



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## March Webinar Depression and SBIRT Management

Nick Szubiak  
Director of Practice Improvement

# Setting the Stage: Today's Moderator



Madhana Pandian  
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SAMHSA-HRSA Center for Integrated Health Solutions

**Slides for today's webinar will  
be available on the CIHS  
website:**

**[www.integration.samhsa.gov](http://www.integration.samhsa.gov)**

**Under About Us/Innovation Communities**

# Our format...



## Structure

Short comments from experts  
Specifics from their point of view

## Polling You

Every 20-minutes  
Finding the “temperature” of the group

## Asking Questions

Watching for your written questions

## Follow-up and Evaluation

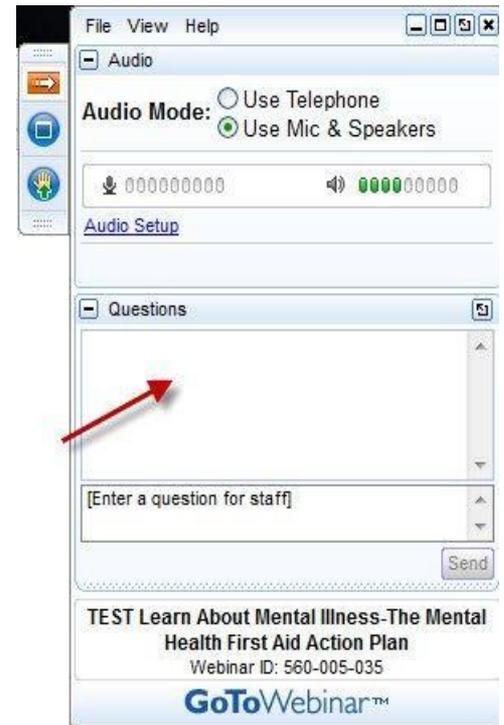
Ask for what YOU want or expect  
Ideas and examples added to the  
AOS Resource Center

# How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



# Innovation Community Participants



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# Innovation Community Participants



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# Listserv

Look for updates from:

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# Setting the Stage: Today's Facilitator



Nick Szubiak

Integrated Health Consultant

SAMHSA-HRSA Center for Integrated Health Solutions

# Today's Webinar: Teams and Performance Indicators

1. Defining Our Terms...What is a team?
2. The Impact of Teamwork on Health Outcomes.
3. Creating a Powerful Team...What works?
4. Workflows: Developing, Evaluating and Implementing
5. Utilizing and Communicating Data

**“Team” & “Teamwork” means something different to everyone...**



# A continuum of Healthcare Teams

**Multi-disciplinary Team** = hierarchical, each role separate, some communication, parallel processes.

**Inter-disciplinary Team** = interdependent, maintain distinct professional responsibilities & assignments, must make dramatic adjustments in their orientation to co-workers.

**Trans-disciplinary Team** = shared decision making, every member can do everyone else's role if needed, one process, much communication.

Cooper et al. (2003). The Interdisciplinary team in the management of chronic condition: Has its time come? RWJF.

# The Interdisciplinary Team:

People with distinct disciplinary training working together for a common purpose, as they make different, complementary contributions to patient-focused care.

Leathard , A., ed. (1994). *Going Interprofessional: Working Together for Health & Welfare*. Routledge, London.

# Five Components of Effective Interdisciplinary Teams:

1. Defining appropriate team goals.
2. Clear role expectations for team members.
3. A flexible decision-making process.
4. The establishment of open communication patterns.
5. The ability of the team to “treat” itself.

Leipzig, Hyer et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline J Am Geriatr Soc 50:1141–1148.

# Defining appropriate team goals

- Develop a team dashboard that includes measurable, and meaningful/relevant goals.
- The goals must relate to broader organizational goals.
- Tie the goals to a quality improvement/PDSA process.
- Incorporate discussion of the goals into every meeting.

# Clear role expectations for team members

- The more complex the task the clearer roles must be.
- All team members have their own opinions of what their role is and what their team member's role is...
- If suspected or seen role ambiguity & conflict should be discussed right away.
- Routinely, clearly state who “owns” or is “responsible” for a task to help foster this thinking.

