STATE HEALTHCARE INNOVATION PLAN, *PATIENT CENTERED MEDICAL HOME TRANSFORMATION MENTORSHIP WEBINAR: CULTURE CHANGE*

Notes: November 7, 2017

Jeanene Smith: We have a great set of clinics that are going to talk today about strategies for the culture change that is needed to really fully move through the patient centered medical home (PCMH) model.

To refresh, the objectives are to share the implementation experiences and lessons learned of our two mentor clinics. Then as opportunity for any mentees, those of you that have questions and want to get some additional information, to ask after we have the two mentors talk about what they are doing in their sites. It is also a way we will be sure to have their contact information, but to build these relationships across Idaho so you all can share what works in your clinic and might really work well in another clinic, but you may not know they exist. So this is to really build that relationship. There is a formal innovation mentorship framework document that is available, if anyone is interested, on some of the ideas that our work group developed around this whole concept.

I just got a refresh from the learning collaborative. I believe Nancy Kamp gave a presentation on some organizational change of which what this culture change is really part of, and "Lasting success lies in changing individuals first; then the organization follows" was a quote that she had up. But this team-based approach and quality improvement is really important in trying to understand every of the team members' beliefs and values and aligning towards a common goal to really shape and support this new culture shift. So it is not just a one-time thing in order to get recognition, but it is really a whole way of life inside the clinic going forward.

It does not necessarily fall into any one particular standard if you are looking at NCQA (National Committee for Quality Assurance) recognition, or even in the PCPCH (Patient Centered Primary Care Home) Oregon standards, but it is really part and parcel of several standards, including the Team Based Care and Practice Organization Standards, where you are having to identify transformation leads and how do you educate and structure your staff's responsibilities. And then the performance—some of the reporting performance that is in the practice, it kind of falls a little bit under that Competency Number 15 as well.

Today's mentors, and we are going to flip the order here and start with Kaniksu Health Services, which is in Region 1. Amber Villelli is the Director of Performance Improvement, will kick us off, and then for about 15 minutes kind of describe what they are doing there. Then we will flip over to Family Health Center, and Dr. Scott Dunn and Brandy Giese are on for that.

Let me put up the questions for the mentors to kind of talk around. We will start with Amber. And those are sort of the same questions I shared with you earlier. So if you want to start off, that would be great.

Amber Villelli: Hi, everyone. I am Amber Villelli. I work with Kaniksu Health Services as their Director of Performance Improvement. We have four clinics in two different counties in North Idaho. We are a community health center and we have integrated behavioral health, dental, family practice, and pediatric services. There are about 150 employees and 28 providers across all four clinics and we see about 14,500 patients every year. All four of our clinic sites have been recognized PCMH (Patient Centered Medical Home) Level 3 by the NCQA. Since 2014 we have first received our recognition under the 2011 standards, and just last month we received Level 3 recognition at all four clinics under the 2014 standards.

Looking at culture and how we move forward with the PCMH model, I would say that one of the biggest hurdles that we undergo, number one there is an environment now where documentation and reporting needs are translating to our providers as a roadblock to good care, and so we really need to foster that culture of acceptance and getting our staff to embrace a dynamic environment and function as a team. We know that providers often look at the strenuous requirements of the PCMH model and think that it can be paralyzing to their way of practice. And so we really have to focus on maintaining that or getting our staff to embrace that change on a regular basis.

And one of the biggest things that we struggle with is that we have providers that come from different backgrounds. We have many providers that have been practicing for 40 years and then we have a couple that are new graduates. And so the expectations and familiarity with PCMH and involving that patient at the center of their care is different for each of those providers. So we really work on trying to be flexible and to train our providers.

So what are efforts to change the culture today? Lots of communication with staff and with our patients. We work hard to help them hear the terminology of PCMH and understand the impact so that they can form a true appreciation for the changes that we have made to become a patient-centered medical home. We use a lot of data to support and prove that change and let them know that good change has occurred and the trend continues in the right direction. We work hard to instill a sense of pride in our staff for the accomplishments and inform everyone of how they individually contributed to the success of recognitions, but also ensuring that they remain energized about the goals, because at no point is this project done. We have to continue to transform every day and the standards are continually changing and the expectations of our patients are continually changing. So we just work hard to really energize everyone on a regular basis and let them know that this is not a test that we take and we are done; it is really a model of practice and we have to continue to change over time.

