Strengthening Vermont's System of High Performing Medical Homes

Stanley Weinberger, MD, MS
Chris Pellegrino, MS, ASQ CMQO/E
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Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

Disclosure

- We have no relevant financial relationships to disclose or conflicts of interest to resolve
- We will discuss no unapproved or off-label pharmaceuticals

CHAMP Quality Improvement Project Global Aim over 2-Year Timeframe

Increase % of High Performing Medical Homes (HPMH) who:

- Provide reliable, comprehensive, family-centered preventive services and well child visits based on Bright Futures. Use a 2-generation approach with families.
- Provide care coordination & case management at appropriate levels.
- Use community services & supports for healthy development.
- Use QI to constantly adapt and improve.

K. Johnson and C. Bruner. A Sourcebook on Medicaid's Role in Early Childhood- Advancing High Performing Medical Homes and Improving Lifelong Health. Child and Family Policy Center. October 2018.

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CHAMP Quality Improvement Project Specific Aim

Medical homes will engage in the elements of a HPMH by:

- providing comprehensive well-child care focusing on kids at their 12 and 24 month and 3 and 6-year visits, based on *Bright Futures* and EPSDT guidelines
- with 10% improvement from baseline
- by June 30, 2021.

ABP : MOC Part 4 credits
ABFM: MOC Part IV credits
AAFP CME: Prescribed Credits

Metrics for HPMH 2-year project

Preventive Services

1. Blood Lead Screening
2. Vision/Strabismus
3. Oral Health
4. Hearing
5. Social Determinants of Health
6. Developmental Screening
   - Social Emotional Screening
   - Autism
7. Parental Depression

Referrals/Case Management/Care Coordination

Racial and Health Equity

Clinician wellness

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This Year: A "Bundle of Measures" and Clinician Wellness

Two measurement/improvement options to choose from

Option A: 12 month and 24 month chart review

Measures:

12 month visit	24 month visit
SDOH	SDOH
Lead	Lead
Oral health	Oral health
Developmental Screening (between 9-12mo)	Developmental Screening (between 18-24mo)

Option B: 3 and 6 year chart review

Measures:

3 year visit	6 year visit
SDOH	SDOH
Vision	Vision
Strabismus	Strabismus
Oral health	Oral health

Clinician Wellness

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Strengthening Vermont's System of High Performing Medical Homes

October 23: Complete/submit Office Systems Inventories

October 23: Complete Maslach Burnout Inventory

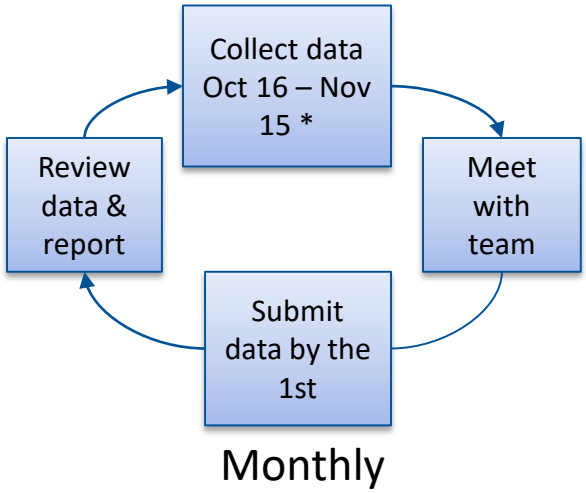
November 1: Submit 3 months of baseline data before making changes

July 16 – August 15

August 16 – September 15

September 16 – October 15

Develop/submit PDSA Activity Log



Dec to May: Collect and submit monthly data (6 months)

Meet with your team, Review data and results

Develop/Submit PDSA Logs (1/month)

