IMPLEMENTATION GUIDE

ENGAGED LEADERSHIP

Strategies for Guiding PCMH Transformation

May 2013

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Introduction

An organization adopting the Patient-Centered Medical Home (PCMH) Model of Care is making a commitment to system-wide transformation. Staff at all levels of the organization must be willing to continually examine processes, adapt to change, and make improvements. These sweeping and transformative changes require the visible and sustained engagement and tangible support of a wide range of leaders including executive leaders (e.g., CEO, Executive Director), financial leaders (e.g., CFO), board members, funders, community supporters, and even payers.

Leaders drive change within their organizations from the top down and the bottom up. Leaders inspire providers and care teams to re-imagine care delivery and reconsider how the organization interacts with patients.

Leaders facilitate PCMH transformation by charting the course for change and supporting and sustaining change efforts. For PCMH transformation to be successful, leaders must provide the necessary time and resources, remove barriers, and provide continuous inspiration and motivation for staff. Most importantly, leaders must implement strategies that make change possible by fostering and encouraging a supportive environment for staff. While guiding their organization through transformation, leaders will need to develop specific strategies. Leaders will need to develop protocols for empanelling patients to ensure continuity of care, address pushback as care team members' roles change, find ways to protect time for care coordination, and encourage staff to include patients and families on quality improvement (QI) teams.

Message to Readers

PCMH requires engaged leadership at all levels of an organization, starting with the CEO and board of directors, and continuing down through mid-level managers and front-line staff in leadership or champion positions. The primary audiences for this guide are executive leaders (e.g., CEO, Executive Director) and mid-level managers, although the document describes the roles that a variety of leaders play in implementing the key changes of Engaged Leadership. The document uses sections, shading, and appendices to help readers navigate and zero in on the information most pertinent to their specific leadership roles. Use the interactive table of contents to jump from section to section. Board members and executive leaders are encouraged to also read the Engaged Leadership Supplement: How Health Center Board Members Can Support PCMH Transformation.

Practices beginning the PCMH transformation journey often have questions about where and how to begin. We recommend that practices start with a self-assessment to understand their current level of "medical homeness" and identify opportunities for improvement. The SNMHI's self-assessment, the Patient-Centered Medical Home Assessment (PCMH-A), is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared.

Readers are also encouraged to download additional Safety Net Medical Home Initiative Engaged Leadership materials:

- PCMH Strategic Planning, Quality Improvement, and Business Processes Tool.
- Webinars provide additional examples, tips, and success stories and highlight the best-practices of SNMHI sites and other leading practices.
- Recommended materials from other sources are provided under Additional Resources.

The Change Concepts for Practice Transformation: A Framework for PCMH

"Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Safety Net Medical Home Initiative (SNMHI) established a framework for PCMH transformation to help guide practices through the transformation process. The framework includes eight change concepts in four stages:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
- Reducing Barriers to Care: Enhanced Access and Care Coordination.

The Change Concepts for Practice Transformation have been most extensively tested by the 65 safety net practices that participated in the SNMHI, but they are applicable to a wide range of primary care practice types. The Change Concepts have been adopted by a number of other improvement initiatives, reflecting their generalizability in primary care regardless of patient population or practice structure. The Change Concepts were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. They are supported by a comprehensive library of resources and tools that provide detailed descriptions and real examples of transformation strategies. These resources are free and publicly available. To learn more, see the Change Concepts for Practice Transformation.

Key Changes for Engaged Leadership

The eight Change Concepts provide a framework for PCMH transformation. Each change concept includes multiple "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context. The key changes for Engaged Leadership are:

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- 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.

Engaged leaders are the drivers behind PCMH transformation: They make the case about the need to improve the current state of disjointed care, articulate a vision for a better future, and set the tone for change.

Chart the Course: Build Will for Change

Leadership's most important role in PCMH transformation is to drive and inspire change.

The buy-in in supporting a change effort is building will for change. To do this, leaders must be able to make the case for transformation. Leadership must be able to articulate a better vision for the future and provide a framework for how to get there.

To buy-in to the PCMH Model of Care, and have confidence in their ability to make or carry out the changes required, staff need to:

- Understand why change must occur.
- Understand the intended outcomes of change.
- Have effective implementation strategies.
- Understand their role in the change process.
- Understand the benefits of transformation for patients, other staff, and themselves.

Communication is the first step in building will for change. Leaders clarify and confirm their expectations for PCMH by embedding PCMH values into strategic planning, quality improvement, and daily business processes.

Make the Case

To engage in the hard work of PCMH transformation, staff need to understand the what, why, and how of PCMH:

- What is the PCMH Model of Care.
- Why the PCMH Model of Care is important.
- How transformation will benefit patients, families, other staff, and themselves.

The Change Concepts for Practice Transformation explain the goals of the PCMH Model of Care in operational terms. Share these goals with staff.

To gain support for devoting financial resources to the work of PCMH transformation, leaders also need to be able to articulate the business case for investing in transformation—the costs and benefits of adopting the PCMH Model of Care.

Why invest in PCMH?

The PCMH Model of Care has garnered attention and support from a wide variety of healthcare stakeholders: payers, employers, patient advocacy groups, healthcare professionals, and policymakers. One reason for this diverse and sustained support is that PCMH can improve the value of healthcare for all stakeholders. PCMH care, which promises "whole-person" care, well-coordinated services, and enhanced access to a clinical team, is poised to deliver the Institute for Healthcare Improvement's triple aim: improved health, improved experience, and reduced cost.[1] While evaluation results have been mixed, and many are still underway, outcome studies have documented improved quality and patient health outcomes,[2] patient experience, practice efficiency,[3] and provider and staff satisfaction.[4] Primary care practices and their patients benefit from these transformation outcomes. PCMH care has also been shown to stabilize or reduce overall healthcare costs, primarily from reduced emergency department (ED) use, hospitalization, and hospital re-admission.[3] Payers and communities benefit from these outcomes. New models of care delivery and payment, such as Accountable Care Organizations (ACOs), are finding innovative ways to reward primary care practices for contributions to PCMH cost-savings.

To learn more about PCMH outcome and evaluation results, refer to the Patient-Centered Primary Care Collaborative Outcomes & Evaluations Center.

Stay competitive in an ever-changing marketplace

Immediately after the *Joint Principles of the Patient Centered Medical Home*—developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association[5]— were released in 2007, private and public payers and integrated delivery systems launched demonstrations or pilots to test the promise of PCMH and reward the achievements of early adopters. The Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS), and new agencies and programs established by the Affordable Care Act (ACA), have all set goals for PCMH transformation and established programs to support transformation efforts.[6] PCMH is quickly becoming not just a goal, but an expectation of payers and policymakers, and thus a requirement for practices wanting to remain competitive in the marketplace. HRSA, for example, has made PCMH a cornerstone of its Federally Qualified Healthcare Center (FQHC) program through supplemental funding, technical assistance, support for recognition, and formal goal-setting.[6, 7]

Practices, especially those serving low-income patients, need to be prepared to deliver the types of care and access points patients want in order to stay competitive in the healthcare marketplace. Safety net practices in particular will need to position themselves as "providers of choice," to retain current patients and attract new patients as previously uninsured patients gain access to a wider array of providers/facilities as a result of the Medicaid expansion in 2014. PCMH transformation needs to make practices more attractive and thus more competitive as many of the key changes of PCMH are attractive to patients (e.g., enhanced access, new visit types, continuity of care).

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PCMH transformation directly supports the mission, vision, and values of safety-net and other non-profit practice organizations.

Enhanced revenue and participation in new care delivery models

Under the typical fee-for-service (FFS) payment model, providers, and practices are rewarded for volume (e.g., number of visits or procedures); but increasingly, payers, who are interested in overall health system cost savings, are finding ways to reward value (e.g., improved health outcomes). Practices that adopt the PCMH Model of Care will be well positioned to benefit from ACOs and other care delivery models that pay providers and facilities based on patient outcomes. Practices that meet the requirements of these programs may be able to increase their revenue. Even practices not eligible for enhanced PCMH payment or incentives may be able to increase their revenue by improving efficiency. For example, the 36 practices in the TransforMED National Demonstration earned, on average, 10% more in revenue after implementation of the PCMH Model of Care.[8] For more examples of the direct and indirect benefits of PCMH transformation, refer to Table 1: Financial Benefits of PCMH.

