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CENTER FOR CARE INNOVATIONS

PART 1

CP3 Population Health Management Training

blue of california foundation

California Health Care Foundation

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

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

Carolyn Shepherd, Clinical Director

Megan O'Brien, Program Manager, CCI


Care Delivery Transformation

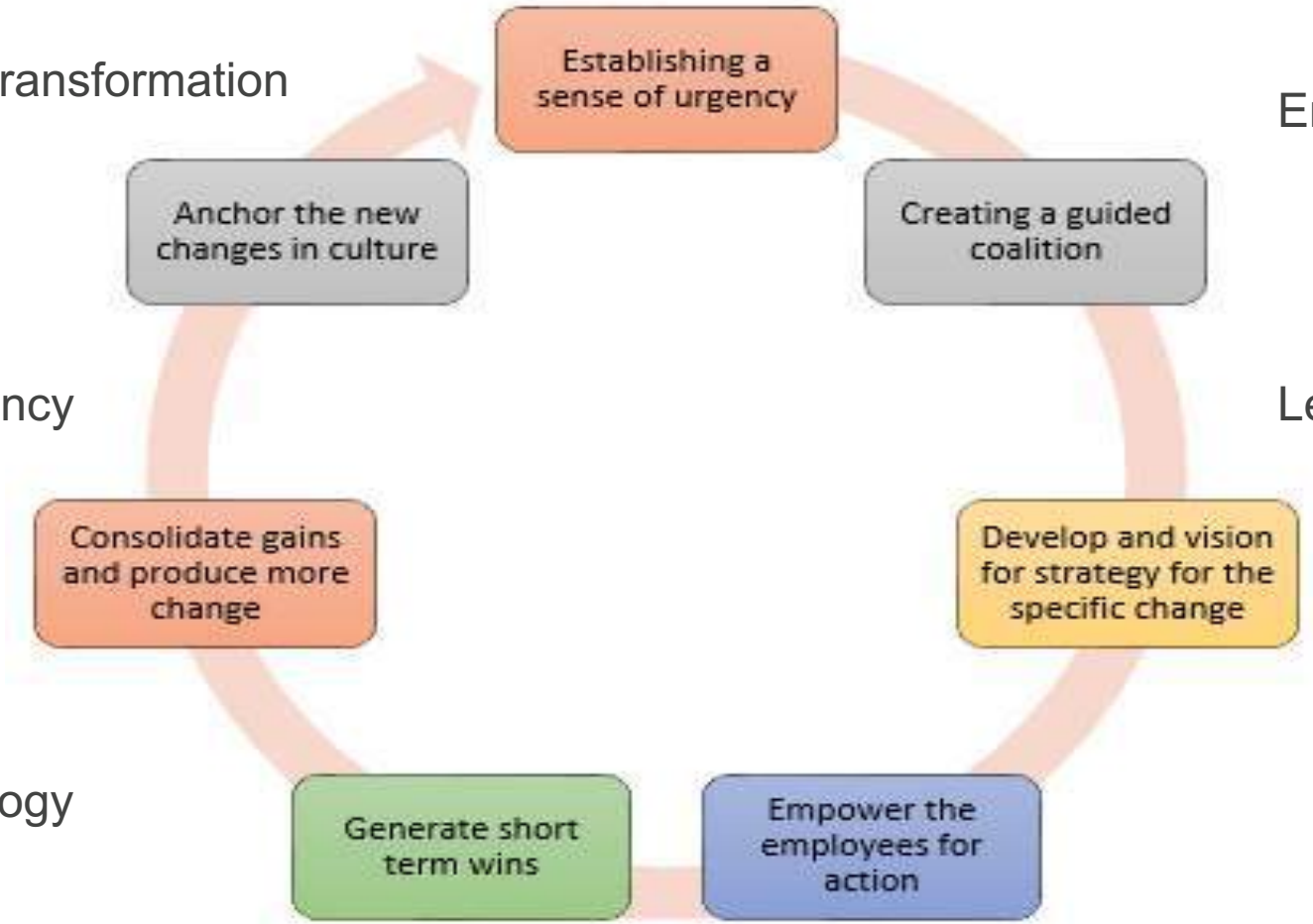
Moving Towards Value Based Care

Starts with Strategy

Care redesign/transformation

Financial efficiency

Technology

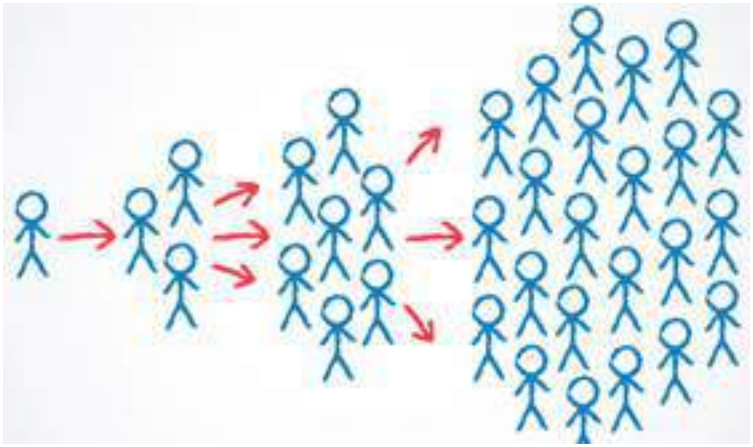


Engaged leadership

Learning organization

Source: John Kotter Framework for Change

Today's Focus



Prototype
Small tests

Pilot

Spread

Scale

Organization	Region	Anticipated Sites
CommuniCare Health Centers	Sacramento Valley	Davis Community Clinic
LifeLong Medical Care	East Bay	West Berkeley Family Practice LifeLong East Oakland LifeLong Downtown Oakland Over 60 Health LifeLong Howard Daniel Ashby Health Center
Monterey County Clinic Services	Monterey	Alisal Health Center Seaside Family Health Center Monterey County Health Clinic at Marina Laurel Family Practice Clinic Laurel Pediatric Clinic Laurel Internal Medicine Clinic Laurel Vista Clinic
OLE Health	Sonoma	Pear Tree Lane Potentially 2 more sites
Ravenswood Family Health Center	East Palo Alto	Ravenswood Health Center
San Mateo Medical Center	San Mateo	Fair Oaks Health Center (Redwood City) Daly City Health Center South San Francisco Health Center Coastside Health Center (Half Moon Bay) San Mateo Health Center (39th Ave)
Tiburcio Vasquez Health Center	East Bay	Union City
Venice Family Clinic	Los Angeles	Colen Family Health Center Robert Levine Family Health Center Milken Medical Building- 604 Rose Simms/Mann Health and Wellness
Vista Community Clinic	Northern San Diego	Horne Pier View Grapevine North River Vale Terrace

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9

Organizations

31+

Sites

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!

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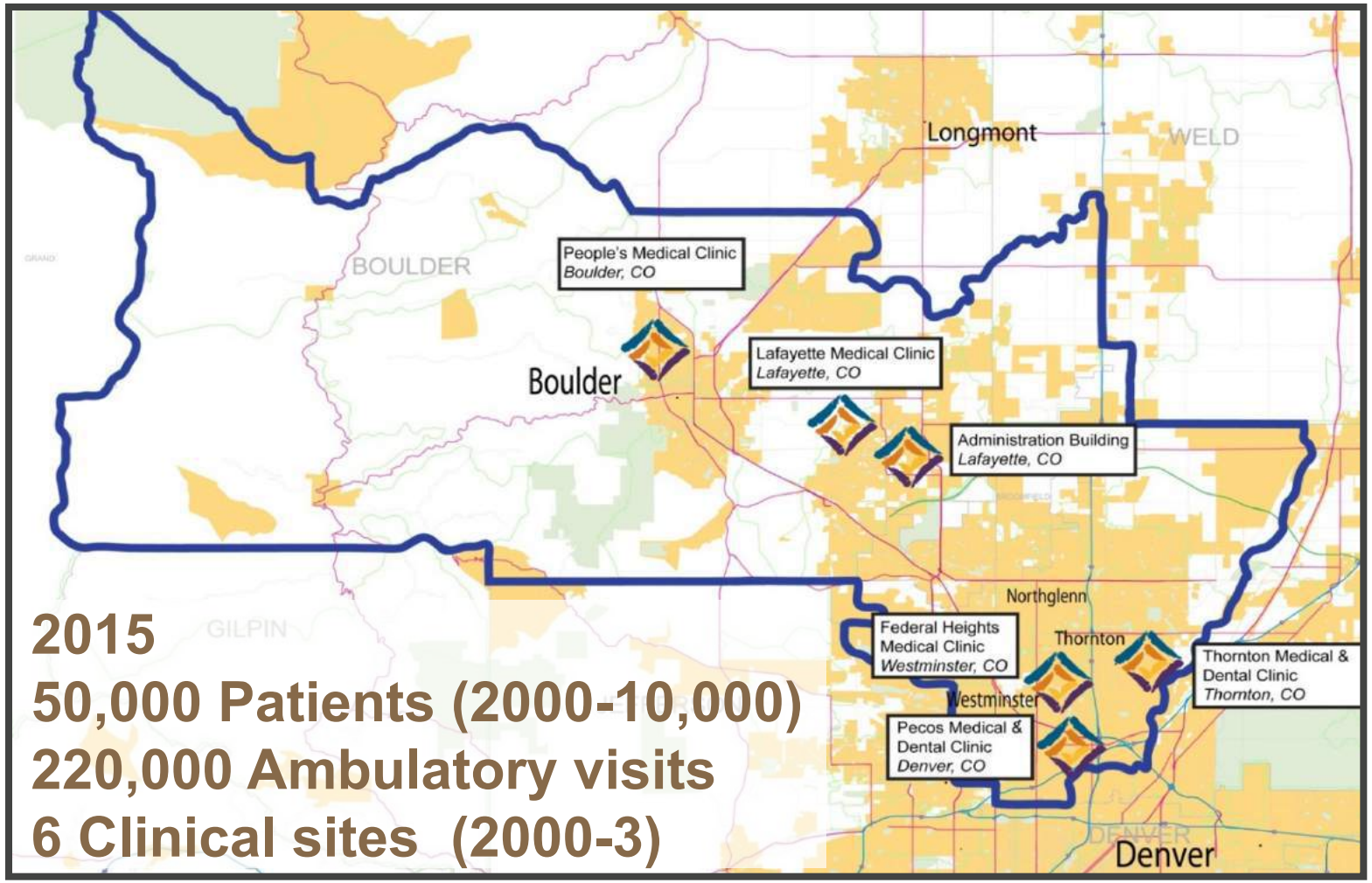
Leading Change: One FQHC's Example of Directing Teams to High Performing Roles and Functions to Manage Populations Health

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

Clinica Family Health Services



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

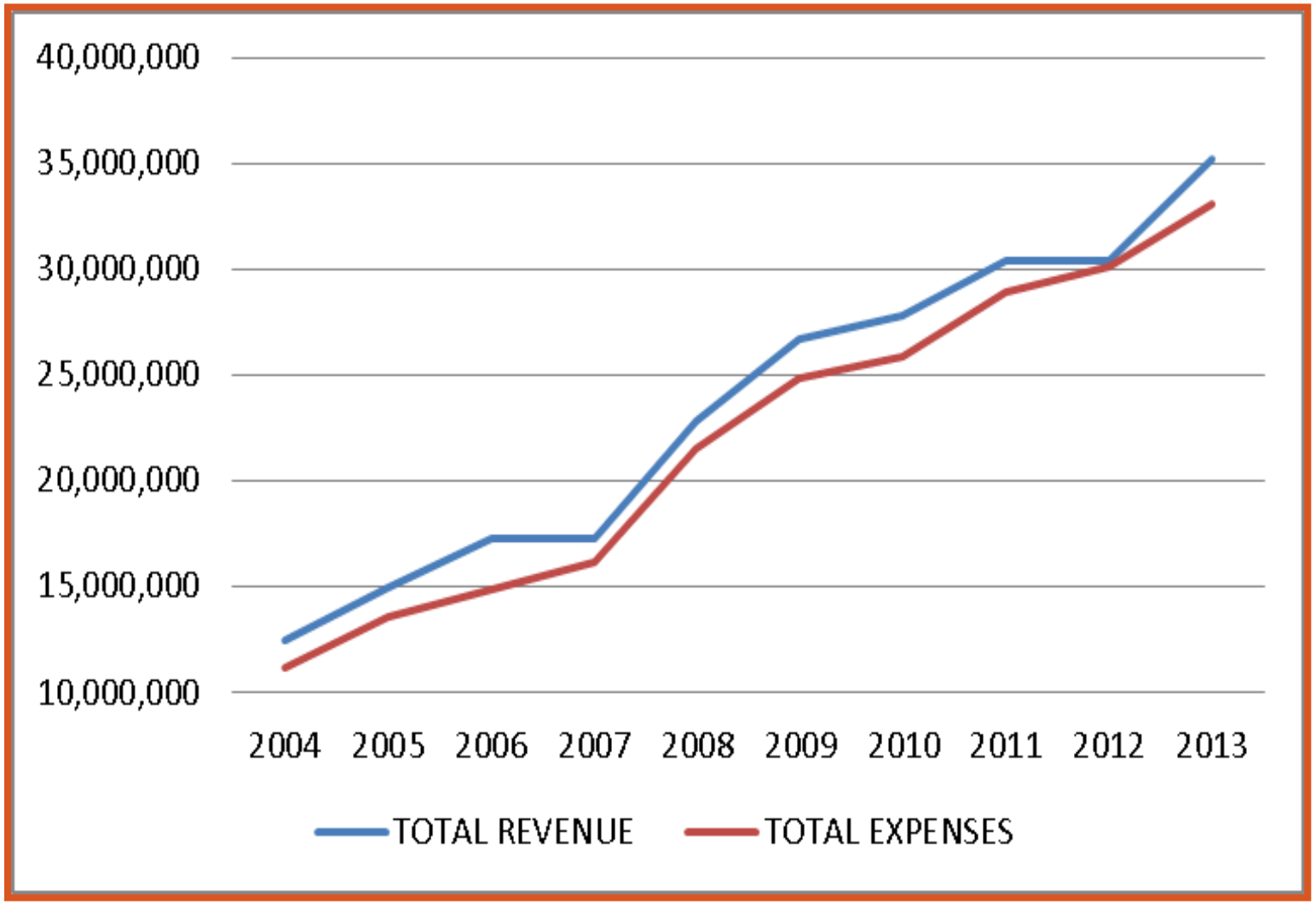
- 470 Staff
- Providers
  - 46 physical health providers
  - 16 behavioral health providers
  - 8 dental providers
  - 14 nurse-providers
- 6 Sites
  - 5 family medicine clinics + MHC
  - Winter clinic in the Homeless Shelter
  - 2 full pharmacies, 3 dental clinics
  - Admit to 2 community hospitals, faculty at FM Residency

