CollN to Advance Care for Children with Medical Complexity

Webinar: Team Sharing and Fishbone Diagrams
May 21, 12:30-2:00pm EST

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number #UJ6MC31113: *Health Care Delivery System Innovations for Children with Medical Complexity* ($2,700,000 annually). This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsement be inferred, by HRSA, HHS or the U.S. government.
Anna Maria Padlan, HRSA/MCHB Project Officer

Boston University School of Social Work
Center for Innovation in Social Work & Health

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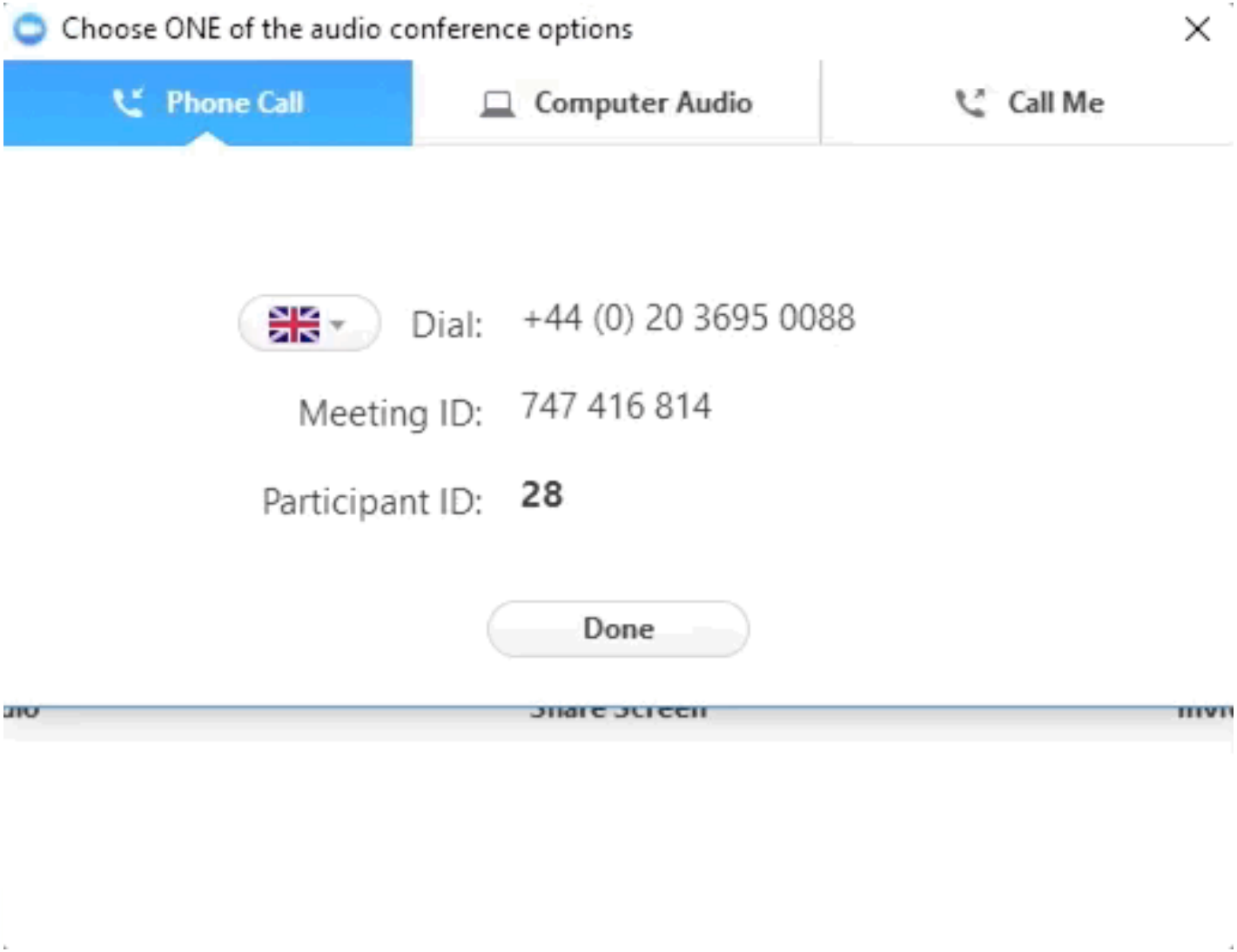
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28
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Housekeeping & Hellos

- This call is being recorded
- Make sure to mute your phone when you are not speaking
  - Press the “mute” button on your handheld or press *6 to mute and *6 again to unmute
- Please do not put us on hold
- If using phone audio, please take a minute now to link your phone with your computer
- Participation is essential
- Chat box

Webinar Objectives

- Share team updates and learn from one another
- Introduce the fishbone diagram and 5 whys as tools to help teams uncover root causes
- Provide team time to apply new tools

CMC CoINN Project Updates

- National Advisory Committee webinar held this past Friday, May 18th
  - Summarized state team project status reports (thank you!)
  - Discussed outcome measurement
- State team FAQs (and some answers…)
- Additional questions?
  - Please type into chat box!

Team Updates

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Alabama

2 Minute Timer
(Click to Begin)

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Colorado

2 Minute Timer
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Indiana

2 Minute Timer
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Kentucky

2 Minute Timer
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Massachusetts

Project Formation

- The Massachusetts Team is focusing on improving the experience of children and families as CMC undergo surgical procedures
- We have chosen this focus because the clinical team has believes that there are definite improvements that can be made in the coordination of activities around surgical care
- Also the clinical team feels that often families do not have adequate opportunity to be true partners in making decisions regarding whether and when surgery should be performed

Validation

- With the help of our Improvement Coach, we have been sharpening our AIM statement to precisely define the area(s) of difficulty for the CMC
- At our recent all team meeting with parent and multidisciplinary team members, the parents gave strong positive validation that the surgical process is often confusing and that they would welcome interventions that increased their partnership in decision making

Forward Movement

- **AND** the parent members expanded the clinicians' understanding of which aspects of receiving surgical care were particularly troubling. They pointed out that often they encounter difficulty with being prepared for what is going to happen with the surgery and they said that post-discharge is often like most confusing for them.
- As a result, we are expanding our inquiry and plans for improvement to the entire SURGICAL EXPERIENCE, not just the isolated surgical event.

