Idaho Patient Centered Medical Home (PCMH) Integrated Behavioral Health Webinar – (April 19, 2017) Transcription

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Speaker/Moderator: Jeanene Smith

Notes

Leading the PCMH Journey of Change

Jeanene Smith:

I am a family physician and part of the PCMH transformation team. Our learning objective is to understand how ready your organization might be for change, tools and approaches to help do it effectively, some steps to guide you through a roadmap, and the importance of change management and how it will be an ongoing and part of the sustainability of the model of PCMH.

Speaking of change the whole concept of PCMH continues to evolve and is in constant sort of change as many of you are aware and have your clinics were recognized under the 2011 standards which then were changed to be what was in the 2014 standards. As many of you have heard about or in the process of understanding is that the National Committee for Quality Assurance (NCQA) is now moving onto a 2017 structure to its program with the intent of course that continuous quality improvement through these changes, but realizing that some of the change is similar. Patient access is certainly a key component but what they are exactly asking about with these staidly changes overtime. Change I really part of the model.

There are all sorts of buzz words for this; the integration of care, making sure that it is person centered, being accountable, being a health home versus a medical home, thinking about population health, and risk stratification. There are a lot of buzz words that really are describing some of these changes that you and the clinics really have to face in order to achieve the new model of care.

The essences behind why change, is that there really is this new energy on focusing less on volume or counting widgets as some call it to moving on more to the value of care. This evolved over that last many years and really moving towards the triple aim of improving population health outcomes. At the same time improving the individual experience of the patient and their families and being efficient and effective and lowering the overall cost of care so that it can be provided more broadly and effectively. While Idaho is predominantly fee for service, what we are seeing elsewhere in the nation is manage care plans are also moving towards this value base payment. As are more and more of the commercial payers as well moving away from that volume or widget means of reimbursement.

This is a quote that one of my fellow coaches explains:, to improve is to change, but to be perfect is to keep and continually change Basically many of us do not feel that comfortable with change over time it is a constant continuous process in order to achieve perfection.

There is a lot of need for support for this change and a lot of you that are on this call today are a part of that support to your clinics and to your organization on how to support the change. You really have to be preparing, planning, implementing, and thinking about how to sustain any changes you are making in this process. It includes not just a couple of people inside a clinic or organization but it has to be an overall culture shift of the organization with a focus on the people because a change it is not usually that effective if we just do it to people but it is certainly much more effective if we do it with everyone.

Poll Questions

When you think about your organization is there one major change going on or are getting ready for a major change?

Yes	91%
No	9%

Is your organization ready for this major change and well-equipped to manage both the technical and people side of change?

Not ready at all	0%
Somewhat ready	32%
Ready if need to but could be better prepared	43%
Quite ready	18%
Have everything in place to fully take on these changes	7%

For those who might be more mathematically inclined there is sort of an approach to this that has been developed to think about change. With change really being dependent on multiple factors in terms of whether you are going to be able to do it or not. You need to understand if there is dissatisfaction, is there some motivation to change a way from the status quo. In addition to that multiplied by is there a clear and good understanding of the desired future state that you want to get to with your change. Then real practical steps on how to get there, that you can really guide folks to. You can really get stuck if no one is really too dissatisfied, they are not going to want to change or they really do not get a good feel for the vision or the goal, there might be some that do but not enough to make that change. Or there are not clear steps that they are unhappy with the way it is now, they really like to change and see that new world, but how do they get there. Those are three major factors, because otherwise you have to overcome that cost of change that it is just too much to make those changes if one of those three factors is not there to help you along.

Another way for the less mathematically inclined, is the change worth making what is that return on investment here and why should we do this, is your leadership inside your clinic and or inside your organization committed to that change. Do you have enough resources and technical assistance to help you make those changes and have resources that help explain it and you have a clear plan? There are some skill sets of people understanding quality improvement, how to do rapid cycle change and assessments to help you carry out a plan. Part of that rapid cycle change helps you learn on how it is going and then continuing for that broad patient engagement in a full change process.

Which one(s) of these ingredients for change do you believe you have in place for the next change project you are taking on?