Financial Benefits

PCMH transformation has many benefits for practices, including direct and indirect financial benefits. Direct benefits include efficiency, which can increase revenue. Indirect financial benefits result from improved provider and staff experience, which can decrease turnover and recruitment costs, and improved patient experience, which improves patient retention and in some cases qualifies practices for performance-based incentives.

However, PCMH transformation requires resources: time and dollars. Leaders can support transformation by devoting resources to the work of transformation. They can also advocate for payment systems that adequately support the enhanced functions of a PCMH. Practices able to successfully transform are well positioned for success: They will benefit from emerging payment systems and care delivery models that reward improved outcomes, they will benefit from the efficiencies they achieve through system redesign, and they will remain highly competitive in a rapidly changing healthcare environment.

Clarify Roles and Responsibilities

All staff have a role to play in PCMH transformation. Leadership must clarify specifics of those roles and make sure that each staff member understands the importance of his/her contributions to transformation.

Ideas for leaders to consider:

- Encourage everyone to learn about PCMH. Encourage staff to think about how the PCMH Model of Care will benefit patients and also improve their own jobs. Help them by talking about and repeating tangible examples and stories of how PCMH benefits patients and improves staff satisfaction. Consider the value of a front desk staff member being able to describe the benefits of PCMH care to a new patient; or the value of an IT support team member being able to identify an unnecessary barrier and suggest an improvement.
- Provide examples of how all staff can contribute to PCMH transformation.
- Help staff understand their specific roles.

PCMH enhances the value of health care for all stakeholders:

- Patients receive better care.
- Patients experience better outcomes.
- Healthcare professionals are more satisfied with their work.
- Practices operate more efficiently.
- Communities receive better value for their healthcare dollars.
- Payers achieve savings, most of the time.

Table 1: Financial Benefits of PCMH

Efficiency	
Empanelment	Empanelment allows practices to predict patient demand and staff accordingly, resulting in fewer unused appointment slots and fewer opportunities for lost revenue.
Continuous and Team-Based Healing Relationships	The allocation of non-clinical work to non-provider staff working as part of a well-functioning team protects provider time for acute and complex care services, which typically have higher reimbursement rates. Staff working in a team-based model are better able to prevent care gaps by "max-packing" visits and providing planned care; resulting in higher per-visit revenue.[3]
Enhanced Access	Enhanced access, specifically the availability of same-day appointments, has been shown to reduce no-shows and deferments to the emergency department and other sources of care, again reducing the likelihood of lost revenue. Telephone, email, and group visits, all of which enhance practice efficiency, protect providers' time for acute and complex care services, which typically have higher reimbursement rates.
Satisfaction	
Reduced burnout	There is strong evidence that staff working in PCMH practices have higher job satisfaction and are less likely to suffer "burnout" than staff working in traditional office practices.[4, 9] Group Health Cooperative (headquartered in Seattle, WA) saw a significant reduction in workplace stress (as measured by a "burnout" inventory tool) after implementing the PCMH Model of Care in a pilot practice. At 12 months post intervention, only 10% of staff at the PCMH site reported a high degree of burnout, compared to 30% of controls.[9] A study published by the *Archives of Internal Medicine* in 2012 found that higher PCMH scores correlated with higher provider and staff morale and overall job satisfaction.[4]
Reduced turnover	PCMH can result in improved morale and overall job satisfaction, improved retention rates, and therefore minimize turnover and recruitment costs.
Improved recruitment	Practices that adopt the PCMH Model of Care and invest in infrastructure (e.g., electronic health records) should be highly attractive to residents and new physicians. Practice attractiveness is particularly important for safety net practices, which often have a difficult time recruiting and retaining staff, particularly physicians. The primary care workforce shortage is an acute problem. Practices that can demonstrate team-based approaches to care delivery should be attractive to a wide range of primary care providers, including important members of the care team such as behavioral health providers. These practices will benefit from reduced recruitment and turnover costs.
Improved patient experience	While some studies report dips in patient experience during the transformation process, most research documents improvements after implementation.[2, 10] Improved patient experience leads to improved patient retention rates and, potentially, additional revenue. For example, payers such as CareOregon (a Medicaid Managed Care Organization) and the Capital District Health Plan pay performance bonuses for meeting patient experience targets.[11, 12]

Case Study: CareOregon Champions—Encouraging Leaders at Every Level

David Labby, MD, former Medical Director of CareOregon (2010)

CareOregon is a Medicaid managed care plan that began implementing Patient-Centered Medical Homes across its five organizations and 15 clinics in 2006.

Labby says it is not just the CEOs, boards of directors, and medical directors that need to act as leaders. Organizations must identify the leaders among nurses, PAs, front office staff, and those who treat patients to 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 board and 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 transformation, but Labby says every organization needs a strategy for leadership development for every employee. 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 particularly 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 need to be constantly asking, 'Are we on 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.

Leadership is something you always have to work on, there is no cookbook.
David Labby, MD, former Medical Director of CareOregon

Develop Communication Strategies

Practice leadership must find every opportunity to keep the vision of PCMH alive, applicable, and current. Find multiple ways to convey that PCMH is part of the regular work of the practice, so that it becomes the new way of doing business, not a time-limited or special project. Consistent communication about the importance of PCMH sends a strong signal within the practice and to the external community. Employ multiple communication strategies to send the message that PCMH is "the way we do things here," and not just a passing fad. Keep the conversation about PCMH alive in daily practice; and don't rely solely on buzzwords and jargon, which can be easily ignored.

Ideas for leaders to consider:

- Consider how to communicate PCMH values in every document about the practice.
- Include the vision of PCMH in a brief statement at the beginning of every meeting.
- Display and regularly update graphics or a data dashboard that illustrate quality and efficiency data for executive leaders, board members, front-line staff as well as patients and families.
- Be transparent with quality data displays: participate in regional and national public reporting initiatives.

Payers and policymakers are beginning to hold healthcare providers accountable for improving population health outcomes. The PCMH Model of Care allows primary care practices to meet this challenge by improving quality, efficiency, and patient-centeredness.

Generate Ideas, Foster Innovation

Leadership's role is to explain, teach, model, and facilitate the Change Concepts for Practice Transformation. The specific ways in which the Change Concepts are implemented will vary practice by practice, and leadership should take into account innovative ideas from practice staff as they consider implementation options. Supportive leaders solicit change ideas and strategies from their staff to personalize PCMH transformation. Because staff are responsible for carrying out day-to-day activities and changes supporting PCMH transformation they understand the details of patient interaction in ways that may not be obvious to leadership. Practice team and quality improvement meetings provide excellent opportunities for this sort of staff engagement.

Additionally, other PCMH demonstration projects can be great sources of ideas, "lessons learned," and inspiration.

Ideas for leaders to consider:

- Listen to and share stories of successes and challenges related to how front-line team members have tested new ways of providing patient-centered care.
- Conduct executive "walk arounds" at the practice site. Have leaders hold impromptu group discussions in the break room about transformation efforts.
- Describe the PCMH Model of Care and the practice's PCMH goals on a poster visible to staff and patients (e.g., waiting room area).

Harvesting the creativity and energy of staff by supporting and encouraging involvement and idea generation inspires and ignites change.

Identify and Mentor Champions

Champions can help leaders articulate the vision of the PCMH Model of Care and build will for change. Champions are practice staff who support the PCMH Model of Care and actively voice that support through words and actions.

When identifying champions, reach out to respected staff who have regular interaction with large numbers of staff, patients, and families. The HR director; medical director; office manager; managers of nursing, social work, behavioral health, pharmacy, dental; and lead MAs, PAs, RNs, ARNPs, and LPNs may all be good champion candidates.

Excellent indicators of "champion" behavior include:

- High level of engagement, vital and informed interest, and enthusiasm for being part of the change.
- View change as an opportunity to grow.
- Understand the practice environment, staff and patients, and concerns.
- Ability to work collaboratively with coworkers and create positive relationships.
- Respect and trust from co-workers.
- Demonstrate willingness and ability to learn when faced with challenging or new situations.
- Genuine interest in the transformation process.

Regular meetings between champions and practice leadership help address areas of concern and refine shared key transformation messages. Champions may or may not have coaching experience or knowledge, and may or may not know best practices to support team members through transformational change. Ongoing training and opportunities to develop team communication and continuous improvement skills are essential.

Timely one-on-one support and recognition from practice leaders will help to sustain champions' resilience and enthusiasm. Champions often find themselves providing the first line of emotional support to staff experiencing upheaval brought on by transformational change, and they are sometimes considered a safe target for frustration and pushback because they usually have little authority over coworkers. Address this reality with champions before problems arise. Be sure to serve as a resource if and when challenges arise. Successful mentoring and support for champions further embeds a culture of improvement during transformation and leads to higher staff retention.

