The Yin And Yang: Translating State Health Reform Efforts Into Front Line Care And Learning From Practice-Level Experiences To Improve Policies

Colleen Reuland, MS
Director- Oregon Pediatric Improvement Partnership
Instructor – Department of Pediatrics
• Overview of the Oregon Pediatric Improvement Partnership model for supporting translation of policies into practice.

• Overview of efforts to ensure meaningful and relevant practice-level partnership and engagement with patients.

• Overview of efforts to ensure practice level inform policy-level improvements.

• Provide you with you real-world examples and “aha moments” from primary care practices in addressing key health reform priority areas.

• Provision of feasible, meaningful and actionable tools and strategies related to practice-level quality improvement and to address key component of medical home.
OPIP Mission

• OPIP is meant to create a meaningful, long term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

• OPIP is dedicated to building health and improving outcomes for children and youth by:
  1) Collaborating in quality measurement and improvement activities across the state;
  2) Supporting evidence-guided quality activities in clinical practices;
  3) Incorporating the patient and family voice into quality efforts; and
  4) Informing policies that support optimal health and development for all children and youth.
OPIPs Goal in Working with Practices to Improve Care: GET A STRIKE...or Knock out as many Pins as Possible
Tools in the Toolbox for QI Projects in Your “Home”

- Holding productive and effective meetings
- Using PDSA Cycles to test small changes
- Connecting with other practices
- Team concepts and Collaboration skills
- Workflow and process analysis
- Using data to inform change
- Understanding and addressing barriers to improvement
- Engaging Patients and Families in improvement efforts
- Developing action plans to meet improvement goals
- Understanding and implementing policies and related implications
- Attaining useful tools, resources, expertise

Support Toolbox

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Yin and Yang: Relationship with Policy and Front-Line Health Policies

Health Policies

Systems

Practices

Patients
Yin and Yang: Applied Examples

• Billing for 96110
  – Identified an inadvertent block of two 96110 claims (*allowing billing for a general and autism specific tool*)

• Patient Centered Primary Care Homes Standards
  – Submitted multiple memos to enhance focus on children, CYSHCN and address feasibility issues in practice

• Metrics and Scoring
  – OPIP’s Medical Director (RJ Gillespie) serves on the committee
  – Sig. number of measures focused on children

• Coordinated Care Organizations (Health Systems)
  – Submitted a memo on ensuring maternal and child health focus
  – Observed impact in targeted CCOS
Reform, Reform Everywhere!.... So what are YOU to do?
OPIP Work with Practices
Operationalizing Policy Level Reforms

• Kindergarten Readiness
  1. Developmental screening and follow-up for children identified at risk
  2. Developmental promotion for all children

• Medical home – Patient Centered Primary Care Homes
  3. Identify your population of children and youth with special health care needs (CYSHCN)
  4. Partner with families
  5. Care coordination

• Meaningful quality measurement and improvement
  6. Relevant and actionable use of patient experience of care survey
Elephant in the Room: Factors that Predict Practice Level Success in Quality Improvement

- Practice ability to provide and work in team-based models of care
- Culture of learning
- QI strategy – where are you going, why, and how?
- Quality improvement skills
- Time and resources to do QI
- Engagement of Patients as partners in QI
Tools to Address a Practice’s Capacity to do Quality Improvement

- Work in team-based models of care
- QI strategy – where are you going, why, and how
- Quality improvement skills
  - General IHI trainings
  - QI project planning tools available from OPIP
  - [https://projects.oregon-pip.org/resources/quality-improvement](https://projects.oregon-pip.org/resources/quality-improvement)
- Time and resources to do QI
  - Quality improvement advisory committee
  - QI team and paid time
- Engagement of Patients at Partners in QI
  - Parents on your advisory committees
  - Focus groups on topics you are focused within your QI team
  - Parents a partner on your QI team
  - [http://oregon-pip.org/resources/1_OPIP_ParentPartner_NIPN_12-20_FINAL.pdf](http://oregon-pip.org/resources/1_OPIP_ParentPartner_NIPN_12-20_FINAL.pdf)
  - [http://oregon-pip.org/resources/family_community.html](http://oregon-pip.org/resources/family_community.html)
Health Reform Related to Kindergarten Readiness:
Innovative Practice-Level Approaches
Kindergarten Readiness: Practice-Level Supports

• **Standardized and Routine Developmental screening**
  1. 9, 18, and 30 or 24 month visits use standardized tool
  2. Longitudinal surveillance at EVERY visit, by the five domains

  • **Tool**: Standardize developmental surveillance in well-child visit forms to focus on five domains of development; create an algorithm that addresses WHAT to do when a child isn’t meeting the milestone

  • **Tool**: Use of parental education and supports for developmental promotion
### Your Growing and Developing Child:

Please indicate whether your child is able to do the following tasks right now.

