MEASURES AND QUALITY IMPROVEMENT

CO-LOCATION OF PRIMARY CARE
AND BEHAVIORAL HEALTH

Date: August 15, 2017
General partner questions and comments will be addressed today via the chat function.

Jacqueline Delmont, MD, MBA
Delmont Healthcare
Grassi & Co.
Agenda

1. Introduction
2. Measurement informed care
3. Process metrics
4. Outcomes metrics
5. Quality improvement strategies
Introduction

- This webinar will cover clinical and operational measures recommended for co-location of primary care and behavioral health services and an overview of strategies for quality improvement.
- Depending on your setting and implementation design, some but not all of the measures may be appropriate for your clinic.
What is co-location?
Co-location of behavioral health in primary care settings

- Co-location of mental health and/or substance use services
- Target population: Patients with more complex and stable behavioral health problems (e.g. schizophrenia, bipolar disorder, severe depression, psychoses) that can be appropriately managed in a primary care setting
- Behavioral health services can be provided by a co-located psychiatrist or psychiatric nurse practitioner, preferably supported by psychologist or social worker
What is co-location?
Co-location of primary care in behavioral health settings

- Target population: behavioral health patients with difficulty navigating routine primary care services
- Primary care services can be provided by any independently licensed provider (MD, DO, NP)
- Primary care services will include functions including:
  - standard preventive care services
  - screening and medical management issues specific to behavioral health population
  - population health management for common chronic conditions
  - collaboration with care management services
Why is Measurement Important?

“When you can measure what you are speaking about and express it in numbers, you know something about it; but when you cannot measure, when you cannot express it in numbers, your knowledge is of a meager and unsatisfactory kind; it may be the beginning of knowledge, but you have scarcely, in your thoughts, advanced to the stage of science.”

Lord William Kelvin (1824 – 1907)
Agenda

1. Introduction
2. Measurement informed care
Measurement Informed Care

1. Standardizes response to treatment or any intervention
2. Identifies and targets the symptoms not improving
3. Monitors treatment progress
4. Guides stepped care
5. Improves care quality and clinical outcomes
6. Assists with patient self-management
7. Aligns with health care and payment reform initiatives
Measurement-based treatment to target for populations

Systematic screening of a target population to proactively identify patients in need of care and improvement rates

Use of a registry to track a defined population of patients with identified behavioral health needs

PHYSICAL HEALTH:
- BMI
- Hb A1C
- BPC/Hypertension
- LDL-C

BEHAVIORAL HEALTH:
- PHQ-9
- GAD-7

SUBSTANCE ABUSE:
- AUDIT / DAST-10

Adapted from: Behavioral Health Integration Framework Evaluation (BHI-FE) Project
Establish Measurement Monitoring

Determine process and outcomes measures to be used to monitor progress and impact of implementation based on your program design and goals

- Some metrics may be tied to incentive payment opportunities

Evaluate potential data sources that can be used to regularly report on measures:

- Clinical data from the EHR
- Scheduling data
- Claims data from payers
- Aggregated data sources (e.g. PSYCKES, ACOs, IPAs)
Agenda

1. Introduction
2. Measurement informed care
3. Process metrics
Effectiveness
did we achieve the expected results?
(e.g. screening rates, referral rates, engagement with services and treatment)

Capacity
estimated volume based on FTEs

Productivity
visits per session/week/month/year

Efficiency
have we performed within our budget?
Examples of process metrics in behavioral health

