Whole Person Care Collaborative

February 1, 2021
Welcome

Introductions

Consent Agenda
  December Minutes
  February Agenda
Announcements/Updates
Partner Updates

• Managed Care Organizations

• Community Based Organizations

• Clinical Partners
Announcements

Instagram

Facebook

“BUILDING HEALTHIER COMMUNITIES ACROSS NORTH CENTRAL WASHINGTON”
Collective Medical Webinar

• Sharing Care Information on the Collective Medical Platform
  • **Wednesday, February 24th from 1:00-3:00**

• Intended audience is current users of Collective Platform that have been logging into the system for at least two months

• You will need to register to attend the webinar. The registration link can be found in attachments and was also sent out via email. If you have questions, or need assistance with registration you can reach out to Mariah.

• The webinar recording will be available for those unable to attend
Monthly Reports

Due Feb 3rd (1st Wednesday of the month)

“Provide Stage 2 base funding to the organization in the annual amount of $insert annual amount according to the organization’s 2016 Medicaid encounters and current change plan score. Base funding will be disbursed on a quarterly basis, within 90 days from completion of deliverables. This base funding is intended to help compensate the organization for needed capacity building efforts and/or the time required of team members involved in change planning and practice transformation efforts.” WPCC MOU Section IV, Subsection C
Population Health LAN

• Kicked off in October

• Monthly Topics included (listed in order):
  • Telehealth basics as applied to Diabetes and Depression
  • Panels, COVID-19 and Overdue Care
  • Population Health Management and QI during the pandemic
    • Fishbone Diagram
  • Population Health Management – Choosing next steps
    • Options to transition from root causes to next steps

• February 9th we will be discussing:
  • “Moving from Root Causes to PDSAs: What Changes Can We Make that will Result in Improvement? While root causes indicate why our systems may be broken or not performing as we would like, how do we change systems to make them better? This session will discuss how teams can approach this next step. We will walk through approaches to design PDSAs using examples from the teams.
• Wednesday, February 24th
• Deeper Dive into tools introduced during PH LAN

Example:

<table>
<thead>
<tr>
<th></th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henry</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ian</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Emily</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mercedes</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>6</strong></td>
<td><strong>9</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>
Questions
Data Updates
Pay for Performance Trends & Chronic Disease Profiles

Caroline Tillier
## NCACH P4P Results

### Acute Care Utilization

<table>
<thead>
<tr>
<th>Metric</th>
<th>CY2017</th>
<th>CY2018</th>
<th>CY2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital Utilization per 1000 Members</td>
<td>52.728</td>
<td>49.459</td>
<td>45.806</td>
<td>↓</td>
</tr>
<tr>
<td>All-Cause ED Visits, per 1000 MM: 0-17 years</td>
<td>28.498</td>
<td>29.479</td>
<td>29.884</td>
<td>↓</td>
</tr>
<tr>
<td>All-Cause ED Visits, per 1000 MM: 18-64 years</td>
<td>50.317</td>
<td>49.953</td>
<td>50.997</td>
<td>↓</td>
</tr>
<tr>
<td>All-Cause ED Visits, per 1000 MM: 65+ years</td>
<td>55.334</td>
<td>61.688</td>
<td>45.156</td>
<td>↓</td>
</tr>
<tr>
<td>Plan All-Cause Hospital Readmissions: 18-64 years</td>
<td>9.841</td>
<td>10.032</td>
<td>9.798</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Data Source:** Health Care Authority  
Measurement Periods: Baseline Year 1 (Calendar Year 2017), Baseline Year 2 (Calendar Year 2018) and Baseline Year 3 (Calendar Year 2019)  
Performance in CY 2019 will be compared to baseline CY 2017  

