Healthcare and Homelessness Workshop #3 - Day 1

March 2022

Institute for Healthcare Improvement

COMMUNITY SOLUTIONS

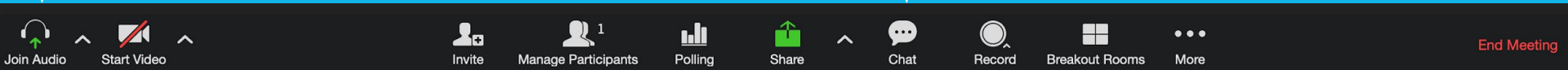
Welcome!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

- Name
- Community
- Agency/Role
- Where are your feet touching the ground today?
  https://native-land.ca/



Introductions

Catherine Mather
Project Director

Aleya Martin
Sr. Project Manager

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Faculty Coach

Catherine Craig
Faculty Coach

Anna Bialik
Improvement Advisor

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Project Advisor

Laura Baker
Project Manager

Danielle Augustine
Project Manager

Ben Bradley
Improvement Advisor

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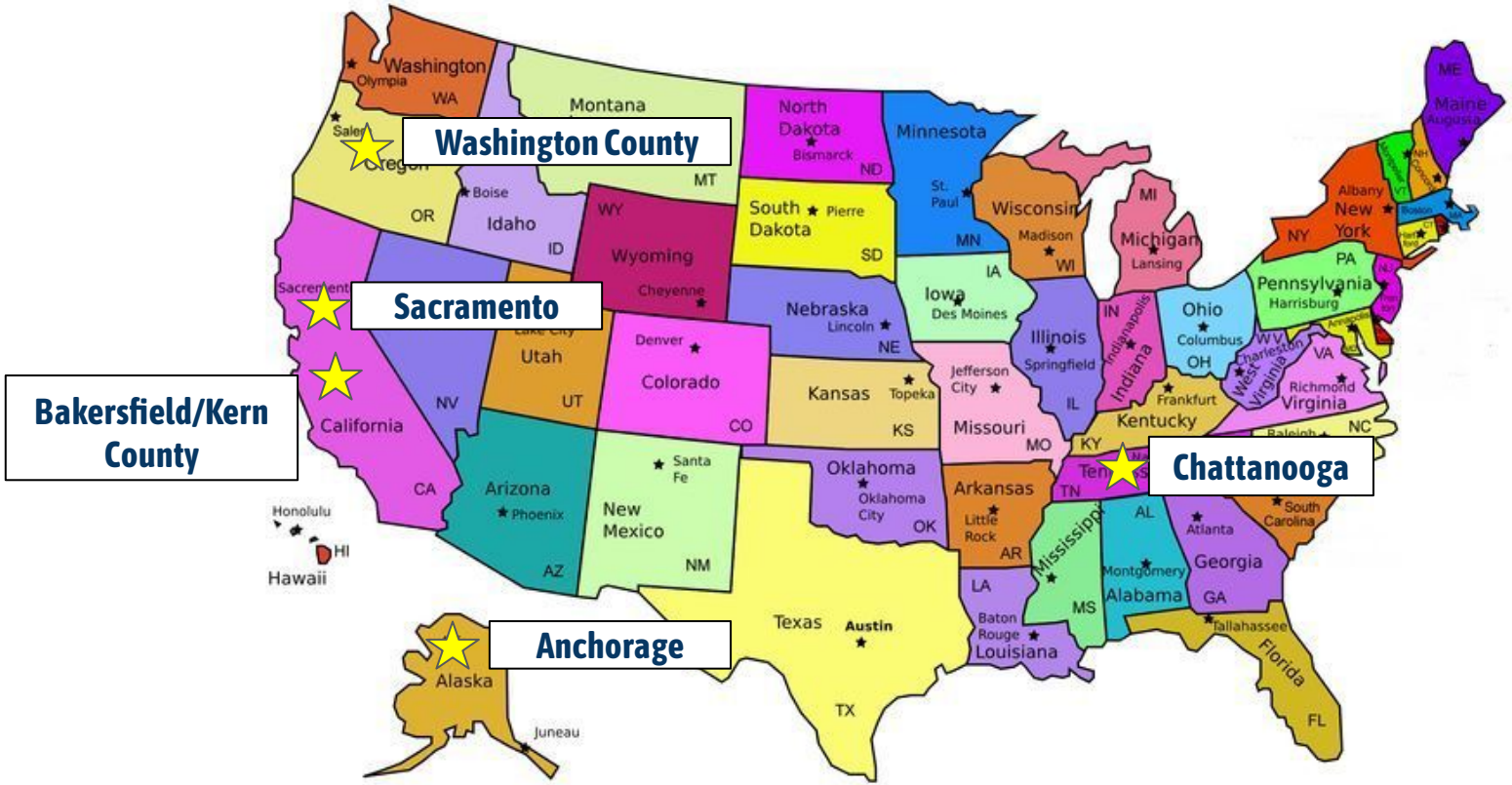
Pilot Teams


Washington County
Sacramento
Bakersfield/Kern County
Chattanooga
Anchorage
Washington
Olympia
WA
Montana
North Dakota
Bismarck
ND
Minnesota
St. Paul
MN
Wisconsin
Madison
WI
Michigan
Lansing
MI
New York
Albany
NY
Maine
Augusta
ME
Vermont
New Hampshire
Massachusetts
Rhode Island
Connecticut
Salem
Oregon
OR
Boise
Idaho
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Wyoming
Cheyenne
South Dakota
Pierre
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Des Moines
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AL
Georgia
Atlanta
GA
South Carolina
Florida
Tallahassee
FL
Louisiana
Baton Rouge
LA
Texas
Austin
TX
Honolulu
HI
Hawaii
Alaska
Juneau

Agenda - Day 1: March 1, 2022

Time	Agenda Item
2:00 - 2:10 pm ET 11 - 11:10 am PT 10 - 10:10 am AKT	**Welcome and Icebreaker**
2:10 - 2:25 pm ET 11:10 - 11:25 am PT 10:10 - 10:25 am AKT	**Overview of workshop**
2:25 - 3:55 pm ET 11:25 am - 12:55 pm PT 10:25 - 11:55 am AKT	**Act with the individual, design for the population**
3:55 - 4:00 pm ET 12:55 - 1:00 pm PT 11:55 am - 12:00 pm AKT	**Wrap-up and prep for day two**

Agenda - Day 2: March 2, 2022

Time	Agenda Item
2:00 - 2:10 pm ET 11 - 11:10 am PT 10 - 10:10 am AKT	**Welcome Back**
2:10-3:05pm ET 11:10 am - 12:05 pm PT 10:10 am - 11:05 am AKT	**Building stories that meet the moment: Using storytelling to build will and accelerate progress**
3:05-3:35 pm ET 12:05 - 12:35 pm PT 11:05 - 11:35 am AKT	**Team time breakouts: Crafting your community stories**
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3:55 - 4:00 pm ET 12:55 - 1:00 pm PT 11:55 am - 12:00 pm AKT	**Wrap-up and next steps**

Workshop Objectives

At the end of Workshop 3, participants will:

- Understand how to use learnings from small tests of change to reach population-level goals
- Understand how to use the 5X scale-up method to scale-up effective interventions
- Understand how to leverage communications throughout the Healthcare + Homelessness Pilot to build will and accelerate progress
- Start planning your community's communication strategy

Our Aim

Over the course of this 2 year Pilot initiative, pilot teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Shared Definitions: Chronic Homelessness

Chronic homelessness is defined by the Department of Housing and Urban Development (HUD).

