<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8:30 - 8:45</td>
<td>Welcome, Objectives &amp; Ice Breakers</td>
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<tr>
<td>8:45 - 9:00</td>
<td>KP’s Commitment to High-Quality, Affordable Care</td>
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<tr>
<td>9:00 - 10:15</td>
<td>Regional Presentations</td>
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<tr>
<td>10:15 - 10:45</td>
<td><strong>Thrive Break</strong></td>
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<tr>
<td>10:45 – 11:55</td>
<td>Regional Presentations (continued)</td>
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<tr>
<td>11:55 - 12:15</td>
<td>Panel Q&amp;A – Regional Presentations</td>
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<td>12:15 - 1:15</td>
<td><strong>Lunch</strong></td>
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<td>1:15 - 1:50</td>
<td>Accelerating Learning and Spread (XLS) Strategy</td>
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<tr>
<td>1:50 - 2:25</td>
<td>The Role of Data</td>
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<tr>
<td>2:25 - 2:50</td>
<td>Panel Q&amp;A – XLS &amp; The Role of Data</td>
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<tr>
<td>2:50 - 3:20</td>
<td><strong>Thrive Break</strong></td>
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<tr>
<td>3:20 - 3:45</td>
<td>“Each One Teach One” Interactive Exercise</td>
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<td>3:45 - 4:00</td>
<td>Closing Remarks</td>
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OBJECTIVES

Articulate the mission-critical interdependence of quality and affordability in health care.

Apply 2-4 tools, tactics, or promising practices to drive high quality and affordability.

Describe how to accelerate learning and spread through applied data and design excellence.

Engage in networking and open, generative discussions to advance thinking on shared opportunity areas.
ICEBREAKER

LET'S PLAY A GAME.
WE EACH SAY TWO
THINGS ABOUT OURSELVES AND THE OTHER
HAS TO GUESS WHICH ONE IS A LIE.

I LOVE TO
PLAY GAMES
LIKE THAT.

MY SECOND
THING IS THAT
I EAT FOOD.
ABOUT KAISER PERMANENTE

- Integrated health care delivery system
- 10.6 million members
- 194,294 employees
- 18,652 physicians
- 51,010 nurses
- 7 regions, serving 8 states and the District of Columbia
- 38 hospitals
- 626 medical offices/outpatient facilities
- $60.7 billion operating revenue

Source: 2015 Kaiser Permanente Annual Report
OUR MISSION

To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.
Eight Kaiser Permanente health plans receive “5 of 5” in 2016 in national rating.

In 2016, KP members in 5 geographic areas rate KP highest in satisfaction in the J.D. Power Member Health Plan Study. Additionally, KP members rate KP highest in JDP Medicare Advantage study.

KP IS RECOGNIZED NATIONALLY

In 2016, for the 6th year in a row, KP has earned the PQA’s Excellence in Quality Award for medication safety and appropriate use.

In 2016, for the 6th year in a row, KP is the only plan in California to earn the 4-star rating for overall quality of care in OPA’s Healthcare Quality Report.

In 2015, KP was honored with Leapfrog’s inaugural “Living the Vision” award for excellence.

In 2016, for the 4th year in a row, KP’s California health plans received top rating for quality and service.

In 2016, 37 KP medical centers continue to be Stage 7 Award winners, recognized for successful electronic health record implementation.

In 2016, 15 Kaiser Permanente facilities honored in 2015 as ‘Top Performer’ for Quality and Safety by The Joint Commission.

In 2016, for the 9th straight year,(KP) is the only plan in California to earn the 4-star rating for overall quality of care in OPA’s Healthcare Quality Report.

In 2016, KP members in 5 geographic areas rate KP highest in satisfaction in the J.D. Power Member Health Plan Study. Additionally, KP members rate KP highest in JDP Medicare Advantage study.

In 2016, 37 KP medical centers continue to be Stage 7 Award winners, recognized for successful electronic health record implementation.

In 2016, for the 6th year in a row, Kaiser Permanente received Satmetrix’s highest customer loyalty ranking in the health insurance category.
NATIONAL FOCUS ON HEALTH CARE AFFORDABILITY

Percent of Household Spending, 1930-2013

Source: US Bureau of Economic Analysis

© 2016 Kaiser Permanente
The United States spends more money per person on health care than any other country, but our life expectancy is shorter despite our high health expenditures. Dartmouth Atlas research shows that spending is inversely correlated with the likelihood of receiving recommended care.

Sources: ¹OECD Health Data, 2010; Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, 2012; http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx
NEW AGE OF MEDICAL ADVANCES

While some 21st Century medical advances have led to remarkable outcomes, others measure, detect, and treat conditions below clinical significance; external advocates have rallied to empower providers and patients to choose care that is truly necessary.

“Medical science has made such tremendous progress that there is hardly a healthy human left.”

- Aldous Huxley
“Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests.”
INDUSTRY-WIDE OPPORTUNITY TO “CHOOSE WISELY”

The ingrained “more is better” medical & consumer culture, direct-to-consumer advertising, and limitations (training, tools, & time) on providers’ ability to have difficult conversations about clinical alternatives and trade-offs, continue to serve as a bottleneck.

- Approximately 30% of health spending – roughly $750B – is wasted on unnecessary services.
- Nearly 3 in 4 physicians say unnecessary tests and procedures represent a serious problem in healthcare.
- Yet, over 70% of physicians order an unnecessary test at least once a week.

“The most expensive instrument in medicine is the physician’s pen.”

EMPOWERED CONSUMERS

5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. Do I really need this test or procedure? Medical tests help you and your doctor or other health care provider decide how to treat a problem. And medical doctors help to actually treat it.

2. What are the risks? Will there be side effects? What are the chances of getting results that aren’t accurate? Could that lead to more testing or another procedure?

3. Are there simpler, safer options? Sometimes all you need to do is make lifestyle changes, such as eating healthier foods or exercising more.

4. What happens if I don’t do anything? Ask if your condition might get worse—or better—if you don’t have the test or procedure right away.

