Implementing Patient-Centered Care
&
Building the Adaptive Reserve for Change

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Presentation Overview

- Healthcare redesign contexts:
  - Patient Centered Medical Home
  - State Innovation Model
- Overview of Lean + Learning Collaborative approaches to support redesign efforts
- Present data on culture for change
- Show relationship between culture, redesign & outcomes
- Discussion

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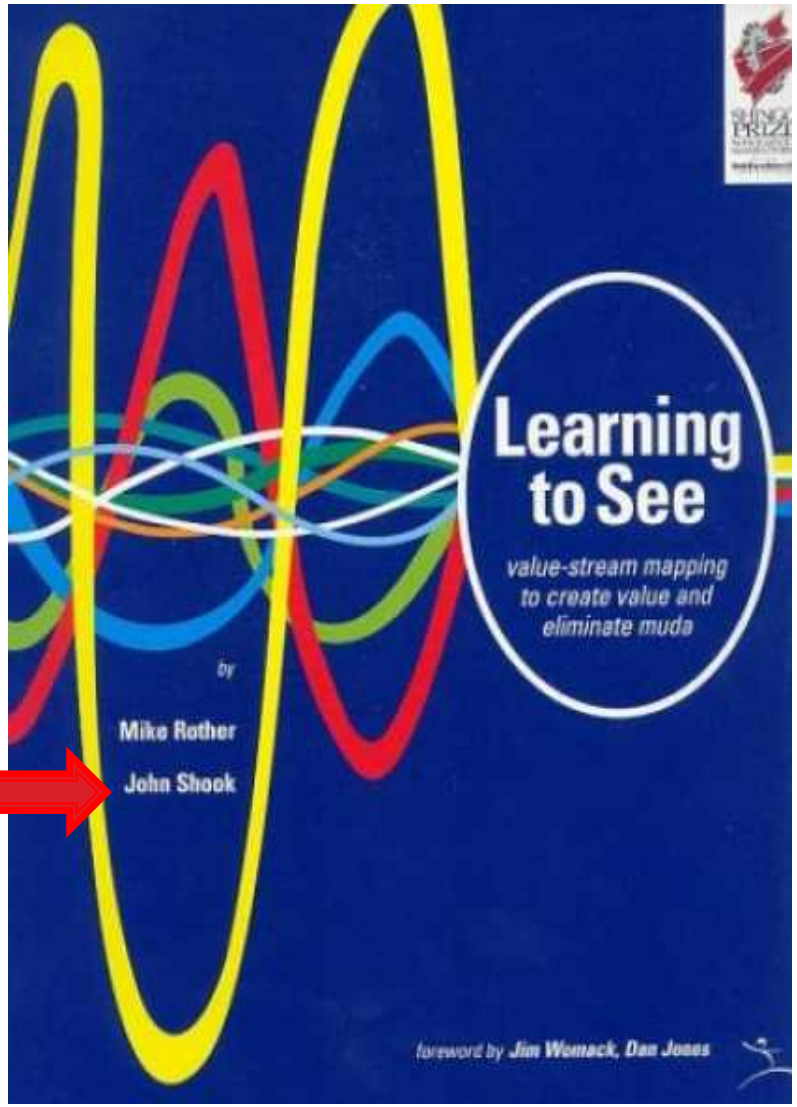
How Do We Implement Patient-Centered Care?

- **Physician groups asked for help**
  - We understand the concepts, but less certain how to implement – "*How do we get there from here*?
  - Significant change fatigue – little 'adaptive reserve'
  - Primary care practice teams unaccustomed to process redesign
  - "We can't see the path to get there."

Lean Thinking & Process Improvement

Lean tools and activities help those who do the work:

- Look at your workflow differently
- Point to opportunities for improvement
- Attempt solutions



- >200 Clinic's from 24 different POs supported by Lean CQI since 2007

BCBSM Physician Group Incentive Program 2011 Program Year

Lean for Clinical Redesign & Patient Centered Medical Home Collaborative Quality Initiative (Lean CQI)

Initiative Plan

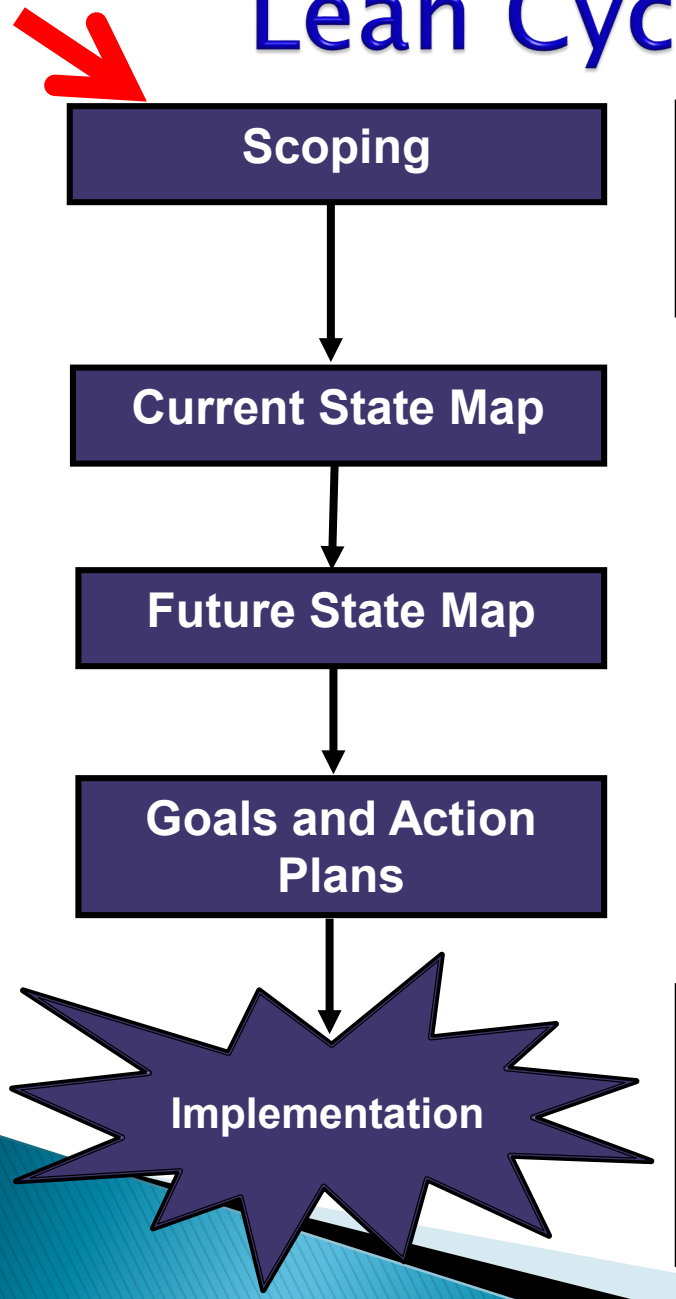
valuepartnerships

LEAN FOR CLINICAL REDESIGN

LEAN THINKING

The people who redesign the work, should include the people who do the work.

Lean Cycle Overview



Pre-Workshop	Define the problem to work on, identify suppliers, inputs, processes, outputs, and customers (SIPOC)
Session 1	Map out all steps in the process, make note of waste and steps that do not add value to the patient
Session 2	Map an ideal process that eliminates waste and increases value to the customer(s)
Session 3	Develop a detailed plan of attack (who, what, and when) to get from current to future state
Check Progress ~ monthly for 3-6 months	Leaders and process owners review progress