# A flexible decision-making process

- A team is a problem-solving, decision-making mechanism. This is not to imply that an entire group must always make all decisions as a group.
- The issue is one of relevance and appropriateness; who has the relevant information and who will have to implement the decision.

# A flexible decision-making process cont.

Teams can choose from a range of decision-making mechanisms including:

1. Decision by default (lack of group response)
2. Unilateral decision (authority rule)
3. Majority vote
4. Consensus
5. Unanimity

# A flexible decision-making process cont.

Similarly, when a group faces a conflict it can choose to (a) ignore it, (b) smooth over it, (c) allow one person to force a decision, (d) create a compromise, or (e) confront all the realities of the conflict (facts and feelings) and attempt to develop an innovative solution.

The choices it makes in both of these areas will significantly influence how the team functions.

# The establishment of open communication patterns

- Create avenues for communication (e.g., logs, regular team meetings, use of common language, etc.).
- Maintain regular contact with agency leadership.
- Maintain regular one-on-one supervision.

# The ability of the team to “treat” itself

- Include a “Team self-audit” process that is tied to the team’s dashboard.
- Encourage questioning & the voicing of alternative views.
- Declare team breakthroughs & team breakdowns when necessary.
- Encourage necessary acts of leadership.

# Adaptive Reserve

Borill et al. (2000) found that teams with greater occupational diversity reported higher overall effectiveness and the innovations introduced by these teams were more radical and had significantly more impact both on the organization and on patient care.

Managers' lives. Stressed to kill. Journal of Health Service. 10;110(5691):24-5.

# Take Care of Your Team...

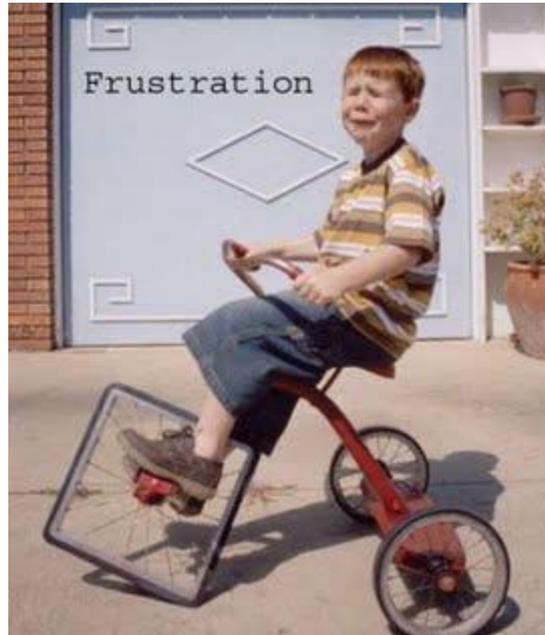
“Transformation occurs, not at a steady & predictable pace, but in fits & starts. After the strenuous task of implementing a particular PCMH component, the practice had to simultaneously manage the ripple effects, maintain the change, & prepare for the next...”

“...the work is daunting, exhausting & occurring in practices that already felt as if they were running as fast as they could. This type of transformative change, if done too fast, can damage practices and often result in staff burnout, turnover, & financial distress.”

# Team Care

- Recognize teams are dynamic, emotion laden, and need constant attention and reassurance.
- Hardwire rewards into the work flows.
- Be careful to hire team members not positions.
- Get in the habit of monitoring and responding to changes in morale/trust.

# 5 Most Common Responses to the Talk about Data or Measurement



The element of  
**CONFUSION**

# “Hey Nick...” What I’ve heard about Data/Measurement

“Behavioral Health staff aren’t good at math...after all that’s why we went into Behavioral health...”

“What we do and who we work with are too complex to measure...”

“You can’t hold me accountable for a consumer not achieving their goals...”

“The demand to use data is just another way to get us to work harder/more...”

“Our EMR is not useful...and I don’t see that changing anytime soon...no really I’m serious.”

