CCI
CENTER FOR CARE INNOVATIONS

KP Transformation Accelerator

Final In-Person Learning Session
Wednesday, October 10, 2018
Center for Total Health | Washington, D.C.

Today's Agenda

1. Sharing & Using Data for Improvement
2. Team Pitch Rounds
3. Spreading Changes
4. Lunch
5. Shared Advocacy Project
6. Sustaining Changes
7. Closing Activity & What's Next

Materials and slides for today's learning session are available at:

https://www.careinnovations.org/accelerator-team/

Who is in the room?

Health Center Teams

Mary's Center

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

CCI health & wellness services

FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED
FMCS we care

LA CLÍNICA DEL PUEBLO

Support Partners & Faculty

CCI CENTER FOR CARE INNOVATIONS

RPCC Regional Primary Care Coalition

KAISER PERMANENTE®

Where are we in our Transformation Accelerator journey?

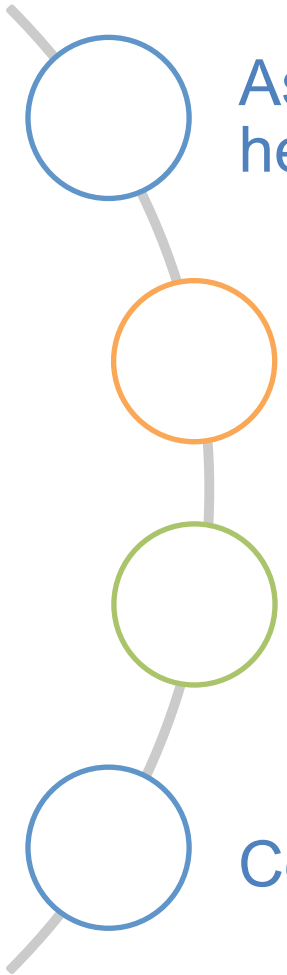
Phase 1 → Program Launch	Phase 2 → Team-Based Care	Phase 3 → Planned Care	Phase 4 → Data Analytics	Phase 5 → Spreading & Sustaining	Program Ends: December 2018
April 2017 Convening	October 2017 Learning Session	February 2018 Webinar			Coaching Ends
August 2017 Webinar	December and January Site Visits	Shared Advocacy Project Begins	July 2018 Learning Session	October 2018 Learning Session	Final Reports and Assessment Due
Coaching Begins	Progress Report Submitted	May 2018 Virtual Learning Sessions			Final Grantee Interviews with Evaluators
Project Charters & Driver Diagrams Submitted		Progress Report Due			

KP Transformation Accelerator Evaluation Update

October 10, 2018

Center for Community Health and Evaluation
www.cche.org

Evaluation goals



Assess changes in health center capacity and impact on patient health outcomes

Understand the contribution of the Transformation Accelerator program to health centers' progress

Provide real time feedback to CCI & partners to inform the program

Communicate results to key stakeholders

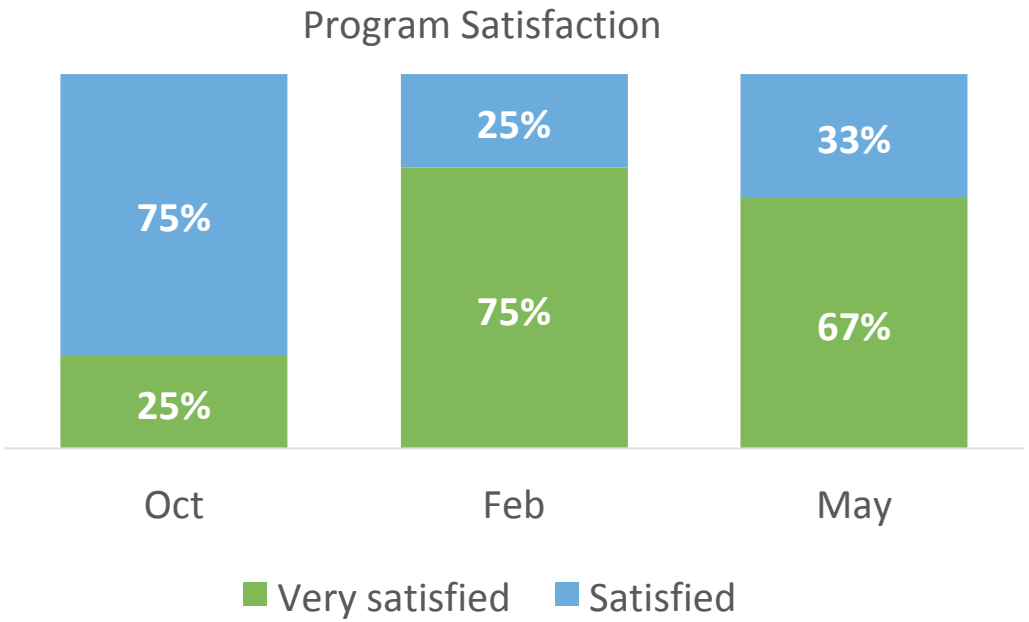
Data Collection

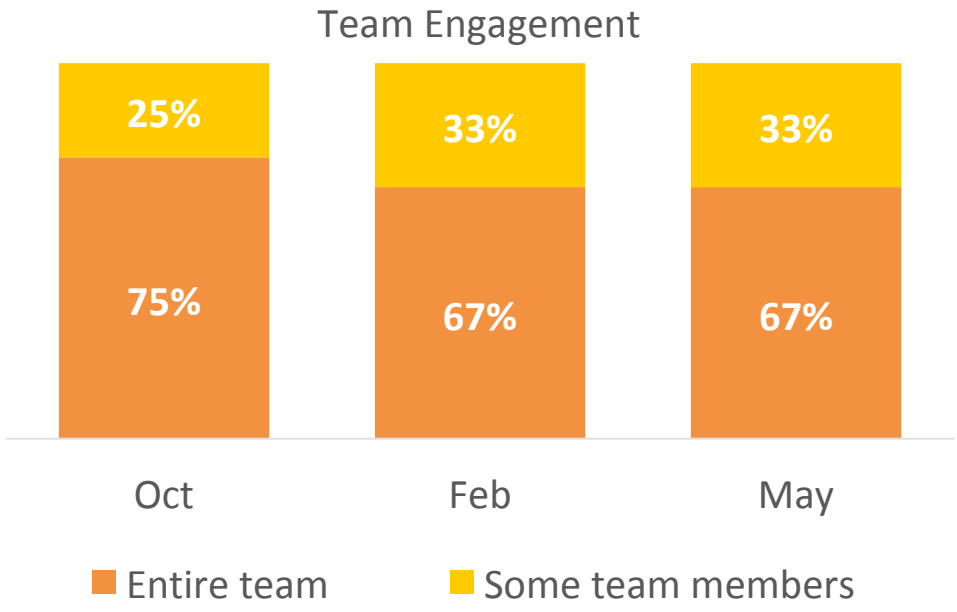
- Quarterly pulse surveys
- Quarterly health center interviews
- Capacity assessments
- Data tracking via run charts
- Informal and formal interviews with CCI program staff
- Observation of convenings & webinars

Initial evaluation results:

Program feedback provided to CCI

Program feedback: Satisfaction & engagement is high

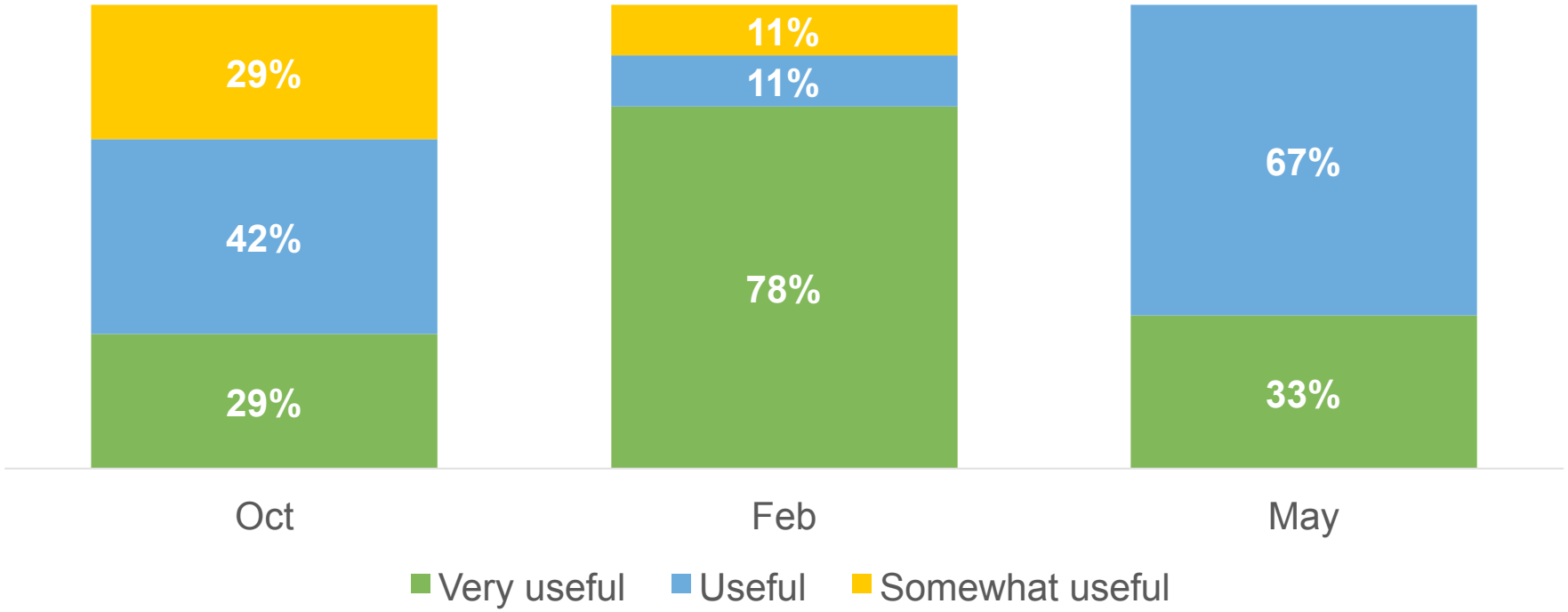




"The team is getting more engaged…I'm seeing some of the providers are getting a deeper appreciation for quality work and how it can be used..."

-Health center interview (July)

Program feedback: Coaching seen as useful



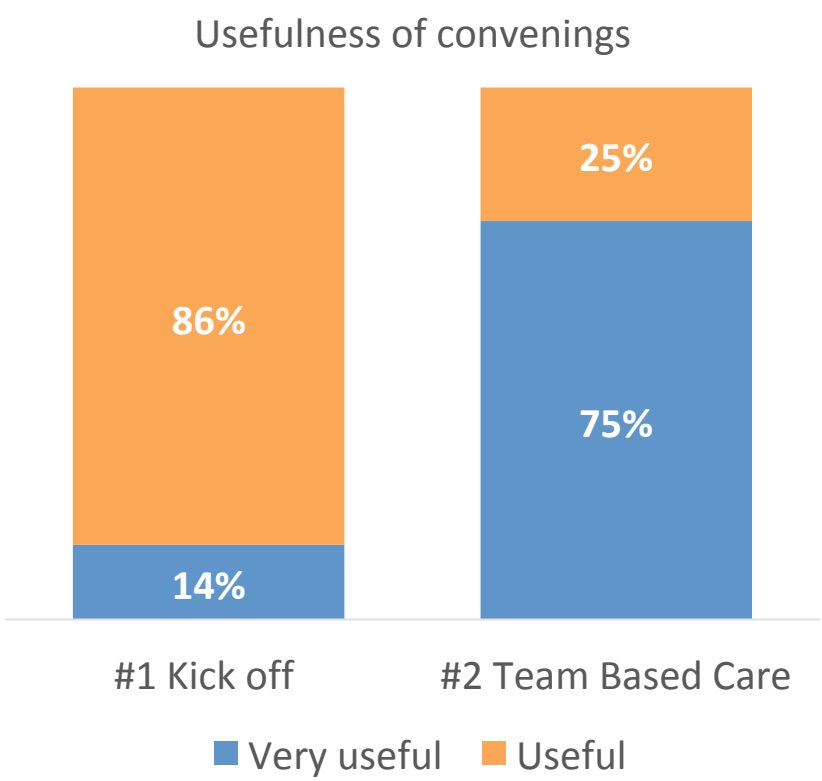
"Both [coaches] are very experienced and knowledgeable and it's always a pleasure to hear their advice."

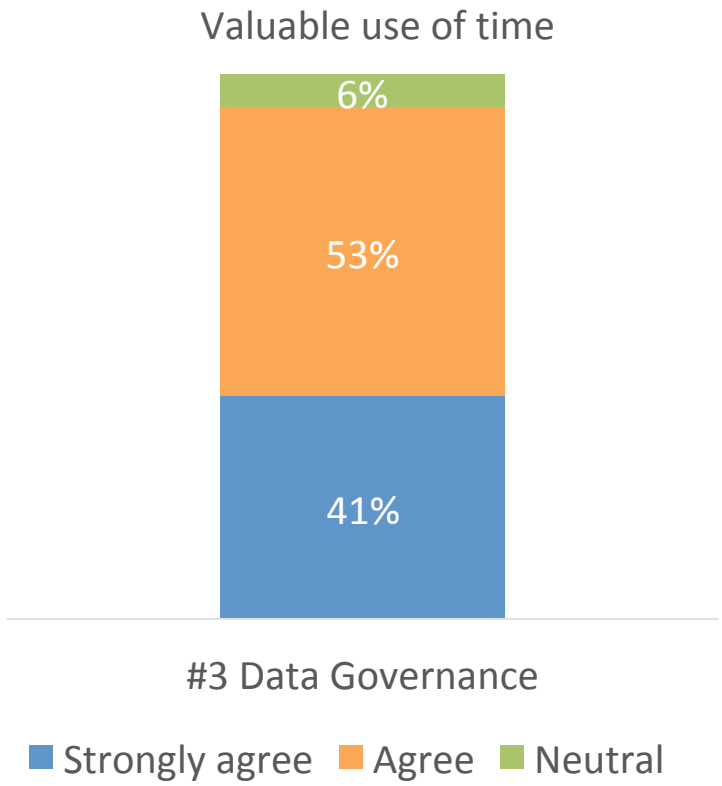
-Health Center Interview (Oct)

"[Coaching] forces you to keep the project in front of you. It forces the group to reinvest and look at the data to see where we are."

- Health center interview (July)

Program feedback: Convenings are highly rated





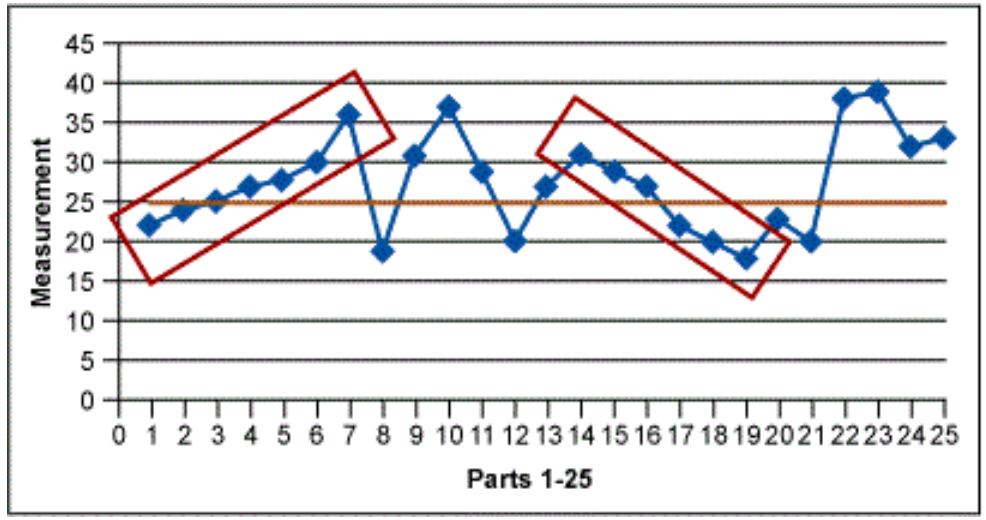
"… it was a good balance between sharing information and giving us time to work as a team. Often you go to a full day convening, you get excited, have all these ideas, and then you can't implement them. So, it was a good balance between learning and doing time."