5. How much does it cost? Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover, and about generic drugs instead of brand-name drugs.

Source: ConsumerHealthChoices.org

Save your life

Cancer screening is oversold. Know the tests to get—and those to skip.

For years it’s been assumed that doing aggressive cancer-screening can save lives. Yet, prevent-cancer tests, such as mammograms and colonoscopies, can identify cancers that are too tiny to cause any symptoms or simply not there.

The medical and public health community has systematically oversold the benefits of screening for breast and colon cancers. In a study by the Kaiser Family Foundation and The Commonwealth Fund, cancer-screening rate for women aged 50 to 75 was estimated to be 70% and for men aged 50 to 74, it was 45%.

A recent article in the New England Journal of Medicine found that the number of early breast and colon cancers lead to increased life expectancy by an average of only 3.5 years.

Cancer-screening tests may or may not save lives. They might cause disabilities, even death. The choice is up to you.

Source: Consumer Reports

© 2016 Kaiser Permanente
WELCOME TO THE RENEWALS BUSINESS

All signs point to a retail market: new dynamics unfamiliar in health care, but not in broader economy.

Source: Advisory Board
CONSUMER DEMANDS FOR TRANSPARENCY AND ACCOUNTABILITY

Integrated Healthcare Association Honors Eleven California Physician Organizations for Achieving "Excellence in Healthcare"

OAKLAND, Calif., Nov. 18, 2014 (GLOBE NEWSWIRE) -- Today, the Integrated Healthcare Association (IHA) announced the first annual winners of its new Excellence in Healthcare Award. In keeping with the national trend of empowering consumers of the healthcare system while delivering high quality care, the IHA recognizes provider organizations in California that control costs while ensuring their patients receive high quality care. The Excellence in Healthcare Award is a distinct departure from the IHA pay for performance awards based on quality benchmarks and other measures of health outcomes. The IHA Excellence in Healthcare Award is based on comprehensive data that allows consumers to make informed choices about the care they receive.
We achieve the KP Mission and the Institute for Health Care Improvement's Triple Aim through our unyielding focus on delivering high-quality care and following the principle of doing no harm. We recognize an ethical responsibility to remain good stewards of our members’ resources so that we are able to bring our high-quality, coordinated care to more people within our communities.

At Kaiser Permanente, medical decisions are made by physicians in partnership with their patients. We support conversations between physicians and patients to discuss wise treatment decisions and to choose care that is supported by evidence, is not duplicative of tests or procedures already received, won't cause harm, and is necessary and in the best interest of patients.
HIGH-QUALITY, AFFORDABLE CARE

REGIONAL SPEAKERS

Group Health Cooperative – Matt Handley, MD
KP Southern California – Joanne Schottinger, MD
KP Colorado – Tracy Ellen Lippard, MD
KP Georgia – Scott Pugel, MD
GROUP HEALTH COOPERATIVE
Matt Handley, MD
Medical Director for Quality & Safety
REGIONAL STATISTICS
Group Health Cooperative “Vital Signs”

- 610,000 members
- 6,900 employees
- 1,000 physicians
- 600 nurses
- 30 medical offices
OUR FOUNDATIONS

Improving Health

Safety First

Reducing the cost of poor quality

- Reduce event rates where we can by avoiding underuse (MI, CVA, etc.)
- Coordinate care to prevent avoidable harms (reduce readmissions, duplication, etc.)

Stewardship

The outcome to maximize is Value
RESOURCES STEWARDSHIP AT GROUP HEALTH

Three Complementary Approaches:

1. Shared Decision Making (focused initially on preference sensitive surgical conditions)

2. Understanding Variation in the “Propensity to Act”  Transparent sharing of global utilization of services (imaging, referrals, lab, etc.) Promoting a learning community among our staff

3. Evidence Based Clinical Improvement targeting low value care – Choosing Wisely programs.
AT THE CORE: BETTER CONVERSATIONS

We know that we are at our best when we engage our patients and each other. To improve value, we need better conversations:

*With patients:*

- Demonstrating empathy, eliciting a patient’s concerns, values and preferences.
- We know that some clinicians struggle, concerned that patients may perceive that they are being denied care, adversely impacting the patient care experience.
- We also know that our clinicians whom patients rate highest usually use fewer services.

*With each other:*

- We are generally more comfortable talking about overuse with patients than with each other.
- We are best when we remain curious and generous.
TRUE PATIENT-CENTERED CARE

- Optimal Patient Care
- Shared Decision-Making
- Evidence Based Medicine
- Patient-Centered Communication Skills
SHARED DECISION MAKING IS A PROCESS

• SDM is the process of interacting with patients who wish to be involved in arriving at an informed, values-based choice among two or more medically reasonable alternatives.

• SDM is more than handing out a decision aid (tools that clarify the risks and benefits of different options, and help activate patients to consider their preferences and values).
SDM IMPACTS PATTERNS OF CARE

Patients make decisions more consistent with goals and concerns.

Feel more informed and more clear about decisions.

Generally favor more conservative care (25% lower rates of preference sensitive surgery)
TRANSFORMING THE CULTURE
“Two Experts in the Room”

Provider expertise
- Diagnosis
- Disease etiology
- Prognosis
- Treatment options
- Outcome possibilities

Patient Expertise
- Experience of illness
- Social circumstances
- Attitude to risk
- Values
- Preferences

Shared Decision
- A mutual decision that best meets patient needs
PATIENT DECISION AIDS – A KEY TOOL FOR SDM

• Tools to facilitate SDM
• Present balanced information
  – Organized around specific decisions
  – Ideal communication to convey information about risks and benefits
• Encourage patients to work with their physicians when making decisions
• Help patients clarify and communicate their goals and concerns
DECISION AIDS IMPROVE RISK COMMUNICATION

- Low Numeracy, Elderly
- Low Numeracy, Student
- High Numeracy, Elderly
- High Numeracy, Student

