Strategies for Guiding PCMH Transformation from Within

Executive Summary

PCMH transformation requires the visible and sustained engagement and tangible support of a wide range of leaders within the practice: the Boards of Directors, C-suite executives, and clinic managers. To drive and sustain PCMH transformation, leaders must provide the vision for change, help identify changes to test, and build and sustain the will within the practice for transformation.

Because PCMH transformation is an organization-level change initiative, it cannot be accomplished without the active, continuous support of leaders who embed PCMH principles into the business and operations of their organization, from strategic planning and goal setting, through communications, data capture, and QI training. Leaders must establish and communicate the business case for PCMH and help staff understand that PCMH transformation benefits patients by improving experience and health outcomes, and also the practice's bottom line by improving staff recruitment, retention, and satisfaction.

To help leaders drive and sustain PCMH transformation in their organizations, the SNMHI has produced the *Engaged Leadership Implementation Guide: Strategies for Guiding PCMH Transformation from Within*. The guide uses the Institute for Healthcare Improvement's (IHI) *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care* framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation. These action points are:

1. Establish and oversee specific system-level aims at the highest governance level.
2. Develop an executable strategy to achieve the system-level aims and oversee their execution at the highest governance level.
3. Channel leadership attention to system-level improvement: personal leadership, leadership systems, and transparency.
4. Put patients and families on the improvement team.
5. Make the Chief Financial Officer a quality champion.
6. Engage physicians.
7. Build improvement capability.

Other tactics presented in this guide include:

- Setting up regular sponsor/improvement team meetings with leaders and highlighting specific successes in board and committee meetings and reports.
- Assuring that the organization has data reporting capabilities, including the use of billing data, and developing systems-level measures to determine if changes being made are transforming care.
- Using data to communicate successes and continue to drive PCMH transformation. This includes recognizing that data needs of various audiences will be different (e.g., Board members need "big dot," system-level data, while front line staff need to know from day to day how many patients have been impacted by their interventions). Knowing the audience for the data, and what the leader seeks to accomplish, will increase the impact.

Most importantly, leaders must instill confidence and enthusiasm for the challenging work of PCMH transformation, provide motivation for continuous improvement and innovation, and provide support for their staff as practice teams redesign themselves and their processes to provide better quality, more accessible, and more patient-centered care.

IMPLEMENTATION GUIDE

ENGAGED LEADERSHIP

Strategies for Guiding PCMH Transformation from Within

November 2010 Transforming Safety Net Clinics into Patient-Centered Medical Homes

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The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute.

QUALIS HEALTH

THE COMMONWEALTH FUND

MacColl Institute at Group Health Cooperative

Introduction

An organization becoming a patient-centered medical home (PCMH) is making a commitment to system-wide transformation. Any such transformation requires the visible and sustained engagement and tangible support of a wide range of leaders: the Boards of Directors, C-suite executives, and clinical managers. It also requires staff at all levels of the organization to adopt and model change. Change is difficult, and lack of leadership is commonly cited as the number one reason change attempts fail.

So what must leaders do to guide their organizations through a successful PCMH transformation? First, leaders must manage change within the organization from both the top down and the bottom up. They must also provide the necessary time and tools, remove barriers as they are encountered, and provide motivation. Most importantly, they must implement practices that make change possible by fostering and encouraging a supportive environment for PCMH transformation. This implementation guide presents concrete strategies leaders can use to ensure their organizations achieve transformation.

Change Concepts for Practice Transformation

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a Patient-Centered Medical Home for the "Transforming Safety Net Clinics into Patient-Centered Medical Homes" Initiative. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. Over the course of the

"Transforming Safety Net Clinics into Patient-Centered Medical Homes" Initiative, we will cover each of these change concepts in turn. An implementation guide will be prepared and made available for each concept. This implementation guide is focused on Engaged Leadership, a critical element of the medical home, and one we think must be addressed early on, as its principles are overarching.

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. **Engaged Leadership**
5. Quality Improvement (QI) Strategy
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care

Elements of Engaged Leadership

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Establish and support a QI team that meets regularly and guides the effort. This team is creating changes, testing changes, seeing which changes have impact, and if they do.
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.

Message to Readers

SNMHI implementation guides are living documents. Updates will be issued as additional tools, resources, and best-practices are identified. This implementation guide provides an introduction to the first two elements of the Change Concept "Engaged Leadership":

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Establish and support a QI team that meets regularly and guides the effort. This team is creating changes, testing changes, seeing which changes have impact, and if they do.

Transformative change relies upon knowledge sharing and knowledge transfer. The partner clinics and Regional Coordinating Centers participating in the SNMHI are members of a learning community working towards the shared goal of PCMH transformation. This learning community produces and tests ideas and actions for change. The Initiative celebrates the contributions and accomplishments of all its partner clinics and Regional Coordinating Centers and, in the spirit of collaborative learning, implementation guides often highlight their work.

This guide includes resources and learnings from Denver Health (Colorado), Health West, Inc (Idaho), Multnomah County Health Department (Oregon), CareOregon (Oregon), and HealthPartners Medical Group. Additionally, SNMHI is indebted to the Institute for Healthcare Improvement (IHI) for the significant role it continues to play in developing healthcare leadership tools, and for its successful models for change which are cited in this guide.

Walking the Walk

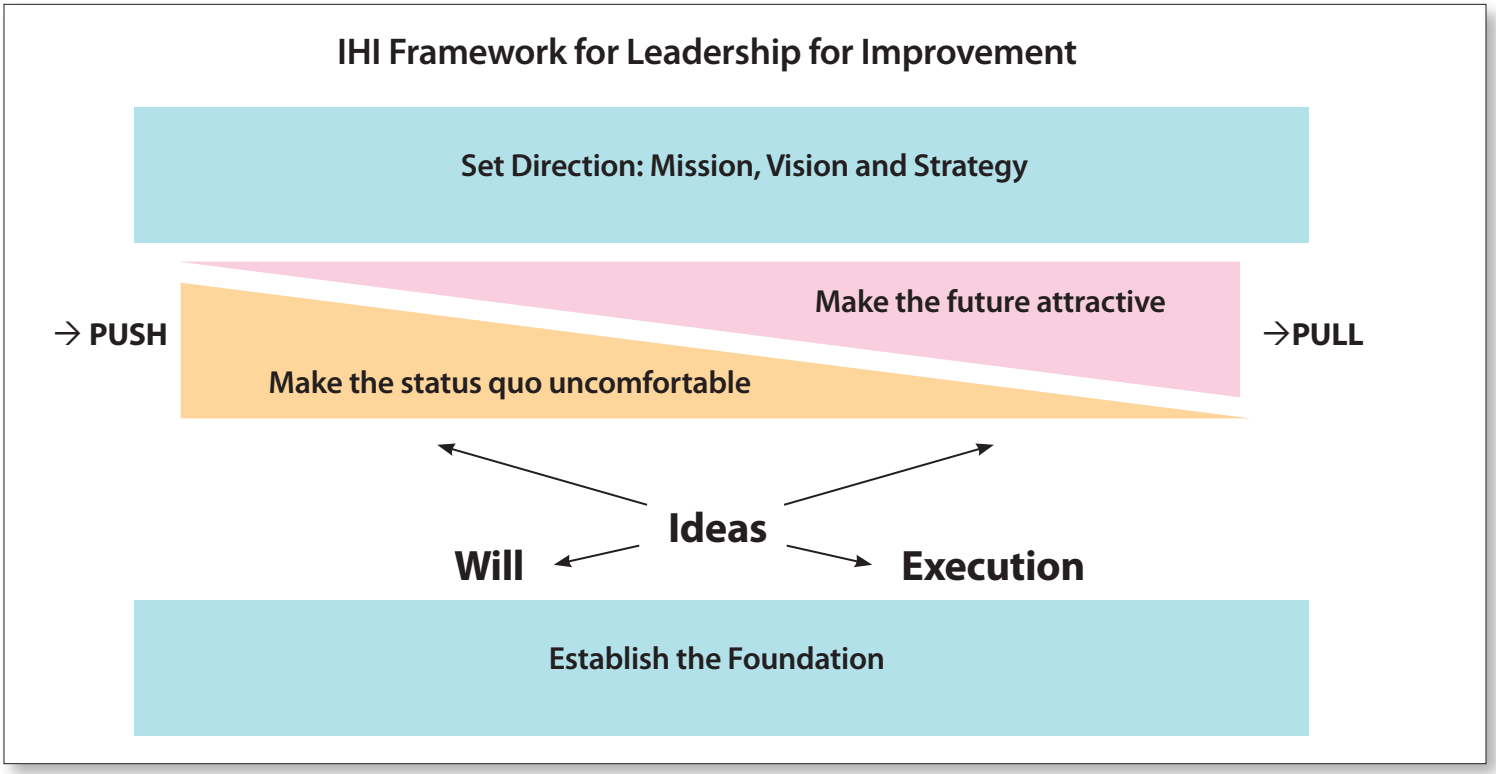
PCMH transformation calls for a paradigm shift in the way all practice staff think about medical care. Instead of focusing on the acute needs of individual patients seeking care, the PCMH model expects practices to take an organized, proactive approach to improving the health of a population of patients. PCMH transformation is hard work, and requires deep and continuous engagement of leaders. A study of 36 primary care practices trying to implement the medical home found that many characteristics which can only be supported by leaders, such as change management and adaptive reserve, were as or more important than the technical interventions used.[1]

Engaged Leadership is a journey that must be sustained in order to transform to the PCMH, not just a set of processes. It is imperative that leaders "walk the walk" by supporting transformational change every day, building will and executing change. A leader simply cannot watch from the sidelines.

