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2019 STFM Conference on

Practice & Quality Improvement

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Extreme Makeover: Ambulatory Practice Edition

Achieving the Quadruple Aim through Transformational Practice Redesign

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Disclosures

None

Who is in the room?

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Goals & Objectives

After this presentation, participants will be able to:

1. Describe the change management tactics used in the University of Colorado's APEX team-based care transformation lessons learned maintaining change in a complex environment.

2. Translate CU's transformation experience to their own institutional context.

3. Develop a strategic plan for transformational practice redesign using the key strategies, tactics, tools and experiences.

4. Discuss implications for new CMS regulations on E&M coding and medical students documentation in a team-based context.

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Kotter's Change Management Model

Source: John Kotter

CHANGE ROADMAP

CHANGE ROADMAP

What problem(s) are you trying to solve?

List some reasons why your project might fail (including people)

1. **Establish a sense of urgency** – people must genuinely believe that the status quo will not suffice and that the program/project must begin now
   - List 3 reasons why anyone should care about this particular effort:
     1.
     2.
     3.
   - In what ways can you inspire people to change ("burning aspiration")?
   - In what ways can you create a "burning platform" to drive people to change?
2. **Create a guiding coalition** – generating buy-in is key to success.
   - List members of your **Guiding Coalition** – formal leaders who can help you lead change:
   - How will you convince them to get on board?
   - List members of your **Volunteer Army** – opinion leaders who can help you lead your change:
   - How will you convince them to get on board?
   - What will you ask your guiding coalition to do to inspire others to follow?
3. **Develop a vision and strategy** – people must be inspired to join you.
   - What is the vision for your project? Describe (succinctly) what you will achieve that is not happening today:
   - Name 3 strategies that will help you achieve your vision:
     1.
     2.
     3.
   - What will your elevator pitch be?
4. **Communicate the Change Vision** – *remember to communication to all your stakeholders.*
   - List at least 5 ways you can communicate your vision (include forums, meetings, publications, in person conversations, etc.)
     1.
     2.
     3.
     4.
     5.
   - How will you change your communication for different audiences (key stakeholders, skeptics, etc.):
   - How often will you communicate? Who will be responsible?
5. **Empower broad-based action** – *make it easy to support the project (eliminate barriers).*
   - List at least 3 major barriers to the success of your program/project:
     1.
     2.
     3.
   - List ideas for overcoming these barriers:
   - List ways in which you could make it EASIER to support the program/project:
6. **Generate short-term wins** – *convert skeptics and reward supports through frequent, clear demonstrations that your agenda carries benefits over the status quo.*
   - List 3 short-term wins you can achieve within the first 1-2 weeks:
     1.
     2.
     3.
   - List 3 rewards that you afford to give in response to success (don't forget appreciation – it's often free!)
     1.
     2.
     3.
   - List 3 ways you'll share these short-term wins with others:
     1.
     2.
     3.
7. **Consolidate gains, produce more change.**
   - List 3 bigger wins that are closer to your final version that you will build toward in the next few months:
     1.
     2.
     3.
   - List 3 structures/systems that would need to be changed to insure bigger, long-term success:
     1.
     2.
     3.
8. **Anchor new approaches in the culture**
   - List 3 ways in which you can tie this success back to what people personally are about:
     1.
     2.
     3.
   - How might you alter policies and procedures to sustain the change?
   - How might you alter expectations around who is hired and promoted to sustain the change?

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INTRODUCTION

Primary Care Redesign | Kotter's Model for Change

↓

THE NEED FOR CHANGE

Create a Sense of Urgency | Form a Guiding Coalition

↓

CHANGE DIRECTION

Create a Vision | Communicate the Vision

↓

FINDING DOLLARS AND MAKING SENSE

How Do We Pay for This? | Evaluation

↓

CHANGE BEHAVIOR

Empower Others to Act | Create Short Term Wins

↓

SUSTAIN THE CHANGE

Consolidate & Make More Change | Institutionalize New Approaches

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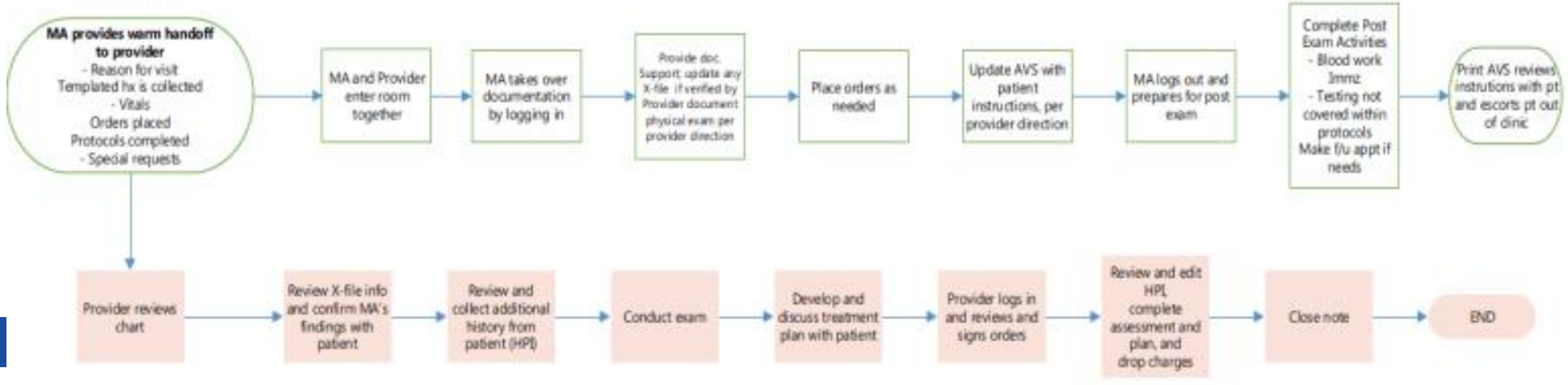
Brief APEX/PCR Model Overview

Staff and Provider Primary Care Redesign Workflow
2/26/2018

Patient Access Representative

Medical Assistant Rooming Process

Provider & MA Patient Exam Process



PCR Model Overview – Expanded Rooming

- PARTy Scheduling – 20 Minute Rooming Time
  - Agenda setting
  - Initial HPI collection (Brief HPI)
  - Update medical/surgical/social/family histories
  - Medication reconciliation
  - Gaps in care capture
  - Complete tasks via protocol
  - Screenings (PHQ2)
  - Advanced Directives

Expanded Rooming – Medication Reconciliation

- **Detailed medication reconciliation**
  - Removes (via protocol)
    - Patient Reported Meds no longer taking
    - Meds placed in error
    - Duplicate (ie same med, but 2 doses)
    - Therapy completed
    - Old prescriptions (original RX > 12 months)
  - "Flags" other medications
    - Patient reporting taking differently
    - Patient reports not taking
  - Pend medications needed refilled

Expanded Rooming – Gaps in Care

- **Gaps in care – orders & pends (if no protocol) any test/service overdue based on the Health Maintenance Module in Epic**
  - Preventive services or chronic disease monitoring
    - Lipids screening
    - DM2 screening
    - Colon cancer screening
    - Mammograms
    - Cervical caner screening
    - TSH monitoring – for patients with hypothyroidism
    - DM monitoring test – A1c, Monofilament, microalbumin, lipid, eye exam
    - Hep C screening
    - DEXA scans
    - AAA screening
    - Immunizations
    - HIV screening

In-Room Support

- Warm handoff outside the room
- MA documentation assistance in the exam room
  - Additional HPI collection
  - Physical exam
  - Place orders
  - Patient instructions

Goals of In-Room Support

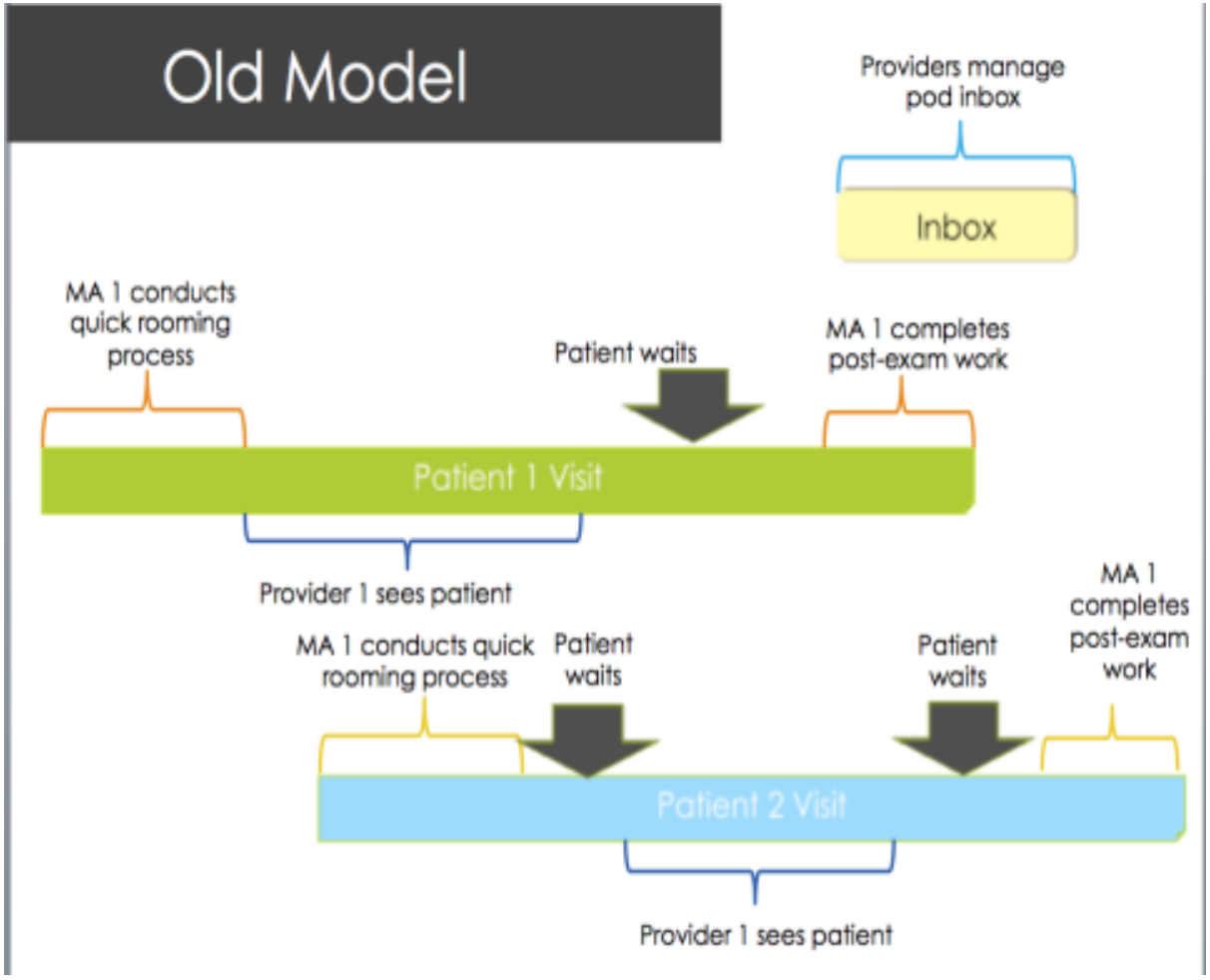
- Provider-Patient engagement
  - Without a computer in-between
- Decrease distraction during visit
  - Present with the patient
- Documentation support (75-90% of HPI, exam, ROS)
- **No turnover needed** for post-exam
- No need to leave the exam room, look for MA, communicate the post-exam needs

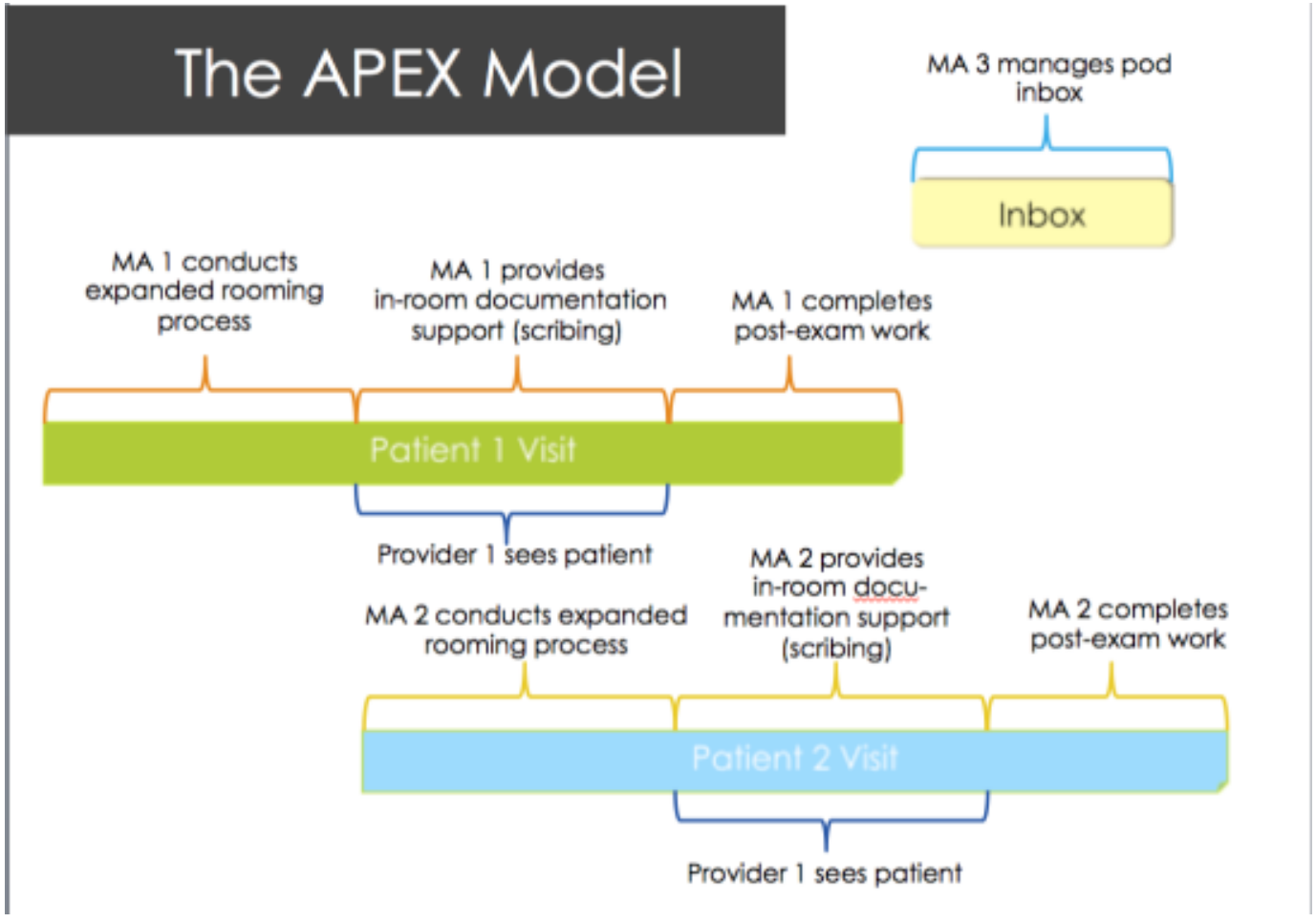
Post Exam

- Completes post exam task in the exam room
- **No turnover needed** MA stays with patient
  - Lab draws
  - Immunizations
  - Schedules follow up appointments
  - Prints and reviews after visit instructions
  - Escorts patients to lobby (no check out required)

In-basket Management

- All messages (except symptomatic triage calls) go to a central clinic pool managed by MAs
- MA address messages as much as possible
  - Call patient for more information
  - Provide information requested as needed (referrals, completed orders, prior authorization status, etc)
  - Pend any orders
  - Draft patient request letters
  - Redirect messages as needed
  - Can managed about 30-40% of messages
  - Forwards to provider, as needed for sign offs, additional information, etc


Old Model
Providers manage pod inbox
Inbox
MA 1 conducts quick rooming process
Patient waits
MA 1 completes post-exam work
Patient 1 Visit
Provider 1 sees patient
MA 1 conducts quick rooming process
Patient waits
Patient waits
MA 1 completes post-exam work
Patient 2 Visit
Provider 1 sees patient

