PARTICIPANT HANDOUTS
Distance Learning Event:
Utilizing Data Effectively to Advance Team-Based Care

Presented by:
Melissa Stratman, CEO Coleman Associates

Live Broadcast Date/Time:
Wednesday, August 15, 2018
12:00–1:30pm Mountain Time / 1:00–2:30pm Central Time

Event Overview:
‘Data-driven decision making’ and ‘team-based care’ are two phrases that are thrown around everywhere in healthcare today. What does data-driven decision making look like practically and how we can determine which metrics to use, why to use them and how to leverage them to impact decisions. In this 90-minute webinar we will cover key operational and quality metrics that are used increasingly at the Care Team Level to guide decisions and help influence workflows and processes. Learn what a healthy, data-driven team looks like, learn some of the characteristics of these high performing teams and some steps to get you from here to there.

Learning Objectives:
At the end of this session the attendees will be able to
1. Identify key metrics that impact everyday workings of Patient Care Teams
2. Identify effective and ineffective data communication tools
3. Articulate the most important aspects in communicating effectively around operational data
4. Understand the relationship between data and improving team based care outcomes

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CCHN ARCHIVE
This event will be archived online. The online version will be available within two weeks of the live event. For information about all CCHN archives, please visit http://cchn.org/webinar-archive/.
DESCRIPTION OF CCHN
Colorado Community Health Network (CCHN) is a non-profit organization representing the 20 Colorado Community Health Centers (CHCs) that together are the backbone of the primary health care safety-net in Colorado. CCHN is committed to educating policy makers and stakeholders about the unique needs of CHCs and their partners, providing resources to ensure that CHCs are strong organizations, and supporting CHCs in maintaining the highest quality care. For more information about CCHN, please visit www.cchn.org.

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, please visit www.CHAMPSonline.org.

SPEAKER BIOGRAPHY
Melissa Stratman has a diverse healthcare background and is the owner and CEO of Coleman Associates. Coleman Associates is a healthcare training and consulting firm with a strong mission and an over 20 year reputation helping improve operations, finances, teamwork, quality of work life as well as patient outcomes and satisfaction.
Using Data Effectively for Advancing Team-Based Care

Webinar - August 15, 2018
Interactive Question

Does your clinic currently use data to improve functionality of care teams and/or clinic operations?

- Yes, we use data to improve care team functionality and clinic operations
- Yes, we use data to improve care team functionality only
- Yes, we use data to improve clinic operations only
- No, we do not use data to improve these areas
- Unsure
Interactive Question

How many total people are watching this event at your computer (yourself included)?
Learning Objectives

At the end of this session the attendees will be able to

- Identify key metrics that impact everyday workings of Patient Care Teams
- Identify effective and ineffective data communication tools
- Articulate the most important aspects in communicating effectively around operational data
- Understand the relationship between data and improving team based care outcomes
Potential Conflict of Interest

- I, Melissa Stratman, own and manage a consulting firm that for hire helps organizations to learn, incorporate and fully adopt some of the principles of data use in team-based care that are outlined here.
Using Data Effectively for Advancing Team-Based Care
Team Based Care

- There are many ways to look at Team Based Care. Today we look at it through the lens of data and data used in exemplary team-based care model.
- Three areas of consideration
  - People
  - Processes and
  - Technology
The Hub of Patient Care

Let me in

Don’t waste my time

Care about me more than I do

Figure me out & fix me

Give me the best

What Patients Want
The Hub With NCQA PCMH 2017 Concepts & Competencies

- **What Patients Want**
  - Let me in
  - Give me the best
  - Don’t waste my time
  - Figure me out & fix me
  - Care about me more than I do

- **PMCH AC**, Competency AC 01, 02, 03,
- **PMCH: KM & TC**, Competency TC, 04
- **PMCH: CM 04 -06 & KM 20, CC 04-05**
- **PMCH CC 04, CC19, QI Competency B**
- **PMCH: KM, Competency C & F, KM12, KM21**
Team Based Care Deconstructed

- At that time, it became clear to Coleman Associates that for healthcare to experience the boosts that other industries had credited to a team culture…. in healthcare we would have to move FROM a provider- patient relationship centered model TO a team-based model of work that is wholly patient centric.
Author Patrick Lencioni

