Denise Tahara
Video Transcript

Intro by Melissa Frascella:
It is my absolute honor and pleasure to be able to introduce a woman who has had such an impact on my life, on my career—Denise Tahara.

She tells us that context matters.

She also works with organizations on performance improvement, integrative care, pediatric obesity and food insecurity. And, she also holds a public accountant certification from New York state as well.

So, a little bit of context.

<Denise> I'm not a bean counter at heart. But I get it.

But just very important to set the stage and telling us that context matters today.

So thanks, Denise.

Denise Tahara:
You're welcome, thanks.

I was thinking about how to put together, sort of—you know, my recent journey. And this point that I've come to is that context matters. Where we are, what we do, really, really matters and how we organize and how we operate. So we have spent yesterday mostly talking about the "what" of health care systems. So today, I'm going to talk a bit about the "what" and then we're going to talk a little bit about the "how." How do we make these changes, how do we improve, how do we change the trajectory in which we're headed.

And so the first thing I'd like to talk about is the fact that we have conversations about the health care system. We say it's broken, it's fragmented, it's lots and lots of things

that we say that are all mostly negative and very challenging, especially when we think about the health care disparities.

And so it occured to me that I'd better go back and take a look at what the definition is of a system. And the reality is, as you look and you see the gears here, is that systems are interconnected parts and they are working together toward a particular end or goal.

And let's reflect on how we're doing. So, how are we doing? I mean, does that really sound like a health care system? In fact, what we think of a health care system really wasn't designed for health and healing.

So, I find when I talk to people, this is really what they tell me. It's sort of this black hole. We see things going in, we don't always see them going out. We're not sure what we used. If you're on the bean counter side you're thinking about resources that are just continuously consumed and we never, ever seem to see how they manifest themselves.

Yesterday was a discussion about how do we measure some of those things that we can't immediately measure but we have to measure 'cause we have to report back. So we sort of get stuck in this sort of perverse cycle when we think about what we're supposed to be doing and how we're supposed to be achieving that end goal of health and wellness.

So, what if we started with a blank page and we started reimagining our health care system. What would that look like? What would be some of the outcomes that we expect or we would like to see. Just shout out.

Healthy people, good. Efficiencies, somebody said. And somebody said something about personal connections. Well, I believe, in fact—and I put access and affordability because of the Affordable Care Act—I sort of linked them together a little bit. That was really the intent of the Affordable Care Act. It was the first piece of multiple legislation but we never got to the second part because we got so stuck on the first one.

So if we reimagine this care here, this health care system, we start with this as being our output or outcome. And from there we then should be reimagining how to build that system to be able to achieve that aim.

So, how many people do mazes backwards? Okay. Cough it up. I do. Why do you do mazes backwards? It's more efficient, right? First of all, you know where you're supposed to end up, and so you're going to look at the path that's going to get you there the easiest. So, and, you don't fall, and you don't make mistakes—in health care we don't have time to make mistakes—and so we start at the end because that's what's most efficient and the best use of our ability to think about how to execute.

So, in systems thinking, systems talk about converting inputs into outputs. And I'm going to go through with you, probably a little tediously—just tell me if you get it and I'll move on—how this works. Systems thinking is about transforming inputs into desired outputs. Our outcome should be healthy people. And I was glad to hear that was the first thing that was mentioned because that's really what we should be creating to in order to operate.

So my mentor, Dr. Deming said that systems succeed when you optimize all the elements of the system. And what that means is understanding what the stakeholders' needs are, their expectations are, and that includes everyone.

So who are stakeholders in health care systems? You've got providers, you've got patients, you've got government obviously. You've got a whole myriad of people involved in providing and delivering care. So why not think about how we optimize, maximize.

Anybody, any engineers in the room? You did linear programming. There was a way that you used to study, you would write a subject line of maximizing something. Subject two, a series of constraints. And so that's how we should be thinking about health care. Is understanding what are those constraints so that we can address those constraints, so that we can do what we need to do to achieve our aim of health, of healthy people.

