



From Good Intentions To Automatic Actions

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Speaker 1 0:00

Hello and welcome, everyone. Thank you for participating in today's webinar from good intentions to automatic action. I'm Rick Gutierrez, senior associate for OPEN MINDS, and will be facilitating today's session. A few housekeeping items before we begin: today's webinar is being recorded. The webinar will be available on the One Care Population Health Academy in the next few weeks. Should you have any questions during the webinar, please enter those in the Q and A box button on the on your screen, and we'll address those questions at the end of our session. The webinar is brought to you by the One Care Population Health Academy and Allera Health. One Care Population Health Academy is a premier educational program created for behavioral health executives, managers, and clinicians covering key areas such as population health management, value-based contracting, and elements of integrated systems of care. Members get access to key information from industry experts, tools, and resources to enhance whole-person care for populations with complex needs. Simply sign up at onecareacademy.org and get access to all of these resources and more free of charge. And now I'd like to introduce our presenters. Nancy Jo Sutton McCloyd is a licensed clinical social worker with over 20 years of experience spanning some of the most complex and diverse populations in behavioral health, from crime victims and therapeutic foster children to soldiers, pediatric patients. and individuals in recovery. An Arizona native, she brings a deep commitment to her home state and the communities she serves. In her current role at Allera, Nancy Jo manages quality and operations for two Arizona-based One Care clinically integrated networks. Over the past year and a half, she has become a driving force in practice and network transformation, managing value-based contracts and leveraging data analysis to design and implement strategies that move the needle on HEDIS outcomes across both networks. Trish Smith is a public health and healthcare quality professional with a clinical background, is a licensed practical nurse, and has a master's of public health degree. Her experience spans over 20 years in pediatric care for individuals with intellectual and developmental disabilities, care management, maternal child health, and healthcare quality improvement. She has also worked as an international board-certified lactation consultant, bringing a strong foundation in family-centered care and health education. In her current role at Allera Health, Trish supports pediatric practices in navigating quality, compliance, performance improvement, while keeping the people behind the metrics at the center of their work. She helps practices strengthen.

She helps practices strengthen workflows, use data more effectively, and implement sustainable strategies that support value-based care and improved outcomes. Now, for our learning objectives today, we will identify barriers to sustainable quality improvement, apply strategies to embed quality into everyday workflows, and recognize how culture and collaboration and population need need influence success. And with that, let's turn it over to today's speakers.

Speaker 2 3:02

Thank you, Rick and Liam, and good afternoon, everyone. Thank you for joining us. Also, thank you to OPEN MINDS for hosting today's session. We called our session from good intentions to automatic action because it's about one question every quality leader eventually asks: Why do care gaps stay open even when everyone knows what to do, and what does it take to make closing them simple and part of the routine? So before we get started into strategies, we just wanted to give a quick picture of who we are because it shapes everything that we're going to talk about. Alara Health brings independent integrated behavioral health and primary care providers into clinically integrated networks or CINs. These networks operate under value-based contracts. In practical terms, organizations that would otherwise operate completely on their own in a CIN share accountability for quality utilization and total cost of care. The model that OneCare uses rests on three things: first, clinically integrated networks themselves; second, the technology and analytics, which is a very important part of helping a network achieve its goals, and you can see the care optimization suite is just an itemization of what is included in our technology and analytics. This provides shared network data, care coordination, training resources, all in one place, and then finally accountability. Our agencies are measured together on HEDIS quality of performance. So as we go today, keep that structure in mind: shared data, shared measures, shared incentive. Everything we describe assumes that foundation, and it's also what makes culture change both possible and sometimes challenging. Now let's look at the three networks we'll draw from today. In Southern Arizona, I'm sorry. In North Carolina, the network that Trish oversees is for it's child focused and pediatric. There's three pediatric providers serving about 440 5000 members, having and having only three practices in that network does have some advantages for coordination, but it does make a smaller base to spread the work across. Trish is going to take you inside that network in the second half of our presentation. I support our two Arizona networks in Southern Arizona. We have a network that serves adults with general mental health needs. That's about five agencies and about 6000 members. In Central Arizona, our network serves adults with serious mental illness, which is six agencies and about 29,000 members, so you can see that some of the networks are a bit larger, which leads to its own complications in managing those networks. Each of those agencies is its own organization, with its own leadership, its own culture, and its own priorities. So that matters a lot because the more agencies you work with, the more relationships you need to build, and the longer it takes to change the culture. So as we go, we're gonna talk to you about a range of populations. I know we are focused on pediatrics today, but we'll also talk about adults and adults with serious mental illness. Different populations, but they're all the same challenge. Gaps close when workflow makes the right action easy. So that's our focus for today. As we go on in this presentation, just keep in mind for yourself what transfers across settings and what has to be adapted for my own situation. All right. Let's start with a premise that I think is familiar for most. Nearly every organization I've worked with already knows what good care looks like. Clinicians know which screening their patients need. Leadership knows the HEDIS measures. The problem isn't really knowledge. The problem is consistency. Getting it to happen with every provider at every location on every shift, even on a busy day where there's short staff or people are running behind, that's that's where the issues arise. So most organizations start out reactive, chasing gaps after they show up in a report.

