



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Welcome to Your Regional Meeting!!

# Tuesday

**8:30 – 8:45am Welcome/Recap of Day 1**

**8:45 – 9:00am Q & A with TRAC Help Desk**

**9:00 – 9:45am Ensuring a Person-Centered Approach to Establishing Health Goals**

**9:45 - 10:00am Stretch Break**

**10:00 –12:00pm Measuring Sustainable Change**

**12:00 – 1:00pm Lunch (on your own)**

**1:00- 2:45pm Demonstrating Value**

**2:45 – 3:00pm Wrap-up**



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Ensuring a Person Centered Approach to Establishing Health Goals

# Today's Goal

Demonstrate tools PBHCI grantees can use to enhance everyone's skills in working with individuals to set person-centered HEALTH goals that activate self-management.

- IMPACT Goal Setting *Cheat Sheet*
- IMPACT Presentation
- Sample IMPACT Role Play



# Engagement verses Activation

- An example of “engagement” is meeting with your doctor
- “Activation” is what you do after leaving your doctor’s office
- New health behavior increases with activation of self-management, especially with chronic conditions

Three keys to activate self-management include:

1. Person-centered planning based on existing strengths and supports
2. Writing an IMPACT goal resulting from person-centered planning
3. Implementing weekly actions plans to break goals into small successes

# Writing an IMPACT goal

## Creating a Whole Health Goal with **IMPACT**

A goal is something we want and are willing to work for. We do the work because of the benefits that come from accomplishing the goal. It is the potential benefits that motivate us to act.

Create a whole health goal that is concise, easy to review and will ultimately lead to success in creating new health habits. Does your goal statement answer these six IMPACT questions?

### **I** mprove

Does accomplishing the goal improve the quality of my health and resiliency?

### **M** easurable

Is the goal objectively measurable so I know if I have accomplished it?

*For something to be measurable, it usually has to state an amount — how much, how often or how many one wants.*

### **P** ositively Stated

Is it positively stated as something new I want in my life?

*It is more motivating to work toward getting something that you want than focusing on something that you want to get rid of, avoid or change.*

### **A** chievable

Is it achievable for me in my present situation and with my current abilities?

*If you do not think your goal is achievable within the given time frame, you can either lower the scope or change the time frame.*

### **C** all forth Actions

Does it specify actions that I can take on a regular basis to create healthy habits or a healthier lifestyle?

*A goal is something you work to achieve over a period of time; therefore there are actions you can take to achieve your goal.*

### **T** ime Limited

When do I plan to accomplish my goal?

*The goal needs to be stated so that you know by when you plan to accomplish it.*

If you answered 'no' to any of these questions, then revise your goal so it meets all six criteria for IMPACT.

This document was developed for SAMHSA Primary and Behavioral Health Care Integration grantees by the SAMHSA-HRSA Center for Integrated Health Solutions. Visit [www.integration.SAMHSA.gov](http://www.integration.SAMHSA.gov) for more tools and resources on setting health goals.

# Creating New Health Behavior

## How to set a health goal with **IMPACT**

A goal is something we want and are willing to work for. We do the work because of the benefits that come from accomplishing the goal. It is the potential benefits that motivate us to act. A whole health goal that is concise, easy to review, and will ultimately lead to success in creating new health habits meet these six **IMPACT** criteria:

**Improve**  
**Measurable**  
**Positive**  
**Achievable**  
**Call forth Actions**  
**Time Limited**



# Weekly Action Plans

Learning to create a **weekly action plan** that helps a person reach his or her whole health goal is crucial to success. The actions must be healthy and such that a person can engage in them multiple times a week.

## **ACTION PLANS FOR GOALS THAT REQUIRE DEVELOPING A NEW BEHAVIOR, HABIT, OR LIFESTYLE**

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While the actions in the weekly action plan may vary from week to week, the actions need to relate to the set goal and consist of healthy behaviors that create a new discipline in one's lifestyle. Remember, the action plan needs to be something that the person wants to do and can expect to do during the next week. The action plan needs to focus on what a person is creating that is new and is helping him or her move in the desired direction, not changing or eliminating what is "wrong." Don't focus on bad habits. That gives these habits power.

# Examples of Weekly Action Plans

## Stress Management:

- 1) What will you do? **I will practice the Relaxation Response**
- 2) How much will you do? **10 minutes**
- 3) How often will you do it? **Four days this week**
- 4) When will you do it? **Before I go to work**

## Healthy Eating:

- 1) What will you do? **I will eat fruits and vegetables**
- 2) How much will you do? **Three servings of fruits and/or vegetables**
- 3) How often will you do it? **Three different days this week**
- 4) When will you do it? **At lunch and/or dinner**

## Physical Activity:

- 1) What will you do? **I will walk**
- 2) How much will you do? **One-half mile**
- 3) How often will you do it? **Three times this week**
- 4) When will you do it? **After work and before dinner**



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Applying the Continuous Quality Improvement Process to the PBHCI Initiative