All stakeholders feel it is a change worth making	38%
Leadership is committed to the change	77%
There are resources sufficient to make the change	35%
There is a plan for work and resources to be used to make the change	58%
The organization reflects on past changes to learn/improve	48%

It looks like good leadership going on, there seems to be a third of you stakeholders feel like it is a change worth making and there are resources. About half of you really have a plan and almost that many also know what you can learn from your previous experiences. Possibly you have had clinics at cohort one and have gone through this already. Now with these new sets of clinics you can apply that. Again these are key ingredients to really be successful with change.

One of the key ingredients are the people that you are working with via front office, back office, the providers, the administration of your clinic or your organization, and how people respond and react to change is really important to monitor and appreciate. The providers for instance might resist one change just because it is too much work for them, but they might embrace one that does not really involve them but gets the visits with the patients to be more effective and really works out. Different changes may mean different approaches, different personalities, and reactions to the change need to be thought through. Still thinking overall systematically, how to address that you are dealing with people that have to deal with change.

Many of you have seen this before but there is always a sort of bell curve people handling things, via it be change, trying to adopt a new evidence based approach in clinical medicine, and change in how you do administrative function. There are always those that are the big visionaries that want to innovate and make a change. There is a champion that many of you have probably identified them as your provider champion. Then there are early doctors that say this is a great idea, let us go with this. Both of those are really important to bring in that next majority of your staff. Then if you have them you almost achieve over the 50% of the participation which will bring along the late majority. Then there are always those that are the lagers, those that will never do this. I used to hear this when I worked at the state of Oregon from providers out in various parts of the state who said they would retire before they deal with an Electronic Health Record (EHR) or I was ruining their world by creating a patient centered primary care home standards. Many of them did retire but the new residence coming out of training or have been around these new changes are looking for practices that can really be innovative and adopt the new model of care. You probably want to spend your time engaging the earlier doctors, and have the early adopters engage that early majority and then as you get more critical mass you can pull in those late majorities. Eventually the lagers will come along or they might just find a different situation that they might be better fit for what they want to do.

This slide is here to try and think about the fact that many of us when we start to make change get very focused on the technical part of it. I do think that NCQA certification does this more, maybe not as much in the patient centered home standards of Oregon, but it is like have you got the policy written and have you checked the boxes. Very focused and sucked in so to speak with the technical changes it is really important but sometimes you forget about the adaptive change and you cannot do that. We will fix everything last, have everything on paper, and then maybe we should have that conversation with the providers about what we are doing. You really need to engage along the way to help change the mindset. Otherwise you will meet resistance with the change and it will feel like a top down sort of

event. Engaging along the way to help with that adaptive change is really important. Sometimes those that are resistant might actually have some good ideas that help to shape the technical changes, so it is more easily and they feel like part of it and wanting to participate.

What I am going to go through next are five key questions that you want to think about as you are thinking about your journey through change. They really are to try and help blend that sort of technical aspect to the adaptive change that you need to do. These are the five questions and we will go over these one at a time. What is the change? There are some clinics that are ready to go on, they have done some change in care coordination and now they really want to do some behavioral health integration and are really out there moving towards that new higher level. Other clinics have never done anything and have not even thought about identifying their first high risk frequent flyer in and out of the clinics, in and out of the hospital patients. You need to think about where the stage is your clinic at and what is the strategy going to be exactly? What are you trying to change? Can you describe where you want that change to be? What is your aim? What is the goal? Is it being clearly articulated? You want all of those depression surveys done regularly every time the patient comes in and you have a goal of x so that you are really defining the change. How do you know if you get there, you say well we have adopted this policy and we think that we are doing it, and I think that in the new 2017 NCQA standards you are actually going to have to show that you implemented it, knowing that you met this mark or you are half way to the mark, all that helps you gauge how that is going and are you there yet.

Making sure that the strategy around that question is understand what satisfaction is going on like we talked about before, you have talked about the return on investment, the benefits are greater than the cost. You have enough resources, you never fully have enough but at least sufficient resources to be able to pull this off or you have thought differently about what resources you have to pull it off. You have some early adopters and innovators there to help you push this along and engage the rest and it is not too big because you do not want a sweeping change, it also is not so small that it is not making a difference. It is really necessary and required but not necessarily an option so that you do not get as broad of participation as possible.

