PART 1

CP3 Population Health Management Training

Comprehensive Track, In-Person Learning Session 1
Thursday, July 21, 2016 from 8:00am-4:30pm
Waterfront Hotel, 10 Washington St., Oakland, CA 94607
Today’s Faculty

Tammy Fisher, Program Director, CCI

Carolyn Shepherd, Clinical Director

Ben Grossman-Kahn, Co-Founder & Principal, Catalyz

Megan O’Brien, Program Manager, CCI
Moving Towards Value Based Care
Starts with Strategy

Care redesign/transformation
- Establishing a sense of urgency
- Anchor the new changes in culture

Financial efficiency
- Creating a guided coalition
- Consolidate gains and produce more change

Technology
- Develop and vision for strategy for the specific change
- Generate short term wins

Engaged leadership
- Empower the employees for action

Learning organization

Source: John Kotter Framework for Change
Today’s Focus
<table>
<thead>
<tr>
<th>Organization</th>
<th>Region</th>
<th>Anticipated Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>CommuniCare Health Centers</td>
<td>Sacramento Valley</td>
<td>Davis Community Clinic</td>
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<tr>
<td>LifeLong Medical Care</td>
<td>East Bay</td>
<td>West Berkeley Family Practice</td>
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<td>LifeLong Howard Daniel</td>
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<td>Monterey County Clinic</td>
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<td>Alisal Health Center</td>
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<td>Services</td>
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<td>Seaside Family Health Center</td>
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<td>Monterey County Health Clinic at Marina</td>
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<td>Laurel Family Practice Clinic</td>
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<td>Laurel Internal Medicine Clinic</td>
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<td>Laurel Vista Clinic</td>
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<td>OLE Health</td>
<td>Sonoma</td>
<td>Pear Tree Lane</td>
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<td>Potentially 2 more sites</td>
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<td>Ravenswood Family Health</td>
<td>East Palo Alto</td>
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<td>San Mateo Medical Center</td>
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<td>Fair Oaks Health Center (Redwood City)</td>
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<td>Daly City Health Center</td>
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<td>San Mateo Health Center (39th Ave)</td>
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<td>Tiburcio Vasquez Health</td>
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<td>Union City</td>
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<td>Venice Family Clinic</td>
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<td>Robert Levine Family Health Center</td>
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<td>Sirims/Mann Health and Wellness</td>
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<td>North River</td>
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<td>Vale Terrace</td>
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Icebreaker

- **Introduce** yourself
- **Examine** the object at the center of your table
- **Briefly describe** what you would use the item for at home
- **Pass it** to someone else at the table

*Think outside of the box!*
Leading Change: One FQHC’s Example of Directing Teams to High Performing Roles and Functions to Manage Populations Health

Carolyn Shepherd, M.D., former Chief Medical Officer, Clinica Family Health Services
Clinica Family Health Services

2015
50,000 Patients (2000-10,000)
220,000 Ambulatory visits
6 Clinical sites (2000-3)
Clinica Family Health Services

• Patient = key member of Team Based Care model
• Patient = focus for our vision, strategies and tactics
• 50% uninsured
• 40% Medicaid until 1/1/2014
• 56% < Poverty
• 98% < 200% of poverty
• 60% prefer to speak in a language other than English
Clinica Family Health Services

• 470 Staff

• Providers
  – 46 physical health providers
  – 16 behavioral health providers
  – 8 dental providers
  – 14 nurse-providers

• 6 Sites
  – 5 family medicine clinics + MHC
  – Winter clinic in the Homeless Shelter
  – 2 full pharmacies, 3 dental clinics
  – Admit to 2 community hospitals, faculty at FM Residency
Clinica Team Based Care Today

- Continuity
- Team Based Care
- Access
- Alternative Visits
- Patient Engagement
- IT Support
  - In-reach
  - Outreach
  - Performance Improvement

It’s all about the healing relationship with the patient
Clinica Family Health Services
Clinica Family Health Services