The and it's really important to shift from reactive to proactive, catching the gap. We want to do it before the visit or during the visit, so that the end goal is automatic. And we're just illustrating that journey on this slide. So first is the good intention. We should close this gap, and good intentions do matter, but they depend on effort and memory and individual motivation. Anything that depends on someone remembering will eventually be forgotten. So it's important to take that good intention and develop it into a reliable system.

Speaker 2 8:15

This is how we identify the workflow, who owns it, and what happens next. The gap needs to be visible. The workflow needs to be designed, and someone specific has to own the step. Most organizations are working somewhere between these first two circles on the journey, and that's okay. That's that's really where most organizations tend to fall into when things get really busy or really complicated. But what we would like to show you how to do is change that thinking into an automatic action. It's simply how we do things at this clinic, right? Quality is so built into the routine. There's no reminder needed. So if you remember one thing, remember if quality depends on someone remembering one more thing during a busy clinic day, the system is too fragile. Our goal today is to show you how to build systems that aren't. So, how do you actually get from good intention to automatic action? So, across our networks, we've seen the move from good intention to automatic action happen in in these six steps. This is the roadmap for the rest of our presentation. The step one is to know why the staff understand what the measure is, but do they know what it's actually trying to accomplish? What is the foundation, and why are we doing this? is very important, but often skipped when we're talking about developing workflows, especially for the line level staff who have a big influence on actually getting that gap closed. If people don't connect to the why, they'll work around whatever system you build to do the workflow they believe is. Serving best, so that would be step step one. Step two is to make sure that it is visible. So, what is it that we need to achieve? It needs to show up where the work happens, either before or during the visit, and not in a report after the patient has long left the office, and maybe they aren't accessible anymore. Step three: the right action has to become the the path of least resistance. We need to make sure it's easy. And then, of course, we need to define roles. Specific people need to be accountable for specific actions, not this team is accountable for closing this gap. When everyone owns something, no one does. So it's very important to define those roles, and then we need to make it stick. So success needs to be affirmed, loud, and proud. So people want to repeat it. Definitely, positive reinforcement works. It works in therapy. It works in parenting, and it works with staff too. And then step six: shift that culture. It's repeated and it's celebrated with success, and it's passionate because they know the why. And then it turns into simply this is how we do things. So, two things to remember about this work, this path, is for first each step builds on the one before it, and then this isn't a one-time thing. So any time an outcome is not what you expect, got to go back to step one and see. Okay, where is the lack? Do they not understand why it's important? Are they not seeing it happen? Is it hard to do? Who's in charge? And you need to go through all the steps again to make sure that the structure is in place to make the staff successful. So we're going to look at what those steps look like in practice. So we're going to go through each each step along the way in a little more detail, and we're going to start with the why. So step one is the why, and here's something that I've learned: is staff rarely resist quality. Quality is important. Everybody likes to do a good job, but what they resist is unexplained requirements. If they don't know what's important, then why are we doing it? So we need to close this gap. For a contract is not a motivator. It just feels like a lot of extra work, but here's what this gap means for this person who's standing in front of you: gives you passion and it feels like a purpose. So staff need to make these connections. Why it matters to the patient, not just it's on the report

and they need to check that box. Although sometimes as a motivator for some people, and then how that specific role affects the outcome.