Participate in monthly collaborative call/webinar

June: Complete Maslach Burnout Inventory

New This Year – all in REDCap

Unique link

Tracking system

PDSA Form in REDCap

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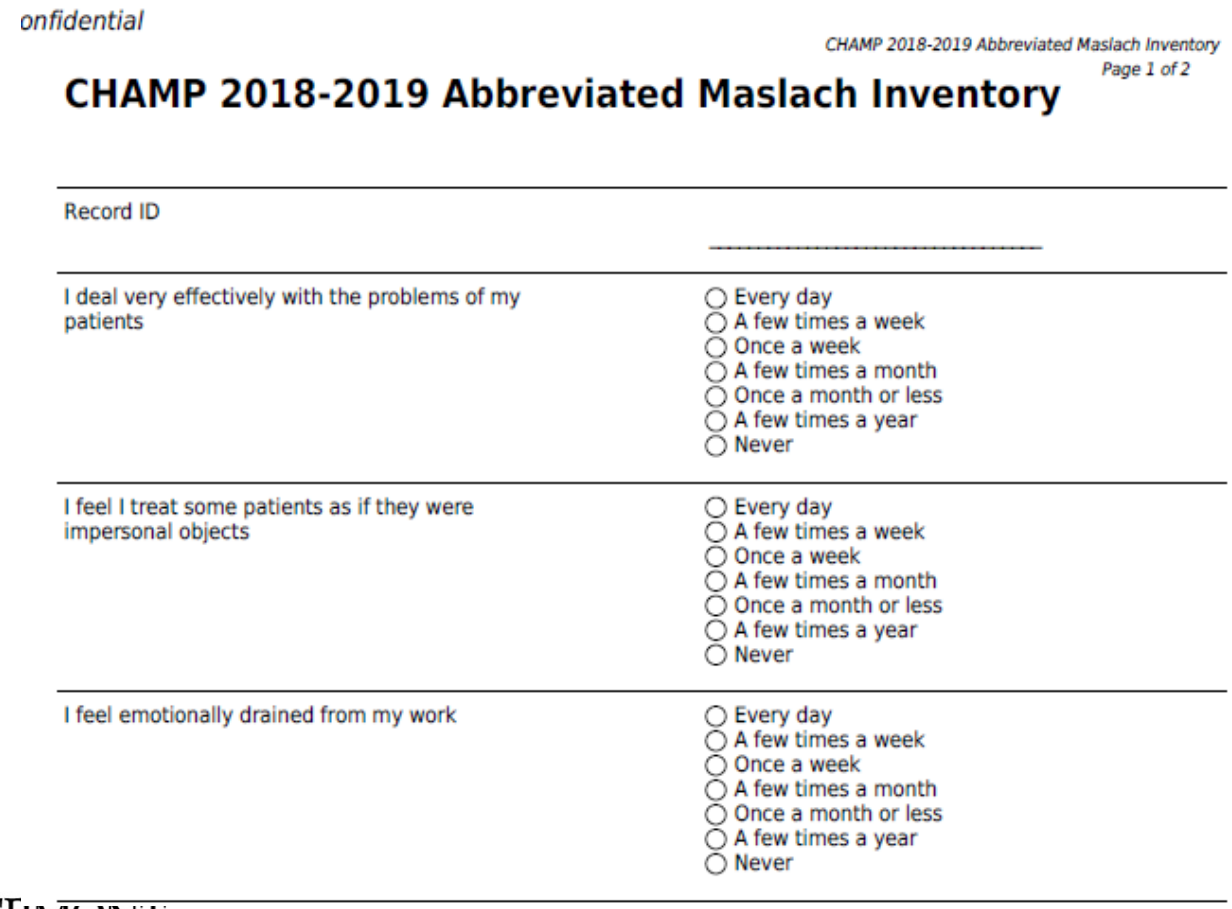
Clinician Wellness



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CHAMP 2018-2019 Abbreviated Maslach Inventory
Page 1 of 2

CHAMP 2018-2019 Abbreviated Maslach Inventory

Record ID	_____
I deal very effectively with the problems of my patients	◯ Every day ◯ A few times a week ◯ Once a week ◯ A few times a month ◯ Once a month or less ◯ A few times a year ◯ Never
I feel I treat some patients as if they were impersonal objects	◯ Every day ◯ A few times a week ◯ Once a week ◯ A few times a month ◯ Once a month or less ◯ A few times a year ◯ Never
I feel emotionally drained from my work	◯ Every day ◯ A few times a week ◯ Once a week ◯ A few times a month ◯ Once a month or less ◯ A few times a year ◯ Never