Supporting Transformational Change: The Leader's Role

Three elements are essential for any change: will, ideas, and execution. One of the primary responsibilities of leaders is to build and sustain the will to change.

Figure A. IHI Framework for Improvement



Source: Reinertsen JL, Bisognano M, Pugh MD. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available on www.IHI.org)

In the brief section that follows, we will detail the activities that leaders should undertake in order to set this foundation of will, ideas, and execution – and then in following sections we will cover the actionable strategies leaders can use to support and sustain the execution of PCMH transformation.

Building Will, Part I: Set Organizational Direction: Mission, Vision and Strategy

Clinic leaders need to set a vision that captures PCMH transformation. For instance, asking, "Do the organization's goals and vision include explicit language about becoming a patient-centered medical home?" If not, work with board members, C-suite executives, clinic managers and directors, and consumer advisory groups to include PCMH in the next strategic planning meeting agenda.

Leaders must assure that the PCMH work is embedded into strategic and business processes.

As part of direction setting, leaders must assure that the PCMH work is embedded into strategic and business processes . This is essential in creating conditions for sustainability. Below is a list of strategic and business processes with associated questions to consider for the C-suite. If the answer to the questions below is "no," consider what you, and other leaders in the organization can do to embed PCMH transformation into the organization's business processes.

Stephen Weeg, M.Ed., Executive Director, Health West, Inc.: Keeping a Singular Vision

Health West, Inc, a multi-site community health center in Idaho, has effectively adopted the Patient-Centered Medical Home Model by continually engaging leadership. "It's never past tense, it's a never-ending involvement on the part of clinic leaders," says Stephen Weeg, Executive Director.

"As the leader, you create the energy and work environment that keeps change in the forefront. The demands of the day can distract but you need to keep your eye on the prize and know where you want to go," Weeg says.

Health West leadership is institutionalizing the change processes. Agenda structures for quality meetings now incorporate change concepts in order to focus leadership and staff on how business is addressing PCMH. "We think about what kind of QI initiatives tie into building the medical home, and how it becomes part of what we do each day," Weeg says.

They're also seeing improvements in the bottom line. "PCMH is the right thing to do in terms of clinical care, the medical home model fits into excellence in service and excellence of care. It's benefitting our patients and our practice. We're seeing some increased volume and patient visits because we are being more proactive," Weeg adds.

"Whether it's risk management, QI, medical home, or customer service, everything you read says that success or failure resides with how engaged the leaders are. I keep the concept tight and focused, and come up with constructs that tie all the pieces together so that it's a singular initiative focused on excellence in customer service. It's doable if I think of it as a singular vision."

No one will make changes if they do not understand the need to do so; they cannot make changes without ideas as to what they might do differently; and they certainly cannot transform their organization without effective strategies for implementation.

Table 1: Embedding PCMH in Business Processes

Strategic/Business Process	Questions to Consider
The Vision Statement	Does the vision statement include having a patient-centered medical home for every patient? Does leadership have the ability to operationalize this vision by defining clear, actionable, measurable targets for staff at all levels in the organization?
Business Planning	The business planning process should explicitly include the PCMH improvement work, including allocated resources (staff/time) to the initiative, and areas of focus over an expected time period. How does this initiative interface and/or compete with other business planning processes (such as EMR conversion)? Does the business plan include the goals and expected results of the PCMH initiative? Does the business plan allocate a section or header specifically on the PCMH with expected outcomes? A good business plan will include potential barriers to success and assign senior leaders to assure success.
Building a System of Improvement	How do clinical leaders and C-suite plan for improvement over a proposed period of time? Is there a charter or written document with clearly outlined goals, metrics and accountability structure? Which PCMH change concepts will reach full implementation and by when? How does the plan include the view points of patients? Are there clear deliverables and metrics/outcomes associated with the deliverables? How does the organization balance short-term and long-term needs?
Communication Strategy	John Kotter states that credible communication, and a lot of it, is necessary to assure the hearts and minds of the 'troops' are captured.[2] Is there a senior leader assigned to develop continuous communication around the PCMH initiative? Is there a communication grid or tool that identifies all potential ways of communicating to staff, the board and providers, and sustaining communication strategies over time?
Managing Team Improvement Activities	Is there a C-suite member assigned as a sponsor for the PCMH initiative? Is there a periodic (such as quarterly/monthly) review of PCMH progress between the sponsor and the PCMH team in order for the leader to stay close enough to the effort? Is there an executive leader report regularly submitted to C-suite? Is there a systematic review of all strategic initiatives with clinical leaders and sponsors to identify interface and impact of initiatives on one another?
Data Capture Capability	Does the organization have a way to capture data? How consistent and reliable are the data? Is an EMR being implemented soon? If so, are clinical leaders involved with PCMH part of the design/interface with HIT in developing EMR?
Training for Leaders on Quality Improvement	Is there training for clinical leaders and C-suite that includes skills and competence in sponsoring quality improvement activities? Do leaders understand performance improvement data? Is there training on viewing the organization as a system?

Building Will, Part II: Continue to Build Will across the Practice Site and Develop Communication Strategies for Leaders

Every staff member in the practice site has a role to play in transformation. It is the job of leadership to communicate those roles, and to make sure each staff member understands the importance of his/her contributions to transformation.

Identify and Mentor Champions

Leaders should begin by identifying champions who will promote the concepts of the PCMH. While the Board and C-suite executives should be well versed in the strategic direction, many others within the organization can be tapped to underscore the importance of transformation. When identifying champions, consider those respected individuals who have regular interaction with large numbers of other staff and patients. These may include the HR Director; the Medical Director; Office Manager; managers of Nursing, Pharmacy, Finance; and lead MAs, PAs, RNs, and LPNs. Front desk staff and IT support staff need to understand and communicate to others about how the PCMH model will carry forward the mission of the clinic and improve their individual jobs.

Develop and Refine Communications Strategies

Communications strategies for champions will vary, with different messages appropriate for the various champions to deliver to their respective audiences. Leaders should share and demonstrate the following communication strategies with all levels of leadership continuously over time and through multiple media:

- High-level leaders should attend meetings and promote the organizational commitment to PCMH transformation.
- Tell and listen to stories of how front-line team members have tested new ways of providing patient-centered care, sharing successes and challenges.
- Conduct executive "walk rounds" at clinics and sites.
- Ask for the right quality and efficiency data and package these data in graphical displays for both executive leaders/board members and front-line staff.
- Be transparent with the quality data displays: participate in regional and national public reporting initiatives.
- Reward and recognize teams that can demonstrate progress, e.g., leaders round with a coffee cart and engage staff in conversation.

Invest in Systems and Staff to Support Clinical Quality and Operational Data

To support leadership and mentor champions, leaders should invest in systems and staff to support the generation of reports with credible, meaningful clinical quality and operational data. These reports should provide information at the site level, provider/team level, and patient level. Reports such as these provide important motivation for transformation.

Generating Ideas for PCMH Transformation

The eight Change Concepts identified by the SNMHI and listed in the beginning of this guide can serve as a conceptual springboard for generating more specific operational ideas by the organizational leadership and staff. Leadership's role is in explaining and teaching the change concept, but good leaders won't overlook the staff for ideas and solutions . They are the people closest to the operations, and are responsible for the day to day activities that support PCMH transformation. Harvesting the creativity and energy of staff can make a leader's job easier. Additionally, other national demonstration projects for PCMH transformation can be a source of ideas and inspiration.

Leadership's role is in explaining and teaching the change concept, but good leaders won't overlook the staff for ideas and solutions.

David Labby, MD, Medical Director, CareOregon: Encouraging Leaders at Every Level

CareOregon is a Medicaid managed care plan that has been working on Patient-Centered Medical Home among its five organizations and 15 clinics since 2006.