**Indicates direction of desired change for each metric:**
## NCACH P4P Results

### Access and Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>CY2017</th>
<th>CY2018</th>
<th>CY2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant medication management: Acute (12 weeks)</td>
<td>46.418</td>
<td>42.436</td>
<td>50.595</td>
<td>↑</td>
</tr>
<tr>
<td>Antidepressant medication management: Continuation (6 months)</td>
<td>32.385</td>
<td>29.21</td>
<td>34.269</td>
<td>↑</td>
</tr>
<tr>
<td>Asthma Medication Ratio: Ages 5-64 Years</td>
<td>52.273</td>
<td>49.724</td>
<td>53.364</td>
<td>↑</td>
</tr>
<tr>
<td>Child and adolescent access to primary care: ages 12-24 months</td>
<td>97.354</td>
<td>98.134</td>
<td>97.86</td>
<td>↑</td>
</tr>
<tr>
<td>Child and adolescent access to primary care: ages 25 months-6 years</td>
<td>92.227</td>
<td>91.734</td>
<td>92.718</td>
<td>↑</td>
</tr>
<tr>
<td>Child and adolescent access to primary care: ages 7-11 years</td>
<td>95.645</td>
<td>95.56</td>
<td>95.893</td>
<td>↑</td>
</tr>
<tr>
<td>Child and adolescent access to primary care: ages 12-19 years</td>
<td>96.449</td>
<td>96.361</td>
<td>96.332</td>
<td>↑</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HBA1c Testing</td>
<td>88.705</td>
<td>89.12</td>
<td>89.081</td>
<td>↑</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>88.153</td>
<td>87.141</td>
<td>88.291</td>
<td>↑</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (Retinal) Performed</td>
<td>55.02</td>
<td>52.77</td>
<td>49.209</td>
<td>↑</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (Prescribed)</td>
<td>84.564</td>
<td>82.386</td>
<td>80.473</td>
<td>↑</td>
</tr>
</tbody>
</table>
### Behavioral Health and Follow-up Care

<table>
<thead>
<tr>
<th>Metric</th>
<th>CY2017</th>
<th>CY2018</th>
<th>CY2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7 Days</td>
<td>11.728</td>
<td>16.495</td>
<td>21.951</td>
<td>↑</td>
</tr>
<tr>
<td>Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30 Days</td>
<td>20.062</td>
<td>26.46</td>
<td>34.495</td>
<td>↑</td>
</tr>
<tr>
<td>Follow-Up After ED Visit for Mental Illness: 7 Days</td>
<td>85.591</td>
<td>75.862</td>
<td>70</td>
<td>↑</td>
</tr>
<tr>
<td>Follow-Up After ED Visit for Mental Illness: 30 Days</td>
<td>89.914</td>
<td>83.621</td>
<td>81.212</td>
<td>↑</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness: 7 days</td>
<td>71.97</td>
<td>70.395</td>
<td>68.493</td>
<td>↑</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness: 30 days</td>
<td>86.364</td>
<td>82.237</td>
<td>85.616</td>
<td>↑</td>
</tr>
<tr>
<td>Mental Health Treatment Penetration: 6-17 years</td>
<td>63.117</td>
<td>65.729</td>
<td>67.362</td>
<td>↑</td>
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<tr>
<td>Mental Health Treatment Penetration: 18-64 years</td>
<td>45.44</td>
<td>48.546</td>
<td>50.382</td>
<td>↑</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration: 12-17 years</td>
<td>31.235</td>
<td>29.286</td>
<td>22.973</td>
<td>↑</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration: 18-64 years</td>
<td>23.747</td>
<td>27.157</td>
<td>31.551</td>
<td>↑</td>
</tr>
</tbody>
</table>
### NCACH P4P Results

