Best Practices for Measuring Practice Transformation to Implement the Triple Aim

Presented By:
Chet Fox, MD, FAAFP, FNKP; Lynne Nemeth, PhD, RN, FAAN; Zsolt Nagykaldi, PhD; Paula Darby Lipman, PhD; Rodger Kessler, PhD, ABPP

Moderated By:
Rebecca Roper, MS, MPH, Director, Practice-Based Research Network Initiative, Agency for Healthcare Research and Quality

Sponsored by the AHRQ PBRN Resource Center
November 19, 2014
Agenda

- Welcome and introductions
- Presentations
- Q&A session with all presenters
- Instructions for obtaining CME credits

Note: After today’s webinar, a copy of the slides will be e-mailed to all webinar participants.
Disclosures

• None of today’s presenters have financial relationships to disclose.

• Presenters will not discuss off label use and/or investigational use of medications in their presentations.
How to Submit a Question

• At any time during the presentation, type your question into the “Questions” section of your GoToWebinar control panel.
• Select “Send” to submit your question to the moderator.
• Questions will be read aloud by the moderator.
Today's Presenters

TRANSLATE: Framework for Evaluating Practice Transformation

Chet Fox, MD, FAAFP, FNKP
Professor, University at Buffalo;
Director, Upstate New York Practice-based Research Network (UNYNET);
Research Director, AHRQ P30 Network of Networks
Center of Excellence Grant
Today’s Presenters

Measuring Practice Transformation

Lynne Nemeth, PhD, RN, FAAN
Professor, College of Nursing, Medical University of South Carolina;
Investigator, Primary (Care) Practices Research Network (PPRNet)
Achieving and Measuring Practice Change: The Solberg-Mold Practice Change/QI Model

Zsolt J. Nagykaldi, PhD
Associate Professor and Director of Research, Department of Family and Preventive Medicine, University of Oklahoma Health Sciences Center;
Research Director, Oklahoma Physicians Resource/Research Network (OKPRN)

Paula Darby Lipman, PhD
Senior Study Director, Westat
Today’s Presenters

The Errors of our Ways: From behavioral co-location carve-out to transformed integration of care

Rodger Kessler, PhD, ABPP
Fellow, Health Economics Unit and Assistant Professor of Family Medicine, University of Vermont College of Medicine;

Director, Collaborative Care Research Network, National Research Network Senior Scientist, American Academy of Family Physicians;

Clinical Associate Professor, Doctor of Behavioral Health Program, Arizona State University Doctoral Program
Polling Question:
Check which describes your experience with measuring/evaluating practice transformation (PT):
TRANSLATE

Framework for Evaluating Practice Transformation
Chet Fox MD
University at Buffalo
History

- Late 1990’s Kevin Peterson wanted to improve DM care in PCP offices
- Did literature search on modalities that would be effective
- He found nine that were put into the acronym TRANSLATE
- Did successful randomized control trial in over 8,000 diabetic patients
- It was modified and adapted for a 40 practice NIH R-01 pragmatic clinical trial comparing Computer Decision support to facilitated support
- TRANSLATE Rubric was developed for evaluation
TRANSLATE

- **Target**
- **Reminder**
- **Administrative Buy-In**
- **Network Information System**
- **Site Coordinator**
- **Local Clinician Champion**
- **Audit and Feedback**
- **Team Approach**
- **Education**
Target

- Goal setting
- Needs to be
  - Clear Measurable and feasible
- Common office problems
  - No targets
  - Trying to do too many things at once
Reminder

- Actionable information at the point of care
Administrative Buy-in

• Commitment of Resources
  • Money
  • Personnel
Networked Information Systems

- Population Health
- Registries
- Preferably easily created

SQL has several built-in registries that allow for management of the following:
- Diabetes
- Congestive Heart Failure
- Atrial Fibrillation
- Hypertension
- Cardiovascular Disease
- Asthma
- Depression
- Obesity
- Medication Adherence
- And others...