2014 UDS Data Comparison

- Clinica
- Colorado CHCs
- National CHCs

[Bar chart showing data comparison across various categories for Clinica, Colorado CHCs, and National CHCs.]
Goals & Aims

Goal: Success in APM | Aims: High Value Health Care & Joy in Practice

Quadruple Aim
- Better Outcomes
- Better Experience
- Lower Costs
- Joy in Work

Value Based Payment
- Better Outcomes
- Better Experience
- Lower Costs
- Joy in Work
Clinica Family Health Services

NCQA PCMH Level 3
2010/2013

NCQA Diabetes
2011/2014

Joint Commission
Accredited since 2002

Nominated by staff, awarded:
2012/13/14/15/16
Activity: Improving A1c

Order the importance of these functions in improving A1c for your patients...

- Continuous Quality Improvement
- Electronic Patient Registry
- Team Based Care
- Patient Education
- Case Management
- Self-Management
- Clinician Education
- Clinician Reminders
- Patient Reminders
- Measuring and Sharing Outcomes
- Information Sharing (HIE)
Value Based Care - Diabetes

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<td>3</td>
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How do we get there?

CEPC

Bodenheimer, Tom et al
2014 10 Building blocks of high performing primary care
*Ann Fam Med* 166-171
How do we get there?

RWJF LEAP Project
How do we get there?
Comprehensive track areas of focus

Team Based Care
Teamwork & Task work

Planned Care
Prepared Team Activated Patient

Population Management
Identify & Segment Populations Patient Outreach
How do we get there?

Population Management
- Identify & Segment Populations
- Patient Outreach

Planned Care

Team Based Care
- Teamwork & Task work

1. Engaged leadership
2. Data-driven improvement
3. Empowerment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive- ness and care coordination
10. Template of the future
## Clinica Template of the Future

### Time Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care clinician (MD, NP, PA)</th>
<th>Medical Assistant 1</th>
<th>Case Mgmt RN</th>
<th>Primary care clinician</th>
<th>Medical Assistant 2</th>
<th>Front Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td></td>
<td></td>
<td></td>
<td><strong>Huddle</strong></td>
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<tr>
<td>8:10</td>
<td><strong>E-visits &amp; phone visits</strong></td>
<td><strong>Portal mgmt &amp; phone f/u</strong></td>
<td><strong>RN Care management</strong></td>
<td><strong>Acute Patients</strong></td>
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<tr>
<td>8:30</td>
<td><strong>Complex patient</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td><strong>Complex patient</strong></td>
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<tr>
<td>9:30</td>
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<tr>
<td>10:00</td>
<td><strong>Coordinate with hospitalists and specialists</strong></td>
<td><strong>BP coaching clinic</strong></td>
<td><strong>Huddle with MD, NP, RN</strong></td>
<td><strong>E-visits &amp; phone visits</strong></td>
<td><strong>Prep for afternoon group visits</strong></td>
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<tr>
<td>10:30</td>
<td><strong>Huddle with MDs, RN, NP</strong></td>
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</table>

- **Clinica Template of the Future**

- **Huddle**
  - **E-visits & phone visits**
  - **Portal mgmt & phone f/u**
  - **RN Care management**
  - **Acute Patients**
  - **Complex patient**
  - **Complex patient**
  - **Coordinate with hospitalists and specialists**
  - **BP coaching clinic**
  - **Huddle with MD, NP, RN**
  - **Greet pts. and use pt. centered registry for planned care outreach**

**• 30 patients are seen or contacted in the first 3 hours of the day**
Access to Care

TRIMESTER AT ENTRY FOR PRENATAL CARE

- % 3rd Trimester
- % 2nd Trimester
- % 1st Trimester

Laying the Groundwork: Sharing & Strengthening AIM Statements

Tammy Fisher, Senior Director, CCI
“Sometimes you get a lot of ideas flowing and it is hard to stay on track.”
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Source: Associates in Process Improvement.
Characteristics of Strong Aims