- 5 Dysfunctions of a Team
  - Trust, Commitment, Healthy Conflict, Accountability, Attention to Results (data)
- Three Signs of a Miserable Job
  - Anonymity, Immeasurement, Irrelevance
Evolution to Team-Based Care

- This is much harder than it sounds … technically and culturally.
- We are still very much in process. Very few places have “nailed it” in part… It is often changing.
- Everyone touts “team based care” yet the models are wildly diverse…not always in a good way.
- In most instances, patients are not yet raving about our new ways of working in teams.
Team Based Care is No Longer Just ‘A Good Idea’

- Why team based care is the future....
  - Patient demand for services seems to be increasing....especially in areas of behavioral support.
  - Patient expectations are changing.
  - Our expectations about our work day/work life balance are changing.
  - The amount of “outside the visit work” seems to be growing as technology leads us to new ways of giving care.
No Longer Just ‘A Good Idea’

Why team based care is the future....

- The current model seems to be leading to stress / burn out.
  - Triple Aim (quality, patient experience and cost) → Quadruple Aim (+ burn out)
- Primary care provider numbers are decreasing.
- We can train support staff more quickly than physicians …teams must take on more.
- Some support functions are easily automated.
No Longer Just ‘A Good Idea’

- From a changing financial picture…
  - Reimbursement structures are shifting forcing us to look for new ways to provide effective care.
  - Ability to engage in risk – reward systems requires higher quality, tighter systems and a knowledge of your patients
  - The catch-as-catch-can system of healthcare delivery is not a financial model.
Data-Driven Change is Needed

- We need to continue to evolve, but these changes must be made thoughtfully, using evidence and data to drive, tailor and sustain changes.
Leading Change with Data
Today We Will Discuss

- Data Goals
- Common Pitfalls in using data
- Communicating goals & data to inspire action
- Outside influences:
  - Patrick Lencioni’s Three Signs of a Miserable Job
  - Simon Sinek, Ted Talks
  - Jim Collins, Good to Great
  - Quint Studor
- Undergirded by a Case Study you can read about
A Case Study

- Health Center Organization with > 30 sites
- Large to small size sites across urban & suburban
- Residency program
- EHR and electronic systems
- Reasonable reputation within the community
- Ready to take their strategic plan forward
- Committed top leadership with a patient-centric mentality
- Ready to pursue both NCQA and Joint Commission PCMH
- Looking for true transformation that both patients and staff could feel
- Read more about them at Coleman Associates.com (Making PCMH Leven 3 a Reality) or in the Journal for Ambulatory Care Management (July and August 2018)
DPI Results

**Median Cycle Time**
- 36 minutes
- 67% decrease from baseline

**Average no-show rate**
- 13%
- 43% decrease from baseline

**Average TNAA**
- Full-time PC>7 days Full-time OB=5 days
- Full-time PC=7% decrease from baseline; Full-time OB=50% decrease from baseline

### Overall Median Cycle Time
- Baseline: 110 minutes

### Overall Avg. No-Show Rate
- Baseline: 12%

### Overall Avg. Third Next Available Appointment
- Baseline: 10.5 days
Why Do YOU Use Data?
Patrick Lencioni’s Three Signs of a Miserable Job
“Human beings need to be needed, and they need to be reminded of this pretty much every day. They need to know that they are helping others, not merely serving themselves.”

– Patrick Lencioni

“See management is an everyday thing. Strategy & financial reporting are not.”

– Patrick Lencioni
Why Do We Track Data?

- Because good data provides a better patient experience.
- To give employees a goal post.
- To know whether progress is being made or not.
- To put the day in perspective.
- To create a Performance-Based Culture instead of one based on feeling.
- Because our bottom line depends on it. FFS.
- HEDIS/UDS Measures & Value Based Payment.
- Your board or external management may require it.
Piloting new ideas requires freedom and an encouragement to try all ideas and see which ones work and which ones fail.

This is NOT in conflict with standardization but instead requires bravery and the ability to build new tests on the solutions found, and then standardize.

This is also not the same as try something new all the time... innovation is important, but it should be in a guided environment.
What Data Do You Monitor at Home?

- In your personal life, what data do you monitor on a frequent basis?
What Should You Measure?
Importance, Urgency, & Simplicity

- **Speedometer**: Critical to safety, changes frequently, & is calculated in MPH
- **Odometer (Mileage)**: Affects service management, resale value, updates within minutes if following directions, & is calculated by measuring the distance traveled
- **Fuel Gauge**: Essential to avoid breakdowns or excess gas stops and it’s variable based on the speed and length of your trip
- **Oil Pressure Warning Light**: Gives advanced warning of potential mechanical failure because engine can breakdown with sudden drop in pressure
What it Doesn’t Have?