#### Opioids and SDOH

<table>
<thead>
<tr>
<th>Metric</th>
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<th>CY2019</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Prescribed Chronic Concurrent Opioids and Sedatives</td>
<td>21.545</td>
<td>18.408</td>
<td>14.433</td>
<td>↓</td>
</tr>
<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;50 mg MED</td>
<td>32.967</td>
<td>32.736</td>
<td>32.33</td>
<td>↓</td>
</tr>
<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;90 mg MED</td>
<td>16.187</td>
<td>15.788</td>
<td>14.186</td>
<td>↓</td>
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<tr>
<td>Percent Homeless (Narrow Definition): 0-17 years</td>
<td>0.215</td>
<td>0.242</td>
<td>0.328</td>
<td>↓</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition): 18-64 years</td>
<td>2.762</td>
<td>2.958</td>
<td>3.322</td>
<td>↓</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration (Opioid): 18-64 years</td>
<td>36.964</td>
<td>43.639</td>
<td>53.615</td>
<td>↑</td>
</tr>
</tbody>
</table>

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*↑↓* Indicates direction of desired change for each metric
Depression

January – December 2017

Source: WA All Payer Claims Database

September 1, 2018 – August 31, 2019

Source: WA All Payer Claims Database
Depression & Diabetes (co-occurring)

January – December 2017

September 1, 2018 – August 31, 2019

Source: WA All Payer Claims Database
Population Health LAN

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Discussion
Columbia Basin Family Medicine
What Data Do We Need?

- What do we want to change?
  - Reduce risk of COVID exposure for our patients, staff, and residents.
  - Employees will feel confident about our protocol and ability to keep staff and patients safe.

- Do we have a protocol in place?
  - Prior to COVID, we let providers and staff use their own discretion in letting patients’ family/guests come in with them.
  - No clear guideline on guest protocol with patients in the clinic.
How We Found Our Data

- Brainstorming with our team composed of multiple members coming from different backgrounds (Admitting, Nursing, Provider, MA, etc.).
  - Encouraging participation with open ended questions and taking all ideas equally.
- Keeping a count of all cases where COVID S/Sx or exposures were found in patients that were either not screened or were “negative” at Check-In.
- Input from providers within our facility.
- Anonymous staff surveys to gauge confidence in our current flow. Short and to the point. Takes less than 5 minutes to complete.
  - Rate us from 1 to 10 (10 being highest score).
  - If your rating is less than 7, what can we do to increase your confidence?
  - Do you have any ideas/suggestions for improvement of COVID-19 protocols?
An Ode to Surveys: How they help us track PDSA success

10/19/2020

12/03/2020
Plan

- **Goal:** Decrease COVID infection risk for residents, patients, and staff by controlling flow of patients within the facility. We want to create a net that will catch “leakers” but not those we want to come in.

- **How:** Standardized protocol on how to manage flow of patients with COVID exposure or S/Sx of COVID.

- **Protocol:**
  - Limit family/guests during visits.
  - More thorough epidemic screening at time of Check-In.
  - Offer virtual visits for those that are high-risk or that don’t need to be seen in person.
  - Convert visits with COVID S/Sx or exposure to a virtual visit (if possible).
  - COVID testing will be done in designated areas outdoors.

- **Prediction:** Staff confidence will increase, and we will see little to no “leakers” in the clinic. Exposed (or symptomatic) patient flow will be controlled.
- Patients are only allowed 1 guest with them at their visit. All others will not be allowed in. Minimal exceptions made for families with children.

- Patients with S/Sx or exposure of COVID will have their encounter converted to a virtual visit if possible. If they must be seen physically, extra precautions will be taken. Guests must also be screened at Check-In.

- All COVID testing will be performed outdoors in a designated location in the parking lot.

- A sign will be placed outside the entrance stating that COVID testing appointments must check-in by phone.
- Vet the protocol with all providers.
- Train staff on the new protocol.
- Implement new protocol.
Health Screener to check temperature and offer mask if patient does not have one

- If patient has a temperature, a purple laminated card will be handed to them and they will give that card to the Admitters to alert them of possible S/Sx.
- If anyone accompanying the patient has a fever they will be told that since they have a fever they will need to return to the car and wait for the patient.