# The Care Pathway is the intersection of...

Clinical Processes/Practices Expressed in EBP's

+

Administrative Processes Expressed in the Staff  
Workflow

+

the Consumer's Recovery/Tx Plan Expressed in  
their Life Everyday

# What is a Workflow?

An orchestrated and repeatable pattern of clinical and administrative staff behaviors designed to drive clinical and administrative processes and outcomes.

In other words, the behavioral patterns/routines staff engage in everyday when they come to work.

# Measuring the Components

Evidence-based/Best/Promising  
Practice Fidelity

+ Person Center Plan Goals

+ Protocols for Clinical/Admin.Workflow

=Repeatable, Measurable Steps  
to Achieving Business &  
Healthcare Targets

# Why does this matter?

*“If you are not measuring a process you don’t know what you are doing.”*

*“If you are not measuring processes you can’t improve.”*

*“If you are not measuring processes you are operating blindly and therefore are at risk for delivering ineffective and wasteful care at best.”*

*If you are not measuring your care provision and administrative processes you can not achieve **the triple aim** of population health management, cost containment , customer centered care ... in other words survive in healthcare marketplace today.*

# Purpose of Workflow Analysis

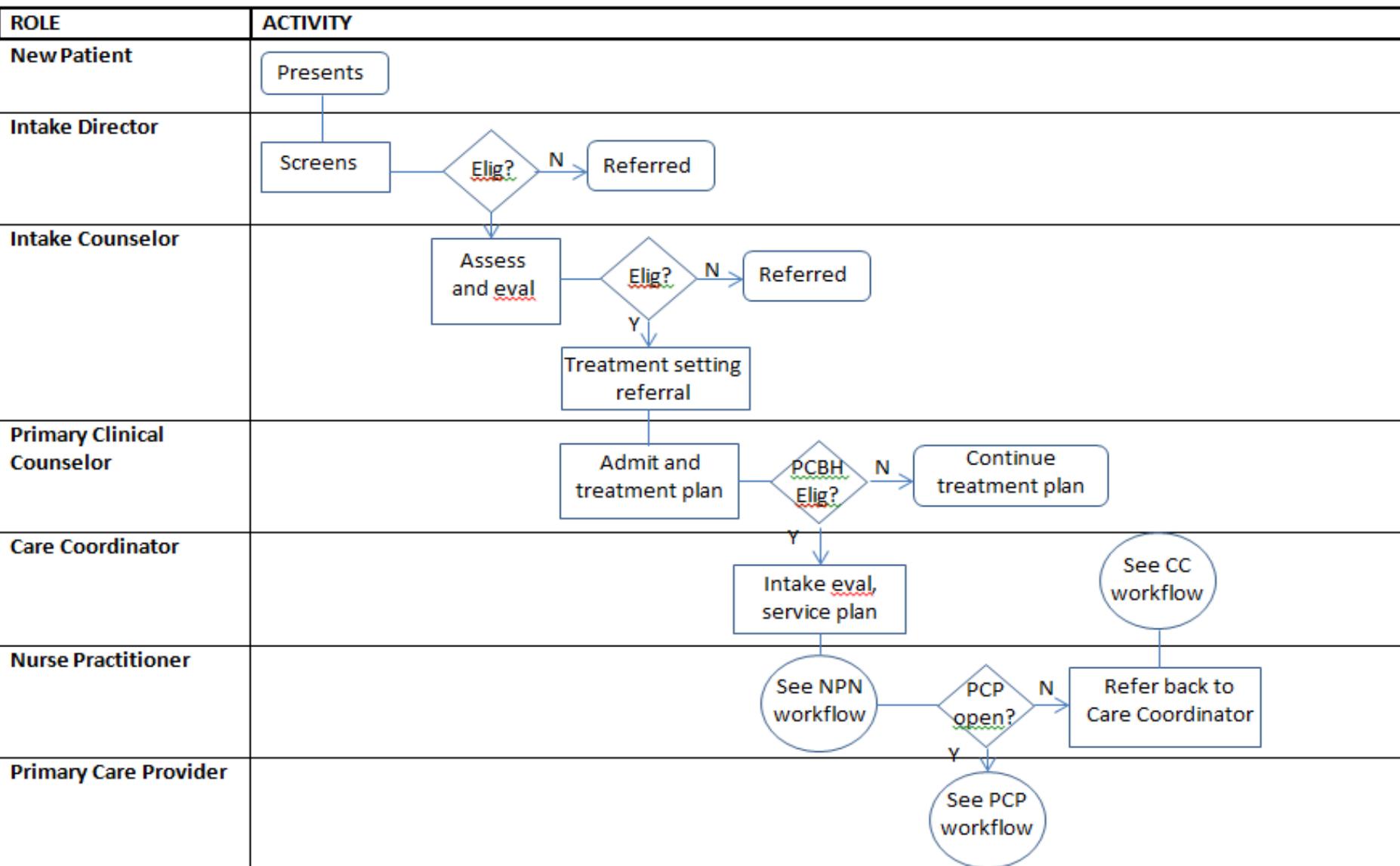
Promotes cross-discipline understanding of each step & the measures being used to collect data.