So, it's quite ironic that all these begin with the letter C. So I just selected a few of them. But what I want you to pay attention really to are the two bookends of capacity, compassion. My background, my undergraduate degree was in hotel administration. Actually, for me to switch to health care, I thought it was a real easy transition but the health care folks didn't like it so much. You know, they thought I was focusing on making beds. But you still have twenty-four-hour service—beds, meals, a whole lot of ancillary services that you have to coordinate to make that person satisfied when they leave.

So the answer on any question, we were told—when a professor asked you something—what's the answer to the question, you always say, location. Right? That's your clue. So I tell my students the answer to every question, that if you're not sure or you've been sort of snoozing through class, and I say what do you think about, you raise your hand and you say capacity. Because capacity really connotes capability and competency as well as the amount or number. And it really is at, it depends, because it really is a function of what are the capacity limiters, where you have bottlenecks—these are terms that we hear—where do we fail in the system? So it's a really good proxy for pretty much everything. Capabilities, competencies, connectivity, communication—and I'd like to argue that we really are lacking—I was glad to hear that somebody said this, personal content, compassion. And that's an element that we really need to include.

So going back to systems, we have inputs, processes, and outputs. Inputs are what we have or what we need, process is what we do. What are outputs, of our desired output of health and well-being. However, we don't operate in a vacuum. We operate in a context and an environment. And for an organization, a health care provider, this is what that environment looks like. And there's a variety of drivers or factors that determine what we do, how we do it, and who we do it to. These are policies, regulations, political, financing, economic, technological. And these should be things that help facilitate our abilities, but sometimes they are constraints to our ability to do this.

So, do we get it right?

The things that are different about health care services—I can tell you that doctors all tell me—well, you know, services. You can't take it from a management perspective because that's just not care. I would argue that we have to first start with thinking about converting our thoughts from treatment to care. Because that helps in the healing process. Just pivoting a little bit helps us in the healing process. Services are simultaneously delivered and consumed. Not only that, there's that proximity that we have that we don't necessarily have with other services.

You call on the phone, you speak to a service representative. Immediate consumption—you can't count it, you can't quantify it, you can't get it back. Right? So that's going back to that capacity.

If somebody—you have those hour appointments and you use 15 minutes—you now have time that you can't be using to treat another patient or to care for another patient

or to cure and care for another patient. So it’s personal. And patients feel vulnerable.

But all of the discussions, all of the measurements, all the things we talk about, really focus on the provider.

If we go back to that previous slide, we see policies, regulations, financing, economic, technological—these are all things that help or drive our ability to deliver care. But what about from the patient’s perspective?

This is what it looks like. It’s a labyrinth. No direction for navigating. It’s complicated, it’s complex. I particularly like this one here because it shows a circle around the patient. And that’s sort of what these things do. They circle around the patient. And much of the communication is from the keyboard in. Which means we don’t incorporate the patient voice or give patients that opportunity to feedback or give us check-ins to tell us how we’re doing and how they’re doing. We admonish patients when they said—I didn't take my meds.—Why didn’t you take your meds?—It says take with food.

So what do you say? Well, the provider should say—well, let me connect you with SNAP, let me connect you with something else or let me give you an orange. But we don't train physicians necessarily to have that part of the conversation.

So if we go back to this systems diagram, we realize that—oh my goodness—we have a whole set of other drivers and factors that impact and influence our ability to utilize and access the correct point of entry into the system and to absolutely benefit, to be that, on the output, to be that healthy patient.

We have access to food, culture and social factors, housing, transportation. I've been told by many that they would rather pay their rent than eat or go to the doctor. And that stable housing is such an important variable and factor in their lives. It drives everything. Including not taking pills because it says take them with meals. Including not going to the doctor and end up then in the ED with a much more higher acuity which was discussed yesterday, and you saw the data on that.

