Oregon QI Collective
Diabetes Learning Collaborative Kick-off
July 15, 2019
Welcome!

Please help yourself to coffee and fruit!
Framing the Day
HRSA Disclaimer

This presentation and collaborative is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,491,396. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.
Data Confidentiality Agreements

All FQHC/CHC information should be treated as *strictly confidential* prior, during, and following QI Collective events, as well as any other data sharing work groups or committees.

Data you see on this call *should not* be shared outside of this workgroup and clinic Executive Leadership.
Introductions

Clinic Teams
• La Clinica
• One Community Health
• Outside In
• SouthRiver CHC
• The Wallace Medical Concern
• Virginia Garcia Memorial Health Center
• Framing the day
• Team breakout
• Presentation and activity
• Networking lunch
• Applied practice
• Break
• Team breakout
• Wrap up
Objectives of the Day

• Network with peers to understand clinical, environmental, social and personal factors that contribute to or hinder the success of diabetes care improvement

• Identify techniques that can help understand the diabetic patient experience in order to design services for increased patient engagement

• Create a work plan with your health center team that considers the experience of the patient as a tool for increased engagement
Warm-Up Activity: Rock, Paper Scissors

How to play:

• Pair up and play one round
• If you win, find an opponent who also won
• If you lose, cheer on the opponent you lost to by chanting their name
• Keep playing until there is only one winner and one name chanted

Rock beats scissors

Paper beats rock

Scissors beats paper

© Oregon Primary Care Association
To dive deeper into clinical diabetes improvement by incorporating patient experience into the design of culturally and community specific diabetes care services
What is our starting point?


• Overall prevalence by population in 2017:
  » American Indian/Alaska Native – 15.1%
  » Non-Hispanic Blacks – 12.7%
  » Hispanics – 12.1%
  » Asians – 8.0%
  » Non-Hispanic Whites – 7.4%
Underlying tension between metrics-driven care and patient-centered care

- Quality metrics
- Traditional medical model
- Competing priorities
- Improvement goals
- Strategic goals
- Requirements from funders/grants
- Focus on system transformation

- Social barriers
- Personal priorities
- Cultural and community identities
- Financial constraints
- Individual preferences
- Comfort/familiarity with healthcare system
- Family engagement
Health Systems

Individuals and Families
Shifting the Paradigm
Center for Consumer Engagement in Health Innovation

https://www.healthinnovation.org/work/carevideos/module-a-shifting-the-paradigm

• Values to respect:
  » Expertise of those with lived experience
  » Dignity of risk
  » Self-determination
Patient Engagement: How do we define this anyway?

“The actions individuals must take to obtain the greatest benefit from the healthcare services available to them.”
- *The Center for Advancing Health*

“The process of building the capacity of patients, families, carers, as well as healthcare providers, to facilitate and support the active involvement of patients in their own care, in order to enhance safety, quality and people-centeredness of health care service delivery.”
- *World Health Organization*
Team Breakout
What influences diabetes care improvement?

• System-level considerations
  » Clinical practice
  » HRSA Site Visits – **Diabetes Performance Analysis**
    • Diabetes poor control data
    • Contributing and restricting factors
    • Planned or ongoing improvement activities

• Patient- and community-level implications
  » Examples:
    • Social determinants of health
    • Cultural preferences
Create your own diabetes improvement story:

» Designate a scribe
» Consider your pre-work - three strengths and opportunities
» Discuss and write down what makes these things true
» Keep these in mind throughout the day

» For CHCs with only one team member, partner up and discuss to create your own story sheet!
Building a Patient-Centered Approach
Patient-Centered Care

“Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”

Institute of Medicine, 2001
Crossing the Quality Chasm: A New Health System for the 21st Century
Principles of Patient-Centered Care

https://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/
Methods for Enhancing Patient-Centered Primary Care

Structural
- **Patient-Centered Primary Care Home**, especially standards relating to access and care coordination
- **Trauma-Informed Care** policies, procedures and facilities design
- **Patient Advisory Councils**
- **Patients as partners in QI and Co-Design**

Relational
- **Health Literacy** for patient education and communication
- **Motivational Interviewing** spirit and skills for patient engagement
- **Trauma-Informed Care** principles and interpersonal skills
- **Patient-Centered Observation Form** for creating patient-centered workflow and exam behaviors
Motivation Mountain

STAGES OF CHANGE

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Slippery slope of ambivalence
Movement towards change

