Monitoring Team Effectiveness: Measuring with Metrics, Not to Metrics

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Practical Tools for Making Change • November 8-10 • Orlando, FL

Pre-Conference Workshops • November 7

→ **Boot Camp**: Designing Palliative Care Programs in Community Settings
→ **NEW! Payment Accelerator**: Financial Sustainability for Community Palliative Care

**Seminar Keynote Lineup**

Diane E. Meier, MD, FACP
Director, Center to Advance Palliative Care

Edo Banach, JD
President and CEO, National Hospice and Palliative Care Organization

Elisabeth Rosenthal, MD
Author, *An American Sickness* and Editor-In-Chief, Kaiser Health News

Jay D. Bhatt, DO
President, HRET and Senior VP and CMO, American Hospital Association

Christy Dempsey, MSN, MBA, CNOR, CENP, FAAN
Author, *The Antidote to Suffering* and CNO, Press Ganey Associates

Edward Machtinger, MD
Director, Women's HIV Program, University of California, San Francisco

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  – Bringing Comfort to People with Advanced Dementia with Ann Wyatt, CaringKind
    • October 17, 2018 at 1:30pm ET

→ Virtual Office Hours:
  – Metrics that Matter for Hospices Running Palliative Care Services with Lynn Spragens, MBA
    • September 18, 2018 at 4:00pm ET
  – Improving Team Effectiveness with Tom Gualtieri-Reed, MBA and Andy Esch, MD, MBA
    • September 27, 2018 at 3:30pm ET

Register at www.capc.org/providers/webinars-and-virtual-office-hours/
Goals

➔ Demonstrate ways to use transparent, simple data to reduce team stress
➔ Identify core operational metrics that are good proxies for value & support growth
➔ Illustrate why managing bigger teams is easier with data!
3 Important Domains: Our Focus is Operational

- Patient volumes & staffing
- Billing
- Service standards
- Process metrics
- Referrer satisfaction

Operational

How well are we using resources? Are we meeting service standards?

Financial

How effectively are health care services being used?

- Readmissions
- Use of ICU
- Total cost of care
- Patient volume

Quality of care

How are we impacting patient/family experience?

- Patient & family satisfaction
- Pain & symptom impact
- Readmissions
Logic Model: Cause & Effect

What we have most control over!

Resources (Inputs)
- FTEs
- Skills
- Systems

Patient Care
- Team Processes
- Reliability & Timeliness
- Feedback & QI

Outcomes
- Value / Quality
- Value / Cost Savings
- Value / Retention & Sustainability

National Palliative Care Registry™

CAPC Impact Calculator
Why now? [External factors]

- Senior Leaders expect more from more (resource use evaluation)
- Our variation/quirks also impact stakeholders (reducing quality)
- Team performance gaps inhibit our ability to help patients & families
- Retention & team health depend on it
Why now? [Internal factors]

Good News

- Teams are bigger
- More IDT
- Busier
- More settings

Bad News

- Bigger
- > Complexity
- IDT > Complexity
- Busy > Less Communication
- Settings < Informal contact

Demonstrating Effectiveness is Key to Value & Resources to grow…
Observations re Stress

➔ Stress Increases with uncertainty

➔ Uncertainty increases with complexity

➔ Complexity increases with team scope & scale
More FTEs = Chaos

How many potential routes for communication exist for:
• Team of 1 (1)
• Team of 2 (4)
• Team of 4 (16)
• 2 Teams of 4 (64?)
• 2 Teams of 4 & 3 CbPC NPs?

Complexity increases exponentially, not linearly.
Myths of Team Management

→ We are high performing individuals, so in aggregate we will be a high performing team.

→ Informal communication is sufficient in bigger teams.

→ Because we are adults, we will just figure it out (and all have the same answer…mine).
Risks of “Managing to Metrics”

- Focus on measure as the outcome vs. use as a proxy
- ”Gaming” behavior (2 visits vs. 1, preference for simple problems)
- Reducing teamwork

Managing with Metrics =
More teamwork for best outcomes
Efficient vs. Effective

Do More!

Have Impact!

Volume

Silos/Widgets

“Right size” it

Streamline

Use team well
Productivity is a “Dependent” Variable

- Location & travel time
- Patient needs
- MD culture
- Collaborators/roles

New Consult Volume

- Non-billable work
- Teaching (academic)
- Education & Outreach
- Change Process Projects

Counting other “Value Added”? Effectiveness (Impact)

- Staffing mix
- Role clarity and teamwork
- Schedules & Norms
- Systems & Tools

IDT Staffing

- Follow-up Capacity
- Speed to action
- Coverage (weekends?)
- Communication & Handoffs

• Non-billable work
• Teaching (academic)
• Education & Outreach
• Change Process Projects

15
Ex: Importance of Clarity of Purpose

→ If organization values your capacity for NEW patients and timeliness,

Don’t use “visit volume” as an outcome.

