Change Management and Service Delivery Transformation

Chris Espersen and Melissa Stratman Coleman Associates

©Coleman Associates and Chris Espersen
Utilizing the Same Readiness Assessment Tool...
Just as a reminder

From the Authors (JSI and NACHC)

“

- A self-assessment of
- 1-3 indicates little or initial development of competency in the readiness area,
- 4-6 signals substantial progress and competency, and
- 7-9 shows maturation and systemization of a competence.”
### SUMMARY OF RESPONSES:
Organizational Leadership and Partnership Development

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RESPONSE 1</th>
<th>RESPONSE 2</th>
<th>RESPONSE 3</th>
<th>RESPONSE 4</th>
<th>RESPONSE 5</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The BOD is knowledgeable about payment reform efforts and their implications for the health center’s mission and services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The health center’s governance requirements and structure facilitate governance role in payment reform initiatives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Administrative and clinical leadership have a shared organizational vision for and commitment to involvement in payment reform.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Administration and clinical leadership demonstrate commitment to payment reform model being pursued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The health center examines implications of specific payment reform opportunities in relationship to existing mission, service area, and scope of services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The health center has experience developing partnerships to address service area needs and take advantage of opportunities in the local health care marketplace.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The health center partners with local hospitals and specialists to meet the goals of the payment reform models.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The health center has established relationships with social services and/or other organizations in the community needed to support the payment reform model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL(S)**
The health center has experience developing partnerships to address service area needs and take advantage of opportunities in the local health care marketplace.
Question #6

1-3
- Have informal referral relationships with other service providers.
- Can articulate your “competitive advantage.”

4-6
- Have formal partnerships with other service providers to address specific needs of target population.
- Guide your efforts with a negotiation/partnership strategy.

7-9
- Lead partnership development efforts to develop integrated service delivery approaches for meeting target population needs, & leveraging funding opportunities.
- Partnerships focus on developing non-redundant, community-level systems of care.
Question #6

- What opportunities do you have to network with other partners (coalitions that other service providers attend)?
- What do you need and what do you want from a collaboration?
- Are you sharing data with others, and are others sharing data with you?
- How do you create mutually beneficial goals?
- How will you proactively troubleshoot issues that arise?
- Why do others want to work with you?
Question #6
What this looks like in practice

- You systematically and thoroughly evaluate gaps in the care continuum.
- You are the “go-to” partner or convener.
- You do not engage in “turf-wars” and are able to help others let go of these battles as well!
- You are master of your story, and have a strategic approach in place that you can efficiently and effectively execute with new partners.
- You have a vision of integrated, comprehensive care for your patients, and you lead diverse partners towards recognition of this vision.
The health center partners with local hospitals and specialists to meet the goals of the payment reform models.
<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establish positive working relationships with hospitals and specialists in the service area.</strong></td>
<td><strong>Shared service delivery models including (co-location, hospital diversion programs or service integration, other collaborations).</strong></td>
<td><strong>Have developed new product/services to meet target population needs or to take advantage of new payment reform opportunities along with hospital/specialty groups.</strong></td>
</tr>
<tr>
<td><strong>Participate in CHNA.</strong></td>
<td><strong>Analyze utilization patterns, and needs and opportunities of service area population with hospital and/or specialty groups.</strong></td>
<td><strong>Have analyzed the cost-effectiveness and outcomes of partnership efforts.</strong></td>
</tr>
</tbody>
</table>
Question #7

- What are the services that are under-utilized?
- What are the services that are over-utilized?
- What are the services that patients need, but don’t exist in your community?
- Do the costs of the partnership result in outcomes that will lend themselves to VBP?
- How do you adapt to changes in service delivery that will result in better outcomes, while still maintaining your bottom line?
- How can you advocate/ stay true to mission for patients not part of VBP arrangements?
Question #7
What this looks like in practice