FISH DIAGRAM PROBLEM

- Parents of Children with Medical Complexity report that they are not adequately engaged in partnership with providers during their children's surgical experiences.

Minnesota

2 Minute Timer
(Click to Begin)

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Oregon

2 Minute Timer
(Click to Begin)

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Texas

2 Minute Timer
(Click to Begin)

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Washington State CMC CoINN AIM STATEMENT

2 Minute Timer
(Click to Begin)

AIM STATEMENT FOR PROJECT

The WA State CMC CoINN aims to improve the transition of care and establish nutritional homes for infants discharged from the NICU with a feeding tube. Capitalizing on the statewide resources of the WA State Nutrition Network for CYSHCN and the WA Community Feeding teams, and the expertise of PAVE Partnerships for Action Voices for Empowerment to engage parents and caregivers in identifying opportunities and addressing barriers, we will improve the outcomes of 150-300 infants who live in two geographically distinct areas of WA State. We intend to increase by at least 90% the number of caregivers who identify with a nutritional home and increase by 80% the number of infants with a comprehensive nutrition plan of care. We also intend to decrease by 70% the number of NICU graduates with unmet nutrition and/or tube management needs; and decrease by 25% the inpatient and ED utilization of these infants due to feeding or tube management issues, by July 31, 2021.

Measure	Operational Definition	Baseline	Goal
Increase the % of NICU OG/NG tube dependent discharges ("Cohort") who have a nutrition home	Numerator: All cohort members Denominator: All cohort members with a nutrition home Measured at discharge, 3 and 6 months (intervention) and 12 months (post intervention)	UNK	90%
Increase the % of NICU OG/NG tube dependent discharges ("Cohort") who have a comprehensive nutrition plan of care	Numerator: All cohort members Denominator: All cohort members with a current comprehensive nutrition plan of care Measured at discharge, 3 and 6 months (intervention) and 12 months (post intervention)	TBD	80%
Increase the % of NICU OG/NG tube dependent discharges ("Cohort") who have a comprehensive nutrition plan of care that has been fully operationalized	Numerator: All cohort members with a comprehensive nutrition plan of care Denominator: All cohort members with a comprehensive nutrition plan of care that has been fully operationalized Measured at discharge, 3 and 6 months (intervention) and 12 months (post intervention)	UNK	50%
Decrease the % of OG/NG tube related ER or IP encounters of NICU NG tube dependent discharges("Cohort")	Numerator: All cohort members Denominator: IP/ ED NG tube related encounters of all cohort members Measured at 3 months, 6 months (intervention) and 12 months (post intervention)	TBD	25%
Increase the % of NICU OG/NG tube dependent discharges ("Cohort") parents/caregivers who report their nutrition needs are met	Numerator: All cohort members Denominator: Parents/caregivers reporting their nutrition needs are met Measured at baseline, 3 months, 6 months (intervention) and 12 months (post intervention)	UNK	70%

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DEFINITION, DELIVERABLES & SCOPE

DEFINITION OF CHILDREN WITH MEDICAL COMPLEXITIES:
Children and youth between ages 0-21 with:

- Multiple, significant chronic health problems that affect multiple organ systems;
- Resulting in a) functional limitations and b) high health care need or utilization; and,
- Often the need for or use of medical technology

Word	Operational Definition
NICU graduate	Infant discharged directly from a NICU
Feeding Tube	Oral or nasal pharyngeal tube (ICD10 0D6737; CPT 96.07)
Social Complexity	Socio-economic factors such as housing, health literacy, food insecurity that can negatively impact quality of life, clinical outcomes and utilization
Nutrition Home	*To be defined through parent focus groups and stakeholder interviews*
Support System	*To be defined through parent focus groups and stakeholder interviews*

PROJECT DELIVERABLES

- All enrollees have a nutrition home
  - Connection to a feeding team
  - Connection to a primary care PCP
- All enrollees have a dynamic, shareable, comprehensive nutrition plan of care
  - Escalation/sick plan
  - Feeding therapy plan
  - Nutrition plan
  - NG tube management plan
  - Valued by parent/caregiver
- Support system for nutrition/feeding tube needs

PROJECT SCOPE:

In Scope	Out of Scope
Medicaid insured	Commercial payer ? Medicaid as secondary
Nutrition/Feeding plan of care	Plan of care elements that are not about nutrition/feeding
Direct discharges from NICU	Discharges from other than NICU
Use of parent/caregiver focus groups/interviews to identify opportunities, determine/validate interventions in English and Spanish	Focus groups in other languages
Phase 1: Seattle Children's Hospital NICU discharges with OG/NG tube	NICU grads from other hospitals
Phase 1: Children residing in Puget Sound	Children residing outside of Puget Sound
QI IRB	Research IRB

TEAM MEMBERS & ROLES

Subcommittee Meeting Structure

Monthly leadership meetings held at PAVE or via WebEx:

June 21, 2018
July 26, 2018
August 23, 2018
September 26, 2018 Learning Session in Chicago
October 4, 2018
November 1, 2018
November 29, 2018
No meeting in December