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TOOL / TREATMENT</th>
<th>TIME LINE (follow-up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for Clinical Depression</td>
<td>PHQ-9</td>
<td>1 month, 3 months, 6 months. Until is discharged</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>Guide for depression treatment</td>
<td>Remained on medication during the entire 12-week acute treatment phase.</td>
</tr>
<tr>
<td>Adherence to Antidepressant Medications Management</td>
<td>Effective Continuation Phase Treatment</td>
<td>Remained on medication for at least 6 months.</td>
</tr>
<tr>
<td>Adherence to Antipsychotic Medications for people with Schizophrenia</td>
<td>At least 2 antipsychotic medications</td>
<td>During 1 year of measurement and remained on medication for at least 80% of their treatment period</td>
</tr>
<tr>
<td>Pre-Screening / Screening for Alcohol and other Drug Abuse-dependence</td>
<td>AUDIT-C / DAST-Q1 AUDIT/Full- DAST</td>
<td>Number of patients screened</td>
</tr>
<tr>
<td>Alcohol and Other Drug Dependence Treatment (AOD)</td>
<td>New episode of AOD dependence who initiated treatment</td>
<td>1 visit within 30 days of initiation visit</td>
</tr>
<tr>
<td>Engagement of Alcohol and Other Drug Dependence Treatment (AOD)</td>
<td>Initiated treatment and had 2 or more additional services with of AOD dependence</td>
<td>Initiation and 2 visits within 44 days</td>
</tr>
<tr>
<td>Cardiovascular monitoring for people with Cardiovascular disease and Schizophrenia</td>
<td>LDL-C test</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Diabetes monitoring for people with Diabetes and Schizophrenia</td>
<td>LDL-C test &amp; HbA1c test</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Diabetes Screening for patients with Schizophrenia or Bipolar Disorder in Antipsychotic Medication</td>
<td>Diabetes screening</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Follow up after Hospitalization for Mental Illness</td>
<td></td>
<td>Within 7 or 30 days after discharge from hospitalization</td>
</tr>
</tbody>
</table>

## Examples of process metrics

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TOOL / TREATMENT</th>
<th>TIME LINE (follow-up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/established patients</td>
<td>Annual wellness visit</td>
<td>1 month, 3 months, 6 months. Year 1, Year 2 etc</td>
</tr>
<tr>
<td>Obesity screening</td>
<td>BMI</td>
<td>Number of patients screened</td>
</tr>
<tr>
<td>Hypertension screening</td>
<td>BP measurement</td>
<td>Number of patients screened</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>Mammogram yearly age 40-75</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Colon Cancer screening</td>
<td>FOBT, colonoscopy 50 years ≥</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Immunizations: Flu shot</td>
<td>Vaccination</td>
<td>Number of patients immunized during flu season</td>
</tr>
<tr>
<td>Cardiovascular monitoring for diabetes or hypertension</td>
<td>LDL-C test</td>
<td>During the measurement year</td>
</tr>
<tr>
<td>Follow up after Hospitalization</td>
<td></td>
<td>Within 7 or 30 days after discharge from hospitalization</td>
</tr>
</tbody>
</table>

Agenda

1. Introduction
2. Measurement informed care
3. Process metrics
4. Outcomes metrics
Outcomes measures aim to measure the following:

- Stabilized chronic health conditions and improvement rates (e.g. $A_{1C}$ levels, depression scores, blood pressure, etc.)
- Increase in quality of life self-reporting
- Improved self-management skills associated to comorbid health conditions
- Lowered utilization dollars
- Fewer emergency department/urgent care visits
- Staff and patient satisfaction/experience
Examples of outcomes metrics

1. Depression Improvement Rate
2. Cholesterol Management for Patients with Cardiovascular Conditions
3. Controlling High Blood Pressure
4. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
5. Comprehensive diabetes care: LDL-c control (<100 mg%)
6. Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)

Milbank Memorial Fund. Integrating Primary Care into Behavioral Health Settings. Martha Gerrity
Agenda

1. Introduction
2. Measurement informed care
3. Process metrics
4. Outcomes metrics
5. Quality improvement strategies
Quality Improvement

Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

One Quality Improvement Methodology for Engaging in Change: The Model for Improvement

• A framework to help organize and execute improvement work
• Tests are **small**, **simple**, and reversible
• Significant opportunity for learning


Note: This is just one performance improvement methodology; Lean Breakthrough has been frequently used at NYC Health + Hospitals.
One Quality Improvement Methodology for Engaging in Change: The Model for Improvement

What are we trying to accomplish?
Team Aims

How will we know that the change is an improvement?
Measurement

What changes can we make that will result in an improvement?
Tests of Change/Interventions

Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Note: This is just one performance improvement methodology; Lean Breakthrough has been frequently used at NYC Health + Hospitals.
Developing an AIM Statement: A Quick Review of General Guidelines

State Aim clearly
Describe what needs to be improved

Include numerical goals
Creates the need for change and directs measurement

Set stretch goals, but don’t be too ambitious
Communicates that maintaining status quo is not an option

Be prepared to refocus the Aim if you find it is unrealistic
- Keep within a manageable scope
- Focus on a smaller part of issue
- Be realistic

Avoid “Aim Drift”
Make sure you don’t slip back on your goals; continue to repeat Aim
Example: Project Charter focused on Diabetes Screening in Patients with Schizophrenia or Bipolar Disorder

What are we trying to accomplish?

Increase the percentage of diabetes screening tests to 82%* over the next 6 months for adult patients diagnosed with schizophrenia or bipolar disorder that are dispensed antipsychotic medications. We will accomplish this by:

- Developing a protocol in one clinic setting to ensure these patients obtain a screening for diabetes at least annually.
- In-servicing clinicians to obtain necessary information about the protocol to ensure their understanding.
- Creating outreach strategies to effectively communicate the need to patients that they must come to the clinic to complete the test.

How will we know that the change is an improvement?

- % of diabetes screening tests given to adult patients with schizophrenia or bipolar disorder that are dispensed antipsychotic medications
- % of providers in-serviced about the screening protocol
- % of patients contacted to come to the specific clinic setting to complete the diabetes screening test

What changes can we make that will result in an improvement?

*eQARR Report 2016 State Medicaid Average for this measure is 82%: https://www.health.ny.gov/health_care/managed_care/reports/eqarr/2016/statewide/medicaid/behavioral_health.htm
Quality Improvement General “Rules for Engagement”

Form an Interdisciplinary Team ✓
Set Aims/What Your Team Hopes to Accomplish ✓
Establish Measures* to Determine Improvement ✓
Select Tests to Make Changes – Keep it Simple ✓
Conduct Small Tests of Change ✓
Implement Changes on a Larger Scale, with Tweaks, Based on What’s Been Learned from the Tests ✓

*A note about data collection for measurement in quality improvement…

- How much data is really enough?
- Measurement for improvement is different from measurement used in research (see next slide)

Sources: Institute for Healthcare Improvement (IHI): www.ihi.org
World Health Organization (WHO): http://www.who.int/patientsafety/education/curriculum/who_mc_topic-7.pdf?ua=1
# A Note About Measurement for Research vs. Measurement for Quality Improvement

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Measurement for Research</th>
<th>Measurement for Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To discover new knowledge</td>
<td>To bring new knowledge into daily practice</td>
</tr>
<tr>
<td>Tests</td>
<td>One large “blind” test</td>
<td>Many sequential, observable tests</td>
</tr>
<tr>
<td>Biases</td>
<td>Control for as many biases as possible</td>
<td>Stabilize the biases from test to test</td>
</tr>
<tr>
<td>Data</td>
<td>Gather as much data as possible, “just in case”</td>
<td>Gather “just enough” data to learn and complete another cycle</td>
</tr>
<tr>
<td>Duration</td>
<td>Can take long periods of time to obtain results</td>
<td>“Small tests of significant changes” accelerates the rate of improvement</td>
</tr>
</tbody>
</table>

Experimenting/Testing versus Implementing

**Experimenting/Testing**
- Changes are not permanent
- Significant opportunity for learning
- Does not require universal awareness

**Implementing**
- Supporting processes are required in order to become routine
- Requires increased awareness
- Takes longer
- Requires additional support
- Must address social aspects

Upcoming Webinars to Support Implementation

- Implementation
- Physical health screening approaches
- Behavioral health screening tools
- Billing guidance
Questions?
For more information

ONECITY HEALTH SUPPORT DESK:

Call 646-694-7090

Email ochsupportdesk@nychhc.org with the subject line “PCBH Integration Question”

Hours of Operation:
Monday through Friday
9am to 5pm ET

PRESENTER:

Jacqueline Delmont, MD, MBA
Delmont Healthcare
Grassi & Co.
Email: jdelmont@delmonthealthcare.com