Connects multiple dimensions –billing, data collection and reporting, clinical services, practice management, etc.

Promotes understanding of each team member's role(s)--  
What do you do? Why and how do you do it?

Means to identifying Key Performance Metrics/Indicators for improvement.

**Process: New patient, Central Intake, Screening and Referral to PBHCI for Eligibility Assessment, sees Primary Care Provider**



# Steps to Conducting a Workflow

**Step 1:** Decide what process to examine. It's best to choose a very specific process (e.g., New pt. walk in intakes versus intakes)

**Step 2:** Gather the team members involved in the process (including clinical, admin., finance, & MIS/IT staff).

**Step 3:** Create a preliminary flowchart by walking through each step in the process. Define for each step what data is collected, the form(s) completed, how long it takes, & how the step is billed/paid for.

# Steps to Conducting a Workflow

**Step 4:** If the process is complex determine who you need to observe & interview.

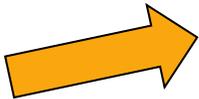
**Step 5:** Conduct the observations & interviews.

**Step 6:** Evaluate which steps in the process need to change & develop Plan-Do-Check/Study-Act Cycles to monitor effectiveness.

# The Process Workflow Map



A rounded rectangle is used at the beginning of a process, with the word “start” inside and at the end of a process with word “end” inside. It is not used for any other reason.



Arrows represent direction and sequence between process steps.



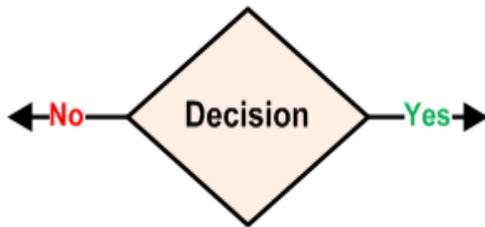
Put a **single** step inside of a rectangle. You should not put more than one step in a rectangle.

# The Process Workflow Map



Use a circle to indicate that you need to “go to” another process or page to where it continues someplace else.

Use a diamond for all decision points or questions. Place the question or decision inside of the diamond.



From the diamond, you can branch in multiple ways, depending on the nature of the decision or question.

# Remember!

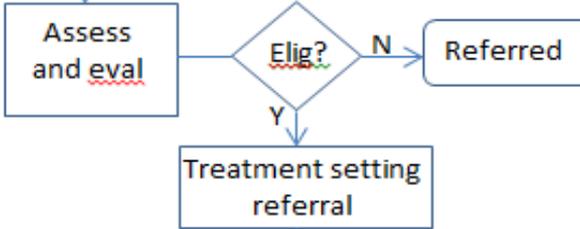
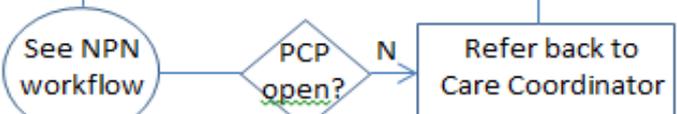
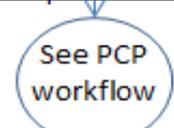
Have a parking lot list for items that come up that need to be followed up on later (e.g., “that form we use in this step is awful we need to rewrite it...”).