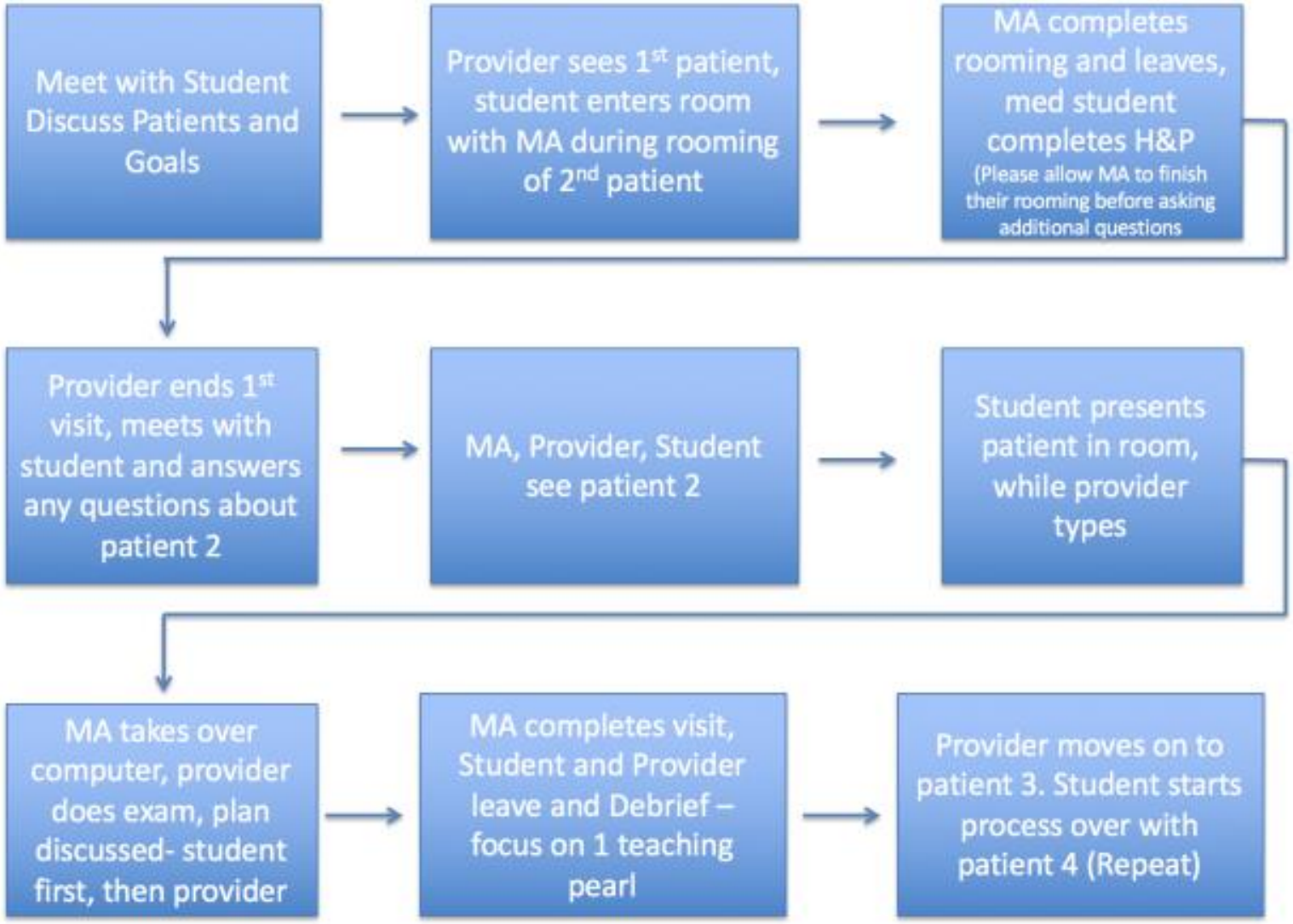

The APEX Model
MA 3 manages pod inbox
Inbox
MA 1 conducts expanded rooming process
MA 1 provides in-room documentation support (scribing)
MA 1 completes post-exam work
Patient 1 Visit
Provider 1 sees patient
MA 2 conducts expanded rooming process
MA 2 provides in-room documentation support (scribing)
MA 2 completes post-exam work
Patient 2 Visit
Provider 1 sees patient

Medical Students in the Model

- Training clinics usually have goal to train learners
- Barriers formed
- The model limits the ability to train students
- Students cause problems for the model
  - "They can't do this in a transformed clinic"
- How do they practice taking appropriate information that the MA has taken over
- Patient dissatisfaction from being asked multiple times for same info

Overcoming barriers

- Develop workflows that meet all goals (learner and clinic)
- Brainstorm solutions
  - Dedicated RIE on learners in the model
  - Reviewing compliance/rules and integrate
  - Standardization
  - Distribution to providers with students who are using the model
  - Student empowerment to work within model



If behind have student wait out an additional encounter and read on previous or future patient visit

Teaching the Model to Medical Students

- University of Colorado SOM students rotate through clinic in all 4 years of medical school
- MS1 and MS2 work with specific providers 4-10 sessions per semester
- MS3 initially had 4 weeks, evaluation complaints about needing 3-4 weeks to immerse and begin to understand this model
- MS4 elective option at AFW to immerse in team based care setting for 4 weeks

Teaching the Model to Medical Students – Recent Changes

- Moved MS3 rotation to 8 weeks to provide more exposure and ability to develop and hone patient care skills in a interdisciplinary transformed practice
- Orientation documents include introduction to current APEX model
- 30 minute weekly conference with all types of learners to review foundational disease in a time pressure free environment.
- Creating of end of rotation presentation for complex patient and spending 8-16 hours with other care team members.

Teaching the Model to Medical Students - Current Issues

- Medical school moving to a curriculum that emphasize early longitudinal clinical experience including assignment to a "medical home" for all 4 years.
- Integrating medical student documentation with new CMS rule change.

Teaching the Model to Residents

- 1st years – MA updates PMSFH, gaps, med recon (4-6 patients/session)
  - 2 MAs:2 interns (ie 2 interns = 1 senior resident/faculty)
- 2nd year – Include initial HPI with ROS collection (8 patients/session)
  - 2 MAs:1 R2
- 3rd year – Full model – all of the above + in room documentation support (scribing) (10-11 patients/session)
  - 2 MAs:1 R3

Coding and Documenting

- CMS regulations on E&M coding
  - Provider does not need to re-document things in the chart
  - Original - "I reviewed the family and social history as documented by the MA"
  - New - I reviewed the histories as documented in the record"
- Medical Student documentation
- System-wide pilot for 4th years

Pilot Site 1 Quantitative Data at 3 Years

Access

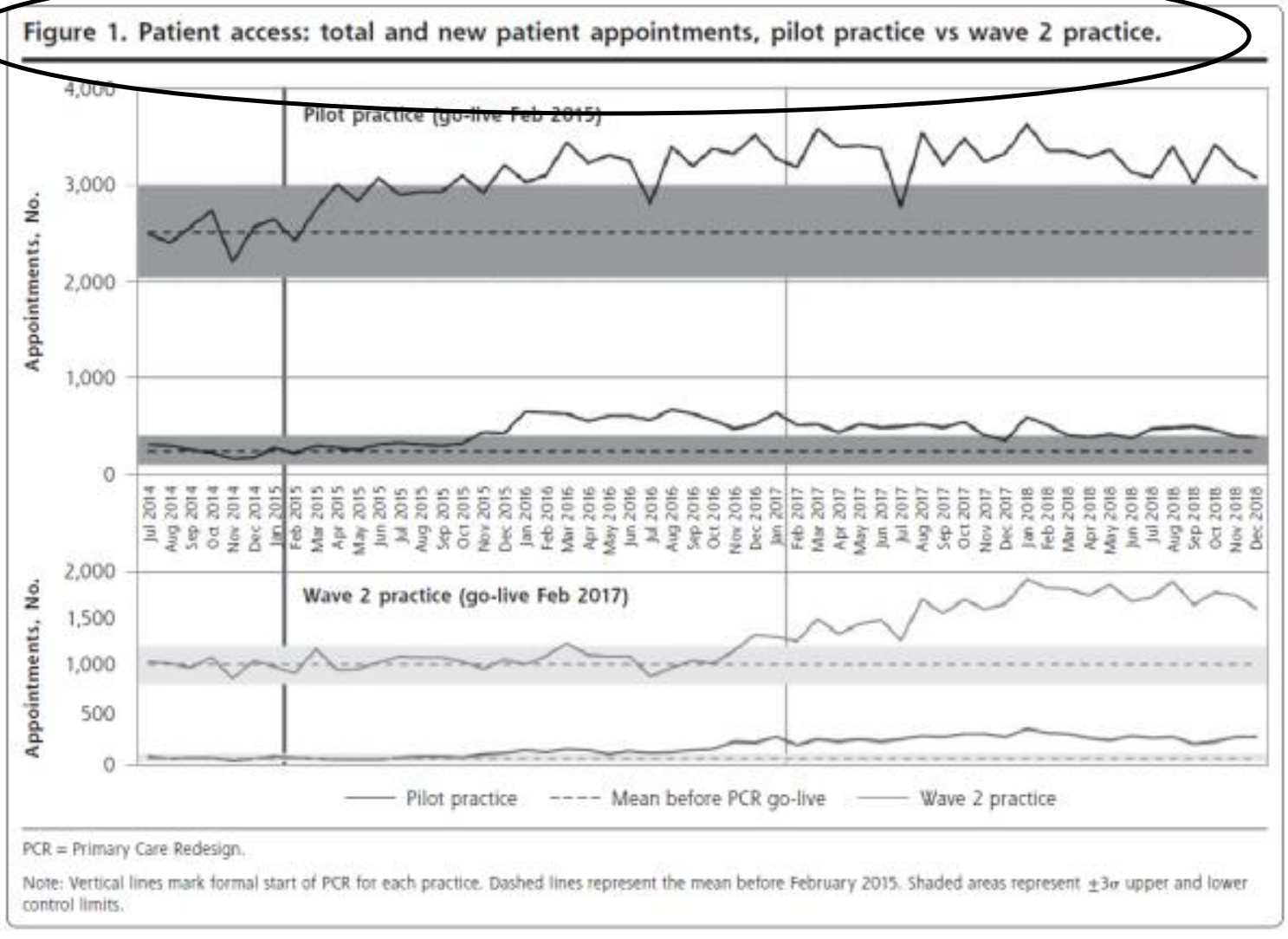


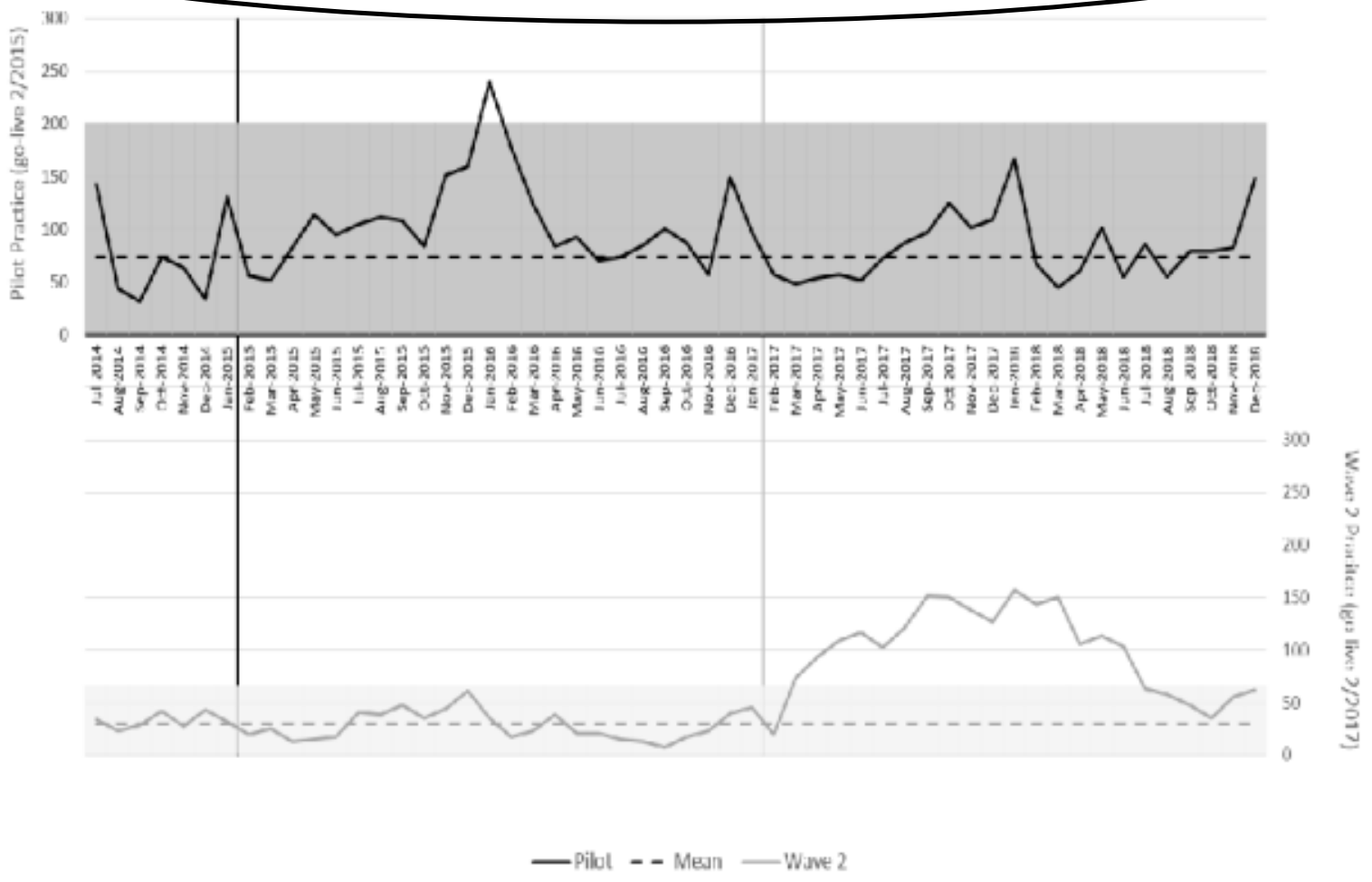
Figure 1. Patient access: total and new patient appointments, pilot practice vs wave 2 practice.

PCR = Primary Care Redesign.

Note: Vertical lines mark formal start of PCR for each practice. Dashed lines represent the mean before February 2015. Shaded areas represent ±3σ upper and lower control limits.

Access

Supplemental Figure 1: New patient appointments made within 2 days of request, Pilot vs. Wave 2 Practice Shaded areas represent 3 standard deviations ± pre-implementation mean



Supplemental Figure 2: Colorectal Cancer Screening, Pilot vs. Wave 2 Practice Shaded areas represent 3 standard deviations ± pre-

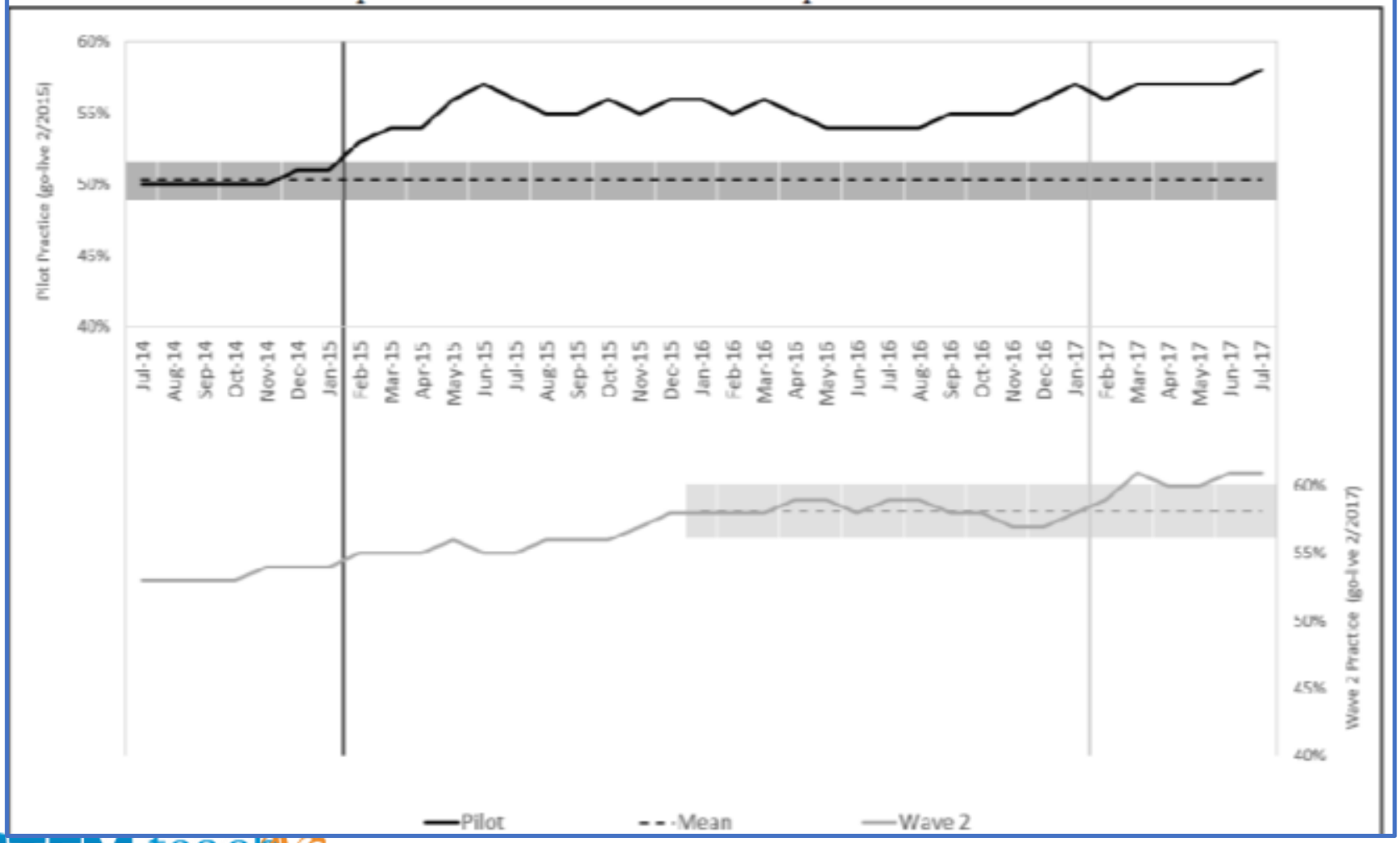
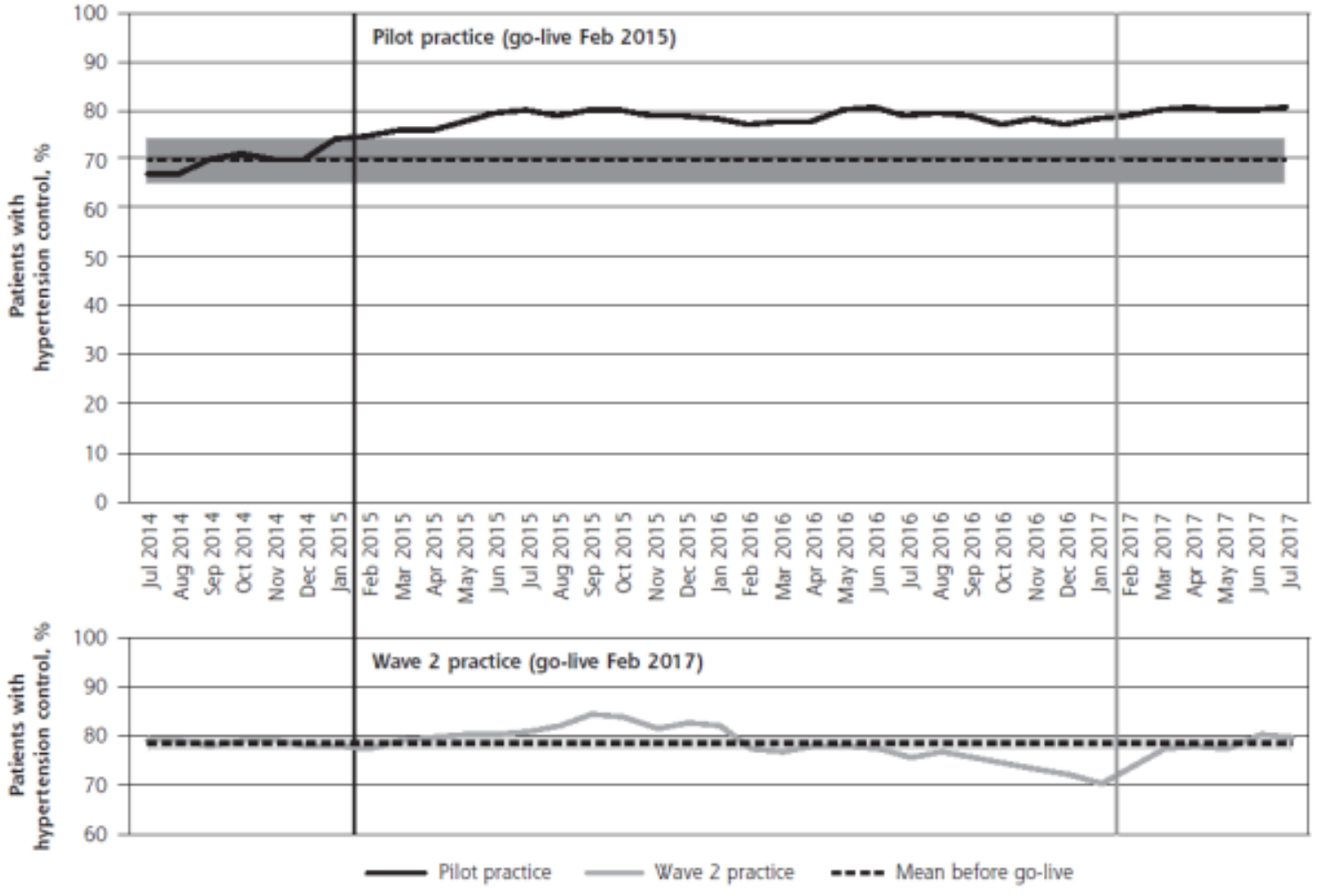