Health screener will let patient know to sit on right or left side of lobby (well vs unwell) after Check-In.
CBFM: COVID-19 Protocol

**Admitting:**

- **Appointment Scenarios:**
  - **If Patient Has Purple Card:** Screen for S/Sx while checking them in. Notify clinicians that their patient is symptomatic. Ask if they are to convert to virtual visit or be seen in person. If converted to telephone visit, have patient go back to their car and wait for virtual visit call.
  - **Patient Calling for Appt:** If patient has any S/Sx or exposure, schedule as virtual visit.
  - **Symptomatic/Exposed Patient Checking In:** Convert to virtual visit and have patient go back to their car.
  - **If exposed/symptomatic patient (adult only, children should be seen via telephone/office visit) presents in person or calls and wants a COVID test only:** Create Nurse Visit with “for COVID testing only.” Send email to CBFM group that “Sally Smith will be here at 10:00 for COVID only” or “Sally is in the parking lot for COVID only test.”
  - Remind patient to sit on right or left side of lobby (well vs unwell).
  - When asking screening questions, address the group. “Do any of you have....?”
    - If someone other than the patient screens positive, ask them to return to car (if adult), offer telephone visit.
    - If it is a mom/kid scenario, call the MA/nurse and let them know. “The parent of your 1:30 does have a sore throat.”
  - If patient has more than 1 person with them let them know that due to space constraints only 1 person is allowed to accompany the patient. This does not apply to children under 12, unless parent is comfortable with child being able to care for themselves in the lobby.
MA/Nurses:
- When calling the patient back ask, “I know you’ve already been asked, but do you currently have a cough, fever....?”
  - If patient has bypassed check-in and presents with S/Sx, immediately put on N95 and PPE and alert the provider. The patient is already in the clinic so we will see them in the clinic.
  - If the patient has more than 1 person with them, let them know that only 1 person is allowed in the clinic with the patient. Everyone else will have to wait in the lobby.

Providers:
- If COVID test is warranted after a virtual visit, the patient will be directed to drive to the COVID testing location and call Admitting when they arrive. A CBFM employee will meet them outside for testing.
Send surveys out to gauge staff confidence across affected departments.

- See what works and what doesn’t.
- Did our confidence score go up?

Follow up with providers to confirm that the number of “leakers” has decreased or stopped completely.
At this point, we found that our protocol was satisfactory and we adopted the improvement.

- Providers were happy that there were few/no surprise symptomatic patients coming into the exam rooms.
- Surveys showed that the improvements were successful in boosting staff confidence.
- Tracking sheets showed little/no “leakers.”
And... Back to Plan Again!

- After analyzing our data, we noticed the protocol was interpreted too strictly by staff. Our net had holes that were too small, and we were catching patients that were meant to pass through.

- More education on CDC guideline definitions regarding “exposure” and the time frames to follow were needed.
Questions/Discussion
Moses Lake Community Health Center

Stephanie Dowland
Superior Service

Patient centered communication between patients and frontline staff

“Healthcare with a Heart”
Superior Service

Patient centered communication between patients and frontline staff
MLCHC Service Culture

• **Service Standards**
  • Welcoming
  • Caring
  • Helpful
  • Professional

• **CLEAN-T**
  • Connect
  • Listen
  • Empathize
  • Ask and Anticipate
  • Next Steps
  • Thank you
Rough Timeline

**Problem ID**
- August 2019 Stephanie develops initial “Problem Statement”
- Work to understand the problem

**Plan Development**
- Curriculum development
- COVID pause
- “Restart” plan
- Curriculum re-development

**Actual Training**
- Align with Leadership
- Training and coaching and feedback sessions
- Plan for Spread – Align with Dental and Quincy Leadership
Timeline detail

- **Original purpose of training:** Additional, more intensive training for CCRs to handle challenging calls from patients and diffuse challenging situations.

- **Revised purpose of training:** After analyzing calls and patient experience, we revised to a larger scope, adding focus on improving the quality of routine calls as well. By improving the quality of the CCRs communication in a routine call, we could prevent “escalation” into conflict.