<table>
<thead>
<tr>
<th>Task</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your child hold her head steady when sitting with support?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your child roll over?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fine Motor:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Does your child grasp a rattle?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Does your child follow with her eyes from one side all the way to the other?</td>
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<td></td>
</tr>
<tr>
<td><strong>Social/Emotional:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does your child look at her own hand?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does your child like to cuddle?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does your child calm down on her own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive/Communicative:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Does your child laugh?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Does your child turn to a rattling sound?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
# EMR Based Forms for Developmental Surveillance

## DEVELOPMENTAL SURVEILLANCE: Donald Duck

### 15 MONTH DEVELOPMENTAL SURVEILLANCE MILESTONES

#### GENERAL:
- Do you have any concerns about your child’s learning, development or behavior? (Yes/No)

#### SOCIAL EMOTIONAL:
- Does your child wave bye-bye? (Yes/No)
- Does your child drink from a cup with very little spilling? (Yes/No)

#### COGNITIVE AND COMMUNICATIVE:
- Give parent ASQ-Communication learning activities
- Does your child speak 1 word? (Yes/No)
- Does your child speak 3 or more words? (Yes/No)

#### FINE MOTOR:
- Does your child put blocks in a cup? (Yes/No)
- Does your child scribble? (Yes/No)

#### GROSS MOTOR:
- Does your child walk well? (Yes/No)
- Does your child bend down without falling? (Yes/No)
- Is your child able to take steps backwards? (Yes/No)
Parent Education: ASQ Learning Activities

**Communication**

Activities to Help Your Toddler Grow and Learn

Your toddler is beginning to enjoy language and words. She has many new words now and is beginning to put two words together for simple sentences. She looks at you when you are talking to her, says “hi” and “bye,” and points to things she wants. She also enjoys singing and will try to imitate singing favorite songs.

**Chatter Stretchers**

Your toddler may use single words for requests, such as “juice” when he wants a drink. Help him stretch his sentence by saying it for him. (“Would you like some juice?” “Say, I want juice, please.”) Praise him when he attempts to make the sentence longer.

**What Happened Today?**

When you get home from an outing, ask your toddler to tell someone else about what happened or what the two of you saw. “Tell Grandpa about the horse we saw.” Help her if you need to, but let her tell as much as she can.

**“Help Me” Game**

Ask your toddler to help you by giving simple directions such as “Help Daddy. Can you get my shoes?” or “It’s time to change your diaper. Can you get in a diaper?” You may need to point with your finger to help him in the beginning. Be sure to say, “Thank you. You’re such a big help” when he helps.

**Animal Sounds**

Teach your toddler the sounds that animals such as cats, dogs, and cows make. Read books about baby animals, and play with your toddler by making the baby animal sounds. Later, pretend you are the animal’s parent and your toddler is the baby animal. Call each other with animal sounds. This game can be a lot of silly fun.

**Read, Read, Read**

Find times to “read” throughout the day. At this age, you can point to pictures and words and your child will begin to learn what words are about. At the grocery store, point to and read signs to your child. At a restaurant, let your child “read” a menu. At home, help her “read” magazines by looking at pictures.

**Junk Box**

Put together a junk box of safe, everyday items that are interesting to explore and feed. Examples of things to put in the box are plastic cups, a soft sock, a spoon from a detergent box, a sponge, and a small shoe. When your child pulls something out of the box, say, “Look, you found a soft blue sock,” or “That sponge is squishy.” Use new language for your child, and change items in the box every few days.