Our first steps and key strategies. One of the first things that I did when I took over kind of project managing this PCMH transformation was to form a team I called the PCMH team. And I really looked at bringing members of the administrative staff and medical leadership as well as different people from every clinic that we had and representatives from every service area. So we had people from the front office staff, the call center staff, you know, the panel managers, the nurses, the MAs (Medical Assistant), providers,

behavioral health, dental, et cetera. We had everybody represented on this PCMH team and we met monthly. And the first thing I did was had everybody kind of go through the PCMHA (Patient Centered Medical Home Assessment) and just to get an understanding of the term and like what they knew and what they did not. And that was really informative for me, because it showed me that most of our staff had no idea what we were doing already to kind of adhere to these requirements. And so as we went through the PCMHA I explained to them what we were doing administratively across all the clinics and how we were supporting transformation on that level.

And then, after about three months of educating them and teaching them what we were up to I had everybody redo the assessment and it changed drastically; people were now becoming familiar with the projects that we were undertaking and the terminology and really what the PCMHA was asking. So that was good to see. Then as a team we just began to audit every element in the NCQA retirements one at a time, and we would tackle one element and have the members of each clinic go back to their clinics and bring back to the next meeting kind of a PDSA (Plan, Do, Study, Act) cycle. They would go and audit the requirements and the documentation needs for each one of those elements and report back to the team on what they found. As a group we would kind of get together and say what is working best, what do we need to adjust, and then we would redesign our business processes and retrain the teams on the best practice to make sure that we were being consistent across the board and we were doing the most effective approach to every business practice.

Additionally, we worked hard to create training opportunities for all of the staff, where we would teach them about why we are doing PCMH. We can ask them to do a lot of these tasks and change a lot of their business processes, and it all seems very paralyzing until they kind of understand why we are doing it and what the big picture is and what the national direction of healthcare is and how PCMH is really focused on changing the major issues within the healthcare system nationally and how they were contributing to changing that.

So that really helped us. We additionally worked that into our new provider and nurse orientation process so that every person coming into the organization was getting training on what it meant to be a PCMH, how they could contribute and what our goals were.

Are there any questions so far or should I just continue to move through there?

Jeanene Smith: You can keep going and we will circle back for more questions.

Amber Villelli: Finally, the last thing that we do on a monthly basis is we have a quality meeting where we get our leadership together and we go through all of our CQMs (Clinical Quality Measures). So all of our clinical quality measures, and we create goals and we address any issues that we have in reaching those goals, and we strategize on ways to achieve them throughout the year or the quarter.

We also discuss any proposed business or policy changes in terms of PCMH and get approval for those so that the team can move forward on making those changes.

You asked who and how did we undertake this effort, and I would say that leadership—our leadership, our medical leadership as well as our executive leadership is 100-percent on board in support of this transformation. And that is invaluable. Without them backing us and consistently supporting us in all of the changes that need to happen, we would not be successful.

I was able to also create a team, so there is myself, and I have three members on my team that help in this transformation; they go out to the clinics and help engage the employees there and train them on what it means to be a PCMH, et cetera. And then also, you know, we took advantage of things like the SHIP (State Healthcare Innovation Plan) project, that helps with the coaching and getting our staff involved as well.

In terms of financing, because we are a community health center we do not actually pay the fees to become recognized, or the application fees with the NCQA. That does not mean that we do not incur costs, because we most certainly do in terms of a lot of the practices that we implemented, like care management and behavioral health integration. We now offer a lot of services because of PCMH that we did not before, and a lot of them are not reimbursable to date, so we absorb those costs. But we see that as a benefit to our patients and we are willing to do that. We obviously look for grant opportunities, et cetera, to kind of help us in those areas.