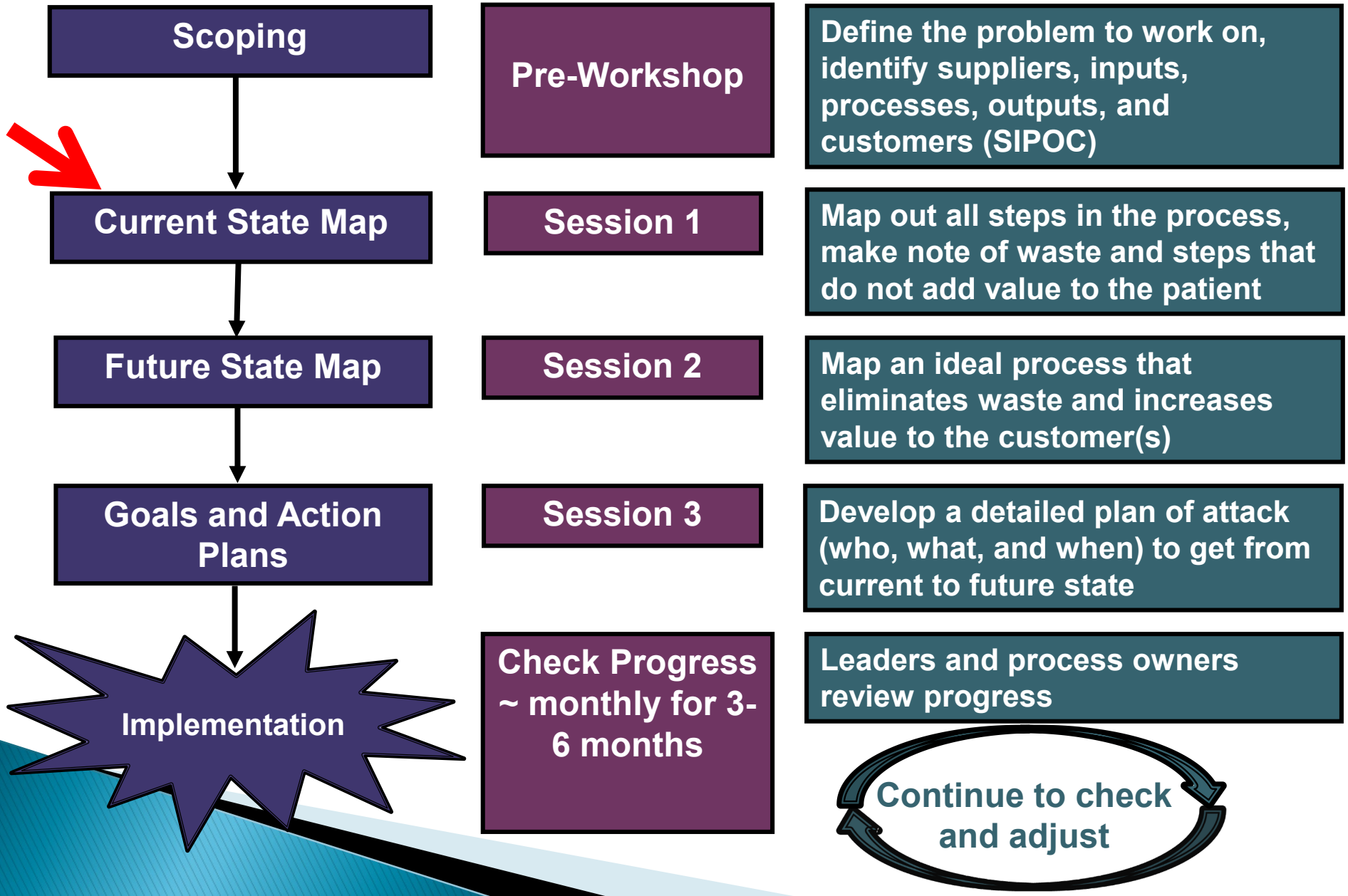
Continue to check and adjust

Doctor No!

"And I just want this Lean stuff to find someone else to do the preventive care for my patients so I don't have to."

– MD during scoping session –

Lean Cycle Overview

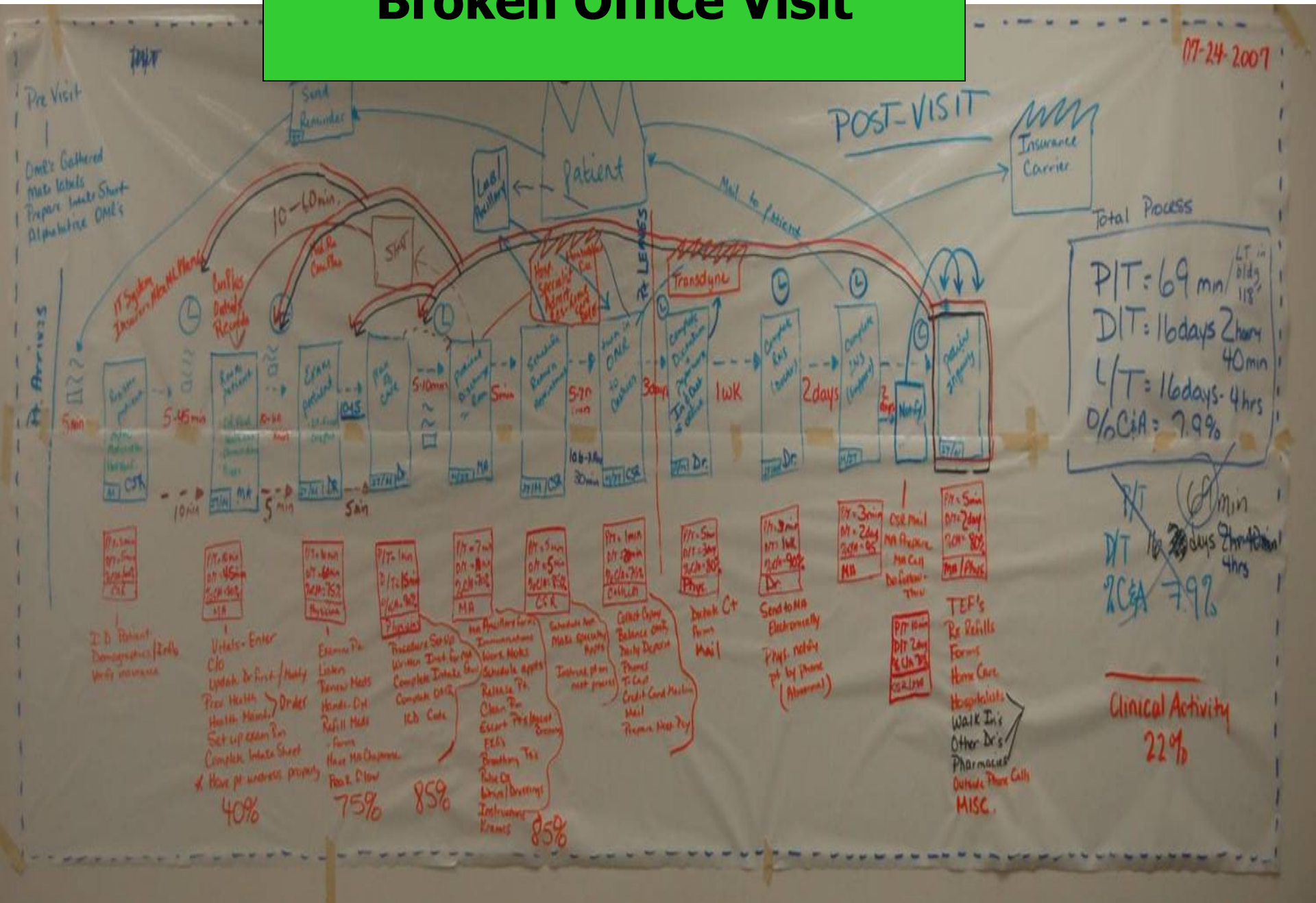


Why Value Stream Mapping?

- A tool that helps ***teams*** 'see' an entire ***process***
- Everyone on the mapping team becomes aware of the entire process, including:
  - ***Value:*** Defined by the customer (patient & others)
  - ***Waste:*** Non-value added processes, wait time during and between processes, re-work

From the customer's perspective

Broken Office Visit



Current State: Wait

Visualize your work & point to problems!

% Complete & Accurate Measure

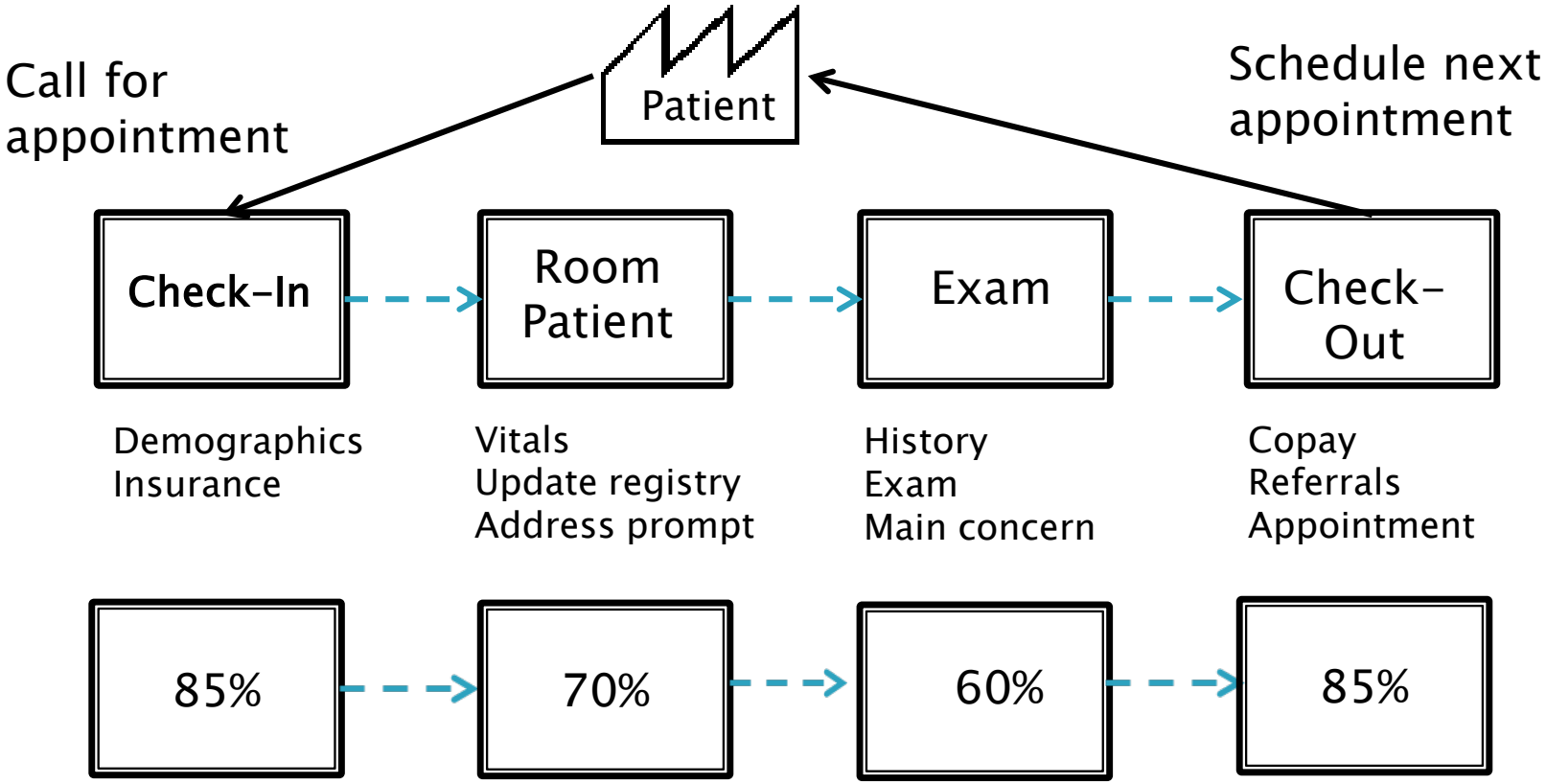
- % Complete & Accurate (%C/A): Percent of time you have everything you need at the beginning of your process step to complete this step successfully