Speaker 2 12:43

So their role in closing that gap. What is that going to do for the person who's who's sitting in front of them, whether they're at the front desk, an MA, a clinician, or a care manager, and why it's more important than just a payer requirement or a bottom line. So, I have a great example, and it's very connected with the pediatric population because HPV vaccinations are very important to get done. But because HPV vaccinations didn't exist until a certain time, there's a large population of adults who'd never got that, so cervical cancer screen is super important, especially since HPV is so rampant in the population that was not able to benefit from that vaccine. So, in our network serving adults with serious mental illness, that is a measure that we are trying to achieve, and when we started in our Central Arizona network, many of the behavioral health staff didn't see a role for themselves in that measure. Some even felt, and it's not my job, or ew, I don't want to talk about that with with a member. So they just didn't bring it up at all. So we had to start with the why, because people living with SMI face real barriers to routine preventative care, and cervical cancer, if caught early, is very treatable. But if it's not caught, it can lead to death. So we made the role connection for the behavioral health staff, knowing that behavioral health staff know the members better than anyone else usually, and for members with a trauma history, a gynecological exam can feel really frightening. And behavioral health is the best equipped to help someone work through that fear. So once the behavioral health team knew the why, oh, this is a very important health concern that can be deadly to our members, and then they felt that role connection of oh this is how I play into this gap closure hesitation turned into ownership and they felt like it was very important for them so it's just remember it's just important to remember that that people are also motivated differently so the why is very important. But also, it's up to leadership to understand what are the different motivations in a professional workplace. You know, patient impact. A lot of people, especially if you're in the behavioral health field, very motivated about helping people get better or helping people perform better. Professional pride. A lot of people in performance, they have professional pride in themselves or in their organization. Healthy competition is also another way to motivate and seems to be very effective in, especially in clinically integrated networks and some leadership in the clinic level, like clinical director level, financial sustainability is very motivating for them. They want to keep their staff employed. They want to keep serving members, and they want to be able to hire more. So it's really important to understand the motivations and help each person understand the why based on how they're motivated. So once the staff understands the why. The next question is whether they can see it when the action is needed. Some sometimes the gap isn't where you think it is. We're going to actually give you an example from the Central Arizona Network of an agency who was working on controlling blood pressure as a measure for the seriously mentally ill population, and this is where you have to look at the workflow, not just put out a process and say please follow this, but come in and see how does that workflow fit into this clinic. So the belief that we started out with was our process works. This agency was working on controlling high blood pressure, leadership did a really great job. They built automated capture of the CPT two code so they can close that gap in the provider notes. It was very smart. It was a great way to make it not reliant on a person. Like I said in the beginning, if it's reliant on a person's memory, then it's a weak system, a fragile system. So they did a really good job. So I go in to watch the workflow, and sat with the the head nurse, and I just asked a simple question: just walk me flow through the flow, show me how this works.

Speaker 2 17:14

And as she showed me how it worked, we couldn't find that CPT two code anywhere in the note, so we looked into it further and realized that the gap we thought was being addressed was not. The providers weren't the ones recording the blood pressure, so having it automated from their note didn't catch the CPT to code. It was the MAs and the nurses, and we need it automated from their note to catch that code. So once it was brought to the attention of the agency, they said no problem. They fixed it, and actually the result was in that year they exceeded far exceeded their controlling blood pressure target, keeping their population healthy, and of course meeting that he does measure, so it's not. It wasn't the why. It wasn't the motivation. It was, is what we said we're doing actually happening. So you found the workflow where the workflow breaks by observing it in real time. The next step is redesigning it so the right action happens even when no one's thinking about it. Just like I said, that CPT two code capture was automated. We needed to make sure it was working. We caught the break, and then we adjusted accordingly, and it was being automatically captured. But there are other items besides catching billing codes that are just as important to the system, and that would be step three, making the action easy. So you can see when a gap stays open, our first instinct is usually more training, and training does matter. But often we train people well, send them back to the same thing, and expect a different result, and that is not going to help that culture change progress. So the question at this top of the slide is: Did we train staff? Did we? What happens when no one's remembering? Did we train the staff on this? So if you look at the left, when quality depends on memory, every everyone's on a tightrope. Walk across the care gap. Busy day means a misgap. There's staff turnover, which resets the process. Maybe they're not well trained. Results depend on who's working that day, and doing it right feels like an extra effort. So if we have a system that carries the memory instead of the person, the system will help the gap be flagged before the visit. A prompt appears in the workflow at the right moment automatically, and the same process every shift, no matter who's working, no matter the turnover, and the right thing's the easiest. So training helps keep one person on that that balanced bridge, but the system gets. Everyone across that bridge. So just think about your own organization, and you can probably identify at least one step in your quality process that still depends on someone remembering, and that would be probably your most fragile point in your workflow. And so it's probably where your gaps are the widest. One part of making action easy that is often overlooked is what staff actually say in the room, which is another tool that's important to give staff. We're telling staff address the care gap. Here's your training, but it's really important to also show exactly how to bring it up. Expectations tell staff what to do. Talk tracks actually tell them how to say it. So when a topic feels sensitive, staff avoid it. Just like I said in my example earlier, behavioral health staff was like, "Ew, I don't want to talk about that. I don't know anything about it." And it's not because they don't care; it's because they don't have the words. And silence feels a lot safer than saying the wrong thing or the uncomfortable thing. So the lack of knowledge means lack of confidence, and if we're looking at the example that I discussed earlier, we did the network did develop some talk tracks and also an FAQ sheet. So if a patient asked a question and they felt prepared to answer, it led to a lot of confidence and ability to relay that confidence to the member, saying this is important, and I really feel passionately about that. Help the members say, "Okay, maybe it's important. Maybe I need to do this." Same goes for the pediatric population because talking to parents about getting an HPV vaccination. Most of us think about HPV. We think about sex, and parents are like, my 12-year-old is not having sex.

