |
| Our organization makes accommodations in how we practice in order to respond to the needs of patients that may have difficulty with things such as keeping appointments, or following treatment plans. |
| To ensure care is equitable, our organization identifies the needs of diverse populations and implements steps to help meet those needs. |
| We regularly use feedback from patients and families to improve services. |

# For Community Partnerships

| COMMUNITY PARTNERSHIPS |
| --- |
| Patient care is well coordinated with community resources (e.g., support groups, food pantries, shelters).† |
| Partnerships with community organizations are actively sought to develop formal supportive programs and policies across the entire system. |
| We have established relationships with community agencies to facilitate our referrals to them. |
| Linking patients to outside resources is accomplished through active coordination between the provider practice, community service agencies and patients. |
| Community programs provide regular feedback about patients' progress that is used to modify programs to better meet the needs of patients. |

# DISCUSSION 1

*15 minutes*

1. Equity with Clients
2. Equity for Healthy Start Organization
3. Community Partnerships

***How might you adapt and use these measures?***

## For Healthy Start Clients:

# Care Integration

| CARE INTEGRATION |
| --- |
| My care team considers other aspects of my life when helping me make health care decisions.† |
| The staff here try to help me with things I might need right away, like food, shelter, or clothing. |
| My care team helps coordinate all the services I receive. |
| The staff here work together and coordinate with my other service providers to come up with a plan that meets my needs. |
| I am asked about any stressful life experiences that may harm my health and emotional well-being. |
| I am given information about how my stressful life experiences may affect my overall health. |

# For Healthy Start Clients:
# Care Experience

| GOALS OF AND EXPERIENCE WITH CARE |
| --- |
| My care team and I regularly review my care plan so it reflects my preferences and current circumstances.† |
| I am encouraged to express my honest opinions about the program including my dissatisfactions and disagreements. |
| My care team helps to reduce barriers when connecting me to other services. |
| Members of my care team know what's on my care plan, including the things that are important to me. |
| My care plan includes all of the things that are important to me. |
| Does your care plan include: |
| Thinking about the care you received [in the last # months], how much effort was made to listen to the things that matter most to you about your health issues? |
| Thinking about the care your received [in the last # months], how much effort was made to help you understand your health issues? |

For Healthy Start Clients:

# Health and Well-being

| HEALTH AND WELL-BEING |
| --- |
| The services I receive here help me live a better life.† |
| The staff truly believe in me – that I can achieve my goals.† |
| How confident are you that you can manage most of your health problems? |
| Compared to 3 months ago, how would you rate your problems or symptoms now? |
| Compared to 3 months ago, how would you rate your ability to deal with daily problems now? |
| I feel safe in this program. |
| I trust the staff in this program. |

# For Healthy Start Staff

| |
|---|
| I feel respected and included by the other members of our care team.† |
| Providers and staff routinely help patients to develop strategies and skills for managing their health and well-being. |
| My work makes me feel satisfied. |
| I believe I can make a difference through my work. |
| Our organization has a system in place to identify, review, address and evaluate the social and emotional experience of clients and staff to ensure that policies and practices promote emotional safety and respect. |

## For Health Start Centers:

# When reflecting on work with clients

| |
|---|
| When developing care plans, the care team here routinely collaborates with patients to co-create goals.† |
| The health and wellness goals and objectives in the client's service plan are worded in a way that is client-centered and reflects the client's expressed goals in his/her own words. |
| Our organization has an effective system in place for soliciting and documenting patient goals and we regularly review those goals with patients. |
| Care is designed to meet the preferences of patients. [for adult settings] OR Care is designed to meet the preferences of patients and their families. [for pediatric settings] |
| Providers and staff view patients as equal partners in their care. |
| Our clinical documentation system is set up to support and reinforce the importance of staff assessing and addressing both health and wellness needs as a routine part of an integrated care plan. |