- Valve wear Gauge: Because valve wear happens slowly over time, and the effect are not immediately important.
- Crash Indicator: Because the fact that a crash has happened is overwhelming and doesn’t require confirmation.
- Paint Fade Pattern: Because the degree to which the paint is fading is not materially relevant to any issue of efficiency, safety, or comfort.
Our Frame of Reference

- The orange dots are actually the same size
- But our perception tells us something quite different …..
- Measurement removes that bias

Ebbinghaus Illusion
The Ideal Culture Around Data

- Public
- Transparent
- Simple—one page
- Understandable—even to a novice
- Not anonymous
- Up-to-date

**MOST IMPORTANTLY… it stirs to action
…Not responding is the same as accepting results**
5 Common Pitfalls We See

In our Dramatic Performance Improvement Work™, the most common pitfalls we see are:

1. Leadership has data, but staff don’t see it. You can find out whether this is true by asking a MA, ”what’s your provider’s No-Show rate?”

2. Data is too high level and staff don’t relate to it. For example, overall Cycle Time is posted but individual Patient Care Teams don’t know their Cycle Time.
5 Common Pitfalls to Use Data

3. Data is shared in monthly or worse, quarterly format. It’s too late to do anything to change it when it’s shared too late!

4. Staff see the data but don’t get “what’s in it for them.” For example, do they get recognized based on their metrics? Does someone get recognized more for high performance or not? What about those who aren’t pulling the oars, is there accountability for results?

5. The data is inaccurate or staff don’t trust it. Often fancy Dashboards download big data from EHR into excel. If it’s not validated, it can be wrong and therefore, mistrusted.
What Metrics Drive your Team-based Care?
How Do You Know If You’re Making Progress?

- No-Show Rate
- Productivity
- Capacity Used
- TNAA
- Cycle Time
- Quality Metrics
- Pharmacy Refill Rates?
- Services per visit
Measuring Data in Real Time

<table>
<thead>
<tr>
<th>Appr Time</th>
<th>Arr Time</th>
<th>Out Time</th>
<th>CT</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>8:02</td>
<td>8:27</td>
<td>20</td>
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<td>8:30</td>
<td>8:40</td>
<td>9:00</td>
<td>20</td>
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<td>9:00</td>
<td>9:04</td>
<td>9:27</td>
<td>20</td>
<td></td>
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<tr>
<td>10:06</td>
<td>10:37</td>
<td>10:29</td>
<td>32</td>
<td></td>
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<td>11:00</td>
<td>11:25</td>
<td>11:25</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>11:10</td>
<td>11:10</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

# Pt Sched: 5
# Pt Seen: 6
Utilization: 75%
Baseline: 50%

No Show %: 0
Missed Opp: 2
Avg CT: 21.8

<table>
<thead>
<tr>
<th>Appr Time</th>
<th>Arr Time</th>
<th>Out Time</th>
<th>CT</th>
<th>Notes</th>
</tr>
</thead>
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<tr>
<td>7:52 am</td>
<td>8:32 am</td>
<td>9:00</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>8:17</td>
<td>8:51</td>
<td>9:30</td>
<td>3A</td>
<td></td>
</tr>
<tr>
<td>8:29</td>
<td>9:30</td>
<td>10:21</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>11:02 am</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:35 am</td>
<td>11:30 am</td>
<td>55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pt Sched: 7
Pt Seen: 6
Utilization: 80%
Baseline: 80%

No Show %: 1
Missed Opp: 1
Avg CT: 47

It was not able to get exact for availability.
Patient Messaging in Real Time
About Data to Affect Culture
Change

NO SHOW = NO GOOD

Yesterday we had 6 patients no show for scheduled appointments.
That means that 6 appointments went unused.

We need YOU to help us work to our full potential.
Please tell us as soon as you know you cannot make it.
Thank you for your help!
Another Patient Messaging Tool

**March 2014**

692 patients **did not call** to cancel their appointment in March!

**Working together** to improve your patient experience!

If you can't make your appointment call (555) 123-4567. Timely cancellations provide better access and care to all patients, including you!!