- Provides rationale/context for importance of project
- **Focused:** Sets a clear goal to focus the team
- **Measurable:** Can develop clear measures to track progress toward aim; have data to do so!
- **Time specific:** Establishes time frame
- Defines patient population
- Addresses the right problem

- Meaningful
- Compelling
Internal Alignment

To help our patients and communities we serve be healthy

To be the most highly regarded health center in CA

Strategic Plan

3-5 year focus areas

High value health care – triple aim

High performing team

Financial viability

SMART aims (larger org-wide aims)

Expand provider capacity to take care of more patients; approximately 500 more lives per 1.0 FTE provider

Aims

1...

2...

3...

1- year SMART aims

Develop and test workflows for doing telephone visits at one site

Mini Aims

1...

2...

3...

Aims

1...

2...

3...

Mini Aims

1...

2...

3...
Defining the Problem (Opportunity)

• What are we trying to make better?
• What are our problems and the root cause of the problem?
  – 5 Why’s

• Describe the opportunity.
  – Aim statement
The 5 Why’s

CHANGE PACKAGE: REDUCING INAPPROPRIATE USE OF THE EMERGENCY DEPARTMENT

GET READY

- Build will and infrastructure for improvement
  - Secure senior management buy-in
  - Form an interdisciplinary improvement team

GET SET

- Use data to identify key drivers of ED use
  - Identify variation, opportunities for improvement, and establish goals
  - Validate sources for variation by soliciting input from physicians and patients
  - Identify key changes to reduce inappropriate use of the ED

GO!

- Test and adapt improvements to fit your environment
  - Offer financial incentives to physicians who see patients after business hours and on weekends
  - Open urgent care clinics after business hours and on weekends
  - Educate patients on alternatives to the ED for non-emergent conditions
A Tale of a CA Independent Physician Association

• Reduce unnecessary use of the ED
• Changes/solutions
  – Focus on frequent flyers
  – Provide data to clinicians with a high volume of patients that had unnecessary visits
  – Explore setting up urgent care clinic
• What happened?
  – Little to no movement in avoidable ED rate
Let’s try one together...

• Volunteer?
Define Your Problem

• You have 10 minutes in your team
• Describe your problem:
  – *who, where, and how much?*

🎯 Select one aim statement
• Use the **5 Why’s** to identify the root cause of your aim
• Group report out: Share insights
Group Exercise (15 minutes)

• Get together with 2 other teams (3 teams/group)
• Remember, introduce yourself
• Share your draft aims via storyboard, 5 minutes, including Q/A
  • What problem (s) are you addressing?
  • What are your aims?
  • What would you change about your aim, given new learning?
• All group report out: any insights?
  Use post its: likes and suggestions
High-Performing Teams
Introductions
Team Check-In

High Energy

High Mood

Low Mood

Low Energy

1 2 3 4
Question of the Day

What is your favorite guilty pleasure TV show to watch?
today

- Leveraging Individual Strengths
- Working as Teams vs Groups
- Team Norms
- Communication
Creating Teams
Generations
“As work-life expectancy...expands we may find ourselves still employed at 75...There could be as many as seven different generations at work at a time...”

Rawn Shah, Forbes

In millions

Note: Annual averages plotted 1995-2014. For 2015 the first quarter average of 2015 is shown. Due to data limitations, Silent generation is overestimated from 2008-2015.

PEW RESEARCH CENTER
“Generational thinking is like the Tower of Babel: it only serves to divide us. Why not focus on the behaviors that can unite us?”