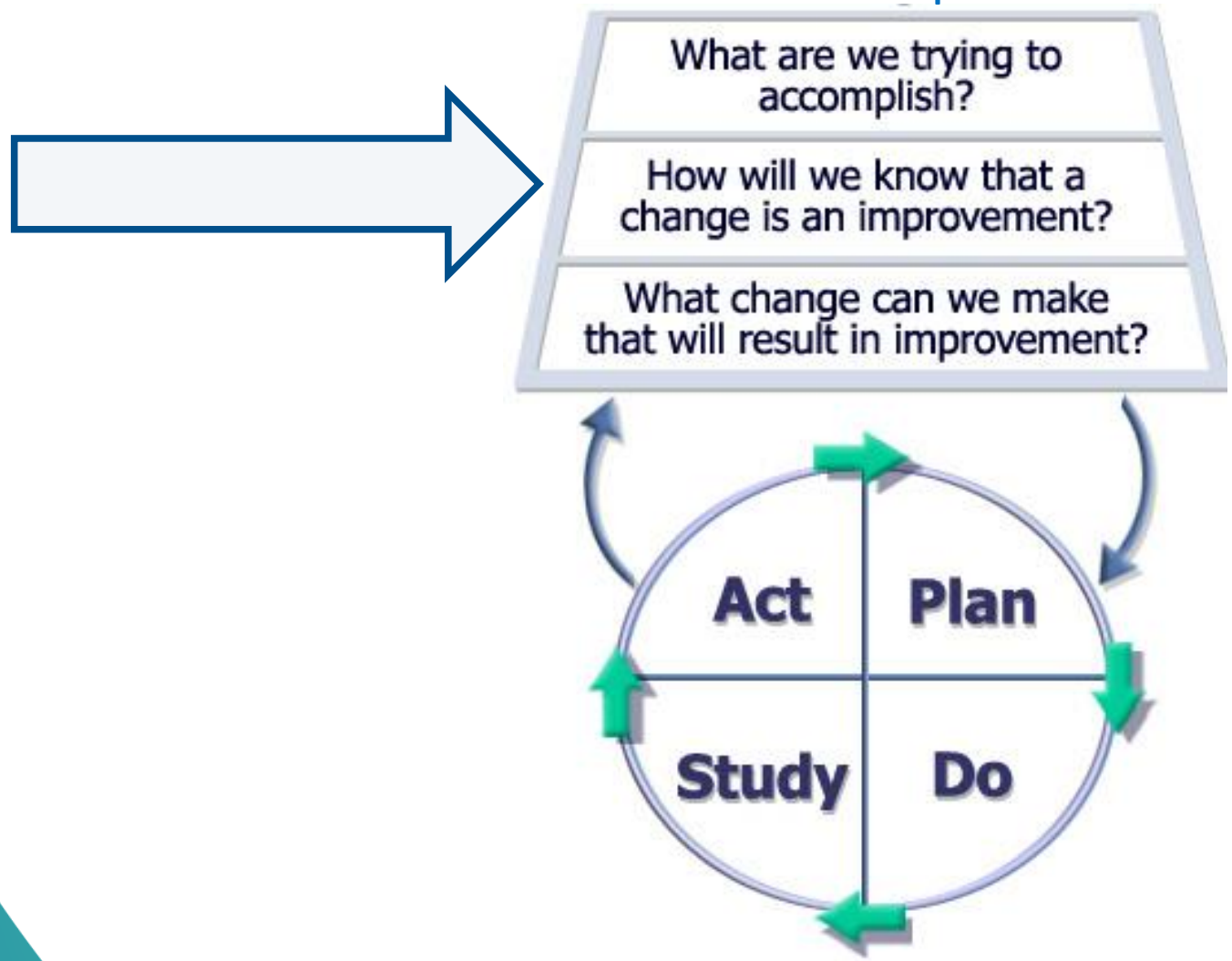
For Healthy Start Centers:

# Integrating Care for Clients

| CARE INTEGRATION |
| --- |
| We develop treatment plans that are based in an integrated approach to patients' physical, behavioral, and emotional health, and health-related social needs.† |
| There is one integrated treatment plan for each patient and the plan is available to all members of the care team that need to access it. |
| Providers and staff are well-informed about patients' current social needs (e.g., housing, transportation). |
| All patient information is equally accessible and used by all providers to inform care. |

# Let's spend some time thinking about measures in another breakout session

## The Model for Improvement



# DISCUSSION 2

*15 minutes*

Client Feedback

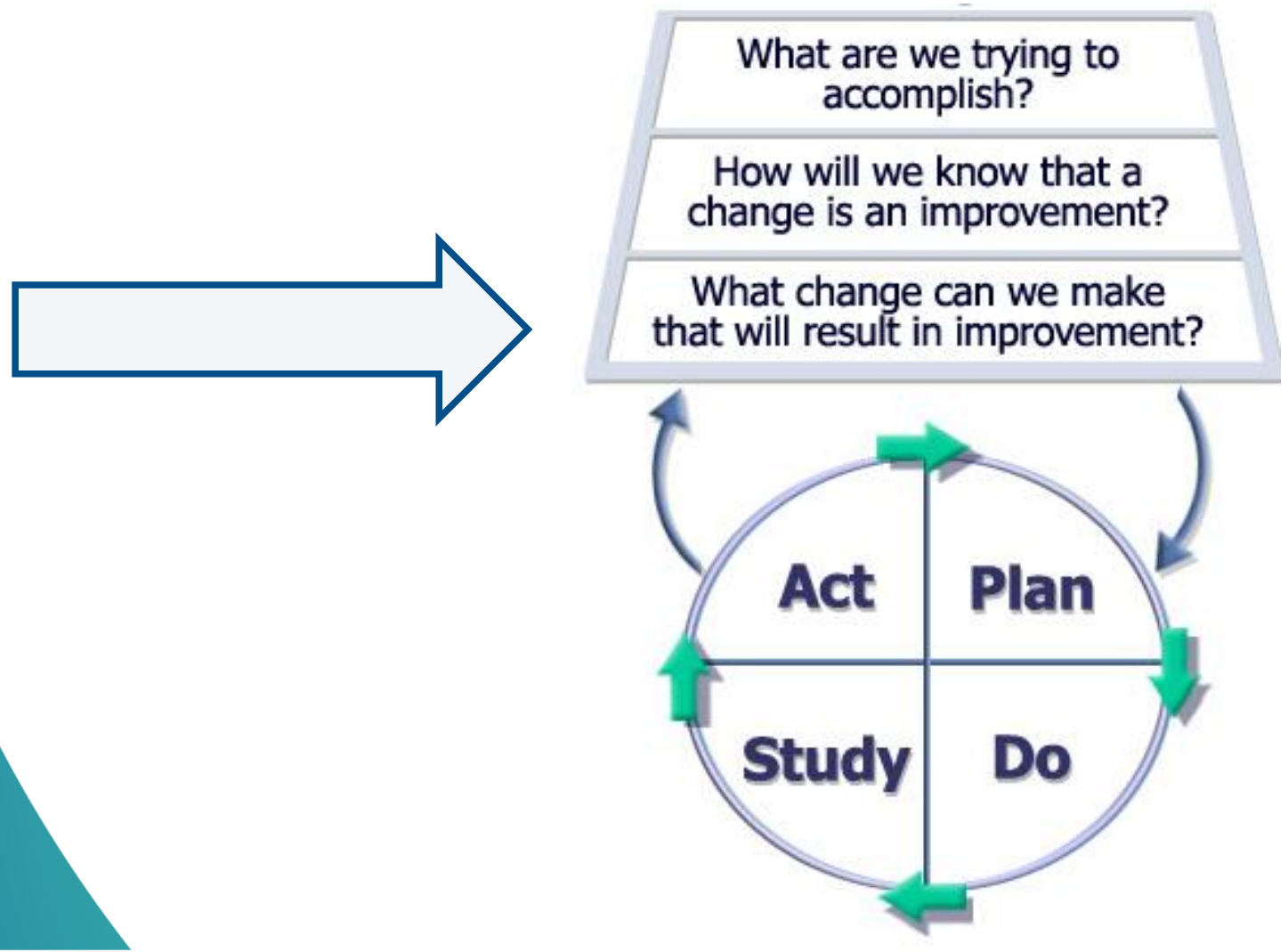
1. Care integration
2. Care experience
3. Health and well-being