- Health center interview (March)

"The convenings have been very well done, I think the convenings have been some of the best that I've seen."

- Health center interview (March)

Program feedback: Run charts have been helpful



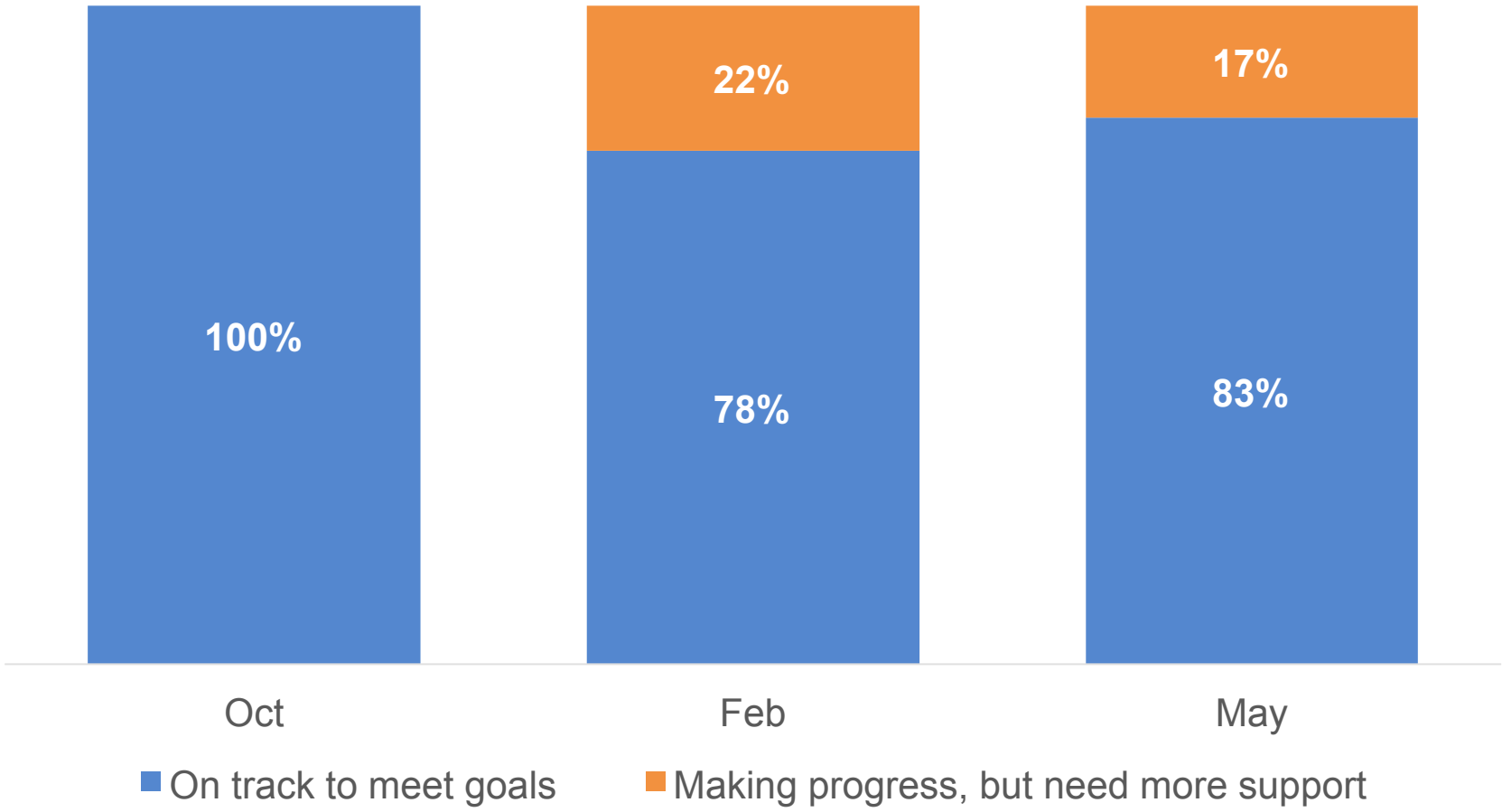
"[Run charts] are something we have already used but it's a good way to display the data for everyone to understand. We try to make sure all levels of staff see it, and sometimes we show them to patients."

-Health center interview (May)

"I think the run chart really helped. I want to present data that way from now on. I work with data all the time, and run chart was a new term. I like how they broke it out. It's nice to present data in a new way. So, that was very helpful."

-Health center interview (May)

Health center progress:
Teams feel confident about progress toward goals



Health center progress: Facilitators & challenges

Facilitators

- Staff/leadership buy-in
- Dedicated project time
- High quality TA

"I see people are more empowered, especially the team working on this, and since participating in this, they are advocating. There is overall improvement with the site and people are paying attention."

- Health center interview (March)

Challenges

- Staff turnover
- Staff buy-in
- Competing priorities
- Time
- Data challenges

"…trying to get providers to understand what we're doing. We have so many projects going on, and I think providers can feel overwhelmed, and it takes time to get buy in."

- Health center interview (July)

Evaluation next steps: What to expect

Evaluation Next Steps

Final pulse survey - coming in the next few weeks

Final interview-scheduling starts soon

Data tracking-will continue through the end of the program

Informal and formal interviews with program staff

Focus of final data collection efforts

- To what extent have participating health centers **made progress on capacity building goals**?
- To what extent have participating health centers **improved targeted clinical, operational and/or financial performance**?
- To what extent have **practice changes been sustained and spread**?

Questions and comments

Maggie Jones
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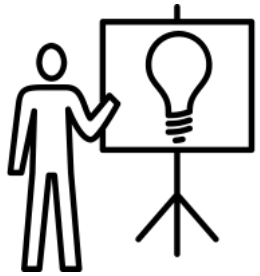


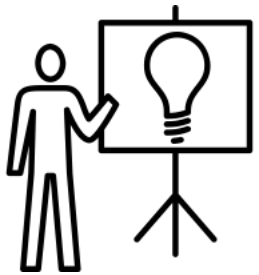
Team Pitches

Pitch Rounds

1. Greater Baden Medical Services
2. La Clínica Del Pueblo
3. Mary's Center
4. CCI Health & Wellness Services
5. Family and Medical Counseling Service, Inc.

Components

- Your core team
- Aims and measures
- Primary drivers and changes
- Data visuals such as run charts, graphs, or tables
- Learnings and challenges



Team Pitches

GREATER BADEN
MEDICAL SERVICES
Primary and Preventive Health Care

Greater Baden Medical Services

Core team members have included:

Dental

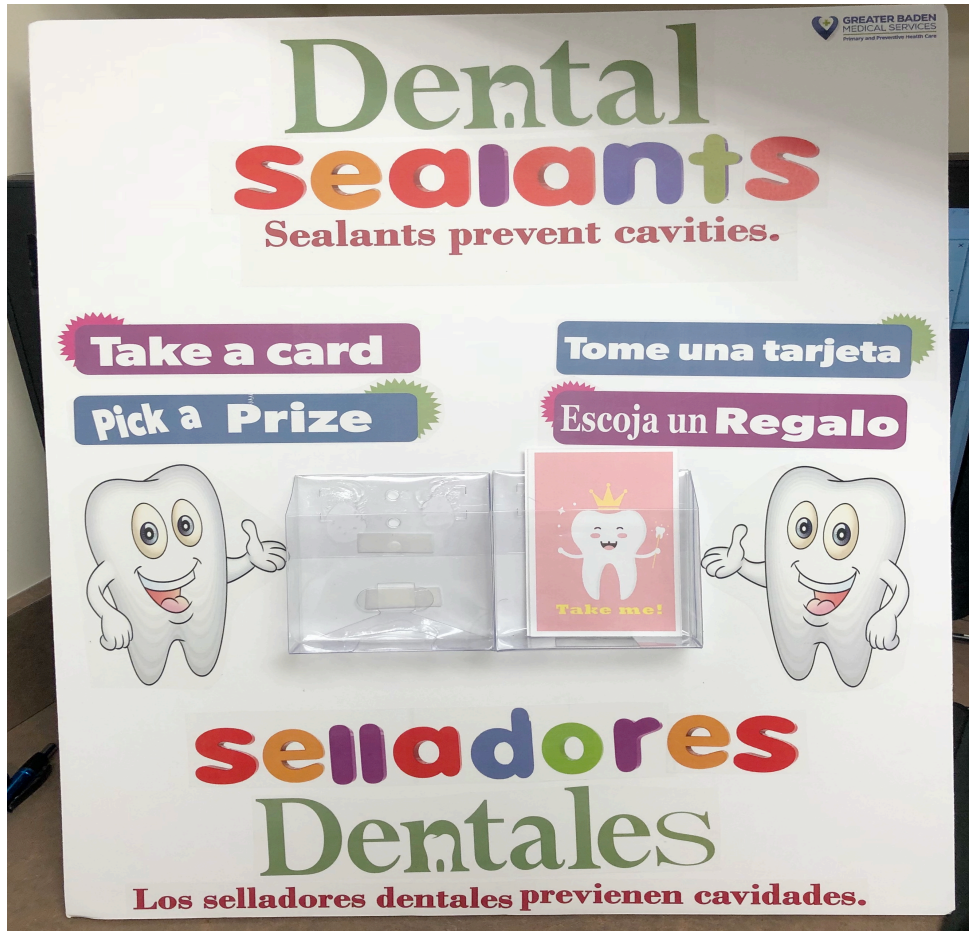
- Dr. Henry, dentist
- Guadalupe Limrick, dental assistant

Pediatrics

- Dr. Vasudevan
- Tamika Heard, Clinical Medical Assistant
- Deb Apperson, CRNP, Quality

1. Future state

More children of all ages that take advantage of our on site dental services.

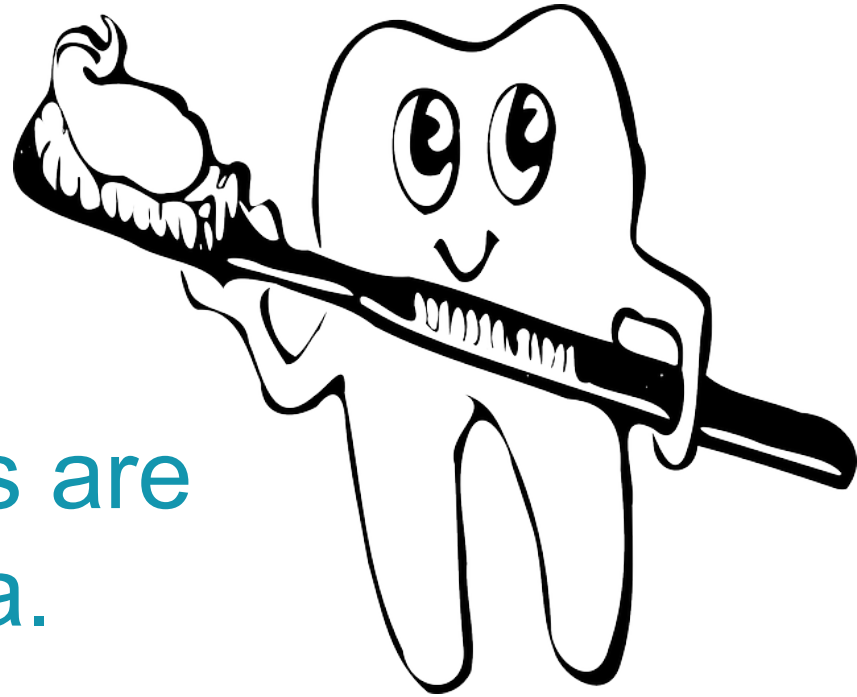


2. Key learnings

- We learned that providing a specific intervention to a small subgroup of patients presented more challenges than we expected.
- Knowledge deficit
- Time constraints
- Rigid schedule template

3. Impactful changes

- Education on the need for sealants
- Pediatric room posters.
- Providing same day access appointments
- Documentation and correct codes are essential to capture accurate data.



3. Impactful Changes

Section N – Dental Sealants for Children between 6-9 Years **12.50%**

Line	Description	Demographic	Number of Patients with Sealants to First Molars (c)	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Percentage Per Line
22	Children aged 6 through 9 years,at moderate to high risk of caries who received a sealant on a first permanent molar	100% and below	2.00	9.00	22.22%
		101-150%	0.00	3.00	0.00%
		Over 200%	0.00	1.00	0.00%
		Unknown	1.00	11.00	9.09%
		Grand Total	3.00	24.00	12.50%

Data on number of 6-9 year olds with mod-high risk YTD = 24

4. Benefits

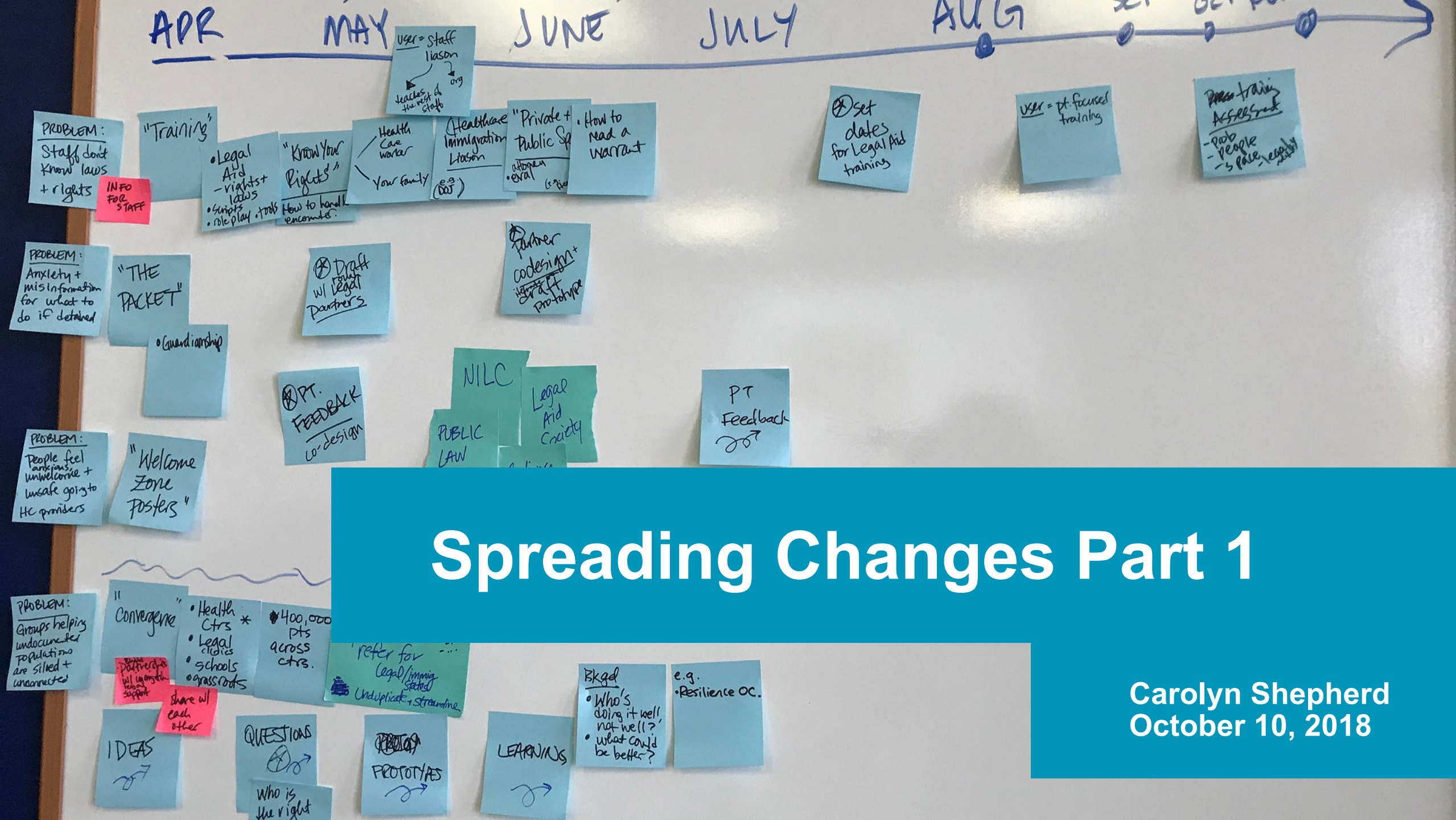
- An unexpected benefit to the providers on the team was an increased interest in data
- GBMS is exploring pre-visit planning process in dental services.
- The lessons learned are applicable for spreading to other outcomes such as improving the use of inhaled corticosteroid use in asthma

