What's With All the Numbers?:
Quality Indicators within Integrated Behavioral Health Programs

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Faculty Disclosure

We have not had any relevant financial relationships during the past 12 months.

Learning Objectives

At the conclusion of this session, the participant will be able to:

Learning Objective #1
- Identify clinical metrics and benchmarks for PCBH programs.

Learning Objective #2
- Describe and discuss data mining options for collecting metrics to demonstrate quality improvement related to PCBH.

Learning Objective #3
- Discuss unique barriers in collecting and assessing metrics for developing and sustaining PCBH programs.


Resources

- SAMHSA Center for Integrated Care
  - http://www.integration.samhsa.gov/
  - http://integrationacademy.ahrq.gov/atlas
- Evaluation Processes
  - Institute of Health Improvement ("How to Improve")
    - http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

PCBH.... What is it?

- Consultant model
- Member of primary care team, work side-by-side
- Goal is to improve PCP management of behavioral issues and improve satisfaction
  - Wide variety of interventions and goals
  - Brief visits, limited follow-up
  - Immediate feedback to PCP
  - Any behaviorally-based problem, any age
- Immediate access, minimal barriers
- Population health principles

Program Questions

- Integration is the standard
- Not a question of should we integrate, rather how do we integrate?
  - Identify Barriers to QI
  - Model Fidelity
  - QI Metrics and QI Healthcare Alignment
  - Provider Satisfaction
  - Patient Satisfaction
  - Clinical Quality Indicators
Barriers to QA/QI

Barriers to Quality Assurance and Improvement
• What barriers have you faced in your practice settings?
  – Clinical?
  – Administrative?
• Time
• Resources (manpower)
• Electronic Health Records
• Stakeholders
• Be Pro-active with identifying

Barriers to QA/QI
• Poorly defined quality measures
• Lack of linked electronic health information
• Limited descriptions of behavioral health for program metrics
• Limited to MH
• Lacking
  – Medical linkage
  – Clinical relevance
  – Fiscal outcomes

Vannoy et al., 2011

Kilbourne, Keyser, & Pincus, 2010
Overcoming Barriers

- Promotes organization self-monitoring
- Promotes improvement
  - Accountability
  - Sustainability

Overcoming Barriers

- Quality improvement as part of standard clinical training curricula
- Refinement of technologies to promote adequate data capture of mental health services
- Need for behavioral health researchers to improve the evidence base for behavioral health treatment
- Use of incentives to promote provider accountability for improving care

Kilbourne, Keyser, & Pincus, 2010

Barriers

- Barriers will exist
  - what works best for your practice
- Team-based approach to QA/QI management
- “Change fatigue” will happen
- Start small and celebrate victories along the way!
- Use management QI strategies
  - (PDSAs, pro formas, PI teams, LEAN, ReAim, RIE)
**Start with Standardizing**

- Executive leadership review and definition of how you are implementing and fostering the culture of integrated care
- Identify expectations from leadership, providers, staff, and patients
- Mirror the quality management to the medical practice review and consider reviewing the established metrics first
- Every quality indicator MUST be measureable and SMART!

**Quality Indicator Focus**

- **Operational**
  - Model fidelity
  - Culture specific
- **Fiscal**
  - Program sustainability
  - Program growth
- **Quality**
  - Value based
  - Experience of care
  - Population health
  - Satisfaction
  - Cost

*Ultimately: Help clinics meet the Triple Aim & providers manage their patients*

**How do we evaluate PCBH?**

**Operational and Model Fidelity**

- Productivity/Access
- Session frequency
- Time spent with patients
- Penetration rates
- Top diagnoses
- Clinical quality indicators
- Care team meetings
- Huddling
- Documentation
- Communication
- Location
- Provider satisfaction
- Patient satisfaction
- Utilization outcomes
- Many others
Operational / Model
Session Specific Metrics

• Number of visits per episode of care
  - Why important?
  - Benchmarks
    • Clinic dependent
    • Mean number of visits = 2-4 visits
    • Median = 2 visits
    • Mode = 1 visits
    • No more than 10-15% of patients receiving more than 6 visits in 12 month period with specific justification of care: PHM or group medical visit focus

Increase percentage of patients who are seen for mental, medical, or behavioral health treatment needs by the integrated behavioral health provider.

• Percentage of clinic patients having a BH consult
  - Benchmark
    • Clinic dependent
    • 25-30% of clinic
  • Duplicated vs unduplicated
    • 40-100% for a robust clinic

• Top diagnosis
  - Benchmark
    • Clinic dependent
    • PHM focus
    • Quality improvement focus
    • Provider study

Clinical Quality Metrics
- Review PCMH NCQA Requirements for IBH.
- Review NQF, UDS, HEDIS Metrics

PCMH 2, Element D, Factor 3: MUST PASS The Practice Team:
• Increase frequency of utilization of huddle care team form / IBH as part of daily primary care team huddles

NQF 0710: Depression Remission at Twelve Months:
PCMH 3, Element B, Factor 9:
• Improve percentage of depression remission (PHQ-9 score of less than 5) at 12 months for patient’s with PHQ-9 over 9.
Experience of Care

**Process**
- Percentage of pts that were asked to complete a healthcare satisfaction measure
- Percentage of providers asked to complete satisfaction measure

