Making the Numbers Count: How Do We Know If Integrated Care Works and Who Cares?

Becky Hayes Booher, PhD
Senior Program Officer
Maine Health Access Foundation
• “Change is disturbing when it is done to us, but exhilarating when it is done by us.”
  – (Elizabeth Moss Kanter, Professor, Harvard Business School)
Change starts with information
Data’s Role (Today’s Discussion)

- Initiative Evaluation Overview
- Quality Improvement
- Population Health
- Patient Care
- Informing Policy
Evaluation Overview

“Torture the data and it will confess to anything.”

Ronald Coase, Nobel Prize Laureate in Economics

• (English major in me: “…and they will…”

Maine Health Access Foundation
Mark Friedman Questions

Performance Accountability Measures

• How much did we do?
• How well did we do it?
• Is anyone better off?

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<thead>
<tr>
<th>How much did we do?</th>
<th>How well did we do it?</th>
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<tr>
<td># Customers served (by customer characteristic)</td>
<td>% Common Measures % Activity-specific Measures</td>
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<td>Is Anyone Better Off?</td>
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<td># Improved Health Outcomes</td>
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Performance Accountability Questions

• Who are our “customers”?  
• How can we measure if our “customers” are better off?  
• How can we measure if we are delivering services/care well?  
• How are we doing on the most important of these measures?  
• Who are the partners who have a role to play in doing better?  
• What works to do better, including no-cost and low-cost ideas?  
• What do we propose to do?
“Customer” Satisfaction

• Did we treat you well?
• Did we help you with your problem? (Are you better now?)
Evaluation Focus

- Performance Accountability Questions
- Population Accountability Questions
- Process and Outcome
What is the story behind these data?

• What are the stories that can influence policy?
Two Kinds of Change Strategies

MODELS

ADAPTIVE INITIATIVES

Tanya Beer, Associate Director
Center for Evaluation Innovation
If implemented correctly and with quality, a pre-determined set of activities can be expected to produce a predictable chain of outcomes over time and in different settings.

Program delivery:
- Client-based interventions
- Training and education
- Capacity building

Dynamic conditions and multiple factors require adaptation along the way, so both the pathway to change and the outcomes themselves may change over time.

- Systems change
- Advocacy & policy change
- Program Innovations
- Emergency Response
Four Stages of Model Development and Scale-Up

Stage 1: Developing the Model
Stage 2: Testing the Model
Stage 3: Testing it in Other Places
Stage 4: Scaling It Up

Matching Evaluation Questions to Model Stage and Scale

Stage 1: Defining the Model
What are the essential parts of the project?
Is the project sufficiently promising?
How does the project need to be refined?
Are we investing enough to delivery the project as intended and with a high level of quality?

Stage 2: Testing the Model in its Original Setting
Is the project effective?
What are the outcomes and impacts?
How do the project’s results compare to other projects we could invest in?

Stage 3: Applying the Model in New Places and Testing it Again
Were the outcomes achieved in the new settings?
What elements need to be refined to fit new contexts?
Does the model produce results across places or populations?

Stage 4: Scaling Up and Continuing to Test & Adapt
What else needs to be learned about effectiveness at scale?
Are we investing enough to maintain high quality in new locations or at a new scale?
Are the outcomes being sustained and expanded?

Evaluation Questions about Adaptive Initiatives

✓ How is the system responding to our efforts now?
✓ Are we triggering new ways of thinking, new patterns of interaction among institutions, organizations, and/or individuals?
✓ What do initial results reveal about expected progress?
✓ What elements merit more attention, investment, or changes?
✓ How have changes in the environment affected our results and the system as a whole?
✓ To what kinds of results, both expected and unexpected, are we contributing?
✓ What has produced the results so far and how can we continue to produce the results we seek?
EXAMPLE: Five Elements of Systems Building

- **Context**: Improving the *political context* that surrounds the system so it produces the policy and funding changes needed to create and sustain it.

- **Components**: Establishing high-performance programs and services that produce results for the target populations.

- **Connections**: Creating strong *linkages* across system components that further improve results for target populations.

- **Infrastructure**: Developing the *supports* systems need to function effectively and with quality.