Technical Definition	Spirit of the Definition
People with a disabling condition that: ● experienced 1 year or more of continued homelessness ● 4 or more episodes of homelessness within 3 years*	People who are experiencing long-term or repeated episodes of homelessness that have complex needs that render them vulnerable

Shared Definitions: Measurable Reduction

People Currently Experiencing Homelessness

<

People Experiencing Homelessness at Baseline**

Pilot Initiative Objectives

- ✔ Prevent, reduce and end chronic homelessness through collaboration with health systems
- ✔ Identify interventions/ways of working that have the greatest impact;
- ✔ Make the business case for both the health system and the overall community;
- ✔ Understand the effects of housing for the health of the chronically homeless population and the impact on healthcare institutions operationally, including the morale of staff as a result of actively participating in problem solving; and
- ✔ Achieve cost reductions or greater value for funds spent.

Our Journey Together in the Pilot

Kick-Off Call
December 2020

Foundations Phase
December & January 2020

Virtual Workshop 1
Jan 28 & 29, 2021

Action Period 1
Feb - June 2021

Virtual Workshop 2
June 23 & 24 2021

Action Period 2
June - December 2021

Celebration Call
December 2021

Continued Action Period
Jan + Feb 2022

Virtual Workshop 3
March 1 & 2 2022

Action Period 3
March - Summer 2022

Workshop 4
Summer 2022

Action Period 4
Summer 2022-Dec 2022

Pilot Extension
2023

Workshops and Action Periods TBD
2023

Site Harvesting
Oct 2023-Dec 2023

Action Period: March through Summer

As a Pilot Team....

Participate in Pilot Site Coaching Calls
Participate in All Pilot Site Monthly Calls
Revisit community level aim and project portfolio - do your projects get you to your aim? Does your aim account for a population level reduction in homelessness?
Continue testing projects in your portfolio
Take next steps on community communication plan
Prepare for Workshop 4

Act with the individual, design for the population

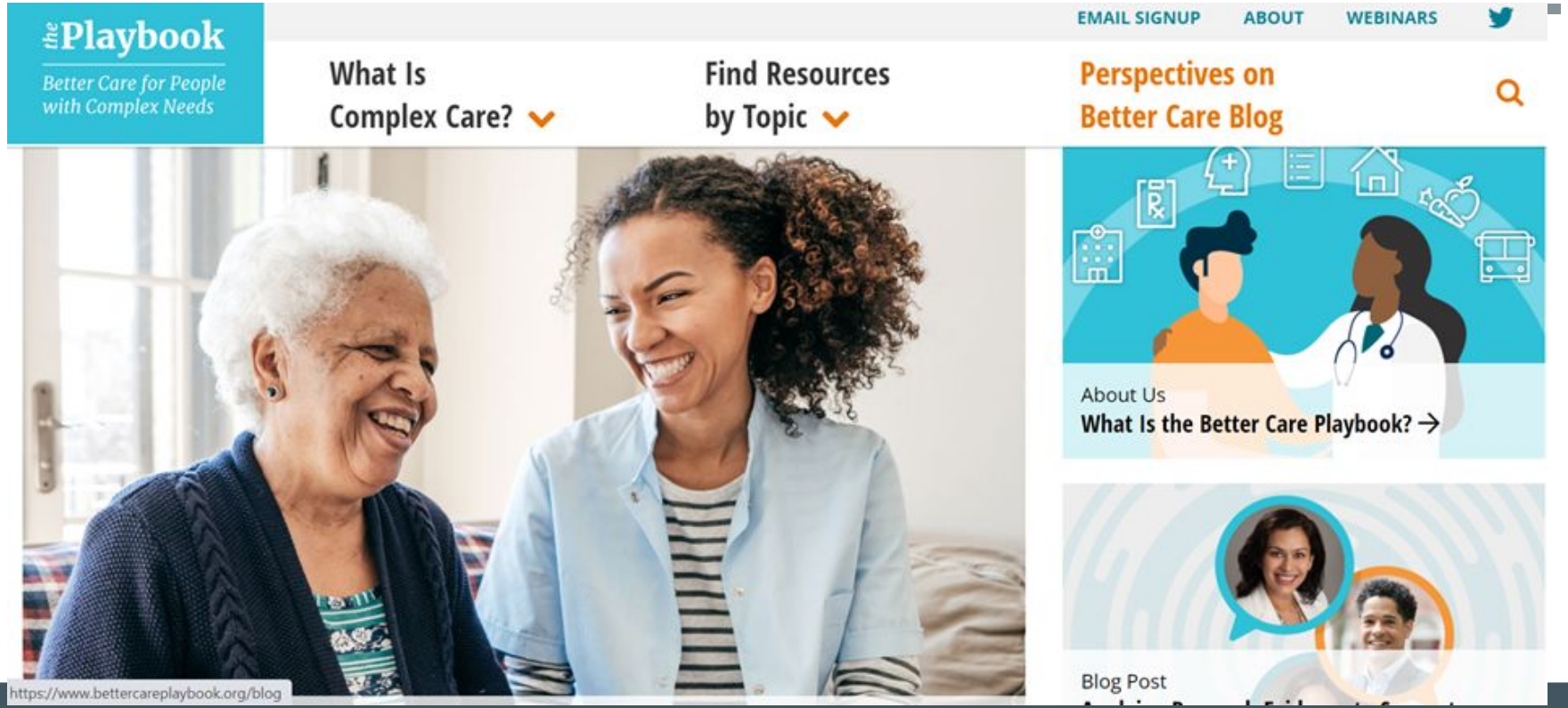
Objectives

Understand how to use 5X method

Understand how tests of change can roll up to large scale change

Describe how boosting health and experience outcomes for one group can lead to community transformation

Better Health, Lower Costs Collaborative

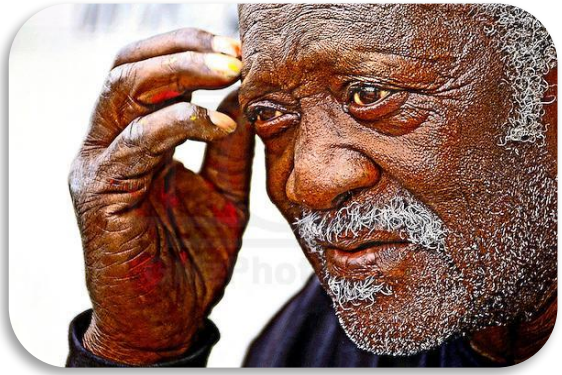


Co-Create a Care Plan With Five Individuals

Chronic Heart Failure

History of Addiction to IV Drugs and Alcohol

COPD



Developmental Disorder

Schizoaffective Disorder

Hepatitis C

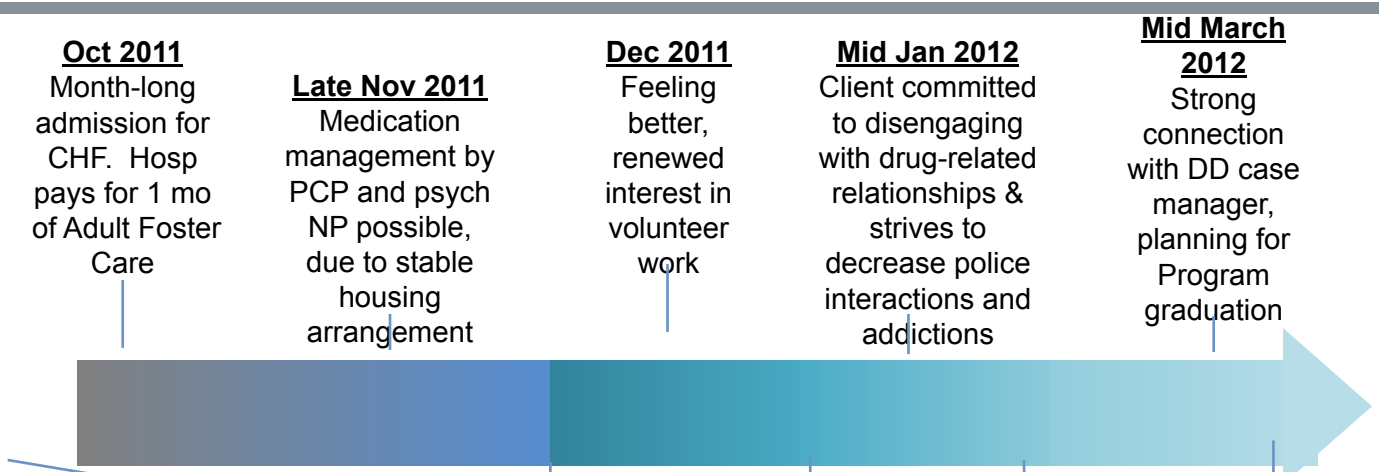
Intermittent Homelessness

October 2011:
Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.