Use Data to Drive and Guide Improvement

Measurement is essential for demonstrating and tracking progress: It helps educate and inform leaders, the board, staff, patients and families, as well as the public at large, about improvement successes and opportunities for further improvement. To build and sustain support for transformation, leaders must develop a system for integrating quality improvement (QI) data into the transformation process and communications to staff.

Effective leaders continually reinforce the value of QI and use data to demonstrate the results of change efforts. Leaders themselves must understand how measurement and data are used so that they can effectively communicate the ways that measurement and reporting support practice goals for improvement, meet regulatory mandates, and provide data required for payment.

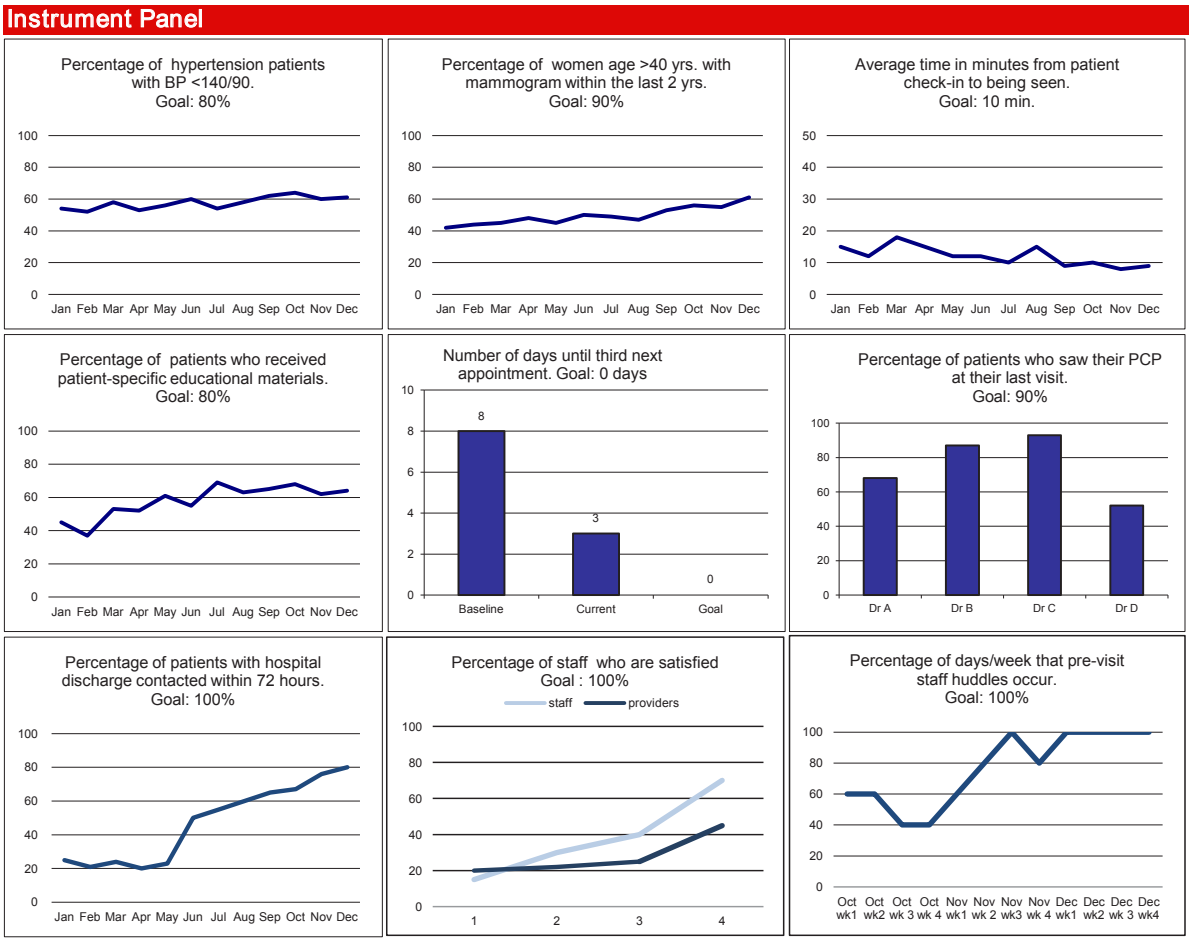
Identify and Select Measures to Monitor Change

The Institute for Healthcare Improvement (IHI) recommends that leaders first develop a strategic theory of what it will take to transform their organization. Vetting this theory with the board and QI committee (if your organization has convened a QI committee) sends a strong message to providers and staff about the importance of both change and measurement.

Continually emphasizing that measurement is key to improvement efforts helps create a data-driven culture.

Leaders need to work with their QI committee to identify and select measures to monitor change. PCMH transformation requires system-wide changes, thus, leadership needs to encourage their QI committee to identify and monitor "system-level measures"—measures that reflect all of the many areas PCMH transformation will touch. To learn more about system-level measures, see Appendix A: Examples of System-Level Measures. Measures can be featured on a dashboard, which leaders and staff can use to monitor progress, identify problems, and celebrate successes.

Example of Data/Monthly Dashboard Report XYZ Community Health Center



Effective leaders inspire culture change by involving patients and staff in the process, assuring support from their board, and by using data and stories to inspire change.[13]

Invest in Systems and People

Invest in systems and staff to support the collection, analysis, and reporting of clinical quality and operational data. See Appendix B: Engaged Leadership and Health Information Technology for more information on how leaders can support the generation of reports with credible and meaningful quality and operational data.

Leaders must also ensure that all staff have the knowledge and skills they need to work with data. It is important for everyone to understand why and how data are collected. Staff need to be comfortable with measurement and know how to interpret graphs and other reports to make best use of the information. Providing measurement training strengthens staff ability to accurately interpret measures and supports the intention that each person understands his/her role in helping to improve performance in the measures under review.

Communicate with Data

Leaders should ensure that all members of their organization have access to key measurement strategies and corresponding data—this includes providers, front-line staff, board members, and, when appropriate, other partners.

Communicating data can be a powerful tactic to build will for change and to sustain momentum and enthusiasm for the work of transformation. Leaders should use data to tell stories that inspire change. It is helpful to tailor data displays for specific audiences. For example, leadership and the board are most likely interested in the "big picture" of patients' health and outcomes. Dashboards can provide a snapshot of clinical quality using selected measures. Providers and staff are responsible for day-to-day patient care. They are most likely interested in specific measures that help them see where they are performing well and where there are opportunities for improvement. Patients and families are most likely interested in measures that demonstrate that their health has improved over time because of the care they are receiving. Table 2: Communicating Quality Data to Multiple Audiences outlines differences in how executive leaders and front-line staff may optimally view quality improvement data with an eye toward action and follow-up.

Ideas for leaders to consider:

- Continually track QI efforts and discoveries and celebrate progress and successes. Acknowledge achievements and opportunities for improvement.
- Make key measures prominent. Ensure staff know what the practice is tracking to gauge progress toward transformation.
- Use data to show staff how the changes they are making impact patients and families.
- Highlight data using boards, visibility walls, or other visual displays of data at staff meetings.
- Consider featuring one or two stories during each board meeting to illustrate what changes are occurring due to findings from data. Invite providers, staff, and patients or family members to attend board meetings so that leaders hear firsthand what happened and why. Testimonials are powerful and send a message to front-line staff and providers that their work is valued. To learn more about board engagement and how boards can use data to drive and guide change, see the Engaged Leadership Supplement: How Health Center Board Members Can Support PCMH Transformation.

Incorporate and regularly communicate data throughout the organization and to the board.

Table 2: Communicating Quality Data to Multiple Audiences

Data	Measures
Data reports valued by executive leaders: 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 diabetic patients who received all appropriate, evidence-based care for which they are eligible, e.g., timely HbA1c tests, lipid panels, annual foot and eye exams (standard of care).
Quality data that motivate front-line staff daily, weekly, or monthly graphs	• % of appointments in which patients were seen by a member of their assigned care team (continuity). • % of patients receiving lab work prior to their visit. • % of eligible diabetic patients who received outreach calls within established timeframes.

Support QI Teams

Close contact between leadership, the QI committee, and QI teams is essential. Regular and frequent meetings:

- Spur progress forward. They require that teams continuously review progress to prepare data reports for leadership.
- Allow leadership to monitor progress to ensure it is in line with the direction and goals of the PCMH initiative.
- Stay up-to-date on the team's challenges.

