

Welcome and Introduction



Behavioral Health – Primary Care Integration

RHP 10 Learning Collaborative September 29, 2015

Agenda

- Learning Collaborative metrics review
- How we did it: Teams describe changes that resulted in improvement
- Story Starters
- Break
- Regional Updates
- Expert Panel: HIE Interoperability
- Lunch
- Keynote Presentation
- Troika activity
- Break
- Sharing your story: Videos
- Wrap-up



Improvement progress, Behavioral Health shared measures

Hunter Gatewood, MSW, LCSW

The role of shared measures reporting

Learning Collaborative

Best practices + measureable improvement + cross-organization learning

What we will cover

- Update on Collaborative teams
- Wins
- Reporting progress of LC overall
- Plan for shared measures

Number of teams reporting

» Behavioral Health – 4 teams

- > MHMR Tarrant County
- > Baylor Health Care System
- > JPS Health Network
- > Wise Regional Health System

Wins

» Total interventions achieved for 2014 and 2015

> Behavioral Health: 162,348



Wins

» Intervention rate for 2014 and 2015 YTD

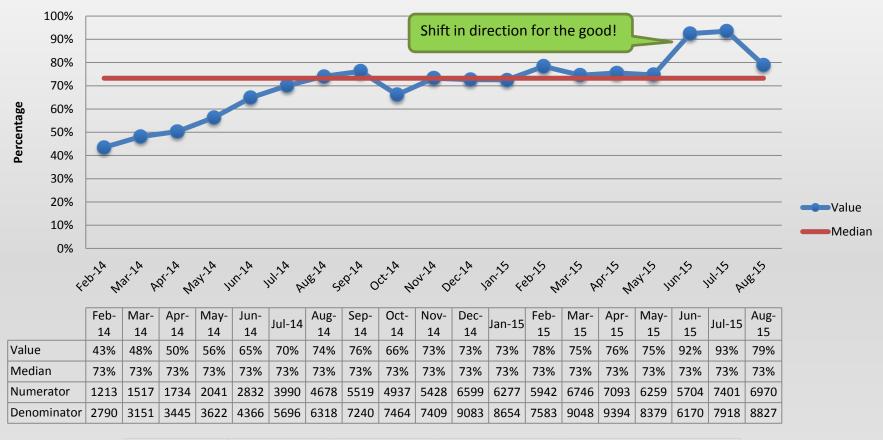
> Behavioral Health:

+ Increase from 46% to 48%



Behavioral Health

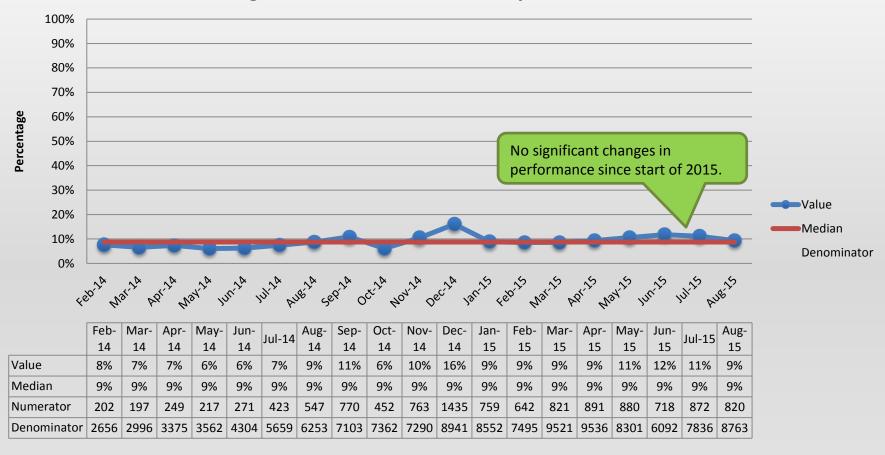
Collaborative (4 Teams): Percentage patients screened with crossspecialty tool



	2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 2015 YTD	
\rightarrow	67%	79%	40,488	52,392	92,880	

