# Integration Efforts to Support Whole Person Care in Minnesota

<table>
<thead>
<tr>
<th>Health Care Homes (HCH)</th>
<th>Behavioral Health Home services (BHH)</th>
<th>Certified Community Behavioral Health Clinics (CCBHCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN’s version of the “patient centered medical home”</td>
<td>MN’s federal “health home” benefit for medical assistance enrollees with serious mental illness</td>
<td>A federal demonstration project in which MN was 1 of 8 states selected to participate</td>
</tr>
<tr>
<td>Part of MN’s 2008 Health Reform Legislation with the first clinic certified in 2010</td>
<td>State Plan Amendment (SPA) was approved by CMS on March 21, 2016 and implemented effective July 1, 2016</td>
<td>Two year demonstration project July 1, 2017-June 30, 2019</td>
</tr>
<tr>
<td>Over 350 certified Health Care Homes (56% or primary care providers)</td>
<td>25 certified BHH services providers</td>
<td>6 certified community behavioral health clinics participating in the demonstration project</td>
</tr>
<tr>
<td>Person-centered, team based approach to primary care engaging patients/families as partners in their care</td>
<td>Comprehensive whole person approach delivering federally required services</td>
<td>Required to provide a range of culturally competent mental health, substance use disorder services, and primary care screening with coordination across the spectrum of care</td>
</tr>
</tbody>
</table>

© ICSI 2018 | www.icsi.org
Why we are here.
Integrated/Coordinated Care

- Primary Care Provider & Coordinator
- Public Health Nurse
- Specialty Care
- Behavioral Health
- Hospital
- Lab, Radiology, Pharmacy
- Nurse Educators
- Care Guides
- RN Care Coordinator

Patient
Centers of Excellence

Physical Health

Mental Health

Social Services
Whole Person Care Model

Source: National Approaches to Whole-Person Care In the Safety Net – March 2014. California Association of Public Hospitals & Health Systems and the California Health Care Safety Net Institute
Five Elements - Whole Person Care Complex Model

- **Care Coordination**
  - Deals directly with the patient
  - Develops personalized care plans
  - Integrates multidisciplinary teams

- **Multidisciplinary HealthCare Team**
  - Approach patient care as a team
  - Seamless hand-offs among care providers

- **Care Collaborators**
  - Nonmedical entities
  - Personal care needs

- **Informatics**
  - Health risk assessment tool
  - Remote patient monitoring, emergency signaling
  - Stratification and predictive modeling Workflow and notifications
  - Accessible patient information systems

- **Incentive Structure**
  - Single accountable entity
  - Organization preventive health, behavioral health, and long-term care
  - Individual level: care coordinators, care team

We know what “success” can look like

“

We are asking people to participate in meetings that don’t naturally occur, to make changes that may not align with our interests and take risks with uncertain rewards.”

ICSI Member 2018

It’s not the WHAT.

It’s the HOW.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Start*</th>
<th>End*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome &amp; Program Overview</td>
<td>9:00</td>
<td>9:10</td>
</tr>
<tr>
<td>Setting the Stage</td>
<td>9:10</td>
<td>9:30</td>
</tr>
<tr>
<td>Networking – Table Introductions</td>
<td>9:30</td>
<td>10:00</td>
</tr>
<tr>
<td>BREAK</td>
<td>10:00</td>
<td>10:10</td>
</tr>
<tr>
<td>The Science of Improvement</td>
<td>10:10</td>
<td>11:00</td>
</tr>
<tr>
<td>Speed Networking</td>
<td>11:00</td>
<td>11:30</td>
</tr>
<tr>
<td>Time</td>
<td>11:30-12:30</td>
<td>12:30-1:15</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS and MDH Q&amp;A - Panel Begins at Noon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision &amp; TRIZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15% Solutions &amp; Cultivating Next Steps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrap Up and Close</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Networking – Table Introductions

• Introduce Yourself
  • Name
  • Organization
  • Role

• How is your organization integrating “whole person care”?