Thomas Koulopoulos & Dan Keldsen
"The Gen Z Effect: The six forces shaping the future of business"
Models for Teams
Hackman 5 Factor Model

Real Team

Compelling Direction

Enabling Structure

Supportive Context

Competent Coaching

Richard Hackman, Professor of Social & Organizational Psychology, Harvard
Model for Team Effectiveness

1. Psychological Safety
   Team members feel safe to take risks and be vulnerable in front of each other.

2. Dependability
   Team members get things done on time and meet Google's high bar for excellence.

3. Structure & Clarity
   Team members have clear roles, plans, and goals.

4. Meaning
   Work is personally important to team members.

5. Impact
   Team members think their work matters and creates change.

Google
1. Psychological Safety
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Individuals
“When team members first come together, the most pressing piece of business is to get oriented to one another and to the task.”

Richard Hackman, Ruth Wageman, Colin Fisher

“Leading teams when the time is right”
T Shaped People

Breadth of Knowledge

Depth of Expertise
Exercise

Fill out the T-Shape for yourself.

Put a star next to any of your deep T skills you feel you are NOT currently leveraging in your current role.
Exercise

Pair up with someone else from your team, and share your T shapes with each other.
Teams
## What Defines Teams?

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>TEAMS</th>
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<tbody>
<tr>
<td>Members work on a common goal</td>
<td>Members are fully committed to common purpose and operationalized performance goals that they developed</td>
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<tr>
<td>Work rules &amp; roles may not be clear</td>
<td>Clear work rules and roles – e.g., collaborative norms, inquiry norms</td>
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<tr>
<td>Members accountable to manager</td>
<td>Members accountable to each other via mutual ongoing feedback</td>
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<tr>
<td>Low trust (or distrust) may predominate</td>
<td>High trust and mutual support</td>
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<tr>
<td>Leadership is assigned to one person</td>
<td>Leadership is shared</td>
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<tr>
<td>Members accomplish their goals individually; outputs are additive</td>
<td>Member cooperation is essential, team outputs result from synergy</td>
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</tbody>
</table>
Exercise

What are all the things we could do to ensure a team would NOT be successful?
Exercise

Put a star next to any actions you think may be showing up in some manner in your organization.
Team Norms & Working Agreements

- Honoring other voices
- Declare conflicts of interest
- Get to the point
- Remember the whole
- Keep time agreements
- Honor confidentiality
- Honesty/transparency/disclosure
- Have fun
Exercise

Develop a list of 4-6 working agreements/team norms that might help prevent the activities or behaviors you identified in the TRIZ exercise.
“Guidelines like these are great when they are drive and reflect behavior, but when they are consistently violated, they are worse than having no guidelines at all because the stench of hypocrisy fills the air”

Bob Sutton, Stanford
Team Guidelines from a new Boss
Communication
“According to our data, it’s as true for humans as for bees: How we communicate turns out to be the most important predictor of team success, and as important as all other factors combined, including intelligence, personality, skill, and content of discussions. The old adage that it’s not what you say, but how you say it, turns out to be mathematically correct.”

Alex “Sandy” Pentland, Entrepreneurship Program Director, MIT Media Lab
Giving Feedback
Attitude vs Behavior
Coaching & Giving Feedback
There are simply no known physical or mental illnesses that cannot be better treated with compassion than without. And, when hospital staff are supported in expressing their natural compassion, speaking the truth, and articulating feelings and needs, the quality of care will- and does- skyrocket.”

Melanie Sears, Humanizing Health Care
Task Work: Strengthening Roles, Functions, and Integration for Managing Population Health

Carolyn Shepherd, M.D., former VP of Clinical Services, Clinica Family Health Services
How Do We Get There?