Healthy Start

1. Staff Feedback
2. Working with clients on care coordination
3. Integrating care for clients

***How might you adapt and use these measures?***

# Last Workshop



# Deciding on the Scale of the Test

| | | No Commitment | Some Commitment | Strong Commitment |
|---|---|---|---|---|
| **Low degree of belief that change idea will lead to Improvement** | **Cost of failure large** | ***Very small-scale test*** | ***Very small-scale test*** | ***Very small-scale test*** |
| | **Cost of failure small** | ***Very small-scale test*** | ***Very small-scale test*** | ***Small-scale test*** |
| **High degree of belief that change idea will lead to Improvement** | **Cost of failure large** | ***Very small-scale test*** | ***Small-scale test*** | ***Large-scale test*** |
| | **Cost of failure small** | ***Small-scale test*** | ***Large-scale test*** | ***Implement*** |

The Improvement Guide p. 146

**Current Commitment Within Organization**

# During Implementation

- Map out the flow of the new process
- Provide training on the new process
  - Chance to explain the "why" of the change
  - New skills may be needed
  - Include method of maintenance
- Provide recognition
  - Publicize the results and learning
  - Show appreciation for people's efforts
- Understand and address the causes of resistance
  - Seek and use input from those affected by the change

During Implementation:

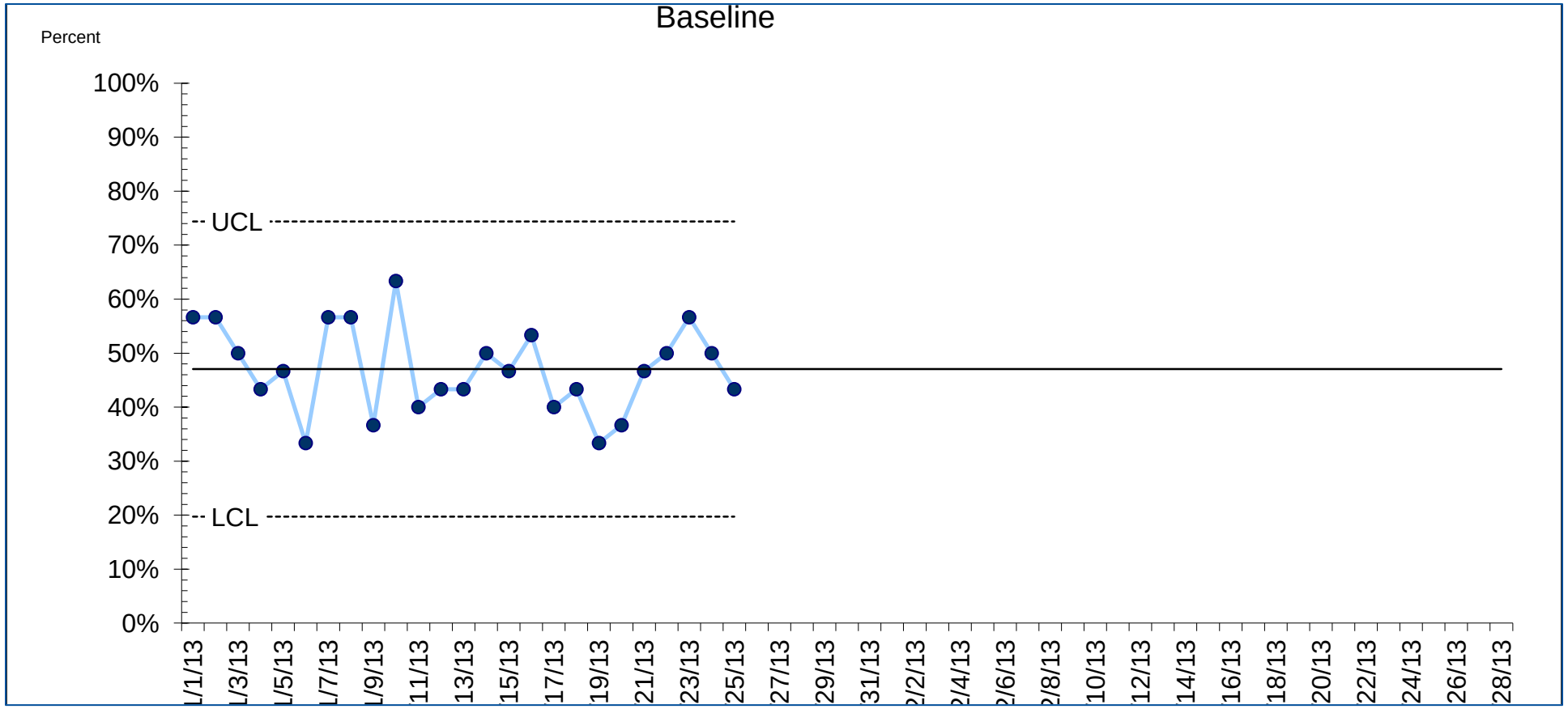
# Addressing the Social Aspects of Change