Figure 2. Clinical quality metrics: hypertension control, pilot practice vs wave 2 practice.



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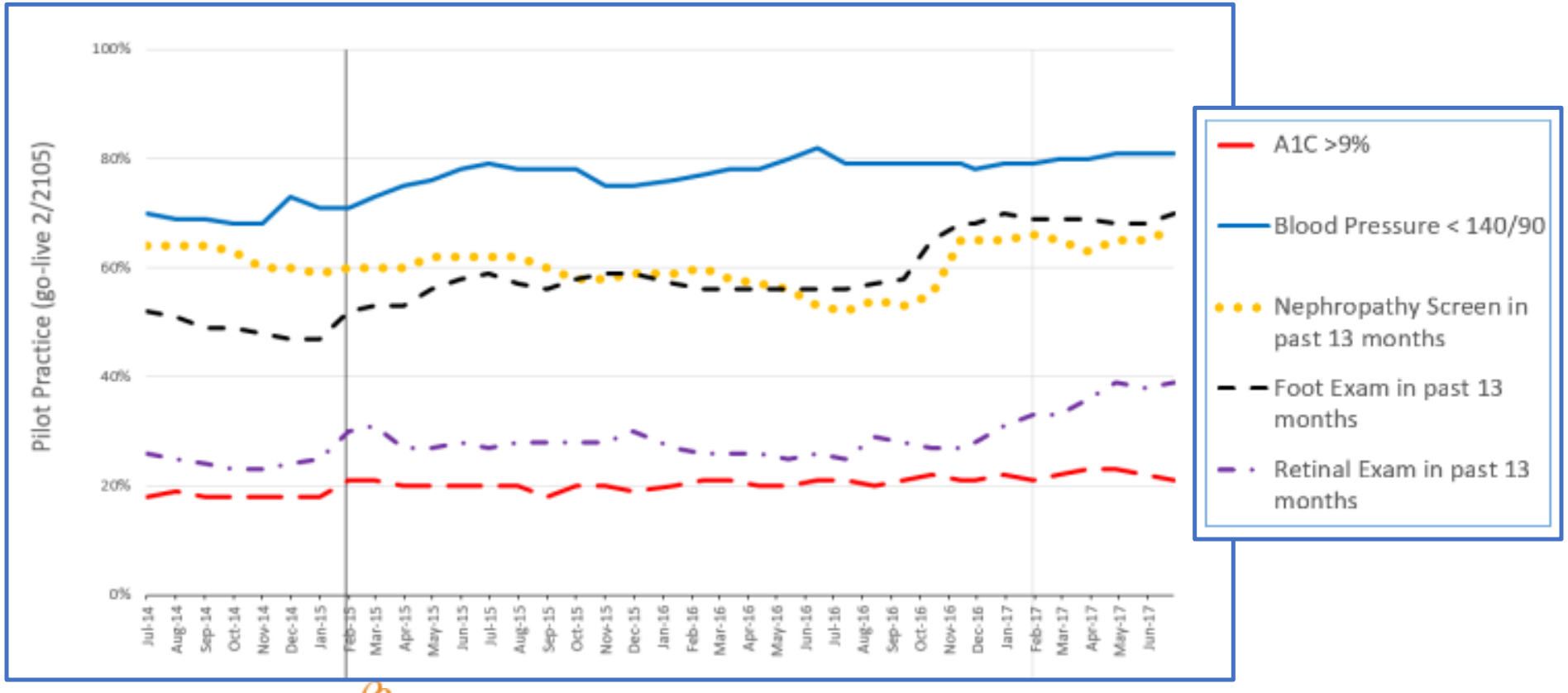
Diabetic Quality – Pilot Practice



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Diabetic Quality –
Wave 2 Practices

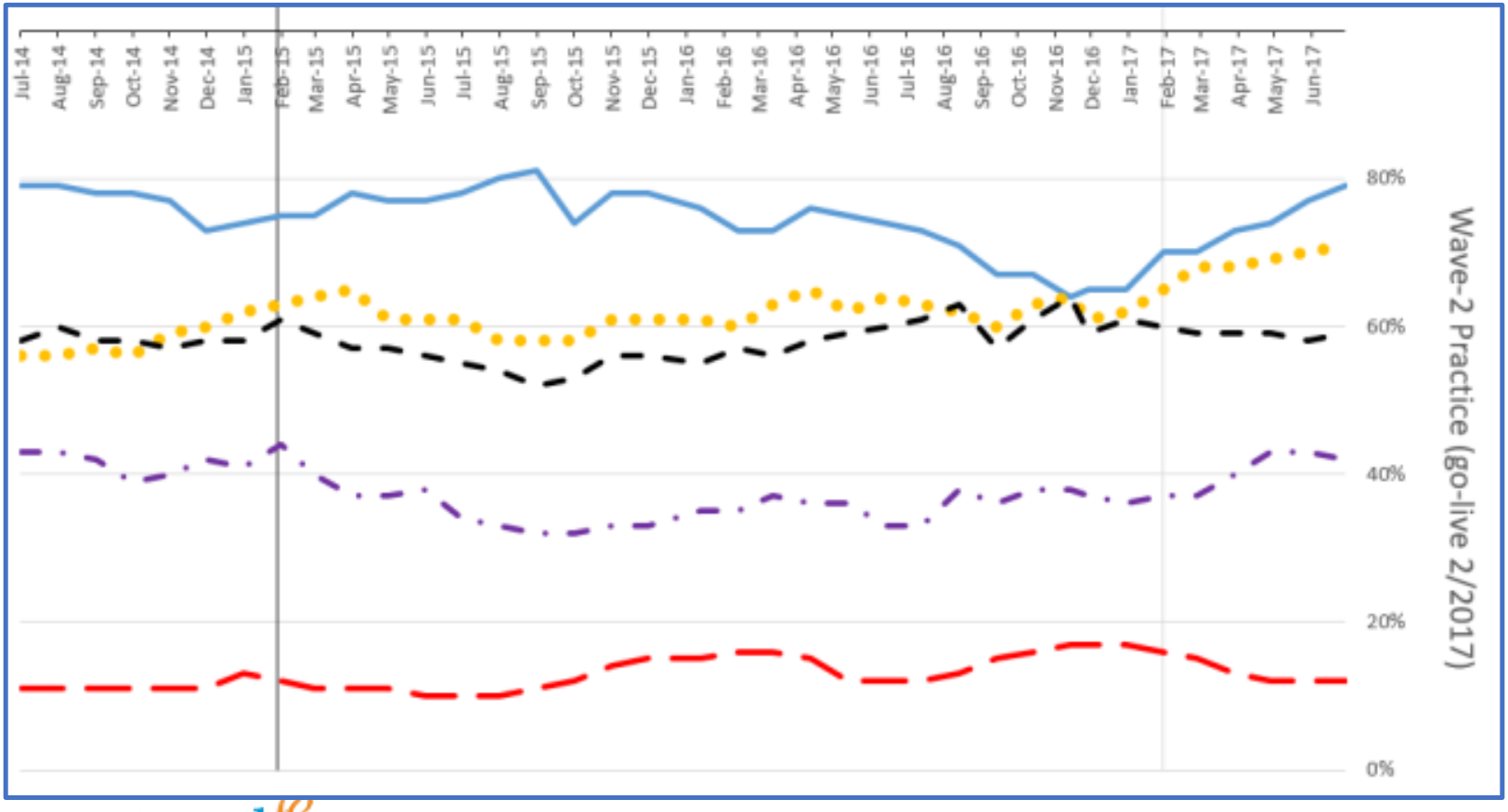
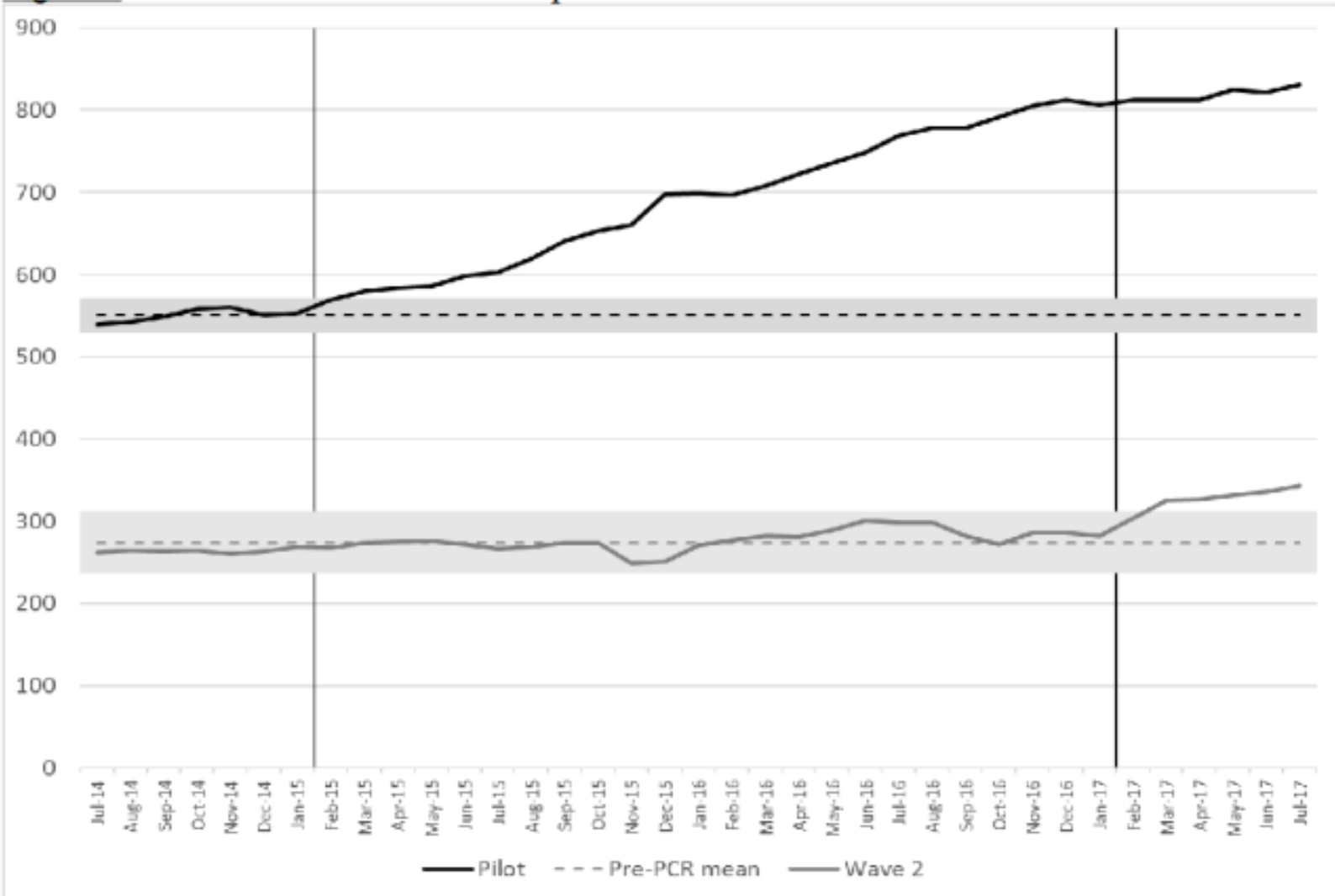


Figure 4: Patients with diabetes on the problem list seen in the last 13 months



Vertical lines mark formal start of PCR for each practice. Dashed lines represent the pre-2/15 mean. Shaded areas represent ±3σ upper and lower control limits.