[Unless you really want to just count RVUs...]
Steps to Using Your Data and Metrics to Improve Performance

1. What is important to measure?
   - What is the problem you are trying to solve?
   - What is important to your stakeholders?

2. How will you measure your progress?
   - What data do you have?
   - What data do you need?

3. How will you use what you measure?
   - Who will review the data?
   - What will you do with the information?
## Operational Metrics that Improve Team Health

<table>
<thead>
<tr>
<th>Stress Driver or Indicator</th>
<th>Example Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discontinuity, handoffs, uncertainty, and covering for missing staff</td>
<td>How many days this month did the service have the “planned” # of team members? (18 of 20? 10 of 20?)</td>
</tr>
<tr>
<td>Unpredictability of patient flow, capacity, or referrals</td>
<td>F/U visits per new patient, by different patient types, and compared to overall LOS</td>
</tr>
<tr>
<td>Unplanned schedule changes or inconsistent access</td>
<td>No show rates, access times, &amp; appt. templates (<em>outpatient</em>)</td>
</tr>
<tr>
<td>Consistently over per day threshold. Unmatched staffing schedule with rounding schedule</td>
<td>New consult requests by day (and day of week, and time of day)</td>
</tr>
<tr>
<td></td>
<td>Referrals by service</td>
</tr>
</tbody>
</table>
Example: Does **Team Availability** Match Planned Capacity for Patient Flow and Needs?

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>Prov A</th>
<th>Prov B</th>
<th>Prov C</th>
<th>Prov D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FTE Status</strong></td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>8:00 AM</strong></td>
<td>PC</td>
<td>LEAVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>9:00 AM</strong></td>
<td>PC</td>
<td>MTG</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10:00 AM</strong></td>
<td>PC</td>
<td>MTG</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11:00 AM</strong></td>
<td>PC</td>
<td>ADM</td>
<td>MTG</td>
<td>ED</td>
</tr>
<tr>
<td><strong>12:00 PM</strong></td>
<td>PC</td>
<td></td>
<td>MTG</td>
<td>MTG</td>
</tr>
<tr>
<td><strong>1:00 PM</strong></td>
<td>PC</td>
<td>PC</td>
<td>PC</td>
<td>ADM</td>
</tr>
<tr>
<td><strong>2:00 PM</strong></td>
<td>PC</td>
<td>PC</td>
<td>PC</td>
<td>RES</td>
</tr>
<tr>
<td><strong>3:00 PM</strong></td>
<td>PC</td>
<td>PC</td>
<td>PC</td>
<td>LEAVE</td>
</tr>
<tr>
<td><strong>4:00 PM</strong></td>
<td>PC</td>
<td>PC</td>
<td></td>
<td>LEAVE</td>
</tr>
<tr>
<td><strong>5:00 PM</strong></td>
<td>PC</td>
<td></td>
<td></td>
<td>PC TOTALS</td>
</tr>
<tr>
<td><strong>6:00 PM</strong></td>
<td></td>
<td></td>
<td></td>
<td>MTG</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>9 hrs</td>
<td>8 hrs</td>
<td>8 hrs</td>
<td>5 hrs</td>
</tr>
</tbody>
</table>

**Codes:**
- PC: on site /direct patient care
- MTG: meeting
- OC: on call / backup
- ADM: Admin Time
- RES: Research
- LEAVE: All personal leave
- 8 HRS: 8 HRS
- 4 HRS: 4 HRS
- 1 HR: 1 HR

**Center to Advance Palliative Care**
We are budgeted for 2 full teams 5 days a week, including vacation coverage, but over the past month we only had two full teams on 8 days (Tuesdays and Wednesdays).

→ **Self-reported team member stress is highest on Fridays.**

→ **Our response time (from consult request to consult seen) is within our 8 hour target only 60% of the time, but on Wednesdays is at 90%.**

→ **We average 6 new consults per day (7 day week), 8 to 9 per day (5 day week), but on 7 days this month we had >12 new requests.**

→ **We seem to waste time juggling to meet our most urgent needs, and our team huddles focus on a lot of redundant updates to try and manage handoffs…**

**Thoughts on ways to use this data?**

**What else do you need to know?**
Ex: Variation in Practice

➔ We have 2 physicians on service every day (1 per team), but we get there by having 8 different clinicians rotating in.

➔ Our other IDT members have fairly consistent assignment, but complain about inconsistent expectations and processes.

➔ Our MDs complain that the team isn’t very helpful and slows them down.

➔ Our referring clinicians complain that they “don’t know what to expect” and our practice style slows them down, so they hesitate to refer.

Ex: Lost Opportunities

Our CbPC program has 4 NPs doing home visits. We thought they would average 1 new and 4 f/u per day, but we are not achieving that.