Speaker 2 21:45

Don't bother me with that. So having the staff have a framework to work from that doesn't approach it in that way, but instead addresses it as a health concern that the parents need to be open, open-minded about, and think about, help the staff feel better at addressing it with parents. So the line at the bottom says, "Training improves knowledge. Standardized language changes behavior." I would also like to say that standardized language also gives confidence, and giving confidence really helps people who are interacting with staff feel able to make good decisions and feel like the staff are doing their best interest in mind. So we've designed the system. We've given the staff the words, but the system alone doesn't change the culture. Only the people do. So we have steps with the workflow. We've defined roles. We're making it stick, and now we're talking about the social side. So the four steps listed on the bottom show what we've already gone through: systems that create the conditions for change, but culture shifts when people move it. So that starts at step one with why. That culture shift starts with the passion behind or a reason behind what we're doing, and the person who usually moves the culture in a systemic way or a clinic-wide way is rarely who you would expect it to be. It's not always the director or the compliance officer. It'd be great if we could just say change your culture and it would happen, but it doesn't happen that way. So often, it's the person who colleagues watch, and they watch them, and they're like, "How are they acting about this change? Are they accepting it, or are they not?" So finding that person takes development of relationships. It's really important to know an agency well enough to see who is invested, or even who's a skeptic? Because if you can win over a skeptic, that's even more powerful. Someone who's like, I don't know, I don't think this is great, but then you help them see the light, so to speak. Very powerful in shifting the culture in an agency. So this is great. We're looking at people, but we also need to remember that we find that skeptic or we find that champion. We need also the other people listed on the box on the right. We need the formal leaders because they're the ones that make the policy and procedure changes and the decisions. We need the informal leaders, which includes those champions, but everyone else who people admire and look up to and will follow, and then those early adopters who prove it works. If they can see it work somewhere else, it's really easy to adopt that into a clinic that hadn't tried it yet. So, how to do how to get that early adopter and that champion into a bigger culture change is definitely addressed when a team moves a number or something is achieved in a way that was impressive and what you want to see. Name them specifically, publicly. Do that recognition. That little competition, and maybe there's just some pizza party or a little goofy dollar store trophy that the clinic gets to hold on to. It's just finding those ways to recognize that they're true champions is going to go a long way in changing the culture. But just always remember, because I keep saying it's not dependent on the person. If it's dependent on the person, it's not going to work. So just remember, champions do create the belief. Workflow design is what makes it survive turnover. So champions eventually move on, but the system that they built is going to make sure it stays. So that's what culture looks like inside of an agency, but our network is made up of many agencies. All three of our networks are made up of many agencies, and some of them are in competition with each other. So how do we do this with a clinically integrated network? Culture change is a bit slower because there's a bit more people to deal with, but we want to move from competition to co-opetition, and address the tension that anyone working in a network will recognize. Agencies and a CIN share accountability for quality, but they also compete for the same. Sometimes for the same referrals, the same staff, and sometimes the same clients.

Speaker 2 26:20

So pretending that tension doesn't exist actually guarantees that the work could be undermined. So it's really important that you address the tension is real. Use it is what the slide says, and it's important to

address that tension. So you can look at what makes co-opetition hard to achieve. On the left, we're asking competitors to share what works. Sometimes that can feel like you're sharing your secret sauce, right? And that feels uncomfortable. But in a network where everyone's held accountable for quality outcomes, it's really important to share what works so that everybody does well. Sometimes board priorities may not match the culture that is built on the ground of the agency, so that's sometimes hard to overcome. And then, with leadership change, a new director or a new CEO, a lot of times the trust can reset with that. And then, the bigger the network, I've mentioned this before, the bigger the network, the more difficulty it may be to change that culture because there's just a lot more relationships and trust to build, and a lot more groundwork that goes into to that culture change. So let's look at what actually makes it work. First of all, the tension is real. Use it. Name that tension directly and say it out loud. You compete in the marketplace. You share a quality target. None of you can reach alone. Both are true. So let's work with that, and then you start there. That honesty opens more doors than anything else, and it builds that trust that maybe not automatically given. Also, making success visible at the network level is just as important as at the agency level. So when an agency tries something that works, celebrating it public publicly, showing that success to the rest of the network, even sharing the tools that they've developed, and say, "Hey, everybody, look at this great tool that this agency was able to develop. I think we should all use it." And then along the same veins, being the partner who shows up. So when there is an agency that's struggling with a measure, but this agency is very, very successful, it'd be great for that successful agency to say, "Hey, let's talk, and we can see what I am doing that might help your agency." And then finally, building trust with data. If everyone sees how everyone's doing and have that transparency, then and it's open and there's no judgment involved in it. It's just open knowledge that's very helpful in building trust. So that instead of saying, "Well, I'm not sure so and so is pulling their weight," you can say, "Okay, that clinic's struggling. What can we all do to help that clinic do better?" So the line at the bottom is the one I want to leave you with before I hand off to Trish, which is change is never overnight. It's gradual, relational, and it compounds. So the trust you build this quarter makes next quarter's conversation easier. So everything I share comes from adult behavioral health networks, and Trish is now going to show you these same principles and how they play out with when the patient's a child and the whole family is part of the care. So Trish,