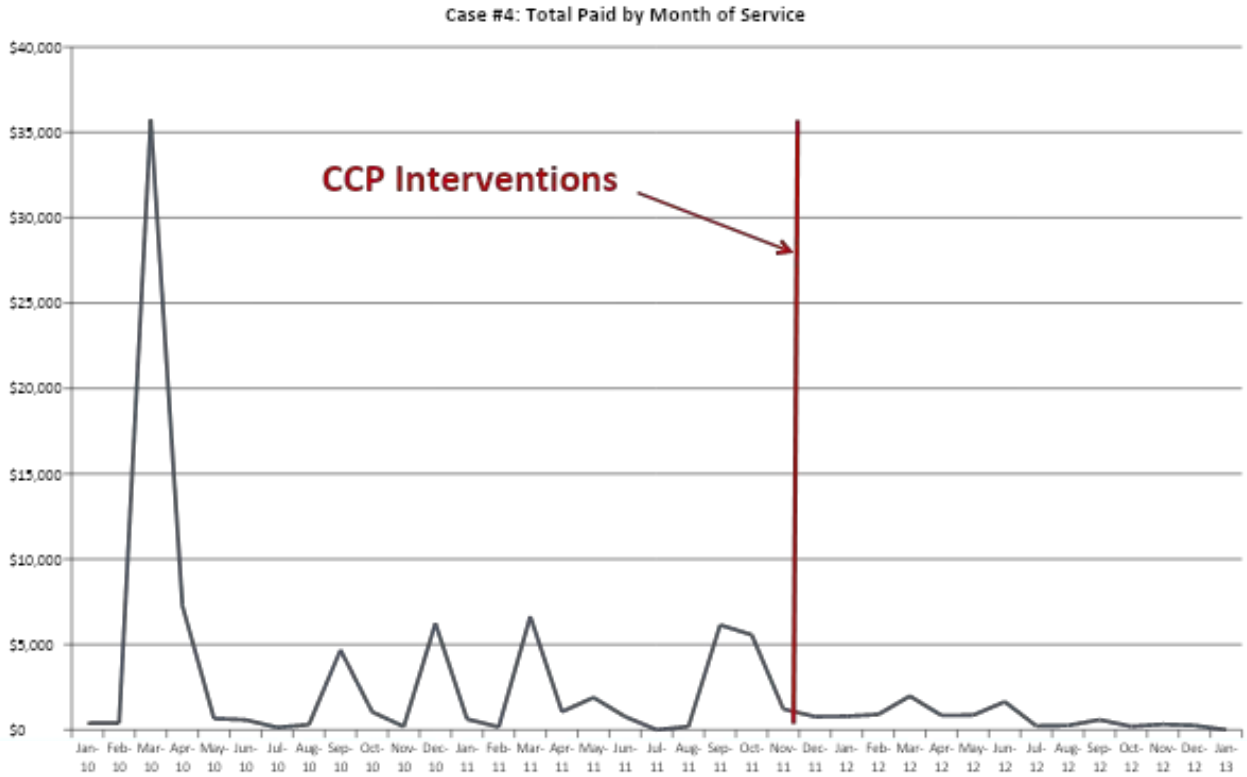
Type 2 Diabetes

66 Year Old African American Man

Timeline of Interventions with William



William's Cost Trend



What did we learn from William?

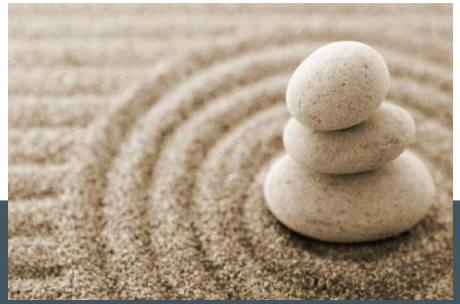
- Social isolation is a huge risk factor for our population
- Pay attention to the outliers – usual CHF hospitalization is 5.4 days, but William was in for almost a month. Why?
- Sometimes it takes focused advocacy to get an appropriate level of state and county assistance – William had benefits due to his DD that were not being provided; he slipped through the cracks
- Housing = health care; hard to expect anyone to be adherent on medications if they have unstable housing

Designing for the Population

- Building trust/rapport is paramount
- Engaging around what matters to the individual
- Think outside the “medical services” box – what are the socially or behaviorally determined risk factors?
- Who else can help? Recognize that what the individual might need most might be something you are not in the position (or trained) trained to provide
- Don’t forget about the influence of health literacy, esp related to medication management
- Try to step into the shoes of your patient

Scale Up from 5-25 Patients

- CareOregon initially hired 2 Community Outreach Workers to become new team members at pilot FQHC clinics – brought a new community-oriented behavioral health skillset
- Good results in first 6 months (high clinic & patient satisfaction, utilization trends looking positive)
- CMMI Innovation Award allowed us to scale up significantly



What Washington County is learning

- Tell us about a few of the things you've learned through collaborative case conferencing
- What surprised you?
- What did you learn about how the system is working well?
- What did you learn about how the system poses challenges to housing and health?
- What practices did you find that built trust among partners?

Integrated Case Conferencing

Lauran Hardin, MSN, CNL, FNAP, FAAN
National Center for Complex Health and Social Needs, an initiative of the Camden Coalition of Healthcare Providers

What's a case conference?

- Case review of people with complex circumstances that is:

  Focused on capturing **person centered story**
  Includes **cross continuum team** – each person/agency intersecting with the patient
  Focused on collaborative finding of **solutions**
  Ideally results in a **shared plan of care**

Types of Case Conferences

- Discharge Planning
- Transition of Care
- Shared Patient Rounds/Housing placements review
- Monthly plan of care update
- Complexity that requires a collaborative approach

Principles of Case Conferences

- Focused on capturing holistic patient story across systems
- Focused on solutions and strengths – **not failures**
- Focused on Root Cause – Medical, Behavioral (MH + SUD), Social and Systems
- Focused on clinical and **SYSTEM** issues causing instability
- Intentional practices to include all voices, capture a shared plan of care

Preparing for Effective Case Conferences

Cross Continuum Team Identification

Comprehensive Patient Story

Structures for Success

Cross Continuum Team

Cross Continuum Team

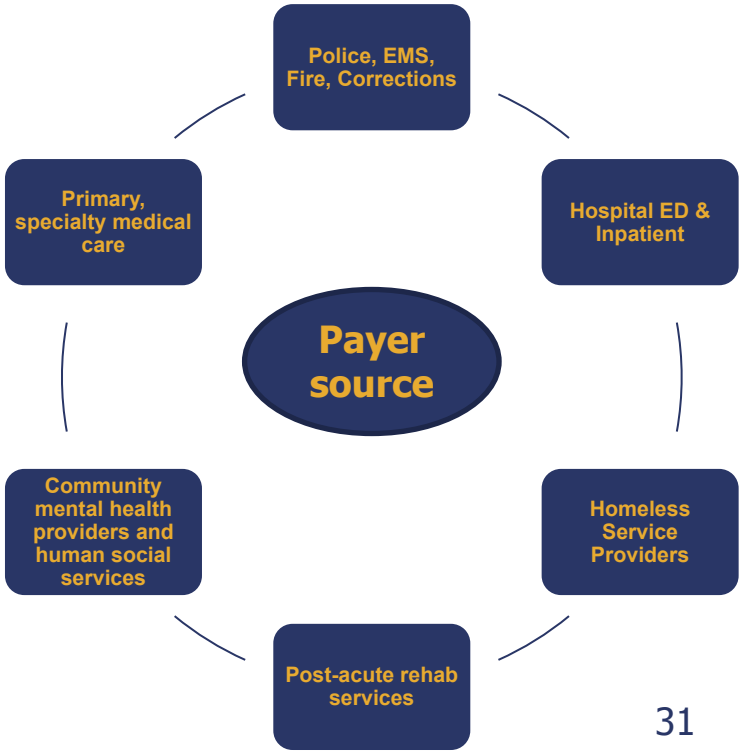
Who is already serving this patient?