Meetings with ad hoc participants and stakeholders as needed

TEAM PARTICIPATION

Team Members and Roles

Name	Team Role	Contact Info
Paula Holmes, RN	Sr Director/Project Lead, Seattle Children's (Leadership Team)	Mailing Address: 4800 Sand Point Way NE, Seattle, WA 98105 Phone: 206-987-8979 Email: paula.holmes@seattlechildrens.org
Sharon Feucht, RD	Nutrition content expert/Nutrition Network liaison, UW CHDD (Leadership team)	Mailing Address: Phone: Email: sfeucht@uw.edu
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Jill McCormick	CMC Parent with parent support expertise, PAVE (Leadership Team)	Mailing Address: 6316 S 12th St, Tacoma, WA 98465 Phone: 253-565-2266 Email: JMcCormick@wapave.org
Meredith Pyle, PhC	WA State Title V CYSHCN Director, Department of Health (Leadership team)	Mailing Address: Phone: 360-236-3536 Email: Meredith.pyle@doh.wa.gov
Ashlea Tade	Program Manager, Seattle Children's (Leadership Team support)	Mailing Address: 4800 Sand Point Way NE, Seattle, WA 98105 Phone: 206-987-1874 Email: Ashlea.tade@seattlechildrens.org
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Joan Zerzan RD	Nutrition content expert, DOH consultant (ad hoc member)	Email:joan.zerzan@doh.wa.gov
Kathy Mullin	SCH Care Coordination Director, Seattle Children's Hospital (Ad Hoc member)	Mailing Address: 4800 Sand Point Way NE, Seattle, WA 98105 Phone: 206-987-2652 Email: Kathy.mullin@seattlechildrens.org
NNP/PA TBD	NICU Provider representative (Ad Hoc member)	
Parent TBD	Parent of a child < 3 yo with a feeding tube (Ad Hoc member)	

STAKEHOLDERS

STAKEHOLDERS

Stakeholder Name	Impact on Project (*High, Med, Low*)	Strategies to Communicate and/or Gain Support
SCH Leadership	Med	Monthly updates; Interest: project impact on LOS and cost savings
HCA	Low for project High for APM	Quarterly updates; Engagement in year 3 re: payment model
MCO	Low for project High for APM	Engage at least one MCO in the project in year one
Parents/Caregivers	High	Use focus groups, KI interviews, qualitative surveys to assure active participation in program design, implementation, testing and evaluation; PAVE Family Voices as the mechanism for communication and engagement; engage a parent of an infant with a feeding tube as an ad hoc member for support system PDSA
PCPs	Med	Identify and engage a small number of PCP clinics as program partners for nutrition home PDSA
NICU providers	Med	Engage an NNP or NICU PA as an ad hoc member for discharge planning PDSA
Nutrition Network/Feeding Teams	High	Quarterly updates; utilize at least one local team for nutrition plan of care

Wisconsin

What WI is most Proud of

What WI is most Proud of:

1. Established Bi-Weekly meetings since January 2018
2. Project Charter completed.
3. Overall Collaborative Aim Statement created:
    1. The overall goal of our children with medical complexity (CMC) CoIIN team is to improve the quality of life for our state's CMC, the wellbeing of their families, and the cost-effectiveness of their care. We will do this by a) using a Shared plan of care, b) developing and using an Anticipatory Guidance Tool (AGT).
        1. We AIM to:
            1. 85% of WI CCP participants have a Shared Plan of Care (SPoC) with 3 essential elements (medical summary, family strengths and preferences and negotiated actions) updated at least every 6 months.
            2. 85% of WI CCP participants receive annual health benefits screening and referral using an anticipatory guidance tool (AGT)
4. Set date for day long retreat with all team members
5. Created an engaged team with Title V partners, support from our DHS partners and most importantly our two family representatives.

Mary Webster, MSN, RN, CCM
Senior Program Director
Population Health Improvement Partners

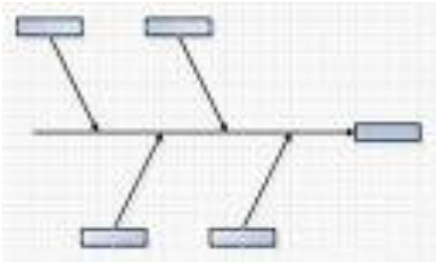
Understanding the Root Cause: Fishbone Diagrams and 5 Whys

Kerri Deloso, MHA, CLSSBB
Program Director
Population Health Improvement Partners

E Learning Review

- Your take aways from the E Learning module?
- Do you have your problem statement/idea ready?
  - Examples include:
    - Patient's getting incomplete discharge paperwork
    - No shows in the clinic
    - Lack of a standard referral process to specialists
- We will be allowing for time for your teams to practice the Fishbone with your problem statement