See the “sample business process workflow” that accompanied this power point presentation.

Most importantly have fun and ask questions.

The next slide shows an example of a work flow.

**Process: New patient, Central Intake, Screening and Referral to PBHCI for Eligibility Assessment, sees Primary Care Provider**

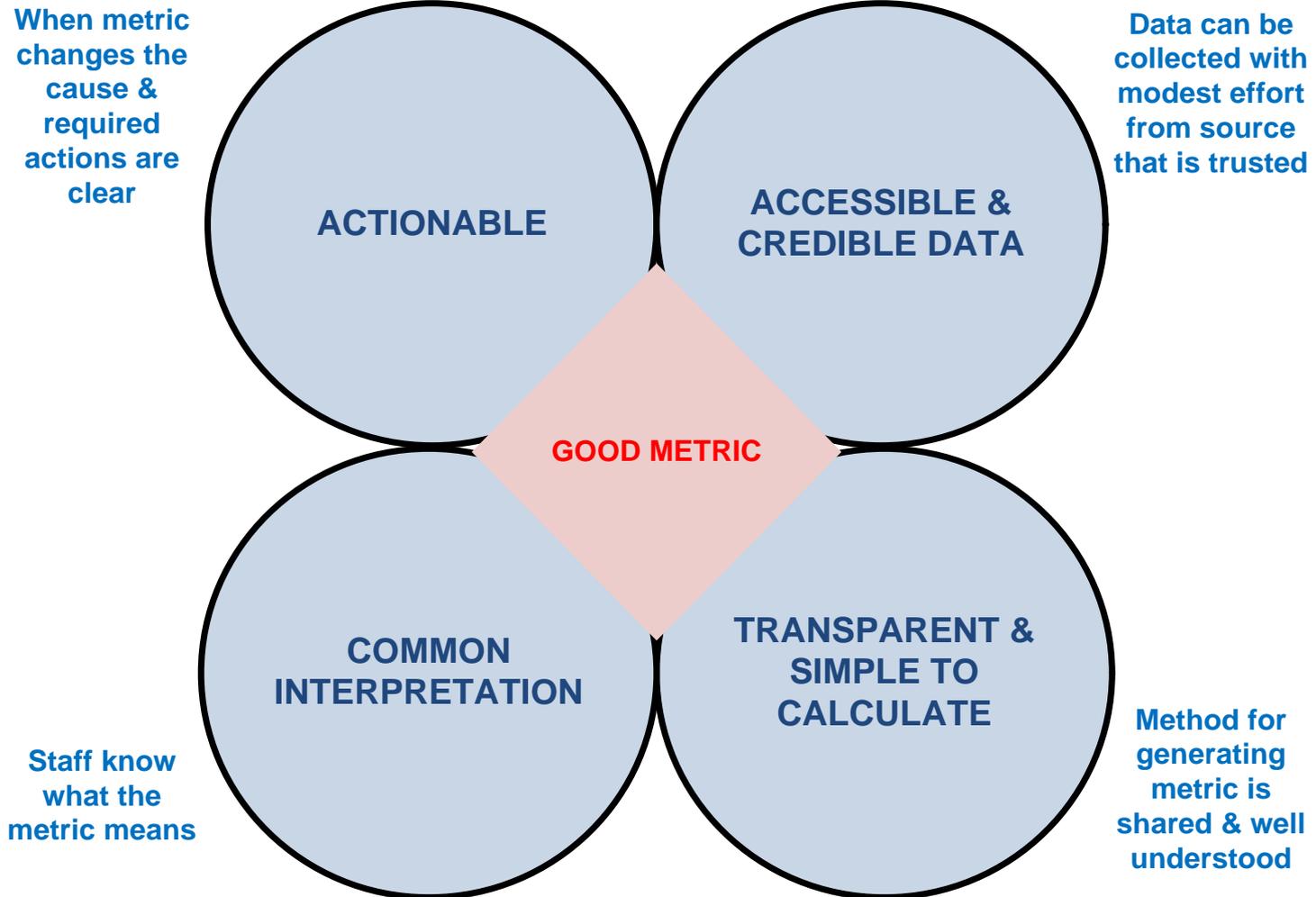
ROLE	ACTIVITY
New Patient	
Intake Director	
Intake Counselor	
Primary Clinical Counselor	
Care Coordinator	
Nurse Practitioner	
Primary Care Provider	