The second question as you start to think about rolling out your changes is how do we organize for that. As I was talking about a minute ago you might not have all of the resources but can you establish some key roles and change management infrastructure and many of you have that, some of you set that up prior to coming into State Health Insurance Assistance Program (SHIP). Certainly across cohort one and across the group practices have developed these, and also think who are your leaders onsite at each clinic that help. Even though you have a larger team on an executive level you have well placed early adopters and or innovators on the site regularly to be able to really root the clinic on. Assessing how well and ready you may have five clinics you want to oversee to make this change and you need to assess, well three of them are really great and can do this but these two are going to have to do a slightly different approach. Looking across your clinic if you really are a small clinic and all by yourself out in very remote area, then who are your partners that could help support that change. That might even be outside the clinic walls.

You need a sponsor, someone that can guide you, especially in the larger organizations, you want someone up in the higher levels that are a really proponent for this that you can take issues to who may need a higher level of change happening somewhere else to effect the change you need in your clinics. The team lead, the change agent, is it the population health nurse specialist, is it the care coordination leads, who is going to keep everyone moving, and then who are you key participants at least initially. Maybe you are going to roll it out, I know in my clinic we rolled it out in one model we started out in one and we started folks from that pod to help inspire the other pod to finally adopt that model overtime.

Readiness for change is basically like putting in your tomatoes and making sure that you have got the right amount of ingredients in the soil and watering it and hoping that it will grow. Understanding how your organization or clinic and knowing it, you know your area much better than any of us do on

whether you can make the change and the change exactly to make. How do you align what is normally happening with the new norms and how do you intertwine those and what other adaptive work do you need to do to make it successful.

Again if you think back to the equation, you have to have a compelling mission and vision and you are clearly articulating. And not to forget that it is true both in the Oregon patient centered home and the NCQA is really changing the mindset to focusing on the costumer, or in this case the patient and the family. Oftentimes we do things in healthcare that is more focused on the providers or the health delivery system delivery. In this case it is not necessarily the third next available appointment perspective, but more like we are here for you and your family 24/7 in one way or another to help you navigate the system and stay healthy. Really being flexible and responsive to your own environment both in the clinic and around, your patients' needs and their families challenges. A positive climate is really important so being positive. Maybe your change did not work so well last time, but let's think about how we can make it better the next time and really aligning incentives and having the capacity to change.

Question three is thinking about if we are going to change something maybe something to change is just tracking referrals, and whether stuff came back from the specialist or from the hospital stay. Who is involved in that? It might not be the providers case because somebody brought the mail in or there is a required person to look into see what got emailed. The flip side is that it might have been sent to the provider, the back office staff or the front office staff do not know what happened. You have to think about each change and who would be affected by the imposing tracking system on referrals in that particular example. Then thinking about is this going to increase my workload to somebody, then if it does how do we change how we do that work? I know one of the clinics I worked with last year, they had separate nurse and provider situations up and down this hallway, but they never worked up and down the hallway and they did not cross cover each other to try to take the load off. As they thought about it, they thought maybe we could pair this up as a team and start to share the load and spread the volume of work. Not only are you seeing 20 some patients or more a day, you are also getting a ton of phone calls, a ton of prescription, etc. If you are going to be imposing change during that time how, can you make sure that the regular work is happening while you are flying or redesigning the plane? Really thinking about who is effected by the change and how.

Change is often external, certainly people they feel though it is opposed on them but it can be planned and engineered and it sort of happens. A transition, a real movement over to the change has got to be internally embraced by the people amongst the team, and you sort of have to experience that change. Many of us hated the thought of going to an electronic health record, but now most of us would never go back to the old paper charts. It was like it was absolutely painful to make that change, but we have transitioned and embraced the new change and we all react to it personally. There are stages, not necessarily stages of grief per say but there is a grieving of letting go. Again, different across your clinic and across your participants. Many times there is dissatisfaction, as you build on that dissatisfaction and make these changes people move into the neutral zone. Then as they start to notice the patient visits are going more smoothly because you have anticipated the needs of the patient that day, you are creating that new beginning. The systematic approach to my day is actually helping me get patients in and out effectively and getting the care they need. The care coordinator is helping me make the connections and I do not have to go look them up somewhere, it is going to make the providers much happier and it makes less frustration on the rest of the staff as well.