Population Management
- Identify & Segment Populations
- Patient Outreach

Planned Care
- Prepared Team
- Activated Patient

Team Based Care
- Teamwork & Task work

- 1 Engaged leadership
- 2 Data-driven improvement
- 3 Empanelment
- 4 Team-based care
- 5 Patient-team partnership
- 6 Population management
- 7 Continuity of care
- 8 Prompt access to care
- 9 Comprehensive-ness and care coordination
- 10 Template of the future
Value Based Care-Diabetes

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Leveraging Team Based Care

Team Based Care: Task Work

Build the Care Team

Do the Work
Build the Care Team

1. Identify organizational leadership for teams and start building a team culture

2. Develop a core care team structure or structures
   - What are the needs of our patients?
   - Start with what you have
   - Consider what you can add
   - TEST IT
   - Reduce variation.
LEAP Primary Care Team

How are you dealing with care team variation?
3. Develop clear roles and responsibilities for every member of the team

- Work at the top of the skillset and credentials
- Expand the roles of additional staff members
- Research state policies regarding licensure and scope of practice
- Partner with union personnel.
4. Encourage and enable staff to work independently.
   - Develop standard work processes for the delivery of common services
   - Maximize the use of standing orders

How are you using standing orders?
Standing Orders: Lessons Learned at Clinica

• Start by picking non-controversial protocols such as nurse treating head lice, front desk ordering mammograms for women over 50, MAs giving vaccines due or clinical pharmacist adjusting insulin.

• Test several PDSA cycles of a standing order template that works for your team. Assure all the protocols then follow the same template. This makes it easier for staff to find what they need quickly.

• It is very important to assure provider buy-in by reviewing these protocols carefully with provider staff. Get agreement that the evidence supports the protocol and teams will follow the protocol.

• Pay attention to providers who have resistance. Address their issues openly with the team.

• Include whether co-sign is required or if optional, when it’s recommended. This is often a strategy to get acceptance from reluctant providers. A similar strategy is to include PEER audits of complex protocol visits.

• Provider team needs to agree that if a problem develops, providers need to contact clinical leadership directly, not the staff person assigned in the protocol to do the work. It is a performance issue if a provider sabotages the established process.

• Attend to the Nursing Board requirements. For example, in Oregon where “diagnosing” is an issue, make the protocols “symptom specific”-dysuria rather than UTI, sore throat rather than Strep pharyngitis, etc.
Standing Orders: Lessons Learned at Clinica

- Include **when to ask for more help in the protocol.** This explicitly empowers staff to seek help. Suggest symptoms that might indicate another diagnosis or warning signs.
- **Demonstrate documentation and billing in your EHR in the protocol.** This helps to decreased variation and assure that the data is entered so it can be collected for clinical measures.
- Plan for **ad hoc updates**, such as when the antibiotics change for treatment of lower GU GC, need to remove the quinolones and leave only the cephalosporin regimens. This could be done by a nurse, or a clinical pharmacist, or a provider.
- **Assure an annual review and update of the protocol.** It was too big a task to do them all at once. We put them on a calendar through the year. This could be great work for providers or nurses on FMLA who want some hours.
- **Re-train staff after the review,** including all staff on the team. This can be a brief 5 minute conversation during a team huddle. It is good for the front office, the CMAs, nurses and providers to all receive the review training. This will decrease confusion, sabotage, and variation in care and informs staff about nursing role. This is an opportunity for “team talk”, what the team can provide to the patient.
- **Handing off work is hard for providers.** **Clinical leader needs to encourage and support providers** to let the process work and to stay out of the way.
Build the Care Team

5. Engage patients as a member of the care team and help them understand what they can expect in a team-based model of care.
   - Help patients understand what to expect in a team-based care model
   - Develop simple scripting that reinforces the model

How are you doing this?

http://cepc.ucsf.edu/engaging-patients-improving-care-video
6. Provide team members with regular, dedicated time
   – Meet about patient care and quality improvement
   – Facilitate strong team relationships

*How many minutes per week do you spend in meeting time with team? (Include huddles)*
Build the Care Team

7. Provide training so that staff members learn new tasks and how to coordinate with team members.
   - Staff members learn new tasks
   - Team members learn how to coordinate care delivery