Dedicated time and attention from leadership also signals importance, and can help QI teams overcome barriers that can derail improvement efforts.

Quality improvement teams' work can sometimes seem invisible to the practice as a whole. Effective leaders provide frequent updates and communication regarding QI activities. Regular communication signals importance and can also help all staff feel engaged in QI work; this in turn builds support for the QI team.

Ideas for leaders to consider:

- Host practice-wide QI meetings to help clarify the practice's PCMH vision, identify process improvement priorities and approaches to remove barriers, and report-out on progress. The results of these meetings should be regularly reported to executive leadership, the board of directors, patients, and other practices within the organization (if relevant). These monthly meetings will keep the practice focused. Preparing meeting agendas and action items for follow-up between meetings is helpful to keep all teams on track.

Embed PCMH in the Organization

Leaders need to ensure that PCMH values are reflected in the practice's mission, vision, and values; are used to guide strategic planning; and made prominent in the practice's hiring and training policies.

The board can also support PCMH transformation and help institutionalize PCMH values in the practice. To learn more, see the Engaged Leadership Supplement: How Health Center Board Members Can Support PCMH Transformation.

Embedding PCMH into the fabric of an organization ensures that changes made will be sustained into the future.

Strategic Planning

Review your practice's mission, vision, and values. Is PCMH specifically referenced? Are the principles of PCMH care used to inform the practice's strategic planning efforts? See the corresponding Engaged Leadership tool PCMH Strategic Planning, Quality Improvement, and Business Process Tool for a worksheet to track whether a strategic process has been met by a PCMH-specific strategy, and if unmet, who to task with the responsibility.

Ideas for leaders to consider:

- Attend staff meetings regularly and promote the organization's commitment to PCMH transformation.
- Provide specific examples of how PCMH fulfills the organization's mission, vision, and values. Ask staff for their examples and ideas.
- Recognize and reward teams that demonstrate progress.

Hiring and Training

Reflect PCMH values in hiring and training policies. It is vital to translate PCMH values into behavioral terms to describe what is expected in everyday work (i.e., what people are actually doing that illustrates PCMH care). Describe PCMH behaviors in employee performance reviews, job descriptions, recruitment documents, and interview questions for potential staff. This will further an organization-wide understanding of expected behaviors and help leaders to coach staff with concrete, actionable examples. Additionally, potential employees can judge if the practice is the right fit for them through reading job descriptions that emphasize PCMH. Prospective employees interested in working in a PCMH-friendly culture will be attracted to apply to work in the practice. Many practices have found this to be a beneficial recruitment tool.

Ensure that all staff transitioning into a new role or taking on a new responsibility are trained and prepared. Assess current staff skills and consider what new skills they will need for their new work. Consider the long-term developmental needs of staff and develop a budget to support high-priority training. Consider skills needed in the upcoming fiscal year, how staff can gain those skills, and which staff would benefit from skills training. Cross-training staff can increase flexibility, as well as broaden understanding of the overall work and daily challenges in the practice. Alternatively, one person can attend training for a specific skill set, be coached on how to be an effective trainer, and then spread newly gained skills within the practice. Providing staff training and supporting enhanced skill development has the added benefit of increasing morale and employee satisfaction and preventing burnout.[14]

Mid-level managers and executive leaders may also need training. Consider enrolling executive leadership in appropriate training forums or seminars. Alternatively, for larger systems, consider developing an internal training program and bringing in external expert consultants. Consider how to include board members or patient advisors in these trainings. Refer to Table 3: Leadership Training Modules: Content Areas and Objectives.

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 reduces an organization's cost of operations.[15] • Able to integrate concepts into strategic planning and action plans.
A coherent waste-reduction improvement strategy (such as Lean Methods)	• Identify how Lean Methods 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 enable standardization and reliability.
Sophisticated practices in flow management	• Understand how process maps, workflow diagrams, and other tools can identify bottlenecks in practice patterns and processes. • Begin to identify barriers in physical settings that can impede efficient care.
Concepts and practices of scale-up and spread of improvements	• Articulate spread of innovation theory. • Understand the importance of executive leader sponsorship and attention to improvement initiatives.

Support and Sustain Change by Ensuring Adequate Time and Resources

A key role of leaders during PCMH transformation is to identify and allocate resources to best support PCMH transformation needs. Resources include time, dollars, staffing, equipment, technology, and other types of support that either help staff implement or sustain PCMH key changes.

Protected Time for Improvement

Pulling staff away from daily clinic-based work to focus on less-tangible practice improvement processes is a challenge—it must be considered an investment in the practice's future paid today. But without time to focus on practice improvement, the practice will continue with existing processes. Leaders need to balance daily priorities while keeping in mind the essential long-term goals of PCMH transformation. Carving out time from the weekly schedule for staff to meet and focus on continuous improvement processes is difficult, but essential. A multi-pronged approach to embedding QI into practice structure can help.

Staff need support from leadership, which in turn needs support from the board, to protect time for the QI work that drives and sustains PCMH transformation.

Financial Resources

In addition to protected time, staff need access to other resources to support PCMH transformation efforts. For most practices, PCMH transformation will require an up-front investment including some of the following:

- New staff positions (e.g., registered nurse, additional front office staff).
- Staff training (e.g., skills training for medical assistants).
- PCMH recognition fees and time spent on application preparation.
- Infrastructure/capacity upgrades (e.g., phone system).
- Health information technology (e.g., registry, electronic health record, data management and/or reporting application).

Most practices will also experience ongoing operating costs. Some costs can be offset through efficiency improvements or participation in an enhanced payment demonstration.
Common operating costs include:

- New "touch" points (e.g., phone visits, email visits, group visits) (if not billable services).
- Unpaid patient outreach services for preventive or chronic illness care.
- Unpaid referral management or enhanced care coordination activities.
- Ongoing staff training and support services.
- HIT system upgrades and enhancements.

To calculate your practice's specific PMCH transformation costs, refer to the PCMH ROI Calculator. To learn more about PCMH transformation costs, see Table 4: Investing in PCMH.

PCMH Transformation Costs

Practices beginning the PCMH transformation journey often have questions and concerns about transformation costs. Participating in a PCMH demonstration or pilot that includes enhanced payment (or provides grants for infrastructure or training costs) can help defray the cost of transformation–but many practices have successfully transformed without enhanced payment by re-allocating resources and improving efficiency.

The cost of transformation depends on many factors, including existing staffing models, health information technology, facility set-up, and staffing levels. Expenses for most practices can be categorized in two ways: up-front investment costs and operating costs. Actual costs vary and are determined by the practice's organization at the start of the transformation journey, choices about transformation priorities, and whether there is external support (e.g., enhanced payment).

Up-front investment costs include capital and other infrastructure costs, such as the cost of purchasing a new phone system. The term "PCMH operating costs" refers to recurring expenses associated with providing services that are not reimbursable in a FFS environment. Examples include new access points (e.g., phone or email visits), patient outreach, care coordination, and referral management. "Operating costs" also include other recurring expenses such as staff training. Research is being conducted to better quantify the cost of PCMH transformation. Current data are limited, especially in the safety net setting. However, data from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers suggest that, while low compared to the overall benefits, FQHCs with more attributes of a PCMH have higher overall operating costs.[16, 17]

To calculate your practice's specific PMCH transformation costs, refer to the PCMH ROI Calculator.

Table 4: Investing in PCMH

Category	Action
Capital costs: Facilities	Consider possible facility changes to support PCMH transformation. Many practices have been able to fund small projects that support team functioning and patient experience (e.g., co-location to improve team communication). If physical/structural changes are not feasible, consider other alternatives to improve communication among team-members. Innovative ideas include: • Walkie-talkies or other wireless communication devices (e.g., Vocera). • Team email boxes or inboxes. • Designated team meeting locations. Innovative practices have also found inexpensive ways to help patients identify and connect with their care team. Examples of these innovations include: • Team business cards with care team name and contact information. • Painting exam rooms to help patients identify their care team's space. • Providing colored or named t-shirts to help patients identify the people on their team (e.g., blue team or Pod A). • Care team photograph posted in the team's assigned exam rooms. Providing resources for efforts such as these help signal to staff that leadership is willing to invest in PCMH.