Clinica Team Based Care Today

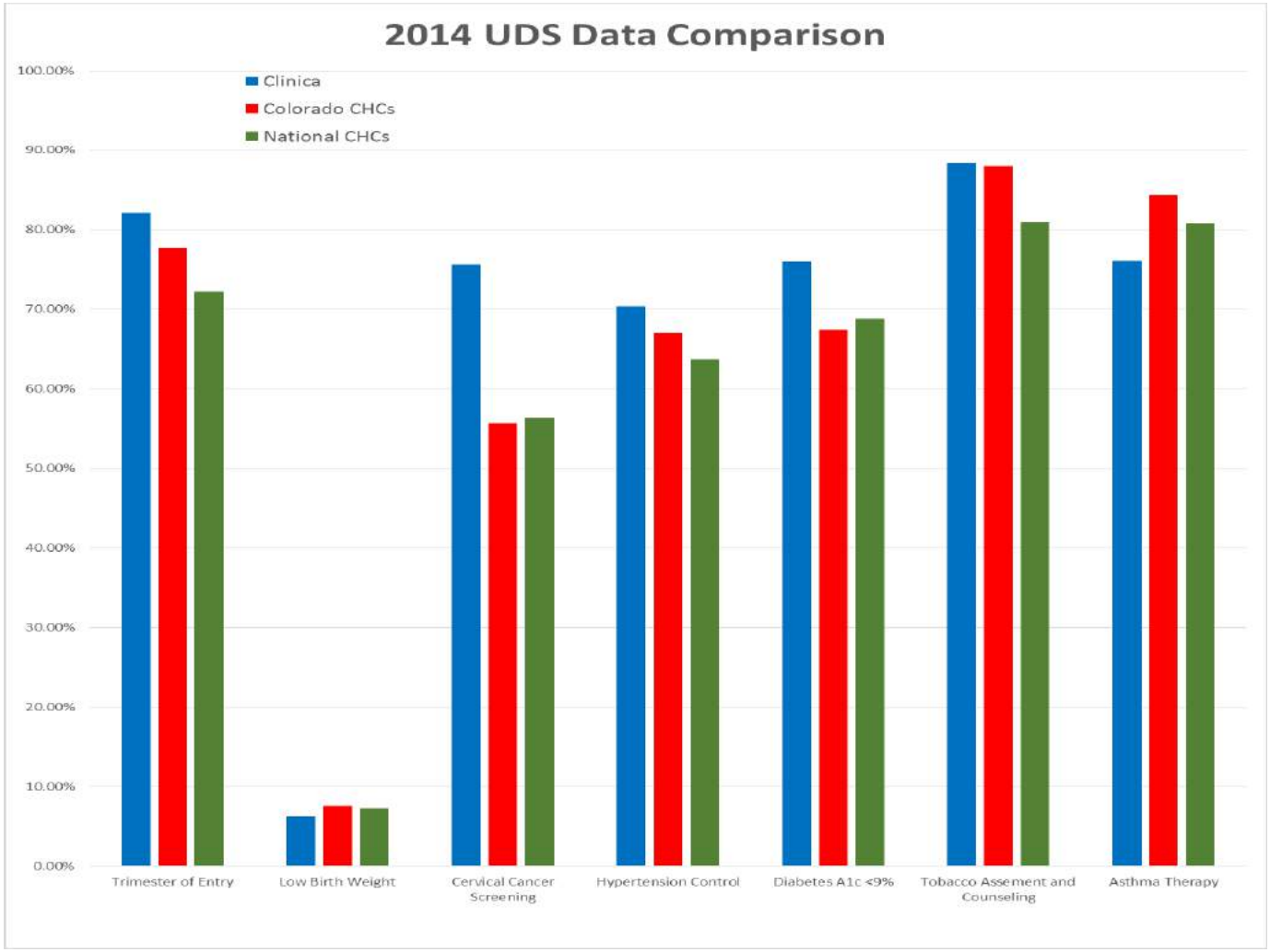
- Continuity
- Team Based Care
- Access
- Alternative Visits
- Patient Engagement
- IT Support
  - In-reach
  - Outreach
  - Performance Improvement

It's all about the healing relationship with the patient

Clinica Family Health Services



Clinica Family Health Services



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

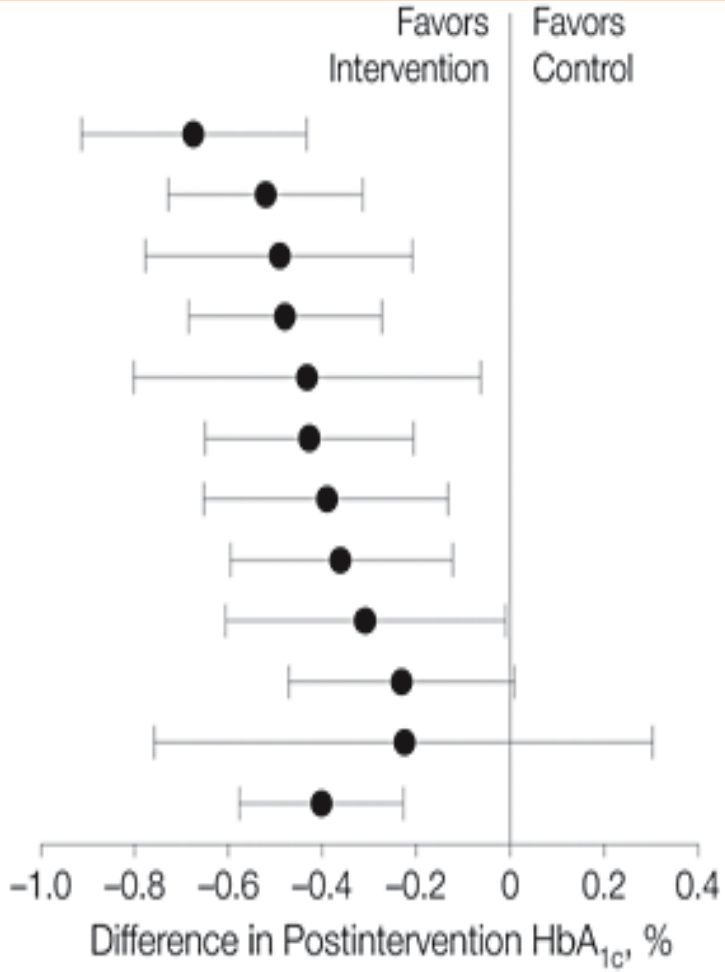
Activity: Improving A1c

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

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

Value Based Care-Diabetes

Quality Improvement Strategy	No. of Trials
Team Changes	26
Case Management	26
Patient Reminders	14
Patient Education	38
Electronic Patient Registry	8
Clinician Education	20
Facilitated Relay of Clinical Information	15
Self-Management	20
Audit and Feedback	9
Clinician Reminders	18
Continuous Quality Improvement	3
All Interventions	66



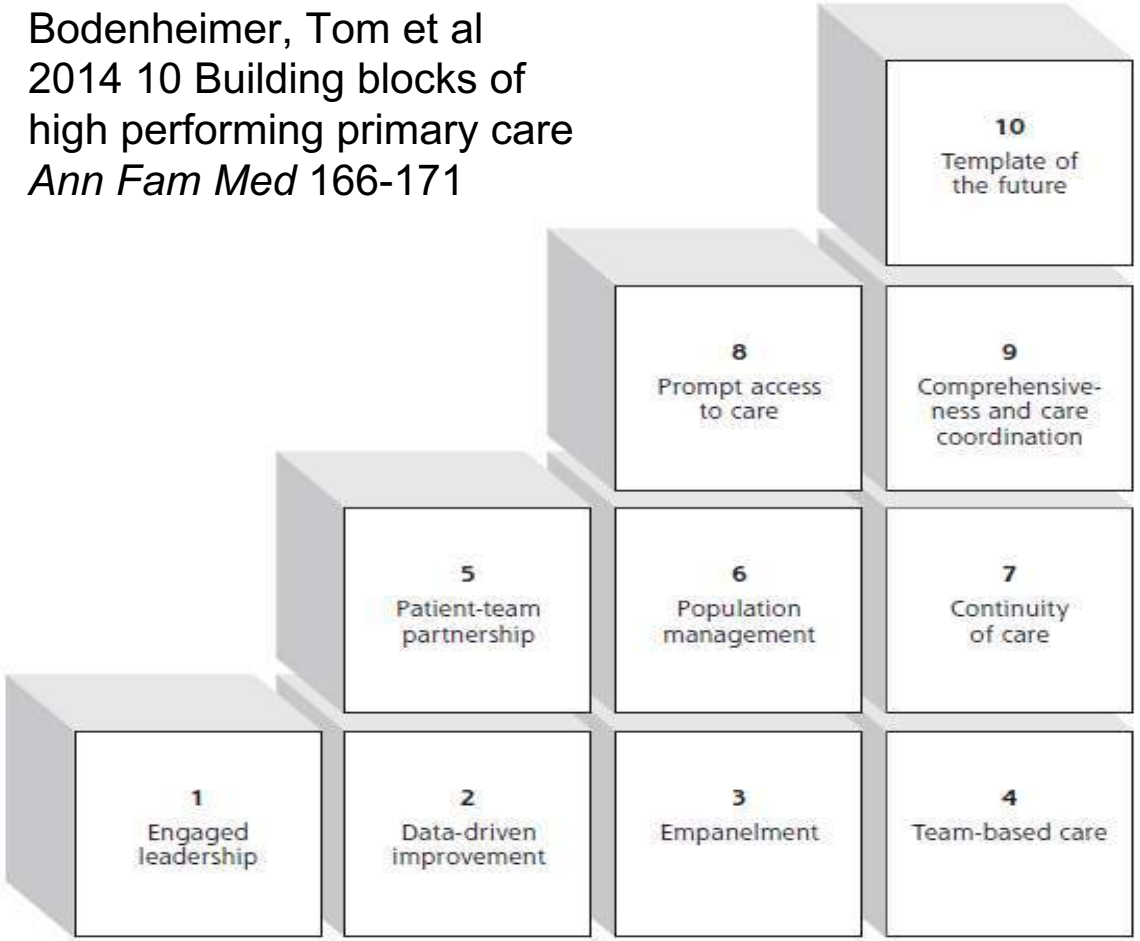
Shojania, K. G. et al. JAMA 2006;296:427-440.

How do we get there?

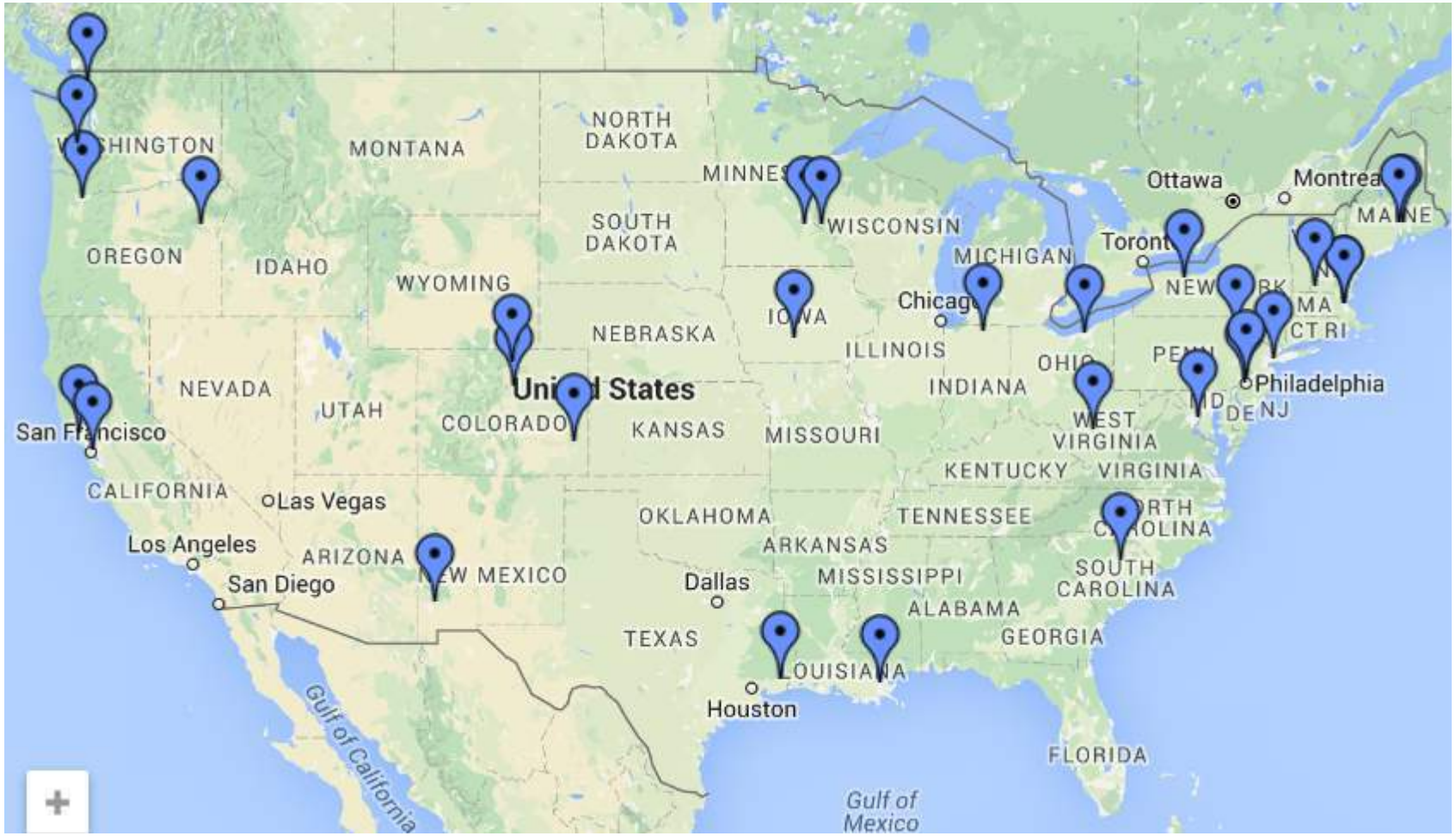
CEPC

Figure 1. Ten Building blocks of high-performing primary care.

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

How do we get there?

Population Management

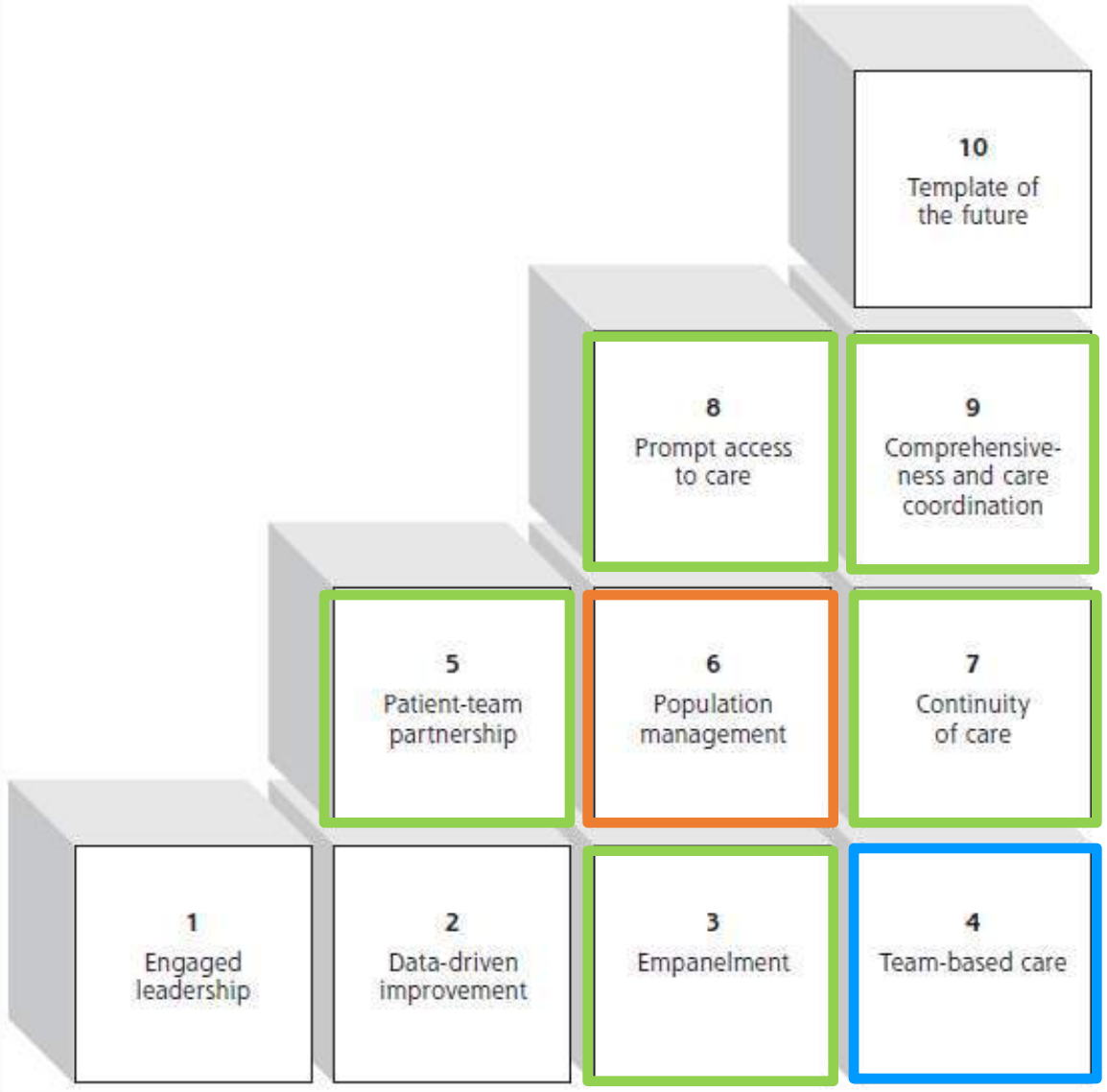
Identify & Segment Populations
Patient Outreach