The registries are designed to meet the specific needs of the customers.
Site Coordinator

- Local accountability
- Person responsible for making sure the work is done.
- Any number of people can take this role
  - The doctor in a small practice
  - The office manager
  - Head Nurse etc.
Local Clinician Champion

- For Clinician buy-in
  - Explanation of Evidence Base
- Does not have to be MD (but usually is)
  - NPs and PAs have done a good job with this
    - Large regional variation
    - Some only accept MD
Audit and Feedback

- Longitudinal Reports
  - How the practice is progressing over time
- Benchmarking Reports
  - How the practice is doing compared to others
Team Approach

• Based on other successful work such as:
  • Toyota Quality Circles
  • Patient safety in the Airline industry.
• Huddles (brief micro-team meetings) have also shown success
Education

• Training in all its forms:
  • Academic Detailing*
  • Collaborative Learning Groups*
  • In-service
  • CME etc.

* Most commonly used in practice transformation
<table>
<thead>
<tr>
<th>Translate element</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Targets</td>
<td>No targets set</td>
<td>Vague or non-measurable targets</td>
<td>Clear, measurable, but not feasible targets</td>
<td>Clear, measurable and feasible targets</td>
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<tr>
<td>Reminders</td>
<td>No Reminders available</td>
<td>Reminders available but never used</td>
<td>Reminders available but used infrequently</td>
<td>Reminders routinely used</td>
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<tr>
<td>Administrative buy-in (Resource allocation)</td>
<td>Leaders resistant</td>
<td>Leaders agreeable but unwilling to commit resources (cool)</td>
<td>Leaders agreeable and willing to commit limited resources (lukewarm)</td>
<td>Leader willing to commit all resources necessary (enthusiastic)</td>
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<tr>
<td>Network Information Systems (Registries)</td>
<td>No information system or unable to create registries</td>
<td>Able to create registries but none created</td>
<td>Few registries created or used &lt; 3 conditions</td>
<td>Registries created and used for at least 3 conditions</td>
<td></td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>No site coordinator identified</td>
<td>Site coordinator identified but has no time for QI activities</td>
<td>Site coordinator has limited time to do QI</td>
<td>Site coordinator with clear mission, resources, and personnel to complete QI work</td>
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<tr>
<td>Local Physician Champion</td>
<td>Not identified</td>
<td>Identified but uninvolved (name only)</td>
<td>Lukewarm support</td>
<td>Enthusiastic support</td>
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<tr>
<td>Audit and Feedback</td>
<td>Never done</td>
<td>Reports available but not disseminated</td>
<td>Reports disseminated occasionally and only at the practice level</td>
<td>Individual reports disseminated at least 2 times per year</td>
<td></td>
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<td>Team approach</td>
<td>No teams formed</td>
<td>Limited teams that function from a top down approach</td>
<td>Limited teams that get input from just a few individuals</td>
<td>Non-hierarchical broadly based teams</td>
<td></td>
</tr>
<tr>
<td>Education - CME, collaborative learning groups, staff training</td>
<td>No opportunities for education</td>
<td>Rare educational opportunities</td>
<td>Occasional educational opportunities</td>
<td>Frequent educational opportunities</td>
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Total score for all elements at benchmark 0.0
Preliminary Results
Total Score
Change by Individual element (all practices)
Individual elements for individual practice
Polling Question:
Have you had experience using an implementation survey to identify areas on which to focus transformation efforts?
MEASURING
PRACTICE
TRANSFORMATION

Lynne S. Nemeth, PhD, RN, FAAN
Professor: College of Nursing
Investigator: PPRNet
Medical University of South Carolina
ACKNOWLEDGEMENTS

- Steven M. Ornstein, MD
- Andrea M. Wessell, PharmD
- Cara B. Litvin, MD, MS
- Ruth G. Jenkins, PhD
- Paul J. Nietert, PhD
- PPRNet Member Practices

R03HS018830 and R18HS022701
Agency for Healthcare Research and Quality (AHRQ)
OBJECTIVES

- Disseminate a conceptual model for improving primary care using health information technology (IPC-HIT)
- Discuss model concepts and practice activities
- Explain how these concepts were used to develop a survey measuring “meaningful use”
- Consider implications of measuring these activities for their correlation with clinical quality measures (CQM)
Secondary analysis of seven PPRNet studies qualitative data (2001-2012)
- Cardiovascular/stroke prevention, alcohol screening and brief intervention, broad primary care measures, colorectal cancer screening, medication safety, standing orders
- 134 practices nationwide participated in this collaborative learning community