Behavioral Health

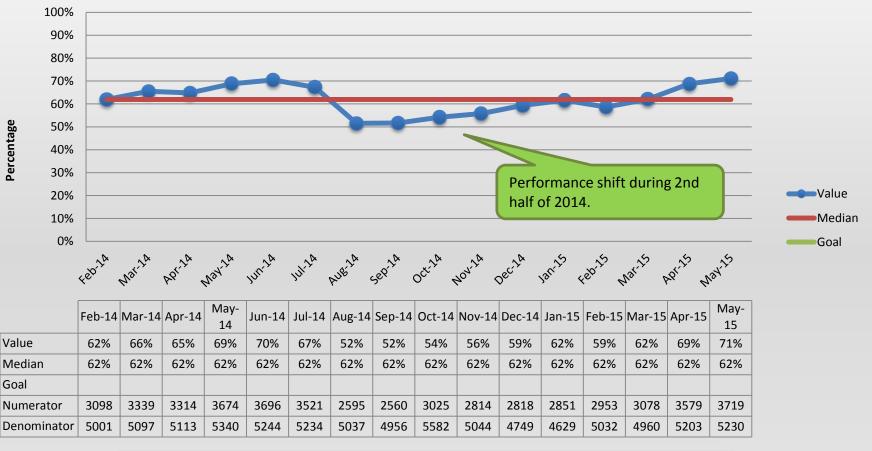
Collaborative (4 Teams): Percentage of patients who received integrated care intervention in past 12 months



2014	2015 YTD	2014	2015 Interventions	Total Interventions: 2014
Performance	Performance	Interventions	YTD	2015 YTD
9%	10%	5,526	6,403	11,929

Behavioral Health

Collaborative (3 Teams): Percentage patients whose condition improved with intervention



2014	2015 YTD	2014 Patients	2015 Patients	Total Patients Impacted
Performance	Performance	Impacted	Impacted YTD	2014 - 2015 YTD
61%	57%	34,454	23,085	57,539

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Plan for shared measures

- Continue monthly reporting
- LCC will continue to have 1:1 with collaborative for best practice sharing
- JPS anchor offers data TA as requested



Effective Interventions of RHP 10 Providers

REFRESH?

What comes to mind when you hear the word

"REFRESH"



REFRESH » VISION

» THINKING

» CLARITY

Successful Transformation is 70-90 percent leadership and only 10-30 percent management





THE POWER OF VISION

- > Vision drives people to CHANGE
 - + Vision plays a key role in producing useful change by helping to **direct**, **align**, and **inspire action**.
- > Vision drives people to **SACRIFICE**
 - + People will sacrifice if the potential <u>benefits</u> of the vision are **attractive** and they really believe that a transformation is **possible**.
- > Vision drives people to have PASSION
 - + Vision communicated well captures the **hearts** and **minds** of employees.

» VISIONARY LEADERS

> Step Out of Their Own Comfort Zone

Invite and Welcome Critique

>Stay Close to Those They Lead

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#### > Change for the sake of REFRESHING

# REFRESH THINKING



# **REFRESH THINKING**

"Nothing is so embarrassing as watching someone do something that you said could not be done." Sam Ewing

#### The way we THINK is the way we ACT

# REFRESH THINKING

- » Possibility Thinking
  - > Creates ENERGY
  - > Increases Possibilities
  - > Draws Opportunities
  - > Brings the right People to You
  - > Creates positive momentum

Thinking for a Change

#### » Refresh the *Environment* of Possibility Thinking:

- > Don't Focus on Impossibilities
- > Look for Possibilities in Every Situation
- > Dream One Size Bigger
- > Question the Status Quo

# **REFRESH CLARITY**

#### THE TOP CHALLENGE FACING BUSINESSES TODAY IS CLARITY

# **REFRESH CLARITY**

"More important than the quest for certainty is the quest for clarity."

Francois Gautier

**CLARITY: Information and communication** that is relevant, unambiguous and honest

#### » Refresh Clarity:

- > Communicate in **Simplest** possible terms
  - + Make the complex simple
  - + Acronyms kill clarity
- > Communicate in **clear** language
  - + No Fuzzy Words

# *"Measure what is measurable and make measurable what is not so." –Galileo*

- » Near/close/far
- » Short/long
- » A lot/a little
- » Many/few/much
- » Bad/good
- » Heavy/light

- » High/low
- » Significant
- » Fast/slow
- » Young/new/old/aged
- » Expensive/cheap
- » Almost/nearly/every



» Refresh Clarity:

> Communicate the **true** condition...