- Often our NP arrives, but is delayed by other services that are also in the house, like PT;
- Sometimes the patient is not there – gone to a specialist appointment;
- We have to enter data in 3 different systems -2 E.H.R.s and billing, so it uses a lot of time;
- We have a 1 month wait time for new patient appointments.

Root Causes? Ideas for action? Data needs?
## Example of Weekly Report for TEAM

<table>
<thead>
<tr>
<th>Week:</th>
<th>Current</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Referrals</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Total Consults</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Total add’t visits</td>
<td>65</td>
<td>75</td>
</tr>
<tr>
<td>Direct Patient Care Hours (actual)</td>
<td>100</td>
<td>125</td>
</tr>
<tr>
<td>Hours available svc/(consults +f/u)</td>
<td>1.2</td>
<td>1.25</td>
</tr>
<tr>
<td>Ave census</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>“caps”, “turn backs”, “delays”…</td>
<td>4,5</td>
<td>0</td>
</tr>
<tr>
<td># of consult responses &gt; 8 hours</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

How would you use the data? What do you need next?
Principles that work

➔ Transparency / Engage the team
➔ Use data to re-frame challenges and build buy-in to goals
➔ Small tests of change
➔ Enlist help from experts in the organization
Ideas to get started

➔ Ask the individuals on the team
   – To ID sources of stress and characteristics of “bad” days, and sources of strength with characteristics of good days
   – To offer ideas about tasks that might not add value, or can be simplified,
   – About ways to use different IDT better

[Ideally ask for individual written responses that can be accumulated and blinded by someone else]
Next steps

➔ Share results
➔ Discuss (resist “ready/aim/fire”)
➔ Prioritize a few important things that seem actionable
➔ Have team collect ID baseline data for a small sample
➔ Set a goal
➔ Review data, refine goal
➔ Celebrate successes (and revised hypotheses!)
➔ Move on to another measure
A Common Problem…

Make Data Fun Again…

- Value of therapeutic “closet cleaning” …store or freeze unused data
- Pick a few things to ”wear” and try them on with different accessories (different breakdowns)
- Have a party…brainstorm re-use and re-fresh options – what do you need that is not in the closet? Can you borrow it?
- Can you sew? Try a little manual data collection to test theories.
4 Examples of Chart Styles

**Mean**

- **Average LOS before Referral**
  - Number of Days
    - Jan-15: 4.9
    - Feb-15: 7.2
    - Mar-15: 6.1

**Distribution or Frequency**

- **Distribution of Pre-Palliative Care Referral Days (Patients by LOS)**
  - Number of Patients over 3 mos

**Control Chart**

**Trend of Single Variable (Cost)**
Internal Sources of Data

- Team Observations or Manual Collection
- Internal Financial, Volume and Staffing Reports
- Team Meeting Notes
- Schedules & Change Records
- Call records re "reason codes" & appointment changes
- Electronic Medical Record (Consult requests, date/time stamps, etc.)
- Chart Audits
- Patient and Family Feedback / Staff Feedback
- Quality Improvement Reports
- Health System or Payer Partner “Macro” & Longitudinal data
Examples of Successes

➔ New Standardized Template + Training = more billing revenue and less stress for same volume

➔ More structured team roles & meetings = less time on handoffs & more capacity

➔ Flexibility to substitute call-backs for visits = more/quicker capacity for New Patients

➔ Addition of Nurse Coordinator to manage flow
Examples of “Opportunity”

→ Current reports emphasize “visit” volume

→ Data reported as means and medians, vs. more detailed breakdown/grouping (response time, day of week, type of svc)

→ Lack of clarity about weekly, monthly, and annual goals

→ Invisibility of non-billable work

→ Lack of clarity about service goals when initiating care
Building Goals into Metrics

➔ Use clear **baseline data** to define a gap (“opportunity of not acting”) & set a goal (make an offer for improvement)

➔ Put a **stake in the road** to help direct efforts - (by 2019 we will have 1 NP dedicated to the ICU(s) & impact an additional 20 patients/month)

➔ Define a **“threshold” level** to celebrate (we hit 100 new consults/month)...

➔ Use a **“process reliability”** monitor (85% of our consults are initiated within 24 hours of request)
Examples of Alternative Metrics

➔ Team based volume (vs. individual)

➔ “Net cost per consult” (annual team measure)*

➔ Satisfaction of referring clinicians

➔ Changes in patient mix, location, and timing

➔ Access measures (response time, f/u quality)

*Net cost per consult can fall as team size rises, given mix of team, justifying non-billable staff.
Recommended Approach

- Bite sized data
- Discussion/hypotheses
- Small tests & Refinement
- Improved processes
- Results & "street cred"
Summary

→ Data can help normalize discussions about variation and practice
→ Simple data is powerful
→ Process (discussion, brainstorming) is essential
→ This can be fun
→ It can translate into value/budget priorities

…and we are here to help you!
Questions?

Please type your question into the questions pane on your WebEx control panel.