Question four is how do we get from here to there? If you remember having a clear path so you have figured out you want to make a change, you have figured out that no one is that thrilled with how the old way is, you have a vision on how to change it. You need to be really clear and think about how you are going to get there. There are levers of change, how you communicate with everyone to get them onboard, and how you educate and train. In NCQA standards there is actually an element of demonstrating you are doing some ongoing training model to your staff or as you bring new employees in are you training them from day one to the new way that you do care, which may not be

the way that the clinic they came from or school they have not worked this way. Then how do you reinforce it, how do you reward, do positive reinforcement, and then support those individually as you need to. So you can plan how you are going to go, but you really have to travel from here to there and think through the rocky road along the way.

Communication is really key, I remember having a conversation with one of the clinics last year and I was thinking back on my own clinic where not just having people talked to but having them interact and have a conversation is important. Also reflecting on if they are hearing what the leads are saying. You have intent to change, you have a message about change, you try to channel it through your medical assistants meetings, your nurses meetings, and your provider meetings then everyone hears it a little different. So trying to get some feedback to make sure that message is not being misinterpreted along the way. Certainly if you have some lagers in there and are not going to be too excited about it, so is their translation of it is not necessarily as optimal as it could be. So making sure there is a common understanding, common awareness, and there is some key actions and feedback to those conversations.

Training again is sort of that same thing, another means of communication. It is also empowering people with tools as people are being told to track something. Then as you engage them in sort of a plan, do, and act cycle do they see why what they do is a critical link in making that change. Engaging people and training them over why you are doing something, is going to get a much better response and evaluate whether the training is having an impact on the individuals. As you do your orientation with your new employees, are you training them the way you want them to do things? I know that I worked up in south central in Alaska and they actually put their employees in a six week training course, that is south central way of doing advanced medical home up there before they ever hit the floor inside the clinics. Most places cannot afford to do that, but it is really critical that you are thinking about who you are bring in to be part of your team and how do you train them to be part of that team.

Reinforcement is really important and making it easier to do things. We see that in the EHR where I cannot order a prescription unless I put a diagnosis. From a billing perspective there is the diagnosis that helps people bill. There are other triggers that you can automatically; we always have a morning huddle everyday across our clinic, we have how we are doing and we but the data up. Then think through how to make it easier to do the right thing. The code for the fit colon cancer screening, we were really pushing that one time. All the computers in all the rooms had a little sticky note that had the code so that we were doing it, were actually thinking about it, or asking it via medical assistants checking the patient in or me following up and making sure it was going to happen when I went in to see the patient.

Personal support, helping people through these transitions, helping with the communication, training, making it easy, resistance will not work because of this then you take it back and try to rework it. It is not perfect and there is a variety of responses to change and it is not always going to be the easiest part of the change process getting everyone supported. Going and having a one on one with some of the folks that are having more challenges and trying to understand why it is a challenge, what else is going on with them that make it more of a bottle neck change so that you can start to unravel that?

Resistance, I am not going to read all of this but I think it is interesting to think about. Just because someone is really upset over this new disruptive change that is going on, it does not mean it is a sign of disloyalty that they are not part of the team or the company spirit. It is that they are having issues with the change and to think about that, that resistance is manageable if you think about going through those five steps that we just went through. It is not aimed particularly at whoever the lead is or the person telling someone to do something. It is really just a natural response to change and you just have to think systematically how you are going to work through it, maybe you are never going to but you can still work with everyone else to try to figure out as a learning experience. What might be resistance on one thing and in one area of your clinic or one particular clinic might not be a problem just because of different personal reactions to the change. Common mistakes in managing resistance

is attempting to change the persons view with logical arguments about why they should change, trying to adjust everything to one person but thinking more broadly about the issue. Equally it is important not to ignore end users' emotions and behaviors concerning the change because they might have some really valuable insight. They may have been practicing for 20 years, this is what they have learned and this is what they found. Maybe there are some tweaks to the overall approach in that particular site that would be really valuable. What might be logical or make since to you might not make since to the person resisting, and not just to give up and work around that person that can be a problem as well because you really need to have a collective team and everybody cost covering. It is important not to ignore the challenges that person is having in the resistance.

