Community and Family Medicine
Grand Rounds
Tuesday, May 30, 2017

Transforming Primary Care:
Redesigning the Work for Improvement

John B. Anderson, MD MPH
Chief Medical Officer, Duke Primary Care
Assistant Professor of Medicine, Community and Family Medicine
Agenda

- Motivation for change
- Transforming Primary Care Collaborative (TPCC)
- Improvement framework
- Outcomes/Opportunities/Challenges
Duke Primary Care

- 28 sites
- 27 primary care practices
- 6 urgent care centers
- 7 counties in the Triangle area
- Average practice size = 6 providers

**Top Diagnoses:** Preventive Services (Adult and Child), Hypertension, Diabetes, Hyperlipidimia, Pharyngitis, Bronchitis, URI, Sinusitis, Otitis Media

**Encounters:**
- Fiscal Year 2016 Actual = 640,000
- Fiscal Year 2017 Projected = 700,000

**Primary Care Providers:** 165
**Urgent Care Providers:** 50
**Support Staff:** 700
Motivation – Forces for Change

- Patient-Centered Medical Home
- Population Health
- Burn-Out and Resilience
- Operational Improvement
Why do this?

PCMH

Value Based Care

IHI 6 AIMS

Quality Metrics

Patient Experience

Healthcare Regulation

Skill-Task Alignment

Return Joy to Practice

Improve Staff Job Satisfaction
Summary of Comparative Results

- **Moderate strength** indication that interventions meeting PCMH criteria are generally associated with **small improvements in patient experiences**—Both overall and care coordination measures

- **Low strength** indication that PCMH implementation is associated with improved **clinical staff experiences**

Summary of Comparative Results

• **Low strength** indication that PCMH may improve care processes
  - Based on a combination of:
    - Moderate evidence of an effect for preventive services
    - Insufficient evidence to evaluate impacts on care for patients with chronic illness

• **Insufficient evidence** to determine the impact of PCMH implementation on clinical outcomes

Insanity: doing the same thing over and over again and expecting different results.
“Every system is perfectly designed to achieve the results it gets”

- Dr. Don Berwick
How to best spread the work across the team members?
Roles and responsibilities?
Shared decisions? Conflict resolution?
Foster trust and respect?
How to ensure effective communication?

The Myth of the Lone Physician: Toward a Collaborative Alternative
Saba, Villela, Chen, Hammer, Bodenheimer. Annals of Family Medicine, 10 (2) 2012 169-173
Sharing the Work

• 53% of face-to-face PCP visit time as involving content that could be assigned to staff, another modality or not happen at all.

• Activities that could be shifted include:
  – Discuss existing condition, medication review, preventive care, coordination of care, recordkeeping

• Opportunity to move some efforts outside of face-to-face

• Success influenced by quality of working relationships (trust and communication) and skill level of staff

The Goal

*Transform the primary care visit and indirect care delivery outside the visit*

- Maximize provider efficiency
- Return “Joy” to practice
- Increase patient engagement
- Improve clinical and operational outcomes
- Create capacity for true Population Health and Value-Based care
What Is TPCC

• It is a model to facilitate a *collaborative* approach to identifying opportunities for improvement and *testing* new methods to deliver care in Primary Care at Duke. The improvements are developed and tested by *front line* staff and providers. Once new workflows are validated through this process they then become our *new standard* of care.
Our Journey to Future State
Changing Systems

- Evidence-Based Guidelines
  - Clinical Practice Guidelines
- System Change Strategy
  - Patient Centered Medical Home (PCMH)
- Change Model
  - Lean Thinking and Rapid Cycle Improvement
- Learning Model
  - Learning Collaboratives

Improved Processes
Improved Outcomes
Improved Satisfaction
Enhanced Access
More Appropriate Costs
Return of “Joy” to Practice

Adapted from material presented by Edward H. Wagner, MD MPH
What is Lean?

“The endless transformation of waste into value from the customer’s perspective”.

-Womack and Jones, *Lean Thinking*

“Every worker applying the scientific method to every part of daily work.”