Table 4: Investing in PCMH continued

Category	Action
Health Information Technology; Infrastructure upgrades	HIT improves the ease, accuracy and speed of data collection and reporting. HIT also enables team-level and panel-specific data reports, essential to QI activities. Investing in HIT helps staff accomplish some of the key changes of the PCMH Model of Care. A fully-operational electronic health record (EHR) that meets Meaningful Use criteria is ideal. If that is not feasible, consider less expensive alternatives such as registries or practice management systems to facilitate panel management and patient outreach. Many practices have found they need to upgrade or restructure communication systems to improve access and responsiveness to patient needs. Upgrades to phone systems, email systems, answering service technologies, and medication refill systems may all be necessary. Consider ways in which technology can be leveraged to enable patients to directly and efficiently reach their care team. Changes can be as simple as adding phone trees to an existing call service or setting up direct access phone lines. These relatively inexpensive options help staff provide PCMH care. Implementing the patient portal function of the EHR provides easy and efficient access to the care team as well.
Staffing	Many practices lack the ability to hire new staff as part of PCMH transformation. However, leaders can re-allocate staff positions, redesign staff roles, and train or re-train staff to optimize team performance. Consider how to address staffing needs for PCMH transformation. (To learn more about optimizing care team roles, see the Continuous and Team-Based Healing Relationships Implementation Guide.)
Training	PCMH transformation requires ongoing staff training, particularly skills training for staff taking new or enhanced roles (e.g., medical assistants, panel managers, and front desk staff). Many practices are able to train staff directly, but time spent "off the line" has a cost for trainer and trainee. Be sure to include "off the line" time in the operating budget. Investing in the skills and competencies of staff is essential to support team-based care —training builds staff confidence and will help staff manage change.
Quality Improvement	Quality improvement is an essential component of PCMH transformation. QI is ongoing work, and for it to be successful, all staff need to play a role. Be sure the operating budget includes time for a variety of staff to engage in QI activities. (See the Quality Improvement Strategy Part 1 Implementation Guide to learn more about QI activities.)

Case Study: Keeping a Singular Vision – Leadership's Integration of PCMH

Stephen Weeg, M.Ed., Consultant and Retired Executive Director, Health West, Inc. (2013)

Health West, Inc, a multi-site community health center in Idaho, effectively adopted the Patient-Centered Medical Home (PCMH) model by continually engaging leadership. "It's never past tense, it's a never-ending involvement on the part of clinic leaders and the Board of Directors," says Stephen Weeg, consultant and retired Executive Director. "As the leader, I worked to create the energy and work environment that kept change in the forefront. The demands of the day could be distracting, but I kept my eye on where I wanted the organization to go," Weeg said.

Health West leadership was institutionalizing multiple change processes as part of their transformation efforts. Agenda templates structured for board, management, staff, and quality meetings incorporated the Change Concepts in order to focus leadership and staff on how business was addressing PCMH. Weeg explains their journey:

> If people throughout the organization don't understand it, there's no way they can support its implementation. We thought about what kind of QI initiatives tied into building the medical home, and how it all became part of what we do each day. You can't take on too many things at one time and succeed. I always tried to think about it through patients' eyes, "Is this the way I want my care to be organized?" We focused on getting outcome data down to the provider level early on. Change occurred once each provider was able to compare their own behavior in regard to their colleagues. Initially we blinded provider data. We then un-blinded it very quickly to be able to move forward; nobody wanted to be the one dragging their feet. We didn't do it punitively… Most people don't come in and say I'm here to do a rotten job today. We didn't have a lot of push back, though when data was shared and a provider wasn't close to their peers, they were much closer to their peers the next time provider data was shared.

Health West, Inc, began organizing staff for transformation in 2009. Later that year, after their EHR was implemented, Health West began to actively engage the board in the organization's transformation. Weeg explains:

> We needed to bring them up to speed so that they understood what a PCMH meant because it permeated all aspects of their decision making. We started out doing a Board 101 orientation about PCMH over the course of a couple of meetings. It energized the board. They started to understand how they wanted to do things differently; they looked at it from the patient's point of view, which made a lot of sense. From their own experience in healthcare—it made a lot of sense—and it felt good to people.

One board member, a retired MD said, "This is no different than what I did 40 years ago… yes, the complexity has changed a lot since then- the increased number of providers, and number of drugs available, but the care concept is the same." That board member became a strong advocate for the transformation and emphasis on quality patient care.

> We took turns sending engaged staff and the medical director to make reports to the board. It was critical to have the board in active support of the medical home and the work that needed to be done to achieve it. The board asked, "Do you have the money and resources you need to accomplish transformation?" "How will the changes improve patient care?" "How will this position Health West for the changes coming in health care?" Organizational change is too big and too important to do without the board's active involvement. During our transformation process, nobody left; nobody said it was the wrong thing to do. It really was an energizer, a smart direction and a good thing to do. It significantly enhanced the role of the board in our organization.

continued on page 18

Case Study Continued

"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 kept the concept tight and focused, and came up with constructs that tied all the pieces together so that it was a singular initiative focused on excellence in customer service and patient-centered care. It was doable because I thought of it as a singular vision. We learned together over time what a PCMH means and how it works. Then we moved forward with strategic planning, visioning, and important decision-making using the filter of PCMH for guidance. Board monitoring signals importance, and if board members make reviewing and acting on PCMH data a priority, senior leaders and front-line staff will, too."

"In 2010, the board said we needed to revise our mission statement to make transformation one key part of Health West's mission/vision. In the fall of 2010, the Board completed a new strategic plan that rearranged infrastructure, mission, and vision. Our mission became "Empowering our patients and communities by proactively providing quality, affordable patient-centered healthcare." We were determined to get things done for transformation with each clinic and to achieve NCQA™ PCMH recognition. In early 2012, we began submitting the applications for recognition for all six clinics; I then started to talk with the board about succession planning. I wanted to ensure we had the model integrated enough for it to carry forward without me. By late summer, all six clinics had received NCQA recognition. I also wanted to ensure that my successor was someone that understood PCMH and would continue to support it and the board's desire to continue honing transformation. The job description for my position was revised to include PCMH and the position posting listed knowledge and experience in PCMH as a preference. Questions regarding PCMH were included in the candidate interviews."

Manage Change

PCMH transformation is difficult work. Practices that succeed have "adaptive reserve"—the ability to continually learn and grow—allowing the practice to effectively manage the change process. Adaptive reserve is dependent on supportive leadership.[18]

Active involvement of senior leaders in the change process is crucial for success. In fact, in one study of clinical redesign processes, researchers found that "direct involvement of top- and middle-level leaders" was the most critical factor for success.[19]

One of the most important principles in organizational change is similar to the Hippocratic Oath: first, one must *do no harm.* Implementing change poorly is often worse than not implementing change at all. Poor implementation negatively influences staff perspective and their willingness to change and further undermines future efforts. Effectively supporting the dynamics of change and transition builds the organization's capability to manage change in the future.

Leaders can help their staff manage change in a number of ways. Suggested key actions:

- Identify a framework for the change and the tools to be used.
- Outline a few distinct priority projects to support PCMH transformation with a specific aim and require specific action from all staff.
- Assign a timeline to priority projects.
- Identify a cross-sectional oversight team to focus on PCMH implementation actions (e.g., develop and staff panel manager position(s)). This team can meet monthly or more often when appropriate to guide efforts of one or two small teams that identify and carry out PDSA cycles related to the overall quality improvement strategy. (See the Quality Improvement Strategy Part 1 Implementation Guide for additional information on process improvement teams.)
- Dedicate staff time and resources to both executive sponsors of each priority project and to "day-to-day" leads for each priority project.
- Assign accountability. Designate staff to provide routine (e.g., monthly) progress reports on these few priority projects to executive leadership and the board.
- Update executive leadership and board meeting agendas to incorporate priority project progress reports on a regular basis.

Tips for dealing with change

- **Clarify which existing processes will continue as is and which will change.** This may create an initial sense of discontinuity, but staff acceptance typically increases with time. Initial staff reactions when facing a new situation range from denial, anger, and frustration to anticipation and excitement. Staff will likely have many questions including:
  - How will this change impact me?
  - Can I do this?
  - Do I want to do this?
  - What do I stand to gain or lose?

- **Take time to pause and reflect.** Periodically, transformation leaders must pause from "doing" the work to reflect on how work is progressing, what they are learning about implementing change, and how they will do things differently as they continue through the process. This reflection process can be effective for problem solving when scheduled as a regular (e.g., monthly, bi-monthly) dialogue with the project team leader and team. This is a valuable conversation for the project team as a regular group activity.

  Reflection also provides an opportunity to practice seeing "mistakes" as opportunities for learning and to celebrate progress and success.