5. Negative impacts

- If we stop focusing on screening our targeted population for moderate to high risk for caries and providing sealants there will be an individual cost of potential dental and health issues.
- Improving this outcome will get lost in the busyness of practice

6. The “pitch” – or “ask” of your leadership

- Training for pediatric and pediatric staff on innovative thinking concepts learned to excel in promoting dental health.
- Time to engage each other and share ideas
- Selection of “champions” to promote these ideas and put them into practice



Spreading Changes Part 1

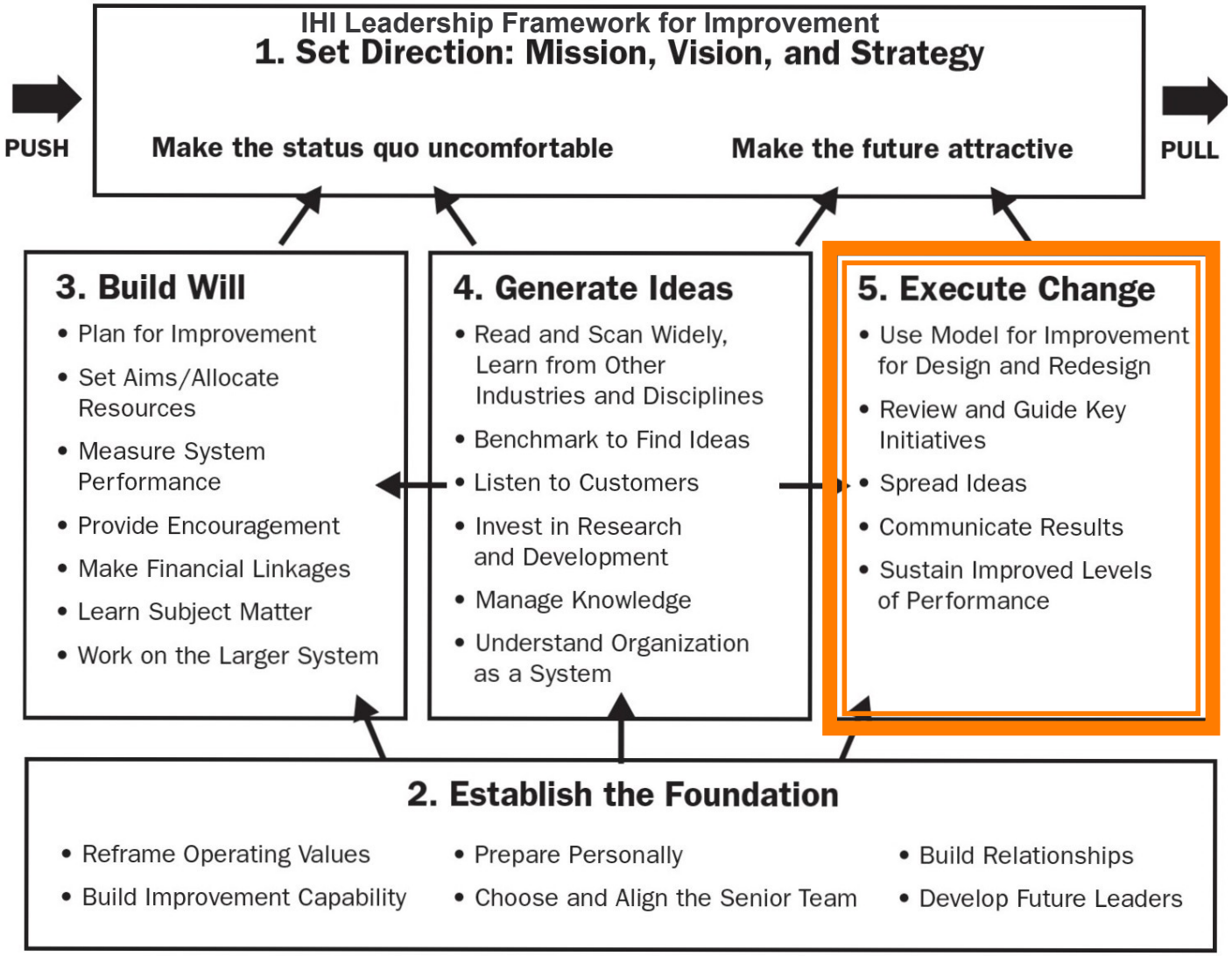
Carolyn Shepherd
October 10, 2018

"It's not the innovation that matters most it's what happens after the change."

Dr. Rob Reid, SNMHI

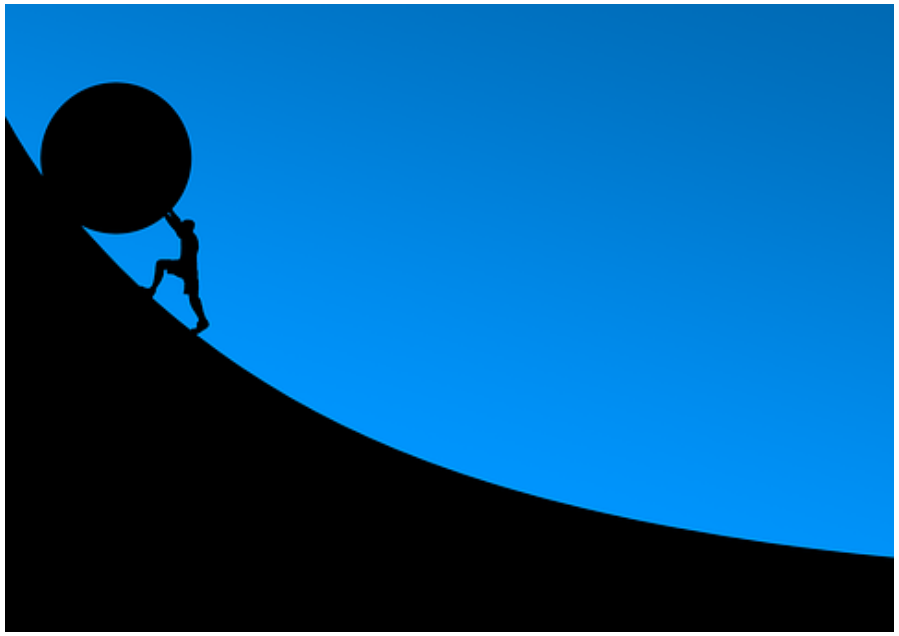
What's the Challenge with Spread and Sustainability?

1. Will
2. Ideas
3. Execution



Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition).* Cambridge, Massachusetts: Institute for Healthcare Improvement; 2008.

Why Is Spreading Change so Challenging?



- Start with large projects
- Find one person willing to do it all
- Expect heroics to overcome poor processes
- If a pilot project works once then spread it unchanged
- Look at process and outcome measures quarterly
- Fail to pay attention to process reliability
- Default to innovators to create system-wide spread

Adapted from: Lloyd R. Applying the Science of Improvement to Daily Work. Chicago: HRET; 2012.

Spread vs. Adoption

Optimally, spread is the result of the process of adoption.

Adoption is the group of behavioral changes embraced by the people who do the work.

Spread	Adoption
Push ideas outward to others	Pull ideas into myself
My agenda at the center of a larger organization	My agenda at the sharp end of delivering care
Use of organizational structure and hierarchy to communicate about change	Use of social systems to communicate about change
A focus on tools, techniques and processes	A focus on relationships and facilitation

Table Exercise

Think about a recent change that you spread in your organization…

- What was the change?
- Who did you spread to?
- Did others adopt the change? Why or why not?
- If you could do it all over again, what would you do differently?

Group report out

Critical Domains for Spreading Change

Leadership	Communication	Infrastructure	Measurement
• Critical role for both formal and informal clinic leaders throughout the change process	• Strategy for reinforcing vision, information gathering and sharing and supporting behavior changes	• Creating policies, processes, staffing and physical space for enhancing change	• Assessing continued improvement and avoiding regression to the past

Organizational Leadership for Spreading Change

Executive Leadership

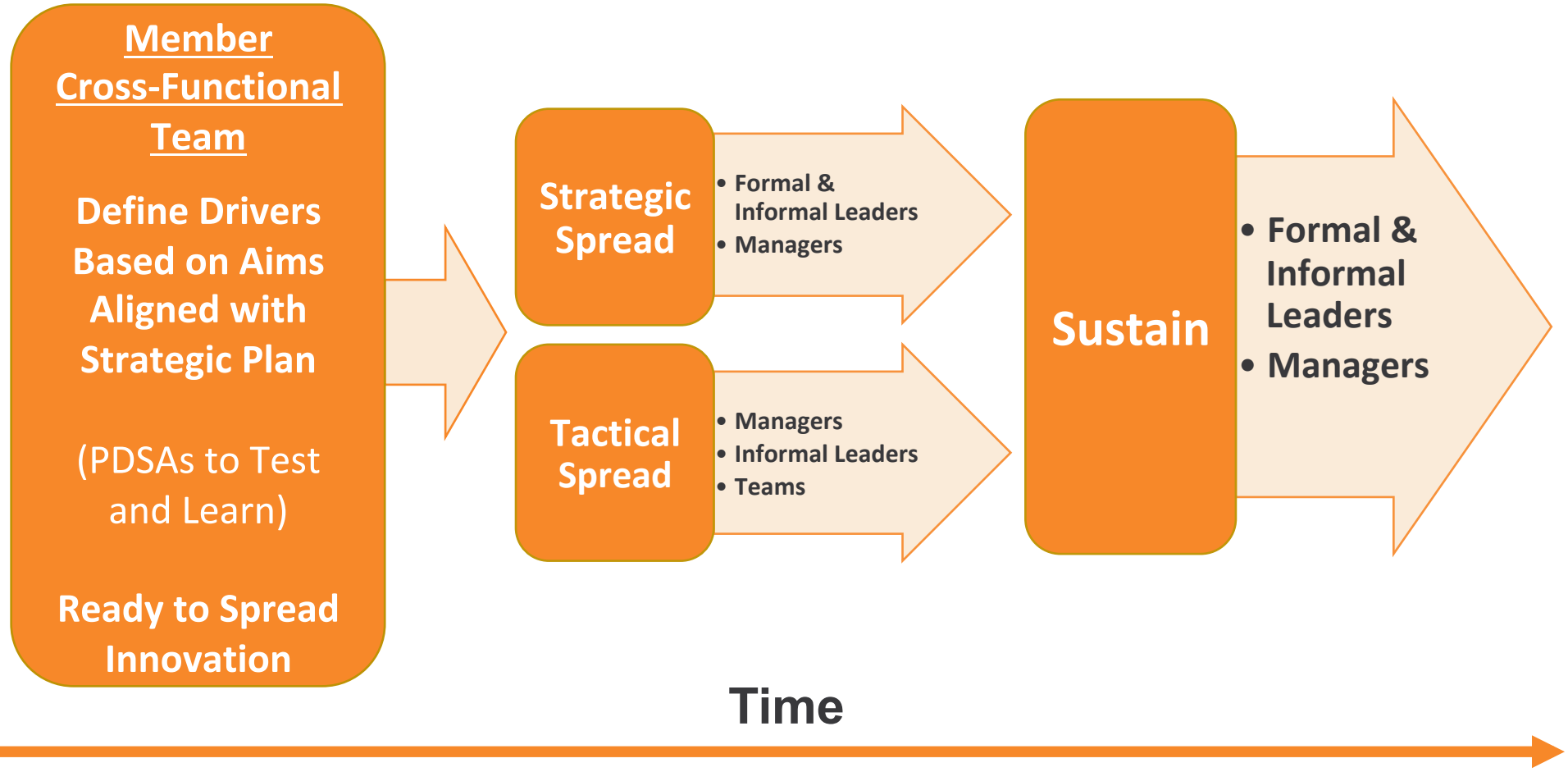
Strategic Spread

Management Leadership

Tactical Spread

Team Leadership

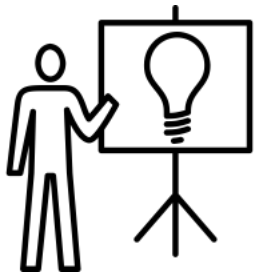
Leadership Accountability for Change over Time



Leadership for Spreading Change

- Create vision
- Lead by example
- Leverage history
- Motivate, inspire, coach
- Support and build teamwork for adoption

Take a break!