Findings
- Practices use HIT/staff in new ways
- Complex interventions rely on four main concepts
IMPROVING PRIMARY CARE USING HEALTH INFORMATION TECHNOLOGY (HIT)

PPRNet - TRIP - QI

Adapt & use HIT tools

Practice team care

ACTIVATE PATIENTS

Transform practice culture & quality

INVESTMENTS NEEDED

> IN HIT RESOURCES
> EDUCATE/ PRACTICE DEVELOPMENT
> ESTABLISH LEADERSHIP

REWARDS

> FINANCIAL ALIGNMENT WITH QUALITY MEASURES
> RETENTION OF STAFF & PROVIDERS

IMPROVED OUTCOMES
QUALITY MEASURES: PPRNet, NCQA, CMS
## Concepts and Strategies: Complex Interventions

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<th>Concepts</th>
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<th>Adapt and Use HIT Tools</th>
<th>Transform Practice Culture and Quality</th>
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| **TRIP-II to ATRIP (2001-2006)** | • “Involve all staff”, new roles/responsibilities  
• Clinicians agree to decrease practice variation | • Staff increased use of EHR | • Emphasis on quality, set goals, celebrated successes  
• Quality committees/ coordinators | • Handouts, posters, screening/immunization events  
• Press releases |
| **AA/AM/SO/C-TRIP (2005-present)** | • Structured screening tools (MAs/nurses)  
• Complementary team roles better defined, providers closing loop | • Specific templates used for decision support  
• Revised/edited, add macros, applied age, gender, Dx/ Rx templates  
• Lab interfaces, scanning, eRX, web-based patient portals added | • Liaisons coordinate projects/communication, use PLRs  
• Staff education; SO’s increased, explicit policies, practice culture rewarded by P4P etc. | • Brief intervention, counseling, treatment, referrals  
• Targeted messages: “Rethinking Drinking”; Screen for Life; birthday letters, HM reminders in letter  
• Active f/u for completion of tests; outreach |
| **MS-TRIP (2007-present)** | | | | • Patient update forms, bring all meds, labs in advance  
• Long appts for med reviews, med list provided at end of visit |

### Specific Approaches by Study

- **TRIP-II to ATRIP (2001-2006)**:  
  - • “Involve all staff”, new roles/responsibilities  
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- **AA/AM/SO/C-TRIP (2005-present)**:  
  - • Structured screening tools (MAs/nurses)  
  - • Complementary team roles better defined, providers closing loop

- **MS-TRIP (2007-present)**:  
  - • Medication reconciliation, outreach as needed  
  - • Rx/Dx templates applied, improved medication reconciliation, increased attention to dosing alerts  
  - • Performance reports for outreach, refill protocols, standing orders for labs, printed medication lists used  
  - • Patient update forms, bring all meds, labs in advance  
  - • Long appts for med reviews, med list provided at end of visit
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- Complementary team roles better defined, providers closing loop | - Medication reconciliation, outreach as needed |
| Adapt and Use HIT Tools | | - Specific templates used for decision support  
- Revised/edited, add macros, applied age, gender, Dx/ Rx | - Rx, Rx templates applied, improved medication reconciliation, increased intervention to dosing alerts |
| Transform Practice Culture and Quality | | - Performance reports for outreach, refill protocols, standing orders for labs, printed medication lists used | |
| - Emphasis on quality goals, celebrate successes  
- Quality committees/coordinators | - Staff education; SO’s increased, explicit policies, practice culture rewarded by P4P etc. | |
| Activate Patients | | Brief intervention, counseling, treatment, referrals  
- Targeted messages: “Rethinking Drinking”; Screen for Life; birthday letters, HM reminders in letter  
- Active f/u for completion of tests; outreach | - Patient update forms, bring all meds, labs in advance  
- Long appts for med reviews, med list provided at end of visit |
| - Handouts, posters, screening/immunization events  
- Press releases | | |