- You are innovators, coming up with creative, effective solutions by leveraging community resources.
- You can demonstrate success with financial data and community wide outcomes.
- You can tell a story about how your efforts are helping the community, or others want to tell your story.
Question #8

- The health center has established relationships with social services and/or other organizations in the community needed to support the payment reform model.
<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
</table>
| - **Have an inventory of all organizations serving target area and specific populations. (SDH).** | - **Analyze which partnerships are most critical for reaching payment reform goals.**  
- **Staff are leaders of relevant community coalitions and/or stakeholder groups.** | - **Partnerships in place, with rigorous MOU/role definition, to develop new products/services which meet population needs or take advantage of VBP.**  
- **Analyze the financial and health outcomes of partnership efforts.** |

© 2017 Chris Espersen
Question #8

- Do you have access to a comprehensive environmental scan, and do you understand its implications?
- How can you maximize opportunities to network with other agencies?
- Do you have a good system in place to organize and track MOUs?
- Do the costs of the partnership result in outcomes that will lend themselves to VBP?
Question #8
What this looks like in practice

- You can demonstrate success with financial data and community wide outcomes.
- You successfully pivot when change leads to lost revenue, and turn these changes into opportunities.
- Your efforts are reflected in your value based reimbursements.
- Your partnerships create excitement and energy internally and externally!
We want to look in more depth at

## SUMMARY OF RESPONSES:
Change Management and Service Delivery Transformation

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RESPONSE 1</th>
<th>RESPONSE 2</th>
<th>RESPONSE 3</th>
<th>RESPONSE 4</th>
<th>RESPONSE 5</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. The health center has experience with and knowledge of change management practices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Clinical and administrative leaders support change processes in a systematic fashion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. The health center has experience managing care for groups of patients and/or populations with chronic conditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. The health center has experience managing high-utilizer/high cost patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. The health center provides robust care coordination.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. The health center is a Patient Centered Medical Home (PCMH)/Patient Centered Health Home (PCHH).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. The health center provides patient-centered care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Behavioral health services are integrated with primary care services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The health center provides enhanced access to meet the needs of the target population.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. The health center has linguistic and cultural competence to meet the target population’s needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. The health center engages in population health assessment and initiatives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL(S):
The health center has experience with and knowledge of change management practices.
Question #9

- Do you have a multi-disciplinary team that does troubleshooting and problem solves?
- What metrics do you share with staff and with what frequency?
- Do staff on the front lines understand data metrics you use and report? Clinical metrics? Operational metrics?
- How do you connect the dots for staff between goals and outcomes?
- When someone has a problem... is it standard to seek data first to validate & drive decision making? (This is different from seeking data to prove there isn’t really a problem).
Question #9

- What do staff do when they have a solution for something?
- What would you like the culture of making mistakes in your organization to be?
  - How is it currently?
- Are there areas that staff know are off limits for touching or making improvements (Sacred Cows as David Brandt calls them)?
Question #9

1-3
- The health center has had **limited involvement** in Human Resources and Services Administration (HRSA)-funded disease collaboratives, Patient Centered Medical Home transformation, achieving Meaningful Use standards, or other clinical practice transformation efforts.
- Continuous Quality Improvement (CQI) efforts are **primarily focused on clinical processes**.
- The health center uses structured CQI methods such as Plan, Do, Study Act (PDSA), lean production, six sigma, and related tools.

4-6
- The health center has selected and implemented a formal model for CQI in both clinical and non-clinical arenas, engaging staff from all levels of the organization in defining and implementing initiatives.
- The health center has participated in **multiple practice transformation initiatives** and has spread successful practices throughout the organization.
- The health center **consistently uses** CQI methods such as PSDA, lean production, six sigma and related tools.