Labby says it's not just the CEOs, Boards of Directors, and Medical Directors that need to act as leaders, but organizations must identify the leaders among nurses, PAs, front office staff and those who treat patients, and grow and leverage those leaders to implement change.

"You cannot do this kind of transformational work unless you engage and create leadership at every level," says Labby. "Even if you have the Executive leadership totally committed, this is not going to happen just by command and control."

"The job of leadership is releasing the energy and creativity and passion of those doing the work – they understand it and can come up with the best solutions for improvement," Labby says. "It's a whole new culture we're building, the model is no longer just based on visits, its outcomes."

There are many ways to accomplish it, but Labby says every organization needs a strategy for leadership development for every employee. "The practice of building leadership is part of the practice of leadership," he says. Labby sees his job as helping the team become a high functioning unit.

Labby sees the job of leadership as focusing on a few key steps when working on PCMH transformation:

- Inspiring people – clinics need a strategy for creating and renewing the vision;
- Empowering people – give them time, skills and competencies to lead, to do the work and to improve the work;
- Measuring goals and defining real success – organizations need to give people a way to succeed that is measurable and objective;
- Assessing progress – organizations should constantly be asking, 'Are we are the right path? Is this enough?' Given the goals, are the steps the right ones?

"Leadership is something you always have to work on, there is no cookbook," he says.

Executing Change: IHI's Seven Leadership Leverage Points for Organization-Level Improvement

The Institute for Healthcare Improvement (IHI) is a well-recognized leader in transformational change. For more than 20 years, IHI has researched and disseminated successful change methods. In 2005, researchers from IHI interviewed management experts from industries both inside and outside of healthcare to determine the most important places for leaders to exert their efforts in guiding change. These "leverage points" were described in a white paper, which was subsequently revised in 2008 using the learnings from hospitals that successfully implemented the elements of the 100,000 Lives Campaign.[3] Since these leverage points have stood the test of time and have been robustly demonstrated to be useful, we are using IHI's leadership framework to explain actionable strategies leaders can use to build and sustain engagement in order to support PCMH transformation.

One of IHI's Seven Leadership Leverage Points is "Develop an executable strategy to achieve the system-level aims and oversee their execution at the highest governance level." The execution is the hardest of the three steps and yet it is extremely important that leaders have a commonly articulated plan to get the job done.

- Begin by **identifying a framework** or tools to outline a few distinct priority projects that will support PCMH transformation with a specific aim for all team members to work on. Consider the IHI Framework for Execution and / or the "execution cascade" and "driver diagrams."
- **Assign a timeline** to these priority projects.
- **Dedicate staff time and resources** to both executive sponsors of each priority project and "day-to-day" leads for each priority project. Assign accountability to designated staff for providing routine / monthly progress reports on these few priority projects to executive leadership.
- **Update executive leadership** meeting agendas to incorporate these priority project progress reports.

- At each meeting, leaders should ask "Is our strategic approach to transforming to a Patient-Centered Medical Home working? How do we know?" **Leaders (at every level) should be looking at the right data** for their level of responsibility, e.g., clinic system or hospital leaders should be looking at "big dot" items while front-line leaders should be reviewing process data that drive the "big dots" or system-level outcome measures. Looking too far into the weeds is not useful for system leaders. *Table 4: Whole System Measures versus Drivers and Projects* on page 17 looks at "big dot" strategic pillars.

Finally, when executing change, leaders, including the CFO, must provide resources needed to enable front-line staff to transform care delivery. For example, providing staff resources for quality data reporting or providing resources for staff training on quality improvement methods, such as Lean or rapid, Plan-Do-Study-Act cycles. Site-specific and clinical leaders can also provide support by giving staff dedicated time to plan improvements, attend training classes, and preparing quality data for communication to front-line staff and executive leadership.

Execution is a multi-phased operation and leaders must stay engaged during transformation. The following sections of this implementation guide will help leaders understand the specifics of executing change.

IHI Leadership Framework

IHI's Seven Leadership Leverage Points and Framework for Improvement

As noted in the introduction, the Institute for Healthcare Improvement (IHI) developed "Seven Leverage Points for Leadership".[3] These points, taken from experience in healthcare and other industries, are the areas in which leaders should expend their valuable time and resources, as they offer the greatest leverage in executing transformational change. They are described in some detail, listed as 1–7 in the section below, and offer some how-tos for leaders in safety net practices.

The seven leverage points are:

1. Establish and oversee specific system-level aims at the highest governance level.
2. Develop an executable strategy to achieve the system-level aims and oversee their execution at the highest governance level.
3. Channel leadership attention to system-level improvement: Personal leadership, leadership systems, and transparency.
4. Put patients and families on the improvement team.
5. Make the Chief Financial Officer a quality champion.
6. Engage physicians.
7. Build improvement capability.

1. Establish and oversee specific system-level aims at the highest governance level

Reinertsen et al describe the improvement roles for the organization's highest levels of leadership and management as follows:

- Establish a set of system-level measures for performance;
- Set goals or levels of achievement for the set of measures that clinical and staff leaders will be expected to achieve;
- Provide routine review of performance measures; and
- Communicate a commitment to providing resources to assure all goals for measures are achieved.

See Appendix A for more on how IHI defines systems.

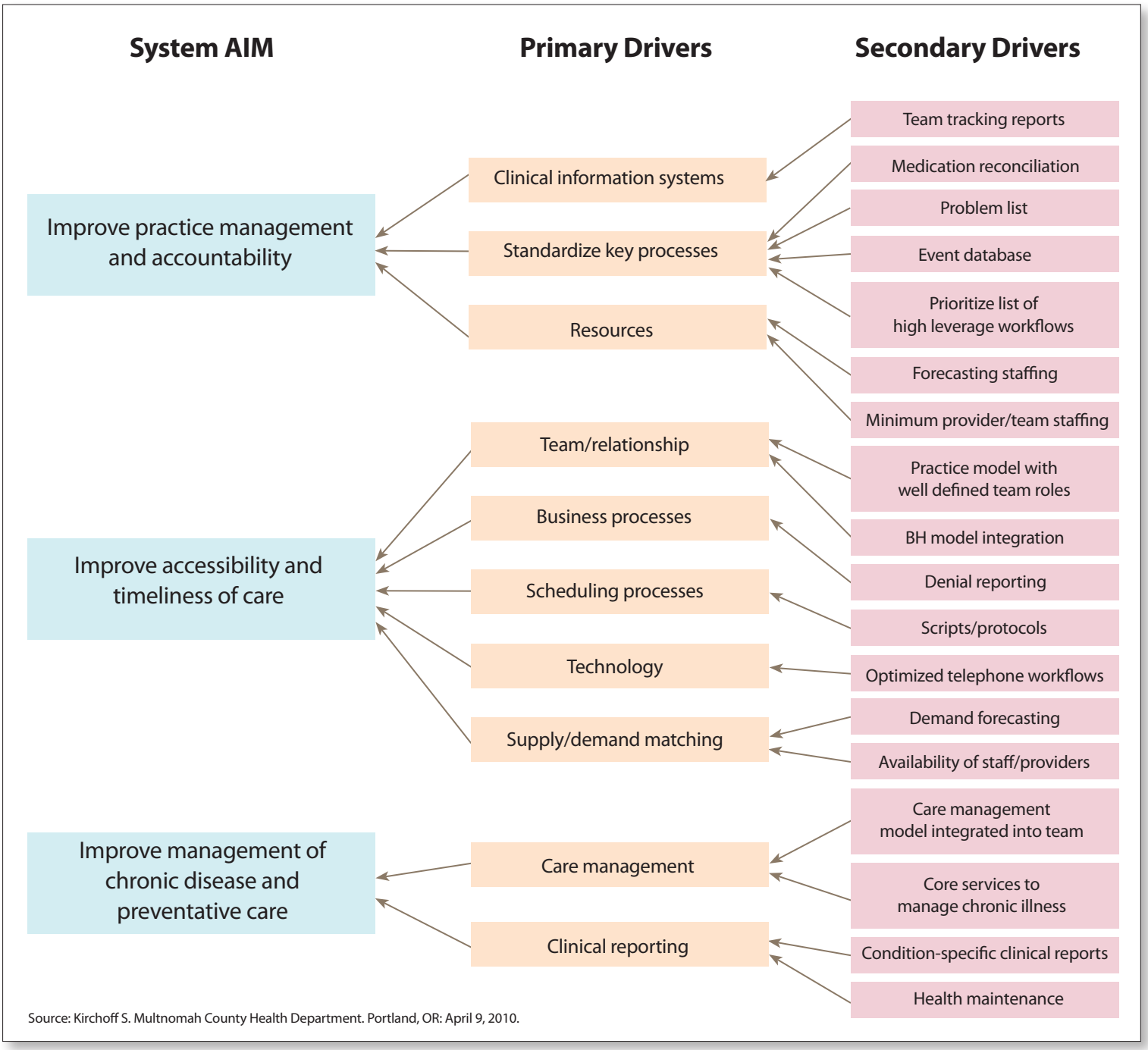
Table 2. Example of System-Level Measures for PCMH

