Leading Through Healthcare Transformation
Agenda

- Healthcare Transformation is Upon Us
- A Systems and Patient-Centric Approach to Practice Improvement
- Leading Transformation: Leadership Competencies and Derailers
- A Call to Action: The Patient Journey
- Group Exercise
Healthcare Transformation is Upon Us

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Key Drivers Are Influencing Healthcare Stakeholders

Healthcare Reform
- Care Delivery
- PCMH/ACO
- Hospital Readmissions
- Increased Patient Volume

Quality Standards
- Outcomes-Based Performance Programs
- Protocols / Guidelines
- HEDIS
- NCQA

Reimbursement
- Hospital-Based Revenues (IHSs)
- P4P
- Reimbursement caps (ASP+6%)
- Medicare
- Commercial Payers (Health Plans, PBMs)
- Employers

Technology
- EMR/meaningful Use
- e-Rx
- e-Visits
- Patient Portals
- e-Tools
- Evidence-Based Diagnostics
- Therapeutic Decision Support

Consumers
- Impact of Economy (especially given consumers are carrying more of the financial burden of HC)
- More Informed and Engaged through Technology
- Changing Expectations
- Utilization of Alternative Medicine
Common Areas of Focus for All Healthcare Stakeholders

- Value/Outcomes-Driven
- Patient-Centric
- Team-Based Care
- Population/Community Management
- Systems-Thinking/Continuity of Care
- Shared Savings
- Patient Engagement
Future of Patient-Centric Care

Accountable Care Organizations
- Organizations that are willing to take responsibility for the overall costs and quality of care
  - Have the size and scope responsibility

Clinical Integration
- System-wide organization (same philosophy as PCMH)

Patient-Centered Medical Home
- Practice level
  - Patient-centered model
  - Use of evidence-based medicine
  - Reason to expect that it will improve quality and bend the curve on costs
  - Payment models decrease incentive for volume and encourage investment in practice changes to promote quality

Source: ACP Conference, June 2009. Presentations by Michael Barr, VP, Practice Advocacy and Improvement, ACP, Lawrence Casalino, MD, PhD, Markus Meier, Asst. Dir, FTC, Kelly W. Hall, Executive Director, Strategic Planning at Partners Community HealthCare Inc.
Today’s Care

- My patients are those who make appointments to see me
- Care is determined by today’s problem and time available today
- Care varies by scheduled time and memory or skill of the doctor
- I know I deliver high quality care because I’m well trained
- Patients are responsible for coordinating their own care
- It’s up to the patient to tell us what happened to them
- Clinic operations center on meeting the doctor’s needs

Medical Home Care

- Our patients are those who are registered in our medical home
- Care is determined by a proactive plan to meet health needs, with or without visits
- Care is standardized according to evidence-based guidelines
- We measure our quality and make rapid changes to improve it
- A prepared team of professionals coordinates all patients’ care
- We track tests and consultations, and follow-up after ED and hospital
- An interdisciplinary team works at the top of our licenses to serve patients

Adapted with permission by IBM from Daniel F. Duffy, M.D.
The Patient Journey = The Patient Experience

Patient Journey Map: A Team based strategic model assessing chronic disease patient care.
Chronic Care Model (CCM)

Community
- Resources & Policies
  - Self-Management Support

Health System
- Health Care Organization
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Slide from E. Wagner
Wagner Chronic Care Model: The Foundation of the Patient Journey

**Chronic Care Model** – an evidence-based framework for health care that delivers safe, effective, and collaborative care

### Patient Self Management
- Empowering motivated and activated patients
- Emphasize patient role in managing illness
- Personal goals
- Tools to change behavior
- 1-1 and group education
- Cultural sensitivity and family involvement
- Measurement & feedback
- Improve patient communication with health care providers

### Clinical Focus
- Evidence-based clinical decisions
- Education curriculum supported by evidence-based guidelines
- Care team works to maximize cooperation and application of best clinical expertise
- Patient Registry to identify patient population

### Patient-Centric Approach
- Collaborative, team-based care
- Anticipate problems and provide quality-of-life service
- Care team works together with patient
- Office task chart
- Accessible office hours/same-day appts
- Organized patient visits
- Care team meets to review patient population work
- Systems for communication and follow-up
- Patient follow-up calls and information

### Tracking
- Patient tracking and information sharing
  - Patient census
  - EMR/paper record
  - Reminder system for patient and case team
  - Feedback loop
  - Care planning
Pace of Change: Bundled Payments Will Be a Disruptive Factor That Accelerates Health Reform

- CMS movement / mandates for bundled payments/ACO model
  - DRG payment rolled out over a 6-10 year period before hospitals became comfortable
  - Leaning a new world of bundled payments will force a wave of change on hospitals and their local provider base
    - Care transitions
    - Increased home care utilization...
  - This could also result in ACOs expanding into new geographies to manage bundled payments (because local players are not capable)
On the Path Toward Accountability