The top two challenges for us were most definitely clinical quality improvement and care management. So quality improvement, we went from reporting our uniform data systems, UDS (Uniform Data Systems), is a report that we need to submit for being a community health center, and so they look at a number of quality measures. But we used to just go through a 70-chart sample and kind of report what was happening, right? We did not have any improvement goals or any strategies on improving those over time. We just reported what was currently happening.

With that leadership support, like I said, they were able to help us in getting the technology that we needed and the staff that we needed to really change that and have real-time data and create goals and strategies towards improvement. We have actually seen some of our CQMs improve from 25 to 50-percent over the last six years. So now we are very intentional with where we are going with our clinical quality improvement.

The other biggest barrier was care management. That really became something that we needed to focus on three years ago, and I attended an IHI (Institute for HealthCare Improvement) conference and they focused on care management. I learned a lot from the conference on how other practices were kind of modeling their care management and how to do motivational interviewing and practical application of that, et cetera. When I brought that back, our leadership was just excellent and supported us in taking this on and we just worked with the nursing team and created a program that we just did PDSA cycles on over the last three years, and we finally have a robust program. It has been a challenge and it is definitely the hardest thing we have done, but now I can say that it is actually improving the outcomes for our patients and we get positive feedback around the program all the time.

Major lessons learned from the effort. I think you can read all the studies that you want around PCMH and how it improves triple aim, but until you can actually prove that in your own clinics, I think getting 100-percent buy-in from your clinical staff is difficult. We

are at the part where we are seeing that and we can show the improvement through our data, we can see our patient satisfaction scores improving. We see now, you know, our employee morale improving. So all of this is working and we can show it inside our own walls. And so that is great.

And then, of course, just making sure to continually audit all of your business processes. When you think you have something wrapped up and over time they change and morph and they are no longer meeting the requirements of PCMH. So I think that as long as you are continually auditing and you have a team dedicated to really managing that project that you will be successful.

I think that is all I had, unless you guys had any questions.

Jeanene Smith: Amber, can you give some examples of kind of that how you have energized and that sense of pride? Other than the great results you are seeing, are there other strategies that you guys have used to keep the motivation going?

Amber Villelli: I think, with the PCMH team was the first strategy around that. Because, honestly, I could have, with the quality team or the performance management team, we could have taken care of it on our own. But that is not what we wanted to do; we want to engage everybody and we want everyone to feel ownership over the parts that they do and to feel pride when we get that accomplishment. So bringing in people from the teams or from the individual clinics and getting their input and having them build the processes really has helped. Being able to show them the data around how, for example, we recreated our referral process and seeing that we went from, you know, 40-percent loops closed to 75-percent loops closed in a six-month period, they did that. They made that happen, they built that process and then they felt pride in it when we were able to show the effects of their work.

I think communication, we are struggling with that and we are always trying to communicate more and more. But just telling the staff that this is their win, they did this and, doing things like press releases around the accomplishment and celebrating it with just a little party or a cake or whatever it is, getting it out to the staff so that they can feel pride around that accomplishment.

Jeanene Smith: Do the individual clinics then do a sort of similar group, where they are bringing front and back and provider together regularly as well or how does it translate down from that larger four—across the four clinics you have got that team? How have the individual clinics motivated paralyzed providers or others?

Amber Villelli: We have worked to help the members of the team go out and engage everyone in the clinic in their PDSA cycles. Making sure that they are not just going back to their desk and doing the work on their own, but really pulling in the members of their team to deliver that. Then, for example, when we became part of the SHIP grant we selected people from each clinic to be involved in that and really supported them in attending the meetings and going to the regional meetings and sending them down to Boise. We work hard to send new employees every time we can to external training opportunities so that they can get energized and spread the word around the clinics.

Then, right now we just have excellent medical leadership. Our nursing director and our nursing trainers and our Super-User team, as well as our chief pediatric officer and our chief family practice provider, they are all super-engaged and they are always out and reinforcing the business processes that we put in place. So with them being onboard, I think that helps a lot.

Jeanene Smith: That is great. We are going to flip over and hear from the other mentors, Family Health Center. Dr. Dunn is on the line now, along with Brandy Giese. Dr. Dunn, can you go through the same set of questions, describing your efforts out there?