Provider & Staff Burnout

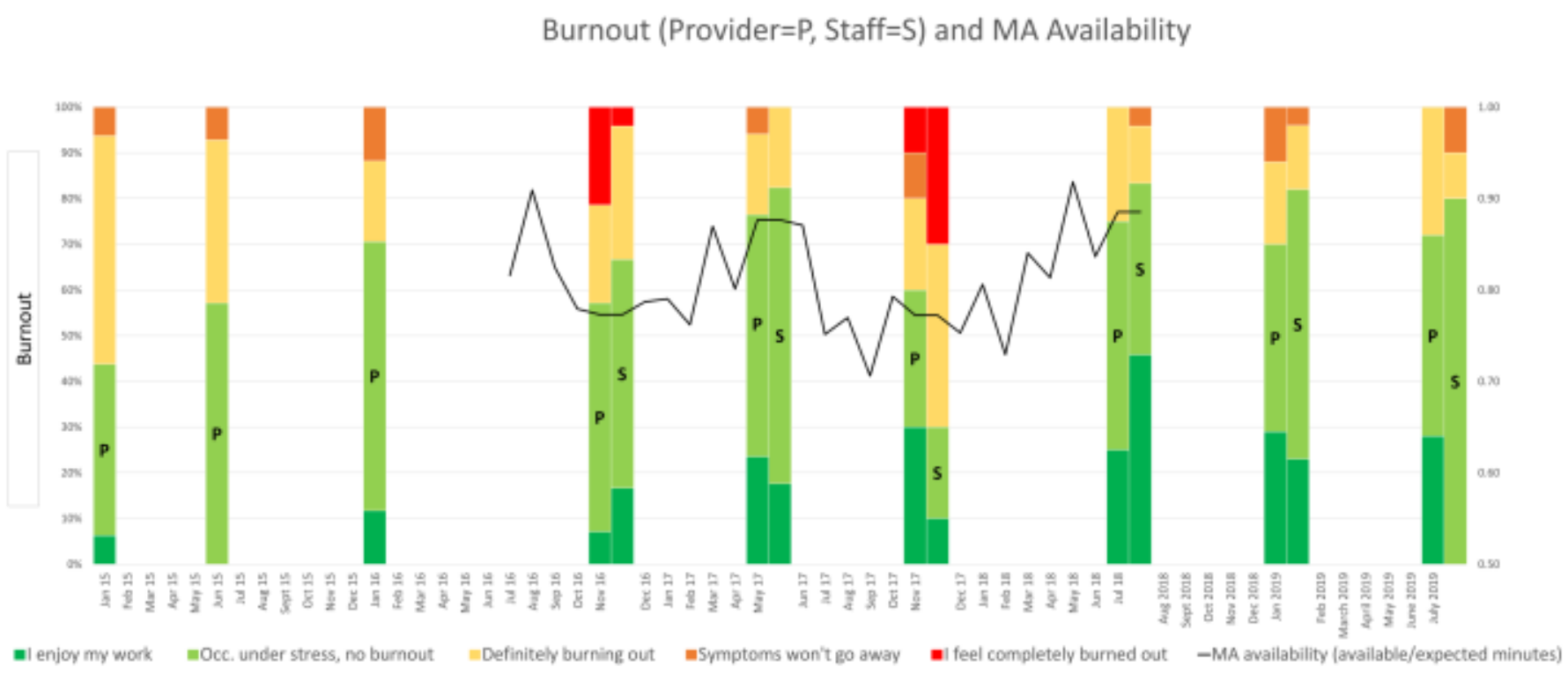
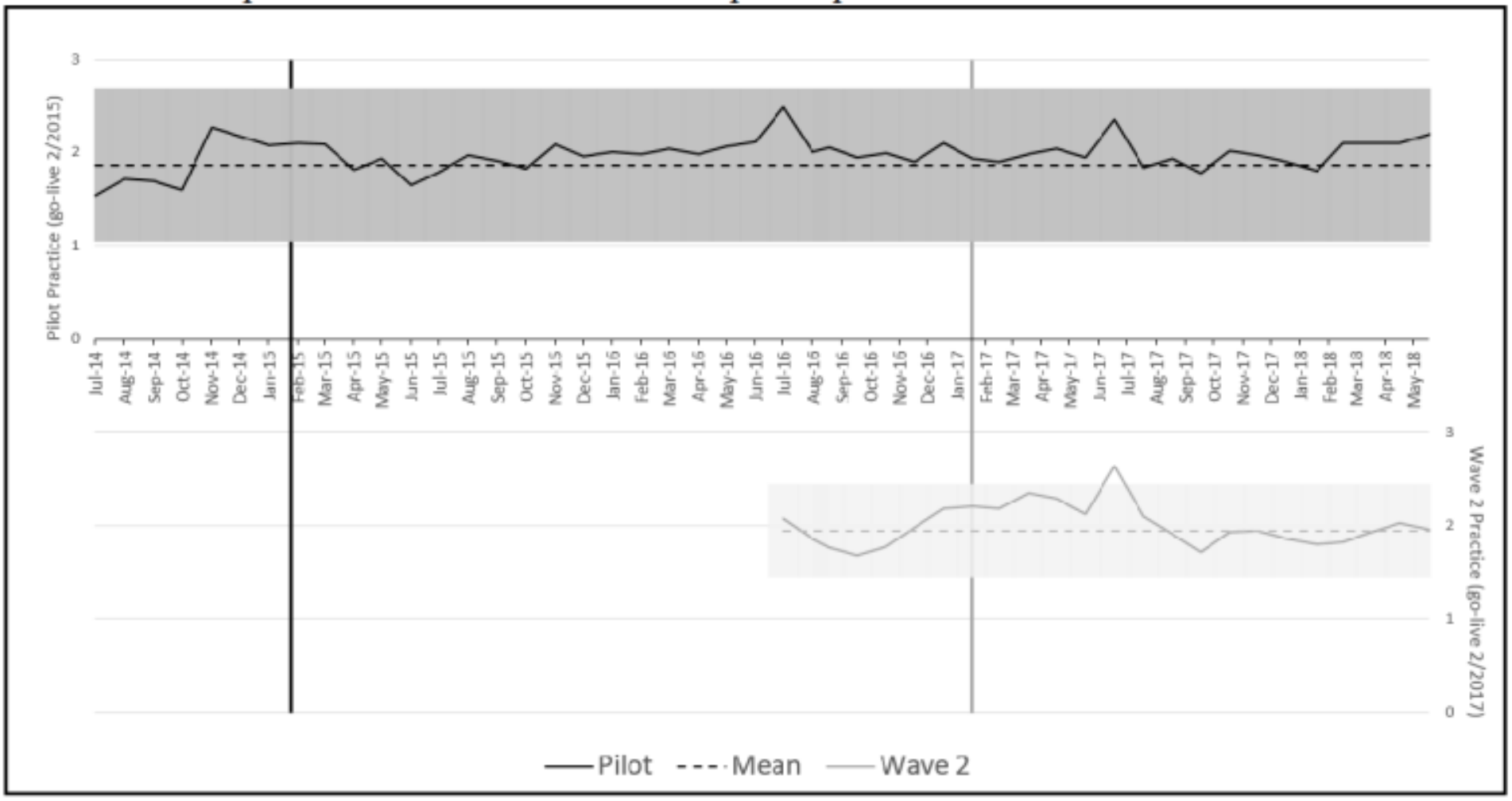
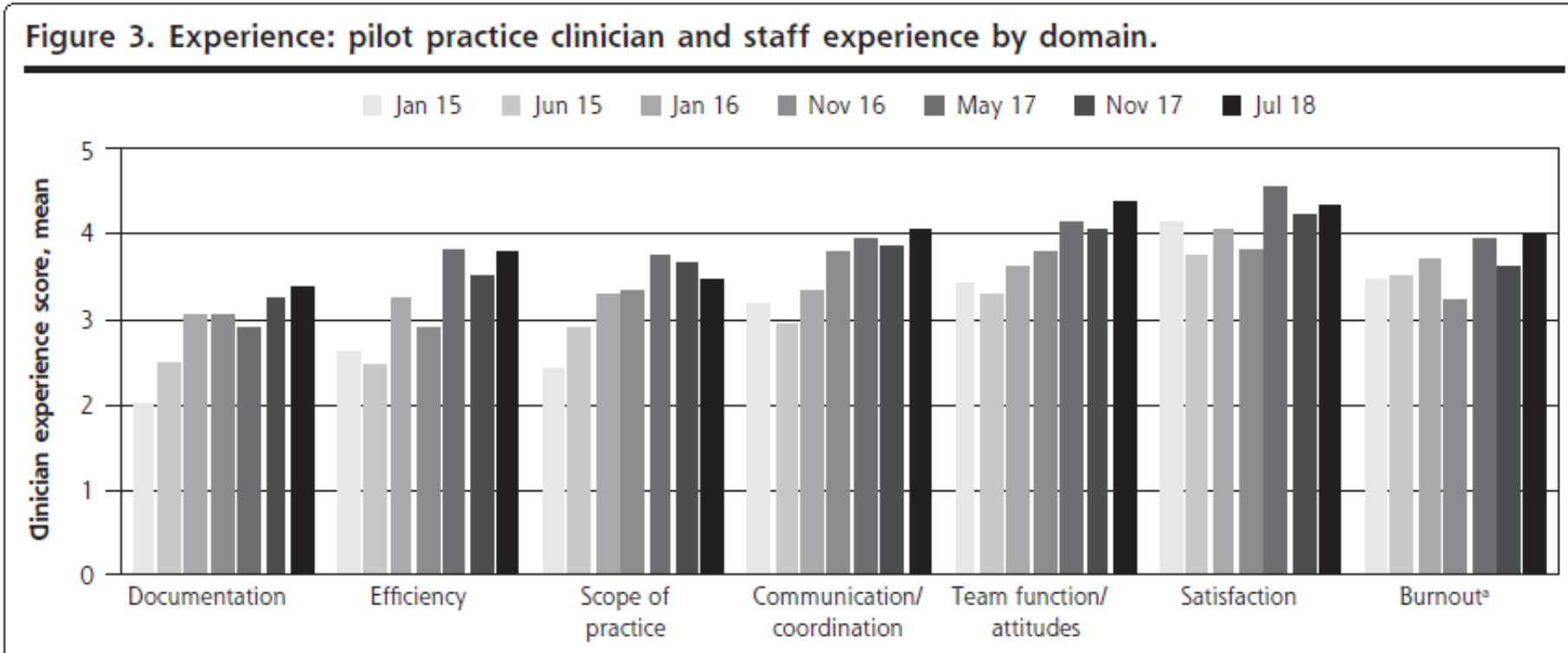


Figure 5: Staffing Hours Per Visit, Pilot vs. Wave 2 Practice
Shaded areas represent 3 standard deviations ± pre-implementation mean



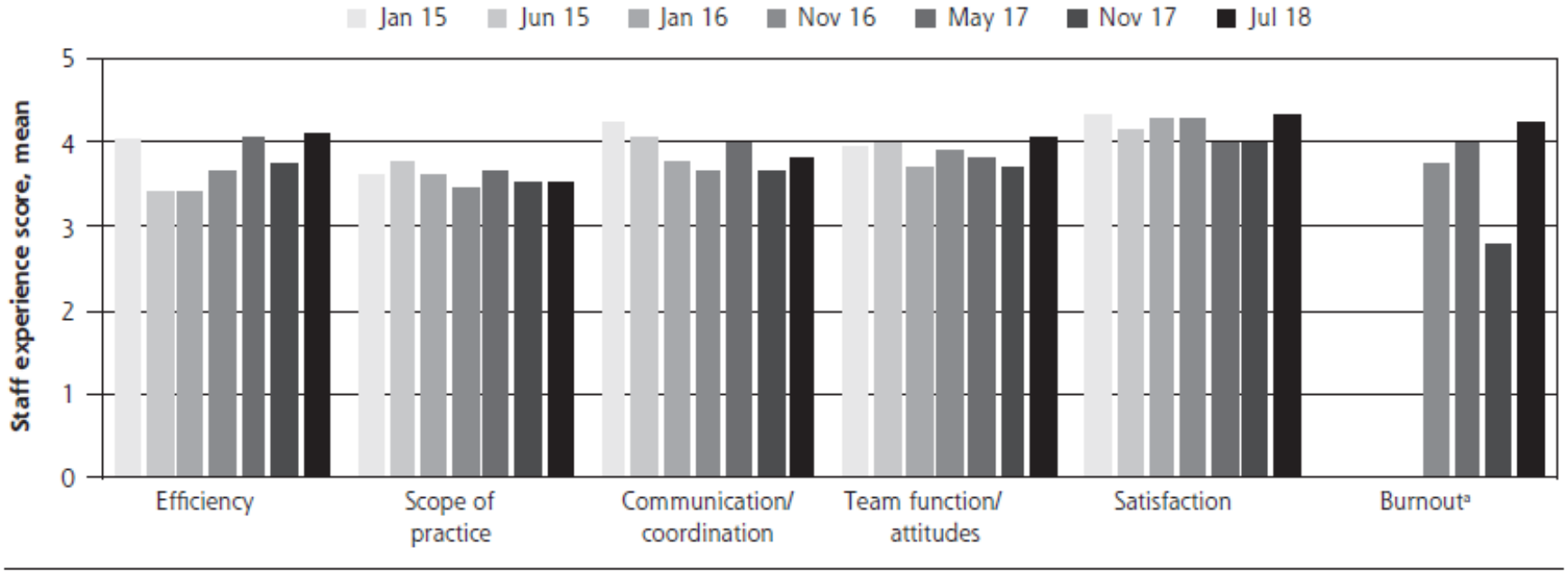
Vertical lines mark formal start of PCR for each practice. Dashed lines represent the pre-2/15 mean. Shaded areas represent ±3σ upper and lower control limits.

Provider Experience*



***for Burnout Score, higher=better**

Staff Experience*



[a] Negatively worded items were reverse coded so higher values are desirable for all items including burnout.

Note: All questions except that for burnout used 5-point Likert scales for level of endorsement (not at all, slightly, somewhat, mostly, completely) or agreement (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree).

***for Burnout Score, higher=better**

Digging Deeper: Qualitative Evaluation

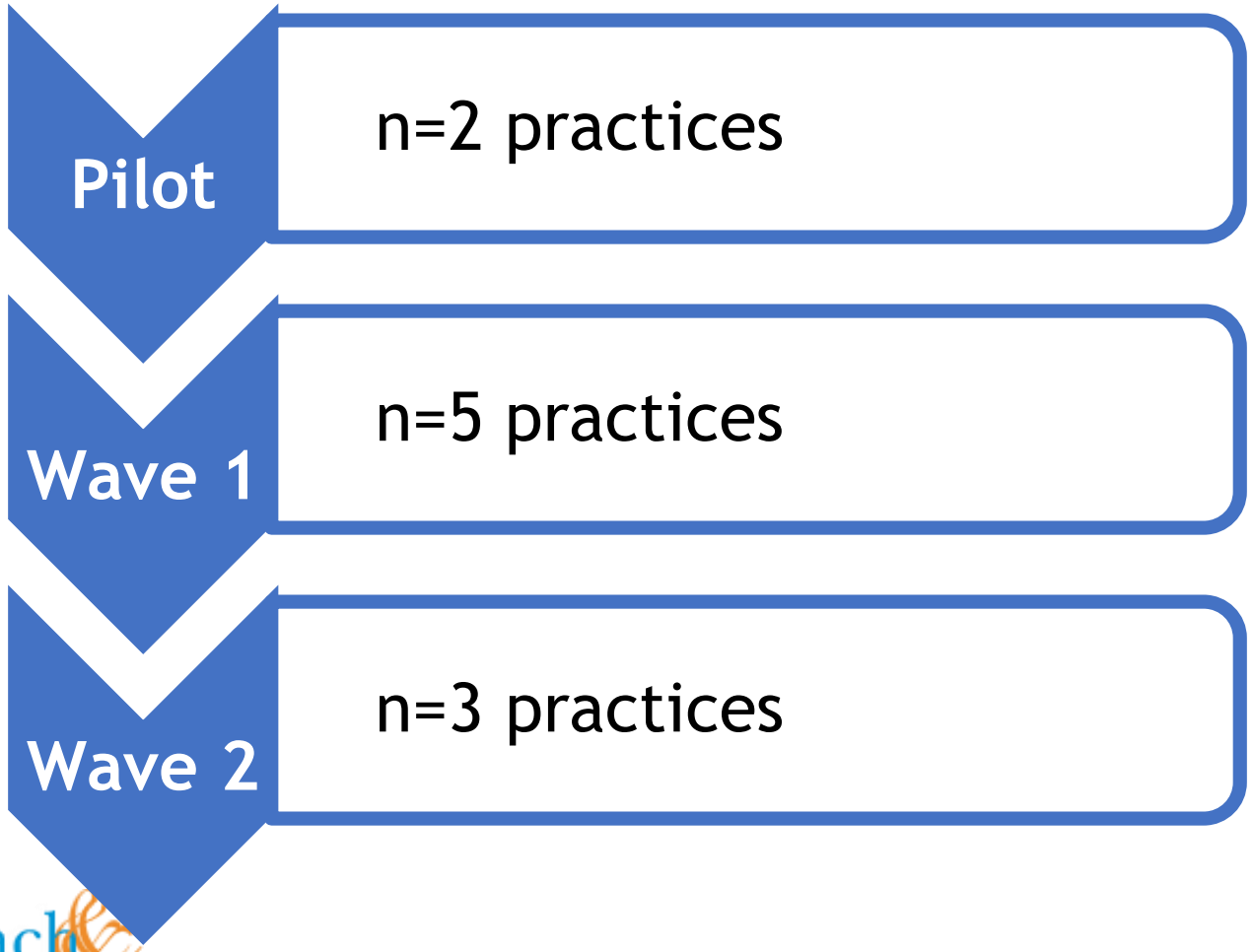
- What do clinicians and staff perceive are the effects of PCR?
  - Quality of care
  - Clinician and staff job satisfaction
  - Clinic efficiency
  - Team dynamics and communication
- Qualitative Methods
  - 30- 60 minute semi-structured interviews with 30 clinicians and staff in 2 pilot practices (9 months post-implementation)
  - Structural coding and thematic analysis

Digging Deeper: Quality

"Patients feel like they've had most of their issues addressed, especially the most important things" – Provider

"I love being able to close a lot of those gaps in care. It makes me feel like I'm a real part of the team" - MA

Implementation Scale Up



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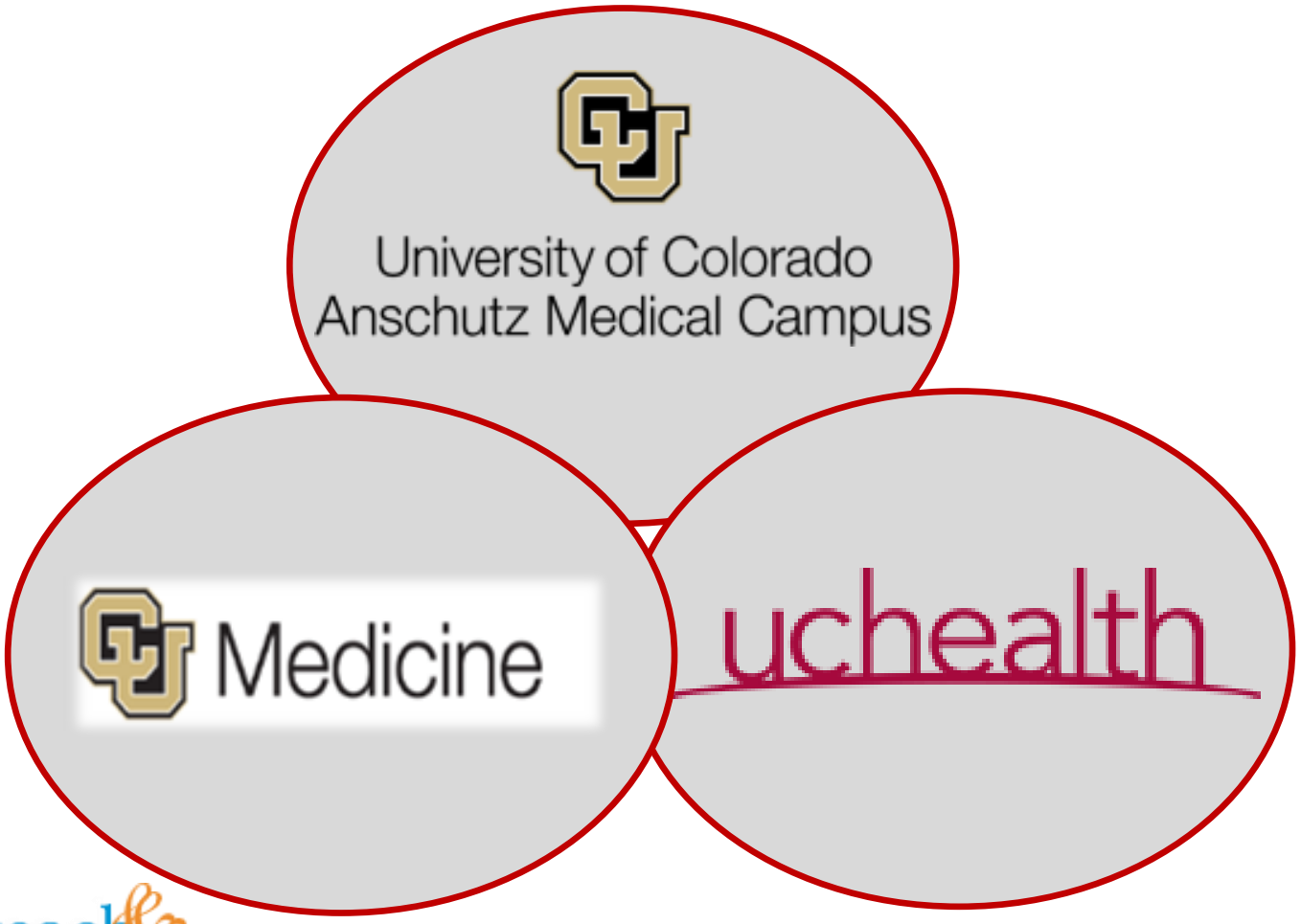
Team Identification