Understand the Root Cause



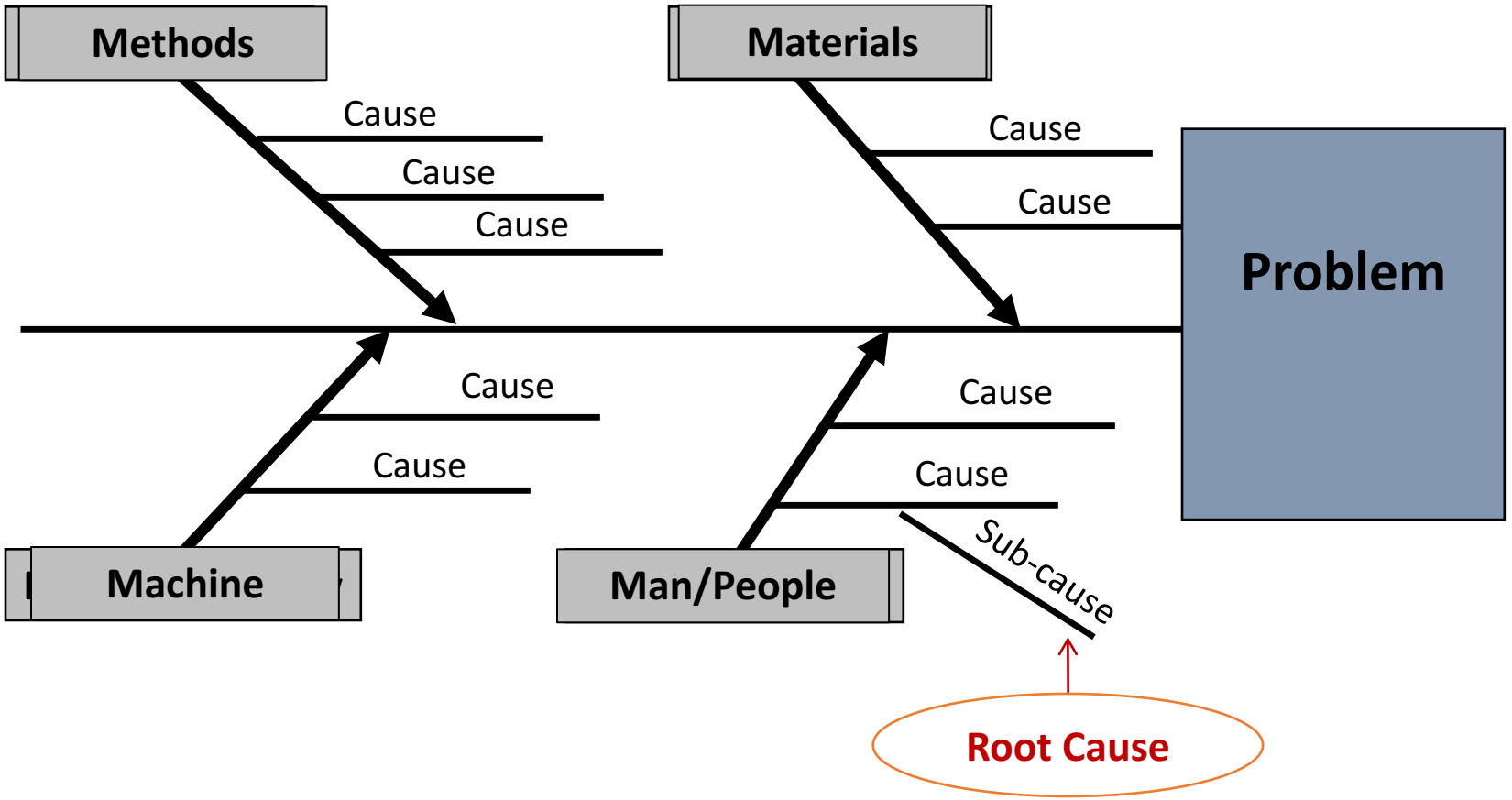
Fishbone Diagram

- What it is?
  - A visual display that allows teams to organize information and identify *multiple* causes of a problem

- Why use it?
  - Provides structure during brainstorming
  - Enables team to think through all potential causes
  - Creates a snapshot of the team's collective knowledge
  - Breaks problem into smaller pieces
  - Focuses on causes rather than symptoms
  - Helps prioritize and focus on specific areas

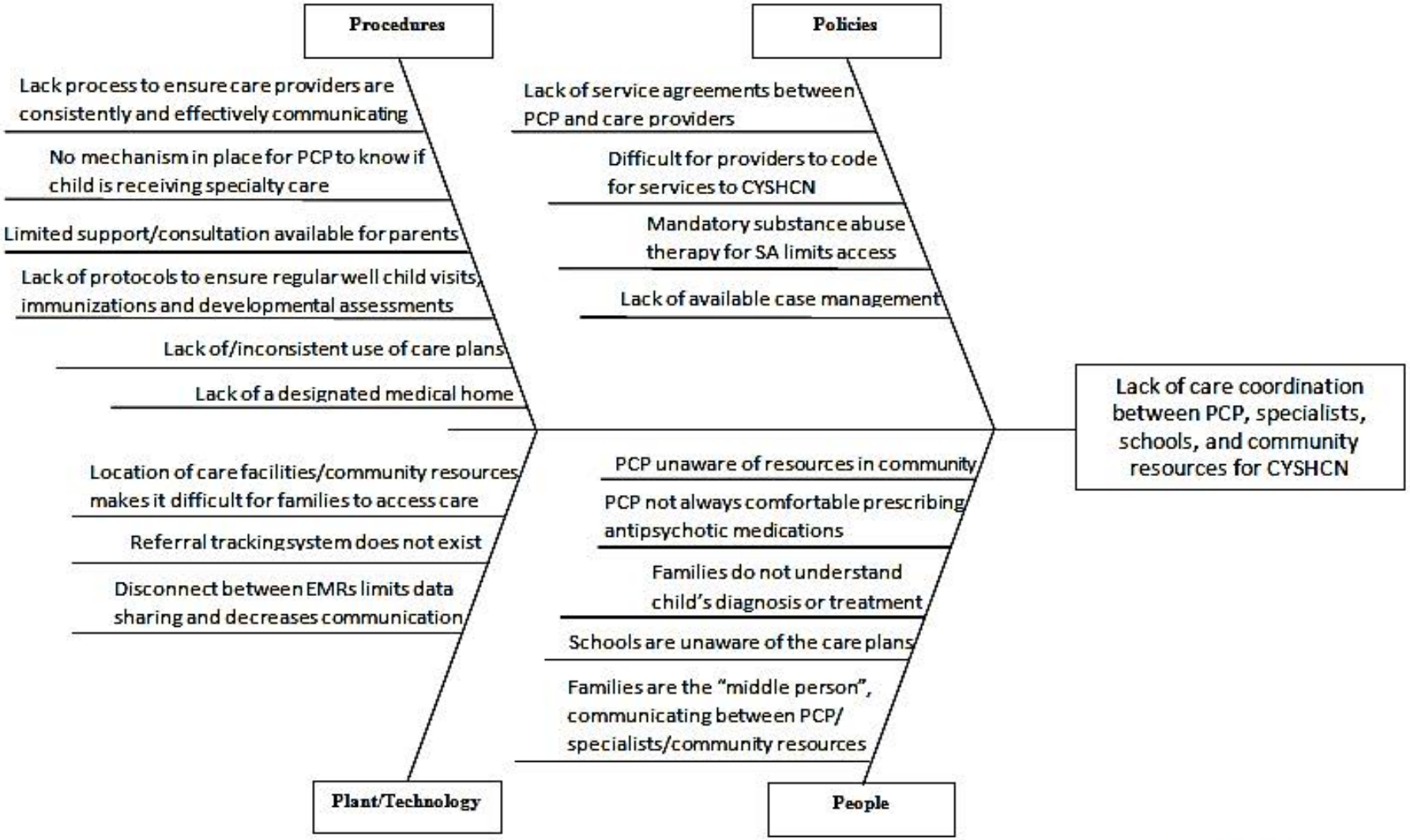
Understand the Root Cause

Fishbone Diagram



Understand the Root Cause

Fishbone Example: Care Coordination



Understand the Root Cause

RCA: Communication across programs re. depression screening/general referrals/etc.