*Shared training is critical-all teach, all learn.*

*What is working for you?*
Build the Care Team

8. Develop career ladders for staff
   – Recruitment
   – Retention
   – Justice.
Table Top Exercise-10 minutes:

1. Draw a picture of who is on your care team.

2. What are you best at? What is the most challenging?
   - Team culture
   - Team structure
   - Clear roles and responsibilities
   - Staff work independently
   - Patients are part of the team
   - Teams have regular dedicated time
   - Continuous training
   - Career ladders to support new skills

3. Draft Pick: who would you add next?
Clinica

Core Team
- 3 In-clinic FTE of Clinician MD, NP, PA
- 3.5 MAs
- 2 Nurses
- 1 Behavioral Health Professional
- 2 Front Office Technicians
- 1 Medical Records Technician
- 1 Case Manager

Extended Team
PDP, Dental Hygienist, Nutritionist, PharmD, Call Center Attendant, Financial Screener, Home visit nurse, Home visit case manager

Affiliated Team
Psychiatrist, Ophthalmologist

Draft Pick: (1).5 FTE PharmD every team; (2) Scribing solution (MAs), (3) Substance abuse counselor
1. Assess performance.
   - Evaluate practice systems and ability to execute key functions with ambulatory guide assessments such as PCMH-A, BBPCA or PCTGA.
Determinants and consequences of employee attributions of corporate social responsibility as substantive or symbolic

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Substantive CSR
Symbolic CSR
Employee attitudes
Employee behaviors

\textbf{A B S T R A C T}

Interest in corporate social responsibility (CSR) has grown beyond traditional macro-level research to also consider employee-level outcomes of CSR. This nascent stream has focused on the relationship between organizational CSR initiatives and employee outcomes within the organization. Distinguishing between substantive and symbolic CSR (i.e., genuine CSR vs. greenwashing), we argue that to understand employee outcomes requires identifying their underlying attributions of their organizations’ CSR initiatives and the process by which these differential attributions are formed. Integrating theorizing and findings from the organizational behavior, marketing, and strategy literature, we propose a model of employee attribution formation of organizational CSR initiatives as substantive versus symbolic to differentiate the positive outcomes to organizations when causally evaluated as engaging in substantive CSR, from the null or possibly negative employee outcomes when these initiatives are attributed as symbolic. Implications for practice and applications to management are also discussed.

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Do the Work

2. Build effective core teams.
   – Plan for reassessment of core team
   – Build relationship with the patient
   – Include resources and time.
3. Use rapid cycle tests of change to evaluate process changes
   – Improving key functions is complex disruptive change management
   – Be rigorous about applying improvement science

How do you assure organizational learning from your PDSA cycles?
Clinica PDSA Database

PDSA Database

Cycle for Learning and Improvement

Sort by site
- Admin
- Lafayette
- Pecos
- People’s
- Thornton
- All Clinics

Sort by category
- Adv. Access
- Billing
- Call Center
- Clinical
- Dental
- Group Visit
- PDSA w/incomplete act section
- PDSA w/incomplete study section
- Completed PDSA
- ECS
- Finance
- Financial Screening
- Front Desk
- Group Visit
- Other
- HR
- Medication/Pharm
- Master Planning/Scheduling
- IT
- Work/Patient Flow

Add New PDSA
View all PDSA entries

CCI CENTER FOR CASE INNOVATIONS
4. Make new or improved functions standard work and sustainable.
   – Leadership critical
   – Dismantle old systems
   – Incorporate change in training, HR, pay structure.
Do the Work: LEAP Work Modules

- Planned Care
- Care Management
- Medication Management
- Referral Management
- Enhancing Access
- Self-Management Support
- Population Management
- Behavioral Health Integration
- Communication Management
- Clinic-Community Connections
Population Management

Population management helps improve performance by enabling practices to proactively reach out to patients needing care, rather than waiting for them to call or come in.