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Our Team

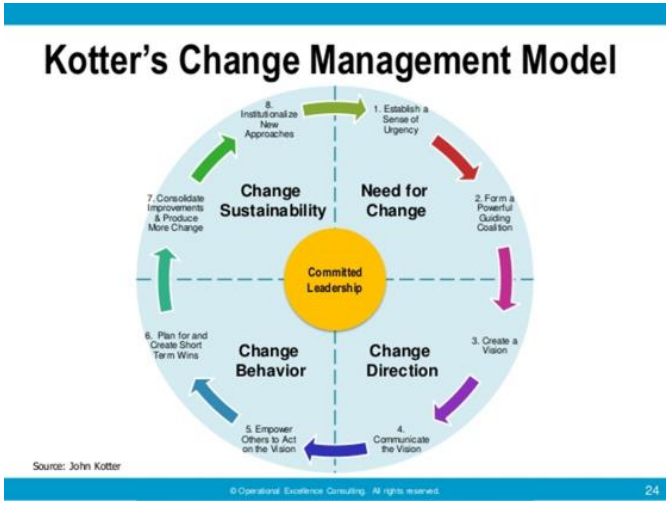
- Executive Level Stakeholders
  - Vice Chair of Clinical Affairs (SOM)
  - Director of Primary Care (UCH)
  - CEO University Hospital (UCH)
  - CEO of UCHealth
  - COO of UCHealth
- Clinic Leadership Team
  - Medical Director (SOM)
  - Clinical Nurse Coordinator (UCH)
  - Practice Manager (UCH)
  - Medical Assistant (UCH)
  - Processes Improvement support (UCH)
  - IT/EPIC support (UCH)
  - Practice Transformation Facilitator (SOM)


QUESTIONS

Stage 1: Need For Change

1. Establish a sense of urgency

2. Form a powerful guiding coalition



Create a Sense of Urgency: The Burning Platform

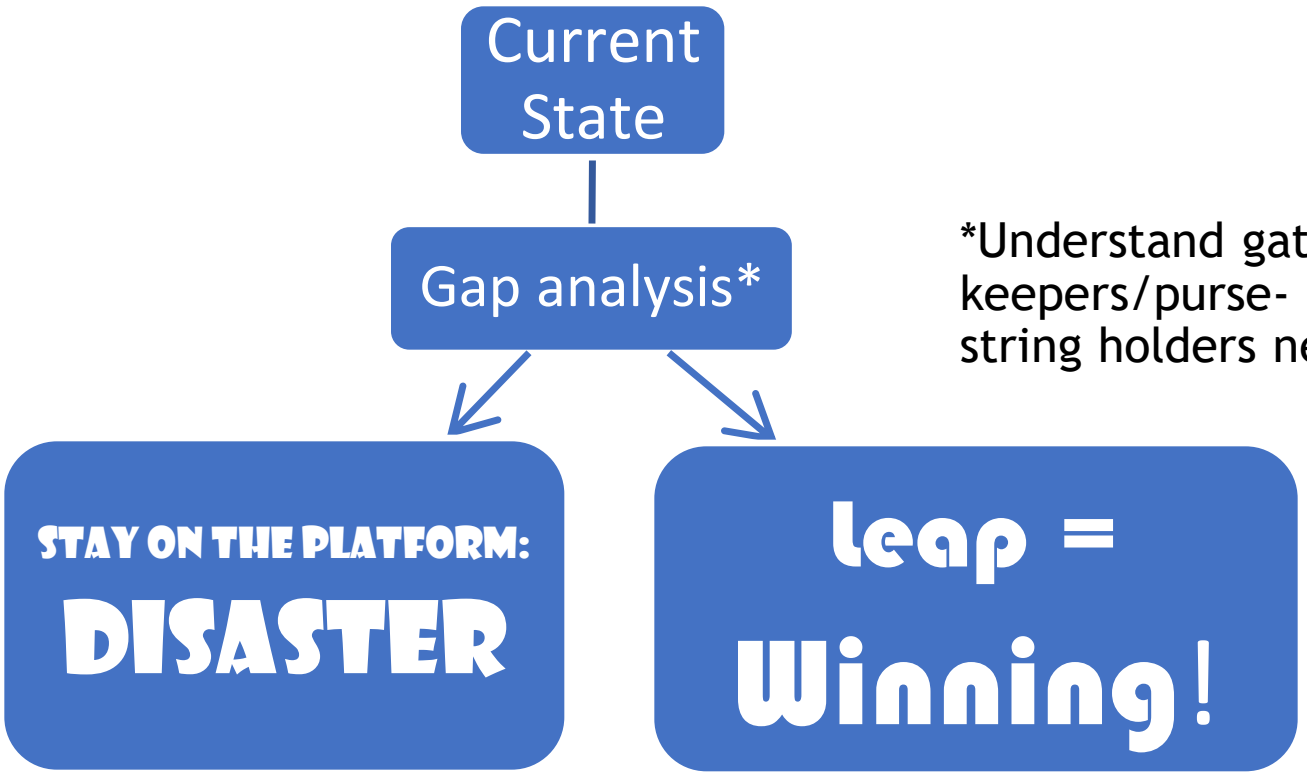
- Likely death is better than certain death
- What I want vs. WE NEED
  - Categorical imperative
- ***THE*** most important step

Create a Sense of Urgency: Identify Threats

- Identify biggest…
  - Crises/threats/ dangers
  - Real/potential/ immediate

You're in for a Bumpy Ride

Stage 1
Urgency of Alternate Futures



*Understand gate keepers/purse-string holders needs

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Stage 1
Create a Sense of Urgency: You Want Me to WHAT?

- Tailor your message
  - What and who turns the wheels? How?
  - What do they want/not want/fear?
  - "I have made this longer than usual because I have not had time to make it shorter" - Pascal

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Stage 1
Create a Sense of Urgency: What's the Problem?

"We need world-class primary care to compete on value in this competitive market. **We are expensive yet provide a poor experience of care** for staff, providers and patients, **resulting in burnout, turnover, poor quality, high cost that erodes our brand**."

"Multiple local disrupters are developing innovative care models. Without immediate action we won't have enough providers or covered lives to compete for narrow networks. **We won't survive without transformative change in primary care**."

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Stage 1:
Create a Sense of Urgency: Fan the Flames

Stage 1: Form a Powerful Guiding Coalition

- Intelligence, commitment, power
  - Lead & effect change, not merely manage
- Diverse, distributed, accountable
  - Bound by the burning platform
- Nerve Center of the Campaign
  - Receive & transmit across the hierarchy
  - Synthesize information into new ways of working
- Work with respect, energy & purpose

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Stage 1:
Form a Powerful Guiding Coalition

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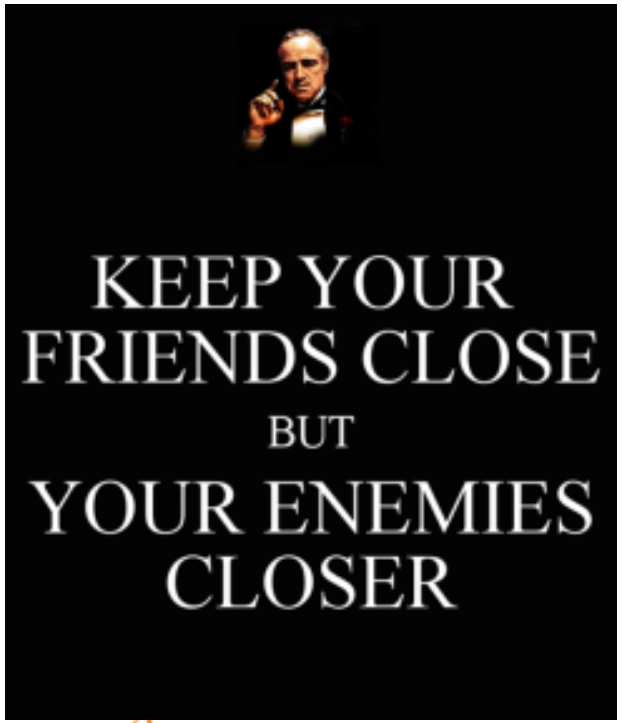
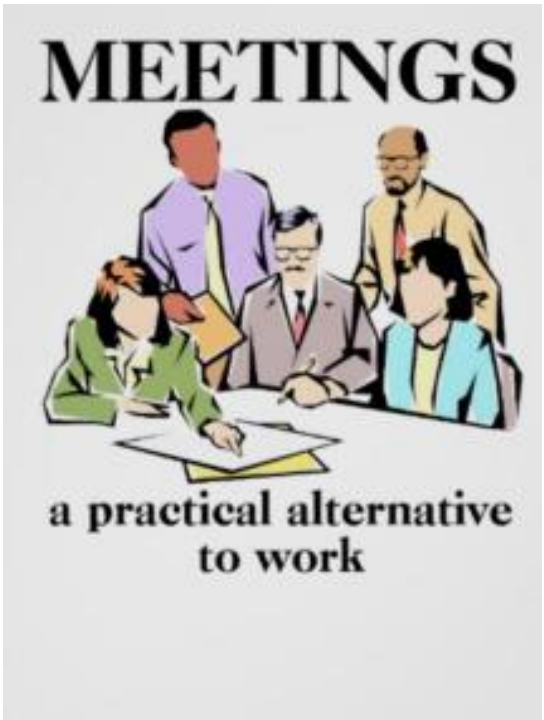
Stage 1:
Form a Powerful Guiding Coalition





Stage 1: Need for Change

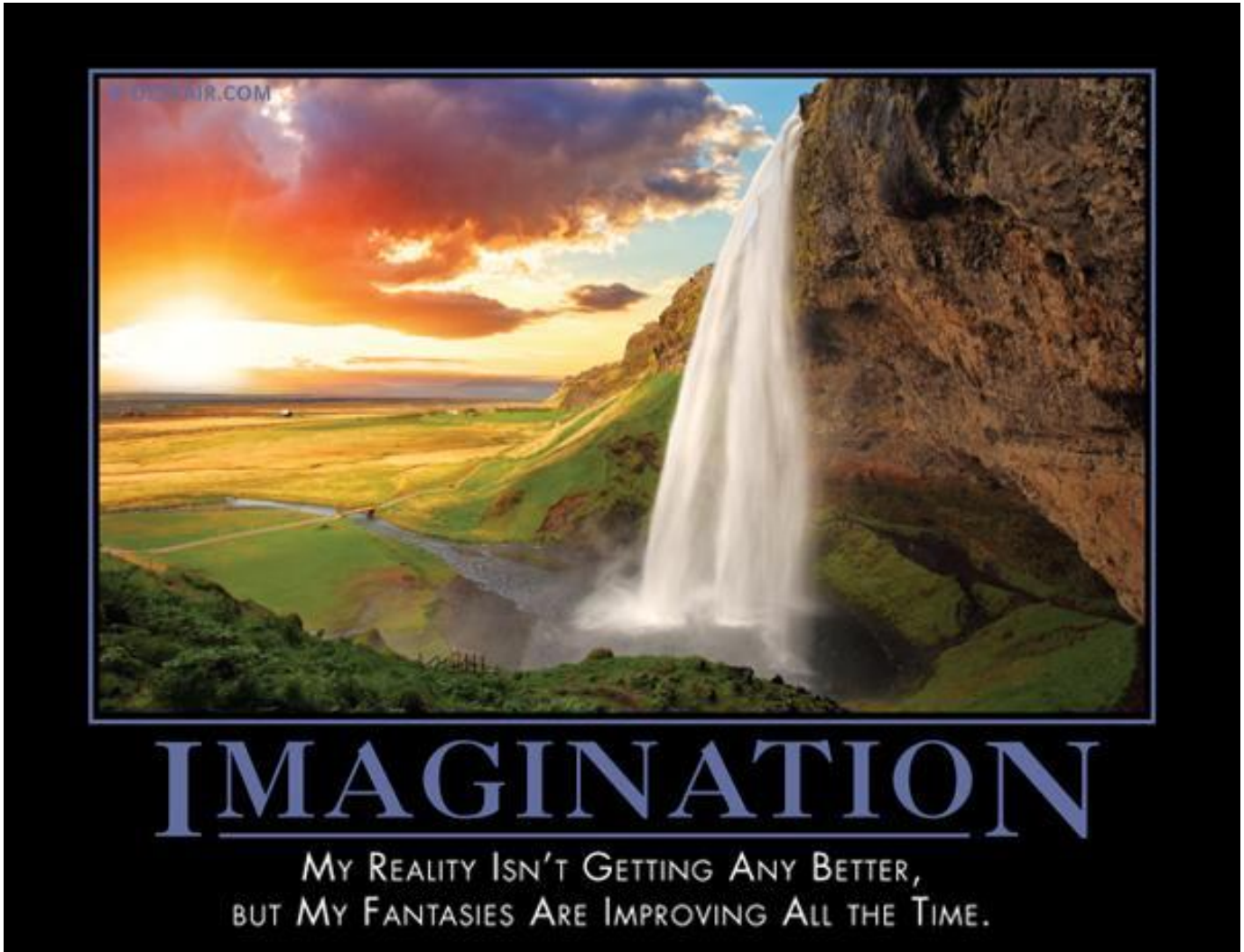
Group work

- Think about the problem you're trying to solve
  1. List some reasons why your project might fail
  2. Establishing a Sense of Urgency
     a. Burning Platform
     b. Burning Aspiration
  3. Who will be in your guiding coalition?

CHANGE ROADMAP

Stage 1: Need for Change
Establish a sense of urgency
Form a powerful guiding coalition

What problem(s) are you trying to solve?	**List reasons why your project might fail** (including people)
Establish a Sense of Urgency Identify Burning Platform (crises, existential threats)	**Establish a Sense of Urgency** Identify Burning Aspiration (inspiring others to change)
Create a Guiding Coalition (formal leaders/ friends/enemies/frenemies)	



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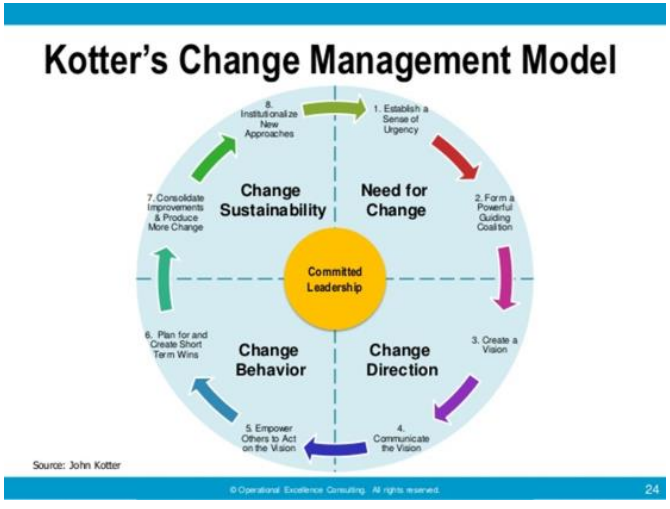
Stage 2: Change Direction

3. Create a vision

4. Communicate the vision



Create a Strategic Vision: Put Your Problem Statement in the BHAG

- Big Hairy Audacious Goal
  - 1-2 sentences to capture the desired future
  - Link to important shared values
  - Can your coalition describe the vision in five minutes or less?
  - Practice your "vision speech" often.