- **Work from the future state.** Focus on the image of what a fully implemented PCMH looks and feels like. This strategy is more engaging than focusing on broken aspects of the current structure. Give staff a sense of direction and purpose by shifting the focus of patient care from episodes of illness of an undefined group of people to providing preventative and comprehensive care for a defined population of patients over time to improve their overall health.

- **Have a realistic timeline for implementation.** Expecting staff to one day drop a set of behaviors believed to serve customers or add value and perfectly perform a new set of value-adding behaviors is not reasonable.[18] Change may spread slowly at first, involving small numbers of staff and processes, so that leaders can learn from failures and build on successes before going organization-wide.[20] Staff need time and support to feel comfortable with new processes and system changes.

- **Address resistance.** Practice transformation disrupts organizational patterns and may realign sources of organizational power.[20] Lack of understanding as to why change is necessary, and what it will accomplish, can result in change being viewed as unnecessary upheaval.[21] Resistance can also occur when staff fear being perceived as incompetent while learning new skills and approaches. Leaders can help motivate staff and instill confidence in their ability to make necessary changes by connecting the PCMH vision to the practice's existing processes and strengths.[22] Do not spend a great amount of time trying to convince the resisters, but do listen to understand their point of view. Address PCMH limitations frankly and honestly, and find ways to reduce staff anxiety and resistance to change.

- **Understand the cycle of change.** Doing so helps the entire staff endure the tough spots and sustain the effort to reach full productivity in a new and improved process.

A well-implemented change process may involve organizational discomfort, much like a new medical treatment regimen often involves patient discomfort and anxiety. Communicating an understanding of change dynamics and coaching staff through the ensuing ups and downs can help staff stay engaged and build resilience. The outcome is well worth the cost.

Helpful change management strategies in a nutshell:

- Refocus on vision and goals.
- Listen to concerns.
- Invite participation in problem-solving.
- Recognize what is currently working well.
- Post progress notes.
- Use mistakes as opportunities for learning.
- Credit team achievements.
- Cultivate a positive perspective.
- Foster healthy team dynamics.
- Provide skills training.
- Provide small opportunities for respite, celebration, and refreshment.

Table 5: Conceptual Framework for Change Management[23]

Essential Ingredients for Successful Change in Complex Organizations						the result is...
When these ingredients are present...	Vision	Skills	Incentives	Resources	Action Plan	Change
		Skills	Incentives	Resources	Action Plan	Confusion
	Vision		Incentives	Resources	Action Plan	Anxiety
	Vision	Skills		Resources	Action Plan	Resistance
	Vision	Skills	Incentives		Action Plan	Frustration
	Vision	Skills	Incentives	Resources		Treadmill

Conclusion

Support from leadership is required for any major change initiative, especially initiatives like PCMH transformation that require system-wide culture change.[24]

Active involvement of senior leaders in the change process is crucial for success,[19] and lack of leadership support is a common reason given when PCMH change efforts stall. Effective leaders provide the necessary time and resources, remove barriers, and provide inspiration and motivation for staff. Effective leaders also understand their practice as a series of interrelated processes that determine performance (systems thinking); they recognize the gap between current and optimal practice and make changes to close the gap; and they successfully manage change by implementing proven strategies for quality improvement and engaging staff in the process[25] of transformation.

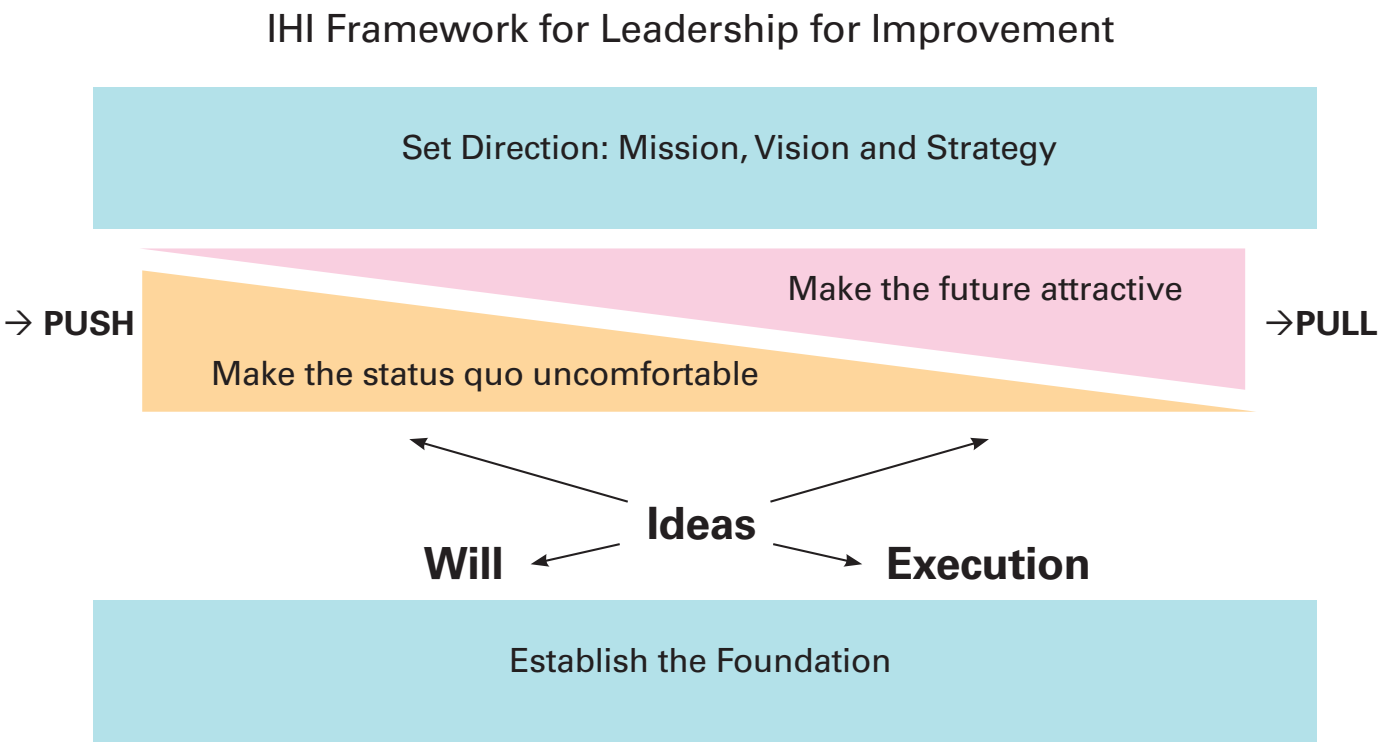


Use Proven Strategies: The Institute for Healthcare Improvement's Seven Leadership Leverage Points for Organization-Level Improvement

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)

For more than 20 years, the Institute for Healthcare Improvement (IHI) has studied and spread successful change methods. In 2005, researchers from IHI interviewed management experts from industries inside and outside of healthcare to determine the most important places for leaders to focus their efforts in guiding change. These "leverage points" were described in a white paper using the experience of hospitals that successfully implemented the elements of the 100,000 Lives Campaign,[13] a number of national initiatives, direct fieldwork, as well as interviews with change leaders within and outside of healthcare. Since these leverage points have stood the test of time and have been robustly demonstrated to be useful, the IHI's leadership framework is provided as an example of strategies leaders can use to build and guide PCMH transformation.

Figure 1: IHI Framework for Improvement



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

Reinertsen et al. describe the improvement roles for the organization's board and 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 are expected to achieve.
- Provide routine review of performance measures.
- Communicate a commitment to providing resources to ensure all goals for measures are achieved.

See Appendix A: Examples of System-Level Measures.

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. Once an organization identifies "drivers" of change, it can apply focused efforts to implement them. This is important for defining change targets, communicating those targets to internal and external stakeholders, and gaining buy in for change efforts.

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." Experience has shown that effective senior leaders engage these three methods of attention to accomplish system-level improvement.

Personal Leadership

- Staff pay attention to how leaders are spending their time. Prioritize personal schedules to make sure there is time to review data on system-level measures, prepare questions based on data, and meet with project leaders to support the work.
- Strategically select when to participate in project team meetings. Leaders send the wrong message by showing up late or leaving meetings early, not asking questions, taking phone calls, or checking email during meetings. Active involvement in project reviews with work teams sends a powerful message about the importance of the work.
- Tell stories that communicate positive results, accomplishments, and lessons learned. Listen to concerns and strive to thoughtfully answer all questions.