So, putting it together in a large way, here's what a health care system looks like. You have our inputs, process and outputs. We have the drivers of health care. We have key quality characteristics. So earlier I asked how are we doing? A lot of the metrics are

metrics that are good for the organization. Which are these things here—optimize, systems characteristics. We don't always look at these—here. How are we doing on wellness and well-being?

So we have to think about those characteristics that the patient and their families are looking at or considering when they're choosing our health care system, or not, or choosing no health care at all.

Going back to inputs, here are some factors—environment, social, economic, community provider, and I argue we need to include empathy, compassion and humanity and design into the system.

Coordinated care director <inaudible> is a dream, but there's communication networks, we need to build a feedback mechanism, community support, healing. And again, these are the <inaudible> I want to draw your attention to here, is, this is the opportunity for feedback. So when a patient is discharged from the hospital, they fill out a questionnaire. After you've been to doctors' visits—I know many of you, I now get questionnaires—how are we doing? And hopefully, that information doesn't go into that black hole,
it goes into inform what we are using, how we are using, how we are doing it, so that we can make the patient experience that much better.

So, starting with our outputs of health and well-being, we now need to add the patient lens to that. And so what does that look like? It means understanding those factors in the ecosystem that are supporting or impeding people's ability to make healthy choices and to participate actively in their—and advocated, somebody said earlier—for their health care. It also means that we have to do this sort of zooming in and zooming out.

So I like to think about being on the upper deck of a Minnesota Vikings game. What the field looks like. You're sort of looking at the whole thing. You're looking at offense, defense, you're looking at both teams and everything. Whereas when you're down on the field level, you're looking at the quarterback and you're looking at the tight end and the receiver—I hope I have all the right people. I usually use a baseball analogy but I'm in Minnesota. But you're looking at the players and you're looking at how they interact with each other and what they need.

So we need to be doing both. Zooming in to see specifically what's important to the patient, zooming out to understand what's going on in the environment.

One of the first laws of service that I learned, and I study, and that I teach is that satisfaction is equal to perception minus expectation. So, which of these things can we influence? All three, right?

The expectation from our patient is generated by a lot of things of what they read on the internet, what they hear from the referral or from word of mouth. That's before they enter our system. When they re-enter our system based on their experience, now we've set the expectation bar higher, hopefully.

The perception is what is it really like for them versus what they expect? And that determines how satisfied they are. The more satisfied they are, the better their experience is going to be and the better the healing process is going to be.

So, now we talked about the what. I'm going to spend the next few minutes talking about the how. Here are some tools that you can use and that we should be using to collect and organize information to better understand what the patient is feeling, what the patient is doing and also the provider. These are some of the tools that we have and I'm going to go just briefly into each of them.

We worked with a group of parents of children with complex care needs and we asked them to, in a focus group, to put together a care map. Which is basically, lay out all the pieces on the page, on a piece of paper, that are touchpoints for you with the health care system, including pain points. And what we did was, using Post-Its, which are one of my favorite inventions—thanks the squirrel, right—used Post-Its and we started organizing and grouping this information. So that we can then tackle or address those to see where there are disconnects outside our sector. So systems thinking requires us to not only look within our particular network or a system, but to also look at those touchpoints outside, that influence how patients are able to to care.

So what jumps out of the page here for you? Wow! Right? It's wow! Oh my gosh, right? What else jumps out? Most of these patients had a physical and developmental complex care need, but yeah, it's a big absence right?

So again, trying to convert some of the operations and systems thinking that I learned from Dr. Deming. Root cause analysis is what a lot of you do. And you probably used Ishikawa's diagram which is a fishbone, right? 'Cause it looks like a fishbone. I mean, that's the only reason why it's called fishbone diagram. But he had machines, methods, materials and man as the groups of factors that influence this outcome.