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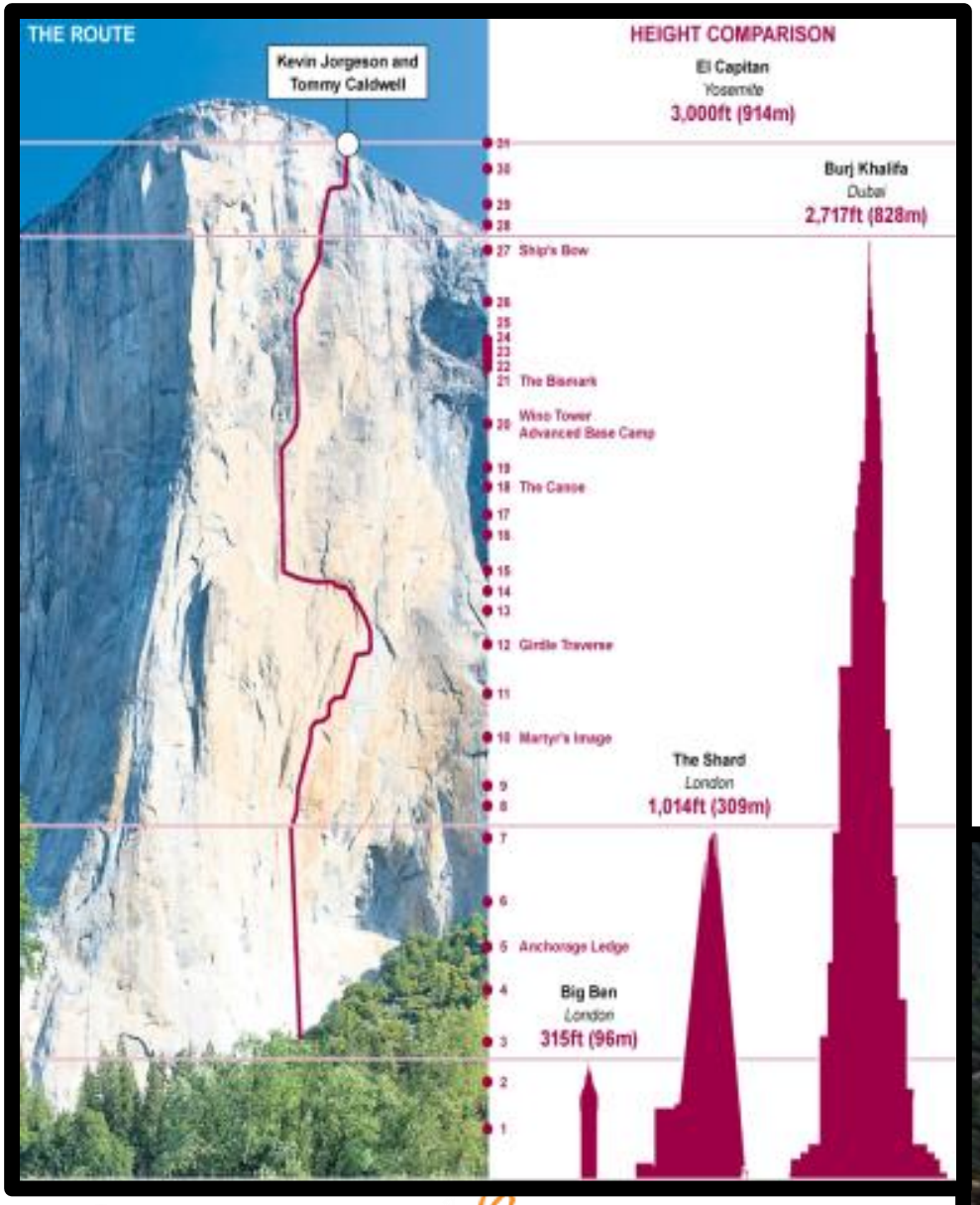

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- Create a strategy to execute your vision
- Actions/Initiatives co-created by coalition and stakeholders to reach your BHAG

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Stage 2
Create a Strategic Vision:

"In the next 24 months we will design, implement and test an innovative MA staffing model that is informed by sophisticated population health and patient experience informatics and integrated with behavioral health, clinical pharmacy and care management."

"Whoops—I accidentally pressed 'elevator pitch.'"

"In 5 years we will become the state's primary care system of choice for patients, providers, payers, employees and employers by creating JOY IN PRACTICE and an AWESOME PATIENT EXPERIENCE."

"**WE WILL ACHIEVE THE QUADRUPLE AIM**"

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Communicate the Vision
Recruit a Volunteer Army

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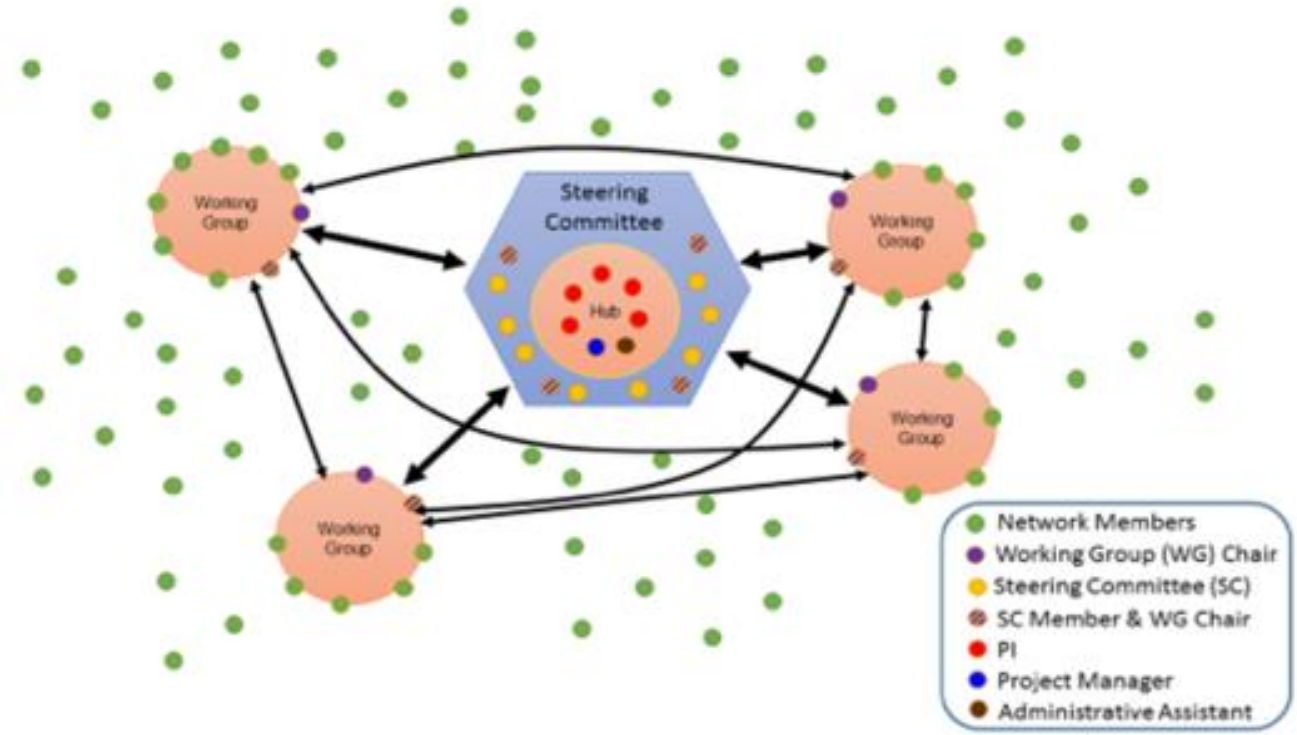
Communicate the Vision: Recruit a Volunteer Army



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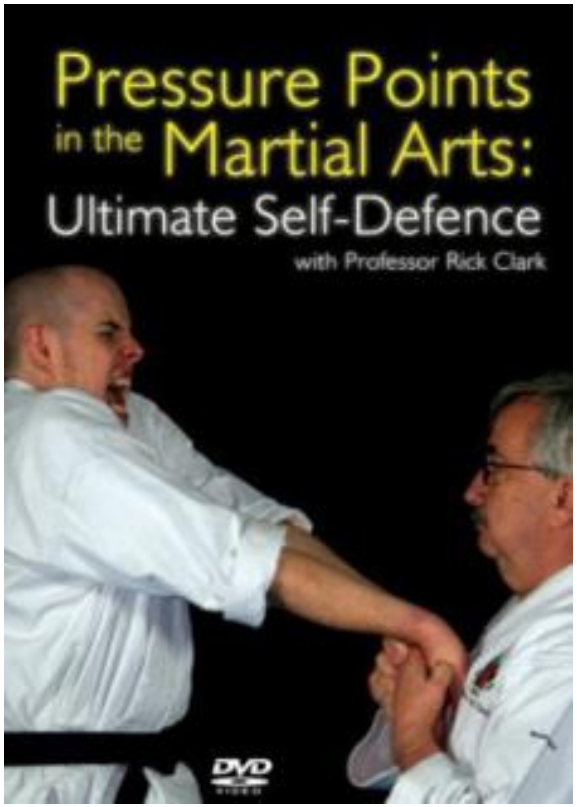
Communicate the Vision: Recruit a Volunteer Army

- Leverage & Influence
- Gain Provider, Staff and Patient Buy-in



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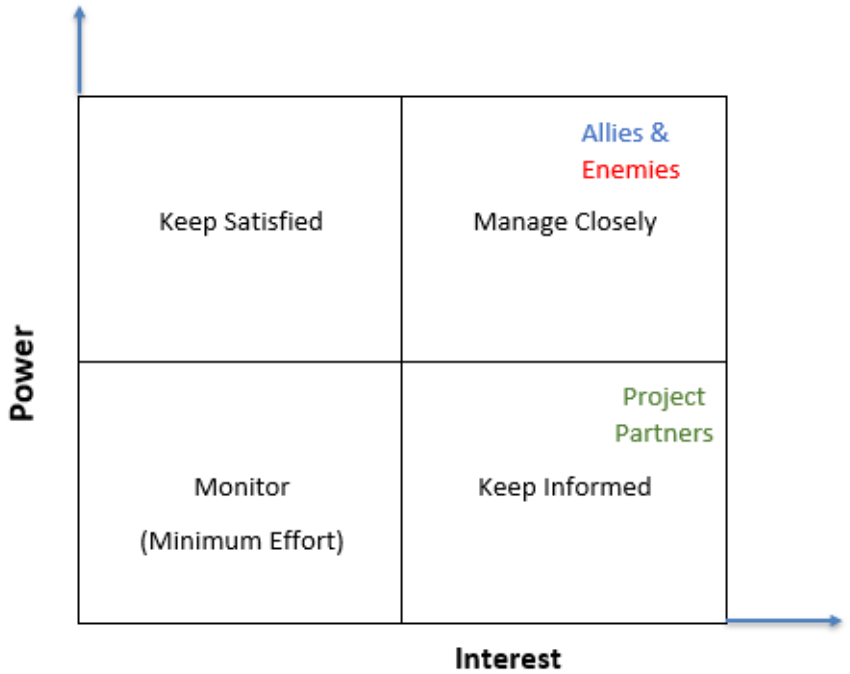
Stage 2:
Getting Support – Stakeholder Management

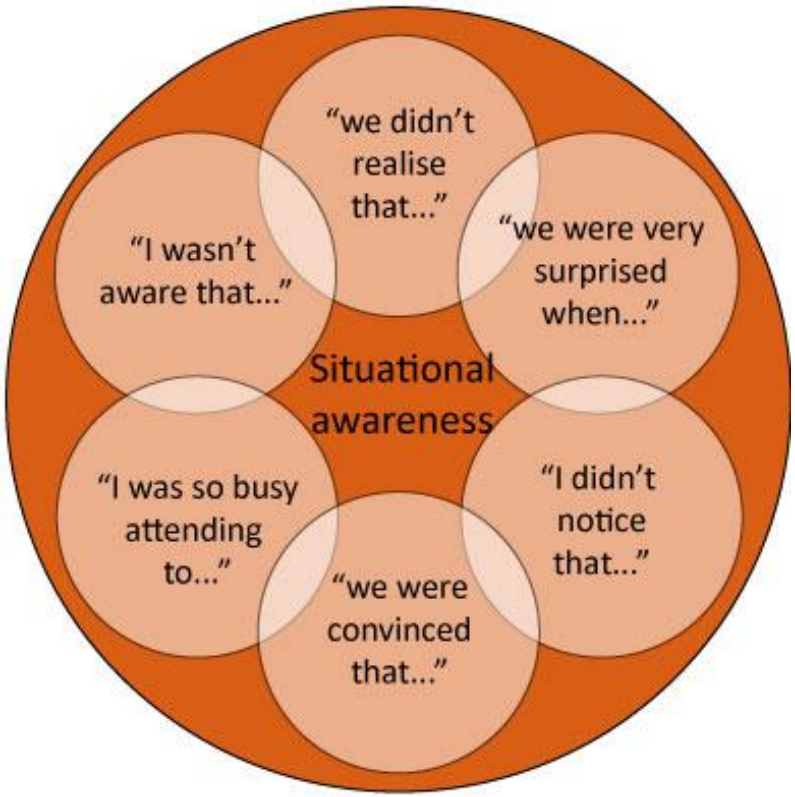


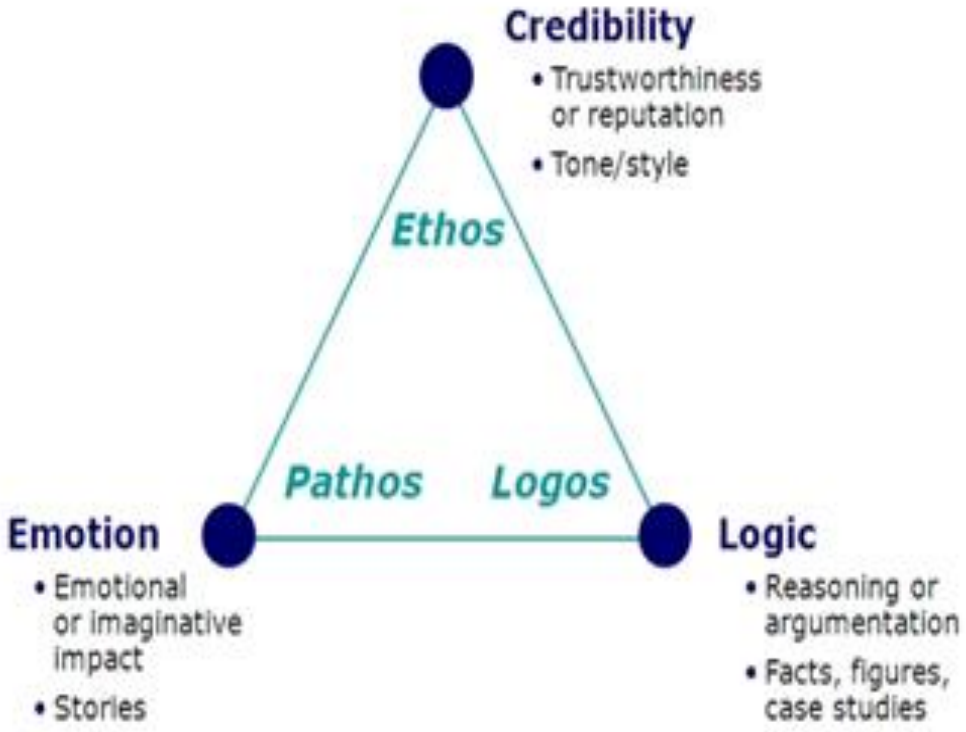
Step 1: Identify Stakeholders

Step 2: Prioritize Stakeholders

Step 3: Understand Stakeholders

Communicate the Vision: Lessons Learned





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Communicate the Vision: Lessons Learned

- Have someone at the important meetings.
- This is part of the coalition's job, forever!
- Build excitement – lectures, newsletters, web banners, infographics, logos, acronyms, colloquia, press
- Make an evaluation plan

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Stage 2
Selling the Vision: Stakeholder Engagement

- Group work
  - Put your problem statement in the BHAG
  - Draft a Vision Statement
  - Recruit a Volunteer army
    - Stakeholder identification and engagement
    - Elevator Speech(s)
  - Communication Plan

10 MINUTE BREAK


QUESTIONS

Finding Dollars & Making Sense

- Negotiation and trade-offs
- Paying for the future
- Staffing
- Infrastructure
- Evaluation/QI/change management

Funding: How Do We Pay For This?

Increase Revenue

- **Tangible**
  - Facility based billing
  - Downstream revenue
  - Visits, Max packing
- **Intangible**
  - Footprint/Market share
  - Referral base
  - Value based contracting
  - Covered lives

Reduce or Contain Costs

- **Tangible**
  - Staffing
  - Space, construction
  - Capital
  - Borrowing
- **Intangible**
  - Recruitment & retention
  - Providers, staff, patients

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How Do We Pay For This? A Banking Analogy

- Old way: Cash business
- New Way: Start up credit
- Goal: meet common goals with cost-neutral enhancements

Physician Burnout - MGMA Staffing Averages are a Primary Cause

Join the conversation on Twitter #CPQI19

Posted by Dike Drummond MD

Tweet | Share | Like 12 | Share | G+

How did the physician overwhelm in the trenches of patient care get to be so pervasive?

In this article, let me show you a *hidden management thought pattern* that creates abusive levels of understaffing in the majority of healthcare organizations every day.

MGMA: Medical Practices Designated As "Better Performing" Emphasize Cost Management, Productivity and Patient Satisfaction

Organizations deemed "better-performing medical practices" by the MGMA *Performance and Practices of Successful Medical Groups: 2014 Report Based on 2013 Data* excelled in four performance-management categories: profitability and cost management; productivity, capacity and staffing; accounts receivable and collections; and patient satisfaction. The practices designated as better performers i[illegible] to the MGMA 2014 Cost Survey.

Median Support Staff per FTE Physician for Primary Care Practices

	Physician Owned	Hospital/IDS Owned
Total business operations support staff	0.81	0.45
Total front office support staff	1.31	1.82
Total clinical support staff	2.09	1.71
Total ancillary support staff	0.33	0.55
Total support staff	**4.57**	**3.64**

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GIGO & MGMA: Make Great Medicine Again?

- **Median staffing ratios → Median performance →**
  → Your Burning Platform

- **Better practices' ratios →**
  → Better performance

Infrastructure

Evaluation - Make a Plan

Evaluation - Make a Plan

- Baseline, periodic
- Stakeholder needs
- Your needs
- Outcomes & process

- Tell your story

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Evaluation - What Do We Have to Work With?