• What brought you here today?
Morning BREAK
The Science of Improvement: Influencing and supporting change
We know what “success” can look like - recap

It’s not the WHAT.

It’s the HOW.

“We are asking people to participate in meetings that don’t naturally occur, to make changes that may not align with our interests and take risks with uncertain rewards.”

ICSI Member 2018
What comes to mind when you hear “quality improvement?”
• **Getting to work**
  – Goal: On time
• **Getting to work**
  – Goal: On time

• **Cooking / recipes**
  – Goal: Tastes good, doesn’t take too long
• **Getting to work**
  – Goal: On time

• **Cooking / recipes**
  – Goal: Tastes good, doesn’t take too long

• **Family routines**
  – Everything gets done, everyone is happy
How culture affects improvement

We are more likely to test and accept changes at home, than at work.

Home = Safe  
Work = Risk/Consequences
What might be some improvement work you want to do?

• Care coordination and seamless transitions
• Adapting “best practice” or “promising practices”
• Providing additional services
• Forming partnerships
• Educating staff and providers
• Certification
• Contracts
Technical Challenges

• Problem well defined
• Implementation is clear
• Value of “expert” to provide answer
• Answer can be found within present structure
Adaptive Challenges

Complex Issues Require Change in

HABITS
ATTITUDES
VALUES
The most powerful tool in improvement = thoughtful conversation
Begin with the Experience in Mind

<Who/noun> needs a way to <what/verb> because <why>?
<Who/noun> needs a way to <what/verb> because <why>?

Samples:

• **Providers** need a way to comprehensively assess their patients so they can ensure they can develop a care plan that addresses the “whole person”

• **Patients** need a way to access services quickly so they maintain wellbeing

• **Staff** need a way to know what services the patient’s insurance pays for so they can help get them to the right resource.
Problem: Corrosion

1. Harsh Cleaning Products
2. Pigeon Poop
3. Spiders
4. Mites
5. Lights

Solution: Change the Lighting
Where to start?

You may have many possible solutions

• All ideas have value

• You’ve likely tried some of those ideas already

• Avoid paralysis
<table>
<thead>
<tr>
<th>Gain</th>
<th>Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big Gain / Low Effort</td>
<td>Big Gain / High Effort</td>
</tr>
<tr>
<td>Small Gain / Low Effort</td>
<td>Small Gain / High Effort</td>
</tr>
</tbody>
</table>
The Model for Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act → Study → Do → Plan → Act

The Model for Improvement

What are we trying to accomplish?

Aim/Objective

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

I want to do <what> by <when>. 
By <this date>,
we will <increase or decrease> <what>,
for <for whom>,
by <how much>.

• By September 30, 2018, we will increase our “connection rate” for patients with depression by 10%.

• By next Tuesday, I will set up coffee with one potential partner organization.
What change can we make that will result in improvement?
hy-poth-e-sis
noun

A supposition or proposed explanation made on the basis of limited evidence as a starting point for further investigation.
What is your hypothesis?

I think if I do this (______________), then this (______________) will happen.

Example:

I think if we create a partnership with Public Health, then our patients would have faster access to community services.
What small change will you TEST?
Plan
What change are you going to make? How will you do it? What is your hypothesis about what will happen?

Do
What actually happened – what did you observe?

Study
What did you learn? Did what you thought would happen actually happen. What worked, what didn’t?

Act
What will you adopt, adapt, or abandon for the next round?
Adopt, Adapt, or Abandon

**Adopt:**
What did we see that we should keep doing?

**Adapt:**
What did we see that has potential if we did it differently?

**Abandon:**
What did we see that we DO NOT want to do again?
A Repeating Process

Changes That Result in Improvement

Learning & Improvement

Data

Predictions, Theories, Ideas
How long is a cycle?

Small test of change cycles are short:

- A single incident/encounter
- An hour
- A day
- A week
Lessons From Puzzle Activity

• *Safe* to try something new

• Improvement comes from *testing* and *learning*

• Process greatly enhanced by *collaboration*

• Ok to *adopt* what works, *abandon* what doesn’t and *adapt* something that has potential

• *Failure can be an option*, when the test is small
“Testing a change on a small scale actually speeds up the pace and increases the impact of improvement.