7-9
- The health center has developed an identity as a “learning” or CQI organization.
- QI measures are **regularly shared** with team members, leadership and staff.
- The health center has **institutionalized support for change management**, such as robust data and information systems and analysis to inform change processes, expectations of leadership staff to lead and support change efforts, and coaching (external or internal) to address implementation barriers.
What this looks like in practice…

- Data is shared, owned and discussed by all.
- QI is not just an episodic thing… although it may have episodic pushes it is an ongoing evolution of processes as “the way we do things around here.”
- Multi-disciplinary teams are working together to improve the quality in various areas.
- While change is always uncomfortable, it is a way of life that is felt in the work culture.
Clinical and administrative leaders support change processes in a systematic fashion.
Question #10

- What are the items on the agenda of every departmental meeting?
- Do meetings provide updates across silos on how change is being managed and prioritized in the organization?
- How have your performance reviews evolved in recent years? (e.g. are their PCMH metrics included in your reviews? Do peers or teams provide a component of formalized evaluation feedback?)
- How is staying relevant and current on new processes and systems included in your strategic plan?
<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
</table>
| - The health center does not have an organizational approach to supporting change processes. | - There is an organizational commitment to build staff capacity for change management through training and mentorship.  
- Leaders have developed strategies to address past negative experience with change.  
- Appropriate organizational resources (staff, technology, etc.) are dedicated to supporting the change process. | - Change processes are imbedded in the organizational culture including job descriptions, performance review, and organizational benchmarks/score cards.  
- There is regular communication, at all levels of the organization, regarding the purpose and objectives of change processes, their progress, and outcomes. |
Question #10

- There is honest and open dialogue around past change struggles.
- Someone(s) is/are responsible for making sure that change happens, that it is data-driven, and that it follows strategic goals.
- Job descriptions and performance reviews reflect a changing culture and evolving expectations.
- Leaders can effectively communicate ‘what’s in it for staff’ with all of the changes.
- Staff understand data metrics and how the needle gets moved on those metrics.
Question #11

- The health center has experience managing care for groups of patients and/or populations with chronic conditions.
Question #11

1-3

- Identify high-risk patients informally or through chart review.
- Have implemented a disease collaborative at a minimum of one site.

4-6

- Use disease registries to categorize subpopulations by clinical priorities.
- All service delivery sites participate in disease collaboratives and share best practices across the organization.
- Specific disease conditions are included in CQI efforts on an ongoing basis.

7-9

- Engage in continuous visit management for specific conditions.
- Model of care includes systematic follow up for preventive and chronic care planned visits.
- Disease registries automatically prompt and remind about services.
Question #11

- How do you ensure planned visits?
- How do you outreach to patients for preventive chronic disease, and hospitalization follow-up care?
- How do you know if your outreach efforts are successful?
- How do you address and document patient self-management ability and barriers?
- How do you increase patient’s self-efficacy in managing their chronic conditions?
Question #11
What this looks like in practice

- Your efforts are integrated, providing holistic and efficient patient follow-up.
- You systematically identify and track high risk patients
- Your population health metrics related to chronic disease show improvement.
- Your practice incorporates patient and caregiver preferences into self-care plans.

© 2017 Chris Espersen
Question #12

- The health center has experience managing high-utilizer/high cost patients.
## Question #12

<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Have not engaged in specific initiatives for high-utilizer/high cost patients.</strong></td>
<td>- <strong>Participate in (MCO) or hospital initiatives to address inappropriate utilization and prevent hospital re-admissions or admissions for ambulatory care sensitive conditions.</strong></td>
<td>- <strong>Have a contract with ACO or MCO to conduct care management/coordination for your own high utilizer patients.</strong></td>
</tr>
<tr>
<td><strong>Systematically identify your own patients who are high utilizers of health center and/or system resources.</strong></td>
<td></td>
<td>- <strong>Have a contract with ACO/MCO to provide care management/coordination for high utilizer non-CHC patients in the service area.</strong></td>
</tr>
</tbody>
</table>
Question #12