© Coleman Associates
An Exercise

- When you view the following data communication tools (Data Dashboards), give me the thumbs up or thumbs down on whether you can easily tell:
  - Are they doing well or not?
  - Is it simple?
  - Would front-line staff respond and be motivated by it?
Teams sorted according to **Light Status** with a focus on No-Show Reduction!

**Green** means teams met Collaborative No-Show reduction target of ≤ 5%.

**Orange** means teams that have achieved greater than 50% No-Show reduction, but have not yet met Collab goal.

**Red** means teams have not achieved 50% No-Show reduction.

🌟 **Gold Stars!** As we wind down LAPI, we want to acknowledge teams who have ended strong and achieved their personal best in one or more of the following categories: No-Show Rate, Cycle Time, Productivity and Missed Opportunities.

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**TEAM RESULTS for WEEK 7:**

<table>
<thead>
<tr>
<th></th>
<th>Baseline No-Show Rate</th>
<th>No-Show Rate</th>
<th>Cycle Time</th>
<th>Productivity</th>
<th>Missed Ops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredibles</td>
<td>35%</td>
<td>0%</td>
<td>37.3</td>
<td>4.1</td>
<td>4</td>
</tr>
<tr>
<td>Victoria</td>
<td>36%</td>
<td>2.05%</td>
<td>38.7</td>
<td>3.2</td>
<td>4</td>
</tr>
<tr>
<td>- Transformers</td>
<td>15%</td>
<td>2.2%</td>
<td>39</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Nest</td>
<td>18%</td>
<td>9%</td>
<td>37</td>
<td>3.1</td>
<td>3</td>
</tr>
<tr>
<td>Access Angels</td>
<td>31%</td>
<td>10%</td>
<td>46</td>
<td>0.7</td>
<td>6</td>
</tr>
<tr>
<td>MMS</td>
<td>29%</td>
<td>12.0%</td>
<td>64.32</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Proc - Kambio</td>
<td>21%</td>
<td>12.8%</td>
<td>36</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Evard - Team Grand</td>
<td>36%</td>
<td>23.7%</td>
<td>103</td>
<td>1.9</td>
<td>0</td>
</tr>
</tbody>
</table>

© Coleman Associates
Check out Team Results, LAP3, WEEK 1:

No-Show Rate - Collab Average

Uh oh! 67% of DPI PCTs are running their entire DPI Model. That's 5% less than last week.

EPIC training, last week, plus more teams need to roll out to another team per week.

LAP3 Week 1 Productivity

Green = teams over 3 pts per hour

LAP3 Week 1 Cycle Time

Hawthorne 6/6

TNAA Capacity Used

© Coleman Associates
Patient Pick Up Volume Per Day

Oct 2016 - Jan 2017: 140
Oct 2017 - Jan 2018: 168

20% Overall Improvement in # of Pharmacy Pick Ups Per Day
Pharmacy Return to Stock Rate

37% Overall Decrease in RTS Rate
# A Quality Dashboard

## Patient Experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Period</th>
<th>Target Value</th>
<th>2017 YTD Baseline</th>
<th>FY Q1</th>
<th>FY Q2</th>
<th>FY Q3</th>
<th>FY Q4</th>
<th>2017 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH % of patients with overall satisfaction rates of &quot;very satisfied&quot;</td>
<td>Monthly</td>
<td>96%</td>
<td>79%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>108%</td>
</tr>
<tr>
<td>PCMH % of patients who would recommend to a friend or relative</td>
<td>Monthly</td>
<td>95%</td>
<td>79%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>105%</td>
</tr>
<tr>
<td>PCMH % of providers with overall satisfaction rates of &quot;very satisfied&quot;</td>
<td>Monthly</td>
<td>82%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87%</td>
</tr>
<tr>
<td>SOC Total Number of Patients Served</td>
<td>Quarterly</td>
<td>195,000</td>
<td>193,782</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>180,179</td>
</tr>
<tr>
<td>PCMH Unreported/Refused to Report Race</td>
<td>Quarterly</td>
<td>42%</td>
<td>45%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42%</td>
</tr>
<tr>
<td>PCMH % of patients with income of &gt; 40%</td>
<td>Quarterly</td>
<td>32%</td>
<td>21%</td>
<td></td>
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<td></td>
<td></td>
<td>32%</td>
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</table>

