InnerWork
Change from the Inside Out

Needs Assessment Summary

Multiple Clinical Care Organizations

www.innerworkcompany.com 1 - 888-216-3565

Introduction

This summary document is provided as a "take-away" tool for participants in **Partners Healthcare Primary Care Leadership Summit.**

- It lists **sample organizational findings** across multiple clinical care organizations that are "practices", such as Patient Centered Medical Homes versus larger medical centers.
- These findings are actual findings from several workplace development projects conducted by InnerWork senior consultants in the last three years.
- These assessments were conducted to support the practice leaders to develop themselves, and their teams. An "integral change" approach was taken to and help all the team members work on key issues that could improve the operational excellence and patient focus of their practice, as well build high performance teamwork and engage people in deeper levels of personal change.
- Findings like these formed the basis for customized team development programs and coaching that focused on self change, team change and organizational change.
- As you read these findings, note the similarities and differences between your practice and these other practices who also are engaged with creating higher performing work places the practice of medicine / healthcare continues to change and evolve rapidly.

The following findings are organized into two main classifications: **"Strengths"** and **"Areas for Change".**

Strengths (Findings)

In this section, respondents (across a range of organizations) outlined their perspective on the authentic **strengths** of their organization in confidential "focus group" style interviews with a senior InnerWork consultant.

Patient Experience / Superior Care

- "We are meeting patient needs effectively overall!"
- Superb hand-offs on messaging and tasks; "track team running a relay"
- Patients notice / appreciate the focus / thorough care

- Invest time needed with patients (despite financial /productivity demands)
- Patient service orientation strong – will "bend" / "make it happen"
- Deep feeling for patients. Empathic. "Not always cure, but we can heal"
- All team members were very proud of their model of care, which allowed for a deeper focus and time on patient care that formed strong bonds and connections to their patients.
- Many team members cited the correlation of their approach to high patient satisfaction scores. Comments included:
    - "Our patients love us, and we love them!"
    - "Our physicians have won awards for the quality of their patient care and patient communication."
    - "Our team of physicians and clinical team members help our patients really understand their issues. This helps them get involved and taking steps to get well."
    - "We get the patients involved too. We have these patient feedback tools – little suggestion pads to get their ideas and recommendations."

Pre Appointment Patient Testing

- Some team members suggested that they often were able to enhance the quality of care and patient connection when patient tests were done BEFORE the office visits. They said this also reduced unnecessary testing and service utilization when patients engaged in their care plan.

Note: improving this process even more was also an area for change and improvement (see below)

High Performing Team Behaviors

The team members cited many very positive team-based strengths in their practice. Some of the key behaviors they say are frequently exhibited are:

- Great sense of humor: "one of our top traits!"

- Interpersonal support: people very supportive and often willing to step out of role to support others
- Problem solving: team can "rally" around a problem or issue and generate a solution quickly
- "Can-Do" – work climate generally characterized by positive attitudes, emotions, and many pro-active "can-do" behaviors in staff – "we get it done!"
- Taking Initiative w/o being asked: happens regularly, "it's like we are dancing when it works!"
- Thinking ahead and anticipating needs of the provider, and doing what needs to be done that increases efficiencies (i.e., vaccines already put in")
- Innovative mind-set: willing to be open and try new things
- "People aware. Interested. Positive attitude. Shared Responsibility"
- Doctors: "Admins cover well. They often say, "Sure, I can help". Very positive response".
- Pride: "We make sure this place works". "We do things better here."
- When short-staffed / crisis: "we excel" (leisurely pace – less accountable)

Workplace Climate - Progressive improvement!

- "We enjoy each other"; more "good times" at work
- "Care about each other too"; "more than a job"; "not just "other employees"
- New feeling of "sense of community"; "family"; "in this thing together"

High Performance Work Teams – Clinical Care Team Level

- Good communication within care provider teams!
- Teams "flow" / work even when members change out
- "Teams at Best"
    - Fluid coverage of patients and needed tasks

    - Encouraged to create their own "flow" / improvements
- "Huddles": Working for team communication / problem solving / task execution

Open Communication

- Many team members commented that there was a true willingness to listen to each other and have open dialogue.

Staff Meetings with Excellent Engagement

- Several team members commented that their staff meetings had good participation and contributions from all levels. They were pleased that they had input, and all team members and leaders encouraged open idea sharing and collaborative discussions to solve issues.

Support and Respect for the Practice Leaders

- Respondents shared that there was a high level of respect and appreciation for their practice leaders.

Innovation

On Innovation, several team members cited specific examples of their work culture of innovation as compared to other typical medical practices.

- "We are willing to try a different test, a different protocol."
- "We have these cool blood pressure apps!"
- "We are implementing virtual office visits."
- "Our disease management approach also includes a Health Coach."