- Who are your high risk patients?
- How do you flag and track these patients?
- How do you provide follow-up care to them?
- How do you proactively prevent avoidable utilization?
- How are you measuring activation and self-efficacy?
- What clinical and utilization markers are you using to measure your success?
Question #12
What this looks like in practice

- You have a system to lower risk (i.e., decrease utilization and improve clinical indicators) …
- …which leads to graduation of patients…
- …which allow “new” high risk patients into your program.
- You have a performance story to market your program.
- You are able to “scale up and spread” your program due to its track record of improving outcomes and lowering costs.
Question #13

- The health center provides robust care coordination.
Question #13

- How far outside your walls does your “blanket of care” extend?
- Do you have Community Health Workers or other community links? Do you have or have ties to programs that truly consider social determinants of health?
- Do you have efforts arranged with outside offices? Hospitals?
- What is your relationship with your local Emergency Department (ED)? How is it to coordinate care between you and your ED?
- How well-versed is your staff on motivational interviewing?
The health center has robust referral tracking and follow-up system.

Care coordination includes motivational interviewing and efforts to address social determinants of health.

Health center uses promotoras/community health workers to support care coordination.

Health center coordinates care with major specialty and hospital groups. Health center is able to provide and/or receive information about care provided by specialty groups and hospitals.

The health center has systemic process for establishing patient-driven care plan, and ongoing follow-up and patient support for the plan, using motivational interviewing or other techniques. Health center is involved in partnerships to reduce hospital readmissions and to develop systems to coordinate behavioral and physical health care, or otherwise coordinate care across providers. Robust health information exchange allows health center to share information with other health care providers in real time.

The health center focuses primarily on obtaining specialty, behavioral health and hospital care for patients needing follow-up care.

Referrals are made and tracked, but there is not a system for determining whether referral is successfully completed.
Question #13

- Health Centers are no longer defined by their geographic footprint.
- Care is formally extended to community partners as well as home/social experiences.
- Health Centers need knowledge (training) and relationships to meet social needs as they impact health and wellness.
- Health Center culture should be one in which other caregivers are partners in care, not competitors.
  - Competition to be better is great...if the patient benefits and it not short-changed.
- Robust health information exchange allows for information sharing with other health care providers in real time.
Question #14

- The health center is a Patient Centered Medical Home (PCMH)/Patient Centered Health Home (PCHH).
Question #14

- Do you have team-based care?
- Are you PCMH recognized? JCAHO or NCQA…
- Have internal processes changed as a result of PCMH efforts?
- Have you leveraged PCMH to better link departments to each other?
- Do patients feel like they are being seen in a medical home?
- Did anyone notice a difference in the patient experience with PCMH?
The health center has **not applied** for PCMH/PCHH or similar state level recognition.

The health center has **begun implementing some aspects of patient centered medical home** (team-based care, use of decision support tools, etc.).

The health center has implemented all aspects of medical home, and is actively **preparing for certification/recognition**.

Staff receive ongoing training and support in implementing PCMH.

The health center has attained recognition status (such as NCQA level one or two) by a national recognition/certification entity for at least one service delivery site.

PCMH standards are **imbedded in organizational and staff expectations and resource allocation**.

The health center has **achieved recognition status** (such as NCQA level one or two) at all service sites.

The health center has achieved advanced recognition status (such as NCQA level three) by a national recognition/certification entity at all service sites.
Question #14

- PCMH is a great guideline to ensure that appropriate check boxes are attained for standards of operations and overall care.
- PCMH does not fix problems that you do not allow it to “fix.”
- Medical Home status should be palpable to the entire organization.
- Staff have been entrusted by management to use their judgment as it relates to ensuring a medical home experience for every patient.
Question #15

- The health center provides patient-centered care.
Question #15

- Are staff oriented around the traditional provider model or are all the services that a patient need organized around a hub?
- Is your staff organized by teams? How do you know?
  - Do they sit in areas by discipline or by team?
  - Do patients have a team of people that they see regularly?
  - Do the teams stay consistent and would patients be able to pick their team out of a line up?
- How much do staff use the portal? Is it easy or efficient for a patient to use the portal (not likely, but I had to ask?) What percentage of patients are on the portal?
- What does providing culturally sensitive care at your health center look like?
Question #15

1-3
- The health center conducts patient satisfaction surveys routinely.
- The health center uses patient feedback to inform CQI activities.
- The health center communicates with patients in a culturally appropriate manner and in the client’s preferred language.