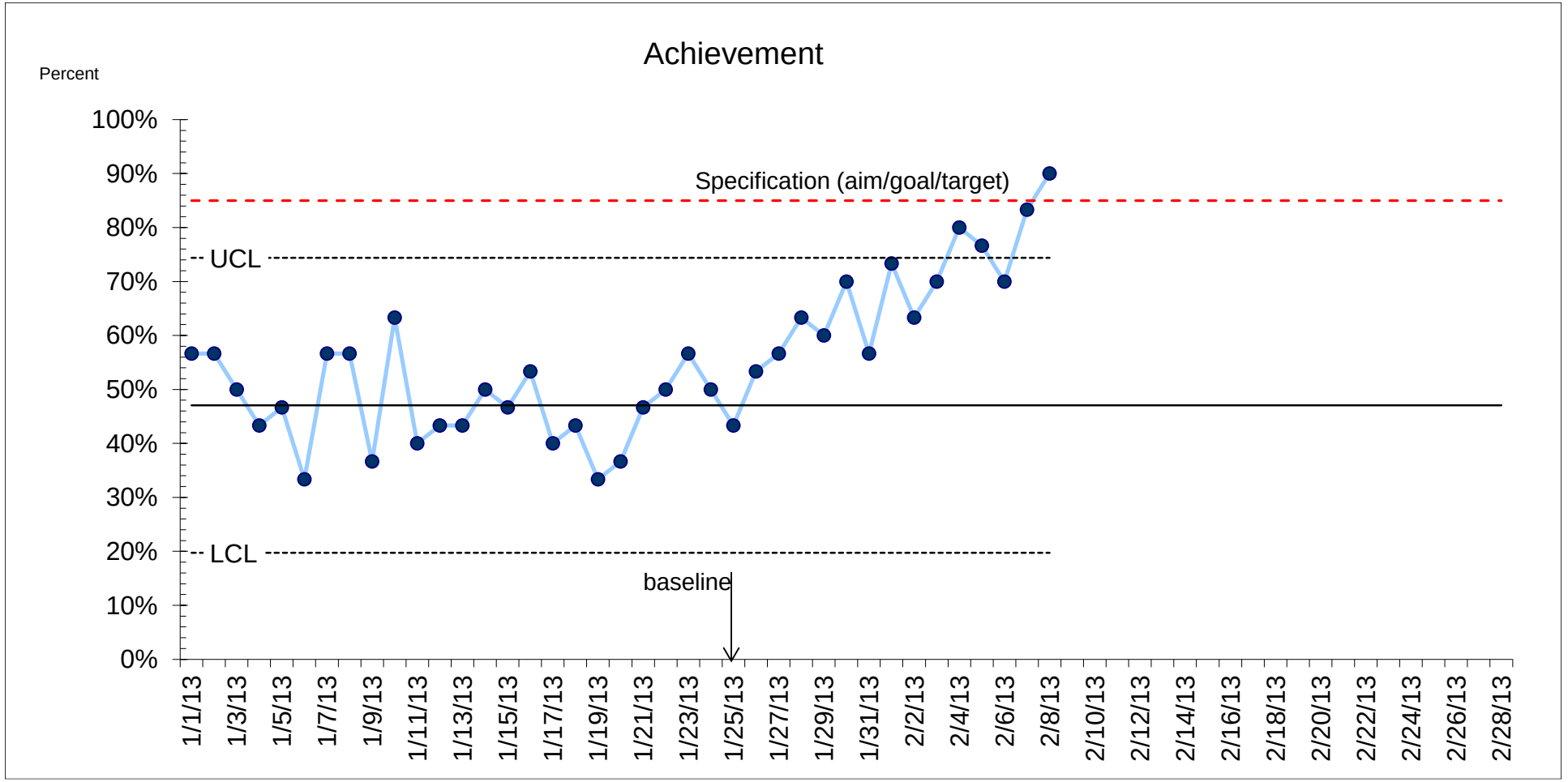
- Provide information on why the change is being made.
- Give specific information on how the change will affect those who will benefit the most.
- Seek and use input from others, especially those affected by the change, while the change is being tested. Include the community and your client partners.
- Publicize the results and learning.
- Show appreciation for people's efforts.
- Understand and address the causes of resistance.