Level Three PCMH certification process - Excellent Engagement

- Practice leaders report that their staff generally were "interested in new policies and protocols; new standards and consistency" for achieving and maintaining Level Three PCMH Certification

Areas for Change and Improvement

In this section, respondents (across a range of organizations) outlined their perspective on the **Key areas for Change and Improvement** in their organization in confidential "focus group" style interviews with a senior InnerWork consultant.

1. Business / Organizational Change Issues & Opportunities

The following key business / organizational issues & opportunities were cited for improvement.

External Business Pressures

- Team members report being challenged to provide quality of care and patient focus that has been needed during a transition to a "true PCMH", while being measured by various productivity metrics common in the current primary healthcare environment (i.e., volume patient appointments per day, etc.). Comments included:
    - "I have to say achieving the vision is tough. Administrators too often want to dictate how we practice and do our work."
    - "Budgets have to be met. But I am still very proud of what we can do, and how we strive to be cohesive and deliver for the patient."
    - "We are experimenting with new models of value driven care vs. volume driven care. And we have solid results. Our quality and patient satisfaction rivals all other practices. But our financial and productivity measures may not be comparable to other practices."
    - "The payment models haven't caught up with some of our tech innovations. For instance, we can't get reimbursed for telemedicine appointments."

Making the Case for ROI

- Several team members noted that the improving the health of a patient population by changing the quality of care being provided to create healthier outcomes is still challenging. With a short-term quarterly or even annual focus, it is not easy to actually PROVE financial cost-savings or cost avoidance benefits in the short term---when these savings will be realized over the longer term. Comments included:

- "What we are doing will have impact and effect over several years. We are reducing risk factors, and increasing patient awareness, and getting them to take more responsibility for their health."

Increasing Organizational Level Communication

Several team members suggest that practice leaders need to take more time to be consistent and substantive on routine organizational communications.

- They reported needing more information on general finances, and operational constraints; and how to engage the staff in any needed cost savings/efficiency needs
- The staff also wanted information on how they were meeting established goals and any important metrics, and what was needed for them to engage and solve issues with the practice leaders.

Senior Management Engagement

- Several team members suggested that there would be value in getting more engagement and communication with the top leaders of the healthcare system. It seemed that some staff were seeking some organizational level of validation and recognition from these leaders for "doing the right thing" and innovating in healthcare.
    - "It would be great to have them visit our practice and learn about the great things we are doing, and hear from them too about their concerns".

2. Process & Procedural Issues / Related Process Roles and Responsibility Issues

The following process and procedural issues, and the staff roles and responsibility issues often connected to these process / procedural issues, were cited as key areas for change and improvement.

Continuous Improvement

- Team members report a general openness to continuous improvement and quality improvement initiatives, but report that there is not sufficient and sustained practice leadership and staff engagement to focus on / prioritize a few key initiatives for action when faced with the press of daily demands.
- They also cited there were not action plans developed to move these kind of initiatives forward.

- Other team members had significant concerns that unless more time would be allocated to this activity, the usual pressures would win out. Comments included:
    - "Usually it is just 'Do the work'. Process improvement and innovation might have to wait."
- Several team members cited that most Change Initiatives (design, process, procedures) were operating at a "slow pace".
- Practice leaders report that it is "tough to find / allocate the time, but the desire is there".
- Practice leaders report needing to see more pro-active suggestions for Change / ideas for improvement from the staff: "Bring it"

Some examples of opportunities cited to increase quality and efficiencies that could improve work flow and reduce stress included:

- Triage / Phone Triaging: "We have tried to work on it"; "Not a clear and final mandate developed yet. One of the top issues to solve for here."
- Coverage – ensuring adequate coverage through better planning and staff cooperation, and reducing resentment when it does not work well
- Scheduling – balancing the schedule to allow staff to distribute and more evenly share the "urgent care workload" with the "health maintenance workload"; rooming patients and balancing timing of patient visits with type of services / level of care needed by types of patients
- (Paper Billing) – "We are losing revenue here. Not working well."
- Pre-Visit Labs – "When it works it is great, but I can't say we really have a good set procedure here and it is very frustrating for us across the different roles of the practice---from the front desk to our clinical partners. This breakdown creates a ripple effect in our work flow, yet it is a core process that boosts patient care and provider productivity when it works."
- Handling the Urgent Patients – several team members suggested the process issues and communication issues "needs to be examined and tuned" when handling urgent patients that change the daily schedule. "We need a better process here. We often do not know who is going to do what."

- Calls from Patients Who "Self-Identify" as "Urgent": current process that nurses must screen calls can be inefficient and overtax nurses who have limited time vs. taking "whole person" view of the patient who is anxious but not "truly sick-sick", and just schedule them for a visit without nurse interviews being mandatory.