Planned Care

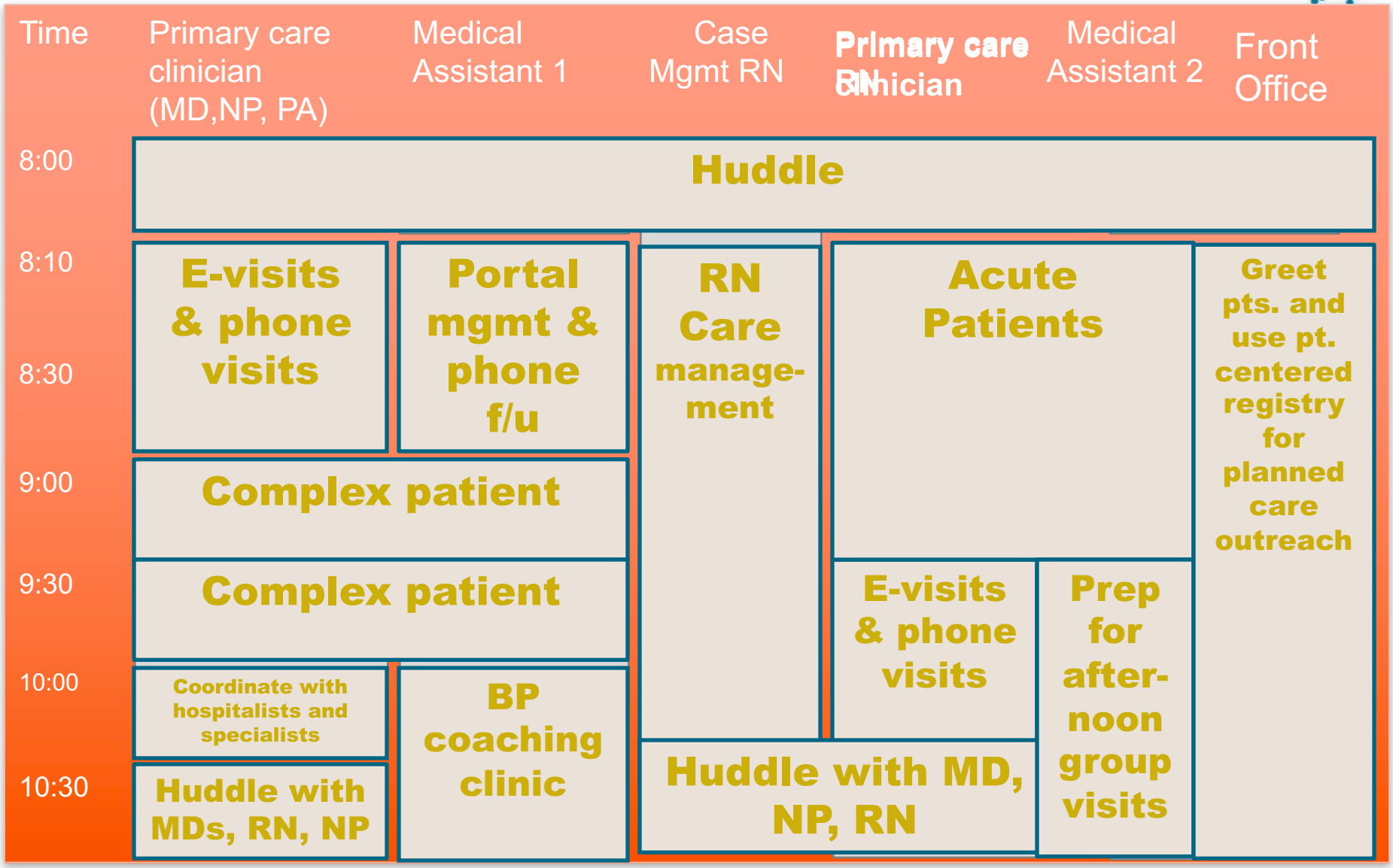
Prepared Team
Activated Patient

Team Based Care

Teamwork &
Task work

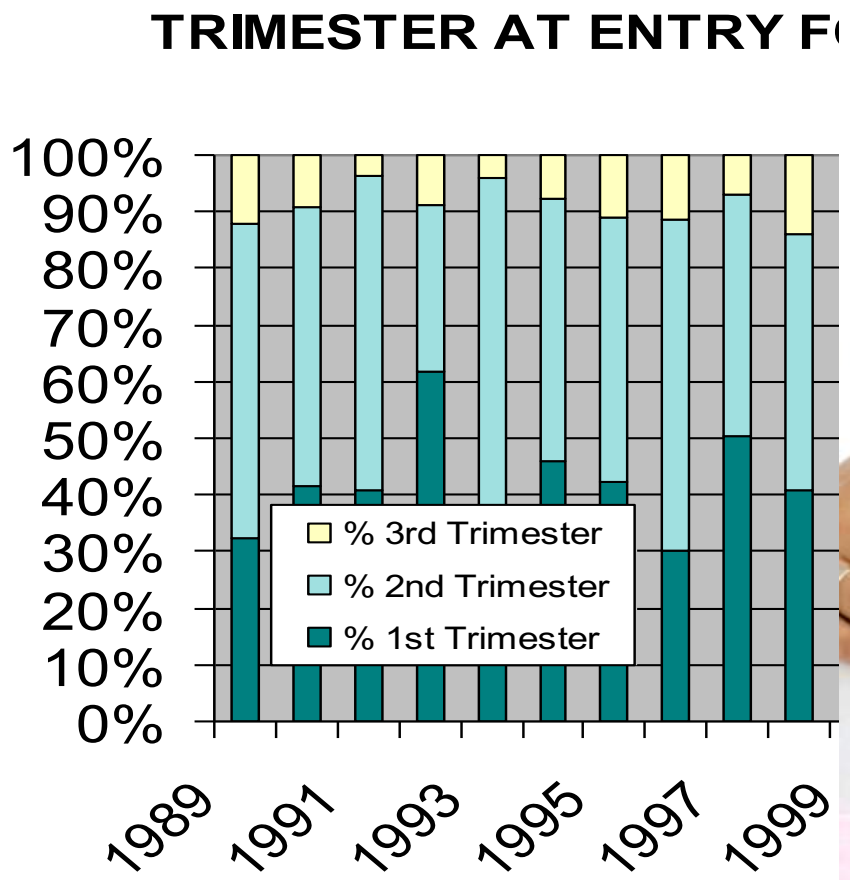


Clinica Template of the Future



- 30 patients are seen or contacted in the first 3 hours of the day

Access to Care



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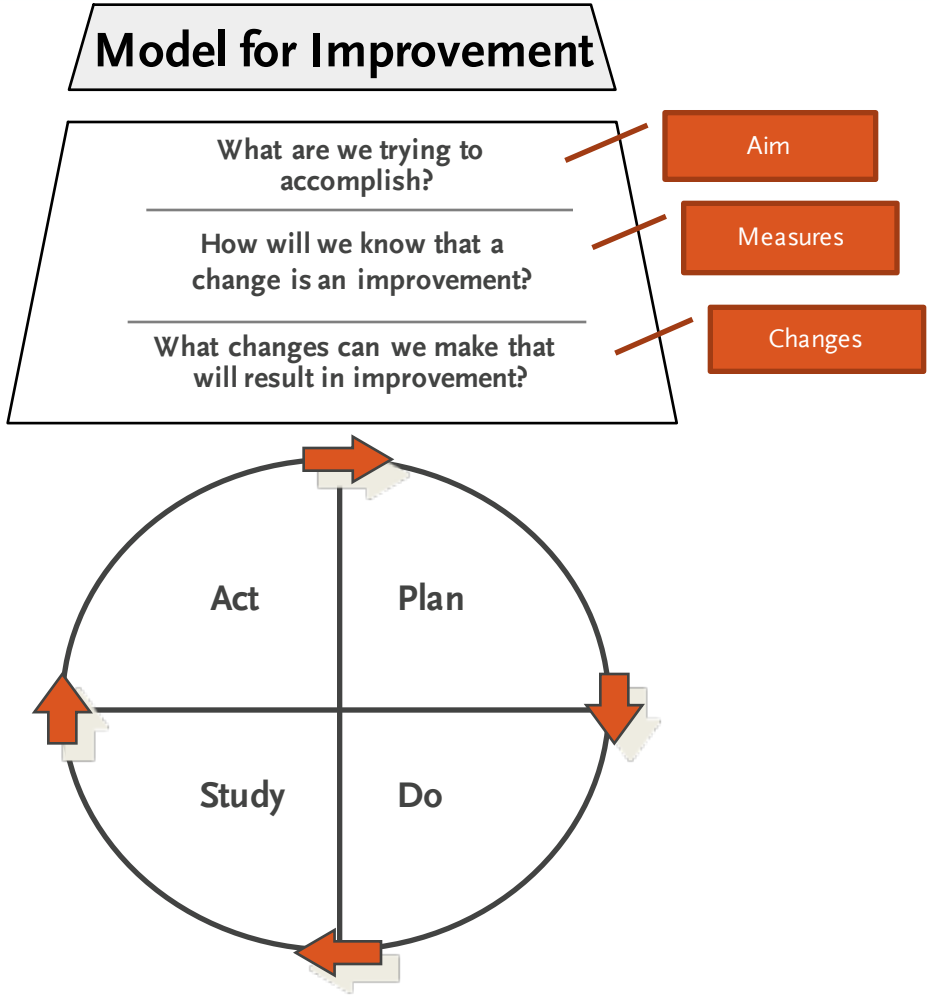
Laying the Groundwork: Sharing & Strengthening AIM Statements

PART 2

Tammy Fisher, Senior Director, CCI


“Sometimes you get
a lot of ideas
flowing and it is hard
to stay on track.”
Spreading Innovations Patient Portal grantee

Look familiar?



Source: Associates in Process Improvement.