Leadership Systems

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 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."[13] 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 when 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 team-based payment incentives, can be instrumental in shaping change, but

not without strong leadership."[10] 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."[26] Ask senior leaders and managers what performance data are "top of mind" to get a better sense of the effectiveness of leadership systems. It can be very revealing to see in action the reliability and timeliness of measurement and reporting and the frequency that it is reviewed with senior leaders.

Transparency
Share data as openly as possible to spur improvement—consider sharing progress data publicly. When the public and patients experience improved care delivered through the PCMH model, staff within the organization usually experience an increased desire and motivation toward improvement.

4. Put patients and families on the improvement team.
It is important to have the right team supporting PCMH transformation—beginning with the leaders and continuing throughout the organization. The IHI and other organizations find that involvement of patients and families is a critical and often under-represented aspect of system-level change. Patients and families can add value in many ways, including:

- Patient and family presence in meetings focuses conversation on patient needs and innovative ideas and solutions rather than staff complaints.
- Patients receive care across the continuum of care and remind us to be patient-centered and to find community-based solutions.
- MDs/RNs/staff 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. Fifty-one percent of board members must be health care consumers. Find ways to include these consumers' participation in day-to-day activities as well.

See the Patient-Centered Interactions Implementation Guide for more details on how to integrate patients into practice quality improvement.

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

- Regularly scheduling patient conversations with senior executives focusing on PCMH progress and patient input.
- Conducting focused weekly walk-arounds by administrators, medical directors, and clinic managers to interact with families, patients, and staff.
- Integrating patients and families into existing QI structures, such as the board, the QI committee, and other organization-wide committees and projects.
- Inviting a patient or family member to tell a story at every board meeting.

5. Make the Chief Financial Officer a quality champion.
Transformation is far more likely to occur if system-level measures of financial status and quality of care are embraced by CFOs/financial managers/clinic operations managers. 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 and viability in the short and long term. To become champions of transformation, the CFO and other financial officers must also 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, often unimproved processes. The new thinking is to focus efforts on quality-focused 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.

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 change work. Failure to engage this group will almost certainly derail transformation, because of their central role and historic power within the organization. Physician engagement is embedded throughout this implementation guide, as physicians are often clinic leaders (and therefore must assume both leadership and champion roles) and also front-line providers of care. Address physician engagement by communicating how the PCMH will benefit physicians' work environments and quality of life. This can be particularly important in reaching physicians not familiar with the PCMH model of care. The IHI White Paper, "Engaging Physicians in a Shared Quality Agenda," is an excellent resource.[27]

7. Build improvement capability.
The organization's entire leadership team needs to be well versed in basic QI strategies. Transformation to a PCMH is a QI initiative on the largest scale—and the leaders' knowledge about QI will help them function as 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 day-to-day clinical care delivery.[15]

Invest in training senior and clinical leaders in QI so that they can drive system-level improvement. These competencies (behavioral and technical) need to be included in the professional development plans of senior leaders as well as staff and providers. Clinical leaders then will be able to facilitate effective process improvement teams, act as internal consultants to assist colleagues in solving problems, and educate formally and informally. Health systems use a variety of QI models. We recommend five content areas to be included in a QI curriculum. These are consistent with recommendations from numerous QI organizations to ensure that senior leaders have the skills they need to sponsor, drive, or lead QI initiatives. See Table 3: Leadership Training Modules: Content Areas and Objectives for the five content areas.

Additional Resources

These tools and resources were compiled as a result of recommendations from QI specialists and healthcare system leaders engaged in PCMH transformation, and do not represent a systematic search, either by review of the literature on leadership or an environmental scan of internet sites. These resources have been used by recognized leaders and organizations and, as such, represent a convenience sample from trusted sources. The tools and resources are presented in three categories: Leading Change, Developing and Leading a Continuous Improvement Culture, and Optimizing the Care Team.

Leading Change

Leading change requires skills that stretch the boundaries of traditional leader training and practice. The following tools and trainings can assist leaders in developing skills in facilitative leadership and team-building.

Training Programs

San Francisco Quality Culture Series Course Outline
SF Quality Culture Series Final Program Report: The SF Quality Culture Series (SFQCS) was a year-long collaborative learning program for leadership teams designed to build their improvement capacity and leadership skills in primary care. This report summarizes the program experience.

About Facilitative Leadership
The Art of Facilitative Leadership: This document provides a brief overview of the six major themes of facilitative leadership, and the fundamentals of a facilitative leader.

Facilitative Leadership Training
This in-person learning experience, offered by the Interaction Institute for Social Change, explores the relationship between leadership and participation. It builds on everyday leadership challenges as a basis for practice, and includes modules on collaborative planning and problem solving, creating vision, coaching, and inspiring others.

Reading Materials: Toolkits, White Papers, Articles and More

A Leaders' Guide to Creating the Business Case for Planned Care: A Toolkit

This white paper provides a change package that represents the high leverage opportunities to generate the business case. It provides guidance on how to get started on making your own business case and creating resources to fund transformation. *Citation:* Faculty of HRSA's Finance and Redesign Pilot Collaborative. *A Leaders' Guide to Creating the Business Case for Planned Care: A Toolkit. Rockville, MD;* Health Resources and Services Administration, May 2006.

Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)

The second edition of this white paper incorporates new perspectives on the seven leverage points, particularly in their execution, and gives specific examples of their application in the field. A self-assessment tool helps leaders design and plan their work to lead system-level improvements.

Execution of Strategic Improvement Initiatives to Produce System-Level Results

The Institute for Healthcare Improvement (IHI) uses a simple mantra to describe the essential elements for strategic improvement: Will, Ideas, and Execution. You have to have the will to improve; you have to have ideas about alternatives to the status quo; and then you have to make it real—execution. This paper proposes a framework for execution of strategic initiatives aimed at producing system-level results.



Developing and Leading a Continuous Improvement Culture

Engaged leaders provide motivation for staff by articulating the connection between PCMH transformation and the organization's mission, vision, and values. They engage all staff in quality improvement efforts and encourage learning and growth. Leaders also build and communicate a strategic plan that is reflective of their focus on quality improvement. Most importantly, leaders support improvement efforts by providing improvement teams with resources (including protected time) and tools to implement and test changes, and remove barriers that impede progress. With leadership support, the first step to transforming a practice is to implement a QI strategy, which includes a measurement strategy, and to embed it in the fabric of the practice's business and clinical operations. The following tools and resources can assist leaders in developing these skills.

Reading Materials:
Toolkits, White Papers, Articles, and More

Engaging Physicians in a Shared Quality Agenda
This white paper presents a framework from which hospital leaders might build a written plan for physician engagement in quality and safety. The paper includes tools to help hospital leaders assess organizational factors that will inform the degree of difficulty in engaging physicians, as well as to identify and prioritize initiatives for which physician engagement is essential. While the principal focus of the paper is on American hospitals and their organized medical staffs, the framework might also be applied to many other types of healthcare systems and in settings outside the United States.

Executive Review of Improvement Projects—A Primer for CEOs and other Executive Leaders
The principal focus of this brief practical guide is to provide tips for how leaders can draw attention to the improvement effort, encourage big ideas, and make changes stick.

Putting Measurement into Practice with a Clinical Instrument Panel
This article provides measurement tips for developing a measurement strategy, a starter set of performance measures, and a link to an Excel tool to customize a measurement dashboard. *Citation:* Endsley S. Putting measurement into practice with a clinical instrument panel. *Fam Pract Manag. 2003 Feb; 10(2):43-48.*

The Run Chart: A Simple Analytical Tool for Learning from Variation in Healthcare Processes
This article makes the case for the importance of examining healthcare measures over time using run charts. It also describes how to construct and interpret a run chart or data trended over time. *Citation:* Perla RJ, Provost LP, Murray SK. The run chart: A simple analytical tool for learning variation in healthcare processes. *BMJ Qual Saf. 2011; 20: 45-61.*

Optimizing the Care Team

The PCMH Model of Care requires support from the entire healthcare system, but the heart of transformation is at the practice level, where most changes are implemented. Individual practice team members take on new roles and tasks, lead change efforts at the practice level, and communicate and coordinate among themselves and with other care settings. The tools below help to address team level issues such as change fatigue, embedding change in practice, and mitigating staff turnover by empowering all members of the care team to play an active role in PCMH transformation.



Reading Materials:
Toolkits, White Papers, Articles, and More

How Inclusive Leadership Can Help Your Practice Adapt to Change

This paper in Family Practice Management shares observations and strategies from 40 clinics on how inclusive leaders invite contributions from others. Practices in the study that displayed inclusive leadership were more likely to have achieved full implementation of the Chronic Care Model. Citation: Bowers KW, Robertson M, Parchman ML. How Inclusive Leadership Can Help Your Practice Adapt to Change. Fam Pract Manag. 2012;19(1):8-11.