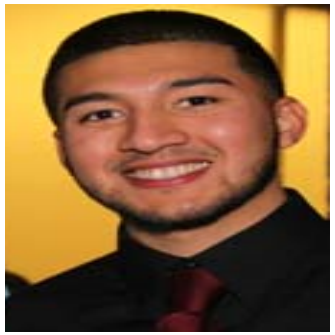
Team Pitches

LA CLÍNICA DEL PUEBLO

Pitch Presentation

October 10, 2018

La Clinica del Pueblo – KPTA Core Team



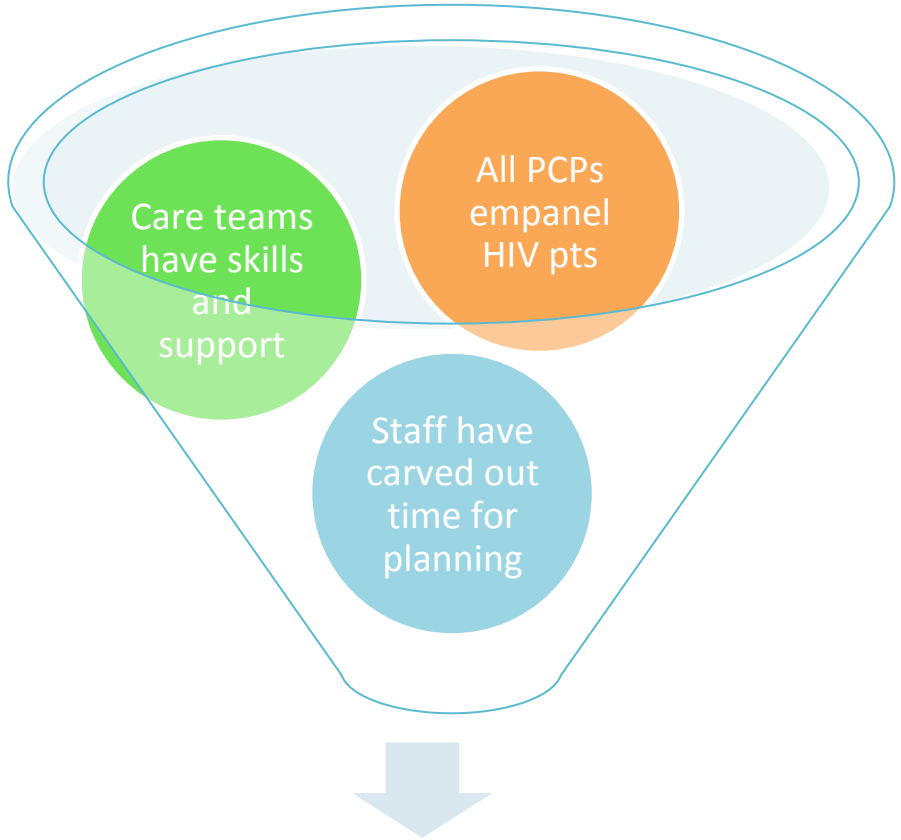





- Marlene Fuentes, Director of Clinical Operations
- Catalina Sol, Chief Programs Officer
- Ricardo Fernandez, Chief Medical Officer
- Claudia Husni, Physician
- Kenia Garay, Patient Care Coordinator
- Palmyr Cardenas, Patient Care Coordinator
- Melanie Lugo, Care Coordinator
- Nelson Cruz, Health Educator/Navigator
- Lucy DeOliveira, Director of Nursing/CM
- Axel Reyes, Sexual Health Program Manager
- Suyanna Barker, Senior Director for Health Equity and Community Action

LA CLÍNICA DEL PUEBLO

I. Future state



Spanish-speaking immigrants living with HIV in Prince George's have accessible, culturally and linguistically appropriate, high quality services

LA CLÍNICA DEL PUEBLO

2. Key learnings-- adding HIV services to our Hyattsville site

- There is a demand for services, both from internal patients and external stakeholders
- Key staffing gaps needed to be addressed in our workflows
- We had thought about mentorship for clinician, but identified value of this in other roles
- Team members identified need for training on stigma and creating safe space
- It was important to involve DC counterparts in the planning and roll-out

LA CLÍNICA DEL PUEBLO

3. Impactful changes

Training	Most value derived from interaction between members of various teams, particularly around understanding LGTBQ issues
Data	Generating data reports on all clients served per month allowed us to monitor unexpected events
Recruitment	Offering tours of the facility to meet team members supports existing Prince George's County patients to transfer care from DC to MD
Workflow	Tools to debrief and meeting to evaluate workflows after first patient was seen helped to identify unaddressed areas of protocol

LA CLÍNICA DEL PUEBLO

4. Benefits from KP project

- Team building in Hyattsville
- Increased collaboration between teams, across sites and departments
- Opportunities for learning and skills building for our providers
- More accessible service options for our patients
- Still coming -- Increase in access to services for newly diagnosed patients to services

LA CLÍNICA DEL PUEBLO

5. Negative impacts of ending project

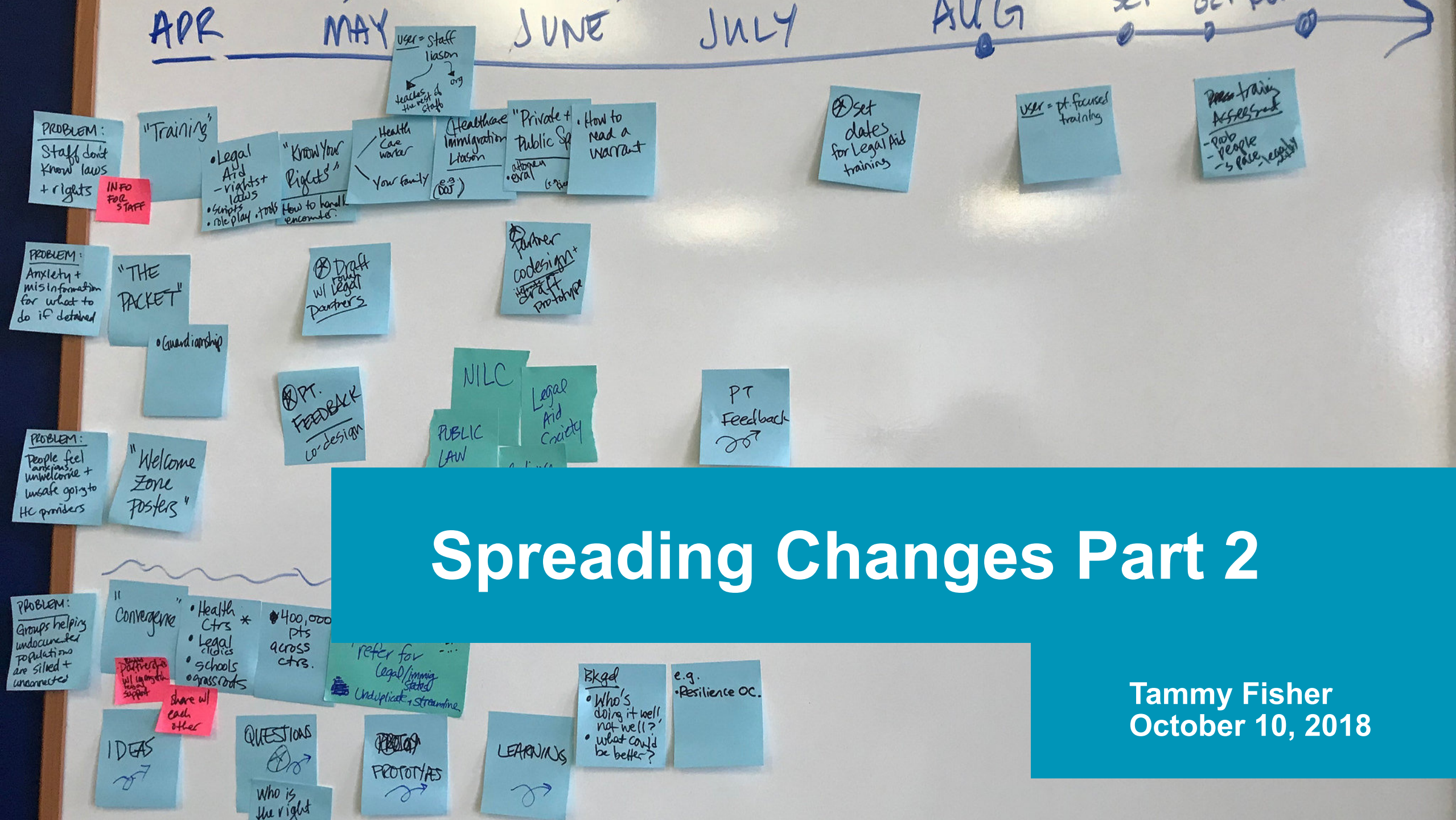
- Reputational – have made commitments to patients, staff, and external partners
- Momentum – team takes time to build
- Quality – still more to learn about services and standards, refine workflows
- Access – without planning we will continue to have limited number of providers who have ability to empanel patients living with HIV

LA CLÍNICA DEL PUEBLO

6. The "pitch" – or "ask" of your leadership

- Maintain dedicated space for direct service staff and providers to meet, plan, and evaluate service delivery
- Begin mentorship around HIV care with additional clinicians

LA CLÍNICA DEL PUEBLO

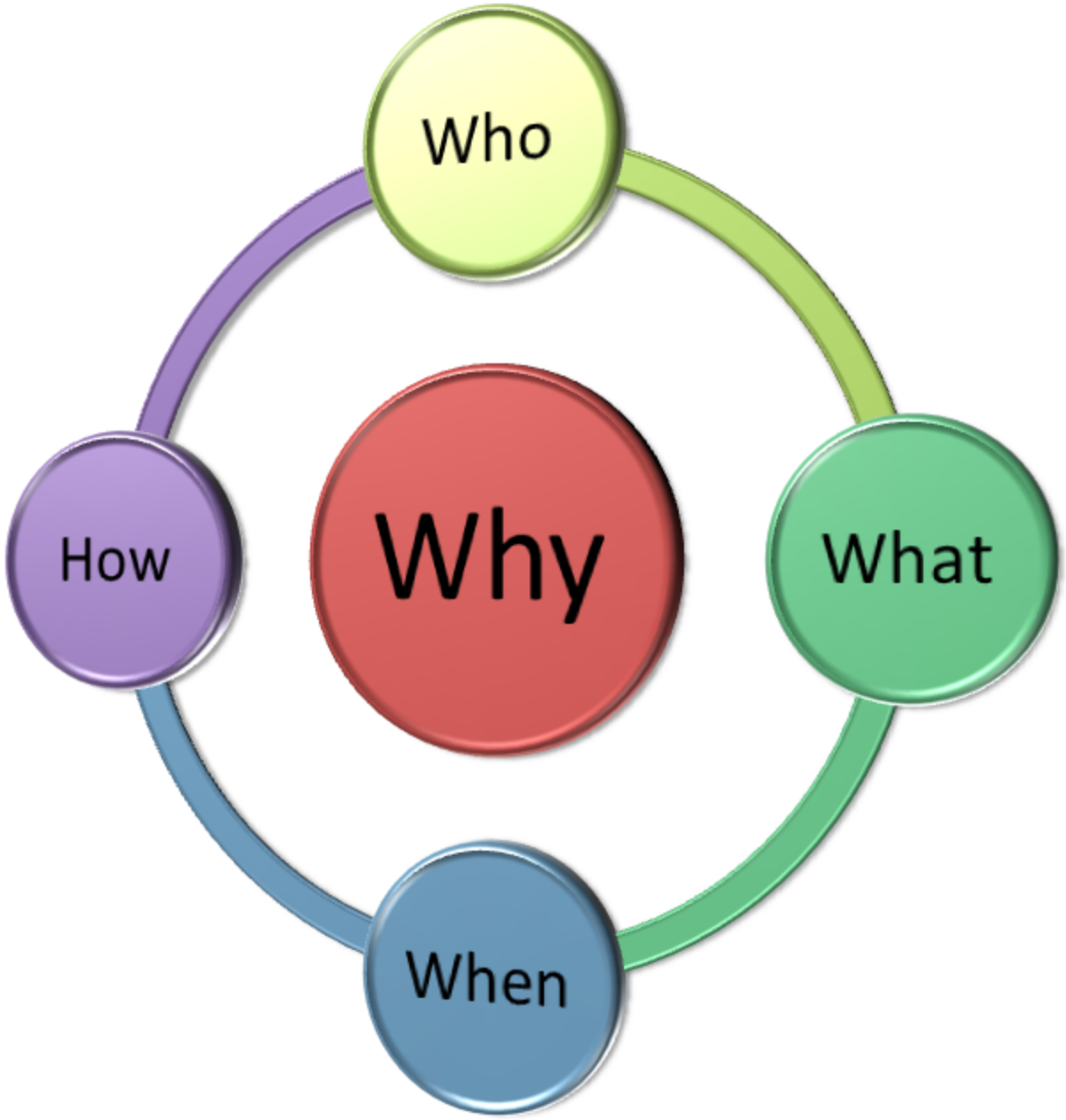


Spreading Changes Part 2

Tammy Fisher
October 10, 2018

Communication

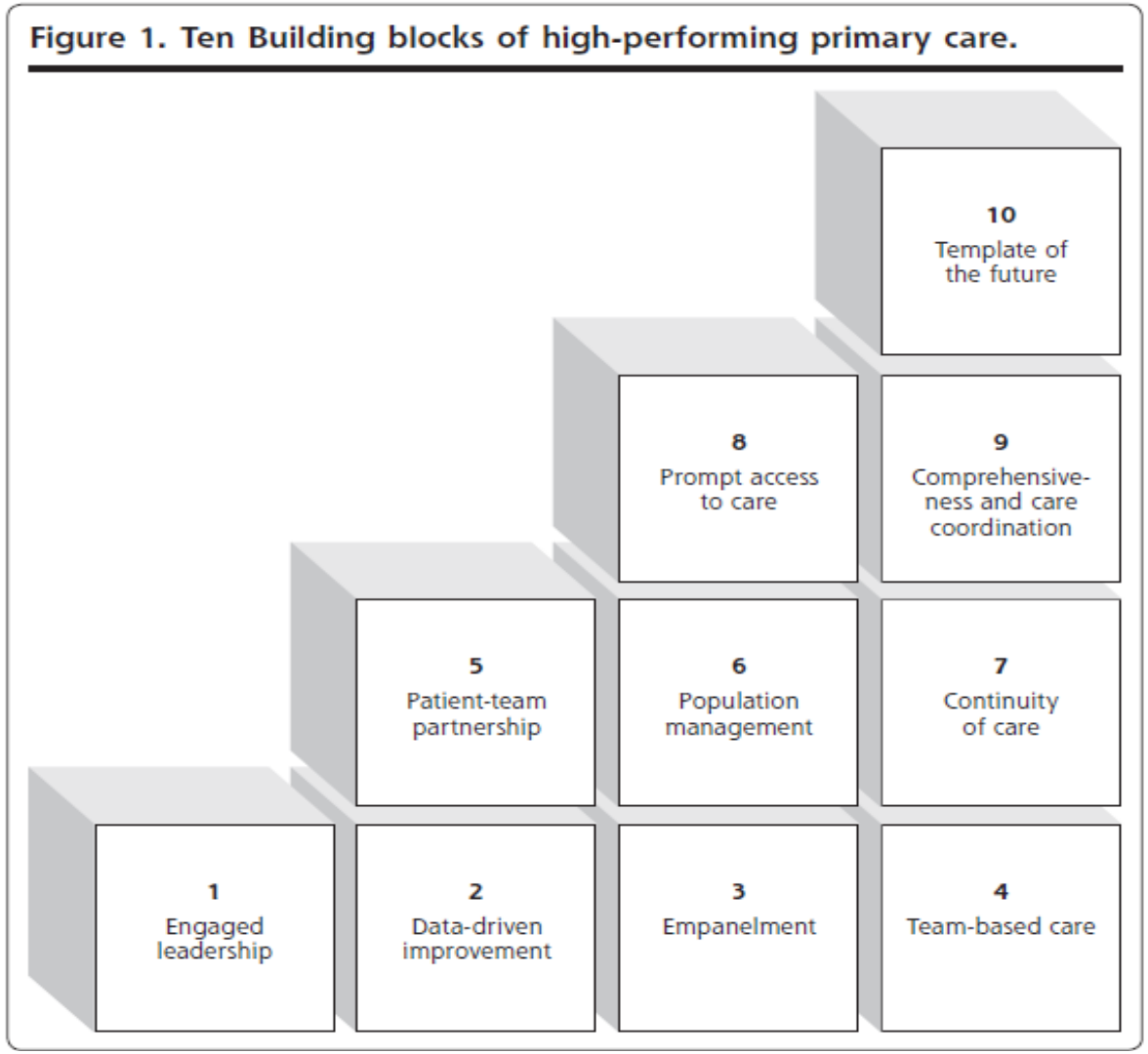
- Identify changes to spread
- Identify audiences, assess for readiness
- Identify effective communication channels based on readiness
- Leverage existing communication structures
- Develop communication action plan



What Do We mean by Change Concepts and Changes?