Worst Presentation | Best Presentation
0% | 100%
10% | 90%
20% | 80%
30% | 70%
40% | 60%
50% | 50%
60% | 40%
70% | 30%
80% | 20%
90% | 10%
100% | 0%
SHARED DECISION MAKING – A SIX-PART PROCESS

1. Invite Participation
2. Present Options
3. Provide Benefits and Risks
4. Elicit Preferences
5. Facilitate Decision Making
6. Implement Decision
THE HOLY GRAIL
Better Outcomes, Better Care Experience And Lower Costs
BRIGHT SPOT: SHARED DECISION MAKING AT GROUP HEALTH COOPERATIVE

The Group Health SDM Story

• Implemented in 2009 across 5 specialties
• Reliable distribution of decision aids
• Mandatory training for surgeons
• Over 60,000 patients involved
• Outcomes consistent with studies
• Published in Orthopedics, Gyn, Urology
• Moving “upstream” into Primary Care
• Expanding available topics
• Expanding training to all clinicians

Video Decision Aids

• Hip osteoarthritis
• Knee osteoarthritis
• Spinal stenosis
• Herniated disc
• Benign Prostatic Hyperplasia
• Uterine fibroids
• Abnormal uterine bleeding
• Early stage breast cancer
• Breast reconstruction
• Ductal carcinoma in situ
APPROACH TO IMPLEMENTATION

- Aligned leadership – SDM is a strategic differentiator
- “Non-elective model of adoption”
- Start in Specialty, then Primary Care
- Lean Process Improvement
  - Reliable distribution of decision aids
  - Incorporation into standard work of teams
  - Visual systems to make the work visible
  - Incorporation into manager/leader standard work
- Clinician training
PRAGMATIC CONSIDERATIONS FOR IMPLEMENTATION
A Two-Pronged Approach

Technical Change
Reliable distribution of decision aids

Adaptive/Cultural Change
Shift in culture to promote different conversations
COMPLEMENTARY APPROACHES

Technical Change:
• We know how to do this – complicated but not complex
• Classic implementation strategies for underuse

Adaptive/Cultural Change:
• This is hard – complex rather than complicated
• No data without stories; no stories without data
• Tap into aspirations, not defects
• Recognize that clinicians believe that they already do this
• Collect and share stories
• Use the patient’s voice
• Leadership presence
THE HOLY GRAIL
Better Outcomes, Better Care Experience And Lower Costs
MEASUREMENT CONSIDERATIONS

• We approached this as an evidence based intervention and focused on measuring implementation rather than effectiveness
• We were able to publish observational data consistent with RCTs
• We did not worry about small “n” problems with provider level data – each miss is a patient story
• We have switched from measuring defects to successes

We measured:
• Counts of decision aids early on to build reliable workflows
• Impact of decision aids on the patient experience to gain buy-in with our providers
• Provider satisfaction
• Utilization and cost
VOLUME OF DISTRIBUTION

In Process Measurement
SUCCESS RATE
In Process Measurement

GPD SDM Success Rate
Percentage of Procedures with a SDM Video Order
(Hips, Back, Knee and Hysterectomy & Benign Prostatectomy)

Target: 80%

2015 Q3 success rate: 73%
96% of 2,156 patients surveyed

“Decision aid videos helped me understand my treatment choices”
95% of 2,139 patients surveyed

“Decision aid videos helped me prepare to talk with my provider”
QUALITATIVE PROVIDER INTERVIEWS

Overall positive or neutral about decision aids

- Benefits of decision aids outweigh minor concerns
- Patients are more informed
- Takes less time
- 90% of surgeons attended a Shared Decision Making CME event in 2011
- Overall positive comments about training experience
Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs

ABSTRACT Decision aids are evidence-based sources of health information that can help patients make informed treatment decisions. However, little is known about how decision aids affect health care use when they are implemented outside of randomized controlled clinical trials. We conducted an observational study to examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint-replacement surgery and costs in a large health system in Washington State. The introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12–21 percent lower costs over six months. These findings support the concept that patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients’ and physicians’ preferences, may reduce rates of elective surgery and lower costs.
KEY LEARNINGS

• Be wary of Pilot-itis

• The Technical change (video distribution) is easier than the Adaptive/Cultural change (having different conversations)

• Leadership matters – it is hard to lead adaptive change

• The case for change should be mostly aspirational (best for patients) rather than critical (demonstration of current variation)

• There is a WIFM for clinicians
  ✓ Patient centered – different conversations are reinforcing
  ✓ Saves time
  ✓ Improved informed consent/Liability protection
ADVICE FOR IMPLEMENTATION

• Requires strong leadership
• “Non-elective model of adoption”
• Recognize and support two complementary approaches – Adaptive/Cultural
• Classic process improvement
  – Reliable distribution of decision aids
  – Incorporation into standard work of teams
  – Visual systems to make the work visible
  – Incorporation into manager/leader standard work
• Invest in clinician training
SOUTHERN CALIFORNIA
Joanne Schottinger, MD
Assistant Medical Director for Quality and Clinical Analysis
REGIONAL STATISTICS
Southern California “Vital Signs”

- 4.2 million members
- 69,554 employees
- 6,756 physicians
- 23,156 nurses
- 14 hospitals
- 221 medical offices
REGIONAL DUAT – DESIGNED FOR SUCCESS

   - Evidence-Based Prescribing/Disease Management Initiatives
   - Quality – Cost – Safety - Affordability

2. Regional Committee (Primary/Specialty/P&TC Chair)
   - MD/PharmD Co-Chairs
   - Leveraged Data/Reporting/Communications
   - Project Manager – Bi-Monthly Teleconferences via WebEx

3. Regional DUAT Model Replicated in all Areas
   - MD Leader, Champions, DECs, COMs, APDs, AMDs, others
   - Data/Reporting/Communication/Academic Detailing
   - Project Manager support

4. Regional DUAT Teleconferences with Local DUATs
   - Best-Practice sharing roundtable; learning from each other
   - “Moving the Regional Bar to the Right”
# REGIONAL DUAT – DESIGNED FOR SUCCESS