Dr. Scott Dunn: Sure. Good morning, everyone. Can you hear me okay?

Jeanene Smith: Yes, you are great.

Dr. Scott Dunn: Perfect. Well, Family Health Center is an independent clinic, much smaller operation than you just heard about; four full-time physicians, one part-time, and one mid-level, part-time. We only have one location.

First question, why is the issue of culture change important? And I think just because changing the mindset helps us to understand what a medical home really can be and gets us out of the rut of our old habits that we have been doing for years. So that is in my mind one of the important changes to kind of change that mindset.

First steps for us were to do team formation. We have been able to accomplish working as a team in our physician, nurse, and front desk teams. I think largely that has fallen to the nurses to do a lot of the pre-visit planning and preparation, which has helped us to be more comprehensive and continuous in our care. So to me that was a real big deal and I think that is something that the patients see, you know, as a change, as a difference, when they come, when they visit us, and when they interact with our teams, they do not think of just having a doctor taking care of them; they think of a team taking care of them and ask for their team by name, and I think that is really a great relationship. Inevitably, medical home is all about relationships, so that is important.

Brandy Giese: One of the other things we did is we evaluated who could do what and, having everybody to the top of their license. So there are a lot of paths that we had nurses doing that we realized our front staff could do. Part of that made the front staff feel like part of the team as well, and that in itself creates job satisfaction, because they are not just answering the phone, they are not just receptionists; they are an integral part of the team and they enjoy being able to be a part of our team.

Dr. Scott Dunn: And the patients, again, identify those relationships as being part of why they identify us as their home. We undertook this effort I guess because we could see that what we were doing, although we were comfortable with it, it was not as good as we wanted. We knew we could do better and we could see the change in care sort of maturing over time, and so we wanted to be a part of that change.

We financed this—the next question, how do we finance it—well, as an independent clinic we are, of course, 99-percent reimbursed fee-for-service, so beyond the per-member per-month that we got from participating in the pilot and then as a part of SHIP, we also tried to leverage the transition of care payments that sort of started

simultaneously about the same time, as well as trying to sort of maximize the wellness visit that Medicare rolled out and then kind of became a standard for all the insurers. So that has helped to justify financially some of the things that we have done.

Brandy Giese: We have had a few grants over the years, too, that is helped that go along with the quality improvement. So anytime you can get involved in that, that is always helpful.

Dr. Scott Dunn: The next question, efforts to change the culture. And I think, you know, we are trying to improve access and sort of expanding on the virtual medical home concept, using our local CHEMS (Community Health Emergency Medical Services) provider, the community EMS. We have one of our staff that is functioning somewhat as a case manager for our patients and then we are also exploring our telehealth. I just finished the telehealth visit about an hour ago, and that is, you know, new for us, it is something that of course is going on around the country, but we are trying to step into that arena and provide that access for patients as well.

Brandy Giese: We also try and do, weekly staff meetings. When we are running our quality reports we try and kind of create an atmosphere of competition among the teams to keep them motivated so that they understand that why they are clicking certain buttons and why it is making a difference.

Dr. Scott Dunn: It is an interesting question you had asked right at the very end of the last presentation about how do you keep motivation going, and inevitably people respond to stories, success stories. So we encouraged our teams to share their success stories with each other, and it not only makes them proud of what they were able to help a patient with, but it kind of spreads that good cheer around; people understand that this does make a difference for patients.

What are our two top challenges? I came up with four actually. The first was provider workload. Our doctors often kind of said, "I am just trying to get done today's work as best I can. It is kind of overwhelming to think about adding something to that." And so it was a challenge to kind of get them to see it a different way when it seemed like they were just buried in doing it the same old way that they had been doing. Working with peers. Obviously, trying to make the financial matter work, again, in a fee-for-service world that has been a challenge. Our EMR, of course, does not always lend itself to what we are trying to do, so there are some workarounds.

We found staff turnover to be a bit of an issue as well, particularly with doing care management. So we have gone through several rounds of strategy, trying to overcome that.