• People are less resistant to a test than large-scale implementation
• Fewer people involved in a small-scale test
  —Less logistics to be planned
• Problems can be identified and corrected early on”

Source: Berman, S. Accelerating the Pace of Improvement: An interview with Thomas Nolan.
How will we know that a change is an improvement?
Types of Measures

Outcome Measure (what): What are you **ultimately** trying to do?

Process Measure (how): Are you doing the right things **to support** getting there?

Balancing Measure (unintended consequences): Are the changes you are making causing problems in other areas?
Measures Sample

**Outcome Measure (the big what):** # of patients who reached remission, with a PHQ-9 result less than five, six months (+/- 30 days) after an index visit.

**Process Measure (test of change measure):**
- # of patients with PHQ-9 given within +/- 30 day window.
- # of patients who were referred to therapy or prescribed meds at index visit.

**Balancing Measure (unintended consequences):** Amount of time spent by care coordinators to track and follow-up on patients with depression and other chronic conditions.
Tips About Measurement for Improvement

• Seek usefulness, not perfection
• Use small, frequent sample sizes
• Don’t wait for the information system
  • Pen and paper, quick surveys
• Use qualitative and quantitative data
  • Thoughtful conversation and reflection has value (e.g. “Is this working for you?” “On a scale of 1-10, how confident are you....”)

© ICSI 2018 | www.icsi.org
Reflect
Speed Networking

• Introduce Yourself
  • Name
  • Organization
  • Role
• What’s an answer/solution you have learned about enhancing Whole Person Care?
• What partnership or resources are you curious about/seeking?
• What’s your “burning question?”
Speed Networking - Logistics

- The group forms two lines/circle
- Face a partner in the other line/circle
- Three minutes to exchange info, then rotate when you hear the chimes.
- One line remains stationary (still)
- One line shifts one spot to the right (move)
- Repeat
LUNCH
11:30 – 12:30
MDH/DHS Panel begins & 12:00
Collaborative Communication: Embracing a “Yes, and…” Culture
We can’t do it alone

“How do I get them to buy-in?”
Buy-in:

Someone else, or some group of people, has done the development, the thinking and the deciding, and now they have to convince you to come along. *You are being sold their idea* -- so that you can implement their idea without your involvement in the initial conversations or resulting decisions.

Ownership:

You are a stakeholder of an idea, a decision, an action plan, a choice; you have participated in its development; *it’s a choice you freely made.*

Source: Lisa Kimball - www.groupjazz.com
Team (noun):
a group of people who work together at a particular job

Oxford Dictionaries
Traditional Teams:

- **Care Team** (provider and nurse/MA or unit)
- Leadership/Management Team
- Quality Improvement Team
- Department/Work Unit
Healthcare today

- Triple Aim
- Health Care Home
- ACO/ACC/IHP
- MACRA
- Value Based Contracting
- Pay for Performance
- Care Coordination
- Community Engagement
- Transformation
Teams in Healthcare

Triple Aim Era Teams:

• “Team Based Care” (care team + care coordinators, PHN, RN specialists)

• Health vs. Health Care (patients as part of the team, community engagement partnerships)
Team (verb):
To come together [as a team] to achieve a common goal
• Target Model
• Fundraising Team
• Annual Meetings
• Hospital Janitor
Wanted: Collaboration

How do we work together to achieve shared goals?

- Designing new systems
- Smooth transitions for patients
- Partnerships between organizations to coordinate care
- Notifications and feedback loops
- Patient self-management plans
- Staff engagement/ownership for new initiatives
A model for teamwork culture – outside of healthcare
“improvise”

to compose, or simultaneously compose and perform, on the spur of the moment and without any preparation; extemporize
Improvisational Theater / Jazz

• No script / sheet music
• Highly interactive
• Requires listening and mindfulness (flow state)
• Produce a product that would not be created alone
• Takes practice
Avalanche Scene to Rap
How do they do that?