- **Medication reconciliation, outreach as needed**
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| Adapt and Use HIT Tools       | AA/AM/SO/C-TRIP (2005-present) • Structured screening tools (MAs/nurses)                        |
                               | • Complementary team roles better defined, providers closing loop                               |
| Transform Practice Culture and Quality | MS-TRIP (2007-present) • Medication reconciliation, outreach as needed                          |
| Staff increased use of EHR   | • Specific templates used for decision support                                                |
                               | • Revised/edited, add macros, applied age, gender, Dx/ Rx templates                            |
                               | • Lab interfaces, scanning, eRX, web-based patient portals added                              |
| Emphasis on quality, set goals, celebrated successes | • Rx/Dx templates applied, improved medication reconciliation, increased attention to dosing alerts |
| Quality commitment coordinators | Liaisons coordinate projects/communication, use PLRs, Staff education; SDs increased,    |
|                                | Performance reports for outreach, refill protocols, standing orders for labs, printed        |
|                                | Patient update forms, bring all meds, labs in advance                                         |
| activate patients             | • Brief intervention, counseling, treatment, referrals                                         |
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| Press releases                |                                               |
## Concepts and Strategies: Complex Interventions

### Specific Approaches by Study

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| Practice Team Care | • “Involve all staff”, new roles/responsibilities  
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| Adapt and Use HIT Tools | • Staff increased use of EHR | • Specific templates used for decision support  
• Revised/edited, add macros, applied age, gender, Dx/ Rx templates  
• Lab interfaces, scanning, eRX, web-based patient portals added | • Rx/Dx templates applied, improved medication reconciliation, increased attention to dosing alerts |
| Transform Practice Culture and Quality | • Emphasis on quality, set goals, success metrics  
• Quality improvement committees/ task forces | • Liaisons coordinating communication, using ELRs  
• Explicit policies, practice culture rewarded by P4P etc. | • Performance reports for outreach, refill orders for labs, printed medication lists used |
| Activate Patients | • Handouts, screening events  
• Press releases | • Community engagement, patient education, treatment, referrals  
• Bring all meds, lab results  
• Advance refills on diabetes, smoking, drinking | • Long appts for medication reviews, purchased list provided at end of visit |

- Specific templates used for decision support
- Revised/edited, add macros, applied age, gender, Dx/ Rx templates
- Lab interfaces, scanning, eRX, web-based patient portals added
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<td>• Press releases</td>
<td>• Patient education, sending all med and lab orders</td>
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<td>• Long application forms, reminder cards, postcards for medication lists used</td>
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<td>• Updated forms, reminders at end of visit</td>
<td>• Performance reports for outreach, refill protocols, standing orders for labs, printed medication lists used</td>
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- **Rx/Dx templates applied**, improved medication reconciliation, increased attention to dosing alerts
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- **Emphasis on quality, set goals, celebrated successes**
- **Quality committees/ coordinators**
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**Specific Approaches by Study**

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<td><strong>Targeted messages</strong></td>
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<td><strong>Patient updates</strong></td>
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<th>Activate Patients</th>
<th>Specific Approaches by Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handouts, posters, screening/immunization events</td>
<td>Structured screening tools (MAs/nurses)</td>
</tr>
<tr>
<td>Press releases</td>
<td></td>
</tr>
<tr>
<td>Brief intervention, counseling, treatment, referrals</td>
<td></td>
</tr>
<tr>
<td>Targeted messages: “Rethinking Drinking”; Screen for Life; birthday letters, HM reminders in letter</td>
<td></td>
</tr>
<tr>
<td>Active f/u for completion of tests; outreach</td>
<td></td>
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</tbody>
</table>

- **Handouts, posters, screening/immunization events**
- **Press releases**
**Concepts and Strategies: Complex Interventions**

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Specific Approaches by Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Team Care</td>
<td>TRIP-II to ATRIP</td>
</tr>
<tr>
<td>• “Intervention and role of Practice Team”</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>Adapt and Use HIT Tools</td>
<td>TRIP-II to ATRIP</td>
</tr>
<tr>
<td>• State of the art technology; increased patient and provider engagement</td>
<td></td>
</tr>
<tr>
<td>• Increased alerts (e.g., lab results)</td>
<td></td>
</tr>
<tr>
<td>• Reports for care coordination</td>
<td></td>
</tr>
<tr>
<td>Transform Practice Culture and Quality</td>
<td>TRIP-II to ATRIP</td>
</tr>
<tr>
<td>• Emphasis on goals related to success with health</td>
<td></td>
</tr>
<tr>
<td>• Quality committees/coordinators</td>
<td></td>
</tr>
<tr>
<td>• Implicit policies/practice culture rewarded by P/M</td>
<td></td>
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### Concepts and Strategies: Complex Interventions