Dimension of Quality	System-Level Measure	Example of System-Level Goals	System-Level Goal
Patient-Centeredness	Patient satisfaction score	% of patients responding "highly satisfied" to "Overall, how satisfied are you with your care?"	70%
	Patient experience score	% of patients responding "My care team gives me exactly the help I want (and need) when I want (and need) it."	75%
Efficient	Reduce avoidable ED visits	% reduction in % of patients receiving care in the Emergency Dept	5% reduction
	Reduce inpatient admissions/readmissions	% reduction in % of patients w CHF or asthma who had an inpatient stay	5% reduction
Effective	All or none measures for prevention	% of eligible patients who received all recommended preventive cancer screenings: colorectal, cervical, breast, etc.	90%
	Diabetes and hypertension outcome measures	% of eligible diabetes patients who have HbA1c<7%	80%
Timely	Follow-up appointment after hospital within 5 days	% of hypertensive patients who have BP<140/90	85%
	Access to specialty care within 7 days	% of patients who were able to schedule appts within 7 days	95%
	24/7 access	% of appts after 5:00 pm during weekdays and on weekends	25%
Equitable	Assure migrant workers and family members have equal access to care.	% of migrant workers or family members who receive all recommended immunizations	75%

2. Develop an executable strategy to achieve the system-level aims and oversee their execution at the highest governance level

IHI and other organizations promote the use of driver diagrams to help with execution strategies. If an organization can identify the "drivers" of change, it can appropriately implement them. This is important for defining change targets, communicating those targets to internal and external stakeholders, and gaining buy-in for change efforts. Below is an example of a driver diagram, from Multnomah County Health Department.

Figure B. Sample Driver Diagram from Multnomah County Health Department



Source: Kirchoff S. Multnomah County Health Department. Portland, OR: April 9, 2010.

3. Channel leadership attention to system-level improvement: Personal leadership, leadership systems, and transparency

To quote IHI: "What leaders pay attention to tends to get the attention of the entire organization."

Personal Leadership:

- How are leaders spending their time? Prioritize personal schedules to make sure there is time to review data on system-level measures, prepare questions based on data meet with project leaders to review questions.
- Participate in project team meetings. Leaders can also send the wrong message by showing up late or leaving meetings early, not asking questions, taking phone calls, or checking email during the meeting, etc.
- Tell stories to communicate positive results, accomplishments, and learnings.

Leadership Systems

There are numerous approaches to organizational leadership and none of them are incorrect. The literature provides a number of perspectives on leadership systems and their characteristics as specifically used in the transformation to PCMH. Facilitative leadership systems empower staff members to suggest new ideas and solutions in an environment that is safe and non-threatening. "We saw several examples of facilitative leaders whose respect for all members of the practice was apparent, and this respect created energy, enthusiasm, and commitment that resonated throughout the practice."[3] While adaptive leadership styles provide the vision and ongoing resources for a team to be successful. "Clinicians who experience high burnout and dissatisfaction are receptive to transformation, but only if leaders can clearly articulate the vision, ensure adequate resources, and let teams take charge of the process of change. Technical solutions for improving primary care, such as payment incentives, can be instrumental in shaping change, but not without strong leadership."[4] Researchers identified several unique personal traits in leaders that appeared to impact the transformation to PCMH: "persistence, tolerance for risk, instinct for leverage on clinical and financial outcomes, and a strong sense of personal accountability for preventable crises in patient health."[5]

"Clinicians who experience high burnout and dissatisfaction are receptive to transformation, but only if leaders can clearly articulate the vision, ensure adequate resources, and let teams take charge of the process of change. Technical solutions for improving primary care, such as payment incentives, can be instrumental in shaping change, but not without strong leadership."

Transparency:

- Share data as openly as possible to spur improvement – consider sharing progress data publicly.
- When the public, and patients, pay attention to PCMH then people within the organization will have an increased desire and motivation towards improvement.

For instruction and examples about frequency and content of leadership meetings in support of PCMH transformation, please see Appendix B, Sample Agenda.

4. Put patients and families on the improvement team

It is important to have the right team supporting any transformation – beginning with the leaders and continuing throughout the organization. The IHI and other organizations also find that involvement of patients and families is a critical and often underutilized aspect of system level change. Patients and families can add value in many ways, including:

- In meetings, the presence of patients and families helps focus the conversation on innovative ideas and solutions rather than complaints about why they can't do anything (that is, change the focus toward the patient's needs).
- Patients receive care across the continuum of care and remind us to be patient-centered and find community-based solutions.
- MDs/RNs feel supported and inspired by the stories of patients and by their commitment to contribute.
- Federally qualified health centers (FQHCs) already have a requirement to include consumers on leadership teams – leverage these consumers to participate in the day-to-day activities as well.

For organizations without existing patient/family participation in QI teams, in order to support PCMH, consider:

- Daily patient conversations with senior executives focusing on PCMH progress and patient input.
- Administrators, Medical Directors and Clinic managers conduct walk-arounds to interact with families, patients and staff.
- Structural integration of patients and families into existing QI structures, such as the Board QI committee and other committees and projects.
- Patient stories at board meetings.

5. Make the Chief Financial Officer a quality champion

Transformation is far more likely to occur if system-level measures of both financial status and quality of care are embraced by CFOs/Financial Managers/Clinic Operations Managers. In order to support change and allocate the resources necessary for transformation, CFOs must understand the benefits of the PCMH, specifically how transformation will contribute to the organization's financial performance/viability both in the short and long term. And in order to become champions of transformation, CFO and other financial officers must understand the importance of quality improvement and find ways to improve and promote quality while keeping their organization financially viable. In the past, CFOs and other financial managers often responded to financial stresses by making cuts to existing, unimproved processes. The new thinking is to focus efforts on quality-based elimination of waste – that is, redesigning processes to drive out waste while maintaining and improving quality. For example, decreasing no show rates or decreasing cycle times (time from when the patient walks through the clinic door to when they walk out) save costs and promote PCMH transformation.

In the past, CFOs and other financial managers often responded to financial stresses by making cuts to existing, unimproved processes. The new thinking is to focus efforts on quality-based elimination of waste – that is, redesigning processes to drive out waste while maintaining and improving quality.

6. Engage physicians

Physicians play a critical role in PCMH transformation, and leaders need to develop and execute an effective strategy to actively engage them in the work. Failure to engage this group will almost certainly derail the transformation, because of their unique role and power within the organization. Physician engagement is embedded throughout this implementation guide, as physicians are usually clinic leaders (and therefore must assume the leader and champion roles) and also front-line staff. Address physician engagement by communicating how the PCMH will benefit physician's work environment and quality of life. This can be particularly important in reaching younger MDs. The IHI White Paper, "Engaging Physicians in a Shared Quality Agenda," is an excellent resource.[6]

7. Build improvement capability

The entire leadership team of an organization should be well versed in basic quality improvement strategies. The transformation to the PCMH is a quality improvement initiative on the largest scale – and the leaders' knowledge about QI will help them to be more effective champions of the transformation.

The objective of a leader attending QI training is to translate theory, tools, and experience into the framework of clinical care delivery.[7]

Invest in training senior and clinical leaders in quality improvement so that they are capable of driving system-level improvement. These competencies (both behavioral and technical) should be included in the professional development plans of senior leaders as well as staff and clinicians. Leaders then will be able to facilitate an effective process improvement team, act as an internal consultant to assist colleagues in solving problems, educate both formally and by walking the walk. Health systems use a variety of QI models. We recommend five content areas to be included in a quality improvement curriculum. These are consistent with recommendations from numerous quality improvement organizations to assure that senior leaders have the skills they need to sponsor, drive, or lead QI initiatives.