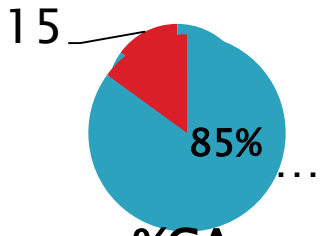
- NOT the % of time the worker gets the process completed

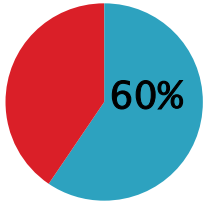
- Total % Complete & Accurate = multiply each step:

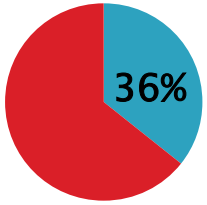
%CA * %CA * %CA * %CA
.85 * .70 * .60 * .85 = .303 or 30%

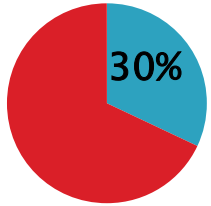
% Complete & Accurate Calculation





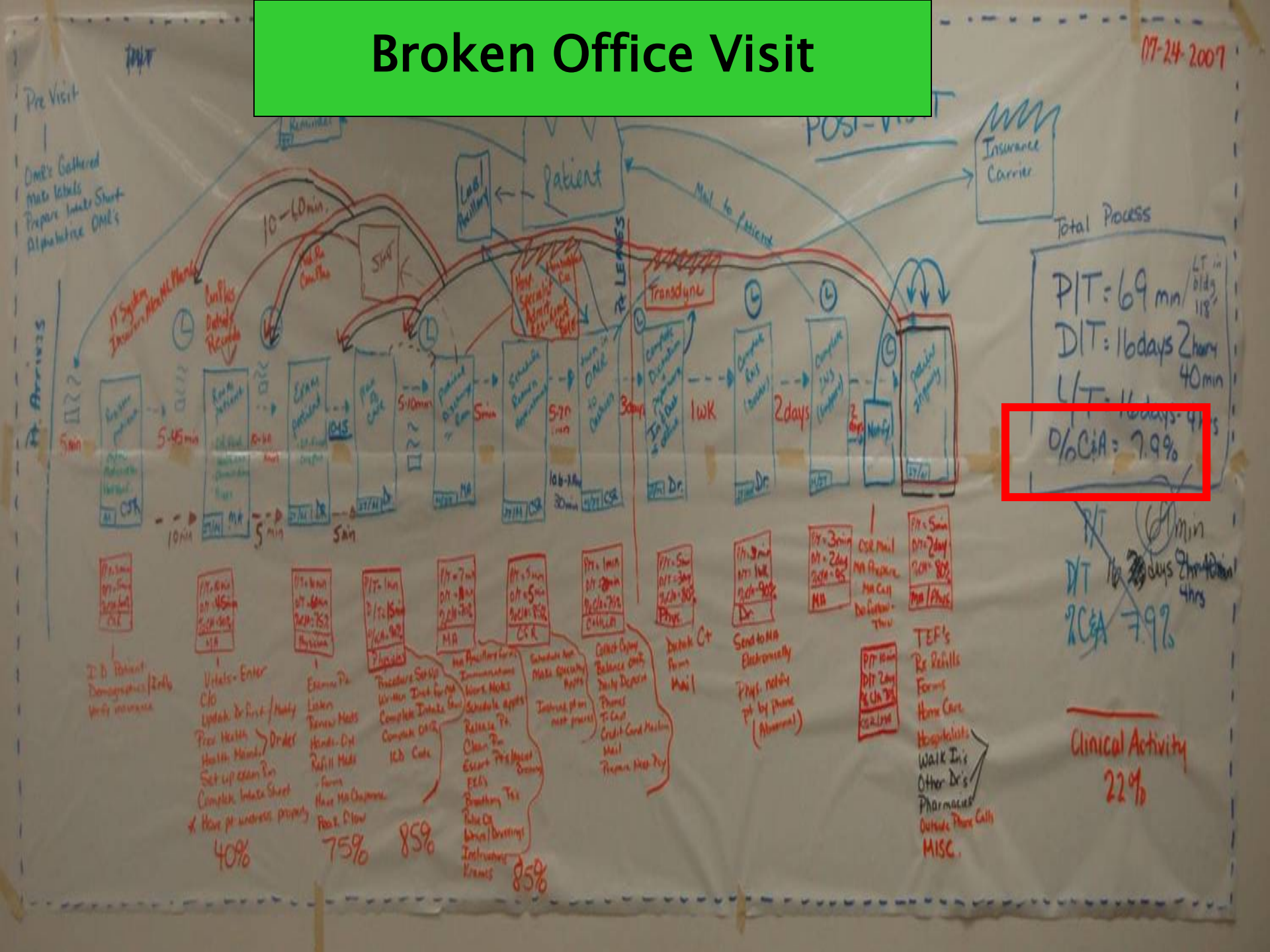






%CA .85 X %CA .70 X %CA .60 X %CA .85 = .30 or 30% !