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Areas that are at of favorable to Regional Targets for overall initiative
Areas that are at of favorable to Regional Average but unfavorable to Targets for overall initiative
Areas that are unfavorable to both Regional Targets and Regional Average for overall initiative
Areas that are not included in the initiative scoring
REGIONAL DUAT – DESIGNED FOR SUCCESS

Average Metric Score (n = 15), All Initiatives
(January-March 2015)

Directional Goal
PATIENT QUALITY – OUR #1 PRIORITY

High-Risk Meds – Key Initiative Progress Trends

- CMS 5-STAR HRM Measure - Estrogens
- CMS 5-STAR HRM Measure - Non-Benzos
- CMS 5-STAR HRM Measure - Digoxin
- Tertiary TCAs

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BRIGHT SPOT: 2016 DUAT INITIATIVES

Safe opioid prescribing
- 100 MED threshold

High Risk Medications in the Elderly

Brand when Generic Available

Diabetes
- Med adherence and Metformin optimization
  - Oral agents and insulin per algorithm

Specialty Drugs
- DMARDs
  - Chemotherapy at End of Life
BRIGHT SPOT: 2016 RUAT INITIATIVES

Patterned after DUAT, with partnership between Radiology and ordering clinicians

Focus on safety and avoiding unnecessary radiation

Avoiding imaging in low back pain, uncomplicated headache, Sinusitis

Guideline directed intervals for screening with DEXA and Mammography
BRIGHT SPOT: LUAT AND THE BURDEN OF OVERPAPULATION

<table>
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<th>Screening rates only</th>
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<th>Annual rates dropped to</th>
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<td>78%</td>
<td>LUAT</td>
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<td>but</td>
<td>focus on guideline recommended intervals</td>
<td>Screening rates rose to 85%</td>
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<tr>
<td>40%</td>
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<td>Some lab costs savings but substantial appointment access generated</td>
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of women getting annual Pap smears when guidelines recommended Q 3 YR
GEORGIA
Scott Pugel, MD
Physician Director of
Resource Stewardship
REGIONAL STATISTICS
Georgia “Vital Signs”

- 287,432 members
- 2,768 employees
- 477 physicians
- 849 nurses
- 26 medical offices
ARTICULATING THE PROBLEM
Linking Practice Variation & Choosing Wisely

KP Georgia’s Challenge:
Keeping the known barriers in mind, develop and implement a change management program that could formally link the standardization of care to nationally adopted guidelines and recommendations.
BARRIERS TO A SOLUTION

The NICS identified six key levels of health care where barriers may impede best practice. These are:

1. The guidelines themselves (feasible, credible)
2. Professionals’ individual levels of awareness, knowledge, attitude, motivation to change and behavioral routines
3. Patients’ knowledge, skills, attitude and compliance
4. Professionals’ social context (culture, collaboration)
5. Organizational context (support/barriers)
6. Economic and political context (policy)
The Choosing Wisely guidelines were initially developed by the American Board of Internal Medicine (ABIM) and the American Board of Family Medicine (ABFM).

Kaiser Permanente Georgia Region Choosing Wisely Campaign Goals:

- Increase our capability to provide the best evidence-based care
- Improve quality via delivering value added care
- Promote meaningful care discussions in the exam room
- Promote meaningful discussion regarding practice variation

Quality first, with emphasis on increasing quality of care, enhancing the member experience, and reducing practice variation.
### SOLUTION DEVELOPMENT

#### The Plan

#### Change Management

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<th>Communication Planning</th>
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<td>Communication Strategy Development</td>
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<td>Stakeholder Identification</td>
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<td>Stakeholder Mapping</td>
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<tr>
<td>Report Specification Development and Drafting</td>
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<td>Ratification of Reports</td>
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<td>Delivery/Rollout Plan Development</td>
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<td>CME/Contextual Material Development</td>
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<td>Linkage to KP Mission and Vision</td>
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<td>Usage Toolkit Development</td>
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SOLUTION DEVELOPMENT
Understanding the Issues & Risks

Issues

Clinician Ownership
• Time allotment for provider involvement
• Disruption in workflow
• Consensus building for guideline and report adoption

Reporting Limitations
• Competing priorities across organizational initiatives
• Trust in report development and data sources

Risks

Lack of Consistency In Adoption
• Member perception/dissatisfaction
• Provider satisfaction
• Staff satisfaction
COMMUNICATION PLANNING

Communication Strategy Goals

**Internal**
- Foster a collaborative, performance-driven culture
- Reduce change anxiety (non-punitive)
- How we address “next steps”
- Maintain a high level of provider satisfaction

**External**
- Maintain a high level of member satisfaction
- Solidify KP position as a plan of choice for employers
- Become the first health plan in metro Atlanta to publicly embrace the Choosing Wisely campaign
COMMUNICATION PLANNING

Internal Communication: Grouping and Vehicles

- Leadership
- Chiefs/Leads
- Providers
- Operations
- Currently Subscribed Members
- Currently Subscribed Employers
- Potential Employers and Members
REPORT DEVELOPMENT AND DELIVERY
Ambulatory Medicine

**Development Process**
- Report Specification Development
- Draft Report Development
- Ratification of Specification and Draft Report by Chiefs

**Delivery Process**

**Targeted Rollout**
- Chief/Lead collaboratively worked with Hub providers on specific initiatives
- Targeted roll-out phase lasted for a period of 60 days (2 months)

**Full Rollout**
- Department wide roll-out completed the week of 7/21
- Leveraged ‘success’ strategies and ‘targets’ identified in Targeted Rollout period