Table 3: Leadership Training Modules: Content Areas and Objectives

Content Area	Objectives
The model for improvement and small-scale rapid tests of change	• Understand methods used in the PCMH initiative to implement change • Understand Deming's "System of Profound Knowledge", including examples where better quality should reduce an organization's cost of operations[7] • Able to integrate concepts into strategic planning and action plans
A coherent improvement strategy such as the Toyota Production System	• Identify how lean principles apply to the clinical office setting • Able to recommend ideas and strategies to improvement teams to create office efficiencies • Able to integrate concepts into strategic planning and action plans
Concepts and practices of high-reliability organizations	• Identify ways that the system can reduce unwanted defects in care process and outcomes • Understand the importance of standardization of care • Begin to identify policies or procedures that would enable standardization and reliability
Sophisticated practices in flow management	• Understand how flow diagrams and other tools can identify bottlenecks in the clinic setting • Begin to identify barriers in physical settings that can impede efficient care
Concepts and practices of scale-up and spread of improvements	• Articulate diffusion of innovation theory • Understand the importance of senior leader sponsorship and attention to improvement initiatives

Consider attendance of the senior leadership team at appropriate training forums or seminars. Alternatively, for larger systems, consider an internal training program and bring in outside experts. Consider approaching your region's medical home facilitator about coordinating a region-wide senior leader training. If this is feasible, consider how to include board members as well as members of your region's Stakeholder Advisory Group.

The Business Case for PCMH

The business case is a key component for building will and for bringing the board, and financial and executive leaders on board as champions. Leaders need to drive and clarify the business case for the organization; including understanding the total cost of quality. What at face value might appear to be a costly and unbudgeted expense could in fact turn out to be a critical resource that dramatically boosts productivity with a very short return on investment. Leaders should strive to understand, document, and communicate the business case for PCMH transformation throughout the organization. The business case for PCMH transformation includes five elements:

- Alignment with changing payment models
- Reduced staff turnover
- Improved staff recruitment
- Improved quality
- Cost efficiency for payers and communities

Alignment with changing payment models: There is a high degree of confidence that our current payment models will change, but questions remain about when payment reform will occur and what models (e.g., pay for performance, global payment, accountable care organizations) will be broadly adopted. There is general agreement, however, that payment models applied in the future will reward value over volume and will demand better coordination of services. The PCMH model, which provides a framework for care coordination, proactive preventive and chronic illness care, access, and continuity, is well poised to meet these expectations. Adopting the PCMH model will position safety net practices to take advantage of newly emerging payment models, which are likely to better reward primary care.

Reduced staff turnover: Staff satisfaction is another critical communication point in support of the business case for PCMH transformation. Managing constant staff turnover is an expensive, time consuming effort, and there is strong evidence that staff working in PCMH practices are more satisfied and are less likely to suffer "burnout" than staff working in traditional office practices. Group Health Cooperative saw a significant reduction in workplace stress (as measured by a "burnout" inventory tool) after implementing the PCMH model in a pilot practice. At 12 months post intervention, 10% of staff at the PCMH site reported a high degree of burnout, compared to 30% of controls.[8] The PCMH can result in improved morale and a sense of contribution which all lead to improved retention rates.

Improved recruitment: The PCMH is the future model of primary care and it is being incorporated into the basic training of primary care residency programs. Practices that adopt the PCMH model and provide the required infrastructure support (e.g., electronic health records) will be highly attractive to residents, new physicians, and other important members of the care team. The shortage of primary care providers, particularly in rural and other underserved areas, makes the attractiveness of PCMH particularly important for safety net practices, which often have a difficult time recruiting and retaining staff, particularly physicians. Clinics that can demonstrate team-based approaches to care delivery and infrastructure support will be better be able to recruit and retain health professionals in this intensely competitive recruitment environment.

Improved quality: The PCMH model evolved based on the early evidence base that children with special needs had improved outcomes as a result of the coordinated care associated with having a primary care medical home.[9] The rapid adoption of electronic health information coupled with greater demands for transparency will make quality of care a key differentiator of primary care practices. Safety net practices that adopt the PCMH model and improve their quality of care will be attractive to a broader patient base and thus a broader payer mix, including grant based organizations which are increasingly demanding accountability for the resources they pledge.

Cost efficiencies for payers and communities: Information on the cost-effectiveness of the PCMH model continues to accumulate. Research demonstrates that patients treated at sites following PCMH principles have 15%-20% reduced total healthcare spending per year compared to patients treated by regional peers.[5] At Group Health, pilot sites saw a net cost reduction of $10.30 per patient per month.[4] The North Carolina Medicaid program reported annual savings in excess of $244 million as a result of their PCMH and Blue Cross Blue Shield of North Dakota reported annual savings of $500 per member per year as a result of their PCMH model.[10] Unite Here, a New York City based Taft Hartley self insured fund for garment workers, reported nearly a 20% reduction in global costs due to their medical home model and change in roles of the medical assistants in their staff model clinic.[11]

Business Case: Group Health Cooperative

Group Health Cooperative's evaluation of its medical home pilot, launched in 2006, provides some of the strongest cost-savings data to date. Group Health Cooperative's PCMH pilot produced a positive return-on-investment (ROI) within 21 months: Group Health saved $1.50 for every dollar it invested in its PCMH program. These cost savings resulted from reduced utilization of emergency departments (29%) and reduced avoidable hospitalizations (6%).

These outcomes provide the foundation for safety net providers to make the case with their local payers and influence the reimbursement system to shift some of the medical costs to primary care in order to benefit from a reduction in avoidable hospitalizations, emergency room visits and unnecessary subspecialty visits.

Many of the business case examples to date relate to situations in which the delivery system is integrated with the insurance mechanism (e.g., Group Health Cooperative), or to incentive programs in which the insurer realizes most of the savings and may distribute some back to participating providers. The Patient Protection and Affordable Care Act of 2010 offers additional incentive for primary care providers to transform to PCMH as part of an Accountable Care Organization (ACO). ACOs are described under the "Shared Savings" Provision of the Act, as collaborating groups of providers across the continuum of care that will be eligible to receive bonuses from Medicare if they meet quality and performance standards and reduce costs to the Medicare program. PCMH can reduce those costs to Medicare through reducing ED and acute care utilization.

PCMH transformation will require most safety net practices to reallocate existing staff resources and reassign responsibilities. It may also require investments in infrastructure or facilities, and will likely require some learning or training time resulting in lost opportunities for revenue. To some degree, these costs should be offset by gains made possible by enhanced productivity—the ability to see patients who are in greatest need of an in-person visit with a provider. That said, it is important to emphasize that national efforts to invest more dollars in primary care are essential. It is the role of senior leaders to understand these efforts, build will for the organization, and drive changes that minimize lost productivity and maximize quick returns on investment.

Leadership's Role with Quality Improvement Data

In order to provide and sustain will, to execute and evaluate changes, and to promulgate the business case, leaders must become comfortable with data. In this section we describe how leaders can best use data in support of PCMH transformation.

Engaging Leaders in Identifying and Using System-Level Measures to Guide Direction

Leaders must develop a system for integrating Quality Improvement (QI) data into PCMH transformation. Leaders should ask the question, "What data do we need as leaders to know we are transforming care?"

1. System Level Dashboards

Findings from the literature have determined that dashboards (or scorecards) are generally used to create awareness rather than to guide operations and performance measurement. Improved systems of care are linked to 1) shorter, more focused dashboards, 2) active use of dashboards for operations management, and 3) strong influence of board quality committees in dashboard content and implementation.[12]

Many dashboards contain detailed 'process of care' measures that doctors understand, but administrative managers and board members may not. In addition, many dashboards mix together two questions that leaders should ask about quality:[13]

1) How does our quality compare to others?
2) Are we on track to achieve our quality aims?

Refer to Appendix C for examples of dashboards.

2. How to Identify Whole System Measures[14]

In order to manage a system, leaders must make predictions about the quantitative impact of the transformation to PCMH on outcomes. The IHI recommends as a first step developing a strategic theory of what it will take to transform the organization's clinical office system. In turn, this strategic theory will drive the creation of the strategic quality dashboard. Questions for senior leaders to ask include:[13]

Table 4: Whole System Measures Versus Drivers and Projects

Big Dots (Pillars, Strategic Focus)	Drivers (Core Theory of Strategy)	Projects (Operational Plans)
What are your key strategic aims for PCMH transformation? How good must we be by when? What are the system level measures of those aims?	Down deep, what really has to be changed, or put in place, in order to achieve each of these goals? What are you tracking to know whether these drivers are changing?	What set of projects (key change efforts) will move the drivers far enough, fast enough to achieve your aims? How will we know the projects are being executed?

Steps to developing whole system measures

We recommend the following steps to developing "whole system measures" for the PCMH:

1) Develop your core strategies or key drivers with enough specificity so that they can be understood by staff, management, board members, and clinicians.
2) Outline your organization's tactics: the PCMH 'projects' and implementation plans that you believe will allow the key driver to occur.
3) Determine the big dots or strategic aims at the system level to assure that the organization is meeting its strategic aims.
4) Limit the number of system-level measures to 12 or fewer measures. A good rule of thumb is to limit the number to what can be fit on one page. Format reports so that the measures are illustrated as run charts showing change over time.
5) Include your data reporting support person in the process in order to assure that the strategic aims are measurable, or if not, to help you determine a good proxy that might be measurable.
6) Use the key driver diagram in all presentations and reports to continue to reinforce the message of what your organization needs to accomplish in order to transform care.