Exceptional Teamwork

Unbridled Collaboration
7 Rules of Collaborative Communication
Rule 1 - Trust

Trust your partners and yourself

• You are enough.

• Assume good intentions.

• Believe the people you are working with are the best people you can be working with right now.

• Create an environment of safety.
Don’t negate or deny your partners

• Saying “no” stops the flow and stunts ideas.

• Ideas are “gift” and “offerings”.

• Goal: Honor and validate.
Rule 3 – Give and Take

Be flexible in your role

• Sometimes you are the leader, other times a supporter, sometimes a follower.

• Power is easily and willingly handed among trusted partners.

• LET EACH OTHER SHINE!
Rule 4 – Know your environment

Be aware of what’s going on around you

• Listen, watch, concentrate.
• Be here now.
• Seek to understand how others are feeling and what they are non-verbally communicating.
• Be ready to jump in and help.
Rule 5 - Make Each Other Look Good

Be trusted partners

• Don’t let those around you fail.
• Jump in and help.
• Their success benefits everyone.
Keep things moving

• Movement encourages creativity.
• Don’t dwell on where you are or where you have been.
• Move the problem forward toward resolution.
• Make changes when you are stuck.
Work to the top of your intelligence

• Be innovative and creative.
• Stay true to the mission.
Tools for working together in any environment

- Trust
- Yes, and…
- Give and take
- Environmental awareness
- Letting each other shine
- Making actional choices
- Working to the top of your intelligence
We already use these skills*

Rules of “Brainstorming”:

• Creativity welcome
• No bad ideas
• No judgment - Safe environment
• Think big!

*reserved for off-site retreats or special circumstances
Activity

1. “No, but...” + Universal Not Face
Activity

1. “No, but...” + Universal Not Face

2. Yes, And...
Leadership tensions in the shift

**FEE FOR SERVICE**
- Structure & Familiar
- Personal expertise
- Script
- Results & Systems

**VALUE BASED CARE**
- Agility & New/Different
- Team with other skills
- Improvise
- People – inclusion, teaming

The Next Generation of Healthcare Leadership – New demands in the shift to Value Based Care. Korn Ferry. 2017
Collaborative Communication

• Seek to validate and honor

• Create an environment of safety where people can
  • Be heard
  • Feel supported
  • Can test ideas, when appropriate

• Keep moving forward
Vision & TRIZ
• It’s 2020 and you’ve realized your vision of fully integrated whole person care for individuals. Communities and workplaces are supporters of physical, mental, and social wellness and the concept of health is embraced as not just merely the absence of disease or illness. Individuals have access to the array of physical, behavioral and social supports they need, when they need them. Providers, care teams, partners, and communities have the training, resources and support they need to contribute to a healthy community.
• What does it feel like?
• What do you see around you?
• How would your staff describe the culture?
• How do the physicians describe the culture?
• Do patients see or feel a difference?
Step 1: In a serious spirit of fun….

Make a list of everything you could do to sabotage your vision.
Step 1: In a serious spirit of fun….
Make a list of everything you could do to sabotage your vision.

Step 2: Is there anything on the list that resembles your current practice?
Step 1: In a serious spirit of fun…. Make a list of everything you could do to sabotage your vision.

Step 2: Is there anything on the list that resembles your current practice?

Step 3: Create your plan to achieve or avoid the “what not to do” items in step 2.

- Is there anything you could address and create a plan around for improvement?
- What opportunities do you see for improved collaboration (what’s not happening now that’s impeding whole person care)? How could we partner better?
Afternoon BREAK
Assume that 85% of what happens is out of your control.

What is your 15 percent?

Where do you have discretion and freedom to act?

What can you do without more resources or authority?
Next Steps – Crafting a Plan

Improvement Planning Worksheet

- OPPORTUNITY
- AIM/GOAL
- HYPOTHESES
- MEASURES
- **Action:** By next Tuesday I will...
What can we do by next Tuesday?
Integrating Primary Care and Behavioral Health
June 19 Regional Meeting – Mankato.

Minnesota Department of Health
Minnesota Department of Human Services