4-6
- The health center has a robust system for assessing patient experience (using ongoing feedback mechanisms, focus groups, etc., in addition to satisfaction surveys).
- Enabling services are an integral component of care delivery, tailored to the needs of the patient.

7-9
- Patients are fully engaged in care planning and care, and are provided with self-management support.
- The health center provides an electronic patient portal for access to patient records and scheduling of care.
Question #15

- Patients can engage more readily in care that is designed for them culturally.
- Patients are more linguistically and culturally diverse now than ever before... and so is the workforce. It is important to leverage that advantage.
- The patient experience isn’t measured just in an annual survey but rather through many points of contact (e.g. robust confirmation calls).
- The portal.... *should* be awesome. Smart phones are awesome, apps are awesome. We have to work to make more portals worth using.
Question #16

- Behavioral health services are integrated with primary care services.
Question #16

- How many Behavioral Health (BH) specialists do you have?
- In what capacity or with what qualifications do they operate?
- Are BH specialist tied to the team?
- Do behavioralists attend the Patient Care Team huddles?
- Where is BH located in relationship to the other services in the clinic?
<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
</table>
| - The health center has strong referral relationships with behavioral health providers. | - Behavioral health services are offered on site with warm hand-off. | - Behavioral health services are integrated in care at all sites.  
- Health Center has substantive partnerships/collaborations with behavioral health entities. |

©Coleman Associates
Question #16

- Behavioral health services are no longer able to be a side arm of care…they must be “integrated” into care for all patient experiences.
- Clinic staff know how to tie patients to BH in Real Time.
- BH has its own Behavioral Health schedule and panel of patients.
- Social work, mental health providers, community health workers – they all tie together and with priority to work in tandem with medical and dental health for a complete picture of care.
Question #17

- The health center provides enhanced access to meet the needs of the target population.
What are the needs of your target population?
Do they need appointments? Walk-in times? Someone to come to them? Digital access?
Thinking of your current access... how patient (and family) oriented is it?
How many WCCs can be scheduled back to back for a big family?
What is your late policy?
When was the last time you called your own after hours number to “try it out?” What do you have to say to get a weekend or after hours appointment?
When is care not available to your patients and what is the back up option?
The health center offers extended weekday evening and weekend hours at a minimum of one service delivery site, and for some services.

The health center has implemented extended hours for all services and at most sites.

Scheduling options are patient and family-centered and are accessible to all patients.

Health center has implemented open access.

Patients have 24/7 access to care team via phone, email or in-person visits.

Health center has collaboration with other providers for readily accessible urgent care (or provides care directly).
Question #17

- Patients can have 24/7 access to care team via phone, email or in-person visits.
- Visits offered “after hours” should be just as accessible as other care times.
- Panels should reflect the scheduling needs of patients.
  - Often this implies changes to staff and provider schedules.
- Late policies undermine your ability to see patients when they do come through the door.
- Group and family care can be encouraged through different work spaces, emerging video technologies, etc.
The health center has linguistic and cultural competence to meet the target population’s needs.
Question #18

- What is the diversity of your site?
- Cultural diversity is very broad... For some it is ethnic? Religious? Linguistic? Gender identity? Economic (more often in rural)?
- What does cultural diversity look like to your center?
- How well do you handle non-English Speakers?
  - Are staff aware of how to access a language interpreter? Is it easy?
  - What non verbal events occur when patients don’t speak English?
- Are staff prepared to ask questions about a patients gender and sexual identity?
- Are staff aware of major holidays and events that effect religions around you?
### Question #18