- Processing "Top Care" Forms into the Medical Record – how to obtain a "360" check and ensure the form gets into the patient's Medical Record

Identifying / Using Key Procedures and Protocols

- Some team members report that some procedures and protocols are not clearly identified AND/ OR the agreed-to procedures and protocols that have been developed are NOT actually being followed by staff. This also seems to be creating some confusion in roles and responsibilities. Comments included:
    - "Often feels like too much ambiguity"
    - "Often feels like we have no agreed-to protocols"

- Some team members and some practice leaders report that although a procedure or protocol may be agreed-to and actually written down, it is not always followed.
    - "We may have trained them on it, but they forget or choose to ignore the procedure or protocol. This happens from the doctors right down to the medical assistants".

- Example: existing documentation on "How to Review Medical Record" – "can't say anyone uses it, but it certainly exists."

Clarifying Roles and Responsibilities

- Some senior clinical provider staff commented that there was not sufficient clarity yet about what tasks could be "passed off" or delegated to more junior clinical staff or administrative staff.

- These senior provider staff wanted to be sensitive to these professionals and their significant work load, so the current lack of clinical / work flow task clarity is creating uncertainty and hesitancy among these team members.

- Because team members have a strong work ethic, team members reported they were "getting it done" and accepting the work load---despite the lack of clarity.

- However, sorting out and clarifying appropriate task responsibilities where there is ambiguity could help the staff (especially since the team members cited that they were willing to go "off role" to get more urgent tasks addressed).

3. Team-Based Performance Issues / Self Change Issues

The following team performance patterns, and individual / team behaviors, were cited as key areas for change and improvement to increase the team's performance in a PCMH team-based work environment.

Managing Levels of Team Involvement & Leadership Decision-Making

- Several team members reported that staff input and opinions are able to be shared and valued, which increased a feeling of "consensus" in the team.

- However, several team members suggested that, depending on the situation and decision / plan to be made, the practice leaders need to "lead", and "make a decision"-----and the staff needs to commit to that decision and follow-thru as needed.

- Some practice leaders suggested that great efforts are made to gather staff input, but they needed to take action too. "This can't be a democracy on some decisions". Comments included:

    - "We have an open environment but sometimes we err on too much discussion that does not drive to a decision or a plan. We need to get a "mandate", or agree on a plan sometimes, and then try it for a week or a month."

    - "We don't have a good way yet to highlight and call out that we all need to follow up on a decision or mandate, and hold ourselves accountable."

    - "We don't really know how to manage staff involvement effectively".

Cross Team Communication between Clinical Care Teams

- Several team members reported that there was a "gap" in the communication flow **<u>across</u>** the intact clinical care teams that impacted accurate, timely patient care, created frustration, and also increased patient safety concerns
- Some team members said this issue had never been systemically examined.
- Some team members reported that one of the causes of "poor cross team communication" was that staff members tended to communicate with selected colleagues only.

- "I revert to "my go-to people"; "go to people I am comfortable with"

Some cross team breakdowns cited that needing solutions included:

- **Pharmacy calling random person for prescription refill**
- **Abusive patient on chronic opioid with prescription renewal demands**
- **Test results called in or returned when MD away- where do they go**
- **MD needs RN for coverage when other primary RN away. Need equitable x-coverage system**
- **MA coverage when primary MA is away. Need to identify expectations and improve flow consistency/ virtual huddle**
- **MA coverage when at lunch – how to communicate**
- **MD away and patient needs a visit. What is protocol for booking a visit within all practice?**
- **Communication: how to ensure notes should be left for ALL patient interactions.**
- **Close the loop: how do we trust that assigned tasks will be completed?**

Performance Feedback / Team Feedback

Several team members suggested that positive feedback and acknowledgement and constructive feedback was generally "not strong" in their teams.

- "Sometimes "atta-boys" and "atta-girls" are heard, but we are not very systematic".
- "We don't really celebrate much around here. People are logging long hours and we are doing very good work, but not much appreciation going around".

Several team members cited some real challenges regarding **giving constructive feedback**, and cited this was the most important area for change and improvement in team feedback practices. As barriers, staff cited:

- Office Floor Plan – it was difficult to provide constructive feedback confidentially with an open floor plan

- Avoidance – there were not any team agreements in place that encouraged people to provide constructive feedback and/or request / be open to constructive feedback, so practice leaders and team members tended to avoid giving constructive feedback

- "Work-Arounds" - Where there were concerns about helping team members engage in some behavior changes / performance improvement changes, people "opted-out" of giving feedback and "worked around them"

- Time Constraints – some team members cited their work demands as not giving them sufficient time to discuss / share constructive feedback

- Management expectations – some team members suggested practice leaders don't explicitly set expectations that there needs to be increased routine interpersonal feedback

- Low Openness – some people reported that MA's and secretaries were "not very open to feedback from the senior medical staff"

- Little upward feedback to Practice leaders:
    - MA's – withholding FB/suggestions for change with doctors and NP's
    - Admins reluctant / withholding FB to doctors and NP's

- Management Too Busy - Practice leaders report that they were not taking enough time for providing feedback. They agreed that they needed to make Feedback a valued Team Practice!