Speaker 3 29:39

all right. So we talked about how to move from good intention to automatic action, and how important it is to build quality into your everyday workflows rather than relying on people to remember one more thing. So let's talk about some of those same principles and what they look like when we're working with pediatrics. So the framework is the same, but the challenges can look pretty different. So to give you some. Context: One of the networks that Allera supports is the Pediatric Primary Care Clinically Integrated Network in North Carolina, and the network includes three participating practices serving approximately 48,000 attributed children and adolescents across 20 different counties in North Carolina. So these are all independent practices that work together under a shared approach to quality and improvement and value-based care, and because they're part of the same network, they have shared accountability. But that doesn't mean that they all operate in the same way. So they have different staffing structures, they have different resources, they have different patient populations, and sometimes they have extremely different ways of accomplishing the exact same task. So one of our challenges is figuring out how to create consistency across the network without expecting every single practice and clinic location to operate identically. That is not real world situations. So we want to standardize the things that matter for quality, while still allowing practices to adapt their workflows to their environment and what

works best for them. So when we're doing that in pediatrics, we have another layer of complexity to consider, and that is the fact that the child is often, most often, not the person making the actual decision about accessing care, and that's what we're going to talk about in the next slide. So in pediatrics, it's easy to focus on the individual child who has a care gap, but there's actually an entire system surrounding that child that really influences whether that gap actually gets closed. So let's look at think about something as straightforward as a well child visit, right? So the the practice identifies that the child needs their visit or that they're already overdue, but scheduling the appointment may actually depend on reaching the caregiver, finding a time that works with the caregiver's schedule, arranging transportation. Sometimes you have to coordinate around school for the patient and work for the caregiver. So that's all enough on its own, and that's assuming that the family even knows that that visit is needed. So then, if you toss in some behavioral health needs, you got referral to specialists. You have school-based services. There's other social needs, and everything becomes even more complicated. So a provider might make a referral, but that doesn't necessarily mean that the family was even able to connect with the specialist. So right there is an open loop. So sometimes the services actually have happened, but the information haven't made its way back to the primary care practice from the specialist. So it's it's important to remember that open care gaps don't always mean that the care itself has never occurred. Sometimes it means that the information has not been caught up, and that's a really important distinction. And it also means that simply telling a practice, "Hey, you need to close your care gaps," is is not a very helpful thing to tell them. So we have to understand what's preventing that gap from closing, and whether the barrier is something that the practice can address on its own, or if the barrier requires coordination with one of these other spokes in this massive wheel. So that is why designing pediatric workflows has to include the family and the systems around the child, not just the actual clinical encounter. So that is going to bring us to how we use data to identify those opportunities. So one thing we learned is that giving staff more data does not automatically translate into better performance, right? We can make reports. We can show them every single open care gap, every quality measure, and every member who needs something, and that's great. But if the reports don't tell the staff actually doing the work what they need to do next, then we're really just giving them a list and expecting them to manage it. So for already busy practice staff, that that's not a great way to go about things.

Speaker 3 34:07

So we actually try to take that information and make it something that's actionable. So first, we have to identify the right population, right? Who actually has that care gap? Is the information current? Has the service actually already been completed, but it's not reflected. Is the data coming from the payers or from the EHR? So we have to understand exactly what is preventing these gap closures. Right? Are they just overdue? Was it never done? Can we not get a hold of the family? That in itself can be its own barrier. Maybe the the front desk needs to simply schedule the appointment, but maybe the clinical team needs to check on documentation, or maybe somebody needs to help connect the parent with some transportation resources. So they're they're really different interventions that can all apply to the exact same care gap. And so, even though a report can identify three patients as having the same care gap, they could all have vastly different reasons about why their care gap is still there in the first place. So, if you're looking at 1000s of attributed members, you you can't necessarily address every care gap that everyone has all at once, right? So, we take performance data to identify the opportunities that are most actionable and build targeted workflows around those opportunities. A lot of you have heard the phrase to go after the low-hanging fruit, and sometimes the staff doesn't need the entire orchard; they just need you to point out where the low-hanging fruit is to guide them on how to get there. So just important, just as importantly, we

