The Evaluation & Performance Measurement of Integrated Health Services

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About the Center

**In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA).**

**Goal:**
To promote the planning, and development and of integration of primary and behavioral health care for those with serious mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety net provider settings across the country.

**Purpose:**
- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
- To provide technical assistance to PBHCI grantees and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders
Services Available from CIHS

Individual Technical Assistance:
- Phone and Video Consultations, Email, Site Visits
- Medicaid Health Home Consultation to States

Group Learning Experiences:
- Regional and State-based Learning Communities
- Trainings and Presentations
- National Webinars

Tools:
- Web-based Resources (http://www.integration.samhsa.gov)
- Training Curricula
- White Papers and Factsheets
- eSolutions Newsletter
Learning Objectives

• Making the Case for Analytics

• Proper data collection infrastructure

• What to Measure?

• Performance Measurement: Turning Data into Action
MAKING THE CASE FOR DATA COLLECTION & PERFORMANCE MEASUREMENT
Why is the Use of Data for Clinical Decision Support so Difficult?

“The main reason seems to be a lack of integration of 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.”

2006 AHRQ Conference on Health Care Data Collection & Reporting for Performance Measurement

Primary Challenges:

✔ Data acquisition has impacts on staffing resources
✔ Variations in data collection requirements, documentation, and data quality
✔ Organizational and cultural challenges associated with data collection and reporting efforts
✔ Economic pressures associated with collection
✔ Competing priorities in the health care industry
✔ Technology challenges

AHRQ Publication No. 07-0033-EF/March 2007
## Collecting & Sharing Health Data

### BENEFITS
- More efficient workflow (e.g. less time spent handling laboratory results)
- Improved access to clinical data
- Streamlined referral processes
- Improved quality of care—Better health outcomes
- Improved patient safety, including fewer prescribing errors and fewer hospital readmissions
- Cost savings (e.g. eliminating costs of storing paper records)
- Downsizing personnel
- Increased revenue (e.g. government incentives for use of health IT)
- Pay-for-performance incentives

### BARRIERS
- **Lack of Leadership**
- **Lack of strategic plan for data use & health IT**
  - Costs of EHR implementation
  - Cost of establishing and maintaining links between EHRs and HIE networks
  - Security and privacy issues
  - Liability Provider’s concern to be held liable for information from outside sources/labs
  - Misaligned incentives (who pays and who benefits)
  - Provider reluctance to relinquish control of patient information to competing systems
  - Technical barriers (e.g. lack of interoperability among EHRs)
  - Lack of IT training and support

Fontaine, Ross, et al. (2010). Systematic Review of HIE in Primary Care Practices, JABPM
Primary Drivers of Successful Data Collection & Use

- Do you have a **strategic plan** for how data is shared and leveraged to improve care? If you do, is it being used/updated regularly?

- Is your **leadership involved** in the creation, articulation, and monitoring of this plan?

- Are your IT, QI, finance and clinical leads **meeting regularly** to execute this plan?
PROPER DATA COLLECTION INFRASTRUCTURE
Analytics at Work: Smarter Decisions
Better Results  Davenport, Harris & Morison

Requirements for analytics:
• Accessible High Quality Data
• Enterprise/Future Orientation
• Analytical Leadership
• Strategy Targets
• Analysts
Analytics at Work: Smarter Decisions Better Results  Davenport, Harris, & Morison

Stage One: The Analytically Impaired
The organization lacks one or several of the prerequisites for serious analytical work, such as data, analytical skills, or senior management interest.
Stage Two: Localized Analytics

There are pockets of analytic activity within the organization, but they are not coordinated or focused on strategic targets.
Stage Three: Analytic Inspired

The organization envisions a more analytic future, has established analytic capabilities, has a few strategic initiatives under way, but progress is slow often because of lack of leadership, future orientation, reliable data, strategic targets or staffing/analysts.
Analytics at Work: Smarter Decisions Better Results  Davenport, Harris, & Morison

Stage Four: Analytic Agencies/Companies
The organization has the needed human and technological resources, applies analytics regularly, and realizes the benefits across the organization. But its strategic vision/focus is not grounded in analytics, and it hasn’t turned analytics to competitive advantage.
Stage Five: Analytic Competitors

The organization routinely uses analytics as a distinctive business capability. It takes an enterprise-wide approach, has committed and involved leadership, and has achieved large-scale results. It portrays itself both internally and externally as an analytic competitor.
What to Measure?
Avedis Donabedian’s Model

**Structure** is the characteristics associated with a health care setting (e.g., a PCP embedded in CMH treating people with severe mental illness).

**Process** involves what is done in the health care setting (e.g., screening & treatment of smoking addiction).

**Outcome** is the ultimate status of the patient after a given set of health care interventions (e.g., reduced smoking).
Process Variance and Outcomes

1. Outcomes are an important means of establishing value and accountability in healthcare

2. Outcomes are dependent on processes

3. Replicable outcomes are dependent on consistent processes

4. Process variance creates a challenge in ability to determine reasons for successful outcomes
## Example of Process Indicators Scorecard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current Quarter - Actual</th>
<th>Current Quarter - Target</th>
<th>Previous Quarter</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average days between intake and health assessment</td>
<td>7.2</td>
<td>5</td>
<td>6.5</td>
<td>11%</td>
</tr>
<tr>
<td>% of consumers who are up-to-date on health indicators</td>
<td>84%</td>
<td>80%</td>
<td>74%</td>
<td>14%</td>
</tr>
<tr>
<td>Count of wellness classes offered</td>
<td>15</td>
<td>10</td>
<td>12</td>
<td>25%</td>
</tr>
<tr>
<td>Average attendance at wellness classes</td>
<td>9.1</td>
<td>8</td>
<td>12.4</td>
<td>-27%</td>
</tr>
</tbody>
</table>
Patient Registry

“...an organized system to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes.”