The last question about major lessons, the thing that came to my mind was incremental change. We have been doing this basically for about six years or so, and, we are nowhere close to being a model clinic. We have our successes, but we have our failures. We have - a move forward and a move backward - and so it is a constant process. Be grateful and happy with the successes that you have, but understand that it is an incremental process and do not try to look at it as you are going to change the world overnight.

Brandy Giese: Any change is an improvement, and starting small is okay. It takes time.

Dr. Scott Dunn: Any questions?

Jeanene Smith: Yeah. So I am going to start. But how many teams in your—having a much smaller setting, what is your number of teams that you have that seem to work as a provider or doubling up?

Dr. Scott Dunn: Yeah, so our teams are one physician or midlevel, combined with one nursing leader, usually an RN (Registered Nurse), and one nurse assistant, usually an LPN (Licensed Practical Nurse), and then one front desk admin support person. So, each team is four people roughly, and so each provider is a different team.

Jeanene Smith: Okay. You had a weekly staff meeting across your teams. So how often; how do you guys…

Dr. Scott Dunn: Yeah, so back to the question.

Jeanene Smith: Yeah, this is trying to understand how you keep the teams engaging and building that culture inside the individual teams, or just a little bit about that.

Dr. Scott Dunn: Yeah, we have struggled with the huddle concept. I am partly to blame for that, because the doctors are not as reliable as the nurses and the admin staff. But what we did find was helpful was having, we call it Lunch and Learn. So we just picked a day that we consistently have each week and have everybody bring their lunch and have a relatively short meeting, whether it be informational, whether it be some continuing education, or whether it be more logistics. But we just have a consistent weekly time for all of the clinical staff to get together.

Jeanene Smith: That is great. But then you also talked about how you have gotten the patients to understand their teams. Can you talk a little bit about how that got started to, kind of say, "I am on the blue team" or the red team or Dr. Dunn's team, how does that all work with the patient?

Dr. Scott Dunn: Yeah, I think part of the pre-visit planning and intake process, going through, the preventative things we try to accomplish with every visit, what the patients figured out was that the doctor was only a relatively smaller part of the equation and the other team members did a lot of the extra work and a lot of the extra counseling and guidance. That sort of helped change their view of who actually is the right person to talk to; because they end up talking with their nursing staff on the team often more than the doctors.

Brandy Giese: So kind of patient education, changing the terms. Everything that we try and say to the patients, "Okay, it will go to your nurse team or your care team," not an individual person. We have got fliers and brochures and all of that kind of stuff. So patients just get used to it; you can retrain them.

Jeanene Smith: Yeah, I have seen examples of where they have, you know, changed the business cards to the whole team rather than the doctor, or even put it on their after-visit summary, "You are part of this team" or something to help with that educational process. But it sounds like you have been pretty successful there.

Are there questions from the audience? Jump in, anyone.

Audience: This is Sherry from Saint Mary's in Cottonwood.

Jeanene Smith: Hi. Go ahead and ask your question.

Audience: Hi. I do not have a question. I was just going to echo some of the statements that the doctor just made. One of the things that really helped us be successful in working on this was having actual weekly meetings, where the team was there, we could talk about the challenges, the benefits. So I would echo what he said and really put the importance and value in that. We did not do that the very first time around, with the very first clinic that we did, but we have since started doing that. And it certainly makes it a whole lot easier and it keeps it on everybody is plate as opposed to, "Oh yeah, we talked about that a month ago, did we not?" kind of thing. So I would just echo the importance of that.

Jeanene Smith: Dr. Dunn and Brandy; I know Amber talked about how they had really folded everything into the training. One of your challenges was staff turnover. So how have you guys started to get the PCMH culture sort of embedded in your recruiting for new staff or training new staff, be it provider or not, just other office staff?

Dr. Scott Dunn: Well, it is always a challenge. But we have most of our turnover with our care manager, and initially our first couple tries was with a care manager that was kind of separate from the teams and was trying to, you know, cover across teams. What we have ended up doing is sharing that role amongst the team leaders; the nursing team leaders do the care management now, and so it has divided the workload and therefore created five or six care managers that can share with each other both, you know, strategy as well as covering if they are on vacation or whatever. And so they learn from each other, and that way if we lose one of them we have not lost all of our training, in essence, because it gets spread, again, to whoever comes onboard next.