To me it doesn't matter what outcome you put here, I always like to see health and healing. But if you're looking at—let's have pediatric obesity—you put there, what are ways to reduce pediatric obesities, and you look at these factors and pretty much everything that we can think about when we're talking about patients really fits into these four categories. Social factors, economic factors, environmental factors, that can be toxins but it can also be a place where you're located, and provider. And yesterday we talked about the fact that zip code matters, zip code matters.

So, my favorite tool's flowcharting. I think it's really helpful to people who don't understand how things work, to put it down and lay out all of the activities to deliver care or to do something. And so, the exercise that I usually have organizations do is, "tell me what it looks like and tell me how it was designed." And we start there with the differences, right?

How many times have you heard a staff member tell you, "We've developed this work-around. We got it because what's there in place isn't really working for us. It's taken too long. We figured out a better way to do it." Why not make that the new process? But, they don't feel empowered or there's no voice for them to feed that back.

Frontline workers are your best friends. They're going to tell you exactly because, especially in health care, they're dealing immediately face-to-face with that patient.

So, a few things I just want you to know is this notion here, of a feedback loop. It's a decision box here. So, you refer a patient—and I'm sorry to have my back to you but I just want to be able to point—you refer patients to a provider. Did they receive the service? Yes, good. Now update the information and, what I like to think of as a playbook versus a record. A playbook really can have some planning in it. We can encourage all of these connections from these other sectors, not just limited to the test results and the outcomes from encounter—helps move us from an encounter base to a continuum of care life force approach to care. And this is extremely valuable to have. And what we have, is many times, the lack of feedback and feed-forward.

Here, we designed this for children with complex care needs—and this repeats based on this whole intake, access, create, delivery, refer and follow-up. We created that as an ongoing process for every time you have a referral. So this paper could be like a million pages long. I didn't want to make it too small for you to see.

So, where are the system failures? Oh, there are just so many.

The process flow charts help us identify where those are. Mostly things where there is little opportunity for patient voice. Do you have check-ins regularly with the patients? Do you have the opportunity for them to tell you, "It says, take with meals" and connect them then to a food bank or SNAP or get them to some other way to get nutrition or talk to them, say "Take it anyway"?

Patient interactions are not supported by the service. Do we have translating services? Do we have evening hours? Do we help patients with that referral? Do we make that appointment for them, for that next appointment, not just with us but for the next referral where they need to go? Do we have electronic medical records? Do we communicate that information? Or, is the operation infrastructure poorly designed that people get lost within?

I can tell you I had to take my mother in for some tests once, and she had an appointment, in a particular place. And I walked around with her for half an hour to try to find the elevator to take her to the place. We ended on the OR floor, we ended on the presurgery floor, we ended all over the place. And as a matter of fact, we were still walking around the hospital, we get a call saying, "You know you're late. Are you still coming?" I mean what do you do? I mean me, I exploded! But what do you really do? "Are you kidding?" And meanwhile, my mother has osteoarthritis, spinal stenosis and we're walking around this enormous hospital and there's like, you know, just follow the yellow line. Okay. Well, when they redid the floor they took the tape up and they didn't replace it. So, you know, you're sort of standing and spinning around many times.

So, I'm an optimist, and I tell people when I work with special organizations—I don't like to talk about failure—I like to talk about opportunities for improvement. And so, if we are doing that, we now need to add the patient lens. And to do that we need to make sure that we incorporate the voice of the patient.

When we think about steps that are unclear, where there are redundancies, where there are misplaced steps, no value-added.

I was doing some work with an organization who is going for joint commission accreditation and the nurse said, “I don't want to fill this out, it’s another piece of paper.” Well, without that piece of paper, that doesn't indicate that you’ve in fact completed the service so that we can get paid. So it’s not a piece of paper, it’s value added. And that is a compelling conversation with providers who just don't want to do more papers. And I get it.

From the CPA in me, you take a look at where do you make the investment? Well, you make the investment in processes that impact other processes ‘cause you're going to get a bigger bonus. There’s synergy there.