- **Primary Care/FQHCs**
- **Specialists**
- **Care Managers**
- **Social Service Agencies**
- **Key Relationships**

Capture from Record Review

Add to it in the conference

Stakeholders across the community continuum of care and services: Cross Continuum Team



Capturing a Deeper Story

Comprehensive Patient Story

Do the homework to save time in the meeting

Use as a basis to round out the story

Using a Root Cause Framework:
4 quadrants of complexity

- Medical
- Behavioral
- Social
- Systems

Using a Root Cause Framework: Medical

Medical

- What diagnoses or conditions are driving instability or frequent access to the healthcare system?
- Are there symptom management concerns that are not being addressed? (i.e. pain, shortness of breath)

Using a Root Cause Framework: Behavioral

Behavioral

- What diagnoses or conditions are driving instability or frequent access to the healthcare system?
- Is current or past substance use driving instability?

Using a Root Cause Framework: Social

Social

What conditions are driving instability or frequent access to the healthcare system?

-Housing

-Food Security

-Transportation Social Isolation

-Felony Records, Legal Issues

-Personal Safety

Using a Root Cause Framework: Systems

System

What conditions are driving instability or frequent access to the healthcare system?

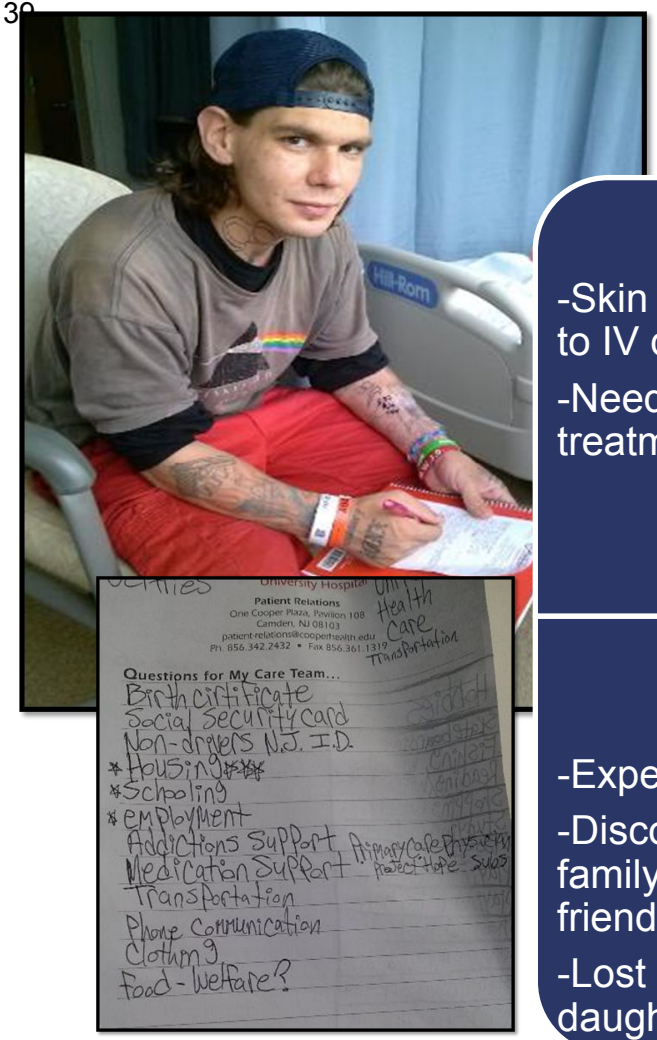
-Lack of access to medications

-Lack of access to care

-Breakdowns in plan of care between settings

-Lack of evidence based treatment

-Policies that prevent admission



Thinking about the whole picture

4 quadrants of complexity

Medical

-Skin and blood infections related to IV drug use

-Needs 6 weeks on IV antibiotic treatment in supervised facility

Behavioral

-Opioid Use Disorder

-Bipolar Disorder

-Not currently on medication, in treatment or associated with a program

Social

-Experiencing homelessness

-Disconnected from immediate family, but in contact with best friend

-Lost visitation privileges with his daughter

Systems

-Hospital unable to discharge for his IV antibiotic therapy, subacute facility will not accept him because of drug use history

-Hospital staff has confrontation relationship with him – labeled “high risk” and “non-compliant”

Team Members:
Date:

Complex Case Conferencing Script

I. **4-quadrants of complexity**

Client Initials:
Age:

Please fill in the boxes below based on any information you know about the individual you're working with:	
Medical	BH and Substance Use Disorder
•	•
Social	Systems
•	•

II. **Utilization (Past Year)**

Type	Number in previous 12 months	Root Cause
ED		
Inpatient admissions		
Length of stay (days)		

Eco-Map

Chart of ***(client initials)*** existing relationships / Cross Continuum Team			
Relationship (family, friend, provider, community organization, etc)	Type of relationship (Strong, Weak, Stressed)	Potential long-term support (Yes or No)	Notes/Action Items

Case Conference Script

Alter patient-identifying information unless you have authorization from your patient.

(Patient) is a **(Age) (Race/Ethnicity) (Male/Female)** with driving medical diagnoses of: **(List patient's medical conditions).** Patient also has the following mental health diagnoses: **(List patient's mental health diagnoses)**. Patient has the following social challenges **(List patient's social root causes).**

(Patient) has been enrolled in our services **(How many days Pt. has been with your team)**. This patient has had **(# of Visits)** since our services began. We are scheduled to see the Pt. on **(Date of next scheduled interaction with patient).**

(Patient) barriers are **(List barriers/issues you are facing with patient). (Patient) strengths are (List strengths you have noticed with patient)**.

The patient responded well when **(list interventions/techniques you have used with the patient).** The patient did not respond well when **(list interventions/techniques you have used with the patient)**. The patient is experiencing the following challenges with the system **(list system root causes)**.