*Uncertainty of timing, not direction, our principal strategic challenge*

Source: The Advisory Board, 2010
One year data from payer pilots has demonstrated that individual practices can provide the equivalent of higher quality at lower cost as published data from large integrated systems.
A Systems & Patient Centric Approach to Practice Improvement

Diane Cardwell, MPA, ARNP, PA-C
Director of Practice Transformation
TransforMED
Building Learning Organizations

- Healthcare delivery as a complex adaptive system
- Utilizing a systems approach to change
- Aligning individual goals with practice/system goals
- Continuous quality improvement that is driven by metrics
The TransforMED Patient-Centered Model
A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: trust, respect, shared decision-making
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care
Access to Care & Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice-Based Services
- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Care Coordination
- Community-based services
- Collaborative relationships
  - Emergency room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care transition

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options
Care Management

- Population management
- Wellness promotion & Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies
- Quality metrics & outcomes
Practice-Based Care Team

- Provider leadership
- Effective communication
- Task designation by skill set
  - Defined roles & responsibilities
  - Workflows to ensure accountability
- Patient & family participation
- Process metrics - accountability
Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Personnel/HR management
- Optimized office design/redesign
- Change management
It is too expensive

What is in it for me?

We don’t have the staff for that

They won’t pay for it
PCMH Transformation

- Change Management
  - Teamwork
  - Leadership
  - Communication
Team Work
Change Is Not Easy, It Takes a Team Effort!
Leading Transformation: Leadership Competencies and Derailers

Tracy L. Duberman, PhD
President & CEO
The Leadership Development Group, Inc.
Challenges for Physician Leaders

- Identifying and communicating metrics to define physician "value" to patients and health partners
- Understanding clinical systems thinking and applying the concepts to new models of care delivery
- Communicating effectively to engage physicians and other healthcare providers to work as a high performance team
- Implementing patient-centered clinical integration
- Leading culture change rooted in trust between physicians and the health systems they support
The Leadership Development Group (TLD Group) & Group Practice Forum (GPF) Exploratory Study

- Partnership based upon synergistic expertise in leadership assessment and development and organizational need identification
- Study designed to elicit success model for physician leaders given today’s challenges
- Study results combined with GPF’s research and knowledge on health systems’ challenges/priorities can be used as a framework to position future and current leaders for success
Leadership Study Methodology

- Designed to Focus on Three Areas:
  - Physician Executive Core Leadership Competencies
  - Pivotal Experiences
  - Derailers that may inhibit success

- Conducted Phone Interviews & Administered Psychometric Tests with Key Leaders

- Participant organizations:
  - Austin Regional Clinic
  - Clinical Care Group of the University of Pennsylvania Health System
  - Dean Health System
  - Healthcare Partners Medical Group
  - Holston Medical Group
  - Medical Edge Healthcare Group
  - St. Vincent Physician Group
  - Advisors from Group Practice Forum
  - The Iowa Clinic
  - TransforMED
Results – MD Leadership Competency Model

**Physician Leadership Effectiveness**

- **Leading Self**
  - Self Awareness
  - Self Management
  - Self Development

- **Leading Others**
  - Build Effective Teams
  - Communicating & Inspiring

- **Leading Change**
  - Resiliency
  - Courage & Authenticity
  - Change Management

- **Leading for Results**
  - Decisiveness
  - Systems Thinking
  - Business Acumen
Results – Psychometric Assessments

- **MBTI**
  - ENTJ (Extraversion, Intuition, Thinking, Judging)
    - Typically logical, analytical and objectively critical
    - Natural leaders, ENTJs prefer to be in charge and like long-range planning and strategic thinking
    - Characteristics:
      - High Tolerance for Stress
      - Less likely than the general population to show their feelings and emotions in stressful situations
      - High problem-solving ability
      - Strong Analytical Skills (Methodical Approach)

- **Bar On EQ-i Results**
  - Balance of Independence and Collaboration
    - Ability to balance desire to act independently with a willingness to work in collaboration with others, which is critical in the new environment where close collaboration and coordination are required
  - Highly Self-Actualized
    - Drawn to pursuing meaningful work that is consistent with own sense of purpose, which enhances their ability to inspire and rally others around a shared vision
Results – Pivotal Experiences

- Early managerial/administrative experiences
- Formal Leadership training boot camp & fellowship programs
- First-hand experiences that fueled the passion for making a difference
- Losing a key position and learning from mistakes along the way
- Mentoring by a respected physician or non-physician leader
- Coaching by an external coach
Results – Derailers

- Being risk averse
- Limited self-awareness
- Inability to manage change
- Being inflexible and/or impatient
- Being too self-involved and individualistic
- Being naïve about the importance of politics
- Inability to persuade groups towards a common goal
- Allowing the tactical to take the place of more strategic work
- Unwilling to give up instant gratification for longer term success
- Unclear role expectations for self and inability to communicate expectations to others
Best Practice Development Programs Integrate Organizational, Individual, and Job Factors to Attain Optimal Performance

Organizational Environment
- Culture and Climate
- Structure and Systems
- Maturity of the industry and strategic position of the organization
- Core competence
- Larger context

Individual
- Vision, values, philosophy
- Knowledge
- Competencies or abilities
- Life career stages
- Style
- Interests

Job Demands
- Tasks
- Functions
- Roles

Best Fit

70:20:10 Development Model

Experience:
Developmental tasks and challenges in current job and stretch assignments

Education:
Structured training courses, e-learning, speakers, reading, etc.