Characteristics of Strong Aims

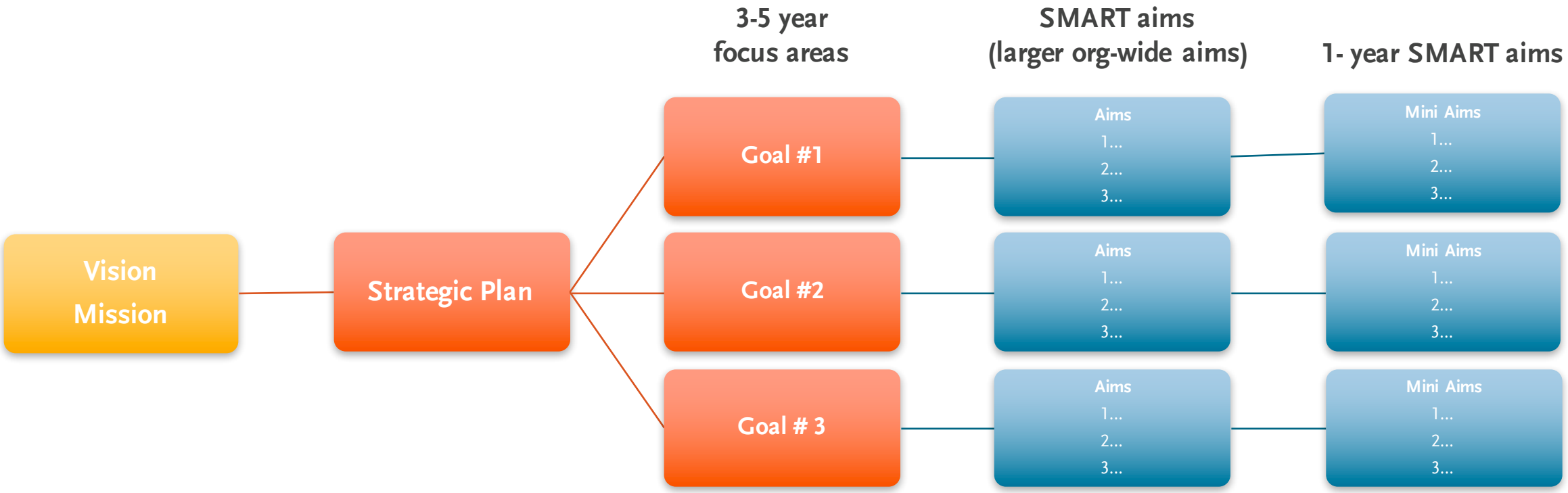
Technical

- 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

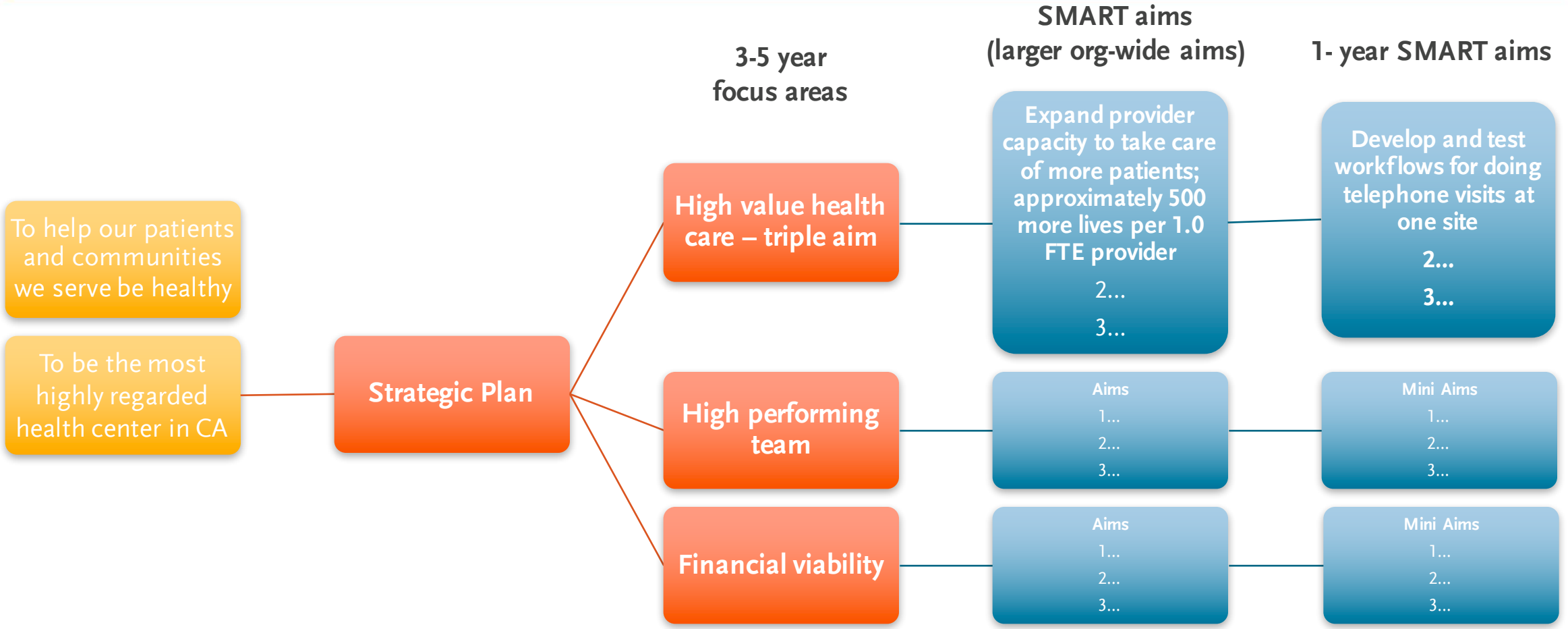
Emotional

- Meaningful
- Compelling

Internal Alignment



Internal Alignment

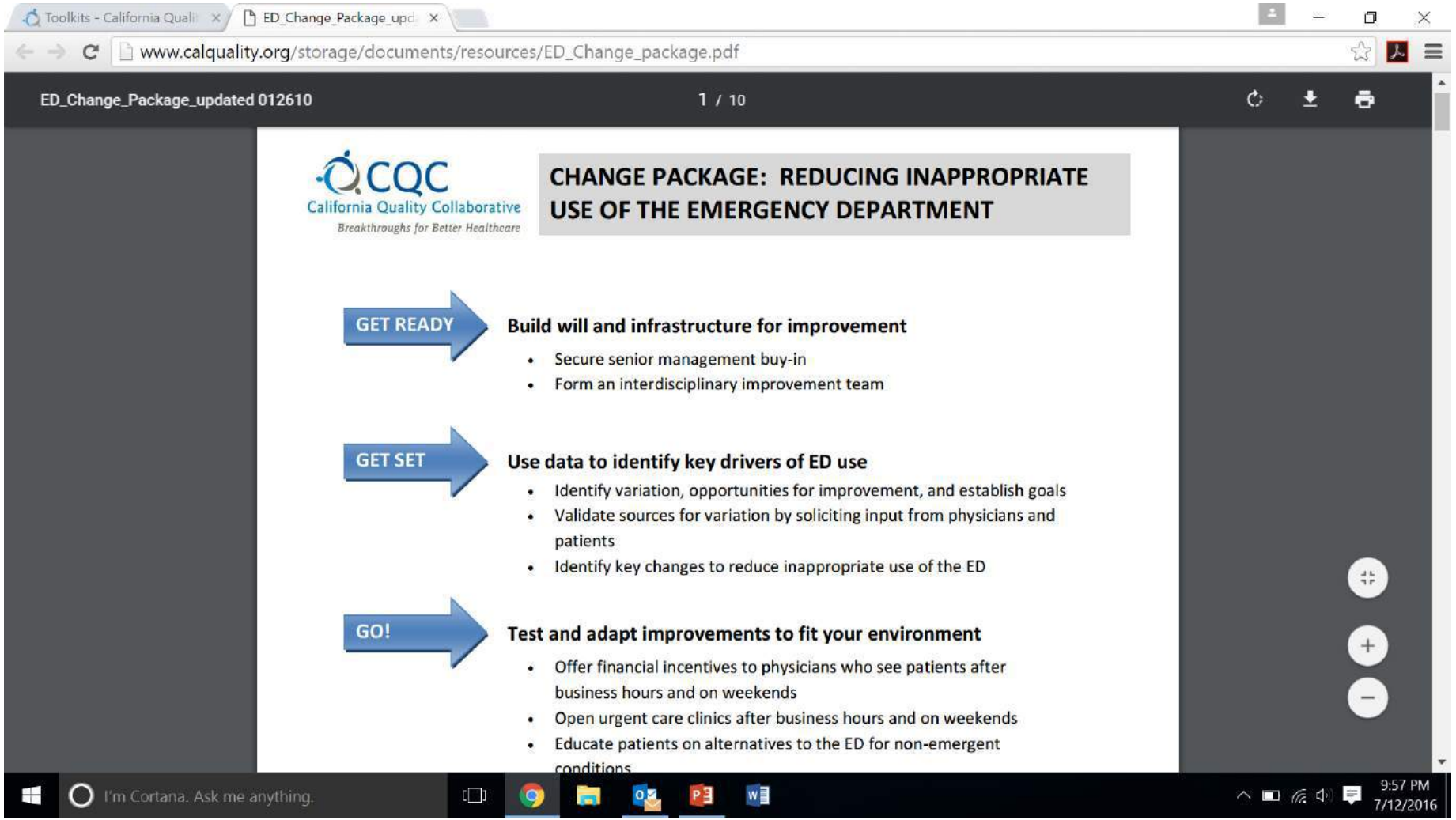


Defining the Problem (Opportunity)

- 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


Toolkits - California Quali
ED_Change_Package_upd
www.calquality.org/storage/documents/resources/ED_Change_package.pdf
ED_Change_Package_updated 012610
1 / 10
CQC
California Quality Collaborative
Breakthroughs for Better Healthcare
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
I'm Cortana. Ask me anything.
9:57 PM
7/12/2016

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

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Introductions

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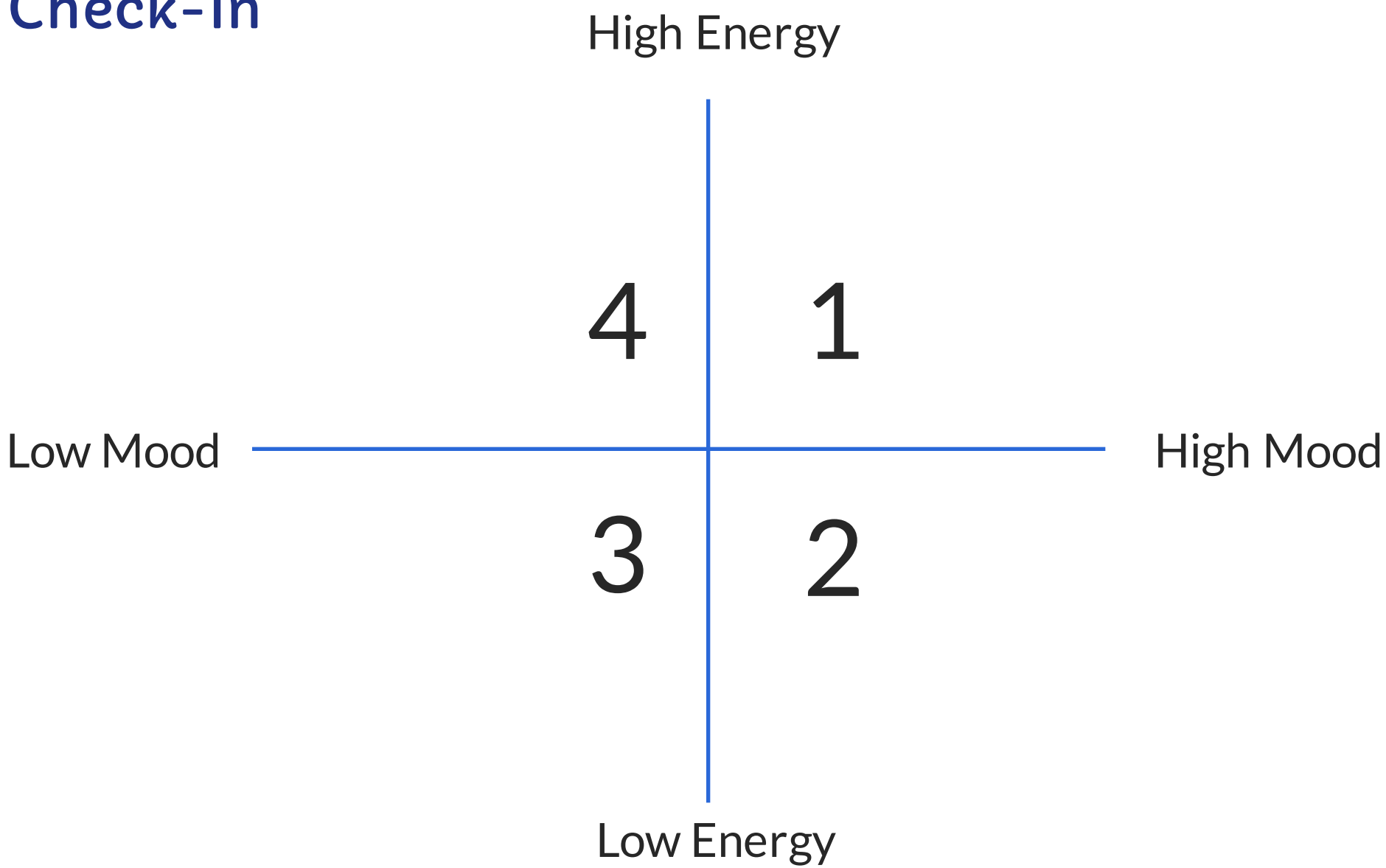
Team Check-In



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Question of the Day

What is your favorite guilty pleasure TV show to watch?

catalyz

today {

- Leveraging Individual Strengths
- Working as Teams vs Groups
- Team Norms
- Communication

Creating Teams

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Generations

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*"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

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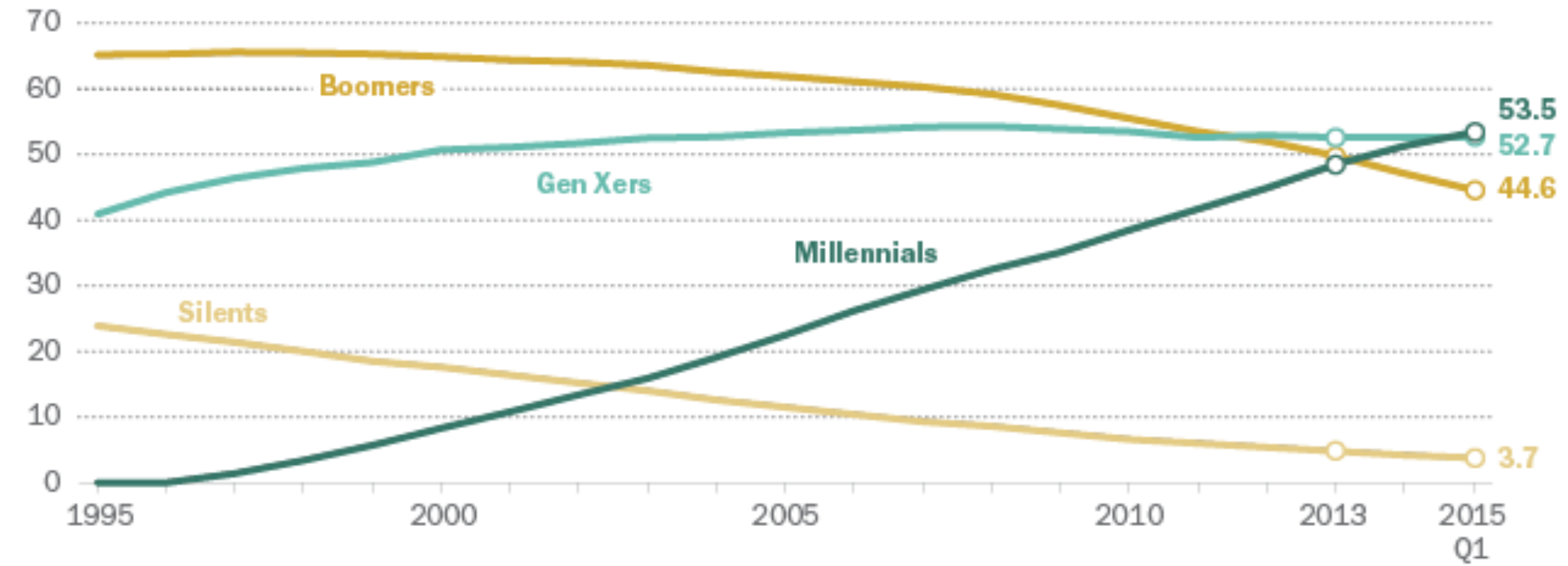
U.S. Labor Force by Generation, 1995-2015

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.
Source: Pew Research Center tabulations of monthly 1995-2015 Current Population Surveys, Integrated Public Use Microdata Series (IPUMS)

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”

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Models for Teams

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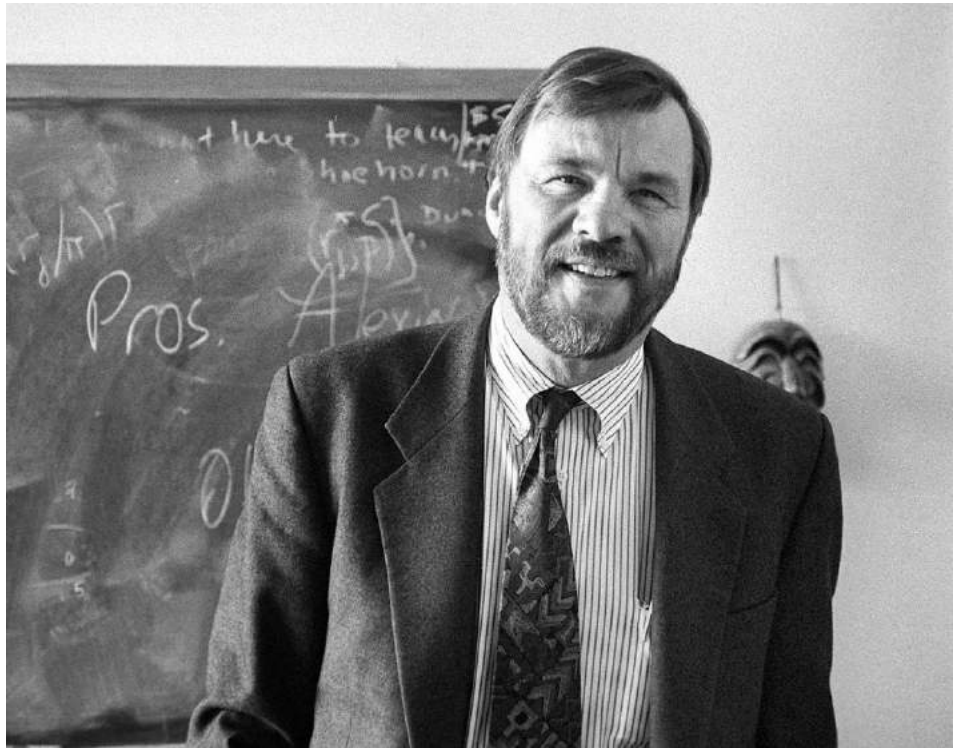
Hackman 5 Factor Model



Richard Hackman, Professor of Social & Organizational Psychology, Harvard

- Real Team
- Compelling Direction
- Enabling Structure
- Supportive Context
- Competent Coaching

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Google

Model for Team Effectiveness

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Real Team

Compelling Direction

Enabling Structure

Supportive Context

Competent Coaching

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Individuals

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*“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”

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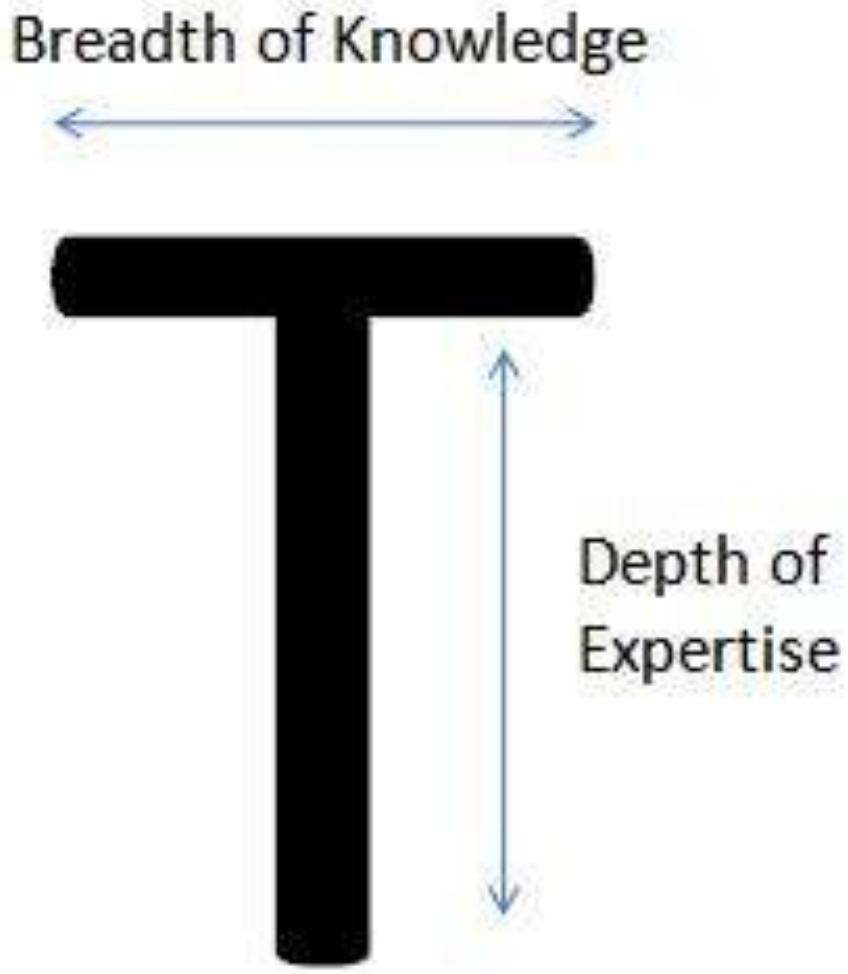
T Shaped People