# **Primary Goal: Assist organizations to solve problems and systematically implement improvement strategies**

## Topics covered

- Defining quality
- Continuous Quality Improvement (CQI) Framework

# What is quality? Anything you do to improve...

- Safety
- Effectiveness
- Client-Centered
- Timeliness
- Efficiency
- Equity
- Appropriateness
- Coordination
- Accessibility

# Edward Deming Process Management Theory:

***“ ... the best way to reduce costs  
is to improve quality”***

# First Law of Quality Improvement

**“Every system is perfectly designed to achieve exactly the results it gets”**

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# The Clinical Pathway & Staff Workflow

# The Clinical Pathway

**Where Evidence-based, Best or Promising Clinical Practices & Administrative Processes are Expressed in the Staff Workflow**

**&**

**Where the Consumer's Recovery Plan is 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.

# Variation = Waste = Poor/Expensive Care

The degree to which a clinic can work as a team and standardize clinical and admin. processes to reduce variation/waste will determine the quality of care provision and financial sustainability of the clinic

Measuring processes and resulting outcomes is the only way to determine if a process is efficient and effective (or variable and wasteful)

# Standardization & Measurement

# Measuring the Components

Evidence-based/Best/Promising Practice  
+ Treatment & Care Process Targets  
+ Standardized Clinical/Admin. Workflow  
**= Actionable information in the  
form of Clinical &  
Administrative Outcome  
Metrics**

# 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.

# 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 swim lane 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.



# ***Analytics at Work: Smarter Decisions Better Results***

by Davenport, Harris & Morison

**D** for accessible, **high-quality Data**

**E** for an **Enterprise** orientation

**L** for analytical **Leadership**

**T** for strategic **Targets**

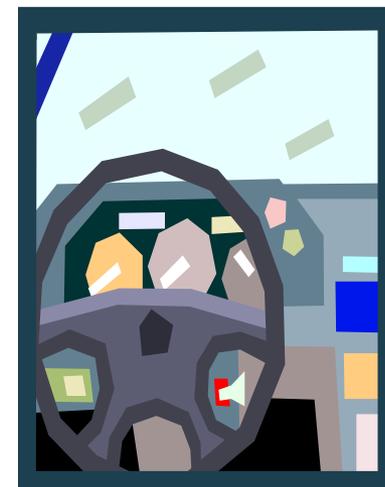
**A** for **Analytical** talent

# PHM In Four Steps:

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

# Dashboard Data Elements

- **Cost:** Service Utilization, Case Rates, etc.
- **Operations:** No Shows, Insurance Mix, etc.
- **Staff Work Plan:** Performance on Scope of Practice Tasks
- **Clinical:** Labs, Assessment/Screening Results, Vitals, etc.
- **Care Coordination:** Medication Reconciliation, etc.
- **Benchmark Comparisons:** Between Organizations, Clinicians, Teams, etc.
- **Risk Cutoffs:** Reveal when data are out of specification (e.g., A1c > 6)



# Simple Bundling Logic Model

Demographic & Condition	Level of Service Criteria/Cost	Service Bundle	Length of Care/ Time to Tx	Target Parameters
<p>Adult</p> <p>Male</p> <p>Substance Addicted</p> <p>High Blood Pressure</p> <p>Unemployed</p> <p>Homeless</p>	<p>Low Intensity</p> <hr/> <p>Moderate Intensity</p> <hr/> <p>High Intensity</p>	<p>Medication Services</p> <p>Care Management</p> <p>Supported Employment</p> <p>Smoking Cessation Services</p> <p>Housing Services</p>	<p>Low Intensity 0-9 Months</p> <hr/> <p>Moderate Intensity 9-12 Months</p> <hr/> <p>High Intensity 12 -18 Months</p>	<p>DLA 20 Target</p> <p>Smoking Cessation</p> <p>BP w/in Normal Range</p> <p>Engagement/ Willingness to take Medication</p> <p>Appt Kept Rate</p> <p>Hosp. &amp; ED Use</p> <p>Employment</p> <p>Housing Status</p>

# Case Rate Example

**Choose Condition:** High Blood Pressure (BP)

**Define Population:** Diagnosis, Screening/Assessment Scores

**Define Services:** BP Screening at intake/quarterly; Referral & Coordination w/ Primary Care & Pharmacy

**Episode Length of Time:** 9 months

**Calculate Cost:** How much on average would it cost to treat this episode of care?

# Case Rate Example

**[Total Cost divided by (Number of Patient Days in an Episode x Number of Patients)] times 365**

**Total Cost for High BP Care Coor: \$50,000**

- Number of Patient Days in an Episode: 180
- Number of Patients: 100/year
- Case Rate Per Member Per Day: \$3 PMP Month: \$84  
PMP Year: \$1014

Source: Adapted from R. Manderscheid; Talk Titled: Intro. to Case Rates & Capitation Rates