"A life lived with integrity – even if it lacks the trappings of fame and fortune is a shining Star in whose light others may follow in the years to come." Denis Waitley

# CLARITY

#### » Soften truth..."Opportunity" instead of "Problem"

- > A problem is a gap...something that stands in the way, between where you are and where you need to be.
- > An opportunity is a path that will move you from where you are to where you'd like to be.
- » A problem is urgent matter; an opportunity is not.You can take an opportunity or leave it

"Having no problems is the biggest problem of all." Taaichi Ohno,

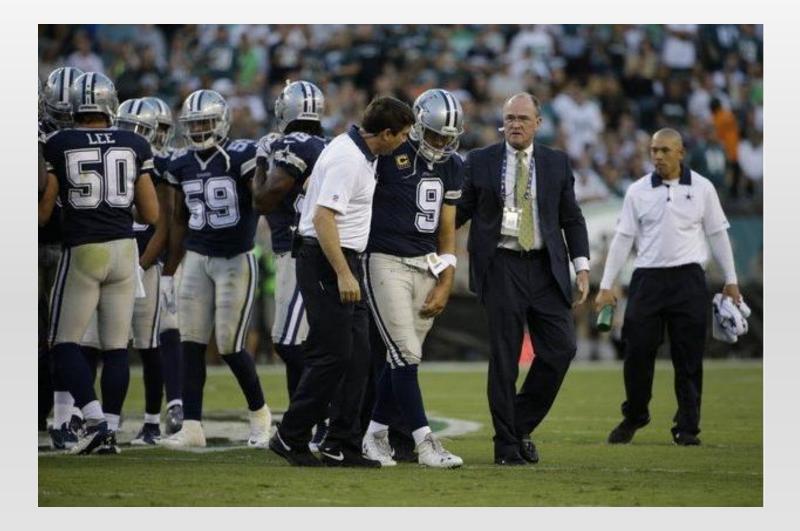
# VICTORY







- » Early warning signals
- » Break goals into bite-sized chunks
- » Provides trends and direction
- » Celebrate successes
- » Take corrective action
- » Enhances change
- » Improves accountability





## **REFRESH**?

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# What comes to mind when you hear the word "REFRESH"







#### • THINKING

#### • CLARITY

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REPRESENTATION

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Winter and the first war

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## Fuzzy Words

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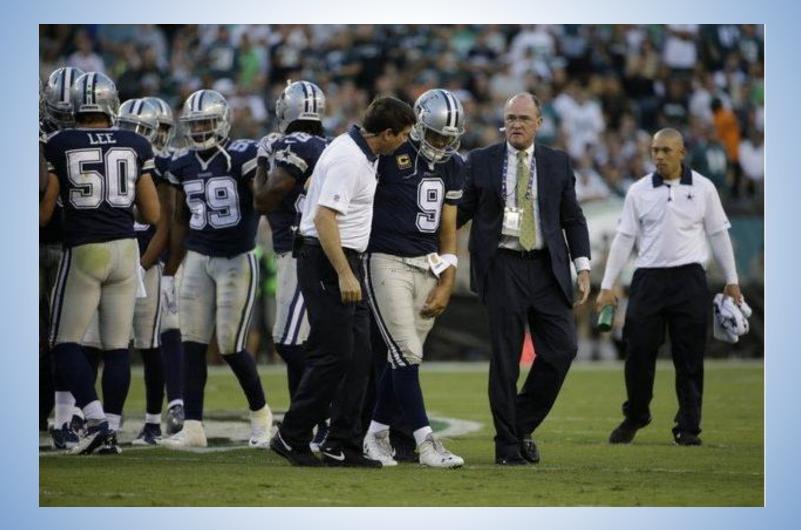
## **METRICS DRIVE VICTORY**





### **Keeping Score**

- Generates excitement
- Early warning signals
- Break goals into bite-sized chunks
- Provides trends and direction
- Celebrate successes
- Take corrective action
- Enhances change
- Improves accountability





### Behavioral Health and Primary Care Learning Collaborative

Health Care Transformation Initiative



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Health Care Transformation Initiative