**Delivery Vehicle**
- Manual emailing during targeted rollout (Un-blinded, Hub specific)
- Automated emailing for full rollout (Un-blinded, Entire department)
- Report Portal for ad hoc requests/non standard time frames
- Emailed to providers the first day of every month
<table>
<thead>
<tr>
<th>Choosing Wisely Initiative</th>
<th>Targeted Hub</th>
<th>Responsible Area Chief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not do Dexa screens on women under 65 and men under 70</td>
<td>Crescent</td>
<td>Dr. Charles Curry</td>
</tr>
<tr>
<td>Do not use a CBC as a routine screening test</td>
<td>Cascade &amp; Southwood</td>
<td>Dr. Lajune Oliver</td>
</tr>
<tr>
<td>Do not order annual EKGs for low risk patients</td>
<td>Gwinnett</td>
<td>Dr. Charles Curry</td>
</tr>
<tr>
<td>Do not do imaging for uncomplicated headaches</td>
<td>Glenlake &amp; Townpark</td>
<td>Dr. David Seidel</td>
</tr>
</tbody>
</table>
REPORT DEVELOPMENT AND DELIVERY

Sample Ambulatory Medicine Provider Report
TRAINING & EDUCATION

Benefits of Shared Decision Making

- Improved **quality**
  - Outcomes that are more concordant with patient's values

- Improved patient and clinician **satisfaction**

- Reduced patient **anxiety**

- Increased **adherence**

- Significantly improved **utilization** of resource intense, preference sensitive procedures
TRAINING & EDUCATION

Toolkit Usage

Equip providers and staff with a Choosing Wisely toolbox specific to the initiatives on which they are focused. Choosing Wisely toolbox could include:

1. Hyperlink Examples
   - Patient friendly links to Choosing Wisely collaterals for quick reference
   - Choosing Wisely links with module specific navigation
   - Choosing Wisely link in HealthConnect
   - Fifteen Things Physicians and Patients Should Question

2. Pre-printed Hand-outs/Posters
KEY TIME POINTS

Average Number of Unnecessary CBCs Ordered – by Month

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Median</th>
<th>Standard Deviation</th>
<th>Mean + 1 Standard Deviation</th>
<th>Mean - 1 Standard Deviation</th>
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<tbody>
<tr>
<td>2013-07</td>
<td>25.90</td>
<td>26.00</td>
<td>17.44</td>
<td>43.34</td>
<td>8.45</td>
</tr>
<tr>
<td>2013-08</td>
<td>25.48</td>
<td>26.00</td>
<td>15.57</td>
<td>41.05</td>
<td>9.90</td>
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<tr>
<td>2013-09</td>
<td>22.95</td>
<td>24.00</td>
<td>14.19</td>
<td>37.14</td>
<td>8.76</td>
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<tr>
<td>2013-10</td>
<td>24.05</td>
<td>25.00</td>
<td>16.71</td>
<td>40.76</td>
<td>7.34</td>
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<tr>
<td>2013-11</td>
<td>21.03</td>
<td>22.00</td>
<td>14.20</td>
<td>35.23</td>
<td>6.83</td>
</tr>
<tr>
<td>2013-12</td>
<td>19.98</td>
<td>17.50</td>
<td>14.71</td>
<td>34.69</td>
<td>5.27</td>
</tr>
<tr>
<td>2014-01</td>
<td>15.33</td>
<td>14.00</td>
<td>11.83</td>
<td>27.16</td>
<td>3.50</td>
</tr>
<tr>
<td>2014-02</td>
<td>17.35</td>
<td>16.00</td>
<td>13.98</td>
<td>31.33</td>
<td>3.37</td>
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<tr>
<td>2014-03</td>
<td>15.64</td>
<td>12.00</td>
<td>14.20</td>
<td>29.84</td>
<td>1.44</td>
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<tr>
<td>2014-04</td>
<td>13.99</td>
<td>7.00</td>
<td>16.43</td>
<td>30.42</td>
<td>-2.44</td>
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<tr>
<td>2014-05</td>
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<td>4.00</td>
<td>29.91</td>
<td>49.01</td>
<td>-10.81</td>
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<tr>
<td>2014-06</td>
<td>6.84</td>
<td>2.00</td>
<td>11.31</td>
<td>18.16</td>
<td>-4.47</td>
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<tr>
<td>2014-07</td>
<td>6.13</td>
<td>1.00</td>
<td>11.73</td>
<td>17.86</td>
<td>-5.60</td>
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</table>
DEPARTMENT PERFORMANCE OVER TIME

Do not use a CBC as a routine screening test.
DEPARTMENT PERFORMANCE OVER TIME

Do not order annual EKGs for low risk patients.
## BRIGHT SPOT: CHOOSING WISELY

### Adult Primary Care 2015 (compared to 2013)

<table>
<thead>
<tr>
<th>Test Type</th>
<th>2013 Percentage</th>
<th>2015 Percentage</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCs at a physical</td>
<td>42.5%</td>
<td>3.1%</td>
<td>-39.4%</td>
</tr>
<tr>
<td>EKGs at a physical</td>
<td>14.9%</td>
<td>0.6%</td>
<td>-14.3%</td>
</tr>
<tr>
<td>DEXA scans</td>
<td>11.8%</td>
<td>2.5%</td>
<td>-9.3%</td>
</tr>
<tr>
<td>Imaging of headaches</td>
<td>6.5%</td>
<td>3.4%</td>
<td>-3.1%</td>
</tr>
</tbody>
</table>

**Additional Data:**
- 26,000 fewer unwarranted CBCs a year at a physical
- 6,500 fewer unwarranted EKGs a year at a physical
- 800 fewer unwarranted DEXA scans a year
- 60 fewer unwarranted CT/MRI scans a year
SUCCESS STORIES

Back office impromptu meetings

• Team posted provider report adjacent to Choosing Wisely guideline and supporting literature.
• 10 minute back hallway meeting as a team to review and discuss.

Team Projects

• Team independently decided to choose a separate Choosing Wisely guideline on PSA ordering as their team project.
• Choosing Wisely reports team able to support them with similar reporting format.
TIPS FOR SUCCESS

Consistency In Messaging From Leadership
• Collaboration helps drive change
• Recognition of success for strong performing providers/MOB’s

Endorsement of a Choosing Wisely Public Relations Campaign
• Internal and External

Organizational Adoption: “Spirit of the Campaign”
• Be open to examining practice variation within teams and departments
• Be aggressive in seeking new opportunities for improvement
“The member was ecstatic! He had researched Choosing Wisely and read Consumer Reports and found that everything we are doing is the right thing for him.”