1. Link each patient to a specific practice team and provider.
   - Before a practice can begin managing patient populations, it must assign each patient to a specific provider and/or team who is responsible for their care. This is sometimes called “empowerment.” A major benefit of empowerment is that it clarifies clinical accountability. Population management should reinforce continuity of relationships and care, and it is often performed, at least in part, by the MA within a core practice team.
   - [View Resources]

2. Decide which patient populations and which data elements to track.
   - After enacting processes, the next step is to identify the patient groups the practice wishes to manage. Most electronic health records (EHRs) can generate patient model registries—lists of patients who share certain characteristics, paired with key data elements relevant to their condition and care. Some EHRs can also produce exception reports—lists of patients needing a service.
   - Since registries essentially use the same data that are the basis for performance measures, the process of selecting who to manage and what to measure is linked. For example, to measure mammography performance one needs the result and date of each woman’s last mammogram. This is the same information needed to identify women who are due for another mammogram or whose follow-up is also important to track, thinking about assessing the quality and completeness of the data before the practice will need to act on it.
   - [View Resources]

3. Select and train population management staff.
   - LEAP sites implement population management in many different ways. Some sites use centralized staff to review registries and send exception reports to practice teams. Others make time for front office staff, MAs, and nurses working with individual provider’s review registries (or exception reports based on registered, identify patients needing services, and call them. Calling patients as they tell them they need more care can be frightening if not done well, so it’s helpful to provide staff with training and scripts.
   - [View Resources]

4. Develop criteria that specify when to take action.
   - For each population and data element, the practice must decide on the criteria for action. For example, the practice wants to provide better follow up for patients with uncontrolled hypertension; it must specify what it means to be out of control (e.g., blood pressure higher than 140/90) and beyond the optimal range for follow up (e.g., see visit more than six months ago).

Helpful Resource:
improvingprimarycare.org
Testing Teamwork and Task Work at your FQHC

Tammy Fisher, Senior Director, CCI

PART 4
Idea Generation:
How Might We Statements...

• Problems:
  – 3NA is 30 days for new patients;
  – Panels will increase due to capitation, adding patients that we don’t know about
  – Patients experience transportation issues leading to no shows
  – There aren’t enough appointment slots to see all of these patients!

• Aim:
  – Develop and test alternative touches to increase access by touching 50 patients per day by April 30, 2017

How might we achieve our aim?
# Brainstorm Ideas: 1-2-4 All

What ideas do you have for accomplishing your aim?

<table>
<thead>
<tr>
<th>1 minute</th>
<th>By yourself</th>
<th>• Write ideas on stickies.</th>
</tr>
</thead>
</table>
| 2 minutes| Pair up with 1 other person in your team | • Share and build on ideas.  
• Write new ideas on stickies. |
| 4 minutes| Get into a foursome | • Share and develop ideas.  
• Are there similarities, differences?  
• Write them on stickies. |

*Put all stickies on flip chart paper by team.*
Concrete

Conceptual
Prototype or “Just Test It”

• **Prototype**
  – When developing a new solution
  – When prototypes require less resources relative to the actual solution/change
  – When the **cost of failure** is high

• **Just test it**
  – When adapting an existing solution/change that doesn’t require a lot of resources and/or disruption
Small Scale Testing

- **PDSA**

  - **Plan**
    - Select a technique
    - Write down your assumptions
    - Identify partners
    - Keep it small!

  - **Do**
    - Carry out the test
    - Collect information
    - It should take minutes, hours, days, not weeks!

  - **Act**
    - What changes are to be made?
    - Next cycle?
    - Test under different circumstances

  - **Check/Study**
    - What did you hear, observe, learn?

- **Rapid experimentation**
  1. Write out your idea/solution
  2. Write out your key assumptions
  3. Brainstorm possible ways to test it
  4. Select one experiment you can test fast
  5. Put your experiment in the real world
  6. Reflect on what you learn and “build” or “abandon”
Team Time!