Exposure and Exchange:
Mentoring and networking; assessments, coaching and feedback
### 70:20:10 Development Examples

<table>
<thead>
<tr>
<th>70% Experience</th>
<th>20% Exposure &amp; Exchange</th>
<th>10% Education</th>
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<tbody>
<tr>
<td>• Facilitate a meeting</td>
<td>• Complete self-assessments</td>
<td>• Internal training courses</td>
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<tr>
<td>• Represent your department at a cross-functional meeting</td>
<td>• Gain insights from 360° assessments</td>
<td>• External seminars and conferences</td>
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<td>• Train a team member</td>
<td>• Gather performance feedback from manager/stakeholders</td>
<td>• College courses</td>
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<tr>
<td>• Integrate a plan across units</td>
<td>• Attend networking events</td>
<td>• Additional degrees</td>
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<tr>
<td>• Delegate and empower others to do assignments</td>
<td>• Participate in mentoring program as both protege and mentor</td>
<td>• Additional credential(s)</td>
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<tr>
<td>• Bring multiple approaches together and combine them in creative ways</td>
<td>• Contract with coach</td>
<td>• Read a book or paper</td>
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<td>• Gain support and commitment from others for idea or project</td>
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<td>• Subscribe to journals</td>
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<td>• Bring conflict/disagreements into the open and work to resolve them collaboratively</td>
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<td>• E-learning</td>
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<td>• Provide clear direction and priorities</td>
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<td>• Become an active volunteer in professional organizations</td>
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## Sample Process for Building Effective Practice-Based Care Teams

### EXPERIENCE (70%)

- Promote provider leadership development
- Coordinate and share Information
- Organize Teams Around Skill Sets
- Encourage Peer Pressure for Good Performance
- Develop workflows to ensure patient & family participation
- Determine process metrics and accountability

### EXPOSURE (20%):

- Complete self-assessments
- Gain insights from 360° assessments
- Gather performance feedback from manager/care team
- Attend networking events
- Participate in mentoring program as both protégé and mentor
- Contract with a coach

### EDUCATION (10%):

| Mainstream Article: | “Turning Doctors into Leaders” Thomas Lee, HBR  
|                    | “Creating a Coaching Culture” Anderson, et al |
| Case Studies       | “Becoming a Provider of Choice/Practice-Based Care Teams” |
| Course Work:       | CCL, Becoming a Conflict Competent Leader |
The Patient Journey

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Patient Journey Creates a Map of the Patient Experience through the Healthcare System

My Practice — New Considerations:

- Diagnosis
- 6-Month Follow-Up Visit
- 1-Year Follow-Up Visit

Coordinated care
Patient empowerment
Health literacy
Patient population management
Electronic medical records
Sample Patient Journeys

Asthma

Diabetes

Osteoporosis

COPD
Sampling of Tools Supporting the Patient Journey
The information presented in this case is a hypothetical example and not based on an actual patient.
# The Patient Journey Highlights Team-Based Care Models: Every Member Plays A Part

## Shared Responsibilities to Reach a Common Goal

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<tr>
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<th>Patient Registry</th>
<th>Motivational interview</th>
<th>Checked medication adherence</th>
<th>Updated EMR</th>
<th>Distributed educational tools</th>
<th>Lifestyle SMBG (diet/exercise)</th>
<th>Outreach to patient after appointment</th>
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Quality / Cost
- Maximize the numerator
- Decrease the denominator
LEADERSHIP

The leader always sets the trail for others to follow.
Group Exercise

- Tennis Ball Exercise
  - Rapid cycle improvement
  - Competing teams
  - Change can feel good
Nominal Group Process for Decision Making

- Methodology for achieving team consensus quickly
- Benefits
  - Works with small and large groups
  - Everyone participates from all levels of the group organizational structure
  - Supports rapid cycle change and quality improvement
Nominal Group Process

1. Present the question or issue and give the group a few minutes to silently reflect and come up with their individual ideas.
2. Group members share ideas, each of which is recorded on a flip chart.
3. The group discusses the ideas, clarifying and combining similar ideas as needed.
4. The group reviews the ideas silently and each member ranks the ideas by preference.
5. A preliminary vote is taken.
6. After viewing one another’s rankings, group members vote again.
Nominal Group Process Exercise #1

- In teams, use nominal group process technique to determine the top 3 barriers to engaging your physicians to embrace change and the PCMH.
Nominal Group Process Exercise #2

- In teams, use nominal group process technique to choose the top 5 solutions to each barrier.