I would like help with **(list areas of treatment/intervention).**

_____
_____
_____
_____
_____
_____
_____
_____
_____

I have noticed the following system process improvement opportunities:

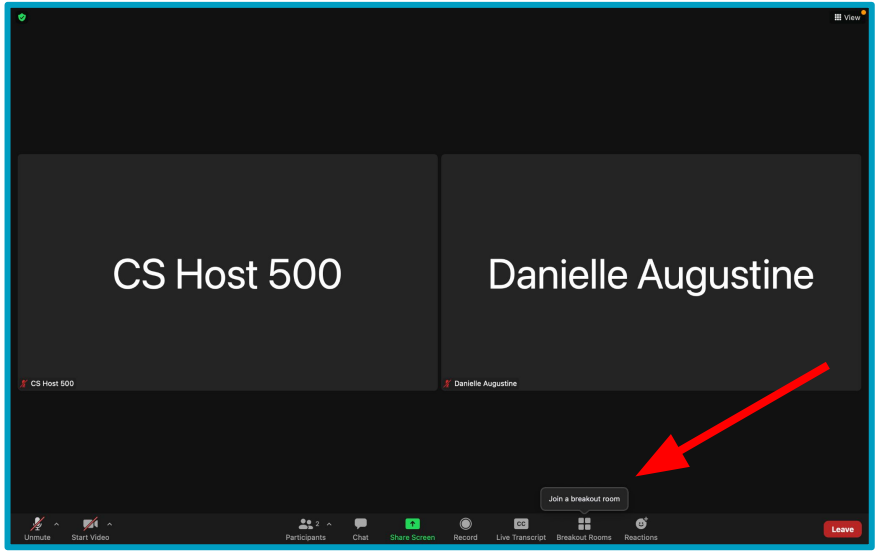
_____

A Targeted Report

MS is a 26 yo male with diagnoses of Bipolar, SUD and skin and blood infections r/t IV drug use. He's had 15 ED visits and 6 IP admissions in the last year. His cross continuum team includes PCP x, BH provider x, Payer CM x. He is homeless with minimal social support and recently lost visitation privileges. Medical root cause of admissions is infection, BH root cause SUD and no medications for Bipolar, Social root cause includes homelessness and grief/trauma. System root cause includes inability to admit to LTC for 6 week course of IV treatment. Our purpose is to collaborate and share resources to improve his outcomes, connect the care team and save time for all in delivery.

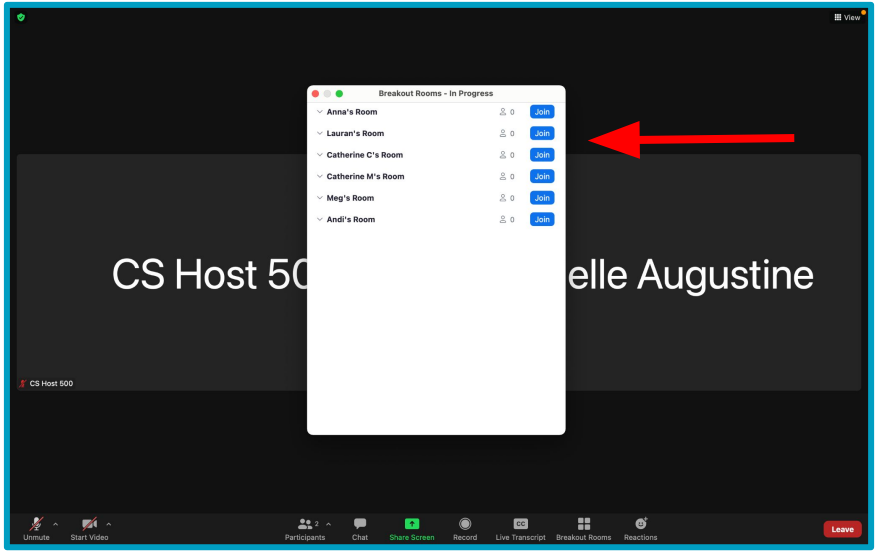
How to join breakout rooms

STEP 1



Click the **“Breakout Room”** button at the bottom

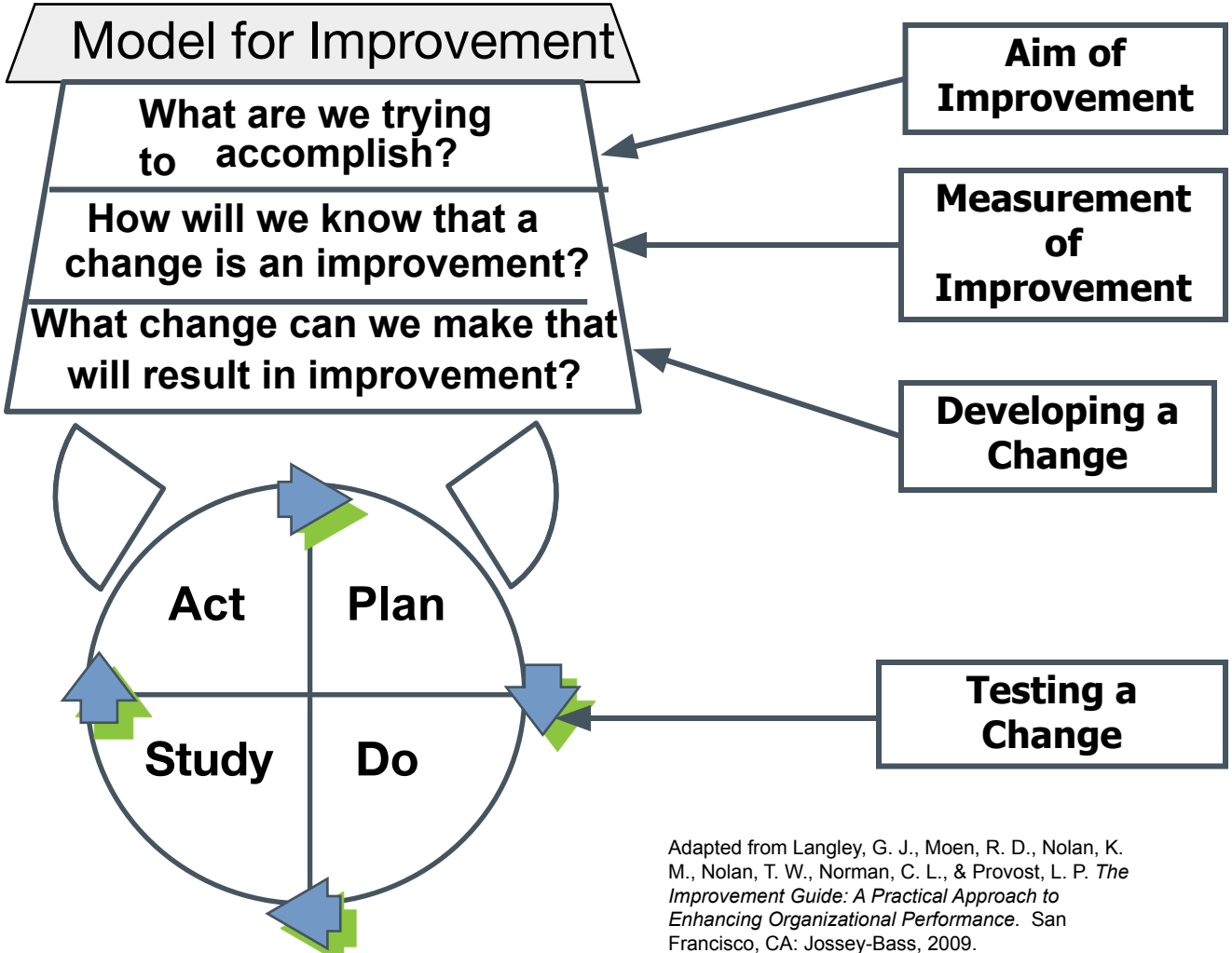
STEP 2



Click **“Join”** next to the breakout room of your choice

Small group discussions

- What will it take to get case conferencing going? If you have already, what did it take?
- How can you surface this kind of learning around a few people?
- Who in your extended team do you need to share this method with?
- What obstacles do you foresee in being able to learn from 1-5 people?

