Delivering High-Quality Primary Care

December 12, 2017
<table>
<thead>
<tr>
<th>Speakers</th>
<th>David Dorr, MD, MS</th>
<th>Julia Murphy, MSc</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Areas of Focus</strong></td>
<td>- Practice transformation</td>
<td>- Practice transformation</td>
</tr>
<tr>
<td></td>
<td>- Informatics capability enhancement</td>
<td>- Scaling models of care</td>
</tr>
<tr>
<td></td>
<td>- Changes from Policy to Practice</td>
<td>- Performance management</td>
</tr>
<tr>
<td><strong>Project Highlights</strong></td>
<td>- Lead, Oregon Regional Learning collaborative for CPC/CPC+</td>
<td>- Lead, Scaling a model of high-performance primary care</td>
</tr>
<tr>
<td></td>
<td>- TOPMED</td>
<td>- Lead, implementing outcomes based performance management (NHS Scotland)</td>
</tr>
<tr>
<td></td>
<td>- Faculty, Peterson Center on Healthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.ohsu.edu/cmp">www.ohsu.edu/cmp</a></td>
<td></td>
</tr>
</tbody>
</table>
Session Objectives

1. Learn how foundational activities, like improving patient access and delegating administrative and clinical tasks, can help unlock the joy of practicing medicine and allow care teams to focus on patients the way they hoped for when they started their training.

2. Understand how primary care practices can create and maintain practice level ownership and engagement for transformation.

3. Understand how these modules set up practices to take on more complex care delivery changes, and how they begin cementing a culture of continuous improvement.

4. Develop and test an evidence-driven curriculum in primary care practices.

These presenters have nothing to disclose.
Enumerate a detailed model with structures, processes, and expected outcomes?

To deliver high quality primary care, should we ...

OR define outcomes that we hope for, train practices in improvement and innovation techniques, and ask them to go wild?
The Consolidated Framework for Improvement Research tells us: ‘a bit of both’

BUT change can be...

- Fatiguing, leading to burnout, turnover and stagnation
- OR it can be joyful, meaningful, and exciting

How do we facilitate the uptake and spread of models that can provide joy and avoid (or, better, reduce) burnout?

- FOCUS ON RELATIONSHIPS;
- TAP INTO INTRINSIC MOTIVATION; and
- THEN FACILITATE THE PROCESS OF ADOPTION
Current model of high-performance primary care

10 Features of High-Performance Primary Care

- **Deeper relationship with patients**
  - Always on
  - Conservation and conscientiousness
  - Patient complaints are gold

- **Expanded breadth of responsibility**
  - In-source rather than out-source
  - Stay close after referral
  - Close the loop

- **Leverage the team, not physical assets**
  - Upshift staff roles
  - Hived workstations
  - Balance compensation
  - Invest in people, not space and equipment

“America’s Most Valuable Care”

15,000 practices reviewed

< 5% of practices matched high-performance criteria

Site visits to identify features
Engineering content from best practice principles

Clinical Processes

Administrative Processes

10 Features

4 Worksystems

People Management

Operations Management

Information Management

Patient Partnership

22 Modules

100+ “Future State Functions”
We made the model actionable by embedding it in a process.
Our process is designed to create meaningful and lasting change by connecting intrinsic motivators to technical changes.

**Intrinsic motivators**

- Building relationships
- Doing the best job possible
- Continuing to learn

### The most influential technical changes people can make:

- Administrative and clinical leadership dyad
- Dedicated 1:1 staffing ratio (provider/care team relationship)
- Daily huddling (regular communication mechanism)
- Same day access to own doctor (patient/provider relationship)
- Ensuring all follow-up and preventive care is provided
Stories

“Our relationships with our own patients are very important to us. Changing from a walk-in clinic to a primary care practice with same day access brought joy back to the practice because the providers are seeing their patients.”

Medical Director

1:1 Nurse/MD pairings are part of our culture and our physicians have been very vocal about keeping our staffing ratios to allow for these pairs whenever they are threatened.”

Practice Manager

As nurses, we want to have the kind of relationships with patients that allows us to care for, teach, and support them because we know one another.”

LPN
Reflection

• Reflect on your own experience implementing improvement efforts in primary care

• How have your factored in:
  o Building relationships
  o Enabling people to do the best job possible
  o Continuously learning

• How has this impacted the success of your effort?
Extrinsic motivators become increasingly important as practices make harder changes.
“Productivity pressures threatened to derail our same day access. There was pressure to fill rather than hold any slots for same day availability. As a practice we had to show system leaders that we had the demand to fill those slots.”

Physician Leader

“As the system rolled out same day access across practices the expectation that patients see their own doctor changed. We had to meet with central scheduling leaders and explain why we wanted patients scheduled to see their own doctor.”

Physician Leader

“Securing staffing to support a 1:1 provider/nurse model required that I ask for an exception to the current staffing model. The regional leaders were hesitant to commit to the change and further conversations were required at the system level in order to ensure that the nurses at my clinic wouldn’t be floated out to cover in other locations.”

Project Manager
System constraints that conflict with practice changes

- RVU pressures derail changes to access
- Centralized services not aligned with practice-level priorities
- Workforce shortages put staffing ratios at risk
- Practice reimbursement doesn’t reward non-encounter based work making new work outside the visit difficult to sustain
- Physician compensation doesn’t align with risk-bearing contracts
System leadership need to be actively engaged in practice-level changes

1. A senior executive (sponsor) oversees the work and visits the practice monthly
2. Sponsor gets agreement from key senior leaders at the start of contracting
3. Sponsor engages the full range of leaders who might be impacted
4. Practice and system leaders regularly review goals and progress
5. Leadership protects practices from constraints in the larger system
Reflection

• Reflect on your own experience of implementing improvement efforts in primary care
  • How have you engaged system leadership to support practice level progress?
  • How have you resolved conflicting messages in support of practice level changes?
• How has this impacted the success of your effort?
### Actionable changes that could be acted upon in your own improvement efforts

<table>
<thead>
<tr>
<th>Tapping into intrinsic motivators</th>
<th>Aligning extrinsic motivators</th>
<th>Engaging system leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice dyad talks daily about what’s working, what’s not and what needs to change</td>
<td>• Physicians only participate in changes that require their involvement to minimize loss in billable time</td>
<td>• System leaders attend practice meetings (participate in PDSAs) where their role is to listen, ask questions, help identify barriers and take action to resolve system constraints</td>
</tr>
<tr>
<td>• Practice dyad asks practice members what they’d like to change and lets them lead that change</td>
<td>• Request from leadership a small change in compensation to reward non-encounter based work</td>
<td>• Practice dyad talks with their leaders regularly to understand what is important to them and to engage them in what matters to the practice</td>
</tr>
<tr>
<td>• Design the change at the smallest unit possible and collect information on what matters most to those involved in the test</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Many of you might already have a starting point, e.g....
3 questions to answer

• What motivates or compels you to do this work?

• What actionable changes described here could you take back to your own organization?

• What would help you be more effective in implementing changes at the practice and/or system level?