Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

December 22, 2020

Population Health Management: *How can I start thinking of patient care from a systems perspective?*

Denise Chang, MD

Speaker Disclosures

- No disclosures

Learning Objectives

- Define accountable care and describe how it relates to population health management
- Describe examples of quality aims in integrated care
- Understand how to apply QI concepts to the Principles of Collaborative Care

What I hope you take away today…

- Incorporate systems level view into patient care and your role as a psychiatric consultant
- Learn how to apply a Quality Improvement framework to your work

What we have covered so far….

Month	Topic/Activity
July 28 12:00 – 1:00 pm	Integrated Care Models: Where does my practice fall on the integrated care spectrum?
August 25 12:00 – 1:00 pm	Working with Behavioral Health Care Managers: How can I communicate effectively with BHCMs?
September 22 12:00 – 1:00 pm	Working in Primary Care Settings: How can I communicate effectively with PCPs?
October 27 12:00 – 1:00 pm	Implementing Integrated Care: How do I help my organization build and sustain a successful program?
November 24 12:00 – 1:00 pm	Best Systematic Caseload Review Practices: How can I most effectively use my time?
December 22 12:00 – 1:00 pm	Population Health Management: How can I start thinking of patient care from a systems perspective?

Question of the day

How will we know if our Integrated Care efforts are improving the health of our population?

What is Population Health?

"Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group."

Reference: www.ihi.org

Questions to ask yourself…..

- What is your target population?
- What is your system doing to improve behavioral health for your population?
- What other mental health services exist in your system?
- How does your Integrated Care practice fit into the larger mental health services within your organization?
  - Do you have a stepped care model?

How do you measure impact?

Step 1
- Select program metrics that reinforce CoCM principles

Step 2
- Review metrics regularly with clinicians and quality / implementation team

Step 3
- Identify potential areas for improvement

Step 4
- Apply QI methods to conduct iterative small-scale tests of change

Step 1

- Select program metrics that reinforce CoCM principles

FIDELITY TO CORE

SAMPLE METRICS

Population-Based Care

# of pts. on active caseload
% of caseload with > 2 contacts / mo
% of caseload with no contact for > 2 mo

Measurement-Based Treat to Target

% of pts. with PHQ-9 score in last 2 weeks
% of pts. not improved w/psych review in ≤ 4 wks
% of pts. with 50% decrease in PHQ-9 after 10 wks

Patient-Centered Collaboration

Frequency of case review meeting
% of pts. on with psych review note in EHR
Time to first (third) available appointment

Evidence-Based Care

HEDIS Antidepressant Medication Management
% of pts. with ≥ 8 sessions of BA / PST

Accountable Care

Step 2

- Review metrics regularly with clinicians and quality / implementation team

Week 4

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	3	1 (33%)	26	0 (0%)	-	-	26	0 (0%)	-

Week 8

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	6	3 (50%)	18	0 (0%)	-	0 (0%)	18	0 (0%)	-

Week 12

Site	# of Pts	CM Initial Assessmt	Mean PHQ-9	CM f/u	Mean # visits	2 Contacts / month	Last Mean PHQ-9	# w/ Psych Note	PHQ-9 Improvemt
A	17	16 (94%)	14.5	9 (56%)	3	0 (0%)	13.7	14 (82%)	2 (22%)

Step 3

- Identify potential areas for improvement

Program Maturity

New

Developing

Mature

Enrollment: *Are we enrolling everyone who would benefit?*

How are patients being screened for enrollment? How are referrals made and are they appropriate?

- Sample metrics: Active caseload size; % of eligible patients enrolled

Engagement: *Are we engaging all the enrolled patients into care?*

How are we engaging with enrolled patients? What outreach methods are employed (e.g., telephone, letter, EHR portal, warm connection at primary care visits)?

- Sample metrics: % of pts. with ≥ 2 contacts/mo; % of pts. with no contact for ≥ 2 mo

Patient Outcomes: *Are patients improving?*

How often are rating scales used? Is treatment to target occurring? What is the quality of treatment? Is treatment evidence-based, appropriate, and taking into account the full biopsychosocial assessment, patient preferences, and barriers? How are improved patients identified for relapse prevention? How often are we discharging patients to make room for new patients?