- **Scale**: Ensuring a *comprehensive system* is available to as many people as possible.
# Expected System-Level Outcomes

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<tr>
<th>Context</th>
<th>Components</th>
<th>Connections</th>
<th>Infrastructure</th>
<th>Scale</th>
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<tr>
<td>• Shared vision</td>
<td>• New system programs or services</td>
<td>• Shared goals</td>
<td>• Cross-system governance</td>
<td>• System spread</td>
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<td>• Leadership</td>
<td>• Expanded program reach or coverage</td>
<td>• Shared standards</td>
<td>• Shared data systems</td>
<td>• System depth</td>
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<td>• Public engagement</td>
<td>• Improved quality</td>
<td>• Shared competencies or skills standards</td>
<td>• Cross-system training and professional development</td>
<td>• System sustainability</td>
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<td>• Media coverage</td>
<td>• Increased operational efficiency</td>
<td>• Seamless services</td>
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<td>• Shifts in system ownership</td>
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<td>• Public will</td>
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<td>• Political will</td>
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<td>• Policy changes</td>
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Model-based strategies are well-suited to many integrated care clinical practices

- Logic models
- Metrics aggregated from individual provider/site reports
- Straightforward “progress dashboards” tracking a fixed set of metrics over time
- Questions about client- or population-level outcomes (once the model is mature)
Sample Integrated Care Logic Model

Participants: Providers and patients in XYZ health system

Resources
- MeHAF funding
- Evidence
- Staff experience

Activities
- Re-design PC delivery
- Train providers
- Screen patients
- Provide MH treatment

Short-term Outcomes
- % providers implementing
- # patients screened → BH
- # patients w/ appropriate treatment

Long-term Outcomes
- PC & BH delivered consistently
- # patients w/ better health
- Pt-centered care

Environmental Context
- Fragmented service delivery
- Inadequate workforce
- Medicaid changes
- Evidence-based practices
Quality Improvement

• Track and give timely feedback on what you want to accomplish.
Evaluation Outcomes

Measures

- Cost and utilization (ED, inpatient and other systems as available)
- Clinical measures of health and functioning
- Stability (e.g., income and insurance enrollment)
- Service intensity (frequency and duration)
- Strength of partnerships and collaborations
- Policy and systems change (evidence of improved coordination, streamlined access, permanent policy changes to address/eliminate barriers)
Information prompts knowledge
Tools

- AHRQ Lexicon—CJ Peek (Handout)
- 6 paradigms with 12 parameters (indicators)
  - A practice team tailored to needs of each patient/situation
  - With a shared population and mission
  - Using a systematic clinical approach
  - Population expecting integrated care as the standard
  - Supported by office practice, leadership, business model
  - Continuous quality improvement and measurement of effectiveness
AHRQ’s New Atlas

• **New Atlas of Integrated Behavioral Health Care Quality Measures**

• A new Atlas of Integrated Behavioral Health Care Quality Measures (IBHC Measures Atlas) can help primary care organizations measure whether they are providing high quality integrated behavioral health care.

Site Self Assessment

• Designed as internal discussion facilitation tool
  – Common definitions and understanding of what IC looks like
  – Onsite Common goals

• Not a cross-site evaluation tool.
• Not validated, but quickly expanding use (AHRQ)
Site Self Assessment

• 10-point scale. Goal is not a 10.
• Use baseline (but anticipate inflated scores)
• Administer again in 6 months
• Administer annually thereafter
• Always include the entire team in discussions
Site Self Assessment

- Emphasis on patient engagement—not just in shared decision making but at planning/implementation systemic decision making as well.
- Emphasis on beyond health care system walls (coordination of care).
## Original Proposed BHI Measures for Maine: Quality Counts Grantee

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39. In the last 12 months, did anyone in this provider’s office ask you if there was a period of time when you felt sad, empty, or depressed?
40. In the last 12 months, did you and anyone in this provider’s office talk about things in your life that worry you or cause you stress?
41. In the last 12 months, did you and anyone in this provider’s office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?
### Compare Practice Ratings

**Effective**

Provides the care that experts recommend

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<th>Diabetes Care</th>
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**Safe**