#### DSRIP Projects That Relate to Behavioral Health and Primary Care Integration

#### **Expand Behavioral Health**

Addition of a new location and expanded hours

#### **Integrated Health Care**

 Primary health care services and behavioral health care services under one roof

#### Substance Use Disorder (SUD) Outpatient Integration

 Addition of Licensed Chemical Dependency Counselors (LCDCs) and Peer Support Specialists into all mental health clinics

#### **Detoxification Expansion**

 Expansion of facility beds from 12 to 20 and augmentation of current services with addition of Peer Support Specialists





## **Tobacco Use & Behavioral Health**

- According to the CDC, people with behavioral health diagnoses are about twice as likely to smoke
- The prevalence rates are extremely high for individuals with behavioral health conditions:
  - 60% of people with lifetime depression are either current or former smokers
  - **70%** of people with bipolar disorder smoke
  - **88%** of people with schizophrenia are smokers
- Among MHMR substance use services population:
  - 81% smokers as opposed to 20% smokers in the general population



#### Physical Health Benefits of Smoking Cessation





Source: Cleveland Clinic, 2014

## **The Integration Project**

## **Services**: Smoking-Cessation Screening and Intervention

Provided in a behavioral health setting

#### Geographic region served: Region 10

**Population:** Individuals with mental health, substance use and co-occurring disorders who may be homeless



## **Screening & Intervention**

## The Fagerstrom Test for Nicotine Dependence (Fagerstrom)

- 8-question survey
- Most widely used and studied measure of physical dependence on tobacco
  - Staff trained using the University of Massachusetts Medical School Tobacco Treatment for Specialist Course
  - Nicotine Replacement Therapy
  - Smoking Cessation Groups
  - Referral to community resources and programs



## DY3 & DY4 Impact

- 1,716 individuals screened for nicotine dependence
- Of those who screened positive for nicotine dependence, **31%** participated in smoking cessation intervention
- 40% of individuals had improved condition after completing intervention





### **Challenges**

#### **Challenge: Screening Processes**

- Solution: Implement Plan-Do-Study-Act (PDSA) cycles at different program sites
  - Identify gaps in current screening process
  - Implement changes to screening and/or data tracking processes to tailor process to unique needs of project site and target population
  - Develop process maps

#### **Challenge: Data Collection**

- Solution: Implement PDSA cycle to improve quality of data collected
  - Identify gaps in data entry and retrieval process
  - Redesign process at each clinic
  - Retrain clinic staff
  - Analyze data to ensure all usable data is captured

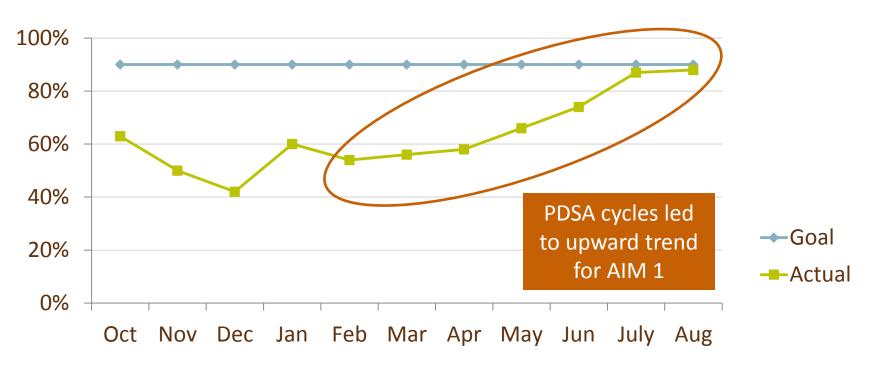
#### **Challenge: Engaging Individuals in Intervention**

- Solution: Implement PDSA cycle to increase participation rates for smoking cessation groups
  - Administer questionnaire at clinic site
  - Give brief presentation on physical health benefits of smoking cessation
  - Analyze data and determine best steps to provide more targeted smoking cessation services

### AIMS Statement #1

Percentage screened with team's selected cross-specialty screening (Fagerstrom)

