SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Developing High Functioning Teams Innovation Community

Final Webinar!
August 18, 2015

SAMHSA HRSA Health Resources & Services Administration
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1. Summary Learnings
2. Hearing from Colleagues

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Summary Learnings

Gathered from:

- Work Plans
- Small group calls
- Webinars
- Evaluations*

Innovation Community Activities

Monthly webinars

AIMS Team Building Tool

Individual coaching calls

Small group calls

Implementation Plan submissions

Guest experts:

- Claire Neely, MD, Institute for Clinical Systems Improvement
- Paul Ciechanowski, MD, University of Washington
- Anna Ratzliff, MD PhD, AIMS Center

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Implementation Plans

- Ensure agency strategically places providers in appropriate setting while maximizing licensure and supporting physical healthcare environment. **(Liberty Center Connections)**
- Streamline behavioral health referrals to and feedback from external agencies by instituting a direct referral process. **(CHC of North Port)**
- Workflow for screening depression in primary care that serves as a mechanism to identify clients in need of further depression assessment with BHS will be implemented over the next 6 months. **(United Community and Family Services)**
- Conduct outreach and community education (schools, faith communities) to increase utilization of behavioral health services. **(Myrtle Hilliard)**

THEMES

Strategies, Challenges & Examples

- Workforce training
- Team huddles
- Electronic records
- Coordinated care
- Metrics
- Process

Workforce Training: Strategies

- New social worker shadowed PC staff for 4 full days. Turns out they are a pretty good resource for doing med rec along with a team nurse. **(Harbor)**
- One PCP meeting per quarter dedicated to BH training, providers surveyed to prioritize topic, and integrated case review based on training topic **(CHC of North Port)**
- Each team member sharing with others how they introduce the services they provide to patients (elevator speech) to inform each other. **(UPMC)**

Workforce Training: Challenges

- PC resistance to doing psych Rx beyond the basics
- Personal issues may arise when behavioral health becomes part of the scope of work
- Hard to do brief models of care because patients are complex (homelessness, chronic conditions)
- Cultural divide – BH knows how to handle suicide, but stool samples? Not so much!

Workforce Training: Examples

- Front desk - Some BH and some PC
- Bachelor's level care managers, med assistants **(CODAC)**
- RN, LPN and MA - PHQ & SBIRT as additional vital signs **(Myrtle Hilliard)**
- PC - How to manage a manic episode
- BH – Recognizing abnormal lab values **(Jeff Care)**

*Breakthrough when staff see what they can do to contribute, leads to better buy-in (**Myrtle-Hilliard)***

Team Huddles: Strategies

- Added daily huddle based on team recommendations. Improving the patient experience (getting care much faster), communication and billing capacity. **(Lutheran)**
- Increased the frequency of team huddles to succinctly discuss patients before and after each visit. **(UPMC)**
- Trying out different huddle times. First thing in the morning worked for some, but not others. Now doing right after lunch. **(Jeff Care)**

Team Huddles: Challenges

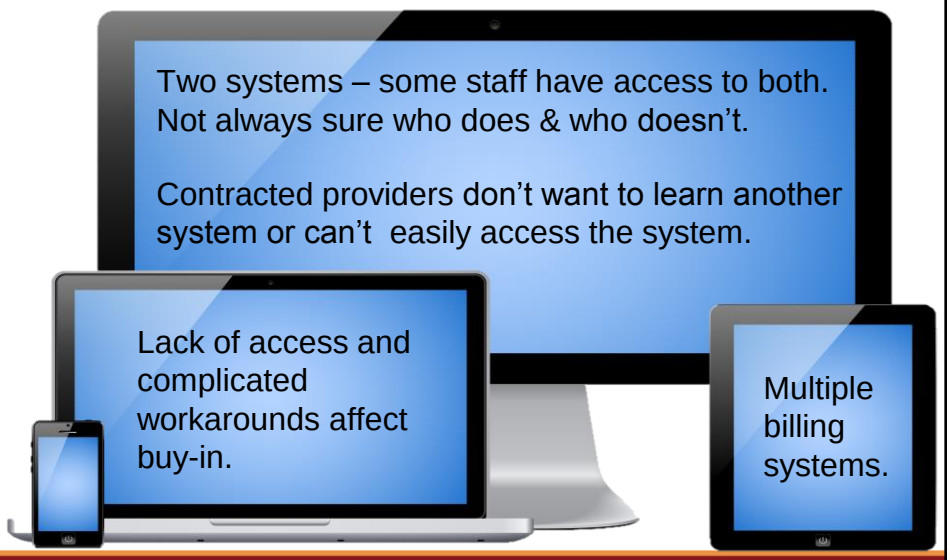
- Some providers lacking participation, don't see the value with their time.
- Striving for more efficient hand-off sheet, more succinct presentations during team huddles.