Carl Czuboka, MD
KPGA Chief of Ambulatory Medicine
COLORADO
Tracy Ellen Lippard, MD
Medical Director of Geriatrics & Medicare
REGIONAL STATISTICS
Colorado “Vital Signs”

- 667,447 members
- 7,246 employees
- 1,100 physicians
- 2,000 nurses
- 30 medical offices
COMPLEX CARE
The Problem To Solve

5 percent of patients account for almost half of health care costs.

They suffer from multiple chronic health conditions, functional limitations, and unmet social needs.

They are often poorly served by current health care delivery, resulting in expensive downstream medical costs.

FEATURES OF SUCCESSFUL COMPLEX CARE PROGRAMS

Interdisciplinary, person-centered primary care

Careful targeting of interventions to persons most likely to benefit

Close communication and coordination among members of care team

Strong information and technology support

Promotion of patient and caregiver engagement in the care process

BRIGHT SPOT: PRIMARY CARE PLUS
Kaiser Permanente Colorado’s Solution

Primary Care Plus - Individualized, interdisciplinary care, focused on what matters most to the patient.

PC+ is a critical Kaiser Permanente Colorado solution to better align and personalize care delivery, while driving down health care costs, for the Colorado region’s population of high-need, high-cost Medicare members (approximately 9% of the Colorado region’s total Medicare members).

The PC+ care model is an interdisciplinary and proactive outreach and monitoring program and is based on thoughtful review of the core features of other successful complex care programs.
Align and personalize care delivery for Medicare members whose needs are complex and high cost by:

- Accurately identifying the “right” members for the program
- Improving the “right” care at the “right” time, in the “right” place, by the “right” team members
- Decreasing avoidable cost (avoidable hospital utilization, ER, specialists, medications)
- Increasing team function and satisfaction in the Primary Care department across disciplines
CARE GROUP SEGMENTATION

CG 1. Healthy

CG 2. Chronic Conditions

CG 3. Advanced Illness

CG 4. Frailty & End of Life

Benefits

- Services are aligned to needs of each Care Group
- Person-centered care is based on individual needs and values
- Geriatrics services are utilized optimally
- Healthcare is more cost effective

Eligibility:
• 65+ OR 18-64 and on Medicare AND
• Care Group 3, 4 OR Care Group 2 with triggers on Medicare Total Health Assessment AND
• Top 50% cost over the past 2 years

• Chart review
• Motivational interview to identify member goals and priorities
• Develop Care Plan

• Interdisciplinary Team (IDT) includes PCP, Clinical Pharmacist, RN, Palliative Care Specialist and LCSW
• Refine Care Plan

• Proactive outreach every 1-3 months
• Member may also contact RN directly
• Assess goal progress and any changes that require additional support
• Regular Care Plan updates
HOW PC+ DIFFERS FROM “USUAL” CARE

| PC+ provides an in-depth review and recommendations by an interdisciplinary team. | Using motivational interviewing techniques, the RN discovers and documents the member’s priorities and goals so that they can be shared with the interdisciplinary team. | Members can contact their PC+ RN directly. | The RNs contact the members on a regular basis – proactively checking in on goal progress or changes in the member's life that may indicate a need for additional support. |
HOW MEMBERS AND CAREGIVERS PERCEIVE PC+ CARE

Members and caregivers generally noted that being in the PC+ program offered them better access to care and more attentive care than outside of the program.

**Single Point of Contact**
"It makes you feel more comfortable. There’s somebody there you can go to. Instead of having to “call this number and go through this system” and all that. You can call her and she'll get back to you. That's comfortable for us to know that she’s there." – Member

**Better Access to Care**
"I called and she could tell that I needed help and I had an appointment the next day. I could never have gotten that with the normal appointment line. […] I probably would have just given up and waited to see if I got better or go to the hospital." – Member

**Care Continuity**
"She helps us navigate and better yet, it’s continuous so I don't have to start from zero. You get a new doctor and you usually have to start all over but [our PC+ RN] has everything there." – Caregiver

**Wellness Motivation**
"She has been working with me to stop smoking and to walk more. It’s hard but if I didn’t have her regular calls, it would be harder." – Member

**Reliable Information**
"We’ve gone over my pills and what would be better and when to take them… really helpful, because your pill usually says “take in the morning” and that’s it and she went over all my pills and I really like that opportunity." – Member
COMPLEX CARE RESULTS

PC+ Pilot Outcomes

- **PC+** required greater investment in care coordination, behavioral and social support, pharmacy, and palliative care.

- **PC+** proved valuable in decreasing inpatient utilization.

- Compared to a matched control group, **PC+** participants had a **21%** increase in office visit costs, which was dramatically offset by a **75%** decrease in inpatient costs.
### BENEFITS ACROSS THE “TRIPLE AIM”

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual cost savings were</td>
<td>3.5X the FTE investment (including RN care coordination, behavioral and social support, pharmacy, and palliative care).</td>
</tr>
<tr>
<td>In initial pilot group,</td>
<td>104 PC+ participants had 21 important pharmacy interventions (i.e. Alendronate starts) within the first 6 months of enrollment compared to 0 in the matched control group.</td>
</tr>
<tr>
<td>Specialty palliative care/hospice touches increased from</td>
<td>8% to 55% in the intervention group.</td>
</tr>
<tr>
<td>Via an early assessment facilitated by KP’s Care Management Institute,</td>
<td>PC+ was satisfying to providers, staff, members, and caregivers.</td>
</tr>
<tr>
<td>A holistic focus on the patient’s goals and priorities, meeting social and behavioral health needs, interdisciplinary team care planning, and proactive outreach and care coordination helped avert the financial and quality of life burdens associated with inpatient stays.</td>
<td></td>
</tr>
</tbody>
</table>
CHALLENGES TO MANAGING COMPLEX CARE

Potential Opportunity → Identification → Engagement → Doing the “right thing” → Doing the “right thing” reliably → Realized Improvement
ADVICE FOR IMPLEMENTATION

- Interdisciplinary, person-centered primary care
- Careful targeting of interventions to persons most likely to benefit
- Close communication and coordination among members of care team
- Strong information and technology support
- Promotion of patient and caregiver engagement in the care process
Q&A WITH REGIONAL PRESENTERS

**Purpose**

*Clarify and enrich* your learnings from these four presentations.
LUNCH
ACCELERATING LEARNING & SPREAD (XLS) STRATEGY

Jason Jones, PhD
Vice President Information
Strategy for Care Transformation
WE ARE NOT ALONE

With alarming regularity, many promising pilots in the health care improvement and implementation field have little overall impact when applied more broadly.”