**Goal:** Increase from 0% to 90%

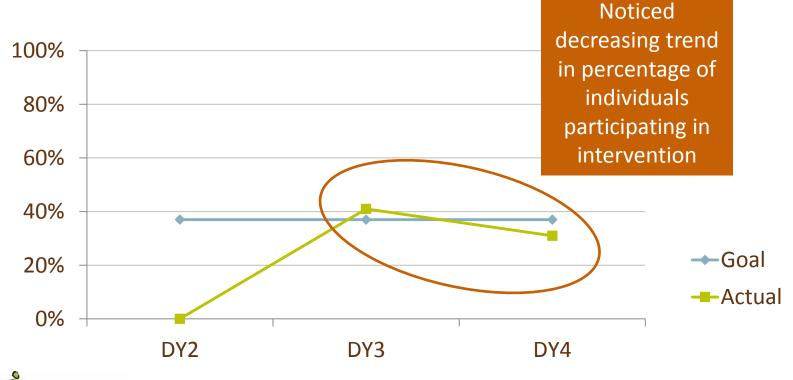




### **AIMS Statement #2**

Percentage who received the team's selected integrated care intervention in past 12 months

**Goal**: Increase from 0% to 37%

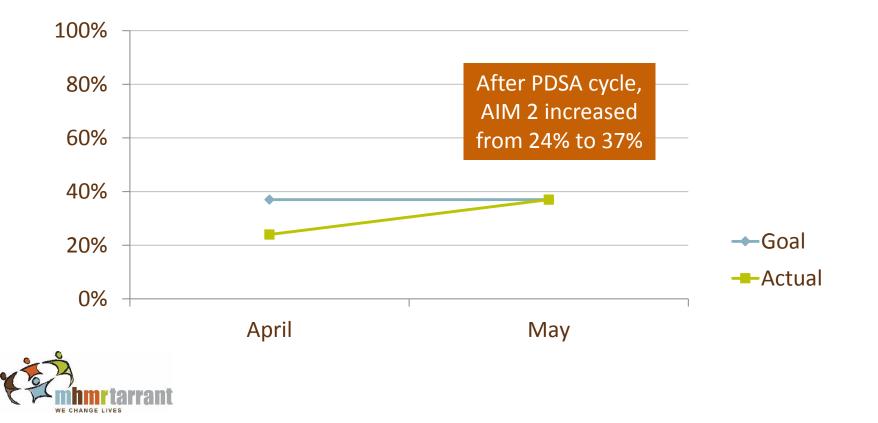






Percentage who received the team's selected integrated care intervention in past 12 months

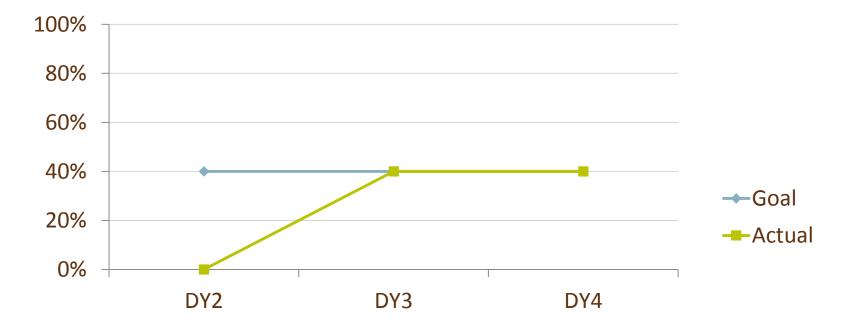
**Goal**: Increase from 0% to 37%



### **AIMS Statement #3**

Percentage receiving integrated care whose condition improved

**Goal**: Increase from 0% to 40%





### **Lessons** Learned

- Benefit of regular team meetings to analyze data and to implement PDSA cycles
- Importance of ongoing staff training to maintain high quality data entry/collection
- Need to tailor interventions to best meet needs of program site and target population
- Usefulness of feedback from program individuals to improve intervention



### **Thank you!** Any Questions?



#### **Session Objectives**

- Invite individual reflection and participation Improve collaboration between projects and organizations
- Strengthen relationships & spark partnerships
- Share ideas to improve patient engagement



# **Story Starters**

Story starters is a good get-to-know-you icebreaker to help people share interesting stories about themselves, their projects, teams and achievements. This activity works for large and small groups. For very large groups, simply have everyone split into rounds of 8-10 people.



Participants are to complete the following sentences on the cards presented to them:

- 1. October begins DY4 reporting, I .....
- 2. My greatest achievement was ....
- 3. One thing I would like to achieve in DY5 is ....
- 4. A best patient story is ....
- 5. The silliest thing I did with my team was....
- 6. If my team were to have a theme song, it would be....
- 7. If my team were to have a mascot, it would be....
- 8. My greatest challenge during my tenure regarding the 1115 Waiver was...