- Your vs. Stakeholder needs
- Who what when where how why?
- What can we work with?
  - Quality reporting, Patient Experience, Business Operations
  - Qualitative – formal, informal

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Evaluation

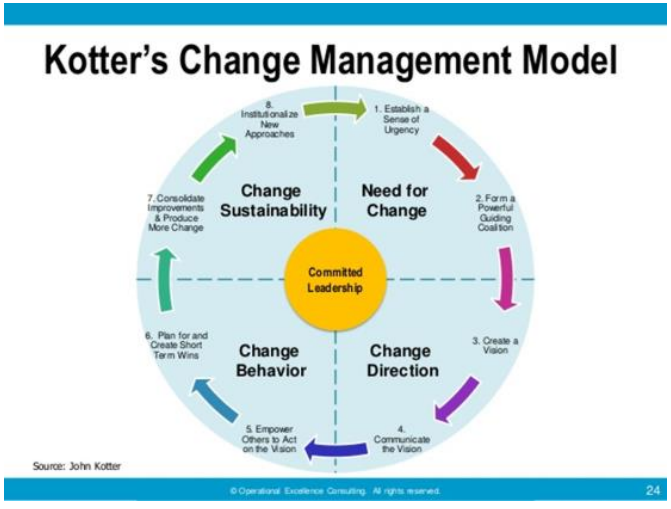
What Do We Have to Work With?

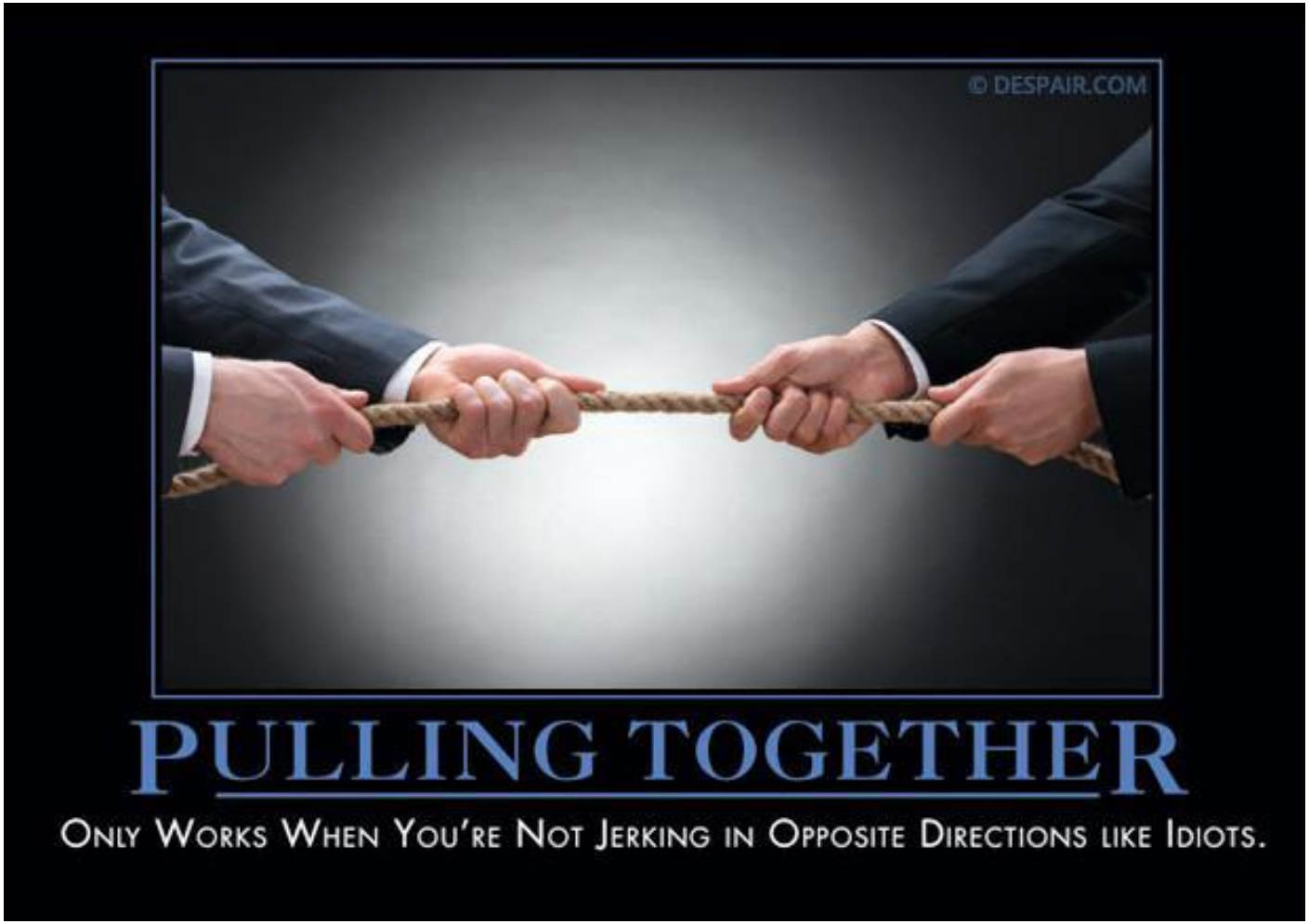
- What do you want?
- What will you give up?

Stage 3: Change Behavior

5. Enable others to act

6. Plan for and create short term wins




© DESPAIR.COM
PULLING TOGETHER
ONLY WORKS WHEN YOU'RE NOT JERKING IN OPPOSITE DIRECTIONS LIKE IDIOTS.

Enable Others to Act

- Brainstorming, Root Cause Analysis
- Culture
  - "That's not how we do it"
  - "Been there – done that"
  - Communication & trust
- Individuals, rules & regs, physical obstacles
- Silos, parochialism, volume targets, complacency, legacy rules, absent stakeholders
- Permission vs. forgiveness
- Broken record: burning platform, problem statement, or strategic vision

Enable Others to Act: 10 Things To Be

10. Polite
9. Tenacious
8. Three

7. Grateful
6. Creative
5. A Ninja
4. Empathic

3. The right person
2. Ready to confirm & codify wins
1. The one to keep the patient front and center

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Stage 3
Creating Short-Term Wins: Implementation

- Model creation/ adaptations
- Considerations for choosing a pilot site
- Evaluation planning
- Change management

Stage 3
The University of Colorado Experience

- CU's Key Lessons Learned
  - Preparing the Space
  - Initial Rollout
  - Coaching
  - Compliance Issues
  - Challenges with Staffing
  - Standardization

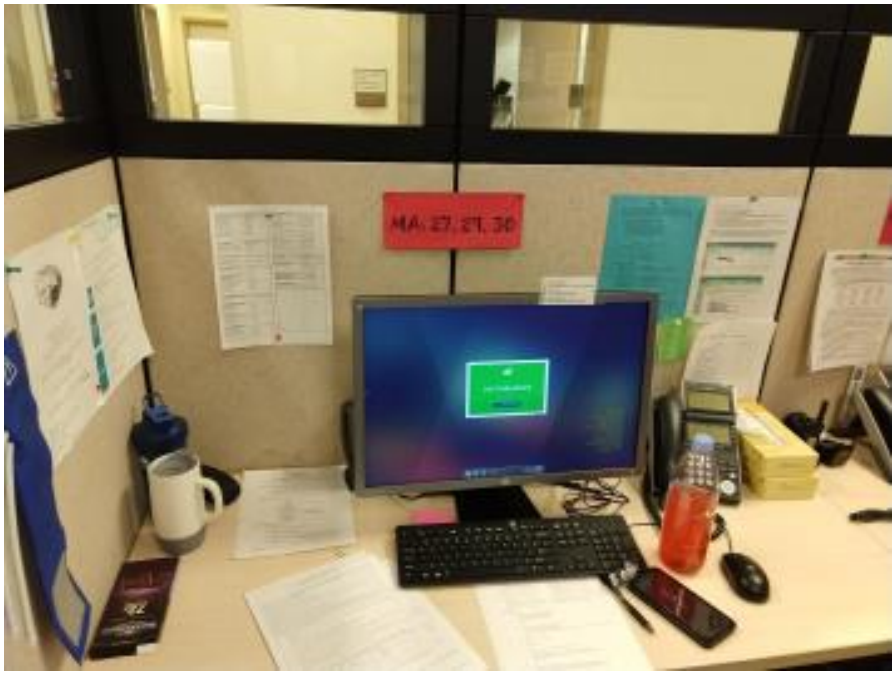
Building Internal Motivation

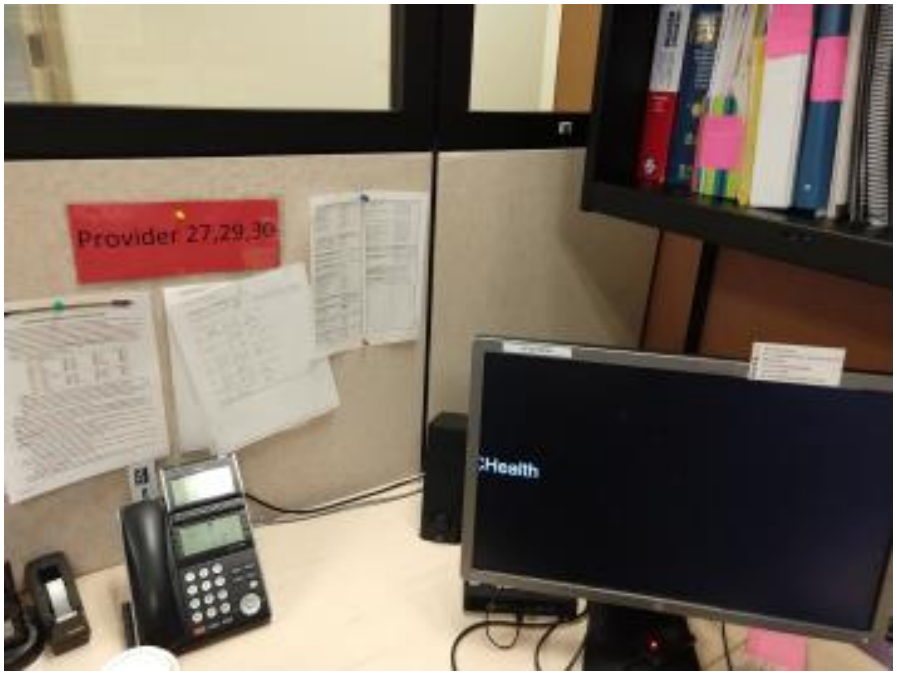
- Drew upon clinic culture to be leaders of system change
- To providers: Less time documenting
- To MAs: More involvement with patients

Preparing the Space

Enough exam rooms?

Preparing the Space





Initial Rollout

- Closed part of clinic x 2d for mock visits followed by debrief lunches
- Two weeks of 40 min visits per provider
- Phased in changing certain 40 min visit types to 20 min visits

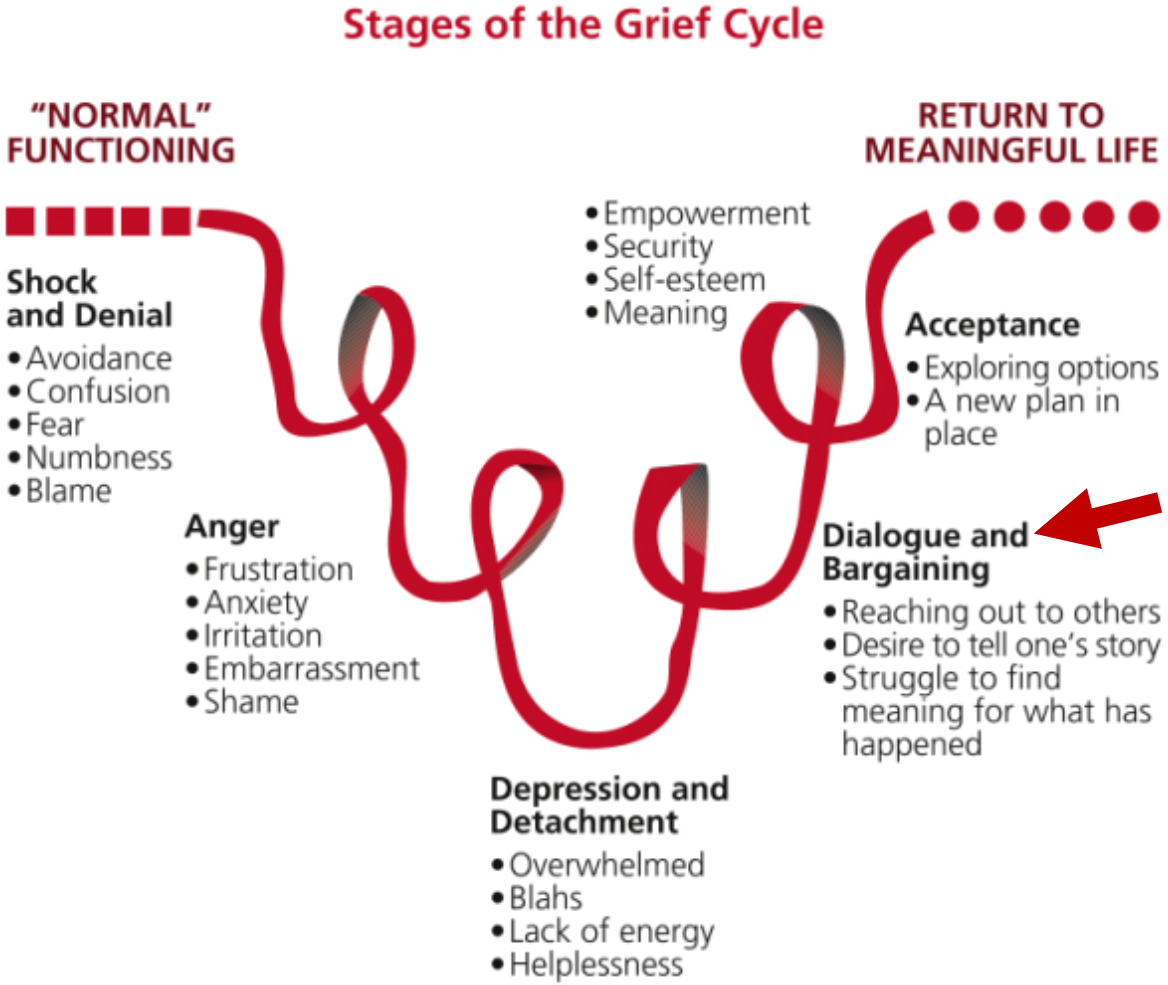
Practice Facilitator is on "Team Practice Transformation"

- Coach on the practice leadership team played an influential 3rd party role
- 6 months of team building
- Change is "needed but not easy" attitude

"The first thing [the coach] did is she did a lot of listening, a lot of observing, making herself present."

"She was not evaluating. She bridged a lot of communication issues that were going on between providers and staff."

The first 6 months of transformation



You are here

Compliance Backpedaling

- 15 months in - compliance took issue with documentation practices
- 1st change: italics to verify
- 2nd change: new Epic builds
  - Required high level IT support/strategic leadership

MA Pay Scale Negotiations

- 16 months in -- wracked with MA turnover in the setting of low hourly rate for geographic area

"I like the work but need to feed my family."

- Plan A: If you interview elsewhere, tell leadership what you've been offered → more turnover
- Plan B: Arrange direct meetings between MAs and system leaders → raises and pay ladder

Ongoing MA Hiring/Retention

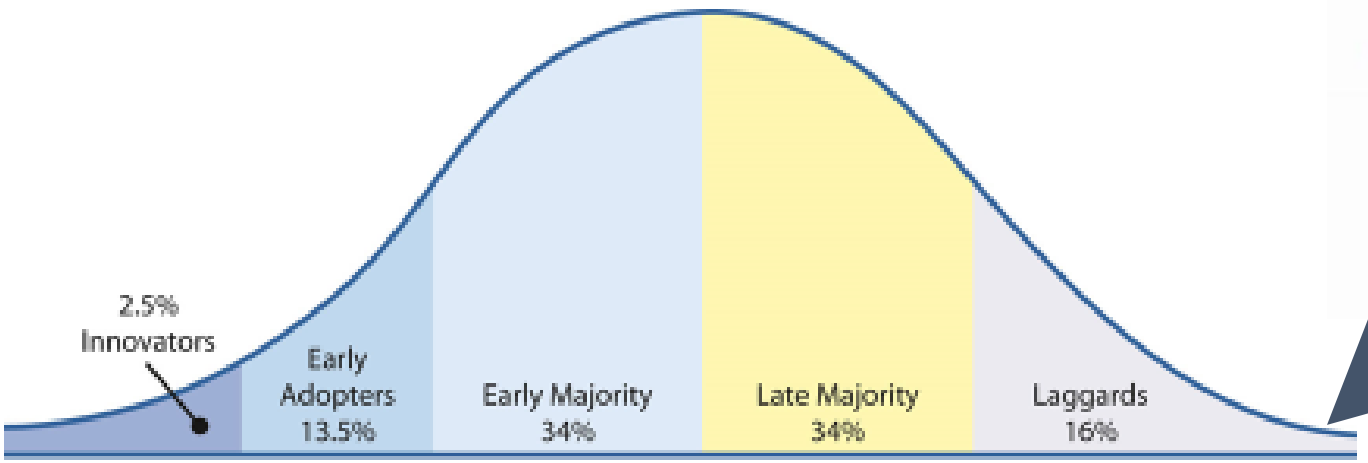
- Pay raise
- Development of MA ladder
- Recruitment bonus
- Central hiring
  - Clinic assignment determined after training

Digging Deeper: Qualitative Evaluation

- MA Pay and Turnover
  - There are MAs who appreciate the more involved scope of work
    - Not true for all; will self-select out of the position
  - Expect to be paid accordingly
  - Turnover - demand for MAs high in the region
- MA Training
  - Didactics (e.g., terminology) vs Experiential Learning (e.g., mock visits, seeing it in action at other clinics)
    - Both very important
  - MA "Super user" - train and onboard new MAs

Spreading Good Ideas

Social Phenomenon or Leadership Opportunity?