- Sample metrics: % of patients with 50% reduction in PHQ-9 after 10 weeks

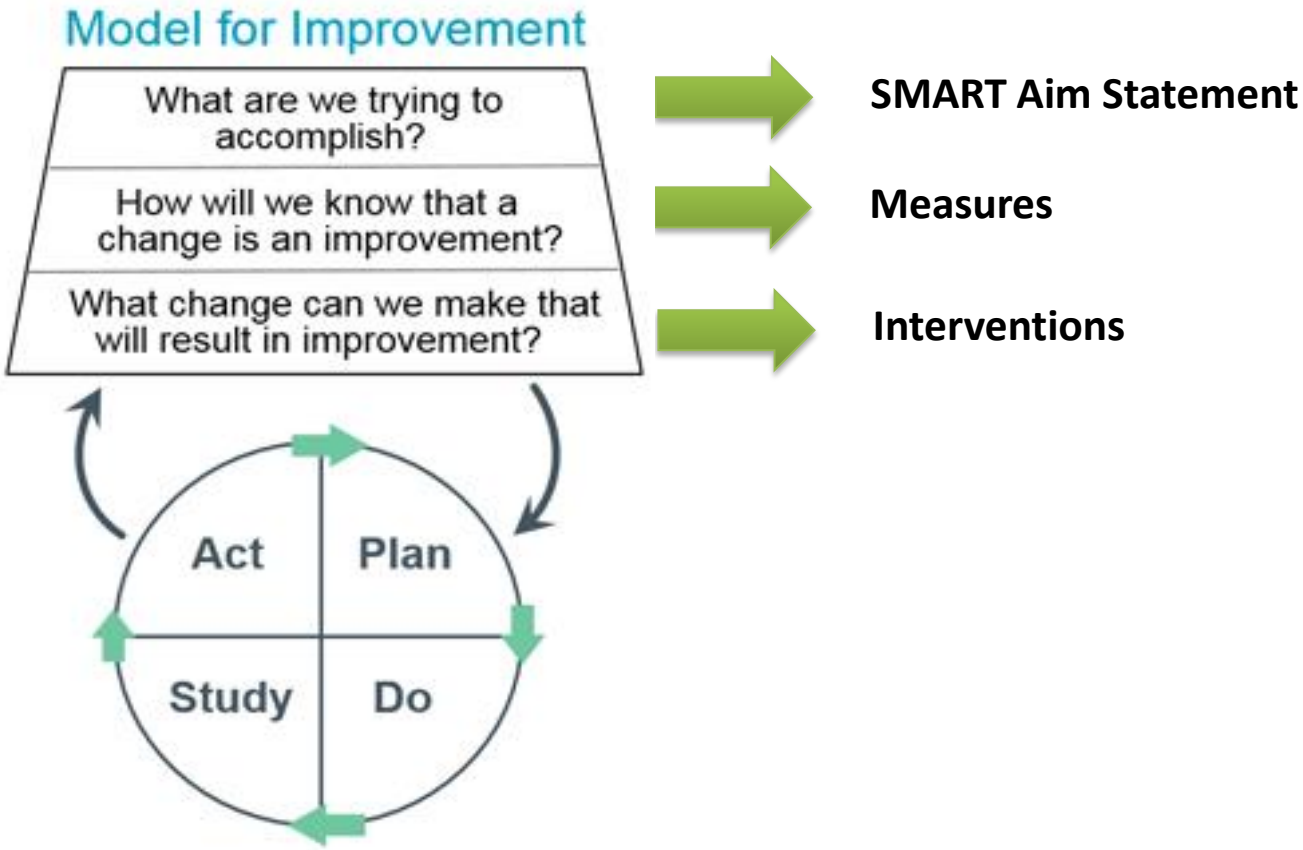
Psychiatric Consultation: *Is caseload review consistent and effective?*

How do team members prepare for case review? Is an agenda set in the beginning of the case review? How are patients flagged for discussion? How much time is spent reviewing each patient? How frequently are patients reviewed? How do you ensure patients that are not engaged in care do not 'fall through the cracks'?

- Sample metrics: % of patients not improved who receive psychiatric case review

Step 4

- Apply QI methods to conduct iterative small-scale tests of change



SMART Aim Statement

Measures

Interventions

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

Step 4

- Apply QI methods to conduct iterative small-scale tests of change

SMART Aim

Specific, Measurable, Achievable, Relevant, Timely

"We will increase the rate of depression improvement from 35% to 60% in 6 mos."