Team Huddles: Examples

- Every morning for high risk & special needs pts, determine what does BH & PC each need and referrals anticipated. **(Jeff Care)**
- Now able to review the day's patients in just 5-7 min.
- Every morning 8:05am -8:15am. **(Lutheran Fam Svcs)**
  1. Review the schedule for the day
  2. Patients of concern (test outcomes, hospital discharge, med reconciliation, behavioral health concerns)
  3. Supporting patients with unique needs (language barriers, link to specialists.)

*The daily huddles have helped the team realize they need to depend on each other throughout the day to meet the various needs of our patients.**(Lutheran Fam Svcs)***

Electronic Records: Challenges



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Coordinated Care: Strategies

- Decide where BH enters the workflow, for which patients & how to introduce. BH needs to be willing to be interrupted. **(Fam First Health)**
- Come up with a team priority list, patient priorities and where the two meet. **(UPMC)**
- Warm handoffs to social worker to discuss psychosocial issues, housing, transportation etc. frees up the physician to see the next patient. **(Harbor)**
- Create a common goal to support no matter what the visit is for – behavioral health or physical health. **(Jeff Care)**

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Coordinated Care: Challenges

- Staff turnover – losing a champion or other key staff can really hinder progress.
- Competing priorities can push issues off of the radar. Healthcare transformation is labor and change intensive while many healthcare organizations have neither the revenue nor staff to keep pace with the demand for change.
- Working with some of the primary care providers who feel overwhelmed and see integration as time consuming and one more thing that has to be done. Want to just hand off the patient.

Coordinated Care: Examples

- Team building lunches 1x month. Ice breaker questions: What characteristic do you value most in a co-worker? What is the most exciting thing about your job? **(VIP Community)**
- POD team: Nurse, Dr, MA, care coordinator **(Hamakua)**
- Revised outside referral process to be electronic and include follow-up to close the loop. **(CHC of North Port)**
- The biggest breakthrough was the bonding and development of trust that has taken place as a result of lunch and learns. (**FL Dept of Health Sarasota Co)**

Metrics: Examples

- Health behaviors for change.
- PHQ-9, A1c, reduced hospital stays. **(Harbor)**
- A1c, blood pressure, cholesterol, depression - “ABCD” from guest speaker.
- Specialty referrals, social service support referrals, depression screening, Substance use screenings, domestic violence screenings, BMI, CHO, BP, A1c. **(Lutheran Fam Svcs)**

Process: Strategies

- Start with team engagement activities from day one. May range from developing or reaffirming the mission/vision to developing or revising the daily workflow to daily huddles to weekly meetings. The concept being that everything you do is done as a team because every decision impacts the team. **(Lutheran Fam Svcs)**
- Could be feeling stuck with what we have in terms of space, but instead took overall change seriously and moved people around for the benefit of the patients.

Process: Examples

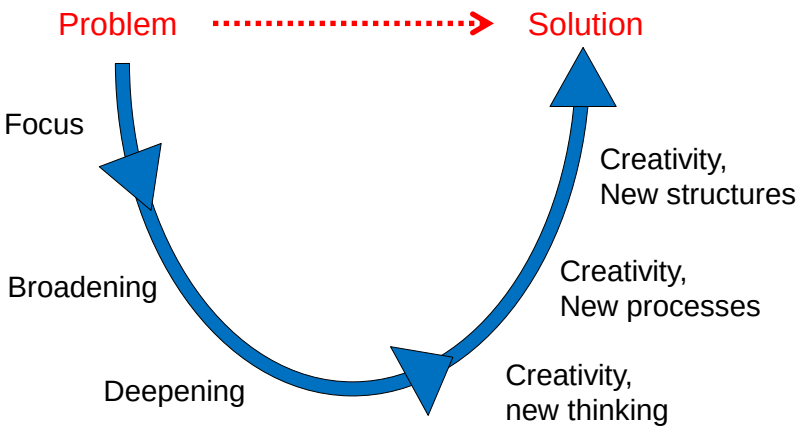
- Selected the “burning platform” - a topic that would motivate participation of key stakeholders in an improvement team. **(FL Dept of Health Sarasota Co)**
- Getting together to listen to the webinars as a group, and then having time right after to discuss ideas.
- Trying out the care model on a few pilot patients before going large-scale. Doing a “soft” roll-out of our integrated team approach with simulation cases first then a small group of patients so we could refine our process. **(UPMC)**