# Application of Basic Continuous Quality Improvement Approaches

## FOCUS PDCA

**F**ind an improvement area

**O**rganize a team

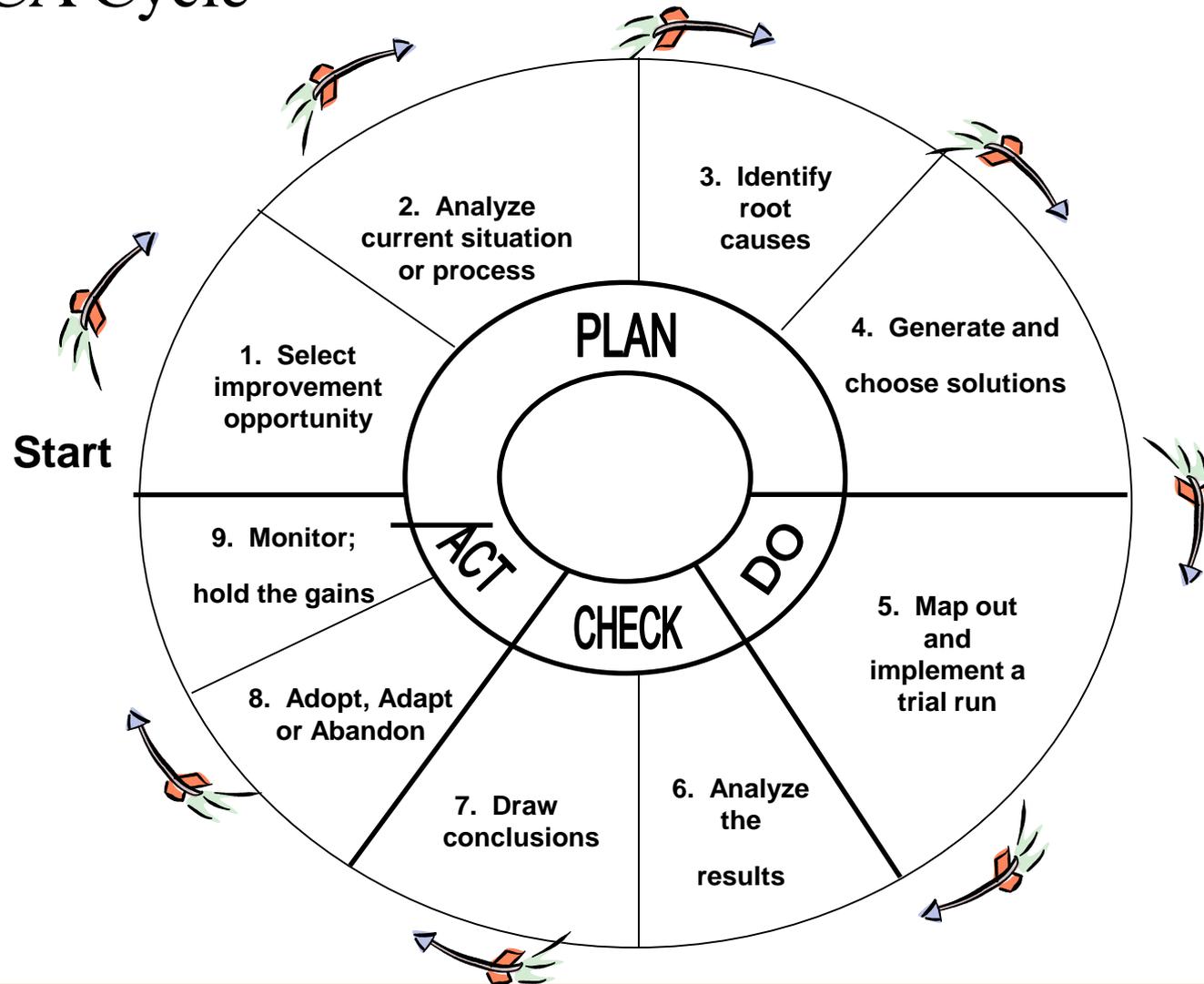
**C**larify current practices

**U**nderstand source of variation/problem

**S**elect a strategy

**Plan Do Check Act**

# PDCA Cycle



# Brief update on TRAC:

- IPP data is migrated from CDP. Westat will be sending grantees (and GPOs) files showing what they were able to enter, what had problems and needs grantee help, and for the grantees to see if anything is missing that should be there.
- Westat is in the process of entering DCI paper forms into TRAC. It is taking them longer than expected.
- Grantees should contact the Helpdesk if they have problems. If the problems do not get resolved, I can intervene.
- All training for IPP data, client services data and TRAC is being provided by Westat - - not GDTA.

# Brief update on TRAC:

- Grantees should contact the Helpdesk if they have problems. If the problems do not get resolved, I can intervene.
- All training for IPP data, client services data and TRAC is being provided by Westat - - not GDTA.
- There are no locks on the TRAC system, so grantees can continue to enter.
- Grantees still cannot enter follow-up data if the baseline data is not in TRAC. They can enter any new clients into TRAC or follow-ups if the baseline is in TRAC. This is a priority for Westat