A change concept is a general notion or approach to change that has been found to be useful in generating specific ideas or changes that lead to improvement

- Huddle with data report
- Flag patients missing pap
- Educate and prep patient for pap



Creating Attraction for Spread

1. Strength of evidence: clinically appropriate
2. Advantageous: better than status quo
3. Compatible: fits with existing office systems
4. Simplicity: change is straightforward
5. Compatibility: ties to values
6. Trialability: break change into small steps
7. Observability: see success at a pilot site

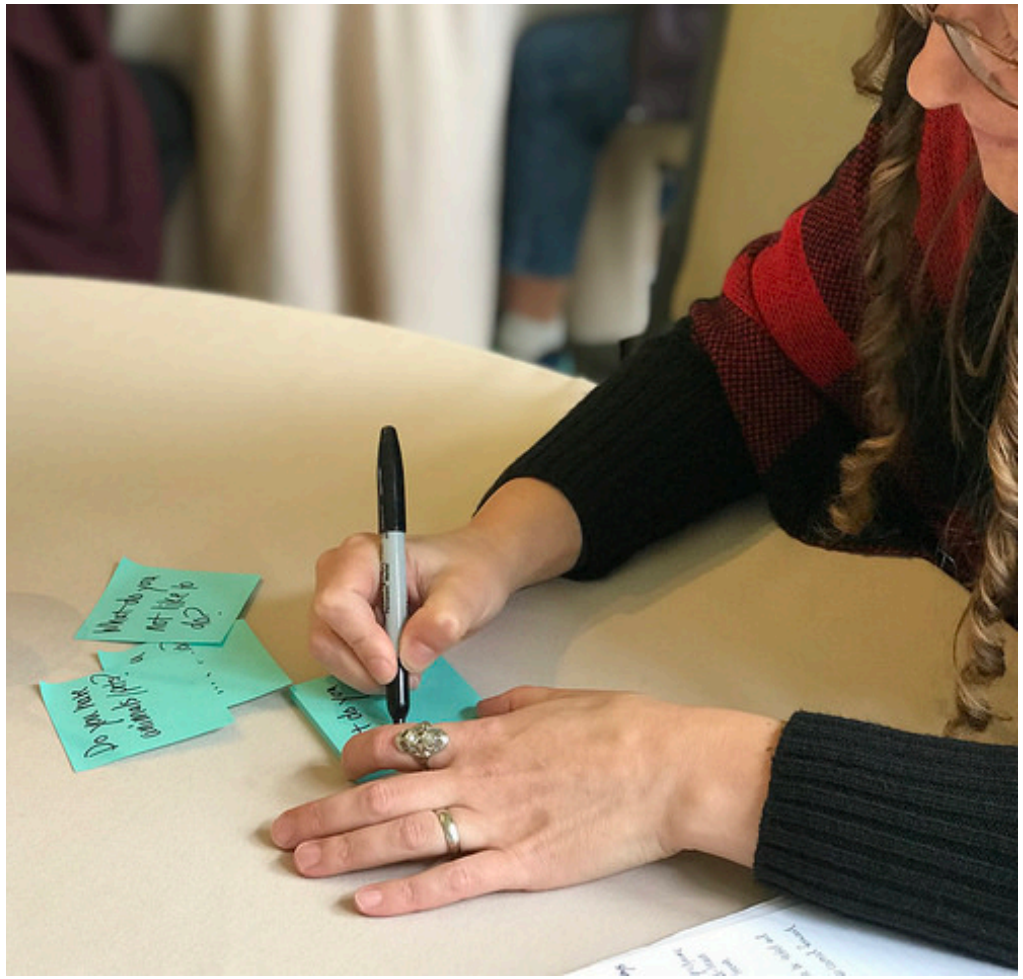
Table Exercise

What changes do you want to spread?

In your Communication Action Plan:

Answer the first question, “What is the change you’d like to spread?”

- Write down one change from your KPTA project that you want to spread.



Adoption is a DOING thing

"Better Ideas"

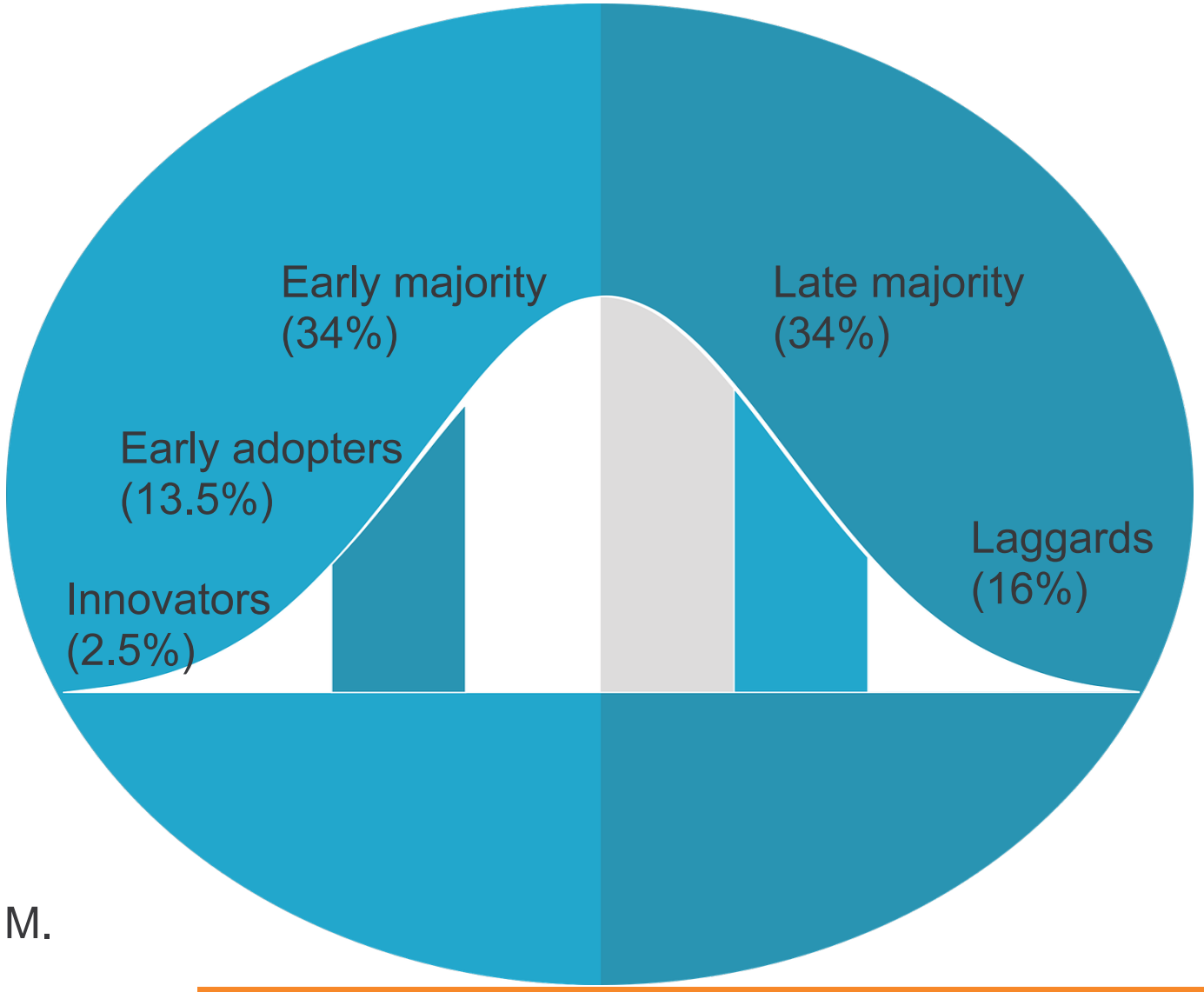
COMMUNICATED

In a certain way

Thru a **SOCIAL** system

Happens over time

Diffusion of Innovation



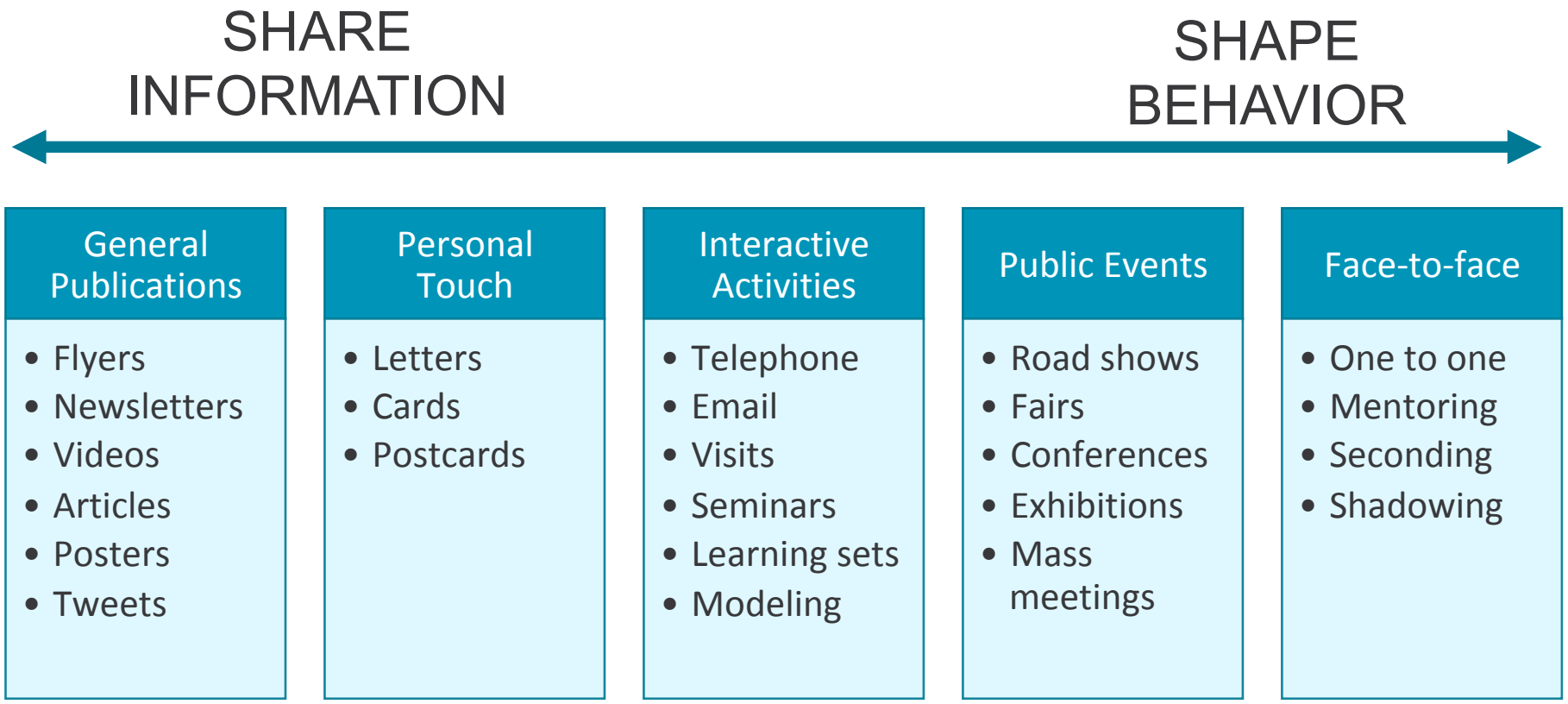
Adapted from Everett M. Rogers

Assessing Readiness for Change

Stage	How can you tell?
1. Pre-contemplation	Unaware of opportunity/need
2. Contemplation	Making a judgment based on perceived advantages and barriers
3. Preparation	Taking some steps i.e. learning more
4. Action	Implements/adopts change
5. Maintenance	Decides to continue with change

(Prochaska and DiClemente, 1994)

The WAY We Communicate Is Important



Adapted from Ashkenas, 1995 © 2001,Sarah Fraser

Communication Action Plan

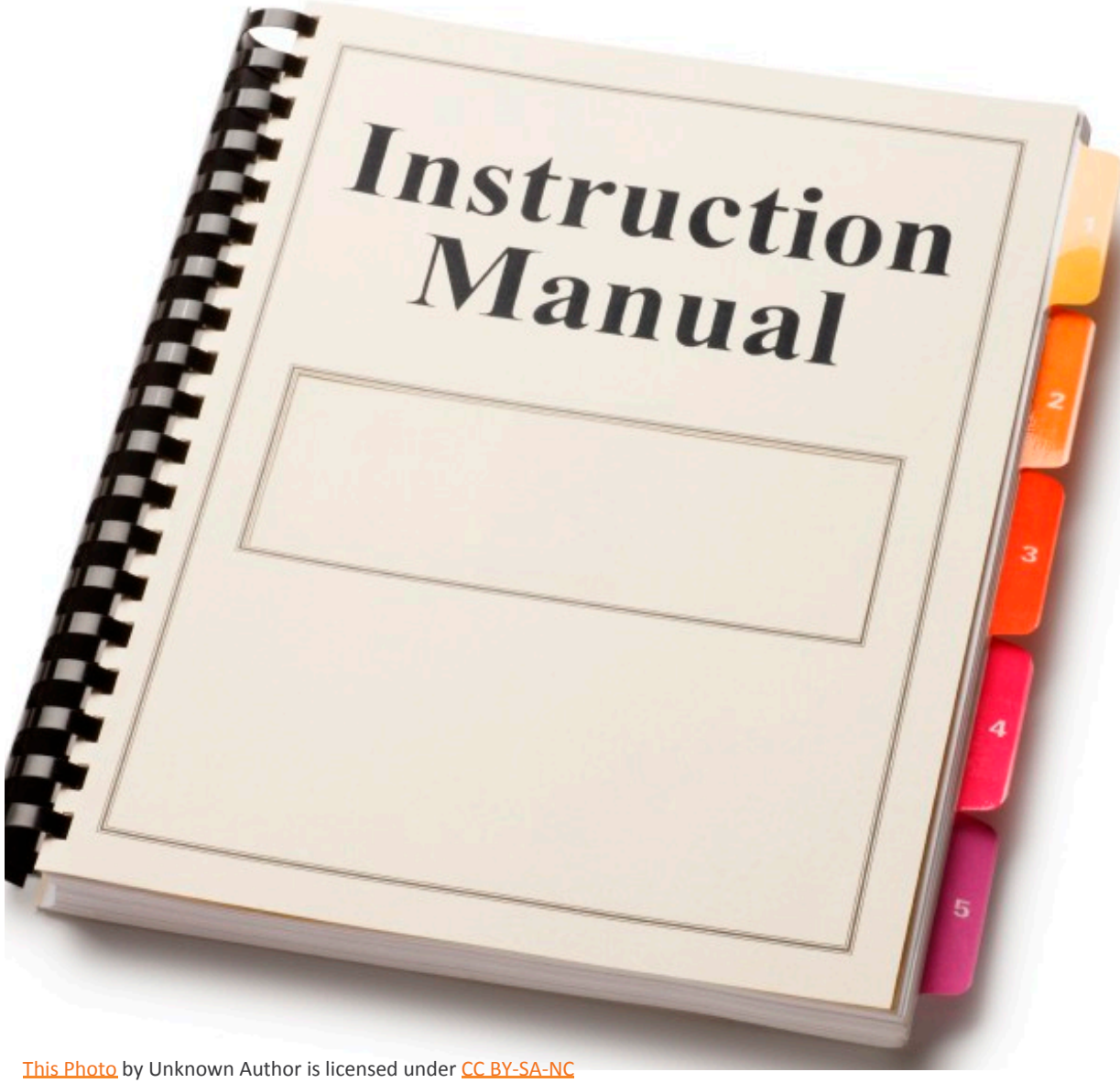
What is the change you'd like to spread? _____