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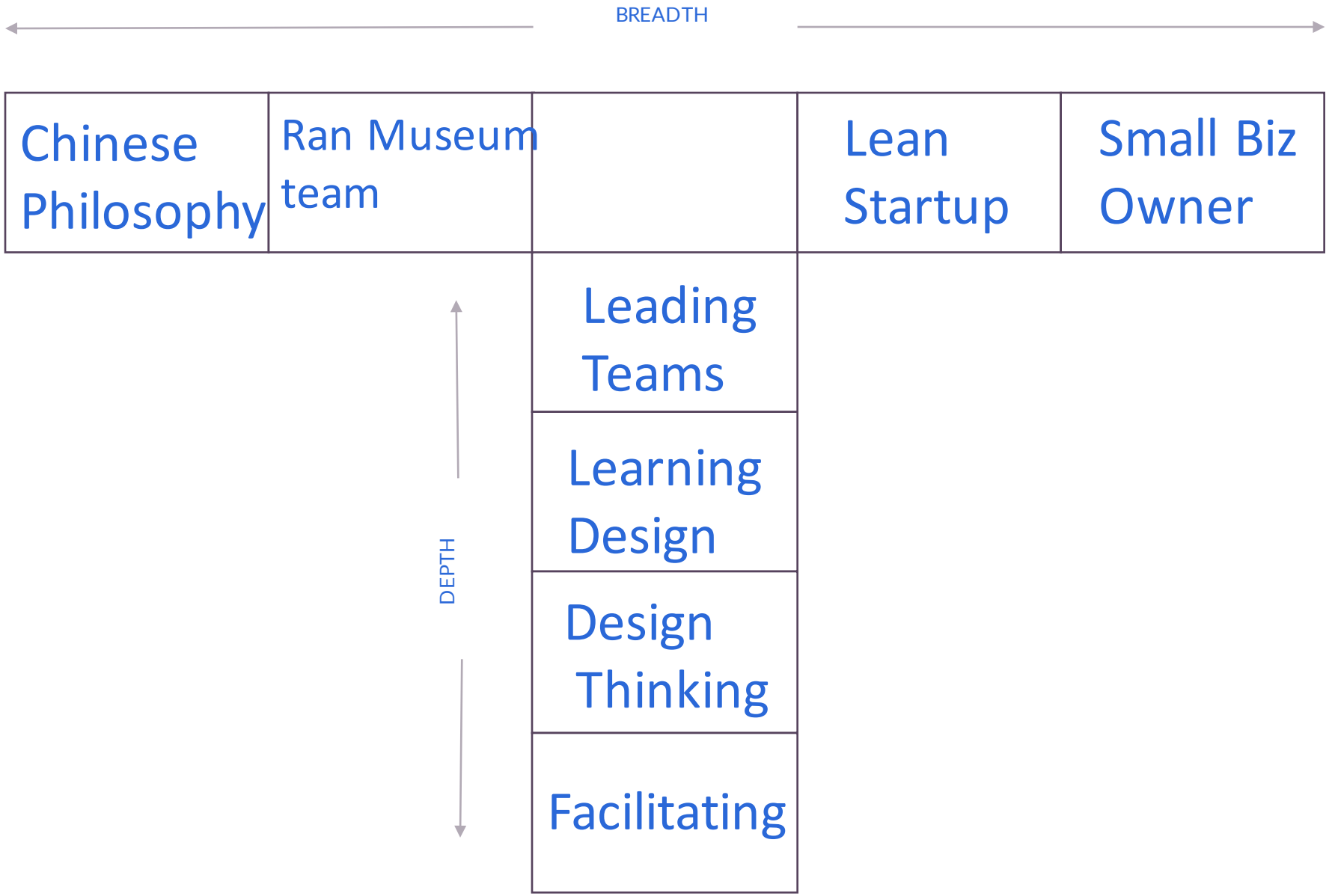
BREADTH
Chinese Philosophy
Ran Museum team
Lean Startup
Small Biz Owner
DEPTH
Leading Teams
Learning Design
Design Thinking
Facilitating

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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.

T-Shapes

Exercise

Pair up with someone else from your team, and share your T shapes with each other.

TRIZ

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Teams

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Groups

Teams

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What Defines Teams?

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

INVERTED THINKING

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Exercise

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

TRIZ

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Exercise

Put a star next to any actions you think may be showing up in some manner in your organization

TRIZ

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Team Norms
&
Working Agreements

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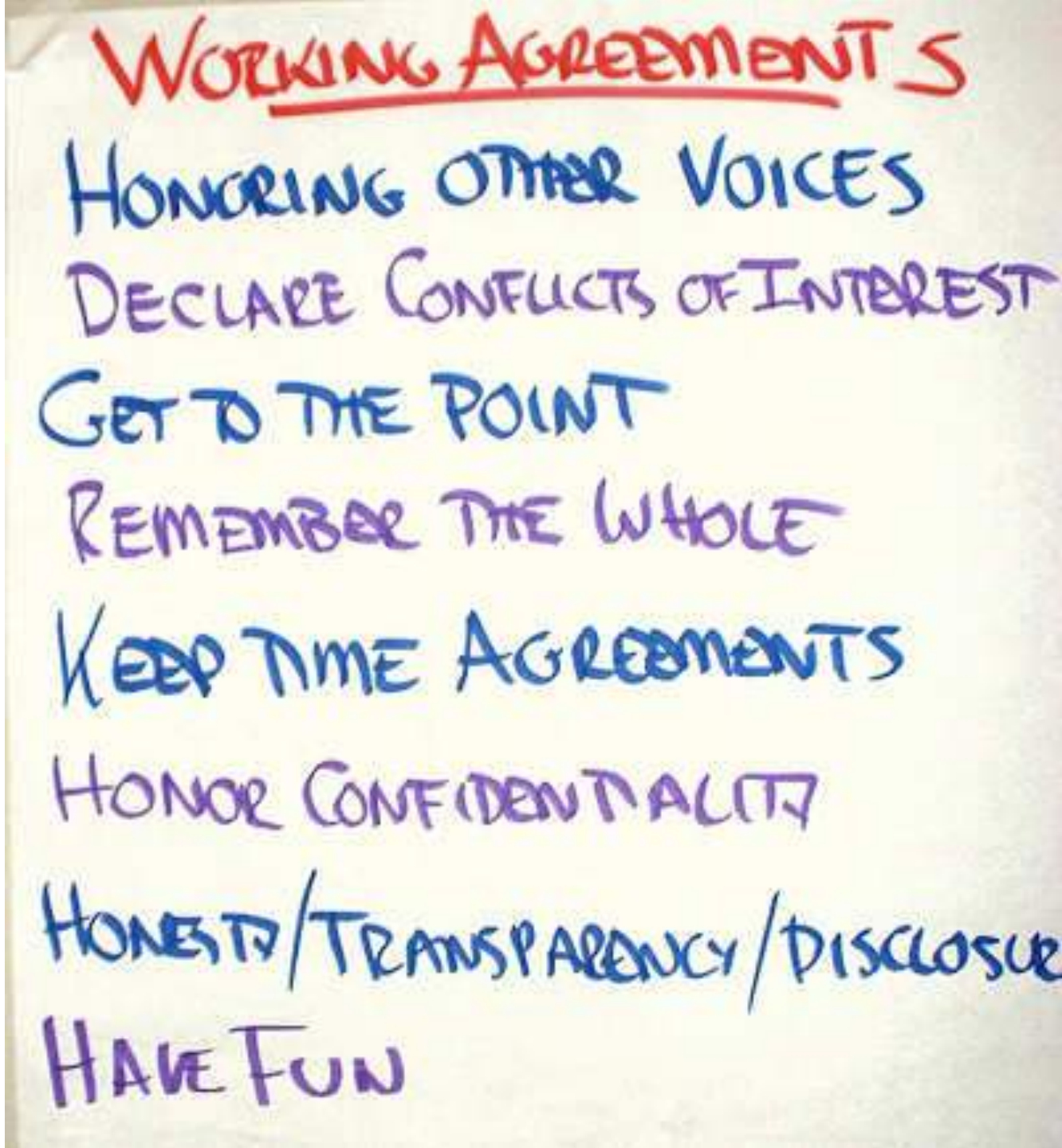
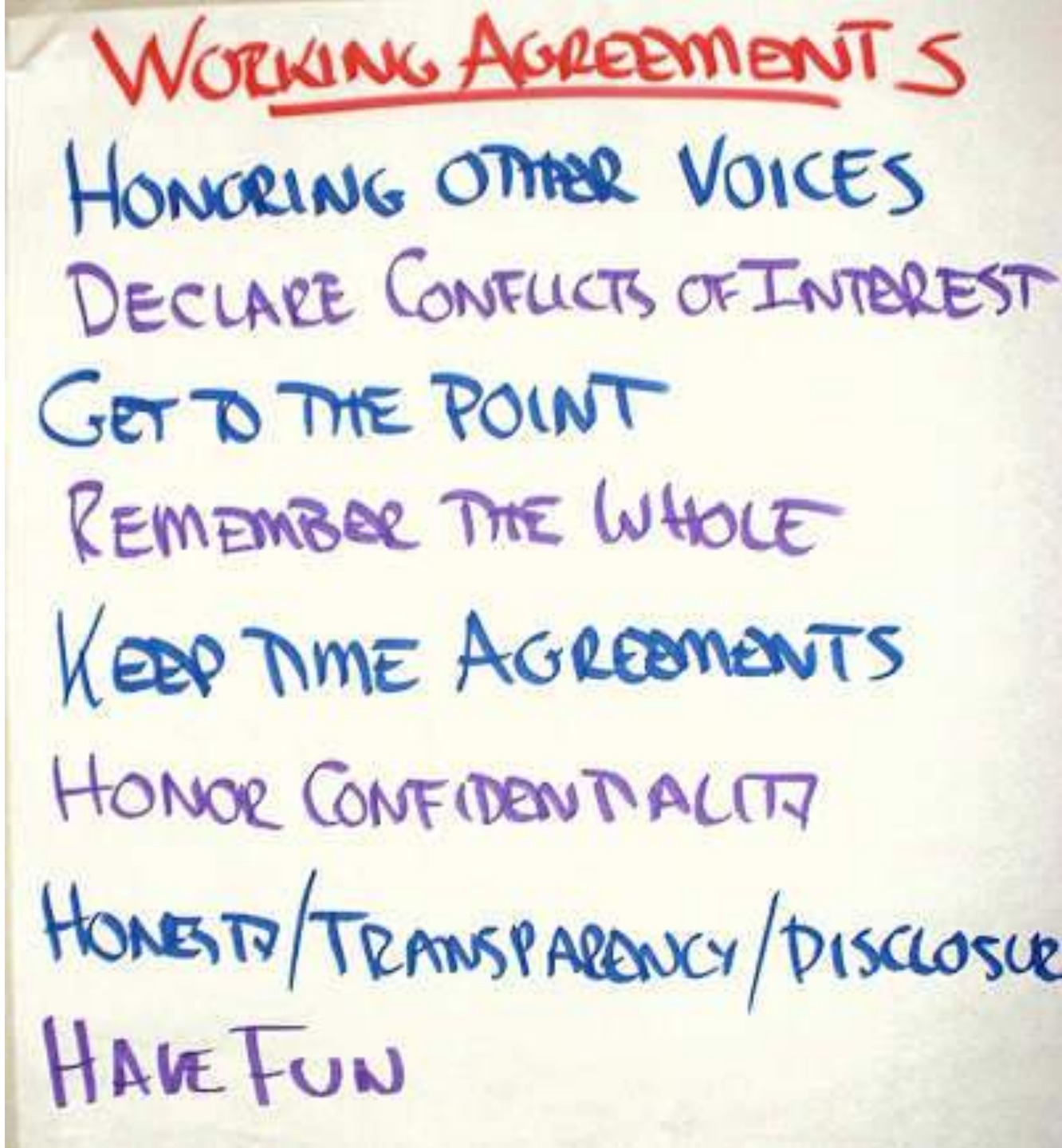


Exercise

Develop a list of 4-6 working agreements/team norms that might help prevent the activities or behaviors you identified in the TRIZ exercise



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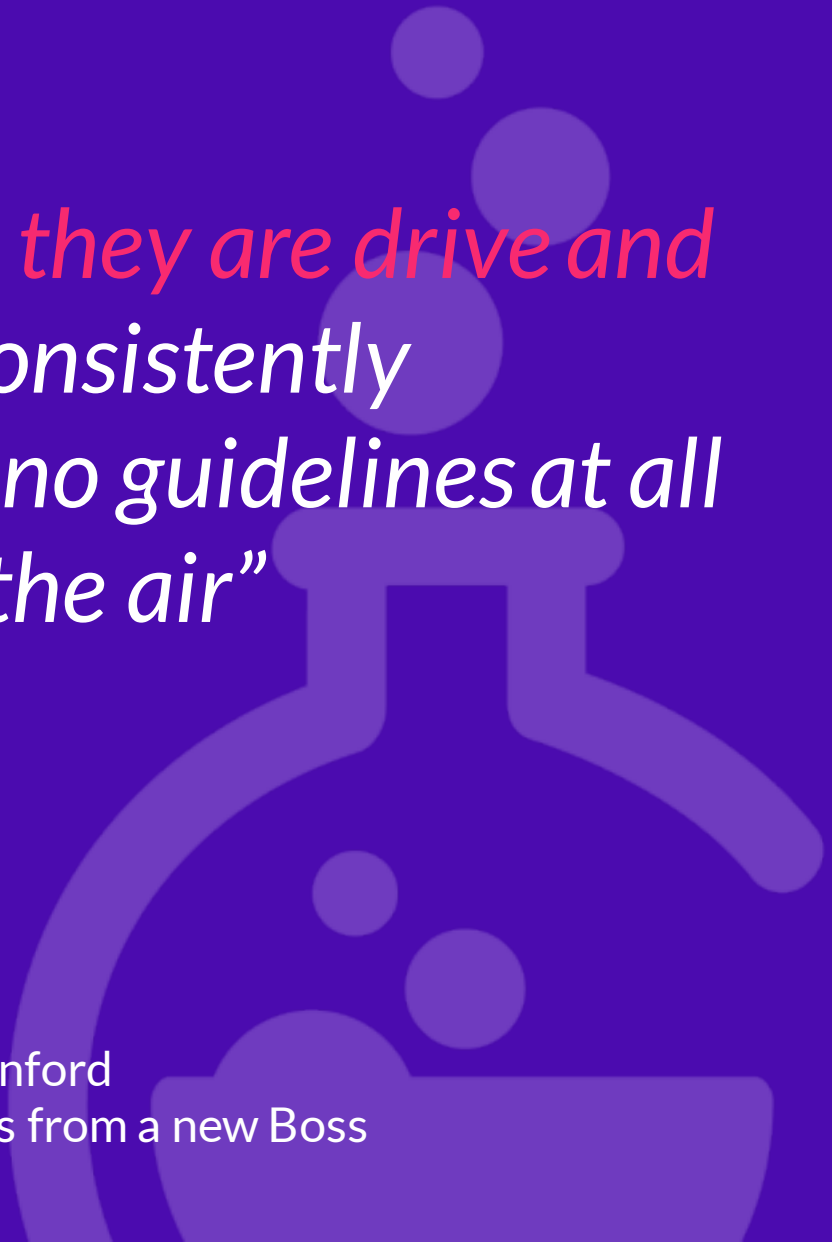
"Guidelines like these are great when they are drive and reflect behavior, but when they are consistently violated, they are worse than having no guidelines at all because the stench of hypocrisy fills the air"

Bob Sutton, Stanford
Team Guidelines from a new Boss



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Communication

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"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

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Giving Feedback
Attitude vs Behavior

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Coaching & Giving Feedback

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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"

catalyz

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

PART 3

How Do We Get There?