Has systems to prevent medical errors

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<th>Practice</th>
<th>Systems to track test results, send reminders, avoid medication errors</th>
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**Patient Satisfaction**

What patients say about this practice

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<th>Practice</th>
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**Other Areas of Consumer Interest**

Taking new patients, office hours, health benefit discounts, and other useful information

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<tr>
<th>Practice</th>
<th>Accepting New Patients</th>
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<td>Lisbon Family Practice</td>
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Using Data to Improve Outcomes

ACT
Plan the next cycle
Decide whether the change can be implemented

PLAN
Define the objective, questions and predictions. Plan to answer the questions (who? what? where? when?)
Plan data collection to answer the questions

STUDY
Complete the analysis of the data
Compare data to predictions
Summarise what was learned

DO
Carry out the plan
Collect the data
Begin analysis of the data

MAINE HEALTH ACCESS FOUNDATION
Applying Strategies for Change

• Ask the three questions of PDSA (see handout):
  1. What are we trying to accomplish?
  2. How will we know that a change is an improvement?
  3. What changes can we make that will result in improvement?
Example Plan:

• Improvement Goal: Increase the number of adults screened for common mental health conditions and provide follow-up assessment for all positive screens.

• Plan for Change (who, what, when, where): Identify tool, identify population to screen, identify staff (who?), train staff, map screening and follow-up process (flowchart), develop script, distribute tool

• Plan for Change (test): For example, screen 10 patients per week for one month.

• Small Group—Design PDSA plan for something you can start next week.
My comfort level with data

I know I keep asking you this but could you explain the issue again?

Well, something that you could never comprehend conflicts with something that you'd never understand.

Oh.
The health outcomes of a group of individuals, including the distribution of such outcomes within the group

--Dr. Noah Nesin, PCHC
EHR is Part of the Answer

- Define Panel
- Identify those who need of specific care
  - Those being seen
  - Those not being seen
- Clinical Prompts
- Treatment pathways

--Dr. Noah Nesin, PCHC
**We Have Data!**

--Dr. Noah Nesin, PCHC

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**MASTER Provider Listing ALL PROVIDER INACTIVE AND ACTIVE (Read-Only)**

Microsoft Excel
So What Good Is It?

• Set priorities
• Guide work processes
• Monitor progress
• Inform strategic planning.

--Dr. Noah Nesin, PCHC
MSW Visit Rate – No Shows When Provided In Primary Care

Patient Data

- Total appts
- Therapy sessions
- New Evals
- N/S cancel
Electronic data has its limits!
Five Stages of Data Acceptance

- **Denial:**
  - “These aren’t my patients.”
  - “You’ve missed where I did that.”
  - “My patients are different.”

- **Anger:**
  - “If I had better help…”
  - “I’m busy trying to take care of my patients!”
  - “You’re not in it so you don’t know what it’s like.”
  - “Bean counters!”

--Dr. Noah Nesin, PCHC
Five Stages (continued)…

• **Bargaining:**
  - “That patient is awaiting a kidney transplant so can she be removed from my list so I don’t get dinged?”
  - “I have tried it all and these patients are non-compliant. Why should they count against me?”
  - “My patients are different.”

• **Depression:**
  - “Am I a bad provider?”
  - “I don’t think I can do this.”
  - “What’s the point of trying if I can’t achieve the benchmark?”

--Dr. Noah Nesin, PCHC
And Then ACCEPTANCE!

• “What do I need to do to improve?”
• “I think if we change our work process around that…”
• “Can you get me the list of my patients who aren’t meeting this measure?”

--Dr. Noah Nesin, PCHC
How Do We Help Them Get There?

- Understanding
- Support
- Listen to suggestions for improving data/format.
- Patience
- Persistence
- RELATIONSHIP/TRUST
Practical Considerations in the Use of Data (Accelerating Acceptance)

- Clinically meaningful
- Actionable
- Limit errors
- Discuss in small groups
- Separate from pay
- Keep in context
- Limit exposure

--Dr. Noah Nesin, PCHC
Accelerating Acceptance

- Providers should have input into the guidelines used.
- Provide benchmarks (peer, internal, external).
- Enable providers to correct patient specific data.
- Keep data up to date.
- Report trends.
- Use clinical prompts.
- Stress work processes.