Making It  Stick

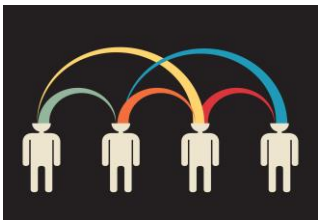
- Do <u>all</u> team members have a shared understanding of the objectives & strategy? (How do we know?)
- Can each team member articulate how they contribute and add value to the objectives?
- In what way is data a team member?
- How do we promote positive gossip?
- Who are our rising stars?

Theory U

Otto Sharmer, PhD, MIT, 2007



Hearing from Colleagues



United Community & Family Services

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United Community and Family Services Norwich, CT

Developing High Functioning Teams
Innovation Community Presentation
Jennifer Granger, COO
August 18, 2015

UCFS United Community & Family Services

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About UCFS

- Founded in 1877
- Federally Qualified Health Center (8/1/15) and an FQHC Look Alike since 2002.
- 17,000 users received 115,000 visits in FY15
- Outpatient Services: Primary Medical, Women's Health, Behavioral Health and Dental
- Other Services: Community-based Behavioral Health and Eldercare
- 12 facilities, including 5 outpatient centers serving Eastern CT

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Depression Screening Improvement Project

Objective 1

- Engage a high functioning team with a shared vision to integrate depression screening in primary care.

Objective 2

- Identify opportunities to improve the rate of depression screening in primary care and referral to behavioral health services.

Objective 3

- Use the Depression Screening Improvement Project as a collaboration model to replicate within UCFS

Implementation

Identified the "burning platform" that brought the right team members to the table.

- Depression Screening in Primary Care and Referral to BHS

Assessed team and agency performance

- Assessing Chronic Illness Care (ACIC)

Selected models to give structure to the process:

- Chronic Care Model
- Model for Improvement
- Change Package of Key Changes for Depression

Implementation Continued

Defined measures and began implementing tests of change.

- 90% of primary care patients age 18 and older are screened for depression annually using the PHQ-2 during their primary care appointment.
  - Of those with a positive screen score of 2, 80% will complete a hardcopy of the PHQ-9
    - Of those patients with a PHQ-9 score of 15 or higher, 100% will receive a referral to a BHS provider

Outcomes / Next Steps

Completion Rate of PHQ-2

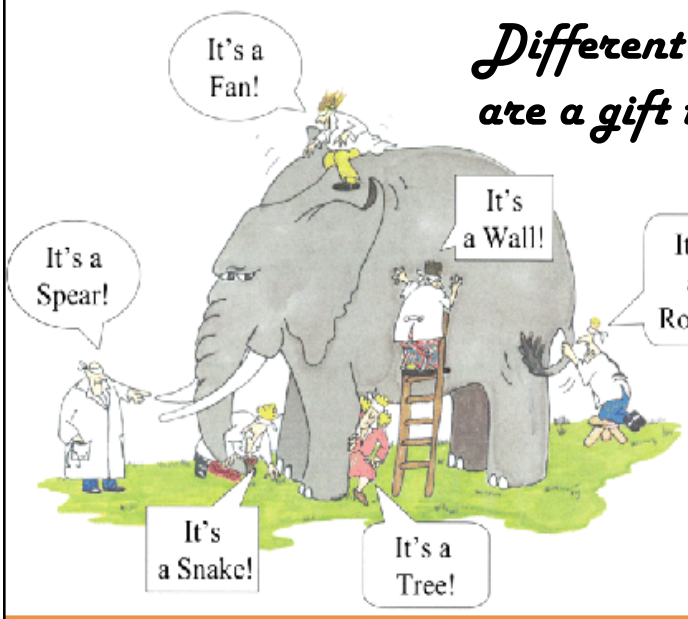
- Workflow of current process completed
- Assigned PHQ-2 to Medical Assistant as part of "vitals"
- Increased from 51% (baseline) to 58%

Continue to design and run PDSA tests of change through 12/31/15

Re-administer ACIC to assess improvements to system

Resources

- maccollcenter.org
- improvingchroniccare.org
- ihi.org



Different perspectives are a gift to innovation

Thank **YOU** for participating!