Population Management

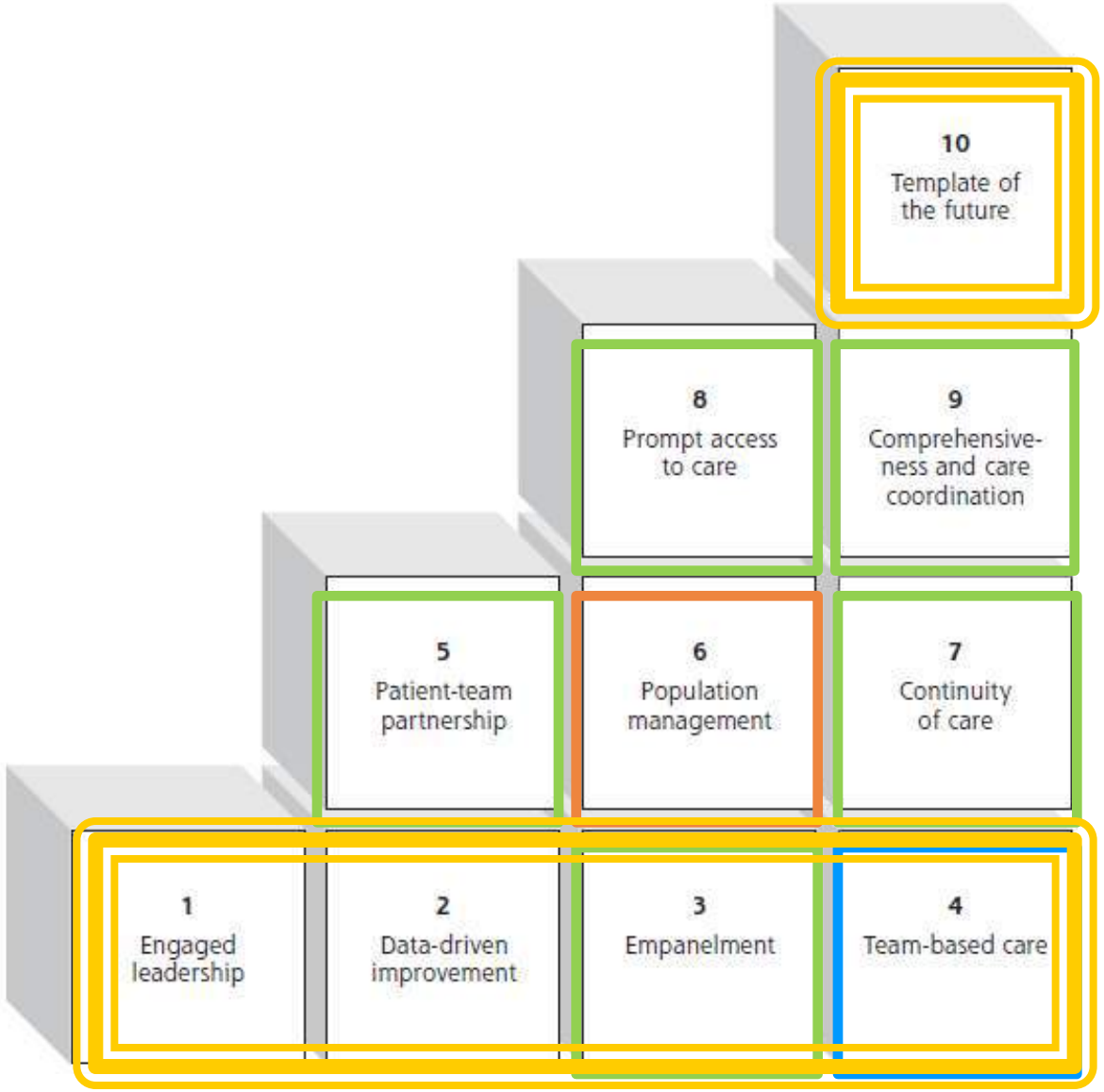
Identify & Segment Populations
Patient Outreach

Planned Care

Prepared Team
Activated Patient

Team Based Care

Teamwork & Task work



Value Based Care-Diabetes

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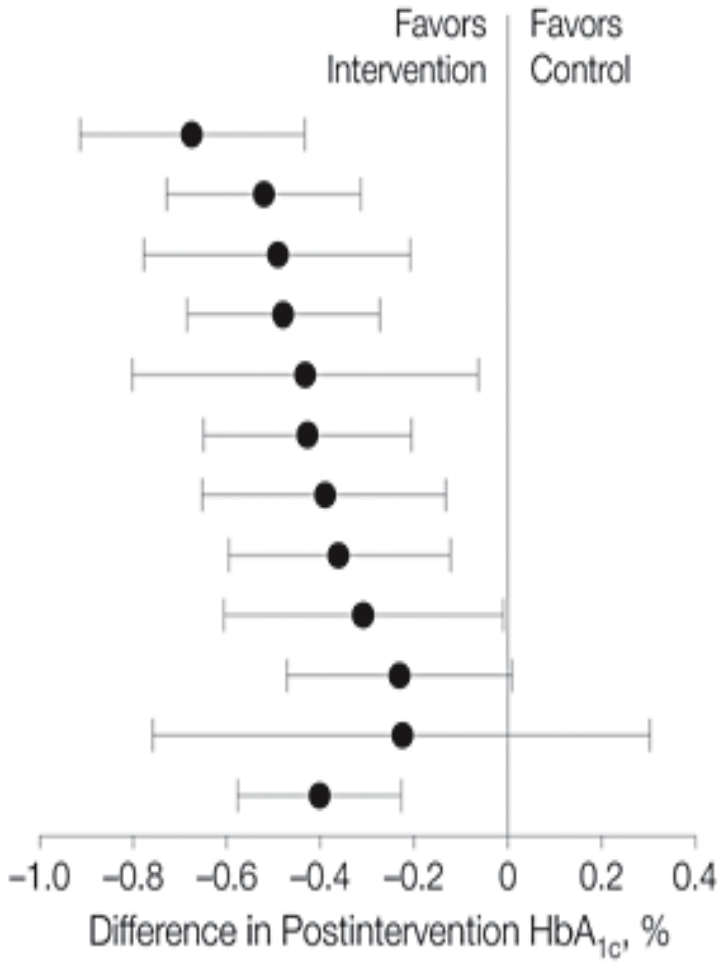


Shojania, K. G. et al. JAMA 2006;296:427-440.

Leveraging Team Based Care

Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

Team Based Care: Task Work

Build the Care Team

Do the Work

Build the Care Team

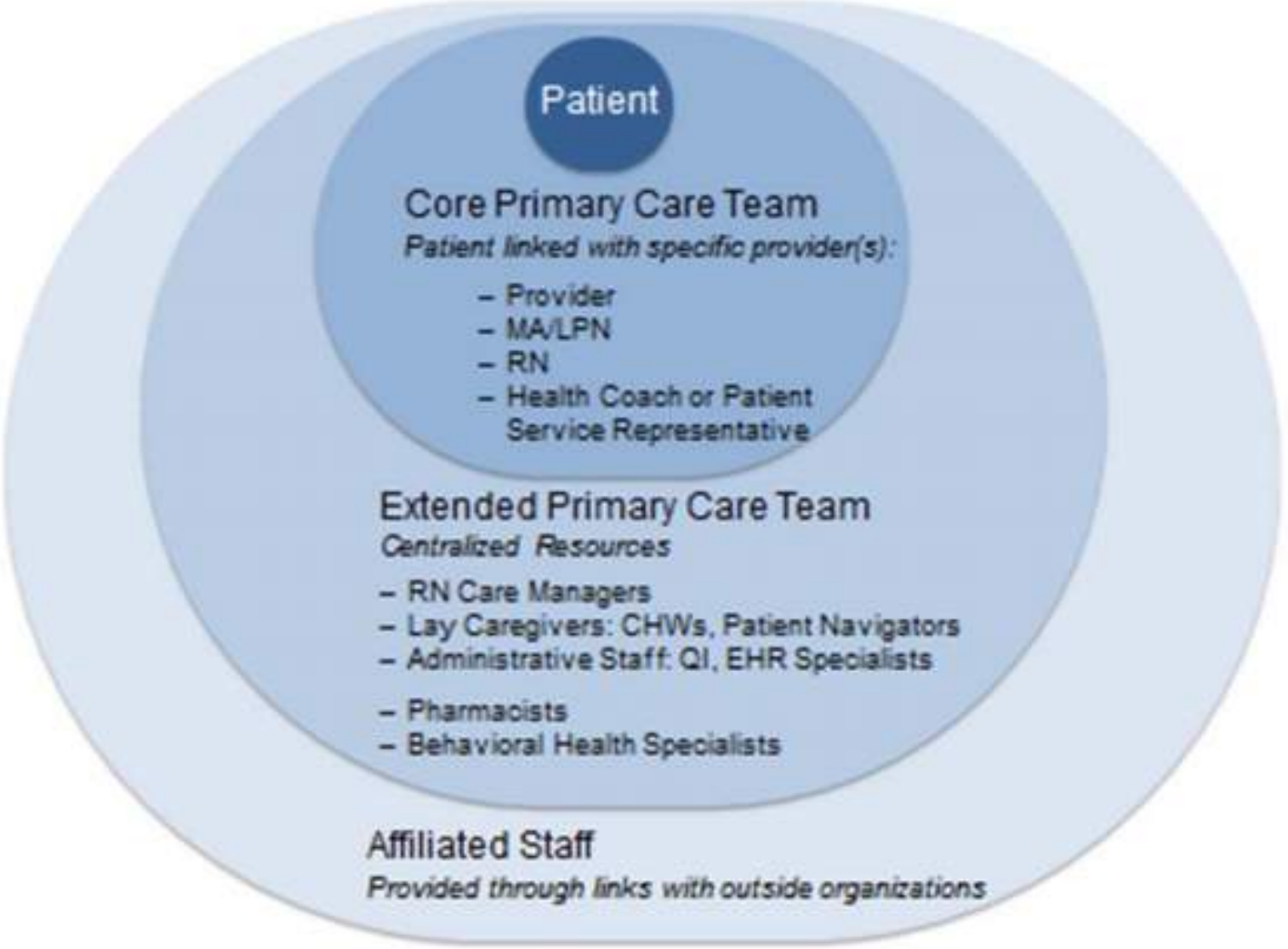
1. Identify organizational leadership for teams and start building a team culture

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?



Build the Care Team

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.

Build the Care Team

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

Build the Care Team

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?

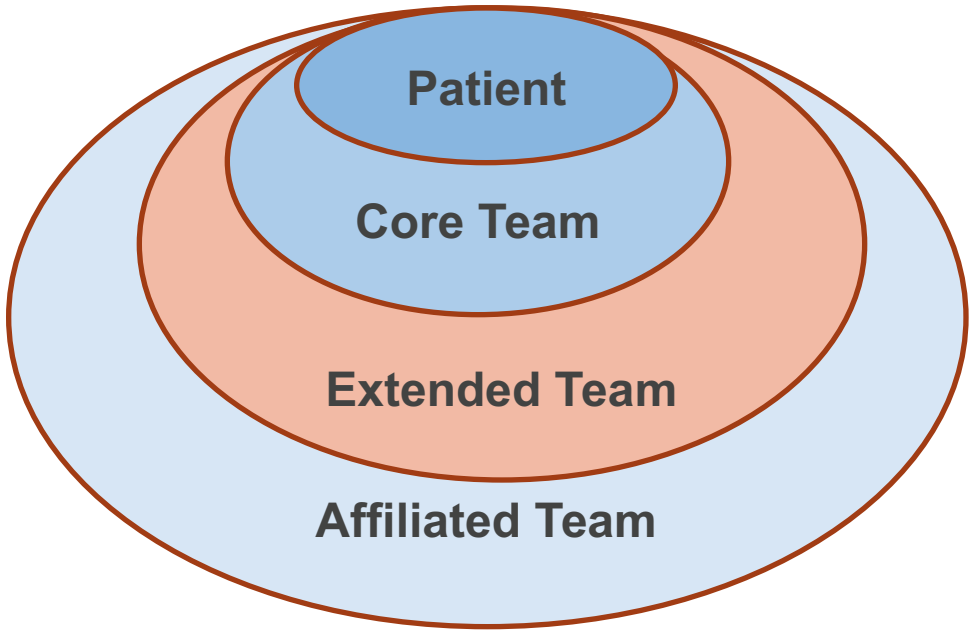
Build the Care Team

8. Develop career ladders for staff

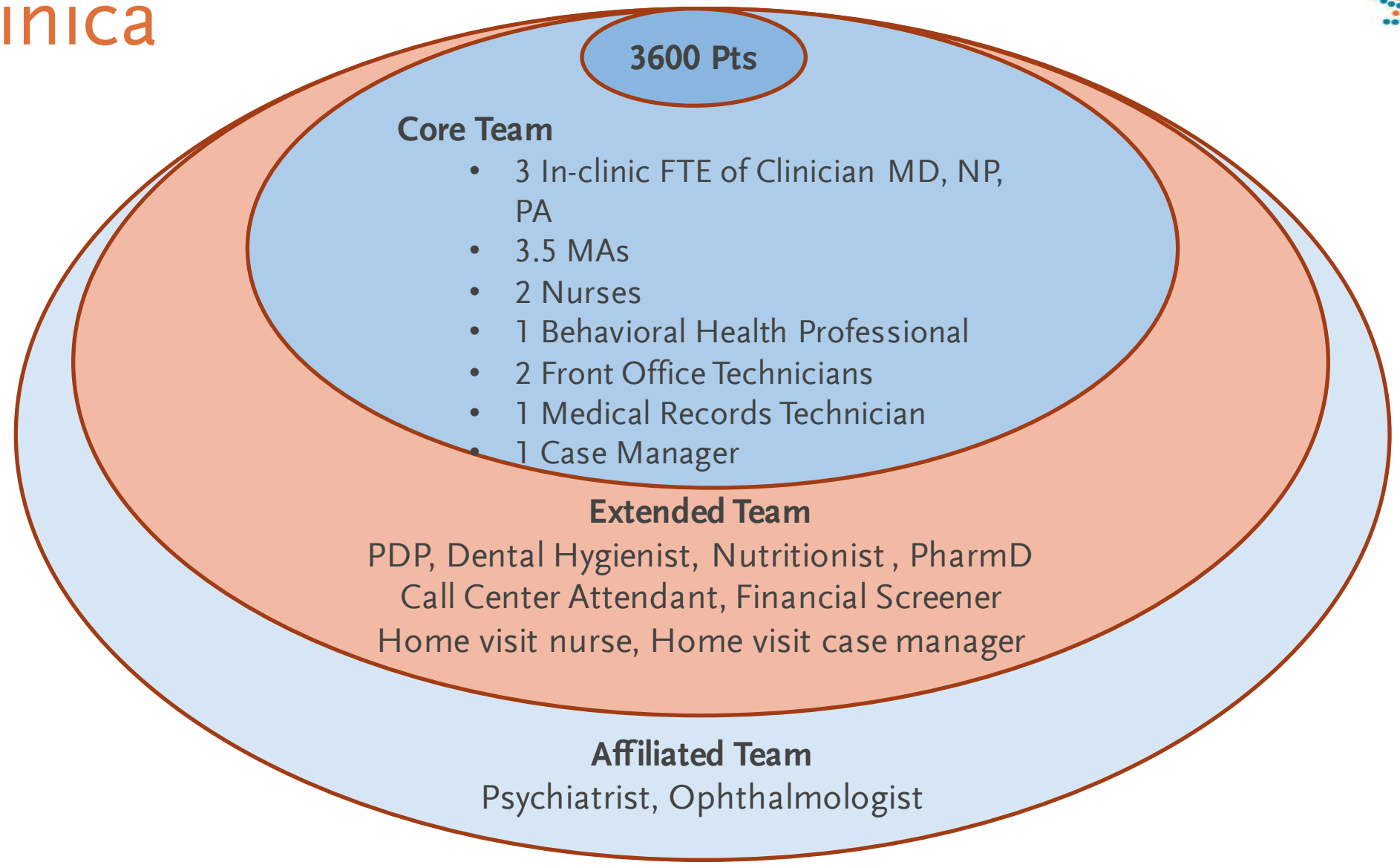
- Recruitment
- Retention
- Justice.