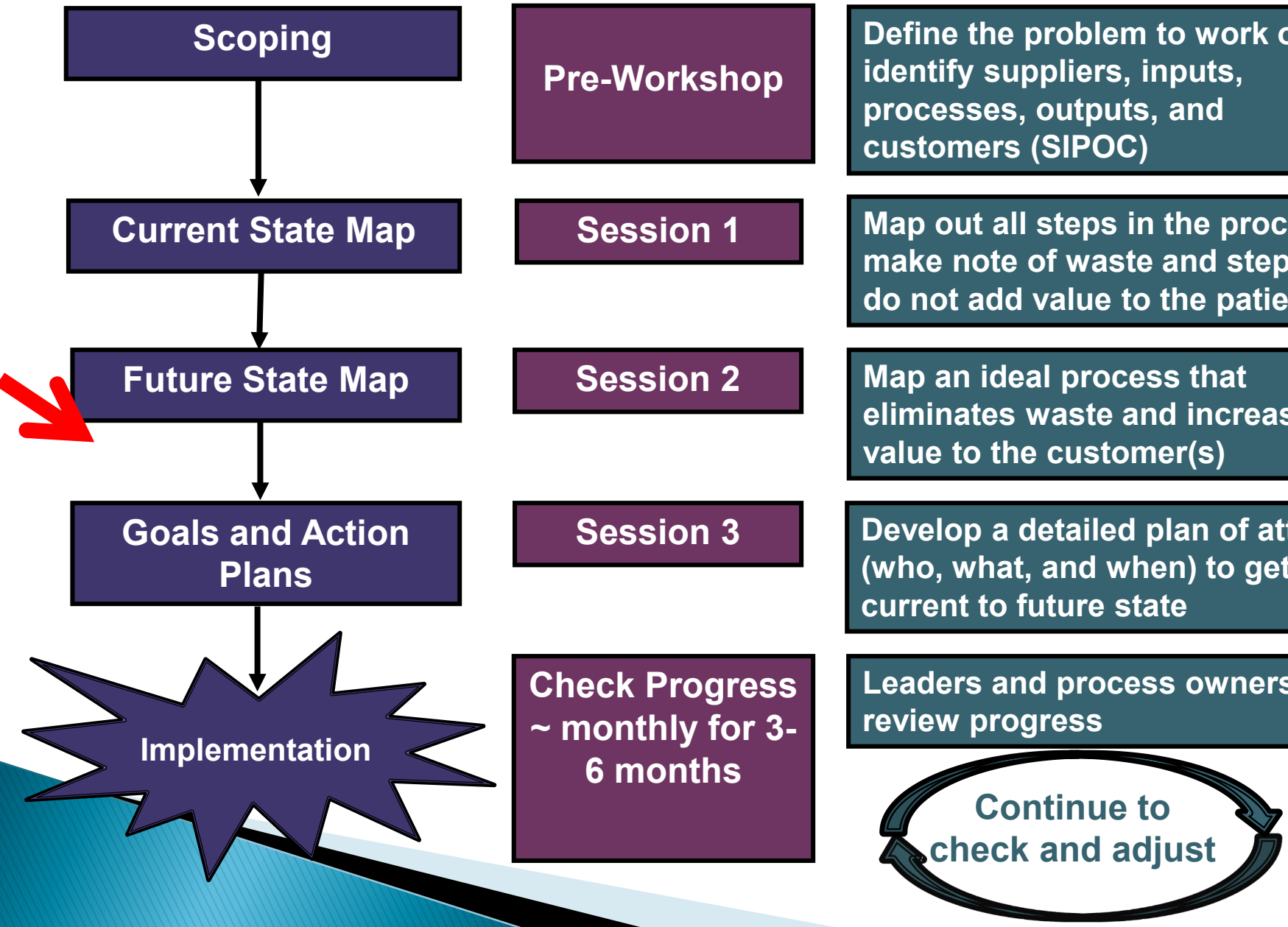
Broken Office Visit



Sometimes, this is what it feels like!

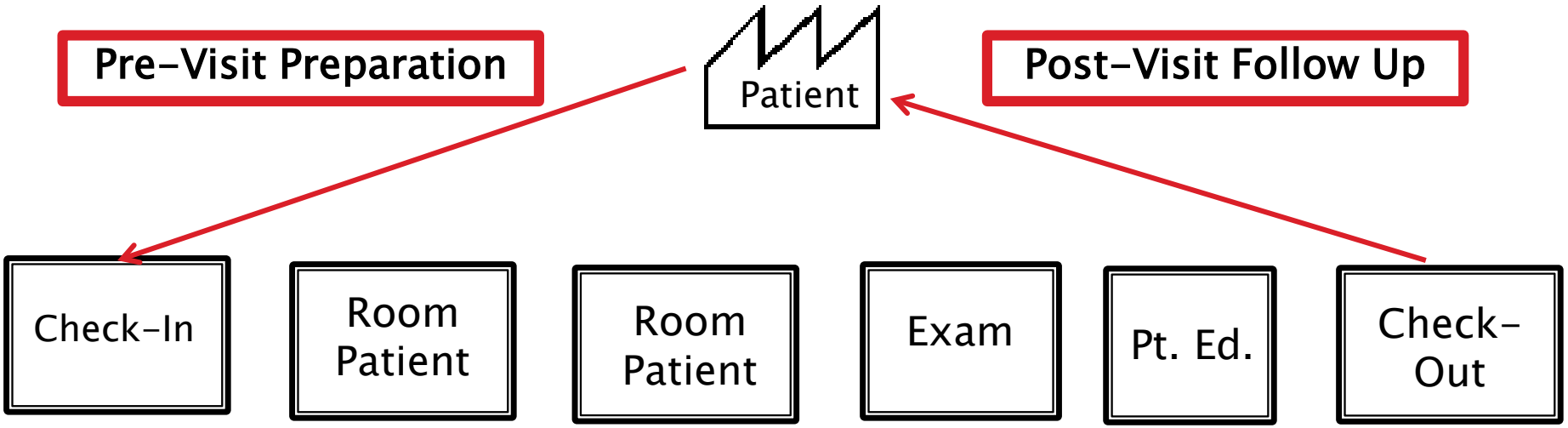
https://www.youtube.com/watch?v=HnbNcQlzV-4

Lean Cycle Overview



REDESIGN QUESTION:

What's not in your current state, that should be in your future state?



Future State: Common Expectations

- Improved patient care and satisfaction
- Standard process for information flow
- Work done now, not later
- Life Improves!!
- Consistency in way work is completed
- Treat more patients
- Mid-level providers partner with physicians in care of patient
- Improved system for process improvement
- "You can't give me enough patients!" (former 'Dr. No')

Doctor Yes!

"We just finished our 3 day (Lean) program and the excitement is palpable. Our pilot office is completely engaged – from the front desk, to the medical assistant, to the provider visit, to the phones, to the practice manager. We evaluated every part of the care from the first phone call to the follow-up visit and everything in-between."

MD & President, e-mail sent to BCBSM

State Innovation Model (SIM)

"Focuses on development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders."
(https://www.michigan.gov/mdhhs/0,5885,7-339-71551_64491-298450--,00.html)

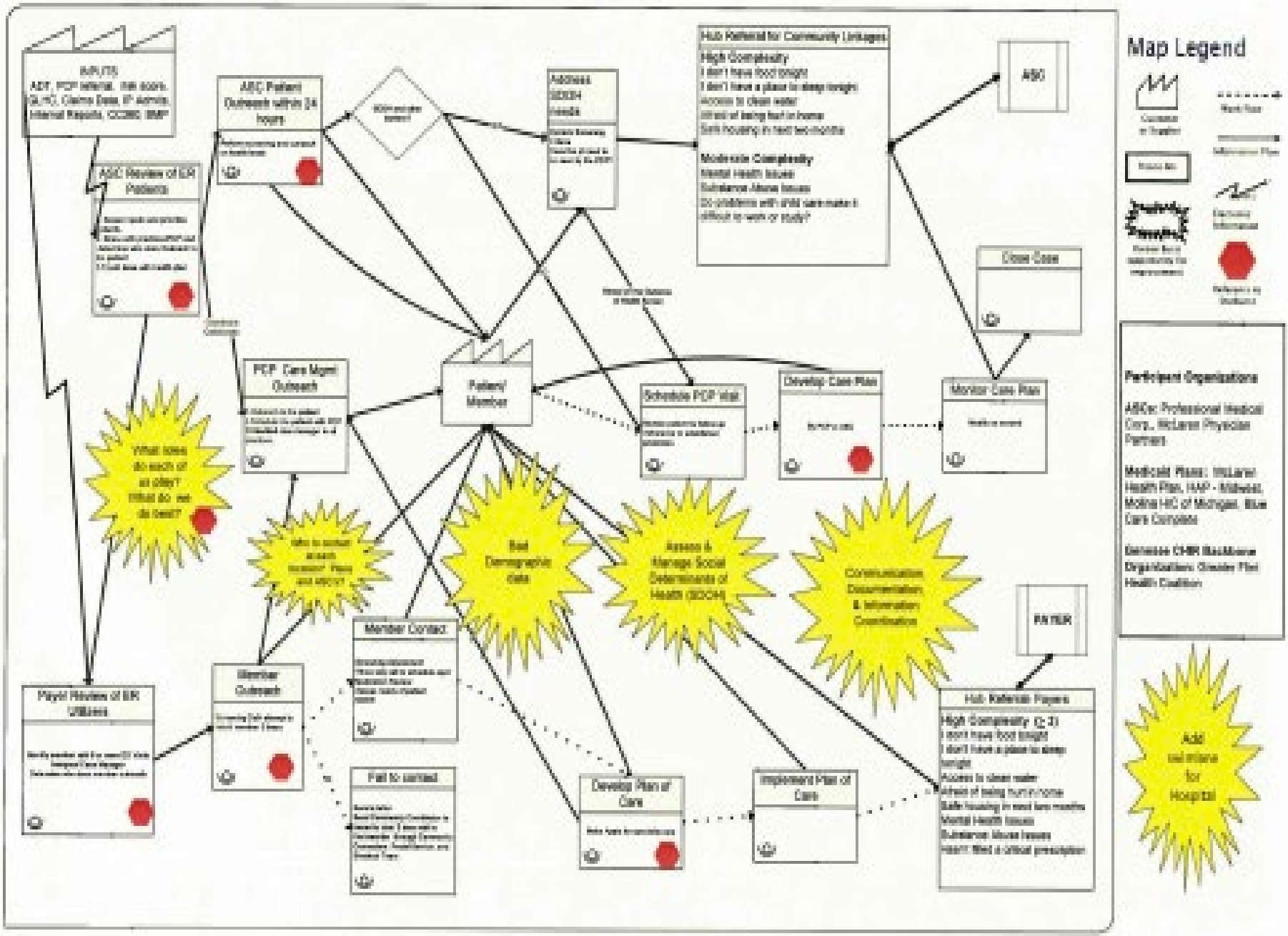
Two Priorities:

1) ED Utilization
2) Assess Medicaid patients' Social Determinants of Health (SDOH)
   - Build process to address SDOHs

Genesee SIM Region:

1) Six Medicaid health plans
2) Three ACOs (Genesys, Hurley, McLaren)
3) Greater Flint Health Coalition (The "neutral backbone")

Process Map of Management for Genesee County patients with High ER Utilization and Referrals to Hub for Community Linkages



ICC Workgroup Future State

Coordinate What We Are Doing

Patient

Patient informed of who will contact them for which purposes

Patient responsibility for managing care plan

We need to build stronger communication & documentation across our medical neighborhood

Other Care Management Plans

Challenge of how Sub Hub can inform embedded care management and coordinate

SDOH

Improved access & willingness of Hospitals to provide this info

ASC assumes lead role of managing patient

Plans know if patient is being managed from billing codes (12 of them) Is there a better way?