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Specific Approaches by Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Team Care</strong></td>
<td>- TRIP-II to ATRIP (2001-2006)</td>
</tr>
<tr>
<td>- • “Involve all staff”, new roles/responsibilities</td>
<td></td>
</tr>
<tr>
<td>- • Clinicians and staff survey for practice variation</td>
<td></td>
</tr>
<tr>
<td><strong>Adapt and Use HIT Tools</strong></td>
<td>- AA/AM/SO/C-TRIP (2005-present)</td>
</tr>
<tr>
<td>- • Staff increased</td>
<td>- Medication reconciliation, improved order sets, increased standing orders, dose alerts</td>
</tr>
<tr>
<td><strong>Transform Practice Culture and Quality</strong></td>
<td>- MS-TRIP (2007-present)</td>
</tr>
<tr>
<td>- • Emphasis on quality/performance/creation</td>
<td>- Rx/Dx templates and charts, improved order sets, increased standing orders, dose alerts</td>
</tr>
<tr>
<td>- • Quality committees/ coordinators</td>
<td>- <strong>Patient update forms, bring all meds, labs in advance</strong></td>
</tr>
<tr>
<td><strong>Activate Patients</strong></td>
<td>- • Long appts for med reviews, med list provided at end of visit</td>
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<td>- • Handouts, posters, screening/immunization events</td>
<td></td>
</tr>
<tr>
<td>- • Press releases</td>
<td>- Performance reports for refill protocols, standing orders for labs, printed medication lists used</td>
</tr>
<tr>
<td><strong>Concepts</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Patient update forms, bring all meds, labs in advance**
- **Long appts for med reviews, med list provided at end of visit**
Meaningful Use Study provided opportunity

Proposed Meaningful Use Stage 3 CQM
- 21 measures selected relevant to primary care

Survey developed using five iterative rounds to examine practices substantial engagement or “meaningful use” of their EHR

Each item mapped to the CQM domain, IPC-HIT concept and CFIR domain
EXEMPLARS OF MEANINGFUL USE SURVEY

- IPC-HIT concepts
  - Practice Team Care
  - Adapt and Use HIT tools
  - Transform Practice Culture and Quality
  - Activate Patients

- CFIR domains
  - Intervention Characteristics
  - Outer Setting
  - Inner Setting
  - Characteristics of Individuals
  - Process of Implementation
Do you agree with the following CQM?
What proportion of your practice's clinical staff members are educated on specific clinical quality goals for the following?
Are practice clinical staff authorized by standing order protocols to order or perform the following?
To what extent does your practice use EHR reminders (flags, health maintenance, or note templates with prompts, etc), as decision-support to help meet the following clinical quality goals?
To what extent does your practice use EHR tools (embedded web links, templates, letters) for patient education that reinforce the selected population management/public health goals?
<table>
<thead>
<tr>
<th>Survey Category</th>
<th>CQMs Associated (Multivariate Analyses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Agreement</td>
<td>CRC Screening</td>
</tr>
<tr>
<td>Staff Education</td>
<td>Breast ca screen, DM nephropathy screen, IVD ASA, Depression screen</td>
</tr>
<tr>
<td>CDS (HER Reminders)</td>
<td>Breast, Cervical, &amp; CRC ca screen DM nephropathy screen HF: ACE/ARB &amp; BB Chlamydia, Depression screen Flu pneum vaccines</td>
</tr>
<tr>
<td>Standing Orders</td>
<td>(Many in bivariate analyses, none when controlling for DCS use)</td>
</tr>
<tr>
<td>HER Patient Educ</td>
<td>Cervical ca screen, HGA1C control, HF: BB</td>
</tr>
</tbody>
</table>
Future research is needed

- Exemplars of Meaningful Use Survey needs further testing to be able to more widely measure transformation.
- A quantitative measure can be used to further test associations of practice strategies with CQM performance.
- There is an important need to understand how practices can make improvement—measurement of these core strategies may signal specific areas that can be used to address the goals.
QUESTIONS:
nemethl@musc.edu
Achieving and Measuring Practice Change: 
The Solberg-Mold Practice Change/QI Model

Co-presenters:

Zsolt Nagykaldi, PhD (University of Oklahoma Health Sciences Center & OKPRN)
Paula Darby Lipman, PhD (Westat)
Acknowledgements