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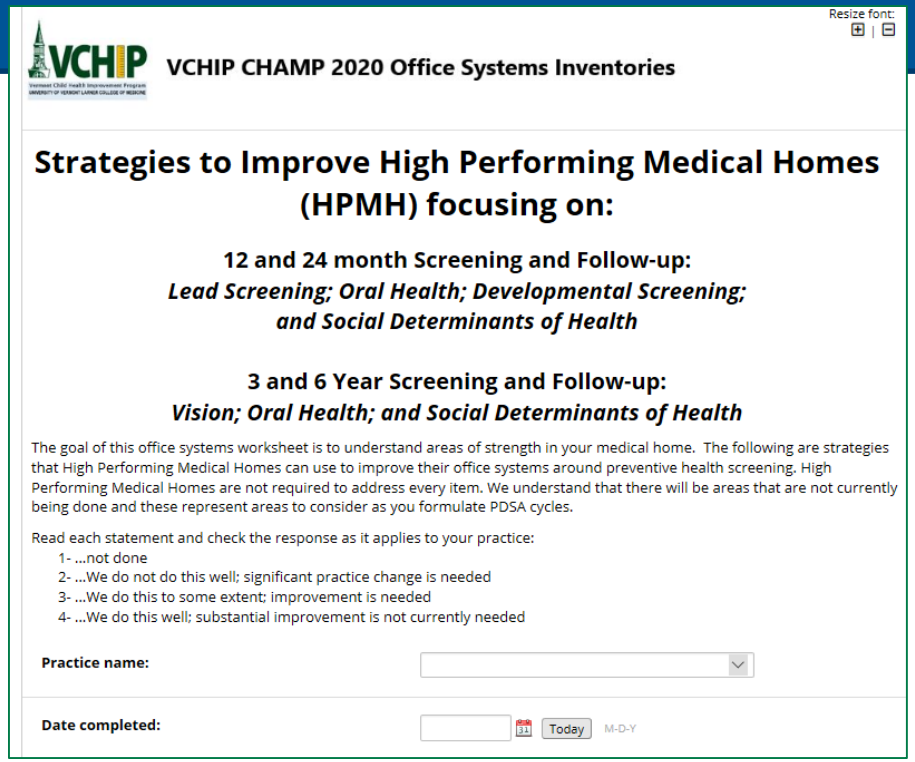
Office Systems Inventory



Resize font:

VCHIP CHAMP 2020 Office Systems Inventories

Strategies to Improve High Performing Medical Homes (HPMH) focusing on:

12 and 24 month Screening and Follow-up:
Lead Screening; Oral Health; Developmental Screening; and Social Determinants of Health

3 and 6 Year Screening and Follow-up:
Vision; Oral Health; and Social Determinants of Health

The goal of this office systems worksheet is to understand areas of strength in your medical home. The following are strategies that High Performing Medical Homes can use to improve their office systems around preventive health screening. High Performing Medical Homes are not required to address every item. We understand that there will be areas that are not currently being done and these represent areas to consider as you formulate PDSA cycles.

Read each statement and check the response as it applies to your practice:

1- ...not done
2- ...We do not do this well; significant practice change is needed
3- ...We do this to some extent; improvement is needed
4- ...We do this well; substantial improvement is not currently needed

Practice name:

Date completed: Today M-D-Y

Strategy	1 2 3 4
Reliable, comprehensive, family centered preventive services screening aligned with Bright Futures	
Blood Lead Testing:	
(1) We complete blood lead testing in all children regardless of insurance or risk factors at 12 and 24 months.	○1 ◉2 ○3 ○4 reset
(2) We complete blood lead testing at other ages per Bright Futures and Vermont Department of Health (VDH) guidelines for children with risk factors or signs/symptoms of lead poisoning (per VT HAN Pediatric Blood Lead Testing Guidelines Feb 2020).	○1 ○2 ○3 ○4 reset
(3) We follow the VDH algorithm to guide confirmatory or repeat testing as appropriate if lead level is elevated.	○1 ○2 ○3 ○4 reset
(4) We either use the state laboratory to run our tests OR our point of care test results are sent to the state lab for tracking.	○1 ○2 ○3 ○4 reset
Vision:	
(1) We conduct visual assessments, including for strabismus, via physical exam beginning in the newborn period and continuing at every Health Supervision Visit (HSV) to help identify children who may benefit from interventions to correct or improve vision.	○1 ○2 ○3 ○4 reset
(2) We screen children for visual acuity at routine HSVs per the Bright Futures recommended schedule using validated screening tools based on critical factors (age of the child, developmental and/or verbal ability, and cooperation and/or ability to reliably perform test).	○1 ○2 ○3 ○4 reset
(3) We use instrument-based screening for enhanced detection of conditions that may lead to amblyopia and/or strabismus. Screener used:	○1 ○2 ○3 ○4 reset