Why should people adopt the change (goal clarity)? _____

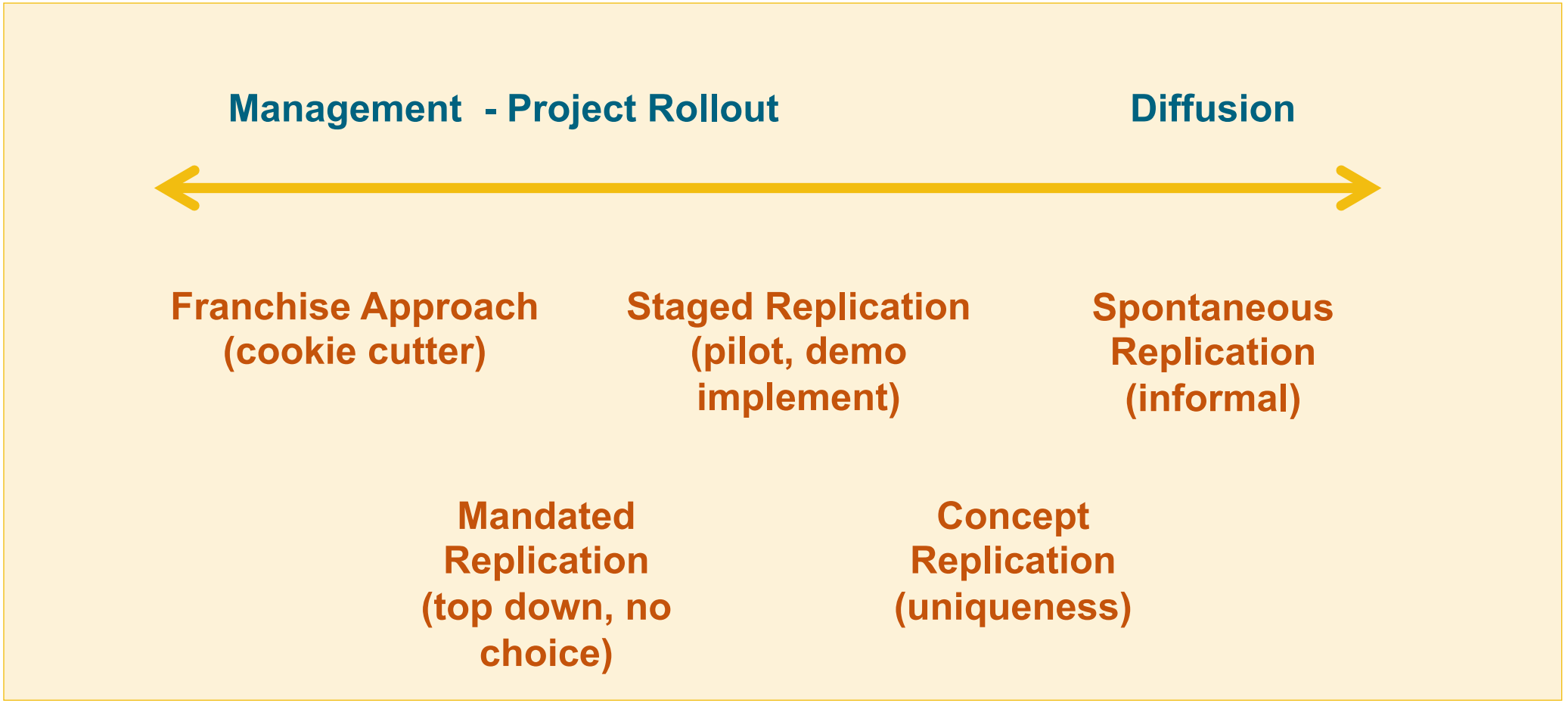
Key audiences Who do you want to spread to?	Unlock commitment Are there pre-existing attitudes, awareness, experiences we need to address? Where are people in the change process?	Impactful messages What are the key messages, what do people need to know? How do you say it so it will resonate?	Decisive Action How do you want the audience to act, think, or feel? Create the path, what do you expect them to do?	Execution excellence			
				Channels or methods – how will the change be communicated?	Timing – when will the change be communicated?	Who will communicate the change?	Status- what happened?

Infrastructure

- Spread methodology/approach
- People to lead and manage the change – embed in job descriptions
- Training, including policies and procedures, skills and competencies
- Career ladders and succession planning
- Technology
- Community partnerships

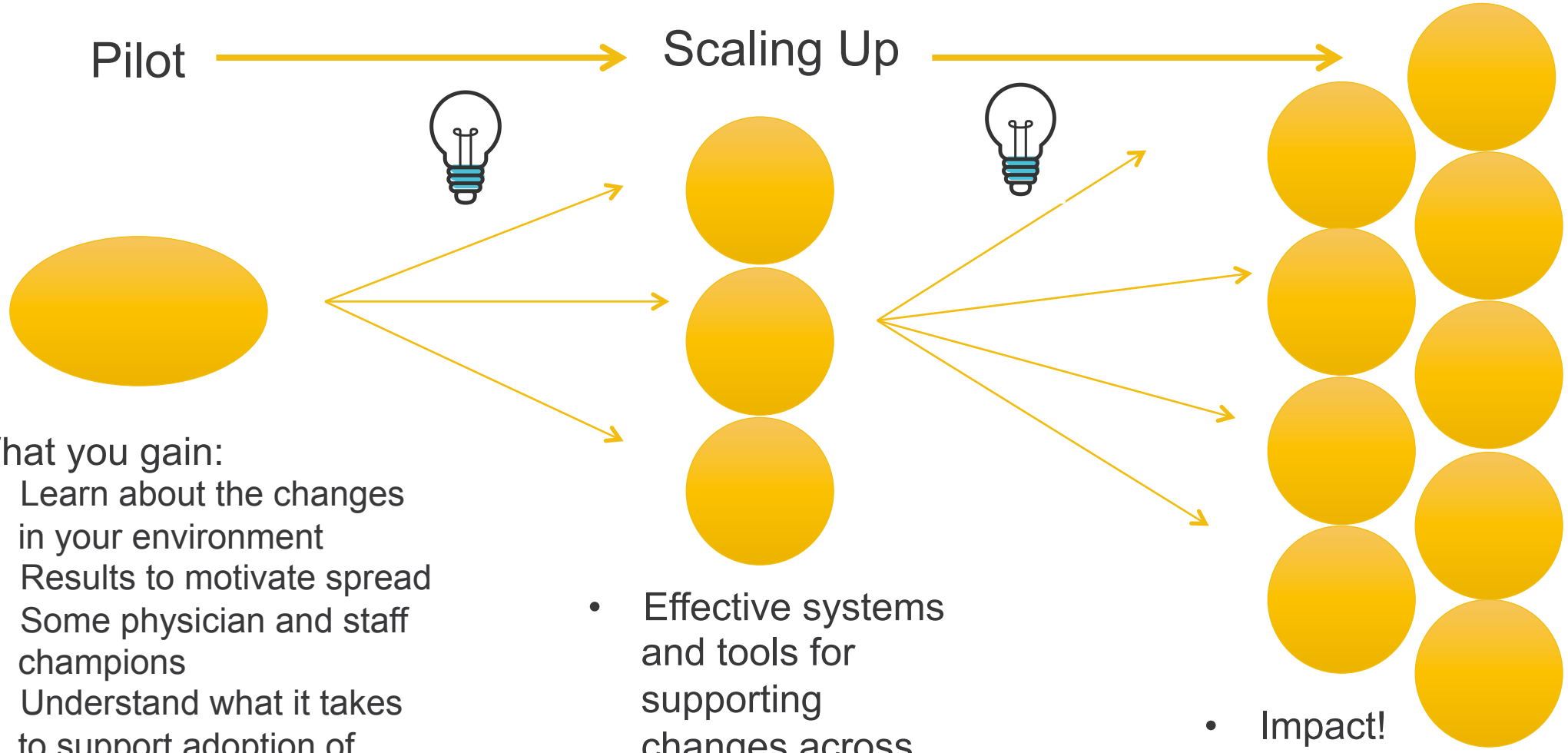


Spread Models



Adapted from Sarah W Fraser, 2001

Staged Approach



What you gain:

- Learn about the changes in your environment
- Results to motivate spread
- Some physician and staff champions
- Understand what it takes to support adoption of practice changes

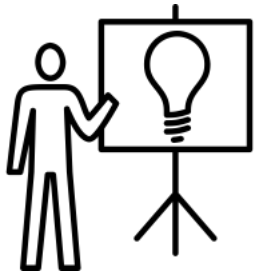
- Effective systems and tools for supporting changes across many sites

- Impact!

Table Exercise

How might you approach spread of the change you identified?

- At your table, discuss in your team
  - What spread methodology might you use?
  - Who will lead the change? Who will manage the change?
  - What training is needed?
  - What ideas do you have for training staff?
- Table report outs
  - Share your ideas!

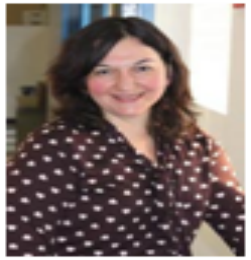


Team Pitches

Mary's Center

Mary's Center

Ashley Harris, MD, MHS
Cancer Screening Champion



Alis Marachelian, MPH
Senior Director Community Health Initiatives & Strategic Alliances

Dara Koppelman RN, BSN, BA
Chief Nursing Officer

Nathalie Gonzalez, MPH
Senior Manager of Quality and Outcomes

Rosa Goyes
Associate Director Community Health Education, Training & Research

We have a multidisciplinary core team made up of members with different perspectives who contribute to this project.

1. Future state

- Improve cervical cancer screening rates at our Prince George's County, MD site from baseline 75% to 82.5%.
    - Strategy: To identify, develop and implement and point of care system to identify care gaps for patients.

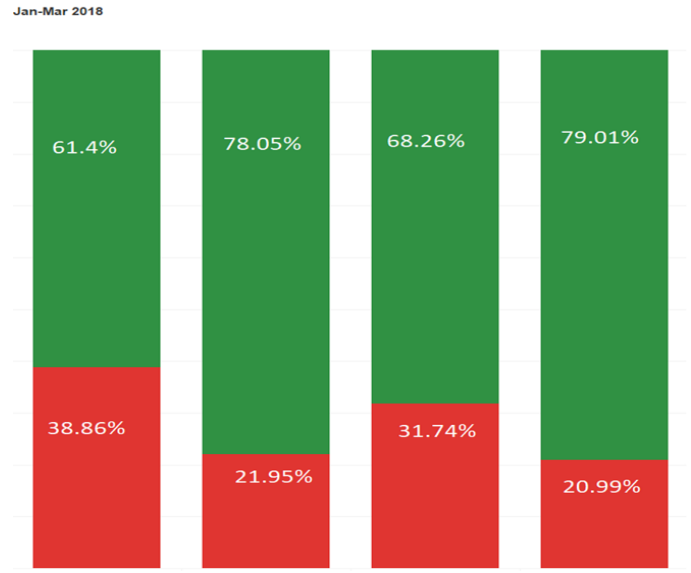
- Expand the use of the Point of Care Alert tool developed into all sites and add other clinical measures to it.

2. Key learnings

- Former policy provided guidelines of screening and attempted to accommodate participants
- Participant's misunderstanding of cervical cancer screening
- Competing medical priorities
- Data pull coding

3. Impactful changes

- Updated policy
- Individual provider data dashboard
- Point of Care Alert tool pilot
- Update/constant review of data script
- Workflow changes



4. Benefits

- Updated policy provides specific guidance to medical staff
- Data to demonstrate range to improve
- Development of Point of Care Alert tool – improved chart review
- Engagement of staff involved in cancer screening: improved workflow with feedback

4. Benefits cont…

- Improved cancer screening rates
- Lower costs
- Educated, engaged and healthier participants
- Tool can be expanded to include other measures

5. Negative impacts

- No measurement of tool used long term (efficiency/efficacy)– lack of improvement
- People fall back into “old ways”
- Missed opportunities to close gaps of care
- Higher costs
- Measured outcomes goals

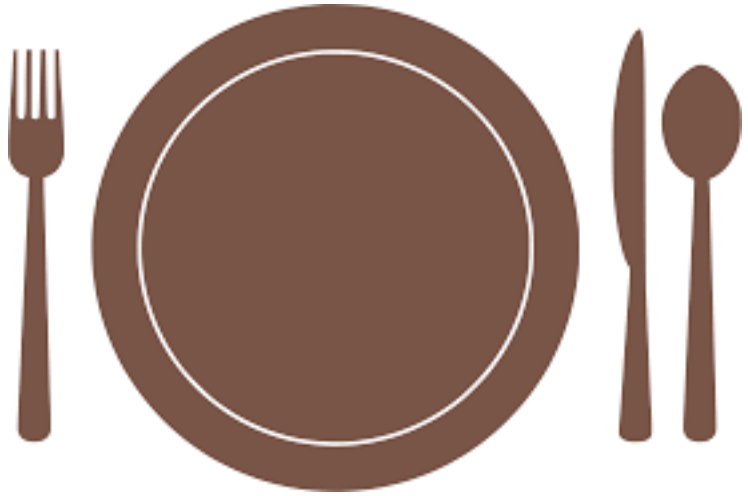
6. The “pitch”

- In order to sustain the spread this project:

- It is a continuum
- Time
- Staff
- Support platform
- Accountability / Engagement

Thank you!

Lunch



Prince George's County Community Health Center Collaborative

Transformation Accelerator Shared Project
October 10, 2018

Health Equity

Health is a "State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity.“

World Health Organization

Health Equity is the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Healthy People 2020

Reducing Health Disparities by Addressing Health Determinants

Health Disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Determinants of Health influence an individual's or population's health. "Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies."

Ecological Systems Theory

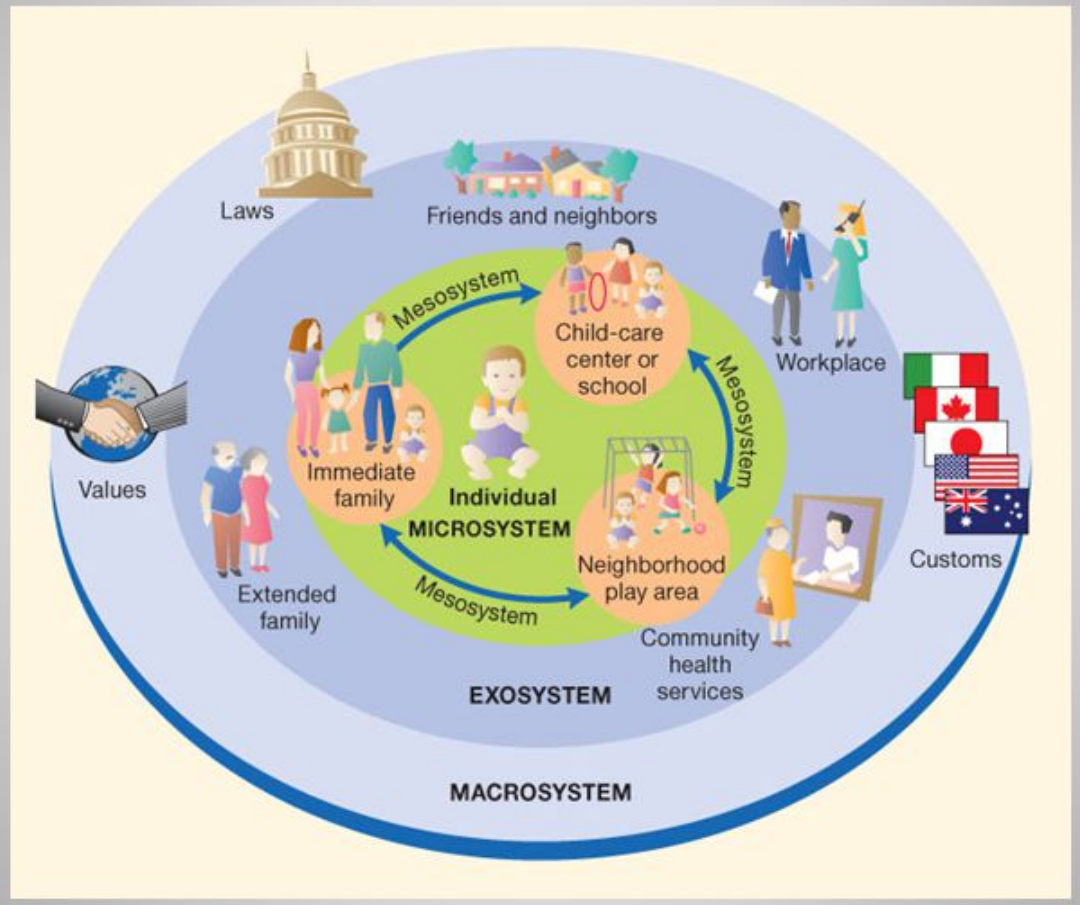


Figure 1.5

Transformation Accelerator
Shared Project Goals

- Create a shared impact statement and common “ask” for Prince George’s County policy-makers and elected officials.
- Increase Health Center participation in health planning processes and advocate for policies and programs that will improve the health of County residents.
- Educate County Executive and County Council members about the contributions of the Community Health Centers and advocate for support for health services for the uninsured and policies that improve the health and well-being of all County residents.
- Develop strategies to address key health concerns in Prince George’s County.