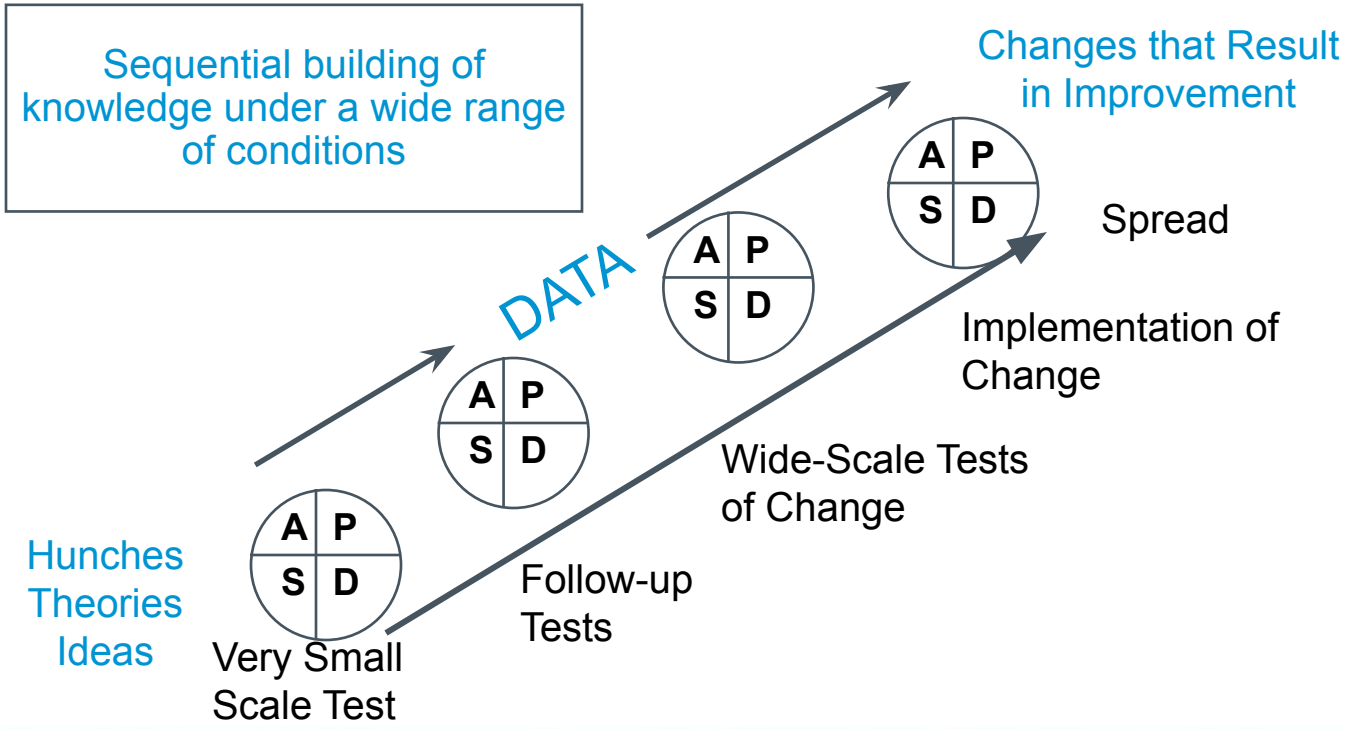


Adapted from Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.* San Francisco, CA: Jossey-Bass, 2009.

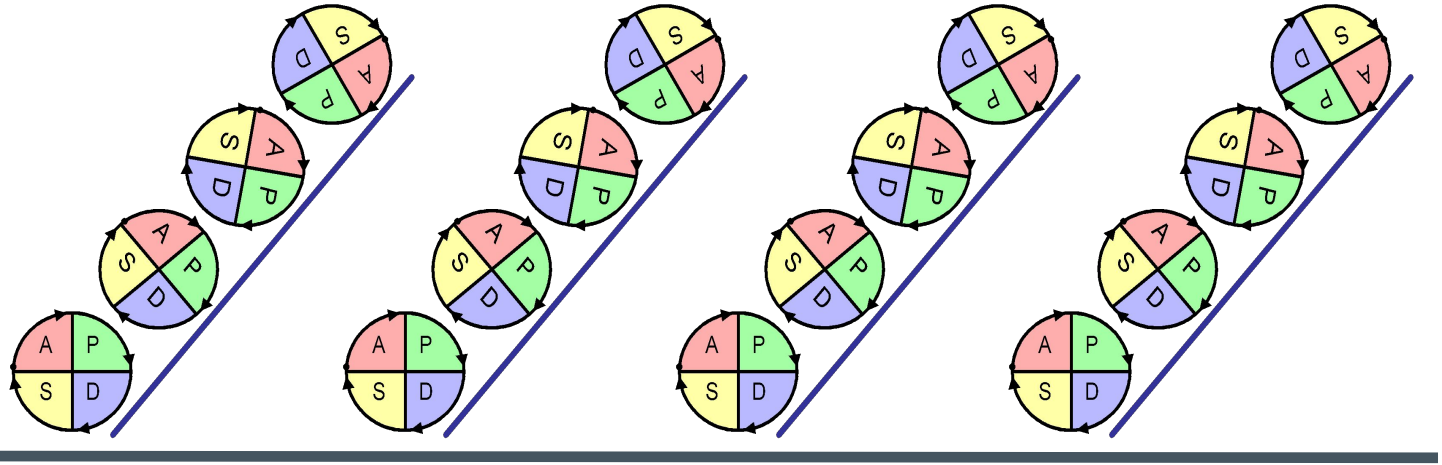
Why Test?

- Increase the belief that the *change will result in improvement*
- *Predict* how much improvement can be expected from the change
- Learn how to *adapt the change* to conditions in the local environment
- *Evaluate* costs and side-effects of the change
- *Minimize resistance* upon implementation

Repeated Use of the PDSA Cycle



Multiple PDSA Cycle Ramps



Commitment: New CoC/Health Care Case Conferencing Infrastructure

Housing Placements: Identify & develop process to address bottlenecks in housing placements

Inflow: Connect at-risk individuals with diversion/preventi on resources

Governance: Explore how health systems & CoCs can connect measurement systems

Adapted from: IHI Improvement Coach Professional Development Program

Learn for the population

From small tests of change to community transformation

Structural Issues for Scale-up

Example at 25	IT	Human Resources	Physical	Funding	Learning system
Care Model Design					
Patient Identification/ recruitment					
Patient Engagement					
Community Support					

Structural Scale-Up Issues for Key Change Ideas

Key Change Areas	5-25	125	250-625
Care Model	• Temporarily reallocate a portion of existing staff or use volunteers/ students to help with pilot • Keep a log of workforce development needs and train ad hoc • Recruit for relevant experience • Include primary care in program planning	• Allocate staff from other duties if trends have been promising • Collaborate and share staff resources across organizations • Hire new staff if funding has been secured • Consider non-traditional workforce • Begin to formalize the necessary workforce training • Recruit for commitment and passion • Pay attention to optimal/average LOS in program	• Develop standard case review and supervision process • Create formal orientation and workforce training plan • Address potential for staff burnout • Formalize primary care participation and look at specialty and home health roles • Develop partnership with acute care system, mental health and addictions providers
Community Support	• Begin building a registry of potential partners by tracking the other organizations/ agencies that are serving each patient • Have new partners serve a few individuals on a trial basis	• Choose one or two community stakeholders and formalize collaboration (including those with valuable data) • Formalize referral processes • Predict and match demand with capacity	• Continue to partner with community resource agencies critical to patient population

Action Step

- Make a plan with your pilot community team to rigorously learn from a few patients over the next month

Wrap up Day 1, Look ahead to Day 2

In one word….how are you feeling right now?

Wrap up Day 1, Look ahead to Day 2

In the chat please share **what went well** today….

In the chat please share **it would be better if**….

(try to focus on changes that can be made for tomorrow's sessions)

Institute for Healthcare Improvement

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March 2022

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Welcome!

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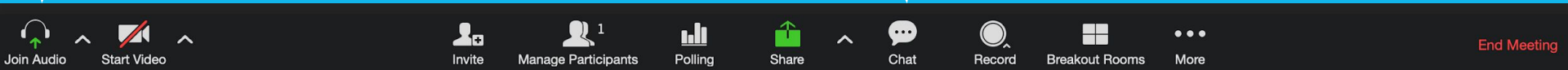
Turn on your video!

Say hi in the chat box! Tell us:

- Name
- Community
- Agency/Role
- Where's the best place you've traveled to in your life? (so far!)