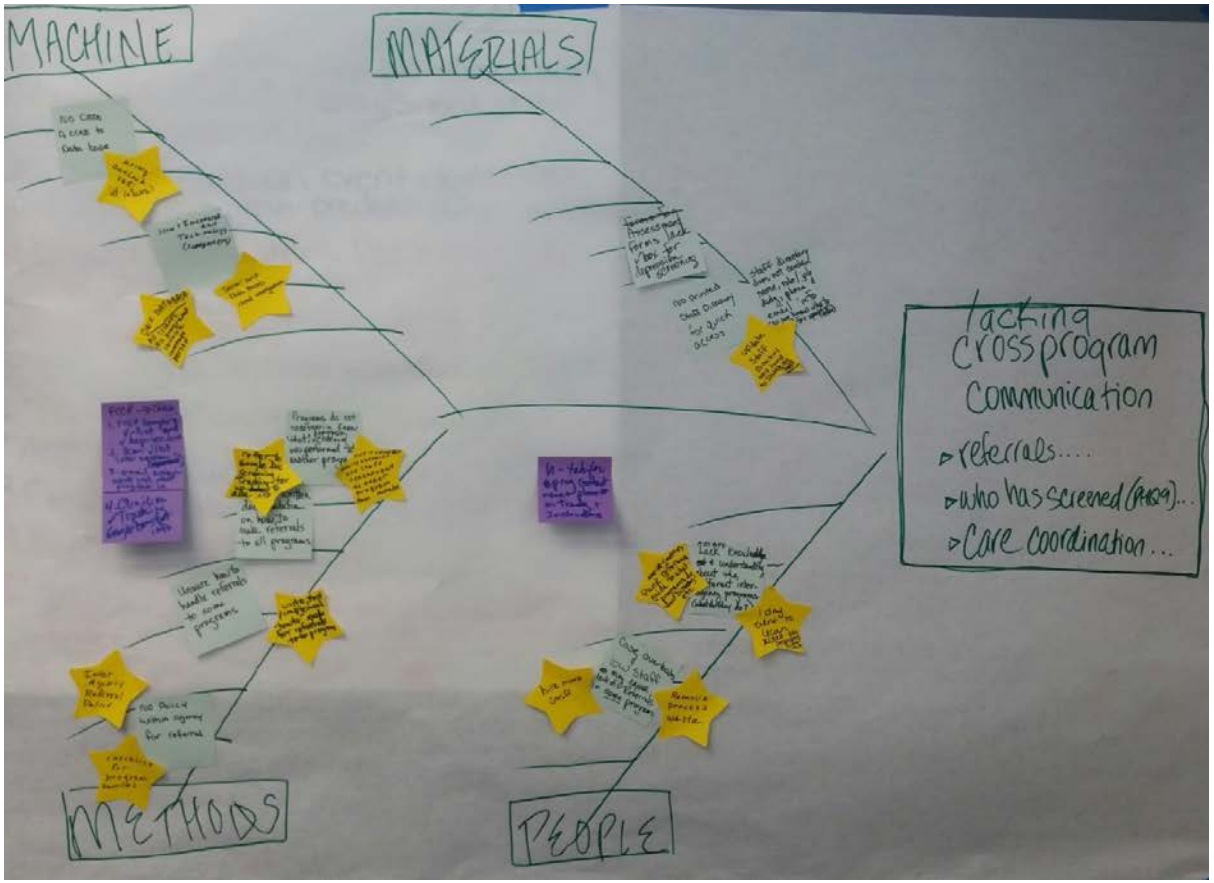
Machine
No cross access servers

No SINGLE client database

Slow and inconsistent technology

Methods
No policies for intra-agency referrals or referral follow up

Unsure how to handle referrals to some programs



Materials
Assessment forms lack check box for depression screen

No printed staff directory for quick access

Staff directory does not include program

People
Case overload and low staff may hinder referrals from some programs

Lack knowledge of other internal programs

Understand the Root Cause

Fishbone Diagram: How to Construct It?

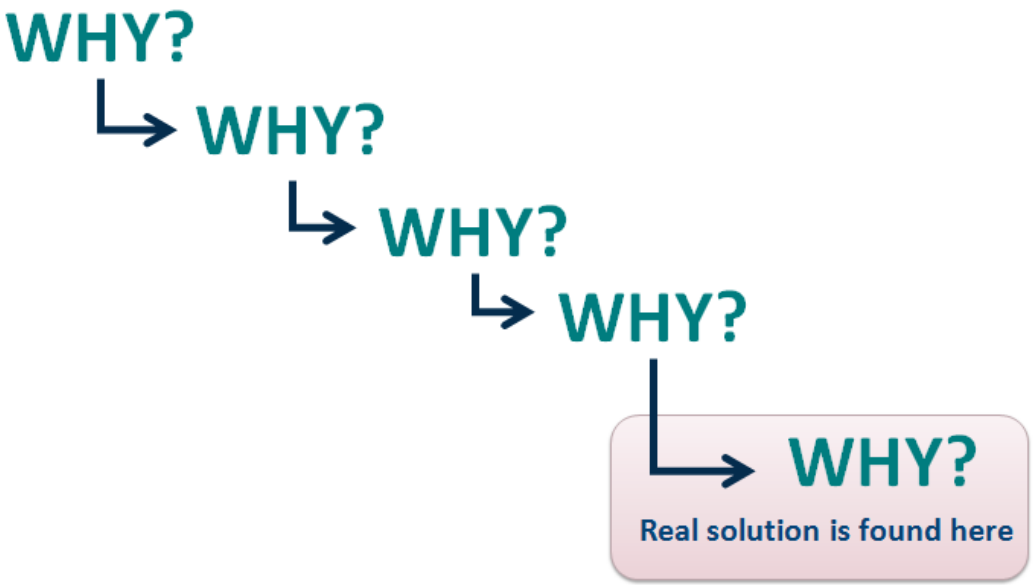
- Identify your problem and put it at the "head" of the fish
- Determine major categories for the diagram
  - Consider: **M**achine, **M**ethod, **M**aterials, **P**eople
- Identify factors that fall under each category
  - Data collected from observations, focus groups, surveys (including customer/staff feedback)
  - Brainstorm ideas as a group
- Evaluate your diagram
  - Look at the "balance" of the diagram
  - Focus on the category that has the most factors
  - Prioritize the factors within the category
    - Determine if you need to use the 5 Whys to drill down to find root cause
- Identify solutions for each factor
- **TEST, TEST, TEST** each idea with PDSA cycles