Perla & colleagues, *Health Affairs* blog, April 2015

Source: Bevan 2016
EFFECTIVE LEARNING ORGANIZATIONS

Learning organizations understand...
what needs to be done to facilitate operational change,
why they exist—the imperative of customer experiences -- and
how change can occur at a pace consistent with external pressures.
BRINGING METHODS TOGETHER

Design driven by user needs and experiences

Systems driven by quality and efficiencies
CUSTOMER FOCUS

Implement depression care management programs across KP

A member who feels “off” emotionally can get trusted, personalized help, when, where and how they want it
XCELERATING LEARNING & SPREAD – 4 PHASES

Focus
Setting the strategic direction and priorities.

Understand
Defining what problems that need to be solved.

Design
Creating and rapidly prototyping a portfolio of solutions.

Integrate
Planning and implementing solutions at scale.
XCELERATING LEARNING & SPREAD – HOW IT WORKS

https://www.youtube.com/watch?v=KLjXU6tU0aE
EXERCISE: ANTICIPATING & REMOVING BARRIERS (PREP)

• As we go through the deck…
• Make a list of why XLS will fail
# XCELERATING LEARNING & SPREAD (XLS)

## Design Excellence

### Focus

<table>
<thead>
<tr>
<th>Strategic Intent</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What matters most?</td>
<td>Big strategic breakthroughs</td>
</tr>
</tbody>
</table>

### Understand

<table>
<thead>
<tr>
<th>Problem Definition</th>
<th>Scanning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong scanning capabilities</td>
<td></td>
</tr>
</tbody>
</table>

### Design

<table>
<thead>
<tr>
<th>Design</th>
<th>Prototype &amp; Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate portfolios</td>
<td>NEW</td>
</tr>
</tbody>
</table>

### Integrate

<table>
<thead>
<tr>
<th>Demonstrate</th>
<th>Operationalize</th>
<th>Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can this work?</td>
<td>How will this work?</td>
<td>Does it work?</td>
</tr>
</tbody>
</table>

## Key Questions

**Focus**
- **Key Questions**
  - Where do we need to make strategic progress?
  - What are our clinical, operational and breakthrough strategies?
  - Are we willing to commit resources?

**Understand**
- **Key Questions**
  - What is the problem?
  - What is the customer/user experience?
  - Where is the opportunity to make the most impact?
  - What effective practices currently exist?

**Design**
- **Key Questions**
  - What portfolio of solutions can address the opportunity?
  - Which solutions might delight patients and members?
  - What toolkit will we use in operations?
  - What information will we need to learn and spread?

**Integrate**
- **Key Questions**
  - Can the solution work in operations?
  - Are we ready to move to 3-5 sites?
  - What can we stop doing?
  - Did we transform behaviors and the experience in a meaningful way?
  - Do we proceed to full spread & scale?
FOCUS Setting the strategic direction and priorities.

- Where do we need to make strategic progress?
- What are our clinical, operational and breakthrough strategies?
- Are we willing to commit resources?
UNDERSTAND  Defining what problems need to be solved.

• What is the problem?
• What is the customer/user experience?
• Where is the opportunity to make the most impact?
• What effective practices currently exist?
DESIGN Creating and rapidly prototyping a portfolio of solutions.

• What portfolio of solutions can address the opportunity?
• Which solutions might delight patients and members?
• What toolkit will we use in operations?
• What information will we need to learn and spread?
INTEGRATE  Planning and implementing solutions at scale.

- Can the solution work in operations?
- Are we ready to move to 3-5 sites?
- What can we stop doing?
- Did we transform behaviors and experience in a meaningful way?
- Do we proceed to full spread & scale?

Demonstrate | Operationalize | Implement | Sustain
---|---|---|---
Can it work? | How will it work? | Does it work? |
$$ | $$$ | $$$ |
WHAT’S DIFFERENT IN THIS MODEL?

• Starts with a clearly identified problem

• Designs the portfolio and plans early testing and learning

• Makes clear data-based decisions across the life cycle – where to move next, release of funding, etc.
Our approach is to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts.

A key operating assumption of building capacity is that different groups of people will have different levels of need for PI knowledge and skill.
EXERCISE: ANTICIPATING & REMOVING BARRIERS (15 MINUTES)

• With the list of why XLS will **fail**…

• In pairs: Come up with a shared list to fail (5 min)

• In groups of 4: Come up with a new list of things you’re doing now that resemble the items on the list above (5 min)

• Stay with your group: For each item above, what initial step can you take to prevent that failure (5 min)
THE ROLE OF DATA INFORMING QUALITY & AFFORDABILITY WORK

Jim Bellows, PhD
Managing Director, Evaluation and Analytics
Kaiser Permanente Care Management Institute
#USES OF DATA IN OPTIMIZING PERFORMANCE

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>UNDERSTAND</th>
<th>DESIGN</th>
<th>INTEGRATE</th>
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</thead>
<tbody>
<tr>
<td>Strategic Intent</td>
<td><strong>Understand the opportunity</strong></td>
<td><strong>Design metrics to match solution</strong></td>
<td><strong>Drive improvement in operations</strong></td>
</tr>
<tr>
<td>Themes</td>
<td>• Population and outcome</td>
<td>• Develop metrics</td>
<td>• Operationalize reporting</td>
</tr>
<tr>
<td></td>
<td>• Current state, variation, gaps</td>
<td>• Agree on measurement plan</td>
<td>• Communicate results</td>
</tr>
</tbody>
</table>

1. What matters most? - Big strategic breakthroughs
2. Problem Definition - Strong scanning capabilities
3. Design - Generate portfolios

- Design metrics to match solution
- Drive improvement in operations
- Understand the opportunity

- Gate Review
- Demonstrate - Can this work?
- Operationalize - How will this work?
- Implement - Does it work?
- Sustain

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DATA HELPS KP BE A LEARNING HEALTH CARE SYSTEM

In a learning health care system, research influences practice and practice influences research.