3. Incorporate QI Data into Board and Strategic Advisory Group Meetings

Communicating data can be a powerful tactic to build will for change. When communicating with different audiences, it is important to recognize that different data displays may be appropriate in order to drive interest and results. Table 5 demonstrates some possible differences in how executives and front-line staff may view quality improvement data.

Table 5: Communicating Quality Data to Multiple Audiences

Data	Measures
Data reports valued by executives: monthly or quarterly data	• % of appointments available within 0–3 days (timely care delivery) • % of patients reporting that they were always satisfied with the care they received (patient satisfaction) • % of patients w diabetes who received all appropriate, evidence-based care for which they are eligible, e.g., timely HbA1c tests, lipids, foot and eye exams (high quality care)
Quality data that motivate front-line staff: weekly or monthly graphs.	• % of appointments in which patients were seen by a member of their care team (continuity) • % of patients receiving lab work prior to their visit • % of eligible patients with diabetes who received outreach calls

As your organization develops system-level reporting, leaders should incorporate and communicate these data systematically into Strategic Advisory Group (SAG) meetings as appropriate. Consider featuring one or two stories to illustrate the changes and actions behind the data. Invite clinicians, staff, and/or patients to these meetings so that leaders hear firsthand what happened and why. Testimonials are powerful. It also sends a message to front-line staff and clinicians that their work is valued. Public recognition is particularly important to some individuals in your organization. Strategically including clinical opinion leaders along with PCMH leaders will reinforce the importance of the work.

4. Regular Meetings with the Improvement Team

Leaders should acknowledge how challenging the work is and the importance of sticking with it.

Senior leaders need to meet with improvement teams every 4-6 weeks. This level of frequency creates accountability for both the leaders and the improvement team. The leader is providing dedicated time and attention to the team. The leader is responsible for assisting the team overcome barriers that can derail improvement efforts. This also means that the improvement team is held accountable for reviewing progress over that short period of time. Data reports must be prepared. These 'sponsor' meetings bring all accountable parties to the table. Key elements of running an effective sponsor meeting include:

- Always include aim statement/goals on the agenda as a reference.
- Review data, ask hard questions if necessary when the 'dots' are not moving.
- Focus on overcoming barriers – ask team members to speak candidly about their theories of what is going on and how to overcome barriers. Ask them to tell you what they need from you to succeed.
- Instill confidence and energy around the work they are doing.
- Acknowledge how challenging the work is and the importance of sticking with it. Remind them of how the work ties into business and strategic priorities.
- Use a confidence scale to determine how confident they are that they will meet goal. If confidence is low, there is likely work that the leader needs to do. Probe until you have enough information to take action.
- Provide specific positive feedback to the team.

Conclusion

Using the IHI *Leverage Points for Leaders* as a guiding structure, we've introduced several new actionable strategies that will assist clinic managers, C-suite executives, and Boards with achieving the transformational change of moving from safety net clinic to patient-centered medical home. Some of the most important take-aways for leaders are:

- Conduct management rounds to learn first-hand what clinic care teams are doing and what barriers they face.
- Develop systems-level measures to determine if the changes being made are transforming care.
- Assure the organization has data reporting capabilities, including the use of billing data.
- Engage the entire senior leadership team in QI, and in particular the CFO.
- Highlight specific successes in board and committee meetings and reports.
- Set up regular sponsor/improvement team meetings with leaders.
- Establish senior leader sponsors for the various 'projects' within the PCMH Initiative.
- Overcome barriers to success even if this means making difficult decisions or changing 'the way we do things'.
- Coach other senior leaders if you see they are struggling with leading QI initiatives.
- Instill confidence and enthusiasm in this challenging work!

Related Change Concepts

Engaged leadership needs to be present in an organization for each of the other Change Concepts to succeed. The most direct linkage between Engaged Leadership and another Change Concept is Quality Improvement Strategies. That said, leadership support and engagement for the other six Change Concepts is critical for successful implementation.

Additional Resources

Workbooks and Tools

Online Course: "Practice Leaders in Medical Homes" For Leaders Who Wish To Transform Their Practices into Medical Homes. Johns Hopkins Bloomberg School of Public Health; www.medhomeinfo.org/tools/physiciancourse.

Presentations and Media

Knowledge Building Session: Empanelment Webinar (May 27, 2010). Presenters: Anna Roth from Contra Costa Regional Medical Center (Martinez, CA), Carolyn Shepherd from Clinica Family Health Services (Lafayette, CO), Stephen Weeg from Health West (Pocatello, ID) and Andrea Fox from Squirrel Hill Health Center (Pittsburgh, PA). Moderated by Sharon Eloranta, MD, Qualis Health. Webinar recording and slide available at: http://www.qhmedicalhome.org/safety-net/engagedleadership.cfm.

Powerpoint Presentation by John Fontanesi, Ph.D., University of California, San Diego, CA on "A Business Case for Electronic Immunizations Registries" CDC Award # U1W/CCU914714-01Award.

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Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.

QUALIS HEALTH

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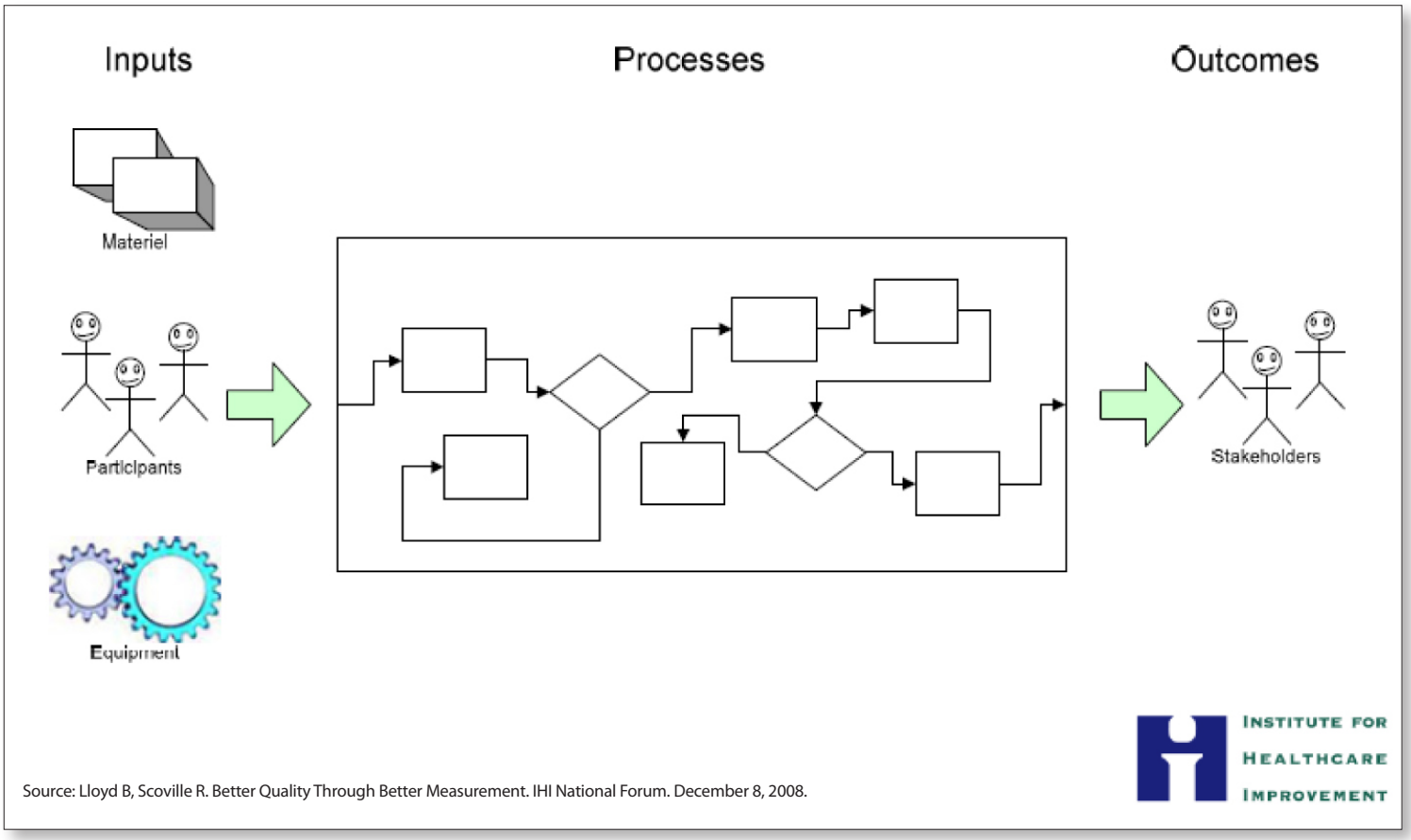
MacColl Institute at Group Health Cooperative

APPENDIX A-- What is a System?