## Patient Safety

<table>
<thead>
<tr>
<th>Measure</th>
<th>Period</th>
<th>Value</th>
<th>2017 YTD Baseline</th>
<th>FY Q1</th>
<th>FY Q2</th>
<th>FY Q3</th>
<th>FY Q4</th>
<th>2017 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety - % of patients with income of &gt; 40%</td>
<td>Quarterly</td>
<td>32%</td>
<td>21%</td>
<td></td>
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<td></td>
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<td>32%</td>
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<tr>
<td>Patient Safety - % of patients who would recommend to a friend or relative</td>
<td>Monthly</td>
<td>95%</td>
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<td>82%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87%</td>
</tr>
<tr>
<td>Patient Safety - % of serious safety events (SSEs) reported to in 48 hrs</td>
<td>Monthly</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Patient Safety - % of safety events reported</td>
<td>Monthly</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Patient Safety - % of critical lab values reported to providers within 1 hour</td>
<td>Monthly</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
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</table>

## Health Outcomes

### Chronic Disease

<table>
<thead>
<tr>
<th>Measure</th>
<th>Period</th>
<th>Value</th>
<th>2017 YTD Baseline</th>
<th>FY Q1</th>
<th>FY Q2</th>
<th>FY Q3</th>
<th>FY Q4</th>
<th>2017 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with diabetes who have had an eye exam</td>
<td>Monthly</td>
<td>55%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>55%</td>
</tr>
<tr>
<td>% of patients with diabetes who have controlled BP of 140/90</td>
<td>Monthly</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Diabetes: Adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is &lt; 8% (out of control) or had no test</td>
<td>Monthly</td>
<td>80%</td>
<td>11%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>% of patients with comprehensive diabetes care - nephrology</td>
<td>Monthly</td>
<td>96%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>96%</td>
</tr>
<tr>
<td>% of patients with comprehensive diabetes care - nephrology</td>
<td>Monthly</td>
<td>96%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>96%</td>
</tr>
<tr>
<td>Chronic Disease - Colorectal Cancer Screening: Patients age 50 to 75 years who have appropriate screening for colorectal cancer (includes colonoscopy ≤ 10 years, flexible sigmoidoscopy ≤ 5 years, or annual fecal occult blood test)</td>
<td>Monthly</td>
<td>94%</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
</tr>
<tr>
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<td>21%</td>
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<td></td>
<td></td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Asthma: Patients age 5 to 64 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed long term control medication or an acceptable alternative pharmacologic therapy during the current year</td>
<td>Monthly</td>
<td>80%</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Coronary Artery Disease/Atrial Fibrillation: Patients age 18 years and older who were discharged for AMI, CABG, or PTCA, or who had a diagnosis of ICD, and who had documentation of use of aspirin or another antithrombotic during the measurement year</td>
<td>Monthly</td>
<td>85%</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>Chronic Disease - Cardiovascular Disease: Adult patients 18 years and older, with hypertension whose most recent blood pressure was less than 140/90 (adequate control)</td>
<td>Monthly</td>
<td>94%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
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### Behavioral Health

<table>
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<th>2017 YTD Baseline</th>
<th>FY Q1</th>
<th>FY Q2</th>
<th>FY Q3</th>
<th>FY Q4</th>
<th>2017 YTD</th>
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<td>Follow-up after hospitalization for mental illness - 30 day follow-up</td>
<td>Monthly</td>
<td>65%</td>
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<tr>
<td>Follow-up after hospitalization for mental illness - 30 day follow-up</td>
<td>Monthly</td>
<td>65%</td>
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<tr>
<td>Initiation and engagement of ADI/Dependence Treatment - Engagement</td>
<td>Monthly</td>
<td>65%</td>
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<tr>
<td>Initiation and engagement of ADI/Dependence Treatment - Engagement</td>
<td>Monthly</td>
<td>65%</td>
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</table>
Data Wall
LAP3 Week 2 Data:

Light Statuses:

**Green:** Next Week: No-Show Rate is <10% or lower. Cycle time is within 20% of goal. (Below 37 minutes). Productivity is over 3.25 PPH, Capacity-used in 90% or higher, TNAA is 3 days or less!

**Yellow:** Next Week: No-Show Rate is 30-49% below baseline. Cycle Time is 37-50 minutes (within 21-66% of goal). Productivity is between 3 – 3.25 PPH. Capacity-used is 85 – 90%. TNAA is between 7-4 days.