Strategy

- Create a briefing paper and develop a consensus advocacy position proposing a program to establish a primary health care program for the uninsured.
- Establish regular communication with the Chief Health Officer to request inclusion in health planning and propose a program for providing primary health care for uninsured County residents.
- Educate elected officials about the health disparities in Prince George's County and the role of Community Health Centers in addressing these disparities.
- Promote the creation of a $3.5 million pilot program to address the health needs of lower-income, uninsured adults and request an investment of $1 million to expand the Care for Kids program to serve children who are ineligible for MCHIP.

Comparison of Maryland County Indicators Ranked from 1 to 24

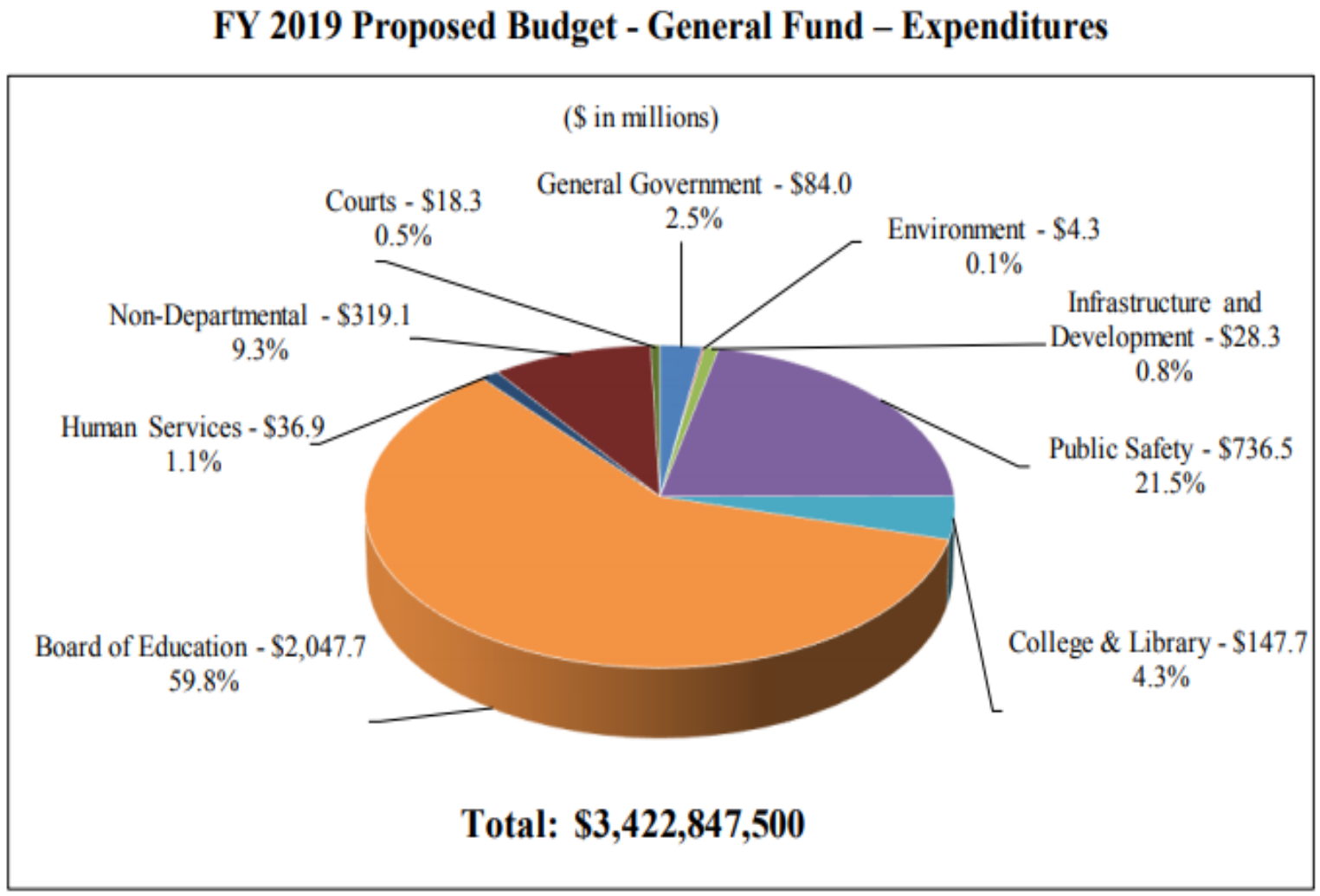
Ranked Indicators	Prince George's County	Montgomery County
Health Outcomes	14	1
Health Behaviors	10	1
Clinical Care	22	2
Social & Economic Factors	16	4
Physical Environment	7	11

County Health Rankings and Road Maps 2018

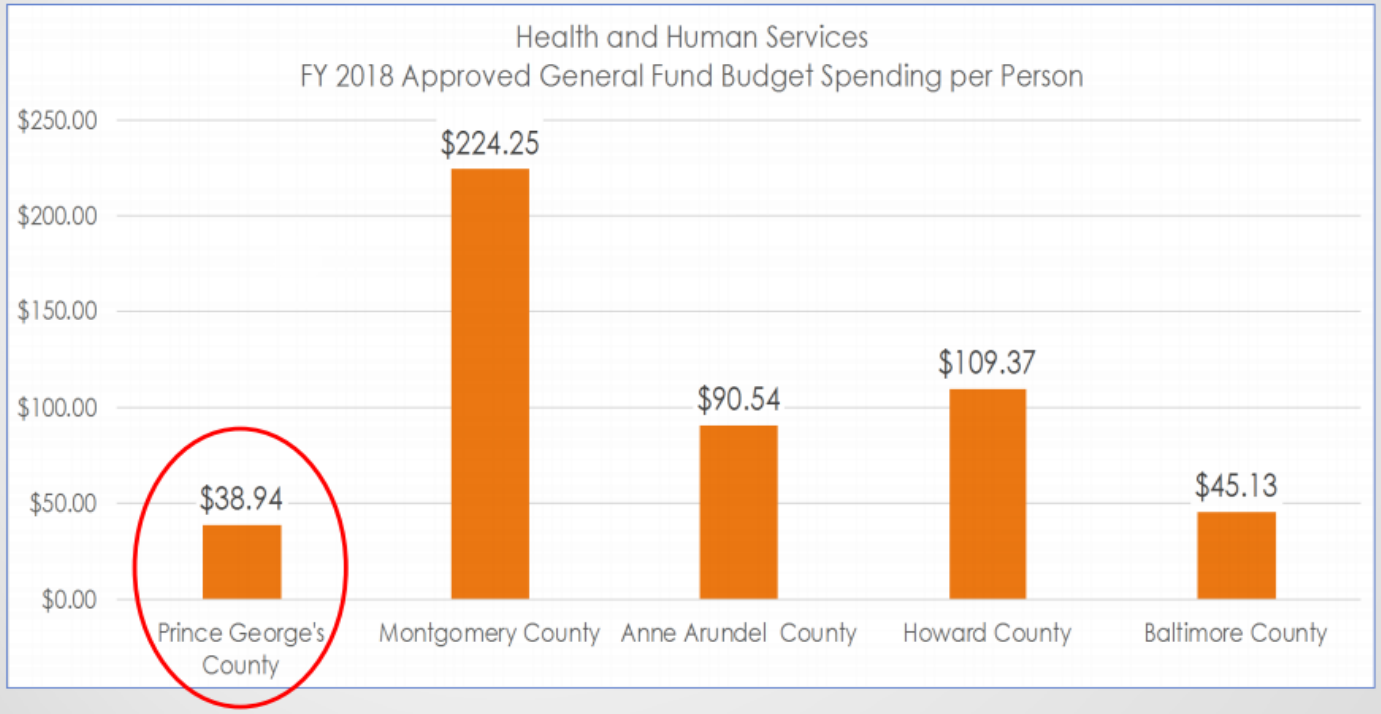
Prince George's County Proposed 2019 Budget

Despite an $1.5 million in the Human Services budget, it still represents a small portion of the overall Budget.

It is significantly less than Investments of neighboring Maryland counties and the District of Columbia.



Sector Investment: Per Capita Regional Comparison, FY18



Prince George's County Council, 4/3/18

12

https://pgccouncil.us/586/CouncilConnection
April 6, 2018

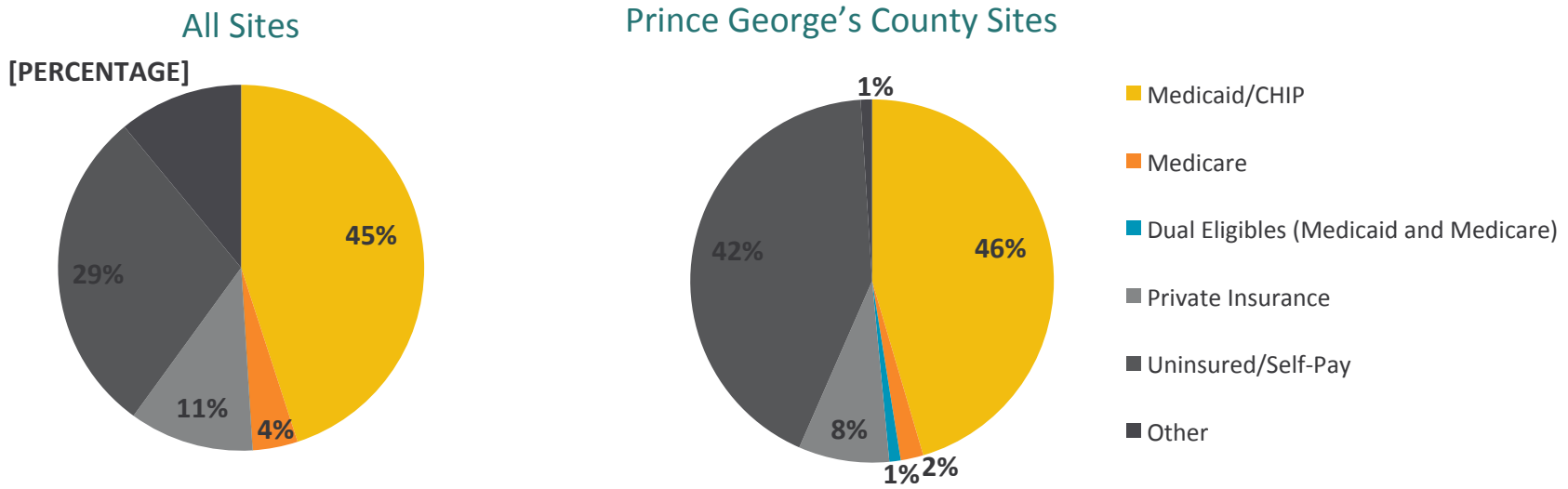
Providing Care for the Uninsured

- Community Health Centers bear the burden of uncompensated care for uninsured residents, many of whom have complex health and socio-economic needs.
- Supporting care for the uninsured will reduce health disparities and improve the health of Prince George's County residents.
- Investing in the primary health care infrastructure will ensure that quality health care services are available, accessible, and sustainable.
- There are many examples of successful, locally-funded programs designed to promote health equity that can be adapted for the County.

FQHCs in Prince George's County

- In 2017, six FQHCs served 34,000 Prince George's County residents at 11 facilities within the County and facilities in neighboring jurisdictions.
- Together, they provided:
    - 61,500 medical visits
    - 5,500 behavioral health visits
    - 2,500 dental visits

42% of Patients served in Prince George's County lacked Health Coverage

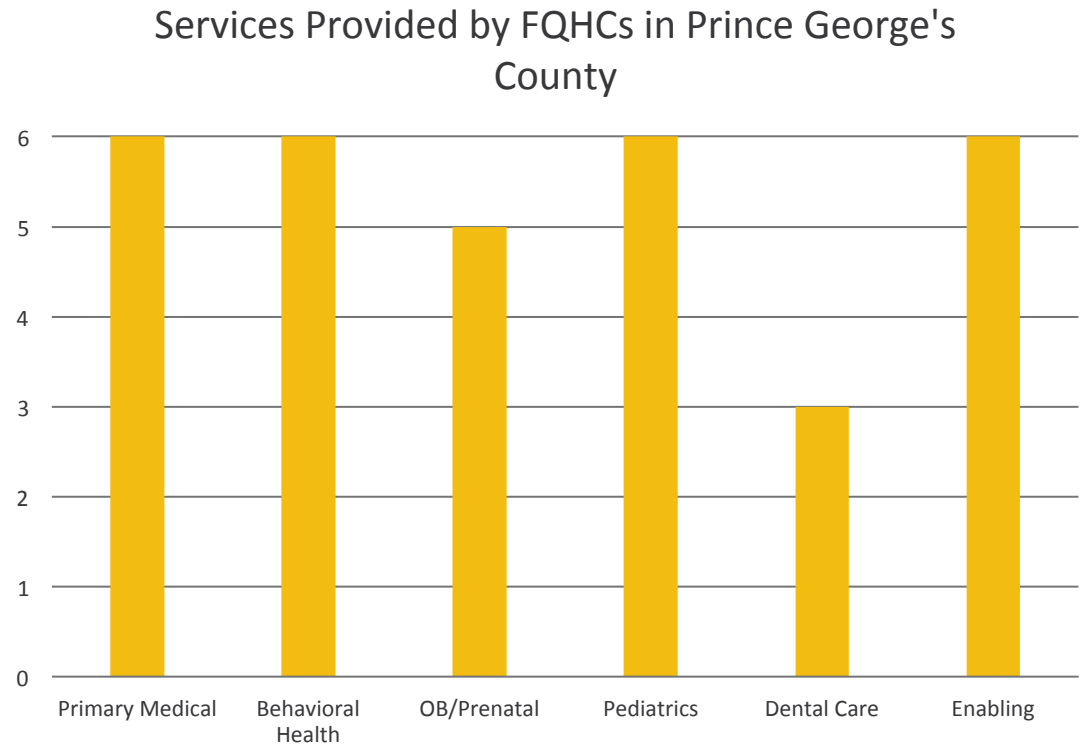


Patients served in Prince George's County are more likely to be uninsured or self-pay than in the District of Columbia or Montgomery County, both of which have locally-funded programs that cover lower-income, ineligible residents.

FQHCs Serve Under Resourced Communities and Vulnerable Residents

In 2016,

- 39% of patients were children under the age of 18
- 98% of patients were racial or ethnic “minorities”
- 73% of patients spoke a primary language other than English



FQHCs Contribute Health and Economic Resources to Prince George's County

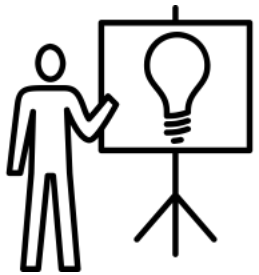
- Employ **322** Prince George's County residents
- Engage **37.5** FTE clinicians and **6** licensed behavioral health professionals to practice in the County
- CHCs create opportunities for health professionals' training including:
    - medical residency programs;
    - clinical rotations for social workers;
    - specialized programs for medical assistants and community health workers.