Exploring values, concerns and priorities, evoking change talk, importance and confidence
Identifying a change plan, addressing barriers, supporting change efforts

© Oregon Primary Care Association
Key Questions for Enhancing Patient-Centered Care

• How can we do a better job of sharing power with patients in every possible way, large and small?
• How can we do a better job of meeting patients where they are at and supporting them at every step along the stages of change?
Co-Design requires:

- Power sharing
- Engagement
- Collaboration

Human-Centered Design

SIX PRINCIPLES for WORKING DIFFERENTLY

TEST & SHAPE
PITCH & COMMIT
IMAGINE & MODEL
QUESTION & REFRAME
DIMENSION & DIAGRAM
SEE & EXPERIENCE

Borrowed from the Center for Care Innovations
Inclusion & Empathy
Collaboration
Start small & learn fast
Make things tangible
Sharing unfinished work early & often
Catalyst Innovation + Design Thinking Framework

SEE & EXPERIENCE
Learn about your challenge through immersive experiences and listening to first-hand perspectives.

DIMENSION & DIAGRAM
Make sense of what you documented and learned from your research.

QUESTION & REFRACT
Refine and focus the scope of your challenge based on key insights from your research.

IMAGINE & MODEL
Dream up many ideas to address the challenge. Draft a plan for how you’ll test key features of your best ideas with users and stakeholders.

TEST & SHAPE
Make quick, rough drafts of your ideas. Get the examples in front of people and incorporate their feedback -- repeat!

PITCH & COMMIT
Communicate with people outside of your core team about your project and why it’s worth doing.

GOALS
What will you do?
- Learn about your challenge through immersive experiences and listening to first-hand perspectives.
- Make sense of what you documented and learned from your research.
- Refine and focus the scope of your challenge based on key insights from your research.
- Dream up many ideas to address the challenge. Draft a plan for how you’ll test key features of your best ideas with users and stakeholders.
- Make quick, rough drafts of your ideas. Get the examples in front of people and incorporate their feedback -- repeat!
- Communicate with people outside of your core team about your project and why it’s worth doing.

METHODS
How will you do it?
- Observation: Shadowing, Show + Tell Interviews
- Collaborative Cycle: Empathy Mapping, Journey Mapping
- "How Might We..." Statements, Analogous Examples
- Brainstorming, Voting, 2x2 Matrix, Solution Mapping
- Paper Prototypes, Storyboarding + Scenes, Role Play
- 7-Part Pitch Structure, Calculating Value, Video Storytelling "I Like I Wish, I Wonder"

ACTIVITIES
What will it involve?
- Collect quotes, photos, and video from observational, shadowing, and interview research.
- Analyze qualitative research and convey patterns using visual frameworks.
- Articulate your challenge in a concise, focused, and optimistic way.
- Encourage people with diverse perspectives to contribute ideas, Prioritize which ideas to try first and which specific elements to test.
- Create and test at least three variations on your best idea(s) using sketches, scripts, mock-ups, and other tangible formats.
- Present a compelling story about your challenge to organizational leadership and propose next steps.

MINDSETS
What will ensure your success?
- Inclusion + Empathy
- Collaboration
- Starting small + learning fast
- Making things tangible
- Sharing unfinished work early + often

© Oregon Primary Care Association
Opportunity area:
Improve staff collaboration within the Alternative Payment & Advanced Care Model Program
Key things we learned and observed:

1) There is a education gap at OPCA relating to APCM. Engaging with APCM requires significant investment in climbing the learning curve.

2) The project is very complex and feels complex both for our staff and for the health centers. There is probably a lot to be gained from simplification.

3) There is a kitchen sink effect with APCM. We throw a lot of things and people in the mix with it.

4) There is some tension between being expansive and inclusive, and trying not to increase the complexity and breadth of the project.
Questions lead to solution ideas:

1) Reduce the complexity in the project, where appropriate and possible
2) Move from siloes of knowledge to a shared pool
3) Clarify the right level of detail for staff to understand about APCM and support staff to feel confident in their ability to understand and connect dots to OPCA’s flagship program
OPCA serves a powerful network of community health centers.

OPCA’s 32 community health centers are dedicated to caring for the health of people experiencing poverty and marginalization in Oregon. Together, health centers serve more than 45,000 Oregonians by joining together and sharing knowledge. Oregon health centers are collectively improving primary care and advancing health equity in their communities.