**Evaluate**
Collect data and analyze results to show what does and does not work.

**Implement**
Apply the plan in pilot and control settings.

**Design**
Design care and evaluation based on evidence generated here and elsewhere.

**Adjust**
Use evidence to influence continual improvement.

**Disseminate**
Share results to improve care for everyone.

Internal and External Scan
Identify problems and potentially innovative solutions.

STARTING WITH QUALITY IS OUR MOST SUSTAINABLE PATH TO AFFORDABILITY
WHY IS QUALITY OUR BEST STARTING POINT?

Focusing on quality objectives leads to better member buy-in and provider engagement.

Quality indicators often actualize before affordability indicators, providing projects momentum and sustainability.
STARTING WITH QUALITY IS OUR MOST SUSTAINABLE PATH TO AFFORDABILITY

Shared Decision Making (GHC)
How can we help patients get the treatment that best fits their preferences?

Utilization Action Teams (SCAL)
How can we prevent cervical cancer in our patients?

Choosing Wisely (GA)
How can we spare our patients from receiving non-efficacious care?

Complex Care (CO)
How can we understand and address patients’ needs when usual protocols aren’t enough?
INFORMATION AND DATA REINFORCES PRIORITIES

Choose Wisely

• Stakeholders that count
• Priority populations
• Measures that matter
• Processes ↔ outcomes
• Value to customers
INFORMATION AND DATA REINFORCES PRIORITIES; CHOOSING WISELY

Shared Decision Making (GHC)
Patients are important customers of information and data

Choosing Wisely (GA)
Focus on a reasonable number of opportunities, relevant to daily clinical practice

Utilization Action Teams (SCAL)
Balance measurement sets, e.g., both overuse and missed opportunities

Complex Care (CO)
Measure what matters most, even if it’s hard
- easy: utilization
- hard: quality of life
ALIGN INFORMATION AND DATA, FROM POLICIES AND PROGRAMS TO POINT-OF-CARE DECISION SUPPORT

• What do we need to do?
• Are we getting it done?
• Which patients need attention?
• What are the clinical options?
• What will work best for me?

Health system level – Guidelines and standards
Organization level – Priorities and accountability
Population level – Care management
MD level – Decision support and feedback
Patient level – Empowerment
RIGHT DATA + RIGHT COMMUNICATION ➔ ACTION

Timely

Owned – *clarify accountabilities*

Actionable – *show time trends*

Specific

Talked about – *make transparent*
RIGHT DATA

**Shared Decision Making (GHC)**
Aligned messages to both clinicians and members

**Choosing Wisely (GA)**
Coupled data with CME to produce desired result

RIGHT COMMUNICATION

**Utilization Action Teams (SCAL)**
Agreed on common patient safety goals and tightly linked to reports

**Complex Care (CO)**
Used focus group data to design solutions to close care gaps

ACTION
GUIDED ANALYTICS CONNECTS DATA ACROSS LEVELS

Organizational Dashboard
- Multiple focus areas, both outcomes and processes
- Goals, status, trends, variation

Actionable Local Reporting
- Drillable to encounter level
- Based on control chart principles

Encounter Level Reporting
- Supports improvement at front lines
- Provides rapid insight into opportunities
DATA GOES BEYOND NUMBERS

Shared Decision Making (GHC)
Provider feedback

Utilization Action Teams (SCAL)
Literature review

Choosing Wisely (GA)
Analytics carefully validated by chart review

Complex Care (CO)
Developmental Evaluation
- Chart review
- Focus groups
EMBRACE “GOOD ENOUGH” DATA

• Only test hypothesis to the degree necessary

• Data that is directionally accurate may be sufficient to motivate action

• Differentiate between coding changes vs. “real” changes

• Understand that analytics may be limited for developmental programs
BUILD COLLABORATIVE RELATIONSHIPS

Clinicians + patients

Quality analysts + Cost analysts

Leadership + front line

Clinicians + analysts
QUALITY LEADERS’ DATA RESPONSIBILITIES

Start with the end in mind
- What decisions must be made?
- What actions do you want to motivate?
- What information do the stakeholders need?

Choose the right analytic products
- Think beyond the dashboard, especially point-of-care decision support

Get the right things measured, measured right

Engage stakeholders and foster collaboration

Use results to drive improvement
OUR JOURNEY CONTINUES

- Standardizing data definitions across the enterprise
- Making clinical decision support increasingly specific to context
- Tracking and aligning with members’ priorities and preferences
- Balancing public reporting with internal priorities
- Coordinating among many decentralized analytic units
- Balancing timeliness and rigor in program evaluation
- Integrating data across legacy systems

…and so much more.
Q&A / “Taking it Home”
Based on what you just heard, what is one thing that you can do to advance spread and scale at your organization, utilizing data?
“EACH ONE TEACH ONE” - INTERACTIVE EXERCISE

Purpose

Seize the opportunity to contribute to today’s learnings!

1. Consider these 2 questions:
   a. What are a few areas your organization is exploring to advance high-quality and affordable care?
   b. Based on above, what could you add to what you learned today, to enhance our collective learning around high-quality and affordable care, and accelerating learning and spread?

2. Each participant reflects, then shares “adds” with table-mates.

3. The table agrees on 1-3 “adds” to report out to the room.