have to close that loop. So if someone makes an outreach attempt or completes that referral or resolves the gap, then we also have to make sure that that information is documented and it's accessible to the appropriate team. So otherwise, that process just starts all over again because the right person cannot see that that care gap has been closed. So let's look a little bit at pediatric workflow success. So it brings us back to the three concepts that we started with: good intentions, reliable systems, and automatic action. So, and I think this is especially relevant in healthcare because most of the time people really do try to do the right thing, right? The problem isn't necessarily that there's a lack of knowledge or that there's a lack of motivation, but often it's that that process depends on too many individual decisions or people remembering the right thing at exactly the right time. So let's use preventive care as an example, and we will go through with good intentions. Everybody understands that well-child visits, immunizations, that those are important. Providers want their patients to receive the recommended care. Staff want to help the families get it. Care managers want to make sure that nobody gets slipped through the cracks, but understanding the importance doesn't necessarily mean it's going to happen consistently. So that's where we need that reliable system. So instead of waiting until a quality report tells us that a kid has already missed the opportunity, we start looking and at where can we build the actions into an existing workflow? So that might be something as simple as identifying overdue services during a pre-visit planning, or maybe having a consistent process for reviewing gaps when the member checks in, or maybe establishing a clear handoff to care management when a family needs additional assistance. So the important part is we're not creating entirely separate quality improvement processes that staff have to remember to perform in addition to their everyday clinical tasks. We are taking these activities and incorporating them into the work that's already happening, and so automatic action is what we're working towards. So that's identifying and addressing a care gap as a straight-up normal part of the visit, rather than something that's additional for staff to do. So it doesn't mean that the process runs automatically with no people, or that you know exceptions don't happen. But it does mean that the system consistently prompts the appropriate action, regardless of who's working that day. And for us, you know, success isn't just seeing a quality measure improve and seeing numbers look good. It's about being able to explain what changed in this workflow to produce that improvement and is it sustainable, right?

Speaker 3 38:44

So working through this with our pediatric practices has definitely reinforced a few important lessons, and so we will talk about some of those lessons that we have learned through the pediatric network in the next slide. So there's three things I would really emphasize from our experience working with pediatric networks, and the first is that the information has to be close to the action. The more steps there are in between identifying a problem and actually doing something about it, means that there's more opportunities for the problem to go unresolved. If someone has to leave their normal workflow, open another report, look up a patient, figure out what has to happen, then go talk to somebody else. That's a lot of opportunities that we're creating for it to fall through the cracks. So, whenever possible, we want the information to be available when and where someone can actually use it. So the second lesson we've learned is that the workflows have to work for families, not just staff, and not just one individual child. So what we can design can look like an absolute perfect process, but if the family can't realistically navigate it, then it's not going to be a. So, for example, if we're repeatedly calling a caregiver around 2 o'clock in the afternoon, we might technically be meeting an outreach expectation of reaching out to that member. But what if they're working and they're not able to answer the phone during that time of the day? So, making more phone calls is not going to solve that problem. So, we have to be willing to look at barriers from the family's perspective as well. And the third is that practice ownership matters. All of our

independent organizations make up a sin, but they all have their very own leadership workflows and priorities, right? So we don't want to come in and say this is how you're going to run. It's our job to help them understand their performance and find those opportunities and develop solutions that work within their specific environment. So this means that you actually have to listen to the people doing the work, the people receiving the care, the people using the resources, and figure out what else has been successful, and if you can't figure that out within your own practice, that is where the entire network comes in, where we can look at when is something being effective for a different practice, and in what way can we modify that. So the relationships between all of the different practices, as well as Alera as the manager, are what is allowing us to move beyond just checking performance and reporting it to actually improving the processes that influence that. So that leads to what I think is one of the most important messages from this entire presentation: the goal is not more work. When we talk about quality quality improvement, there's a tendency to immediately think about, okay, well, what else do we need to do? What else did staff need to do? There's another checklist. We got to find another report. We got to set another reminder. Do another training. But that's actually not what we're trying to accomplish, right? The goal is not to add more work; is to make the work that is already being done more effective and more reliable. So there's three places to start. With that, the first place is observe the actual workflow, not the policy, because the policy says what leadership wants to happen and what leadership thinks is happening. But what actually happens when the patient walks through the door is what you need to know. So where are the handoffs? Where are people duplicating efforts, doing the same thing, and where does that process rely on somebody to remember something? Because that, as Nancy Joe pointed out, is our more fragile point in your process. Second, we want to replace the memories with a system. It could be a prompt in the EHR or something built into a standardized process, but it's got to be a clearly assigned responsibility in typically an existing workflow. So it doesn't always necessarily mean that there's a new technology or that there has to be this massive change.