- **Aligning CCR expectations:** We also came to understand that CCRs receive mixed messages from the medical team and from management about their priorities, for example there has been the perception that efficiency or speed is more important than the quality of the interaction. We spent considerable time aligning medical team leadership on what is expected of CCRs, including reexamining metrics used to evaluate their performance.

- **Process Improvement:** Some internal processes – particularly those that put the CCR “in-the-middle” as gatekeeper between the medical team and the patient – also need to be evaluated and revised to achieve “superior service”. CCR training alone won’t do it all.
Curriculum development

- Learned and modeled from CCMI’s MI Training
  - Focused on the recorded phone call as a learning opportunity
  - Embraced the CCR as an equal partner and process expert – cannot be over stated
  - Practice and feedback sessions over time

- 4 hours of content
  - Give CCRs tools and additional skills in service to help them:
    - Build-in a relational way of speaking with the patient alongside the tasks for scheduling, check-in and problem solving.
    - Communicate more flexibly with patients in problem solving situations
    - Respond to challenging interactions with patients and diffuse patient upset

- Practice and feedback sessions
  - Key component to know if behavior actually changes
MLCHC CCR Service Training

Objectives

Give CCRs tools and additional skills in service to help them:
- Build in a relational way of speaking with the patient alongside the tasks of scheduling, check-in, and problem-solving
- Communicate more flexibly with patients in problem-solving situations
- Respond to challenging interactions with patients and diffuse patient upset

Training Agenda

1:00 pm
Welcome and get started

Relational ways of doing routine CCR tasks – and why it’s important
Work on specific ways to make calls and interactions less like a transaction and more like a conversation
- Reinforcement of neuroscience information learned in the Service Event to better understand how our words, tone of voice, and demeanor impact other people
- Practice adding specific language to the patient encounter to make it more conversational

Break

Using Empathy and Validation as tools in problem solving
Reinforce the steps of communication in problem-solving, including how empathy plays an important part
- Review and reinforce how to make an empathetic and non-judgmental response, use open language to avoid power struggles, and validate the patient's concerns
- Practice listening and validation skills and finding ways to express empathy

Break

Responding to patient upset or challenging behavior
Understand the primary tools for diffusing conflict and working with patients who are upset
- Review methods to reduce conflict: empathetic and non-judgmental response, nonverbal messages, when and how to apologize
- Practice by listening to calls and identifying opportunities to use methods for diffusing conflict

Wrapping up: Practice and coaching, how it will work

5:00 pm
Complete
#1: What is this person’s situation or experience?

#2: Can you be accepting of how they see the situation or experience? (Any challenges to seeing the situation as they do?)

#3: What emotion is this person feeling due to this situation or experience?

#4: What could you say to acknowledge this person’s situation and feeling?

---

4 Attributes of EMPATHY

See their world

- See the situation from their perspective

Accept them

- Accept that they see it that way (Stay out of judgement)
- Recognize and identify with the emotion

Communicate

- Communicate that you understand

Understand feeling
Practice and Feedback

• Make the process as transparent as possible
  • Model in the training.
  • Include a list of what practice and feedback sessions are and aren’t

• Give CCR as much control is possible
  • They pick the call and listen to it FIRST
  • They know what the rubic is ahead of time, and complete it themselves

• Start with “easy” content and move to more difficult
Rubrics

• Specific to Easy, Medium and more challenging calls.
Making a routine interaction more like a conversation

One way to make a routine interaction less like a transaction and more like part of relationship is to make it more like a conversation.

S-L-O-W the pace

- Slow down the opening greeting on the phone, think 5 seconds rather than 3 seconds. Switch between 2 or 3 different greetings so that your greeting stays fresh.
- Think about speaking in sentences and put a “vocal period” between your sentences.

What you say in response to what they say

They say: “I need to make an appointment with Dr. Tolley.”
You could say:
“Sure, let’s see what’s available. Who am I speaking with?”

Add conversational phrases to break up the tasks

They say: “I’m feeling sick so I need to see him right away.”
You could say:
“I’m sorry you’re not feeling well. Let’s see how quickly we can get you in.”