Take 10 minutes for participants to complete the questions presented and then go around the table and share the results. Answer 1 question at a time going around the table.



### **Break (Proceed Downstairs)**

10:30-10:45am

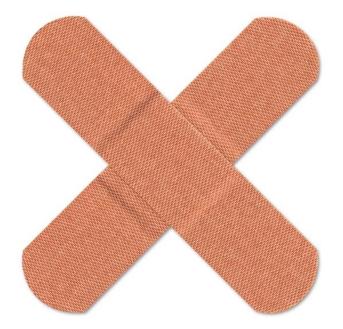
# From workaround to solution

The ongoing challenge of integrating care and the promise it brings

#### Overview

- The two schools of thought
- Setting a vision
- Assessing where you are
- Establishing a goal
- Measuring your progress
- Advocate for change
- Celebrate

#### Choose your side?





#### Setting your vision

#### Advocating for a Mission and Vision Focused on Integrated Care

Shared Mission and Vision

- **Organizational mission.** Clinic members, at all levels, are able to articulate a clear organizational mission.
- Service as mission. The organization's mission is to serve patients by providing population-based care in an integrated care model.
- Focusing on team approach. Leaders are clear that providing integrated care is the way to achieve the organization's mission.
- **Clear vision.** Leaders define a clear vision for integrated care as a model of care for the clinic.
- **Ongoing improvement.** The vision for integration is a clear guiding framework, and over time, practice members at all levels help to clarify and improve the integrated care model in practice.

#### Assessment

- Where are you now?
- Where do you want to go?
- Basic quality improvement

### Data and EHR

Oh, the details

#### EHR and the workaround game

- We observed 4 EHR workarounds used by practices in response to challenges:
- 1) double documentation and duplicate data entry;
- 2) scanning and transporting documents;
- 3) reliance on patient or clinician recall for inaccessible clinical information; and,
- 4) use of freestanding tracking systems.

Cifuentes, M., Davis, M., Fernald, D., Gunn, R., Dickinson, P., & Cohen, D. J. (2015). Electronic Health Record Challenges, Workarounds, and Solutions Observed in Practices Integrating Behavioral Health and Primary Care. *The Journal of the American Board of Family Medicine, 28*(Supplement 1), S63-S72. doi:10.3122/jabfm.2015.S1.150133

#### Set your goal

- Clinical
- Operational
- Financial
- Training/education

#### Measure your progress

- Minimal data
- Quality data
- Meaningful data

#### Advocate for change

- Consider the who (target)
- The what (stories)
- The why (data)
- The how (plan)

#### Celebrate

- Push for more
- Think broadly
- Share with others
- Dance

### Thanks

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# Troika Insights

- As simple as 1-2-3
- Learning to ask for help is a core skill
- Consulting is a core skill
- Give-and-take reciprocal action is a generative patter





### Troika

# Get Practical and Imaginative Help from Colleagues Immediately

#### **1. Structuring Invitation**

- Invite the group to explore the questions "What is your challenge?" and "What kind of help do you need?"
- 2. How Space Is Arranged and Materials Needed
- Any number of small groups of 3 chairs, knee-to-knee seating preferred. No table!
- 3. How Participation Is Distributed
- In each round, one participant is the "client," the others "consultants"
- Everyone has an equal opportunity to receive and give coaching
  4. How Groups Are Configured
- Groups of 3
- People with diverse backgrounds and perspectives are most helpful



#### **5. Sequence of Steps and Time Allocation**

- Invite participants to reflect on the consulting question (the challenge and the help needed) they plan to ask when they are the clients. 1 min.
- Groups have first client share his or her question. 1-2 min.
- Consultants ask the client clarifying questions. 1-2 min.
- Client turns around with his or her back facing the consultants
- Together, the consultants generate ideas, suggestions, coaching advice. 4-5 min.
- Client turns around and shares what was most valuable about the experience. 1-2 min.

Groups switch to next person and repeat steps



Something that stands out from the discussion today is....

# I would like to follow up with....OR I was inspired by this idea...





## Thank You, Please Proceed Downstairs