# Implementation

- Policy
- Procedure
- Training
- Hardwire the Change
- And . . .
  - It takes longer than testing. More people are effect. Expect and honor resistance – there is usually a good reason. Discover it and reflect.

# Holding Gains




Achievement
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10%
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Specification (aim/goal/target)
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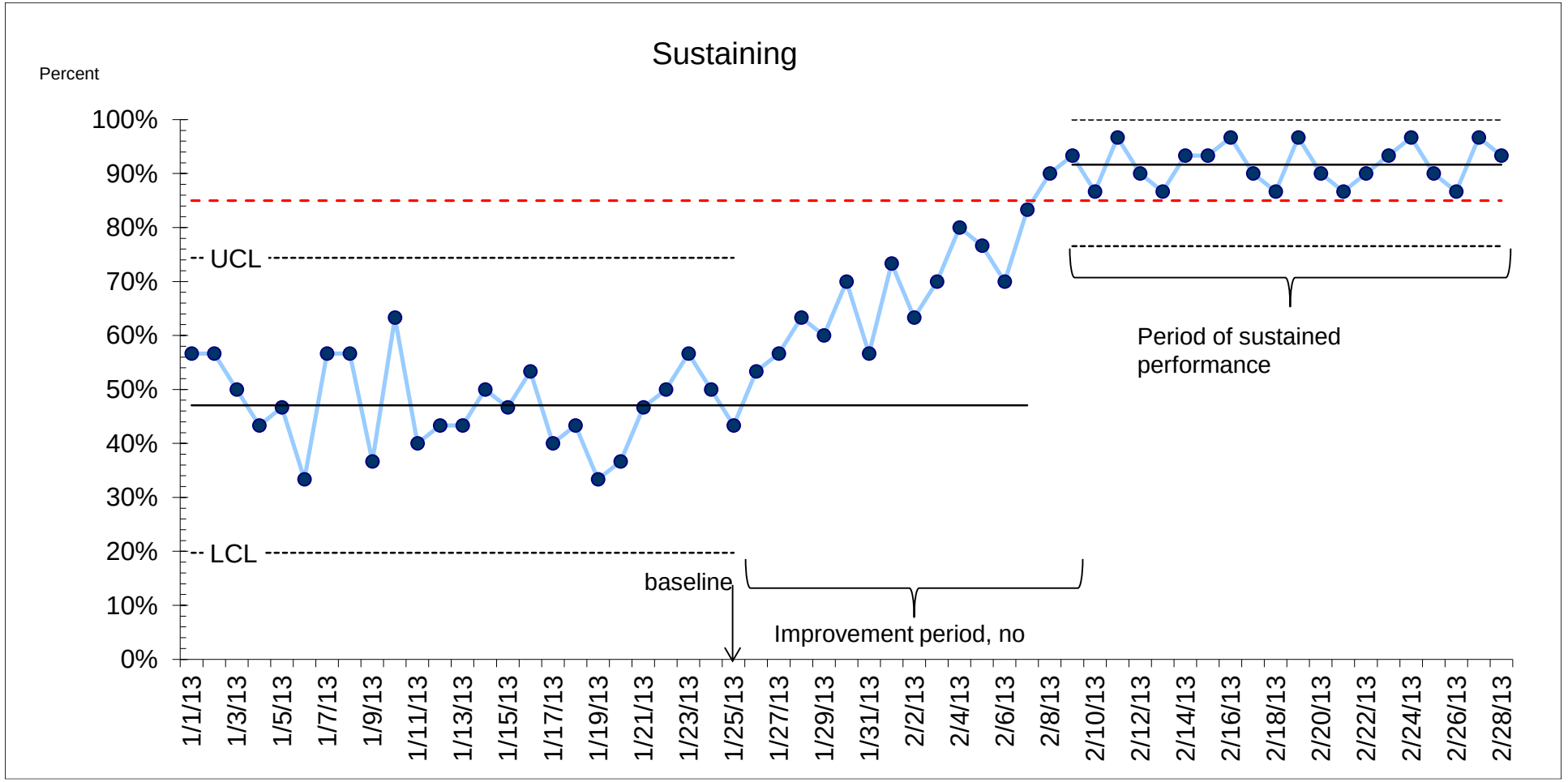
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UCL
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baseline
Improvement period, no
Period of sustained performance