<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The health center has assessed linguistic/cultural needs of the population(s) in the service area.</td>
<td>- The health center has identified any new cultural/linguistic groups that would be served under a payment reform initiative.</td>
<td>- The health center systematically develops relationships and partners with a variety of community groups.</td>
</tr>
<tr>
<td>- The health center makes <strong>language translation and interpretation services available</strong> to meet the needs of its patient population.</td>
<td>- The health center regularly conducts staff and provider <strong>linguistic/cultural competency training</strong>.</td>
<td>- Care team regularly assesses and addresses language and communication barriers in care delivery.</td>
</tr>
<tr>
<td></td>
<td>- The health center BOD composition is <strong>reflective</strong> of the community served.</td>
<td>- Expectations for cultural and linguistic competence are included in staff job descriptions and performance reviews, and in organization performance metrics.</td>
</tr>
</tbody>
</table>
Question #18

- The goal is to provide care that a patient will very clearly understand.
- Board members and staff should reflect the diversity of your patients.
- Staff can be trained/approved to work as interpreters for patients.
- Training should be provided around Cultural, Ethnic, Religious and linguistic needs as well as Sexual identity.
- Understanding others is not a nice thing to do, it’s part of the job description and performance reviews.
- Assess staff members competency.
Question #19

- The health center engages in population health assessment and initiatives.
## Question #19

<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
</table>
| - **Participate in community led PH assessments.** | - **Have partnerships with other agencies.**
| - **Participate in coalitions.** | - **Staff who participate are senior-level clinicians and administrators.**
| - **Staff who participate are mid-level administrators.** | - **Planning and implementation are part of efforts.**
| | | - **Lead coalitions addressing social determinants of health.**
| | | - **Proactively develop multi-sector partnerships to address health conditions impacted by SDH.**

© 2017 Chris Espersen
Question #19

- How are you utilizing service level data to determine needs?
- How are you utilizing environmental scans to identify partners?
- Are you seen as a leader in community, and as expert level facilitators/conveners?
- Do you understand how the local environment exacerbates or alleviates social determinants of health?
- Do you know how to get all appropriate stakeholders at the table, including those who are not part of the “usual suspects”?
Question #19
What this looks like in practice

- Beginner:
  - You are invited or seek invitation to groups that are assessing, but not necessarily addressing

- Intermediate
  - Your senior leaders are invited to groups that are actively working on addressing issues (Healthy Homes Des Moines)

- Advanced
  - You have identified a need, health conditions that require a community response, and have assembled players to address this (Family BMI initiative)
We want to look in more depth at

**SUMMARY OF RESPONSES:**
Robust Use of Data and Information

Use this table to compile scores from your health center leadership and management staff. Compare the scores and note any commonalities and differences in assessment among respondents which may need to be explored. Indicate any activities and resources to help the health center increase their readiness level or maintain a high readiness level, as appropriate.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RESPONSE 1</th>
<th>RESPONSE 2</th>
<th>RESPONSE 3</th>
<th>RESPONSE 4</th>
<th>RESPONSE 5</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. The health center regularly uses data to understand the socio-economic characteristics of population in service area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. The health center regularly uses data to understand the specific health needs of population in its service area.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. The health center uses data to understand its role within the broader health care marketplace, and its market share.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. The health center has assessed the capacity of its current providers and facilities, and the need for additional staffing or space to support the services to be provided under a specific payment reform model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. The health center’s health information technology (HIT) systems allow for tracking of client and service information needed to inform payment/service delivery models.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. The health center’s electronic health record (EHR) supports clinical practice and care management of client populations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. The health center has robust Health Information Exchange (HIE) with providers/partners of proposed payment reform effort.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL(S)**
The health center regularly uses data to understand the socio-economic characteristics of population in its service area.
<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Aggregate data on the insurance and socio-economic status of its own population.</strong>&lt;br&gt;- BUT, you examine data <em>infrequently</em>, typically in preparation for UDS reporting.</td>
<td>- <strong>Regularly examine data regarding the insurance and socio-economic status of both its own patients and residents of the service area.</strong>&lt;br&gt;- <strong>AND you analyze trends over time.</strong></td>
<td>- <strong>Conduct in-depth analysis of socio-economic needs of populations targeted by specific payment reform efforts.</strong></td>
</tr>
</tbody>
</table>
Question #20