“an organization’s cultural commitment to applying the scientific method to designing, performing, and continuously improving the work delivered by teams of people, leading to measurably better value for patients and other stakeholders.”

- John Toussaint, MD
Spread- IHI Collaborative Model

Select Topic
Recruit Faculty
 Develop Framework and Changes

Enroll Participants

Prework

A
S
D

P
A
S
D

P
A
S
D

LS1
AP1
LS2
AP2
LS3
AP3

Summative Congresses and Publications

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act
Our Lean Collaborative Change Model

Current State

Future State

RIE #1

Learning Session

Model Practices

RIE #2

Learning Session

RIE #3

Learning Session

RIE #4

Learning Session

Collaborative Practices
PDSA Results:
Model Practices
<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>CLINICAL STAFF (CMAs/LPNs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate abnormal results to patients</td>
<td>Complete patient forms</td>
</tr>
<tr>
<td>Communicate normal results to patients (letter, phone or MyChart)</td>
<td>Perform other pre-visit work</td>
</tr>
<tr>
<td>Complete patient forms</td>
<td>Manage Rx refill requests between visits</td>
</tr>
<tr>
<td>Manage Rx refill requests between visits</td>
<td>Collect any needed specimens (e.g., brings pt to bathroom to collect urine)</td>
</tr>
<tr>
<td>Perform other pre-visit work</td>
<td>Record tobacco use status</td>
</tr>
<tr>
<td>Prepare patient letters (e.g., work excuse, permission to return to work)</td>
<td>Place patient in room for visit</td>
</tr>
<tr>
<td>Review any info from MyChart prior to visit</td>
<td>Collect vital signs</td>
</tr>
<tr>
<td>Review patient info in Maestro Care prior to visit</td>
<td>Complete any POC testing (by protocol)</td>
</tr>
<tr>
<td>Assess health maintenance/gaps in care</td>
<td>Identify Rx refill needs at visit</td>
</tr>
<tr>
<td>Code and enter the Level of Service for the visit</td>
<td>Record chief complaint(s)</td>
</tr>
<tr>
<td>Collect Medical History from patient</td>
<td>Administer in-clinic medications, vaccines, and other treatments</td>
</tr>
<tr>
<td>Complete primary note documenting visit</td>
<td>Collect any equipment needed for visit</td>
</tr>
<tr>
<td>Conduct physical examination</td>
<td>Complete hearing/vision or other screening activities</td>
</tr>
<tr>
<td>Determine self-management support needs &amp; educate patient</td>
<td>Review allergies</td>
</tr>
<tr>
<td>Document self management goals</td>
<td>Perform medication reconciliation</td>
</tr>
<tr>
<td>Enter any referrals resulting from visit</td>
<td>Complete any additional in-office testing (e.g., EKGs)</td>
</tr>
<tr>
<td>Enter Medical History in Maestro</td>
<td></td>
</tr>
<tr>
<td>Enter medication and other orders</td>
<td></td>
</tr>
<tr>
<td>Establish patient's self management goals</td>
<td></td>
</tr>
<tr>
<td>Identify Rx refill needs at visit</td>
<td></td>
</tr>
<tr>
<td>Perform medication reconciliation</td>
<td></td>
</tr>
<tr>
<td>Provide medication counseling</td>
<td></td>
</tr>
<tr>
<td>Record tobacco use status</td>
<td></td>
</tr>
<tr>
<td>Review allergies</td>
<td></td>
</tr>
<tr>
<td>Review Patient Instructions and discharge the patient</td>
<td></td>
</tr>
<tr>
<td>Review patient progress toward goals &amp; incorporate into treatment plan</td>
<td></td>
</tr>
<tr>
<td>Screen for health literacy</td>
<td></td>
</tr>
<tr>
<td>Review patient progress toward goals &amp; incorporate into treatment plan</td>
<td></td>
</tr>
</tbody>
</table>
*In order to see 20 pts/day and finish the work in 8 hours, the total work effort/pt would need to be less than 19 minutes (at 80% productivity level) or 24mins (100%)
Prepared Patient, Prepared Practice Team