Appendix A: Examples of System-Level Measures

Dimension of Quality	System-Level Measure	Example of System-Level Goals	System-Level Goal
Patient-Centered	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 ED.	5% reduction
	Reduce inpatient admissions/readmissions	% reduction in % of patients with 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 including but not limited to colorectal, cervical, or breast.	90%
	Diabetes and hypertension outcome measures	% of eligible diabetes patients who have HbA1c<7%.	80%
Timely	Follow-up appointment after hospital within five days	% of hypertensive patients who have BP<140/90.	85%
	Access to specialty care within seven days	% of patients who were able to schedule appointments within seven days.	95%
	24/7 access	% of appointments after 5:00 pm during weekdays and on weekends.	25%
Equitable	Ensure migrant workers and family members have equal access to care	% of migrant workers or family members receiving all recommended immunizations.	75%

Appendix B:
Engaged Leadership and Health Information Technology

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This addendum is supplemental to the primary Engaged Leadership Implementation Guide.

Although many parts of the Patient-Centered Medical Home (PCMH) Model of Care can be effectively implemented with minimal HIT, each of the Change Concepts is easier to adopt and sustain when HIT is optimized. However, HIT implementation can be disruptive of clinical workflows and staff can easily become inundated with information management work if the process is not well managed. Change management, described in more detail earlier in this Guide, is one tool leaders can use to support their practices implement or optimize HIT.

This addendum provides information leaders can use to help their practices harness HIT for PCMH transformation. For more information on HIT and the PCMH, see the Quality Improvement Strategy Part 2 Implementation Guide.

Use Data to Help Manage Change

Table 1 below describes the essential ingredients for an organization to successfully manage change. Leadership will need to have a vision, build skills, provide incentives and resources, and also ensure that there is an action plan in place to build a foundation for change. Without all of these key elements, the risk of an unsuccessful change effort is high.

Each of the essential ingredients for successful change management described in Table 1 will be most effective if firmly grounded in reliable data. An essential leadership role is to use data to create a shared understanding throughout the organization that the present state is undesirable, the planned future state is preferable, and the transition between them is both clear and manageable. To do this effectively, leadership must understand what data are available and how to use the data to build a compelling narrative for change.

Table 1: Conceptual Framework for Change Management[23]

Essential Ingredients for Successful Change in Complex Organizations						the result is...
When these ingredients are present...	Vision	Skills	Incentives	Resources	Action Plan	Change
		Skills	Incentives	Resources	Action Plan	Confusion
	Vision		Incentives	Resources	Action Plan	Anxiety
	Vision	Skills		Resources	Action Plan	Resistance
	Vision	Skills	Incentives		Action Plan	Frustration
	Vision	Skills	Incentives	Resources		Treadmill

Data Sources

Information from an electronic health record (EHR) is clearly a rich source of data for managing change, but many data sources exist to support PCMH transformation.

Data sources without an EHR:

- Practice management and billing software.
- Patient surveys.
- Staff surveys.
- Staff turnover data.
- Observations and communication from within the organization.
- Financial data.
- Utilization reports from emergency departments and affiliated hospitals.

Data sources with an EHR:

- All of the above.
- EHR canned reports based on key categorical data elements.
- Business Intelligence software reporting out of a relational database.

Data Uses

Each of the data sources listed above can be used to demonstrate current performance and performance gaps across a range of important measures including service quality, clinical quality, efficiency, financial performance, patient satisfaction, and staff satisfaction. While a board of directors may be most interested in financial performance and service quality, care teams may be more responsive to efficiency, clinical quality, and patient satisfaction data. Others in the organization may be interested in different performance measures.

As an organization engages with the Change Concepts for Practice Transformation, leadership must use data to manage the difficult transitions by keeping the organization's eye on the goal. For example:

- Monitor the transition to Empanelment and Continuous and Team-Based Healing Relationships using data (e.g., age-sex adjusted panel sizes) to close panels that are too large and distribute resources to teams based on panel composition.

- Support workflow changes with data showing improvements in efficiency and quality resulting from the process change that may not be obvious to people involved in the change because of disruption in their familiar work environment.

- Accompany new lines of work requiring new skills and additional tasks with financial data showing how revenue streams are changing in a positive direction, and that the financial health of the organization is improving as a result of the change.

Critical Leadership Topics

Leadership needs to have some content expertise in two specific areas that pertain directly to HIT: EHR implementation and reporting data out of an EHR.

For successful EHR implementation, leadership needs to:

- Be engaged and stay engaged throughout the processes of selection, implementation planning, go-live, stabilization, and optimization.
- Involve providers early and give full support to provider champions.
- Ensure adequate, appropriate, and properly timed training. Ensure protected time for provider training and make sure everyone completes training, especially providers.
- Ensure good bidirectional communication between leadership and front-line staff.
- Ensure that all critical interfaces are adequately tested and working before go-live.
- Perform a full dress rehearsal that includes testing all business-critical workflows before go-live.
- Ensure that adequate resources are present during go-live including real-time on-going training and support.

To ensure successful reporting out of an EHR, leadership needs to:

- Ensure that reporting resources stay focused on strategic priorities.
- Invest in a relational database to house EHR data for reporting and business intelligence software that meets the organization's reporting needs.
- Focus on standardizing the workflows responsible for entering and validating key data, on which mission-critical reporting relies (e.g., problem list, medication lists, and PCP assignment).
- Assemble and fully support a team of people with skills to write, validate, and maintain the clinical quality reports on which the organization will depend.
- Use reports to leverage change, guide change tactics, and generate support for the process of change.

In most organizations, the transition to a PCMH and the transition to using increasingly sophisticated HIT to support the PCMH are inseparable. Leadership needs to focus on using data to create support for change and to manage unfolding change by removing barriers as they arise. As the quality of information improves with better HIT, leaders can deploy new information to stabilize systems after transitions that may cause disruption of clinical workflow. Information can be leveraged to improve quality and efficiency and to make improvements. Leadership's role is to guide the organization through the challenging transition to a PCMH by integrating HIT and HIT data into each of the Change Concepts to meets its strategic goals.

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Recommended citation: Safety Net Medical Home Initiative. Altman Dautoff D, Philips KE, Manning C. Engaged Leadership: Strategies for Guiding PCMH Transformation. In: Phillips KE, Weir V, eds. *Safety Net Medical Home Initiative Implementation Guide Series. 2nd* ed. Seattle, WA: Qualis Health and The MacColl Center for Health Care Innovation at the Group Health Research Institute; 2013.

Acknowledgments: This document was created by the Safety Net Medical Home Initiative (SNMHI). The partner sites and Regional Coordinating Centers that participated in the SNMHI were members of a learning community working towards the shared goal of PCMH transformation. The *SNMHI Implementation Guide Series* was informed by their work and knowledge, and that of many organizations that partnered to support their efforts. We gratefully acknowledge the contributions of partner sites and Regional Coordinating Centers, and especially the following individuals and organizations that contributed to this specific guide.

Reviewers and content contributors to the second edition: Edward J. Sayer (Hilltown Community Health Center); Tina Hahn (Pittsburgh Regional Health Initiative); Laurie Francis (Oregon Primary Care Initiative); Ray P. Medina (Aunt Martha's Youth Service Center); Stephen Weeg; and Bonni Brownlee (Qualis Health).

Based on the following resources from the first edition of the SNMHI Implementation Guide Series:

- Safety Net Medical Home Initiative. Powell J, Eloranta S, Chaufournier R, Daniel D. Engaged Leadership Implementation Guide: Strategies for Guiding PCMH Transformation from Within. 1st ed. Burton T, ed. Seattle, WA: Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute, November 2010.
- Safety Net Medical Home Initiative. Schaefer J, Daniel D. Engaged Leadership Implementation Guide Supplement: Senior Leader Toolkit. 1st ed. Reed R, ed. Seattle, WA: Qualis Health; June 2012.

With contributions from: Institute for Healthcare Improvement, Health West, CareOregon, Multnomah County Health Department, Denver Health, and HealthPartners Medical Group. Authors also acknowledge the editorial contributions of Brian Austin.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which was 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 received 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 was 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 was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care 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.

QUALIS HEALTH

THE COMMONWEALTH FUND

GroupHealth

MacColl Center for Health Care Innovation