* Ages: 16–20 months
Kindergarten Readiness: Practice-Level Supports

• **Remember – the point of screening is NOT the screen**

• Point of screening is to identify children at risk and to ensure follow-up steps
  – Referring children identified at risk to Early Intervention and other services
  – Referring in a way that **you find out WHAT happened** with the referral and whether they got in
  – Tracking that referral and status of the referral
  – **Using information received** to **inform your primary care efforts**

Do not cite or reproduce content without appropriate citation.
Follow-Up Based on Developmental Screening Results: Innovative Strategies Used

- Use a referral form that addresses the HIPAA and FERPA issues so that you can hear back
  - Tool: Common referral form

- Ask for information that you can use to coordinate care
  - Tool: Evaluation Results
Follow-Up Based on Developmental Screening Results: Innovative Strategies Used

Tool: Evaluation Results

Are you the child’s Primary Care Physician (PCP)? Y ___ N ___ If not, please enter name of PCP if known: ________________________

I request the following information to include in the child’s health records:

☐ Evaluation Report ☐ Eligibility Statement ☐ Individual Family Service Plan (IFSP)

☒ Early Intervention/Early Childhood Special Education Brochure ☒ Evaluation Results
Follow-Up Based on Developmental Screening Results: Innovative Strategies Used

![Evaluation Form]

**EVALUATION RESULTS**

<table>
<thead>
<tr>
<th>Child:</th>
<th>DOB:</th>
<th>Site:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s):</td>
<td>Age:</td>
<td>District:</td>
</tr>
<tr>
<td>Address:</td>
<td>Phone:</td>
<td>Preschool:</td>
</tr>
<tr>
<td>Physician:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type of Evaluation:**

- Developmental Delay
- Regional Referral
- Hearing Screening

**Developmental Areas of Assessment**

<table>
<thead>
<tr>
<th>Code Key</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>$S$</td>
<td>$S$</td>
</tr>
<tr>
<td>Adaptive</td>
<td>$S$</td>
<td>$S$</td>
</tr>
<tr>
<td>Social</td>
<td>$S$</td>
<td>$S$</td>
</tr>
<tr>
<td>Communication</td>
<td>$S$</td>
<td>$S$</td>
</tr>
<tr>
<td>Motor</td>
<td>$S$</td>
<td>$S$</td>
</tr>
</tbody>
</table>

**Background & Referral Information**

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Follow-Up Based on Developmental Screening Results: Innovative Strategies Used

• Track referral and use external & internal resources to ensure the child & family receives supports and services
  – Up to 50% of children who FAILED screen in primary care and were referred to EI do NOT go
    • Non-white and non-English speaking more likely to NOT access services

Tools to Ensure Access of Services:
  – Follow-up with the family within 36 hours to encourage access of referral and answer questions
  – Implement a standardized methods and role within the practice for tracking a referral
  – For those children who do not access service, consider family and community-based supports
    • Children who fail standardized developmental screening tools like the ASQ are eligible to receive CaCoon Home Visiting Services
    • Use the CaCoon Referral Form to hear back from CaCoon
    • [http://www.ohsu.edu/xd/outreach/occyshn/projects/cacoon.cfm](http://www.ohsu.edu/xd/outreach/occyshn/projects/cacoon.cfm)
Health Reform Related to Medical Home/Patient Centered Primary Care Homes (PCPCH):

Innovative Practice-Level Approaches for Children and Youth
Lessons of the National Center for Medical Home Improvement and with OPIP Led Efforts

• If you do nothing else in becoming a medical home for children and youth, do this:
  1. **Identify your population** of children and youth with special health care needs in way that is based on the child/family needs – not condition specific
  2. Develop the capacity for **practice-based care coordination** and the use of SHARED care plans
  3. Gain **family participation/feedback**

Adapted from Carl Cooley’s presentation to the T-CHIC Annual Meeting, June 2012
Why worry about identifying CYSHCN?

- In order to improve care for CYSHCN...you have to know who they are.