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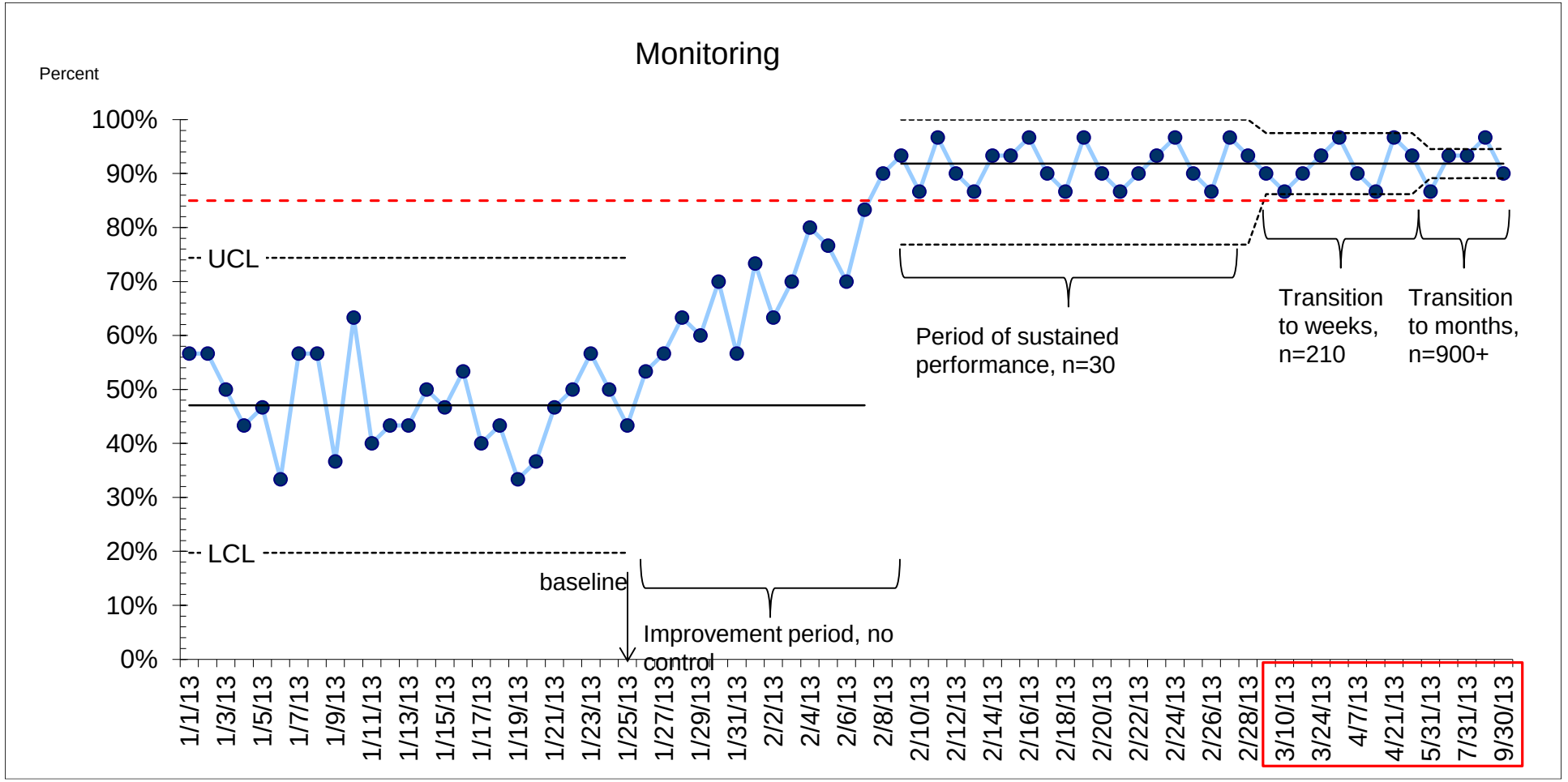
Monitoring
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UCL
LCL
baseline
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Period of sustained performance, n=30
Transition to weeks, n=210
Transition to months, n=900+
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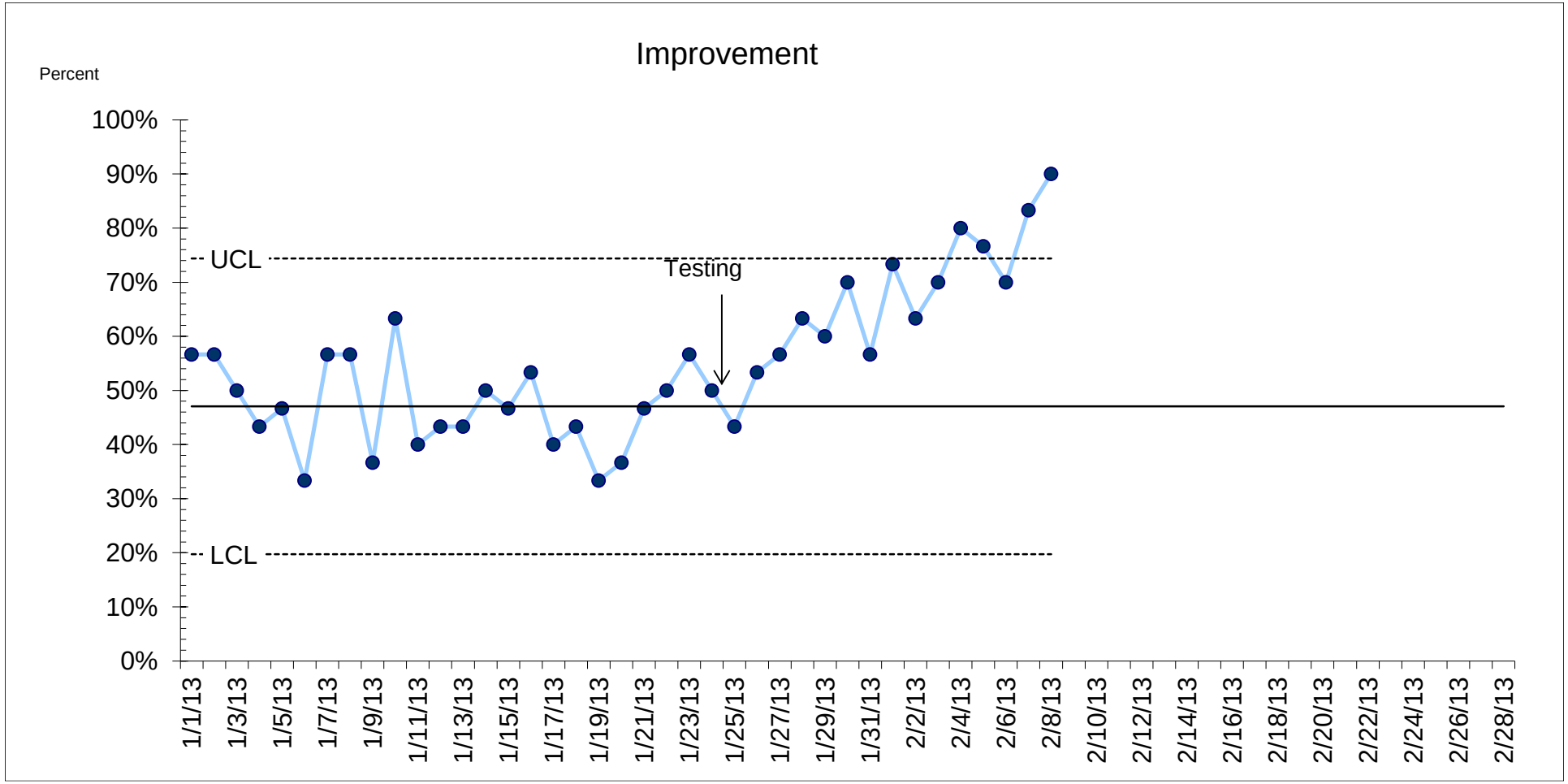
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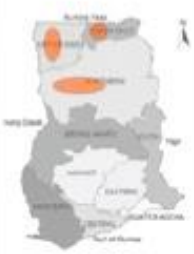
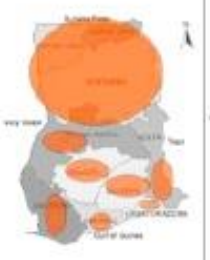
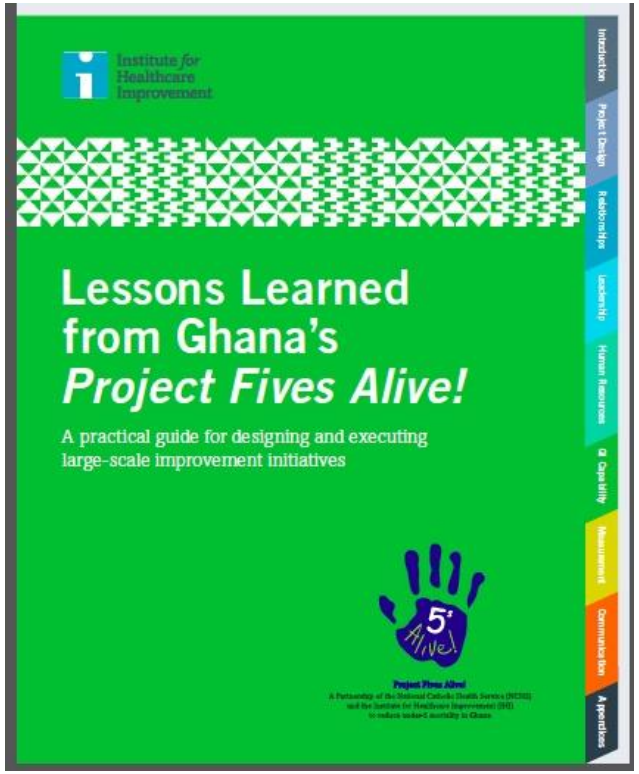
# Spread: What does spread mean in context of Health Start?