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Your Electronic Binder

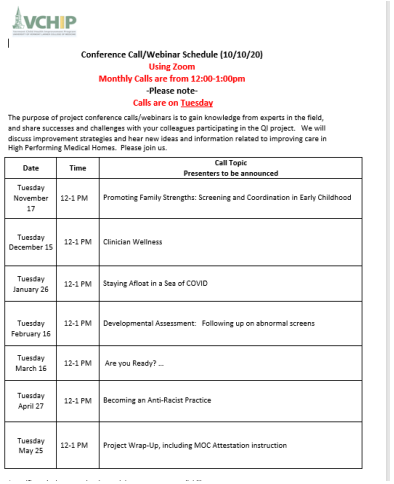
Information in (electronic) binder includes

Goals/Measures and Data Collection:

- Instructions for completing data collection
- Project measures and definitions sheet
- Data collection sample (REDCap)
- PDSA Activity Log (REDCap or paper/fax)

Other information:

- Monthly Collaborative Calls
- Contact information
- MOC/CME Tracking Log if needed
- Model for Improvement overview



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Conference Call/Webinar Schedule (10/10/20)

Using Zoom

Monthly Calls are from 12:00-1:00pm

-Please note-

Calls are on Tuesday

The purpose of project conference calls/webinars is to gain knowledge from experts in the field, and share successes and challenges with your colleagues participating in the QI project. We will discuss improvement strategies and hear new ideas and information related to improving care in High Performing Medical Homes. Please join us.

Date	Time	Call Topic Presenters to be announced
Tuesday November 17	12-1 PM	Promoting Family Strengths: Screening and Coordination in Early Childhood
Tuesday December 15	12-1 PM	Clinician Wellness
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Tuesday May 25	12-1 PM	Project Wrap-Up, including MOC Attestation instruction

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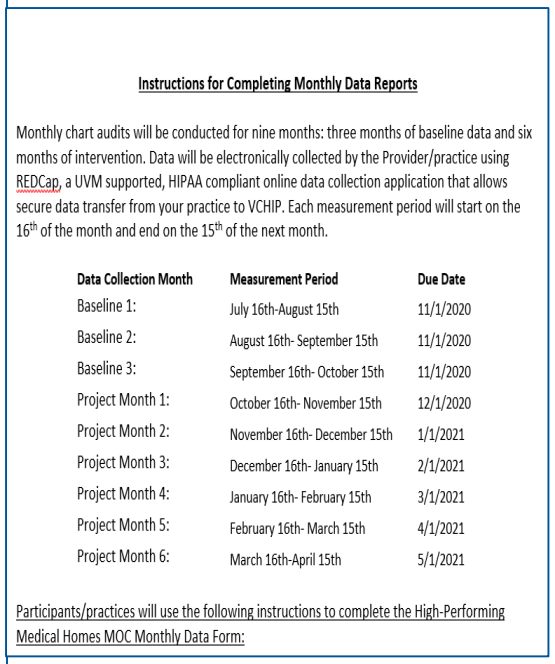
Data Collection Instructions

Instructions for Completing Monthly Data Reports

- Select age group you will focus on
  - 12 and 24 month visits
  - 3 and 6 year visits
- Goal is to collect from at least 10 charts monthly
- Use random selection if more than 10 charts are available
- Enter data based on the scheduled visit type even if patient came in early or late
- More than 10 charts can be entered

Other Notes:

- Each HS visit could be completed in person or telehealth or some kind of combination
- Timing of visits may be asynchronous (ex. 24 month visit could be done at 27 month or components of HS visit could be completed at different stages).