**Red:** Next Week: No-Show Rate is less than 29% below baseline. Cycle time is 51 minutes or higher. (within 70% of goal.) Productivity is less than 3 PPH. Capacity-used is lower than 85%. TNAA is 8 days or higher.
# Behavioral Health Productivity Monitoring

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
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<td>2</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Total:** 18 / 8  16 / 15  30 / 13  32 / 4  16
Performance Dashboard

**Cycle Time**
- Goal: Minimize cycle time.
- Measures total time in the building for patients. This is a measure of patient experience.

**Patients Per Hour**
- Goal: Maximize patient throughput.
- Measures the efficiency of the Patient Care Team and includes a 0.33 Credit for each HSS Sign-off.

**% Voice Confirmed**
- Goal: Improve patient communication.
- Measures your ability to reach your patients and is directly linked to your No-Show Rate.

**Weekly Access Summary Report**
- ALL TEAMS
- Tracks various metrics weekly.

**TNAA**
- Goal: Improve patient access.
- Measures access by identifying the time (in Days) that a patient has to wait (On average) to be seen.

**No Show Rate**
- Goal: Minimize no-shows.
- Measures the relationship patients have with their health center. High No-Show rate = reduced patient access.
Aqua Pod

Cycle Time: Measures total time in the building for patients. This is a measure of patient experience.

19.8% Clinic Reduction in Cycle Times

Average Patients Seen per Session

Goal = 10

Patients per session: Measures the efficacy of the Patient Care Team. The goal is to NOT affect the 20 minutes allotted for provider face to face time with the patient but to eliminate the “extra stuff” around the visit.

10.2% Clinic Increase in Productivity

Dashboard Game

We want your feedback and questions! What does the data mean to you and how does it affect your daily tasks? Giving away a “Dashboard Bar” to everyone who emails me with answers to these two questions!

% of Charts Closed

90% of Charts Closed: Measures the relationship between chart accuracy and provider satisfaction.

Missed Opportunities

Missed Opportunities: Measures the patient’s needs and effectiveness of the patient care team tetrisizing options.

3rd Available

3% Clinic Reduction in TNAA

Third Next Available: Measures access to care by identifying the time that a patient has to wait to be seen.

* Vacation
Last week, Baby Got Back on Track rolled out No-Show reduction to all schedules. This caused a huge uptick in No-Show Rate, which will be discussed as LS2 as well as tactics and tools to get it back down now that the DPI Team has rolled out confirmation calls to everyone.
A Site in Los Angeles

No-Show Rate

54% Overall Reduction

No-Show Rate - November - February

Baseline = 33%

Goal = ≤ 10%
First Steps… One Site’s Mock Up
The Final Product
What did you see

- Text in patterns you saw in data tables that “speak” to you.
What Are Your Take-Aways?
Goals and Baseline Data
What is your baseline for your initiative?

- No-Show Rate
- Productivity
- Capacity Used
- TNAA
- Cycle Time
- Quality Metrics
Case Study

- It was very unusual and very effective and unlike any other group to not approach goals from the perspective of where are ‘we now and how much can we improve?’
- Instead we approach it from the perspective of ‘where do you want to be?’
Jim Collins on Goals

“Like the moon mission, a true BHAG (Big Hairy Audacious Goal) is clear and compelling and serves as a unifying focal point of effort – often creating immense team spirit. It has a clear finish line, so the organization can know when it has achieved the goal; people like to shoot for finish lines... People ‘get it’ right away; it takes little or no explanation.”

- Jim Collins & Jerry Porras

Credit: https://www.jimcollins.com/article_topics/articles/BHAG.html
Setting B.H.A.G Goals

- Set specific & measurable goals.
- Set the bar high.
- Tell them which mountain to climb and then let them climb it. Then provide the resources that they need to do the job.
- Measurement is objective, not subjective.
  - (See Performance Dashboard article on ColemanAssociates.com)
- “If you limit your choices to what seems possible or reasonable, you disconnect yourself from what you truly want, and all that is left is a compromise.”
  — Robert Fritz
Make Your Goals Audacious!