- How will local program and policy changes affect your patients?
- Do statistically significant disparities exist within your patient populations?
- Do you integrate disparity initiatives into your quality improvement program?
- Do you understand local program eligibility requirements and include this information in your service provision planning?
Questions #20
What this looks like in practice

- You understand the socio-economic gaps that prevent patients from greater quality of life and low total cost of care.
- You produce visualizations of socio-economic data of your service area.
- You compare your patient socio-economic status with that of your service area.
- You develop strategies on how to maximize VBP for your service area population.
The health center regularly uses data to understand the specific health needs of population in its service area.
Question #21

<table>
<thead>
<tr>
<th>1-3</th>
<th>4-6</th>
<th>7-9</th>
</tr>
</thead>
</table>
| - **Have data** on the primary health conditions of its own patient population. | - **Are aware of** broader health needs in service area, including:  
  - behavioral  
  - oral health  
  - Comorbidities  
  - Primary prevention needs (e.g. smoking and obesity rates, etc.) | - **Have a thorough understanding** of specific health status and health needs of the population targeted by health reform, based on your own data, information available from other provider groups and/or published literature. |

© 2017 Chris Espersen
Question #21

- What data do you incorporate into your HRSA Program Requirement 1 (Needs assessment)?
- Do you share and compare data and data strategies with community partners?
- Do you understand and utilize qualitative and quantitative means in your analyses?
- Do you use data not only internally, but also externally to advocate for services and policies that will benefit your patients?
Question #21
What this looks like in practice

- You consistently utilize data from local public health and other initiatives (e.g., County Health Rankings) to inform service provision and partnerships.
- You use qualitative means to understand secondary and tertiary drivers of needs, health issues and barriers.
Question #22

- The health center regularly uses data to understand its role within the broader health care marketplace, and its market share.
Question #22

1-3
- Regularly examine its penetration rate for low-income and uninsured populations in its service area. The health center has gathered data on other safety net providers serving the same patient population and their penetration rate.

4-6
- The health center analyzes penetration into the service area/target population for a specific initiative. Understanding of other providers seen by own patient population: has mapped out specialty and hospital referral patterns.

7-9
- Knows penetration in service area population, untapped demand within service area for specific services and/or populations; major competitors and how much of market they capture.
Question #22

- Do you utilize UDS Mapper or other analytic tools to analyze service area penetration?
- How often do you examine market penetration rate?
- Do you understand not only the population that your competitor’s serve, but how they serve them?
- What marketing strategies do you use? What do your competitors use? Who are the target audiences?
- Do you track patient retention?
- Do you have processes in place, beyond patient experience surveys, to improve patient retention?
Question #23

The health center has assessed the capacity of its current providers and facilities, and the need for additional staffing or space to support the services to be provided under a specific payment reform model.
Question #23

1-3
- The health center has quantified current capacity and the need for any additional capacity.

4-6
- The health center has identified specific strategies for maximizing current capacity (using providers to full extent of license; expanding facility hours, etc.), and/or for expanding capacity.

7-9
- The health center has identified the specific staffing needed for proposed payment reform initiative, including potential impact on current demand, staffing mix or space needs that are different than those historically used.

© 2017 Chris Espersen
Question #23

- Have you analyzed different scenarios and implications on space and staff time?
- Are staff practicing at the top of their license?
- Do you have processes in place to stop “scope creep” in its tracks?
- Do you have role delineation that considers patient acuity and real and potential environment changes?
- Do you periodically assess why you do what you do, and how to make it better?
- Do you include front-line staff in these assessments?