Encounter

Engage

Educate

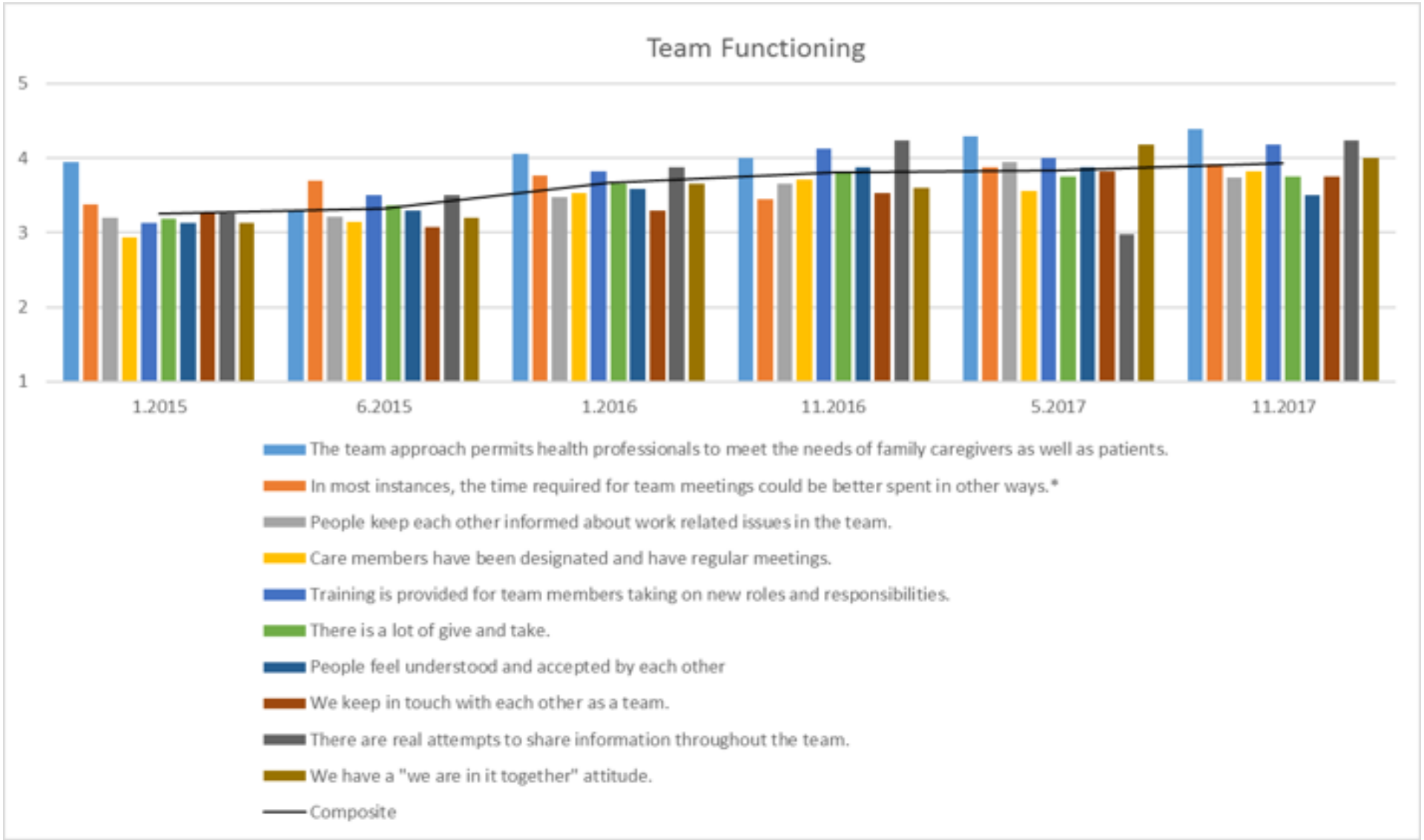
Create a Sense of Urgency

Enforce

Everett Rogers. *Diffusion of Innovations*. 1962.

Digging Deeper: Qualitative Evaluation

- Key Themes: Implementation Experience
  - Ability to see the model "in action"
  - Ensuring regular provider-MA pairings
  - Accommodating the "learning curve" (at least a few months)
  - Ensuring role clarity (e.g., what is the role of nurses?)


Team Functioning
5
4
3
2
1
1.2015
6.2015
1.2016
11.2016
5.2017
11.2017
The team approach permits health professionals to meet the needs of family caregivers as well as patients.
In most instances, the time required for team meetings could be better spent in other ways.*
People keep each other informed about work related issues in the team.
Care members have been designated and have regular meetings.
Training is provided for team members taking on new roles and responsibilities.
There is a lot of give and take.
People feel understood and accepted by each other
We keep in touch with each other as a team.
There are real attempts to share information throughout the team.
We have a "we are in it together" attitude.
Composite

Provider Experience

"My interactions with my patients are way more connected and attentive"

"I'm able to focus much more on thinking and medical decision making"

"Over time my MAs can predict where I'm going with the visit and they feel empowered to document what's going on without having to ask."

Staff Experience

"If you rely on a provider to remember something it will fail because they have too much to do"

"My work is more fulfilling knowing I'm part of a team that makes a difference in people's care"

"Our roles weren't clear, which created a lot of issues around communication and who is doing what"

Creating Short-Term Wins

- People want evidence of success within 12-24 months
- Sustain momentum
- Created, not hoped for
- Key system leaders as practice standardized patients
- Collecting early implementation stories

Celebrate Short-Term Wins: Time for Cake!

Building on Short-Term Wins

- We're in it together
- Staff and provider retreat
- Developed Lead MA position
- Skills training
- Led to long-term positive change

Step 5 - Change Roadmap
Empower Broad-Based Action

Make it easy to support the project
(eliminate barriers)

Brainstorm Barriers
(culture, habits, silos, space, compliance, etc.)

Ideas for overcoming barriers
(Over-communication, evaluation, coaching, QI, setting expectations, flexibility, etc)

Ways you could make it <u>EASIER</u> to support the program/project

Step 6 - Change Roadmap
Generate short-term wins

Brainstorm short-term wins
(achievable within the first 1-2 weeks)

Brainstorm rewards
(that you afford to give in response to success)

Brainstorm ways you'll share these short-term wins with other

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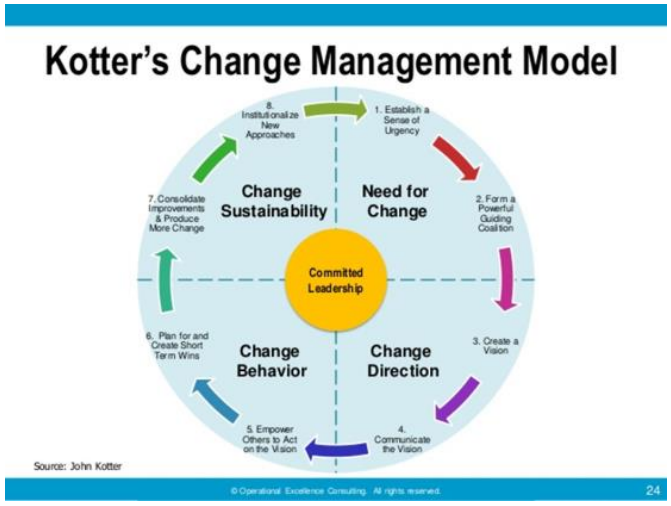
10 MINUTE BREAK


QUESTIONS

Stage 4: Change Sustainability

7. Consolidate improvements and produce more change

8. Institutionalize new approaches



Stage 4
The University of Colorado Experience

- CU's Key Lessons Learned
  - Standardization vs. adaptability
  - Practice facilitation and coaching
  - Continuous quality improvement
  - Plan for sustainability

Digging Deeper: Qualitative Evaluation

- Interviews with organizational leadership (n=8)
  - What factors influence plans for sustainment and scale up across the organization?
- Key Themes
  - Primary motivation to sustain: Achieving the "Quadruple Aim"
  - Standardize the patient experience across sites (establish the brand)
  - Need to understand core elements (system-wide standardization) and adaptation (local customization)
  - Importance of ongoing learning and information needs re: care team member experience

Stage 4
How To Sustain the Gains

- Creating a new culture
- Methods for engagement
- Ongoing communication to leadership
- Maintaining a steady state

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CELL BLOCK RED

Balancing the Culture

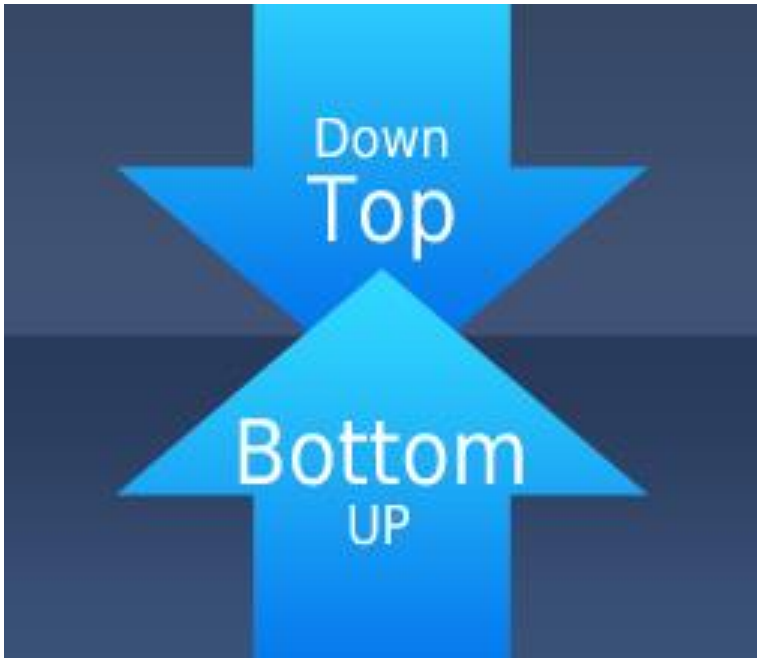
- Buy-in (early and often)
- Engaged leadership & stakeholder
- Consistent messaging
- Practice Transformation Facilitation
  - Change Management
  - Managing Expectations
  - Complex Adaptive Systems

Good Clinic Culture

- Safety of feedback
- Importance of good communication
- Importance of gratitude
- Safe space to fail
- Provider behavior is important (gaps example)

Balancing the Culture

- Flipping the top down approach
  - What does that mean?
  - Why is it important?
  - How do you do it?



Building Your Team and Culture Strategies

Engaging the staff/providers

- Development of an Engagement Council
- Team meetings
  - To include time to share gratitude with each other (shout outs)
  - Resolve any conflicts/communication issues/misunderstandings
  - Develop strategies/goals/ground rules on how to work together
- Focus groups
  - Time for leadership to get feedback from staff on how things are going
  - Collect ideas on next steps or finding solutions to problems
- Provider "lunch'n'learns
  - Opportunities to provide updates
  - Receive feedback
  - Show gratitude
- Clinic wide retreat
  - Teambuilding exercises
  - Set goals for the year
- Book clubs
  - Crucial Conversations is a good place to start
- Daily huddles (to include in session huddles
  - Tool for communication during clinic day
  - Prepare for the clinic session
- Celebrations
  - Must be planned
  - Opportunities to recognize hard work, show and share gratitude
  - Annual award ceremony
- Staff education series
  - Communication
  - Conflict management
  - Medical home concepts
- Clinic observations
  - Create environment where feedback is safe
  - Observe staff with patients/providers – give feedback on effective communication/workflow
  - Observe providers with staff and patients – provide feedback on clinic efficiency, utilize team members, communication with team
- Clinic newsletter
  - Opportunity to provide updates
  - Show gratitude
  - Staff/provider spotlights

Continuous Quality Improvement

- Quality improvement
  - Bi-weekly QI meeting with clinic leadership
    - Review clinical quality metrics
    - Determine workflow adjustments
    - Gate keepers of new and ongoing QI projects
  - Monthly all staff and clinician QI meetings
    - (lunch is provided – very important!)
    - QI teams – depression outreach, hypertension, tobacco cessation, paperwork workflows
    - Focus on team-building, clinic education
      - (implicit bias training, micro-aggressions training, transgender healthcare training, etc.)

Sustaining Change (Locally)

- Provider meetings
- Lunch and learns
- Pod specific staff meetings (monthly)
- Focus groups

Sustaining Change (System Level)

- MA audits
- PCR IT leadership team
- MA Academy (scribe curriculum)
- Bi-weekly PCR workgroup meetings

Organizations do not change, people do

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Sustaining the Gains

7. Consolidate gains, produce more change.

- List 3 bigger wins that are closer to your final version that you will build toward in the next few months:
  1.
  2.
  3.

- List 3 structures/systems that would need to be changed to insure bigger, long-term success:
  1.
  2.
  3.

8. Anchor new approaches in the culture

- List 3 ways in which you can tie this success back to what people personally are about:
  1.
  2.
  3.

- How might you alter policies and procedures to sustain the change?

- How might you alter expectations around who is hired and promoted to sustain the change?

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Suggested Readings:

- A Team-Based Care Model That Improves Job Satisfaction
- *Practice Transformation Under the University of Colorado's Primary Care Redesign Model*
- Leading Change: Why Transformation Efforts Fail
- Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties
- In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Learn More During Our Other Sessions:

- *How Does Your Garden Grow? Complex Adaptive Systems and the Cultivation of High Performing Ambulatory Team – Friday, 3:40pm – 5:10pm*
- *My MA Is My Scribe! Tools to Evaluate and Improve Team-Based Documentation Support – Saturday, 10:30am – 11:30am*
- *It's Not Me, It's You: A 3-Year Analysis of MA Turnover in an Advanced Primary Care Practice – Saturday, 12:30pm – 1:00pm*

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QUESTIONS

Evaluate

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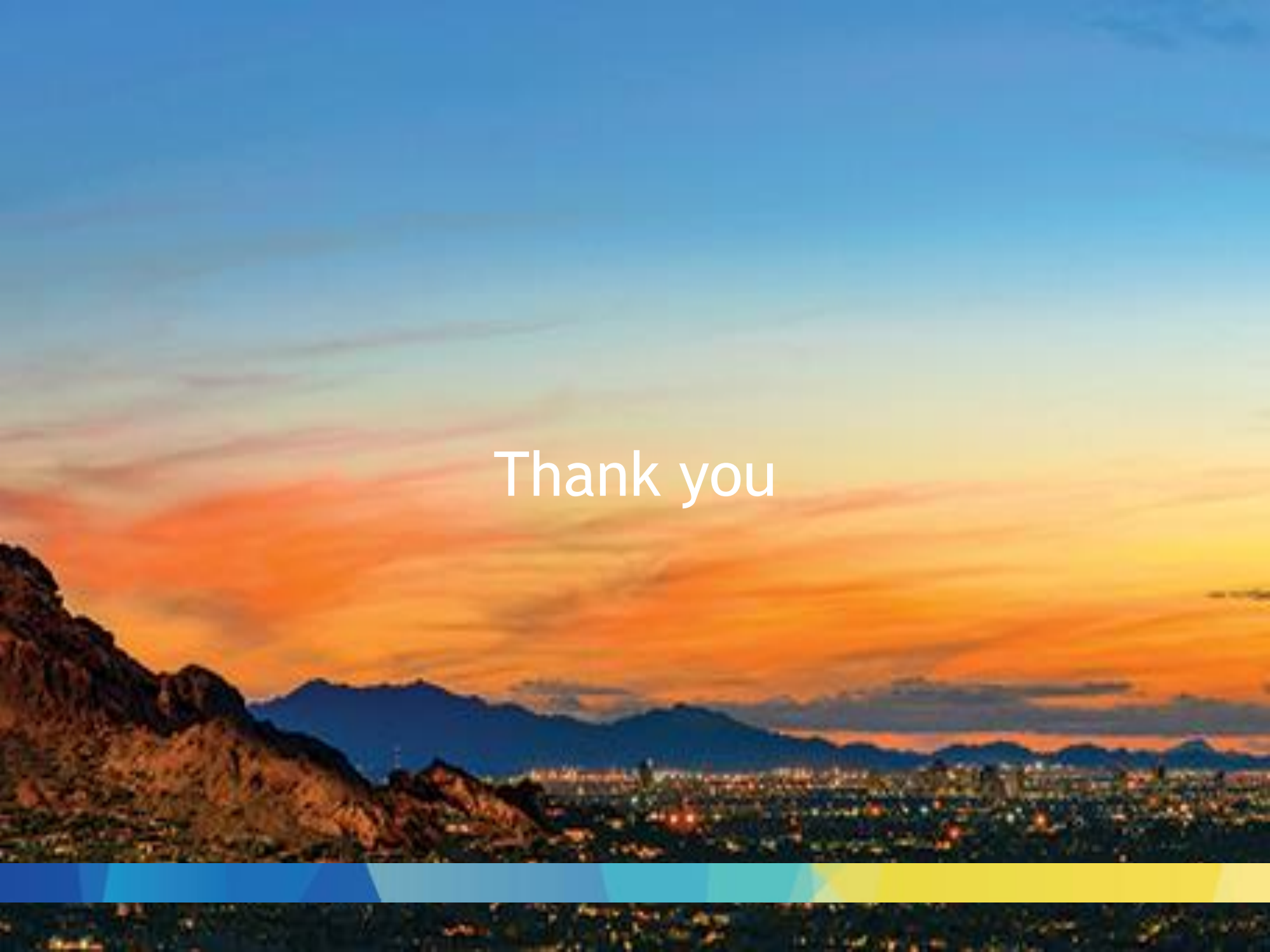
Simply click on the "clipboard" icon  on the presentation page.


Thank you