- Agenda established
- Goals set
- Meds reconciled
- Refills pended
- History updated
- Vitals collected
- Screenings completed
- Orders pended
- Supplies available
- Informed provider
## Creating Standard Work

<table>
<thead>
<tr>
<th>What</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-visit work</td>
<td>Prepare the team &amp; the patient for the visit.</td>
</tr>
<tr>
<td></td>
<td>Improves skill-task alignment on the team</td>
</tr>
<tr>
<td>Pre-visit huddles</td>
<td>Prepare the team daily</td>
</tr>
<tr>
<td>Printing med list at check-in</td>
<td>Engage the patient in medication reconciliation</td>
</tr>
<tr>
<td>Intake changes (w/ social, family, medical hx, pt ed tab)</td>
<td>Improve skill-task alignment among team. Comply with JC requirements</td>
</tr>
<tr>
<td>Co-location</td>
<td>Increase communication among provider and clinical team. Facilitates improvement in flow.</td>
</tr>
<tr>
<td>Overdue Results</td>
<td>Reduce in-basket management for providers and optimize skill task alignment. Close the loop with patients regarding lab orders.</td>
</tr>
<tr>
<td>Depression screening</td>
<td>Identifies population with mental health needs.</td>
</tr>
<tr>
<td>Discharge Process</td>
<td>Patient centered, reduces bottlenecks at front desk, ensures patients leave with a clear plan of care. Reduces follow up questions via phone &amp; MyChart.</td>
</tr>
</tbody>
</table>
Depression Screening Implementation

Patients w/ Depression Screening Complete in Past 12 months

- Jul-15: 2,143
- Aug-15: 2,882
- Sep-15: 3,857
- Oct-15: 6,931
- Nov-15: 9,269
- Dec-15: 11,718
- Jan-16: 12,406
Maximizing the Utilization of Rooming Staff

Model Practice Rooming Staff Productivity
RIE #1 to RIE #2

*Based on staff collected data (average daily count and P/T by task)
Providers still working long hours

*Example of a providers’ time in Maestro

This area chart allows you to see where the user is spending time in the system throughout the day for four key areas.

- **1-7am**
- **6-12pm**

- Notes/Letters
- Order Entry and Review
- In Basket
- Clinical Review
New Models Highly Dependent on Team Based Care
“Share the Care”
### RIE#3: PDSA Summaries

<table>
<thead>
<tr>
<th>Staffing</th>
<th>PDSA #1: Encounter Specialist</th>
<th>PDSA #2: Test, Treatment, Discharge Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2:1 CMAs to Provider</td>
<td>1.5 CMAs to Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roles</th>
<th>CMAs add “scribing” of all documentation during the provider visit to their current duties. Both CMAs serve in the same role</th>
<th>1 CMA completes pre-visit &amp; intake. .5 CMA (shared) completes test, treatment &amp; discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LPN/CMA: manages indirect work for providers</td>
<td>LPN/CMA: manages all indirect work for provider</td>
</tr>
</tbody>
</table>
Encounter Management Care Team Planning & Implementation Process Overview

**Planning**
- Practice Readiness Evaluation
- Practice Leadership Prep - Today
- Practice Team Prep
- Prepare Staffing
- Establish Go-Live Plan

**Training**
- CMA Foundation Training and Encounter Specialist Introductory Class
- Shadowing Experience
- Teamlet Readiness
- Dress Rehearsal