- Identifying CYSHCN is different than identifying adults with special health care needs:
  - Chronic conditions vary considerably in severity, degree of impairment and service needs.
  - A complete condition list would be unwieldy and include many children who do not require special services.
  - A functional status approach would not capture children who function well but need special services to maintain function.
  - The inherent difficulties in measuring functioning of very young children and infants.
Tools: How Does a Practice Standardize Identification

- Three general techniques:
  1. Provider “gestalt”
  2. Running diagnostic codes
  3. Using a patient/parent completed tools to understand needs
     a) Consequences-based screener like the CYSHCN screener developed by the CAHMI
     b) Use other strength and risk based screening tools
        – E.g. Adolescent well-visit tool

- Most practices do a combination, depending on goals and purposes for identification

CSHCN Screener: 5 key consequences

Asks about 5 different health consequences:

1) Limited or prevented in ability to function
2) Prescription medication need/use
3) Specialized therapies (OT, PT, Speech)
4) Above routine use of medical care, mental health or other health services
5) Counseling or treatment for on-going emotional, behavioral or developmental problem

_______________________________________________________________________________

a) Due to medical, behavioral or other health condition

AND

b) Condition has lasted or is expected to last for at least 12 months
Adolescent Strengths and Risks Screening Tool: Maximizing the Adolescent Well Visit

**Name:**

**Date of Birth:**

**Date:**

1. Why did you come to the clinic today?
2. Do you have any concerns to discuss with the doctor today?
3. Who lives in your home?
4. Who do you talk to when things aren’t going well?
5. Have you ever been in counseling?
6. Are you in counseling now?
7. If yes, who are you seeing?

**School**

1. Are you in school? Yes No
2. If yes, what school?
3. What do you like most about school?
4. Compared to last year, are your grades the same better worse?
5. Have you ever cut classes, skipped school, been expelled, or been suspended?
6. What do you do after school?
7. Do you work? Yes No If yes, on average how many hours per week?

**Health Habits**

1. Have you seen a dentist in the last year? Yes No
2. How many times a week do you exercise? Yes No
3. What do you do for exercise?
4. Are you satisfied with the size or shape of your body, and your physical appearance? Yes No
5. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills, laxatives, or starving yourself? Yes No
6. Does anyone in your family drink or take drugs so much that it worries you? Yes No
7. Do you regularly use:
   a. Seatbelts?
   b. Helmets?
   c. Sunscreen?

**Personal Concerns**

(Check any items below which concern or trouble you)

- Stress at home
- Making Friends
- Anxiety or Nervousness
- Sleeping Problems
- Drug use
- Alcohol use
- Tobacco use
- Sexually intercourse
- Other

**Thoughts about Yourself**

1. If you had four wishes what would they be?
2. Is there anything about yourself or your life you would like to be different? Yes No

<table>
<thead>
<tr>
<th>Over the past 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Medical Home Strategy #2:
Practice-based Care Coordination and the
Use of SHARED care plans
Learnings about Care Coordination: Three Commandments

1. Thou Shalt Not Start First with Hiring a Care Coordinator

2. Thou Shalt FIRST Consider and Understand Care Coordination Functions and How They Will be Met Across the Practice (and possibly supported by a care coordinator)

3. Thou Shalt Do Shared Care Plans ONLY when ready (They are HARD!)
Care Coordination: A Framework

Figure 1. A Framework for High-Performing Pediatric Care Coordination

Care Coordination Definition:
Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.

Defining Characteristics of Care Coordination:
1. Patient- and family-centered
2. Proactive, planned, and comprehensive
3. Promotes self-care skills and independence
4. Emphasizes cross-organizational relationships

Care Coordination Competencies:
1. Develops partnerships
2. Communicates proficiently
3. Uses assessments for intervention
4. Is facile in care planning skills
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Takes an adaptable and flexible approach
8. Desires continuous learning
9. Applies team-building skills
10. Is adept with information technology

Care Coordination Functions:
1. Provides separate visits and care coordination interactions
2. Manages continuous communications
3. Completes/analyzes assessments
4. Develops care plans with families
5. Manages/tracks tests, referrals, and outcomes
6. Coaches patients/families
7. Integrates critical care information
8. Supports/facilitates care transitions
9. Facilitates team meetings
10. Uses health information technology

Source: Richard C. Antonelli, Jeanne W. McAllister, and Jill Popp
MAKING CARE COORDINATION A CRITICAL COMPONENT OF THE PEDIATRIC HEALTH SYSTEM: A MULTIDISCIPLINARY FRAMEWORK
May 2009

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Care Coordinators: FIVE Key Learnings from Practices