- James W. Mold, MD, MPH (PI, OKPRN)
- Cheryl B. Aspy, PhD (OKPRN)
- Paul D. Smith, MD (WREN)
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- Lyndee Knox, PhD (LANet)
- Paula Darby Lipman, PhD (Westat)
- Chet Fox, MD (UNYNet)
- Leif I. Solberg, MD (HealthPartners)

Supported by AHRQ grant (1R18HS019945): Leveraging practice-based research networks to accelerate implementation and diffusion of chronic kidney disease guidelines in primary care practices
The Solberg-Mold Practice Change/QI Model

Proposed effects of the QI Interventions on Change Elements

Priority
- Performance Feedback
  - Baseline and "mini" chart reviews over the project (by the PF)

Change Capacity
- Academic Detailing
  - Faculty introduces the project at kick-off meeting (links the PF to practice)
- Practice Facilitation
  - Practice assessment, tailoring interventions, empowering teams

Change Process Content
- Local Learning Collaboratives
  - Geographical or virtual learning practice communities for cross-pollination and problem solving
- HIT Support
  - New technology resources or enabling staff to use existing tools efficiently
The Solberg-Mold Practice Change/QI Model

Example: The CKD Project Funded by AHRQ (2010-2013)

• Multi-PBRN R18 to implement and disseminate CKD clinical guidelines in primary care practices (multi-comp.)
• Academic detailing on CKD management best practices
• Regular performance feedback on reaching practice goals
• Facilitation of CKD guideline implementation (workflow redesign, tailoring, sharing solutions, empowering staff)
• Technical support for new features in EHR (e.g., eGFR)
• First wave (32) of practices accelerates diffusion to other practices (64) using LLCs
Measuring Change Process Capability

• The Change Process Capability Questionnaire (CPCQ)

• Developed to measure an organization’s ability to maintain change
  • 30 factors and strategies ranked most important for successful implementation by experienced quality improvement leaders

• Relationship between survey scores and depression improvement among 41 medical groups

• Solberg, Asche, Margolis, Whitebird - Am J Med Qual 2008
Measuring Change Process Capability

Priority - visual analog scale

• “Considering all the priorities your clinic has over the next year (e.g., EHR, financial goals, QI of various conditions, physician recruitment), what is the priority for your clinic to improve [target] care (on a scale of 0-10, where 0 = not a priority, 5 = medium priority, and 10 = highest priority of all)?”

Organizational factors

• Previous history of change
• Plans for organizational refinement
• Ability to initiate and sustain change

Strategies: specific approaches to managing change or to adoption of improved [targeted] care (e.g., periodic measurement of performance or delegating physician work to non-physician staff)

• Yes (worked well, did not work well)/No
Findings: Change in Practice Performance (Aim 1)

Aim 1: Determine whether “early adopter” practices (Wave I) could recruit additional practices (Wave II) to implement CKD guidelines and facilitate the implementation process in these second-wave practices

• Following the intervention, Wave I practices increased use of ACEIs/ARBs, discontinuation of NSAIDs, testing for anemia, and testing and/or treatment for vitamin D deficiency.

• Most were able to recruit two additional practices for Wave II

• Wave II practices also increased their use of ACEIs/ARBs and testing and/or treatment of vitamin D deficiency.
Aim 2: Determine whether the change processes used by Wave II practices would be the same as or different from those used by the early adopters

- Differences between measures of priority, change capacity, and care processes between baseline and post-intervention were estimated using the paired t-test.
- For all practices:
  - Priority for improving care of patients with CKD remained relatively high (no significant pre-post change)
  - No significant change in subscales designed to measure organizational factors associated with practice change capacity (i.e., history of change, continuous refinement and sustaining change)
- Number of change strategies increased for Wave I practices only
  - However baseline scores were higher in Wave II practices.
Conclusions

• The CKD project was able to increase the number of implemented strategies for practice improvement as delineated by the Solberg-Mold QI model.
• It is feasible to effectively operationalize the Solberg-Mold practice change model in quality improvement projects in primary care practices.
• Diffusion, generally considered to be a passive process, can be facilitated by PBRN researchers and member practices using a combination of assistance and incentives.
• Wave II practices showed improvements in care of CKD patients similar to Wave I practices but with less PF assistance.
• PBRNs are well-positioned to replicate this process for other evidence-based innovations.