**Implement**
- Go-live
- Elbow to Elbow support
- Frequent De-briefs

**Study/Act**
- 7 day Post-live review
- 30 day post-live review
- 90 day post-live review
### October 2016

<table>
<thead>
<tr>
<th>SUN</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
<th>SAT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>4</strong></td>
<td><strong>5</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td><strong>7</strong></td>
<td><strong>8</strong></td>
<td><strong>ES</strong></td>
<td><strong>Training</strong></td>
<td><strong>Course</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>9</strong></td>
<td><strong>10</strong></td>
<td><strong>11</strong></td>
<td><strong>12</strong></td>
<td><strong>13</strong></td>
<td><strong>14</strong></td>
<td><strong>15</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Utilize this week to set up your preference list to match the provider you will be working with. Setup you common dx buttons and begin discussing different templates that your provider uses.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>19</strong></td>
<td><strong>20</strong></td>
<td><strong>21</strong></td>
<td><strong>22</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Pick some sessions this week to observe the provider you will be working with. This will allow you to see their flow and how they conduct their office visits. Don’t worry about documenting right now, practice uploading templates for your provider and just take everything in!</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>23</strong></td>
<td><strong>24</strong></td>
<td><strong>25</strong></td>
<td><strong>26</strong></td>
<td><strong>27</strong></td>
<td><strong>28</strong></td>
<td><strong>29</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Practice with documentation modules and audio files.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>30</strong></td>
<td><strong>31</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>4</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Dress Rehearsal and GO LIVE Week!!!!!!!!</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ES Name  
Duke Primary Care  
Encounter Specialist Training

Please refer to the Duke Sakai website for tutorials on how to set up your preference list, common dx buttons and how to share templates. Make sure you review the lessons listed and practice your medical terminology using the games and flash cards provided. Review Maestro Navigation lesson on Duke Sakai.

I will provide you with a website to access various audio files.  
[https://sites.google.com/site/scr/betaining/practice-audio](https://sites.google.com/site/scr/betaining/practice-audio)
<table>
<thead>
<tr>
<th></th>
<th><strong>Encounter Specialist</strong></th>
<th><strong>Enhanced Encounter Support Team</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Role</strong></td>
<td>2 CMAs share workload support 1 provider. Completes pre-visit planning, intake, documentation support, facilitates records &amp; results review during visit, completes tests and treatments, reviews care plan with patient, and schedules follow up appts including some direct scheduling of referrals.</td>
<td>.5 CMA (shared) augments existing CMA support to complete test &amp; treatment, review care plan with patient, and schedule follow up appts including some direct scheduling of referrals.</td>
</tr>
</tbody>
</table>
| **Initial outcomes from brief testing period** | • Improved attn. and focus of provider during visit  
• Reduction of the burden of documentation resulting in improved workdays  
• Restoring “joy in practice”  
• Improved job satisfaction for staff by being a part of the entire visit and a valuable member of the team  
• Improved patient satisfaction | • Facilitates patient flow, reducing waits and delays for patients  
• Reduces provider time spent waiting on staff availability  
• Reduces stress of staff trying to support efficient providers with busy schedules |
| **Anticipated Outcomes with prolonged implementation** | • Reduced provider burnout  
• Less turnover and reduction of FTE status  
• Ability to see more patients and create additional access in existing infrastructure  
• LOS will better represent the work completed during a visit  
• Improved job satisfaction for high performing staff leading to reduction in CMA turnover | • Ability to see more patients and create additional access in existing infrastructure  
• Improved job satisfaction for staff leading to reduction in CMA turnover |
| **Ideal Provider Candidate for Implementation** | • Provider with appointment supply <demand  
• Provider willing to collaborate with and teach staff | • Providers who are masters of efficiency in maestro  
• Provider with appointment supply <demand  
• Providers who have a higher number of acute visits and can therefore see greater # of patients without complex documentation needs |
| **Dependencies**           | • Ability to recruit additional workforce needs  
• Staff with team player attitude and strong aptitude  
• Strong onboarding process  
• Strong ES training program | • Ability to recruit additional workforce |
Panel Manager Role

• Improve verbal communication among team
  • Develop formal or informal huddling process to reduce messaging and delays

• Implement InBasket scrubbing standard work
  • Attach nurses to provider InBaskets- in teams

• Enhance Triage - implement Triage module- Go-Live completed in April 2016
  • Enhance MyChart message management: Retrain and empower staff to handle messages appropriately without provider involvement.
  • Agree on standard guidelines of communication of normal results
Care Management Team: Responsible for supporting the patient in achieving improved health outcomes in partnership with the encounter and care coordination teams.

Care Coordination Team: Responsible for the management of indirect work in support of the office visit. Coordinating care before, during and after the visit.