Sacramento

Kaiser Permanente and the other three regional health systems in Sacramento will jointly fund three full time positions at Sacramento Steps Forward to accelerate system transformation in line with the Built for Zero model, in alignment with the national Healthcare x Homelessness Pilot with Community Solutions and the Institute for Healthcare Improvement.

COMMUNITY SOLUTIONS

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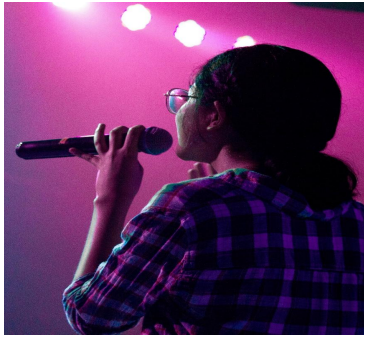
- Start planning your community's communication strategy

Building stories that meet the moment: Using storytelling to accelerate your work

Jo Ann Endo, MSW
Institute for Healthcare Improvement Senior Managing Editor
Wednesday, March 2, 2022

Communications for Improvement

- Builds will by conveying the need for change
- Strengthens and sustains momentum for achieving goals
- Inspires, motivates, and informs
- Accelerates change to deliver better outcomes
- Helps to “build a bigger tent”



Why focus on communications?

- No credible QI initiative would proceed without a measurement strategy.
- Why would you proceed without a clear strategy to communicate why you need to improve and how you plan to do it?

A Communications Framework

- **Aim:** What do you want to achieve?
- **Audience:** Who do you need to engage?
- **Message:** What do you need to say?
- **Channels:** How will you reach your audience?
- **Story:** How will you engage your audience?
- **Review:** What will you learn for next time?

1,000 Lives Improvement, Wales

What is your elevator pitch?

- **Practice your elevator pitch** — What is the main idea you need to convey? How are you going to make what you say stand out?
- **Connect** — Link your idea to what you know the other person cares about. Say things like, *"I heard your remarks about health equity. I have an idea that may help you." "Here's something we can do that would help with the implementation of your organization's strategic plan."*

Adapted from "How to Speak So Leaders Will Listen" by IHI Senior Fellow Derek Feeley http://www.ihi.org/communities/blogs/how-to-speak-so-leaders-will-listen

What is your elevator pitch (continued)?

- **Appeal to humanity** — Engage on an emotional level. Tell a story about a program participant or a staff member who has been influenced by the problem you're trying to address or the change you're trying to make.
- **Be personable** — Research indicates that likability is one of the key characteristics of good influencers. Bring your best self to the conversation. Be authentic.

Adapted from "How to Speak So Leaders Will Listen" by IHI Senior Fellow Derek Feeley http://www.ihi.org/communities/blogs/how-to-speak-so-leaders-will-listen

Who Can Help You? Who Can Stop You?

Audience	Help?	Stop?	Allow?	What Matters to Them

Adapted from a grid designed by Christina Gunther-Murphy and Karen Baldoza, IHI

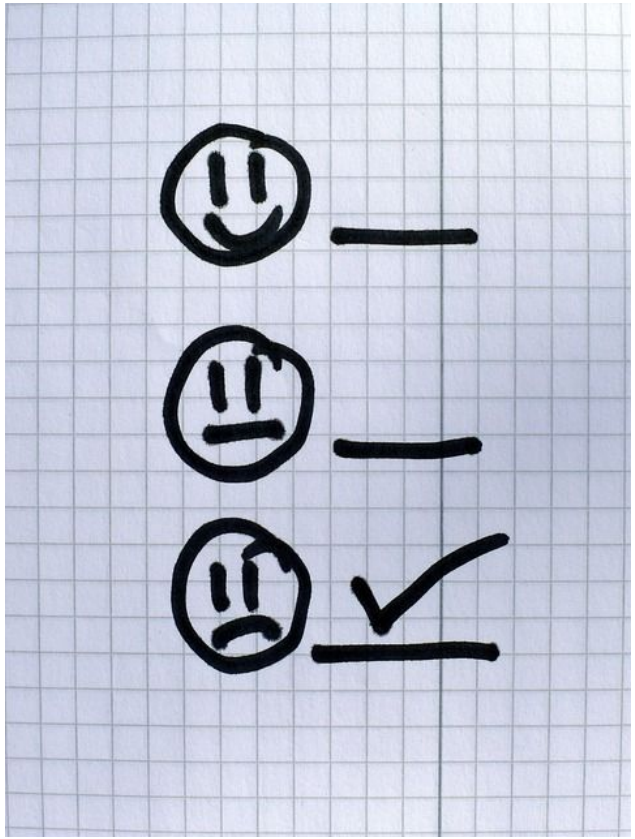
“Communications is an essential element of all improvement efforts.” - Don Berwick

https://www.youtube.com/watch?v=Vboa90s8jmg

Start Planning

Take a few minutes to write down your answers to these questions:

- Who do you need to engage?
- Who can help? Who can stop you? Who will be neutral?
- What are the compelling stories to tell? Who should tell them?
- What are the different messages your different audiences need to hear?
- Who would be a good messenger?



Questions?