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

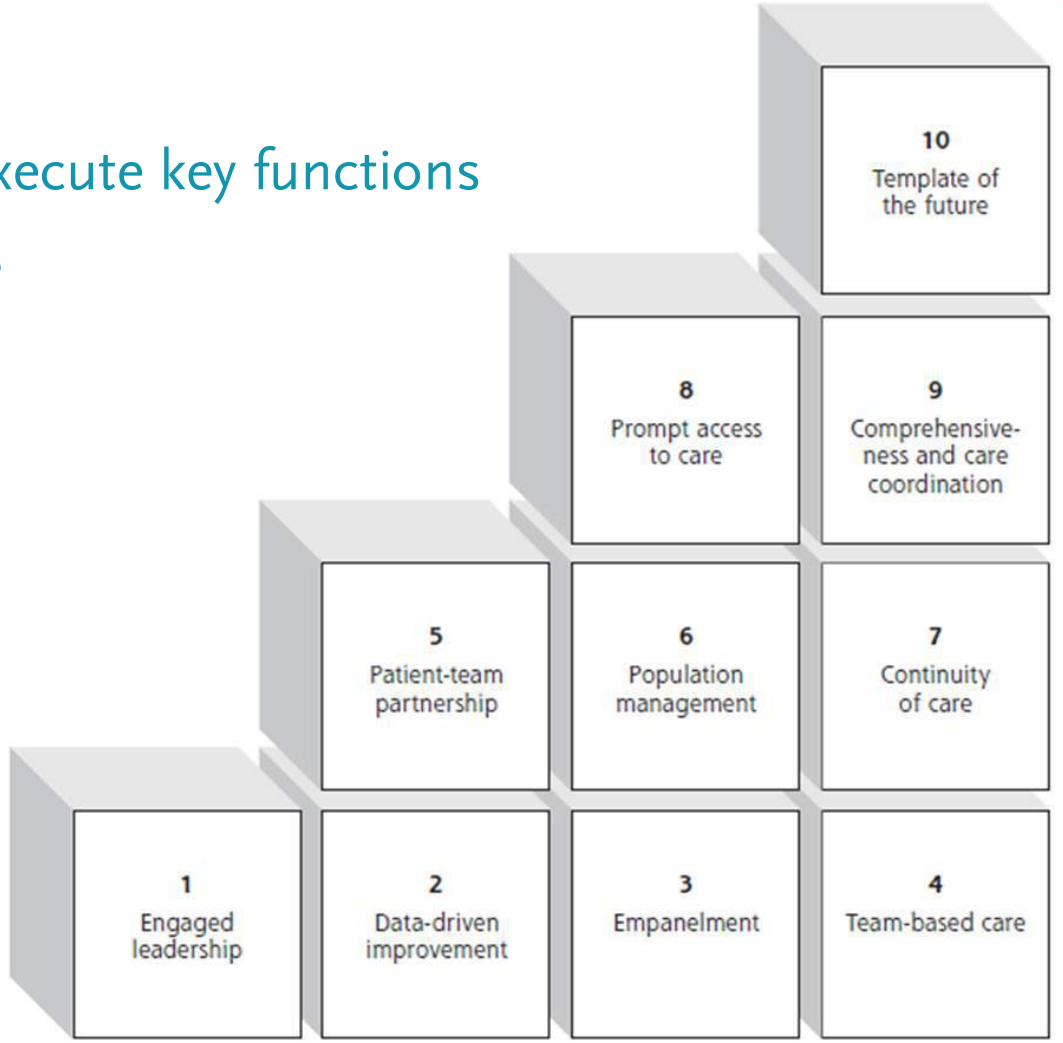


Draft Pick: (1).5 FTE PharmD every team; (2) Scribing solution (MAs), (3) Substance abuse counselor

Do the Work

1. Assess performance.

– Evaluate practice systems and ability to execute key functions with ambulatory guide assessments such as PCMH-A, BBPCA or PCTGA.



Substantive vs Symbolic Implementation

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Determinants and consequences of employee attributions of corporate social responsibility as substantive or symbolic

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Employee attitudes
Employee behaviors

ABSTRACT

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.

Do the Work

2. Build effective core teams.

- Plan for reassessment of core team
- Build relationship with the patient
- Include resources and time.

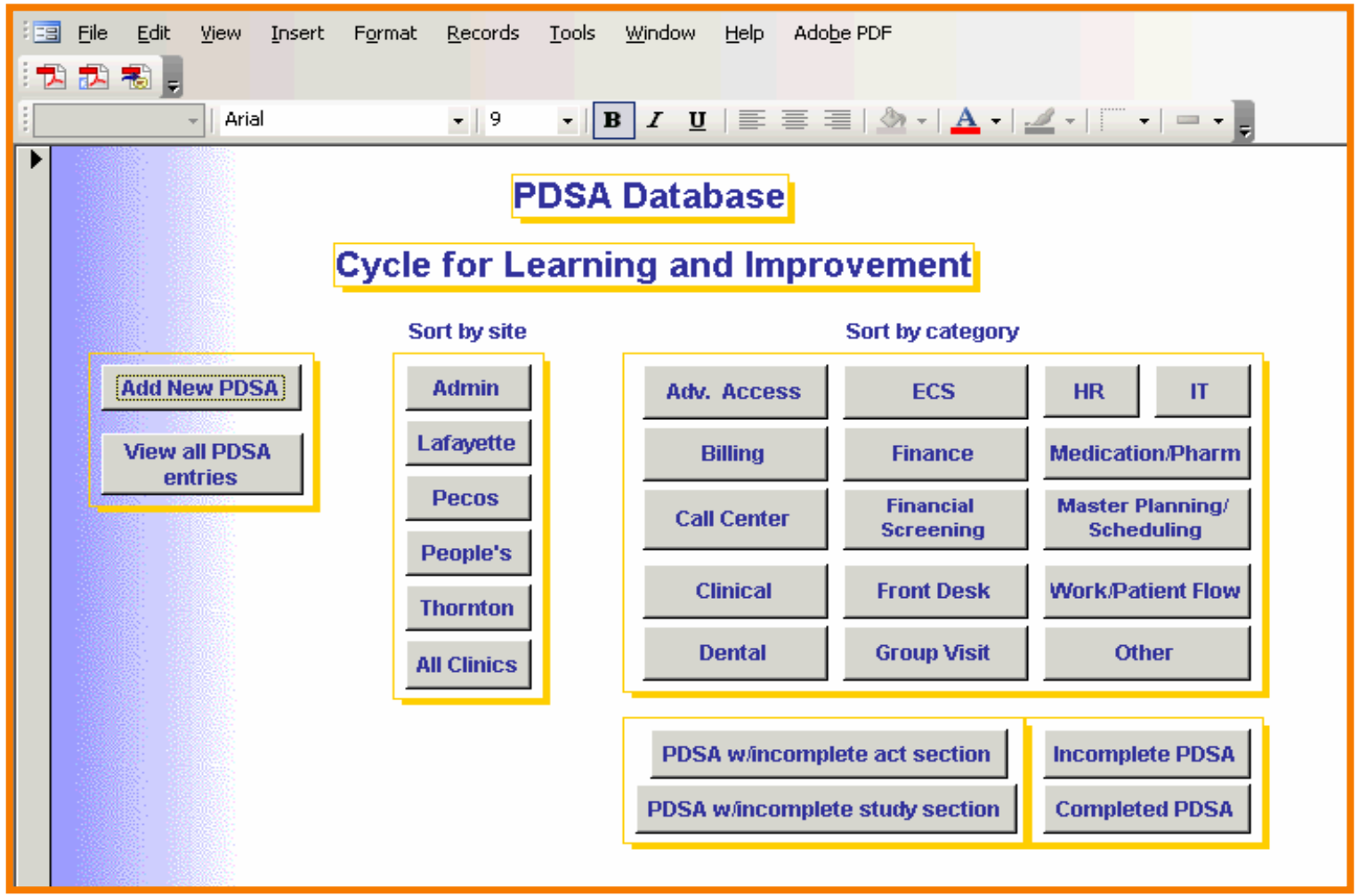
Do the Work

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



Do the Work

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

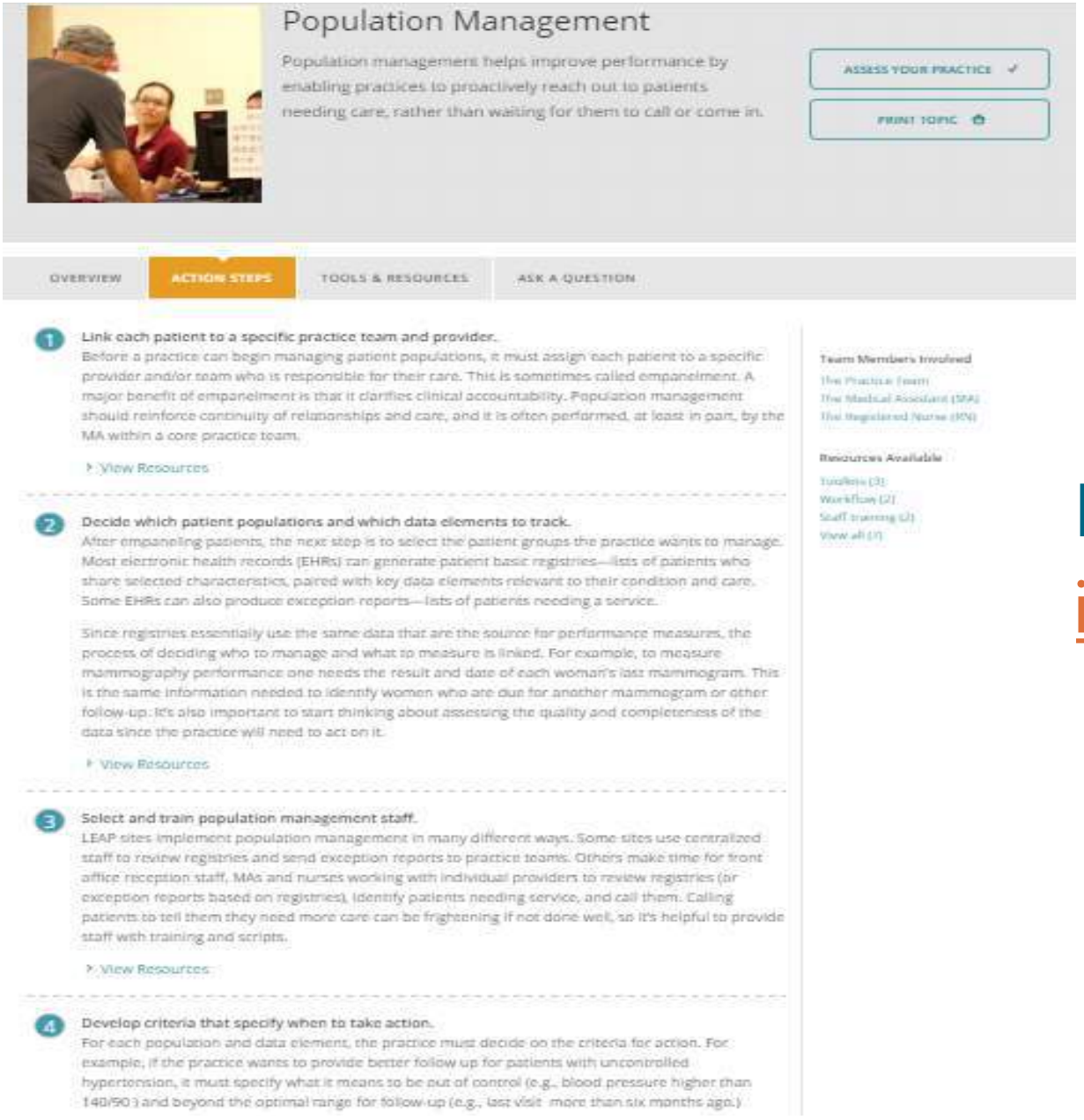
Self-Management Support

Population Management

Behavioral Health Integration

Communication Management

Clinic-Community Connections



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?

1 minute	By yourself	• Write ideas on stickies.
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.		

ORGANIZE YOUR IDEAS

Concrete

Conceptual

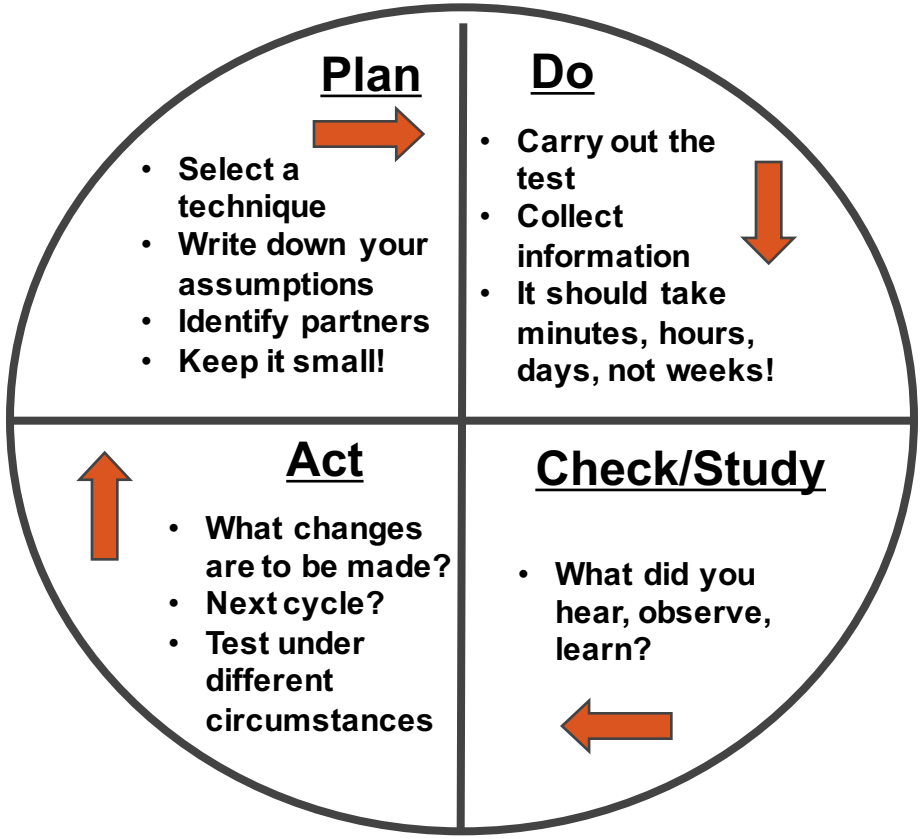
Prototype or "Just Test It"

- **Prototype**
  - When developing a new solution
  - When prototypes requires **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

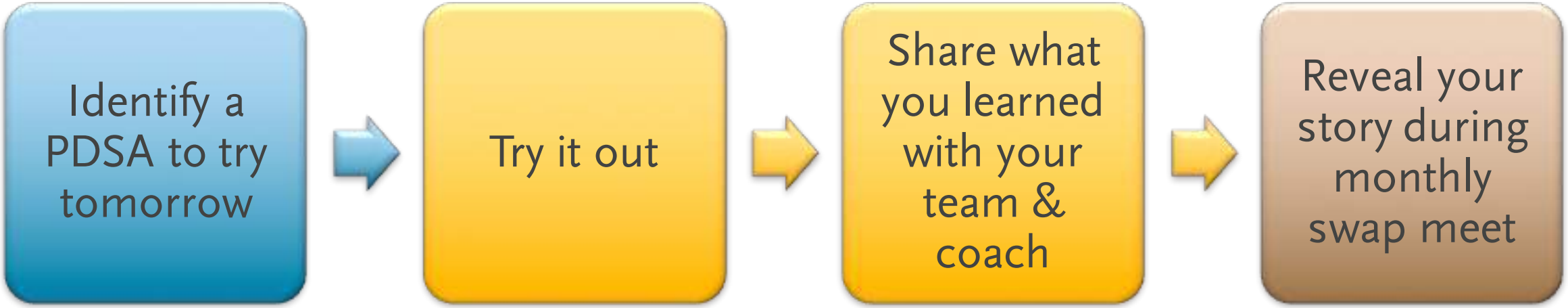
Small Scale Testing

- **PDSA**



- **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!