Understand the Root Cause

5 Whys

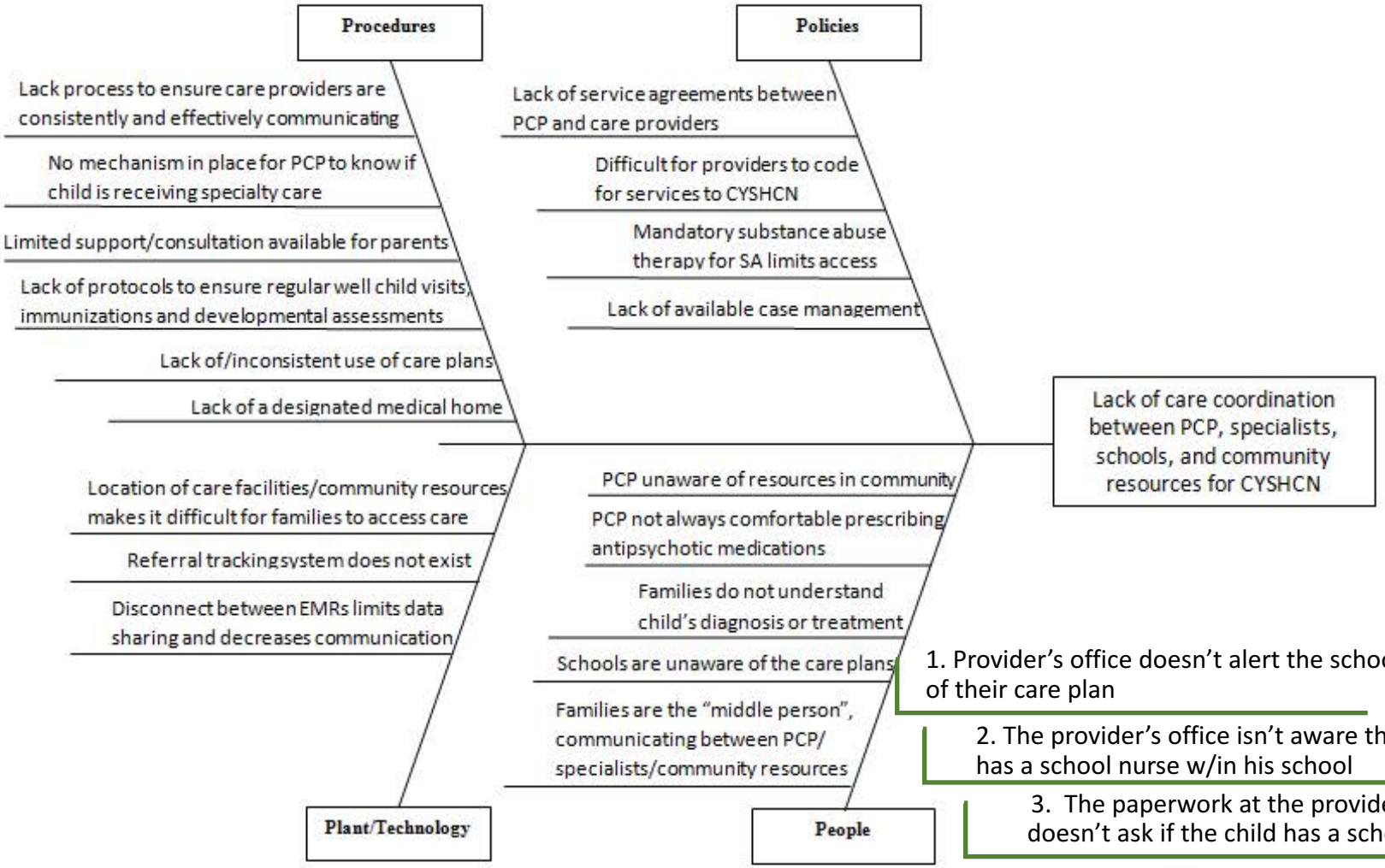
What it is?

- A question asking method
- Used to quickly determine the root cause of a problem