FQHCs Advocate on Behalf of their Communities

Data only tells part of the story; a person's lived experience is a powerful tool for advocacy.

- Makes the data real and creates empathy
- Portrays needs in a personal, relatable and respectful way
- Exemplifies determination and resilience
- Provides patients and their families with a voice
- Illustrates the relationship between inequities, resulting health disparities and outcomes

So Tell Us Their Story . . .



Team Pitches

CCI health & wellness services

KPTA Storyboard

CCI Health & Wellness Services
Greenbelt

10,000

economically disadvantaged/homeless/disabled

state medical assistance coverage or uninsured

Services

Prenatal, Reproductive Health, Family Planning,
(Preventive Cancer Screenings, Nutrition Counseling, Centering)

Claudia Guevara
Health Center Manager

Transformation Goals

from 78% to 85%

preventive cervical cancer screenings
Patients (21-29 yrs) by July 2018

Screening Guidelines

Approved July 2017

Driver Diagram

January, 2018

Org. goal
Increase the percentage of patients 21 to 29 years of age who had a preventive cervical cancer screening (Cytology or PAP) within the past 3 years from 78% to 85% by the end of FY18.

Project outcome
To ensure that women beginning at the age of 21 are receiving there pap's every 3 years if results are normal and yearly if results are abnormal.

Primary Driver (1)
Having a more efficient way of tracking when women are due for Pap's

Secondary Driver (1)
Make sure to get results if patient received Pap smear elsewhere and Verify that each patient eligible for annual Pap gets in for an appointment.

Ideas to test
Add a pop up for patient who is due for a Pap, or need results from last pap.

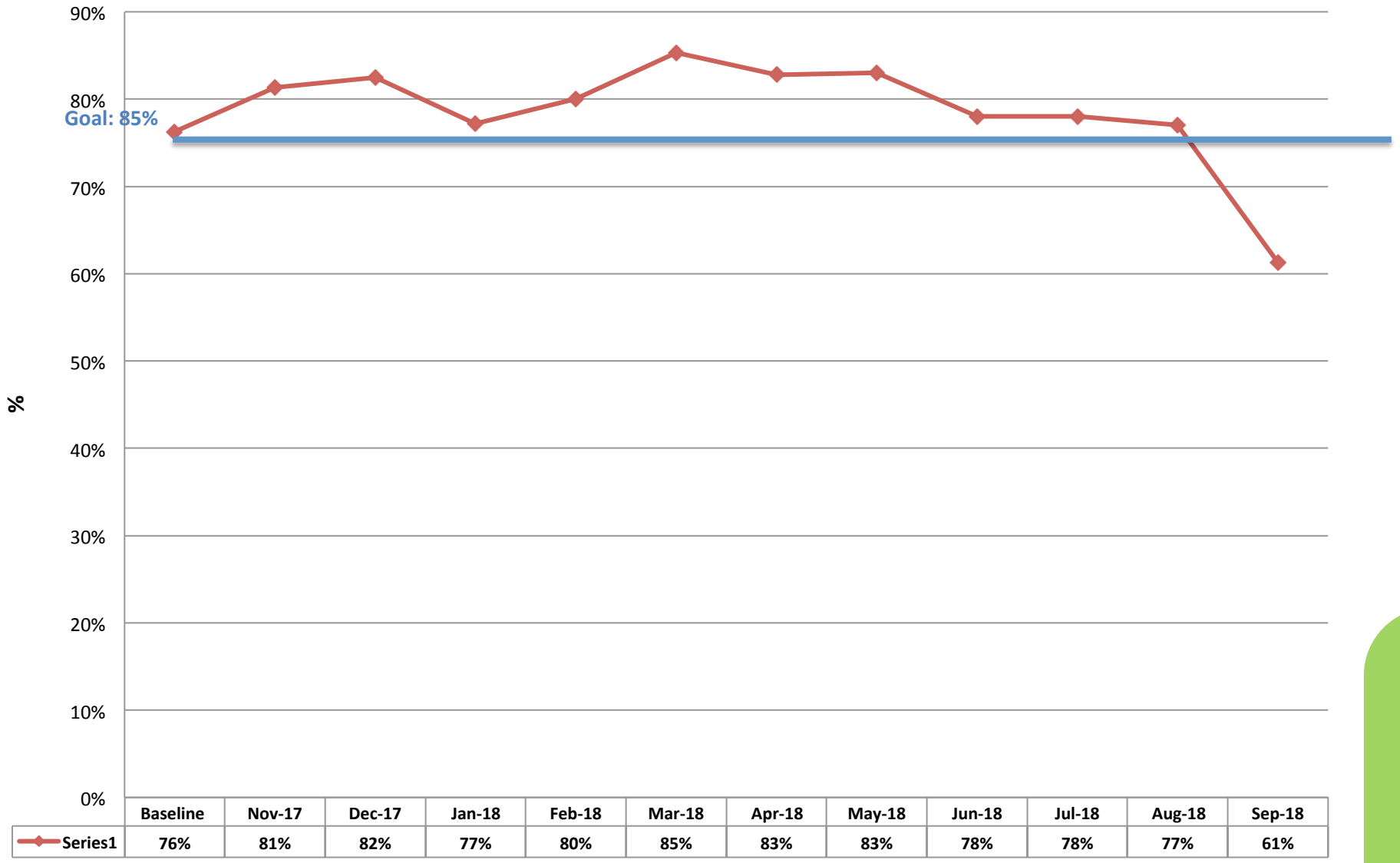
Secondary Driver (2)
Verify the workflow for MA's once a patient results are abnormal.

Primary Driver (2)
Protocol for abnormal Pap's to be standard for all CCI.

Ideas to test
Work with LabCorp and i2i to receive reports on abnormal labs.

All this in a new facility & location

CCI - Cervical Cancer Screening Greenbelt - FY2018



	Baseline	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Series1	76%	81%	82%	77%	80%	85%	83%	83%	78%	78%	77%	61%

Project Measures

- ✓ Data Management
- ✓ New site and location
- ✓ Transitioning period where two different site's teams are working together

Challenges

- ✓Data Management
- ✓Huddle Reports
- ✓Flags and Alerts
- ✓Patient recall process
- ✓Lab results
- ✓Abnormal results

Lessons Learned

Take a break!

Sustaining Changes

Sustaining Change

Keep changes going.
Ensure behavior changes to produce reliable new model of care.

Leadership	Communication	Infrastructure	Measurement
• Critical role for executive and management leaders to sustain change	• Strategy for reinforcing vision, information transparency and supporting behavior changes	• Creating polices, processes, staffing and physical space for ensuring change	• Assessing continued improvement and avoiding regression to the past

Sustaining Change Assessment

Sustaining Change-Monitoring Key Organizational Areas

KPTA Innovation:_____ Date:_____

Key Area	Questions to uncover possible conflicts	Yes or No	Possible actions:
Work design and infrastructure	• Are clear definitions of roles and responsibilities aligned with the new KPTA innovation?		
	• Are the roles and responsibilities flexible enough to allow people to adjust to the new ways of doing things?		
	• Does the work environment infrastructure encourage sustaining the change?		
Demands from managers	• Are the new KPTA expectations clear to managers?		
	• Do they understand what's new, changed or not required anymore?		
	• Are they clear about their boundaries?		
Performance measurement	• Do performance measures track desired KPTA innovation outcomes and behaviors?		
Recognition systems	• What gets noticed by leaders and influencers in the organization?		
	• What gets mentioned in formal and informal situations?		
	• On what achievements and conditions are promotions based?		
	• Do employees value current means of recognition?		
Goal setting	• Are individual goals consistent with overall KPTA innovation aims?		
Skills and competencies	• What new skills and competencies are needed for KPTA innovations?		
	• What skills and competencies are now redundant?		
Management systems	• Do management systems measure the elements of KPTA innovation we wish to pay attention to?		
	• Have new processes been introduced? How will they be measured? How often?		
Communication processes	• What new information and feedback needs to circulate freely?		
Relationships	• Is the new working environment creating new patterns of interaction among individuals and departments? Can these relationships be strengthened?		
Leadership	• Does leadership continue to support and communicate the urgency for the KPTA innovations?		

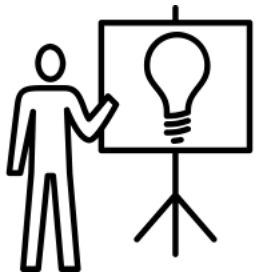
Adapted from: The Heart of Change Field Guide Dan S. Cohen

Team Time!
Communication Action Plan

What is the change you'd like to spread? _____

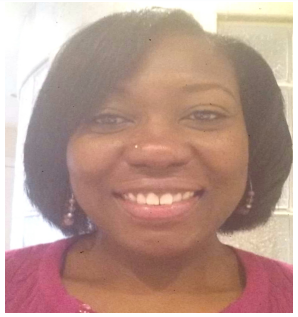
Why should people adopt the change (goal clarity)? _____

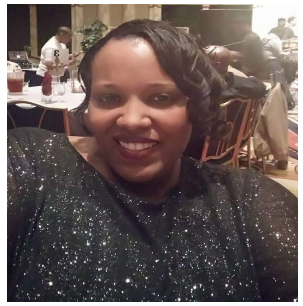
Key audiences Who do you want to spread to?	**Unlock commitment** Are there pre-existing attitudes, awareness, experiences we need to address? Where are people in the change process?	**Impactful messages** What are the key messages, what do people need to know? How do you say it so it will resonate?	**Decisive Action** How do you want the audience to act, think, or feel? Create the path, what do you expect them to do?	**Execu**	
				Channels or methods – how will the change be communicated?	Timing – w will the cha be communicat



Team Pitches

Family and Medical Counseling Service, Inc. (FMCS)

Who is on your core project team to support work done in the Transformation Accelerator Program?

Angela Wood, COO

Pat Grimes, NP (Through October, 2018)

Wenona Posey, Clinical Office Manager

Mia Thompson, Care Coordinator

LaDonya McClure, Billing Supervisor

1. Future state

- Continue to conduct Outreach to identify new patients for services.
- Continue to develop additional partnerships in the community that support cross referrals for primary care and support services.
- Maintain new hours of operation -- 40 hours per week, including one Saturday per month.
- Continue to monitor the appointment fill rate on a monthly basis.

2. Key learnings

- Many individuals in the community are accustomed to receiving care in other communities or are not in care.
- Extensive community outreach is required to identify and engage individuals in care including:
  - Street Outreach
  - Outreach to community organizations
  - Outreach to specialty care providers
  - In-reach to patients in the practice in need for follow-up
- Consistency in the hours of operation is essential to establishing a new practice in the target community (40 hours)

3. Impactful changes

- **Change 1:** FMCS modified the medical scheduling template changing to a standard 20 minute slot for all appointments and increased the hours that we are open at the MD slot by one hour.
- **Change 2:** FMCS has facilitated meeting with MCO's that we are credentialed with in MD.
- **Change 3:** FMCS Change 3: FMCS is opening the clinic for one Saturday per month and on Mondays.
- **Change 4:** FMCS put a system in place for monitoring number of available appointments each month in comparison to the number of filled appointments each month.
- **Change 5:** FMCS is participating in numerous community outreach events to increase awareness of our service delivery package.

4. Benefits

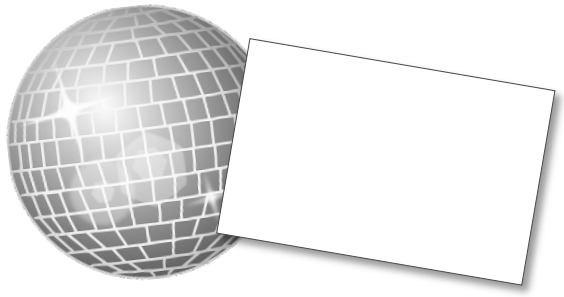
- More appointment slots available
- Increased access to same day appointments and walk-ins
- Increased ability to use data for program planning
- Knowledge/respect for the various staff roles and how they support program operations
- Identification of new and different outreach strategies

5. Negative impacts

- Limited program growth
- Lack of engagement with other providers

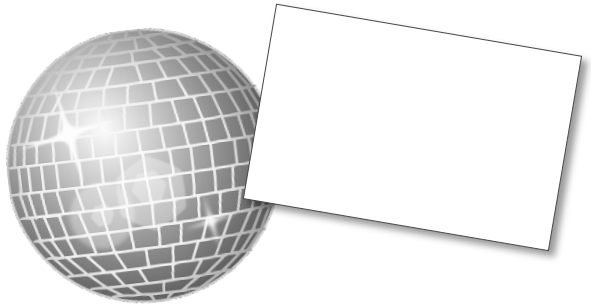
6. The “pitch” – or “ask” of your leadership

- Resources to support the outreach efforts
  - Staff
  - Incentives
  - Marketing materials



Inspiration Disco

- Write on an index card ONE lesson from the Transformation Accelerator program that inspired you.



Inspiration Disco

- When the music begins, take a pen and walk around, **continually trading** your index cards to one another. Do not read the cards, just dance and trade.

- When the music **STOPS**, read the card in your hand. On the back, rate the observation from **1 to 5.** We will repeat this process 3 more times.

.....1.....2.....3.....4.....5.....

not so much wow, I agree

- After the 4th round, add your score and total the points. Who's got a 20? 19? 18?

Transformation Accelerator: Realizing the Power of Partnerships

Mindy Rubin, Kaiser Permanente

Sharon Zalewski, Regional Primary Care Coalition

RPCC
Regional Primary Care Coalition

KAISER PERMANENTE®

Prince George's County Community Health Center Collaborative

- Strengthen and Sustain a Collaborative Framework
- Promote the Value and Values of Community Health Centers
- Build Relationships Strategically and Establish Public/Private Partnerships
- Advocate to Improve Access to Quality Health Care, Education, Housing and Economic Opportunity
- Empower and Support Patients, their Families and their Communities

RPCC
Regional Primary Care Coalition

KAISER PERMANENTE®

Kaiser Permanente of the Mid-Atlantic States

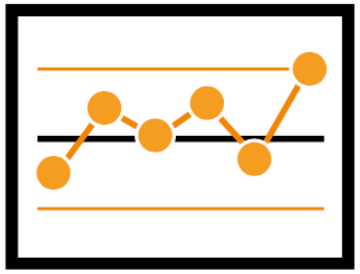
Improving the health and well-being of Prince George's County residents is a priority for Kaiser Permanente. Equity is an underlying value infused in its Community Health Programs which focus on:

- Access to Quality Health Care
- Economic Opportunity
- Policy and Advocacy
- Stakeholder Engagement

Kaiser is working on its 2019 Community Health Needs Assessment which will provide a framework for future investment in the County.

KAISER PERMANENTE®

What's Next?



Submit Monthly Data

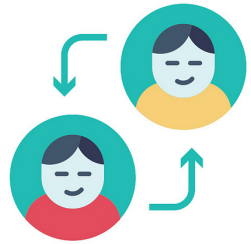
Nov. 7th and Dec. 7th

Coaching with Tammy & Carolyn

See updates from Tammy for schedule

Final Report

Due: Dec. 31st



Final Grantee Interview with Evaluators

December/ January

Final Report Components

1. Narrative Report

Impact | Future Plans
Lessons Learned

2. Transformation Accelerator Assessment

Assess organizational change

3. Expenditures Report

>$10K spent on technical assistance

Thank you!

*Please complete the evaluation survey.

*Materials and slides for today's learning session are available at:

https://www.careinnovations.org/accelerator-team/resources/#learningsession