Speaker 3 42:51

It sometimes could be a very very small adjustment, like Nancy Joe brought up, with making sure that the CPT codes were being captured from the right notes and making sure that everything was set up, and then third, support the people that are going to be your champions and going to make that change stick. So once you find that staff, get some credibility with their peers, and then they're willing to listen to you and help improve the process, and that gives the entire team the resources that they need to make sure that the changes we are working on are going to be sustainable, and that's really the the point of moving from good intentions to automatic actions. We're not trying to get people to work harder at quality. We're trying to redesign systems that make doing the right thing easier and more consistent for all staff members. So three takeaways. We wanna we wanna send you guys with three things that you can apply with what you have, no matter where you're at next week. Right? You don't have to completely redesign your entire organization to start improving your quality of performance. There's there's things you guys can very easily do. So one place to begin is to pick a measure, pick a care gap that's been difficult to improve, and start thinking about what is exactly going on in this workflow. Talk to the people who are responsible for it every day, the frontline staff that could do it in their sleep. Figure out what exactly is it that they can do in their sleep, and is it the same as what is written on that policy? Find out what gets in their way. Clinical staff is absolutely excellent at creating workarounds because stuff has to get done. So when you are there, you can actually watch the process and speak with the staff and find out what makes this a pain in your eyes, and what are you doing about it? Because that workaround is either going to be a problem or can become a permanent solution. You just have to figure out which one. So the other thing is

that you have to keep in mind that the relationships with these. Frontline staff members are really what drives these improvements. Having the right tools and training and data, you know, are very important. But it's also very important to have people who trust each other to, you know, feel comfortable enough to identify problems and share pain points, share ideas, and people be willing to try something different, and that is what helps the improvements become part of the actual culture instead of just something new that staff is going to roll their eyes at and think now I have to do even more. So we want you guys to make sure that you can take these steps and think about how you can build them into your existing infrastructure and workflows. I just want to share that we appreciate the opportunity to share some things that Nancy, Joe, and I have learned working with our networks. And we know you guys all have different challenges. And we'd love to hear if you guys have any questions or experiences with making quality improvement more sustainable, and we are happy to continue the conversation after today's session. If you need, our contact info is on the screen.

Speaker 2 46:14

Trish, I think there's some questions about the pediatric practices having different EHRs, and maybe some examples of engaging specialists to help with quality metrics, like that system of care you were talking about.

Speaker 3 46:28

Yes. So yes, in in the network of the three practices, two out of the three practices use one EHR, and the third one uses a completely different EHR. And that in itself is definitely something that has to be navigated, but we've learned that once we sit down to really figure out what is the staff actually seeing on their screen, because you can tell me something's going on in an EHR, but there's so many different EHRs that that could mean so many different things. So that's part of why we find it extremely helpful to actually go to where the work is being done to observe the workflow. Like Nancy Joe said, we can see on paper that CPT two codes are being automatically captured, but it wasn't until seeing it in person and going through that workflow that Nancy Joe was able to realize, oh, it is set up. It's just not set up in the right place. So, as much as I want to say having different EHRs is problem some, I actually think it leads to some more creative opportunities and and solutions that we can find, and then go how can we make this work with the other EHRs?

Speaker 1 47:36

Right. Well, thank you, Nancy, Joe, and Trish. This has been really an interesting and informative presentation today. Just a reminder to our audience: please use the Q and A to submit any questions you might have. And I think we have a few more questions here. Can you please give some examples of how you engage pediatric specialists to help with quality metrics?

Speaker 3 47:56

Yeah. So this is a really good one where the data comes into play in a big big way. Not a lot of people are going to look at the data in a systemic way. As far as across the entire network, what kind of prescriptions are our specialists giving? What kind of follow up care are they offering? How often are these people

seeing these specialists? So Alara's advantage is that we get to look at that that data on the back end, and we're able to go through and find, oh, this this particular prescription is costing a lot of money. Well, who's who's prescribing it? Is it within the clinics or is it outside among specialties? So that's something that is a constant thing that we work on with the pediatric network is is identifying things that may appear to be completely out of the network's reach, but in fact can be addressed by building the relationship with the specialists and speaking with them on, hey, are you guys aware that this is be this is happening this way? And over here, they do it a little differently. Maybe that's something we could talk about. So I think it really goes back to that relationship building of being able to use your data, find out exactly what you're going to do with it, and then build a relationship around all of the people that have anything to do with closing that gap or, or you know, improving that that quality metric.

Speaker 1 49:21

Okay. Follow up question: Are you able to share some of the performance on specific metrics that you've achieved in the pediatric sin?

Speaker 3 49:28

Absolutely. So my absolute favorite story in the whole wide world is one of one of our pediatric practices decided they were really going to tackle the culture change around the HPV vaccine, and so not only did they create the the visual reminders for the clinic staff for the providers, they were able to align all of their providers on how they were going to bring up the HPV vaccine. Not only that, they decided they were going to. It up even earlier in their in in the age range, and they were going to bring it up at age 10 instead of the standard age 12, and that allowed them more time to work with the parents and to approach it as, hey, this is routine cancer prevention. Your child is 10 years old. Most people are not going to immediately jump to this is an STI. This is something sexually transmitted. So, being that they were able to work into their workflow these amazing, you know, visual prompts and assign every single step to specific staff members, they the care management team knew exactly how they were going to follow up after these these appointments, and after doing this for about two years, this particular practice is now able to pass the statewide the the state set goal for the IMA measure with HPV vaccines by the end of quarter one, and the reason they were able to do that is because their entire culture shifted and offered something earlier and gave them the space and the time and the knowledge on how to move that well before that they were being expected to move it. Which is, if you're familiar with HEDIS, is during the year in which the child turns 13, so they set themselves up in a way that did not rely on any anyone's memory and gave them a little bit of buffer in the timing. And so now, when they hit January one, they have an entire cohort of of kiddos who are already complete with their vaccinations, and and they have been knocking it out of the park with the with that specific measure, and it's now just become the way they do things. They don't feel like they're doing anything special anymore because it's become their culture.