- Resist the urge to be conservative in setting your goals.
- Dream big to push others to be more ambitious.
- Create a big, bold vision and then provide the needed support to achieve quick wins.
- Once you have traction, emphasize it and rally the troops around your mission!
- “Think big, dream big, believe big, and the results will be big” - Unknown
Simon Sinek on Leaders Who Inspire Action

- Your next step might be to watch the Simon Sinek Video about how Great Leaders inspire action
- Watch for:
  - Why does Apple do it better than their competition?
  - Think of how you can adapt Sinek’s advice to communicate your goals using this language.
- What is your WHY?
Effective Campaigns for Change
Include:

- All Staff:
  - Not just the COO, but the CEO, CFO, CIO aka a united front saying the same thing.
  - Practice makes perfect. Rehearse an elevator speech.

- Frequent Communication:
  - Staff meetings, board meetings, rounding (Quint Studor Group), Traveling Roadshows, emails, newsletters, desktop messages, patient messaging

- Passion, Excitement & Tangible Results:
  - The more excited YOU are, the more that trickles onto everyone else.
  - Use tests and data that people can see to spread the innovation. Make it TANGIBLE.
Coleman’s Traveling Road Shows, Simple & Effective

- Take your goals and data on the road!
- Meet staff where they’re at.
- Bring some flip chart paper.
- Track who you talked to!
- Follow up with those you didn’t reach.
- It’s easy and it’s effective.
A Process for Communication Goals

1. Define the WHY – Your purpose, cause & belief. Why does your organization exist?
2. Explain the HOW
3. Define the WHAT
4. Take off your ‘manager’ hat, speak as if you were doing a Traveling Roadshow to MAs or Front Desk staff.
5. Keep it Simple.
6. Tell a Story.

“People don’t buy what you do, they buy how you do it.”
Credit: Simon Sinek, Leaders Who Inspire Action
Moving to More Advanced/Timely/Accurate Reporting

Building And/Or Refining Your Dashboard
Does Your All-Staff Dashboard Pass the Next Five Steps?

Discuss the following 5 questions and then write down your answers, Yes or No.

1. Do staff see themselves in the data? (Y/N)
2. Is the data shared in a timely way? i.e. Weekly? (With the option for daily?) (Y/N)
3. Do you recognize, reward and feedback to staff based on your Dashboard? (Y/N)
4. Is the data accurate? (Y/N)
5. Are the formulas patient centric? (Y/N)
How Did You Score?

- If the answer to any of the former three questions is NO, consider updating your Dashboard or data tools
1. Solicit Feedback on Your New Dashboard Version

- When you round, ask staff to share their results with you.
- Take a copy of the Dashboard with you.
- Do staff know the results? Can they share them with you or not?
- Ask for direct feedback.
2. Share Data in a Timely Manner

- Think about what motivates your staff….
- Consider offering a weekly prize to identify and recognize key metrics
- Ask local management to announce midweek standings… (this gives staff time to re-adjust and course-correct)
3. Recognize & Reward Performance

- Highlight high performers on your Dashboard or on your data wall using smiley faces, thumbs up, stars, whatever.

  - In our experience, we’ve heard staff who said, “I just want to get the smiley face.”

- At a higher level, build performance into your annual performance reviews

- Consider team-based incentives

- Utilize “carrots.” See article on our website, A Carrot a Day to Reward & Retain Staff
“Most companies have no problem getting better results at first. The problem is keeping them…”

*Quint Studer* **Results that Last**
4. Is the Data Accurate?

- Have you or someone you trust compared data in the Dashboard to a daily snapshot in your EMR? **Trust, but verify.**
  - For example, the Dashboard says the team saw 12 patients on 3/15/18. Can you open the schedule on 3/15/18 and see 12 patients with kept appointments?
  - So often, we see staff lose faith in a Dashboard when they check it themselves and see that it’s wrong. Fact check the data before it gets published!
5. Are the Formulas Patient-Centered?

- This is heavily dependent on the metrics, but check that your EHR or excel Dashboard is pulling the data correctly and from the patient point of view.
- For example, when does cycle time start, when does it end?
- Does TNAA include weekend days?
What Questions Do You Have?
Thank you for Joining Us!

Your opinions are very important to us.

Please complete the Evaluation for this event. Those attending the entire event and completing the Evaluation questions will receive a Certificate of Participation.

Each person should fill out their own Evaluation Survey.

Please refer to the SurveyMonkey link in the reminder email sent out in advance of the event, and will be included in a follow-up email to those logging onto the live event. Please pass the link along to others viewing the event around a shared computer.

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