1. Given the functions of care coordination across the practice, what functions and roles live within the care coordinator
2. Identify the team-based roles and responsibilities across the practice with respect to the care coordinators
3. Develop a standardized way that children/youth will be sent to the care coordinator (e.g. tools provided for identifying CYSHCN). Ensure this approach is FAMILY-centered.
4. Develop a job description for the care coordinator
   Tool: Example job descriptions
   (https://projects.oregon-pip.org/resources/care-coordination/care-coordinator-job-descriptions)
5. Use patient/family completed tools that help the care coordinator and team know the child and family needs for care coordination
   Examples: (https://projects.oregon-pip.org/resources/care-coordination/pre-visit-calls-tools)
6. Ensure that care plans are SHARED care plans
   Examples: (https://projects.oregon-pip.org/resources/share-care-plans)
Aren’t we already doing shared care plans?

• Key differences between action plan and shared care plan:
  – Action plan is completed by a provider, shared care plan is co-written
  – Action plan has directions, shared care plan has patient-centered elements, most importantly patient goals (and steps to take to get to those goals), and barriers experienced by the patient
  – Shared care plan emphasizes the patient’s central role in managing their own health
FAMILY PROFESSIONAL PARTNERSHIPS
Maxims of Patient Centered Care

The needs of the patient come first

Nothing about me without me

Every patient is the only patient

Engaging families and/or youth

• In working with practices, this is difficult but meaningful in many ways

• Some ideas for how to engage families:
  – Recruiting families for QI teams or standing clinic committees
  – Focus Groups
    • Recruit a group of parents to discuss specific topics
    • Example: focus group to review service needs for CYSHCN
  – Parent Advisory Group
    • Can also be subject-specific, or have the agenda driven by the parents
  – Survey patients and families about their experience of care
    • Formal surveys
    • Shorter surveys of topics of interest
Overall lessons learned by practices

- Practices who have successfully engaged patients find their perspective invaluable
- Practice that created a focus group found out things they never knew about the challenges their patients face
  - Predominately Hispanic population...a culture where the word autism doesn’t exist and isn’t understood
- Providers tend to be reluctant to let patients “behind the veil” but learn a lot from the process
- Patients are not in it to be adversarial...but are very interested in helping make the practice better for everyone.
Health Reform Related to

Quality Measurement:

Innovative Practice-Level Use of
Patient Experience of Care Surveys
CAHPS, CAHPS Everywhere!
Is Data Used to Improve Care?

CAHPS-HP with the Children Chronic Conditions

CAHPS-Health Plan (HP)

CAHPS Clinician and Group (CG)

Emphasized in Oregon Medical Home Standards, Unstandardized Data Collection, Practices collecting data and doing nothing more

CAHPS CG-Patient-Centered Medical Home

Supported by CHIPRA Demonstration Grant for Practices, Q-CORP Effort, CMMI Grant

National CAHPS; CMS Adult and Child Quality Grants; State Sponsored; CCO Incentive Metric; Several CCOs also collecting through CPCI; Other Efforts

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Goal of the Health Reform Efforts:
Achieve the Triple Aim

Each survey represents the voice of one important person with a valid perspective.
Why Should A Front-line Health Care Provider Care About Patient Experience Of Care Surveys?

• What is measured is what is focused on
• Patient experience of care surveys provide unique and valuable information
  • For some aspects of quality care, the **patient report** is the **most reliable** and valid source of data (*as compared to claims data and chart reviews*)
• Increased priority for practices to routinely and systematically collect patient experience of care data, use the data to improve
  • Component of medical home certification processes
  • Conceptual component of provider-level Maintenance of Certification
Comparison of NCQA PCMH and CAHPS CG PCMH Related to Access

CAHPS CG PCMH After Hours Access

Q19. Usually or always able to get care needed from provider’s office during evenings, weekends, or holidays

- T-CHIC
- Oregon
- Practice #1
- Practice #2
- Practice #3
- Practice #4
- Practice #5
- Practice #6
- Practice #7
- Practice #8

0% 20% 40% 60% 80% 100%

NCQA PCMH Element 1B After-Hours Access

- T-CHIC
- Oregon
- Practice #1
- Practice #2
- Practice #3
- Practice #4
- Practice #5
- Practice #6
- Practice #7
- Practice #8