The Errors of our Ways:
From behavioral co-location carve-out to transformed integration of care

Rodger Kessler Ph.D. ABPP
Fellow, Health Economics Unit
Assistant Professor of Family Medicine University of Vermont College of Medicine
Director, Collaborative Care Research Network, National Research Network Senior Scientist,
American Academy of Family Physicians
Clinical Associate Professor, Doctor of Behavioral Health Program Arizona State University
Doctoral Program
Critical Issues in Behavioral Integration

Same issues as those driving Primary Care Transformation

- Measurement
  - Patient Based
  - Practice Based
- Panel Based Focus on Complexity
- Transparent Bi-directional EHR with minimal text and extractable data fields used to impact care
- Implementation Science Driven Evidence Based Care
Most Co-Located Care is not Integrated into Medical Practice

- 40% of practices have a behavioral health clinician, almost 50% case managers meager substance abuse clinicians

- Referrals, referral tracking, scheduling, information sharing less well integrated than other medical sub-specialties

- Behavioral protocols: obesity 59%, insomnia 38% and headaches 34%.

*Kessler, Miller, Kelly, Graham and Kennedy et.al, JABFM 2014*
All Respondents (95)

Vermont Integration Profile 4.0
(VIP) updated 5Nov2014
Median scores from Managing Directors and Behavioral Health Clinicians

Other Results received:
3 - Practice Manager
3 - Managing Physician
0 - Student Intern
The components of value added Behavioral Intervention in the PCMH

• Combine medical and behavioral benefits into one payment pool
• Target complex patients for priority behavioral health care
• Use proactive onsite behavioral "teams"
• Match behavioral professional expertise to the need for treatment escalation inherent in stepped care
• Define, measure, and systematically pursue desired outcomes
• Apply evidence-based behavioral treatments
• Use cross-disciplinary care managers in assisting the most complicated and vulnerable.

Kathol DeGruy and Rollman 2014 AFM
Integration must involve measurement

• The Vermont Integration Profile
  -measures clauses of Peek’s Lexicon

Workflow  Workspace  Clinical Services
Model Identification  Patient engagement
Shared care plans  Follow up
All Respondents (95)

Vermont Integration Profile 4.0 (VIP) updated 5Nov2014

The VIP has 8 domains from 0 (absent) to 100 (continuously present). Within each domain, each bar represents a practice and line (orange) represents median value of responses.
An in process panel based example

- NIMH grant number Practice level Diabetes Intervention using PRO’s and EHR data to plan and deliver care
- Patient behavioral risk data become registry functions to assist in identification of cohorts
- Out of office patient reported data collection including patient assessment of willingness to work on an identified risk
- Team based care
EHR Clinical and Quality Improvement Compatibility

- Templated drop down populated clinical assessment and notes
- Bi directional access communication
- Same scheduling and rescheduling process
- Retrievable elements and easily accessed reports
- Clinical and claims data able to associate
Implementation Science Driven Evidence Supported Care

• Most behavioral care delivered is not evidence supported even when there is evidence based care available

• There is little relationship between emerging primary care integration developers and the Behavioral Medicine and Health Psychology research base

• Systematic PROCESS improvement focus to primary care behavioral integration is rare, despite evidence supported toolkits and resources
Conclusions

• Behavioral transformation rarely receives the attention that primary care transformation receives but must be held to the same standard.

• Until the population health measurement, informatics and systematic process improvement include a strong focus of transformation of behavioral care.

• Primary care is left with behavioral health co-location, not transformation.

• It is no longer a technological issue or research limitation, it is a primary care leadership and investigator issue.
Thank You!

Rodger Kessler Ph.D. ABPP
Mark Kelly
Jon van Luling
Andrea Auxier Ph.D.
Daniel Mullin Ph.D.
C.R. Macchi Ph.D.
Juvena Hitt
Benjamin Littenberg MD

https://redcap.uvm.edu/redcap/surveys/?s=vEpGbwyFE6
Polling Question:
Is integration of evidence-supported behavioral interventions an important element of PC transformation?
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- Questions will be read aloud by the moderator.
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Polling Question:
How frequently do you apply learnings from AHRQ PBRN Resource Center Webinars to PBRN-related work?
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