A system is defined as the network of factors that lead to outcomes of value to stakeholders. These factors are comprised of structures, processes, culture, personnel, geography and much more. Improving outcomes requires understanding the dynamics of the system. The Associates for Process Improvement describe a system as having three elements:[15]

- Inputs
- Processes
- Outcomes

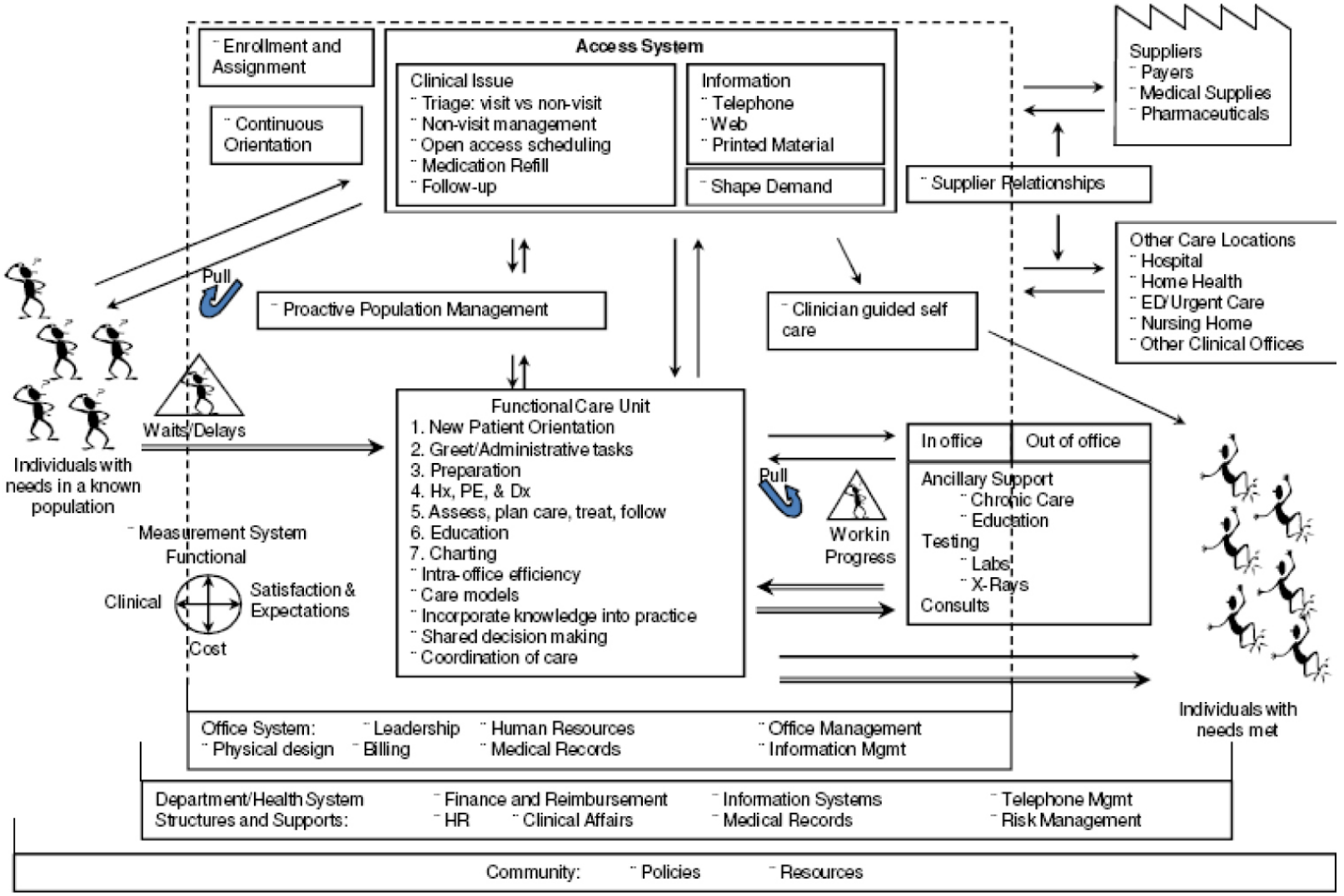


Source: Lloyd B, Scoville R. Better Quality Through Better Measurement. IHI National Forum. December 8, 2008.

What's in a System

System **inputs** include equipment and materials, such as supplies and drugs. Participants include staff, patients, management and clinicians. **Processes** are a series of activities and decisions that lead to outcomes, such as a patient encounter or a standing operating procedure. **Outcomes** are defined as the value that is gained for the stakeholders, the patient and family, board members, and most of the participants.[16]

Don Berwick and Tom Nolan (IHI Senior Fellow) developed a systems-level view of the clinical office. Within are parallels to the system implementing the patient centered medical home. They also identified four overarching themes within the system: access, interaction, reliability and vitality (of the workforce).



The Clinical Office as a System

Source: Nolan T, Berwick D, Gilfillan R, Tomcavage J, The Medical Home as a Large Scale System. IHI National Forum. 2008

APPENDIX B: Sponsor/Improvement Team Agenda (example)

Senior Leader:

Improvement Team Members:

1. Review Aim Statement & Goals for our clinic (these will stay the same each month):

   Aim Statement #1

   Aim Statement #2

2. What are the important/unique/challenging aspects of the initiative that our sponsor and senior leadership should keep in mind?

3. Review significant accomplishments over the past month – focus on results:
   (include progress/resolution of any issues from previous reports, if appropriate)

4. Review monthly data reports, if available:
Run charts for each of the measures should be attached in a separate report

5. Discuss the clinic team experience/issues:
Identify specific issues that may be unique to this team. Competing priorities or resource issues could be included here.

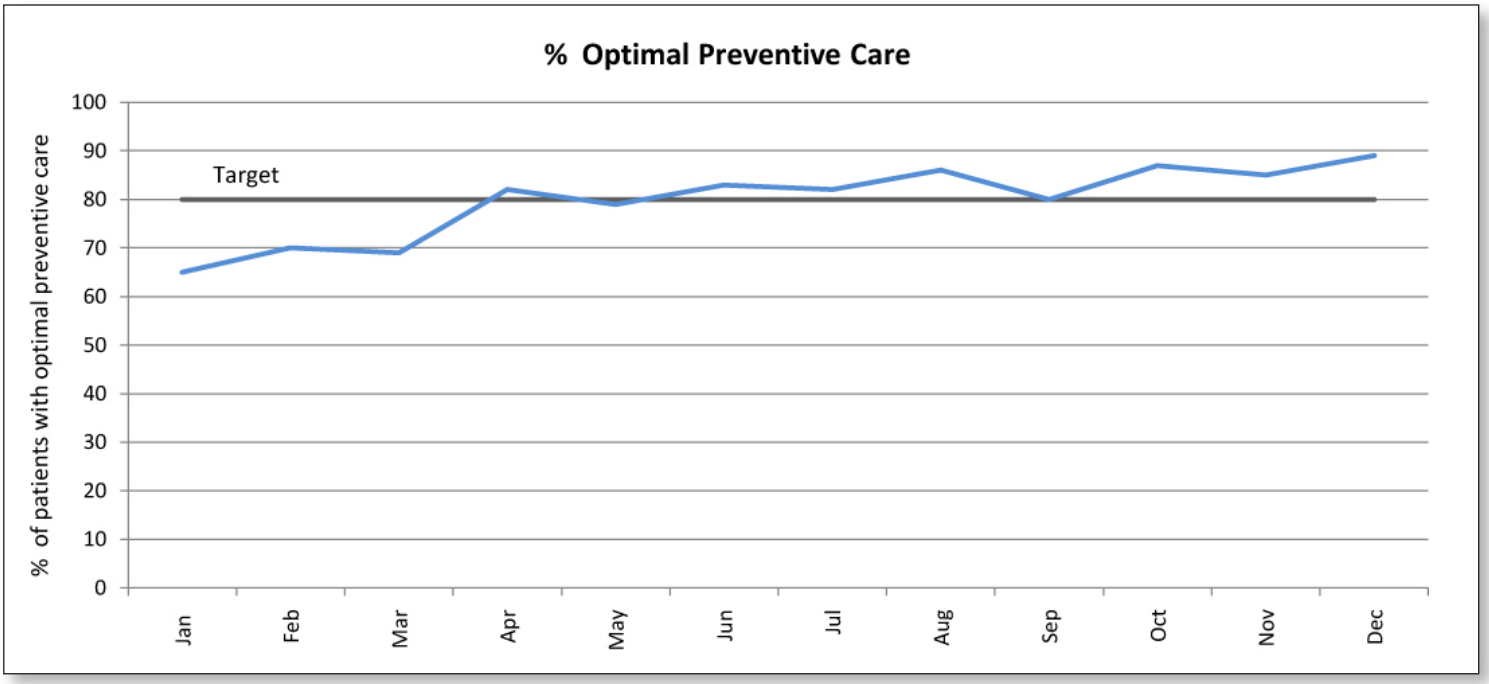
6. Identify what problems/issues have been encountered in the last month that the team needs help with:

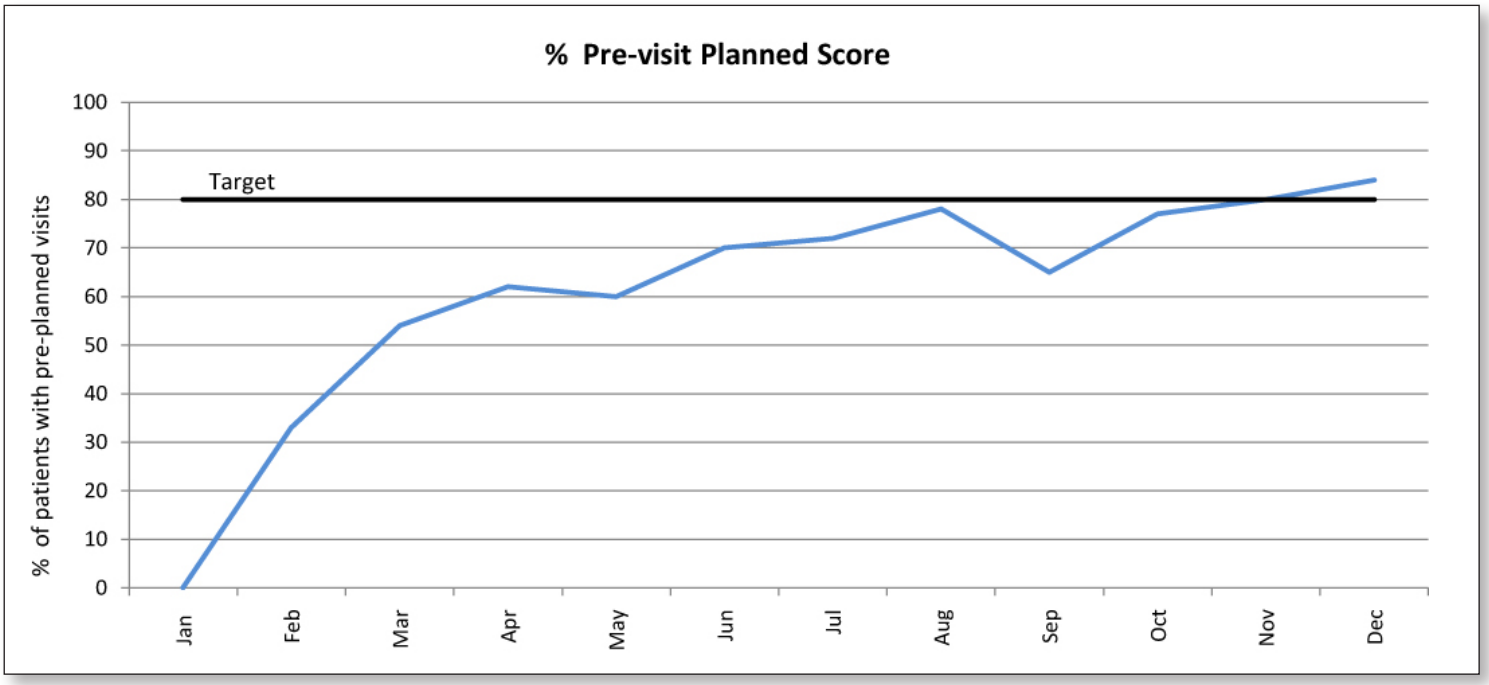
7. Determine the level of confidence that the team will meet its aims and goals within the project timeframe:

1	2	3	4	5	6	7	8	9	10
No confidence									High confidence

8. Next Steps

APPENDIX C: Sample Dashboard

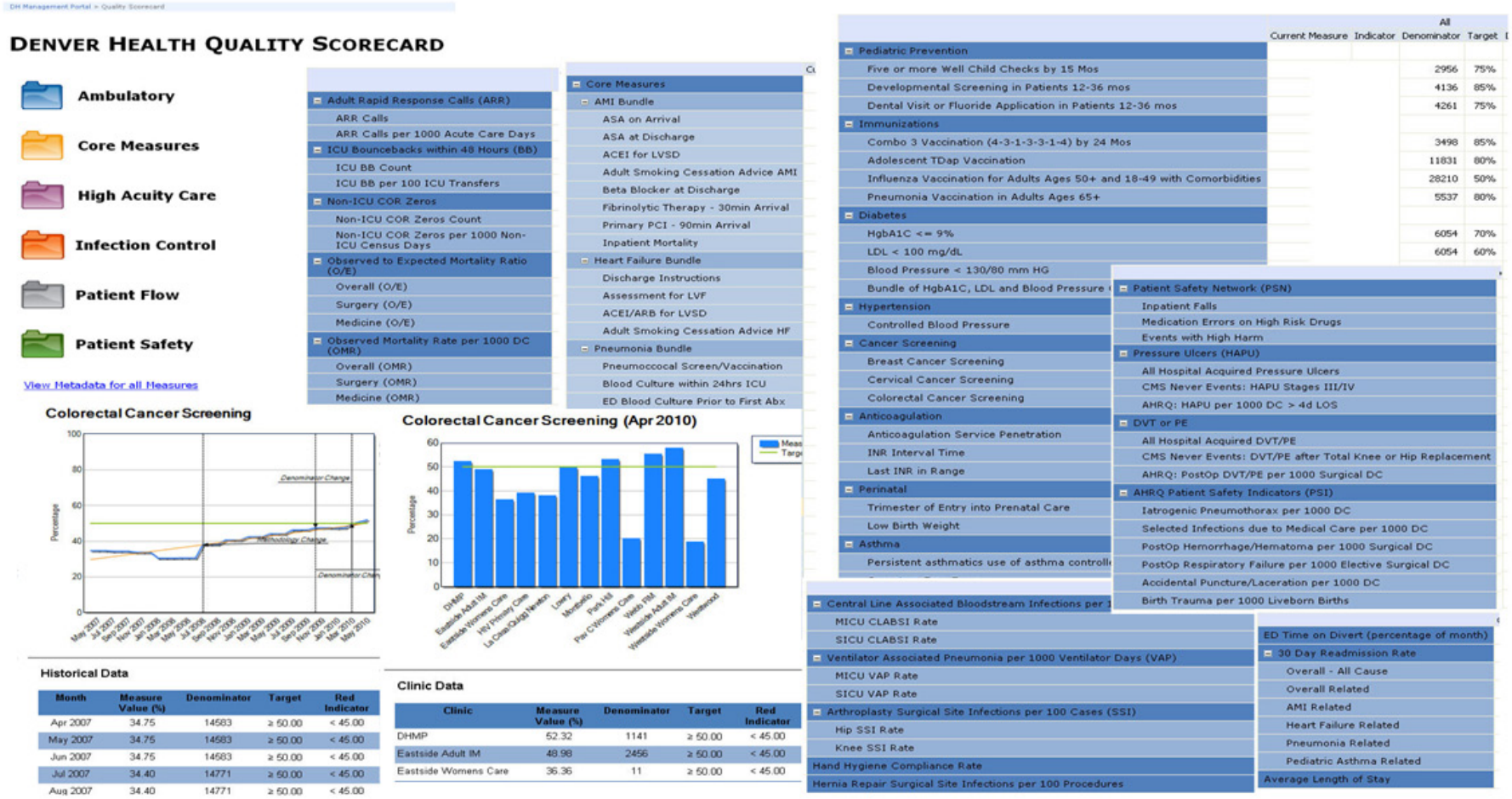




Other Examples of Measures

% Optimal Diabetes Care Measure
% Generic Pharmaceutical Usage
% Willingness to Recommend Office to Family and Friends
% Received Enough Information from Providers
% Hypertensive Patients with B/P Controlled at Last Visit
Average Visits per Day

Sample Quality Scorecard from Denver Health



Source: Denver Health (written communication). Denver, CO: October, 2010.