Add verbal empathy

They say: “I need help with my appointment.”
You could say:
“Looking at the schedule, unfortunately Dr. Tolley is not in the office today. However, it’s not your first choice but I could see which other providers have openings today so you could be seen right away.”

Close in a personal way

“So, you’ll be seeing Dr. Simon later today at 3 pm. I’m glad we were able to get you in.”

---

**Self-Assessment Worksheet: ASSESS YOURSELF**

Use this rubric to assess how you're doing on making interactions less transactional and more relational. Choose three calls and assess each of them.

<table>
<thead>
<tr>
<th>S-L-O-W the pace</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the pace of your opening. Use an adjective to describe what you sounded like.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast</td>
<td>Medium</td>
<td>Slow</td>
<td></td>
</tr>
<tr>
<td>I sounded</td>
<td>I sounded</td>
<td>I sounded</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What you say is in response to what they say</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you respond verbally to their initial statement?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsive</td>
<td>Not responsive</td>
<td>Responsive</td>
<td>Not responsive</td>
</tr>
<tr>
<td>Examples</td>
<td>Examples</td>
<td>Examples</td>
<td>Examples</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Add conversational phrases to break up the tasks</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count the conversational phrases you used and identify examples</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many?</td>
<td>How many?</td>
<td>How many?</td>
<td></td>
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<tr>
<td>Examples</td>
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<td>Examples</td>
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<table>
<thead>
<tr>
<th>Add verbal empathy</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count the verbal empathy phrases you used and identify examples. Did you capture as many opportunities as possible?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many?</td>
<td>How many?</td>
<td>How many?</td>
<td></td>
</tr>
<tr>
<td>Examples you added</td>
<td>Examples you added</td>
<td>Examples you added</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personalize or make this interaction unique</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify things you said to personalize or make this interaction unique to this person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples you added</td>
<td>Examples you added</td>
<td>Examples you added</td>
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MLCHC CCR Service Training 2020
Potentially Problematic Requests

“Problems” are sometimes started when the patient asks for something that we normally don’t do, or that we aren’t allowed to do by regulation or law, or that would be outside our typical processes.

For example: When the patient asks to speak to their provider
Typically, you would not automatically send this call on to the care team without screening for the reason and trying to solve the problem yourself. But often, this creates frustration for the patient.

They say: “I want to speak to my doctor or the nurse.”

Wait to open the registration/chart. Listen and take notes.

You could say:
“I want to make sure I get you to the right place. Who am I speaking with? And who is your doctor?
The medical team likes for us to ask a few questions before we transfer calls over. Can you tell me a little about what you’re looking for or what you need?”

Let’s get you to the nursing staff; they’ll be the best ones to help you. If I can pull up your chart, I’ll let them know you’re on the line. What’s your date of birth?”

For example: When the patient has a request and you need more Information

They say: “I have a question about my medication. I need to speak to the nurse.”

Wait to open the registration/chart. Listen and take notes.

You could say:
“If it’s okay, let me find out a little more from you so I make sure to get you transferred to the right place.”

Use reflecting back and clarifying questions to prompt more information:
“You have a question about a medication;
“So your question is about whether or not you need to take the medication?”
“So it’s a question about allergies and drug interaction?”
“So you’re wondering how much it will cost with the new pharmacy pricing?”

Choose carefully what to insist upon and when to be flexible

- Think about “ hoop” you’re asking the patient to jump through. For example, if have 2 patient identifiers already, is this the best time to ask for more confirming information?
- How much information do YOU need and how much will the patient have to repeat to another staff member?
- Does our typical process best serve the patient in this situation? What might serve them better?

Problem Solving Situations: ASSESS YOURSELF

Use this worksheet to “debrief” a problem solving interaction for yourself. Assess what worked well in handling it and where you could try something different another time.