Is patient actively engaged with other care management plan? Health Plans, PHP, BMP, Other?

Patient Requirements
- Who is already being managed ASC vs Payer?
- Reasons for utilization
- Barriers/SDOH
- SDOH
- Positive approach/nonjudgmental
- Non-duplicative explanation
- ID of who is doing outreach
- Coordinated communication
- Standardized Stratification
- Proactive Identification

Outreach Building/ Patient Accountability
- Overutilization of phone minutes
  - Texts vs voice calls
  - Preferred method of contact
- Single point of contact
- Everyone on our team knows my health history; common care plan
- Why do I have to repeatedly tell my story
- Consent for confidential diagnosis release (for all relevant partners)
  - Standardized consent process
- We need to define who the team is
- Understand next steps
  - Understand my obligations (rules of engagement)
- Continuous shared communication of outcomes

Care Plan Development
- Interactive/Shared Common Care Plan
- Define team, responsibility and time frames
- Patient centered obtainable goals
- Patient education/comprehension buy-in
- Team approach
- Team review process of goals
- Identify barriers
  - Review SDOH (& address)
- Refer to Hub
- Standardized/common care plan
- Role based
- Minimum standards of care plan accessible to the team for sharing and collaboration
- Patient perspective
- Identify what patients does not want to do
  - Aversion/choice/preference
- Effective/Efficient engagement of team
- Available resources
- Understanding team hand-offs (who/when/what)
- Outbound referrals
  - Tracking

Implementing Care Plan
- Identify priority interventions
- Progress on goals
- Motivational interviewing
- Plans of options
- Evaluate progress
- Set value
- Documentation of action plans, resources, tools
- Who will do what, when (patient knows point of contact)
- Follow up on next steps (referrals, calls, provider comm.)
- Establish points of communication across team members
- Provider knows what insurance plans can provide and vice versa
- Reduced lost contact

In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

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ABSTRACT

We highlight primary care innovations gathered from high-functioning primary care practices, innovations we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

Ann Fam Med 2013;11:272-278. doi:10.1370/afm.1531.

Working at Starbucks would be better.
Benjamin Crocker, MD, October 3, 2007

I look forward to going to work each day. I'm loving it!
Benjamin Crocker, MD, July 13, 2011

Recommendations

1. Define the scope of work you wish to redesign
   - Where is 'start' and 'stop'
   - Clarify what is out of scope (see SIPOC, a scoping tool)
2. Involve members of your team representing every step in that scope – they are the experts!
3. Remove things in your current state that do not add value to you or your patients, so that…(see #4)
   - What % of the time does the prior step allow the next step to be completed correctly the first time through (%C/A)?
4. You can redesign your future state to include new, innovative processes that will improve outcomes

BUILDING A CULTURE FOR CHANGE

Lean for PMH Learning Collaborative

- 19 primary care clinic teams from 3 competing physician organizations
- Meet together 7 times over 13 months
- Lean + Collaborative Learning (IHI model)
- Scope:
  - Preventive care
  - Chronic care mgt
  - Care coordination
- 19 value stream maps!
- Cross-team sharing

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Lessons from First Demonstration Project on Practice Transformation to a Patient–Centered Medical Home

"…*concerns that current demonstration designs seriously underestimate the magnitude and time frame for the required changes, overestimate the readiness and expectations of information technology, and are seriously undercapitalized*. We fear that with current assumptions, many demonstrations place participating practices at substantial risk and may jeopardize the evolution of the PCMH."

Nutting PA et al., *Ann Fam Med* 2009; 7:254-260

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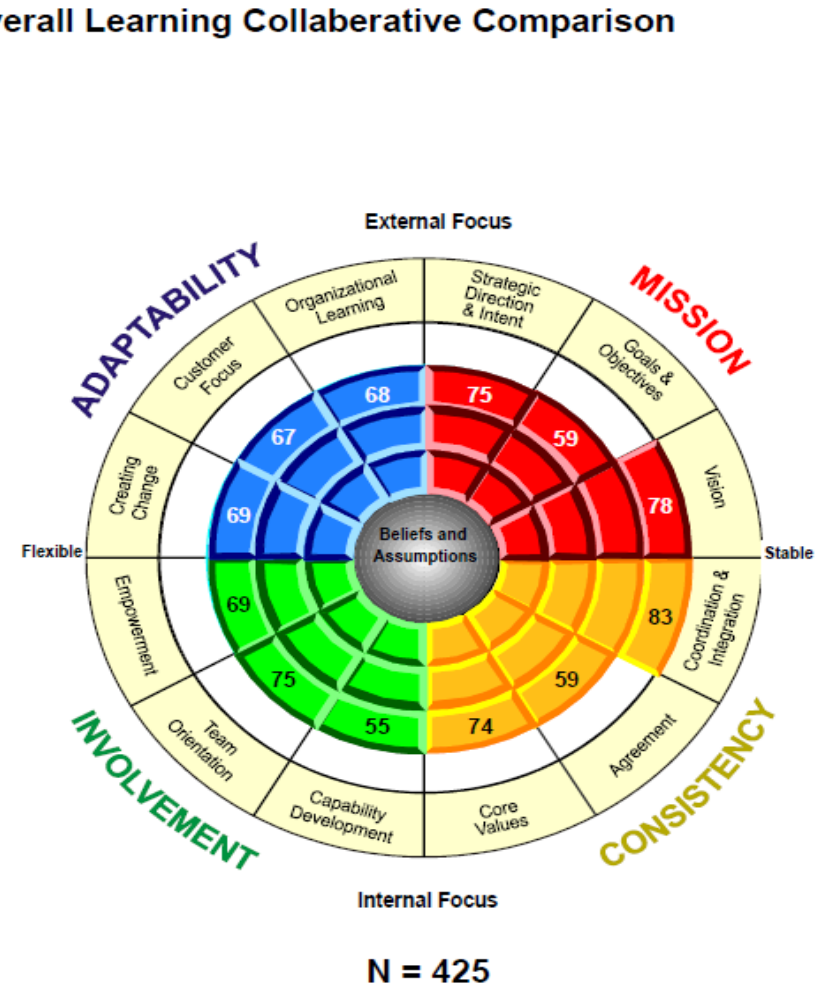
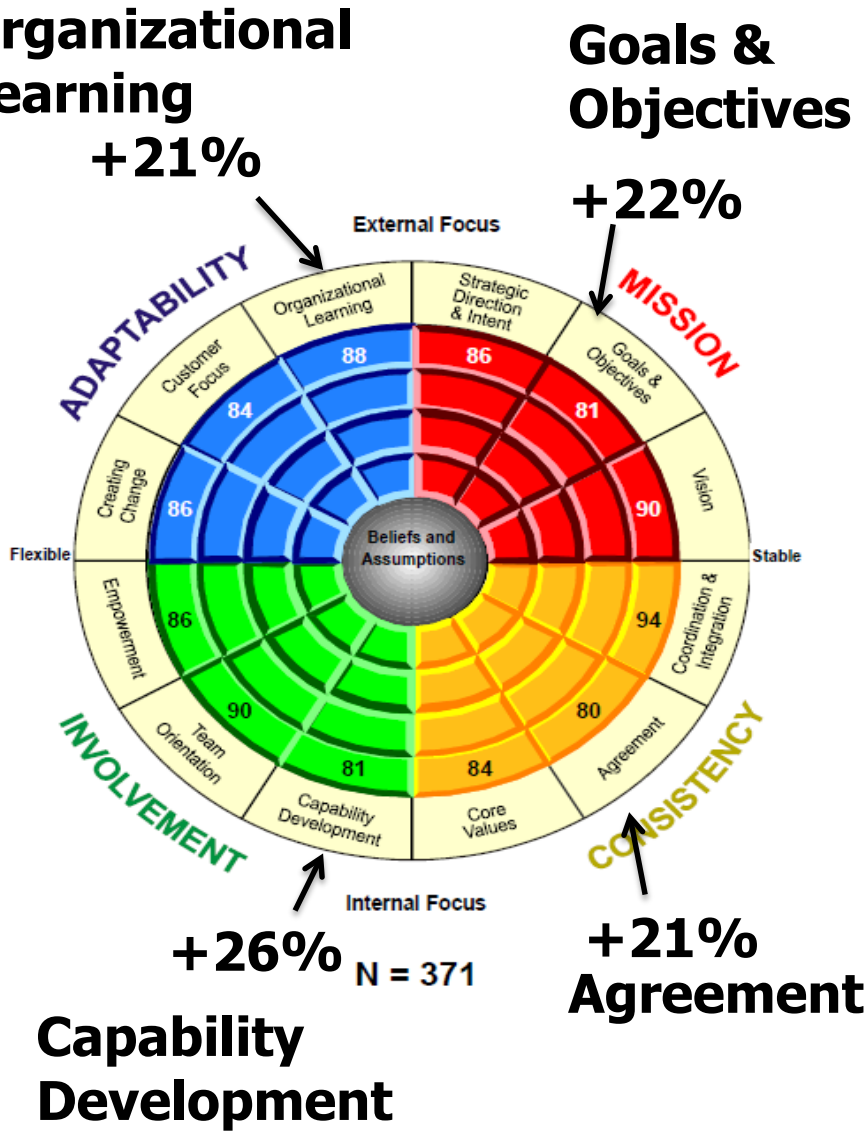
Building Adaptive Reserve

(Developing the 'Internal Muscle' for change)

- How do we build a culture that supports continuous improvement?
- How do we engage and support the people who do the work in feeling empowered to take on change?