**Outcomes**
- Level of pt satisfaction with access
- Level of pt satisfaction with effectiveness
- Pt recommendation of office to others
- Level of provider satisfaction with role enhanced, job, engagement, and quality of care delivered

Population Health

- Review PCMH NCQA Requirements
- Review NQF, UDS, HEDIS Metrics

**Process**
- Number of pts seen in PC in a week/month/quarter
- Percentage of pts seen in PC that were screened for a given problem (e.g., health status, depression, ADD)
- Percentage of pts that screen positive for a problem
- Percentage of pts that screen positive that were referred to the PC BH staff for further assessment or intervention

**Outcome**
- Pt quality of life functioning (e.g., score on a quality of life measure)
- Pt health functioning (e.g., score on PHQ)
- Pt physical health indicators (e.g., body mass index, waist girth, weight, blood pressure, blood glucose levels, lipid levels, pain level, alcohol use, physical activity, tobacco use)

Cost

**Process**
- Percentage of pts that were referred to the PC BH staff that kept the appointment (pts with untreated problems have higher overall cost)
- Percentage reduction in ED usage / specific utilization
- Percentage of patients that were referred for a BH appointment outside of the primary care clinic
- Type and duration of PC BH treatment
- Percentage of types of billing codes used and reimbursed

**Outcomes**
- Annual percent increase in per capita costs
- Emergency room visits
- Emergency room visits for mental health presentation alone
- Frequency of hospital admissions
- Annual revenue generation
Questions to Form Decision-Making

1. What is your goal for the program?
2. What are the predictors of model fidelity?
3. How can I measure success?
4. How can I demonstrate
   1. Patient impact?
   2. Fiscal impact?
   3. Provider impact?
5. How do I get reliable data?

Data Mining Options

Collecting metrics to demonstrate quality improvement in PCBH

Where/How do I find the Data?

- Claims data
- ROI for insurance companies
- Joint ventures with insurance companies
- Registries
- Survey Data
- Electronic Health Records
- HIE (Health Information Exchanges)
- HEDIS, UDS, NQF, Physician Quality Reporting
- Self-reporting
- Other ways?
Electronic Health Systems and Technology

- EHR Systems/ HIT
  - Population identification
  - Identification of care gaps
  - Stratification
  - Patient engagement
  - Care management
  - Outcomes measurement

Barriers to Data

- Forms of Data: *How to choose?*
  - Claims
  - Chunking
  - Small amounts
  - Analytical vs Clinical
- Volume of Data
  - *How to understand it?*
  - *How is it relevant?*

Data Points

- Clinical Indicators
  - Mortality
  - Health status
  - Biometrics
  - Disease prevalence
  - Disability status
  - Health Maintenance
  - Health assessments (screening tools)
  - ED visits
  - Re-admission
  - PHM
- Standardization
  - HEDIS
  - UDS / NOF / CMS
  - Annual QI Goals
  - RVUs/Productivity
  - Fiscal ROI
  - NCQA PCMH
- Organizational
  - Employee wellness
  - Job satisfaction
  - Employment sustainment
  - Satisfaction
- Model
  - Length of session
  - CPT coding
  - Diagnosis coding
  - Visit type
  - Productivity
  - Huddles
  - Communication
  - Documentation
Quality Assurance/ Evaluation

- Plan-Do-Study-Act (PDSA)
- RE-AIM Framework (Reach, Effectiveness, Adoption, Implementation, Maintenance): As you design, plan, or evaluate an intervention, there are questions that you should ask yourself:
  - Reach your intended target population
  - Efficacy: Intervention effectiveness; negative consequences?
  - Adoption by target staff, settings, or institutions
  - Implementation consistency; costs and adaptations made during delivery
  - Maintenance of intervention effects in individuals and settings over time
- Process and Program Evaluations (e.g., Precede-Proceed):
  1) Planning 2) Evaluation

Since time is ticking...

- We will focus on only a few metrics, mainly related to productivity/access to care standard examples
  - Benchmark provided but unique to each clinic/organization

We will have time for questions!

Productivity / Access to Care

- Patient per hour/clinic
  - Benchmarks
    - 1.5 patients per hour OR
    - 50% of PCP’s expectations per clinic
      - PCPs expected to see 10 patients per clinic, BHCs expected to see 5 patients per clinic
- Initial vs. Follow-ups
  - Danger to both sides of the coin
  - Benchmarks
    - 1:1 or 50% of visits being initials
- Warm-handoffs/Same-day vs schedule
  - Benchmark
    - 50%
Managing: Productivity/Access Per Clinic

The solid straight bars indicate your control limits for standard expectation, lowest limit, and possible productivity bonus.

Initials/RA vs. F/u

Warm-handoff/Same day vs Scheduled percentage
Productivity and Access to Care Efforts

• Improved patient and family care and satisfaction; early identification; pt centered; enhanced adherence and collaboration; shared decision making
• Consultation; self management support, reduced health disparities; improved care team access
• Improved cost containment; targeted use of resources; revenue generation; decreased other specialty visits, brief screenings for early identification; increased provider coding

QUESTIONS
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Session Evaluation

Please complete and return the evaluation form to the classroom monitor before leaving this session.

Thank you!