Interventions: Prioritize based on most important causes.

Pareto principle: 80% of effects come from 20% of causes.

Tools: Driver diagram, Fishbone diagram help identify potential intervention targets

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

Step 4

- Apply QI methods to conduct iterative small-scale tests of change

Measures: Think Broadly. Define precisely.

◊ Outcome measures. The final patient-oriented result.

- *What patient experiences.* Example: Depression remission

◊ Process measures. Whether the system is doing the right things to obtain the desired outcome.

- *What is done to/for the patient?* Example: % of pts. receiving ≥ 2 contacts/month

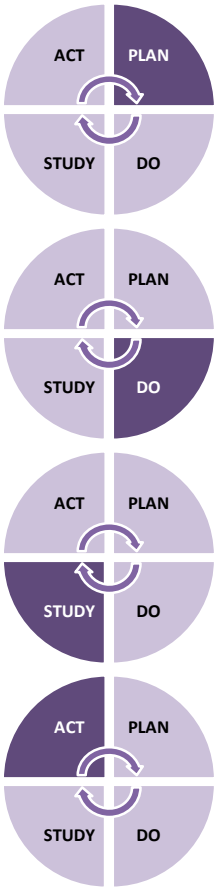
◊ Balancing measures: Unintended consequences or other factors that may affect outcomes.

- *How else does this affect the system?* Example: Team member turnover

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTipsforEffectiveMeasures.aspx

PDSA Cycle Overview

Iterative ***small*** tests of change. One test can reveal a fatal flaw.



Plan

Plan your test. Include your predictions. Plan data collection.

Do

Run your test on a small scale. Document observations and problems. Collect data.

Study

Analyze your results and compare them to your predictions. Summarize and reflect on your learning.

Act

Adapt (modify), adopt (scale up), or abandon (try a different idea). Plan your next PDSA.

What Can We Do By Next Tuesday?

Design a PDSA cycle that you can complete in less than a week.

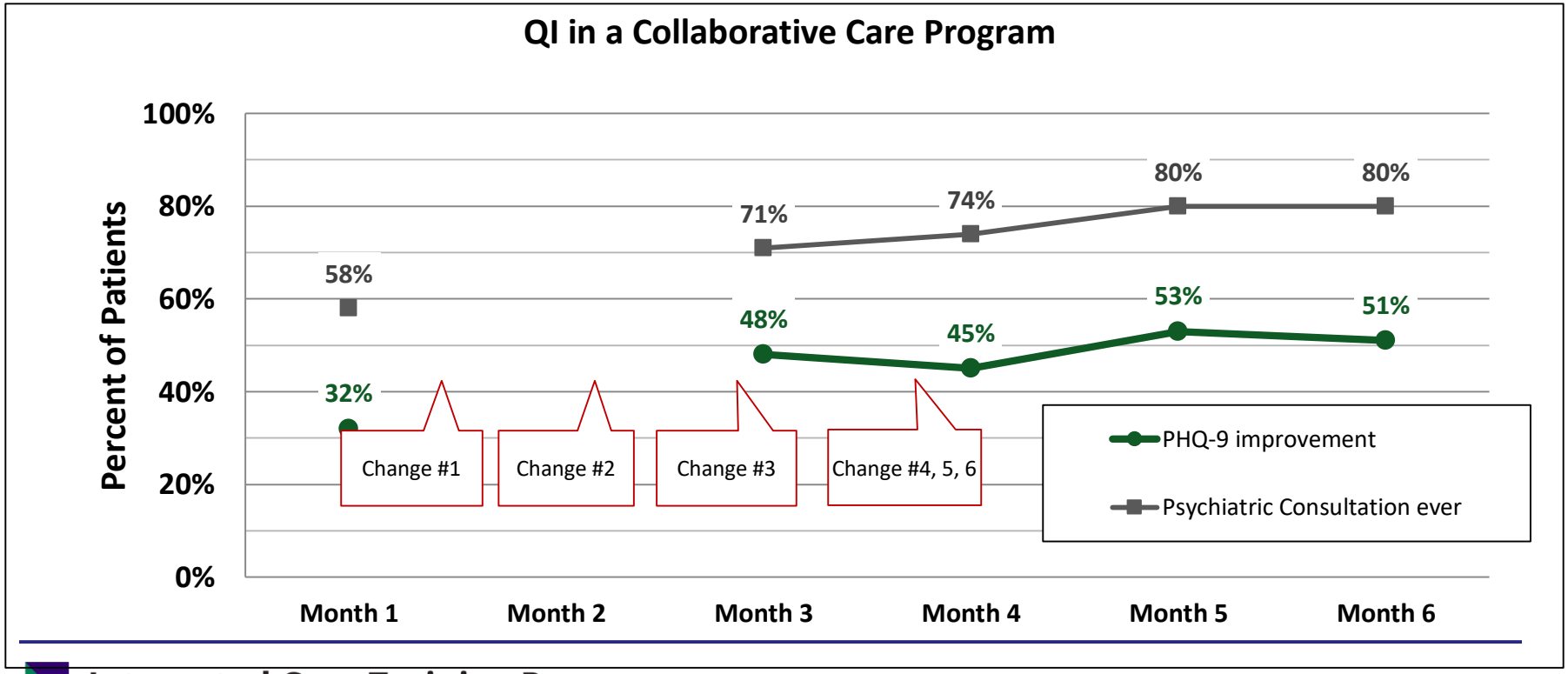
Example:

- Goal: Increase # patients achieving depression remission
- Attach PHQ-9 to patient registration paperwork for 3 days
- Measures:
  - % patients with PHQ-9 done
  - % patients with PHQ-9 > 10 and no treatment change
  - % patients with PHQ-9 < 5
  - Patient satisfaction with depression care

Step 4

- Apply QI methods to conduct iterative small-scale tests of change

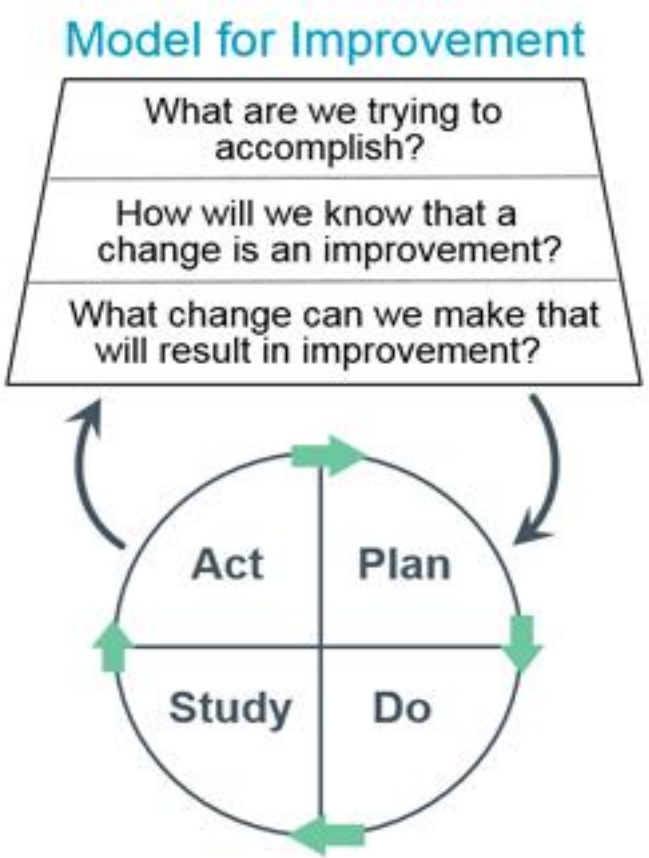
"We will increase the rate of depression improvement from 35% to 60% in 6 mos."



Integrated Care Training Program

Take Home Exercise

- When thinking of changes, don't forget to:
  - Link to your overall goal
  - Find meaningful metric (for clinic, ex: waitlist times)
  - And MEASURE it!!!



What can you do by NEXT TUESDAY?

Next time: Look at the larger health system perspective

- How does Collaborative Care fit into larger mental health services within your organization?

- How do you know your Integrated Care program is meeting the goals of the larger organization?

Takeaways

- Incorporate systems level view into patient care and your role as a psychiatric consultant
- Learn how to apply a Quality Improvement framework to your work
- *Resource:*
  - *Institute for Healthcare Improvement (www.ihi.org)*

Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link