Jeanene Smith: And have both of you, both sites, started to look at when you were hiring, are you seeing employees with potential employees that have some of this background or are you having to sort of start with scratch with some of your front and back-office staff?

Dr. Scott Dunn: Yeah, we start from scratch.

Jeanene Smith: Is that true, Amber, too? Because it is probably challenging in the more remote parts to get folks with previous experience with PCMH coming in?

Amber Villelli: Exactly. Yeah, I think in this area it would just be between Dr. Dunn and us swapping employees if that were to happen. Otherwise we are starting from scratch too, so. The providers, however, coming out of school are very familiar with PCMH-modeled care and onboard with practicing it. It is a much easier transition for new providers that are not just finished residency.

Jeanene Smith: Yeah. I wondered if you could both talk a little bit about your provider getting..you both talk about the need for leadership, which is often the providers as well as the providers that are probably somewhat reluctant to this new model. Are there some success stories or some other additional tips to help bring that along? Because that is a challenge. I know I heard it here with my years in Oregon that, "I would rather quit than do something

new," be it an electronic health record or a patient-centered home model, across many providers. Can you speak a little bit about recalcitrant providers and what you have done?

Amber Villelli: Yeah. I think that, like I said before, it can be paralyzing. And there are so many requirements pushed down on our providers right now from the Meaningful Use Program to UDS (Using Uniform Data Systems) and now PCMH. And it is; it is a lot. And you do get a lot of pushback. That the way that we have been most successful is incorporating them in the big picture. It seems very daunting if you are just told to perform a task and you are told to push a button because of this requirement or this program that we are involved in. But when you bring them to Boise and let them sit in on the meetings and hear, you know, other organizations and their success stories, like Dr. Dunn said, that is such a good motivator. That has been really helpful. And have them attend the regional SHIP meetings. That has been very helpful.

And then also, like I said before, our leadership is really engaged and really good at communicating with our staff that this is all kind of setting us up for the future and it is not just a menial task that we are going to be done with or we are going to click the button and move on. But PCMH is really like creating the foundation for value-based payment remuneration model that we are all going to be part of very soon. And so it is really just setting us up to be more successful in the future. And I think having that understanding and continually training our staff on what that means and what that contributes to our future is what helped most of all.

Jeanene Smith: Brandy and Dr. Dunn, more thoughts on pulling the providers along?

Dr. Scott Dunn: I would echo this; Amber is probably better than I am, but I think that inevitably no matter if they are an old dog or if they are a new grad, but inevitably there is at least something in the patient-centered medical home model that seems attractive. They may not buy into the whole idea, but there is a part of it that they might like. So then let them take that part and participate in the part that they like, that they think is going to be the most helpful, and have that be their first introduction. And we found that, everybody seems to have their own interests. So to a certain extent, being flexible, allowing them to dive in where they see the value and then trying to move the rest along as a part of it. It is challenging.

Jeanene Smith: And did you face more challenges in trying to introduce the virtual and the telehealth? I mean I see them taking it a little bit further there, so how has that been received in terms of the culture?

Dr. Scott Dunn: I think, we are still in the pilot phase and we have only had just my team doing it. But everybody is interested, they are all kind of looking over our shoulders and they are, you know, aware of it nationally and they are kind of excited by the idea, so I think, [be] open-minded, you just try to create the culture of willingness to try new things and be an experiment and then change and adjust as needed, and then spread the success around so everybody can participate. But we are taking it one step at a time.

Jeanene Smith: And other folks please jump in if there are some more questions. Anybody want to ask or type in a question, and I will read it out to them as well?

I think in working with a lot of the clinics in Idaho these last couple years, they are sort of varying in terms of engaging the front with the back office. Were there some initial challenges that both of you faced in getting that to happen, or would you say that went pretty smoothly? Sometimes it can sometimes be that we are just doing PCMH in the back office and not engaging the front. Some suggestions for those that are starting to entwine that front desk into the back office work?