1. Identify a PDSA to try tomorrow
2. Try it out
3. Share what you learned with your team & coach
4. Reveal your story during monthly swap meet
Immediate Next Steps

1. Finalize aims with coach
2. Begin/continue engagement & communication about project
3. Do and document PDSAs
4. Share experiences on September swap meet
Leading Change
Warm Up
Switch
Technical vs Adaptive Change
## Technical vs Adaptive

<table>
<thead>
<tr>
<th>Technical</th>
<th>Adaptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly Defined Problem</td>
<td>Not clearly defined problem. Requires learning</td>
</tr>
<tr>
<td>Clear and known solution. Have all information required, goal is to optimize execution.</td>
<td>Solution unknown- requires learning, experimentation and gathering more information</td>
</tr>
<tr>
<td>Evokes a rational and logical response.</td>
<td>Evokes an emotional response- people may avoid or struggle to deal with this</td>
</tr>
<tr>
<td>Uses existing processes, practices, behaviors</td>
<td>Challenges existing processes, practices and behaviors</td>
</tr>
<tr>
<td>Led with authority- leaders can tell people what to do and are responsible for solution.</td>
<td>Requires engaging stakeholders and bringing them along- solution resides within them.</td>
</tr>
</tbody>
</table>
Leading adaptive change is about disappointing people at a rate that they can tolerate.

People don’t fear change, they fear loss.
People don’t want to buy a quarter-inch drill. They want a quarter-inch hole!
WIIFM

Find a partner

Pitch them on making a change required by your experiment plan-phrase in a way that shows value from provider/medical perspective

Make the pitch again, but this time, frame it as a WIIFM-reframe in a way that shows value and benefit to the stakeholder/patient.
Power of 20%
Car Wash A

HALF GOT THIS

Collect 10 Stamps, get 1 FREE Car Wash
Terms & Conditions
This offer can not be used in conjunction with any other offers.

Car Wash B

THE OTHER HALF GOT THIS

Collect 10 Stamps, get 1 FREE Car Wash
Terms & Conditions
This offer can not be used in conjunction with any other offers.
Endowed Progress Helps mitigate the following issues

Too Hard to Start Something New

Fear of doing the wrong thing

Paralysis of the Blank Page
Brainstorm:

How might you provide stakeholders with a sense of “endowed progress”?

How might you remove barriers to completing the first few tasks?
Thank you!

Ben Grossman-Kahn
ben@catalyz.io
650.269.4515
What’s Next?

Onsite sessions

Coaching & Content experts

Technical webinars

Swap meets

Resource website

Site visits
## Program Timeline

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>May</td>
<td>Pre-work virtual meeting 5/26</td>
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<tr>
<td>June</td>
<td>Onsite #1: Change Mgmt., Aims, Team Care 7/21</td>
</tr>
<tr>
<td>July</td>
<td>Onsite #2: Team Care Planned Care 9/21</td>
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<tr>
<td>Aug</td>
<td>Onsite #3: Planned Care Pop. Health Mgmt. 11/17</td>
</tr>
<tr>
<td>Sept</td>
<td>Onsite #4: Pop. Health Mgmt. (date TBD)</td>
</tr>
<tr>
<td>Oct</td>
<td>Monthly Coaching Calls (up to 6 hrs/mo per organization, across participating sites)</td>
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<tr>
<td>Nov</td>
<td>Monthly “Swap Meets” (expected to attend if you are a presenter or reactor)</td>
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<tr>
<td>Dec</td>
<td>Curbside Consults with faculty (expert office hours)</td>
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<tr>
<td>Jan</td>
<td>Technical Webinar: Teamwork 6/30</td>
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<tr>
<td>Feb</td>
<td>Site visits</td>
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<tr>
<td>Mar</td>
<td>Technical Webinar</td>
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<td>Submit monthly report template to CCI</td>
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<td>Core Activities</td>
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</table>

### Expected Core Activities
- Expected to participate in 1 learning session and 2 swap meets
CONTACT INFORMATION

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• Megan O’Brien: mobrien@careinnovations.org

THANK YOU!