In order to fulfill our mission of health equity for all, health centers in Oregon need the space not just to deliver healthcare, but to foster health in the communities they serve by tailoring care and services to the unique barriers and circumstances of their patients. They need the time to develop trusting relationships with patients and to reach those in need, and work in a way that is culturally and linguistically appropriate.

Our goal is to align payment with an efficient, effective, emerging care model that lowers overall costs while improving quality, access, and health equity for all.

OPCA and Oregon community health centers developed the Alternative Payment Methodology and Advanced Care Model (APCM) in partnership with the Oregon Health Authority, as a transformative model that puts our communities on the path to optimal health.

In the Alternative Payment Methodology and Advanced Care Model (APCM), the fee-for-service model is replaced by a capitated (per-enrollee, per-month) payment that community health centers can use to partner with patients to create a plan for supporting better health. This new payment methodology supports the expanded health center team to provide health and wellness services when and where the patient needs them, rather than limiting payments to traditional provider encounters.

Care teams can now spend the time to develop a deeper understanding of the patient’s medical and life circumstances to jointly determine the appropriate priorities and care plan. This approach allows the care team to treat the whole person by paying attention to their overall wellness, as well as the underlying economic, environmental and social drivers of health and wellness.

APCM DELIVERS RESULTS:

- 15% ↑ colorectal cancer screening rates
- 21% ↑ depression screening with follow up

APCM health centers run over 40% of all 5 STAR Clinics – Oregon’s highest level of Patient-Centered Primary Care Home recognition.
Isn’t this the Model for Improvement?

<table>
<thead>
<tr>
<th>Model for Improvement</th>
<th>Scientific Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are we trying to accomplish?</td>
<td>• <em>Developing a change:</em> Ask a question, create a hypothesis</td>
</tr>
<tr>
<td>• How do we know a change is an improvement?</td>
<td>• <em>Testing a change:</em> Conduct experiments, collect data</td>
</tr>
<tr>
<td>• What changes can we make that will result in an improvement?</td>
<td>• <em>Implementing a change:</em> Analyze data and draw a conclusion</td>
</tr>
</tbody>
</table>

© Oregon Primary Care Association
How is Human-Centered Design different?

• Spends more time exploring the landscape of the problem before defining and framing what you are solving for

• Provides tools and methods to do that landscape exploration by collecting robust qualitative data

• Helps understand experience of the user through empathy, direct observation, interaction and engagement with your user (not numerical measurement)

• Brainstorming, prototyping and co-designing solutions are key components leading up to conducting tests of change
So now what?

• Human-Centered Design methodologies take time, training, practice and dedication for full utilization

• **Our goal:** To get your feet wet with the concept of observing and listening empathetically to your patients in order to co-design diabetes services and achieve improvements in diabetes care
Warm-up Activity: Self-observation

Experience Questionnaire

• Think of something you experienced today and name it.
• Write down the steps or stages of that experience.
• Consider the emotions, feelings and thoughts you had at each step or stage.
• Reflect on any behaviors you displayed that someone may have observed.
<table>
<thead>
<tr>
<th>Step / Stage</th>
<th>Emotional / Observational Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave house</td>
<td>Rushed, “Wish I could stay home.”</td>
</tr>
<tr>
<td>Get baby in car</td>
<td>“Please don’t start crying.”</td>
</tr>
<tr>
<td>Drive</td>
<td>Angst, “What emails do I have waiting for me?”</td>
</tr>
<tr>
<td>Arrive at daycare</td>
<td>Relief, excited to see baby smile</td>
</tr>
<tr>
<td>Organize</td>
<td>Worried, busy, “Hope we have it all!”</td>
</tr>
<tr>
<td>Feed her</td>
<td>Nurturing, in awe, “She is so sweet.”</td>
</tr>
<tr>
<td>Leave for work</td>
<td>Rushed, “I’m hungry and need coffee.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observable Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locking door, hands full</td>
</tr>
<tr>
<td>Talking to baby, multi-tasking</td>
</tr>
<tr>
<td>Talking to partner, checking phone</td>
</tr>
<tr>
<td>Smiling, hands full</td>
</tr>
<tr>
<td>Putting things away, giving instructions</td>
</tr>
<tr>
<td>Cuddling, sitting on the floor, checking clock</td>
</tr>
<tr>
<td>Walking fast, deep breathing</td>
</tr>
</tbody>
</table>
Warm-up Activity: Self-observation

Experience Questionnaire

• Share with your neighbor
  » What was interesting about this activity?
  » What would you like to highlight?
  » Where do you see opportunities?
LUNCH!