Replicate steps that add value. Look at places where you’re resource-intensive and see if there are alternate ways to provide that. And most importantly close those loops. They are open and that means a sort of an information black hole.

So, here is a more completed systems diagram. And this was designed for patients looking at Peatro Adressi. Again we have the drivers, we have the key quality characteristics. But now we break out more specifically, opportunities within the community. So if we’re looking at obesity, partnerships with farmers, green space trails, availability of leisure activities, safe place to live and play—which is what most people want.

We have now broken out more advocacy and more coordination and management across diseases, a more coordinated process. The built environment. What helps them or supports them to make those decisions, those lifestyle decisions. And then, not only is there optimized characteristics of effectiveness, efficacy, equity and advocacy, but also some specific things regarding patient engagement and involvement in their care.

So, now what? What do we learn, where do we go, what do we do? Well, who should be at the table? The answer is everybody. That means we should have patient voice. So there are hospitals now that have patient advisory councils. Frontline workers should absolutely be there. People across sectors should be participating in this. Why? Because you have to coordinate with the medical device people. You have to coordinate

with the school systems. You have to organize transportation. But most importantly, who owns the care process?

And this is the challenge that many clinicians face. “I'm saddled with that responsibility and I don’t get reimbursed for it and it's very time-consuming.”

So who manages that? You may have care coordinators that work within your own practice, but how about those who stand sectors? How about those who stand other places? Who is looking at the stakeholder needs and the stakeholder expectations? And mostly, who curates this journey? Who's going to help that patient or that patient family get through this process time and time again? Because it's not an encounter, and we need to move from an encounter to a continuum.

So, I'm glad you asked how do you do this because I created a road map for you. And so basically, the boxes at the top here are sort of the steps to take to—first of all, is you have to have commitment from leadership that you're going to implement a new approach to care, that you’re going to think about organizing things and what you do a little bit differently and maybe, do them a little bit differently. And then, what I put together are some steps here to sort of help you sort of tease your questions, help you sort of guide you through that process.

So if I say “ready the system” what does that mean? Okay! We’re all set, ready, go! No. What it means is create that guiding coalition. Who is going to be involved in this? Who’s taking ownership for it?

And again, then moving it through—you know—looking at the ecosystem, understanding where there are key points, pain points and key actions that need to be taken, to again, to help move the patient through their care delivery process and also get the community involved.

And so finally, the key takeaway I hope you get, is that context matters. Where people live, where you work, where you do what you do, is important. And you cannot look at care within the confines of your facility. You have to take a look at what's going on in the community that it's going to help, support or impede your ability to get things done. We need to sort of change the paradigm a little bit.

Design is really the first sign of human intention. So we need to be thinking about how to design that experience to help and support patients along the way. We need to use multiple lenses and voices. And if you saw, in my systems diagrams, I included the provider voice because it's really essential. Providers can tell you how it's working or not working or what's going on or what needs to go on. And so they're a vital part of that process and we need to get their voice as well.

And, we need to give them some guidance. Who's your care curator? You may have multiple curators. For the most part patient parents will tell you, especially for children with complex care needs, or parents period. They are the curator. They are the advocates. They walk around with large binders—not full of women—but full of information about how, what is going on with your patient. As a matter of fact, they even re-educate the quote, care coordinator every time their episode is recertified. In fact, they feel that many of the people who are the care coordinators are certified—certifiable I should say.

Continue to think about the context. And continue to think about this sort of zooming in and zooming out. Know what are specifically the needs of the patient but also, what are the needs of the system and how do we reconcile those so that they're aligned. We talked a lot off line—a number of us were talking about the alignment of these objectives and these aims.

Context matters to the healing journey and so does humanity. And we really are losing sight of that in the way that we're delivering care. And I encourage you to reflect and have some empathy for everybody who's participating in care delivery.

So because I'm an academic, <shown on slide> I have my list of references.

Thanks very much.