### Access Registry - Example

<table>
<thead>
<tr>
<th>Baseline Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRAC ID</strong></td>
</tr>
<tr>
<td>F0001</td>
</tr>
<tr>
<td>F0002</td>
</tr>
<tr>
<td>F0003</td>
</tr>
<tr>
<td>F0007</td>
</tr>
<tr>
<td>F0008</td>
</tr>
<tr>
<td>F0009</td>
</tr>
<tr>
<td>F0019</td>
</tr>
<tr>
<td>F0020</td>
</tr>
</tbody>
</table>
# Glenn County Health Care Collaborative
## INDIVIDUAL WELLNESS REPORT

**Name:** Bea Well  
**Clinician:** John Smith  
**Case Manager:** Jane Doe

### Progress on Key Health Indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator (Goal)</th>
<th>Baseline</th>
<th>6-Month Reassessment</th>
<th>12-Month Reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lungs</strong></td>
<td>Breath CO (0-6)</td>
<td>25</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td><strong>Weight</strong></td>
<td><strong>BMI (18.5-24.9)</strong></td>
<td>25.8</td>
<td>28.1</td>
<td>25.3</td>
</tr>
<tr>
<td></td>
<td>Weight</td>
<td>162.0</td>
<td>174.0</td>
<td>158.0</td>
</tr>
<tr>
<td></td>
<td>Waist Circumference</td>
<td>35.5</td>
<td>31.5</td>
<td>32.2</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td><strong>Systolic BP (90-140)</strong></td>
<td>133</td>
<td>135</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td><strong>Diastolic BP (60-90)</strong></td>
<td>80</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td><strong>Blood Sugar</strong></td>
<td><strong>Fasting Glucose (70-99)</strong></td>
<td>115</td>
<td>-</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td><strong>Hemoglobin A1C (4.0-5.6)</strong></td>
<td>5.4</td>
<td>-</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Heart Health</strong></td>
<td><strong>Total Cholesterol (125-200)</strong></td>
<td>197</td>
<td>-</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td><strong>LDL Cholesterol (20-129)</strong></td>
<td>111</td>
<td>-</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td><strong>HDL Cholesterol (40+)</strong></td>
<td>76</td>
<td>-</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td><strong>Triglycerides (30-149)</strong></td>
<td>52</td>
<td>-</td>
<td>64</td>
</tr>
</tbody>
</table>

### Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her excellent progress in reducing/stopping her tobacco use.

### Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

### Action Step(s):

Bea Well will walk for 20 minutes five days per week.

Bea Well will eat at least 3 servings of vegetables every day.

Bea Well will go to bed by 10 pm at least 5 nights per week.

**Client Signature:** Bea Well  
**Staff Signature:** John Smith  
**Date:** 9/15/2012
Common Physical Health Indicators

- Fasting Glucose/Hemoglobin A1c
- Blood Pressure
- Body Mass Index (BMI)
- Waist Circumference
- Cholesterol (HDL, LDL, Triglycerides)
- Breath CO
Common Behavioral Health Indicators

Depression – PHQ-9/2; Beck Depression Inventory

Anxiety – GAD-7

Alcohol/Addiction – Audit-C, CAGE

Psychosis Screening- SIPS (Structured Interview for Prodromal Syndromes)
"Incredible, but is it billable?"
Common Financing Indicators: How many patients need to be seen?

Question #1
- Do you know how much money your organization needs to make in order to support your integrated care vision? Key elements - number of consumers seen; how often are they seen per year; payer mix; reimbursement per visit.

Question #2
- Have you identified the baseline caseloads for both primary care and behavioral health clinicians? (i.e., NP = 750, PC = 1500 at 3 visits per patient per year, 15-20 minute visits).

Question #3
- Are your clinicians seeing enough patients to meet the financial need?
A GUIDE TO DATA COLLECTION
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 purpose of data collection and sharing?
Business Process Analysis

• Supports Clear, Precise, Accessible Communication

• Step-by-step financial, clinical & practice management activities

• Promotes cross-discipline understanding of each step & the measures being used

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

<table>
<thead>
<tr>
<th>ROLE</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td>Presents</td>
</tr>
<tr>
<td>Intake Director</td>
<td>Screens → Elig? N → Referred</td>
</tr>
<tr>
<td>Intake Counselor</td>
<td>Assess and eval → Elig? N → Referred</td>
</tr>
<tr>
<td></td>
<td>Treatment setting referral</td>
</tr>
<tr>
<td>Primary Clinical Counselor</td>
<td>Admit and treatment plan → PCBH Elig? N → Continue treatment plan</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>Intake eval, service plan → Y See CC workflow</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>See NPN workflow → PCP open? N → Refer back to Care Coordinator</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>See PCP workflow</td>
</tr>
</tbody>
</table>
Clinical Measures Resources

- CQAIMH-Center for Quality Assessment and Improvement in Mental Health
- CMS-Centers for Medicare and Medicaid Services
- MCM-Minnesota Community Measurement
- NCQA-National Committee for Quality Assurance
- NOMS-National Outcomes Measurement Set
- PCPI-Physician Consortium for Performance Improvement
- CARF-Commission on the Accreditation of Rehabilitation Facilities
Questions?

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The resources and information needed to successfully integrate primary and behavioral health care

For information, resources and technical assistance contact the CIHS team at:

Online: integration.samhsa.gov
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org