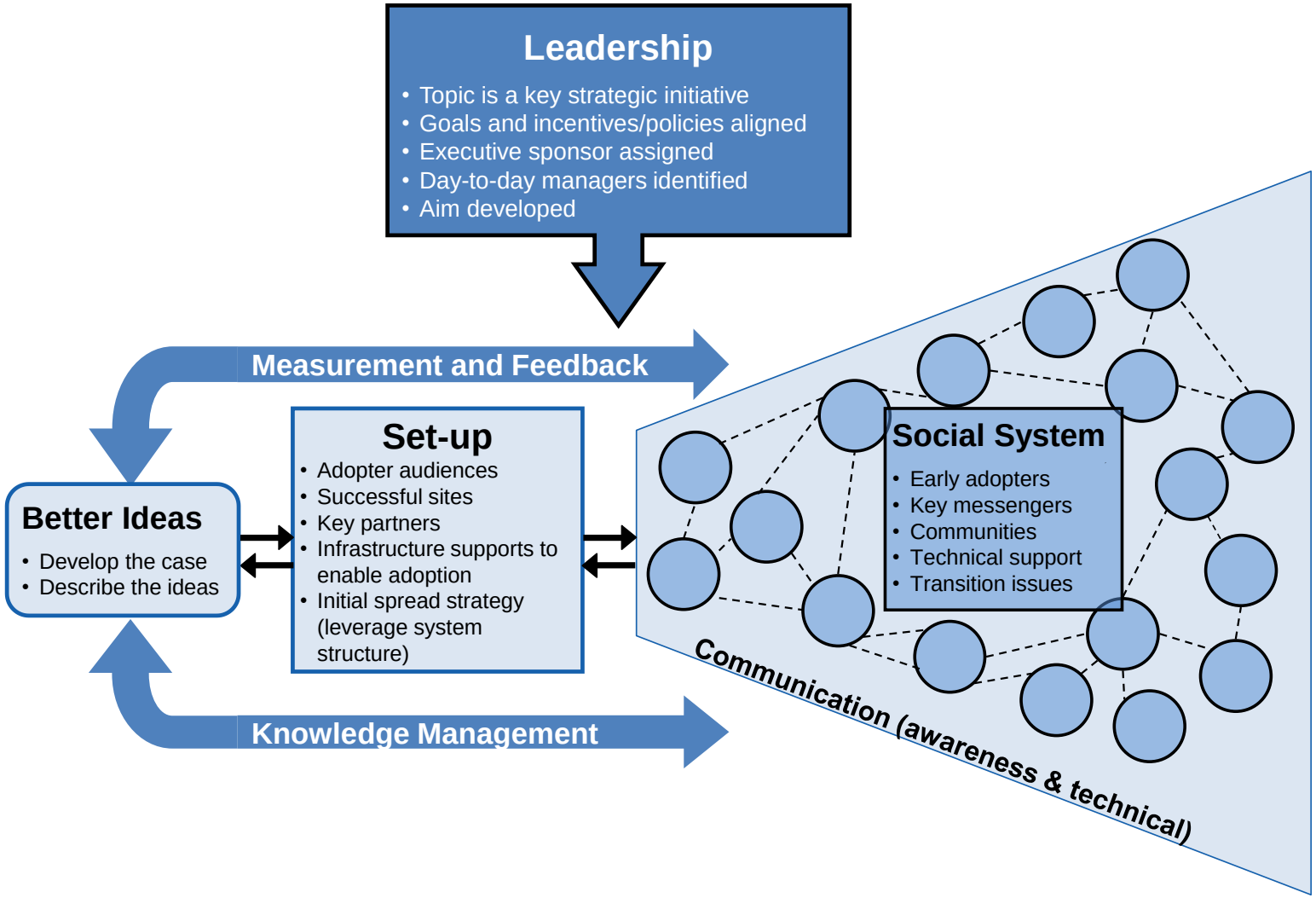
- Spread depends on where you stand
  - From 1 provider to 5 to 25 to all
  - From 1 group of clients to all
  - From 1 Healthy Start Site to 5 to 25 to 125 to all
  - From 1 Health Start to 5 community partners etc.