Note: an additional barrier may be lack of skill in giving constructive feedback.

Openness to Coaching and Feedback

Connected to the above issue on increasing feedback (particularly constructive feedback), some team members suggested that there needs to be **greater openness to giving and receiving interpersonal coaching and feedback** to make a "jump to next levels" of personal and team functioning.

Team members seemed to be asking the question: "When we see how one of our colleagues can make small adjustments to improve, are both parties willing to have those "coaching conversations"?

(Note: in a high performing work team, this coaching and feedback would include peer-to-peer coaching, supervisory coaching, and upward feedback to the practice leaders).

- Example: Medical Assistants who could learn how to observe the work environment and work flow more carefully, and anticipate better the needs of the provider they are paired with, and proactively provision what is needed---without being asked.

- Example: Medical Assistants needed to improve their general problem-solving ability and take initiative to fully complete charts, handle information gathering from deaf patients using writing versus waiting for an interpreter, managing patient flow and communication between waiting rooms and treatment rooms, and more

- Example: Doctors who move so quickly through the patient line-up that they may miss critical notes or follow-ups that need to be communicated to the staff

- Example: Doctors who may overschedule a patient for follow-ups without giving the patient sufficient context and rationale, and the patient---who may be busy professional---cancels, leaving a hole in the schedule

Upgrading Team Accountability

- Several team members cited concerns about ensuring higher levels of personal and team accountability in the practice. Some team members were working "very hard", while others were not. Comments included:
    - "Some people just do less. And you can't catch their eye."
    - "They give you this "I'm overwhelmed" attitude a lot versus---what can I do?"
    - "They don't supporting others well. They: won't check-in and ask "How can I help".
- Some team members recommended that practice leaders need to communicate better around their expectations on personal accountability. Comments included:
    - "They need to hold others to same work performance habits and standards that most of us hold ourselves accountable to".
    - "Not accepting slacking off"
    - "Some team members not always doing what they should be doing. Not a one-time issue"
    - "Some team members may avoid more accountability. Requires other to step in and cover off. i.e., "Reminder calls not being made"
    - "They don't get much feedback, so we need to say something to the leaders and if they hear about it, then they think we are "squealing to mgmt."

Some team members reported that the result of this low accountability in some team members was **diminished team capacity and performance**. Comments included:

- "Know who to go to. Slackers get less. Accountable people get more".
- "I manage my anxiety by going to people who will have my back"
- Staff: "Brought up to mgmt. Nothing gets done. Poor follow through"

Some practice leaders report that indeed…"feedback / corrective action is being conducted with the low performers; but it is being done with confidentiality and the staff does not know about it".

4. Work Climate Issue - Work Place / Work-Related Stress

The following work climate issue was cited as a key area for change and improvement. Solutions to it cut across the business level, process level, team level and individual levels of human and organization performance.

- Several team members cited that "work stress", "burn-out" and "lack of self-care" has become a significant issue.
- Several team members cited examples of some roles / team members who had workloads that were "not sustainable".
- Several team members suggested that it would be important to recruit and fund incrementally more staff that are needed in some key roles.
- Several team members empathetically singled out and recognized high performing team members as making "out-sized contributions", but that they may be "over-taxed" / "maxed out"
- Some people suggested the practice leaders were "driven" and "set the pace" and it was "hard to match them some days"

Comments on this finding included:

- "We aspire to be the practice of the future of medicine and healthcare. And we tell our patients to manage their stress. But behind the scenes here, we have lots of stress that is impacting our health."
- "Some of us have other interests. It is hard to find the time for these interests. Many of us are in early and leave late."

- "To be honest, some days I just need to do basic things, and just do them over and over again. I don't have the energy and need to manage my stress."
- "There are so many great parts of my job, but work/life balance is not one of them. I am logging 10 – 11 hours too many days just to get the work done."

Summary

- **Managing & directing effective change requires gathering this information, prioritizing it, and sharing it back with the team and inviting them to engage in changing things at the organizational, team, and self / individual level.**
- **Initiating and organizing an interactive change process to address these kinds of needs may take some time, but an initial engagement in positive change is needed, focused on the highest priority areas for personal, team, and organizational change.**
- **Focusing only on process improvement change is partial, and does not address deeper personal and team dynamics on which successful and sustainable process improvement works best.**