↑↓Statistically significantly higher/lower than State score.
Spotlight of OPIP’s Work with Bay Clinic Pediatrics on Patient Experience of Care:

• Patient experience of care
  – CAHPS CG PCMH (with CYSHN Screener)
  – Fielded for Two Months (July-September)

• Methods
  – Part of department strategy, clinic-wide/cultural commitment
    • Healthy competition between providers
  – Promotion (front desk, waiting rooms, exam rooms)
  – Administration
    • Web-based or paper versions (depending on patient preference) disseminated by PROVIDERS at all visits for a pre-determined interval (2 months)
    • In addition, surveys are being sent by mail to a subpopulation- CYSHN identified by gestalt for each provider

Do not cite or reproduce content without appropriate citation.
Spotlight of OPIP’s Work with Bay Clinic Pediatrics on Patient Experience of Care:

- **Patient-centered administration**
  - Mapped out process for administering in the office
  - Created survey administration materials
    - Posters for the parent
    - Scripts for office staff
    - Letters
    - Survey monkey version

- **QI Coaching**
  - Process for who how data will be reviewed
  - Process for how improvement opportunities
  - Levers to use with CCO

- **Analysis and reporting**
  - Feedback reports of data
PARENTS— We Need You

We want to PARTNER WITH YOU to GIVE THE BEST CARE possible.

Bay Clinic Pediatrics is committed to hearing from you!

Here is What You Can Expect:

1. After Your Child’s Visit: Give Us Feedback
   - By completing a confidential questionnaire at home about the health care your child received.
   - When: July-September
     The Pediatricians at Bay Clinic will give eligible children’s parents a survey.

2. Using Your Feedback: Bay Clinic Will Understand Where We Can Do Better
   - When: September-October
     We will review the summarized, confidential questionnaire results.

3. Share Results, Work to Improve
   - We will share what we learned from your feedback and areas where we will aim to improve. Let us know if you want to help us on our improvement project.
   - When: October-November
     We will share with families at Bay Clinic Pediatrics the results of our questionnaire and information about how we will be working to improve.

THANK YOU IN ADVANCE FOR PARTNERING WITH US.

Do not cite or reproduce content without appropriate citation.
Dear Parent or Guardian,

I am personally inviting you to take a few minutes to complete a survey about your child’s care. The results from this survey will help me understand where we can partner to better meet your child’s needs and provide the best care possible.

Your partnership and feedback is important to me.

Please go to: https://www.surveymonkey.com/s/BayClinic to complete the survey.

- Your Participation is voluntary and your responses are kept confidential. You will not be asked for your name or your child’s name.
- Bay Clinic will use the survey results to identify what we can do better.
- If you prefer to fill out a paper-based version of the survey, please ask the front desk at today’s visit and we can give you one that you can mail back, or call (541) 269-0333 ext. 400.

Thank you for help.
Sincerely,

Jon Yost, MD
Leveraging the CAHPS CG PMCH to Enhance Patient Engaging in Quality Improvement: Examples from OPIP’s Medical Home Learning Collaboratives

• **Medical Home/ Quality Improvement Advisory Groups**
  - Patient representation on the groups
  - Shared the data and asked for feedback about what it means

• **Group-level meeting with Patients to Get their Feedback**
  - Practices held group-level meetings with patients to share the findings and get their insights on improvement opportunities

• **Public Displays of Data**
  - Posters displaying the data at check in, hallways to the exam room, in the exam room
  - Website and Facebook website
Final Thoughts

If you do nothing else...

1. Develop and clarify your practice ability to change
   – Develop a thoughtful improvement team and structure
   – Know that QI work is never done
   – Measures are part of the improvement cycle

2. Start small.
   One small change can and will make a big difference.
   – Consider one (not many) of the strategies I provided that worked with other practices
   – Start with a group of early adopters.
Resources:

1. Join the OPIP “QI for Kids Homies” Listserv
   • As our current learning collaboratives wind down, we are creating listserv for practices doing QI to ask each other questions

2. If you have a care coordinator, have him/her join the care coordinator listserv if they meet the requirements

3. Go the links provided and check out the tools

4. OPIP website: oregon-pip.org

5. Email me if you can find something or have question: reulandc@ohsu.edu