# A Classic Spread Story

| | | | | | |
|---|---|---|---|---|---|
| Total Population | 350,000 | 5 Million | 11 Million | 11 Million | 22 Million |
| Under-5 Population | 60,000 | 500,000 | 1.7 Million | 1.7 Million | 3.3 Million |
| |  |  |  |  |   |
| **NOV 2007** | **JUL 2008** | **SEPT 2009** | **OCT 2009** | **AUG 2012** | **MAY 2013** |
| Start-up: MONTHS 1–8 | Wave 1: MONTHS 9–22 | Wave 2: MONTHS 23–63 | Wave 3: MONTHS 24–89 | Wave 1R: MONTHS 58–89 | Wave 4: MONTHS 63–89 |
| | | | | *Referral Project launch* *41 Referral Teams* | |
| Number of QI Teams | 30 | 228 | 330 | 430 | 709 |
| Number of Sub-Districts | 25 | 195 | 222 | 265 | 544 |



# IHI Spread Framework



# DISCUSSION 3

1. What is something you are interested in spreading?
2. To whom?


Thank you for including
me in your learning!

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# Q&A

NICHQ
National Institute for Children's Health Quality

# Survey

- Please scan the QR code or visit https://link.nichq.org/zc8 to complete the survey
- Your responses will help shape the future Learning Academy sessions!

# Next Steps

Danisha Charles
Healthy Start TA & Support Center

# Healthy Start CoLab

- Connect with your fellow Learning Academy participants and Jane on the Healthy Start CoLab!

- If you do not have a CoLab account, please email healthystart@nichq.org

Healthy Start
Deadlines & Events

HEALTHY start TA & SUPPORT CENTER

## June 2021

**Deadlines:**

Jun 4 NPCL International Fatherhood Conference Survey Due
Jun 15 HSMED-II Report (CSV or XML) Due
Jun 30 Aggregate Report (Excel) Due
Jun 30 Grantee Performance Report Due

**Events:**

Jun 1 Webinar: Legacy of Slavery & Impact of Racism on Breastfeeding
Jun 2 HS Breastfeeding Cohort Meeting #4 — *Cohort members only*
Jun 7 Networking Café
Jun 8 Fatherhood Talk Tuesday
Jun 9 NPCL International Fatherhood Conference – *Registrants only*
Jun 10 NPCL International Fatherhood Conference – *Registrants only*
Jun 16 Healthy Start COIN Meeting #7 — *COIN members only*
Jun 16 HS Evaluation Cohort Meeting #3 — *Cohort members only*
Jun 18 Quality Improvement Learning Academy Meeting #5
Jun 21 TIROE CoP Learning Session #2 – *COP members only*
Jun 24 CAN Learning Academy Meeting #2

www.healthystartepic.org

Can be found on the EPIC website or
bit.ly/hs-deadlines-and-events



HEALTHY start TA & SUPPORT CENTER
NICHQ National Institute for Children's Health Quality

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## Questions?

Email Jane Taylor at jane1taylor@mac.com or the TA & Support Center at healthystart@nichq.org

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Thank
You!