© 2017 Chris Espersen
The health center’s health information technology (HIT) systems allow for tracking of client and service information needed to inform payment/service delivery models.
Question #24

1-3

- Systems can capture unique encounters, services provided, utilization and diagnosis.
- System readily produces aggregate reports on encounters, utilization and diagnoses.

4-6

- Systems can capture and report on unique encounters, services provided, utilization and health outcomes for specific groups of patients (age, chronic conditions, dual eligibles, high utilizers, etc.).

7-9

- Systems capture & produce reports on SDH & patient preferences for involvement in decision making & communication modalities.
- Systems capture & report on non-traditional “touches” such as email, phone call, group visits, etc. & enabling services.
Question #24

- Do you systematically capture SDH data?
- Do you provide training on SDH and enabling service assessment and documentation?
- Do you conduct competency assessments on SDH and enabling service assessment and documentation?
- Do you have documentation guides, processes, protocols and procedures for front office and enabling services staff?
- Do you have reports not only for clinical measures, but for patient reminder methods?
Question #24
What this looks like in practice

- You use communication modes that align with patient preferences for appointment and other care reminders.
- You can measure effectiveness of different outreach efforts.
- You stratify and analyze clinical data by social determinant of health data.
- You analyze unduplicated enabling service provision.
- You use SDH and enabling service data in your strategic planning process.

© 2017 Chris Espersen
Question #25

- The health center’s electronic health record (EHR) supports clinical practice and care management of client populations.
Question #25

1-3
- Have separate health records and practice management systems.
- EHR captures visit-level data and diagnosis, but is not integrated with lab, Rx, or case management data.

4-6
- The EHR includes patient & provider reminder functionality, e-prescribing, and clinical decision support components.
- EHR facilitates reporting on MU, UDS, and Medicare Shared Savings Program quality measures.

7-9
- Systems facilitate analysis of both clinical and cost data for specific groups of patients.
- Use existing data to analyze potential impact of specific initiatives on patient care and access.
Question #25

- Does your system ensure data are structured?
- Do you have data documentation guides?
- Do you have a “Rosetta Stone” for your clinical and Health Information Technology staff?
- Does your EHR have robust validation methods?
- If not, do you have backup validation methods?
Question #25
What this looks like in practice

- Your organization has implemented data fidelity and validation strategies.
- You use your EHR/EPM to measure effectiveness and impact of your care management initiatives.
- You stratify reports to better understand variation and opportunities for improvement.
- You analyze efforts and roles to maximize staff capacity and their impact on patient outcomes.
Question #26

- The health center has robust Health Information Exchange (HIE) with providers/partners of proposed payment reform effort.
Question #26

1-3
- Obtain data on hospitalizations of its patients through a manual process.
- Data are claims based and not available “real time.”

4-6
- Payment reform partners exchange patient data through manual or request-based processes.
- Partners have shared referral tracking & follow-up system
- Participate in state or regional-level all-payer claims data efforts.

7-9
- Data are exchanged among partners in real-time using HIE.
- Are able to leverage cost and utilization data available from partners for advanced data analysis and management.
Question #26

- Do you receive your hospitalization data well after the patient was discharged?
- Does your organization understand HIE implementation and participation fees?
- Do you have a HIE provider champion?
- Do you have a data quality stewardship program at your organization?
- Do you have staff to support adoption and maintenance of HIE?
Question #26
What this looks like in practice

- You have real-time insight regarding your patient population.
- You are able to create a follow-up plan with patients before they leave the hospital.
- You know the total cost of care of your patients.
- You incorporate data from Health Information exchanges in your quality improvement efforts.
- You incorporate information from HIE into patient outreach, care management, and care coordination efforts.

© 2017 Chris Espersen