<table>
<thead>
<tr>
<th>Listening</th>
<th></th>
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</thead>
</table>
| What is the problem? | Write the problem as presented by the patient. 
Note the time in the call when you fully understood the problem. |
| Questions & Reflecting Back | Clarifying Questions: Reflecting Back: |
| Count the clarifying questions you asked and the instances when you reflected back what you were hearing |

<table>
<thead>
<tr>
<th>Validation</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Acknowledging their experience and emotion</td>
<td>Experience: Emotion:</td>
</tr>
<tr>
<td>Count the instances where you acknowledged the problem from their POV and their emotion</td>
<td></td>
</tr>
<tr>
<td>Is what they wanted reasonable?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Explaining Limitations or Boundaries</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you explain the limitations from your POV?</td>
<td>Note examples of your explanations</td>
</tr>
<tr>
<td>Note examples of your explanations</td>
<td></td>
</tr>
<tr>
<td>How did the patient respond to your explanations?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem Solving with the Patient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you offer as next steps to resolve the problem?</td>
<td>Note examples of the next steps you offered</td>
</tr>
<tr>
<td>How did the patient respond to what you offered?</td>
<td></td>
</tr>
<tr>
<td>Do you feel you came to a solution that satisfied the patient?</td>
<td></td>
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</tbody>
</table>

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Diffusing or Reducing Conflict and Responding to Patient Upset

Sometime this is called “de-escalation”. What is de-escalation?

De-escalation in the health care setting is a tool for responding to a frustrated, upset or angry patient. It refers to the steps one can take to reduce the conflict or emotion in a situation where emotions are running high. The goal is to lessen the conflict and open the possibility for problem-solving.

An important note: Safety First. If a patient’s behavior is threatening or is turning physically aggressive, always prioritize your own and other’s safety over trying steps to de-escalate.

Listen: Be completely attentive and listen. Set aside distractions; turn away from the computer, take notes if necessary to help you track what the patient is telling you. Show you are listening carefully in your body language and facial expression. Reflect back what you’ve heard to show you’re listening.

Be Empathetic and Non-Judgmental: Do your best to understand the person’s point of view and the experience that brought them to this place. Be aware of your own judgments and biases about their actions or circumstances leading up to the problem at hand. Being empathetic when someone’s voice is raised or their language is harsh can be very hard to do. Hear the difference between someone being “upset” and someone being “upset AT YOU”.

Validate the concern or upset: validation is verbally acknowledging the other person’s experience and emotions without judgment or defensive reaction. When someone feels heard and understood it lessens the need for battle and it can calm the “fight or flight” reaction of the brain caused by frustration, anger or defensiveness. Validation is part of demonstrating empathy and respect.

Manage your facial expression and tone of voice: Keep your own facial expression and tone of voice calm, considerate and patient. Speak in an open and confident way. Avoid defensive or aggressive reaction or language.

Defensive behavior on your part could be things like:

- Non-verbal reactions: facial expressions like eye rolling, glaring or angry expressions, body language that shows annoyance like sighing in frustration, turning away, looking at a co-worker with a frustrated expression, shutting down conversation like ignoring or becoming non-responsive to questions.
- Reflecting blame or reacting aggressively: statements that are defensive or aggressive, like “it wasn’t me who caused the problem” or “it wasn’t us, your pharmacy didn’t get the orders right.” or “it could help you if you weren’t being rude.”

Show Flexibility: Use your best judgment to determine if the standard procedure is negotiable or if there is opportunity to be flexible to avoid further frustration and power struggle. Often some flexibility on your part will head off conflict.

Apologize: Offer a non-defensive, sincere apology that relates specifically to the cause of the patient’s upset or frustration. Remember that you are apologizing not just for your own actions but for our organization as a whole.
None of this would have been possible without Susan Smallidge, MLCHC’s external Organizational Development Coach.

susan@smallidge.com
Questions/Discussion
Next meeting: March 1, 2021

VBP Survey Results and WPCC Improvement Data
Presentations from:
Children’s Home Society & Molina Healthcare