Adaptive Reserve: Before & After





Adaptive Reserve

	PRE	POST	Change*
INVOLVEMENT			
Empowerment			
• Employees are highly involved in their work	34%	51%	+17%
• Decisions are usually made at the level where the best information is	68%	86%	+18%
Team Orientation			
• People work like they are part of a team	52%	76%	+24%
• Teams are our primary building blocks	64%	81%	+17%
Capability Development			
• The "bench strength" (capability of people) is constantly improving	47%	79%	+32%
• There is continuous investment in the skills of employees	53%	82%	+29%

*All change scores are statistically significant ($p < .05$)

Adaptive Reserve

CONSISTENCY			
Core Values			
• The leaders and managers "practice what they preach"	70%	85%	+15%
• There is a characteristic management style and a distinct set of management practices	66%	85%	+19%
Agreement			
• When disagreements occur, we work hard to achieve "win-win" solutions	37%	77%	+40%
• It is easy to reach consensus, even on difficult issues	57%	75%	+18%
Coordination & Integration			
• Our approach to doing business is very consistent and predictable	68%	88%	+20%
• It is easy to coordinate projects across different parts of the clinic	76%	89%	+13%

*All change scores are statistically significant ($p < .05$)

Adaptive Reserve

	PRE	POST	Change*
ADAPTABILITY			
Creating Change			
• The way things are done is very flexible and easy to change	45%	71%	+26%
• Attempts to create change usually supported	54%	76%	+22%
Customer Focus			
• Patient comments and recommendations often lead to changes	39%	59%	+20%
• Practice team has a deep understanding of patient wants and needs	78%	94%	+16%
Organizational Learning			
• Innovation and risk taking are encouraged and rewarded	44%	65%	+21%
• Learning is an important objective in our day-to-day work	58%	78%	+20%

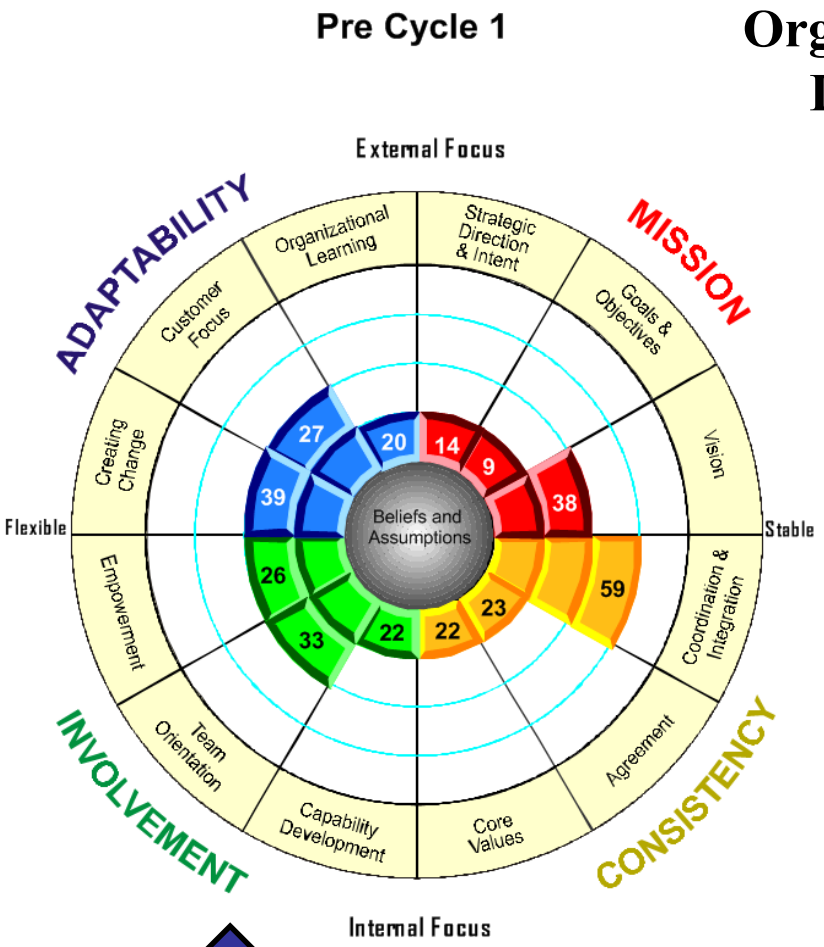
*All change scores are statistically significant ($p < .05$)

Adaptive Reserve

MISSION			
Strategic Direction & Intent			
• There is a clear strategy for the future	68%	85%	+17%
• Our strategic direction is clear to me	74%	86%	+12%
Goals & Objectives			
• There is widespread agreement about goals	63%	83%	+20%
• We continuously track our progress against our stated goals	51%	72%	+21%
Vision			
• Our vision creates excitement and motivation for our employees	60%	78%	+18%
• We can to meet short-term demands without compromising long-term vision	75%	87%	+12%

*All change scores are statistically significant ($p < .05$)

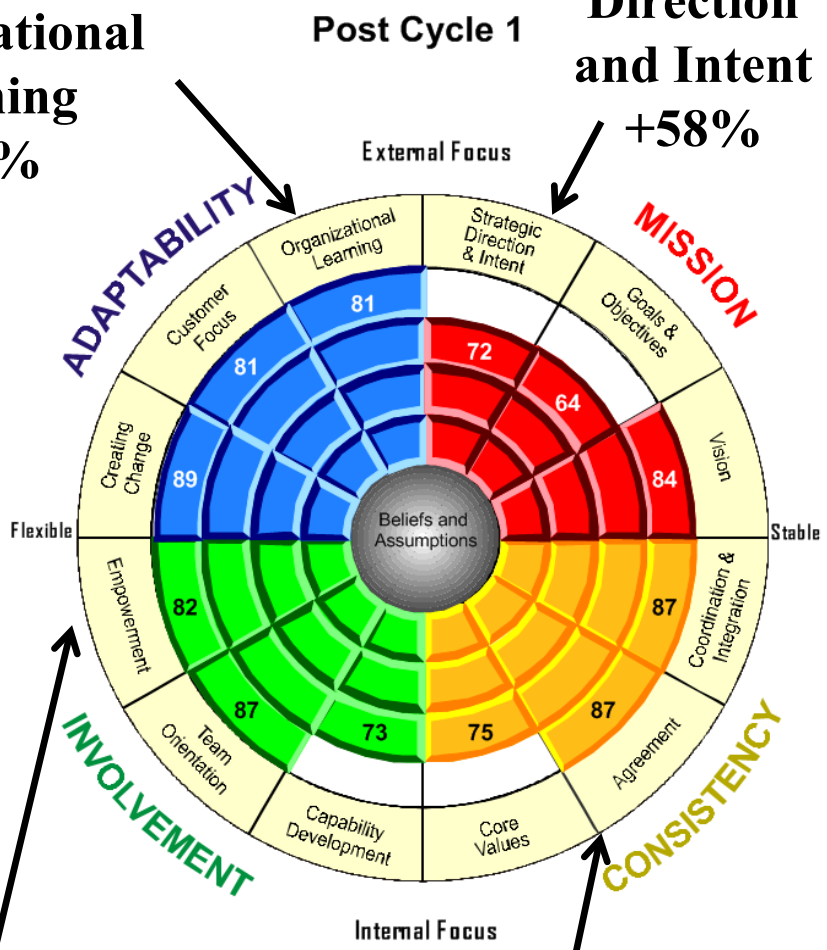
Figure 3: Denison scores for Eight Most Improved MAG clinics



N = 82

'Doughnut of Doom'