Amber Villelli: What I noticed was that the nurses were kind of apprehensive, I do not want to say that they did not trust the front staff, but it took some time for them to understand that they were there to help and that they could do the job. And then once that happened, now they almost cannot imagine that they did all the work that they used to do, that the front staff now helps them with. It is just getting over that first.

Jeanene Smith: And is that true, Amber? You had brought the front desk in through those group meetings right from the get-go, so that probably helped a lot to overcome some of the barriers.

Amber Villelli: Yeah, that helped a lot. And I think having your front staff engaged is really important, I mean because they are the first touch with our patients. They have to be onboard and understand. But also director of business operations worked hard to kind of do that same working at the top of your license, like strategy for her front office and call center staff, where she created a tiered program. And so you could be in tier one, two, or three, and at each tier you are having more responsibility and more integrated responsibility with the back staff. And so really when people were kind of graduating to that level three status they were well-integrated, well-informed, and had relationships with the staff, which was helpful. And like they said, we are able to take a lot of responsibility and run with it.

Jeanene Smith: Although sometimes the short work staff turnover and/or shortages can often hit the front a lot. So are there attempts to figure out what the front was doing so they could take on those additional tasks without feeling overburdened? Or any thoughts on that front from either of you?

Amber Villelli: Yeah, for us when the front office staff kind of graduated to that third tier, they were letting go of some of the more menial front-office staff tasks and grabbing onto the more complicated integrated tasks. So I think that they still had those skills, when they were struggling with coverage and things like that, to be fall back into the front office and answer calls and check in patients and all that. But they have learned more and graduated to a higher responsibility.

Dr. Scott Dunn: My thought was, we would add one thing at a time, kind of see how it goes, see how much time it takes, see how much time they have leftover, and then we would add another task to their plate, and just kind of one at a time. And that helped to gauge their capacity for getting that done without feeling overwhelmed.

Jeanene Smith: And have either of your clinics been doing sort of staff satisfaction? I know it sounds like you really monitor your patient satisfaction, to see whether your changes have really made it a better environment that they want to stay and work in. Any monitoring of that so far?

Dr. Scott Dunn: Not doing anything formally, but we are encouraged by the fact that our staff turnover seems to be down and they all seem to embrace their role and seem to embrace their role in the bigger picture. So it is like we have a champion at almost every desk that is really grabbing it and owning it, so that is been really great.

Jeanene Smith: Yeah. All right. Well, and another chance if folks want to pipe up and ask some questions or raise their hand.

So any last words of wisdom for the crowd from either site? We really appreciate you guys taking the time today to share. I think these were just, again, from the learning collaborative, but, you know, these are some of the ingredients if you were making effective change muffins or something, that would be a change worth making. Leadership is what we heard from both of these clinics; resources, trying to make those work; a plan on how to use those skills; perseverance; ability to learn; and broad participation and engagement, which these two clinics are great examples of today.

The mentors are kind enough to let us share their contact information. You can reach Dr. Dunn and Brandy via Brandy at Family Health Center, and/or Amber at Kaniksu, to ask additional questions that you might have and want to get some additional tips. And we appreciate the mentors being available for that.

And there will be an evaluation going out to just see what everyone thought about this topic and what other kind of ideas or suggestions, because we would like to continue to do more of these. We want to try to find some mentors that would be willing to talk about their efforts around risk stratification as part of chronic care management later this month or first part of December; we have to find the mentor and see when their availability is. And then we hope to have an additional webinar in January before the end of this year and we will see about beyond that. But it is a nice chance to share and learn from each other.

If anybody has some good ideas, you can either talk to your PHD SHIP regional people, the various QI specialists that work with your clinics and/or contact me, Jeanene Smith and/or Nancy Kamp with additional ideas or suggestions on, or if you want to volunteer to be a mentor.

So with that, thank you again, Dr. Dunn, Brandy Giese, and Amber Villelli. We really appreciate your time today and hope you have a good rest of the afternoon.

Operator: Thank you, everyone. This concludes today's session.