# Why is the Use of Data for Clinical & Administrative Decision Support so Difficult?

“The main reason seems to be a lack of integration of (data) health IT into clinical workflow in a way that supports the cognitive work of the clinician and the workflows among (partner) organizations, within a clinic and within a visit.”

Carayon & Karsh, (2010). AHRQ Publication No. 10-0098-EF

# Choosing a Good Metric/Key Performance Indicator



Source: Gemignani & Gemignani

# PHM Measures Must have *Specifications*

The measure specifications will provide the following:

Brief measure description

Definition of measure numerator.

Definition of measure denominator

Exclusions to measure, if applicable

Description of report periods

Tables detailing the dx and billing codes

## Components of PHM:

1. Knowing what to ask about your population
2. Data registry describing your population
3. Engage in CQI Process to respond to the findings
4. Use Dashboards for making data understandable

# Data, Information, & Knowledge

## What is data?

- Granular or unprocessed information

## What is information?

- Information is data that have been organized and communicated in a coherent and meaningful manner

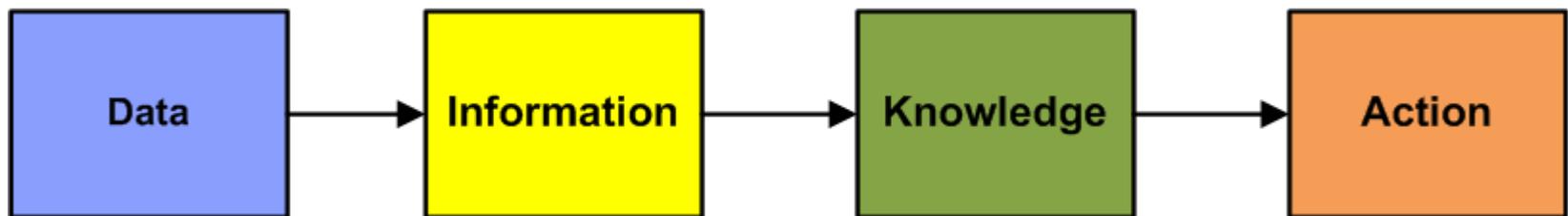
## What is Knowledge?

- Information evaluated and organized so that it can be used purposefully

# What is the ultimate purpose of collecting & sharing data?

*To turn it into action!*

*(AKA Continuous Quality Improvement)*



## Components of PHM:

1. Knowing what to ask about your population
2. Data registry describing your population
3. Engage in CQI Process to respond to the findings
4. *Use Dashboards for making data understandable*

# What is a Dashboard?

- A dashboard translates your organization's strategy into metrics that provide timely information and insights that enable staff to proactively improve decisions, optimize processes, and plans.
- In short it, enables staff to monitor, analyze, and manage their work.

Performance Dashboards: Measuring, Monitoring, & Managing Your Business. 2nd Edition 2011 Wayne Eckerson

# How to use a Dashboard

1. Monitoring: Convey information at a glance
2. Analysis: Identify exceptions & drill down to details
3. Management: Improve alignment, coordination, & collaboration

Source: Performance Dashboards: Measuring, Monitoring, and Managing Your Business.  
2nd Edition 2011 Wayne Eckerson

# Dashboards

- Should allow the data to tell a story about the people you serve & the care provided
- Should be “simple” to Start--target only a few key aspects of population & their care
- Should be Colorful--use red, yellow, green to draw the eye