Understand the Root Cause

Fishbone and 5 Whys Example



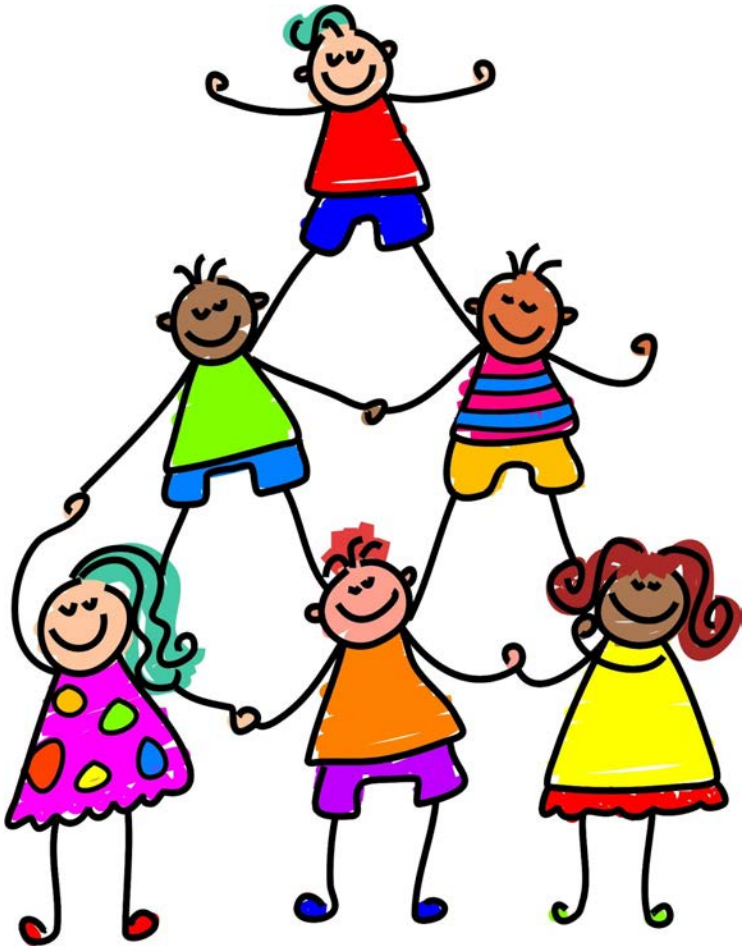
1. Provider's office doesn't alert the school nurse of their care plan
2. The provider's office isn't aware the child has a school nurse w/in his school
3. The paperwork at the providers office doesn't ask if the child has a school nurse

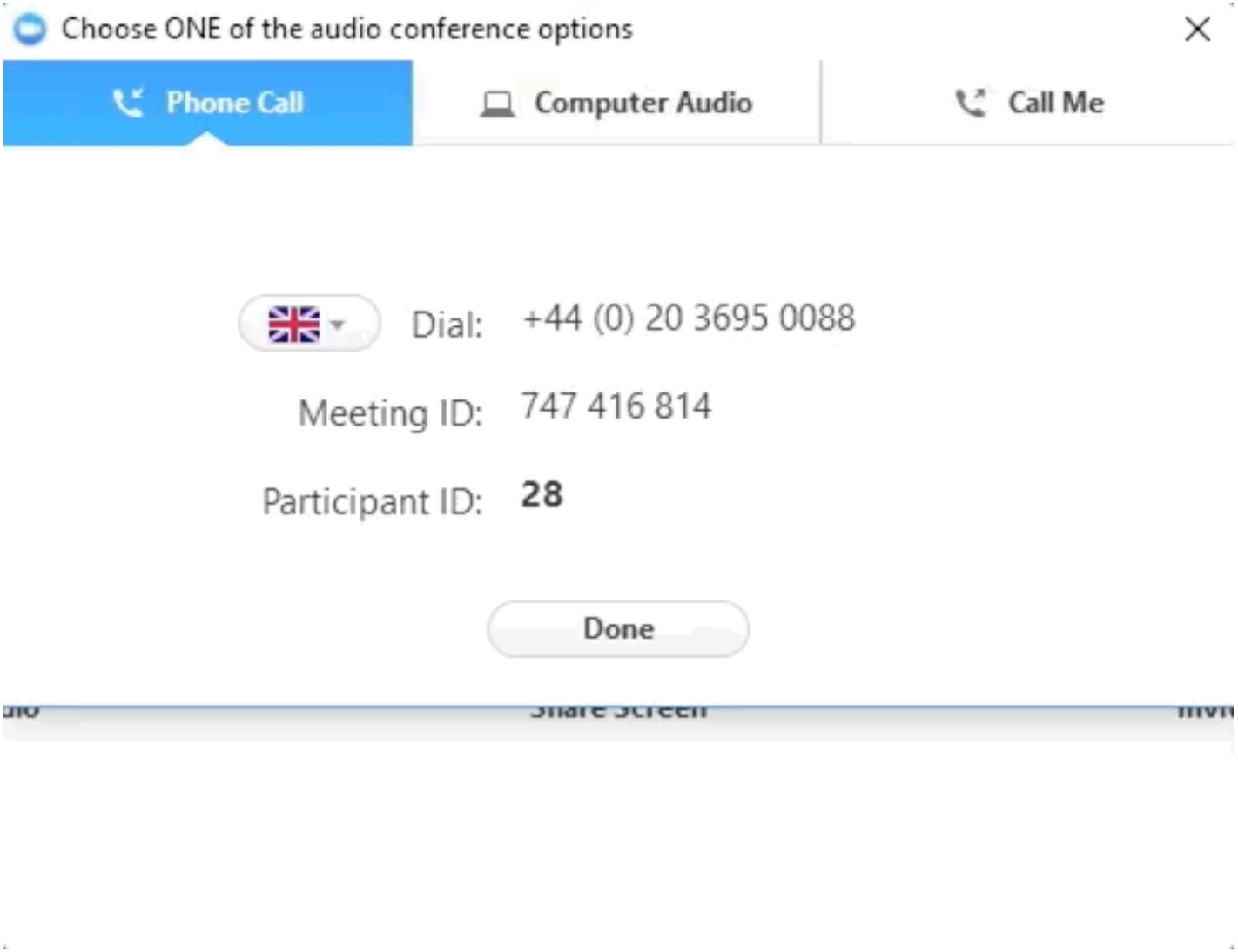
Understand the Root Cause

Let's Try It!