Instructions for Completing Monthly Data Reports

Monthly chart audits will be conducted for nine months: three months of baseline data and six months of intervention. Data will be electronically collected by the Provider/practice using REDCap, a UVM supported, HIPAA compliant online data collection application that allows secure data transfer from your practice to VCHIP. Each measurement period will start on the 16th of the month and end on the 15th of the next month.

Data Collection Month	Measurement Period	Due Date
Baseline 1:	July 16th-August 15th	11/1/2020
Baseline 2:	August 16th- September 15th	11/1/2020
Baseline 3:	September 16th- October 15th	11/1/2020
Project Month 1:	October 16th- November 15th	12/1/2020
Project Month 2:	November 16th- December 15th	1/1/2021
Project Month 3:	December 16th- January 15th	2/1/2021
Project Month 4:	January 16th- February 15th	3/1/2021
Project Month 5:	February 16th- March 15th	4/1/2021
Project Month 6:	March 16th-April 15th	5/1/2021

Participants/practices will use the following instructions to complete the High-Performing Medical Homes MOC Monthly Data Form:

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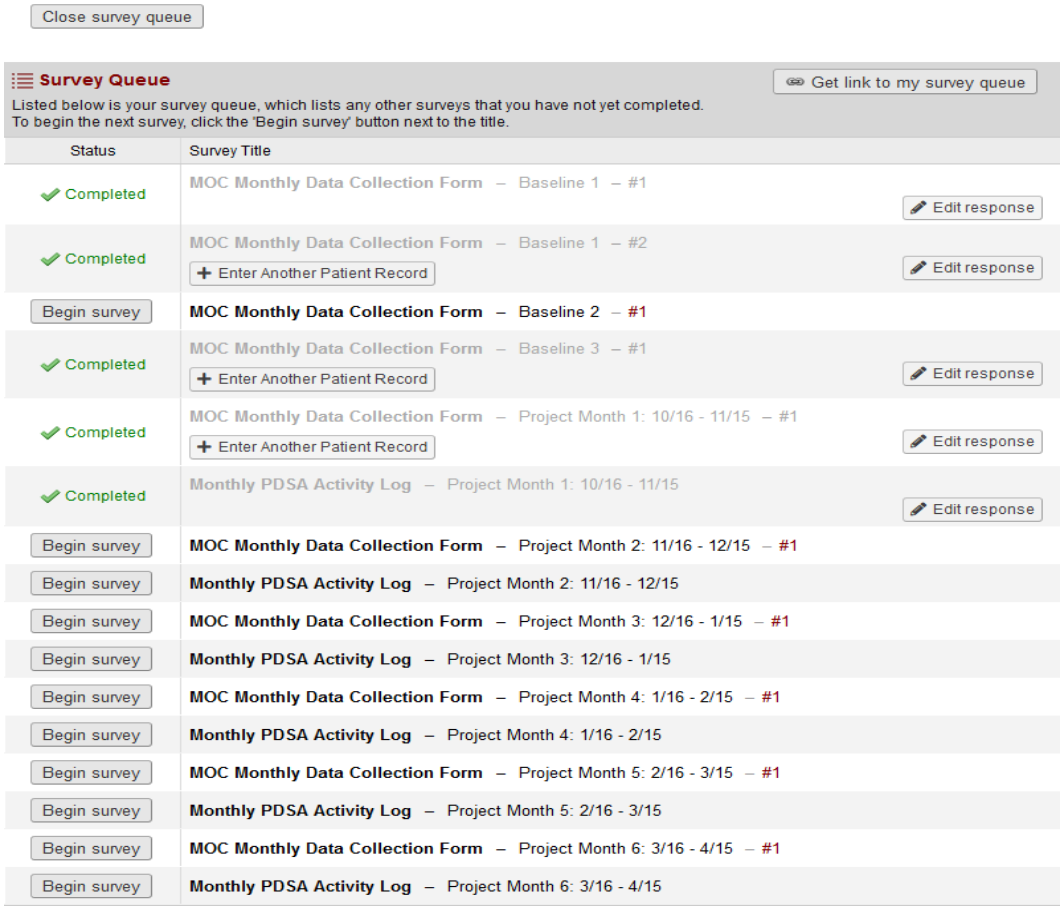
Data Collection

New: Unique link & tracking

Each practice will receive their own **unique** survey queue link. This link will remain the same throughout the project.
The survey queue will give you access to the monthly data collection and PDSA activity log forms.
Use this link to track your data collection progress. You can save the link but a link will be emailed out every month.