Encounter Management Team: Responsible for preparing for and providing direct patient care in an office visit setting.

Duke Primary Care Comprehensive and Collaborative Care Team
<table>
<thead>
<tr>
<th>What</th>
<th>About</th>
<th>Impact to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Visit Planning</td>
<td>MA or LPN identifies patient needs prior to the visit through pt phone calls and chart review.</td>
<td>Ensures pt is properly prepared for the provider visit, focusing the visit agenda and thereby reducing chaos of the office visit.</td>
</tr>
<tr>
<td>Encounter Specialist</td>
<td>MA or LPN that supports the visit from pre-work to discharge, providing documentation support during the provider visit</td>
<td>Reduce the burden of documentation. Allow providers to focus on patients and clinical decision making.</td>
</tr>
<tr>
<td>Enhanced Encounter Support</td>
<td>Increased staffing support on the floor to provide pre-visit, intake, discharge and test and treatment support while reducing waits and delays.</td>
<td>Provide additional staffing support for providers who are highly efficient and need additional resources to ensure there are not waits and delays for both patients and the provider.</td>
</tr>
<tr>
<td>Panel Managers</td>
<td>LPN or RN that provides nurse visit, triage, and indirect work support including scrubbing of provider inbaskets and patient messages.</td>
<td>Reduce the burden of the indirect, computerized work that is pushed to providers.</td>
</tr>
<tr>
<td>Collaborative Care Nurse</td>
<td>An RN that provides care including conducting AVVisits, patient education, chronic dz management support and TCM.</td>
<td>Supports providers by sharing the care of their patient panels.</td>
</tr>
<tr>
<td>Population Health Specialist</td>
<td>Provides care coordination for the patients in need of both clinical and psycho-social support.</td>
<td>Supports providers by managing patients with complex needs that can be logistically challenging and be a burden on the provider and other care team members.</td>
</tr>
</tbody>
</table>
### Organized for Population Health

#### Population Health Nurses (embedded RN Care Managers)
- Annual Wellness Visit Strategy
- Transitional Care Management
- Chronic Care Management
- Expansion of Depression Care
- Medication management
- Behavioral health
- High risk patient management
- Advanced care planning
- Geriatrics
- Lactation Consulting Services & Newborn Care

#### Depression Care Managers
- Implementation of the IMPACT model for depression care
- Psychiatry case review and back-up

#### Diabetes Care Program
- Diabetic education
- Group visit interaction
- Nutrition counseling
- Maestro documentation and f/u with providers
- Standard Work for intake
- Standard work for between visit care

#### Development of Pharmacy support
- Refill Management – Centralize?
- TOC Med Rec
- Medication Management Support
- Clinical care / input (Opioid / Chronic Pain, HTN, hyperlipidemia, others?)

#### Population Health Specialist
- Embedded in Practice
- Patient navigation
- Align patients and resources
- Connect with Care Management team
- Care Team support
Collaborative Depression Care Outcomes

- Response = 50% reduction in PHQ
- Remission = PHQ < 5

<table>
<thead>
<tr>
<th></th>
<th>IMPACT Study Usual Care</th>
<th>IMPACT Study Collaborative Care</th>
<th>Sutton</th>
<th>Hillsborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N=895</td>
<td>N=906</td>
<td>N=60</td>
<td>N = 50</td>
</tr>
<tr>
<td>Response</td>
<td>19%</td>
<td>45%</td>
<td>55%</td>
<td>40 %</td>
</tr>
<tr>
<td>Remission</td>
<td>8.3%</td>
<td>25%</td>
<td>27%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Slow, impoverished, scientifically unfounded methods such as “reliance on inspection for improvement” — define what you want (“quality”), measure it, and act on the outliers (the deficient few) — do not help us achieve continual, pervasive, and never-ending improvement. Reliance on inspection does not foster creativity, learning, and pride — it poisons them, because its main harvest is not learning, it is fear.

There is a better way — scientific, grounded in theory, proven in practice, and ready for our use: continual improvement, learning in the face of complexity.