Organizational Learning +61%



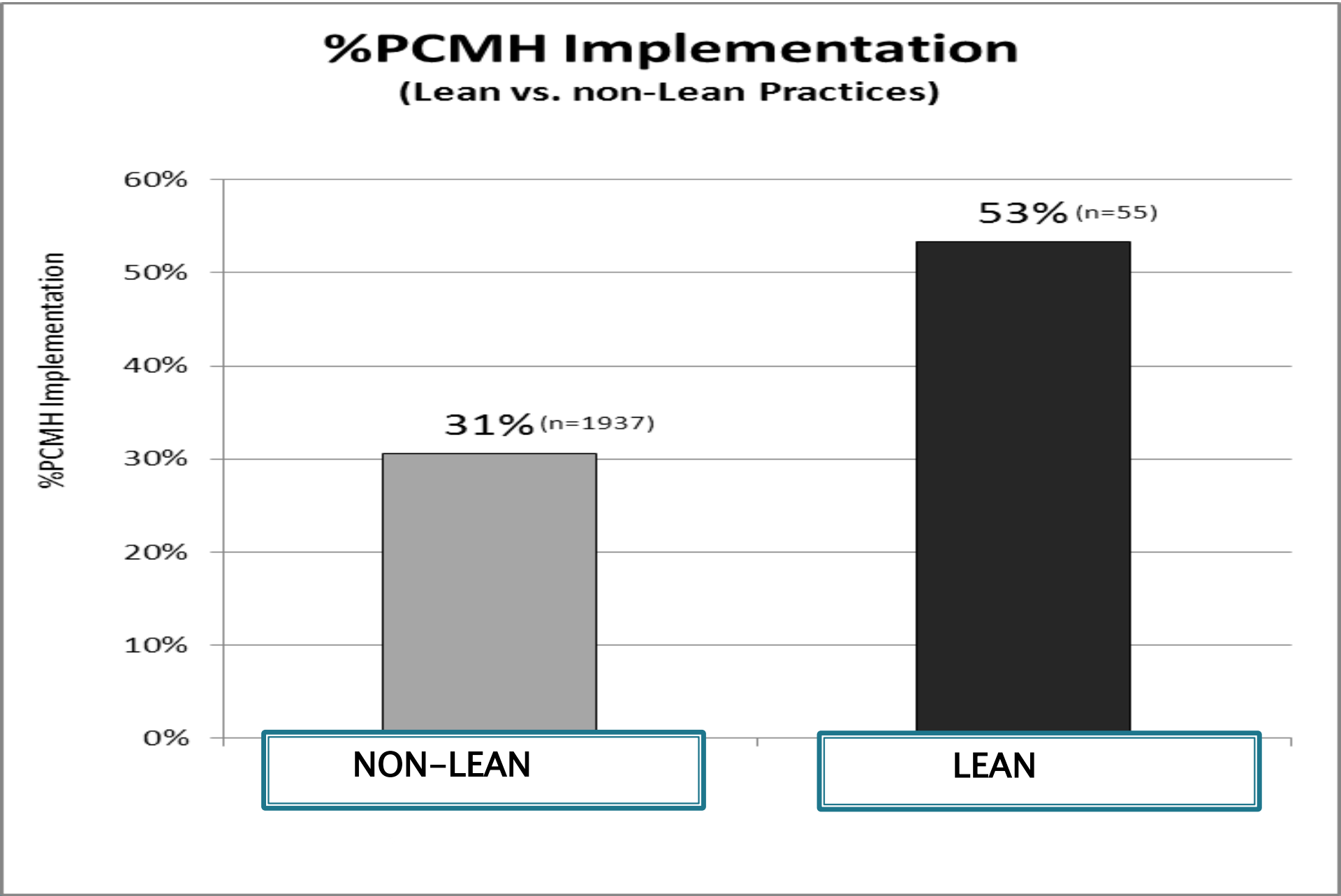
N = 65

Empowerment +56%

Strategic Direction and Intent +58%

Agreement +64%

Adaptive Reserve & PMH Implementation

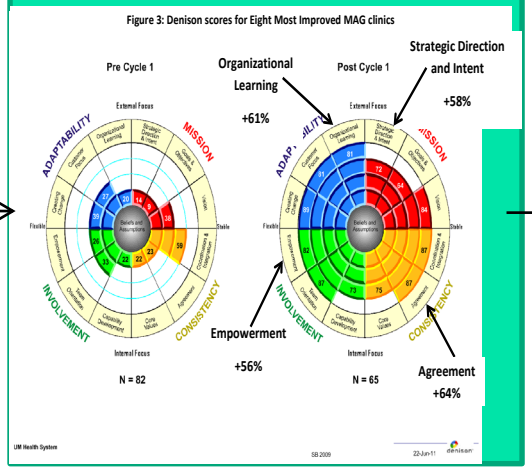


Analysis

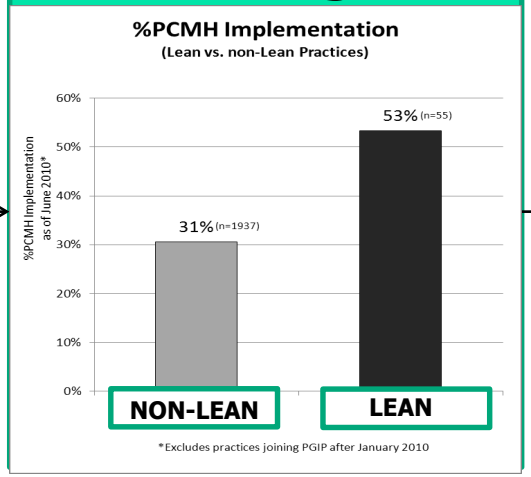
Lean Cycle

- Empower people to change
- Build Adaptive Reserve

Increase Culture for Change



Support PMH Redesign



Reduce Healthcare Costs & Improve Quality

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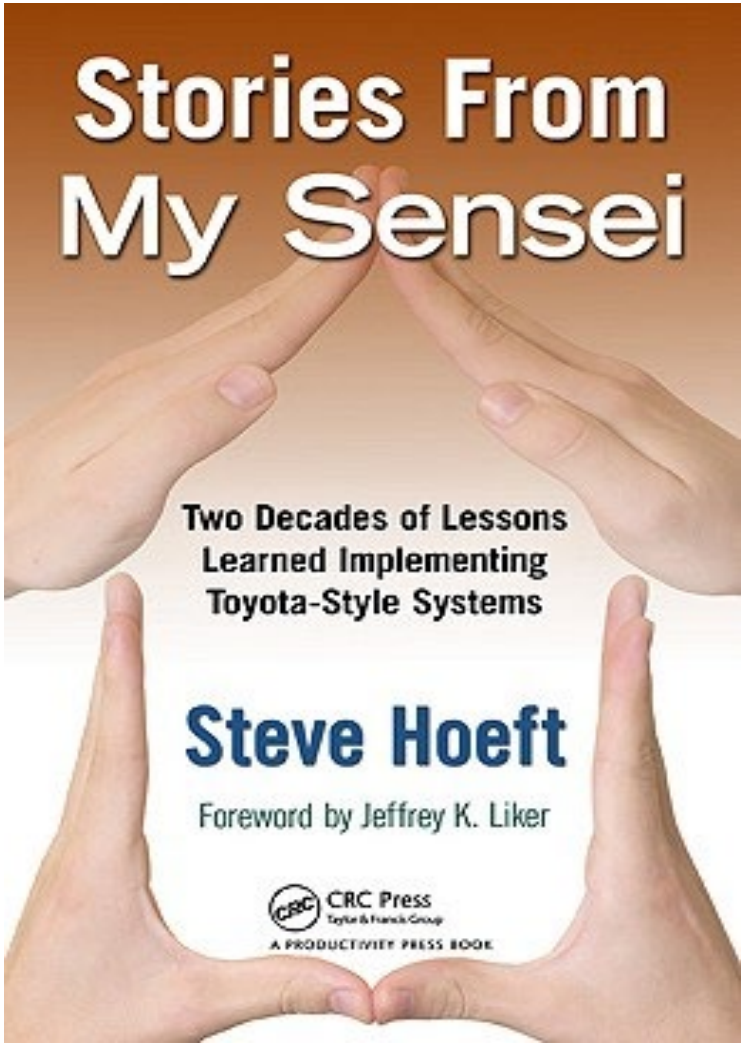
Embrace The Rock!

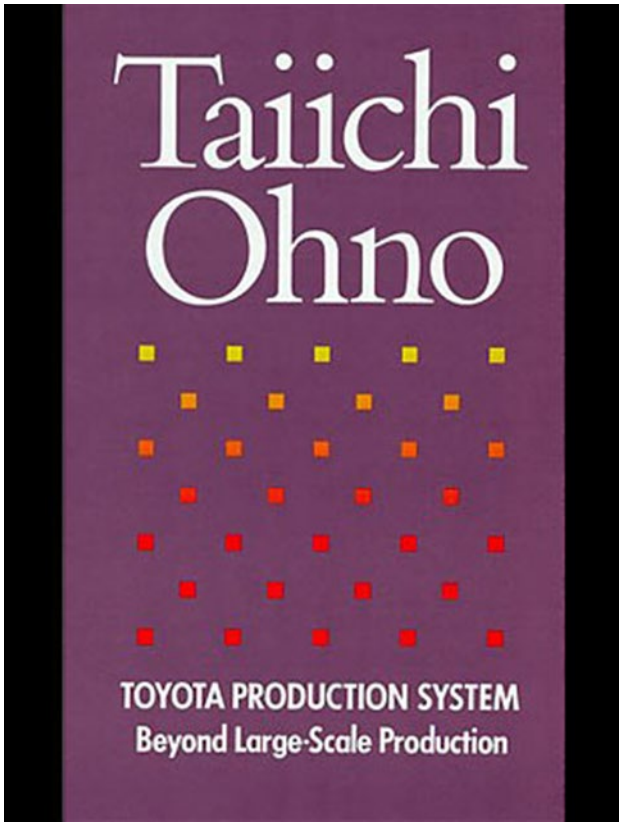


QUESTIONS?