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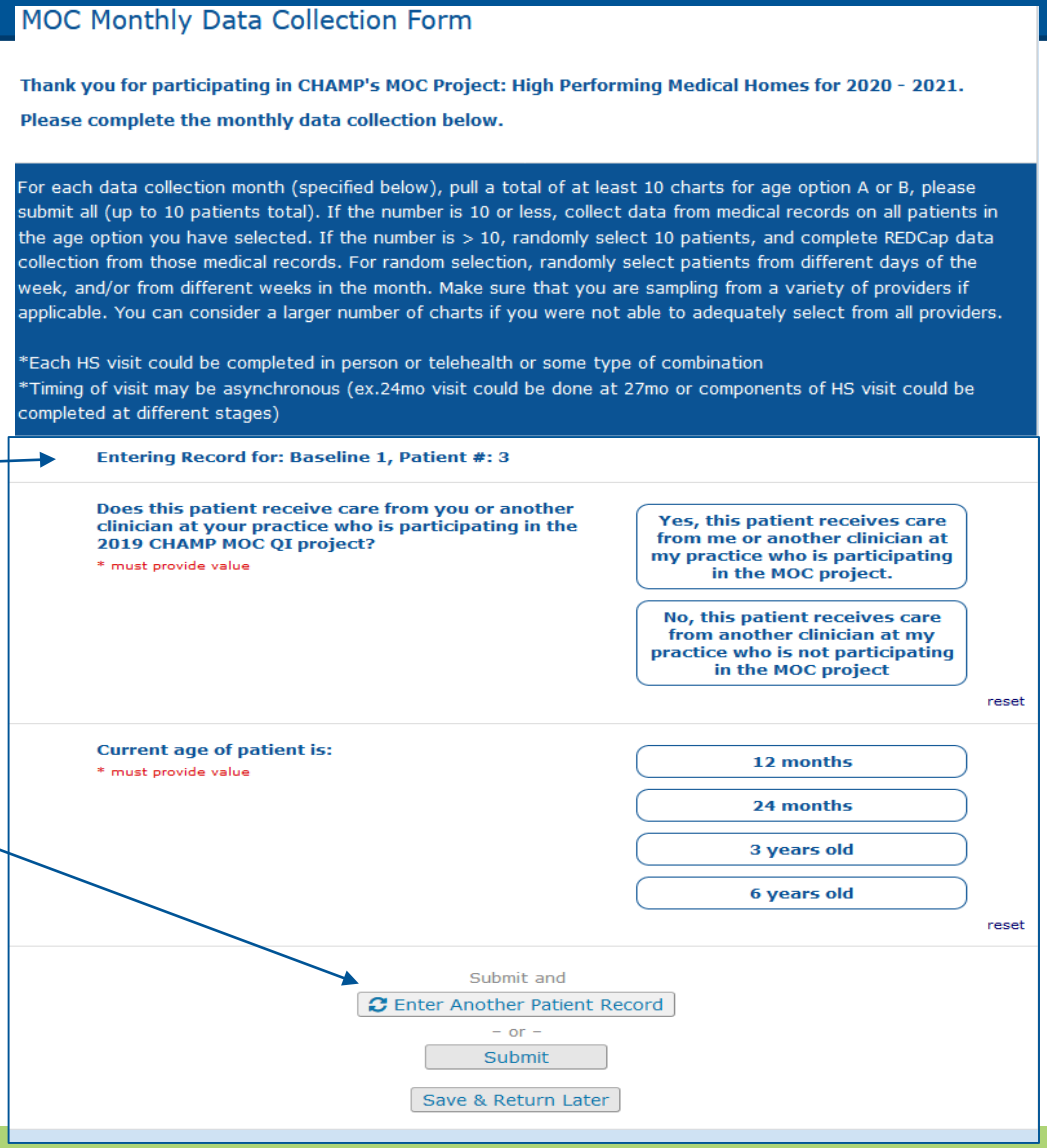
Monthly Data Collection



Tracks which record and month you are on here

You may enter data at your own pace and in different sittings. Use these options to save your place and return.