-Don Berwick
Adapted in IHI Leadership Blog post April 16, 2015
Duke Primary Care – Continuous Improvement

The Place

The People

The Process

Continuous Improvement

Improvement Tracking Center + Improvement Huddles + PDSA = The Purpose
Your Improvement Tracking Center is a Workplace for Team Discussions and Decisions.

Daily Visual Management is achieved through a Daily Improvement Tracking Center.
Improvements in Patient Experience

- Comparing Pre-TPCC (July 2015-March 2015) to post-TPCC (April 2015-September 2016)

- Global Satisfaction - Patients checking the “top box”
  - Before TPCC: Average per provider across time = 81.7% (March 2015 = 81.8%)
  - After TPCC: Average per provider across time = 84.9% (March 2017 = 86.3%)
  - Because of the “ceiling effect” of satisfaction scores, this is significant

- Physician Communication
  - Before TPCC: Average per provider across time = 91.9% (March 2015 = 91.2%)
  - After TPCC: Average per provider across time = 92.7% (March 2017 = 93.3%)
    • Statistically significant

- Reduced variability in patient satisfaction among providers
Qualitative Assessment of TPCC

- In-depth interviews with 16 CMAs and 9 PCPs in the program
  - October - November 2016

- Views of encounter specialists and providers were primarily positive

- Interviewees felt this model is different and generally improved from prior practice and interaction with patients

- Encounter specialists and providers were concerned about burnout of encounter specialists

- Movement up the clinical ladder and increased pay for encounter specialists are critical

- Communication from leadership is key
Qualitative Assessment of TPCC

• **Screening and training** are important, including consideration of the role of providers in this process.

• Moving forward, the encounter specialist model may not be the best model for every provider and every CMA.
  – **Success is also dependent on fit** between the particular provider and encounter specialists within a team.

• Additional suggestions: consider other metrics (e.g., RVUs, satisfaction); provide clarity regarding roles and responsibilities; ensure adequate staffing; weigh standardization of the process across providers vs. flexibility.
What Providers are Saying

• “Our team of three really feels like a team.”

• “I also think the quality of the care I am giving is better. I can listen to the history with my full attention since I am not struggling with technology all the time.”

• “The medical assistants are happier overall.”

• “I do think you have succeeded at least for me in bringing back the joy of medicine. Thank you!”
Progress to Date

- Standard work for CMAs in place across DPC
- Panel manager spread in progress
- Spread limited by support staffing
- Encounter Specialist support:
  - Currently implemented in 6 sites
  - 15 providers
  - Planning for next wave in June
Quality Data – Cardiovascular Composite

DPC- CAD Composite
Target 65%

58% of practices are meeting target
~50% of providers are meeting target
Quality Data - Diabetes Composite

DM Composite YTD FY 17 (July-March)
Target 25%

100% of practices are meeting target
69% of providers are meeting target
Duke Primary Care Breast Cancer Screening
FY 17 Target: 75%
Cultural Challenges for Providers

- Autonomy
- Accountability
- “Personal” vs “Team” relationship with patients
- Renewed sense of purpose among team members vs undesirable work
- Patient acceptance of other team members
- Change inertia
Lessons Learned and Confirmed

• Share the **Why**, go back to the **Why** often
• Go slow to go quick
• Staffing is critical and rate-limiting
• Drift will happen- plan for it and manage it
• Champions are critical to success
• **Copy/Paste** Adopt/Adapt
Simply put, an organization that promotes continuous learning and improvement is one that “make[s] the right thing easy to do” (Halvorson, 2009). Its environment reduces stress on front-line staff, improves job satisfaction, and prevents staff burnout (Boan and Funderburk, 2003). Its environment simplifies procedures and workflows so that providers can operate at peak performance to care for patients, and embraces cognitive supports such as checklists and reminders that make providers’ jobs easier. In this environment, internal processes and procedures align with the organization’s aim or mission and with leaders’ vision and actions.

Institute of Medicine, “Best Care at Lowest Cost: The Path to Continuous Learning Health Care in America” 2012