- Identify a problem
- Brainstorm potential causes by creating a fishbone diagram
- Don't forget to dig deeper using the 5 Whys, when needed
- Begin prioritizing potential causes, as time permits
- Be prepared to report out

BREAK OUT TIME

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Dial:
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Meeting ID:
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Participant ID:
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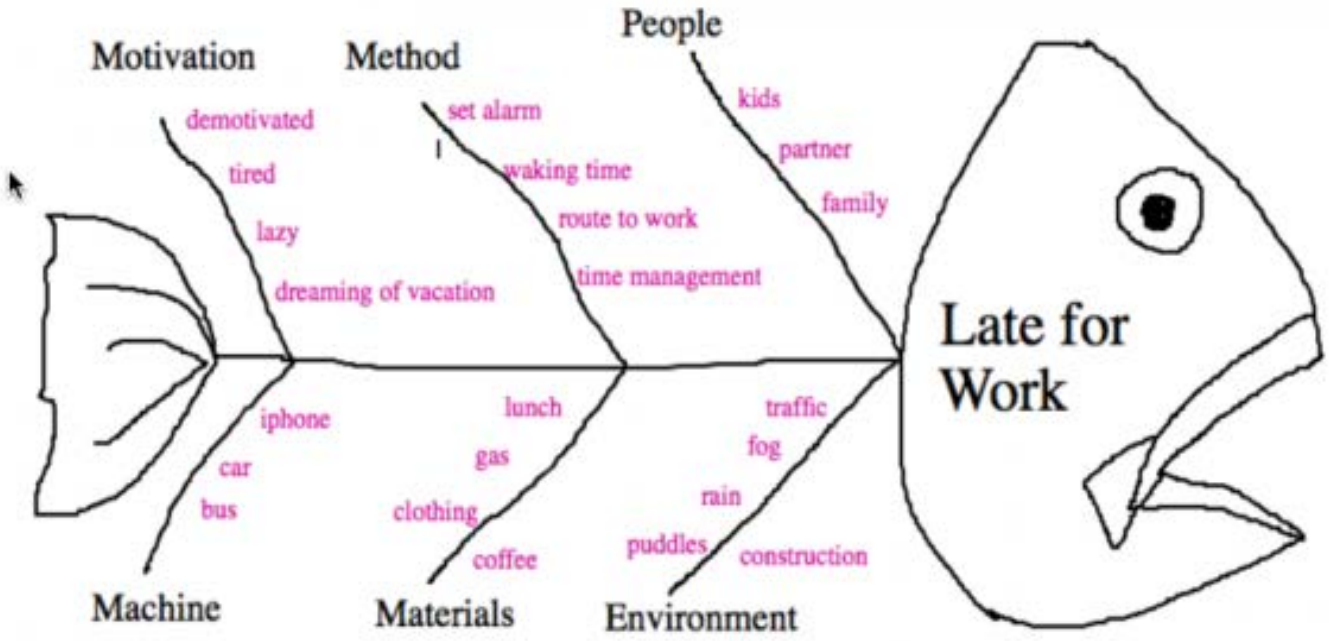
State Team Breakout Instructions

- When prompted, please click JOIN
- **Participating in the Breakout Room**: Once you've joined the breakout room, you will have full controls. You can:
  - **Mute/Unmute** to speak
  - **Participants** - view the Participants list
  - **Share screen** – **state team lead will share their screen to show & edit fishbone diagram for each team**
  - **Chat** - type messages to the other participants in your breakout room
  - **Annotate** – Any Participant can annotate the displayed file
  - **Ask for Help** - will notify the meeting host that you need assistance and they will be asked to join your breakout room.
- When the host ends the breakout rooms, you will be notified and given the option to return to the main room immediately, or in 60 seconds.

FISHBONE Exercise Debrief



Wrap Up and Next Steps

- **Continue to work on your Fishbone/5 Whys if necessary**
- **Continue your team meetings and coach calls**
- **Sending out list of aims/team composition**
- **Monthly e-mails re: progress and asks**
- **Sharing upcoming events (through 2018)**
  - **Next webinar 9/17**
  - **Next in-person learning sessions 9/26-9/27**

CMC CoINN Upcoming Events

Mar	**Webinar: Quality Improvement - Team Selection/Project AIM** *(State Team Reps)* 3/14, 12:30pm-2pm		••	
Apr		**Learning Session** *(State Team Reps)* 4/17 & 4/18, 8:30am-4:30pm Location: AAP, Itasca, IL	••	
May	**NAC Virtual Meeting** *(NAC members only)* 5/18, 12pm-3pm **Webinar:** *Topic Based on Need* *(State Team Reps)* 5/21, 12:30pm-2pm		••	
Jun			••	
Jul	**Webinar:** *Topic Based on Need* *(State Team Reps)* 7/12, 2pm-3:30pm		••	
Aug		**NAC On-Site Meeting** *(NAC members only)* 8/23, 10am-4pm Location: TBD	••	
Sep	**Webinar:** *Topic Based on Need* *(State Team Reps)* 9/17, 12pm-1:30pm	**Learning Session** *(State Team Reps)* 9/26 & 9/27, 8:30am-4:30pm Location: AAP, Itasca, IL	••	
Oct			••	
Nov	**Webinar:** *Topic Based on Need* *(State Team Reps)* 11/29, 1:30pm-3pm		••	
Dec			••	

A Conversation on Meaningful Family Engagement, from Clinical Care to Health Policy

Date: Wednesday, June 6
Time: 10 to 11 a.m. Pacific Time; 1 to 2 p.m. Eastern Time

Register Now

Engaging with families is vital to transforming the health care system and positively impacting the life course of vulnerable populations. Families have extensive experience in partnering with professionals to improve systems of care, are organized and connected across the country, and stand ready to assist at every level of next efforts for improvement. Learn how to meaningfully involve families at every level of health care systems and engage them as critical partners in designing policies that will improve care for all children.

Join us for a lively discussion on the article, Families of Children with Medical Complexity: A View from the Front Lines. The lead author and experts in the field will review the article's key content and share ways to strengthen family engagement. We suggest attendees read the article prior to the event. Audience Q&A is highly encouraged. Attendees can listen via web or phone.

We need your feedback!

- **Webinar Evaluation** – please participate!
  - Link: https://www.surveymonkey.com/r/7THLKHX
    - See chat box to click directly on the link
  - Short & sweet: Only 1 page, 5 questions
  - Carpe Diem!

- CONTACT US anytime!
  - PHIP coach: Project implementation questions
  - BU: Administrative questions

THANK YOU!

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Understand the Root Cause – References

•Tague, N. *The Quality Toolbox*. Milwaukee, WI; American Society for Quality; 2005.

•Public Health Foundation. *The Public Health Memory Jogger II: A Pocket Guide of Tools for Continuous Improvement and Effective Planning.* GOAL/QPC; 2007.