Fun #2: Go See (Go to the Gemba)

- *"Your ears will lie to you, but your eyes never will."*
- *"Data is of course important…, but I place the greatest emphasis on facts."*

– Taiichi Ohno



Fun #2: Go See (Go to the Gemba)

The Exercise

- Plan to spend 30-60 minutes in your clinic for this Go See.
- Choose a spot in the clinic where you can observe without disrupting. The waiting area is a good place for your initial Go See.
- Notice the flow of activity and the details *for the customers.* What happens? In what order? Where is there clarity? Where is there confusion?
- What adds value, what does not add value?
- Pay attention to interactions, both non-verbal and verbal.

Your Objectives

- See value from the customer's perspective.
- Part 1 – Record process times.
- Part 2 – Record what you see and hear, and note opportunities for improvement.
- Part 3 – (optional) Draw the movement – the flow – of the customers' experience in the clinic.

Go See Guidelines*

- Try to focus on what actually occurs – or doesn't
- Remember to be an unbiased learner
- If asking questions of employees or patients, let them know that you are just trying to learn more, and appreciate their candor
- Don't jump to solutions
- Focus on the "Why" not the "Who"

* For more information see: http://www.slideshare.net/cmarchwi/taking-a-gemba-walk-8567946

Study of Primary Care Redesign in Michigan

- Study of 2,432 primary care practices attempting PCMH
- Multiple control variables (patient, practice, physician org., socio-demographic)

PCMH significantly associated with:

- 3.5% higher composite quality score (adults)
- 5.1% higher preventive composite score (adults)
- 12.2% higher composite quality score (pediatrics)
- $26.37 lower per-member-per-month costs (adults)

$26.37 * 12 mos. * 1.8M members =$569,592,000 cost savings / year

HSR Health Services Research

DOI: 10.1111/1475-6773.12085
RESEARCH ARTICLE

Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs

Michael L. Paustian, Jeffrey A. Alexander, Darline K. El Reda, Chris G. Wise, Lee A. Green, and Michael D. Fetters

Objective. To examine the associations between partial and incremental implementation of the Patient Centered Medical Home (PCMH) model and measures of cost and quality of care.

Data Source. We combined validated, self-reported PCMH capabilities data with administrative claims data for a diverse statewide population of 2,432 primary care practices in Michigan. These data were supplemented with contextual data from the Area Resource File.

Study Design. We measured medical home capabilities in place as of June 2009 and change in medical home capabilities implemented between July 2009 and June 2010. Generalized estimating equations were used to estimate the mean effect of these PCMH measures on total medical costs and quality of care delivered in physician practices between July 2009 and June 2010, while controlling for potential practice, patient cohort, physician organization, and practice environment confounders.

Principal Findings. Based on the observed relationships for partial implementation, full implementation of the PCMH model is associated with a 3.5 percent higher quality composite score, a 5.1 percent higher preventive composite score, and $26.37 lower per member per month medical costs for adults. Full PCMH implementation is also associated with a 12.2 percent higher preventive composite score, but no reductions in costs for pediatric populations. Incremental improvements in PCMH model implementation yielded similar positive effects on quality of care for both adult and pediatric populations but were not associated with cost savings for either population.

Conclusions. Estimated effects of the PCMH model on quality and cost of care appear to improve with the degree of PCMH implementation achieved and with incremental improvements in implementation.

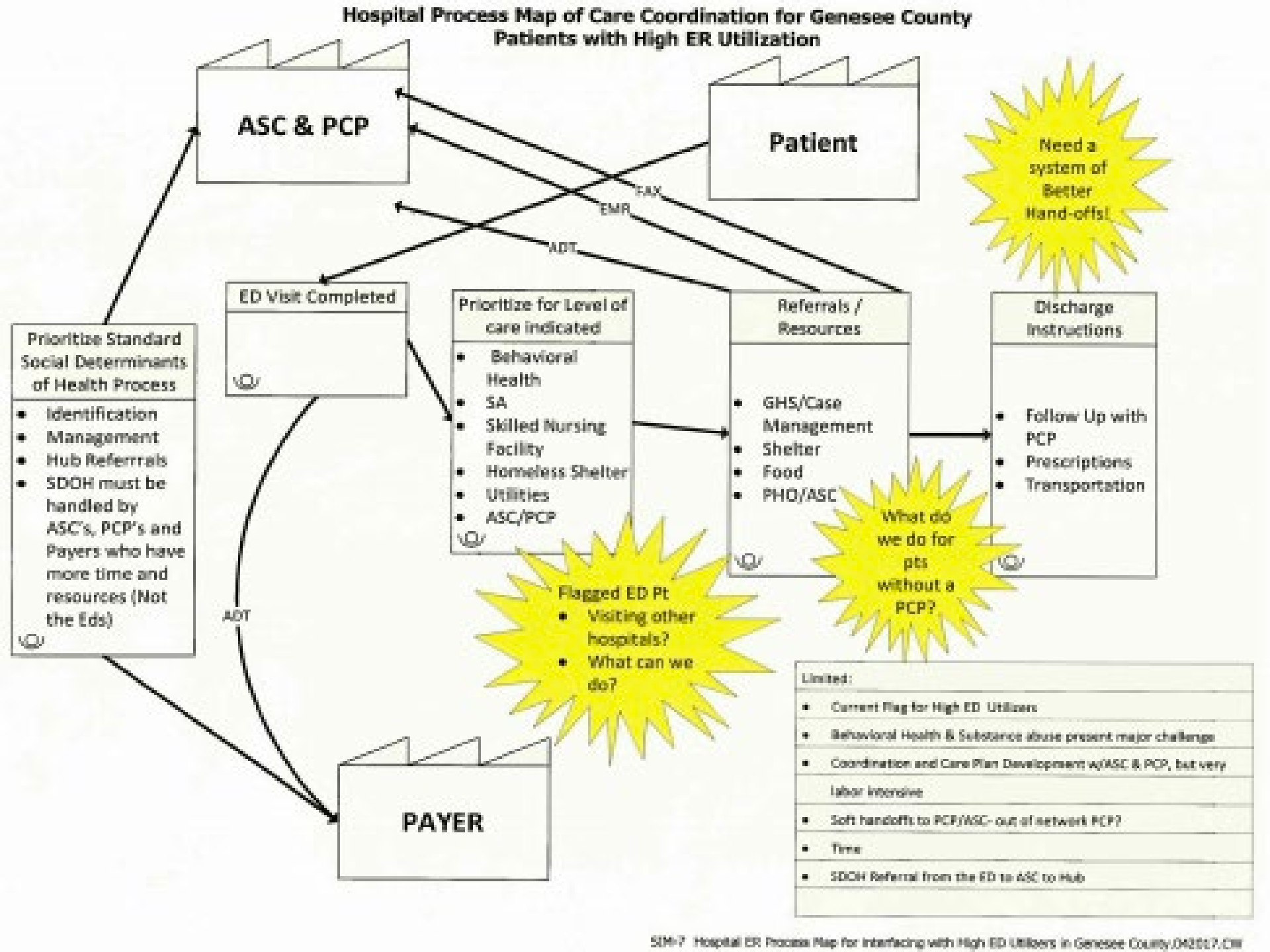
Key Words. PCMH, medical home, cost, quality

Fun #4: Just Do It!

"The Nike's":

- Are there any 'Just Do Its' – process changes that can be made easily / quickly?
  - Pick 1 and try it
- Avoid major redesign work; we will address those next session
- PDCA: Plan, Do, Check & Adjust

Hospital Process Map of Care Coordination for Genesee County Patients with High ER Utilization



Detroit Free Press

Blue Cross study: 1 doctor overseeing care better for health, cuts costs

July 8, By Robin Erb
Free Press Medical Writer

A single doctor overseeing your care not only improves your health, it shrinks the cost of maintaining it, according to a new study based on the actual cases by Blue Cross Blue Shield of Michigan doctors.

The study found adult patients who belong to a Patient Centered Medical Home (PCMH) saved an average of $26.37 a month per person, or an estimated $155 million collectively over the first three years, according to the study published this month in the journal, Health Services Research.

The results are especially relevant as the most sweeping provisions of the Affordable Care Act of 2010 take effect in the coming months.