--Dr. Noah Nesin, PCHC
The Stop Light Report

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80.30%  63.69%  56.54%  60.80%  84.80%  81.41%  70.29%

70.00%  80.00%  65.00%  65.00%  >90  75.00%  80.00%

---Dr. Noah Nesin, PCHC
The Bar Graph Report

--Dr. Noah Nesin, PCHC
AT MY GYM THEY SAID I SHOULD ASK YOU WHETHER IT'S OKAY FOR ME TO EXERCISE.

I GET THAT QUESTION A LOT... BUT NOBODY SAYS CONSULT A DOCTOR BEFORE BUYING A RECLINER OR A BIG-SCREEN TV.

“SIDE EFFECTS MAY INCLUDE BLOATING AND WEIGHT GAIN.”
Use the EHR: Clinical Prompts

View All Protocol

--Dr. Noah Nesin, PCHC
Use the EHR:
Depression Screen is Due

--Dr. Noah Nesin, PCHC
Use the EHR: Guidance

Use the EHR: Guidance

Depression Screening Guidelines

USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (Grade: B).

USPTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place (Grade: C).

Please review below and select the appropriate responses.

PHQ-2: N/A negative < 3; positive 3 or >
PHQ-9: N/A negative < 5; positive 5 or >
(5-9 mild; 10-14 moderate; 15-19 moderately severe; 20+ severe depression)
Depression Screen: N/A
Reason Depression Screen Not Done: N/A

☐ NO Depression Screen Documented: Print Screening Handout Now
☐ Patient DECLINED screening
☐ Not Indicated at this time: urgent or emergent situation
☐ Not Indicated at this time: patient motivation
☐ Not Indicated at this time: Diagnosis of Depression
☐ Not Indicated at this time: mental and/or physical incapacity
☐ NO Depression Screen Documented: Send Screen to Patient Now

(C) 2013

--Dr. Noah Nesin, PCHC
Who is empowered to act on patient specific data?

- Receptionist?
- Medical Assistant?
- Primary Care Provider?
- Behavioral Health Provider?
- Walk In Care Provider?
- PsychNP?
- Check out staff?
- Referralists?
- Care managers?
- Panel managers?
- Pharmacists?
- Others?

— Dr. Noah Nesin
Excellent Care:
Start tracking things that matter…

• Flu shot rates
• Mammogram rates
• Pap Smear rates
• Colon screening rates
• Hypertension control in diabetics
• Tobacco use screen
• Depression screen
• Intimate violence screen (ACE)
Judicious Use of Resources…

• Right care, right time, right place
• Imaging tests (CT, MRI)
• Consults
• General resource use (cost of care)
• Re-hospitalization rates
Outstanding Patient Experience…

- CG-CAHPS
- Internal patient surveys
- Patient advised initiatives
- Cycle times
- Access
- Outcomes!
Making Data Tell a Story

• Compelling stories help shape policy (internal and external) to support integrated care
Advocacy Strategies

• Build relationships, partnerships.
• Be proactive.
• Tell a compelling story.
  – Human element (sans drama)
  – Data
  – Cost effectiveness
  – Resulting outcomes
• Embed into other key endeavors.
• Identify key leverage points (employers)
Policy Development: Less Silver Bullet; More Silver Buckshot.

- What are your experiences?
Creating Policy Messages

• In your small group, select a policy change you would like to see happen. Develop a messaging plan.

• Consider these questions:
  – What compelling human interest stories will build the case?
  – What data do you have that will help build a compelling story? What data do you still need? How will you get it? Present it?
  – How will you involve patients/families?
  – Who are potential partners (current and needed)?
Sharing

• Share 1 key idea about messaging.
• Share 1 key strategy for influencing policy, using data/stories.
“It is a capital mistake to theorize before one has data.”

Sherlock Holmes, A Study in Scarlett (Arthur Conan Doyle)
Stay in Touch

Becky Hayes Booher, PhD
Senior Program Officer
Maine Health Access Foundation
bhboober@mehaf.org
207-620-8266, ext. 114
150 Capitol Street, Suite 4
Augusta, ME 04401
www.mehaf.org
www.mehaf.org/integratedcarelearningcommunity/