Sit with someone you don’t know and pick a topic on your story sheet to discuss!
Applied Practice
Applied Practice: Understanding the Patient Experience

Observe video clip.
Learn about a challenge through immersive experiences & listen to first-hand perspective.

Practice Empathy mapping.
Make sense what you documented and learned from your research.
Empathy Mapping

An empathy map is a collaborative tool to gain a deeper insight and learning from those you engage with.
Completing an Empathy Map

Fill out the Empathy Map

- **What did they SAY?**

- **What did they DO?** Describe which actions and behaviors you noticed or would infer based on what they said.

- **What did they THINK?** Dig deep. What do you think that your user might be thinking? What are their motivations, their goals, their needs, their desires? What does this tell you about his or her beliefs?

- **How did they FEEL?** What emotions might your user be feeling?
Let’s watch the clip

- [https://www.youtube.com/watch?v=SfZGR-hMV94](https://www.youtube.com/watch?v=SfZGR-hMV94)

- Now that you’ve see the video, complete your own empathy map.
Discussion Qs

• Identify needs (activities and desires with which the individual could use help with)

• Identify insights (realizations that you could leverage to respond)

• How might you use your understanding of their experience to co-design supportive service for this person?
Additional Methods to Consider

• *Observation* – Allows you to witness different perspectives or elements of a patient’s experience

• *Shadowing* – Allows you to see an experience through the patient’s eyes

• *Interviews* – Allows you to listen and learn about something a patient wants you to know

• *Focus Groups* – Allows you to hear from multiple patients with varying perspectives
BREAK!
Team Breakout
Patient-Centered Care Reminders

STAGES OF CHANGE

Pre-Contemplation  Contemplation  Preparation  Action  Maintenance

- Exploring values, concerns and priorities
- Evoking change talk, empowerment and confidence
- Identifying a change plan
- Addressing barriers
- Supporting change efforts
- Movement towards change
- Slippery slope of ambivalence

Picker’s Eight Principles of Patient Centred Care

- Respect for patients’ preferences
- Coordination and integration of care
- Information and education
- Physical comfort
- Emotional support
- Involvement of family and friends
- Continuity and transition
- Access to care

© Oregon Primary Care Association
Let’s create a work plan!

• In your teams:
  » Take a moment to review your story sheets and content/activities of the day
  » Identify an opportunity for improvement
  » Create a SMART goal/aim statement
  » If time allows, begin developing your test and data collection plan
Key Considerations for your PDSAs

• We encourage you to:
  » Test a method or tool to more deeply understand and gather diabetic patient experiences
  » Focus on engaging your diabetic patients into your improvement approach
  » Consider populations experiencing disparities in diabetes poor control as a starting point

• PDSAs will be integrated into action periods that occur between learning sessions throughout the Collaborative.
Wrap-up
Final Thoughts

• What was interesting about today?

• What did you learn?

• What questions do you have?
Center for Care Innovation Resources

• Center for Care Innovations
  » Daily Doses of Innovation
  » Catalyst Method: Empathy Mapping
  » Case Study: Group Visits Improve Diabetes Self-Management
  » Transforming A Diabetes Care Playbook
  » Using Your Analytics Ecosystem to Manage Hypertension and Diabetes Patients

© Oregon Primary Care Association
Resources

- World Health Organization – Patient Engagement: Technical Series on Safer Primary Care
- HRSA – Health Literacy and Patient Engagement
- The EBD Approach – Experience Based Design: Using Patient and Staff Experience to Design Better Healthcare Services
- Conversations on Healthcare: Embedding Empathy Into Health Care Training
- Diabetes Distress Assessment and Resource Center - Diabetes Distress Survey (for patients and providers)
- Behavioral Diabetes Institute – Tools to Face the Psychological Demands of Diabetes
Next Steps for CHCs: Action Period #1

• Finalize your SMART goals and PDSA plans
  » Send to Akira by **Monday, September 30th**

• Begin any baseline data collection and tests, if necessary

• Come prepared to report out progress October webinar
  » Webinar #1 scheduled for 10/14/2019 from 1:00-2:30 PM
  » Please have at least one team member present
Next Steps for OPCA

• Reminders about your action assignments
• October webinar invite
• Follow-up with materials from today
• Available for any questions!
THANK YOU!

Please take a moment to complete the evaluations on your table (pink sheet).