Jo Ann Endo, MSW

Senior Managing Editor, Digital Content & Blog

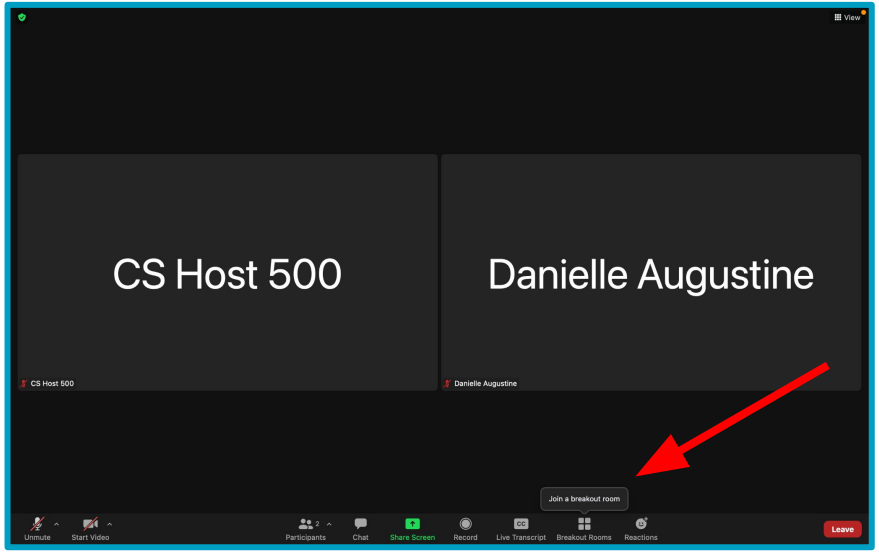
Institute for Healthcare Improvement

JEndo@IHI.org

Team time:
Crafting your Community Stories

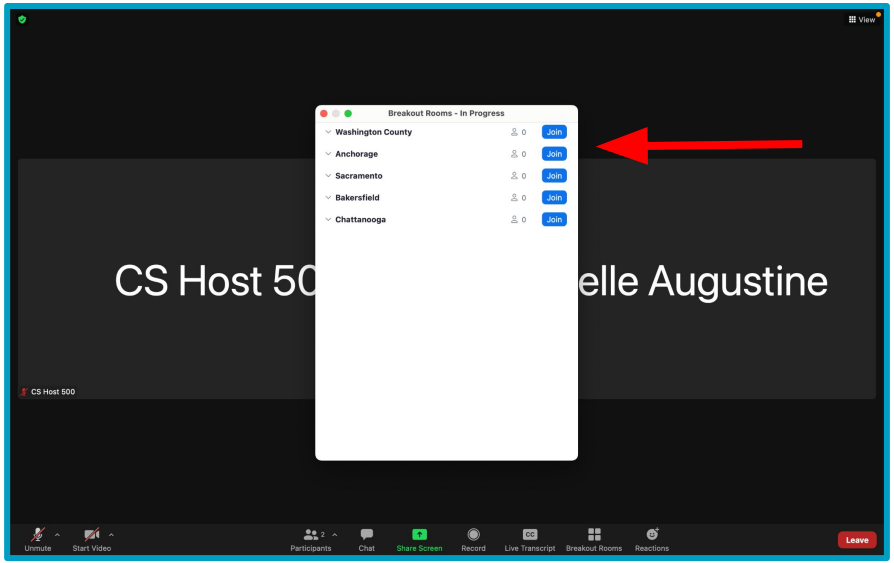
How to join breakout rooms

STEP 1



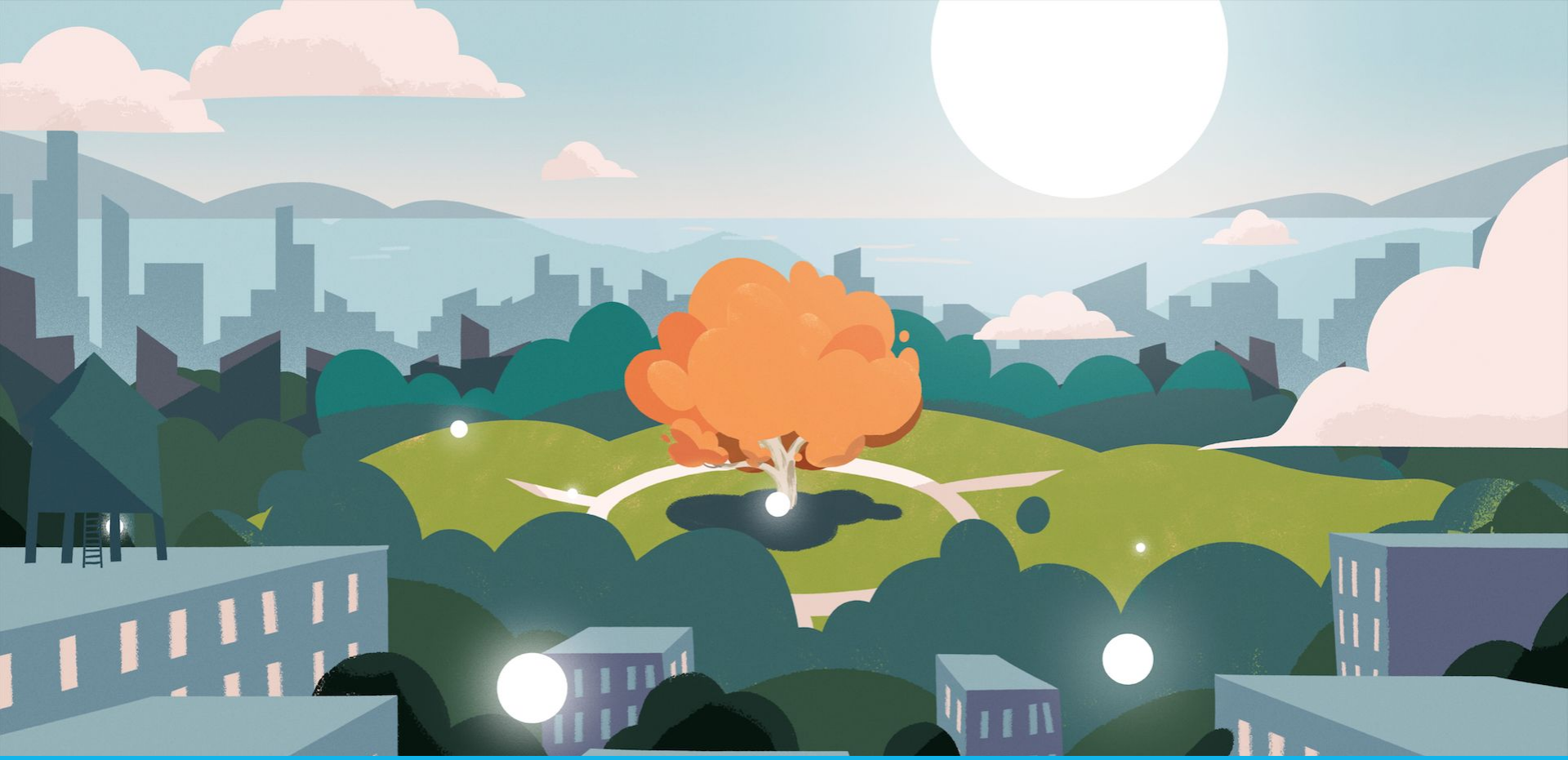
Click the **“Breakout Room”** button at the bottom

STEP 2



Click **“Join”** next to the breakout room of your choice

Group share-out: Sharing our stories



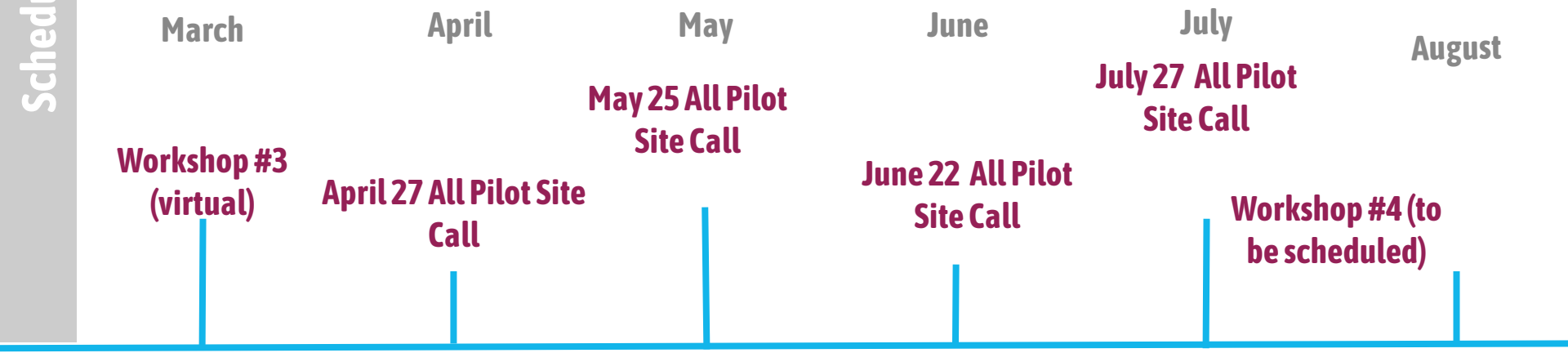
What to Expect in 2022

Looking Ahead: March Coaching Calls

Washington County	• March 9, 2022 (rescheduled Feb call) 12-1pm ET/9-10am PT • March 21, 2022 2-3:30pm ET 11am-12:30pm PT
Sacramento	• March 23, 2022 12-1:30pm ET / 9-10:30am PT
Anchorage	• March 24, 2022 2-3:30pm ET / 10am-11:30am AKST
Chattanooga	• March 28, 2022 12-1:30pm ET
Bakersfield	• March 28, 2022 1:30-3pm ET / 10:30am-12pm PT

Looking Ahead

Schedule



Action Period: March through Summer

As a Pilot Team....

Participate in Pilot Site Coaching Calls
Participate in All Pilot Site Monthly Calls
Revisit community level aim and project portfolio - do your projects get you to your aim? Does your aim account for a population level reduction in homelessness?
Continue testing projects in your portfolio
Take next steps on community communication plan
Prepare for Workshop 4

Wrap up - Please share in the chat...

In one word....how are you feeling right now?

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Wrap up - please share in the chat...

What is one action you plan on taking as a result of this workshop?

Thank You

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