Speaker 1 51:59

Very good. Another question here: In your opinion, what percentage of clinician-facing workflow prompts should be integrated into the EHR?

Speaker 3 52:08

Yeah, so that's a tough one because from the back end, I feel like we often go, "Well, let's just prompt them a reminder." But what we've heard feedback from from our agencies and our practices is that there such thing exists as as alert fatigue. When you start seeing things constantly popping up from the EHR, you start ignoring them. You stop. You you stop seeing all of the different things because they're always there, right? A reminder that's in your face all the time isn't really a reminder. It's just noise, right? So we actually limit a lot of specific prompts directly in the EHR and work to build it into the workflow in other ways that will become second nature to the the clinical facing. I do

Speaker 2 52:58

have I do have to say that there are agencies in the Arizona SINS that use not just alerts because alerts are easily overlooked, but just a graphic, just a little heart picture next to the patient's picture that reminds them that they need to pay attention to their blood pressure. Maybe a little stork for the pregnancy measure. So sometimes choosing just something alternative besides an alert saying you know check blood pressure is is really helpful as well.

Speaker 3 53:29

Yep, spot on, Nancy Joe. the The practice that I'm referring to with the HPV vaccines has a purple folder. Anytime a rooming sheet goes in a purple folder, they don't have to have any words or any alerts. The clinicians automatically know when they see a purple folder. That means there's a quality metric that needs to be addressed, and they open it up. And oh, look, there's the stamp that says which metric needs to be addressed. So it's it's creating defaults that that simply become just the way things are done, not necessarily making sure that all these alerts are in the clinician spaces.

Speaker 1 54:03

Okay. Does your pediatric sin submit supplemental data to the payers? Is it standard supplemental data directly from the EHRs or some other approach?

Speaker 3 54:14

So we do not use direct EHR connectivity. That is something that our network at this time has decided that it is not advantageous for them to do. It is being pushed very hard by the payers, and so we actually stick with file transfers via, you know, safety, the SFTP sites that are used, you know, to make sure that we're safely transmitting that information. But we do go ahead and and comply with, you know, med record requests and and audits for charts and things like that. But we do not have current direct connectivity from the payers into the EHRs.

Speaker 1 54:58

Maybe one more question. How do you get the front line staff to change their work behavior when you're not in their direct line of management supervision and you don't do the work alongside them every day?

Speaker 2 55:10

That's a great question. If you don't mind me jumping on this one, Trish. So that's a lot based on the relationship development that we've been talking throughout this whole program, the the reality of this work as you know population health management company helping the UCINs achieve these goals is that we don't have authority, but we do have relationships and we build trust, and we work from the why as well? So if you start with the why and make it personal, and you develop the relationships with both the formal and the informal leaders, that's how you get the rest of the staff to follow. Also celebrating successes, but what I do have to say is that if we're not open to input from these organizations, they're not going to trust and follow. And so, as much as we would like them to take our input, we really, really like to have input from the organization, so that give and take creates a relationship that builds trust and security, so that when Alara is making a recommendation to improve a practice, it comes with some, you know, expectation that it'll probably work. And if it doesn't, we're going to adjust to make sure it works because our goal is the same as the organization's.

Speaker 3 56:41

Yeah, I also think you you hit it spot on, Nancy Joe. That that we we highly highly value the staff's feedback and input. We do not march around saying this is what you shall do. We show up and we say now you teach us what what do you do, where does it go wrong, and what do you want easier? Because it's literally our job is to try to make their jobs easier, not to show up and boss them around and tell them what to do. So I think it's it's much more about creating that that trusting relationship than having any sort of you know supervisory sort of appearance or you know take on things.

Speaker 1 57:24

Well, that about wraps it up for today. Like to once again thank our speakers Trish and Nancy Joe for this wonderful presentation. I'd also like to thank our audience for attending and listening in. This presentation and recording will be available in the next few weeks on the One Care Population Health Academy. So make sure to enroll and not miss out on this exclusive resource, and don't forget to register for the OPEN MINDS Technology and Analytics Institute in Philadelphia on October 27 through the 29th. Please visit technology.openminds.com to register. And thank you, everyone. Have a great day.

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