You really want to build good rapport; I have heard the provider champion is out having coffee and lunch with some of the providers who are most resistant. Same would be for the care coordination nurse needs to work with another nurse to do so it would appear why a nurse would be working. Then cross peer having a team across that brings all of those issues collectively together and conversations about it. Really asking open ended questions, supportive, invite open expression not just have a report out at your clinic meetings and listening. Listening is always important, providers were taught that in our training to listen but sometimes we come in and have an idea of what some people might think they have and we miss and the patient never gets to tell their story and they often leave dissatisfied. Same with your team members, really understanding what is going on, using that person's energy to help manage the situation and actually engage them by helping you problem solve how to improve the system. Then you just have to go through and keep managing that resistance and walking through those five questions and thinking about them.

The fifth question is how do we align change strategies with behaviors? In other words after you have planned this all out, time to actually start doing it and use your process, structures, and roles in place to try and manage the change and manage that resistance. In some ways it is a quality improvement process itself. Are we on course and if not what do we need to do to get back, and what are we learning from our experiences? Can we apply that to how we are applying the model to the clinic? You just keep going through and working the plan over and over but also always continuously learning from your team members on how to improve that process to make that change into a full transition.

In summary there is not absolute magic, I know there is a lot of information that I have gone through today but these slides are available to you. All of us coaches and SHIP QI folks are ready and willing to help you manage these difficult and challenging aspects of change. Remember that formula you really want to help maximize the dissatisfaction and then targeting and thinking about the personal reaction to some of the changes. There are the with needs, what is in it for me and there are a lot of great stories from a lot of clinics of my life is better with this new model, so how can you try and target helping an individual understand there are ways this model might actually make things better. Even though you are so used to and stuck on the old way. Really keeping those key levers that you need to change to keep being clear on where you are going, clear about how to get there, and clear on whether or not you are there and measuring things. Those five questions you might have to keep going through and around, you might think you have planned it out and it is all perfect and sometimes you have to go back around again and again.

Question and Answer

Michael Ryan – We were just talking today about how some of the people as we work towards PCMH they are insulated a few layers from the administrators and managers that are working on this and they are actually like the clinical staff that are carrying out some of these changes. When the administrators or two or three layers from the actual clinical staff are going to be doing the bulk of the PCMH work. How is the best way to communicate that to them? Do you rely on your clinic managers to spread that message or what thoughts might you have?

Jeanene Smith – There is a variety of approaches, I think having an onsite thinking about it and back and forth conversation with that clinic. I am assuming that clinic administrator manager is sort of the

bearer of bringing; this is what we are going to do now because all of us across our five clinics are doing this. Having that back and forth so that the people doing it better understand why. Maybe that takes more than the clinic administrator themselves maybe there is a need for that upper leadership to come and help support that clinic administrator in those discussions, or having more one on one, and also maybe having some one-on-ones with the different parts of the clinics to help understand their particular role in that change to be at the front office, back office, or the providers. I think that it is a combination effort but that is where it gets into that training if you are being asked to track all of those referrals like I was talking about before, well why should I do this. How do you help answer those questions? The clinic administrator role is really critical it is not only a conveyor of this is what we are going to do, but making sure the patient administrator understands why and he or she has enabled their staff to understand that really well, clear vision and clear step. That might take that high level to come in those individual clinics and make sure of that to be a real success at that change.

Michael Ryan – I think so. We do not want to rely too heavily on our clinic managers, but we also do not want to be the heavy handed, this is what is happening now.

Jeanene Smith – My clinic from last time just had team meetings and reporting out. There was not back and forth. Having all the medical systems together with care coordinators and discuss what was supposed to be done, what would work and how to approach it. Where you have employees help shape it to fit in there so it is not on the back of the administrator. Empower others to be those change agents and not the administrator being the sole source of the change agent role.