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New: PDSA Tracking Form in REDCap – download/upload function

What's in a PDSA Cycle?

VCHIP Small Test of Change Worksheet Date: _____

Planning What happened last month that will inform this month's test of change. Identify the problem you are trying to solve.

Specific Aim: Chosen Aim to move forward on a Project Goal:

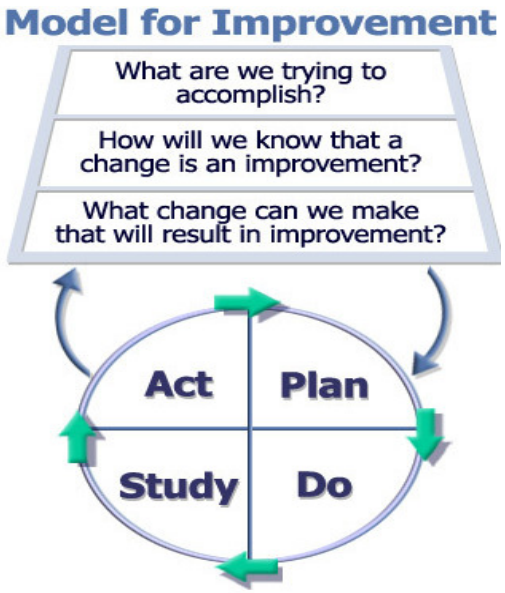
Describe your first (or next) test of change.	Responsible	When	Where
List the tasks needed to set up this test of change.	Responsible	When	Where
Predict what will happen when the test is carried out.	**Measures of Success**		

Do Run the test. Describe what happened when you ran the test:

Study Describe the measured results and how they compared to the predictions:

Act Describe what modifications to the plan will be made for the next cycle from what you learned:

Worksheet from the Institute for Healthcare Improvement



Quickly test changes on a small scale, observe what happens, tweak changes, test again

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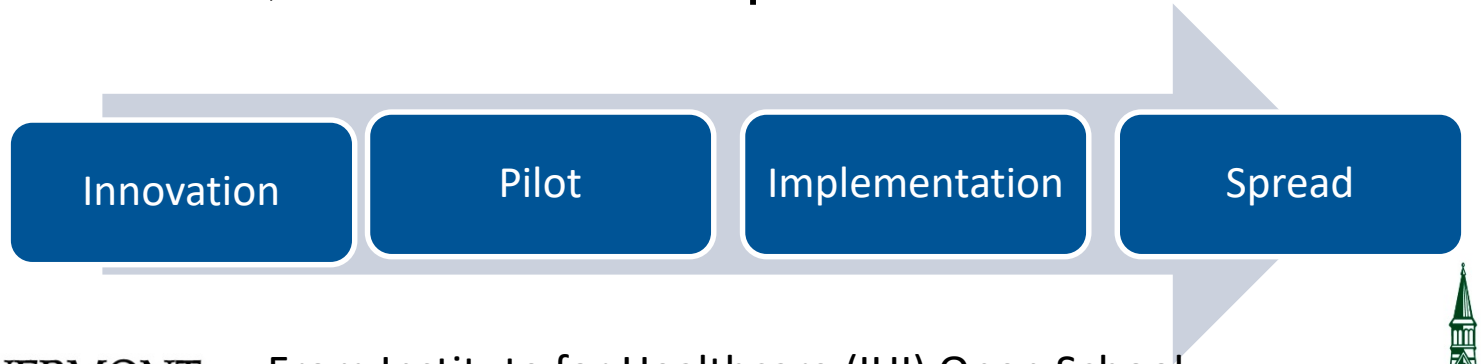
Office Systems Inventory

- Review your completed Office Systems Inventory
- Review your practice report (if available*)
- Where are your gaps?
- What are your priorities?
- What changes will you make?
- What will you “trial” first?
- What will have the biggest impact?
  - What will your 1st PDSA cycle be?

Getting Started

- Attending the Learning Session
- Identify a champion
- Assemble your team
- Best practices, protocols based on the Guidelines
- Gaps in care processes
- New ideas for change
- Measures, data collection plan



From Institute for Healthcare (IHI) Open School

Collaborative Calls

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Questions or Feedback?

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THANK YOU VERY MUCH!

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