Identify a PDSA to try tomorrow
Try it out
Share what you learned with your team & coach
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

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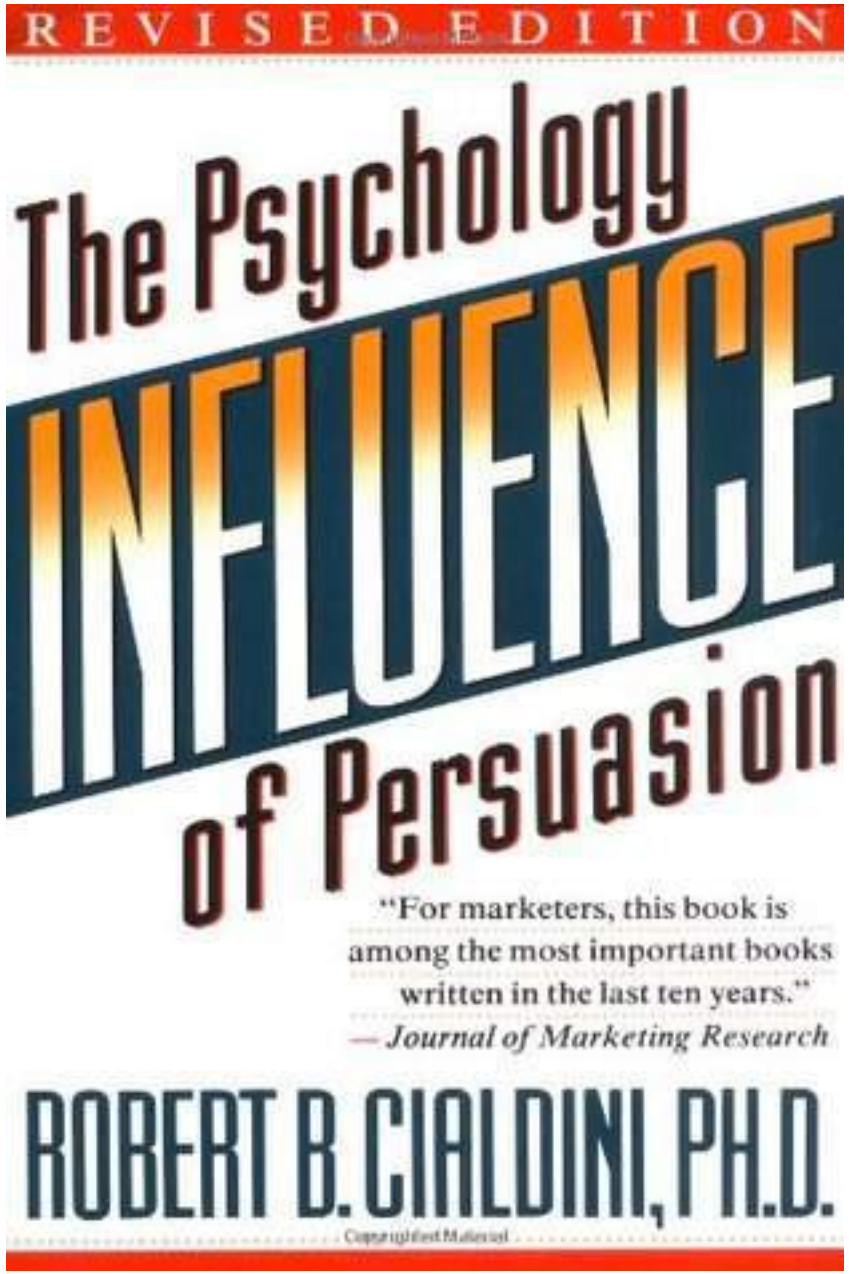
Warm Up



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Switch

Technical vs Adaptive Change

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deoxyribose
guanine
adenine
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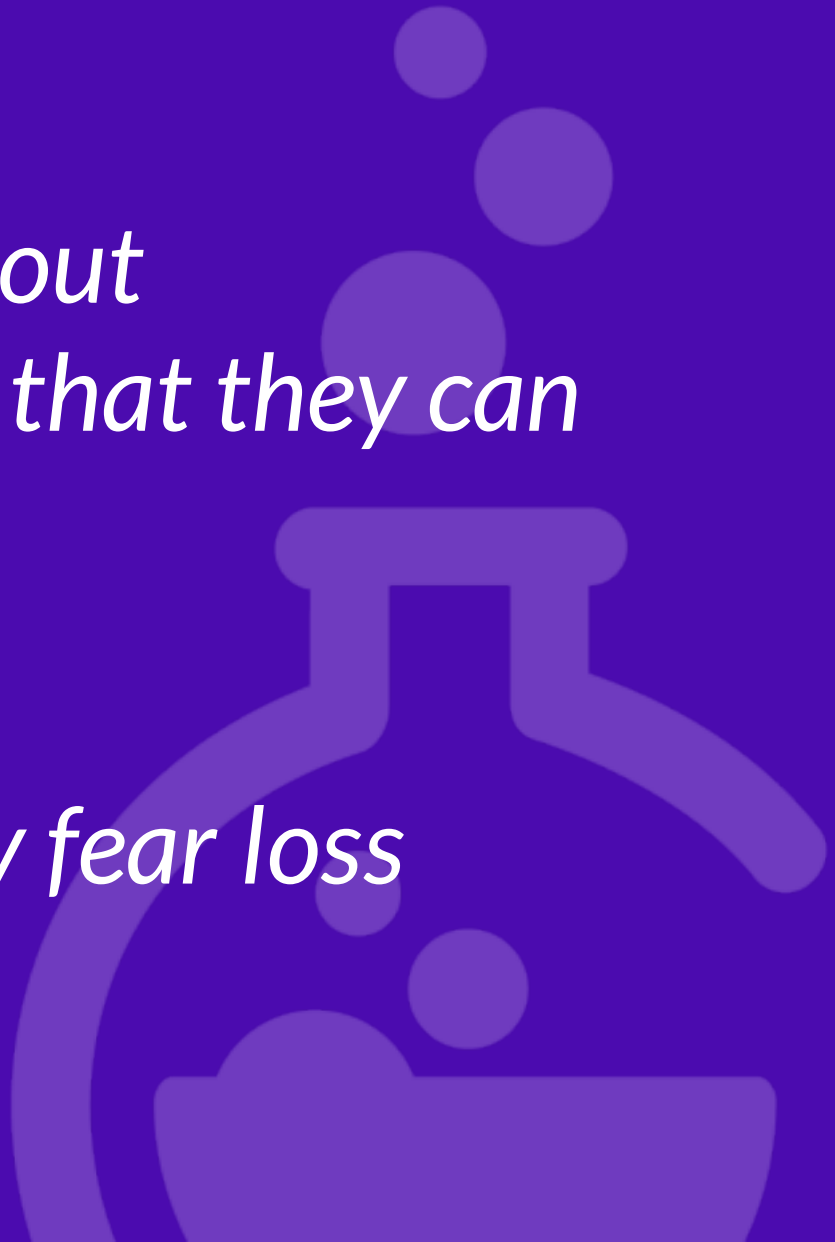
Technical vs Adaptive

Technical	Adaptive
Clearly Defined Problem	Not clearly defined problem. Requires learning
Clear and known solution. Have all information required, goal is to optimize execution.	Solution unknown- requires learning, experimentation and gathering more information
Evokes a rational and logical response.	Evokes an emotional response- people may avoid or struggle to deal with this
Uses existing processes, practices, behaviors	Challenges existing processes, practices and behaviors
Led with authority- leaders can tell people what to do and are responsible for solution.	Requires engaging stakeholders and bringing them along- solution resides within them.

Leading adaptive change is about disappointing people at a rate that they can tolerate

People don't fear change, they fear loss



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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%

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Car Wash A

Car Wash B

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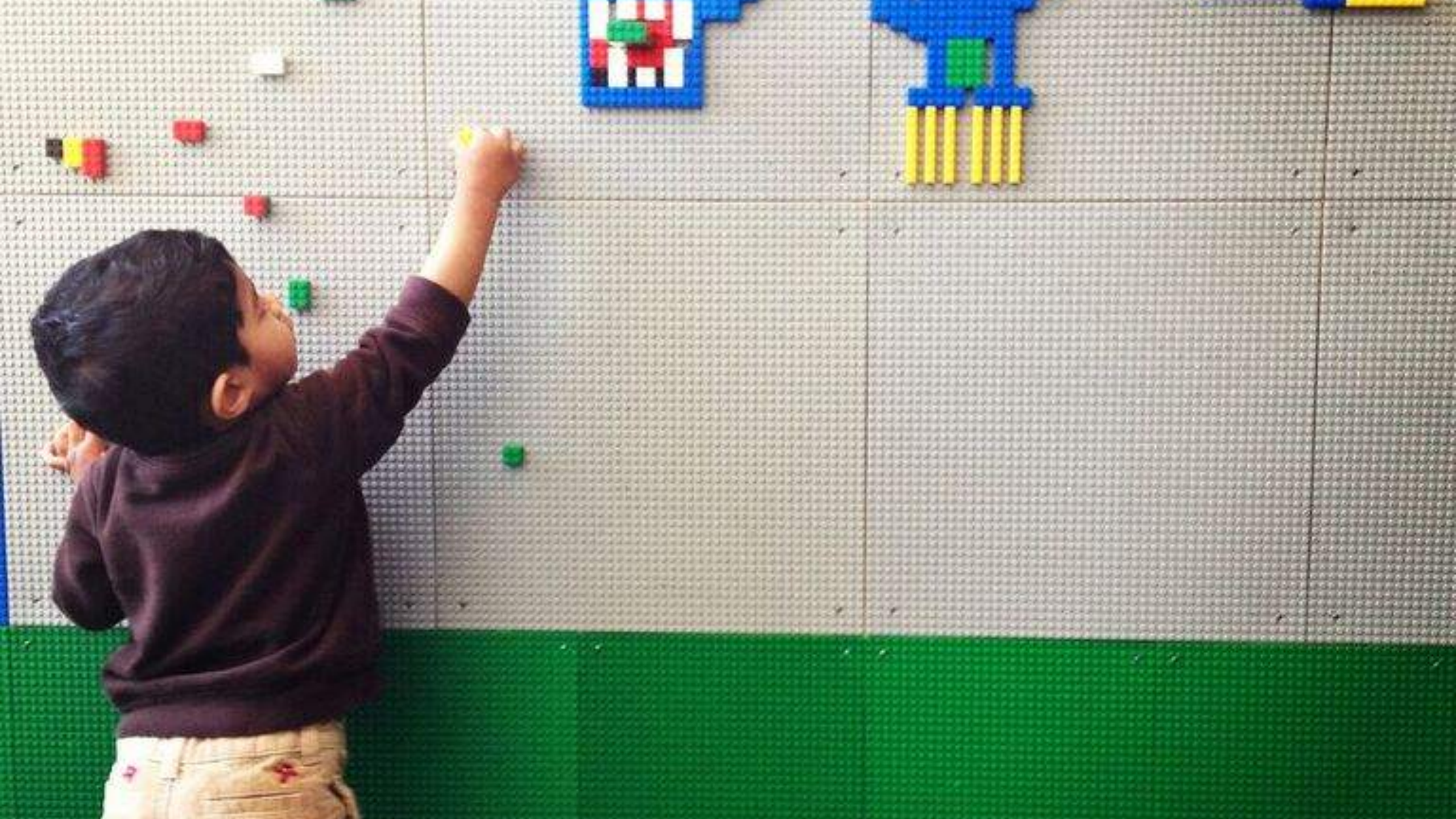

Endowed Progress Helps mitigate the following issues

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?


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Thank you!

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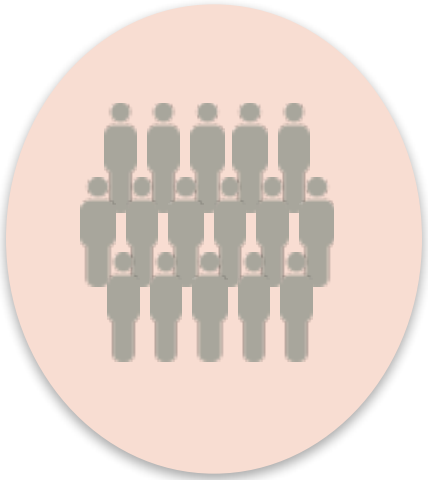
What's Next?



Onsite sessions

Coaching & Content experts

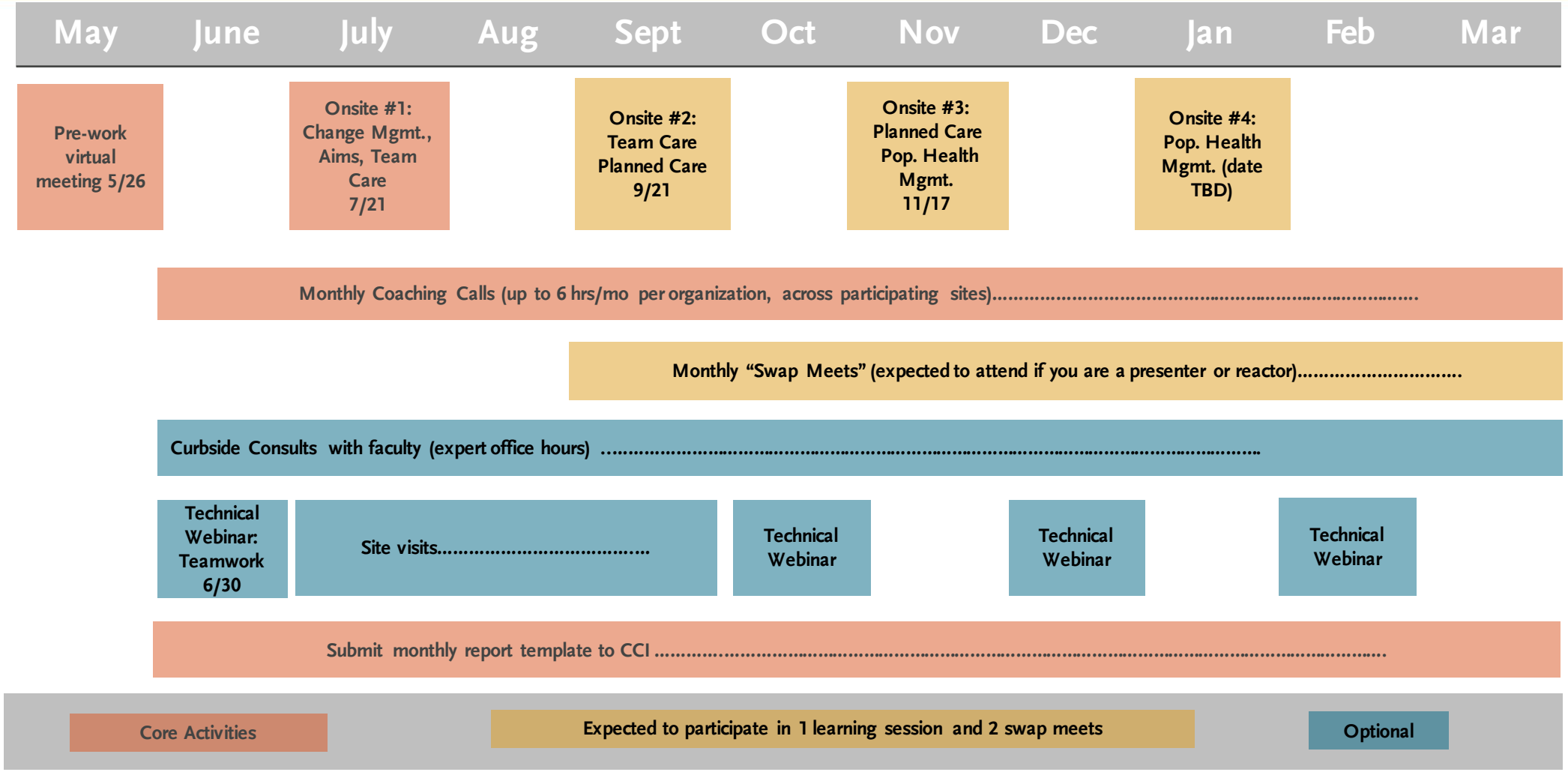
Technical webinars

Swap meets

Resource website

Site visits

Program Timeline



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THANK YOU!