# Basic Dashboard...

## Health Outcomes by Provider

EHR Patients January - December 2007

Smith MD, John

Community Health Center

Measure	Dec-07 Smith MD, John	Dec-07 CHC	Stoplight Analysis			
			Variance from CHC	Dec-07 Alliance	Variance from Alliance	
			Variance:	Better than	Within 5%	Worse 5%+
<b>HDC Diabetes Metrics</b>						
1 Diabetes Patients	49	401		1,880		
2 A1c Values 2 or more, >=91 days	65%	50%	31.6%	47%	39.1%	
3 Average A1c Value	7.8	7.8	0.0%	7.9	-1.3%	
4 A1c value 1 or more (%)	90%	89%	1.4%	89%	1.3%	
5 Self Management Goal (%)	35%	38%	-8.5%	12%	194.0%	
6 ACE Inhibitor or ARB (%)	87%	78%	11.8%	70%	23.9%	
7 Statins (%)	79%	61%	29.3%	52%	53.4%	
8 Blood Pressure Value (%)	100%	100%	0.5%	100%	0.3%	
9 Blood Pressure less than 130/80 (%)	37%	28%	33.3%	41%	-11.2%	
10 LDL value (%)	82%	73%	12.5%	60%	35.5%	
11 LDL less than 100 (%)	50%	52%	-4.3%	45%	12.0%	
<b>Preventive Care Metrics for General Population</b>						
1 # Patients	212	2,675		14,637		
2 % Visits With Blood Pressure	78%	73%	7.3%	88%	-11.2%	
3 % Women 50-69 With A Mammogr	83%	68%	22.1%	55%	52.6%	
4 % >=50 Screen for Colorectal Canc	3%	9%	-67.5%	8%	-60.9%	
5 % >=50 With Influenza Vax	39%	18%	112.1%	18%	114.3%	
6 % >=65 With Pneumo Vax	87%	59%	46.7%	26%	233.9%	
7 % w/LDL	65%	44%	46.1%	30%	114.6%	
8 % w/LDL With Last <130	80%	72%	10.2%	68%	16.2%	
9 % w/Smoking Status	80%	58%	38.8%	44%	83.0%	
10 % Smokers w/ Cessation Interv	41%	56%	-27.1%	48%	-15.8%	

# Basic Excel Dashboard

Pt ID	Age	Gender	Race	Axis I	Axis III	PCP	PCP seen last 6 months? (Yes/No)
345245	45	M	White	295.30	250.00	Smith	Yes
867594	50	F	Black/ AA	296.34	250.00	Doe	Yes
948728	34	T	White	296.54	250.72	Jones	No
430284	44	F	Asian	295.30	250.72	Catcher	No
684950	22	M	Asian	296.34	250.72	Smith	No

# Why is this important?

- Improve Quality of Care
- Requirements of the grant
- Outcomes support the work we do
- Data can help change behavior
- Improves quality of care – ex: med compliance – data to help pt's choice, patient awareness of mood, data to help
- PCP with med management



# Open Discussion – Your Experiences Implementing Screening, Brief Intervention and Referral to Treatment



# RESOURCES

*SAMHSA-HRSA Center for Integrated Health Solutions*

<http://www.integration.samhsa.gov/clinical-practice/SBIRT>

[http://www.integration.samhsa.gov/sbirt/SBIRT\\_Factsheet\\_ICN90408\\_4.pdf](http://www.integration.samhsa.gov/sbirt/SBIRT_Factsheet_ICN90408_4.pdf)

<http://www.samhsa.gov/sbirt>

<http://store.samhsa.gov/product/TAP-33-Systems-Level-Implementation-of-Screening-Brief-Intervention-and-Referral-to-Treatment-SBIRT-/SMA13-4741>

# RESOURCES

## Team Based Care Toolkit

[http://www.integration.samhsa.gov/workforce/team-members/Cambridge\\_Health\\_Alliance\\_Team-Based\\_Care\\_Toolkit.pdf](http://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf)

## Two articles on Workforce Competencies for BH working in PC

[https://integrationacademy.ahrq.gov/sites/default/files/AHRQ\\_AcadLitReview.pdf](https://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf)

<http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf>

## National Council Resources

<http://www.thenationalcouncil.org/consulting-best-practices/areas-of-expertise/>